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Glossary of Terms

CHS	Church Health Services
CSO	Civil Society Organization
DPLGA	Department of Provincial and Local Government Affairs
GoPNG	Government of Papua New Guinea
LLG	Local Level Government
M&E	Monitoring and Evaluation
MTDP	Medium Term Development Plan
NDoH	National Department of Health
NDPM	National Department of Planning and Monitoring
NEC	National Executive Council
NEFC	National Economic and Fiscal Commission
NGO	Non Government Organization
NHIS	National Health Information System
Organic Law	Organic Law on Provincial Governments and Local-level Governments
PHA	Provincial Health Authority
PNG	Papua New Guinea

Message from the Minister for Health and HIV/AIDS

Health is vital to life in PNG. Whether gardening, dancing, attending church, selling fish in the market or working in formal employment, all Papua New Guineans and their families benefit when each person participates fully.

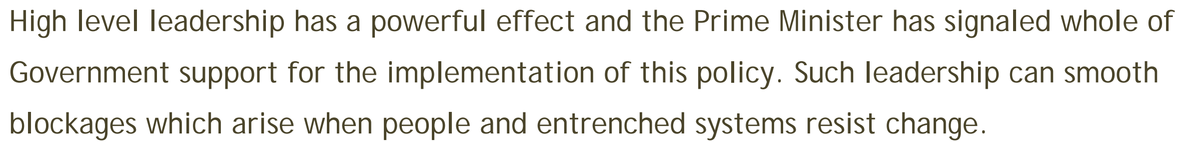
We are facing threats to the health of our people. Too many women die giving birth to our children. Babies lose mothers and husbands lose wives. Families, communities and workplaces lose the productive years of their women.

Our babies and young children under five years still die from preventable causes. TB is an existing threat. Multi drug resistant TB and extreme drug resistant TB are looming threats. HIV appears to be leveling in prevalence in some provinces but continues to increase rapidly in others. HIV also takes the productive years of our men and women.

On the front line of health service delivery, committed men and women working hard within and outside Government to have brought about some welcome improvements. These achievements come despite insufficient resources, difficult roads and transport and access to necessary drugs. Examples include a rise in rates of immunization of children and a drop in malaria related mortality and morbidity.

User charges can prevent the poorest people of PNG from enjoying the right to access primary health care. In the *Alotau Accord for a Government of Reconciliation, Unity and Hope*, the Government announced that it will maintain its commitment to accessible and affordable health care by providing free primary health care and subsidized specialist services. The National Department of Health has thrown its strength behind this great endeavor.

Health is everybody's business. We are confident of the cooperation and partnership of the Department of National Planning and Monitoring, Department of Treasury, the Department of Provincial and Local-Level Government Affairs which have powers and responsibilities which directly affect health financing. We are similarly confident of Provincial Governments and of our long time partners in health service delivery, the Christian Health Services of PNG.


High level leadership has a powerful effect and the Prime Minister has signaled whole of Government support for the implementation of this policy. Such leadership can smooth blockages which arise when people and entrenched systems resist change.

The people of PNG expect that we do not shy away from a difficult task. They seek leadership, maturity, cooperation and commitment. As Minister for Health, together with my Department, I embrace my role as leader of this important reform process to improve equity and access to our health system for our people. We welcome partnerships with other Government Departments and the Christian Health Services of PNG to implement the Alotau Accord and provide Free Primary Health Care and Subsidized Specialist Services to all Papua New Guineans.

Hon. Michael Malabag, OBE, MP,
Minister for Health and HIV/AIDS

Foreword from the Secretary for the National Department of Health

The National Department of Health (NDoH) is the steward of PNG's health system. In taking up this responsibility, the NDoH has detailed its priorities, objectives and strategies in the National Health Plan 2011-2020. It is working to achieve strengthened primary health care for all and improved service delivery for the rural majority and urban disadvantaged.

The PNG Constitution and the Millennium Development Goals (MDG's), aim to improve public health for all, including the poorest people. Poor people are deterred from seeking health care for themselves and their families when fees are charged.

The commitment of this Government to Free Primary Health Care and Subsidized Specialist Services is welcomed and wholly supported by the NDoH. It complements the current National Health Plan and its successful implementation will improve access and equity of the health system for all Papua New Guineans.

Sustainable implementation is the focus of this policy. The health system is complex and responsibility for legal or administrative "levers" which affect its operation are spread across several Government Departments. The robust and committed support of the Department of Treasury, the Department of Provincial and Local-Level Government Affairs and the Christian Health Services of PNG is crucial.

The Governments strong commitment to improving the health of all Papua new Guineans is welcomed. It is given voice in the Alotau Accord.

Powerful government leadership inspires and encourages us to work hard with our partners to smooth the impediments and implement the policy. We give effect to the Government vision which seeks to bring about some real improvements in the lives of the poorest and most vulnerable of our people. This is a truly worthwhile endeavor.

Mr. Pascoe Kase
Secretary for the National Department of Health

WHAT IS THE ALOTAU ACCORD?

The *Alotau Accord for a Government of Reconciliation, Unity and Hope for Stability and Prosperity*is described as a "Platform for Action" for the new O'Neil/ Dion Government. It articulates a vision, mission and strategies for the 9th term of Parliament and is a formal statement of government policy. Health care is identified in as a Priority Impact Project as follows:

The government will maintain its commitment to accessible and affordable health care by providing free primary health care and subsidized specialist services.

WHY IS THERE A NEED FOR FREE PRIMARY HEALTH CARE AND SUBSIDIZED SPECIALIST SERVICES?

The first part of the *Constitution* declares National Goals and Directive Principles. The first of these makes a "call for improvement in the standard of public health to enable our people to attain self-fulfillment."[1] Policies and laws to foster better health service delivery and better health outcomes are consistent with this priority. Three of the Millennium Development Goals, to the attainment of which PNG has made a commitment, are also about health or access to health care.[2]

User charges can prevent the poorest people of PNG from enjoying the right to access primary health care. The objectives of this policy are to:

- promote access to services according to the need for such services;
- promote equitable provision of services;
- help realize PNG's Constitutional commitment to a better standard of public health and PNG's commitment to the MDG's and
- help realize the National Health Plan 2011-2020's goal of 'strengthening primary health care for all and improved service delivery for the rural majority and urban disadvantaged'.

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[1] *Constitution of the Independent State of Papua New Guinea*, National Goals and Directive Principles 1(4). See www.paclii.org accessed 16 February 2013.

[2] UNDP Millennium Development Goals at http://www.un.org/millenniumgoals/ accessed 16 February 2013

What is primary health care and subsidized specialized services for the purposes of the Alotau Accord?

The definition of primary health care is derived from the Declaration of Alma Ata:

education concerning prevailing health problems and the methods of preventing and controlling them; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;[3]

Primary health care, for the purposes of this Policy, is usually provided as ambulatory care in non-hospital or outpatient settings.

Specialized health care services:

Curative services requiring the specialized attendance of a medical practitioner.

Specialized health services, for the purposes of the Policy, is usually provided to inpatients in hospitals.

What is in this Policy?

This policy achieves implementation of the Alotou Accord commitment to health with a system wide approach across facility levels in two stages.

Stage One would see immediate implementation for facility levels one to three, aid posts, community health centres and urban clinics.

Stage Two would see implementation by December 2013 in levels four to seven, being district, provincial and regional hospitals and our national hospital in Port Moresby.

What are facility levels?

The PNG health system operates at seven levels of service delivery delivered by facilities commencing with Village Aid Posts and Community Health Posts providing health promotion, health improvement, health protection, primary health and maternity care at the local rural and remote community level.

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[3]Declaration of Alma Ata at http://www.who.int/publications/almaata_declaration_en.pdf accessed 14 February 2013

It is important to undertake implementation of the policy in two stages because the shift to removing user fees for primary health care and further subsidizing specialized health services will have an impact on the way the system currently functions.

The "recalibration" of the system as a result of removal of some user fees and reduction of others could potentially affect the way people use the system, with flow on effects to the viability of the system if not managed carefully.

It is predictable the patient behavior would change in response to the provision of free primary health care and subsidized specialized health services system wide. People would be very likely to flock to the higher facility levels of the system.

Hospitals are considerably more expensive to equip, maintain and staff than lower level facilities. PNG cannot afford an influx of people seeking to have their primary health care needs met in hospital s at levels four to seven in the health system.

Ironically, those parts of the system under the greatest threat would be the higher level, best run and best quality services. This policy begins implementation at the lower facility levels to avoid further strain on a fragile system.

System wide implementation using facility levels beginning with the lower three levels helps avert the risk of overloading some parts of the system.

From these lower levels, referral arrangements may be made for care at higher levels where this is needed. The higher level hospitals offer complex tertiary level clinical services.

An effective referral system from lower levels of the system is crucial to ensure rational use of higher and more expensive levels of the system to maximize access and utilization of resources.

This policy recommends an orderly implementation which enables support of the appropriate use of facility levels and support of referral from lower to higher levels of the system to maximize resource use and access.

HOW WILL IMPLEMENTATION BE MANAGED?

For Facility levels one to three - on NEC approval of the Policy, implementation begins immediately for levels one to three of the system, being aid posts, health centres and urban clinics.

Arrangements will made for payment of appropriated funds to offset the loss of user fees in aid posts, health centres and urban clinics. User fees will be abolished altogether in these facilities.

For Facility levels four to seven - while implementation occurs for levels one to three, the NDoH Implementation Team will consult with health facilities at all levels of the system to plan an orderly transition to implementation of the Alotau Accord in relation to health at the four higher system levels by December 2013.

The implementation team with consult on effects of the reform generally, but will consider in particular:

- how to ensure an implementation process which minimizes recalibrating patient behavior to choose use higher levels of the system in preference to lower levels and to place catastrophic strain on the system in the process.
- The effect on patient behavior in the face of free primary health care and subsidized specialized health services across facility levels four to seven of system and how to create rules to ensure people don't swamp higher level better functioning health facilities to the point of threatening their viability.
- The effect on the workforce and adequacy of the workforce to serve greater numbers of patients.
- Infrastructure consequences. Patient care is not just being seen by a health professional. Patient care is supported by pathology, blood examinations, x rays etc. The effect on infrastructure will also be considered.
- Effect on referral patterns. Are patients shifting to access the lower levels of the system, thus preserving higher levels for the specialized services they are intended to provide?

Phase One – System Wide Implementation in Facility Levels One to Three via Two Concurrent Action Plans

Implement free primary health care at levels one to three of the system. This includes aid posts, health centres and urban clinics irrespective of whether the services are provides directly by provincial government, provincial government funded health services or Church run health services in receipt of Government funds.

The legal and administrative arrangements for government run health services and Church run health services are quite different. While Phase One envisages implementation across facility levels one to three of the health system irrespective of who delivers the health service, there is a need for two concurrent action plans to achieve system wide implementation across all facilities at levels one to three.

Action Plan 1 – Government run health services at facility levels one to three

What are the objectives of Action Plan 1?

- Acknowledge entrenched practice of charging user fees at several levels of the health system including at levels one to three

- Recognize that that provincial government funded health facilities have no power to charge user fees by operation of the Organic Law.
- Recognize that many health facilities still charge, despite the lack of power, and have relied on user fees to manage recurrent periods of lack of funding caused by bottlenecks in the health financing system of payment of health function grants.
- Acknowledge that there have been bottlenecks in the health financing system leaving provincial health facilities short of funds and these must be removed to remove the need to charge user fees.
- Finalize data collection on current user fees collected by all health facilities at levels one to three to identify what funds are required to offset the removal of all user fees at facility levels one to three.
- Develop a joint NDoH/DPLGA communication strategy to advise provinces about the reforms and the implementation strategy, so that provinces will be in a position to prepare to fast track payment of health function grants to facilities and to answer questions posed by facilities about the reforms.
- Department of Finance immediately move to fully implement Finance Instruction 1A/2010, in any province where this is not already implemented. The Finance Instruction has the effect of rolling overunspent funds from the health function grant in a given fiscal year to the next fiscal year to continue to be applied to health service delivery under the health function grant.
- Department of Finance to create a new Finance Instruction to frontload health function grants to ensure funds to offset user fees are available to all health facilities before the lack of funds from removal of users fees is felt, thus removing the need to charge user fees.

Who is responsible for Action Plan One?

There is joint responsibility by NDoH and the Departments of Treasury, Finance and Provincial and Local-level Government Affairs. All these Departments control health system levers and must provide robust support of the implementation of this policy according to the levers of the health system they control in health financing and in particular, the delivery of funds to provinces via the health function grant and their timely disbursement by provincial treasuries.

Action plan 2 – Church run health services at Facility levels one to three

Approximately 50% of health services in PNG are provided by Church health services. This makes them a crucial partner in health service delivery in PNG. While Church health services have a strong urban presence, they predominantly serve the rural areas of PNG, which means that they principally work with the people that this policy aims to reach.

Church health services continue to partner the Government of PNG is providing health services under difficult circumstances to the most vulnerable people in this country. The

Christian health services are private entities and receive government monies to support health service delivery under Christian health Services of PNG Act and various memoranda of Understanding and contractual agreements

What are the objectives of Action Plan 2?

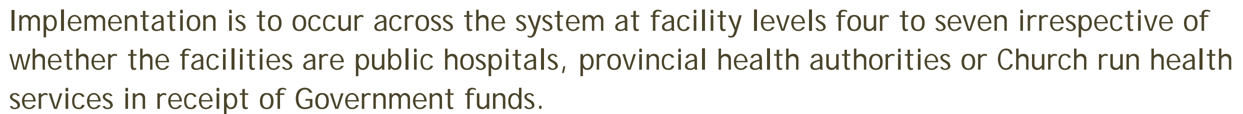
- Acknowledge the practice of charging user fees at several levels of the health system including at levels one to three
- Recognize that many church run health facilities have relied on user fees to manage recurrent periods of lack of funding caused by bottlenecks in the health financing system of payment of health function grants.
- Acknowledge that there have been bottlenecks in the health financing system leaving church run health facilities short of funds and these must be removed to remove the need to charge user fees.
- Finalize data collection on current user fees collected by all church health facilities at levels one to three to identify what funds are required to offset the removal of all user fees at facility levels one to three.
- Work with Christian health Services of PNG to make the necessary alterations to agreements with CHC and with various health services to change, as necessary, memoranda of understanding and service agreements about charging user fees.
- Develop a joint NDoH/Christian Health Services communication strategy to advise provinces about the reforms and the implementation strategy, so that provinces will be in a position to prepare to fast track payment of health function grants to facilities and to answer questions posed by facilities about the reforms.
- Department of Finance pay amount appropriated to assist NDoH with Alotau Accord Implementation and allocated to Christian Health Services to the HSIP Trust.
- NDoH and Christian Health Services to work together to agree on appropriate payment arrangements to Church run health facilities in levels one to three to offset user fees for Christian health Services.

Who is responsible for Action Plan Two?

NDoH in partnership with the Christian Health Services of PNG.

Phase two- free primary health care and subsidized specialized health services at Facility Levels four to seven of the health system

This Phase achieves implementation of free primary health care and subsidized specialized health services at levels four to seven of the system. This includes district hospitals, provincial hospitals, regional hospitals and PNG's referral hospital, Port Moresby General.



Implementation is to occur across the system at facility levels four to seven irrespective of whether the facilities are public hospitals, provincial health authorities or Church run health services in receipt of Government funds.

The legal and administrative arrangements for government health services and Church run health services are quite different. While Phase Two envisages implementation across facility levels four to seven irrespective of who delivers the health service, there is a need for two separate approaches to achieve system wide implementation across all facilities at levels four to seven.

Implementation of Phase Two

The NDoH Implementation Team will consult with stakeholders, including, in particular, those currently managing hospitals at levels four to seven of the health system about the effect of the Alotau Accord implementation generally, but in particular the following relevant considerations:

- Rules about continuing to charge for patients arriving at level four to six facilities outside the catchment areas of those facilities; and
- Considering the likely impact on patient numbers and any necessary adjustments to:
  - Workforce;
  - Infrastructure;
  - Equipment; and
  - Drug supplies.
- An effective referral system from lower levels of the system is crucial to ensure rational use of higher and more expensive levels of the system to maximize access and utilization of resources.

Consultation will be finalized within three months of the NEC approval of this Policy.

System wide Implementation for all level four to seven health facilities

The implementation of the amendments to the fees regulations and the similar changes to Church health services must be implemented at the same time to present an unintended recalibration of the system to encourage people to flock away from church run health services to cheaper health services provided by government providers and thus threatening the viability of the system.

Phase two – public hospitals and provincial health authorities

The NDoH will move to seek amendment of the *Public Hospitals (Fees and Charges) Regulation 1978* and the *Dental Charges Regulation 1969* whichinclude a number of exemptions which cover many services which would be considered to be primary care. They also set out charges for services which would be considered to be specialized health care.

The fee schedules in both sets of regulations must be amended to give effect to the Alotau Accord for public hospitals and provincial health.

NDoH to finalize data on fees currently collected by health facilities at levels four to seven and to calculate required level of funds to offset.

Department of Treasury and Finance to support timely payment direct to public hospitals and provincial health authorities based on NDoH data.

Phase two – Church health services at facility levels four to six

Christian Health Services and Church health services at levels four to six are included as stakeholders in the consultation for Phase Two.

The NDoH will work with Church health services in receipt of government funds to use similar categorization of primary care and subsidized specialized health services to ensure consistent provision of government funded health services from Government facilities and those which are run by Churches in receipt of government funds.

Department of Finance to pay amount appropriated to assist NDoH with Alotau Accord Implementation and allocated to Christian Health Services to the HSIP Trust.

NDoH and Christian Health Services to work together to agree on appropriate payment arrangements to Church run health facilities in levels four to six to offset user fees for Christian health Services.

Social marketing of the Alotau Accord commitment to free health care and subsidized specialized health services

Public understanding of the exact nature of the Government commitment is important. The Government has committees to free primary health care and subsidized specialized health services. The newspaper and other media reports suggest confusion about what the Alotau Accord commitment for health actually means. The concept of "Free primary health care and subsidized specialized health services" does not seem to have caught the public attention. Some newspapers have reported "free health care" and this may be the public expectation in some areas and the correction of that perception may give rise to disappointment and for some stress to be placed on health facilities at all levels of the system. This will need careful managing and appropriate social marketing. This is a government wide responsibility however the NDoH will develop a communication strategy as part of the implementation of this Policy.

The Alotau Accord commitment to free primary health care and subsidized specialized health serviceswill be implementedin two phases.

There is a great need for planning, partnership and cooperation to ensure that all the health system levers operate as necessary to enable an orderly implementation of the policy which does not overload an already fragile system.

In this section of the Policy, risks to its successful and sustainable implementation are identified together with actions and approaches for mitigation.

THERE ARE OTHER IMPEDIMENTS TO EQUITY AND ACCESS IN THE PNG HEALTH SYSTEM

User fees are not the only deterrent to equity and access to health care in PNG. Other deterrents include PNG's rugged topography, poor communications, poor road infrastructure and transport systems and the lack of rural electrification.

Mitigation: Direct mitigation of these factors is beyond the scope of this Policy, but the Government has made improvement of roads and infrastructure a priority in the Alotau Accord.

THE CURRENT CHARGING OF USER FEES IS AN IMPORTANT SOURCE OF REVENUE FOR STRUGGLING HEALTH FACILITIES

User fees are a small proportion of monies available to health facilities. They are still a reliable and readily available source of funds to address immediate operational needs when payments of health function grants are unreliable.

Mitigation: Work closely with Department of Treasury, DPLGA, Christian Health Services and provincial governments to ensure funds are paid early and in the amounts budgeted to the health facilities.

FACILITIES CONTINUE TO CHARGE USER FEES IN BREACH OF THE POLICY

Staff at health facilities may continue charging informal user fees against instructions and in breach of the policy. For provincial health facilities, it would also constitute a breach of the Organic Law and *National Health Administration Act*.

Mitigation: Increased frequency of support and supervision visits to monitor activities, implementing a communications strategy to inform communities on their rights under this policy – increased role of CSOs. The support of DPLGA and provincial governments is crucial.

Delays in replenishing revenue lost from user fees at facility level

This could lead to deterioration in the quality of services – from increased demand for services, drug shortages and low staff morale from increased work load.

Mitigation: Provision of targeted complementary funding and effective mechanisms that ensure funds reach the facility level. Role of Departments of Treasury and Finance and provincial governments are crucial in supporting timely movement of funds through the system

Staffing

There is a potential for increased work load which may require additional staffing at some health facilities.

Mitigation: The Implementation Team must consider current shortfalls in human resources for health as part of their work in Phase one and in consultations as part of Phase two. This will also be an important consideration for monitoring and evaluation.

Disruption of referral patterns

The removal of user fees has the potential to increase the demand for rural health services which could result in overcrowding, inadequate supplies and deterioration in quality of services provided. Patterns of referral from lower level facilities to higher level facilities may be disrupted.

Mitigation: The Implementation Team must consider the community response to free primary health care and subsidized specialized health services as implemented in Phase one and apply this learning to implementation plans for Phase two.

NOTES