Universal health coverage on the journey towards Healthy Islands in the Pacific

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Abbreviations

CHW	community health worker
DPT	diphtheria, pertussis and tetanus
EAP	East Asia Pacific
LMIC	lower-middle income country
MHMS	Ministry of Health and Medical Services
MoH	Ministry of Health
NCD	noncommunicable disease
NDoH	National Department of Health (Papua New Guinea)
NRH	National Referral Hospital (Solomon Islands)
PEN	WHO Package of Essential NCD Interventions
PHA	Provincial Health Authority (Papua New Guinea)
PHC	primary health care
PHMM	Pacific Health Ministers Meeting
PICs	Pacific island countries and areas
PSC	Public Service Commission
RDP	role delineation policy
SDP	service delivery package
TB	tuberculosis
THE	total health expenditure
U5MR	Under-Five Mortality Rate
UHC	universal health coverage
VHW	village health worker
WB	World Bank
WHO	World Health Organization

Executive summary

Pacific health ministers committed to the Healthy Islands vision in 1995. The vision emphasizes the importance of health service delivery to ensuring that children and adults can grow, learn, play and age with dignity. Combined with a focus on the community, the Healthy Islands approach has strong links to the notion of health services for all, or universal health coverage (UHC). In 2015, Pacific health ministers further committed to pursue their vision by ensuring that service delivery is based on UHC principles (WHO, 2015d).

In addition to regional commitments, UHC principles have been embedded within the national health policy frameworks in many Pacific island countries and areas (PICs). This report focuses on the subsequent challenge of implementing UHC. Experience from across the Pacific and globally suggests that the best trigger for progress towards the Healthy Islands vision and UHC for most PICs will be a focus on refining and strengthening primary health care (PHC). PHC is the foundation of the health system and the most equitable and efficient approach for UHC, with a strong affinity with the Healthy Islands vision.

The status of UHC across PICs considered in this report is varied. While indicators for health outcomes and service coverage show overall improvement over the last few decades, a number of PICs have shown mixed results in some health indicators in the last decade. Total health expenditure per person in most PICs is comparable to other countries with similar levels of income, although with higher public expenditure and lower out-of-pocket costs. However, in many PICs, real expenditure[1] per person is stagnating or decreasing due to modest economic growth as well as less predictable and decreasing donor funding. Papua New Guinea, which represents 80% of the Pacific population, is experiencing a decrease in health expenditure, potentially reversing past health gains. Mobilizing domestic resources and prioritizing health within a sustainable macroeconomic framework remain essential.

Building and maintaining healthy, prosperous communities in most PICs will require currently available resources to be used in the most equitable, efficient and effective way possible. On the other hand, in some contexts efforts are needed to prevent or reverse the negative trend in health financing, for example by pursuing funding from domestic, regional and/or international sources.

A literature review, interviews and a technical consultation identified three cross-cutting and interrelated implementation challenges faced by PICs in pursuing the Healthy Islands vision and UHC, with a particular focus on PHC. They are:

I. using the right health service delivery models at the PHC level, with a particular focus on integration of both public health and clinical services, and improving coverage of noncommunicable disease (NCD) services;
II. increasing the share of resources allocated to lower-level health facilities and community-based services for PHC; and
III. improving managerial, administration or supervisory capacity to ensure that resources reach lower-level health facilities.

[1] Real expenditures are adjusted to reflect the impact of inflation (or deflation) over time.

All of these challenges require strong political will across governments and within the health system. With such leadership, efforts currently under way to overcome these challenges across the Pacific include articulating service models and packages, planning and budget reforms, and strengthening administrative services and human resource management.

This report sets out practical actions to overcome these challenges to implementation. In doing so, these recommendations suggest how countries can best implement both national and regional commitments, including those in the most recent statement from the Pacific Health Ministers Meeting, the 2015 Yanuca Island Declaration. The recommendations call for efforts to:

I. strengthen, demonstrate and sustain political will for action;
II. determine the right services and the right models to achieve UHC;
III. plan and budget resources for UHC; and
IV. strengthen health workforce management.

The report also makes specific recommendations to development partners on how they can best support the journey towards the Healthy Islands vision across PICs.

1 Introduction

Pacific island countries and areas (PICs) have adopted a unifying, long-term, cross-sectoral vision for health development based on the notion of Healthy Islands. Ensuring access to quality health services for individuals and communities or universal health coverage (UHC) forms part of this vision.

The aim of this report is to assess:

- the potential contribution of UHC to the Healthy Islands vision;
- the current health-care needs, coverage of and access to essential services in PICs, and associated implementation challenges;
- the successes in implementation of strategies to improve, maintain and extend coverage of and access to essential services; and
- recommendations for implementation to progress towards UHC and Healthy Islands by 2030.

The report is based on a synthesis of data gathered through:

- a review of peer-reviewed literature on Healthy Islands and grey literature on Healthy Islands and UHC for each country;
- available data from the Healthy Islands Monitoring Framework, WHO's Global Health Observatory, the World Bank (WB) World Development Indicators and country-level core indicators on the status of UHC;
- nine interviews with Heads of Health or their delegate from eight PICs;
- a technical consultation with experts from countries, development partners and independent members of the UHC Technical Advisory Group in March 2017; and
- a consultation with Pacific Heads of Health during their meeting in April 2017.

This report begins by examining the links between Healthy Islands, UHC and primary health care (PHC), drawing on national, regional and global frameworks (Section 2). It describes the status of UHC in the Pacific (Section 3) and current implementation challenges (Section 4). The report then details current efforts towards UHC and Healthy Islands in PICs, highlighting examples of successful implementation (Section 5). It concludes with recommendations for progress implementation (Section 6).

2 Healthy Islands and UHC

The Healthy Islands vision

Pacific health ministers reaffirmed their commitment to the Healthy Islands vision during the 20-year anniversary of the Pacific Health Ministers Meeting (PHMM) in 2015. Originally endorsed by the ministers in 1995, Healthy Islands are places where:

- children are nurtured in body and mind;
- environments invite learning and leisure;
- people work and age with dignity;
- ecological balance is a source of pride; and
- the ocean which sustains us is protected.[2]

A recent 20-year review of the vision of Healthy Islands found that it provides leaders across the Pacific with a unifying, long-term vision for improving health outcomes (WHO, 2015a). It recognizes the importance of addressing the social and environmental determinants of health and emphasizes cross-sectoral action, particularly with respect to education, nutrition and environment. It also places importance on "the capacity of local institutions to prevent, treat, rehabilitate and palliate diseases and their consequences" (WHO, 2015a, page ix).

Health service delivery is thus essential to the Healthy Islands vision ensuring that children and adults can grow, learn, play and age with dignity. Combined with a focus on "family and community values, the foundation of Pacific culture", Healthy Islands has strong links to the notion of health services for all, or UHC (PHMM, 2015). This is supported by global evidence that universal access to key services improves health outcomes; a study of 153 countries found that improved coverage of health services leads to better health, especially for the poor (Moreno-Serra & Smith, 2012). The links between the Healthy Islands vision and UHC were concretized in the 2015 Yanuca Island Declaration in which Pacific health ministers committed to pursue the Healthy Islands vision by working towards "a defined package of services based on UHC principles" (PHMM, 2015).

UHC as part of the Healthy Islands vision

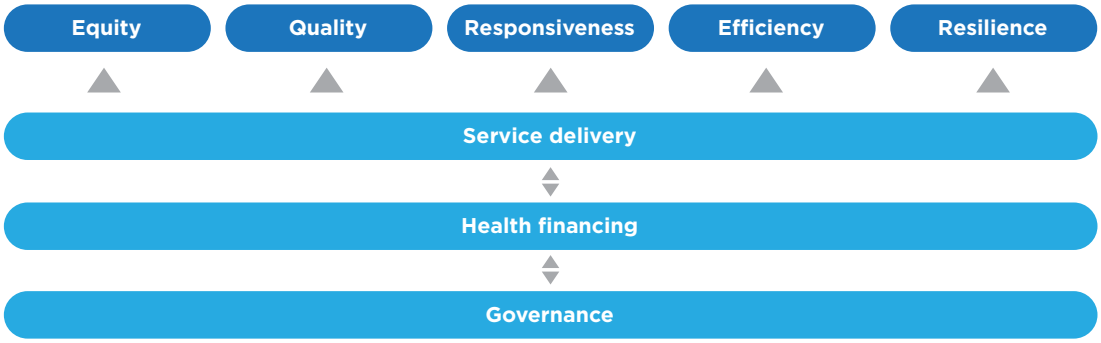
UHC is based on the principle that all individuals and communities should have access to quality essential health services without suffering financial hardship and is a major part of the Sustainable Development Goals agenda (WHO & WB, 2017). UHC has classically included three components: the health services covered, the population covered and the extent of financial protection given to the population. More recent descriptions of UHC attempt to build on the lesson that achieving UHC in practice necessitates equal emphasis on equity, quality and efficiency, as well as recognizing the importance of health systems strengthening.

Thus, the recent UHC Action Framework for the Western Pacific Region, endorsed by 37 countries in October 2015, takes a broader view of UHC (WHO, 2016). It sets out five essential health system dimensions that are necessary to achieve UHC, and that have been largely adopted in a new framework for health systems strengthening and UHC, published by the World Health Organization

[2] Added at the 1999 meeting in Palau.

(WHO) and World Bank (WB) in 2017. These five dimensions are: *equity*; *quality*; *responsiveness or accountability*; *efficiency*; and *sustainability or resilience*. As shown in Fig. 1, these five dimensions are achieved through improvements across three entry points – service delivery, health financing and governance.

Figure 1. A framework for health systems strengthening and UHC



Source: WHO & WB (2017).

The five dimensions set standards for promotive, preventive, curative and rehabilitative services provided through community-based programmes, in facilities (primary, secondary or tertiary level) or at the regulatory level to achieve UHC in a given context. The Sustainable Development Goals define UHC with respect to "essential services" – maternal and child health, communicable and noncommunicable disease, and public health interventions that have been shown globally to have the largest impact on health outcomes. Yet the choice of services provided as part of UHC at different levels of the health system is a political, economic and technical decision that will differ from country to country based on the disease burden and resources (WHO, 2014).

Each of the five UHC dimensions is also strongly embedded within actions to further the Healthy Islands vision that were endorsed by Pacific health ministers in their most recent meeting, as reported in the 2015 Yanuca Island Declaration (PHMM, 2015). Table 1 defines each of these dimensions and includes extracts from the 2015 Yanuca Island Declaration. The only dimension that was not well referenced by the Pacific health ministers in their most recent meeting was financial equity or protection from financial hardship. Most health services in the Pacific are tax-funded, publicly provided health services. Thus, in most PICs, ensuring financial protection is less of a challenge than in other contexts. However, in some countries for some services, fees to either public or private providers, or transport costs can be a deterrent to seeking or utilizing care and are a growing issue. In addition, the growth of demand for specialized tertiary care both domestically and internationally, which may be purchased privately or publicly, is putting pressure both on household and government budgets. Mobilizing domestic resources through taxation and prioritizing health within a sustainable macroeconomic framework remain critical challenges, particularly during periods of economic recession.

As shown in Table 1, realizing the Healthy Islands vision is dependent upon achieving UHC and this is well reflected within the regional policy framework. The five dimensions of UHC are also strongly intertwined in the national health policy framework in many PICs.

Table 1. Links between the five dimensions of UHC and Healthy Islands

Dimensions	**Definition of the dimension** (WHO & WB, 2017)	**Link to the Healthy Islands vision from the 2015 Yanuca Island Declaration** (WHO, 2015d)
Equity	Equitable access to needed services and protection against financial hardship.	• "Consider equitable access, especially for remote and rural populations" • Limited references on financial equity
Quality	The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.	• "Ensure adequate facilities and well-trained staff..." • "Foster a community empowerment and engagement approach in our programmes..."
Responsiveness or accountability	The extent to which a health system meets people's expectations and preferences concerning non-health matters, including the importance of respecting people's dignity, socio-cultural beliefs and preferences, autonomy and the confidentiality of information.	• "Strengthen Pacific leadership, governance and accountability" • "Improve the quality of data and evidence for policy- and decision-making, resource allocation and progress tracking" • "Involve communities in managing health facilities"
Efficiency	The extent to which available inputs generate the highest possible level of health outcomes. Avoid waste or poor operational performance in the production of health services or outcomes (technical inefficiency) or a suboptimal choice of inputs, such as a mix of labour skills (allocative inefficiency).	• "Define a service delivery package for the level of primary health care to meet population needs ..." and also consider "reviewing the distribution of budgets to reflect the need for a greater focus on preventive work" • "Develop and improve leadership and management capacity... deploy and retain competent managers in critical services and programmes" • "Integrate... immunization with other programmes, such as the Package of Essential Noncommunicable Disease Interventions for Primary Health Care"
Sustainability or resilience	The capacity of health actors, institutions and populations to prepare for and effectively respond to crises; maintain core functions when a crisis hits; and, informed by lessons learnt during the crisis, reorganize if conditions require it.	• "Develop, update and implement national action plans on disaster management for health that include prevention, preparedness, response and recovery..." • "Build comprehensive health surveillance and early warning systems..." • "Make health-care facilities... safe to ensure uninterrupted service delivery during disasters."

Time to refocus on implementation of Healthy Islands and UHC: primary health care as a starting point

As all PICs have committed to working towards realization of the Healthy Islands vision and UHC through both regional and national commitments, it is time to focus on implementation of these goals. PICs have made significant improvement in health outcomes in the last few decades. However, challenges remain and more recent health outcomes and the coverage of essential services show mixed results (further detailed in Section 3). There is a growing sense among politicians, citizens, ministries of health and commentators that more should be achieved, with the 20-year Healthy Islands review reporting widespread concern of "deteriorating levels of the local health response on many islands" (WHO, 2015a).

Reversing these trends requires acknowledging the current contextual challenges. Increasing, yet dispersed and isolated, populations with heightened expectations of health care, as well as growing noncommunicable disease (NCD) burdens, combined with an unfinished communicable disease agenda in some contexts, make service delivery more complex (WHO, 2015a). Decline in the accessibility and quality of rural and remote health services has likely contributed to their bypassing and the overutilization of hospitals in urban centres. At the same time, there is limited opportunity for increased internal or external resources to fund health services.

In this context, Pacific health ministers rightly declared in their most recent meeting that "business as usual is no longer acceptable" (PHMM, 2015; WHO, 2015a). With this statement in mind, this report builds on the recommendations that the ministers adopted in their last meeting in 2015 and focuses on how to implement them based on successes from across the Pacific. Drawing on the WHO and WB UHC framework, it looks at actions that can be taken across the three entry points to do so.

Experience from across the Pacific and globally, as recognized in the new WHO and WB UHC framework, suggests that the best way to work towards the Healthy Islands vision and UHC for most PICs will be a focus on strengthening PHC (WHO & WB, 2017). PHC provides a foundation for the health system and has a strong affinity with the Healthy Islands vision in a number of ways. First, it is through PHC that most Pacific islanders will gain access to the essential health services they need to grow, learn, play and age with dignity, and that the health system can help create Healthy Islands. Second, PHC places equal emphasis on both preventive and curative services and cross-sectoral action envisaged in the Healthy Islands approach. PHC also places emphasis on the ongoing relationship between people and the health workers who respond to their changing health needs over their life course and serve as their guide through the health system, providing referral and follow-up as needed (Childs Graham, 2016; WHO & WB, 2017).

PHC is not a new idea in the Pacific or globally, but it needs ongoing emphasis and support. There is mounting evidence to support its role as a starting point for UHC and Healthy Islands (WHO & WB, undated; Childs Graham, 2016) as follows:

1. PHC improves health outcomes and helps countries to reduce child mortality rates and increase life expectancy, according to studies of its impact (Hsieh et al., 2015).
2. PHC meets most of the health needs (estimated at 90%) of most of the population, most of the time, reducing pressure on other parts of the system and increasing efficiencies.
3. PHC reduces inequities as poor, rural and remote populations are more likely to use PHC.
4. PHC can help provide an early warning system when disease outbreaks emerge and respond to crises that arise.

PHC is thus the most equitable and efficient way to ensure UHC and essential health service packages – services that are likely to enable maximum gains in health outcomes based on the disease burden and patterns of vulnerability – reach the entire population (WHO & WB, 2017). These include services that are often categorized within "public health" and "clinical" frames. PHC offers the most cost-effective means to cope with many of the social and health challenges of all population groups, including the elderly. Making these services available through PHC could be achievable within the current fiscal envelope for some countries in the Pacific, given the potential to make efficiency gains at all levels of the health system.

Strengthening PHC will require sustained political will for change from politicians, within health sectors and from citizens to refine the health service delivery model, reallocate resources to PHC and ensure those resources get to where they are needed. PHC is a long-term investment to improve health outcomes, but will also lead to short-term gains in improved health system performance and reduced loads at secondary and tertiary health-care facilities.

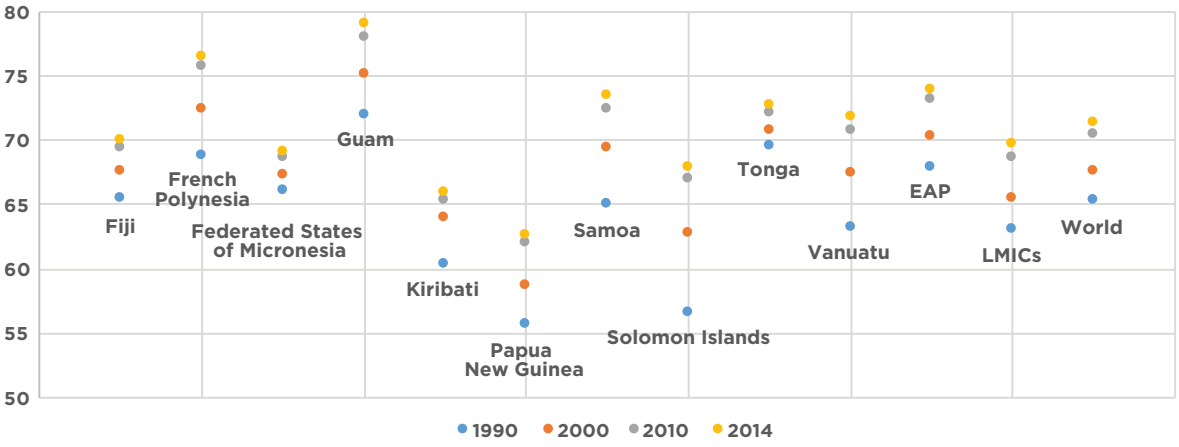
3 | Status of UHC in the Pacific

This section examines key indicators used to assess UHC on health outcomes, health service coverage and resourcing for UHC. While there is a wealth of information collected at facilities in many PICs, ministries of health are in the process of more systematically collecting, analysing and making use of these data within health information systems. Thus the data that are publicly available do not yet give a clear picture of service coverage in a comprehensive manner and in a way that is comparable across countries. Health Systems in Transition reviews also provide a wealth of information on health systems and health service coverage, but are only available for Fiji, Solomon Islands and Tonga at this stage (WHO, 2011, 2015b, 2015c). Hence, this section mainly uses data from the global-level estimation.

Possible recent stagnated progress in health outcomes in some countries

While trends in health outcomes in the Pacific are varied and on the whole improving, improvements in some countries remain volatile or are stagnating. For example, life expectancy in some countries was above the world average in 1990, but had dropped below it by 2014. Between 2000 and 2014, only two PICs surpassed the rate of increase in life expectancy across lower middle-income countries (LMICs) (Fig. 2). This trend may be partly explained by the onset of the NCD epidemic in PICs.

Figure 2. Life expectancy at birth (years), both sexes in 1990, 2000, 2010 and 2014 in PICs



EAP = East Asia Pacific (excluding high-income countries); LMICs = lower middle-income countries
Source: World Bank, World Development Indicators. May 2017

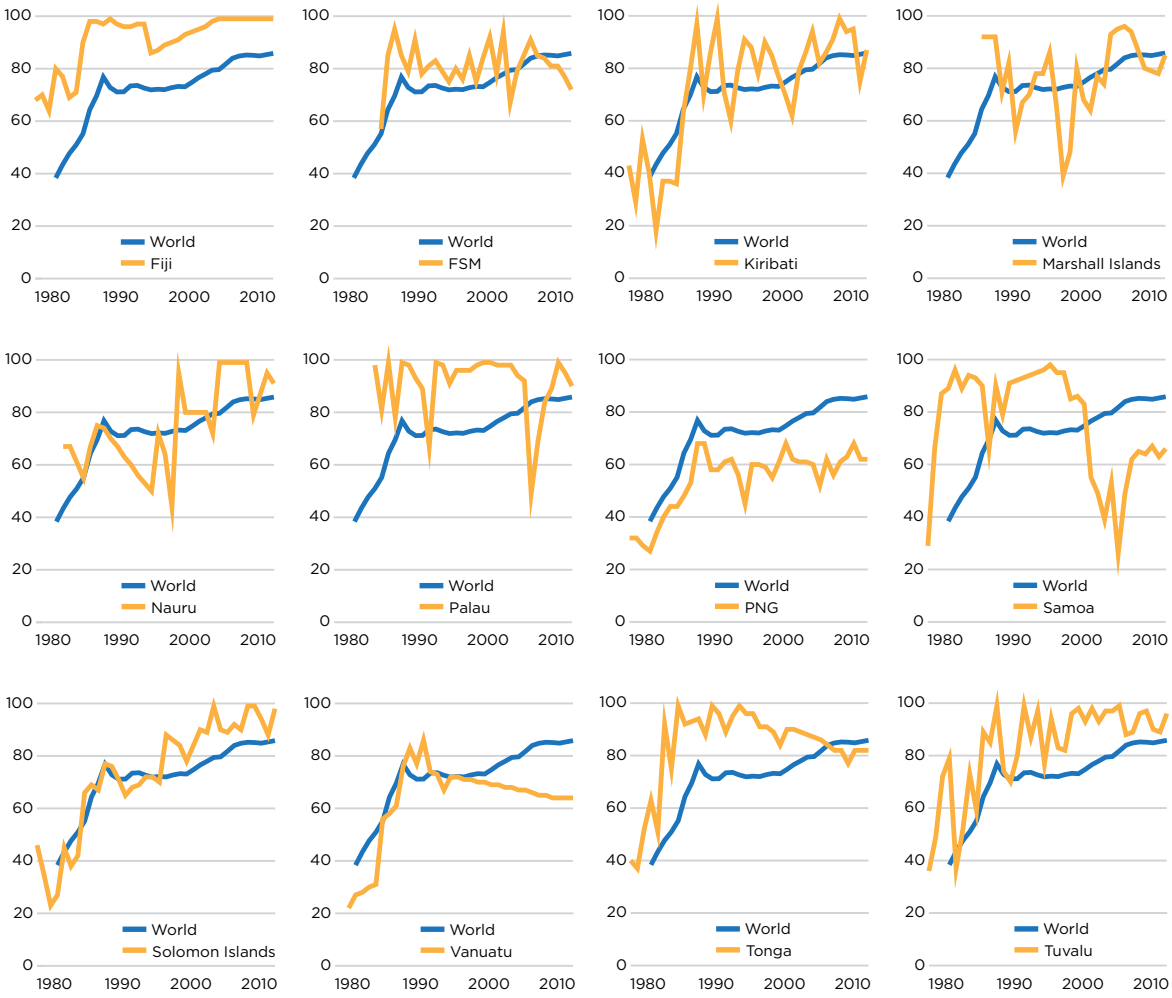
Under-five mortality rates (U5MR) show a pattern similar to life expectancy patterns (data not shown). Although rates are difficult to measure in most PICs due to the small population sizes, the U5MR is useful to show trends over time compared to the other groups. Among PICs with a U5MR of less than 80 deaths per 1000 live births in 1980, some countries made large gains until around 1990, but no country kept up with the rate of change between 1990 and 2015 in the East Asia Pacific (EAP), excluding high-income countries. Similarly, in PICs with a U5MR of greater than 90 in 1980,

progress in reducing the U5MR has stagnated in the past decade and reductions have not kept up with changes across LMICs. Demographic and Health Surveys data in some PICs also show an inequity of U5MR between the poor and the rich (data not shown).

Gaps and inequities in coverage of key interventions

Mixed health outcomes are mirrored by trends in service coverage. For example, with respect to diphtheria, pertussis and tetanus (DPT) immunization, most PICs made great progress before 1990, but coverage has been more varied since then, as shown in Fig. 3.[3] Data show considerable fluctuations across PICs. There may be a number of reasons for this: the quality of the data, the reliance on campaigns to achieve coverage and fluctuations in financing.

Figure 3. Proportion of children (12–23 months) immunized with DPT (3 doses), 1980–2015



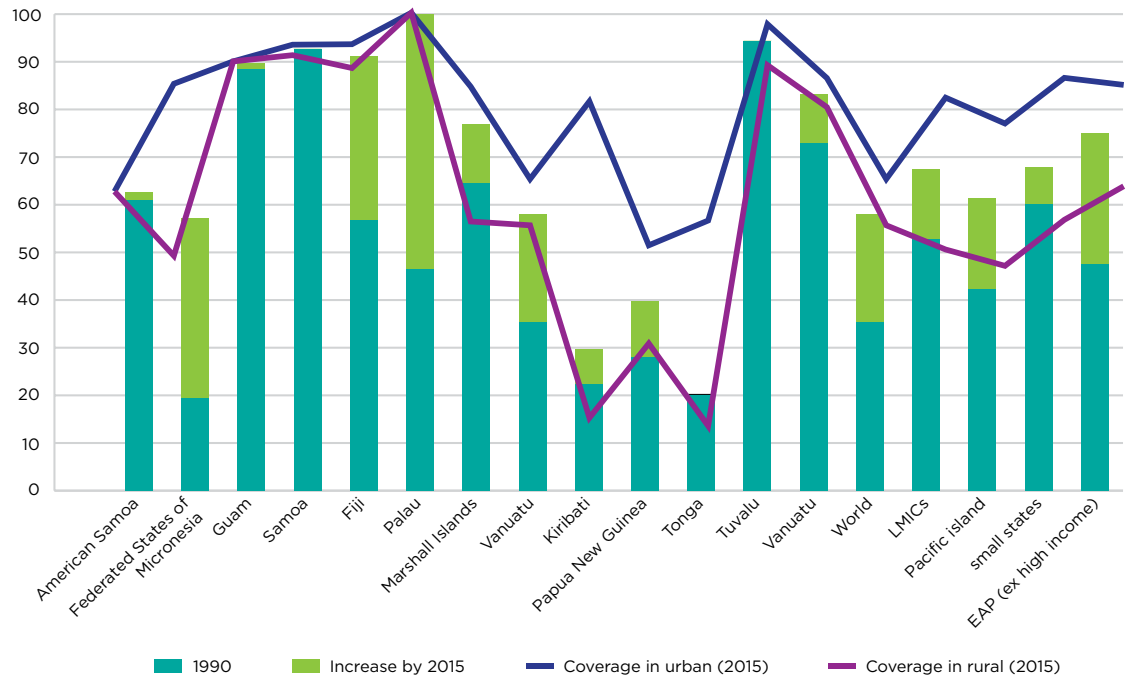
Source: World Bank, World Development Indicators. May 2017

[3] Data were sourced from the international World Development Indicators database to allow for comparison and may differ from country data.

Many PICs now produce disaggregated data on service coverage at the subnational level. In Papua New Guinea and the Federated States of Micronesia, where these data are available online, there was considerable variation in immunization coverage across provinces/states (data not shown).

Some countries have made good progress in some areas, including on access to improved water sources, as shown in Fig. 4. Vanuatu (+32%) and Kiribati (+17%) made the greatest progress among PICs between 1990 and 2015. Collectively PICs averaged slightly higher access to improved water sources compared to LMICs by 2015, but slightly lower than the rest of the EAP region (excluding high-income countries). However, there were gaps between rural and urban populations in many PICs and some PICs are lagging behind.

Figure 4. Proportion of population with access to improved water sources, 1990–2015



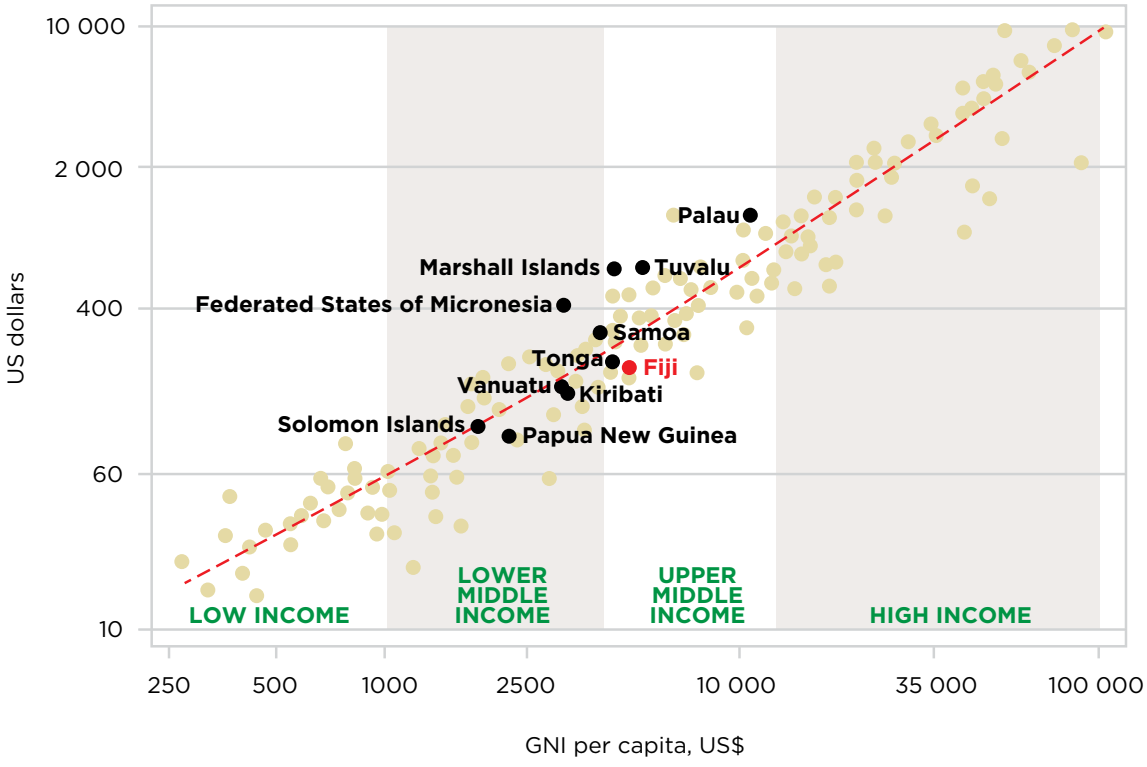
Note: Nauru and Solomon Islands only have data from 1997 and 2000 onwards, respectively.
Source: World Bank, World Development Indicators. May 2017

Constrained resourcing for UHC

While the 20-year review of the Healthy Islands vision questioned whether sufficient funds had been available for health in the Pacific since 1995, taking into account the costs of serving small, remote and dispersed populations (WHO, 2015a), total health expenditure (THE) per person in most PICs is comparable or greater than spending in other countries with similar levels of income (Fig. 5).

However, with the exception of a few countries that show slight increases, many PICs have stagnating or decreasing real THE per person after adjusting for the impact of inflation or deflation over time (Fig. 6). In some countries, this is because, despite nominal increases, relatively high population growth and/or inflation have translated into stagnation or decreases in real health expenditure per person. In other countries, this is because nominal THEs have not increased. In Papua New Guinea, where 80% of the region's population resides, both nominal and real health expenditure has been decreasing since 2013 due to reduced revenue and reduced allocations to the health sector from the national government budget (WB, forthcoming[a]), potentially reversing past health gains.

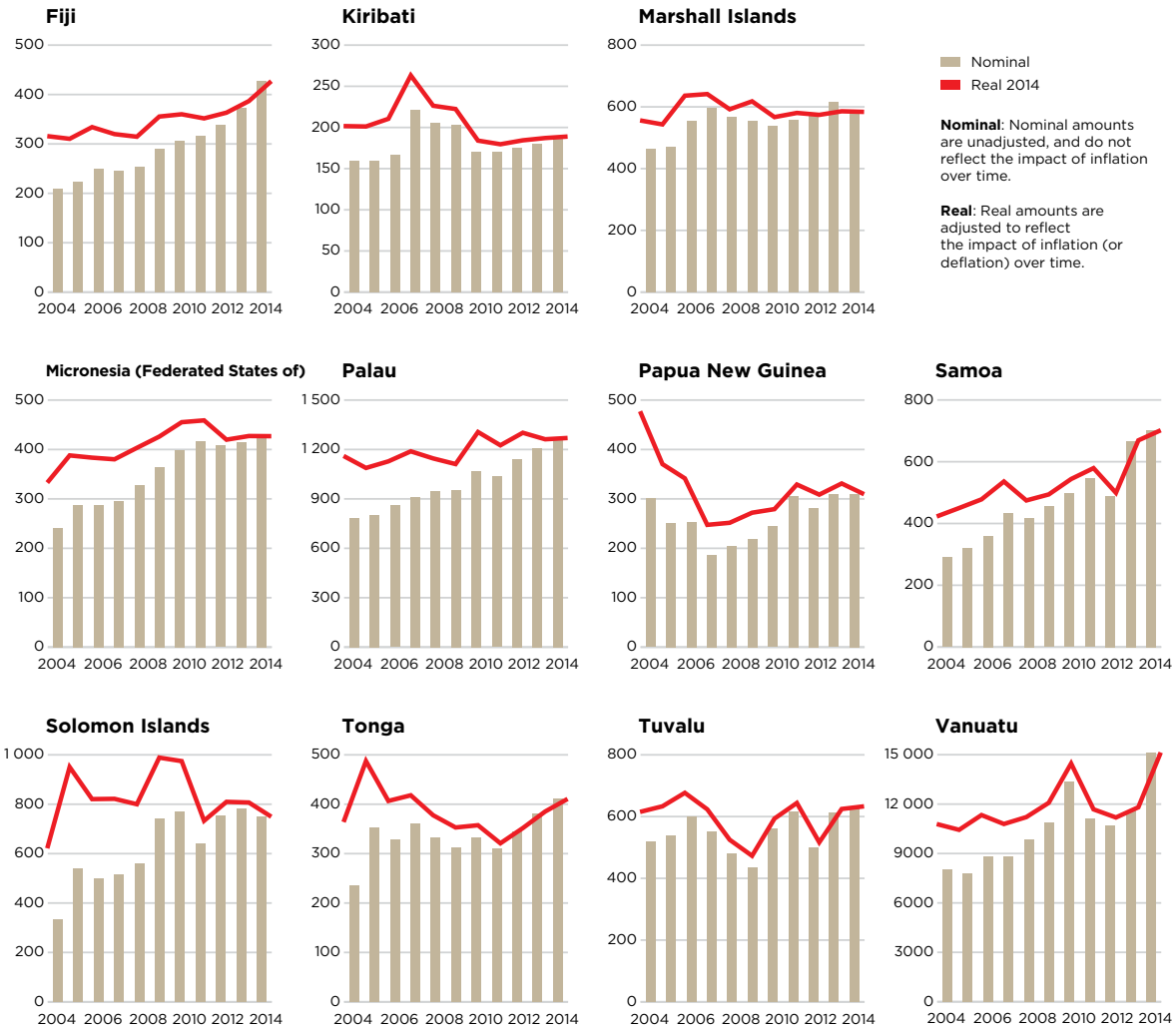
Figure 5. THE per person versus income 2014, in US dollars (average exchange rate)



GNI = gross national income

Sources: World Bank, World Development Indicators and WHO Global Health Observatory. May 2017

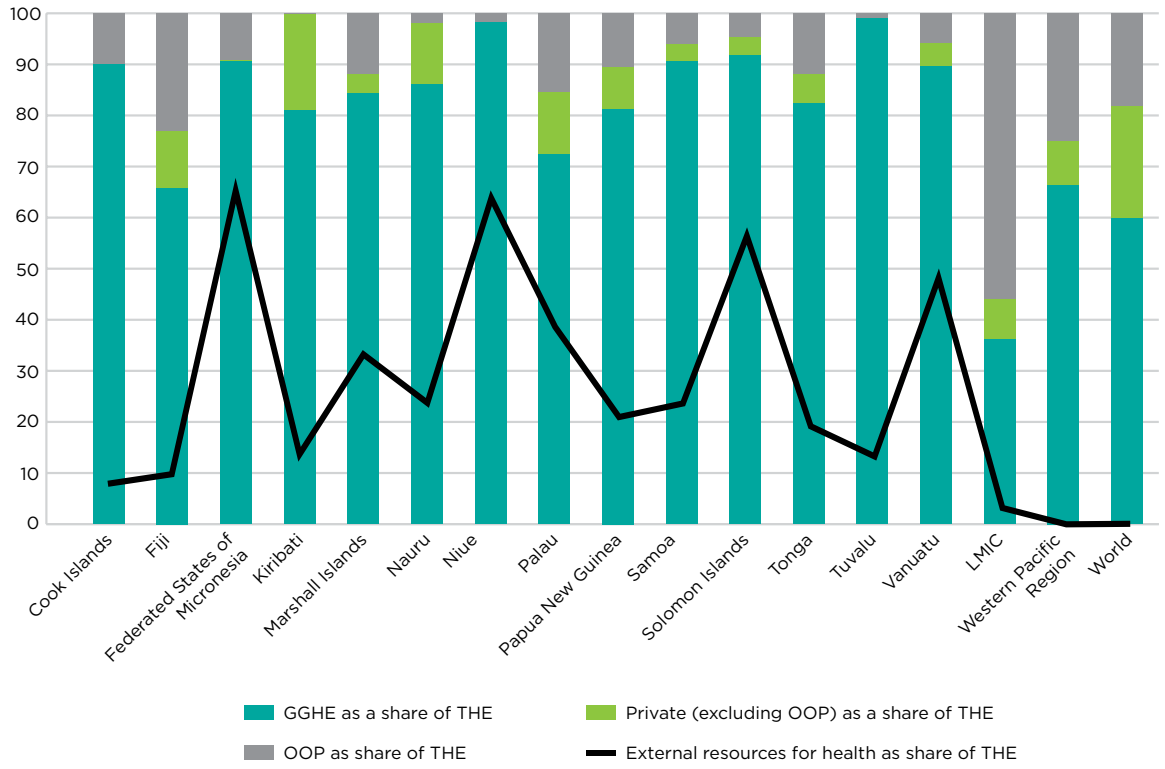
Figure 6. Nominal and real THE per person, 2004–2014



Source: World Bank, World Development Indicators. May 2017

Health expenditures in PICs are predominantly public – in some cases, with a relatively high reliance on external support and on low out-of-pocket payments (Fig. 7). Total government health expenditure as a share of total government expenditure is high in most PICs compared to other countries with similar levels of income (data not shown), and governments often spend as much as 10–15% of their total expenditures on health. Papua New Guinea is an exception to this, spending 6.8% of general government revenue on health in 2014 (WB, forthcoming[a]). In most PICs, people contribute to general revenue while they are healthy through income and consumption tax, and receive free or low-cost health services when they get sick, regardless of their level of income or capacity to pay at that point in time. However, transport costs can be a deterrent to seeking or utilizing care and there is increasing private and public expenditure in purchasing specialized tertiary care both inside and outside national borders.

Figure 7. Composition of THE in PICs, 2014

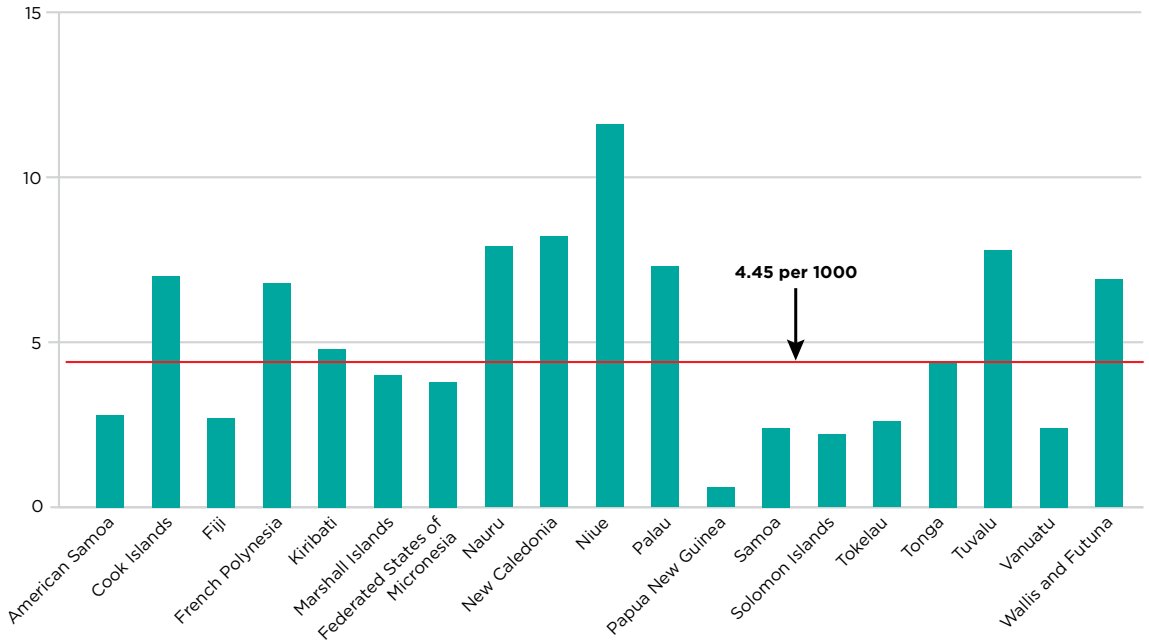


Source: Global Health Observatory, May 2017

External resources account for a larger proportion of THE in many PICs compared to LMICs, the WHO Western Pacific Region and the world, as also shown in Fig. 7. This includes countries that receive significant development assistance (Kiribati, Nauru, Niue, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu), as well as countries that form part of the Compact of Free Association with the United States of America (Federated States of Micronesia, Marshall Islands and Palau). External financing is expected to remain significant, but to decrease due to reduced bilateral support and transition from donor-funded national programmes such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and Gavi, the Vaccine Alliance as countries' income rises. Countries that rely on territorial associations for a large share of THE also expressed uncertainty about sustained or increased resources in the current political and economic environment (interviews). Furthermore, external resources are often earmarked for specific diseases and not channelled through government systems.

Analysis of health workforce numbers also shows gaps in the availability of resources across PICs, which may grow as a large proportion of the health workforce reaches retirement age in a number of countries. As shown in Fig. 8, some PICs have yet to reach the WHO goal of 4.45 health workers per 1000 population by 2030. In addition, as per countries' annual reports (data not shown), there are fewer health workers per population in rural areas than in urban areas in a number of PICs.

Figure 8. Health workers (physicians, midwives and nurses) per 1000 population in PICs



Source: WHO, Healthy Island Monitoring Framework, unpublished (copy on file with author), 2017.

In summary, while indicators for health outcomes and service coverage show overall improvement over the last few decades, a number of PICs have shown mixed results in some health indicators in the last decade. THE per person in most PICs is comparable to other countries with similar levels of income, but in many PICs, real expenditure per person is stagnating or decreasing. In the context of modest economic growth and less predictable and decreasing donor funding, increased resources are unlikely to be immediately available for health systems in most PICs. In this context, building and maintaining healthy, prosperous communities in most PICs will require that available resources be used in the most equitable, efficient and effective way possible. On the other hand, in some contexts efforts are needed to prevent or reverse the negative trend in health financing, for example, by pursuing increased domestic, regional and international funding such as climate change–related funds.

4 | Three implementation challenges

As noted in Section 2, PICs have largely adopted the Healthy Islands vision and UHC within their national policy frameworks (WHO, 2015a), yet the trends in health outcomes and coverage outlined in Section 3 suggest that there are challenges in implementation. This section will discuss three cross-cutting and interrelated implementation challenges faced by many PICs, albeit to varying degrees, in pursuing the Healthy Islands vision and UHC, with a particular focus on PHC as a trigger for these efforts. These implementation challenges cut across the entry points identified in the WHO and WB UHC framework, but focus on service delivery (implementation challenge 1), financing (implementation challenge 2) and governance (implementation challenge 3).

Implementation challenge 1: Using the right health service delivery models at PHC level, with a particular focus on integration of both public health and clinical services, and improving coverage of NCD services.

> *Within the [Ministry of Health and Medical Services] MHMS there is limited partnership across programs, between programs and provinces, between the National Referral Hospital (NRH) and the provincial hospitals. Currently, each service is planned in isolation, leading to gaps and overlaps, and missed opportunities to share and maximise resources. (Solomon Islands MHMS, 2015)*

In many PICs, PHC still forms the backbone of the service delivery system, but it is under-prioritized, -resourced and -supported (refer to implementation challenge 2). Over recent decades, while vertical public health programmes advanced across PICs, insufficient attention was given to improving, adapting and strengthening comprehensive PHC services. There is now global recognition that gains in equity, efficiency and quality can be made in reintegrating public health activities into the PHC system, and that this is the most sensible route to UHC.

Across a number of PICs there is currently a lack of integrated planning for service delivery between public health programmes at the national level and little empowerment of subnational leaders to coordinate them. Many programme managers at the subnational level also play dual clinical and management roles, confusing their reporting lines and limiting their availability to engage with other managers in a strategic fashion. This will have to change as vertical programmes funded by development partners, such as the Global Fund and Gavi, transition to government financing, systems and processes.

More attention also needs to be placed on NCD and preventive service delivery. While most PICs have made significant ground in introducing integrated NCD services (as discussed in Section 5), some PICs, particularly those with a large unfinished communicable disease agenda, have more work to do. Improving the quality of NCD services also requires stronger integration between different levels of the health system, with robust coordination for managing chronic conditions, and with PHC playing the leading role, referring patients to specialist care as needed in accordance with established protocols.

Rebuilding and improving PHC starts with defining what services will be delivered where, by whom, and with what support. This requires updating old service models to encompass the full range of services and reintegrating public health activities. The actual model will vary by country, but all will have a blend of facility- and community-based delivery, which needs to be planned, costed

and resourced. In addition, essential promotive and preventive regulatory services (for example, tobacco control) need to be factored into planning and budgeting. All health systems need to continuously adapt to changes in disease patterns and technology, as well as to new evidence. This ensures the services being provided are the most cost-effective and appropriate given the needs and available resources.

Implementation challenge 2: Increasing the share of resources allocated to lower-level health facilities and community-based services for PHC.

> *The [Papua New Guinea] National Health Plan (NHP) 2011–2020 has a strong focus on the rural majority and the urban poor, but there is no evidence that a significant shift in focus towards these groups has occurred… Redistribution of both operating and capital expenditure [to provincial hospitals] is contrary to the intent of the NHP 2011–2020, but in a sense is being driven by citizens "voting with their feet" and coming to provincial hospitals for their medical care, as the rural health sector developments are not yet gaining traction. (Papua New Guinea NDoH, 2016)*

> *Resources are mostly allocated heavy top down, which does not align itself to the concept of the PHC approach and role delineation to provincial levels [in Vanuatu]. The challenge is always there and that is to reverse the resource allocation and make it heavy bottom up because that is where 80 percent of the services are where people live. (Vanuatu Ministry of Health [2012], cited in Anderson, 2013)*

The absence of clear health service delivery models (refer to implementation challenge 1) can make it difficult to track and compare funding trends across PICs, and also to judge whether funding is aligned with the goal of PHC. The way in which ministries budget and report on their resources, with cost centres per province or district and pharmaceutical supplies rather than facilities, also makes it difficult to account for such spending. However, data do show that the PHC system receives a relatively small share of the total resources, and in some countries with trend data, this amount has recently fallen.

Consistent staffing is essential for the operation of PHC. Multiple studies have found that under-staffing contributed to the temporary or permanent closure of lower-level facilities. Facilities may be closed due to poor staff attendance, derelict infrastructure or when staff members go on annual leave or study leave, retire or move and replacement staff is not assigned. As noted in Section 3, there are fewer health workers per population in rural areas in a number of PICs and there are reported disparities in the availability of pharmaceuticals and other supplies in some contexts.

At the core of this challenge is resource allocation. Increasing funds available for PHC in the community and at facilities may not require significant additional health resources, but rather a certain level of reallocation. Resource allocation processes vary across PICs, but some PICs still plan and budget largely on the "historical approach", which is "very much supply-driven, influenced by historical allocations, pressures from national programmes, staff themselves, but also by development partner programme funding" (WB, forthcoming[b]: paragraph 146). This approach can fail to link inputs (for example, funding, human resources, etc.) with service delivery and outcomes.

Changing this approach requires technical work in setting standards for services. This includes assessing the extent to which service providers meet those standards, and ministries of health working across government with public service commissions (PSC) and treasuries to ensure that gaps in meeting those standards are translated into budget and staffing. In addition, as recognized

by the interviewees, it also requires efforts to recognize and address political economy issues of shifting resources within governments, citizens, ministries of health and development partners. This is particularly the case as ministries face growing pressure to provide more specialized tertiary services that are available overseas or in private settings.

Implementation challenge 3: Improving managerial, administration or supervisory capacity to ensure that resources reach lower-level health facilities.

> *Even if greater resources are allocated to mobile or patrol clinics in [Papua New Guinea], on time receipt of funding remains an issue. (Irava et al., 2015)*
>
> *You will fail if you don't have strong financial and human resource systems. (Interviewee)*
>
> *The way you make [our] health system better is to strengthen fundamental business processes and people who operate them. Avoid band-aid solutions. Ideal is system where problems are fixed early. The way we run our health system is the way we should treat disease. Focused on primary, not secondary and tertiary. (Interviewee)*

Getting resources to facilities is both a governance and an administrative issue. These issues may involve government agencies outside ministries of health; for example, delays by Treasury in releasing operational funds have an impact on the availability of resources. Yet it is clear from the interviews that there are also issues within ministries themselves. Most interviewees expressed frustrations with "managerial", "supervisory" or "implementation" capacity from the executive down to facilities. They described an "absence of a managerial feedback loop" and limited supervision of staff at facilities on the periphery. Relatedly, interviewees expressed equal frustration with "corporate services" or "fundamental business practices" across administration, human resources, finance and procurement that are not up to scratch and are hindering service delivery. These issues combine to present real constraints for facilities, with the most illustrative example provided by interviewees being difficulties in fixing a leaking tap at the facility level.

Interviewees stressed the complexity of national health system management in PICs where a small number of administrative staff have responsibility for multiple functions. Some noted that key administrative positions are not remunerated as well as positions with the same level of responsibility in other government agencies. It is difficult to recruit staff for such positions.

At the subnational level, the nature of these challenges varies across ministries of health in PICs depending on their degree of centralization and specific functions. In highly centralized systems, the role of leaders at the subnational level has been unclear and fraught with frustrations in attempting to manage uncoordinated service inputs from national programmes (as noted above under implementation challenge 1). In decentralized systems, processes at the subnational level were still considered a bottleneck to getting the resources to service providers (interviews). Thus interviewees in both centralized and decentralized systems wanted to create more "capability to manage budget and take action locally" so that they can "buy a nail" without engaging the central/subnational level. Interviewees also noted seeing a preponderance of "training" at the subnational level, but not training specifically on management nor much supervision taking place.

Interviewees noted the lack of information available about service delivery at the community or facility level and the costs of running such services. While health information systems are improving across most PICs, little progress has been made on collecting information on expenditures. The next step is linking such data to service delivery.

5 | Successes in implementation

Efforts are under way across the Pacific to overcome the implementation challenges outlined in Section 4. None of these challenges can be overcome without political will. This section highlights examples of change where political will exists, where individual champions of change drive reform and where institutions and partnerships are not only receptive to change, but enable and amplify it over the long term.

Success 1: Right services, with the right model in the right places

Highlight 1: Essential service packages and/or role delineation policies

Many Pacific countries are currently developing or revising new health service packages, with Solomon Islands having recently done so, Tonga and Vanuatu actively reviewing options, and Fiji, Papua New Guinea and Samoa considering doing so. In Solomon Islands, the Ministry of Health and Medical Services (MHMS) commenced the development of a role delineation policy (RDP) and service delivery package (SDP) in tandem in 2011. The reform responds to: a documented decline in the quality of service delivery with approximately 70% of facilities requiring repair; increased bypassing of sub-hospital facilities, with doctors only available in Honiara and some provincial capitals; and the opportunities presented by a significant number of newly trained doctors returning from Cuba (Parnell, 2016).

The RDP restructures the health system, abolishing nurse aide posts and strengthening area health centres and rural health clinics, including through task shifting to doctors (Cuban medical graduates). A pilot of the RDP and SDP was launched in 2015 and found that financing, human resource and governance issues had not been adequately considered in the original policy; "simply providing SDP did not enable staff to make necessary changes on their own" (Parnell, 2016). After the pilot, the MHMS focused on embedding the RDP and SDP within the *National Development Strategy* and the *National Health Strategic Plan (2016–2020)*. Drawing on the lessons from the pilot, the SDPs were revised in late 2016 to encompass staffing, infrastructure, equipment, medicines and other registers and manuals needed (Parnell, 2016).

One of the main reforms progressing alongside this and that will support the implementation of the RDP is the organizational structure reform. This reform focuses on clarity of job descriptions and reporting lines, more integration for efficiency gains, incentives for rural postings and improved management at the health zone level. The current structure of the MHMS is heavy at the national level and limits the ability of implementers at lower levels to deliver the much-needed services both in terms of coverage and quality. Challenges in implementing the reform remain, including:

1. Costing the service package to ensure that the services and standards are rolled out with the right resource allocation. As noted by the MHMS in its National Health Strategic Plan: At present, the National Referral Hospital (NRH) infrastructure planning and potential costs… is in advance of the general hospital and rural facility infrastructure planning and costing… The current ratio of investment… is 11:4:1. In other words, 11 dollars will be spent on NRH infrastructure for every four dollars spent on [area health centres] AHC and every dollar on [rural health clinics] RHC. There is an urgent need to progress the RDP's service delivery

package costings so that out year financial forecasts present a better balance between central and peripheral expenditures on infrastructure. (Solomon Islands MHMS, 2015)

2. Allocating and supporting efficient expenditure of increased resources by provinces.
3. Negotiating, incentivizing and preparing for task shifting to doctors and possible upskilling of nurse aides.

In Nauru, in order to improve equitable access at the community level, the Ministry of Health recently created three community health centres with three zones as entry points. Three community nurses with PHC training now provide outreach services in their zones.

Highlight 2: Introduction and integration of new services for NCD

Integration of services is taking place at all levels of the health system. In the Commonwealth of the Northern Mariana Islands clinicians are encouraged to ensure that patients admitted to hospital receive the full range of public health interventions with a view to preventing rehospitalization. In Samoa, a community-based NCD early detection and management programme, the PEN Fa'a Samoa, was launched in 2014 to adapt the WHO Package of Essential NCD Interventions (PEN) protocols to the local context. As part of the programme, village women's committees were trained to provide support in screening for and managing NCD and risk factors within their villages and to run health awareness and promotion activities (tobacco, alcohol, sugar, salt, physical activity). A pilot commenced in two villages in 2015 and research is needed to determine its efficacy.

In Tonga, community-based NCD management by trained nurses aims to improve the identification of patients at risk of NCDs, provide advice and assistance to prevent onset, and help those with a diagnosed condition to manage their illness. While still in its early stages, this approach has been successful in halting the incidence of foot ulcers, diabetes sepsis cases, amputations and NCD-related hospital referrals, indicating patient complications are being avoided through early interventions and that patients are being discharged early because of the availability of quality health staff and home-based care options.

In 2016, the Government of the Marshall Islands decided to conduct a mass screening programme in Ebeye Island to integrate programmes that have traditionally worked in a vertical way. The programme involves screening the adult population for tuberculosis (TB), leprosy and diabetes; measuring blood sugar, cholesterol and blood pressure levels; and using radiography and genetic testing to find active cases of NCD and TB. The next phase will reintroduce PEN protocols for effective NCD management, community health promotion activities and active case management for communicable diseases.

Highlight 3: A workforce to make the health system more visible in communities

Paid or volunteer community-based health workers have been providing PHC in communities (and/or health posts) across PICs, including Fiji, the Federated States of Micronesia, Papua New Guinea, Samoa, Solomon Islands and Vanuatu. They are a cost-effective way to extend the reach of essential health services into communities and have been shown globally to improve maternal and child health outcomes and have the potential to impact NCD prevention.

Community or village health worker (CHW or VHW) programmes were established in Fiji and Vanuatu in the 1970s (Irava, 2016; Laverack & Westberg, 2013) and are currently being revitalized.

Government agencies in Fiji and Vanuatu are now playing an increasing role in managing CHW: there are currently 1805 CHWs managed by the Ministry for iTaukei (indigenous) Affairs in Fiji and 212 VHWs managed by the Ministry of Health in Vanuatu. In Fiji, the programme was costed at or about 0.24% of THE and could be affordably scaled up to ensure that every urban setting and/or village has a CHW or to provide incentives to the CHW to meet demand (Irava, 2016).

Community-based health workers are most effective when embedded within the health system. Lessons from recent reviews in Fiji and Vanuatu suggest that the success of such programmes depends on: availability of operational resources; clearly defined roles in provision of services; community participation in governance committees; good in-service training, supervision and mentoring; and monitoring and evaluation of service delivery.

In Solomon Islands, nurse aides originated from a VHW programme and they are now a skilled cadre of paid health workers, but their continued role in the health system is unclear in the context of the new RDP (refer to highlight 1). Continued clarity on the purpose and contribution of community-based health workers and ensuring connections between health systems and communities is thus an ongoing task. Such decisions should be informed by analysis of the quality, effectiveness and cost-effectiveness of the model used to reach communities.

Highlight 4: More trained medical doctors for PHC

There has been significant work across the region over the last few years on developing appropriate training pathways for medical graduates. In some countries this has been initiated by the need to integrate foreign-trained medical graduates returning to Kiribati, Nauru, Palau, Solomon Islands, Tonga, Tuvalu and Vanuatu. In collaboration with Fiji National University, national bridging and/or internship training programmes have been developed across the region for the foreign-trained medical graduates and there is an opportunity to align deployment programmes to strengthen PHC (Kafoa & Condon, 2016).

The Ministry of Health in the Cook Islands has recently entered a partnership with the Royal New Zealand College of General Practitioners and the University of Otago to establish the Cook Islands Fellowship in General Practitioner. The fellowship has been customized to the Cook Islands' context and will combine aspects of the College vocational training programmes in general practice and rural hospital medicine, as well as the Australian College of Rural and Remote Medicine's training programme and will be fully accredited by relevant bodies in the Cook Islands.

Success 2: Right resource allocation, planning and budgeting

Highlight 5: Planning and budget reforms

The MHMS in Fiji has been reforming its approach to planning and budgeting since the early 2000s. Two major changes have occurred. The first change involved increased engagement with and devolution of powers to divisions in the planning and budgeting process, which had a number of flow-on effects. At the central level, there was a "realisation that how we [in MHMS Suva] allocate resources can lead to implementation challenges". For example, if one staff member is responsible for managing multiple programmes, then they may not have time to progress implementation across each programme, leading to low expenditure. This led to a new approach where

geographical divisions are responsible for developing their business plans with the support of "key resource" personnel from headquarters who aim to help identify and resolve potential bottlenecks.

The second change relates to reforms to the structure of the MHMS budget. Through the ongoing work of the Budget Steering Committee and staff involved with preparing Fiji's National Health Accounts, the MHMS identified the need to be able to budget and track expenditure at the facility and programme levels, so that it could link facility and programme budgets to service delivery. To facilitate this, the MHMS proposed a new budget structure with revised cost centres to the Ministry of Economy, which was accepted with revisions. Previously the budget included one cost centre for "urban hospitals", including divisional hospitals, specialized hospitals and divisional offices. This has now changed into one cost centre for each of the facilities, commencing in the current fiscal year. There is also a cost centre for each division (excluding urban hospitals), as well as Fiji Pharmaceuticals Biomedical Services and the Headquarters of the Ministry of Health and Medical Services , bringing the total to 12 cost centres. These cost centre budgets are directly accessible by the superintendent at each hospital and each divisional head, with the Permanent Secretary having delegated his or her authority to approve expenditures to a certain limit. This cost centre change initiative is seen as a first step and there are further plans to include sub-centres within hospitals and divisions so that expenditures can be better tracked.

Papua New Guinea has a long history of trying to find new ways to best ensure that facilities have the resources they need to deliver services across the country. The National Department of Health has been working with provinces to develop health service plans covering all services from communities to aide posts to rural health centres to hospitals, which will be implemented through annual activity plans. The plans are informed by facility audits based on national health facility standards that were approved in 2011. Among the challenges in Papua New Guinea, there is a need to link these provincial plans to annual allocations to provinces and facilities, which are determined through a separate process led by the National Economic and Fiscal Commission. In addition, analysis and action are required to overcome bottlenecks in getting budgeted resources to facilities. In order to make two public financial management reforms – namely, facility-based budgeting and direct facility funding – work, close collaboration with other relevant government agencies such as the National Economic and Fiscal Commission and the Department of Finance and Treasury is required.

Success 3: Right administrative and management practices

Highlight 6: Review of corporate services and associated reforms

The Ministry of Health in Tonga recently undertook a review of corporate services and is now undertaking associated reform. The review was initiated following multiple complaints from different sources (including the Minister) about the performance of key divisions, including administration (human resources, finance and procurement), planning and executive offices. The review found that current system arrangements are reducing efficiency and hindering service delivery, and lead to a series of staffing and procedural reforms. One positive example of a successful reform in Tonga relates to asset management. They are now planning to develop a costed maintenance plan utilizing the Ministry's Asset Registry. This improved planning process is intended to convince the Ministry of Finance to allocate necessary resources. Systems are now being put in place to ensure that the outer islands have access to funds and the ability to "buy" directly for small items.

Simultaneously, government-wide civil service reforms are being introduced, including a performance management system, which offers a monetary reward for good performance and training if improvements are needed. The Ministry of Health (MoH) anticipates that the reform, which will include all health workers who are civil servants, will help promote the connection between institutional goals and personal responsibility and performance.

Highlight 7: Provincial Health Authority reform

The Papua New Guinea Government has started the process of introducing the Provincial Health Authority (PHA) to take full responsibility for delivering health services across the country. After three pilot PHA provinces, four new ones have recently come on board. Four additional PHA provinces are planned for introduction in 2017. This exercise will continue over the next few years until all provinces have adopted the policy reform initiative. The PHA Act is voluntary, and thus it rests entirely on the respective governors to take part. While the overall outcome of decentralization and the establishment of PHAs is reported to be mixed and not considered in-depth here, there are emerging lessons on what is needed at the provincial level to achieve results.

Both the interviews and the grey literature stressed the importance of leadership from both the PHA Chief Executive Officer as well as the PHA Board for improving service delivery in a given province (Papua New Guinea NDoH, 2016; interviews). This leadership or "know-how" is likely to emerge once people have been in their roles for a few years. In addition to leadership within the PHA, the "connectivity between political, administrative and technical capacity" between Members of Parliament, the Governor, the PHA Board, the PHA Chief Executive Officer, the provincial government and health staff in hospitals and districts, as well as the churches is essential (Papua New Guinea NDoH, 2016). The role of Members of Parliament is of particular importance in Papua New Guinea (as well as the Solomon Islands) because they may contribute part of their constituency development funds to the health system.

The NDoH (2016) reports impressive results from high-performing provinces. For example, Es'ala district in Milne Bay province increased the proportion of deliveries taking place in facilities by 33% (from 40% to 73%) in two years. Similarly, Sumkar district in Mandang increased the contraceptive prevalence rate by 50% in two years. As the NDoH (2016) notes, the downside of impressive performance in some provinces is increased inequities between the high- and low-performing provinces (refer to Section 3).

Highlight 8: Integrated supervisory visits

The Vanuatu MoH has introduced integrated supervisory visits to ensure a regular supportive and harmonized approach to assessing the performance of health workers and health facilities, as well as identifying and addressing reasons for low performance. To date, the approach has involved the development of integrated checklists covering facility standards and management, case management, management of drugs and other supplies, information management and community-level activities. Malaria, tuberculosis, syndromic surveillance and neglected disease programmes have joined integrated supervisory visits so far, with reproductive, maternal and child health, NCD and HIV due to be integrated in 2017.

Provincial and zone-level supervisors have been trained on the approach and the use of these checklists in all provinces and the approach is being met with positive feedback. Challenges include the need to ensure sufficient funds are available for supervision and that those funds are available

through one imprest (rather than multiple imprests raised by each of the vertical programmes that are funding the supervision); the need to ensure coordination of integrated supervisory visits with other facility activities; and the need to adapt the checklist for different levels of the health system.

For a more comprehensive understanding of implementation successes across the Pacific, additional story collection may also be helpful. Interviews were conducted with a range of countries for this report, including small and large countries, countries from Melanesia, Micronesia and Polynesia, as well as with states associated with the United States of America and New Zealand and those that are fully independent. As no interviews were conducted with French territories, further understanding of the status of UHC in these contexts may help elucidate additional lessons for the rest of the Pacific. In addition, implementation research on the UHC-related reforms that are taking place in PICs would help to create a better understanding of the factors that help drive change and successful outcomes.

6 | Recommendations

Recognizing that business as usual is no longer an option, Pacific health ministers recently recommitted to the Healthy Islands vision and envisioned UHC as a way to do so in the 2015 Yanuca Island Declaration. The quickest and best route to UHC in the Pacific is to get it right at the lowest and most accessible level through strengthened PHC. Good PHC delivered from facilities and at the community level should be the starting point for change. For secondary and tertiary health care, the focus should be on efficiency, equity, quality and good adherence to the referral policy (domestic and overseas referral, as well as visiting specialists). UHC with a focus on PHC should improve health outcomes in the long term while strengthening the functioning of the entire health system in the short term.

As discussed throughout this report, PICs face common implementation challenges in their efforts to realize the Healthy Islands vision and UHC. PICs know the way forward; these recommendations set out practical actions to overcome common challenges to progressing UHC and implementing the 2015 Yanuca Island Declaration:

Governments may consider doing the following:

1. Strengthen, demonstrate and sustain political will for action

1.1 Build will for change by ensuring that everyone – including politicians, MoH staff and citizens – understands why and how their own country will improve health service delivery to achieve UHC and Healthy Islands and what that will mean for them (MoH).

1.2 Demonstrate commitment to action through greater transparency on health system performance and resource allocation (MoH).
- Widely disseminate information about system performance, such as core performance indicators and resource allocation data, through appropriate forums (facility noticeboards, newspapers, MoH website or social media).
- Support civil society organizations and communities to engage in health sector debate.

1.3 Institutionalize accountability for action and change within government through parliamentary mechanisms, for example: by forming a parliamentary committee focused on Healthy Islands/ UHC or holding an annual debate and applying whole-of-society and whole-of-government approaches (MoH, Cabinet, parliamentarians).

2. Determine the right services and the right models to achieve UHC

2.1 Strengthen PHC as a trigger for change (MoH).
- Define an evidence-informed costed package of PHC services to be delivered by health facilities or direct to communities, considering community needs based on existing epidemiological and demographic knowledge.
- Ensure facilities are accessible, equipped and supported to deliver their part of the service package with improved access to medicines and health technologies.
- Support micro planning, with community participation, for service delivery at the subnational level (e.g. districts or zones).
- Promote community engagement in health promotion and health services delivery.

2.2 Attract and maintain the right staff in the right place with the right skill mix (MoH and PSCs).
- Develop workforce profiles and job descriptions based on service packages and delivery models.
- Build attractive career pathways, with associated incentives and educational opportunities, for front-line doctors, nurses and the community-based public health workforce, especially in rural and remote areas.
- Ensure public health training is given due recognition by government.

2.3 Monitor health system performance using health information system (MoH).
- Define performance assessment indicators for each level of health service delivery per individual country context (Healthy Islands monitoring framework and the regional UHC monitoring framework to be part of references).
- Use regular reporting and feedback to the subnational level and facilities based on the performance assessment indicators to improve service management.
- Develop continuous quality improvement plan based on the performance assessment and appropriate supervision (use information for actions and decisions).

2.4 Improve optimal resource use in secondary and tertiary care facilities (MoH, Ministry of Finance).
- Ensure secondary and tertiary facilities operate efficiently and effectively to do better with existing resources, including use of clinical guidelines and health technology assessments.
- Review and refine referral systems and guidelines (at all levels) so that clinical needs and equity determine access to higher-level services.

3. Plan and budget resources for UHC

3.1 Create a fit-for-purpose financial management system to get resources to the lowest levels of the system (MoH, Ministry of Finance, subnational governments).
- Clarify and streamline delegation of planning, budgeting and authorization of expenditure.
- Consider moving towards a results-based budget, linking allocations to service delivery.
- Advocate for management flexibility for reallocation, with appropriate controls.

3.2 Develop one health sector annual plan and one budget based on the national health strategic plan, the essential service package and associated service delivery model (MoH, Ministry of Finance, PSCs, subnational governments).
- Build capacity (especially for both subnational and public health programme managers) to make the operational planning and budgeting systems work through proper tools, guidance and mentoring.
- Create a participatory annual operational planning and budgeting process that will get resources to PHC.
- Ensure that allocation of staffing from PSC supports the MoH medium-term and annual plans.
- Conduct an annual review of the previous annual operational plan and budget based on performance assessment reports from national, subnational or health facility levels and publish the review.
- As part of the review, identify potential efficiency, saving and equity-improving measures across the system such as programme integration and quality improvement.
-

4. Strengthen health workforce management

4.1. Strengthen health workforce management system (MoH and PSCs).
- Review current situation of health workforce management (how it works).
- Develop (or review) health workforce development plan and identify implementation issues.
- Maintain a health workforce information system including location, retirements, vacancies, retention and attrition.
- Review the job descriptions of expected retirees and vacancies, and take advantage of the opportunity to update and change.
- Develop incentives for recruitment and retention in remote areas and lower levels.

4.2 Implement management/leadership training and development (MoH and academia).
- Implement health service management training (including workforce management, finance, IT, procurement and supply chain management, quality assurance, community relations) through both short-term and formal training (regional and national levels).
- Introduce coaching and mentoring for all managers within the MoH.
- Select appropriate courses or educational processes (for example, learning sets) for senior leadership and consider how the Heads of Health meeting and the Director of Clinical Services Meeting can be utilized as forums for mutual learning.

4.3 Improve continuing professional development (MoH and PSCs).
- Develop stronger regulatory licensing mechanisms linked to monitoring the implementation of continuing professional development for health workers.
- Ensure that development partners progressively utilize national accredited training providers to deliver any courses that they fund.
- Better utilize existing mechanisms such as Pacific Open Learning Health Net, scholarships and fellowship opportunities to meet individual and health system competency needs.

Development partners may consider doing the following:

- Work collectively with government counterparts on strengthening PHC as a starting point for change and monitor implementation by using existing health information systems.
- Align with not only national health strategic plans, but also the annual operational planning process by being on plan and on budget, as well as on system to the extent possible.
- Align support with the service delivery model and the essential service packages developed by governments, including supporting and building capacity in health financing and the costing of service delivery models.
- With government counterparts, advocate more investment in PHC and health workforce development in the Pacific.

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Annex 1. List of interviewees

No.	Name	Position
1	Ms Elizabeth Iro	Secretary of Health, Ministry of Health, Cook Islands
2	Mr Philip Davies	Permanent Secretary, Ministry of Health and Medical Services, Fiji
3	Dr Siale 'Akau'ola	Chief Executive Officer, Ministry of Health, Tonga
4	Dr Kennar Briand	Interim Health Secretary, Ministry of Health, Marshall Islands
5	Mr Len Tarivonda	Director, Department of Health, Vanuatu
6	Ms Muniamma Gounder	Acting Director, Planning and Policy Development Division, Ministry of Health and Medical Services, Fiji
7	Mr Navy Mulou	Health Economist, National Department of Health, Papua New Guinea
8	Mr Idrish Khan	Planning and Policy Development Division, Ministry of Health and Medical Services, Fiji
9	Ms Esther L. Muña	Chief Executive Officer, Commonwealth Healthcare Corporation, Commonwealth of the Northern Mariana Islands

Annex 2. List of technical consultation participants

1) Technical advisors

No.	Name	Position
1	Salausa Dr John Ah Ching	Associate Minister for Health of Samoa
2	Mr Philip Davies	Permanent Secretary, Ministry of Health and Medical Services of Fiji
3	Dr Tenneth Dalipanda	Permanent Secretary, Ministry of Health and Medical Services of Solomon Islands
4	Dr Greg Dever	Human Resources for Health officer for Pacific Islands Health Officers Association (PIHOA)
5	Dr Donald Matheson	UHC Technical Advisory Group member, General Manager, Brisbane North PHN & Metro North HHS Health Alliance in Australia
6	Dr Chang-yup Kim	UHC Technical Advisory Group member, Professor, Seoul National University in the Republic of Korea
7	Dr Lepani Waqatakirewa	UHC Technical Advisory Group member, International health consultant, former Permanent Secretary for Health, Fiji

2) WHO Secretariat

No.	Name	Position
1	Dr Corinne Capuano	Director, Division of Pacific Technical Support, WHO
2	Dr Vivian Lin	Director, Division of Health Systems, Western Pacific Region, WHO
3	Dr Wendy Snowdon	Team Coordinator, Pacific NCD and Health through the Life-Course, WHO
4	Dr Kunhee Park	Acting Team Coordinator, Pacific Health Systems and Policy, WHO
5	Mr Roland Dilipkumar Hensman	Technical Officer, Health Information System, Solomon Islands Country Office, WHO
6	Dr Changgyo Yoon	Technical Officer, Pacific Health Systems and Policy, WHO
7	Mr Patrick Connors	Intern, Pacific Health Systems and Policy, WHO
8	Ms Katherine Gilbert	Nossal Institute for Global Health, University of Melbourne (WHO consultant)
9	Ms Beth Slatyer	Nossal Institute for Global Health, University of Melbourne

3) Observers

No.	Name	Position
1	Dr Rebecca Dodd	Department of Foreign Affairs and Trade of Australia
2	Ms Vamarasi Mausio	Ministry of Foreign Affairs and Trade of New Zealand
3	Ms Maude Ruest	World Bank
4	Dr Revite Kirition	Health advisor, Secretariat of the Pacific Community

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