Asia Pacific Observatory
on Health Systems and Policies

HEALTH SYSTEMS IN TRANSITION 03/2014

FIJI LIVING HiT UPDATE

Chapter 3: Health Financing

3.1 Section summary

This section describes financing of the health sector in Fiji including an overview of the system, levels of spending, sources of financing and payment mechanisms. Government budget allocations for health have remained relatively constant despite the increasing demand and cost for health care. Since 1995, the Government of Fiji has allocated between 7% and 10% of its total expenditure to health; the latest figure being 7.2% in 2012. In the same period, government health expenditure as a proportion of gross domestic product (GDP) has fluctuated between 2.7% and 3.5%, while total health expenditure (THE) has hovered around 4% of GDP; it was 4.5% in 2012. These proportions of GDP spent on health are the lowest among Pacific island countries. Per capita health expenditure has increased steadily since 1995 up until 2009, decreasing slightly until 2011.

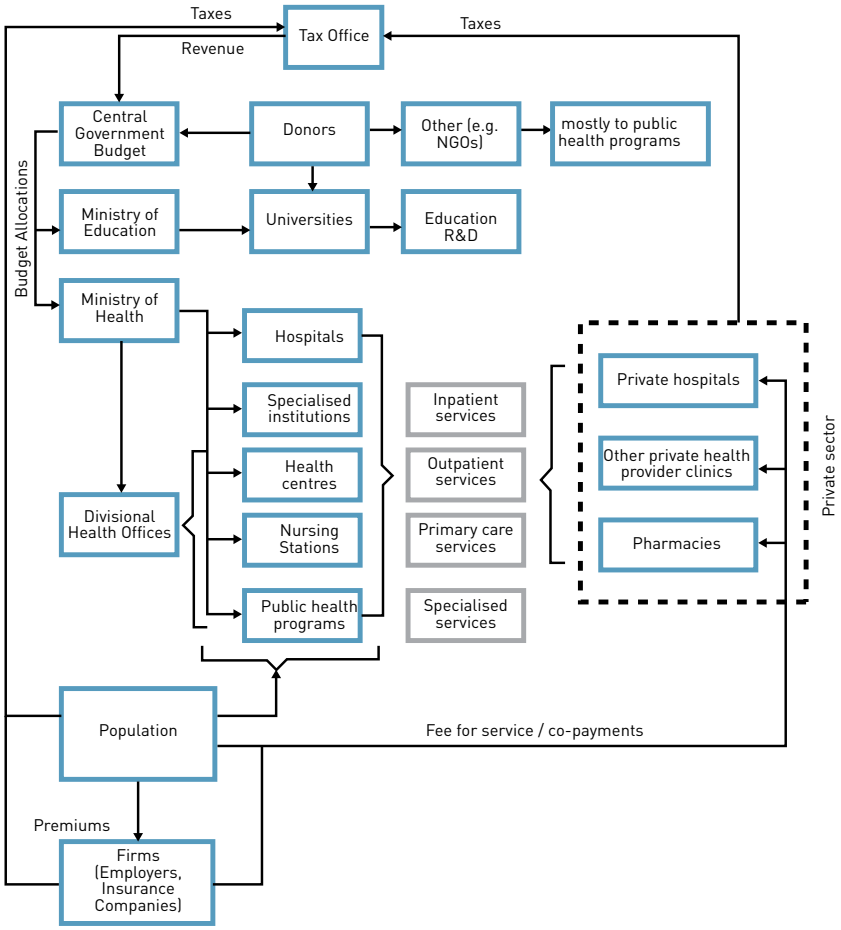
The share of health expenditure spent on inpatient services decreased from 35.4% in 2005 to 26.5% in 2012. In 2012, government health expenditure represented 60% of THE, lower than all other Pacific island countries, but relatively high when compared internationally. Private health expenditure has increased and was 34% of total health expenditure in 2012. This increase is largely because of out-of-pocket (OOP) expenditure, which has more than doubled over the period 2005 (12%) to 2012 (27%). Apart from government and private sources of funds, development partners represent 6% of THE.

The Fiji health system has been financed mainly through general taxation. OOP expenditure, although relatively low when compared with many countries, is the second highest source of financing for health. There are no compulsory social insurance schemes. A 2012 social health insurance feasibility study concluded that it would be difficult to achieve an adequate base of contributors for a national health insurance system (Rannan-Eliya et al., 2013), and voluntary health insurance is uncommon (due mostly to lack of affordability). Nevertheless, spending premiums for private health insurance increased from 2005 to 2012.

Public provision of health care is free or at very low cost for all persons in the country. User fees are charged for some basic and selected services, but even at revised 2012 rates they are modest compared with the costs of providing these services. Certain population groups are exempted from paying user fees. Private health spending is not adequately documented. Private providers charge user fees that are considerably higher than those in public facilities; private fees are not regulated by the Government but to some extent by market forces. Private providers are mainly situated in urban areas and their services are used mostly by those who are formally employed.

Figure 3-1 depicts the health financing flows of the Fiji health system. The diagram shows where revenue for health is generated, the health providers that receive this revenue, and the health services they provide that are funded from this revenue.

Figure 3-1 Financial flows in the Fiji health system



Source: Asia Pacific Observatory on Health Systems and Policies

The same government health services are available to all residents of Fiji; foreigners are entitled to the services at a cost twice that of resident user fees. Given Fiji's geography, urban populations inevitably have greater access to health services than rural populations. Access to specialized health services and cost of transport is a major barrier for those living in remote areas, and the government budget for emergency transport is limited, as is the allocation for overseas evacuation and treatment.

The Government operates a consolidated fund in which taxation revenues and user fees are pooled. Ministry of Health (MoH) officials submit budget proposals to the Government based on national-, regional- and local-level submissions, and they compete with other ministries for their financing. Allocations are usually based on historical budgets and the ruling government's annual priorities. External sources of funding include contributions from multilateral and bilateral development agencies, and nongovernment organizations – an estimated 6% of THE in 2012.

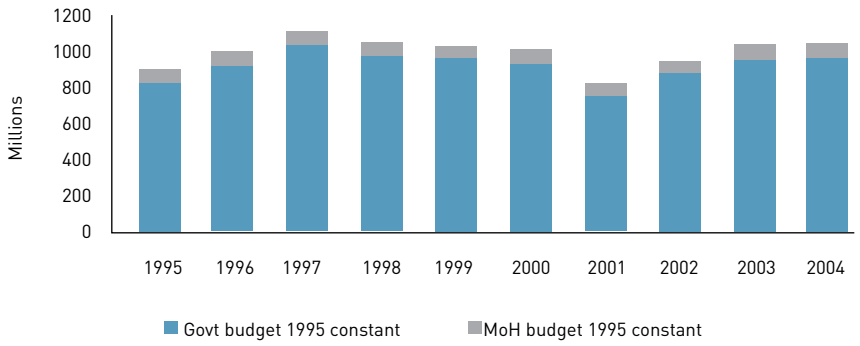
Payment mechanisms for health-care providers are relatively straightforward, as the Government both finances and provides the majority of services. The MoH receives its budget (finances) according to resource inputs such as human resources, services, capital investments, and purchase of pharmaceuticals and medical equipment, and uses a similar process in distributing these funds across various government-owned health facilities. The majority of health workers in the country are salaried staff of the MoH or government wage-earners. Some services are outsourced such as cleaning and security, and there are plans to outsource others such as laundry and food catering. Private general practitioners receive a fee-for-service payment, and some are contracted to private organizations to provide employee health care. Private insurers can either cover all health service costs upfront or reimburse patients on provision of receipts. Pharmaceuticals and other medical goods are imported by the government-funded Fiji Pharmaceutical & Biomedical Services Centre, which supplies all government health facilities. Private pharmacies can choose to purchase from the Centre with allowable wholesale and retail mark-ups set by the Fiji Prices and Incomes Board and the Fiji Commerce Commission.

3.2 Health expenditure

The health-care system in Fiji is financed mainly through general taxation. The other major source of financing is OOP payments, which are mostly generated in the private health sector. Private health insurance and donor organizations contribute smaller amounts of financing.

Government budget allocations for health have remained relatively constant despite the increasing demand for and cost of health care. Over the decade 1995–2004, the Government allocated between 9% and 11% of its total annual public expenditures to health, except in 1999, when the allocated percentage was its lowest at 7.6%.

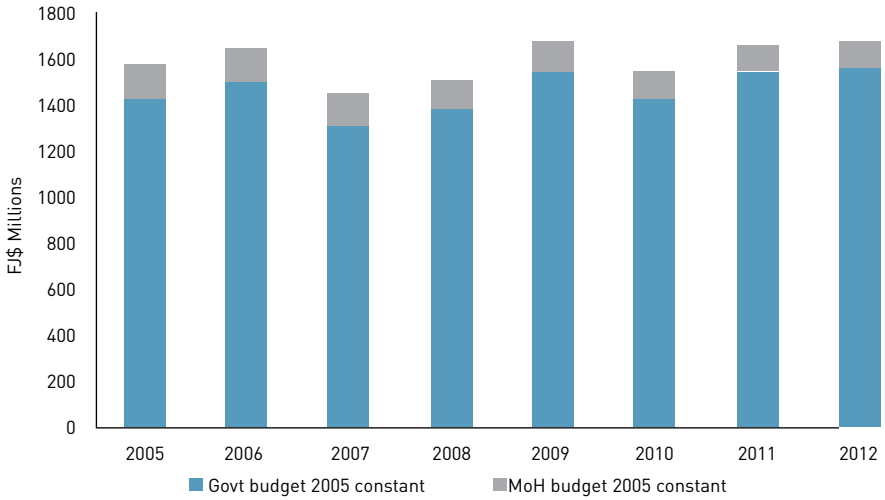
Figure 3-2 Total government budget and health budget (in constant 1995 FJ$)



Source: Azzam (2007)

The total government budget showed a slight increase over the period 2005 to 2012. Total government expenditure amounted to FJ$ 1424.5 million in 2005 (33% of GDP). By 2012, it had risen to FJ$ 2077.9 million (34% of GDP). However health expenditure as a percentage of total government expenditure has decreased as a percentage share from 9.6% in 2005 to 7.4% in 2012. Over the period 2005 to 2012, health expenditure has averaged 8.8% of government expenditure.

Figure 3-3 Total government budget and health budget (constant 2005 FJ$)



Sources: Ministry of Health (2005, 2006, 2007, 2008, 2009, 2010, 2011 and 2012a).

Table 3-1 summarizes information obtained from Fiji Health Accounts reports for 2005 to 2012 and WHO data.[1] Since 1995, government health expenditure as a proportion of gross domestic product (GDP) has hovered between 2.7% and 3.5%. This is one of the lowest rates among Pacific island countries (see Fig. 3-3), despite the fact that Fiji is more economically developed.

1 Caution is advised in comparing these figures since it is probable that the estimation methodologies used in National Health Accounts (NHA) reports differ from those used in the World Health Organization (WHO) report. The figures for 1995 to 2005 are from WHO, while the figures for 2007 to 2012 are from Fiji NHA reports.

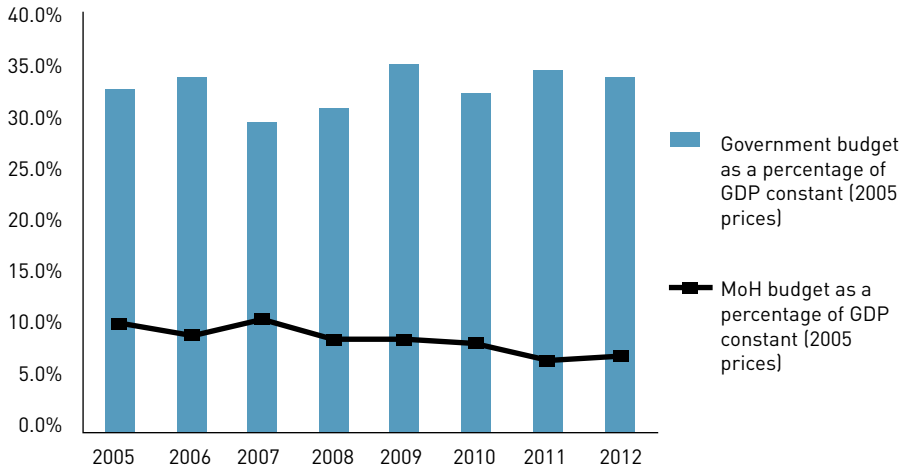
Table 3-1 Trends in health expenditure in Fiji

Expenditure	1995a	2000a	2005b	2007c	2008c	2009d	2010d	2011d	2012d
Total health expenditure (THE) in US$ per capita	125.4	166.7	170.1	170.7	168.5	198.7	193.8	182.9	-
THE as % of GDP	3.9	4.7	4.1	4.3	4.2	4.9	4.8	4.4	4.5
Public expenditure on health as % of THE	58.2	69.0	72.0	71.2	69.6	62.9	60.8	61.7	60.3
Private expenditure on health as % of THE	-	-	24.0	25.4	24.5	31.0	30.4	33.4	33.8
Mean annual real growth rate in GDP	-	–1.7	3.6	–6.6	0.2	–1.3	–0.2	2.1	2.5
Total government spending as % of GDP	34.9	35.1	31.4	33.2	35.2	33.9	32.0	33.7	37.4
Government health spending as % of total government spending	8.6	9.8	9.6	10.0	8.2	9.3	9.2	8.1	7.2
Government health spending as % of GDP	3.0	3.5	3.2	3.3	2.9	3.1	2.9	2.7	2.7
Out-of-pocket payments as % of THE	-	-	11.9	15.4	15.5	22.5	20.0	27.2	26.8

Sources: (a) World Health Organization (2013) for years 1995 and 2000; (b) Azzam (2007) for year 2005; and (c) Fiji Health Accounts (2007, 2008, 2009, 2010, 2011 and 2012)

Figure 3-4 shows that while the government budget as a percentage of GDP has fluctuated, it has remained relatively constant between 30 and 35. However, the government health budget as a percentage of GDP shows a gradual decrease from approximately 11% in 2005 to approximately 8% in 2012.

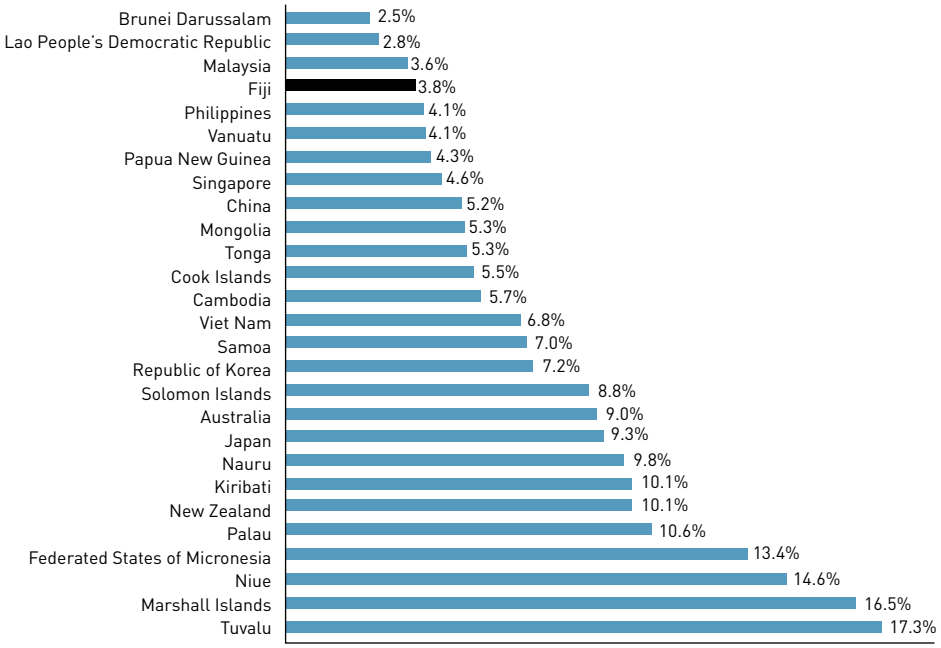
Figure 3-4 Government and Ministry of Health (MoH) budget as a share (%) of GDP, 2005–2012



Sources: Ministry of Health (2005, 2006, 2007, 2008, 2009, 2010, 2011 and 2012).

Estimates from Fiji Health Accounts reports show a slight increase in THE as a percentage of GDP, from 4.1% in 2005 to 4.5% in 2012. This indicator is within the 4–5% range recommended by the World Health Organization (WHO) regional strategy on health financing (WHO, 2009). The increase is largely driven by investments in the private sector since government health spending as a percentage of GDP has decreased from 3.2% in 2005 to 2.7% in 2012.

Figure 3-5 Total health expenditure as a share (%) of GDP, WHO Western Pacific Region, 2011



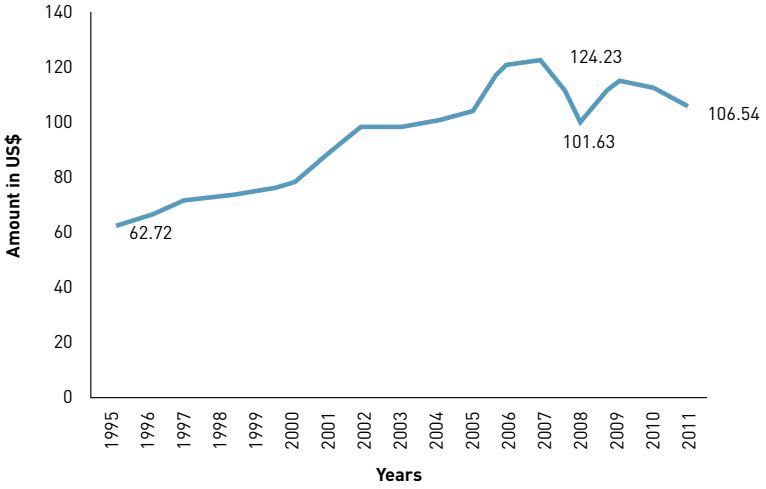
Note: No 2011 values are available for American Samoa, French Polynesia, Guam, Hong Kong (China), Macao (China), New Caledonia, Northern Mariana Islands, Tokelau, Wallis and Futuna.

Source: WHO (2013)

Table 3-1 shows that private health expenditure as a percentage of THE increased from 24% in 2005 to 34% in 2012. This increase was largely a result of OOP expenditure which more than doubled over the same period. OOP expenditure as a percentage of THE increased from 11.9% in 2005 to 26.8% in 2012.

There was a steady upward trend in government per capita health expenditure from US $62.72 in 1995 to US $124.23 in 2007 (see Fig. 3-6). However in 2008, there was a decrease to US $ 101.63 due to a reduction in government health expenditure. Thereafter from 2008 to 2011, government health expenditure has remained fairly constant.

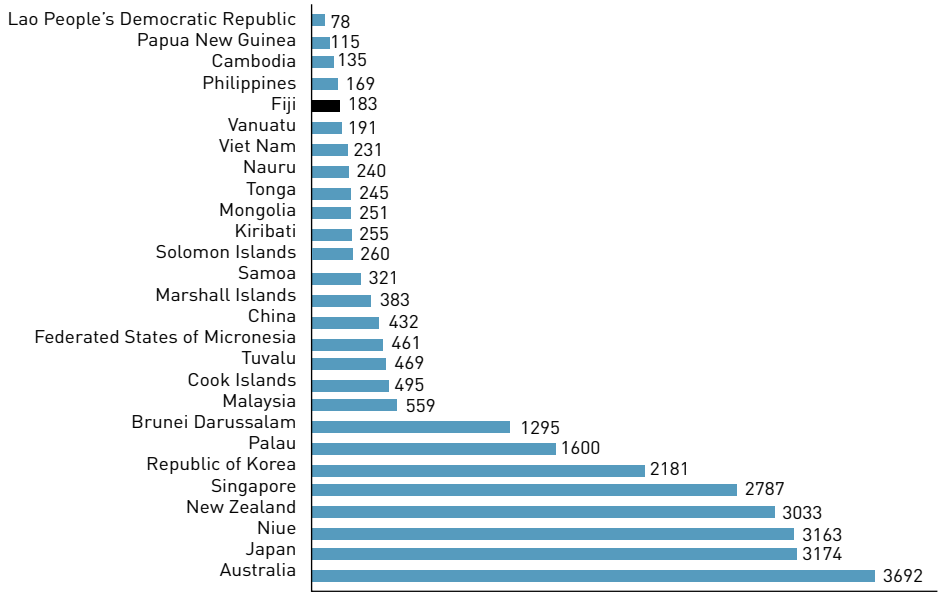
Figure 3-6 Government health expenditure per capita



Sources: Ministry of Finance (1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012)

In Figure 3-7 the per capita health expenditure of Fiji is compared with that of other countries in the region for the year 2011. With the exception of Papua New Guinea, Fiji spends much less per capita on health than other Pacific island countries.

Figure 3-7 Total expenditure on health per capita at PPP international dollars, WHO Western Pacific Region, 2011



Note: No 2011 values are available for American Samoa, French Polynesia, Guam, Hong Kong (China), Macao (China), New Caledonia, Northern Mariana Islands, Tokelau, Wallis and Futuna.
Source: WHO (2013)

Inpatient and outpatient services together account for more than 50% of THE in the years 2005 to 2010. However in 2011 and 2012, with the adoption of the new System of Health Accounts (SHA) methodology[2] (OECD, 2011), combined inpatient and outpatient expenditure account for less than 40% of THE. Table 3-2 shows the proportion of THE for outpatient services as relatively unchanging over the period 2005–2010. Inpatient services, on the other hand, experienced some fluctuation with an increase to 49.2% of THE in 2008 followed by a decrease to 36.4% in 2010. Dental outpatient expenditure increased from 0.3% of THE in 2005 to 4.3% in 2010, as a result of the expansion of public sector dental services. Public health and prevention remained relatively constant over the period 2005–2010. From 2007 to 2010 the category 'All other health services' (which refers to health education and training, health research and development, and non-profit institutions serving households) has shown a steady increase.

Table 3-2 Health expenditure by function (service programme)

Expenditure	% of total expenditure on health					% of current expenditure on health	
	2005	2007	2008	2009	2010	2011	2012
Health services							
Inpatient care	35.4	48.7	49.2	38.5	36.4	19.5	18.5
Outpatient/ambulatory physician services	22.0	20.8	21.1	21.8	22.4	16.9	17.4
Outpatient/ambulatory dental services	0.3	4.9	3.3	4.8	4.3	3.8	3.8
Ancillary services	1.2	1.5	1.0	2.2	2.6	10.5	9.5
Traditional healers	1.2	0.8	0.8	0.3	0.4	-	-
Pharmaceuticals and medical nondurables	13.0	5.2	5.7	12.2	10.9	18.3	17.7
Public health and prevention	4.6	5.4	5.3	4.7	4.2	11.4	13.9
Health administration	8.3	9.6	7.8	7.6	9.9	17.1	17.2
All other health services	14.0	3.1	5.8	7.9	8.9	2.5	2.0

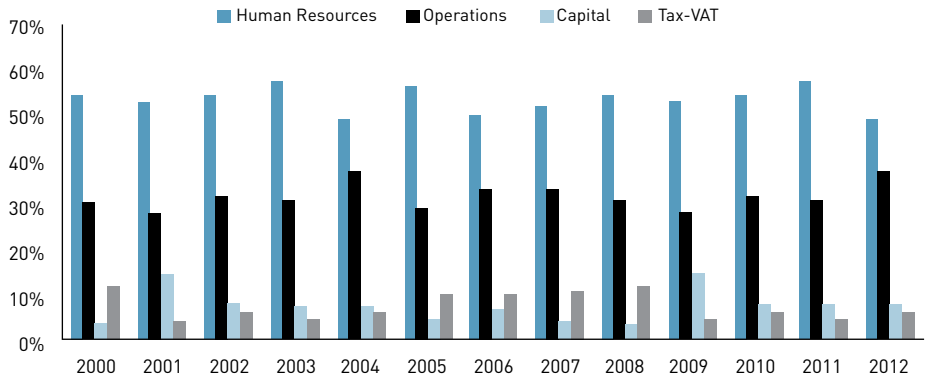
Note: The years 2005–2010 use SHA 1 methodology while 2011–2012 uses SHA 2011
Sources: Azzam (2007); Fiji Health Accounts (2007, 2008, 2009, 2010, 2012)

In terms of expenditure by service inputs, government health funding spent the majority of its funds on human resources for health (Fig. 3-7). From 2000

2 Caution is warranted in comparison of the figures between the years 2005 and 2010 against the figures for the years 2011 to 2012. This is because data for 2005 to 2010 use the SHA 1 methodology while data for 2011 and 2012 use the SHA 2011 methodology.

to 2012, government health human resources have averaged 53% of total government health expenditure. Operations averaged 32% over the same period and include expenditure for medicines and durable medical goods. The remaining 15% is shared between capital investments (mostly infrastructure and medical equipment) and value added taxes (taxes paid on health services and products).

Figure 3-8 Government health expenditure by service input (% of TGHE expenditure)



Sources: Ministry of Finance (1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012 and 2013)

3.3 Sources of revenue and financial flows

Fiji's health services have been historically and predominantly financed by the Government. Financing of health care is still largely reliant on public funding from general taxation. Successive governments have assessed that the low socioeconomic status of much of the population precluded the introduction of cost recovery through user fees and/or that such a move would be unpopular. Therefore, public provision of health care is mostly free or available at very low cost for all persons in the country. Modest user fees are charged for some selected services provided by the public system. The revenue generated from user fees amounted to an average of 1.6% of health expenditure over the period 2003–2012 (Table 3-3). Revenue increased slightly in recent years (2010–2012) and this was a result of a revision of user fees in 2010 and again in 2012.

In 2012, the Government initiated a study to look into the feasibility of implementing a Social Health Insurance (SHI) scheme (Rannan-Eliya et al., 2013), with the objective of increasing financing for health. Recommendations arising from that report suggested it would be difficult to achieve a significant contribution base given the large size of the informal sector. There was also a need to first develop strong managerial, administrative and technical capacity, as well as regulatory oversight before implementing such a scheme.

Voluntary health insurance schemes are not widely used by the population. OOP expenditure, although a relatively small proportion of expenditure compared with

many countries, is the second largest contributor after government funding. While public sector expenditure is well-documented in annual government reports, the contribution made by private financing or the amount spent through the private health sector is only estimated in national health accounts reports.

Table 3-3 Government financial expenditure on health and user-fee collection (FJ$)

Year	Actual health expenditure ('000)	Government revenue from health services ('000)	Revenue as percentage of expenditure (%)
2003	124 423	270	0.2
2004	130 149	1410	1.1
2005	130 756	1336	1.0
2006	149 312	971	0.7
2007	137 779	1650	1.2
2008	127 656	1111	0.9
2009	155 838	1719	1.1
2010	153 830	2732	1.8
2011	149 784	6172	4.1
2012	158 348	6071	3.8

Sources: Fiji Health Accounts (2007, 2008); Ministry of Health (2009, 2010, 2011 and 2012a)

User fees were first legislated for in the Public Hospitals and Dispensaries Act 1955 to provide added revenue to the Government, but were not introduced until the early 1960s. Despite the fact that the fees were based on costs in the 1940s, they remained largely unchanged until some minor modifications were made in the early 1980s and later in the late 1990s. In 2000 outpatient fees at public health facilities were suspended by the Government but were later reintroduced. Table 3-4 summarizes the charges revised in 1983, in 2010 and 2012. The user fees mandated in the 2012 revision and which is currently in use are modest in comparison with the costs of service provision. The 2012 fee revision was reduced from the 2010 revision when a decline in use of health services was noted. Some fees were dropped all together, such as those charged at outpatient clinics.

All collected revenues received at public health facilities are paid into the Government's consolidated fund account and are not directly available (nor do they have authority) for use by the MoH. Persons exempt from user fees include members of the Republic of Fiji Military Forces, Police Force and Royal Navy, officers of the prisons service, persons detained in hospitals under any statutory authority, and children under the age of 15. Services provided in the general interest of public health are also excluded.

Private providers of health-care services (e.g. general practitioners, eye care specialists, dentists, private hospitals and pharmacies) charge fees for their services that are often considerably higher than the amounts charged in public

health facilities. These may be four to five times the public charge or, in some cases, substantially higher. For example, a tooth extraction that costs FJ$ 5 (2012 revised fees) in government facilities may cost anywhere between FJ$ 25 and FJ$ 50 at a private dental practitioner. Currently there is no regulation governing fee-setting for most private health facilities; user fees vary widely across private practitioners. In 2012 the Fiji Commerce Commission set the prices for 75 essential drug items in the pharmaceutical market. Such regulation is envisioned to increase across other private health sector services, with the Fiji Commerce Commission and the Fiji Consumer Council being strong advocates and the regulators for such interventions. The objective of these interventions is fair trade and pricing, as well as increased affordability to consumers.

Table 3-4 User fees for selected services at public health facilities

Services at public health facilities	Cost / day residents (1983 amendment)	Cost / day residents (2010)	Cost / day residents (2012)
Private suite (per day)	25	115	115
Private ward single bed (per day)	10	46	46
Semi-private wards 2 beds (per day)	6	34.5	34.5
General paying ward (per day)	4	23	23
Outpatient clinic (divisional hospitals)	0.5	0.6	0
Outpatient clinic (other facilities)	0.2	0.2	0
Special clinics	2	2.3	0
Consultant clinics	< 8.0	0.6	0
Minor operation	< 30.0	< 230.0	< 230.0
Intermediate operation	< 60.0	< 690.0	< 690.0
Major operation	< 150.0	< 2875.0	< 2875.0
Use of delivery rooms by private doctor	50	230	150.0
Dental examination	1	5.8	3.0
Dental tooth extraction	2	5.8	5.0
Dental X-ray	2	5.8–9.2	5.0–8.0
Conservative dentistry (e.g. amalgam)	3.0–8.0	3.5–230.0	3.0–120.0
Oral surgery	5.0–30.0	23.0–103.5	10.0–90.0
Prosthetics-F/F dentures	1.0–60.0	3.0–200.0	3.0–150.0
Periodontics	1.0–24.0	3.5–230.0	3.0–50.0
Orthodontics	20.0–100.0	115.0–460.0	100.0–390.0
X-rays (immigration, employment, etc.)	10	23	23
X-rays (various other procedures)	8.0–40.0	23.0–460.0	23.0–460.0
Laboratory tests	1.0–10.0	8.1–115.0	8.0–115.0
Cath lab charges			
Insured patients		3450	3450
Uninsured patients earning > 15k		1725	1725
Patients earning < 15k		575	575

Note: Fees for non-residents are usually double those charged to residents; "<" means "less than"
Sources: Public Hospitals and Dispensaries Act (1983 and 2010 amendment);
Ministry of Health (2012b)

Private health service providers are mainly located in urban locations and are used largely by those in formal employment. Revenues of private providers were estimated at FJ$ 80 million in 2011 and FJ$ 87 million in 2012 (Fiji Health Accounts, 2013). In both 2011 and 2012, Fiji's private pharmaceutical industry (mostly retail outlets) accounted for approximately 50% of that revenue.

There are no compulsory social insurance schemes. The supply of voluntary private health insurance is limited and affordable only for those earning relatively high incomes (see section 3.6). The proportion of the population covered by voluntary health insurance is unknown, but is thought to be concentrated in towns and urban areas, and among the formal working sector. The proportion of THE funded through private health insurance continues to increase from 4.9% in 2005 to 7% in 2008 and 9% in 2012 (Fiji Health Accounts, 2013). This increase is assumed to be driven by both the increased costs of health insurance packages and increasing memberships.

3.4 Overview of the statutory financing system

Coverage: breadth, scope and depth

The statutory public (government) health system offers the same services to all legal residents of Fiji. Nonresidents are entitled to access these services, but at twice the cost of user-fees, when fees are charged. Health facilities, which are organized in a three tier arrangement (i.e. hospitals, health centres and nursing stations), provide a range of health services according to their role and function in the system. Pharmaceuticals on the essential drugs list are provided free of charge at government health facilities. Some health services are not available within the country due to inadequate resources, whether human, physical or financial. The population of Fiji is dispersed across many small islands, and this poses a significant challenge to the delivery of health services. Urban populations have greater access to health services (particularly specialized health-care treatment) than those in rural and remote areas. Private health-care facilities, which are concentrated in urban areas, provide services at a cost to anyone who is able to pay. These services are mainly outpatient services.

Access to specialized health services and transport costs are major barriers to access, especially for those living in remote areas. The MoH allocates a budget for emergency transport, including air flights, but this service is rationed as the budget allocated to it is limited. Restrictions also apply regarding access to overseas evacuation of persons requiring health treatment that cannot be provided within the country. Expenditure on emergency domestic travel and overseas treatment varies considerably from one year to another. It was around FJ$ 3.5 million in 2007, fell to around FJ$ 1 million in 2008(Fiji Health Accounts, 2010) and rose again to approximately FJ$ 2.5 million in 2012 (Fiji Health Accounts, 2013). In 2012 this expenditure was distributed equally between domestic and international treatment (and travel) referrals.

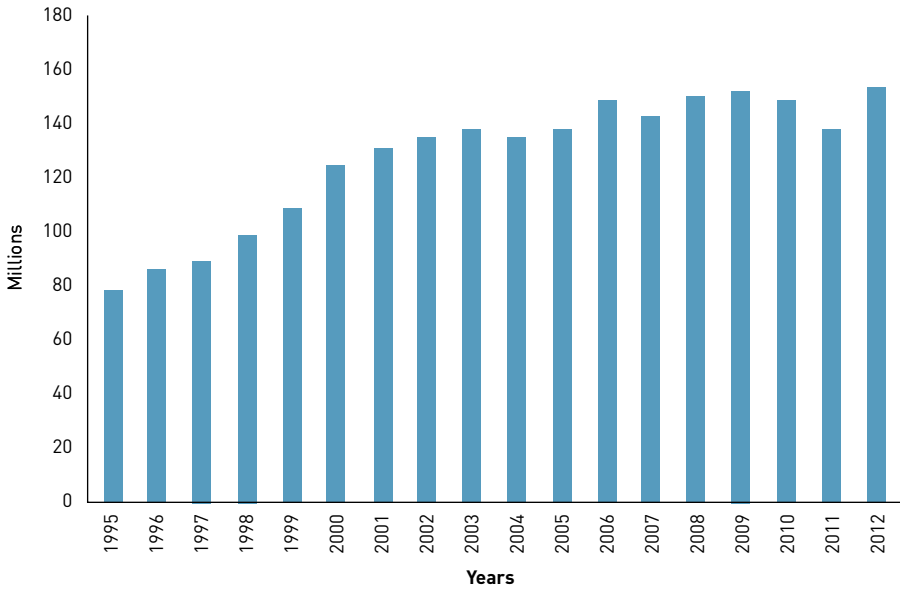
Collection

Government revenue collected by the Fiji Inland Revenue & Customs Authority through taxation is used to finance the public health system. Taxes represented approximately 85% of total government revenue in 2012 (Ministry of Finance, 1995–2013). Tax revenues accrue mainly from indirect taxes such as value added tax (29%) and customs taxes (16%), and through direct tax via income taxes (19%). Income taxes accrue primarily from the formal employment sector.

Pooling of funds

As most health care is funded from government revenues through the allocation of a budget to the MoH, there is a high level of pooling of finances for health. The Government operates a consolidated fund, which includes taxation revenues and user fees. MoH officials submit budget proposals to the Government based on national-, regional- and local-level submissions, and they must compete with other government ministries for their financing. The size and content of the allocated budget is usually based on historical trends of previous resource inputs, whether the past year has reported an overuse or underuse of fund allocation and government priorities. In the past the MoH has generally managed to operate within its assigned budget; however, there have been occasions where the MoH has needed more funds following national disasters, such as cyclones and floods. In these situations, supplementary budget allocations are made available upon request from the MoH.

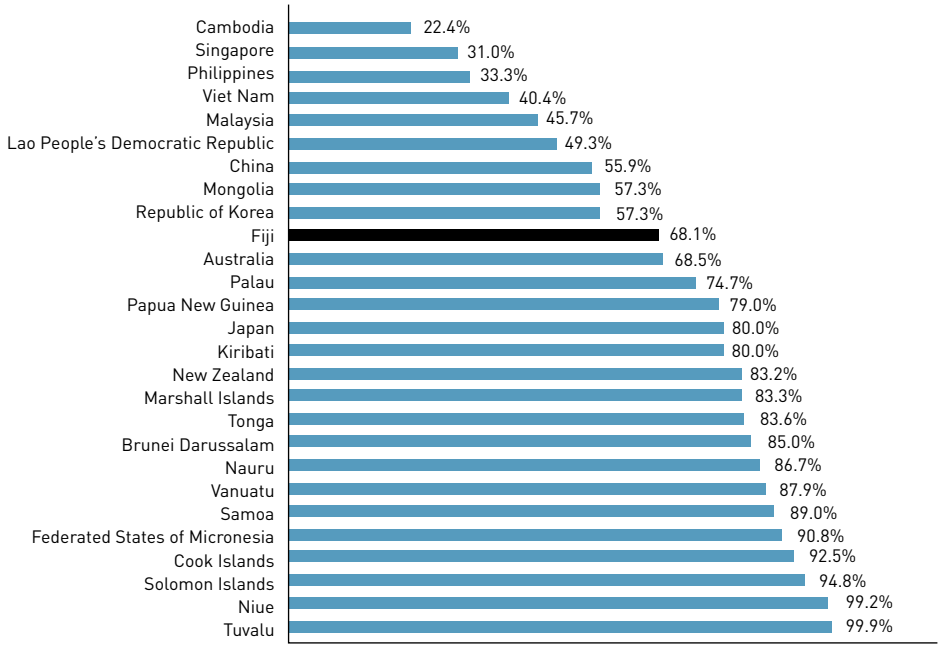
Figure 3-9 Government budget allocation for health



Sources: Ministry of Finance, 1995–2013

The Fiji Government's budget allocation for health has increased fairly steadily from 1995 to 2009 in real terms (See Fig. 3-8). Government expenditure was 68% of total health expenditure in 2008 and this decreased slightly to 60% in 2012. Although government financing constitutes a relatively high proportion of funding, it is still lower when compared with all other Pacific island countries (Fig. 3-9).

Figure 3-10 TGHE as a share (%) of total health expenditure, WHO Western Pacific Region, 2011

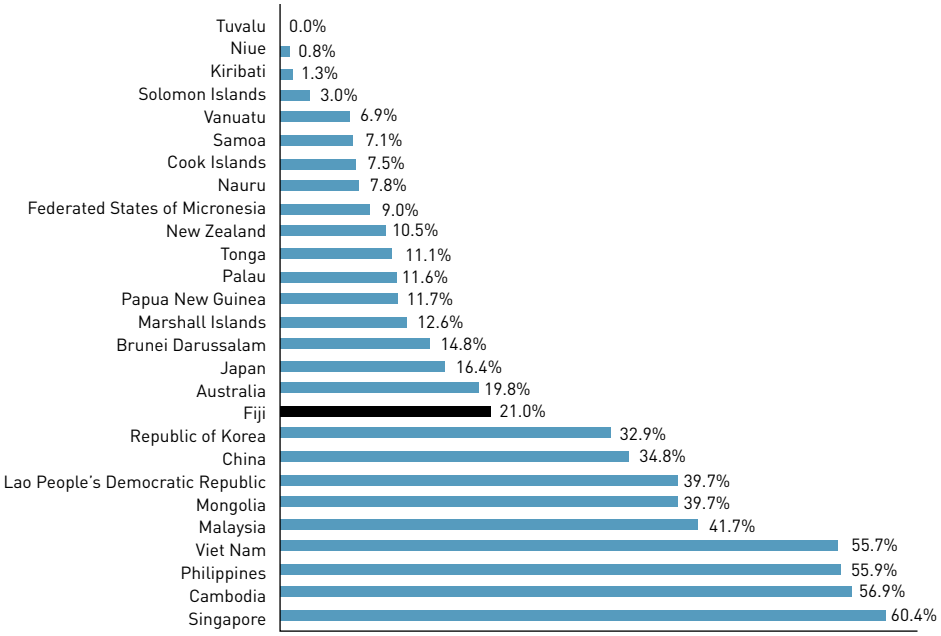


Note: No 2011 values are available for American Samoa, French Polynesia, Guam, Hong Kong (China), Macao (China), New Caledonia, Northern Mariana Islands, Tokelau, Wallis and Futuna.
Source: WHO (2013)

3.5 Out-of-pocket payments

Out-of-pocket payments constitute the second largest source of finance for health services, after government expenditure. Fiji is in the middle range of reliance on OOP expenditure in WHO Western Pacific Region countries (Fig. 3-10). As a percentage of total health expenditure, OOP payments increased from 12% in 2005 to 21% in 2011. In 2005, OOP payments totalled FJ$ 21.7 million; by 2011, OOP had risen to FJ$ 67.8 million. In the same time period both public financing and employer funding for health decreased. Most OOP payments were for private health services, mainly prescriptions, over-the-counter medications and outpatient services. The rise in OOP expenditure may reflect an increase in the use of the private sector health services. A health equity analysis of OOP reported in Fiji's Household Income and Expenditure Survey show that most OOP is generated from wealthier households in urban areas.

Figure 3-11 OOP expenditure as a share (%) of total health expenditure, WHO Western Pacific Region, 2011



Note: No 2011 values are available for American Samoa, French Polynesia, Guam, Hong Kong (China), Macao (China), New Caledonia, Northern Mariana Islands, Tokelau, Wallis and Futuna.
Source: WHO (2013)

OOP payments may be in the form of cash but can also be in-kind, especially in rural areas and for the services of traditional healers. It is estimated that expenditures on traditional healers amounted to FJ$ 2.1 million in 2005, FJ$ 1.6 million in 2007 and FJ$ 1.7 million in 2008. In 2008, this amounted to 0.8% of THE. These figures are likely to be underestimations since most traditional healers are paid in-kind and it is difficult to put a dollar value on such payments.

3.6 Voluntary health insurance

In Fiji the coverage of voluntary health insurance is uncommon and affordable only by the formally employed. Most coverage is through employer-based schemes that provide accident and injury coverage, as well as co-payment for general medical insurance. A total of 10 companies operate across the insurance sector in Fiji but only 4 operate voluntary health insurance schemes. Health insurance accounted for only 0.3% of the insurance market premium payments in 2009 (Reserve Bank of Fiji, 2009) and this remained constant in 2012.

Companies contract mostly with insurance firms and brokers (rather than hospitals and individual practitioners) to provide treatment to their clients (mostly their employees) and to cover related costs at both public and private health facilities. Some schemes also cover overseas medical evacuation and treatment.

According to Fiji Health Accounts reports, health insurance expenditure by both individuals and organizations was FJ$ 8.9 million in 2005, FJ$ 14 million in 2008 and FJ$ 24.8 million in 2012 (Fiji Health Accounts, 2012). This increase is mainly due to higher enrolment, as well as a growing number of memberships from organizations and individuals that has resulted in increased premiums. The 2012 Reserve Bank of Fiji Insurance Annual Report (2012) states that group policies for medical schemes have increased from 429 in 2011 to 491 in 2012.

3.7 Other sources of financing

The remaining source of finance for health care is from external sources, including multilateral and bilateral development agencies and nongovernmental organizations. In Fiji, these include United Nations agencies (WHO, UNICEF, UNDP, UNFPA, UNAIDS), the Governments of Australia (through AusAID), New Zealand (through NZ AID), China, Japan (through JICA) and the Global Fund to Fight AIDS, TB and Malaria (Global Fund). In 2005, donor agencies' contributions to health amounted to FJ$ 9.5 million or 5.3% of total health expenditure. In 2007, it decreased to FJ$ 6.9 million (3.4% of THE) following the coup d'état of December 2006, and then rose again by 2012 to FJ$ 15.3 million (6% of THE). Global Fund support to Fiji largely contributed to the increase in donor funds from 2010 onwards; however, it may cease in 2014 because the World Bank has elevated Fiji's status from a lower-middle-income country to an upper-middle-income country. External support to the MoH is not yet well harmonized to achieve a more effective use of the donor funds available.

3.8 Payment mechanisms

Payment mechanisms for providers of health services are relatively straightforward since the Government both finances and provides the majority of services.

Paying for health services

The size of the annual government health budget is reliant on the available government revenue and negotiations on budget submissions between the MoH and the MoF. The MoH receives allocations to resource input line items, such as human resources, services, capital investments, and purchase of medical and nonmedical equipment. The MoH uses this same approach when allocating finances to various government-owned health facilities (including hospitals, health centres and nursing stations).

Paying health workers

The majority of health workers in the country are salaried staff of the MoH, divided into two categories: established staff and unestablished staff. Established staff are governed by the Public Service Act while the conditions and rules for unestablished staff are stated in the Joint Industrial Council agreement. Project,

cleaning and casual positions are commonly unestablished. Private health-care providers may be contracted by the Government and paid on an output basis according to the terms of individual contracts.

Salaries of government staff are set in detailed national pay scales drawn up by the Public Service Commission. The percentage of health expenditure spent on the compensation of human resources was 61% in 2011 and 60% in 2012 (Fiji Health Accounts, 2013). There are no incentive payments for the number of patients seen or procedures performed, or payment according to results. Salaried staff move up the salary scale according to their years of experience within the MoH (this practice is slowly changing), level of education and role within the organization. It is generally considered that under-the-table payments to health workers are infrequent; this has not been highlighted as a problem by those in the public who have used the complaints procedures.

Employee associations and trade unions represent workers' interests and often negotiate salary and working conditions on their behalf. In 2007, the Fiji Nursing Association was vocal on issues pertaining to salaries and employment conditions for nurses, but was unable to make gains. Several industrial strikes have been unsuccessful and have left staff feeling undervalued, which has contributed to emigration.

General practitioners in private practice receive payment from individuals for health services rendered. There is no legislated ceiling for fees charged by private practitioners, so they can charge at their discretion within market constraints. Current consultation fees range from about FJ$ 30 to FJ$ 50, excluding the cost of medications, which are obtained through private sector pharmacies. A very small number of general practitioners enter into contracts with private organizations to provide care for employees, and private insurers refund some of patients' health expenditure.

Health workers in the private sector may work in hospitals, clinics and private surgeries that are legally established as private corporations. They are governed by the rules of these corporations and usually receive a fortnightly salary. The Fiji Employment Relations Bill 2006 (MoLIRE, 2006) sets certain work terms, minimum salaries and conditions.

Pharmaceuticals are imported by the government-funded Fiji Pharmaceutical & Biomedical Services Centre, which supplies all government health facilities. In 2011 pharmaceuticals accounted for 9.2% of total government spending on health, and in 2012 this decreased to 7.1%. Private pharmacies can also purchase medicine and drugs from the Centre. There are approximately 55 private retail pharmacies located in Fiji. Private general practitioners are legally entitled to dispense and supply medicines as long as they are not located within five kilometres of a private pharmacy, in which case charges for medicines are added to patients' consultation and treatment fees. When drugs are out of stock at government pharmacies, patients have to purchase medicines at their own

expense from private pharmacies. The Fiji Prices and Income Board, together with the Fiji Commerce Commission, control the prices in the market by setting percentage mark-ups for both wholesalers and retailers.

Acknowledgments

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