

# Knowledge Brief

*Health, Nutrition and Population Global Practice*

## FINANCING THE FRONTLINE: AN ANALYTICAL REVIEW OF PROVINCIAL ADMINISTRATIONS IN PAPUA NEW GUINEA'S RURAL HEALTH EXPENDITURE 2006-2012



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### KEY MESSAGES:

- Certainty in cash disbursement is a prerequisite to improved service delivery, yet variability in cash disbursement from Port Moresby to the provinces continues.
- There are areas of uncertainty as to who is responsible for what. A working group to review the assignment of rural health functions is needed.
- Expenditure on certain priority activities in some provinces appears to have improved. There is a need to understand how this improvement in spending relates to performance.
- Provinces with higher levels of own-sourced revenue generally spend lower amounts on frontline health services.

### Introduction

In a country where more than 85 percent of the population lives in rural areas, developing a sustainable approach for assessing the allocation and effectiveness of spending on the country's rural health service is critical. This report updates the analysis of our first report, *Below the Glass Floor*, and looks for ways to continue the discussions in search of solutions for the issues identified.

Papua New Guinea's network of rural health facilities is enormously widespread across the country's challenging terrain. For most Papua New Guineans these health clinics, and the extension patrols that clinic staff carry out, are the only health service people see and can access. Roughly half of the country's health

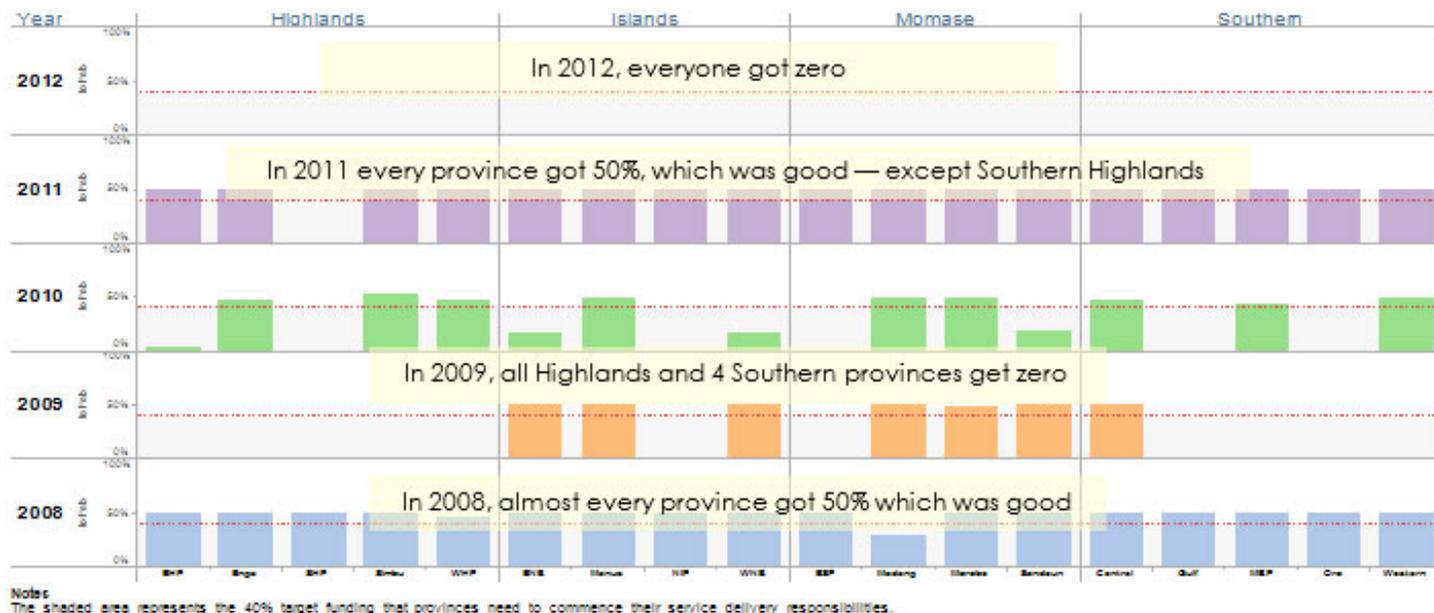
centres are administered by churches (with government funding) and the other half directly by the government. Most activities associated with frontline rural health services are the responsibility of provincial governments; however this picture is changing with the introduction of provincial health authorities.

### Key questions

#### 1. Is there clarity over service delivery responsibilities?

Papua New Guinea's rural health system has many participants. Developing an unambiguous agreement of service delivery responsibilities is a fundamental prerequisite in achieving progress.

Figure 1: Cash Release by February in 2008-12 (by Province and Region).



When ambiguity is present, it often acts like a sinkhole, and fosters a gap in service delivery.

This is particularly likely when the system itself suffers from low funding and broader capacity constraints.

Our analysis and consultation have highlighted a number of key areas requiring discussion and agreement in terms of service delivery responsibility. These include: the transfer of patients from rural health facilities to facilities with higher levels of care; the distribution of medical supplies; the ‘grey area’ between church health and government administration responsibilities; activities supporting the provision of clean water to facilities and to communities.

Another important area is that of facility maintenance. Facility maintenance can be designated as one of two types, either ‘minor’ or ‘more substantial’. The assigning of responsibility, as well as the location of funding, for a specific type of maintenance, is likely to depend on the nature or ‘type’ of maintenance to be carried out. The appropriate protocol for minor maintenance may well be ill-suited for more substantial maintenance.

## 2. Are operational funds reaching service delivery providers?

### Is the funding aligned?

‘Getting the money right’ is not only a matter of providing the right amount, it’s also a matter of getting the money to the right place and to the people who ultimately need to spend it. Recent studies and analysis suggest further

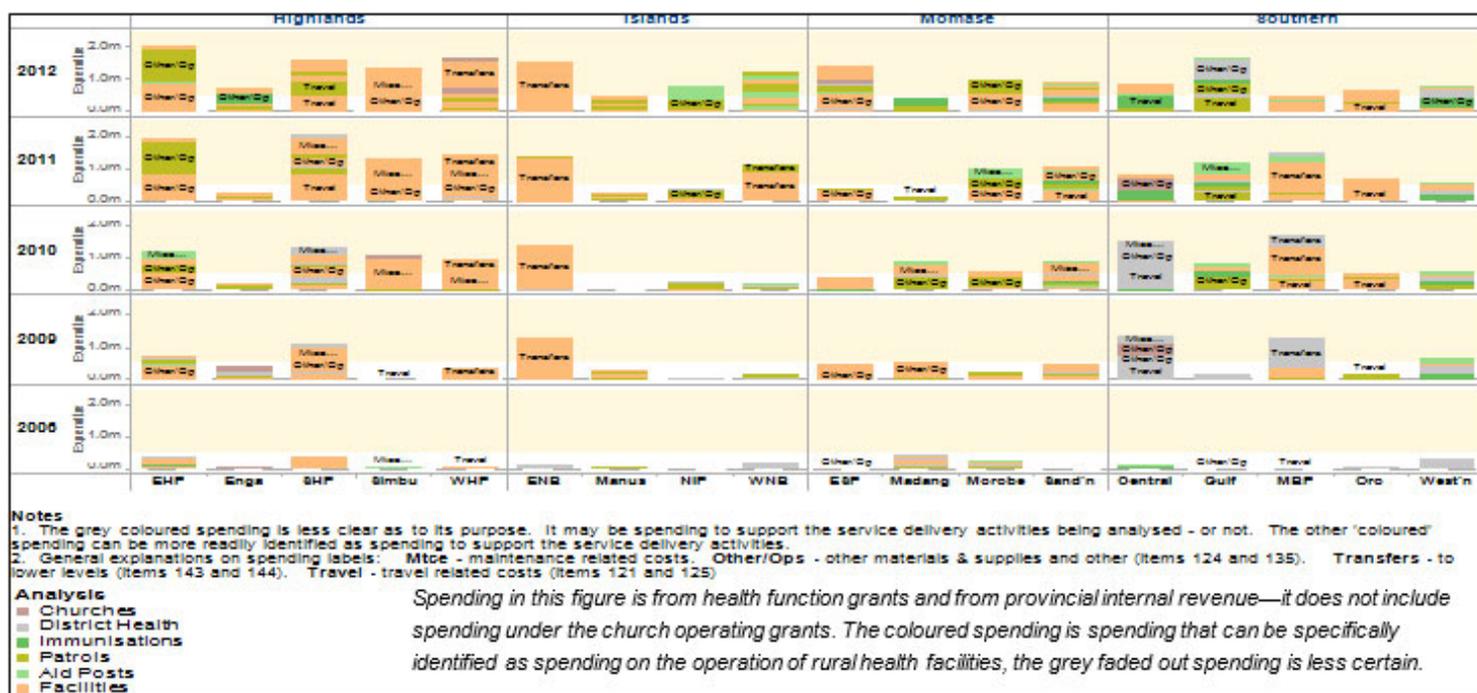
work may be necessary in this area to better align funding with those at the frontline who need to spend it (see figure 2 to note the disparities in spending).

For example, to access funds to support activities at the provincial level, a community health worker would be required to travel the provincial capital. This is often impractical, time consuming and incredibly costly.

Thus the transaction costs become very high rendering service delivery inefficient. Recent anecdotal evidence supports the findings of the District Case Study (DPLGA 2009) that, in the absence of ready funding, many facilities revert to user fees to continue operating.

### Do provinces with higher levels of own-sourced revenue support rural health?

Not all provinces receive significant operational funding from function grants (See figure 2). Some provinces need to fund rural health services largely from their own-sourced revenue, that is, internal revenue. The analysis is disappointing. In most cases, provinces with higher levels of own-sourced revenue spend relatively less on supporting rural health services. This observation is a concern. The intergovernmental system relies on own-sourced revenue to support basic services.



### Considering the role of the national level in transferring recurrent grants to support operations.

Certainty in cash disbursement is a prerequisite to improved service delivery, yet the picture of variability in cash disbursement from Port Moresby to the provinces continues (see figure 1 above). In 2011, 17 of the 18 provinces received 50 percent of their appropriations by February. This contrasts sharply with 2012, when no operational funds were transferred to support the frontline in January or February.

### 3. Are there visible improvements in the delivery of rural health services?

The findings of the recent Promoting Effective Public Expenditure (PEPE\_ study—which included a survey of rural health facilities—were sobering. And yet the picture of spending on rural health facilities and outreach from provincial expenditure data suggests there has been a visible improvement in many provinces (see below). We need to better understand the relationship between expenditure and performance. The availability of expenditure and performance information allows us to seek greater insight which can guide future developments aimed at improving the financial flows and their alignment with key service delivery activities.

Province	Funding Profile	Frontline Spending	
		Category	Percentage
Manus	High Grant	Higher	70%
Gulf	High Grant	Higher	70%
East New Britain	Mixed	Higher	68%
Eastern Highlands	Mixed	Higher	63%
West New Britain	Mixed	Higher	62%
Simbu	High Grant	Medium	52%
East Sepik	High Grant	Medium	52%
Western Highlands	Mixed	Medium	48%
Southern Highlands	High OSR	Medium	40%
Central	Mixed	Medium	37%
New Ireland	High OSR	Low	30%
Sandaun	High Grant	Low	27%
Oro	High Grant	Low	27%
Enga	High OSR	Lower	25%
Morobe	High OSR	Lower	20%
Madang	High Grant	Lower	19%
Western	High OSR	Lower	17%
Milne Bay	High Grant	?	12%

## Recommendations

The operating context in Papua New Guinea is highly decentralised with many participants. Achieving improvements in the delivery of rural health services will require the following:

1. A highly decentralised context with many participants relies on an unambiguous agreement of service delivery responsibilities. A working group could be convened to clarify functional responsibilities and resolve uncertainties.
2. Getting the 'right amount' to the 'right place' 'on time' needs to be a guiding priority. Budgets and funding streams need to be appropriately aligned to ensure the right amount gets to the right level. The National Department of Health has conducted exploratory initiatives in using facility-based budgeting and funding. These findings can be used to inform and develop national policy.
3. The impact of 'low funding for rural health' in provinces with higher levels of own-sourced revenue [GST and royalties] needs to be considered. If rural health is not suitably prioritised and funded, rural health services in these provinces will continue to suffer.
4. There is a need to continue the dialogue at the national level around the timing of grant releases. Achieving a predictable timely release of funds – from the national level to the subnational level [and ultimate spenders] – is a prerequisite for improved service delivery.
5. Effective timely monitoring and reporting is critical in a highly decentralized context. The relationship between subnational expenditure and performance needs to be better understood. There should be a positive correlation between increased spending and [increased] performance activities leading eventually to improved outcomes.

## Endnotes

<sup>1</sup> **Funding Profile:** In Papua New Guinea, provincial administrations receive their funding from two major sources. The first is from own-sourced revenue, and the second is from national grant transfers. The intergovernmental financing system uses national transfers to contribute to any shortfall in a province's funding from its own-sourced revenue. This means the mix of own-sourced revenue and national grants vary markedly by province. The concept of a 'funding profile' enables us to group 'like'

provinces in three classifications: first, those provinces with higher levels of own-sourced revenue and hence lower grants; second, those provinces with lower levels of own-sourced revenue and hence higher grants; and third, those with a more even mix of both.

## <sup>2</sup> Frontline Spending Compared To a Cost Estimate:

The study groups its findings according to a metric that compares spending against a 'cost estimate' benchmark of what should be spent to deliver a service in a particular location. The cost estimate is based on the National Economic and Fiscal Commission's admirable work *The Methodology and Results of the 2011 Cost of Sub-national Services Study (O&M)*.

## References

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*This HNP Knowledge Brief highlights the key findings from a study by the World Bank titled "Financing the Frontline: An Analytical Review of Provincial Administrations' Rural Health Expenditure 2006-2012" by Alan Cairns. Please contact Xiaohui Hou at [xhou@worldbank.org](mailto:xhou@worldbank.org) or Alan Cairns at [alancairns@xtra.co.nz](mailto:alancairns@xtra.co.nz) for any queries.*

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