

Knowledge Brief

Health, Nutrition and Population Global Practice

A SNAPSHOT OF HEALTH EQUITY IN PAPUA NEW GUINEA: AN ANALYSIS OF THE 2010 HOUSEHOLD INCOME AND EXPENDITURE SURVEY

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KEY MESSAGES

- In Papua New Guinea the poorest quintile is most vulnerable to illness, yet has the lowest utilization rates of healthcare facilities.
- When looking at age groups the elderly (> 55) are the most vulnerable to illness and the least likely to seek treatment.
- The lack of healthcare workers and the distance to facilities are among the most dominant reasons cited for not utilizing health care in the poorest quintile.
- The perceived quality of services is a barrier to health care utilization across all quintiles.
- Out-of-pocket (OOP) payments have minimal catastrophic impact, yet have been found to still be a barrier to utilization — especially amongst the poorest quintile.
- The government should focus on and prioritize strengthening the health services delivery to achieve Universal Health Coverage.

Introduction

Papua New Guinea (PNG) faces a number of formidable obstacles to achieving equitable health care for the whole population. All aspects of health care access in PNG — including geographical access, qualified health workers, infrastructure, medicines and medical supplies — favour the richest quintiles. The PNG government is striving to change this reality but the achievements to date are still quite limited.

This brief analyses the finding of the 2010 Household Income and Expenditure Survey. It highlights a baseline that can be used for current programs and more in-depth health equity

analysis in the future. Whilst the findings in this brief are not new, they serve as a reminder of the barriers to health care utilization and reinforce the key issues that impact access to PNG's health system.

Sickness Reporting and Health Services Utilization

Health equity is the “absence of systemic disparities in health between groups with different levels of underlying social advantages/ disadvantages”¹. Better understanding PNG's health equity issues can improve resource distribution based on need.

The illness reporting (Figure 1) shows the poorest quintile of the population has a higher percentage of illness, that is, need. The

poorest are also the least likely to seek treatment when having reported some health discomfort (Figure 2).

When looking at sickness reporting by age groups it was found that the elderly (> 55) are the most vulnerable to illness. When looking at health care utilization by age it showed that the elderly were the second least likely group to seek treatment, with only the 13-24 age bracket lower.

Figure 1: Illness reporting in the 30 days prior to the PNG HIES 2010 survey, by wealth quintiles.

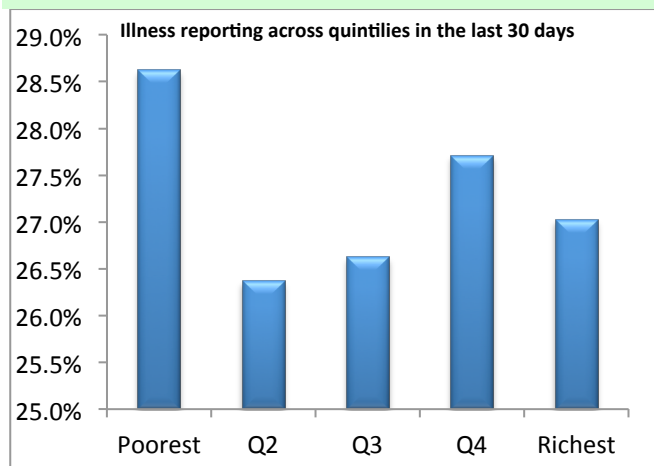
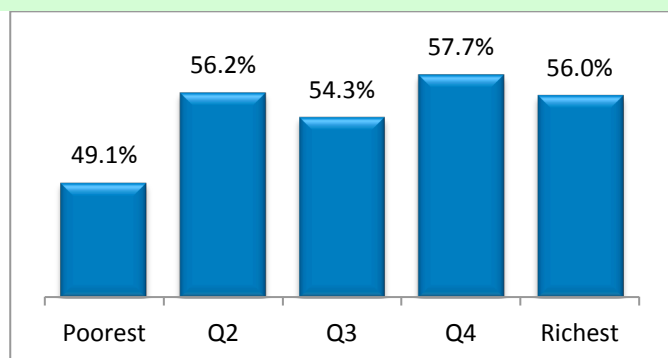


Figure 2. Percent of people who sought treatment for their health complaint, by quintiles.



Distance to healthcare facilities and the lack of health workers at facilities were amongst the most dominant reasons cited for not utilizing health facilities in the poorest quintile (Figure 3).

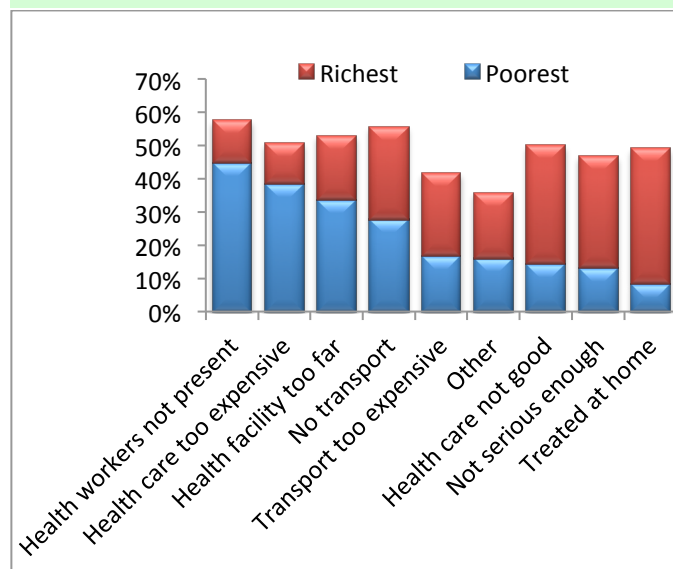
PNG faces a critical shortage of health workers. PNG currently has 6 health workers per 10,000 people, well below the 23 that WHO recommends are needed to achieve the MDGs². In addition to the low numbers of health workers, the current workforce has been found to be inadequately trained, aging and demotivated by poor working conditions, including pay and infrastructure. Staffing shortages, poor conditions, and insufficiently trained staff are felt most acutely in the poorer/ rural areas.

The terrain and a predominately rural and scattered population (only 12.5 percent of PNG's population live in urban centres) make ease of physical/ geographical access to health services a challenging deliverable for the PNG government. The GoPNG

has attempted to meet this challenge by providing facilities such as mobile clinics and public health posts in remote areas, however members of the remote communities have underutilized these facilities/ initiatives.

Quality of healthcare is a barrier to healthcare access and utilization across all quintiles, especially in the poorest quintiles.

Figure 3: Reasons for not visiting a health facility, between poorest and richest



Out-of-Pocket Payments

OOP spending on health is considered catastrophic when “a household’s financial contributions to the health system exceed 40 percent of income remaining after subsistence needs have been met”³ — that is, expenses are high relative to the resources available to the household and thus disrupts the household’s normal living standards⁴.

Like other Pacific Island countries PNG has relatively low OOP expenditure for health, especially when compared with many of the Asian countries. The statistics indicate that the OOP payments have minimal catastrophic impact on PNG households. OOP took up no more than 30 percent of total consumption in any household in PNG. Only 0.02 percent of households spent more than 20 percent of their total consumption on OOP, and 0.23 percent of households spent more than 10 percent of their budgets. When examining how OOP is distributed across quintile groups, the two poorest quintiles of the population spend a higher proportion of their consumption on health as compared to the richer population.

Whilst OOP payments have been found to have minimal catastrophic impact, the expense of healthcare has still been shown to be a barrier to healthcare utilization, especially amongst the poorest. Therefore, it still affects the equity of the health system.

What are the Policy Implications?

1. Overall the priority should be to use available funds more efficiently and equitably. The government of PNG is moving towards Universal Health Coverage, along with many other developing countries. The goal is to ensure that all people obtain the health services they need without suffering financial hardship when paying for them. The government of PNG has strived to provide “Free Primary Health Care and Subsidized Secondary Care”. Now, the government should focus on and prioritize strengthening health services delivery, which includes having a health workforce that can support an affordable, efficient, well-run health system that meets priority health needs. An effective health system requires good governance, sound systems of procurement, sufficient supply of medicines, current health technologies and well-functioning health information systems.
2. Access to quality health facilities and healthcare workers needs to be continually improved and monitored. This improvement must include an increase in the number of trained health workers. Provision must be made for ongoing professional learning, including interpersonal and teamwork skills. Health workers must have access to suitable working environments and appropriate resources (that is, medicines, medical supplies and up-to-date protocols). These improvements will nurture the health worker- patient relationship by improving the attitudes of the workforce and the confidence patients have in the health workers’ skills. Attention must be paid to engaging and retaining health workers in rural areas.
3. The utilization of healthcare facilities needs to be monitored and improved, especially amongst the poorest quintiles. Funding must commensurate with need. Initiatives geared toward the most vulnerable that are not increasing utilization, that is, mobile clinics or patrol visits need to be reviewed and amended. Though increased resources were allocated to these initiatives, the on-time receipt of funding by the front line services remains an issue. The cost and distribution of medicine needs to be improved and monitored.
4. OOP payments need to be continuously improved and monitored. This includes measuring the effects that the Free Primary Health Care policy, the impact of a potentially tighter fiscal space, and the ramification of delays in cash releases to facilities all have on OOP payments, especially in the poorer quintiles. Whilst OOP payments have minimal catastrophic impact, the expense of healthcare has still been shown to be a barrier to healthcare utilization, especially amongst the poorest and thus affects the equity of the health system.

Conclusion

The key factor to improving health equity in PNG is increasing access to health care to those most in need, i.e. the poorest quintile and the elderly. To achieve this the GoPNG will need to continually monitor and address the barriers to health care utilization for these groups. Effective use of available funds will help PNG achieve equitable access to healthcare across the population.

End Notes

1. Braveman, P. & Gruskin S. (2003). Defining equity in health. *Journal of Epidemiology & Community Health*, 57(4), 254-258.
2. World Health Organization. <http://www.who.int> & <http://www.who.int/workforcealliance/countries/png/en/>
3. Xu K, Evans DB, Kawabata K, Zeramdini R, Klavus J, Murray CJL. (2003). Household catastrophic health expenditure: a multi-country analysis. *Lancet*. (362), 111-7.
4. O’ Donnell, O., E. van Doorslaer, R. Rannan-Eliya, A. Somanathan, S. R. Adhikari, B. Akka-zieva, D. Harbianto, C. G. Garg, P. Hanvoravongchai, A. N. Herrin, M. N. Huq, S. Ibragi-mova, A. Karan, S.-M. Kwon, G. M. Leung, J.-F. R. Lu, Y. Ohkusa, B. R. Pande, R. Racelis, K. Tin, L. Trisnantoro, C. Vasavid, Q. Wan, B.-M. Yang, and Y. Zhao. Forthcoming. (2008) “Who Pays for Health Care in Asia?” *Journal of Health Economics*, 27 (2), 460 – 475

This HNP Knowledge Note highlights the key findings from a study by the World Bank titled ‘A Snapshot of health equity in Papua New Guinea: An analysis of the 2010 Household Income and expenditure survey.’ Wayne Irava, Katie Barker, Aparnaa Somanathan, Xiaohui Hou

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