

The Causes and Effects of Unspent Health Funding in The Solomon Islands

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Abstract. A group of 16 middle level health service managers studying leadership and management in the Solomon Islands National University (SINU) in 2018 conducted a focus group discussion on the issues related to the inability to expend public funds allocated for the delivery and improvement of health services. The group agreed that this problem was at the centre of poor service provision and the inability to achieve all components of annual operational plans and budgets (AOP&Bs), declining staff commitment, erosion of community confidence in health services, compromising the authority of service directors and creating pressures on higher level services. The group proposed several strategies to overcome the causes of unspent funds.

1. Introduction.

The first cohort of Ministry of Health and Medical Services (MHMS) participants in the Post Graduate Certificate in Health Leadership and Management (HLM) agreed that the inability to spend funds allocated for the achievement of AOP&Bs is the most immediate constraint to health service provision. The group comprised a cross-section of middle managers of provincial, clinical, public health and allied health service professionals from across the Solomon Islands. The process of creating AOP&Bs requires a considerable amount of work in forecasting activities at all levels of the health system and in identifying the cost of activity implementation and the sources of funds.

Funding sources in support of the activities detailed in AOP&Bs include national government allocations made to the MHMS, funding from development partners and from a range of nongovernment organisations, all of which identify and fund issues specific to their organisational interests. Funding sources and amounts for the activities detailed in AOP&Bs are ideally agreed in advance and the timing of funding tranches identified, although this is not always the case as some externally funded activities are not included. However, the group reported that many AOP&B activities are not implemented due to funding shortfalls arising from a range of reasons identified below and in Figure 1.

2. The Causes of Unspent Funds

2.1. Annual plans may be unrealistic. The exercise of annual planning commences with an assessment of what might be achieved within the forthcoming year and with the anticipation that resources will be forthcoming within an identified annual quarter of implementation. The group expressed that these plans are often unprioritized and unrealistic and that budgets are sometimes overestimated, as the AOP&Bs are produced with the grand intention of addressing all issues affecting the health of service populations.

The inclusion of development partner and NGO funds in AOP&Bs depends on estimated funding ceilings agreed with MHMS centrally. At the provincial level the development partners' amounts and criteria for funding releases and acquittals may not be clearly communicated or understood. The perception that funding will be released at the levels agreed, and in the quarters identified, may be unrealistic given that funding processes are not communicated and that the human resource capacity to implement development partner plans may be overestimated.

2.2. Poor Prioritization

Despite significant improvement to the availability of health information on which programme directors could identify priority zones or populations for increased action, the group agreed that there appears to be little use of such information in preparing AOP&Bs, resulting in the inclusion of activities that may either produce limited health gains or divert staff from higher priority concerns. The comment was made that health information that identifies high priority zones or concerns may become available after AOP&Bs are completed.

2.3. Limited budgeting capacity among technical programme directors.

Anticipating actual costs and creating budgets is a relatively complex financial task for which staff are untrained, so there is a tendency to overestimate costs to avoid potential shortfalls. This approach entails a significant risk that overestimations and consequent unspent allocations will force a reduction in funding in future years. Proposed budgets may not take all costs into account or may be based on an idealistic approach to achieving gains that are beyond the capacity of staff to achieve, or on the unrealistic assumption that development partner funds are unlimited.

The lack of knowledge of how funding systems work results in a limited capacity to adjust implementation plans. Variable timing of funding releases results in staff implementing some activities in periods that are inconsistent with the AOP&B, while planned activities are deferred until funding becomes available. Accordingly, the availability of human resources for implementation within identified timeframes cannot be assured, reducing the potential for delivery or for differing health teams to coordinate their service provision or community visits.

2.4. Limited knowledge of financial instructions. The group identified that government financial instructions are not well understood at the programme level. Most of the staff who make funding submissions are trained as clinicians or public health staff, not versed in financial processes and untrained in the applications of the financial instructions. That submissions require approvals by MHMS central administrative staff and tender board (above SI \$100,000) or by the Ministry of Finance and Treasury subjects them to bureaucratic processes that are not understood by service providers. An incorrectly prepared submission may be returned for clarification or further details before approval, presenting delays to funding availability. Frequently, these delays compromise planned implementation, disrupt the sequence of AOP&B activities and place pressure on implementation in subsequent quarters.

2.5. 'Unretired' funds

Imprests (or advances) allocated to staff for activities where direct payments for goods and services are not possible need to be retired (acquitted) within a limited timeframe of 90 days after the end of the activity. On occasions, acquittals may be submitted late because funds were not used for the original activity stated on the imprest, or because the activity was delayed. Where misuse occurs, staff may falsely claim to have conducted the activity and submit false receipts or fail to produce any receipts to retire the imprest. An example may be that a community visit is planned, and funds are allocated for per diems and other staff allowances. If supervisors find that the activity has not occurred, and staff do not return the money, staff salaries can be deducted to recuperate the amount. This potential for salary deductions produces a hesitancy among staff to take out imprests in the future, for fear they may get salary deductions should they fail to acquit even genuinely used funds on time.

2.6. Human resource planning, distribution and staff commitment

The creation of new staff positions in the national health establishment is the subject to approval from the Ministry of Public Service and depends on the availability of finances. Currently there is a freeze on creating new positions and an insufficient current establishment and financial capacity to absorb the graduates of nursing schools. The group expressed the concern that the lack of HR needs assessment and planning have not kept pace with population growth and demographic change. In addition, the current distribution of existing staff needs to be reviewed, as staff may not be at their assigned posts due to lack of housing and amenities, resulting in some areas having more staff than needed and others less. The problems of HR production, planning, distribution, monitoring and performance management reduce the capacity to conduct AOP&B activities.

Further, an overloading of activities on some cadres, particularly nurses, occurs when new programmes are commenced or rolled-out without any increase in staff. Similarly, some planned staff training activities that may have supported career development or increased technical knowledge and skills are cancelled due to shortages of staff and the need to cover essential service provision.

The effect on staff of task overloading, the inability to conduct activities as planned or reduced access to training may result in staff losing commitment or leaving the service to pursue other interests, further contributing to staff shortages.

2.7. Inadequate monitoring oversight of AOP&B implementation

The group expressed the concern that once the AOP&B is prepared and agreed, monitoring of implementation needs to be more frequent and active, and plans adjusted in response to changing circumstances and funding availability. Activities delayed or postponed to subsequent quarters require adjustments to staff availability, travel and resources. Without regular monitoring of implementation these adjustments are not made, and implementation is compromised.

2.8. Donor and NGO activities may take precedence over AOP&B activities

The activities generated by development partners and NGOs may not appear in AOP&Bs, may be peripheral to achieving health outcomes, may be initiated at any level of the health system and can potentially bypass Provincial Health Directors and the AOP&B forecasting process. External resources may be immediately available, while Ministry funding for AOP&B activities may be delayed. The example was given that a funding agency may want to achieve a greater understanding of health issues in a location and initiates staff activity to conduct a survey or community consultations. Staff engaged in such activities may not be available to conduct AOP&B activities when funds become available and will either defer planned activities to a later period or not conduct them at all.

2.9. Slow approval and pending files

Funding impress and procurement submissions are subject to bureaucratic processes that may delay their approvals, either legitimately or due to slow process, yet feedback on their progress through process is not forthcoming, creating uncertainty on implementation. At the implementation level unrealistic expectations of rapid funding releases on request arise from misunderstandings of funding release processes.

2.10. The impact of natural disasters

The Solomon Islands is subject to natural disasters; mainly earthquakes and tsunamis. These disrupt entire communities and necessitate service responses that are not forecasted within AOP&Bs and require staff deployment to provide essential services. At times funds will be

diverted from planned routine activities to respond to immediate needs, but rarely are the funds returned to conduct the planned AOP&B activities.

3. The Effects of Unspent Funds

3.1. Inability to implement AOP activities

The implementation of activities identified in AOP&Bs is compromised by the causes identified above. Necessary supplies, equipment and staff may not be available when they are needed, resulting in deferred or unimplemented activities and concentration on activities generated by other interest groups.

3.2. Difficult Processes

Problems with procurement of drugs and equipment arising from delayed funding releases and the limited capacity of staff to work through bureaucratic processes seriously compromises the ability of service providers to address basic health needs.

3.3. Declining staff commitment

These disruptions and uncertainties contribute to declining staff commitment, increased absenteeism, difficulties in delegation and a perceived loss of management authority. The AOP&B process may lose credibility among health staff, who perceive the process as being unrealistically prescriptive.

3.4. Loss of community trust

Perhaps the greatest effect of funding, supply and implementation failures is the loss of community trust in their health service providers, particularly at the periphery. Failure to implement activities or to attend planned community gatherings for service provision results in communities not attending future meetings, contributing to inadequate screenings and health assessments and delaying necessary treatment or referral responses.

3.5. Bypassing primary health care services

The loss of trust in health workers generates a perceived need in the community to bypass primary health services to access higher level services, particularly at the National Referral Hospital (NRH) in Honiara. The pressure on NRH has become a major issue requiring a strategy to improve primary health care services at local levels.

3.6. Declining health outcomes and indicators

The failure to deliver planned services reduces the potential to improve health indicators, increases the rates of complications, delays treatments and referrals and increases disability and death.

4. Proposed Solutions

The group proposed the following solutions to address the identified causes and to avoid their effects.

4.1. Activities must be in the AOP&B

The allocation of staff time and resources to introduced activities generated by external funders should not be considered for implementation unless they are detailed and confirmed within the AOP&B. Ministry, provincial and programme directors will need to continue encouraging external funders to prepare their resource allocations for inclusion in AOP&Bs and to ensure that the timing of their budget releases are consistent with the financial systems

of the Solomon Islands. The communication of these requirements to external funders must be made at the highest level and reinforced at the provincial and service director levels.

4.2. Prioritization of activities

Programme directors preparing components of AOP&Bs are required to use the best available information to identify services and locations where priority activities are to be implemented. The health information system (HIS) produces information that provides evidence for prioritization. Proposed activities that cannot demonstrate a potential to impact on health outcomes will only be included in AOP&Bs as activities of low priority and only resourced and actioned after higher priorities have been addressed.

4.3. Strengthen monitoring of AOP&B implementation.

Provincial and programme directors will establish or strengthen systems for monitoring the implementation of AOP&Bs and for evaluating the quality of service provision. Monitoring allows responsible officers to determine whether priority activities are being conducted as planned while evaluation allows a determination of how effective the activities have been. This information is essential for adjusting implementation plans and identifying the impact that activities have had on health indicators.

4.4. Financial training for eligible officers

Staff at or promoted to the grade of level 7 must receive training on budget preparation and government financial instructions from MHMS accounting staff. Such training must be routinely provided and reinforced with systems for eligible officers to periodically refresh their knowledge of these processes and to correct misunderstandings that result in procedural delays.

4.5. Strengthen procurement staffing at the national and provincial levels

The group proposed the strategy that an increase in staff in the MHMS's procurement section at the national level would allow allocated responsibility for supporting identified provinces or service sections, and to work with them to improve processes, to provide feedback on submissions. They could also provide practical training in procurement for directors and staff at level 7 and above within the provinces they are allocated responsibility for.

In addition to the Ministry's procurement section the provincial governments also have procurement authorities and tender boards. Provincial Health Directors need to familiarise themselves with the alternative sources of procurement and the requirements and processes of both.

4.6. Strengthen accountability

Financial instructions include sanctions against the misuse of funds that are not adequately enforced. These sanctions are designed to create conformity with the instructions and, if not enforced, create a perception that systems can be flexibly applied without accountability.

4.7. Create position numbers that are attached to service facilities.

The role delineation policy (RDP) outlines the services and staffing needs at each level of the health system. A human resources development plan that allocates each staff member a position number and identifies the facility to which they are posted will improve the distribution of staff and conform to the staffing needs identified in the RDP, so that services can be provided as planned and to the periphery of the health system. This will require supervision and a degree of enforcement that requires staff allocated a facility position number to be at

their allocated posts in order to receive their salary. This will strengthen the health service's capacity to provide services as planned and for resources to be applied throughout the system and to reach the periphery.

4.8. Improve system-wide communication

The communication of administrative processes, timing of funding releases, budgeting and acquittals criteria, accountabilities, sanctions and penalties must be improved across the health system. All strategies identified above must be communicated to the degree where all staff are familiar with the administrative requirements appropriate to their level of appointment.

5. Discussion

While it is necessary to have systems that guard against misuse or wastage of resources and corruption, it was agreed that the failures to fully communicate bureaucratic processes for supply and funding is a significant issue with significant effects. The group agreed that an incorrect assumption is operating; that financial instructions are understood across the health system. That they are not understood requires a response to improve communication of national and development partner funding, procurement and acquittal processes.

The group commented on an apparent perception among development partners and NGOs that the Solomon Islands health system can accommodate additional objectives without planning within the AOP&B process, or within the capacity of the available human resources. The potential to divert Ministry and Provincial health staff from planned activities contributes to the failure to implement core activities and to utilise allocated resources. The MHMS needs to continually encourage development partners, NGOs and other external funders to work within the Solomon Islands financial systems and planning processes.

The loss of community confidence in health care providers has far-reaching consequences beyond the immediate potential for increased death and disability. The bypassing of primary health care services can be reduced with the provision of the complete care packages appropriate to each level of service as detailed in the RDP. But despite such provision the above problems will persist unless financial capacity is strengthened, and the AOP&B processes are adhered to by all health system partners. Those who provide development assistance must ensure that their goodwill adheres to the principles of social responsibility and does not undermine the systems that are designed to coordinate planning and resourcing of services that are essential to the health of the people.

References.

Role Delineation Policy for Solomon Islands, Solomon Islands Ministry of Health and Medical Services, Government of the Solomon Islands, 2018

National Health Strategic Plan 2016-20, Solomon Islands Ministry of Health and Medical Services, Government of the Solomon Islands, 2016

Fig. 1. The causes and effects of unspent allocated national and donor funds in the Solomon Islands health services.

