

RE-DESIGN OF THE HEALTH SERVICES IMPROVEMENT PROGRAM (HSIP) TRUST ACCOUNT

Final 26 November 2012

DESIGN TEAM

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ACKNOWLEDGMENTS

The HSIP Trust Account Re-Design Team wishes to thank the National Department of Health, Provincial Administrators, Provincial Health Advisors, Chief Executive Officers, Provincial Treasury and Budget staff, Central Agency Departments (including DNPM, Auditor General, Treasury, Finance, DPLGA, and NEFC), Churches Medical Council and Development Partners for their open and frank discussions.

The team wishes specifically to thank the National Department of Health for their support and Ms. Elva Lionel, Acting Deputy Secretary Health Policy and Corporate Services for her guidance and wealth of information.

ABBREVIATIONS AND ACRONYMS

AIP	Annual Implementation Plan
ADB	Asian Development Bank
AGO	Auditor General Office
AMU	Advance Management Unit – Now known as FMSB (compliance function)
ARB	Autonomous Region of Bougainville
ASR	Annual Sector Review
AusAID	Australian Agency for International Development
CHG	Church Health Grants
CHP	Community Health Post
CHW	Community Health Worker
CIMC	Consultative Implementation and Monitoring Committee
CMC	Church Medical Council
CP	Central Province
DHC	District Health Coordinator
DOF	Department of Finance
DOT	Department of Treasury
DNPM	Department of National Planning and Monitoring
DP	Development Partners
DPLGA	Department of Provincial and Local-Level Government Affairs
DPO	Disability Partner Organisations
DSP	Development Strategic Plan
DSIP	District Services Improvement Program
DWU	Divine Word University
EHP	Eastern Highlands Province
ENB	East New Britain
ESP	East Sepik Province
FI	Financial Instruction
FMSB	Finance Management Service Branch
GDP	Gross Domestic Product
GoA	Government of Australia
GoPNG	Government of Papua New Guinea
GNI	Gross National Income
HDI	Human Development Index
HFG	Health Function Grant
HHISP	Health and HIV Implementation Service Provider
HSIP	Health Services Improvement Program
HSFC	Health Sector Finance Committee
HSPC	Health Sector Partnership Committee
IASRG	Independent Annual Sector Review Group
IFMS	Integrated Financial Management System
IMRG	Independent Monitoring and Review Group
KRA	Key Results Area
LLG	Local Level Government

MBP	Milne Bay Province
MDG	Millennium Development Goals
MEF	Monitoring and Evaluation Framework
MPA	Minimum Priority Activity
MTDP	Medium Term Development Plan
MTEF	Medium Term Expenditure Framework
NDOH	National Department of Health
NEFC	National Economic and Fiscal Commission
NGO	Non Government Organisation
NHIS	National Health Information System
NHP	National Health Plan
NIP	New Ireland Province
NRI	National Research Institute
NZMFAT	New Zealand Ministry for Foreign Affairs and Trade (NZAID)
OIC	Officer in Charge
PAF	Performance Assessment Framework
PBM	Provincial Budget Model
PER	Provincial Expenditure Review
PFM	Public Financial Management
PFMA	Public Finance Management Act
PGAS	PNG Government Accounting System
PHA	Provincial Health Authority
PHFC	Provincial Health Finance Committee
PIP	Public Investment Program
PLLSMA	Provincial and Local-Level Services Monitoring Authority
PNG	Papua New Guinea
RPHSP	Rural Primary Health Services Program
RIGFA	Reform of Intergovernmental Financing Arrangements
SBS	Sector Budget Support
SEM	Senior Executive Management (of NDOH)
SHP	Southern Highlands Province
STI	Sexually Transmitted Infections
SWAp	Sector Wide Approach
TA	Trust Account
UNFPA	United Nations Fund for Population Activities
UNDP	United Nations Development Program
UNICEF	United Nations Children's Fund
WHO	World Health Organisation
WHP	Western Highlands Province
WNB	West New Britain
WB	World Bank
YTD	Year to date

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EXECUTIVE SUMMARY

The Health Services Improvement Program (HSIP) is the Government of PNG's Sector Wide Approach (SWAp). It is underpinned by the principles of government ownership, alignment to government systems, managing for results and mutual accountability. Development Partners provide their support for the SWAp through alignment to the National Health Plan 2011-2020, using Public Finances (Management) Act 1995 systems, GoPNG planning systems and a common monitoring framework.

The HSIP Trust Account (2009) is managed by the National Department of Health (NDOH). The Provincial Health Adviser and Provincial Treasurer in each province and Bougainville operationally manage nineteen Subsidiary Accounts.

The purpose of the Re-design was:

1. To undertake further technical and operational analysis at national and provincial levels on HSIP trust account functionality and performance in line with agreed financing 'options' and existing alignment with GoPNG PFM systems;
2. Redesign the HSIP trust account to perform agreed financing Options and align it more directly with GoPNG systems; and
3. Recommend a prioritisation and sequencing plan (timetable) to shift from use of HSIP to GoPNG financial systems in the medium term.

A key driver for change is the changing context of the PNG Health Sector. A new National Health Plan; successful implementation of intergovernmental finance reforms; changing development partner priorities; GoPNG's policy of decentralisation; better definition of the different roles that national and provincial governments play in service delivery; have all contributed to the need for a new way forward to complement these whole of government reforms.

Since 2009 there have been many reviews of both the HSIP TA and the NDOH. The most recent Audit by the PNG Auditor General outlines a set of necessary actions to strengthen compliance with PNG Public (Finances) Management Act across NDOH and is being actively implemented.

The HSIP Trust Account balance at May 2012 was K127 million of which K102.36 million are GoPNG funds; K1.6 million is earmarked donor pooled funding; and K22.6 million is earmarked by donors for particular health programs. AusAID continued funding to the Trust Account requires a revised financing agreement which will be based on the re-design. It should also be noted that NZMFAT will continue to provide funding for the 'Direct Health Facility Funding' pilot in Bougainville to 2013.

Past expenditure of funds from the HSIP TA provincial accounts shows that funds have been increasingly accessed between 2005 (K4.5m) to K21m in 2010 (PER 2010). These funds have been used for untargeted health activities, based on Annual Implementation Plans. Spending was largely guided by exclusions outlined in the Trust Account Manual. The extent of expenditure was governed by a centrally driven acquittals culture, which restricted access, but was designed to drive improved

governance. This element defines HSIP in the provinces as an incentive program; provinces draw down the next tranche of funds following satisfactory provincial expenditure and acquittal.

An Options Paper (Cairns 2012) formed the basis of the re-design and the extensive consultations with provinces. These Options included: gap filling of first quarter health function grant (HFG) payments; Incentive Funding (recurrent and targeted capital); targeted training funding; targeted capital funding; emergency transfer activities; and Direct Facility Funding.

The Provincial Expenditure Review (PER) for 2010 has shown that broadly, in the provinces, expenditure on health service delivery is now approaching on average 42% of the actual costs required – up from 25% in 2008 (PER NEFC 2012). This change is largely due to the Reforms of Intergovernmental Financing (RIGFA) as well as the monitoring activities of the NEFC, Treasury and DPLGA.

While health services expenditure may be increasing, at the health facility level particularly in the rural and remote areas, there are still major limitations - observed during the recent 'Capacity Diagnostic Mission (2012). Dilapidated facilities, uninhabitable housing, water systems that fail and little in-service training, particularly in capacity to understand the processes required to attract funds and acquit expenditure. In disadvantaged districts service delivery is almost non-existent because of the high costs to overcome these limitations.

The re-design provides support to the provinces for their work in direct service delivery. It takes into account the major funding sources of the Health Function Grant (national budget), internal revenue capacity and the Church Health Grant (national budget through the NDOH) and is designed to complement these funding sources to deliver basic rural health services and implement provincial and district health plans.

The redesign builds on:

- International agreements by the donor community to improve ownership and to integrate support into government systems and processes;
- GoPNG commitment to decentralisation in order to address the needs of the rural majority;
- The National Health Plan in strengthening the core activities of the NDOH;
- The reforms to provincial health financing under RIGFA and the Minimum Priority Activities;
- The capacity of GoPNG agencies to expend public and donor funds to impact on health outcomes; and
- Recommendations to better target HSIP TA funds.

The re-designed HSIP TA has a new goal **to improve access to rural health services, particularly in disadvantaged districts, through providing targeted funding and improving the implementation, reporting and governance of the TA at national and provincial levels.**

In the redesign, HSIP TA at the national level will support coordination, monitoring and reporting activities: that is, NDOH core functions. The HSIP TA can be drawn on

for additional administrative capacity in times of high activity with the relevant temporary staffing or ability to outsource activities (for example health infrastructure scoping). Specifically the HSIP TA will supplement the NDOH commitment to the National Health Conference, key meetings with Development Partners, monitoring activities (regional reviews and site visits) to ensure service delivery and standards; improved analysis of the annual sector performance report and feeding in to the next year's priorities; greater distribution of the performance report and participation in the NEFC sponsored regional provincial conferences.

At the provincial and district level, the re-design refines options for the HSIP TA to better address rural and remote service delivery as a priority by changing the HSIP TA from an untargeted fund to be increasingly targeted over time.

Untargeted provincial allocations will decline during the transitional period of four years. Targeted funds for provinces are: recurrent (specifically rehabilitation of existing infrastructure), targeted training of CHW and health managers, 'disadvantaged district' rehabilitation as a quarantined item, and continuing obstetric emergency transfer. Specifically, HSIP TA funding guidelines would encourage:

- Refurbishment of facilities and staff housing at health facilities, particularly at district level, as agreed in existing provincial and district development plans;
- Additional opportunities for accredited training of Community Health Workers, for example, through distance education and on-site support;
- Coordinated training of district health managers and facility managers in public finance systems that enable them to participate in budget and planning, expenditure and reporting - a DWU pilot (2010) has proved successful and is recommended as the most appropriate;
- Remote and disadvantaged districts will have quarantined funds, as more funds will be required to cover the higher costs involved;
- Obstetric emergency transfers will continue in line with the GoPNG commitment to improved maternal health outcomes. Non-obstetric emergency transfer is covered under the Health Function Grant.

While there are various reports on the most disadvantaged districts in PNG, the redesign recommends the Poverty Mapping in Rural PNG research (2004) to identify those districts where HSIP targeted funds should focus.

Provincial Health Authorities (with a functioning Board and appointed Chief Executive Officer) can access funding from the HSIP TA and report on outcomes in the same way as non-Provincial Health Authority Provinces.

The proposed pooled funding budget for the first four years of the program is **PGK 150,240,000**. Targeting of provincial funds requires a staged transition phase to ensure provincial activities, currently using HSIP recurrent funding, are not disrupted severely. In addition, this means that provinces can continue to use HSIP TA as an 'all weather fund'. However, this would decrease over time and the HFG and Internal Revenue would be used as the major source of recurrent GoPNG funds.

A budget breakdown over four years is suggested:

	National NDOH core	Disadvant. District	Provincial Targeted	Provincial Non- Targeted	Secretary's Disaster Fund	Specific Activities	TOTAL
Y1	3,160	12,000	9,820	11,100	500	1,305	37,885
Y2	2,240	15,500	11,740	8,100	500		38,080
Y3	2,240	17,045	12,140	5,100	500		37,025
Y4	2,240	20,000	10,310	2,100	500	2,100	37,250

Consideration could be given to accelerating the transition from untargeted with a potential move to increased targeted funding from year 3. In addition Provinces showing capacity and compliance with good governance practices may be considered for a pilot of Provincial Budget Support. Accelerated transition or a move to piloting Provincial Budget Support should be part of the annual monitoring of the program with recommendations to Partners through the HSPP.

Options selected for inclusion in the redesign have the potential to impact positively on women: access to family health in the local area; priority obstetric transfers; improved training of CHW and OIC, a significant number of whom are women. The redesigned HSIP TA has the potential to improve PNG Human Development Index and Gender Development Index. Improving disability access and awareness through training is also included.

In some provinces with high revenues, the level of disadvantage remains high and health outcomes are extremely poor. A funding program such as HSIP TA does not have sufficient resources to effect the major behavioural change required to redress a gap in some provincial priorities, particularly those identified as having sufficient internal revenue to meet the cost of health services. The redesign quarantines funding (initially) to twenty disadvantaged districts, regardless of the provincial resource envelop. In this way, HSIP TA can continue to contribute even though the HFG may be affected as per the RIGFA design fundamentals. However to encourage investment in health services by Provincial Governments the redesign also recommends that Development Partners fund up to 50% of the package proposed. Provinces will meet this commitment through options such as the Public Investment Program (PIP), DSIP or their own internal revenue.

The Secretary, Department of Health is the Chief Authorising Office for the Trust Account, including the Subsidiary Accounts, even though day-to-day management is delegated to a Deputy Secretary. The Secretary will re-set the governance arrangements and oversight their implementation in the new Corporate Plan (2013-2017) being developed at the time of writing.

Greater strategic flexibility is recommended by using a Secretary's Instruction mechanism on an annual basis. NDOH activities would be prioritised by this Instruction and would inform the budget processes. A reiteration of HSIP TA agreed NHP priorities in the provinces would accompany the HSIP TA ceilings in May of each year, in line with redesign parameters. Development Partners will support the recruitment of short term/long term technical support to facilitate improvement in

activities across all sections including donor coordination, planning, budgets, finance, procurement and audit and report directly to the Deputy Secretary.

Recommendations are made to better align the HSIP TA with GoPNG PFM processes. One of the major issues is the timely communication of all donor commitments by May of each year and to transparently communicate the ceilings and priority activities to DNPM in time for the Budget formulation process. In recent times this has broken down resulting in multiple ad hoc activities. Commitment to the GoPNG budget cycle timeline is essential for Treasury, DNPM, NDOH and the provinces to ensure transparency of all sources of public funds. In future it is important that the HSIP TA is accurately represented in the Development Budget and the provinces as a separate funding source.

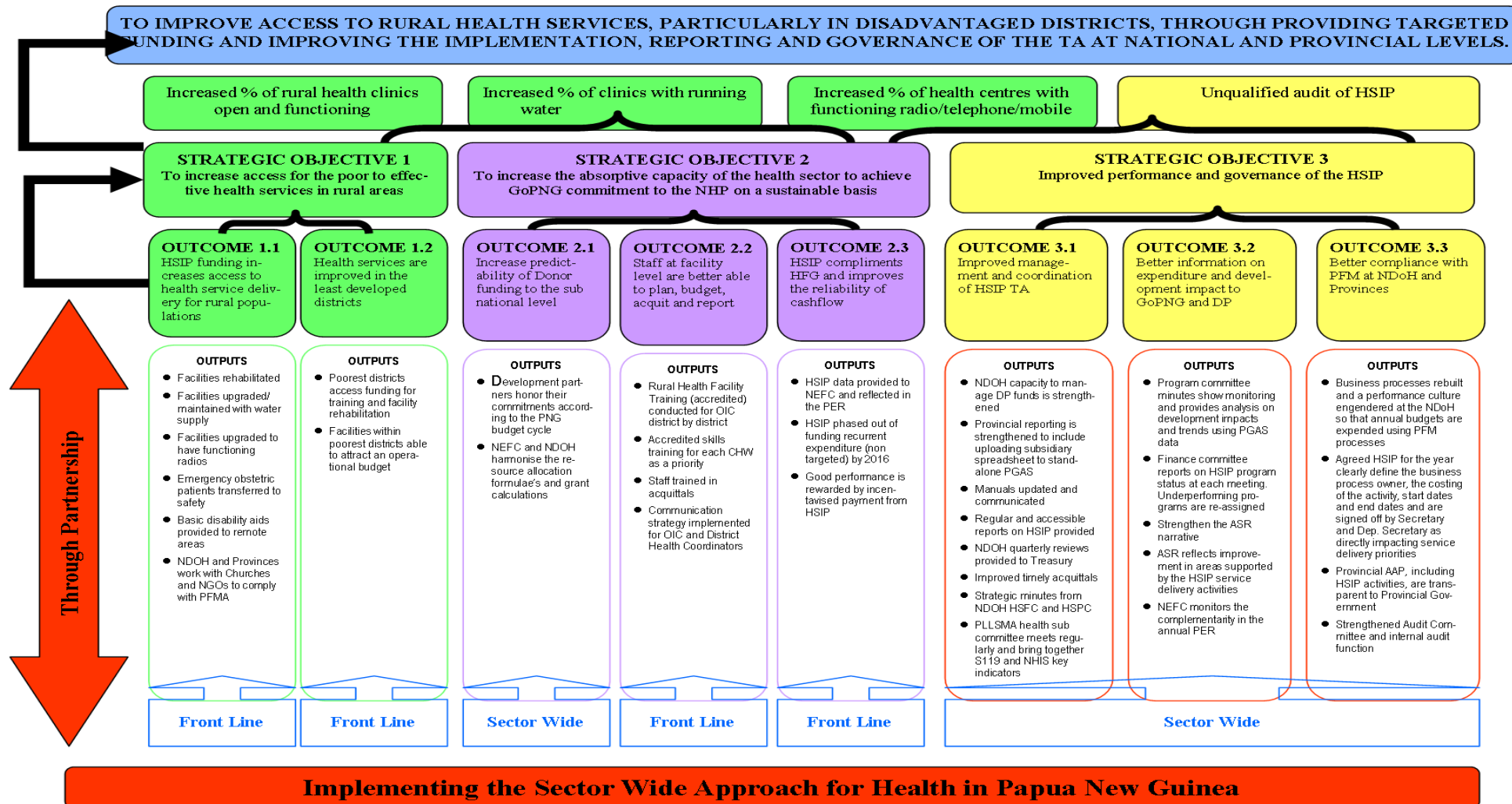
The transition of the SWAp to sector budget support remains a long-term goal. To achieve this will require robust finance systems and both GoPNG and Development Partner confidence. The option of dissolving the TA and moving to a budget support model was not considered feasible at this time. However, a process of accelerated transition to a provincial budget support model is included.

A monitoring and evaluation strategy aligns with the National Health Plan. All outputs and outcomes are measured using existing indicators and reporting processes. Improvements (and additionality) will be measured by improved trending in Key Result Area (KRA) 3 over the five years of implementation, from the current baseline.

Importantly, the redesign recommends consistent monitoring of service provision and standards improvement through NDOH participation in regional reviews in the provinces. It is preferable this occurs on a quarterly basis through participation in existing regional reviews. Annual monitoring of implementation on-site at the facility/District level will be undertaken by the PLLSMA Health Sub Committee (with relevant support as required) to ensure that targeting is achieving NHP goals and objectives. A more qualitative evaluation of improved service delivery (funded by HSIP TA) at the facility level is envisaged in the final year against provincial benchmarks and the NHIS indicators. This activity will complement the mid-term evaluation of the National Health Plan as outlined in the M&E plan.

A risk identification and management matrix (Annexure 16) identifies risks by the six outcomes of the redesigned HSIP TA operations. The potential high risk in implementing the Disadvantaged District package requires additional governance controls and these have been included in the updated HSIP TA manuals.

HEALTH SERVICES IMPROVEMENT PROGRAM—PROGRAM LOGIC



CHAPTER ONE - PROJECT ORIGIN AND DESIGN PROCESS

1.1 Activity Origin

The Health Services Improvement Program (HSIP) is the Government of PNG's (GoPNG) Sector Wide Approach (SWAp) for the health sector. The HSIP Trust Account (TA) provides a mechanism for coordinating donor support managed through the National Department of Health (NDOH) and 19 Subsidiary Accounts (excluding Hela and Jiwaka) managed jointly by the Provincial Health Adviser and Provincial Treasurer in each province and Bougainville.

The TA was initially created by the Asian Development bank in 1996 and was intended to be a temporary mechanism to allow for strengthening of GoPNG public financial systems before aid was channelled through GoPNG systems in a more aligned and harmonized manner¹.

The Trust instrument (Annexure 1) was revised in 2009 and transferred trusteeship to NDOH.

The Trust Account's purpose is to hold development funds of donor partners and GoPNG, to further the Sector Wide Approach (SWAp). A SWAp avoids the transaction costs and coordination issues of a multi-donor, multi-project based modality. The SWAp is intended to assist with the implementation of the National Health Plan as the overarching policy document for PNG health.

While it is recognized that HSIP TA plays a vital role in funding rural health services (30% of rural health services were funded by HSIP TA in 2010), concerns have been expressed about the performance of HSIP TA, including the effectiveness of the governance structures, weak absorptive capacity at the different levels of the service supply chain, financial management challenges, its parallel management structures and the difficulty in getting resources to provinces and districts².

Since 2009, there have been many critical reviews of the HSIP TA. Some of these are summarized below in order to create a platform for the re-design process.

In May 2007, the Independent Monitoring and Review Group (IMRG) concluded that more resources had been committed through the HSIP TA mechanisms than were originally anticipated. The IMRG recommended consolidation of the HSIP-Management Branch including introduction of an effective performance management system; increasing capacity at all service delivery levels; greater emphasis on implementation at the service delivery levels; more focus on the poorest; and improved relationship with the Central Agencies.

¹ SWAp Review, May 2010

² Terms of reference for the Re-design of HSIP TA, May 2012

In 2008, AusAID's Office of Development Effectiveness reported ³ that spending from the pooled Development Partner (DP) fund had been less than 40% of levels assumed in the program budget; it proved difficult to spend money at the provincial level; the acquittals process was considered onerous; pool funds were accounted for by health sector staff (who have no formal financial training) rather than by provincial or district treasuries; and the approach has a built-in disincentive to use funds at the district and facility/ LLG levels where remoteness makes it difficult to obtain original receipts. This led to provinces being suspended from the program. These criticisms are still valid.

The 2010 SWAp review⁴ recommended that the HSIP TA transition to a Provincial Budget Support modality, similar to the Provincial Performance Improvement Initiative (PPII) from 2012. The argument was that the risks were largely the same as with the current parallel approach. Under that proposal, pooled funds would be provided via the consolidated revenue to finance an agreed percentage of eligible government health expenditure by NDOH and province. The approach had the advantages of being seen to use government systems, with additional risk management in place. The SWAp review findings were not generally supported at that time.

The Duesbury Nexia HSIP Trust Account Financial Transaction Audit and Process Review (2011) commissioned by AusAID reviewed key processes and internal controls. The review found insufficient staff capacity and a lack of ownership by NDOH to drive the necessary changes. A comprehensive implementation plan was suggested to NDOH. Nexia recommended a targeted intervention, which would provide a shadow management team to take responsibility for key functions while building capacity in NDOH to manage the TA. Accountability, timeliness, transparency, and efficiency would become the cornerstones that support and encourage a performance culture – driven from the top of NDOH as well as from DPs, and monitored through regular reporting and performance evaluation. A subsequent audit report by the Global Funds also delivered similar adverse findings. As a result of this report NDOH and the Global Fund agreed to an external Principal Recipient arrangement outside of the TA.

Since 2009, the processes of PNG reform affecting health service delivery have been multi-faceted. The most successful of these is the Reform to Intergovernmental Financing Arrangements (RIGFA). NEFC and Treasury introduced a conditional Health Function Grant (HFG) on an equalization basis, determined by need and based on the differential cost of services at district level. The Reform posed Minimum Priority Activities (MPA) as baseline health activities for the provinces. As a result of successive annual provincial workshops to communicate and monitor these Reforms, provinces have accepted the notion of 'ring-fencing' funds for particular purposes. In 2010, DPLGA shepherded the Function Assignment Determination, which clarified

³ Office of Development Effectiveness, Evaluation of health service delivery in PNG, Solomon islands and Vanuatu: AusAID, Canberra, 2008

⁴ SWAp Review, May 2010

the roles in service provision at the provincial and LLG levels. In 2010 NDOH launched the overarching policy document: the National Health Plan 2011 – 2020. Additional reforms are also flagged in the Provincial Health Authorities Act, National HIV Strategy; and the system of accounting - the Integrated Financial Management System, which may eventually replace the PNG Government Accounting System (PGAS). In 2010, the Department of Personnel Management delegated greater HR functions to Provincial Administrators (although there is no cap on expenditure centrally). There has been a dramatic increase in the development budget through the District Service Improvement Program (DSIP) some of which was intended to improve health infrastructure. And finally, throughout PNG, mobile communications systems have vastly improved through the Digicel network bringing a 3G capacity to most of PNG. This has potential for financial systems connectivity, improved monitoring and overall health sector coordination.

The development context has also changed: the United Nations agencies are now working as one; World Bank is actively engaging in health; NZMFAT is reconsidering its future in funding health through the HSIP TA; the review of the Government of Australia (GoA) and GoPNG Development Cooperation Treaty and refocusing of the Australian aid program; the Joint Advisor Review; agreement on the new GoPNG and GoA Health and HIV Partnership for Development and the five year AusAID Health Delivery Strategy together providing the parameters for Development Partner support for health development in PNG. The HSIP re-design takes in this changing context.

1.2 Initial Desk Review

Key materials for the Desk review are listed in Annexure 19 and involved examination of key AusAID policy documents; NDOH and NEFC data reports, activity plans, legislation, and studies on health service delivery; HSIP reports and options papers; and related documents. Other detailed information emerged as the team began the consultations.

An Options Paper⁵ (Annexure 2) was a key document provided to inform the re-design, weighing up potential health activities such as targeted recurrent financing; incentive financing; and earmarked financing for select functions such as first quarter transfers and emergency transfers.

The Desk Review highlighted many of the risks in HSIP TA operations such as:

- High transaction costs and poor controls (Audit Reports);
- Complex management requirements within NDOH (resource intensive);
- Parallel provincial systems – duplicated planning, lack of systematic monitoring or reporting additional HSIP activities;

⁵ A. Cairns, Options Paper, Future Development Partner Support to the Health Sector improvement Program Trust Account (HSIP TA), Health Sector Partnership Committee, May 2012

- Lack of evidence of aid effectiveness; questionable sustainability, no exit strategy;
- Lack of confidence expressed by Development Partners;
- Non-alignment of GoPNG systems; the lack of relationship between HSIP and HFG and the MPA;
- The Annual Sector Review has limited narrative on long term development impacts and outcomes and there has been no other formal evaluation;
- Governance systems have changed over time, however the Manual has not been substantially updated, is not user-friendly, provides little direction and requires further alignment with the PNG Public Finance Management Manual; and,
- Changes at the political and administrative levels affecting NDOH.

1.3 Design team and mission

The Design Team was tasked to: undertake technical and operational analysis at national and provincial levels on HSIP functionality and performance; re-design the HSIP TA to perform agreed financing 'options' and align it more directly with GOPNG Public Finance Management (PFM) systems; and recommend a prioritization and sequencing plan (timetable) to shift use of HSIP to GOPNG financial systems in the medium term. The Terms of Reference (ToR) are at Annexure 3.

1.4 Method and Consultation

The key issues identified during the desk review were further explored during the Provincial **Field Review**. The Team took the opportunity to observe portions of the four NEFC sponsored regional workshops (2012) to support the RIGFA in Alotau (Southern Region), Kokopo (Highlands and Islands Regions) and Madang (Momase Region). In addition, the review team conducted four one-day workshops specifically on HSIP with key health and budget officials from 16 provinces within the four regions. All provinces except Southern Highlands, East Sepik and Morobe were consulted. An additional workshop was conducted with key stakeholders in Buka (Autonomous Region of Bougainville – ARB). Opportunistic meetings with other participants from national and provincial levels were also held during the fieldwork.

Methods used to collect the required information were guided by the use of key questions for consistency of the assessment. This data - qualitative and quantitative - forms the baseline for future assessment of the re-design and is at Annexure 4.

The Team was able to assess HSIP TA trend performance by provinces; changes needed to refocus HSIP towards the agreed priority options; specific issues for the PHA provinces; human resource issues regarding capacity, training and reporting; issues regarding inclusion of church health services and NGOs; and risks related to transitioning from HSIP to GOPNG systems. Meetings were held at national level with Central Agencies (DNPM, DOT, and DOF), DPLGA, NDOH staff, Church Medical Council, and Development Partners. Annexure 5 provides a list of people consulted.

CHAPTER TWO – SITUATION ANALYSIS

The HSIP Trust Account (2009) is a government of PNG instrument governed by the laws of PNG. Its operations are defined by the PNG Public Finances (Management) Act (1995). The financial activities include planning, budgeting, expenditure monitoring, reporting, procurement processes and auditing. Financial management improvement initiatives are communicated through the Public Finance Management Manual and Financial Instructions (FI).

The host organisation is the PNG National Department of Health and the Chief Accountable Officer is the Secretary of Health. The HSIP TA consists of a Parent Account and 19 Subsidiary Accounts in the provinces and Bougainville.

The situation analysis covers the status of the Trust Account and current management issues. It also covers the current operations of the subsidiary accounts and their management.

The Trust Account's purpose is to hold development funds of donor partners and GoPNG, to further the Sector Wide Approach (SWAp). A SWAp avoids the transaction costs and coordination issues of a multi-donor, multi-project based modality. The activities funded within the HSIP TA are intended to assist with the implementation of the National Health Plan as the overarching policy document for PNG health.

2.1 Health in PNG and International Development Issues

The National Health Plan 2011-2020 (NHP), launched in August 2010, recommends a 'Back to Basics' approach to rehabilitate the health sector, following years of neglect and under funding. The NHP is aligned to the Government of Papua New Guinea's (PNG) wider plans, VISION 2050, the Development Strategic Plan 2010-2030 (DSP), and the Medium Term Development Plan 2011-2015 (MTDP) and seeks to increase access to health services for the rural population and the poor. The re-designed Health Services Improvement Program Trust Account (HSIP TA) reflects these goals.

While significant efforts by both the Government of PNG and Development Partners have been implemented over the last ten years, health outcomes remain unacceptably low⁶. The poor, women and children, and rural populations fare the worst. PNG is unlikely to meet several of the Millennium Development Goals (MDGs): 4 (reduced child mortality), 5 (improved maternal health) and 6 (reduced communicable diseases) by 2015⁷. The Governments' vision of a happy healthy, population that will be ranked among the top 50 of the United Nations Human Development Index (HDI) by 2050 will require significant improvement in basic services for the people.

⁶ AusAID, PNG- Australia Health Service Delivery Strategy 2011-2015

⁷ UNDP website

The United National Development Fund (UNDP) estimates 37% of the PNG population live below the poverty line and access to basic services in remote and rural areas remains a challenge. Disparities exist across and within provinces and districts, with some resource rich provinces, for example Western Province, measuring the lowest scores on poverty indicator scales.

Service delivery is impacted upon by systemic factors such as: essential medical supply stock-outs; an unskilled and ageing workforce; physical barriers; deteriorating infrastructure; health funds not reaching the front line; access to information and transport, high user fees; chronic corruption; - that combine to reduce access to health services to the rural poor.

PNG has a crisis of poverty and access to health services as outlined in a 2004 World Bank Report. It highlights the two principal challenges for poverty reduction as: restoration of economic growth and maintaining provision of basic services, especially in education and health (WB Poverty Assessment, 2004).

Research has been undertaken on Least Developed Districts (NEFC 2004) and the Disadvantaged Districts (Hansen et al 2001). A more recent set of data - District Profiles (NRI 2010) does not rank disadvantaged districts so is less useful in this context. Mapping Poverty in Rural PNG (Gibson et al 2004) is a study that brings together previous poverty studies by district, and combines the household expenditure and population census to provide a list of the twenty most disadvantaged districts in PNG. The redesign uses this list as the basis of its poverty strategy (which can be revised in future should further research be published). The 20 most disadvantaged districts are at Annexure 11.

The 2011-12 Provincial Capacity Diagnostic studies showed that rural and remote facilities and staff housing at both facility and district level were generally in an unserviceable state.

2.2 The Sector-Wide Approach

HSIP is aligned with SWAp principles and with those of Paris Declaration and Accra Agenda for Action as shown below:

- Single Health Sector strategy/plan owned and led by Government (**ownership**)
- A medium term expenditure framework that reflects the sector strategy
- Alignment to government systems where possible (**Alignment and harmonization**)
- An agreed performance monitoring strategy with indicators for measuring achievement of results (**Results**)
- A formalized government led process for aid coordination and dialogue at the sector level (**Mutual accountability**).

Partners have progressed significantly on principles one and two, putting their donor efforts into implementation of the NHP through Annual Implementation Plans. There is an Annual Sector Review based on a National Health Information System, which is the basis of a performance monitoring strategy. There is significant alignment in the

current design and operations of the Trust Account with the PNG Public (Finances) Management Act.

The frustration of government about the capacity of PNG to spend on service delivery through Public Financial Management (PFM) systems and the public service gave rise to the District Services Improvement Program (DSIP) as a model to fast track infrastructure improvement. District service delivery and improved infrastructure are the intended outcomes of some K14m in funding to each of 89 Districts over the past 4 years. Development outcomes achieved are as yet unclear or documented. The DSIP demonstrates the policy direction of the elected government over the past few years in moving the focus of service delivery to districts and LLG.

Supporting the centrality of districts, LLG and facilities in reaching the people, the Department of Finance embarked on an ambitious plan to implement PGAS in the Districts, and recently through the Districts, to LLG (Proposed Financial Instruction 2012). This should improve the enabling environment of service delivery. Where there are District Treasuries in operation, financial services and suppliers, health services could be funded at that level. The Department of Finance, with donor support, supported these reforms through capacity building in the provinces and districts through the Finance Training Branch and the Provincial Capacity Building Program (PCaB) in five provinces.

The assessment of provincial PFM capacity is available from two main evidentiary sources:

1. The EU supported a Public Expenditure and Financial Accountability (PEFA) Assessment in Milne Bay in 2010-2011 as a proxy for provincial capacity in PNG. Many of the PER rankings are used as baselines for PFM improvement. Two initial 'platforms' are listed for priority – fiscal discipline and service delivery performance. (Strengthening PFM in Milne Bay Province 2012-2016)
2. The annual Provincial Expenditure Reviews (NEFC) provide detailed analysis of capacity to expend funds (HFG and HSIP). Of particular relevance in health expenditure is the 'nature test'. The nature test is a general high level assessment of whether the expenditure looks in keeping with the intended purposes.
 - In 2010, the vast majority of provinces were ranked 'good' on the nature test for health. Only four provinces (Western Highlands, Enga, Eastern Highlands and West New Britain) were ranked 'average'. Western Province was ranked 'not good' indicating that there were significant areas of expenditure that were questionable.

2.3 Stakeholder views on the current status of the HSIP TA

The metaphor in NDOH is that, several years ago, the HSIP TA was like an old wooden wharf with super tankers lining up to be unloaded with no wharf staff or equipment to facilitate it. This reflects the history that the HSIP TA has attracted funding beyond the administrative capacity of NDOH. In the recent past, a sudden funds input from the Global Fund left many of the HSIP administrative systems under further stress. This is documented clearly in the Nexia International Report - HSIP Trust Account Financial Transaction Audit and Process Review (2010).

There has been a series of adverse audits of the HSIP TA, all critical of the controls and the effectiveness of administrative systems. There is also a common view that although the systems and processes are sound it is the implementation that is poor. Therefore changing these sound systems and processes may not achieve any demonstrable change in compliance behaviour. At the same time Development Partners have questioned the achievement of any significant development impacts.

There have been multiple reviews of the HSIP TA – IMRG 2007-2009, the SWAp Review 2009-2010 (incorporating The Missing Middle and the Review of HSIP TA (Foster & Piel); Nexia Report; annual PNG Auditor General Audit of NDOH, which includes the HSIP TA. Issues raised in these reviews show no positive trending for improved performance.

The Re-design was not 'another review' or 'another audit'. Continuing issues raised by previous reviews and audits are an important starting point to redress in the re-design. It follows that an 'unqualified Audit report' would provide a statement of vast improvement of the PFM processes of both the NDOH and the HSIP TA and would be a significant performance outcome.

Despite the problems and difficulties over the past few years, the new leadership team of the NDOH is keen to maintain the SWAp and learn the lessons of the past. It is not keen to revert to a previous 'multiple projects' scenario.

Consultations with national agencies were undertaken and the results are summarised below.

The Department of Finance has fiscal responsibilities for all Trust Accounts in PNG. The Trust Account must continue to use Public Finances Management systems by law. The Finance Department should record monthly reconciliations that are sent from NDOH; however the Budget Outcome 2011 revealed a zero balance.

NEFC position was that the primary responsibility for basic health services is with GoPNG, to ensure both sustainability and affordability. In practice, the concern was that HSIP should not displace expenditure of the Health Function Grant (HFG) and the focus on Minimum Priority Activities. There needs to be a better budget strategy of scheduling quarterly releases of the HFG by Treasury.

The Department of Provincial and Local-level Government Affairs (DPLGA) has responsibility for coordination between the three levels of government to improve service delivery. DPLGA monitors service delivery through the Provincial and Local-

level Services Monitoring Authority (PLLSMA) via its annual Provincial Performance Report (Section 119 of the Organic Law). DPLGA hosts the Health Sector Sub-committee, which is chaired by the Deputy Secretary NDOH. This Sub-committee contributes to coordinated understanding across central government of NDOH initiatives. There is a current project of ensuring that s119 information and NHIS do not provide conflicting data.

The NDOH also reports its intention to support the revival of the Health and Population Sub Committee of the Consultative Monitoring and Implementation Committee (CIMC). This committee will also support improvement in consistency of monitoring of data.

The Auditor General has started a performance audit of the Church Health Services. In addition, it has been agreed that the Auditor General oversees the 2012 Audit of HSIP by a reputable PNG based international accounting firm. This is an improvement that Development Partners have agreed to one single audit rather than past experience of multiple audits by donors.

2.4 Analysis – Parent and Subsidiaries Accounts

2.4.1 Parent Account

The Parent Account information is held in a PNG Government Accounting System (PGAS) within the NDOH (connected to DOF), with PGAS cheques written following GoPNG forms signed by delegates, forms FF3 and FF4, approvals process.⁸ Oversight of the Parent, Subsidiary and recurrent funds is provided by the Health Sector Finance Committee (HSFC).

HSFC is an important decision committee where NDOH Executive and donors meet and address both the recurrent and HSIP accounts. A large amount of financial data on both the parent account and subsidiary accounts is provided. The table below shows the available funds by Development Partner in May 2012.

Table 1 - Summary of DP and GoPNG funds in the HSIP TA May 2012 (Kina)

Development Partner	May 2012 Available Funds	Pooled Funding	Earmarked
100 - ADB	1,431,002.65		1,431,002.65
200 - UFPA	207,632.53		207,632.53
600 - Global Funds	1,295,735.27		1,295,735.27
700 - NZ AID	2,884,284.71	1,565,663.65	1,318,621.06
800 - AusAID	16,891,800.07		16,891,800.07
900 - WHO	1,481,707.77		1,481,707.77
SUB TOTAL DP	24,192,163.00		
000 - GOPNG	102,355,049.38		
TOTAL	126,547,212.38	1,565,663.65	22,626,499.35

⁸ FF3 and FF4 are standard PFMA processes

There is K24.2m of 'earmarked' donor funds currently in the account, which targets individual DP activities. Many of these are from previous years' commitments.

Annexure 7 was presented at the May 2012 Finance Committee. In brief it shows:

- A list of some 200 activities for expenditure from the parent account;
- The PGAS vote codes applicable to each activity;
- K34m has been spent with a further K1m in outstanding commitments, although in which financial year this occurred is unclear;
- Available funds of K127m made up of K24m of DP funds and K102m of GoPNG funds which appear to be largely development funds although there are some recurrent funds;
- There are no start or end dates;
- It is not clear if the expenditure is a 2012 YTD total;
- The business process owner is not identified.

The 2012 endorsed MTEF identifies that there are only 23% of DP commitments over the next two years flowing through the HSIP. The remainder is provided outside of the HSIP (and to an extent outside of GoPNG budgeting). The only pooled funds currently within the HSIP TA are NZMFAT. These are also effectively earmarked for the Direct Health Facility Funding (DHFF) Pilot in Bougainville. These are signals from the DPs that the HSIP TA has lost investor confidence. It should also be noted that HSIP as a direct financing vehicle has declined in relevance in the provinces as HFG has increased in absolute terms and prominence and the focus on DPs is increasingly on efficiency of funds and system development.

The K102m in the TA are GoPNG development and recurrent funds (approximately K8 million for medical equipment purchase) unused from previous budgets. Lack of expenditure is likely to impact on future budget allocations.

In partnership, DP's and NDOH need to ensure that any development funds in the future going into the TA need to be recoded to the HSIP TA in the Budget Papers. Progress on capital projects are presented to DNPM quarterly reviews. Any recurrent funds need to be 're-voted' early in the annual cycle and spent on service delivery, rather than being placed in the Trust. Progress on recurrent expenditure is reported to Treasury on a quarterly basis.

The NDOH 2012 Budget provides a recurrent (Goods and Services) component of K164 million of which K 128 million is earmarked for medical supplies.

Table 2 - Comparison of 2012 Recurrent NDOH Budget (K,000) by Expenditure Type

	A	B	C		
Description	2011 Appropriation	2012 Budget Submission	2012 Appropriation.	Variance A - C	% Change A-C
Personal Emoluments	53,258.1	101,400	62,158.4	8,900.3	16.7 %
Goods and Services	155,422	164,700	163,380.3	7,958.3	5.1 %
Current Transfers	24,403	19,200	18,034.9	- 6,368	- 26%*
Capital Expenditures	28,600	32,900	28,574**	-26	<1%
TOTAL	261,684	318,200	272,147.6	10,463.6	3.9%

* The shortfall in this item is related to a reduction in retirement/retraining benefits. Grants to individual and non-profit organisations were increased from 13,462,000 to 14,183,500.

** The K 28 Million for medical equipment in the 2011 appropriations has been continued in 2012.

The challenge for NDOH in 2012 is to expend the resource envelope of both the HSIP earmarked funds, pooled funds and NDOH recurrent budget and development budget to improve health service delivery. This would provide over K200m to contribute to health service delivery and PNG health outcomes. The challenges include a lack of administrative capacity in NDOH and contracting capacity both in NDOH and in the private sector, and absorptive capacity in rural and remote PNG.

2.4.2 Provincial (Subsidiary) Accounts

a) HSIP Subsidiary Accounts

As at May 2012, Subsidiary Accounts held a total of nearly K8m (May 2012 Report to Finance Committee on Status of Accounts). The slump in subsidiary account expenditure from 2010 can be attributed to various causes such as the increased uptake of Provinces of the HFG, provinces prioritising HFG spending first before HSIP TA, and an increase in late/outstanding acquittals resulting in a slower draw down of funds from the HSIP TA.

Provincial expenditures from the HSIP in 2010 were K7.9m spent across the provinces and Bougainville; of this 11 Provinces spent K1.8m on approved capital expenditure items. This expenditure is allowable under existing arrangements with Secretary NDOH approval. The table below shows the pattern of expenditure 2010 -2012.

Table 3 – Budget and Expenditure for Provincial Subsidiary Accounts 2010-2012

Year	Budget	Transfer	Actual	Bank Balance
2010	16.5	16.0	7.9	4.9
2011	16.5	6.02	10.2	5.6
2012 (as at 1 May 2012)	16.5	5.7	-	7.9

In 2011, K10m was spent and funds previously distributed by AusAID were effectively frozen. No new funds were provided due to expiry of the financing agreement in 2011. Some accounts were suspended and activity slowed. Exceptions to this rule were the funds designated for Supplementary Immunisation Activities (SIA) for all provinces and distributed in 2011/2012.

One of the 'Options' to be considered was that HSIP should be a gap filler since the HFG warrants from Treasury rarely arrived in the province before April. Untargeted HSIP provincial funds can be used for MPA. As at May there was almost K8m available, and this questions the need for first quarter top ups. In addition, Treasury and Finance have recently revised procedures to ensure that national grants stay in the accounts for the purposes intended.

The June 2012 HSIP report to the HSFC shows ongoing concerns with the acquittals. This has been exacerbated by the recent large influx of funding to Provinces to undertake the Supplementary Immunisation Activity (SIA). Funding flows to Provinces is regulated by timely submission of acquittals to the NDOH.

(b) *Emergence of RIGFA , the HFG and MPAs*

As previously mentioned, RIGFA has resulted in increasing conditional funding for health at the provincial, thence district and LLG levels since 2009. As this is a vital GoPNG reform that is working, it is essential that HSIP funds do not displace HFG. Future adverse trends can be monitored as increasing unspent HFG, as measured by annual Provincial Expenditure Reviews (PER).

The Provincial Expenditure Reviews (NEFC 2005 – 2010) are a regular data source of provincial expenditure on health. This monitoring publication also included HSIP expenditure and is able to provide trending data 2005-2010 sourced from the PNG Government Accounting System (PGAS) and other HSIP data.

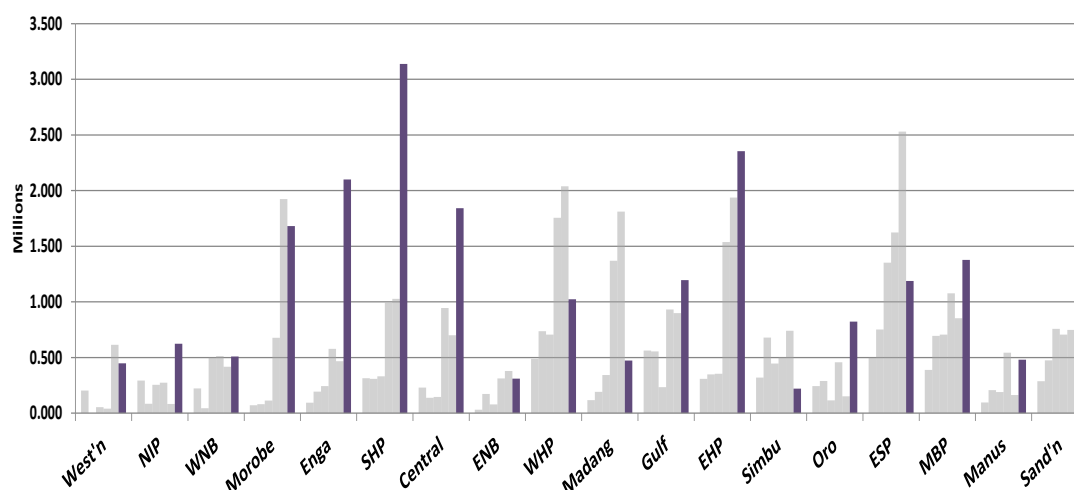
Anecdotally there are issues in some provinces with the implementation of RIGFA. However, evidence that RIGFA has traction is found in the latest expenditure available in the PER 2010, analysed from PGAS data. The PER 2010 (pp 52-63) reports:

- All provinces increased their health spending through the HFG totalling K54 million. The trend in spending in every province is 'up' on the previous year.
- The decline in spending on casual wages is marked and encouraging.
- Provinces are spending on average 42% of the estimated cost of services, when HSIP is added this reaches 69%.
- Internal revenue spending increased by K2 million to K7.3 million to 18% of all goods and services expenditure.

- While low funded group of provinces continue to outperform all others, the medium funded group are showing signs of progress. However five of the six largest revenue-rich provinces continue to spend on other priorities than health.
- In 2010, three provinces transferred large amounts to lower levels of government (Districts and LLG) under Item 143 being East Sepik, Milne Bay and East New Britain.
- Spending on construction (Item 225) was again significant for the third year in succession (K7.3 million)
- In 2010, routine maintenance (Item 128) appeared in the top 5 expenditure codes for the first time.

Spending through the HSIP overall increased over time and the Graph below shows the trends in HSIP (only) spending over five years 2005-2010, reported in the PER 2010.

Figure 1 - Health HSIP Spending 2005-2010



Source: NEFC 2012

c) Cost of Services – Provincial Budget Model (PBM)

The PBM is derived from the NEFC cost of services study, first undertaken in 2005. The spreadsheet based model is designed to assist provinces budget more realistically. For example providing a health service to one District may be substantially more expensive than another due to transport and geographic barriers. There has been some take up of the model and NEFC continues to facilitate its use.

Below is an excerpt from the PBM for Madang Province showing how the cost of services is calculated. It should be noted that the cost of services includes both government and church run health services. Churches also receive additional grants from National Government through the NDoH. It should also be noted that facility maintenance is based on a facility being already in a

reasonable state with maintenance covering the basic repairs. NEFC can provide data for all provinces to this level of detail.

Table 4 - PBM - Madang Cost of Services

Facility item costs	Total for Province	Bogia District	Madang District	Middle Ramu District	Rai Coast District	Sumkar District	Usino-Bundi District
a. Non-medical supplies	30,484	5,543	6,235	4,850	4,157	4,157	5,543
b. Facility maintenance	193,894	34,708	35,792	37,961	27,148	24,979	33,305
c. Rural HC transportation (fuel & maintenance)	568,048	163,546	69,455	103,442	49,979	91,199	90,427
d. Maintenance of medical equipment	226,996	41,272	46,431	36,113	30,954	30,954	41,272
e. Fridge gas	24,202	4,400	4,950	3,850	3,300	3,300	4,400
f. Fridge maintenance	38,500	7,000	7,875	6,125	5,250	5,250	7,000
g. HC radio maintenance	32,727	5,936	6,462	5,522	4,649	4,385	5,772
Total facility costs	1,114,851	262,405	177,201	197,864	125,438	164,225	187,719
Number of health centres (gov't & church-run)	44	8	9	7	6	6	8
Average funding allocation per HC	25,338	32,801	19,689	28,266	20,906	27,371	23,465

In Madang province, both Bogia and Rai Coast districts are designated in the poorest 20 districts in PNG.

d) Relationship between HFG and HSIP

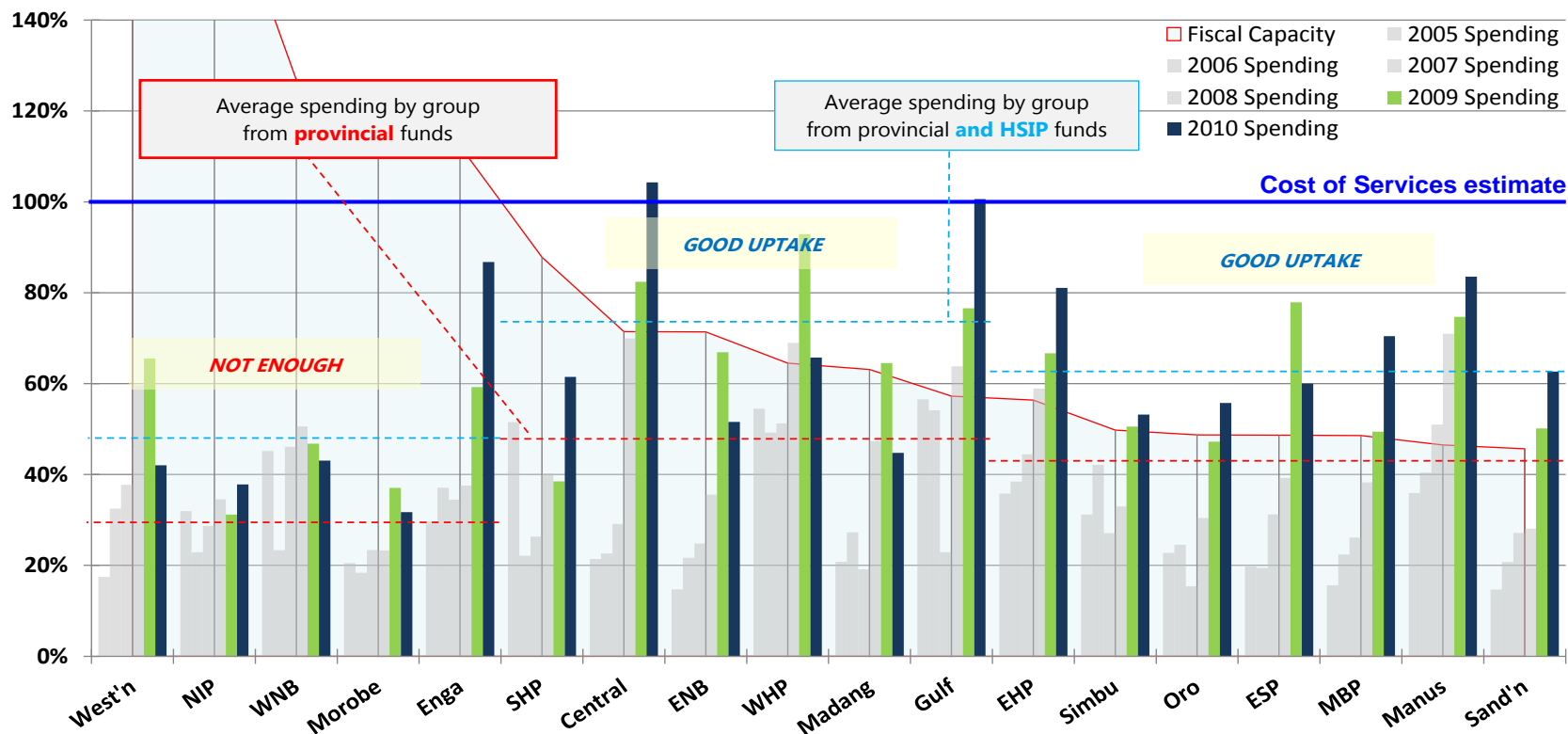
The total Health Function Grant for provinces in 2012 is K64.35m, while the transfers of HSIP funds were K10m from a budgeted amount of 16.5 million⁹. The contribution of the HSIP to health service delivery in the provinces is important because it is accessible to the Health Division, but restricted due to audit controls.

The second graph (next page) adds provincial spending from grants and internal revenue together with recurrent spending through the HSIP facility and compares the result against what is estimated is necessary to deliver a basic set of health services to people.

⁹ The reduction is related to AusAID funds already distributed being frozen in 2011-2012. It is expected that new funds will flow following release of the new design and the signing of a new financing agreement.

Figure 2 - The impact of Health spending of HSIP Funding: 2005 to 2010

Graph 30: The impact on Health spending of HSIP funding: 2005 to 2010



Source: NEFC 2012

As the PER notes: “As a group, higher funded provinces continue to do poorly and are outperformed by low and medium funded provinces.” (PER 2012:62).

e) Total Resource Envelope - HFG, HSIP, Internal Revenue and CHG

The Church Health Grant is an additional national health grant that adds to the sum of available health funds in the provinces. Funds are provided through the NDOH budget (through the Church Medical Council) to Church Health Secretaries in the Provinces.

Annexure 8 utilises the best available data, to provide some insight into provincial governments’ resource envelope for goods and services from national government, including internal revenue, church health grants, health function grant and the HSIP funds. These are approximately K100m in 2012.

Cost of services figures for NCD and ARB are not included as these two geographic areas of PNG have their own laws and funding arrangements.

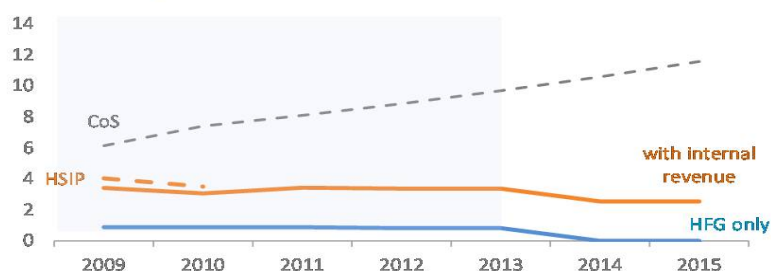
As can be seen from the table in Annexure 8, in 2012 for most provinces the total goods and services grants received are drawing close to the estimated cost of providing the basics of service delivery when the Church Health Grant (CHG) is added.

In 2014, when the RIGFA transition guarantee is removed, five resource rich provinces will lose much of their HFG and will have to rely on internal revenue, HSIP and CHG to fund basic services. It follows that the national government may have less influence on basic service provision (MPA) in those provinces. The projections for each province are provided at Annexure 9.

To illustrate these concerns, a projection of funds available to Western Province, relative to the cost of services (COS) is provided here.

Figure 3 - Funding Rural Health in Western Province

Funding Rural Health in Western Province



- Costs increase over time
- The health function grant is likely to stop in 2014
- Much more internal revenue is needed to adequately fund basic services
- HSIP has not been well accessed historically
- Funding needs to reach the appropriate level where spending on basic services needs to happen

Of concern is the fact that although the province does not appear to take health service delivery as a priority responsibility, at least two of its districts are among the most disadvantaged and the province itself ranks lowest of all in PNG on the Human Development Index.

This argument has two sides. By taking no action to 'replace' HFG, it is hoped that revenue rich provinces will use more internal revenue on service delivery. On the other hand, if these provinces fail to allocate internal revenue (or in some cases the perceived abundant internal revenue is not available), and there is little national government or donor funding, the rural poor will suffer a great injustice. This issue needs to be addressed at a policy level.

Church Health Grants are provided directly (through the Church Medical Council) to Church Health Secretaries in each province. As national grants, they should be as transparent and accountable as the Health Function Grant. In reality, neither provincial nor national governments are given information about the expenditure of these grants. Evidence suggests some is used for facility funding. NDOH is seeking support from Treasury/Finance to move CHG from Vote 241 to Vote 240 in future budget submissions. This will provide the opportunity for the Secretary for Health to direct priorities and potentially improve governance and accountability.

Provincial Audit Committee

PNG Finance Department advised that there are seven Provincial Audit Committees established (Eastern Highlands, Madang, Sandaun, Morobe, Enga, New Ireland, and Milne Bay). Finance also conducts performance assessment to see how the Committees are performing. Finance can advise which Audit Committees are capable of auditing HSIPTA. Currently only EHP Audit Committee has performed an audit in 2009/2010 on HSIP and Finance can provide a copy of the Report.

2.5 Other issues

Provincial HSIP allocations are often drawn down slowly for many reasons, as outlined in the ODE Report (2008). Subsidiary accounts rely on a tranche drawdown conditional on an 80% acquittal of previous funds. Draw down must wait for an audit team from NDOH. Accounts can be suspended pending further audit and investigation.

Just as the NDOH is placing unused GoPNG Development and Recurrent funds in the Parent Trust Account some provinces are also placing GoPNG development funds in the subsidiary accounts. This should be monitored by audit teams to avoid further reputational risk to the Trust Account mechanism. Any evidence of HFG funds being moved into subsidiary accounts should be identified and highlighted to the HSFC.

The formula for the Health Function Grant is transparent in the NEFC Annual Fiscal Reports www.nefc.gov and NEFC sponsored publications. The provincial funding for the CHG is contained within the NDOH budget papers. The provincial allocation for

HSIP is not transparent to external stakeholders. CHG and HSIP allocation formulae do not appear to relate to the NEFC model although significant effort has recently been undertaken to address this.

2.5.1 Monitoring and Reporting

No analysis of the types of expenditure from HSIP subsidiary accounts was available in a summarised form. Spreadsheets viewed showed that much of the recent expenditure was on immunisation and patrols, perhaps as a result of the Supplementary Immunisation Activities approved in 2011. Spreadsheets from the subsidiary account align with PGAS vote codes in the main, and the feasibility of uploading these into the NDOH PGAS parent account using provincial codes is advisable. This would be far more reliable than spreadsheets saved on individual computers, and would allow better analysis of the activities and outputs related to expenditure. It would also be one step closer to removing the parallel system should this be deemed possible in the future.

2.5.2 Church Health Services

Churches play a major role in providing health services in PNG. While managing most training schools for nurses and community health workers they also deliver 50% of the services at rural level. Funding is provided through a national grant, which is distributed through the Churches Medical Council to facilities. Churches to some degree supplement this grant.

Staffing components of the grants were established through NEC decisions many years ago and included ceilings on staff numbers and payment rates. Over time this has created a significant disparity between public sector and church health workers. Exacerbating this situation is the salaries being offered by the private sector which far exceeds those offered by the public and church sectors. Church Health Services are experiencing a significant haemorrhage of workers to the public and private sector.

In addition to this the number of unregistered facilities has increased dramatically. While this is reflective of the need for those additional services it also has placed a significant burden on national budgets for medical supplies and the overall grants provided for maintenance and operations.

Church Health Grants are under increasing scrutiny regarding transparency of expenditure, coordination with provincial government and PFM processes. In 2012, NDOH received a summary statement of expenditure for the first time.

2.5.3 Delivering Services to Districts and Facilities

One of the accepted principles of improved service delivery is that more funds should be delivered directly to facilities, or at least to the district level. A pilot process to establish this direct form of funding from NZMFAT is being undertaken in Bougainville.

Through evidence provided at NEFC workshops (2012), the PER 2010 and HSIP consultations, HFG funding is being devolved to district and facility levels in those provinces where planning and budgeting is at a high standard. Where there are good management practices in place – planning, budgeting and reporting – there appears to be no barrier to devolving HFG, HSIP or CHG down to district and facility level. However, there is one barrier to using HSIP and that is that unless acquittals meet a high standard, funding to the province will be suspended. Thus, it is more likely that HFG and CHG funds are used for operational funds in the districts and facilities.

Evidence was also gathered that educating Officers in Charge (OIC) on the processes for accessing funds (planning and budgeting for their facility), and responsibility for reporting - was likely to lead to the provision of operational funds at the appropriate scale using PNG processes.

A new initiative being trialled where funds can reach the facilities through mobile phone technology has been raised by NEFC. This has the potential to have significant benefits for remote facilities, which may need further consideration and monitoring.

2.5.4 Planning & Budgeting

In terms of the PNG budget cycle, the HFG ceilings to be appropriated are calculated by the NEFC and advice is provided to the Treasurer in July. Ceilings are then provided to provinces to frame up provincial plans and budgets for the following year.

Many provincial budgets show the Minimum Priority Activities (MPA) as separate (now standardised) cost codes and other activities funded by the HFG. Some provincial budgets show the HSIP activities and source of funds.

The HSIP process has not followed the PNG budget cycle in recent years. Development Partners provide their commitments, which are then put through a provincial allocation formula in the Department. The HSIP ceilings are provided to provinces by NDOH, not always in time for planning and inclusion in the budget process. Development Partners and NDOH need to commit to providing information that allows provinces to include HSIP funds as a source in the PNG budget cycle.

The 2011 allocations were in the range of K365,000 (Western) to K1.72m in East Sepik. The allocation formulae utilises specific criteria and takes into account the Provinces capacity to pay, population, health status, rural poverty and capacity to spend. The allocation formula has not been revised since 2005. The re-design team recommends that the new formulae be weighted to the disadvantaged, and be cognizant of the effect of the RIGFA on Provinces such as Western. The formulae will need to also take into account the new Provinces Hela and Jiwaka as well as Provincial Health Authorities.

The subsidiary accounts are not operated through or saved on PGAS. Cheques payable from subsidiary accounts are from a commercial bank

(which is allowable by Government) in the province. Signatories are the provincial health adviser and the provincial treasurer as required by the Trust instrument.

Quarterly tranches are provided: conditional on the acquittal of 80% of the previous tranche. Some provinces' accounts have been suspended if there are concerns on expenditure or the nature of acquittals received. Gulf, Simbu and Western were suspended in 2011; transfers were delayed in several others. HSIP is implementing PFM governance obligations to a far greater extent than elsewhere in PNG because of the risk requirement of donors. It may be argued that the strict acquittals conditionality slows expenditure, or alternatively, that the provincial HSIP operations are providing an improved governance and incentives framework. In the absence of any other control, the acquittals processes are providing the strategic framework for HSIP in the provinces. Provinces are well aware of what they can spend money on, what processes need to occur both before and after expenditure and the penalties for non-compliance that largely concur with PFMA.

As a result of these controls, the subsidiary accounts in the provinces are kept in accordance with the level of perceived risk. At the current levels of allocation, transfer and expenditure control, the HSIP (non-targeted component) will remain a marginal component in most provinces unless there is greater investment in improving compliance. Because of the general increase in the HFG (as a function of increasing national revenues) the range of funds provided over 2009-12 is considered appropriate; the controls in place will prevent displacement of HFG by non-targeted funds.

The Department of Finance is assisting Provinces to establish internal audit functions. Audit Committees are being established with similar roles as those at the national level.

2.5.5 Poverty and Equity

Addressing poverty and the disadvantaged are important goals to achieve the MDGs. Disadvantaged communities are often kept so because of the high costs of service delivery, communications and general isolation. HSIP should find ways to offset these costs to deliver to disadvantage and poor rural communities. There are many disadvantaged districts in PNG identifiable through the Human Development Index and specifically the recent National Research Institute districts database.

One option for the re-design is for HSIP to be better targeted as an equity program, addressing poverty, gender, disability and geographic disadvantage better. Then HSIP has the capacity to at least provide funds for a minimal set of services to the most disadvantaged.

Rather than challenging or displacing GoPNG funds, the HSIP could also be re-designed to improve both the absorptive capacity¹⁰ and the enabling environment at the facility level. The potential diminishing returns of funding increases can be offset by a set of interventions which could significantly improve the health of poor people in a relatively short time by addressing this problem at service delivery level.

This list of deficiencies concurs with the changes required to achieve the vision of health delivery in KRA 3 of the NHP. That is: there is a need for well maintained facilities, well trained staff, medical equipment and supplies, communications and running water.

2.5.6 Infrastructure

The state of facilities is a cause of concern and is well documented (2011-12 Capacity Diagnostic Reports from five provinces: ADB Assets Analyses 2012). The Provincial Expenditures Review (2010) showed expenditure on the facilities maintenance items allowable under the Health Function Grant was low: 13% for construction and renovation and 7% on routine maintenance.

The 2012 Annual Sector Review identified that: "Proportion of aid posts open has fluctuated between 66-71% in the last five years. Generally, the level has been stable in all regions since 2007. Of concern are Oro, Enga and Morobe where only 1 in every 2 aid posts is open"

In addition the indicator for '% of health facilities with running water and sanitation' shows a drop since 2009. This is also the situation with the indicator '% facilities with functioning telephone and/or radio' demonstrating a gradual decline.

The above demonstrates that there still has been no demonstrable improvement in these key indicators since 2009

Given the maintenance backlog in evidence, further encouragement to spend on this item will be beneficial to service delivery.

As a coordinating concern, the HSIP TA will host a major Project, co-funded by GoPNG, Asian Development Bank, AusAID, and JICA, to be undertaken in eight provinces over the next eight years. This is a well-researched major asset improvement project, which will not be jeopardised by small maintenance and rehabilitation of existing facilities projects brought forward from existing provincial and district plans.

Qualified staff at the facility level is essential, Officer-in-charge training and CHW training are high on the list of imperatives to improve the enabling environment of health. Communications and water supply maintenance are

¹⁰ *Scaling up vs Absorptive Capacity*. ODI Briefing Paper May 2005.

also high priorities. However medical supplies and medical equipment replacement is being addressed from NDOH budgets.

2.5.7 Health Services Improvement?

Plans developed in NDOH, while perhaps too complex, are in keeping with agreed program planning. There has been a perception by many NDoH and Provincial Health Staff that “if it is in the AIP as HSIP, it is funded”. This is exacerbated by the lack of direction to staff during the early planning stages of resource ceilings and priorities. The Medium Term Expenditure Framework (MTEF) is not driving budget and allocation of resources. Plans are not scrutinised effectively by management at all levels of the system.

Planning at the provincial level appears to follow the MPA conditionality and the NHP. In addition, provinces have been guided by the exclusions expressed in the current Manual. The exclusions are well known in the provinces, again due to the work of the acquittals auditing team. The Provincial Manual will require update to provide clearer guidance on how funds can be utilised following re-design.

NEFC, through its regional workshops, is building capacity in this area in several ways. Firstly, it has developed a summary budget template which would allow decision makers to see at a glance the sources of revenue and sectoral allocations. Secondly there is a Provincial Budget Model (PBM) to assist provinces allocate funding levels based on the higher costs of service delivery. The PBM is based on the Cost of Services’ and is being currently revised. It allows provinces to understand the different costs of provision by district and facility. This model has been taken up by several provinces to allow district allocations to align more closely to costs. Often the costs of providing services to those districts are very high as it can depend on airlifting supplies and labour. However, the costs should not be a barrier to equitable service provision. Here HSIP might assist in providing necessary funds, and especially by referring provinces to the NEFC PBM for guidance. Thirdly, NEFC has developed a standardised chart of Accounts, which, if adopted for HSIP expenditure will allow for easier monitoring of expenditure. The Department of Finance, with donors, supported these reforms with capacity building in the Provinces and Districts through the Finance Training Branch and the Provincial Capacity Building Program (PCab) in six provinces.

Service delivery (improvement) in the provinces is measured by the DPLGA Provincial Performance Reports (section 119), DPLGA Peer Reviews, Treasury Second Quarter Budget Reviews and Provincial Budget Reviews. The NEFC Provincial Expenditure Reviews and Regional Workshops are becoming essential sites of performance information provided by the provinces.

Under the SWAp arrangement, health improvements are recorded in the Annual Sector Review, an analysis of health outcomes by province from the National Health Information Systems (NHIS).

The National Department of Health has obligations under PFMA to provide quarterly reviews of all its activities under the budget cycle. The most important of these is the Second Quarter Budget Review which provides the opportunity to look at expenditure and activities and reallocate where relevant and appropriate. Since the HSIP TA is included in the NDOH development budget - activities and outputs should be recorded by the Corporate Services Division, after requesting data from the HSIP management arms. This data should be approved through the Finance or Program Committee and thence the SEM prior to submitting to Treasury and the Department of National Planning and Monitoring (DNPM).

NDOH also has responsibilities to provide an Annual Report on its activities. This Report should include the HSIP contribution, as well as the extent of expenditure of GoPNG funds to achieving improved health outcomes.

It was noted that in the NHP Draft Monitoring and Evaluation Plan, a Performance Assessment Framework has been established. This framework uses NHIS data but further work is required to operationalize effective use of the data collected. These processes need to be strengthened and a reporting framework established to provide greater transparency of health sector activities.

2.5.8 Provincial Chart of Accounts

In 2007 NDOH proposed to include the Ten Health Programs in the Planning and Budgeting System (PBS). This meant creating an additional digit in the PBS/PGAS database. This request was made at the NEFC/Treasury regional Budget Workshops. Treasury advised that PBS database was limited to only 14 digits vote codings and it was not possible for an additional digit. Treasury further advised the new Finance IFMS may consider accommodating the request when it comes live (although this is still not live in central agencies and implementation in the provinces may be some way off if at all). Subsequently, Sandaun Province developed a program Chart of Account, intended as a pilot for use by provinces. This has yet to be verified to be consistent with the approved Program Budgeting concept. Treasury only acknowledged their effort. Recently NEFC produced a uniform COA which is to be negotiated with Treasury and Finance, considering that IFMS is still not advancing,

The proposed changes to the COA will impact on the current systems in Finance, Treasury and provinces but stronger leadership is required for closer consultation between the interested parties and the key stakeholders to create pathway to supporting these initiatives. The changes may be expected to be implemented incrementally.

2.5.9 Provincial Health Authority

The Health Sector is implementing a new initiative, the Provincial Health Authority, in three pilot provinces (Eastern Highlands, Western Highlands and Milne Bay). This initiative, established under the Provincial Health Authorities

Act (2007) allows for the Governor of the Province and the Minister for Health to agree on integrating health service into one authority. An evaluation of the implementation is expected soon and will be reported to PLLSMA.

The current Trust Deed does not provide for the Provincial Health Authorities to be recipients of HSIP funding. Significant negotiations are still required between NDOH and Departments of Finance, Treasury and DPM to progress details of implementation.

2.5.10 Hela and Jiwaka

The national elections are now completed and the imminent final step in the establishment of the two new Provinces will be undertaken with the resumption of parliament in 2012. The current Trust Instrument will need to be amended to establish two new subsidiary accounts for Hela and Jiwaka.

CHAPTER THREE - STRATEGY SELECTION AND RATIONALE

3.1 Guiding Policies and Principles

The re-design of the Health Service Improvement Program (HSIP) is encouraged by the re-confirmed commitment of all Partners to the implementation of the Sector Wide Approach (SWAp) for Health in PNG as a means of harmonising and coordinating contributions to improve service delivery. The following are the key policies and principles that have guided the new design.

3.1.1 Government Leadership and Ownership

The single most important Government policy document for health is the National Health Plan 2011-2020 (NHP) which reflects the GoPNG key development plans, and is focussed on a “Back to Basics” approach with a key outcome of improved service delivery for the rural majority and urban disadvantaged.

In accordance with the National Health Administration Act (1997) the role of the National Department of Health (NDOH) is to “oversee the carrying out of the National Health Plan” and in doing this has a major role in managing DPs contributions and the SWAp TA. The redesign of the HSIP TA recognises these roles.

In line with the NHP, the DPs pooled funding within the HSIP TA targets interventions at the provincial and district levels to assist in providing strategic elements of health service delivery fundamentals – functional local facilities, trained, supervised and committed staff, medical supplies, a supply and maintenance budget for operations and consumables and running water.

3.1.2 Alignment/Harmonisation with Government Systems

An effective and mature SWAp uses Government systems and processes with funds pooled at the highest level and distributed according to a single budget (Sector Budget Support). This requires Development Partner (DP) confidence that funds provided will be utilised in the manner agreed and with correct governance procedures applied.

HSIP TA provides a valuable coordinating mechanism for donor funding in PNG, it is well regarded in the provinces as a contributor to service delivery. As an addition, the new HSIP TA can be positioned as an equity mechanism for targeting the disadvantaged: the rural poor, women and children, and those living with chronic diseases.

The Health Function Grant (HFG) is now a significant and well understood conditional health funding modality across all provinces. Future donor funding must contribute to an enabling environment, rather than displacing GoPNG funds for direct health delivery. In 2012, the health function grants total K64 million.

Provincial Internal Revenue: National grants must be supplemented by provincial internal revenue if the standards of health service delivery are to be achieved. Specifically, those provinces with significant revenues must budget

support for health services, particularly as the health function grant guarantee period ends. In 2010, spending on health from internal revenue was K7.3m and this needs to increase.

Church Health Grants are provided directly to Church Secretary's in the provinces. This is a national grant from Treasury through the National Department. In 2012 these grants amounted to K20 million.

3.1.3 Managing for Results

Future pooled and earmarked support through the HSIP TA must build on the governance culture required by Provinces to ensure release of funds. The design team supports the current standard for acquittals set by the HSIP TA and sees these benchmarks as appropriate, given the risk environment. In this way, HSIP will be a direct contributor to improving the PFM performance of Provinces in relation to its spending and governance of all funds.

There are significant capacity and process/procedural issues at the NDOH that need to be addressed urgently. These have been identified by independent audits and the PNG Auditor General. DPs must support the NDOH to follow the Audit improvement plan as a priority.

Health information is collected at provincial level. Although derived from the same data, the NDOH National Health Information Systems and the Section 119 report (coordinated by the DPLGA) show major variation in results. Indicators for the HFG MPA need to also align to harmonise the data collection systems. The Health Subcommittee of PLLSMA is the vehicle for this work.

3.1.4 Mutual Accountability

The re-designed HSIP TA will improve predictability of DP's funding to the provinces within the GoPNG budget cycle. Over time this will improve the absorptive capacity of rural based PNG health systems to use appropriated GoPNG funds. Partners to the HSIP TA must agree to the key principle of allocating and spending GoPNG funds first before development partner funds.

The team recognises that a key constraint to the performance of the HSIP TA since 2007 has been the inflexibility to fund resources to supplement administrative need during times of intense activity. It is essential that the new HSIP TA match the level of activities and funding to the resources available to manage it. The operational elements of the Trust Account will be amended to enable this flexibility so that NDOH processes are not disrupted unduly.

HSIP TA will seek to increase opportunities for churches and Non-Government Organisations (NGOs), to access funds, while requiring compliance with PFMA processes and procedures, as well as procurement, monitoring and reporting.

3.2 Poverty in PNG

There has been much controversy over the last few years about the level of poverty in PNG. Yet in accordance with the internationally accepted criteria, PNG people in remote areas are considered poor and getting poorer by the day. Even as GDP climbs, as a result of the resources boom, development has stagnated at the local level and poverty has deepened.¹¹

The correlation between poverty and the level of infrastructure and health services is strong. The UNDP estimates that 37% of PNG population live below the poverty line. The study to map poverty in PNG (Gibson et al 2004) created disaggregated maps of poverty based on several relevant databases. One of the key findings was that there can be significant variation in poverty rates within Provinces. The finding that is most relevant to this redesign is that public spending interventions that try to target poor provinces “are likely to miss large numbers of poor people in other provinces, while also benefiting the non-poor in the areas selection for intervention” (Gibson 2004).

A key focus of the redesigned HSIP TA will be initiatives directly contributing to poverty alleviation through health service access, and particularly focussed on the poorest of districts.

3.3 Lessons Learned

The Design Team undertook an extensive review of the available documents and key reference material, as well as discussions with key stakeholders and other AusAID funded programs to identify lessons learned. Several key themes emerged from the research which have guided the design of the new program:

1. Common Funds¹² are usually setup to act as transitional vehicles to the eventual adoption of Sector Budget Support (SBS). The HSIP TA is one of these common funds.
2. SBS does not necessarily support greater decentralisation of funding for service delivery¹³. Research identifies that the associated risk of investing directly through pooled funds (with no conditionality) has not been embraced by DPs as they tend to advocate for a relatively ‘safe’ option such as procurement of medical supplies, where accountability for funds can be monitored more easily.
3. SBS through Government systems reduces the extent that DPs can influence equitable distribution of resources to provinces. NEFC have identified that four Provinces will not receive funding from the national

¹¹ 2009 – Chronic Poverty in PNG, Diana Cammack, Chronic Poverty Research Centre

¹² Common Funds (CF) is defined by OECD/DAC (2008) as “arrangements where donors provide funding to a common basket, to be spent by specific agencies of government on agreed programmes. Funds do not pass through Treasury account following normal budget procedures but are held in separate bank accounts from which funds are transferred directly to concerned agencies, alongside separate reporting procedures”

¹³ AusAID, HRF supported literature 080612

pooled grants from 2014 as a result of the end of the transition guarantee.

4. Many facilities receiving Direct Health Facility Funding in the ARB pilot program continue to charge user fees, which disadvantages the poor¹⁴. The transaction costs of ensuring a change in practice is high.
5. The PER Report for 2010, and presentations from Provinces demonstrate an increasing ability to spend HFGs appropriately and that Treasury will allocate funds sufficient for basic services to about 10 Provinces in 2014.
6. Provincial Budget Support is being trialled through the Provincial Performance Improvement Initiative and may be a model for future Provincial Health Budget Support if certain conditions were met.

In addition to the above there are many non-health program activities, particularly those encouraging PFM compliance and training which provide complementary inputs. These include: GoPNG Finance Training Branch and its provincial facilitators; Provincial Capacity Building Program (PCaB) and the Provincial and Local Government Program supporting the DPLGA PPII. This support, if harnessed for HSIP TA processes, increases the potential for HSIP TA success. Annexure 10 provides a more complete list of related Development Partner Activities.

3.4 Options, Rationale and Strategy Selection

3.4.1 Introduction

The Design Team assessed the options proposed by the Options Paper (Annexure 2), ground-truthed these with extensive consultations and analysed where the best health outcomes could be delivered in a sustainable way, and particularly in a way that complements existing PNG funding mechanisms for health improvement.

The redesign moves away from general funding of recurrent activities (business as usual option) to one of targeting specific high impact provincial interventions designed to accelerate improved rural health services, with funds quarantined to poor and disadvantaged Districts.

Table 5 – Selection of Options for HSIP TA Funding

1	Support Service Delivery in Districts/Facilities–The option directly supports the enabling environment of health service delivery in Districts/facilities to improve health outcomes for rural and remote people
2	Enhances existing Government systems/reforms such as NHP; core responsibilities, RIGFA; avoiding displacement of GoPNG funds and responsibilities
3	Risk – The option assists with management of risks – (fiduciary, development or reputational)
4	Sustainability – The option has the potential to be sustainable in PNG
5	Poverty – The option specifically addresses the needs of the poor and disadvantaged women and children

¹⁴ NDoH, Progress report DHFF Pilot Scheme - ARB

6	Equity – The option overcomes barriers to equity within and between Provinces
7	Gender and Disability – The option addresses gender issues and improved access for people with disabilities

3.4.2 Assessment of Options

The Options Paper scoped out a wide variety of potential future directions, as well as a detailed analysis of the potential benefits and consequences of those Options. The redesign considered all the options, however during consultations and analysis; some Options were not considered optimum for the HSIP TA redesign at this stage.

The Table provides a summary of these options in the light of provincial data (qualitative and quantitative), evidence collated during the re-design process and recommendations for inclusion in the redesigned HSIP TA. Options that did not meet at least three criteria were not included.

Table 6 - Assessment - Review of elements outlined in the Options Paper for HSIP TA Funding

Option	1	2	3	4	5	6	7	Selected Options
Business as Usual	✓							No
1st Quarter Payments	✓		✓		✓	✓		No
Incentive/Leverage Funding	✓	✓			✓			No
Targeted In-service Training	✓	✓	✓	✓	✓	✓	✓	Yes
Targeted enabling funding for Maintenance and Rehabilitation of existing facilities								
Water	✓			✓	✓	✓	✓	Yes
Lighting	✓			✓	✓	✓	✓	Yes
Staff housing	✓	✓		✓	✓	✓	✓	Conditional
Minor rehabilitation and maintenance	✓			✓	✓	✓	✓	Yes
Emergency Activities	✓	✓	✓	✓	✓	✓	✓	Yes, obstetric
Direct Facility Funding	✓				✓	✓		In ARB (NZFMAT)
Targeting disadvantaged Districts	✓	✓		✓	✓	✓	✓	Yes
AIP Recurrent Activities	✓		✓	✓		✓		Yes, but tapering
Churches accessing HSIP TA	✓	✓		✓		✓	✓	Conditional on PFM
NDoH Options*		✓		✓		✓	✓	Core

3.5 Scoping the quantum of pooled funding available

In considering Options for the re-design, the team asked for some indication on the quantum of funds that might be available in the HSIP TA pool. Indicative figures given are shown below.

Kina,000	MTEF 2012-2014 Funding Commitments		Estimated Only Commitments Not Available	
	2013	2014	2015	2016
Resource Envelope	38,537	38,700	34,700	34,700

From this the redesign team determined a budget and assessed the capacity of the Provinces to progress the increased level of funding and targeted activities.

3.5.1 Options Discussion

The Options Paper (Cairns 2012) at Annexure 2 provides a detailed matrix of an expanded list of 15 Options, against criteria of possible donor approaches, benefits, risks, sustainability and displacement issues and absorptive capacity.

Without re-iterating the Options paper discussion in full, the following outlines the major Options considered by the redesign team and the way that these may be incorporated into the redesign and the operational considerations.

3.6 Options, rationale and strategy selection

3.6.1 Business as Usual

Maintaining an untargeted recurrent fund broadly based on AIP at provincial and national levels was a major consideration for the redesign however there was no data available to show its health service improvements or outcomes due to a lack of data analysis. This Option has not been selected. However there will be an element of untargeted recurrent funding tapering to zero in four years depending on review. This will allow the transition from untargeted to targeted interventions (see below).

3.6.2 Targeted Recurrent Interventions:

a) Targeted funding for maintenance and rehabilitation of Existing District health facilities and associated housing

Discussion

Rural facility maintenance and rehabilitation is a priority for the NHP and MTDP. The Government of PNG has recently appropriated significant funds as part of its Development Budget for major hospital and community health centre rebuilding programs. The Medium Term Development Plan for Health identifies K361 million to rehabilitate 365 health centres over five years with a development budget of K72 million per annum. Each health centre is costed at an average of K700,000 regardless of condition or location. It also includes the option of complete rebuild where the investment is required included in

that average. To support this plan, K12,8 million is appropriated for project management units in NDOH and each province.

The HFG Minimum Priority Activity (MPA) 1 (Operational Facilities), identifies funding for general maintenance of facilities and minor equipment as a recurrent funding requirement. This creates a basis of sustainability because it is government funded and based on affordability. However, the significant disrepair of the current facilities cannot be addressed by this funding alone which assumes a level of functionality and is based on the day-to-day maintenance costs. The 2010 PER applauds the K7 million expenditure by provinces

While some rehabilitation and upgrade works may have been undertaken through the DSIP, it is anticipated that the referencing to provincial and district planning processes will prevent duplication and intensified monitoring processes will ensure that funds are used for the purposes intended.

Donors are assisting where major infrastructure is required to support policy outcomes. The new Rural Primary Health Service Program (jointly funded by several partners including GoPNG, AusAID and the ADB) will address major infrastructure needs in 16 Districts across 8 Provinces.

The broad estimate of costs is informed by: the NEFC cost of services through the Provincial Budget Model; the estimated cost by PNG government in the development budget; the Monash costing study and the consultant's observations and experience in PNG.

The NEFC costing is based on a travel cost model: Annual Facility Costs include: Non-medical supplies; facility maintenance; rural HC transportation; maintenance of medical equipment; fridge gas and maintenance and HC radio maintenance.

The Monash costing study takes a different methodological approach and focuses on building repair, size and whether the location is easy or hard. Of the 55 health facilities observed in detail, the average annualised maintenance/ depreciation costs for building infrastructure was K5821 (Low); K11647 (Medium) and K16,858 (High).

Strategy selection

HSIP will provide targeted funding for Provinces to undertake additional maintenance and rehabilitation and maintenance of existing registered rural facilities, both government and church. The redesign takes the approach to most of the facility costs of the health function grant excluding rural HC transportation (except for obstetric emergency transfers (discussed later).

Rehabilitation can include steps, flooring, safe storage of drugs and basic carpentry which are so often absent. Maintenance includes all the consumable elements that facilitate health service provision and help the population to gain confidence in the care provided. For example, clean

mattresses, towelling and linen, basic hygiene through running water. Water supply requires maintenance as taps start dripping or pipes burst. If the cold chain is broken, vaccinations will be unhelpful or dangerous. Where feasible and practical, disability access may be added in line with universal disability standards.

HSIP TA funds can be also utilised for minor repairs to existing staff housing to ensure staff remain on duty and morale improves. These activities should be identified as priorities in existing provincial and district planning documents and elevated on an annual basis to the AIP using HSIP TA funds. Provinces will be encouraged to address their government housing management approaches to ensure rehabilitated houses are occupied by current health service staff. Provinces will need to declare during annual evaluations of progress against AIP activities any concerns with housing occupation.

The Provincial Budget Model can be used to estimate the relative costs that might be incurred in an additional maintenance and rehabilitation endeavour. In the Madang PBM, cited previously, facility item costs were on average K25,000 with a range from K19,000 to K32,801. In practice, rehabilitation and maintenance of many health facilities has not occurred systematically for many years and is only beginning now with the predictability and conditionality of the Health Function Grant. Assistance of this type, firstly can make a difference at reasonably low cost, and secondly will encourage the ongoing maintenance effort to be redoubled.

Provinces are encouraged to maintain facilities in an ongoing way using funds from the Health Function Grant.

b) Disadvantaged Districts quarantined funding for targeted facility rehabilitation

Rationale

Twenty Districts in PNG have been identified as the poorest and disadvantaged areas within PNG (Gibson et al 2004). Many of these also share the problems of remoteness as well as declining health indicators. The impact of distance and difficulty of transportation means that barriers are exacerbated and a special effort needs to be put in for disadvantage populations to address health issues and access.

Ensuring that targeted interventions are provided in these Districts is expected to have a significant effect on the health status of the populations within their catchment areas. The HSIP TA has an opportunity through a quarantined annual allocation to address key facility improvements including staff housing in these remote districts. The recent Health Capacity Diagnostic visited many of these areas and saw the state of these facilities first hand.

The Monash report noted (p.19) “Almost all facilities visited in these provinces described further maintenance issues they deemed needed fixing. These maintenance issues are likely to fall outside the focus of the current ADB

Rural Enclaves Project. Overwhelmingly health centres reported a need to improve staff housing. This was true of almost every health centre visited across PNG. Some interview respondents indicated that they thought ADB were “supposed” to fund these staff housing improvements as well. It is our understanding that the Rural Health Enclaves Project did include some refurbishment of staff housing in Phase One, which may be expanded in Phase two, however as mentioned above, this is a secondary aim of this project. “

The costs of provision to many disadvantaged districts may be tenfold because contractors, fuel and air or sea transport is likely to be involved. Costs can vary widely, however the tender processes in PFMA all require three quotes for significant expenditure. Where this exceeds the limits of PSTB consideration, particular processes may need to be invoked to ensure good procurement practices, consistent monitoring of contract delivery and payment on completion.

Strategy Selection

A significant percentage of targeted recurrent provincial funding for rehabilitation and maintenance will be quarantined annually for this initiative, especially in identified twenty disadvantaged districts. Districts identified as disadvantaged and with declining health indicators (as per the SPAR), may access funding to address specific service improvement initiatives. These will need to be brought forward from existing Provincial and District Plans and itemised in the AIPs. Districts will be required to follow procurement procedures including special conditions for Development Partner funded procurement over K300,000 as detailed in the HSIP TA manuals, ensure health standards in buildings and acquit through PFMA processes. Subsequent funding in future years will be based on the compliance to HSIP TA processes and procedures. In addition to provincial monitoring, the FMSB (compliance function) will oversight the compliance processes and the PLLSMA Health Subcommittee /PCMC will undertake site monitoring visits.

While there are several sources of ranking for disadvantaged districts in PNG, the list provided here is recommended from the study Poverty Mapping in Rural PNG, Gibson et al (2004). The twenty targeted disadvantage districts for HSIP funds are: Middle Fly; Telephoning; Vanimo Green; Nuku; Rai Coast; Aitape-Lumi; Central Bougainville; South Fly; Middle Ramu; Jimi; Goilala; Bogia; Koroba-Lake Kopiago; Obura Wanenara; Kagua-Erave; Ambunti-Dreikekir; Kabwum; Tambul-Nebilyer; Karimui-Nomane; Abau.

The full list of provinces and how the poverty mapping relates to previous data are at Annexure 11.

c) Incentive/Leverage Funding:

Rationale

Funding by the GoPNG Government for health services has increased since 2009 and may increase further as GST revenue are buoyed by resource

industry expenditure. While this funding may translate into increases in HFGs, Provinces such as Western and New Ireland will receive vastly reduced grants from the nationally provided grants from 2014 when the transition guarantee expires. These Provinces will need to increasingly allocate funds from their Internal Revenue to maintain the MPA. However some health divisions have not been able to advocate for IR funds, so that health services in those Provinces may be at risk.

Incentives, to be effective need to be of the same order as the behaviour change required. In provinces such as Western, it is difficult to estimate a leverage amount that would effect this change, given the funds that are already available and the extent to which donors and resource companies fulfil the health service charter.

The HSIP TA promulgated an Award System in the past to reward outstanding and improved performance. Since 2009 these have not eventuate in actual payment and have created significant friction between National and Provincial entities.

However, the HSIP TA is fundamentally an incentive program. Annual allocations to provinces are not given as a grant. After the first tranche, additional funds are only drawn down conditional on expenditure, acquittals, and audit.

Strategy Selection

The fundamental incentive principles already in the HSIP TA are retained in full.

Development Partners should support the National Department of Health and Central Agency Partners to advocate that resource rich Provinces allocate additional internal revenue for health services. The quantum of funds in the HSIP TA is considered insufficient to alter provincial behaviour in resource rich provinces by providing additional leveraging.

Provinces projected to receive minimal HFG from 2014 would still receive funding from the HSIP TA, CHG and financing from the private sector (tax credits). Western Province, for example, would also benefit from the focus on disadvantaged district packages (South Fly, Middle Fly) to ensure that people did not suffer unduly because of the province's 'priority gap'.

For targeted rehabilitation/maintenance options for disadvantaged districts where it is expected that some procurement may be in excess of K300,000 Provinces must demonstrate a commitment to co-fund infrastructure development. This commitment maybe secured through either:

- A multi-year PIP submission in consultation with NDoH;
- District MPs providing DSIP funding through a Kina for Kina approach;
- Provincial government providing internal revenue through kina for kina approaches.

- Other funding sources as appropriate.

d) Targeted in-service training

Rationale

A key strategic objective of the new HSIP TA is to increase the absorptive capacity of the health system as a whole through increased capacity of the front line workers to plan, budget, expend and report on resources/activities. A key outcome of increasing this capacity, and hence funding flows to facilities, is improved access for people and subsequently improvement of health indicators.

District Health Coordinators are expected to have new skills to plan, budget, implement, monitor and report on health service in their area. This capacity is urgent, as more and more funds from the HFG and development funds are transferred. The Department of Finance 'District roll out' has also meant that funds will, in future, be accounted for in PGAS.

Similarly, Officers in Charge (OIC) play a critical role in the operation of health facilities, their day to day operation and decisions. All agree an operational budget is an essential component. At present this is often obtained through user fees. An operational budget requires skills to plan, implement and report. These are basic management skills which are now required alongside technical skills.

Community Health Workers and Nurses are the pillars that underpin the primary health care system. Providing effective in-service training, particularly management training based on PFM, for the rural based service delivery workforce increases the potential for improved health outcomes.

Strategy selection

NDOH and DWU will centrally coordinate the schedule of provincial training. Provinces will nominate Officers in Charge (OIC) and all District Health Coordinators (DHC) to attend training in budget, planning and management as a priority. Provinces will be encouraged to ensure gender equity. Provinces will include the nominations in their AIP. The assumption here is that enabling OICs to develop annual budgets and account for increased funds through the District Office will be a driver for change at the local level. As operational budgets at facility level become predictable and institutionalised as part of the HFG dispersal, the policy of free and improved health delivery may become a reality.

This training will supplement existing Government and Donor partner training activities such as Department of Finance Training, PCAB, PLGP and ESP.

The Divine Word University developed (and AusAID funded) a Rural Health Facility Management Training Program which was conducted as a pilot in 20 Provinces in 2010 and 2011 for 318 health managers and has been extensively and positively evaluated (CBSC 2010). The course has many modules resulting in accreditation. Some modules cover HR for example.

The average cost for attendance at the course was K4000, and was delivered in provincial centres over a two week period.

This training relates to relevant PFM processes and enables participants to understand the budget cycle and produce an annual budget.

It is recommended for the NDoH and Development Partners to support the DWU to schedule training Programs and support logistics and planning. Discussions with DWU indicate that, with central coordination through NDoH HR, DWU would be able to provide this service to Provinces over the five years of the program.

HSIP Subsidiary Accounts can be used to fund local costs, such as travel, for community health workers and nurses to attend in service training. These costs will be included in the annual planning and will be acquitted by the usual processes.

Additional in service training through accredited training institutions by distance education, will also be available as an option for Nurses and Community Health Workers to keep their skills current and improve their motivation to provide health care in difficult circumstances. The team notes there is design work being undertaken on Community Health Worker training.

Training will be coordinated through NDOH HR to meet quality standards and achieve cost efficiencies. In collaboration with their national program counterparts, provinces will schedule skills development opportunities for front line workers within their AIPs. Options should be explored to integrate disability related training into all health related courses and ongoing professional development.

e) Targeted Emergency Obstetric Transfers and Disaster Response

Rationale

HFGs support the transfer of patients in an emergency as part of funding for MPA 1. HFGs overall are expected to continue to rise with 10 Provinces approaching their cost of services estimates by 2014. However the rise of costs associated with patient transfers is still arguably unaffordable in the long run. GoPNG and donors are supporting the improvement of roads and other transport mechanisms and this will see an eventual decline in the number of patients that need to be transported by air. The provision of good primary care at community level may also alleviate the causes of emergency patient transfer in many instances.

PNG is unlikely to meet their MDG target for decreasing maternal mortality. A key cause of maternal death can be averted with early intervention. Emergency transfers, general and obstetric, are supported by the Provincial Treasury through the HFG, the Churches also play a significant part, and NGO and resource companies often supply helicopters to reduce severe

health implications in rural and remote populations. This level of cooperation is to be applauded.

Similarly the accessibility of HSIP TA funding means that funds can be mobilised quickly as a first response to outbreaks of disease or emergencies such as tsunami and volcanic eruptions.

Strategy Selection

HSIP TA will continue to fund transport of obstetric emergencies under the existing protocols and procedures in order to reduce the numbers of mothers and infants dying. Provinces will make allowances for these in their AIP based on the average number of patient requiring emergency evacuation in the preceding year. The capacity of the HSIP TA to provide emergency funding for obstetrics is highly valued and efficient in addressing this need.

HSIP will not fund return of patient, non-born and relative or friend to their homes by the same emergency means of transport.

f) Direct Health Facility Funding

Rationale

Operational funds available at the front line facilities are a key priority of the NHP, and a goal that is to be strived for. The District Case Study (2009) emphasises this point and provides two options: Direct Facility Funding, or allocations to the facilities using existing provincial systems. This option is also anticipated in the cost of services modelling.

Evidence from the 2012 NEFC Regional Service Delivery Workshop demonstrates that many high performing provinces are already transferring a portion of the HFG as operational grants to facilities and that the preferred strategy is through the District Administration. The District Health Coordinator is a key person in organising resources and managing health personnel. The option of using existing systems is likely to enhance the on-ground relationships and accountabilities. These are the systems and processes defined in the Organic Law and the RIGFA legislations and the PFMA.

Providing direct funding directly through NDOH is being trialled in nine facilities in the Autonomous Region of Bougainville (ARB). Conditions include the creation of a managing committee, a strategic plan and a budget, collection of health data and usage and a cessation of user fees. It should be noted that the Autonomous Region of Bougainville is not governed by the decentralisation principles of the Organic Law and does not receive the Health Function Grant.

Strategy Selection

The trial of the pilot in Bougainville should be continued and evaluated particularly for improvements in health facility usage, reduction in patient transfer costs, cessation of user fees and in the longer term, improvements in health outcomes.

3.6.3 Non Targeted: AIP based Recurrent Activities

Rationale

The HSIP TA (both pooled and earmarked) has previously funded a significant percentage of program-based activities within Provinces and the NDoH. These activities have targeted specific health problems such as Malaria, TB, HIV and maternal and child health. Funding from the HSIP TA has generally been available at most times of the year including the first quarter.

Provincial uptake of the HFG has increased significantly in the last two years with a focus on the minimum priority activities, which support the implementation of the program-based activities. Problems still exist in accessing this funding in the first quarter; however advocacy at the highest level of Government by the NEFC and Provincial Governments will hopefully address the roadblocks in the near future.

It is essential that continued support for these reforms be provided by all Partners to ensure its eventual success. Strategies that displace or have the potential to stall the progress of the reform should be either considered for removal or tapering.

HSIP TA is considered a valuable complimentary mechanism to these reforms.

Strategy Selection

HSIP TA pooled funding support for recurrent/program activities will be tapered from 2013 and terminate in 2017, subject to development partner assessment at that time.

As happens now, activities will be clearly identified within the AIP and should not exceed the allocation for each year. Under the redesign or example, 55% of funds available in 2013 may be allocated to general recurrent activities.

Specific Donor Partners/Funding Agencies will provide funding for earmarked activities and these will be in alignment with National agreed priorities and be supported by the DP/agency through the respective Program Managers at the NDoH level and be clearly identified within AIPs.

3.6.4 Non Targeted: First Quarter HFG

Rationale

There has been considerable discussion since 2009 about the delivery of the HFG warrants, which usually happens towards the end of the first quarter of the year. There have been suggestions that HSIP TA institutionalise a delivery of funds in January, for example, so that services could commence early.

Since the start of these discussions there have been improvements in the system. Namely:

- Unexpended HFG must now be rolled over into a designated account and can be used early in the year with a non cash warrant. Codes have been supplied for the expenditure of these funds; and,
- Significant pressure has been applied from PLLSMA and NEFC to the Departments of Treasury and Finance to coordinate an earlier and scheduled release of the Function Grants. This is seen as the best option: to make sure the system works as intended.

Strategy Selection

The design team does not support a 1st Quarter Payment as an institutionalised investment strategy. The issue must be solved at the Central agency level (PLLSMA).

3.6.5 National Department of Health

Rationale

The role of the National Department of Health is to monitor implementation of the National Health Plan as well as provide technical advice, set policy and standards.

The NDoH has a major role in coordinating Development Partner contributions and provides leadership of the Health Sector Partnership Committee (HSPC), the GoPNG and Development Partner Health Summit and the major governance committees supporting the SWAp such as the Health Sector Finance Committee (HSFC) and Health Sector Program Committee (HSPC).

The Finance Management Services Branch (FMSB), including accounts and compliance functions, oversight the management of the HSIP Trust Account. Currently a significant activity cost is incurred with ad hoc requests to change AIP. Many of these requests come from DPs, for example to run a workshop. A key indicator of change would be a reduction in the requests to change AIP activities.

A key role of the NDOH is maintenance of the NHIS and development of the annual report reviewing the performance of the sector. Capacity to analyse data in a timely manner within the NDOH is low. The Monash Report (page 20) noted that the current low capacity at the NDOH to perform annual analysis of routinely collected data relating to both costs and output data of rural health facilities may be strengthened by both employing and training additional staff resources within the NDOH, or contracting this work out to a local university or research institution.

Strategy Selection

Funding from the HSIP TA will support NDOH core functions which should be included in the annual AIP for the relevant branches. HSIP TA can fund the following:

- Bi-annually - for the National Health Conference;
- A contribution to costs to attend Quarterly regional reviews in provinces (to improve communication and collaboration);

- Support the operational costs of the HSIP TA (audit, implementation, evaluation, additional resourcing in times of high activity,
- project management assistance with major procurement/capital to ensure GoPNG development funds are spent in a timely manner;
- Support the running costs of the GoPNG and Development Partners Summit, Health Sector Partnership Committees and Independent Annual Sector Reviews;
- Support an improved development, analysis and printing of the Annual Sector Review; and,
- Specific ear marked funds for activities as agreed by Development Partners/Funding Agencies (for example WHO, UNICEF, UNFPA, Global Funds).

An additional annual allocation of K500,000 will be at the discretion of the Secretary for Health and will be utilised for disasters and emergencies.

A one off, investment in compliance processes will be undertaken in 2013. This will involve intensive support to Provinces, coordinated by the FMSB (compliance function) with long and short term support, to address the current acquittals backlog.

3.6.6 Sector Wide Interventions

In addition to the above interventions to be funded from pooled HSIP TA funds, the following sector wide (or outside HSIP TA) interventions are proposed and will need to be considered by all Partners, both GoPNG and Development:

a) Improving the release of HFG warrants

Advocacy for the early release and a regular schedule of releases, of HFG from Treasury/Finance is a priority.

b) Improved integration between actors at national and sub national level

Support improved coordination with the various agencies that play critical roles in supporting, enabling and monitoring at the sub national level.

Supporting the NDoH and DPLGA to establish and maintain the Health Sub Committee of PLLSMA. The Health Sub-committee should also be involved in monitoring visits to remote facilities that have been refurbished to ensure that the expenditure results in improvements to service.

c) Integrating health information datasets at all levels of the system

Technical Support to bring together the health information data sets collected and analysed by DPLGA and the NDoH (through the NHIS).

d) Increased Church Health Services Funding from HSIP TA

Churches are a major provider of health services within PNG. There are no barriers to churches accessing HSIP funds in the provinces working with provincial health to provide greater integration. This requires compliance the

PFMA with budget and planning, procurement and expenditure acquittal and monitoring and reporting.

The capacity of Church Agencies to implement PNG Public Finance Management systems is reportedly limited at this stage. During the consultation the Design team was told that the CMS was moving towards this goal, and that the new senior management of NDOH were also looking to better align this funding with GoPNG systems.

Development Partner support to increase accountability and transparency and to build the capacity of Church Agencies to plan, budget and report is recommended.

In the interim, many Provinces will continue to allocate funds from HFGs and HSIP TA allocations for Church administered facilities and coordinate activities as agreed in their AIP. Many Church Health Secretaries attend the Provincial Health Finance Committee and the Provincial Planning and Budgeting meetings. They also participate in Provincial Coordinating and Monitoring Committees (sub committees of PLLSMA). However in other provinces there is less integration and coordination.

In summary, Church facilities can access rehabilitation and maintenance of facilities, as well as training activities through provincial planning processes. However all funds must be spent in accordance with the PFMA, procurement must be through those processes and the results must be reported in s119 and the NHS.

3.7 Improving the operational elements of the HSIP TA - Recommendations

Rationale

The HSIP TA was designed in the late 1990's and was intended to be a temporary mechanism to allow for strengthening public financial systems at both the national and provincial level. While a legal entity, with a Trust Deed signed in 2000 (and updated in 2009) by the Minister of Finance, and mirroring the GoPNG financial system it is considered by some as a parallel system. While utilising the PFM Manual as the basis for all processes and procedures it does not align to the budget and planning cycles.

The new design of the HSIP TA will further align budget and planning processes. See Annexure 12 – Aligned Budget Planning and Reporting Processes.

The following recommendations are made to improve the mechanisms of the TA operations.

Recommendations

1. The planning and budget processes of the HSIP TA be further aligned to the Government processes which will include all Development Partners agreeing to providing forward commitments in May of each year with a view to all AIPs being completed and agreed by December. Changes to AIP, once approved, should be minimised.

2. NDoH and Development Partners accept they are mutually responsible for the accurate reflection of Development Partner activities within AAPs.
3. Development Partners support the NDoH to implement the action plan for addressing the recommendations of the Auditor General Report 2010 as a priority.
4. Partners agree to match the volume of funding to the resources available, increasing resources as required for activities such as development funds for infrastructure. This should ensure that the GoPNG Development Budget for Health is achieved within timelines and will reduce the need for funds to be parked.
5. Strengthen the coordination of the HSIP TA with funded short term/long term support to support the NDoH Deputy Secretary to rebuild business processes and governance in both NDOH and HSIP TA.
6. Shadowing, mentoring of key positions within the NDOH with the view to rebuilding business processes and implementing a performance culture within the organization.
7. Build the monitoring capacity of the NDOH including facilitating an improvement to IT infrastructure and information management business process in addition to upgrading the basic skills of staff in simple email and data management.
8. Ensure briefing to the Finance Committee is sufficient to make decisions and monitor development impacts as well as financial reporting.
9. Retain and extend externally funded support for the FMSB (compliance function) and re-introduce specific field visits for providing training and support to Provinces for acquittals.
10. Resource investment in compliance processes through an intensive initiative to address the acquittals backlog.
11. Retain the externally funded Accounts section staff and strengthen as required with project management staff to match the need to expend capital infrastructure funding.
12. Remove the “no salaries’ conditions in NDoH and Provinces to resource the HSIP with staff at critical times. (This will be capped annually at 10% of total budget available).
13. GoPNG and Development Partners agree to a single external audit per annum, which is supported and facilitated through the AGO and funded from HSIP resources.
14. The HSIP Trust Instrument will be amended to include provisions for Hela and Jiwaka and other PHA provinces where there is a Board and a CEO.
15. The overarching Partnership agreement between the GoPNG and Development Partners to be revisited to bring it into alignment with the new environment and the redesigned elements of the HSIP TA.
16. The GoPNG and Development Partner Financing Agreement to be re-developed to bring into alignment with the new design and to enable Development Partners to make financial commitments to the HSIP TA.
17. Fund short-term assistance to finalise the HSIP TA manuals redevelopment.
18. The Secretary for Health issues annual instructions to both the NDOH and Provinces highlighting the agreed priorities for spending in the following year.

19. Regular monitoring on site visits are organised to take the PLLSMA Health Sub-committee to Districts which have mobilised HSIP funding.
20. To review and update the Resource Allocation Formulae to include Hela, Jiwaka and the PHA Provinces.
21. Add special conditions for major procurement of infrastructure over K300,000 to include an independent review and outsourcing where procurement processes capacity is low in Provinces.

CHAPTER FOUR - INVESTMENT PROGRAM & THEORY OF CHANGE

The HSIP TA is a supplementary financial instrument to coordinate major donor funds. **It is not a program in itself.** The investment program and theory of change could be seen as limited to:

- The extent to which the Trust Account can make a difference to the health status of the rural poor in PNG by intervening appropriately in the service delivery chain.
- The necessity to maintain the Trust Account as a coordinating mechanism and a capacity building exercise to improve governance at the central and provincial levels of government, despite resistance to change.
- The capacity of NDOH to improve Public Financial Management Systems to ensure that health funds contribute to health outcomes.
- Capacity of the Trust Account to contribute to the 'back to basics' provision of health service delivery and open pathways to change.
- Applying international evidence-based good practice.

The following investment program outlines a focus on skills and improvement in basic facilities at the district level, to build an enabling environment for GoPNG health for the future.

4.1 The Investment Program

The following pages outline the framework for improved health services, the elements (activities) envisaged, feasibility of the program by year, including an estimate of cost and cash flow and the coordination aspects with other major GoPNG and donor programs. The Framework diagram is attached to the Executive Summary.

4.1.1 The Framework

The overall goal of the new HSIP is suggested:

To improve access to rural health services, particularly in disadvantaged districts, through providing targeted funding and improving the implementation, reporting and governance of the TA at national and provincial levels.

National Department of Health and Development Partners will need to discuss and agree on the goal for the next phase of the HSIP TA. However any future goal must be in alignment with the NHP and the wider Government policies and plans.

The rationale for the program is that, to decrease poverty we must increase access to health services for the rural majority and poor. This is aligned with the NHP in implementing KRA 3 - strengthened health systems.

The re-designed HSIP TA will have three strategic objectives:

1. To increase access for the poor to effective health services in rural areas.
2. To increase the absorptive capacity of the health sector to achieve GOPNG commitment to the NHP on a sustainable basis.
3. Improved performance and governance of the HSIP TA.

The Outcomes and Outputs relating to these three objectives are outlined in brief below. The measures and indicators are contained in the Chapter Monitoring and Evaluation and further detailed at Annexure 15. A set of provincial health baseline data is Annexure 4

Objective 1: To increase access for the poor to effective health services in rural areas	
Outcome 1.1 HSIP funding increases access to health services and improved service delivery for rural populations	Outputs: <ol style="list-style-type: none"> i. Health Facilities maintained and rehabilitated, where practical adhering to universal disability design guidelines and contributing to PNG standards <ol style="list-style-type: none"> a. with water supply b. with functioning radios ii. Emergency obstetric patients transferred iii. Basic mobility aids provided as requested
Outcome 1.2 Health services are improved in the 20 Disadvantaged Districts	Outputs: <ol style="list-style-type: none"> i. 20 Poorest districts have quarantined access to funding for health facility rehabilitation and maintenance which acknowledges increased costs compound disadvantage

Objective 2: To increase the absorptive capacity of the health sector to achieve GOPNG commitment to the NHP on a sustainable basis	
Outcome 2.1 Increase predictability of donor funding to the sub-national level	Outputs: <ol style="list-style-type: none"> i. Development Partners make commitments according to the PNG budget cycle ii. NEFC and NDOH harmonise the resource allocation formulas and grant calculations for non-targeted funds
Outcome 2.2 Staff at facility level are better able to plan, budget, acquit and report	Outputs: <ol style="list-style-type: none"> i. Rural Health Facility Management Training (accredited) conducted for District Health Coordinators and OIC district by district ii. Accredited skills training of CHW as a priority iii. Request data on health staff trained in acquittals through PCab, FTB, and other training programs
Outcome 2.3 HSIP complements HFG and improves the reliability of the cashflow	Outputs: <ol style="list-style-type: none"> i. NDOH HFC monitors PER data for any adverse trends in HFG expenditure that may be related to HSIP design or implementation (eg trends in unexpended data, decline in IR commitment to health, decline in nature test data).

Objective 2: To increase the absorptive capacity of the health sector to achieve GOPNG commitment to the NHP on a sustainable basis	
Outcome 2.1 Increase predictability of donor funding to the sub-national level	Outputs: <ul style="list-style-type: none"> i. Development Partners make commitments according to the PNG budget cycle ii. NEFC and NDOH harmonise the resource allocation formulas and grant calculations for non-targeted funds
Outcome 2.2 Staff at facility level are better able to plan, budget, acquit and report	Outputs: <ul style="list-style-type: none"> i. Rural Health Facility Management Training (accredited) conducted for District Health Coordinators and OIC district by district ii. Accredited skills training of CHW as a priority iii. Request data on health staff trained in acquittals through PCab, FTB, and other training programs
	<ul style="list-style-type: none"> iv. Highly competent provinces (with all governance systems in place, good PER report, improving audit function, functional procurement) may access HSIP in the form of Provincial Budget Support (ie annualised grant not conditional on tranches or tranche acquittal)

Objective 3: To improve performance and governance of the HSIP	
Outcome 3.1 Improved management and coordination of HSIP TA	Outputs: <ul style="list-style-type: none"> i. Provincial reporting is strengthened by uploading of subsidiary spreadsheet to NDOH PGAS ii. Manual updated and communicated through HSIP regional workshops annually iii. Regular and accessible reports on HSIP TA provided on progress, performance and

Outcome 3.2 Better information on expenditure and development impact to GoPNG and Development Partners	Outputs: <ul style="list-style-type: none"> i. Finance Committee reports on HSIP program status at each meeting ii. SPAR narrative strengthened incrementally with each edition (and continues to provide district data) iii. PLLSMA Health Subcommittee conducts site visits to Districts and reports impact; meets with PCMC where possible iv. HSIP regional workshops in tandem with NEFC regional workshops annually
Outcome 3.3 Better compliance with PFM at NDOH and Provinces	Outputs: <ul style="list-style-type: none"> i. Agreed HSIP activities for the year clearly define the business process owner, the costing of the activity, start dates and end dates and are signed off by Secretary and Deputy Secretary as directly impacting service delivery priorities ii. Provincial AIP and budgets include HSIP activities, and are thus transparent to Provincial Government iii. HSIP procurement and s32 delegations reflect those operating

	in each province
✓.	Meeting of Audit Committee (NDOH)
✓.	Improved coordination between NDOH Finance team and Provincial Audit Committees.

4.1.2 The Budget

The HSIP TA will increasingly target funding for specific options that improve access to service delivery with a focus in the poorest and most disadvantaged Districts. In line with the new designs' poverty reduction focus the use of HSIP TA funds must be demonstrably targeted at those in rural PNG who need it most. Moving towards this goal will require a staged transition phase to ensure provinces, currently using HSIP TA recurrent funding can meet key activities requirements and are not disadvantaged.

The following table shows the recommended distribution of the proposed budget for Years 1-4:

Table 7 - Proposed Distribution between chosen strategies Year 1-4

Year	1	2	3	4
Resource Envelope^(a)	37,885	38,080	37,025	37,250
Targeted -Disadvantaged Districts	12,000	15,500	17,045	20,000
Targeted - Facility Rehab and training	8,920	10,840	11,240	9,410
Targeted – Obstetric Emergencies ^(b)	900	900	900	900
Non-Targeted				
• Prov Health Service Activities	11,100	8,100	5,100	2,100
• Investment in compliance processes	1,305 ^(d)			
NDoH – Targeted ^(c)	3,000	2,500	2,500	2,740
HSIP TA Administrative Costs	660	240	240	2,100 ^(e)

(a) Exclude Development Partners earmarked funding and GoPNG funds in HSIP TA

(b) Based on average expenditure in Provinces for Obstetric Emergency transfer from Provincial consultations

(c) Includes 500,000 for emergencies (to be administered by the Office of the Secretary)

(d) Investment in compliance processes – To address backlog of acquittals in Provinces

(e) Includes end of program evaluation and monitoring

4.1.3 The Elements

The re-design team has synthesized the needs expressed by Provinces about the constraints to health sector improvement. These align with the expressions of government and successive reviews – **that change needs to occur at the district and facility level.**

Provinces say consistently that unless we provide training and housing at the district and facility level, they will fail to attract and retain staff with sufficient skills and motivation to take PNG forward and improve the health of rural and

remote communities. Unless we achieve better primary health care, people will use district and provincial hospitals as their first port of call.

Prioritisation of Activities to achieve strategic objectives consists of key elements at the provincial level, as well as a major evaluation work at the end.

Disadvantaged Districts	<ul style="list-style-type: none"> • Refurbishment and maintenance of existing registered facilities • Officer in charge houses remote (refurbish existing) • Officer in Charge DWU Rural Health Facility Management Modules • CHW skills upgrades
Targeted – Facility rehabilitation and training	<ul style="list-style-type: none"> • Health Facility refurbishment (rural) incl water, solar, cold chain, disability access, drug storage, basic furniture, security etc. • District Health Coordinator houses (refurbish existing) • District Health Coordinator DWU Management Training Modules • Officer in Charge DWU Rural Health Facility Management Modules • CHW skills upgrades
Targeted	<ul style="list-style-type: none"> • Obstetric emergency transfer, subject to review annually
NDOH targeted activities	<ul style="list-style-type: none"> • Whole of Sector monitoring and coordination • Provincial support • Monitoring specific districts implementing HSIP through site visits
HSIP operational	<ul style="list-style-type: none"> • Implementation action • Communications Strategy of Re-design • Provincial Monitoring, acquittals input • Project management as required

Targets

After five years, an output report to the government and donors might include statements such as:

- Most district health coordinators have adequate housing and will have done at least one module of accredited health management training. Good staff are recruited and retained as a result. (An additional HR module should be considered, as the DHC is key to personnel management at facility/aid post level).
- Every OIC of a health facility will have completed at least one module of health management training and will be able to prepare a budget for operational funds, acquit these funds, and report on performance better. Facility funding is institutionalised using the Organic Law (HFG) and PFM.
- Most OIC will have refurbished facilities (including staff housing where necessary), particularly in designated CHP areas and will be better able to support Aid Post staff.
- CHW will be more motivated and skilled through accredited training investment provided
- Obstetric emergency transfers will save more lives of women and babies because of the capacity of HSIP funds to be mobilised quickly.
- HFG and CHG funds are increasingly flowing to Districts and facilities as operational funding for a sustainable improvement in service delivery.

- The capacity of NDOH to report on health outcomes is improved.
- Investor confidence will return with improved Audit Reports of the Department and the TA.
- After five years, there will be discernible trends in SPAR health indicators associated with HSIP.

4.1.4 Feasibility testing targets and cash flow

A feasibility exercise was undertaken for the new, targeted elements, testing assumptions about take up and capacity, unit costs and training capacity across PNG, and particularly the disadvantaged district components.

Maintenance and refurbishment of health facilities

The quantum of funds required to maintain and refurbish existing health facilities has been examined by the Monash study and is an ongoing part of the Provincial Budgets Model based on the cost of services, as outlined previously (page 14) in considering investment strategies.

Annexure 14 is provided as an estimate of potential uptake and unit costs for the four -five years of the program initially and the predicted cash flow. It is intended to show that the call on provincial resources is modest ie one district health house refurbished each year, and two years to complete one in a disadvantaged or remote area that cannot be reached by road. The budget figures are not set in stone, estimates can be flexible depending on uptake and performance; Kina can be moved between elements depending on decision made annually in the Finance Committee and the Partnership Committee, communicated through the Secretary's Instruction for the budget year. For example, more funds can be provided for monitoring if required, more resources could be spent in training while the lead time on maintenance and refurbishment occurs.

Costs in the order of K500 – 700,000 are not intended to imply major infrastructure projects. However those costs acknowledge the huge transportation costs implied in providing health equipment (fridges, solar panels, tanks and pipes, composting sanitation systems – to remote locations that are inaccessible by road. Even minor repairs will have huge costs in the multiple delivery charters required.

Emergency Obstetric Transfer arrangements will remain in place as part of the HSIP subsidiary arrangements. Estimates have been broadly based on previous usage and consultations with provinces. This element can also be funded using the HFG, provincial internal revenue and through partnerships with the private sector. The inclusion recognises the goals of PNG in improving maternal mortality over the next few years as a priority.

NDOH core activities

This element includes funds (K2.5-3.0 million) to be spent annually on core coordination, monitoring and reporting at the National level. Elements to be supported are:

- Funds for the Bi-annual National Health Conference;
- Quarterly regional review in provinces (to improve monitoring for expenditure in collaboration with Treasury Second Quarter Budget Reviews;
- Support the operational costs of the HSIP (management branch, audit, end of program evaluation, implementation support, additional resourcing during times of high activity etc);
- Support the running costs of the GoPNG and Development Partners Summit, Health Sector Partnership Committees and Independent Annual Sector Reviews; and,
- Supporting further development, analysis and printing of the Annual Sector Review.

A Secretary's discretionary fund of K500, 000 will be available to address emergencies and disasters in Provinces.

Outside of the design are the current ear marked funds as agreed by Development Partners/Funding Agencies (for example WHO, UNICEF, UNFPA, Global Funds).

A detailed rationale for all HSIP TA elements is contained in the previous Chapter.

The investment program through the subsidiary accounts assumes a slow start to remote and rural health facility refurbishment and starts at the District Level refurbishment of housing for the District Health Coordinator, where, generally, there is better access for materials and equipment from the provincial centre. The District Health Coordinator is regarded as the key to improved performance of the health services. He/She is responsible for all aspects of the PFM cycle, as well as coordination and HR of facilities and management of personnel. The assumption here is based on the provincial wisdom that unless facilities are in a reasonable state, it will not be possible to attract people with the right skills to lead the improved health service delivery charter. It should be emphasised that HSIP funds should only be used to refurbish existing and registered facilities. New buildings (capital), where required must use GoPNG development funds.

The construction, refurbishment activities are reasonably small; K40,000 for general refurbishment of existing buildings, up to K500,000 for disadvantaged districts of which many are remote geographically and transportation costs will form the major component. Each province might undertake a limited variety of projects according to their capacity. PFM procurement processes must be adhered to. The greatest investment is in remote facilities and housing where

the costs are likely to be much higher due to the delivery costs of materials and contracting. These cost assumptions need to be further tested. There is no additional planning required, as many of these activities are in provincial and district planning pending resources.

The upgrade of facilities and housing go hand in hand with Rural Health Facility Management Training, which was piloted in 15 provinces in 2010. The Divine Word University provided accredited modules and is recommended since it is tailored and can lead to certificate or diplomas over time. Initial talks with DWU indicated they could provide the training at scale however they would prefer that it was coordinated centrally. The HR Team in NDOH, with advisory support, have been consulted and are prepared to undertake this task which may leave a sustainable legacy after five years. Such training can lead to significant improvements in public financial management, which will be essential if operational funding is to be provided directly to facilities.

It is envisaged that the investment program is implemented through the 19 subsidiary accounts, with the parent account providing the administrative and evaluative support. A full evaluation of the program is funded in the final year.

The above recognises the significant ongoing role that the NDOH plays in managing the HSIP TA and providing overall direction setting of the SWAp. Capacity development will need to be ongoing. The priorities for support are identified in Annexure 13.

4.1.5 Coordination

1. Joint GoPNG and ADB Program – Rural Health Facilities Refurbishment

The elements of the HSIP Investment Program have some similarity with the Rural Primary Health Services Delivery Project (RPHSDP). This program is responding to the same needs expressed for many years. The RPHSP will also use the HSIP Trust Account, although much of the procurement and contracting will be off budget. The RPHSP Program will target the following 16 Districts in eight provinces:

Western Highlands	Mull-Bayer, Tambul-Nebilyer
Enga	Komiam-Ambum, Laiagam
Morobe	Menyamy Bulolo
East Sepik	Weewak, Maprik
West New Britain	Talasea, Kandrian Glochester
Milne Bay	Alotau, Kirwin Goodenough
Eastern Highlands	Kainantu, Okapa
Autonomous Region of Bougainville	South, Central

The RPHSDP planning in those areas for intervention is continuing. A Master Plan will be developed within those 8 provinces. Broadly the US\$1.2million

project will refurbish on average eight health facilities and two community health posts in each district. Some staff housing refurbishment is also included.

Throughout PNG there are a total of 743¹⁵ health centres/district hospitals at the moment and about 1995 aid posts. It would be difficult to exclude the eight ADB provinces. Each of the eight provinces has more districts than those covered and HSIP could supplement from the Master Plan. While there needs to be coordination with RPHSDP, this exercise can be done at the same time without overlap or duplication. Coordination can be undertaken at the provincial level. Our calculations suggest that 600 health centres will not be covered by the project, as well as many more Aid Posts.

The HSIP redesign designated twenty disadvantaged districts are at Annexure 11. There appears to be no overlap on the geographic areas where ADB will be operating with the exception of Central Bougainville.

It is understood that the ADB project will have a 2-year lead-time in planning. It is unlikely that the HSIP will adversely impact the implementation of the ADB project.

2. District Services Improvement Program (DSIP)

The DSIP had a health component, which included the construction of houses and health facilities as well as improved water supply. Since the output of the program has not been mapped, it is difficult to coordinate without grounded knowledge of the assets at the District level.

Without local knowledge, there could be potential duplication with DSIP projects. Since the HSIP projects will be coordinated by the Provincial Health Adviser and special monitoring arrangements will be in place, it must be assumed that the status of the District Health Coordinators' residences will be known. The location of the facilities and housing to be refurbished or rebuilt will be bought forward from District and Provincial Development Plans to be reflected in the AIP.

4.2 Cross cutting issues

4.2.1 Gender

The re-design team acknowledges that activities must be designed to reach women and men equitably according to their specific needs. Options selected for inclusion in the re-designed HSIP have the potential for impacting women positively and equably in regard to training of OIC and CHW.

The priority strategy selected is to reach the facility level with funds and capacity development to encourage more people to access health facilities,

¹⁵ Information supplied for Health Centres and Aid Posts from the 100% Medical Supplies Kits distribution list

particularly in poorer districts, thus improving the health outcomes of rural people:

- Targeted in-service training will benefit staff of health facilities (officer in charge, nurses, community health workers and midwives) where female staff often predominate¹⁶. Training in health management provided by DWU has been evaluated as equitably delivering for both women and men.
- Targeted enabling funding for rehabilitation of existing infrastructure will ensure a more accessible facility for all people, particularly women who are traditionally frequent users of health facilities for themselves and their children. Improved lighting and water to health facilities should impact on improved maternal and child health and providing an appropriate environment for a safe delivery. Minor repairs for staff housing may decrease turnover of staff and non-attendance for work at health facilities.
- Emergency transfers of obstetric patients can save the lives of pregnant women and impact maternal mortality rates in the long term. The cost effectiveness of this option will be reflected in more intact families, better prospects for productivity and economic development of communities.
- Targeting the poorest districts will deliver benefits for rural women often disadvantaged by remoteness and isolation from services.
- At the completion of the program, some improvement in the Human Development Index and the Gender Development District Index is expected.
- It will be difficult to further specify gender related outcomes as there is no gender analysis provided in the SPAR.

4.2.2 Poverty

The deterioration in health outcomes is recognized as a failure in health service delivery. In rural areas, this has been marked by the lack of attendance of staff and other inputs at health facilities; aid posts closed; user fees charged; and patients forced to bypass lower level services in favour of hospitals, which are more costly and located further away. This has caused significant financial and physical barriers to access to health services even where there was already underutilization of services. Prioritising support for the health facility level and empowering health service staff to be in charge of planning and implementing their services can increase access and thereby decrease poverty.

In provinces where more than 50% of rural health services are delivered by church health services, engaging churches through HSIP / HFG planning processes and encouraging them to comply with GOPNG finance systems

¹⁶ The recent WB Human Resources Assessment (June 2011) found that, in service delivery, 77.5% of nurses and 38.7% of Health Extension Officers are female.

and reporting will also improve access; improve health indicators particularly for the disadvantaged.

At the provincial level, resource revenues have had little impact on health in some provinces; low levels of revenue are allocated to health; and poor public sector financial management means that provincial health budgets are as low as 20% of the cost of service delivery. Some of the poorest rates of service delivery are those provinces with the largest revenue but they are characterized by weak prioritization and poor management of revenues. There is a timely opportunity to use the buoyancy to prioritise and improve health service delivery and strengthen the health financing system.

One specific pro-poor principle is to encourage the reduction in user fees charged by health facilities within poorer districts, as this is a key constraint to increasing health service access among the poor.

4.2.3 Equity/ Equalisation

Equalisation principles (sharing according to need) underpin PNG intergovernmental financing arrangements particularly with regard to distributing transfers to provinces. It is assumed that funds provided by GOPNG (e.g. HFG) and from donors will vary from province to province depending on the fiscal gap between health cost and health funding in the provincial budget. However, Provincial Expenditure Trends demonstrate that some provinces with high levels of internal revenue will not be receiving HFG in the near future and intend allocating very small amounts for health services. These provinces need special consideration and have been accounted for with the pro-poor strategy of prioritising the most disadvantaged districts.

4.2.4 Child protection

The PNG Parliament passed the Lukautim Pikinini Act in 2009. The objective of this Act is to protect and promote the rights and wellbeing of all children regardless of gender and to protect children from all forms of violence, abuse, neglect, exploitation and discrimination, with a clear focus on services for prevention and family strengthening.

Many vulnerable children are at a disadvantage in obtaining essential services necessary to their welfare. They may have lower school attendance rates and are at risk of poor nutrition and health. At the local level, NGOs, FBOs and CBOs play a critical role in extending the reach of these services.

The Act recognizes that the most effective way to support, care for and protect the most vulnerable children is by: supporting caregivers, extended family and communities; ensuring equitable access to education, health, protection, social welfare, birth registration and inheritance law; and increasing awareness of child protection.

The Disadvantaged District elements are designed to address the inequities that exist and go some way to ensuring all children have access to basic health care through their local health facility.

4.2.5 Disability

The PNG National Policy on Disability (2008) reports that 10-15% of the population have disabilities namely, movement, seeing and hearing impairments. Common causes of disability are disease, accidents, ageing and violence. Priority areas for action include: early detection, intervention and education; and accessibility to services.

The re-design team has included basic disability equipment in the list of options to be supported by HSIP funds. Rehabilitation of health facilities to be accessible to people with disabilities will also benefit this disadvantaged group. Any renovations will be in line with universal designs for disability.

In addition, disability awareness will be encouraged in all training programs.

4.2.6 Climate change/disasters

Climate-associated disasters in PNG such as severe storms, flash floods and droughts impose serious constraints on development, and affect food availability and ultimately health. Since 1970 El Nino events have resulted in water shortages and drought in PNG and the impact of these events is likely to increase as a consequence of climate change. Those more likely to be affected will include people with low levels of household income, lack of piped water supply, poor sanitary conditions and growing incidences of lifestyle-related diseases. This, together with PNG's rapidly increasing population growth rate, is projected to place additional stress on health systems.

Solar panels have been installed in many health facilities to power the radio, and can be used to provide light for labour wards. The option of solar power will be encouraged, as often gas and diesel solutions fail because of remoteness or lack of access to recurrent funds.

The HSIP strategy will focus on increasing accessibility and quality of the primary health care system at the local levels, and provide a discretionary component to the Secretary for Health (K500, 000 per annum) as start-up resources during times of disasters.

CHAPTER FIVE - MANAGEMENT AND GOVERNANCE ARRANGEMENTS

5.1 Overview

The Secretary for Health is the accountable officer through whom the DP contributions are coordinated and monitored. The complex nature of the funding provided through HSIP necessitates governance arrangements that will satisfy both the GoPNG and the Partner Countries specific requirements for management of aid funding. Where possible these arrangements have been coordinated under a single over-arching agreement or as a single requirement, such as a single external audit.

5.2 Governance Arrangements

5.2.1 GoPNG and Donor Partnership Agreement

The overall basis of the GoPNG-Development Partner relationship is set out in the Partnership Arrangement, which was signed initially in 2004 with five partners (AusAID, NZAID, WHO, UNICEF, UNFPA) and later amended to include ADB and the World Bank.

The agreement sets out:

- The principles that govern DP-GoPNG relationships;
- The requirements on both parties to the agreement; and,
- Some details on how the HSIP will function.

Some elements of this agreement will need to be redrafted and agreed.

5.2.2 Joint Financing Agreement

New Financing Agreements for individual Development Partners maybe required. These will be developed following finalisation of the design document.

5.2.3 The Trust Instrument

The current Trust Instrument is dated 4th June 2009, and details the management and reporting obligations including cheque signatories. Compliance to this Trust Deed must be a priority of internal audit on an annual basis. The deed will require update to include the new Provinces Jiwaka and Hela and PHAs.

5.2.4 Public Finances (Management) Act 1995

The control and management of the Trust Account will be in accordance with the Public Finances (Management) Act 1995 and relevant Financial Instructions as provided by the Department of Finance from time to time.

5.2.5 Development Partner/Funding Agency Specific Agreements/Plans

Individual Development Partners/Funding Agencies have developed separate country strategies/plans, which contain funding for specific earmarked activities to be provided through the HSIP TA. All activities must be in alignment with NHP priorities and interventions.

Annual plans of activities, with relevant budget ceilings, shall be provided in May of each year for the following year to enable program and provinces to develop AIPs.

5.2.6 Audit of the HSIP TA

The Partner Government is responsible for ensuring that the Program and its associated funding are audited on an annual basis. The annual audit will also examine (i) procurement decisions and /or related contracts; and/or (ii) compliance with partner government procedures and regulations where GOA funds are utilised by the Partner Government for the procurement of goods and/or services.

The Annual audit of the Program will, wherever possible, be undertaken by the Partner Government's Auditor General's Department. Where circumstances arise that the Auditor General Department advises that it will be unable to undertake the annual audit the Parties agree that an independent auditor will be engaged to undertake the annual audit.

The arrangements, including the terms of reference, selection method and costs, for the engagement of an independent auditor will be agreed by the HSFC. The annual audit report will include formal advice detailing any weaknesses in the Program's internal controls and recommendations for strengthening identified weaknesses.

The annual audit report will be provided to all representatives of the HSFC and HSPC and be included as an agenda item for the HSPC meeting at the earliest opportunity. The GOA agrees to limit the number of individual Development Partner audits to a single annual audit where at all possible.

The NDOH agrees that GOA may commission independent audits, including financial, compliance and/or performance audits, of the Program and acknowledges that it will cooperate fully with any such audits. GOA agrees to provide the Partner Government with copies of any independent audit reports.

5.2.7 Role of the Internal Audit

Internal Audit within the Department provides an annual plan to monitor compliance to processes and procedures, which must include the Trust Account. Assessment Reports and recommendations will be provided to the SEM and Development Partners and will provide feedback on annual quarterly basis to facilitate quality improvement.

Internal Audit specifically has carriage of monitoring the progress of the implementation of the AGO recommendations from previous audits and provides updates to the Audit Committee, which is chaired by the Department of Finance.

5.2.8 The PLLSMA Health Sub Committee

The National Department of Health will update Provincial Government (through the PLLSMA mechanism) on the HSIP priorities and the progress of the implementation of the NHP. Issues of mutual concern such as, first

quarter payments, Provincial Health Authority and integrated reporting (S119 and NHIS) are priorities.

The PLLSMA Health Subcommittee also has a role in monitoring the impact of HSIP expenditure by conducting on site missions to districts that receive HSIP funding, particularly disadvantaged districts. A report will be submitted to the Health Finance Committee and PLLMA. Results will be assimilated into the NHIS and Asset Inventory as a validating item.

5.2.9 GoPNG and Donor Partner Health Summit (GoPNG and DP Summit)

The GoPNG and Donor Partner Health Summit is a high level forum between Partners to discuss and agree on common policy, resourcing and performance issues. There will be one summit per year in November chaired by Secretary, National Planning and Monitoring.

The Summit will:

- Assess the achievements and constraints impacting on the Partnership;
- Discuss health policy and strategic matters, referred by the HSPC and seek consensus on contentious issues;
- Review the report of the Independent Annual Sector Review Group (including the progress of the implementation of the National Health Plan);
- Review the approved plans and budgets for the coming year and give endorsement to activities within AIP - specifically those to be included in the Secretary's Instructions as priorities;
- Provide indicative funding commitments for the following year budget cycle to be finalised by May.

5.2.10 Health Sector Partnership Committee (HSPC)

The HSPC is a forum for open and transparent dialogue that informs and influences decisions to be taken by government and its partners, with a view to improving PNG health sector performance. The HSPC is set up to complement not replicate existing legislative-based governance arrangements and terms of reference include:

- Providing advice and reviewing sector-wide budget priorities and expenditure performance; including health function grants and supplementary budget;
- Discussing strategic issues arising from quarterly expenditure and performance reviews;
- Reviewing internal and external audit reports on health spending by NDOH, Provinces and PHAs; and,
- Providing a forum for discussion and advocacy across health sector stakeholders and interests.

5.3 Management Arrangements

5.3.1 Management of the HSIP within NDOH

The day-to-day accountable officer within the NDOH for the management and oversight of the HSIP is the Deputy Secretary – National Health Policy and Corporate Services. Currently the management of the HSIP is spread over several sections within two divisions with no single coordinating officer identified.

The re-design recommends the recruitment of short term/long term support for the Deputy Secretary Health Policy and Corporate Services to facilitate an improvement in business processes and build a performance culture. Skills required include knowledge of GoPNG processes of planning, budgets, finance, procurement and audit, monitoring and reporting. The HSIP must also be able to resource itself during times of high activity. Resourcing would include temporary staffing for developing scope of works, implementation monitoring, acquittals and procurement monitoring and support. In 2013 an intensive initiative to address the backlog of acquittals will be undertaken.

The re-design recommends that, annual Instructions for HSIP priority and targeted funding will be provided to NDoH and Provinces from the Secretary for Health and this will allow targeting in Annual Implementation Plans. The Secretary will communicate priorities agreed at the HSPC in May, together with the budget ceilings in July of each year. An essential focus of these instructions will be improvement in remote and disadvantaged districts.

5.3.2 Overall Management of HSIP, Parent Account and Provincial TA Manuals

The overall management, planning, budgeting, disbursement of funds, expenditure priorities, reporting, and monitoring processes and procedures will be contained within the two updated manuals. The Manuals will refer to the PFM Manual, which is updated by Department of Finance and DOF Financial Instructions issued from time to time. The Manual will outline exclusions, which can be updated from time to time. The NDOH Secretary's Instructions form part of the updated Manual annually.

The Provincial Health Adviser or PHA CEO will be responsible for the activities and ensuring provincial PFM processes are adhered to. This includes planning, monitoring and reporting through the Provincial government systems, the Budget processes and the NHIS/s119.

Additional procurement safeguards may be put in place to address risks in implementation. These processes, to be identified in the Manual and the Financing Agreement may include:

- The Partner Government will manage infrastructure procurement in accordance with the HSIP TA Manuals; section Procurement Procedures (Special Conditions for Major Development Partner Funded Procurement).

- The Partner Government agrees that in situations where procurement capacity is limited or non-functional in provinces that alternate outsourcing options will be implemented.
- The Partner Government will monitor major procurement in the range K100,000 – 300,000 at the National and Provincial level through the HSFC monthly meetings and for over 300,000 as per the PFMA and the special conditions as specified in the HSIP TA Manuals (Procurement Procedures).
- The Partner Government may request the GOA to undertake specific major procurement action on behalf of the program.

The FMSB (compliance function) will provide regular training to Provinces on the processes and any updated instructions. As all processes are aligned with PFM, donor activities to strengthen PFM, such as Provincial Capacity Building Program (PCAb Finance) and the activities of the Finance Training Branch will be directly relevant. Procurement training can also be offered through a variety of institutions and partners.

5.3.3 Health Sector Finance Committee (HSFC)/ Program Committee (PC)

At the National level, the HSFC and Program Committee provide regular oversight/advice on the HSIP, development and recurrent funded activities, including procurement star.

The objective of the HSFC is to ensure accountability, appropriateness, efficiency and transparency of procedures in all financial matters, across all health sector funds. It is recommended that Development Partners take an active interest in these committees and are provided copies of all reports and minutes.

The re-design recommends that HSFC review its monthly informational requirements and determines how decisions are escalated.

The NDOH is undergoing a review of its Corporate Plan and there may be some changes to these key governance committees. The Design Team supports this process and the relevant manuals will be updated to reflect final decisions.

5.3.4 Provincial Health Finance Committee (PHFC)

At the Provincial level the PHFC oversees and guides the operation of the HSIP Subsidiary TA in the Province. This Committee appears to be working as intended in most provinces.

An improvement would be that the PHFC includes the total health envelope in its deliberations.

With the expanded targeted activities, this Committee will have greater responsibility and should be mentored by a roving project management advisor. This advisor should assist with small contractual arrangements and

ensure that payments are made to milestones so that acquittals requirements can be met.

Provincial Audit Committees

Currently there are seven Provincial Audit Committees established. As Finance continues to roll out this program and strengthens the audit function in Provinces it is expected that these committees will increasingly undertake oversight of the HSIP expenditure.

5.3.5 Annual Implementation Plans

Annual Implementation Plans (AIP) are the consolidated action plans for each entity. They are informed by the strategic priorities of the NHP and Provincial Development Plans and developed utilising the provided budget ceilings and matching these to the resources available.

AIPs are drafted each year following the ceilings being made available in June/July. The NDOH Strategic Planning Branch provides technical advice to both NDOH and Provinces during the development of the AIPs. Harmonisation of AIPs across the different levels of the system is also facilitated to ensure that each level of government is addressing their core activities. Following tabling of the National Budget (and subsequent Provincial budgets) the AIP are finalised in December.

5.3.6 Finance Management Services Branch (compliance function)

The FMSB (compliance function) (formerly the Secretariat) will continue to provide oversight and supervision of the HSIP.

Nationally this involves the review of all transactions that occur through the parent account.

For Provinces, expenditure monitoring will be undertaken on a quarterly basis (more frequent if required) through a combination of (planned) desk based and field based reviews. The FMSB will review compliance to the updated manual, the Secretary's Instructions and the approved AIP. Reports developed for each Province will be submitted to the HSFC through the PHFC. Recommendations for remedial action will be discussed at the HSFC and any action to suspend or restrict funds flow will be discussed at that meeting.

The re-design recommends strategic oversight of the audit decisions. This process is not intended to block access to funds but to assist with PFM and governance process improvement. Strategic decisions to provide additional resources to assist provinces that may be having difficulty, is suggested.

The FMSB (compliance function) will provide remedial training to provinces and program areas within NDoH where required which will be funded from within the HSIP TA resources. This training can be included in the RHFMT into the future.

The re-design recommends that the FMSB (compliance function) seeks to better coordinate its activities and findings through the Provincial Audit Committees where these are established. For example, audit review reports should be copied to the PAC as the issues for HSIP will be the same issues in the province. Often the PAC can address issues with local suppliers. The exit handover strategy is that PAC's would take over the FMSB (compliance function) functions. Development Partner programs working within Provinces can be approached to strengthen and support these provincial audit committees.

5.3.7 Provincial Health Authority

The Provincial health Authorities Act 2007 allows for the Governor of a Province and the Minister of Health to agree to establish a separate authority. This authority brings together both the rural and hospital based services under one administration with the view to improving service delivery. The new PHA Board are responsible for determining how rural and hospital services will function and what structures are appropriate.

The current HSIP TA arrangement needs to be amended to allow the PHAs to establish a subsidiary account. In addition the resource allocation formulae will need to be amended to include provision for the PHAs. This will enable funds to directly flow to PHAs.

5.3.8 Quarterly Review Processes

Quarterly reviews are the normal Government process for tracking progress in implementing activities and expenditure. They occur at both National and Provincial levels.

Activity supervision will occur through regular quarterly review processes and specific supervisory visits by the Senior Executive Management team of the NDoH. The HSIP TA will fund attendance at Provincial Regional/quarterly reviews by NDoH.

The re-design recommends that NDOH coordinate with Treasury regional reviews to more efficiently meet with all provinces. Treasury is monitoring HFG expenditure on a quarterly basis as well as performance on MPA, so it would strengthen the whole of government approach if NDOH were also present.

5.3.9 Performance Assessment Framework

The NDoH has developed a Monitoring and Evaluation Plan 2011-2020, which incorporates the Performance Assessment Framework (PAF). Indicators within the PAF have been developed to examine the success of interventions recommended within the NHP. The indicators replicate those that are used within the MDTP and global reporting obligations (such as the MDGs).

An annual assessment is undertaken using data collected from the NHIS, expenditure reports, and program specific reports and provides a scorecard on the performance of the Sector.

Future Annual Sector Reviews (ASR) will include an analysis on development impacts and will be provided to partners at the November GoPNG and DP Summit.

The re-design recommends that the ASR increase the narrative of the data in a form that can be reported in Annual Reports, Partner Country Reports and other publications to better show progress in PNG. Development Partners will support this enhanced reporting requirement with technical assistance as defined by capacity building approaches.

5.3.10 Independent Annual Sector Review Group

The IASRG is mobilised annually to provide an independent analysis of the performance of the Sector and the HSIP contribution.

The HSPC tasks the group in May of each year. It is proposed that this continue.

CHAPTER SIX - SUSTAINABILITY

6.1 Opportunities and Constraints

The Health Service Improvement Program aims to target funding at the most vulnerable and disadvantaged elements of the population to increase access to effective health services and thus improve health outcomes.

The Government of PNG has been implementing several reforms over the past five years focussed on improving service delivery at the front line. The increasing resource envelope in the Provinces as a result of the HFG, Church Grants, DSIP and Internal Revenue provides the environment for change.

The change from 'gap filling' to one of targeted investment by Donors using pooled funds through the HSIP recognises that the GoPNG first responsibility is to fund their own services at the standard that they can afford. Therefore not displacing these reforms by moving away from 'gap filling' improves the prospect of sustainability of these critical reforms. This increases the potential for tapering Development Partner support of pooled funded recurrent activities by 2017.

The re-designed program aims to set the scene for a move away from funding of activities in a parallel nature. The strategy enhances progress towards an advanced SWAp where all funds are incorporated into a single basket addressing a single policy and single set of priorities.

The redesign is focussed on delivering the priorities of the NHP, which is aligned to Government plans. Alignment to these priorities and working in partnership with GoPNG to deliver a holistic approach to implementation provides the best opportunity for sustained change.

The new strategy migrates even further the integration of processes and procedures to that of the Government's PFMA. This increases the potential for understanding and compliance and creates an enabling environment to build a performance culture.

The re-design reaffirms the key leadership role the NDoH plays in managing the SWAp and coordinating Development Partner contributions, and seeks to rebuild process and procedures. Supporting Government leadership and ownership of the design is critical for sustainability of the changes proposed.

The Deputy Secretary will be involved at the highest level in communicating changes to the Provinces and ARB. At the operational level, the changes to the HSIP will be rolled out to all stakeholders via the NDoH FMSB (compliance function) staff because of their existing relationships in the provinces. The staff will be involved in developing a Communications Strategy, which is funded in Year 1. New relationships need to be forged with Provincial Audit Committees and the PHFC.

Utilising an already established capacity building option such as this increases the likelihood of ownership and improves the likelihood of rapid uptake of the changes.

Capacity will also be built at the level of the District and Facility to better plan, budget, manage and report. Much of this capacity building will be reinforced with Donor Programs such as PLGP and PCAB and GoPNG training by the Finance Training Branch (DOF) and Procurement Training in the provinces through the Central Supply and Tenders Board. This strategy will be achieved by using accredited training capacity. The DWU modules have been road tested, evaluated and are recommended. Building staff at this level enhances bottom-up planning as well improving the potential for accelerated responsible spending at the level of service delivery.

It is expected that by 2013/4, ten Provinces will have reached their cost of services threshold. Additional Provinces will also meet their threshold soon after with support of their Provincial Governments. While risks are high for Provinces such as Western and New Ireland who have difficulty in advocating for resources for health the redesigned strategy will address this challenge through its poverty, equity and incentivized approaches. Sustainability of this approach will need to be managed and monitored carefully.

The flexibility of an Annual Secretary's Instruction, allows for some responsiveness to human need where provincial priorities are not demonstrated.

However, on a sustainable basis, the Secretary Health might consider a dialogue with those Provinces that have the funds, but fail to commit them adequately to health provision. Such a dialogue might be supported through PLLSMA.

6.2 Sector Budget Support/Provincial Budget Support

The re-design was asked to explicitly recommend a transition to GoPNG financial management systems.

Incremental changes have been recommended throughout the document that will further align processes. Primarily, DPs need to assist NDOH to comply with budget and reporting processes in the GoPNG annual cycle. Uploading provincial spreadsheets to the PGAS mainframe will assist with the final transition. PGAS enhancements, as they unfold, should be taken up on the PGAS standalone system (as well as the NDOH system). Again, while the IFMS reforms are being implemented, the re-design recommends that a transition is not undertaken. There is a possibility that the IFMS will have sufficient capacity to allow an ease of transition.

The failure of HSIP administration shown in the past few years (Nexia) and the weaknesses identified in NDOH administrations (AGO), mean that there is a long way to go before any further moves to transition to GoPNG systems is possible. Investor confidence must be restored from its current low base. NDOH needs to demonstrate commitment to a performance culture. These elements will take time.

Where Provinces demonstrate compliance with PFM systems through Annual Audits, the HSIP Finance Committee could recommend, as a further incentive, an accelerated transition using a similar approach to that used by the Provincial Performance Improvement Initiative. Under this scenario, the HSIP allocation would

become an annual grant supplementing the HFG, conditional on PFM operational elements being sufficiently robust.

Stakeholders in PNG do not appear to have a strong preference for an end to the parallel system until the basic issues of administration and performance are addressed.

6.3 Exit Strategy

The Health Function Grant potentially includes many of the elements of the re-design. The argument is that the extent of infrastructure neglect warrants an additional surge as has been suggested here.

An exit strategy has been built into the program with a tapering of non-targeted recurrent funding support over a period of four years, subject to the review by stakeholders at that time. This sets the scene for a move to a modified Budget Support, or selective Provincial Budget Support, strategy from 2017. This will need to be carefully designed to avoid the financial risks as well as the potential reduction in development impacts due to the loss of influence by Development Partners to ensure equity and a focus on the poor and vulnerable.

CHAPTER SEVEN - MONITORING AND EVALUATION

The overall objective of the monitoring and evaluation of the HSIP TA is to complement and strengthen existing national, NDOH and provincial monitoring activities.

7.1 National

NDOH outcomes are monitored by the Consultative Implementation Monitoring Committee supported by the Institute for National Affairs, designed to be chaired by the Minister for Planning. The Deputy Secretary of NDOH is responsible for participating at this level.

MDG indicator data is provided to the Department of National Planning (DNPM) for reporting to international reports.

7.2 National – Provincial

While AIP centrality to HSIP declines, the monitoring of National and provincial plans and budgets remains an important core function of the NDOH Strategic Planning Branch.

- ✓ Plans involving HSIP TA funds should be monitored, summarised and reported to the DP Summit and the Health Finance Committee. The quality of this monitoring will engage DPs and assist in regaining confidence.

HSIP expenditure in the provinces can be coded using the NEFC Standardised Chart of Accounts. Spreadsheets of provincial expenditure can be coded quite precisely to measure where (district or province or LLG) and on what the funds are spent. These codes align with current PGAS codes which have been enhanced so that MPA expenditure can be more easily identified. Provinces are moving slowly to adopt this approach.

At present the provincial spreadsheets (SORAPS) are not analysed at all - which is an opportunity lost. Copies of each provincial spreadsheet (now received by FMSB) should be sent to Monitoring Division. Analysis by activities and districts/provinces could be undertaken on broad HSIP activities and would show the movement from untargeted elements to targeted elements fairly easily. Funds spent on disadvantaged district components would be identifiable and in the long term, assumptions about improved infrastructure and better health outcomes would be tested. Data thus analysed could be an addendum to the SPAR. Advisory assistance may be required to set up these analytical processes so it can be a set analytical report to the Finance Committee.

The Provincial and Local-level Services Monitoring Authority (PLLSMA) is the monitoring link between the NDOH and Provinces. For example, currently The Secretary NDOH reports to PLLSMA on MPA progress, NHP progress, PHA implementation and provincial implementation issues. Section 119 Reports (Provincial Performance Reports in to the Organic Law) are presented to PLLSMA. This contains provincial health service provision data. The capacity of DPLGA to provide S119 reports is improving. Publication of this data will be a major step

forward in 'whole of government' monitoring of service delivery. Active participation of senior NDOH personnel will contribute to the culture of transparency and monitoring of performance.

There is one key Health Subcommittee which the NDOH Deputy Secretary chairs to further issues of coordination and monitoring. The current need is to streamline the health indicator and s119 reporting so that there is one source of reliable health data in each province and it is provided to each reporting institution. The streamlining and improvement of variability in the data is a key agenda currently and one which the redesign would encourage. However, coordination is required as the indicators for the health MPA currently align both with s119 data and NHS data and this alignment must be maintained.

The redesign recommends these monitoring activities agendas are pursued.

- ✓ An additional monitoring activity is suggested for the PLLSMA Health Subcommittee – to undertake at least one district health facilities visit per annum to a remote or rural district where there has been uptake of the HSIP facility rehabilitation and training, coordinating with the provincial and district officials. This might mirror the recent capacity diagnostic where health officials confront the capacity of health facilities to provide the standard of care expected. A report must be presented to PLLSMA and the Health Finance Committee (particularly any issues of implementation). The HSIP re-design sets aside K100,000 annually for this purpose, however this is a contribution and should be matched by NDOH as this is a core activity going forward. An assessment of the sufficiency of this amount should be reviewed annually and updated should further funds be required,

7.3 Provincial Level

PLLSMA has a subcommittee at the provincial level which engages all stakeholders including NGO, churches, chambers of commerce and key business entities and state owned enterprises. The committee is known as a Provincial Coordinating and Monitoring committee (PCMC) and is chaired by the Provincial Administrator.

- ✓ The re-design suggests that a senior NDOH regional planner attends one PCMC meeting per annum to ground-truth health implementation and HSIP facility and service improvements. A report should then be written to the Health Finance Committee.

Treasury/NEFC and other central agencies undertake face to face regional second quarter budget reviews where progress on budget expenditure and bank reconciliations is provided. MPA performance data is also examined. Provinces are required to provide data to Treasury for examination. These usually take one day as all provinces in the region travel to one central location. Although there are quarterly budget reviews, the second quarter is the one where people come together and talk and thus is arguably the most important and regularised event organised by Treasury.

- ✓ Health should accompany Treasury to these regional reviews to monitor health implementation performance. Additional time could be requested one: one with the provincial health advisers of the region.

NEFC/Treasury/DPLGA organises Regional Workshops annually in May/June, primarily to report on PER results. All sector advisors attend and present their health performance outcomes against expenditure and the MP indicators in the presence of their peers. Over time the provincial presentations have become more sophisticated in monitoring the indicators required against each MPA.

- ✓ A senior manager or planner from NDOH should attend each regional workshop as a monitoring and networking exercise.
- ✓ The Redesign suggests that Provincial Health Advisers attend one additional day on the side of the NEFC/Treasury workshops to specifically report on achievements and issues with HSIP. This happened during the consultation of the re-design and was led by the Deputy Secretary of Health and Mr Gima Rupa and ex-Treasury official. Provinces would be asked to report on planning, expenditure and outcomes. This would be recorded and presented to the Health Finance Committee.

All three strategic objectives of the re-designed HSIP TA are consistent with Key Result Area 3 (KRA3) of the National Health Plan (NHP) – to strengthen health systems and governance (particularly in financing). KRA 3 ensures that health facilities are in a good state of repair, are open, staffed, have equipment and drugs, have water to the labour ward for safe deliveries, have lighting and a functioning radio/telephone. Strategies for the redesign in the provinces recommended all focus on improving the remote/rural health facility services to encourage access to quality care and to get HSIP funding closer to the users of the health system.

- ✓ Over time, these indicators of KRA 3 should show some improvement in trending, and especially in 'disadvantaged districts' that have taken up the HSIP new strategies. This is the health improvement outcome required.

This KRA is in line with the shared target of the AusAID Health and HIV Subsidiary Arrangement – increased proportion of government (functional grants) and development partner contributions that are expended and meet estimated minimum health expenditure required. This indicator will be used to measure the contribution of HSIP towards the goal at the end of the program.

There is no intention for NDOH to monitor additional indicators to those already in the NHS/MPA/S119. However, the Re-design team suggests the following improvements.

- ✓ Provinces are getting used to a NEFC/Treasury approved standardised chart of accounts (CoA). Not all provinces have adopted the CoA, however there is good progress, which will facilitate better provincial expenditure monitoring across the board. The ultimate goal would be that HSIP funds (source donor) are coded by district and health activity – rehabilitation and in service training.

- ✓ Thus the spread-sheets sent to NDOH (for uploading) would have the donor code, the provincial code (consistent with Treasury); district code and a further 4 digit code which identifies the actual activity. This is in addition to the Item Code (which is not very useful in the PGAS Reports).
- ✓ Additional effort should be made to upload the provincial data sheets onto the PGAS HSIP TA frame in NDOH.
- ✓ The current codes used for provincial reporting evidenced by the redesign team already carry a lot of this data.
- ✓ Assistance to NDOH to routinely examine and analyse this data to provide a report to the Health Finance Committee. This analysis could also be provided to the Monitoring Division to assist with greater depth of narrative in the ASR.

7.4 Donors

Donor partners need to inform their stakeholders/ taxpayers about the overall activities ie how many facilities have been upgraded and how many people have taken up the management training options. Ideally this data can be gathered using existing data collection.

To date the data for donors to report has been problematic, not necessarily because the data is not there but that there is little effort put into analysing data and providing this to donor forums. In part this has contributed to the loss of confidence when the activity is reported as a PGAS item number or under a broad rubric of 'workshops'. This lack of confidence is exacerbated when there are few positive signs in the health improvement data.

- ✓ The Re-design recommends that the copies of HSIP provincial expenditure spread-sheets are provided quarterly to the Monitoring Division who will collate them under broad activities (perhaps related to CoA?, MPA codes as advised in the Budget and Expenditure Instructions from Treasury) eg health patrols, training, emergency obstetric transfer, facility maintenance, medical supplies, etc. This data should be collated by province and provided to the Health Finance Committee every second quarter with a narrative. As the untargeted element of the HSIP declines, this task should become less onerous.
- ✓ Technical Assistance may be necessary to set up simple processes to provide data to the Health Finance Committee and on an annual basis, to the DP Conference and the Annual Health Conference.
- ✓ This will increase the transparency of activities, maintain motivation and reduce risks.

Donors also need to assure their stakeholders that contributions will contribute to improved health indicators in PNG (outcome level). Although the time lag in health outcomes improvement is acknowledged, it must be expected that the GoPNG commitment to the National Health Plan, and the donor commitment through the SWAp, must produce better health outcomes and that this should start to materialise

in the next few years. The existing ASR goes some way to providing long term trend data but needs greater validity checks and analysis.

- ✓ The re-design suggests that the ASR be taken to a new level in providing more narrative. For example if there is an increase in malnutrition of children, what is the likely explanation.
- ✓ Providing a summary to province with a narrative may influence officials to change a strategy to address particular health issues.

Intended outcomes will increase access to health services, particularly for rural people in disadvantaged districts; to increase the predictability of donor funds to the subnational levels; and to skill health facility staff in planning, budgeting and reporting. At the national level, management and coordination of HSIP will be improved; better information on expenditure and development impact will result; and compliance with GoPNG PFM at NDOH and provincial levels will be improved.

The timeframe for this program is 2013-2020 over 2 distinct phases. The first phase from 2013-2016 is focussed on the transition of the HSIP to the redesign priorities and governance arrangements, transitioning away from untargeted funding, and identifying opportunities for sector budget support. The second phase from 2017-2020 will be focussed on consolidating these gains and shifting toward a sector budget support modality where this is appropriate. A formative or mid-term review in 2014 is essential to ensure a realigned HSIP TA is implemented and a summative evaluation/redesign in 2016 will ensure that Phase 2 priorities and delivery modalities remain relevant and targeted..

7.5 Guiding Principles

M&E is integral to program management and the findings from monitoring and evaluation will be clearly linked to management decision-making, accountability of stakeholders, and the generation of knowledge to inform policy development, planning and contribute to wider health development efforts.

The main principles and features of the HSIP MEF are:

- It will meet all current reporting arrangements as per the PFMA and HSIP guidelines, reinforced in the HSIP manuals
- It is an integrated framework using GoPNG planning, monitoring, evaluation and reporting functions across a range of implementing entities – service providers at district and LLG levels, faith-based organisations and NGOs. The use of GoPNG systems may assist Churches and NGOs in their understanding of GoPNG PFM requirements.
- Use of existing indicators, definitions and information sources has been considered when choosing appropriate indicators from existing GoPNG systems of monitoring (alignment and sustainability).
- Consideration has been taken of cross cutting issues such as gender equity, governance, capacity building and sustainability.

- Baseline performance indicators have been generated from existing or continuing sources, where possible e.g. NDOH NHIS; DPLGA's S119; NEFC's Provincial Expenditure Review (PER) Series; Provincial and NDOH AAPs; and the HSIP annual expenditure report. Baseline information is also provided on disadvantaged districts and gender disadvantaged districts. (See Annexure 11)
- It acknowledges the capacity development approach needed to strengthen financial management and data collection from the health facility level; and the support needed for the FMSB (compliance function) within NDOH.
- Other capacity building programs such as GoPNG Finance Training Branch (for provinces and NDOH); PLGP will increase its focus on the provincial procurement function (PSTB) as a result of a fiduciary risk assessment; the PCAB program (supported by EPSP) is currently supporting 6 provinces to improve provincial and district treasuries. The program has a strong focus on timely and correct annual financial statements (S114). PLGP is supporting the DPLGA to improve the performance reporting activities of provinces (S119).
- Internal audit: the department of Finance has a Public Sector Audit Program supported by EPSP. In addition, PLGP will probably increase its technical assistance focus on provincial internal audits as a result of a fiduciary risk assessment.
- The assumption that improved facilities and increased management training will lead to motivated, skilled and resourced staff, (as suggested in multiple consultations over the years) needs to be tested if there is no trending in health outcome data at the end of five years).

Expected outcomes from implementation of HSIP TA that will contribute to **good governance** include:

- The development and improvement of strategic partnerships between DPs and between NDOH, provincial governments and implementers due to increased transparency of HSIP activities;
- Strengthening of the whole of government monitoring systems of PLLSMA, PCMC, s119 through greater participation in central agency events;
- Improved presence of NDOH in the provinces to facilitate and motivate the implementation (not planning which is already sufficient) and reporting against the national health plan;
- Improved capacity at national level for health management including improved monitoring and reporting at all levels; improved understanding of PFM requirements.
- Capacity building and institutional strengthening across all program areas, particularly as new staff are inducted into NDOH;

Indicators of good governance in HSIP TA include:

- Audits of NDOH, HSIP TA and Provincial health show continuous improvement
- Program planning aligns with institutional strategies and priorities e.g. NHP KRA3
- Transparency of the planning and financial resourcing processes through better scrutiny of the AIPs and financial control processes at national and provincial level;

- Much greater participation in regular monitoring of activities by provincial and national level staff; and
- Coordination of donor support through annual agreements and commitments to funding amounts so that NDOH and provinces can include HSIP funds in their annual budgets (preferably coded appropriately).

A detailed Monitoring and Evaluation Plan is provided at Annexure 15. Quantitative and qualitative baselines of provincial health, the relativities against national averages and expenditure data from the Provincial Expenditure Reviews – are at Annex 4.

The Monitoring and Evaluation Framework provides:

1. A table showing the objectives relating to outputs and quantifiable activity level targets over a four year period prior to a detailed evaluation which coincides with the NHP Mid-term review.
2. A table showing the linkages between the strategic objectives and long term health outcomes, as measured by the NHIS and reported in the SPAR, as well as the monitoring responsibilities and schedules required. This is in line with a commitment to align indicators with those currently in place.

The HSIP Manuals and the Financing Agreements will reference the M&E Framework at Annexure 15.

Reporting will include:

- Through activity reporting from implementers at provincial level (data contributes to measurement of KRA3 and ASR);
- In quarterly expenditure reports by FMSB (compliance function), to the Health Finance Committee
- Better analysis of overall NHP development impact (trending) and included in an improved SPAR through the IASRG;
- At the Mid-term review of the NHP. The current M&E framework for the NHP outlines an extensive qualitative and quantitative evaluation process to report to government and stakeholders. The qualitative evaluation includes consultation with local communities about health services and outcomes. Districts, which have applied HSIP TA funding, should have a better-reported improvement in health services and health usage figures should be increasing. Many other indicators should be trending upwards. An amount of K2 m is included at this time, this amount should be considered a contribution to the evaluation of the NHP but not the sole supplier of funds.

CHAPTER EIGHT – RISK AND RISK MANAGEMENT

The Government of PNG has committed itself to the National Health Plan by promising K14 billion over 10 years. The greatest overall risk is that the Department of Health is not able to build a health sector capable of absorbing this level of commitment, and that donor funds create additional administrative burdens. At the provincial level, the Treasury has committed to a Health Function Grant that in 2012 stands at K64.35 million for direct service delivery in the provinces. Additional funds are provided to Bougainville, NCD and the Church Medical Council. Hospital, staffing and medical supplies are also evidence of national government commitment. Management of these funds to directly improve health outcomes is essential.

The risk environment surrounding the HSIP Trust Account and within NDOH is high. There are many recent reviews and reports describing the risks and identifying management strategies. The risk environment as at June 2012 is exacerbated by the large amount of PNG funds in the Trust Account that are earmarked for capital works; funds held in Interest Bearing Deposits; a high turnover of senior management; and a loss of confidence by Development Partners.

There has been poor capacity within NDOH to manage, control, monitor and report on all health activities, including HSIP TA. There has been potential for fraud and situations where the use of donor funds may not impact sufficiently on health service delivery to maintain confidence of investors. Conversely DPs must take partnership responsibilities to request information strategically in ways that might improve NDOH monitoring and reporting capacity and to adhere to the budget cycle and planning processes, thus reducing administrative and transaction costs.

While the Secretary for Health is the Chief Accountable Officer, NDOH senior executives and DPs must accept partnership responsibilities to communicate and collaborate to reduce these risks.

There have been many PFM Assessments in PNG – the most recent are described below.

A detailed study of PFM assessment and risks are contained in the recent Assessment of National Systems (2012). In summary:

*“The fiduciary risks in using downstream components of PNG’s PFM systems in delivering the aid program are **Very High**. Corruption risk is also assessed as **Very High**.” (ANS Draft Report May 2012)*

In 2011, The European Union undertook an Assessment of Provincial Systems on behalf of the donor community, using Milne Bay as the case study. A five-year road map to improve management and implement greater compliance with PFM systems was agreed to.

The re-design team also completed AusAID “Working in Partner Systems” Assessments for the Parent and subsidiary accounts. (Annexures 17 &18)

The redesign clarifies the management arrangements required and overall the necessary commitment by provinces and the National Department of Health to improve PNG Auditor General Assessments. This will pave the way for better investor confidence in the HSIP TA. Recommendations for changes to the Manuals are at Annexure 13.

Major risks are reputational for both NDOH and Development Partners if the SWAp does not prove successful in re-focusing on the service delivery environment at the periphery and in disadvantaged areas. The major management strategies for addressing this risk are improved capacity to report on improvements in health services, particularly in disadvantaged districts.

Provincial risks are better managed due to the tranche limits and the periodic acquittals testing. NEFC examines individual provincial PGAS data which alerts provinces to expenditure transparency which is available and published. Provinces are aware of these systems and know the expectations under which HSIP is given. These controls are retained. In order to remove the bottlenecks, a major immediate investment in compliance training is recommended for all beneficiaries of HSIP funding.

“Particular mention is made of the risk environment surrounding PNG procurement systems at both the National and subnational levels. As the ANS (2012) outlines: the PEFA, MAPS and sectoral et. al. analyses reviewed in the context of this assessment together confirm that there are significant shortcomings or weaknesses across virtually all components of PNG’s PFM systems and processes, both nationally and sub-nationally. The fiducially risks for AusAID in using PNG’s PFM systems, nevertheless, differ markedly between the upstream and downstream components.

Overall, the assessment here is that:

- Utilising the upstream components of PNG’s PFM systems (On Plan, On Budget and On Parliament) entails **Low Risks** (indeed, no fiduciary risks) for AusAID. Processes here essentially involve recording of estimated expenditures as part of the annual budget and annual and within year reporting of actual spending: there is no legal or contractual obligation on AusAID to actually incur expenditures indicated in, or appropriated as part of the annual budget.
- The risks of using the downstream components of PNG’s PFM systems are assessed generally to be **Very High**, implying a need for AusAID, on a case by case basis, either to implement its own, parallel, procedures or to implement additional oversight and control processes to ensure otherwise sound PNG systems are being properly adhered to.” ANS p 22.

The redesign supports the need for donors to implement, on a case by case basis, its own procedures that provide additional oversight where the costs of procurement are high, for example in the disadvantaged district estimates. Additional procurement

safeguards may be put in place to address risks in implementation and identified in the Manual and the Financing Agreement

DPs and NDOH should give urgent prioritisation to current risks by reducing the GoPNG funds held in the trust account to an acceptable level (where the need for IBD is reduced if not eliminated) and support effective resourcing to enable funds to be correctly expended in a timely way. DPs need to commit funds to a level where the NDOH has the capacity to effectively administer within PFM processes.

A full risk register at Annexure 16 addresses risks at the Outcome level of the redesigned HSIP. It is designed to be periodically reviewed by the Health Finance Committee and a report given to the Secretary for Health and Development Partners.

CHAPTER NINE – BUDGET SUMMARY

9.1 Overview

The program will be implemented over two distinct phases. Phase 1 commencing in 2013 and completing in 2016 will transition away from the current untargeted funding strategy to a more focussed approach with opportunities being explored as they arise to move to a sector/provincial budget support model. The second phase commencing in 2017 and completing at the end of the National Health Plan cycle in 2020 is expected to build on the approaches in phase one and shift further to a budget support modality.

The proposed budget for the first phase of HSIP Trust Account (2013-2016) is **K150,240,000**. This excludes those funds earmarked (including individual donors for program/project activities and GoPNG development budget funded activities) and disbursed through the HSIP TA.

The following proposed budget has been designed around broad forward funding estimates from Development Partners taking into account the absorptive capacity of the system and the individual components requirements.

9.2 Assumptions and Resource Envelop

In calculating the resource envelope the following apply:

- In February 2012 the HSPC endorsed the Medium Term Expenditure Framework (MTEF) for 2012-2014. The endorsed MTEF 2012-2014 documents the broad estimates of Development Partners for the year 2013 and 2014. These estimates have been used as baselines for the remaining two years of the budget period and assume that the level of funding will continue.
- AusAID funds remaining within the HSIP TA at 31st December 2012 will be carried over for funding for 2013.
- NZMFAT estimates it will carry over K8 Million in 2012 as well as K8 Million for 2013 (providing a total of 16 Million)¹⁷. In addition 4 Million is committed for 2014. NZMFAT has not indicated its intention to renew its agreement with NDoH to fund health after mid 2014.
- UNFPA and Global Funds are no longer utilising the HSIP TA mechanisms.
- The quantum of funds to be flowed through the HSIP from the ADB supported RPHSP has not been confirmed. Estimates only are available.
- The available funds (both earmarked and non-earmarked) within the HSIP TA are only 23% of the funds provided by Development Partners to Health. The remaining funds are managed by DPs themselves or provided directly to Provinces and or other stakeholders.

9.3 Proposed Program

The HSIP will increasingly over life of the program target funding for specific options that improve access to service delivery with a focus in the poorest and most

¹⁷ NZMFAT funding agreement restricts funds to Provincial AIPs.

disadvantaged Districts. In line with the new designs' poverty reduction focus the use of HSIP funds must be demonstrably targeted at those in rural PNG who need it most. Moving towards this goal will require a staged transition phase to ensure provinces, currently using HSIP recurrent funding, can meet key activities requirements and are not disadvantaged.

In determining a budget, the capacity of the Sector to spend and undertake the increased infrastructure activities has been considered. The proposed breakdown of individual activities within each category and annual targets are provided in Annexure 14.

Table 8 - Indicative Program Budget Year 1 - 4

Year	1	2	3	4
Targeted - Disadvantaged Districts	12,000	15,500	17,045	20,000
Targeted - Facility rehab and training.	8,920	10,840	11,240	9,410
Targeted - Obstetric Emergency Transfer ^(b)	900	900	900	900
Non-Targeted				
• Provincial Health Service Activities	11,100	8,100	5,100	2,100
• Investment in compliance processes	1,305 ^(d)			
NDoH - Targeted ^(c)	3,000	2,500	2,500	2,740
HSIP TA Operational	660	240	240	2,100 ^(e)
Annual Budget ^(a)	37,885	38,080	37,025	37,250

(a) Exclude Development Partners earmarked funding and GoPNG funds in HSIP TA

(b) Based on average costs of obstetric emergency transfer in Provinces via Provincial consultations

(c) Includes 500,000 for emergencies (to be administered by the Office of the Secretary)

(d) Investment in compliance processes - To address backlog of acquittals in Provinces

(e) Includes end of program evaluation and monitoring

9.4 Indicative Funding Contributions from GoPNG and Development Partners

The following table identifies the proposed contributions of each Partner to the proposed program budget.

Budget figures are considered indicative and dependent on annual agreement through the HSPC utilising reviews of previous year's expenditure and performance patterns at both the National and Provincial levels.

Table 9 - Indicative GoPNG and Development Partner Contributions to Program Budget

Year	1	2	3	4
GoPNG				
Disadvantaged District	6,000,000	7,750,000	8,522,500	10,000,000
AusAID ⁽¹⁾				
Disadvantaged District	6,000,000	7,750,000	8,522,500	10,000,000

Year	1	2	3	4
Targeted Facility Rehab & Training	5,680,000	10,840,000	11,240,000	9,410,000
Targeted - EO Transfer Fund		900,000	900,000	900,000
Non Targeted	0	4,100,000	5,100,000	2,100,000
Targeted National	4,205,000	2,740,000	2,740,000	4,840,000
NZAID ⁽²⁾				
Prov Health Service Activities	11,100,000	4,000,000		
EO Transfer Fund	900,000			
Targeted Facility Rehab & Training	4,000,000			
TOTAL	37,885,000	38,080,000	37,025,000	37,250,000
<i>Earmarked DP Funding ⁽³⁾</i>	<i>20,822,000</i>	<i>20,857,000</i>	<i>20,857,000</i>	<i>20,857,000</i>

(1) Excludes AusAID carryovers from 2012

(2) NZMFAT advises that it is likely to carry over K8 million from 2012 to 2013 – providing a total of 16 Million for 2013. NZMFAT has not committed funds past mid 2014. It is unknown if any funds will be made available following the expiry of the current agreement.

(3) Estimated earmarked funding from WHO, UNICEF, UNFPA, ADB – not subject to the redesign targeted options

9.5 Implementing the Budget

Implementation of the budget will be in accordance with the HSIP TA Manuals, which details the special conditions for major procurement over K300,000 and identifies opportunities for co-funding with the GoPNG in rolling out the Disadvantaged District package.

The Resource Allocation Formulae will be updated and will be applied to the Provincial Health Service Activities (untargeted) portion of the allocated funds. Targeted components and the Disadvantaged District package will be subject to agreement with Partners on an annual basis and distributed through the Secretary for Health Annual Financial Instructions.

The Emergency Obstetric Transfer funds will be provided on an as needed basis.

ANNEXURES