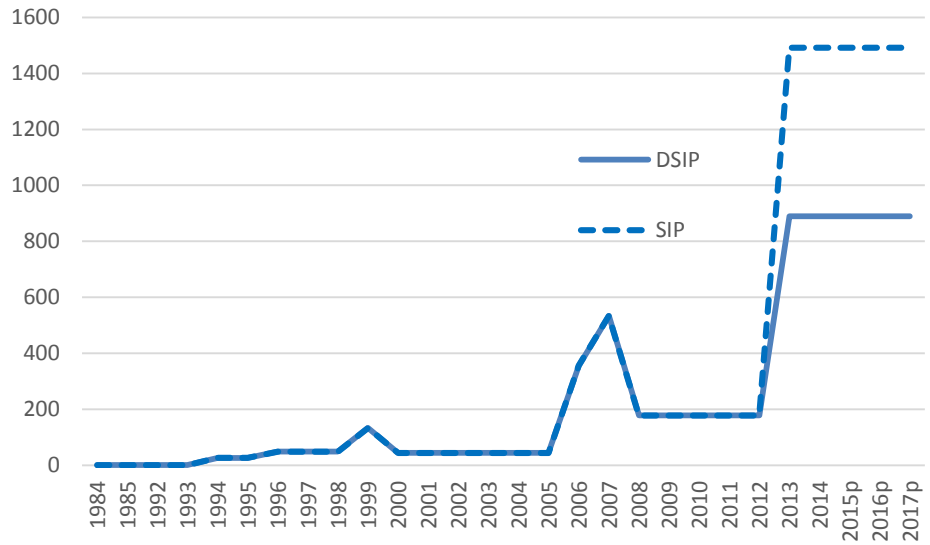
7 DSIP: ARE HEALTH AND EDUCATION BENEFITTING?

7.1 MP development funding: an overview

Since the 1980s, PNG MPs have received funding to spend in their electorate, initially through the Electoral Development Fund and, more recently, through the District Services Improvement Program (DSIP).

Figure 7-1 shows the huge increases in these programs over the last decade and in the 2013 budget. In the 2013 budget (and again in the 2014 budget) PNG's 89 open electorates (normally made up of one or two districts) were allocated K10 million each, more than double the previous average annual allocations from 2007-12. Although our survey occurred before this increase, the fact that DSIP has become so much more important only makes its study more important.

Figure 7-1: The rise of constituency funding in PNG (Kina million)

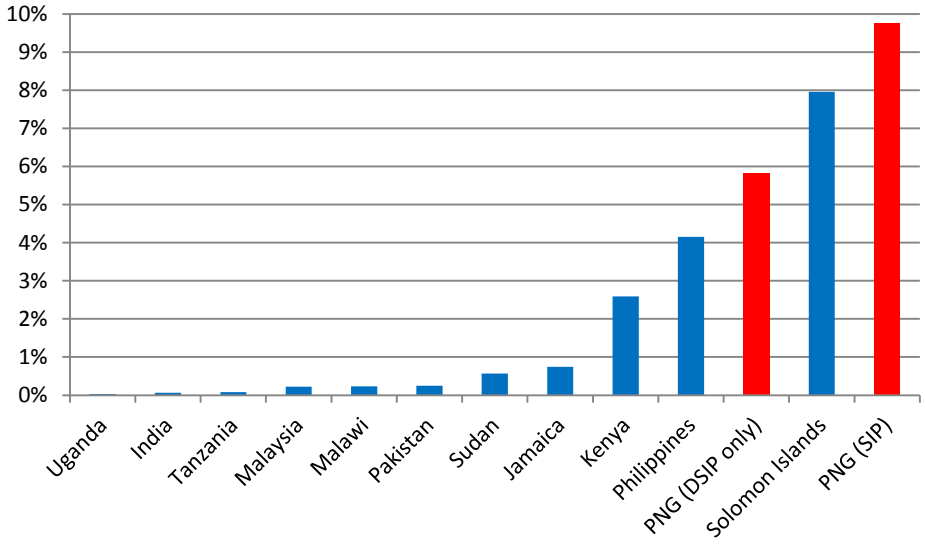


Note: DSIP: Electoral Development Fund from 1984-2005 and DSIP thereafter. SIP includes PSIP and LLGSIP funds as well. 2013 and 2014 are budget figures. 2015 onwards are projected figures. Sources: Ketan (2007), IMF (2013) and budget documents.

It is not only the DSIP that has increased. In 2013, K500,000 was also allocated to each Local Level Government (LLG) through the LLGSIP: there are normally about three or four LLGs per open electorate. And provinces have been given K5 million per open electorate in each province through the new Provincial Services Improvement Program (PSIP). Adding these sums to the DSIP gives an amount of K1,490 million for these programs every year from 2013 onwards under a combined Services Improvement Program (SIP). The PSIP alone (K445) is more than the amount that the provinces receive through functional grants (K398 million in 2013).

Indeed, PNG seems to rely more heavily on constituency funding to disburse its budget than any other government in the world (Figure 7-2). Many countries have constituency funds, but they are typically just a few percentage points or less of government spending. In PNG, they are 6 per cent if counting only the DSIP and almost 10 per cent if counting the PSIP and LLG funding as well.

Figure 7-2: Ratio of constituency funding to total budget spending: a cross-country comparison



Notes: 2009 data except for Solomon Islands (2013) and PNG (2014). See Figure 7-1 for the difference between DSIP and PSIP. Sources: Hickey (2010); World DataBank; IMF (2013); PNG national budget documents.

The governance arrangements in place for these three funds put decision making in the hands of committees in which politicians have significant influence in decisions on spending.

The Joint District Planning Budget Priorities Committee (JDPBPC) is the decision-making body for the DSIP. It is chaired by the MP of the district (or electorate) and also includes LLG presidents and community members. The District Administrator is the CEO of the JDPBPC. District officials are responsible for informing schools and health facilities about allocations made, as well as implementation plans.

The PSIP is managed through the Joint Provincial Planning Budget Priority Committee (JPPBPC), which is normally chaired by governors of the provinces, and also includes constituency or open MPs.

The LLG Services Improvement Program (LLGSIP) is supposed to be implemented through the JDPBPC rather than the LLG Assembly, since there are no clearly established mechanisms for development spending at the LLG level.

Although MPs clearly have a lot of say in how these funds will be spent, the PNG Government is clear that SIP funding is not for MPs to spend

as they like, but rather to finance infrastructure, including to improve service delivery. According to administrative guidelines for spending SIP funds (DIRD 2013), 40 per cent of funding under all three programs is meant to be spent on 'health services improvement' and 'education services improvement' (20 per cent each). This equates to 40 per cent of K1.5 billion, or about K700 million a year. This is a huge amount: it is more than four times the amount that provinces receive through their function grants for health and education (K150 million).

Media reports give conflicting accounts, ranging from well-planned and executed projects to allegations of cash payments. This has made it difficult to judge the overall effectiveness of DSIP spending as a whole. Indeed, given its decentralised and dispersed nature, evaluating the quality of spending under the DSIP across PNG would be a difficult undertaking. Whether DSIP is an extension of direct payments to MPs to be used as a personal slush fund, a genuine service delivery program or something in-between is debatable. What cannot be denied is its growing importance.

The PEPE survey was certainly not an evaluation of the DSIP. However, it did ask some questions about funding allocations and the implementation of projects benefiting schools and health clinics. Both surveys asked the same questions to the Officers in Charge (OIC) of the surveyed health clinics and the Head Teachers of the surveyed schools. This chapter reports the answers they gave to the questions we asked them about the DSIP.

In summary, the chapter shows that there is little funding from the DSIP reaching primary schools and health clinics, that the scheme is seen as unfair by Head Teachers and OICs, and that a significant number of projects are not only behind schedule but may never be finished.

7.2 DSIP project allocations

Based on the survey responses, schools are more likely than health clinics to receive a DSIP project. Respondents were asked if their facility had ever been the beneficiary of a DSIP-funded project. 20 per cent of schools said they had, and 12 per cent of health clinics (Table 7-1). Among health clinics, aid posts miss out on the DSIP. Only 3 per cent of aid posts, but 23 per cent of health centres, reported ever receiving a DSIP project. So, schools and health centres are about equally likely to receive a DSIP project.

Most schools (62 per cent) received funding directly into their bank account for their project. But most health clinics (75 per cent) received the project in-kind: that is, someone else arranged for the project's implementation, for example, the district or provincial administration. This reflects the much more developed financial management practices at schools than at health clinics, discussed in Chapters 6 and 7. For

example, only 44 per cent of health clinics have a bank account, whereas almost all schools do.

Although health clinics are less likely to receive DSIP funding, if they do get a project it is likely to be more expensive. The average DSIP project size for recipient health clinics was K92,000; the average for primary schools was K64,568, one-third less.

We did not formally record which projects the DSIP funding was used for, but it was evident that DSIP projects were mainly for building new classrooms, health clinic buildings or houses for staff.

Table 7-1: DSIP project prevalence and value: provincial and agency breakdowns

	DSIP project received (%)		Value DSIP project (K)	
	Schools	Health clinics	Schools	Health clinics
Overall	20	12	64,568	92,000
Government	18	15	85,408	91,583
Church	23	9	14,480	92,833
Health centre +	NA	23	NA	103,286
Aid post	NA	3	NA	52,500
Received in cash/bank account	62	25		
Received as in-kind project	38	75		

Notes: Weighting was not undertaken for the provincial health clinic figures and the aid post figures due to the small number of observations. The value of projects was averaged over those facilities that received a DSIP project. NCD officials did not estimate the value of their DSIP projects.

Only 38 per cent of schools and 26 per cent of health clinics believe that the DSIP is a fair system. Both Head Teachers and Officers in Charge agree they should be able to apply for funding directly, rather than the JDPBPC making decisions based on their own priorities.

Table 7-2: Perceptions of DSIP fairness and application process (%)

	Schools	Health clinics
DSIP is a fair system	38	26
They should be able to apply for funding	64	69

7.3 DSIP project implementation and completion

DSIP projects are mainly delivered through private contractors, district administrations or by the facilities themselves (Table 7-3). Private contractors implement most health projects (57 per cent), but schools are much more likely to implement their own projects (45 per cent). This probably reflects the fact that schools have more autonomy and capacity to manage their own projects. It may also be that school projects are simpler, as well as less expensive.

Table 7-3: DSIP implementation modalities (%)

	Schools	Health clinics
DSIP project implementation by:		
Facility	45	14
Private contractor	14	57
District administration	25	22
Another process	16	7

Note: Percentage of those facilities that report a DSIP project.

For health clinics, only one-third of DSIP projects were completed in full and on time (Table 7-4). Schools did much better, with almost two-thirds of projects completed in full and on time. For both types of facility, projects that were behind schedule were seriously delayed (by about a year on average). In fact, respondents thought that about 40-45 per cent of projects that were delayed would never be finished. This means that 31 per cent of all DSIP health projects are forecast never to be finished, and 16 per cent of all DSIP school projects.

Table 7-4: DSIP completion rates and implementation delays

	Schools	Health clinics
DSIP project completed in full and on time (%)	65	32
If not completed in full and on time…		
months project is behind schedule	12	11
project will never be completed (%)	41	45

It should also be borne in mind that completion does not mean utilisation. We did not formally ask this in the survey, but the experience of coming across a brand-new but yet-to-open health centre in Gulf Province was striking. We were told that basic construction had been completed more than 12 months ago, but that the clinic could not be opened due to a dispute between government and church health officials about ownership of the health facility and who would be responsible for finding a health worker to take up the vacant post at the centre.

A new, but unopened health clinic built in Gulf Province with funding from the District Service Improvement Program.

7.4 Conclusion

There are many arguments about the DSIP and whether it is a good use of public funds, but it seems certain to stay. Not only is the government committed to maintaining a very high level of public expenditure going to DSIP and similar funds. Recent legislative moves indicate a desire to effect bureaucratic change to expand capacity at the district level and consolidate the local decision-making power of MPs.

The District Development Authorities Bill was introduced into the PNG Parliament in late 2013. The District Development Authority will replace the JDPBPC, which is currently the decision maker concerning the DSIP. All public servants in the district, including police, teachers and health workers are proposed to come under the District Development Authority, the CEO of which will be the District Administrator. The Members of Parliament that represent open district electorates and hold 89 of the 111 seats in the National Parliament (commonly referred to as Open MPs) will be the Chair of their respective District Development Authority, giving them greater influence over funding allocations and human resources.

Given all this, it is important to learn what we can from the functioning of the DSIP to date. What can we conclude from this study?

First, not a lot of funding seems to be flowing from the DSIP to PNG's schools and health facilities. If we take the average amount going to schools and health centres, and multiply this by the total number of each, the complete value of cumulative DSIP funding as of 2012 to primary schools is K46.2 million and to health facilities is K37.6 million, with a total of K83.8 million. This is 23 per cent of a single year's allocation of the DSIP prior to the 2013 increases. But we asked facilities if they had *ever* received a DSIP-funded project. The projects reported could have been funded out of several years' allocations. If they were funded out of four allocations, then the percentage flowing to primary health and education falls to just 6 per cent. This is just a rough estimate, but it does suggest that little from the DSIP is making its way to PNG's schools and health clinics.

Clearly, the increased funding should make a difference. If the same share of DSIP funding continues to go to health and education then, after a few years, we can expect the inflow to primary health facilities and schools to increase fourfold to K352 million. But if health and education get their regulated share, then the stock of projects underway at any one time should be at least double that (allowing some funding to flow to secondary schools and hospitals).

We cannot say whether health and education are getting so little because other sectors are getting a lot more or because of waste and corruption. But it is clearly in the interests of individual schools and health facilities, as well as their national departments, to lobby for more funding.

Second, there is general dissatisfaction with the fairness of how the DSIP projects are allocated. Reforms should be considered to allow schools and health facilities to bid directly for projects, and rules should be developed to allow all facilities to access funding periodically.

Third, projects are often either significantly behind schedule or never completed. About 30 per cent of all the DSIP health projects and 16 per cent of all the education projects are forecast never to be finished. Two-thirds of the health projects and one-third of the education projects are a year behind schedule. Poor spending and delays with implementation can be damaging for the reputation of the DSIP at the local level, and of course are bad for value for money.

Fourth, we once again see a difference between the health sector and the education sector. Education projects are almost twice as likely to be finished on time. Schools are much more likely to receive funding in cash, and to be in charge of the projects themselves. Perhaps this makes it easier to run a successful DSIP project? More generally, it is likely that the better developed governance structures at schools mean that their projects are more likely to succeed.

Fourth, projects may be completed but not used. There is clear evidence from our survey of the need for new and rehabilitated infrastructure in most provinces, from run-down health clinics to dilapidated teachers' housing. The DSIP has been, and continues to be, the main funding source that can finance these types of projects. The relative capacity of provinces to ensure contractors are monitored and projects are completed on time is widely variable, but important to ensuring effective spending. The focus should be on maintenance and replacement, not the construction of new, additional assets. MPs and administrators should coordinate closely to ensure that new facilities are not left idle, or, put differently, that construction is only undertaken where staff are available to make use of the facilities being built.