

Chapter 7

Policy Making in Health

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This chapter highlights the current state of affairs in regard to health policy under the decentralization arrangements introduced in 1995. It contrasts the achievements of the health sector during the pre-independence, centralized system with the decentralized systems of governance implemented after independence. It then presents a set of options for policy makers to consider in their endeavour to rectify the declining state of the health services and, most importantly, the state of the people's health.

Papua New Guinea has an accomplished history of sound health policy, and well-articulated health plans. Indeed Papua New Guinea health policies and plans have been widely complemented. Examples of the policies approved and in process for approval include: user fees policy for public hospital and dental services; national drugs policy; national cold chain policy (for pharmaceuticals); hospitals standards policy; partnership policy; health human resources policy; non-government organizations and churches salaries and allowances policy; national health insurance policy; and minimum standards for rural health services policy.

Notwithstanding this strong history of sound health policy, the periods covered by post-independence health plans have witnessed a slow but steady decline in the services available to rural people, and a stalling of improvements in key health indicators.

There are many and complex reasons for this demise. A key factor has been the impact of successive decentralization reforms on the organization and management of health services. Critical flaws are the lack of integration between national health planning and any budgetary planning, and the separation of the policy arm from the implementation arm of the health system.

A health system is a complex and highly technical operation based on scientific principles, and must have a clear vertical link from policy development to its implementation. For a health service to operate effectively there needs to be a single point of budget and management accountability, with direction being provided by people with technical knowledge and skills.

Clearly, these structural and organizational issues cannot be viewed outside of the concurrent social, economic and governance decay in Papua New Guinea.

In the pre-independence time, there was a high level of optimism about the future of Papua New Guinea, the bureaucracy was effective and resource prospects were flourishing. However, since then the effectiveness of Papua New Guinea as an independent state has been questioned and successive governments criticized for mismanagement. The economic climate continues to be extremely fragile, law and order problems remain high on the agenda, corruption is a major problem throughout the country and the capacity of the bureaucracy to deliver basic government services continues to slowly decline. A recent independent review by the Australian Strategic Policy Institute highlights the lack of capacity of the bureaucracy to deliver health services, as one of the key challenges that impact upon the viability of Papua New Guinea as a functioning state. The report suggests that only a generational timeframe is now realistic for arresting the decline (White and Wainwright 2004). Thus, while the structural issues identified here perhaps once could have been addressed by making changes to the Organic Law on Provincial Governments and Local-level Governments, the problems are now too deeply ingrained to be resolved so simply.

Potential for health systems to improve health

There is evidence that the provision of simple, cost-effective interventions can improve health status in Papua New Guinea. Before independence, significant gains were made in the health status of the population. Infant mortality fell from 134 to 72 per 1,000 live births, child mortality fell from 91 to 45 per 1,000, and life expectancy increased from 40 years to 50 years. These improvements have been directly attributed to the provision of health services.

The successes were attributable partially to the pre-independence organization and administration of health services, which was centralized with highly defined vertical public health programs. Well coordinated programs were designed and implemented with emphasis on the district level. Districts, health centres and hospitals became the focal points of service delivery and provincial hospitals provided technical and logistical support whenever required. This highly centralized control ensured more effective management of resources by a functioning bureaucracy that closely supported delivery and management of health services.

At the district level, government services were integrated, even though nationally many programs were vertical. Highly integrated and coordinated support of programs enabled efficient delivery of important priority health services which resulted in marked improvements in the health status indicators of the people. However, these improvements have not continued in the past two decades.

Policy formulation and planning

Decentralization in the 1970s and 1980s

Papua New Guinea first decentralized to nineteen provincial governments in the late 1970s (see chapter 12). Following independence, the government introduced the Organic Law on Provincial Government to decentralize the management and administration of government services, including health. The two main components of health services — rural health and hospitals — which enjoyed a centralized vertical but integrated planning and management approach were now to be under separate authorities. Rural health services became decentralized while hospital services were only delegated to the provinces for planning, management and administration (Thomason, Newbrander and Kolehmainen-Aitken 1991).

For the health system, this presented some significant issues. Appointment of provincial health officers became politicized, mobility of the health workforce declined, and the national Department of Health found it impossible to maintain standards and ensure health policy implementation in the hospitals, which were delegated functions, or in rural health, which was transferred. Functional roles and responsibilities for the two components were poorly defined, leading to much confusion for both national and provincial governments, and consequent uncertainty at both national and provincial government levels. This uncertainty led to poor resource allocation, lack of coordination, and inefficient management of the health services, and thus the deterioration in quantity, quality and coverage of basic health services provided from rural health facilities and hospitals. Gains made under the centralized health system prior to independence were not sustained.

Further decentralization in 1990s

Despite these and a number of other problems which followed the initial decentralization, there was a further decentralization in 1995 through the enactment of the Organic Law on Provincial Governments and Local Level Governments (OLPGLLG), which further decentralized to around three hundred local-level governments.

The present OLPGLLG was adopted with the aim of improving government service delivery, especially health services, to the majority rural population. Where the previous legislation had failed, this new law ambitiously attempted to improvise and enhance the government's ability in service provision by empowering and decentralizing further into the districts the rural health services component. The practical effect of the new OLPGLLG has been to give provincial governments and local-level governments significantly greater discretionary control over spending at the sub-national level, without effective checks and balances to ensure national policies are being implemented.

National public servants in each of the provinces report to a provincial administrator, who is the head of the provincial administration. Each district (corresponding to the area of an open electorate) is under the administration of a district administrator. District health staff report to the district administrator who has limited knowledge of health programs and of what it takes to make the health system perform properly. The hospital CEOs, senior clinical staff and provincial health advisers who have the knowledge and experience to run the health system cannot discipline staff in rural areas, nor direct them or financial and other material resources to where they are needed.

Effective implementation of health policy requires the ability to ensure that resources are directed to the key policy priorities. Under the organic law the sources available for health funding include the national budget (including the District Development Program — see chapter 12) and provincial and local-level government budgets (mostly funded from grants under the OLPGLLG but including some internal revenue). There is no provision at the national level for reviewing the overall sectoral allocation, nor sectoral allocations among provinces or districts within provinces (although the OLPGLLG does provide for joint planning and budgetary priority committees at provincial and district levels). It is currently impossible to even review provincial budget allocations for health, let alone centrally direct or influence them.

There are two key issues in the funding arrangements, which lead to what is essentially an untenable situation. Funding for provincial governments is no longer calculated on the basis of functions they perform, instead the grants are calculated primarily on the basis of population and geography. The funding may not be adequate to carry out all the necessary functions. Grants paid to provincial governments are essentially unconditional, so while the national government can set national policy, it cannot make provincial governments outlay money to implement it.

A further and presumably unintentional anomaly has been the establishment of public hospitals under a separate piece of legislation, the *Public Hospitals Act*. Following the passage of the *Public Hospitals Act*, hospitals have operated as quasi-statutory authorities, responsible to an independent board of management, and through it to the national minister for Health. They are funded from the national budget. This administrative and financial separation of hospitals from rural health services has caused problems in ensuring that hospitals deliver their support services to the rural healthcare system. The lines of direction and control are uncoordinated. Since hospitals are independent of provincial governments, the provincial governments must negotiate the basis on which the services of the two different systems are provided.

The existing situation

The OLPGLLG and the subsequent enabling legislation were meant to further clarify roles and responsibilities between the levels of government and their respective administrations. The organic law was intended to give the role of policy setting to the national government, in order to ensure consistency and unity of national direction. If national health policy is to be carried out, the provincial governments must fund priorities in these areas, and allocate staff into the priority activities. If they do not, however, there is little the national government can do about it. The national government has done very little in the way of establishing mechanisms to ensure that provinces fund important areas of national policy. During the interview process for the 2001 functional and expenditure review of the health sector, one provincial administrator told a member of the review team, 'You may have a National Health Plan and a national policy that says health is a top priority, but that's irrelevant because in our province health is a fourth or fifth priority'.

Even though the intentions of the political and constitutional reforms are commendable, experiences so far in many provinces in fulfilling these intentions are far from convincing. Poor management practices coupled with inadequate allocation of resources, lack of staff capacity, and poor state of facilities and infrastructure at district level are just a few areas that do not support the intention of the reform. The political will may be there, but the public service machinery simply does not have the capacity to deliver.

One of the current underlying issues is that of staff motivation and the required levels of competency. Staff now have to work within a health sector that on the one hand has a clear vision with established prioritized policies but on the other hand is without clear standards, and suffers from eroded and weakened management systems. They have to operate under complex management procedures with weak provincial, district and local health managerial competence. In many cases, their technical skills have not been updated and their technical competence has been allowed to erode during the post-independence period. Disillusioned health workers in many provinces know that provincial governments are choosing not to prioritize health services for resource allocation.

The disillusionment and de-skilling is not confined to provincial health staff. The national Department of Health is also struggling to maintain a cadre of highly skilled and motivated leaders, after a succession of disappointments and continually deteriorating health statistics. Unwittingly, the escalating level of dependence on donor funds to maintain even the most basic of health services has probably played a role in increasing the disempowerment of senior health officials. The sheer numbers of donors and their technical advisers in some areas has probably undermined the leadership and influenced direction of the

Department of Health. The expectations of donors and their teams to 'be serviced' by senior health staff, reduces time available for focusing on core business. An unanticipated consequence of donor interest and support for the health sector, in some provinces, has been the premeditated under-resourcing of health services by provincial governments, in the expectation that donors will fill the gap. This has been consistently reinforced over a number of years.

Policies at independence

Papua New Guinea's health system was developed on two basic principles — that health services should be brought as close to the people as possible, and that the least-trained health worker who is competent to provide such care should deliver all health service activities.

These principles, which address the two basic issues of *access* to and *quality* of health care within the context of a nation with limited resources, are relevant today. A small number of diseases (pneumonia, malaria, diarrhoea, tuberculosis, measles and anaemia) that can be diagnosed and treated at aid posts or outpatient clinics cause 40 per cent or more of deaths of men and women under the age of forty-five years. Another 10 per cent of deaths are attributed to meningitis, typhoid and some of the most important causes of maternal death that could be managed in a health centre ward. The most important preventive services — immunizations and antenatal care — can be provided through mobile and stationary clinics, and do not require a sophisticated service delivery infrastructure. These services can be, and have been in the past, provided to the majority of the population in Papua New Guinea.

Policies adopted at independence remain valid today. Indeed they have been reinforced through the priorities of the *Medium Term Expenditure Framework 2004–2007*, which provides the basis for prioritization for funding and technical support to the following areas: increased coverage of key public health programs, maintenance of essential clinical services for the main causes of morbidity and mortality, and improved sector efficiency and quality. All the activities within the *Medium Term Expenditure Framework* are contained in the overall policy framework set by the *National Health Plan*.

Policy implementation: policy into practice

Despite the sound history of health policy and planning, it has not passed the implementation test. The Department of Health has no control over most of the planning, budgetary and staffing decisions that affect the implementation of national health policies. The Department has made commendable progress to deliver on its obligations under the organic law, and overcome the inherent dysfunction caused by it. A number of important building blocks are in place to facilitate the implementation and monitoring of key health policies within the OLPGLLG. These include:

- A *National Health Administration Act*, which provides a framework for the planning and coordination of provincial health services and the roles and responsibilities of the various levels of government in health;
- A National Health Plan which clearly outlines health policy for the next ten years;
- Minimum standards for district health services, which articulate the health service requirements for districts;
- Partnership agreements which set out the basis of national-provincial funding and performance;
- A performance-monitoring framework, which is the basis for monitoring health system performance; and
- A *Functional Expenditure Review of Health Services and Policy Options for Reform*.

The *National Health Administration Act*, passed in late 1997, establishes a framework for health planning and coordination between the Department of Health and provincial and district authorities. The act provides a rational basis for balancing the practical reality of provincial control, with the organic law vision for national policy setting and technical supervision by national line departments. Despite the clarity of the *National Health Administration Act*, there remains a significant blurring of roles and accountability in its implementation.

The *National Health Plan 2001–10* provides the policy basis for the sector. The plan is sound, but its ultimate successful implementation remains in question. The quality of the National Health Plan as a policy framework notwithstanding, the decentralized service delivery and funding structure mandated by the OLPGLLG, coupled with unreliable government transfers, poses a significant challenge to the successful delivery of health services.

A further problem is the disjunction between the sectoral planning systems and the multi-sectoral district-based planning system, which forms the basis for budgeting at both the local and provincial levels. Integrating health planning into these systems represents a major challenge for health staff, particularly because the system of planning at district level is intertwined with political processes. While this will have the benefit of ensuring that plans meet local needs, there is a real capacity deficit at district level in many provinces in terms of planning, management and utilization of information.

Minimum standards for district health services. Under the law, provincial and local-level governments are supposed to ensure that quality health services are planned, resourced, delivered and sustained. In order to form a basis for defining what this means in practice, the Department of Health has developed minimum standards for district health services. These form the basis for service planning, implementation, and evaluation at provincial and district health service levels. The key issues which remain to be tested in relation to the standards are whether,

in an aggregate sense, the minimum standards are affordable. A second issue is whether the provisions of the law, in reality, provide an effective basis for the Department of Health to enforce the standards. A third issue is who will enforce the standards, and how will they do so.

Partnership Agreements have been developed between the department and each province. These agreements set out the respective commitments of both parties. The most important requirements for continued participation by provincial government will be a commitment to implement the National Health Plan in the province, and the maintenance of agreed levels of funding by the provincial government for health services and activities. The agreements also define target performance levels for each province.

In 2001, however, not one province allocated the targeted 15 per cent of its discretionary budget to health, and seventeen provinces allocated less than 10 per cent of their discretionary funds to health (*Provincial Health Finance Review 2001*). This has called into question the value of the partnership agreements as a means of leveraging provincial governments to carry out their assigned obligations. Poor health service delivery in one province can impact negatively on other provinces and the nation. Papua New Guinea needs a healthy population and it is not the prerogative of one province to determine not to support a fundamental building block for economic development — a healthy productive population.

A *Performance Monitoring Framework* was designed to operationalize a national system of performance monitoring that can be used as part of the partnership agreements to define agreed levels of performance for provinces.

The 2001 *Functional and Expenditure Review* of the health sector highlighted the incapacity of staff with sufficient skills to manage complex health functions independently at 89 different district locations around the country, as envisaged by the OLPGLLG. The review also noted key issues with the intergovernmental financing arrangements under the OLPGLLG: the funding formulae based on population and area, rather than the actual cost of delivering transferred functions; the lack of ability to address inter-provincial inequity; and the multiple sources of funding for health. The overwhelming conclusion of the review was that the new structure has not worked in the health sector (PSRMU 2001).

Policy options

Since the introduction of the OLPGLLG in 1995, there has been a 'bottleneck' in fully implementing the health reforms. What can be better managed and influenced is the process of implementing health services in an environment where there is full control of resources and focus on a few priorities in order to gain momentum and success. The health system needs to be delivered from a single, coordinated service delivery network, with a single point of management

and resource accountability, within each province. The system should be directed and controlled by health professionals and should be responsive to the delivery of national policy and the implementation of the National Health Plan.

In light of these constraints, the government might consider one or more of five options for the recentralization of health services.

Option 1. No change

This policy involves no change but seeks rather to continue to pursue initiatives that are being undertaken by provincial and local-level governments. It is based on the assumption that the implementation of the reforms can be improved and that by modification and improvement of processes, service delivery will improve. It also assumes that resourcing of facilities, especially at the district and local levels, will improve in the not too distant future.

The main attraction of this option is that it requires no further organizational and legislative change. It also has the advantage of providing more time for authorities to take steps to improve the implementation of decentralization. For a few well-performing provinces, like Milne Bay, the 1995 OLPGLLG provided an opportunity for an active and committed province to move well ahead of many others in the delivery of health services, and to access additional funds for health from sources such as the Papua New Guinea Incentive Fund, an AusAID fund that rewards well-performing entities.

However, after more than a decade, the many disadvantages of this option are becoming painfully apparent for most provinces. Many of these have been outlined in this chapter and in most provinces it is a policy that is not working.

Option 2. Recentralize all OLPGLLG health functions to public hospitals

This option seeks to affirm the concept of re-centralization, but rather than taking the concept holistically, it aims to utilize alternative established mechanisms to advance the cause. The option proposes to re-centralize authority from the provinces but rather than fully transferring power and functions to Port Moresby, shifts it to the public hospitals which are physically located in the provinces. The public hospital services are a national function under the *Public Hospitals Act* and could be utilized for this objective. But while they are a national function, as they are located in the provinces they provide a potential mechanism for central coordination and monitoring of priority health programs. Under this option, rural health staff would be transferred to the existing hospital structure, which would establish a division of rural or public health services.

This option is very attractive to many who believe that hospitals can play an influential role in guiding, setting and monitoring clinical, public health and management support standards in the provinces. It would be relatively simple

to achieve. Hospitals are large organizations, and are the focal point for the greatest health sector expertise and resources in each province. They could provide a central management and coordination point in each province for health services. The policy of designating all public hospitals as in-service training centres for a province indirectly supports this option. The technical skills and management expertise of hospital staff can be applied to the benefit of rural health services as well as the maintenance of biomedical equipment, and logistic, financial and human resource management skills.

As against this, this policy option has been criticized on the grounds that the main focus of hospitals tends to be curative health provision, and few see them as centres of public health expertise. Many would be fearful that as hospitals are increasingly pressured by their immediate population, they will fail to prioritize public and rural health. The provincial health advisers may not be supportive of this option, as it would mean the loss of their independence from the public hospitals. Provincial administrators may also see this as a loss of control and resources. If the hospitals are accountable for health services, then decisions on the allocation of provincial funds for health services and would be channeled through the hospitals. This is likely to meet with resistance. It may also compromise provincial government funding. Provincial governments are not obliged to allocate a particular proportion of their budgets to health and may not continue to provide funding to health if the responsibility for service delivery is shifted to hospitals.

While CEOs have been chosen for their hospital management skills, these are not necessarily the same skills required to run a public health system. The hospitals may be strained by the additional responsibilities, especially at the district level. Hospital CEOs have not had to cope with the difficulties of administering staff and activities at a distance. A final shortcoming as a national policy is that not all provinces have a provincial hospital, so this option would not be viable in all provinces.

Option 3. Re-centralize all provincial health functions under the provincial health board

This option also seeks to affirm the concept of re-centralization, but recognizes the necessity for coordination, and aims to utilize previously established coordination mechanisms at the provincial health board level. Under this policy option, existing provincial health boards would take over management of the health system in the province.

This is a familiar model and one that most provinces would consider favourably. It retains control of resources and staff at the provincial level, but centralizes coordination and management of resources from the districts. There are several obvious advantages in adopting this option. First, it is the least likely

to encounter resistance from provinces. Secondly, it bases its rationale on assisting provinces to be self-reliant, is sustainable in the long run, and would not necessarily need major institutional, administrative, economic or political restructuring and manipulation. Thirdly, it is consistent with the spirit of the 1995 reforms.

As with the other options, however, there are also some disadvantages. Provincial health boards are in varying shapes, with some having only just been established; few have demonstrated their effectiveness on a continuing basis. Unless hospital staff become employees of the provincial health board, this system retains the disadvantage of the hospitals and rural health services being managed separately, and would continue to challenge coordination and integration. It is likely to be resisted by district administrators, as it reduces their power and span of control. If hospital staff are directed by the provincial health board, there is a risk that the poor management of hospitals witnessed during the delegated period may reemerge. Gains in hospital management may be lost. Hospital funding may also suffer. Hospitals are funded directly by the national government and because they are statutory authorities they are treated as grant recipients and run their own accounting systems.

Option 4. Re-centralize all health functions under the national Department of Health

This option proposes to re-centralize authority from the provinces through complete transfer of power and functions to Port Moresby. It is likely to encounter most resistance from provinces, is against the spirit of the 1995 reforms, and would be a huge undertaking in terms of planning and resourcing.

For those with memories of the pre-independence system, there may be perceived advantages in re-centralizing services. It yields a single point of accountability and allows for centrally-planned resource allocation and prioritization of key health programs.

Re-centralization would be attractive from a central point of view. However, for one thing, Papua New Guinea has adopted a decentralized political and administrative system and this is now ingrained in the minds of people. Several provincial governments and their administrations have in good faith pursued decentralization, have learnt a lot from the experience, have invested a lot of time, resources and effort in the process, and are making a success of it. For another, recentralization implies unlearning the processes and systems developed, and relearning centralized political and administrative systems. This option poses the question: is full re-centralization of health services a fundamental necessity to improve health service delivery and consequently improve health status indicators for our people? A further question about the 1995 reforms is

whether they were always unlikely to improve essential social services such as health and education.

Option 5. Outsource provincial health implementation to competent third parties

This policy would enable provinces which were unable to self-manage their health services to outsource provincial health implementation to competent third parties, including the national Department of Health, private sector entities, and NGOs. This is already partially the case in many provinces, where the churches act as health implementers. It could enable several provinces to form a network which could service their requirements.

This approach would provide for poor performing provinces to opt for outside assistance to manage and coordinate their health services. It could take advantage of economies of scale by consolidating service delivery mechanisms, for example, by more effective use of charter flights and boat travel.

As against this, it would require a funding process agreed between the province and the third party implementers, and regular and complete reporting of the use of provincial funds.

Choosing policy options

A single policy option will not suit all provinces. A province that is already making headway in terms of implementing the 1995 reforms and seeing benefits in health service delivery, would probably wish to continue along this path. One of the drawbacks of the decentralization process was that it disregarded the varying stages of development, economic and political, between provinces and districts. Measures need to be tailored to the specific needs of the different parts of the country.

In considering the policy options, a number of factors need to be considered: first, services should be managed at provincial or district level only if they have the capacity; secondly, no matter which policy option is chosen, funding arrangements need to ensure the timely flow of resources to priority programs; thirdly, some options will require legislative change, enabling line reporting by district staff other than to the district administrator; fourthly, reform of intergovernmental financial arrangements is needed to provide for tying funding to health system performance.

Conclusion

It needs to be recognized that the system of administration prescribed by the OLPGLLG constitutes a major constraint on strengthening the health system. The Department of Health is limited in what it can do to impact on the health of the nation's people, because the power to determine how much is spent on

health care, and how health staff are deployed and managed, is in the hands of individual provincial governments.

From a population health point of view, Papua New Guinea has never needed an effective and functioning health system more. Papua New Guinea is on the brink of an AIDS crisis of southern African proportions (see chapter 19). Tuberculosis is reemerging as a major public health problem and is an increased risk with the escalating HIV/AIDS epidemic. Non-communicable or 'lifestyle' diseases are posing a substantial threat to the adult population and threaten to create a chronic burden on the health system which is already incapable of providing basic interventions for the common communicable diseases of pneumonia, malaria and immunizable diseases. Papua New Guinea has long had unacceptably high levels of maternal mortality and these continue unabated. The gravity of the situation, and the consequences of not taking steps to ensure the rebuilding of the system to a level where basic services can be delivered, cannot be over-stated. Papua New Guinea needs to determine its own policy solutions; however, any policy option must incorporate recognition of the depleted state of the health system and its key human resources. Without a strategy for rebuilding systems and human resource capacity to deliver health services, none of the policy options outlined above will succeed.

Postscript

Several important developments have taken place since this paper was written. These include the passing of the Provincial Health Authorities Act (2007), amendments to inter-governmental financial arrangements (2008), the delegation of powers from Department of Personnel Management to line agencies, and the establishment of a Public Private Partnership Taskforce and development of a draft National Public Private Partnership Policy (2008).

The Provincial Health Authorities Act was passed in May 2007. The purpose of the new law is to enable provinces to create provincial health authorities to deliver both public health services and curative services. The initial roll-out will take place in three provinces in 2009. Further work is underway with the Department of Treasury to develop the new financial arrangements necessary to bring together hospital funding from the national government and provincial funds for public and rural health service delivery, and with the Department of Personnel Management to establish management and staffing structures for the provincial health authorities.

In July 2008, the National Parliament approved important changes to the intergovernmental financial arrangements, aimed at strengthening the delivery of basic services by provincial governments. The new system is intended to ensure the flow of funding to key service sectors operating at district level, including health facilities and integrated health patrols. Service delivery priorities

are reflected in a set of minimum priority activities approved by an interdepartmental committee responsible for overseeing the implementation of the new system. During 2009, implementation indicators will be developed to enable provincial administrations to monitor and report on both achievements in implementation of programs as well as spending of budgeted funds. The Department of Provincial and Local Government Affairs will be looking at some instances of provincial and local-level funding and service delivery, including specific attention to the funding of rural health centres and aidposts.

In April 2008, the government signed a MoU with the Asian Development Bank (ADB) for Technical Assistance to develop a national public private partnership policy for Papua New Guinea; a draft public-private partnership policy was completed in August 2008. The Department of Health has requested technical assistance from the ADB to develop the capacity to facilitate and monitor public-private partnerships for the health sector.

These developments have the potential to improve implementation of health services to the rural population and to facilitate the development of a differentiated approach to health service delivery in Papua New Guinea on a province-by-province basis. However, whatever the organizational arrangements, sufficient skilled human resources and equipment will still be required to ensure that the Papua New Guinea Minimum Standards for Rural Health Services are provided. This will require the mobilization and organization of resources from national and provincial governments, and donors.

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