Moving from strategy to action

Health policies and strategies based on core values are important. As important as policies and strategies are, the actions that lead from them are even more important. Ultimately, it is the health outcomes that follow from that action that really matter. All actions that influence health or the health system should be analysed through the prism of a holistic approach to health systems based on the values of primary health care.

The Western Pacific Region is diverse. The health sector context is changing rapidly with socioeconomic development and globalization. Strategies and actions decided upon now may not be appropriate in the future. Flexibility and the ability and willingness to recalibrate the system in the future are important. However, if a core set of values underpin decision-making, it is more likely that change can be accommodated more successfully.

6.1 National health policy and planning processes

Each country needs to develop its own health planning and policy processes to fit its own needs. However, there are core principles that apply almost universally.

6.1.1 A sound policy process that reinforces core values

There is considerable variation in national health strategy and policy processes. In some settings, there is no single guiding document and national health policy and strategy is more implicit based on years of accrued experience, legislation and tradition. This Regional Strategy provides guidance for core values to be considered for inclusion in national health strategy and policy development processes. It also discusses some of the attributes of a robust national health policy and strategy process, which have been further elaborated from other sources. Some of the most important attributes of robust policy and strategy processes are:

- building consensus on a sound situation analysis;
- broad consultative processes involving essentially all stakeholders;
• a mechanism for high-level endorsement of the process;
• priorities are determined through consultative processes;
• alignment with other relevant national development policies;
• country ownership.\textsuperscript{45, 46}

\textbf{6.1.2 National policy must be realistic and able to be translated into operational-level action}

As important as policy and strategy are, most of the activities that affect the daily lives of people occur at a much lower level. The aspirations of national policy often fail to be realized. Much is lost as national policy is translated into actual activity at the operational level. There are many reasons for this. Some key attributes of realistic planning processes are those that are:

• developed by the people who will implement them;
• compatible with the resources and capacities that exist;
• anchored through long-term political and legal commitments;
• able to link strategic and operational planning;
• addressing the concerns of the middle levels of the health sector;
• enjoying commitment from multiple stakeholders both inside and outside government.

Capacity without resources will not lead to improved health outcomes. The same is true of resources without capacity. Both must be assessed realistically and plans made to use that capacity and those resources in the most equitable and efficient manner. Ideally, this planning will involve those who are at the level of implementation. Managers at the implementation level should be empowered to carry out those tasks. Capacity-building may be necessary. Care must be taken to ensure that capacity-building efforts do not undermine implementation. Capacity-building should truly build total system capacity, rather than just capturing capacity for one activity while neglecting others.

\textbf{6.1.3 Comprehensive, balanced and coherent planning linked to subnational plans}

A whole-of-system approach calls for activity at all levels of the health system across the set of building blocks used for analysis. The routes of connection between different levels of the system need to be open and well understood by all involved. The


strategic, policy and planning processes in each country should lead to a definition and understanding of the roles and responsibilities at each level and whether that level has both the resources and the capacity to fulfil that role. Interventions and activities should be adjusted to work within that capacity, while working on both short- and long-term efforts to increase both capacity and resources, if needed. The planning process must also link the overall plan with disease-specific plans and programmes within the sector.

The levels to be considered for roles and responsibilities differ in different settings but are likely to include: individuals and households; communities; primary level; secondary level; tertiary level; and managerial units at all levels, such as district health offices and ministries of health. The roles and responsibilities cut across both curative and public health. They also involve intersectoral action, particularly at the managerial levels.

Formal planning for operational units within governments is often done on a yearly or biennial basis, frequently tied to the fiscal cycle of the government. The monitoring process for the plan should be carried out at regular intervals throughout the implementation period. Re-planning based on the results of monitoring is often necessary and should be an option available to managers, if justification can be given.

### 6.1.4 Private sector requires special consideration

Planning in more highly privatized systems is much more diffuse. Influencing the behaviour and performance of private systems often depends on combining both incentives (e.g. reimbursement, continuing education, promotion and recognition) and sanctions (e.g. licensing, regulation and fines). If the roles and responsibilities of all actors in the system are well understood, accountability for outcomes can be stronger, and action to improve both outcomes and accountability is more likely. However, such accountability requires that accurate information exists and the managers are sufficiently empowered to perform their roles.

### 6.2 Management as a core function at all levels

Management of health services is a core function. Management occurs at all levels from community to facility to mid-level and at provincial and national levels. The degree of responsibility and authority at each level will vary from country to country. However, management at the operational level, where services are actually delivered, is crucial.
Box 7. Management Matters, Not Just Resources

Service delivery depends on having necessary resources (staff, drugs, equipment, information, etc.), but it also depends to a large degree on how those resources are managed. The success of any organized health programme, in any country, depends on effective management. Many health systems worldwide face a lack of competent managers. Weakness in managerial capacity, especially at peripheral levels, has been widely cited as a constraint to scaling up or improving health services and a factor limiting the capacity of the health sector to address inequity.

Managers are a vital component of the health workforce. If they are not present in sufficient numbers and with appropriate skills, the system cannot function. They are needed at all levels of services and facilities to support implementation of national health plans.

Managers should spend a substantial part of their time managing resources and partnerships to ensure provision of services needed by the population. Other important management functions include: respectful and non-hierarchical modes of communication, participatory strategies that actively engage staff and the community, collaboration and teamwork, partnerships between departments, agencies and sectors, and the ability to learn and adapt to health system and contextual changes.

Key management posts are those where the decisions and actions taken have greatest impact on improving coverage and quality of service delivery. These posts should be identified and properly described and formalized in terms of clarity of role, authority and expected performance; the competencies required; job descriptions based on these; linkages between levels; and appropriate salary packages.

Where and how you train managers make a difference

Years of relying upon formal management courses have not delivered concrete results. One reason is that front-line managers have not been supported to translate training into actions at the workplace. Different aspects of management competencies are developed in different ways. Knowledge can be gained in the classroom; skills are built through action learning and at the workplace; while attitudes are shaped with experience and depend on the local social and work environments. Management competencies will be learnt most effectively if training takes place where people work, with the team that works together and when it addresses what they experience daily in their jobs.

Training alone is not enough

Even with action learning and on-the-job training to develop competencies, improvements in service delivery will only occur if managers have the necessary resources, support systems and an enabling work environment. Strengthening management must be seen in the context of overall health system strengthening. Management training alone cannot overcome major system weaknesses, especially lack of resources.

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

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

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

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

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

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

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

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

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

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

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

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

Key issues to consider in low-resource settings include:

- National- and peripheral-level planning must be linked.
- Upgrade management at peripheral levels.
- Supportive supervision is needed where managers are less experienced or skilled.
Rigorous priority setting is even more crucial in low-resource settings and is likely to include items that are not traditionally medical.

A clear service delivery model that is feasible must be defined.

A service package that is feasible and has the potential for being delivered universally must be defined and be the highest priority.

Methods to avoid capture of public resources by the better off are needed, while still planning to meet their legitimate needs.

Methods to integrate services in ways that make use of external funds more efficiently must be sought.

Better cross-programme collaboration is necessary if there are to be effective services at grassroots level across the continuum of care.

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

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


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