Chapter 5

Implementing the Plan



The best plan, the greatest plan, is the one we achieve.
Professor David Kavanamur

Implementation is the process of turning a policy into practice. It is common to observe a gap between what was planned and what occurred as a result of a policy; or to find out that much of what was intended to be implemented was never done. The health sector is such a complex area that an overall health policy has much less chance of being implemented as planned than a simple, straightforward policy aiming to change one single issue.

Keeping this in mind, the central level policy-makers of the *National Health Plan 2011–2020* have concluded that in the current PNG environment there are several issues to be taken into account to enhance the policy implementation. These include:

1. Wide involvement of various stakeholders in the NHP development process.
2. Emphasis on values of service providers and health workers.
3. Planning mechanisms within the levels of government and other service providers.
4. Linkages with the whole-of-government planning mechanism.
5. Accountability and performance of different policy implementers.
6. Close partnerships.
7. Effectively managing risks.
8. Planning a strategic implementation process.

Involvement of Stakeholders

From the very beginning of the NHP development until the final version, various stakeholders have been involved. This has included a wide variety of institutions and individuals, as well as the general public. Overall, the interest in the NHP has been extensive, indicating commitment to implement the NHP and also raising expectations for the NHP to be able to spearhead the major changes required.

Values: The Foundation for Implementation

The extent and the quality of implementation of the National Health Plan depends on political will, enabling resources and systems, and particularly on the manner in which health professionals perform their work.

To realise the Vision of this Plan, all health workers, administrators, and support staff within the health sector, need to ensure the Values identified in Chapter 4 underpin all that we do.

Roles and Responsibilities of Different Levels of the Sector

Implementation of this Plan will be in accordance with the recognised different levels of responsibility:

- **National** — policy, standard setting, technical advice and monitoring
- **Provincial** — overseeing implementation
- **District** — implementation.

Planning Hierarchy within the Health Sector

National Level

Chapter 2 described how this Plan receives its overarching direction from key long-term GoPNG documents. The purpose of this chapter is to further explain how specific health sector strategies and planning cascade from the National Health Plan.

The NDoH will develop medium-term (5 years) strategic plans. They will guide the development of national health program plans and provincial health plans (see below). The plans draw from the overall GoPNG Medium-Term Strategies, namely the Medium-Term Fiscal, Manpower, Development, and Reform Strategies.

Medium Term Development Plan

The NDoH will work with the Department of National Planning and Monitoring to develop the five-year Medium Term Development Plan (MTDP) for health. The MTDP prioritises and sequences the implementation policies and activities of sectors and links resources to outputs.

National Health Sector Development Plan

During the period of the current National Health Plan, two five-year National Health Sector Development Plans will be developed. These plans link to the MTDP and collate information from the Provincial Development Plans. They also include information that identifies strategic capital investment projects.

National Health Standards

Under the previous *National Health Plan 2001–2010,* health service standards were directed by the Minimum Standards for District Health Services, and Hospital Standards and Standard Treatment Manuals for the curative health services. A single integrated and updated set of Minimum Standards will be developed for the period of this NHP. It will include standards for services, facilities, workforce, and others. Provinces, hospitals, and PHAs will use these standards set by NDoH when developing their plans.

National Program Five-year Strategic Implementation Plans

Each program will develop its five-year strategic plan on the basis of the NHP. These provide guidance on program priorities, and up-to-date, proven, and cost effective interventions. The respective branches in the National Department of Health have the responsibility to provide high-level technical support to the provinces, as they develop and implement the provincial plans.

Annual Activity Plans

Activity plans are made for each year, at the national level by and for the NDoH branches. These plans are directed by the NHP and the plans mentioned above.

The national government is also responsible for developing different policy instruments to enhance the implementation of the NHP. These will include changes in and introduction of new legislation and regulations and contracting.

Provincial Level

Provincial Development Plan

Provincial administrations develop five-year development plans to guide sectors. These are aligned to the MTDP and NHP priorities. The health sector uses this information in the development of five-year Provincial Health Sector Implementation Plans. During the course of this current NHP, two five-year health sector implementation plans will be completed.

Provincial Five-year Health Sector Implementation Plan

Health service delivery in each province is guided by the five-year health sector implementation plan, which directs all health sector service providers. These medium-term plans will take their direction from the NHP and the specific National Program Five-year Strategic Implementation Plans, as well as the overall Provincial Development Plan.

According to their mandates, provinces must develop plans that are in line with the NHP and its priority strategies, as well as the specific objectives and strategies.

Annual Activity Plans

Activity plans include activities that will be implemented by each management unit, the cost, timeframe, source of funds, and means of verification. Standard templates will be updated to reflect the evolving 'whole-of-government' concepts in the development of annual district and local level budgets and plans (see below).

The **Provincial Annual Activity Plan** is a yearly consolidated action plan and should be developed jointly with all service providers, public and private. The **District Annual Activity Plans**, again developed by all the service providers in the district, form the core of the Provincial Annual Activity Plan. Over the period of this National Health Plan, concerted efforts will be made to encourage and improve **Facility Level Planning.** Given the intention to roll out reforms to enable direct facility funding, each health facility should be able to plan and budget autonomously according to a defined resource envelope. Aggregation of Facility Level Plans will comprise the core of the District Annual Activity Plan.

Provincial Health Authority

Planning by the PHAs in the provinces will be consistent with the planning framework. The standards, guides, and templates will be developed by the NDoH and will be used across the sector.

Ongoing Integration of Health Sector Planning with Whole-of-Government Priorities

The challenge for any implementation process is to ensure that national priorities and strategies are adequately translated and incorporated into the annual operational plans of central and provincial governments. The role of the Joint Planning and Budget Priorities Committees at the provincial and district levels are crucial in promoting bottom-up planning. Each local level government plan is expected to reflect the needs and priorities of communities, while each provincial plan is expected to relate to local realities and national priorities. (This is illustrated in the 'Kundu Approach' described in Chapter 2.)

Similarly the implementation of health sector national priorities and strategies face this same challenge, and operate within the same system of both bottom-up and top-down planning. The key to ensuring synergy between health sector and whole-of-government plans at each level of administration lies with the PLLSMA at the national level, and with the PCMCs at the provincial level. These coordinating mechanisms play a critical role in facilitating dialogue and advocacy across sectors, and will be increasingly used as part of the implementation structures for the new National Health Plan.

Impacts of Whole-of-Government Reforms on Health Sector Implementation

The implementation of this Plan, and indeed all of the proposed plans detailed above, will take place in the context of significant ongoing 'whole-of-government' reforms. Of those that directly have an impact on the health sector, perhaps the most important are the recent changes to the system of intergovernmental financing[5]. Not only do these reforms ensure a more equitable transfer of resources from the national to provincial level, but they also help to clarify the service delivery responsibilities of each level of government.

Other reforms currently being pursued by the GoPNG are efforts to make decentralisation work. The health sector is still coming to grips with the dislocation wrought by the introduction of the Organic Law on Provincial and Local-level Governments (OLPGLLG, or the 'new organic law'). *The National Health Administration Act 1997* was an early response to this dislocation, but a more practical solution to the disruption of vertical management of health services in the provinces was only embraced following the passing of the *Provincial Health Authorities Act 2007*.

The *Provincial Health Authorities Act 2007* made provision for Provincial Health Authorities to be established in each province. Management of hospitals and rural health services, and therefore all health workers in the province, could once again be managed under a unified authority. This system is being piloted at the time of developing this NHP. It is expected that an accelerated roll-out of this ground-breaking reform will commence as results of the pilot become clear.

[5] These reforms, largely directed by the National Economic and Fiscal Commission under the broad banner of 'Reform of Intergovernmental Financing Arrangements' (RIGFA), were brought into effect by the *Intergovernmental Relations (Functions and Funding) Act 2007*.

Empowering Individuals and Communities

The extensive consultation process conducted to inform this Plan, coupled with the insights provided by analysis of the evidence presented in Volume 2, has revealed the need to strengthen the focus of health care provision in a manner that will ensure all Papua New Guineans are empowered to be involved in, and responsible for, their own health. This is reflected within Key Result Area 7 Promote Healthy Lifestyles. Achieving a prevention-focused approach to health in PNG will involve:

- Ensuring formal health services are brought closer to the community, particularly to those groups of people living in remote rural areas and those living in disadvantaged urban areas.
- Extending the reach of health promotion and awareness activities from health facilities to each community. The Community Health Post roll-out will incorporate a dedicated health worker to community engagement/awareness activities and will encourage and supervise the growth of informal health services within communities such as Village Health Volunteers, Village Health Committees, and safe practice of traditional medicine.
- Eliminating barriers to the access of health services caused by both geographic factors and economic factors. Protecting the rights of access for particularly vulnerable groups, such as women and girls, victims of domestic violence, and individuals wishing to seek services free of discrimination (for example, sexual and reproductive health services) is an imperative which will be upheld at all levels of implementation.
- Improving the access of each village and every household to safe water and sanitation.
- Ensuring health facilities at every level of the system are equipped to cater for the provision of high quality care for mothers and children. Rehabilitating facility infrastructure, water supplies and sanitation, and renewing basic clinical equipment and assets (for example, immunisation refrigerators) is a high priority of this Plan.
- Working with all sectors to improve the delivery of the full complement of services required at the community level for a better of standard of living. Integrating the provision of health services with education services[6] is a part of the long-term vision for Community Health Post roll-out, and will need to be supported by reliable and accessible transport networks and commercial services, as outlined within GoPNG Vision 2050. Improving the whole spectrum of services available at the local level will contribute to both healthier lives for individuals and securing the long-term dedication of health workers to rural areas.
- Working more effectively with multiple players at the local level, including churches, NGOs and private organisations looking to provide health care to their employees and surrounding communities.

Accountability and Performance Monitoring

To improve implementation of the NHP, information on performance is crucial. A Performance Assessment Framework has been developed and it will provide the different levels of government with a tool to measure performance and to hold the lower tiers accountable for the use of resources (see Chapter 8). The ways that effective or poor performance will be rewarded or discouraged is a management issue and should be planned for.

However, performance indicators alone do not give an appropriate picture of what is happening and what is not in implementation. At all levels, health managers need to keep themselves closely informed through specific information gathering, observations, and consultations, to find out the reasons for any deviations in implementation and to take action, either to improve the implementation or to revise the policy.

An important part of the NHP will be implemented by the private sector, namely the churches. Accountability on both sides, government and the churches, has room to improve. Making use of purchaser–provider relationship tools will bring change and enhance the NHP implementation.

As part of its responsibility to monitor the overall implementation of the NHP, the NDoH will establish a Project Implementation Coordination and Monitoring Unit to monitor the progress of capital investment priorities.

[6] Results of the PNG Demographic and Health Survey of 2006 show a strong correlation across a number of the health measures between more years of education and better health. The report shows that greater years of education for girls results in delayed commencement of child bearing and correlates with improved spacing between children. Mothers who have received more education are less likely to give birth at home. Higher education levels are also linked to greater knowledge of methods and sources of family planning, and with improved care of infants and children. With respect to health promotion, women who have attained higher education levels show greater use of mass media.

Partnerships

The pursuit of a sector-wide approach (SWAp) for health, and the emergence of many of the building blocks of such of an approach, was a feature of health sector development over the past decade. In the coming decade, a realigned sector-wide approach will further consolidate the leadership role of the National Department of Health. In this context the National Health Plan states the common vision, strategies, and outcomes to guide all partners in their inputs to the sector.

The Medium Term Expenditure Framework will play an enhanced role in facilitating the coordination of sector financing, while the monitoring and evaluation framework outlines agreed outcomes and provides a basis for joint reviews and performance monitoring.

Improving service delivery in health will be difficult without also strengthening partnerships within and beyond the health sector. The long and successful partnership with the churches has potential to evolve in line with the new challenges faced by the sector.

Improved relationships with central agencies will be essential for the health sector to secure support in resource allocation and advocacy at the highest political level.

Health will be actively involved in broader GoPNG efforts to improve coordination of service delivery implementation. The Provincial and Local Level Services Monitoring Authority (PLLSMA) and Provincial Coordination and Monitoring Committees (PCMCs) provide ready-built interaction points for health sector stakeholders to align their activities with other service delivery agencies.

Risk Management

Managing risks is the key to successful implementation of any plan. While this NHP has been developed to be achievable in the known environment of PNG, some assumptions made will be strongly challenged if the revenues expected from the LNG Project do not materialise. On the other hand, if infrastructure development funds are made available, then the capacity of the country's building industry to meet the demands of the economic boom will be tested and may have an impact on the Plan's objectives.

A critical success factor in achieving the Plan's outcomes is the focus on a back to basics/primary health care approach. A lack of available funds and/or a loss of this focus may result in a worsening situation for rural health services and health indicators in general.

It will be essential for the health sector to monitor these risks and reflect their impact in annual reporting.

Roll-out of Strategic Implementation Planning

The national level policy-makers will develop planning guides and templates to enhance and encourage the implementation of the NHP. This will include management of uncertainty and risks and instituting mechanisms for consultations, monitoring, and fine-tuning the NHP.

Through these documents, the national level will be in close contact with the implementers and aiming to respond to the difficulties encountered and support the front-line health workers.

In addition, approved recommendations from the SWAp review will be incorporated into implementation of the Plan, to ensure the goal of 'one Plan, one budget' is achieved.


OPEL

Chapter 6

Financing the Health Sector



Background

As the PNG health sector moved ahead with implementing a sector-wide approach (SWAp) in the early stages of the previous National Health Plan period, it was understood that a key building block would be a framework to manage sector expenditure and potential funding shortfalls. As the Medium Term Expenditure Framework (MTEF) has expanded and improved since its initial development early in the last decade, it has helped reveal more about the nature of how the health sector is financed in PNG. Most immediately, it is clear that in recent times, overall government-funded recurrent service expenditure has increased substantially.

Figure 21 reveals that, in particular, overall personnel expenditure — inclusive of church health services and provincial general hospitals — has increased by almost 60%. Overall, expenditure on operational costs for rural health services has doubled between 2007 and 2010, largely due to changes to the system of intergovernmental financing, which have seen a three-fold increase in the value of health function grants over the corresponding period.

In fact, as Figure 22 shows, the actual levels of funding for rural health service operating costs now almost match the National Economic and Fiscal Commission estimates of what is required to cover the costs of a minimal level of service delivery[7]. Yet despite these welcome improvements, it is clear that this additional funding is not being adequately transformed into tangible improvements in health outcomes. One of the key lessons of the past decade is that more money by itself does not lead to improved service delivery.

While this Plan envisages that more money will ultimately be needed in the health sector to achieve the necessary improvements in the future, it recognises that far greater attention must be paid to ensuring more effective usage and allocation of our existing financial resources. The health sector will focus on putting its existing financial resources to better use over the next decade.

[7] Estimated Operational costs (Goods and Services, excluding medical supplies) — Rural Health Services. NEFC costs adjusted to 2010 prices.

Figure 21 Recurrent Expenditure — Rural and Hospital Services 2007–2010

Recurrent Expenditure 2007–2010 (K'million)	Expenditure		Appropriations	
	2007	2008	2009	2010
Personnel Expenditure (PGH, RHS)	225	258	315	355
Medical Supplies	59	75	80	93
Operational costs:				
General Hospitals	34	44	53	62
Rural Health Services:				
Church services	14	14	17	18
Central Health Grants (200)	13	15	28	39
HSIP	8	10	13	17
Internal Revenue (700)	6	6	6	6
Total Rural Health Services	40	45	65	80
Total Operational costs	74	88	118	143
Total Recurrent Costs	**358**	**421**	**513**	**591**

Figure 22 Goods and Services, excluding Medical Supplies — Rural Health Services (NEFC cost estimates)

Estimated Goods and Services Costs (K'million)			
Facility operations and outreach:		**Financed by:**	
Government facilities	18	Health Function Grants	39
CHS facilities	18	Internal revenue	6
Total facility costs	37	HSIP	17
Patients transfers	24	CHS operational grants	18
Medical supplies distribution	4		
Province/district administration	18		
Total (excluding rural water supply)	**83**	**Total RHS financing**	**80**

Reflecting this focus, the remainder of this section will consider:

- **Resource usage:** How our financial resources are spent.
- **Resource allocation:** Allocating our financial resources more effectively.
- **Resource mobilisation:** How to obtain additional financial resources to close possible gaps.

Resource Usage

In recent times, the drive to increase funding of the resource envelope for the health sector has tended to overshadow the clear opportunities available for Papua New Guinea's health sector to improve within the existing financial situation.

As suggested above, it is arguable that the PNG health system should be functioning more effectively given that the MTEF shows public expenditure on health (including contributions from development partners) in 2010 is approximately K925m. This equates to public expenditure on health of around K140 per capita.

The suggestion that the total of funds available to the health sector is perhaps more adequate than previously thought seems to contradict the experience at the facility level, where front-line service staff report being impeded in their efforts by the lack of operational funds.

The reason for this inconsistency is that health sector funds are not being effectively used. Too many funds are ultimately not reaching their intended destination.

Findings from the Case Study of District Service Delivery confirm the problems of getting funds out to the facilities, and indicate that facilities to a fairly large extent charge user fees to compensate for the lack of funds and resources in the facilities. The study also pointed to a tendency of funds budgeted by provinces for increased program administration purposes and not front-line services. In addition, there are increasing Indications that provinces cannot spend the increased amount of funds.

The National Economic and Fiscal Commission (NEFC) have attempted to quantify the extent to which actual resource usage does not match the intended purpose of health sector funding. Their analysis[8] shows that in 2007, provinces on average funded only 21% of the actual costs required in health, but on average spent 197% of the actual costs required for administration.

It is critical that funds reach the point of service delivery, which is the health facility level. Evidence from both the Case Study of District Service Delivery and the Rural Health Services Costing Model reveal that lack of operating funds and medical supplies at the facility level have been key inhibitors of improved service delivery[9]. Because health staff compensate for their lack of resources by charging user fees, equitable access to health services is compromised.

To ensure health sector funding reaches the service delivery front-line, the National Department of Health will implement direct facility funding. Districts and provinces will maintain oversight and management responsibilities, and retain their ability to direct funding allocation, but once allocated funding will be channelled directly to facility accounts. This will empower facility staff to manage their own budgets.

The National Department of Health, on behalf of the health sector, will also engage with central agencies to rectify the slow movement of funds through the government's financial management system. In addition, it will work to improve its own financial management systems and increase accountability for the health sector's use of its resources.

Resource Allocation

In addition to effective usage of financial resources, it is vital that these same financial resources are allocated — that is, distributed — across the sector efficiently, and in a manner that will generate the best possible outcome.

In recent times, coinciding with improvement of the MTEF, and the contribution of various studies, a holistic, whole-of-government, sector-wide perspective has become clearer. This perspective is an essential prerequisite to achieving improved resource allocation. The development of a single Health Sector Funding Plan and Strategy (KRA 3.1.3) will facilitate improved sector-wide finance decision-making.

Figure 23 demonstrates the need to consider resource allocation decisions from a sectoral perspective. It reveals that health sector financial resources, represented by staff, facilities, and operating costs, are not distributed equitably across the country.

Those groups of provinces that have relatively poor service indicators are not as well-resourced, in per capita terms, as those with relatively better service indicators. For example, there is on average almost twice as many service staff per 10,000 people in the least well-served group of provinces than in the relatively well-served group.

Similar discrepancies exist in terms of the operating costs available to health workers in different provinces, and with the number of facilities per population. To achieve a more equitable distribution of health sector resources, a gradual relative shift to strengthen service capacity resources to the less well-served provinces is required.

One of the current difficulties to implementing allocation changes is the sheer number of players, who individually decide how to allocate their share of the total health sector financial envelope. This often means that allocation decisions for different components of the health system are made in isolation from the broader financial implications. The collective efforts of all health sector players are needed to ensure financial resources are allocated where they are most needed.

[8] See NEFC (2008), Closing the Gap: Review of All Expenditure in 2007 by Provincial Governments.

[9] Rural Health Services Costing Model.

Figure 23 Distribution of Health Services and Resources Per Capita by Provinces

Provinces ranked by service indicators per capita					Service staff per 10,000	Facilities per 10,000	Operating costs	
Province	Population	Disch.	OP	Deliv.			NEFC per cap	Funds per cap
Eastern Highlands	515,307							
Southern Highlands	759,183							
Morobe	672,755	2.9%	0.97	0.24	8.7	0.8	8.46	7.80
Simbu	299,543							
Western Highlands	536,128							
North Solomon	200,278							
Central/NCD	557,966	4.2%	1.16	0.43	13.0	0.9	9.53	8.21
Enga	370,844							
Northern	164,675							
East Sepik	408,447							
Madang	451,834							
West Sepik	224,546	4.1%	1.79	0.34	13.0	1.2	18.35	19.27
Manus	53,276							
Milne Bay	256,366							
Gulf	131,264							
East New Britain	268,211							
West New Britain	242,963	5.6%	2.11	0.54	17.1	1.4	20.80	17.52
Western	198,775							
New Ireland	148,761							
Total	**6,461,122**	**3.9%**	**1.38**	**0.37**	**12.1**	**1.02**	**12.79**	**11.88**

To assist in improving health sector resource allocation, evidence and information for policy-making will be improved. The Medium Term Expenditure Framework (MTEF) currently helps to demonstrate to policymakers the total pool of funds available to the health sector, and the estimated requirements. Use of the MTEF will be enhanced, and its links to policy-making and financial allocation decisions strengthened.

Improving our understanding of health sector costs is another way to improve evidence and information to help policymakers make better decisions about how to allocate financial resources.

The recently developed Rural Health Services Costing Model provides insight to decision makers about the opportunity costs of different financial allocation choices.

The resources required to obtain one outcome can then be compared with those required to achieve another. Every choice to spend money for one purpose means there is less available for a different purpose. The Model will be improved as more information comes to hand, and is integrated into the MTEF.

Resource Mobilisation

Expenditure on health in Papua New Guinea remains overwhelmingly publicly-funded, and is likely to remain so. In 2010, the entire publicly-funded resource envelope available to health, as calculated by the MTEF, is approximately K925 million. Of this, a little more than 30% is provided by development partners. Reliance on development partner expenditure on public health will reduce from its current proportion. However, because of the focus on resource usage and allocation, the health sector will be better placed to ensure the contributions of these valued partners will be spent accountably and more effectively.

The dramatic increase in population expected over the life of this Plan will demand a significant increase in resources. The health sector must continually make the case through advocacy, and via tangible results,

that investment in health by the Government of PNG is a worthwhile and fruitful investment. A healthy populace is a prerequisite to achieving the aspirations contained within Vision 2050.

The health sector will also improve its relationship with private-sector partners, particularly with those resource and agribusiness companies that are providing health care to their employees and their families. Partnerships such as these will be leveraged to take the pressure off public expenditure on health, and to foster innovative service delivery models. The sector will also consider investing in public–private partnerships to deliver large-scale infrastructure programs, in line with Government of Papua New Guinea policy. At the same time, development of public–private alliances will be pursued, and those critical existing relationships — especially with Church Health Services — will be strengthened. Opportunities for mobilising resources for health from existing avenues will also be pursued. In particular, more efforts will be made to ensure that District Service Improvement Funds are spent on health.

Alternative Health Care Financing

The Government of PNG is the major financier as well as provider of health services in PNG. The churches also contribute about 50% of health service delivery in rural areas. However, it must be noted that church health services in PNG are mainly supported by the GoPNG with annual grants for both operational and staffing grants.

Currently the government, through general taxation, finances health services in PNG. However, this source of funding for health is declining not only in real terms, but has also declined as a proportion of total government expenditure over the last three decades. The current high population growth rate of 2.7% per annum has placed undue demands on existing health resources, in particular health financing.

The government is therefore looking at alternatives for health care financing in PNG.

One of these options is health insurance. Currently health insurance in PNG is private and voluntary, and the market size for it is small. However, the demand for private health care is increasing and this has created the need or potential for using health insurance as an option for health care financing. This has been documented in several studies on health insurance that were conducted in PNG.

Funding from health insurance to pay for the health care of the formal sector employees will ease the burden of the government in meeting the health care needs of the population of PNG. In essence this will mean that the government's scarce resources for health can be used to pay for health care for the rural majority of the population and the urban disadvantaged. It will allow those who have the ability to pay for their health care to do this through a viable health insurance scheme that will eventually be adopted by the PNG Government.

Health insurance can be supported through a policy framework, as well as through supporting legislation. The government is serious about the policy aspects of harnessing health insurance as a health care financing option. In 2005, NEC through its Decision No: 282/2005 and Meeting No: 57/2005 approved the policy as part of the revenue budget initiative. The NEC decision was expected to be implemented jointly by the Department of Labour and Industrial Relations and the Department of Health. The NEC Decision called for the implementation of a proposed compulsory employer-sponsored national health insurance scheme.

A Task Force was set up to oversee the implementation of this NEC Decision, assisted by a private consultant. However, the implementation was not realised at that time. There is currently strong political support and commitment for this outstanding NEC Decision to be re-activated.

Chapter 7

Cost of the Plan



This section provides background to the costing of the Plan. It is an aggregate estimate of the health sector spending requirements for the next ten years.

Approach

The approach to the costing has been to:

- Capture the current cost of the PNG health system based on the Medium Term Expenditure Framework (i.e. what does the health sector cost now?).
- Estimate the likely cost of the interventions proposed in the Plan.
- Project the potential availability of funds — Government and Development Partners — for the health sector over the period.

Costing was done by service level, and looking at the cost of delivering a package of services to a given population in an integrated manner, as opposed to costing out individual programs. Thus costs were estimated for the major capacity inputs required to enable health facilities to provide services to a given population, including the inputs of health service staff, medical supplies, operational funds, and infrastructure in terms of buildings and equipment.

Individual program interventions are covered as they form part of the package of services. Apart from general outpatients, inpatients, and maternity services, which are the main service capacity drivers, using more than 70% of facility capacity, the costs of immunisations, TB, HIV/AIDS, safe motherhood, child health, and malaria interventions have been specifically captured in terms of their supplies/commodity requirements.

Three key sources of evidence to ensure the robustness of the NHP costing have been the Rural Health Costing Model (developed in partnership with Monash University and the Asian Development Bank), the Medium Term Expenditure Framework for the Health Sector, and the National Economic and Fiscal Commission (NEFC) cost of services study.

With the help of these, a picture of a base year (2010) was developed from which to add projected costs of additional activities contained in the Plan, and thereby the additional costs required to fund the NHP. Data on current and past services, the number of units and staff for the different levels was obtained from the National Health Information System.

Figure 24 Costing of the *National Health Plan 2011–2020* by Capacity Inputs and Levels

Capacity Inputs and Service Levels (K'million)	2010 Base year	2011–2015 Total	2011–2015 Per year	2016–2020 Total	2016–2020 Per year	2011–2020 Total	2011–2020 Per year
Personnel							
Rural Health Services	150	865	173	1,050	210	1,916	192
General Hospitals	172	863	173	950	190	1,813	181
Pre-Service Training	16	91	18	109	22	200	20
Central	33	167	33	169	34	336	34
Total	371	1,986	397	2,279	456	4,265	426
Medical Supplies							
Rural Health Services	82	530	106	689	138	1,218	122
General Hospitals	47	261	52	305	61	567	57
Population Supplies (LLINs, condoms)	20	93	19	96	19	188	19
Total	149	884	177	1,090	218	1,973	197
Operating Costs							
Rural Health Services	80	559	112	699	140	1,258	126
General Hospitals	62	437	87	760	152	1,197	120
Pre-Service Training	1	6	1	7	1	13	1
Central	239	1,047	209	1,044	209	2,091	209
Total	382	2,049	410	2,509	502	4,559	456
Capital							
Rural Health Services		390	78	64	13	454	45
Rural Water Supply	22	108	22	108	22	215	22
General Hospitals	1	1,249	250	1,376	275	2,625	262
Pre-Service Training							
Central		32	6	48	10	79	8
Total	22	1,778	356	1,595	319	3,374	337
Total expenditure requirements	**925**	**6,697**	**1,339**	**7,473**	**1,495**	**14,170**	**1,417**
Funding							
GoPNG Appropriations	631	3,156	631	3,156	631	6,313	631
Development Partner Funding	294	1,468	294	1,468	294	2,936	294
Total Funding Available	**925**	**4,624**	**925**	**4,624**	**925**	**9,249**	**925**
Funding Shortfall		**2,073**	**415**	**2,849**	**570**	**4,921**	**492**

Main Capacity Inputs and Service Levels

The costing was organised on the basis of the following main capacity inputs.

Recurrent Costs:

- Personnel
- Medical supplies
- Operating costs (operation and maintenance).

Capital Costs:

- Buildings
- Medical and general equipment (including transport)
- Long-term training (HR development plan not yet available).

The service levels were also used to organise the data:

- Rural health services
- Provincial general and national referral hospitals
- Central level, including pre-service training, central program support (M&E, IEC, research, administrative services/overheads), including specialised support services such as the CPHL/laboratory network.

Of the total funds available — in particular from Development Partners — K206m has not been possible to capture in the costing (see Figure 25 for a breakdown). This amount is part of the K239m that appears as Central level operating costs[10] and represents various specific program support and overhead costs, and discrete project funding, including ongoing capital projects. These currently available funds are thus reflected as cost requirements, assuming these costs are required in the Plan period, although in a cost neutral manner, as they have not been part of the deliberate costing of requirements.

Main Cost Intervention Areas

The NHP costing reflects three main cost intervention areas (in order of priority):

- Rural health services improvement
- Strategic hospital improvement
- Other hospital improvement.

Figure 25 Program Support

Program Support (K'million)	2010
Global Funds for Malaria, HIV/Aid, TB[11]	54
AusAID[12]	95
NZAID[13]	14
UN agencies (UNICEF, WHO, UNFPA)	26
ADB	12
GoPNG Development budget (Torres Strait health issues)	5
Total non-costed program support	**206**

[10] The remaining central level operating costs are represented by the NDoH G&S, excluding medical supplies 240 appropriations in 2010.

[11] Global Funds: Staff employment, training, M&E, TA, various administrative overheads, excluding medical supplies.

[12] AusAID: Non-medical supplies, Malaria and AIDS support, WHO, Clinton Fund, STI clinics, medical school, IMR, TA, excluding pooled funds.

[13] NZAID: including various NGO support, excluding pooled funds.

Figure 26 Costing of the *National Health Plan 2011–2020* by Main Cost Intervention Areas

Cost Intervention Areas (K'million)		2011–2015		2016–2020		2011–2020	
		Total	Per year	Total	Per year	Total	Per year
Public expenditure in the health sector in 2010	Recurrent	4,512	902	4,512	902	9,024	902
	Capital	112	22	112	22	225	22
	Total	4,624	925	4,624	925	9,249	925
Additional costs							
Rural health services improvement	Recurrent	297	59	921	184	1,218	122
	Capital	385	77	60	12	445	44
	Total	683	137	980	196	1,663	166
Strategic hospital improvement	Recurrent	34	7	257	51	292	29
	Capital	863	173	41	8	904	90
	Total	897	179	298	60	1,195	120
2nd phase PGH; PMGH; ICT	Recurrent	75	15	188	38	263	26
	Capital	418	84	1,383	277	1,801	180
	Total	493	99	1,570	314	2,063	206
Total Health Expenditure	**Recurrent**	**4,919**	**984**	**5,877**	**1,175**	**10,797**	**1,080**
	Capital	**1,778**	**356**	**1,595**	**319**	**3,374**	**337**
	Total	**6,697**	**1,339**	**7,473**	**1,495**	**14,170**	**1,417**

Rural Health Services

Costs are linked with actual service outputs and the required resources calculated to deliver targeted levels of service provision to the population, with an annual growth of 2.7% built into the cost projections. Costs are estimated for running rural health services with appropriately resourced health facilities (operating at minimum standards) if a package of improved service targets was being delivered.

The RHS cost study indicated wide variations in staff productivity, and suggested there is in most areas capacity for increased service delivery using present staffing levels, although increases in staffing levels will be required to provide for an increasing population in the future. The study also showed significant deficits in spending on infrastructure and equipment, and medical supplies.

Service delivery would also be improved immensely with further operational funding available at health centre level, particularly to cover transport and other costs, which can be used to improve the low level of outreach services currently being undertaken by health centres.

The additional cost requirements for **rural health services improvement** builds on the following interventions:

- Adequate medical supplies in the facilities.
- Adequate operational funding reaching facilities for operations and outreach.
- Better use and distribution of health staff.
- Rural Health Services building upgrades and rehabilitation and equipment replaced to minimum standards.
- Improvements to Central Public Health Laboratory (CPHL) and rural laboratory network.
- Community Health Posts trial in five provinces.

The cost estimates take into consideration that overall increases in services per population as a result of these interventions are expected to reach 2004 levels by 2015, or increase of general service volumes compared with current service provision by up to 40%[14].

Hospital Sector

It is expected that better performing and resourced rural and district health services, able to achieve better outcomes in preventive services and early intervention, will lead to reduced overall load on the hospital sector.

Analysis of lengths of stay overall, as well as for similar clinical groups, shows a considerable variation between hospitals, ranging generally from 6 days up to 16 days per admitted patient. This indicates that there is in most areas sufficient available capacity for increased service delivery, using present staffing levels. In addition, reducing the burden of just three significant infectious diseases (malaria, pneumonia, and tuberculosis) can be expected to significantly reduce hospital admissions, and in turn hospital bed days.

Additional cost requirements for **strategic hospital improvement** include:

- Enhancement of four hospitals to strengthen regional services (Health Vision 2050 initiative, including Mount Hagen, Angau, and Nonga), and increase in their recurrent resources by 20%.
- Resources for Master Planning for Port Moresby.
- Resources for emergency minor works in all provincial hospitals.
- Redevelopment (capital works program) for Angau, Kerema, Goroka, and Nonga provincial general hospitals.

Additional cost requirements for second phase improvement of provincial general hospitals and Port Moresby based development includes:

- Enhancement of two district hospitals to provincial hospital standards (for Jiwaka and Hela).
- Redevelopment (capital works programs) for Boram, Kavieng, Popondetta, Wabag, and Daru provincial general hospitals; and construction of a new Central provincial general hospital.
- Port Moresby General Hospital redevelopment.
- Pacific Medical Centre.
- ICT development.

During the process of costing the NHP, certain key messages have impressed themselves repeatedly:

- Significant improvements in the health sector can be made without necessarily needing more money.
- Efficiency gains can readily be achieved in both rural health services and hospital services.
- The health sector should be achieving better outcomes with existing levels of staff.
- Drugs and supplies are a key blockage to service improvement.
- The availability of operational funding at the facility level is a key blockage to service improvement.

The following diagram shows the funding gaps between projected estimates of funding availability and the major cost intervention areas. The major cost interventions are arranged in an accumulative way, such that strategic hospital improvement includes rural health services improvement.

The current (2010) health share of the overall GoPNG recurrent budget is about 16%. Provided the health share of the overall GoPNG recurrent budget remains constant at 16% over the NHP period, then about half of the additional costs required for rural health services improvement can be covered[15], and this will need to increase to 18% to cover the additional rural health services improvement costs fully (assuming DP funding remains at current levels).

Funding of all cost interventions, i.e. total health expenditure over the NHP period of K14.1 billion, will require 27% of overall GoPNG recurrent budget be allocated to health (again assuming DP funding remains at current levels).

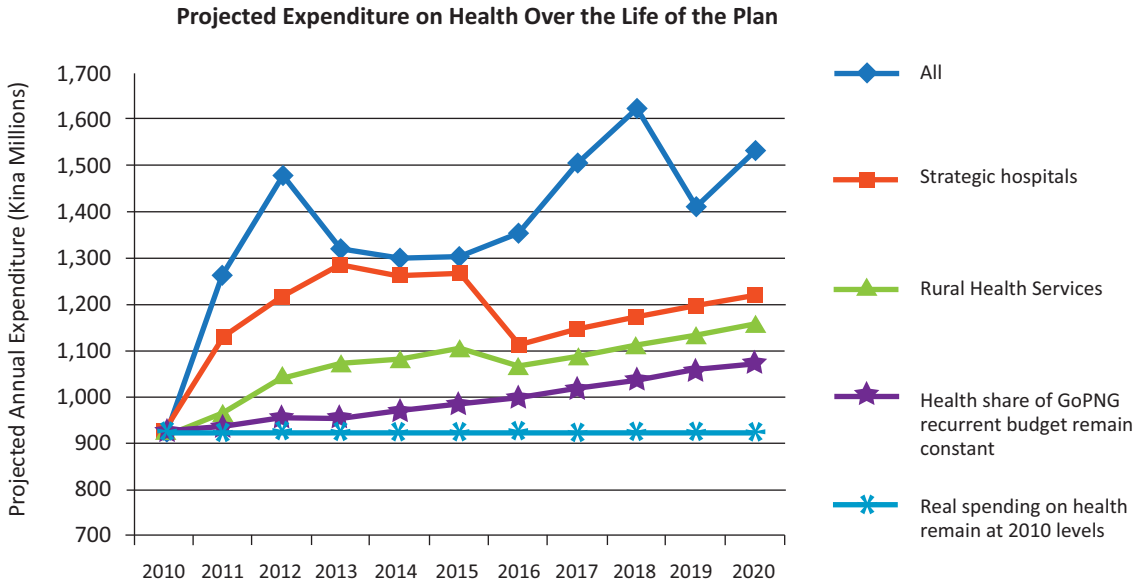
[14] Represented by outpatient services: current (2008) outpatients per capita is 1.37 (total 8.9m) against 1.54 in 2004 (total 8.9m). With a general annual population growth of 2.7%, 1.54 outpatients per capita will translate into more than 12m outpatient services provided in 2015.

[15] Refer to projections from Treasury budget outlook for 2010.

Figure 27 Current Funding (including Government and Development Partners)

PNG Appropriations (K'million)	2010
Recurrent expenditure	619
Capital/Development	12
Total PNG Appropriations	631
Development Partners (K'million)	**2010**
Development Partners	207
Global funds (HIV/Aids, TB, Malaria)	87
Total Development Partners	294
Total Funds available (K'million)	**925**

Figure 28 Projected Expenditure on Health over the Life of the Plan



Chapter 8

Performance Monitoring Framework



The performance monitoring framework for the National Health Plan will provide a guide to measuring progress towards the agreed targets. It sets out what will be measured and when it will be measured.

Why Monitor and Measure Health Sector Performance?

Planning is about achieving results. From the community, right through to the highest levels of the health sector, all want to see improvements in performance and realisation of the goals and objectives of the Plan.

The purpose of monitoring is to improve the performance of the health sector. It is a part of the management process, and focuses implementation with the overall goals and objectives in mind. There are several reasons for measuring health sector and system performance, including to:

- Develop policies, strategies, and plans.
- Evaluate specific interventions (for example, the impact of IMCI).
- Generate knowledge and comparisons (for example, between districts and provinces, and international reporting).

How Do We Measure Performance?

Each Key Result Area has objectives, in addition to the global aim of achieving better health for PNG. Indicators have been selected that provide for regular review of whether these objectives are likely to be achieved. These indicators are brought together into a Performance Assessment Framework (PAF), which will inform the development of the Performance Monitoring Plan.

The PAF provides the key guide to measuring progress towards the agreed targets, including what will be measured and when it will be measured. The PAF includes a limited number of indicators that provide an overall assessment of services. These indicators measured on an annual basis are relevant to NDoH Provincial and District Health Offices, and examine approaches that are under the direct control of the sector. Each program and province will have more detailed indicators to explore implementation at a deeper level.

Who Receives the Performance Monitoring?

Most importantly, performance monitoring provides information to managers at each level of the health system. There are also reporting obligations.

The *National Health Administration Act 1997* states that monitoring is the responsibility of the National and Provincial Health Boards and District Health Committees. The National Health Board is required to report to the Minister for Health. The Minister reports annually to Parliament. The sector is also required by central agencies to report on progress towards the internationally agreed Millennium Development Goals, and the Papua New Guinea Development Strategic Plan 2010–2030. The Health Sector Improvement Program (HSIP) requires that progress towards agreed goals and targets is documented on a regular basis with development partners.

The Performance Assessment Framework is a single instrument that provides the necessary reporting on the National Health Plan, and also meets these broader reporting requirements.

How Will It Operate?

There are three sources of data available to measure inputs and results:

- Facility and service data, most commonly collected through the National Health Information System (NHIS), and providing information about activity and morbidity.
- Administrative and management records and reports, which provide information about inputs into the sector (for example, financial and human resources, and supervision).
- Household surveys, which provide information about coverage, determinants of health, and mortality. The DHS and other routine community surveys serve this need.

These sources collectively provide information on the performance and improvements in health service delivery, and also provide information on why certain areas may not be improving. By simultaneously considering information on expenditures and performance of service delivery, management will be able to respond to performance shortcomings.

The quality of data will accurately depict performance achievements, and also instil confidence in the ability to monitor performance.

Data collection systems will be supported through adequate training and supervision, independent assessment of data quality, and the capacity of systems to provide disaggregated and resourceful information. Appropriate data governance systems are to be established to ensure data quality.

The health information system will be further integrated into existing provincial accountability mechanisms, facilitated through the Department of Provincial and Local Government Affairs (DPLGA), through the Provincial and Local Level Services Monitoring Authority (PLLSMA). This will be primarily achieved by incorporating the PAF indicators into the Section 119 reporting for the health sector. This is expected to further enable the health sector to engage provincial administrations to better understand and appreciate health sector performance issues. Provincial Administrators will have the opportunity to respond to health issues from an informed basis.

The success of the performance assessment will come from its ability to lead to strengthened capacity to achieve results. Regular performance analysis is critical for achieving this. Therefore, it is expected that quarterly reviews examining detailed performance data will be undertaken within provinces and at a national program level. On an annual basis a report against the indicators of the PAF will be published, providing a sector-wide snapshot of national and provincial progress toward goals and targets. The report will provide performance information by province, and will facilitate further discussion on how to adapt planning to meet needs where effectiveness is reduced.

This Plan is also proposing to establish a National Public Health Institute that will, when operational, provide further objective monitoring of the health sector and promote dialogue on emerging health challenges.

What Will Be Measured?

The PAF defines a set of indicators across each Key Result Area. There are several higher level indicators that provide measures of longer-term gains. The indicators listed below are supported by detailed description of measurements, data sources, and responsibility. A full list of annual indicators can be found in Annex 2. It is expected that these will be refined and be agreed prior to the first reporting period in 2012, and then incorporated into the Performance Monitoring Plan.

Figure 29 Impact Indicators

Indicators	Frequency
Maternal Mortality Ratio	5 years
Childhood mortality: • Neonatal Mortality Rate • Infant Mortality Rate • Under-5 years Mortality Rate	5 years
Proportion of population with access to improved water source and sanitation facility	2 years
Contraceptive Prevalence Rate	5 years

Figure 30 Review Schedule

Review Type	Frequency
Health Sector Reviews	Annual
Mid-term Review	2016
Final Review (including lessons learned)	2019
Formulation of next ten-year NHP	Starting 2019

Provincial level indicators will be developed in line with national targets, following the launch of the Plan. These will be considered for incorporation into provincial Section 119 reporting.

When Will It Be Measured?

The broad accountability framework for health services delivery in PNG will be based on one health strategy — the National Health Plan — and its validation process. Partners in health will participate in the development, review, approval, and use of the PAF. To this effect, all partners to the sector will participate in joint annual performance reviews, mid-term reviews, and evaluations of the National Health Plan. Evaluation of the National Health Plan will be undertaken at times deemed suitable and in response to the annual reports of the PAF.

To the extent possible, the use of additional or separate performance reviews and indicators will be phased out. Information on program progress will be gained through an independent joint periodic review that meets the needs of government and development partners, assessing the information gleaned through the PAF, and probing deeper into the achievements and problems faced by front-line management and service delivery staff.

Annexes

1. Development and Consultation Process for the Plan

2. Annual Reporting Indicators

3. Lists

Annex 1

Development and Consultation Process for the Plan

The development of the *National Health Plan 2011–2020* was different to previous plans. This is because the Senior Executive Management (SEM) and National Health Plan Secretariat put in place a communication strategy and provided wider consultations to our stakeholders, partners, and implementers during the process of developing the NHP. The consultation process was coordinated and managed by NHP Secretariat in the Strategic Policy Division.

Stakeholders and Partners in Consultation	Representatives

Minister for Health and HIV/AIDS:

- NEC endorsed the development of the NHP 2011–2020
- Minister briefed at every stage of development.

PRIMARY HEALTH CARE
POLITICAL COMMITMENT AND SUPPORT

Service delivery to the rural majority and the urban disadvantaged

Secretary for Health and Milne Bay nurses at the southern region NHP consultation workshop, Alotau.

National Health Plan Committees:

- Technical Advisory Group (TAG)
- Steering Committee (SC)
- National Health Plan Secretariat.

WE CARRY OUT THE DIRECTIONS FROM SEM

National Health Plan Secretariat

Stakeholders and Partners in Consultation	Representatives

Senior Executive Management (SEM):

- Conducted briefing and consultation meetings
- Provided guidance and directions during different stages of developing the NHP.

SETTING POLICY AND STANDARDS AND PROVIDING DIRECTIONS IS OUR BUSINESS

SEM members at Madang Consultation Workshop

Steering Committee and Technical Advisory Group:

- Provided direction, technical advice, and feedback on the different stages of the development and finalisation of the National Health Plan.

PROVIDING GUIDANCE IS OUR RESPONSIBILITY

TAG and SC committee members

National Health Conference, June 2009:

- The National Health Conference in Goroka debated thematic papers on a priority framework and feedback was received, which has formed the basis for the priorities of the *National Health Plan 2011–2020.*

National Health Conference participants, Goroka

Stakeholders and Partners in Consultation	Representatives

National Department of Health Workshops 1, 2 & 3:

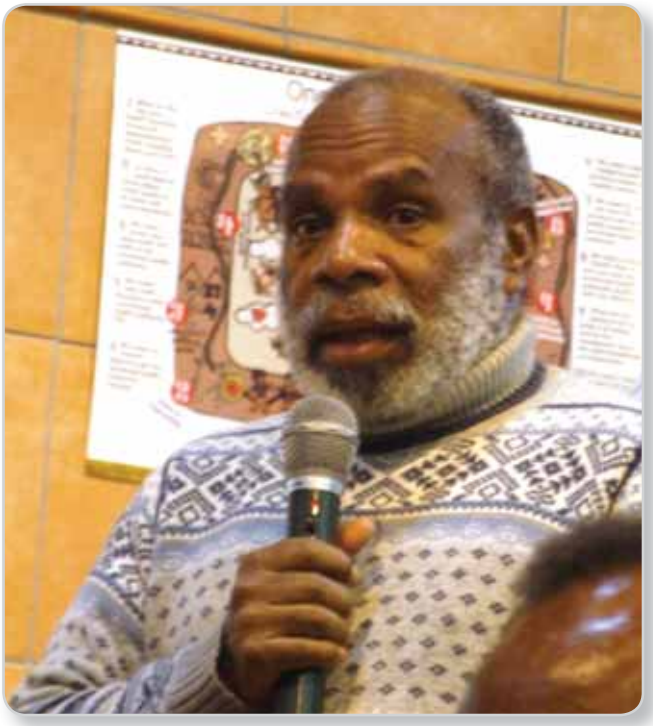
- Brainstorming and program and performance review feedback.
- Development of Thematic Framework for June 2009 National Health Conference.
- Provided feedback on the first working draft of NHP.

MONITORING IMPLEMENTATION OF POLICY AND STANDARDS IS OUR BUSINESS.

Central Agencies:

- DPLG, DNPM, Treasury, PM Department, DPM, Education, Community Development, PLLSMA were all consulted.

HEALTH CANNOT DO IT ALONE, WE NEED YOUR SUPPORT



Provinces, Hospitals and Districts:

- Four Provincial and Regional Consultation Workshops conducted.
- One national consultation and reviewed and provided feedback on the first working draft of the NHP.
- Provinces, Hospitals, and Districts provided feedback during the different stages of the development of the NHP.

IMPLEMENTATION AND REPORTING IS OUR BUSINESS

PHA, Hospital CEO, PA, DA, DHM

Stakeholders and Partners in Consultation — Representatives

Churches and Non-Government Organisations:

- Participated at the Regional Workshops and National Workshop and provided feedback on the first working draft.
- They are our **major partners** in providing health services to the **rural majority** and their contribution and feedback during different stages was very important in framing the NHP for the people of PNG.

TOGETHER WE WILL MAKE A DIFFERENCE

Church Health Secretaries, Pathfinder International, Family Health Association

Training Institutions:

- Universities, Nursing colleges and Community Health Worker Training Schools, Deans and Principals were consulted and feedback received at every stage of developing the NHP.

WE WILL PRODUCE WORKFORCE REQUIREMENTS

Health workers participating in NHP Workshop Alotau, MBP

Development and Donor Partners:

WE NEED YOUR SUPPORT

Stakeholders and Partners in Consultation — Representatives

District Consultation Workshop:

- A two-day workshop was conducted for District Administrators, District Health Managers, and Provincial Health Advisers to communicate and provide feedback on the NHP.

IMPLEMENTING NATIONAL AND PROVINCIAL POLICIES, STANDARDS, AND GUIDELINES IS OUR BUSINESS

District Administrators, District Health Managers

Public Awareness and Radio Talkback:

- Radio Talkback by the Secretary and SEM
- Opinion box distributed to province Radio Spot in NBC and Wantok Radio

HEALTH COMMUNICATION IS OUR BUSINESS

Radio talkback show at NBC

Stakeholders and Partners in Consultation

Wider Consultation:

The Department of Health undertook wider consultation with health professionals, the general public, and our stakeholders.

Thank you all for your participation in this very important initiative.

SECURING A HEALTHY FUTURE FOR THE PEOPLE OF PAPUA NEW GUINEA IS OUR BUSINESS

Representatives

All of us are the implementers of the *National Health Plan 2011–2020*.

NCD and Central Participants

Annex 2

Annual Reporting Indicators

It is important to note that these will be refined further as part of the development of the Performance Monitoring Plan.

Indicator Number	Key Result Area	Program	Indicator
1a	Service Delivery	*Access to services*	Proportion of rural outreach clinics per population under 5 years.
1b			Proportion of aid posts that are open.
1c			Proportion of districts with Community Health Posts (after their development).
2		*Facility supervision and support*	Proportion of health centres that have received at least one supervisory support visit from District and/or Provincial management staff during the year.
3		*Curative services*	Proportion of general hospitals (PMGH and the provincial hospitals) that have at least three of the five key specialties.
4		*Service infrastructure*	Proportion of health centres/hospitals with functioning radio/telephone.
5a	Partnerships and coordination	*Service agreements*	Proportion of provinces that have established service level agreements with church and non-government organisations.
5b			Number of national service level agreements with church and non-government organisations.
6	Health systems and governance	*Provincial financing*	General expenditure (health functional grants and HSIP) at district/facility level as a percentage of total provincial expenditure on health.
7a		*Health workforce*	Density of paediatric-trained nurses (per 10,000 of population).
7b			Density of midwives (per 10,000 of population).
7c			Total number of paediatricians in clinical and public health settings.
7d			Total number of obstetricians in clinical and public health settings.
8		*Medical supplies*	Percentage of months that facilities have all key medical supplies.
9a	Child health	*Immunisation coverage*	Proportion of 1-year-old children immunised against measles.
9b			Proportion of 1-year-old children vaccinated with three doses DTP-HepB-Hib pentavalent vaccine.
10		*Nutrition*	Prevalence of underweight children under 5 years of age.
11a		*Case fatality*	Case fatality rate for pneumonia in children under 5 years in hospitals.
11b			Case fatality rate for pneumonia in children under 5 years in health centres.
12		*Neonatal health*	Proportion of neonates that are classified as having low birth weight.

13	Maternal Health	*Safe motherhood*	Proportion of pregnant women who receive any antenatal care.
14			Proportion of births attended by skilled health personnel.
15			Referral rate for emergency obstetric support.
16a		*Family planning*	Couple years of protection.
16b			Contraceptive acceptor rate.
17a	Disease Control	*Malaria prevention and treatment*	Number of reported cases of malaria.
17b			Proportion of children under 5 years sleeping under insecticide-treated bed nets.

Annex 3

Lists

Abbreviations

AAP	Annual Activity Plan
AP	Aid Post
ARV	Antiretroviral
CHP	Community Health Post
CHW	Community Health Worker
CMH	Commission on Macroeconomics and Health
CPHL	Central Public Health Laboratory
DHS	Demographic and Health Survey 2006
DNPM	Department of National Planning and Monitoring
DSIP	District Service Improvement Program
DTPw-HB/Hib	Diphtheria-Tetanus-whole cell Pertussis-Hepatitis B/Haemophilus Influenza Type B
EOC	Emergency Obstetric Care
GDP	Gross Domestic Product
GoPNG	Government of Papua New Guinea
HC	Health Centre
HIV and AIDS	Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome
HRIS	Human Resource Information System
HSIP	Health Sector Improvement Program
IBRD	International Bank for Reconstruction and Development
ICT	Information Communication Technology
IMCI	Integrated Management of Childhood Illness
IT	Information Technology
JPPBPC	Joint Provincial Planning and Budgets Priorities Committee
KRA	Key Result Area
LLG	Local Level Government
LLIN	Long Life Impregnated Nets
LNG	Liquid Natural Gas
LTDS	Long Term Development Strategy (now PNG Development Strategic Plan 2010–2030)
MDG	Millennium Development Goal
MDR-TB	Multi-Drug Resistant Tuberculosis
MTEF	Medium Term Expenditure Framework
NAC	National AIDS Council

NDoH	National Department of Health
NEFC	National Economic and Fiscal Commission
NHAA	*National Health Administration Act 1997*
NHIS	National Health Information System
NHP	National Health Plan
NGO	Non-Government Organisation
NIHF	National Inventory of Health Facilities
OECD	Organisation for Economic Cooperation and Development
PAF	Performance Assessment Framework
PCMC	Provincial Coordination and Monitoring Committee
PEP	Post Exposure Prophylaxis
PHA	Provincial Health Authority
PHAA	*Provincial Health Authorities Act 2007*
PHC	Primary Health Care
PHO	Provincial Health Office
PLLSMA	Provincial and Local Level Service Monitoring Authority
PMGH	Port Moresby General Hospital
PNG	Papua New Guinea
PNG DSP	Papua New Guinea Development Strategic Plan 2010–2030 (previously LTDS)
PPP	Public–Private Partnership
PPTCT	Prevention of Parent-to-Child Transmission
STI	Sexually Transmitted Infection
SWAp	Sector-wide Approach
TB	Tuberculosis
TB DOTS	Tuberculosis Directly Observed Treatment, Short-course
UN	United Nations
USD	United States Dollar
VHV	Village Health Volunteer
WHO	World Health Organization

Definitions

Burden of disease	The impact of a health problem in an area, measured by financial cost, mortality, morbidity, or other indicators.
Case fatality rates	The ratio of deaths within a designated population of people with a particular condition, over a certain period of time.
Central Agencies	Government of PNG Core Departments, which includes Department of Treasury, Department of Finance, Department of National Planning and Monitoring, Public Sector Management Reform Unit, and Department of Provincial Local Government Affairs.
Child Mortality Rate (CMR)	The number of children under five years of age dying per 1,000 live births in a given year. Also known as the Under-Five Mortality Rate.
Child survival	A field of public health concerned with reducing child mortality. Child survival interventions are designed to address the most common causes of child deaths that occur, which include diarrhoea, pneumonia, malaria, and neonatal conditions.
Determinants of health	The range of personal, social, economic, and environmental factors that determine the health status of individuals or populations.
Essential medical supplies	Those that satisfy the priority health care needs of the population. They are selected with due regard to public health relevance, evidence on efficacy and safety, and comparative cost-effectiveness. They are intended to be available within the context of functioning health systems at all times in adequate amounts, in appropriate dosage forms, with assured quality and adequate information (WHO).
Exclusive breastfeeding	'An infants' consumption of human milk with no supplementation of any type (no water, no juice, no nonhuman milk, and no foods) except for vitamins, minerals, and medications' (American Academy of Pediatrics).
Health indicators	Measures that reflect or indicate the state of health of a certain group of persons in a defined population.
Healthy Islands	A healthy island is one that is committed to and involved in a process of achieving better health and quality of life for its people, and healthier physical and social environments in the context of sustainable development.
Health financing	How financial resources are generated, allocated, and used in health systems. Examples of health financing issues include: (i) how and from where to raise sufficient funds for health; (ii) how to overcome financial barriers that exclude many poor from accessing health services; or (iii) how to provide an equitable and efficient mix of health services.
Health outcomes	The effect on health status from performance (or non-performance) of one or more processes or activities carried out by health care providers.
Health outcomes	A change in the health status of an individual, group, or population, which is attributable to a planned intervention or series of interventions, regardless of whether such an intervention was intended to change health status.
Health promotion	The process of enabling people to increase their control over and to improve their health.

Health services	All services dealing with the diagnosis and treatment of disease, or the promotion, maintenance, and restoration of health. They include personal and non-personal health services.
Health system	A health system is the sum total of all the organisations, institutions, and resources with the primary purpose of improving health.
Health workers	'All people engaged in actions whose primary intent is to enhance health' (World Health Report 2006).
Infant Mortality Rate (IMR)	The number of children dying under one year of age, divided by the number of live births that year. The infant mortality rate is also called the infant death rate.
Maternal Mortality Ratio (MMR)	Number of women dying of pregnancy-related causes out of 100,000 live births in a given year (ODI/HPN paper 52, 2005, Checchi and Roberts).
Neonatal Mortality Rate (NMR)	Number of deaths during the first 28 completed days of life per 1,000 live births in a given year or other period. Also known as the neonatal death rate.
Non-communicable diseases	Diseases that are not contagious, but may be acquired through a person's lifestyle, genetics, or environment.
Primary health care	Often abbreviated as PHC, primary health care is: 'Essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-determination' (Alma Ata international conference).
Private health care providers	Organisations providing health services that are not part of government.
Public health	Public health is a social and political concept aimed at the improving health, prolonging life, and improving the quality of life among whole populations, through health promotion, disease prevention, and other forms of health intervention.
Public–Private Partnership (PPP)	A method to procure and deliver infrastructure and services through cooperation between a public institution and one or more private enterprises.

Figures


National Health Plan

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