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

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

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

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

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

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

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

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

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

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

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

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

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

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

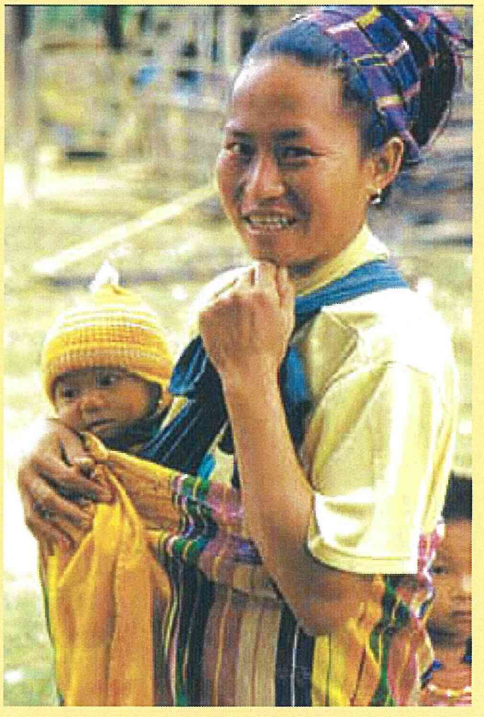
Key issues to consider in low-resource settings include:

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

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

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

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



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

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

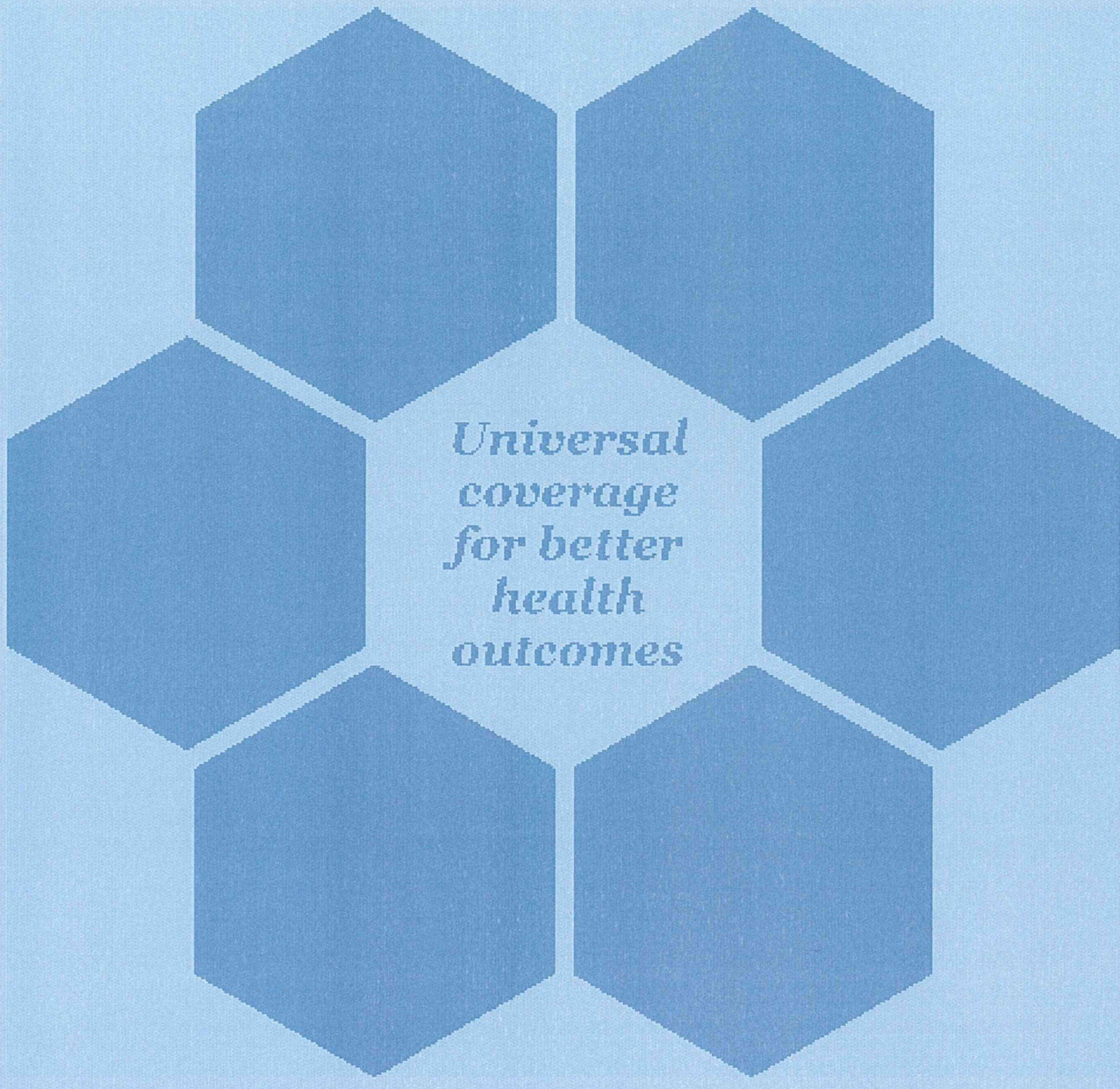

Universal
coverage
for better
health
outcomes

7 Commitments

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

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

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


Universal
coverage
for better
health
outcomes

Annex 1

WORLD HEALTH ORGANIZATION

ORGANISATION MONDIALE DE LA SANTÉ

RESOLUTION

REGIONAL COMMITTEE FOR THE WESTERN PACIFIC

COMITÉ RÉGIONAL DU PACIFIQUE OCCIDENTAL

WPR/RC61.R2
13 October 2010

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

The Regional Committee,

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

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

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

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

.../

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

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

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

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

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

2. URGES Member States:

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

.../

[1] Document WPR/RC61/5.

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

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

3. REQUESTS the Regional Director:

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

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

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

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

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

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

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

Annex 2A

HEALTH SYSTEMS INDICATOR TOOLKIT

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

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

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

a. Leadership and governance

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

Indicator No. 1: Policy Index Score

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

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

Indicator No. 2: Marker Indicators of Governance

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

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

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

b. Health care and financing

Indicator No. 1

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

Indicator No. 1a

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

Indicator No. 2

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

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

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

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

c. Health workforce

Indicator No. 1

- Number of health workers per 10 000 population

Indicator No. 2

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

Indicator No. 3

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

d. Medical products and technology

Indicator No. 1

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

Indicator No. 2

- Ratio of median local medicine price to international reference price for core list of drugs
- NB: There was no indicator for essential health technology or laboratory. It is proposed that a third indicator be added regionally:

Indicator No. 3

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

e. Information and research

Indicator No. 1

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

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

f. Service delivery

Indicator No. 1

- Number and distribution of health facilities per 10 000 population

Indicator No. 2

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

Indicator No. 3

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

Indicator No. 4

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

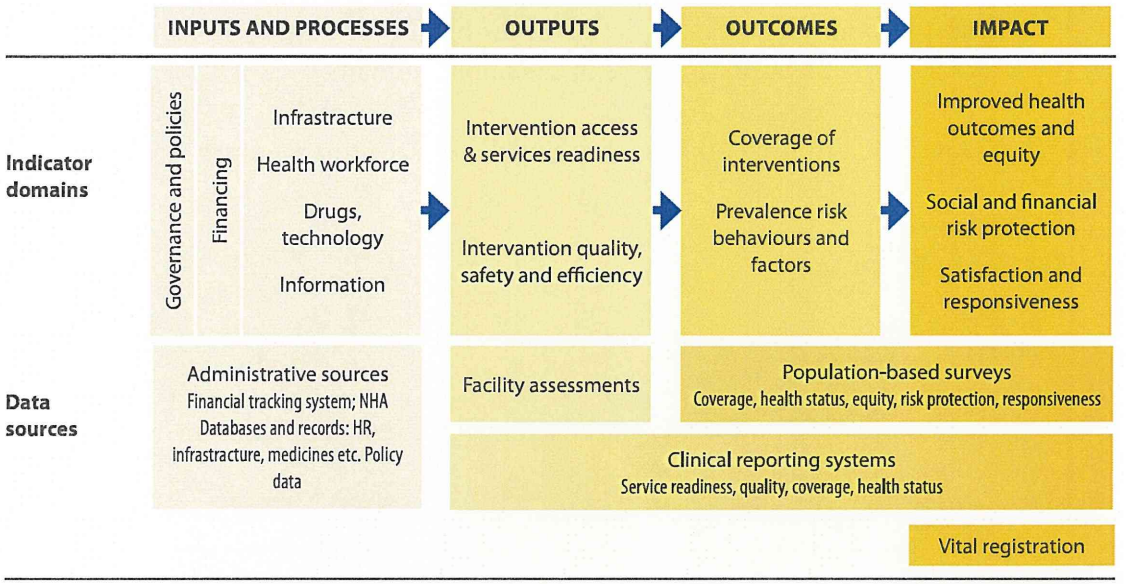
Indicator No. 5

- Service quality standard to be selected locally

Annex 2B

MONITORING AND EVALUATION OF HEALTH SYSTEMS REFORM

A general framework



Indicators: WHO core set

INPUTS AND PROCESSES	OUTPUTS	OUTCOMES	IMPACT
Health financing	***Service access and readiness***	***Coverage of interventions***	***Health status***
Total health expenditure per capita	Tracer medicines availability in health facilities	Antenatal care (4+ visits)	Life expectancy at birth
Health workforce	Median price ratio for tracer medicines	Skilled birth attendance	Child mortality (under-5)
Health workers per 10,000 population	Outpatient visits per person per year	DPT_3 immunization coverage	Maternal mortality ratio
Annual number of graduates of health training institutions per 100,000 population	***Service quality, efficiency and safety***	Contraceptive prevelance	Mortality by major cause of death by sex and age
Infrastructure and IT	Facilities that meet with minimum infection control standards (%)	Children with ARI to health facility	TB prevalence in population
Health facilities per 10,000 population	TB treatment success rate (DOTS)	Children with diarrhoea receiving ORT	HIV prevalence among adults
Hospital beds per 10,000 population	30 day hospital case fatality rate AMI and stroke	Household ITN possession	Notifiable diseases (IHR)
% of doctors using electronic health records	Waiting time to elective surgeries: cataract	Cervical cancer screening (20-64 years)	***Financial risk protection***
	Surgical wound infection rate (% of operations)	ARV therapy	Out of pocket as % of total health expenditure
		ARV prophylaxis among HIV+ women	
		Health insurance	
		Risk factors and behaviours	
		Tobacco use (adults)	
		Access to safe water	
		Access to improved sanitation	
		Low birth weight among newborns	
		Breastfeeding exclusively for 6 months	
		Obesity in adults	
		Children under 5 who are stunted	
		Condom use at last higher risk sex	

WHO list of core indicators

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

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

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

* Classification of "target":

●●● clearly set

●● can be set

● unclear/difficult to set

** HIC: High-income countries

LMIC: Low- and middle-income countries

Annex 3

LISTING OF RELEVANT GLOBAL AND REGIONAL STRATEGIES

World Health Reports

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

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

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

Regional Strategies

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

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

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

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

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

Annex 4

GROUPING OF COUNTRIES AND AREAS GEOGRAPHICALLY AND BY INCOME

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

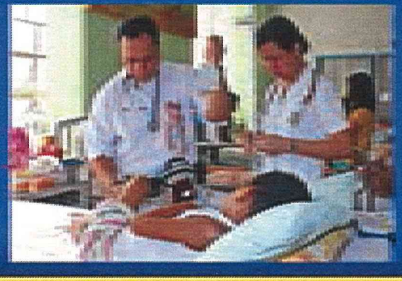
Source: Social determinants of health. Health in Asia and the Pacific. New Delhi, World Health Organization, 2008: 7-33. Available at http://www.wpro.who.int/publications/Health+in+Asia+and+the+Pacific.htm

WHO Western Pacific Region
PUBLICATION

ISBN-13
978 92 9061 501 9

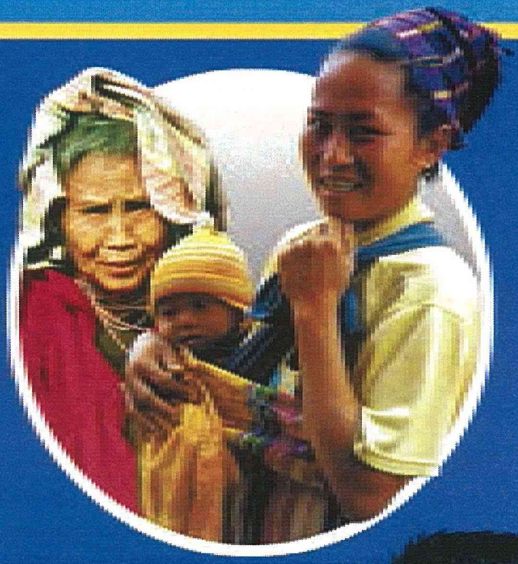
Regional Strategy for Health Systems Based on the Values of Primary Health Care

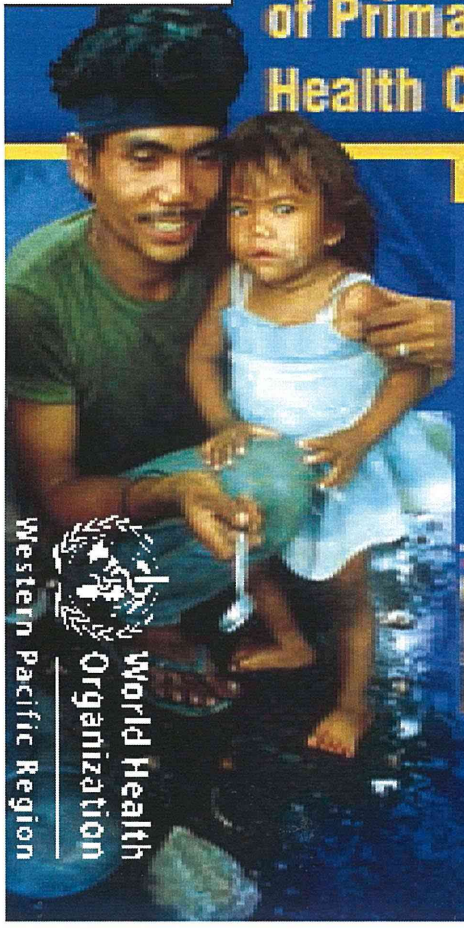
Vision:
Universal coverage for better health outcomes



Core values of PHC:

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





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

Leadership and governance

Government has responsibility for the people's health.

Health financing

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

Health workforce

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

Medical products and technology

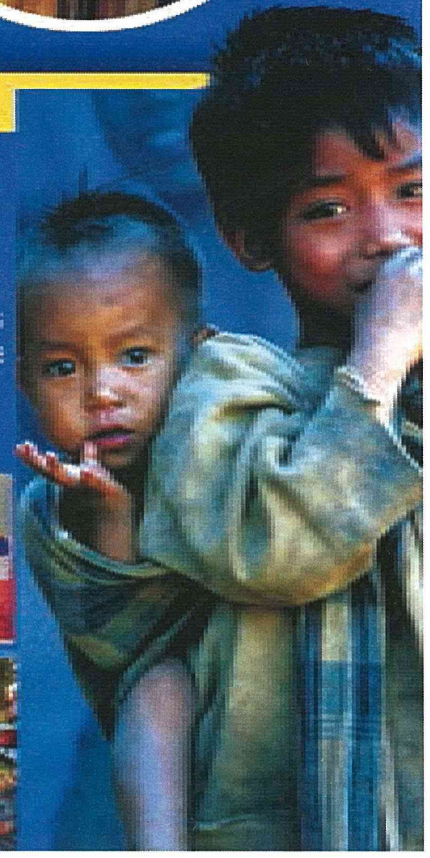
Access to safe essential medicines and technologies is the right of every patient.

Information and research

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

Service delivery

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



World Health Organization
Western Pacific Region