VANUATU

MINISTRY OF FINANCE AND

ECONOMIC MANAGEMENT

PUBLIC EXPENDITURE REVIEW

HEALTH SECTOR

2011

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Acknowledgement

This report is a product of the Treasury Unit of the Ministry of Finance and Economic Management and the Corporate Unit of the Ministry of Health in Vanuatu and was prepared by the following team:

Diane J. Northway (Lead Author)
Jessica Alilee
Willie Rex
Jameson Mokoroe
Steve Anderson

Edited by:
Nikunj Soni

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Contents

Tables

Figures

Acronyms

ANC	Ante Natal Care
CMS	Central Medical Stores
CRP	Comprehensive Reform Programme
DOTS	Tuberculosis Directly Observed Treatment Short -course
DP	Department of Personnel
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GOV	Government of Vanuatu
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
HSS	Health Sector Strategy 2010-2016
JPA	Joint Partnership Agreement
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MFEM	Ministry of Finance and Economic Management
MOH	Ministry of Health
NDH	Northern District Hospital
NGO	Non-Governmental Organization
PAA	Priority Action Agenda
PER	Public Expenditure Review
PLAS	Planning Long, Action Short
TB	Tuberculosis
THE	Total Health Expenditure
UF	User Fee
UN	United Nations
UNDP	United Nations Development Program
VCH	Vila Central Hospital
WHO	World Health Organization

EXECUTIVE SUMMARY

This PER report seeks to provide a review of the overall Government spending within the Health Sector. Over the years, large amounts of financial resources are invested annually into this sector, simply because the Government sees the immediate impact these services have on the livelihood of its people. The Government also has the overall obligation to provide these vital services to the national population, at the lowest possible costs but at some reasonable standards. This is the first ever full review of spending within this sector and forms part of a series of reviews to be conducted by the Treasury over the next five years.

The Government also allocates approximately 11% – 13% of its entire recurrent budget to this Ministry annually. In addition donors also provide substantial support through their ongoing sectoral budget support program via aid in kind or through grant assistance to this Ministry. Yet expenditures within this sector continue to be a growing concern. Some commentators have argued that the available financial resources should achieve better results than what is currently the case, others have argued for greater resources into the sector. Value for money is also one major concern within this sector, and will continue to be amongst the national challenges this sector could encounter in the near future. This report does not seek to give definitive answers to these questions as to do so would be futile, but rather aims to highlight issues and challenges that can hopefully lead to better policy outcomes in terms of financial management in the future.

Health services differ from one location to another, as one moves around the country's archipelago. While the Government see this as its major challenge, it is still hoped that if resources are managed efficiently, better results could still be achieved, as compare to what is currently provided to the general population. This is why a Public Expenditure Review (PER) has been undertaken to generally take stock over all expenditures that have occurred in the past both from Donors and the Government. Lessons learned should then hopefully set the groundwork for improved expenditure management within this sector in the near future.

Section 3 of this report gives a detailed explanation of the findings and some recommendations that emanate from this report. Below are just some of the key issues this analysis raises.

Is there enough money going into the health sector?

The answer to this question is 'yes' if you compare on an aggregate cross country basis and 'no' if you compare on a needs basis, but perhaps more worrying is that the trend for Government spending is going the wrong way. This is because there is always justification for more spending on health. However, some of the key points in this debate are the following:

- In terms of its share of the Government budget – then the Ministry of Health does more or less the same by regional comparison.
- However, if you remove the impact of the increase in health workers salaries in 2006, then spending on this sector has not kept in line with population growth or even the growth of the rest of the National Budget. Therefore, the trend is worrying.

- On the other hand, the trend in donor funding is improving – especially since 2004 and more importantly an increasing amount of the funding is coming through Government systems.
- However, it seems like donor funds are paying for public health spending that is essentially recurrent in nature and therefore to an extent the donor community is making some of the investments in the health sector that should be borne by the recurrent budget.

Is the money being spent efficiently?

The answer to this question is probably no. It is 'probably' no because the lack of data on the impact of health services makes it tricky to give a definitive answer.

What the analysis shows is that over the past few years more Government resources have been stored centrally within the Corporate Services budget. The reasons for this have been to maintain aggregate control of the budget, due to weaknesses in financial management within some parts of the Ministry. However, at the end of the day what this has resulted in is a declining direct spending on both hospitals and community health and increased 'apparent' spending on Corporate Services.

Government allocation to public health is substantial however these mostly cover salaries and administrative costs. There appears to be no Government funds spent on the actual public health activities and campaigns because this is funded almost entirely by the donor community.

One concern that is common to both the programs run by donors and also the Government budget is there has been a lack of internal financial reporting within the Ministry of Health and as a result, it would appear that line managers may be making expenditure decisions with poor information.

What this suggests is that there is a need for greater financial reporting and literacy within the Ministry of Health and that as the capacity of line managers improves then greater responsibility for funds management and greater budget should be devolved to the line managers.

On a more positive note there has been progress on this in 2011 with the Ministry working to make sure that all line managers receive their financial results every month and that they all are being progressively trained and up-skilled in financial management.

Is the money being in spent in line with the Governments overall strategy?

The answer to this is probably yes. Again, it is 'probably' yes due to poor service target and service delivery data collection and reporting make it hard to give a more precise answer.

There has been notable progress in some areas such as:

- Policy statements are elaborated in the Health Sector Strategy 2010-2016 (HSS)
- Some progress in bringing external support to health under the leadership of the MOH and in alignment with the policies set out in the Health Sector Strategy 2010-2016

- January 2011 the Ministry of Health and its development partners signed a Joint Partnership Agreement in relation to the delivery of the Vanuatu Health Sector Strategy 2010-2016.

- Some additional health centres and dispensaries have been added
- Substantial targeted funding for support to malaria public health program mobilised particularly from AusAID and GFATM
- VT14.9M invested in post basic midwife and nurse practitioner training in 2009-2010

However, there remain some difficult challenges to achieving the objectives of the Government:

- Not all external funding is incorporated in the Corporate and Business Plans – e.g. pharmaceutical funding (Japan), TA[1]
- Multiple financial management arrangements for some external funders persist – e.g. GFATM
- Some external funding and support not included in plans and budgets – e.g. NGOs, facility level expenditure from collection of fees
- Resource allocation seems to be moving away from community health
- Medicine supply to health facilities remains a major challenge.
- Chronic shortages in health workforce persist

Some recommendations coming from the analysis

1. Changes to the health sector will not happen overnight, however the following steps can be done on a gradual and consistent basis;

   - MoH in liaison with MFEM, need to reallocate financial resources to better accommodate its health sector strategy
   - There is a need for reprioritization of funding allocations to support strategy and policy. Sound financial information and analysis should advocate for the need for injecting funds into the health sector. This should see improvement in the inequitable access to health as well as more resources directed to community health and hospitals and less in corporate services.
   - To better advocate for financial resources from government and donors, health resource indicators must be introduced

[1] It should be noted however that non financial donations do not need to be included in the income and expense accounts in terms of IPSAS rules, however, under IMF rules they do represent resources flowing into the Ministry and should be included in decision making documents looking at the management of resources.

- Training for line managers to be able to provide timely and frequent quality financial reports.
- Delegating of budget to line managers to encourage ownership of budget thus increase performance and management
- Continue to improve pharmaceutical systems to establish an appropriate budget level.
- Outputs and outcomes from investments should be challenged at all levels of management.

2. There is a need to re-examine the management of human resources within the health sector internally and within the overall context of skills availability and affordability;
    - The structure of the Ministry of Health must better reflect financial reality, it cannot be purely needs based otherwise we will continue to see a mis-match of resources and services not delivered due a lack of staff. There needs to be a realisation and plans for maximising service delivery based on realistic forecasts of skills availability instead of simply skills need.
    - There is a need to look at how to better manage, track and support human resources within the whole of the health sector to look at ways in which services can be delivered in light of what will be ongoing skills shortages.

This analysis does show considerable progress, particularly in the past year or two, and also suggests ways in which the Ministry of Health may wish to continue their ongoing program of reform.

At the end of the day, reports such as Public Expenditure Reviews are only ever tools for senior management. It is hoped that this analysis will serve to assist the Ministry of Health continue to improve upon the services they deliver to the people of Vanuatu.

1. INTRODUCTION AND SECTOR OVERVIEW

1.1. CONTEXT FOR THE HEALTH SECTOR PUBLIC EXPENDITURE REVIEW

This Health Public Expenditure Review (PER) is prepared as the first of a series of sector public expenditure reviews to be conducted by the Government of Vanuatu (GOV) over the next five years to complement the work of the Treasury in its analysis of effective and efficient use of public monies.

The PER gives an overview of allocations and trends in public expenditure in the sector and provides analysis of the effectiveness of expenditure allocation, disbursement and execution and compares these to the vision and strategies set out for the health sector. It aims to appraise the current public finance situation in the health sector, to inform ongoing development proposals and to develop a strategy for substantive progress towards increased efficacy of public expenditure in health in Vanuatu.

Influenced by the global financial crisis, Vanuatu experienced a slow-down of economic growth in 2009 and 2010. Despite the dual challenge of large fluctuations from external influences on the economy and a limited production base on the domestic side, good macroeconomic management has helped Vanuatu to a position of gradual economic rebound and GDP growth is expected to pick up to 3¾ per cent in 2011 on the back of stronger investment growth, expanding tourism arrivals, and higher copra production.[2] The key downside risks are delays in infrastructure investment and a longer-than projected impact of natural disasters in Australia and New Zealand on Vanuatu's tourism industry. The surge in global commodity prices is projected to push inflation up to 4 per cent in 2011. In light of this it will be important for government to keep to the overall budget expenditure ceiling in 2011 to underscore commitment to fiscal consolidation. If output growth falls below projections, revenue should be allowed to function as an automatic stabiliser. A broadly balanced budget in 2012 should also restore much-needed fiscal space to respond to future shocks. Careful prioritisation and a concentration on efficiency within public expenditure will be of utmost importance to achieve this.

1.2. HEALTH PER FOCUS AREAS

This is the first PER of the Vanuatu health sector. In addition to the overall analysis of public expenditure on health, this report will focus on the following issues: allocation of resources, the operational efficiency and effectiveness of public service delivery and impact on the poor, financial management and their effect on the health sector, governance reforms and health financing initiatives. Due to the limited nature of the private health sector in Vanuatu, restricted to a small number of private practitioners operating in urban areas and some private pharmacies, this PER focuses on public provision of health care and excludes analysis of the private sector.

[2] IMF Article IV Report 2011

1.3. OBJECTIVES OF THIS STUDY

The main purpose of this PER is to examine the flow of public funds within Vanuatu's health sector, using the most current information available. In doing this, the PER will, where possible, also examine the performance of the health system in ensuring and financing the provision of care and in improving the welfare of the population. While emphasis is on the focus areas outlined in the section above, this will not be to the exclusion of other, overarching themes, such as the effectiveness and equity of current and likely future allocation of resources.

1.4. LIMITATIONS

While data has been gathered as extensively and analysed as intensively as possible, inevitably an exercise such as this will still have shortcomings. Among the most serious are lack of data on the level and location of care at which expenditure took place, as well as on Provincial level expenditure in general; some missing information on donor and NGO activities; and incomplete data on health facility performance.

1.5. OVERVIEW OF THE REPORT

The report is organised as follows:

- Part 1 discusses the context and scope of the PER. Vanuatu's health sector and its strategy is described and linked to national policies; key documents and issues are outlined. The existing challenges of the health sector are reviewed, both in relation to the burden of disease and as regards the functioning of services within the sector.

- Part 2 outlines key tendencies in public expenditure on health. This includes review of the mobilisation and sources of funds; their relationship to total public spending; geographic disaggregation; and change over time. This section of the report reviews how these funds are allocated: it examines where they are spent, on what and by whom. The alignment of public spending is compared to the policy objectives described in Part I.

- Part 3 assesses the efficiency, effectiveness and equity with which these outputs are used, and the impact that they are having on health outcomes in Vanuatu. The budget management process is reviewed, conclusions are presented on the effectiveness of public expenditure in the health sector. Recommendations to address identified weaknesses are made.

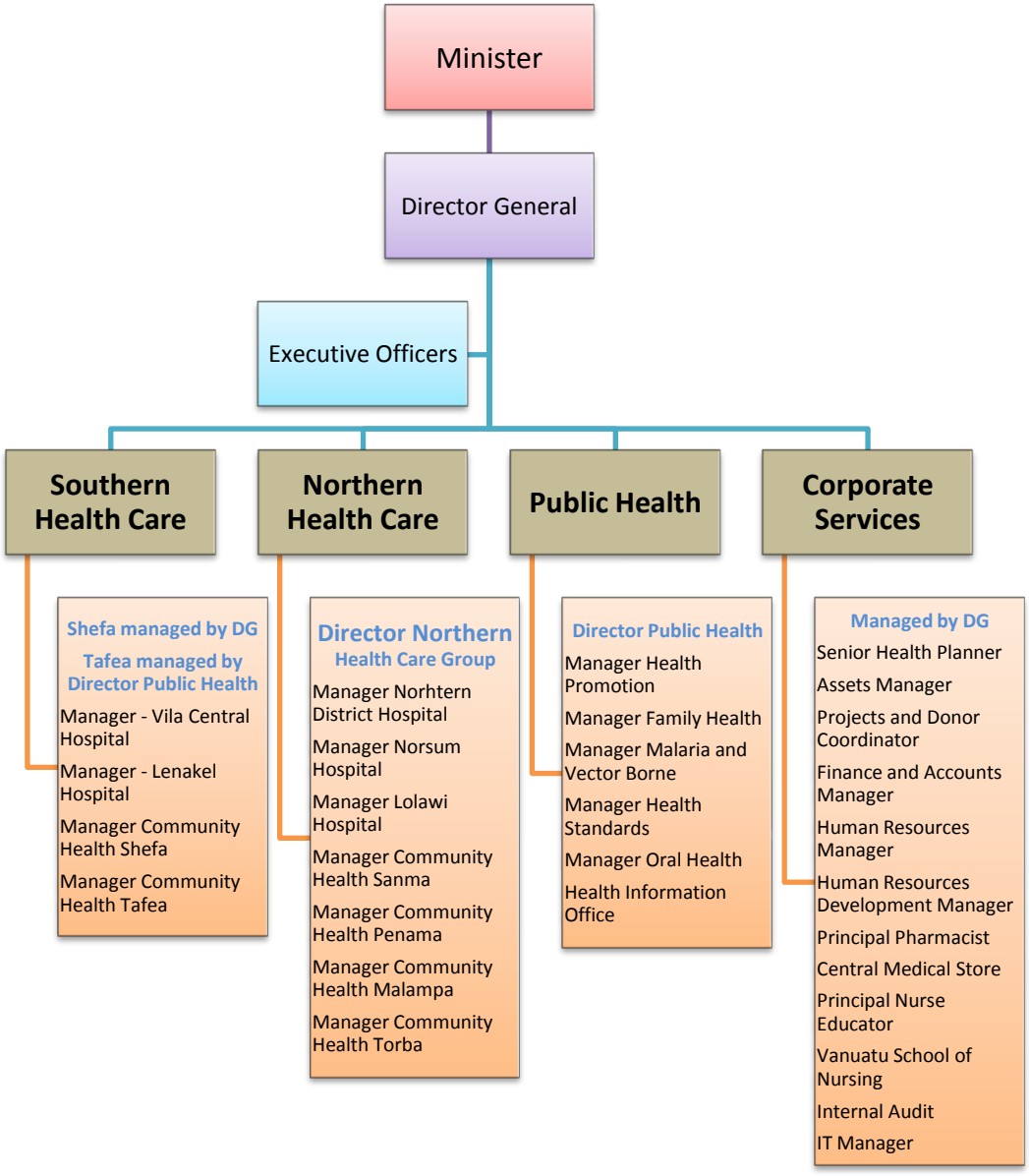
- The final Part 4 considers the availability and quality of public expenditure monitoring information and makes recommendations for capacity building needs of the Ministry of Health (MOH) in terms of setting up a fully functioning internal monitoring and evaluation system.

1.6. INSTITUTIONAL STRUCTURE OF THE SECTOR AND RESPONSIBILITIES FOR EXPENDITURE ALLOCATION AND MANAGEMENT

The MOH has overall responsibility for the GOV health system. It advises the Government on health policy, operates Vanuatu's public health services and provides public health promotion and preventative services. There are a small number of private practitioners and private pharmacies in urban areas. However, most of the health services in Vanuatu are provided by the government sector.

The organisational structure of the MOH is shown in Figure 1.

Figure 1 Ministry of Health – Current Structure



The formal health sector is made up a three-tier structure for service delivery: hospitals, health centres and dispensaries. There are five main hospitals in Vanuatu. Vila Central Hospital (VCH) in Port Vila and the Northern District Hospital (NDH) in Luganville are the main referral hospitals for Vanuatu's Southern and Northern Health Care Directorates respectively[3]. Provincial hospitals are found at Norsup, Lolowai and Lenakel and a provincial hospital for Torba province is under construction, but not yet operational. All hospitals provide obstetric, medical, paediatric, surgical, inpatient and outpatient services, and VCH and NDH also have specialist outpatient clinics. The urban areas of Port Vila and Luganville are served by dispensaries governed by the municipal administrations of Port Vila (five dispensaries) and Luganville (three dispensaries). These are staffed by a nurse or nurse practitioner and provide primary and limited preventive services.

Rural health care is provided through a network of health centres and dispensaries. Health centres are staffed by a nurse practitioner, a midwife, a registered nurse and sometimes a nurse's aide, while dispensaries are staffed by a nurse and a nurse's aide. The health centres are responsible for supervising dispensaries and aid posts in their catchment areas, including receiving referrals and conducting supervisory, public health program and clinical outreach visits.

Aid posts make up the informal, or community owned, component of the health service and are staffed by village health workers who have received up to three months of basic training in primary and preventive care. Aid posts receive supplies and outreach supervision from the nearest health facility.

Table 1: Health facility distribution

Health Facilities by Province of Vanuatu as of 2010

Province	Aid-posts	Dispensaries	Health Centres	Hospitals	MCH Teams	Total Health Facilities
Torba	20	7	3	0	1	**31**
Sanma	66	22	6	1	2	**97**
Malampa	44	19	9	1	2	**75**
Penama	50	22	6	1	2	**81**
Shefa	38	19	4	1	3	**65**
Tafea	48	12	1	1	2	**64**
Total	**266**	**101**	**29**	**5**	**12**	**413**

Source: MOH

3 Recently responsibility for Southern Healthcare was transferred from a specified Director position to the Director General (Shefa) and the Director of Public Health (Tafea).

1.7. CURRENT HEALTH SECTOR PRIORITIES, INDICATORS AND PERCEIVED CHALLENGES

This section reviews the Government of Vanuatu strategy and policy in respect of its health sector and the health status of the population. The major government policies influencing current health sector direction are identified and an overview of indicators of national health status is provided in order to establish if there are major changes in status as a result of the government's stated priorities. Major challenges for the sector are highlighted along with a discussion of the role of public expenditures in promoting human developments and reducing poverty.

The GOV policy statements for human development are set out in a ten-year plan, the Priorities and Action Agenda (PAA) 2006-2015 (An educated, healthy and wealthy Vanuatu). This strategy document presented by the Department of Economic and Sector Planning, Ministry of Finance and Economic Management (MFEM) in June 2006 integrates actions from national and regional plans introduced to complement the earlier Comprehensive Reform Programme (CRP) and specific actions associated with the achievement of Millennium Development Goals (MDG).

The PAA notes, in particular, that although increased financial resources have been allocated to the health sector there have been disappointingly small improvements in rural service delivery. Rural health services lack resources and capacity to deal with the needs of the people and frequently run out of supplies. Other stated concerns include the potential effects on health arising from increasing urbanisation; slow growth in agricultural productivity and weakening national food security; increasing youth unemployment; declining standards of nutrition; increasing incidence of non-communicable diseases (NCD); the growing threat of HIV/AIDS and the increasing incidence of poverty and hardship being experienced by a growing number of families.

The policy objectives for health in the PAA are as follows:

- Improve the health status of the people
- Improve access to services
- Improve the quality of services delivered
- Make more effective use of services

The PAA emphasises a primary health care approach as the most cost-effective approach to public healthcare and service delivery and gives high priority to preventive treatment including immunisation, improved nutrition and the promotion of healthy lifestyles. High priority is also given to reproductive health encompassing maternal and child health, family planning and control of Sexually Transmitted Infections (STI) and assessment of the threat of HIV/AIDS. Curative services are to be maintained.

Planning Long, Acting Short: Action Agenda 2009-2012

This national plan was developed by the GOV in 2008 as a response to the expected impact of the global economic downturn on Vanuatu from 2009. It was initiated to set national strategic directions aimed at continuing good development and reform policies for the next 25 years establishing a long-term agenda to

address key threats relating to domestic economic vulnerabilities, social and economic disintegration, political instability, and international challenges. An initial four years matrix was developed to provide continuity in development and reform policies initiated under the CRP and articulated in the PAA. The matrix sets out the policy priorities and action agenda of the government for the period from 2009 to 2012 and identifies the highest priority actions to be undertaken by the government with assistance from its development partners. Priority actions for health were identified by the MOH and incorporated in the MOH Corporate Plan and Annual Business Plans.

Table 2: Planning Long, Acting Short: Health strategies and indicators

Strategy	Indicator
Strengthen the capacity of the Ministry of Health	• New National Health Policy finalised and implemented. 2009
Strengthen the delivery of basic health services to all, in remote, rural and urban areas.	• Resource allocation to favour community health (away from central hospitals and administration) rebalanced 2010 • Reach of essential health services to remote areas increased 2009-2012 • Immunisation levels increased, supply of essential medications to health facilities maintained 2009-2012
Vigorously control and progressively eliminate malaria from Vanuatu	• By 2014, eliminate malaria from TAFEA, stop all deaths and decrease nation-wide incidence to 7/1000 from 23.3/1000 in 2007 2009-2010
Invest in training and supporting the health workforce, particularly nurses to staff rural facilities	• Numbers of nurses trained and engaged increased– staffing shortfalls at rural facilities reduced 2009-2011

Health sector strategy

At the health sector level, these policy statements are elaborated in the Health Sector Strategy 2010-2016 (HSS). The overarching vision of the HSS is to have an integrated and decentralised health system that promotes an efficient, effective and equitable health services for the good health and general well-being of all people in Vanuatu.

Specific objectives of the HSS (in line with the PAA, MDGs and Pacific Island Ministers of Health):

- Ensure that the whole population has access to a range of evidence based and affordable health promotion and preventive services.
- Ensure universal equitable access to emergency, curative and rehabilitative services.
- Ensure that quality PHC remains pre-eminent as the central strategic health priority for the country, and that this is reflected in the budget.
- Ensure that the health systems necessary to provide such services, which are accountable to clients and are cost-effective, are developed and strengthened in line with international best practices.

- Actively engage in partnerships with donor agencies, private sectors, civil society groups and other development partners to assist in optimising health service delivery.
- Adopt a three-year strategic planning framework (Corporate Plan) with rolling yearly implementation plans (Business Plans) that should drive the budgeting process.
- Ensure that all significant external funding is in line with the priorities and directions of the MOH.
- Aim to achieve improvements in specific priorities, including maternal and child health mortality and morbidity.

Service delivery policies and strategies from HSS

1. Base the delivery of services on a Primary Health Care (PHC) approach to ensure access to sustainable provincial services including strong links with provincial governments.
2. Improve the health status of people through:
    a. reducing illness and death in children <5
    b. promoting birth spacing and reducing teenage pregnancies
    c. reducing disabilities and death among productive adults.
3. Improve access to services through:
    a. adoption of the role delineation tool to distribute resources more fairly based on community health needs
    b. implementation of mechanisms to evaluate tertiary services and provide guidance on their access both within Vanuatu and beyond
    c. develop an integrated primary health care and public health care strategy for Vanuatu
    d. giving a higher priority to improving transportation and communication to improve access for patients and remove the isolation of health workers and improved strengthened partnership and ownership of health programs developments through the coordination of donors, NGOs and other sectors of government, chiefs, churches and others with regards to facilitating the implementation of the Health Sector Plan.
4. Improve the quality of services delivered through:
    a. implementing a comprehensive Hospital and Health Service Quality and Service Standards program
    b. recognising the potential for the key role to be played by health professionals providing leadership and ensure there is a continued skill based development and retention in the health workforce.
5. Make more effective use of resources through:

a. improving the collection of data to enable the monitoring of health status and support health planning and management

b. adopting only health initiatives that are cost effective and proven in the South Pacific and continue to roll out the planning process to include high priority services and new programs.

Achievement of the HSS health outcome goals are expected through the implementation of specified implementation strategies:

1. Organisational re-structuring and strengthening strategies

- Develop and maintain integrated spectrum of services in which preventative, curative and rehabilitative care are offered through a hierarchy of health facilities and support services connected by referral and supervisory links.
- Continuous improvement through best practices with a customer focus.
- All health facilities have water supply, sanitation and communications and are properly equipped and supplied for provision of health services offered. IT used for health information.
- Reduce health consequences of emergencies and disasters.
- Planning and management delegated or decentralised to provincial level.
- Health systems including financial management and health financing strengthened and best practices adopted to ensure transparency and accountability at all levels.
- MOH to explore sustainable alternative methods of funding to improve and support health care delivery including donor's contributions.
- HIS strengthened to support policy and decision making.

2. HR development and management strategies

- Produce adequate numbers of skilled personnel.
- Career pathways.
- Adequate incentives and rewards.
- Effective performance management system.
- Strengthened nurse training, nurse-aide training and further development for Village Health Workers.

3. Better coordination with our partners

- Adoption of a Sector Wide Approach with external support from partners harmonised and aligned to national strategy and plans.

- NGOs encouraged to implement health services with annual reporting on activities to MOH.

4. Development of strategic and operational planning processes

Corporate plans

- The MOH will prepare three-year Corporate Plans, updated annually, incorporating priorities defined in the GOV Medium-term strategic framework (MTSF) established by GOV.
- MOH to include a budget in the corporate plan incorporating government and external budgets and targets set and means to achieve them.
- Annual Report to be prepared by each Ministry.

Annual business plans and budget development

- To specify activities, commitments and directives for action and targets to be achieved. Each unit/department in MOH has responsibility to prepare annual plan and budget.

HSS indicators

The Ministry of Health's Sector Strategy 2010-2016 contains strategies, targets and performance indicators to measure progress in the priority areas. Performance indicators to reflect overall progress in the sector include those on:

- infant and child mortality;
- maternal mortality;
- births attended by trained health personnel;
- immunisation coverage;
- contraceptive prevalence;
- malaria, TB and non-communicable disease incidence; and
- availability of timely and accurate health statistics.

Vanuatu has made good progress in reducing child mortality and is on track to further reduce this rate to at least 25 per 1,000 by 2015[4]. This is said to be a realistic estimate grounded in an assessment of existing resources, gaps in human resources, and issues of access to health facilities in remote rural areas and outer islands; as well as plans to improve these over the next five years to reach the MDG for under-five mortality. The MDG Report for 2010 goes on to say that most child deaths are still from preventable causes, such as pneumonia, diarrhoea and neonatal conditions, and many more could be averted with improved primary and preventive care, including by skilled birth attendants. Lower rates of child mortality are reported in urban areas than rural areas.

[4] Millennium Development Goals 2010 Report for Vanuatu, Prime Minister's Office 2010

1.8. HEALTH SECTOR OUTCOMES AND TRENDS IN POLICY

Table 3: Key health MDGs

Goal	Measure	1990	2015 target	Recent data
MDG 4 Reduce child mortality	Children under-5 mortality rate per 1,000 live births	58 (1989)	19 (25 with existing resources)	30 (2007, MICS)
	Infant mortality rate per 1,000 live births	45 (1989)	15 (20 with existing resources)	25 (2007,MICS)
	Children under-1 immunised against measles	66%	95% (measles eliminated from 2012)	Routine coverage 80% Catch up coverage 97% (2009)
MDG 5 Improve maternal health	Maternal mortality ratio per 100,000 live births	96 (1998)	24 (MOH less than 50)	86 (2007)
	Number of maternal deaths each year	2 (1998)	No more than 3 per year	6 (2007)
	Proportion of births attended by a skilled birth attendant	79% (1990-1995)	85%	80% (2008, MOH)
MDG 6 Combat HIV/AIDs, malaria and other diseases	TB prevalence per 100,000 population	140	<70	74
	Incidence and death rates associated with malaria (incidence per 1,000 population, per 100,000 population)	Incidence: 198 Death: 22	Incidence: 7 Death: 0	Incidence: 16 (2010) Death: 0.9 (2009)
	Proportion of children under 5 sleeping under insecticide-treated bed net	13% (2002)	95%	81% (2009)

Source: GOV, PMO, 2010

The Infant Mortality Rate (IMR) has steadily declined since 1990. This is the result of a number of child survival intervention strategies stated earlier. The current IMR is 25 per 1,000 live births and the realistic target is to further reduce the IMR to at least 20 per 1,000 live births based on current and planned resources and activities. The policy goal of the Ministry of Health is to achieve a neonatal mortality rate of less than 10 neonatal deaths per 1,000 live births per year. However, it should be noted that not even Vanuatu's national referral hospital, VCH, has a Neonatal Intensive Care facility to care for premature or otherwise life-threatened babies. The principal cause of maternal mortality is post partum haemorrhage and few MoH community health facilities have blood transfusion capability, so access to "skilled birth attendants" will not, in itself, eliminate maternal mortality. In the medium term, therefore, all high risk births need to be in a hospital.

Vanuatu is participating in the WHO regional initiative to eliminate measles by 2012. However, trends based on WHO/UNICEF statistics indicate a routine coverage rate of between 60 per cent and 80 per cent between 1990 and 2009 except for the years with measles immunisation campaigns (2000, 2006 and 2009). Routine vaccination programs do not achieve high measles coverage rates and supplementary immunisation activity (SIA) is carried out leading to wide annual fluctuations in the routine immunisation

statistics and also wide variations between provinces probably due to the difficulty for people in remote areas to access health services.

The MDG Report for Vanuatu, 2010, identifies a wide range for maternal mortality rates (MMR) in Vanuatu with UNICEF reporting an MMR for 2000-2006 of 68 per 100,000 live births, while the Asian Development Bank (ADB) cites the ratio as high as 130 per 100,000 in 2000. While records are inadequate on cause of death, health workers cite haemorrhage as the most common reason for maternal deaths and pregnancy complications at night and absence of suitable transport as contributing factors. Accessibility to health services account for regional differences in obstetric care. Delivery by a skilled birth attendant ranges from around 32 per cent of deliveries in Torba province where health facilities are very limited to 94 per cent in Shefa province.

Tuberculosis is one of the major communicable diseases in Vanuatu. The Ministry of Health with support from development partners have implemented a highly successful campaign to achieve targets for TB reduction. It is however challenging to provide statistical information about TB, particularly the Case Detection Rate, which is currently estimated to be less than 50 per cent.

Malaria is the major public health problem in the country. The malaria control program in Vanuatu is strongly organised around a vertical program approach supported by development partners with a strategy concentrated on intensified vector control through high coverage with long-lasting insecticide treated bed nets, early case detection and prompt effective action. In 2008, the rapid diagnostic test for malaria was progressively introduced in all health facilities. Annual parasite incidence decreased from a baseline of 73.9 positive cases per 1000 inhabitants to 23.3 per 1000 in 2007. The annual parasitic incidence (API) was 13.3 per 1000 in 2009 as compared to 15.6 per 1000 in 2008. This remarkable decline has opened up the prospect of further reduction and eventual elimination of malaria. The Ministry of Health has introduced long-lasting, insecticide-treated nets, using funding from the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria and AusAID, to combat malaria. The use of bed-nets now seems to be widespread, with 56 per cent of children sleeping under nets in 2007. In 2009, LLN distribution has increased to 81 per cent. Nevertheless, concentrated efforts are still needed to achieve the elimination target.

Dengue fever, dengue haemorrhagic fever and filariasis are also very significant communicable diseases, and the Directorate of Public Health has implemented an extensive vector borne-disease control program over the past 20 years. The five rounds of mass drug administration against filariasis have been completed and the program is now in an evaluation and surveillance phase.

Five cases of HIV infection have been reported in Vanuatu, two are on antiretroviral therapy, one on prophylaxis against opportunistic infections and two have died.

Emerging health challenges

Vanuatu faces major challenges in the development and delivery of health services. The population of about 234,023 is spread over 80 islands and it is difficult for the Ministry of Health to provide health services to such a dispersed population.

The Government also has to face challenges due to the rapid growth of the population. The number of people is expected to have doubled by 2030, resulting in a very young population. As a result, health services will have to provide more and more services in the areas of antenatal, natal and postnatal care, as

well as neonatal care. Diseases of childhood will continue and more and more paediatric and obstetric care services will be required. At the same time, the elderly population will also keep increasing due to longer life expectancy, and the diseases of the elderly will be another serious problem.

With urbanisation and changing lifestyles, the incidence of chronic diseases, such as diabetes, hypertension and stroke, are increasing. The leading causes of mortality reported in 2006 were heart disease, cancer, asthma, stroke, pneumonia, liver diseases, neonatal death, diabetes mellitus, septicaemia, and hypertension. The mortality pattern over the years shows an increasing trend towards non-communicable diseases becoming the leading cause of mortality in the country. A STEPS survey undertaken by WHO in 2005 found 66 per cent of those sampled were either overweight or obese, 15 per cent suffered from hypertension, 11.8 per cent were diabetic and 22.6 per cent had elevated serum cholesterol. Diabetic vascular disease is now the most common reason for admission to surgical wards, representing about half of patients admitted at NDH and an estimated quarter at VCH. To address these issues properly, the health services need human resources trained in both the clinical and preventive health fields that are adequate in terms of both numbers and quality. Further, proper equipment for good diagnosis, treatment and rehabilitation is needed. Production of human resources for health will be the major challenge to be addressed in the near future.

1.9. REGIONAL COMPARISONS

Table 4: Regional comparisons of key health-related data

	Vanuatu	Solomon Islands	Tonga
Per capital expenditures on health in US$ nominal rates (inc out-of-pocket spending) (2008)	$96.94	$67.5	$109.04
Total Health Expenditure as % GDP (2008)	4.06%	5.26%	4%
Government expenditure on health as % of total recurrent government expenditure (2008)	11.37%	16%	8.5%
Life expectancy (yrs, 2008)	69	65.8	72
Crude death rate	5.5	7.6	6.8
IMR	27	30	13
U5MR	33	36	22
TB incidence (per 100,000)	74	120	24
TTB prevalence (per 100,000)	88	150	22
TB mortality	11	19	3
Measles rate (% yr)	80	60	99
ANC (at least 1 visit)	84	74	98

	Vanuatu	Solomon Islands	Tonga
MMR (per 100,000 live births)	86	100	76
Births attended by skilled health staff (%)	93	43	99

Source: Country Health Information Profiles 2010 WHO Western Pacific Office

1.10. THE STATUS OF SECTOR STRATEGY DEVELOPMENT AND ASSOCIATED ANALYTICAL WORK

The MOH has developed its sector strategy for the period 2010-2016. This builds on the health priorities identified in the wider government Policies and Action Agenda and more recently the Planning Long, Action Short implementation plan. The MOH prepared an Annual Report for 2010 showing progress against targets in accordance with PLAS requirements.

In January 2011 the Ministry of Health and its development partners signed a Joint Partnership Agreement in relation to the delivery of the Vanuatu Health Sector Strategy 2010-2016. The intention of this agreement is to bring all external support to health under the leadership of the MOH and in alignment with the policies set out in the Health Sector Strategy 2010-2016. The three-year Corporate Plan and the annual Business Plans and budgets will incorporate all sources of funds including government and external sources. Progress against these plans will be monitored through the development and implementation of a Performance Assessment Framework (PAF).

In response to this the MOH has been implementing a new planning and budgeting process to integrate the annual business planning and budgeting process. This process involves all MOH managers and begins with the MOH issuing guidelines on policy, priorities and an indicative outline budget within which to work. This process was initiated in 2010 for the 2011 budget preparation. It has continued for the 2012 planning and budgeting cycle with further instruction and provision of planning and budget templates and associated training for responsible budget managers.

In addition to the development of the sector strategy, the health sector has benefitted from the development of supporting plans intended to inform sector strategy. These include the preparation of a Vanuatu Health Workforce Plan 2004-2013, intended to provide strategic direction for the training and management of health workers and increasing efficiency in workforce utilisation and improving workforce productivity. The plan aimed to improve the balance between expensive tertiary care and more affordable primary care. This plan was eventually not used to inform annual plans and budgets, and in its place the MOH have developed a revised health organisation structure and have presented this to the Public Service Commission for review and approval prior to implementation.

Also in 2004, a Provincial Assets Development Plan was prepared identifying the numbers and equipment needs for health facilities to serve rural populations based on population size, distance to hospital services and the types of service required at these facilities. Capital needs were identified and costed in order to inform budget requests between 2005-2008. Unfortunately allocations of the necessary capital funds were not added to the MOH budget in those years to effect the acquisitions identified in the document. As it is

possible that some progress may have been made in a less coordinated fashion it is recommended that the original plan is updated prior to implementation.

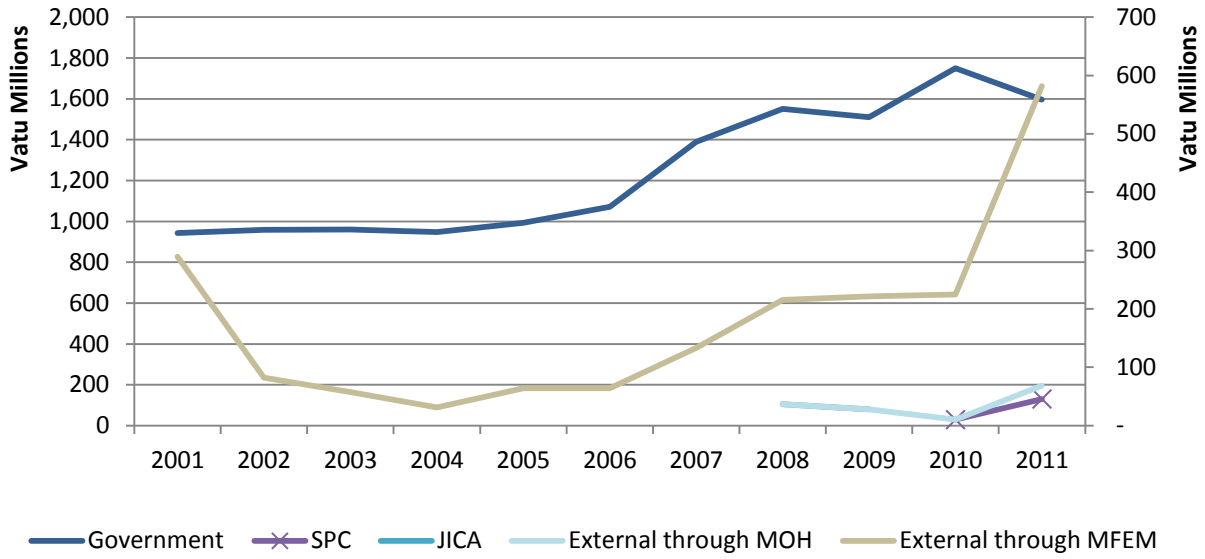
There are also costing studies underway and others planned. A costing study of the Vila Central Hospital is underway with AusAID support with costing of community health facilities expected.

2. ANALYSIS OF PUBLIC EXPENDITURE IN THE HEALTH SECTOR

2.1. RESOURCE ALLOCATION

The health sector in Vanuatu is financed from three main sources: government revenue, external donor funds and private monies, either out of pocket contributions or through private health insurance. Government revenue and external donor funding are the most important sources of funds in the sector, together accounting for 92.4 per cent of health spending. The latest draft National Health Accounts for Vanuatu identified private households contributing just 9.6 per cent of Total Health Expenditure (THE) and private insurance 3 per cent of the total.

Figure 2: Government and external public health sector fund trends from 2000 to 2011



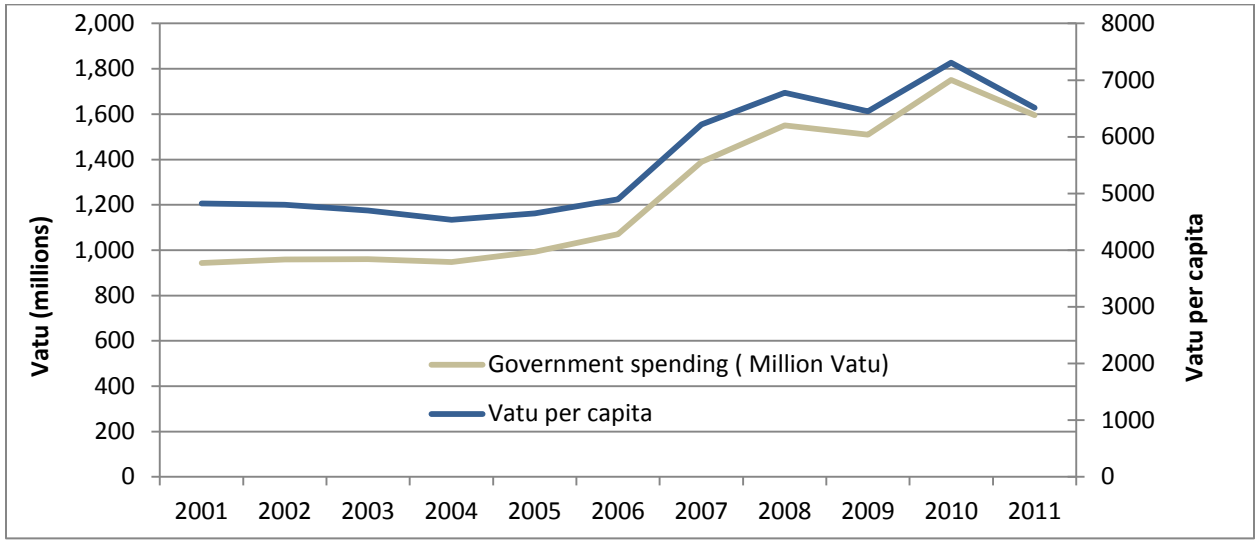
Source: MFEM expenditure data for 2001-2010 and budget data for 2011. External financing from MOH is incomplete and only relates to JICA grant for pharmaceuticals and SPC/GFATM for 2010 and 2011

Due to the small size of the private health sector in Vanuatu, the focus of this report is expenditure within the public health service and it excludes expenditure in the private sector. In the next sections we examine the levels of funding available to the public sector in Vanuatu. Public funding is defined as domestic government funding for health care plus external (donor and International Non-Governmental Organisations (INGO) funding plus official user charges paid in public facilities. The last decade has seen an increase in both the government and external partners' contribution to health financing. The figure below, prepared using data from the MFEM for government resources and for external financing, shows the growth of both of these sources of public health funds.

2.1.1. GOVERNMENT EXPENDITURE ON HEALTH

The largest government contribution to health care is through the government budget allocated to the MOH. The municipal governments of Port Vila and Luganville also provide funding for urban dispensaries and although within the scope of public expenditures, this report does not provide information on their extent except to provide some information on health sector staffing.

Figure 3: Trends in total government spending on health (current prices) and vatu per capita



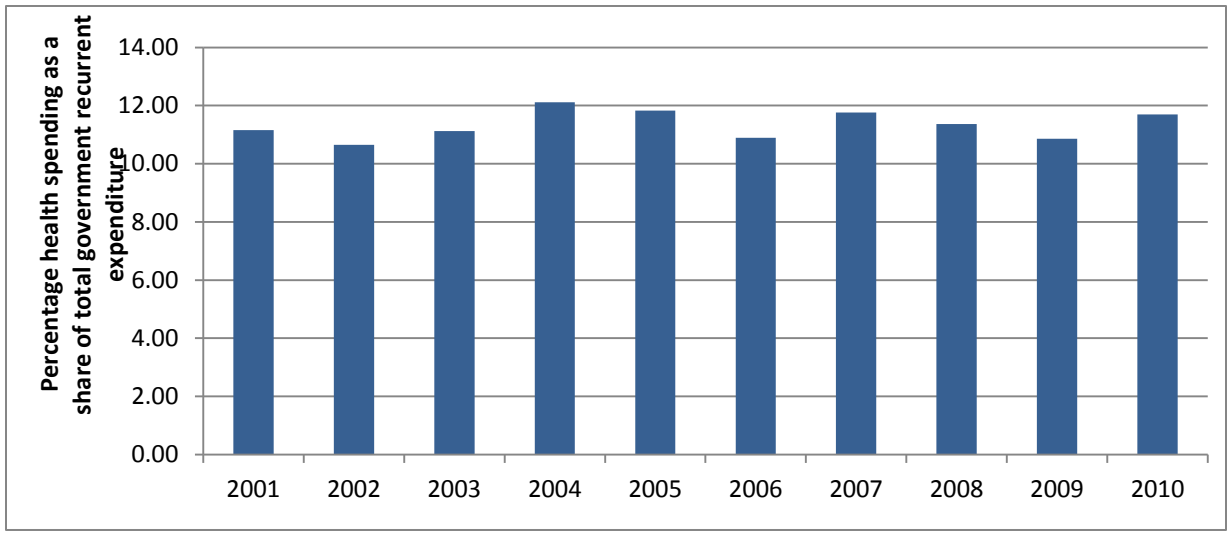
Source: MFEM

Total funding to the MOH increased from VT 943 million in 2001 to VT 1,596 million in the 2011 budget, a 69 per cent increase (VT 1,308 million, a 38 per cent increase at constant prices). However, the share of the government recurrent budget and GDP does not reflect increased resource allocation to health ahead of other sectors.

Government expenditure on health as a percentage of total government spending has varied from a low of 10.65 per cent in 2002 to its highest share at 12.12 per cent in 2004. In 2007 the share of government spending on health was 11.76 per cent and reduced during 2008 and 2009 (11.37 per cent and 10.85 per cent respectively) but increasing to 11.69 per cent in 2010. 2011 budget levels are again forecast to show a reduction in health share.

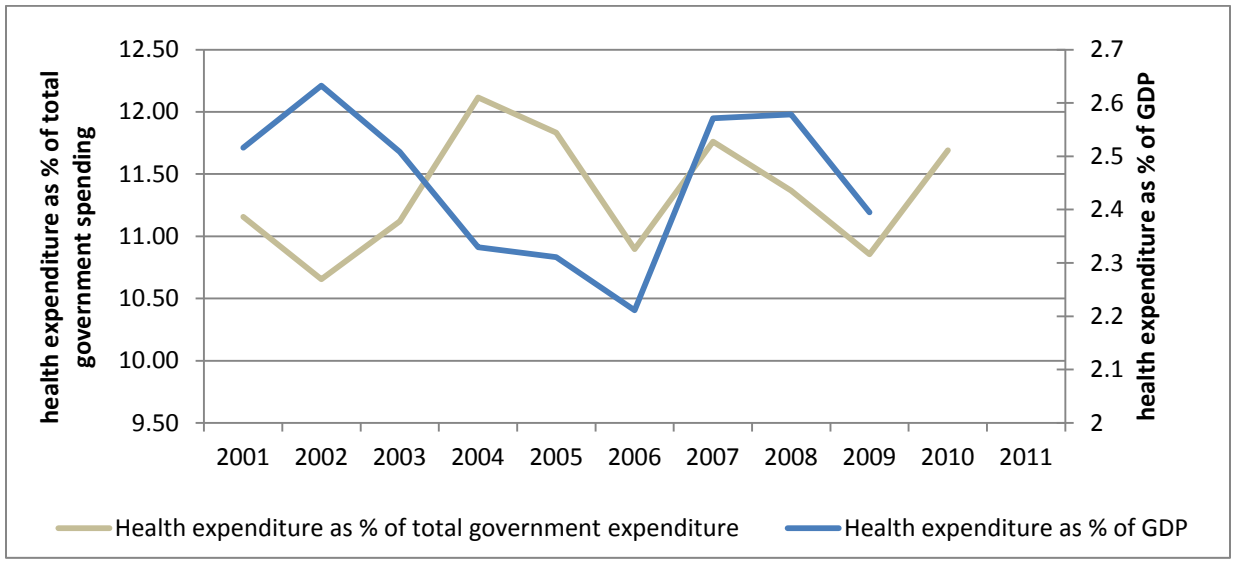
As a share of GDP, government recurrent health spending varies from its lowest at 2.21 per cent in 2006 to its peak in 2008 at 2.58 per cent. At constant prices, government spending on health per capita has increased from VT 4,826 to VT 5,993 a real increase of 24 per cent, showing that growth in health spending per capita is slower than the growth in population. This is reflected in figure 3 by the narrowing of the gap between the trend lines for government health expenditure and that for health expenditure per capita.

Figure 4: Percentage of health spending share to total government recurrent expenditure from 2000 to 2010



Source: MFEM

Figure 5: Trend in government health expenditures 2000 – 2010 as share of total government spending and GDP



Source: MFEM

Table 5 below identifies the data trends for government budget allocations to the health sector between 2001 and 2010 reflecting current prices and adjustments for constant prices using the GOV Consumer Price Index.

Table 5: Trends in government budget allocations to the health sector 2000 - 2010

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Government nominal health expenditure (VT million)	943.0	956.0	960.5	947.4	992.9	1070.8	1390.0	1550.6	1509.5	1750.5
Government health expenditure at constant prices (VT million)	943.0	948.6	939.9	907.5	951.1	974.4	1204.7	1282.8	1237.8	1435.0
Government Health Expenditure as a % of GDP	2.51%	2.63%	2.51%	2.33%	2.31%	2.21%	2.57%	2.58%	2.40%	N/A
Per capita expenditures on health in VT nominal rates	4826	4800	4702	4535	4647	4900	6218	6780	6450	7310
Per capita expenditures on health in VT (constant rates 2006=100)	4826	4748	4601	4344	4451	4459	5389	5609	5288	5993
Total government expenditures at current prices (VT million)	8452.5	9001.2	8638.0	7819.3	8391.36	9827.6	11818.6	13641.5	13906.2	14972.2
Total government public expenditures at constant prices (2006=100) (VT million)	**8452.5**	**8903.4**	**8452.3**	**7490.1**	**8038.0**	**8943.1**	**10242.7**	**11285.2**	**11400.6**	**12274.5**

Source: MFEM

2.1.2. HEALTH SPENDING BY ADMINISTRATIVE LEVEL

The share of total health expenditure for public health and health service delivery at hospital and community levels have declined while spending at the central policy and administrative levels have increased as a share of the total between 2006 and 2010. The share of spending for cabinet, central level policy and administration (including Southern and Northern Healthcare Directorates, service delivery at hospitals and community health centres, government public health activities and medical supplies and pharmaceuticals is shown in Table 6 below.

Table 6: Government health spending by administrative level

	2006 Vatu Mill	%	2007 Vatu Mill	%	2008 Vatu Mill	%	2009 Vatu Mill	%	2010 Vatu Mill	%
Cabinet Operations	31.0	*2.9*	31.6	*2.3*	42.8	*2.8*	42.6	*2.8*	46.2	*2.6*
Central level (incl. South and North Directors)	137.6	*12.8*	197.2	*14.2*	322.7	*20.8*	303.5	*20.1*	444.9	*25.4*
Hospital Services	510.9	*47.7*	673.9	*48.5*	695.1	*44.8*	680.3	*45.1*	764.9	*43.7*
Community Health	231.3	*21.6*	308.6	*22.2*	307.9	*19.9*	311.3	*20.6*	316.2	*18.1*
Public Health	50.8	*4.7*	65.4	*4.7*	67.7	*4.4*	59.9	*4.0*	53.5	*3.1*
Medical Supplies Stock	109.3	*10.2*	113.3	*8.2*	114.4	*7.4*	112.0	*7.4*	124.8	*7.1*
Total health recurrent expenditure	**1,070.9**	***100.0***	**1,390.0**	***100.0***	**1,550.6**	***100.0***	**1,509.6**	***100.0***	**1,750.5**	***100.0***

Source: MFEM

The major increase in expenditure at the cabinet level is for salaries and allowances and transportation costs. Salaries and payroll allowances together make up over 75 per cent of the cabinet budget. Salary allowances have become more significant as a source of remuneration during this period. While permanent salaries have increased by 24 per cent between 2006 and 2010, the growth in salary allowances during the same period has reached increases of 72 per cent.

Table 7: MOH cabinet spending between 2006 and 2010

	2006		2007		2007		2009		2010	
	VT	%	VT	%	VT	%	VT	%	VT	%
Permanent salaries	16,672,606	*53.73*	16,863,013	*53.41*	21,658,337	*50.54*	22,847,353	*53.60*	20,667,173	*44.73*
Payroll Benefits	8,143,632	*26.24*	9,512,830	*30.13*	18,058,134	*42.14*	12,125,222	*28.45*	13,989,607	*30.28*
Travel and allowances	1,349,653	*4.35*	2,629,723	*8.33*	2,032,573	*4.74*	-41,156	*-0.10*	5,325,138	*11.53*
Vehicle costs	3,180,021	*10.25*	760,827	*2.41*	137,861	*0.32*	4,292,706	*10.07*	2,785,006	*6.03*
Other costs	1,684,252	*5.43*	1,806,455	*5.72*	963,367	*2.25*	3,402,276	*7.98*	3,434,576	*7.43*
Total cabinet spending	**31,030,164**	***100***	**31,572,848**	***100***	**42,850,272**	***100***	**42,626,401**	***100***	**46,201,500**	***100***

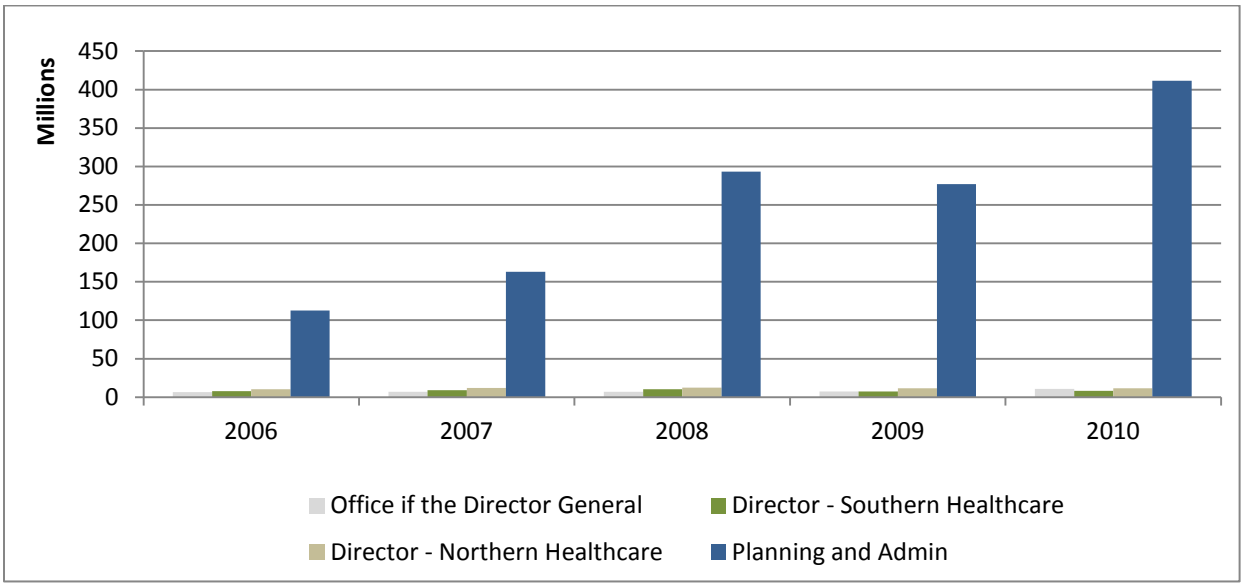
Source: MFEM

Travel and allowances and vehicle costs fluctuate from year to year depending on the number of overseas missions and purchases of additional vehicles.

Table 7 also shows that the largest percentage gain in financial resources is at the corporate level of the MOH. This level is made up of the Office of the Director General, Planning and Administration, and the Directors of Healthcare for the North and the South. A review of the last 5 years expenditure shows that the major movements can be attributed to increases to the Corporate Services or Planning and Administration Division[5].

[5] This has been renamed as Corporate Services during restructuring however has not been amended in the financial reporting system.

Figure 6: Corporate costs expenditure trend from 2006 to 2010



This Corporate Service cost centre is used to capture large items of exceptional expenditure[6] and MOH government development costs included as New Project Proposals (NPP). The use of this recording system is to control such expenditure centrally, however it should be noted that the expenses are not necessarily incurred for the central level and could be for health delivery services at hospital or community level. A review of the major job codes reveals that this cost centre is used to fund the subsistence and travel costs of medical students studying in Cuba, specialist doctor visits from abroad, post basic midwife and nurse practitioner payments, the Vanuatu College of Nurse Education (VCNE), building services for the MOH, DG office support services and others. The financial services office is also recorded in this cost centre and further investigation into the high costs identifies that this job code is also used to record exceptional expenditure that could be allocated to the user department. For example, electricity expenses of VT 21M were attributed to financial services in 2009. The biggest growth of costs attributed as corporate services include the cost of termination payments to those seeking early retirement and expenditure of the VCNE. Increased termination payments is a central government initiative whereby those agreeing to take early retirement from government service receive payments of 2 months salary for each year of government service as an incentive to reduce the size of government. In the case of the MOH termination payments are substantial with the highest levels recorded in 2008 and 2010.

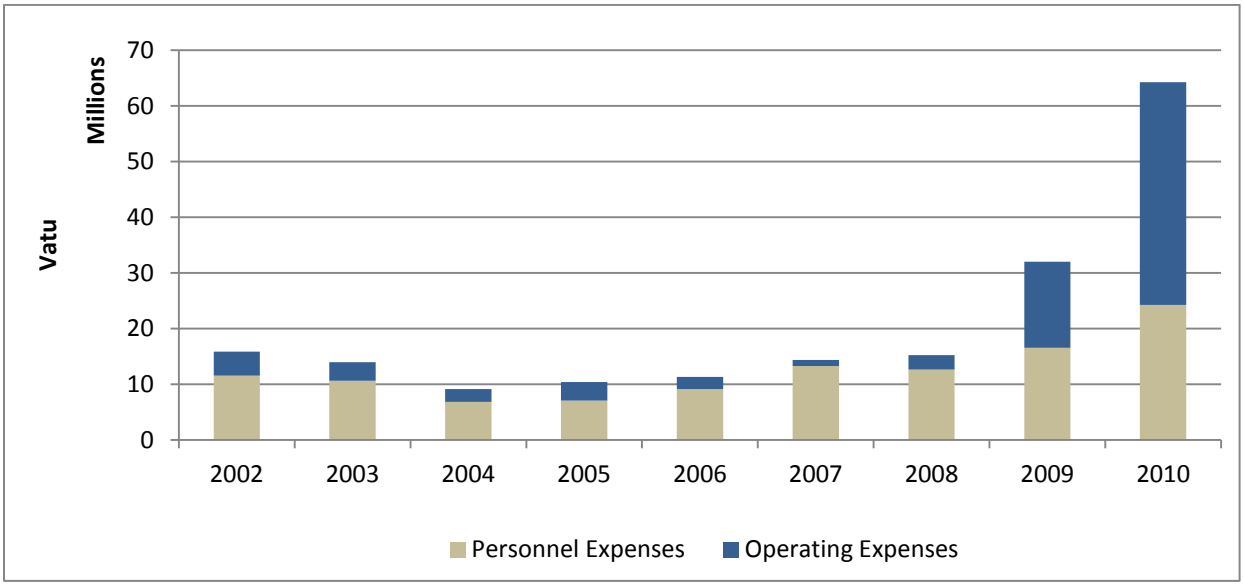
Table 8: Termination allowances paid between 2006 and 2010

	2006 (VT mill)	2007 (VT mill)	2008 (VT mill)	2009 (VT mill)	2010 (VT mill)
Termination payments	16.64	29.63	115.91	60.61	188.83

[6] This includes several high cost items such as 'severance pay", medical supplies for CMS and the Government contribution to the VCNE.

There has been considerable growth in expenditure relating to the VCNE, both in personnel costs and in operating costs. While operating costs will include exceptional costs relating to rebuilding the facility, the increase in personnel costs requires further explanation. The increases in costs are not matched by substantial increases in student enrolments. The latest enrolment figures show 24 enrolments in 2008, and 30 and 32 in 2009 and 2010 respectively.

Figure 7: Vanuatu College of Nurse Education 2002 to 2010



2.1.3. HEALTH SPENDING BY ECONOMIC GROUP

Between 2006 and 2010 salaries and allowances represented about 62.5 per cent of the share of total expenditure (table 9), however this reduced to 58.0 per cent in 2010. Operating costs increased from an average of 23-25 per cent of total government health expenditure to 32.1 per cent of spending in 2010. As discussed in the previous section the major cost items in operating costs relate to termination payments for those staff taking retirement, increased costs of VCNE, building costs associated with the MOH and arrears of utility payments from earlier years.

Funding for capital items is captured in the government recurrent budget as an operating cost and has fluctuated between 1.0 per cent of the budget in 2010 to 6.1 per cent in 2006. The MOH does not receive a designated capital allocation but can identify capital requirements within their budget ceiling allocated from the MFEM. A cash accounting system is used in Vanuatu and fixed assets are expensed in the year in which the expenditure occurs. The MOH can also apply for specific priority allocations under a NPP application, which is considered in addition to the general recurrent budget process. Other capital items are financed from external funding agencies.

Table 9: Government health expenditure by economic classification

	Actual expenditure (Million Vatu)									
	2006	**%**	**2007**	**%**	**2008**	**%**	**2009**	**%**	**2010**	**%**
Salaries and Allowances	664.9	*62.1%*	866.5	*62.3%*	936.7	*60.4%*	946.6	*62.7%*	1014.3	*58.0%*
Operating Costs (excl drugs)	252.1	*23.5%*	331.5	*23.8%*	365.6	*23.6%*	379.7	*25.2%*	562.2	*32.1%*
Drugs and medical Supplies	102.5	*9.6%*	111.1	*8.0%*	108.6	*7.0%*	115.1	*7.6%*	120.9	*6.9%*
VAT	25.8	*2.4%*	40.7	*2.9%*	45.4	*2.9%*	35.3	*2.3%*	35.5	*2.0%*
Recurrent expenditure	**1045.3**	***97.6%***	**1349.8**	***97.1%***	**1456.3**	***93.9%***	**1476.7**	***97.8%***	**1732.8**	***99.0%***
Investment - buildings	0.0	*0.0%*	3.5	*0.2%*	0.8	*0.1%*	0.8	*0.1%*	0.8	*0.0%*
Investment - Equipment	11.5	*1.1%*	6.6	*0.5%*	63.9	*4.1%*	12.4	*0.8%*	13.4	*0.8%*
Investment - Vehicles	14.1	*1.3%*	30.1	*2.2%*	29.6	*1.9%*	19.6	*1.3%*	3.3	*0.2%*
Capital expenditure	**25.6**	***2.4%***	**40.2**	***2.9%***	**94.3**	***6.1%***	**32.8**	***2.2%***	**17.5**	***1.0%***
TOTAL	**1070.9**	***100.0%***	**1390.0**	***100.0%***	**1550.6**	***100.0%***	**1509.5**	***100.0%***	**1750.2**	***100.0%***

Source: MFEM

2.1.4. STAFFING AND SALARIES ALLOCATIONS

Expenditure on staff payments has increased by 52.5 per cent from VT 664.9M in 2006 to VT 1014.3M in 2010 but as a proportion of the government health expenditure payment on salaries has declined from 62.1 per cent in 2006 to 58 per cent in 2010. In 2007, salary appropriations were substantially increased as a result of a recommendation for an increase in salaries and wages by the Government Remuneration Tribunal (GRT) after the Appropriation Act for 2006 was passed. The MFEM is responsible for the payment of salaries and wages to the MOH under a centralised payroll and payments system. Approximately 15 per cent of staff payments occur at the central level of the health system and the Northern and Southern health care directorates take an equal share of the remainder. If this data is reorganised to hospital and community services it can be seen that hospital services have been gaining a share of workforce costs at the expense of community services. Table 10 shows that in 2010 hospital workforce costs consumed 59.4 per cent of total health wages compared to 56.7 per cent in 2006, while in 2006 community health payroll expenditure was 27.8 per cent of the total health payroll costs compared to only 25.6 per cent in 2010.

From 2006 to 2009, permanent wages represented approximately 80 per cent of all salary costs however, this has changed for 2010 where basic salaries of permanent staff only account for 73 per cent of total personnel costs. Basic allowances such as family allowances, home island passage allowances and provident fund have remained relatively constant in relation to total personnel costs. This is not the case for

other and special allowances, which have increased in importance as a share of overall personnel expenditure.

Table 10: Distribution of payroll costs between 2006 and 2010

	2006		2007		2008		2009		2010	
	VT M	%	VT M	%	VT M	%	VT M	%	VT M	%
Central level	**103.2**	***15.5***	**132.2**	***15.3***	**115.4**	***12.7***	**138.5**	***14.6***	**151.7**	***15.0***
Hospital Services										
Vila Central Hospital	181.1	*27.2*	246.3	*28.4*	264.1	*29.1*	272.0	*28.7*	308.9	*30.5*
Lenakel Hospital	36.0	*5.4*	50.6	*5.8*	59.0	*6.5*	55.8	*5.9*	57.8	*5.7*
Northern District Hospital	108.3	*16.3*	138.8	*16.0*	143.8	*15.8*	151.7	*16.0*	159.8	*15.8*
Torba Hospital	0.0	*0.0*	0.0	*0.0*	4.2	*0.5*	-0.5	*-0.1*	0.0	*0.0*
Norsup Hospital	34.3	*5.2*	41.9	*4.8*	43.8	*4.8*	44.9	*4.7*	47.6	*4.7*
Lolowai Hospital	17.1	*2.6*	24.0	*2.8*	24.8	*2.7*	28.5	*3.0*	28.9	*2.8*
Sub-total hospital	**376.8**	***56.7***	**501.6**	***57.9***	**539.8**	***59.4***	**552.4**	***58.4***	**603.0**	***59.4***
Community Health Services										
Shefa Community Health	29.5	*4.4*	37.5	*4.3*	39.8	*4.4*	43.0	*4.5*	45.8	*4.5*
Tafea Community Health	18.9	*2.8*	27.4	*3.2*	30.6	*3.4*	28.5	*3.0*	27.7	*2.7*
Torba Community Health	17.1	*2.6*	22.4	*2.6*	23.2	*2.5*	22.9	*2.4*	25.0	*2.5*
Sanma Community Health	36.4	*5.5*	45.3	*5.2*	49.5	*5.4*	48.8	*5.2*	48.4	*4.8*
Penama Community Health	42.0	*0.1*	49.6	*0.1*	54.7	*0.1*	52.4	*0.1*	52.2	*0.1*
Malampa Community Health	40.9	*6.2*	50.6	*5.8*	55.8	*6.1*	59.9	*6.3*	60.4	*6.0*
Sub-total community health	**184.9**	***27.8***	**232.7**	***26.9***	**253.4**	***27.9***	**255.7**	***27.0***	**259.6**	***25.6***
Total	**664.9**	***100.0***	**866.5**	***100.0***	**908.6**	***100.0***	**946.6**	***100.0***	**1014.3**	***100.0***

In addition it can be seen from table 11 below that overtime allowances increased by 350 per cent between 2009 and 2010. Payments to contract and daily rated staff fell during this period presumably influencing the amount of overtime it was necessary to pay to maintain services.

Table 11: Personnel cost trends between 2006 and 2010

	2006		2007		2008		2009		2010	
	VT M	%	VT M	%	VT M	%	VT M	%	VT M	%
Family Allowance	13.1	*2.0*	17.8	*2.1*	17.5	*1.9*	17.8	*1.9*	18.1	*1.8*
Gratuities Allowance	2.4	*0.4*	3.6	*0.4*	5.2	*0.6*	3.9	*0.4*	3.9	*0.4*
Housing Allowance	32.6	*4.9*	63.7	*7.3*	68.4	*7.3*	71.8	*7.6*	75.2	*7.4*
Other Allowance	5.3	*0.8*	9.4	*1.1*	10.8	*1.2*	12.0	*1.3*	23.4	*2.3*
Home Island Passage Allow	0.6	*0.1*	1.0	*0.1*	1.0	*0.1*	1.2	*0.1*	0.9	*0.1*
Staff rentals Allowances	0.5	*0.1*	0.0	*0.0*	0.0	*0.0*	0.0	*0.0*	0.0	*0.0*
Special Allowances	17.9	*2.7*	23.9	*2.8*	35.3	*3.8*	29.1	*3.1*	50.2	*5.0*
Provident Fund	24.2	*3.6*	29.7	*3.4*	31.8	*3.4*	32.9	*3.5*	34.7	*3.4*
Contract Wages	0.0	*0.0*	0.9	*0.1*	0.4	*0.0*	1.2	*0.1*	0.3	*0.0*
Daily Rated Wages	31.9	*4.8*	4.1	*0.5*	4.5	*0.5*	5.4	*0.6*	2.3	*0.2*
Overtime	10.1	*1.5*	13.2	*1.5*	12.8	*1.4*	14.2	*1.5*	63.7	*6.3*
Permanent wages	526.4	*79.2*	699.4	*80.7*	749.0	*80.0*	757.3	*80.0*	741.6	*73.1*
Total	**664.9**	***100.0***	**866.5**	***100.0***	**936.7**	***100.0***	**946.6**	***100.0***	**1014.3**	***100.0***

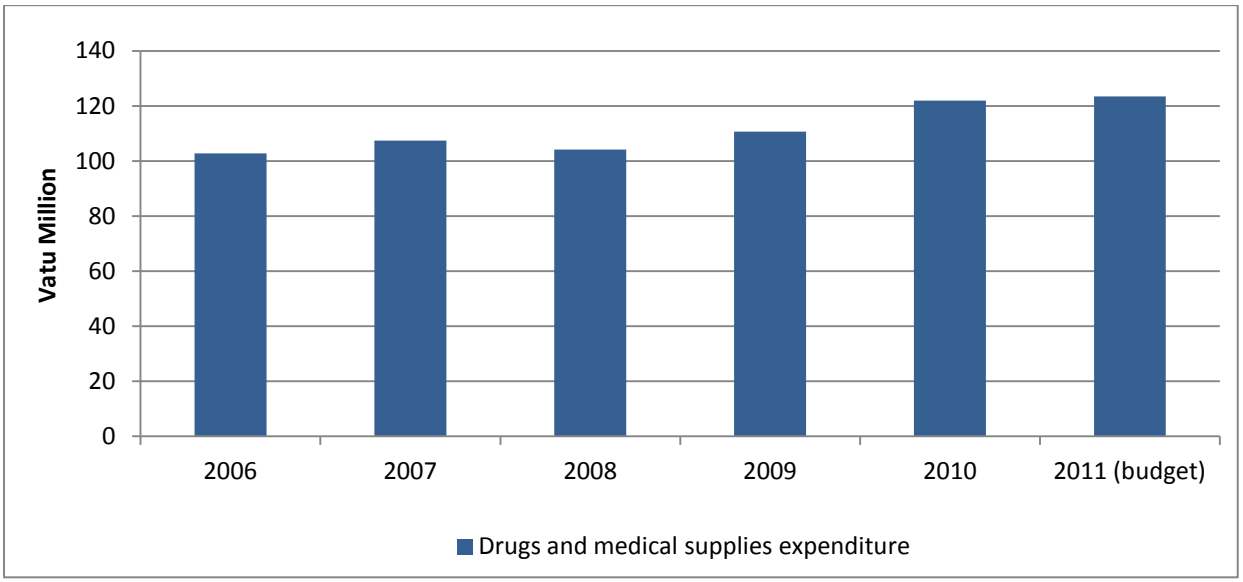
Source: MFEM

Unfortunately, it is not possible to make comparisons of changes in salary costs compared to changes in staffing numbers due to incomplete staffing records. The 2010 Annual Report contains some staffing numbers on a consolidated basis, but does not this for all categories of health staff. Likewise, while some of the provincial health offices have provided staffing numbers others have not.

2.1.5. PHARMACEUTICALS ALLOCATIONS

Government accounts show that spending on pharmaceuticals and other medical supplies has increased by 18.8 per cent from VT 102.7M in 2006 to VT 122.0M in 2010 with 2011 appropriations of VT 123.5M. However, there are additional sources of pharmaceuticals to the MOH that are not captured in the MOH financial statements. The Japanese government is currently supplying pharmaceuticals to Vanuatu under a medium term agreement and from 2008 additional funds have been provided from MFEM to meet payments of unpaid invoices. In 2010 this amounted to VT103M financial support from MFEM.

Figure 8: MOH spending on pharmaceuticals and other medical supplies 2006 to 2010[7]



Source: MFEM

The government allocation to MOH for pharmaceuticals is not separately identified in the accounts and is grouped together with other medical supplies procured by Central Medical Stores (CMS). While exact analysis of expenditure is not currently available, budget estimates from CMS indicate the breakdown for 2011 is as shown in the table below, indicating that the MOH budget for pharmaceuticals is under-budgeted compared to actual costs. It is worth noting that whilst the CMS procures, holds and distributes medical supplies as well as drugs that this budget line includes both. However, despite the analysis in Table 12 providing some details, it should be understood that these medical supplies are made up of essential items

[7] This represents MOH spending only. In 2009 and 2010 MFEM settled payments for emergency pharmaceutical supplies owing to failure to procure from Japan grant during this period.

related to the medication of patients (eg: catheters, drips, canulae, surgical gloves, etc.) and their diagnosis (eg: pathology reagents and X-Ray film).

Table 12: Estimated budget allocations for pharmaceuticals and other medical supplies

Expense description	Estimated allocation	% allocation
Pharmaceuticals	60 million vatu	48.7%
Non-pharmaceuticals	35 million vatu	28.3%
X-Ray supplies	2.5 million vatu	2.0%
Dental supplies	5 million vatu	4.0%
Laboratory supplies	12.5 million vatu	10.1%
Vaccines	8.5 million vatu	6.9%
Total budget (2011)	**123.5 million vatu**	**100.0%**

Source CMS

The MOH has become increasingly dependent on pharmaceutical donations from external development agencies. Since 2008 the Japanese government has made an annual allocation of JPY 100M (VT 105M) available to the MOH for pharmaceutical supplies in the form of a non-project grant. This amount exceeds the government allocation for drugs by 175 per cent. The procurement of these supplies is managed by the Japanese government and Vanuatu receives the drugs as purchased goods. In 2008 the grant was fully utilised, however, in subsequent years the full allocation has not been used and the funds remain available to the MOH for future purchases.

Table 13: Analysis of pharmaceutical allocation and utilisation of Japanese Grant Funds

Year	Allocation Brought forward	Annual Allocation	Value of goods received	Allocation to be carried into future years
2008	-	VT 105M	VT 105M	-
2009	-	VT 105M	VT 80M	VT 25M
2010	VT 25M	VT 105M	-	VT 130M
2011	VT 130M	-	VT 60M	VT 70M
2012	VT 70M			

The timing of receipts of pharmaceuticals, and in particular, the non-receipt of supplies in 2010 has resulted in major stock-out problems which are still having an impact on MOH resources in the later part of 2011. The MOH currently has an outstanding procurement order with the Japanese government, which is not due to be received until the end of the first quarter of 2012, and so the MOH is seeking additional funds from its development partners and the GOV as a supplementary allocation in order to make emergency purchases of essential drugs currently not in stock. Due to the geographically dispersed nature of the country, plus the

added problem of unpredictable supply channels, the cost of drug and supply distribution also varies. Generally, non-urgent supplies are distributed by use of the inter-island ship network, but if supplies are needed more urgently then distribution by air is required. This can substantially add to the cost of pharmaceutical supply.

2.1.6. FACILITY COSTS AND CAPITAL SPENDING

In 2004 the MOH adopted the role delineation model as a guide for the number and type of facility and their distribution. Existing facilities were designated as hospital, health centre, dispensary or aid post depending on the size of the population served, travel time and distance from population centre to facility, services provided and skills needed to staff the facility. The role delineation also defines the appropriate building and equipment specifications for the services to be provided at each type of facility. The model was used to prepare a Provincial Asset Development Plan for each province, mapping the locations of current health centres and dispensaries and surveying each facility to determine if the communications, power, transport and medical equipment met model requirements. This informed the preparation of the Provincial Asset Development Plan for 2005-2008, which identified that total investments of VT 93.61M, would be needed across the provinces to upgrade and equip existing health centres, dispensaries and aid posts. This costed plan was intended to be used to inform budget negotiations with the central government and also with development partners. It is not evident from expenditure patterns that this plan has been used for this purpose. The PADP has also not been updated since its initial preparation. The model also requires further development and testing for service delivery at provincial and referral hospitals.

The Ministry intends to prepare a Strategic Fixed Asset Replacement Plan (SFARP), as a way of updating the previous PADP. This SFARP is intended to be used as a basis for negotiations with both the Government and donor partners.

Table 14: PADP building and equipment requirements by province

PADP Program	Torba VT Mill	Sanma VT Mill	Malampa VT Mill	Penama VT Mill	Shefa VT Mill	Tafea VT Mill	Program Total VT Mill
Dispensary upgrading		1.10	1.10	1.10		2.20	**5.50**
Clinic Renovations	2.20	3.30	2.20	1.10		3.30	**12.10**
Staff House Construction	1.10	5.50	2.20		2.20	8.80	**19.80**
Clinic radios and solar installations		3.85	3.30	3.85	1.65		**12.65**
Solar Repairs and Upgrade	0.39	0.39	2.70	1.54	2.70	2.31	**10.03**
Solar Vaccine Fridge Acquisition	0.25	1.00	0.25	0.25	0.50	2.00	**4.25**
Steriliser Acquisition		1.50	3.75	3.00			**8.25**
ATV Acquisition		5.50	3.30	4.40	1.10	2.20	**16.50**

PADP Program	Torba VT Mill	Sanma VT Mill	Malampa VT Mill	Penama VT Mill	Shefa VT Mill	Tafea VT Mill	Program Total VT Mill
Boat and Motor Acquisition		1.95	0.65	0.65		1.30	**4.55**
Provincial totals	**3.94**	**24.09**	**19.45**	**15.89**	**8.15**	**22.11**	**93.63**

The figures below show the total number of beds per population and the ratio of population to health centre at each province in 2010. During the period reviewed there has been some increase in the number of facilities provided at provinces, however actual running costs are not fully captured in the accounts for these facilities due to job codes not being allocated to the new facilities in accordance with earlier practice. Nationwide the current number of hospital beds is 363 representing 1.55 per 1,000 population. While comparisons are problematic, data indicates this is significantly lower than Tonga, which has 3.2 beds per 1,000 people, and also lower than the Solomon Islands, which reported 1.9 beds per 1,000 in 2003[8]. Comparisons across provinces indicates that Sanma has the highest hospital bed per capita ratio[9] while Penama province reports the lowest ratio at only 1.04 beds per 1,000 population.

The role delineation model defines an ideal number of people per health centre being 2000-3000 for health centre level 3a for remote communities (remote communities require referral by air) and 2500-5000 for populations where air referral is not required. Only Torba and Malampa are within this standard and with only one health centre the population of Tafea at 32,540 is significantly underserved.

Table 15: Province health facility coverage

Province	Pop (2009)	Hosp bed	HC	Dispensaries	Bed/1000	Pop per HC	Pop per Disp
Malampa	36,724	55	9	19	1.50	4,080	1933
Penama	30,819	32	6	22	1.04	5,137	1401
Sanma	45,860	104	6	22	2.27	7,643	2085
Shefa	78,721	128	4	19	1.63	19,680	4143
Tafea	32,540	44	1	12	1.35	32,540	2712
Torba	9,359		3	7	0.00	3,120	1337
Average	**234,023**	**363**	**29**	**101**	**1.55**	**8,070**	**2317**

Source: MOH

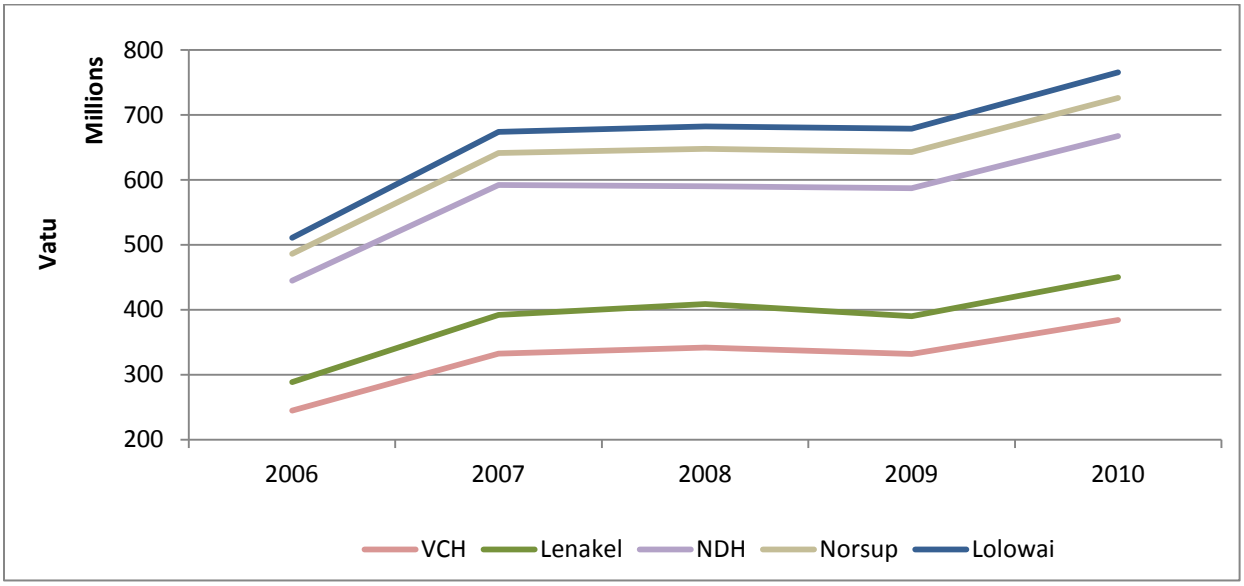
The figure below identifies that government expenditure at hospitals has remained fairly constant between 2007 and 2009 but in all cases increased in 2010. In the case of VCH personnel expenses increased by 13.5 per cent between 2009 and 2010 while operating expenses increased by 25.6 per cent for the same

[8] http://www.nationmaster.com/graph/hea_hos_bed_per_1000_peo-beds-per-1-000-people

[9] The population of Sanma and Torba provinces are combined as there are no operational hospital beds in Torba province. However if Torba is excluded then Sanma province has 2.26 hospital beds per 1,000 population.

period. Major increases are for subsistence payments and for utilities including electricity, water and cooking gas. In the case of Lenakel hospital all increases are found in operating expenses, particularly building, vehicle and equipment repairs. NDH has seen personnel expenditure increase by 5 per cent in 2010 and operating costs by 26 per cent. Personnel expenditure at Norsup hospital increased by 6 per cent, chiefly in the payment of special allowances, and at Lolowai hospital expenditure on local accommodation and subsistence allowances and building repairs account for increases.

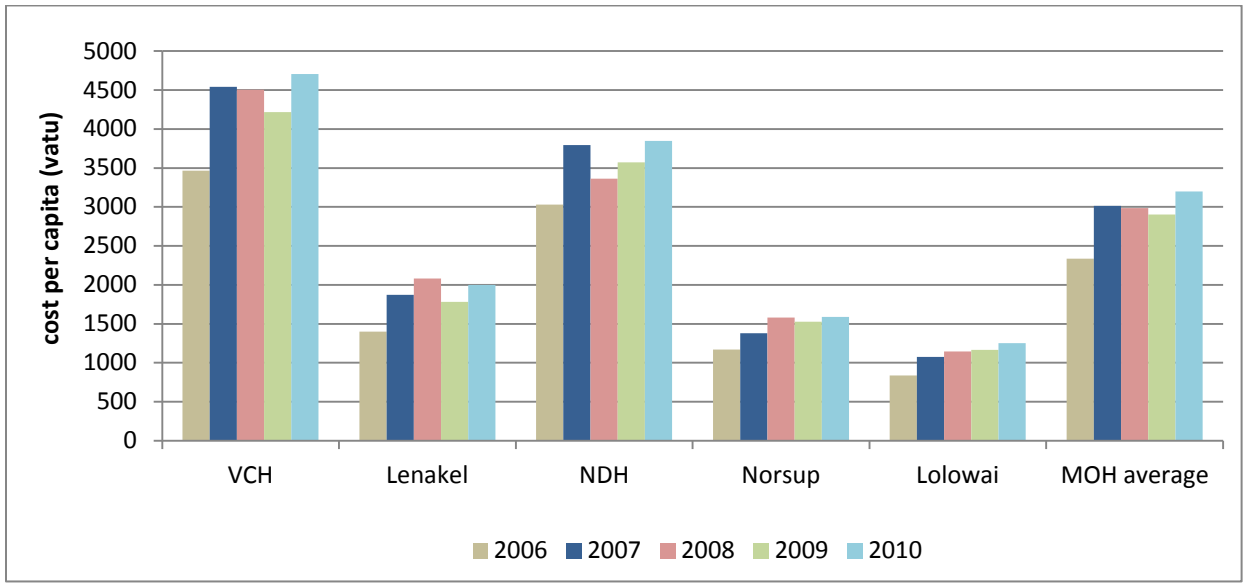
Figure 9: Hospital expenditure trends 2006-2010



Hospital costs per capita reveal that higher cost per capita are found in those areas where referral hospitals are located, which is expected since they also serve other province populations for referrals to tertiary care. In the case of the provincial hospitals, the cost per capita is highest at Lenakel hospital in Tafea province. However, as there is only one health centre in the province it is likely that the hospital also acts as a primary service provider in addition to providing provincial hospital function. The lowest provincial hospital cost per capita is found at Lolowai hospital, which also has the lowest ratio of hospital beds per capita.

It is worth noting that the two referral hospitals receive referred cases that are essentially secondary care in nature. This is due to the very limited capacity of some other hospitals in Vanuatu. In essence this means that the catchment area for hospitals is far larger than just the immediately surrounding towns – it essential stretched to the whole country.

Figure 10: Hospital costs per capita



If expenditure on community health services is tracked from 2002 to 2010 (figure 11 below) it can be seen that Malampa province has experienced the largest increase in spending over time with continuous increases from 2005. Shefa and Torba provinces have also increased spending in recent years, albeit at a lower level than Malampa, while community health expenditure at Sanma province has remained at the same level from 2008 to 2010. Community health expenditure has actually reduced for Tafea and Penama provinces. Per capita costs for community health services over the same time period and compared for northern and southern health care indicates that there is a considerably higher spend per capita for community health services in the north than in the south.

Figure 11: Expenditure trends in community healthcare 2002-2010

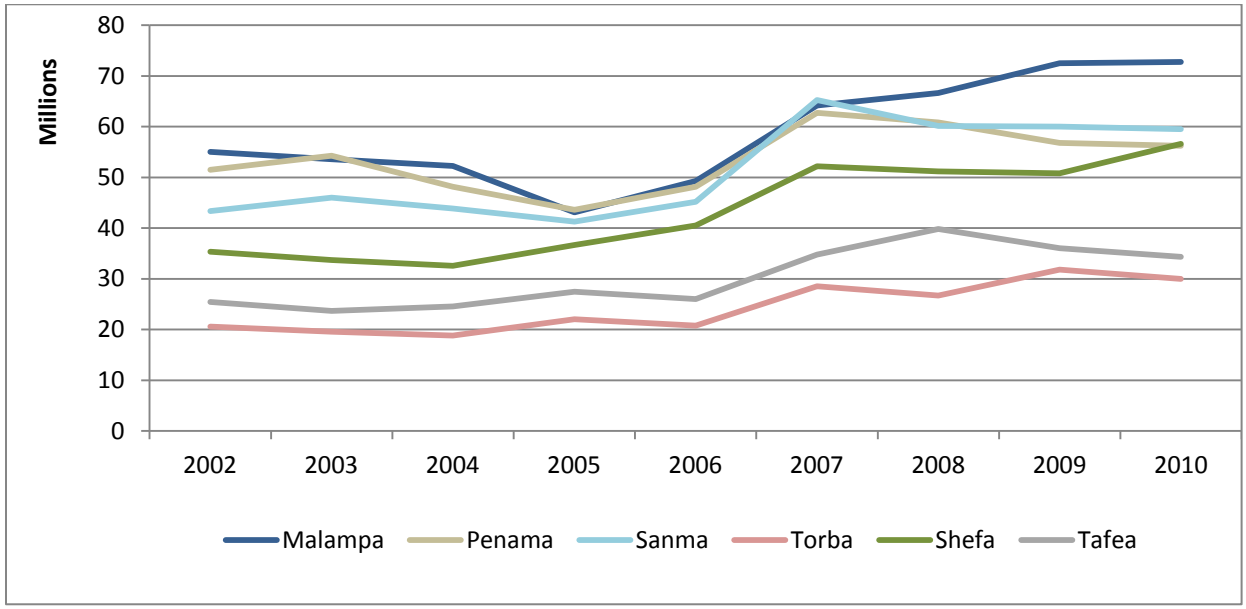
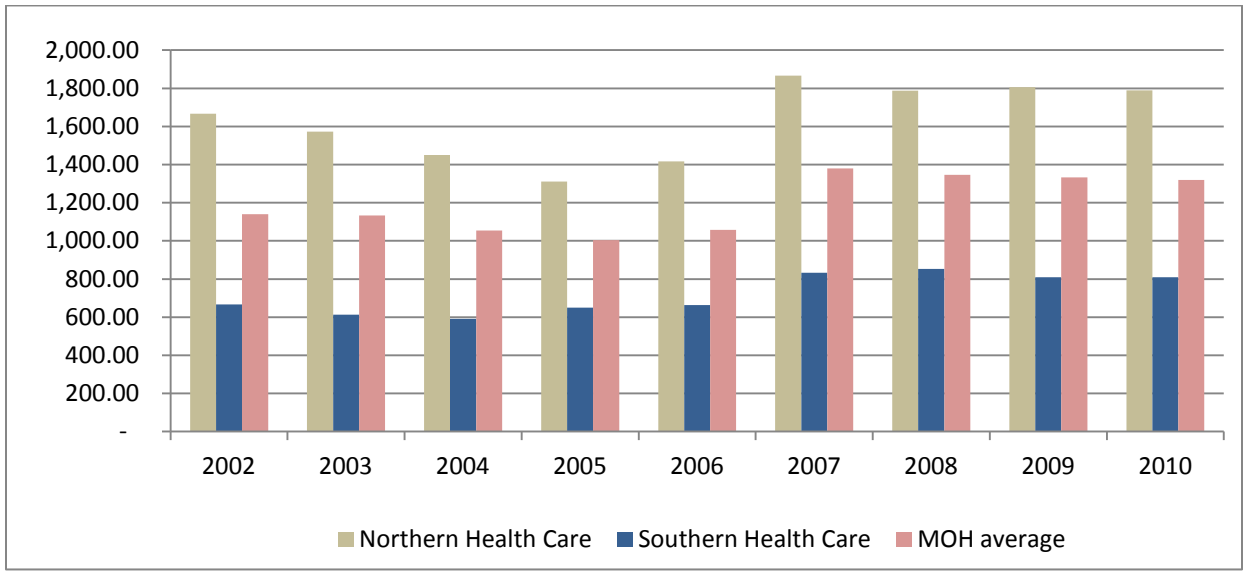


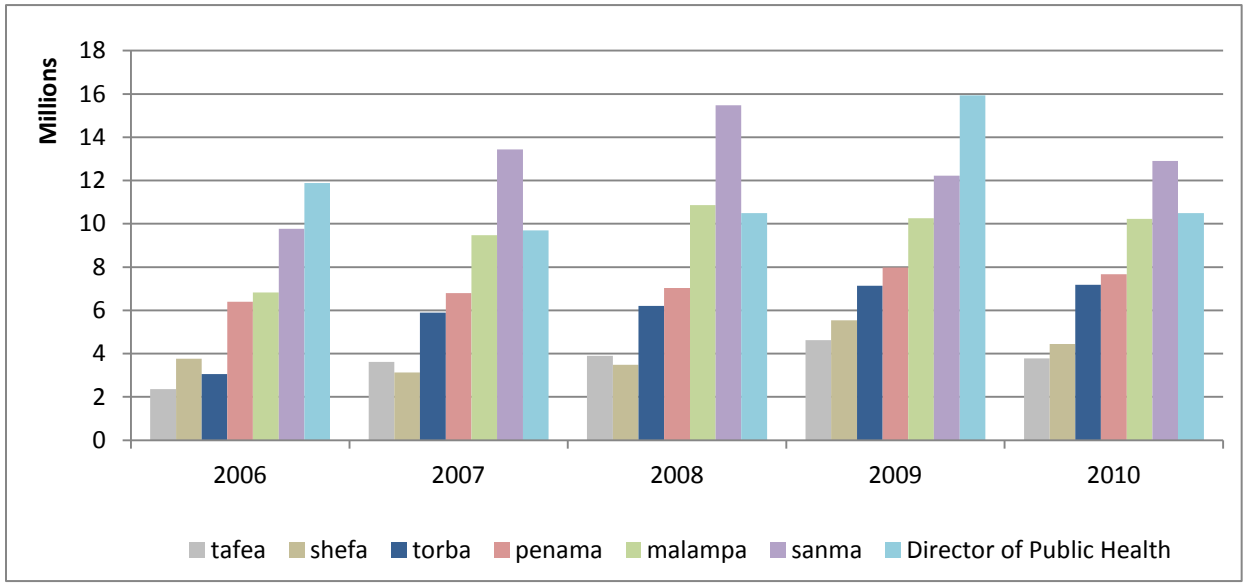
Figure 12: Per capita cost of community health expenditure 2002 - 2010



2.1.7. ALLOCATIONS TO PUBLIC HEALTH PROGRAMS – GOVERNMENT RECURRENT BUDGET

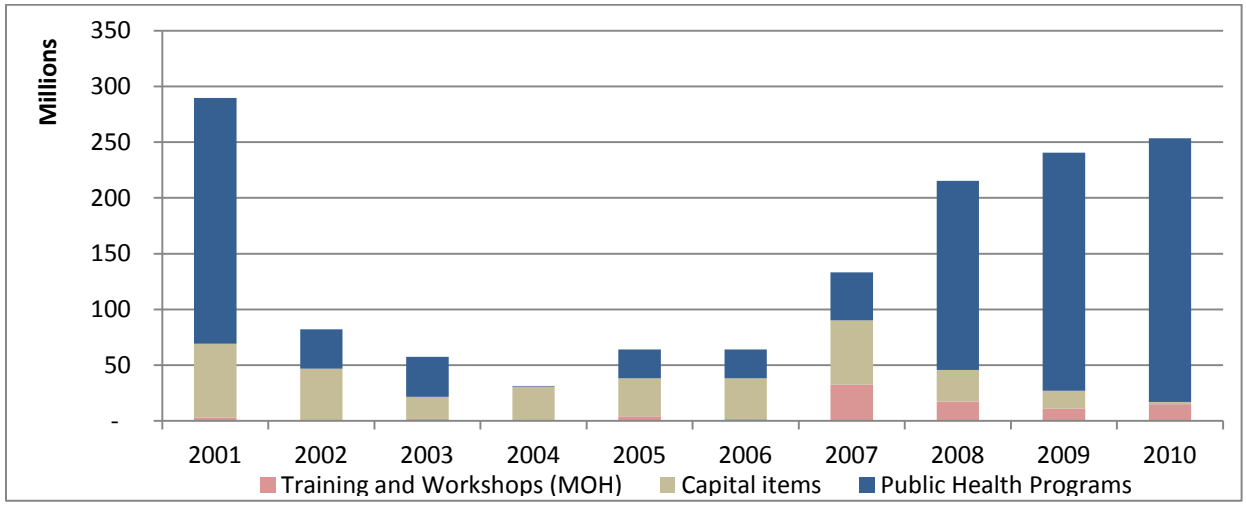
The GOV funds public health programs in a number of ways. Program management and administration of public health programs are funded at the central MOH and at public health offices at provinces. The government also partly funds public health activities and campaigns with additional funds provided by external donors.

Figure 13: Public health program salary and office costs at MOH and provinces



Program activities are implemented using both government and external funds from development partners. Increasingly external funds are focusing on public health programs and training and workshops, and less on capital items compared with earlier years. The data represented in figure 14 below is compiled from data from the MFEM financial information system and GFATM expenditure for 2010. Other external funding, which is managed through the MOH rather than through the government finance system, is not available. In general, there has been a decreasing trend for external funds to be used for capital spending at hospitals and increased spending on MOH training and workshops and supporting the implementation of public health programs. The exceptional expenditure in 2001 is due to capital costs for a dental clinic in Luganville funded by the Government of China. The GOV reports donor support of VT 224.6 million processed through the government finance system in 2010. In addition, Global Fund support to the MOH in 2010 added a further VT 29 million.

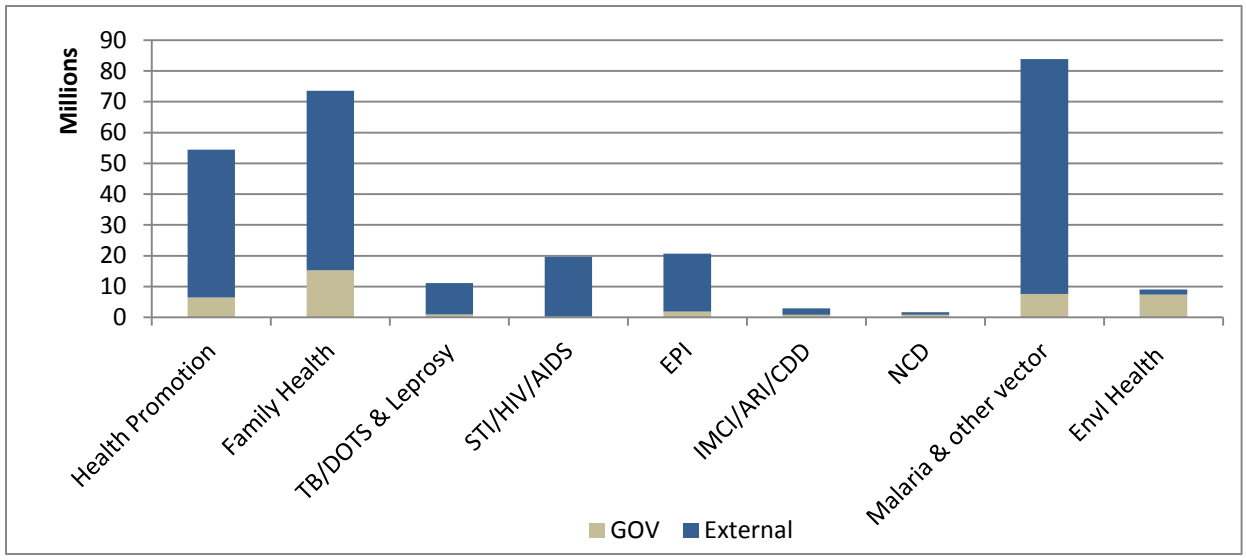
Figure 14: Trends in external development partner funding 2001-2010



Source: MFEM and GFATM

The public health programs attracting most funding in 2010 are malaria and other vector borne diseases, family health and health promotion with the smallest allocation from both government and external sources being for non-communicable diseases. Combined funding is shown in figure 15 below.

Figure 15: Allocations to public health programs in 2010 (GOV and external)



Source: MFEM

Management of external funding through the government channels occurs in a number of ways. Ideally, grant financed projects are managed through the GOV Development Fund financial management system through the MFEM. Alternatively, grant financed projects are managed outside the development fund through separate project accounts held by line managers. In the case of Global Fund contributions the funds are managed through the Vanuatu Country Coordinating Mechanism and the MOH. In addition donors can manage their funds and make purchases directly. An example of this is found in the purchase of drugs and medical supplies by JICA and provided to the MOH as goods in kind. Other examples of aid in kind include technical assistance, which remains outside of the GOV's fiscal reporting. The latest Public Expenditure and Financial Assessment (PEFA) estimated that less than 50 per cent of total donor support to Vanuatu currently use GOV procedures and it is not known how much of external support to health is managed in this way.

AusAID is currently the largest donor to the Vanuatu health sector and is currently providing an initial four-year commitment of $17.4 million over 2010-11 to 2013-2014. AusAID along with other signatories to the Joint Partnership Agreement provide their contributions on-budget and on-disbursement, and are aligned with Government of Vanuatu policy and plans. AusAID is currently supporting malaria ear-marked funding (through Fund 4), Medical Specialists (AusAID), VHW (Fund 4), HIV/STI (AusAID), Cervical Cancer Screening (Fund 4) and technical assistance (Fund 4 and AusAID). Japan is a health partner member and is providing approximately VT 105M as an annual grant for pharmaceuticals and medical equipment provided as goods in kind. Japan also provides five volunteers and support to cold chain supply through Japanese Pacific Immunisation Programme Strengthening (JPIPS).
The GFATM provides grants managed through SPC. GFATM grant management is through its own systems and reporting requirements and GFATM provides large grants for TB, HIV and Malaria. WHO does not provide direct funding except for small grants, however does provide technical assistance through a primary care specialist and two malaria experts. WHO is also working in disaster preparedness, UNFPA

provides US$802,883 annually for policy support, provincial training and scholarships to Fiji School of medicine and is represented by UNICEF in country. UNICEF has a focus on EPI, maternal care, nutrition, IMCI, water sanitation and hygiene.

Medical personnel are provided by Cuba and China and both Peace Corps and VSO are providing volunteers to the sector (11 and 10 respectively).

2.1.8. USER FEES IN PUBLIC HEALTH FACILITIES

There are three types of user fees charged in the health sector. Inpatient fees are charged in public hospitals for hospital accommodation, surgical and other diagnostic fees. The process for managing these fees is identified in the Public Finance and Economic Management Act (PFEMA) of 1998 and there is a requirement by law for fees to be deposited to the Treasury. These inpatient fees are included in the government budget as revenue and are monitored through the GOV financial management system.

A second stream of income from public hospitals is that from outpatient fees. Outpatient fees are not covered by the PFEMA legislation, but rather are managed as 'Patient Care Funds' spent at the discretion of hospital management and a hospital committee advises management on the use of income raised in this way. There is no requirement to formally report to the MFEM or MOH on income and expenditure although financial statements have recently been issued to the MOH from the VCH Patient Care Fund Trust.

The third type of fees for service charged in the sector are charges to patients of health centres and dispensaries under the Community Health Act. The Act allows fees to be retained at the local level under the responsibility of a locally appointed committee and used for maintenance and other facility expenses. The MOH Provincial Manager (or designated deputy) is a member of the committee. There is no requirement to provide financial statements to the MOH or MFEM and revenues and costs therefore are outside of the formal budget reporting system.

Official hospital inpatient fees in 2010 of VT 15.6M represented only 2 per cent of government expenditure for public hospitals (VT 764.9M) and therefore are not a significant form of cost recovery. The MFEM also reports longstanding debtors associated with fee income and at the end of 2010 there were debts of VT 0.65M that had been outstanding between 91-180 days suggesting either debt management could be improved or these were unlikely to be recovered due to inability of the patient to provide payment.

2.2. BUDGET EXECUTION

This section reviews whether the spending units succeed in executing the budget they received. In recent years the MOH has exceeded its budget allocation and has been obliged to request additional funds from the government in the form of supplementary allocations or requested emergency funding from external development partners. Supplementary appropriations are requested to provide emergency funding for utilities and pharmaceuticals in order to maintain essential services. Supplementary appropriations granted are listed in the table below for the years from 2001 onwards. The MOH has also applied for a supplementary appropriation for 2011, which is being considered at the time of this report.

Table 16: Government original and supplementary appropriations to the Ministry of Health 2001 – 2010

Year	Original appropriation	Supplementary appropriation	External virement[10]	Final budget	% budget increase	Actual expenditure	% variance exp to budget
2001	918,528,000	0	- 2,600,000	915,928,000		943,017,731	-2.96%
2002	936,240,000	0	- 150,000	936,090,000	2.20%	958,976,120	-2.44%
2003	961,632,000	0	0	961,632,000	2.73%	960,517,706	0.12%
2004	942,390,840	0	0	942,390,840	-2.00%	947,372,020	-0.53%
2005	981,812,028	9,911,000	- 1,000,000	990,723,028	5.13%	992,883,392	-0.22%
2006	997,954,000	68,008,652	- 2	1,065,962,650	7.59%	1,070,848,579	-0.46%
2007	1,414,855,729	0	0	1,414,855,729	32.73%	1,390,018,789	1.76%
2008	1,472,402,539	88,396,300	- 13,645,476	1,547,153,363	9.35%	1,550,620,842	-0.22%
2009	1,450,109,521	53,228,243	0	1,503,337,764	-2.83%	1,509,466,068	-0.41%
2010	1,736,457,661	0	0	1,736,457,661	15.51%	1,750,451,526	-0.81%
2011	1,596,058,054	0	0	1,596,058,054	-8.09%		

Source: MFEM

Although expenditure to final budget variances are small, adverse variances of up to 7.3 per cent (2006) would be seen if expenditure is compared to the original budget. In 2010 the MOH overspent its budget by VT 14M, however this does not take into account the VT 103M paid by MFEM on its behalf for emergency pharmaceutical purchases.

The Public Finance and Economic Management Act of 1998 allows appropriated amounts to be transferred between activities of an agency if approved by the Director General. A review of such movements provides more detail of those management units within the MOH that are budget gainers at the expense of budget losers. During 2010 virement provided additional allocations of VT 19.4M to VCH, VT 5.0M to Lenakel hospital, VT 2.3M to NDH and VT 2.0M to Lolowai hospital funded from reductions in central corporate budgets of VT 15.0M and VT 1.5M from the Southern Healthcare Directorate and VT 6.6M from the non-operational Torba hospital and VT 2.7M from Norsup hospital. At the community healthcare level, transfers were made from Shefa and Tafea provinces representing transfers from community health services to hospital services and while Torba hospital contributed VT6.6M of budget Torba provincial services only gained VT 2.0M demonstrating that budget virements were in favour of hospital services at the loss to community health service allocations.

There are some financial management explanations behind the need to make these budget changes during the year. Budget preparation is based on previous year's budgets rather than expenditure, which perpetuate previous errors in budgeting and over and under allocations. More focused planning and

[10] It should be noted that the past practise of making virements between ministries is no longer allowed.

budgeting using accurate costing principles should improve this over time. The MOH is carrying out some costing work of the VCH to establish the true running costs and this will inform future budget allocations.

Table 17: Budget virement during 2010

		2010	
Cost centre		**VT Increase**	**VT Decrease**
MHBB	**Corporate Services**		
61VA	Planning and Admin		15,000,000
MHCA	**Hospital Services**		
61RA	Director - Southern Health Care		1,500,000
61RB	Vila Central Hospital	19,362,459	
61RG	Lenakel Hospital	5,000,000	
61SB	Northern District Hospital	2,267,218	
61SD	Torba Hospital		6,600,000
61SF	Norsup Hospital		2,667,218
61SG	Lolowai Hospital	2,000,000	
MHCB	**Community Health Services**		
61RH	CH Shefa Province		1,500,000
61RI	CH Tafea Province		3,362,459
61SH	CH Torba Province	2,000,000	
Total		**30,629,677**	**30,629,677**

Source: MFEM

There are also trends in budget allocation and budget virement. Prior to 2007 salary budgets were over-allocated with surpluses later transferred to operating costs. This was rectified in the 2007 budget preparation with all surpluses stripped out and virements made from operating costs to cover payroll shortfalls. In 2008 and 2009, most of the virements were again from payroll to operations. There had been a number of vacancies budgeted for in 2008 to 2009, leaving little budget for operations. These budgeted vacancies were not filled creating payroll savings and the incentive to vire from payroll to operations. 2009 saw an increase in the virement total from VT 27M in 2008 to VT 57M. This had decreased last year to VT 30.6M. In a move to improve this the MOH recognises that the budget for some staff members is represented incorrectly and in some cases does not even reflect their actual place of work and are currently reviewing and correcting these for future budget allocations. Until recently there has been little attention paid by the MOH to payroll management. All government staff are paid by the MFEM via the integrated SmartStream Human Resource Management Information System (HRMIS) module. Line managers are supposed to check payroll listings before the payroll is run but this has not been strictly enforced by the MOH.

Budget execution is also affected by other adverse financial management practices including a failure to post pharmaceutical orders to overseas suppliers at the time of ordering and resulting in insufficient funds to meet obligations to suppliers. If used correctly, the SmartStream financial management system would not allow orders to be placed in excess of available funding and would limit the occasions the MOH has to resort to supplementary budget obligations to meet its financial commitments.

Monthly financial reporting has traditionally been weak and regular reports were not prepared for the MOH management highlighting potential budget shortfalls in time for remedial action to be taken in a timely manner. The MoH began, in 2011, to issue statements of financial results (expenditure including commitments year-to-date, against budget year-to-date) to each cost centre manager. In late 2011 this was being backed-up by a first stage of financial management training of all line managers.

2.3. IMPACT OF EXPENDITURES

This section begins with a consideration of the efficiency and effectiveness of public expenditure in the sector through a review of outcome indicators reported in the MOH Annual Report and reports to be prepared under the JPA arrangement. For the purposes of this report, outcomes are defined as the impacts on health and other relevant indicators arising from the delivery of outputs. The JPA review process will measure outcomes performance against agreed targets set by donors and MOH staff aware of prevailing resource constraints and the potential for achievement. The measured outcomes are compared with both international comparisons and also national comparisons are pursued to for inter-provincial comparisons. The efficiency of inputs is described particularly relating to the key health expenditure inputs of medical staff and pharmaceuticals, which together make up much of the health budget. Efficiency in the financial management processes of procurement, resource allocation and accounting is also considered.

Where possible expenditure from government and external sources are considered together in analysis although the data is limited by the inability to classify donor expenditure and user fee expenditure by functional classification due to the way data is collected and reported.

2.3.1. OUTPUTS TO OUTCOMES EFFICIENCY – HEALTH PERFORMANCE INDICATORS

Unfortunately, performance and output health information is incomplete at the MOH and targets relating to these outputs are not specified in either the sector strategy or the annual plan and budget. In addition, the Annual Report 2010 includes narrative on activity implementation progress and some province data but is not comprehensive enough for output to outcome analysis.

2.3.2. VARIATION AMONG PROVINCES FOR KEY EFFICIENCY INDICATORS

Effectiveness and efficiency of public health expenditure are restricted by historical expenditure driving allocations, rather than needs-based or performance-based spending. The per capita costs of health inputs and the average costs of health outputs vary considerably among provinces. There are wide variations between provincial expenditure for wages and operational costs. The highest combined hospital and community health wage costs per capita in 2010 are found in Sanma and Shefa provinces due to the higher staffing levels for the referral hospitals where in both provinces the wage cost per capita is between VT 4500-4550. The other four provinces also demonstrate similarity between salary cost per capita with a range from VT 2,600-2700. For hospital wage costs per capita, there is a considerably wide range from VT 3,925 per capita wages for Shefa reducing to only VT 936 per capita at Penama reflecting the absence of medical staff at Lolowai hospital during 2010. Community health wage per capita should be much more even if the primary health care services are operating efficiently. However, it can be seen that such as Torba Province, where the fixed administrative/overhead costs of the Provincial Health Departments are distorted by the low population denominator, are the highest at VT 2,669 compared with the lowest at Shefa

with community health costs of only VT 582 per capita. It is likely that the referral hospital at Port Vila is also providing some primary care. Operating costs are less uniform with a wider spread reflecting the low population base at Torba and the higher operating costs of the referral hospitals in Shefa and Sanma. Without reliable performance data it is not possible to calculate efficiency indicators.

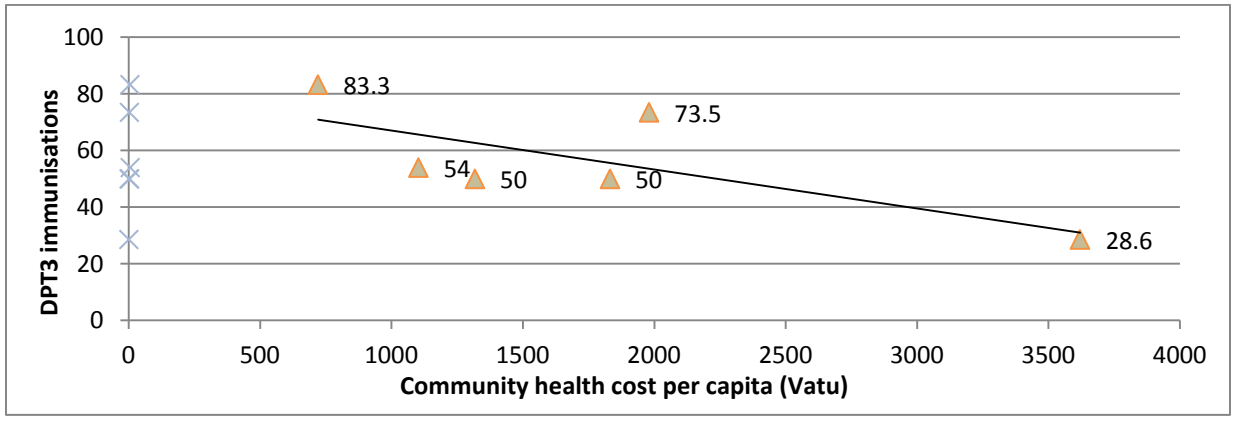
Table 18: Provincial healthcare cost per capita

	Community Health Vatu per capita		Hospital Vatu per capita		Hospital and Community health Vatu per capita	
	Salaries	Operating	Salaries	Operating	Salaries	Operating
Torba	2669	952	0	0	2669	1272
Sanma	1056	262	3485	1255	4541	1517
Malampa	1644	336	1295	312	2940	648
Penama	1694	138	936	336	2630	474
Shefa	582	138	3925	946	4507	1084
Tafea	853	250	1775	248	2628	498

Immunisation coverage and other key indicators are weakly correlated with levels of provincial spending, suggesting scope for more efficient allocations to provinces. The data is from the MFEM financial system and includes administration costs at provincial health offices but excludes distribution data from CMS and any goods and services provided from national public health programs. A wide range of spending compared to the number of immunisations reported in the Multiple Indicator Cluster Survey Report 2007 is recorded with the lowest spend and highest rate of immunisation at Shefa and lowest immunisation rate but highest spend at Torba.

It should be noted that immunisation campaigns are managed and largely funded from the relevant central Public Health Program and just taking the costs of immunisation within provincial community health can be misleading, for example the cost of the vaccines is not included in these figures.

Figure 16: Immunisation coverage and provincial spending



Source: MICS, MFEM

2.3.3. PERSONNEL COSTS AND EFFICIENCY

Staffing statistics are not easily available from the MOH and comparative data had been extracted from the WHO Country Health Information Profile report 2010.

Vanuatu has a low density of physicians and nurses and midwives compared to similar countries in the region. It is reported to have 26 physicians, or 0.11 per 1,000 population, compared with 118 physicians (0.21 per 1,000 population) in the Solomon Islands and 57 (or 0.55 per 1,000 population) in Tonga. The total number of nurses and midwives staff is 380 or 1.63 per 1,000 people compared to 1080 (1.96 per 1,000 pop) in Solomon Islands and 364 (3.54 per 1,000 pop) in Tonga. Without staff distribution data and health output data it is not possible to present meaningful comparisons with other health systems in the region.

2.3.4. PHARMACEUTICALS PROCUREMENT AND DISTRIBUTION EFFICIENCY

Government and external spending on pharmaceuticals has increased, but stock outs of essential drugs persist at facility level.

Pharmaceutical allocations from government funds are managed by Central Medical Stores on behalf of the central MOH. CMS are responsible for the selection, procurement, warehousing and distribution of pharmaceuticals and other medical supplies to six-provincial level stores, which in turn manage distribution to front-line service points. CMS supplies directly to Ambrym and Paama due to transportation problems from Malekula.

At the provincial level, there is a 2 monthly ordering process in place thereby generating 6 orders per year from the provinces for regular supplies. However there is also a large reliance on emergency stock procedures and CMS tend to receive many emergency requests for general usage supplies under stock-out situations. The current process requires that each facility should have 4 months stock on hand, however stock-out occurrences are frequent across the board. Currently there is insufficient information on stock-outs at provincial facilities, however the MOH Annual Report 2010 identifies that during 2010 in addition to the 6 orders from the 5 provincial stores located at the hospitals there were an additional 84 orders from Paama and Ambrym resulting in 114 normal orders. In addition to this there were 389 urgent orders (including 161 from VCH and 134 from NDH) implying that stocks occurred frequently during the year. Urgent orders are distributed using airfreight at a much higher cost than the inter-island ships used for normal orders.

In addition to the government allocations for pharmaceuticals there are additional contributions from external development partners. From 2008, the Japanese government has been providing additional pharmaceutical supplies providing up to VT105M per annum of stock based on purchase requests from the MOH. GFATM provide funds for pharmaceuticals and medical supplies to support malaria, HIV/AIDS and TB related activities. AusAID also provide financing for pharmaceutical supplies for malaria activities, UNFPA provide reproductive health commodities and UNICEF provide vaccines to the EPI program. Vaccines supplied by UNICEF are managed directly by the EPI program and are not distributed by CMS.

Despite external sources of pharmaceutical supply, the amount of financial resources available for pharmaceuticals is always a matter for concern for the DG and is frequently the subject of requests for additional financing from external development partners and supplementary budget appropriations from the

government. During the budget preparation process budget ceilings are set based on the previous year's budget levels and therefore at a level which has continuously failed to be sufficient to meet sector needs. The budget ceiling for 2010 and 2011 has been set at the level of VT 123.5M for both years. It is recommended that attempts should be made to prepare a realistic budget based on service delivery activities, estimated quantities of pharmaceuticals to carry out these activities and costed at current prices. The move towards an integrated planning and budgeting approach should help to achieve this as each health sector manager assists with the identification of their departmental needs.

CMS has recently adopted MSupply to manage its pharmaceutical management. System installation has been completed at provincial hospitals and training for end users is underway with technical support from AusAID. Current price data is also being input and it is expected that this system will greatly enhance the MOH ability to achieve improved pharmaceutical management.

CMS also intends to begin to charge all issues of drugs and medical supplies to the cost centres they are issued to. Budgets will be established for all cost centres and those cost centre managers charged with the responsibility of managing their drug budgets.

2.3.5. PROCUREMENT MANAGEMENT AND DISTRIBUTION EFFICIENCY

The Government Contracts and Tenders Act 1998 requires that all purchases over VT 5M should be competitively tendered through the Tender Board, unless another process is approved by the Tender Board. Within the act there is explicit provision for alternative methods such as two-stage tendering, selective tendering and period contracts for repetitive purchases. The GOV centralised payments system incorporates a commitment control system that does not allow commitments without budgetary provision.

There is very little procurement undertaken by health. The major purchases in health are for pharmaceuticals and medical supplies that are procured centrally by the MOH and distributed to the provinces and health facilities by CMS as discussed in section 2.3.4.above. Procurement is from a number of pre-qualified suppliers and not tendered through the Tender Board. These pharmaceutical procurements have been managed outside of the government financial system and arrears of payments due have not been recognised through the system controls until critical levels have been reached and the MOH has been forced to seek external financial support to cover these arrears. At provincial level most procurement is through local procurement conditions and the LPO system.

2.3.6. FACILITY EFFICIENCY

Data limitations mean that it is not possible to conduct a comprehensive assessment of the technical and allocative efficiency of the health system. The Vanuatu financial systems do not capture facility level budgets and expenditures to establish average and marginal costs of health service provision, which would be useful for technical efficiency comparisons. Some cost information is available but performance data is missing. The average salary and operating costs in 2010 for health centres and dispensaries at each province are shown in the table below providing some information however without corresponding output data efficiency cannot be measured.

Table 19: Average operational costs of health centres and dispensaries in 2010

	Ave HC cost	Ave Dispensary cost
Torba	2,513,235	1,251,151
Sanma	2,630,931	1,411,640
Malampa	3,388,604	1,159,037
Penama	4,383,750	1,134,886
Shefa	5,656,836	1,099,760
Tafea	4,213,667	1,300,175

Source: MFEM

2.3.7. FINANCIAL MANAGEMENT EFFICIENCY

PLANNING AND BUDGETING

Planning and budget preparation processes are undergoing reform in the Vanuatu health sector. Prior to 2010, budget setting was very much a top down exercise managed by MOH management and largely based on historical budgets incrementally adjusted according to parameters issued by the MFEM. A new planning and budget preparation process began its introduction for the 2011 budget cycle with further enhancements for the 2012 budget cycle. The new process is based on providing linkages between planning and budget preparation and increasing delegation to service delivery public health program managers. These managers are responsible for identifying their priority activities and including them in the annual business plans and budgets. For the 2012 planning and budget cycle the MOH Finance Manager introduced Planning Guidelines, a 2012 Business Plan Template, a 2012 Budget Template and a 2012 New Policy Proposal (NPP) Form. A two day workshop introduced these various forms and templates to those managers tasked with preparation. Budget ceilings determined by the MOH, in line with the sector ceiling notified by MFEM, were issued to these managers.[11] The process of involving managers in plan and budget preparation is intended to build ownership for the plans and introduce accountability for the use of financial resources. However, linkages between plans and budgets remain disjointed, as plans are prepared in Annual Business Plan format and based on planned outputs and activities, while the budget plan formats are based on financial inputs, such as fuel, travel, stationery. The budget form provides the overall baseline for each division and details on how much was actually spent on each line item in 2010, they were then asked to make their own allocation to each line item for 2012.

During the preparation of this report the MOH preparation of the 2012 budget was underway and the MOH was facing the challenge of reducing their plans in line with subsequent reductions in the budget ceilings allocated to the MOH. The finance department made broad-brush reductions and informed the health managers of their revised budget ceilings so they in turn could reduce their previous budget calculations. The result of this budget-cutting exercise has effectively increased allocations to VCH, while other service delivery facilities experience cuts. The biggest reduction is at the Corporate Service level where retirement

[11] These budget ceilings were later reduced in line with reductions in total allocation to health. Reductions were notified after the health managers had prepared their first draft of plans and budgets.

benefits have been reduced considerably. The MOH 2012 budget now remains vulnerable to overspending in this area should benefits be required and also for the cost of pharmaceuticals which continues to be budgeted at the same level as previous years despite regular overspends.

The current health sector strategy has not been costed and currently there is no health medium-term expenditure framework (MTEF) linking sector needs with forward estimates guided by a nation-wide MTEF. Without identifying the likely resources available to health or the cost of implementing the strategy in the coming years, resource allocation in line with health priorities is difficult. The MOH is working towards identifying the cost of achieving its health MDGs through application of the Marginal Budgeting for Bottlenecks (MBB) model that identifies additional resources required to implement activities necessary to reach MDG targets and also can be used to inform resource allocation. Information from this model could inform the formation of a costed strategy by providing projections of financial resource required in the sector and matching this with government projections of medium-term financial resource.

The Vanuatu government financial management information system integrates the national budget with most donor resources under one unified budget. However, the government does not have oversight of all available resources in the health sector and as mentioned above, there is not yet a long-term national strategy for funding health system needs and how this should be allocated (absence of MTEF). Estimates of external funding to the health sector is notified by the MOH to MFEM and included in the government budget. The development fund remains separate to the health recurrent budget in the national budget presentation, it can therefore be considered to be on-disbursement but off-budget and not tracked in line with the MOH Annual Plan structure. For example, the 2011 budget book shows the following:

Table 20: Government program budget estimates 2011 – forecast health funding from donors

MHCC	Public Health Services	Cash/Grants	Aid in Kind	Total
07A461	Strengthening VHW & Community Based Health Management	23,634,951	0	23,634,951
08A661	Malaria Project	125,400,000	0	125,400,000
08A861	Strengthening Health Service & Service Delivery	54,859,505	0	54,859,505
11O161	Australian Government Health Sector Support Workforce Capacity	0	172,725,219	172,725,219
11P161	UNFPA Reproductive Health Project	51,897,875	0	51,897,875
11Q161	UNICEF Health Projects	83,173,775	0	83,173,775
11R161	WHO Government Projects	70,000,000	0	70,000,000
Program Total		**408,966,106**	**172,725,219**	**581,691,325**

The identifying account codes are of a different structure to those used for the health recurrent budget and also the Annual Plan code format introduced by the MOH.

PROVINCIAL LEVEL BUDGETS

Funding shortfalls make it difficult for provincial health offices and provincial hospitals to implement their plans. Although in recent years the MFEM has released the budget in full, provincial health managers find that funds received are often far short of the amounts included in their monthly cash plans. The budget process at provincial level is influenced by the different resource streams to the provinces and the planning procedures required for each resource stream

- Salaries and allowances of provincial community health staff are mainly provided from government funds. MFEM prepares these budgets based on staff in post.
- Government budgets for provincial operating costs (excluding drugs and medical supplies supplied by CMS) are based on historical expenditure and determined through negotiation with MOH.
- Internal reallocation within the MOH to cover arrears of payments elsewhere in the sector can leave provincial health budgets with unplanned budget reductions during the fiscal year.
- The budget for drugs and medical supplies distributed by CMS is prepared centrally by the MOH and negotiated with MFEM. The MOH is currently considering delegating this budget to health facility managers.
- Resources distributed to the provinces by Public Health Programs
- Resources provided directly by donors in connection with Public Health Program activities (for example AusAID/SCFA providing funding directly to the provinces to pay for some province-led expenditures of the National Malaria Program, such as per diems and incentives)
- NGO and church support provided directly to some provinces and individual health facilities
- User fees collected at health facilities which is not included in resource allocation at any level but provides the only flexible source of funds for facility managers

ACCOUNTING AND REPORTING

The government Financial Management Information System is operated using SmartStream software. SmartStream has operational modules for general ledger, funds control, accounts payable, accounts receivable, purchasing, human resource management information and payroll and an asset register.

Line ministries have access to the government system through a wide area network that covers all ministry headquarters in Port Vila and a number of provincial offices in Luganville. The roll-out of the integrated financial management system in principle helps by providing online access to budgets, commitments made and remaining balances, but all provinces do yet not have access so progress is unbalanced across the sector. A review of the financial statements produced from the system also indicates there is a need for further training on the use of the MOH budget classification codes as miscoding is quite common in some parts of the budget. The MOH is also revisiting this coding structure and any changes made will need to be communicated to the provincial level and a comprehensive training program implemented. As budget delegation increases and provincial managers become familiar with the financial statements and reports it is likely that they will start to challenge some of these obvious errors, which in turn will lead to corrections and improved quality of financial information.

Recent improves in budgeting, including a simpler more rational aggregate budget based broadly on a programmatic basis should result in improvements both in terms of expenditure coding, financial reporting and analysis in the future.

MULTIPLE ACCOUNTING SYSTEMS

A number of parallel accounting systems persist alongside the government systems. Most of the health partners have moved towards the use of government systems for the management of their external funds. However, other funds continue to be reported outside of the government budget monitoring process, such as those provided by GFATM where the MOH has adopted the GFATM accounting systems, account codes and reporting formats to manage these resources. This puts an additional burden on the MOH financial systems, as these external funds need to be incorporated in sector reports, but cannot be extracted from the government system as part of the health budget,

3. FINDINGS AND RECOMMENDATIONS

3.1. FINDINGS

This section of the report draws together the findings from the focus areas of the previous section; resource allocation and resource disbursement, budget execution and impact of expenditure. A general finding in relation to the preparation of this report is that there is a wealth of financial information available from the government financial system, although this is incomplete for those external sources of funds that are off-budget such as some development partner funds and user fees from facilities. However, the collection of performance output data from facilities is much less accessible and in cases not available, making a full analysis of effectiveness of health expenditure difficult.

3.1.1. PROPORTION ALLOCATED IN LINE WITH STRATEGIC OBJECTIVES

This section reviews the health strategies included in the Planning Long, Action Short with resource allocation implications.

PLAS Strategy - Strengthen the delivery of basic health services to all, in remote, rural and urban areas.

Indicators:

- **Resource allocation to favour community health (away from central hospitals and administration) rebalanced in 2010**
- **Reach of essential health services to remote areas increased between 2009-2012**
- **Immunisation levels increased, supply of essential medications to health facilities maintained**

There have been increased financial resources made available to the health sector in Vanuatu from both government and external sources. Government allocations to health are constant in terms of total government spending and recent years have seen increased resources in line with increases in overall government expenditure. Despite these increases there has been no improvement in resource allocations to rural service delivery. While community health services received 21.6 per cent of the government health budget in 2006, this had fallen to 18.1 per cent in 2010. This may well reduce further in 2012 as the health sector is forced to reduce spending in some areas and early indications are that cuts are being made at facility level with the exception of VCH, which will actually receive a budget increase on recent years. The PAA, PLAS and Health Sector Strategy all identify a Primary Health Care approach as being the most cost-effective approach providing access to sustainable provincial services, however the VCH continues to gain funding while primary care services in the southern provinces are funded at a considerably lower level than those in the north.

The linkages between the sector strategy and resource allocation across the sector are weak. The sector strategy is not costed and it is not known if financial pressure on VCH could be substantially reduced if a primary care approach was scaled up in the south, leaving VCH to focus on providing only referral hospital services. With greater financial analysis, it may be possible to identify what resources could be freed up if a

greater emphasis on primary care is realised. There is no national MTEF available to guide the sector however even in the absence of national budget ceilings a sector multi-year expenditure framework would greatly assist the health sector with annual budget negotiations. The MOH will be able to use this in discussion with their development partners.

It appears that many investment decisions have weak links to the sector strategy. Some activities are selected based on available ear-marked donor funding rather than a continuous process of prioritisation according to available resources. Other weaknesses in investment decisions are also evidenced by NPPs submitted by the MOH having a bias towards hospitals rather than community health services.

There does not appear to be any substantial intention to allocate resources to increase the reach of essential health services to remote areas. The Torba mini-hospital is still not functional and is victim to budget stripping by the MOH to reallocate to operational health facilities under financial pressure. Community health services in Tafea province have the lowest level of financial support in the country.

The supply of medicines to health facilities continues to be a challenge to the MOH and the MOH Annual Report 2010 reports a higher number of emergency distributions to facilities compared with normal planned distributions. A pharmaceutical management system is being introduced and is expected to greatly improve pharmaceutical supply management in the future. In addition the MOH intends to delegate pharmaceutical budgets to hospitals and provincial health offices. It is yet to be seen how this will affect future allocations but the increase in information expected to be available from system implementation will be of great benefit to the ministry. The supply of pharmaceuticals continues to be a major cause of concern to the MOH and is considerably underfunded from the government although there is increasing support from development partners.

PLAS Strategy - Vigorously control and progressively eliminate malaria from Vanuatu

- **Indicator - By 2014, eliminate malaria from TAFEA, stop all deaths and decrease nation-wide incidence to 7/1000 from 23.3/1000 in 2007**

In addition to malaria control being one of the major health strategies in the government development plan it is also a key objective in the health sector strategy. The MOH and its development partners are providing a substantial amount of financial resource to malaria and other vector borne diseases. In 2010 the total allocation from government and its development partner funds was VT 83.9M. The malaria program is currently in receipt of the largest allocation of public health program funds. Malaria is recognised as one of the major health issues in the country and resource allocations indicate that it is seen as a priority for funding. However, there are other health concerns that do not have the same level of resource allocation. For example, non-communicable disease, is recognised as a growing concern in Vanuatu, but combined spending on prevention was only VT 1.6M, or 0.6 per cent of total public health allocation.

PLAS Strategy - Invest in training and supporting the health workforce, particularly nurses to staff rural facilities

- **Indicator - Numbers of nurses trained and engaged increased– staffing shortfalls at rural facilities reduced**

Resource allocations go some way to support this strategy. A considerable amount of budget has been allocated to the upgrading of the VCNE by the MOH. The number of students enrolled has increased from 24 in 2008 to 32 in 2010, however it is not clear whether the nurses trained will be employed in the hospitals or in the community. While the location of nursing staff numbers are not accurately known across the sector, a review of payroll expenditure shows that a higher proportion of the total payroll is spent at hospitals at the expense of community services, which is actually losing as a share indicating that this objective is not being met.

3.1.2. PROPORTION DISBURSED IN LINE WITH ALLOCATIONS

Disbursements to the health sector are generally made in full. The government budget has been disbursed in total in recent years. Indeed, not only has full disbursement occurred, but the MOH has been forced to apply for supplementary allocations to be able to pay outstanding debts incurred over and above the amounts disbursed. Frequently the MOH uses current year disbursement to cover previous year debts. The MFEM has also cleared outstanding payments on behalf of the MOH without disbursement. This was seen in 2010 when MFEM paid VT 103M to pharmaceutical suppliers.

In the case of development funds from partners, amounts are received in the MFEM and released as advances to public health programs to cover activity costs. Unutilised funds are returned to the MFEM on liquidation of expenses.

Inter-sector disbursements may not be made in total to some facilities. It has been common practice for the MOH to make transfers of funds from one budget to another to cover areas of shortfall from slower spending units to faster spending units. Under these circumstances provincial hospitals and community health providers are often deprived of their full allocation.

Figure 6 of this report also shows increasing budget allocations held centrally in the Corporate Service budget unit. This is justified by the Finance Manager as an internal control to make sure the funds are spent as intended. However, in line with other decentralisation initiatives, and in the interest of transparency, an alternative approach would be to allocate and disburse these funds to the managing unit where the costs are incurred, but to improve the financial monitoring in order to monitor the use of these funds.

Financial management reporting in general is greatly lacking. The main government monitoring tool for sector performance is the MOH Annual Report however this does not require financial statements. Monthly finance reports are not prepared for senior management and facility managers are only in receipt of information relating to their own responsibility area if they have access to the computerised financial management system. As part of increased budget delegation, it is recommended that a regular monthly financial reporting culture is established within the MOH and managers provided with training on the interpretation and use of financial information as part of management. As resources are limited and budgets are increasingly delegated there is the potential that increased transparency may lead to competition between facilities for scarce resource allocation, however in time this should improve transparency and contribute to better efficiency as individual good performance standards emerge.

3.1.3. EFFICIENCY, EQUITY AND EFFECTIVENESS OF EXPENDITURE

The efficiency, equity and effectiveness of health expenditure in Vanuatu cannot easily be demonstrated due to the lack of performance data. Where possible, efficiency has been reported in the previous section of the report. However measures of equity are not possible without more detailed information relating to output data from the facilities providing services. There are plans to conduct a Demographic Household Survey for health in Vanuatu and this will greatly enhance the data available and allow more comprehensive assessment. The household income and expenditure survey contains some health information and combined with performance data could provide a source of data for future analysis.

3.2. RECOMMENDATIONS

1. The MOH should improve its medium term financial planning by costing its health sector strategy and in liaison with MFEM develop a medium-term expenditure framework in order to establish a resource framework for financial modelling. However, at the same time it needs to be understood that improvements in management which should, in part, address the overspending and even allow for some redirection of funding to other parts of the MoH, will take time.

2. The health sector strategy should be costed to support potential reprioritisation of funding in support of strategy and policy. The addition of this financial information and analysis should support advocacy for increased allocations to Vanuatu's most pressing health needs as identified through the strategic and local planning and thus ensuring that identified strategic actions are fully financed. There are a number of initiatives underway that should provide evidence to support prioritisation of finances. A costing study of VCH is already underway with the aim of identifying the optimum level of funding this facility should receive. It is also recommended that the same exercise be carried out for provincial hospitals and community health services. It is important for resource planning to establish the real costs of providing quality community health services particularly in respect to variations in geography and human resource distributions**.** The role delineation model and the current work on MBB for MDGs could be potential sources of evidence to support improved financial planning.

3. Introduce health resource allocation indicators into annual sector reporting for government and development partners in order to advocate for better resource allocation. These indicators could include:

i. Share of total government expenditure allocated to health

ii. Share of health sector expenditures directed to provincial and community health (%)

iii. Percentage increases in budget allocations to primary health care from hospitals

iv. Per cent increased allocations to remote and/or poor population

v. Measure of primary health care efficiency: for example, cost per OPD visit,

vi. Measure of hospital care efficiency: for example, cost per occupied bed-day

vii. Share of GOV health expenditures spent on non-personnel costs

4. The quality and frequency of financial reporting in the sector should be a priority for the MOH Finance Section. The MOH should identify which facility managers are not able to access materially accurate, timely and relevant financial information on a regular basis. Training on the use of financial data as a management tool should accompany the increased provision of financial data.[12]

5. The process of delegating budget management to service delivery managers should continue in parallel with increased financial performance monitoring by senior management.

6. One of the major areas of financial concern is the funding of the pharmaceutical budget. The actual budget required to supply the essential drugs should be established to ensure adequate funding from government sources in association with development partners. Continued progress with MSupply installation and regular review of the information from the system will assist with this.

7. Cost benefit analysis of major health investments should be introduced to ensure expected outputs from investments are in line with health strategy.

[12] Financial results (year-to-date) are provided each month to all cost centre managers and to senior managers. Also an Internal Management Reporting process has been approved by the DG for immediate implementation. This provides for all line managers to report on their financial results, every month, to their directors and for the directors to report to the DG.

4. CAPACITY BUILDING NEEDS OF THE HEALTH SECTOR

4.1. MONITORING AND EVALUATION SYSTEM

The general state of monitoring and evaluation within the Vanuatu health sector is improving. Examples of recent improvements are:

- The Joint Partnership Agreement (JPA) process involves regular participative data collection using agreed indicators, with discussion of reasons for the observed results. Under this arrangement the MOH provides monthly financial statements to partners.
- The terms of the JPA brings external financing on-budget through the GOV financial management and reporting system improving completeness of information and hence improved monitoring.
- The MOH compiles and distributes an Annual Report for the GOV under the Planning Long Actions Short process, with discussion of findings and recommendations for improvement in the following year.
- The MOH is implementing a pharmaceutical management information system that will enable better monitoring of cost and usage of pharmaceutical leading to better budgeting.
- The planning and budgeting process being established by the MOH provides identified objectives and indicators for local level implementation.
- The JPA should greatly improve the collection and availability of information from the country's many donors.
- Revision of budget and account code classification has commenced.
- National Health Account preparation has been initiated with draft reports completed for 2005 and 2007.

Yet there is still much missing, and its lack is a significant handicap to decision-makers across the sector. Examples of continuing problems include the following:

- Reliance on self-reporting with weak verification procedures could be questioned.
- There is not yet any systematic MOH attempt to review the efficiency of its activities.
- Accounting data is lacking on the recipients of funds. It is very difficult to tell how much is spent on health centres, dispensaries, aid posts and so on due to obvious job code errors. Some of the new facilities established do not have job codes allocated and spending is allocated to a default code reducing the quality of financial information.
- Pharmaceutical unit costs and usage by facility are not published. Analysis of this could help lead to important cost savings.

- Data is extremely scarce on the health sector activities of Port Vila and Luganville Municipal Councils.

- While financial information for government recurrent budget and development partner funds through Fund 4 are available to SmartStream users there are some limitations. The development partner funds are recorded in a different code structure to recurrent budget health expenditure and are recorded in aggregate limiting further access into how the fund was actually spent (salary, drugs, vehicles and others)

- Development partner funds managed outside of the MFEM system are not easily available as they are managed by individual public health program managers rather than finance departments

- Expenditure incurred from patient fees collected and their application at facility level is not available for planning and budgeting purposes.

- Continued use of own financial systems and reporting systems by some donors rather than agree to adopt those used by the GOV.

4.2. IMPLEMENTATION OF RECOMMENDATIONS

The GOV monitors sector performance through its Planning Long, Action Short implementation framework that sets out the objectives, indicators and reporting requirements for actions taken and progress made. In addition, the health sector has its own sector strategy, which includes a framework for monitoring and evaluation. The JPA signed earlier this year between the MOH and its development also has a performance assessment framework.

It is not recommended that a separate mechanism is set up between MFEM and MOH to monitor the implementation of the recommendations in this report. As both are involved in health sector strategy monitoring and the JPA framework it is suggested that the implementation framework for agreed actions recommended in this PER should be incorporated into the appropriate sector plans and associated progress reported as part of the usual reporting requirements.

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