

# **FIJI HEALTH ACCOUNTS**

# **NATIONAL HEALTH EXPENDITURE**

**2011 - 2014**

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## **National Health Expenditure**

### **2011-2014**

**A publication of the Ministry of Health and Medical Services, Republic of Fiji**

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## Foreword

The National Health Accounts (NHA) report provides valuable information that contributes towards evidence based strategic planning and policy development. Such evidence and information also provides options to health planners to make key decisions on health for improvement and efficiency in service delivery. The Ministry of Health and Medical Services (MoHMS) will be implementing its National Strategic Plan 2016-2020 and priority area 8 of this plan focuses on sustainable financing. The information provided through this report will assist in making strategic health financing decisions. These decisions are vital to ensure that the MoHMS remains committed in providing accessible, equitable and affordable health services to all Fijians.

The MoHMS has so far produced four (4) rounds of NHA reports since 2010. This is the fifth (5th) round of NHA report for years 2013-2014 and describes the health care system from an expenditure perspective and provides evidence-based information that can be used as a tool to track and provide better insight to policy makers on efficient utilization of health funds.

This report has been compiled using the System of Health Accounts (SHA) 2011 framework and thus captures comprehensive information on Fiji's health expenditure for the years 2011 to 2014. Disease-based costs presented in this report (using the ICD-10AM classification) cover the public, private sectors, inpatients and outpatients. This is an improvement from previous years NHA reports.

I take this opportunity to thank the NHA Committee for the collaborative effort in developing this report. I further acknowledge the contribution from all stakeholders in supporting MoHMS initiative in building evidence base information required to make appropriate future health care financing decisions with the overall aim of strengthening health systems and improving the delivery of health services in Fiji.

The MoHMS looks forward for the same support in the future.



**Dr Meciusea Tuicakau**  
**Acting Permanent Secretary for Health and Medical Services**

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## Acknowledgements

The production of Fiji Health Accounts (FJHA) is an on-going activity for the Ministry of Health and Medical Services (MoHMS) since 2010. This is the fifth round and this report is based on the System of Health Accounts (SHA 2011) framework. The development of this edition has been made possible through a collaborative effort between public & private sectors and academic institutions.

Our sincere appreciation and gratitude goes to Ministry of Finance for the everlasting support and also recognising the importance of this publication and its use. Officers from the Department of Strategic Planning & National Development (DSPND), Budget division, Financial Management Information Systems (FMIS) unit and Fiji Bureau of Statistics (FBoS) formed part of the National Health Accounts (NHA) Committee and have greatly contributed by providing the statistical information, raw data on a timely basis and also assisted towards the compilation of this publication.

It is important to note that this publication would have not been possible without the participation and support of many individuals and organisations in the private sector such as insurance companies, private hospitals, private health clinics, private laboratories, ambulance companies, private providers including doctors and pharmacists, health partners & development partners, non-governmental organisations, banks and other statutory bodies; that have cooperated in providing data through survey questionnaires.

We wish to acknowledge the collaboration and support of the Centre for Health Information Policy and Systems Research (CHIPSR) of College of Medicine, Nursing & Health Sciences (CMNHS) at the Fiji National University (FNU) for the outstanding and exceptional effort in data management and analysis work. Interpretation of the results and the drafting of the report were done by the entire NHA team. The NHA Team would also like to recognize the effort and support of all those who had provided assistance in compiling the report.

Our sincere gratitude and heartfelt thanks to all NHA Team members from MoHMS for possible assistance and support provided during the duration of the development of this publication.

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### **The NHA Team**



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## Abbreviations

CHE	Current Health Expenditure
CHIPSR	Centre for Health Information Policy and Systems Research
CMNHS	College of Medicine, Nursing & Health Sciences
CRA	Community Rehabilitation Assistance Program
CWMH	Colonial War Memorial Hospital
DBC	Disease Based Costing
DFAT	Department of Foreign Affairs and Trade
DMO	Divisional Medical Officers
DSHS	Deputy Secretary Hospital Services
DSPH	Deputy Secretary Public Health
DSPND	Department of Strategic Planning and National Development
FBOS	Fiji Bureau of Statistics
FHSSP	Fiji Health Sector Support Program
FJ\$m	Fiji Dollars in Millions
FJHA	Fiji Health Accounts
FMIS	Financial Management Information System
FNU	Fiji National University
FP	Factors of Provision
FPBS	Fiji Pharmaceutical and Biomedical Services
FPS	Fiji Pharmacy Society
FRCA	Fiji Revenue and Customs Authority
FS	Revenue of Financing Schemes
GCHE	Government Current Health Expenditure
GDP	Gross Domestic Product
GF	Global Fund
GHE	Government Health Expenditure (GCHE plus capital spending)
GL	General Ledger
GP	General Practitioners
HC	Health Care Functions
HF	Health Care Financing Schemes
HIES	Household Income and Expenditure Survey
HiT	Health in Transition
HK	Capital Expenditure
HP	Health Care Providers
HR	Human Resource
ICD-10AM	International Coding of Disease 10 Australian Modification
ICHA	International Classification of Health Accounts
ICT	Information Communications Technology
IP	Inpatient
JICA	Japan International Cooperation Agency
K	Thousand Dollars
KOICA	Korea International Cooperation Agency
MFAT	Ministry of Foreign Affairs and Trade
MoF	Ministry of Finance

MoHMS	Ministry of Health and Medical Services
MOU	Memorandum of Understanding
MS	Medical Superintendents
NCD	Non-communicable Diseases
NEC	Not Elsewhere Classified
NGOs	Non-government Organizations
NHA	National Health Accounts
NZAID	New Zealand Aid Programme
OECD	Organisation for Economic Co-operation and Development
OOP	Out of Pocket Expenditure
OP	Outpatient
PATIS	Patient Information System
PCHE	Private Current Health Expenditure
PHC	Public Health Centres
PHIS	Public Health Information System
PRC	People's Republic of China
PSIP	Public Sector Investment Programme
SDHs	Sub Divisional Hospital
SHA	System of Health Accounts
TB	Tuberculosis
TGE	Total Government Expenditure
TGHE	Total Government Health Expenditure
THE	Total Health Expenditure
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USD	United States Dollar
VAT	Value Added Tax
WHO	World Health Organization

## Executive Summary

1. Current Health Expenditure (CHE) in Fiji was estimated FJ\$310.3m in 2014 with per capita health spending of FJ\$358.40 or USD\$191.00 per capita.
2. CHE in 2014 comprised of Public funds of FJ\$191.1m (61.6%), Private funds FJ\$107.3m (34.6%) and Development partner funds FJ\$11.9m (3.8%).
3. In 2014, CHE as a proportion of Gross Domestic Product (GDP) is estimated at 4.4%. Over the four year period 2011 to 2014, ratio of CHE to GDP averaged at 4.2%.
4. The Private sector financing of health expenditure was dominated by household spending. In 2014 Out of Pocket (OOP) Expenditure as a % of Private Current Health Expenditure (PCHE) was 73.2% and as a % of CHE was 25.3%.
5. Hospitals accounted for the largest amount of CHE. In 2014, 82.6% of hospital expenditure was financed by public sources and the remaining 17.4% by the private sector.
6. Curative care accounted for the largest portion of CHE (40.9%) in 2014. Of the curative care expenditure, 59.4% was spent on outpatient care and 40.6% was spent on inpatient care in 2014.
7. Government Current Health Expenditure (GCHE) per capita on hospitals and public health centres (excluding Specialized services) was FJ\$183.83 in Northern, FJ\$157.82 in Central, FJ\$150.34 in Western and FJ\$125.75 in Eastern.
8. In 2014 the Human resource cost on GCHE was \$116.3m (62.2% of GCHE) and 37.5% of CHE.
9. Government Capital spending was 11.3% of Government Health Expenditure (GHE) in 2014. This has increased since 2011 (7.4% of GHE).
10. For the year 2014 in terms of inpatient admissions, diseases of the Pregnancy, childbirth and the puerperium accounted for the most expenditure at 32.1% of total inpatient costs. In the case of outpatient visits, procedural services accounted for the most expenditure at 23.6% of total outpatient costs.

## Summary of Key Indicators 2011-2014

Indicators		2011	2012	2013	2014
General	Population	853,794	857,849	862,068	865,716
	Gross Domestic Product (GDP) at Current Price (Nominal) (FJ\$m)	5,738.8	6,010.1	6,440.0	7,129.8
	Total Government Expenditure (TGE) (FJ\$m)	1,898.3	2,013.7	2,136.3	2,883.3
	Current Health Expenditure (CHE) (FJ\$m)	230.4	251.5	267.8	310.3
	CHE plus capital spending(FJ\$m)	245.5	266.2	291.9	342.9
	CHE per capita (FJ\$)	269.9	293.2	310.6	358.4
Revenues of Schemes	Government Current health expenditure (GCHE) (FJ\$m)	138.7	149.1	158.5	191.1
	Private health expenditure	80.6	87.2	98.1	107.3
	Development partner	11.1	15.2	11.1	11.9
	GCHE as a % CHE	60.2%	59.3%	59.2%	61.6%
	Private expenditure as a % of CHE	35.0%	34.7%	36.6%	34.6%
	Development partner funds as a % CHE	4.8%	6.0%	4.1%	3.8%
	CHE as a % of GDP	4.0%	4.2%	4.2%	4.4%
	GCHE as a % of TGE	7.3%	7.4%	7.4%	6.6%
	GCHE as a % of GDP	2.4%	2.5%	2.5%	2.7%
	GCHE per capita (FJ\$)	162.5	173.8	183.9	220.7
	Private health expenditure as a % of GDP	1.4%	1.5%	1.5%	1.5%
	Development partner funds as a % GDP	0.2%	0.3%	0.2%	0.2%
Financing Schemes	Government financing Schemes as a % of CHE	60.2%	59.3%	59.3%	61.8%
	Voluntary Health Insurance Schemes as a % of CHE	5.6%	5.7%	8.6%	9.1%
	Out of Pocket (OOP) Expenditure as a % of CHE	29.4%	28.9%	27.9%	25.3%
Health Functions	Curative care as a % of CHE	42.0%	41.9%	41.5%	40.9%
	Inpatient care as a % of Curative care	47.8%	45.7%	40.5%	40.6%
	Outpatient care as a % of Curative care	52.2%	54.3%	59.5%	59.4%
	Preventive care as a % of CHE	14.2%	16.7%	22.9%	25.0%
Health Providers	Hospital spending as a % of CHE	49.5%	46.6%	45.6%	46.3%
	Ambulatory health care as a % of CHE	15.8%	17.5%	22.8%	21.5%
	Medical goods as a % of CHE	18.3%	17.6%	14.4%	11.7%
Factors of Provision	Expenditure on Government Human Resources as a % of CHE	37.3%	35.3%	34.7%	37.5%
	Expenditure on Government Human Resources as a % of GCHE	61.9%	59.6%	59.6%	62.1%
Capital formation	Capital expenditure as a % of CHE plus capital spending	6.2%	5.5%	8.3%	9.5%
	Government capital expenditure as a % of GHE	7.4%	5.9%	8.4%	11.3%

# 1. Background

## 1.1. About this Report

This report records health expenditure in Fiji using the System of Health Accounts (SHA) 2011 framework.

There have been some improvements in estimation techniques since the first attempt made by the National Health Accounts (NHA) Committee in using SHA 2011 methodology (used in the 2011 & 2012 NHA report). Thus readers will note that expenditure figures reported here for the years 2011 & 2012 differ from that presented in the last NHA report for the years 2011 & 2012.

The report makes an effort to provide health expenditure in Fiji by understanding and analyzing the following:

- Funding Sources or Revenue of Financing Schemes (FS) – actual source of raising revenue such as domestic revenue (government revenue), direct bilateral transfer (development partner funding).
- Health Care Financing Schemes (HF) – Modes of financing and providing health services such as through central Government.
- Health Care Providers (HP) – Encompasses organizations and actors that deliver health care goods and services as their primary activity.
- Health Care Functions (HC) – The type of health services performed and types of goods consumed.
- Factors of Production (FP) - Focus on expenditure by inputs into the production process such as salaries and wages, travel and communication, repairs and maintenance.
- Capital Expenditure (HK) – Investment in infrastructure through construction and procurement.
- Disease Based Costing (DBC) – expenditure based on International Classification of Disease -10 Australian Modifications (ICD-10AM).

## 1.2. Structure of the Health Sector and the Flow of Funds

### 1.2.1. Structure of health sector

The Ministry of Health and Medical Services (MoHMS) is responsible for providing clinical and preventative healthcare services. Clinical services are mainly provided at the hospitals and some health centres; whilst the preventative healthcare services are through preventive



care programs, hospitals, health centres and nursing stations. Healthcare services are implemented through a decentralized health system that caters for integrated health care at primary, secondary and tertiary care level. The administration and management of human resources, finance and drugs & medical supplies, are centralized.

The MoHMS provides health services to all the population of Fiji through hospitals, health centres and nursing stations. Medical Superintendents (MSs) are responsible for the Clinical services in the divisional and specialized hospitals while subdivisional hospitals, health centres and nursing stations are managed by Divisional Medical Officers (DMOs). The DMOs report directly to the Deputy Secretary Public Health (DSPH) whereas the MSs report to the Deputy Secretary Hospital Services (DSHS).

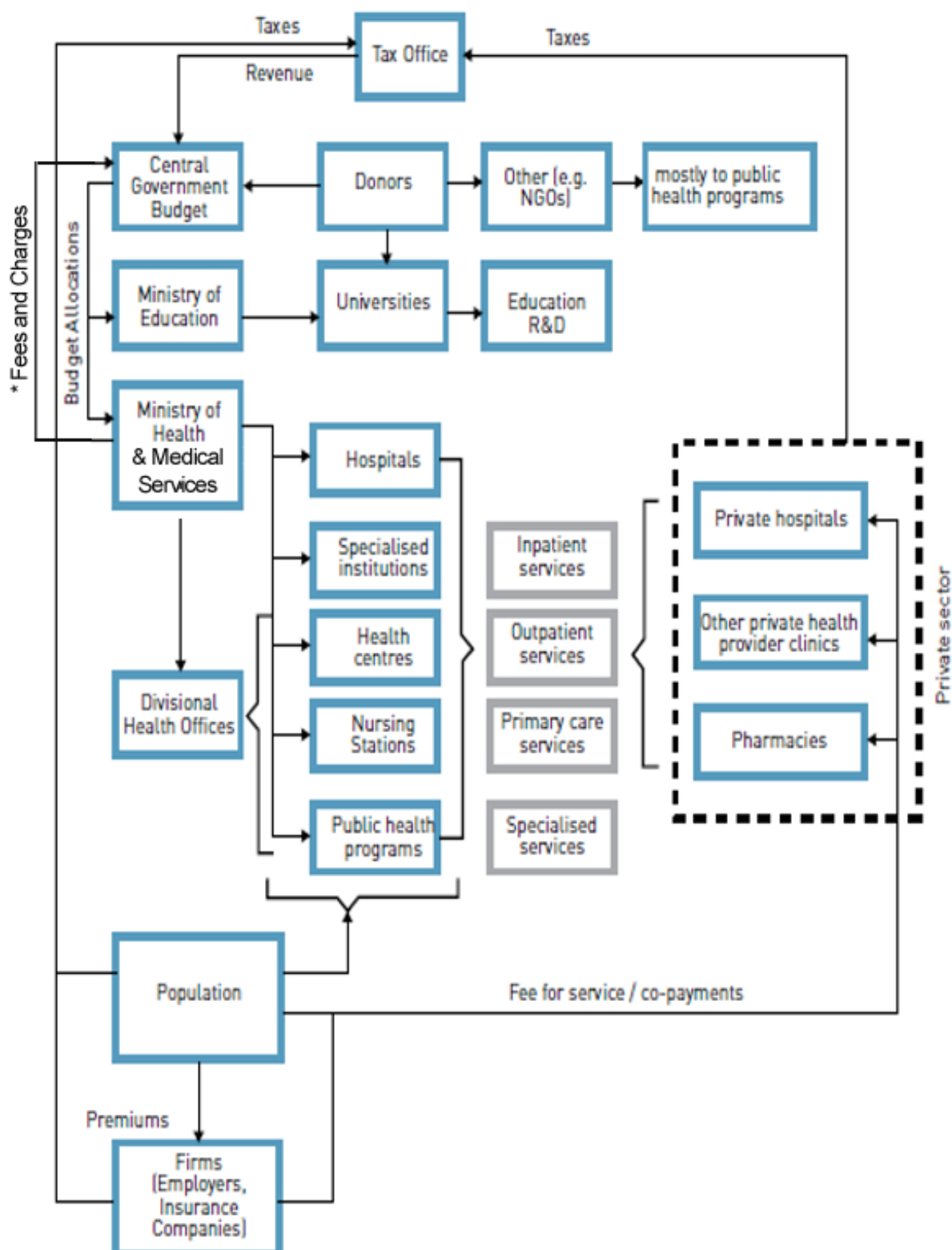
Eighteen sub-divisional hospitals also provide primary and secondary level clinical and preventive health services within a designated medical area that also has health centres and nursing stations under each of the health facility providing primary health care services.

There are three specialized hospitals providing specialized health services namely, St. Giles for psychiatry, P.J Twoomey Hospital for Tuberculosis (TB) and Leprosy and the Tamavua Rehabilitation Centre to restore good health through therapy. Private sector provision of healthcare services consists mainly of outpatient services through general practitioners, inpatient services primarily through two private hospitals and the sale of medicines by retail pharmacies.

### **1.2.2. Flow of funds**

A major change in tracking the flow of funds towards health in SHA 2011 is the identification of the actual source of how revenue was raised and collected by responsible agencies (Revenue Source) in addition to the institution that manages and distributes funds (Financing Agents). SHA 2011 apart from demonstrating that majority of the public health sector funding in Fiji is financed by Government, also explores in detail how revenue is generated and collected. Furthermore, SHA 2011 also describes the distribution of household or business/corporate taxes, Development Partner grants and transfers and government taxation through various modes of delivery schemes which could also be through central government schemes, insurance schemes or directly through household out of pocket expenses. The funds are also tracked to providers of health care and their functions as per depicted in Figure 1-1.

Figure 1-1 The Flow of funds in the FIJI Ministry of Health and Medical Services Care System



\*Fees and Charges – relates to all types of hospitals fees, fumigation and quarantine charges collected by MoHMS

Source: Asia Pacific Observatory on Health Systems and Policies (Section 3: Financing, Fiji Health in Transition (HiT) Report)

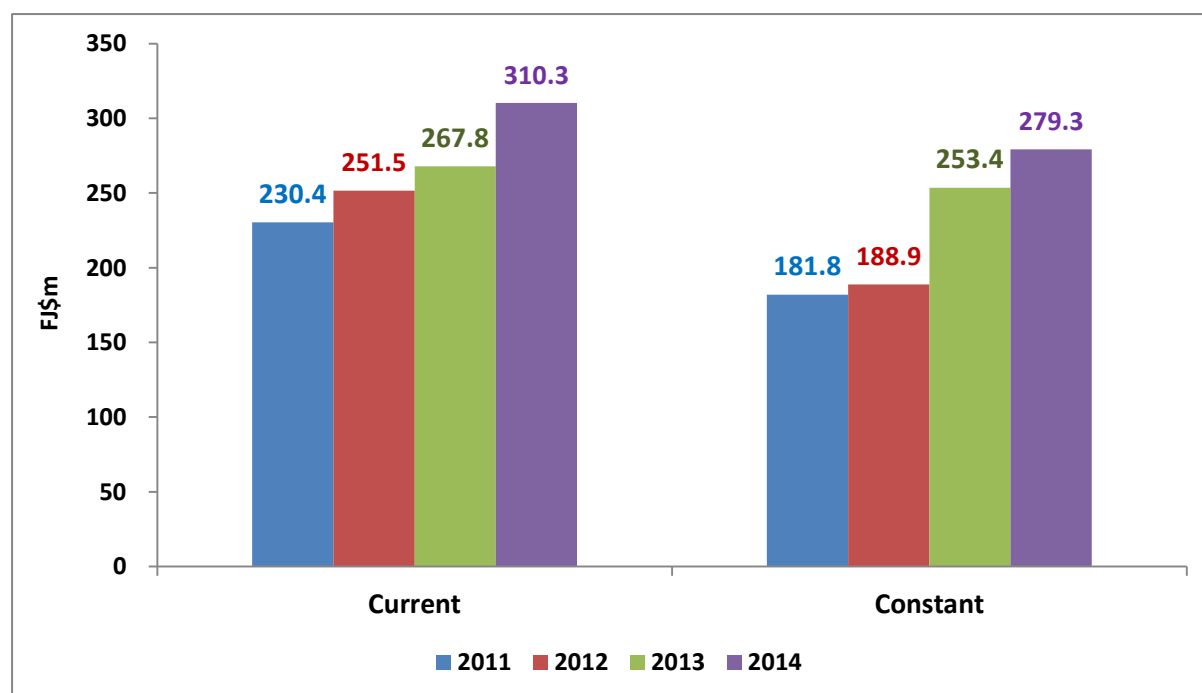
## 2. Current Health Expenditure

According to System of Health Accounts (SHA) 2011 the aggregate Current Health Expenditure (CHE) combines in a single figure the monetary value of the final consumption of all health care goods and services. CHE equals final consumption expenditure on health care goods and services by residents (individuals or organizations) of a given country during a given period. CHE excludes capital expenditure on health care.

### 2.1. Trends in CHE

CHE has increased over the four years (2011 to 2014). In nominal (current) terms CHE has increased by 34.7% and in constant (real) terms CHE has increased by 53.6% for the same period (refer to Figure 2-1).

Figure 2-1 Current Health Expenditure (current and constant prices)



Source Table 2-1

**Table 2-1 CHE at Current and Constant Prices and Growth Rates**

Year	Amount (FJ\$m)		Growth Rate over Previous Year (%)	
	Current	Constant <sup>(a)</sup>	Current	Constant
2011	230.4	181.8	0.0%	0.0%
2012	251.5	188.9	9.1%	5.7%
2013	267.8	253.4	6.5%	4.1%
2014	310.3	279.3	15.9%	10.2%

(a) Constant prices are calculated using the implicit GDP deflator (2011=100).

## 2.2. Current Health Expenditure in Relation to GDP

The ratio of Fiji's CHE to its Gross Domestic Product (GDP) provides an indication on the proportion of the health sector contributing to the overall economic activity. Over the four years (2011 to 2014), health spending as a ratio of GDP averaged 4.2% (Table 2-2).

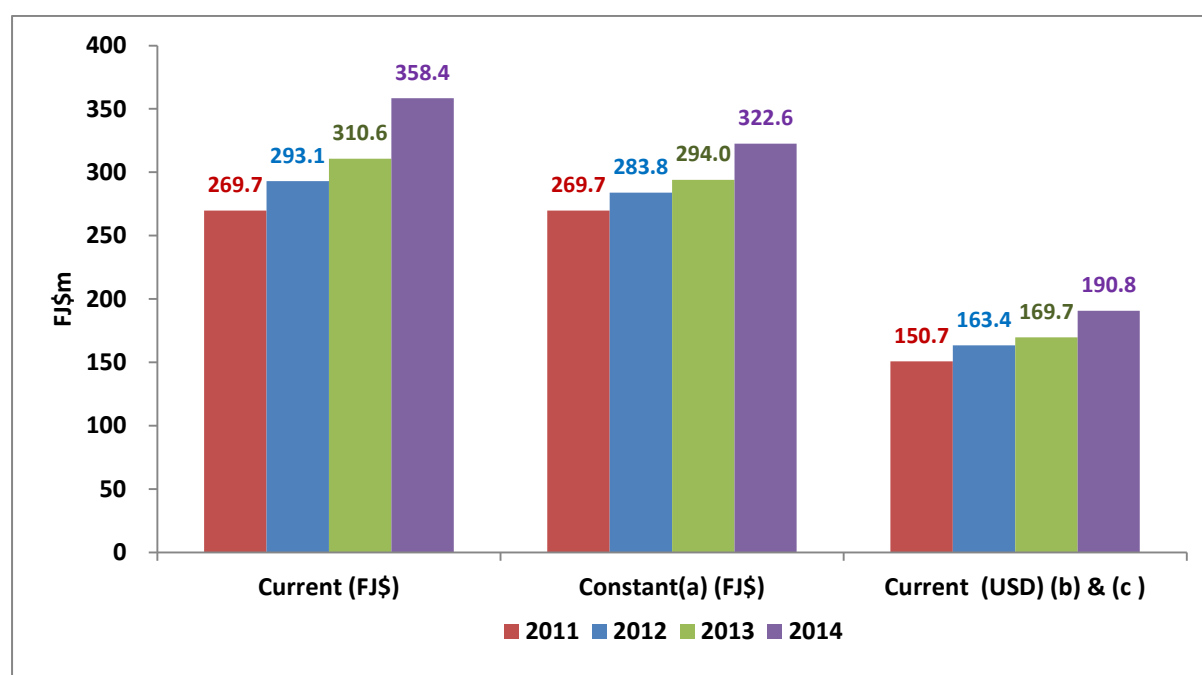
**Table 2-2 CHE, GDP, Annual Growth Rates and Share of Health on GDP**

Year	Current Health Expenditure		GDP		Ratio of CHE to GDP (%)
	Amount (FJ\$m)	Nominal Growth Rate (%)	Amount (FJ\$m)	Nominal Growth Rate (%)	
2011	230.4	0.0%	5,738.8	0.0%	4.0%
2012	251.5	9.1%	6,010.1	4.7%	4.2%
2013	267.8	6.5%	6,440.0	7.2%	4.2%
2014	310.3	15.9%	7,129.8	10.7%	4.4%

## 2.3. Current Health Expenditure per Capita

As the population grows, and demands for improved healthcare also rise, health expenditure in most countries increase correspondingly. It is useful to examine on average how much is spent per person on health. Figure 2-2 shows the trend of how much is spent per person on health. Per capita CHE in real terms recorded a significant increase of 51.6% over the four years (2011 to 2014). In US dollar terms the per capita health expenditure increased by 26.6% for the same period.

Figure 2-2 Per Capita Current Health Expenditure (CHE)



Source: Table 2-3

Table 2-3 Per Capita CHE and GDP

Year	Current Health Expenditure per Capita				GDP per Capita		
	Current (FJ\$)	Constant(a) (FJ\$)	Current (USD) (b) & (c)	Real Growth Rate (%)	Current (FJ\$m)	Constant (FJ\$m)	Current (USD)
2011	269.7	269.7	150.7	0.0%	6,718	6,718	3,753
2012	293.1	283.8	163.4	5.2%	7,004	6,783	3,906
2013	310.6	294.0	169.7	3.6%	7,470	7,071	4,081
2014	358.4	322.6	190.8	9.7%	8,236	7,413	4,383

(a) Constant prices are calculated using the implicit GDP deflator (2011=100).

(b) USD Conversion: 2011- USD\$1=FJD\$1.79 and 2012 - USD\$1=FJD\$1.79

(c) USD Conversion: 2013- USD\$1=FJD\$1.83 and 2014 - USD\$1=FJD\$1.88

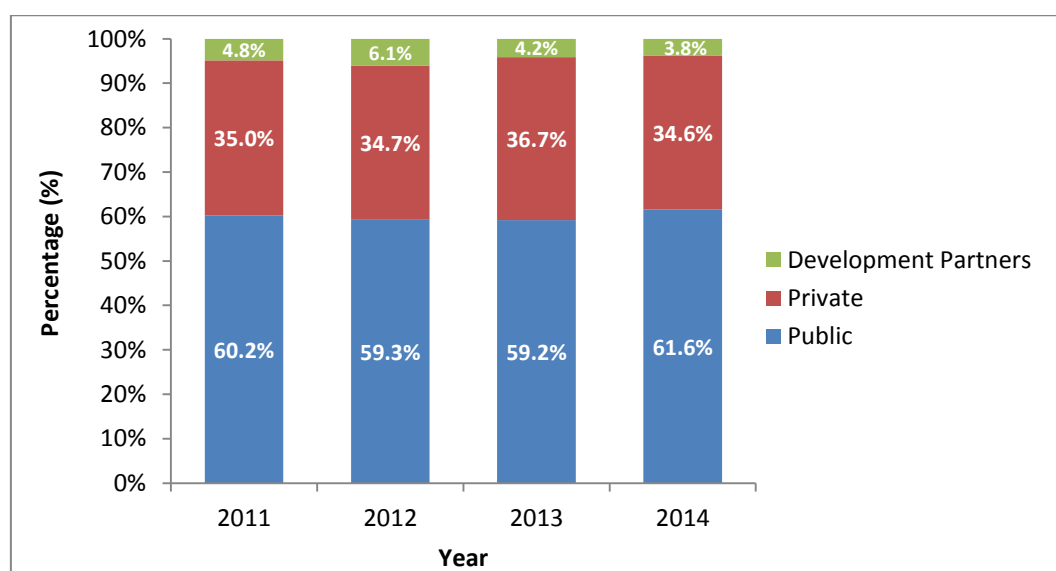
### 3. Financing of Current Health Expenditure

The revenues of health financing schemes (FS) describes i) the contribution mechanisms the particular financing schemes use to raise their revenues, and ii) the institutional units of the economy from which the revenues are directly generated.

#### 3.1. Revenues of Financing Schemes

The primary source of revenue over the four years (2011 to 2014) for the health sector comes from the central Government budget (public). The other sources of funding are the private sector and development partners. Figure 3-1 provides the share of funding from the three sources over the four years (2011 to 2014).

Figure 3-1 Current Health Expenditure by Financing Source



Source: Table 3-1

Table 3-1 Current Health Expenditure by Financing Source

Year	Current Health Expenditure (FJ\$m)			Share of Current Health Expenditure (%)			Total	Current Health Expenditure as a Share of GDP (%)			
	Public	Private	Development Partners	Public	Private	Development Partners		Public	Private	Development Partners	Total
2011	138.7	80.6	11.1	60.2%	35.0%	4.8%	100%	2.4%	1.5%	0.2%	4.0%
2012	149.1	87.2	15.2	59.3%	34.7%	6.1%	100%	2.5%	1.5%	0.3%	4.2%
2013	158.5	98.1	11.1	59.2%	36.7%	4.2%	100%	2.5%	1.5%	0.2%	4.2%
2014	191.1	107.3	11.9	61.6%	34.6%	3.8%	100%	2.7%	1.5%	0.2%	4.4%

As per Table 3-1, CHE increased in dollar terms over the four years (2011 to 2014) across all sources with their proportions as a share of CHE remaining relatively steady.

## 3.2. Financing Schemes

SHA 2011 defines health care financing schemes as the types of financing arrangements through which people obtain health services or get access to health care.

Health care financing schemes include direct payments by households for services and goods and third-party financing arrangements. Third party financing schemes are distinct bodies of rules that govern the mode of participation in the scheme, the basis for entitlement to health services and the rules on raising and then pooling the revenues of the given scheme e.g. health insurance schemes.

**Table 3-2 Current Health Expenditure by Financing Schemes (FJ\$m)**

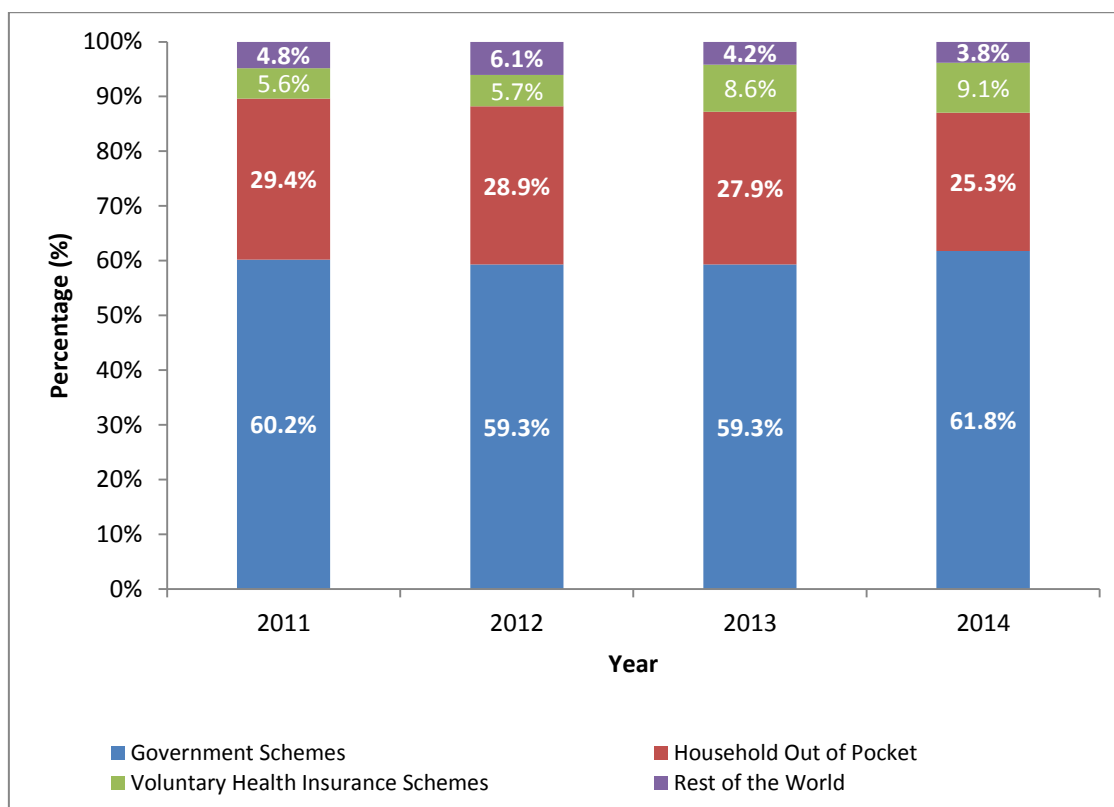
Table 3-2 shows the funding by financing schemes over the four year period (2011 to 2014).

Category	2011	2012	2013	2014
	Amount (FJ\$m)	Amount (FJ\$m)	Amount (FJ\$m)	Amount (FJ\$m)
<b>Government Schemes</b>	<b>138.7</b>	<b>149.1</b>	<b>158.9</b>	<b>191.6</b>
Ministry of Health and Medical Services	138.7	149.1	156.1	187.8
Ministry of Defence*	0.0	0.0	2.8	3.8
<b>Voluntary Health Insurance Schemes</b>	<b>12.8</b>	<b>14.5</b>	<b>23.1</b>	<b>28.3</b>
Employer-based insurance (other than enterprises schemes)	5.3	6.3	13.8	17.1
Other primary coverage schemes	7.5	8.2	9.3	11.3
<b>Household Out-of-pocket (OOP)</b>	<b>67.8</b>	<b>72.7</b>	<b>74.6</b>	<b>78.5</b>
<b>Rest of the World (Development Partners)</b>	<b>11.1</b>	<b>15.2</b>	<b>11.1</b>	<b>11.8</b>
<b>Total</b>	<b>230.4</b>	<b>251.5</b>	<b>267.8</b>	<b>310.3</b>

\* Ministry of Defence information was not surveyed for years 2011 and 2012

Figure 3-2 provides the share of financing schemes. Government remains the major scheme followed by Household Out-of-pocket (OOP), Voluntary Health Insurance and Development partners (classified as Rest of the World). Except for development partners, expenditure for the rest of the schemes increased over the four year period (2011 to 2014).

**Figure 3-2 Current Health Expenditure by Financing Scheme (%)**



Source: Table 3-2



## 4. Current Health Expenditure by Providers

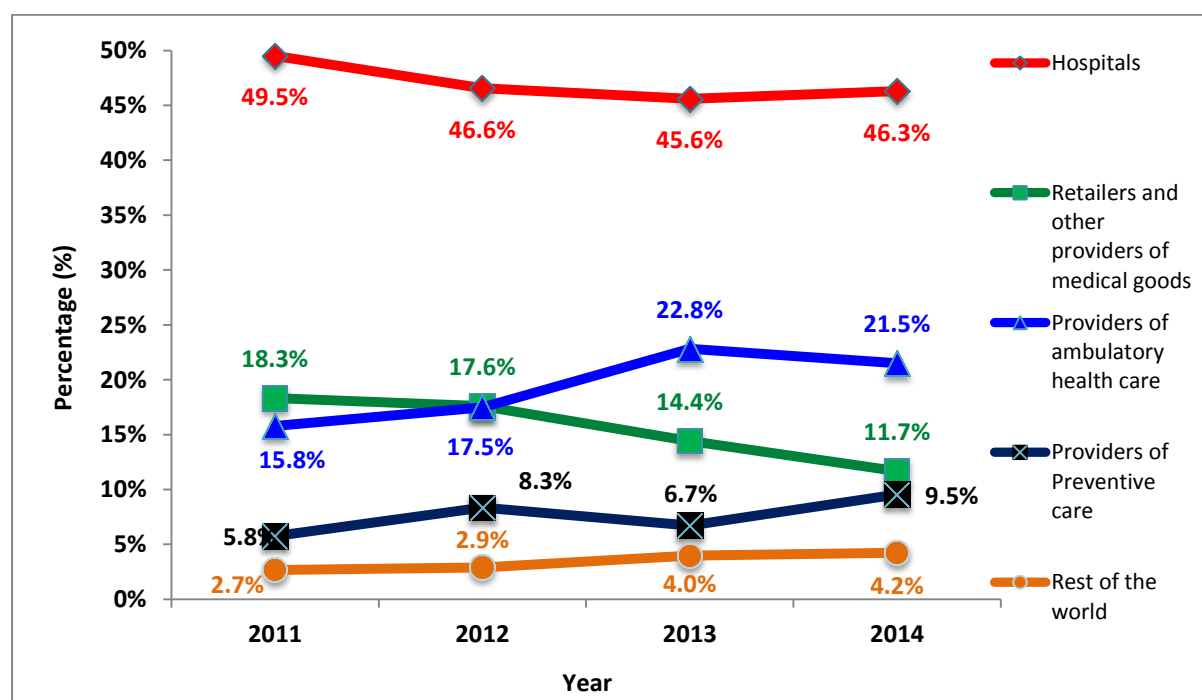
The Health Care Providers (HP) classification encompasses organizations and actors that deliver health care goods and services as their primary activity, as well as those for which health care provision is only one among a number of activities (SHA 2011).

### 4.1 Health care Providers

Hospitals, Retailers and other providers of medical goods, and Providers of ambulatory health care remain the top three Health Care Providers in Fiji in terms of expenditure over the period 2011 to 2014.

The largest expenditure in the public sector is from Hospitals and Providers of Ambulatory health care (health centres & nursing stations) while in the private sector, it is Retailers and other providers of medical goods and also Providers of Ambulatory health care (private general practitioners, dentists, and optometrists). Providers of Preventive care are mostly from the public sector.

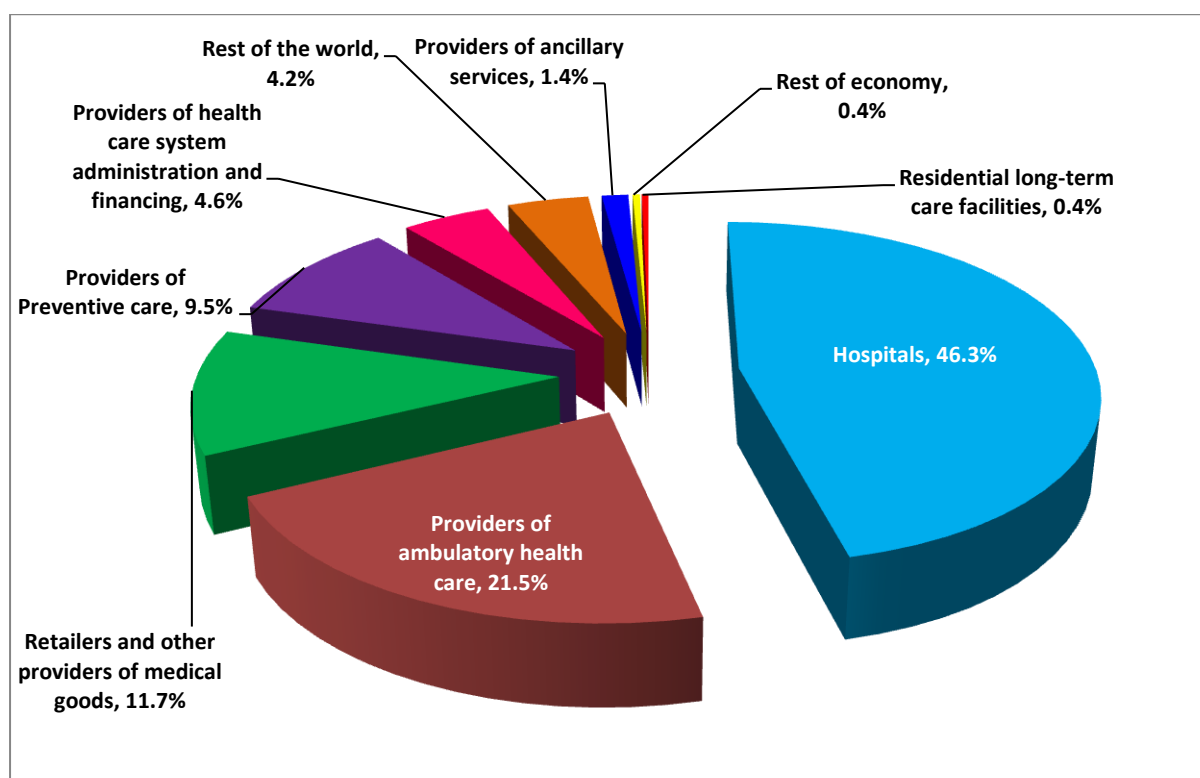
Figure 4-1 Share of Current Health Expenditures by Providers (%)



Source: Table 4-1

Expenditure in all health providers increased over the period 2011 to 2014. In 2014, the largest expenditure was on hospitals and the lowest expenditure was on Residential long-term care facilities (refer Figure 4-2).

Figure 4-2 Share of Current Health Expenditures by Providers (%), 2014



Source: Table 4-1

Table 4-1 Current Health Expenditure by Providers (FJ\$m)

Providers	2011	2012	2013	2014
Hospitals	114.1	117.1	122.1	143.7
Residential long-term care facilities	0.7	0.8	0.8	1.1
Providers of ambulatory health care	36.4	44.0	61.1	66.7
Providers of ancillary services	2.0	2.2	3.3	4.3
Retailers and other providers of medical goods	42.2	44.2	38.6	36.2
Providers of Preventive care	13.3	21.0	18.0	29.6
Providers of health care system administration and financing	12.1	12.9	12.3	14.4
Rest of economy	3.4	1.9	0.9	1.2
Rest of the world	6.1	7.3	10.6	13.2
<b>Total</b>	<b>230.4</b>	<b>251.5</b>	<b>267.8</b>	<b>310.3</b>

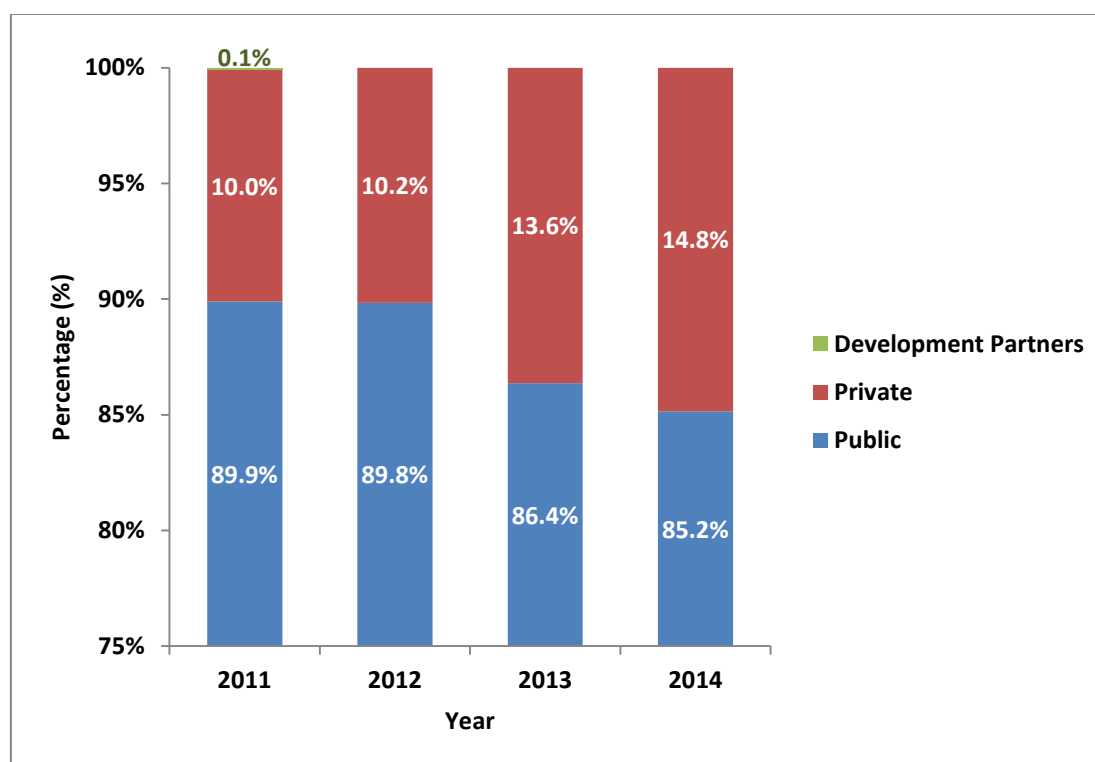
## 4.2 Hospital Expenditure

Majority of the Hospital expenditure is funded by Government sources. At an average Hospital expenditures are 47.0% of the CHE over the period -2011 to 2014.

Figure 4-3 highlights the share of CHE incurred at hospitals by financing sources. The share of public expenditure decreased from 89.9% in 2011 to 85.2% in 2014 however in dollar

terms this increased by FJ\$19.8m over the same period. Private sector expenditure increased from 10.0% in 2011 to 14.8% in 2014; in dollar terms this increased by FJ\$9.9m over the same period.

**Figure 4-3 Share of Current Health Expenditure at Hospitals by Financing Source**



Source: Table 4-2

**Table 4-2 Current Health Expenditure at Hospitals by Financing Source**

Year	Public	Private	Development Partners	Total
	FJ\$m	FJ\$m	FJ\$m	FJ\$m
2011	102.6	11.5	0.1	114.1
2012	105.2	11.9	0.0	117.1
2013	105.4	16.6	0.0	122.1
2014	122.3	21.3	0.0	143.7
	Share (%)	Share (%)	Share (%)	
2011	89.9%	10.0%	0.1%	100%
2012	89.8%	10.2%	0.0%	100%
2013	86.4%	13.6%	0.0%	100%
2014	85.2%	14.8%	0.0%	100%

### 4.3 Non-Hospital Expenditure

Non-Hospital expenditures include all other providers (e.g. Ancillary services, Ambulatory care, Preventive care programmes) except for Hospitals. At average Non-Hospital expenditures was 53.0% of the CHE over the period 2011 to 2014. Much of Non-hospital spending was by the Providers of Ambulatory health care, such as private general practitioners and private dentists. The expenditures by these providers have almost doubled from FJ\$36.4m or 15.8% of CHE in 2011 to FJ\$66.7m or 21.5% of CHE in 2014. Retailers and other providers of medical goods also recorded high expenditure although this has declined from FJ\$42.2m or 18.3% in 2011 to FJ\$36.2m or 11.7% in 2014 (refer Table 4-1 and Figure 4-1).

Providers of Preventive care consist of various health programmes. The expenditure on Preventive care has doubled from FJ\$13.3m or 5.8% of CHE in 2011 to FJ\$29.6m or 9.5% of CHE in 2014 (refer Table 4-1 and Figure 4-1).

## 5. Current Health Expenditure by Function

Health expenditure by function simply means "for what services and goods has the health money been spent". The analysis by function systematically classifies the purposes or functional uses of health expenditures and is important for any health system – it delivers information to the policy level. For example on how the relation between inpatient and outpatient care is, or how much was spent on preventive care and on government administration. Health expenditure by function provides a platform for policy makers to move from input based to output based health service delivery.

Table 5-1 shows the distribution of Current Health Expenditure (CHE) by health care functions from 2011 to 2014. Except for Medical goods which recorded marginal decline in expenditure, there was rise in expenditure for all other functions over the period 2011 to 2014.

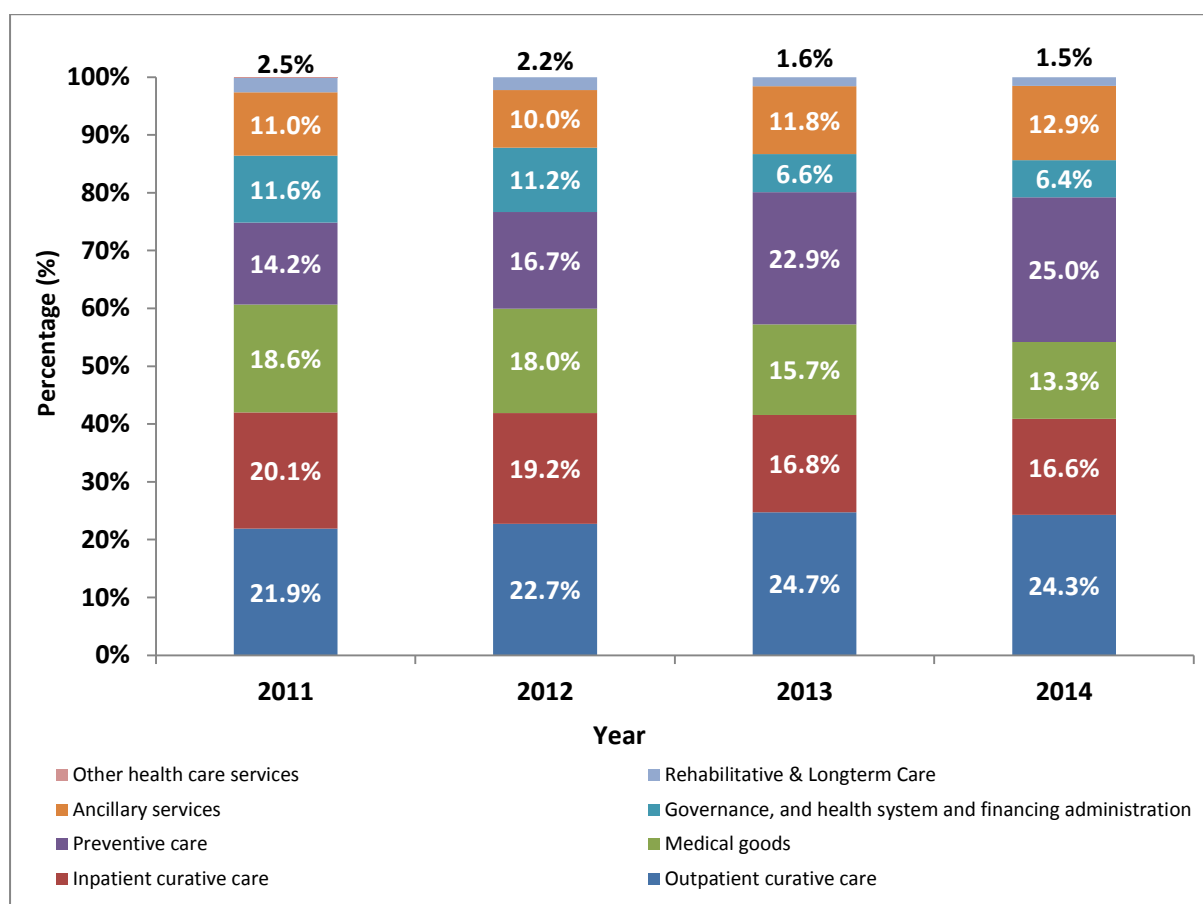
**Table 5-1 Current Health Expenditure by Function (FJ\$m), 2011 to 2014**

Health Care Functions	2011	2012	2013	2014
Inpatient curative care	46.5	48.5	45.1	51.5
Outpatient curative care	50.4	57.2	66.2	75.3
Rehabilitative & Long-term Care	5.9	5.5	4.2	4.7
Ancillary services (a)	25.2	25.1	31.5	39.9
Medical goods	43.0	45.4	42.0	41.3
Preventive care	32.6	42.1	61.3	77.6
Governance, and health system and financing administration	26.7	28.1	17.5	19.9
Other health care services	0.2	0.0	0.0	0.0
<b>Total</b>	<b>230.4</b>	<b>251.5</b>	<b>267.8</b>	<b>310.3</b>

(a) Ancillary services to health care include laboratory and imaging services

Figure 5-1 shows that expenditure on outpatient curative care is more than inpatient curative care. The increase in outpatient care expenditure is largely due to the increase in private health expenditure over the years. The expenditure on preventive care has also increased by FJ\$45.0m in 2014 from 2011 and accounted for 14.5% of CHE (refer Table 5-1).

**Figure 5-1 Current Health Expenditure by Functions (%), 2011 to 2014**



Source: Table 5-1

## 5.1. Curative (Inpatient and Outpatient) Care Services

The largest part of health spending by function is for curative care (inpatient and outpatient care services) as shown in Table 5-1.

Curative health care expenditure has been increasing over the years in dollars terms (refer Table 5-1) but declining as a proportion of CHE. Curative health care expenditure was 43.0% of CHE in 2011, and has marginally decreased to 40.9% in 2014. Curative care expenditure in 2014 was made up of 16.6% inpatient and 24.3% outpatient of CHE (refer Table 5-1). In 2013, 16.8% of the curative care was inpatient care and 24.7% was outpatient care of CHE. Thus an increase in outpatient care and a marginal decrease in inpatient care as a share of CHE.

Table 5-2 reflects that curative care is mainly financed by public sector. Inpatient care is primarily financed by public sector with the share declining over the years. Similarly, the outpatient care is also largely financed by public sector. Over the years the share of private

sector for curative care has increased even though private spending has decreased slightly over time as a proportion of overall CHE.

**Table 5-2 Share of Curative Expenditure by Function (%), 2011 to 2014**

Year	Inpatient		Outpatient	
	Public	Private	Public	Private
2011	86.4%	13.6%	57.9%	42.1%
2012	86.5%	13.5%	56.9%	43.1%
2013	80.2%	19.8%	52.0%	48.0%
2014	79.7%	20.3%	50.9%	49.1%

Note: Private expenditure also includes Development partners

## 5.2. Medical Goods

Medical goods include pharmaceutical and therapeutic appliances and comprise the sales of medicines and other medical goods from private pharmacies and other retailers. Under the SHA guidelines, public expenditure on pharmaceuticals during an inpatient/outpatient episode of care is categorized as curative expenditure. Therefore drug consumption under government facilities are coded to inpatient and outpatient care and not included under this category. Thus the expenditure on medicines and medical goods included in this category accounts mainly for retail sales by private pharmacies.

Over the period 2011 to 2014 the expenditure on medical goods as a proportion of CHE fluctuated between years and has decreased from 18.6% in 2011 to 13.3% in 2014 (refer Figure 5-1). However, the expenditure in dollar terms has been fairly stable on average was approximately FJ\$43.0m. Fiji spent maximum of FJ\$45.4m in 2012 and minimum of FJ\$41.3m in 2014 on medical goods to outpatients (Table 5-3).

**Table 5-3 Medical goods Expenditure by Subclasses, 2011 to 2014**

Functions	2011		2012		2013		2014	
	FJ\$m	Share (%)	FJ\$m	Share (%)	FJ\$m	Share (%)	FJ\$m	Share (%)
Prescribed medicines	24.6	57.3%	26.0	57.4%	24.2	57.7%	24.3	58.9%
Over-the-counter medicines	13.0	30.4%	13.7	30.3%	12.3	29.4%	11.2	27.0%
Other medical non-durable goods	5.1	11.9%	5.4	11.9%	2.7	6.4%	2.6	6.3%
Glasses and other vision products	0.0	0.0%	0.0	0.0%	1.6	3.9%	1.7	4.2%
All other medical durables, including medical technical devices	0.2	0.4%	0.2	0.5%	1.1	2.7%	1.5	3.6%
<b>Total</b>	<b>43.0</b>	<b>100%</b>	<b>45.4</b>	<b>100%</b>	<b>42.0</b>	<b>100%</b>	<b>41.3</b>	<b>100%</b>

Table 5-3 shows expenditure on medical goods by subclasses from 2011 and 2014. It reflects that expenditure on medical goods spent on prescribed medicines has been fairly stable. In 2014, 58.9% of expenditure on medical goods was spent on prescribed medicines, while 27.0% on over the counter medicines.

### 5.3. Preventive Care

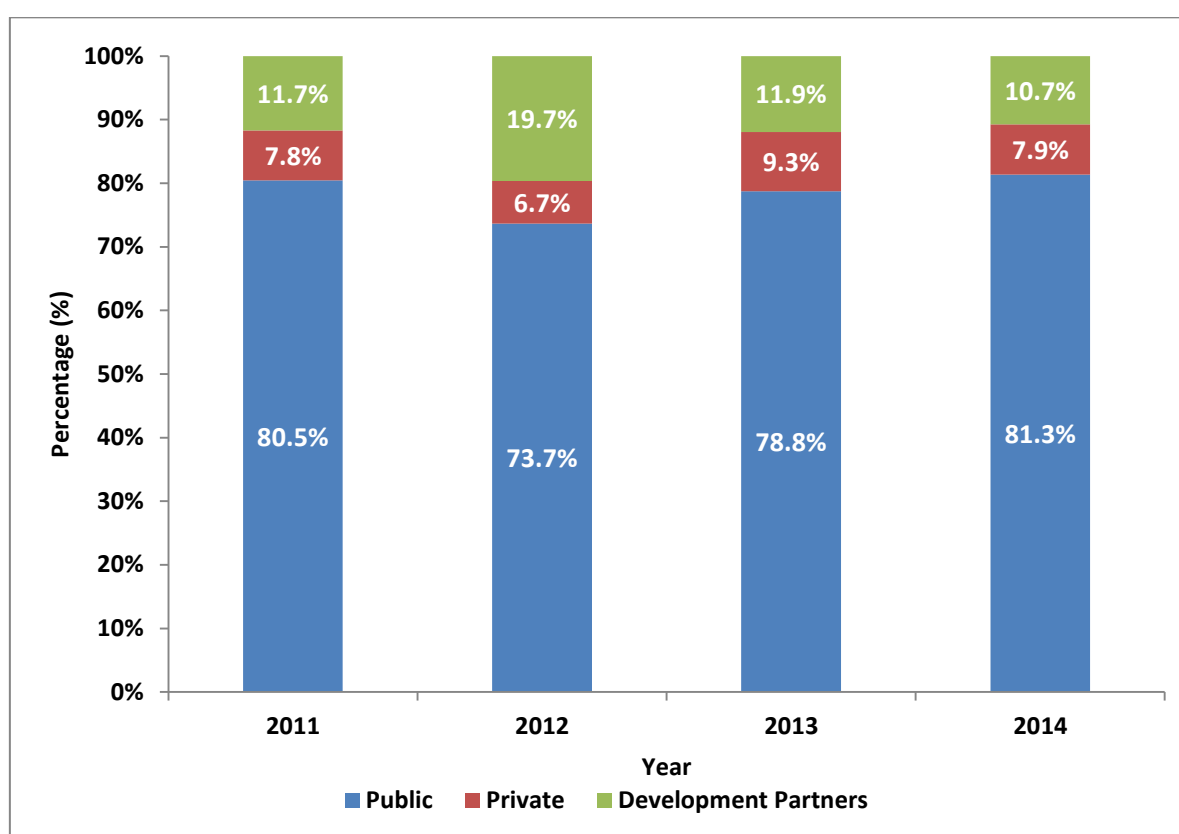
“Preventive care is any measure that aims to avoid the occurrence or the severity of injuries and diseases and their complications. Prevention is based on a health promotion strategy that involves a process to enable people to improve their health through the control over some of its immediate determinants. This includes a wide range of expected outcomes, which are covered through a diversity of interventions, organized as primary, secondary and tertiary prevention level” (SHA 2011). The expenditure mostly includes primary and secondary prevention programmes.

Preventive care expenditures accounted for FJ\$77.6m or 13.3% of CHE in 2014. This signifies a substantial increase in comparison to 2011 (FJ\$32.6m or 18.6%). This increase was due to an increase in both public and private funding for prevention interventions.

Figure 5-2 shows that preventive care is largely funded by public sector (government) and has been fairly stable, on average approximately accounted for 78.6%.



Figure 5-2 Share of Preventive care by Source (%), 2011 to 2014

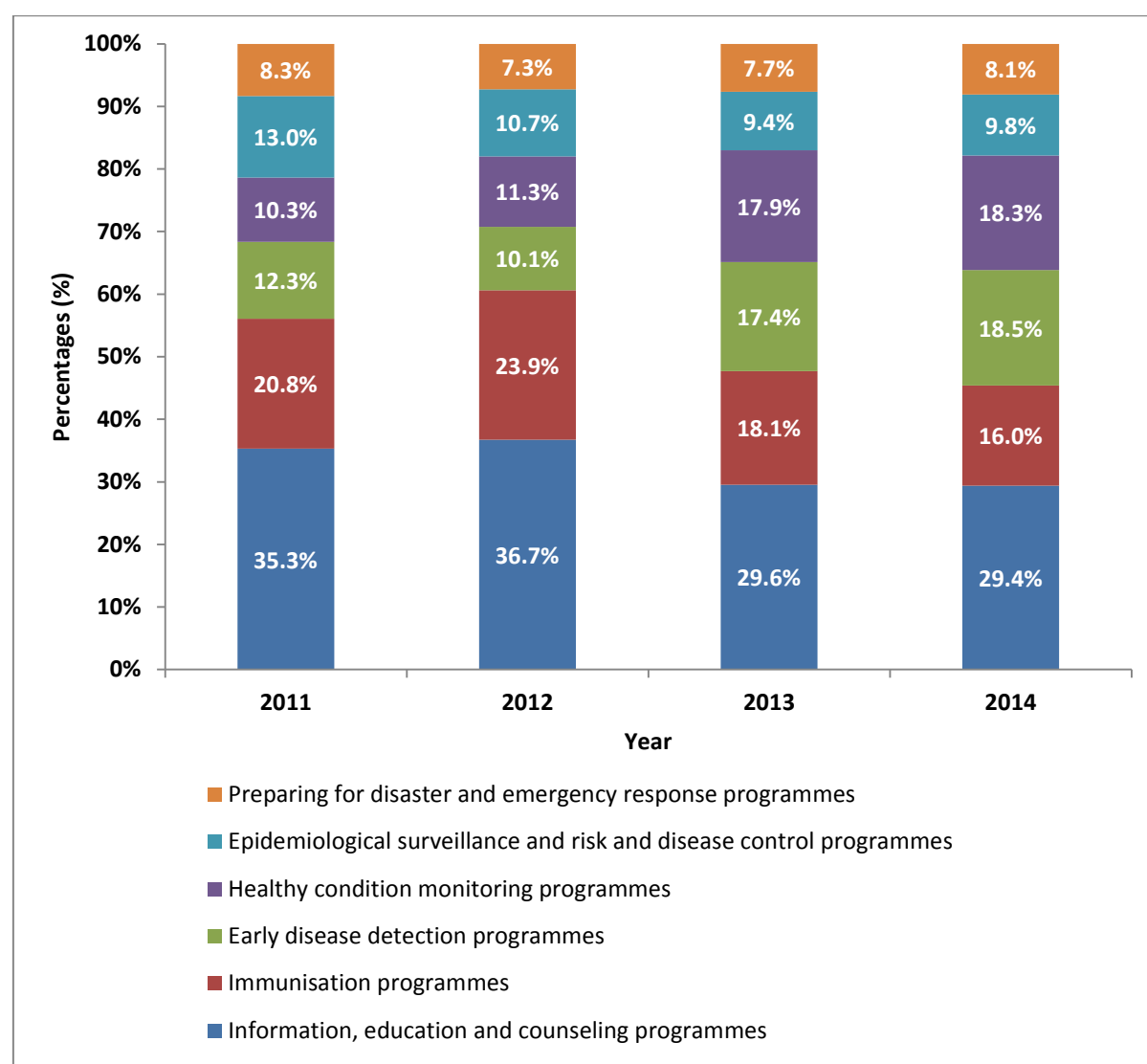


Source: Table 5-5

The expenditure on preventive care across all the categories had increased over the years in dollar terms while as a share of CHE it fluctuated (refer Table 5-4). Figure 5-3 illustrates that approximately on average one third of the preventive care expenditure was spent on information, education and counseling programmes. However, in dollar terms it has increased by FJ\$11.3m from 2011 to 2014 (refer Table 5-4).

The expenditure on early disease detection programmes and healthy condition monitoring programmes also increased over the years both as share and in dollar terms (refer Table 5-4). Furthermore, the expenditure on Epidemiological surveillance and risk and disease control programmes and preparing for disaster and emergency response programmes has been fairly stable as a share of CHE and has increased in dollar terms.

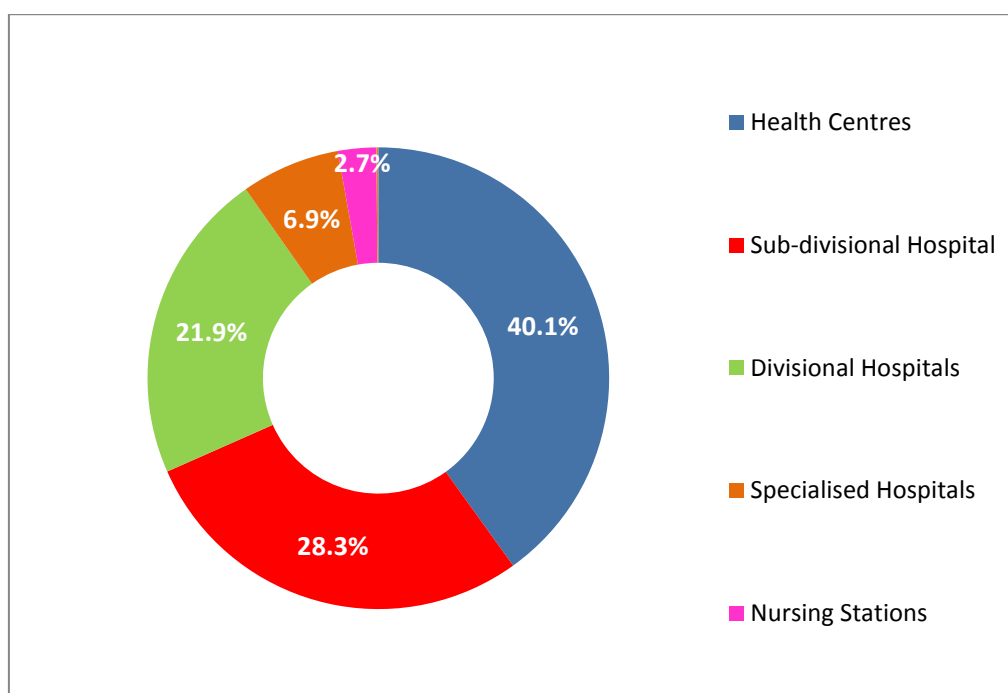
Figure 5-3 Share of Preventive care by categories of service (%), 2011 to 2014



Source: Table 5-5

Figure 5-4 reflects the distribution of preventative care expenditure by health care providers. It shows that preventative care activities exist across the public spectrum of health facilities from tertiary care facilities (Divisional hospitals) to small nurse managed health clinics (Nursing Stations). Health Centres account for the largest proportion of preventative care spending (40.1%) while Nursing Stations the least (2.7%). Close to 57% of preventative care expenditure is incurred at hospitals.

Figure 5-4 Share of Preventive care by providers (%), 2014



**Table 5-4 Preventive care by categories of service (FJ\$m), 2011 to 2014**

Preventative	2011				2012				2013				2014			
	Public	Private	Donor	Total	Public	Private	Donor	Total	Public	Private	Donor	Total	Public	Private	Donor	Total
Information, education and counseling programmes	6.8	2.6	2.1	11.5	8.2	2.8	4.4	15.4	10.3	5.7	2.1	18.1	14.5	6.1	2.2	22.8
Immunization programmes	6.2	0.0	0.5	6.8	8.6	0.0	1.5	10.0	8.7	0.0	2.4	11.1	10.3	0.0	2.1	12.4
Early disease detection programmes	3.9	0.0	0.1	4.0	4.0	0.0	0.3	4.3	9.1	0.0	1.5	10.7	12.3	0.0	2.0	14.3
Healthy condition monitoring programmes	3.1	0.0	0.3	3.4	3.5	0.0	1.2	4.7	10.3	0.0	0.6	11.0	13.6	0.0	0.6	14.2
Epidemiological surveillance and risk and disease control programmes	3.6	0.0	0.6	4.3	4.1	0.0	0.4	4.5	5.2	0.0	0.6	5.7	6.9	0.0	0.7	7.6
Preparing for disaster and emergency response programmes	2.6	0.0	0.1	2.7	2.6	0.0	0.4	3.1	4.6	0.0	0.1	4.7	5.6	0.0	0.7	6.3
<b>Total</b>	<b>26.3</b>	<b>2.6</b>	<b>3.8</b>	<b>32.6</b>	<b>31.0</b>	<b>2.8</b>	<b>8.3</b>	<b>42.1</b>	<b>48.3</b>	<b>5.7</b>	<b>7.3</b>	<b>61.3</b>	<b>63.1</b>	<b>6.1</b>	<b>8.33</b>	<b>77.6</b>

**Table 5-5 Preventive care by categories of service (%), 2011 to 2014**

Preventative	2011				2012				2013				2014			
	Public	Private	Donor	Total	Public	Private	Donor	Total	Public	Private	Donor	Total	Public	Private	Donor	Total
Information, education and counseling programmes	59%	22%	18%	100%	53%	18%	29%	100%	57%	31%	11%	100%	63%	27%	10%	100%
Immunization programmes	92%	0%	8%	100%	85%	0%	15%	100%	79%	0%	21%	100%	83%	0%	17%	100%
Early disease detection programmes	96%	0%	4%	100%	94%	0%	6%	100%	86%	0%	14%	100%	86%	0%	14%	100%
Healthy condition monitoring programmes	92%	0%	8%	100%	74%	0%	26%	100%	94%	0%	6%	100%	96%	0%	4%	100%
Epidemiological surveillance and risk and disease control programmes	86%	0%	14%	100%	91%	0%	9%	100%	90%	0%	10%	100%	91%	0%	9%	100%
Preparing for disaster and emergency response programmes	95%	0%	5%	100%	86%	0%	14%	100%	97%	0%	3%	100%	89%	0%	11%	100%
<b>Total</b>	<b>80%</b>	<b>8%</b>	<b>12%</b>	<b>100%</b>	<b>73%</b>	<b>7%</b>	<b>20%</b>	<b>100%</b>	<b>79%</b>	<b>9%</b>	<b>12%</b>	<b>100%</b>	<b>81%</b>	<b>8%</b>	<b>11%</b>	<b>100%</b>

## 6. Government Current Health Expenditure

Government is the largest source of funding for the provision of health services. This chapter looks at Government Current Health Expenditure (GCHE) and provides details to show where and how the money was being spent.

### 6.1. Government Expenditure on Health

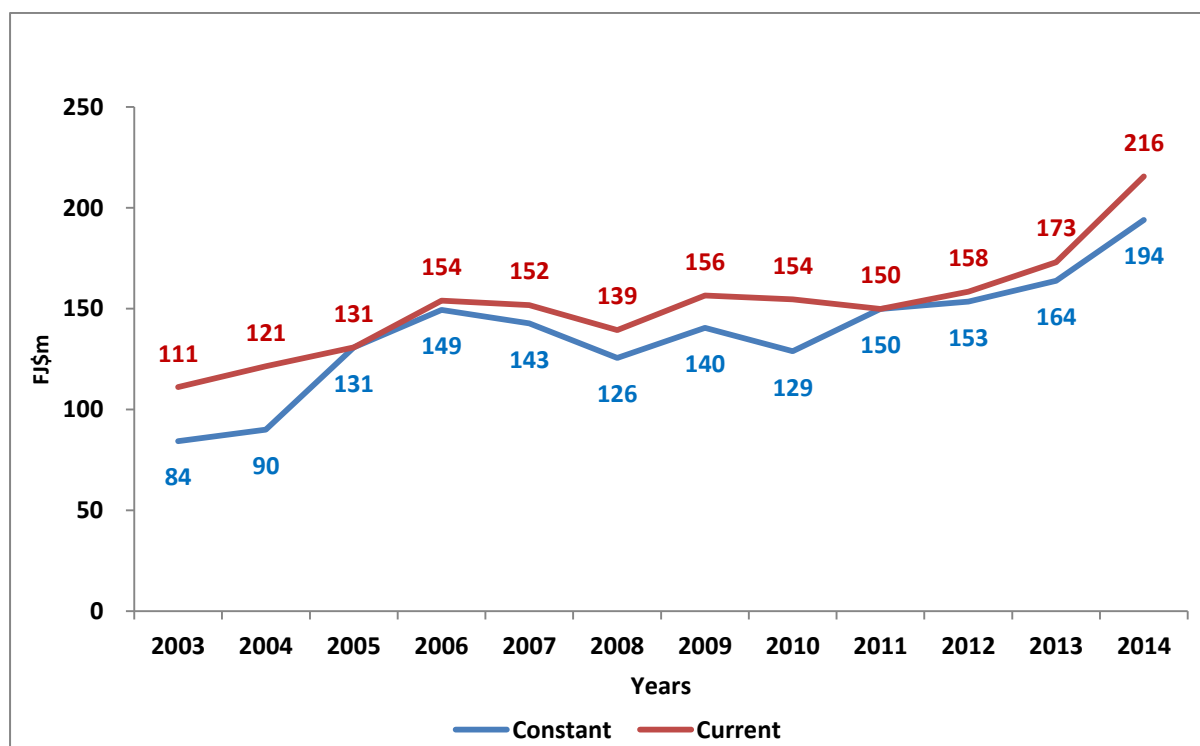
An analysis of Government spending (refer Table 6-1) shows that over the twelve (12) year period, Government Health Expenditure (GHE) which comprises of GCHE plus Capital spending has increased in both nominal value (current) and real value (constant). In real terms this means that Government has been spending high and there has been an escalating trend since 2010. The highest expenditure on health was in 2014 (FJ\$194.0m) over the twelve year period.

**Table 6-1 Government Health Expenditures (FJ\$m)**

Year	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
<b>Current(Nominal)</b>	111	121	131	154	152	139	156	154	150	158	173	216
<b>Constant(Real)</b>	84	90	131	149	143	126	140	129	150	153	164	194

Note: The TGHE values is the summation of GCHE plus capital spending

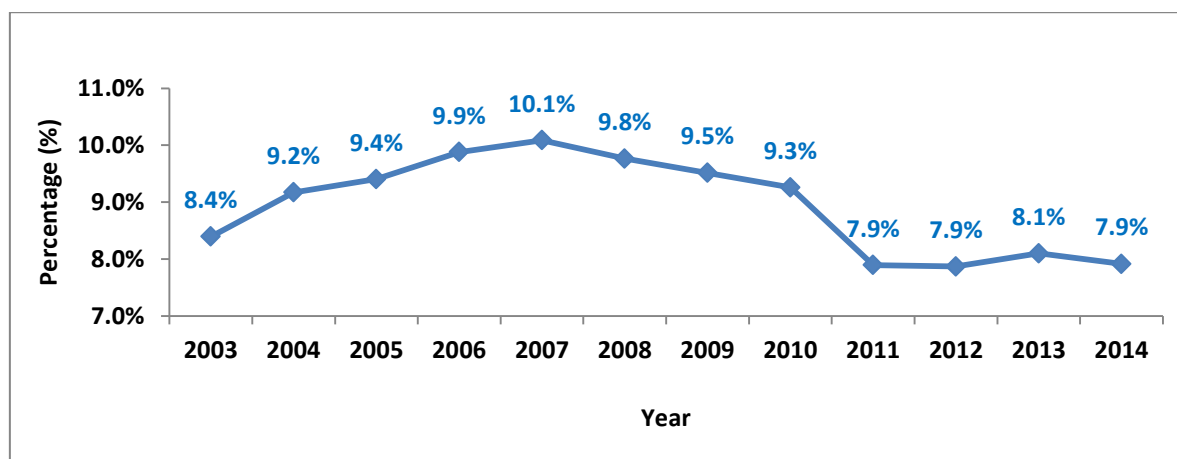
**Figure 6-1 Government Health Expenditure in Real (Constant) and Nominal (Current) value**



Source: Table 6-1

The GHE as a percentage of Total Government Expenditure (TGE) averaged around 9.0% and has remained relatively constant over the period from 2003 to 2014 except in 2011 and 2012 where it dropped to 7.9% (refer Figure 6-2).

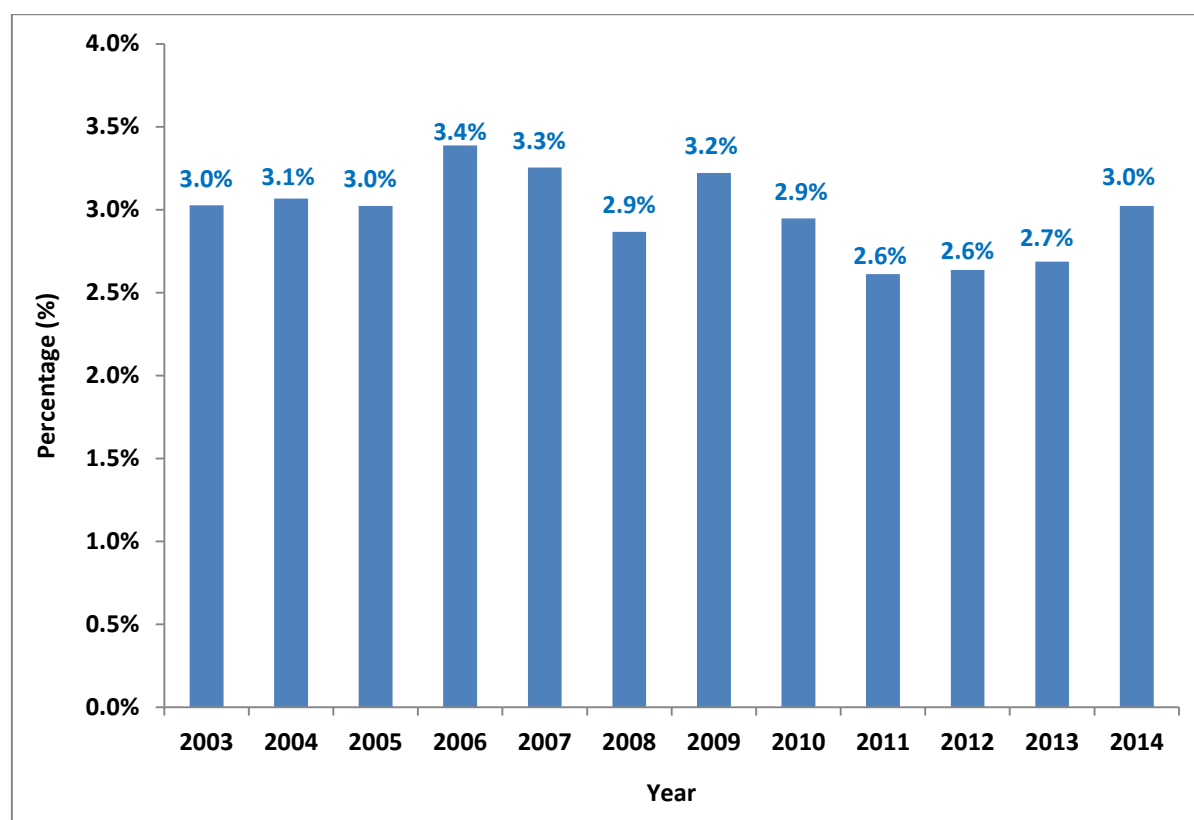
**Figure 6-2 Government Health Expenditure as a Percentage of TGE**



The increase and decrease of the GHE as a percentage of TGE is largely driven by fluctuations in Government revenues (thus affecting the Government fiscal position) over those years, but less aligned with the health status of the population and the increasing (financial) needs for people with chronic diseases. The drop in share for 2011 was a result of a decrease in GHE and increase in TGE.

As a percentage of Gross Domestic Product (GDP), GHE has averaged 3.0% over the period of 2003 to 2014. The percentage has remained relatively constant without any significant increase over the last 10 years (refer Figure 6-3). The WHO states that it is difficult for countries to achieve universal health coverage and equal access to health care if countries spend less than 4-5% of GDP on health (World Health Report 2010).

Figure 6-3 Government Health Expenditure (GHE) as a percentage of GDP



## 6.2. Government Current Health Expenditure by Sources

Government had spent FJ\$158.5m in 2013 and FJ\$191.1m in 2014, an increase of FJ\$32.6m in the GCHE in 2014 over 2013 (refer Table 6-2). This reflects a huge increase from 2013 to 2014 approximately by 20.6% and also the increase is substantial in comparison of Government spending from 2007.

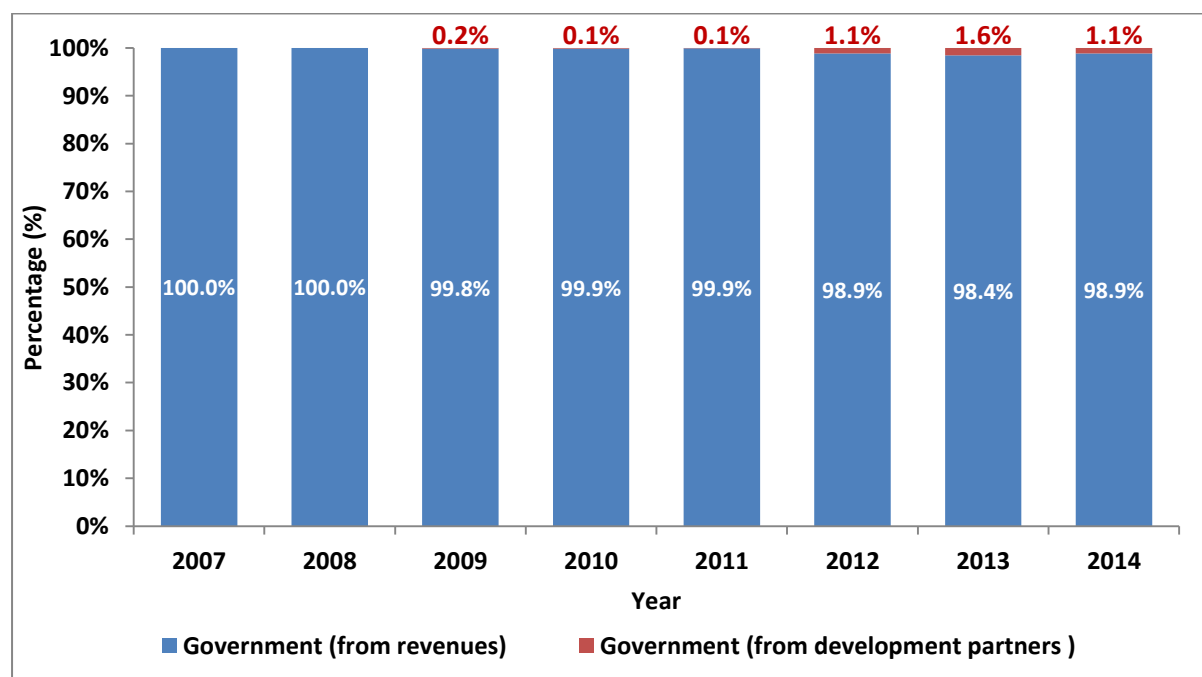
Table 6-2 Sources of Government Current Health Expenditures (FJ\$m)

Sources	2007	2008	2009	2010	2011	2012	2013	2014
Transfers from Government domestic revenue (allocated to health purposes)	146.6	134.5	133.3	142.5	138.6	147.4	156.0	189.0
Transfers distributed by Government from foreign origin	-	-	0.2	0.2	0.1	1.7	2.5	2.1
<b>Total</b>	<b>146.6</b>	<b>134.5</b>	<b>133.5</b>	<b>142.6</b>	<b>138.7</b>	<b>149.1</b>	<b>158.5</b>	<b>191.1</b>

The GCHE also includes expenditures against development partners such as cash grants which are traditionally channeled through the Government system and reflected in the annual budget. This arrangement was endorsed by Government from 2009. Over the two

year period (2013 and 2014) the GCHE averaged of 99.0% funding directly from Government domestic revenues and 1.0% funding distributed by Government from foreign origin as shown in Figure 6-4. The share of GCHE has remained fairly constant from 2011 to 2014.

**Figure 6-4 Share of GCHE by Sources**



Source Table 6-2

### 6.3. Government Current Health Expenditure by Providers

Government health providers exist at different levels within the health care system and they are determined by many factors with one key factor being the types of the health services provided at the facility. As outlined in Table 6-3, the Government health providers comprises of Hospitals, Residential Long-term care facilities, Providers of ambulatory health care, Providers of ancillary services, Providers of Preventive care, Providers of health care system administration and financing, Rest of economy (which constitute other industries within the country as secondary providers of health care) and Rest of the world (which constitute overseas health providers).

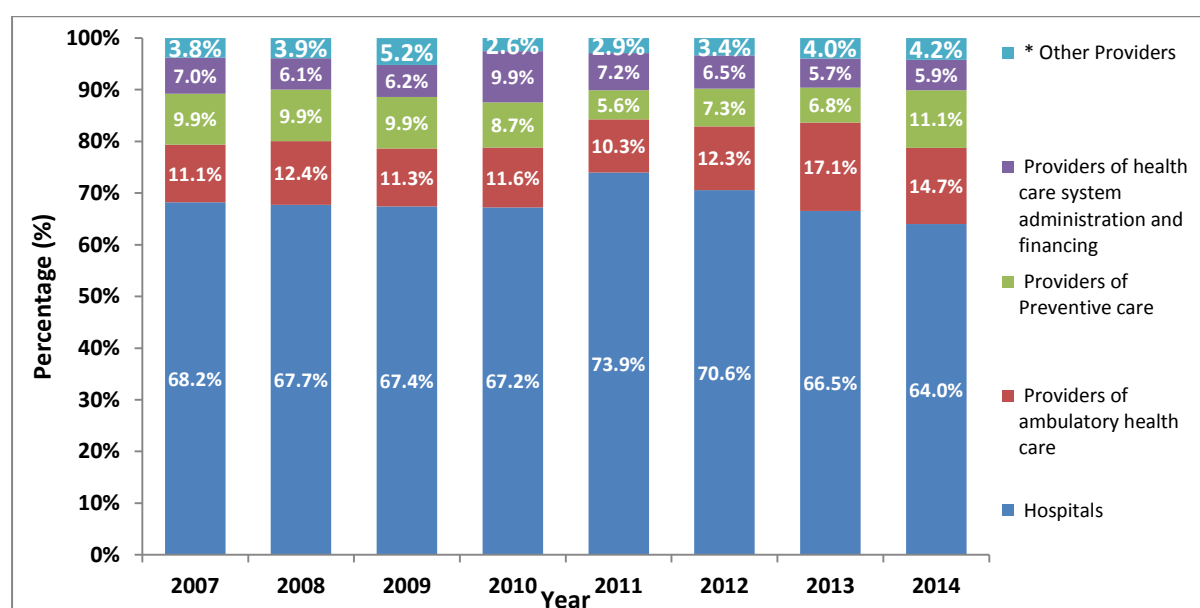


**Table 6-3 Government Current Health Expenditures by Providers (FJ\$m)**

Providers	2007	2008	2009	2010	2011	2012	2013	2014
Hospitals	100.0	91.1	90.0	95.9	102.6	105.2	105.4	122.3
Residential long-term care facilities	0.8	0.9	0.8	0.7	0.7	0.8	0.8	1.1
Providers of ambulatory health care	16.3	16.6	15.0	16.5	14.3	18.4	27.1	28.1
Providers of ancillary services	1.3	1.0	1.5	1.6	1.6	1.5	2.6	3.3
Retailers and other providers of medical goods	-	-	-	-	-	-	0.2	0.3
Providers of Preventive care	14.5	13.4	13.3	12.4	7.8	10.9	10.7	21.3
Providers of health care system administration and financing	10.3	8.2	8.3	14.1	10.0	9.6	9.0	11.3
Rest of economy	3.0	2.9	3.8	0.1	0.3	1.0	0.9	1.2
Rest of the world	0.5	0.5	0.9	1.3	1.4	1.6	1.7	2.2
<b>Total</b>	<b>146.6</b>	<b>134.5</b>	<b>133.5</b>	<b>142.6</b>	<b>138.7</b>	<b>149.1</b>	<b>158.5</b>	<b>191.1</b>

Figure 6-5 shows the share of Government current health expenditures amongst the health providers from 2007 to 2014.

**Figure 6-5 Share of Government Current Health Expenditure by Provider (%)**



Source: Table 6-3

\*Other Providers includes - Rest of economy, Providers of ancillary services, Residential long-term care facilities, Rest of the world & Retailers and other providers of medical goods

Hospitals which include divisional hospitals, sub-divisional hospitals, mental and specialized hospitals account for the largest share of Government spending. Figure 6-5 shows for the last eight years hospitals remain the major recipient of Government health spending. Hospital expenditure equates to 64.0% of GCHE in 2014. Of this value 62.5% is spent on

divisional hospitals, 30.1% in sub divisional hospitals, 7.4% in specialty hospitals and 2.2% in private hospitals. The private hospital expenditure is from other ministries.

Providers of ambulatory health care refer to expenditures at health centers and nursing stations. In 2014 the category expanded FJ\$28.1m or 14.7% of GCHE an increase of expenditure by 4.4% from 2011 (refer Figure 6-5). However this value is only 23.0% of what Government spends on hospitals. The ambulatory care expenditure consisted of both health centres and nursing stations.

Providers of Preventive care expenditures accounted for FJ\$21.3m or 10.1% of GCHE in 2014 (refer Figure 6-5). These expenditures increased by approximately 63.0% in 2014 when compared to 2013, however, increased by almost 100% in comparison to 2011.

Health care system administration and financing includes activities under the overall administration of the health care sector, including administration of health financing such as formulation, coordination, administration and monitoring of overall health policies and budgets which accounts for Fj\$11.3m or 5.9% of GCHE in 2014 (refer Figure 6-5). The share of health care administration expenditure has gradually decreased however, in dollar value it has increased in 2014.

The Other providers category as shown in Figure 6-5 is made up of the following components: “Rest of economy, Providers of ancillary services, Residential long-term care facilities, Rest of the world & Retailers and other providers of medical goods”. These are discussed next in detail.

Rest of the economy refers to industries or organizations that offer health care as a secondary activity. Rest of the economy accounts for FJ\$1.2m or 0.6% of GCHE in 2014 (refer Figure 6-5).

Ancillary services refer to expenditures for laboratory services, imaging services and patient transportation. These services accounted for FJ\$3.3m or 1.7% of GCHE in 2014 (refer Figure 6-5). Whilst the increase is very marginal in terms of share, the expenditure has doubled since 2011.

Residential long-term care facilities refer to expenditures at the three geographical divisions of Senior Citizens Home (also known as old Peoples home) which accounts for FJ\$1.1m or 0.6% of GCHE in 2014 (refer Figure 6-5).

Rest of the world refers to Government funds spent on overseas health providers and this equates to a value of FJ\$2.2m or 1.1% in 2014 of GCHE (refer Figure 6-5). There has been a

continuous increase in expenditure in this category as previously reported in the National Health Account reports from 2007-2012.

Retailers and other providers of medical goods refer to sale of drugs and medical supplies to private pharmacies for retail sales. This accounted for FJ\$0.3m or 0.1% in 2014 of GCHE (refer Figure 6-5).

Expenditure on salary and wages is distributed across all providers and is incorporated into expenditures of health providers.

#### 6.4. Government Current Health Expenditure by Geographic Locations

GCHE in the geographic divisions were expanded mainly through divisional hospitals, subdivisinal hospitals and public health centres. The distribution of facilities is depicted below.

Facilities	Geographic Divisions			
	Central	Western	Northern	Eastern
Divisional hospitals	1	1	1	
Sub-divisional hospitals	5	5	3	5
Health Centres	21	28	20	15
Nursing Stations	21	25	21	31
Specialized hospitals	2	-	-	-

Collectively the divisional hospitals incurred the largest expenditure over the period 2007 to 2014. In 2014 the reported expenditure amounted to FJ\$76.5m or 40.0% of GCHE (refer Table 6-4). The divisional hospitals mainly cover CWM, Lautoka and Labasa Hospitals. The subdivisinal Hospitals (SDHs) in the geographical divisions incurred the second largest expenditure over the period 2007 to 2014. In 2014 the reported expenditure amounted to FJ\$35.3m or 15.8% of GCHE. The Public Health Centres (PHC) in the geographical divisions incurred an expenditure of FJ\$25.4m or 13.3% of the GCHE in 2014. Overall the expenditures in Central, Western and Northern PHCs had increased in 2013 and 2014 when compared from 2007 whilst the Eastern PHC decreased.

Note that what is displayed here is spending by location of health facility and may or may not correspond to spending by residents. Mobility of residents often results in persons moving between divisions and provinces and using health facilities located in those geographic regions. Further note that CWM as the national referral hospital also caters for referred patients across all divisions.

**Table 6-4 GCHE on public health facilities (FJ\$m)**

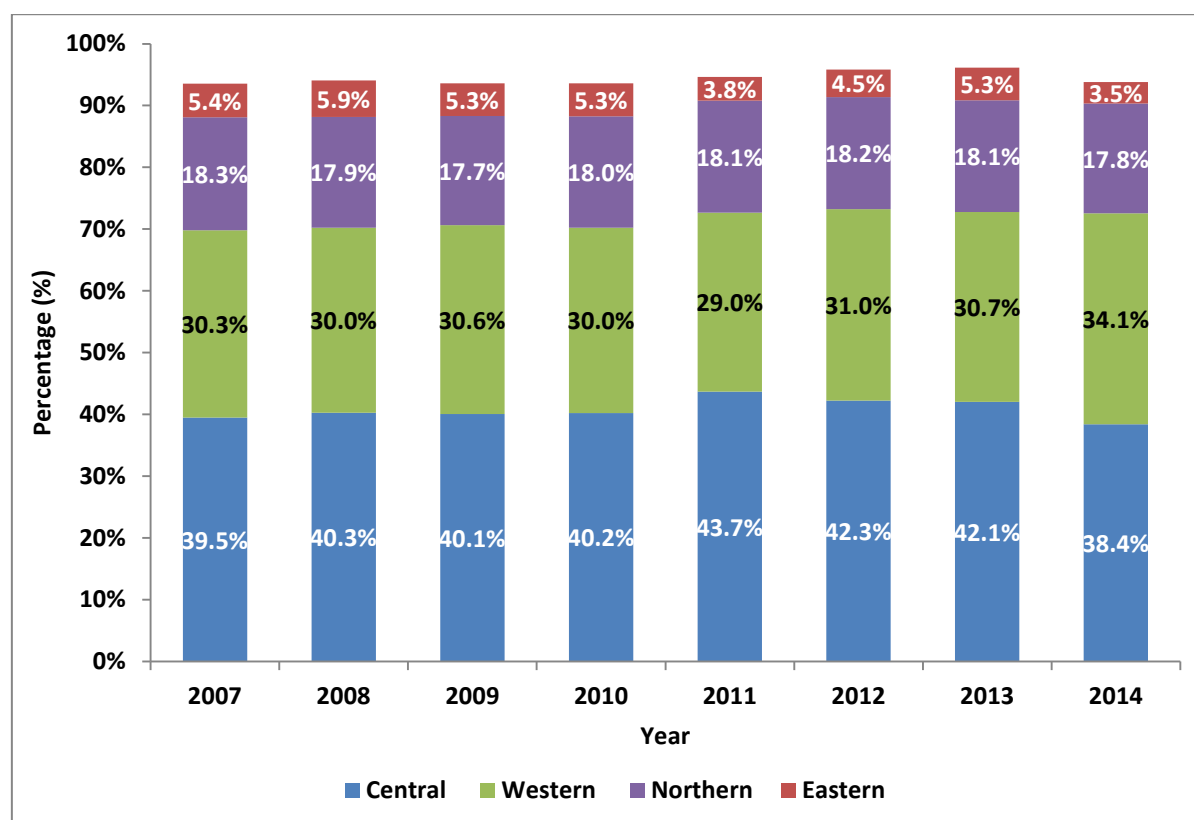
<b>Providers by Geographic divisions</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>
<b>Central</b>	<b>45.8</b>	<b>43.1</b>	<b>41.8</b>	<b>45.0</b>	<b>51.0</b>	<b>51.9</b>	<b>54.7</b>	<b>56.2</b>
Divisional hospitals	33.9	31.5	30.9	32.6	39.1	37.0	35.0	35.6
Subdivisional Hospitals (SDHs)	6.4	6.5	5.7	6.4	4.9	5.2	6.3	7.1
Public Health Centres (PHC)	5.4	5.0	5.2	5.9	7.1	9.7	13.4	13.5
<b>Eastern</b>	<b>6.3</b>	<b>6.3</b>	<b>5.5</b>	<b>5.9</b>	<b>4.5</b>	<b>5.5</b>	<b>6.9</b>	<b>5.1</b>
Subdivisional Hospitals (SDHs)	4.8	4.6	4.2	4.7	3.4	4.2	4.3	4.5
Public Health Centres (PHC)	1.5	1.7	1.3	1.2	1.0	1.3	2.6	0.6
<b>Western</b>	<b>35.2</b>	<b>32.0</b>	<b>31.9</b>	<b>33.5</b>	<b>33.9</b>	<b>38.0</b>	<b>40.0</b>	<b>49.9</b>
Divisional hospitals	19.4	17.5	18.2	18.2	19.7	21.3	19.8	25.8
Subdivisional Hospitals (SDHs)	10.3	8.9	9.0	10.3	10.8	12.6	14.1	17.5
Public Health Centres (PHC)	5.5	5.6	4.7	5.1	3.4	4.1	6.1	6.6
<b>Northern</b>	<b>21.2</b>	<b>19.2</b>	<b>18.4</b>	<b>20.2</b>	<b>21.2</b>	<b>22.3</b>	<b>23.6</b>	<b>26.0</b>
Divisional hospitals	13.0	11.7	11.6	12.2	13.7	14.7	13.7	15.2
Subdivisional Hospitals (SDHs)	4.7	4.0	3.6	4.2	4.7	5.0	6.4	6.2
Public Health Centres (PHC)	3.6	3.5	3.2	3.7	2.7	2.6	3.5	4.6
<b>Specialized Hospitals (National Level)</b>	<b>7.5</b>	<b>6.4</b>	<b>6.7</b>	<b>7.2</b>	<b>6.3</b>	<b>5.1</b>	<b>5.0</b>	<b>9.1</b>
Mental health hospitals	3.7	3.2	3.4	3.7	3.1	2.9	2.8	4.2
Tamavua hospital (TB and Leprosy)	3.8	3.1	3.3	3.5	3.2	2.2	2.2	4.9
<b>Total</b>	<b>116.0</b>	<b>106.9</b>	<b>104.4</b>	<b>111.7</b>	<b>116.8</b>	<b>122.9</b>	<b>130.2</b>	<b>146.2</b>

Public Health Facilities = Divisional Hospitals, SDHs, PHCs & Specialized Hospitals

Figure 6-6 shows the share of GCHE incurred by facilities (divisional, SDHs and PHCs) in the geographic divisions, excluding expenditure incurred by specialized facilities. There has been a decrease in share of expenditure in Central, Northern and Eastern division whilst increase in Western division from 2013 to 2014.

The largest share of GCHE was spent in the central division which amounted to FJ\$54.7m or 42.1% in 2013 and FJ\$56.2m or 38.4% in 2014 (refer Table 6-4 and Figure 6-6). The northern division expenditure increased in dollar terms but declined in terms of share. Eastern division expenditures were the lowest which was FJ\$6.9m or 5.3% in 2013 or FJ\$5.1m or 3.5% in 2014. Except for Eastern division all other divisions increased in expenditure over the eight year period from 2007 to 2014. The specialized hospitals represented FJ\$5.0m or 3.8% in 2013 and FJ\$9.1m or 6.2% in 2014.

Figure 6-6 Share of GCHE by geographic divisions (excluding Specialized services), (%)

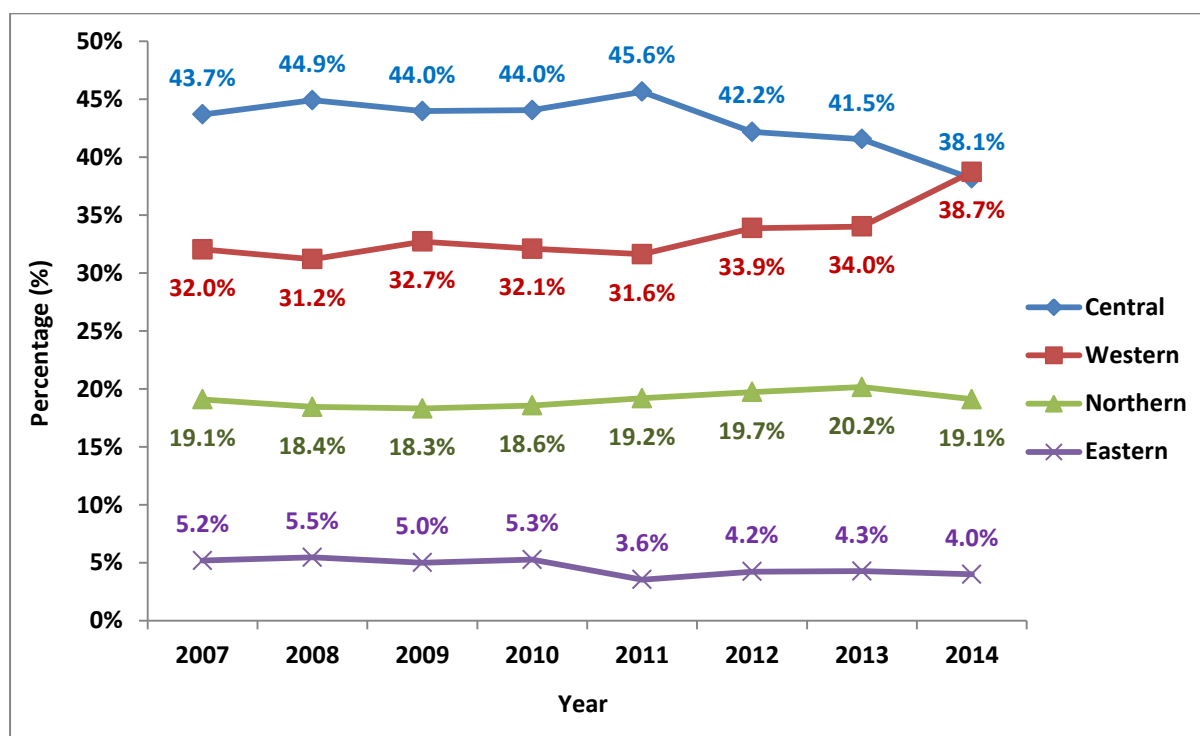


Source: Table 6-4

In 2014 the sub divisional hospitals were allocated an average expenditure per facility as follows: Central FJ\$1.4m, Western FJ\$3.5m, Northern FJ\$2.1m and Eastern FJ\$0.9m. In the same year the health centres were allocated an average expenditure per facility as follows: Central FJ\$600K, Western FJ\$200K, Northern FJ\$200K and Eastern FJ\$40K.

Figure 6-7 and Figure 6-8 shows the distribution of GCHE incurred by hospitals and health centres respectively by the geographic divisions. The hospital is inclusive of both divisional and sub divisional hospitals but exclusive of specialized hospitals.

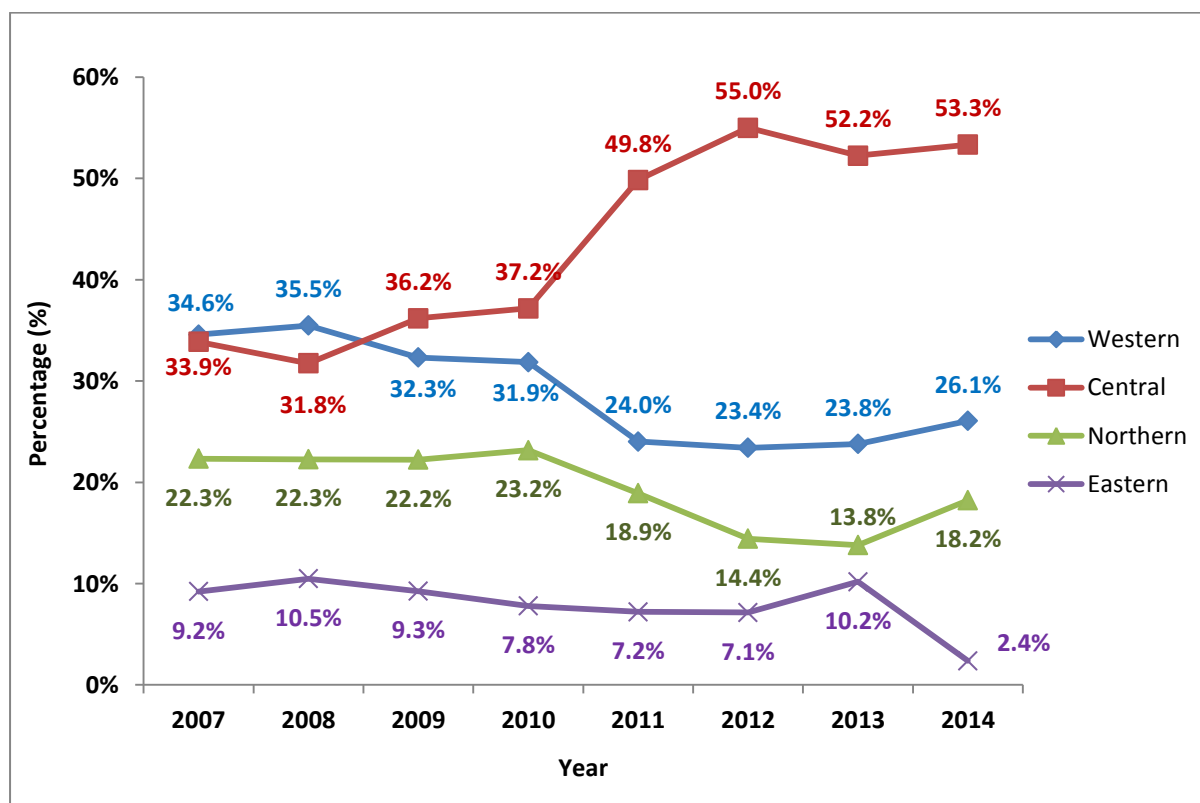
Figure 6-7 Share of GCHE on hospitals by geographic divisions



Source: Table 6-4

Hospitals = Divisional Hospitals + Sub divisional hospitals (excludes specialized hospitals)

Figure 6-8 Share of GCHE on Health Centres by geographic divisions



Source: Table 6-4

For both hospitals and health centres, Central division has the highest GCHE expenditures followed by Western, Northern and then Eastern. The Central division caters for a larger population and is also the main referral centre for all other hospitals and health centres. In the central division, hospital expenditures increased whilst health center expenditures decreased.

**Table 6-5 GCHE on hospitals plus health centres by Province (FJ\$m)**

Province	2007	2008	2009	2010	2011	2012	2013	2014
Rewa	36.3	33.6	33.0	34.9	41.6	41.0	38.5	39.0
Ba	29.2	26.8	27.0	28.0	28.9	32.5	32.3	41.3
Macuata	15.1	13.7	13.5	14.4	15.4	16.4	15.3	17.7
Tailevu	5.0	4.4	4.5	5.2	5.4	6.0	7.9	8.2
Cakaudrove	4.6	3.9	3.5	4.1	4.2	4.2	6.2	6.2
Nadroga/Navosa	3.6	3.0	2.8	3.2	3.0	3.4	4.8	5.5
Naitasiri	2.8	3.1	2.8	3.2	2.6	3.2	5.4	6.5
Ra	2.4	2.3	2.0	2.4	1.9	2.1	2.7	2.9
Lau	2.3	2.2	1.9	1.9	1.6	2.1	2.9	1.6
Lomaiviti	1.9	1.9	1.7	2.0	1.3	1.7	1.8	1.8
Bua	1.6	1.6	1.5	1.7	1.5	1.6	2.0	1.9
Serua	1.5	1.7	1.4	1.5	1.5	1.7	2.6	2.1
Kadavu	1.4	1.5	1.2	1.4	1.0	1.2	1.6	1.0
Rotuma	0.7	0.7	0.6	0.7	0.5	0.6	0.7	0.7
Namosi	0.2	0.2	0.2	0.2	0.1	0.1	0.1	0.1
<b>Total</b>	<b>108.5</b>	<b>100.5</b>	<b>97.7</b>	<b>104.6</b>	<b>110.5</b>	<b>117.8</b>	<b>124.6</b>	<b>136.5</b>

Note - Expenditure excludes specialized hospitals

The five provinces receiving the largest budget allocation in the eight year period from 2007 to 2014 were Rewa, Ba, Macuata, Tailevu and Cakaudrove. The provinces receiving the least budget allocation in the eight year period from 2007 to 2014 were Namosi, Rotuma, Kadavu, Serua and Bua. Rewa, Ba and Macuata are expected to have high expenditure since they house the three divisional hospitals (CWM, Lautoka, and Labasa hospital respectively).

The trend over the period 2007 to 2014 show that apart from the top five recipient provinces of budget allocations, all other provinces have mostly remained unchanged or decreased in terms of budget allocation.

Table 6-6 provides the GCHE on health facilities (divisional, SDHs and PHCs) per capita by provinces and divisions. The per capita information is computed using the 2007 census of population figures and projected population<sup>1</sup> figures provided by Fiji Bureau of Statistics for the years 2008 to 2014. Fiji Bureau of Statistics (FBoS) does not produce population estimates at sub-national level, due to the non-availability of demographic indicators at this level.

<sup>1</sup> Population figures are projected estimates sourced from the Fiji Bureau of Statistics (FBoS)

**Table 6-6 Per capita GCHE on hospitals plus health centres by Divisions and Province (FJ\$)**

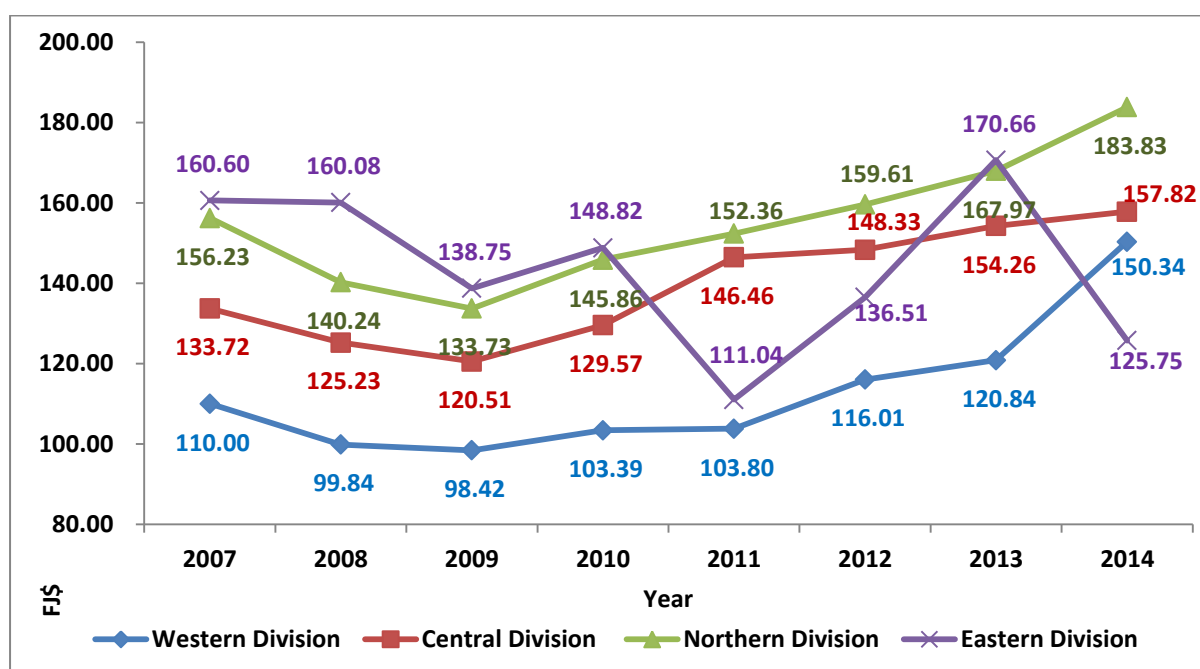
Province by Divisions	2007	2008	2009	2010	2011	2012	2013	2014
<b>Eastern Division</b>	<b>160.60</b>	<b>160.08</b>	<b>138.75</b>	<b>148.82</b>	<b>111.04</b>	<b>136.51</b>	<b>170.66</b>	<b>125.75</b>
Rotuma	349.14	329.92	318.94	343.16	240.73	284.00	315.86	339.43
Lau	215.25	206.99	178.54	170.08	149.77	187.19	260.26	144.59
Kadavu	135.46	150.03	119.80	132.75	95.38	113.64	148.19	95.60
Lomaiviti	117.17	114.55	102.17	120.82	79.21	99.04	107.94	105.90
<b>Northern Division</b>	<b>156.23</b>	<b>140.24</b>	<b>133.73</b>	<b>145.86</b>	<b>152.36</b>	<b>159.61</b>	<b>167.97</b>	<b>183.83</b>
Macuata	207.87	188.36	183.54	195.61	208.09	221.19	205.25	236.74
Bua	112.21	111.83	103.26	115.55	106.12	112.36	136.59	128.24
Cakaudrove	93.07	77.82	69.45	81.68	84.00	82.99	122.27	122.14
<b>Central Division</b>	<b>133.72</b>	<b>125.23</b>	<b>120.51</b>	<b>129.57</b>	<b>146.46</b>	<b>148.33</b>	<b>154.26</b>	<b>157.82</b>
Rewa	359.51	331.99	322.48	341.06	404.33	396.59	369.81	373.86
Tailevu	90.58	79.20	79.49	92.33	94.57	105.22	137.40	142.15
Serua	80.12	91.24	73.79	80.79	78.77	90.28	140.20	111.30
Namosi	26.05	31.85	23.34	27.12	11.44	13.17	11.61	17.27
Naitasiri	17.51	19.14	17.29	19.48	15.82	19.55	32.40	38.84
<b>Western Division</b>	<b>110.00</b>	<b>99.84</b>	<b>98.42</b>	<b>103.39</b>	<b>103.80</b>	<b>116.01</b>	<b>120.84</b>	<b>150.34</b>
Ba	125.94	115.00	115.15	118.98	122.54	137.07	135.55	172.45
Ra	81.60	77.67	68.07	79.06	61.50	68.19	87.93	93.68
Nadroga/Navosa	61.06	50.89	47.39	53.89	50.90	56.77	79.04	91.17
<b>Total</b>	<b>129.57</b>	<b>119.61</b>	<b>115.08</b>	<b>123.13</b>	<b>129.47</b>	<b>137.27</b>	<b>144.50</b>	<b>157.69</b>

Note - Expenditure excludes specialized hospitals

Across the four divisions, the provinces with the highest per capita health expenditure are notably those that have the divisional hospitals situated within them (Macuata, Rewa and Ba). However across all provinces, Rewa and Rotuma have the highest per capita health spending. Rewa houses the main national referral hospital in the country and Rotuma due to its geographical location.



Figure 6-9 Per capita GCHE on hospitals plus health centres by Divisions and by Province (FJ\$)



Source: Table 6-6

Note - Expenditure excludes specialized hospitals

Figure 6-9 shows from 2007 to 2014; provinces of Western, Central and Northern division show an increasing trend per capita. Eastern division has a fluctuating trend from 2009.

## 6.5. Government Current Health Expenditure by Functions

This section focuses on Government current health expenditures (GCHE) by function and is reflected in Table 6-7.

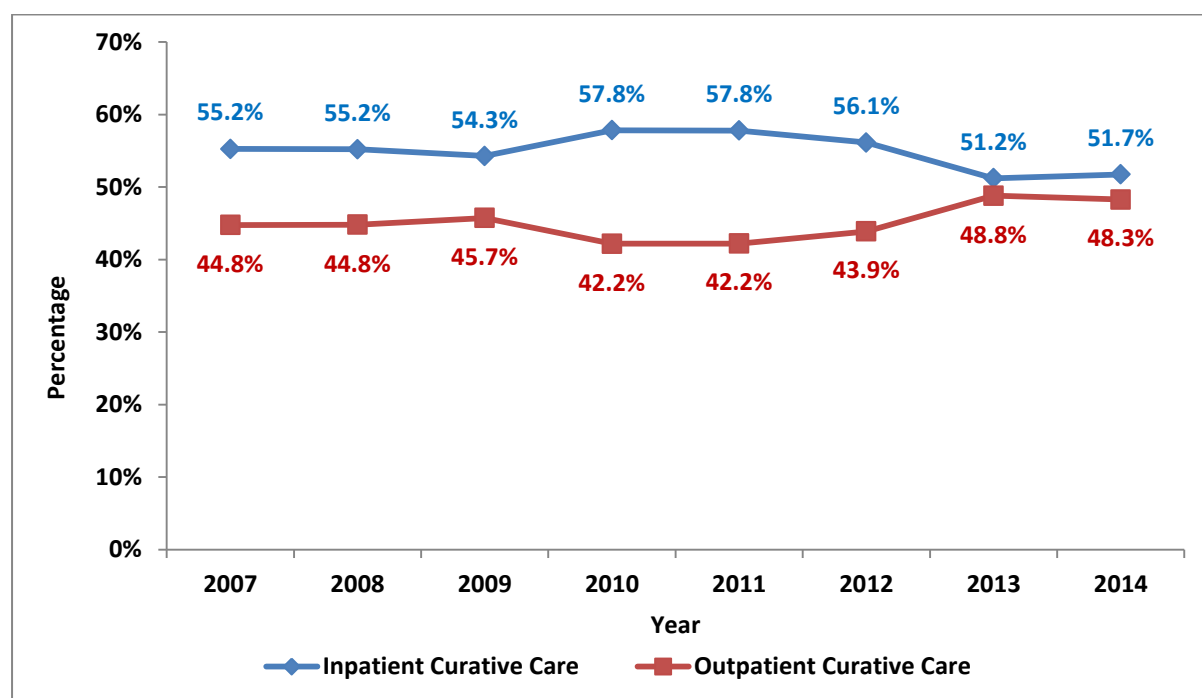
Table 6-7 Government Current Health Expenditures by Functions (FJ\$m)

Functions	2007	2008	2009	2010	2011	2012	2013	2014
Curative care	68.6	62.5	64.0	64.1	69.2	74.2	70.6	79.4
Inpatient curative care	37.9	34.5	34.7	37.1	40.0	41.6	36.1	41.1
Outpatient curative care	30.7	28.0	29.3	27.0	29.2	32.6	34.4	38.3
Rehabilitative care	5.1	4.9	4.7	5.0	5.2	4.7	3.4	3.6
Long-term care (health)	0.5	0.5	0.5	0.5	0.7	0.8	0.7	1.0
Ancillary services (non-specified by function)	14.2	12.8	13.3	14.1	15.9	16.1	20.6	25.2
Medical goods (non-specified by function)	-	-	-	-	-	-	0.7	1.8
Preventive care	36.2	34.7	32.3	33.8	26.3	31.0	48.3	63.1
Governance, and health system and financing administration	21.9	19.2	18.7	25.3	21.4	22.3	14.2	16.9
<b>Total</b>	<b>146.6</b>	<b>134.5</b>	<b>133.5</b>	<b>142.6</b>	<b>138.7</b>	<b>149.1</b>	<b>158.5</b>	<b>191.1</b>

Note: GCHE on medical goods for MoHMS are incorporated into the above categories mainly in inpatient and outpatient care. The amount that appears under Medical goods comes from other Ministries.

Curative services incur the largest expense, FJ\$70.6m or 44.5% in 2013 and FJ\$79.4m or 41.6% in 2014 (refer Table 6-7 and Figure 6-11) of GCHE. Curative services comprise of both inpatient and outpatient services. The allocation of curative care expenditure between inpatient and outpatient is shown in Figure 6-10. In 2007 spending on Inpatient Curative care was 55.2% and in 2014 was 51.7%. In 2007 the Outpatient Curative care was 44.8% and in 2014 was 48.3%. Costs in nominal terms have not changed much over the eight year period in both services.

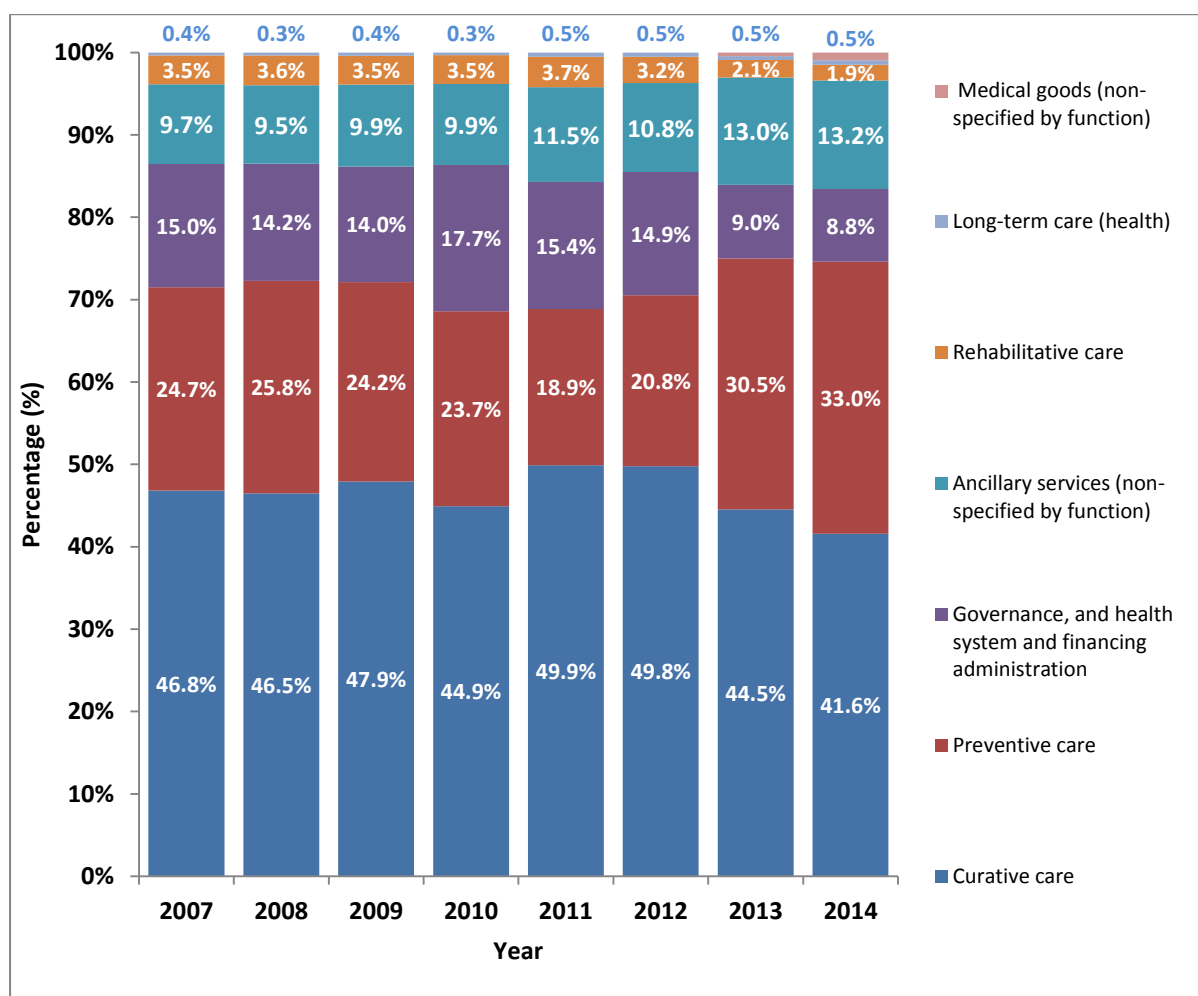
**Figure 6-10 Government Curative Care by Inpatient and Outpatient (%)**



Source: Table 6-7

In-patient services are provided at hospitals whilst outpatient services are provided both at hospitals, health centres, and nursing stations. In both cases the expenditure has increased in 2014 however as a share of GCHE it has declined.

Figure 6-11 Share of Government Current Health Expenditure by Functions (%)



Source: Table 6-7

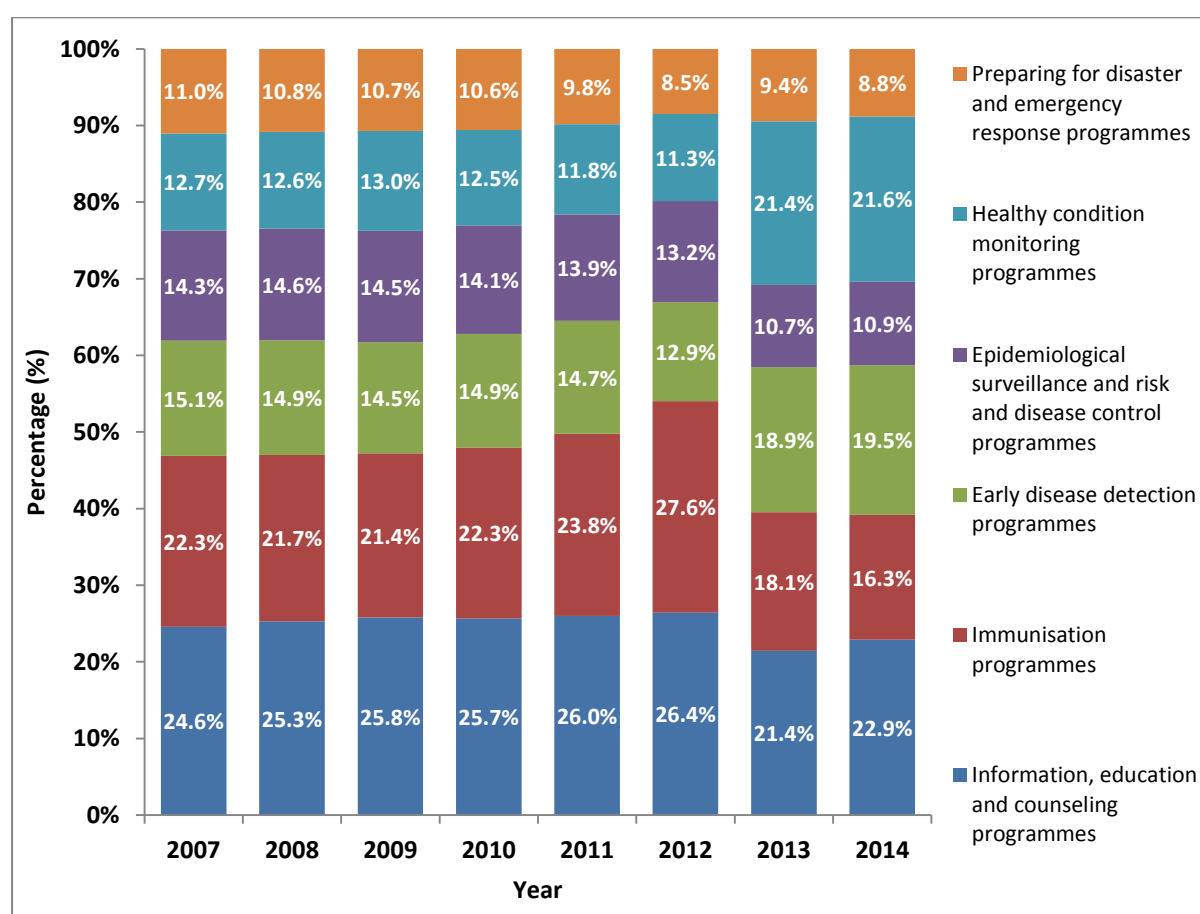
Preventive care has the second largest share of health expenditure which accounts for FJ\$48.3m or 30.5% in 2013 and FJ\$63.1m or 33.0% in 2014 of GCHE. There have been significant increases in the Preventive care programmes over the last eight years. Preventive care programmes are further broken down into six (6) categories of services and the expenditures have been distributed accordingly by respective years as shown in Table 6-8.

Table 6-8 Preventive care categories (FJ\$m)

Preventive care	2007	2008	2009	2010	2011	2012	2013	2014
Information, education and counselling programmes	8.9	8.8	8.3	8.7	6.8	8.2	10.3	14.5
Immunisation programmes	8.1	7.5	6.9	7.5	6.2	8.6	8.7	10.3
Early disease detection programmes	5.4	5.2	4.7	5.0	3.9	4.0	9.1	12.3
Healthy condition monitoring programmes	4.6	4.4	4.2	4.2	3.1	3.5	10.3	13.6
Epidemiological surveillance and risk and disease control programmes	5.2	5.1	4.7	4.8	3.6	4.1	5.2	6.9
Preparing for disaster and emergency response programmes	4.0	3.8	3.5	3.6	2.6	2.6	4.6	5.6
<b>Total</b>	<b>36.2</b>	<b>34.7</b>	<b>32.3</b>	<b>33.8</b>	<b>26.3</b>	<b>31.0</b>	<b>48.3</b>	<b>63.1</b>

Most of the health expenditures in the Preventive care programmes over the eight year period are on Information, education and counseling programmes whilst lowest expenditures are on Preparing for disaster and emergency response programmes as shown in Figure 6-12.

Figure 6-12 Share of Preventive care categories (%)



Source: Table 6-8

Governance, and health system and financing administration is the third largest functional expenditure which accounts for FJ\$14.2m or 9.0% in 2013 and FJ\$16.9m or 8.8% in 2014 of GCHE (refer Figure 6-12). These are expenditures which involve administration of management of funds, formulation and administration of Government policies and monitoring and evaluation of such resources. Generally there is decline in this expenditure in 2014 when compared over the eight year period since 2007.

Ancillary services which is related to diagnosis and monitoring services accounted for FJ\$20.6m or 13.0% in 2013 and FJ\$25.2m or 13.2% in 2014 of GCHE. The expenditure has increased over the period 2007 to 2014.

Rehabilitative care has the second lowest expenditure and accounted for FJ\$3.4m or 2.1% in 2013 and FJ\$3.6m or 1.9% in 2014 of GCHE. Rehabilitative services are treatments provided to improve or restore impaired body functions and structures (e.g. disease, disorder and injury) to improve the quality of life.

Long term care (health) has the lowest expenditure and accounted for FJ\$0.7m or 0.5% in 2013 and FJ\$1.0m or 0.5% in 2014 of GCHE. Long term (health) consists of a range of medical and personal care services that are consumed with the primary goal of alleviating pain and suffering and reducing or managing the deterioration in health status in patients with a degree of long-term dependency e.g. Senior Citizens home.

The GCHE on medical goods for all years 2007 to 2014 are incorporated mostly into curative care (in-patient and outpatient care). Government spending in purchasing of drugs is shown in Table 6-9.

**Table 6-9 Government drugs expenditure**

Year	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
FJ\$m	6.3	3.9	9.3	7.8	6.4	13.2	6.6	9.9	10.2	8.8	9.5	9.0

2003 – 2006 expenditure figures from MoHMS EPICOR System

2007 – 2014 expenditure figures from FMIS system

## 7. Private Current Health Expenditure

Private Current Health Expenditure (PCHE) represents all money spent on health by households, private firms, non-government organizations, religious and community based organizations and excludes development partners and the public (government) sector.

### 7.1. Private Current Health Expenditure by Sources

The Private sector expenditure increased substantially by FJ\$26.7m from FJ\$80.6m in 2011 to FJ\$107.3m in 2014 (refer Table 7-1).

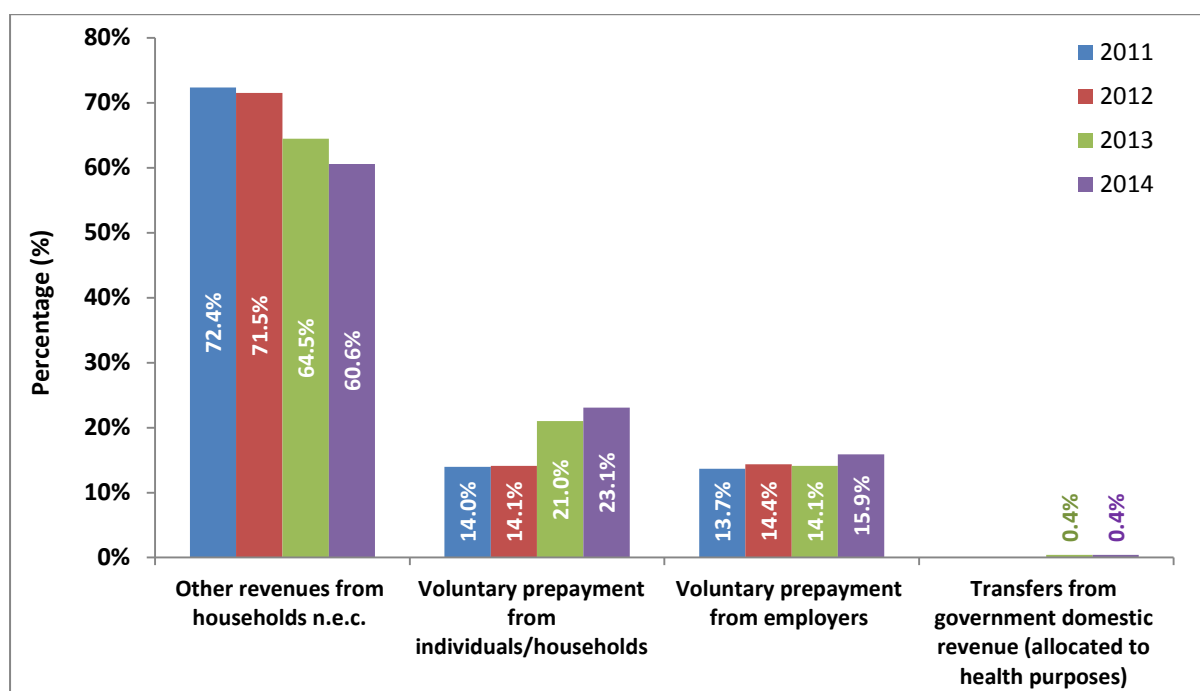
Table 7-1 depicts that the primary source of revenue for the private sector is mainly from households (other domestic revenues) which accounted for 60.6% (FJ\$65.0m) in 2014. Over the four years, the largest increase was for voluntary prepayments by FJ\$19.5m.

**Table 7-1 Private Current Health Expenditure by Sources, 2011 to 2014**

Description	2011		2012		2013		2014	
	Amount (FJ\$m)	Share (%)	Amount (FJ\$m)	Share (%)	Amount (FJ\$m)	Share (%)	Amount (FJ\$m)	Share (%)
Transfers from government domestic revenue	0	0.0%	0	0.0%	0.4	0.4%	0.4	0.4%
<b>Voluntary prepayment</b>	<b>22.3</b>	<b>27.6%</b>	<b>24.8</b>	<b>28.5%</b>	<b>34.4</b>	<b>35.1%</b>	<b>41.8</b>	<b>39.0%</b>
Voluntary prepayment from individuals/households	11.3	14.0%	12.3	14.1%	20.6	21.0%	24.8	23.1%
Voluntary prepayment from employers	11.0	13.7%	12.6	14.4%	13.8	14.1%	17.1	15.9%
<b>Other domestic revenues</b>	<b>58.3</b>	<b>72.4%</b>	<b>62.3</b>	<b>71.5%</b>	<b>63.3</b>	<b>64.5%</b>	<b>65.0</b>	<b>60.6%</b>
<b>TOTAL</b>	<b>80.6</b>	<b>100%</b>	<b>87.2</b>	<b>100%</b>	<b>98.1</b>	<b>100%</b>	<b>107.3</b>	<b>100%</b>

Figure 7-1 shows that the expenditure for all categories increased except for other domestic revenue from households as a share of PCHE. However, expenditure in dollar terms increased for all categories for revenue sources (refer Table 7-1).

Figure 7-1 Share of Private Current Health Expenditure by Source, 2011 to 2014



Source: Table 7-1

## 7.2. Private Current Health Expenditure by Financing Schemes

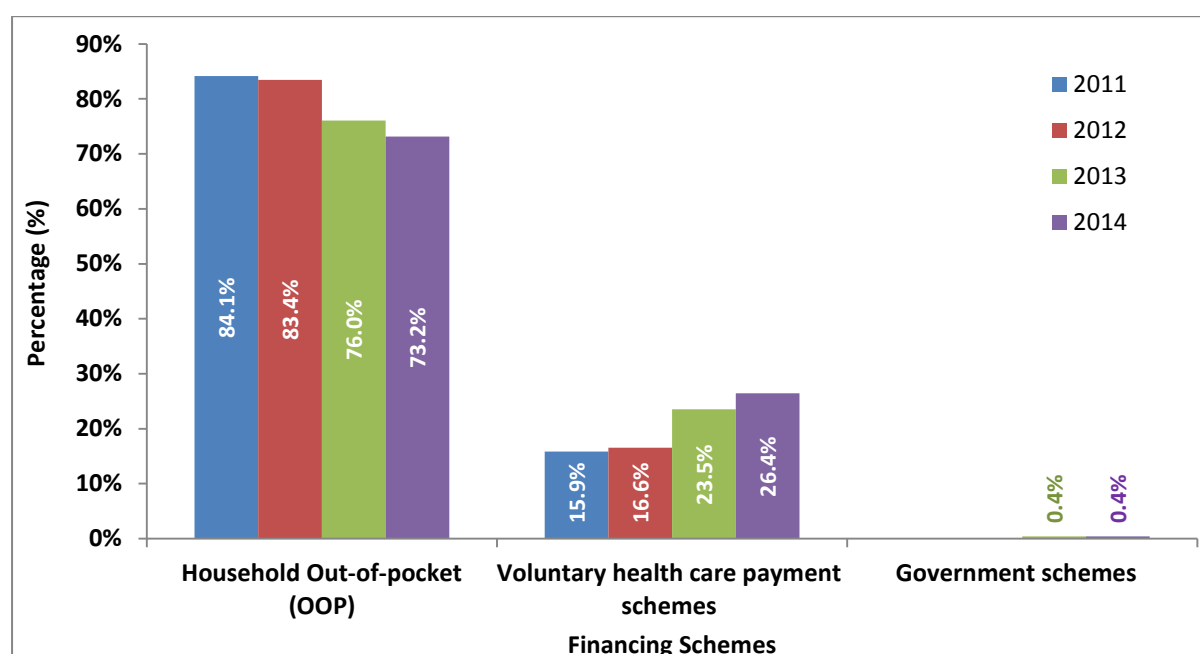
Households Out-of-pocket (OOP) is the dominant financing scheme over the four years. OOP accounted for 73.2% of PCHE in 2014. Voluntary health care payment schemes contributed significantly towards the increase in PCHE (refer Table 7-2).

Table 7-2 Private Current Health Expenditure by Schemes, FJ\$m 2011 to 2014

Schemes	2011		2012		2013		2014	
	Amount (FJ\$m)	Share (%)	Amount (FJ\$m)	Share (%)	Amount (FJ\$m)	Share (%)	Amount (FJ\$m)	Share (%)
Government schemes	0	0.0%	0	0.0%	0.4	0.4%	0.4	0.4%
Voluntary health care payment schemes	12.8	15.9%	14.4	16.6%	23.1	23.5%	28.3	26.4%
Employer-based insurance (other than enterprises schemes)	5.3	6.6%	6.3	7.2%	13.8	14.1%	17.1	15.9%
Other primary coverage schemes	7.5	9.3%	8.2	9.4%	9.3	9.4%	11.3	10.5%
Household Out-of-pocket (OOP)	67.8	84.1%	72.7	83.4%	74.6	76.0%	78.5	73.2%
<b>TOTAL</b>	<b>80.6</b>	<b>100%</b>	<b>87.2</b>	<b>100%</b>	<b>98.1</b>	<b>100%</b>	<b>107.3</b>	<b>100%</b>

Figure 7-2 highlights that OOP as a share of PCHE declined over the period 2011 to 2014 while voluntary health care payment schemes have increased.

Figure 7-2 Share of Private Current Health Expenditure by Schemes, 2011 to 2014



Source: Table 7-1

### 7.3. Private Current Health Expenditure by Providers

Retail and other providers of medical goods accounted for largest share of PCHE. The expenditure on Hospitals and Private Medical Practices (mainly Private doctors) has doubled over the four years (refer Table 7-3).

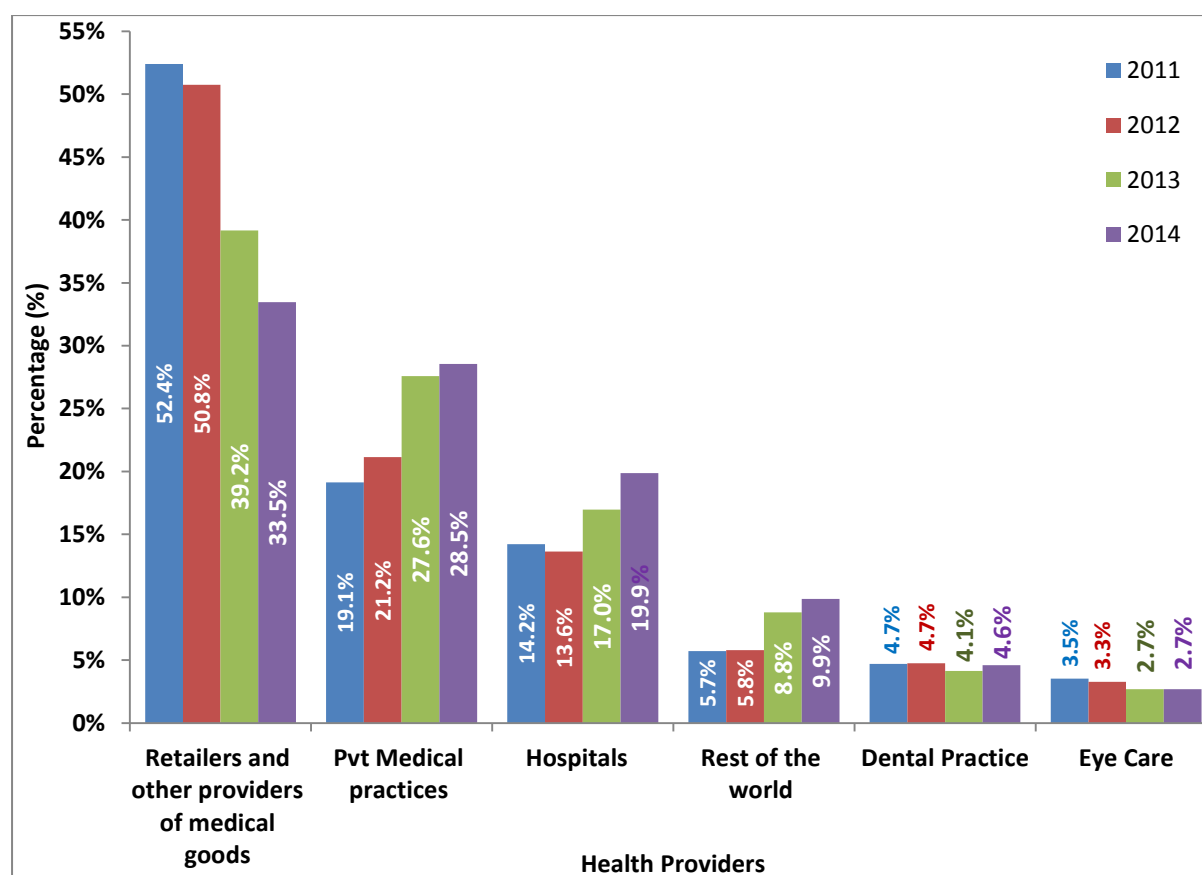
Table 7-3 Private Current Health Expenditure by Providers, 2011 to 2014

Providers	2011		2012		2013		2014	
	Amount (FJ\$m)	Share (%)	Amount (FJ\$m)	Share (%)	Amount (FJ\$m)	Share (%)	Amount (FJ\$m)	Share (%)
Hospitals	11.5	14.2%	11.9	13.6%	16.6	17.0%	21.3	19.9%
Pvt Medical practices	15.4	19.1%	18.4	21.2%	27.1	27.6%	30.6	28.5%
Dental Practice	3.8	4.7%	4.1	4.7%	4.1	4.1%	4.9	4.6%
Optometrists	2.8	3.5%	2.8	3.3%	2.6	2.7%	2.9	2.7%
Ambulatory health care centres	0.1	0.1%	0.2	0.2%	0.0	0.0%	0.0	0.0%
Providers of ancillary services	0.2	0.2%	0.4	0.4%	0.6	0.7%	1.0	1.0%
Retailers and other providers of medical goods	42.2	52.4%	44.2	50.8%	38.4	39.2%	35.9	33.5%
Rest of the world	4.6	5.7%	5.1	5.8%	8.6	8.8%	10.6	9.9%
<b>TOTAL</b>	<b>80.6</b>	<b>100%</b>	<b>87.2</b>	<b>100%</b>	<b>98.1</b>	<b>100%</b>	<b>107.3</b>	<b>100%</b>



Figure 7-3 shows an increase in expenditure across all private health care providers except for retailers and other providers of medical goods. Retailers and other providers of medical goods decreased both in dollar value and as a percentage share of PCHE.

**Figure 7-3 Private Current Health Expenditure by Providers, 2011 to 2014**



Source: Table 7-3

#### 7.4. Private Current Health Expenditure by Functions

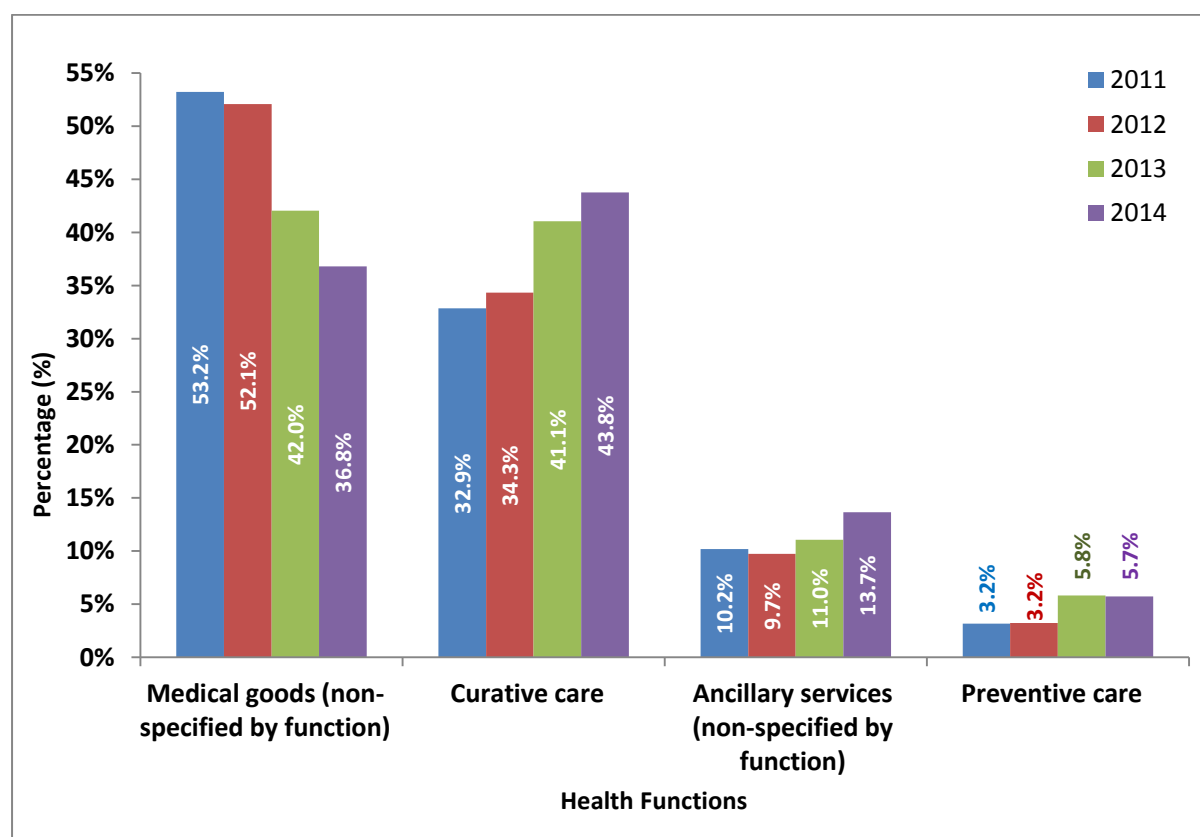
Curative care (both inpatient and outpatient services) accounted for the largest functional expenses out of the PCHE, 43.8% in 2014 (refer Table 7-4). In 2014 inpatient care was 21.5% whilst outpatient was 78.5% of curative care. Expenditure on preventive care increased from FJ\$2.6m in 2011 to FJ\$6.1m in 2014. Preventive care expenditure was mostly for information, education and counseling.

**Table 7-4 Private Current Health Expenditure by Functions, 2011 to 2014**

Functions	2011		2012		2013		2014	
	Amount (FJ\$m)	Share (%)	Amount (FJ\$m)	Share (%)	Amount (FJ\$m)	Share (%)	Amount (FJ\$m)	Share (%)
Curative care	26.5	32.9%	29.9	34.3%	40.3	41.1%	47.0	43.8%
Inpatient curative care	5.4	6.7%	5.4	6.2%	8.7	8.9%	10.1	9.4%
Outpatient curative care	21.1	26.2%	24.5	28.1%	31.6	32.2%	36.9	34.4%
Rehabilitative care	0.02	0.03%	0.04	0.05%	0.0	0.04%	0.0	0.05%
Ancillary services (non-specified by function)	8.2	10.2%	8.5	9.7%	10.8	11.0%	14.7	13.7%
Medical goods (non-specified by function)	42.9	53.2%	45.4	52.1%	41.3	42.0%	39.5	36.8%
Preventive care	2.6	3.2%	2.8	3.2%	5.7	5.8%	6.1	5.7%
Governance, and health system and financing administration	0.4	0.5%	0.5	0.6%	0.0	0.0%	0.0	0.0%
<b>TOTAL</b>	<b>80.6</b>	<b>100%</b>	<b>87.2</b>	<b>100%</b>	<b>98.1</b>	<b>100%</b>	<b>107.3</b>	<b>100%</b>

Figure 7-4 reflects that the share of PCHE by Functions increased for all categories except for medical goods.

**Figure 7-4 Share of Private Current Health Expenditure by Function, 2011 to 2014**



Source: Table 7-4

## 8. Development Partners (Rest of the World)

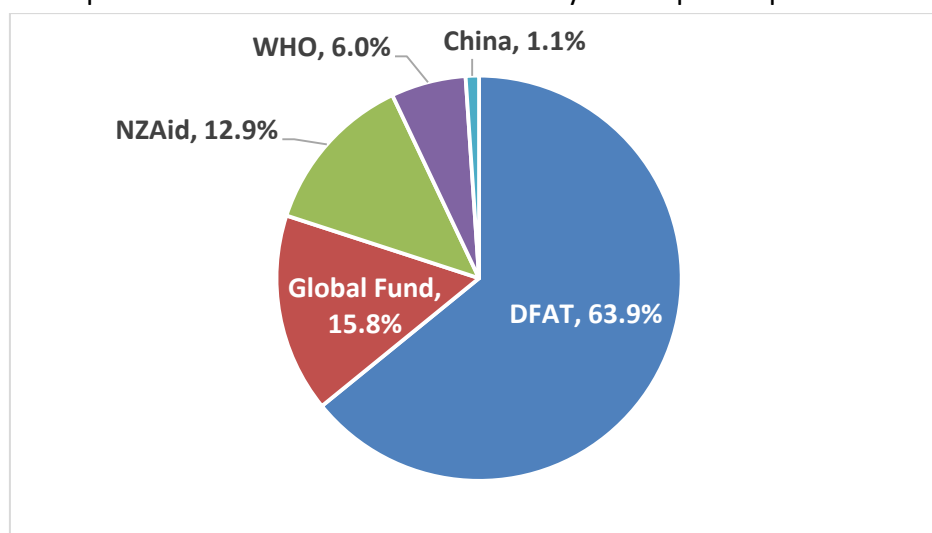
Development partners in this section also refer to Rest of the World as classified in SHA 2011. The information presented in this section reflects development partners who responded to the NHA questionnaire. Table below shows the total development partner funding for the years 2011-2014.

Total development partner funding

Development Partners	Total Contribution			
	2011	2012	2013	2014
DFAT	3.9	9.1	12.9	11.1
Global fund	3.5	3.0	2.7	2.7
NZAid	1.3	2.3	1.2	2.2
WHO	1.2	1.3	1.1	1.0
China	-	-	-	0.2
UNAIDS	0.2	-	0.03	0.03
UNICEF	0.4	0.6	0.1	0.02
Japan	2.0	1.6	-	-
UNFPA	0.02	0.0001	-	-
Other	0.0002	-	-	-
<b>Total Donor Contribution</b>	<b>12.5</b>	<b>17.8</b>	<b>18.0</b>	<b>17.4</b>

Note: This total development partner funding presented in the above Table comprises of both Current Health Expenditure (CHE) and Capital Expenditure (HK)

Figure below depicts the share of the contributions by development partners.



In 2014, DFAT had the largest spending which accounted for 63.9% (FJ\$11.1m) of the total development partner funding followed by Global Fund, 15.8% (Fj\$2.7m). The third largest was NZAID which accounted for 12.9% (FJ\$2.2m).

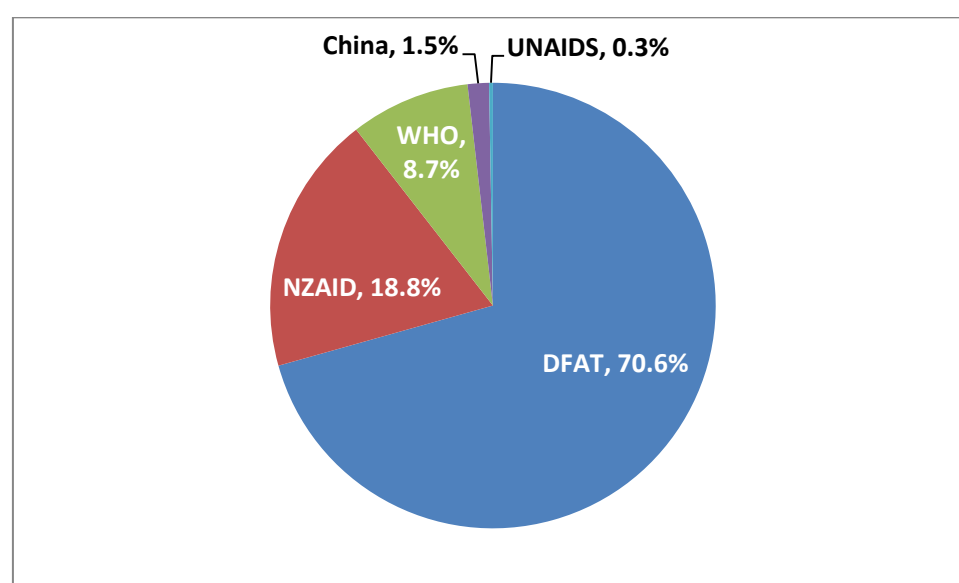
The Ministry of Health & Medical Services (MoHMS) continues to benefit from the development partners and receive this support through direct (cash grants), Aid-in kind (technical expertise, supplies and equipment) and ad-hoc cash grants. The MoHMS traditional bilateral partners are Department of Foreign Affairs and Trade (DFAT), New Zealand Aid (NZAID), Japanese International Cooperation Agency (JICA) and the People's Republic of China (PRC) and multilateral agencies include World Health Organization (WHO), United Nations Children's Funds (UNICEF) and the Global Fund (GF). Table 8-1 reflects direct development partner funding to the MoHMS which has increased from FJ\$11.1m in 2011 to FJ\$11.9m in 2014.

**Table 8-1 Financing contributions by Development Partners - Direct foreign transfers**

Development Partners	2011	2012	2013	2014
DFAT	3.0	9.1	9.4	8.4
WHO	1.1	1.3	1.1	1.0
Japan	1.8	1.4	0.0	0.0
China	0.0	0.0	0.0	0.2
NZAID	1.3	1.6	0.6	2.2
Global fund	3.5	1.3	0.0	0.0
UNICEF	0.4	0.6	0.0	0.0
UNAIDS	0.2	0.0	0.0	0.0
<b>Total</b>	<b>11.1</b>	<b>15.2</b>	<b>11.1</b>	<b>11.9</b>

This total development partner funding presented in 2014 in Table 8-1 is similar to that reported by OECD database (as accessed on 12<sup>th</sup> November, 2015 ) on donor funds disbursed to Fiji (FJ\$11.02m in 2014).

**Figure 8-1 Share of funding by Development Partners, - Direct foreign transfers (%), 2014**



Source: Table 8-1

Figure 8-1 depicts the share of the expenditure by development partners. In 2014, DFAT had the largest spending which accounted for 70.6% (FJ\$8.4m) of the total development partner funding followed by NZAID, 18.8% (FJ\$2.2m). The third largest was WHO which accounted for 8.7% (FJ\$1.0m).

**Table 8-2 Financing contributions of Development Partners as a share of CHE**

Year	CHE (FJ\$m)	Funding by Development Partners(FJ\$m)	Share of Development Partners funding to CHE (%)
2011	230.4	11.1	4.8%
2012	251.5	15.2	6.1%
2013	267.8	11.1	4.2%
2014	310.3	11.9	3.8%

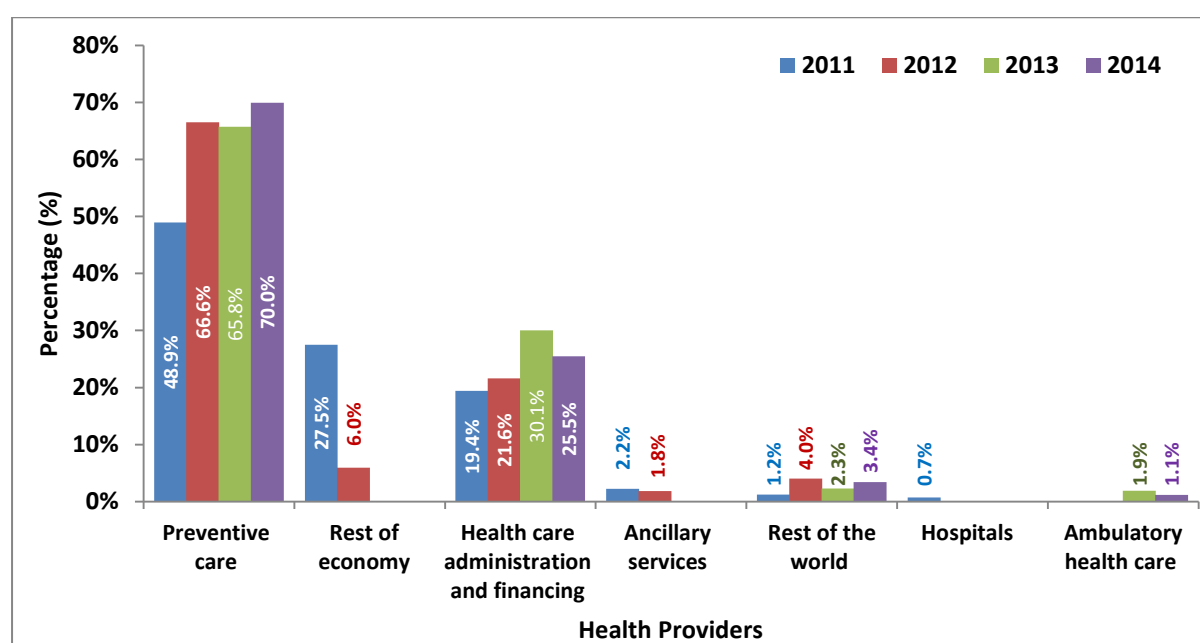
Table 8-2 shows that development partner funding as a share of Current Health Expenditure (CHE) had fluctuated over the four year period (2011 to 2014). In 2014 the share was 3.8% of CHE which reflects a reduction of 1.0% from 2011.

## 8.1. Development Partners funding by Providers

Preventative care programs accounted for the largest portion of the development partner funding increasing from 48.9% in 2011 to 70.0% in 2014 (refer Figure 8-2). Healthcare administration and financing, the second largest expenditures item for development partners, has also increased gradually over the period 2011 to 2014.

The appearance of certain expenditure items in some years and yet missing in other years shows priorities of donor funding changes across years.

Figure 8-2 Allocation of Development Partners funding by Providers



Source: Table 8-3

Table 8-3 Allocation of Development Partners funding by Providers

Providers	2011	2012	2013	2014
Hospitals	0.1	-	-	-
Providers of ambulatory health care	-	-	0.2	0.1
Providers of ancillary services	0.2	0.3	-	-
Providers of preventive care	5.4	10.1	7.3	8.3
Providers of health care system administration and financing	2.2	3.3	3.3	3.0
Rest of economy	3.1	0.9	-	-
Rest of the world	0.1	0.6	0.3	0.4
<b>Total</b>	<b>11.1</b>	<b>15.2</b>	<b>11.1</b>	<b>11.9</b>

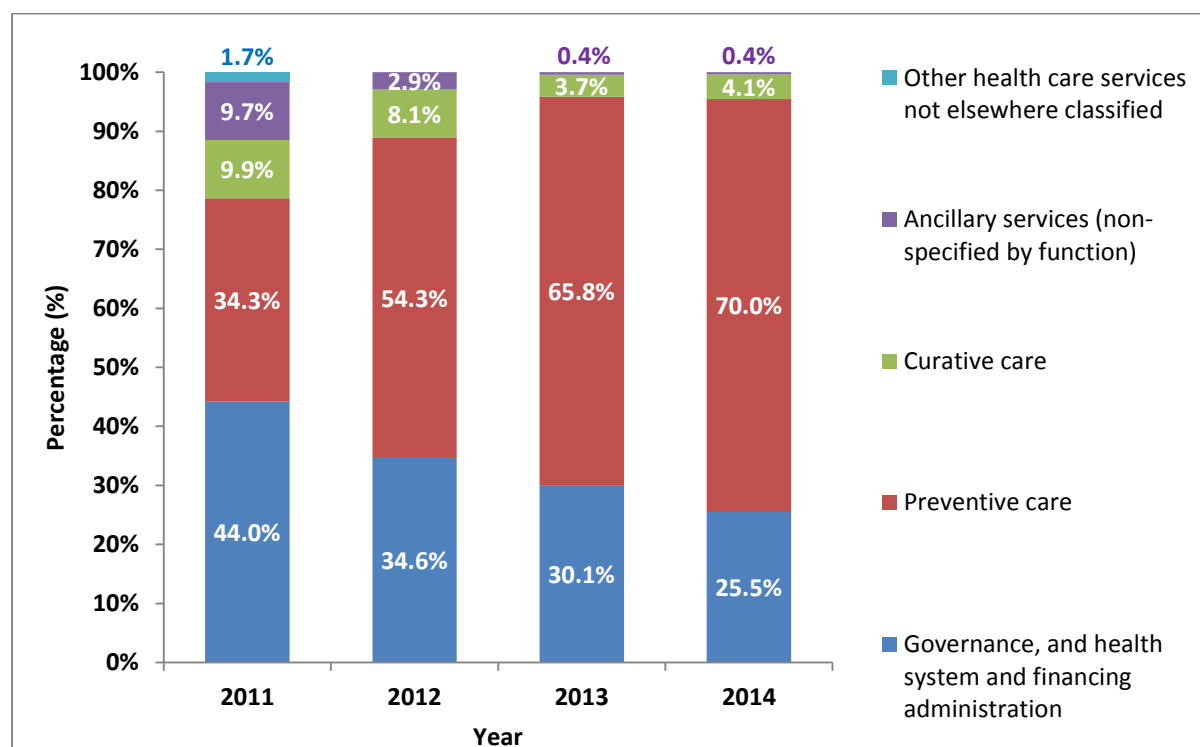
## 8.2. Development Partners funding by Functions

Preventive care accounted for largest portion of the development partner funding over the four year period (2011 to 2014), increasing from 48.9% in 2011 to 70.0% in 2014 (refer Figure 8-2). In 2014, development partner funds were largely used for preventative care (70%) followed by governance, health system, financing and administration (25.5%). Combined these two areas reflect 95.5% of development partner investment.

**Table 8-4 Allocation of Development Partners funding by Functions**

Functions	2011	2012	2013	2014
Curative care	1.1	1.2	0.4	0.5
Ancillary services (non-specified by function)	1.1	0.4	0.0	0.0
Medical goods (non-specified by function)	0.0	-	-	-
Preventive care	3.8	8.3	7.3	8.3
Governance, and health system and financing administration	4.9	5.3	3.3	3.0
Other health care services not elsewhere classified (n.e.c.)	0.2	-	-	-
<b>Total</b>	<b>11.1</b>	<b>15.2</b>	<b>11.1</b>	<b>11.9</b>

**Figure 8-3 Share of funding by Function (%), 2011 to 2014**



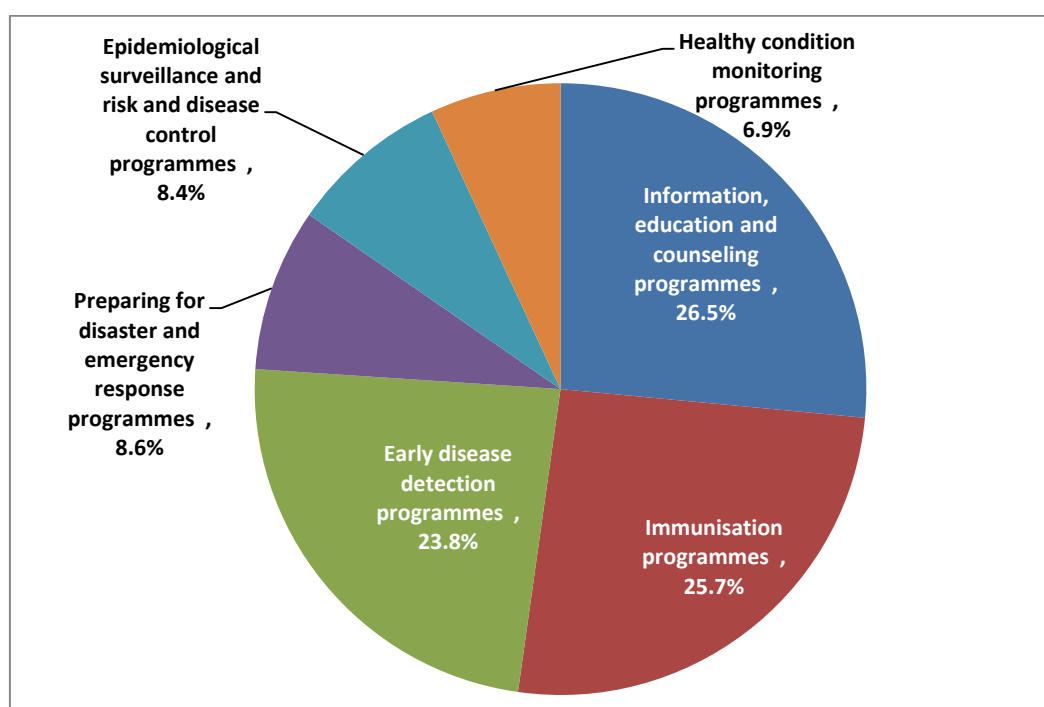
Source: Table 8-3

**Table 8-5 Preventive care funding by Development Partners, FJ\$m**

Preventive care	2011	2012	2013	2014
Information, education and counselling programmes	2.1	4.4	2.1	2.2
Immunisation programmes	0.5	1.5	2.4	2.1
Early disease detection programmes	0.1	0.3	1.5	2.0
Healthy condition monitoring programmes	0.3	1.2	0.6	0.6
Epidemiological surveillance and risk and disease control programmes	0.6	0.4	0.6	0.7
Preparing for disaster and emergency response programmes	0.1	0.4	0.1	0.7
<b>Total</b>	<b>3.8</b>	<b>8.3</b>	<b>7.3</b>	<b>8.3</b>

The Table 8-5 provides the breakdown of the Preventive care funding by Development partners into various preventive care categories. The development partners have largely invested in information, education and counselling programs, Immunization and Early disease detection programmes for prevention and control.

**Figure 8-4 Share Preventive care funding by Development Partners (%), 2014**



Source: Table 8-5



### 8.3. Development Partners spending by Capital Expenditure

The Table below provides the breakdown of the capital expenditure by the Development partners. Since 2013, DFAT, Global Fund and NZAid has been largely investing in health sector.

Development Partners	Capital Expenditure (HK)			
	2011	2012	2013	2014
DFAT	0.9	-	3.6	2.7
Global fund	-	-	0.2	0.6
WHO	-	-	-	-
Japan	0.3	0.1	-	-
China	-	-	-	-
NZAid	0.1	0.7	0.6	-
UNFPA	-	-	-	-
UNICEF	-	-	-	-
UNAIDS	-	-	-	-
Other	-	-	-	-
<b>Total Donor Contribution</b>	<b>1.2</b>	<b>0.8</b>	<b>4.4</b>	<b>3.3</b>

Table 9-5 in Chapter 9 provides the types of Assets in which the development partners have invested over the period 2011 to 2014.

## 9. Capital Expenditure

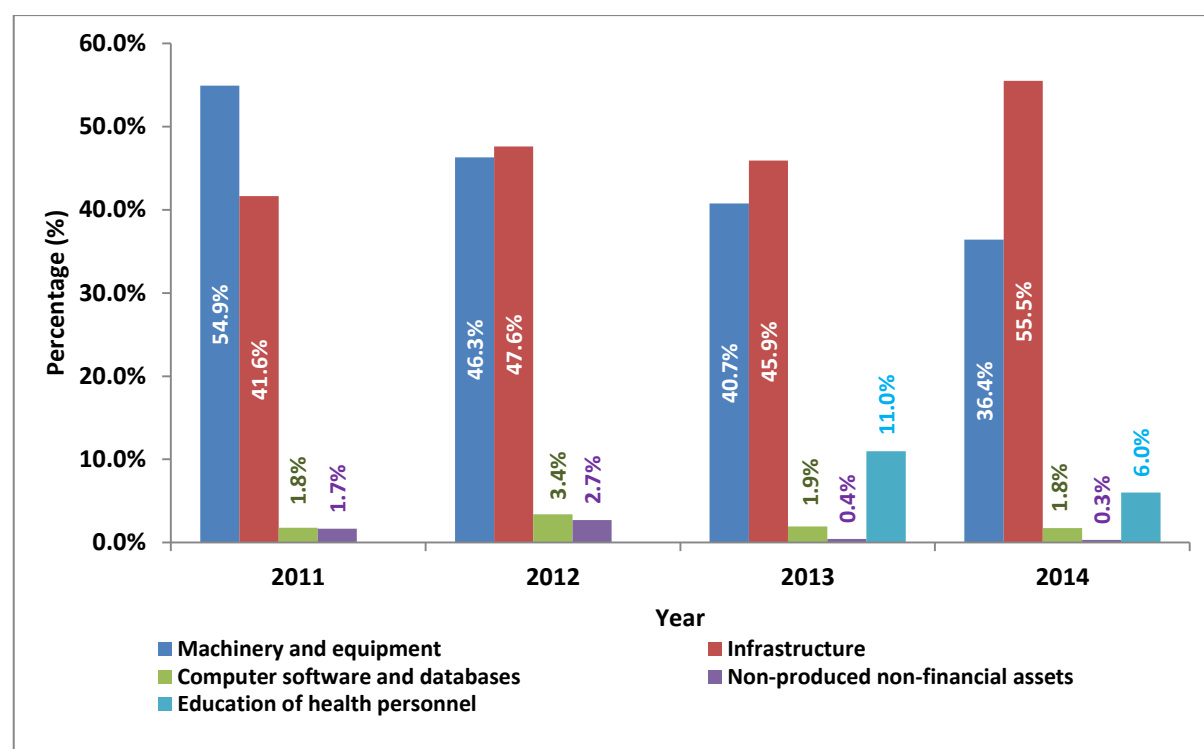
SHA 2011 describes Capital Expenditure (HK) as a very integral component in health expenditure towards production of health services. For example construction of new health facilities or expansion/upgrading of existing ones, investment into new medical equipment or upgrading or enhancements in computer or information systems. The HK information helps in analyzing the health systems production capability whether it's appropriate, deficient or excessive.

This chapter provides how much Capital Expenditure has been spent on the production of services which was contributed by Government, private and development partners and what types of services have been provided. The information presented on private and development partners have been consolidated from the survey responses.

### 1.1. Types of Assets in production of health services

Capital Expenditure is classified under two major categories where i) Gross Capital formation comprises of infrastructure, machinery & equipment, ICT & other related machinery; and ii) Non - produced non – financial assets comprising of land and others.

Figure 9-1 Capital Expenditure by type of asset, (nominal Fiji dollars)



Source: Table 9-1

Figure 9-1 provides the amount spent on various types of assets for the period 2011 to 2014.

The total Capital Expenditure as shown in Table 9-1 is a composition of both public and private for the period 2011 to 2014. There was a two fold increase of FJ\$17.6m from 2011 (FJ\$15.1m) to 2014 (FJ\$32.7m). This increase was largely from the public sector. The main increase in HK was for infrastructure; machinery and equipment (refer Table 9-1).

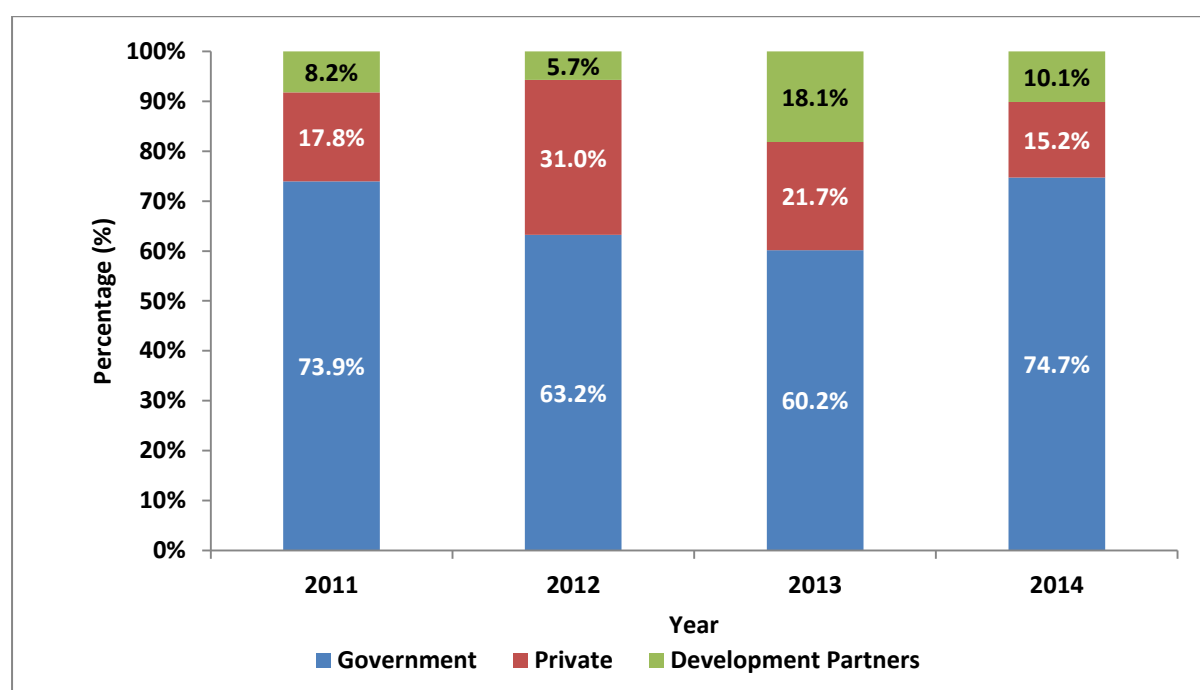
**Table 9-1 Capital Expenditure by type of asset, FJ\$m**

<b>Capital Account</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>
<b>Infrastructure</b>	<b>6.3</b>	<b>7.0</b>	<b>11.1</b>	<b>18.1</b>
Residential and non-residential buildings	6.3	6.9	10.7	17.9
Other structures	0.0	0.1	0.4	0.2
<b>Machinery and equipment</b>	<b>8.3</b>	<b>6.8</b>	<b>9.8</b>	<b>11.9</b>
Medical equipment	5.7	4.9	8.0	10.2
Transport equipment	0.3	0.4	0.2	0.2
ICT equipment	1.0	0.2	0.5	0.7
Machinery and equipment	1.2	1.3	1.2	0.8
<b>Intellectual property products</b>	<b>0.3</b>	<b>0.5</b>	<b>0.5</b>	<b>0.6</b>
Computer software and databases	0.3	0.5	0.5	0.6
<b>Non-produced non-financial assets</b>	<b>0.3</b>	<b>0.4</b>	<b>0.1</b>	<b>0.1</b>
Non-produced non-financial assets	0.3	0.4	0.0	0.0
Land	0.0	0.0	0.1	0.1
<b>Memorandum items</b>	<b>0.0</b>	<b>0.0</b>	<b>2.7</b>	<b>2.0</b>
Education of health personnel	0	0	2.7	2.0
<b>Total</b>	<b>15.1</b>	<b>14.7</b>	<b>24.2</b>	<b>32.7</b>

## 1.2. Capital Expenditure by Sectors

Figure 9-2 shows the contribution of Capital Expenditure by each sector for the years 2011 to 2014. Government was the largest contributor to Capital Expenditure followed by private sector. Both Government and private sector expenditure includes the construction or upgrading of infrastructures, purchase of bio-medical & dental equipment, vessels, vehicles such as ambulances and ICT equipment & software in their respective sectors. The Capital Expenditure by development partners is mostly investments made in the form of new infrastructure, maintenance of existing health facilities and equipment purchase. The major increase in 2014 was mainly due to the infrastructure development, upgrading of hospital health facilities and building of new health centers and nursing stations.

Figure 9-2 Capital Expenditure by sectors



Source: Table 9-2

Table 9-2 Capital Expenditure by sectors, FJ\$m

Sector	2011	2012	2013	2014
Government	11.1	9.3	14.5	24.4
Private	2.7	4.6	5.2	5.0
Development Partners	1.2	0.8	4.4	3.3
<b>Total</b>	<b>15.1</b>	<b>14.7</b>	<b>24.2</b>	<b>32.7</b>

### 1.3. Government Capital Expenditure

Government capital expenditure mostly includes the construction or maintenance/upgrading of infrastructures and purchase of equipment such as bio-medical & dental equipment, vessels, vehicles mostly ambulances and ICT equipment & software. The Government Capital Expenditure had significantly increased from FJ\$11.1m in 2011 to FJ\$24.4m in 2014 (refer Table 9-3). Capital Expenditure depends mainly on two things 1) Government's Public Sector Investment Programme (PSIP) allocation of funds. 2) Time taken by Ministry to implement the capital project.

**Table 9-3 Capital Expenditure by Government**

Capital Account	2011		2012		2013		2014	
	Amount (FJ\$m)	Share (%)	Amount (FJ\$m)	Share (%)	Amount (FJ\$m)	Share (%)	Amount (FJ\$m)	Share (%)
<b>Infrastructure</b>	<b>5.3</b>	<b>47.4%</b>	<b>4.1</b>	<b>43.9%</b>	<b>6.9</b>	<b>47.3%</b>	<b>15.7</b>	<b>64.2%</b>
Residential and non-residential buildings	5.3		4.1		6.9		15.7	
<b>Machinery and equipment</b>	<b>5.9</b>	<b>52.6%</b>	<b>5.2</b>	<b>56.1%</b>	<b>7.7</b>	<b>52.7%</b>	<b>8.7</b>	<b>35.8%</b>
Medical equipment	4.7		3.4		6.2		7.6	
Transport equipment	0.0		0.4		0.0		0.0	
ICT equipment	0.1		0.2		0.3		0.3	
Machinery and equipment	1.1		1.2		1.2		0.8	
<b>Total</b>	<b>11.1</b>	<b>100%</b>	<b>9.3</b>	<b>100%</b>	<b>14.5</b>	<b>100%</b>	<b>24.4</b>	<b>100%</b>

Infrastructure expenditure within Government Capital Expenditure had increased by three fold in 2014 to FJ\$15.7m from FJ\$5.3m in 2011 (refer Table 9-3). Machinery and Equipment expenditure is primarily for ongoing purchases of new medical equipment for new and existing health facilities and replacement of obsolete ones which had also increased by FJ\$2.6m in 2014.

#### 1.4. Private Capital Expenditure

Private capital expenditure includes the construction or maintenance/upgrading of infrastructures and purchase of equipment such as bio-medical & dental equipment and ICT equipment & software. Table 9-4 displays that overall private sector Capital Expenditure had increased by FJ\$2.3m in 2014 from FJ\$2.7m in 2011 to FJ\$5.0m in 2014. Largely the increase in Capital Expenditure was on machinery and equipment.

**Table 9-4 Capital Expenditure by private sector**

Capital Account	2011		2012		2013		2014	
	Amount (FJ\$m)	Share (%)	Amount (FJ\$m)	Share (%)	Amount (FJ\$m)	Share (%)	Amount (FJ\$m)	Share (%)
<b>Infrastructure</b>	<b>0.9</b>	<b>35.1%</b>	<b>2.1</b>	<b>45.8%</b>	<b>2.5</b>	<b>48.4%</b>	<b>1.6</b>	<b>32.8%</b>
Residential and non-residential buildings	0.9		2.1		2.4		1.4	
Other Structures	0.0		0.0		0.2		0.2	
<b>Machinery and equipment</b>	<b>1.2</b>	<b>45.5%</b>	<b>1.6</b>	<b>35.3%</b>	<b>2.1</b>	<b>40.7%</b>	<b>2.6</b>	<b>53.4%</b>
Medical equipment	1.1		1.5		1.8		2.0	
Transport Equipment	0.0		0.0		0.2		0.2	
ICT Equipment	0.0		0.0		0.2		0.4	
Machinery and equipment n.e.c.	0.1		0.1		0.0		0.0	
<b>Intellectual property products</b>	<b>0.3</b>	<b>10.0%</b>	<b>0.5</b>	<b>9.9%</b>	<b>0.5</b>	<b>9.0%</b>	<b>0.6</b>	<b>11.6%</b>
Computer software and databases	0.3		0.5		0.5		0.6	
<b>Non-produced non-financial assets</b>	<b>0.3</b>	<b>9.4%</b>	<b>0.4</b>	<b>9.0%</b>	<b>0.1</b>	<b>2.0%</b>	<b>0.1</b>	<b>2.1%</b>
Non-produced non-financial assets	0.3		0.4		0.0		0.0	
Land	0.0		0.0		0.1		0.1	
<b>Total</b>	<b>2.7</b>	<b>100%</b>	<b>4.6</b>	<b>100%</b>	<b>5.2</b>	<b>100%</b>	<b>5.0</b>	<b>100%</b>

## 1.5. Development Partners Capital Expenditure

Capital expenditure by development partners shows an overall increase from FJ\$1.2m in 2011 to FJ\$3.3m in 2014 (refer Table 9-5).

In 2014, the increase in expenditure was mainly for education and training for health personnel which equates to 59.5%. The expenditure on infrastructure had increased by FJ\$0.7m over the period from 2011 to 2014.

**Table 9-5 Capital Expenditure by Development Partners**

Capital Account	2011		2012		2013		2014	
	Amount (FJ\$m)	Share (%)	Amount (FJ\$m)	Share (%)	Amount (FJ\$m)	Share (%)	Amount (FJ\$m)	Share (%)
<b>Infrastructure</b>	<b>0.1</b>	<b>4.6%</b>	<b>0.8</b>	<b>100.0%</b>	<b>1.7</b>	<b>38.4%</b>	<b>0.8</b>	<b>25.3%</b>
Residential and non-residential buildings	0.1		0.7		1.4		0.8	
Other structures	0.0		0.1		0.2		0.0	
<b>Machinery and equipment</b>	<b>1.2</b>	<b>95.4%</b>	<b>0.0</b>	<b>0.0%</b>	<b>0.0</b>	<b>1.0%</b>	<b>0.5</b>	<b>15.2%</b>
Medical Equipment	0.0		0.0		0.0		0.5	
Transport equipment	0.3		0.0		0.0		0.0	
ICT equipment	0.9		0.0		0.0		0.0	
<b>Memorandum items</b>	<b>0.0</b>	<b>0.0%</b>	<b>0.0</b>	<b>0.0%</b>	<b>2.7</b>	<b>60.6%</b>	<b>2.0</b>	<b>59.5%</b>
Education of health personnel	0.0		0.0		2.7		2.0	
<b>Total</b>	<b>1.2</b>	<b>100%</b>	<b>0.8</b>	<b>100%</b>	<b>4.4</b>	<b>100%</b>	<b>3.3</b>	<b>100%</b>

## 10. Factors of Health Care Provision

This classification of health expenditure in this chapter specifically focuses on the inputs needed to produce the health care goods and services (Factors of Provision - FP). The discussion and results presented here are for public and private sectors.

The Government Current Health Expenditure (GCHE) by “factors of provision” was captured from the Financial Management Information System (FMIS). The FMIS is Government electronic accounting system which captures and records financial information at a detail level. The Government’s budget system is an input-based however, the costs captured by FMIS is also at an input-based. Information presented in this chapter on private sector was based on the survey responses received.

### 10.1. Factors of Provision for CHE

Table 10-1 below provides details of various resource inputs within the GCHE. The FP by GCHE in 2011 was FJ\$138.7m and in 2014 was FJ\$187.3m. The expenditure in 2014 had increased substantially. Major increase was in Human Resource (HR) costs and Other health care goods.

**Table 10-1 Factors of Provision by GCHE**

Category	2011		2012		2013		2014	
	Amount (FJ\$m)	Share (%)	Amount (FJ\$m)	Share (%)	Amount (FJ\$m)	Share (%)	Amount (FJ\$m)	Share (%)
Human Resource (HR) Costs*	71.0	51.2%	77.4	51.9%	79.2	50.8%	103.5	55.3%
FNPF	6.5	4.7%	6.3	4.2%	6.5	4.2%	8.8	4.7%
Other HR Costs*	8.4	6.1%	5.1	3.4%	7.2	4.6%	4.0	2.2%
Health care services	12.7	9.1%	13.6	9.1%	14.1	9.0%	15.6	8.3%
Health care goods	-	0.0%	-	0.0%	-	0.0%	-	0.0%
Pharmaceuticals (Drugs)	10.3	7.4%	8.9	6.0%	9.7	6.2%	9.0	4.8%
Other health care goods	17.0	12.2%	20.6	13.8%	22.5	14.4%	26.2	14.0%
Non-health care services	1.7	1.2%	1.7	1.2%	1.7	1.1%	1.6	0.9%
Non-health care goods	-	0.0%	-	0.0%	0.7	0.5%	0.9	0.5%
Taxes (VAT)**	6.6	4.8%	8.3	5.6%	6.8	4.4%	10.3	5.5%
Other items of spending	4.6	3.3%	7.2	4.8%	7.5	4.8%	7.4	3.9%
<b>Total</b>	<b>138.7</b>	<b>100%</b>	<b>149.1</b>	<b>100%</b>	<b>155.7</b>	<b>100%</b>	<b>187.3</b>	<b>100%</b>

The FP by GCHE presented in Table 10-1 is only for MoHMS and does not include other Ministries

\*HR Costs refers to Wages & Salaries and Other HR Costs refers to Allowances, Overtime and Relieving etc.

\*\* Taxes here refer to VAT paid on the purchase of healthcare goods and services. It was not possible to distribute these across the categories in the above table.

The private sector also had high input costs in 2013 and 2014. The FP by Private Current Health Expenditure (PCHE) in 2013 was FJ\$79.0m and in 2014 was FJ\$83.5m (refer Table 10-2). The expenditure in 2014 had increased substantially. Major increases were recorded in

Human Resource (similar to public sector), Pharmaceuticals and Non-health care goods. Unfortunately, there was no information for private sector for years 2011 and 2012.

**Table 10-2 Factors of Provision by Private CHE**

Category	2013		2014	
	Amount (FJ\$m)	Share (%)	Amount (FJ\$m)	Share (%)
Human Resource (HR) + Other HR Costs	22.3	28.3%	24.5	29.4%
Health care services	14.2	18.0%	14.7	17.6%
Health care goods	28.5	36.1%	29.6	35.4%
Pharmaceuticals (Drugs)	11.8	15.0%	12.3	14.7%
Other health care goods	16.7	21.1%	17.3	20.7%
Non-health care goods	13.9	17.6%	14.7	17.5%
<b>Total</b>	<b>79.0</b>	<b>100%</b>	<b>83.5</b>	<b>100%</b>

## 10.2. Factors of Provision by Health Providers, GCHE

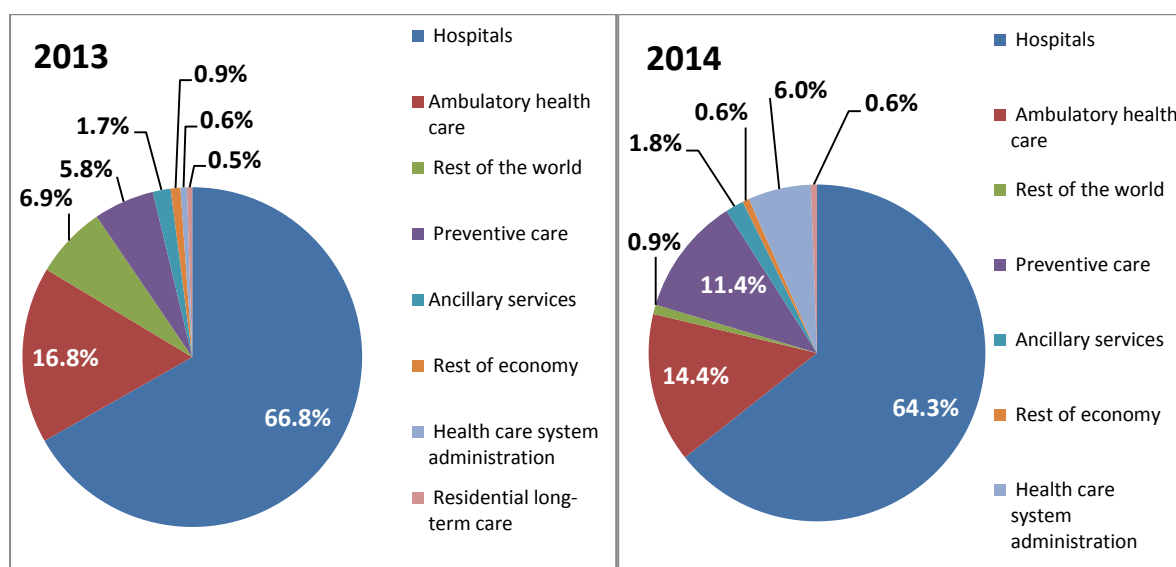
In this section we look at how resource input costs are distributed across the government owned health providers.

### 10.2.1. Factors of Provision by Health Providers, Government

Government health providers exist at different levels within the health care system and they are defined by the types of health services they provide. Figure 10-1 provides the distribution of input costs amongst the various providers in the public sector. In both years 2013 and 2014 Hospitals had the largest costs followed by Ambulatory services. However, due to overall Government's initiative for a healthier population there was a lot of emphasis put on prevention and in 2014 was the third largest expenditure. Administration costs also increased in 2014. All other cost categories remained stagnant.



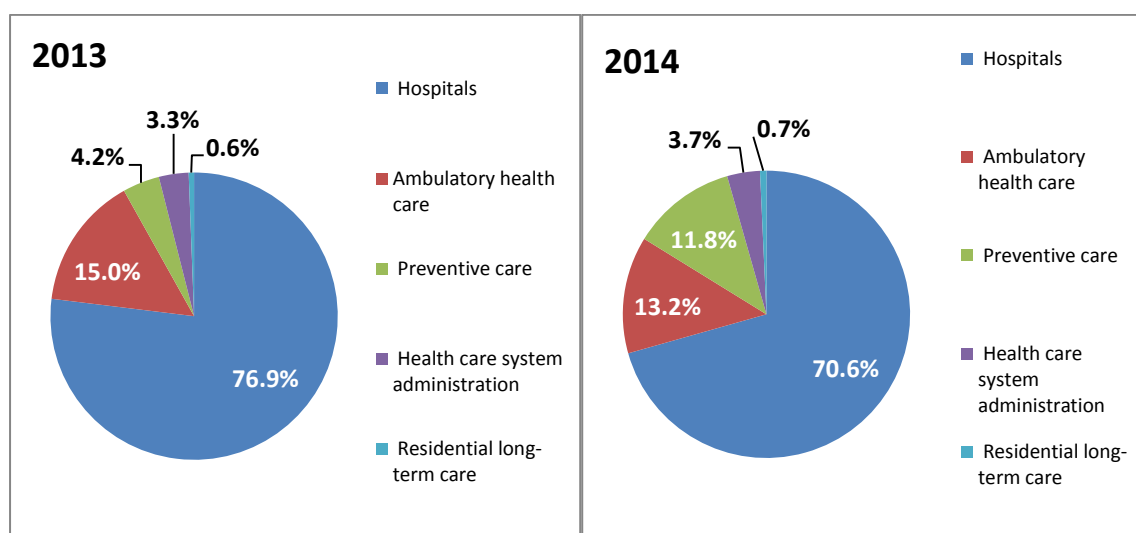
**Figure 10-1 Factors of Provision costs by health Providers**



### 10.2.2. Human Resources

Human resource remains the largest expenditure in the public sector. Figure 10-2 shows that the majority of HR associated expenditure was incurred at hospitals, 76.9% in 2013 and 70.6% in 2014. Providers of Ambulatory care which incorporates Health centers and Nursing stations account for the second largest expenditure; 15.0% in 2013 and 13.2% in 2014. Preventive care costs changed significantly from 4.2% in 2013 to 11.8% in 2014.

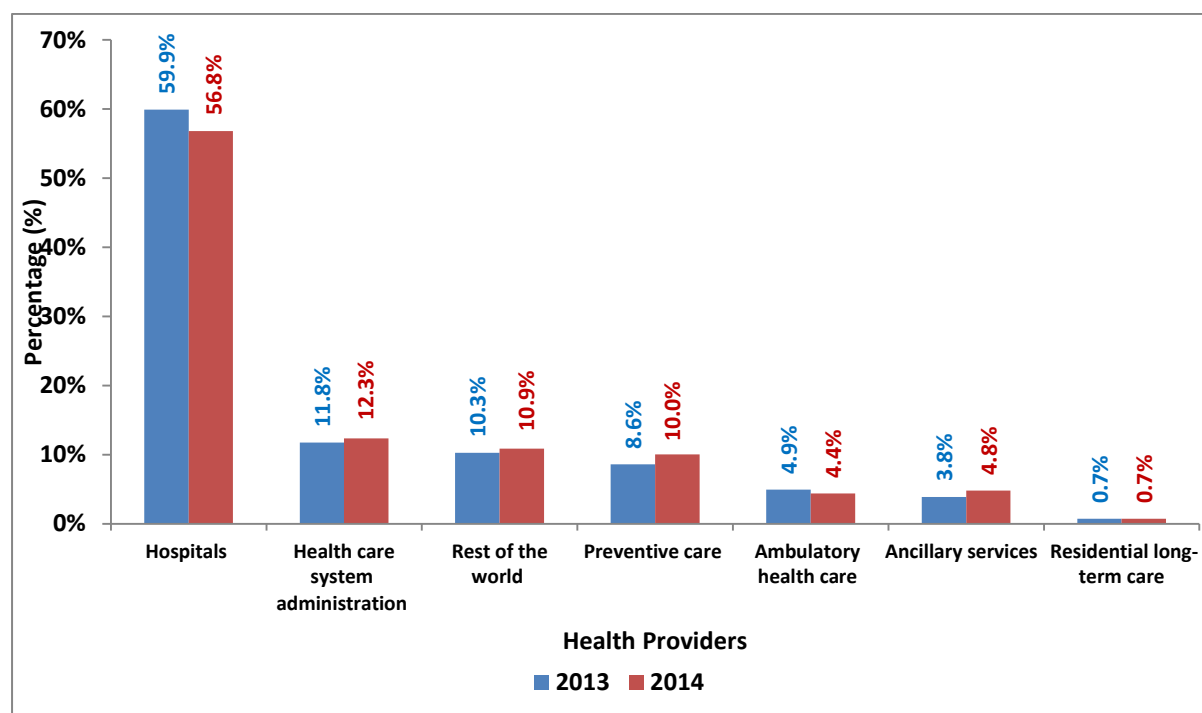
**Figure 10-2 Human Resource Expenditure by health Providers**



### 10.2.3. Health care services

Health Care services expenditure was highest at the hospital averaging 60.0% over the two years (2013 and 2014). There were no significant changes across the other categories.

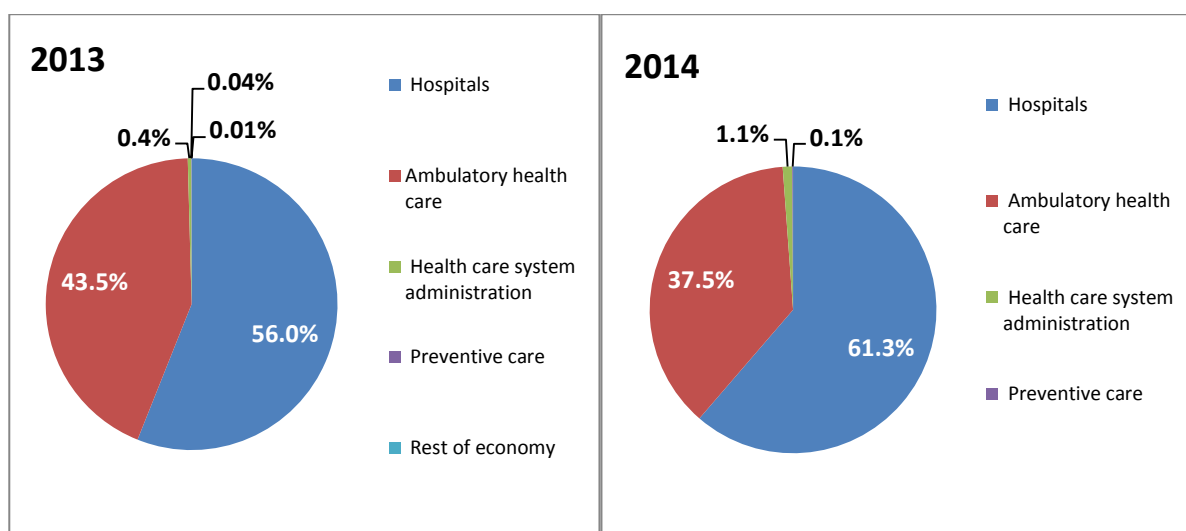
Figure 10-3 Healthcare Services Expenditure by health Providers



### 10.2.4. Pharmaceuticals

The pharmaceutical expenditure at the hospitals had increased which accounted for 56.0% in 2013 to 61.3% in 2014 (refer Figure 10-4). The pharmaceutical expenditure at Ambulatory health care accounted for 43.5% in 2013 and decreased to 37.5% in 2014.

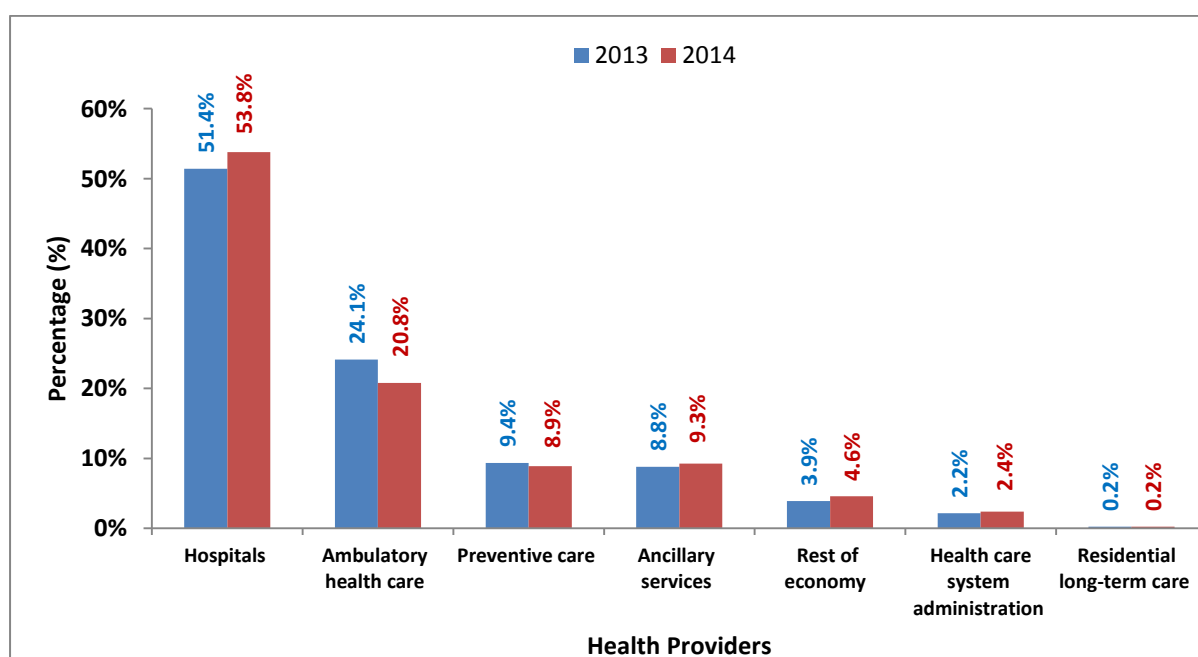
**Figure 10-4 Pharmaceutical Expenditure by Health Providers**



### 10.2.5. Other health care goods

Health care goods are goods and services purchased by the Provider used in the diagnosis, treatment or prevention of a disease or other abnormal condition. Hospitals account for 51.4% in 2013 and 53.8% in 2014 followed by Ambulatory health care which accounted for 24.1% in 2013 and 20.8% in 2014. The other Providers shared the remaining costs (refer Figure 10-5).

**Figure 10-5 Other health care goods expenditure by health Providers**



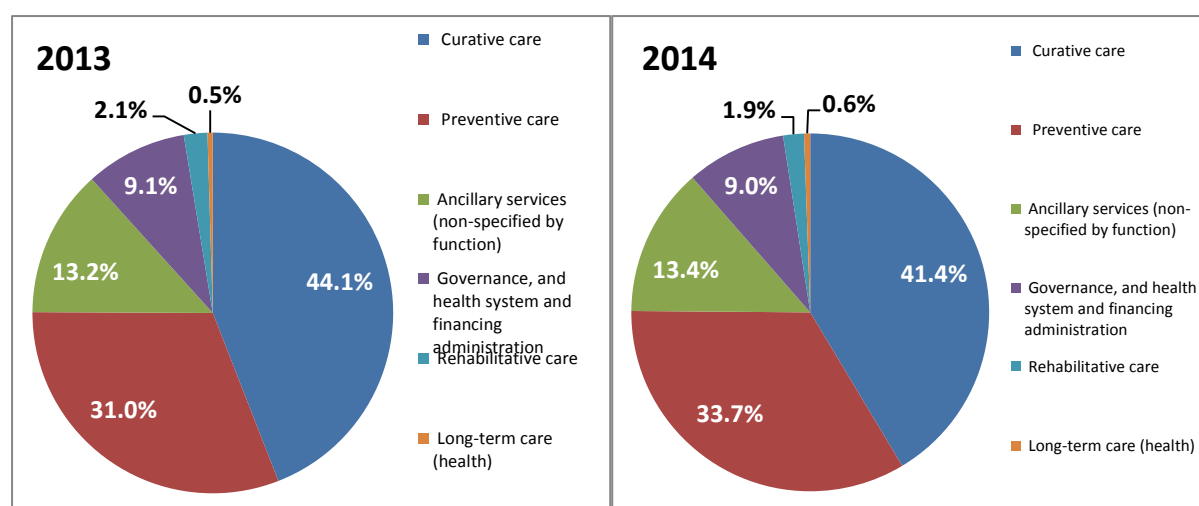
### 10.3. Factors of Provision by Health Functions, GCHE

In this section we look at how resource input costs are distributed across the Government for the type of services that has been provided.

#### 10.3.1. Factors of Provision by Health Functions, Government

Government provides a variety of services through its providers that exist at different levels within the health care system. Figure 10-6 provides the distribution of input costs amongst the type of services that has been provided in the public sector. Across all FP (resource inputs), curative care accounted for the most expenditure followed by Preventive care, Ancillary services whilst the other cost remained stagnant and with the least expenditure in Long term health care. Curative care comprises of inpatient and outpatient services provided at the health facilities.

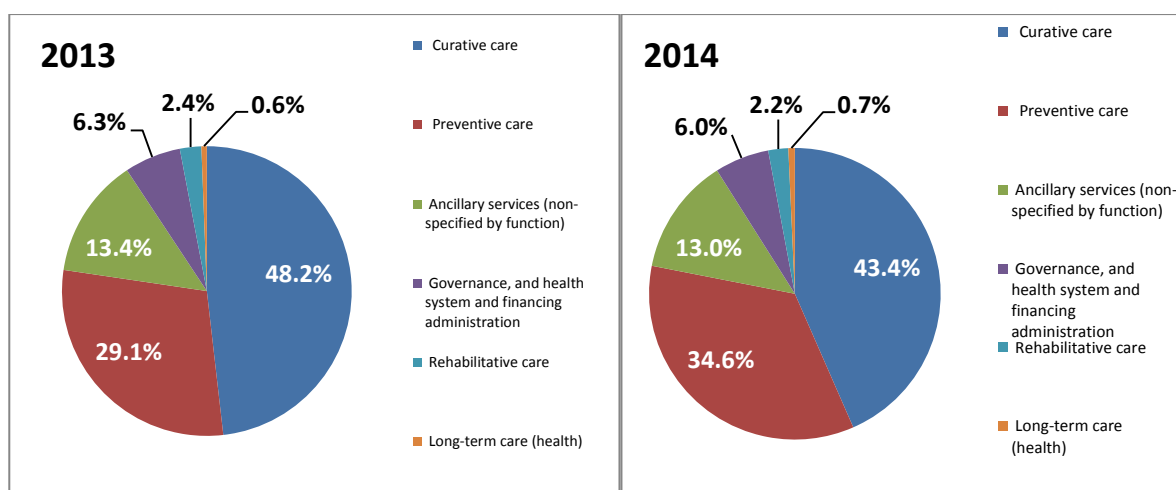
Figure 10-6 Factors of Provision costs by Health Functions



#### 10.3.2. Human Resource

Human resource (HR) cost has remained the largest input costs in delivering the type of services in the public sector. Figure 10-7 shows that the majority of HR cost was on delivering the Curative care, 48.2% in 2013 and 43.4% in 2014. Preventive care accounted for the second largest HR costs, 29.1% in 2013 and 34.6% in 2014 followed by Ancillary services, 13.4% in 2013 and 13.0% in 2014. Other HR costs did not significantly change across the remaining types of services.

Figure 10-7 Human Resource costs by health functions



## 11. Disease Based Costs

The disease costing presented here is based on inpatient and outpatient data from both public and private sectors.

Patient days (for inpatient analysis) and outpatient visits (for outpatient analysis) coded by International Coding of Disease 10 Australian Modification (ICD 10 AM) classification were used to allocate facility expenditure by disease category.

### 11.1. Expenditure by Disease for Inpatients

#### 11.1.1. Expenditure by Disease for Inpatients

All text based diagnoses have been classified by ICD 10 AM, as this is the standard morbidity classification used in the public health sector in Fiji. The total inpatient cost of disease for 2013 stood at FJ\$45.1m compared to FJ\$51.5m in 2014. This was an increase of FJ\$6.5m (14.2%). This increase was mostly in the category of certain infectious and parasitic diseases (A00-B99) (refer Table 11-1).

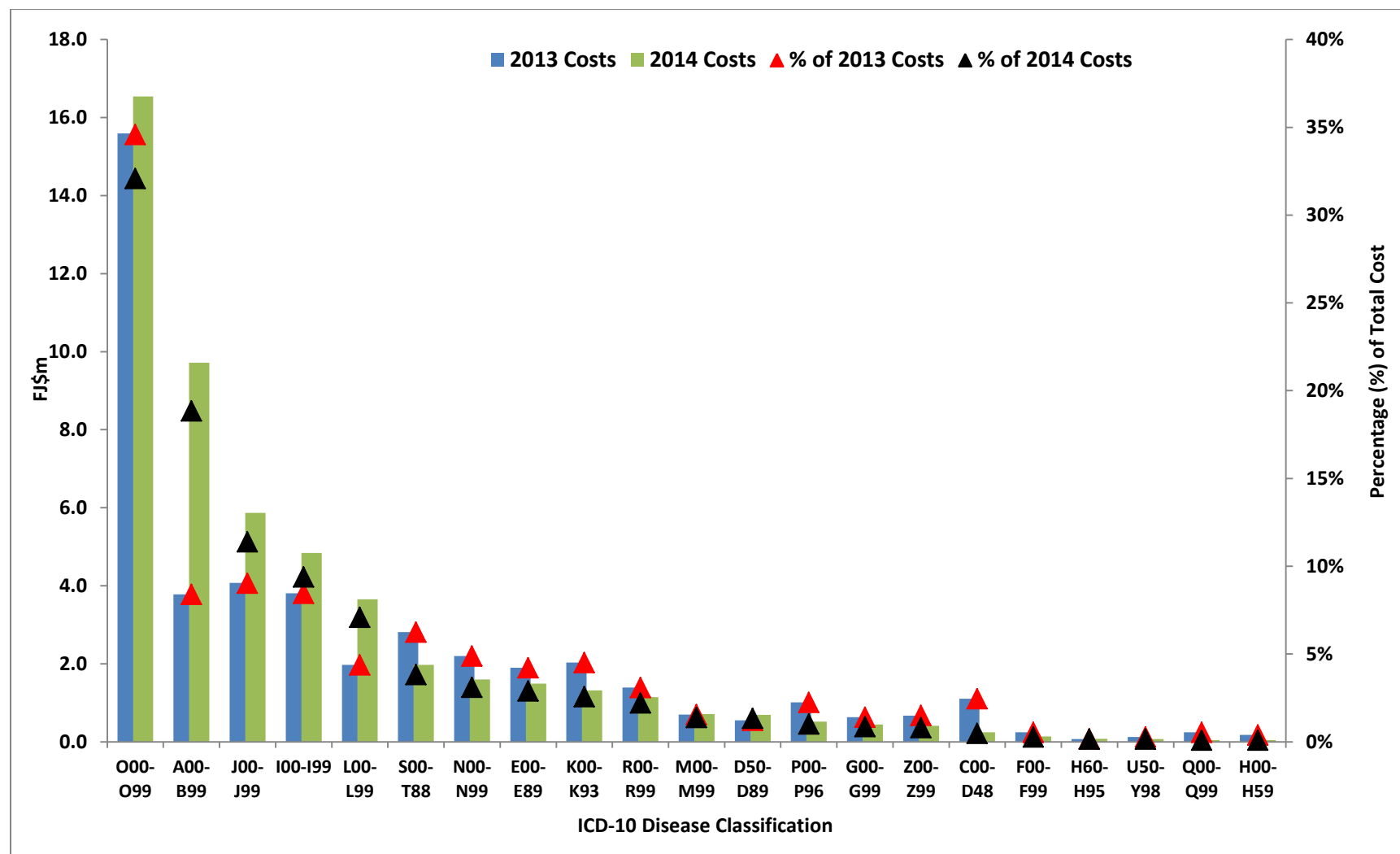
At a glance, the largest proportion of the expenditure in 2013 was borne by Pregnancy, Childbirth and the Puerperium (34.6%), followed by, Diseases of the Respiratory System (9%), followed by Diseases of the Circulatory System (8.4%). It is important to note that with greater insight and further analysis, non-communicable diseases accounted for 25% of the cost of disease in 2013 [this accumulates the total percentages of neoplasms, endocrine, nutritional and metabolic disorders, mental and behavioural disorders, diseases of the circulatory system, injury, poisoning and certain other consequences of external causes, external causes of morbidity and mortality and factors influencing health status and contact with health services].

The comparison with 2014 yields a similar rank order to 2013. The largest portion of the cost is attributable to Pregnancy, Childbirth and Puerperium [32.1%]; followed by certain infectious and parasitic diseases [18.8%] due to frequent disease outbreaks and diseases of the respiratory tract [11.4%]. However, once again with further analysis, the non-communicable diseases make up 18% of the total cost of illness.

**Table 11-1 Inpatient Disease-based Cost for 2013 and 2014**

ICD 10 AM CODE	ICD 10 AM CODE DESCRIPTION	2013		2014	
		Amount (FJ\$m)	Share (%)	Amount (FJ\$m)	Share (%)
A00-B99	Certain infectious and parasitic diseases	3.8	8.4%	9.7	18.8%
C00-D48	Neoplasms	1.1	2.5%	0.2	0.5%
D50-D89	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	0.6	1.2%	0.7	1.3%
E00-E89	Endocrine, nutritional and metabolic diseases	1.9	4.2%	1.5	2.9%
F00-F99	Mental, Behavioral and Neurodevelopmental disorders	0.2	0.5%	0.1	0.3%
G00-G99	Diseases of the nervous system	0.6	1.4%	0.4	0.9%
H00-H59	Diseases of the eye and adnexa	0.2	0.4%	0.0	0.1%
H60-H95	Diseases of the ear and mastoid process	0.1	0.2%	0.1	0.2%
I00-I99	Diseases of the circulatory system	3.8	8.4%	4.8	9.4%
J00-J99	Diseases of the respiratory system	4.1	9.0%	5.9	11.4%
K00-K93	Diseases of the digestive system	2.0	4.5%	1.3	2.6%
L00-L99	Diseases of the skin and subcutaneous tissue	2.0	4.4%	3.7	7.1%
M00-M99	Diseases of the musculoskeletal system and connective tissue	0.7	1.5%	0.7	1.4%
N00-N99	Diseases of the genitourinary system	2.2	4.9%	1.6	3.1%
O00-O99	Pregnancy, childbirth and the puerperium	15.6	34.6%	16.5	32.1%
P00-P96	Certain conditions originating in the perinatal period	1.0	2.2%	0.5	1.0%
Q00-Q99	Congenital malformations, deformations and chromosomal abnormalities	0.2	0.5%	0.0	0.1%
R00-R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	1.4	3.1%	1.1	2.2%
S00-T88	Injury, poisoning and certain other consequences of external causes	2.8	6.2%	2.0	3.8%
U50-Y98	External Causes of Morbidity and Mortality	0.1	0.3%	0.1	0.1%
Z00-Z99	Factors influencing health status and contact with health services	0.7	1.5%	0.4	0.8%
<b>Total</b>		<b>45.1</b>	<b>100%</b>	<b>51.5</b>	<b>100%</b>

Figure 11-1 Inpatient Disease Expenditure by ICD 10AM in 2013 and 2014 as a Percentage



Source: Table 11-1

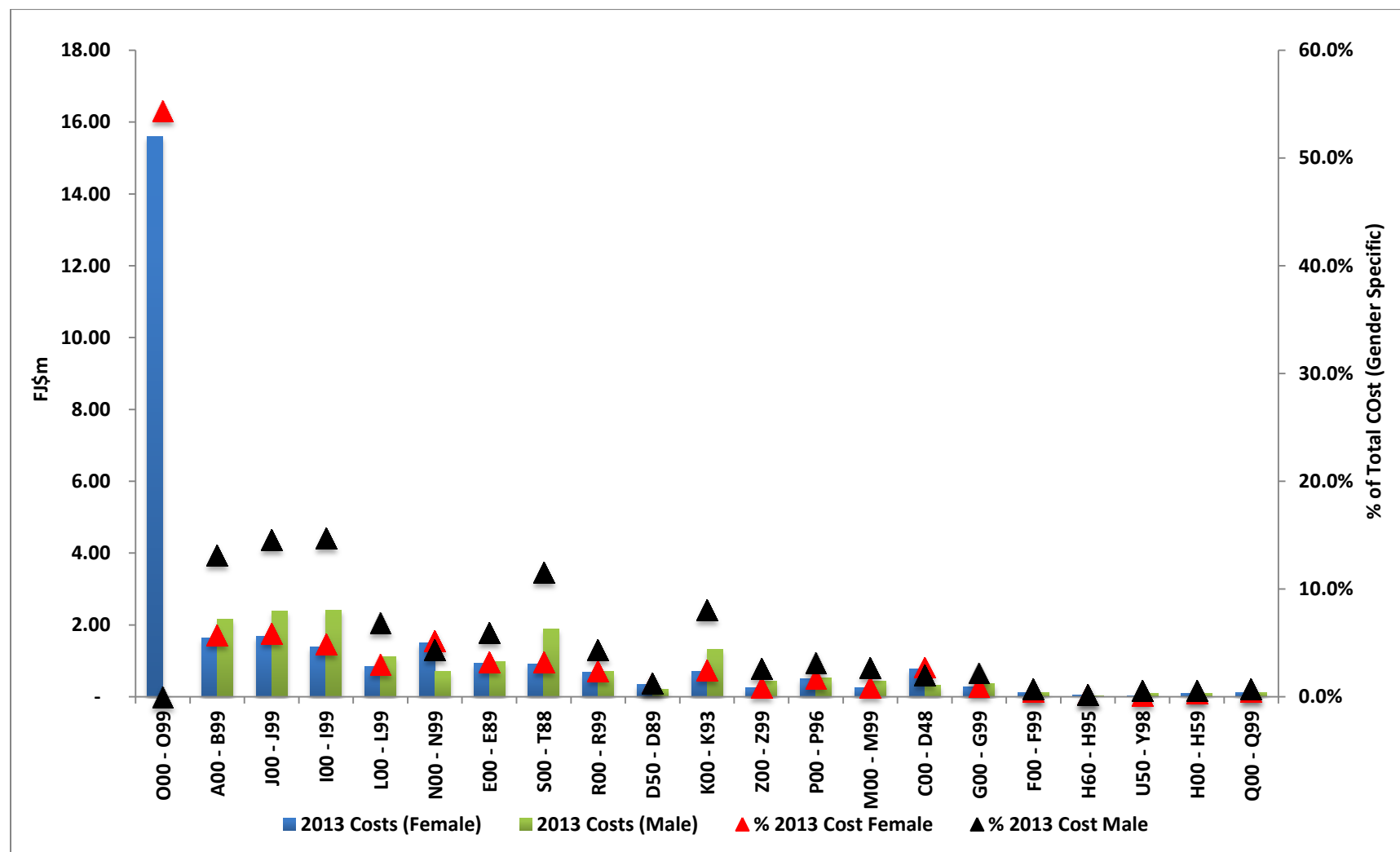


The top 5 ranked chapters in terms of cost by ICD 10AM Code in 2013 were O00-O99- Pregnancy, childbirth and the puerperium , J00-J99 - Diseases of the respiratory system, I00-I99 -Diseases of the circulatory system, A00-B99 -Certain infectious and parasitic diseases, S00-T88 - Injury, poisoning and certain other consequences of external causes. In comparison to 2014, O00-O99- Pregnancy, childbirth and the puerperium, A00-B99 -Certain infectious and parasitic diseases, J00-J99 - Diseases of the respiratory system, I00-I99 -Diseases of the circulatory system and L00-L99 Diseases of the skin and subcutaneous tissue were the top 5 ranked chapters in terms of cost by ICD 10 AM Code.

### **11.1.2. Expenditure by Gender**

The highest % of total cost borne by females in 2013, was attributed to Pregnancy Childbirth and Puerperium (54%), followed by Diseases of the Respiratory System (5.9%) and then Certain Infectious and parasitic Diseases (5.7%). In males the cost attribution was highest in Diseases of the Circulatory System (14.7%), followed by Diseases of the Respiratory tract (14.6%) and then Certain Infectious and Parasitic Diseases (13.1%) refer Figure 11-2.

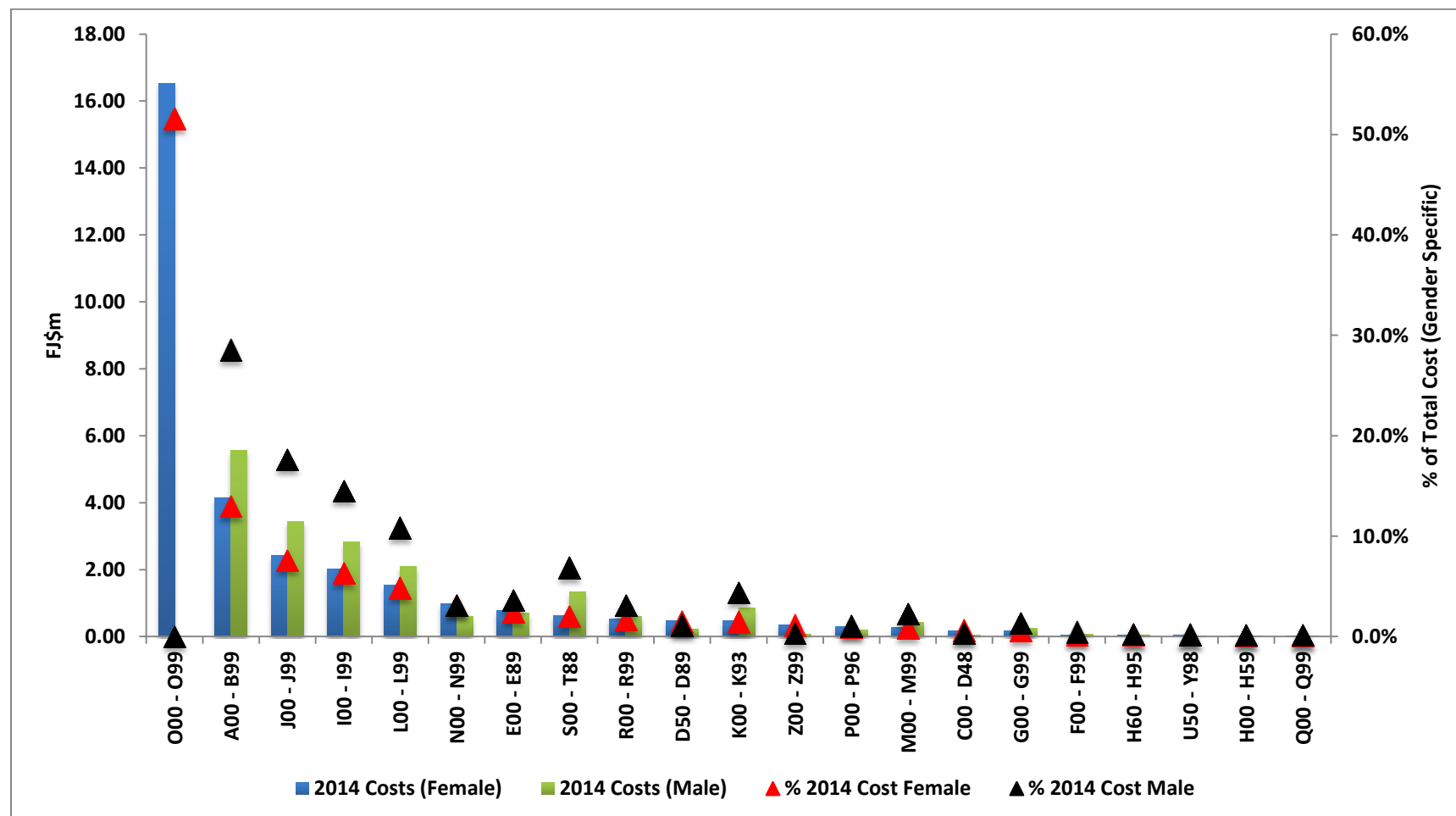
Figure 11-2 Inpatient Expenditure by Gender and ICD 10AM in 2013



The highest % of total cost borne by females in 2014, was attributed to Pregnancy Childbirth and Puerperium (52%), followed by Certain Infectious and Parasitic Diseases (13%), then Diseases of the Respiratory System (7.6%). In males the cost attribution was highest in Certain Infectious and Parasitic Diseases (28.5%), followed by Diseases of the Respiratory tract (17.6%) and then Diseases of the Circulatory System (14.5%).

For females the trend remained similar, except for reversal of certain infectious and parasitic diseases and diseases of the respiratory tract in 2014 (from 2013). In males, there was a resequencing of disease categories where certain infectious and parasitic diseases was leading in 2014, followed by diseases of the respiratory tract and then diseases of the circulatory system. Diseases of the circulatory system were the leading cause of inpatient cost in males in 2013, followed by diseases of the respiratory tract and then certain infectious and parasitic diseases (refer Figure 11-3).

Figure 11-3 Inpatient Expenditure by Gender and ICD 10AM in 2014



The percentage change in gender by ICD 10AM chapter is demonstrated in Figure 11-4. The greatest fluctuations are demonstrated in the male gender in certain infectious and parasitic diseases ( $\uparrow 158\%$ ), diseases of the skin and subcutaneous tissue ( $\uparrow 88\%$ ) factors influencing health status and contact with health services ( $\downarrow 85\%$ ), neoplasms ( $\downarrow 82\%$ ), Congenital malformations, deformations and chromosomal abnormalities ( $\downarrow 77\%$ ), diseases of the eye and adnexa ( $\downarrow 73\%$ ), diseases of the ear and mastoid process ( $\downarrow 73\%$ ) and external causes of morbidity and mortality ( $\downarrow 63\%$ ). There are also some fluctuations in cost for males noted in mental, behavioral and neurodevelopmental disorders ( $\downarrow 27\%$ ).

For females the greatest changes in cost were for certain infectious and parasitic diseases ( $\uparrow 156\%$ ), Congenital malformations, deformations and chromosomal abnormalities ( $\downarrow 86\%$ ), diseases of the skin and subcutaneous tissues ( $\uparrow 82\%$ ), neoplasms and diseases of the eye and adnexa ( $\downarrow 76\%$ ), followed by mental, behavioral and neurodevelopmental disorders ( $\downarrow 56\%$ ).

**Figure 11-4 Percentage Change by Gender and ICD 10AM between 2013 and 2014**

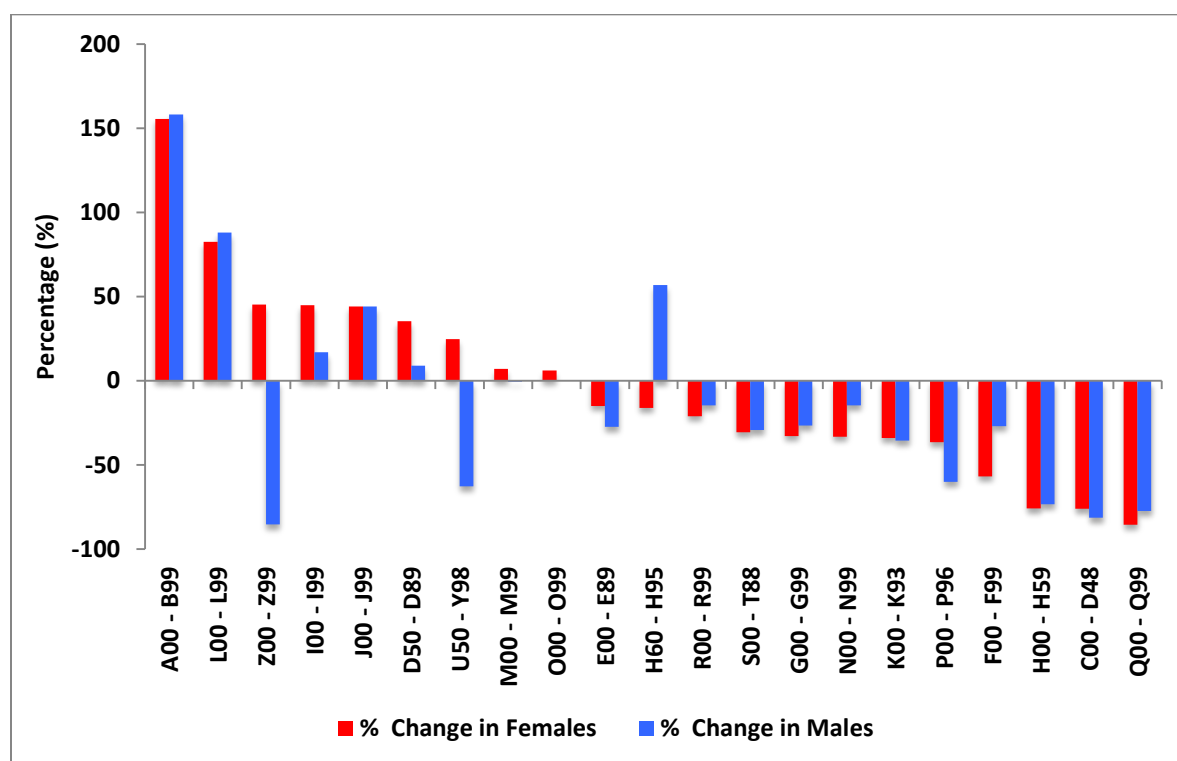


Figure 11-5 Disease based expenditure as a % of total expenditure for the given gender: 2013

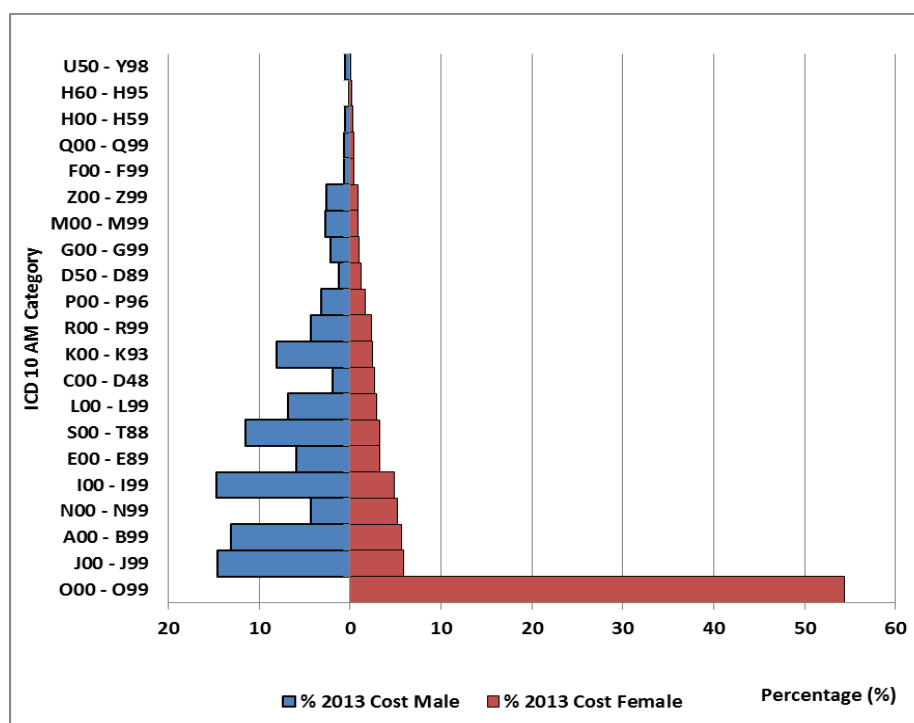
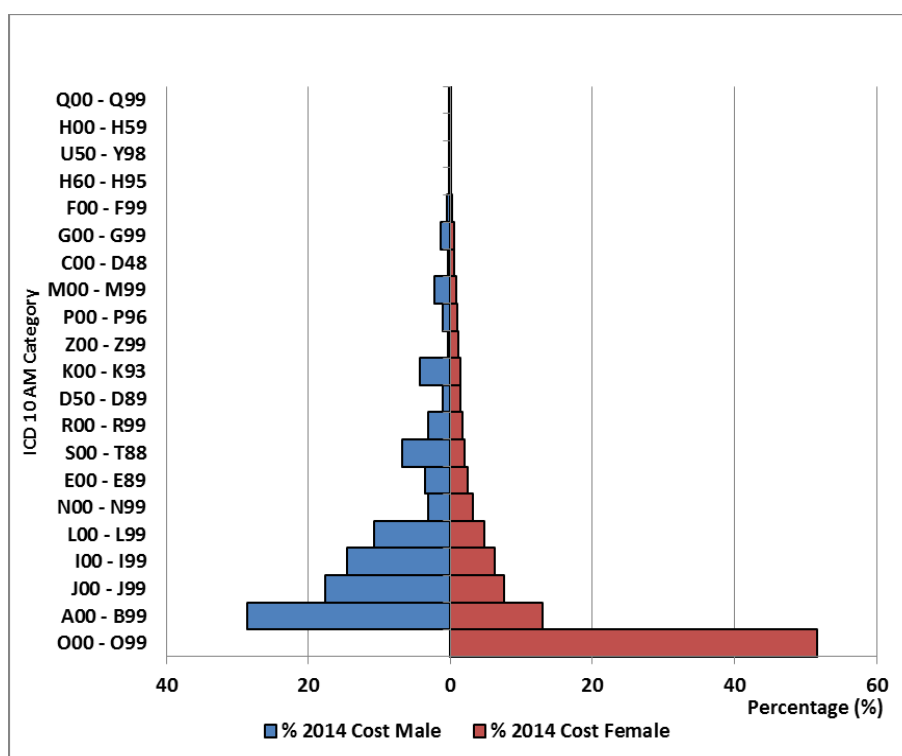


Figure 11-6 Disease based expenditure as a % of total expenditure for the given gender: 2014



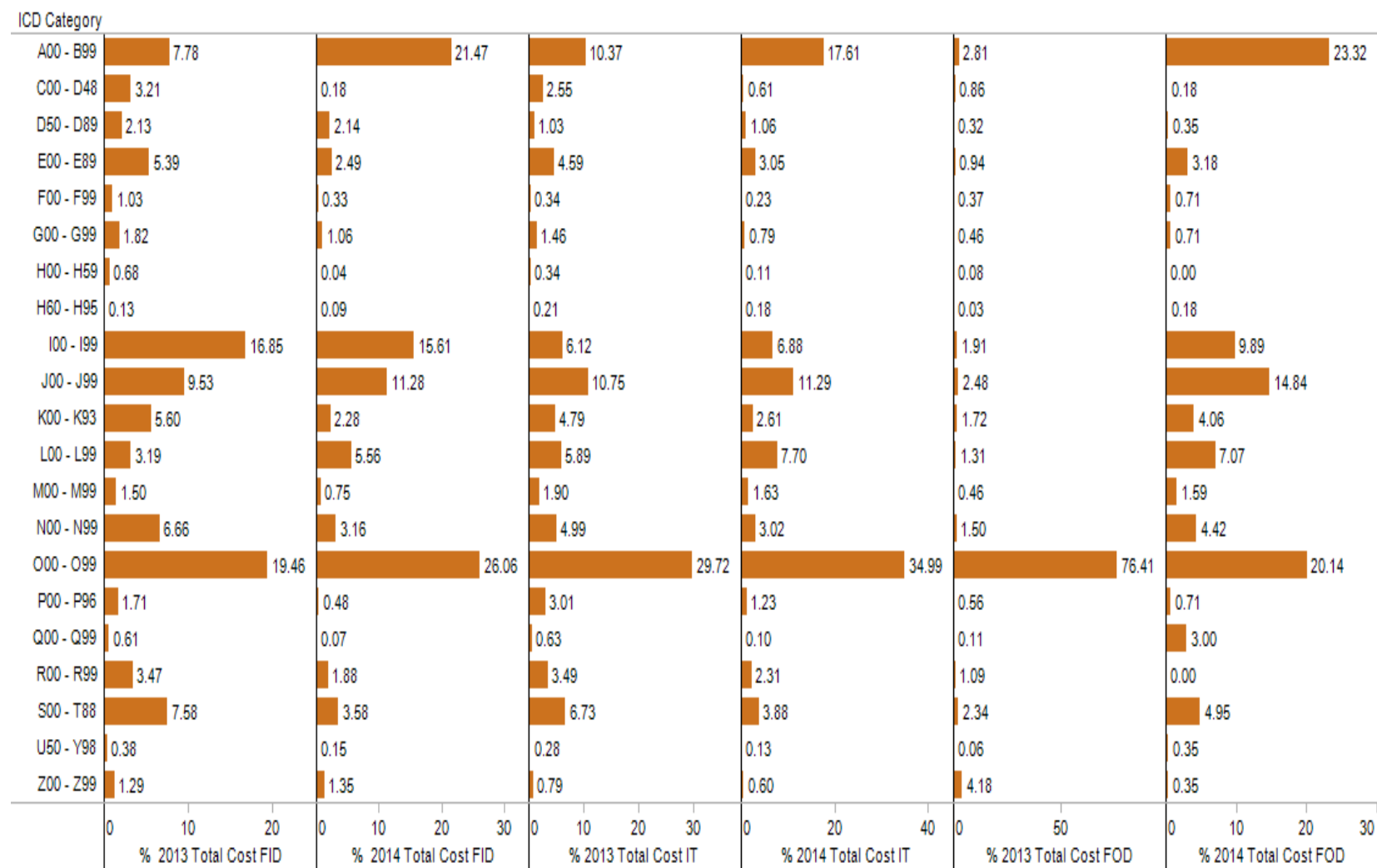
### 11.1.3. Expenditure by Ethnicity

The greatest costs in the ITaukei and Fijians of Indian-descent (FID) populations were on Pregnancy, Childbirth and Puerperium (FJ\$1.3m), Infectious and Parasitic Diseases (FJ\$6.3m), Diseases of the Respiratory System (FJ\$4.0m) and Diseases of the Skin and Subcutaneous tissue (FJ\$2.8m) and this was the same order of categories for the ITaukei and FID population in 2013. The FOD population followed the same rank order in 2013 for the top three. However in 2014 there was a resequencing of categories where the Fijians of Other-descent (FOD) population had infectious and parasitic diseases as the diseases of highest cost, followed by Pregnancy, Childbirth and Puerperium and then Diseases of the Respiratory System. Figure 11-7 shows disease expenditure by ethnicity.

**Table 11-2 Inpatient Disease Cost per Capita by Ethnicity for 2013 and 2014**

Year	Fijians of Indian descent	ITaukei	Fijians of Other Descent
2013	44.37	48.03	129.98
2014	50.78	68.11	25.20

Figure 11-7 Share of inpatient expenditure by ethnicity and ICD 10AM: 2013 & 2014





The greatest percentage changes were noted in Infectious and Parasitic Diseases, Diseases of the Skin and Subcutaneous Tissue and Pregnancy, Childbirth and Puerperium in both 2013 and 2014 in the 2 major ethnicities.

#### **11.1.4. Expenditure by Age Group**

The age category 0-4 occupied 8.7% of the total inpatient services related costs in 2014 (↓0.51% from 2013). The age group 5-9 accounted for 1.7% of inpatient service expenditure in 2014 (↓50.2% from 2013) (refer to Figure 11.8).

The age group 10-14, accounted for 4.9% % inpatient service expenditure in 2014; there was a reduction of 186.5% from 2013. Age group 15-19, accounted for 13.8% inpatient service expenditure in 2014; there was a reduction of 402.7% from 2013.

The age group 20-24, accounted for 14.9% of inpatient service expenditure in 2014 (↓56.2% from 2013). The age group 25-29 accounted for accounted for 11.4% of inpatient service expenditure in 2014, with a subsequent reduction of 9.8% from 2013.

Only 6.32% of total inpatient services expenditure in inpatient service expenditure was dedicated to the 30-34 year age group in 2014 (↓39.8% from 2013). The age category 35-39, accounted for 4.1% of the total inpatient services expenditure in 2014 (↓43.2% from 2013).

The age category 40-44, accounted for 4.9% of the total inpatient services expenditure in 2014 (↑9.7% from 2013). The age category 45-49 accounted for 4.5% of the total inpatient services expenditure in 2014 (↑6.1% from 2013).

The 50-54 age categories consumed 50.8% of the inpatient service expenditure in 2014 (↑25.5% from 2013). The 55-59 age category accounted for 5.2% of the inpatient service expenditure in 2014 (↑ 12.2% from 2013)

The age category 60-64 occupied 3.47% of total inpatient services cost in 2014. It was observed that there was a drop of 10.1% in inpatient services expenditure from 2013. For the 65-69 age categories, only 5% of the total inpatient services expenditure was allocated to this segment in 2014. It was observed that there was an increase of 27.6% in inpatient services expenditure from 2013 for this segment

The patients who were 70 years or older, consumed 6.1% of total expenditure in this inpatient services segment in 2014. When compared to 2013, there was an increase of 4.4% in the inpatient expenditure.

**Figure 11-8 Inpatient services related distribution of costs by Age Group: 2013 & 2014**

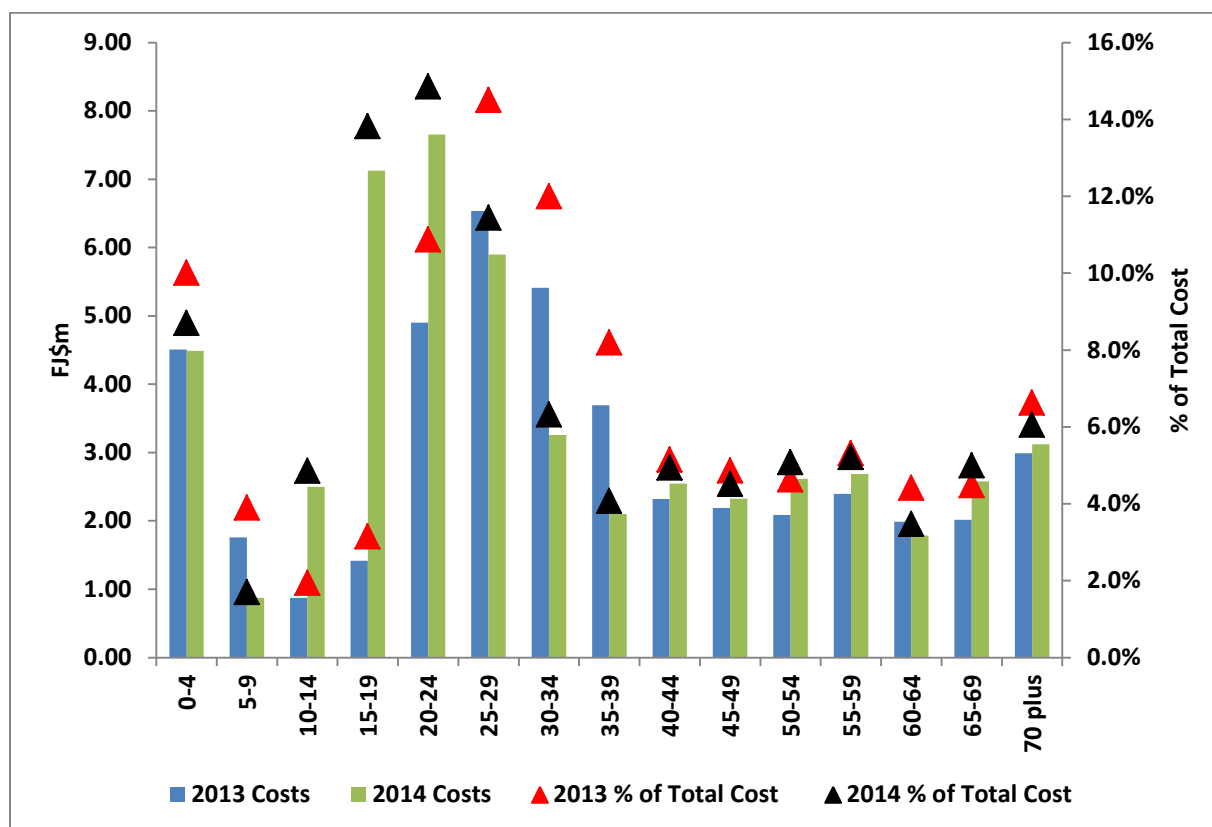


Figure 11-9 and 11-10 refer to the % distribution by cost for Age Groups by ICD 10AM category. The greatest costs were incurred in the category O00-O99 for both years in the reproductive age group (15-44 age group).

Figure 11-9 Distribution of Cost by Age Group and ICD 10AM Category for 2013 (FJ\$m)

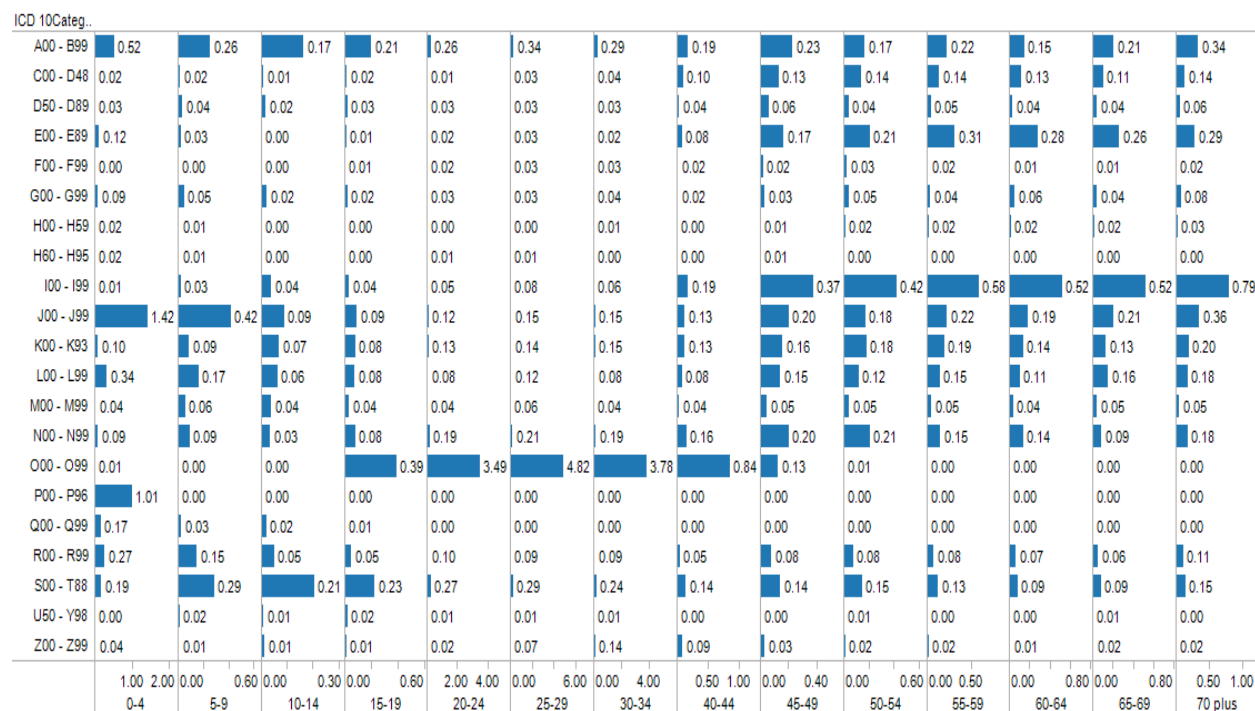
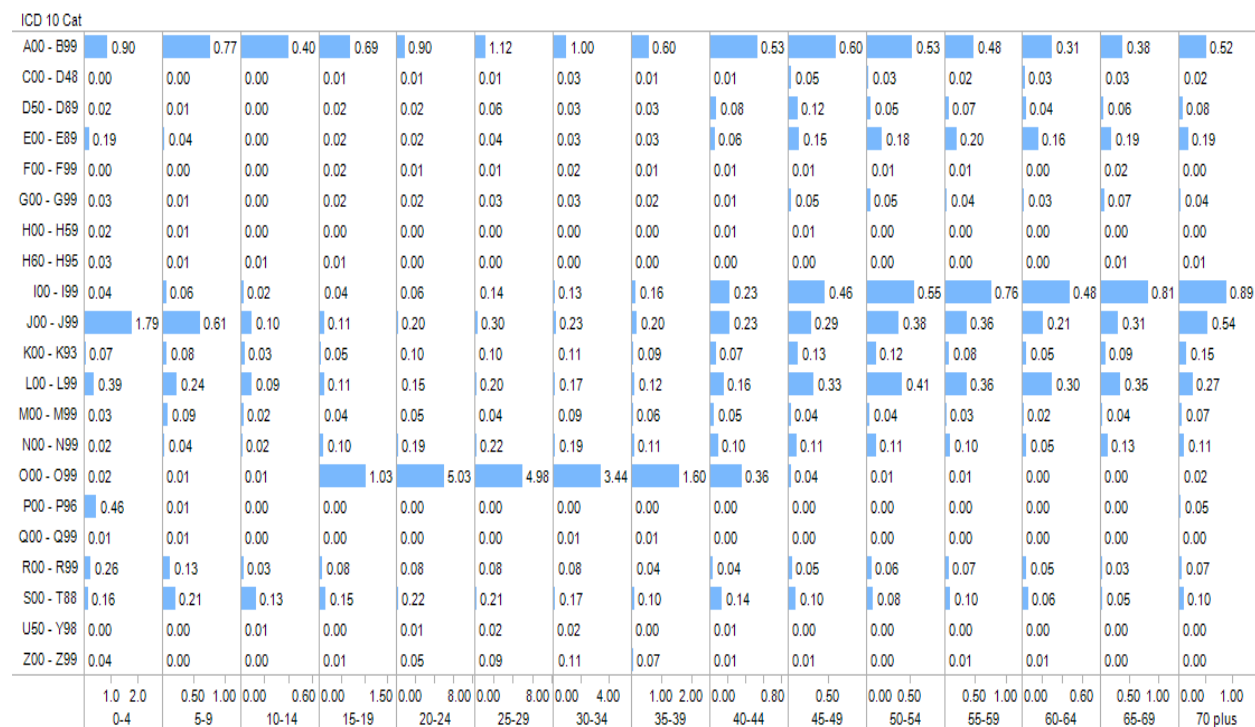


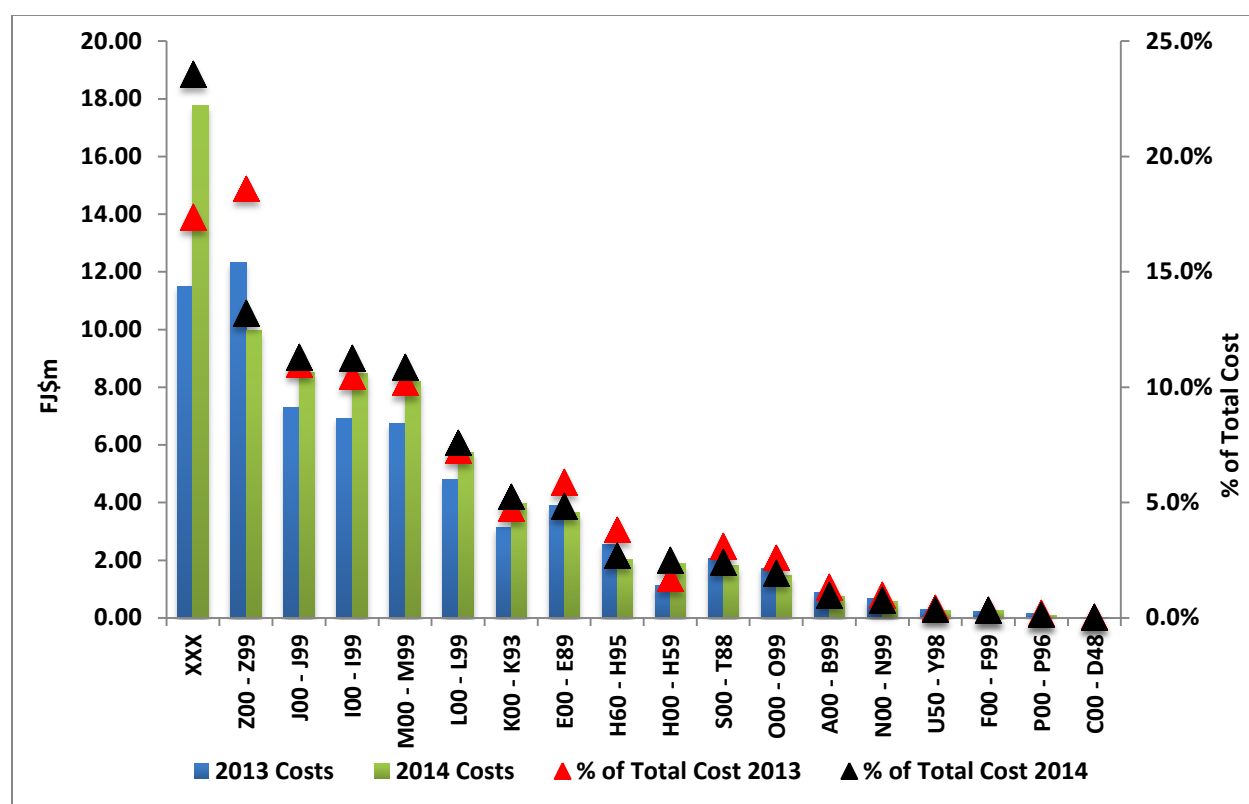
Figure 11-10 Distribution of Cost by Age Group and ICD 10AM Category for 2014 (FJ\$m)



## 11.2. Expenditure by Disease for Outpatients

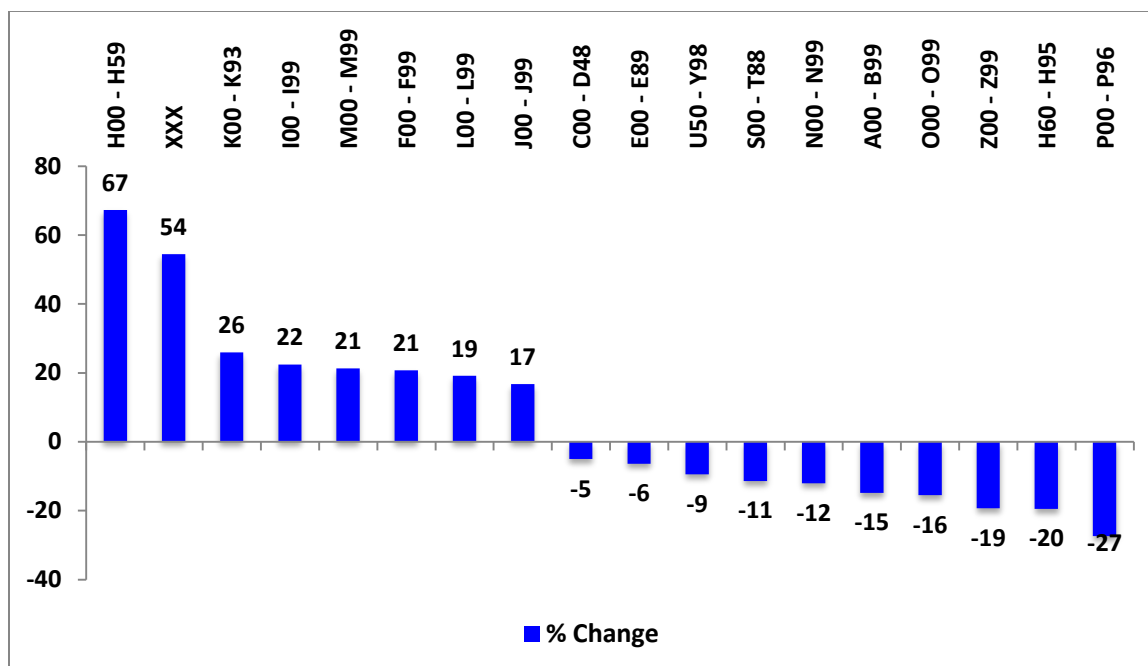
Conditions that could not be coded amounted to the largest portion of the outpatient costs. This is concerning as information given by outpatient providing facilities is not specific enough to be allocated a code. The challenge remains to capture outpatient encounters to provide useful evidence for policymakers. This category demonstrated a 54% increase from 2013

Figure 11-11 Outpatient Cost by ICD 10AM: 2013 & 2014



Note: - XXX represents procedural services in outpatient visits where no ICD 10 AM codes was assigned

Figure 11-12 Percentage Change between 2013 and 2014 by ICD 10AM



### 11.2.1. Outpatients Costs by Ethnicity

The highest cost was accounted for by Fijians of Indian Descent, followed by the iTaukei and then Fijians of Other Descent for both 2013 and 2014. However there were increases in costs for FID (↑27%) and FOD (↑6%). Alternatively, the IT population demonstrated a 0.2% decrease in costs in the reporting period.

Figure 11-13 Cost breakdown by Ethnicity comparative 2013 & 2014

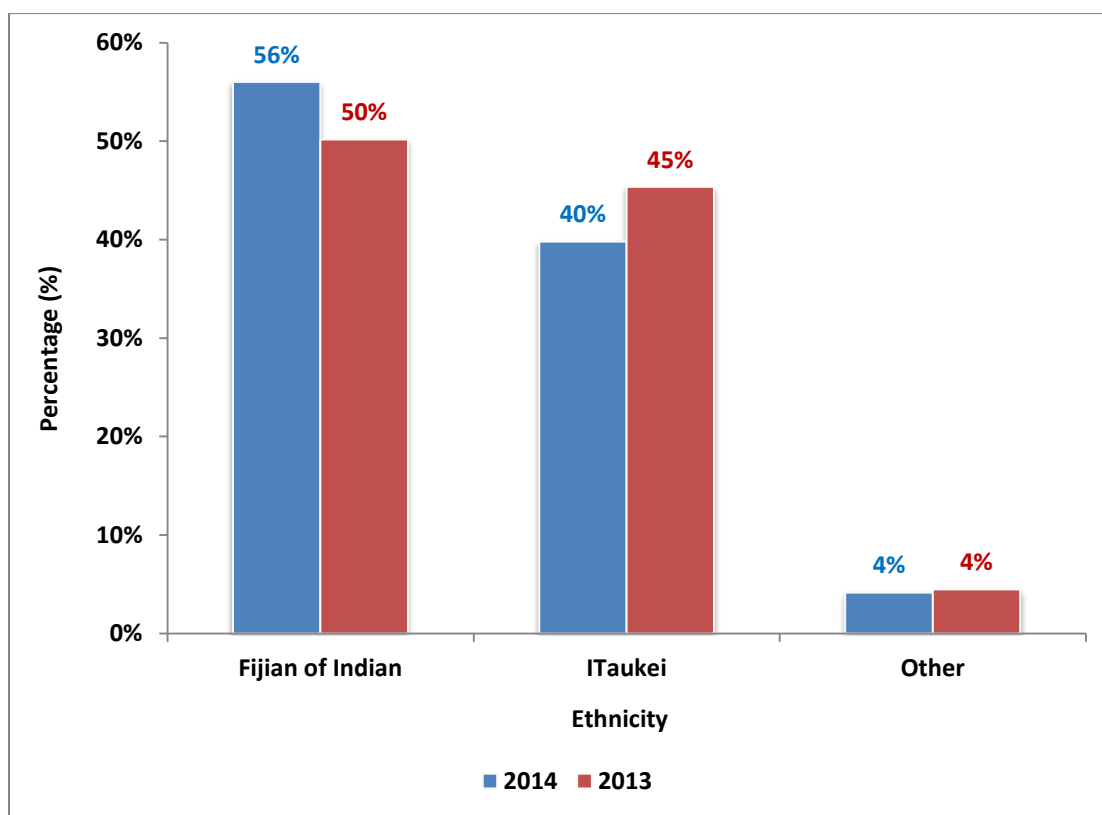


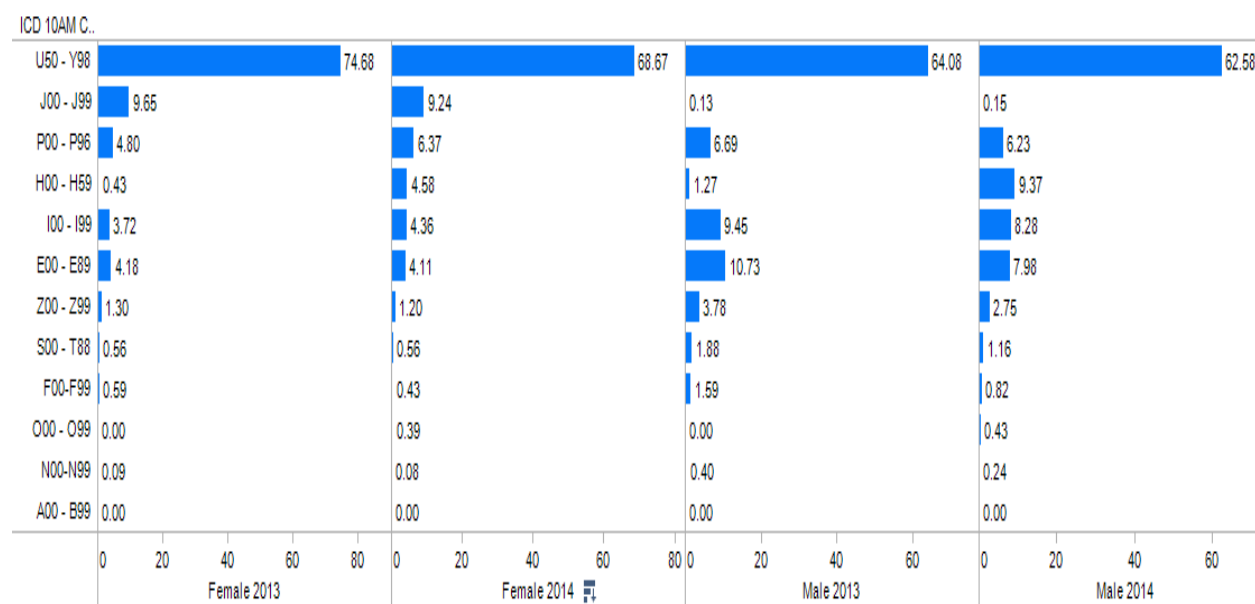
Table 11-3 Outpatient Disease Cost per Capita by Ethnicity for 2013 and 2014

Year	Fijians of Indian descent	ITaukei	Fijians of Other Descent
2013	116.02	57.97	51.41
2014	149.58	57.14	53.35

### 11.2.2. Outpatients Costs by Gender

The percentage distribution of costs between females and males, were 72 and 28% for 2013 and 66 and 24% in 2014, respectively. The greatest outpatient costs were borne by the female gender. However between the years the costs % increase in costs for females was 4%; there was also an increase in costs among males between 2013 and 2014 by 39%.

**Figure 11-14 Percentage distribution of OPD Expenditure by Gender and ICD 10AM: 2013-2014**



The greatest % cost was attributed to external causes of morbidity and mortality for both genders for both years. Diseases of the circulatory systems and diseases of the eye and adnexa, endocrine, nutritional and metabolic diseases ranked among the top five for males in % cost in the OP setting.

Female costs, apart from external causes of morbidity and mortality, were also attributed to diseases of the respiratory system, certain conditions originating in the perinatal period, diseases of the eye and adnexa and diseases of the circulatory system (as the top five).

## 12. Technical Notes

This section describes the technical aspects related to the production of this FJHA report. These technical aspects describe the estimation and data collection techniques used to estimate the financial figures reported in this document. This report presents the Fiji National Health Accounts expenditure for the years 2012 to 2014 using the SHA 2011 classification system.

The transition to the SHA 2011 classification continue to present many challenges (discussed at the end of this chapter) to the compilation of this report and different approaches and estimation methods were used in situations where the data available or collected was not sufficient in detail to meet the detailed reporting requirements of the SHA 2011 classification. However there have been some improvements in estimation techniques since our first attempt at the SHA 2011 methodology (used in the 2011 & 2012 NHA report). Thus readers will note that expenditure figures reported here for the years 2011 & 2012 differ from that presented in the last NHA report for the years 2011 & 2012.

Certainly, estimation techniques and approaches will continue to improve over time, and expenditure numbers will be further refined as methods improve and the SHA 2011 classification is institutionalized.

### 12.1. Fiji SHA 2011 Classifications

To develop the Fiji SHA 2011 classification, the NHA committee first looked at the international SHA 2011 classification skeletal structure. The committee also looked at the Fiji SHA 1.0 classification structure that was used in NHA reports for the years 2007 to 2010. The SHA 1.0 was first mapped to the international classification and then this was contextualized to Fiji's reporting needs and the Fiji SHA 2011 classification was developed. Contextualized meant that sub-categories were created where the Country saw it important that certain expenditure be reported separately. For example all government hospitals and health centres were created as sub-categories in the Fiji SHA 2011 health provider classification.

### 12.2. Government data sources

Government data was primarily obtained from the following sources:

- FMIS data from the MoF
- Patient utilization data from the Health Information Unit for the MoHMS
- Pharmaceutical data from the Fiji Pharmaceutical & Biomedical Services



- Expert opinions from various staff of the MoHMS
- National macro-economic data was obtained from the Fiji Bureau of Statistics
- Health expenditure data from other Government Ministries

### **12.2.1. Financial Data**

The audited financial data for the years 2013 and 2014 was obtained from the Ministry of Finance. Data was extracted in the raw form directly out of the Financial Management Information System (FMIS). This raw data had expenditures by actual transaction line items and linked to an accounting code (GL code). This GL code was the basis on which expenditure was mapped to the Fiji SHA 2011 classification system codes. GL codes that contained expenditure that needed distribution to more than one classification code was distributed based on various rules of allocation. In most cases the rules of allocation either used past year's actual expenditure distributions or expert opinion.

#### **12.2.1.1. Patient utilization data**

Inpatient and Outpatient data were obtained from several databases at the Health Information Unit of the Ministry of Health. These databases included:

- Patient Information System (PATIS)
- Public Health Information System (PHIS)
- Hospital Discharge Data (HDD)
- Hospital Monthly Returns (HMR)
- National Notifiable Disease Surveillance System (NNDSS)

#### **12.2.1.2. Disease-based data**

Inpatient disease data coded by ICD-10 classification was obtained from the Health Information Unit for the years 2013 and 2014. This data was a combination of all patient information system databases (see list in 11.2.1.1).

#### **12.2.1.3. Macro level data**

This data was obtained from the Fiji Bureau of Statistics latest issue of Key National Statistics 2015. These data include Gross Domestic Product, Total government spending and population figures.

### 12.2.2. Data estimation techniques

Various estimation techniques were used to enable mapping of Public sector expenditure to the Fiji SHA 2011 classification. These are discussed below.

#### 12.2.2.1. Revenues of Financing Schemes (FS) and Financing Schemes (HF)

The GL codes in the financial raw data, in most cases, were able to classify the schemes and revenue sources. In cases where GL codes were insufficient to identify sources or schemes, financial officers (mainly the senior accountants and managers) from both the MoHMS and the MoF were consulted. Coding of sources and schemes was not too difficult considering that the public health system is largely Government financed through tax revenue.

#### 12.2.2.2. Health Providers (HP)

The GL codes in the FMIS system allowed mapping of some expenditures directly to public hospitals and health centres. This means that each hospital or health centre has its own unique GL code. This was not the case with Nursing Stations (apart from those nursing stations in the maritime zones) which were all clustered under one GL code. Thus most expenditure for Nursing Stations was lumped together under one HP classification code since it was difficult to disaggregate individual expenditures by each Nursing Station.

GL codes in the FMIS system that represented individual public health programs were mapped to created classification codes under section HP.6 of the Fiji SHA classification.

There were cases where one GL code represented expenditure for more than one provider and where these providers had individual mapping codes in the HP classification. In these cases discussions with financial officers and program managers enabled a percentage distribution rule that was used to distribute expenditures to providers.

There were cases where separation was not possible and the team had to decide to which provider in the classification the expenditure was coded to. For example some Nursing Stations expenditure was locked under the GL code of the nearest Health Centre. However there was no way to estimate what this Nursing station expenditure might have been and thus this was left coded to the Health Centre rather than to the HP code for Nursing Stations.

The Fiji Pharmaceutical and Biomedical Service (FPBS) expenditure was attached to one GL code however FPBS is not a provider in the Fiji SHA classification. FPBS expenditure (mainly government spending on drugs, consumables and durable medical goods) was distributed across health providers in the HP classification using drugs distribution (includes

consumables) percentages as allocation keys. The drugs distribution database was accessed from FPBS.

### **12.2.2.3. Health Functions (HC)**

The Fiji financial management information system (GL codes) cannot separate expenditures by functions as outlined in the functional classification.

In the case of expenditure on Curative Services (HC.1), for a small number of facilities this was obtained by using the percentage distribution of unit costs presented in a previous facility costing study (Irava et. al 2010) since this was at present the best source of data.

For other facilities consultations were held with Divisional and Sub-divisional doctors and nurses on a percentage distribution of costs across the functional classification. The same was done for public health programs where program managers and officers were asked to distribute their expenditure across the functional classification mainly the category Preventive Care (HC.6). Expert Opinion was predominantly used in most cases.

### **12.2.2.4. Capital Expenditure (HK)**

The SHA 2011 guidelines report capital expenditure in a separate classification from current expenditure. Capital expenditure was identified by specific GL codes that represented all capital related expenditure. At this stage capital expenditure only included capital acquisitions and purchases during the reported period. Changes in inventories, capital consumption and disposable of assets were not accounted for.

### **12.2.2.5. Disease-based expenditure**

Allocation key for inpatient expenditure distribution to diseases was patient bed days. Allocation key for outpatient expenditure distribution was number of outpatient visits.

## **12.3. Private Sector data**

Private data was primarily obtained from the Surveys of private health providers and stakeholders. Secondary reports and documents such as Annual reports (when available and accessible) were also used to clarify or verify reported expenditures. The response rates of the various private sector surveys conducted are shown in Table 1 for the years 2010, 2012 and 2014. Some providers have increased their response rates while others have declined.

Based on the survey questions, health spending (using a revenue approach) was calculated in four different ways – daily, weekly, monthly and annually. This is shown in detail in Table

2. On comparing the four different figures, we found that the monthly and annual estimations were more realistic and thus the higher of the two values were used as the final health expenditure for the health providers.

Table 1: Response rates of surveys of the private sector

Name	Surveyed population 2010	Surveyed population 2012	Surveyed population 2014	Response Rates (%)		
				2010	2012	2014
General Practitioners	127	148	126	54	80	78
Private Dentist	35	37	33	35	81	85
Retail Pharmacies	54	55	58	54	56	66
Private Hospitals	1	2	2	100	100	100
Private Employers	0	17	27	57	24	52
Private Laboratory and X-Ray	3	2	2	67	50	100
Private Insurance	10	4	4	30	50	50
Private Optometrists	15	14	15	67	71	80
Development Partners	14	13	18	71	54	28
NGO's	29	19	25	3	5	0

Table 2: Revenue estimations of private sector surveys

<b>Daily revenue</b>	Calculated using average fee per patient multiplied by total number of patients seen in a year
<b>Weekly revenue</b>	Average number of patient per week multiply by 50 weeks (here assuming 2 weeks closure in the year) to get total number of patients and then multiply by average consulting fees per patient
<b>Monthly revenue</b>	Average revenue reported per month multiplied by 12 months
<b>Annual revenue</b>	Annual revenue reported in survey

In the case of the non-responses from private doctors, dentists, optometrists, and pharmacies health expenditure was estimated using the average expenditure of those that responded by geographical region (Central, Western and Northern). This expenditure was then distributed across sources, schemes and functions based on the total percentage distributions presented by those who responded.

No estimations were done for employers, insurance companies, private ancillary services, private hospital, and development partners. Those who responded were included and those

that did not respond were excluded (these were providers after several attempts failed to respond).

Data received in the private surveys were compared with

- aggregate revenue data obtained from FRCA across the different providers
- the insurance survey results were compared with data presented in the Reserve Bank of Fiji annual insurance reports
- total out-of-pocket expenditure reported in surveys was compared with out-of-pocket reported in the last HIES survey and adjusting for inflation

In certain cases it was difficult to remove instances where double-counting was suspected. In these instances expenditure was included with the assumption made that the double-counts would be off-set both by the non-responses (e.g. development partners, non-governmental organizations, employers, etc.) and with the under reporting suspected of those that responded (especially private doctors, dentists, eye care and pharmacies).

### 12.3.1. Private Sector survey limitations

There were various limitations in the private sector surveys that should be noted here, and must be considered when interpreting the health expenditure numbers presented of the private sector.

- The low response rates from across the providers but especially from development partners, non-governmental organizations (NGOs), and employers means that the expenditures reported here are likely under-reported. Donor and NGO response rates are at their lowest this round in comparison to previous rounds of NHA surveys.
- Unfortunately many who responded either provided responses that were incomplete, inaccurate or deliberately flawed. Thus data cleaning and verification was a long process and required several follow-ups with respondents to clarify received data. Estimations were used to replace deliberate flawed data when follow-ups to respondent were unsuccessful.
- The survey questionnaires could have been better designed. The shift to SHA 2011 reporting guidelines meant that previous survey questionnaires had to be redesigned to capture new data. There were no exemplary surveys available for the team to follow and thus the team designed and developed their own questionnaires. A tight time schedule also resulted in the questionnaires not being properly pilot tested.

## 12.4. Lessons learnt

This section details the lessons learnt from the entire process during the production of this NHA report.

- The membership of the committee needs to extend to include representatives from the private sector and development partners. This may help in improving survey response rates.
- The involvement of the Ministry of health finance team would allow feedback with regards to improving the recording and allocation of expenditures, as well as provide clarity to the NHA committee on how funds are allocated and expended.
- There needs to be better management and coordination with regards to the surveys of the private sector. A more systematic process towards recruiting enumerators, training them on the surveys, remuneration and reporting of collected data needs to be established to allow smooth execution of the surveys. Improved communication and establishment of relationships between professional bodies such as the Fiji Medical Council, Fiji Dental council, etc. needs to be strengthened. A stronger case with regards to confidentiality of information and the usefulness of the NHA report to the private sector needs to be made.
- There is a possibility to tag the reporting of health information needed for the NHA report to the registration of medical doctors and dentists. This would help simplify the survey process of the private sector and perhaps in the long term provide a routine data source for the private sector (without the need to run surveys).
- There still needs to be increased awareness created amongst both the private and government sectors on the purpose and usefulness of the NHA report. Education and advocacy workshops should be organized with invitations sent out to all private health providers and organizations included in providing some health service (primary or secondary providers) in the country. The intention to develop more policy briefs from the current report will further increase the awareness and usefulness of the report amongst the executive management of the MoHMS.
- Institutional memory of the NHA process needs to be documented and captured. This would make easy the future production of NHA by giving clarity to future committee members on what procedures and estimation techniques were employed in past productions of NHA.

- The mapping of raw financial data to the SHA-2011 classifications was not straight forward. Some of the limitations had to do with the way in which the FMIS system recorded and captured the data. A discussion between the MoHMS and the Finance Ministry needs to happen where requests should be made that all health providers be given the status of cost centres in the system. This is not impossible since 80% of providers currently exist as such in the FMIS system. This would allow direct mapping of expenditures of health providers to the provider classification in SHA-2011.
- A more standard methodology needs to be established with regards to how data is coded to the functional categories for various health providers and public programs. If costing studies are one of these ways, then more up to date costing of facilities needs to be undertaken to provide unit costs for the functional categories.
- In the case of Fiji, the financing schemes (the major change in SHA-2011) provided little advantage or improvement from SHA 1 since the health financing system in the country is largely government taxed financed. The mapping between revenue sources and financing schemes was easy to undertake.

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## 14. Glossary

### Definition of Terms used in this report

**Ambulatory health care** relates to procedures and treatments that are provided at private clinics by General Practitioners, dentists, optometrists' etc. and health centres and nursing stations at Government facilities

**Ancillary services** are services such as X-Ray, Laboratory and patient transportation

**Beneficiary characteristics** of those who receive the health care goods and services or benefit from those activities (beneficiaries can be categorized in many different ways, including their age and gender, their socio economic status, their health status and their location)

**Capital expenditure** is the construction or expansion of health facilities and purchase of medical equipment or ICT equipment that helps in the production of health services

**Capital formation** the types of assets that health providers have acquired during the accounting period and that are used repeatedly or continuously for more than one year in production of health services

**Clinical Services** means types of procedure or a series of such procedures such as diagnostic, therapeutic, rehabilitative, or palliative services that are provided by a facility to patients. This may be synonymous with curative care

**Constant (Real) value** relates to Gross domestic product (GDP) at current price deflated by price index of goods and services. It is also called real value

**Curative care** is a combination of inpatient care and outpatient care. Curative care refers to treatment and therapies provided to a patient

**Current (Nominal) value** relates to Gross domestic product (GDP) at current prices which means GDP at prices of the current

reporting period. It is also called nominal value

**Current Health Expenditure** final consumption expenditure of resident units on health care goods and services excluding capital expenditure on health care

**Day Curative Care** includes only day cases of non-rehabilitative services within the same day

**Factors of production** the types of inputs used in producing the goods and services or activities conducted in the health boundary

**Financing agents** are institutional units that manage health financing schemes

**Governance, health system and financing administration** are administration of government policy; the setting of standards; the regulation, licensing or supervision of producers; management of the fund collection; and the administration, monitoring and evaluation of such resources, etc.

**Government current health expenditure** is similar to current health expenditure provided by public (Government) sector

**Gross capital formation** in the health care system is measured by the total value of the assets that providers of health services have acquired during the accounting period (less the value of the disposals of assets of the same type) and that are used repeatedly or for more than one year in the provision of health services

**Gross Domestic Product** is the market value of all officially recognized final goods and services produced within a country in a given period of time.

**Gross fixed capital formulation** in the health care system is measured by the total value of the assets that providers of health services have acquired during the accounting period (less the value of the disposals of assets of the same type) and that are used repeatedly or

for more than one year in the provision of health services.

**Health Care Functions** relates to the type of services that has been provided

**Health care goods** these are goods and services purchased by the provider used in the diagnosis, treatment or prevention of a disease or other abnormal condition. E.g. are pharmaceuticals, consumables, vaccines etc.

**Health care services** these are services purchased by the health provider to complement the package of services offered within the same unit. E.g. travel, cartage and telephone expenses

**Health Financing Schemes** components of a country's health financial system that channel revenues received and use those funds to pay for, or purchase, the activities inside the health accounts boundary

**Health Functions** the types of goods and services provided and activities performed within the health accounts boundary

**Health Providers** are entities, organizations or units that receive money in exchange for or in anticipation of producing goods and services as their primary activity as well as those for which health care provision is only one among a number of activities

**Hospitals** comprise licensed establishments that are primarily engaged in providing medical, diagnostic and treatment services that include physician, nursing and other health services to inpatients and the specialized accommodation services required by inpatients. In public sector hospitals includes major hospitals, specialized hospitals, and subdivisional hospitals and in private sector all private hospitals

**Household out of Pocket** are payments done by a group or family or individuals directly from personal the personal funds

**Household provision of health care** is the provision of health care services not only

takes place in health care facilities, but also in private households, where care for the sick, disabled or elderly is provided by family members

**Households** are a group or family or individuals of the country

**Infrastructures** in the health care system are components, residential and non-residential building and other structures

**Inpatient curative care** includes stay overnight of non-rehabilitative services and excludes hospital day-care and home-based hospital treatment

**Intellectual property products** are the result of research, development, investigation or innovation leading to knowledge that the developers can market or use their own benefit production because use of knowledge is restructured by mean of legal or other productions.

**Internal transfer and grants** - transfer: includes revenues allocated to government schemes which may be an internal transfer within the same level of government or a transfer between central and local governments, Grant: includes: grants by central government to local government financing schemes

**Machinery and equipment** used in hospital for delivery of health services

**Medical goods** relates to both pharmaceutical goods and therapeutic appliances

**Neoplasms** a new and abnormal growth of tissue in some part of the body

**Non-health care services and Non-health care goods** these are goods and services used for health care production, but of a non-specialized health nature. They are of a general nature such as those required in the operational activities of the provider, as in management offices (e.g. software, pens and paper), kitchens (in hospitals and to supply to overnight patients if they are not outsourced

services), transport (e.g. oil and tools to operate vehicles) or other types of more general usage, such as electricity, water and the like.

**Non-produced non-financial assets** in health care system relates to land purchase and development

**Occupational health care expenditure** is the sum of expenditures incurred by corporations, general Government and non-profit organisations on the provision of occupational health care. Occupational health care includes the surveillance of employee health (routine medical check-ups) and therapeutic care (including emergency health care services) on or off business premises

**Other health care goods** includes all medicines and pharmaceutical products such as vaccines and serum and other consumable goods, such as cotton, wound dressings and tools used exclusively or mainly at work, for example, clothing or footwear worn exclusively or mainly at work (such as protective clothes and uniforms)

**Outpatient Curative Care** includes general medical services provided on day care basis

**Per Capita** for each person taken individually

**Preventive care** is any measure that aims to avoid the occurrence or the severity of injuries and diseases and their complications. Preventive medicine or preventive care consists of measures taken to prevent diseases, rather than curing them or treating their symptoms

**Primary health care services** first level health services provided at a health facility e.g. health centres or sub-divisional hospital

**Private Current health expenditure** is similar to current health expenditure provided by private sector

**Products** the various goods and services provided by the providers, including the non-

health care goods and services produced and consumed

**Public Sector Investment Programs** are capital programs allocated in Government budget for construction, maintenance & refurbishment of facilities, purchase of medical equipment and ICT equipment

**Rehabilitative care** is the care provided to patients with the intention of curing their disease or improving their condition.

**Residential and non-residential** building acquired less those disposed by health care providers are included in the category. Example is nursing and residential care facilities, hospital setting and ambulatory facilities.

**Residential long-term care facilities** comprises establishments that are primarily engaged in providing residential long-term care that combines nursing, supervisory or other types of care as required by the residents

**Rest of the economy** refers to industries or organizations that offer health care as a secondary activity or promote health with a multi-sectorial approach but do not provide health care services

**Rest of the World** represents development partners or donors or foreign Governments who provides health services to residents

**Retailers and other providers of medical goods** relates to retail pharmacies, retail sellers and other suppliers of durable medical goods and appliances

**Revenues of financing schemes** provides information from whom the revenue is provided for health care

**Therapeutic appliances** such as spectacles, hearing aids, orthopedic appliances

**Total Government Expenditure** means expenditure by general Government

**Total Government Health Expenditure** relates to combination of both current health expenditure plus capital expenditure provided by Government

**Trade in health** imports of health care goods and services provided to residents by nonresident providers, and exports of health care goods and services provided to non-residents by resident providers

**Transfers distributed by government from foreign origin** refers to allocation of funds by Government from the aid or donated funds received

**Transfers from government domestic revenue** (allocated to health purposes) refers to allocation of funds by Government through general tax

**Voluntary payments** refers to payments done at one's free choice

**Voluntary prepayment** refers Voluntary premiums or payments received from the households or other institutional units to secure an entitlement to benefits. Eg premiums received from an insurer to secure benefits of the voluntary health insurance schemes

## 15. Appendix

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# Matrices

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**Table 1: Current Health Expenditure of Revenue sources by financing schemes, 2013**

	Government schemes	Voluntary health insurance schemes (a+b)	Employer-based insurance (a)	Other primary coverage schemes (b)	NPISH financing schemes	Household out-of-pocket payment	Rest of the world financing schemes (non-resident)	Total	Percentage
Transfers from government domestic revenue (allocated to health purposes)	156.43	-	-	-	-	-	-	156.43	58.4%
Transfers distributed by government from foreign origin	2.46	-	-	-	-	-	-	2.46	0.9%
Voluntary prepayment	-	20.12	13.84	6.29	-	74.63	-	94.75	35.4%
Voluntary prepayment from individuals/households	-	6.29	-	6.29	-	74.63	-	80.91	30.2%
Voluntary prepayment from employers	-	13.84	13.84	-	-	-	-	13.84	5.2%
Other domestic revenues n.e.c.	-	-	-	-	3.23	-	-	3.23	1.2%
Other revenues from NPISH n.e.c.	-	-	-	-	3.23	-	-	3.23	1.2%
Direct foreign transfers	-	-	-	-	-	-	10.87	10.87	4.1%
Direct foreign transfers	-	-	-	-	-	-	10.87	10.87	4.1%
<b>Total</b>	<b>158.89</b>	<b>20.12</b>	<b>13.84</b>	<b>6.29</b>	<b>3.23</b>	<b>74.63</b>	<b>10.87</b>	<b>267.75</b>	<b>100.0%</b>
<b>Percentage</b>	<b>59.3%</b>	<b>7.5%</b>	<b>5.2%</b>	<b>2.3%</b>	<b>1.2%</b>	<b>27.9%</b>	<b>4.1%</b>	<b>100.0%</b>	

**Table 2: Current Health Expenditure of Revenue sources by financing schemes, 2014**

	Government schemes	Voluntary health insurance schemes (a+b)	Employer-based insurance (a)	Other primary coverage schemes (b)	NPISH financing schemes	Household out-of-pocket payment	Rest of the world financing schemes (non-resident)	Total	Percentage
Transfers from government domestic revenue (allocated to health purposes)	189.40	-	-	-	-	-	-	189.40	58.4%
Transfers distributed by government from foreign origin	2.15	-	-	-	-	-	-	2.15	0.9%
Voluntary prepayment	-	24.78	17.06	7.72	0.00	78.49	-	103.27	35.4%
Voluntary prepayment from individuals/households	-	7.72	-	7.72	-	78.49	-	86.22	30.2%
Voluntary prepayment from employers	-	17.06	17.06	-	-	-	-	17.06	5.2%
Other domestic revenues n.e.c.	-	-	-	-	4.95	-	-	4.95	1.2%
Other revenues from NPISH n.e.c.	-	-	-	-	4.95	-	-	4.95	1.2%
Direct foreign transfers	-	-	-	-	-	-	10.42	10.51	4.1%
Direct foreign transfers	-	-	-	-	-	-	10.42	10.51	4.1%
<b>Total</b>	<b>191.64</b>	<b>24.78</b>	<b>17.06</b>	<b>7.72</b>	<b>4.95</b>	<b>78.49</b>	<b>10.42</b>	<b>310.28</b>	<b>100.0%</b>
<b>Percentage</b>	<b>59.3%</b>	<b>7.5%</b>	<b>5.2%</b>	<b>2.3%</b>	<b>1.2%</b>	<b>27.9%</b>	<b>4.1%</b>	<b>100.0%</b>	

**Table 3: Current Health Expenditure of health providers by Revenue Sources, 2013**

	Transfers from government domestic revenue	Transfers distributed by government from foreign origin	Voluntary prepayment (a+b)	Voluntary prepayment from individuals/ households (a)	Voluntary prepayment from employers (b)	Other domestic revenues (c+d)	Other revenues from households (c)	Other revenues from NPISH (d)	Direct foreign transfers	Total	Percentage
<b>Hospital</b>	<b>105.47</b>	<b>-</b>	<b>12.29</b>	<b>7.78</b>	<b>4.51</b>	<b>4.34</b>	<b>2.63</b>	<b>1.72</b>	<b>-</b>	<b>122.10</b>	<b>45.60%</b>
Divisional Hospitals	68.48	-	1.02	0.25	0.77	-	-	-	-	69.50	25.96%
Sub-Divisional Hospitals	31.14	-	-	-	-	-	-	-	-	31.14	11.63%
Private Hospitals	0.84	-	11.27	7.53	3.74	4.34	2.63	1.72	-	16.46	6.15%
Specialised Hospitals	5.00	-	-	-	-	-	-	-	-	5.00	1.87%
<b>Residential Long -Term care facilities</b>	<b>0.79</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>0.79</b>	<b>0.29%</b>
<b>Providers of ambulatory health care</b>	<b>27.25</b>	<b>-</b>	<b>8.71</b>	<b>5.57</b>	<b>3.14</b>	<b>24.86</b>	<b>23.99</b>	<b>0.87</b>	<b>0.21</b>	<b>61.03</b>	<b>22.79%</b>
Public Health Centres	25.64	-	-	-	-	-	-	-	-	25.64	9.57%
Private ambulatory health care	1.06	-	8.71	5.57	3.14	24.86	23.99	0.87	0.21	34.84	13.01%
Nursing stations	0.38	-	-	-	-	-	-	-	-	0.38	0.14%
All other ambulatory centres	0.17	-	-	-	-	-	-	-	-	0.17	0.06%
<b>Providers of ancillary services</b>	<b>2.52</b>	<b>0.12</b>	<b>0.09</b>	<b>0.06</b>	<b>0.03</b>	<b>0.55</b>	<b>0.52</b>	<b>0.03</b>	<b>-</b>	<b>3.28</b>	<b>1.23%</b>
Providers of patient transportation and emergency rescue	2.27	-	-	-	-	-	-	-	-	2.27	0.85%
Medical and diagnostic laboratories	0.00	0.12	-	0.06	0.03	0.55	0.52	0.03	-	0.76	0.29%
Other providers of ancillary services	0.25	-	-	-	-	-	-	-	-	0.25	0.09%
<b>Retailers and other providers of medical goods</b>	<b>0.36</b>	<b>-</b>	<b>4.72</b>	<b>3.57</b>	<b>1.15</b>	<b>33.53</b>	<b>33.17</b>	<b>0.36</b>	<b>-</b>	<b>38.61</b>	<b>14.42%</b>
<b>Providers of preventive care</b>	<b>9.30</b>	<b>1.41</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>7.32</b>	<b>18.03</b>	<b>6.73%</b>
<b>Providers of health administration and financing</b>	<b>8.12</b>	<b>0.86</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>3.34</b>	<b>12.33</b>	<b>4.60%</b>
Government health administration agencies	8.00	0.79	-	-	-	-	-	-	3.34	12.13	4.53%
Other	0.12	0.07	-	-	-	-	-	-	-	0.20	0.07%
<b>Rest of the economy</b>	<b>0.88</b>	<b>0.07</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>0.95</b>	<b>0.35%</b>
<b>Rest of the world</b>	<b>1.74</b>	<b>-</b>	<b>8.63</b>	<b>3.63</b>	<b>5.01</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>0.25</b>	<b>10.63</b>	<b>3.97%</b>
<b>Total</b>	<b>156.43</b>	<b>2.46</b>	<b>34.44</b>	<b>20.60</b>	<b>13.84</b>	<b>63.28</b>	<b>60.31</b>	<b>2.97</b>	<b>11.13</b>	<b>267.75</b>	<b>100%</b>
<b>Percentage</b>	<b>58.42%</b>	<b>0.92%</b>	<b>12.86%</b>	<b>7.69%</b>	<b>5.17%</b>	<b>23.64%</b>	<b>22.53%</b>	<b>1.11%</b>	<b>4.16%</b>	<b>100%</b>	



**Table 4: Current Health Expenditure of Health providers by Revenue sources, 2014**

	Transfers from government domestic revenue	Transfers distributed by government from foreign origin	Voluntary prepayment (a+b)	Voluntary prepayment from individuals/ households (a)	Voluntary prepayment from employers (b)	Other domestic revenues (c+d)	Other revenues from households (c)	Other revenues from NPISH (d)	Direct foreign transfers	Total	Percentage
<b>Hospital</b>	<b>122.43</b>	<b>-</b>	<b>15.52</b>	<b>9.85</b>	<b>5.67</b>	<b>5.71</b>	<b>3.47</b>	<b>2.24</b>	<b>-</b>	<b>143.65</b>	<b>46.30%</b>
Divisional Hospitals	76.48	-	1.70	0.37	1.34	-	-	-	-	78.18	25.20%
Sub-Divisional Hospitals	35.55	-	-	-	-	-	-	-	-	35.55	11.46%
Private Hospitals	1.34	-	13.81	9.48	4.33	5.71	3.47	2.24	-	20.86	6.72%
Specialised Hospitals	9.06	-	-	-	-	-	-	-	-	9.06	2.92%
<b>Residential Long -Term care facilities</b>	<b>1.10</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>1.10</b>	<b>0.35%</b>
<b>Providers of ambulatory health care</b>	<b>28.29</b>	<b>-</b>	<b>10.59</b>	<b>6.70</b>	<b>3.89</b>	<b>27.69</b>	<b>26.71</b>	<b>0.98</b>	<b>0.13</b>	<b>66.70</b>	<b>21.50%</b>
Public Health Centres	25.36	-	-	-	-	-	-	-	-	25.36	8.17%
Private ambulatory health care	1.38	-	10.59	6.70	3.89	27.69	26.71	0.98	0.13	39.79	12.82%
Nursing stations	1.40	-	-	-	-	-	-	-	-	1.40	0.45%
All other ambulatory centres	0.16	-	-	-	-	-	-	-	-	0.16	0.05%
<b>Providers of ancillary services</b>	<b>3.18</b>	<b>0.11</b>	<b>0.16</b>	<b>0.11</b>	<b>0.05</b>	<b>0.87</b>	<b>0.84</b>	<b>0.03</b>	<b>-</b>	<b>4.31</b>	<b>1.39%</b>
Providers of patient transportation and emergency rescue	2.75	-	-	-	-	-	-	-	-	2.75	0.89%
Medical and diagnostic laboratories	-	0.11	0.16	0.11	0.05	0.87	0.84	0.03	-	1.14	0.37%
Other providers of ancillary services	0.43	-	-	-	-	-	-	-	-	0.43	0.14%
<b>Retailers and other providers of medical goods</b>	<b>0.47</b>	<b>-</b>	<b>4.97</b>	<b>3.77</b>	<b>1.20</b>	<b>30.75</b>	<b>30.44</b>	<b>0.31</b>	<b>-</b>	<b>36.19</b>	<b>11.66%</b>
<b>Providers of preventive care</b>	<b>20.32</b>	<b>0.95</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>8.33</b>	<b>29.60</b>	<b>9.54%</b>
<b>Providers of health administration and financing</b>	<b>10.23</b>	<b>1.09</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>3.04</b>	<b>14.36</b>	<b>4.63%</b>
Government health administration agencies	10.09	1.09	-	-	-	-	-	-	3.04	14.21	4.58%
Other	0.14	-	-	-	-	-	-	-	-	0.14	0.05%
<b>Rest of the economy</b>	<b>1.20</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>1.20</b>	<b>0.39%</b>
<b>Rest of the world</b>	<b>2.19</b>	<b>-</b>	<b>10.59</b>	<b>4.34</b>	<b>6.25</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>0.40</b>	<b>13.18</b>	<b>4.25%</b>
<b>Total</b>	<b>189.40</b>	<b>2.15</b>	<b>41.82</b>	<b>24.77</b>	<b>17.06</b>	<b>65.01</b>	<b>61.45</b>	<b>3.56</b>	<b>11.90</b>	<b>310.28</b>	<b>100%</b>
<b>Percentage</b>	<b>61.04%</b>	<b>0.69%</b>	<b>13.48%</b>	<b>7.98%</b>	<b>5.50%</b>	<b>20.95%</b>	<b>19.80%</b>	<b>1.15%</b>	<b>3.84%</b>	<b>100%</b>	

**Table 5: Current Health Expenditure of health providers by financing schemes, 2013**

	Government schemes	Voluntary health insurance schemes (a+b)	Employer-based insurance (a)	Other primary coverage schemes (b)	NPISH financing schemes	Household out-of-pocket payment	Rest of the world financing schemes (non-resident)	Total	Percentage
<b>Hospitals</b>	<b>105.47</b>	<b>6.58</b>	<b>4.51</b>	<b>2.07</b>	<b>1.72</b>	<b>8.33</b>	<b>-</b>	<b>122.10</b>	<b>45.6%</b>
Divisional Hospitals	68.48	0.80	0.77	0.04	-	0.22	-	69.50	26.0%
Sub-Divisional	31.14	-	-	-	-	-	-	31.14	11.6%
Private Hospitals	0.84	5.78	3.74	2.04	1.72	8.12	-	16.46	6.1%
Specialized	5.00	-	-	-	-	-	-	5.00	1.9%
<b>Residential long-term care facilities</b>	<b>0.79</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>0.79</b>	<b>0.3%</b>
<b>Providers of ambulatory health care</b>	<b>27.25</b>	<b>3.73</b>	<b>3.14</b>	<b>0.58</b>	<b>1.08</b>	<b>28.98</b>	<b>-</b>	<b>61.03</b>	<b>22.8%</b>
Public Health Centres	25.64	-	-	-	-	-	-	25.64	9.6%
Private ambulatory health care	1.06	3.73	3.14	0.58	1.08	28.98	-	34.84	13.0%
Nursing stations	0.38	-	-	-	-	-	-	0.38	0.1%
All other ambulatory centres	0.17	-	-	-	-	-	-	0.17	0.1%
<b>Providers of ancillary services</b>	<b>2.64</b>	<b>0.03</b>	<b>0.03</b>	<b>-</b>	<b>0.03</b>	<b>0.58</b>	<b>-</b>	<b>3.28</b>	<b>1.2%</b>
Providers of patient transportation and emergency rescue	2.27	-	-	-	-	-	-	2.27	0.8%
Medical and diagnostic laboratories	0.12	0.03	0.03	-	0.03	0.58	-	0.76	0.3%
National blood services	0.25	-	-	-	-	-	-	0.25	0.1%
<b>Retailers and other providers of medical goods</b>	<b>0.36</b>	<b>1.15</b>	<b>1.15</b>	<b>-</b>	<b>0.36</b>	<b>36.74</b>	<b>-</b>	<b>38.61</b>	<b>14.4%</b>
Pharmacies (Private)	0.36	1.15	1.15	-	0.36	36.74	-	38.61	14.4%
<b>Providers of preventive care</b>	<b>10.71</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>7.32</b>	<b>18.03</b>	<b>6.7%</b>
<b>Providers of health care system administration and financing</b>	<b>8.98</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>3.34</b>	<b>12.33</b>	<b>4.6%</b>
Government health administration agencies	8.79	-	-	-	-	-	-	8.79	3.3%
Others	0.20	-	-	-	-	-	-	0.20	0.1%
<b>Rest of economy</b>	<b>0.95</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>0.95</b>	<b>0.4%</b>
<b>Rest of the world</b>	<b>1.74</b>	<b>8.63</b>	<b>5.01</b>	<b>3.63</b>	<b>0.05</b>	<b>-</b>	<b>0.20</b>	<b>10.63</b>	<b>4.0%</b>
<b>Total</b>	<b>158.89</b>	<b>20.12</b>	<b>13.84</b>	<b>6.29</b>	<b>3.23</b>	<b>74.63</b>	<b>10.87</b>	<b>267.75</b>	<b>100%</b>
Percentage	59.3%	7.5%	5.2%	2.3%	1.2%	27.9%	4.1%	100%	

**Table 6: Current Health Expenditure of health providers by financing schemes, 2014**

	Government schemes	Voluntary health insurance schemes (a+b)	Employer-based insurance (a)	Other primary coverage schemes (b)	NPISH financing schemes	Household out-of-pocket payment	Rest of the world financing schemes (non-resident)	Total	Percentage
<b>Hospitals</b>	<b>122.43</b>	<b>7.99</b>	<b>5.67</b>	<b>2.32</b>	<b>2.24</b>	<b>11.00</b>	<b>-</b>	<b>143.65</b>	<b>46.3%</b>
Divisional Hospitals	76.48	1.44	1.34	0.10	-	0.27	-	78.18	25.2%
Sub-Divisional	35.55	-	-	-	-	-	-	35.55	11.5%
Private Hospitals	1.34	6.55	4.33	2.22	2.24	10.73	-	20.86	6.7%
Specialized	9.06	-	-	-	-	-	-	9.06	2.9%
<b>Residential long-term care facilities</b>	<b>1.10</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>1.10</b>	<b>0.4%</b>
<b>Providers of ambulatory health care</b>	<b>28.29</b>	<b>4.96</b>	<b>3.89</b>	<b>1.07</b>	<b>1.12</b>	<b>32.34</b>	<b>-</b>	<b>66.70</b>	<b>21.5%</b>
Public Health Centres	25.36	-	-	-	-	-	-	25.36	8.2%
Private ambulatory health care	1.38	4.96	3.89	1.07	1.12	32.34	-	39.79	12.8%
Nursing stations	1.40	-	-	-	-	-	-	1.40	0.4%
All other ambulatory centres	0.16	-	-	-	-	-	-	0.16	0.1%
<b>Providers of ancillary services</b>	<b>3.28</b>	<b>0.05</b>	<b>0.05</b>	<b>-</b>	<b>0.03</b>	<b>0.95</b>	<b>-</b>	<b>4.31</b>	<b>1.4%</b>
Providers of patient transportation and emergency rescue	2.75	-	-	-	-	-	-	2.75	0.9%
Medical and diagnostic laboratories	0.11	0.05	0.05	-	0.03	0.95	-	1.14	0.4%
National blood services	0.43	-	-	-	-	-	-	0.43	0.1%
<b>Retailers and other providers of medical goods</b>	<b>0.47</b>	<b>1.20</b>	<b>1.20</b>	<b>-</b>	<b>0.31</b>	<b>34.21</b>	<b>-</b>	<b>36.19</b>	<b>11.7%</b>
Pharmacies (Private)	0.47	1.20	1.20	-	0.31	34.21	-	36.19	11.7%
<b>Providers of preventive care</b>	<b>21.36</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>1.10</b>	<b>-</b>	<b>7.14</b>	<b>29.60</b>	<b>9.5%</b>
<b>Providers of health care system administration and financing</b>	<b>11.32</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>3.04</b>	<b>14.36</b>	<b>4.6%</b>
Government health administration agencies	11.18	-	-	-	-	-	-	11.18	3.6%
Others	0.14	-	-	-	-	-	-	0.14	0.0%
<b>Rest of economy</b>	<b>1.20</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>1.20</b>	<b>0.4%</b>
<b>Rest of the world</b>	<b>2.19</b>	<b>10.59</b>	<b>6.25</b>	<b>4.34</b>	<b>0.16</b>	<b>-</b>	<b>0.25</b>	<b>13.18</b>	<b>4.2%</b>
<b>Total</b>	<b>191.64</b>	<b>24.78</b>	<b>17.06</b>	<b>7.72</b>	<b>4.95</b>	<b>78.49</b>	<b>10.42</b>	<b>310.28</b>	<b>100%</b>
Percentage	61.8%	8.0%	5.5%	2.5%	1.6%	25.3%	3.4%	100.0%	

**Table 7: Current Health Expenditure of health providers by health functions, 2013**

	Inpatient Curative Care	Outpatient Curative Care	Rehabilitative & Long Term Care	Ancillary Services	Medical Goods	Preventive Care	Governance and Health system administration	Total	Percentage
<b>Hospital</b>	<b>38.53</b>	<b>32.49</b>	<b>3.09</b>	<b>21.43</b>	<b>1.39</b>	<b>21.29</b>	<b>3.87</b>	<b>122.10</b>	45.60%
Divisional Hospitals	25.73	15.42	1.12	14.24	0.60	8.94	3.45	69.50	25.96%
Sub-Divisional Hospitals	5.75	10.22	1.06	3.37	-	10.74	-	31.14	11.63%
Private Hospitals	5.48	5.86	0.06	3.73	0.79	0.55	-	16.46	6.15%
Specialised Hospitals	1.58	0.99	0.86	0.09	-	1.06	0.42	5.00	1.87%
<b>Residential Long -Term care facilities</b>	<b>-</b>	<b>-</b>	<b>0.73</b>	<b>-</b>	<b>-</b>	<b>0.05</b>	<b>-</b>	<b>0.79</b>	0.29%
<b>Providers of ambulatory health care</b>	<b>1.11</b>	<b>28.21</b>	<b>0.34</b>	<b>6.01</b>	<b>2.40</b>	<b>22.97</b>	<b>-</b>	<b>61.03</b>	22.79%
Public Health Centres	-	7.65	0.28	0.37	-	17.33	-	25.64	9.57%
Private ambulatory health care	1.11	20.48	0.06	5.64	2.40	5.15	-	34.84	13.01%
Nursing stations	-	0.07	-	-	-	0.31	-	0.38	0.14%
All other ambulatory centres	-	-	-	-	-	0.17	-	0.17	0.06%
<b>Providers of ancillary services</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>3.04</b>	<b>-</b>	<b>0.15</b>	<b>0.10</b>	<b>3.28</b>	1.23%
Providers of patient transportation and emergency rescue	-	-	-	2.27	-	-	-	2.27	0.85%
Medical and diagnostic laboratories	-	-	-	0.76	-	-	-	0.76	0.29%
Other providers of ancillary services	-	-	-	-	-	0.15	0.10	0.25	0.09%
<b>Retailers and other providers of medical goods</b>	<b>0.29</b>	<b>0.33</b>	<b>0.01</b>	<b>0.04</b>	<b>37.95</b>	<b>-</b>	<b>-</b>	<b>38.61</b>	14.42%
<b>Providers of preventive care</b>	<b>0.72</b>	<b>-</b>	<b>-</b>	<b>0.13</b>	<b>-</b>	<b>16.81</b>	<b>0.35</b>	<b>18.02</b>	6.73%
<b>Providers of health administration and financing</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>0.05</b>	<b>-</b>	<b>-</b>	<b>12.28</b>	<b>12.33</b>	4.61%
Government health administration agencies	-	-	-	-	-	-	12.13	12.13	4.53%
Other	-	-	-	0.05	-	-	0.15	0.20	0.07%
<b>Rest of the economy</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>0.95</b>	<b>0.95</b>	0.35%
<b>Rest of the world</b>	<b>4.43</b>	<b>5.18</b>	<b>-</b>	<b>0.81</b>	<b>0.21</b>	<b>-</b>	<b>-</b>	<b>10.63</b>	3.97%
<b>Total</b>	<b>45.08</b>	<b>66.21</b>	<b>4.17</b>	<b>31.51</b>	<b>41.95</b>	<b>61.28</b>	<b>17.55</b>	<b>267.74</b>	100%
<b>Percentage</b>	16.84%	24.73%	1.56%	11.77%	15.67%	22.89%	6.55%	100%	

**Table 8: Current Health Expenditure of health providers by health functions, 2014**

	Inpatient Curative Care	Outpatient Curative Care	Rehabilitative & Long Term Care	Ancillary Services	Medical Goods	Preventive Care	Governance and Health system administration	Total	Percentage
<b>Hospital</b>	<b>44.40</b>	<b>37.27</b>	<b>3.27</b>	<b>27.24</b>	<b>2.64</b>	<b>24.84</b>	<b>3.99</b>	<b>143.65</b>	<b>46.30%</b>
Divisional Hospitals	29.10	17.05	0.65	17.50	1.08	9.24	3.57	78.18	25.20%
Sub-Divisional Hospitals	6.37	11.85	1.16	4.22	-	11.94	-	35.55	11.46%
Private Hospitals	6.00	7.22	0.07	5.28	1.56	0.74	-	20.86	6.72%
Specialised Hospitals	2.93	1.15	1.39	0.24	-	2.92	0.42	9.06	2.92%
<b>Residential Long -Term care facilities</b>	<b>-</b>	<b>-</b>	<b>1.04</b>	<b>-</b>	<b>-</b>	<b>0.06</b>	<b>-</b>	<b>1.10</b>	<b>0.35%</b>
<b>Providers of ambulatory health care</b>	<b>1.24</b>	<b>31.45</b>	<b>0.41</b>	<b>7.01</b>	<b>2.97</b>	<b>23.62</b>	<b>-</b>	<b>66.70</b>	<b>21.50%</b>
Public Health Centres	-	7.77	0.36	0.31	-	16.91	-	25.36	8.17%
Private ambulatory health care	1.24	23.42	0.05	6.70	2.97	5.41	-	39.79	12.82%
Nursing stations	-	0.27	-	-	-	1.13	-	1.40	0.45%
All other ambulatory centres	-	-	-	-	-	0.16	-	0.16	0.05%
<b>Providers of ancillary services</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>3.89</b>	<b>-</b>	<b>0.25</b>	<b>0.17</b>	<b>4.31</b>	<b>1.39%</b>
Providers of patient transportation and emergency rescue	-	-	-	2.75	-	-	-	2.75	0.89%
Medical and diagnostic laboratories	-	-	-	1.14	-	-	-	1.14	0.37%
Other providers of ancillary services	-	-	-	-	-	0.25	0.17	0.43	0.14%
<b>Retailers and other providers of medical goods</b>	<b>0.30</b>	<b>0.39</b>	<b>0.01</b>	<b>0.04</b>	<b>35.46</b>	<b>-</b>	<b>-</b>	<b>36.19</b>	<b>11.66%</b>
<b>Providers of preventive care</b>	<b>0.45</b>	<b>-</b>	<b>-</b>	<b>0.08</b>	<b>-</b>	<b>28.85</b>	<b>0.22</b>	<b>29.60</b>	<b>9.54%</b>
<b>Providers of health administration and financing</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>0.05</b>	<b>-</b>	<b>-</b>	<b>14.31</b>	<b>14.36</b>	<b>4.63%</b>
Government health administration agencies	-	-	-	0.00	-	-	14.21	14.21	4.58%
Other	-	-	-	0.05	-	-	0.10	0.14	0.05%
<b>Rest of the economy</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>1.20</b>	<b>1.20</b>	<b>0.39%</b>
<b>Rest of the world</b>	<b>5.16</b>	<b>6.20</b>	<b>-</b>	<b>1.60</b>	<b>0.21</b>	<b>-</b>	<b>-</b>	<b>13.18</b>	<b>4.25%</b>
<b>Total</b>	<b>51.55</b>	<b>75.32</b>	<b>4.72</b>	<b>39.91</b>	<b>41.28</b>	<b>77.62</b>	<b>19.89</b>	<b>310.28</b>	<b>100%</b>
<b>Percentage</b>	<b>16.61%</b>	<b>24.27%</b>	<b>1.52%</b>	<b>12.86%</b>	<b>13.30%</b>	<b>25.02%</b>	<b>6.41%</b>	<b>100%</b>	

**Table 9: Current Health Expenditure of Health functions by Revenue sources, 2013**

	Transfers from government domestic revenue	Transfers distributed by government from foreign origin	Voluntary prepayment (a+b)	Voluntary prepayment from individuals/ households (a)	Voluntary prepayment from employers (b)	Other domestic revenues n.e.c. (c+d)	Other revenues from households n.e.c. (c)	Other revenues from NPISH n.e.c. (d)	Direct foreign transfers	Total	Percentage
<b>Curative care</b>	<b>69.98</b>	<b>0.72</b>	<b>22.19</b>	<b>11.90</b>	<b>10.28</b>	<b>17.98</b>	<b>16.42</b>	<b>1.56</b>	<b>0.42</b>	<b>111.29</b>	<b>41.57%</b>
<b>Inpatient curative care</b>	<b>35.43</b>	<b>0.72</b>	<b>7.32</b>	<b>3.98</b>	<b>3.34</b>	<b>1.40</b>	<b>0.79</b>	<b>0.62</b>	<b>0.20</b>	<b>45.08</b>	<b>16.84%</b>
General inpatient curative care	23.07	0.72	4.74	2.98	1.77	1.40	0.79	0.62	-	29.94	11.18%
Specialised inpatient curative care	12.36	-	2.58	1.00	1.58	-	-	-	0.20	15.14	5.66%
<b>Outpatient curative care</b>	<b>34.56</b>	<b>-</b>	<b>14.87</b>	<b>7.93</b>	<b>6.94</b>	<b>16.58</b>	<b>15.63</b>	<b>0.95</b>	<b>0.21</b>	<b>66.21</b>	<b>24.73%</b>
General outpatient curative care	26.07	-	12.54	6.96	5.58	12.76	11.91	0.85	0.21	51.59	19.27%
Dental outpatient curative care	8.48	-	2.33	0.97	1.36	3.81	3.72	0.09	-	14.62	5.46%
<b>Rehabilitative &amp; Long term care</b>	<b>4.13</b>	<b>-</b>	<b>0.04</b>	<b>0.01</b>	<b>0.03</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>4.17</b>	<b>1.56%</b>
<b>Ancillary services</b>	<b>20.40</b>	<b>0.26</b>	<b>4.63</b>	<b>3.47</b>	<b>1.17</b>	<b>6.17</b>	<b>5.37</b>	<b>0.80</b>	<b>0.05</b>	<b>31.51</b>	<b>11.77%</b>
Laboratory services	9.39	0.26	1.76	1.55	0.20	3.18	2.74	0.44	0.05	14.63	5.47%
Imaging services	8.74	-	2.79	1.88	0.91	2.99	2.63	0.35	-	14.51	5.42%
Patient transportation	2.27	-	-	-	-	-	-	-	-	2.27	0.85%
Other ancillary services	-	-	0.09	0.04	0.05	-	-	-	-	0.09	0.03%
<b>Medical goods</b>	<b>0.90</b>	<b>-</b>	<b>6.14</b>	<b>4.01</b>	<b>2.13</b>	<b>34.91</b>	<b>34.54</b>	<b>0.37</b>	<b>-</b>	<b>41.95</b>	<b>15.67%</b>
Prescribed medicines	0.81	-	3.35	2.30	1.05	20.03	19.82	0.21	-	24.19	9.03%
Over-the-counter medicines	0.06	-	1.26	1.12	0.14	11.00	10.89	0.12	-	12.33	4.60%
Other medical non-durable goods	0.03	-	1.53	0.59	0.94	3.88	3.84	0.04	-	5.44	2.03%
<b>Preventive care</b>	<b>48.10</b>	<b>0.20</b>	<b>1.44</b>	<b>1.21</b>	<b>0.23</b>	<b>4.22</b>	<b>3.98</b>	<b>0.24</b>	<b>7.32</b>	<b>61.28</b>	<b>22.89%</b>
Information, education and counselling programmes	10.32	0.06	1.44	1.21	0.23	4.22	3.98	0.24	2.07	18.11	6.76%
Immunisation programmes	8.74	-	-	-	-	-	-	-	2.37	11.11	4.15%
Early disease detection programmes	9.11	0.02	-	-	-	-	-	-	1.55	10.68	3.99%
Healthy condition monitoring programmes	10.28	0.04	-	-	-	-	-	-	0.63	10.95	4.09%
Epidemiological surveillance and risk and disease control programmes	5.17	0.01	-	-	-	-	-	-	0.55	5.73	2.14%
Preparing for disaster and emergency response programmes	4.48	0.08	-	-	-	-	-	-	0.14	4.70	1.75%
<b>Governance and Health system administration</b>	<b>12.92</b>	<b>1.29</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>3.34</b>	<b>17.55</b>	<b>6.55%</b>
<b>Total</b>	<b>156.43</b>	<b>2.46</b>	<b>34.44</b>	<b>20.60</b>	<b>13.84</b>	<b>63.28</b>	<b>60.31</b>	<b>2.97</b>	<b>11.13</b>	<b>267.75</b>	<b>100%</b>
<b>Percentage</b>	<b>58.42%</b>	<b>0.92%</b>	<b>12.86%</b>	<b>7.69%</b>	<b>5.17%</b>	<b>23.64%</b>	<b>22.53%</b>	<b>1.11%</b>	<b>4.16%</b>	<b>100%</b>	

**Table 10: Current Health Expenditure of Health functions by Revenue sources, 2014**

	Transfers from government domestic revenue	Transfers distributed by government from foreign origin	Voluntary prepayment (a+b)	Voluntary prepayment from individuals/ households (a)	Voluntary prepayment from employers (b)	Other domestic revenues n.e.c. (c+d)	Other revenues from households (c)	Other revenues from NPISH (d)	Direct foreign transfers	Total	Percentage
<b>Curative care</b>	<b>79.12</b>	<b>0.45</b>	<b>26.09</b>	<b>14.15</b>	<b>11.93</b>	<b>20.72</b>	<b>18.77</b>	<b>1.95</b>	<b>0.49</b>	<b>126.87</b>	<b>40.89%</b>
<b>Inpatient curative care</b>	<b>40.66</b>	<b>0.45</b>	<b>8.33</b>	<b>4.69</b>	<b>3.63</b>	<b>1.75</b>	<b>0.99</b>	<b>0.76</b>	<b>0.36</b>	<b>51.55</b>	<b>16.61%</b>
General inpatient curative care	25.71	0.45	5.73	3.64	2.09	1.75	0.99	0.76	0.11	33.76	10.88%
Specialised inpatient curative care	14.95	-	2.59	1.05	1.54	-	-	-	0.25	17.79	5.73%
<b>Outpatient curative care</b>	<b>38.45</b>	<b>-</b>	<b>17.76</b>	<b>9.46</b>	<b>8.30</b>	<b>18.97</b>	<b>17.78</b>	<b>1.19</b>	<b>0.13</b>	<b>75.32</b>	<b>24.27%</b>
General outpatient curative care	28.37	-	14.78	8.27	6.52	14.32	13.24	1.08	0.13	57.61	18.57%
Dental outpatient curative care	10.08	-	2.98	1.19	1.79	4.65	4.54	0.12	-	17.71	5.71%
<b>Rehabilitative &amp; Long term care</b>	<b>4.68</b>	<b>-</b>	<b>0.05</b>	<b>0.01</b>	<b>0.04</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>4.72</b>	<b>1.52%</b>
<b>Ancillary services</b>	<b>25.08</b>	<b>0.19</b>	<b>6.98</b>	<b>4.88</b>	<b>2.10</b>	<b>7.61</b>	<b>6.61</b>	<b>1.00</b>	<b>0.04</b>	<b>39.91</b>	<b>12.86%</b>
Laboratory services	11.80	0.19	2.26	2.03	0.23	4.07	3.52	0.56	0.04	18.36	5.92%
Imaging services	10.53	-	3.67	2.42	1.25	3.54	3.09	0.45	-	17.74	5.72%
Patient transportation	2.75	-	-	-	-	-	-	-	-	2.75	0.89%
Other ancillary services	-	-	1.06	0.43	0.62	-	-	-	-	1.06	0.34%
<b>Medical goods</b>	<b>2.00</b>	<b>-</b>	<b>7.09</b>	<b>4.35</b>	<b>2.74</b>	<b>32.19</b>	<b>31.86</b>	<b>0.33</b>	<b>-</b>	<b>41.28</b>	<b>13.30%</b>
Prescribed medicines	1.91	-	3.87	2.49	1.38	18.53	18.34	0.19	-	24.31	7.83%
Over-the-counter medicines	0.06	-	1.26	1.15	0.11	9.84	9.74	0.10	-	11.16	3.60%
Other medical non-durable goods	0.03	-	1.96	0.71	1.25	3.82	3.78	0.04	-	5.81	1.87%
<b>Preventive care</b>	<b>62.97</b>	<b>0.20</b>	<b>1.62</b>	<b>1.38</b>	<b>0.25</b>	<b>4.49</b>	<b>4.21</b>	<b>0.28</b>	<b>8.33</b>	<b>77.62</b>	<b>25.02%</b>
Information, education and counselling programmes	14.40	0.09	1.62	1.38	0.25	4.49	4.21	0.28	2.21	22.81	7.35%
Immunisation programmes	10.29	-	-	-	-	-	-	-	2.14	12.43	4.01%
Early disease detection programmes	12.32	0.02	-	-	-	-	-	-	1.98	14.32	4.62%
Healthy condition monitoring programmes	13.60	0.03	-	-	-	-	-	-	0.57	14.21	4.58%
Epidemiological surveillance and risk and disease control programmes	6.85	0.01	-	-	-	-	-	-	0.70	7.57	2.44%
Preparing for disaster and emergency response programmes	5.51	0.05	-	-	-	-	-	-	0.72	6.28	2.02%
<b>Governance and Health system administration</b>	<b>15.55</b>	<b>1.31</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>3.04</b>	<b>19.89</b>	<b>6.41%</b>
<b>Total</b>	<b>189.40</b>	<b>2.15</b>	<b>41.82</b>	<b>24.77</b>	<b>17.06</b>	<b>65.01</b>	<b>61.45</b>	<b>3.56</b>	<b>11.90</b>	<b>310.28</b>	<b>100%</b>
<b>Percentage</b>	<b>61.04%</b>	<b>0.69%</b>	<b>13.48%</b>	<b>7.98%</b>	<b>5.50%</b>	<b>20.95%</b>	<b>19.80%</b>	<b>1.15%</b>	<b>3.84%</b>	<b>100%</b>	

**Table 11: Current Health Expenditure of health functions by financing schemes, 2013**

	Government schemes	Voluntary health insurance schemes (a+b)	Employer-based insurance (a)	Other primary coverage schemes (b)	NPISH financing schemes	Household out-of-pocket payment	Rest of the world financing schemes (non-resident)	Total	Percentage
<b>Curative care</b>	<b>70.71</b>	<b>15.90</b>	<b>10.28</b>	<b>5.61</b>	<b>1.77</b>	<b>22.71</b>	<b>0.20</b>	<b>111.29</b>	<b>41.6%</b>
<b>Inpatient curative care</b>	<b>36.15</b>	<b>5.31</b>	<b>3.34</b>	<b>1.97</b>	<b>0.62</b>	<b>2.80</b>	<b>0.20</b>	<b>45.08</b>	<b>16.8%</b>
General inpatient curative care	23.79	2.79	1.77	1.02	0.62	2.74	-	29.94	11.2%
Specialised inpatient curative care	12.36	2.52	1.58	0.94	-	0.06	0.20	15.14	5.7%
<b>Outpatient curative care</b>	<b>34.56</b>	<b>10.59</b>	<b>6.94</b>	<b>3.65</b>	<b>1.16</b>	<b>19.91</b>	<b>-</b>	<b>66.21</b>	<b>24.7%</b>
General outpatient curative care	26.07	8.32	5.58	2.74	1.06	16.13	-	51.59	19.3%
Dental outpatient curative care	8.48	2.26	1.36	0.91	0.09	3.78	-	14.62	5.5%
<b>Rehabilitative care and Long-term care</b>	<b>4.13</b>	<b>0.03</b>	<b>0.03</b>	<b>-</b>	<b>-</b>	<b>0.01</b>	<b>-</b>	<b>4.17</b>	<b>1.6%</b>
<b>Ancillary services</b>	<b>20.66</b>	<b>1.71</b>	<b>1.17</b>	<b>0.55</b>	<b>0.84</b>	<b>8.29</b>	<b>-</b>	<b>31.51</b>	<b>11.8%</b>
Laboratory services	9.65	-	0.20	-	-	-	-	9.65	3.6%
Imaging services	8.74	-	0.91	0.51	-	-	-	8.74	3.3%
Patient transportation	2.27	-	-	-	-	-	-	2.27	0.8%
Other ancillary services	-	-	0.05	0.04	-	-	-	-	0.0%
<b>Medical goods</b>	<b>0.90</b>	<b>2.26</b>	<b>2.13</b>	<b>0.13</b>	<b>0.37</b>	<b>38.43</b>	<b>-</b>	<b>41.95</b>	<b>15.7%</b>
Prescribed medicines	0.81	0.26	0.26	-	0.21	21.86	-	23.13	8.6%
Over-the-counter medicines	0.06	0.14	0.14	-	0.12	12.01	-	12.33	4.6%
Other medical non-durable goods	0.03	1.86	1.73	0.13	0.04	4.56	-	6.49	2.4%
<b>Preventive care</b>	<b>48.30</b>	<b>0.23</b>	<b>0.23</b>	<b>-</b>	<b>0.24</b>	<b>5.19</b>	<b>7.32</b>	<b>61.28</b>	<b>22.9%</b>
Information, education and counselling programmes	10.37	0.23	0.23	-	0.24	5.19	2.07	18.11	6.8%
Immunisation programmes	8.74	-	-	-	-	-	2.37	11.11	4.2%
Early disease detection programmes	9.13	-	-	-	-	-	1.55	10.68	4.0%
Healthy condition monitoring programmes	10.32	-	-	-	-	-	0.63	10.95	4.1%
Epidemiological surveillance and risk and disease control programmes	5.18	-	-	-	-	-	0.55	5.73	2.1%
Preparing for disaster and emergency response programmes	4.55	-	-	-	-	-	0.14	4.70	1.8%
<b>Governance and Health system administration</b>	<b>14.20</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>3.34</b>	<b>17.55</b>	<b>6.6%</b>
<b>Total</b>	<b>158.89</b>	<b>20.12</b>	<b>13.84</b>	<b>6.29</b>	<b>3.23</b>	<b>74.63</b>	<b>10.87</b>	<b>267.75</b>	<b>100%</b>
Percentage	59.3%	7.5%	5.2%	2.3%	1.2%	27.9%	4.1%	100%	



**Table 12: Current Health Expenditure of health functions by financing schemes, 2014**

	Government schemes	Voluntary health insurance schemes (a+b)	Employer-based insurance (a)	Other primary coverage schemes (b)	NPISH financing schemes	Household out-of-pocket payment	Rest of the world financing schemes (non-resident)	Total	Percentage
<b>Curative care</b>	<b>79.57</b>	<b>18.42</b>	<b>11.93</b>	<b>6.49</b>	<b>2.20</b>	<b>26.43</b>	<b>0.25</b>	<b>126.87</b>	<b>40.9%</b>
<b>Inpatient curative care</b>	<b>41.11</b>	<b>5.92</b>	<b>3.63</b>	<b>2.29</b>	<b>0.87</b>	<b>3.40</b>	<b>0.25</b>	<b>51.55</b>	<b>16.6%</b>
General inpatient curative care	26.16	3.33	2.09	1.24	0.87	3.39	-	33.76	10.9%
Specialised inpatient curative care	14.95	2.58	1.54	1.04	-	0.01	0.25	17.79	5.7%
<b>Outpatient curative care</b>	<b>38.45</b>	<b>12.51</b>	<b>8.30</b>	<b>4.20</b>	<b>1.33</b>	<b>23.03</b>	<b>-</b>	<b>75.32</b>	<b>24.3%</b>
General outpatient curative care	28.37	9.61	6.52	3.10	1.21	18.41	-	57.61	18.6%
Dental outpatient curative care	10.08	2.89	1.79	1.10	0.12	4.62	-	17.71	5.7%
<b>Rehabilitative care and Long-term care</b>	<b>4.68</b>	<b>0.04</b>	<b>0.04</b>	<b>-</b>	<b>-</b>	<b>0.01</b>	<b>-</b>	<b>4.72</b>	<b>1.5%</b>
<b>Ancillary services</b>	<b>25.27</b>	<b>3.23</b>	<b>2.10</b>	<b>1.13</b>	<b>1.05</b>	<b>10.36</b>	<b>-</b>	<b>39.91</b>	<b>12.9%</b>
Laboratory services	11.99	-	0.23	-	-	-	-	11.99	3.9%
Imaging services	10.53	-	1.25	0.70	-	-	-	10.53	3.4%
Patient transportation	2.75	-	-	-	-	-	-	2.75	0.9%
Other ancillary services	-	-	0.62	0.43	-	-	-	-	0.0%
<b>Medical goods</b>	<b>2.00</b>	<b>2.84</b>	<b>2.74</b>	<b>0.11</b>	<b>0.33</b>	<b>36.10</b>	<b>-</b>	<b>41.28</b>	<b>13.3%</b>
Prescribed medicines	1.91	0.21	0.21	-	0.19	20.50	-	22.81	7.4%
Over-the-counter medicines	0.06	0.11	0.11	-	0.10	10.89	-	11.16	3.6%
Other medical non-durable goods	0.03	2.52	2.42	0.11	0.04	4.71	-	7.31	2.4%
<b>Preventive care</b>	<b>63.27</b>	<b>0.25</b>	<b>0.25</b>	<b>-</b>	<b>1.38</b>	<b>5.59</b>	<b>7.14</b>	<b>77.62</b>	<b>25.0%</b>
Information, education and counselling programmes	14.49	0.25	0.25	-	0.58	5.59	1.90	22.81	7.4%
Immunisation programmes	10.29	-	-	-	-	-	2.14	12.43	4.0%
Early disease detection programmes	12.34	-	-	-	0.50	-	1.48	14.32	4.6%
Healthy condition monitoring programmes	13.63	-	-	-	-	-	0.57	14.21	4.6%
Epidemiological surveillance and risk and disease control programmes	6.87	-	-	-	0.20	-	0.50	7.57	2.4%
Preparing for disaster and emergency response programmes	5.66	-	-	-	0.09	-	0.53	6.28	2.0%
<b>Governance and Health system administration</b>	<b>16.85</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>3.04</b>	<b>19.89</b>	<b>6.4%</b>
<b>Total</b>	<b>191.64</b>	<b>24.78</b>	<b>17.06</b>	<b>7.72</b>	<b>4.95</b>	<b>78.49</b>	<b>10.42</b>	<b>310.28</b>	<b>100%</b>
Percentage	61.8%	8.0%	5.5%	2.5%	1.6%	25.3%	3.4%	100%	

# **This report presents health expenditure estimates:**

- as proportion of gross domestic product (GDP)
- how much has been spent per person (per capita basis)
- by source of funding (where the money comes from)
- by financing schemes (who manages the funds)
- who provides the services ( providers)
- for what services the money was spent on (functions)
- how much is spent on health by Government and private sector
- how much health is funded by development partners
- how much is spent on capital
- by cost of inputs needed to produce the health care goods and services (Factors of Provision)
- by disease

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