

TONGA

1. CONTEXT

1.1 Demographics

Tonga's estimated population for 2010 was 103 365, giving a population density of 159 persons per square kilometre. The population, about 23.4% of whom live in urban settings, is young, with 38% in the 0-14 year-old age group. The fertility rate remains high, although it has been falling slowly, decreasing from 4.1 in 1986 to 3.7 in 2010. The population growth rate is around 0.3%, a low figure taking into consideration a crude birth rate of about 25.4 per 1000 population and the fact that child mortality rates are the lowest in the Pacific. The explanation is found in the high net emigration rate, which averaged 19.8% between 1986 and 1996. It is estimated that as many as 100 000 Tongans live overseas, most of them in Australia, New Zealand and the United States of America. The Tongan community in New Zealand alone accounts for some 50 000 people.

1.2 Political situation

Tonga is a constitutional monarchy. The Tongan constitution of 1875 remains in use and was federated by George Tupou I. The head of State is the Tongan monarch, currently King George Tupou V, who was crowned in 2008. The Monarch oversees the three areas of the executive: the Cabinet, as appointed by the Monarch; the Privy Council, which includes all members of the Cabinet and the Monarch; and the Legislative Assembly.

A significant change in the structure of the Legislative Assembly occurred on 25 November 2010. For the first time, the majority of seats (17 of a total of 30 seats) in the Assembly were held by people's representatives. The current breakdown is nine seats for nobles (selected by the country's 33 nobles) and 17 elected by popular vote, based of their constituency. The King may administer up to four additional seats, traditionally given to previous serving members of the Cabinet, although these powers have not been invoked in the 2011 Government.

There is no party system in Tonga, but notably 12 of the 17 people's representative are from the Friendly Island Democracy Party. Five popularly elected MPs joined with the nine nobles to elect a noble, Lord Tu'ivakano, as Prime Minister. No women were elected to the new Parliament in November 2010. A woman may become Queen, but the Constitution forbids a woman from inheriting hereditary noble titles or becoming a chief.

1.3 Socioeconomic situation

Agriculture forms the backbone of the economy, and the export of pumpkins for the Japanese market plays a particularly important role as a foreign exchange earner. The fishing industry is in recession due to decreasing catches over several years. Tourism is slowly increasing in importance, although the prospects of Tonga developing a mass-tourism industry are limited. Remittances from Tongans living abroad play an increasingly important role in the economy. The total value of private remittances was estimated at TOP 200 million (US\$ 105 million) in 2004, roughly 55% of the gross domestic product (GDP), which was estimated at TOP 361 million (US\$ 189.6 million). The Government is heavily dependent on development support for capital investments.

Economic development has been sluggish in recent years and real growth in GDP fell from 2.3% in 1998-1999 and 5.4% in 1999-2000 to only 1.4% in 2003-2004. The figure was 2.5% in 2004-2005, giving an average GDP growth for 1998-2005 of 2.9% per year. The Government has liberalized the economy in recent years and has abolished government monopolies and allowed competition in several areas, including telecommunications, power supply and civil aviation.

Tonga joined the World Trade Organization in December 2005 in an agreement that saw the country reduce its import tariffs on most goods to 15% and open its domestic markets, including health care provision and education, to foreign investors. A 15% consumption tax was introduced on goods and services in April 2005, which compensates for the loss of income from import duties. The tax base is small, with only about 4000 people having a taxable income, and income tax is low, at 10% and 20% progressive, resulting in revenue from income tax of TOP 5.3 million (US\$ 3.16 million) from government and TOP 6.5 million (US\$ 3.88 million) from non-government employees per year. Property taxation is negligible and land ownership is concentrated among the

royal family, churches and nobles. The labour force participation rate in 2003 (Labour Force Survey 2003) was 64% (75% for men and 53% for women).

The literacy rate is very high (99%) and most children complete compulsory primary school classes. Education absorbed 14% of the national budget in 2004. While most primary schools teach in Tongan, secondary education is mainly conducted in English. The education rate is similar for both genders, with some advantages for girls at the secondary level. Despite equal opportunities in education, however, the number of women in leading positions remains limited. An important step was taken in 2005 when the first female Member of Parliament was elected. Tonga has ratified the Convention on the Rights of the Child (CRC), but has failed to fulfil the reporting requirements. It has yet to sign the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW). Women continue to be discriminated against in legislation, including land ownership rights, child support rights and inheritance laws.

The standard of living has improved dramatically over the last 50 years and there is now little absolute poverty. The country is placed 85th in the United Nations Development Programme's Human Development Index (HDI), the highest ranking of any Pacific island state, reflecting the comparatively high GDP per capita of US\$2988 (2008-2009), the high life expectancy and the near-universal literacy. Disposable income per capita is considerably higher than GDP per capita as a result of remittances from Tongans working abroad. The value of those remittances is also increasing much faster than the domestic economy and official development assistance, and the strong performance in the HDI is partly explained by the high disposable income. However, many families are dependent for food security on what they can produce on their farmland, and limited access to such land is an increasing problem. An estimated 4% of the population live on less than US\$1.00 per day and about 6.7% of households live below the food poverty line. The Government uses the term 'hardship' to describe economically disadvantaged groups in Tonga and hardship is defined as "having difficulties in meeting basic needs, such as education and transport". When translated into monetary terms, hardship is the equivalent of living on less than TOP 28.17 (US\$ 14.79) per week (indexed value), and an estimated 23% of the population fall into that category. People who live on the outer islands, where access to education and health care is poor, transport costs are high and income opportunities few, have higher rates of hardship.

1.4 Risks, vulnerabilities and hazards

No available information.

2. HEALTH SITUATION AND TREND

2.1 Communicable and noncommunicable diseases, health risk factors and transition

Tonga has gone through an epidemiological transition since the 1950s, with increasing life expectancy and falling fertility rates, childhood mortality and maternal mortality. Life expectancy at birth increased from 40 years in 1939 to 65 years for males and 69 years for females in 2010. The proportion of deaths caused by infectious diseases fell from 32% in the 1950s to 6% in the 1990s, while the proportion of deaths from diseases of the circulatory system grew from 5.6% to 38% during the same period. However, there is likely to be considerable underreporting of many noncommunicable diseases. Postmortem examinations are limited to criminal cases and death certificates are, at best, based on clinical findings, and frequently on reports from relatives. More importantly, as many as 18% of deceased people do not have a proper death certificate stating the cause of death, and 'unknown cause of death' actually ranks as second when included in the list of leading causes of death. While the mortality data are considered to be fairly consistent over time for those who die in hospital, there are clearly distortions in morbidity reporting caused by misclassification and inconsistent ICD-10 coding, particularly for communicable diseases.

The steep increase in the burden of noncommunicable disease (NCD) is worrying and is the most important current health problem. Obesity, diabetes and cardiovascular diseases have increased to levels of epidemic proportion and prevalence rates now surpass those of most industrialized countries. Tonga developed a multisectoral national strategy to prevent and control NCD in 2003. There are multiple reasons for the rapidly growing NCD burden, of which the most important include increasing rates of overweight and obesity, reduced physical activity, smoking, and, to some extent, the ageing of the population. Economic development, motorization, improved access to processed imported food and the adoption of 'western' dishes with high fat and high sugar contents have had a strong negative impact on people's health.

Food, gifts of food and feasting traditionally play an important role in Tongan culture. Higher economic standards, improved communications and better access to processed and high-fat and high-sugar foods have led to a rapidly increasing overweight and obesity problem. Figures from 2004 show that the average weight for a Tongan male increased over 30 years by 17.4 kg to 95.7 kg, while the average weight for a woman increased by 21.1 kg to 95.0 kg, a rise in body weight with few comparisons in the world. There are indications that people are becoming overweight and obese earlier in life; girls and young women in particular tend to gain weight during adolescence and pregnancy. The overall adult obesity rate (BMI>30) was 60% in the 2004 survey. Women have higher obesity rates than men over all age groups and they are more obese (mean BMI 34.5 compared with 31.0 for men). Most people continue to perceive fatty food as something desirable, a taste that may be explained partly by the scarcity of fat in the traditional fishing and farming society and by historic periods of food shortage. Other findings indicate that the quantity of food consumed by Tongan adults is as much to blame as its composition. Studies have shown that the average Tongan male consumes double the quantity of food and amount of calories consumed by the average Australian male. Women are more overweight than men, while men have a higher prevalence of other risk factors, including hypertension, elevated blood lipids and smoking.

The overall adult prevalence of diabetes type II has increased from 7% to 18% over the last 30 years. As a consequence of their higher obesity rates, women have higher rates of diabetes than men, with 19.1% of women and 16.5% of men meeting the definition of diabetic. A community survey in 2000 showed that as many as 80% of people with diabetes remained undiagnosed and untreated. Access to health services for people with diabetes and its complications has improved, but the health system does not have the capacity to provide quality care for all those who need it, and primary and secondary prevention have so far not been enough. The number of registered diabetic patients at the specialist clinic at the referral hospital on Tongatapu increased by 54% between 1999 and 2003 from 1463 to 2247, which corresponds to more than 9% of the serviced population aged 30 years and more. A hereditary predisposition towards impaired glucose tolerance is likely to play some role in the high rates of diabetes, but this is a non-modifiable factor and has in itself little to contribute to the design of public health interventions.

Physical inactivity is also thought to be an important cause of overweight, particularly for women and middle-aged people. It is unusual today for people to walk or bicycle, as the number of vehicles is increasing rapidly. The increasing number of cars on the roads, together with outdated traffic safety measures, contributed to the record 24 traffic-related deaths in 2003, a figure that put Tonga ahead of the United States of America in the number of traffic deaths per 100 000 population. Seatbelts are not compulsory and only 1% of drivers were found to be using them in a Ministry of Health survey in 2004. The single most important cause of traffic injury is driving under the influence of alcohol, kava or marijuana. All 24 deaths in 2003 were caused directly or indirectly by intoxication. The section on alcohol in the current Traffic Act is antiquated and not enforceable in practice, and neither the health services nor the police have the equipment to measure blood alcohol or to 'breathalyze' motorists. The health and social problems caused by the harmful use of alcohol has received increasing attention in Tonga lately and this will hopefully result in measures aimed at reducing access to alcohol and enforcing drink-driving controls in the future.

The incidence of cancer is perceived to be increasing, but weaknesses in diagnosis, surveillance and reporting do not allow for reliable analysis of trends. The sharp increase in overall cancer incidence is likely to be partly or entirely explained by changes in reporting rather than by a true increase. Diagnostic capacity is limited for many malignancies, and it is not always obvious when the reported figure refers to cytological diagnoses or when clinical (non-confirmed) diagnoses have been included. A cancer register was established in 2004 to capture both clinically determined cancers and laboratory-confirmed cases. Although that important development improved the statistical information on cancer incidence, the proportion of cytologically and histologically confirmed cancer cases remains low compared with overall cancer incidence, and the autopsy rate is very low. A pilot project on Pap-smear screening for cervical cancer was started in 2005. Mammography is not available. Liver cancer, which is closely related to infection with hepatitis B virus (HBV), is common in Tonga, where HBV infection rates in the adult population are hyperendemic (10%-14%). It will take another two to three generations until immunization against HBV, which was introduced in 1989, impacts on incidence. Lung cancer now ranks among the three most common cancers, a result of smoking, and it is expected that the incidence will continue to increase.

Of the 17 hospital-certified deaths among those aged one to four years in 2003, eight were from infectious causes, one from dehydration, two from malignancies and two from road trauma. Of the eight children who died as a result of infection, six were from septicaemia and infection of the central nervous system (CNS), one from dengue

fever and one from pneumonia. This picture resembles the situation in an industrialized country more than that of a poor developing one. There is limited information available on childhood morbidity, but the two deaths from road trauma indicate that child safety is a potential area for improving child health.

Infectious diseases have, to a large extent, been brought under control in the last 30-40 years, with some important exceptions. Tonga does not have the vector for malaria, but a few imported cases are diagnosed each year in people returning from visits to areas with malaria transmission.

A fifth and final round of mass drug administration (MDA) for the eradication of lymphatic filariasis took place in 2005, with 100% geographical coverage and an estimated population coverage rate of >90%. A nationwide post-MDA campaign serosurvey was conducted in 2006 to evaluate the results.

Leprosy has, in practice, been eradicated, although the latest infection was diagnosed in 2004. This was an imported case in a Tongan adult who returned after having lived his entire life in American Samoa. The last case of indigenous transmission was in 1998 and today there are a handful of well documented people living with complications of leprosy.

Hepatitis B is highly endemic in Tonga and screening of blood donors, government employees and visa applicants shows that more than 10% of the adult population are positive for HbsAg. A survey in pregnant women in 2005 found an HbsAg-positive rate of 13.9%. Childhood immunization against hepatitis B started in 1989 and the first immunized cohorts are now entering reproductive life. A serosurvey of 211 preschool children in 1998 found a 3.8% prevalence of chronic hepatitis B infection, indicating a lower-than-expected efficacy for hepatitis B immunization. Increasing efforts are now being made to improve hepatitis B vaccine delivery, particularly the timeliness. A study using convenience testing for HbsAg in children admitted to Vaiola Hospital started in 2005 for surveillance purposes; of more than 100 children tested so far, none has been positive for HbsAg.

Poor household hygiene and sanitation, as well as contamination of drinking water sources, are thought to contribute to the typhoid fever cases. However, in year 2010 there was only one confirmed case of typhoid fever. The Ministry of Health places great importance on finding and treating asymptomatic chronic typhoid carriers through contact tracing and stool sampling, and this limits the spread of typhoid. However, it can be argued that Tonga is in the position to eliminate typhoid fever altogether if adequate coordinated resources were to be allocated to treat carriers, improve sanitary practices and ensure the supply of safe water in all villages.

Eight new cases of tuberculosis (all forms) were reported in 2009. All tuberculosis treatment follows the directly observed treatment, short-course (DOTS) strategy and there is active contact tracing. The cure rate for patients diagnosed in 2008 was 100%.

HIV prevalence remains very low. A total of 14 people have been diagnosed with HIV infection over the last 16 years and, as of January 2006, there was only one person known to be living with HIV. The volume of HIV serology testing is high, with an average of 2500-3000 HIV tests carried out annually as part of screening of blood donors, government employees and visa applicants, and an estimated 45 000 HIV tests have been carried out since the start in the 1980s. A pilot trial of voluntary counselling and testing (VCT) at the antenatal clinic at the referral hospital reported a very high uptake, but no decision has been taken to continue to offer antenatal screening. Risk behaviour surveillance and high-risk group serosurveillance started in 2005 and will provide valuable information on the risk of transmission. Antiretroviral treatment (ART) is not available through the public health system and there are no officially endorsed guidelines for treatment of HIV infection or prevention of mother-to-child transmission.

The diagnostic capacity for sexually transmitted infections (STI) is limited to gonorrhoea and syphilis (with the exception of HIV). The number of cases is thought to be much higher than revealed by the statistics, as many patients are treated by private practitioners who do not notify the Ministry of Health. The ratio of men to women receiving treatment for gonorrhoea is 10:1, indicating weak contact tracing and a lack of appropriate services for women. A serosurvey in pregnant women in 2005 found a high overall prevalence of chlamydial infection of 14.5%. The rate was 27.5% in women <25 years of age, an indication that transmission may be increasing in younger women. The RPR-positive rate for syphilis was 3.2%, which is alarming considering that the Ministry of Health took the controversial decision to discontinue syphilis screening in pregnancy a few years ago. The same study also asked questions about sexual risk behaviour, which showed that the condom use rate is very low and

that condoms are primarily seen as a method of contraception to be used within marriage and not to protect against STI.

2.2 Outbreaks of communicable diseases

The country experienced a large outbreak of dengue fever (serotype 1) in 2003, causing six deaths in children, and transmission continued into 2005. The outbreak was confined to the main island of Tongatapu in the first year, but transmission then spread to all island groups except the Niuaus. Two adult deaths due to dengue were recorded in 2005. It is unlikely that dengue will become endemic in Tonga because the population is not large enough to sustain transmission over time. However, vector control and vector surveillance is poor and the measures introduced to prevent fatalities and control transmission during outbreaks are suboptimal. It looks inevitable that the introduction of another serotype will cause a new outbreak of dengue fever, with fatalities.

Tonga experienced an outbreak of watery diarrhoea from December 2005 to February 2006, with altogether six fatalities in children below one year of age. This was an unusually large outbreak and, for the first time, Rotavirus was confirmed in a sample sent to the Pasteur Institute in New Caledonia.

2.3 Leading causes of mortality and morbidity

See Section 2.1.

2.4 Maternal, child and infant diseases

More than 98% of pregnant women attend antenatal clinics, 98.5% deliver in a health facility and 100% of deliveries are attended by trained staff. The maternal mortality ratio (MMR) was 36.5 per 100 000 live births in 2007. Indicators that are based on relatively uncommon events, such as the MMR and the infant mortality rate (IMR), will show large variations between years due to chance and it can be more informative to either compare absolute numbers or to examine rates over five-year or 10-year periods. The mean MMR for the five-year period from 1999 to 2003 was 39.4 per 100 000 live births, which translates to one death per year. It is of concern that the MMR has been stable over the last two decades and that it has proven very difficult to reduce it further. The absolute majority of maternal deaths take place in hospital, which is an indication that patient monitoring and emergency services, such as availability of blood for transfusion, need strengthening.

Tonga is the best performing country in the Pacific in terms of infant and child mortality. The unusually low infant mortality rate of 9.1 deaths per 1000 live births at the 1990 baseline for the Millennium Development Goals (MDGs), together with the fact that the IMR has remained unchanged for the last decade, makes it unrealistic for the country to achieve the MDG for infant mortality. There are several explanations for the low IMR, but at the core is the Government's commitment to delivering key interventions, such as immunizations, antenatal care and trained delivery care to the entire population. The result shows that it is possible to provide high coverage of essential services in an island state with isolated populations, and that it pays off.

There is little absolute poverty in Tonga, no chronic undernutrition (stunting), no important micronutrient deficiencies and no malaria, all factors that contribute to well-nourished and healthy mothers and children. The comparatively low teenage (<20 years) pregnancy rate (4.1% in the 2000-2003 period) is another protective factor. Breastfeeding promotion is receiving increasing attention as an important public health intervention. The goal of establishing Vaiola Hospital as a baby-friendly hospital in 2005 was, unfortunately, not achieved. This would have meant that two-thirds of all children in Tonga would have been born in a baby-friendly environment. Work has started to translate the International Code on Marketing of Breast-milk Substitutes into national law and regulations.

The challenge for child health lies in protecting the impressive gains made so far while at the same time identifying and implementing affordable and sustainable interventions that will reduce mortality rates further. Mortality from *Haemophilus influenzae* type B (Hib) infection lies almost entirely in the 0-1 age group and the introduction of routine childhood immunizations against Hib in 2005 is a good example of an affordable new intervention to improve child health.

Immunization rates are higher than in many industrialized countries, and neonatal tetanus and poliomyelitis have been eliminated. Rubella vaccine (measles-rubella [MR] vaccine) was added to the immunization schedule in 2002 in response to a large outbreak of the disease. There have been no detected cases of congenital rubella syndrome

(CRS) since that outbreak. The immunization campaign with MR vaccine to break the epidemic included all children aged 0-15 years and all women up to 45 years of age, with a coverage rate of above 80%, meaning that population immunity against measles can be expected to be high. The last confirmed measles infection was in 1998 and the country set 2007 as a target for measles elimination. Immunization against Hib was introduced in April 2005, with a catch-up immunization campaign for children below two years of age. It has been estimated that Hib vaccine will prevent one to two infant deaths per year, as well as several more cases of severe sequelae caused by Hib meningitis. Hospital paediatric departments are documenting the impact of Hib vaccine on admissions for meningitis and pneumonia.

2.5 Burden of disease

See Section 2.1.

3. HEALTH SYSTEM

3.1 Ministry of Health's mission, vision and objectives

Mission: To support and improve the health of the nation by providing quality, effective and sustainable health services and being accountable for the health outcomes.

Vision: By 2020, we are the healthiest nation compared with our Pacific neighbours, as judged by international determinants.

Objectives:

- (1) To fight the NCD epidemic and communicable diseases using effective preventive measures, being good role models and developing public participation and commitment.
- (2) To deliver the range and quality of services to meet the basic health requirements of the public.
- (3) To provide appropriate health services to all the outer islands and community centres through effective resourcing.
- (4) To build staff commitment and development by demonstrating to staff that they are valued.
- (5) To deliver services in a professional and friendly manner.
- (6) To continue to improve the standard of existing facilities and ICT, and to construct new facilities and introduce new ICT where needed.
- (7) To improve management of financial resources through: better revenue collection, balanced budgeting, compliance with procurement procedures, timely processing of payments and compliance with proper financial procedures.

3.2 Organization of health services and delivery systems

The Ministry of Health works in four programme areas: (1) policy formulation and administration; (2) preventive health services; (3) curative health services; and (4) dental health services.

Government health services are provided free of charge and physical access to care is good for the majority of people, with the exception of small populations living on isolated islands. Primary curative care and preventive services are delivered through a system of 14 health centres.

There are four hospitals in Tonga: the tertiary Vaiola Hospital in Nuku'alofa, with 196 beds; and three district hospitals, Prince Ngu's hospital in Vava'u, Niu'ui hospital in Ha'apai and Niu'eki hospital in Eua. The overall bed occupancy rate is low, 34% in 2003, an indication that the hospital system is oversized and has not adapted to changes in the disease pattern and to improvements in physical access. However, transportation between islands remains difficult and acute referrals to the tertiary hospital are uncommon, making centralization of services problematic. The four hospitals also serve the populations on their respective islands with primary health care and they all run busy outpatient and emergency departments.

Patients requiring specialist care that is not available in Tonga can be referred to New Zealand under two treatment schemes, one funded by the Government of Tonga and one by the Government of New Zealand. The decision to refer is made on a case-by-case basis by the Medical Transfer Board. Specialist treatment teams in such areas as eye surgery, plastic surgery, corrective orthopaedic surgery and rheumatic heart disease visit Tonga regularly.

3.3 Health policy, planning and regulatory framework

See Section 3.2

3.4 Health care financing

A 2003 household survey on health care expenditure showed that 89% of all health services were delivered by public hospitals and only 6.2% by health centres. As per the Tonga NHA 2003-4, the total expenditure on health care in Tonga for the Financial Year 2003/04 amounted to US\$ 11.6 million and the per capital expenditures to US\$ 113.58. The total expenditure on health is 5.8% of the GDP. This level of expenditure is in line with middle income countries. The Government covered 54% of total expenditures on health, household 125, and donors 34%. However, when expenditure on traditional healers and international referrals is excluded, it becomes obvious that the Government covers the absolute majority of both curative and preventive care costs and that 'out-of-pocket' payments for health care are low. However, when expenditure on traditional healers and international referrals is excluded, it becomes obvious that the Government covers the absolute majority of both curative and preventive care costs and that 'out-of-pocket' payments for health care are low.

About 12% of the population have some kind of health insurance. The private sector is still small and consists mainly of traditional healers and government-employed doctors practising 'after hours'. About 14% of total expenditure on health is for traditional healers, although they are mostly paid in kind. Expenditure on drugs accounts for approximately 7.8% of total expenditure on health. There is a health insurance system, but it only covers government employees.

3.5 Human resources for health

There are large variations in equipment, staffing and catchment populations depending on location but, on average, a health centre serves 7200 people and is typically staffed by a health officer and one to three nurses. There were 58 physicians in 2010 (0.56 doctors per 1000 population). In the same year, there were 379 nurses (3.7 nurses per 1000 population). In 2010, there were 10 dental officers. The number of private providers is increasing, but the majority of private doctors remain government employees and run part-time private clinics, many from their homes.

The Ministry of Health had a total of 945 established posts in 2002, with an overall vacancy rate of 25%, making it one of the biggest employers in the country. Doctors normally train in Australia, Fiji or New Zealand, often on bilateral scholarships or WHO fellowships. Three-year health officer training courses are organized by the Ministry of Health when required. Nurses train at the Queen Salote School of Nursing in Tonga. On average, 30 nurses graduate each year from the basic nursing training programme. A decision has been made to increase the intake several-fold in order to make up for the continuous loss of nurses to Australia, New Zealand and the United States of America. The Nursing School also runs a postgraduate certificate training programme in collaboration with the nursing department at the Auckland University of Technology, New Zealand. The first training programme in intensive care nursing started in 2005 and postgraduate training programmes in midwifery, internal medicine, surgery and public health were offered in 2006-2007.

3.6 Partnerships

One of the core values of the Ministry of Health is to develop and sustain partnerships with relevant health stakeholders. An example of a recently established successful partnership is the Tonga-Australia Partnership for Development. Its aim is to support progress towards poverty reduction and improvement in living standards for Tongans, through improved health outcomes. The Partnership will support the Government of Tonga to implement the Ministry of Health Corporate Plan 2008/2009-2011/2012 to achieve the following targets:

- Reduced prevalence of noncommunicable disease risk factors including:
 - tobacco use: 2% decrease in prevalence of smokers by 2015; and

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- obesity: 2% decrease in overall prevalence of obesity by 2015
 - A budget for preventive health care that has reached 10% of the total public health operational budget by 2015.
 - A common national standard in the primary health care available to all communities in Tonga, including in utilization of services.

There are other examples of partnerships between the Ministry of Health and other organizations, such as the Health Promoting Church Partnerships and the Health Promotion Foundation. There is also close collaboration with WHO in strengthening the health system, based on primary health care principles. In addition, the Ministry of Health has very good working relationships with the governments of Australia, China, Japan, New Zealand and the European Union (EU), and the Government of Cuba has also assisted Tonga by providing medical training for Tongan students. There are ongoing partnerships with the following organizations: the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the Global Fund, the Asian Development Bank, and several others.

3.7 Challenges to health system strengthening

The most critical question for the health system today is how to increase the resources available for health. Government health expenditure is about US\$ 100 per capita per year and, given that this pays for free medical treatment and free drugs, it is fair to say that Tongans get a lot of value for their money. Around 10%-15% of the total government budget has been spent on health for the last two decades and it is unlikely that share will increase substantially in the future. Since government income is likely to grow only slowly in the coming years, there will be little space for growth in health sector spending within the current health financing system. At the same time, the pressure on the health system will increase with the increasing NCD burden and the ageing of the population. Identifying alternative sources of health care financing is thus one of the top priorities of the Ministry of Health. In December 2005, the Cabinet approved the introduction of user fees. A decision has also been made to introduce social health insurance. Initially it will cover civil servants, but the intention is to gradually include larger sections of the population. Tonga has achieved many of the health goals within its reach given its existing health spending level, and the challenge now is to increase the resources for health promotion and health care without jeopardizing the health of poor and disadvantaged groups in the population.

The increase in noncommunicable diseases (NCD) has now reached epidemic proportions. In addition to human suffering, NCD can have a negative impact on family economies. The loss of income due to disease and the cost of treating chronic conditions can put enormous strain on families and destroy years of work to improve a family's situation. Ultimately, there will be a negative impact on the country's economic development as more resources have to be used for health care and productive and experienced middle-aged people in the workforce are lost to chronic disease or death. Identifying and implementing effective population-targeted preventive measures that can slow the increase of disease and, in the future, reverse the trend, are of the highest priority. The national multisectoral strategy for the control and prevention of NCD, developed in 2003, is a sign that the Government takes the issue very seriously. There are plans to establish a Health Promotion Foundation with funding from dedicated taxation on tobacco and alcohol. Such a mechanism could provide crucial resources for health promotion, an area of health that is currently heavily dependent on external support.

There is a recognized need to improve both the quality of and access to health care, particularly for NCD, in view of the increasing burden caused by the ageing population. A large proportion of patients with diabetes and cardiovascular disease remain undiagnosed and untreated. It is therefore a priority to both increase access to care and improve the quality of care for people with NCD. This must include solutions for financing the treatment of chronic conditions and for increasing patients' knowledge of their condition and their responsibility for care. Active participation in treatment and patient empowerment are both essential for successful treatment of chronic conditions.

There is a need to strengthen both the collection of information and the analysis and dissemination of health data for decision-making. The outcomes of investments in health care financing and prevention of NCD must be able to be evaluated so that strategies can be modified when needed. The information must be easily available, cheap and reliable, and should therefore be based on ongoing surveillance rather than repeated and costly surveys. A first step towards such a system is the strengthening of vital statistics on births and deaths, as well as a consistent

hospital-based diagnosis registration system. The Government has already started important work in this area, but there is a need to strengthen the system of data collection as well as increase the capacity to process and interpret the information gathered. The Ministry of Health is expected to invest substantially in the area of health information in the coming years, partly with resources made available through a World Bank loan.

4. LISTING OF MAJOR INFORMATION SOURCES AND DATABASES

<i>Title 1</i>	:	<i>Annual reports 1995 to 2004;</i> <i>Ministry of Health Corporate Plan 2001-2004;</i> <i>Ministry of Health Corporate Plan 2005-2008;</i> <i>EPI and Reproductive Health Services annual reports 2000-2003</i>
<i>Operator</i>	:	Ministry of Health
<i>Title 2</i>	:	Tonga Department of Statistics
<i>Web address</i>	:	http://www.spc.int/prism/country/to/stats/
<i>Title 3</i>	:	<i>Social and economic update and pro-poor policy formulation, Tonga.</i> Pacific Island Economic Report series
<i>Operator</i>	:	Asian Development Bank TA6245 (reg)
<i>Title 4</i>	:	<i>Tonga's report on progress towards the Millennium Development Goals (MDGs)</i>
<i>Title 5</i>	:	<i>Annual report of the National Reserve Bank 2003-2004</i>
<i>Title 6</i>	:	Health Sector Support Project (HSSP/WB) Project Implementation Plan (PIP)
<i>Title 7</i>	:	<i>National Health Accounts report of July 2004</i>
<i>Title 8</i>	:	<i>Report of the Minister of Health for the year 2010</i>
<i>Operator</i>	:	Ministry of Health

5. ADDRESSES

MINISTRY OF HEALTH

<i>Office Address</i>	:	Ministry of Health, Vaiola hospital
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<i>Fax</i>	:	(676) 24 291
<i>Office Hours</i>	:	08.30 – 16.30

WHO COUNTRY LIAISON OFFICER IN TONGA

<i>Office Address</i>	:	Ministry of Health, Nuku'alofa, Tonga
<i>Postal Address</i>	:	P.O. Box 70, Nuku'alofa, Tonga
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<i>Office Hours</i>	:	08.30 – 16.30 Time zone Manila +5 hrs, CET + 12 hrs

6. ORGANIZATIONAL CHART: Ministry of Health

