6 Principal health care reforms

6.1 Section summary

Aspects of the health system have been reviewed and reforms recommended since the 1970s, including by select committees and special commissions. Many of the themes taken up in earlier reviews remain valid today. For example, a 1979 report focused on delegating responsibility, human resource challenges and encouraging the use of outpatient facilities, all issues that are still relevant. Similar themes, with a focus on hospitals, were taken up in 1982 and in the 1990s, recommendations were made on financing and, once again, on decentralization. Following the 1997 recommendations, a comprehensive five-year reform project was initiated within the context of changes across the whole government. This concentrated on decentralizing management of the health system and building management capacity.

A change of government in 1999 brought the government-wide changes to an end, followed by the 2000 coup d’état, which severely constrained reform in the health sector. But some decentralization, however, was achieved with powers delegated to chief executive officers at divisional level. Support for decentralization, improved community and rural health services, rural health service delivery and human resource development continued under a new programme beginning in 2005. In 2008, nevertheless, many of the decentralization reforms were reversed, some before they could take hold. In any event, a decade of efforts at reform is judged to have produced beneficial change despite the disruptions.

Further reform of the health sector is needed. Two areas are a particular challenge for the future. First, reforms are needed in the production, distribution and retention of human resources across all groups of health professionals. Second, long-term reform of the health financing
system is needed to ensure that health funding remains adequate and sustainable.

### 6.2 Historical perspective

Since the late 1970s, a series of reviews of different aspects of the health sector in Fiji have recommended reform. While a number of these recommendations were taken up, and the context in which the health system operates has evolved, many still remain relevant today. The Report of the Select Committee of Inquiry into Health Services in Fiji (Fiji Government 1979a) found that planning responsibility was rarely delegated from MoH headquarters, including for control of hospital staff postings and transfers, and that hospital administrators had minimal influence over hospital expenditure. It also found that Colonial War Memorial Hospital administration was weak and of low calibre. The report identified poor staff morale, high staff turnover, high rates of transfer and inadequate numbers of staff as issues of concern. The Select Committee recommended that authority be delegated from the headquarters to workers in charge of hospitals and further highlighted the need of decentralizing services and of encouraging patients to utilize outpatient clinics at peripheral health centres and subdivisional hospitals.

The Coombe Report (1982) was directed to improving hospital standards through new administrative arrangements, and placed particular emphasis on human resources, proposing the delegation of duties from MoH headquarters to divisional structures, which would provide a career structure for health professionals, improve general human resources management and raise hospital standards. The 1993 World Development Report (World Bank 1993) examined problems of health sector financing and recommended to government that efforts should be made to develop a strategic focus and ensure coordination and direction of donor funding according to national priorities. An Auditor General’s Report (1996) and a Senate Select Review Committee (1997) both highlighted the management problems faced by the MoH due to its complex organizational structure, unmanageable span of control and lengthy chain of command. Importantly, the report also pointed out that the MoH lacked the autonomy to decide on matters such as personnel and finance. As a result of these findings and the ongoing concerns for the management of CWMH, a WHO mission to
review divisional hospital management took place in 1997. In consultation with the MoH, the review’s terms of reference were extended to include the Ministry of Health headquarters. Soon after, Dunn (1997) recommended the redefinition of the role of MoH headquarters, the transformation of divisional hospitals into decentralized business units, the redrafting of legislation and the revision of centralized processes of finance, human resources management and information systems, as well as supply and maintenance.

6.3 Analysis of recent reforms

These recommendations for decentralizing management authority and responsibility to the divisional levels formed the rationale for the Fiji Health Management Reform Project 1999-2004, a partnership of the Government of Fiji and the Government of Australia. The goal was to improve health service delivery in Fiji through decentralization and building management capacity within the health sector, within a wider ‘whole of government’ reform being planned by the government at that time.

Soon after commencement of the project, the national election of March 1999 produced a change in government, which effectively stopped the prior government’s ‘whole of government’ reform plans. As the Ministry of Finance and the Public Service Commission reform plans then ceased, the potential to implement the health management reform project as designed was consequently constrained. After a year of policy inactivity, in March 2000, a coup d’état further disrupted plans. Management reform activities thereafter were reduced to management strengthening and the decentralization of a limited number of MoH roles through delegations to divisional chief executive officers. A subsequent phase of AusAID funding to the health sector, from 2005 to 2010, was implemented as the Fiji Health Sector Improvement Programme, which aimed to support continued decentralization of the MoH and to strengthen selected divisional level community health services, rural health service delivery and human resource development.

A recent study shows that both reform programmes were welcomed by staff and empowered them to make decisions at the local level that aided the improvement of the delivery of health services. Support to strengthening
the divisional structures to meet health needs of the community was also widely appreciated (Mohammed, 2010). Although the aim of devolving centralized authority to new divisional authorities within the context of whole of government reform was not fully achieved, the project did facilitate new responsibilities for divisional medical officers/CEOs and the decentralization of selected administrative functions.

In 2008, many of the decentralization reforms were reversed, in some cases before structural reform had taken place to consolidate them. The ‘rollback’ of the health sector reforms was ostensibly due to the higher cost of the decentralized structure. It was also due to a belief that recentralization of power would improve the efficiency of the services. The title of CEO reverted to the prior title of permanent secretary and health system management was recentralized. The Public Service Commission withdrew the delegation of authority for CEOs at different levels to hire certain categories of staff. The recentralization of these responsibilities has worked against the recommendations of multiple reports and the objectives and achievements of the reform process. Nevertheless, it is clear that Fiji has retained some essential elements of a decentralized model, even though it has recentralized policy making, decision-making and reporting.

### 6.4 Future developments

Significant reform of the health sector is not foreseen in the immediate future. Inevitably, this has an impact on the nature of planned external support to the sector. AusAID support to the health sector for the period 2011-2014, for example, will focus more directly on Millennium Development Goal (MDG) 4 (reduce the under-five mortality rate by two-thirds) and MDG 5 (reduce the maternal mortality rate by three-quarters). It will also focus on reducing the prevalence of diabetes mellitus and other non-communicable diseases, and strengthening information systems rather than supporting broad sectoral reforms as in the past. AusAID will also support the collaboration between technical agencies and NGOs and the MoH to achieve national health objectives that the Ministry is not able to achieve on its own.

Another area of current effort is revitalization of primary health care. Fiji has been active in this area over many years, with a particular emphasis
on community environmental health and health promotion. In the face of the growing burden of non-communicable diseases, there is now an effort to increase health promotion and preventive care, recognizing that this is a more cost-effective way of addressing this challenge than expensive curative care.

One area that is expected to receive more attention in the immediate future is human resources due to the major constraints imposed on service delivery, and human resource development itself, by staff shortages, partly as a consequence of the emigration of skilled personnel. Training programmes will be further developed to increase the output of health professions, particularly in medicine, postgraduate medicine, specialist ICU and paediatric nursing, laboratory science and public health. Concurrently, policy alternatives will be developed that aim to improve the retention of health professionals in Fiji and to address the issues of career path, salaries, working conditions and international networking.

Health financing is another area of expected development, including the establishment of the system and resources for completing periodic National Health Accounts to inform financing policy. Health systems research is to be further developed to assist management of the health system through a period of difficult economic conditions, where demand is increasing while resources are constrained.