6 HEALTH FINANCING AND THE FREE HEALTH POLICY

6.1 Introduction

Health clinics can get support for their operations in one or more of three ways. They can receive funding in cash; they can get in-kind support; or they can raise funds themselves through user fees (or in some cases, by health workers donating their own salaries). One of the primary purposes of the PEPE health survey was to examine the financial support received at the facility level and how it translates into the delivery of services. There has been little systematic research on this subject to date.

PNG's free primary health care policy came into effect on 24 February 2014, after PEPE fieldwork was conducted. However, the survey findings offer useful insights into how the policy could impact the financial situation of health clinics. The Public Hospitals (Charges) Act (1972) sets user fees for hospitals, but states that all primary health services are to be provided free of charge. However, charging fees for primary health services has in fact been common practice (Sweeney & Mulou 2012; DLPGA 2009). The new free health policy aims to bring about an end to the practice of charging fees and to offset the lost income by providing subsidy payments from the central government to provinces to be distributed to health clinics.

The next three sections of this chapter explore the importance of each of the three sources of support for different types of health facilities: funding, in-kind and user fees. Section 6.5 brings them together to explore their relative importance. Section 6.6 discusses the implications of the findings for the government's new free primary health policy. The conclusion considers policy implications more broadly.

Most of the tables and figures in this chapter are based on responses by Officers in Charge (OICs) to a detailed set of questions about health clinic financing in the PEPE survey.

The chapter shows that health clinics struggle to access reliable funding to deliver services. Most clinics are reliant on in-kind support or need to raise funds themselves through charging fees. Many clinics receive no external support at all and the introduction of a free health policy risks making the situation worse. Some provinces support their health clinics much better than others and there is potential to learn from the practices of better performers.

6.2 Funding support

The PNG Government has significantly increased the size of health function grants paid to provinces to finance core health facility operations. These payments have steadily increased over time to reach

K64.4 million in 2012 and K73.8 million in 2013. Provinces should distribute the health function grant to their health clinics through funding budgets or as in-kind support from the provincial and district health office for materials and activities. National funding allocations for church-run health clinic operations are administered through Christian Health Services and were just over K21 million in 2012 (Piel et al. 2013).

Facility-level budgeting and annual activity plans have been widely promoted at the national level and in many provinces, particularly for health centres, as a way for clinics to access operational funding and support to deliver core services. But do health clinics submit budgets, and are they getting funding in return?

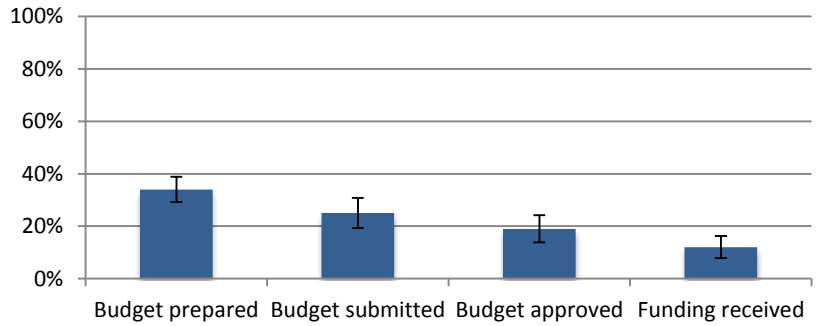
How many clinics submit budgets and receive funds?

The survey found at least eight different funding bodies to which health clinics submitted budgets (see Annex Table 6-A1 for the details). But, as Figure 6-1 shows, only 34 per cent of the health clinics surveyed in fact prepared a budget or plan for submission to any funding body at all.

One 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. Health centres normally operate independently from their referral health facility, whereas an aid post is normally considered an extension of a health centre's operations. However, the variation in budgeting is lower than expected: only 41 per cent of health centres completed budgets, while for aid posts the figure was 25 per cent. The figure for health centres is surprisingly low considering the emphasis placed on facility budgeting.

Preparing a budget or plan represents only the first step of the budget process. There are a series of steps that health clinics should follow in order to receive funding. In 2012, 34 per cent of clinics prepared a budget, 25 per cent submitted them, 19 per cent had them approved, yet only 12 per cent actually received any funding as a result.

Figure 6-1: Clinics preparing and submitting budgets; and receiving approval and funding



Note: All percentages are of all clinics. Throughout the chapter, error bars represent 90 per cent confidence intervals.

Table 6-1 shows the details by province and clinic type. There are few obvious patterns, but East New Britain stands out at the top of each category. 80 per cent of clinics in East New Britain prepared health budgets and 33 per cent received funding in return. In Enga, only 11 per cent of clinics prepared budgets and none actually received funding.

Table 6-1: Clinics preparing and submitting budgets; and receiving approval and funding (%)

Percentage of clinics with budgets…	Prepared	Submitted	Approved	Resulting in funding
Overall	34	25	19	12
	(3.0)	(3.1)	(3.5)	(2.6)
East New Britain	85	62	48	33
West New Britain	38	29	7	7
Morobe	32	30	25	20
Sandaun	33	11	11	6
Eastern Highlands	38	27	18	18
Enga	11	11	11	0
Gulf	18	18	17	9
NCD	14	13	6	0
Health centre	41	31	24	16
Aid post	25	18	12	5
Government	33	22	18	11
Church	35	29	19	12

Note: In this and other tables in this chapter, the numbers in brackets are standard errors.

How much funding do clinics ask for, and how much do they receive?

The financial value of the budgets submitted varies significantly across funding providers (Table 6-2). The average budget submitted for funding in 2012 was K63,771. Health centre budgets averaged K87,067 and aid post budgets averaged only K8,706. Considering the health surveys were conducted towards the end of the year, health facilities should have received most of, if not all, their budgeted funding for 2012 (the PNG financial year follows the calendar year). For health clinics that submitted budgets, the value of the funding received was K31,645 -- about half the average value of the budgets submitted.

Church-run clinics submit much larger budgets (K107,500 versus K45,467 for government clinics) and receive, on average, about two-thirds of what they ask for, compared to only one-fifth in the case of government clinics. As a result, church clinics that submit budgets get K77,254 but government clinics only receive K9,567.

Table 6-2: Funding received from budget submissions

	Avg. value budget submitted (Kina)	Avg. value budget received (Kina)
Overall	63,771	31,645
East New Britain	61,000	15,467
West New Britain	74,000	123,683*
Morobe	102,408	92,195
Sandaun	10,000	1,666
Eastern Highlands	6,867	5,942
Enga	82,500	0
Gulf	137,667	53,666
NCD	37,500	0
Health centre	87,067	44,003
Aid post	8,706	2,434
Government	45,467	9,567
Church	107,500	77,254

Note: One health clinic in West New Britain received more than requested. These averages are over those clinics that submitted a budget.

Can health clinics receive funding without submitting a budget?

Just over 6 per cent of health clinics surveyed claimed to receive funding without submitting a budget, not much less than the percentage that received funding after submitting a budget (12 per cent). The average funding received by those facilities that did not submit a budget was more than K71,000, which is more than double the average for health clinics that submitted a budget. However, 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. (See Annex Table 6-A2 for further details.)

It was mainly church-run clinics that received funding without submitting a budget. The two government health clinics in this group did not get their funding from government grants but from donor programs or an NGO.

Clearly, the system of budget-based funding and cash support for health facilities has never been entrenched, despite the introduction of the health function grant.

There could be several explanations for how little cash clinics receive from external providers. Provincial governments might have higher priorities than health funding, or the funds might be used for administrative costs rather than being disbursed to the clinics. It may be a symptom 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. Alternatively, there may be a perception that health facilities lack the capacity to manage their own funding effectively. Such a decision could be justified considering that the OIC of most facilities is usually a clinical officer rather than a financial and administrative manager, and

that facilities lack local oversight of their operations. Provincial and district health officials, both church and state, may see financial management as their responsibility so that OICs can focus primarily on treating patients rather than managing accounts. In this case, we would expect external providers to assist through in-kind support.

6.3 In-kind support

We call in-kind support to deliver services 'administered assistance'. The survey asked health workers if they received administered assistance either for materials or to assist them to carry out activities from a funding provider (such as the government, a church health agency or a donor). In the case of materials, we also requested a valuation of the support received.

Purchasing materials on behalf of health clinics

36 per cent of health clinics reported that funding providers purchase supplies or materials on their behalf (Table 6-3). In contrast to funding support, slightly more government than church-run clinics received this kind of assistance.

Medical equipment and building materials were the most common supplies received from funding providers. More than half of the health facilities that received purchased materials and supplies provided estimates of the value of the goods received. The average was just under K40,000. Church agencies provided a higher estimate of K78,600, compared to K20,200 for government clinics. Although there are inherent limitations to the accuracy of these estimates, it is revealing that the estimated value of items received is still higher than the funding that health facilities receive from budget submissions.

Table 6-3: Clinics receiving supplies or materials from funding providers

	Percentage of clinics that received				Estimated value of items (if received) (Kina)
	Supplies/ materials	Building materials	Medical equipment	Fuel	
Overall	36	13	13	3	39,493
	(2.8)	(1.9)	(2.0)	(1.0)	
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
NCD	56	0	50	0	15,333
Health centre	41	14	17	4	51,637
Aid post	26	12	9	2	6,100
Government	36	10	14	3	20,200
Church	36	15	15	4	78,600

Notes: Building materials, medical equipment and fuel are all subsets of supplies/materials. There is also an 'other' category, not shown here. OICs in West New Britain did not provide estimated values of supplies or materials received.

Supporting health clinics to deliver health programs and activities

Funding providers also make available administered or in-kind support in the form of health activities and programs. This 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. Survey data reveals that almost half of the health clinics surveyed claimed to receive support in this form (Table 6-4). This makes it the most common way for funding providers to support health clinics.

Almost half of the health clinics that receive activity and program-based support requested this support, whereas the other half said that it was delivered at the discretion of their funding provider (Table 6-4). This provides an insight into who makes decisions on what services health clinics deliver. Across the provinces, 90 per cent of health facilities in Morobe Province requested support, while only 20 per cent 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.

Table 6-4: Clinics receiving support for activities and programs (%)

	Received support through programs	If received, requested by health facility?	Clinics satisfied with support received		
			Very satisfied	A little satisfied	Not satisfied
Overall	46	55	48	32	20
	(8.3)	(5.4)	(5.4)	(5.1)	(4.4)
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
NCD	31	40	80	20	0
Health centre	52	65	39	35	27
Aid post	39	44	61	26	13
Government	45	69	39	37	24
Church	49	46	55	19	26

It would not have been realistic to ask OICs to quantify the value of the support they received through activities and programs. Instead, we asked them to judge the quality of support provided. 48 per cent were very satisfied, and only 20 per cent were not satisfied (Table 6-4). 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 operations. The data also suggests that the opposite is true as well: 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 per cent of NCD health facilities reported that they were 'very satisfied' with administered support.

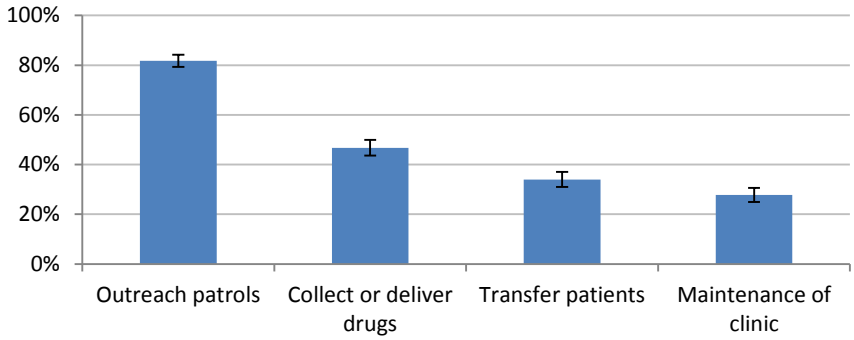
We also asked OICs what the program and administrative support was for. 80 per cent of those who received such support said it helped them to conduct patrols: see Figure 6-2 (and Annex Table 6-A3 for details). This result is consistently high across all the provinces except for NCD, which is to be expected given its dense population.[15]

Another area where administered support seems to assist health clinics is in collecting and delivering medical supplies. Almost half of the health clinics receiving administered support to deliver services believed it helped them manage their drug supply. 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 clinics do not have ambulances, let alone vehicles for collecting and distributing medicines. Most are therefore reliant on district and provincial health vehicles to distribute medicines to the facility-level.

The other two activities for which health clinics receive substantial administered support are patient transfers and maintenance. For administered support assisting in the maintenance of the health facility, church-run clinics are more likely to be supported than government clinics. This finding is consistent with church-run health clinics claiming that they more regularly carry out maintenance (see Table 4-7 for further details). Funding providers are much more likely to provide administered support for patient transfers to health centres than aid posts. This is concerning because patient transfers are just as important at aid posts, which are often harder to reach.

15. There are several different types of health patrols, such as maternal and child health patrols, immunisation, supervisory and integrated patrols. An important finding from the District Case Study (DLPGA 2009) was that many provincial and district health officials regularly assisted health clinics to conduct immunisation patrols on an annual basis. These types of patrols were 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. Therefore, it is unclear whether administered support assists health clinics to regularly conduct immunisation or primary health care patrols.

Figure 6-2: Administered support helps clinics to conduct the following activities



6.4 User fees

There is very little data across a large sample on the fees that primary health care clinics charge patients. As noted earlier, the practice is against the law, although it is known to be widespread. Clinics can raise fees in one of two ways: as consultation fees for services provided, or as charges for drugs and other medical supplies. These are considered in turn below.

Consultation fees for services provided

There are a range of services that may or may not be charged for. Table 6-5 shows the percentage of clinics that charge children and adults for specific treatments. In the case of children, only 30 per cent of health clinics charged for stitches, and the average price for those that did charge was K7.14. 66 per cent charged for a general consultation with a child, but the price (K1.15) was much lower. 31 per cent of health clinics charged for maternal care services.

Specific services that health clinics 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 per cent of health facilities charged a fee of close to K25 on average. Similarly, more than half of the health clinics surveyed charged for treating patients involved in tribal fights. In general, there was little difference between church and government clinics in terms of either their propensity to charge or the amount of the fees they charge, but 40-49 per cent of church clinics charged for consultations relating to domestic violence or tribal fights, whereas only 17-19 per cent of government clinics did.

Anecdotal explanations from survey fieldwork reveal that several health clinics regarded 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, which acts as a disincentive for violent behaviour.

Table 6-5: Service charges for common treatments – children and adults

	Charge fee for service (%)	Average cost if charged (Kina)
Specific to children:		
General consultation	66 (2.7)	1.15
Immunisation	20 (2.3)	1.21
Disease testing	17 (2.1)	5.26
Stiches	30 (2.6)	7.14
Specific to adults:		
General consultation	69 (2.6)	1.62
Maternal care	31 (2.6)	10.43
Births	35 (2.7)	15.71
Domestic violence	63 (2.7)	23.50
Tribal fights	59 (2.8)	25.68

Fees for drugs and medical supplies

The other way for health clinics to raise revenue is by charging for drugs and supplies for patients. As Chapter 4 showed, there is an increasing tendency for health clinics to offer drugs free of charge (see Figure 4-5). Nevertheless, on average, 42 per cent of clinics reported charging patients across 12 common drugs and medical supplies.

As Table 6-6 shows, there was a significant range in both availability and cost across the 12. The table shows that 11 per cent of health clinics charged for condoms, and 63 per cent for baby books. 49 per cent of clinics charged for a common drug such as paracetamol. Average charges, when imposed, ranged from 1 to 8 kina.

Table 6-6: Charges for common drugs and supplies at health clinics

	Available at time of survey (%)	Charge fee for medication (%)	Average cost if available and charged for (Kina)
Common drugs:			
Paracetamol	77 (2.3)	51	1.30
Amoxicillin	91 (1.7)	45	1.30
TB blister packs	36 (2.8)	31	1.46
Maternal and child health:			
Pregnancy tests	16 (2.1)	67	7.88
Baby books	35 (2.7)	63	2.40
Measles vaccine (HC+ only)	75 (2.8)	17	1.70
Ergometrine (HC+ only)	75 (2.8)	31	6.41
Condoms	82 (2.2)	11	1.21
Anti-malarial drugs:			
Fansidar	95 (1.1)	47	1.17
Choloquine	95 (1.2)	45	1.20
Mala-wan	50 (2.9)	49	1.42
Malaria RDT	45 (2.9)	37	1.42
Average	65	42	2.40

Table 6-6 reveals significant variation in charging practices across provinces. For example, about 90 per cent of health clinics in Gulf Province offered paracetamol free of charge, whereas only 28 per cent did in Morobe Province.

Total fees raised by health clinics – consultations and drugs

Across the whole sample, Table 6-7 shows that health clinics raise, on average, about K7,000 a year from charges for services and drugs or supplies. This is based on OIC estimates for an average month. This average hides a huge variation across provinces. East New Britain health clinics collect more than K12,000 a year, while Gulf Province clinics raise an average of just over K700 in a year. One of the most significant reasons for the differences is that some provinces have had a free primary health care policy, while others have actively encouraged their facilities to charge fees.

The difference between user fees raised at health centres and aid posts is also large.

Table 6-7: Average annual user fees raised at health clinics

	Percentage of clinics charging patient fees	Average user fees raised (Kina)
Overall	83	6,998
	(2.1)	(68.7)
East New Britain	100	12,240
West New Britain	100	5,880
Morobe	79	8,734
Sandaun	69	2,261
Eastern Highlands	92	7,317
Enga	84	8,671
Gulf	54	1,311
NCD	87	6,166
Health centre	92	9,796
Aid post	75	3,344
Government	81	6,696
Church	87	6,772

Notes: The user fee averages and percentage charging take into account fees from both services (consultations) and for drugs and supplies. The averages are over those that do charge.

User fee affordability

Just less than half the surveyed OICs believed that all or most patients could afford the fees charged, while more than 70 per cent of users believed fees charged by the clinic are about the right amount (Table 6-8). OICs estimated that about 40 per cent of families nevertheless received free treatment. This indicates that user fees have been charged flexibly. Church-run clinics had a higher estimate of the affordability of their fees, and correspondingly were less likely to waive

them. Across all clinics, only 22 per cent of users believed fees were too high.

Table 6-8: OIC and user views on fees, affordability and exemptions

	Perspective of OICs (%)		Perspective of users (%)		
	All or most patients can afford fees	Proportion of families receiving free treatment	Fees too high	Fees too low	Fees about right
Overall	46	41	22	7	71
	(7.0)	(2.8)	(2.1)	(1.3)	(2.3)
East New Britain	62	22	34	10	56
West New Britain	29	28	28	5	67
Morobe	44	44	17	0	83
Sandaun	39	68	17	8	75
Eastern Highlands	40	04	38	6	55
Enga	47	67	6	24	70
Gulf	45	82	10	0	90
NCD	69	42	21	0	79
Health centre	52	32	27	8	65
Aid post	39	50	16	8	76
Government	39	46	25	10	65
Church	52	36	24	3	73

Table 6-9 compares responses from OICs and users on the question of patients who cannot afford health services. 18 per cent of community respondents, but only 1 per cent of OICs, reported that non-payment resulted in non-treatment. Perhaps this is not surprising, as OICs might be unlikely to admit that they refuse patients treatment.

The Eastern Highlands had by far the highest proportion of users and OICs who said that non-payment resulted in non-treatment: 43 and 9 per cent respectively. Numbers for other provinces were 30 per cent or less for users and virtually zero for OICs. This indicates that both provinces and health clinics may have substantial discretion in formulating their own policies and plans for delivering services.

Table 6-9: What happens if you don't pay user fees? Community and OIC views

	Perspective of OICs				Perspective of users			
	Exempted	Pay according to ability	Pay in-kind	Refused treat-ment	Exempted	Pay according to ability	Pay in-kind	Refused treat-ment
Overall	37	35	19	1	34	30	10	19
	(2.8)	(2.8)	(2.3)	(0.6)	(3.0)	(2.9)	(1.9)	(2.9)
East New Britain	48	52	0	0	38	37	0	19
West New Britain	29	29	29	0	43	29	0	14
Morobe	56	22	22	0	67	12	8	8
Sandaun	44	33	6	0	7	40	20	27
Eastern Highlands	27	55	9	9	0	57	0	43
Enga	21	68	5	0	50	19	15	11
Gulf	48	13	17	0	20	20	49	11
NCD	82	6	6	0	86	0	0	14
Health centre	45	39	7	2	30	27	7	29
Aid post	32	32	29	0	38	33	14	10
Government	46	31	14	2	35	33	11	14
Church	36	37	23	0	34	21	11	27

Note: This table shows only the most common responses (as well 'Refused treatment'), so totals may not add to 100 per cent.

6.5 The relative importance of different financing sources

The data presented in previous sections of this chapter showed the reliance of health clinics on different financing sources. This section summarises the overall picture, in three different ways.

Table 6-10 summarises the support that health clinics receive across the three sources. Overall, only 18 per cent of health clinics receive cash funding (whether or not as the result of a budget request). 58 per cent receive in-kind support through either purchased materials or as in-kind support for health activities. 83 per cent raise some funds through user fees.

Health clinics may be either reliant on one source of support, a combination, all three or none at all. 41 per cent receive no external support at all. Of these clinics, 29 per cent are reliant only on user fees but nine per cent do not even receive fees, meaning they do not receive anything to deliver services. Aid posts are less likely to receive support than health centres for their basic operations.

Table 6-10: Extent of support received from funding, in-kind and fees (%)

	All	Health centre	Aid posts	Government	Church
In receipt of					
Funding	18 (2.2)	22	15	12	24
In-kind support	58 (2.8)	68	46	57	60
External support (funding or in-kind)	59 (2.8)	71	46	59	62
User fees	83 (2.8)	92	75	81	86
No external support	41 (2.8)	29	54	41	38
... But user fees	29 (2.6)	25	36	32	26
... No user fees either	12 (1.9)	4	18	9	12

Table 6-11 adds in information on how much is received. This is not available for in-kind program support, but it is still insightful. The average primary health clinic in PNG gets K24,000 in non-salary operational support (excluding program support). This can be compared to the K87,500 in non-salary support schools get, nearly all in funding (not in-kind). An aid post on average gets only K4,200. Church clinics receive much more than government clinics on average: K43,500 compared to K13,700. There is significant provincial variation with clinics in Sandaun and Eastern Highlands getting less than K10,000 each on average. Gulf and East New Britain clinics receive similar amounts on average, but East New Britain clinics get almost ten times as much in user fees, and a greater number get access to budget funding as well. This suggests that it is not just the total amount of resources that clinics have access to, but the form of those resources that matters.

Table 6-11: Average support received from funding, in-kind and fees

	Funding		In-kind		User fees		Total
	Share receiving	Value if receiving	Share receiving	Value if receiving	Share receiving	Value if receiving	Across all clinics
	%	Kina	%	Kina	%	Kina	Kina
Overall	12	31,645	36	39,493	83	6,998	23,823
East New Britain	33	15,467	30	45,250	100	12,240	30,919
West New Britain	7	123,683	31	-	100	5,880	-
Morobe	20	92,195	40	26,000	79	8,734	35,739
Sandaun	6	1,666	28	7,750	69	2,261	3,830
Eastern Highlands	18	5,942	22	7,900	92	7,317	9,540
Enga	0	0	32	50,000	84	8,671	23,284
Gulf	9	53,666	41	72,626	54	1,311	35,315
NCD	0	0	56	15,333	87	6,166	13,950
Health centres	16	44,003	41	51,637	92	9,796	37,224
Aid posts	5	2,434	26	6,100	75	3,344	4,216
Government	11	9,567	36	20,200	81	6,696	13,748
Church	12	77,254	36	78,600	87	6,772	43,458

Note: In-kind and therefore total figures unavailable for West New Britain clinics.

A third way to examine the relative importance of these sources of support is to find out how health clinics meet the costs of providing specific services. The PEPE survey asked health clinics how they met

the expenses to deliver seven key services and operational activities. These included the three Minimum Priority Activities (MPAs) – supposed to be supported through the health function grant – of outreach patrols, operations such as maintenance and the delivery of medical supplies. Three other important activities – patient transfers, maintaining utilities (such as a water supply) and paying casual staff (e.g. for porter or cleaning services) – were also included in the survey.

Respondents were given the following options for how they pay the expenses of delivering basic activities: own budget; request support from province/district/church/private/donor; user fees; own salary; referral health facility; other; or do not provide. The 'own budget' option refers to the use of funding received through the budget process or as direct payments. 'Requesting support from a funding provider' (province/district/church/private) refers to in-kind support. Choosing the 'referral health facility' option means that the supervising facility of the clinic being surveyed is responsible for the activity, such as a health centre in relation to an aid post that it supervises.

The first thing to note from Table 6-12 is that many services are simply not provided. On average, 29 per cent of the clinics surveyed responded that they did not provide the service in question. It also shows that user fees are the most important funding source for meeting the expenses associated with the three key services (casual wages, fuel and patient transfers). For the other three services – health outreach patrols, facility maintenance and collecting or delivering medicines – in-kind support is requested from funding providers. Contributions from health workers' own salaries is an important source of support for several activities. On average, user fees are as important a source of support as in-kind support for these seven services.

Table 6-12: Percentage of health clinics that normally meet expenses for conducting key health services through …

	Own budget	In kind	User fees	Own salary	Other	Referral health clinic	Do not provide
Health outreach patrols	11	31	11	5	12	12	27
Maintenance of facility	7	29	11	4	15	8	30
Collect/deliver drugs	11	26	25	9	13	17	8
Patient transfers	26	13	20	1	10	7	28
Maintaining utilities	11	21	18	3	10	7	39
Fuel for transport	13	10	24	6	10	5	40
Casual wages	14	10	23	3	6	3	40
Average	14	20	19	5	11	9	29

Note: 'Referral health clinic' means that the clinic to which the facility in question refers patients is responsible for the activity rather than the facility itself. Aid posts might respond in this way in relation to their supervising health centre.

On the whole, the survey findings show that clinics are often starved of support, and that user fees are a critical funding source for health clinics to carry out basic and essential operations. Clearly the current situation is unsatisfactory, as it is resulting in a large number of clinics

simply not providing services. Before considering new approaches, we first consider the likely impact of the free health care policy.

6.6 Implications for the free primary health care policy

Although the free health care policy was introduced in 2013, after the PEPE survey, the survey findings are of clear relevance to an assessment of its likely impact.

The first question that arises is whether the budgeted subsidy payments allocated under the new policy will be sufficient to offset the user fees that health facilities normally collect. Using survey data on user fees collected by health facility type, estimates of total annual fees raised were close to K12 million (Table 6-13). This figure is slightly higher than, but actually very similar to, the total subsidy allocations made through the free primary health care policy in 2014.

Table 6-13: Estimates of user fees (Kina) raised across health clinics

Facility type	Avg. user fees raised (Kina per clinic per month)	Number of health clinics	Total user fees per month (Kina)	Total user fees per 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	1,033	14	14,467	173,599
Urban clinic	538	69	37,154	445,853
Total/average	3,163	3,384	984,178	11,810,135

Note: Number of health clinics from Government of Papua New Guinea (2010).

Determining how the new subsidy payments would be distributed is more problematic. Subsidy payments could be allocated evenly across clinics (as school subsidy payments are), but this would not take into account the widespread variation in fees collected across clinics. Since user fees are often very important for funding health facility operations, the resulting reduction in income for most clinics 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.

Alternatively, 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 before 2014.

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 (NEFC). 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 again that it would not be based on the current fees charged.

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 that some health clinics are not left with less funding as a result of the policy will be virtually impossible, even if the overall subsidy allocation is greatly increased.

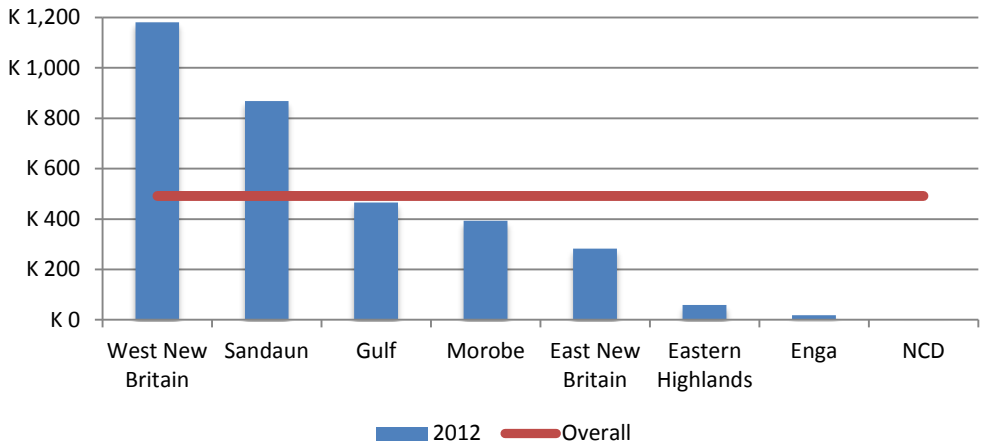
A key question for distributing subsidy payments is how to get funds to health clinics. Again, if the education model was used, the funds would be put into the clinic's bank account. However, the survey data reveals that only 44 per cent of clinics have bank accounts (Table 6-14).

Table 6-14: Health clinics with operational bank accounts (%)

	With bank account
Overall	44
	(2.8)
East New Britain	81
West New Britain	36
Morobe	42
Sandaun	44
Eastern Highlands	53
Enga	24
Gulf	26
NCD	13
Health centre	52
Aid post	33
Government	42
Church	44

Even if bank accounts were set up for every clinic, OICs would still have to access their funds. This could be expensive and inefficient. The magnitude of this challenge should not be underestimated, given the high costs of accessing financial services across PNG. The PEPE survey collected data on the total costs for health workers to access their pay and return to their posts. Since most health workers receive their pay directly into bank accounts, they need to access their pay at banks, ATMs or EFTPOS-type facilities. Figure 6-3 shows the average cost was about K490. There is enormous variation across provinces: the average cost is more than K1000 in Sandaun. And note that the costs of collecting school subsidy payments are more than double this level.

Figure 6-3: Average cost in kina to collect pay and return to post



Simply increasing subsidy payments for health clinics in a similar manner to schools under the Tuition Fee-Free policy is unlikely to be an appropriate short-term solution. Schools not only have bank accounts, which more than half of health clinics lack, they also have much better developed governance and supervision arrangements. Each school has a Board of Management (BoM), and, as Chapter 3 showed, it is influential, especially when it comes to finances. 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). While some health facilities have a Village Health Committee (VHC), these bear more resemblance to school P&C Committees, which represent community interests, rather than having a management or oversight role. Schools are also much more likely to receive supervisory visits than health clinics to monitor spending practices.

6.7 Conclusion

The health financing system in PNG does not provide reliable funding to health clinics to deliver services. Most clinics do not receive cash funding to meet expenses for their core operational activities and therefore need to collect fees or rely on in-kind support. Only 18 per cent of clinics reported receiving cash funding. 41 per cent had no access to any kind of external support (funding or in-kind) at all. These clinics are completely reliant on collecting user fees. 12 per cent of clinics neither charged fees nor had access to any external resources, and so simply had no means to cover any non-staff costs.

These results confirm the findings of earlier research. The District Case Study (DPLGA 2009) visited 25 health facilities in 2008/2009. It also showed that clinics experienced difficulties accessing funding and pointed to their reliance on user fees. This finding was confirmed by fieldwork reported in Sweeney and Mulou (2012) undertaken in 2009, which involved interviews at 44 health clinics, and by fieldwork

undertaken by the Monash Costing Study, also in 2009, based on some 50 health clinics (Inder et al. 2011).

What is striking about these new findings is not only that they are based on a much larger and nationally representative sample, but also that they come some three to four years later. In 2008, the health function grant was K14.5 million. In 2012, it was K64.4 million: about four times bigger. Recent NEFC reports have concluded that expenditure on front-line services, while still inadequate, has been growing (for example, NEFC 2012). A recent World Bank et al. (2013) report, based on a review of provincial expenditures, concludes that "there has been a real improvement since 2009 in the levels of funding and spending on frontline rural health services." (p. 11). However, as that study noted, these findings required further investigation by fieldwork to see whether increased expenditure was actually being translated into more and better services. What our fieldwork reveals is that whether there has or has not been an improvement, the situation is still far from satisfactory.

Our data suggests that the health function grant is not commonly used to fund budgets, but is kept at the provincial and district health office and, to the extent that it is directed to health clinics, is provided as in-kind support. But, even allowing for this, few resources seem to be reaching the frontline. Having 40 per cent of clinics with no external support at all, in cash or in-kind, is not a satisfactory situation. Given this lack of resources at clinics, it is not surprising that, as Chapter 4 showed, only a third of health clinics actually carried out maintenance of the clinic in 2012, or that just over a quarter of health centres conducted regular outreach patrols, or that only 36 per cent had adequate access to fuel to collect drugs. These three activities are part of the core priority services that the health function grant should fund to help enable health facilities to deliver these types of services.

What should be done? The PNG National Health Plan 2011-2020 acknowledges that "front-line service staff report [are] being impeded in their efforts by a lack of operational funds." (Government of PNG 2013). It calls for the introduction of a "direct facility funding" model whereby "allocated funding will be channelled directly to facility accounts." Such an approach is currently being trialled in Bougainville. Donor funding is being used to channel funds directly into health centre bank accounts, and health centre committees have been formed to help the OIC prepare budgets and manage expenditure. An evaluation of progress since 2011 (WHO and NDoH 2013) found that health centres receiving direct financing were able to deliver more health services, across a range of measures, than non-participating health centres in Bougainville.

This approach clearly has its merits, but also potential drawbacks. If mainstreamed, funds would still flow through provincial governments, and may be difficult to integrate into current financial arrangements. Many clinics do not have bank accounts, and would struggle to access

them once established. Establishing local oversight bodies would take a long time. Given the shortage of health workers, it is not clear that OICs should be given the additional burden of financial management.

A variant of this approach is direct funding to health clinics from the central government, that is, the application of the approach used by primary schools. Unlike with respect to primary schools, the central government is directing its funding to compensate clinics for the abolition of health charges through provincial governments, but, to avoid diversion or delays, it could start sending the funds directly to clinics. There will, once again, be issues at the clinic level (difficulties in accessing the funding, lack of oversight, staffing constraints), but the school subsidy experience suggests that the funding will at least reach the clinics' bank accounts.

A third model is that used by East New Britain. In this province, each health clinic is given a 'ring-fenced' entitlement in the provincial budget to a specific amount of funding from the health function grant. Some remote facilities receive a loading to account for the higher cost of services in their area, and health centres receive much more than aid posts due to their greater responsibilities. The funds are channeled to each of the province's 18 Local-Level Governments, and held in the relevant District Treasury on behalf of each facility. This is a 'facility budget allocation' model, rather than a 'direct-to-facility grant' model like PNG's system of school grants, because funds are not placed in a bank account operated by each facility.

It appears that East New Britain's system increases the flow of funds to each health facility. Facility staff access funds through their supervising Local-level Government. Over several years, the province has provided additional staffing, funding and infrastructure to its 18 LLGs, partly with a view to improve their ability to oversee the operation of health facilities. This includes LLG health manager positions, which appear to be unique to East New Britain. These officers are responsible for supporting specific clinics, so are able to work with the OIC to access funds according to the facility plan. This helps to ensure the clinic provides a comprehensive service to patients and that basic activities are conducted, such as regular maintenance, outreach patrols and drug collection. Given East New Britain's performance on health delivery, such a model warrants further investigation.

Further investigation of all of these approaches is required before a final recommendation is made. This will be undertaken as part of the second phase of this research project. What is clear at this stage is that there needs to be a shift to ensure that greater funding reaches clinics, putting flexible resources at their disposal.

This chapter has also revealed important differences between church and government-run clinics when it comes to financing. Church health clinics are no more likely to receive funding or in-kind support than government clinics but, if they do receive it, they receive much more:

almost eight times more for funding, and about four times as much for in-kind support. Chapter 9 considers the consequences of this increased funding for performance.

Whatever reform plans are put in place, in the short term the abolition of health user fees is going to make things worse, especially for the 30 per cent of health clinics that have no other source of finance for non-staff expenses. More generally, the survey responses suggest that user fees have become the most widely available, easily accessible and reliable source of funding for health facilities to use in the delivery of front-line services. For the reasons given in the previous section, it will be very difficult, if not impossible, to compensate clinics for the abolition of fees. While the intention of the policy is to improve access to services, its implementation will likely weaken, rather than strengthen, the health system.

Whether or not the free health care policy is reversed, the system of financial management in the primary health sector needs to be overhauled. Learning from approaches that seem to work and from pilots underway is probably the best way forward. Regular monitoring of the level of resources reaching health clinics will be crucial.

Chapter 6 Annex

Table 6-A1: 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	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

Table 6-A2: Health clinics that received direct funding without preparing a budget

Province	Agency type	Facility type	Funding provider	Amount received
Morobe	Lutheran	Rural Hospital	Lutheran health services	34,2000
Morobe	Government	Aid post	German health partnership	15,000
Morobe	Lutheran	Aid post	Local-level Government	20,000
Gulf	Other religious	Rural hospital	Tel investment – Oilsearch Ltd	128,000
Gulf	Catholic	Aid post	Catholic Health Services	1,200
East New Britain	United	SHC	United Church – Operation grant	10,000
Sandaun	Other religious	Health centre	DSIP	37,000
Enga	Catholic	Health centre	HIV/AIDS NGO	30,000
NCD	Government	Urban clinic	PNG Sustainable Development Program	60,000

Table 6-A3: Percentage of clinics assisted with administered support to carry out various activities in 2012

	Health outreach patrols to villages	Patient transfers to referral HC/hospital	Maintenance of health facility/ housing	Collecting or delivering drugs
Overall	82	34	28	47
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
NCD	40	20	20	60
Health centre	92	51	40	60
Aid post	75	9	7	33
Government	88	35	23	48
Church	73	32	34	38