2 Organization and governance

2.1 Section summary

Fiji’s health system is based on a three-tier model that provides an integrated health service at primary, secondary and tertiary levels. This system was inherited from the British colonial administration and has undergone several modifications over time. From 1999 to 2003, the Fiji Health Management Reform Project introduced a more decentralized approach to management of the system, but these changes were rolled back in 2008.

While there are 17 pieces of legislation that govern and regulate the provision of health services, the health system is basically divided into two health programmes: primary and preventive health care services and curative health care services. These two programmes and their respective disciplinary areas largely determine the organizational structure and the modus operandi in the MoH. There are also various statutory bodies, councils and committees (such as the National Food & Nutrition Centre, the National Health Promotion Council, and the National Advisory Committee on AIDS) that provide supportive roles in the management and administration of specific health services.

The planning process for the MoH is based on the government’s national strategic planning process. Recently, the government has strengthened the intersectoral approach to project management and implementation to ensure effective resource utilisation and minimize wastage. The MoH Clinical Services Planning Framework also plays a key role in the planning process. Ongoing efforts to strengthen the Health Information Unit should improve the information available for planning.
2.2 Overview of the health system

The MoH manages a comprehensive decentralized health system of integrated primary, secondary and tertiary care following the Fiji Health Sector Management Reform Project 1998–2002, although the administration of human resources, finance and supply remains centralized.

Primary health care and public health care services are managed and administered through four Divisional Health Services (DHS) offices: Central & Eastern combined in Suva; Western in Lautoka; and Northern in Labasa, each led by a Divisional Medical Officer (DMO) and responsible for providing public health services. There are five subdivisions in the Central Division, four in the Eastern Division, six in the Western Division and four in the Northern Division. The four DMOs are responsible to the Deputy Secretary Public Health who heads the Public Health Division in the MoH headquarters in Suva. Public health services are provided through 16 subdivisional hospitals (SDH), 77 health centres (HC) and 101 nursing stations (NS). The subdivisional hospitals, with an average capacity of 12-40 beds, provide inpatient care and outpatient services within each subdivision. Three area hospitals, smaller in capacity than a subdivisional hospital (usually with no more than 15 beds), complement the subdivisional hospital by delivering services in isolated populations.

Each subdivisional hospital supervises a designated medical area that includes a number of health centres and nursing stations. A health centre is managed by a medical officer or nurse practitioner working with one or two nurses. It provides the first level of referral for a number of nursing stations, and is generally staffed by one nurse who conducts outreach visits to communities in a designated nursing area. Community nursing stations complement and function like stations, except that they are built and funded by the community themselves, following approval by the government and according to government standards. In addition, MoH-trained community members serve as Village Health Workers (VHW) in Fijian villages and Community Health Workers (CHW) in Indo-Fijian communities.
Patients may first see a VHW/CHW or a nurse during an outreach visit or may go to a nursing station, health centre or subdivisional hospital. They may be referred to a higher level health facility: one of the three divisional hospitals (in Suva, Lautoka and Labasa) or the Colonial War Memorial Hospital (CWMH). All consultations, admissions and laboratory and radiological examinations are free to the public in public health facilities, except for some dental and special treatments or those in which patients choose to be admitted to a paying ward.

The sixteen subdivisional hospitals and the three divisional hospitals provide a comprehensive range of services, including core specialist services. The three divisional hospitals and several at subdivisional level also serve as teaching hospitals for nursing and medical students. The Colonial War Memorial Hospital serves as the national referral hospital for Fiji and is available to other countries in the region, as it provides additional specialized services, including renal, cardiac and cancer services.

There are three specialized hospitals: St. Giles Psychiatric Hospital; the P.J. Twomey Hospital for tuberculosis and leprosy; and the Tamavua Rehabilitation Hospital. Each divisional and specialized hospital is headed by a medical superintendent who reports to the deputy secretary for hospital services, head of the Clinical Administration Section in the MoH. The Clinical Services Planning Framework developed in 2005 outlines the delivery of clinical health services at the various service levels within each specialty area, benchmarked against the MoH Strategic Plan.

A small private sector includes two private hospitals in Suva (and another under construction) that provide a range of specialized services, several day clinics and 130 private general practitioners located mostly in the urban centres of the two main islands, Viti Levu and Vanua Levu. There is a private maternity hospital in the Western Division (co-funded through government grants) and another one is planned.

In rural areas, traditional healers are visited for a variety of health problems, which can range from minor health ailments to more life-threatening diseases like cancer and poisoning.
2.3 Historical background

Fiji gained its independence from the United Kingdom in 1970. It inherited a health care system in which provision of health services was subsidized; although there was a schedule of hospital charges, there were also non-fee paying wards and a provision in the Hospital Act for a medical superintendent to waive fees. A user-pays system was implemented in 1978 for those who could afford to pay for private rooms. In 1970, revenues from fees comprised 10.5% of all health expenditure, but after 1973, this fell to between 2.5 and 3.5%. The population is accustomed to a high level of public funding for health services and any attempt to significantly increase revenues through user fees would represent a major change, with political and population health ramifications. In recent years, the potential to increase government health sector allocations has been limited by slow national economic growth and periodic austerity measures, compounding historic underfunding.
Fiji’s decentralized primary health care (PHC) system throughout the 1970s aimed to deliver good quality basic care to all. Fiji was implementing elements of primary health care well before the 1978 Declaration of Alma Ata made the concept internationally known. Negin et al (2010) identified that ´some elements of PHC existed in Fiji before 1976 although not institutionalized, funded or formalized´. Home visits and village health days were part of health workers’ roles. Medical officers’ responsibilities extended beyond their clinical role to advising communities on public health issues, while Fiji’s communal culture facilitated a high degree of community engagement and participation. In practice, however, the centralized structure of the health system has tended to work against primary health care, with resource allocation tending to favour the maintenance and development of hospital services.

As primary health care activities declined in the 1980s, Fiji was beset by the now common Pacific experience of increases in non-communicable diseases (NCD). The imperative to sustain primary health care services remains, in particular, for preventive care. Health promotion activities, however, appear to be having little effect in producing healthier lifestyles, partly due to limited food consumption choices.

The Fiji School of Medicine, which celebrated its 125th year in 2010, was started by the Chief Medical Officer of the colony, Dr William MacGregor as The Suva Medical School in 1885. Its establishment was prompted by events and factors such as a devastating measles epidemic in 1875, fear of smallpox and cholera from indentured labourers from India and the acute shortage and high cost of European medical officers (Brewster 2009). The Suva Medical School progressively developed into the Central Medical School in 1928 and the Fiji School of Medicine in 1962. It now offers courses in medicine, dentistry, health sciences and public health. Fiji has a long history of training health professionals for the Pacific region, many of whom have become chief medical officers and national leaders.

### 2.4 Organization

In the last two decades, the MoH has embarked substantially on the model of a three-tier system of primary care with the objective of providing divisional, subdivisional and area-based health care facilities. This three-
tier system is staffed by specialist medical and nursing staff, generalist medical and nursing staff and primary care providers, including MBBS graduates, medical assistants, postgraduate trained nurse practitioners and generalist nursing graduates, with the aim of maintaining a decentralized system with a strong primary health focus. The public system is complemented by approximately 130 urban-based general practitioners registered with the Fiji Medical Council.

The Minister for Health is a member of the Cabinet of Government of Fiji. The MoH is headed by a Permanent Secretary for Health appointed by the Public Service Commission.

**Permanent Secretary for Health**
The Permanent Secretary for Health provides overall leadership and direction for the MoH and is mandated under legislation to ensure the safe practice of health professionals and the provision of quality health services to the people. In doing so, the incumbent is accountable to the Minister for Health and the Prime Minister through the Public Service Commission for the attainment of health outcomes, as per MoH Annual Corporate and Strategic Plans.

**Division of Hospital Services**
The Division of Hospital Services is the responsibility of the Deputy Secretary Hospital Services (DSHS) who provides policy advice to the Permanent Secretary on clinical services and related issues. Governed by the Public Hospitals & Dispensaries Act, the DSHS is responsible for the provision of clinical services, including the monitoring of health system standards in all health facilities, for the formulation and development of appropriate policies and for effective decision-making in resource management.

**Division of Public Health**
Headed by the Deputy Secretary Public Health, the Division is responsible for services ranging from the development and formulation of public health policies and their translation into priority health programmes to the provision of primary health care to the population, as legislated under the *Public Health Act 2002*. It also includes the evaluation of various public health programmes under their national advisers, such as Family Health,
Non Communicable Diseases, Health Promotion, Control of Communicable Diseases, Food & Nutrition, Environmental Health and Oral Health, to ensure effective delivery of primary health care to the people of Fiji.

Division of Administration and Finance
The Division of Administration and Finance plays a key service support role regarding asset and contract management, human, financial and physical resource development and information management. This division is led by the Deputy Secretary of Administration and Finance who reports to the Permanent Secretary for Health, and also provides policy advice on the implementation, monitoring and evaluation of civil service reforms in the MoH.

Division of Information, Planning and Infrastructure
Led by the Director of Health Information, Planning & Policy, this division is responsible for co-coordinating the development, formulation and documentation of MoH policies, the National Health Plan, department/section/unit plans, and medium-term strategies in alignment with the MOH’s long term mission and vision. It oversees the MoH Health Information System Development Programme, aimed at achieving a cost-effective and user friendly system that meets management’s timely reporting, monitoring, evaluation and information needs for decision-making, and is charged with strengthening essential health research activities.

Division of Pharmacy and Biomedical Services
The Director of Fiji Pharmaceutical & Biomedical Services is responsible to the Permanent Secretary of Health for the provision of policy advice and management support in initiating and coordinating, formulating and implementing national strategies and plans in relation to pharmaceutical services and biomedical equipment. Technical matters related to medicine and therapeutics and their regulation, under the Pharmacy & Poisons Act 1997 and the Dangerous Drug Act 2004, are the responsibility of the Chief Pharmacist.

Division of Nursing Services (DNS)
The Director of Nursing Services is accountable to the Permanent Secretary of Health for policy advice and nursing development. The Director holds
a statutory role as the Registrar of the Nurses, Midwives and Nurse Practitioners Board as mandated by the *Nurses, Midwives & Nurse Practitioners Act 1999*. The Director administers the Act in overseeing the functions of the Board in the registration of nurses, regulation of nursing practice and provision of nursing education, and liaises with the other directors and national advisers for the achievement of health outcomes.

### 2.5 Decentralization and centralization

Fiji’s health system has been undergoing structural reform since implementation of the Fiji Health Management Reform Project in 1999 (see Section 6). The major focus of the reform was to decentralize the Ministry’s management operations, improve the management capacity in the central office and in the divisions and strengthen specific aspects of the Ministry’s management systems, included updating health legislation, developing management and health information systems, enhancing planning and policy capacity, formulating standards and guidelines for management, and improving asset management and maintenance systems. A new management structure was approved by Public Service Commission in 2001, but was not fully implemented until 2003 due to funding constraints.

To accommodate decentralization, new patient, financial and human resource information systems were created to support managers. Decentralization occurred at two levels. The first was the delegation of specified responsibilities from the central agencies of the Ministry of Finance (MoF) and the Public Service Commission to the Permanent Secretary for Health. The second level was the delegation of powers by the Permanent Secretary for Health to the three Directors of the Western, Northern and Central/Eastern Divisions. The change and the need for coordinated management due to decentralization required the development of internal operational guidelines.

In 2008, the decentralized management structure created under the Fiji Health Management Reform Project was withdrawn, the health system was re-centralized and the divisional management structures were reverted to their prior form (see Section 6).

The current structure is presented on the next page.
Figure 2-2: Current structure of the Ministry of Health.

Source: Ministry of Health (2010a)
2.6 Planning

The Government’s key planning document, which sets out strategic directions for each ministry and department, is the Roadmap for...
Democracy and Sustainable Socio-Economic Development, 2009-2014, which captures Fiji’s commitments to international agreements, such as the Millennium Development Goals (MDGs), and the National Strategic Framework for Change. These documents complement the Five-year National Strategic Development Plan, 2007-2011. The target outcomes for the MoH contained in the Roadmap are linked to key performance indicators (KPI) and outputs, with some KPIs linked to the MDGs. KPIs are reported on annually with feedback on achievements submitted to the Ministry of National and Strategic Planning.

The MoH develops its national health plans and strategic plans in recognition of the major health priorities of the people of Fiji and through extensive consultations with major stakeholders, including the private sector, nongovernmental organizations and central government agencies. The Strategic Plan, along with the KPIs, forms the basis of annual corporate plans which, in turn, guide the business plans and annual plans of various institutions and departments. The MoH liaises with the Ministry of Finance and Public Service Commission for the preparation of the annual corporate plans in terms of budget and human resources, respectively.

One problem facing the Ministry of Health is its limited capacity for the analysis and interpretation of available population health status and health system data. This hampers both planning and policy formulation and means that short-term concerns dominate at the expense of longer term planning and policy setting.

2.7 Intersectorality

The government’s policy of a strong intersectoral approach has seen the set-up of the Strategic Framework for Coordinating Change Office in 2009. This Office monitors and evaluates government programmes and projects described in the various annual corporate plans, and coordinates activities where there is an overlap in the responsibilities between different stakeholders (Ministry of Health, 2009a). For example, in the prevention of typhoid, the MoH is in partnership with the Ministry of Works, Transport & Public Utilities for the improvement of water supply and sanitation, and in childhood obesity, it coordinates with the Fiji School of Medicine and the Ministry of Education.
As an outcome of MoH health promotion activities, the Public Service Commission introduced the Public Service Workplace Health Promotions Policy Framework in 2008, leading to the promotion of the safe hospitals concept in 2009. The Department of Environment is now implementing the Environment Management Act (EMA) 2009, and is working towards its enforcement through the MoH’s Environmental Health Department. The MoH has included an objective on disaster preparedness in its Strategic Plan 2011–2015.

The MoH seeks competitive tenders from the private sector for capital works and maintenance projects, and for the provision of hospital services of laundry, security and food preparation.

2.8 External support

Both financial and human resources for health are supported by multilateral and bilateral development partners and non-government organizations. These include the United Nations agencies (WHO, UNICEF, UNDP, UNFPA, UNAIDS), the governments of Australia (through AusAID), New Zealand (through NZ AID) and Japan (through JICA), the Asian Development Bank (ADB), the European Union (EU) and the Global Fund to fight AIDS, TB and Malaria. Development partner relationships are formalized through overall and programme-specific agreements, increasingly characterized by commitment to the 2005 Paris Declaration on Aid Effectiveness. Collaboration includes supply of specific items (e.g. vaccines, family planning commodities, selected pharmaceuticals), the financing of targeted health programmes, staffing support, technical assistance, and infrastructure and human resource development through training programmes and fellowships. Technical support for selected health services is provided through the UN system, regional organizations and the non-government sector, particularly for adolescent health, immunizations and selected disease monitoring and prevention programmes. The MoH is supported by technical assistance from the UN agencies, particularly WHO. The MoH is a member of the Pacific Public Health Surveillance Network, coordinated by Secretariat of the Pacific Community (SPC) in Noumea (covering 22 Pacific island countries and territories).
The most recent example of significant broad support to the health sector is the AusAID-funded Fiji Health Sector Improvement Programme, implemented from 2005-2010. A final assessment of the Programme conducted in 2010 highlights the breadth of its support to the health sector. Achievements included finalizing clinical services planning and the strengthening of mental health, diabetes, foot care, health promotion and immunization services. It was also credited with developing systems for improved stock management and rural infrastructure improvements, such as the introduction of divisional medical boats, the rollout of MoH radio telephones and the introduction of solar lighting in targeted rural health facilities. In addition, a patient safety, quality and risk management project was established. The Programme also helped improve the Patient Information System (PATIS) and supported several staff positions at the Fiji School of Nursing. While acknowledging these achievements, the assessment concluded that the Programme had been a ‘broad brush’ approach that could have benefitted from a closer targeting of resources towards the achievement of Fiji’s key performance indicators and MDG commitments (Sutton et al 2008).

2.9 Health information management

Health Information Unit (HIU)

The Health Information Unit supports the MoH in its functions of planning, monitoring, evaluation and research to improve the quality, efficiency and effectiveness of health services delivery. Its functions are to collect data from across the health system and to compile, analyse and interpret this into useful and timely reports, including for identifying disease outbreaks. It also provides hospital medical records departments with policy guidance on medical records and information system management.

The Unit is facing numerous challenges in providing accurate and reliable information in a timely fashion due to lack of human resources and technical capacity. Currently resources are directed towards data input rather than information output, and the statistical analysis of the data is not yet fully developed. The analysis and interpretation capacity of the Unit need to be strengthened for its potential to be fully realized. The health information policy is currently under review and efforts are being made
to improve the operations of the Unit. The Global Fund is supporting the Health Information Unit to improve the production, management and use of information, as well to develop a health information system strategic plan. While this effort will focus on three diseases (AIDS, TB and malaria), it should help to improve the overall system.

National Health Information Committee

The National Health Information Committee (NHIC), headed by the Director of Health Information, Planning and Infrastructure in MoH Headquarters, is made up of representatives of the Divisional Health Information Committees. These committees have the primary roles of overseeing the effective utilization of health data at all levels of management, and strengthening networking with other committees, such as Divisional Health Research Committee, Divisional PATIS User Group, Data Integration Working Group, and Human Resource Information System (HRIS) users.

The terms of reference and membership of the National Health Information Committee have recently been reviewed. The revised membership includes directors from MoH headquarters and the following divisions: nursing; information systems; epidemiology; communicable diseases; family health; laboratory; and human resources.

Information systems

Data are collected from all levels of the system, from nursing stations to specialist hospitals, and include inpatient data from the electronic hospital patient information system (PATIS), monthly hospital returns, monthly obstetric returns, medical cause of death certificates and pathology reports for the cancer registry. Community health data are collected through a public health information system (PHIS), diabetic notification forms, weekly notifiable disease returns and maternal death reporting forms. In all, manual data collection utilizes a wide variety of forms.

PATIS was implemented during the Fiji Health Management Reform Project and now works in the three divisional hospitals and in several subdivisional
hospitals. Many data fields in the PATIS database, however, are not filled for many patients, suggesting a need for improved coordination of medical history taking and data entry. Public health data are summarized manually at subdivisional hospital level in a consolidated monthly return, which records the numbers of cases of public health concern, immunization rates and health service activity. These monthly data are entered into the computer system at the divisional level.

Both PHIS and PATIS have the potential to contribute to better health policy and planning, for example, by tracking costs and by providing information that could be used to adjust the distribution, skill mix and task shifting for all categories of health workers. However, potential is constrained by limited capacity for data extraction, analysis and interpretation and its use in policy and planning remain a key problem.

**Health technology assessment**

Currently, there are no health technology assessment agencies in Fiji. The MoH is yet to conduct a systematic evaluation of the effectiveness, costs and impact of health care technology. The need for the standardization of capital items and for contracting their maintenance and parts supply has been raised on many occasions. Sutton et al (2008) noted that ‘old or non-functioning equipment impacts on service delivery’ and that ‘at the root of this problem is the ongoing difficulty of recruiting biomedical engineers’.

**2.10 Regulation**

The MoH administers a number of Acts (see Table 2-1), as delegated by Parliament and, since the suspension of Parliament in December 2006, by Decree. The MoH sets standards through powers delegated to the Minister of Health, and these are enforced and monitored by the various regulatory bodies appointed under the relevant legislation. These regulatory bodies include: Central Board of Health; Fiji Medical Council; Fiji Dental Council; Fiji Pharmacy and Poisons Board; Nurses, Midwives and Nurse Practitioners Board; Private Hospital Board; Rural Local Authorities; Hospital Boards of Visitors; Fiji Optometrists Board; and the Fiji National Council of Disabled Persons.
### Table 2-1: Legislation administered by the Ministry of Health

<table>
<thead>
<tr>
<th>Title of the Act</th>
<th>Year of enactment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Mental Health Decree</td>
<td>2010</td>
</tr>
<tr>
<td>2. Fiji Medical &amp; Dental Practitioner Decree</td>
<td>2010</td>
</tr>
<tr>
<td>3. Emergency Ambulance Services Decree</td>
<td>2010</td>
</tr>
<tr>
<td>4. Radiation Health Decree</td>
<td>2009</td>
</tr>
<tr>
<td>5. Medical Imaging Technologist Decree</td>
<td>2009</td>
</tr>
<tr>
<td>7. Dangerous Drug Act</td>
<td>2004</td>
</tr>
<tr>
<td>8. Public Health Act</td>
<td>2002</td>
</tr>
<tr>
<td>10. Nurses, Midwives &amp; Nurse Practitioners Act</td>
<td>1999</td>
</tr>
<tr>
<td>13. Private Hospital Act</td>
<td>1979</td>
</tr>
<tr>
<td>15. Medical Assistant Act</td>
<td>1978</td>
</tr>
<tr>
<td>17. Methylated Spirit Act</td>
<td>1957</td>
</tr>
<tr>
<td><strong>Fiji National University Decree (FSM &amp; FSN) under MOE</strong></td>
<td>2009</td>
</tr>
</tbody>
</table>

**Regulation and governance of health resources**

The MoH receives its annual budget allocation from Cabinet through the Ministry of Finance and Ministry of National Planning, and conforms to government accounting procedures and regulations. In purchasing health products, the MoH seeks the endorsement of the relevant regulating authority and complies with Ministry of Finance tendering procedures as enforced by the Fiji Procurement Office (formerly the Controller of government supplies). For example, in the purchase of medicines, the Fiji Pharmacy and Poisons Board ensures drug safety and efficacy (by only approving the import of drugs meeting British or United States standards), while the Fiji Procurement Office oversees the tendering process.

Staffing of the MoH is regulated through the Public Service Commission, the regulator of all government public sector staff establishments and human resource functions. The Commission negotiates with the public
sector employee unions to agree on conditions of employment, salary scales and entitlements, and code of conduct regulations. In negotiations with Ministry of Finance, the Commission responds to national level constraints on public sector expenditure, and sets limits on MoH staffing, or introduces austerity measures. The retirement age was reduced from 60 to 55 years in 2009 (in contrast to countries that have raised the retirement age). This change caused some disruption to the health system as many of the most qualified nurses, doctors and specialists were over the age of 50. Some, however, were re-hired on contract after retiring.

**Regulation and governance of providers**

The *Public Hospitals and Dispensaries Act 2002* and the *Public Health Act 2002* regulate the activities of the health services, within the terms of *Finance Management Act*, the Public Service Regulations, *Health and Safety Act*, *Human Rights Commission Act 1999* and International Health Regulations. Private sector hospitals are additionally regulated by the *Private Hospitals Act 1979* and are required to conform to the various Acts that regulate health practitioners and their practice. The MoH regulates its practitioners under the delegated powers of the Minister for Health by setting the standards for practice and for the registration and accreditation of courses. The various regulatory bodies ensure that standards are enforced and monitored for the health professionals registered under them.

The Medical and Dental Practitioners Decree 2010 (Fiji Government, 2010a) has replaced the *Medical and Dental Practitioners Registration Act*, but maintains the regulatory bodies of the Fiji Medical and Dental Councils. Accreditation of the training programmes offered at the Fiji School of Medicine is undertaken by the University of the South Pacific for programmes in which students enrolled prior to 2010, and by the Fiji National University for newer enrollees, subsequent to its incorporation in January 2010 into the Fiji School of Nursing, Fiji National University College of Medicine, Nursing and Health Sciences.

**Regulation and governance of pharmaceutical care**

**Marketing authorization:** As Fiji has no Drug Registration Programme, it does not issue any Marketing Authorizations. However, products entering
the Fiji market need to meet the criteria of the British Pharmacopoeia and US Pharmacopoeia. All products entering Fiji need to be registered in their country of manufacture.

**Pharmacovigilance:** The National Medicines and Therapeutics Committee, through the Essential Medicines Section of the Fiji Pharmaceutical Service, monitors adverse drug reactions and receives and handles issues pertaining to therapeutic efficacy.

**Patent protection:** The MoH monitors compliance with the Patents Act as it applies to medicines. Direct-to-consumer advertising of prescription pharmaceuticals is prohibited under the *Pharmacy and Poisons Act 1997*, and the MoH limits the sale of products that are available 'over-the-counter', including analgesics and anti-inflammatory agents, cough, cold and allergy preparations, dermatological preparations, gastrointestinal drugs, including those for acid-related disorders, laxatives, vitamins and minerals.

**Regulation of wholesalers and pharmacies:** A pharmacy can only be owned and operated by a pharmacist with the approval of the Pharmacy and Poisons Board and the premises require the board’s approval as suitable for a pharmacy. Wholesalers (including non-pharmacists) need to apply for a Pharmaceutical Wholesale License from the Pharmacy and Poisons Board.

**Generic substitution:** The purchase and distribution of generic products is supported under the National Drugs Policy 1994, to which the MoH adheres. A private sector pharmacy, when substituting a generic drug for a prescribed one, must inform both patient and prescriber that the substitution has been made.

**Mail-order/Internet pharmacies:** These are not permitted to operate in Fiji by order of the Pharmacy and Poisons Board.

**Price control:** Pharmaceuticals are subject to direct price control under the *Counter Inflation Act*: a maximum mark-up of 35% on prescription medicines (plus a 45-cent dispensing fee) and 30% on over-the-counter medicines is permitted. The selling price of medicines includes the ex-
factory price, wholesaler’s profit margin, pharmacy profit margin and a Value Added Tax (VAT) of 12.5%.

**Essential Drug List (EDL):** All products on the list are available free of charge for public patients (i.e. those visiting government health facilities), but there is no reimbursement of products from the private sector. Fiji’s National Essential Drug List is part of the Essential Medicines Formulary. The National Medicines and Therapeutics Committee requires ‘evidence based research’ to justify ‘cost-effectiveness’ of a recommended item. The National Drug Policy aims at improving cost-effectiveness in the consumption of pharmaceuticals and, in particular, through measures to influence physician prescribing behaviour.

**Monitoring of rational drug use:** A variety of methods are used to monitor rational drug use, including prescribing, dispensing and patient compliance surveys and the comparison of epidemiological data with drug purchasing data.

**Regulation of medical equipment devices and aids**

Fiji has no existing law to regulate medical equipment, devices and aids. These could conceivably be incorporated into amendments to the current Pharmacy and Poisons Act 1997. As mentioned above, tendering for capital items is regulated by the Fiji Procurement Office. However, commodities such as family planning and contraceptive devices, sourced through WHO, UNFPA, UNICEF and other global agencies, and which have received credible international testing, are adopted accordingly.

There is no legislation or regulation of the purchase and safety of biomedical equipment. The MoH refers to a biomedical equipment catalogue, which sets some direction on the types and safety of equipment. The lessons learned from Fiji’s experience of biomedical engineering point to the importance of attractive career packages for biomedical technicians, maintenance contracts, staff training and parts supply as conditions of purchase. The MoH is trying to control the acquisition and evaluation of clinical health products through the National Clinical Products Management Policy.
Registration/licensing and planning of health care personnel

The nine groups of health professionals listed in Table 2-2 are registered under different pieces of legislation.

All regulatory bodies are part of the MoH structure. The Permanent Secretary for Health is the chairperson of all these boards and councils and the MoH provides a secretariat to each. Applicants to the relevant board or council apply through the secretariats on standard forms, pay registration fees and provide evidence of their qualifications. The processing of local graduates of the Fiji School of Medicine and the Fiji School of Nursing is simple, while overseas applications require verification from their certifying authority. Several Pacific regional countries have memoranda of understanding with Fiji’s authorities to mutually recognize graduates of their programmes, such as the visiting doctors and nurses on clinical services teams (cardiac or complex surgery), who need temporary certification status with the Fiji Medical Council or the Nurses, Midwives & Nurse Practitioners Board.

Table 2-2: Legislation governing health workers

<table>
<thead>
<tr>
<th>Professional Cadre</th>
<th>Legislation</th>
<th>Regulatory Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Practitioner</td>
<td></td>
<td>Fiji Dental Council</td>
</tr>
<tr>
<td>Medical Assistant</td>
<td>Medical Assistant Act (Cap.225A)</td>
<td>Medical Assistant Council</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>Pharmacy and Poisons Act</td>
<td>Fiji Pharmacy &amp; Poisons Board</td>
</tr>
<tr>
<td>Nurses, Midwives &amp; Nurse Practitioners</td>
<td>Nurses, Midwives &amp; Nurse Practitioners Act</td>
<td>Nurses, Midwives &amp; Nurse Practitioners Board</td>
</tr>
<tr>
<td>Optometrist, Chiropractor and Acupuncturist</td>
<td>Medical &amp; Dental Practitioner (Amendment Act) Decree</td>
<td>Fiji Optometrist Board &amp; Fiji Medical Council</td>
</tr>
<tr>
<td>Medical Imaging/Radiographer</td>
<td>Medical Imaging Technologist Decree (2009)</td>
<td>Medical Imaging Technologist Council, to be formed.</td>
</tr>
</tbody>
</table>
The Fiji Medical Council and the Fiji Dental Council have recently amended their licensing procedures to require annual registration as evidence of participation in a Continuing Professional Development (CPD) programme. The Fiji Medical Council, among other responsibilities, is the legal/legislative body that sets the educational standards and carries out revalidation of qualifications to ensure the medical competence of both local and expatriate doctors.

The MoH has initiated a process to register all paramedic/allied health professionals who are currently not required to register, beginning with the Medical Imaging Technologist Decree 2009. An exception is registration of para-dental cadres, including dental therapists, technicians and hygienists, now covered under the Medical & Dental Practitioners Decree 2010.

The qualifications of Fiji-trained professionals (in particular, nurses, midwives, doctors and dentists) mainly are recognized within the Pacific region. However, Fiji-trained professionals need to apply for professional registration in other destination countries and are required to pass professional examinations prior to registration and licensing.

2.11 Patient empowerment

The MoH has set up structures and policies for clinical governance and risk management in which both the patient and provider have a role to play. The system provides for feedback from patients on their degree of satisfaction with the care they receive in hospitals. Until 2004, when the Human Rights Commission in Fiji increased awareness of the potential for legal redress among service users, health had been viewed by consumers as the domain of professionals.

Patient information

Whether using public or private health services, patients have a right to information on their health, the tests needed, the provisional diagnosis, the prognosis if appropriate, the proposed treatment and any associated costs. Hospitals provide booklets containing basic information, such as visiting hours, how to lodge complaints, how to minimize the risk of hospital acquired infections, and rules related to meals.
Informed consent is required before clinical procedures are commenced, and parental consent is required for any health intervention involving a minor under age 18. However, this ideal may not always be achieved for all patients, given the mix of languages and variable levels of literacy in Fiji.

**Patient rights**

Patients are empowered through the Bill of Rights enshrined in the Constitution of the Fiji Islands, whereby the rights of individuals are protected. Section 22 contains the right to life. The function of the Human Rights Commission under the Human Rights Commission Act of 1999 is to promote respect for human rights and make recommendations to the government on compliance. Breaches of human rights are dealt with by the Human Rights Commission and the courts.

The MoH houses the Fiji Health Research Ethics Review Committee, which reviews the ethics of proposed research involving patients or using information pertaining to vulnerable groups.

**Patient choice**

Patients in urban areas can opt for private or public health services depending on their ability to pay. The public system also provides private rooms for paying inpatients. The determining factor for most people is one of affordability. Some patients may choose to use both systems according to their circumstances and their perceived urgency of care. Similarly, some will choose to transfer from private to public care when informed of the cost of their treatment plan in the private sector, and where similar services are available in the public sector. No one in Fiji is excluded from the public system. Non-residents can access the public system with minimal costs.

**Patients and cross-border care**

Fiji has restrictions on funding for patients seeking treatment outside the country. Patients who travel overseas for treatment are referred through the government funded system for overseas treatment, or funded by private insurance schemes, following assessment by specialists (see Section 5.4).
According to revised MoH guidelines, publicly-funded overseas treatment can be approved only if the diagnosis and/or treatment are not available locally, or cannot be delivered within a reasonable timeframe by a visiting team of specialists, and are of a one-off nature. There must also be a good prognosis for the patient having a healthy life for at least three to five years following the treatment.

All applications for overseas treatment are sent to the office of the Director of Hospital Services. Necessary documents include those supporting the patient’s socioeconomic status (e.g. bank statements, district officer’s approval for fund raising) and documents supporting acceptance for treatment and associated costs by an acceptable overseas health facility. Compiled information is referred to the Overseas Medical Treatment Committee and the National Medical Advisory Committee through the recommendation of the patient’s specialist, after liaising with the selected recipient overseas hospital.

**Complaints procedures**

Patients can lodge complaints against the treatment received in any government or private health facility by writing directly to the hospital authority, or to the Permanent Secretary for Health in the case of public system. The hospital will initiate an investigation before a decision is made. Where a complaint involves a health practitioner, the matter is dealt with by the regulatory professional body. Legal provision exists for inquiries into the performance or conduct of professionals and for prescribed penalties for negligence, and in which the accused is entitled to natural justice and may be represented by a legal representative. The Nurses, Midwives and Nurse Practitioners Board has guidelines in place for nursing managers in the public system to submit all relevant complaints against a nurse’s professional conduct for the Board’s deliberation. In addition, patients have recourse to systems outside the MoH, such as engaging their own legal representative or applying to the Legal Aid Commission for complaints against the health system. It is not known how well the public knows and understands the procedures for lodging complaints. Health staff report that the process can be extremely drawn-out, particularly if it involves legal proceedings.
Patient safety and compensation

In 2006, the MoH launched the Year of Patient Safety in its efforts to create awareness of improvements in the care of patients and in minimizing health risks, such as hospital acquired infections. Infection control guidelines and procedures are in place in all health facilities. Resources are being pooled to achieve safety outcomes through clinical governance and clinical practice improvement initiatives. The Risk Management Units of the divisional hospitals coordinate efforts to promote patient safety through risk management, quality improvement and customer service programmes. Compensation for loss of life or injury is managed by the Ministry of Labour’s compensation legislation.

Physical access

All health facilities are subject to the Fiji Building Code. Physical access for people with disabilities is mandatory, including wide entry for wheelchairs into buildings and toilet facilities and the provision of railings and elevators. This requirement is safeguarded under the Constitution in Section 38(2) on the Right to Equality.