

Access-to-Information in Health Care Service Delivery in Papua New Guinea: Report

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March 2012

Introduction:

Global Integrity, in close collaboration with the Australian Agency for International Development (AusAID) and the Consultative Implementation and Monitoring Council (CIMC) in Papua New Guinea (PNG), has completed an indicator-based expert assessment of access-to-information in health care service delivery in PNG. The objective of the pilot assessment is to identify access-to-information issues that have been theorized to play an important role in determining whether service delivery beneficiaries are empowered (or not) to demand improved services in health care at the provincial level in PNG and to hold providers accountable for their performance. The preliminary results of this assessment suggest that it is premature to conclude whether and why citizen access to and use of information can hold providers accountable (complementary analytic tools need to be mobilized to obtain a more conclusive sense). Nevertheless, we argue that our data do provide a window into *what* information gaps exist. As such, this pilot study can potentially serve as a diagnostic tool for identifying and cataloguing informational lacunae.

The health sector in PNG faces several problems, including high infant and maternal mortality rates, infectious diseases (including tuberculosis and HIV), and acute shortage of resources such as essential drugs. The challenges associated with poor physical access and infrastructure make service delivery expensive and out-of-reach to many citizens, especially rural populations. These problems are compounded by a decentralized and fragmented health care system that has led to a lack of coordination and oversight of responsibilities between national and provincial/district government agencies, hospitals, health clinics, civil society organizations (CSOs), and budget institutions. The passage of the Organic Law in 1994-95 attenuated the central government's ability to implement national policies by making provinces responsible for handling primary health care services. However, the management of hospitals, pharmaceutical purchases, and oversight remains the responsibility of the (weak) national government. From this a cumbersome bureaucracy was born (or exacerbated).¹

Might a more informed citizenry help to ameliorate deficiencies in the delivery of health services? Access-to-information has been viewed as a key site of intervention among those in the development and governance communities to hold service providers accountable and effect meaningful change, as “asymmetric information can limit the extent to which citizens are able to challenge policy makers and providers” (Rinegold et al. 2012: 14). In PNG, where national-level

¹ This summary is based on the World Bank (2007) and Foster et al. (2009).

information systems are ineffective, there is “[constant] funding of new forms of intervention and technical assistance [...] to improve the health information system [...]” among foreign donors “concerned about the need to measure the success of their own health projects” (Street 2011: 833 [footnote 11]). We remain agnostic on whether such interventions as information campaigns, access-to-information legislation, and redress mechanisms activate citizen participation – and thus, more broadly, effective service delivery – based on the preliminary data of this particular assessment. However, the indicators serve as a potentially useful barometer to identify what accountability mechanisms and transparency institutions exist (or not) and whether they are effective (or not).

The assessment on information access in PNG health care service delivery builds on the success of a long-standing partnership between Global Integrity and AusAID. Over the past three years, the two organizations have collaborated in generating national-level assessments of public sector anti-corruption and accountability mechanisms in Cambodia, Fiji, Indonesia, Papua New Guinea, Philippines, Solomon Islands, Timor-Leste, Tonga, and Vanuatu. The health assessment of PNG, along with a separate but parallel study of sub-national governance in the Philippines, signals the organizations’ recognition of the increasing importance of sector-level and sub-national governance interventions.

Methodology:

To generate the indicators, Global Integrity applied the same methodology used in our national-level, sector, and sub-national assessments. A local research team (CIMC) was selected from a small but competitive pool of candidates with intimate knowledge of health care issues in PNG and a keen understanding of our methodology. Global Integrity staff, in consultation with CIMC, then collaboratively designed a suite of “actionable” indicators focused on information access in health care service delivery based on a combination of desk research and interviews with relevant experts in the field.

Two sets of indicators were produced: “core” (i.e., indicators that are universally applicable across national-jurisdictional boundaries) and “non-core” (i.e., country-specific indicators that are locally inflected). Each province was assessed via 116 indicators for a combined total of 580 indicators for the five provinces. The indicators were further organized into four major categories or “buckets”: Access to the “Rules of the Game,” Information on Citizen Redress Mechanisms, Availability of Budgetary information, and Information on Citizen Participation. Scores for each indicator were based on whether it was “in law” (*de jure*) or “in practice” (*de facto*). That is, “in law” indicators assessed whether particular legislation, types of information, legal regulations, and fundamental rights existed. These *de facto* indicators were scored with a simple “yes” (100) or “no” (0) score. “In practice” indicators assessed the effectiveness, implementation, enforcement, and citizen access to those same *de jure* institutions and mechanisms scored along an ordinal scale of 0 to 100.

The selection of field sites was an equally collaborative process. In a country as linguistically, politically, and culturally diverse as PNG, we selected five provinces that reflected the country’s multiplex character: National Capital-Port Moresby, East New Britain-Rabaul, East Sepik,

Eastern Highlands-Goroka, and Morobe-Lae. Desk and field research were carried out by the CIMC team over a span of six weeks. Interviews were conducted with key informants with expertise in the health sector.

Due to technical challenges, CIMC staff was unable to submit and review data through Global Integrity's interactive technology platform, Indaba. Nevertheless, the review process was able to proceed via Excel spreadsheets and e-mail. Global Integrity staff reviewed the data for consistency, accuracy, and balance. An independent peer reviewer with expertise in health care issues in Papua New Guinea was contracted to review all five scorecards to help make corrections and adjustments to the final data when necessary. The reviewer was asked, in particular, to address some of the following questions: Was the indicator or sub-indicator scored by the lead researcher factually accurate? Were there any significant events or developments that were not addressed? Did the indicator or sub-indicator offer a fair and balanced view of the sector and information transparency environment? Was the scoring consistent with the entire set or sub-set of integrity indicators? Was the scoring controversial or widely accepted? Was controversial scoring sufficiently sourced? Were the sources used reliable and reputable? In keeping with Global Integrity's commitment to methodological transparency, all peer review comments were published alongside the final scorecard. They played an important role in the adjustment of final scores prior to publication.

Preliminary Findings:

Although all the provinces in our study performed poorly across the board, it is notable that the national capital of Port Moresby earned the lowest overall rating in our assessment. This seems to cut against the grain of what one might assume about health care service delivery in PNG, where a greater percentage of the health budget (36%) goes to urban rather than rural areas (33%) even though more than 80 percent of the population is rural (Foster et al. 2009: 51). Rather than revealing a correlation between spending and the quality/strength of various types of information intervention in health care, then, our study provides some evidence that funding patterns do not necessarily relate to availability (of information and services).

By way of contrast, the province of East New Britain-Rabaul enjoyed the "highest" overall score in our assessment. From information on health care access and citizen redress channels to citizen participatory mechanisms and budgets, ENB-Rabaul earned relatively stronger ratings across all categories than the other provinces assessed. For example, information on health staff/patrols appears to be disseminated in a more "user-friendly" way in the province because there is relatively high radio coverage in the rural area that on occasion **"keeps people informed [...] of the patrol schedule"** [indicator 1.27]. Indeed, **"Radio East New Britain plays a vital role [in] disseminating information with high coverage in rural areas."** In addition, **"to disseminate information most facilities rely on their notice boards. Information on the determination of roles and responsibilities has been distributed to the public through the print media and through CIMC public forms"** [indicator 1.39]. This implies, as noted by the peer reviewer, that

ENB-Rabaul is more effective at disseminating information than other provinces.² Our assessment, however, also revealed ENB-Rabaul to have the biggest “implementation gap” (i.e., the difference between the legal framework and its enforcement/implementation) of the five provinces covered in the study.

The strongest performing category across all the provinces was the cluster of “in law” indicators on the availability, accessibility, and usability of information on health care, as well as the existence of information on quality of performance and whether information was standardized in a way that made it comparable across health providers – what we call the “rules of the game” (category 1). Certainly there are legal requirements for information to be made publicly available on such issues as essential drugs lists, types of health facilities, codes of ethics for health providers, and standards in health services [e.g., indicators 1.20, 1.22, 1.29, 1.40]. Nevertheless, there is room for improvement, especially in the implementation and enforcement of such legislation. With respect to whether codes of ethics are available and accessible/user-friendly, for example, **“health training institutions are responsible for providing [such information]. This information is meant for people who train to work in the medical profession. Thus it is not made available out in the open for the public to access. It can only be provided to people who express a genuine interest in accessing it”** [indicator 1.31, Eastern Highlands-Goroka]. With respect to information on access to basic patient rights, in the words of the peer reviewer: **“many citizens do not know that information on patient’s rights exists. Provincial health offices are often reluctant to release this information. It is therefore very difficult for citizens to request or access this information, making it essentially out of reach”** [indicator 1.36, Eastern Highlands-Goroka]. In provinces like East Sepik-Wewak, **“the only mechanism for access to this information is a personal appearance at the provincial health office. Because, in most cases, officials are reluctant to give this information to citizens, do not have it readily available in a published form, or are not fully informed themselves, these mechanisms are defunct”** [indicator 1.36, East Sepik-Wewak].

Although the relatively robust legal framework around the “rules of the game” constitutes a bright spot in the PNG health care landscape, the poverty of information/knowledge around forms of citizen participation in the decision-making process of health care service delivery – the lowest rated category – should give us pause. Citizen participation in hospital boards is legally enshrined in the Provincial Health Authorities Act, which encourages “the local community to participate in planning and in the decision-making process in relation to the provincial health authority.” However, only a handful of health facilities in each of the assessed provinces have boards appointed by the Minister of Health that occasionally have representatives from civil society. There is a dearth of formal and informal community and consultative groups that

² One possible explanation for this result, which should be followed-up with more contextually “thick” and political economic studies, is that ENB-Rabaul’s infrastructure seems relatively more developed compared with other provinces in the country due to the legacy of colonialism that produced an administrative/infrastructural apparatus (Tammisto 2010: 47); the tourism industry; and foreign aid from organizations like the World Bank (see <http://go.worldbank.org/J49OUNWB60>) that helped to rebuild Rabaul’s physical, economic, and social infrastructure after the 1994 volcanic eruptions that decimated the ENB province and Rabaul town.

advocate for patients, and everyday awareness of such groups is rare [indicators 4.10 and 4.24]. While some citizens have **“organized themselves into Healthy Island Committees [in Morobe-Lae and particularly ENB-Rabaul] to address their health issues at the local level, [it] depends on the availability of provincial health promotions officers and community health workers to organize and facilitate meetings”** [indicators 4.13 and 4.24]. In general, then, as the peer reviewer put it, **“there are very few patient advocacy groups and citizens are often unaware of those that do exist. The majority of citizens would not even know what a patient advocacy group is.”**

We take note, finally, that the fractured government system across units, departments, programs, and facilities is reflected in our assessment by the lack of coordination between national and provincial/district levels in making budgetary information available. For instance, while local health clinics are required to document the acceptance and allocation of government-funded health grants via the Public Finances (Management) Act, local health facilities may **“not have bank accounts and the funds are administered by the provincial health authority”** [indicator 3.16]. Most local health clinics, in fact, do not even have budgets that are then publicly released; their budgets are managed, instead, **“by the Provincial Health Manager. The clinics themselves don’t know how much staff, drugs, and medicines, etc. will be provided,”** a finding corroborated by the peer reviewer [indicator 3.24]. And while information on the transfer of financial resources from national agencies to local health clinics is desired by some citizens, it is rarely made available to the media and public [indicator 3.21].

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