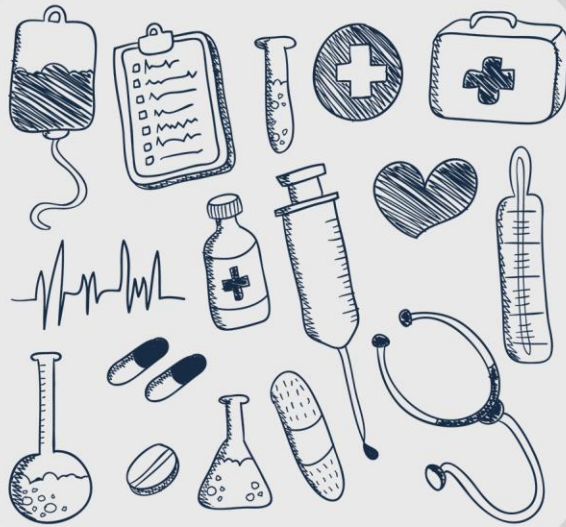




**MINISTRY OF HEALTH  
& MEDICAL SERVICES**



# **FIJI HEALTH ACCOUNTS**

**2014 - 2019**

# **NATIONAL HEALTH EXPENDITURE**

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## Abbreviations

CHE	Current Health Expenditure	IP	Inpatient
CHIPSR	Centre for Health Information Policy and Systems Research	JICA	Japan International Cooperation Agency
CMNHS	College of Medicine, Nursing & Health Sciences	K	Thousand Dollars
CRA	Community Rehabilitation Assistance Program	KOICA	Korea International Cooperation Agency
CWMH	Colonial War Memorial Hospital	MFAT	Ministry of Foreign Affairs and Trade (aka New Zealand Aid Programme NZAID)
DBC	Disease Based Costing	Mo Eco	Ministry of Economy
DFAT	Department of Foreign Affairs and Trade	MHMS	Ministry of Health and Medical Services
DIS	Disease	MOU	Memorandum of Understanding
DMO	Divisional Medical Officers	MS	Medical Superintendents
DSHS	Deputy Secretary Hospital Services	NCD	Non-communicable Diseases
DSPH	Deputy Secretary Public Health	NEC	Not Elsewhere Classified
FBOS	Fiji Bureau of Statistics	NGOs	Non-government Organizations
FHSSP	Fiji Health Sector Support Program	NHA	National Health Accounts
FJ\$m	Fiji Dollars in Millions	OECD	Organisation for Economic Co-operation and Development
FJHA	Fiji Health Accounts	OOP	Out of Pocket Expenditure
FMIS	Financial Management Information System	OP	Outpatient
FNU	Fiji National University	PATIS	Patient Information System
FP	Factors of Healthcare Provision	PCHE	Private Current Health Expenditure
FPBS	Fiji Pharmaceutical and Biomedical Services	PHC	Public Health Centers
FPS	Fiji Pharmacy Society	PHIS	Public Health Information System
FRCA	Fiji Revenue and Customs Authority	PRC	People's Republic of China
FS	Revenue of Financing Schemes	PSIP	Public Sector Investment Programme
GCHE	Government Current Health Expenditure	SDHs	Sub Divisional Hospital
GDP	Gross Domestic Product	SHA	System of Health Accounts
GF	Global Fund	SPO	Strategic Planning Office
GHE	Government Health Expenditure (GCHE plus capital spending)	TB	Tuberculosis
GL	General Ledger	TGE	Total Government Expenditure
GP	General Practitioners	TGHE	Total Government Health Expenditure
HAPT	Health Accounts Production Tool	THE	Total Health Expenditure
HC	Health Care Functions	UNAIDS	Joint United Nations Programme on HIV/AIDS
HF	Health Care Financing Schemes	UNFPA	United Nations Population Fund
HIES	Household Income and Expenditure Survey	UNICEF	United Nations Children's Fund
HiT	Health in Transition	USD	United States Dollar
HK	Capital Expenditure	VAT	Value Added Tax
HP	Health Care Providers	WHO	World Health Organization
HR	Human Resource		
ICD-10AM	International Coding of Disease 10 Australian Modification		
ICHA	International Classification of Health Accounts		
ICT	Information Communications Technology		



I am pleased to present the National Health Accounts [NHA] for the financial years 2014-2019. The report contains pertinent information of health expenditure trends over the 5 year period. NHA provides useful baseline data for Ministry to guide policy decisions and is regarded as the major source of health expenditure information used by both internal and external stakeholders.

The NHA report offers an overview of the nation's health expenditure flows throughout time, and this knowledge has been useful in comprehending the various funding sources and shifting trends in health expenditure. The household out-of-pocket expense is a vital indicator in directing our work toward the universal health coverage. This report looks at the health care systems and services, from an expenditure perspective and provides important insight into the financing arrangements and how health services are accessed.

Fiji's current health expenditure (CHE) was estimated to be FJ\$503.6m in 2018–19, or FJ\$548.3 per capita. In 2018–19, CHE was funded by a combination of public (FJ\$310.8m) and private (FJ\$150.9m) sources, as well as from development partners (FJ\$42.0m).

Curative care in 2018–19 was made up of 41.5% of inpatient care costs and 58.5% of outpatient care costs. Non-communicable Diseases (NCDs), which include accidents and nutritional inadequacies, accounted for most spending in 2018–19 and amounted to 46.9% of the total CHE.

Ministry's longer term plan is to strive towards a more comprehensive health financing model, including the provision of equal access to high-quality services and adequate financial risk protection. The NHA estimates offer baseline information to aid in the creation of initiatives aimed at increasing service coverage and access as well as lowering out-of-pocket costs.

I appreciate the NHA Committee's commitment and work on this project, as well as the important assistance from other sectors and key stakeholders. This report equips decision-makers with knowledge to create plans to advance the greater objective of universal health coverage through increasing access, equity, efficiency, and financial risk protection.

A handwritten signature in black ink, appearing to read 'James Fong'.

.....  
**Dr. James Fong**  
**Permanent Secretary for Health and Medical Services**

## Executive Summary

National Health Accounts (NHA) is the total estimated health spending in the country incurred by both the public and private sectors. NHA provides information that can help a country track health expenditure from sources of financing to health services and ultimately to beneficiaries (ultimate users). Current Health Expenditure (CHE) in Fiji was estimated at FJ\$ 503.6 m in 2018-19 with per capita health spending of FJ\$548.3/USD\$255 per capita. CHE in 2018-19 comprised of public funds of FJ\$ 310.8m(56.0%), Private funds of FJ\$150.9m (34.4%) and Development partner funds of FJ\$42.0m (9.6%).

In 2018-19, CHE as a proportion of Gross Domestic Product (GDP) is estimated at 4.3%. Over the five-year period 2014 to 2018-19, ratio of CHE to GDP averaged at 4.2%. The WHO states that it is difficult for countries to achieve Universal Health coverage (UHC) and equal access to health care if countries spend less than 4-5% of GDP on health (World Health Report 2010).

The Private sector financing which is 30.0% of CHE was dominated by household spending. Most of the household spending was as Out of Pocket [OOP]expenditure. The OOP expenditure as a percentage of Private Current Health Expenditure (PCHE) was 63.2% and as a percentage of CHE it was 19.2%.

Hospitals accounted for the largest amount of CHE. In 2018-19 ,85.6% of hospital expenditure was financed by public sources and the remaining 14.4% by the private sector (inclusive of development partners). Ambulatory health care providers accounted for 9.3% (FJ\$46.9m) in 2018-19. The majority of the Ambulatory Health Care Providers were public health centers (37.2%) Curative care accounted for the largest portion of CHE (53.4 %) in 2018-19. Curative care expenditure in 2018-19 constitutes both outpatient care expenditure<sup>1</sup>(58.5%) and inpatient care expenditure (41.5%). Preventive Healthcare expenditures in 2018-19 was 15.6 %.

Government Current Health Expenditure (GCHE) per capita on hospitals and public health centers (excluding Specialized services) was FJ\$ 319.9 in Northern, FJ\$112.4 in Eastern, FJ\$208.3 in Central and FJ\$242.2in Western. In 2018-19 the Human resource cost on GCHE was \$225.5m (72.6% of GCHE) and 44.8% of CHE. Government Capital spending was 8.1% of Government Health Expenditure (GHE) in 2018-19. This has increased since 2011 (7.4% of GHE).

In 2018-19, Non-communicable Diseases (NCDs) including nutritional deficiencies and injuries accounted for the most expenditure and represented 46.9% of total CHE. Communicable Diseases (CD) expenditure accounted for 28.5% and Maternal and Child Health (MCH) expenditure accounted for 5.5% of CHE.

This report describes the health care system from an expenditure perspective. Such information provides policy or decision makers opportunities for improving access, equity, efficiency and financial risk protection as part of the national effort to bring services closer to our citizens and accelerate Fiji's progress towards "Universal Health Coverage".

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<sup>1</sup> Outpatient care includes outpatient care as well as day care services



## Summary of Key Indicators 2014-2018/19

No.	Indicators	2014	2015	2016-17	2017-18	2018-19
1	Population	865716	869458	869458	884887	918465
2	Gross Domestic Product (GDP) (FJ\$m)	7,039.50	7,541.30	10,327.30	11,065.00	11,650.60
3	Total Government Expenditure (TGE) (FJ\$m)	2,883.30	2,693.90	3,024.40	3,703.60	3,600.30
4	Current Health Expenditure (CHE) (FJ\$m)	310.2	326.5	357.5	478.4	503.6
5	Capital expenditure (HK) (FJ\$m)	32.7	36.9	38.1	42.7	36.3
6	CHE plus capital expenditure (FJ\$m)	342.9	363.4	395.6	521.1	540
7	CHE per capita (FJ\$)	358.3	375.6	411.2	540.6	548.3
8	Government Current health expenditure (GCHE) (FJ\$m)	191.5	206.1	233.6	287.3	310.8
9	Private Current health expenditure (PCHE) (FJ\$m)	106.8	112.1	110.9	156.7	150.9
10	Development partner Current health expenditure (FJ\$m)	11.9	8.3	13.1	34.4	42
11	GCHE as a % CHE	61.70%	63.10%	65.30%	60.10%	61.70%
12	PCHE as a % of CHE	34.40%	34.30%	31.00%	32.80%	30.00%
13	Development partner Current health expenditure as a % CHE	3.80%	2.50%	3.70%	7.20%	8.30%
14	CHE as a % of GDP	4.40%	4.30%	3.50%	4.30%	4.30%
15	GCHE as a % of TGE	6.60%	7.70%	7.70%	7.80%	8.60%
16	GCHE as a % of GDP	2.70%	2.70%	2.30%	2.60%	2.70%
17	PCHE as a % of GDP	1.50%	1.50%	1.10%	1.40%	1.30%
18	GCHE per capita (FJ\$)	221.2	237	268.6	324.7	338.3
19	Government financing Schemes as a % of CHE	61.80%	63.10%	65.30%	62.10%	61.90%
20	Voluntary Health Insurance Schemes as a % of CHE	9.10%	13.50%	14.60%	13.30%	10.30%
21	Out of Pocket (OOP) Expenditure as a % of CHE	25.30%	21.00%	17.30%	19.50%	19.20%
22	Curative expenditure as a % of CHE	40.90%	50.30%	55.30%	51.90%	53.40%
23	Inpatient expenditure as a % of Curative expenditure	40.60%	41.90%	38.50%	42.60%	41.50%
24	Outpatient expenditure as a % of Curative expenditure	59.40%	58.10%	61.50%	57.40%	58.50%
25	Preventive expenditure as a % of CHE	25.00%	22.60%	22.10%	20.70%	15.60%
26	Government Health Administration expenditure as a % of GCHE	9.00%	10.10%	4.00%	6.20%	11.10%
27	Hospital spending as a % of CHE	46.30%	45.10%	50.80%	51.20%	56.80%

<b>28</b>	Ambulatory health care providers as a % of CHE	21.50%	22.20%	21.20%	13.00%	9.30%
<b>29</b>	Medical goods as a % of CHE (excludes Government)	11.70%	13.70%	12.20%	10.50%	11.00%
<b>30</b>	Expenditure on Government Human Resources as a % of GCHE	62.10%	61.00%	82.00%	68.70%	71.00%
<b>31</b>	Government Pharmaceuticals (Drugs) Expenditure as a % of GCHE	4.80%	6.60%	-	16.20%	13.40%
<b>32</b>	Capital expenditure as a % of CHE plus capital expenditure	9.50%	10.10%	9.60%	8.20%	6.70%
<b>33</b>	Government capital expenditure on health as a % of GHE (GCHE plus Government capital expenditure)	11.30%	13.10%	11.20%	8.00%	8.10%
<b>34</b>	Non-Communicable Diseases (NCD) expenditure as a % of CHE (NCD, Nutritional deficiencies, Injuries)	-	54.00%	54.80%	51.00%	46.90%
<b>35</b>	Communicable Diseases (CD) expenditure as a % of CHE	-	23.30%	29.90%	31.80%	28.50%
<b>36</b>	Maternal and Child Health (MCH) expenditure as a % of CHE	-	6.90%	5.50%	4.30%	5.50%
<b>37</b>	Primary Health Care Expenditure (PHCE) as % of CHE	-	62.20%	62.50%	56.30%	54.70%
<b>38</b>	PHCE as % of GDP	-	2.70%	2.20%	2.40%	2.40%
<b>39</b>	PHCE (Government) as % of GDP	-	1.70%	1.40%	1.50%	1.40%
<b>40</b>	PHCE (Development Partners) as % of GDP	-	0.10%	0.10%	0.20%	0.30%
<b>41</b>	PHCE (Private) as % of GDP	-	0.90%	0.70%	0.70%	0.60%
<b>42</b>	PHCE (Gov + Development Partners) as % of GDP	-	1.80%	1.50%	1.70%	1.70%
<b>43</b>	PHCE per capita	-	233.5	257.1	304.2	299.7
<b>44</b>	PHCE (government) per capita	-	144.4	161.1	188.3	183.6
<b>45</b>	PHCE (Development Partners) per capita	-	9.1	13.9	26.9	34.3
<b>46</b>	PHCE (Private) per capita	-	80	82.1	89	81.8
<b>47</b>	PHCE (Gov + Development Partners) per capita	-	153.5	175	215.2	217.9

# 1. Background

## 1.1. About this Report

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

The information for the year 2014 in this report was based on the analysis done through STATA software whilst the information from 2015 onwards in this report were produced using the Health Accounts Production Tool (HAPT) which also includes disease accounts. Comparison of data could be made at an aggregate level however, when compared at a lower-level readers might notice marginal changes due to different methodology and estimation techniques.

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) which was remapped to Global Burden of Diseases (GBD) and then HAPT Disease (DIS) code.

## 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 (MHMS) is responsible for providing clinical, preventative and rehabilitative healthcare services. While some health facilities and hospitals primarily offer clinical services, hospitals, nursing stations, and preventive care programs generally offer healthcare services that are intended to prevent illness or injury. An integrated health care system that supports primary, secondary, and tertiary care levels is implemented and supported through a decentralization of some services. Finance, medications, and medical supplies are all consolidated in management and administration.

The MHMS provides healthcare services to the whole Fijian population. Divisional Medical Officers (DMOs) oversee sub-divisional hospitals, health centers, and nursing stations while Medical Superintendents (MSs) oversee clinical services in divisional and specialized hospitals.

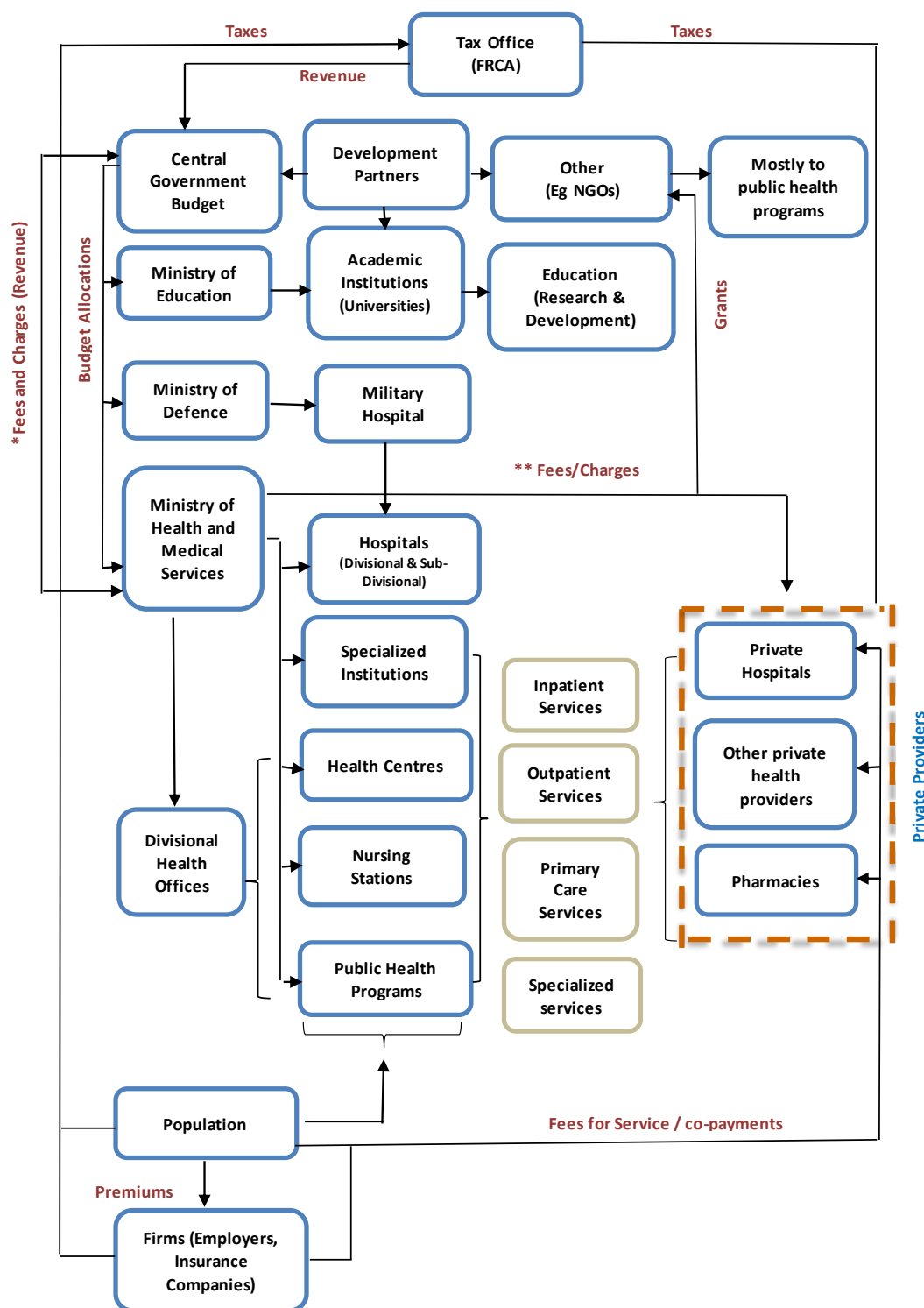
Within a designated medical region, 17 sub-divisional hospitals additionally offer primary and secondary level clinical and preventive health services, as well as health centers and nursing stations under each of the healthcare facilities offering primary health care services.

St. Giles [Psychiatry] and P.J. Twomey Hospital [TB, Leprosy, and Rehabilitation] therapy, are two specialty hospitals offering specialized health services. Most healthcare services provided by the private sector include outpatient services provided by general practitioners, inpatient services provided mostly by two private hospitals, and the sale of medications 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 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 (Revenue)** – relates to all types of hospitals fees, fumigation and quarantine charges collected by MHMS

**\*\*Fees/Charges** – relates to payments made by MHMS to private providers E.g., Locum services

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

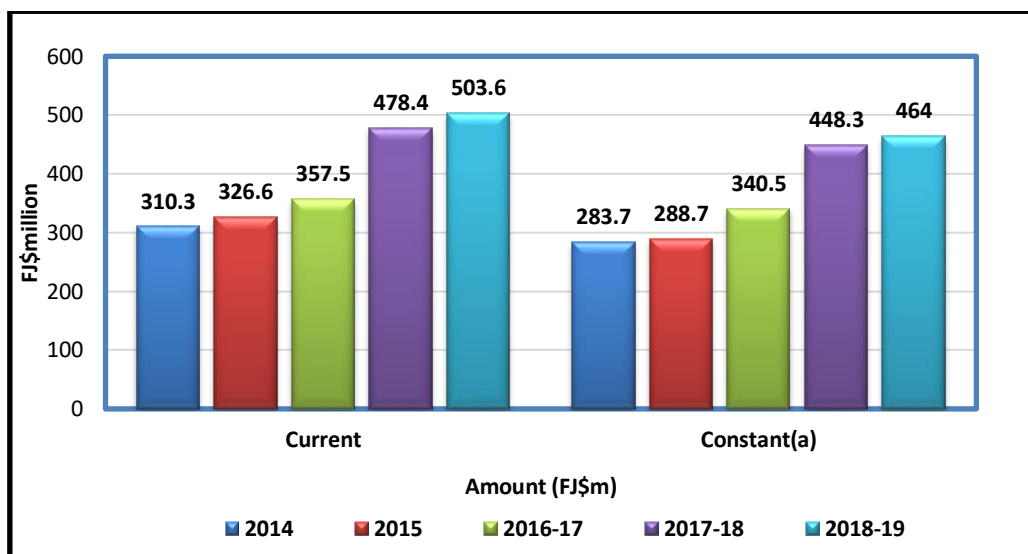
## 2. Current Health Expenditure

Current Health Expenditure is the 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 five years in both nominal (current) and constant (real) terms. (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(a)	Current	Constant
2014	310.3	283.7	-	-
2015	326.6	288.7	5.2	1.7
2016-17	357.5	340.5	9.5	17.9
2017-18	478.4	448.3	33.8	31.6
2018-19	503.6	464	5.3	3.5

(a) Constant prices are calculated using the implicit GDP deflator (2014=100).

## 2.2. Current Health Expenditure in Relation to GDP

Over the five years (2014 to 2018-19), health spending as a ratio of GDP averaged 4.2% (Table 2-2).

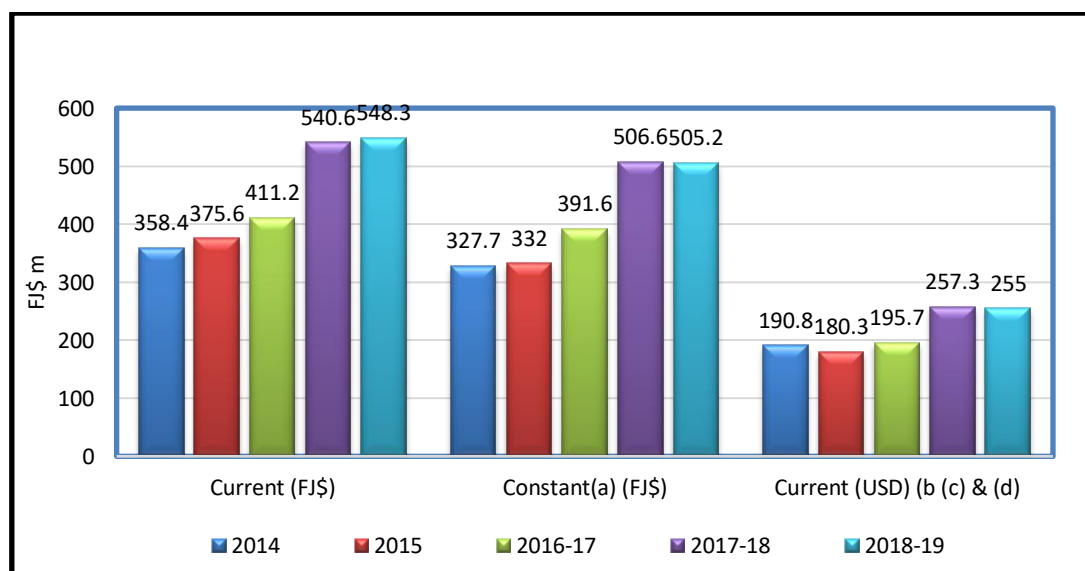
**Table 2-2 CHE, GDP, Annual Growth Rates and Share of CHE to GDP**

Year	Current Health Expenditure		GDP		
	Amount (FJ\$m)	Nominal Growth Rate (%)	Amount (FJ\$m)	Nominal Growth Rate (%)	Ratio of Current Health Expenditure to GDP (%)
<b>2014</b>	310.3	15.9	7,039.50	9.3	4.4
<b>2015</b>	326.6	5.2	7,541.30	7.1	4.3
<b>2016-17</b>	357.5	9.5	10,327.30	36.9	3.5
<b>2017-18</b>	478.4	33.8	11,065.00	7.1	4.3
<b>2018-19</b>	503.6	5.3	11,650.60	5.3	4.3

## 2.3. Current Health Expenditure per Capita

Examination of expenditure on health per person is an important factor to monitor the health care expenditure with level of population growth. Figure 2-2 shows the trend of how much was spent per person on health. There was an increase in CHE per capita in nominal (current) terms over the five-year period and slight decline in constant (real) terms as compared to the last year.

**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) & (d))	Real Growth Rate (%)	Current (FJ\$m)	Constant (FJ\$m)	Current (USD)
<b>2014</b>	358.4	327.7	190.8	11.5	8,131	7,435	4,328
<b>2015</b>	375.6	332	180.3	1.3	8,674	7,668	4,164
<b>2016-17</b>	411.2	391.6	195.7	17.9	11,878	11,312	5,652
<b>2017-18</b>	540.6	506.6	257.3	29.4	12,504	11,718	5,951
<b>2018-19</b>	548.3	505.2	255	0	12,685	11,686	5,900

(a) USD Conversion: 2014 - USD\$1=FJD\$1.88

(b) USD Conversion: 2015- USD\$1=FJD\$2.08

(c) USD Conversion: 2017-18- USD\$1=FJD\$2.10

(d)USD Conversion: 2018-19- USD\$1=FJD\$2.15



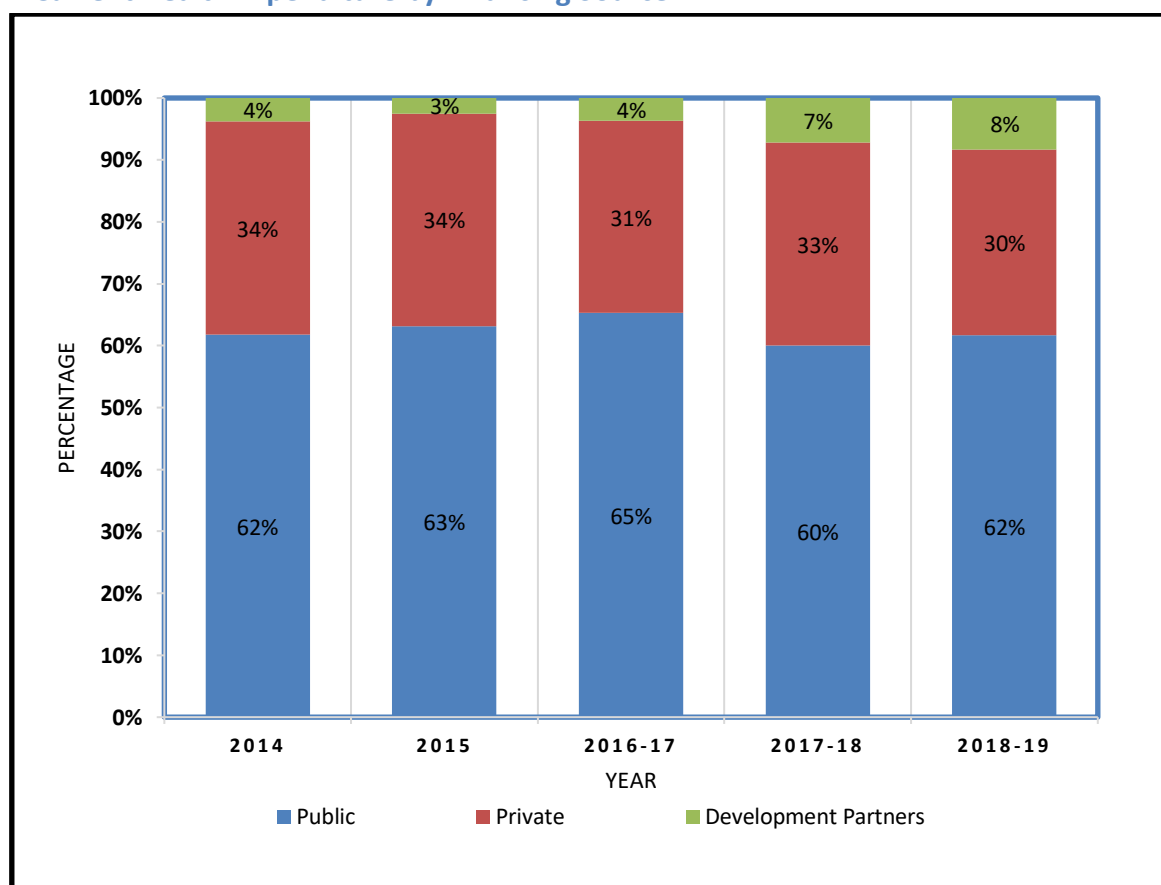
### 3. Financing of Current Health Expenditure

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

#### 3.1. Revenues of Financing Schemes

The primary source of revenue for the health sector was from the central Government budget (public). The other sources of funding were from the private sector and development partners. Figure 3-1 provides the share of funding from the three sources over the five years.

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 (%)				Current Health Expenditure as a Share of GDP (%)			
	Public	Private	Development Partners	Public	Private	Development Partners	Total	Public	Private	Development Partners	Total
<b>2014</b>	191.5	106.8	11.9	61.7	34.4	3.8	100	2.7	1.5	0.2	4.4
<b>2015</b>	206.1	112.1	8.3	63.1	34.3	2.5	100	2.7	1.5	0.1	4.3
<b>2016-17</b>	233.6	110.9	13.1	65.3	31	3.7	100	2.3	1.1	0.1	3.5
<b>2017-18</b>	287.3	156.7	34.4	60.1	32.8	7.2	100	2.6	1.4	0.3	4.3
<b>2018-19</b>	310.8	150.9	42	61.7	30	8.3	100	2.7	1.3	0.4	4.3

As per Table 3-1, CHE for public and private sectors increased in dollar terms over the five years whilst the development partners funding declined in 2015 but increased again in 2017-18 onwards as a share of CHE. The CHE as a share of GDP for all sources remained steady (except for the year 2016-17).

### 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)**

Category	2014	2015	2016-17	2017-18	2018-19
	Amount (FJ\$m)	Amount (FJ\$m)	Amount (FJ\$m)	Amount (FJ\$m)	Amount (FJ\$m)
<b>Government Schemes</b>	<b>191.6</b>	<b>206</b>	<b>239</b>	<b>297</b>	<b>312</b>
Ministry of Health and Medical Services	187.8	206	239	295.9	205.9
Ministry of Defence and Others	3.8	0	0	1	106.1
<b>Voluntary Health Insurance Schemes</b>	<b>24.8</b>	<b>42.0</b>	<b>47.4</b>	<b>53.3</b>	<b>49.4</b>
Employer-based insurance (other than enterprises schemes)	17.1	21.4	20.6	35.5	34.7
Government-based voluntary insurance	0	0	0	1.3	0
Other primary coverage schemes	7.7	20.6	26.8	16.4	14.7
NPISH (NPISH financing schemes (including funding from development partners))	3.6	2.1	4.9	10.5	2.6
Enterprises					4
<b>Household Out of Pocket</b>	<b>78.5</b>	<b>68.7</b>	<b>61.9</b>	<b>93.5</b>	<b>96.5</b>
<b>Rest of the World</b>	<b>11.8</b>	<b>7.7</b>	<b>4.4</b>	<b>24.1</b>	<b>39.2</b>
<b>Total</b>	<b>310.3</b>	<b>326.6</b>	<b>357.5</b>	<b>478.4</b>	<b>503.6</b>

Table 3-2 shows the funding by financing schemes over the five-year period.

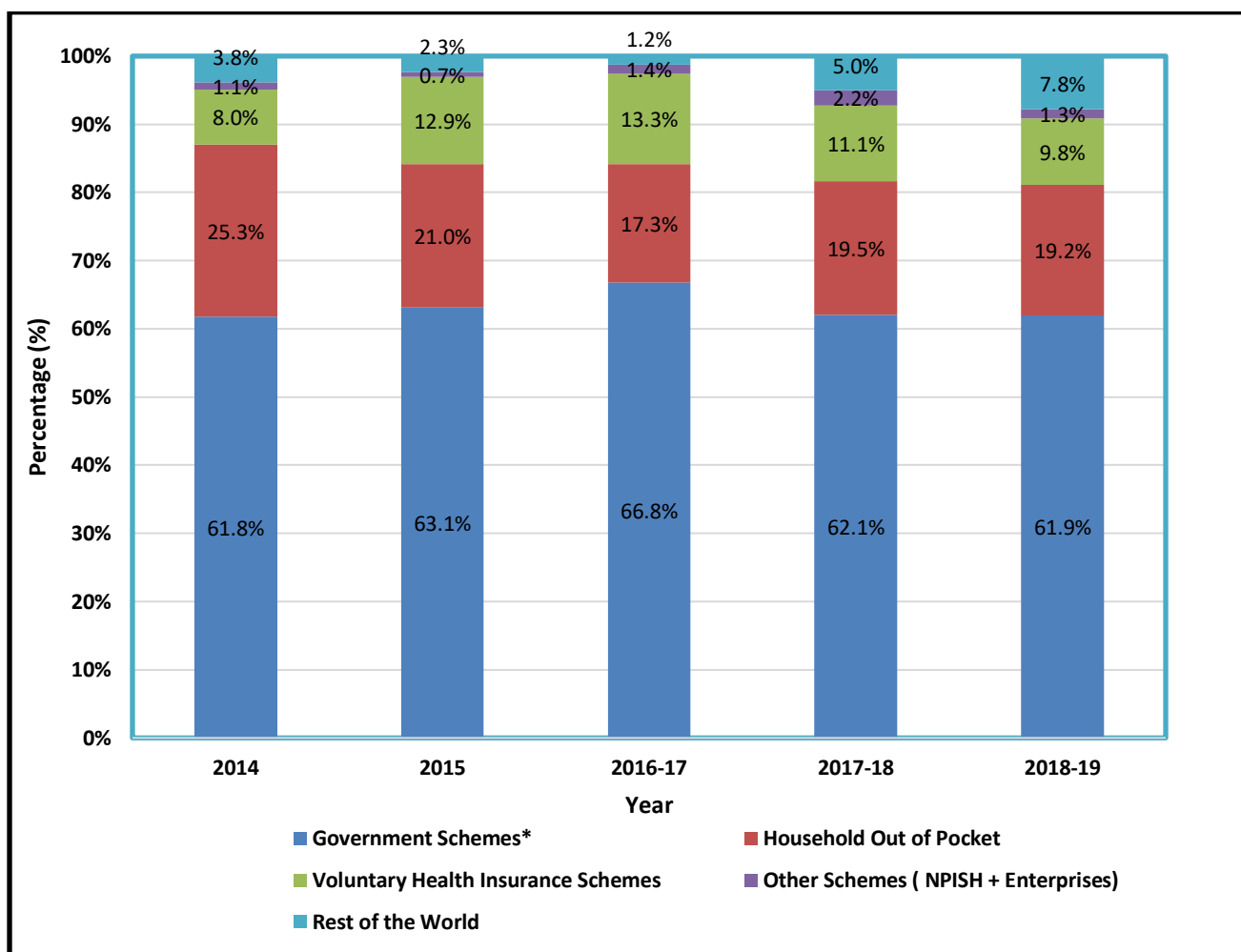
\* 2014 (FJ\$16.5m) was coded to Household Out of Pocket

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).

In 2018-19, the *Voluntary Health Insurance* had decreased with a slight increase in *Household Out-of-pocket* (as compared to the 2017-18). In previous years, other primary coverage schemes e.g., insurance coverage taken by individuals which was not contracted or subsidized was accounted for as OOP. However, the tool does not allow the other primary coverage schemes to be coded to OOP and treats as a Voluntary Health Insurance thus the substantial change in expenditure.

Expenditure for development partners has also increased in 2018-19.

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



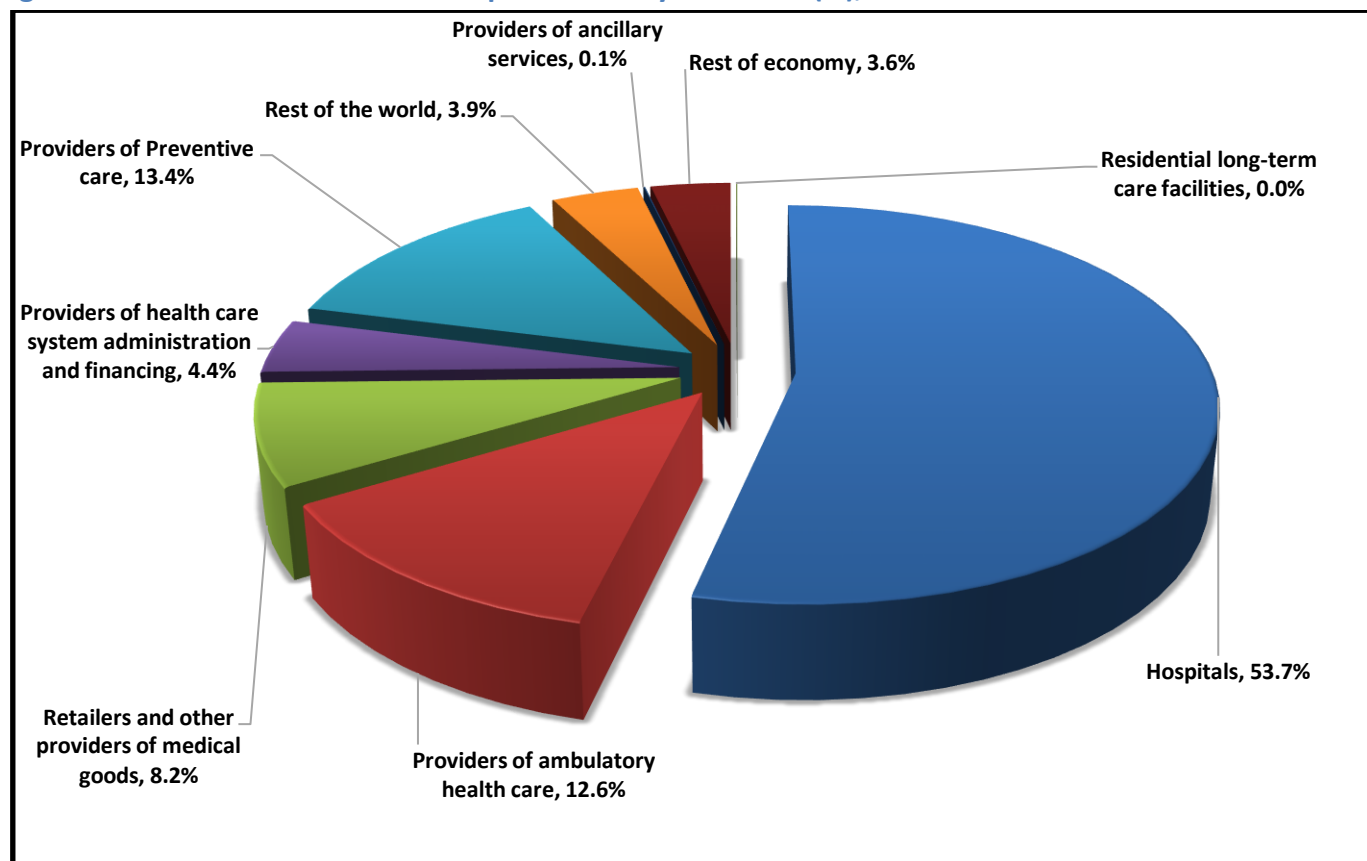
Source: Table 3-2

\*Government Schemes comprises of Ministry of Health and Medical Services & Ministry of Defence

## 4. Current Health Expenditure by Providers

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

**Figure 4-1 Share of Current Health Expenditures by Providers (%), 2018-19**



Source: Table 4-1

Hospitals, Providers of Ambulatory Health care, Providers of Preventive care and Retailers and other providers of medical goods remain the top health care providers in Fiji in terms of expenditure.

The major component of the expenditure was expenditure in Hospitals, Providers of Health care system, administration and financing, Providers of Ambulatory healthcare and Providers of Preventive care in the public sector. The private sector expenditure dominated by the expenditure on Retailers and other providers of medical goods followed by hospitals.

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

Providers (FJ\$ (m))	2014	2015	2016-17	2017-18	2018 - 19
Hospitals	143.7	147.2	181.8	245.0	286.1
Residential long-term care facilities	1.1	1.1	0.2	0.2	0.2
Providers of ambulatory health care	66.7	72.5	76.0	62.1	46.9
Providers of ancillary services	4.3	3.6	3.7	18.8	15.8
Retailers and other providers of medical goods	36.2	44.7	43.6	50.4	55.4
Providers of Preventive care	29.6	20.4	22.9	40.2	22.4
Providers of health care system administration and financing	14.4	22.1	14.9	33.2	59.3
Rest of economy	1.2	1.4	0.7	4.2	0.2
Rest of the world	13.2	13.5	13.7	24.3	17.2
<b>Total</b>	<b>310.3</b>	<b>326.6</b>	<b>357.5</b>	<b>478.4</b>	<b>503.6</b>

In Table 4-1, the category *Rest of the World* represents health providers abroad who provided medical treatment for citizens evacuated overseas either through Government Overseas Medical Treatment Scheme or private funding (e.g., insurance companies).

## 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. 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. The expenditure for all functions increased over the five-year period except for ancillary services and preventive care.

**Table 5-1 Current Health Expenditure by Function (FJ\$m), 2014 to 2018-19**

Health Care Functions	2014	2015	2016-17	2017-18	2018-19
Inpatient curative care	51.5	68.8	76.1	105.7	111.8
Outpatient curative care	75.3	95.3	121.6	142.5	157.4
Rehabilitative & Long-term Care	4.7	5.3	7.1	9.7	12.2
Ancillary services	39.9	13.4	10.8	35.9	29.1
Medical goods	41.3	46.3	47.3	55	56.9
Preventive care	77.6	73.6	78.9	98.8	78.5
Governance, and health system and financing administration	19.9	22.7	14.5	29.9	55.9
Other health care services not elsewhere classified (n.e.c.)	0	1.2	1.3	0.8	1.8
<b>Total</b>	<b>310.3</b>	<b>326.6</b>	<b>357.5</b>	<b>478.4</b>	<b>503.6</b>

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

(b) Ancillary services for 2015 is for private sector only.

In Table 5-1 all the services have increased substantially in absolute terms, but the major change is seen in administration and preventative care.

### 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 dollar terms (refer Table 5-1).

Curative care expenditure in 2018-19 was made up of 22.2% inpatient care and 31.3 % outpatient care as a proportion of CHE (refer Table 5-1)

Table 5-2 reflects that split of curative care by public and private sectors. Over the years the share of public sector expenditure for curative care had increased as a proportion of overall CHE.

**Table 5-2 Share of Curative Expenditure by Function (%), 2014 to 2018-2019**

	Inpatient		Outpatient	
Year	Public (%)	Private (%)	Public (%)	Private (%)
2014	79.7	20.3	50.9	49.1
2015	71.8	28.2	65.2	34.8
2016-17	75.2	24.8	66.8	33.2
2017-18	69.9	30.1	70	30
2018-19	74.8	25.2	72.2	27.8

Note: Private expenditure also includes Development partners

## 5.2. Medical Goods (excludes Government)

Medical goods include pharmaceutical and therapeutic appliances and comprised of the sales of medicines and other medical goods from private pharmacies and other retailers.

**Table 5-3 Medical goods Expenditure by Subclasses, 2014 to 2018-19**

Functions	2014		2015		2016-17		2017-18		2018-19	
	FJ\$m	Share (%)	FJ\$m	Share (%)	FJ\$m	Share (%)	FJ\$m	Share (%)	FJ\$m	Share (%)
Prescribed medicines	24	58.9	22	47.6	22	46.1	18	33	20	39.3
Over-the-counter medicines	11	27	17	37.7	17	35	17	31.1	19	38.2
Other medical non-durable goods	3	6.3	2	4.8	2	4.6	2	3.7	6	10.9
Glasses and other vision products	2	4.2	2	3.2	4	7.8	5	8.4	0	0
Hearing Aids									1.5	3
All other medical durables, including medical technical devices	2	3.6	3	6.8	3	6.5	13	23.8	4	8.7
<b>Total</b>	<b>41</b>	<b>100</b>	<b>46</b>	<b>100</b>	<b>47</b>	<b>100</b>	<b>55</b>	<b>100</b>	<b>51</b>	<b>100</b>

Table 5-3 shows expenditure on medical goods by subclasses. The expenditure on medical goods spent on prescribed medicines has been stable till 2016-17. There was a decrease in 2017-18, and this again increased



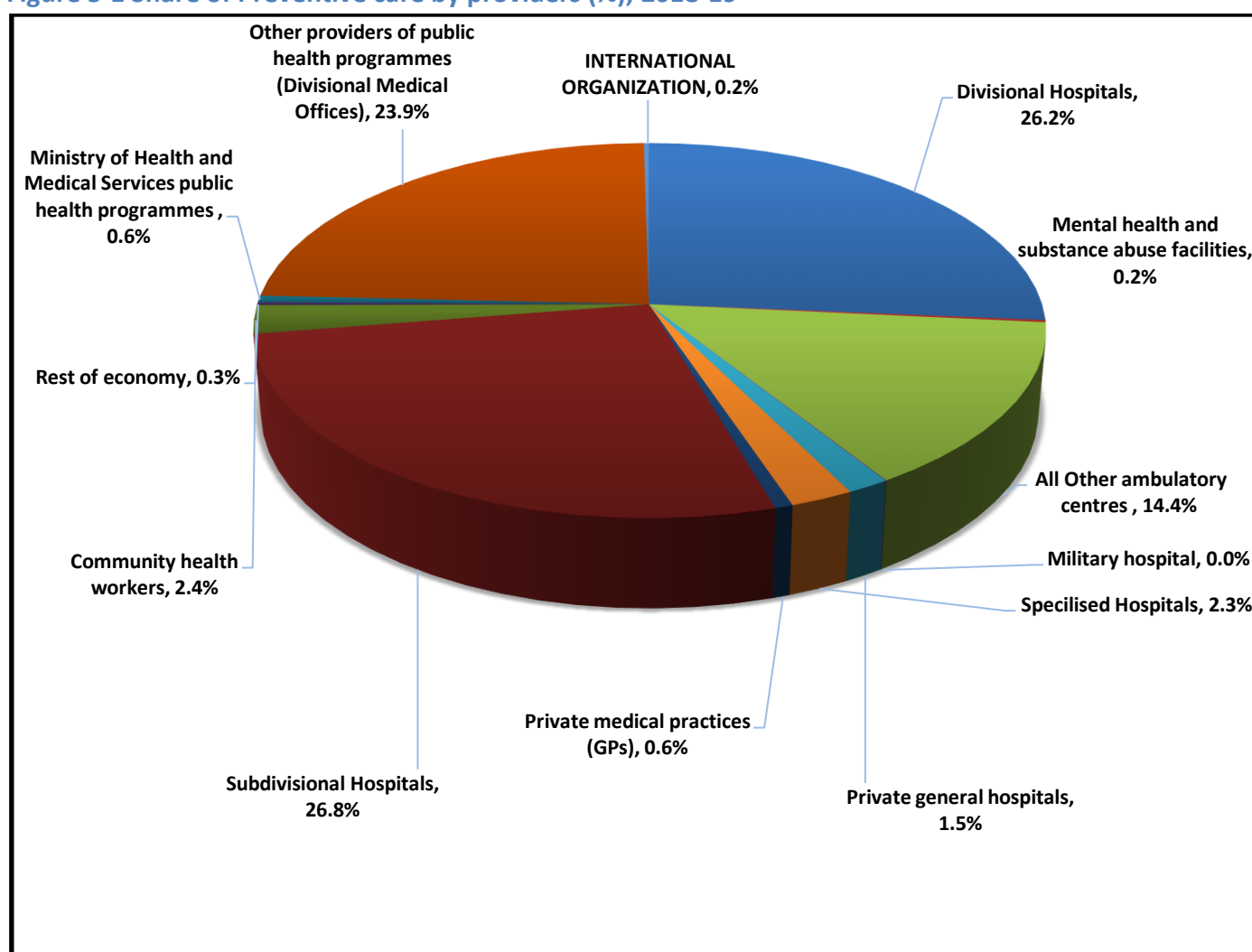
in 2018-19 whilst the all-other medical durables, including medical technical devices had increased till 2017-18 and then declined in 2018-19.

### 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. Preventive care includes a wide range of expected outcomes, which are covered through a diversity of interventions, organized at primary, secondary and tertiary prevention level” (SHA 2011). In Fiji the expenditure mostly includes primary and secondary prevention programs.

Figure 5-1 reflects the distribution of preventive care expenditure by health care providers. It shows that preventive care activities exist across the public spectrum of health facilities from Divisional Hospitals to Nursing Stations. Close to 55% of preventive care expenditure was incurred at hospitals whilst Health Centers account for 15% and preventive care providers was around 25 %.

**Figure 5-1 Share of Preventive care by providers (%), 2018-19**



## 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.

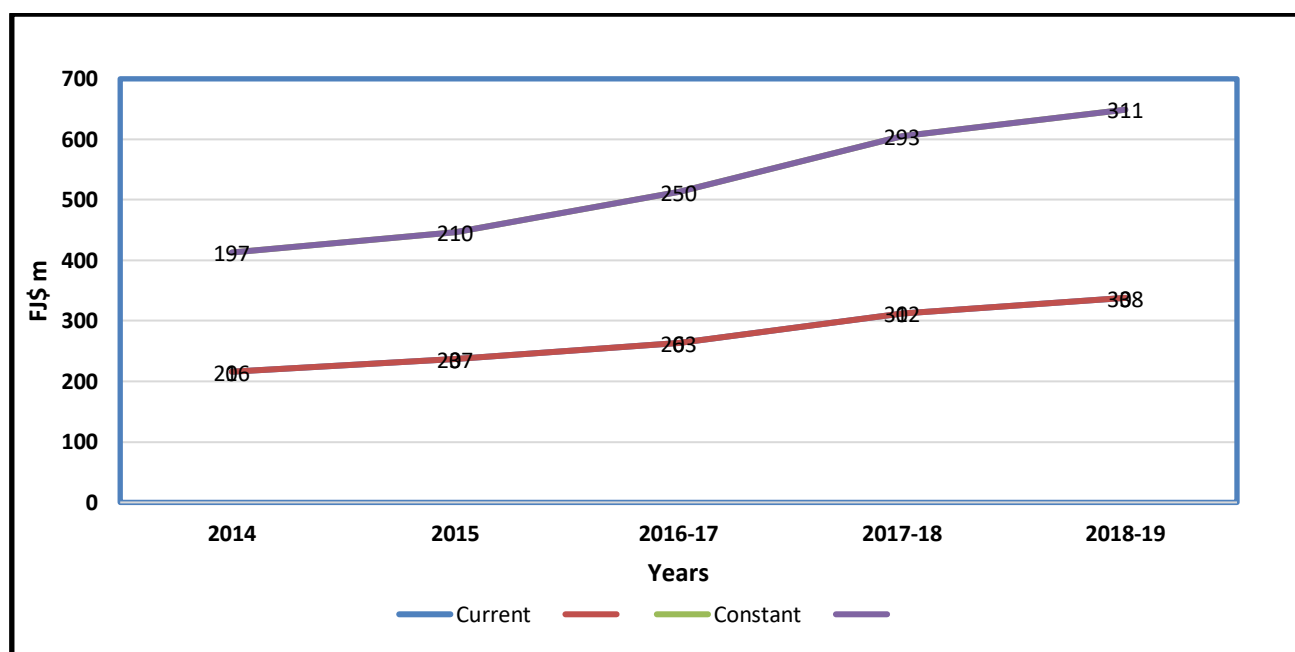
### 6.1. Government Expenditure on Health

An analysis of Government spending (refer Table 6-1) shows that over the five (5) 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 spending has been high and that has been an escalating trend since 2014. The highest expenditure on health was in 2018-19 (FJ\$311m) over the five-year period.

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

Year	2014	2015	2016-17	2017-18	2018-19
<b>Current</b>	216	237	263	312	338
<b>(Nominal)</b>					
<b>Constant</b>	197	210	250	293	311
<b>(Real)</b>					

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

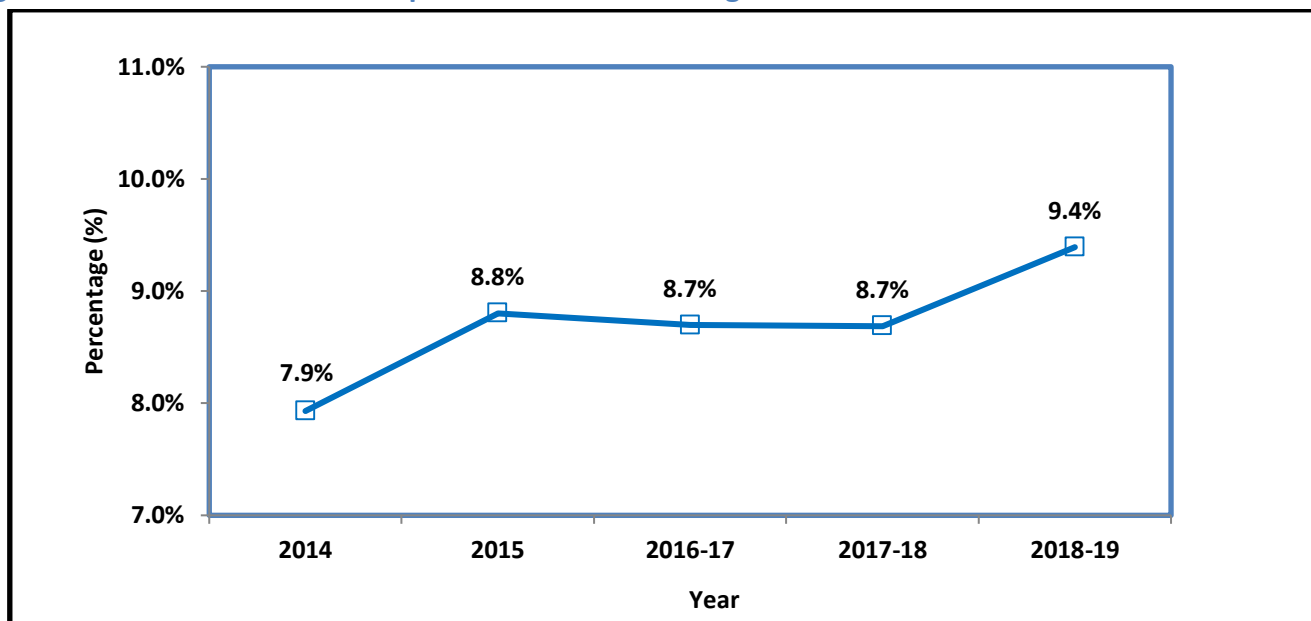


**Figure 6-1 Government Health Expenditure in Real (Constant) and Nominal (Current) value**

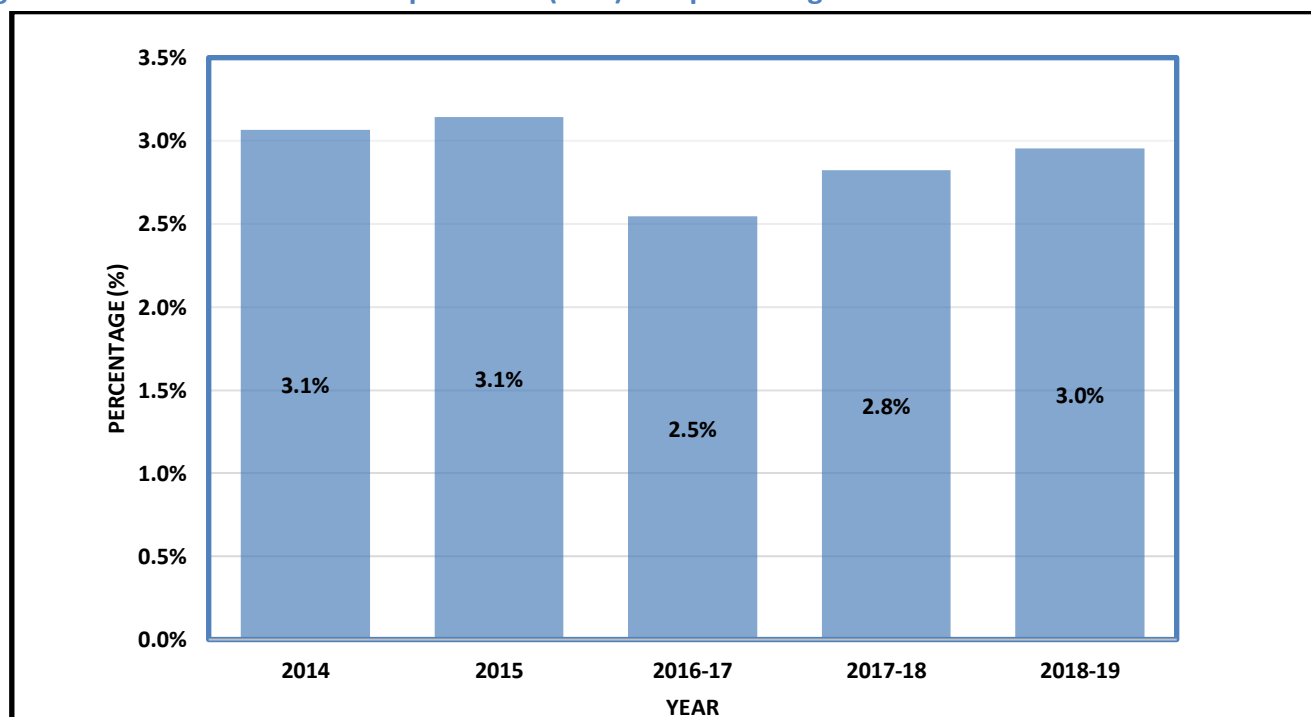
Source: Table 6-1

The GHE as a percentage of Total Government Expenditure (TGE) averaged around 8.7% and has increased from 2014 to 2015, remained relatively constant between 2015- 2017-18 and increased again in 2018-19

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



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



As a percentage of Gross Domestic Product (GDP), GHE has averaged 2.9 % over the period of 2014 to 2018-19. The percentage has remained relatively constant without any significant increase over the last five 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).

## 6.2. 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. The Government health providers are outlined in Table 6-2.

Providers	2014	2015	2016-17	2017-18	2018-19
Hospitals	122.3	127.1	159.7	207.8	244.8
Residential long-term care facilities	1.1	1.1	0.2	0.2	0.2
Providers of ambulatory health care	28.1	37.4	37.2	26.8	19.9
Providers of ancillary services	3.3	3.1	2.6	1.8	3.2
Retailers and other providers of medical goods	0.3	0.4	3.1	1	-
Providers of Preventive care	21.3	14	15	23.3	18.7
Providers of health care system administration and financing	11.8	20.2	13.5	24.1	21.7
Rest of economy	1.2	1.4	0.5	0.1	-
Rest of the world	2.2	1.4	1.8	2.1	2.3
<b>Total</b>	<b>191.5</b>	<b>206.1</b>	<b>233.6</b>	<b>287.3</b>	<b>310.8</b>

Table 6-2 further shows the share of Government current health expenditures amongst the health providers from 2014 to 2018-19. *Hospitals* which include divisional hospitals, sub-divisional hospitals, mental and specialized hospitals account for the largest share of Government spending.

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

GCHE in the geographic divisions was expended mainly through divisional hospitals, sub divisional hospitals and public health centers. The distribution of facilities by geographical divisions are depicted as follows: -

Facilities	Geographic Divisions			
	Central	Eastern	Western	Northern
<b>Divisional Hospitals</b>	1	0	1	1
<b>Sub divisional Hospitals</b>	5	5	6	3
<b>Health Centers</b>	21	15	20	25
<b>Nursing Stations</b>	21	31	21	25
<b>Specialized Hospitals</b>	2	0	0	0

Collectively the divisional hospitals incurred the largest expenditure over the period 2014 to 2018-19 (refer Table 6-3). Overall, the expenditure in all divisions had increased in 2018-19 when compared to 2017-18.

**Table 6-3 GCHE on public health facilities (FJ\$m)**

Providers by Geographic divisions	2014	2015	2016-17	2017-18	2018-19
<b>Central</b>	<b>56.2</b>	<b>64.2</b>	<b>77.3</b>	<b>96.7</b>	<b>104.7</b>
Divisional hospitals	35.6	38.9	48.4	65.6	70.7
Sub divisional Hospitals (SDHs)	7.1	7.8	9.1	20.7	27.9
Public Health Centres (PHC)	13.5	17.5	19.8	10.4	6.1
<b>Eastern</b>	<b>5.1</b>	<b>8.5</b>	<b>9.2</b>	<b>7.4</b>	<b>8.9</b>
Sub divisional Hospitals (SDHs)	4.5	5.3	5.6	5.9	6.2
Public Health Centres (PHC)	0.6	3.2	3.5	1.5	2.7
<b>Western</b>	<b>49.9</b>	<b>49.6</b>	<b>62.7</b>	<b>72.4</b>	<b>85</b>
Divisional hospitals	25.8	24.7	30.6	40.3	47.6
Sub divisional Hospitals (SDHs)	17.5	15.3	25.8	25.7	33
Public Health Centres (PHC)	6.6	9.6	6.4	6.5	4.4
<b>Northern</b>	<b>26</b>	<b>32.6</b>	<b>36.2</b>	<b>41.9</b>	<b>50.6</b>
Divisional hospitals	15.2	19.9	23.1	28.8	36.5
Sub divisional Hospitals (SDHs)	6.2	7.4	8.2	9.2	9.9
Public Health Centres (PHC)	4.6	5.3	4.9	3.9	4.2
<b>Specialist Services (National Level)</b>	<b>9.1</b>	<b>7.7</b>	<b>8.7</b>	<b>9.7</b>	<b>11.6</b>
Mental health hospitals	4.2	1.9	4.2	5.5	5.9
Tamavua hospital (TB and Leprosy)	4.9	5.8	4.4	4.2	5.7
<b>Total</b>	<b>146.2</b>	<b>162.6</b>	<b>194</b>	<b>228</b>	<b>261</b>

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

**Table 6-2 GCHE on hospitals plus health centers by Province (FJ\$m)**

Province	2014	2015	2016-17	2017-18	2018-19
<b>Ba</b>	<b>41.3</b>	<b>40.9</b>	<b>41.6</b>	<b>51.2</b>	<b>57.1</b>
<b>Bua</b>	<b>1.9</b>	<b>2.2</b>	<b>2.7</b>	<b>0.7</b>	<b>2</b>
<b>Cakaudrove</b>	<b>6.2</b>	<b>7.3</b>	<b>4.8</b>	<b>1.9</b>	<b>2.9</b>
<b>Kadavu</b>	<b>1</b>	<b>2.8</b>	<b>1.8</b>	<b>0.7</b>	<b>0.6</b>
<b>Lau</b>	<b>1.6</b>	<b>2.8</b>	<b>3.4</b>	<b>2.5</b>	<b>2.2</b>
<b>Lomaiviti</b>	<b>1.8</b>	<b>2.2</b>	<b>2.7</b>	<b>1.2</b>	<b>0.7</b>
<b>Macuata</b>	<b>17.7</b>	<b>23.2</b>	<b>26.1</b>	<b>31.2</b>	<b>36.6</b>

Nadroga/Navosa	5.5	5.8	16.8	14.6	15.8
Naitasiri	6.5	7.8	3.2	1.4	0.7
Namosi	0.1	0.1	3.7	1.4	1
Ra	2.9	2.6	3.9	3.9	4.5
Rewa	39	44	67.7	75.5	72
Rotuma	0.7	0.8	1	0.8	0.7
Serua	2.1	3	3.7	1.4	1
Tailevu	8.2	9.4	2.7	0.8	0.7
<b>Total</b>	<b>136.5</b>	<b>154.8</b>	<b>185.7</b>	<b>188.9</b>	<b>198.3</b>

Note - Expenditure excludes specialized hospitals.

The three provinces which received the largest budget allocation in the five-year period from 2014 to 2018-19 were Rewa, Ba and Macuata (refer Table 6-3). The provinces that received the lowest budget allocation in the five-year period from 2014 to 2018-19 were Namosi, Rotuma, Kadavu, Serua and Bua. Rewa, Ba and Macuata had high expenditure since the three divisional hospitals (CWM, Lautoka, and Labasa hospital) falls within the ambit of these provinces respectively.

Table 6-4 provides the GCHE on health facilities (divisional, SDHs and PHCs) per capita by provinces and divisions. The per capita information was computed using the 2007 and 2017 census of population figures for the year 2007 and 2017-18 respectively and projected population<sup>2</sup> figures provided by Fiji Bureau of Statistics for the years 2008 to 2016-17 and 2018-19. 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.

Across the four divisions, the provinces with the highest per capita health expenditure were notably those that have the divisional hospitals situated within them (Macuata, Rewa and Ba). However, across all provinces, Rewa and Rotuma had the highest per capita health spending. It must be noted that Rewa province has the main national referral hospital in the country (CWMH) whilst Rotuma's geographical location could have contributed to the high expenditure.

**Table 6-3 Per capita GCHE on hospitals plus health centers by Divisions and Province (FJ\$)**

Province by Divisions	2014	2015	2016-17	2017-18	2018-19
<b>Eastern Division</b>	<b>125.8</b>	<b>210.01</b>	<b>218</b>	<b>136.4</b>	<b>112.4</b>
Rotuma	339.4	381.85	466.3	485.4	469.7
Lau	144.6	251.13	306.7	257.9	227
Kadavu	95.6	262.43	169.6	60.47	56.69
Lomaiviti	105.9	129.03	159.3	79.14	44.45
<b>Northern Division</b>	<b>183.8</b>	<b>231.03</b>	<b>237.8</b>	<b>255.5</b>	<b>319.9</b>
Macuata	236.7	307.95	346.4	472.5	554.2
Bua	128.2	149.15	181.9	43.88	141.5
Cakaudrove	122.1	141.64	94.41	36.68	57.9
<b>Central Division</b>	<b>157.8</b>	<b>180.77</b>	<b>227.5</b>	<b>212.6</b>	<b>208.3</b>
Rewa	373.9	419.33	645.3	698.5	666.3
Tailevu	142.2	162.12	46.14	12.85	10.14
Serua	111.3	159.96	196.2	67.61	48.36

<sup>2</sup> Population figures are projected estimates sourced from the Fiji Bureau of Statistics (FBoS)

Namosi	17.27	16.82	519	172.1	123.1
Naitasiri	38.84	46.76	18.91	7.81	4.21
Western Division	<b>150.3</b>	<b>148.53</b>	<b>187.9</b>	<b>206.7</b>	<b>242.2</b>
Ba	172.5	169.97	173	206.7	246.4
Ra	93.68	84.16	128.6	129.3	151.5
Nadroga/Navosa	91.17	95.87	276.7	247	271.2
<b>Total</b>	<b>157.7</b>	<b>177.99</b>	<b>213.6</b>	<b>213.5</b>	<b>233.8</b>

Note - Expenditure excludes specialized hospitals

#### 6.4. Government Current Health Expenditure by Functions

This section focuses on Government current health expenditures (GCHE) by function and the Table 6- reflects the type of goods and services.

**Table 6-4 Government Current Health Expenditures by Functions (FJ\$m)**

Functions	2014	2015	2016-17	2017-18	2018-19
<b>Curative care</b>	79.4	111.5	138.5	173.7	197.2
<i>Inpatient curative care</i>	41.1	49.4	57.2	73.9	83.6
<i>Outpatient curative care</i>	38.3	62.1	81.3	99.7	113.6
<b>Rehabilitative care</b>	3.6	3.5	7	9.6	12.2
<b>Long-term care (health)</b>	1	1.8	0.1	0	0
<b>Ancillary services (non-specified by function)</b>	25.2	3.1	2.6	5.5	7.8
<b>Medical goods (non-specified by function)</b>	1.8	0.5	3.1	1	0
<b>Preventive care</b>	63.1	63.7	68.4	76.2	75.3
<b>Governance, and health system and financing administration</b>	17.3	20.9	13.5	21.4	18.2
<b>Other health care services not elsewhere classified (n.e.c.)</b>	-	1.2	0.4	-	-
<b>Total</b>	<b>191.5</b>	<b>206.1</b>	<b>233.6</b>	<b>287.3</b>	<b>310.8</b>

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

*Curative care*, *Preventive care* and the *Governance, and health system and financing administration* are the three largest expenditure functions. In 2018-19 the spending on inpatient curative care was 41.5% and the outpatient curative care was 58.5%. Costs in nominal terms in both services shows an increase in 2015 onwards. The expenditure for *Ancillary services* in 2015 was redistributed to curative care resulting in the substantial change in expenditure.

**Table 6-5 Preventive care categories (FJ\$m)**

Preventive care	2014	2015	2016-17	2017-18	2018-19
Information, education and counselling programmes	14.5	15.3	16.5	18.4	19.4
Immunisation programmes	10.3	9.8	10.9	11.6	11.3
Early disease detection programmes	12.3	10.8	12.2	12.8	13
Healthy condition monitoring programmes	13.6	11.6	10.4	10.4	10
Epidemiological surveillance and risk and disease control programmes	6.9	9.5	9.1	12.8	11.2
Preparing for disaster and emergency response programmes	5.6	6.7	9.3	10.2	10.4
<b>Total</b>	<b>63.1</b>	<b>63.7</b>	<b>68.4</b>	<b>76.2</b>	<b>75.3</b>

Most of the health expenditures in the Preventive care programs over the five-year period are on *information, education and counseling programs* whilst lowest expenditures are on preparing for disaster and emergency response programs as reflected in Table 6-6.

The GCHE on medical goods for all years 2014 to 2018-19 are incorporated mostly into curative care (in-patient and outpatient care). Table 6-7 provides the Government expenditure on medicines since 2014.

**Table 6-6 Government drugs expenditure**

Year	2014	2015	2016-17	2017-18	2018-19
FJ\$m	9	13.5	25	46.7	41.5

2014 expenditure figures from FMIS system

2015 – Includes both drugs and free medicines scheme expenditure



## 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 from FJ\$106.8m in 2014 to FJ\$150.9m in 2018-19 (refer Table 7-1).

Table 7-1 depicts that the primary source of revenue for the private sector is from *other revenues from households*.

**Table 7-1 Private Current Health Expenditure by Sources, 2014 to 2018-19**

Description	2014		2015		2016-17		2017-18		2018-19	
	Amount (FJ\$m)	Share (%)	Amount (FJ\$m)	Share (%)	Amount (FJ\$m)	Share (%)	Amount (FJ\$m)	Share (%)	Amount (FJ\$m)	Share (%)
<b>Compulsory prepayment (Other, and unspecified, than FS.3)</b>	-	-	-	-	-	-	1.8	1.2	0	0
Compulsory prepayment from individuals/households	-	-	-	-	-	-	1.8	1.2	0	0
<b>Voluntary prepayment</b>	<b>41.8</b>	<b>39.1</b>	<b>42</b>	<b>37.5</b>	<b>47.4</b>	<b>42.7</b>	<b>51.9</b>	<b>33.1</b>	<b>49.4</b>	<b>32.8</b>
Voluntary prepayment from individuals/households	24.8	23.2	21	18.8	12.7	11.5	15.9	10.2	14.7	9.8
Voluntary prepayment from employers	17.1	16	21	18.7	34.7	31.3	36	23	34.7	23
Other voluntary prepaid revenues	0	0	0	0	0	0	0	0	0	0
<b>Other domestic revenues n.e.c.</b>	<b>65</b>	<b>60.9</b>	<b>70.1</b>	<b>62.5</b>	<b>63.5</b>	<b>57.3</b>	<b>102.9</b>	<b>65.7</b>	<b>101.4</b>	<b>67.2</b>
Other revenues from households n.e.c.	61.5	57.5	68.7	61.2	55	49.6	84.3	53.8	96.5	63.9
Other revenues from corporations n.e.c.	0	0	0	0	6.9	6.2	12.3	7.8	4	2.7
Other revenues from NPISH n.e.c.	3.6	3.3	1.4	1.3	1.6	1.4	6.3	4	1	0.6
<b>TOTAL</b>	<b>106.8</b>	<b>100</b>	<b>112.1</b>	<b>100</b>	<b>110.9</b>	<b>100</b>	<b>156.7</b>	<b>100</b>	<b>150.9</b>	<b>100</b>

## 7.2. Private Current Health Expenditure by Financing Schemes

*Households Out-of-pocket (OOP)* was the dominant financing scheme over the last five years. *OOP* accounted for 63.9 % of PCHE in 2018-19. Voluntary health care payment schemes also contributed significantly towards the increase in PCHE (refer Table 7-2).

**Table 7-2 Private Current Health Expenditure by Schemes, FJ\$m 2014 to 2018-19**

	2014		2015		2016-17		2017-18		2018-19	
Schemes	Amount (FJ\$m)	Share (%)	Amount (FJ\$m)	Share (%)	Amount (FJ\$m)	Share (%)	Amount (FJ\$m)	Share (%)	Amount (FJ\$m)	Share (%)
Voluntary health care payment schemes	24.8	23.2	42	37.5	47.4	42.7	52	32.2	49.4	32.8
Employer-based insurance (other than enterprises schemes)	17.1	16	21.4	19.1	20.6	18.6	35.5	22	34.7	23
Other primary coverage schemes	7.7	7.2	20.6	18.4	26.8	24.2	16.4	10.2	14.7	9.8
Household Out-of-pocket (OOP)	78.5	73.5	68.7	61.2	55.8	50.3	94	58.2	96.5	63.9
Out-of-pocket excluding cost-sharing	62.3	58.3	68.7	61.2	55.8	50.3	89.2	55.2	90	59.6
Cost sharing with third-party payers	16.2	15.1	0	0	0	0	4.9	3	6.5	4.3
NPISH schemes	3.6	3.3	1.4	1.3	1.6	1.4	6.3	3.9	1	0.6
Enterprise financing schemes	0	0	0	0	6.1	5.5	9.2	5.7	4	2.7
<b>TOTAL</b>	<b>106.8</b>	<b>100</b>	<b>112.1</b>	<b>100</b>	<b>110.9</b>	<b>100</b>	<b>161.6</b>	<b>100</b>	<b>150.9</b>	<b>100</b>

\* 2014 (FJ\$16.2m) is included in Household Out of Pocket

## 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 has decreased. The decrease in expenditure reflected for private medical practices could also be attributed to the decrease in survey response rates.

**Table 7-3 Private Current Health Expenditure by Providers, 2014 to 2018-19**

Providers	2014		2015		2016-17		2017-18		2018-19	
	Amount (FJ\$m)	Share (%)	Amount (FJ\$m)	Share (%)	Amount (FJ\$m)	Share (%)	Amount (FJ\$m)	Share (%)	Amount (FJ\$m)	Share (%)
Hospitals	21.2	19.9	20.1	17.9	22	19.9	34.4	22	41.3	27.4
Pvt Medical practices	30.5	28.5	27.2	24.3	26.8	24.2	23.9	15.3	18.5	12.3
Dental Practice	4.9	4.6	4.3	3.8	3.5	3.1	4.9	3.1	5.5	3.6
Eye Care	2.9	2.7	3.6	3.2	4.9	4.4	6.5	4.1	3	2
Ambulatory health care centres	0	0	0	0	0	0	0	0	0	0
Providers of ancillary services	1	1	0.5	0.4	1.1	1	17	10.8	12.6	8.4
Retailers and other providers of medical goods	35.7	33.4	44.2	39.5	40.6	36.6	49.4	31.5	55.4	36.7
Providers of preventive care					0	0	1.5	1	0.2	0.1
Providers of health care system administration and financing					0	0	1.6	1		0
Rest of the world	10.6	9.9	12.1	10.8	12	10.8	17.5	11.2	14.3	9.5
<b>TOTAL</b>	<b>106.8</b>	<b>100</b>	<b>112.1</b>	<b>100</b>	<b>110.9</b>	<b>100</b>	<b>156.7</b>	<b>100</b>	<b>150.9</b>	<b>100</b>

#### 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 (refer Table 7-4). In 2018-19 inpatient care was 38.8 % whilst outpatient was 56.8 % of curative care. Expenditure on *Preventive care* also increased however the expenditure was mostly for Immunization, early disease detection and with a major increase in Epidemiological surveillance and risk and disease control programmes.

**Table 7-4 Private Current Health Expenditure by Functions, 2014 to 2018-19**

	2014		2015		2016-17		2017-18		2018-19	
Functions	Amount (FJ\$m)	Share (%)	Amount (FJ\$m)	Share (%)	Amount (FJ\$m)	Share (%)	Amount (FJ\$m)	Share (%)	Amount (FJ\$m)	Share (%)
Curative care	46.8	43.8	52.6	46.9	56.2	50.7	66.4	42.4	70.7	46.9
Inpatient curative care	10.1	9.4	19.4	17.3	18.8	17	27.2	17.3	27.5	38.9
Outpatient curative care	36.7	34.4	33.2	29.6	6.6	5.9	9.5	6.1	43.2	61.1

<b>Rehabilitative care</b>	0	0.05	0	0	0	0.01	0	0.03	0	0.01
<b>Ancillary services (non-specified by function)</b>	14.6	13.7	10.2	9.1	8.2	7.4	30.4	19.4	21.4	14.2
<b>Medical goods (non-specified by function)</b>	39.3	36.8	45.8	40.8	44.3	39.9	54	34.5	56.9	37.7
<b>Preventive care</b>	6.1	5.7	3.5	3.1	2.2	1.9	4.2	2.7	1.9	1.2
<b>Governance, and health system and financing administration</b>	0	0	0	0	0	0	1.6	1	0	0
<b>TOTAL</b>	<b>106.8</b>	<b>100</b>	<b>112.1</b>	<b>100</b>	<b>110.9</b>	<b>100</b>	<b>156.7</b>	<b>100</b>	<b>150.9</b>	<b>100</b>

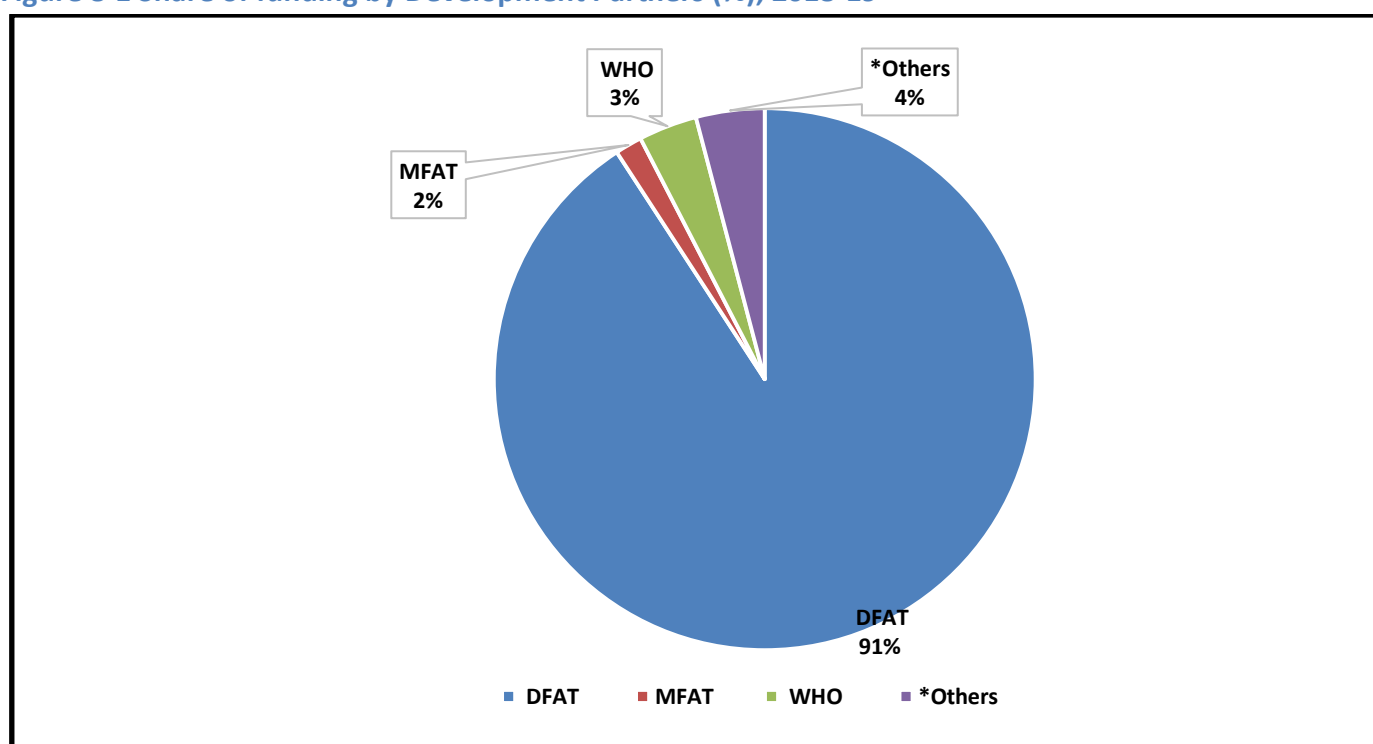
## 8. Development Partners (Rest of the World)

Development partners in this section also refer to “Rest of the World” as classified in SHA 2011.

The Ministry of Health & Medical Services (MHMS) continues to benefit from its bilateral partners and multilateral agencies and receive support through either direct (cash grants), Aid-in kind (technical expertise, supplies and equipment) and ad-hoc cash grants.

The information presented in this section covers development partners who responded to the NHA questionnaire. Figure 8-1 shows the share of development partner funding for the years 2018-19.

**Figure 8-1 Share of funding by Development Partners (%), 2018-19**



Source: Table 8-1

Note: This total development partner funding presented in the Figure comprises of Total Contribution, Current Health Expenditure (CHE) and Capital Expenditure (HK)

\*Others - Consist of UNDP and Development Partners (names not provided) provided funding support to NPISH

Table 8-1 shows the total development partner funding from 2014 to 2018-19. The total development partner funding consists of both Current Health Expenditure (CHE) and Capital Expenditure.

**Table 8-1 Financing contributions by Development Partners (FJ\$m)**

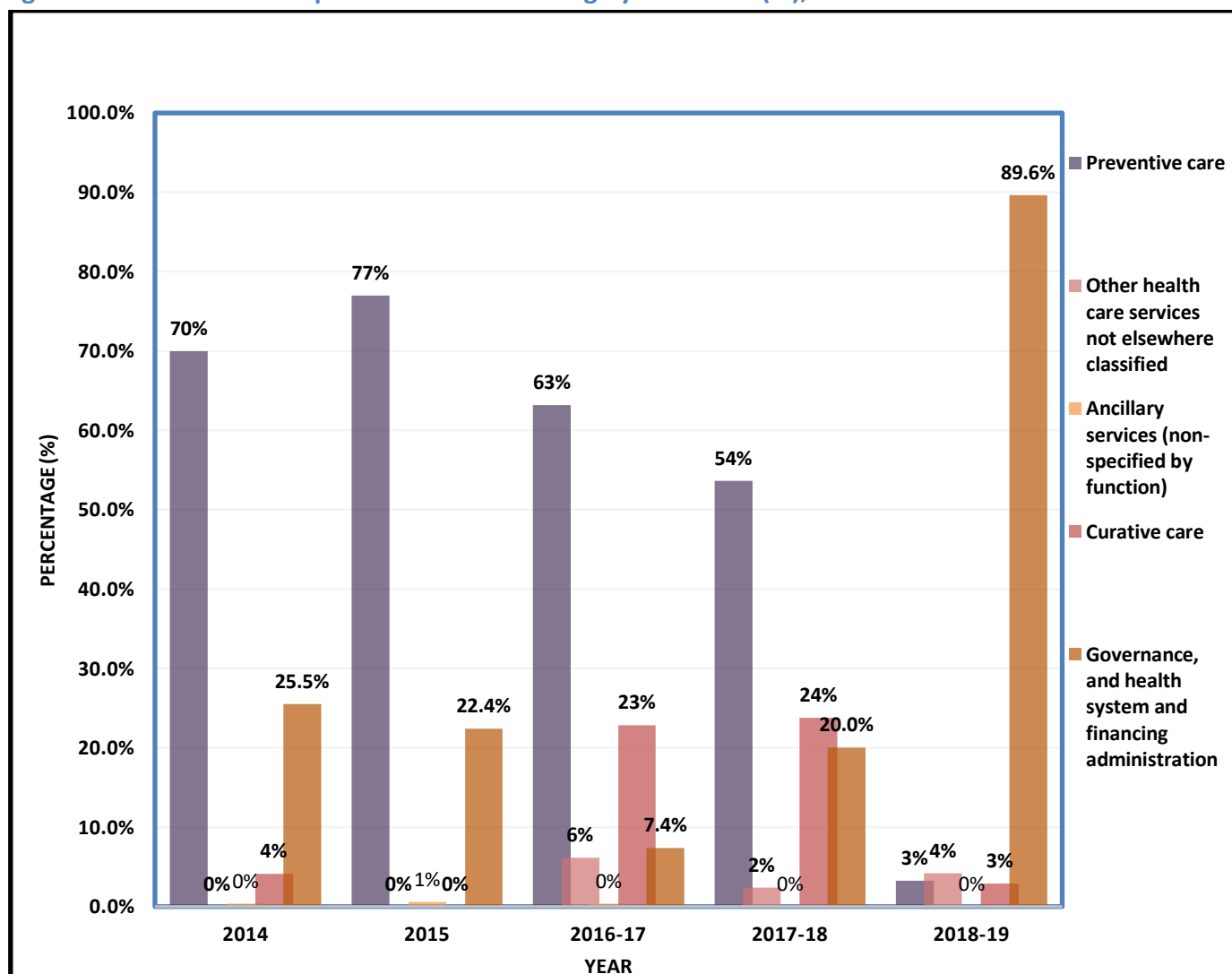
Development Partners	CHE					HK					Total Contribution				
	2014	2015	2016-17	2017-18	2018-19	2014	2015	2016-17	2017-18	2018-19	2014	2015	2016-17	2017-18	2018-19
DFAT	8.4	5.1	2	7.3	38.1	2.7	0.4	-	-	-	11.1	5.6	2	7.3	38.1
WHO	1	0.6	0.9	3.1	1.5	-	-	-	-	-	1	0.6	0.9	3.1	1.5
Japan	-	-	-	1.5	-	-	-	-	-	-	-	-	-	1.5	-
China	0.2	-	-	-	-	-	-	-	-	-	0.2	-	-	-	-
NZAid	2.2	-	-	-	-	-	-	-	-	-	2.2	-	-	-	-
Global Fund	2.1	1.4	2.8	3.7	-	0.6	0.018	-	-	-	2.7	1.4	2.8	3.7	-
UNFPA	-	0	-	-	0.4	-	-	-	-	-	-	0.045	-	-	0.4
UNICEF	0.022	-	1.5	0.2	0.1	-	-	-	-	-	0.022	-	1.5	0.2	0.1
UNAIDS	0.033	-	-	0.2	0	-	-	-	-	-	0.033	-	-	0.2	0
KOICA	-	0.4	2.9	2	-	-	0.3	-	-	-	-	0.7	2.9	2	-
ROC (Taiwan)	-	0.4	-	-	-	-	-	-	-	-	-	0.4	-	-	-
UNDP	-	0.1	-	-	-	-	-	-	-	-	-	0.1	-	-	-
Other	-	0.3	3.1	3.2	1.2	-	-	-	-	-	-	0.3	3.1	3.2	1.2
MFAT		-	-	13	0.7		-	-	-	-		-	-	13	0.7
Secretariat of the Pacific Community		-	-	0.2	-		-	-	-	-		-	-	0.2	-
Total Donor Contribution	14.1	8.3	13.1	34.4	42	3.3	0.7	-	-	-	17.4	9.1	13.1	34.4	42

Note: USD Conversion: average of the FY. 2015 Ministry of Economy monthly exchange rate - denotes that data was not available

## 8.1. Development Partners funding by Functions

Preventive care accounted for largest portion of the development partner funding till the 2017-18, but in 2018-19, it was mostly administrative support in the form of technical assistance and operational research amongst others.

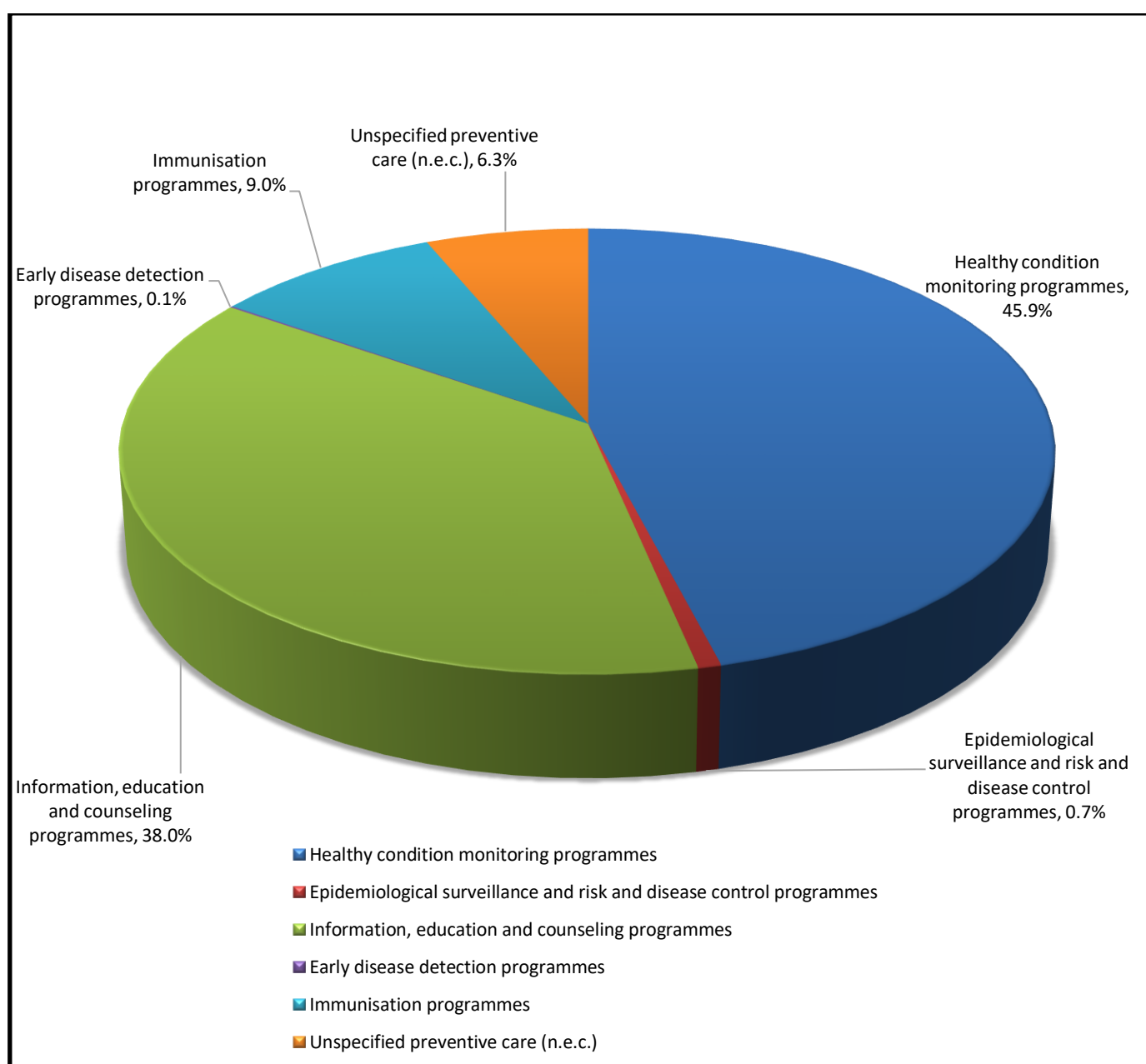
Figure 8-2 Share of Development Partners funding by Functions (%), 2018-19



*Preventative care* and *Governance, health system, financing and administration* combined reflected above 90% of development partner investment in health sector.

Figure 8-2 provides the breakdown of the Preventive care funding by development partners into various preventive care categories.

Figure 8-3 Share of Preventive care funding by Development Partners (%), 2018-19





## 9. Capital Expenditure

SHA 2011 describes Capital Expenditure (HK) as a very integral component of health expenditure that contributes towards production of health services. The HK information helps in analyzing the service delivery in the health systems production capability i.e. whether it's appropriate, deficient or excessive.

This chapter provides the breakdown of Capital Expenditure on the production of services by Government, private sector and development partners including the types of services that have been provided. The information presented on private sectors and development partners has been consolidated from the survey responses.

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

Capital Expenditure is classified under two major categories that are Gross Capital formation which comprises of infrastructure, machinery & equipment, ICT & other related machinery: and non-produced non – financial assets comprising of land and others.

The total Capital Expenditure as shown in Table 9-1 is a composition of both public and private for the period 2014 to 2018-19. The expenditure had increased by FJ\$3.6m from 2014(FJ\$32.7m) to 2018-19 (FJ\$36.3 m). 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**

	2014	2015	2016-17	2017-18	2018-19
Capital Account	Amount FJ\$m	Amount FJ\$m	Amount FJ\$m	Amount FJ\$m	Amount FJ\$m
<b>Infrastructure</b>	<b>18.1</b>	<b>23.3</b>	<b>26.4</b>	<b>19.2</b>	<b>26</b>
Residential and non-residential buildings	17.9	23.1	26.4	19.2	26
Other structures	0.2	0.2	0	0	0
<b>Machinery and equipment</b>	<b>11.9</b>	<b>13</b>	<b>10.1</b>	<b>18.8</b>	<b>9</b>
Medical equipment	10.2	12.4	9.4	16.6	7.7
Transport equipment	0.2	0.2	0.2	0.6	0.3
ICT equipment	0.7	0.4	0.5	1.5	1
Machinery and equipment	0.8	0	0	0	0
<b>Intellectual property products</b>	<b>0.6</b>	<b>0.4</b>	<b>0.7</b>	<b>0.7</b>	<b>0.6</b>
Computer software and databases	0.6	0.4	0.7	0.7	0.6
<b>Non-produced non-financial assets</b>	<b>0.1</b>	<b>0.1</b>	<b>0.2</b>	<b>0.3</b>	<b>0.1</b>

Non-produced non-financial assets	0	0	0.1	0	0
Land	0.1	0.1	0.1	0.3	0.1
Memorandum items	2	0	0	0	0
Education of health personnel	2	0	0	0	0
Unspecified gross fixed capital formation (n.e.c.)			0	3	
<b>Total</b>	<b>32.7</b>	<b>36.9</b>	<b>37.4</b>	<b>42.0</b>	<b>36.3</b>

## 9.2. Capital Expenditure by Sectors

Table 9-2 shows the contribution of Capital Expenditure by each sector for the years 2014 to 2018-19. 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. 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 2018-19 was due to the infrastructure development, upgrading of hospital, health centers and nursing stations and procurement of new medical equipment.

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

	2014	2015	2016-17	2017-18	2018-19
Sector	Amount FJ\$m	Amount FJ\$m	Amount FJ\$m	Amount FJ\$m	Amount FJ\$m
Government	24.4	31	29.5	24.96	27.35
Private	5	5.1	7.9	16.14	8.98
Development Partners	3.3	0.7	0	0.91	0
<b>TOTAL</b>	<b>32.7</b>	<b>36.9</b>	<b>37.4</b>	<b>42</b>	<b>36.3</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). This information assists to track the expenditure and the resources required to meet the needs. The focus is on ensuring an efficient, appropriate allocation of resources in the production of health care services. 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 detailed level. The Government’s budget system is input-based however and the cost captured by FMIS is also at an input-based level. Information presented in this chapter on private sector was based on the survey responses received.

### 10.1. Factors of Provision for CHE

In terms of the overall share of expenditure by Factors of Health Care Provision (FP) by CHE in 2018-19, Government was largest by (61.7%) followed by Private (30.0%) and Development Partners (8.3%).

Figure 10-1 Share of expenditure by Factors of Health Care Provision by CHE (%), 2018-19

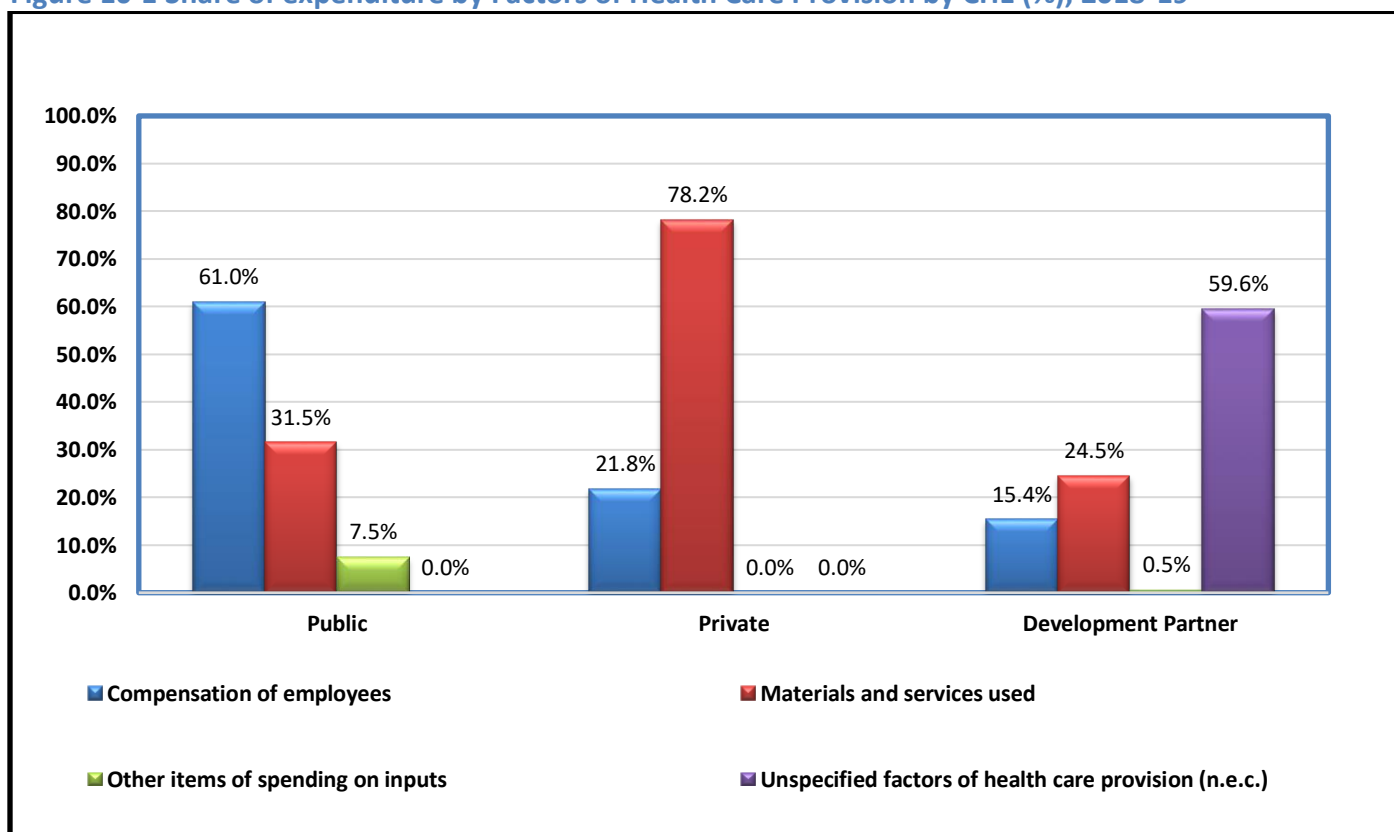


Figure 10-1 shows that Government had very high input costs in the production of health care services to maintain and sustain the level of service delivery.

Table 10-1 provides details of various resource inputs within the Government sector.

Table 10-1 Factors of Provision by GCHE

Category	2014		2015		2016-17		2017-18		2018-19	
	Amt (FJ\$m)	Share (%)	Amt (FJ\$m)	Share (%)	Amt (FJ\$m)	Share (%)	Amt (FJ\$m)	Share (%)	Amt (FJ\$m)	Share (%)
Wages and salaries	103.9	55.4	0	0	170.9	73.2	171.1	59.6	198.4	63.8
FNPF	8.8	4.7	0	0	12.2	5.2	16.1	5.6	18.3	5.9
Wages and Salaries - Allowances, OT, Relieving etc	4	2.1	0	0	9.3	4	6.6	2.3	4	1.3
Self-employed professional remuneration	0	0	0	0	0	0	3.3	1.2	4.9	1.6
Laboratory & Imaging services	0	0	0	0	0	0	1.5	0.5	5.8	1.9
Health care services	15.6	8.3	0	0	8.9	3.8	9	3.1	10.6	3.4
Vaccines	0	0	5.7	97.9	0	0	7.1	2.5	5.9	1.9
Contraceptives	0	0	0.1	2.1	0	0	0	0	0	0
ARV	0	0	0	0	0	0	0	0	0	0
Pharmaceuticals (Drugs)	9	4.8	0	0	0.3	0.1	39.5	13.8	12.3	3.9
Diagnostic Equipment	0	0	0	0	0	0	0	0	0	0
Other health care goods	26.2	13.9	0	0	10.5	4.5	3.2	1.1	9.6	3.1
Training	0	0	0	0	0.4	0.2	0.3	0.1	0.1	0
Technical Assistance	0	0	0	0	0	0	0	0	0	0
Indemnity	0	0	0	0	0	0	0.1	0	0	0
Operational research	0	0	0	0	0	0	0	0	0	0
Indemnity	0	0	0	0	0	0	0	0	0.2	0.1
Non-health care services	1.6	0.9	0	0	10	4.3	3.5	1.2	5.4	1.8
Non-health care goods	0.9	0.5	0	0	6	2.6	7.7	2.7	8.6	2.8
Other materials and services used (n.e.c.)	0	0	0	0	0	0	8.5	2.9	6.4	2.1
Taxes (VAT)	10.3	5.5	0	0	1.9	0.8	6.4	2.2	6.8	2.2
Other items of spending	7.4	3.9	0	0	2.6	1.1	3.4	1.2	13.5	4.3
Unspecified factors of health care provision (n.e.c.)	0	0	0	0	0.3	0.1	0	0	0	0
Total	187.7	100	5.8	100	233.6	100	287.3	100	310.8	100

\*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 FP by GCHE in 2014 was FJ\$187.7m and in 2018-19 was FJ\$310.8m. The expenditure in 2018-19 had increased substantially. Major increases were in *Human Resource (HR) costs, Vaccines & Pharmaceuticals (Drugs)* under Health care goods and *non-health care goods* (maintenance and operations expenditure).

*Hospitals* had the largest input costs followed by *providers of ambulatory health care*, when the inputs costs were distributed amongst the providers in the public sector.

*Curative care* had the largest input costs followed by *Preventive Care*, when the input costs were distributed amongst the type of services provided in the public sector.

## 11. Disease Based Costs

The disease expenditure presented here is largely based on inpatient utilization from the public sector facilities, and outpatient data from both public (patient databases) and private sectors (surveys).

Patient days (for inpatient analysis) coded by International Coding of Disease 10 Australian Modification (ICD 10 AM) classification were used to allocate facility expenditure by disease category. Public inpatient disease distribution was used to distribute private sector inpatient data; the latter accounts for less than 10 of total inpatient activity in the country.

Outpatient visits (for outpatient analysis) used the number of visits by disease condition to allocate expenditure. Disease conditions were then mapped to the disease (DIS) categories in the Health Accounts Production Tool (HAPT). The Public Sector data was obtained from databases whilst the Private Sector data was obtained from surveys of the private sector providers.

### 11.1. Expenditure by Disease

Table 11-1 shows the distribution of total CHE across the disease categories. NCDs account for the most expenditure and represents 38.9% of total CHE. Within the NCD category, cardiovascular diseases were the most dominant illness.

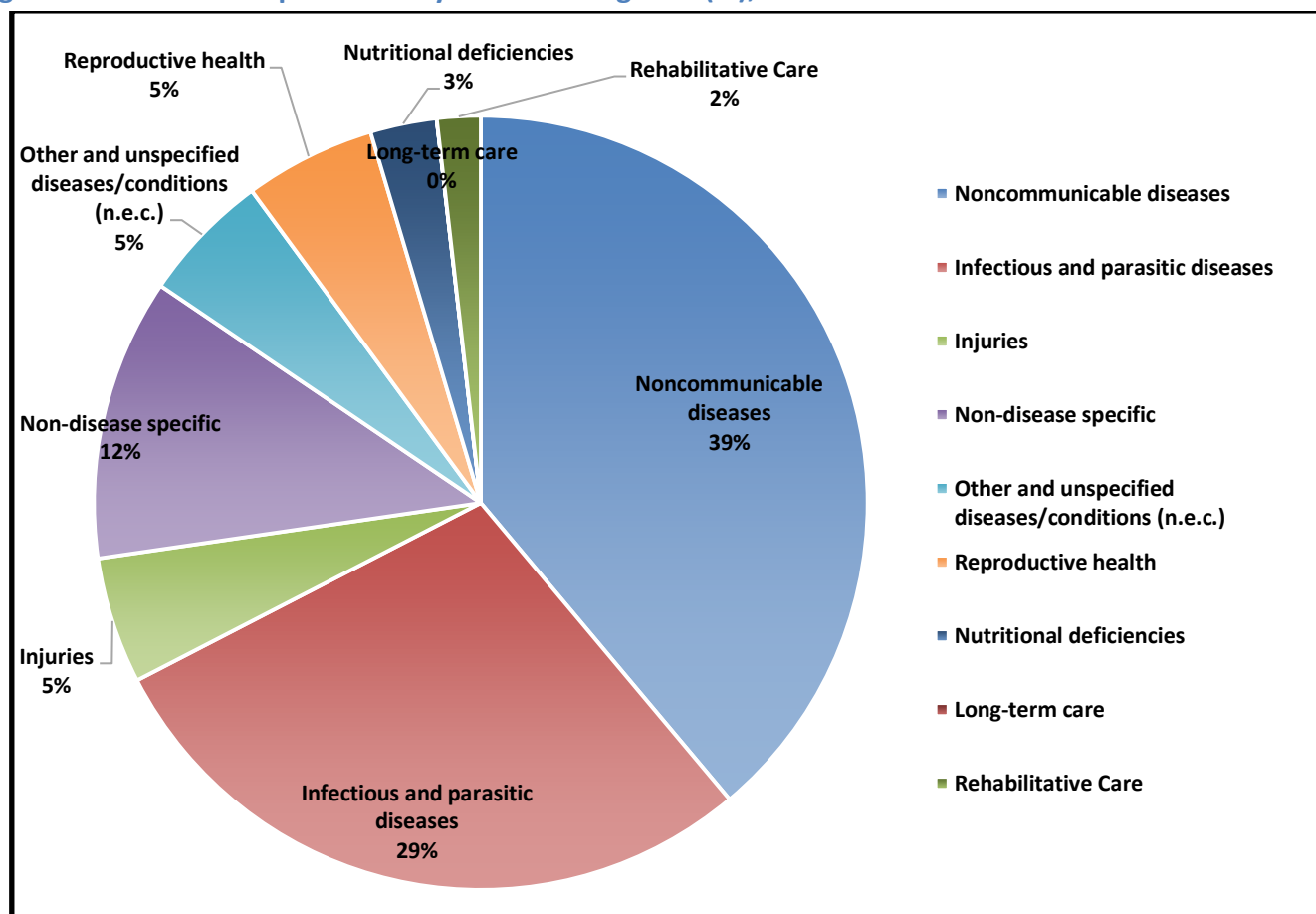
**Table 11-1 Expenditure by disease categories (FJ\$m), 2015- 2018-19**

	2015		2016-17		2017-18		2018-19	
Classification of diseases / conditions	Amount (FJ\$m)	Share (%)	Amount (FJ\$m)	Share (%)	Amount (FJ\$m)	Share (%)	Amount (FJ\$m)	Share (%)
Non-communicable diseases	134.7	41.2	127.9	35.8	192.2	40.2	195.8	38.9
Infectious and parasitic diseases	75.9	23.2	106.9	29.9	152.2	31.8	143.7	28.5
Injuries	29.4	9	61.2	17.1	37.2	7.8	26.6	5.3
Non-disease specific*	24.9	7.6	18.9	5.3	33.4	7	59.3	11.8
Other and unspecified diseases/conditions (n.e.c.)**	23.5	7.2	14.6	4.1	21.6	4.5	27.4	5.4
Reproductive health	22.5	6.9	19.7	5.5	20.8	4.3	27.6	5.5
Nutritional deficiencies	12.2	3.7	7	1.9	14.3	3	14	2.8
Long-term care	1.9	0.6	0	0	0	0	0	0
Rehabilitative Care	1.6	0.5	1.3	0.4	6.7	1.4	9.2	1.8
<b>Total</b>	<b>326.6</b>	<b>100</b>	<b>357.5</b>	<b>100</b>	<b>478.4</b>	<b>100</b>	<b>503.6</b>	<b>100</b>

\* This represents those expenditures that could not be directly coded to a disease category. An example would be the salaries of the Secretary for health.

\*\* This represents those expenditures which were incurred by patients with unknown conditions  
Figure 11-1 is a diagrammatic pie chart showing the distribution of CHE by disease (2018-19) as presented in Table 11-1.

**Figure 11-1 Share of expenditure by disease categories (%), 2018-19**



Source: Table 11-1

When looking at the disease expenditure distribution between the Public and Private Sector, the disease categories *Non-communicable diseases* are the prevalent diseases in both sectors. The private sector expenditure represents those individuals that can afford the fees charged and have insurance coverage to seek care at private health facilities.

**Table 11-2 Disease expenditure by sources (FJ\$m), 2018-19**

Classification of diseases / conditions (FJ\$m)	Public	Private	Development Partners	Total	Share (%)
Infectious and parasitic diseases	121.3	21.8	0.6	143.7	28.5
Reproductive health	20.4	6.7	0.5	27.6	5.5
Nutritional deficiencies	1.9	11.7	0.3	14.0	2.8
Non-communicable diseases	112.2	82.3	1.3	195.8	38.9
Injuries	20.2	6.4	0.0	26.6	5.3
Non-disease specific	20.8	1.1	37.4	59.3	11.8

Rehabilitative Care	9.2	0.0	0.0	9.2	1.8
Long-term care	0.0	0.0	0.0	0.0	0.0
Other and unspecified diseases/conditions (n.e.c.)	4.7	20.8	1.9	27.4	5.4
<b>Total</b>	<b>310.8</b>	<b>150.9</b>	<b>42.0</b>	<b>503.6</b>	<b>100</b>



Figure 11-2 shows the disease distribution by health providers. Again, *Non-communicable diseases* featured strongly across all the main health service providers including hospitals, ambulatory health care centers, and retailers and providers of medical goods.

**Figure 11-2 Share of Disease expenditure by Providers (%), 2018-19**

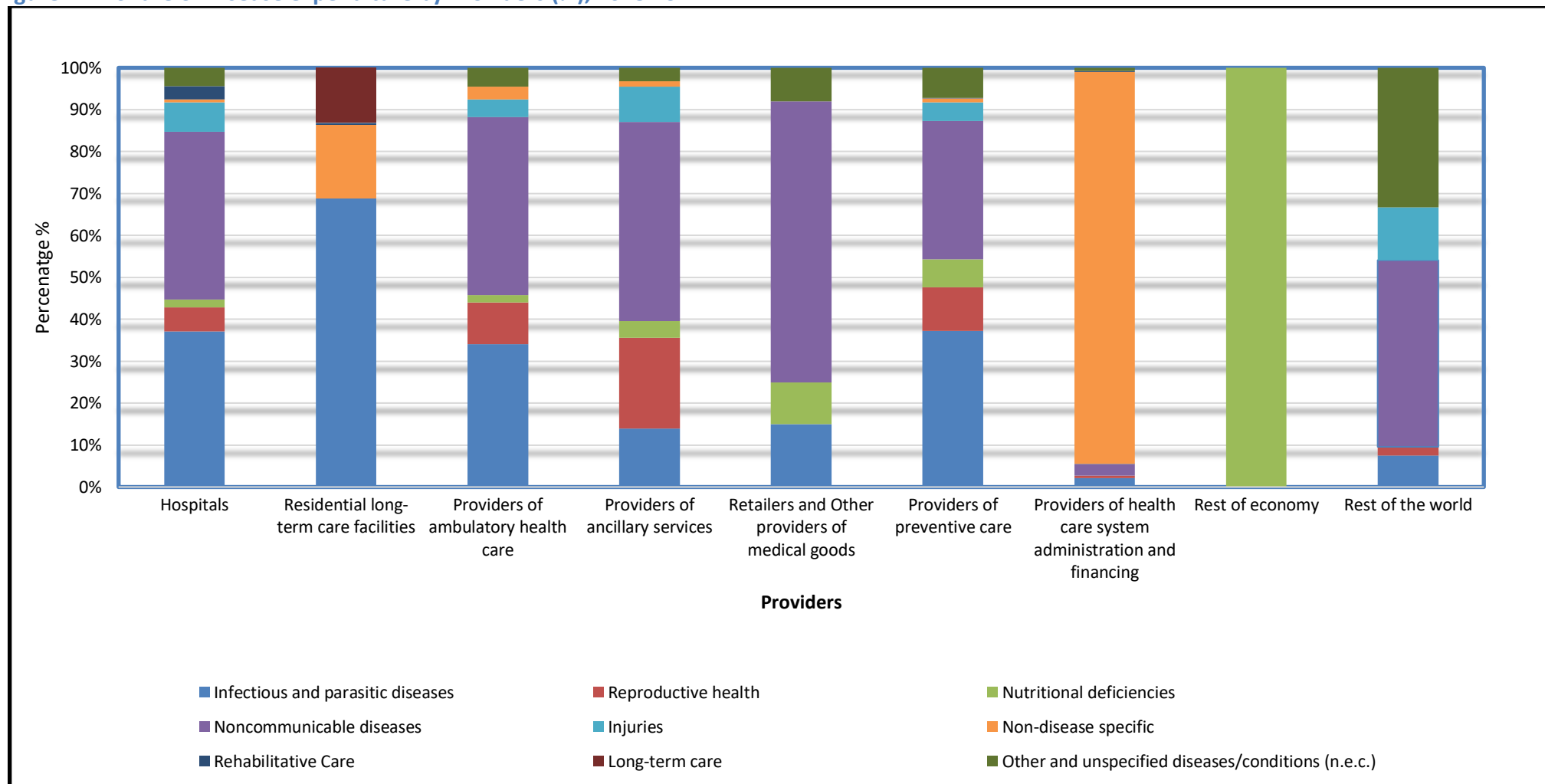


Table 11-3 shows the disease distribution across the functional classification. Again, *Noncommunicable diseases* were highest amongst all patients seeking curative care (both inpatient and outpatient) in 2018-19.

**Table 11-3 Disease expenditure by Functions (FJ\$m), 2018-19**

Classification of diseases / conditions	Curative care	Inpatient curative care	Outpatient curative care	Rehabilitative care	Long-term care (health)	Ancillary services (non-specified by function)	Medical goods (non-specified by function)	Preventive care	Governance, and health system and financing administration	Other health care services not elsewhere classified (n.e.c.)
Infectious and parasitic diseases	81	59.6	21.4	1.5	0	5.6	8.3	47.2	0.1	0
Reproductive health	13.7	4	9.7	0.2	0	4	0	9.7	0	0
Nutritional deficiencies	3.9	3	0.8	0	0	2.3	5.5	2.3	0	0
Noncommunicable diseases	126.9	31.4	95.5	1.5	0	12.9	38.5	14.9	0	1.1
Injuries	23.4	5.7	17.8	0	0	2.2	0	1	0	0
Non-disease specific	1.5	0.5	1	0	0	0.2	0	2.1	55.5	0
Rehabilitative Care	0.3	0	0.3	8.9	0	0	0	0	0	0
Long-term care	0	0	0	0	0	0	0	0	0	0
Other and unspecified diseases/conditions (n.e.c.)	18.5	7.6	10.9	0	0	2	4.5	1.4	0.3	0.7
<b>Total</b>	<b>269.2</b>	<b>111.8</b>	<b>157.4</b>	<b>12.2</b>	<b>0</b>	<b>29.1</b>	<b>56.9</b>	<b>78.5</b>	<b>55.9</b>	<b>1.8</b>

## 12.Primary Health Care

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part of both country's health system, of which it is the central function and focus, and of the overall social and economic development of the community. It is the first level of contact for individuals, the family and community with the national health system bringing health care as close as possible to where people live and work and constitutes the first element of a continuing health care process. (Alma Ata Declaration, 1978).

PHC is firmly embedded within the Sustainable Development Goals (SDGs)<sup>3</sup>. More recently, the political commitment to PHC as the cornerstone of sustainable health systems for universal health coverage was reaffirmed and reinvigorated in the Declaration of Astana (4).

Tracking PHC spending is necessary to establish baselines and set future goals around investments. Detailed information on how funds are directed to specific PHC services can help national policymakers track the progress of national-level PHC strategies. When combined with other information on inputs, activities, and outcomes, PHC expenditure information can become a powerful analytical tool for guiding investments and evaluating value for money in health spending.

While there is no ready-made SHA 2011 classification for PHC, components of PHC expenditure can be identified within the SHA 2011 framework. The healthcare function (HC) and healthcare provider (HP) classifications can be used to define PHC expenditure. It should be noted that in the SHA 2011 framework, capital and current expenditures are separated. Both HC and HP classifications exclude capital investment expenditure as the focus is on the consumption of the health services in a given period, set at 1 year.

According to the definition the PHC spending is defined as expenditure on outpatient care (curative as well as Long term care, excluding Specialized outpatient care), home based care (curative as well as long term care), medical goods (80 % of total medical goods) , preventive care and Health system Governance and administration ( 80 % of HC.7.1).

**Table 12-1 Primary Health Care Expenditure (PHCE) by sources of Funding FJ\$(m)**

	2015		2016-17		2017-18		2018-19	
	FJ\$(m)	%	FJ\$(m)	%	FJ\$(m)	%	FJ\$(m)	%
<b>Government</b>	125.6	61.8	140.1	62.7	166.6	61.9	168.6	61.3
<b>Private</b>	69.6	34.3	71.4	31.9	78.8	29.3	75.2	27.3
<b>Development Partners</b>	7.9	3.9	12.1	5.4	23.8	8.8	31.5	11.4
<b>Total</b>	<b>203.1</b>	<b>100</b>	<b>223.6</b>	<b>100</b>	<b>269.2</b>	<b>100</b>	<b>275.2</b>	<b>100</b>

<sup>3</sup>As a cross-cutting feature of the targets in SDG 3 ("Ensure healthy lives and promote well-being for all at all ages"), rather than an explicit goal.

**Table :12.2 PHCE by Providers**

	2015		2016-17		2017-18		2018-19	
	FJ\$(m)	%	FJ\$(m)	%	FJ\$(m)	%	FJ\$(m)	%
Hospitals	66.4	32.7	86.4	38.6	105	39	120.1	43.6
Residential long-term care facilities	1	0.5	0.1	0.1	0.1	0.1	0.1	0.1
Providers of ambulatory health care	61.2	30.1	67.4	30.1	53.4	19.9	41.7	15.2
Retailers and Other providers of medical goods	35.7	17.6	34.9	15.6	40.3	15	44.3	16.1
Providers of preventive care	20.2	10	22.8	10.2	36.4	13.5	19	6.9
Providers of health care system administration and financing	17.7	8.7	11.9	5.3	25.5	9.5	46.4	16.8
Rest of economy	0.3	0.1	0	0	4.2	1.5	0.2	0.1
Rest of the world	0.6	0.3	0	0	4.3	1.6	3.4	1.2
<b>Total</b>	<b>203.1</b>	<b>100</b>	<b>223.6</b>	<b>100</b>	<b>269.2</b>	<b>100</b>	<b>275.2</b>	<b>100</b>

The PHCE by providers gives an idea about how the gate keeping is successful in the health system. In Fiji in 2018-19 the major providers of PHCE were hospitals followed by administrators, pharmacies, and ambulatory care providers.

### Government Health Expenditure on Primary Care

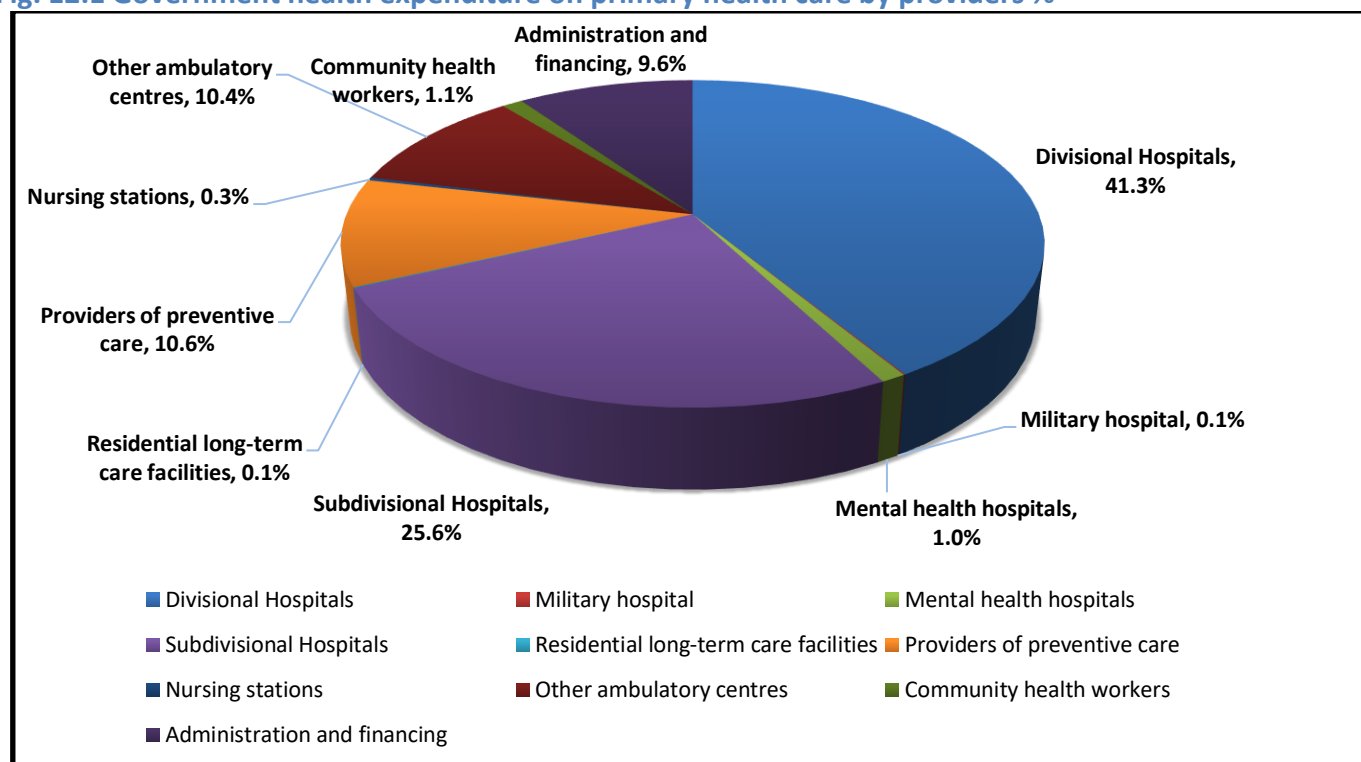
Fiji health system is three tier system where the Divisional hospitals provides mainly tertiary and secondary care, the sub-divisional hospitals are tasked with primary and secondary care and rest of the facilities provides primary care (except for specialized hospitals).

**Table 12.3: Government health expenditure on primary health care by providers (FJ\$(m) and %**

Health care providers	FJ\$(m)	%
Divisional Hospitals	69.67	41.30%
Military hospital	0.1	0.10%
Mental health hospitals	1.65	1.00%
Sub-divisional Hospitals	43.09	25.60%
Tamavua hospital (TB and Leprosy)	0	0.00%
Residential long-term care facilities	0.15	0.10%
Providers of preventive care	17.86	10.60%

Nursing stations	0.5	0.30%
Other ambulatory centres	17.46	10.40%
Community health workers	1.91	1.10%
Administration and financing	16.23	9.60%
<b>Grand Total</b>	<b>168.61</b>	<b>100.00%</b>

**Fig. 12.1 Government health expenditure on primary health care by providers %**



The primary care is mainly provided at divisional hospitals level followed by sub-divisional hospitals.

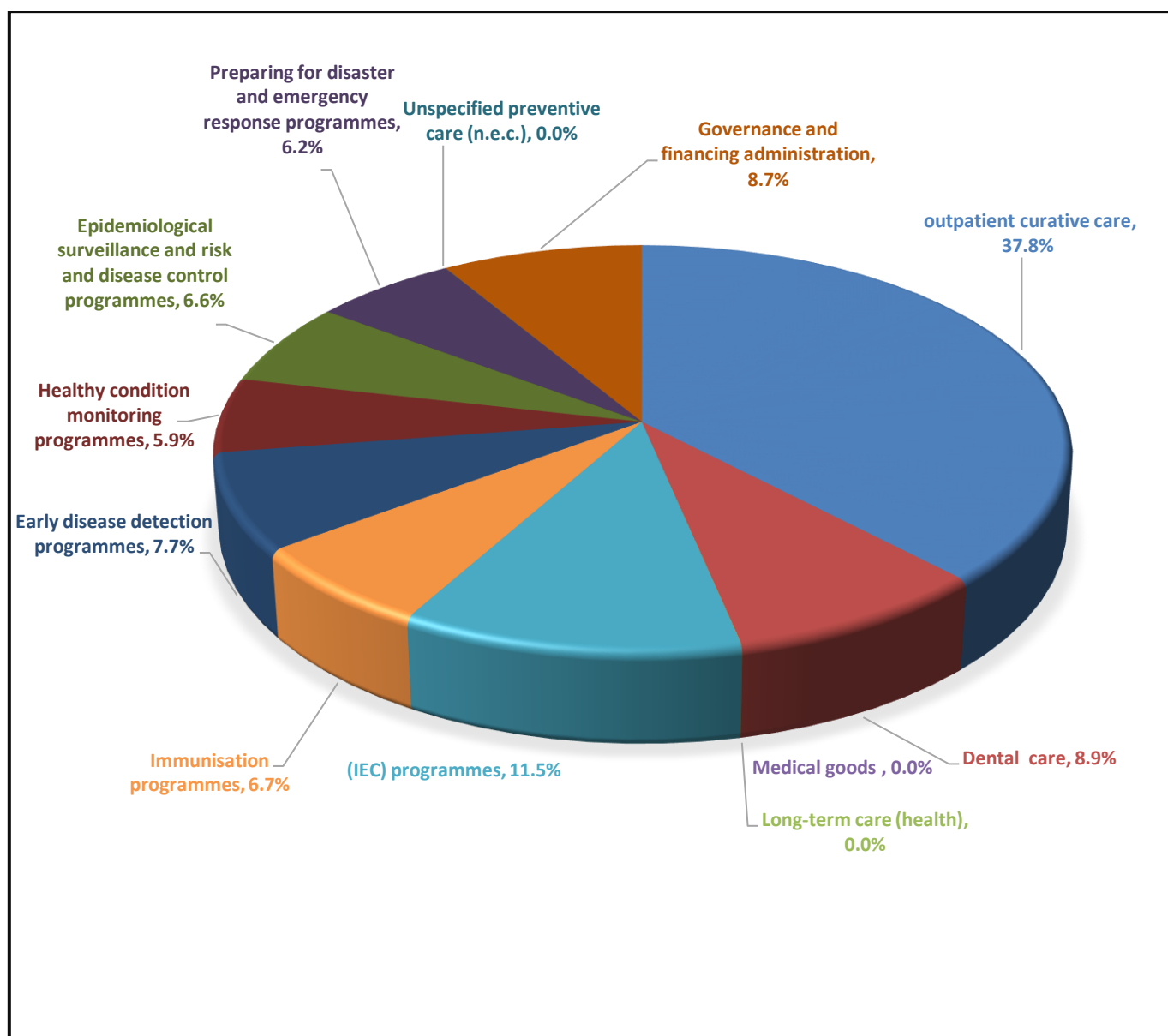
**Table 12.4: Government health expenditure on Primary Health care by functions (FJ\$(m) and %**

Health Care Functions	FJ\$(m)	%
General outpatient curative care	63.72	37.80%
Dental outpatient curative care	14.96	8.90%
Long-term care (health)	0.02	0.00%
Medical goods (non-specified by function)	0	0.00%
Information, education, and counselling (IEC) programmes	19.39	11.50%
Immunisation programmes	11.28	6.70%
Early disease detection programmes	13	7.70%
Healthy condition monitoring programmes	10.01	5.90%

Epidemiological surveillance and risk and disease control programmes	11.16	6.60%
Preparing for disaster and emergency response programmes	10.44	6.20%
Unspecified preventive care (n.e.c.)	0.03	0.00%
Governance, and health system and financing administration	14.58	8.70%
<b>Grand Total</b>	<b>168.61</b>	<b>100.00%</b>

The main expenditure on primary care through the preventive care activities (HC.6) approx. 45% followed by general outpatient care.

**Fig. 12.1: Government health expenditure on primary health care by functions %**



## 13. Technical Notes

This section describes the technical aspects related to the production of this NHA 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 2014 to 2018-19 using the SHA 2011 classification system.

As access to more detailed data increases and estimation techniques improve, health accounts expenditure estimates will also continue to change. Thus, readers will note that some expenditure figures reported here for the years 2014 to 2018-2019 may differ from that presented in previous NHA reports for those years.

Since 2011 the Fiji NHA has used the SHA 2011 methodology to classify health expenditure. The challenges relating to the SHA 2011 methodology has overtime decreased as our experience with the methodology grew.

### 13.1 Fiji SHA 2011 Classifications

The existing Fiji SHA 2011 classification was mapped to the classification module in NHAPT for classifying health expenditures for 2018-19. This mapping was done easily with some minor changes including the creation of some new categories for better reporting of health expenditure. The Fiji SHA 2011 classification can be viewed in the matrices as the end of this report.

### 13.2 Government data sources

Government data was primarily obtained from the following sources:

- Financial data from the Ministry of Economy (FMIS)
- Patient utilization data from the Health Information Unit for the MHMS
- Pharmaceutical data from the Fiji Pharmaceutical & Biomedical Services
- National macro-economic data was obtained from the Fiji Bureau of Statistics
- Expert opinions from various staff of the MHMS

#### 13.2.1 Financial Data

The audited financial data for the years 2018-19 was obtained from the Ministry of Economy. 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.

### 13.2.1.1 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)

### 13.2.1.2 Disease-based data

Inpatient disease data coded by ICD-10 classification was obtained from the Health Information Unit for the years 2018-19. This data had to be mapped to the disease classification in the NHAPT.

### 13.2.1.3 Macro level data

This data was obtained from the Fiji Bureau of Statistics (FBOS) office. The macro level data included Gross Domestic Product, Total government spending and National population figures.

## 13.2.2 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.

### 13.2.2.1 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 MHMS 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.

### 13.2.2.2 Health Providers (HP)

The GL codes in the FMIS system allowed mapping of some expenditures directly to public health facilities and programs. With regards to health facilities, each hospital and Health Centre has its own unique cost-center code embedded within the GL code. This was not the case with most Nursing Stations (apart from some nursing stations in the maritime zones) which reported all their expenditures under one GL code. It was difficult to disaggregate individual expenditures by each Nursing Station and so these were together reported under one HP classification code.

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 2011 classification.



There were cases where one GL code represented expenditure for more than one health facility and where these facilities had unique individual mapping codes in the HP classification. In such circumstances rules of allocation were developed to distribute expenditures to the appropriate health facilities. The rules of allocation were developed according to 3 methods based on what data was available.

The 3 methods in order of preference were:

- Utilization of service or actual transactions enabled distribution of expenditure.
- Allocated budgets used as proportions to distribute actual expenditure.
- Expert opinion on the percentage distribution of the expenditure.

For example, sanitary expenditure for several facilities is recorded under one GL code. To distribute this expenditure across the different facilities to enable mapping to the health provider (HP) classification, the allocated budget to each facility as specified in the service agreement to the contracted party was used as the rule of allocation. Examples of other expenditure that required distribution included security services, cleaning services, pharmaceuticals and other supplies from FPBS, etc.

There were cases where separation of expenditure was not possible. In these situations, the core NHA technical team had to decide to which provider in the classification the expenditure was best coded to. For example, some Nursing Stations expenditure was locked under the GL code of the nearest Health Centre. However, it was not possible to estimate what this Nursing station expenditure was and thus this was left coded to the HP classification for that Health Centre rather than to the HP code for Nursing Stations.

The Fiji Pharmaceutical and Biomedical Service (FPBS) expenditure was reported under 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.

### 13.2.2.3 Health Functions (HC)

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

Expert opinion was obtained from senior management within facilities on the percentage distribution of expenditure by functions for their facilities. 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.

In some instances, where data was not available, utilization of services was used to distribute expenditure to various functions.

### 13.2.2.4 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 (SEG 9 and SEG 10) that represented all capital related expenditure. Capital expenditure reported here only pertains to capital acquisitions and purchases during the reported period. Changes in inventories, capital consumption and disposable of assets were not accounted for.

### 13.2.2.5 Disease-based expenditure

Coding of expenditure by disease was done using the patient utilization data from the Health Information Unit of the MHMS. Inpatient data provided both patient days and ICD-10 coding which was used as allocation keys for distributing expenditure coded under the inpatient functional classification. The disease ICD-10 classification was then mapped to the disease DIS classification in the NHAPT.

Outpatient data was used to provide the number of outpatient visits. Outpatient data disease conditions had to be mapped to the DIS category of the NHAPT.

Disease mapping from ICD-10 to DIS followed the SHA 2011 guidelines on mapping and assistance was also sought from Coders working at the HIU in the MHMS.

## 13.3 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 five years. Some providers have increased their response rates while others have declined. The most notable decline was observed amongst Private General Practitioners.

**Table 1: Response rates of surveys of the private sector**

	Surveyed population				Response Rates (%)			
Name	2014	2015	2017-18	2018-19	2014	2015	2017-18	2018-19
General Practitioners	126	140	106	91	78	53	66	55
Private Dentist	33	38	39	37	85	74	72	68
Retail Pharmacies	58	60	71	62	66	72	83	55
Private Hospitals	2	3	5	4	100	67	80	75
Private Employers	27	25	12	4	52	20	33	50
Private Laboratory and X-Ray	2	2	5	4	100	100	60	25

<b>Private Insurance</b>	4	4	4	2	50	0	75	0
<b>Private Optometrists</b>	15	14	17	14	80	86	71	86
<b>Development Partners</b>	18	15	14	10	28	33	57	60
<b>NGO's</b>	25	23	12	7	0	13	33	57
<b>Overall Response Rate Across all health providers surveyed</b>					66	54	68	58

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 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 patients 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 and the outliers 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, private ancillary services, private hospital, and development partners. Those who responded were included and those that did not respond were excluded (providers were excluded only they failed to respond after several attempts to contact them). In case of Development partners, the expenditure by KOICA has been taken from the OECD- CRS data. This database was also used for better understanding of the program by the development partner and the appropriate coding according to SHA 2011.

To estimate health insurance expenditure the Reserve Bank of Fiji 2019 annual report on insurance was used to provide the estimate for health insurance along with insurance surveys. This amount was then distributed across the various classifications using responses from the 2018-19 NHA surveys.

For some reported expenditure 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).

Outpatient disease distribution for the Private sector was based on survey responses while inpatient disease distribution was done using the public sector inpatient disease distribution allocation keys.

### 13.3.1 Private Sector survey limitations

Despite the increased experience with conducting these NHA surveys over the last 5 years, various limitations still exist. It is important that these are noted and understood especially when interpreting the health expenditure numbers presented of the private sector in this report.

- The low response rates from across the providers but especially from private general practitioners, development partners, insurance companies and employers mean that the health expenditure numbers reported here are likely under-reported. Private General Practitioners, insurance companies and employers' response rates are at their lowest ever this year since these surveys commenced in 2010.
- 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 to reduce both length and complexity. The shift towards using the NHAPT required that surveys for employers, donors and NGOs were generated automatically within NHAPT. Respondents found these electronic surveys complex and difficult to fill. This may have contributed to the reduced response rates observed in this round of NHA.

### 13.4 Lessons learnt

This section details the lessons learnt from the entire process during the production of this 2018-19 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.
- Data received in the private surveys perhaps can be compared with other sources of data to improve estimates. These other sources include:
  - Aggregate revenue data obtained from FRCA across the different providers.
  - Total out-of-pocket health expenditure reported in HIES
  - Global donor databases that record funds disbursed to countries e.g. OECD DAH
- 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 annual surveys separately).
- Despite several rounds of 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 MHMS.
- Institutional memory of the NHA process needs to document and captured annually since every yearly production has its own nuances. This would make easy the future production of NHA by giving clarity to future committee members on what procedures and estimation techniques was 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 MHMS and the Finance Ministry needs to happen where requests should be made that all health providers be given the status of cost centers in the system. This is possible since already 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. Health facility utilization data should be improved as this would be most useful for

classifying expenditure by functions. Current method where data is distributed largely based on expert opinion should be replaced with more accurate routine data sources.

- Disease based coding of data should be further strengthened. It would be helpful if all facilities that provided inpatient data had individual patient data coded by ICD-10. Outpatient data should also be classified to some disease classification (ICD-10 preferably) for all health facilities including Health Centers and Nursing Stations.
- 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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## 15 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 centers 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.

**Employer-based insurance** One main type of group insurance is insurance purchased by employers, through a contract between the employer (the company) and the insurance entity. The premium paid by the employer is usually risk-related at the group level, but the contributions paid by the individuals are usually not risk-related.

**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.

**Government-based voluntary insurance** this specific type of insurance scheme is initiated and subsidized by the government in order to provide primary coverage for specific groups of the population. Such schemes may be initiated, for example, when the government does not have the administrative capacity necessary for running a compulsory insurance.

**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** include 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)

**Other primary coverage schemes** this category includes primary coverage insurance taken by individuals or group insurance other than Employer-based insurance and Government-based voluntary insurance. For example, insurance companies can offer group insurance to patient organisations and the like.

**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** comprise 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 health 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 e.g. cash grants

**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. E.g., premiums received from an insurer to secure benefits of the voluntary health insurance schemes

## 16. Matrices

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**Table 1: Financing schemes (HF) by Revenues of health care financing schemes (FS), 2018-19**

<b>FJ\$(m)</b>	<b>Transfers from government domestic revenue (allocated to health purposes)</b>	<b>Transfers distributed by government from foreign origin</b>	<b>Voluntary prepayment</b>	<b>Voluntary prepayment from individuals/households</b>	<b>Voluntary prepayment from employers</b>	<b>Other domestic revenues n.e.c.</b>	<b>Direct foreign transfers</b>	<b>ALL FS</b>
<b>Government schemes and compulsory contributory health care financing schemes</b>	310.3	1.7						312
<b>Voluntary health care payment schemes</b>	0.5	0	49.4	14.7	34.7	5	1.2	56.1
<b>Employer-based insurance (Other than enterprises schemes)</b>			34.7		34.7			34.7
<b>Other primary coverage schemes</b>			14.7	14.7				14.7
<b>NPISH financing schemes (including development agencies)</b>	0.5					1	1.2	2.6
<b>Enterprise financing schemes</b>						4		4
<b>Household out-of-pocket payment</b>						96.5		96.5
<b>Out-of-pocket excluding cost-sharing</b>						90		90
<b>Cost sharing with government schemes and compulsory contributory health insurance schemes</b>						6.5		6.5
<b>Rest of the world financing schemes (non-resident)</b>		0.1					39.1	39.2
<b>ALL HF</b>	<b>310.8</b>	<b>1.7</b>	<b>49.4</b>	<b>14.7</b>	<b>34.7</b>	<b>101.4</b>	<b>40.3</b>	<b>503.6</b>

**Table 2: Health care providers (HP) by Revenues of health care financing schemes (FS), 2018-19**

<b>FJ\$(m)</b>	<b>Transfers from government domestic revenue (allocated to health purposes)</b>	<b>Transfers distributed by government from foreign origin</b>	<b>Voluntary prepayment</b>	<b>Voluntary prepayment from individuals/households</b>	<b>Voluntary prepayment from employers</b>	<b>Other domestic revenues n.e.c.</b>	<b>Direct foreign transfers</b>	<b>ALL FS</b>
<b>Hospitals</b>	244.8		18.2	5.7	12.5	23.1		286
<b>Divisional Hospitals</b>	156.1		0.3		0.2			156
<b>Subdivisional Hospitals</b>	77.2					6.5		84
<b>Private Hospitals</b>			18	5.7	12.3	16.6		35
<b>Mental health hospitals</b>	5.9							5.9
<b>Specialised hospitals (Other than mental health hospitals)</b>	5.7							5.7
<b>Residential long-term care facilities</b>	0.2							0.2
<b>Providers of ambulatory health care</b>	19.9		6.9	1.8	5.1	20.1		47
<b>Private medical practices (GPs)</b>			6.4	1.6	4.7	12.2		19
<b>Private dental practice</b>			0.2	0.1	0.1	5.3		5.5
<b>Nursing stations</b>	0.5							0.5
<b>Community health workers</b>	1.9							1.9
<b>Optometrists</b>			0.4	0.1	0.3	2.6		3
<b>Primary Healthcare Centres</b>	17.5							18
<b>Providers of ancillary services</b>	3.2		5	5		7.6		16

Providers of patient transportation and emergency rescue	3							3
Medical and diagnostic laboratories			5	5		7.6		13
National blood services	0.2							0.2
Retailers and Other providers of medical goods			5	1.7	3.3	50.4		55
Providers of preventive care	18.7	1.2				0.2	2.2	22
Providers of health care system administration and financing	21.7	0.3					37.4	59
Rest of economy		0.2						0.2
Rest of the world	2.3		14.2	0.5	13.8		0.7	17
<b>ALL HP</b>	<b>310.8</b>	<b>1.7</b>	<b>49.4</b>	<b>14.7</b>	<b>34.7</b>	<b>101.4</b>	<b>40.3</b>	<b>503.6</b>

**Table 3: Health care providers (HP) by Financing schemes (HF), 2018-19**

FJ\$(m)	Government schemes and compulsory contributory health care financing schemes	Voluntary health care payment schemes	Employer-based insurance (Other than enterprises schemes)	Other primary coverage schemes	Household out-of-pocket payment	Rest of the world financing schemes (non-resident)	ALL HF
<b>Hospitals</b>	<b>233.3</b>	<b>21.2</b>	<b>12.5</b>	<b>5.7</b>	<b>20.1</b>		<b>286.1</b>
Divisional Hospitals	156.1	0.3	0.2				156.4
Subdivisional Hospitals	77.2				6.5		83.6
Private Hospital		21	12.3	5.7	13.6		34.5
Mental health hospitals	5.9						5.9
Specialised hospitals (Other than mental health hospitals)	5.7						5.7
Residential long-term care facilities		0.2					0.2
Providers of ambulatory health care	19.9	7.6	5.1	1.8	19.5		46.9
Private medical practices (GPs)		6.8	4.7	1.6	11.7		18.5
Private dental practice		0.3	0.1	0.1	5.2		5.5
Nursing stations	0.5						0.5
Community health workers	1.9						1.9
Optometrists		0.5	0.3	0.1	2.5		3
Primary Healthcare Centres	17.5						17.5
Providers of ancillary services	3.2	5		5	7.6		15.8
Providers of patient transportation and emergency rescue	3						3
Medical and diagnostic laboratories		5		5	7.6		12.6
National blood services	0.2						0.2



<b>Retailers and Other providers of medical goods</b>		<b>6.1</b>	<b>3.3</b>	<b>1.7</b>	<b>49.3</b>		<b>55.4</b>
<b>Providers of preventive care</b>	<b>19.6</b>	<b>1.7</b>				<b>1.1</b>	<b>22.4</b>
<b>Providers of health care system administration and financing</b>	<b>22</b>					<b>37.4</b>	<b>59.3</b>
<b>Rest of economy</b>	<b>0.2</b>						<b>0.2</b>
<b>Rest of the world</b>	<b>2.3</b>	<b>14.3</b>	<b>13.8</b>	<b>0.5</b>		<b>0.7</b>	<b>17.2</b>
<b>ALL HP</b>	<b>300.4</b>	<b>56</b>	<b>34.7</b>	<b>14.7</b>	<b>96.5</b>	<b>39.2</b>	<b>503.6</b>

**Table 4: Health care providers (HP) by Health care functions (HC), 2018-19**

FJ\$(m)	Inpatient curative care	Outpatient curative care	Rehabilitative care	Long-term care (health)	Ancillary services (non-specified by function)	Medical goods (non-specified by function)	Preventive care	Governance, and health system and financing administration	Other health care services not elsewhere classified (n.e.c.)	ALL HC
<b>Hospitals</b>	<b>95.7</b>	<b>123.1</b>	<b>12</b>		<b>10.7</b>	<b>0.1</b>	<b>44.6</b>			<b>286.1</b>
Divisional Hospitals	54.2	75.1	3.8		2.7		20.6			<b>156.4</b>
Subdivisional Hospitals	23.6	35.4	1.9		1.6		21.1			<b>83.6</b>
Private Hospital	15.6	11.2			6.4	0.1	1.2			<b>34.5</b>
Mental health hospitals	2.3	1.3	0.6				1.6			<b>5.9</b>
Specialised hospitals (Other than mental health hospitals)			5.6							<b>5.7</b>
Residential long-term care facilities							<b>0.1</b>			<b>0.2</b>
Providers of ambulatory health care	<b>2.3</b>	<b>28.2</b>			<b>0.8</b>	<b>1.3</b>	<b>14.3</b>			<b>46.9</b>
Private medical practices (GPs)	2.1	15.1			0.8		0.5			<b>18.5</b>
Private dental practice		5.5								<b>5.5</b>
Nursing stations							0.5			<b>0.5</b>
Community health workers							1.9			<b>1.9</b>
Optometrists	0.2	1.5				1.3				<b>3</b>

Primary Healthcare Centres		6.1					11.3			17.5
Providers of ancillary services					15.8					15.8
Providers of patient transportation and emergency rescue					3					3
Medical and diagnostic laboratories					12.6					12.6
National blood services					0.2					0.2
Retailers and Other providers of medical goods						55.4				55.4
Providers of preventive care	0.5	1			0.3		18.8		1.8	22.4
Providers of health care system administration and financing	1.1	1.8	0.1				0.4	55.9		59.3
Rest of economy							0.2			0.2
Rest of the world	12.2	3.3			1.4	0.1	0.2			17.2
ALL HP	111.8	157.4	12.2		29.1	56.9	78.5	55.9	1.8	503.6

**Table 5: Health care functions (HC) by Revenues of health care financing schemes (FS), 2018-19**

<b>FJ\$(m)</b>	<b>Transfers from government domestic revenue (allocated to health purposes)</b>	<b>Transfers distributed by government from foreign origin</b>	<b>Voluntary prepayment</b>	<b>Other domestic revenues n.e.c.</b>	<b>Direct foreign transfers</b>	<b>ALL FS</b>
<b>Curative care</b>	<b>197.2</b>	<b>0.5</b>	<b>33.3</b>	<b>37.4</b>	<b>0.7</b>	<b>269.2</b>
Inpatient curative care	83.6		20.6	6.9	0.7	111.8
Day curative care	16.9		1.2	1.8		19.9
Outpatient curative care	96.8	0.5	11.6	28.6		137.5
Rehabilitative care	<b>12.2</b>					<b>12.2</b>
Long-term care (health)						<b>0</b>
Ancillary services (non-specified by function)	<b>7.8</b>		<b>9.9</b>	<b>11.4</b>		<b>29.1</b>
Laboratory services	0.9		6.7	8		15.6
Imaging services	0.7		3.3	3.4		7.4
Patient transportation	6.1					6.1
Medical goods (non-specified by function)			<b>5.3</b>	<b>51.6</b>		<b>56.9</b>
Prescribed medicines			1.8	18.2		20
Over-the-counter medicines			1.7	17.7		19.4
Other medical non-durable goods			0.5	5		5.5
Glasses and Other vision products			0.3	1.2		1.5
Hearing aids						0
All Other medical durables, including medical technical devices			0.4	4		4.4
Unspecified medical goods (n.e.c.)			0.5	5.5		6.1

Preventive care	75.3	1	0.8	1	0.4	78.5
Information, education and counselling (IEC) programmes	19.4	0.4	0.3		0.1	20.2
Immunisation programmes	11.3	0.1				11.4
Early disease detection programmes	13					13
Healthy condition monitoring programmes	10	0.3			0.3	10.6
	11.2					11.2
Preparing for disaster and emergency response programmes	10.4					10.4
Unspecified preventive care (n.e.c.)		0.1	0.5	1		1.7
Governance, and health system and financing administration	18.2	0.3			37.4	55.9
Other health care services not elsewhere classified (n.e.c.)					1.8	1.8
ALL HC	310.8	1.7	49.4	101.4	40.3	503.6

**Table 6: Health care functions (HC) by Financing schemes (HF), 2018-19**

FJ\$(m)	Government schemes and compulsory contributory health care financing schemes	Voluntary health care payment schemes	Employer-based insurance (Other than enterprises schemes)	Other primary coverage schemes	NPISH financing schemes (including development agencies)	Enterprise financing schemes	Household out-of-pocket payment	Rest of the world financing schemes (non-resident)	ALL HF
Curative care	197.6	36.6	26.9	6.4	0.5	2.7	34.3	0.7	269.2
Inpatient curative care	83.6	22	17.9	2.7	0.2	1.2	5.5	0.7	111.8
Day curative care	16.9	1.5	0.6	0.6		0.3	1.5		19.9
Outpatient curative care	97.1	13	8.5	3.1	0.3	1.1	27.3		137.5
Rehabilitative care	12.1								12.2
Long-term care (health)									0
Ancillary services (non-specified by function)	7.8	10.6	3.6	6.3		0.6	10.8		29.1
Laboratory services	0.9	7.1	2.2	4.4		0.5	7.6		15.6
Imaging services	0.7	3.5	1.4	1.9		0.2	3.2		7.4
Patient transportation	6.1								6.1
Medical goods (non-specified by function)		6.4	3.6	1.7	0.6	0.6	50.5		56.9
Prescribed medicines		2.2	1.2	0.6	0.2	0.2	17.8		20
Over-the-counter medicines		2.1	1.2	0.6	0.2	0.2	17.3		19.4

Other medical non-durable goods		0.6	0.3	0.2	0.1	0.1	4.9		5.5
Glasses and Other vision products		0.3	0.2	0.1			1.2		1.5
Hearing aids									0
All Other medical durables, including medical technical devices		0.5	0.3	0.1			3.9		4.4
Unspecified medical goods (n.e.c.)		0.7	0.4	0.2	0.1	0.1	5.4		6.1
Preventive care	75.9	1.3	0.6	0.3	0.3	0.1	0.9	0.4	78.5
Information, education and counseling (IEC) programmes	19.5	0.6	0.3		0.3			0.1	20.2
Immunisation programmes	11.4								11.4
Early disease detection programmes	13								13
Healthy condition monitoring programmes	10.3							0.3	10.6
	11.1	0.1							11.2
Preparing for disaster and emergency	10.4								10.4

<b>response programmes</b>									
<b>Unspecified preventive care (n.e.c.)</b>	0.1	0.6	0.3	0.3		0.1	0.9		1.7
<b>Governance, and health system and financing administration</b>	18.5							37.4	55.9
<b>Other health care services not elsewhere classified (n.e.c.)</b>		1.1			1.1			0.7	1.8
<b>ALL HC</b>	312	56.1	34.7	14.7	2.6	4	96.5	39.2	503.6



**Table 7: Factors of health care provision (FP) by Revenues of health care financing schemes (FS), 2018-19**

<b>FJ\$(m)</b>	<b>Transfers from government domestic revenue (allocated to health purposes)</b>	<b>Transfers distributed by government from foreign origin</b>	<b>Voluntary prepayment</b>	<b>Other domestic revenues n.e.c.</b>	<b>Direct foreign transfers</b>	<b>ALL FS</b>
<b>Compensation of employees</b>	<b>220.7</b>		<b>10.9</b>	<b>26.6</b>		<b>258.2</b>
Wages and salaries	198.4		10.9	26.6		236
Social contributions	18.3					18.3
All Other costs related to employees	4					4
Self-employed professional remuneration	4.9					4.9
<b>Materials and services used</b>	<b>65</b>	<b>1.7</b>	<b>38.5</b>	<b>74.9</b>	<b>40.2</b>	<b>220.3</b>
Laboratory & Imaging services	5.8		3.8			9.7
Other health care services (n.e.c.)	10.6		21.9	17.9	0.8	51.2
Vaccines	5.9					5.9
Contraceptives					0.2	0.2
Other pharmaceuticals (n.e.c.)	12.3		3.8	28.2		44.3
Diagnostic equipment						
Other and unspecified health care goods (n.e.c.)	9.6		5.7	17.1		32.5
Training	0.1				1.7	1.7
Technical Assistance		1.5			37.6	39.1
Operational research						0
Indemnity	0.2					0.2
Other non-health care services (n.e.c.)	5.4		3.2	11.6		20.2

Non-health care goods	8.6					8.6
Other materials and services used (n.e.c.)	6.4	0.2				6.6
Other items of spending on inputs	20.3					20.3
Taxes	6.8					6.8
Other items of spending	13.5					13.5
Unspecified factors of health care provision (n.e.c.)						
ALL FP	310.8	1.7	49.4	101.4	40.3	503.6

**Table 8: Classification of diseases / conditions (DIS) by Revenues of health care financing schemes (FS), 2018-19**

FJ\$(m)	Transfers from government domestic revenue (allocated to health purposes)	Transfers distributed by government from foreign origin	Voluntary prepayment	Other domestic revenues n.e.c.	Direct foreign transfers	ALL FS
Infectious and parasitic diseases	121.3	0.6	6.5	15.3		143.7
HIV/AIDS	29.9		0.1			30
TB/HIV	8.3		0.2			8.5
Other OIs due to AIDS	1.1					1.2
Unspecified HIV/AIDS and OIs (n.e.c.)	1.9		0.5			2.5
STDs Other than HIV/AIDS	0.4					0.4
Unspecified HIV/AIDS and Other STDs (n.e.c.)	4.1		0.4	0.1		4.5
Drug-Sensitive Tuberculosis (DS-TB)	3.9					3.9
Multidrug-resistant Tuberculosis (MDR-TB)	3		0.1			3.1
Extensively drug-resistant Tuberculosis (XDR-TB)	0.4					0.4

Unspecified Pulmonary Tuberculosis (n.e.c.)	8.1		0.3			8.4
Extra pulmonary TB	2.9		0.1			3
Unspecified tuberculosis (n.e.c.)	4.4	0.1	0.2			4.6
Malaria	3.2		0.1			3.3
Respiratory infections	6.1		0.9	1.1		8.1
Diarrheal diseases	6.2		0.1			6.3
Neglected tropical diseases	6.6	0.2				6.8
Vaccine preventable diseases	11.4	0.1				11.6
Other and unspecified infectious and parasitic diseases (n.e.c.)	19.3	0.2	3.5	14.1		37.1
Reproductive health	<b>20.4</b>	<b>0.1</b>	<b>2.8</b>	<b>3.9</b>	<b>0.4</b>	<b>27.6</b>
Pregnancy	6.1		0.1	0.2		6.5
Obs and gynae	0.9		0.1			1.1
Other Maternal conditions	0.4		0.2			0.6
Perinatal conditions	5.4		0.8	1		7.3
Contraceptive management (family planning)	2.8					3.1
Male reproductive conditions	1.2		0.1			1.3
Unspecified reproductive health conditions (n.e.c.)	3.5	0.1	1.4	2.6		7.7
Nutritional deficiencies	<b>1.9</b>	<b>0.3</b>	<b>2.8</b>	<b>9</b>		<b>14</b>
Noncommunicable diseases	<b>112.2</b>	<b>0.2</b>	<b>23.1</b>	<b>59.3</b>	<b>1.1</b>	<b>195.8</b>
Neoplasms	3.3		3.2	0.4		6.9
Musco skeletal	12.8		1.1	0.2		14.1

Diabetes	2.1		0.2			2.3
Dual hypertension and diabetes						
Other and unspecified endocrine and metabolic disorders (n.e.c.)	2.3		0.1			2.3
Hypertensive diseases	5.4		0.2			5.6
Other and unspecified cardiovascular diseases (n.e.c.)	5.2		2.5	0.1		7.8
Mental (psychiatric) disorders	0.3					0.3
Behavioural disorders						
Neurological conditions	0.3		0.1	0.1		0.4
Unspecified mental & behavioural disorders and neurological conditions (n.e.c.)	4.5	0.1				4.6
Respiratory diseases	15.6		3.2	11.9		30.6
Diseases of the digestive	9.8		1.1	1		11.9
Diseases of the genito-urinary system	0.7		1.9	2.3		4.9
Eye conditions	9.4		0.5	2.6	1.1	13.6
Ear nose throat conditions	2.3		0.2	0.1		2.6
Skin conditions	5.2		1	0.5		6.6
Other Sense organ disorders	0.3					0.3
Oral diseases	15.7		0.2	5.3		21.2
Other and unspecified non-communicable diseases (n.e.c.)	17	0.1	7.7	34.7		59.5
Injuries	20.2		4.7	1.7		26.6
Attempted self-harm	0.1					0.1
Minor procedures	17		3.6			20.6

<b>Other Injuries</b>	<b>3.1</b>		<b>1.1</b>	<b>1.7</b>		<b>5.9</b>
<b>Non-disease specific</b>	<b>20.8</b>		<b>0.2</b>	<b>0.9</b>	<b>37.4</b>	<b>59.3</b>
<b>Rehabilitative Care</b>	<b>9.2</b>					<b>9.2</b>
<b>Long-term care</b>						
<b>Other and unspecified diseases/conditions (n.e.c.)</b>	<b>4.7</b>	<b>0.5</b>	<b>9.3</b>	<b>11.5</b>	<b>1.4</b>	<b>27.4</b>
<b>ALL DIS</b>	<b>310.8</b>	<b>1.7</b>	<b>49.4</b>	<b>101.4</b>	<b>40.3</b>	<b>503.6</b>

**Table 9: Capital Account (HK) by Institutional units providing revenues to financing schemes (FA), 2018-19**

<b>FJ\$(m)</b>	<b>General government</b>	<b>Corporations (Other than insurance corporations) (part of HF.RI.1.2)</b>	<b>Non-profit institutions serving households (NPISH)</b>	<b>All FA</b>
<b>Gross capital formation</b>	<b>26.9</b>	<b>7.6</b>	<b>1.1</b>	<b>35.6</b>
<b>Infrastructure</b>	<b>21.7</b>	<b>4.3</b>	<b>0</b>	<b>26</b>
<b>Residential and non-residential buildings</b>	<b>21.7</b>	<b>4.3</b>		<b>26</b>
<b>Machinery and equipment</b>	<b>5.2</b>	<b>2.7</b>	<b>1.1</b>	<b>9</b>
<b>Medical equipment</b>	<b>4.8</b>	<b>1.9</b>	<b>1.1</b>	<b>7.7</b>
<b>Transport equipment</b>		<b>0.3</b>		<b>0.3</b>
<b>ICT equipment</b>	<b>0.4</b>	<b>0.5</b>		<b>1</b>
<b>Intellectual property products</b>	<b>0</b>	<b>0.6</b>	<b>0</b>	<b>0.6</b>
<b>Computer software and databases</b>		<b>0.6</b>		<b>0.6</b>
<b>Non-produced non-financial assets</b>		<b>0.1</b>		<b>0.1</b>
<b>Land</b>		<b>0.1</b>		<b>0.1</b>
<b>Unspecified gross fixed capital formation (n.e.c.)</b>	<b>0.5</b>	<b>0.2</b>		<b>0.6</b>
<b>All HK</b>	<b>27.4</b>	<b>7.9</b>	<b>1.1</b>	<b>36.3</b>

