

# Successes and Challenges

## Achievements

### *Increased Financial Allocations to Rural Health Services and Collaboration with Information Technology Division, DOF*

Under the first policy reform area “Shift Emphasis from Urban to Rural Health Services,” the first of the benchmarks reflecting the government’s priorities was to increase financial allocations for rural health services by not less than 10% every year in 1997, 1998, and 1999 over the 1996 level of expenditure. Annual health expenditure undertaken at the national level was made available by DOF’s Public Accounts Division in April or May of the following year. The difficulty was with decentralized health expenditure, which—although recorded by the Provincial Treasuries—was not reported. A result of the New Organic Law and the difficulties associated with its implementation, the situation continues to persist.

In collaboration with the DOF’s Information Technology Division, it was determined that the data were recorded on PGAS and available on backup tapes kept by all Provincial Treasuries. The data, however, were not routinely shared by all provinces with the DOF. Using HSDP resources and the argument that DOF, NDOH and ADB all required public health expenditure monitoring to evaluate performance under the policy matrix, the backup tapes were obtained from all Provincial Treasuries.

Information Technology Division staff and technical assistants collaborated with NDOH, through the ADB TA, to define a standard health expenditure report with as much useful information as the available data

would allow. Data were reviewed for integrity and some data sets required cleaning. A series of software programs were developed to produce the required information, in particular provincial health expenditure under the grants (200 series), provincial health expenditure from self-generated provincial revenues (700 series), and the treasury payroll for public servants employed in the public health sector. This information completed the data necessary to produce annual provincial health expenditure and annual public health sector expenditure reports.<sup>27</sup> The information has been produced for all years between 1996 and 2001, in standard format. Dissemination of the annual Public Health Expenditure Report averages 600 to 800 copies each year.

Analysis of the annual public health sector expenditure revealed rural health services expenditure increased by more than 10% for each of the years 1997–1999 over the 1996 level of expenditure, specifically: (1997) 44.1%, (1998) 22.4%, and (1999) 16.2%. The large increase in 1997 is due to the inclusion of AusAID project aid for the first time. The increase in 1999 drops to 1.9% when HSDP contribution is factored-out.

### ***Increased Medical Supplies to Rural Health Services***

Appearing under both the first policy reform area “Shift Emphasis from Urban to Rural Health Services” and the third policy reform area “Undertake Financial Reforms in the Health Sector,” benchmarks were exceeded in both cases. The first benchmark was to “increase the value of drug supplies to health centers and aid posts to K3.0 per capita in the area served.” In 1998, the value was K4.29 per capita; in 1999, it was K6.00 per capita. The second benchmark was to “increase the allocation for drugs and medical supplies to 25% of NDOH’s budgetary allocation for 1998.” In 1998, the allocation of drugs and supplies as a percentage of total NDOH expenditure was 28%. In 1999, the value increased to 31.8%.

In terms of the contribution made by HSDP to the total expenditure on drugs and medical supplies, in 1998 the contribution was 34.7% and in 1999 it was 26.6%. More importantly, the nature of the contribution has resolved the persistent problem of inadequate drug supplies reaching the lowest level of the public health system, the aid posts. A standard aid post medicine kit was designed with three rounds shipped annually. The kits are delivered directly to the PHOs, bypassing NDOH’s area medi-

cal store network. The PHOs use HSDP-supplied trucks and funds to distribute the kits to all functioning aid posts. Because the kits are assembled in-country, health promotion materials from various sources (WHO, NDOH, National AIDS Council) have frequently been added to the kits for broad rural dissemination.

The aid post medicine kit system is widely viewed by NDOH, other central agencies, and provincial governments as a successful initiative. Responsibility for procurement and distribution rests entirely with NDOH, PHOs, and rural health facilities. The ADB TA provided minimal supervision, monitoring, and reporting. While the aid post medicine kit system needs to be reviewed and refined, it should be maintained as a permanent feature in NDOH's provision of medicines nationwide.

### *Management Processes*

While the fourth policy reform area "Enhance the Efficiency of Health Service Delivery" has as its principal benchmark the establishment of national and provincial health boards (see Administration Under the Organic Law on Provincial Governments and Local Level Governments, Chapter 2), the underlying objective was to improve the management of the delivery of public health services. As presented in this section, the management structures and processes developed and implemented under HSDP have served as an overall management strengthening process extending beyond the HSDP policy matrix. This success is to a great extent based on the ownership developed through the wide consultation and participation in their establishment, and the investment in capacity building in the provinces through regular supervision and the performance review process.

Many of the PHOs and their respective provincial governments have responded well to the continuous process of management strengthening. The process has served to highlight the principal governance issues, creating a more transparent environment in which these issues receive greater attention and often become the subject of local discussion and remedial action. While all provinces receive the same oversight, their problems and recognized weakness are given individual attention, in a manner and at a pace that are acceptable, most often, to their respective provincial governments. A frequently updated tracking sheet, Health Sec-

tor Improvement Program: Status of the Provincial Trust Accounts, allows the PHOs to assess their management performance at a given point in time and in relation to other provinces. This information is widely distributed throughout the public health system and to all stakeholders. A recent example can be found in Appendix F.

## **Reforms and Innovation**

The implementation of HSDP raised numerous issues both within NDOH and in the provinces, and across other central government agencies. Building on initial good will and perceived success, the resolution of issues relating to the performance of NDOH and provincial public health officials became crucial to the continued success of HSDP. Concomitantly, the performance of other key government agencies including the DOF, DPM, DPALLG, and AGO became accepted as inextricably linked to the performance of the public health sector.

### *Provincial Performance Audits*

Early in 2000, it was recognized that the pattern of performance in the provinces with respect to HSDP was not dissimilar to the pattern found among provincial governments. The absence of authority over the PHOs by NDOH and the HSDP Secretariat meant there was no recourse for failure to comply with advice and assistance other than to withhold future funding, even though this would compromise the overall health status.

In order to resolve the stalemate and to lend greater credibility to NDOH's leadership and the functions of the HSDP Secretariat, an independent audit firm was contracted to conduct performance audits on the use of HSDP funds by PHOs. The audits reviewed their conduct of business against HSDP procedures, expenditure statements, and supporting documentation. Assets procured under HSDP were physically verified and a determination made as to whether value for money was obtained and if the assets were used for their declared and intended purpose. Four provincial performance audits were conducted in 2000, eight in 2001, and seven in 2002.

The audit reports were discussed internally by NDOH senior management and the concerned PHA was given the opportunity to respond to the findings. Several PHAs were found to be severely deficient in their management of HSDP funds. In these cases, the Secretary for Health initiated dialogues with the concerned provincial administrators, in their capacity as chairpersons of the Provincial Health Board, to seek corrective action.

These independent performance audits and the resulting situation wherein NDOH enjoined a provincial government to undertake remedial action with regard to its senior manager for health was an uncharted administrative process. Most cases were politicized, and it sometimes took from one to two years before an acceptable resolution could be found. In some cases the DOF, DPALLG, and AGO were informed and requested to intercede in an official capacity. However, while these national agencies have some degree of responsibility with regard to the provincial governments and the concomitant authority to act on behalf of the State, the principal issue is one of personnel management within a provincial government, the independence of which is defined in the New Organic Law. Nonetheless, there is some evidence that this recourse has assisted in breaking the stalemate situation.

### *Department of Health Performance Audit and Reform Process*

The undertaking of independent performance audits in the provinces served to underscore the need for a similar review process in NDOH. This situation was made clear by the Secretary for Health and ADB was requested to assist in establishing an independent review of NDOH's financial management and procurement process.

Terms of references were prepared by NDOH and the AGO was approached for assistance in undertaking the selection process for an accounting firm. The AGO approved NDOH's request to initiate a performance audit not normally provided for under government regulations. It was also agreed that AGO would undertake the selection process and only international accounting firms would be invited to participate. The audit costs were covered with HSDP funds.

The performance audit<sup>28</sup> covering financial management and procurement<sup>29</sup> was carried out over a two-month period and the findings

were presented by the accounting firm to NDOH senior executive management in mid 2001. The report established that controls over procurement and expenditure within NDOH were ineffective and were not conducive to efficient operation. In particular, there was an inadequate managerial control framework, inadequate operational procedures and controls that do not ensure compliance with the Public Finance and Management Act, and the inability or unwillingness of management to take appropriate action in the event of suspected breach of statutory requirements or ethical business practice. Subsequent senior executive management meetings were held to review the performance audit findings, which resulted in a decision to proceed with the implementation of the recommended corrective measures. More importantly, senior executive management recognized that NDOH could not undertake the proposed reforms alone and the consulting branch of the accounting firm, which conducted the performance audit, was contracted to assist in the implementation of the reform measures.

Among the tasks carried out in the first eight months were:

- Assistance in bringing up-to-date the bank reconciliation of NDOH, 18 months out-of-date, required by DOF;
- Reforming the internal audit section of NDOH which had become dysfunctional, providing both purpose and on-the-job supervised training, and using the section to assist in the implementation of subsequent reforms (e.g., review of all NDOH rental agreements and establishment of an NDOH rental policy);
- Review of the accounts division and the proposal of a new structure, revised procedures, and a training program for staff;
- Re-engineering the procurement function to limit the number and nature of procurement centers and formulation of written procedures for the capital expenditure procurement center and for the human resource management procurement center;
- Assistance in the recruitment of private sector accounting staff; and
- Assistance in developing regular expenditure reporting by NDOH senior executive management for management purposes.

The process of bringing about change has been slow. Only incremental progress has been achieved thus far, but with the potential to positively influence public service culture. The exercise has polarized public

servants within NDOH into those supporting the reform process and those opposed. The internal debate generated has created undercurrents, which frequently influence the outcome of individual initiatives making up the process. Setbacks are not uncommon and, occasionally, progress attained appears inexplicable. Participation in the reform process is extensive; the slow pace of progress a necessary trade-off for broad consultation and consensus building.

The reform process should be expected to require several years to take hold within NDOH and perhaps longer, depending on the pace of reform processes undertaken in other national departments and central agencies. Many of the weaknesses identified within NDOH are present to varying degrees in all government agencies. Progress in NDOH will have to be matched with progress in other agencies to ensure sustainable public service reform.

Perhaps one of the greatest constraints to progress in the reform process is the inability or unwillingness of senior management to exercise personnel management options in relation to non-performance or breach of ethical business practices. NDOH's ineffectiveness in this area of management responsibility is entrenched, supported by non-responsive central government agencies, in particular DPM and DOF. Public service reforms addressing personnel management issues will have to reach across all government agencies and all levels of government in order to have a permanent impact on public service culture.

### *Department of Finance and Public Health Sector Expenditure*

The production of a standard report on public health expenditure for six consecutive years has established that required information can be produced given sufficient persistence and collaboration between DOF, NDOH, and development partner agencies. Many government departments and development partners alike have positively received the broad dissemination of the annual report. The standard reports have helped to create a growing body of information users, especially among decision-makers. This is a slow process and one in which an interruption of even a single year would result in a serious setback in the sustainability of the information cycle.

The added value of having standard information over a six-year pe-

riod is highlighted by the inclusion of the public health sector expenditure trends, particularly in the provinces, in the ongoing debate on the strengths and weaknesses of the New Organic Law. The difficulties encountered in the information production process also underscore systemic weaknesses in DOF, both at the national and decentralized levels, and in the government payroll system. NDOH, like every government department, has a vested interest in seeing DOF address and resolve these weaknesses. For NDOH, to actively subscribe to DOF's strengthening process is to contribute to the DOF's fundamental mission to support other government departments and agencies.

The Financial Management Improvement Program (FMIP)<sup>30</sup> established in the DOF is undertaking fundamental reforms to correct recognized weaknesses. NDOH maintains a policy of liaising with DOF and the FMIP in order to provide inputs to their reform process, which reflects the needs experienced by the public health sector. NDOH has successfully influenced the budget structure and the re-centralization of the appropriation for both hospital funding and church health services funding to overcome the dilution suffered at the level of provincial governments. In working with the FMIP, NDOH seeks to participate in the DOF reform process as it applies to NDOH and, eventually, at the decentralized levels. This developing working relationship is increasingly seen as being beneficial to all parties.

### *Opportunities in Managing Cash flow*

An unexpected outcome was the flexibility offered by the HSDP trust account to manage cash flow in a decentralized way. NDOH's managing of cash flow to allow for the "unexpected" instead of the standard DOF manner has enabled rapid crisis resolution including clearing shipments of medicines off the wharf because DOF was experiencing a cash flow crisis, reopening NDOH offices following lockout due to non-payment of electric bills, avoiding NDOH phone disconnections by covering final requests for payment, making up a shortfall in the cost of travel arrangements for essential purposes, and many other instances. The result is that NDOH has been allowed to function relatively smoothly, with fewer disruptions to core activities, in a period of fiscal uncertainty. HSDP has also had a similar stabilizing effect in most PHOs.

Managing cash flow guided by a minimum comfort safety margin has also allowed for opportunities to be seized. In the case of the independent audits of PHOs as well as the independent review and one-year consultancy to reestablish internal controls and management systems within NDOH, although not budgeted, both NDOH and DOF agreed to cover the associated costs with HSDP funds.

Managing cash flow from one fiscal year to the next and across different fiscal years for bilateral development partners has also provided for much needed stability. In a well-established cycle of profligate government spending in the fourth quarter and very tight availability of funds in the first quarter, HSDP has consciously managed its own cash flow to compensate for the less than regular government spending patterns. Also, important bilateral development partners have fiscal years six months out of synchrony with Papua New Guinea's fiscal year and the HSDP trust account has served to facilitate bilateral assistance across the fiscal years of these development partners.

## Challenges

HSDP included 34 policy actions in four policy areas: (i) shift emphasis from urban to rural health services, (ii) shift orientation from curative to promotive and preventive health services, (iii) undertake financial reforms in the health sector, and (iv) enhance the efficiency of health service delivery. The release of the second tranche was subject to the fulfillment by the Government of eight specific conditions,<sup>31</sup> of which six were complied with at the time of the midterm review. While substantial progress has been made in financial reforms in the health sector and the allocation of drugs and funds to the rural health facilities has benefited from HSDP and AusAID input, other targets have not been attained. Little has happened with regard to the planning and management of human resources. The on-site training of health center staff is not systematically developed and supervision is very weak at all levels. Mother-and-child health patrols have increased only marginally and only in some provinces, and immunization rates are falling. In brief, HSDP did not succeed in preventing the slow and steady collapse of the health system in rural areas.

The causes for these failures are complex, including cultural and social issues in personnel management, but many are rooted in the breakdown of the vertical integration of health services brought by the New Organic Law. Decentralization can alleviate overloading of central government and improve access to decision-making and participation by more people. However, decentralization can also lead to deterioration in the use and control of resources if the administrative capacity is lacking, which is the case in Papua New Guinea. Of major importance, too, is the continuous degradation of the economic situation in the country and the deterioration in the transport infrastructure. Other factors identified by the Health Sector Review<sup>32</sup> are:

- *The management culture of the Papua New Guinea public sector is not performance based with few rewards available for officials who perform well and few sanctions available to deal with those that perform badly. Budgeted funds are not always available to enable implementation of sector activity plans.*
- *Many provincial authorities have not prioritized health services through budget support. Provincial governors have all agreed to allocate 15% of provincial revenue to health. None have yet done so. Peripheral health services have been damaged by disproportionate retrenchments of key health staff when savings have been required.*
- *Health policy is generally sound. However, a number of significant gaps were noted with respect to: (i) AIDS/HIV, where there appears to be confusion over roles and responsibility; (ii) family planning, where this effective mechanism for reducing maternal and infant mortality appears to be under-prioritized; (iii) human resource development, where there appears to be little enthusiasm to address the multiple issues that face the management of this key resource; and (iv) poverty, where there appears to be little recognition of the need to specifically address the problems of providing services to the disadvantaged.*
- *Supportive supervision, a basic management tool for achieving and maintaining performance, is absent or weak at all levels of the health system.*
- *While policy is sound, implementation of the policies has been weak or non-existent reflecting both the lack of vertical integration in*

the health sector and management weaknesses.

- Focus has been on developing high quality studies, policy papers, and guidelines and a lot of effort has been invested in planning rather than in *service delivery*.

Confronted with these difficulties, the Government and donors involved in the health sector began to explore mechanisms that would permit a broader framework for policy dialogue and action, within an integrated, strategic approach. This development took place while there was increasing frustration and dissatisfaction in NDOH with the proliferation of projects, which were overwhelming NDOH's management capacities and distracting attention from overall sector management, and the dissatisfaction of donors with disappointing performance of project-based assistance. The search for new forms of partnership and a review of international initiatives resulted in the adoption of a Sector-Wide Approach (SWAp) as a medium-term collaborative program of work.