

The Health Sector Development Program

Design

A specific technical assistance project to assist NDOH with the development of the 1996–2000 National Health Plan²⁰ helped to consolidate objectives and strategies across all provinces in a single, comprehensive health plan. In terms of infrastructure and technical assistance to the public health sector, the sequence of ADB projects and the convergence of multiple development projects in the public health sector had set the stage for a sector development program loan. HSDP is composed of two policy-based loans²¹ in the total amount of US\$50 million and one investment loan²² targeting human resource development in the amount of US\$10 million. The appraisal mission took place in July 1996, ADB's Board of Directors approved the loans in March 1997, HSDP loans were declared effective in October 1997, and the inception mission took place the same month. The first tranche draw down was completed in February 1998. The first release of equivalent funds in Kina to NDOH was in April 1998.

For the purpose of this review, only the “Sector Program” covered by the two policy-based loans will be considered. The investment component of HSDP, commonly referred to as the Human Resource Development Project, was structured and managed independently as a project and thus falls outside the scope of this review.

Core Design Features

The design of HSDP took place in the wake of the political process establishing a framework for the decentralization of political authority, responsibility, budgeting, and spending, all embodied in the New Organic Law. However, the implementation and practical considerations necessary to achieve effective decentralization were given insufficient attention. In particular, NDOH lost authority over the decentralized public health infrastructure in the provinces and districts. Provincial and district governments assumed complete responsibility and authority over local health services.

The only exceptions to relinquished authority were found in the Department of Finance (DOF) and the Department of Provincial Affairs and Local Level Government (DPALLG). The national government retained some measure of authority over the decentralized budget and expenditure process by keeping the Provincial Treasuries under the authority of DOF, while DPALLG was mandated to ensure that standards for decentralization would be developed and implemented in all provinces, districts and local level governments.

Design Strengths

The National Health Policy, developed in a broad consultative process in 1995, was approved by the National Executive Council (cabinet) on 29 May 1996 and officially launched by the Prime Minister during the National Health Conference on 3 June 1996. The policy focuses on improving health services to the rural majority and the need to adopt health promotion and preventive health strategies to ensure improved health status. It also addresses issues of management reform in all areas and all levels of the public health hierarchy.

The policy gave shape to the National Health Plan, a cohesive document that presented a comprehensive set of objectives and strategies in the public health sector to be pursued over five years. The objectives and strategies described under HSDP, consolidated as benchmarks for the purpose of evaluating performance especially with regard to qualifying for the second tranche release, are drawn from the government's National Health Plan 1996–2000.

Because HSDP was a program loan, DOF was made its Executing Agency while NDOH was made its Implementing Agency. This arrangement had the added advantage of ensuring that responsibility and authority were not dissociated under the then largely untested New Organic Law. The primary rationale was to ensure that DOF would indeed make the Kina equivalent of the loan proceeds available to NDOH. In practice, it produced the added benefit of providing the basis for close consultation between the two departments and facilitated the development of improvements in accounting, monitoring, and reporting in both of them, leading to greater transparency and a growing willingness to address issues of governance.

An important design feature was the creation of a management committee, the Program Coordination Committee (PCC), the membership of which was drawn from many key government agencies. This was to ensure broad awareness of and participation in HSDP, its endeavors and progress. Participation in the PCC was further broadened to include the senior health representative in all 20 provinces (Provincial Health Advisors) and all interested stakeholders in the public health sector.

A technical assistance project²³ was attached to HSDP. The terms of reference were to assist in the implementation of HSDP, which by extension implied achieving objectives consistent with the National Health Plan and the key benchmarks required for the release of the second tranche of the loan. Monitoring and demonstrating conclusively that the benchmarks were indeed achieved was also an essential task.

Design Weaknesses

The non-prescriptive nature of and the diversity of settings and objectives ascribed to sector development program loans make them poorly understood, or at least susceptible to multiple interpretations. This was, and to a certain extent continues to be, the case for HSDP.

Since HSDP was widely seen as ADB's participation in the ERP, there was a not uncommon belief that the sector development program loans were intended to be budgetary support, albeit to the health sector, similar to the assistance from the other contributors to the ERP. At different times during the life of HSDP, often coinciding with changes in DOF's top management, the preferred interpretation was that the Kina equivalent

of the loan proceeds could be transferred to consolidated revenue and simply used to cover NDOH's recurrent budget without the increase in funding necessary to implement the National Health Plan. While this was identified by ADB as the principal risk to a successful outcome, the issue was frequently couched in ambiguity, allowing for differing interpretations of the sector development program loans.

The relatively large size of the loans, totaling US\$50 million, released in two equal tranches, created some discomfort within NDOH in relation to the proportionate responsibility the loans carried. Within DOF, early on, there was a near certainty that HSDP could only be budgetary support. This was evidenced by the non-inclusion of HSDP in the initial 1998 budget, ostensibly because a vote number had not been created in the budget to accommodate HSDP. Once it was agreed that the funds would be appropriated in the annual budget cycle, HSDP became one of the largest, and frequently one of the first, targets for budget reduction measures. Both the continual need for overall budgetary discipline and the frequent changes in DOF's top management ensured that, at each budget cycle, a protracted and intense battle to defend appropriations under HSDP was inevitable.

Contributing to DOF's position that the sector development program loans should be treated as budgetary support were the loan agreements, which focused on policy embodied in the policy matrix. Notably absent were familiar project-like management structures, large dedicated staff numbers commensurate with the size of the loans, and prescribed inputs with a schedule of outputs to be measured against objectives. DOF was not convinced that NDOH should have access to, and discretion over, a large pool of funds outside of the government's accounting system. By allowing the transfer of HSDP funds to an NDOH-controlled trust account, DOF was relinquishing authority and discretion to regulate cash flow and to influence expenditure patterns. DOF was not, at that time, suitably prepared to accept a sector development program.

Laying the Foundation for Implementation

The year 1997 was a troubled one for Papua New Guinea, which saw many reversals in government, frequent changes in department heads,

and the onset of a serious drought. NDOH and DOF struggled for ascendancy in their respective interpretation of HSDP loans. This created delays on the part of the government to open imprest and trust accounts and establish a vote in the budget. Delays were also experienced by ADB as Asian Development Funds were not available for Loan 1517-PNG (SF) and loan effectiveness had to be postponed.

The delays allowed for a concerted lobby effort by NDOH of most DOF division managers, many middle managers, and consultants. With time, this established a favorable environment within DOF, which then became receptive to the interpretation that HSDP was intended not for budgetary support but rather for supplementary funding to implement the objectives of the National Health Plan.

With the understanding that NDOH and DOF had a shared responsibility in ensuring the success of HSDP, a period of consultations and negotiations between the two departments resulted in accepted definitions of the roles, responsibilities, and authority of both parties, at the national and provincial government levels.

Among the key agreements were:

- The Trust Instrument, which defines the operation of HSDP parent and all provincial subsidiary trust accounts;
- The level of accounting responsibility acceptable to DOF for the Provincial Treasuries;
- Acceptance by both NDOH and DOF of accounting and reporting requirements to be the responsibility of Provincial Health Advisors (PHAs);
- The creation of the HSDP Secretariat and its functions and its location in DOF;
- The appearance of HSDP appropriation in NDOH Vote 240, making NDOH responsible for all expenditure;
- The use of the Papua New Guinea Government Accounting System (PGAS) for all accounting of HSDP expenditure; and
- The Procedures Manual for Provincial Health Advisors and Provincial Treasurers.

All agreed definitions were presented in detail to the PCC for review and debate before being endorsed for implementation. Detailed minutes of all PCC meetings as well as HSDP quarterly reports establish a record of the agreed definitions.

Procedures Manual for Provincial Health Advisors and Provincial Treasurers

The contents of the Procedures Manual, which establishes the necessary references and internal controls to ensure that implementation of HSDP activities would proceed efficiently and in a timely and transparent manner, were negotiated between NDOH and DOF over a nearly one year period. The Loans and Revenue Division was chosen to represent DOF with respect to overall responsibility as Executing Agency. The Public Accounts Division helped to define DOF accounting requirements and acknowledge limitations. The Budgets Division worked with NDOH in defining and officially recognizing the standard health program categories. The Information Technology Division assisted with establishing codes on the PGAS and provided technical support to the HSDP Secretariat. Direct discussions were held with many Provincial Treasurers to evaluate their propensity to participate in HSDP. Senior financial managers in NDOH assisted with the accounting procedures. Lastly, the Procedures Manual was reviewed by an independent accounting firm and found to be responsive to the needs of HSDP and compliant with government standards. At the PCC meeting held on 13 May 1998, the Secretary for Finance and the PCC made the final endorsement.

The following are the essential features of the Procedures Manual:

- An overview of HSDP, which responds to commonly asked questions;
- A statement of priorities drawn from the National Health Plan along with advice on how to obtain the best value for money;
- A description of the roles and responsibilities of the key participants and organizations, including the PCC, the HSDP Secretariat, and the Benefit Monitoring Unit;
- A description of the trust account system—including the division of authority, NDOH-initiated expenditure, province-initiated expenditure, and operating conditions and procedures—and progressive trust account ceiling levels which reflect performance levels;
- Accounting and monitoring procedures and requirements specific to HSDP and compliant with government standards, filing, and the paper trail and bank reconciliation;

- Reporting requirements, monthly and quarterly (expanded upon in later documents); and
- References including the HSDP Secretariat functions, the HSDP Trust Instrument, accounting forms, standard health budget, expenditure code structure, and coding for provinces and districts and items of expenditure (chart of accounts).

The procedures for undertaking expenditure of HSDP funds are largely drawn from the government's own procedures found in the Public Finances (Management) Act (1995). In the case of HSDP, they are presented in a more forthright manner and with greater practical context. In addition, modifications related to the data requirements on HSDP accounting forms provide for greater exploitable information potential in line with the monitoring requirements established under HSDP.

Financial Management Performance Requirements

Of paramount importance to the success of HSDP was the introduction of measures, which established minimum management performance levels (essentially, strict adherence to the procurement and financial management rules) in the provinces as a prerequisite to qualify for continued HSDP funding. This was possible as HSDP funding was appropriated at the NDOH level. As such, NDOH was under no obligation to provide funds to a given province although, clearly, the objectives of the National Health Plan can be met only through the active support of provinces, which in turn implement their annual health activity plans.

NDOH found itself in a position of authority (officially relinquished under the New Organic Law) as it could regulate the flow of resources, through HSDP funding, and do so conditionally. The Procedures Manual precisely sets out the conditions, restrictions and requirements, which establish the ground rules for provinces to receive funding under HSDP.

To qualify for continued HSDP funding, systematic supervisory reviews determine compliance with the following minimum requirements:

- Expenditure undertaken is identified in the Annual Health Activity Plan and/or is in respect of national priorities;
- Only expenditure authorized at the decentralized level, as defined in the procedures manual, has been undertaken;
- Value for money has been obtained on the basis of a competitive

- pricing process;
- All original supporting documentation is present and filed for all expenditure;
- Monthly cashbook and bank reconciliation is provided to the HSDP Secretariat;
- A minimum 80% of expenditure is acquitted (balance carried over to next review); and
- Previously identified issues are resolved.

However well designed and presented, the validity of a Procedures Manual is tested in its application and the enforcement of procedures in a fair and equitable manner. This implies an active management entity which ensures front line supervision and management and which reports to a higher authority on matters and issues necessitating high-level decisions.

The HSDP Secretariat

Based on the principal design feature of HSDP, the establishment of the HSDP Secretariat in DOF lent credibility to that department's designation as the Executing Agency as well as creating a permanent liaison entity between NDOH and DOF.

The functions of the HSDP Secretariat are described in detail in the Procedures Manual for Health Advisors and Provincial Treasurers (see Appendix A). In summary, the HSDP Secretariat provides support to the PCC, ensuring that it is kept informed of progress and all pertinent issues. The HSDP Secretariat also organizes, prepares, and takes the minutes in all PCC meetings and is responsible for all record keeping.

The HSDP Secretariat provides an important liaison function with relevant DOF divisions, between DOF and NDOH, and with other Departments and government agencies including the DPALLG, the Department of Personnel Management (DPM), and the Auditor General's Office (AGO). It provides close support to all PHOs and, to a lesser extent, the Provincial Treasuries. It assists NDOH planning/budgeting initiatives and assistance in the provinces and districts. The Secretariat also fulfills an important liaison function for the development partners, keeping ADB, AusAID, New Zealand Agency for International Development (NZAID), WHO, and

other interested parties informed of progress and issues.

An essential function of the HSDP Secretariat is to provide comprehensive accounting support to the PHOs and, more recently, to the project section of NDOH. The Secretariat maintains a stand-alone PGAS station used to record all expenditure under HSDP. Standard HSDP expenditure reports are produced and special analysis is available upon request. In an independent financial review of the Trust Account conducted on behalf of AusAID,²⁴ it was found that the Secretariat, its operations and procedures, satisfy the accountability requirements for contributions made by AusAID, thereby allowing AusAID's participation in the mechanism (See Developing Partners Finding Common Ground, Chapter 5).

In addition to accounting support, the HSDP Secretariat has an important supervisory function. *Field Visits* and reviews in the provinces cover procurement processes, an evaluation of performance both with respect to public health activities and to procedural requirements, and provide assistance in the resolution of local management issues. This function has led to considerable progress in some PHOs, facilitating them to improve upon their overall management skills and to be more effective in their role as a coordinating entity of provincial health services.

The HSDP Secretariat also serves the important function of providing an effective internal review of NDOH expenditure of HSDP funds, which covers approximately two thirds of all HSDP expenditure. As established under the HSDP Trust Instrument, both NDOH and DOF are obligated signatories to all fund transactions. The independent situation of the Secretariat, situated in DOF, allows for the critical review of HSDP expenditure initiated by NDOH. The Secretariat is then able to advise DOF on the nature of HSDP expenditure ensuring a high degree of transparency.

Program Coordination Committee

As head of the Executing Agency, the Secretary for Finance was the PCC chairperson. However, the Secretary for Health most often chaired PCC meetings in the absence of the Secretary for Finance. DOF representation was good and usually included the Budgets Division, Public Accounts Division and Information Technology Division. The Department of Na-

tional Planning and Monitoring (DNPM), closely associated with DOF, was also usually well represented. Meeting on average three times a year, the PCC brought together senior NDOH staff, PHAs, CMC and non-government organization (NGO) representatives, and other public health stakeholders in a unique forum with key DOF and DNPM representatives and, on occasion, representatives of the DPM, DPALLG, and the National Monitoring Authority.

Under the steady leadership of the Secretary for Health, issues of importance not only in the context of HSDP but to health services delivery overall were discussed openly and constructively. Indeed, PCC meetings offered a rare opportunity for DOF and DNPM managers, among others, to hear directly from key representatives in the health sector.

The issues debated, which the PCC influenced, included the official recognition by DOF and its Budgets Division of the standard program categories establishing a uniform budget structure in health for all three levels of government. The PCC also served as an important forum to discuss annual appropriations in health, at both the national and provincial levels. A recurring theme was the weak budgetary support to health services in many provinces as well as the unstable appropriation of HSDP funding from year to year.

The poor performance of many provinces in passing along the payment of wages and operational support for church-run health services received much attention and airing of views. The resolution saw NDOH, DOF and CMC agree to withdraw church health funding from provincial governments and instead channel the funds through NDOH, which then ensures that the funds are transferred to CMC and the various church health services around the nation.

The PCC was the ideal forum to table financial reports on health expenditure, which although up-to-date and informative were not initially well received by DOF and DNPM. These reports were essentially Technical Assistance (TA)-driven but strongly supported by NDOH as an internal requirement for proactive management. Opinions changed and positive attitudes developed as the reports were produced year-after-year, and the information was widely shared and used in a constructive manner.

An important function of the PCC was to provide a forum for PHAs to report on their successes and difficulties to the extensive PCC membership. This allowed for an informal peer review process on the one hand,

and a de facto recognition of NDOH's hierarchical position, especially in the person of the Secretary for Health, on the other. Provinces, which could demonstrate improvements, were openly commended. As for those which were deemed to be non-performing, the Secretary for Health would demand improvement, stipulating requirements and a time schedule. Only some PHAs, however, were responsive. Changes in NDOH, with the appointment of a new Secretary and the transformations brought by the participation of other donors in the Trust Account mechanism (see Developing Partners Finding Common Ground, Chapter 5), led to the interruption of the PCC, which finally was revived as part of the Sector-Wide Approach preparation process.

Implementation Support to Provincial Health Offices

Training

The difficulties encountered in apprising DOF senior staff and managers of the nature and operation of HSDP underscored the importance of adequately training provincial health staff and provincial treasurers and of informing the decentralized public health staff and the provincial and district level governments as broadly as possible. To this end, formal training was organized for all signatories to the provincial trust accounts and the successful completion of the training was made a prerequisite for the first disbursement of funds. This required both the Provincial Health Advisor and the Provincial Treasurer to work side-by-side in the training sessions. Practice situations and examples were selected based on their high probability of creating disagreement and, possibly, conflict between the two principal signatories. This provided the opportunity to resolve many issues before they actually occurred in the provinces. It also gave both parties the opportunity to develop a working relationship where frequently none had existed. The Secretaries of both NDOH and DOF expressly endorsed this strategy.

Supervision

The initial release of funds to a PHO was contingent on the success-

ful completion of the training. The next release of funds depended on the outcome of a review of the use of the initial advance of funds. The required review would take place in the province, conducted by the HSDP Secretariat under the heading Field Visit, in order to better address the difficulties encountered. As it turned out, all manner of interpretations of HSDP procedures as well as of strategies in implementing health plans and priorities generally revealed a less than optimal use of HSDP funds at the start. The prevalence of this initial finding covered nearly all provinces.

It became necessary to negotiate the resolution of problematic items of expenditure on a case-by-case basis. This allowed for practical, on-the-job training with frank discussions addressing both public health issues and governance issues. In the process and in most provinces, a working relationship was forged between the HSDP Secretariat and the PHO, sometimes extending to the provincial administrator and elected representatives. It became evident that active, constructive supervision based on a detailed review process was necessary to effect the changes sought to ultimately improve health status.

It gradually emerged that while PHAs and many of their staff would respond positively to the Field Visits and the detailed review process, many of the district-level and facility-based staff would not recognize the PHA's authority or HSDP procedures. In effect, there were few "trickle-down" benefits from the review process and on-the-job training. More frequently found was an attitude of challenge and non-compliance shaped by the fragmentation of the public health system hierarchy engendered by the New Organic Law.

Mediation

To respond to the poor performance of the decentralized public health staff in some provinces, opportunities were sought to include greater numbers of public health staff in organized management meetings and consensus-building sessions during Field Visits. The meetings often revealed that the PHO would have a poor record of communication with health staff and local public health stakeholders. The resulting low levels of trust and isolation, both willed and physical, meant little cooperation could be found, a situation far from desirable when success largely de-

depends on organization and functioning systems. In some cases, conflicts within or simply a lack of support from the provincial government would negatively influence the respect for hierarchy and contribute to broad-based poor performance by public health staff.

Some PHAs have taken the initiative to improve relations with district-level staff and facility-based health staff. However, to establish a dialogue and to engage in a management process to encourage and coordinate public health activities usually requires much confidence building. In these instances, mediation by the HSDP Secretariat and the ADB Technical Assistance to facilitate dialogue and to actively support the PHAs proved to have a positive influence on future performance.

Discord has also not been uncommon between the PHA and the chief executive officer of the provincial hospital and between the PHA and the church health secretaries and representatives of NGOs. Competition for scarce resources and, occasionally, land disputes have made cooperation between these province-based public health agencies difficult. As each has a recognized role in the delivery of public health services, all are eligible for HSDP funding. Mediation on a case-by-case basis by the HSDP Secretariat has proven useful in improving relations and access to HSDP funds. Frequent follow-up has usually been required to prevent backsliding.

Monitoring and Reporting

A hallmark of HSDP was monitoring and reporting. Each Field Visit or review would be written-up in a standard format covering issues and recommendations. Selected examples are provided in Appendix B. They illustrate the range of issues addressed in the context of HSDP monitoring, which are not limited to the Program but also encompass broader issues within the public health system. Usually only a page or two in length, the Field Visit report would be shared within a week of the review with the PHA and NDOH senior management. Over time, the reports were circulated more widely, especially when some issues proved impervious to resolution and greater awareness to generate greater peer pressure to conform seemed to be required. While the reports were frequently critical, they were constructive in nature and always proposed solutions to the shortcomings discussed.

The Field Visit reports were often shared, through the HSDP Secretariat, with other provinces. This proved beneficial particularly in frequently encountered issues as these were more easily discussed and resolved if it were established that other provinces were experiencing the same issues.

Short financial reports were produced and widely circulated, especially in the course of Field Visits and speaking invitations to various seminars and workshops. Annual HSDP expenditure reports by province and program category and by province and item category (type of input), limited to just two pages, allowed easy comparison between provinces and helped establish whether expenditure mirrored stated priorities.²⁵

Monthly tracking sheets which monitored, by province, trust account balances and fund transfers and a summary progress report on expenditure and availability of funds were reproduced in large quantities and circulated widely within NDOH, DOF, and all the provinces and among development partner agencies.²⁶ This type of constant feedback helped to minimize misrepresentations as to the availability of funds, especially in the provinces, and to ensure a high level of transparency to guard against the misuse of funds.

Transparency

A conscious effort to be as transparent as possible not only helped to define HSDP but also helped to guarantee its survival. The combined effect of the Procedures Manual, written Field Visit reports and Secretariat reviews, various monthly tracking sheets, comprehensive quarterly reports, annual public health sector expenditure reports, and an independent audit program covering the use of HSDP funds (see Reforms and Innovations, Chapter 4) was to stave off any serious threat of large scale abuse.