Consultant's Report: Financing the Front Line

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Strengthening Health Sector Financing and Financial Management in Papua New Guinea

CONTENTS

ABBREVIATIONS

ADB	–	Asian Development Bank
DOH	–	Department of Health
HFG	–	health function grants
PHA	–	Provincial Health Authority
PNG	–	Papua New Guinea

I. OVERVIEW

A. Summary

1. **Improving health sector financing.** Improving sector funding, and financing in Papua New Guinea (PNG) requires a multilayered approach in the newly decentralized health sector. This multi-layered approach includes addressing issues at the national and subnational levels, and viewing finance as one of several information elements that collectively guide health management decisions to drive better health sector performance.

2. **Fragmentation and coordination.** Frontline health financing in PNG is fragmented, which impacts the ability of Provincial Health Authorities (PHAs) to deliver effective health serves. Health sector financing needs streamlining, and resources used more effectively to deliver services at the provincial, district, and local levels.

3. **Information systems.** Information systems are a critical element in promoting better performing PHAs, including a modern financial management system that provides accurate, and timely information. The PNG electronic national health information system and human resource management information system both provide timely management information.[1] The PNG subnational financial systems in health do not. This needs to be rectified.

4. **PHA performance communicated and monitored**. Financial and other health performance information needs to be used effectively (i) internally to guide sub-national management decisions; (ii) externally to inform the community; and (iii) nationally to report to the Department of Health (DOH), and through the DOH to the Minister for Health. The aim is that PHAs transparently demonstrate they are meeting their accountability for (i) efficient and effective use of resources; (ii) progress towards universal health coverage; and (iii) achieving health gains towards achieving the health Sustainable Development Goals. In turn the information will provide the evidence-base to inform national policy development, and the DOH for its support, guidance, and direction to the frontline health system.

II. HEALTH SECTOR FINANCING AND FINANCIAL MANAGEMENT IN PNG

B. Untangling Health Funding Streams

5. **Fragmented health financing.** Financing for frontline health in PNG is fragmented, and there has been a consistent failure to achieve a timely and predictable flow of funds from national government to provincial governments, and the on-allocation to health facilities. Funding streams are presented in Table 1 below.

6. Some national funding goes directly to PHAs, some to hospitals, some to provincial administrations, and some to faith-based providers which provide approximately 50% of heath services in PNG. Other funding streams contribute further to fragmentation including those from provincial internal revenue, from provincial service improvement program funds, and from district service improvement program funds. Allocations from these are based on local negotiations, further contributing to complexity, and fragmentation.

7. The annual budget process for PHAs and hospitals for staff, and other operational costs is led by the national Department of Treasury. This is not part of the intergovernmental financing arrangements between national and provincial governments.

8. **Rural health financing complexities.** Rural health funding is also complex. Provincial internal revenue is expected to be a primary source of operational funding for rural health

[1] The electronic heath information system is implemented in 186 facilities in 5 provinces, and national roll-out is continuing; the electronic human resource information system is implemented in 15 provinces, and national roll-out is also continuing.

services. Provincial governments allocate provincial internal revenue between sectors and priorities. There are annual budget negotiations with the PHAs to secure the health sector share of provincial internal revenue. In practice, few provinces allocate monies from internal revenue to support the recurrent costs of rural health services.

9. **Health funding grants**. Where provinces have insufficient revenue, the PNG national government provides a health funding grant (HFG) to provinces to fill the operational funding gap. The HFGs are part of the country's intergovernmental financing arrangements, and historically were paid directly to provincial administrations for on-distribution to PHAs for their rural health services.[2] In the 2018 budget, HFGs have been appropriated directly to PHAs. This is a major and positive development that should remove a key funding flow bottleneck.

10. **Faith-based health services**. Providers of faith-based health services receive dedicated staff and operation grants from the national government, as compared to the public providers relying on funding from the provincial governments, either through internal revenue, or the HFGs. There is no mechanism for the PHA to monitor funding grants to faith-based health providers.

11. **Facility funding**. A number of provinces have previously, or are currently, implementing a form of facility funding or budgeting. The aim is for frontline facilities to have greater certainty of access to an amount of funding for service delivery.[3] Lessons from the various facility-based funding and budgeting initiatives, and the growing use of technology at facility level, show that health facility funding and budgeting can be a workable approach.

12. **Capital funding.** The Service Improvement Program is the main source of capital funding sub-nationally. The health sector is required to work with provincial and district administrations to secure capital funds within locally defined allocation processes. The timely release of funds is influenced by national warrants and other cash release processes, including government cash shortages. Completion of capital works projects can be undermined by delays in release of cash.

Table 1: Health Funding Streams for Frontline Health Services

Source of funds	Purpose	PHA Budget Control	In-year Accessibility to Funds
PHA budget allocations	PHA and provincial hospital staff and operations	High. PHA negotiates via annual budget process.	Subject to DOT/DOF dispersal
Provincial salaries	Staff salaries for provincial health staff.	High. 'Funded' positions are paid.	Normally satisfactory.
Provincial Internal Revenue	Rural health services operational costs.	Low. Historically hard to secure.	Subject to Provincial Administration

[2] Some Provincial Administrations retain the funds on 'their books', and the PHA is required to work through the Provincial Administration (and the Provincial Finance Office [formerly called the Provincial Treasury]) throughout the year to access and spend those funds.

[3] Direct facility funding describes an approach where the monies allocated to the facility are controlled by the facility – often in a facility bank account. Facility based budgeting describes an alternate approach, where a facility is provided a specific budget (which ring fences funds for their use) but the monies are retained within the system.

	Health capital projects.		collection and release process.
Health Function Grant (operational only)	To supplement rural health services operational costs.	Predictable budget source, but low influence by the PHA.[4] NEFC recommends levels.	Timing and predictability from national level uncertain. Transfer from Provincial Administration uncertain.
Church Health Services Grants (staff & ops)	CHS facility staff and operational costs.	DOH administration.	Subject to DOT/DOF dispersal
Service Improvement Program (PSIP & DSIP)	Potentially available for capital projects in the health sector.	Low. Hard to secure.	Timing and predictability from national level uncertain.

CHS = church health services; DOH = department of health; DOF = department of finance; DOT = department of treasury; DSIP = district support improvement program; NEFC = national economic and fiscal commission; PHA = provincial health authority; PSIP = provincial support improvement program

C. Costs and Distribution

13. **Facilities and staff.** The number and distribution of health facilities and health staff are key determinants of health costs, and of equity of access to health services. A facility that provides quality health services that meet community needs typically attracts staff and equipment, and recurrent funding to deliver the services. Mapping of health facilities would help the sector better understand their distribution across provinces, and help with strategic planning decisions to ensure targeted capital and operational health funding for maximum impact, and sustainability.

14. **National health standards costs.** There are national health standards but little understanding of their cost implications. This should be rectified.

15. **Health workforce shortage.** The general view is that there is a national health workforce shortage in PNG, and that more health workers should be trained, including doctors and nurses. In 2018, for example, doctors from Cuba are being recruited to partly bridge the gap in medical workforce supply, and the PNG medical school is aiming to increase its medical graduate output.

16. **Health workforce data.** There is little data on health workforce allocative efficiency, productivity, or clinical standards. There is also little data on health workforce numbers, and a current payroll cleansing effort to determine these. An analysis of health workforce constraints and gaps nationally and by province, and development of sustainability options, would provide information to support better health workforce planning, as will the

[4] Under the intergovernmental financing arrangements, the HFG is payable to the Province Government/Provincial Administration; the PNG National Economic and Fiscal Commission calculates the HFG – as part of a suite of provincial recurrent administration and function grants – and recommends the amounts to the Treasurer.

management development programs in the proposed new ADB health sector investment in PNG.

D. Strengthening PHA Budget Processes

17. **Improving budget coordination.** The provincial health system is a collection of actors at various levels with particular responsibilities who receive money from a variety of funding streams. The aim of health sector decentralization, led by PHAs, is to draw the various parts together creating an integrated approach to health service delivery for more effective health services, and better health gains. The planning and budget process has high strategic value for supporting a strongly coordinated sector effort, and its more effective resourcing.

18. The PNG health sector receives funding from a variety of sources (Table 1). PHAs will need to use the planning and budget process effectively to coordinate activities, and to actively engage and negotiate with other stakeholders to secure appropriate funding for recurrent activities and capital projects.

19. The decentralized health sector in PNG has an ongoing challenge to secure and coordinate funding for recurrent activities, and for capital projects. The health sector is undergoing major change as it decentralizes, and there is a need to better understand the cost of delivering provincial and district health services to enable evidence-based funding allocations.

20. **Budget processes standardized.** A standard approach to PHA budgeting would assist PHAs, and central agencies tasked with overseeing the budget process. This approach would seek to coordinate the various elements of the health sector within the province, and communicate an integrated budget to the wider audience.

E. Strengthening Financial Information Systems

21. **Integrated information systems required.** Good information systems in finance, in health gains and clinical outcomes, in human resources, and in procurement are central to the development and effective functioning of PHAs. The PHA boards, management, and clinicians require timely information to monitor, manage, and deliver health services efficiently and effectively. This information is also required at the national level to monitor sector performance, and to support evidence-based policy development.

22. **Outdated financial systems.** PHAs currently use legacy software systems from provincial hospitals (Attaché) and provincial administrations (PGAS), as well as spread sheet-based systems.[5] A modern yet pragmatic financial management information system will be a critical element for PHAs in meeting accounting needs internally, and reporting requirements nationally. An assessment of the PHA financial management needs will help identify possible solutions to the current disparate and dated financial data capture, and reporting arrangements.

F. Effective monitoring and reporting

23. **Analysis and communication.** Effective monitoring, and reporting is a critical skill requiring development within PHAs for analysts, managers, and clinicians as it relates to clinical governance particularly. Data generated by the financial and other information systems requires analysis, and communication internally and externally to the wider audience (Table 2). Basic financial reporting is a discipline to be instilled in PNG. To be fully

[5] Attaché is a commercial accounting package used in many Provincial Hospitals across PNG; PGAS is the existing Government accounting system, that is used by Provincial Administrations across the country; PGAS is being replaced by a new integrated financial management systems known as 'IFMS'.

effective, financial analysis needs to be integrated with other health information analysis, and communicated to management and others in an easily understood way.

G. Effective National Oversight

24. **Department of Health improved.** National health monitoring and reporting systems, and skills need improving in the DOH. The Minister of Health is responsible for overseeing the performance of PHA. To better support this responsibility, the DOH needs to develop better capability and capacity to (i) monitor PHA performance; (ii) provide support, guidance, and direction for PHAs delivering quality health services that meet community needs, and achieve improved health outcomes; and (iii) use the information to inform evidence-based national policy development.

25. In summary, effective national oversight will ensure PHAs transparently demonstrate they are (i) meeting their accountability for efficient and effective use of resources, (ii) showing progress towards universal health coverage, and (iii) achieving health gains towards achieving the health Sustainable Development Goals. To achieve this, effective financial management and systems are required.