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Executive Summary

The Solomon Islands health system is characterised by moderately high levels of health spending relative to income, financed through government general revenues and external donor resources, and minimal out-of-pocket spending. As a consequence, the system provides relatively good financial risk protection, with negligible rates of catastrophic health spending. The current system of health financing and delivery has delivered better than average health outcomes relative to income per capita, and has been resilient to the political and economic crises that have affected the country in recent years.

Significant additional investments will be needed in future, however. Good health outcomes have been achieved with relatively few health inputs per capita. Also, the distribution of health inputs and resources across the provinces is highly unequal and does not reflect the distribution of health needs. Current demographic trends indicate that the population will continue to grow in the short to medium term, while economic growth is expected to be weak. Additional investments will be needed in future to meet the demands of the growing population, which will put pressure on already low levels of per capita inputs. There is also a critical need to strengthen the quality and effectiveness of health service delivery and improve the distribution of health services. At present, referral services are concentrated in urban areas. In addition, these additional resource requirements will have to be met while maintaining the high levels of financial risk protection and coverage that are the hallmarks of the present system. The additional investments will have to be financed in a sustainable manner.

Increasing the level of general revenue spending and/or introducing contributory, insurance-based health financing arrangements are two broad financing options available for the Solomon Islands. Community-based and private health insurance arrangements can help fill gaps in financing, but are not viable health financing options in the context of the Solomon Islands. An alternative option is to rely on external donor resources to provide a cushion against declining public health spending in the short to medium term, while mobilising additional resources through efficiency savings in the sector.

Increase fiscal space by increasing general revenue allocations to health

Weak economic growth prospects and fiscal tightening in the short to medium term (2010-2014) mean that the macroeconomic conditions are not conducive to significantly expanding fiscal space for health. Any increase in the health budget in real terms would depend upon an increase in real revenues, which in turn would depend on economic growth and SIG revenue generation capacity. Economic growth may improve after 2014, driven by a rebounding of demand abroad, strengthening of commodity prices and new mining related investments. SIG revenue generation capacity may also improve beyond 2014 if proposed economic reforms to strengthen the tax base and tax administration prove effective. Under this economic growth scenario, SIG health spending as a share of GDP is not likely to decline significantly thanks to the high elasticity of SIG health spending with respect to GDP. It is clear however, that in the short to medium term, significant increases in fiscal space for health are not likely.

External donor resources, already a significant source of fiscal space for health, are likely to provide an important cushion in the face of slow public expenditure growth. User fees are not a viable option in the context of the Solomon Islands. The revenues raised through user fees are likely to be outweighed by the costs of administering user fees, and impact on the poor in terms of reduced utilisation.

Introduce contributory insurance based health financing

The feasibility and sustainability of social health insurance (SHI) as a health financing mechanism depends on how quickly it can be scaled up to cover the entire population, given that the informal
sector accounts for over 80% of the population. Weak economic growth prospects and fiscal tightening would rule out the introduction of SHI in the Solomon Islands at present. Far from being an additional source of revenue for health, it is likely to be a further drain on SIG revenues, as additional government spending will be required to scale up insurance.

Many of the pre-requisites needed for successful introduction of SHI are not present. Effective collection and pooling of SHI revenues requires a high degree of government administrative and technical capacity, which is limited in the Solomon Islands given the lack of any previous experience with social security schemes. The necessary regulatory capacity has not been developed yet either. Government provided health services that are essentially free at the point of use are regarded as an entitlement by the Solomon Islands population. In the absence of compelling evidence or information that SHI represents a better alternative to the status quo, the introduction of contributory health financing schemes may not be politically viable.

**Assessing the two health financing mechanisms**

*Risk pooling and financial protection.* Current health financing arrangements in the Solomon Islands are effective at pooling risks and ensuring a high degree of financial risk protection. If social health insurance is introduced for formal sector workers, with other financing arrangements for the informal sector, this may result in the fragmentation of risk pools and reduced financial protection for those outside the formal sector.

*Efficiency in revenue collection and pooling.* Government general revenues are the most efficient means to collect and pool revenues for health in the context of the Solomon Islands, where the informal sector is large, and capacity to collect and enforce insurance contributions is limited. In addition, general taxation has a less distortionary effect on labour and capital markets than payroll taxation associated with SHI.

*Equity in the financing and use of services.* Under the present system of health financing and delivery, health care use is quite pro-poor. The introduction of user fees could be detrimental to equity in health service use. Under SHI financing, deficiencies in both breadth and depth of coverage can undermine equity in service use.

**Mobilising resources through efficiency savings**

Continuing to rely on general revenue financing while mobilising additional resources through efficiency savings will be the most feasible and sustainable option in the context of the Solomon Islands. There is significant scope to do so in the following ways: shift resources towards more cost-effective primary care services; maintain a physical investment plan and budget adequately for the incremental recurrent costs of new investment; improve the mix and productivity of inputs; leverage resources allocated for vertical programs to strengthen health services more broadly; and improve the geographic targeting of expenditures. Underlying these improvements is the need to strengthen budget planning and expenditure management, and alignment with national priorities. Improving the effectiveness and coordination of external donor resources will be equally important. This option will enable the Solomon Islands to maintain the positive features of the current system, including high levels or risk-pooling, financing protection and equity, while mobilising additional resources through efficiency gains.
Acknowledgements

This Policy Note was written by Aparnaa Somanathan. Rob Condon (Public Health Physician and Advisor, AusAID) made significant contributions to the chapter on mobilising resources through efficiency savings.

The authors would like to thank Juan Pablo Uribe and Emmanuel Jimenez for their guidance and advice, Fadia Saadah and Muhammad Pate for initiating this work and Edith Bowles and the Honiara World Bank office for their assistance and cooperation with this note. The authors would also like to thank Susan Ivatts, Tobias Haque and Cate Keane (Financial Management Advisor, Ministry of Health and Medical Services) for their valuable advice and guidance on data sources. The authors are grateful for comments provided by the peer reviewers for the decision meeting, Ajay Tandon, Douglas Addison, Owen Smith and Vivek Suri.

This note would not have been possible without the support and cooperation of the Ministry of Health and Medical Services as well as development partners in the Solomon Islands.
### Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARI</td>
<td>Acute Respiratory Infection</td>
</tr>
<tr>
<td>CBHI</td>
<td>Community-based health insurance</td>
</tr>
<tr>
<td>DHS</td>
<td>Demographic and Health Survey</td>
</tr>
<tr>
<td>EAP</td>
<td>East Asia Pacific</td>
</tr>
<tr>
<td>HIS</td>
<td>Health Information System</td>
</tr>
<tr>
<td>GR</td>
<td>General revenues</td>
</tr>
<tr>
<td>HSSP</td>
<td>Health Sector Support Program</td>
</tr>
<tr>
<td>IMCI</td>
<td>Integrated Management of Childhood Illness</td>
</tr>
<tr>
<td>IMF</td>
<td>International Monetary Fund</td>
</tr>
<tr>
<td>IMR</td>
<td>Infant Mortality Rate</td>
</tr>
<tr>
<td>MHMS</td>
<td>Ministry of Health and Medical Services (Solomon Islands)</td>
</tr>
<tr>
<td>NRH</td>
<td>National Referral Hospital</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary Health Care</td>
</tr>
<tr>
<td>RAMSI</td>
<td>Regional Assistance Mission to the Solomon Islands</td>
</tr>
<tr>
<td>SHI</td>
<td>Social Health Insurance</td>
</tr>
<tr>
<td>SI</td>
<td>Solomon Islands</td>
</tr>
<tr>
<td>SIG</td>
<td>Solomon Islands Government</td>
</tr>
<tr>
<td>WDI</td>
<td>World Development Indicators</td>
</tr>
<tr>
<td>WEO</td>
<td>World Economic Outlook database</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
1. Introduction

The objective of this Policy Note is to provide an assessment of available options for financing health care in the Solomon Islands. In doing so, the analysis will factor in the country-specific economic, social and political factors, which will ultimately influence the performance of the health financing mechanisms.

The Note was motivated by the Solomon Islands Government’s (SIG) interest in knowing whether financing options other than general revenue financing would be feasible and sustainable in the context of the Solomon Islands. In particular, SIG wished to consider whether Social Health Insurance presents a better alternative to General Revenue financing. The Note therefore seeks to provide the evidence and information needed to guide the Solomon Islands Government (SIG) in making decisions about different health financing options.

Analytical framework for assessing health financing options

The analysis of health financing options for the Solomon Islands is underpinned by the three basic principles of public finance: the collection and pooling of revenues, and the purchase of services. Revenue collection involves raising an adequate and sustainable level of revenues in an efficient and equitable manner. The pooling of revenues involves combining the revenues so that the members of the pool share collective health risks, thereby protecting them from large, unpredictable health expenditures. Finally, health services need to be purchased efficiently to maximize health outcomes and ensure equitable access to good quality health services. Health care financing reform implies introducing changes to one or more of these three key functions of financing.

Based on these principles, the Note will compare the different financing options against four criteria. First, the financing mechanism should be sustainable and feasible. Second, the financing mechanism should be able to pool risks and ensure financial protection. Third, the financing mechanism should lead to greater efficiency in how revenues are collected and in how the resources are allocated across inputs and services than at present. Fourth, the financing mechanism should enhance equity in financing and access to services.

Four types of health financing arrangements exist that foster prepayment, raise revenues, pool risks, and purchase services. They are: (i) financing through government general revenues; (ii) social health insurance; (iii) community health insurance; and (iv) voluntary health insurance. Each is linked to distinctive instruments for revenue collection, pooling and purchasing. This Note will assess each of these four options in terms of their ability to mobilise resources sustainably, pool risks, and improve efficiency and equity in the context of the Solomon Islands. Alternatively, additional resources could be mobilised for the health sector through efficiency savings. This will be a fifth option considered in this note.

Methodology

The Note is based on the review and analysis of existing data and documents. Information about current fiscal policy and future economic prospects in the Solomon Islands was obtained through discussions with, and documents published by SIG, the International Monetary Fund (IMF) and the World Bank.
Information about the current system of health financing was obtained from the Ministry of Health and Medical Services (MHMS) and a review of documents produced by the World Bank and AusAID. In addition, the Note draws on documents and reports on the international experience of health financing reform, translating the lessons learnt to the Solomon Islands context.

The 2006 Household Income and Expenditure Survey (HIES) was analysed to examine inequities in health care use, and the impact of household out-of-pocket payments for health care on consumption. Data on health outcome indicators were drawn from the Solomon Islands Demographic and Health Survey 2006, and cross-country analysis of DHS results produced by the World Bank\(^1\).

The primary audience for the report is SIG and the development partners.

**Structure of the Note**

The remainder of this Note is organized as follows. Chapter Two provides a brief overview of the Solomon Islands health system. Chapters Three to Five examine the main financing options. Chapter 6 compares the health financing options in terms of their ability to ensure financing sustainability, risk pooling and financial protection, efficiency, and equity in the context of the Solomon Islands. Chapter Seven examines opportunities for efficiency savings in the health sector as an alternative way to mobilise resources within the current system. Chapter Eight concludes this Note.

**2. Health system overview**

The Solomon Islands has achieved better than average health outcomes relative its level of income. What is remarkable is that the health sector has been largely resilient to the political and economic crises that have affected the country in recent years. The Solomon Islands is a low-income country, with a population of just over 0.5 million spread over an archipelago of nearly 992 islands covering 28,000 square kilometres. Despite the challenges that these conditions pose for service delivery, health outcomes are generally good, backed up by high coverage rates, relatively equitable access to services and high rates of customer satisfaction, as discussed below.

**Health outcomes and utilisation**

The Solomon Islands made significant gains in health outcomes through to the 1990s, experienced some setbacks during the tensions in 2002-2004 but is on the way to regaining pre-conflict levels of outcomes. Infant mortality rates are low relative to average incomes in the Solomon Islands compared to the rest of the world (Figure 1). The Demographic and Health Survey estimated the IMR at 26 per 1000 births in 2007, although there is some uncertainty around the accuracy of this figure\(^2\). Available data indicate that IMRs have been trending downwards, with some reduction in momentum during the crisis years of

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\(^2\) WHO and UNICEF informed the author that the under-five mortality rate fell from 121 per 1000 live births in 1990 to 88 per 1000 in 2000 and 72 per 1000 in 2006.
2002-2003. Acute Respiratory Infections (ARIs) and diarrhoeal diseases remain the primary cause of childhood mortality according to the SIG Health Information System (HIS). While the prevalence of ARIs has remained largely steady, the prevalence of diarrhoeal diseases declined from 1998 to 2002, but has increased since then. The incidence of malaria also increased during the ethnic conflict, but has since returned to pre-conflict levels.

![Figure 1: Infant mortality rates relative to income per capita](image)

Source: From WEO (2008) and WDI (2008) databases

Notes: DHS 2006 estimated infant mortality in the Solomon Islands as 26 per 1,000 live births. There is ongoing discussion about the reliability of this estimate. Other estimates place infant mortality at around 40 per 1,000 live births.

Health service contact rates are high by regional comparison and have been resilient to the service disruptions caused by political instability and unrest. The HIES 2006 found that nearly 87 percent of people sought care when ill. Of those who sought care, 85 percent went to a public sector provider and 4 percent (mostly Honiara) to a private sector provider; only 3.5 percent went to traditional healers. By comparison, in many low income countries in the East Asia and Pacific region, only 60-75 percent of the population seeks care when ill and do so from a modern medical provider. The HIS indicates that annual acute care contacts decreased from 1999 onwards, reaching a low of between 1.2 and 1.8 contacts per capita in 2002-03, when political instability and social unrest were at their peak. By 2005, service utilisation had recovered to 2 to 2.5 contacts per capita in all provinces except Malaita.

Maternal and child health service coverage is particularly high. The DHS found that 87 percent of women sought ante-natal care from a trained provider during their pregnancy, and 85 percent of women gave birth with the assistance of a skilled provider. This is higher than in most other countries in the Asia-Pacific region at a similar level of income (Table 1). Another good indicator of access to modern medical services is the share of children under-five who received treatment for fever from a health facility or trained provider. In the Solomon Islands, 68 percent of children under-five received treatment for fever.

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4 AusAID ODE (2009)

5 Author's own estimates based on household survey data from EAP countries.

6 AusAID ODE. (2009)

from a trained provider or health facility, compared to an average of 54 percent in low and lower-middle income countries in the Asia-Pacific region.

Table 1: Maternal and child health service coverage in the Asia-Pacific region

<table>
<thead>
<tr>
<th>Country/Region</th>
<th>DPT3 Immunization Rate (percent)</th>
<th>Skilled Birth Attendance (percent)</th>
<th>Antenatal care received from a trained provider (percent)</th>
<th>Children under-five with fever received treatment from a health facility (percent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solomon Islands</td>
<td>93</td>
<td>85</td>
<td>95</td>
<td>68</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>88</td>
<td>14</td>
<td>52</td>
<td>24</td>
</tr>
<tr>
<td>China</td>
<td>93</td>
<td>97</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>India</td>
<td>55</td>
<td>45</td>
<td>73</td>
<td>71</td>
</tr>
<tr>
<td>Indonesia</td>
<td>70</td>
<td>67</td>
<td>93</td>
<td>66</td>
</tr>
<tr>
<td>Malaysia</td>
<td>96</td>
<td>97</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Papua New Guinea</td>
<td>88</td>
<td>53</td>
<td>79</td>
<td>63</td>
</tr>
<tr>
<td>Philippines</td>
<td>88</td>
<td>59</td>
<td>88</td>
<td>46</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>99</td>
<td>99</td>
<td>99</td>
<td>85</td>
</tr>
<tr>
<td>Tonga</td>
<td>99</td>
<td>98</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Thailand</td>
<td>98</td>
<td>98</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Vietnam</td>
<td>94</td>
<td>83</td>
<td>87</td>
<td>49</td>
</tr>
<tr>
<td>Western Samoa</td>
<td>81</td>
<td>81</td>
<td>93</td>
<td>-</td>
</tr>
<tr>
<td>East Asia and Pacific (EAP)</td>
<td>83</td>
<td>81</td>
<td>86</td>
<td>54</td>
</tr>
</tbody>
</table>

Source: WDI and WHO; Demographic and Health Surveys (2000-2006)
Notes: EAP and LMIC averages are un-weighted

Equity in health care use and outcomes

Infant mortality rates, the only health outcome variable for which data on socioeconomic differentials are available, are characterised by few inequalities between rich and poor groups, as shown in Figure 2.

Figure 2: Infant mortality rates, by quintile

Source: Demographic and Health Surveys (2000-2006)
With regard to health care use, not only are coverage rates high, there are also few inequities in the distribution of service use. Both the DHS and the HIES show that health care utilisation rates are relatively equal across rich and poor households, and in some cases, are quite pro-poor. As Figure 3-Figure 5 show, the average rates of use of three key maternal and child health service indicators are higher, and disparities between the richest and poorest groups lower in the Solomon Islands compared to the rest of the region.

Figure 3: Percentage of women who received antenatal care from a trained provider, by quintile

![Figure 3: Percentage of women who received antenatal care from a trained provider, by quintile](source)

Source: Demographic and Health Surveys (2000-2006)

Figure 4: Percentage of women who gave birth at a health facility

![Figure 4: Percentage of women who gave birth at a health facility](source)

Source: Demographic and Health Surveys (2000-2006)
Figure 5: Percentage of children under-five who received treatment for fever from a health facility or trained provider

Moreover, the Solomon Islands is one of few countries in the region where hospital inpatient care is actually pro-poor as shown in Figure 6. In most countries, public hospital inpatient care is the one most likely to be concentrated amongst the rich because of large financial and physical barriers to access. In the Solomon Islands, like in Malaysia and Sri Lanka, the poorest 20 percent of the population account for over 20 percent of public hospital inpatient care use. Public hospital outpatient care use is distributed equally between the richest and poorest quintiles, as shown in Figure 7.

Figure 6: Public hospital inpatient care use by the poorest and richest quintile
Figure 7: Public hospital outpatient care use by the poorest and richest quintile

![Bar chart showing outpatient care use by quintile in the Solomon Islands, with data for other countries also included.](chart)

Source: Analysis of HIES 2006 for the Solomon Islands; EQUITAP project for other countries

All of these results point to a relatively well-functioning health system, where the poor face fewer barriers to access to public sector services than in many other countries in the region. In general, people’s satisfaction with services was reported to be high in a survey carried out by RAMSI in 2004. There is anecdotal evidence that the quick return to high levels of service use after the conflicts in 2003 is attributable to the high levels of trust and strong relationship between the community and the service providers.

**Health inputs**

A comparison of health infrastructure and staff across the East Asia Pacific region indicates that per capita health inputs are significantly lower in the Solomon Islands, particularly in comparison with other Pacific Islands (Table 2). The high level of population dispersion in the Pacific Islands region, demands a higher ratio of health inputs per capita than more densely populated countries if good access to health care is to be ensured. Fiji, Samoa and Tonga, which are comparable to the Solomon Islands in terms of their population dispersion, are therefore good comparators for the Solomon Islands. With respect to doctors, the Solomon Islands have only 0.2 doctors per 1000 capita, compared to 0.3 to 0.7 doctors per 1000 capita in Fiji, Samoa and Tonga. However, the Solomon Islands have 2.4 nurses and midwives per 1000 capita, higher than Fiji and Samoa. With respect to health infrastructure, the Solomon Islands have 1.5 health facility beds per 1000 capita, higher than many other EAP countries, but still lower than Fiji, Samoa and Tonga.

The distribution of per capita health sector inputs across provinces is highly unequal. Table 3 presents the number of health facilities and doctors per 1000 capita across provinces in 2010, as well as average annual capital consumption in the provinces in 2006 as a measure of the provinces’ relative socio-economic status. Makira and Malaita, two of the poorest provinces, have significantly fewer area health centres and doctors per 1000 capita than richer provinces such as Central and Guadalcanal. Table 3 also shows that Honiara, the capital city accounts for a disproportionately large share of all health infrastructure and staff in the country.

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8 AusAID ODE. (2009)
In addition, although there is very little data on the quality of health infrastructure and services, anecdotal evidence indicates that much of the health infrastructure is outdated and in need of renovation of repair.

<table>
<thead>
<tr>
<th>Country/Region</th>
<th>Doctors per 1000 population</th>
<th>Nurses and midwives per 1000 population</th>
<th>Health facility beds per 1000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solomon Islands</td>
<td>0.2</td>
<td>2.4</td>
<td>1.5</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>0.3</td>
<td>0.3</td>
<td>0.3</td>
</tr>
<tr>
<td>China</td>
<td>1.4</td>
<td>1.0</td>
<td>2.4</td>
</tr>
<tr>
<td>Fiji</td>
<td>0.5</td>
<td>2.0</td>
<td>2.1</td>
</tr>
<tr>
<td>India</td>
<td>0.6</td>
<td>1.3</td>
<td>0.8</td>
</tr>
<tr>
<td>Indonesia</td>
<td>0.1</td>
<td>0.8</td>
<td>0.6</td>
</tr>
<tr>
<td>Malaysia</td>
<td>0.7</td>
<td>1.8</td>
<td>1.8</td>
</tr>
<tr>
<td>Maldives</td>
<td>0.9</td>
<td>2.7</td>
<td>2.3</td>
</tr>
<tr>
<td>Papua New Guinea</td>
<td>0.1</td>
<td>0.5</td>
<td>n/a</td>
</tr>
<tr>
<td>Philippines</td>
<td>0.9</td>
<td>0.6</td>
<td>1.1</td>
</tr>
<tr>
<td>Samoa</td>
<td>0.3</td>
<td>1.7</td>
<td>2.0</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>0.5</td>
<td>1.7</td>
<td>3.1</td>
</tr>
<tr>
<td>Thailand</td>
<td>0.4</td>
<td>2.8</td>
<td>2.2</td>
</tr>
<tr>
<td>Tonga</td>
<td>0.7</td>
<td>3.4</td>
<td>2.8</td>
</tr>
<tr>
<td>Vietnam</td>
<td>0.5</td>
<td>n/a</td>
<td>1.9</td>
</tr>
<tr>
<td>Lower Middle-income Countries (LMC)</td>
<td>1.9</td>
<td>2.3</td>
<td>3.8</td>
</tr>
</tbody>
</table>

Sources: WDI and Kaiser Family Foundation

Table 3: Health inputs per 1000 population across provinces in the Solomon Islands in 2010

<table>
<thead>
<tr>
<th>Province</th>
<th>Annual Per Capita Expenditure (Sol$)</th>
<th>Area Health Centres per 1000 capita</th>
<th>Rural health centres per 1000 capita</th>
<th>Nurse Aid Posts per 1000 capita</th>
<th>Doctors per 1000 capita</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temotu</td>
<td>2,850</td>
<td>0.04</td>
<td>0.21</td>
<td>0.42</td>
<td>0.08</td>
</tr>
<tr>
<td>Makira</td>
<td>2,852</td>
<td>0.06</td>
<td>0.28</td>
<td>0.40</td>
<td>0.04</td>
</tr>
<tr>
<td>Malaita</td>
<td>3,305</td>
<td>0.03</td>
<td>0.17</td>
<td>0.30</td>
<td>0.06</td>
</tr>
<tr>
<td>Choiseul</td>
<td>3,557</td>
<td>0.03</td>
<td>0.32</td>
<td>0.45</td>
<td>0.06</td>
</tr>
<tr>
<td>Isabel</td>
<td>3,718</td>
<td>0.17</td>
<td>0.38</td>
<td>0.89</td>
<td>0.08</td>
</tr>
<tr>
<td>Western</td>
<td>4,671</td>
<td>0.04</td>
<td>0.29</td>
<td>0.38</td>
<td>0.07</td>
</tr>
<tr>
<td>Guadacanal</td>
<td>5,240</td>
<td>0.07</td>
<td>0.13</td>
<td>0.24</td>
<td>0.07</td>
</tr>
<tr>
<td>Rennel-Bell</td>
<td>5,393</td>
<td>0.23</td>
<td>0.45</td>
<td>0.00</td>
<td>0.23</td>
</tr>
<tr>
<td>Central</td>
<td>5,537</td>
<td>0.16</td>
<td>0.20</td>
<td>0.57</td>
<td>0.04</td>
</tr>
<tr>
<td>Honiara City</td>
<td>10,830</td>
<td>n/a</td>
<td>0.12</td>
<td>0.06</td>
<td>1.32</td>
</tr>
<tr>
<td>Average</td>
<td>4,795</td>
<td>0.09</td>
<td>0.26</td>
<td>0.37</td>
<td>0.20</td>
</tr>
</tbody>
</table>

Source: MHMS data collected in 2009-2010. Annual per capital expenditures from HIES 2006

9 http://www.globalhealthfacts.org/index.jsp
Health financing

Levels and trends in expenditures

Total health expenditures were estimated to be US$ 50 per capita in 2008, or about 5.4 percent of GDP (Table 4).

Table 4: Health expenditures in the Solomon Islands, 2006-2008

<table>
<thead>
<tr>
<th></th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total health expenditures (Sol$ millions)</td>
<td>184.9</td>
<td>163.9</td>
<td>266.9</td>
</tr>
<tr>
<td>Total health expenditures per capita (Sol$)</td>
<td>385.1</td>
<td>292.6</td>
<td>386.8</td>
</tr>
<tr>
<td>Total health expenditures per capita (US$)</td>
<td>50.61</td>
<td>38.25</td>
<td>50.16</td>
</tr>
<tr>
<td>Total health expenditures share of GDP (percent)</td>
<td>5.32%</td>
<td>3.96%</td>
<td>5.37%</td>
</tr>
</tbody>
</table>

Source: MHMS, WDI

Health spending in per capita terms, and as a share of GDP are about average relative to the income level of the Solomon Islands, when compared with other countries in the EAP region (Figure 8 - Figure 9). However, when compared with other Pacific Island countries, health spending in the Solomon Islands is low in per capita terms and as a share of GDP (Table 5).

Figure 8: Total and government health expenditures per capita in the EAP region

Source: From WEO (2008) and WDI (2008) databases
Figure 9: Total health expenditures as a share of GDP in the EAP region

Table 5: Health expenditures in the Pacific Islands region

<table>
<thead>
<tr>
<th>Country</th>
<th>GDP per capita (US$), 2006</th>
<th>Total health expenditure per capita, 2006 (US$)</th>
<th>Total health expenditure as % of GDP, 2006</th>
<th>Government health expenditure as % of total government expenditure, 2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solomon Islands</td>
<td>723</td>
<td>51</td>
<td>5.3</td>
<td>12.6</td>
</tr>
<tr>
<td>Cook Islands</td>
<td>9,489</td>
<td>427</td>
<td>4.5</td>
<td>12.4</td>
</tr>
<tr>
<td>Fiji</td>
<td>3,725</td>
<td>149</td>
<td>4</td>
<td>9.1</td>
</tr>
<tr>
<td>Kiribati</td>
<td>921</td>
<td>117</td>
<td>12.7</td>
<td>13</td>
</tr>
<tr>
<td>Marshall Islands</td>
<td>1,948</td>
<td>298</td>
<td>15.3</td>
<td>13</td>
</tr>
<tr>
<td>Micronesia (Federated States of)</td>
<td>2,217</td>
<td>266</td>
<td>12</td>
<td>14.7</td>
</tr>
<tr>
<td>Nauru</td>
<td>5,602</td>
<td>605</td>
<td>10.8</td>
<td>25</td>
</tr>
<tr>
<td>Niue</td>
<td>7,684</td>
<td>1,045</td>
<td>13.6</td>
<td>10.8</td>
</tr>
<tr>
<td>Palau</td>
<td>7,804</td>
<td>835</td>
<td>10.7</td>
<td>16.4</td>
</tr>
<tr>
<td>Papua New Guinea</td>
<td>906</td>
<td>29</td>
<td>3.2</td>
<td>7.3</td>
</tr>
<tr>
<td>Samoa</td>
<td>2,449</td>
<td>120</td>
<td>4.9</td>
<td>10.4</td>
</tr>
<tr>
<td>Tonga</td>
<td>2,241</td>
<td>121</td>
<td>5.4</td>
<td>11.1</td>
</tr>
<tr>
<td>Tuvalu</td>
<td>2,465</td>
<td>281</td>
<td>11.4</td>
<td>16.1</td>
</tr>
<tr>
<td>Vanuatu</td>
<td>1,619</td>
<td>68</td>
<td>4.2</td>
<td>10.9</td>
</tr>
<tr>
<td>Country average</td>
<td>3,557</td>
<td>314</td>
<td>8.4</td>
<td>13.1</td>
</tr>
</tbody>
</table>

Source: WHO WHOSIS data base (2009)

Financing sources

The two main sources of financing for health are SIG and development partners, who account for 94 percent of total health expenditures. SIG accounts for 65 percent of total financing, and external donor
resources for 29 percent. Notably, SIG’s share of total health financing relative to the development partners has increased since 2004, when the tensions ended. From 2006 to 2009, the health sector accounted for between 12 and 14 percent of total SIG expenditures. In 2008, about 71 percent of external donor financing for the health sector was from Australia.

Out-of-pocket payments, including user fees account for 6 percent of total health expenditures. User fees are charged for specific services such as certain dental procedures, radiology and laboratory services, the issue of medical records and documents, as well as specialty outpatient clinic visits. General outpatient clinic services and hospitalisation are provided free of charge to all Solomon Island nationals. While there is anecdotal evidence that health facilities in some areas do charge fees, neither the household survey data nor MHMS administrative data are able to confirm this. Although private health insurance is available, its contribution to total health financing is negligible.

Table 6 provides details of the sources of health expenditure in 2008.

<table>
<thead>
<tr>
<th>Source</th>
<th>Total expenditures (Sol$ million)</th>
<th>Share of total (percent)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SIG</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SIG - Recurrent</td>
<td>169.1</td>
<td>63.36</td>
</tr>
<tr>
<td>SIG - Development</td>
<td>5.5</td>
<td>2.07</td>
</tr>
<tr>
<td><strong>External donor resources</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HSSP / HISP</td>
<td>47.4</td>
<td>17.74</td>
</tr>
<tr>
<td>Tsunami relief funds</td>
<td>13.8</td>
<td>5.16</td>
</tr>
<tr>
<td>SPC</td>
<td>0.1</td>
<td>0.04</td>
</tr>
<tr>
<td>SIMI</td>
<td>7.8</td>
<td>2.91</td>
</tr>
<tr>
<td>AusAID - NPHL</td>
<td>6.5</td>
<td>2.43</td>
</tr>
<tr>
<td>GAVI</td>
<td>0.7</td>
<td>0.28</td>
</tr>
<tr>
<td><strong>Out-of-pocket</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>266.9</td>
<td>100.00</td>
</tr>
</tbody>
</table>

Source: MHMS

---

### Composition and distribution of health expenditures

Curative care services account for the largest share of government health spending. Table 7 provides a summary of total expenditures by program area in 2008. Hospital and specialised health services and primary health care together accounted for nearly 55 percent of total expenditures, while health administration accounts for 25 percent of expenditures. Vertical programs and other preventive and public health expenditures were only about 8 percent of total spending. However, the primary health care category also includes some additional preventive and public health expenditures incurred by provincial health facilities.

---

10 Variations in definitions and coverage of what constitutes government expenditures means there is some uncertainty around the exact share of health total government spending (Foster et al. 2009).
### Table 7: Health expenditures by program area in 2008

<table>
<thead>
<tr>
<th>Category</th>
<th>Total SIG and external donor expenditure (Sol$ million)</th>
<th>Share of total (percent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Administration</td>
<td>63.2</td>
<td>25.20</td>
</tr>
<tr>
<td>Hospital and specialised services</td>
<td>66.2</td>
<td>26.40</td>
</tr>
<tr>
<td>Primary health care</td>
<td>71.6</td>
<td>28.56</td>
</tr>
<tr>
<td>Family health care</td>
<td>1.1</td>
<td>0.42</td>
</tr>
<tr>
<td>Malaria prevention and control</td>
<td>8.0</td>
<td>3.19</td>
</tr>
<tr>
<td>Disease control</td>
<td>1.5</td>
<td>0.59</td>
</tr>
<tr>
<td>Environmental Health</td>
<td>7.6</td>
<td>3.01</td>
</tr>
<tr>
<td>Health promotion and education</td>
<td>1.9</td>
<td>0.76</td>
</tr>
<tr>
<td>Medical Supplies and Equipment</td>
<td>26.5</td>
<td>10.57</td>
</tr>
<tr>
<td>HR Development</td>
<td>3.2</td>
<td>1.29</td>
</tr>
<tr>
<td>TOTAL</td>
<td>250.89</td>
<td>100</td>
</tr>
</tbody>
</table>


The geographic distribution of health spending is skewed in favour of Honiara and not consistent with the pattern of population health needs. For instance, recent data indicate that Malaita presents comparatively more serious health challenges than other provinces, in terms of its health outcomes and service delivery needs. It also accounts for 30 percent of the country’s population. Yet, it receives a much lower share of total health expenditures than would be expected. This pattern of distribution in health spending is reflected in the distribution of health inputs, as shown earlier in Table 3.

**Out-of-pocket payments and financial protection**

Unlike in many countries in the EAP region, out-of-pocket payments do not represent a significant burden for households in the Solomon Islands. The health system provides a high degree of financial risk protection, as only 6 percent of total health financing is derived from household out-of-pocket sources. Moreover, households in the poorest quintile of the population allocate less than 0.05 percent of their monthly household budget for health care expenses (Figure 10).

The extent to which out-of-pocket payments disrupt household expenditures is also an indicator of financial protection. Health expenditures are defined as catastrophic if they exceed a threshold of say, 10 percent or 25 percent of the household budget. Figure 11 shows that in the Solomon Islands, the proportion of households that experienced catastrophic health expenditures in 2006, when the HIES was carried out, was negligible compared to many other countries in the EAP region.

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Why examine financing options?

Despite good health indicators that have been resilient to the political instability and conflict and moderately high levels of spending significant additional investment in the health sector will be needed in future. There are three key factors underlying the need for additional investment.

First, current demographic trends indicate that the population will continue to grow in the short to medium term. Meeting the demands of the growing population is likely to put considerable pressure on existing levels of health inputs, which in per capita terms, are already quite low as shown in Table 2. Population growth is not likely to be a problem as long as: the growth rate of the real economy exceeds that of the population; the share of revenue and grants in GDP does not fall; and, other public
expenditure programs do not reduce the share of the budget allocated to health. As shown in the next chapter, economic growth is expected to be quite weak in the short to medium term, which is likely to translate into slow growth in revenues and grants, and very little increase, if any, in the health budget.

As already noted, the high levels of population dispersion in the Solomon Islands require higher than average allocations of health inputs per capita in order to ensure good access. Good health outcomes in the Solomon Islands have been achieved with significantly fewer health inputs than countries like Fiji, Samoa and Tonga, which face similar problems of population dispersion and access. As economy growth falters and current levels of health inputs are not increased due to budgetary pressures, population growth will lead to a critical shortage of health infrastructure and staff.

Second, there is a critical need to strengthen the quality and effectiveness of health service delivery particularly at the periphery, and thus improve access to health care for rural, remote populations. At present, referral services are concentrated in urban areas, Honiara in particular, and large parts of the country are underserved. As Table 3 shows, the distribution of health inputs is highly unequal, with some of the poorest provinces having lower levels of health facilities and doctors per capita than the richer provinces. This distribution of health inputs is not related to health care needs across the population either, with provinces like Malaita that account for a large burden of morbidity and mortality in the country having few health inputs per capita than other provinces. Moreover, anecdotal evidence indicates that the quality of health infrastructure and staff needs considerable improvement. Improving the distribution of health inputs and strengthening their quality will require additional investments in the health sector.

Third, all of these additional resource requirements will have to be met while still maintaining the high levels of financial risk protection and coverage that are the hallmarks of the present system. Introducing cost recovery in order to meet the additional expenditure needs of the sector would have a direct, negative impact on equity and financial protection.

Finally, the additional investments will need to be financed in a sustainable manner. The present system is characterized by underfunding of recurrent budget and maintenance items relative to what is required to ensure the sustainability of service delivery. Curative health services are financed in large part by external donor resources through infrastructure and budget support. Fund flows are often erratic, and subject to vagaries in government budget allocations, as well as bottlenecks in the funding channels. SIG will need to increase its own allocations to the sector and do so in a sustainable manner. Since this is likely to prove challenging given already high allocations and weak economic prospects in the short to medium term, SIG will also need to examine alternative ways of financing health care or increasing the effectiveness of current spending in the sector.

3. General revenue financing

The current health system is financed mostly by government general revenues and contributions from development partners. Government revenues are raised through taxation and income from the export of primary commodities, especially logging. Health services, which are provided on a universal basis to the whole population, are financed directly through general revenues. There are also a few health facilities established by the church or communities that are financed through general revenues. User
fees are minimal. In this manner, risks are pooled across the entire population. Public financing and provision are integrated in the current system.

In a health system that is financed largely from general revenue sources such as this one, the availability of fiscal space for health is a critical factor. Fiscal space for health refers to the ability of the government to increase spending for the sector, without jeopardizing the government’s long term solvency or crowding out expenditures in other sectors needed to achieve other development objectives.

Assessing available fiscal space involves examining the different options by which sources of government financing for health could be increased. These options include economic growth and fiscal conditions that are conducive to increasing fiscal space for health, the potential for re-prioritising health within the government budget, the availability of external donor resources and/or efficiency savings in government health outlays.

Assessing fiscal space for health in the Solomon Islands

Are economic growth prospects favourable?

In the short term, economic growth prospects in the Solomon Islands are not conducive to significantly expanding fiscal space for health. Economic growth is one of the primary drivers of fiscal space for health. Income growth is a key determinant of the revenue generation capacity of government, as well as public preferences for allocating a greater share of government resources to health (Figure 12). In the Solomon Islands, the global economic recession, which coincided with the sharp decline in logging revenues, has weighed down on growth prospects. Real GDP growth contracted by 2.3 percent in 2009, after growing at 6.9 percent in 2008\(^{14}\) (Figure 13). Modest recovery is expected in 2010 with a growth rate of about 3.5 percent\(^{15}\).

Figure 12: Relationship between national incomes and health expenditures

![Figure 12](image_url)

Source: From WEO (2008) and WDI (2008) databases


\(^{15}\) World Bank (2010) East Asia and Pacific Economic Update 2010
In the medium to longer term, there exists some limited scope for improved economic growth to generate fiscal space for health depending on how quickly the new mining ventures starts generating revenues. Further declines in logging activity are expected to dampen growth prospects. The IMF’s growth projections indicate a sharp increase in GDP growth from 2012 onwards based on the assumption that the new gold mine will start production quickly (Figure 13). However, with GDP growth is lagging behind population growth, GDP per capita is not expected to grow at all over the next four years.

Medium term growth prospects will depend critically on the duration and severity of the recession in the Asia-Pacific region, the strength of commodity prices as well as the start of domestic gold production. If the global economic outlook improves, and SIG is able to overcome constraints in its other major export sectors, then it could, in aggregate, replace the impact of the decline in commercial logging from 2015 onwards. This could create additional fiscal space for health.

Figure 13: Economic outlook - Real GDP growth - actual and projected (2004-2014)

Under the economic growth scenario presented in Figure 13 above, SIG health spending as a share of GDP will not decline provided historical trends in allocations to the health sector are maintained. The elasticity of SIG health spending (exclusive of donor spending) with respect to GDP, was estimated to be 1.38 during the period 1995-2009. This is quite high. If this elasticity remains constant, SIG health spending as a share of GDP is estimated to increase modestly from 3.5% of GDP in 2008 to 4.1% by 2014 (Table 8). This share will be even higher once external donor resources are included (Figure 14).

---

16 The elasticity of SIG health spending relative to GDP was calculated over the period 1995 to 2008, which spans several distinct phases - pre-tensions, the tensions, the RAMSI intervention etc, characterized by volatility in spending. The calculation did not correct for this volatility under the assumption that the period covered was long enough to average out over the variations in spending.

17 Based on analysis of trends over the period 1995-2008
Table 8: Past trends and projections in government spending on health

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>GDP (Sol$million)</td>
<td>28,076</td>
<td>31,167</td>
<td>34,753</td>
<td>41,410</td>
<td>49,720</td>
<td>54,220</td>
<td>59,680</td>
<td>66,430</td>
<td>78,040</td>
<td>89,310</td>
<td>99,030</td>
</tr>
<tr>
<td>Total SIG Spending (Sol$million)</td>
<td>7,662</td>
<td>14,042</td>
<td>16,021</td>
<td>20,926</td>
<td>23,380</td>
<td>27,706</td>
<td>30,496</td>
<td>32,418</td>
<td>34,962</td>
<td>37,421</td>
<td>40,206</td>
</tr>
<tr>
<td>Government health share of GDP (%)</td>
<td>5.00%</td>
<td>5.00%</td>
<td>5.00%</td>
<td>3.72%</td>
<td>5.05%</td>
<td>5.07%</td>
<td>5.46%</td>
<td>6.08%</td>
<td>6.67%</td>
<td>7.16%</td>
<td></td>
</tr>
<tr>
<td>Government health excl donor share of GDP (%)</td>
<td>2.13%</td>
<td>1.22%</td>
<td>3.85%</td>
<td>2.79%</td>
<td>3.53%</td>
<td>3.36%</td>
<td>3.47%</td>
<td>3.61%</td>
<td>3.81%</td>
<td>3.99%</td>
<td>4.14%</td>
</tr>
</tbody>
</table>

Sources:
- GDP data: IMF Staff Latest actual data; the staff estimates GDP at market prices using CPI and GDP at constant prices. Data last updated: 09/2009
- Government expenditure data: Data for 2008-2014 from IMF Staff Estimates and Medium Term Baseline Scenario projections, IMF Article IV 2009; Data for 1997-2008 from World Bank Sources of Growth Analysis
- Government health expenditures: MHMS; Share of government health expenditures derived from external resources: WDI, and confirmed with MHMS

Figure 14: Actual and projected government health expenditures as a share of GDP, 2000-2014

In reality, the economic growth rate may prove to be less optimistic than predicted in Figure 13, if the start of gold production is postponed. Under this scenario, health expenditures as a share of GDP may not increase by as much, or may not increase at all. So, while expenditure elasticities are indicative, the potential for increasing fiscal space for health depends critically on other factors, in particular overall fiscal conditions.

Are overall fiscal conditions conducive?

Higher general government revenues are critical for expanding fiscal space for health. Overall government spending, including health spending is related to the revenue generating capabilities of the country: there is a close correlation between the government budget as a share of GDP and revenues as
a share of GDP (Figure 15). Revenue generation capacity is typically constrained by low levels of per capita income, as well as limited overall resources, large informal sectors and poorly developed administrative structures. Even in the absence of economic growth, there is scope for revenue generation to improve if economic reforms lead to a strengthening of the tax base and tax administration.

Figure 15: Relationship between revenues and health expenditures as a share of GDP

In the short term, a tighter fiscal stance is likely in the Solomon Islands leaving little additional fiscal space for health. The economic slowdown and decline in logging revenues have significantly weakened SIG’s fiscal position. In 2009, fiscal revenues were 13.5 percent below projections. The government responded to falling revenues by introducing a 10 percent reservation on non-payroll expenditures. In addition, emergency cash management practices introduced by MOF led to delays in payments to suppliers and thus, disruptions to the delivery of services. There has also been a freeze on recruitment in the health sector.

As economic growth continues to falter, large budgetary financing gaps are expected to emerge in the short term, accompanied by a tightening fiscal stance through 2010 and beyond. The 2010 budget assumes a 20 percent increase in revenues and spending relative to last year, based on optimistic assumptions about a robust recovery and improved tax compliance. In the absence of improved cash flow forecasting and management, there is a very real risk that revenue projections are not realised and public spending remains constrained through 2010. Under weak economic conditions, to maintain a fully funded budget, nominal expenditure growth will need to slow down from around 29 percent in 2008 to 8 percent in 2014\(^\text{18}\) (Figure 16).

In the medium to longer term, there is scope for a combination of reforms aimed at improving revenue collection and strengthening financial management to improve fiscal sustainability, and potentially generate modest additional fiscal space for health. At 30.3 percent, SIG’s revenue as a share of GDP is not low compared to other lower middle income small states, although it has been unsustainably boosted by logging revenues. SIG reforms to modernise the tax base and reduce tax exemptions are already in progress to improve this. Further tax reforms are being pursued to strengthen the tax base, shift the reliance away from direct taxation and simplify tax administration for the government, as well as the compliance burden for taxpayers. The tax reforms are being undertaken as part of a broader structural reform program. This includes building the administrative and resource capacity of the Inland Revenue Division to enforce compliance. SIG reforms to strengthen public financial management by improving cash management, budget integration and accounting and audit functions are also in progress. This includes ongoing capacity building in the Ministry of Finance and Treasury to improve financial management and governance. While efforts to improve financial management will not generate additional revenues directly, they will improve the efficiency of public spending more generally. IMF projections indicate that the package of economic reforms outlined in the Solomon Islands Medium Term Fiscal Strategy, including the reforms described above, could deliver an additional 3 percentage points of growth per annum in 2010-2013.

Whether improved revenue generation capacity will necessarily benefit the health sector or not depends on the priority accorded to health in the government budget.

Is there scope for re-prioritising health spending?

SIG allocated 10-14 percent of its government budget to health during the period 2002-2008, which provides only limited scope for further reprioritising health within government. As Table 5 shows, this is high compared to most Pacific Islands. It is likely that the availability of external resources for health makes it less of a priority sector for policymakers faced with competing demands for resources from several other sectors.
Can user fees generate additional fiscal space for health?

The potential for user fees to generate additional revenues needs to be weighed against the challenges of implementing a user fee policy and the exemption schemes associated with it. It is worthwhile nothing that even in the absence of official user fees, unofficial fees can imply significant financial barriers to access. In the Solomon Islands, user fees are minimal, and applied only to a limited range of services at the National Referral Hospital, and in some smaller health facilities as described in Chapter 2. Household survey data indicate that unofficial fees are also not significant. If user fees are to be introduced more broadly, exemption schemes will need to be designed and implemented to protect poor and vulnerable groups. Implementing exemptions schemes is challenging in most contexts, but particularly so in the context of the Solomon Islands, where there has been little other experience with implementing means-tested programs. The administrative costs of introducing a user fee policy may well outweigh the amount of revenues collected.

In addition, the international evidence shows that user fees have most impact when retained at the facility level. This would require significant administrative and expenditure management capacity at the facility level. This is not feasible in the current context of the Solomon Islands, where financial management capacity is limited even at the province level, let alone the facility level.

In recent years, growing evidence of the impoverishing effects of out-of-pocket payments have called into question the appropriateness of user fees in low and middle income countries. User fees were widely advocated in the 1980s and 1990s for their potential for cost-recovery at the facility level and ability to promote appropriate referral routes. Recent empirical work on the impact of payments for health care have provided compelling evidence that reliance on user fees, and out-of-pocket payments more generally, can lead to large inequities in service delivery. Moreover, the costs of collecting user fees are non-trivial, especially with regard to making sure exemptions and fee-waivers are effective.

This evidence, and the growing emphasis on poverty reduction have prompted several countries including South Africa, Uganda and Zambia to remove some or all user fees charged at public facilities. Eliminating user fees is not straightforward and alternative sources of funds need to be sought to avoid a decline in the quality and quantity of services provided. Nevertheless, there is a clear shift away from out-of-pocket payments for health care and in favour of prepayment mechanisms (tax and social insurance). This shift has been given greater impetus by the 2005 World Health Assembly resolution encouraging the organisations’ Member States to favour social and other forms of health insurance.

Another argument that is made in favour of user fees is that it could reduce excessive use of expensive, high-level referral services, and encourage people to use more cost-effective, primary care services. However, as discussed later in Chapter 7, efforts to restrict access to higher level referral services by introducing user fees, without improving primary care services at the same time would actually be detrimental to equity as this would increase financial barriers to access for the poor more than the rich.


Can external resources provide a cushion during the economic and fiscal crisis?

External or donor resources, already a significant source of fiscal space for health, are likely to remain important in the short to medium term until macroeconomic conditions improve. The level and nature of development assistance to the Solomon Islands are country-specific, and driven in large part by development partners’ desire to restore political and economic stability to the country. To this end, development partners such as the Government of Australia have made long term commitments to supporting both recurrent and capital expenditures in the social sectors, which are considered priority. While the goal of improving self-reliance and the sustainability of domestic allocations to the social sectors is an important goal, other goals such as ensuring that expenditure levels are maintained and service delivery is not disrupted take greater priority, particularly when macroeconomic conditions are weak.

During the tensions and in the early phase of the Regional Assistance Mission to the Solomon Islands (RAMSI), when MOH was unable to mobilise sufficient SIG resources for provincial health departments, external resource flows helped stabilise government health spending. Figure 17 presents trends in SIG, AusAID and Taiwan (China) financing of provincial health departments, and training and church providers in 2004-2008, from the analysis carried out for a recent AusAID ODE evaluation of Australia development aid to the Solomon Islands23. It shows that AusAID and Taiwan (China) contributions to the provincial health grants raised the level of support in 2004 to what ensued as SIG absorbed complete responsibility for financing provincial health departments’ recurrent budgets in 2006 (Figure 17)24. AusAID continued to support church-run institutions and government training institutions along with SIG so as to stabilize overall support to these special entities. The share of external resources in total government health spending has now declined from 54% (2004) to 31% (2008)25.

Figure 17: Provincial grants by source, 2004-2008

[Bar chart showing trends in SIG, Taiwan (China), and HSTA/HSSP provincial grants by source from 2004 to 2008.]


23 AusAID ODE. 2009.
25 See comment above on data source.
Figure 17 presents results for 2004-2008 in nominal terms. The AusAID ODE report notes that in real per capita terms, spending by provinces has fallen since 2004. This is because the increased spending from SIG resources was insufficient to offset the loss of donor support for provincial health grants.

Give weak macroeconomic conditions, the tightening fiscal stance and potential slowing down of public spending in the short to medium term, SIG may once again have to resort to external resources to provide a vital cushion against declining SIG spending. With health already accounting for a relatively large share of the government budget, allocation of resources away from other sectors to health is unlikely. Any increases in the health budget in real terms would thus depend on increases in overall real revenues. This in turn would depend on economic growth prospects and improvements in overall fiscal space through better tax policy and administration. As discussed above, both of these drivers will remain weak in the short to medium term, making external resources quite important as a cushion against declining government spending.

Meanwhile, there is an urgent need to improve the effectiveness of government general revenue and external resources, increase the predictability and flexibility of external grants, and achieve better alignment between expenditures and sectoral priorities.

4. Social health insurance financing

The introduction of Social Health Insurance (SHI) represents an alternative way of generating resources for the health sector. Typically, in the more mature SHI systems in Europe, working people and their employers, including the self-employed, pay contributions; the funds are pooled and used to finance a package of services that is available to the insures and their dependents. SHI systems have evolved considerably around the world. For instance, governments have extended coverage to those who cannot pay, such as the poor and unemployed, subsidizing their contributions through general revenues. In many cases, the informal sector has also been able to enrol by paying flat contributions, which is subsidized by the government in some cases. At present, no SHI system is financed exclusively by payroll taxes.

The Solomon Islands could introduce SHI by covering the formal sector workers to begin with. Contributions would be in the form of a payroll tax. The National Provident Fund (NPF), which already collects social security contributions from formal sector workers could be a mechanism for collecting health insurance contributions as well. All employees who earn over Sol $20 and have been employed for at least two weeks, are eligible to enrol in the NPF scheme. At present, total membership is around 110,000 including those members who are no longer formally employed, but have not withdrawn their entitlements yet. The current NPF contribution rate, as a proportion of the employee’s wage, is 5 percent for employees and 7.5 percent for employers. If SHI is added on top of the existing NPF scheme, the contribution rate would have to be increased to include health insurance contributions as well. The SHI contributions would then be pooled and used to purchase services for the formal sector workers and their dependents.

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26 This implies that any increase in health expenditures as a proportion of GDP will hinge on an increase in revenues. Borrowing to create fiscal space is not considered an option.
Successful introduction of SHI financing in the Solomon Islands would depend critically on two issues. One is how feasible it is to expand coverage to the entire population, including the informal sector, and whether there is a realistic timetable for doing this. The other is how the increase in the contribution rate, essentially a payroll tax, will affect labour and capital markets, as well as the general revenues already allocated to health.

Expanding SHI coverage to the informal sector is challenging in almost all contexts. The population in the formal sector is relatively easy to enrol and collect contributions from, thanks to the availability of employment earnings records. The population in the informal sector is typically not affiliated with any organization through which to enrol them and collect premiums from. They are also poorer and less able to afford the premiums.

The Solomon Islands population is predominantly in the informal sector. While precise estimates of the size of the formal sector are not available, the number of NPF enrollees and the number of income tax payers can be indicative of the size of the formal sector. About 20 percent of the population belongs to NPF, but this also includes those who are no longer employed. About 8-10 percent of the Solomon Islands population is registered for Pay As You Earn (PAYE) taxation. At least 80 percent of the population, possibly more, is therefore in the informal sector.

Cross-country comparisons have helped identify several factors which are good predictors of the extent to which SHI is successful in expanding coverage in a sustainable manner. They are: the country’s economic growth performance, administrative and technical capacity to operate health insurance programs, regulatory capacity, and political willingness to scale up. Each one is considered below in the context of the Solomon Islands.

Assessing the predictors for successful SHI introduction and expansion

Are the country’s macroeconomic conditions supportive?

Macroeconomic conditions are important to consider because they determine whether it is realistic fiscally to finance the expansion of coverage to the informal sector using general revenues. A country’s ability to mobilise general revenues is determined largely by its economic performance. Macroeconomic conditions are also important because have implications for how the new payroll tax will affect labour and capital markets.

The most effective way to scale up SHI coverage quickly is for the government to use general revenues to subsidise premium payments for the population in the informal sector, given the challenges associated with collecting premiums from them. The few low and middle income countries that have successfully extended social insurance coverage despite large informal sectors did not follow the classic social health insurance model where insurance coverage is linked to insurance payments. Instead, they employed substantial general tax revenues to fund the social health insurance schemes, and extended insurance coverage on a mostly non-contributory basis\(^27\). Mongolia\(^28\) and Thailand\(^29\) both extended

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coverage through social health insurance to 90-100 percent of their population. In order to do so, 60 percent or more of the insurance fund was sourced from general tax revenues. In both cases, increases in taxation were necessary. In Latin America and the Caribbean, where social health insurance is a major source of financing, labour unions are actively involved in managing health insurance contributions. Even so, most countries in this region have had to maintain a parallel tax-financed system with separate providers operated by the Ministry of Health.\(^\text{30}\)

In the Solomon Islands, as discussed in Chapter 3, weak economic growth prospects and the need for fiscal restraint in the short to medium term would rule out any substantial increase in government subsidies to finance the scaling up of SHI. Significant additional health spending would be needed to expand SHI to the 80% or more of the population that is in the informal sector. Moreover, the establishment of SHI involves relatively high start-up costs, which will also have to be financed through general revenues.

The introduction of a payroll-based contribution (payroll tax) on formal sector workers to finance SHI may not be desirable either given the weak macroeconomic conditions. Payroll taxes place a tax on employers and could have a negative effect on future economic growth. A review of labour markets in OECD countries found that tax rates are a significant factor in explaining differences in the amount of market work undertaken by the working age population.\(^\text{31}\) A 10 percent increase in tax rates could decrease labour inputs by 1-3 percent for the working age population.\(^\text{32}\) The direct evidence of payroll taxes decreasing labour inputs in transition economies, however, is less clear cut. What is clear is that high payroll tax rates discourage firms and workers from coming into the formal economy. In addition, under weak macroeconomic conditions, the negative effects of the new payroll tax on the labour market are likely to be more pronounced.

Finally, the introduction of SHI will not necessarily mobilise additional resources for health. It depends amongst other things, on the impact it has on existing general revenue allocations to the health sector. If the Ministry of Finance chooses to reallocate resources away from the health sector because SHI is perceived to be a source of revenue in and of itself, this may offset any positive impact SHI has on health sector resources.

Is there adequate administrative and technical capacity?

Effective collection and pooling of SHI revenues requires a high degree of administrative and technical capacity within the country. Administrative capacity refers to the organizational infrastructure needed to register members, distribute membership cards and collect contributions. Technical capacity refers to the skill set of the labour force needed to operate a health insurance program, including book-keeping, banking and actuarial skills, as well as information systems for monitoring performance.\(^\text{33}\) In Indonesia, for instance, the lack of actuarial skills in government led to the premiums for the Health Maintenance Organisation being set well below cost. By contrast, high technical capacity to provide policy and analytical advice in Thailand made it possible for the country to learn from the means-testing failures of

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32 Wagstaff, 2007
an earlier, failed scheme and create new and improve information systems for the new social insurance scheme.\textsuperscript{34}

In countries where the government already operates large social security programmes, administrative and technical capacity will be high because of previous experience with defining eligibility, identifying beneficiaries and administering programs. The Solomon Islands does not have a comparable social security programme yet. There is no suitable mechanism for identifying the poor, for instance. Therefore the capacity needed to design and implement SHI is limited at present. Having the necessary administrative and technical capacity in place is quite critical to ensuring that the introduction of SHI is successful. It is recommended that the necessary educational qualifications and other skills are introduced first and SHI implementation postponed until such skilled personnel exist.

Is there adequate regulatory capacity?

Regulatory capacity to pass and enforce SHI laws is important to ensure the long-run financial sustainability of SHI programmes. Mandatory enrolment in SHI is desirable in order to have a wide funding base. In settings where regulatory capacity is weak and the government is unable to enforce mandatory enrolment, adverse selection becomes a problem. Individuals with low expected health care costs do not enrol, while those with higher expected health care costs do. Costs rise relative to the SHI funding base, threatening the long-run financial sustainability of SHI.

Non-enrolment of workers and evasion of payments by enrolees is a consequence of weak regulatory capacity, and a common problem in many middle-income countries. In urban China for instance, only 24 percent of private sector employees and 50 percent of state-owned enterprise employees were enrolled in the new urban health insurance scheme in 2004\textsuperscript{35,36}. In Vietnam, only one out of three formal sectors is enrolled in social health insurance\textsuperscript{37}. In Indonesia, it is estimated that 86 percent of those eligible for coverage in the national scheme have taken advantage of an opt-out clause in the legislation\textsuperscript{38}. In Colombia, evasion in the contributory regime caused by underreporting and non-payment is associated with revenue losses of about 2.75 percent of GDP\textsuperscript{39}. In Eastern Europe and the former Soviet Union, the introduction of SHI schemes did not actually result in additional revenues for health care; in Kazakhstan, only 40 percent of expected revenues were actually collected.\textsuperscript{40}

In the Solomon Islands, the necessary regulatory capacity has not been developed yet. Often, the presence of a significant private insurance market provides the basis for developing such regulatory capacity. The small size of the private insurance market in SI precludes this.

\begin{footnotesize}
\begin{enumerate}
\item Hsiao, W. C. (2008). "Scaling up health insurance coverage in South, East and Pacific Asia."
\item Gottret and Schieber 2006
\end{enumerate}
\end{footnotesize}
Is there sufficient political commitment?

Even if all of the other enabling factors are in place, successful scaling up of SHI is not possible without strong political commitment to achieving universal coverage. In Thailand and China, SHI coverage was extended as it was part of a political strategy to gain popular support. In Indonesia, SHI legislation was passed in 2004, but has not been implemented yet due to political disagreements. In general, weak economic conditions do not garner much political support for scaling up health insurance.

Government provided health services that are essentially free at the point of use are regarded as an entitlement by the Solomon Islands population. In the absence of compelling evidence or information that SHI represents a better alternative to the status quo, introducing a contributory health financing scheme may not be politically feasible in the context of the Solomon Islands. This is especially so in the context of weak economic conditions.

Finally, it is worth noting that introducing a SHI scheme solely for formal sector workers first may actually slow down further extensions of coverage. Many Latin American countries introduced SHI several decades ago by covering only the formal sector workers. Their experience has been that the system becomes so entrenched that it becomes an obstacle to extending coverage41. Levelling up to the most comprehensive plan is too costly, while a reduction in comprehensiveness of the benefit package is resisted by those who have it42. If SHI is to be successful, it is critical that there is strong political commitment at the outset to achieving universal coverage via mandatory insurance in the shortest possible time.

5. Private and Community-Based Health Insurance

Private health insurance

Private health insurance (PHI) includes all for-profit insurance plans that involve voluntary membership, and are provided on an individual basis or through organised employee groups. PHI is rarely ever the primary source of financing for health care. In most countries, its main purpose is to provide complementary or supplementary coverage alongside existing public schemes. The only exception is the USA, where private health insurance is the predominant source of financing. But, this leaves 45 million people uncovered. In low and middle income countries, PHI covers only about 2-5 percent of the population and accounts for less than 5 percent of overall health financing43.

At present, PHI accounts for a negligible share of total financing in the Solomon Islands. At the time of writing this report, only one private insurance company offered health insurance plans, catering mostly for the expatriate market. The standard package covers general medical care and repatriation expenses. Group policies are available, but there is little demand for them. PHI is not marketed widely and does not represent an important product for the insurance company. PHI is seen as non-profitable because the claims expenditures are quite high. Administrative costs account for approximately 5 percent of total expenses. Reimbursement is by cash only.

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41 McIntyre (2007)
43 Rannan-Eliya, 2008
Are the pre-requisites for PHI in place?

The Solomon Islands do not have many of the pre-requisites that are needed for the development of a viable PHI market. In most countries, large out-of-pocket shares of total spending create the demand for supplementary voluntary insurance. Out-of-pocket payments for health care are quite minimal in the Solomon Islands. Second, the existence of a viable financial market is critical for the development of private insurance entities because the reserves from premiums collected must be invested to ensure profits over resource outlays; this profit is critical for the sustainability of private entities. The World Bank CPIA report in 2009 noted that capital markets continue to be underdeveloped in the Solomon Islands, with a large section of the population in rural areas not having access to financial services. A third pre-requisite for the development of PHI is a large middle class and high quality private health services to cater for the middle class. With over 75 percent of the population living in rural areas, and service provision dominated by the public sector, this pre-requisite has not been met either. Fourth, strong regulatory oversight and management skills are needed to ensure that all parties involved in PHI carry out their fiduciary responsibilities. The administrative and regulatory costs associated with establishing and maintaining the voluntary health insurance market can be quite substantial.

Can PHI help scale up insurance coverage?

Although there are frequent claims that PHI initiatives can help scale-up insurance coverage in low and middle income countries, in practice, there is little evidence of this. Regardless of the income level of the country, PHI has never been able to surmount the problems associated with voluntary enrolment and cost-inefficiency in order to scale up coverage. In the absence of many of the pre-requisites for PHI to develop in the first place, this form of financing is unlikely to make a significant contribution to scaling up insurance coverage more generally.

Community-based health insurance

Community-based health insurance (CBHI) can be defined broadly as non-profit insurance plans that involve voluntary membership and are controlled by the community. CBHI typically operates in settings where out-of-pocket payments for health care are large, and where the population lacks any major form of insurance. CBHI schemes are found all over the world, and are quite heterogeneous in terms of population covered, services offered and management. There are three common features, however. First, affiliation is based on community membership and the community is strongly involved in managing the system. Second, the beneficiaries are usually individuals who have been excluded from other insurance schemes. Third, members share a common set of social values, which are reflected in rules governing the management of the scheme.

44 Gottrett and Schieber, 2006
45 World Bank, 2009. CPIA
46 Gottrett and Schieber, 2006
47 Rannan-Eliya, 2008
CBHI schemes make fairly modest contributions to overall coverage, and only serve to complete or fill the gaps of other health financing schemes\textsuperscript{49,50}. With the exception of China, and a few schemes in India, CBHI has never been able to cover large segments of the population or reach the very poor\textsuperscript{51}. Coverage rarely exceeds 10 percent of the population. Thus, CBHI can never be relied upon to provide medical coverage to the entire population, but can help meet the needs of specific categories of people such as informal workers in a particular industry, or the inhabitants of a village. In many places, CBHI is used to extend coverage funded by large financing instruments such as social health insurance. In the Philippines for instance, the government is using existing community schemes to develop the national health insurance system\textsuperscript{52}.

There are no significant CBHI schemes in the Solomon Islands at present.

**Can the introduction of CBHI help scale up insurance coverage?**

A strategy of achieving universal coverage through incremental CBHI-driven extensions of insurance coverage is not always a reliable one\textsuperscript{53}. CBHI schemes are often used to draw informal sector workers into a mandatory system. Indeed, both Japan and Korea achieved universal coverage by gradually expanding existing CBHI schemes to become a part of the mandatory insurance system. However, if numerous insurance schemes develop with their own distinct approaches to setting the benefit package and contribution rates, integrating these heterogeneous schemes into a mandatory system could be problematic. Members of different CBHI schemes may resist changes to their program, just as formal sector workers covered by a social health insurance scheme may resist being drawn into a mandatory system that may provide less comprehensive coverage.

**6. An assessment of the health financing options**

This chapter will assess the financing mechanisms described in Chapters Three to Six against four criteria: the extent to which the financing mechanism is sustainable and feasible; the degree of risk pooling and financial protection it provides; the extent to which it will improve efficiencies in how health care is financed and delivered; and the extent to which it will improve equity in financing and the delivery of health care.

It is important to note that there are trade-off’s between these health system goals. For instance, greater efficiency may be achieved at the expense of equity-related goals. It is also important to note that although the financing mechanisms are compared with one another as distinctive financing mechanisms, in practice most systems use a combination of these mechanisms so that the lines between them are quite blurred.


\textsuperscript{52} Gottrett and Schieber, 2006

\textsuperscript{53} McIntyre (2007)
Sustainability and feasibility

Sustainability refers to the ability of the financing mechanism to maintain the revenue base in the long term and mobilize additional resources commensurate with its health care needs. Resources need to be mobilised in a sustainable manner, without jeopardising the government’s long term solvency and without any negative impacts on the labour and capital markets. Feasibility refers to the level of support from stakeholders and the administrative, technical and regulatory capacity of the state to operate that financing mechanism. Table 9 compares the sustainability and feasibility aspects of the four financing mechanisms.

Table 9: Sustainability and financing of different health financing schemes

<table>
<thead>
<tr>
<th>General revenue (GR) financing</th>
<th>Sustainability</th>
<th>Feasibility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Provides the largest revenue base relative to all other financing mechanisms.</td>
<td>- Administration is simple and thus suitable for low and middle income settings with large informal sectors</td>
</tr>
<tr>
<td></td>
<td>- Revenue base may be unstable because health has to compete with other sectors</td>
<td>- No additional costs related to setting up the infrastructure for collecting revenues as it uses the existing tax collection systems</td>
</tr>
<tr>
<td></td>
<td>- In the Solomon Islands: difficult to generate additional GR for health because of weak economic growth prospects and fiscal tightening 2010-2014; possible to generate additional GR if growth prospects improve and revenue generating capacity is increased; donor financing needed to cushion health expenditures during the economic slowdown, but need to consider potential inflationary effects of donor financing on prices and wages in the health sector, which may undermine long-run sustainability</td>
<td>- Regulatory and technical capacity requirements are minimal.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social Health Insurance (SHI)</th>
<th>Sustainability</th>
<th>Feasibility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Significant revenue raising potential because contributions are linked to benefits: politically more acceptable, and revenues once collected, are ear-marked</td>
<td>- Significant requirements in terms of administrative, technical and regulatory capacity needed to operate SHI</td>
</tr>
<tr>
<td></td>
<td>- Size of the revenue base depends on the size of the formal sector; large informal sector (80 percent) in Solomon Islands is a major constraint to SHI</td>
<td>- Setting up this capacity can be costly</td>
</tr>
<tr>
<td></td>
<td>- Need to raise sufficient and stable GR to cover the informal sector and enable universal access; constrained by weak economic growth prospects in the short to medium term in Solomon Islands</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Negative labour market effects due to increase in labour costs and rise in informality; not ideal in a weak macroeconomic environment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- When enrolment is not mandatory, long</td>
<td></td>
</tr>
<tr>
<td>Private Health Insurance (PHI)</td>
<td>- Long run solvency of PHI schemes threatened by voluntary enrolment and adverse selection effects, as well as the small size of insurance pools.</td>
<td>- In many low-income countries, the small size of the formal sector and weaker financial markets limit PHI coverage - Strong adverse selection effects often eliminate the market for many types of coverage; e.g. maternal care and routine outpatient treatment are not insurable under PHI in many countries</td>
</tr>
<tr>
<td>Community-Based Health Insurance (CBHI)</td>
<td>- Small size of the pool means that even one large risk could lead to failure of the CBHI fund - Long-run solvency of CBHI schemes threatened by voluntary enrolment</td>
<td>- Management skills needed to operate CBHI tend to be limited in small, CBHI schemes, undermining long-term viability of the schemes</td>
</tr>
</tbody>
</table>

**Risk pooling and financial protection**

A second set of criteria for assessment is whether the financing mechanism can effectively pool risks and ensure financial protection. This implies a need for cross-subsidies within the health system, both in terms of income (cross subsidies from the wealthy to the poor), and of the risk of illness (cross subsidies from the health or low-risk individuals to the ill or high-risk individuals). Table 10 compares the four financing mechanisms in terms of their ability to pool risks effectively and ensure financial protection.

**Table 10: Risk pooling and financial protection**

<table>
<thead>
<tr>
<th>Risk-pooling</th>
<th>Financial protection</th>
</tr>
</thead>
<tbody>
<tr>
<td>General revenue (GR) financing</td>
<td>- By spreading health expenditures across all taxpayers, achieves the highest degree of risk pooling, in theory, particularly when user fees are minimal - In Solomon Islands this is true in practice, as user fees are negligible</td>
</tr>
<tr>
<td>Social Health Insurance (SHI)</td>
<td>- A single, national SHI program with mandatory enrolment can achieve a high degree of risk pooling - In Solomon Islands, if SHI is introduced for the formal sector with incomplete or no coverage for the informal sector, this will result in the fragmentation of risk pools, limiting the potential for cross-subsidies: better-off, working-age groups will belong to one risk pool with SHI, while poorer, more vulnerable groups will belong to different pools with incomplete coverage</td>
</tr>
</tbody>
</table>
Efficiency in financing and delivery of health services

When taking decisions about health financing reform, it is important to consider whether the new financing system will lead to greater efficiency in how revenues are collected (financing), and in how resources are allocated across inputs and services (delivery). The collection and pooling of revenues implies administrative and regulatory costs, which are likely to be borne by the population through taxes or insurance payments. Minimising these costs would improve efficiency. The distortionary effects of taxes and insurance premiums are another source of efficiency. Similarly, there are technical and allocative efficiencies associated with how the revenues are allocated across inputs and services. Table 11 compares the efficiency effects of the different financing mechanisms.

Table 11: Efficiency in financing and delivery of services under different health financing mechanisms

<table>
<thead>
<tr>
<th></th>
<th>Efficiency in financing health care</th>
<th>Efficiency in the delivery of services</th>
</tr>
</thead>
</table>
| General revenue (GR) financing     | - In Solomon Islands, current system of GR financing offers a broad revenue base, one that is less likely to act as a disincentive for formal job creation (i.e. least distortionary)  
- Solomon Islands has recently undertaken reforms to improve the efficiency of revenue collection  
- Fewer administrative costs associated with revenue collection compared to other insurance mechanisms; e.g. indirect taxes are quite efficient from a revenue mobilisation perspective as they are hard to evade and relatively cheap to collect | - Current system of delivery is characterised by inefficiencies  
- Reducing inefficiencies could mobilise additional resources for the health sector (see Chapter 7) |
| Social Health Insurance (SHI)      | - Distortionary effects of SHI contributions on labour markets and problems of non-enrolment means SHI premia are more costly to collect than taxes | - Potential for using financial incentives to improve provider performance exists though strategic purchasing of services, in theory.  
- For strategic purchasing to be |
**Equity in the financing and delivery of health services**

A fourth set of criteria relate to whether the financing mechanism will enhance equity in financing and access to services. Health financing is *progressive* if the poor pay proportionately less than their share of income, and *regressive* if they pay proportionately more relative to their share of income. The way in which contributions are pooled and services purchased has implications for equity in the use of services.

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The fragmentation of risk pools often leads to different groups receiving different benefit packages, some of which imply greater services coverage than others, and greater inequity. Table 12 compares the equity performance of different financing schemes.

Table 12: Equity in financing and delivery of services under different health financing mechanisms

<table>
<thead>
<tr>
<th>Equity in financing health care</th>
<th>Equity in the delivery of services</th>
</tr>
</thead>
<tbody>
<tr>
<td>General revenue (GR) financing</td>
<td>- Taxation, especially direct taxation, is generally the most progressive form of health care financing as it imposes a greater share of all payments on wealthier groups than on poor groups</td>
</tr>
<tr>
<td>- In Solomon Islands, current pattern of service delivery is quite pro-poor (see Chapter 2), thanks to GR-financed universal coverage, and minimal user fees</td>
<td></td>
</tr>
<tr>
<td>Social Health Insurance (SHI)</td>
<td>- Progressive when limited to the formal sector, because payments are made by the relatively better-off only. - Regressive or proportional when it is the main form of health financing, because premiums are levied as a fixed percentage of earnings across all income groups</td>
</tr>
<tr>
<td>- Where coverage is incomplete, e.g. formal sector with SHI, informal sector with little or no coverage, inequities in service delivery exist - Where coverage is universal, but shallow (not a comprehensive benefit package for all), inequities also exist</td>
<td></td>
</tr>
<tr>
<td>Private Health Insurance (PHI)</td>
<td>- Progressive because payments are concentrated among upper income groups</td>
</tr>
<tr>
<td>- Fragmentation of risk pools and limited opportunities to cross-subsidise associated with large inequities in coverage and financial protection - Fails to reach the very poor, because they cannot afford to enrol</td>
<td></td>
</tr>
<tr>
<td>Community-Based Health Insurance (CBHI)</td>
<td>- Usually regressive because payments are defined as flat-rate contributions, and concentrated among lower income groups, as these are the groups most likely to have CBHI schemes.</td>
</tr>
<tr>
<td>- Fragmentation of risk pools and limited opportunities to cross-subsidise associated with large inequities in coverage and financial protection - Fails to reach the very poor, because they cannot afford to enrol</td>
<td></td>
</tr>
</tbody>
</table>

7. Mobilising resources through efficiency savings

Is there scope for efficiency gains to generate additional fiscal space for health?

Efficiency gains provide significant scope for generating additional fiscal space for health in the Solomon Islands. Many low and middle income countries have been able to expand service provision with only modest increases in spending through efficiency gains. Even a 2 percent annual increase in efficiency
implies a doubling of service delivery every twenty years\textsuperscript{56}. For instance, Botswana doubled service coverage during 1960-80 without increasing the share of health budgets in GDP. Uganda tripled service delivery during 1955-69, only half of which was financed through increased spending, whilst the rest was financed through efficiency gains. Sri Lanka was able to achieve significant reductions in infant and maternal mortality by rapidly expanding coverage from the 1960s to the late 1990s as a result of efficiency gains, even though health spending as a share of GDP fell during this period. In some countries, inefficiencies account for a ten-fold variation in the unit cost of delivering the same services but at different health facilities\textsuperscript{57}.

There are two types of efficiencies to consider in the health sector. Technical efficiency is achieved when the maximum output (e.g. childhood immunisations) and outcomes (e.g. immunisation coverage) are achieved for a given level of inputs. Examples of technical inefficiency include: high levels of absenteeism in public sector facilities; the failure of procurement systems to purchase medicines at the lowest available prices; or more generally, an inefficient mix of medicines and personnel being used to provide a service. Allocative efficiency is achieved when the most appropriate mix of outputs is achieved given inputs. For instance, primary and preventive care services remain underfunded in many countries even though these interventions are far more cost-effective at achieving the desired health outcome goals.

In the Solomon Islands, health outcomes are better than average although health expenditures are lower as a share to GDP relative to many other Pacific Islands. While this is indicative efficiency, health service delivery in the country is still characterised by both allocative and technical inefficiencies. In fact, expanding fiscal space for health in the Solomon Islands is unlikely to substantially improve health outcomes until inefficiencies in the management, financing and delivery of health care are addressed. The remainder of this chapter examines potential areas for improvements in technical and allocative efficiency in the health sector, and links it to the need for improved budget planning and management.

**What are potential areas for efficiency gains?**

(i) **Allocate more resources to primary care and outreach services**

In a classic example of allocative inefficiency, tertiary hospitals account for a disproportionately large share of total health spending in the Solomon Islands. Hospital services are far less cost-effective than primary health care (PHC) services for meeting current health sector needs, which are dominated by communicable diseases and maternal and child health conditions. The Solomon Islands National Health Strategic Plan 2006–10 seeks to promote PHC in the country, and the new 2011-15 Plan is likely to continue this trend.

Underfunding of PHC services is a major cause of this type of inefficiency. For instance, provinces are responsible for conducting integrated PHC outreach programs from their headquarters involving one week tours every month. During these visits, the team comprising staff from each provincial health department/program (including a medical officer in some cases) provides a wide range of preventive and PHC services, referral and specialist clinics, and on-the-spot problem-solving in outlying parts of a province. In reality, the integrated outreach visits take place on average only once every other month.

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The program is not implemented as planned because of insufficient budget allocations for the integrated PHC outreach programs\(^{58}\).

As long as PHC services remain underfunded and of poor quality, efforts to restrict access to hospital care by imposing user fees or other barriers to access would be detrimental to equity. The population has responded to poor quality PHC services by bypassing them in favour of higher level care at hospitals, leading to the current pattern of utilisation and expenditures. As Chapter 2 showed, hospital utilisation is pro-poor because poor households face few barriers in accessing hospital inpatient care services when services at the lower levels of care are unavailable or of poor quality. Bypassing could be prevented by restricting access to hospital care, but this would undermine the high levels of equity in the health system. In order to both improve allocative efficiency and maintain a pro-poor distribution, the government will have to invest more in good quality PHC services.

Shifting the allocation of public sector resources away from tertiary level curative care services and towards primary health care (PHC) and outreach services could lead to significant efficiency gains. It will also improve equity by bringing services closer to the population, and reducing transport costs related to seeking health care.

**(ii) Maintain a physical investment plan and make provisions for the incremental recurrent costs of new infrastructure**

The absence of facility development plans and the failure to account for the incremental recurrent costs of new infrastructure also contribute to allocative inefficiency. At present, clinical facilities can be constructed by donors outside of any strategic facility development plan, and without ensuring that the incremental recurrent costs associated with that investment can be met by the existing health budget. The AusAID ODE study includes an example from Guadalcanal, where a hospital was built right next to an existing primary care facility by an Italian Non-Governmental Organisation, adopted by the province as a health centre and given a budget\(^{59}\). The incremental recurrent costs of staffing and running this facility are quite substantial for the already overstretched provincial health office, but these were not taken into consideration beforehand.

In order to improve allocative efficiency by investing more in PHC services in a sustainable manner, a credible policy for limiting over-investment in tertiary care is needed. Thus, the preparation of a physical investment plan will be critical for ensuring that funding is allocated rationally between primary, secondary and tertiary levels of care, and not driven simply by the availability of funds for new infrastructure.

**(iii) Improve the mix and productivity of inputs**

There is a clear need to identify and correct inefficiencies in the mix of inputs. Funding for salaries is non-discretionary and accounts for nearly 60% of the SIG health budget. Direct Wage Employees, health professionals other than doctors who are hired directly by the provinces, exacerbate this problem as they account for a significant share of provincial health budgets. As a result, the share of the budget that remains for medical supplies and goods is not adequate. Stockouts in drugs and medical supplies are a frequent problem in health facilities.

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\(^{58}\) AusAID ODE (2009)

\(^{59}\) AusAID ODE (2009)
Multiple budget sources available to pay for staff make it harder to rationalise the use of staff and non-staff budgets. Each form of financing has implications for the salary level and employment conditions of the staff member concerned. For instance, the salaries of provincial staff, particularly nurse aids, are financed from different sources, including the central public service, direct employment financed from the provincial health budget or in some cases, the community. A number of aid posts are also directly financed by Members of Parliament and local politicians.

There is also scope for reducing the costs and/or improving the productivity of inputs. Pharmaceutical costs are growing rapidly and subject to budget overruns. A review of pharmaceutical cost management practices is needed. In the longer term, the government would also need to address problems of staff absenteeism, which are significant particularly at the periphery, by improving staff incentive structures.

Another source of inefficiency related to the use of inputs is the failure to make adequate provisions in the budget for the maintenance costs of new buildings and equipment. As much of the infrastructure is financed by external donor resources, there is little incentive on the part of the government to invest in maintenance. This pattern of resource allocation is unsustainable in the long run. One solution is to make all new investment infrastructure conditional on the maintenance costs being phased into the health budget over time.

(iv) Leverage the resources allocated to vertical programs to strengthen service delivery

The direction of disproportionate amounts of funding through vertical, disease-specific programs is another potential source of inefficiency. For example, the Solomon Islands have among the highest incidence of malaria outside Africa, and almost the entire population is at risk. Malaria has attracted significant donor funding and other development partner resources but, as a result, the malaria program now accounts for the largest share of primary and preventive health expenditures – nearly three times the amount allocated to reproductive health.

Donors and the national malaria program are also mindful of the problems that were associated with premature winding-back of technical and financial support during the global eradication program of the 1960s and 70s, and understand their ethical responsibility to maintain support until a very high and sustainable level of control has been achieved. This means that the resource requirements of the malaria program have become – and will continue to be – considerable.

However, earmarking a significantly large portion of government and donor resources to disease-specific programs reduces the share available for overall health systems strengthening. It also distorts the relationship between sectoral priorities and expenditures.

Given the magnitude of resources devoted to vertical, disease-specific programs, efficiency gains can be achieved by leveraging off those resources to deliver broader PHC and outreach services on the one hand, and to purposefully strengthen the underlying health system on the other.
Box 1 presents clear strategies for strengthening PHC and outreach services through the malaria program, which would be quite feasible to implement in the short to medium term.
Box 1: Gaining greater efficiency from disease-specific funding streams in the Solomon Islands60

The Solomon Islands has embarked on an ambitious plan to eliminate malaria from Temotu and Isabel Provinces by 2014, and to achieve a 50% reduction in the incidence of malaria in areas with the highest rates of transmission (Malaita and Guadalcanal Provinces, and urban Honiara).

Achieving these goals will require a sustained, medium- to long-term commitment, especially in the higher incidence provinces and urban areas (which, because of high levels of population movement, continue to represent potent sources of re-introduction of malaria into the “elimination” provinces). Premature cessation of interventions may result in a resurgence of malaria transmission, the emergence of drug-resistance in the parasite and insecticide resistance in the mosquito vectors.

The Government’s plan is underpinned by significant external technical and financial support, including from the Global Fund, AusAID, JICA, WHO and Rotary International. In 2010, the national malaria program will have a budget of SBD 49.25 million (equivalent to 16.3% of the total health budget). Of this, SBD 17.8 million (36.1%) will be derived from HSSP, SBD 26.5 million (53.7%) from the Global Fund, and just over SBD 5 million (10.2%) from general revenues.

Following the Health Financing Workshop held in Honiara on 8 December 2009, participants explored and discussed options for efficiency gains from disease-specific programs with relatively protected funding streams, using the malaria program as a case study. Two broad strategic approaches for functional leveraging off the malaria budget were identified and discussed:

A) Strengthening the delivery of primary and preventive care outreach services
This approach will be feasible for enhancing the delivery of PHC and preventive health services at the Provincial level, where the fixed overhead costs of delivering malaria-related outreach (e.g. bed net distribution or replacement, indoor residual spraying, surveys and case investigation) are already funded under the malaria budget.

B) Strengthening the underlying health system
Under this approach, donor funding is applied to functional aspects of the health system rather than directly to disease-specific interventions. Other divisions within the Ministry of Health and Medical Services would be funded to collaborate in and implement specific aspects of the malaria program that have specific resources allocated to them. Malaria-specific funding would indirectly boost the skill base and capacity of those other MHMS units while, at the same time, sharing or absorbing the costs associated with some non-malaria activities61.

Under Strategy A there are several examples of enhanced outreach services that may be linked to community level malaria activities: health promotion and education; screening for filariasis or antenatal anaemia at the same time as blood samples are taken for malaria incidence surveys or elimination monitoring; surveillance for other diseases of public health importance (e.g. clinical examination for yaws, sputum collection for tuberculosis, stool examination for soil-transmitted helminths); antenatal

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60 This Box was written by Rob Condon, based on discussion between development partners and malaria stakeholders (including the national program), which took place following the health financing workshop of 8 December 2009. Discussion was informed by experience and lessons from AusAID and WHO in rural, malaria-endemic provinces of the Philippines, where outreach constraints are similar to the Solomon Islands and which also face similar challenges in maximising the benefits of disease-specific funding. Similar approaches are already being piloted in Temotu Province.

Improving examination and maternal education; childhood immunisation and growth monitoring; general clinical consultation; and addressing other environmental health problems like scrub typhus (known as ‘Santa Cruz fever’ in Temotu) whenever environmental interventions for malaria are being undertaken.

Under Strategy B, many health system functions at both national and provincial levels could potentially benefit from the increased funding flows and the broader range of activities associated with enhanced malaria control and elimination. For example, health promotion, communication and community mobilisation for enhanced malaria control and elimination will also identify other health issues and could be adapted to address them; malaria information systems can be developed in a way that also strengthens the broader health information system (including shared use of mapping and spatial decision support systems); support for malaria drugs and commodities can be delivered in a way that supports the overall development of national procurement and supply management systems; standard treatment guidelines (e.g. for integrated management of childhood illness (IMCI), or for delivery of a basic package of health services) could be revised and disseminated at the same time as the section on clinical management of malaria is updated; and health worker training on malaria diagnosis and treatment could also be used as an opportunity for updating knowledge on other aspects of primary and preventive care. Where financial system blockages are being tackled to allow better flow of malaria funding to the provincial level, funding for other programs is also likely to benefit.

Both strategies would contribute to increased efficiencies and “fiscal space” through improved geographic targeting, delivery of interventions with a high public health impact, increased overall investment in PHC, and achieving more rational coordination, an optimal combination of inputs and reduced duplication in disease-specific programs. The quickest gains will potentially be in areas where malaria interventions are more intense (e.g. higher-incidence provinces and urban areas) or where outreach and community partnerships are more evolved (e.g. the “elimination” provinces).

To institutionalise this approach, the MHMS will need to develop clearer implementation plans for provincial level primary care and supervisory outreach, costing of a defined package of malaria and other services, and a suitable mechanism for national level oversight, planning, monitoring and accountability.

These options will be further explored by Provincial Health Managers and the Director of the national malaria program in the course of provincial planning and budgeting. Recommendations will then be made to the MHMS Executive Committee for consideration. Other disease- or issue-specific programs (e.g. tuberculosis, immunisation) will be encouraged to take a similar approach.

(v) Improve geographic targeting

Improving the geographic targeting of spending would ensure that the distribution of resources is aligned with needs. There are large disparities in health spending across Solomon Islands: Honiara accounts for a disproportionatley large share of spending, while Guadalcanal and Malaita receive the least. Yet, Malaita has the most over-utilised and under-invested provincial primary care system.62

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Politically, a one-off redistribution to level off per capita expenditures may be difficult to achieve quickly. A more feasible approach is to gradually make inter-provincial adjustments in resource allocations to address high workloads, lagging service coverage and outcomes, and infrastructure deficits. The acknowledged high incidence of malaria in Malaita (see Box 1) presents an opportunity to link this process to a scaling up in malaria interventions that are already funded.

(vi) Further strengthen budget planning and management

Strengthening budget planning and management is key to addressing all of the inefficiencies identified in this chapter. For instance, in (i) above, underfunding of integrated PHC outreach programs was described as an example of allocative inefficiency. Underlying this source of inefficiency is a lack of clarity in the national and provincial health plans about what services need to be provided and how they will provided as part of integrated outreach. This lack of clarity results in a failure to budget and plan adequately for these services. Staff continue to be busy in the static clinics, and are not available or provided with the right incentives to provide outreach services.

Substantial efficiency gains are to be achieved by strengthening budget planning and expenditure management, and linking them to national priorities and goals. This would also improve SIG allocations to the sector simply by improving the credibility of the budget submissions. Two factors are critical to this. One is comprehensive budget management, which integrates development and recurrent budgets from SIG and external resources. This would reduce the fungibility of parts of the development budget, as is the case at present. The other is greater clarity of roles, accountabilities and reporting arrangements between Central and Provincial Governments. One example of this problem is the existence of multiple financing sources for the salaries of provincial health staff, mentioned above.

Budget planning and expenditure management can also be strengthened by: requiring regular financial reporting on the performance of both government and donor budgets to operational units; disaggregating provincial health department budgets and expenditure reports by hospital and non-hospital, recurrent and capital expenditure categories; preparing unit operational plans that clearly delineate current/approved activities from those that are incremental as part of the direct linkage to budget submissions; and clearly defining expected outputs, with explicit links to outcome goals in the MOH strategic plan.

In addition, better planning needs to be matched by better execution of funds. Spending units need to receive the funds allocated to them in a predictable manner so that they are able to spend them in a timely fashion. Often, funds are received too late in the financial year for them to be fully utilised.

A good example of efforts to strengthen budget planning and management are the annual operational plans already being prepared by some provincial health teams, and described in Box 2.
Box 2: Operational Plans

Detailed operational health plans are being prepared by some provincial health teams at present. The operational plans specify activities, responsibilities and some performance indicators, and indicate financial requirements and funding sources. An extract from the Social Welfare Operational Plan is provided below:

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Expected outputs</th>
<th>Activities</th>
<th>Time frame</th>
<th>Total Cost</th>
<th>Funding Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Aiding People in Crises</td>
<td>Provide food and clothing to destitute</td>
<td>1st Q, 2nd Q, 3rd Q, 4th Q</td>
<td>x x x</td>
<td>SIG</td>
<td>SIG</td>
</tr>
<tr>
<td>1.2 Provincial Tours</td>
<td>Free for casework management</td>
<td>1st Q, 2nd Q, 3rd Q, 4th Q</td>
<td>x x x</td>
<td>SIG</td>
<td>SIG</td>
</tr>
<tr>
<td>1.3 Court Reports</td>
<td>Social Enquiry Reports provided</td>
<td>1st Q, 2nd Q, 3rd Q, 4th Q</td>
<td>x x x</td>
<td>SIG</td>
<td>SIG</td>
</tr>
<tr>
<td>1.4 Community Welfare Volunteer Scheme Support</td>
<td>Workshops and support to CWVs in Western &amp; Choiseul Provinces</td>
<td>1st Q, 2nd Q, 3rd Q, 4th Q</td>
<td>x x</td>
<td>SIG</td>
<td>SIG</td>
</tr>
<tr>
<td>1.5 Support to Correctional Services</td>
<td>Weekly Correctional Services Visits to Juvenile and women inmates</td>
<td>1st Q, 2nd Q, 3rd Q, 4th Q</td>
<td>x x x</td>
<td>SIG</td>
<td>SIG</td>
</tr>
</tbody>
</table>

It is important that this planning process is extended throughout the country. To be effective, it has to be accompanied by sufficient additional resources to the provinces to expand access to services to under-served areas. Also, good management supervision and access to timely budgets are crucial for sustaining this type of budget planning. For instance, planning processes have broken down in Malaita as a result of problems in financial management.

(vii) Improving the effectiveness and coordination of development assistance

Given the high aid dependence of the health sector, development partners also have a role to play in improving the efficiency of external spending in the health sector. First, to define health policies and plans, SIG needs to know what resources it can expect from the development partners. Clear, long-term indications of likely aid levels are thus critical. Second, in addition to predictability, a high degree of flexibility is also needed that allows for relatively easy scale-up during downturns, given the volatile macroeconomic conditions. Third, there needs to be greater harmonisation and coordination of external donor spending. On-going efforts by the health development partners’ group to coordinate around the health SWAp are important in this regard; even where donor funds are not yet entirely integrated with the Government financial system (e.g. Global Fund resources for malaria), the existence of a unified work plan and an integrated costing framework under the management of a national Malaria Steering Committee indicates important steps forward. Finally, development partners need to make far greater use of government systems in the medium term, and invest in the capacity needed in government to allow them to make that shift in the future.

8. Conclusion

The Solomon Islands health system has delivered better than average health outcomes, which have been resilient to the political and economic crises that have affected the country. The current system also provides high levels of financial protection and relatively equitable access to health services.
However, these good health outcomes have been achieved with relatively few health inputs per capita. Also, the distribution of health inputs and resources across the provinces is highly unequal. Additional investments will be needed in future to meet the demands of the growing population, which will put pressure on already low levels of per capita inputs, as well as improve the quality and effectiveness of service delivery, and distribution of health services. This Policy Note was motivated by the need to examine ways of financing future investments in the health sector.

Weak economic growth prospects and the need for fiscal tightening mean that it would not be possible to substantially increase government allocations for health during 2010-2014. Economic growth may improve after 2014 driven by a rebounding of demand abroad, strengthening of commodity prices and new mining related investments. SIG revenue generation capacity may also improve beyond 2014 if proposed economic reforms to strengthen the tax base and tax administration prove effective. Under this economic growth scenario, SIG health spending as a share of GDP is not likely to decline significantly thanks to the high elasticity of SIG health spending with respect to GDP. It is clear however, that in the short to medium term, significant increases in fiscal space for health are not likely.

Under present macroeconomic conditions, not only is an increase in general revenue allocations unlikely, but the introduction of SHI would also not be feasible. Given that 80 percent or more of the population is in the informal sector, any new SHI mechanism would have to be accompanied by a large increase in government revenue financed subsidies to cover the informal sector. Other pre-requisites for the introduction of SHI are not in place either.

The Solomon Islands has two ways to generate additional resources for health. One is through external donor sources. These are likely to provide a health spending cushion in the face of weak growth prospects and public expenditure constraints. The other is through efficiency savings. The latter will not simply generate additional resources for health. It will also improve the sustainability of financing in the longer term, and allow the current system to maintain its many positive features such as the high levels of financial risk protection and equity.