Policy Report

Achieving UHC in the Pacific, a Closer Look at Implementation: Summary of a Report for Pacific Health Ministers

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Keywords: implementation, Pacific, primary health care, service delivery, universal health coverage

Abstract—The principles of universal health coverage (UHC) are deeply embedded in health systems across the Pacific. UHC is also one of the stepping stones to achieving the Healthy Islands vision, adopted by Pacific health ministers in 1995, which envisages healthy islands as places where citizens grow, learn, play, and age with dignity. However, recent evidence suggests that though health systems across the Pacific largely remain affordable, there are growing challenges in ensuring access to good quality essential services. This article examines three common challenges to improving essential service delivery across the Pacific and reforms that are currently being put in place to address them. It is based on a report on the status of UHC, with a focus on primary health care (PHC), across 22 Pacific Island countries and territories that was submitted to the most recent meeting of Pacific health ministers in 2017. That report identified the challenges and reform efforts using data from a literature review, interviews with senior policy makers, as well as technical consultations. The three challenges—delivering integrated PHC services with appropriate delivery models; increasing the share of resources allocated to PHC; and improving managerial, administrative, and supervisory capacity to ensure that resources reach and are well used for PHC—are being addressed through country-specific reforms across the Pacific. However, concerted political effort is needed to ensure that these reforms are effective in improving access to good quality PHC for citizens across the Pacific.

INTRODUCTION

In 1995, Pacifica health ministers committed to improving the health of their citizens as part of the Healthy Islands vision. The
Healthy Islands vision recognizes the importance of actions to address the social and environmental determinants of health, as well as to improve health services, to enable children and adults to grow, learn, play, and age with dignity.\(^2\) Its emphasis on service provision and focus upon “community values, the foundation of Pacific culture” (p. 3) links the Healthy Island vision to the concept of universal health coverage (UHC).\(^3\) These links were recently recognized by Pacific health ministers who recommitted to pursue their Healthy Islands vision based on UHC principles at both their 2015 and 2017 meetings.\(^4,5\)

The Pacific provides a unique context for understanding how to move towards UHC, the principles of which are deeply embedded in national health systems. Health expenditures in most Pacific Island Countries (PICs) are predominantly public (from government and donor funding), with relatively high total health expenditure per capita and low out-of-pocket payments (and low catastrophic or impoverishing expenditure), as shown in Figure 1.\(^7\) Across PICs, services are largely provided by public and nonprofit providers, predominantly through nurse-led primary health care (PHC). This model has historically proved successful in catering for small and remote populations; most PICs achieved relatively strong health outcomes until the mid-1990s.\(^4\)

However, there is a growing sense that more should have been achieved across PICs in recent decades. Though indicators for key health outcomes are on the whole improving, progress remains volatile or stagnant in some countries. For example, many PICs have struggled to keep pace with improvements in life expectancy and under-five mortality that have been achieved globally over the past two decades.\(^4,17\) These trends likely reflect an increasing noncommunicable disease (NCD) burden, as well as the underlying challenges in both addressing the determinants of health and improving routine service delivery, with the 20-year review of the Healthy Islands vision reporting “deteriorating levels of the local health response on many islands” (p. ix).\(^4,17\) This perceived deterioration of health services is evidenced in some PICs by relatively poor UHC service indices (for those countries for which it is available) and downward trends in immunization coverage rates as shown in Figures 2 and 3.

Improving these service delivery trends and pursuing UHC is made more complex by the contextual challenges in PICs, which include increasing, yet small, isolated and aging populations with heightened expectations of health care; a large and growing NCD burden; and negative impacts of climate change.\(^4,5\) Combined, these factors are likely to continue to increase demand for more costly specialized services provided at referral hospitals or, where services are not available in a PIC, overseas medical referral. In addition, in many PICs, real total health expenditure per person is stagnating or decreasing and is unlikely to increase in the immediate term in the context of modest economic growth and decreased donor funding.\(^9,10,12,14\)

Efforts to strengthen UHC across PICs thus require a two-tiered approach. In the longer term, in some PICs, such as Papua New Guinea (PNG), health financing from both national and international sources needs to increase to achieve UHC.\(^17\) In the immediate term, in all PICs, existing resources available for UHC need to be used more equitably, efficiently, and effectively, while building the capacity of the health system to attract and make best use of additional resources in the future. In other words, in the immediate term, PICs need to focus on implementing UHC. This pressing task is the focus of this article. It identifies the three most significant challenges to implementing UHC that are common across the Pacific and the actions being taken by PICs to address them. It does so with a focus on PHC, which is the most equitable, efficient, and effective starting point for efforts to pursue UHC and the Healthy Islands vision in PICs.\(^18,19\)

**METHODS**

The article is based on a report titled “Universal Health Coverage on the Journey towards Healthy Islands in the Pacific,” which was submitted to the Twelfth Pacific Health Ministers Meeting in August 2017.\(^20\) That report was based on a synthesis of data gathered from:

1. Published and grey literature on the status of the Healthy Islands vision and UHC in PICs.
2. The Healthy Islands Monitoring Framework, the Global Health Observatory, the World Development Indicators, and national health information systems.
3. Nine interviews with heads of health or their delegates from eight PICs: Commonwealth of the Northern Mariana Islands, Cook Islands, Federated States of Micronesia, Fiji, Papua New Guinea, Royal Marshall Islands, Tonga, and Vanuatu (all PICs were invited to participate).

Data were analyzed thematically to identify the common challenges to UHC, which were then refined based on dialogue with PIC government representatives,
development partners, and academics at a technical consultation in March 2017. Efforts to address these challenges were identified from both the data and dialogue at the abovementioned technical consultation.

IMPLEMENTATION CHALLENGES AND EFFORTS TO ADDRESS THEM

Three main implementation challenges were identified and are briefly presented, along with efforts to address the challenges.
Delivering Integrated PHC Services with Appropriate Service Delivery Models

Within the Ministry of Health (MOH) there is limited partnership across programs. … Currently, each service is planned in isolation, leading to gaps and overlaps, and missed opportunities to share and maximize resources (p. 20). 

In recent decades, as vertical public health programs advanced across PICs, insufficient attention was given to adapting and strengthening integrated PHC services to changing population needs. 

In many PICs, national disease-based and public health programs are planned, resourced, and implemented at the national level in a siloed manner as noted in the quotation above.
Subnational managers, who often manage dual clinical and management responsibilities due to the small size of PIC systems, are not empowered or available to coordinate their inputs, amidst unclear reporting lines and authority. Integration at both the facility and community levels often falls by default to frontline health workers, who often do not receive pre- or in-service training (especially in-service training funded by development partners) that encourages such an approach. Service delivery at both the facility and community levels is thus often haphazard and/or weak, with poorly articulated service delivery models and packages, which are not appropriate for current population size, age, and patterns or disease burden, creating gaps in access.

PICs are now working to refine their service delivery models and service packages, including facility- and community (outreach)-based service delivery, as well as regulatory services (for example, tobacco control). Solomon Islands is now implementing a new role delineation policy and essential service package, based on current population trends and disease burden, alongside broader organizational reform. Tonga is also undertaking a service delivery refresh to enhance availability of a package of essential health services. Integrating new services for NCDs is another focus for some countries. Samoa and Tonga have introduced community-based NCD prevention, screening, diagnosis, and management undertaken by village women’s committees (Samoa) and nurses (Tonga). Some PICs are also revising their health worker mix, particularly at PHC, to better match desired service delivery models. Fiji and Vanuatu are revitalizing community health worker programs, established in the 1970s, in part to prevent NCDs. Training medical doctors for PHC is in process in some PICs, initiated by the demand for doctors at the PHC level and/or increased numbers of returned foreign-trained medical graduates. For example, Cook Islands has recently established a fellowship in general practice, combining aspects of rural and remote medical training programs in Australia and New Zealand.

Increasing the Share of Resources Allocated to Lower Level Health Facilities and Community-Based Services for PHC

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. The challenge is always there, and that is to reverse the resource allocation and make it heavy bottom up because that is where 80% of the services are where people live (p. 61).

Though financial data by facility level are limited across PICs, data show that facility- and community-based PHC receives a relatively small slice of the total resources in some PICs. Although PHC is less resource intensive than higher levels of care, evidence suggests that the share of resources allocated to PHC has fallen in recent times, despite intentions to reverse this trend. For example, the mid-term review of one country’s current national health plan reported that operating and capital expenditures were shifting to provincial hospitals, although the plan had a strong focus on the rural majority and urban poor. There are fewer health workers per population in rural areas compared to urban areas in a number of PICs, with understaffing contributing to the temporary or permanent closure of facilities. Limited supplies and poor infrastructure are other reasons for closure of PHC facilities. Increasing resources for PHC may not require significant additional financing to health but it will require reallocation. Though resource allocation processes vary across the Pacific, some PICs still plan and budget largely on a historical supply-driven approach, responding to the interests of MOH staff and development partners. This approach can often fail to link inputs (such as funding and human resources) with service delivery standards and outcomes.

There is growing recognition that PICs need to “spend better,” including making increased resources available for PHC, to improve health system efficiency and equity. PICs are working to change current allocation patterns by setting desired outputs or outcomes, using these as a basis for budgeting and evaluating the use of such resources against the relevant outputs and outcomes. The PNG MOH has been working with provinces to develop comprehensive health service plans implemented through annual activity plans. Among the challenges faced, there is a need to link these provincial plans to annual allocations to provinces and facilities, which are determined through a separate process outside of the MOH’s control. Fiji has recently achieved two major reforms. First, subnational MOH divisions are now responsible for developing their business plans, with support from national personnel who aim to help identify and resolve potential bottlenecks. Second, the MOH adopted a new budget structure, which delegated greater financial authority to each subnational or hospital head.

Improving Managerial, Administration, or Supervisory Capacity to Ensure That Allocated Resources Reach and Are Well Used for PHC

Even if greater resources are allocated to mobile or patrol clinics … on time receipt of funding remains an issue (p. 3).

Some constraints in getting resources to facilities lie outside MOH; for example, delays by treasury in releasing operational funds. Other constraints are also due to the nature of
managing health systems in PICs, where few staff are responsible for multiple administrative functions. However, there are gaps in managerial, administrative, and supervisory capacity from the executive down to facilities in MOHs across PICs. These include gaps in fundamental business practices (human resources, finance, and procurement) in MOH headquarters. In both centralized and decentralized systems, there is also a perceived need to create more capability to manage budget and take action locally so that facilities can “buy a nail” without engaging the central/subnational level. In addition, there is an absence of a managerial feedback loop, in part due to limited supervision and empowerment of facilities.

PICs are seeking to address these gaps in a number of ways. Tonga conducted a review of corporate services, which found that poor performance hindered service delivery and led to a series of staffing and procedural reforms. Other PICs are attempting to improve management practices through deconcentration and decentralization. Early evidence from the introduction of the Provincial Health Authority (PHA) model in PNG stresses the importance of leadership from both the PHA chief executive officer and board, as well as the “connectivity between political, administrative and technical capacity” (p. 15)—the PHA chief executive officer and board, members of parliament, the governor, the provincial government, and health staff in hospitals and districts, as well as the churches—for improving service delivery.23 Integrated supervisory visits (ISVs) have been introduced in Vanuatu to ensure a regular supportive and harmonized approach to assessing and responding to the performance of health workers and health facilities.

DISCUSSION

These common challenges to implementation, and the approaches that PICs are taking to address them, demonstrate the importance of health systems strengthening to achieving UHC. This link between health systems strengthening and UHC was highlighted by the World Health Organization’s UHC Action Framework for the Western Pacific Region, which can continue to inform efforts to achieve UHC among PICs.6,18

The Pacific faces unique contextual challenges for achieving UHC, particularly in ensuring access for small and remote populations to good quality services. This context also poses unique challenges for UHC reform efforts, with change at the national, provincial, and local levels often dependent on a small number of people mastering complex processes. For example, in PNG, impressive results have been achieved following the PHA reform in high-performing provinces; however, inequities between high- and low-performing provinces have increased.25

This context also demands that PHC be adopted as the starting point for change. However, PICs need to recognize and address political economy issues associated with paying increased attention to PHC, particularly amidst growing pressure on MOHs to provide more specialized services to growing urban populations. Reforming public financial management systems to improve allocative and technical efficiency is both technically and politically challenging. Setting regional benchmarks for optimal funding allocations required for each level of the health system in the Pacific context may help provide political impetus to make such changes.

Given the significance of aid in many PICs, development partners also have an important role to play in working with Pacific governments to pursue UHC. This includes supporting and monitoring implementation by using and improving existing health information systems and committing to an ongoing planned cycle of analytical work. Further steps include aligning their support with service delivery models and essential service packages developed by PIC governments, as well as with MOH systems by being on plan and on budget, and on treasury to the extent possible. PIC reform efforts will not be successful without commitment from development partners given their significant funding—for example, ISV requires funding that is available in one transaction for ISV (rather than multiple transactions raised by each vertical program). Development partners can also work with Pacific people and governments to advocate for more investment to PHC and UHC in the longer term.

CONCLUSION

PICs have demonstrated a sustained and deep commitment to the principles of UHC, and their health systems have historically been accessible and affordable. However, challenges have arisen in maintaining access to good quality services, leading Pacific health ministers to renew their commitment to UHC on the journey to the Healthy Islands vision.6,14 In some PICs this commitment must be met with increased resources. However, because total health expenditure is unlikely to increase in the immediate term across the Pacific in view of the current economic outlook and declining donor funding, PICs today need to find ways to make service delivery more equitable, efficient, and effective using the existing resources. This article identified three common challenges that PICs face and ways to address them. However, the recent efforts identified in this article are in the early stages of implementation, and strong leadership
from within the sector is needed to rigorously monitor and evaluate progress to ensure that these reforms are effective in bringing about positive change.

NOTE
[a] The 22 Pacific Island countries and territories include American Samoa, Commonwealth of the Northern Mariana Islands, Cook Islands, Federated States of Micronesia, Fiji, French Polynesia, Guam, Kiribati, Marshall Islands, Nauru, New Caledonia, Niue, Palau, Papua New Guinea, Piteaïrn Islands, Samoa, Solomon Islands, Tokelau, Tonga, Tuvalu, Vanuatu, and Wallis and Futuna.

DISCLOSURE OF POTENTIAL CONFLICTS OF INTEREST
No potential conflict of interest was reported by the authors.

ACKNOWLEDGMENTS
The article is based on a report titled “Universal Health Coverage on the Journey towards Healthy Islands in the Pacific,” which was submitted to the Twelfth Pacific Health Ministers Meeting in August 2017.

FUNDING
The original report was supported by the World Health Organization based on Tender Notice No. 51176.

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