FINANCING PNG'S FREE PRIMARY HEALTH CARE POLICY:

USER FEES, FUNDING AND PERFORMANCE

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PNG Promoting Effective Public Expenditure Project

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Executive Summary

The Promoting Effective Public Expenditure (PEPE) project is a joint research initiative between Papua New Guinea's National Research Institute and the Development Policy Centre at the Australian National University. Overall, the project aims to analyse how PNG allocates its public money through the national budget and the effectiveness of this expenditure in key service delivery sectors.

The project conducted expenditure tracking and facility surveys to schools and health facilities across PNG. Survey teams travelled to eight provinces, representing each region in late 2012, which included some of PNG's most rural and remote areas. For the health sector, survey teams visited 142 primary health care facilities made up of rural hospitals, various types of health centres and aid posts. Three surveys were conducted at each health facility with the Officer in Charge (OIC), a worker at the clinic (where applicable) and a community member who uses the clinic.

The purpose of the health surveys was to track two major expenditure reforms and evaluate their performance. One of these reforms is the health function grant, which aims to provide health facilities with operational funding to deliver basic services. This includes maintaining the facility's physical infrastructure, conducting outreach patrols to villages, and collecting and delivering drugs. The other reform is the delivery of medical supply kits directly to health facilities through donors. This paper presents survey findings related to the health function grant reform only.

The PEPE health surveys focused on how health facilities receive financial support to deliver basic services. Data were gathered on all revenue raised at the health facility through user fees, funding received through budgets or as direct payments. Administered support delivered to health facilities in the form of materials and operational activities was also considered.

These findings are timely and relevant to informing the implementation of PNG's free primary health care policy, which came into effect on 24 February, 2014. Providing free primary health care across PNG is a key policy of the PNG Government. While it has never been legal for health facilities to charge fees, the practice is common across most of the country. The central premise of this new policy is to offset with subsidy payments the patient fees that are normally collected by health facilities.

Survey findings are used to discuss the importance of health facilities having access to finances to deliver effective services. Since user fees are an important source of revenue, finding a way to allocate and distribute subsidy payments to health facilities to offset these fees will be critical to the success of the free primary health care policy.

Survey findings – user fees raised by health facilities

The survey confirmed that the majority of health facilities charge patients fees for consultations and drugs. However, the various types of services offered and drugs administered usually result in different costs. Therefore, total fees raised by health facilities are widely variable and practices are not uniformly implemented, as some provinces already provide free health services.

Church-run health facilities are more likely to charge for services provided and do so at a higher rate than state-run facilities. Most health facilities charge for a general consultation, but this attracts a low fee. Specific services like maternal care, disease testing and treatment for injuries (such as those resulting from tribal fights and domestic violence) are more likely to be provided for free, but those who do charge ask a higher fee. Patients are just as likely to be charged for drugs as they are for a general consultation. Charging for drugs and medical supplies administered to a patient shows that pricing differences may vary depending on available supply.

There are large variations in total user fees collected, as some provinces do not allow health clinics to charge fees, while others actively encourage the practice. For instance, the average health facility in East New Britain raises more than K1000 a month in user fees, whereas health facilities in Gulf Province raise just K59 a month, on average.

Spending fees on delivering services and the consequences of non-payment

User fees raised by health facilities are important for funding basic services. Survey results show that user fees are one of the most prominent funding sources for meeting the costs of essential operational activities. User fees are important for health facilities to pay for expenses associated with collecting and delivering drugs, maintaining utilities, and paying for fuel and casual wages.

Patients that cannot afford fees are still able to receive treatment in most circumstances. Survey data indicates that despite most health facilities charging fees, about half of the patients presenting still received free treatment. Fees are usually exempted or patients are allowed to pay according to their ability or make an in-kind contribution. However, findings from the user survey show some disagreement in regard to refusing treatment to patients that cannot afford to pay fees.

Survey data indicates that user fees are an essential source of revenue for health facilities. However, as the law has always stated, fees should not be charged for services provided. Instead, health facilities are meant to be adequately funded through government or church health providers to meet basic service delivery requirements.

Survey findings – health facility funding

There are widespread disparities in how health facilities are financed across provinces, particularly between state and church-run providers. These include funding received through an annual budget process, a direct payment into a bank account or as administered support from a funding provider for goods and/or services. Health facilities receive one, a combination or none of these types of support to deliver primary health services in PNG.

Funding received through budgets

Most health facilities did not submit budgets or plans in anticipation of receiving funding. Survey findings reveal that budget preparation varies significantly: from 85 percent in East New Britain to only 10 percent in Enga Province. However, less than half of the health facilities that submitted budgets received any funding as a result of doing so, and the average value of the funding received was much lower than budgeted for.

Funding received from budgets varies most significantly between church and state funding providers. While a higher percentage of health facilities submitted budgets to the provincial and district health offices, the value of the funding received was low. In contrast, the value of budgets submitted to church agencies was much higher and most health facilities received funding as a result.

Funding received through direct payments

Nine health facilities out of the 142 sampled received direct funding without preparing a budget. Interestingly, the average funding received through this mechanism was more than double the average of that received by health facilities that prepared budgets. Seven of these health facilities were church-run and two were state-run. However, both the state-run facilities did not receive funding from government grants. Of the church-run health facilities to receive direct funding, there was a mix of different denominations of church agencies that provide health services in PNG.

Survey findings on health facilities that receive their own funding to deliver services, either from budgets or as direct payments, are underwhelming. There have been large increases in national budget allocations intended to assist facilities with their basic operations. However, much of this funding is not directed to the facility-level to be managed by the health workers who deliver services.

Survey findings – administered support from funding providers

Health facilities receive support to deliver services through administered/in-kind assistance from funding providers. This can be in the form of purchasing supplies or materials on behalf of health clinics. More state-run health facilities received this kind of assistance from their funding providers than church-run facilities. Medical

equipment and building materials were the most common goods purchased by funding providers.

Most commonly, health facilities surveyed claimed to receive support for conducting health activities and programs from their funding providers. Close to half of the health facilities requested this support, whereas the rest claim that programs and activities were delivered at the discretion of the funding provider. Satisfaction levels with administered activity and program-level support vary significantly across provinces. However, the majority of health facilities receiving this administered support believe it helps them to conduct outreach patrols, and to a lesser extent in the collection and delivery of medical supplies. While administered support is the most common form of assistance, it does not mean the support provided is consistent or sufficient to meet minimum standards.

Implications of findings for PNG's free primary health care policy

Will free health care policy subsidies offset the user fees raised?

Based on estimates from survey data, total user fees raised by health facilities are greater than the subsidy allocations made through the free primary health care policy. User fees are the most widely collected and reliable source of revenue for health facilities. There are disparities in the amount collected in provinces that actively encourage fees and those that had a free health care policy in place before 2014. This raises the issue of how funding to subsidise user fees will be allocated across provinces. The large disparities in fees collected indicate that some provinces will receive too much funding, while others will not receive enough.

Allocating and distributing subsidies to all health facilities

There are three options for how the free primary health care policy can allocate subsidy payments across provinces, but all have significant drawbacks. First, subsidy payments could be allocated evenly across provinces. However, some facilities would receive more or less funding based on previous charges, and this could impact negatively on service provision. Second, average user fees raised prior to the policy could be considered in determining allocations, but this would disadvantage provinces that complied with the policy before 2014. Third, subsidy payments could be allocated on a needs basis using cost of service and internal revenue estimates developed by the National Economic and Fiscal Commission. Yet this approach would not be based on previous fees charged and provinces that use fees to deliver services would be disadvantaged.

The free primary health care policy also needs to consider how funding would get to health facilities and the relative costs included, especially for remote aid posts. There will be substantial costs associated with distributing subsidy payments to health facilities. Costs of accessing financial services vary greatly among provinces, as each face their own challenges in reliably accessing financial services.

Financing schools and health facilities is not the same

Health facilities are unlikely to be able to absorb the same amount of funding as schools since they have different management structures. Schools are much better positioned to manage higher levels of funding through established governance mechanisms, including a Board of Management (BOM). BOMs play a central role in decision-making and managing the funding received by schools through the tuition fee-free policy, which provides large subsidy payments. Most health facilities do not have the same structure to effectively administer higher levels of funding. However, there are still lessons for the health sector to learn in terms of effectively implementing and managing subsidy payments.

Introduction

Providing free primary health care across Papua New Guinea has been a key policy for the health sector since the O'Neill–Dion Government took office in 2012. The Prime Minister has made reference to his government's aspirations of 'saving mothers the one and two kina' that it can cost them and their children to visit health facilities across the country (EMTV 2013). Aspiring to provide free health services is attractive for politicians, as it resonates well with the electorate. However, implementation of the policy has been slower than hoped and may have broader implications for the operation of the health system.

The introduction of a 'free' health care policy can be perplexing in the PNG context, considering primary health care services should already be provided free of charge (WHO 2012; NDoH 2010). Rather than enforcing existing laws and policies, the central premise of the new policy is to offset fees normally collected by health facilities by providing subsidy payments from the National Department of Health (NDoH). While such an arrangement may seem sound in theory, the PNG Government has long struggled to find practical solutions for funding health facilities to deliver services. The free health policy only came into existence on 24 February, 2014, and there are already some fundamental questions about how it will be successfully implemented: whether subsidised funding will be enough to offset the user fees raised and how payments will be distributed to every health facility in the country are key concerns. While the intention of the new policy is to improve access to services, its execution could have the effect of weakening rather than strengthening the health system. Implementation arrangements need to be carefully considered, because a reliable alternative funding source to user fees for financing health facility operations is not currently available.

Driven by strong economic growth over the last decade, the PNG government has significantly increased funding for the health sector. However, there is little evidence to suggest that further funding has translated into better health services. Previous research into PNG's health system has suggested that many factors contribute to the poor delivery of health services. These include, but are not limited to, bottlenecks in the financing system and a lack of health workers, critical infrastructure and medical supplies (World Bank 2013; WHO 2012; Thomason et al. 2009; PLLSMA 2009). Indeed, the key priority and catchphrase of PNG's National Health Plan (2010–2020) is 'back to basics', in terms of strengthening the foundations of the health system (NDoH 2010). Official output indicators collected through PNG's National Health Information System (NHIS) do not show signs of significant improvement, which also suggests that more funding may not be translating into improved health services (NDoH SPAR 2013). This raises important questions about why increased investment in PNG's health sector has not converted into better health service delivery. In a context of even greater funding with each passing budget, particularly 2013 and 2014, as well as a commitment to a free health policy, does future investment risk yielding similar outcomes?

To date, there has been a limited amount of independent research that explores how health facilities in PNG receive funding, in what form and how it is used to deliver services. The purpose of this paper is to examine results from the Promoting Effective Public Expenditure (PEPE) project, which conducted health expenditure tracking and facility surveys across PNG in 2012. It presents evidence from survey data, collected by teams of researchers that visited 142 health facilities across eight provinces representing each region of PNG, and which included provincial and district health officials. These surveys gathered data on the functioning of the whole health system, including health workers, infrastructure and drug availability. This paper focuses specifically on health financing results.

The PNG government's health function grant was designed to support the core operations of health facilities and was one of two expenditure reforms tracked through the health surveys. The reform was based on PNG's National Economic and Fiscal Commission's Cost of Services Study (2005), which alerted government and donors to chronic underfunding of health services. In response, health function grants, specifically targeting essential health facility operations, have increased significantly since 2009 (PNG Treasury 2013). They include funding for the operation of health facilities, such as maintenance, conducting outreach patrols to villages, and drug collection and delivery. Funding has increased more significantly in poorer provinces with less internal revenue. They were deemed to require a greater share of national grants to bridge the gap between their cost of service estimates and available funding. The PEPE survey was principally concerned with whether these recent increases in health funding had been accessed by health facilities and used to deliver better services.

Understanding how the health financing system currently works has important implications for the implementation of PNG's free primary health care policy. The central aim of the policy is to subsidise health facilities with direct payments in place of fees they would previously have collected from patients. Survey findings offer insights into how health facilities receive financial support by charging fees, preparing budgets and receiving administered support to deliver services. The other aspect of the new health policy relates to subsidised specialist health services. While this is an important part of the policy, it falls outside the scope of this paper as the PEPE project only surveyed primary health care facilities.

This paper outlines the key aspects of PNG's free primary health care policy and the incentives behind the government's determination to make it work. It then provides a brief outline of the method and approach to conducting the PEPE health survey. Financing data relevant to the free primary health care policy – in particular, user fees charged for services and drugs – are presented. In addition, the consequences for community members that are unable to afford fees are detailed. This includes the perspective of health workers and facility users from the community. The paper then explores how health facilities across PNG receive funding through the budget process, which differs between state and church agencies. This is followed by the survey results on the administered or in-kind support provided to health facilities from funding providers to help deliver services. Finally, survey results are used to

discuss the implications of the survey findings for PNG's free primary health care policy. This discussion focuses on three key points: the allocation of subsidy payments across provinces, the distribution of funds to the facility-level and the reasons why financing a health facility is different from financing a school.

1. PNG's free primary health care policy

1.1 Defining the concept

A major social reform aspiration of the PNG government has been to introduce free education and health services. The Prime Minister and other senior politicians have stated their commitment to providing free primary health services across the country (EMTV 2013; Gerewa 2014). Their incentives may be closely linked to the government's reform efforts in the education sector, which have pursued a tuition fee-free policy for all levels of schooling (elementary, primary, secondary and high schools). In 2012, all schools received significant increases in school subsidy payments in place of parents paying school fees. Similar to school fees charged to parents for sending their children to school, user fees can be charged by health facilities for patient visits.

While the Public Hospitals (Charges) Act (1972) provides set user fees for hospitals, all primary health services are supposed to be provided free of charge. However, charging fees for services has been common practice (Sweeney & Malau 2012; PLLSMA 2009). The reason given for this, based on anecdotal evidence, is that health facilities lack a reliable source of funding to deliver services, so must supplement their revenue by collecting fees. Some health facilities are also known to charge user fees as a way of moderating patient numbers. This is to ensure well-performing health facilities are not overwhelmed with patients from other areas. It is therefore common for health facilities to claim they are forced to charge fees to supplement a perceived lack of funding or as a way to manage patient visits.

Clearly defining primary health care services in PNG can be complicated. The different levels of health providers, stretching from a remote aid post to a large rural hospital, all offer services that could be considered 'primary care'. PNG has a system in place for identifying providers of primary health care (levels 1–6). The NDoH has defined primary health services as those offered by health centres, aid posts and outreach patrols. These services are defined as levels 1–3, which are considered to be primary care, and as of 2014 are no longer able to charge fees. To supplement this revenue source, an initial K20 million was allocated to support the implementation of the free primary health care and subsidised specialist services policy in 2014. Of this funding, K9 million was earmarked for hospitals, with state-run primary health care providers to receive K6 million and church-run facilities to receive K5 million. Whether the initial outlay of funding will be sufficient to compensate health facilities for the user fees they normally collect is unclear. These national funding allocations were not based on any real figures of what health facilities actually collect through fees.

1.2 Risks in implementing the policy

Striving to provide free health services across PNG sounds like a noble endeavour. It is politically attractive, as politicians can claim to be saving voters the cost of health services. Certainly the majority of PNG's rural population have limited access to cash, so this could be an important saving that may unlock barriers to accessing health services. However, introducing free primary health care simply means abolishing the user fees raised by health facilities. The national government will attempt to supplement this revenue through predetermined subsidy payments made to either provincial and district health offices or church agencies. Ensuring these payments reach the health workers that are providing front-line services will be complicated to implement.

There are also political risks to introducing a free health care policy that may not be well crafted and could face serious implementation challenges. The NDoH admitted that 'the policy announcement comes with uncertainties' during presentations at the launch of their policy in late 2013 (NDoH 2013). The policy directive comes from senior politicians and is a result of the Alotau Accord, which articulates the government's key priorities. Attempting to implement such an ambitious policy has the potential to produce unintended consequences, given inherent weaknesses in financing health facilities. The situation could be made worse if implementation is unrealistically pushed to satisfy political pressures and health facilities are left without sufficient funding to deliver services.

There is, however, also reason to believe that outlawing fees may lead to increased demand for services at well-established and high-performing health facilities. In general, rural hospitals and health centres are normally responsible for servicing a catchment population, which may include aid posts under their supervision. These health facilities should be staffed and resourced to cater for this population. However, high-performing health facilities that are easily accessible may be susceptible to visits from patients outside their catchment area. This can overstretch their resources. If all patients are treated for free, the ability of better performing facilities to cope with increased demand maybe too high and could compromise the quality of care provided. In addition, an increased demand for health services and the inability to charge for drugs may also lead to significant shortages of medical supplies. 'Gatekeeping' fees are an important regulator in preventing health facilities from becoming overwhelmed by patients (Dooley 2014). While charging gatekeeping fees discriminates against patients, it is important for ensuring the health facility works within its capacity, which varies based on context.

At the national-level, the only real strategy for ensuring the success of the policy is allocating subsidy payments and continued advocacy. The real test of whether the policy works will depend on the implementation capacity of the provinces and the church agencies. In terms of monitoring, NDoH officials stated at the launch of the free health care policy that they expect to see positive trends in NHIS output data, especially in terms of patient visits (NDoH 2013). This assumes there will be a subsequent increase in demand for health services as a result of the policy and the

subsidy payments. While reaching such a conclusion seems straightforward, this may be over simplifying the matter. Several provinces already have a free health policy and there is little substantive evidence from provinces like Gulf and Sandaun to support the view that it generates higher demand.

These are just some of the preliminary challenges to implementing the free primary health care policy across PNG. The PEPE survey collected health financing data on user fees, funding raised through budgets and administered support that is relevant to the implementation of the policy.

2. The PEPE health expenditure tracking and facility surveys

2.1 Introduction to the PEPE survey

The PEPE project is a joint research initiative between PNG's National Research Institute (NRI) and the Development Policy Centre at the Australian National University (ANU). The overall purpose of the research is to analyse how PNG allocates its public money through the national budget, as well as the effectiveness of this expenditure in key service delivery sectors. PNG faces major challenges in converting resource revenues from its recent boom in mineral wealth into effective development outcomes. Expanding budgetary policy has led to record budgets and fiscal deficits, although translating increasing public expenditure into goods and services to benefit the population remains a significant challenge. In response to these challenges, and to help inform more effective allocations and better expenditure practices, the project conducted a targeted public expenditure tracking and facility survey focusing on schools and health facilities across PNG.

The PEPE survey had two major objectives. The first was to replicate key aspects of the Public Expenditure and Service Delivery (PESD) survey undertaken by NRI and the World Bank more than 10 years ago (World Bank 2004). PESD survey instruments were used as a basis for designing the PEPE surveys in order to use PESD survey data as a baseline to help assess progress or regress in important aspects of service delivery. However, three instruments were used for the PEPE health surveys (Officer in Charge, health worker and user), compared to just an OIC survey for the PESD, which was much less comprehensive. The second objective was to examine the impact of expenditure reforms introduced in recent years to improve education and health services at the local-level. Survey questions were designed to elicit information on the extent to which these reforms have improved service delivery standards. This allowed the research to examine how increased government revenues have translated into better conditions for schools and health facilities over the last decade.

Since the PEPE project was attempting to compare its findings to the 2002 PESD study, it needed to use the same sampling method to ensure some direct comparability. The PEPE survey attempted to revisit as many of the PESD schools and health facilities as possible, which meant that provinces and districts, as well as most of the location sites, were already selected for the project. Using the PESD sampling methodology, two provinces were purposely selected in each of PNG's four regions

to ensure the data collected could be nationally representative. For each province, three districts were selected at random, except for cases where provinces only had two districts. The sample included approximately 10 schools and paired them with health facilities in close proximity, chosen randomly in each district. When schools or health facilities were closed or inaccessible, replacements were randomly selected. The same approach as the PESD was taken in selecting health facilities close to schools, but for the PEPE survey a larger radius was used to increase the sample size. This meant that the PEPE survey attempted to visit the same schools and health facilities across 19 districts and eight provinces in each region: Southern region (Gulf, National Capital District (NCD)); Highlands region (Enga, Eastern Highlands); Momase region (West Sepik, Morobe); and Islands region (West New Britain, East New Britain).

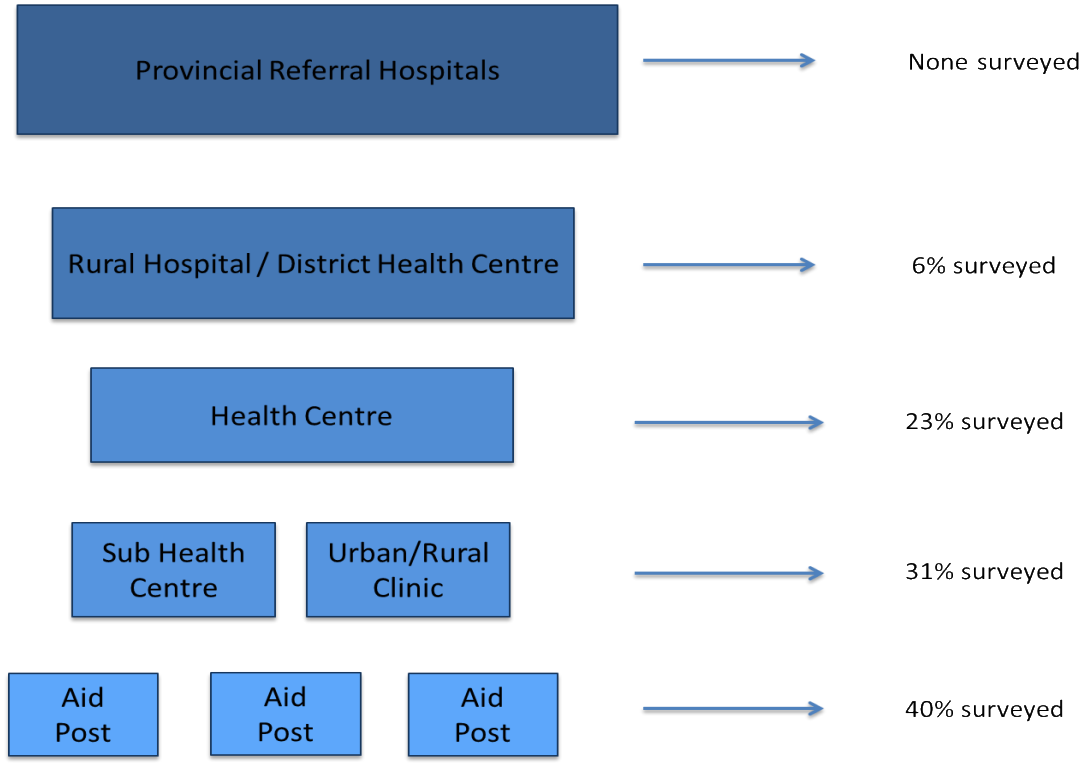
2.2 Characteristics of the survey and respondents

Surveying PNG health centres and aid posts – providers of primary health services

PEPE survey teams visited the complete range of health facilities that make up PNG's rural health network. Three separate surveys were conducted, which included the OIC of the clinic, another health worker at the same clinic (if available), as well as a user of the health facility from within the same community. In PNG, health facilities provide services based on patient needs and their capacity to deliver effective treatment through a referral based system. Aid posts are usually the first point of contact for patients, since they are normally located in rural and remote settings where the majority of PNG's population live. Figure 1 shows that aid posts accounted for 40 percent of the health facilities visited by survey teams. Aid posts are normally managed by a single Community Health Worker (CHW) and can only offer basic treatment. For cases requiring more comprehensive care, they normally refer patients to a health centre or sub-health centre, which are often responsible for managing clusters of aid posts within a defined population of villages or towns, also known as 'catchment areas'. A further 31 percent of health facilities surveyed came under the classification of sub-health centres or urban clinics in more heavily populated areas, and 23 percent were classified as health centres. Rural hospitals or district health centres (normally located in district town centres) represented 6 percent of the health facilities visited.

In presenting findings for this paper, aid posts have been separated from the various types of health centres, because they have more than a single health worker. This means 'health centre plus' represents 60 percent of the facilities surveyed and aid posts represent the other 40 percent. No provincial referral hospitals were surveyed because they represent secondary-level care in PNG's health system and operate somewhat separately from the rural health system.

Figure 1: Percentages of health facilities surveyed by the PEPE project



Agency type and gender of OICs for health facilities visited – state and church

There were slightly more state-run health facilities surveyed than church-run. Table 1 shows the number of health facilities surveyed in each province, which indicates that 59 percent were state-run, 39 percent were church-run and only two percent were privately-run. Due to the variation in the total number of health facilities visited across provinces, figures presented in this paper have been weighted by province to make the data more representative.

It is important to distinguish between state and church-run health facilities for several reasons. First, they are managed separately and have access to different funding sources; each with their own procedures of financial management and accountability. There is even further variation among the denominations of church-run agencies operational in PNG, such as Catholic, Seven Day Adventist and Lutheran facilities (to name a few). Second, health workers of state and church-run health facilities are managed separately, which means there are differences in pay and conditions of employment. Finally, community perspectives and expectations of state or church-run facilities can impact on community ownership of and support for the facility. Given these important differences, this paper distinguishes between state and church facilities in presenting key findings.

Table 1: Health facilities visited – Province and agency type (total)				
	Health facilities (all)	Health facilities (state)	Health facilities (church)	Health facilities (private)
By Province				
East New Britain	21	13	8	0
West New Britain	14	9	5	0
Morobe	20	10	8	2
Sandaun	18	12	6	0
Eastern Highlands	11	6	3	2
Enga	19	13	6	0
Gulf	23	9	14	0
National Capital District	16	13	2	1
ALL Average	**142**	**85**	**52**	**5**

The position of OIC of a health facility can carry significant influence in a village or town setting in PNG. Table 2 shows gender differences of the OICs surveyed: in total 43 percent were female. There was significant variation in the percentage of female OIC's surveyed across the provinces, ranging from only 19 percent in Eastern Highlands Province to 75 percent in NCD. In most provinces, however, there were a greater proportion of female OICs in church-run health facilities. In half of the provinces surveyed, more than 50 percent of church-run health facilities had a female OIC. In PNG's health sector, females occupy a higher proportion of management positions at the facility-level compared to other sectors.

Table 2: Health facility characteristics – gender of OIC (%)			
	OIC is female (all)	OIC is female (state)	OIC is female (church)
By Province			
East New Britain	67	44	80
West New Britain	62	56	75
Morobe	27	50	13
Sandaun	34	42	17
Eastern Highlands	19	17	33
Enga	48	23	50
Gulf	31	33	29
National Capital District	75	69	100
ALL Average	**43**	**45**	**42**

3. Survey findings on health financing – user fees

One of the primary purposes of the PEPE health survey was to examine the financial support received at the facility-level and how it is translated into the delivery of basic services. As an expenditure tracking survey, a key focus was to determine the total revenue available to health facilities from all potential funding sources. The survey identified three major sources of revenue or externally administered assistance for basic service delivery. This section of the paper presents survey data related to each of these sources separately: first, user fees charged by the health facilities for consultations and drugs; then data on the percentage of health facilities that receive funding from budgets, including amounts and their sources; and finally, administered assistance or the in-kind support that health facilities receive from

funding providers in the form of medical supplies, building materials and program-level support.

3.1 User fees charged by health facilities

Offering free consultations to patients – a 10 year comparison

It is common for PNG health facilities to charge fees for services provided to patients. To date, the evidence used to substantiate this claim has mainly come from anecdotal field reports and qualitative studies (PLLSMA 2009). There is very little data on the fees that primary health care facilities charge patients since this practice is against the law, though it is widespread. However, as the PESD survey asked health facilities if they charged user fees in 2002, the PEPE survey was able to make a comparison over a 10-year period; with the added advantage that questions on user fees were expanded greatly to cover the costs of the various consultations and drugs offered by health facilities.

The percentage of health facilities that offer free services to patients has increased across the 10-year comparison of directly matched health facilities from the PESD and PEPE surveys. To make such a comparison with the PESD health data, a free service is defined as a 'general consultation'. Table 3 shows the percentage of matching health facilities that offered free services in 2002 and 2012. The average number of health facilities from the two samples that offered a free service has increased from 30 percent in 2002 to 38 percent in 2012. However, provincial comparisons of free services provided across these same health facilities reveal a significant variation. Three-quarters of the health facilities surveyed in Gulf Province offered free consultations, whereas no facilities in the West New Britain Province reported treating patients free of charge.

Table 3 also demonstrates that matching health facilities surveyed across most provinces were as likely to offer a free service in 2002 as in 2012, with some notable exceptions. Over the 10-year period, health facilities in five of the eight provinces surveyed seem to have kept the same policy of offering free services. The other three provinces varied significantly, such as NCD, where only 10 percent of the health facilities offered patients free consultations in 2002, but 50 percent did so in 2012. The only province less likely to offer free services was Eastern Highlands, where about half of the health facilities surveyed offered a free service in 2002 yet only 14 percent did so in 2012. These findings indicate that despite national policies outlawing fees, provinces exercise their own delegation as to whether their state and church-run health facilities charge fees, which has significant implications for the revenue raised.

Table 3: 10-year comparison of matching health facilities offering free services		
	Matching facilities that offered free service in 2002	Matching facilities that offered free service in 2012
By Province		
East New Britain	16	16
West New Britain	0	0
Morobe	0	36
Sandaun	54	54
Eastern Highlands	48	14
Enga	50	50
Gulf	75	75
National Capital District	10	50
ALL Average	**30**	**38**
By Type		
Health Centre	26	33
Aid Post	34	43

Consultation fees for different services provided

Health facilities provide a range of services that attract different costs, including consultations that are more likely to be provided free of charge. The services provided to children free of charge change according to the treatment required. Simply understanding patient fees for a general consultation hides the variation in costs for specific services. Table 4 shows the variation in the percentage of facilities that charge children and adults for specific treatments. In the case of children, only 30 percent of health facilities charged for stitches, and the average price for those that charged was more than K7. Whereas 66 percent charged for general consultations, but the price was much lower at K1.15. In general, specific services are more likely to be offered free of charge, but those who do charge request a higher fee than a general consultation.

Health facilities that charge adults based on different treatments are also revealing in their variation. Table 4 also shows that 69 percent of health facilities offered maternal care services for free, but for those who did charge, the average cost was more than K10. The difference between church and state-run facilities is also worth noting. Three-quarters of state-run health facilities offered maternal care services for free, whereas only 61 percent of church-run facilities did so, while also charging a higher price on average. At the other end of the spectrum, services that health facilities are more likely to charge for also incur a higher price. One such example is treatment for injuries resulting from domestic violence, where about 60 percent of health facilities charged a fee. Again, church-run health facilities are more likely to charge than their state-run counterparts.

In addition to treatment of injuries due to domestic violence, more than half of the health facilities surveyed charged for treating patients involved in tribal fights. Church and state-run facilities show the largest variation in treating patients involved in tribal fights: church-run facilities are at least 20 percent more likely to charge patients. Anecdotal explanations from survey teams regarding this finding

reveal that several health facilities used high pricing as a disincentive for communities to engage in domestic violence and tribal fights. This explanation may make more sense for treatment of injuries related to tribal fights: the high cost associated with treatment of injuries related to domestic violence seems to punish the victim. However, a senior administrator from a large rural hospital in the highlands explained that women plead with the hospital to keep these costs high because the man, or his extended family, end up paying the fees.

Table 4: Fee free services and charges for specific treatments – children and adults

	Provide service free of charge (All)	Average cost if provided (All)	Provide service free of charge (State)	Average cost if provided (State)	Provide service free of charge (Church)	Average cost if provided (Church)
Common treatments provided at clinics						
Specific to children:						
General consultation	34	1.15	35	1.16	28	1.13
Immunisation	80	1.21	81	1.32	75	1.10
Disease testing	83	5.26	83	3.43	85	9.00
Stiches	70	7.14	69	7.74	72	6.50
Night in ward	70	8.03	75	7.63	63	8.79
Specific to adults:						
General consultation	31	1.62	31	1.65	24	1.59
Maternal care	69	10.43	76	8.38	61	11.68
Births	65	15.71	67	15.67	59	15.07
Night in ward	67	10.52	75	8.84	57	11.14
Domestic violence	37	23.50	40	21.50	29	26.01
Tribal fights	41	25.68	49	24.86	27	26.70

Fees for drugs and medical supplies

Another important component of revenue-raising for health facilities is charging for drugs administered to patients. The survey data indicates that about 60 percent of facilities reported charging patients for medication. This means that they are about as likely to charge for medication as they are for a general consultation. Similar to the differences the data revealed in costs for the types of patient visits, there were also significant variations found regarding which drugs are offered free of charge and how much they cost when a charge is applied.

Of the selected drugs and medical supplies included in the survey, a significant range is revealed in availability and the charges applied. Table 5 shows that 89 percent of health facilities offer condoms free of charge while only 37 percent provide baby books for free. In regard to more common drugs, like paracetamol, 49 percent of health facilities charge. The percentage of facilities that charge for amoxicillin (a common mid-spectrum antibiotic) is slightly higher, but the price of the drugs is roughly the same. However, where health facilities are willing to offer particular drugs for free, there are disparities between provinces. Using paracetamol as an example, about 90 percent of health facilities in Gulf Province offered it free of charge, whereas only 28 percent did so in Morobe Province. Similarly, for the new anti-malarial medication, Mala-Wan, the survey data indicate that 25 percent of

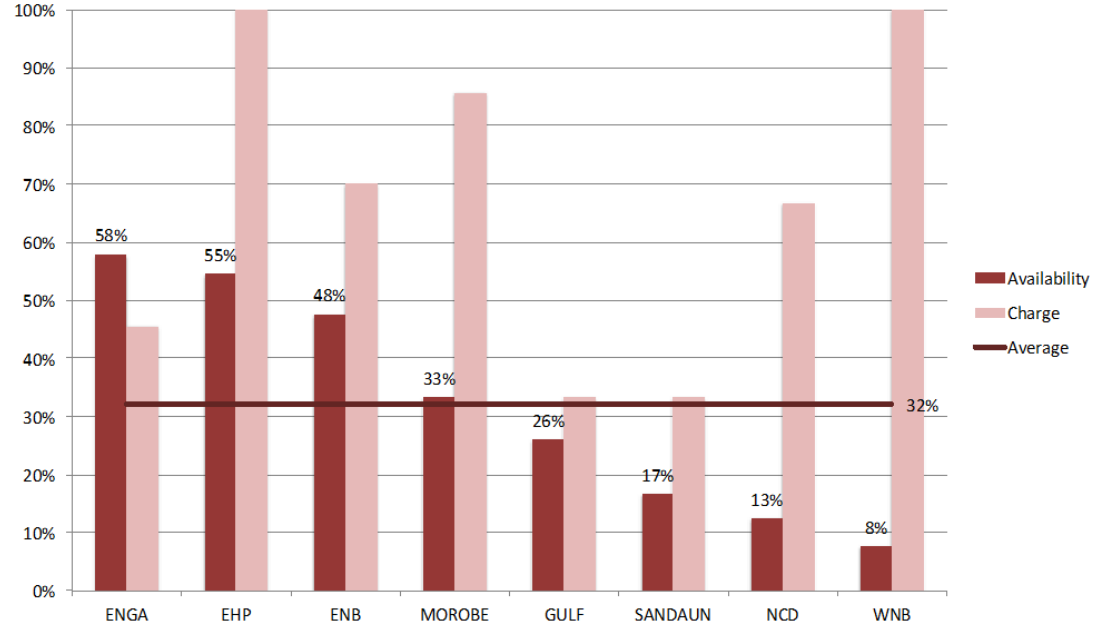
health facilities in the Eastern Highlands Province provided it for free, while it was offered for free by all health facilities in NCD. Charging different prices for different drugs has follow-on implications for the total amount of user fees raised by facilities.

Table 5: Charges for common drugs at health facilities – state and church

	% available at time of survey	Average cost if available	% provide free of charge	% State provides free of charge	% Church provides free of charge
Common drugs:					
Paracetamol	80	1.30	49	50	52
Amoxicillin	91	1.30	55	59	53
TB blister packs	37	1.46	69	81	57
Maternal and child health:					
Pregnancy tests	16	7.88	33	40	63
Baby books	35	2.4	37	49	18
Measles vaccine (HC+ only)	75	1.70	83	81	85
Ergometrine (HC+ only)	75	6.41	69	71	64
Condoms	82	1.21	89	94	85
Anti-malarial drugs:					
Fansidar	95	1.17	53	61	47
Choloquine	95	1.20	55	60	48
Mala-wan	50	1.42	51	48	55
Malaria RDT	45	1.42	63	58	58

The probability that health facilities will charge for a particular drug or medical supply may also be based on its availability. Table 5 shows that baby books and pregnancy tests are the two most common medical supplies that health facilities charge for, but they are also the least likely to be available. This indicates that some correlation could exist between health facilities that charge for drugs and medical supplies relative to supply. Figure 2 shows that while baby books are largely unavailable across most provinces, more health facilities indicated they are willing to charge patients for these books than are available. For example, in West New Britain Province, baby books were available at only 8 percent of health facilities surveyed, but all reported that they charge for the books. This indicates that supply, and presumably demand, could increase costs for certain drugs and medical supplies, which suggests that prices might fluctuate depending on availability.

Figure 2: Availability of baby books and percentage of health facilities that charge



Total fees raised by health facilities – consultations and drugs

User fees raised by health facilities in an average month can come from charging patients for consultations and drugs. Across the whole sample, Table 6 shows health facilities raise K484 in an average month, however; this average hides the huge variation across provinces. East New Britain health facilities collect more than K1000, while in Gulf Province they raise an average of only K59 in a month. The difference between user fees raised at health centres and aid posts is also significant. Health centres raise an average of K751 per month, whereas aid posts only raise an average of K209. The most extreme case is that of the East New Britain health centres, which raise an average of K1550 a month, yet the average for aid posts is just over K111 (the figures are similar for West New Britain). However, health centres and aid posts in the Eastern Highlands and Gulf Province raise similar amounts to each other.

Given that health facilities charge patients different amounts for the various consultations and drugs, it is not surprising that the fees raised vary so significantly. The explanation may be a combination of provincial and health facility policies, as well as the number of patients the facilities treat.

One of the most significant reasons for the differences in the average monthly user fees raised is that some provinces already have a free primary health care policy, while other provinces actively encourage facilities to charge fees. For instance, in East New Britain, health facilities are openly encouraged to charge fees, as long as they are spent on facility operations, whereas Gulf Province has maintained a free health care policy for some years. It is no surprise that East New Britain health facilities raise much more revenue from user fees than those in Gulf Province do. Another important consideration in raising fees is the ability of patients to pay. This means that the user fees raised depends on more than just average patient visits and pricing policies.

Table 6: User fees raised (Kina per month) across provinces, facility and agency type			
	Average user fees raised (All)	Average user fees raised (HC +)	Average user fees raised (Aid Posts)
By Province			
East New Britain	1020	1550	111
West New Britain	490	930	176
Morobe	575	967	182
Sandaun	130	239	36
Eastern Highlands	561	508	667
Enga	607	879	259
Gulf	59	53	66
National Capital District	447	447	-
ALL Average	**484**	**751**	**209**
By Agency			
State	452	758	132
Church	491	608	106

Having established the substantial differences in the revenue raised by health facilities across provinces, an important next question relates to how fees are spent. Survey data shows that 76 percent of health facilities keep records of the user fees they collect. This means that most keep account of the revenue collected from patients. While it is generally expected that fees will be spent on health facility operations, the priorities informing how health facilities spend user fees are not well understood and require further explanation. This was also explored by the PEPE health surveys.

3.2 Spending user fees to deliver services

The user fees raised by health facilities are important for funding basic operations. To date, health policymakers in PNG have had little evidence to draw on in understanding how health facilities spend the fees they collect. There is also limited information about the sources of financing available to health facilities for funding their core operational activities. To address this gap, the PEPE survey asked health facilities how they meet expenses for delivering key services. Also known as Minimum Priority Activities (MPAs), these core functions include operational expenses like outreach patrols, maintenance and the delivery of drugs, which are specifically funded through the health function grant. Other important activities, such as patient transfers and maintaining utilities (such as a water supply) were also included in the survey.

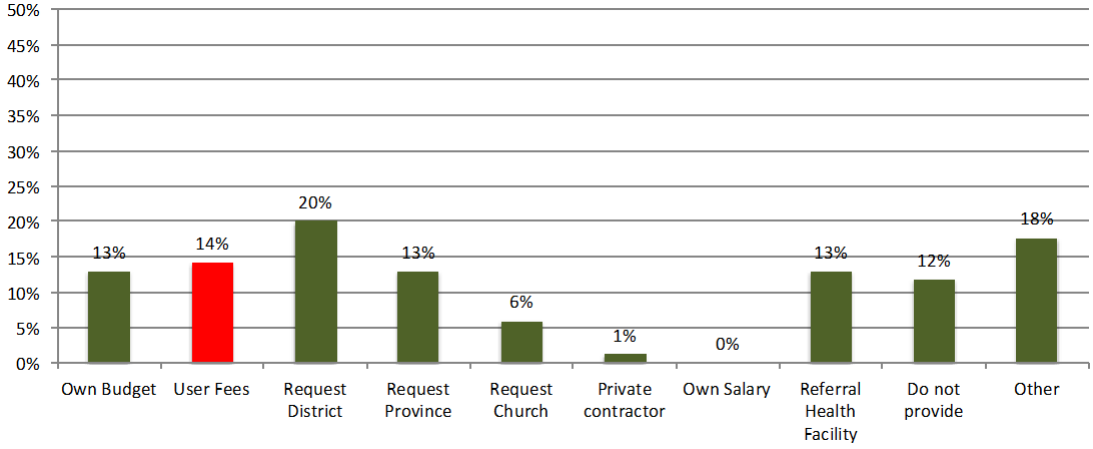
User fees were one of 10 common responses to survey questions about how health facilities meet the costs of delivering basic activities. The other responses included: paying for activities through their own budgets; requesting support from the district, province, church, private contractor or referral health facility; using their own (health worker's) salaries to meet expenses; not providing the service; and 'other'. While most of the costs should be covered through health function grants, these results show that user fees were perhaps the most prominent funding source for meeting these expenses.

How do health facilities meet expenses for delivering services?

Health outreach patrols

One of the most important functions of a health centre is to conduct health outreach patrols to villages that do not have immediate access to health services. These outreach clinics are normally classified as 'child and maternal health clinics', 'immunisation' or 'supervising' patrols. Importantly, aid posts are not usually required to carry out patrols, so responses to financing health patrols were generally from health centres. To conduct outreach patrols, the health centre requires financing to pay for the associated costs, which could include fuel for transport to the patrol site, the payment of per diems to health workers or even casual wages to health volunteers or porters to assist with carrying medical supplies. Figure 3 shows the variation in responses from health facilities: the most common response was requesting support to conduct an outreach patrol from the district health office, and the second most common response was user fees.

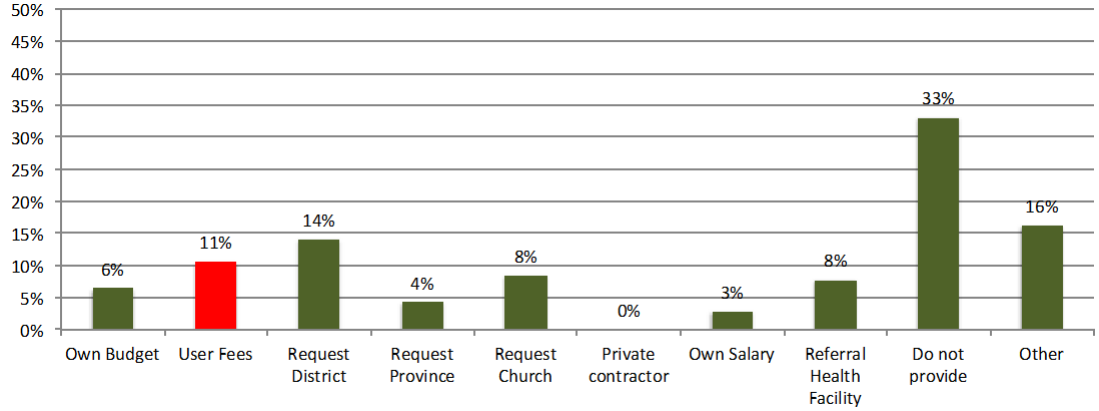
Figure 3: Health facilities normally meet expenses for conducting health outreach patrols through …



Maintenance of health facility and workers housing

Paying for basic maintenance of a health facility, as well as staff housing, is critical for an effectively functioning clinic. Figure 4 reveals the mixed results from the survey in response to questions of how expenses are met for this activity, which indicates that there is no single approach to financing maintenance costs. Perhaps unsurprisingly, user fees only accounted for 11 percent of responses. Funding the maintenance costs of infrastructure normally requires large payments. The most common response, even if relatively low when accounted for individually, was to request maintenance support from the health facility's funding provider. This could include the provincial, district or church health office. This is despite policy guidance stipulating that maintenance should be the responsibility of the health centre itself.

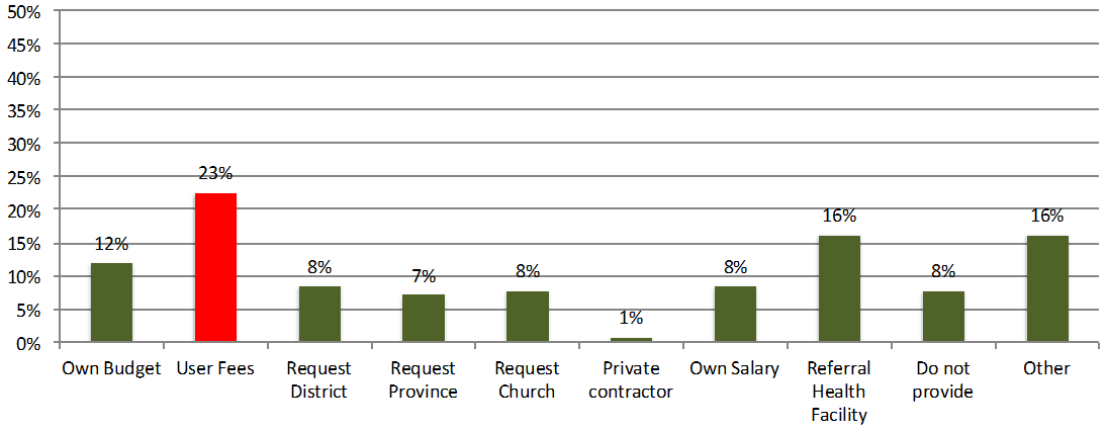
Figure 4: Health facilities normally meet expenses for conducting maintenance of health facility and housing through …



Collecting and delivering medical supplies

The distribution of drugs and medical supplies should also be funded through the health function grant. User fees are a particularly important funding source for collecting and delivering drugs. Figure 5 shows that user fees were the most common source for meeting the cost of conducting this activity, which accounted for 23 percent of responses. On a related point, the survey found that most health facilities ordered drugs based on needs through Area Medical Stores (AMS), but they also needed to fund the costs of collecting medical supplies. For a health centre, this can also mean delivering them to aid posts. Under current arrangements, it seems health facilities pay for this activity through user fees. The other way to receive drugs is through medical supply kits, which are supposed to be delivered to every health facility in PNG. This includes all aid posts, regardless of remoteness, since distribution costs are funded centrally.

Figure 5: Health facilities normally meet expenses for collecting and delivering drugs or other health supplies through …

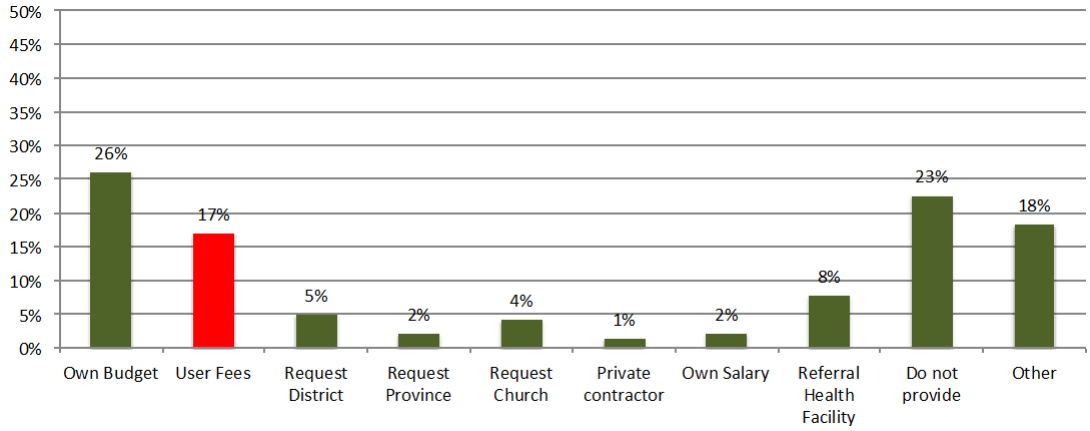


Patient transfer to referral health facility

Transferring patients to a referral health centre or hospital is another critical function that is often overlooked in terms of budgeting and funding for health facilities. The survey data indicates that meeting this expense is largely considered to

be the responsibility of the health facility. The most common response was either that the health facilities paid the costs of transfers through their own budget (26 percent) or from user fees they collected (17 percent), as shown in Figure 6. Almost a quarter of the facilities stated that they were unable to transfer sick patients to a referral health facility where they could receive more comprehensive care. Patients that need to pay their own travel costs are particularly relevant for rural health facilities. Longer distances often mean higher travel costs, and the financial burden may fall upon the patient's family. An important asset for transferring patients to a referral health facility is an ambulance. The survey found that only 25 percent of health facilities had good or adequate access to an ambulance, although in most provinces this figure was much lower for aid posts compared to health centres. This suggests that patient transfer is one essential function that needs urgent strengthening, particularly in rural areas with poorer access and higher transport services costs.

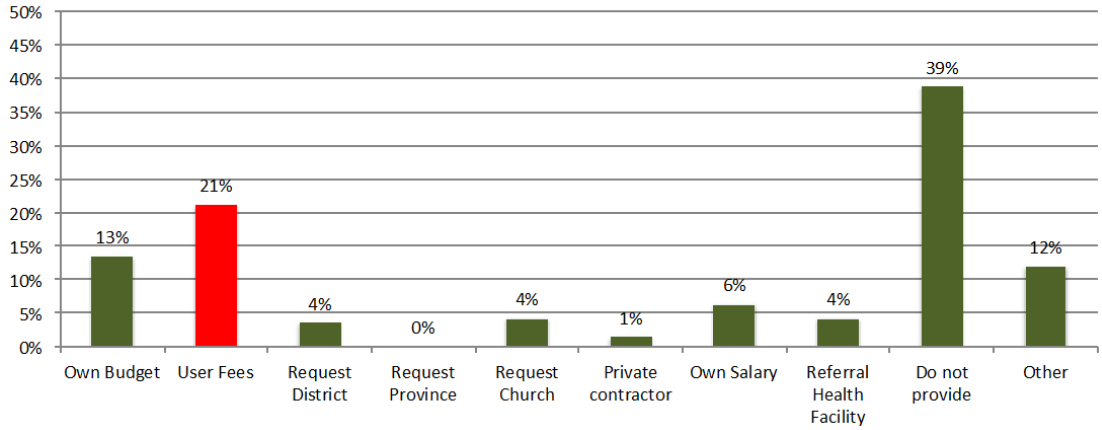
Figure 6: Health facilities normally meet expenses for patient transfers through …



Meeting expenses for fuel and casual wages

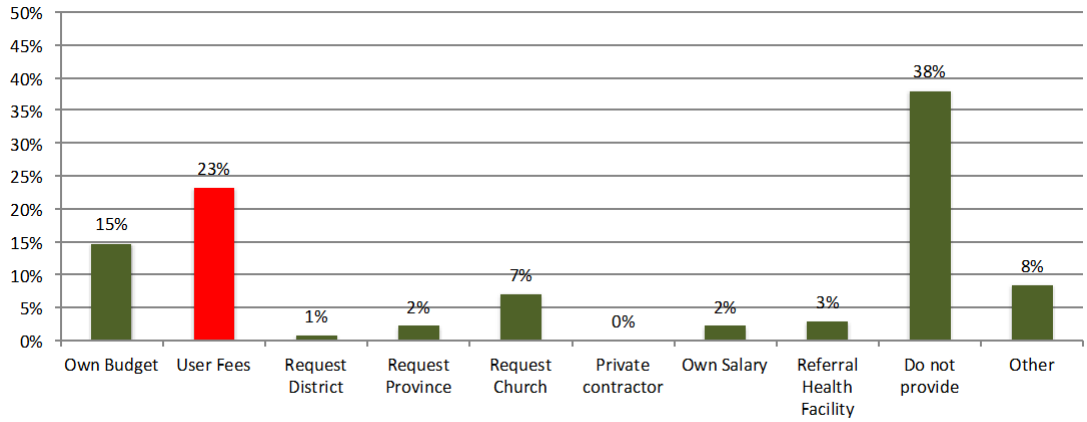
A function closely related to patient transfers is the need for health facilities to pay for fuel, which may be needed for an ambulance or a generator to power the health facility. Again, user fees are a prominent source of funding for meeting these expenses, accounting for 21 percent of responses as shown in Figure 7. A lower but important survey finding was that 6 percent of respondents said they used their own salaries to meet the cost of fuel. These results show that purchasing fuel often requires immediate access to cash, that it needs to be purchased at the facility-level and that it is essential in the delivery of basic services.

Figure 7: Health facilities normally meet expenses for fuel through …



Finally, the ability to pay casual staff is often overlooked, yet it can be important to the functioning of a health facility. This can include paying allowances to health volunteers or porters to carry medicines on a patrol or cleaners and local gardeners to maintain a facility. Figure 8 shows meeting these costs through user fees accounted for almost a quarter of responses. Similar to meeting the costs for fuel, paying casual workers requires access to small amounts of cash. If user fees are a readily available funding source, they may be a sensible way to pay casual staff if regular funding is unavailable.

Figure 8: Health facilities normally meet expenses for casual staff through …



On the whole, the survey findings show that user fees are one funding source, if not the most prominent, that health facilities use to carry out basic operations. This includes collecting and delivering drugs and medical supplies, as well as paying for fuel and casual wages. Larger and more expensive activities (like carrying out maintenance of the facility and/or staff housing and conducting outreach patrols) are less likely to be paid from user fees, but fees are still an important funding source for many health facilities. Considering that user fees are a significant component of the revenue base of health facilities and are used to fund basic services, it is important to understand how health facilities enforce fee payment and deal with the matter of affordability.

3.3 Implications for patients that cannot afford user fees

Affordability, including fees for both consultations and drugs, varied significantly across the provinces surveyed. Table 7 shows the affordability of user fees for patients from the perspective of the OIC. Only about half believed that all or most patients could afford the fees charged. However, while close to 70 percent of OIC's in NCD believed fees were affordable, only just over 30 percent in East New Britain felt this to be the case. Of course, differences in perceived affordability can be explained by factors beyond fees, such as average income levels, which were not explored in the PEPE survey.

The percentage of patients that received free treatment from health facilities was generally high across the provinces surveyed. The reason for this is that in almost all circumstances patients that could not pay fees were rarely refused treatment. Table 7 shows the implications for patients that could not afford user fees. Based on OIC responses, 37 percent said the fee was exempted, while a further 35 percent said that the patient was asked to pay according to their ability and 19 percent said the patient was able to pay in-kind. Only one percent of OICs said that the patient was refused treatment. However, this is the perspective of the OIC, as opposed to a user of the service from the same community.

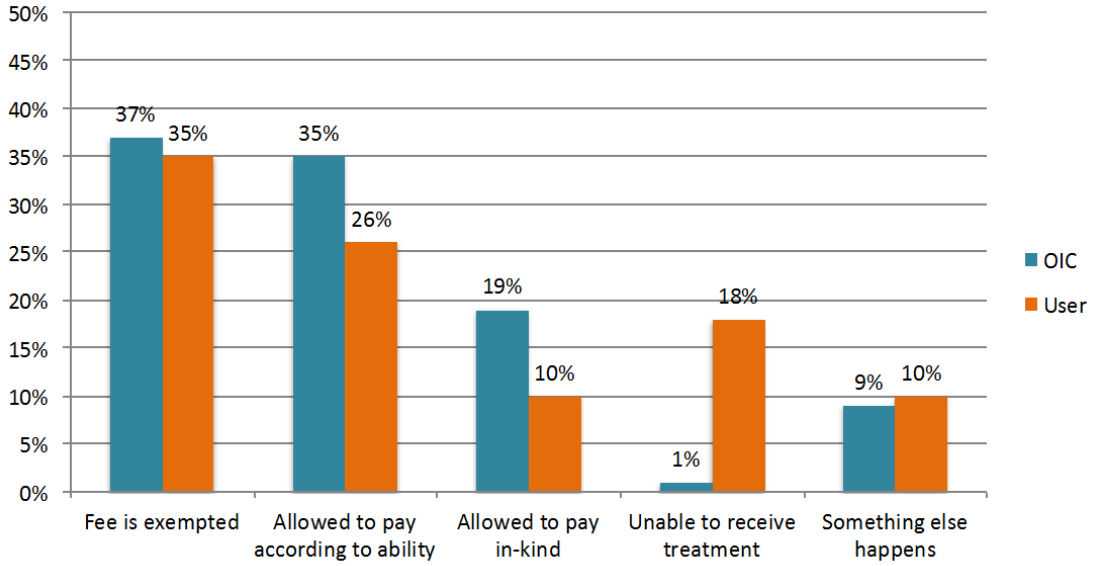
Table 7: Patient affordability of user fees and consequences for the patient

	% patients that can afford fees (All/Most)	% families receive free treatment	Consequences for patients unable to afford fee:			
			Exempted	Pay according to ability	Pay in-kind	Refused treatment
By Province						
East New Britain	62	22	48	52	0	0
West New Britain	29	28	29	29	29	0
Morobe	44	44	56	22	22	0
Sandaun	39	68	44	33	6	0
Eastern Highlands	40	04	27	55	9	9
Enga	47	67	21	68	5	0
Gulf	45	82	48	13	17	0
National Capital District	69	42	82	6	6	0
ALL Average	**46**	**41**	**37**	**35**	**19**	**1**
By Type						
Health Centre	52	32	45	39	7	2
Aid Post	39	50	32	32	29	0
By Agency						
State	39	46	46	31	14	2
Church	52	36	36	37	23	0

Findings from the user survey on the consequences of non-payment of fees show some variation from OIC responses, mainly in relation to refusal of treatment. Figure 9 compares responses from the OIC and user survey on the question of patients that cannot afford health services. Of community respondents, 18 percent reported that they did not receive treatment if they were unable to pay, compared to only one percent in the OIC survey. Perhaps such a response was to be expected, as OIC's

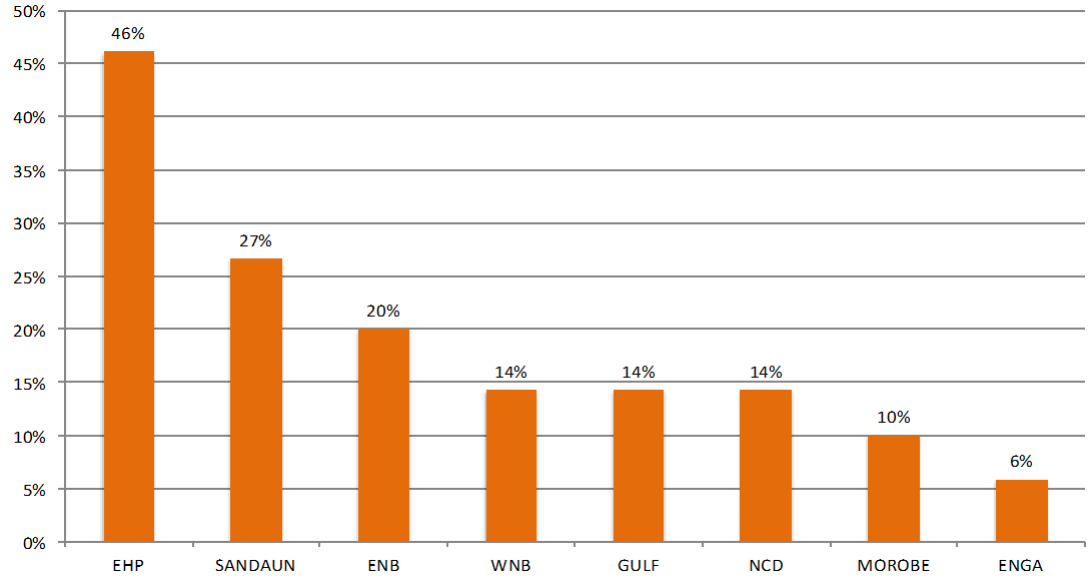
might be unlikely to admit that they refuse patients treatment. However, this is worth considering if the practice of refusing treatment is concentrated by agency type or province.

Figure 9: Consequences of patients unable to pay user fees: OIC vs. user perspectives



Patients that were refused treatment at health facilities differ more significantly based on the practices in particular provinces. Figure 10 shows the percentage of users in each province that were unable to receive treatment for failing to pay fees. The Eastern Highlands Province had by far the highest proportion of users of this kind; accounting for close to half of the responses. The next highest proportion was in Sandaun, with 27 percent. Numbers for other provinces levelled off at 20 percent and under. This indicates that health facilities may have substantial discretion in formulating their own policies and plans for delivering services.

Figure 10: Percentage of patients unable to receive treatment for failing to pay user fees at health facility: community perspectives across provinces



PEPE survey data indicates that user fees are an essential source of revenue for health facilities. While it is clear that user fees are important for funding basic operations, officially, facilities should not be charging fees for services and medicines. Health facilities should be adequately funded through government channels and funding should be delivered through state and church-run agencies. This funding should be provided through provincial governments, sourced through a combination of their own internal revenue or national function grants, which are administered at the provincial, district and local-level for state-run health facilities.

Alternatively, funding through government and donor grants can be made available to the Churches Medical Council / Christian Health Services, which support the various denominations of church health agencies. While funding provided through budgets for financing primary health services has increased significantly in recent years, its relative effectiveness has not been well monitored and was part of the motivation for conducting the PEPE survey.

4. Survey findings on health financing – funding and budgets

There are various approaches to funding health facilities to deliver primary health services in PNG: cash payment directly into a bank account; funding through an annual budget process; or an administered or in-kind contribution from a funding provider. No matter how it is provided, effective operational support for health facilities to deliver services is crucial. The focus of this section of the paper is on how funding is provided at the facility-level. It considers health facility budgets – drafted for a range of different funding providers – and whether financial support was received as a result. It then presents the results of the administered support that health facilities receive from funding providers, which often takes the form of in-kind goods and services, as opposed to direct funding. The results point to widespread differences in how health facilities are financed across provinces, as well as state and

church-run facilities, which has significant implications for the provision of health services.

4.1 Budgeting: sources of funding for health facilities

Since 2009, there have been significant increases in funding for health facility operations through the health function grant. As a result, facility-level budgeting, particularly for health centres, has been widely promoted in many provinces, so that more of this funding is spent on delivering health services. However, the survey data reveals that most health facilities did not submit budgets or any plans in anticipation of receiving funding the following year.

Preparing and submitting budgets to funding providers

The percentage of health facilities that prepared any kind of budget with an expectation of receiving funding in 2012 was lower than expected. Table 8 shows that 34 percent of the health facilities surveyed prepared a budget or plan, but these results are not consistent across the provinces. In East New Britain, 80 percent of health facilities prepared budgets, while in Enga Province the figure was just over 10 percent. East New Britain was the only province where more than 50 percent of health facilities submitted a budget or plan. These results were lower than expected, considering that facility-level budgeting has been strongly encouraged at national and provincial levels following increases in health function grants.

One possible explanation for low rates of facility-level budgeting could be that health centres are much more likely to complete budgets and plans than aid posts. The expected disparity in budgeting, based on facility type, relates to health centres operating independently from their referral health facility, which is often a hospital. On the other hand, an aid post is normally considered to be an extension of a health centre's operations. However, the variation in budgeting is not as high as expected: only 41 percent of health centres completed budgets, while for aid posts the figure was 25 percent. Less than 50 percent of health centres formulating some kind of budget or plan is very low. Since funding for delivering core health services is the focus of the health function grant, budgeting in anticipation of receiving funding should be higher.

Completing a budget or plan represents only the first component of the budget process: actually receiving funding is another, more complicated matter. There are a series of steps that health facilities should follow to move from preparing a budget to receiving funding. The first step is to submit a budget to the funding provider. The survey found at least eight different funding bodies where health facilities submitted budgets, as shown in Table 8. The most common funding body to receive budgets was the district health office, which accounted for 8 percent of responses, followed by a mix of funding providers. While health facilities prepare budgets, it does not necessarily mean they are submitted to the funding provider. Table 8 shows that only 25 percent of all facilities surveyed submitted budgets, which is a lower number than those that prepared them. Once health facilities submit budgets, there is normally an approval process where feedback or confirmation is provided, however;

only 19 percent of facilities received some sort of approval. These findings show that there is no single provider or process for where and how health facilities receive funding.

Table 8: Budget submissions and funding received from budgets in 2012

	Budget preparation		Budget submission		Budget received	
	% facilities prepared budget	% budget submitted to funder	% budgets were approved	% received funding from budget	Avg. value budget submitted	Avg. value budget received
By Province						
East New Britain	85	62	48	33	61,000	15,467
West New Britain	38	29	7	7	74,000	123,683*
Morobe	32	30	25	20	102,408	92,195
Sandaun	33	11	11	6	10,000	1,666
Eastern Highlands	38	27	18	18	6,867	5,942
Enga	11	11	11	0	82,500	0
Gulf	18	18	17	9	137,667	53,666
NCD	14	13	6	0	37,500	0
ALL Average	**34**	**25**	**19**	**12**	**63,771**	**31,645**
By Type						
Health Centre	41	31	24	16	87,067	44,003
Aid Post	25	18	12	5	8,706	2,434
By Agency						
State	33	22	18	11	45,467	9,567
Church	35	29	19	12	107,500	77,254

* Higher value of budget received in West New Britain is due to a health facility receiving much more funding than expected

Funding received from budgets submitted

The average value of the budgets submitted varies significantly across provinces and funding providers. Table 8 shows that the average value of budgets submitted for funding for 2012 was K63,771. The value of budgets submitted in Gulf Province was more than double the overall average, whereas the value of budgets submitted in the Eastern Highlands was less than K10,000. It is important to note that some provincial variation could be explained by the differences between the budget values of health centres and aid posts. Health centre budgets are K87,067 on average, while the average value of aid post budgets are K8,706. Table 9 shows much higher budgets submitted to church agencies as opposed to any other funding provider. The average budget submitted to the district health office is K55,730, while budgets submitted to Church health agencies is almost three times higher at K155,285. The value of budget submissions across provinces and funding providers demonstrates a lack of a common process in access to funding.

The final stage of the budgeting process is receiving funding from submitted budgets. As the health surveys were mainly conducted from mid-November to mid-December, health facilities should have received their budgeted funding for 2012 at the time the survey was run (the PNG financial year follows the calendar year). There were, however, a significant proportion of health facilities that had not received any funding from their budgets at the time of the survey. Table 9 shows that only 12

percent of all health facilities surveyed had received funding from budgets. As expected, the value of the funding that had been received was much lower than the budgets submitted, since many health facilities had received no funding at all for their budgets. The average funding received was K31,645, which is about half the average value of the budgets submitted.

Even for a relatively well-performing province like East New Britain, while 85 percent of its health facilities completed budgets, only 33 percent received funding. While the average value of the budget submissions in East New Britain is K61,000, funding received from the submitted budgets was only K15,467. A comparison of the value of budget submissions and funding received as a result is underwhelming and leads to questions regarding what incentives health facilities have to prepare budgets at all.

Funding received from submitted budgets also varies significantly between church and state funding providers. Table 9 shows the average value of budgets submitted and funding received at the provincial, district and local-level government (LLG) health offices. These values are much lower than for church agencies, especially in terms of funding received. The average church agency budgets were much higher at K155,285, and more than 70 percent of facilities that submitted budgets received some funding, with an average value of K132,300. This suggests that church-run health facilities in the PEPE sample perform better than their state-run counterparts in terms of receiving funding from submitted budgets.

Table 9: Budget submissions and funding received by funding provider

	% budgets submitted	% budgets approved	Avg. total value of budget (K)	Avg. funding received of budget (K)	Month first funds received
By Funding Provider					
district health office	8	5	55,730	22,291	May
Provincial Health Office	4	2	59,250	11,000	May
LLG Health Officer	4	4	34,571	21,500	June
Church Agency Office	4	4	155,285	132,300	-
Local Politician	3	<1	10,000	0	April
Donor or NGO	2	<1	13,770	13,770	-
Referral Health Facility	1	<1	5000	0	May
Other	6	3	30,340	121,275	May

4.2 Funding received without preparing budgets

While less common, some health facilities receive funding without preparing a budget or having a plan to spend it. Fewer than eight percent of health facilities surveyed claimed to receive funding this way, although further investigation of this small sub-sample is useful to ascertain commonalities. Table 10 shows the nine health facilities that received direct funding without preparing a budget. The average funding received was more than K71,000, which is more than double the average of the health facilities that prepared a budget. However, it is important to note that

there is a significant range of values, stretching from K342,000 at a large rural hospital in Morobe to K1,200 at a small aid post in Gulf Province.

The sample shows commonalities among these nice facilities in agency type, as opposed to other characteristics: seven of the facilities are church as opposed to state-run. Importantly, the two state-run health facilities did not get their funding from government grants. One state-run aid post in Morobe received K15,000 from a 'German health partnership', while the other urban clinic in NCD received funding through the PNG Sustainable Development Program. This means that of the two state-run health facilities listed in this category, none of them received direct government funding from the national, provincial or LLG budgets.

Of the church-run facilities, there are no clear trends in terms of the denominations of church agencies that provided direct funding, or in terms of the funding source. For example, a health centre in Morobe reportedly received K37,000 from the District Services Improvement Program (DSIP) and the survey indicates that this was for recurrent spending, which breaks away from the notion that all DSIP expenditure is for development/capital projects.

Table 10: Health facilities that received direct funding without preparing a budget

Province	Agency Type	Facility Type	Funding Provider	Amount received
Morobe	Lutheran	Rural Hospital	Lutheran health services	342000
Morobe	Government	Aid Post	German health partnership	15000
Morobe	Lutheran	Aid Post	Local-level Government	20000
Gulf	Other religious	Rural Hospital	Tel investment – Oilsearch Ltd	128,000
Gulf	Catholic	Aid Post	Catholic Health Services	1200
East New Britain	United	SHC	United Church – Operation grant	10000
Sandaun	Other religious	Health Centre	DSIP	37000
Enga	Catholic	Health Centre	HIV/AIDS NGO	30000
NCD	Government	Urban Clinic	PNG Sustainable Development Program	60000

Survey findings on funding received by health facilities to deliver services, either from budgets or as direct payments, are underwhelming. Large increases in national budget allocations intended to assist facilities with their basic operations do not seem to be directed to the facility-level to be managed by health workers. There could be two explanations for this. The first may be symptomatic of a poorly performing financial management system: funding providers may intend to finance health facilities, but blockages in the process may mean they do not receive the funding. The second explanation may involve perceptions that health facilities lack the capacity to manage their own funding effectively. Such a decision could be entirely rational when considering that the OIC of most facilities is usually a clinical officer as opposed to a financial and administrative manager. In addition, PNG has a shortage of qualified health workers, so provincial and district health officials, both church and state, may see financial management as their responsibility. Such an approach could also be defined as 'administered support' from funding providers for health facilities to deliver services.

5. Survey findings on health financing – administered support

5.1 Purchasing materials on behalf of health facilities

While the majority of health facilities, both church and state, do not receive direct funding through budgets or direct payments, another way they may receive support to deliver services is through administered assistance.

Table 11 shows that 36 percent of health facilities reported that funding providers purchase supplies or materials on their behalf. There is, however, a significant range across this data. NCD reported that 56 percent of its facilities received administered supplies or materials from funding providers, while Eastern Highlands reported only 22 percent. In a contrast to previous findings, slightly more state-run health facilities than church-run facilities received this kind of assistance from their funding providers. These findings show that a higher percentage of health facilities received purchased goods and materials from funding providers than funding through their own budgets and plans.

Health facilities were also asked about the types of goods received from funding providers. Table 11 shows results for three common supplies: building materials, medical equipment and fuel for health facilities to conduct their operations. Medical equipment and building materials were the most common supplies, accounting for 13 percent of responses each, whereas fuel purchased was much lower. Of the health facilities that reported that funding providers purchased materials and supplies on their behalf, more than half were willing to provide estimates of the value of goods received. While the average was just under K40,000, church agencies provided a higher estimate of purchased goods on the whole, at more than K78,000, whereas state-facility estimates were much lower at just over K20,000. Keeping in mind the inherent limitations of asking for estimated values, it is revealing that the estimated value of items received is still higher than the funding amounts that health facilities received from budgets.

Table 11: Funding providers purchased supplies or materials for the health facility in 2012 (% of facilities)

	Supplies/ materials purchased	Building materials purchased	Medical equipment purchased	Fuel Purchased	Estimated value of items received
By Province					
East New Britain	30	5	24	10	45,250
West New Britain	31	15	0	0	–*
Morobe	40	14	19	0	26,000
Sandaun	28	6	6	0	7,750
Eastern Highlands	22	27	9	9	7,900
Enga	32	5	16	0	50,000
Gulf	41	0	30	13	72,626
National Capital District	56	0	50	0	15,333
ALL Average	**35**	**13**	**13**	**3**	**39,493**
By Type					
Health Centre	41	14	17	4	51,637
Aid Post	26	12	9	2	6,100
By Agency					
State	36	10	14	3	20,200
Church	36	15	15	4	78,600

*OIC's in West New Britain did not provide estimated values of supplies or materials received.

5.2 Supporting health facilities to deliver health programs and activities

While both church and state funding providers purchase goods and materials on behalf of health facilities, they also provide administered support in the form of health activities and programs. This activity-level support could include assistance in conducting an immunisation patrol to villages, family planning and health promotion activities or even transferring sick patients from a health centre to a hospital. Table 12 shows that almost half of the health facilities surveyed claimed to receive support in this form from funding providers. Administered support for health programs are the most common way that funding providers support health facilities to deliver services.

Questions about the quality of the assistance provided were asked of health facilities that receive activity and program-based support. Table 12 shows that almost half of them requested this support, whereas the other half claimed that programs and activities were delivered at the discretion of their funding provider. This is an important distinction since it provides an insight into who makes decisions on priority services for health facilities to deliver. Across the provinces, 90 percent of health facilities in Morobe Province requested support, while only 20 percent in Enga Province and Gulf Province did. This finding suggests that provinces and their funding providers have their own policies for determining whether decision-making authority lies with the funding provider or the health facility.

Perspectives on the quality of administered support

The level of satisfaction that health facilities have with administered activity and program support varies significantly across provinces. Health facilities were asked to judge the quality of support provided as 'very satisfied', 'a little satisfied' or 'not satisfied'. Table 12 shows that almost half of the health facilities receiving administered support were very satisfied. At the other end of the spectrum, about a quarter of health facilities were not satisfied. These results may reflect the quality of the support provided or variations in the capacity of funding providers to support health facilities to deliver services.

A comparison across agency and facility type, as well as provinces surveyed, reveals differences in satisfaction levels. Table 12 shows that 55 percent of church agencies were very satisfied with administered support, which is higher than responses from state-run health facilities: only 39 percent. This finding could be explained by differences in human capacity between church health agencies and the provincial or district health office. It is common for provinces to have health staff with specialist technical skills, such as disease control officers, family planning and environmental health staff, based at both provincial and district levels. These officers are capable of conducting health programs in communities, which are usually the responsibility of health facilities. While it is common for provincial and district health officials to support both government and church-run health facilities, capabilities vary across provinces.

One of the better performing provinces in the survey, East New Britain, recorded the highest percentage of health facilities expressing dissatisfaction with the administered support provided. Since East New Britain has the highest percentage of facilities that prepare and submit budgets to funding providers, this could indicate a degree of autonomy in deciding on and carrying out their operations. Yet the data suggests that the opposite may also be true: NCD has low rates of health facilities that complete budgets, so they are almost completely reliant on their funding providers for administered support, and some 80 percent of NCD health facilities reported that they were 'very satisfied' with administered support.

Another important finding from this data is that 59 percent of aid posts, as opposed to only 40 percent of health centres, were 'very satisfied' with the administered support provided for activities and programs. This result is unexpected, considering that a greater percentage of health centres than aid posts receive administered support. However, this finding might indicate that aid posts are more positive about the administered support provided because they are less likely to receive it.

Table 12: Funding providers support health facilities in the form of activities and programs in 2012 (% of facilities)					
	Received support through programs	Requested by health facility?	Very satisfied with support	A little satisfied with support	Not satisfied with support
By Province					
East New Britain	52	45	45	9	45
West New Britain	54	42	57	29	14
Morobe	43	89	56	22	22
Sandaun	50	55	33	44	22
Eastern Highlands	60	83	33	33	33
Enga	22	20	25	50	25
Gulf	61	21	43	36	21
National Capital District	31	40	80	20	0
ALL Average	**46**	**55**	**48**	**32**	**20**
By Type					
Health Centre	52	65	39	35	27
Aid Post	39	44	61	26	13
By Agency					
State	45	69	39	37	24
Church	49	46	55	19	26

5.3 Administered support for health function grant activities

In further examination of the importance of administered program-level support, the survey asked if such assistance supported the core responsibilities of health facilities. These key activities are funded through the health function grant, although, as previously noted, there are few cases of this funding appearing in health facility budgets. If health function grant funding is kept at provincial and district levels, administered contributions from church and state funding providers should assist health facilities carry out these same activities. Table 13 shows four important services delivered by health facilities: conducting health patrols, transferring sick patients, maintenance of the health facility, and collecting and delivering drugs.

Administered support from funding providers is most likely to assist health facilities conduct outreach patrols to villages. Table 13 indicates that more than 80 percent of health facilities receiving administered assistance believe that it helps them to conduct patrols. This result is consistently high across all the provinces except for NCD, which is to be expected given its dense population. There are several different types of health patrols, such as maternal and child health patrols, immunisation patrols and supervisory patrols. An important finding from the District Case Study (2009) was that many provincial and district health officials regularly assisted health facilities to conduct immunisation patrols on an annual basis. These types of patrols are mainly funded through joint donor trust funds under the Health Sector Improvement Program. It is therefore possible that a high percentage of OIC's may have been referring to administered support for immunisation patrols, which are not necessarily focused on providing primary rural health care. Rather, it is the child and

maternal health outreach patrols that health facilities should conduct to each village within their catchment population. Therefore, it is unclear whether administered support assists health facilities to regularly conduct immunisation or primary health care patrols.

Another area where administered support seems to assist health facilities is in collecting and delivering medical supplies. Almost half of the health facilities receiving administered support to deliver services believed it helped them manage their drug supply. Responses across provinces are fairly consistent, ranging from 30–70 percent, as detailed in Table 13. It is not uncommon for provincial and district health offices to keep the component of the health function grant that funds the costs of distributing medical supplies. The large majority of health facilities do not have ambulances, let alone vehicles for collecting and distributing medicines. Most health facilities are therefore reliant on district and provincial health vehicles to distribute medicines at the facility-level.

To a lesser extent, the other two prominent activities for which health facilities receive administered support are patient transfers and maintenance of the health facility. Table 13 shows that both these activities receive less attention from funding providers. For administered support assisting in the maintenance of the health facility, church-run facilities are more likely to be supported as state-run facilities. This finding is consistent with church-run health facilities claiming they more regularly carry out maintenance of the health facility. In terms of patient transfers, funding providers are much more likely to provide administered support to health centres than aid posts. This is concerning since patient transfers are just as important at the level of the aid post, and they are often harder to reach.

Table 13: Administered support from funding providers assists health facilities to carry out the following activities in 2012 (% of facilities)

	Health outreach patrols to villages	Patient transfers to referral HC/hospital	Maintenance of health facility / housing	Collecting or delivering drugs
By Province				
East New Britain	91	45	27	64
West New Britain	71	29	0	57
Morobe	78	33	44	44
Sandaun	100	33	33	33
Eastern Highlands	100	17	33	33
Enga	75	50	0	50
Gulf	79	43	21	71
National Capital District	40	20	20	60
ALL Average	**82**	**34**	**28**	**47**
By Type				
Health Centre	92	51	40	60
Aid Post	75	9	7	33
By Agency				
State	88	35	23	48
Church	73	32	34	38

In broad terms, the survey findings confirm that there is widespread variation in the financing of health facilities through user fees, funding received from budgets and administered support provided to deliver health services. This shows that health facilities may be reliant either on one major source of funding, a combination or none at all. The importance of administered assistance in the delivery of health services is often understated. However, while the data show that funding providers support health facilities to carry out essential services critical, it does not mean that the support provided is consistent or sufficient to meet minimum standards. The next section of this paper will use the survey data to discuss the implications of these findings for PNG's free primary health care policy.

6. Discussion – implications for PNG'S free primary health care policy

The PEPE survey findings offer insights into how the free primary health care policy may impact on the finances available to health facilities. The implications of the policy will differ across provinces due to the variation in fees collected for consultations and drugs, as well as the number of patient visits. In order to identify key implementation issues that may impact the successful outcomes of the policy, this section of the paper aims to highlight several important challenges for the allocation and distribution of subsidy payments to health facilities.

Whether the total allocation of subsidy payments to health facilities will be sufficient to offset user fees raised is an important consideration for the policy. Using survey data on user fees raised by health facility type, estimates of total fees raised are presented for 2012. This figure is then compared with subsidies made through the free primary health care policy to show that the total allocation of K11 million may be insufficient to cover fees normally raised from patient visits. Comparisons between state and church-run health facilities are then used to show that user fees are a more widely collected and consistent source of revenue for health facilities. However, there are disparities in user fees raised in the provinces that actively encourage charging fees and those that already had a free health care policy in place. This raises the issue of how funding to subsidise the user fees previously raised will be allocated across provinces. If an even approach is taken, some provinces will receive too much funding while others will not receive enough.

Of equal importance in determining how free health subsidy payments will be allocated is the need to find a viable and cost effective funding mechanism for getting funds to health workers at the facility-level. The magnitude of this challenge should not be underestimated, given the difficulties in accessing financial services across PNG. Every health facility would need to be reached with funding to make the policy work, which is difficult considering that about two-thirds of health facilities are aid posts, normally located in rural and remote areas. Options for how subsidy payment could be distributed to health facilities and the associated challenges are discussed.

Finally, potential lessons that the health sector could learn from the tuition fee-free education policy are considered. School survey data indicates that subsidy payments

reach bank accounts, although funding for the tuition fee-free policy is much higher than the free primary health care subsidy payments. Schools are also much better established to manage additional funding, whereas the health sector lacks the same capabilities. Despite these notable differences, there are lessons that the health sector can learn if it is to successfully implement such an ambitious policy.

6.1 Will free primary health care policy subsidies offset fees raised from patients?

An important question for the free primary health care policy is whether the funding allocated to supplement user fees is sufficient. Before PEPE health surveys were conducted there was no quantitative data across a large sample that addressed how fees are charged, for what services and the amount collected. Table 14 provides estimates of user fees raised across the various types of health facilities using PEPE survey data averages by facility type. It shows that the total estimate of user fees raised in 2012 is almost K12 million, which is more than the K11 million in subsidy payments allocated under the free primary health care policy. While aid posts raise fewer fees than other health facilities, their large numbers mean that most user fees are collected from aid posts. These estimates show that the subsidy allocations maybe insufficient to offset the fees that would have been raised.

Table 14: Estimates of user fees (Kina) raised across health facilities

Facility type	Avg. user fees raised (per month/facility) (Kina)	Number of health facilities (WHO – 2010)	Total user fees per month (Kina)	User fees raised in a year (Kina)
Health Centre	568	201	114,110	1,369,308
Sub-Health Centre	854	428	365,623	4,387,479
Aid Post	169	2,672	452,824	5,433,886
Rural Hospital	1033	14	14,467	173,599
Urban Clinic	538	69	37,154	445,853
TOTAL	**3,163.24**	**3384**	**984,177.88**	**11,810,135**

User fees are a more reliable source of revenue for health facilities than funding. Table 15 shows that a higher percentage of health facilities, both church and state, raise fees than those that receive funding through budgets. The average value of funding received is much higher for church-run facilities than their state-run counterparts. However, average user fees collected across church and state facilities are more consistent. This indicates that user fees were a more reliable and readily available source of funding: funding received is much more variable. Considering that user fees are the most reliable funding source for the majority of health facilities, effectively supplementing fees collected with subsidy payments will be critical for the operation of health facilities.

Table 15: User Fees and funding received (Kina) in 2012: church/state, aid posts/all other health facilities comparison				
Facility type	% Health facilities funding received	% Health facilities user fees collected	Average funding received in 2012	Average user fees collected in 2012
Church – HC+	25	83	40946	6685
State – HC+	21	78	5772	8338
Church – aid posts	13	88	1325	1165
State – aid posts	5	74	486	1452

In allocating subsidy payments to provinces to offset user fees, the new policy cannot assume that all health facilities charge fees, or raise similar amounts. Some provinces already provide free services, while fees raised at health facilities across PNG are widely variable. To emphasise this point using survey data, comparisons can be made between provinces that regularly charge fees and those that offer free services. Table 16 shows the user fees raised in East New Britain and West New Britain are far greater than in Gulf and Sandaun provinces. This means that the two island provinces would need to receive far greater subsidy payments to cover the fees they usually raise, while Gulf and Sandaun would not need to receive even close to the same amount. Should East New Britain and West New Britain receive greater subsidy allocations if the purpose of the policy is to offset the fees collected? If not, this raises important questions about the follow-on implications that less revenue may have for services provision.

Table 16: User fees raised (Kina) across four provinces in 2012 (11 months) – absolute numbers				
Facility type	Average User fees raised in 2012			
	ENB	WNB	Gulf	Sandaun
Church – HC+	11275	8250	798	3256
State – HC+	19938	9900	0 (None charged)	1375
Church - aid posts	1128	2200	933	- (No observations)
State - aid posts	1254	1826	330	312

Determining how the new policy will allocate subsidy payments across provinces requires further consideration. There seem to be three main options. First, subsidy payments could be allocated evenly across provinces, but as the previous example demonstrates, this approach has significant flaws. Since user fees are often very important for funding health facility operations, a reduction could well impact on the level of service provision. This could leave health facilities with a difficult decision to make: either provide fewer services or fail to comply. Both these options are clearly undesirable.

Second, user fees currently raised could be taken into account using data similar to the PEPE health survey. However, this approach would disadvantage provinces that did not charge fees in accordance with national policies before 2014. PEPE survey data also indicates some correlation between health facilities that do not charge fees and low levels of services delivered. Providing less funding to poorer performing provinces that collect fewer fees is unlikely to help improve their level of service provision.

Finally, subsidy payments could be considered on a needs basis using cost of service and internal revenue estimates developed by the National Economic and Fiscal Commission. This would follow a similar formula to function grant allocations, where poorer provinces with less internal revenue receive more funding. The problem with this approach is that it would again not be based on the current fees charged. It would mean that provinces like East New Britain and West New Britain would receive less funding, since they do not depend on national grants to fund their provincial health budgets.

Each of these options has significant drawbacks in terms of finding an effective way to allocate subsidy payments across provinces. No matter which approach is taken, ensuring health facilities are not left with less funding as a result of the policy involves overcoming significant challenges to implementation. Beyond simply better allocations across provinces, it is also essential to consider how funding will get to health facilities and how distribution costs will be met, especially for remote aid posts.

6.2 How will subsidy payments for the policy be distributed?

The free primary health care policy needs to account for the costs associated with distributing subsidy payments to health facilities on a regular basis. The costs involved with accessing financial services vary significantly between provinces, but they are key operational expenses associated with the policy. Each province faces its own challenges in accessing reliable financial services. This might involve travelling long distances to a bank or the provincial/district health office, where health workers could collect the subsidy payments. Alternatively, provincial/district health officials might decide to deliver the payments to a network of health facilities at intervals during the year.

Regardless of whether provinces or church agencies decide to deliver subsidy payments or have health workers collect them, the cost would be significant for many provinces. Table 17 shows the distance, mode of transport and time for health facilities to reach banking services. As expected, there are significant differences across health facility type, but the main finding is the higher travel times and costs for aid posts when compared to other types of health clinics.

Table 17: Travel distance, mode of transport and time to the nearest bank								
Facility type	Distance to nearest bank (% of health facilities)			Mode of transport (% of health facilities)				Average travel time (hours)
	Within 20km	20–100 km	Over 100km	Walk	Vehicle	Boat	Plane	
Health Centre	38	18	44	15	59	32	9	4
Sub-Health Centre	33	30	37	4	70	33	4	4
Aid Post	30	12	56	9	54	44	9	7
Rural Hospital	14	0	86	0	71	29	14	5
Urban Clinic	81	13	6	0	100	0	0	1

Distributing subsidy payments to aid posts is central to the implementation of the new policy. Aid posts collect fewer fees and therefore require less subsidy payments, but they are more expensive to reach. They also play a critical role in the health system as the first point of assistance for many families, especially in rural and remote areas where the majority of PNG's population lives. Table 18 highlights this point, as patient visits per health worker for aid posts are more than twice the number for health centres. This finding reinforces the importance of the single CHW stationing aid posts, where the majority are solely reliant on the user fees they collect to deliver services. While the fees they collect may be of lesser value than for health centres, they are important in the aid post context.

Table 18: Patient visits per day and user fees raised per patient		
	Number of patient visits per day per health worker	User fees raised per patient (Kina)
By Province		
East New Britain	10	.96
West New Britain	24	.52
Morobe	14	.76
Sandaun	16	.21
Eastern Highlands	10	1.16
Enga	12	.93
Gulf	16	.15
National Capital District	17	.21
ALL Average	**15**	**.59**
By Type		
HC+	10	.67
Aid Post	22	.49
By Agency		
State	15	.53
Church	14	.59

Distributing subsidy payments to aid posts so they do not need to charge fees is a major implementation challenge that requires further consideration by policymakers as aid posts represent the majority of health facilities across PNG. To be compliant with the policy, especially in remote areas, aid posts will need some funding to offset

fees, but getting funds to them or asking CHWs to leave their posts to collect payments would be a significant challenge for many provinces. At what point does attempting to subsidise the small amount of fees that aid posts raise become financially wasteful, given the costs involved in distributing subsidy payments?

Options for getting subsidy payments to health workers

A key question for distributing subsidy payments under this policy is how to get funds to health workers at the facility-level. One option would be to put funds into the facility's bank account, although, judging from survey data, more than 60 percent of the facilities do not have established accounts. Even if they were set up, it would mean all OIC's would have to access their own funds, which can be expensive and inefficient, as previously discussed.

The PEPE health survey asked health workers about the distance, travel time and costs of accessing banking services. Table 19 shows very high costs for health workers and reveals significant variation among the provinces. Sandaun Province is particularly high as surveys were conducted in the very remote Telefomin District. West New Britain, Morobe and Gulf also spent well over K400 on average for a return visit to a bank. This raises the question of whether poor access to financial services or high distribution costs should be factored into subsidy allocations. These types of considerations have been applied in the past with reforms to PNG's inter-governmental financing arrangements, where costs based on remoteness and accessibility to enabling services were taken into account and have been applied to health function grant allocations.

Table 19: Distance, travel time and cost to reach bank, by province

	Distance to nearest bank (% of health facilities)			Travel time (hours)	Cost of return travel (Kina)
	Within 20km	20-100km	Over 100km		(inc. transport, food & accom.)
By Province					
East New Britain	48	38	14	6	254
West New Britain	29	29	43	8	727
Morobe	30	10	60	16	496
Sandaun	11	0	89	14	848
Eastern Highlands	82	9	9	2	62
Enga	58	32	11	2	20
Gulf	0	0	96	18	456
National Capital District	75	13	13	2	2
ALL Average	**38**	**16**	**45**	**10**	**366**
By Type					
Health Centre	44	19	38	6	294
Aid Post	30	12	56	14	475

Another important point to consider is how often health facilities would need to receive subsidy payments. For instance, will a remote sub-health centre receive a one-off payment to subsidise the costs of charging fees or will they receive regular payments throughout the year? Both these scenarios have their downsides. If a one-off-payment was made to a small sub-health centre, they may have excessive

amounts of cash and no place to store it if they were in a rural area without ready access to a bank. However, one round of subsidy payments per year would not effectively supplement how user fees are collected and spent. Survey data indicates that health facilities collect small amounts of fees often. Having some funding available all the time seems to be important for meeting basic costs, like fuel and casual wages. If subsidy payments come in one lump sum, it could influence spending decisions. Even if health facilities have bank accounts, most would struggle to readily and easily access them given travel distances and the costs involved in getting to a bank. These implementation issues are at the core of whether the free health policy will be successful.

A potentially more efficient way of getting subsidy payments to health facilities would be for provincial and district officials to deliver the funds directly. This approach would also need to account for travel time and transport costs. One possibility is that the distribution of subsidy payments could be included in supervisory visits. For this to be feasible, supervisory visits would need to happen more regularly – survey data indicates that only about half of the health facilities received a visit in 2012 – and the number of visits required in order for payments to be made throughout a year may be dependent on the context of the individual province.

If the new policy seeks to replicate user fees, which are collected in small amounts each day and accumulate, multiple visits to facilities would be required. However, when the costs of distribution are accounted for, it is difficult to imagine how this system could be successfully implemented.

Another alternative would be to rely on informal arrangements, such as health workers collecting subsidies for their clinic when they travel into the district or provincial centre. However, this would be less reliable, as financial services are not readily accessible in every province and it would significantly disadvantage remote health facilities where transport costs are likely to be higher. No matter the approach, each province faces potential challenges, which require careful consideration.

6.3 Why a free health policy will not work like the free education policy

Both the free primary health care and tuition fee-free policies are similar in there focus on saving families the expense of health and education services. The free primary health care policy has been allocated K11 million, which is much less than the free education policy: in excess of K600 million in total (PNG Treasury, 2013). However, like the health policy (K20 million in total), the tuition fee-free policy can also be broken down by school type. Elementary and primary schools would be the equivalent to primary health care facilities. Using this as a comparison point, the tuition fee-free policy for elementary and primary schools comes to just over K376 million, compared to K11 million for the free primary health care policy. Given these large differences in funding allocations, it may seem that the health policy requires further funding to match the education sector. However, before further health

subsidy payments can be contemplated, an appropriate mechanism for providing health facilities with financing to deliver basic services needs to be established. The education sector may provide some important lessons in this regard.

Schools have the ability to absorb higher levels of funding than health facilities due to their management structure. Each school has a Board of Management (BOM), which has the greatest level of influence in decision-making at the school, and this extends to financial and asset management. According to the PEPE school surveys, BOMs have an average of about eight representatives that meet close to four times per year. The Head Teacher works with the BOM Chairman to manage and administer the school's finances, in addition to other duties, such as overseeing school operations, supervising teachers and teaching classes as necessary. A single primary school can therefore operate fairly autonomously from other primary schools and even from their feeder elementary or high schools.

The health system is structured very differently. There are no BOMs and the OIC of the health facility is normally the best health practitioner at the clinic, rather than an experienced administrator (with the exception of large rural hospitals). So, if more funding is to be delivered to the health facility front-line, an effective management system is needed. While some health facilities have Village Health Committees, they bare more resemblance to Parent or Citizens Committees at schools, both of which represent community interests, rather than manage finances. The lack of an established structure for health facilities to manage their own finances could be part of the reason for their reliance on administered support from funding providers to deliver services.

Financing of the free primary health care policy through subsidy payments needs to take into consideration the administrative and management responsibilities this may place on the OIC of the health facility. PNG already has a critical shortage of qualified health workers, whose time might be better spent at the clinic treating patients rather than following-up on funding. Perhaps a BOM equivalent for health facilities might be considered to manage subsidy payments under the free primary health care policy? This is not a new concept: similar arrangements are currently being trialled in Bougainville under its Direct Health Facility Funding Project. However, under this pilot project, direct financing of health facilities also includes costs for their operations. This means that the allocations are much higher than those proposed under subsidy payments, which are only supposed to offset user fees.

According to a recent evaluation undertaken by WHO and NDoH (2013), the pilot project in Bougainville shows some encouraging signs, but there are still several challenges to be negotiated before it can be rolled out on a larger scale. However, the pilot is experimenting with a similar funding mechanism to a BOM. This concept has the potential to help the health system better manage the distribution and administration of free health subsidy payments.

Conclusion

The free primary health care policy will have significant implications for services delivered at health facilities across PNG. PEPE health survey data suggests that user fees have become the most widely available, easily accessible and reliable source of funding for health facilities to deliver front-line services. The policies on what to charge for and how much to charge seem to be determined by province, agency type or indeed the facility itself. Individual health facilities charge differently for the services they provide, and this varies based on consultations and the drugs available. This variation seems to have occurred as a result of the absence of a reliable or adequate funding source to enable health facilities to meet their operational costs.

Health function grants have increased significantly in recent years and are important for funding health facilities to meet the cost of delivering services in many provinces. However, survey findings show that these grants are more commonly administered to health facilities from funding providers, rather than being directed and spent at the facility-level. While about half the health facilities surveyed received some form of administered support, in most provinces it was not enough to regularly deliver their core services.

There is widespread variation in how funding is provided to health facilities. Funding can take the form of user fees, funding from budgets, direct funding and administered support for delivering services. Health facilities may be reliant on one source of funding, a combination or none at all. This means that the revenue that health facilities raise from user fees is widely variable and dependent on patient load. Therefore, offsetting user fees based on any formula designed at the national level is highly unlikely to accurately subsidise health facilities for the fees they would have raised. This poses significant challenges for effectively allocating free health subsidy payments and requires careful consideration from policymakers.

An even larger problem is distributing these funds at regular intervals. This is particularly challenging for aid posts. They raise less revenue from fees and are generally more remote and costly to visit, but represent the majority of health facilities in PNG. Abolishing the user fees that are important for paying the costs of delivering essential services comes with significant risks. If health facilities have to forgo charging fees and rely on a convoluted financing system, they may be unable to deliver the same quality of service.

While the intention of the free primary health care policy is to improve access to services, the implementation risks may weaken, rather than strengthen, the health system. PEPE health survey findings suggest that health facilities need more reliable financial support for front-line service delivery before they can move away from charging user fees. The importance of establishing a feasible mechanism for financing health facilities cannot be understated, and is more complex than simply putting funds into bank accounts. Access to cash, especially for remote facilities is important for paying basic operational costs.

Direct financing to schools offers some insights into possible approaches to establishing management structures capable of absorbing more funding. Moving slowly, and learning by trialling approaches to implementation that already work, might be the best way forward from a technical standpoint. However, a steady approach may conflict with political pressures intent on immediately implementing the free primary health care policy across the country. This could lead to either non-compliance or poorer quality services delivered, neither of which would result in better health services delivered to the people of PNG.

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The PNG Promoting Effective Public Expenditure Project

Papua New Guinea (PNG) is experiencing a minerals boom and confronts serious challenges in translating increased resource revenues into effective development outcomes. The National Research Institute and the Development Policy Centre at The Australian National University are undertaking the Promoting Effective Public Expenditure (PEPE) Project to help navigate this critical period.

The project aims to better understand how PNG allocates its public funds and how these funds are provided to and used by those responsible for delivering basic services.

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