INTERIM REPORT ON HEALTH SECTOR MANAGEMENT

BY THE SPECIAL PARLIAMENTARY COMMITTEE OF PUBLIC SECTOR REFORM AND SERVICE DELIVERY

2/6/2015
Introduction

The Special Parliamentary Committee on Public Sector Reform and Service Delivery (the Committee) analysed the Health Management Report 2013 submitted to Parliament. The analysis highlighted numerous areas where health policy was lacking and government policy directives/implementation had not occurred. It also highlighted funding issues within the health sector that had implication for the public sector generally. A copy of the analysis appears as Annex A to this report.

As a result of the presentation of the Health Management Report 2013 and subsequent analysis, the Committee decided to hold an enquiry into health management. The formal enquiry was to be preceded by a fact finding mission to provinces nominated hereunder viz:

1. New Ireland Province
2. West New Britain Province
3. Morobe Province
4. Western Highlands Province
5. Western Province

The fact finding mission included public fora as well as individual interviews and facility inspections. The provinces chosen provided both regional perspectives, PHA verses Public hospital approaches and as well as major health risk areas e.g. TB and cervical cancer.

Major Issues

As a result of the visits to provincial locations and data gathered from public fora and individual interviews, the Committee came across numerous health issues. These include:

Recurring Issues

1. Drug and Sundry Supply
   - Provincial Medical Stores and Procurement
   - Local delivery contracts
2. Medical equipment supply
3. Free Primary Health Policy and the Functional Grant
4. HPV Vaccine Introduction
5. Angau Cancer Centre and Cobalt Source
6. Workforce Planning
7. Need for Amendment to Provincial Health Authority Act
   - Responsible to PA or PEC
   - Need for Minister to be able to appoint Statutory Manager
   - Province to fund rural health component via PHA
8. Need for Amendment of the Public Hospitals Act
9. The Role of NDoH in Health Management

Other Issues

- An effective TB eradication program for South and Middle Fly Districts
- Ineffective Infrastructure Development
- Anti-Smoking Regulation
- Non-Communicable Diseases Strategy
- Nurses Furlough Issues
- Christian Health Services Contract for services/staffing
- CHS distribution of the Functional Grant
- Poor NDoH communication with Provincial Governments and Districts
- Freeze on Operational Funds Western Province
- Mount Hagen Hospital Health Information System
Drug and Sundry Supply

The evidence suggests that the drug kits being sent to health centres contain items that are not required and omit items that are required. The situation not only engenders systemic waste but fails to address the daily drug needs of health centres. The lack of basic drugs either sees patients not effectively treated or health centres and aid posts spending operational funds on purchase of drugs at local pharmacies. This is both expensive and systemically poor. The quality of drugs supplied has also been questioned.

There is also an issue with Provincial Medical/Transit Stores where at least some seem to be selling drugs to the private sector and transferring expired drugs to health centre/aid posts. There is a universal problem related to supply of sundry medical items like gauze etc. The standard response is “Nil stock”.

The transport of drugs to Health centres and aid posts is not effective with expired drugs delivered and failure by contractors to deliver direct to the centre/aid posts. Supplies are dropped off at villages etc for pick up by health staff. There is no Provincial input into contract evaluation or management which is of significant concern. There is no response from NDoH to complaints regarding contractor services.

Medical Equipment Supply

The Committee found a universal lack of equipment at provincial hospitals, district hospitals, health centres and aid posts. Much of this equipment was regarded as basic to clinical management of patients. The further from the provincial hospital, the more acute the equipment shortage. The acute shortage of such equipment clearly puts patients’ lives at risk.

Responsibility for supply of medical equipment, including delivery beds, ward beds, mattresses, pillows, linen etc is the responsibility of the NDoH under Section 20 (g) (2) of the National Health Administration Act 1997. This is further reinforced by Appendix B to the Intergovernmental Relations (Functions and Funding) Act 2009 which specifies in Section 3 the uses to which the Provincial Health Function Grant may be put i.e. equipment purchase is not covered under the functional grant.

The Committee considers the acute shortage of basic medical equipment in medical facilities is a significant failure on the part of the NDoH. It is a gross dereliction of responsibility.

Free Primary Health Policy and Function Grant

The implementation of the free primary health policy is an abject failure. Most health centres and aid posts in rural areas are still charging for services. The exception may be Western Highlands but the Committee did not have the time or resources to go to sufficient rural locations to check operations.

Fees are being charged in order to keep services functioning. This situation is occurring in both state and church run facilities visited by the Committee. The reasons for this situation largely relate to the distribution of the Health Function Grant and Free Primary Health Care funds. Provinces complain that the Health Function Grant (Annex C) is not transferred in a timely manner. Further, the Committee is not convinced that grant monies are being used by Provinces solely as required under Appendix B to the Intergovernmental Relations (Functions and Funding) Act 2009. It appears that if the Grant was used as intended the income for health centres like Bol in New Ireland Province would be around K60,000 per annum. i.e. Free Primary Health Care funds of K12,556 plus K48,000 approx from the Health Function Grant disbursement. Unfortunately, Bol has a budget far less than K60,000 per annum.
The Free Primary Health (FPH) Care funds are distributed by NDoH to state run institutions and separately to church affiliated facilities. The K20 million in funds provided annually to State and church run facilities appear quite insufficient to cover facility operating costs although they are based on NEFC estimates. The Committee will investigate how or if the functional grant (at Annex C) is divided across facilities within provinces, and whether there is sufficient funding to cover operational costs. Anecdotal evidence suggests that provinces are misapplying health functional grant monies and using the funds for general operations. If this is so, it would be a major cause of health system deterioration.

The Committee will specifically investigate how FPH funds given to churches are being distributed and why in the case of the Sacred Heart Health Centre in New Ireland, no funds at all reached the Centre. In addition, the Committee is disturbed that NDoH still does not have a contract with Christian Health Services to deliver health services in PNG, how millions of kina of public monies for salaries and services can be transferred to churches without tender or contract and without any audit trail. The Committee will investigate why this situation persists.

**HPV Vaccine Introduction**

The Committee considers the failure of the HPV vaccine trial in West New Britain to be of national concern. Not only was US$7 million of vaccine wasted and 23,000 girls needlessly left at risk of contracting cervical cancer but it set back a national immunisation program by years. The Committee’s preliminary assessment is that the cause of this monumental debacle was bureaucratic intractability and incompetence within the NDoH. The Committee will investigate exactly who was responsible for the situation, why Ministerial and Prime Ministerial directions to ensure the trial proceeded were effectively ignored by NDoH officials and recommend appropriate disciplinary and/or legal action.

The failure of NDoH officials to work collegiately with donors in respect of nation-wide cervical cancer vaccination will also be investigated.

**Angau Cancer Centre and Cobalt Source**

Frank discussions with the A/CEO exposed the disgraceful state of cancer treatment in PNG. The only cancer centre is the country does not have an operational cobalt source. This means external radiation treatment only is given to women with cervical cancer. No internal radiation treatment can be provided. As a result the centre is referred to as a “palliative care unit” by the A/CEO not a “treatment centre”. The Acting CEO cited statistics for Stage 2 cervical cancer survival in Australia and PNG. A women with Stage 2 cervical cancer in Australia has a 97% chance of living five years from date of detection. By contract in PNG the rate is ZERO. The staff at the cancer centre hold the hands of women while they die. The situation is simply shocking and completely unacceptable.

Meanwhile, it appears that NDoH has been unable to obtain a new cobalt source in the last three years. From Emails viewed by the Committee it appears this is largely due to bureaucratic ineptitude within NDoH. NDoH officials responsible for the situation will be required to appear for the Committee in formal hearing to justify their actions.

This situation compounds the plight of the 23,000 girls in West New Britain and women generally in PNG. Further, the failure of NDoH to institute a national early detection program based on the low cost Thai system is simply condemning women to death. Late detection means death in PNG.

**Workforce Planning**

The Committee through its open fora and interviews with health professionals has already uncovered a systemic problem with workforce planning in the health sector. Over the years there has been a reduction in nursing graduates, dental technicians and dentist numbers. Bio-medical technician numbers have declined markedly. Despite data being available in 2001, showing the
anticipated decline in nursing numbers through retirement and natural attrition, there appears to be no cohesive strategy developed by the NDoH to arrest workforce decline. The sporadic actions to increase graduates from nursing schools, rural doctors, biomedical technicians etc have been largely funded by donors (notably Australian aid). As Dr Mills indicated recently, only 39 of the 88 districts have access to a doctor. Some of these however do not have a resident doctor but rather a doctor makes visits. The statistic that only 44% of districts have access to a doctor is simply deplorable in the 21st century. This implies that of the estimated 6 million rural population of PNG over 3.6 million have no access to a doctor in their district. Today, without exception, staff levels at hospitals, health centres and aid posts do not meet standards set by the NDoH itself. This is a root cause of failure in the health system and cannot remain unattended.

The Committee will be inviting the relevant staff with the NDoH, OHE and Treasury to appear before it to explain why no action has been taken to put a comprehensive, fully costed workforce recovery plan before Government. Why, for successive years the matter was not sufficiently highlighted in annual plans and health budgets. Why the NDoH stood by and permitted staff levels to fall to intolerable levels. The Committee will be analysing the contents of the NDoH Enhancement Workforce Plan.

Need for Amendment to Provincial Health Authorities Act

The Act does not indicate to whom the PHA reports. The Act provides for the Minister to suspend the Board of a PHA but fails to indicate reporting lines. This creates major problems where a PHA Board chooses to isolate itself from the Provincial Government. In this respect it should be noted that the PHA agreement provides for the Province to enter into a voluntary agreement to permit the PHA to dispense rural health on its behalf. The Province has delegated but not abrogated its responsibilities under Division 3 Section 42 (1) (n) of the Organic Law on Provincial and Local Level Governments. There is a need to clearly articulate who the PHA reports to, whether that be the Provincial Administrator, PEC, Minister or some form of joint responsibility. Regardless, there is a clear need for oversight of PHA activities.

The Committee notes the Independent Review of the Provincial Health Authorities 2013 and will be addressing this as part of its hearing process. The Committee also notes the NDoH submission to the Constitution and Law Reform Commission Review of the Organic Law on Provincial Governments and Local-Level Governments of July 2014. Specifically, the Committee notes the NDoH proposal to establish a Health Service Commission to employ health staff for provincial health authorities if they do not take the opportunity to make regulations to set terms and conditions for their own staff subject to the Salaries and Monitoring Committee Act in the same manner as public hospitals.

The Committee considers the above proposal yet another regressive step to engender greater bureaucracy while failing to address the real problem. The pertinent point is that the proposed Commission will still be subject to the Salaries and Monitoring Committee Act. As such it will not alleviate current staffing issues. The real problem at present is that hospitals and the PHAs can’t set salary levels for staff they need. They have to await approval of reorganisation proposals from DPM i.e. they can’t determine their own staffing establishment. These issues affect health delivery. To impose another bureaucracy between the hospital/PHA and DPM will only exacerbate staffing issues. PHAs want devolution of DPM powers and to be excluded from the Salaries and Monitoring Committee Act not creation of yet another bureaucracy.

Need for Amendment to the Public Hospitals Act 1994

As with the PHA Act, there is a need to clearly define reporting roles and responsibilities for the Boards of Public Hospitals. The Boards really do not report to anyone under the Act. Boards need to be made directly accountable to some entity or position for their performance. It is the Committee view that Boards should be subject to an annual performance audit conducted by the NDoH as part of its health policy mandate. It is an
inexplicable omission that legislation provides no avenue to adjudge Board performance other than investigation and suspension by the Minister under Sections 34-36 of the Act.

**The Role of NDoH in Health Management**

The above situation then gives rise to the NDoH defence that it is not responsible for the operations of public hospitals (or Provincial Health Authorities) and is therefore not responsible for health outcomes. The NDoH submission to the Constitution and Law Reform Commission Review of the Organic Law on Provincial Governments and Local-Level Governments of July 2014 states:

*When provinces perform badly and primary health services are unavailable to rural Papua New Guineans, aid posts are shut and district hospitals are dirty and ill run, there is no National power available to the NDoH to address the problem apart from support. This contrasts wildly with the view of the media and the public. Headlines in national newspapers routinely exhort the Minister, the Secretary and the NDoH to address the shortcomings of the system.*

This is a misleading and vacuous defence that is not accepted by the Committee. The Secretary NDoH is chairman of the National Health Board. The National Health Board can inform (in fact has the responsibility to inform) the Minister regarding health management issues and the Minister can take the following action under Section 32 of the National Health Administration Act:

**ADVICE TO PROVINCIAL GOVERNOR.**

*(1)* Where the Minister, acting on the advice of the National Health Board, is concerned that there has been within a province a–

(a) breakdown of health administration; or

(b) failure to provide adequate resources for the operation of health facilities and provision of health services and programmes; or

(c) failure to carry out health functions in accordance with the National Health Plan; or

(d) deliberate and persistent failure to comply with National Health Standards and Operational Directives, he may direct the Governor of the province to take such steps as are necessary to ensure that the administration of health in the province conforms to the National Health Plan and National Health Standards.

*(2)* A direction under Subsection (1) shall be in writing and shall specify a reasonable time for compliance by the Provincial Government with the direction

Where a Province fails to comply with the Minister’s direction, action can be taken under Section 51 of the Organic Law on Provincial and Local Level Governments 2003 to withdraw health functions and funding from the Province.

Further the NDoH:

- Has a policy development co-ordinating role under Sections 20 (a), (b) and (c) of the National Health Administration Act 1997
- Is responsible for budget compilation and co-ordination for the Sector
- Is responsible for purchase of drugs and medical equipment under Section 20 (g) (i) (ii) of the National Health Administration Act 1997

If as Section 20 of National Health Administration Act 1997 states the NDoH has a responsibility to “oversee the carrying out of the National Health Plan in the country” and to “provide advice to the Provincial Government and the Provincial Administrators as to steps which should be taken to ensure the implementation of the National Health Plan” it is difficult to see how the NDoH can absolve itself from health sector performance.
The Committee is of the view that even if the NDoH is not directly responsible for implementation of health policy, it is responsible for effective co-ordination of health activities to ensure policies are achieved e.g. taking a proactive stance where implementation is poor, effective liaison with Provincial Authorities, ensuring timely supply of required drugs and medical equipment, assistance with staffing issues etc. These are actions which the Committee contends the NDoH has manifestly failed to undertake effectively.

The Committee also notes that as with the current Specialist Public Hospitals Bill, the NDoH has been the primary architect of health legislation. Accordingly, the Committee suggests any dysfunctionality in health management is a construct of NDoH health policy development.

These views were echoed vide paragraph 1.17 of the Permanent Parliamentary Committee on Public Accounts Report on the Department of Health of 2012. The Committee report states “Committee finds that the mission and purpose of the Department of Health is confused and uncertain. Committee (members) were told by an Acting Secretary for Health that it was not the duty of the Department of Health to deliver health services. If this is true, whose job is it? Yet, in the same Inquiry the Secretary for Health told us that the Department accepted responsibility for the state of our health sector”.

The Committee accepts that the current health legislative framework is far too complex and the responsibilities of the NDoH need to be made very clear. Perhaps this complexity is one reason why the NDoH appears not to know its own powers and responsibilities under the legislation.

**Need for Minister to be Able to Appoint Statutory Manager**

Recent events in Western Province, West New Britain and Eastern Highlands attest to the need for the Minister to be able to immediately intervene if a public hospital or PHA Board is not operating effectively. The current system contained in Sections 34 and 35 the Public Hospitals Act 1994 and Part V of the PHA Amendment Act 2013 provides for investigations, submission of recommendations to NEC and eventual appointment of an Administrator etc. The system takes months to implement and is just too cumbersome to provide for an effective response mechanism to bad management.

The Committee considers that the Minister must have powers to act as a “circuit breaker” and intervene where effective management is compromised. The health of the nation cannot be held ransom to gratuitous bureaucracy. The Minister needs the power to install a Statutory Manager in cases where he is of the opinion that a Board is failing in its health management responsibilities. As the Committee indicated in its report to Parliament on its Investigative Mission on Fiji And Samoa of 22 August 2014, Section 78M of the New Zealand Education Act 1989 provides that Minister with such powers.

**Provinces to Fund Rural Health Component via PHA**

The PHA Amendment Act 2013 provides under Section 38 for the State to provide funds to the PHA for curative services as follows:

**38. APPROPRIATION.**

(1) There shall be payable to the Board of a provincial health authority out of the Consolidated Revenue Fund such monies as are appropriated by Parliament for delivery of curative services of that provincial health authority from the premises of the provincial hospital.

There appears to be no clear counterpart requirement under the Act for the Province to provide funds for health centres, aid post curative and preventative health services. There is a reference in Section 7 (4) (f) of the Act to the prescribed form of the health partnership agreement including details of:
“financing of public health services and curative services delivered from premises other than provincial hospitals form grants paid to the province and other provincial funds or funds available”

It appears however that despite any possible inclusion of Provincial funding in the partnership agreements, that some PHAs are not receiving required funds from Provincial authorities. The Committee will address this matter at its hearing with NDoH and provinces.

**An Effective TB Eradication Program for South/Middle Fly District.**

The Committee was shocked by the state of health facilities in these areas. Years of facility neglect has recently been compounded by the freeze on operational funds in the Province. It is obvious that with the current state of health facilities, equipment and staffing in the area it will be impossible to adequately address the TB, MDR-TB & XDR-TB issues. The spread of both MDR-TB & XDR-TB poses severe health and economic costs for the nation and must be effectively addressed.

It must be understood that MDR-TB & XDR-TB are the direct result of interrupted, erratic, or inadequate TB therapy, and their spread is undermining efforts to control the global TB epidemic. MDR-TB and XDR-TB develop when the long, complex, decades-old TB drug regimen is improperly administered, or when people with TB stop taking their medicines before the disease has been fully eradicated from their body. Once a drug-resistant strain has developed, it can be transmitted directly to others just like drug-susceptible TB. In essence, it is the abject failure of the PNG TB detection and treatment regime that permits the spread of TB in general and specifically MDR-TB & XDR-TB.

The Committee wishes to acknowledge and commend the strong support given by Australian aid in the fight against TB in Western Province and PNG more generally. The construction of a TB Ward at Daru Hospital, funding for medical staff and the proposed redevelopment of the Mabudawan Health Centre are all integral to an effective TB control and eradication program. But the fight against TB should NOT be left to Australian aid alone to undertake. It is a PNG national issue of significance and the response needs to be owned and driven by PNG.

*Given the foregoing issues however, the Committee has no confidence that the NDoH has the capability and more importantly, the commitment, to manage the necessary health intervention.* The TB issue is of such import that the Committee is proposing immediate action by Government.

The Committee strongly recommends that Government establish a fully funded, comprehensive TB Intervention Program as per that outlined at Annex B to this report. As part of this program, and subject to medical advice, action be taken to immunise all persons under 35 years of age in the districts with BCG vaccine. Supplies of BCG vaccine need to be made available to all health centres in the districts without delay to immunise children. It is further recommended that a position of Project Director be established based in Daru and that appointment to this position be open to international applications. This position should report directly to the Minister for Health.

The position should have direct control of all intervention funds, be able to contract staff as necessary to undertake assigned roles and be able to expend funds directly on new infrastructure and equipment. Some of the staff can later be incorporated into the provincial health establishment. The Project Director must be able to address the epidemic without hindrance from public service bureaucracy. In this regard, a mechanism must be found to avoid delays occasioned by the CSTB in procurement and DPM in respect to position approvals.
Ineffective Infrastructure Development

The projects viewed by the Committee in New Ireland clearly point to ineffective project management. Half completed projects simply waste money. The Committee will be investigating how many NDoH projects there are and the status of those projects. It will be enquiring into why the New Ireland projects were not completed on schedule and what happened to the funds allocated.

Anti-Smoking Regulation

The Committee regards the failure of the NDoH to implement the regulation as somewhat suspicious. It will be investigating who in the Department has carriage of this matter and why more effort has not been placed on reducing cancer related deaths. This is particularly so given recent newspaper reports indicating that 42% of school students aged between 13 and 21 smoke cigarettes and many children as young as 10 are smoking. PNG has one of the highest smoking rates in the world in 2012 ranking 5th. 51.4 % of the population were categorised as smokers. These statistics are simply shocking and display a complete failure by NDoH to reduce smoking and cancer related deaths.

Why in the above circumstances hasn’t the ban on smoking in public places approved vide Tobacco Products Regulation 2/2013 been enforced? Why haven’t the Minister’s directions to implement the ban been actioned?

Non-Communicable Diseases Strategy

Similarly, the Committee wants to know why despite prolonged efforts by two Ministers for Health, there is still no cohesive, costed non-communicable disease strategy in place. Why hasn’t the draft strategy been finalised in the last 4 years?

Nurses Furlough Issues

The Committee is of the view that nurses have been fed misinformation concerning the furlough issue. The Committee will be requiring the Department of Personnel Management and relevant Western Highlands Provincial Health Authority staff to appear before it to explain the situation.

Christian Health Services Contract for Services/Staffing

The NDoH will be required to present at the Committee hearing and explain the context in which millions of kina of public monies are spent on salaries and costs for church run health facilities without any contract or ability to audit the use of those monies. The Department of Finance will be invited to provide advice as to how this situation complies with the requirements of the Public Finances (Management) Act regarding tendering for all services purchased by the State. The NDoH will be asked to explain why it has failed to execute such a contract/s despite numerous directions to do so by the two Ministers for Health.

CHS Distribution of the Free Primary Health (FPH) Care Funds

The NDoH will be invited by the Committee to explain how it audits the distribution of the FPH funds to CHS institutions. Can it reassure the Committee that the funds are used by the churches as intended? Can it explain why the Sacred Heart Health Centre in New Ireland has received no FPH funds? Data at Annex C appear to indicate that the Sacred Heart Health Centre received K24,200 in both 2013 and 2014 but the facility manager says that it received nothing.

The above situation is invited as the NDoH provides a bulk cheque to CHS and CHS then deposits funds into the accounts of CHS health agencies. The health agencies then release funds to their health facilities. There is no audit system to verify health facilities receive their entitlements.
Poor NDoH Communication with Provincial Governments and Districts

The NDoH will be invited to explain why its policy co-ordination is apparently so poor with Provincial and District authorities. Do regular sessions take place regarding health policy implementation with provincial governments? In this respect the Committee is referring to meetings with the Provincial Administrator and Governor not just provincial health staff. The Committee is also anxious to understand the NDoH position about health policy implementation and the role NDoH has ascribed to itself in managing diseases like TB and Malaria. Why it fails to lead in TB eradication but leaves a large part of the response to what can only be described as ineffective provincial administrations.

Freeze on Operational Funds Western Province

The Committee has no wish to interfere in Court proceedings related to Western Province. The Committee must however, point out to Government that the situation where the province has been deprived of operational funds for over 18 months has led to complete service delivery collapse. The current situation is creating a health and service delivery disaster.

The Committee recommends the Government consider the plight of the people of Western Province and either declare a State of Emergency and install an Administrator to take charge of service delivery, seek orders from Court to permit selective release of funds to essential service areas or withdraw health functions from the Province and administer these centrally.

Mount Hagen Hospital Health Information System

The Committee noted with some concern that the Mount Hagen Hospital was spending approximately K1.5 million on a new campus-wide ICT system. The Committee was informed that at this stage, it would only be used for word processing, an accounting package and internet access.

The Committee noted in regard to the ICT system that medical records are still in hard copy form. The Committee is of the view that the hospital should consider introduction of a hospital information system such as PATIS developed under Australian aid for Samoa and Fiji. See Annex D for details. The system provides real time access to patient data in every section of the hospital. In PNG, instead of issuing a separate health card to patients, the Government’s National Identity Card could be used as a unique patient identifier.

Summary

The Committee visits have uncovered a lack of commitment to rural health services by various provincial governments. Sufficient funds are simply not being expended on maintenance, and housing for staff. This situation is highlighted again in the Provincial Health Authority Amendment Act 2013 which provides (Section 38) for National Government funding of provincial hospitals but requires no counterpart funds from the provincial partner for rural health facilities vide full commitment of Health Function Grant monies. This is a situation which the Committee believes must change.

There is unequivocal evidence that the NDoH has failed in its responsibility to provide medical equipment to facilities. The NDoH is shown as unable or unwilling to remedy funding issues. Drugs that are needed are simply not reaching health facilities in a timely manner, if at all. The NDoH is presiding over a revised drug supply system that is wasteful and inept. The NDoH has failed to implement contracts with Christian Health Services concerning staffing and service delivery. No contract exists to cover Free Primary Health care payments and associated service delivery. Further, the NDoH is evinced as a bureaucracy that displays an arrant disregard for human life via the failure of the Gardasil trial and the condition of the Angau Hospital Cancer Facility. It is a Department unable to implement effective workforce planning and this has resulted in continual deterioration of
service delivery. The NDoH is revealed as a Department unable to effectively plan for emerging health trends such as non-communicable diseases, HIV AIDS and drug resistant TB. Its health management approach is typified by a farrago of failed activities and bureaucratic inertia. It is instructive in this respect to see the extent of management issues that the Port Moresby General Hospital has with the NDoH as per Annex E.

The Committee was advised via public fora and interviews with health staff in the provinces of a Department that was more often seen a frustrating health policy than assisting its implementation. The almost universal view expressed was that no help could be expected from the NDoH.

In respect to TB management, the Committee considers that the NDoH has demonstrably failed to manage the epidemic. The Committee considers that the situation with TB is so acute that it recommends an immediate and comprehensive intervention to firstly contain and then prevent the disease.

The implementation of the Government’s Free Primary Health Care initiative is in complete disarray with the majority of facilities visited still charging fees. Fees are being charged as FPH funds are (a) in some cases not reaching the facilities or being delayed by provincial bureaucracy (b) do not cover operational costs. The reasons for this situation will be reviewed by the Committee but again attest to a health Department that cannot manage policy implementation.

The visits also indicate that the Department of Treasury and the Department of Finance are providing less funding to the health sector than is appropriated in annual budgets. The reasons for late delivery of funds, appropriated budget not being passed on to Provinces and the NDoH need to be reviewed. Equally, unilateral withdrawal of funds by Treasury needs to cease. The Committee will investigate these matters. The bottom line however is that there must be “Truth in Budgeting”. Funds appropriated by Parliament must be delivered as budgeted. Agencies cannot function effectively when they receive funding late or not at all or have funds withdrawn without consultation. This represents bad financial management by Treasury.

In the view of the Committee, the above issues constitute major impediments to effective health service delivery and need urgent attention. In aggregate, the issues demonstrate a health system in crisis. The Committee believes the health system itself is sick and needs urgent resuscitation. The Committee will proffer a “resuscitation plan” for health as part of its final report to Parliament on health management. It is obvious however that there have to be major changes in NDoH management if PNG health outcomes are to improve.

A final report will be compiled after the Committee holds its formal hearing on health management in Port Moresby. In that hearing the Committee will be pursing issues raised by the Permanent Parliamentary Committee on Public Accounts (PAC) Report on the Department of Health of 2012 and the Auditor General’s Report on the Department of Health.

The preliminary findings of the Committee highlight that there has been scant improvement in health management or service delivery since the PAC report was tabled. The foreword to the PAC report depicts the state of health management as follows:

“The Department is not capable of delivering health care at a level or consistency that our people have a right to expect. Indeed, it cannot lawfully properly manage or account for public money, property or stores.

The Committee concluded that the current Department has no ability to instigate the National Health Plan or to manage the huge amounts of money it receives annually and needs immediate and urgent rebuilding and redirection”.
Unfortunately, it appears that despite this damming assessment of Department of Health performance and the Department’s assurances of amelioration, health management and service delivery have not improved. Indeed, the Committee has catalogued, in this interim report, further evidence of continuing and additional systemic failures.

**Committee Recommendations**

While the Committee intends to conduct a formal hearing to further examine health management issues, the following recommendations can already be made:

1. The NDoH accept its mandated role in health management and adopt a new corporate ethos that in far less bureaucratic centric and more far more client oriented
2. Senior Management in NDoH accept prime responsibility for the current state of disarray within the health system
3. The NDoH conduct an immediate review, in conjunction with provincial authorities, to reconfigure drug kits to:
   - remove those items not required and include essential items
   - assure the quality of items being procured
4. The NDoH immediately source sundry items such as gauze etc for health facilities and have these delivered without delay
5. The NDoH immediately provide essential equipment to the A&E Department of every public hospital
6. The NDoH commence urgent discussions with donors to develop a nationwide HPV vaccination program
7. The NDoH take immediate action to replace the Cobalt source at Angau Memorial Hospital
8. The NDoH take immediate action to expand the rural doctors training program in concert with donors.
9. The NDoH, in concert with provinces, take action to amend the Public Hospitals Act and the Provincial Health Authorities Act to clarify reporting roles and responsibilities of Boards and to provide for the Minister to install a Statutory Manager where he considers service delivery is imperilled.
10. The NDoH also amend the Provincial Health Authorities Act to require Provinces to transfer the whole of the Health Function Grant to the PHA
11. The Government allocate funds for a comprehensive TB Intervention Program in South and Middle Fly Districts having regard for the need to upgrade infrastructure, provide requisite equipment and nursing/specialist TB staffing
12. A competent Project Director be appointed to manage the project under national emergency provisions
13. Subject to medical advice, the Intervention Program seek to immunise every adult under 35 years of age in the Districts against TB
14. The NDoH take immediate action to resolve issues relating to the non-completion of health infrastructure development in New Ireland Province.
15. The NDoH and CSTB make an amendment to drug delivery contracts to provide for Provincial authorities to oversee contract management and certify delivery before payment is effected
16. The NDoH take immediate action to enforce the Non Smoking Regulation 2/2013.
17. The NDoH provide a comprehensive fully costed non-communicable diseases strategy to the Minister for budget consideration in 2016.
18. The NDoH take immediate action to conclude a contract with CHS and its affiliates for supply of requisite health services. This contract is to include provisions for verification of staffing and services supplied
19. The NDoH to ensure that a system exists to verify FPH funds reach church run facilities
20. The NDoH to institute a system of collaboration with Provincial Governments to ensure health plans are realised. This should include a form of performance appraisal envisaged under Section 32 of the National Health Administration Act
21. The Government consider options to unfreeze Western Province Health Funds including withdrawal of health functions from the Province and administration of these centrally.

22. The WHPHA consider the use of the PATIS system for hospital information management.
Details of Visits to Provinces

Visit to Kavieng

The Committee visited Kavieng from 3-6 May 2015 and inspected a selection of aid posts and health centres and the Kavieng Hospital.

The Committee met with the Acting Provincial Administrator who advised that as of 3 May 2015 the Province had still not received its recurrent budget allocation for 2015 and this was placing severe strain on resources. Out of the promised K10 million in PSIP for 2014 the Province only received K6 million. The Acting PA also highlighted that the National Development Grant was not released on time. When he tries to contact Treasury officers in Waigani no one answers the phone. There has been no advice from Treasury or Department of Finance regarding failure to provide the full 2014 grants or failure to provide the 2015 allocations.

The issue of a permanent appointment of a Provincial Administrator was raised. It was pointed out that there was inaction by Department of Personal Management on the issue.

In respect to health the Acting PA indicated that there had been improvements in rural health over the last few years spearheaded by the Governor. These included the purchase of solar lights for aid posts/health centres and improvement in the numbers of centres that are open. In 2007 there were 27 aid posts closed but by 2015, 13 of these had reopened. Seven remain closed. All health sub-centres have been upgraded to health centre status. A doctor has been appointed recently to concentrate on improving rural health.

It was indicated that transportation and communications were problems. In the south of the Province people go to Kokopo for medical attention as its closer. There are 97 health facilities in the Province and these are characterised by lack of staff. Even where aid posts have been refurbished there are often no staff. The reason for this would appear to be budgetary in nature as positions already exist. To provide extra support arrangements have been made with Australian Doctors International (ADI) to assist with community health issues. This helps relieve the staff shortage but is short term in duration and not a real solution to the problem.

Malaria is the main health problem in the Province but this is exacerbated by lack of drugs. The Province spent over K500,000 on drugs in 2012 from its own resources due to critical drug shortages. The Province has been proactive in malaria treatment by concluding a PPP with Population Services International (PSI) to assist with treatment. Drugs are often procured from local pharmacies as the central distribution system continues to fail. Dysentery is also a major problem on Lihir Island and Newcrest have attempted to remedy the situation via VIP Toilets and clean water provision with limited success.

Under revised procedures distribution in New Ireland is via a contractor viz: LD Logistics. Drugs are often short supplied and either expired or near expiry on delivery. The system is not effective. The Acting PA indicated that the Province had no input into the selection of a contractor and hence local conditions and logistic considerations failed to be taken into account in the tender process.

The Province has also committed a minimum of K500,000 to re-establish the Cold Chain in the Province.

The Province signed an MOU on 14 November 2014 for a Provincial Health Authority (PHA) to be created but to date the NDoH has failed to progress the matter. The Province wants a PHA and more autonomy to rationalise health delivery. The Acting PA indicated that with current salaries it is difficult to attract staff to rural/remote locations. It is hoped that a PHA would provide more flexibility in recruitment.
The Acting PA also raised the complex issue of functional grants being adjusted to take into account internal revenue raised. Rather, the Province considers that population, land area and infrastructure maintenance costs and needs should be considered.

Health facility staff advised the Committee that there used to be separate funding for rural outreach in the budget but now there is none.

Free Primary Health

The FPH funds are insufficient to cover the operation of health facilities as indicated in Annex C. Health facilities are receiving totally inadequate funding to operate effectively. As the OIC at Bol Health Centre indicated, she receives K12,561 per year for operations but her fuel costs alone amount to K48,000 due to the distances involved. See also Sacred Heart Health Centre experience below.

Without exception, health professionals indicated that patient numbers have increased due to the free primary health care system. Patients are also abusing the system and turning up for treatment of very minor cuts and bruises and tying up essential staff.

Kavieng Hospital

Staff in Kavieng Hospital have increased from 135 to 276 to cope with demand but this has added to management problems with only 15 staff houses available. As a result houses have had to be rented for doctors. This then eats into the operational budget for the Hospital.

A new Operating Theatre is 75% complete but is well behind schedule due to cash flow problems within the NDoH/Department of Finance. It is believed the contractor is completing the building using his own funds. The Committee was informed that K1.5 million was required to complete the project. The hospital CEO pointed out that the hospital had no input into the tender process for the building or design. The Committee noted, in respect to the design, that several of the internal doorways were not standard height and were far too low. The Committee was advised that as a result of the operating theatre not being completed, 10 surgeons were competing for space in the labour ward to conduct operations. The situation is life threatening but no one in NDoH seems to be concerned.

The Committee’s general observation was that the hospital was in need of significant maintenance and upgrade of equipment with was generally old and obsolescent. The Committee note with concern that the Medical Transit Store was yet another unfinished project which even if completed as designed is considered unfit for purpose by the Hospital. The Hospital considers that it needs to have requisite shelves etc as part of the fitout. Again the Hospital states that it had no real input into the design. The failure of NDoH to complete projects on schedule is a serious issue and the reasons for this need to be examined.

The Acting Director Health Dr. Joachim Taulo asked the Committee to pass on the need for K1.5 million to complete the General Hospital Theatre and Xray Department, K300,000 to complete the Medical Transit Store and K350,000 to complete Lamusmus Health Post.

Bol Health Centre

This provides a good example of health professionals working under enormous pressure and trying to deliver an essential service. Firstly, the Committee noted that the centre had never been visited by NDoH staff from Waigani. As indicated earlier it receives a totally inadequate budget which it supplements as best it can. It is old and in need of maintenance. It has two delivery beds and one is not operational. It has TB patients housed in the general ward which permits spread of the disease. It has six staff and four houses. Staff have to share accommodation.
While at the Centre the Committee met Dr Singh the consultant dentist who lamented that there was no dentist in the whole of Namatanai and that positions of dental orderly had been abolished. He indicated that dentists need dental orderlies.

**Sacred Heart Health Centre**

This centre was established in 1912 and is in need of maintenance, water tanks etc. There are 17,136 people in the catchment area for the centre. They have linked to the Digicel Foundation to provide outreach and school visits. Digicel has given the centre a new ambulance. The Centre has a small autoclave that works but it needs a larger machine to sterilise equipment. There are 400 births per annum at the centre.

The Matron explained that the Free Primary Health system simply did not operate at the Centre. The Centre was still charging patients otherwise it would simply close down due to budget constraints.

The Matron explained that she was told that she would receive the sum of K333 for operational costs out of the free primary health care funds. She has in fact received no funds at all.

The Matron also indicated that she had to buy strips for glucometers as none were provided via central stores. Drugs arrived that were routinely expired. There were BCG or measles vaccines and recently 20 babies were born and received no vaccine injections. The Matron stated that a basic operating theatre was necessary at the Health Centre so visiting doctors could perform basic surgery without the time, administrative effort and cost of transporting them all the way to Kavieng. The Committee considered that the use of a Mobile Operating Theatre used along the length of the Boluminski Highway way might be a more cost effective solution e.g. the Johnson Medical Mobile Operating Theatre or similar.

She indicated that staff houses had not been maintained for years and staff had to share housing due to an acute shortage. She also indicated that staff were aging but there was no succession planning in place.

She indicated that there were some successes. The TB Dots program was working well and drugs were available. She said that her staff followed patients right back to their villages to ensure they took all their medication. She reported a 75% cure rate.

The Committee considers this situation an appalling indictment of health management. No one has bothered to check whether funds are reaching the intended recipients. It is not clear how funds are being distributed to church run facilities and how these are then being directed to individual health facilities. Indeed, as the staff do not receive payslips it is not clear whether they are receiving the correct pay. From a Public Finances (Management) Act perspective it is not certain whether payments are being made to actual staff or ghost staff. It is not clear whether funds allocated to church run facilities for operations are in fact being delivered to those facilities. How a health centre like Sacred Heart can be allocated a ridiculously small amount (K333) for annual operations is also unclear. Why no funds were received by the facility also requires investigation.

**Issues Raised at Open Forum - Kavieng**

As expected many tales of wastage and administrative ineffectiveness were told e.g.

- Drug supplies sitting in boxes in an open shed behind the post office for months but not delivered
- Referral issues for patients from health centres to the Kavieng Hospital
- Inadequate numbers of delivery beds
- Problem with a private contractor not meeting performance standards for drug delivery but as the contract is administered by NDoH no action can be taken to
rectify matters at the Provincial level. Reporting the matter to NDoH failed to engender any action.

- Failure of NDoH to respond to written requests
- The perceived need for graduating doctors to be assigned to a rural area for a specified time as it is very hard to attract doctors. It was reported that in Malaysia, there was mandatory requirement for doctors to serve 5 years in a rural area. Alternatively, the Rural Doctor Training program needed to receive a funding injection.
- Dental orderly positions needed to be re-established as dentists needed the support.
- Workforce planning in health was lamentable
- Better supervision of sole workers in health was necessary
- An effective relief system needed to be put in place for Aid Posts and Health Centres
- More money was needed at the primary health care level to create required positions and purchase basic equipment
- Equipment that broke down was invariably not replaced and if it was shipped back to NDoH it was never seen again.
- Standards of equipment and drugs purchased need to be improved. The drugs purchased are of poor quality and so is the equipment. Delivery beds are broken within 12 months of supply
- School of Nursing is required for the Niugini Islands so local staff could be trained to look after local people
- There is a need for two dentist chairs for the hospital
- Sister Robert from the Kavieng Urban Clinic indicated that funds provided for the clinic were totally inadequate to do family planning, maternal and child health. There was no water and a shortage of staff, no BP machine and no vehicle allocated. Had to beg to get a car allocated and when none available very scarce funds had to use to rent a car or cancel visits
West New Britain

Meeting with Governor 7 May 2015

The Committee had an extensive meeting with the Governor Hon. Sasi Muthavel. He voiced concern regarding a number of matters.

He indicated that the management of the Provincial Health Authority was a major challenge. He indicated that no one really wanted the job as Chairman and those few that did saw the position in terms of expanding their business interests. He indicated that the Department has recently tried to appoint a person to the position without effectively liaising with the Governor as required by Section 17 (2) of the Provincial Health Authority Act. The Province had rejected the appointment as no formal liaison occurred i.e. no written communication on the matter exists. The province sees this as imposition of a nominee. He indicated that he believed that the Department of Health was really disorganised.

The Province noted that it signed a “Partnership Agreement” to create the PHA. It DID NOT cede its responsibilities under Section 42 (1) (j) of the Organic law for provision of rural health services. Indeed the functions of the PHA include:

(a) advise the Provincial Government on policy matters relating to health, in particular –

(i) the implementation of the National Health Plan in the province;

(ii) the formulation of the Provincial Implementation Plan

(iii) the co-ordination of the health care system in the province

The Governor indicated that he believed the PHA was answerable to no one. As a provincial body it should report to the provincial Administrator/PEC but it did not. Nor did it report to the Minister for Health and HIV AIDS or the Department of Health. Indeed the matter has been further complicated by District Development Authority Act which provides for the DDA to manage district functional grants (including Health).

The Governor then indicated that the province suffered from budgetary problems. Funds were delivered late or not at all. He indicated that for example if the budget indicated the Province would get K60 million, in reality it would get something far less. Provinces were at the mercy of the National government and the Treasury. This created special problems for West New Britain as its internally generated revenue was only K6 million. When he tried to introduce new taxes (e.g. liquor tax) it was opposed by Waigani. He further indicated that even when policy makers sought to deliver funds to the province, bureaucrats frustrated delivery. He noted the recent provision of K6 million in emergency funds were sent as “grant funds”. These have to be captured in the Provincial Budget and hence a supplementary budget has to be passed by PEC before the funds can be used. Hence funds supposed to be used immediately are held up for months while legal necessities are observed. If the funds were not sent as a “grant funds” they could have been used as intended. To make matters worse, the grant funds were sent to the provincial operating account, so they had to be transferred by the Provincial Treasurer to the correct grant account.

The Governor indicated that he thought DSIP and PSIP were working well as funds were reaching the Districts and that church run medical facilities provided the best service. He indicated by contrast that the Kimbe Provincial Hospital was regularly understaffed at night time. The Governor indicated that he was concerned that health initiatives (such as the Gardasil HPV vaccine trial) failed because the hospital did not regard it as a priority. Again he noted that the then Board of the Provincial Hospital did not report to the Provincial Government. He, as Governor, had no control over the Board. In fact Section 7 (2) of the Public Hospitals Act states:
(2) The Board of a public hospital may perform any of its functions in co-operation with the Provincial Government of the province in which the public hospital is situated or with any body established by that Provincial Government for the purpose of encouraging the provision of health services in the province.

It is clear from the Act that the Board of the Hospital is not bound to work in cooperation with the Province. So, despite the Prime Minister calling the Governor several times regarding the need for the Gardasil trial to be given priority, hospital authorities failed to progress the immunisation program. The Department of Health failed to intervene and take required action despite directions from the Prime Minister and Minister for Health and HIV AIDS. As a result 23,000 girls who had the first shot of Gardasil failed to get the second and third injections. They are now not protected from cervical cancer and US$7 million in donated vaccine has been wasted. Moreover PNGs chances of securing further vaccine for a national program have been adversely affected. The whole saga reeks of disarray in the health sector, public servant indifference and callous disregard for human life.

The Governor highlighted that most rural health facilities were run down and in need of equipment. He indicated that there was no hospital in Kandrian.

The meeting concluded with the Governor highlighting the need for visiting Ministers to coordinate with the Province. There were too many funding announcements being made by Ministers while in the Province. Sometimes the required money came and sometimes it did not. This left the Governor with the problem of explaining why funds did not arrive, why facilities were not constructed etc. The most recent was the announcement of K5 million for a Nursing College but no funds have arrived. Ministers create expectations and the Governor has to deal with the political fall-out.

**Valoka Health Centre**

This health centre is operated by the Catholic Church since 1929. It is clean and tidy but in need of obvious maintenance. Roofs are old and gutters rusted away. It is 42 kilometres from Kimbe. It serves 20 catchment areas within the Hoskins LLG and assists four aid posts viz: Siki, Waisisi, Banaule and Hoskins with a total population of 30,000.

It has a generator that operates for three hours per night due to fuel shortages. This provides power for lights and allows water to be reticulated. At other times water has to be stored for births etc. During the day there is no power and hence no 240 volt electronic health equipment can be used. The centre has 39 staff and a total of 11 houses. More accommodation is required. Staff members have to share accommodation.

The health centre has some mattresses but more are needed, it needs wheelchairs and equipment such as a larger steriliser and delivery beds for the people the centre services. The Health Centre also highlighted the need for a medical incinerator to destroy waste. As the Centre is located on the water front, it needs a sea wall to protect it from the ocean. It also needs a perimeter security fence to stop rascals entering at night. A list of medical equipment requested in April 2014 but not supplied is as follows:

- Blood Sugar Level (BSL) machine x 6
- Blood Pressure Machine x 6
- Footscale x 6
- Hanging Scale x 4
- Digital Thermometer x 20
- Doppler Machine x 1
- Ophthalmoscope x 2
- Digital camera x 1
- Resuscitation set x 3
- Auroscope x 6
- Suction machine (manual, electronic)
- Resuscitation trolley (pead, adult) x 2
- Resuscitation bed (pead, adult) x 2
- Ambu Bag (pead, adult)
- Facemask (pead, adult)

The steriliser is inoperable but they have never seen a bio-medical technician at the centre. This shows that effective integration of rural and hospital services have not been achieved at least in respect to church run facilities.

The centre has no permanent doctor and at present one visits only once per month which is totally inadequate. There are no funds for staff to undertake midwifery training at Vunupope.

Staff members receive pay slips but appear not to be receiving the same pay as counterparts in the public system.

Drug supply is a real problem. Even if drugs arrive from the Transit Store in Kimbe, they are often expired or near expiry. Moreover, drugs are repeatedly supplied that are not required. Most then sit at the Centre until disposed of once expired. These include:

- Aminopitsline Injection (overstocked)
- Adrenaline Injection (overstocked)
- Calamine Lotion
- Poridine Iodine Solution 10% 500ml
- Poridine Iodine Solution Surgical Scrub
- Silver Sulphadiazine Cream 1% 500g
- Permethrin Lotion 1% 100ml
- Crystal Violet Solution 1% 500ml
- Betathosone Valerate Cream BIP
- Nel Catheter for Oxygen GS-1004
- Disposable Gloves in box various sizes (S,M,L)
- Clotimaxazole Cream BIP
- Compound Benzoic Acid Cream for tinea
- Methzildopa tablets BIP (200mg)

**Kimbe Provincial Hospital**

The Committee visited the Hospital and inspected facilities. There have been some new buildings at the hospital but these have been mostly provided through the PNG Incentive Fund with a third project to start soon. An area Medical transit store has been constructed, 30 bed nursing quarters, maternal and child health facilities, eye clinic STI Building etc.

Most of the hospital wards are however of 1950s vintage and should be replaced. Wards share ablution facilities and a new septic system is required. The hospital is not equipped to handle the increasing populace. The Accident and Emergency area is a good example. It is staffed by nurses and a Medical Office but the Medical Officer is on maternity leave. There is no doctor (although the A/CEO indicated that recent approval by Department of Personnel Management of a revised organisation included a Registrar for A&E). There is also a complete lack of equipment necessary to save lives. This situation has not been addressed in the last 12 years. As one nurse lamented we can’t save anyone. ECG equipment, oxygen etc are not available. The A/CEO said that the hospital was spending K500,000 annually for medical supplies and some equipment was now beginning to arrive. A team from the Standards Branch of the Department came in 2014 and compiled a list of required equipment in the hospital and health facilities. They spent two weeks in the Province but there has been no action taken to purchase any equipment as far as the hospital is aware.

The Committee noted that two mobile Medical Labs provided by the Governor were still unused and in the hospital car park. The A/CEO indicated the problem was that staff were unfamiliar with the equipment and had to be trained. There appeared to be no concrete steps taken to arrange such training. This situation exemplifies the problem of donor mismatch with requirements and lack of health management.

Discussions with the A/CEO revealed that the standard set of drugs being provided by Borneo Pacific were not those really required at the hospital.
The Committee noted that while A&E was in need of oxygen there were ample supplies at the Medical Transit Store some 500 meters away. The septic system in A&E is operative and has not worked for years. The toilet is now a store room. To repair the toilet requires the floor of the building to be excavated and is prohibitive. Only one quote has been received from a local plumber. Further quotes and options need to be considered. The situation demonstrates a lack of management by hospital authorities and the PHA.

The Committee discussed the issue of the Gardasil pilot with Dr Yvonne Supuri the Rural Medical Officer. She indicated that she and a nurse administered the first dose of Gardasil but there was no commitment to the program either from hospital management or Department of Health. There were issues obtaining destruction certificates for compromised vaccines where the cold chain had been broken. There was a feeling in the hospital that this program was not curative but rather preventative health and should have been resourced externally.

**Staff Forum at Hospital**

The Committee held a staff forum at the hospital. It was readily apparent that such staff sessions were needed with management and far better lines of communication pursued. Nurses complained that they are criticised for turning up late but that no transport was provided, staff overtime had ceased. Doctors by comparison were not chastised for turning up late or not at all. Doctors should be monitored as per nurses.

There was extensive discussion regarding the PHA concept and the performance of the Board.

The question of donor driven activity was raised. It was indicated that World Vision had chosen Bialla Health Centre for a TB initiative. The staff member considered Bialla to be the wrong location for the trial and questioned the right of donors to impose projects that consumed health resources but might not lead to optimum outcomes. Again this matter should have been considered and resolved by health management.

A sister from A&E made an impassioned plea about the situation in the Ward. She indicated that there had been no improvement in the last 5 years. There were no drugs, no doctor and no equipment. “People die in our arms and it is time to fix things.” The Committee saw one patient who was brought in with a stroke. There was no doctor present and the nurses did what they could but she died. This is not to suggest that a doctor could have saved the woman but rather, in some cases, a doctor’s presence is the difference between life and death.

The Nurses Association representative complained that they wanted the PHA to delegate minor procurement to the hospital management. The A/CEO indicated to the Committee that he already had such powers but the proposed expenditure on a TB program (K5,000) was not in the Annual Plan. This again shows poor leadership by hospital management. Such matters should be discussed openly with staff and priorities agreed. There should be open and frank discussion not the maintenance of “silo structure” where only a chosen few know what is going on.

**Public Forum 8 May 2015**

There following issues arose at the forum:

1. There was extensive discussion and debate regarding the merits or otherwise of the PHA concept and management. This included a statement by Dr Golpak that he considered hospitals to be curative and technical in nature and this should not be mixed with public health. Others disagreed and thought the concept very good but that it was WNBPHA management that was the problem. For example, Mr Peter Baki indicated that the PHA Board and never had an orientation session.
2. A view was expressed that the PHA Board had failed to implement required changes to health management.

3. One speaker noted that the A/CEO was hardly seen and never seen in the Children’s Ward. There were no mattresses and people had to sleep on the ground.

4. PHA was formed in April 2013 but since then there had been political interference, the CEO has been suspended for two years and the health situation has not improved one inch. There is no PHA structure in place, no corporate plan for health, no leadership is evident. The PHA operates in isolation and is not responsible to anyone. It members are business people who want to benefit from contracts with the hospital.

5. PHA conflicts with the Organic Law. Who manages AID posts – the PHA, the DDA or the LLG? It appears that the LLG role has been abolished. PHA structure duplicates CEO positions.

6. Hospital CEO suspended and a decline is service is evident at hospital.

7. Medical equipment is lacking, there is a lack of drugs, poor morale and no incentive for workers to turn up.

8. Lack of funding to transfer patients from health centres and back. Lack of dialogue between PHA and Department of Health.

9. One speaker said that she witnessed the death of a woman in the hospital as there was no glucometer to check the patient’s sugar levels. The patient was misdiagnosed and as a result she died. The same week the Hospital/PHA purchased two new vehicles. Where are the priorities?

10. The PEC Health Chairman indicated that there was a need for an open forum to discuss PHA performance each year. The Board of the PHA is a law unto itself and it needs to be held directly accountable to the people or at least the PEC. PEC Health Chairman should be on the PHA Board.

11. Major problem is that hospital CEO acting since 2013. There is an Acting PHA Chairman and Acting Hospital CEO. These positions must be filled without delay.

12. Qualifications of people being employed need to be checked. Many have qualifications from non-recognised institutions.

13. There is a lack of staff and staff simply don’t turn up. Outpatients is crowded and you can sit there for three weeks without being attended to. This makes people go onto the street and buy drugs to treat themselves.

14. One Sister indicated she had been suspended for being vocal. She said the PHA was not working, funds were not reaching rural health centres and aid posts. There was frequent flying in and out of health management but a complete lack of basic health services. There were no mattresses or pillows for children. It was a shameful situation.

15. Joshua Bailey indicated that the hospital was a place to die. It’s not Kimbe Hospital but rather Kimbe Morgue. A permanent CEO for the hospital is urgently required.

**Summary**

1. There is a need for permanent appointments to the positions of PHA Board Chairman and Hospital Manager (previously CEO).

2. The system of appointment and termination is far too slow and administratively complex. If there is to be a PHA, then it would seem rational for it to report to the PEC and for the PEC to appoint the PHA Chairman and Hospital Manager subject to Ministerial veto. The Minister must also have the power to terminate a Board and install a Statutory Manger where a PHA Board fails to perform or is involved in financial mismanagement/theft.

3. There is clearly a lack of equipment in the hospital and health centres/aid posts. The system to purchase equipment must be changed as it is an abject failure. Centralised purchasing must cease. Funds need to be channelled directly to PHAs to purchase equipment required as per an approved list of equipment compiled by NDoH.

4. There is also a mismatch of need verses supply of drugs. Provisioning of drugs needs to be vastly improved. Health Centres etc should be provided with drugs having...
regard to stock levels, usage and need. Wastage should be minimised not inculcated into the system as at present.

5. Consideration must be given to abolition of the central medical store system which has consistently failed to deliver drugs as required. A performance based outsourcing system where a supplier/suppliers are contracted to purchase and deliver drugs to provincial transit centres on a needs basis should be implemented. The PHA should then be responsible for transporting drugs to health centres and aid posts. The PHA can either transport drugs using its own transport or sub-contract delivery to a private logistics firm. The NDoH should manage the main purchase/delivery contracts and test for drug efficacy. A separate contract should be awarded for independent verification of drug delivery and payment recommendation. These contracts should be internationally advertised and an Evaluation Committee with international representation should be convened to ensure strict compliance with the Public Finances (Management) Act.
Morobe Visit

Meeting With Governor/Administrator

A meeting was planned with the Provincial Administrator but unfortunately he was busy in Court. The Governor was also busy and indicated that he would try to attend the public forum on 12 May 2015.

Meeting with Angau Memorial Hospital CEO and Staff

The CEO Jim Abrahams was not available as his plane was delayed in Port Moresby. The Committee therefore met with the Deputy CEO and staff.

The Committee was informed that Angau suffered from a lack of essential drugs and equipment.

The D/CEO indicated that the standard pack of drugs supplied was not appropriate and often drugs were missing from the shipment when they arrived. It was not clear whether the thefts are occurring prior to or after receipt at the base medical store. Government procured drugs are however readily available on the streets for sale and have also be found in one pharmacy in town. Essential drugs are requested but never delivered to the hospital. The hospital therefore resorts to purchasing from local pharmacies. Drugs supplied are also of poor quality.

The hospital regularly runs out of anti-venines, tetanus, immunoglobulin, blood bank bags. The NDoH supply system for drugs and consumables is in complete disarray.

In respect to procurement of equipment, the situation is no better. Equipment that is sent to Port Moresby for repair routinely fails to be repaired and returned. The hospital needs BP equipment, suction equipment, glucometers, etc. Out of frustration, the Board of the hospital has used savings in its budget to buy equipment locally. This then creates maintenance issues. The Board is improvising to try and meet public expectations.

The D/CEO indicated that there was no integration of health services in the Province. While the Hospital had a rural health component staffed by a doctor, its activities for largely confined to urban clinics. This was because of funding and logistics constraints e.g. the Provincial Government did not meet boat hire and fuel costs.

The Director of Nursing indicated that more nurses were required at urban clinics. Without more staff, hundreds of patients simply arrived at hospital outpatients and tied up valuable resources. She indicated that the hospital had 423 beds and had a nursing staff of 300 but an establishment of 406. A complete organismal review was required to match staff resources to patient need. The population of Morobe was growing at an alarming rate and the hospital was stretched to cater for demand. This raised the issue of the PNG Population Policy. Those present were of the view that the policy would fail as additional coordination and funding was required to reduce the birth rate in PNG.

Discussion also centred on the need for better integration of services. LLGs are sending in patients to Angau and not paying for the return ticket. Patients who could be transferred back to the district remain in beds in hospital while funding issues are sorted out. There is a need to clarify who pays in such cases and for an agreed procedure to apply to all transfers.

The Committee took a tour of the hospital and noted a raft of infrastructure developments. It noted that a new administration block, cancer treatment clinic, half-way house, cancer/chemotherapy ward, blood bank, TB dots, eye surgery wards, Paediatrics Ward, 3 x Medical wards, a post-natal ward have been constructed. The Children’s Ward has also been painted. Four operating theatres have also been constructed by JICA. However, only two of these wards are operational. Of the two non-operational theatres, one supposedly has floor problems and the other has lighting issues. (See reasons for this in Dr Abrahams presentation at Morobe Open Forum hereunder)
The Committee also noted with great concern that patients from A&E were left to lie on mattresses in the as they waited for admission to admission to a Ward. Bed space at the hospital is a premium. Why a demountable cannot be provided to cater for this overflow is not understood but is presumably funds related. As the second largest hospital in PNG, the present situation regarding A&E patients is totally unacceptable and the Department needs to act to redress the situation.

During the tour it was noted that while radiotherapy centre was operational no brachytherapy was being supplied. Apparently this was because equipment (cobalt source) was still not provided and required eight nurses are in situ. This situation is astounding as the cancer centre has been operational for 7 years. Effectively, it is providing only a partial service for women with cervical cancer. Cervical cancer is the most common form of cancer in PNG women and is treatable (and curable) via external radiation (EBRT) and internal radiation (brachytherapy).

This raises some very serious management issues for the Department of Health viz:

- Why after all these years is the required equipment not in-situ?
- Have women been told that without the required brachytherapy they run an elevated risk of the cancer spreading. They run the real risk of returning to their home provinces only partially treated and die quite horrible deaths from bleeding, kidney failure and secondary sepsis. Have they been told of their possible fate?

The reason for lack of brachytherapy was explained by Dr Abrahams at the public forum. See below.

It is understood that nurses were trained but because equipment was not in place these skills have not been put to use and retaining is now necessary. The Committee is of the opinion that the situation demonstrates NDoH indifference to the health outcomes of women and sheer management incompetence.

**Malahang Health Centre**

The centre is government operated and supports 17 wards and has a catchment of 38,000 people. It is staffed by 5 nursing officers but has an organisational establishment of 10. It has 9 x CHW staff who are mostly at retirement age and no HEO.

The sister in charge indicated that she had many problems. These included lack of staff to handle workload. She also had funding issues as she was allocated K12,500 in 2013 for free primary health care but this is well below the operating cost of the facility. As a result she still charges for services (K3 per consultation). This funding issue is compounded by the Provincial Government that has withheld 2014 funding pending provision of acquittals by health centres and an arbitrary decision by a Mr Jack Aitu Deputy PHA who refuses to release any funds for 2014 until acquittals for all centres are received. This, if correct, is simply administrative madness.

The sister indicated that the amount received for operations bears absolutely no relationship to costs incurred. She wanted to know who decided on these amounts.

The sister also indicated that she had persistent problems with drug supply. The main order was not supplied, dental and laboratory consumables were not supplied. Drugs close to expiry and not ordered were delivered i.e. dumped on the centre.

Similarly there were problems with equipment delivery. There was nil stock of glucometers, BP equipment, stethoscopes, scales, auroscopes, suction equipment etc. There are insufficient mattresses, beds, bed sheets and no wheelchairs. The only beds in the centre were donated by Rotary. The microscope was donated by a local Member. Nothing has come from NDoH.
In a cruel irony, an NDoH team recently visited the centre (which is the largest health centre in Lae) and downgraded it to Sub-health centre status as it did not have required equipment. This is the very equipment the centre has been seeking from NDoH.

The nurses at the health centre are doing the best they can, but they receive no support from NDoH and very little from the Provincial authorities.

**Public Forum 12 May 2015**

Dr Jim Abrahams A/CEO of the Angau Memorial Hospital gave a presentation on the redevelopment of Angau Memorial Hospital. He indicated that at present it had only about 1\(^{1/2}\) operating theatres in use that were built by JICA in the early 1990’s. They had been allowed to deteriorate and lights and air conditioning etc needed replacement.

He indicated that only about 4-5 operations per day took place and the performance of surgeons needed to be improved. The hospital serves 1.7 million people and its performance needs improvement. He indicated that he had highlighted problems with:

- Facilities that needed to be improved
- Insufficient workforce
- Medical supplies and equipment that were lacking
- Staff attitudes
- Bureaucratic indecision

He indicated that external refurbishment of the JICA wing had been completed with painting, new gutters, air conditioning, showers for doctors, a 47% increase in bed capacity, new beds, and provision of five new wards for only K5.5m. Within 15 months there could be a functioning hospital for a further K28m.

Nine urban health centres needed to be equipped to do emergencies and deliveries to take the load off the hospital. He indicated that he needed to be able to terminate non-performing staff. Many simply did not turn up for work or arrived when they felt like it. The staff absentee rate was considered to be shocking. New leadership was required. The doctor blamed this inaction on DPM for failing to take action to remove Directors as requested by the Board.

The A/CEO highlighted the operation of the Cancer Centre as an area of continued concern. He advised that the manager of the Centre lives in Port Moresby and has no real experience in the Centre. He indicated that the treatment of cervical cancer was of greatest concern. As women with cervical cancer often had low blood counts, chemotherapy was problematic. The preferred therapy was a combination of internal and external radiotherapy. He indicated that the hospital had been without a cobalt source to deliver brachytherapy for three years and NDoH (Mr. George Otto) had failed to organise a replacement despite options being available. Dr Abrahams latest attempt to induce Mr Otto to expedite delivery had been rebuffed.

Dr Abrahams explained that without brachytherapy patients simply were sent home to die. He indicated that the cancer unit was simply a palliative care unit. To reinforce this view the doctor indicated that the survival rate for Stage II cervical cancer beyond 5 years was 97% in Australia. By comparison the survival rate at Angau Cancer Centre was zero.

Dr Abrahams also indicated that drug suppliers were willing to supply HPV vaccine (cervical cancer vaccine) at US$5 per dose and in the West New Britain trial, supply Gardasil at no cost. Yet the NDoH failed completely to pursue these initiatives and protect the young women of PNG from a horrible but preventable disease. The Committee considers that indifference and intransigence displayed by certain “health professionals” within NDoH is truly astounding.
The A/CEO indicated that the process to get foreign nurses and doctors approved for employment was also far too cumbersome and slow. He had professionals willing to work and already living in Lae but could not employ them. The approval system via DPM and registration bodies needs vast improvement.

Dr Abrahams indicate that the hospital accounting system needed significant improvement and was simply a mess. He had brought in experts to reorganise the accounts.

A Nursing Officer at the public forum indicated that aid posts and health centres were in crisis with no facilities, drugs or equipment. There was not enough training of new staff and supervision was far too lax. Another officer expressed that a reason for non-attendance was no transport for shift work, no overtime etc. She also indicated that it was unfair that nurses be chastised for poor attendance while doctors’ attendance was much worse. They don’t want to go to health centres or aid posts and disappear in the middle of the day or simply don’t turn up.

While the new Angau Nursing School will train 100 nurses annually, this is nowhere near the numbers needed by national health.

One manager of a health centre said that she received K18,500 to cover free primary health provision in 2013 from the functional grant. Her health centre caters for 53,000 people. She indicated that the funds were totally insufficient to operate the health centre. She had to pay for fuel, electricity, water, detergent, basic medical items etc. As a result she had to charge fees to patients. The K2 charged to patients goes to the Council to pay for water and power. She conducts fund raising drives to keep the Centre operational. To make matters worse, provincial authorities refused to pay the 2014 grant until all centres submitted their 2013 acquittals. She submitted her acquittals in February 2015 and is still waiting for funds. The Committee considers that this sort of petty bureaucratic attitude further erodes the provision of free primary health services and is untenable.

Another speaker at the forum from Buimo Health Centre indicated that a greater emphasis had to be placed on preventative health and more trips had to be made to settlements to try and reduce the incidence of preventable disease.

A speaker indicated the MCH immunisation was breaking down. Once, the district had a helicopter and teams would fly into villages and immunise babies but this was now not happening. There was no health co-ordination and this was demonstrated by the absence of provincial health staff at the forum. This situation needs to be compared to the operations of the Western Highlands PHA where the hospital provides health centres with free fuel and maintains their vehicles (including church vehicles) at no cost.

**Eastern Highlands**

**Evangelical Brotherhood Church (EBC) Health Centre**

The Committee decided to drive from Lae to Mount Hagen and on the way stopped in at the EBC Health Centre in Goroka.

The Committee met with the Secretary of the EBC Church Agency who is also CHS EHP Chairman. He indicated that church run facilities in the Province had 153 staff and 68 facilities operating. 40% of health services were delivered by churches and 60% by the State in the Province.

Drug and equipment supply was reasonable in the past but the new system has seen shortages occur consistently. Instruments are now 25 years old and are not replaced. Sterilisers are not available etc. In Kainantu drugs were not delivered to site. The Church has to pay for delivery. Supply of essential drugs is satisfactory but items that are not required are sent from Area Medical Store while some drugs that are required have NIL stock.
Medical facilities have no medical incinerators. They are all rusted away years ago. At present material is buried and burned but in some cases just buried or dumped. It is an occupational health and safety issue.

They agencies face severe staff problems. Proposed central payroll system by NDoH has not even started but the agencies want it managed by CHS not NDoH. They want to retain the power to hire and fire staff to maintain standards. Ceiling type funding for CHS facilities is also a problem as they can’t apply minimum health standards. For example a facility may have a staff ceiling of 58 but need 65 staff as a minimum. The temptation is then there to employ 65 staff and reduce the pay of others to cover the shortfall. This then further erodes staff confidence and leads to a migration of CHS staff to State run institutions.

Another staffing problem relates to entitlements. The State has offloaded facilities to CHS but only pays for a specified number of positions. Staff are employed under Charge Code 112 as “hospital management – casuals” not under Code 111 as public servants. As a result permanent CHS staff are treated as casuals. The State does not cover their entitlements such a furlough. These costs have to be met by CHS. This means that with each facility taken over from the State by CHS the debt burden on the churches grows. The system is not equitable and needs funding needs to reflect the real cost of staff employed.

In respect to CHS, while the CHS Act has been in force from 2007, NDoH and DNPM persist with discriminatory practices by supporting only the larger churches via the Church/State partnership. This is blatantly inequitable and affects health delivery e.g. EBC is one of the largest health providers in EHP but receives nothing under the “partnership”. It is excluded from the “club”. The Act is in force and all moneys to church run health services should be channelled through the CHS as “peak body” but distributed directly to specific churches.

Regarding the distribution of the Functional Grant, EBC receives K34,000 per month for the operation of its 2 x Health Centre and 5 x Sub Health Centre and 13 x Aid Posts. This is completely insufficient to operate the centres, maintain vehicles, purchase fuel, pay utilities costs etc. As a result the EBC still charges a K2 fee for consultation. Without the K40,000 per annum allocation from HSIP the system would collapse.

Western Highlands 14 May 2015

Discussions were held between the Committee and Deputy Provincial Administrator, Governor, Governors representatives and Director Curative Services concerning PHA performance. The reasons for success of the PHA concept in Western Highlands were assessed to be:

- An effective Board that had community interest at heart rather than commercial or self interest
- An effective CEO with a team of professionals behind him with a genuine desire for change
- Effective liaison and support given to church run health institutions- a collaborative spirit
- Strong support from the Provincial Government and Members via PSIP and DSIP
- A clear line of responsibility and reporting to the Provincial Government

The Meeting was given an overview of the health situation in the Province by the Director Curative Services. He indicated that unlike Eastern Highlands, he has sole responsibility for managing the hospital. There is no Hospital Manager position reporting to the CEO.

The Province has its Provincial Hospital but has a strategy to reduce pressure on the hospital via the creation of 4 x District Hospitals. One of these is currently under construction, one is at tender stage and two more are in preparation stage. The PHA currently has 30 projects it is managing. These include infrastructure, communications systems, accounting services, attendance systems etc. This project workload is placing a significant strain on resources but is necessary to improve health outcomes. In the last two years under the PHA, health
indicators have started to show some improvement in terms of public health coverage and curative health.

While the PHA does access funds from PSIP and DSIP and donors, its recurrent budget is still insufficient. Often money has to be “borrowed” from projects to keep the hospital functioning. The Health Function Grant is inadequate and erratic in delivery. Staffing is also a problem. The population of Western Highlands and surrounding highlands provinces is growing rapidly. There are only 16,000 health workers but according the standards there should be 60,000. There is a need for more medical schools. PNG is simply not producing enough medical graduates. PNG has one school of medicine but Fiji has three schools and far less people.

Health Performance

The State provides 59% of the health services in the Provinces and the churches provide the balance. Preventative health services are lacking, staff need incentives. Efficiency depends on getting resources in a timely manner. But drug and equipment supply remain major problems. An audit of the Medical Store indicated that 30-40% of the Medical Catalogue standard drugs were not in stock. Basic equipment is also not available and the perennial response is “nil stock”.

Regarding the 100% drug kits that are sent to hospitals, these contain items that are not required and omit items required. There is a need to either change kit content or drop the system in favour of a monthly order of required drugs/supplies from health facilities e.g. X-Ray Detectable Gauze is required for the safety of patients after operations but none is available. Standard gauze is also regularly out of stock. Current cost to supply gauze from City Pharmacy is running at K3,000 per month. The current system is engendering waste and threatening patient lives. In addition the kit for Health Centres contains items that cannot and should not be administered at a Health Centre. The PHA has despatched its pharmacy staff to recall these drugs.

There was a view expressed that the Health Secretary’s position as Chairman of the Pharmaceutical Board represented a conflict of interest. K200-300 million given for drugs supply.

Tour of Mount Hagen Hospital

The Committee undertook a tour of the hospital in the company of the Director Curative Services. The Committee was impressed with the developments that have occurred in the last 10 years and plans for the future K500 million redevelopment of the hospital. There was evidence of new infrastructure (wards, operating theatres etc) and equipment that were all being maintained. There was a fully equipped industrial kitchen and patients received nourishing meals despite there being no Nutritionist on staff.

There was also a major communications system being rolled out by the hospital but there did not seem to be extensive planning for its use other (at this Stage) than internet access and the accounting system. The Committee indicated that the Patient Information System (PATIS) developed for Fiji hospitals by Australian aid may be a suitable for the Mount Hagen Hospital. It has modules for all areas within the hospital environment including Medical Records, X-ray, laboratories, pharmacy, corporate services, nutrition etc. See Annex D for an evaluation of the system.

The Director Curative Services indicated that HIV Aids was now the leading cause of death in the hospital. Access to anti-retroviral drugs at the hospital was good but now they were getting cases that were resistant to AR drugs and that situation was worrying. There was a problem where infected patients were going out again and spreading HIV. As they already had the AR drugs in their system they were passing on HIV that was resistant to AR drugs.
Accident and Emergency (A&E) was a major concern for the hospital. There had been altercations between families of patients and staff and physical violence. The PHA was about to respond by reconfiguring the A&E to keep family members out of treatment areas and to upgrade security. This would include a private security firm and video surveillance systems.

A&E is completely understaffed with only two doctors and on the day the Committee visited only one doctor was present. There are only 7 beds available and this is manifestly inadequate for the number of cases presenting.

It was noted in the Cardiac area that there was an EBOS supplied Stress testing machine that was now two years old. However it had never been used as the supplier could not configure it. The Hospital needs to ensure that where equipment is supplied, it is made operational within a reasonable time frame or returned to the supplier for a full refund of the purchase price. Action should be taken by the PHA to ensure EBOS attends to the issues without delay.

It was noted that the hospital management was trialling a hand punch system to record staff attendance and link this directly to the pay system. Given what the Committee has seen at other health facilities, the introduction of effective attendance monitoring systems is imperative. The introduction of modern management systems is well overdue in the PNG public sector. The same process should be used for all Government Departments and installation should be funded under a project managed by DPM. Staff attendance must be improved.

The Director Corporate Services indicated that the PHA had regular meetings with church run health facilities. It provided churches with free vehicle maintenance and fuel to undertake health services. It had set up a call-in system managed by Digicel where there was access to a nurse on-line. In addition, there was an ability to refer instances where health facilities were unattended directly to PHA management for necessary action.

**Forum – Mount Hagen**

One participant indicated that that there was no basic health care in the hospital and it had no senior doctors. He indicated that the hospital had appointed junior doctors to senior positions and this upset senior doctors. He also criticised that longevity of the Board of the PHA saying that it should be changed after two terms. These views were opposed by other speakers.

One speaker who was a district counsellor indicated that the PHA concept had been very good for rural areas. More health services had reached the people.

A Pastor from Baiyer district indicated that the PHA had brought services to the district after years of neglect. Five Community Health Post’s had been opened and three more were in progress. This would not have occurred without the PHA. He applauded the PHA, its Board and CEO for their efforts. He acknowledged that there were still struggles but the PHA with the churches were addressing health problems.

The Deputy Chief Surgeon and Doctors Association representative for the Highlands Region indicated that he wanted more attention paid to routine cases rather than emergency cases that clogged up operating theatres. In a rather harsh assessment he suggested that emergency cases were largely rascals who had brought trouble upon themselves and that they did not deserve priority. This assessment did not seem to fit the situation that the Committee witnessed in A&E where the general public (men and women) seemed to be occupying doctors time as a result of injuries and vehicle accidents.

He indicated that the PHA is a white elephant and does not support him as a surgeon. IV fluids and drugs were missing. There was a misallocation of funds to vehicles from equipment but this view was countered by another speaker who indicated there was a short
supply of vehicles for rural outreach visits. In respect to clinical governance there was not much input from the CEO. The structure between the patient and PHA was wrong. There was no disciplinary process in place that makes people turn up. The surgeon seemed to assume that the PHA was responsible for provision of drugs, supplies and equipment for the hospital when in fact these are preserved NDoH responsibilities. As noted elsewhere in this report the PHA is instituting a trial of state of the art hand scanning equipment to improve staff attendance.

Dr Madeline Kaupa a paediatrics specialist indicated that the Paediatrics Ward had many children with preventable problems such as diarrhoea. The children were from settlements where there was no reticulated water, poor law and order and the Mount Hagen market was a health hazard. There was a need to improve water supply and sanitation in Mount Hagen. (The Committee agreed that the Mount Hagen Market was clearly a health hazard and that health authorities should require its closure on health grounds until remedial action was taken to restore water supply and improve toilet facilities). The doctor also indicated that systems are as good as the people behind them. There is no PHA in Kundia but the hospital operates well.

A spokesman for the Christian Health Services in the Province Rev Koi indicated that the ten churches in the province provided rural services. If the asked the PHA for a doctor to come out one would be sent. The hospital runs very well considering its limitations. Rural hospitals are being upgraded with PHA assistance. There was a problem with drug supply. LG Logistics which has the contract to deliver drugs does not always deliver and the churches have to collect drugs at their cost. PHA is the way forward for rural areas.

The Acting President of the Doctors Association Mount Hagen indicated that the PHA had a lot of projects it was managing. But service delivery needs auditing. There was not a satisfactory immunisation coverage for the measles vaccine. There was still no equipment in the District and staffing was still the same. (The Committee considered that the PHA was being blamed unfairly for lack of equipment which was an NDoH responsibility and for organisation approval delays that were apparently occasioned by DPM).

The local NBC staff indicated that free primary health care was not reaching the rural areas. Charges were still being levied.

A nurse indicated that she had no housing provided and had to sleep a long way from the hospital due to the cost of rental. There was often a ratio of one nurse to 60-70 patients. She would arrive late and then when she was about to go home there would be an emergency and she would have to stay late. The result was that her husband complained and beat her up. They got divorced as a result. She wants the hospital to provide free or low rental cost accommodation for staff.

A representative of Baptist Health Services indicated that there was a god partnership with the PHA and that the Church received some Free Primary Health Care (FPHC) funds. But the funds did not cover medivac costs for patients and K6,000 per annum for an aid post under FPHC was totally inadequate.

Another practitioner indicated that that a Mendi health centre was stocked full of drugs that were useless at the health centre level and should have been in the provincial hospital. This was a complete waste of valuable drugs.

The Deputy Director Rural services for the PHA indicated that PHA concept was to best way forward. In the past the functional grant was not received and everything ground to a halt. This year the same situation occurred but under the PHA funds have still been made available to the hospital. Things would work even better if funds were transferred directly to the PHA.

Hospital supervisors complained that drugs being supplied by Borneo Pacific were often of poor quality as were medical supplies. IV drips were substandard as were blood transfusion
sets. Beds in the hospital were too low and this required nurses to lift patients which was a serious OH&S issue. The hospital has some new lifting beds but at K20,000 each an alternative needs to be found.

Nurses raised a serious issue about retirement benefits. They indicated that they were told that if they took their furlough that would lose their seniority and have to start again. If they stay over the 60 year age limit they will get paid out of their retirement benefit and not by the State. The Committee indicated that if the above was occurring it was not in accord with the intent of the PSMA and undertook to sort this matter out as a matter of urgency.

Baptist Nurses noted that in the past each Province had a nursing school. Through Government inaction only eight remain and now there were totally inadequate numbers of nurses to fill positions. Each province should have its own nursing college to supply trained graduates. They also noted that rural nursing staff all had accommodation provided and asked why the same was not the situation for hospital nurses.

**Togoba Health Centre**

The Committee visited the Centre. The PHA is project managing the development of infrastructure (a 24 bed general ward) at the site for the SDA Church. The PHA has its own professional project management team. The PMU charges a basic 10% management rate.

The centre had also received funds via PSIP and DSIP. The Centre had two delivery beds supplied via an arrangement between the PHA and Wontok International. The PHA intends to use land at the Centre to build houses for PHA staff. Land ownership issues are being resolved at present.

**Kukuk Catholic Health Centre**

This is a new facility funded via the Incentive Fund. It has four small wards with eight beds, two staff houses, water and electricity. Drug supplies are satisfactory. The Composition of PUSH kits is a problem. Maintenance is the responsibility of the Catholic Church. The Church is currently undertaking staff house renovations. Has a maternity bed that is under-utilised with only 1-2 births per month. The PHA needs to direct more women to the centre and have it tidied up as it could do with a good mop and sweep with a broom.

**Wakam Community Health Post**

This is a new health post. It is one of four erected for K2 million. It includes a clinical building and Mul Baiyer Lumusa Member is providing a second staff house via DSIP.

There were three births at the Centre for the month to 15 May 2015. The centre gets drugs but often there short supplies e.g. at present there is Nil stock of amoxicillin.

**Western Province 19 May 2015**

**Daru Hospital**

Discussions were held with the Acting CEO of the hospital. She explained that she had been in the job since February 2015. She was despatched from Port Moresby to Daru to take charge of the hospital as it was in an administrative mess. She found that it had no proper accounting system and no coherent financial records. She had organised a new accounting system and succeeded in getting staff co-operation.

The drug supplies for the hospital were considered to be satisfactory and a new TB dispensary had been opened as well as new TB Ward and Leprosy Wards funded by Australian DFAT.

A number of nurses had become infected with TB and protocols had been improved. New staff had been recruited to clean the hospital. Nurses were stressed with the situation.
NGOs had trained a lot of TB helpers to go out into rural areas and trace TB patient families and persons in contact. The hospital was waiting for a restructure to be approved by DPM which would increase positions from the current 176 staff establishment to 449 positions. At present the hospital only has 120 staff with 56 positions vacant. These had been advertised several times without success. The reasons for this relate to poor conditions (no housing and exorbitant cost of living). As an example of the cost of living fuel costs K10 per litre and zoom K10.50 per litre. Positions were upgraded to make the jobs more attractive and incentives were provided to doctors but this yielded no results.

The hospital has land for development as housing but no funds. If positions are approved, funded and filed, the hospital then has no place to locate doctors. It needs a new Administrative Building for doctors’ rooms and the Administration.

The hospital cannot attract full time specialists and has been forced to recruit short term specialists from other hospitals as locums. These staff members take leave from their home hospitals and charge K500 per day to the Daru hospital for services. This is a deplorable situation which should not be tolerated. It is akin to double dipping by doctors but results from poor leadership by NDoH. There is no system in place for the hospital to obtain required specialist services.

The A/CEO explained that Health Facility Branch were purchasing a lot of equipment but the hospital needed trained specialists to operate the equipment otherwise it would sit around unused.

The Hospital had received drug kits designed for Health Centres. These arrived without notice or advice. The Health Centre kits are not suitable for these facilities. They contain items of no use and omit items required constantly. Expired drugs are also evident. The Hospital has to buy drugs from Johnsons Pharmacy as the items required are not in kits or in store.

One item that was of concern is the cost for a village based patient to come to Daru for treatment. It costs K200 to get on a dinghy to come to Daru from outlying areas. This is a great disincentive to subsistence villagers and creates health dangers in respect to TB spread.

**South Fly District Administration**

The Committee met with representatives of the South Fly District Administration. They indicated that a major constraint was staff shortage. They had CHWs running Health Centres as there were no HEOs. In addition only about half the positions were filled.

They are unable to employ more staff. The top structure was advertised but the lower positions have not been advertised. They need funding to pay for advertisements. The recruitment to top positions is believed to be stuck in DPM. Whether these positions are funded or not is also unclear.

What is clear is that District Personnel have no communication with DPM and have little idea of the exact situation.

In respect to financing, the Functional Grant has not been paid for 2015 and it is already June. There has been no recurrent funding since 2014. They District believes that this is the result of funds being frozen by Court order in respect to the case against the Governor. Regardless, the bottom line is the District has no operational funds and this situation needs urgent attention by the Solicitor General’s office to have emergency funds released. As the District implores, how can they fight TB without funds or required staff?

The District demonstrated how its cash flow affected services. One round trip to outlying villages costs in the vicinity of K10,000. The funds situation has paralysed government administration.
Health Centres are reported as run down and in need of major maintenance. Housing is falling down. There has been 40 years of neglect and hence it is very difficult to attract quality staff. Remoteness from Kiunga is also a problem. It takes three weeks to obtain cheques.

There is much disquiet concerning the supply of 100% drug kits to health centres and aid posts. Contractors act without reference to District authorities and the District has no idea whether supplies are delivered or not. Attempts to work with contractors have failed. Contractors do not deliver direct to the aid posts but drop off drugs at villages and then they sit there until someone has funds for fuel to collect them. Drug kits are considered inappropriate for Health Centre use. The situation results in very poor health outcomes.

There is almost no equipment in health centres and aid posts. What equipment exists is over 20 years old. The provincial authorities do not provide any equipment. The Area Medical Store is supposed to provide a two monthly order for health facilities pending supply of the drug kits every six months. The Area Store often tells the Health Centres to come down and pack their order themselves. This is costly to travel to Daru for Health Centre staff and also inappropriate drug management.

There is no communication with NDoH and it (NDoH) shows no leadership or interest in the above matters. The District has never had an NDoH team to come and discuss District Health Problems not even during the TB epidemic. They send staff for official openings and for projects but not health discussions. There is no oversight by NDoH of what is happening in rural areas. It is left to donors and NGOs to fill the gap and assist the District.

At present a patient treated for TB at Daru can be released and sent back to his/her village. The Health Centre is supposed to follow up to ensure the patient takes drugs regularly and to test those who have had contact with the patient for TB. TB Treatment supporters are supposed to assist the Health Centre by checking the patient regularly. Due to staff shortages to ensure supporters are doing their job and lack of funding for fuel, the system is completely ineffective. Patients can end up spreading drug resistant TB to whole communities.

Rural health needs a significant injection of funding and as well as staffing if the TB situation is to be managed effectively.

**PUBLIC FORUM DARU**

The District Administrator admitted that health centres and aid posts in the District were not up to standard and were in need of major maintenance. The Province has had no funds for the last 18 months because of the Court case involving the Governor and a Court Order preventing funds usage. The District simply can’t function without money. The Chairman agreed that the situation was untenable and undertook to seek advice from the Department of Justice and Attorney General re possible remedies.

A community leader spoke up and indicated that his daughter, son and wife had died. He indicated that there had been corruption involved in the appointment of the Board of the Daru Hospital and use of funds. The 2009 report of Board highlights the problems in health care but no real action has been taken. There had been political interference and sitting allowances for the then Board members had never been paid.

The executive officer to the District Administrator indicated that she came from Middle Fly District. There are two “hospitals” in the District one church run and the other State run. Hospitals refer patients to Daru. Some patients then die in Daru and their bodies have to be sent back. She asked “When will the district get a doctor?” Who will assist in sending the bodies back when there are no funds? Two patients arrived and stayed with her. She only discovered two weeks later that they had MRD TB and the hospital had not contacted her. The hospital said there were no beds for the patients and she would have to care for them. She said that she could not subject her family to such a risk and in any case had no facilities
to effectively care for them. How can NDoH suggest in these circumstances that TB is under control?

Another participant indicated that living conditions at Wasua Health Centre (Middle Fly) were very poor. Staff housing was falling down, there was water for only 5 hours per day. It costs K500 on MAF and K700 on Tropic air to send a patient to Daru. We don’t have that money. We don’t see any DSIP or PSIP money going into health.

Another Community Leader (David Dari) indicated that there were four health centres in his area. All were run down, staff houses had collapsed, and there was no medical equipment. In the 1980’s the health centres functioned, staff houses were good and medical supplies and equipment were available. Since then things have consistently deteriorated. Now we only have CHWs manning facilities. All centres are the same, no power, no beds, no mattresses, no pillows, no sheets, no proper water supply, no sanitation, and no medical waste incinerators.

An ex-patient and TB sufferer indicated that the people appointed to hospital boards were incapable and more effort had to be made in recruiting people with skills and the community interest at heart rather than commercial or self-interest. Waste Management and staff OH&Gs were major issues of concern as nurses had contracted TB. There are donors galore trying to fill gaps but there is no effective co-ordination by Department of Health. A PHA was necessary. He indicated that there was still K1.2 million in the rural health account and it was not lack of money but rather mismanagement and bureaucracy that was the main problem. The Committee asked the District Administrator whether there were funds in the account but he indicated that he did not know. (This in itself demonstrates a management problem).

A doctor treating TB patients highlighted the dire state of the TB situation in PNG. He indicated that over 300 people had died from TB in Daru hospital over the last three years. Many more probably died in remote areas and never made it to hospital. He cited that case of one young man who was married with a family. The patient was diagnosed with HRTB. He has been taking about 70 tablets per day for months but is still testing positive. He has gone blind and lost his family. We have had the ward overflowing with patients. The new TB ward donated by Australian aid will assist but will not be sufficient. There has been NO monetary input by the NDoH to the problem. There are patients also at Wipim. Governance issues need to be fixed. Provincial funds need to be freed up so we can follow up patients when they are sent back to villages, family members etc need to be tested. Funds for fuel and staffing need to be made available instead of relying on donors. There has been no funding in the last three years. In any case it regularly takes three months to get a cheque from Kiunga.

If the HRTB is not contained it will spread to all parts of PNG. The economic cost of this would be horrific at A$10,000 per patient for drugs alone. There are cases in POM General already. There needs to be a TB Council (like the AIDS Council) to prepare a comprehensive response. It needs to be funded properly to ensure the program in fully implemented.

Another participant indicated that now that the Australian authorities at Saibai Island would not accept PNG TB cases the matter was even more serious. Funds needed to be provided to get patients to/from Daru. The speaker wanted to old system re-introduced. He indicated that funds from Government regularly did not arrive until June. He wanted funds under the Bilateral Treaty allocated to fix health problems.

A spokesperson for Rural Community 45 mons by dinghy from Daru indicated that a new aid post was built but has not been opened. There is no staff housing and no one has been trained. Two aid posts were built under a World Bank Project but there was no capacity building for staff. The last one will be complete in July but there is no housing and no staff. This is simply bad planning and systemic waste.
Mabudawan Health Centre

The Committee travelled to the centre which is about two hours from Daru by dinghy. It has 2 x CHO staff and no HEO. The HEO left after not being paid for 18 months. He has now been gone for about the same period. The Centre caters for a village of about 1000 people plus many thousands from 7 x aid posts in surrounding areas. Some of the seven aid posts were not operational and people came direct to the health centre by boat at all times of night and day. They come from as far away as 100km. The centre is supposed to have seven staff and has only three staff houses. Given the remoteness staff houses are essential to attract staff and because no rented accommodation is available.

When the Committee arrived at this strategic location between Daru and Sibi Island, the cold chain was down, there were tetanus, HepB and Measles vaccines but no BCG, TA combined vaccines. There had been no operational funds for the clinic for 18 months due to the Western Province Court orders. There had been no patrols to immunise people against TB etc. as there was no money. Equipment in the centre was completely lacking or over 20 years old e.g. baby scales. The centre has boxes of 100% kits in store but says these do not meet requirements and intends to send them back to Daru Hospital. The drugs and supplies are not applicable to the types of diseases/afflictions treated at the centre.

In regard to equipment, the Committee had contacted the Centre in advance of its visit and was able to donate stethoscopes, auroscopes, BP kits and baby scales plus a drum of zoom fuel. These were greatly appreciated by the health centre staff. The Committee was dismayed that in an area where there was a TB epidemic, no BCG (TB) vaccine was available for children. The Committee regards the situation as deplorable health management.

The centre has no stretcher to carry people up from the beach. An old cane chair is used in lieu. There is no delivery bed for mothers, no beds in wards, no mattresses, no pillows, no linen, no medical incinerator for TB waste etc. Pathology is not separated from the rest of the centre and this is also not conducive to effective TB control. Of course there is no isolation ward for diagnosed TB cases.

The two way health radio has been out of service for over a year. Mobile phones are used where possible. But this limits the Centre’s ability to call Sibi to tell Australian medical staff that an emergency case is being transferred. There is no electricity other than an old generator owned by the sister in charge of the centre which operates when fuel is available. There is also limited water.

When TB cases are sent to Daru for treatment they are discriminated against by locals who view them as bringing disease into the town. A separate ward at Daru hospital is required for referred outstation patients. It costs K2,800 for the two drums of zoom necessary to send a patient in and return him/her to the centre. These funds are currently coming from World Vision. The Provincial Government and NDoH do nothing. We don’t see any DSIP funds.

While Australian DFAT has committed to construct a new health centre for the area, the state of the present facilities is appalling. The Committee witnessed mothers with day old babies lying on the floor in a run-down facility that has no maintenance since 1981. The Committee viewed steel posts that were erected 12 years ago for a proposed new health centre. The posts remain but nothing was built. The situation is a complete indictment of PNG health management.

Even when the new centre is constructed it will need appropriate staffing. There are issues of staff availability and even if available how staff will be attracted to such a location. These are issues that NDoH needs to find answers to without delay.
ANNEX A

ANALYSIS OF HEALTH MANAGEMENT REPORT 2013

The Minister is to be commended for releasing the Health Management Report 2013 in order to clarify the operations and performance of the Department of Health. Unfortunately the report raises more questions than it resolves but at least it provides a basis for critique of health management. The Committee undertook an analysis and critique of the Health Management Report in the interests of better health outcomes for PNG citizens and specifically young women.

The following areas of concern stem from the report:

Budget Situation

The executive summary of the report indicates that out of a total budget of K865.9 million in Divisions 240 and 241 an amount of only K611,168,090 was actually released in warrants. Only 71% of the budget was received. Why was this the case? Was it an inability of health to absorb the money or a failure of Department of Finance to provide the funds? This is a very important issue as 30% of the budget was not received. If there is to be truth in budgeting and better health outcomes, there is a need to know what happened to 30% of this budget allocation. If Government is to hold Departmental Heads to performance targets, it needs to ensure that they receive the entire appropriated budget.

As an example of what the above situation inflicts on health outcomes, it was understood that there were no funds available for District Hospital improvements in 2014. Clearly however there could have been funds made available if the missing 30% of the Budget had materialised.

Workforce Planning

The Committee notes the adoption of a Workforce Arrest Plan subsequently changed to an Enhancement Workforce Plan. The title should probably be changed again to a “Workforce Enhancement Plan” to make more sense in English. Regardless, what the report should provide is some commentary on the dire staffing situation in regard to health professionals and how generally in terms of staff categories this shortfall will be addressed in coming years. Parliament should be appraised of the issues.

Provincial Health Authorities (PHAs)

The fact that PHAs are being created to integrate provincial hospitals and public health functions under one authority is sound in principle. The question is how it works in reality. Under the Provincial Health Authorities Act 2007, the Board of the public hospital is replaced by the Provincial Health Authority Board. This effectively aggregates responsibilities at the Provincial Level.

The above situation immediately this brings into play provincial politics. The effects of this have already been seen in West New Britain and Eastern Highlands. Where once rural health may have been a problem as it was not co-ordinated, now all health outcomes in the province may be at risk if the Board fails to function. Under the Provincial Health Authority Act Section 40 the Minister can institute an inquiry into a board if he suspects “widespread corruption” and/or “gross mismanagement” of funds. While one can certainly argue that the definition of “widespread corruption” in Section 41 of the Act is clearly deficient, that is not the issue here. After the Minister receives the report he has to make a submission to NEC. After that, the Minister acting on advice, may suspend the Board and appoint a caretaker Board under Section 42 or the Head of State acting on advice may appoint an
Administrator under Section 44. The point here is that until a Minister institutes an inquiry, receives its report, gets NEC endorsement for action and Gazettes that action, the Board continues to operate. Given the aggregation of responsibility in such Boards, the administrative delays inherent in the above system are untenable.

The matter of ineffective Boards has been the subject of investigation by the Special Parliamentary Committee on Public Sector Reform and Service Delivery. The Committee, notes that its recent report to Parliament recommends that Ministers be able to intervene immediately if there is suspected corruption or mismanagement (financial or otherwise). Ministers should be able to suspend a Board and appoint a Statutory Manager to assume control until such time as an investigative report is prepared. The Minister for Health and others Ministers need such powers.

**Medical Supplies Procurement and Distribution Reform**

We have heard much about Borneo Pacific and the quality of drugs. In this context, the NDoH report indicates that the Department purchased two high performance Liquid Chromatography (HPLC) machines in 2013 to perform quality control tests on medicines brought into the country. This begs the following questions:

1. Have any tests on medicines actually been carried out and if so what were the results?
2. Have tests been conducted on medicines imported by private doctors and pharmacies?
3. Is there effective control over pharmacies dispensing out of date drugs and how is this being managed?
4. Has there been any tests conducted in PNG on drugs purchased for public hospitals and if so what were the results?

The point here is that Parliament does not just need to know that the Department has the technical capability and equipment to monitor the quality of drugs imported – Parliament needs to know that the NDoH is actively monitoring drug supplies and the results of such monitoring.

**Improved Governance**

The report highlights that the NDoH delivered on its reporting requirements in 2013 by submitting the Secretary’s Score Card, 2013 Annual Management Report, 2013 Sector Performance Annual Report and Quarterly Review Reports. The Special Parliamentary Committee on Public Sector Reform and Service Delivery, would prefer to see less reporting and more time spent on service delivery. Departments keep getting bound up in “process” rather than “substance” in the public sector. For example, if you ask a public servant even the most simple of questions, the response is always “write me a letter”.

Obviously, some reporting is required but this can be exception reporting i.e. where targets are not met rather than providing hefty tomes that list every activity and are of little value as they are historical in nature.

**Support for Church Health Services (CHS)**

The Department indicates that 60% of rural health services are Church run and that they have assisted Church Health Services (CHS) obtain additional funding to address public verses church salary disparities. This section really shows how out of touch the Department is with church run medical services.

Firstly, there is no such body as Church Health Services. It was replaced by Christian Health Services as a result of the enactment of the *Christian Health Services of Papua New Guinea Act 2007*. Moreover, whilst the NDoH pays for the salaries of CHS staff, there is still no
contract for services with CHS or its affiliates. How can the State justify these payments without a contract? How does the State verify that persons being paid are actually on staff or that required services are being provided e.g. the message re AIDS and condoms? For that matter what are the services/standards required? How can the State dispense K20 million a year without such a contract under the Public Finances (Management) Act? Given that CHS sought such an agreement to commence in 2012 why hasn’t a contract been put in place in the last three years? Why hasn’t a separate contract been signed in respect to Schools of Nursing operations?

Perhaps the lack of such a contract is why there was a Letter to the Editor in The National of 11 September 2014 which indicated that grants for the preceding three months had not been paid by the State and as a result health services via CHS had come to a stop. The letter asked the Prime Minister to intervene. Further, in a recent article is The National Archbishop Stephen Reichert implored the Department to pay CHS staff on time. He said that, over the preceding 18 months, church health workers had often not been paid for two to three months at a time. This situation demonstrates an NDoH disregard for rural health workers.

Dr David Mills told an NRI seminar on 12 November 2014 that although Christian Health Services are seen to be providing the bulk of the rural health services, the situation has changed dramatically since the churches were localised. The missionaries are gone and most of the hospitals have no doctors. There is now near total disintegration of Government capacity at the rural level to administer and implement health services; because of the metamorphosis of PNG "doctor culture" from one of the rural-based generalist practitioner to that of urban-based "specialist" practice. If this trend continues it has profound implications for rural health outcomes in PNG. But the Health Management Report 2013 fails to even mention this fact or develop a strategy to remedy the situation.

**Non Communicable Diseases Strategy**

Why hasn’t the NDoH published a comprehensive and fully costed Non-Communicable Diseases Strategy despite this being requested by then Minister Maxtone Graham – four years ago?

The WHO Technical Support Division has released statistics that show that Pacific Island countries are facing a crises in non-communicable diseases (NCDS) – cardiovascular disease, cancer, diabetes and respiratory disease. NCDs have been reported to be responsible for 75% of deaths in these countries. High rates of tobacco usage, physical inactivity, unhealthy diets and high alcohol usage all impact on the regions health outcomes. Notably very high salt intake is a major risk factor in high blood pressure and hypertension which is a key factor in heart disease and stroke. Salt is hidden in many PNG products consumed on a daily basis such as sausages, snack foods, canned meat and instant noodles.

If, as constantly advised by WHO, non-communicable diseases are at crisis level in PNG and a major threat to the nation’s health, why hasn’t a comprehensive plan been developed? What NDoH has today are elements of a plan but no comprehensive response. It’s not good enough to let people die due to lack of strategy.

**Smoking Ban**

In respect to NCDs, a ban was placed on smoking in public places vide Tobacco Products Regulation 2/2013. Despite smoking being banned in public places over two years ago, the NDoH has failed to enforce the Regulation and smoking continues unabated.

Why haven’t the Department’s health inspectors enforced the Regulation? Why hasn’t the Department worked with police to enforce the Regulation? Why hasn’t the Department sent letters to clubs, restaurants, offices etc to indicate that compliance with the Regulation is required? Why hasn’t the Department held public meetings? Why hasn’t the Department
advertised the introduction of anti-smoking measures? Why hasn’t the Department complied with Ministerial Directions of 20 November 2013 to implement the ban? In short, why has the Department failed to do anything? The Committee considers that it is not a matter of money that has prevented implementation of the ban but rather a complete lack of management commitment.

**Gardasil Trial in West New Britain**

This issue was brought to the attention of the Committee by the Governor West New Britain Hon. Sasi Muthuvel and the Member for Kandrian-Gloucester, Hon Joseph Lelang. The Committee is very concerned at the conduct of the trial.

Gardasil is an approved vaccine for cervical cancer in women. Gardasil vaccine is approved by the WHO and 97 million doses have been administered in 120 countries. It has been proved to protect against two high risk HPV types 16&18 which cause 70% of all HPV cancers in women and 90% in men. It also protects against two low risk HPV types 6&11 which cause 90% of genital warts. It is the vaccine used in the Australian school based HPV vaccination program. It is administered in three doses to young women (and boys in some countries).

A pilot project was commenced in West New Britain after in-principle approval was given by the Secretary of Health and West New Britain Health Services. Axios Australia agreed to provide the vaccine free for the trial. This represented about US$7 million in free vaccine. After 20,000 young women received the first dose, the project began to run into trouble with the provincial hospital management saying that the project was not their priority, apparent falsification on second round vaccinations and wastage of vaccine by breaking of the cold chain.

Instead of addressing the real issues as directed by the Minister, the NDoH sought to absolve itself from responsibility for the fiasco. It simply directed the trial be suspended pending approval by the Medical Research Approvals Committee (MRAC). This effectively meant that the pilot was dead and the 20,000 young women would remain unprotected.

A common definition of medical research is, the basic research, applied research or transitional research conducted to aid and support the development body of knowledge in the of medicine. It is usually divided into two general categories: the evaluation of new treatments for both safety and efficacy in terms of clinical trials and all other research that contributes to the development of new treatments. In terms of this definition the Gardasil program is clearly NOT medical research - unless the NDoH is applying some new and novel definition of medical research. Further, the managers of the pilot project obtained the vaccine from Axios Australia who indicate they are in no way involved in medical research. Questions posed to the Ministry of Health in Apia during the visit of the Special Committee on Public Sector Reform and Service Delivery about Gardasil indicated that Samoa intend to simply administer the vaccine as it is WHO approved.

Why is the Department so bound up in bureaucracy that it fails to consider the welfare of 23,000 young women? Statistics indicate that some of these young women will now get cervical cancer, some of these will present late for treatment and some of this cohort will die as a result. Why did the NDoH sit by for three years and not stop the program earlier if it had reservations? Why has it not sought to determine who falsified vaccine administration data? Why has NDoH not addressed the obvious structural issues where Boards of Public Hospitals are apparently not directly responsible to the Provincial Government or the NDoH (and to remove them for poor performance takes an eternity)?

The Committee was advised that on 6 August 2014 Axios Healthcare in the United States wrote to the Secretary of Health stating that it did not support any form of clinical research, vaccine safety study, vaccine efficacy study or vaccination effectiveness study. The point
being that Axios was adamant that Gardasil vaccination is NOT medical research as suggested by the Department.

The letter also indicated that as Gardasil is required to be given in three doses 0-2-6 months. Due to NDoH inaction, it was already too late to provide doses two and three to the 17,256 girls who received it in round one. Axios did however indicate conditions under which it was willing to supply further doses of Gardasil for the remaining 3,600 girls in Kimbe Schools where round 2 and 3 vaccinations were still possible.

Axios required the NDoH to provide the following by 14 September 2014:

- a comprehensive report describing the current supply chain management system in place and how it will support the proper handling, adequate storage and distribution of the vaccines to ensure a constant and sound management of the cold chain from Port Moresby to the point of administration
- evidence that the NDoH conducted a proper assessment to identify the reasons for the loss of 17,640 vaccines from the lot shipped in August 2013 and that the necessary action had been taken to prevent further challenges related to the receipt, storage and distribution of additional vaccines

This letter was widely distributed to all stakeholders. On 6 August Axios also emailed the same letter to the Secretary NDoH. On 22 August Axios followed up its letter with an Email to the Secretary (copy to stakeholders) indicating that it would appreciate an acknowledgement of receipt of its letter and that a separate copy of the letter had been sent via DHL. On 17 September Axios advised that as the NDoH had failed to respond to the letter Axios had withdrawn its offer to supply the vaccines for the 3,600 Kimbe girls. Effectively, all the time, effort and money spent and all of the 46,400 doses of the vaccine had been wasted. A sum close to US$7 million. This situation reflects complete administrative malaise within NDoH.

The above situation can only be categorised as a display of gross incompetence by the Department of Health. Approximately, K20 million in Gardasil vaccine was wasted, all the medical effort to vaccine girls was wasted and none of the girls is protected from cervical cancer. Not to point too fine a point on it – it is a national disgrace.

Cervical cancer is the most common fatal cancer for women in Papua New Guinea. Eighty percent of these cases can be prevented by immunisation with Gardasil. The virus responsible for cervical cancer has also been implicated in orofacial cancer, the most common fatal cancer in men in Papua New Guinea.

The Special Parliamentary Committee on Public Sector Reform and Service Delivery needs to ask the Department of Health officials the following questions:

- what do we tell the young women who received the 1st vaccination but are now not protected,
- what do we tell the other young women in the province who now will not receive the vaccine?

Do we tell them well, bad luck, due to an incompetent bureaucracy you are not protected and statistically a good percentage of you will contract cervical cancer and some of you will die needlessly as a result? To make matters worse, for those women unfortunate enough to contract cervical cancer, there is only one cancer clinic in PNG at the Angau Memorial Hospital. It was not operational for an extended period as the NDoH has failed to arrange employment of Dr Deepak Ghimire. Further, even though the good doctor was finally employed, cervical cancer is treated by External Beam radiotherapy plus Brachytherapy. The external beam radiotherapy is used to give 48-50Gy radiation and after which Brachytherapy is used to deliver radiation directly onto the tumour. However from 2009 to the present, none of the carcinoma cervix patients have received complete treatment.
Patients have apparently received an incomplete dose as there has been no Brachytherapy. This simply leads to patient deaths.

The Department needs to answer some very serious questions regarding the Gardasil trial and cervical cancer treatment viz:

1. Why didn’t the Secretary comply with the Minister’s directions of 19 November 2013 viz:
   - *The NDoH should formally accept responsibility for receiving the vaccines at POM airport, clearing customs and transferring them to a secure, monitored cold storage facility in Port Moresby.*
   - *The NDoH should correspond directly with AXIOS with respect to the shipping details and paperwork required for timely customs clearance to protect the cold chain.*
   - *The NDoH should take responsibility for stopping the template temperature recorders on receipt of the vaccines and returning them to Merck as directed in the Merck protocol.*
   - *The NDoH should coordinate transfer of vaccines to Kimbe with the West New Britain Provincial Health Department (PHD).*
   - *The PHD should present a plan to vaccinate all girls aged 9-13 in West New Britain. That plan should include vaccination awareness and "opt out" forms for all parents and education for all students destined to receive the vaccines. Once vaccines are given the name date and school should be recorded. A record of 1st, 2nd and 3rd vaccinations should be kept.*
   - *The PHD should work closely with the provincial education department and report to AXIOS & NDoH on vaccination progress at agreed stages of the program.*
   - *The PHD and Provincial Government should support the local program leader, Dr. Yvonne Sapuri with a team of local health centre workers transport and secretarial support for data entry and collation and fully fund this part of the program.*

2. Why didn’t the Secretary comply with the Prime Minister’s direction to the Minister of 9 May 2014 to proceed with the Gardasil trial in the national interest?

3. How could the Secretary’s office give tacit approval for the pilot and not have advised the applicant that prior MRAC approval was required?

4. Why did the Secretary and his subordinates, who knew about the pilot, fail to raise the issue of MRAC approval until the pilot was in its 4th year of operation and met obstacles?

5. Why did the Fact Finding Mission not address the falsification of vaccinations matter in its report when it was clear that the Provincial Administrator had not responded re the issue?

6. How could the NDoH report recommend Axios apply for MRAC approval for the Gardasil pilot when all the issues above remained unresolved. Clearly under the prevailing circumstances, the pilot would fail and should not therefore be approved.

7. What protocols exist to ensure MRAC approval is obtained for all medical research and why did they obviously fail in this instance?

8. Why is MRAC approval apparently required for, not only medical research, but also health related studies and vaccination programs in PNG? Should the protocols be revised and, given IMR complaints, should a time limit be imposed on MRAC to deliver a response re approval or otherwise to research proposals?

9. Why hasn’t Dr Ghimire been appointed despite numerous promises and a long time delay?

10. Why is the cancer unit still not functional?

11. Is it correct that Brachytherapy has not been given to cervical cancer patients and if so why?

12. As no Brachytherapy has not been administered, have patients been informed of the life threatening situation and advised to seek further treatment overseas?
Since the failure of the Gardasil Project, action has taken place by various stakeholders (e.g. Oil Search) to develop a strategy for the HPV vaccine to be administered nationwide. Once again however, staff within the NDoH have proved unwilling to enter into public private partnerships to manage the project. Again, meetings have been abandoned and there is administrative stasis in NDoH which is completely unacceptable in terms of public health outcomes. Again the Minister has had to intervene and reprimand those involved.

Challenges

The Management Report indicates that fragmentation of the health system is seen by NDoH as a challenge. If this is so, why is NDoH further complicating the structure by the creation of specialist hospitals which seem to have no real purpose? The proposed specialist hospitals have three categories with no real distinction between them in respect to powers or functions. The Bill seems to be yet another example of structural complication and bureaucratisation created by NDoH. How do these new hospitals fit in with the Provincial Health Authority concept? For example if Mount Hagen Hospital becomes a Specialist Hospital what happens to the Western Highlands Provincial Health Authority concept?

Clear objectives for the Bill need to be articulated by the Department. Is it intended to give these hospitals more power to manage their affairs? If so, exactly what extra powers does the Bill bestow? It appears to give no real additional powers to hospitals. The point is that we don’t need differentiation for differentiation sake. PNG needs better legislation not more legislation.

The Management Report provides evidence as to the ridiculously low percentage of total health funds budgeted for Health Economics (K30,000) and Performance Monitoring (K167,000). Effectively these units have no funds and staff must simply be sitting around with nothing to do but produce desk based reports. Similarly, the environmental health section of the report shows only 40% of planned 2013 activities were completed etc. Perhaps this is one reason why the report fails to adequately address sector performance but rather lists documents and policies prepared and equates these to performance.

The NDoH Annual Management Report shows serious deficiencies in the health management mechanism in PNG. It shows a Department that embraces bureaucracy rather than improved service delivery and better health outcomes and one which allocates funds in an ineffective manner. Indeed, the NDoH appears to be a massive bureaucracy that is completely out of touch with its professional staff and has completely lost sight of its real objectives.

Conclusion

The failure of public servants to implement Ministerial directions is not confined to the health portfolio. It exists in many Departments and agencies. This is why the Special Parliamentary Committee on Public Sector Reform and Service Delivery has strongly recommended in the reports that:

- Section 148 (3) of the Constitution be amended to give Ministers powers to direct Departmental Heads and

- Departmental Head contracts be revised to provide for a 30 notice of termination without cause and a provision for immediate termination and payment in lieu of the 30 day notice.

The Committee considers that the provision included in the new Public Services (Management) Act for Ministers to suspend Departmental Heads on disciplinary grounds is overly bureaucratic, time-consuming, counterproductive and completely unnecessary as the Queensland Government experience attests. The new Act requires:
The Portfolio Minister writing to the Departmental Head outlining allegations
Waiting 7 days for the Departmental Head to respond
The Portfolio Minister then writing a report to the Minister for Public Service as Chairman of the Ministerial Executive Appointments Committee
The Minister for Public Service then awaiting a report from the Secretary DPM advising whether or not the allegations are serious and are proved
The Minister for Public Service then advising NEC accordingly and
the Portfolio Minister or Minister for Public Service subject to NEC approval effecting suspension on full pay
an investigation then being conducted and eventually disciplinary charges being laid

The view of the Committee is clear – if a Departmental Head commits any act that is inappropriate or fails to adequately perform his/her functions, the State should have an unfettered and immediate right to terminate his/her contract. If the Government wants to have NEC or the Minister for Public Service make that determination rather than the Portfolio Minister, the Committee has no objection. What is not required is a disciplinary process whereby Departmental Heads are effectively protected by systemic complexity that provides many avenues for legal challenge.

The Committee has now arrived at the conclusion that not only should Departmental Heads contracts provide for immediate termination but those of Deputy Secretary’s should have similar provisions. This is because a percentage of these officers also regularly frustrate implementation of Government policy and disobey instructions from their Departmental Heads.

The Minister for Health and HIV AIDS has a very difficult job to do and has achieved much but he, like other Ministers, is hamstrung by Section 148 of the Constitution and the Public Services (Management) Act in his dealings with certain recalcitrant public servants.

The Committee commends the Minister for his tireless efforts at policy reform and infrastructure development. The Committee however recognises that policy changes and infrastructure development will not result in required increases in service delivery without concomitant reform of public sector management. These matters are outside the Minister’s portfolio and control.
ANNEX B

Comprehensive TB Intervention Program
## ANNEX C

### FPH Funds for Provinces

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Provincial Govt. Facilities - K6.1 million is yet to be released to the provinces in next few days. The delay was due to late release of Warrant & cash from Treasury, plus a

Church Health facilities - Due to above reasons your allocation of K4.9 million will be paid through the CMC Secretariat. It will then be deposited into the respective CHs Agencies' bank accounts within the next few days.

Provincial General Hospitals (PGH) - Your funds of K9.0 million will also be paid soon into your respective hospitals' bank accounts. Delay is due to above reasons as mentioned. your share of the allocation as per the allocation list.

Abbreviations: DH = District Hospital, HC = Health Centre, SC = Sub-Centre, UC = Urban Clinics
Free Primary Health Care Funding – New Ireland 2015

<table>
<thead>
<tr>
<th></th>
<th>Health Sub Centre</th>
<th>Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Bol Health Sub Centre</td>
<td>12,556</td>
</tr>
<tr>
<td>2</td>
<td>Kavieng Urban Clinic</td>
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</tr>
<tr>
<td>3</td>
<td>Metemana Health Sub Centre</td>
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<tr>
<td>4</td>
<td>Epo Health Centre</td>
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<tr>
<td>5</td>
<td>Tasingina Health Sub Centre</td>
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<td>6</td>
<td>Tingwon Health Sub Centre</td>
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<td>7</td>
<td>Umbukul Health Sub Centre</td>
<td>4,842</td>
</tr>
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<td>Babase Health Sub Centre</td>
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<td>Lamassa Health Sub Centre</td>
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<td>Masahet Health Sub Centre</td>
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<td>Namatanai Health Sub Centre</td>
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<td>Silur Health Sub Centre</td>
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<tr>
<td>16</td>
<td>Simberi Health Sub Centre</td>
<td>10,582</td>
</tr>
</tbody>
</table>

**Total** 223,671
ANNEX D

Evaluation of PATIS System
ANNEX E

POM GENERAL PROBLEMS WITH NDoH MANAGEMENT PROCESSES

i. Pharmaceutical and medical Consumable Supply
   a. Ongoing shortage of consumables
   b. Ongoing shortage of pharmaceuticals
   c. PMGH forced to procure locally and internationally - in the 4 months to 30 April 2015 PMGH has spent PGK2M+
   d. Critical/Country wide issue around BCG Vaccine running out country-wide in Nov 2014 and none arriving until April 2015
   e. Critical/Country wide issue where the country ran out of Double Blood bags

ii. Funds released slowly – also not in a straight line method – i.e. we have no idea how much we are to get month to month or when we are to get it – makes it impossible to manage cash flow

iii. Decisions and actions are very slow - example. Medical Gas is paid for by NDoH. A proposal for PMGH to move to Bulk Gas and upgrade its Medical Gas Reticulation System and save NDoH 600,000 Kina a year has not moved as yet.

iv. Change of direction after PMGH has expensed funds: PMGH has been rolling out the Msupply Supply Chain/Warehousing system as nominated by NDoH and DFAT. NDoH are now talking about moving to another system (Omega) which PMGH kicked out 2 years ago as it is not user friendly, poor reporting etc. But it will cost the facility significant funds to change. Msupply implementation is funded via DFAT.

v. Hospital Information System: project has not progressed

vi. Hospital Expansion (Women’s and Children’s Hospital) - took nearly 12 months to have NDoH pass the JICA ODA Loan request to Finance

vii. Dire shortage of Doctors and Nurses in the country. PMGH was stopped from opening its own Nursing School by the NDoH.

viii. Urban Clinics/Primary Healthcare (specifically NCD Health): if these clinics and their failure to operate and be effective PMGH will not be able to meet its charter as a specialist and tertiary hospital.

ix. The Port Moresby General Hospital Authority Bill: was drafted to give the BoM greater control over Procurement and HR. The Prime Minister and Health Minister supported this Bill and yet the NDoH succeed at every corner from stopping this initiative moving forward. Subsequently several drafts have been prepared by NDoH which failed to address the key reasons for trying to implement the Authority Bill in the first place.

x. Medical Registration Board: Failing to address applications (Dr Gupta and the Chinese Doctors as examples)

xi. Private Practice by Doctors: PMGH is not against ‘public employee doctors’ undertaking private practice in their private time, however, greater regulation needs to be undertaken around the hours of work they undertake and services they offer.
xii. Budget process: Minimal guidance is provided to enable PMGH Management to formulate its budgets. I.e. PMGH Budget submission for 2015 was PGK217M and we were appropriated PGK72M

xiii. Budget Process: No formal notification of when budget submissions are due – often given 2 weeks notice of when due to NDoH

xiv. General Communication: Correspondence often comes after an event has happened or the day before – meaning it is impossible to attend as other commitments have been made.