A Case Study on the Public and Private Mix of Health Services In Fiji

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Preface

The following case study briefly discusses some of the issues relating to the Public-Private mix of health services in Fiji. In attempting to do this, the case focuses on four specific areas:

- Bonding of Government health workers
- Salaries and Allowances
- Schemes for private practice by Government doctors
- Private health services

The case study does not present a background of the Fiji Health System and readers are requested to refer the Fiji Health Systems in Transition Report 2010, published by the Asia Pacific Observatory as providing a good summary of the Fiji Health System.

There is very little published literature available with regards to the public private mix of health services in Fiji, thus our case draws substantially from our interviews with key persons within the health sector. As promised, we have agreed to keep the anonymity of persons interviewed.

While the case was written for the purpose of informing a briefing paper by the World Bank, the case also presents useful information (especially for health stakeholders) for generating dialogue, healthy debate, and research pursuits about health systems and services in Fiji.

Bonding of Government health workers

In this section, a description of the current systems of bonding of government health workers that have received public funded scholarships/training for undergraduate and post graduate professional development are discussed.

Every year the Ministry of Health (MoH) loses skilled and professional personnel. These persons mainly go abroad to more affluent neighbors New Zealand and Australia, they take jobs in other Pacific Island Countries (PICs) which offer lucrative salary packages, they join development partner organizations such as United Nation Agencies, or they join the private sector as a private GPs or work in the private hospital. For example the Australian and New Zealand 2006 Census show that there were 247 Fiji-born doctors in Australia and 114 in New Zealand; the total of 361 was more that the number of public doctors in Fiji for that same year (Connell and Negin 2009).

Table 1 shows staff attrition in MoH for the year 2010 and Table 2 show the number of medical officer positions and vacant posts within the MoH. It is widely assumed that financial incentives are significant drivers behind this migration. The government is then left with personnel that often require some development in knowledge and skills to be able to ensure continuous functioning of the services of the public sector.

Table 1: Ministry of health staff attrition - 2010

Modes	Doctors	Dentals	Nurses	Pharmacists	Paramedic	Admin & Others	Un-Established
Resignation	36	14	50	8	24	11	40
Deem Resign	2	2	13	2	7	1	24
Retirement	3	1	11	2	2	3	29
Deceased	0	0	2	0	0	0	2
Termination	0	0	0	0	0	0	2
Total	**41**	**17**	**76**	**12**	**33**	**15**	**97**

Source: Ministry of Health Fiji, 2010 Annual report

Table 2: Ministry of Health medical staff posts

	2011	2010	2009	2008	2007	2006	2005
New graduate doctors (FNU)	42	38	37	39	48	36	31
Medical Officers established/approved posts	N/A	407	416	396	396	N/A	405
Medical doctor filled posts within MoH	N/A	374	340	337	318	357	361
Medical doctor vacant posts within MoH	N/A	33	76	59	78	52	44

Source: Ministry of Health Fiji, Annual reports

Currently there are 3 main ways in which the Government attempts to respond to the shortage of medical doctors within the country. The first way is training more doctors at the tertiary level via Government support to the Fiji National University (FNU). However as Table 2 suggest, FNU medical graduates are insufficient to address the shortage.

A second way is the recruitment of doctors from other countries. The trend over the past years has been to recruit from Asian countries. While expatriate doctors have helped reduce the skills scarcity, their recruitment has also had its share of difficulties. Often these doctors are remunerated higher, given free accommodation and other perks when compared with their local counterparts and this causes some tension within the working environment. The skills of some of these doctors have also been questioned. For example the Auditor general's 2005 report highlighted cases where patients have died due to the incompetence of expatriate doctors hired by the Ministry of Health to practice locally. The recruitment criteria have since been revised. In late 2009, 17 expatriate doctors were recruited by the MoH from India and the Philippines and this reduced the number of vacant posts in 2010 (see Table 2).

The Government also annually offers training opportunities (which are aligned to the Government's training needs) for which all government workers are eligible, a practice dating back to as early as 1975. These training opportunities are called "in-service training" and are offered by the Government and donors for a variety of disciplines for both local and overseas training institutions. In a year Government can receive close to 500 training offers from donor agencies. The objective of the in-service training is for capacity building within the public service through the promotion of relevant tertiary training.

In-service training is generally defined as training undertaken by existing government salary and wage earners, where official leave has been obtained to undertake such training, and where the expenses incurred due to that training is paid by the government or donor organizations.

In the past it was found that officers who went on these in-service training schemes rarely returned back to their positions with the Government. To curb this behavior and to ensure that officers returned to their stations after the training, certain mandatory bonding conditions were introduced.

The bonding of Government personnel for training where the costs of the training are being funded out of Government budget (or any aid by donor countries and organizations) is one mechanism of the government's attempts to retain skilled human resources.

The bonding conditions for in-service training are stipulated in the Public Service Commission General Order regulations and are enacted across all government ministries, and therefore cover all government wage earners including health workers.

The bond only applies for training that lasts more than 8 weeks. The bonding agreement requires persons to return to government duties and work for a period of 1.5 times the

duration of study. For example if an officer was sent for 3 years in-service training, than the officer is bonded to the government for 4.5 years of service. After this bonded period is served, the officer is then allowed to resign from their duties if they choose to(Public Service Commision 2011).

If an officer, on completion of in-service training, wishes to leave the government and not serve the years for which he/she is bonded, then the officer is required to pay back financially the cost of the bond in one lump sum. The cost of the bond equals the amount spent on the officer's training and the salary paid to the officer while on training(Public Service Commision 2011).

The bond also contains a signed document by the officer agreeing to the terms and conditions of the bond. The document also has the signatories of two guarantors approved by the Permanent Secretary of the Ministry in which the officer is based. Should the officer abscond from his training or his bond conditions, the guarantors will be asked to pay back to the Government the bonded amount in one lump sum or monthly installments over a period of 3 years.

It is the role of the Public Service Commission (PSC) to ensure that bonded officers are fulfilling their bond conditions. For example the Government via the PSC reserves the right to demand the surrender or declaration of assets from the bondee/guarantors as a measure to assist in the recovery of any sum which might become due to Government. The PSC will inform the Immigration and Police Departments and Foreign Embassies so that appropriate administrative/legal actions may be pursued should bonded Officers or guarantors appear to be about to leave the country. There have been situations in the past where the PSC has also resorted to extreme sanctions such as having these persons listed on the immigration blacklist.

It is only recently that the PSC has taken a stronger stance on ensuring officers comply with the fulfillment of bond conditions. The loan recovery unit within the PSC scholarship unit was established to collect monitor and follow up on students who owed money to the government. With this reform in place the unit has been able to recover 2.3 million in 2009, 3.0 million in 2010, and 3.3 million in 2011and estimate to recover 3.5 million in 2012. But cost recovery can also be a costly exercise. For example in 2011 one of the Governments scholarship training unit, The Ministry of iTaukei affairs, found that a total of 25 recipients under the in-service training scheme owed Government $FJ5 million dollars and most of whom were now residing overseas. By Dec 2011, a total of $FJ102 thousand was recovered but it did involve a lot of effort, time and money to recover these costs.

Every Ministry of the Government is also allocated a training budget that the Ministry can use to meet the Ministry's training needs. The bonding arrangements that govern the recipients who have received training paid from this budget is not clear. For example overseas attachments of clinical doctors that can last from 3 to 12 months often have no bonding agreements. Often the seniority of the recipient, the number of years they have worked for the Ministry and their track record with the Ministry is grounds for a waiver of any bonding conditions. While the Ministry encourages officers to return on completion of

training, there is little they can do (and do) to ensure these trained officers return. We could not find any studies that contained statistics on how many doctors have left the ministry, soon after serving clinical attachments abroad and whether these attachments were influential in their decision to leave the ministry. Our discussions with key people told us that indeed many have since left the ministry.

In 2010, the total number of personnel granted in-service training within the Ministry of Health was 238. According to regulation all in-service training funded by either the Ministry (Government) or donors should have bond conditions attached. Table 3 below shows the total number of personnel who were provided some sort of training within the Ministry of Health in 2010. It is noted that although overseas training attachments can often span 2 years full time overseas, they are often not bonded.

Table 3: Training of MoH Employees

No Training Programs	Number	Total Percentages
Local In- Service (full time and part time)	229	41%
Overseas In- Service (full time)	9	2%
Overseas Training Attachments, Meetings, Conferences, Seminars	180	31%
Local short training courses	145	26%
TOTAL	563	100%

Source: Ministry of Health Fiji, 2010 Annual report

A report by John Dwedney (1997) titled "Fiji National Health Workforce Plan 1997-2012" found that despite the PSC bonded conditions, a high percentage of candidates that are funded for international training and attachments do not return or resign soon after their return to mostly pursue their careers abroad. A later report in 2005 titled "Five year retention strategies plan to minimize skill losses in Fiji's public health sector 2005-2010"(Tagilala 2005) expressed the same sentiments as Dwedney. This later report recommended that persons be bonded for 7 years and selected candidates should have served at a minimum 15 years in public service. However it is difficult for MoH to enact these recommendations since bonding agreements and most of the processes surrounding in-service training is handled by the Public Service Commission (PSC).

Salaries and Allowances

In this section, details of the remuneration of public doctors are discussed and comparisons are made with respect to technicians in other public sectors and to bureaucrats. This section attempts to show if any preferential financial treatment is being extended exclusively to medical staff in the public sector over professionals working in other public sectors.

The salaries and allowances given to public sector employees (and this includes medical doctors) are governed by the Public Service Commission (PSC). In Dec 2011, the PSC confirmed salary adjustments for all public sector employees. A 3% increase in salary was

introduced in 2012 across all civil servants however the nurses and doctors were given an additional 3% increase while the Police force received additional 6% increase. The preferential treatment given to nurses and doctors was to incentivize health workers to remain within the ministry as well so as to build a strong and specialized cadre of doctors and nurses.

Table 4 compares the salaries of public doctors with some other prominent civil servant professions. Bureaucrats top the salary scales across all ministries. Bureaucrats include senior positions such as those at the director levels, deputy secretaries and permanent secretaries and are thus the most senior persons of the various government ministries. These positions are often filled by civil servants that have served the government faithfully and climbed the ranks overtime. Bureaucrat positions, because of the financial incentives and status, are often the aspired epitome career of a civil servant.

In the case of the Ministry of Health (MoH), often a gap is created within medical doctors and clinicians when more experienced technical persons are being recruited to bureaucrat positions. For example the post of the Permanent Secretary for the MoH has traditionally been given to a medical doctor.

The remuneration of Health workers when compared with other sectors within Government do not fair too bad. For instance medical doctors would rank close to the top when compared across the government workforce. Government medical doctors are also able to practice in the private sector and this further supplements their financial gain. Nurses on the other hand, have a much larger population than doctors but in terms of salary fall at the lower end of the scale when compared with other professions. They have one of the lowest starting salary scale and the largest number of incremental steps between minimum and maximum possible salary.

One advantage of the health sector with regards to other sectors is that due to scarcity of human resources, sponsored health trained workers are guaranteed employment with the government on completion of their studies.

While government medical doctors compare well to other occupations within the government in terms of salaries, they are outclassed when compared with doctors in the private sector. While a doctor in the public sector has a salary range from 17 to 80 thousand dollars per annum, in the private sector (mainly general practitioner officers) the starting salary estimated from National Health Accounts is 100 thousand per annum.

Table 4: Public Servants Annual Salaries

	Bureaucrats	Lawyers	Engineers	Scientists & Researchers	Medical Doctors	Dentists	Paramedics	Teachers	Nurses	Pharmacists
Starting/Lowest salary scale	46,554	24,733	24,605	19,205	17,197	14,859	12,666	9,415	8,817	8,211
Highest possible salary scale	104,615	76,445	76,445	50,744	80,359	52,509	50,160	51,035	53,169	52,509
Number of increment steps between highest and lowest	20	30	33	25	43	31	48	39	62	41
Estimate step increment	2,903	1,724	1,571	1,262	1,469	1,215	781	1,067	715	1,080

Source: PSC Circular No: 80/2011 - Public Service Commission (2011)

Schemes for private practice by government doctors

Previously employees of the state were according to government and PSC regulations, prohibited to simultaneously engage in providing private services. The exception was for public medical doctors above the MD04 salary scale (approximately above $35k per annum) who were given the freedom to practice in the private sector after official duty hours with the Ministry (official public service hours are from 8am to 4.30om). Discussion with key people in the Ministry of health suggests that such a policy was introduced sometime in the late 1990s unfortunately we were unable to obtain a copy of this policy. For some recruited specialists and consultants the freedom to engage in private practice was mentioned specifically in individual contracts and unlike general public doctors, private practice was not restricted by official public service hours.

Perhaps a lack of clarity on the above mentioned policy or dissemination of its existence resulted in public doctors engaging in the provision of private services (in various forms) and it was unsure as to whether this practice was permissible under PSC or MoH specific regulations. Often these activities used government health facilities and operated after official public office hours. However some of these private consultations were also carried out during official hours and within government health facilities. In some cases nurses and other allied health workers were involved in assisting doctors in the provision of these services. Personal wealth was thus accumulated at the expense of government resources.

Also during this period there was little indication of monitoring and enforcement and perhaps was a result of a lack of clear understanding about what practice(s) was permissible and what was not. Thus a lack of prohibition and explicit guidelines is partly to blame. Also there were no studies done to also ascertain whether the "said policy" was effective in retaining skilled medical officers within the health ministry.

In 2012, the Public Service Commission, perhaps being aware of such practices happening within the health sector and elsewhere, released a policy document titled "Policy on Locum Practice for Scarce Skills". The policy objective was twofold: firstly to allow the government to engage the services of qualified personnel on short term basis without the person having to become a civil servant, and secondly to allow skilled personnel in public service to indulge in outside work on a limited basis. The policy as intended was thus not only a means of trying to address the skills shortage and retain personnel within the public sector, but it also served to provide clearer and above-the-board guidelines on how civil servants could operate in both public and private settings.

The policy on locum practice for scarce skills became effective on the 1st October 2012 and selectively applicable only to officers in areas considered "scarce skilled". While health is not specifically mentioned, it can perhaps be implied since the health field is an area of scarce skills in Fiji. Although as mentioned earlier, medical officers were being engaged in performing private services prior to this policy and were covered in a separate policy. We were not able to obtain such a policy document, however the general understanding amongst medical doctors was that as long as one was registered with the Fiji Medical

Council either as a General Practitioner or as a Specialist one was free to engage in private services after official public office hours.

Public Officers intending to engage in providing private services will

- require approval from the Permanent Secretaries of their ministries;
- perform only 5-10 hours work in a week;
- take locum on non-official hours; and
- pay the Government 25% of payment received if Government resources have been used in the provision of these services.

The permanent secretaries of the various government ministries shall be responsible for the proper monitoring, controlling and enforcing of the rules and regulations of the locum policy.

Private health services

Public health services account for most of the provision of healthcare services in Fiji via the Ministry of Health. The last National health accounts (2009-10) find public and private health expenditures as approximately 70% and 30% of total health expenditure respectively. The private sector 30% contribution comes from a private hospital, private general practitioners, dentists, pharmacists, opticians, NGOs, insurance companies, and private companies. This section will only discuss the private hospital, the private GPs, and the public-private partnerships of the Ministry of Health.

Private General Practitioners (GPs)

The estimated number of GPs operating private clinics in Fiji was 127 in 2010. Note that this figure excludes GPs working within the Suva Private Hospital, and those working for Universities but registered as medical practitioners and allowed to engage in clinical practice. In 2011, the number of private GPs was estimated at 129, a number taken from those registered with the Fiji Medical and Dental Council.

It is unsure whether that number has increased in 2012. It is possible that the number of private GPs has decreased or remained stagnant due to the introduction of new medical registration guidelines contained in the Medical and Dental practitioner decree of 2010, and enacted by the Fiji Medical and Dental Council.

This new decree states that any medical doctors who intend to practice in Fiji (public or private) can either register as a General Practitioner or a Specialist after a few years of mentoring. A medical graduate needs to have 3 years practice under mentorship before being able to register as a general practitioner with the council. To register as a specialist a general practitioner should have completed master's level studies and a further 2 year mentorship before being able to register.

The services of private GPs in Fiji are mainly outpatient services and these services are mainly clustered around urban centres. Estimated annual earnings (from National Health Accounts) for a private GP start from a minimum of $FJ80k to $FJ100k, and a maximum of +$200k. The estimated outpatient visits to private GPs in 2010 was 700,000 at an estimated revenue of $FJ 25 million.

To date there has not been any studies done on the quality of care received by patients visiting private medical practitioners.

Private Hospital

Fiji has only one private hospital – the Suva Private Hospital (SPH). Here we take the definition that a hospital exists if the medical facility has inpatient beds that allow overnight stays for patients to receive inpatient services. In 2010, SPH employed about 90 staff made up of both full-time and part time employees. SPH had approximately 1700 inpatients and 49,000 outpatient visits. The hospital has 40 inpatient beds.

The Suva Private Hospital (SPH) began operations in 2000 and was established as a means of providing patients with an alternative choice of seeking health services. SPH was also looking to provide treatment that was previously only available overseas. However the overseas treatment scheme patient numbers sent by Government more than doubled over the period 2000 to 2012.

By late 2008 what was then Colonial Bank (now BSP Bank) an initial shareholder in SPH had obtained full ownership rights to SPH. We learnt from our interviews that SPH, since inception, has yet to make a substantial profit however we were not able to obtain financial reports of SPH to validate those statements[1]. BSP bank also has an insurance arm that offers health insurance cover and some of the health benefit packages under these insurance schemes are offered at SPH.

The services at SPH are mostly utilized by the higher income earning bracket of the population as well as those having private health insurance. This is because relative to public health services, the services provided at SPH are not free of charge. The health services provided at SPH are not very different from CWM (the national referral public hospital) and CWM seems to have more sophisticated medical equipment than SPH (e.g. MRIs and CT-Scans). In fact it is quite common to have patients referred from the SPH to CWM when a particular service is not available at SPH. This is made possible by the existence of private paying wards within CWM hospital. The main difference between SPH and CWM is not so much the caliber of the doctors nor the clinical services and medicines received, but more so in general amenities such as waiting times, big private rooms, cleaner surroundings, personal television sets, etc.

A number of government medical consultants and specialists who work at CWM also work at SPH. The government made this allowance to give these consultant and specialists the

[1] We obtained BSP financial reports however these reports were consolidated reports and it was not possible to identify the financials for SPH

ability to increase their financial gains, for fear of losing these skilled persons to the private sector. This arrangement worked well for SPH since it was unsure whether SPH would have been able to recruit from a scarce market as well as financially sustain full time specialists and consultants. In July this year, 13 specialists withheld their services to SPH, causing a major disruption of specialist services at SPH. Of these 13 specialists, 5 were also public servants. The specialists had rejected new contract terms, including the increased administration fees that SPH was charging for all patient cases seen by the specialists at SPH. During this disruption, all specialist services at SPH were referred to CWM.

It is unsure whether services at SPH have returned to normal however episodes like these highlight the difficulty of operating a full-fledged private hospital in an environment that offers free government health services, has scarce medical personnel, high medical technology costs and low patient demand. SPH survival is perhaps being supported by its investors, private health insurance schemes, and the sharing of skilled human resources with the Public Sector.

In 2010 another private hospital was launched, but this soon later filed for bankruptcy and was bought out by FNPF. The facility still exists but downgraded to an outpatient general practitioner facility. The facility still has hopes to expand its services and include inpatient services.

It is doubtful whether Fiji has the capacity to support a wholly private hospital. This is because a private hospital needs a good demand of wealthy patients and a good supply of skilled qualified doctors – something the current environment doesn't have in abundance. A small population, a large informal sector, a free public health service, a scarcity of skilled medical specialists, doctors who demand exorbitant salaries and rising costs of medicines and medical technology are all factors contributing to a struggling private health sector hospital.

Perhaps one private hospital is the limit for Fiji.

Public-private partnerships (PPP)

The Ministry of Health (MoH) has recently been involved in a number of public-private partnerships (PPP). The main reason for these partnerships is that the MoH realizes that it cannot continue to independently meet the health demands of the citizens of Fiji, especially in areas requiring specialized skills, and are of low demand but incur high costs. Some of these more formalized partnerships are listed in Table 5 together with their reason for establishment and their advantages and challenges.

Table 5: Ministry of Health public-private partnerships

Partnership	Reason for partnership	Advantages to MoH	Challenges
Sahyadri Hospitals Services (Private hospital in India)	To bring specialized tertiary health care that was previously unavailable in Fiji, at a subsidized cost to patients. Was seen as a means of reducing the expenses involved in sending patients overseas, both for Government and for individuals.	Decrease in treatment costs when compared if patient sent overseas Possible revenue collection Building local capacity via training of health workers in the long run	Co-operation with local health workers (conflict of interest) Opportunity costs e.g. operating theatres New concept for the health sector Requires a strong evaluation/monitoring e.g. costs of consumables, utilities Equity issues
Kidney Foundation of Fiji	Government on its own did not have the resources to establish a kidney unit within MOH thus the collaboration with the private sector	MOH does not bear the cost of operation Dialysis treatment and services made available in the country	Sustainable grant to fund the increase in demand of services Expensive treatment where people still pay to access the services – Equity issue Requires some evaluation and cost-benefit analysis
Pacific Eye Institute	To address the issues of a skills scarcity by establishing a training institution for eye health professionals for the Pacific region	Trained eye specialists Eye treatment and surgery for patients with minimal cost to MoH	Still a small fee for services Increased utilization Sustainability of donor and NGO funding
Pacific Counseling Service	To address the shortage of patient counselors within MoH	Patients receive counseling services Especially relevant for mental health	Funding sustainability Lack of health specialist in Psychiatrics
Empower Pacific	Provision of Ante Natal services at a decentralized level	Provision of services brought closer to patient Early testing undertaken on mothers and children to investigate diseases or illness that could be treated early	Funding Issue due to increase in demand of services
Four and Salt fortification	Improve child and maternal health	Contribute to the decrease in burden of disease especially relating to NCDs	Legislation and agreement from private partners

Historically in the Fiji health sector, the public and private health services have remained separate where the public system is seeing to provide free health services for all and the private sector seen as alternative health services for the more affluent of the society. Thus the implementation of PPP is difficult especially when the citizens of Fiji have always seen health services out of public health facilities as free-of-charge.

While PPPs increase the availability of specialized health services available in the country, they come with a cost and the question of equity and accessibility arises for those patients who are not able to meet the costs of these services. It is questionable whether in Fiji the introduction of PPPs into the health sector will alleviate the issue of inequitable access to health care, particularly for the inadequately serviced rural poor.

There are also large numbers of less formal short term PPPs that happen during the year and these are mainly public health programs funded by donors and NGOs. One example is the PPP for Continuous Management of Type 1 Diabetes done in collaboration with the International Diabetes Federation. It should be noted that from a local perspective the engagement of donors and NGOs in health services and programs are seen as less of a private partnership than if the partner was solely a private company.

Nevertheless PPPs where the partners are either Donor organizations or NGOs are perhaps preferred since often the incentives for these partners are not a good financial return on investment. However the sustainability of donor and NGO funding is an issue to consider with these partnerships. The MoH PPP with the Flour Mills of Fiji under the flour fortification program is an excellent example of a PPP that satisfies both the financial returns of the private partner while at the same time addressing the health goals of the MoH. Such partnerships should be encouraged.

The presence of paying wards within government facilities is another, less formal arrangement, of a public-private partnership. Patients seen by private doctors can be admitted into the paying wards by paying certain fees and room charges. These patients are seen by their private doctors, enjoy private rooms, and have different served meals from other patients. Apart from these benefits, there is no real difference between the health services (clinical treatment and drugs) received by a paying ward patient with respect to a general patient. While the fees charged for paying wards are considered exorbitant by the average person in Fiji, they are far from the actual costs incurred by the MoH to operate these private wards. The revenue thus generated from the paying wards is not sufficient to meet the operational costs of these wards. But this was never the purpose of paying wards in the first instance. They were established to enable the more affluent clientele an option for privacy and luxury. However their inability to generate sufficient revenue to balance the costs in keeping them is perhaps something for the Ministry to consider.

PPPs are a fairly new mechanism for delivery of health services for Fiji. Thus care is needed by MoH to have in-depth assessments and wide stakeholder consultations before “getting in bed” with a private partner. Economic evaluations and feasibility studies are mandatory. Once the partnership is established, MoH then needs to continually evaluate and monitor

the partnership to ensure that original intentions and goals are being met. Legislation and regulation is an essential aspect of PPPs and these should be developed rather than leaving authoritative decisions and powers with any one organization or position.

Some Key indicators

Key Indicators	2009	2010	2011	Source
Total admissions (public and private)	66,971	76,503	75,738	
Total admissions in public sector	65,212	74,657	73,801	MoH Annual Report
Total admissions in private sector	1,759	1,846	1,937	NHA Survey Estimates
Total admissions in private pay wards of public sector (if applicable)		3,184		Costing Study
Total outpatient visits (public and private)	2,198,476	2,567,331	2,565,470	
Total outpatient visits in public sector	1,477,166	1,818,597	1,788,270	MoH Annual Report + MoH Health centre records
Total outpatient visits in private sector	721,310	748,734	777,200	NHA Survey Estimates
Total hospital beds	2,026	2,032	2,016	
Total hospital beds in public sector	1,986	1,992	1,976	MoH Annual Report
Total hospital beds in private sector	40	40	40	NHA Survey Estimates
Total number of mission type private hospitals/beds	1	1	1	
Total number of industry/employer run private hospitals not serving general population/beds				
Total number of other private hospitals/beds				
Total number of MOH doctors, other public sector doctors	340	374	N/A	MoH Annual Report
Total number of private GP doctors (full time private)	125	127	129	NHA Survey Estimates, Fiji Medical & Dental Council
Total number of private specialist doctors (full time private)				
Annual number of medical graduates	37	38	42	FSM Database MBBS Graduates
Population	882066	893024	901208	MoH Annual Report

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