

Assessment of Social Health Insurance Feasibility and Desirability in Fiji



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The authors of this report wish to state that the contents of the report reflect the views and express the expert opinions based on the evidence collected and do not necessarily express the views of the World Health Organization nor the Fiji Ministry of Health.

Cover Photo taken by Dr Shyam Mahalakanda and shows the registration of patients at CWM hospital Suva, Fiji 2013

Foreword

As Minister for Health, I am accountable to the Government of Fiji, to the health workers and the citizens of Fiji for setting the roadmap in working towards the Vision of the Ministry of Health i.e. *“A healthy population in Fiji that is driven by a caring health care delivery system”*. Our vision provides a clear directive to the Ministry that priorities on health investment should be based on the ultimate principles of equity, risk protection and access for the poorest over satisfaction.

Clearly, as other developing countries, Fiji also faces challenges in the immediate future on the financial front, but there are many other factors that we must address concurrently within the longer term which requires proper planning now in order to provide a continuum of quality care to our people.

While we realize that the people using Health services must be at the heart of everything we do, we will be measured by how we focus on their needs through delivering high quality care that does not differentiate any of our citizens of accessing similar services.

With these ideologies at the root of a good governance structure and strong leadership, the assessment report on the option of developing a Social Health Insurance Scheme in Fiji as highlighted under Pillar 10 of the Peoples Charter for Change, Peace and Progress mandated by Government echoes the same: a strong committed Government that has prioritized protection of our citizens from financial catastrophic situations.

In all fair-mindedness, the report systematically outlines critical key objectives which are also entrenched in Fiji’s public health system thoroughly of improving the health status of the citizens, risk protection and meeting expectations.

Health care financing is one of the many strategies much needed to ensure that our health workers are able to deliver services effectively and efficiently. The reports also assess the current financing arrangement existing in Fiji. Options for strengthening health care financing are also discussed and these are areas that need to be further explored for improvements in partnership with other key stakeholders and development partners.

The assessment report on SHI provides views from both sides of the coins, the pros and cons of SHI to ensure its implications are taken into consideration on whatever direction is taken by Government. It is clear though that Social Health Insurance is not a complete fix to our limited budget towards health but a part of the remedy which also is depended on other mechanisms for a workable SHI.

This collaboration with the World Health Organization also strengthens our already cordial relationship that keeps the needs of the citizens of Fiji at heart. I must acknowledge and pass on my gratitude to WHO and Dr. Ravi P. Rannan-Eliya and Ms. Shanaz Saleem of the Institute of Health Policy and Dr. Wayne Irava of the Fiji National University for the comprehensive assessment of the feasibility of SHI in Fiji.

Finally it is reassuring to note that the report does reflect that Fiji’s health system performs well compared to developing and some developed nation. While we celebrate the successes, let us not forget the stagnation in progressing towards significant targets that must drive all health workers to work even harder.



Dr Neil Sharma
Minister for Health

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Acronyms

CWM	Colonial War Memorial
CHIPSR	Centre for Health Information, Policy and Systems Research
EUS	Employment and Unemployment Survey
FIBOS	Fiji Islands Bureau of Statistics
FNHA	Fiji National Health Accounts
FNPF	Fiji National Provident Fund
HIES	Household Income and Expenditure Survey
IMR	Infant Mortality Rate
MDG	Millennium Development Goal
MMR	Maternal Mortality Rate
MOF	Ministry of Finance
MOH	Ministry of Health
NCD	Non Communicable Disease
SHI	Social Health Insurance

Executive Summary

This assessment of the feasibility and desirability of social health insurance (SHI) was requested by the Minister of Health in response to widespread concerns about the performance of the Fiji health system, and to fulfil the commitment made in the People's Charter to assess the social health insurance option. The People's Charter's vision is guided by concerns for justice and fairness, unity and uplifting the disadvantaged. These concerns and values were reaffirmed to the consultants at the highest levels of government. However, consultations with stakeholders and key informants reveal a more complex set of concerns, not all of which are consistent. Some of these contradictions reflect differences in the importance given to key values and goals.

In terms of health outcomes, Fiji's health system is a good performer. This represents the gains of previous decades, but recent improvements have been minimal. Since the mid-1980s, there has been a failure to achieve productivity improvements in MOH services, and many health outcomes have stagnated. The current healthcare financing system does exceptionally well in ensuring financial risk protection. The level of risk pooling in financing is comparable to many developed countries. Out-of-pocket expenditures are low in absolute and relative terms, and are concentrated in upper-income households. Poor Fijians do not face significant financial barriers in accessing available healthcare services. At the same time, the level and quality of available services dissatisfies upper-middle-income citizens. The level of public financing is not adequate to meet their expectations for quality or for high-end services. Fiji does well in mobilizing public financing for healthcare, but there are limits to how much.

Fiji, like all countries, faces the challenge of how to achieve its health system goals with limited resources. It has to choose which goals to prioritize and what trade-offs to make. No country is able to obtain good health outcomes, effective financial risk protection and high levels of citizen satisfaction, and do so whilst keeping costs low. By funding an extensive delivery system including hospitals that is free or almost free for all patients, Fiji has chosen to prioritize equity, risk protection and access for the poorest over satisfaction of the better-off. Higher-income patients are free to purchase services privately, but government does not assist them. If anything their decision to use private services frees up resources to treat the poorer patients who depend on public services. Their dissatisfaction is the direct result of Fiji's choice to use public funding to guarantee a basic minimum for all. It is also the key driver of demand for SHI.

Most countries that have gone down the SHI route made different choices. They prioritized ensuring access and financial protection for the usually better-off formal sector workers, before they dealt with improving coverage for the poor. In these countries, there is bigger latent demand for SHI, because the government does not provide a free public service. The limited uptake (<10%) of the Public Service Commission's private medical insurance policies reveals the lack of such latent demand in Fiji.

It is certainly technically feasible to use SHI to collect funding in Fiji. The country has a well-functioning provident fund scheme that can be used to collect a mandatory, SHI payroll tax. A 1% levy on wages would mobilize the equivalent of 12-14% of the current MOH budget. However, neither Fiji nor Fiji National Provident Fund (FNPF) have the experience, skills or competencies required to manage payments to providers, and to monitor and control costs. Significant investment in this expertise and human resources will be needed.

The fundamental question is not whether SHI can be introduced, but why? If Fiji introduces contributory SHI, it needs to decide whether it wants this to support better services only for the formal sector and better-off Fijians who would be contributors, or whether it wants the arrangements to be universal and benefit all citizens. The first option would undermine solidarity, and social cohesion, and increase inequity in the current system, and would not be consistent with the broad vision of the People's Charter. It carries long-term risks of embedding a two-tier health system, which will be politically and financially costly to dismantle later. The second option would require an equal or greater increase in tax financing to allow the SHI benefits to be provided to the majority of the population who would not be contributors. The ultimate choice is thus not between SHI and increasing tax funding, but actually between reducing (introduce SHI alone) or maintaining equity (introduce SHI and increase tax financing).

There is a risk that SHI funding will not increase overall financing for health. If SHI is used to increase the funding of MOH services, Ministry of Finance (MOF) might choose to allocate a smaller budget to health, and global evidence shows that this is quite likely. If SHI finances private provision, MOF would need to increase its budget allocations to health if equity is to be maintained. Public sector hospitals lack the capacity, management and information systems or administrative regulations that would enable them to charge a SHI scheme for services and manage such funds. If a SHI scheme is to pay public providers, significant investment in these systems would be needed first.

SHI by itself will not increase efficiency in the health sector. Internationally, SHI systems are often more expensive than tax-financed systems because of the difficulties in controlling prices. SHI might raise costs in Fiji's health system, and make it more difficult to improve treatment of Non Communicable Diseases (NCD). As a middle-income country, Fiji does need new funding to upgrade primary care services to better manage NCDs and chronic illnesses, to fill gaps in secondary and tertiary services particularly for NCDs, and to provide the new technologies that Fijians will inevitably expect. Regardless of efficiency gains, such expansions in coverage will in the long-run need an increase in public financing from the current level of 3% of GDP.

To increase health sector funding whilst maintaining or increasing equity, the only realistic option for Fiji is to increase financing from general revenue taxes. This is also the simplest option to implement. However, its scope will be limited by the difficulties of increasing taxes in the medium term, and the need to convince government that health should increase in priority.

Increasing efficiency in service delivery is the second major option that MOH has to mobilize resources. MOH has under-performed in productivity improvement since the mid-1980s, implying significant potential for efficiency gains. The timing of the productivity slowdown indicates that it is linked to the failures in governance since the mid-1980s. In countries with similar systems, competitive elections are the critical driver creating pressure on health sector managers to improve performance. From this perspective, implementation of the reforms outlined in the People's Charter and transition to elected government provide the necessary preconditions to allow MOH to achieve large efficiency gains in future.

The other options – increasing public sector user fees or expanding private medical insurance – will not generate substantial new funding. Fee levels that would make a meaningful contribution to resource mobilization are politically unfeasible and would substantially damage equity and efficiency in the health system. The economic conditions to support private insurance expansion – lack of free care and high prices to access medical care – do not exist in Fiji.

Given the concerns and values expressed by senior government officials and in the People's Charter, and the capacities available in Fiji, the most feasible and sustainable strategy to improve health sector funding is to:

- (i) Continue to rely on general revenue financing, whilst building the case for increased budget allocations for MOH.
- (ii) Intensify efforts in short-term to address known inefficiencies in MOH.
- (iii) Complete the transition to competitive elections to provide the necessary public pressure and accountability that is needed to sustain efficiency improvements in MOH delivery.

1. Introduction

Background

Since the colonial period, Fiji has relied on a mix of government budgetary financing and out-of-pocket payments to fund its healthcare care system. Government health services are free or almost free, but Fijians can choose to pay for and use private services at their own expense. As in most countries, the Government of Fiji faces constant pressures and demands to improve the range and quality of health services available, and the services that are provided with public money. At the same time, there are limits to what the Government of Fiji and Fijians themselves are willing to or can spend on healthcare. How to manage these conflicting pressures is a challenge that all countries face.

As a middle-income country with the most diversified economy in the Pacific, Fiji cannot expect substantial amounts of foreign assistance to fund its healthcare services. Health services will have to be largely funded from domestic resources. In the past, the Government of Fiji has attempted to pass some of the financial burden of funding healthcare services to public sector patients by imposing user charges for use of government health services. However, in practice these generate only small amounts of money (<1.0% of total healthcare financing), and recent experience suggests that further increases are likely to encounter substantial public opposition.

Proposals have been made in the past to introduce social health insurance (SHI) as a mechanism to mobilize additional financing for the healthcare system, but none have been intensively investigated or implemented. A full assessment of the feasibility, potential and desirability of SHI has not been done, so many of the questions that policy-makers ask have remained unanswered.

The Government of Fiji has been engaged in substantial transformation of governance and state policies with a view to providing Fijians with a more stable and sustainable future, with greater solidarity and better living standards for all. The health system, like other aspects of social policy, has not been immune from the need for review and revitalization. Recognizing the need for strengthening financing and performance of the healthcare system, the Government of Fiji requested from WHO this assessment of the feasibility and desirability of introducing SHI as a new financing mechanism for healthcare in Fiji.

Social health insurance is only one of many potential mechanisms for raising revenues for the health system. General taxation, public sector user fees, private medical insurance and direct patient payments to private providers are other mechanisms, and all of these already exist in Fiji. Improving or expanding on these existing mechanisms represent other potential options available to the Government of Fiji to improve healthcare financing. The choice and use of all of these options need to be set within a broader healthcare financing strategy.

In order to evaluate the feasibility, potential role and desirability of SHI in Fiji, this assessment first assesses the overall financing challenges facing the government, taking into account the economic, social, financial and institutional constraints of the country. This will then serve to identify the critical needs in any financing strategy, in the context of which the potential role of SHI will be examined. In addition to considering its potential role, this

assessment will also examine the potential contribution and requirements of introducing SHI.

Conceptual framework

Global experience consistently finds that a country's health system needs to serve three broad objectives: (i) improving health status, (ii) satisfying and meeting citizen's expectations, and (iii) protecting citizens against financial risk (Roberts *et al.*, 2004). In Fiji, the first focus of most public health managers is to reduce mortality and morbidity, all aspects of improving health outcomes. The government funds hospitals and inpatient services largely because it implicitly recognizes that in the absence of such funding, many Fijians would be exposed to significant financial risk in accessing medical services. At the same time, government faces significant pressures from citizens about the quality and level of services provided and available in the country, which reflect the importance of patient satisfaction and meeting citizens' expectations.

Healthcare financing is one tool that governments have to achieve these objectives. Healthcare financing involves the mechanisms for *collecting* and *pooling* money to fund healthcare services, and which uses such funds to *purchase* services. The collection of revenue cannot be done without paying attention to its impact on health status, citizen satisfaction and financial risk protection. Both government and citizens also have an interest in enduring this is done in a way that is efficient and equitable. Once collected, revenues must be pooled so that most citizens are not exposed to large, unpredictable health expenditures. Finally, health services need to be purchased efficiently and equitably so as to maximize health outcomes, financial protection and consumer satisfaction.

In order to assess the potential role and contribution of SHI, we need to consider how well the financing system in Fiji serves the broader health system objectives, and how well it does in terms of collecting, pooling and using money to fund healthcare services. The contribution of SHI needs to be then assessed in terms of how it will impact these objectives and goals, including whether it will meet the expectations and concerns of both government and citizens. Based on this framework, this assessment will address these questions:

- (i) How well does the current financing strategy meet the country's overall goals?
- (ii) Will SHI help improve achievement of the overall goals, including improving risk pooling and financial protection, and improving citizen's satisfaction?
- (iii) Will SHI improve efficiency and equity in financing and service delivery?
- (iv) What other options exist for improving healthcare financing, and how do they compare with the introduction of SHI?

Based on the answers to these questions, this assessment then will lay out what options the Government of Fiji has and their implications, and make appropriate recommendations.

Methodology

This assessment was conducted by the Institute for Health Policy (IHP) working in collaboration with the Centre for Health Information, Policy and Systems Research (CHIPSR) at Fiji National University. The lead consultant, Dr Rannan-Eliya, made one visit to Fiji, during which the views and concerns of the government and other agencies were canvassed, and relevant data and information sources identified and assessed. CHIPSR led the collation of

necessary data and documentation, and the final analysis was led by the lead consultant.

Significant information that was used includes data provided by the Health Information System of the Ministry of Health (MOH), the Fiji National Health Accounts (FNHA) produced by CHIPSR on behalf of MOH, and other health systems analyses undertaken or collated by CHIPSR. Labour Force Survey data collected by the Fiji Bureau of Statistics (FIBOS) were used to model the impact of an SHI payroll tax, and consultations and information from other government agencies, including the National Provident Fund and Ministry of Finance, were used to assess other aspects of feasibility.

Structure and outline of the assessment

The remainder of this paper is organised as follows. Chapter Two provides a brief overview of health system in Fiji, and assesses its overall performance. Chapter Three assesses the performance of the current healthcare financing arrangements. Chapter Four examines what options exist within the current arrangements to increase funding for the health sector. Chapter Five then examines the option of social health insurance and what impact it would have. This will also present some findings from some modelling of a potential SHI scheme. Chapter Six then summarizes the key findings and makes overall recommendations.

2. Health system context and performance

Health outcomes and trends

Health outcomes in Fiji are good for a country at its level of income, and comparable or better than many of its peers in the region. In terms of infant mortality rates (IMR), child mortality, life expectancy and maternal mortality, Fiji does well in comparison with other low-middle income economies, and better than its neighbours Samoa and Tonga (Figure 1).

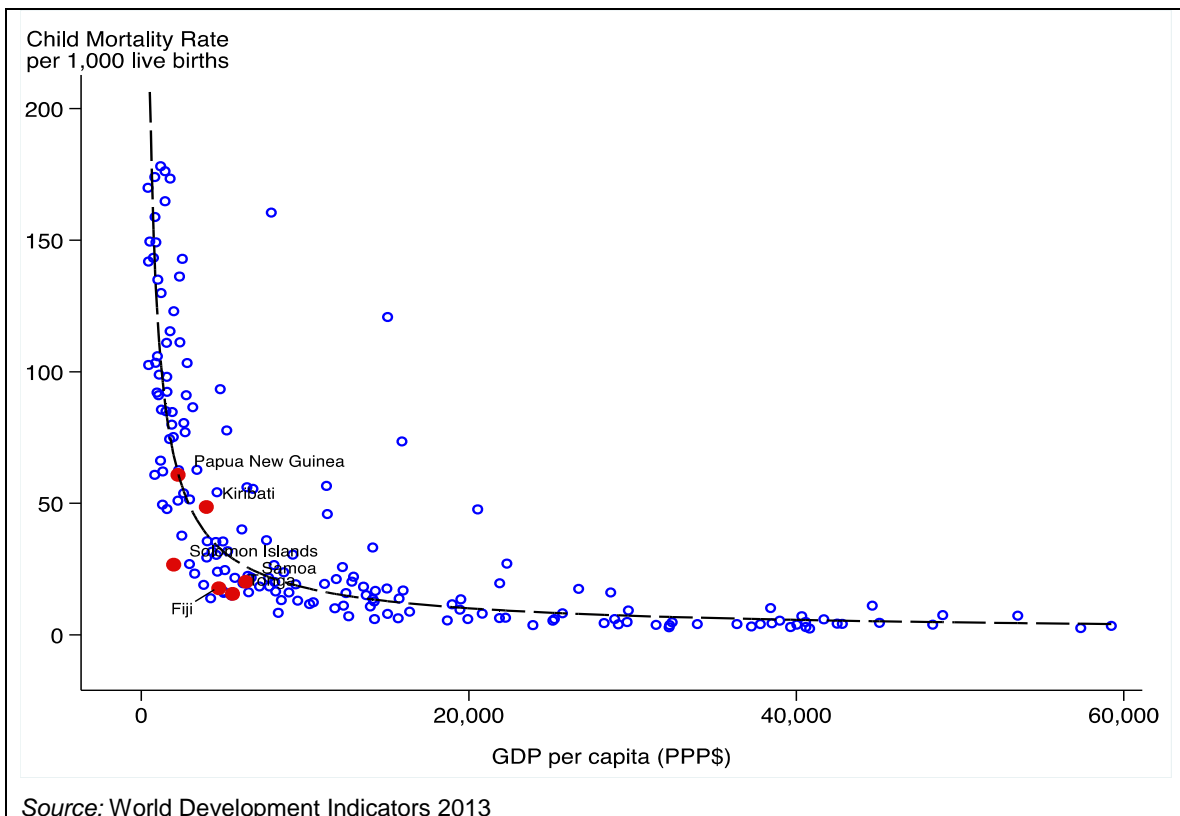


Figure 1: Under-five mortality in relation to income, Fiji and other countries, 2009

This good health performance represents the legacy of exceptional advances made in the 1950s–1970s, and there has been a noticeable stagnation and slow down in improvements since the mid-1980s. For example, the infant mortality rate (IMR) was 15.2 in 2009, which is better than most low and upper-middle income economies, Samoa and Tonga, but represented no change from the level of 15.5 reported in 1987. Under-five mortality and maternal mortality have shown similar patterns of stagnation since the 1980s, and the country is not on track to achieve the rates of improvement required to achieve Millennium Development Goals (MDGs) 4 and 5 (Tulloch, 2011). Maternal mortality can be considered a sensitive indicator of health service performance.

Life expectancy has improved only modestly between 1990 and 2009, from 65 to 66 years for men, and from 71 to 73 years for women (World Health Organization, 2012), with MOH reporting that life expectancy actually declined between 2000 and 2005 (Tulloch, 2011). Poor performance in addressing morbidity and mortality from non-communicable diseases (NCDs) appears to be a major factor in this, with a failure to effectively manage the increasing burden of cardiovascular disease resulting in persisting high levels of adult mortality (Carter *et al.*, 2011). Mortality in Fiji today is dominated by chronic diseases, with cardiovascular disease and cancers accounting for more than 46% of all mortality (Ministry of Health, 2011).

This phenomenon of stagnating adult, and in particular male, mortality in middle-income countries with otherwise good health performance is seen in some other countries. Similar patterns are seen in countries such as Sri Lanka and Malaysia. NCDs, and in particular cardiovascular disease can present significant challenges to many health systems, because a comprehensive response requires not only prevention, but also secondary prevention and care through effective primary, secondary and tertiary care services which are able to offer coordinated and integrated care to affected patients over long periods of time. The observed patterns in Fiji suggest that the Fijian health system is not coping well in making the transition from a situation where acute, maternal and child health conditions predominate to one where chronic diseases of older adults are prevalent.

Health service inputs and outputs

Levels of healthcare service provision in Fiji are relatively high for a low-middle income economy. MOH is responsible for the bulk of health service delivery in Fiji. It accounts for almost all hospital beds, inpatient and preventive care, and appears to provide the bulk of outpatient services. The private sector providers mostly provide outpatient services and retail medicines – there is only one private hospital, Suva Hospital, which has faced continuing financial difficulties. However, detailed estimates of the relative role of the private sector in providing outpatient care are not available, as Fiji lacks a representative, national healthcare utilization survey and so reliable statistics of private sector and overall utilization do not exist.

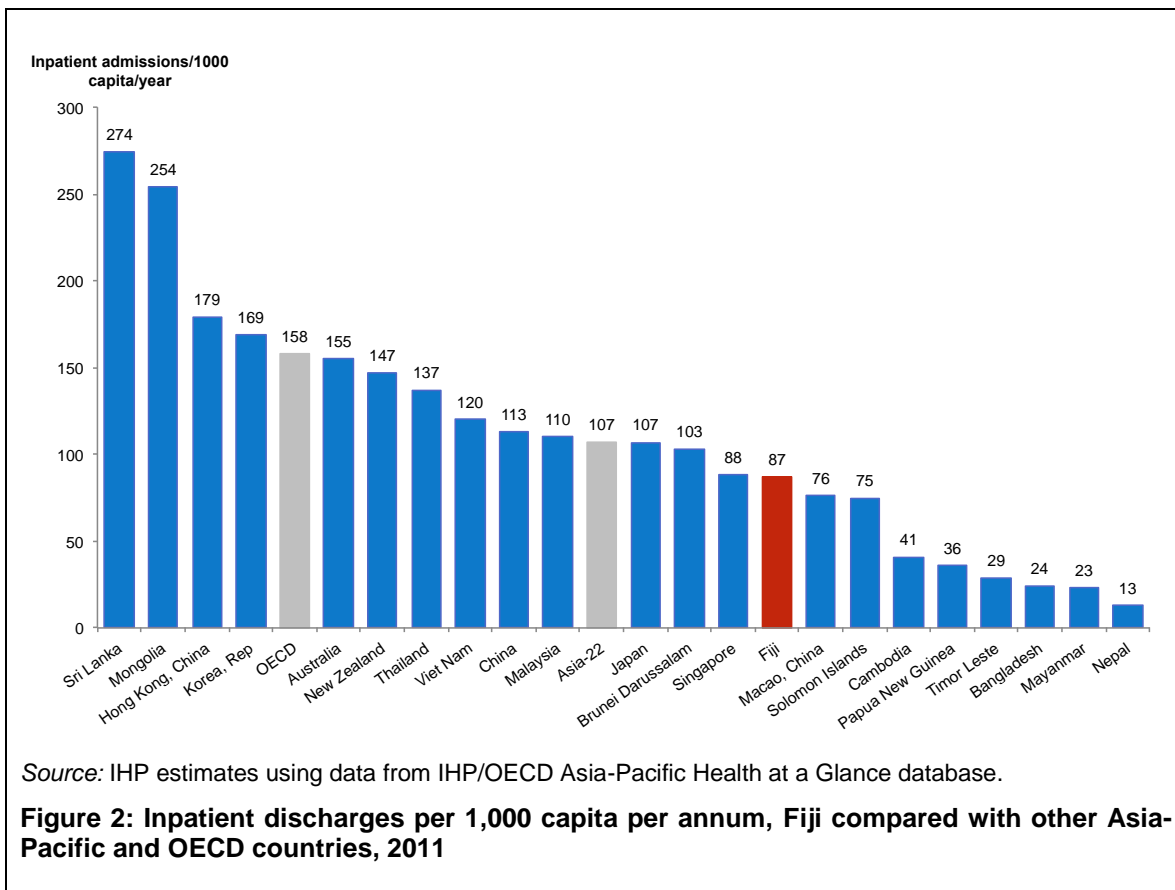
In terms of inputs, the health system appears to achieve relatively good levels of supply given Fiji's size, location and income level. There are around 2 hospital beds per 1,000 people, which is not high, but better than many other low-middle income countries. Fiji faces considerable problems of emigration of doctors and other healthcare professionals, and overall numbers are less than in say Australia and New Zealand, but still reasonably good compared to other Pacific Island countries (Tulloch, 2011).

Levels of preventive service coverage are generally good, with 100% of mothers giving birth in healthcare facilities, and immunization coverage rates generally higher than 95% (World Health Organization, 2012). The public sector is responsible for most of this coverage.

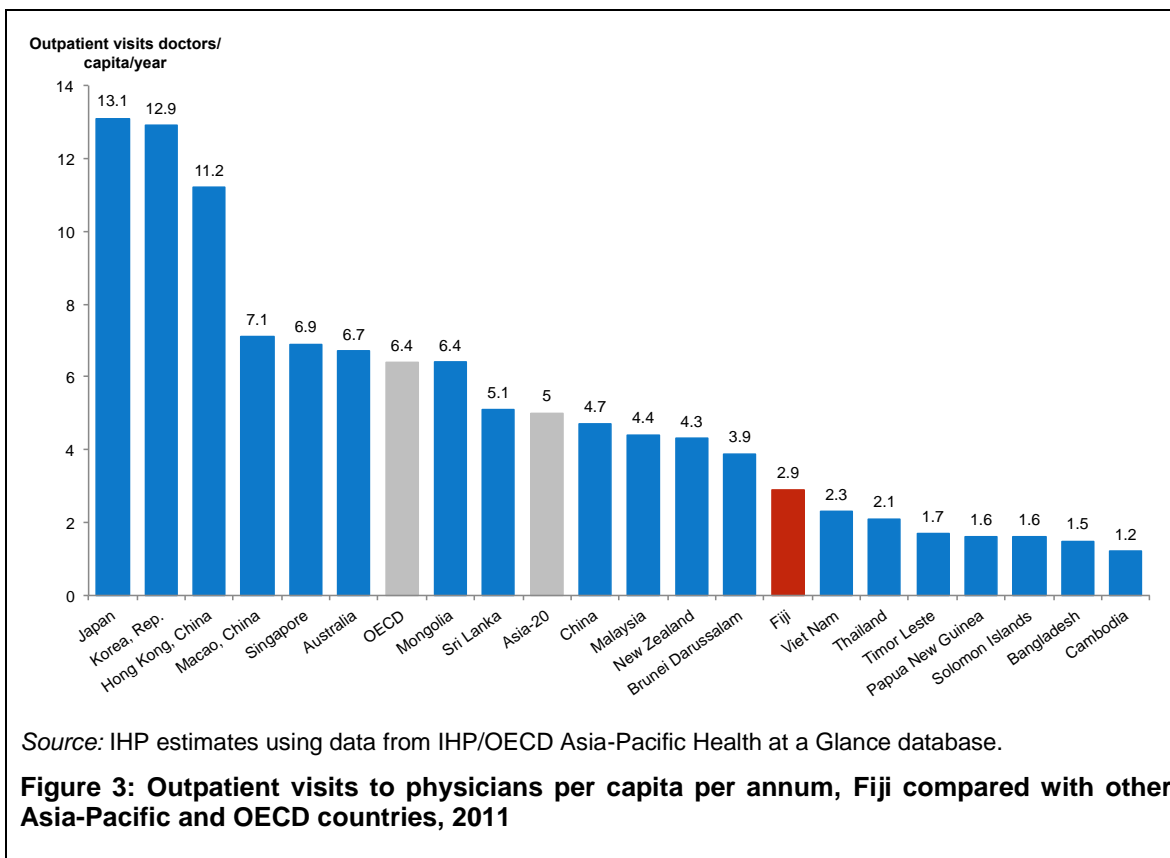
Provision of inpatient services is not so good, with the inpatient discharge rate in 2006 being 8 per 100 capita. This is comparable to other middle-income Asia-Pacific economies (Figure 2), but these rates represent a decline from over 10 per 100 capita in the mid-1980s. A rate of 10 per 100 capita might be considered an adequate level of use for most countries, and most other countries have seen increases in inpatient utilization in that time period, so the decline in use and provision should be of concern. The decline in inpatient discharge rates has also not been accompanied by any reduction in average lengths of stay in MOH facilities, which have changed little from around 6 days in the early 1990s to 6.2 in 2008. Globally, reductions in average lengths

of stay are almost the norm, and a reduction of 2-3% a year might be considered a reasonable level of efficiency gains. The evidence suggests that since the mid-1980s, the MOH delivery system has not been able to sustain continuous improvements in productivity in the delivery of inpatient care.

Outpatient utilization rates are harder to assess, since an unknown share of provision is in the private sector, but MOH data suggests the public sector treats around 1 outpatient per capita each year. This represents a significant decline from over 3 per capita in the early 1980s. There are around 125 private GPs in the country, who might be treating up to a million patients a year, so overall outpatient utilization rates are only around 2–3 visits per capita. This is low in comparison to other regional countries, and below what might be considered an adequate level of 4 visits per capita per year (Figure 3).¹ The apparent decline in patients treated suggested by MOH data represents a worrying trend, and suggests problems of productivity and failure to realize productivity improvements since the mid-1980s. There appears to be little awareness and discussion of these negative trends in Fiji, and the underlying reasons are not readily apparent.



¹ There is currently no generally accepted set of indicators that can be used to define what is an adequate level of healthcare use, with the exception of mostly preventive services. However, some assessment of overall levels of use can be made by cross-country comparison, and one set of benchmarks is the levels of utilization currently achieved in OECD economies. These OECD data would suggest that a minimum acceptable level of use of general medical services might be defined by a threshold of 4 outpatient consultations with physicians per capita a year, and 10 inpatient discharges per 100 capita a year.



Efficiency and equity of healthcare delivery

Efficiency

Although Fiji’s health system achieves relatively good health outcomes, a number of indicators point to problems of inefficiency in service delivery. The available data suggest that Fiji’s healthcare delivery system was achieving sustained improvements in performance until about the mid-1980s. For example, between 1971 and 1981, the annual numbers of patients treated by MOH increased from 7.8 to 10.0 inpatients per 100 capita, and from 2.3 to 2.9 outpatients per capita, which approximates to an annual productivity improvement of 2.5%. This was accompanied by a reduction in IMR from 47 in 1972 to 27 in 1982, equivalent to an annual rate of reduction of 6%, more than the pace required to achieve the MDGs.

The rates of improvement in service delivery and also health outcomes during the 1960s–1980s were comparable with other mixed healthcare delivery systems with effective public services, such as Malaysia and Sri Lanka. However, since the 1980s, service delivery stopped expanding, and the system failed to generate continuing efficiency gains. This failure represents a significant loss in potential resource mobilization from efficiency gains. Most healthcare systems are capable of productivity improvements of 1-3% per year, so financing increases of the same magnitude would have been needed just to maintain the previous rates of improvement in healthcare delivery.

The lack of increase in turnover at MOH facilities is accompanied by other indicators of technical efficiency stagnation such as the failure to reduce average length of stay in MOH facilities. In addition, there is also the evidence of failures to address the increasing mortality and morbidity from NCDs, particularly cardiovascular disease. At the macro-level, there is also the evidence of stagnating health outcomes since the 1990s.

The Fiji HiTs review (Tulloch, 2011) suggests a number of possible explanations for the poor performance in the area of technical efficiency. These include inadequate investment in the healthcare system, lack of trained managers, inadequate salaries, failure to stem the loss of specialists to overseas countries, and lack of incentives for healthcare workers to improve productivity. However, there appears to be little evaluation of these potential causes, and it is not clear why these factors only affected the system from the mid-1980s and not before. Part of the problem is that mixed delivery systems with functioning civil-service run public sectors, such as Fiji's, are relatively unusual, and there is limited understanding of how these systems improve performance.

However, what is known about comparable systems such as Malaysia's and Sri Lanka's, and the abrupt deterioration of performance in Fiji from the mid-1980s suggests a likely explanation. These systems usually depend on sustained pressures from citizens to improve service delivery transmitted through the political system, combined with hard budget constraints related to fixed budgets and denial of revenues from user fees to force efficiency gains. It is possible that the breakdown in democratic governance in the mid-1980s in Fiji, and the inability of the political system since that time to fully represent and transmit citizens preferences led to a weakening of pressures on health sector managers, and also undermined professionalism in the health workforce as a result of the increased political interference in human resource decisions. This is pure speculation, but if it is true, it would suggest that in the long-term the creation of stable democratic governance and a political system that represents the full range of public opinion in Fiji is a pre-condition for sustained increases in system efficiency. This would be consistent with the current focus of the Government of Fiji on improving the effectiveness and representativeness of the governance system in the country.

Equity

There are no data to reliably assess how equitable healthcare delivery is in Fiji. This normally requires data from national healthcare utilization surveys, and Fiji has no such data sources. However, the impression is that there must be some disparities in access between the main islands and outer islands, owing to transport barriers and the lack of specialized facilities in all parts of the country. Such disparities should be expected given the country's physical situation, and few countries with Fiji's resources are able to overcome such physical challenges.

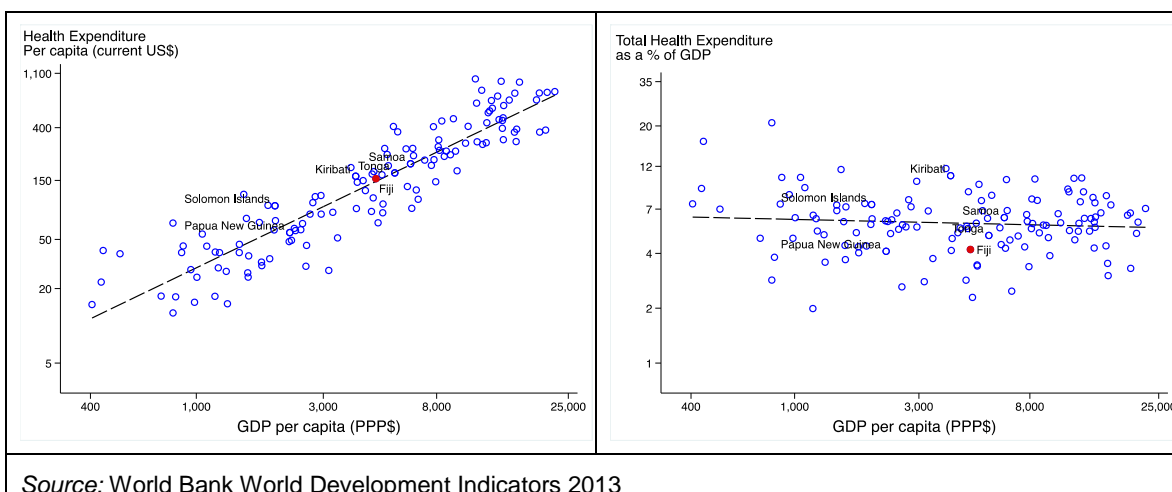
In the Suva-Nausori conurbation and the main islands, access to services would appear to be relatively good, with most people able to reach mostly free MOH services or private services. So it is reasonable to conclude that there are unlikely to be no substantial inequalities in access to basic services in Fiji, although overall use might not be equitable, since the better-off can presumably access more services by opting to use the private sector. Access to specialist care is likely to be more inequitable and suffer from significant inequalities owing to the limited availability of such services, and their concentration in the urban centres. Richer and better-connected Fijians also have access to specialized care overseas, when such services are not available in the country.

3. Assessment of current healthcare financing arrangements

Levels and trends in spending

Total health expenditures in Fiji were \$206 million in 2008, equivalent to 4.2% of GDP and \$246 (USD 158) per capita (Ministry of Health, 2012). This level of spending has changed little in the previous decade. Government and external financing accounted for 70% and 6% of total health expenditure, and private expenditures, mostly out-of-pocket spending, accounted for the remaining 25%. Out-of-pocket spending accounted for 63% of this private spending, or around 0.66% of GDP.

Total health spending of 4.2% of GDP is comparable to other countries at Fiji's income level, although somewhat on the low side (Figure 4). It is substantially lower than several smaller Pacific Island nations, such as Kiribati, Tuvalu and FSM, but expenditures in these smaller Pacific Island nations tend to be higher than in their larger neighbours, because of the higher costs of service delivery, and made possibly only through very large inflows of external assistance funding, which are not available to larger countries such as Fiji.



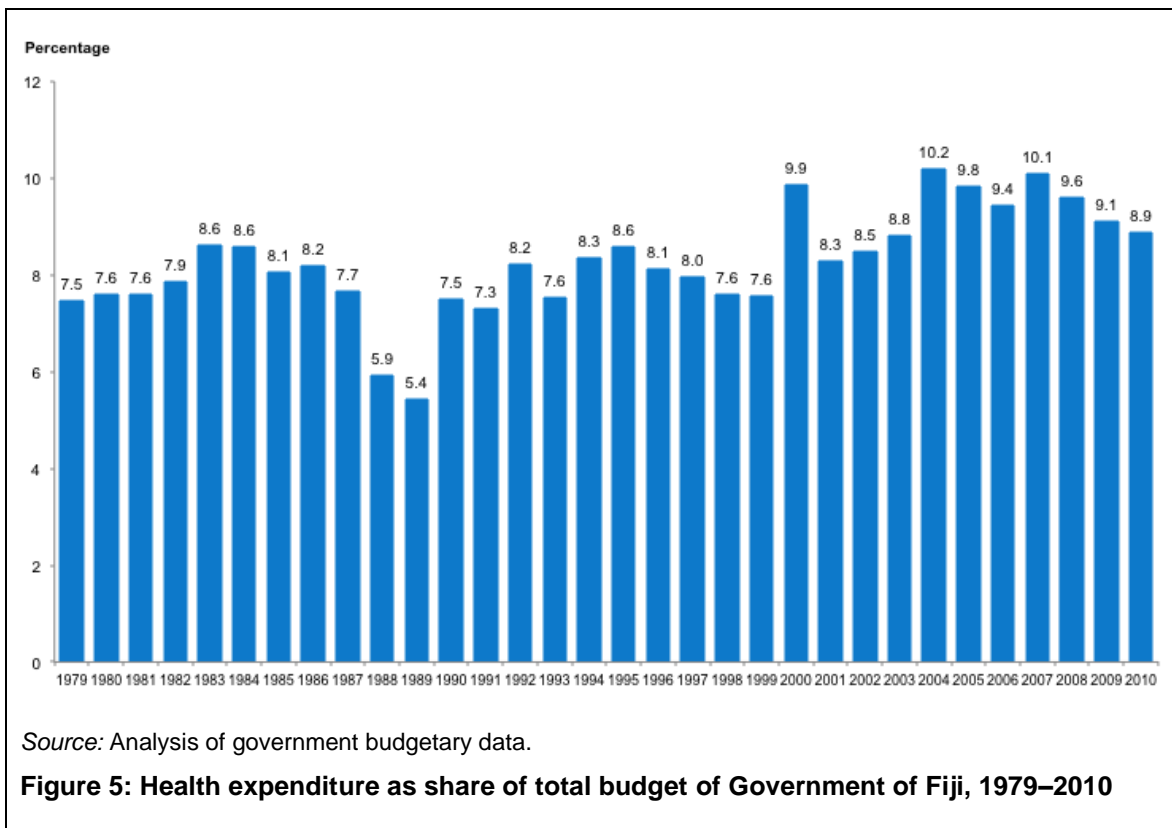
Source: World Bank World Development Indicators 2013

Figure 4: Total health expenditures in relation to per capita GDP, Fiji compared to other developing countries, 2010

Revenue mobilization

Financing mechanisms, such as general revenue taxation or SHI, that pool revenues are important, since they reduce the need for direct out-of-pocket payments for healthcare and so improve overall financial protection. They also are able to generate far higher levels of financing than other mechanisms.

Government and external financing accounted for 76% of total healthcare financing in Fiji in 2008. The government financing is exclusively from general revenue taxation, since there is no SHI in operation in Fiji. In recent years, the government has allocated 7–9% of its total budget to health, which represented 2.9% of GDP in 2008.



The level of government expenditure in Fiji is low in comparison with other countries at a similar level of development. As countries become richer they allocate a greater share of their national income to health through government financing. In addition, small countries tend to have higher government expenditures than others, because of the higher costs of service delivery in these countries and also the lack of substantial private sectors in provision. This is illustrated in Figure 6. The Government of Fiji spends less on health than other countries at its level of income, and much less than other small island countries at a comparable income level. If expenditures in Fiji were comparable to these other countries, government health expenditures would be 1-2% of GDP greater than current levels.

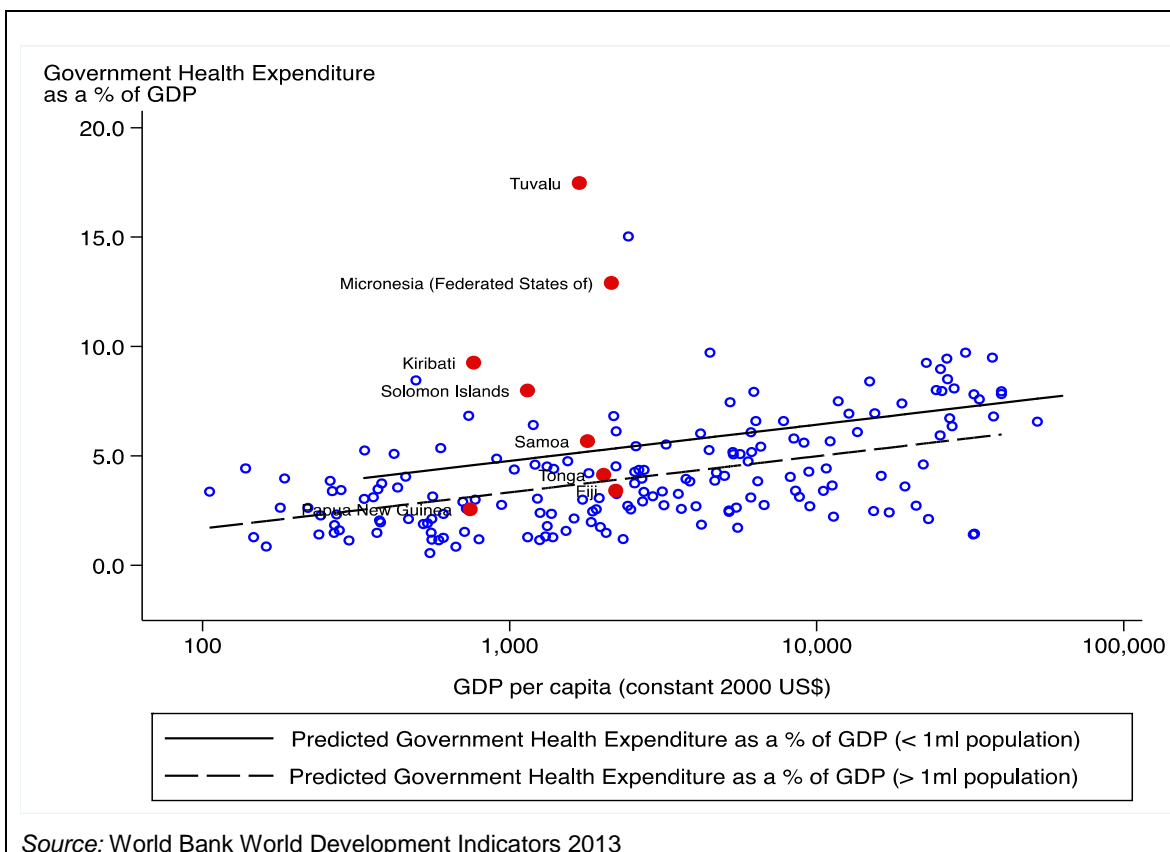


Figure 6: Government health expenditures (% GDP) compared with GDP per capita income levels, 2010

Over the longer term, government health expenditures as a ratio to GDP have increased in Fiji, from around 1.8% in the mid-1960s, to about 2.5% in the mid-1980s, and almost 3.0% today. So the relatively low level of government health spending might partly be related to a failure to increase government health budgets sufficiently as the economy developed.

Out-of-pocket payments

Out-of-pocket financing in Fiji’s healthcare system is low by international standards. It contributes about 15% of total financing, or 0.7% of GDP. As a ratio to GDP, this is low in comparison to both developing countries and also developed countries. As a share of total financing it is comparable to the levels seen in developed countries and many other Pacific Island countries. WHO (2010) recommends countries to reduce the reliance on out-of-pocket financing, in order to improve financial protection and improve equity in access to services, but a high level of out-of-pocket spending is not a major problem in Fiji.

User fees paid at MOH facilities make only a marginal contribution. They amounted to \$1.02 million in 2010, and represent only 0.7% of the total financing of government health services. In recent years, MOH attempted to revise the level of user fees charged for specific services, but strong public opposition led to the proposals being watered down. The global experience with user fees for public sector services is that they mobilize only modest revenues, given the political

difficulty in raising fees to substantial levels, and that net revenues after administrative costs rarely justify the effort (Creese *et al.*, 1995). In addition, user fees consistently affect demand by the poor the most, and increase inequities in access to public services. Increased public sector user fees have little potential to raise substantial revenues for healthcare services in a way that is consistent with public opinion and equity concerns.

Progressivity

How the financing mechanisms distribute the burden of payment across households is an important aspect of any financing strategy. Equity or the fair distribution of payments between rich and poor households is typically analysed in relation to the ability to pay of individual households. A health financing system is termed progressive (regressive) if the richer households contribute a relatively higher (lower) proportion of their income to health care financing than poorer ones. This is usually evaluated using the Kakwani index, which is positive if the financing mechanism is progressive, and negative if it is regressive. In general, general revenue taxation is the most progressive healthcare financing mechanism, whilst SHI tends to be modestly progressive. User fees tend to be regressive, whilst the progressivity of out-of-pocket payments depends on details of the health system.

The current healthcare financing arrangements in Fiji are progressive, with the better-off bearing more of the burden of healthcare financing. Table 1 shows how healthcare payments are distributed across expenditure quintiles in Fiji. Overall payments are progressive (Kakwani index=0.11). This is largely the outcome of the progressive incidence of direct taxes and out-of-pocket payments.

Table 1: Distribution and progressivity of healthcare payments by expenditure quintile, 2009/10

Expenditure group	Share of ATP	Direct taxes	Indirect taxes	Private insurance	OOP payments	All payments
Poorest	5.9	0.4	7.0	6.9	1.7	4.2
2	9.6	1.8	11.3	0.0	4.9	6.6
3	13.6	5.6	15.8	19.6	7.4	11.8
4	20.1	17.4	21.8	6.6	17.1	18.4
Richest	50.8	74.8	44.1	66.9	68.9	59.0
Total	100%	100%	100%	100%	100%	100%
Kakwani index		0.27	-0.07	0.11	0.20	0.11

Source: Based on analysis of HIES 2009/10 and other tax data by CHIPSR.

Direct taxes are highly progressive, but indirect taxes, which account for two-thirds of general revenue taxation in Fiji, are regressive, meaning that the poor pay more than their fair share. Indirect taxation is regressive in European countries, but tends to be progressive in most developing Asia-Pacific economies (O'Donnell *et al.*, 2008), because Asia-Pacific countries have more flexibility in how they levy indirect taxes, and they usually impose higher indirect taxes on goods purchased by the better-off. The experience of Asia-Pacific economies suggests there might be considerable potential to adjust the collection of indirect taxes to make it more progressive in Fiji. It also implies that increases in government expenditures on health would impose a greater burden on the poor if it is financed from increases in indirect taxes, as opposed to increases in direct taxes or increases in the share of government resources allocated to health.

Out-of-pocket payments in Fiji are also progressive and highly concentrated in the richer households. The richest 20% of Fijians account for 69% of all out-of-pocket medical spending, and the poorest 20% only account for 2% of this spending. This is similar to the pattern in many Asia-Pacific developing economies where out-of-pocket payments are mostly related to the better-off patients opting out of public sector provision and choosing to use private services. To the extent that the poor do have access to highly subsidized public services, this is not a bad thing, as it enables governments to target their limited budgetary funding towards the poor.

Financial risk protection

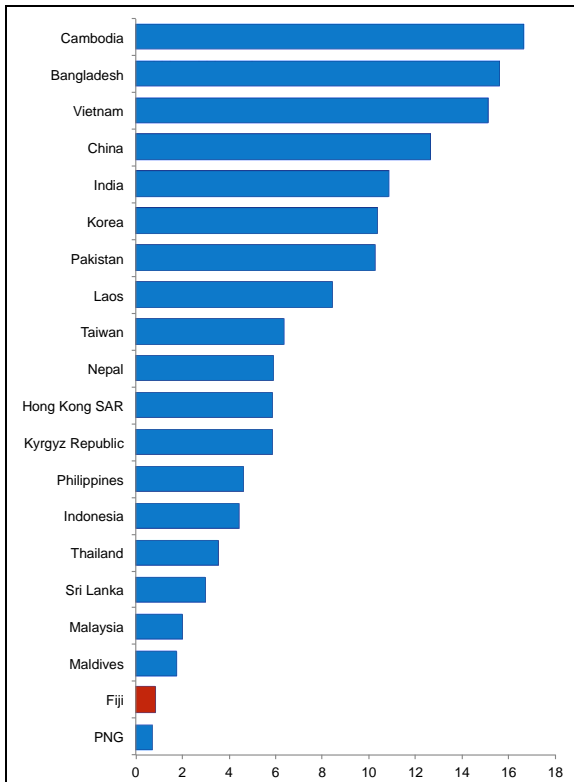
Financial risk protection is one of the three important goals of a health system. The need to incur large out-of-pocket payments to access needed medical care can impoverish and burden households significantly in many countries, as well as acting as a barrier to coverage. Healthcare systems have to serve an important insurance function by pooling resources and distributing the burden of their payment in such a way that patients do not face such large costs to access treatment. The global evidence indicates that the greater the degree on reliance on out-of-pocket spending to finance healthcare, the greater the incidence of financial risk associated with medical treatment (van Doorslaer *et al.*, 2006).

The average Fijian should not have to incur large out-of-pocket payments to access healthcare, since most MOH services are free or almost free. Out-of-pocket payments represent only 16% of total healthcare financing, and 0.7% of total household spending. These figures are quite low compared to other middle-income countries, and comparable to levels seen in much richer developed nations.

In terms of financial risk protection, Fiji's healthcare system does very well. Not surprisingly given the low level of out-of-pocket spending, recent estimates by CHIPSR and the Equitap research network show that the overall incidences of catastrophic and impoverishing expenditures in Fiji are very low compared to other regional countries and low-middle income countries generally. These two measures are commonly used as measures of financial risk protection.

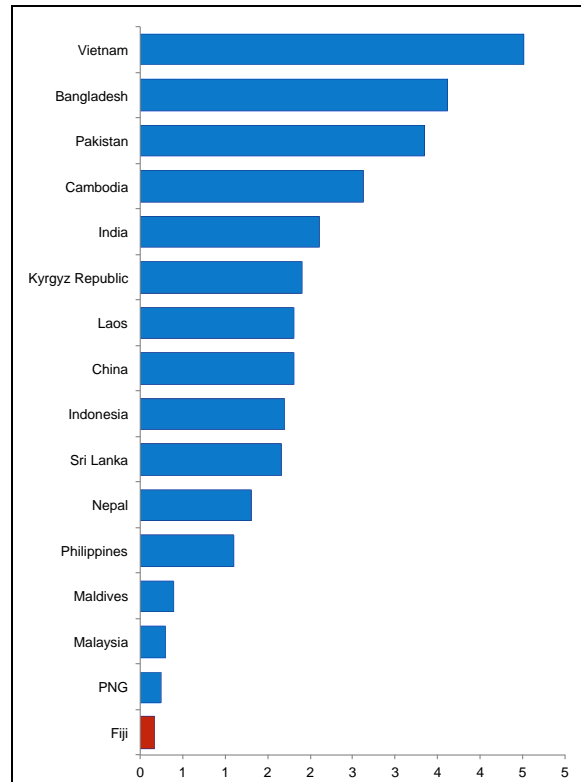
The proportion of households that experience catastrophic expenditures of more than 10% of household expenditures in a given month was less than 1% in Fiji in 2009/10, and if a threshold of 25% of non-food expenditures is used only 0.2% in 2009/10. These levels are much lower than other Asia-Pacific economies, and even lower than in the high-income economies of Japan², Korea and Taiwan who have social health insurance systems (Figure 7). Similarly, the incidence of impoverishing expenditures is also very low in Fiji compared to other regional countries (Figure 8). These low levels of catastrophic and impoverishing expenditures are a consequence not only of the low overall level of household out-of-pocket spending for healthcare, but also its concentration in richer households. Most out-of-pocket spending is by the better-off, who are less likely to face impoverishment when incurring large medical expenditures.

² Unpublished estimates by the Equitap research network for Japan show that the incidence of both catastrophic and impoverishing expenditures is significantly higher than in Fiji.



Source: CHIPSR for Fiji (2009/10) and Equitap and IHP staff estimates for other countries

Figure 7: Incidence of catastrophic medical expenditures (>10% of household spending), Fiji and other Asia-Pacific economies (circa 2000s)



Source: CHIPSR for Fiji (2009/10) and Equitap and IHP staff estimates for other countries.

Figure 8: Incidence of impoverishing medical expenditures (PPP\$2 poverty line), Fiji and other Asia-Pacific economies (circa 2000s)

It is clear that in contrast to most other countries in the Asia-Pacific region, Fiji does not face significant problems of financial risk protection. The general revenue funded MOH delivery system effectively insures Fijians from large financial payments. The fact that this is achieved without a formal insurance scheme that reimburses citizens for medical bills is not surprising. At the global and regional level, such insurance systems do not perform any better than tax-funded systems in providing financial risk protection, once levels of government expenditure are accounted for (Xu *et al.*, 2007; van Doorslaer *et al.*, 2007; van Doorslaer *et al.*, 2006).

Problem diagnosis

Before assessing the available options for improving healthcare financing and the potential contribution of SHI, it is useful to first review what problems might exist and what problems were identified by stakeholders and key informants that might warrant changes in healthcare financing strategy.

At a general level, healthcare financing strategies have to address four key challenges:

- (i) How to best expand risk pooling – This implies shifting from out-of-pocket financing

- (ii) to public or private pooling arrangements that ensure effective financial protection. How to best improve efficiency in how resources are mobilised and how resources are allocated and used.
- (iii) How to best ensure equity in access and coverage to needed and effective medical services.
- (iv) How to ensure citizen and patient satisfaction.

Financial protection

With respect to ensuring effective financial protection, Fiji does not face significant problems. It already has a high level of risk pooling through general revenue taxation, a low level of out-of-pocket spending, and the incidence of catastrophic or impoverishing medical expenditures is very low and comparable with that in many high-income countries. It is also worth noting again that the current healthcare financing arrangements in Fiji already achieve a level of financial protection better than the high-income economies of Asia that rely on SHI (Japan, Korea, Taiwan), and the high-income economy in Asia that does not rely on SHI (Hong Kong SAR).

Efficiency of resource mobilization

The current healthcare financing arrangements are relatively efficient in terms of revenue mobilization, since they rely predominantly on general revenue taxation. The administrative and economic costs of taxation as a fund raising mechanism are far lower than all other options. Interviews with key informants and stakeholders did not identify efficiency of current resource mobilization as being a concern.

Efficiency in resource allocation and use

There is considerable scope for improving resource allocation in the public sector, and probably little dispute about this. However, this is probably not an issue related to the financing mechanisms, but instead to general problems of governance and management capacity, which can only be tackled over the longer-term. Such management and planning functions in most health systems are usually funded from public budgets, and so changes in healthcare financing arrangements will not usually change the challenges involved or the potential scope for solutions.

There does appear to be a significant problem of efficiency in resource use in the public sector. As noted, the Fijian public sector delivery system has failed to achieve substantial improvements in productivity and patient throughput since the mid-1980s, and the impression is of stagnation at earlier levels of delivery efficiency. Since other countries have been able to sustain further improvements in productivity during the past three decades and starting from levels comparable to Fiji in the 1980s, the evidence points to significant potential for improving efficiency.

The level of inefficiencies in resource use in the private sector cannot be assessed. This was not raised as being a key concern during the assessment.

Equity and Coverage

The Minister of Health and officials in the Prime Minister's Office all stressed the importance of ensuring that healthcare coverage is universal, and that any changes apply to the whole population, and do not benefit only certain segments. The design and operation of Fiji's public sector services indicates that a high value is placed on the principles of universality and ensuring access, with user fees eschewed as a major source of financing, and health services offered without discrimination to all citizens. The vision of the People's Charter also reflects the values of social solidarity and the need to strengthen integration between different groups. The

government's plans to strengthen universal franchise and the principle that every vote counts the same will also strongly reinforce the pressure in Fiji for health policies to emphasize equity and ensure access to all citizens.

For basic services, most Fijians appear to have reasonable access and coverage from public sector healthcare institutions. These services are offered on an equal basis to all citizens, regardless of their socioeconomic status and ethnicity. Given the problems of exclusion and social division that have afflicted Fiji in recent decades, government health services would appear to make a significant contribution to overall social solidarity.

A detailed assessment of actual equity in coverage cannot be made owing to lack of appropriate survey data in Fiji.³ What major shortfalls likely exist are mostly the result of the logistical difficulties in providing coverage in the remoter and less populated islands, and in all countries this is both difficult and expensive to ensure. Where these shortfalls exist, there is also no private sector provision, since private sector provision is more concentrated in urban areas than public sector services are. Changes in healthcare financing approaches are unlikely to affect such deficiencies, unless they mobilize a higher level of overall resources, and can apply these increases preferentially to improving coverage in these less-accessible areas.

There is some level of inequity that arises from the ability of middle-income and wealthy Fijians to use private primary care services provided by private GPs (and to a lesser extent private hospital services). However, the experience of similar mixed health systems is that these private services often mostly differ in the dimension of consumer quality – doctors can spend more time with patients, communicate better, offer more convenient clinic hours, and treat patients with greater courtesy. On the other hand, clinical quality of care might not differ that much, especially if the same physicians are involved in treating both public and private sector patients, as is often the case in Fiji. From a public policy perspective, such differences in consumer quality might be acceptable, if the government cannot afford to provide better levels of consumer quality for all patients in the public sector, and if this is not done at the expense of achieving minimum levels of acceptable clinical quality in the public sector.

At the same time, there are clearly deficiencies in coverage of tertiary and some secondary medical services. Many specialized services (e.g., many chemotherapy treatments, neurosurgery, renal transplantation, etc.) are not available in Fiji (in both public and private sectors), and Fijians must travel overseas if they are to access such services. Whilst the government's overseas treatment program does finance many patients needing such care, it is the case that such financing is not adequate to provide coverage for all treatments for all Fijians. However, this particular problem is not simply a lack of adequate financing. Some of these services could potentially be offered in Fiji at reasonable cost, but lack of relevant clinical specialists is often the problem. For example, many orthopaedic operations could be done using existing MOH infrastructure, but there are none or too few surgeons trained to carry out the relevant procedures. These gaps do not need new healthcare financing arrangements or even increased financing to resolve, but could be managed by better planning and management of the training and deployment of clinical specialists. Programs that also bring in foreign consultants for short periods of time to treat local patients, and also train local counterparts can also make a big difference. The Minister of Health has recently initiated such efforts.

³ We note here that the regular conducting of national surveys of healthcare use and spending which allow analysis of utilization and access in relation to socioeconomic status and other demographic characteristics is a key need in Fiji to enable more informed discussion of health policy issues. Fiji currently lacks any such surveys.

Nevertheless, there will always be many specialist services that will not be available in Fiji. Even in developed countries, there are many specialist services that are only offered at a regional level for populations of 2-5 million, since providing them at a lower level would be both costly and also associated with poorer quality owing to inadequate experience of clinicians. Whatever the financing arrangements in Fiji, it does not seem practical or realistic to attempt to finance provision of these services within Fiji. This leaves only the option of financing access to such care outside Fiji, and this option will always confront questions about what services can be afforded and for whom. The richest Fijians can always access such services using their own personal resources, so from a policy perspective the issue is how much funding the Government of Fiji wants to mobilize and spend on providing these services to non-wealthy Fijians, without discrimination between poor and middle-income Fijians. The choice and mix of financing methods could matter if it raises the overall quantum of funding available for such activities.

Citizen and patient satisfaction

Ultimately, what citizens and patients think about their healthcare arrangements does matter, regardless of whether perceptions align with the concerns of expert opinion. These expectations will surely increase in weight as Fiji transitions to competitive elections as envisaged by the People's Charter.

A comprehensive evaluation of current citizen satisfaction is not feasible. This would require extensive investigation, including use of opinion surveys and focus group methods. This assessment relies primarily on discussions with key informants, and inferences made from other comparable health systems.

The following issues were noted in discussions with key informants:

- (i) There is considerable dissatisfaction amongst certain segments of the population about the lack of many critical clinical services in Fiji, and the associated need to travel abroad to obtain such care. It would appear that this dissatisfaction is felt most strongly by the more informed and educated Fijians. Expectations in this group are driven by comparisons with what is available in Australia and other countries.
- (ii) Although MOH offers a wide range of services to all Fijians, better-off Fijians are not satisfied by the level of quality of these services. Much of this quality problem relates to issues such as non-clinical amenities and interpersonal quality. This drives them to use private services, but not all are happy about the cost of using these private services. This group might feel that a better level of services should be made available to meet their expectations, given their higher social status.

Almost all the problems of dissatisfaction raised by key informants relate to the higher expectations of more educated and better-off Fijians, and the mismatch with publicly funded services or private services available in Fiji. No significant evidence was offered of significant problems of dissatisfaction in lower-income groups.

To a large extent, this particular set of problems can only be addressed with increased funding. Increasing the range of services available and improving consumer aspects of quality will cost more. In addition, it might be argued that changes in the financing mechanisms could also improve patient responsiveness by creating more direct financial incentives for providers to respond to what patients want.

It is important to note that this particular pattern of dissatisfaction is common to this type of healthcare system. Fiji is one of a handful of countries that maximizes healthcare coverage

despite limited government spending, by ensuring universal access to almost free basic services provided by the public sector, whilst encouraging the better-off who have higher expectations to opt for better care in the private sector, thus reducing the burden on government financed services. In Asia, this type of system is only found in Sri Lanka, Malaysia and Hong Kong SAR. In these systems, public budgets are too low to fund services for all citizens at acceptable levels of consumer quality, and so universal coverage depends on encouraging the better-off patients to voluntarily opt for private sector services. Although this implies a high level of private spending, since it is mostly by richer patients, it does not prevent relative equity of access and coverage. In these systems, dissatisfaction with quality, particularly consumer quality is always greatest amongst the middle and upper-middle income patients, since they have a higher demand for quality, which is greater than the lower level of quality at which government can afford to provide services. At the same time, these patients are less able than upper-income patients to easily afford their private services, so they also complain more about the cost of private care. In Fiji's case, the expectations for higher consumer quality in government facilities are compounded by the demand for higher-level clinical services that are not available in Fiji.

Summary points

- **The current financing arrangements in Fiji perform relatively well in ensuring effective financial protection, and minimizing disparities in access between rich and poor Fijians.**
- **Better-off and more educated Fijians are not happy with the level of services they receive and feel they should be provided more.**
- **The overall level of healthcare financing is low, and not commensurate with the country's level of economic development.**
- **The delivery performance of public sector services has not been improving, and considerable problems of inefficiency exist.**

The following sections review each of the potential healthcare financing approaches available to the Government of Fiji to improve performance. These are briefly:

- (i) Strengthening government budgetary financing
- (ii) Public sector user fees
- (iii) Expanding the current PSC voluntary health insurance scheme
- (iv) Social health insurance.

4. Current options for strengthening healthcare financing

Government budgetary financing

Government budgetary financing, funded through general revenue taxation is the principal mechanism for funding healthcare services in Fiji today. These directly fund through the MOH budget government-operated healthcare services, which are provided on a universal basis to all residents, with either none or minimal user charges. The main strengths of budgetary financing as it operates in Fiji are that it pools financial risks across the whole population, enables provision of services on a universal basis, and integrates public financing and provision.

Although Fiji relies predominantly on general revenue taxation and integrated public sector delivery, its system is not the same model as in developed nations, such as UK or Sweden.

There are two critical differences:

- (i) General revenue taxation is not sufficient to and does not finance most services for almost all the population.
- (ii) Government financing and delivery exist alongside a significant level of private financing and delivery.

This mixed system is a reasonable and proven way to achieve universal coverage, despite the existence of private services.

As in other developing countries, government budgetary financing in Fiji is not sufficient to provide all or most citizens with access to the full range of medical services. In most developing countries what then happens is that this government funding is used to pay for services primarily for the better-off, resulting in large disparities in access and many segments of the population without coverage and without financial risk protection. However, Fiji achieves close to universal coverage⁴ by targeting its government expenditures to a full range of services that predominantly treat the poorer groups, whilst encouraging the better-off to voluntarily opt out and use private services. This approach to rationing government budgetary expenditures is more effective in improving coverage than paying for a more limited range of public services for all citizens, or setting up government services in such a way that the better-off use public services more than the poor. The latter is what happens in most developing countries, with the poor pushed away from public sector services by combinations of high levels of cost-sharing and or physical barriers to access.

Several countries, including Malaysia, Sri Lanka, Cyprus and Jamaica have historically adopted the approach seen in Fiji, and achieve high levels of population coverage and good health outcomes, despite low levels of government spending. In all these countries, government funds the bulk of inpatient care for almost all citizens, thus maximizing financial protection, since it is inpatient services that can cause the largest financial risks for patients. But outpatient services are often financed significantly by private spending at private doctors.

Within the current healthcare financing arrangements, Fiji has four potential options for addressing the healthcare financing problems identified earlier:

⁴ Universal coverage is defined here as meaning the provision of a high level of coverage by healthcare services without significant inequalities in access, coupled with arrangements that ensure effective financial protection against the costs of medical treatment.

- (i) Finance an increase in budgetary expenditures on health by increasing general tax revenues.
- (ii) Finance an increase in budgetary expenditures on health by introducing ear-marked taxes for health.
- (iii) Finance an increase in budgetary expenditures on health by increasing the share of the government budget allocated to health.
- (iv) Change the allocation of the MOH budget to different services so as to improve overall service delivery.
- (v) Increase efficiency in the use of budgetary financing to deliver government healthcare services.

Any one or combination of these might be adopted. Below we assess each of these options in turn.

Increasing budgetary expenditures on health by increasing general tax revenues

Feasibility and sustainability

The current system of financing using general revenues is clearly sustainable in the short to medium term, but the potential for major increases in the medium term is limited and ultimately a political decision. The Government of Fiji has been able to maintain general revenue taxation at its current level for many years, despite many shocks to the economy. Current and planned tax reforms should only improve the sustainability of general revenue tax collection. In addition, health and education have consistently been the top two spending priorities for successive governments. So past history would suggest that health will continue to be relatively well protected in budget allocations, but further increases is ultimately a political decision.

The level of general tax revenues mobilized by a government is ultimately a policy choice, but the underlying potential is related to the level of economic development, the structure of the economy, and state administrative capacity. The potential for tax mobilization in Fiji is favourable for a middle-income economy. It has a high degree of formality in its economy, it is an island, which facilitates the collection of taxes at the point of import or export of goods, and the government has significant administrative capacity.

Given its level of economic development, Fiji does well in mobilizing taxes. In 2010, the government raised the equivalent of 29% of GDP in taxes. This share is significantly higher than would be expected given its per capita GDP. Figure 9 shows how at the global level tax revenues increase as a share of GDP as per capita GDP increases. Tax revenue mobilization in Fiji is substantially better than other countries at its income level. Its relatively high level implies that there is less potential for substantially increasing tax revenues, given that Fiji is a small open economy with a need to consider its overall competitiveness.

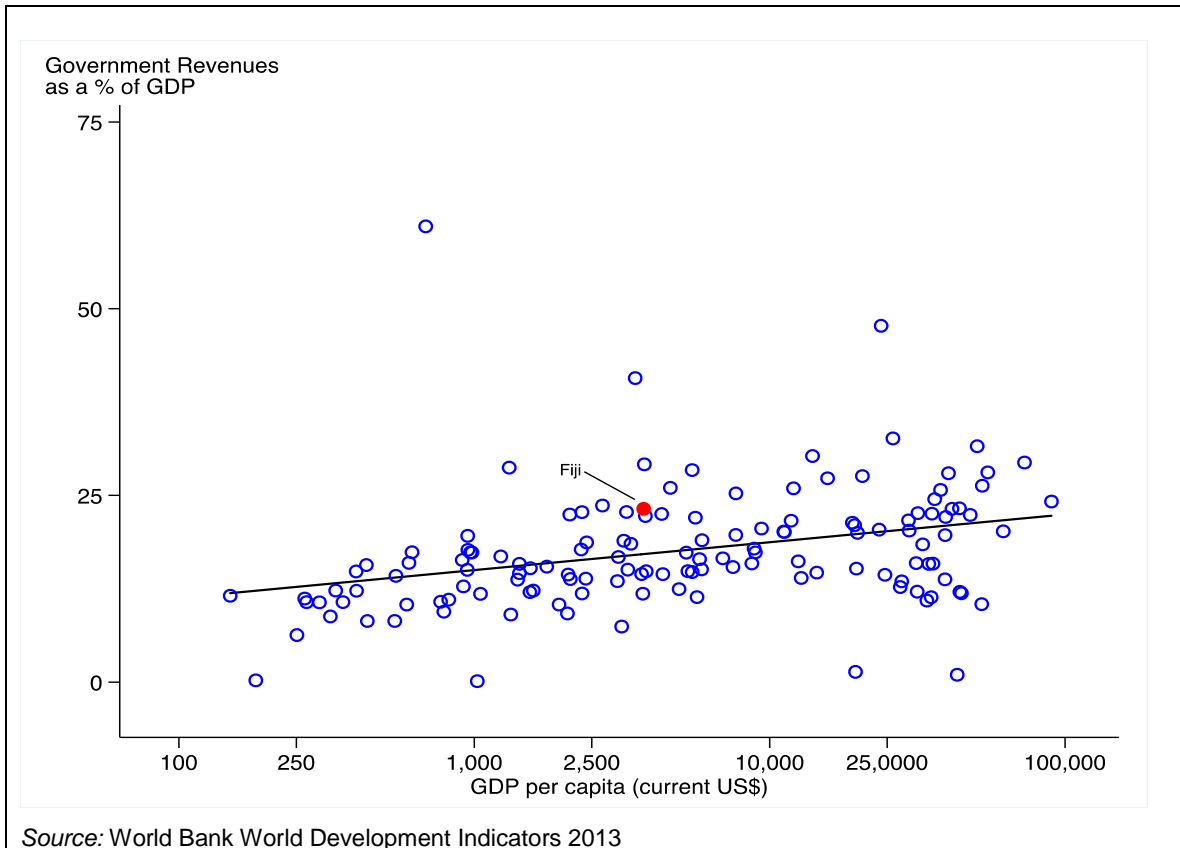


Figure 9: Government revenues (% GDP) compared with GDP per capita, Fiji and other countries, 2006

Although further increases in taxes could be advocated for, it is likely that other concerns will make it difficult to persuade Ministry of Finance (MOF) to agree to substantially higher levels of taxation. In addition, it would be reasonable to also expect that the government is unlikely to want to substantially increase taxes before the planned transition to an elected administration. Substantial revenue increases are probably more feasible under a new administration, and even then only if justified on the basis of other policy changes.

For increasing taxes, the major options for government would be to either increase the rate of VAT, currently 15%, or increase personal income tax rates. Such increases are likely to encounter significant public and political opposition. A VAT rate of 15% is at the higher end of rates seen in other countries, although in Europe rates now range from 15% to 27%. VAT was also only recently increased in 2011, so additional increases in the short-term are probably highly unlikely. Higher personal income tax rates or widening the tax base by lowering the personal exemption limit are the other possibility, but again they probably face the same problems of public opposition, which make increases in the short term unlikely.

Another option for increasing taxes is to raise taxes on goods and services, where the impact on the price of traded goods and services would be minimal, or where there are other benefits. The most obvious candidate for this is usually to raise taxes on tobacco, where increased taxes generally have little negative impact on economic efficiency, and where there are significant health benefits. However, taxes on tobacco in Fiji, are already commendably high. Excise taxes represent 77% of the final retail price of cigarettes, which is the second highest level

in the world, after Cuba (World Lung Foundation, 2013). Cigarette consumption, at 530 cigarettes per capita, is still not that low, so further increases in tobacco excise taxes could reduce smoking even further, but the potential for substantial increases in tax collections is probably modest, as excise rates will be accompanied by reduced volumes of cigarettes consumed.

One final point is that even if general revenue taxes were increased, it is not at all certain that the increase would be distributed to MOH. It is quite likely that only a small proportion of any increase would benefit the health budget, given the many other competing priorities for government spending. In this respect, increases in taxes would only benefit the health sector, if it is accompanied by effective advocacy by MOH for those additional resources to be prioritized to health.

Risk pooling and financial protection

The current arrangements and their reliance on general revenue taxation do well in pooling risks and ensuring financial protection. Further increases in healthcare financing from general revenue taxation would strengthen this aspect of the financing system, and would probably reduce out-of-pocket spending further.

Efficiency

The mobilization of financing through general revenue taxation is generally efficient. Tax rates in Fiji are not at levels, which are likely to be associated with significant economic inefficiencies, and the administrative costs of tax collection in Fiji are low (3% in 2009⁵). Increases in general revenue taxation are thus unlikely to be associated with substantial inefficiencies. Economists often argue that increases in taxes on specific items can create inefficiencies by distorting behaviour of consumers and producers, but this argument holds little value in the case of tobacco since the behavioural changes that would result would be considered good for society.

It could be argued that the way in which general revenue financing is used in Fiji to pay for health services is not conducive to improving efficiency. Under the current system, health facilities are paid on the basis of line-item budgets, and doctors are paid salaries. The alternative is to separate purchasing from provision, and pay government providers on the basis of performance – such reforms were pioneered in the 1980s in New Zealand. However, there is little or no global evidence that such approaches are more efficient. More importantly, such methods of public sector purchasing require substantial levels of public capacity to implement, monitor and manage effectively (Schick, 1998), and such capacity does not exist in most developing countries including Fiji.

Equity

Overall general revenue tax collection in Fiji is progressive, so it is an equitable means to mobilize resources for health services. However, indirect taxes in Fiji are regressive, and account for the bulk of taxes collected (41% in 2010). Indirect taxes do not need to be regressive, and in most Asia-Pacific countries, governments use a range of exemptions and targeted rates to ensure that indirect taxes are progressive, *e.g.*, exempting basic foodstuffs consumed more by the poor. So there may be potential for improvements in Fiji.

So the overall impact on equity from tax increases would depend on how it is achieved. Under current rules, increasing VAT tax rates would impose a higher burden on the poor unless major changes are made to how VAT is levied, so increases in personal income taxes are to be

⁵ Analysis of data published in Fiji Island Revenue and Customs Authority Annual Report 2009.

preferred if the aim is to increase taxes in an equitable manner.

Increasing budgetary expenditures on health by introducing ear-marked taxes for health

Feasibility and sustainability

In many countries, governments have introduced specific taxes earmarked for the health sector. These are often taxes on alcohol and tobacco, and the ear-marking is justified on the basis that these products need to be taxed more in order to pay for their negative health outcomes or to discourage their consumption. Other possibilities for such “sin” taxes include taxes on sugar and fats. These have been introduced in a few tax jurisdictions in the past decade, and the Minister of Health has called for a tax on sugar in Fiji, but overall global experience with this kind of taxation remains limited. Another type of earmarking is an additional mark-up on VAT. In Ghana, an additional 2.5% is charged as VAT to mobilize funding for the health sector. In general earmarked taxes are strongly resisted by finance ministries. They argue with some justification that such taxes can distort economic behaviour and thus lead to economic inefficiencies, and more importantly that earmarking undermines their ability to prioritize fiscal resources fairly across competing sectors.

In most countries, alcohol and tobacco taxes offer the greatest potential for earmarked taxes for the health sector. However, in Fiji’s case, the already high level of tobacco taxation has probably already eliminated this as an option – there is unlikely to be substantial new revenues that can be raised by further increasing tobacco taxes, and MOH is unlikely to ear-mark a share of the existing tobacco excise tax. It is worth noting that countries, such as Thailand, which introduced ear-marked tobacco taxes, usually started from a position where tobacco and alcohol taxes were quite low, so they had substantial room to increase tax allocations without reducing revenue allocation to other sectors.

The main problem with earmarked taxes is that they often do not result in higher levels of government spending. Since finance ministries still need to prioritize resource allocation across sectors, they will often reduce allocations to health from general revenue taxation. In fact, it can make it harder politically to increase general revenue tax allocations for health if health is seen as being specially favoured by the tax system. So although overall financing may increase in the short-term by introduction of an earmarked tax, there is a substantial risk for MOH in the long-term that no net increase is achieved. This is quite clearly seen in Ghana, where the general budget allocations to health levelled off after a health-specific VAT was levied, and where it would appear MOF fully adjusted subsequent budget allocations for health to take into account the additional revenues that MOH received directly from the health VAT (Witter *et al.*, 2009). For this reason, we do not recommend earmarked taxes as a sustainable option in the case of Fiji.

Risk pooling and financial protection

Earmarked taxes for health generally contribute to risk pooling and financial protection, as long as they are levied on a relatively broad range of goods of services.

Efficiency

Earmarked taxes normally cause economic distortions, and thus result in inefficiencies. These can be off-set against other benefits if they seek to reduce undesirable consumption, as sin taxes generally do. Otherwise ensuring a broad base for an earmarked tax, such as with a health-specific VAT, will minimize any inefficiency effects. To the extent that existing tax collection mechanisms are used to collect these taxes, they are also relatively efficient in costs of collection.

Equity

Tobacco and alcohol taxes can sometimes be regressive when the poor or less-educated consume more of these items. The higher incidence of these taxes on the poor must however be weighed against the health benefits, which would accrue preferentially to these same groups, so from an equity perspective, there is less to be concerned about.

Increasing budgetary expenditures on health by increasing budgetary allocations for health

Government expenditures on health through the MOH budget accounted for 10% of all government recurrent expenditures in 2010. During 2004-2009, its share averaged 12%, which was the result of a gradual increase from 8% in the early 1980s. The decline from 12% to 10% in 2010 was partly the result of a reduction in the share of the budget allocated to health. This might be taken as indicative of a lower priority given to health by MOF. However, a share of 10-12% is quite respectable, with most other comparable countries reporting shares of 8-12%.

Given the relative stability of health allocations in the government budget and the recent decline in that share, increasing the health share would seem unlikely without a significant increase in the political priority given to the health budget. There is probably some space for MOH to argue for increase in its allocation back to the recent levels of 12%, but probably not much room to argue for significantly higher allocations in a context when government revenues are unlikely to increase significantly beyond their current 29-30% of GDP. Without substantial increases in the share of revenue in relation to GDP, which is unlikely for reasons discussed earlier, increasing the allocation to health implies reducing the allocations to some other sector, which would not be without some opposition.

Changing the allocation of the MOH budget to different services

Within the existing budget, it may be feasible for MOH to reallocate resources. However, it is not clear that this has significant short-term potential. The problems that provoked this assessment can only be addressed by a shift in resources from primary care to secondary and tertiary care services, and possibly from the outer districts to the more urbanized areas, where the disgruntlement by middle-income Fijians is greatest. Neither of these would be without significant costs – the first in terms of reduced health system performance and health outcomes, and the second in terms of increased inequities. The government already implicitly prioritizes secondary and tertiary care, since it allows the private sector to pick up a substantial portion of the primary care case load, but further reductions in primary care expenditures would most likely affect the poorer groups the most.

Increasing efficiency in use of budgetary financing to deliver government healthcare services

Feasibility and sustainability

Efficiency and productivity improvements have significant potential to increase resources available for health. Since most such improvements involve changes in systems and processes, once achieved they tend to stay locked in, and so are inherently sustainable. They are also key to achieving and sustaining universal coverage, since the only way to achieve high levels of coverage at reasonable cost to people and governments is to ensure that the costs of service delivery are kept low.

Estimates of the potential for efficiency improvement in public sector delivery systems are scarce. The largest study of this found that rates of 1-2% were the norm, and that rates of 2-4% annual productivity improvement were feasible and sustainable for long periods of time (Rannan-Eliya, 2009). The highest rates of productivity improvement are seen in civil-service run public delivery systems quite similar to that of Fiji's, so there is no evidence to indicate that the model of healthcare delivery found in Fiji is not able to do significantly better.

This assessment did not have the means to intensively investigate the potential for efficiency improvements in Fiji. It would be useful to benchmark health facility performance against indicators in other countries, and to assess how these have changed over time, but this was beyond the scope of this study. However, a range of evidence suggests there is considerable scope for increasing efficiency. This includes:

- (i) Patient throughput in the public sector has stagnated since the mid-1980s.
- (ii) Hospital turnover rates and indicators such as ALOS have stalled since the mid-1980s.
- (iii) Evidence of considerable scope for improving cost efficiency in the procurement of medicines and equipment.
- (iv) The existence of a number of options where the need for overseas referrals can be reduced by better training and management of clinical specialists.

There are many means by which cost efficiency can be improved. These include organizing staff and other inputs in healthcare facilities to treat more patients with the same level of inputs, matching patient load better with staff and locations where they can be treated at lower cost, adopting better treatment protocols, using more efficient mixes of inputs, including staff and medicines, and simply improving the competency of healthcare staff to assess and treat patients faster. Learning-by-doing is a major driver of such improvements (Rannan-Eliya, 2009). Sustained improvements in productivity don't come from single interventions or changes, but from incremental changes over time, which in turn need to be underpinned by management and organizational structures that encourage and even force constant efficiency improvements. It would appear that these have been lacking or the necessary institutional arrangements have deteriorated in Fiji since the mid-1980s.

The critical question is probably not whether there is scope for efficiency gains in Fiji, but how can such gains be achieved. The timing of beginning of the deterioration in ability to sustain continuous productivity improvements to the mid-1980s is pertinent. In civil service run public sector delivery systems, there are usually few if any financial incentives to encourage more efficient performance. Improvements usually depend on sustained political pressures on healthcare managers to improve efficiency by treating more patients with the money given to them, management structures that recognize and encourage workers for being productive, and a facilitative organizational culture that prizes serving the public well.

Our speculation is that the ethnic divisions, military coups in Fiji and associated disruptions to governance since the mid-1980s have played a major role in undermining the necessary accountability and management structures that are needed for a public sector delivery system to perform well. These disruptions may have undermined pressures on staff to perform better, increased the weight given to factors unrelated to performance in rewarding staff, damaged the ability of the system to retain highly trained clinicians, and been associated with a deterioration in the core public service ethos. The inability of citizens to freely choose their elected leaders in competitive elections would also have reduced the pressure on political leaders to ensure effective and efficient public sector delivery.

If this analysis is correct, sustaining efficiency gains in future will depend on recreating the overall governance and accountability structures that the public sector delivery system needs to perform well. In this sense, the improvements in governance envisaged by the People's Charter and establishment of the preconditions for competitive elections may be a precondition for sustained productivity performance.

Risk pooling and financial protection

Increasing the efficiency in use of government healthcare services strengthens risk-pooling and financial protection, since these services are funded from general revenue taxation.

Equity

In general, increasing efficiency will promote equity. The costs of increasing coverage can be prohibitive for government, unless the unit costs of service delivery can be reduced. By making feasible higher levels of coverage, efficiency gains generally support the objectives of better access and increasing equity.

User fees in the public sector

Feasibility and sustainability

User fees were introduced in the public sector in the early 1960s. They were fixed on the basis of costs in the 1940s, and were not revised until the early 1980s, so the actual level of fees is very low in relation to actual costs of service delivery. During 2003–2008, user fee collections brought in an average of just 1% of actual recurrent costs at MOH. Significant segments of the population have been exempted from paying fees, including children and members of the military.

Can user fees be increased to fund significant expansion of services? Several factors suggest not. Most importantly, substantial increases appear to be politically difficult. Modest increases in user fees were proposed in 2010, but substantial public opposition and criticism led to them being revised downwards. Even if the higher level of fees had been adopted, it would have only mobilized the equivalent of 3–4% of actual recurrent costs. The political difficulties in raising fees are consistent with earlier experience, with governments often finding it attractive to abolish fees, as they did in 2000 in the case of outpatient fees. In systems such as Fiji's, where the public are long used to the concept of free or nearly free public services, substantial fees can only be introduced at a substantial political cost to government, or in extreme scenarios where government financing has collapsed. The political costs involved can be so substantial, that it is not cost-effective for governments to use political capital in this way – other options will always exist for improving public finances at much lower political cost. Given the transition to elected governments from 2014, the feasibility of major changes in user fee policy in future years is very low, and there is a high probability that substantial increases by the current administration would be reversed by later administrations.

Efficiency

User fees for routine services generally increase inefficiency. Since they will have the effect of reducing utilization, they result in less intensive use of health infrastructure, and so increased unit costs of delivery.

The operation of pay-beds and pay-wards at Colonial War Memorial (CWM) Hospital indicates that the idea that providing a higher level of amenities in return for much higher fees is not fiscally efficient. Even though fees for use of these facilities are much higher than the

normal wards, these increased fees do not cover the additional cost involved in providing these services (Irava et al., 2012). In practice, all these fees achieve is to target a higher level of subsidies to better-off and better-connected Fijians. Such a finding is consistent with evidence from other countries which is that private pay-beds in government hospitals tend to be priced badly, because of lack of expertise in pricing plus lack of systems to annually update prices, and in such a way that they increase the fiscal burden on government.

Risk pooling, financial protection and equity

There is extensive global evidence that even small increases in public sector fees will result in reduced utilization of services by the poor, since they are more sensitive to small price increases. In recent years, growing evidence of the impoverishing effects of out-of-pocket payments has called into question the appropriateness of user fees in low and middle-income countries. User fees were widely advocated in the 1980s and 1990s for their potential for cost-recovery at the facility level and ability to promote appropriate referral routes. Since then, empirical work on the impact of payments for health care have provided consistent and compelling evidence that reliance on user fees, and out-of-pocket payments more generally, can lead to large inequities in service delivery (Gertler *et al.*, 1990; O'Donnell *et al.*, 2007). User fees also do not work very well to discourage preferentially trivial use of medical care, since patients are not able to effectively distinguish when medical care is needed or not. Moreover, the costs of collecting user fees are non-trivial, especially with regard to making sure exemptions and fee-waivers are effective (Creese *et al.*, 1995). Recognizing these problems, both WHO and the World Bank have called for abolition of user fees in most public sector delivery systems. Given that the focus of the government is on improving coverage, increases in routine public sector user fees would not be consistent with other policy objectives.

Expanding current private insurance arrangements for civil servants

Since 1989, the Public Service Commission (PSC) has operated a voluntary scheme to provide civil servants with access to negotiated group insurance coverage provided by private insurers.

Feasibility and sustainability

There is little likelihood that the current PSC scheme can significantly expand resource mobilization for the health sector or reduce the fiscal burden on government by substantially increasing enrolments. The historical data bear this out. In 1990, the PSC insurance scheme enrolled 4,000 civil servants, who accounted for 25% of the total civil service workforce (McFarland, 1993). Since then overall coverage has dropped to 2,000 members and less than 10% of the workforce.

The fundamental problem is that despite the good pricing that the PSC is undeniably able to negotiate by virtue of it being a large purchaser, there isn't substantial demand within the civil service to purchase the available policies given their prices, given that all civil servants already have access to free or almost free care at MOH facilities. In the context of a free care option, the demand for private health insurance is driven by the demand for supplementary care over and above what is offered in the public sector. This demand is much less than would exist if there was no free care available, and it is likely to be concentrated amongst civil servants who have greater preferences for private care, plus are better able to afford the private insurance premiums. In practice, only a small proportion of civil servants are willing to pay via insurance for the higher level of quality available at private providers. Moreover, there is very little demand for the PSC scheme in outer areas, where there is no private provision.

The small uptake of the PSC insurance scheme almost certainly results in significant adverse selection. Sicker civil servants more likely to join, thus pushing up overall premium rates. This in turn would make the scheme too expensive for more civil servants to want to pay for.

Risk pooling, financial protection and equity

Conceivably, the only way in which the current PSC scheme can improve take-up is if enrolment in the scheme is made mandatory or if the price is subsidized through government subsidies. However, such interventions would not improve overall equity in access to services, since civil servants presumably already have better access to care than most. There is no compelling public policy rationale that would justify using scarce budgetary resources to increase access of civil servants to private services, unless this is seen purely as a matter of remuneration, when this group does not itself face significant problems with coverage, nor exhibits significant demand to access private services.

5. Assessment of social health insurance option

Social health insurance (SHI) has not been implemented in Fiji before, but proposals have been made on a regular basis to introduce it since at least the 1980s (McFarland, 1993; ILO, 2006). The People's Charter (National Council for Building a Better Fiji, 2008) has called for SHI to be considered as one of the options that could supplement tax financing. As follow-up to this, the Minister of Health requested this assessment. This request did not specify any particular design of SHI. This section analyses what SHI might look like in Fiji, and assesses its likely contribution.

SHI concept

In its essence, SHI involves the mandatory collection of contributions from designated segments of the population, typically through payroll taxes, and the pooling of these contributions in independent funds to pay for services on behalf of the insured. SHI differs from private health insurance in that the contribution of funds is mandated and enforced by the state.

The original form of SHI, introduced in Germany in the 1883 by the government of Chancellor Bismarck, was funded solely by joint contributions by employers and workers. It provided benefits only to the contributing workers and immediate dependents.

The standard SHI model has evolved since then to include financing from general revenue taxation. In practice in Europe more than one third of total financing in countries that use SHI, now comes from general revenue taxes. Countries have incorporated general revenue taxation as a funding source for SHI, since without it governments are not able to expand SHI to cover the poor who cannot afford premiums, the unemployed, the chronically sick and those in informal employment.

Universal coverage with SHI always requires substantial financing from general revenue taxation, and its share increases the larger the population who are not in formal employment. In Europe, the major driver today of the increase in tax financing in SHI systems is the ageing of the population and the increasing number of retired persons.

The design of a SHI scheme for Fiji will require making many choices. These include how contributions will be collected, who will contribute and who will benefit, the package of benefits, how much general revenue tax financing will be used to support the scheme, and how the scheme will integrate with existing funding and provision arrangements. Most of these are ultimately not technical or economic decisions, but social and political ones.

To help assess the feasibility of a SHI scheme in Fiji, we first present an analysis of what a mandatory, payroll-based SHI scheme might generate in funding, and how those costs would be distributed. We then use this to assess and discuss the policy issues in adopting SHI as an additional financing mechanism in Fiji.

Analysis of a payroll-based SHI system

Feasibility of collection

The most practical way to mobilize revenues through SHI is via a payroll tax on those with employment income. Collecting money from other segments of the population is always difficult and much more expensive.

The introduction of a payroll tax is clearly administratively feasible in Fiji. The Government of Fiji already has two mechanisms to do this: (i) the existing PAYE income tax system, and (ii) the Fiji National Provident Fund (FNPf) scheme. PAYE covers 184,000 taxpayers (2010 statistics) and the FNPf scheme covers 300,000 contributing members (2011 statistics). These represent 22% and 35% of the population respectively.

A mandatory contribution for SHI could be levied using either the FNPf or PAYE system. It would involve relatively small additional administrative costs, since existing contributors or taxpayers would be covered automatically. However, an SHI scheme might change the incentives of employers and workers to comply with tax and social security requirements, and this could potentially increase the administrative costs of enforcing compliance. Depending on the size of the effects on compliance, this could have impacts on the level of formal employment. In many countries with contributory SHI schemes, this results in a reduction in formal sector employment and an increase in informality in the labour market.

Collection through the FNPf system is to be preferred in order to improve SHI sustainability. FNPf covers more workers than PAYE, and it is administratively simpler. Broad-basing SHI contributions increases SHI financial viability. For our analysis, we assume that a SHI scheme will use collect contributions through the FNPf mechanism.

Modelling of SHI revenue generation

To develop a model to examine the potential for SHI revenue generation, we assume that a SHI payroll tax would be imposed on a flat rate basis on all employment income. Alternatives include charging higher rates on workers with higher incomes, and/or capping contributions at a set income level. Charging different rates on different workers will engender political opposition as it will make more transparent the implicit redistribution that a SHI scheme would achieve between high and low income workers, and so we assume this will not be done. We would recommend that any SHI scheme does not impose a ceiling or cap on contributions, since the global evidence is that this undermines long-term financial viability of a scheme and also significantly reduces progressivity in payments.

To simulate the distribution of SHI contributions, we used the data from the FIBOS Employment/Unemployment Survey (EUS) 2004–2005. This is a nationally representative survey of the population, which collected information on individuals' demographic characteristics, employment status, wage levels, FNPf contribution status and type of employment. Data from the more recent 2009–2010 survey were not available from FIBOS. Using the EUS data, we estimated for each surveyed worker what contribution would have been made to FNPf in 2004. This yielded estimates of total FNPf contributions that were 15% less than the revenue reported by FNPf in that year (\$225 million). This discrepancy is well within the range of the under-reporting that one might expect in this type of survey, and provides reassurance that the EUS survey provides a valid profile of FNPf contributors in 2004. We then

applied an adjustment factor to the EUS 2004–2005 income estimates to match the estimated FNPF contributions with actual FNPF contributions in 2011 (\$304 million). This procedure produces a data set with estimates of the distribution of FNPF-liable income in 2011, with the assumption that the distribution of wages within the population has not changed. The percentage of the population who contributed to FNPF did not change significantly between 2004 (36%) and 2011 (34%), so we make no attempt to adjust for changes in the size of the workforce in relation to the population, although it should be noted that there would have been some change in the age and sex distribution. We also estimate in a similar fashion how PAYE tax revenues (\$202 million in 2011) are distributed across workers.

We estimated for 2011 the potential revenue generated by a flat SHI payroll tax by applying different SHI tax rates to the estimated employment income. This makes no choice about how the SHI contribution is shared between employers and workers. Although the exact division of the contribution will have significant short-term implications for SHI acceptability and wages, in the long-term the incidence of a SHI contribution will be ultimately borne by workers in the form of reduced wages, and possibly by consumers in the form of higher prices. Analysis of these effects is not easy, and is not attempted.

Estimates of potential revenue generation through a SHI payroll tax

An SHI payroll tax of 1% would generate an additional \$19 million in revenues. The estimates generated from the model are shown in Table 2. Assuming this is allocated entirely to the MOH under the SHI scheme, and assuming that there is no adjustment in the MOF budget allocations to MOH, this would have increased funding for MOH by 14%. If the SHI payroll tax rate increased to 5%, it would have generated \$95 million, and would have increased funding for MOH by 69%.

Table 2: Potential revenue generated through 1% and 5% SHI payroll tax (\$ million)

Current PAYE income tax; FNPF Contributions							
Income bracket	Employment Income	Tax Rate	FNPF Rate	Combined Rate	Tax Revenue	FNPF Revenue	
0-15,000	843	0%	16%	16%	0	135	
15,001-15,600	57	25%	16%	41%	0	9	
15,601+	<u>1,000</u>	31%	16%	47%	<u>202</u>	<u>160</u>	
Total	1,900				202	304	
Current PAYE income tax; FNPF Contributions + 1% SHI Contribution							
Income bracket	Employment Income	Tax Rate	FNPF/SHI Rate	Combined Rate	Tax Revenue	FNPF Revenue	SHI Revenue
0-15,000	843	0%	17%	17%	0	135	8
15,001-15,600	57	25%	17%	42%	0	9	1
15,601+	<u>1,000</u>	31%	17%	48%	<u>202</u>	<u>160</u>	<u>10</u>
Total	1,900				202	304	19
					Total SHI Revenue = \$ 19 million		
Current PAYE income tax; FNPF Contributions + 16% SHI Contribution							
Income bracket	Employment Income	Tax Rate	FNPF/SHI Rate	Combined Rate	Tax Revenue	FNPF Revenue	SHI Revenue
0-15,000	843	0%	21%	21%	0	135	42
15,001-15,600	57	25%	21%	46%	0	9	3
15,601+	<u>1,000</u>	31%	21%	52%	<u>202</u>	<u>160</u>	<u>50</u>
Total	1,900				202	304	95
					Total SHI Revenue = \$ 95 million		

These represent best-case estimates. In reality, the revenues generated and the amount made available to the health sector will likely be much less. There are three main reasons:

- (i) The analysis does not take into account the administrative costs of the new tax. Based on international experience, the additional costs of collecting the increased FNPF contributions could be estimated as 3–5% of total SHI tax collections. Employers will also bear a portion of the administrative costs.
- (ii) Even though these estimates are based on current rates of compliance with FNPF, evasion of payroll taxes, through under-reporting of wage incomes or failure to register, is likely to lead to some loss of revenues. This loss would increase the higher contribution rate is.
- (iii) This assumes that MOF will not allocate fewer resources to the health sector from the budget than it otherwise would have. Global experience indicates that this is quite likely, for example in Ghana MOF almost completely off-set the increase in SHI contributions.

Characteristics of SHI contributing population

Analysis of the EUS data shows that the contributing population will differ in several respects to the overall national population:

- (i) It will be concentrated in the Central Division. The Central Division accounts for half the population, but would contribute two thirds of the SHI revenues.
- (ii) It will be younger and comprise fewer older people than average.

This has implications for the impact of SHI on the overall health sector. In particular, there will be a mismatch between the revenues generated by SHI and the actual distribution of costs by age. The elderly who represent the fastest increasing cost component in MOH services are far less likely to be covered by SHI contributions. Similarly, the other districts, where the greatest gaps in coverage currently exist will make fewer contributions to a SHI scheme than the more urbanized central districts.

Potential for scaling up SHI revenue mobilization

An SHI payroll tax would cover around 35% of the population, assuming no impacts on FNPF compliance. Households or families that contain at least one FNPF paying member amount to approximately 55% of the population.⁶ Since not everyone who lives in such households would necessarily be considered a dependent by a scheme, an SHI scheme covering contributors and their dependents would leave uncovered 50-55% of the population.

Increasing revenue mobilization through SHI contributions would depend on either expanding the collection of contributions beyond the formal sector workers, or the formal sector expanding. Those who are not covered by the FNPF system are those in informal employment, or who are unemployed or unable to work or are retired. This segment of the population is also poorer than those in work. International experience indicates it is very difficult to collect meaningful levels of contributions from these people. The evidence suggests that the formal sector in Fiji is unlikely to substantially or rapidly increase in size in future. In the past decade, the size of the formal sector has been stable in Fiji, and the potential for it increasing in the medium term appear limited. In the longer term, as the population ages, it will become harder.

⁶ Analysis of EUS 2004–2005 data set.

Benefit coverage

Two critical questions are whom an SHI scheme will cover? and what it will finance? These questions are inter-related.

Beneficiaries

If the scheme pays for increased coverage of services for all citizens, it will be politically very difficult to introduce a payroll contribution by itself. Workers will reasonably ask why the burden of financing is borne only by them. In this scenario, where benefits are provided to all, increasing general revenue taxes would be fairer and more defensible. The introduction of contributory SHI schemes is only politically feasible if there is a clear connection between the new mandatory payments and increased benefits for those who pay. In fact the main political rationale for SHI is that it creates a direct link between contributions and benefits.

If the government wanted to cover all citizens, then it would have to arrange to pay the contributions on behalf of those who cannot afford to pay or from whom contributions cannot be collected. These represent half of the Fijian population, and analysis of the EUS data indicates these will be older on average than those who belong to FNPf paying families, so would have higher medical needs than average. If the costs of these other citizens are financed by MOF, it implies that MOF will have to provide matching funds in the ratio of at least 1 to 1 for every dollar mobilized through SHI to cover treatment costs of contributing workers and their dependents.

Benefits

The second question is what will the SHI funds pay for? There appear to be two possibilities:

- (i) Treatment at services currently offered by private providers, who for the most part in Fiji are pharmacies, private GPs and specialists.
- (ii) New clinical services from the public or private sector that MOH does not currently provide or overseas treatment not available in Fiji.

A 1% SHI payroll tax would be sufficient to almost completely cover current expenditures at private doctors and pharmacies, which account for 15% of total health expenditures. This might make it possible to pay for such private doctor and pharmacy services on the basis of reimbursement of fees or to expand public financing to them using other methods such as capitation.

A substantial increase in funding for private providers through SHI would likely result in an increase in the number of providers in the private sector. This implies that using SHI funding to pay for increased private provision is likely to result in loss of staff from MOH, or an increase in wage costs at MOH to improve retention. In this choice, new funding for existing private services will thus result in an increase in the funding needs of MOH, *i.e.*, would need to be accompanied by some increase in MOF budget allocations.

The alternate possibility is to pay for a range of new clinical services that are either not provided by MOH currently, or are available only in limited volumes. This choice would address the actual funding gaps identified in the original problem diagnosis. If this was selected, the question that government will have to answer is whether this expansion in services will only benefit the SHI covered population. If it does restrict access in this way, then the issue it raises is that the SHI scheme will primarily benefit those who currently have the best access to services, and it will result in no improvement for those who currently experience the largest coverage gaps. Whether this is a problem depends on how important the government believes it is to maintain or

improve equity, social inclusion and integration versus addressing the dissatisfaction of the middle/upper-middle income citizens. The advice of the Prime Minister's Office when asked about this question was that government preferred that coverage is universal and that social cohesion should be maintained.

If universality is to be emphasized, then the second choice of paying for new services requires that MOF will need to provide additional budgetary financing to ensure that the expanded range of services is made accessible to all citizens. Realistically, this implies that MOF will need to provide matching funds in the ratio of at least one to one to balance the SHI revenue mobilization.

Alternatively, the government might decide that universality is the long-term goal, and in the interim accept an expansion in service coverage for the formal sector only, with coverage of the remaining population been increased gradually as other resources become available. However, global experience indicates that this is extremely difficult to achieve, and that introducing a SHI scheme solely for formal sector workers first may actually slow down further extensions of coverage. Many Latin American countries introduced SHI several decades ago by covering only the formal sector workers. Their experience has been that the system becomes so entrenched that it becomes an obstacle to extending coverage. Levelling up to the most comprehensive plan is too costly, while a reduction in comprehensiveness of the benefit package is resisted by those who have it. In the Asia-Pacific region, only three economies have ever managed to expand coverage of SHI to the whole population – Japan, Korea and Taiwan. It is critical that there is the highest level, explicit commitment at the outset to achieving universal coverage via mandatory insurance in the shortest possible time if this approach is to succeed.

Managerial requirements

The financial sustainability of SHI depends critically on strong administrative and technical capacity, and good regulatory oversight. A SHI scheme will need the following capacities:

- (i) The ability and IT expertise to routinely process and manage claims and payments to providers used by beneficiaries.
- (ii) Actuarial skills to monitor and ensure that revenues are matched with likely expenditures.
- (iii) The expertise to set prices and manage cost inflation in covered providers.

Fiji currently does not have the expertise to process and manage large volumes of claims and provider payments, or the actuarial skills to monitor and manage a large SHI fund. This stems from the lack of a pre-existing large-scale social security scheme which collects funds and manages complex payments. The Public Service Commission has the largest pool of insured workers, but it has no capacity or experience in actively managing its beneficiary population or their claims. There is also limited capacity in the private insurance sector, since current private insurance plans in Fiji are indemnity plans, where the insurer reimburses up to a ceiling, and so is not motivated to actively manage costs. There would need to be a large investment in administrative capacity if a SHI scheme is established.

Setting prices and achieving effective cost control requires much higher-level competencies. Many countries with SHI are not able to control costs effectively. Cost control is much harder in SHI systems than in budget-financed systems as Fiji has currently. Either costs increase requiring their SHI funds to be bailed out or countries are forced to cut the level of coverage to ensure revenues match expenditures. Cost control requires such strategies as being able to set and

enforce a uniform price system on all providers, and being able to use market power to actively set these prices. In the Asia-Pacific region, only Japan, Korea and Taiwan have effective capacity in this area. Given the lack of experience with contributory insurance and insurance payment systems in Fiji, it is highly likely that Fiji will not be able to develop these capacities. Failure to do so will create long-term problems of cost control, and ultimately have fiscal implications, since increased prices in the health sector will also put upward pressures on costs in the MOH delivery system. For example, if doctors are able to increase their incomes significantly in the insured sector, it will cost MOH more to retain doctors in MOH facilities.

Impacts of a SHI scheme on healthcare system

Risk pooling

The introduction of SHI is likely to fragment risk pooling in the healthcare financing system. Fiji currently has a high level of risk pooling in its healthcare financing system. General revenue taxation funds almost three-quarters of all health expenditures and funds a single risk pool that covers all citizens. A non-universal SHI scheme will create two risk pools. One better-off, younger group covered by existing MOH services plus SHI contributions, and a second group only covered by the existing MOH arrangements. Remerging these two groups back will only be possible through increases in tax funding at a later date to bring coverage of the second group up to that of the first group.

Equity

The equity impact of a SHI scheme in Fiji depends on the rules governing contribution rates, and on whether the scheme provides benefits to all citizens or only the contributing population. If SHI contributions are levied on a flat rate basis, overall equity in the financing burden will remain largely unchanged. Improvements in equity will only result if the contribution rates are made higher for higher income workers, which international experience indicates is usually difficult.

Table 3: Comparison of SHI contributions with the current distribution and progressivity of healthcare payments by expenditure quintile, 2009/10

Expenditure group	Share of ATP	Direct taxes	Indirect taxes	OOP payments	All current payments	SHI contributions
Poorest	5.9	0.4	7.0	1.7	4.2	1.8
2	9.6	1.8	11.3	4.9	6.6	5.9
3	13.6	5.6	15.8	7.4	11.8	12.5
4	20.1	17.4	21.8	17.1	18.4	20.0
Richest	50.8	74.8	44.1	68.9	59.0	59.8
Total	100%	100%	100%	100%	100%	100%

Source: Based on analysis of HIES 2009/10 and EUS 2004-2005 by authors.

If SHI benefits are provided only to contributors and their dependents, SHI will reduce equity in coverage, since the primary beneficiaries will be those who currently have better than average access. To maintain or improve on the current level of equity in coverage in Fiji's system, SHI would need to be accompanied by increased budget allocations for health by MOF to finance an increase in service coverage for the non-contributing population.

Efficiency

The introduction of SHI will not by itself increase efficiency in the healthcare system, since its main impact will be to increase funding levels. The challenge of reversing the stagnation in productivity in the MOH delivery system will still remain. SHI might permit changes in how public sector providers are paid and a separation of financing from provision, but there is no evidence internationally that such a provider-purchaser split will lead to increased system efficiencies.

It is possible that a switch to SHI financing and fee-based payment would increase inefficiency in management of NCDs. There is international evidence that government-financed, integrated public delivery systems do better than fee-based, insurance systems in ensuring coordinated and integrated care of chronic diseases (Nolte *et al.*, 2009). Given that the management of chronic disease will become more important as NCDs increase in importance in Fiji, introduction of SHI might increase inefficiencies in the health system.

6. Findings and recommendations

What are the concerns?

Motivations

This assessment of the feasibility and desirability of SHI was requested by the Minister of Health in response to widespread concerns about the performance of the Fiji health system and the apparent need for additional financial resources. Those concerns are evident in the People’s Charter, which sets out “Improving health service delivery” as the tenth pillar in the national strategy for rebuilding Fiji as a ‘non-racial, culturally vibrant and united, well-governed, truly democratic nation’.

The People’s Charter is clear that its vision is guided by concerns for justice and fairness, unity and a common identity, and uplifting the disadvantaged. This vision is reflected in its focus on improving the performance of the health system in Pillar 10. The People’s Charter identifies two critical problems in health – one is the poor recent performance of the health system in improving health indicators, and the second is the apparent low level of financial resources for health compared to some other Pacific Island countries. These lead to calls to improve efficiency in the delivery system and to increase funding for health. SHI is mentioned as one possibility for supporting that increase in health financing.

Consultations with stakeholders and key informants during this assessment reveal a more complex set of concerns, not all of which are consistent. Some of these contradictions reflect differences in the importance given to key values and goals. Others reflect the difficulties Fijians have had in assessing the problems faced by their health system and identifying solutions. Such difficulties are not unique to Fiji, and are common to other similar health systems.

Issues as perceived by stakeholders

At the highest level of government, the primary concerns are that the health sector improves the efficiency with which it uses the resources given to it, and that policies should be consistent with the People’s Charter emphasis on universality and bringing Fijians together. Understandably in what is essentially a period of transition there is also a wish that any changes should not provoke significant public opposition. It was stressed that at this level of government, officials had no specific preferences or agenda, and were looking to the health ministry to provide direction. This perspective indicates three sets of overarching values that should guide the health sector in its strategic choices:

- (i) Social solidarity, cohesion, and lifting up the disadvantaged.
- (ii) The importance of technical knowledge in developing solutions.
- (iii) Maintenance of political harmony.

As the key decision-maker in the health sector, the Minister of Health shares similar concerns over improving efficiency in MOH, and the importance of moving towards universal coverage. In addition, the Minister understandably desires more funding for health, with SHI being regarded as just one option for achieving this. The Minister has been making strenuous efforts to overhaul MOH operations, but he also acknowledged the corrosive effect that

the past two decades of political disruption have had on MOH performance. Such a perspective recognizes the links between reforming governance in Fiji and improving public sector delivery.

Discussions with other key informants point to the need to address the dissatisfaction of upper-middle income citizens with the quality and range of services available in Fiji. These citizens have higher expectations than the average Fijian, and do not find adequate the services provided to them by the public sector. Fiji's health system does permit these citizens to privately pay for a higher level of services than provided by the public sector, but they remain dissatisfied because either such services are not offered in the private market, or they are unable to afford the prices charged. SHI is seen as one way in which government can address the needs of this group by providing them with access to a higher level of services and quality than available to the rest of the population.

The desire to meet the needs of upper-middle income citizens through SHI places less importance on the value of solidarity and lifting up the disadvantaged, and places greater priority on addressing the needs of the better-off. There is an inherent contradiction between the values embedded in this and the guiding values outlined at the top of government.

There is some confusion in Fiji about what universal coverage means or requires. Universal coverage has become a major aspiration in most countries. However, it is often equated mistakenly with the idea of paying for healthcare through SHI. Universal coverage – equity of access to services and financial risk protection – can be achieved with or without formal insurance, and general revenue financing alone or alongside private spending can achieve universal coverage as well as SHI. The lack of SHI leads some observers to think that there is no coverage.

What is the reality?

In terms of health outcomes, Fiji's health system remains a good performer. However, this represents the gains of previous decades, and recent improvements have been minimal. The concern in the People's Charter with reversing stagnating indicators is justified.

The current healthcare financing system does exceptionally well in ensuring financial risk protection. The level of risk pooling in financing is comparable to many developed countries. Out-of-pocket expenditures are low in absolute and relative terms, and are concentrated in upper-income households. Poor and average income Fijians do not face significant financial barriers in accessing available healthcare services.

In terms of universal coverage, Fiji does well, and much better than other countries at its level of income development. The limited evidence suggests that gross disparities in access are minimal, and that disparities in coverage are reasonable for a developing country like Fiji.

At the same time, the level and quality of available services dissatisfies upper-middle-income citizens. The level of public financing is not adequate given current efficiencies to meet their expectations for quality or for high-end services. Fiji has done well to expand public financing for healthcare, but economic constraints prevent it from increasing it enough. That shortfall in public financing is felt most strongly by upper-middle income Fijians who have higher expectations, but lack the financial resources of the richest Fijians to purchase what they would like.

What is the problem?

Fiji, like all countries, faces the challenge of how to achieve its health system goals with limited resources. It has to choose which goals to prioritize and what trade-offs to make. No country is able to obtain good health outcomes, effective financial risk protection and high levels of citizen satisfaction, and do so whilst keeping costs low.

Fiji does reasonably well in mobilizing tax revenues, but tax resources are not infinite. The constraints that limit further tax revenue mobilization also limit the potential for revenue generation from SHI. Taxes and mandatory SHI contributions increase costs for firms, and reduce money available to consumers and workers for other purposes. Other sectors also compete to access the same pools of money that taxes and SHI can generate.

By funding an extensive delivery system including hospitals that is free or almost free for all patients, Fiji has chosen to prioritize equity, risk protection and access for the poorest over satisfaction of the better-off. Higher-income patients are permitted to purchase services privately, but government does not use its limited resources to assist them. If anything their decision to use private services frees up resources to treat the poorer patients who depend on public services. Their dissatisfaction is the direct result of Fiji's choice to use public funding to guarantee a basic minimum for all.

Most countries that have gone down the SHI route made different choices. They prioritized ensuring access and financial protection for the usually better-off formal sector workers, before they dealt with improving coverage for the poor. In these countries, there is bigger latent demand for SHI, because the government does not provide a free public service. Without SHI, all citizens in these countries face financial risks in accessing healthcare.

The lack of significant demand for SHI in the Fijian context is demonstrated by the poor uptake of the PSC private insurance policies by civil servants. Despite having access to advantageous pricing, less than 10% find it worthwhile to purchase private insurance. This indicates that most potential SHI contributors will not find such a scheme good value.

If Fiji introduces contributory SHI, it needs to decide whether it wants this to support better services only for the formal sector and better-off Fijians who would be contributors, or whether it wants the arrangements to be universal and benefit all citizens. The first option would undermine solidarity, and social cohesion, and increase inequity in the current system, and would not be consistent with the broad vision of the People's Charter. It carries long-term risks of embedding a two-tier health system, which will be politically and financially costly to dismantle later. The second option would require an equal or greater increase in tax financing to allow the SHI benefits to be provided to the majority of the population who would not be contributors.

The fundamental choice is thus not between SHI and increasing tax funding, but actually between reducing (introduce SHI alone) or maintaining equity (introduce SHI and increase tax financing). The health systems that most resemble Fiji's ended up that way, because equity of access has been the dominant organizing principle. These systems, which include Malaysia, Sri Lanka, Hong Kong and Jamaica, frequently contemplate introducing SHI as a means of mobilizing additional funding, but repeatedly fail to do so because of impossibility of reconciling the goals of SHI, not increasing tax financing and maintaining equity.

The need for increased funding for the health sector could be met by higher taxes and increased budget allocations to MOH. This would be far simpler to implement than SHI. SHI

might be justified on the basis that MOF is not willing or able to allocate more budgetary funding. However, the implication of this is that any SHI scheme would not be universal, since MOF would not provide the additional budgetary funding required to expand SHI benefits to all.

What are the potential impacts of SHI in Fiji?

It is technically feasible for Fiji to mobilize significant funding through SHI using the FPNF arrangements. A healthcare levy of 1% on wages of FPNF contributors would raise the equivalent of 12%–14% of the current MOH budget, and it would require minimal new investment in administrative capacity. However, neither Fiji nor FPNF have the skills or competencies required to manage payments to providers, and to monitor and control costs. Significant investment in this expertise and human resources would be needed.

Mandatory SHI contributions like any tax will create some economic inefficiency. As a payroll tax, it would tend to reduce wages and labour market formality, and might dampen growth in formal sector employment. This impact on the labour market will be greater than if the same amount of money is mobilized through the tax system, which is more broad-based. Such impacts on the labour market might be undesirable when Fiji is struggling to accelerate economic growth.

Introducing contributory SHI where benefits are linked to contributions will fragment risk pooling in Fiji's health system. It will be much harder politically to remerge the risk pools at a future date.

There is a risk that SHI funding will not substantially increase overall financing for health. If SHI is used to increase the funding of MOH services, MOF might choose to allocate a smaller budget to health as a response, and global evidence shows that this is quite likely. If SHI is used to finance private provision, MOF would need to increase its budget allocations to health if equity is to be maintained.

New funding from SHI could be used to pay for existing private services (mostly medicines and GP care), or pay for new secondary and tertiary services (including overseas treatment). Such benefits would be restricted to formal sector workers and their dependents, unless tax financing is increased to extend benefits to everyone else.

Public sector hospitals lack the capacity, management and information systems or administrative regulations that would enable them to charge a SHI scheme for services and manage such funds. If a SHI scheme is to pay public providers, significant investment in these systems would be needed first. It took UK National Health Service hospitals almost two decades to establish such capacity.

SHI by itself will not increase efficiency in the health sector. Internationally, SHI systems are not cheaper than tax-financed systems, and are often more expensive because of the difficulties in controlling prices. The Pacific Islands with SHI – FSM, Marshall Islands, etc. – spend four times as much as Fiji but have outcomes worse or no better than Fiji. SHI might raise costs in Fiji's health system, and make it more difficult to improve treatment of NCDs.

What other options are there?

As a middle-income country, Fiji needs new funding to upgrade primary care services to better manage NCDs and chronic illness, to fill gaps in secondary and tertiary services particularly for NCDs, and to provide the new technologies that Fijians will inevitably expect. Regardless of efficiency gains, such expansions in coverage will in the long-run need an increase in public financing levels from the current 3% of GDP.

To increase health sector funding whilst maintaining or increasing equity, the only realistic option for Fiji is to increase financing from general revenue taxes. This is also the simplest option to implement. However, its scope will be limited by the difficulties of increasing taxes in the medium term, and the need to convince government that health should increase in priority. An increase in allocations may require persuading MOF that MOH uses its existing budget efficiently and continuing tax reforms to improve tax collection.

Increasing efficiency in service delivery is the second major option that MOH has to mobilize resources. MOH has under-performed in productivity improvement since the mid-1980s, implying significant potential for efficiency gains. Other countries with similar systems typically achieve efficiency gains of 2–4% a year through incremental productivity improvements. However, to achieve such gains, Fiji needs to address the reasons why MOH has failed to deliver such improvements in recent decades. The timing of the productivity slowdown indicates that it is linked to the failures in governance since the mid-1980s. In countries with similar systems, competitive elections are the major driver creating pressure on health sector managers to improve performance. From this perspective, implementation of the reforms outlined in the People’s Charter and transition to elected government provide the necessary preconditions to allow MOH to achieve large efficiency gains in future.

Many options exist for improving efficiency. These include better management of human resources at MOH, strengthening management skills of healthcare workers and staff at all levels, reducing corruption, and striving for efficiencies in procurement and logistics. Strategies such as benchmarking and training for management can help in doing this.

Increasing user fees will not generate substantial new funding. The very modest levels that are charged generate less than 1% of current MOH costs, and proposals for substantial increases have met significant public opposition. Fee levels that would make a meaningful contribution to resource mobilization are politically unfeasible and would substantially damage equity and efficiency in the health system.

Expanding private insurance will not generate substantial new funding. The private insurance market is well established in Fiji, but demand remains modest. This is not surprising given that out-of-pocket expenditures in Fiji are relatively low, and since most Fijians have access to free services from MOH. The economic conditions to support substantial expansion – lack of free care and high prices to access medical care – do not exist in Fiji.

Recommendations

Given the concerns expressed by senior government officials and in the People's Charter, and the capacities available in Fiji, the most feasible and sustainable strategy is to:

1. Continue to rely on general revenue financing, whilst building the case for increased budget allocations for MOH.
2. Intensify efforts in short-term to address known inefficiencies in MOH.
3. Complete the transition to competitive elections to provide the necessary public pressure and accountability that is needed to sustain efficiency improvements in MOH delivery.

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