

Donor funding to the PNG health sector: how much, where it came from and where it was spent.

Ali Kevin
Delia Hendrie
Navy Mulou
Urarang Kitur

Abstract

Progressive discussions on health sector SWAp ('sector wide approach') funding between the PNG Government and donors between 1995 and 2003 resulted in the establishment of the Health Sector Improvement Program Trust Account (HSIPTA). The objective was to bring together the government and donors to improve coordination and support national leadership and ownership, more importantly support a single sector policy by increasing annual funding of the Health Department's annual activities. The SWAp mechanism attracted investment from nine donors, which between 2009 and 2013 contributed PGK368.8 million. However, the extent to which donor funds were actually spent on three critical health MDGs – child health (MDG4) maternal health (MDG5) and combatting HIV/AIDS, malaria and TB (MDG6) – is in question.

The paper shows that SWAp funding dropped off steeply after the first two years, making it difficult to keep up the delivery of services. Nonetheless, 69% of the overall funding was indeed committed to the three health MDG programs. Of this, 5% was committed to MDG4, 2% to MDG5 and 62% to MDG6 (32% to HIV/AIDS, 23% to malaria and 7% to TB). However, only 56% of the funds were actually spent, as far as can be seen from available records.

Differences in funding allocated to each MDG may reflect earmarking of funds by donors, potentially impacting aid effectiveness. The value of aid effectiveness was also reduced by not all committed funds being disbursed, with the capacity of the Health Department to implement programs a possible underlying factor.

Key words: Donor, HSIP Trust Account, Millennium Development Goals, Partnership, SWAp,

Introduction

Papua New Guinea (PNG) is a member of many international health initiatives, conventions and treaties. In 2000 it became a signatory to the Millennium

Declaration. To meet its international commitment, the PNG Government through the National Department of Health (NDoH) aimed to work towards achieving the three health-related MDGs by 2015 (NDoH, 2010), which are child health (MDG4), maternal health (MDG5) and combatting HIV/AIDS, malaria and tuberculosis (TB) (MDG6).¹

PNG's major health issues have remained largely unchanged over the past fifteen years with health indicators remaining poor (UNDP, 2014) – PNG having the worst health status in the Pacific region (DNPM, 2015). Compared to low-income countries in the Pacific region, PNG's MMR is 220 per 100,000 live births and that of Indonesia, a comparable country, is 190 per 100,000 (ESCAP, 2014).

PNG experiences a very high disease burden of TB, with prevalence rate of 541 per 100,000 population, death rate 26 per 100,000 and mortality at 54 per 100,000 (UNDP, 2014, p. 43).² Malaria accounts for the highest number of outpatient visits each year, with 1.07 million cases, 14,546 in-patient and 380 recorded deaths in 2012, making this the fourth leading cause of hospital admissions and third leading cause of death (UNDP, 2014, p. 43). HIV/AIDS is endemic in PNG with a prevalence rate of 0.7% nationally (UNDP, 2014, p. 46) A recent report by the United Nations AIDS Fund indicated that about 25,000 people in PNG live with HIV compared to the Philippines with 15,000 people, noting that PNG has a population of 8.5 million compared to Philippines with 98.4 million people (UNAIDS, 2013).

The World Health Organisation (WHO) has called for global solidarity (WHO, 2010a) urging high-income countries to support low and middle-income countries close funding gaps to address their health challenges. The PNG government and donors pursued establishing a health sector wide approach (SWAp) between 1995 and 2003, which resulted in the establishment of the Health Sector Improvement Program Trust Account (HSIPTA) within NDoH (Thomason et al. 2009; Bauze et al. 2009). The aim of the HSIPTA was to bring together the government and donors to improve coordination and support national leadership and ownership, more importantly support a single sector policy by increasing funding of Health Department's annual activities (WHO, 2004). The SWAp mechanism attracted investment from nine donors, who between 2009 and 2013 contributed PGK368.8 million to the HSIPTA. However, the extent to which donor funds were spent on the three health MDGs – child health (MDG4) maternal health (MDG5) and combatting HIV/AIDS, malaria and TB (MDG6) – is in question.

¹ Note that PNG has now committed to the Sustainable Development Goals (SDGs) which followed on from the MDGs in 2015. This paper is about the MDGs.

² The prevalence rate is 70 times higher than in Australia, for example (Centenary Institute, 2013).

Analysis of data

A descriptive study using expenditure data from HSIPTA (between 2009 and 2013) was conducted to address the questions: in regards to donor funding to the PNG health sector, how much was donated, where did it come from and where was it spent?

The HSIPTA expenditure data set was provided to the authors by the NDoH's HSIP accounts section. It was generated through the PNG Government Accounting System (PGAS). The data set is also used in monthly reporting to the Health Finance Committee, in quarterly reviews and in annual audits.

The data set included a column that indicated the function description (e.g. HIV/AIDS), a column for activity descriptions (procurement of ART drugs), a column for source of funding (e.g. Global Fund), a column for appropriations (PGK), and a column for expenditure (PGK).

The following analysis was conducted using the complete set of information provided by the HSIPTA:

1. Overall donor funding to the HSIPTA. The funding source column for each year was summed up including creating a total column with sums of each year added together to get total contribution from donors between 2009 and 2013.
2. Distribution of donor funding to different MDG areas. Grouped each donor using the funding source column and then identified what MDG areas they funded using the function description column for each year. The sums of each MDG area funded by each donor for each year were then summed up to give total funding by each donor for each specific MDG areas as well as other areas.
3. Overall expenditure on each of MDG areas including others. Related MDG areas were grouped using the function description column for each year. The appropriation and expenditure columns were used to sum up total amount allocated and expensed for each MDG area including others (which are not related to the MDG areas).

Limitations

In the HSIPTA data, possible error may have been introduced during manual coding to identify the correct funding sources and to classify expenditure against MDG areas. However, the codes provided by the HSIP accounts section were clear, showing for example funding sources (e.g. 600 – The Global Fund), the function (e.g. 603 – HIV/AIDS), and the activity (e.g. 5252 – procurement of ART drugs). A short-coming that was noticed while organising data for analysis, was that the data table did not have a column indicating whether the funds were earmarked or

not (repeat reference), so assertions in the discussion section will be purely from literature review.

Overall donor funding to the HSIPTA by years

Donors contributed PGK368.8 million to the HSIPTA between 2009 and 2013. However, the level of funding dropped off steeply after two years (Figure 1).

The Australian Aid program,³ the biggest donor in PNG, and the Global Fund were the biggest contributors, giving 44.4% (PGK163.9 million) and 28.3% (PGK104.4 million) of total funding respectively. The other donors provided 10% funding or less to the total funding.

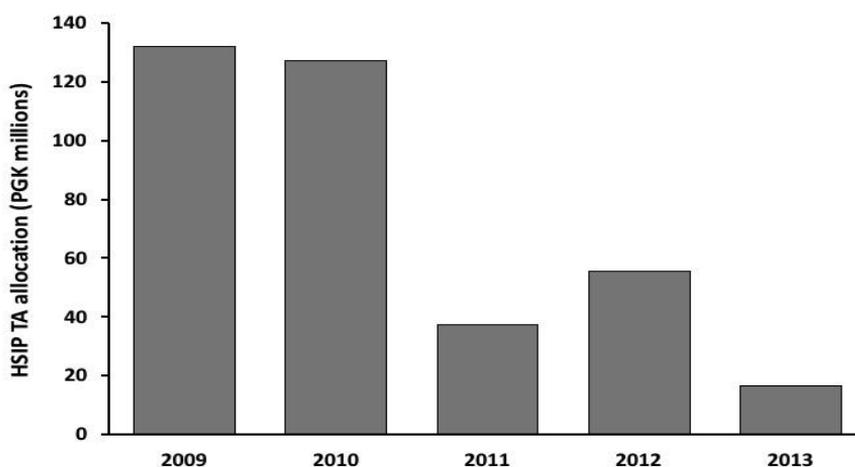


Figure 1. Overall donor funding to the HSIPTA by year, 2009-13

Distribution of donor funding to different MDG areas

Overall, 69% (PGK254.5 million) of the donor funds were committed to the three health MDG areas (Table 1). The other 31% (PGK115.9 million) went to costs not related to the MDGs (key function in health system approaches and performance of provincial health services). Of the PGK254.5 million committed to the three

³ International development assistance from Australia was managed by AusAID, a standalone agency, up to 2013. Following a change of government, the agency ceased to exist and subsequently development assistance has been managed by the Department of Foreign Affairs and Trade under the name 'Australian Aid'. To harmonise current and past usage, the term 'Australian Aid' is used in this paper in a generic sense.

health MDG areas, 62% was allocated to MDG6 (HIV/AIDS, 32%; malaria, 22%; TB, 8%), 5% to MDG4 (child health) and 2% to MDG5 (maternal health).

The concentration of funding on MDG6 is not surprising since the biggest donor, Australian Aid, gave the most of its contribution to HIV (32%) and malaria (16%). It gave much less to child health (6%), TB (1%) and maternal health (0.2%). About 45% of its funds were contributed to non-MDG areas, covering health system approaches focusing on key functions: health financing, medical supplies, health workforce, infrastructure, public health and community mobilisation.

The Global Fund concentrated its funding on malaria (50%), TB (24%) and HIV/AIDS (23%). It provided less than 1% to child health and maternal health activities.

The Asian Development Bank (ADB) funding was concentrated on HIV/AIDS activities (98%) through its Enclave program (needs reference), and most of New Zealand Aid was spent on non-MDG areas (85%), especially improving performance of provincial health services.

The contributions from the small donors, typically focussed on one area only (The Global Alliance for Vaccines and Immunization GAVI, The United States Agency for International Development, USAID) did little to affect the balance of spending on the MDG areas.

	AusAID		Global Fund		ADB		NZAid		WHO		
	PGK (m)	%	PGK (m)	%	PGK (m)	%	PGK (m)	%	PGK (m)	%	
Child Health	10.0	6.1%	0.2	0.2%	-	-	3.5	10.0%	1.6	8.0%	MDG4
Maternal Health	0.4	0.2%	0.1	0.1%	-	-	1.5	4.2%	1.7	8.5%	MDG5
HIV/AIDS	52.6	32.1%	23.6	22.6%	38.2	98.1%	0.2	0.7%	2.0	10.0%	MDG6
Malaria	26.2	16.0%	52.3	50.1%	-	-	-	-	4.9	24.1%	
TB	1.6	1.0%	25.1	24.0%	-	-	-	-	1.5	7.2%	
Non-MDG	73.1	44.6%	3.1	3.0%	0.8	1.9%	30.1	85.2%	8.7	42.3%	
	163.9	100%	104.4	100%	39.0	100%	35.3	100%	20.5	100%	

	UNFPA		UNICEF		GAVI		USAID		Total		
	PGK (m)	%	PGK (m)	%							
Child Health	-	-	0.9	41.2%	0.8	100.0%	-	-	17.0	4.6%	MDG4
Maternal Health	2.1	95.3%	0.2	9.9%	-	-	-	-	6.1	1.6%	MDG5
HIV/AIDS	-	-	1.0	46.5%	-	-	0.5	100.0%	118.3	32.1%	MDG6
Malaria	-	-	-	-	-	-	-	-	83.4	22.6%	
TB	-	-	-	-	-	-	-	-	28.2	7.6%	
Non-MDG	0.1	4.7%	0.1	2.4%	-	-	-	-	115.9	31.4%	
	2.3	100%	2.1	100%	0.8	100%	0.5	100%	368.8	100%	

Table 1. Distribution of donor funding to different MDG areas, 2009-13. Amounts in millions of PNG Kina.

Discussion

The development partners provided up to 60% development funds to PNG (WHO, 2010c). About 23% of these funds were provided to health through the HSIPTA (Richards et al., 2012). Particularly, the PNG Budget papers (2009-2010) indicated a PGK7.1 million (2009 Budget, Vol. 1, p. 96-98) and PGK41 million (2010 Budget, Vol. 1, p.100-102) donor budget through HSIPTA. However, the figures are relatively small and compared to information provided by the HSIPTA accounts section within the NDoH. A further budget of PGK134.5 million Australian aid grant was reported in the 2012 budget papers (Vol. 1, p. 130) but again the budget papers fell short of indicating whether the funds were channelled through the HSIPTA or not. There was no donor budget mentioned in the 2011 Budget papers for HSIPTA (Vol. 1, p. 125), and the 2013 Budget papers (Vol. 3, p. 195) indicated a decline of Australian aid participation in the health sector SWAp.

The Health Sector Partnership Policy (2014) enabled partnership agreements, including providing an enabling an environment to coordinate efforts from all health partners, i.e. to manage all health partners within a comprehensive approach that bundles them against system policies and public health priorities (WHO, 2010c).

However, the Aid Effectiveness agenda in the National Health Plan (2011-2020) was not sufficiently detailed. There were no strategies to strengthen ownership and leadership at NDOH or provinces and districts, including strengthening government systems: targets for alignment and harmonization agenda to stream funding channels for aid effectiveness over the long term (Matheson et al., 2015). The same sentiments were also raised in the PNG 2012 Budget papers (Vol. 1, p. 130).

In addition, the Annual Activity Plans (AAP) put together at national and provincial levels by NDoH and provincial health office were normally a document prepared specifically for obtaining HSIPTA funding (Foster and Piel, 2010). Matheson et al. (2015) argued that AAPs were not comprehensive in spelling out how the plans and budgets at different levels of the health system were to be compiled and integrated to produce an overall health sector operational plan incorporating annual targets, budgets and funding gaps - no credible process in place for planning and budgeting the use of trust account funding, including development budget, and AAPs driven by development partners with no prioritisation (Foster and Piel, 2010).

In fact, the PNG 2012 Budget papers (Vol. 1, p. 130) noted that some progress was made in addressing the outstanding issues e.g. in setting up an audit committee, restructuring divisions to fast track procurement and aligning AAPs to the National Health Plan. But acknowledged that further improvements are necessary.

Looking at the big four donors, Foster and Piel (2010) argued that most of the funds in HSIPTA were project-specific and earmarked, especially, Global Fund and ADB funds (100 per cent earmarked). Australian aid provided relative non-earmarked funds, while New Zealand aid provided 100 per cent non-earmarked funds through provincial HSIPTA for performance of provincial health services.

Key stakeholders' views reported in the HSIPTA redesign work undertaken by Richards et al. (2012) were that HSIPTA attracted a level of funding that was beyond its capacity to implement. The areas of weakness included a lack of administrative and contracting capacity in NDOH, and absorptive capacity in rural and remote PNG.

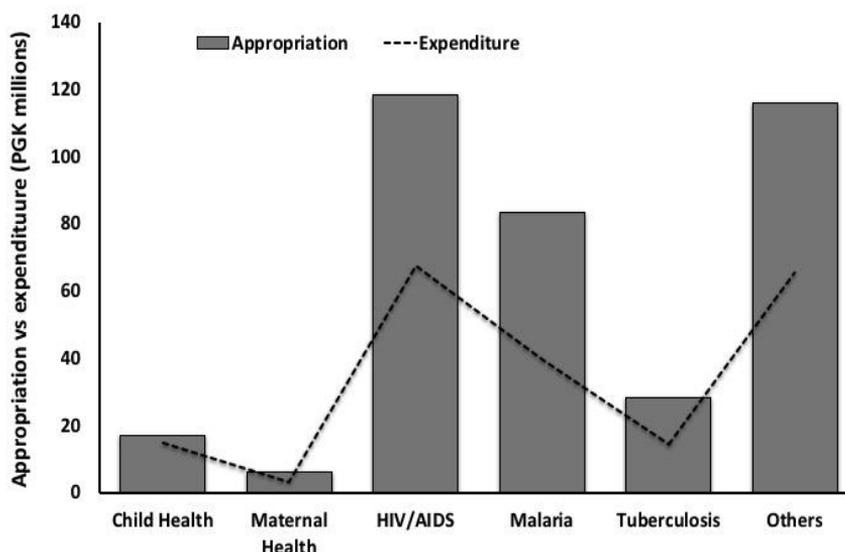


Figure 2. Overall expenditure for each of the MDG areas 2009-13.

This was manifested in several ways. The large amount of funding for HIV, TB and malaria skewed the overall distribution of health funding, putting a heavy burden on the general health care system (WHO, 2010b). Again, because NDoH lacked regulatory and procurement capacity, the Global Fund and GAVI used global procurement mechanisms, instead of PNG Government systems, to procure impregnated bed nets, Rapid Diagnostics Tests, Anti-retroviral Treatment (ART), as well as TB and malaria drugs, which did not address the need to overhaul these systems for the long term (WHO, 2010c). Finally, Richards et al. (2012) argued that the significant decline of donor funding to the HSIPTA after 2010 was itself a result of HSIPTA undergoing review after review in the second half of the program life.

In its final report on the MDGs, the PNG government did acknowledge the support provided by the development partners. But it noted that the three indicator targets for MDG4 (under-five mortality, infant mortality and measles immunisation) were not achieved. MDG5 had six national indicator targets. Progress with the low target for 'skilled birth attendance' was considered 'mixed'; 'contraceptive prevalence rate' was not achieved; the target of reducing the MMR below 500 deaths/100,000 live birth was claimed as achieved, but it is outrageous to boast about only beating a target set so low that PNG was only better off than countries in West and Central Africa; three other indicators were not measured (DNPM, 2015).

MDG6 had 12 national indicator targets. The five for TB were not measured or, if they were, they not reported. Of the four for HIV, two were met and two were not met. The last of these, 'access to antiretroviral drugs (86%)' was claimed as met but in 2018 the National AIDS Council was reporting a 'critical shortage' of anti-retroviral drugs in the country due to budget cuts (RNZ, 2018, April 16). The three

indicator targets for malaria were met by 2015 (cf. NDoH, 2015), but sadly more recent work by the PNG Institute of Medical Research has shown that the real gains achieved during the MDG period, which were also reported for PNG's Melanesian neighbours Solomon Islands and Vanuatu, have been followed by a 'resurgence in malaria' (Hetzl et al., 2018).

Conclusion

Funding for the health MDGs was not stable over the 5-year period, making it difficult for service delivery - funding contributions from donors dropped steeply after 2010. Differences in funding allocated to each MDG may reflect earmarking of funds by donors, potentially impacting aid effectiveness. Value of aid effectiveness was also reduced because not all committed funds were disbursed, with the capacity of the NDoH to implement programs an underlying factor.

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The authors

Ali Kevin, Student, Master of Health Administration, Curtin University, Perth, Western Australia

Dr Delia Hendrie, Senior Lecturer, Health Systems and Health Economics, School of Public Health, Curtin University, Perth, Western Australia

Navy Mulou, Technical Adviser, NDoH Economic Unit, Papua New Guinea

Dr Urarang Kitur, Manager, NDoH Performance, Monitoring & Research Branch, Papua New Guinea