Executive summary

Introduction

Papua New Guinea had an estimated population of over 7 million in 2011, with most of the population (80%) living in rural areas. It is a lower-middle-income country with the economy being heavily dependent on the natural resources sector. It has a complex geography – with large areas of the country accessible only by foot, air or boat. The country is classified into four geographical regions of the Highlands, the New Guinea Islands, Momase and the Southern region.

Administratively, the country is made up of 22 provinces (20 integrated provinces, the autonomous province of North Solomons [Bougainville] and the National Capital District), 89 districts, and 318 rural local-level governments (LLGs) and 31 urban LLGs. (LLGs are also called wards.)

The 2015 Human Development Index categorized Papua New Guinea as having “low human development”, with a rank of 158 out of 188 countries, the lowest of all in the WHO Western Pacific Region. In 2014, the country was ranked 140 out of 155 countries on the United Nation’s Gender Inequality Index. This low level of development ranking is also reflected in the health status of the country, which demonstrates the continued high burden of disease attributable to communicable diseases (tuberculosis [TB] and malaria), and maternal and child health conditions. Various risk behaviour surveys and health statistics have identified a rising prevalence of risk factors for developing noncommunicable diseases (NCDs) as well as prevalence of NCDs in Papua New Guinea, and suggest the country is in the very early stages of a demographic and epidemiological transition.

Mortality rates for both women and men have continued to drop over the past 25 years at a slow but steady rate, and as a result, overall life expectancy has increased by 5 years since 1990. Despite this progress, overall life expectancy for Papua New Guinea is shorter than most of its Pacific neighbours. Infant and under-5 mortality has been steadily declining since 1990; however, there was insufficient progress for Papua New Guinea to meet its Millennium Development Goal (MDG) 4 targets. The maternal mortality ratio is also high and again slow change meant that the MDG 5 targets were also not met (see Chapter 1).
Main findings of the health system review

In terms of organization and governance of the sector, the national health system is decentralized (see Chapter 2). The National Health Plan and related service standards delineate a vision of seven levels of health care, from the basic services delivered through Level 1: aid posts (approximately 2500 open) (with a recently commenced pilot of community health posts), through to 629 subhealth centres and health centres, 14 rural/district hospitals (theoretically one per district), 21 provincial hospitals (three of which are regional referral facilities), urban clinics (69) and one national referral hospital (level 7 of the system), which also acts as the Southern regional referral hospital and provincial hospital for Central Province. The extent of coverage of service delivery varies significantly by geographical region and by programme type.

The primary responsibility (most of the funding and implementation) for primary and secondary health-care service delivery in Papua New Guinea is entrusted to the subnational government (provincial- and local-level governments) as prescribed in the 1995 Organic Law and subsequent legislative instruments to support the implementation of the law (called enabling legislation). The churches play a significant role in health service delivery, operating over 50% of the rural health service network but heavily dependent on national government financing. In addition, there are also employer-provided health-care services (agriculture, mining), a small private for-profit medical sector, some small nongovernmental organizations that provide health-care services, and a much larger traditional sector.

In the decentralized context of Papua New Guinea, responsibility for management and organization of health care is divided between the Central and local governments. The dominant system is that the National Department of Health (NDoH) manages the provincial hospitals, while provincial and local governments are responsible for all other services, which includes health centres, rural hospitals and aid posts. This system was developed under the National Health Administration Act of 1997 and was intended to provide the legal framework for linking and consolidating the functions of all levels of government and other agencies involved in the delivery of health. However, a more unified provincial health system was defined (Provincial Health Authorities Act, 2007), under which a single Provincial Health Authority (PHA) would become responsible for both hospital and rural health services. These authorities have been slowly implemented, although the Government is pushing to move from voluntary provincial sign-up to enact the Provincial Health Authorities Act, 2007 to ensure that all provinces have these in place before 2020 (see Chapter 2: Organization and governance). Thus, at the moment, both systems are present in the country.
The Government of Papua New Guinea proposes to respond to many of the challenges of decentralization by extending institutional capacity for planning and budgeting to lower levels of the organizational system. However, this implementation is also slow, uneven and subject to fund flow challenges (see Chapter 3: Health financing).

The Government is the main financing agent through tax-based financing. External assistance still takes up a significant share of total health expenditure (21%), although there are some indications that the share of international development financing for the health sector in Papua New Guinea is transitioning (see Chapter 3 for details). The private health sector, health insurance and other forms of private investment in health care are at much lower levels than regional averages. Although the government policy is for free primary health care and subsidized secondary care, user fees are still in use. This practice has resulted from shortfalls in levels of funding for the operations of health facilities, and untimely flow of funds, particularly to primary health care facilities. The total out-of-pocket expenditure on health care is estimated to be only 10% of the total health expenditure; however, when coupled with low or declining service utilization rates and high mortality, this probably reflects foregone care rather than a positive feature of the health system.

Diversification of health financing sources and expansion of financing volume is a high development priority in the country. Financing is required to support the National Health Plan and Health Policy goals to abolish user fees, expand health infrastructure, and address the critical shortage of human resources for health in rural and remote areas. Broader efforts by the Government to advance public financial management reforms are also a high development priority, particularly with regard to improving linkages between planning and budgeting to enhance the flow of funds to rural facilities and urban clinics. Models of resource allocation will need to be developed and aligned with the decentralized planning system to ensure more equitable patterns of resource allocation across the country, including for basic essential services such as health and education.

With a resource-dependent economy and therefore a volatile macroeconomic outlook and no significant growth in investment in health projected over the medium term, the fiscal space for health is narrow for the 5–10 years. Given this fiscal outlook, there is strong emphasis on improving the overall efficiency of use of government funds through strengthening financial management systems. Specifically, in the health sector, the health financing framework centres around improving resource usage, resource mobilization and exploration of alternative health financing options.
Recent surveys and analyses have identified significant gaps in the quality and coverage of health-care infrastructure. One analysis confirmed that a substantial number of aid posts have closed (reportedly up to 23%) due to shortages and lack of timely availability of funding and other resources, and staff shortages. A 2012 health facility survey of 142 facilities found that 67% of clinic rooms and 77% of health worker accommodation needed rehabilitation, 55% had year-round water supply, 41% of clinics had refrigeration and 40% electricity, and 50% had toilets. In conjunction with the PHA reforms, the Government of Papua New Guinea Medium-Term Development Plan (MTDP-2 2016–2017), entitled “Pathway to a responsible sustainable future”, proposes rehabilitation of aid posts in the next 5 years (to have one in every ward), trialling of community health posts (with the plan to have by 2050 one in every ward replacing the aid posts), and rehabilitation of health centres and hospitals at district, provincial, regional and national levels.

There are significant gaps in the number and distribution of the health workforce in Papua New Guinea, particularly at the primary level of care where there is the greatest potential for impact on health and development. Underinvestment in public sector training has resulted in limited capacity to produce the required levels and mix of the health workforce. Loss of workers to the private sector (in health and non-health positions) or overseas is part of the retention issue faced by the sector. This contributes to the heath sector having an ageing workforce that is very low on the critical workforce cadre of, for example, midwives and community health workers. To address this most significant gap, the Government is proposing several policies and planning measures, including the establishment of standardized training systems and a centralized human resource management information system, increased production of critical health cadres, development of career pathways for all cadres of staff, and the introduction of performance-based management systems, including contractual mechanisms and performance-based incentives.

There are many geographical, cultural and institutional barriers to the smooth functioning of the health referral system in the country. Although patient pathways are intended to conform to a health referral model, the realities are of referral bypass and a concentration of inpatients and outpatients in urban and periurban locations (i.e. close to provincial centres). Urban and periurban populations consequently have much better access and much higher outpatient contacts than rural and remote populations. Outpatient contacts of 1.4 per inhabitant per year in Papua New Guinea are well below international norms for outpatient contacts and continue to decline; another symptom of the health system problems in Papua New Guinea.
The Ministry of Health has proposed an ambitious health reform agenda to address the problems of inequities, referral bypass and low utilization rates (see Chapters 6 and 7). These include the proposal to finalize the (slow) roll-out of the PHA, a plan to support facility-level budgeting and direct health facility financing, and to expand access to health services in rural and remote areas through implementation of a system of community health posts. In addition to standards of services, resources, equipment and drugs, staff and infrastructure [called the National Health Service Standards], the Government has also identified in financial arrangements a set of minimum priority activities [MPAs] for provinces. For the health sector, the MPAs are operations of rural health services, conducting of health outreach and mobile clinics [called patrols], and distribution of essential medicines. In an era of tighter fiscal constraints and declining donor aid flows, the policy and planning reform context in Papua New Guinea is driven by the need for greater efficiency and equity, best exemplified through a “back-to-basics approach” for investment in primary health care for the rural majority and the urban disadvantaged.

Conclusions
The health system challenges in Papua New Guinea are formidable, given the level of economic and infrastructure development, and the challenge associated with reaching the rural and remote majority in geographical terrains with limited accessibility. The tight fiscal context and the prospect of declining development partner assistance presents formidable financial challenges and will demand higher levels of efficiency in support of universal health coverage with equity goals.

The shortage of qualified human resources for health in rural and remote areas is a significant policy and planning priority and is the major health system constraint limiting access of the population to essential health services and interventions. Although the country is undergoing an epidemiological and demographic transition with a consequent rise in the incidence of NCDs, it is the gaps in provision of basic services for maternal and child health and communicable diseases that presents the most pressing population health need for the rural majority. These challenges support the case for a “back-to-basics approach”, which will entail investment in health system readiness [drugs, functioning equipment, supplies, skilled human resources for health and infrastructure] across the country for improved access to primary health care, particularly in rural and remote areas. Strong health management capabilities are required at provincial and districts levels to execute these interventions. Whole-of-government financing reforms are essential to ensure adequate and timely financing.