HEALTH SECTOR SUPPORT PROGRAM (HSSP2)

MANAGEMENT RESPONSE
INDEPENDENT COMPLETION REPORT RECOMMENDATIONS

GENERAL RECOMMENDATIONS

1. Australia should invest in continued support to health when HSSP2 ends in June 2016. This is for mixed reasons health related, technical and political.	**Accepted.** A third four-year phase of support to the health sector - the Health Sector Support Program (HSSP3) - has been designed and will commence later in 2016.HSSP3 will provide AUD66 million over 4 years to assist the Ministry of Health and Medical Services (MHMS) to implement the National Health Strategic Plan (2016-2020).
2. That support should continue to be as budget support to the health sector, with earmarking as appropriate as per GoA policy. Australia should continue to act as an 'honest broker' to assist the MHMS to bring other DPs fully into the SWAp partnership.	**Accepted.** HSSP3 will continue as "adaptive budget support", in the form of a fusion of earmarked budget support, technical assistance and performance-linked funding.
3. The support should continue to be aligned and focused on supporting the MHMS to deliver the existing and any successor NHSPs through the SWAp partnership mechanisms.	**Accepted.** As per Recommendation 1, HSSP3 will assist the MHMS to implement the National Health Strategic Plan (2016-2020). The SWAp partnership will be maintained, with secretariat support provided by WHO. The SWAp Partnership Arrangement is being updated for 2016 – 2020, in line with recommendations from the HSSP3 design document.
4. Australia must intensify efforts to improve the mechanisms available for, and the quality of the policy debate between MHMS and DPs while ensuring that the NMHS ownership of the process is strengthened. This will involve being a lead partner in the finalisation of the new NHSP, working with the MHMS in focusing the strategy on maintaining gains in primary health care; shifting slowly to more investments in preventive health care; and supporting a strategic approach to health systems strengthening focused to support the NHSP.	**Accepted.** The HSSP3 design document identifies key entry points and strategic reforms for pursuit through policy dialogue, as well as a policy dialogue and engagement strategy. HSSP3 has simpler, more focused objectives, which focus om improving delivery of primary health care, strengthening health systems and driving innovation and reform.
5. The move towards placing increasing investment at the provincial level is a	**Accepted.** HSSP3 stipulates that 40% - 45% of direct budget support be provided

positive move and should continue and accelerate in any follow-on funding.	through provincial grants.
6. The performance related provincial grants are at an early stage of implementation. While apparently successful to date this approach should be carefully considered at design of any follow-on support to ensure that the process remains simple and a positive incentive and not seen as a penalty system for under-performance.	**Accepted.** HSSP3 provides guidelines for improved application of performance-linked aid.
7. The program should consider encouraging the SIG to allocate a greater share of own revenue to health.	**Partially accepted** on the condition that this be underpinned by sound budget analysis.
8. There should be a formal wide-ranging health systems-wide review to identify capacity gaps in the MHMS, including in management and propose a strategic plan to address any gaps. The review should be system-wide, not restricted only to PFM issues and should include both the central and province levels and systems. This review will assist to identify any particular areas of focus (for example human resource strategies and management, health information systems, procurement) that may need additional focus in the new NHSP and support under any new Australian funding.	**Accepted.** Undertaken as part of the HSSP3 design process. The HSSP3 design document identifies core Technical Assistance (TA) required to address capacity gaps.
9. Following on from, or as part of, the systems review and building on the findings of that review, there should be a formal assessment, led by the MHMS with external support, to review the TA needs to support any gaps as identified in the systems review. The TA review should propose a plan for TA across the MHMS both centrally and provincially, including recommendations for recruitment and management. This plan would also identify the role of TA and clarify the approach of each individual TA – that is the balance between capacity building and line-function – and consider the TA procurement and management approach. This MHMS led review should propose and agree a management model for the TA.	**Accepted,** As per R.8. In addition, HSSP3 identifies an agreed model for management of TA.
10. Once a TA plan is agreed, the costs of TA should then be reflected in the individual AOPs. This will increase ownership and allow line managers to	**Not accepted.** DFAT along with some other development partners do not agree with this recommendation. It is more appropriate to identify these costs in the non-appropriated section of the budget.

better understand the true costs of managing their AOP.	
11. Significant continuing support for financial risk management will need to be included in the design of HSSP3 and additional TA resources included for the foreseeable future. This should include support at the provincial level and to the internal audit team.	**Accepted.** HSSP3 identifies, as part of core TA, identifies specific positons required to support financial risk management, including support at the provincial level and to the internal audit team, and the continued use of TA for the implementation of ex-ante controls.

SPECIFIC RECOMMENDATIONS

Strengthen the process of policy debate with government and government ownership of the process	
12. Review the SWAp management mechanisms and ensure that they are 'government friendly'.	**Accepted.** The SWAp Partnership Arrangement is being revised for 2016 – 2020 and the new Arrangement will include increasing emphasis on SIG leadership of the SWAp, including greater participation in decision making by Provincial Directors of Health.
13. Support the development of the proposed donor coordination cell of the MHMS as led by the Director in NVBDCP.	**Accepted.**
14. An updated and current MTEP would be a useful tool to inform the partners' policy debates over future investment decisions, particularly those (for example facility construction and staff training) which may have significant future recurrent cost implications.	**Accepted.** The World Bank will lead on this.
15. The risks inherent in policy decisions being taken, which have far-reaching recurrent cost implementations for the future are appreciated by the incumbent DFAT in-country team. Management of these risks needs to be urgently addressed in the policy dialogue around the design of HSSP3. In addition to direct discussions with the MHMS, DFAT should leverage the experience of the governance team to in accessing and addressing the CEWG if appropriate.	**Accepted.** The World Bank will lead on this.
Sector Capacity and TA	

16. A detailed departmental capacity study, formal TA needs assessment and coordinated TA plan would be of benefit in the design process of HSSP3.	**Accepted.** As per response to Rs.8&9.
17. The costs of TA are not currently reflected in the AOPs and thus the MHMS is unaware of the full cost of running the health service. Reflecting the activities and costs of TA in the AOPs would allow MHMS to see the full costs of support and facilitate management and ownership of TA.	**Not accepted.** As per response to R.10.
18. Redesign of the TA program through a needs assessment process could also address the mix of capacity building services, clarify the management model for the TA and reduce the cost of DFAT management inputs. The capacity development approach should be examined and detailed.	**Accepted.** As per response to R.9. More efficient approach to management of Scope Global contract has been implemented through the use of a single Service Order for management of TA.
19. Continue support to the Internal Audit Unit until assessed as no longer required	**Accepted.** HSSP3 design identifies a phased out approach for TA to the internal Audit Unit.
Performance based funding	
20. Performance based payments should be reviewed for HSSP3 to ensure that they remain effective as incentives. Focus should be on rewards that can be implemented for better performance within the government system.	**Accepted.** Addressed in HSSP3 design.
21. The program should encourage the SIG increasingly to allocate a greater share of revenue to health. WHO have proposed 15 per cent as an international norm. Any such increase should be justified by economic analysis in the Solomon Islands setting.	**Accepted.** As per response to R.7.