

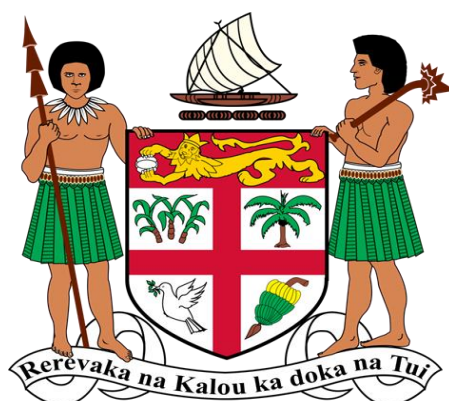


**MINISTRY OF HEALTH
& MEDICAL SERVICES**

Fiji Health ACCOUNTS

NATIONAL HEALTH EXPENDITURE 2016 - 2021

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Fiji Health Accounts

National Health Expenditure

2016-2021

A publication of the Ministry of Health and Medical Services.

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Abbreviations

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

Foreword



The National Health Accounts [NHA] for the fiscal years 2016–2021 are presented with great pleasure. Relevant data on health expenditure changes over a five-year period is included in the study. Considered by both internal and external stakeholders as the primary source of health spending information, NHA offers the Ministry with valuable baseline data to support policy decisions.

Understanding the many funding sources and changing trends in health spending has been made easier with the help of the NHA report, which provides an overview of the country's health expenditure flows across time. The amount that each household must pay out-of-pocket is a crucial metric for guiding our efforts toward universal health care. This

paper examines health care systems and services from a spending standpoint, offering valuable insights into financial structures and health service accessibility.

Fiji's current health expenditure (CHE) was estimated to be FJ\$588.6m in 2020–21, or FJ\$624.2 per capita. In 2020-21, CHE was funded by a combination of public (FJ\$326m) and private (FJ\$220m) sources, as well as from development partners (FJ\$42.6m).

Curative care in 2020-21 was made up of 40.3% of inpatient care costs and 59.7% of outpatient care costs. Non-communicable Diseases (NCDs), which include accidents and nutritional inadequacies, accounted for most spending in 2020-21 and amounted to 52.3% of the total CHE.

The longer-term goal of the ministry is to work toward a more comprehensive health finance model that offers equal access to high-quality treatments and sufficient financial risk protection. The NHA estimates provide baseline data that can help in the development of programs targeted at reducing out-of-pocket expenses and improving service coverage and access.

I am grateful for the dedication and hard work of the NHA Committee on this initiative, together with the crucial support from other industries and important stakeholders. Decision-makers can use the information in this study to develop strategies that will increase access, equity, efficiency, and financial risk protection while advancing the larger goal of universal health coverage.

A handwritten signature in blue ink, appearing to be 'J. Tudravu', written over a light blue grid background.

.....
Dr. Jemesa Tudravu

Permanent Secretary for Health and Medical Services

Executive Summary

The total estimated health spending in the nation incurred by the public and private sectors, is known as the National Health Account (NHA). NHA offers data that can assist a nation in monitoring health spending, starting from funding sources and ending with beneficiaries (end users) of health services. According to estimates, Fiji's current health expenditure (CHE) has reached FJ\$588.6 million in 2020–21, with a per capita health spending of FJ\$624.2, or USD\$296. In 2020–21, the total amount of funding allocated to CHE was FJ\$ 326 million (55.4%), FJ\$ 220 million (37.4%), and FJ\$ 42.5 million (7.2%) from development partners.

Estimates for CHE as a percentage of GDP in 2020–21 place it at 6.1%. The average ratio of CHE to GDP throughout the five-year period from 2016 to 2020–21 was 4.6%. 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).

Household expenditure was the main source of the 37.4% of CHE that came from the private sector. Most household expenses were paid for out of pocket (OOP). In terms of percentages, the OOP expenditure was 23.1% of CHE and 59.0% of Private Current Health Expenditure (PCHE).

The majority of CHE was found in hospitals. In 2020–21, state funding accounted for 78.0% of hospital expenses, with the private sector (including development partners) covering the remaining 22.0%. In 2020–21, ambulatory healthcare providers made up 11.9% (FJ\$69.9m). Between 2020 and 2021, the majority of CHE (55.2%) was attributed to curative care. The cost of curative care in 2020–21 is made up of 40.3% of inpatient care and 59.7% of outpatient care. Spending on preventive healthcare was 19.9% in 2020–21.

The human resource costs for GCHE in 2020–21 was \$147.1 million, or 45.1% of GCHE, and 29.8% of CHE. In 2020–21, government capital spending accounted for 6.8% of government health expenditures (GHE).

Non-communicable diseases (NCDs), which include accidents and malnutrition, had the highest costs in 2020–21, accounting for 52.3% of all CHE. Spending on Maternal and Child Health (MCH) accounted for 11.6% of CHE, while spending on communicable diseases (CD) accounted for 29.5%.

The health care system is described in this study from the standpoint of spending. In an effort to bring services closer to our inhabitants and hasten Fiji's transition to "Universal Health Coverage," this information gives policy and decision makers the chance to improve access, equity, efficiency, and financial risk protection.

Summary of Key Indicators 2016 - 2020/21

| No. | Indicators | 2016-17 | 2017-18 | 2018-19 | 2019-20 | 2020-21 |
|-----|---|----------|----------|----------|----------|---------|
| 1 | Population | 869458 | 884887 | 918465 | 922317 | 942956 |
| 2 | Gross Domestic Product (GDP) (FJ\$m) | 10,327.3 | 11,065.0 | 11,650.6 | 11,762.1 | 9,613.2 |
| 3 | Total Government Expenditure (TGE) (FJ\$m) | 3,024.4 | 3742.2 | 3600.3 | 3353.7 | 3190.3 |
| 4 | Current Health Expenditure (CHE) (FJ\$m) | 357.5 | 478.4 | 503.5 | 532.5 | 588.6 |
| 5 | Capital expenditure (HK) (FJ\$m) | 38.1 | 42.0 | 36.3 | 38.7 | 38.0 |
| 6 | CHE plus capital expenditure (FJ\$m) | 395.6 | 520.4 | 539.8 | 571.1 | 626.6 |
| 7 | CHE per capita (FJ\$) | 411.2 | 540.6 | 548.2 | 577.3 | 624.2 |
| 8 | Government Current health expenditure (GCHE) (FJ\$m) | 233.6 | 286.0 | 310.8 | 312.3 | 326.0 |
| 9 | Private Current health expenditure (PCHE) (FJ\$m) | 110.9 | 158.1 | 150.7 | 191.6 | 220.2 |
| 10 | Development partner Current health expenditure (FJ\$m) | 13.1 | 34.2 | 42.0 | 28.6 | 42.5 |
| 11 | GCHE as a % CHE | 65.3% | 59.8% | 61.7% | 58.7% | 55.4% |
| 12 | PCHE as a % of CHE | 31.0% | 33.1% | 29.9% | 36.0% | 37.4% |
| 13 | Development partner Current health expenditure as a % CHE | 3.7% | 7.2% | 8.3% | 5.4% | 7.2% |
| 14 | CHE as a % of GDP | 3.5% | 4.3% | 4.3% | 4.5% | 6.1% |
| 15 | GHE as a % of TGE | 8.6% | 8.3% | 9.4% | 10.1% | 11.0% |
| 16 | GCHE as a % of GDP | 2.3% | 2.6% | 2.7% | 2.7% | 3.4% |
| 17 | PCHE as a % of GDP | 1.1% | 1.4% | 1.3% | 1.6% | 2.3% |
| 18 | GCHE per capita (FJ\$) | 268.6 | 329.0 | 357.5 | 359.2 | 375.0 |
| 19 | Government financing Schemes as a % of CHE | 65.3% | 61.1% | 62.0% | 61.0% | 55.6% |
| 20 | Voluntary Health Insurance Schemes as a % of CHE | 14.6% | 11.1% | 9.8% | 12.2% | 12.2% |
| 21 | Out of Pocket (OOP) Expenditure as a % of CHE | 17.3% | 18.0% | 19.2% | 21.8% | 23.1% |
| 22 | Curative expenditure as a % of CHE | 55.30% | 52.7% | 58.4% | 54.2% | 55.2% |
| 23 | Inpatient expenditure as a % of Curative expenditure | 38.50% | 38.87% | 44.60% | 39.41% | 40.33% |
| 24 | Outpatient expenditure as a % of Curative expenditure | 61.50% | 61.13% | 55.40% | 60.59% | 59.67% |
| 25 | Preventive expenditure as a % of CHE | 22.1% | 21.2% | 16.4% | 20.0% | 19.9% |
| 26 | Government Health Administration expenditure as a % of GCHE | 4.0% | 5.9% | 4.5% | 4.3% | 6.2% |
| 27 | Hospital spending as a % of CHE | 50.8% | 53.9% | 56.3% | 55.6% | 51.9% |
| 28 | Ambulatory health care providers as a % of CHE | 21.2% | 12.7% | 9.3% | 10.2% | 11.9% |
| 29 | Medical goods as a % of CHE (excludes Government) | 12.2% | 10.9% | 11.0% | 16.2% | 16.1% |
| 30 | Expenditure on Government Human Resources as a % of GCHE | 82.00% | 68.70% | 71.00% | 70.5% | 70.9% |

| | | | | | | |
|----|---|--------|--------|--------|-------|-------|
| 31 | Government Pharmaceuticals (Drugs) Expenditure as a % of GCHE | - | 16.20% | 13.40% | 4.5% | 4.7% |
| 32 | Capital expenditure as a % of CHE plus capital expenditure | 9.60% | 8.20% | 6.70% | 6.8% | 6.1% |
| 33 | Government capital expenditure on health as a % of GHE (GCHE plus Government capital expenditure) | 11.20% | 8.00% | 8.10% | 8.2% | 6.8% |
| 34 | Non-Communicable Diseases (NCD) expenditure as a % of CHE (NCD, Nutritional deficiencies, Injuries) | 54.80% | 51.00% | 46.90% | 52.9% | 52.3% |
| 35 | Communicable Diseases (CD) expenditure as a % of CHE | 29.90% | 31.80% | 28.50% | 26.7% | 29.5% |
| 36 | Maternal and Child Health (MCH) expenditure as a % of CHE | 5.50% | 4.30% | 5.50% | 14.8% | 11.6% |
| 37 | PHCE as % of CHE | | | | 48.4% | 48.4% |
| 38 | PHCE per capita | | | | 279.6 | 302.4 |
| 39 | PHCE AS % GCHE | | | | 40% | 41% |
| 40 | PHCE (government) per capita | | | | 135.3 | 142.2 |

1. Background

1.1. About this Report

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

This report is based on the analysis done through 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.

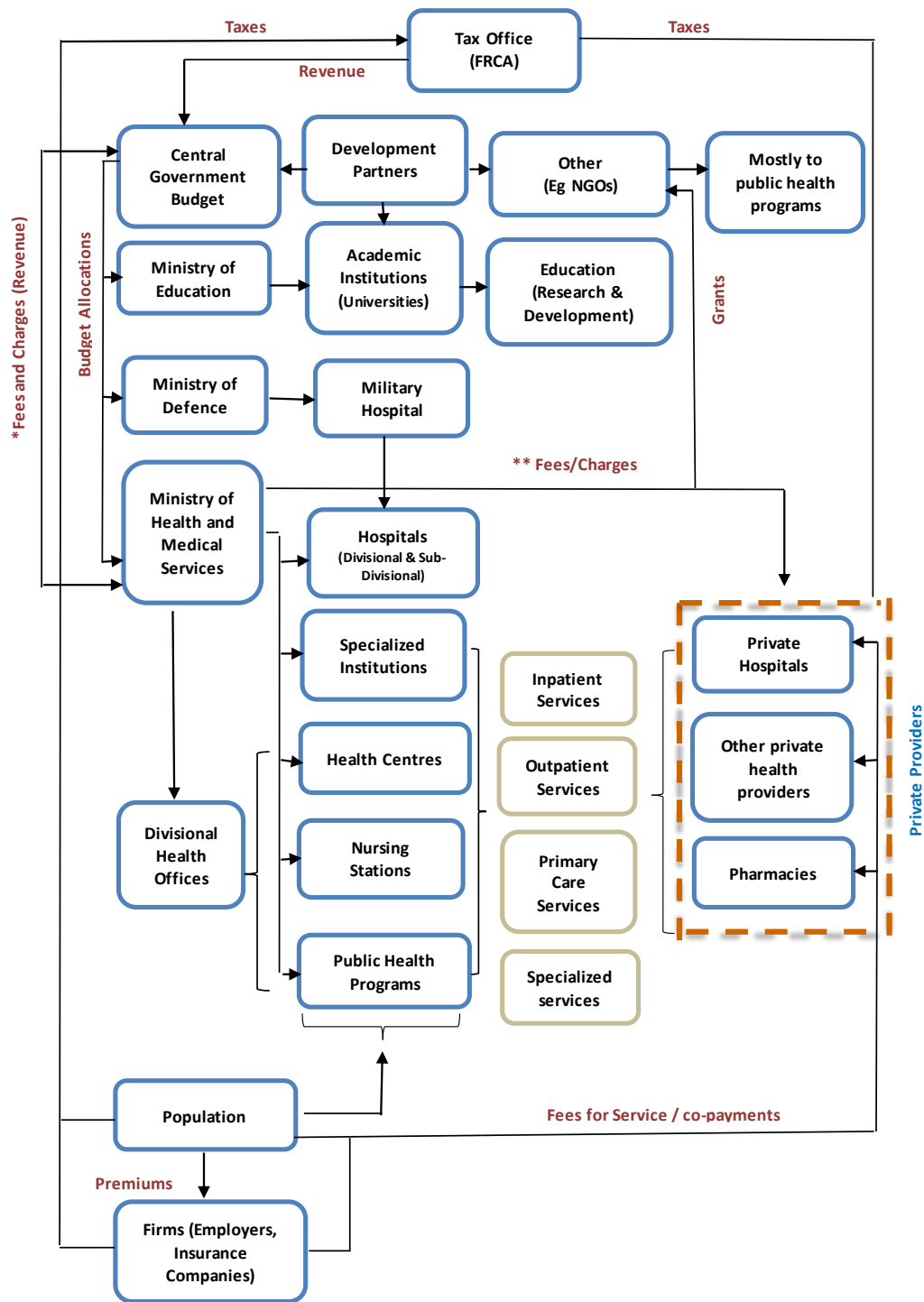
Within a designated medical region, 17 sub-divisional hospitals additionally offer primary and secondary level clinical and preventive health services, as well as health centers and nursing stations under each of the healthcare facilities offering primary health care services.

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

The identification of the true source of money earned and received by accountable agencies (money Source), in addition to the organization that oversees and disburses funds (Financing Agents), represents a significant shift in the tracking of the flow of funds toward health in SHA 2011. In addition to showing that the government provides the majority of funding for the public health sector in Fiji, SHA 2011 thoroughly examines the methods used to produce and collect money. The distribution of business/corporate or household taxes, grants and transfers from development partners, and government taxes through a variety of delivery methods—including insurance plans, central government programs, and direct household out-of-pocket expenses—are also covered by SHA 2011. 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)** – This category includes all hospital fees as well as fumigation and quarantine costs that are gathered by MHMS

****Fees/Charges** – These refer to the sums that MHMS pays to private companies, such as locum services.

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

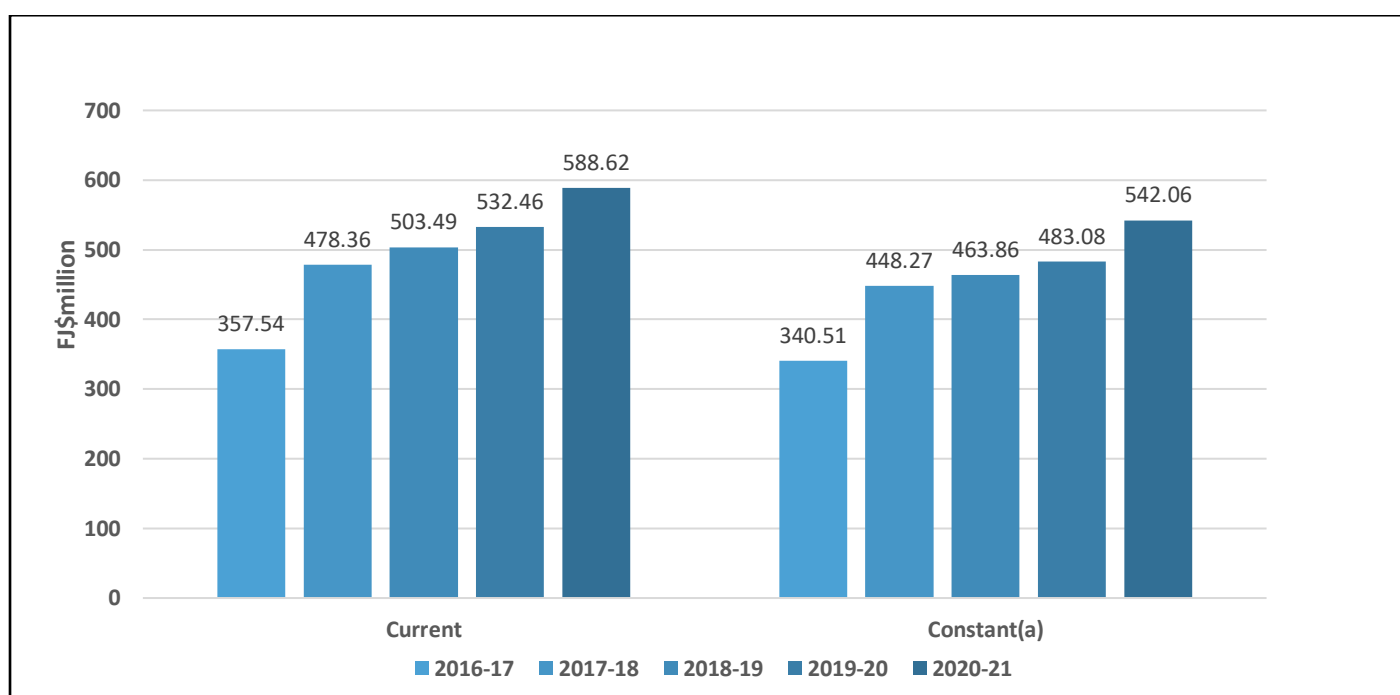
2. Current Health Expenditure

The total amount that citizens (individuals or organizations) of a nation spend on medical goods and services over the course of a specified time period is known as current health expenditure. CHE excludes capital expenditure on health care.

2.1. Trends in CHE

Over the course of the last five years, CHE has increased in both real and nominal 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 |
| 2016-17 | 358 | 341 | - | - |
| 2017-18 | 478 | 448 | 33.8% | 31.6% |
| 2018-19 | 503 | 464 | 5.3% | 3.5% |
| 2019-20 | 532 | 483 | 5.8% | 4.1% |
| 2020-21 | 589 | 542 | 10.5% | 12.2% |

(a) Constant Price is calculated using the implicit GDP deflator (2011=100)

(a) Constant prices are calculated using the implicit GDP deflator (2016=100).

2.2. Current Health Expenditure in Relation to GDP

The average percentage of GDP that was spent on health for the five years (2016-17 –2020–21) was 4.6%. (Table 2-2).

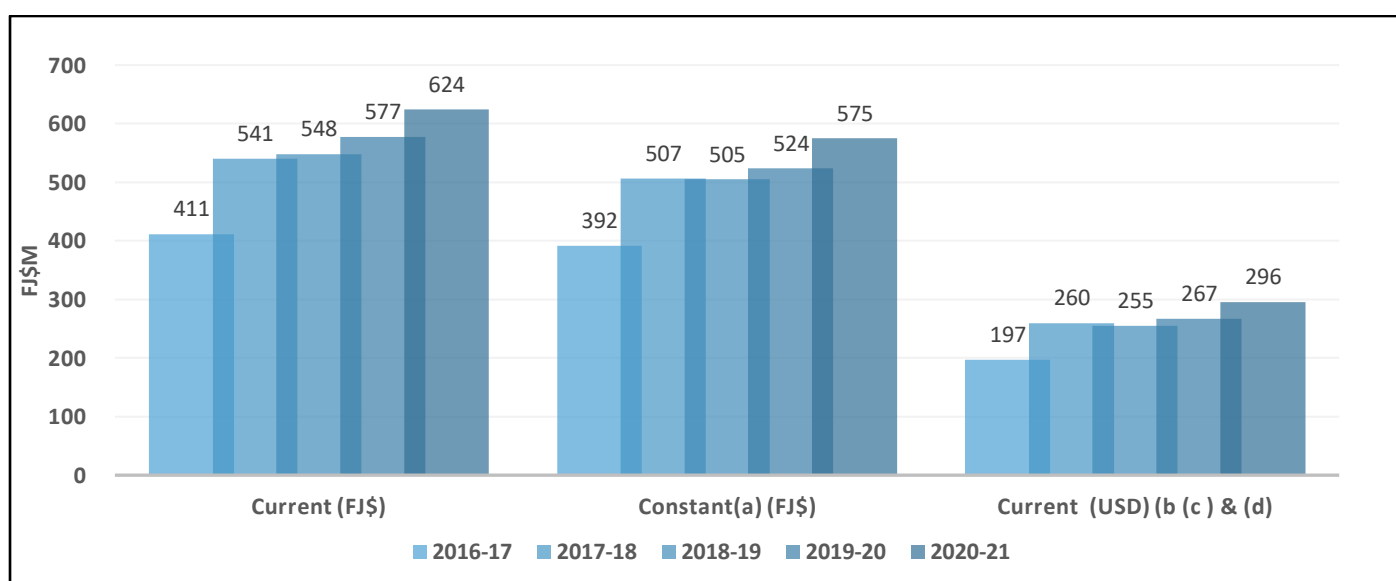
Table 2-2 CHE, GDP, Annual Growth Rates and Share of CHE to GDP

| Year | Current Health Expenditure | | GDP | | |
|---------|----------------------------|-------------------------|----------------|-------------------------|--|
| | Amount (FJ\$m) | Nominal Growth Rate (%) | Amount (FJ\$m) | Nominal Growth Rate (%) | Ratio of Current Health Expenditure to GDP (%) |
| 2016-17 | 358 | 9.5% | 10,327 | 36.9% | 3.5% |
| 2017-18 | 478 | 33.8% | 11,065 | 7.1% | 4.3% |
| 2018-19 | 503 | 5.3% | 11,651 | 5.3% | 4.3% |
| 2019-20 | 532 | 5.8% | 11,762 | 1.0% | 4.5% |
| 2020-21 | 589 | 10.5% | 9,613 | -18.3% | 6.1% |

2.3. Current Health Expenditure per Capita

Analyzing health care spending per person is crucial for tracking health care spending relative to population increase. The trend of the amount spent on health care per person is displayed in Figure 2-2. Over the course of the five years, there was a growth in CHE per capita in both nominal (current) and constant (real) terms (with a minor decrease in 2018–19).

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) |
| 2016-17 | 411 | 392 | 197 | 17.9% | 11,878 | 11,312 | 5,703 |
| 2017-18 | 541 | 507 | 260 | 29.4% | 12,504 | 11,718 | 6,003 |
| 2018-19 | 548 | 505 | 255 | -0.3% | 12,685 | 11,686 | 5,900 |
| 2019-20 | 577 | 524 | 267 | 3.7% | 12,753 | 11,570 | 5,905 |
| 2020-21 | 624 | 575 | 296 | 9.8% | 10,195 | 9,388 | 4,832 |

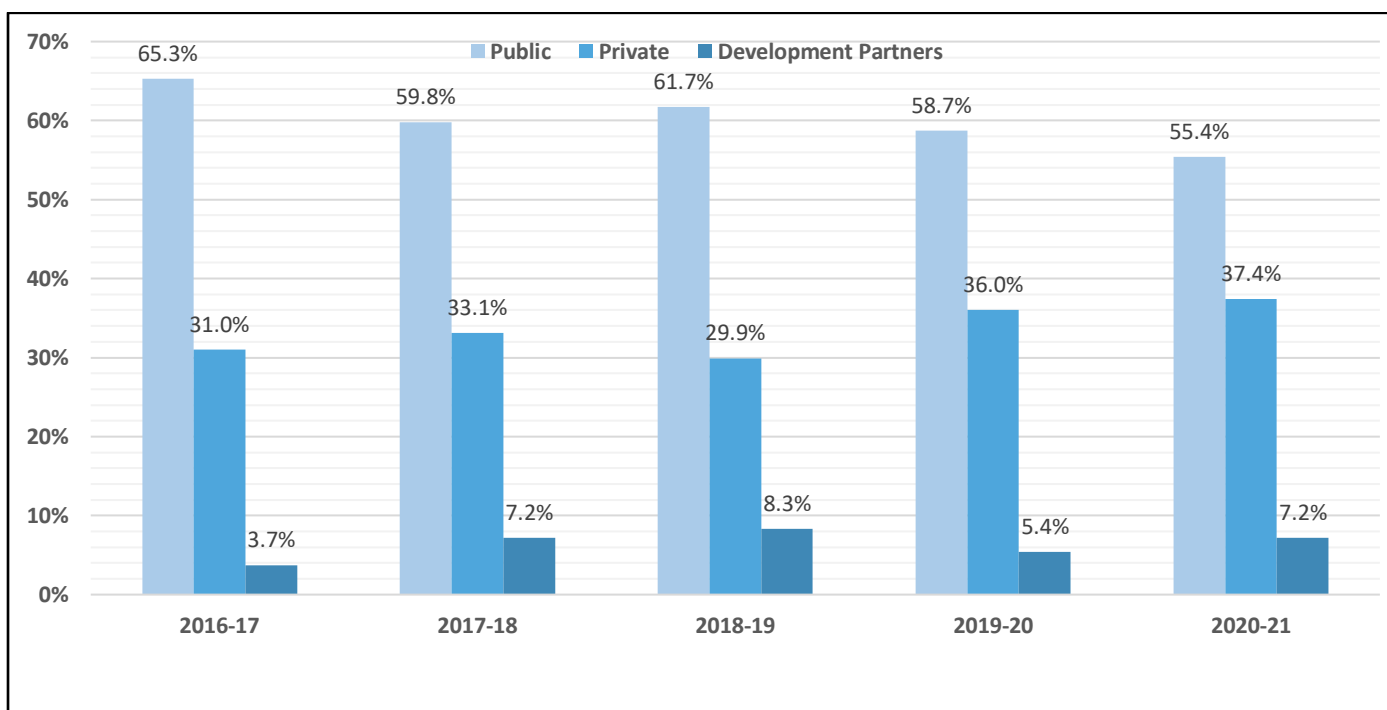
3. Financing of Current Health Expenditure

The financing schemes (FS) specifically utilized to produce the revenues, the institutional units of the economy from which the revenues are directly generated, and the contribution procedures are all described in the revenues of health financing schemes.

3.1. Revenues of Financing Schemes

The central government budget was the main source of funding for the health sector (public). Development partners and the commercial sector provided the remaining funds. The funding allocation from each of the three sources over the five years is shown in Figure 3-1.

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 |
| 2016-17 | 233.6 | 110.9 | 13.1 | 65.3% | 31.0% | 3.7% | 100% | 2.3% | 1.1% | 0.1% | 3.5% |
| 2017-18 | 286.0 | 158.1 | 34.2 | 59.8% | 33.1% | 7.2% | 100% | 2.6% | 1.4% | 0.3% | 4.3% |
| 2018-19 | 310.8 | 150.7 | 42.0 | 61.7% | 29.9% | 8.3% | 100% | 2.7% | 1.3% | 0.4% | 4.3% |
| 2019-20 | 312.3 | 191.6 | 28.6 | 58.7% | 36.0% | 5.4% | 100% | 2.7% | 1.6% | 0.2% | 4.5% |
| 2020-21 | 326.0 | 220.2 | 42.5 | 55.4% | 37.4% | 7.2% | 100% | 3.4% | 2.3% | 0.4% | 6.1% |

As per Table 3-1, CHE for public and private sectors increased in dollar terms during the five years whilst the development partners financing decreased in 2019-20 but increased again in 2020-21 onwards as a share of CHE. As a result of COVID-19 With the exception of 2020–21, all sources' CHE as a percentage of GDP constant.

3.2. Financing Schemes

Health care financing schemes are defined by SHA (2011) as the many forms of financial agreements that enable individuals to access or receive healthcare services.

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 | 2016-17 | 2017-18 | 2018-19 | 2019-20 | 2020-21 |
|---|----------------|----------------|----------------|----------------|----------------|
| | Amount (FJ\$m) | Amount (FJ\$m) | Amount (FJ\$m) | Amount (FJ\$m) | Amount (FJ\$m) |
| Government Schemes | 239.0 | 292.3 | 312.0 | 324.9 | 327.5 |
| Ministry of Health and Medical Services | 239.0 | 186.7 | 206.1 | 277.4 | 326.3 |
| Ministry of Defence and Others | 0.0 | 105.6 | 105.9 | 47.5 | 1.2 |
| Other | | | | | |
| Voluntary Health Insurance Schemes | 47.4 | 53.3 | 49.2 | 65.0 | 71.9 |
| Employer-based insurance (other than enterprises schemes) | 20.6 | 36.8 | 34.5 | 52.4 | 57.1 |
| Government-based voluntary insurance | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Other primary coverage schemes | 26.8 | 16.4 | 14.7 | 12.6 | 14.8 |
| Other Schemes | 4.9 | 39.7 | 7.7 | 15.6 | 26.8 |
| NPISH financing schemes (including development agencies) | 4.9 | 27.4 | 3.7 | 9.0 | 19.0 |
| Enterprises | | 12.2 | 4.0 | 6.7 | 7.9 |
| Household Out of Pocket | 61.9 | 86.1 | 96.5 | 116.1 | 135.7 |
| Households | 61.9 | 86.1 | 96.5 | 116.1 | 135.7 |
| Rest of the World | 4.4 | 7.0 | 38.1 | 10.8 | 26.7 |
| Total | 357.5 | 478.4 | 503.5 | 532.5 | 588.6 |

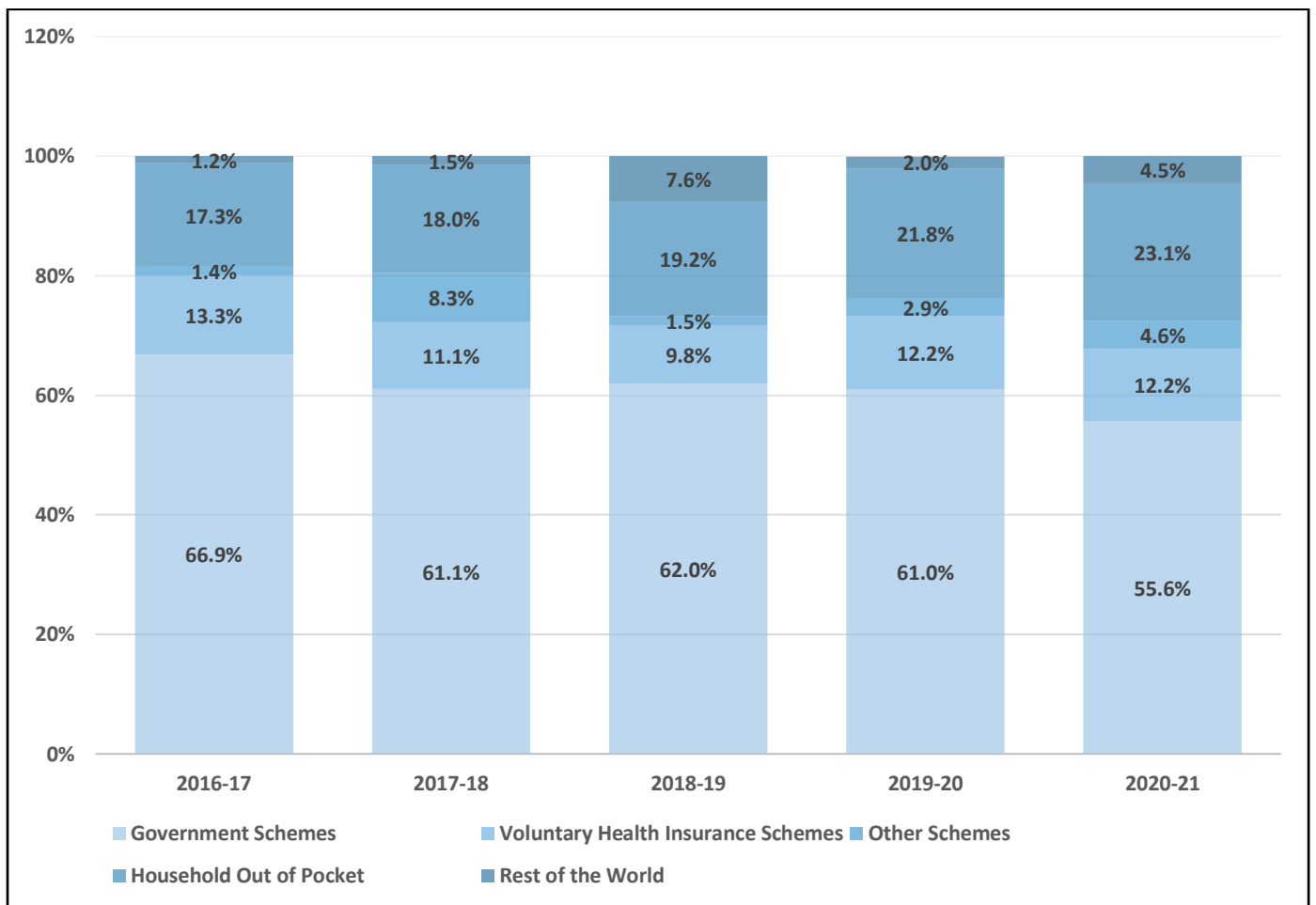
Table 3-2 shows the funding by financing schemes over the five-year period.

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 2020-21, the *Voluntary Health Insurance* had increased with a increase in *Household Out-of-pocket* (as compared to the 2019-20).

Expenditure for development partners has also increased in 2020-21.

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

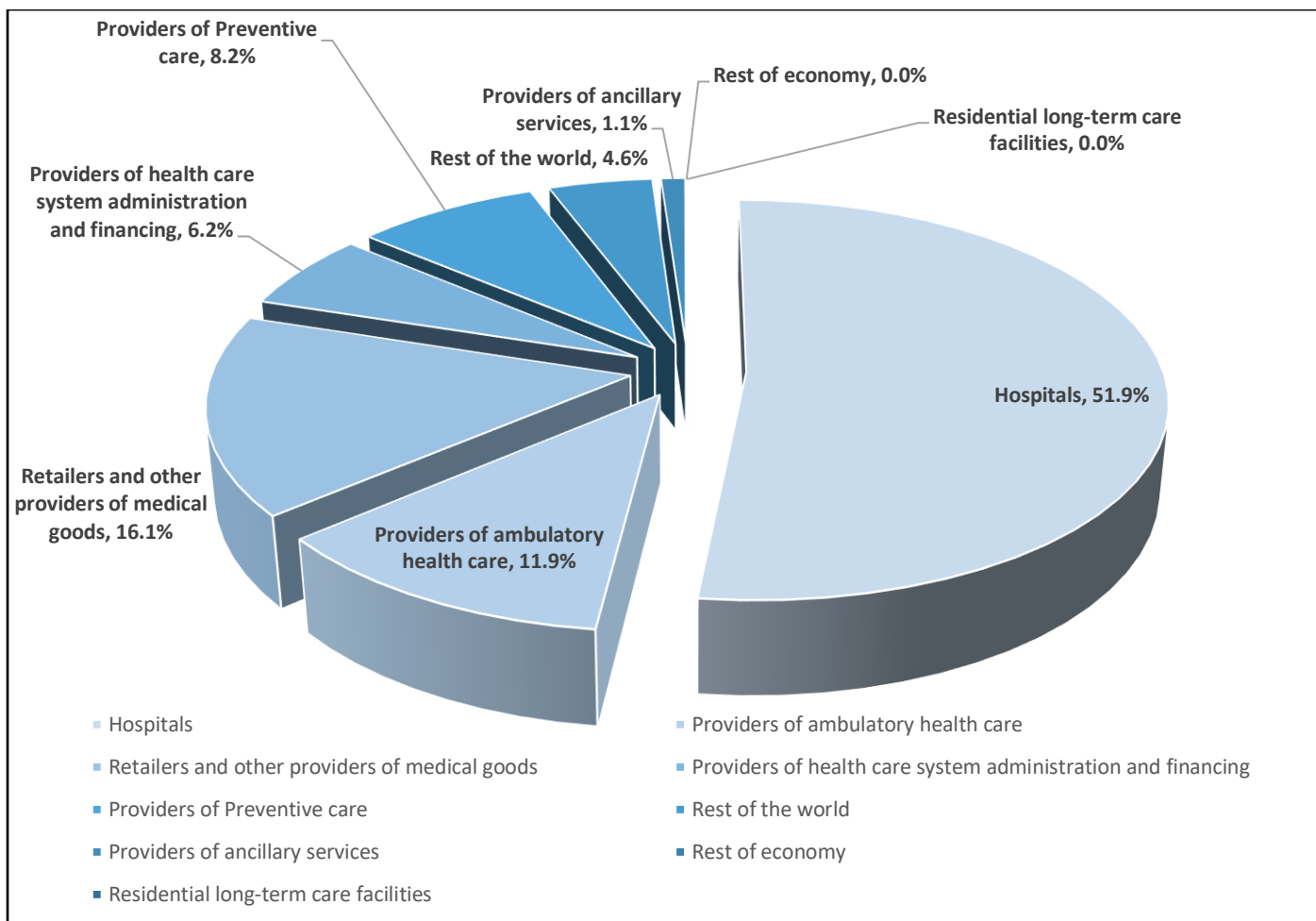


Source: Table 3-2 Government Schemes comprises of Ministry of Health and Medical Services & Ministry of Defence

4. Current Health Expenditure by Providers

Organizations that contribute to the provision of or deliver health care goods and services as their primary activity, as well as those for which health care provision is simply one activity among many, are included in the Health Care Providers (HP) classification (SHA 2011).

Figure 4-1 Share of Current Health Expenditures by Providers (%), 2020-21



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)) | 2016 - 17 | 2017 - 18 | 2018 - 19 | 2019 - 20 | 2020 - 21 |
|--|------------------|------------------|------------------|------------------|------------------|
| Hospitals | 181.8 | 257.73 | 283.71 | 296.30 | 305.70 |
| Residential long-term care facilities | 0.2 | 0.00 | 0.00 | 0.00 | 0.00 |
| Providers of ambulatory health care | 76.0 | 60.94 | 46.91 | 54.21 | 69.93 |
| Providers of ancillary services | 3.7 | 19.94 | 19.28 | 6.82 | 6.29 |
| Retailers and other providers of medical goods | 43.6 | 52.02 | 55.43 | 86.33 | 94.97 |
| Providers of Preventive care | 22.9 | 36.01 | 20.74 | 43.15 | 48.03 |
| Providers of health care system administration and financing | 14.9 | 30.83 | 22.64 | 23.23 | 36.46 |
| Rest of economy | 0.7 | 4.38 | 0.26 | | |
| Rest of the world | 13.7 | 16.52 | 54.52 | 22.42 | 27.23 |
| Total | 357.5 | 478.36 | 503.49 | 532.46 | 588.62 |

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". Any health system would benefit from the analysis by function, which provides information to the policy level and systematically categorizes the goals or functional applications of health spending. Health expenditure by function provides a platform for policy makers to change from input based to output-focused health service delivery.

Table 5-1 displays the Current Health Expenditure (CHE) breakdown by kind of healthcare service. Except for ancillary services and preventive care, all function expenditures increased during the course of the five-year period.

Table 5-1 Current Health Expenditure by Function (FJ\$m), 2016-17 to 2020-21

| Health Care Functions | 2016-17 | 2017-18 | 2018-19 | 2019-20 | 2020-21 |
|---|---------|---------|---------|---------|---------|
| Inpatient curative care | 76.1 | 98.0 | 131.1 | 113.8 | 131.0 |
| Outpatient curative care | 121.6 | 154.0 | 162.9 | 174.9 | 193.8 |
| Rehabilitative & Long-term Care | 7.1 | 6.4 | 10.3 | 6.3 | 7.2 |
| Ancillary services | 10.8 | 33.9 | 36.0 | 19.7 | 6.3 |
| Medical goods | 47.3 | 56.5 | 58.3 | 88.0 | 96.7 |
| Preventive care | 78.9 | 101.4 | 82.4 | 106.5 | 117.2 |
| Governance, and health system and financing administration | 14.5 | 28.2 | 22.6 | 23.0 | 36.5 |
| Other health care services not elsewhere classified (n.e.c.) | 1.3 | 0.0 | 0.0 | 0.0 | 0.0 |
| Total | 357.5 | 478.4 | 503.5 | 532.3 | 588.6 |

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

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

According to Table 5-1, most of the health spending is allocated to curative care (inpatient and outpatient care services). The cost of curative healthcare has been rising over time, as seen by Table 5-1.

Curative care expenditure in 2020-21 was made up of 22.2% inpatient care and 32.9 % 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 (%), 2016-17 to 2020-21

| Year | Inpatient | | Outpatient | |
|----------|------------|-------------|------------|-------------|
| | Public (%) | Private (%) | Public (%) | Private (%) |
| 2016- 17 | 75.2% | 24.8% | 66.8% | 33.2% |
| 2017- 18 | 67.9% | 32.1% | 70.5% | 29.5% |
| 2018- 19 | 62.4% | 37.6% | 63.2% | 36.8% |
| 2019- 20 | 57.1% | 42.9% | 71.7% | 28.3% |
| 2020- 21 | 54.3% | 45.7% | 67.1% | 32.9% |

Note: Private expenditure also includes Development partners

5.2. Medical Goods (excludes Government)

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

Table 5-3 Medical goods Expenditure by Subclasses, 2016-17 to 2020-21

| Functions | 2016-17 | | 2017-18 | | 2018-19 | | 2019-20 | | 2020-21 | |
|------------------------------------|---------|-----------|---------|-----------|---------|-----------|---------|-----------|---------|-----------|
| | FJ\$m | Share (%) | FJ\$m | Share (%) | FJ\$m | Share (%) | FJ\$m | Share (%) | FJ\$m | Share (%) |
| Unspecified medical goods (n.e.c.) | | | 5.0 | 0.1% | 6.1 | 0.1% | 9.5 | 0.1% | 10.4 | 0.1% |
| Prescribed medicines | 22 | 46.1% | 19.8 | 35.0% | 20.0 | 34.3% | 31 | 35.3% | 34.2 | 35.4% |
| Over-the-counter medicines | 17 | 35.0% | 17.1 | 30.3% | 19.4 | 33.3% | 31 | 35.3% | 34.2 | 35.4% |

| | | | | | | | | | | |
|--|-----------|-------------|-------------|-------------|-------------|-------------|-----------|-------------|-------------|-------------|
| Other medical non-durable goods | 2 | 4.6% | 2.0 | 3.6% | 5.5 | 9.5% | 8 | 8.8% | 8.5 | 8.8% |
| Glasses and other vision products | 4 | 7.8% | 0.0 | | 0.0 | 0.0% | 0 | 0.0% | 0.0 | 0.0% |
| Hearing Aids | | | 4.5 | 8.0% | 2.8 | 4.8% | 2 | 1.9% | 1.7 | 1.8% |
| All other medical durables, including medical technical devices | 3 | 6.5% | 8.1 | 14.3% | 4.4 | 7.6% | 7 | 7.8% | 7.6 | 7.9% |
| Total | 47 | 100% | 56.5 | 100% | 58.3 | 100% | 88 | 100% | 96.7 | 100% |

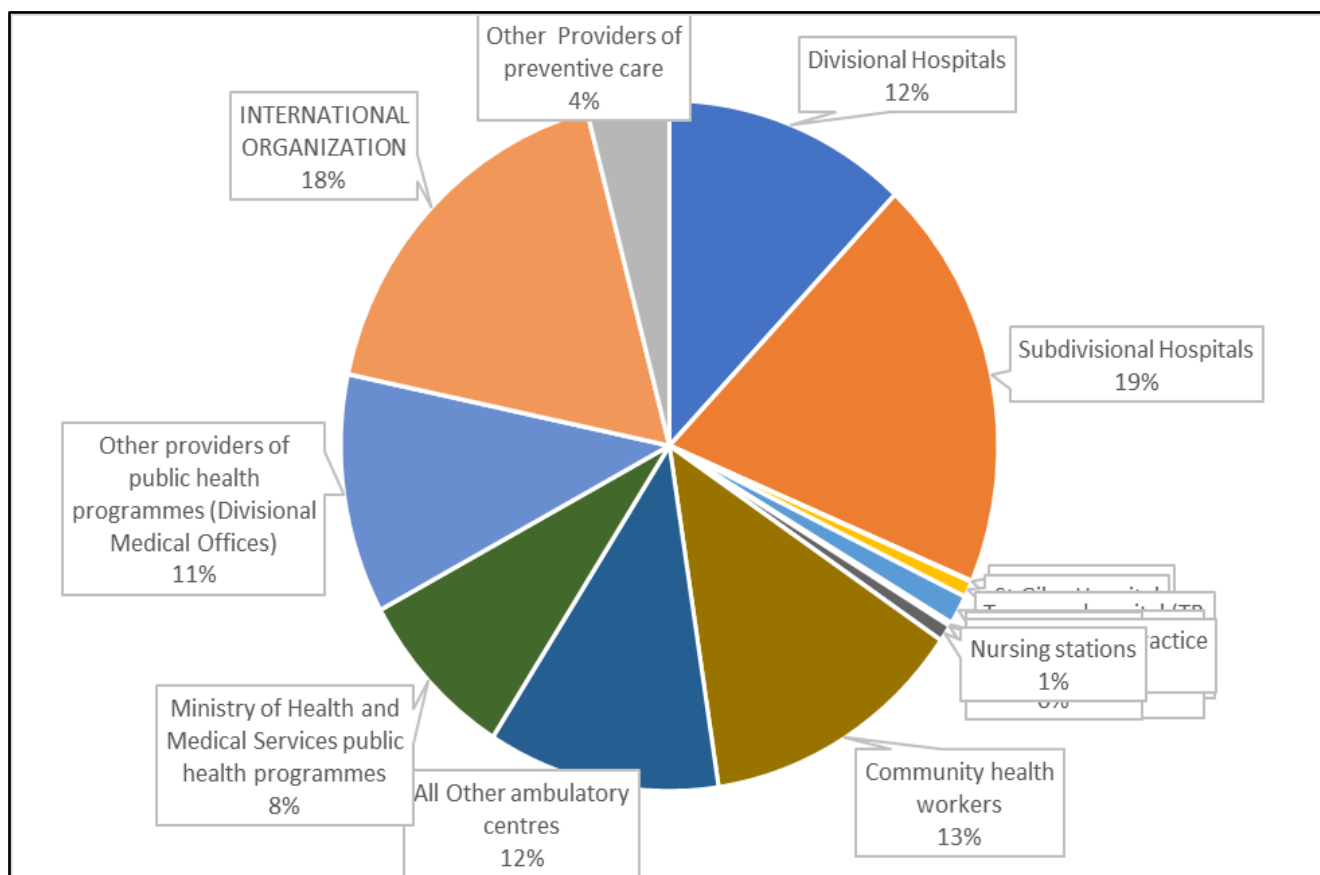
Table 5-3 shows expenditure on medical goods by subclasses. The expenditure on medical goods spent on prescribed medicines has been increasing over the years. (2018-19 onwards).

5.3. Preventive Care

"Preventive care refers to any action taken to lessen the likelihood or severity of illnesses, injuries, and the problems they may cause. Numerous predicted outcomes are part of preventive care, and they are addressed by a variety of treatments arranged at the primary, secondary, and tertiary prevention levels (SHA 2011). Primary and secondary preventive programs account for most expenditures in Fiji.

Figure 5-1 reflects the distribution of preventive care expenditure by health care providers. It demonstrates that preventative care initiatives are present in a wide range of public healthcare settings, including nursing stations and divisional hospitals. Hospitals accounted for over 36% of preventive care spending, followed by health centers with 11% and preventive care providers with around 41%.

Figure 5-1 Share of Preventive care by providers (%), 2020-21



6. Government Current Health Expenditure

Government is the largest source of funding for the provision of health services. This chapter examines Government Current Health Expenditure (GCHE) and includes information on the locations and methods of spending.

6.1. Government Expenditure on Health

According to a government spending analysis (refer Table 6-1), government health expenditure (GHE), which is made up of capital spending as well as GCHE, has increased in both nominal and real values throughout the course of the five-year period (constant). In practical terms, this indicates that government spending has been substantial and has been rising since 2016/2017. Throughout the course of the five years, 2020–21 showed the largest health spending (\$322 million).

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

| Year | 2016-17 | 2017-18 | 2018-19 | 2019-20 | 2020-21 |
|--------------------------|---------|---------|---------|---------|---------|
| Current (Nominal) | 263 | 311 | 338 | 340 | 350 |
| Constant (Real) | 250 | 291 | 312 | 309 | 322 |

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

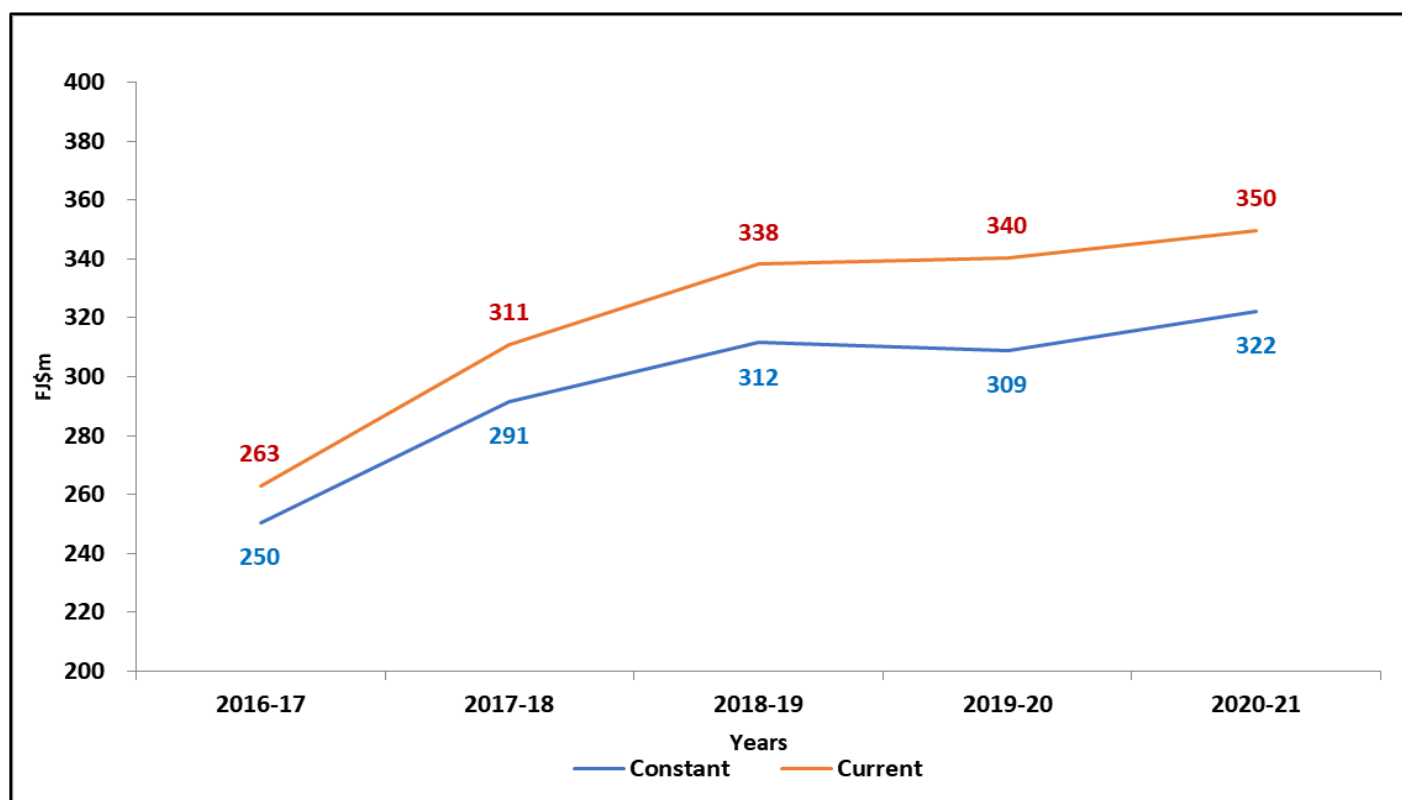


Figure 6-1 Government Health Expenditure in Real (Constant) and Nominal (Current) value

Source: Table 6-1

The GHE increased from 2016/17 to 2020/21 as a proportion of Total Government Expenditure (TGE), averaging approximately 9.5%. (with a minor decrease in 2017/18).

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

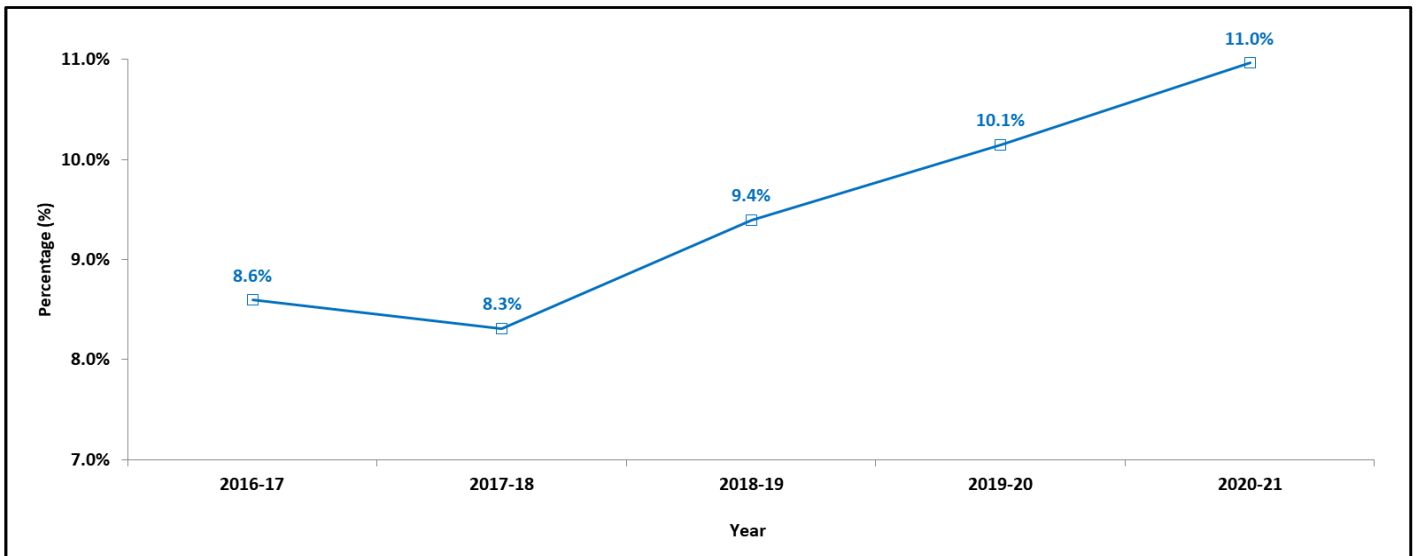
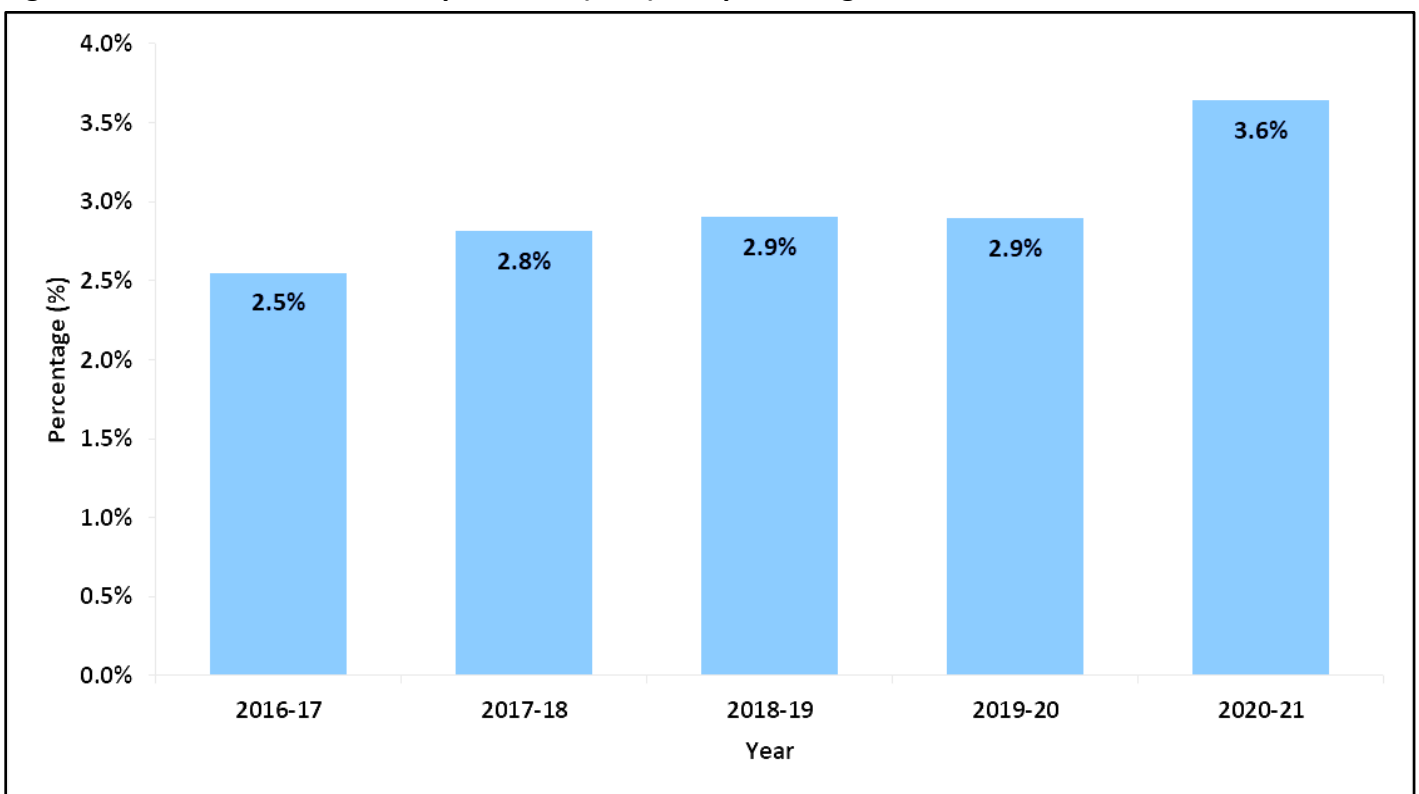


Figure 6-3 Government Health Expenditure (GHE) as a percentage of GDP



GHE has averaged 3.0% of GDP (gross domestic product) from 2016–17 to 2020–21. The percentage stayed largely stable until 2019–20, when it abruptly increased in 2020–21 due to a substantial rise in health care costs and a decline in GDP growth.

6.2. Government Current Health Expenditure by Providers

The many categories of government health providers within the healthcare system are influenced by a wide range of factors, one of which being the nature of the healthcare services offered at the facility. Table 6-2 highlights the health providers that are provided by the government.

Table 6-2 Government Health Expenditures (FJ\$ m) by Providers

| Providers | 2016-17 | 2017-18 | 2018-19 | 2019-20 | 2020-21 |
|--|--------------|--------------|--------------|--------------|--------------|
| Hospitals | 159.7 | 208.4 | 242.5 | 245.5 | 238.5 |
| Residential long-term care facilities | 0.2 | - | - | | |
| Providers of ambulatory health care | 37.2 | 32.1 | 19.9 | 25.0 | 38.8 |
| Providers of ancillary services | 2.6 | 3.3 | 6.7 | 3.7 | 3.3 |
| Retailers and other providers of medical goods | 3.1 | 1.0 | - | 0.9 | 0.9 |
| Providers of Preventive care | 15.0 | 19.4 | 17.7 | 16.8 | 20.9 |
| Providers of health care system administration and financing | 13.5 | 20.4 | 21.7 | 18.1 | 23.2 |
| Rest of economy | 0.5 | 0.3 | 0.0 | | |
| Rest of the world | 1.8 | 1.2 | 2.3 | 2.3 | 0.3 |
| Total | 233.6 | 286.0 | 310.8 | 312.3 | 326.0 |

Table 6-2 further shows the share of Government current health expenditures amongst the health providers from 2016-17 to 2020-21. *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 expanded 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 |
| Divisional Hospitals | 1 | 0 | 1 | 1 |
| Sub divisional Hospitals | 5 | 5 | 6 | 3 |
| Health Centers | 21 | 15 | 20 | 25 |
| Nursing Stations | 21 | 31 | 21 | 25 |
| Specialized Hospitals | 2 | 0 | 0 | 0 |

Collectively the divisional hospitals incurred the largest expenditure over the period 2016 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 | 2016-17 | 2017-18 | 2018-19 | 2019-20 | 2020-21 |
|---|--------------|--------------|--------------|--------------|--------------|
| Central | 77.3 | 109.9 | 103.2 | 113.1 | 109.1 |
| Divisional hospitals | 48.4 | 69.1 | 69.2 | 77.8 | 77.0 |
| Sub divisional Hospitals (SDHs) | 9.1 | 26.7 | 27.9 | 26.0 | 22.2 |
| Public Health Centres (PHC) | 19.8 | 14.1 | 6.1 | 9.3 | 9.9 |
| Eastern | 9.2 | 7.9 | 9.5 | 11.2 | 10.8 |
| Sub divisional Hospitals (SDHs) | 5.6 | 6.7 | 6.7 | 9.7 | 9.1 |
| Public Health Centres (PHC) | 3.5 | 1.2 | 2.8 | 1.5 | 1.7 |
| Western | 62.7 | 70.2 | 84.3 | 82.5 | 83.8 |
| Divisional hospitals | 30.6 | 34.1 | 46.9 | 45.2 | 48.4 |
| Sub divisional Hospitals (SDHs) | 25.8 | 27.3 | 32.9 | 30.3 | 28.1 |
| Public Health Centres (PHC) | 6.4 | 8.8 | 4.4 | 7.0 | 7.3 |
| Northern | 36.2 | 38.6 | 50.1 | 48.4 | 46.9 |
| Divisional hospitals | 23.1 | 25.6 | 36.0 | 33.1 | 32.6 |
| Sub divisional Hospitals (SDHs) | 8.2 | 9.4 | 9.9 | 12.1 | 11.0 |
| Public Health Centres (PHC) | 4.9 | 3.6 | 4.2 | 3.2 | 3.4 |
| Specialist Services (National Level) | 8.7 | 7.8 | 11.5 | 9.9 | 8.8 |
| Mental health hospitals | 4.2 | 4.6 | 5.9 | 5.4 | 4.4 |
| Tamavua hospital (TB and Leprosy) | 4.4 | 3.1 | 5.6 | 4.6 | 4.4 |
| Total | 194.0 | 234.4 | 258.5 | 265.1 | 259.4 |

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

6.4 Government Current Health Expenditure by Functions

This section focuses on Government current health expenditures (GCHE) by function and the Table 6.4- reflects the type of goods and services.

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

| Functions | 2016-17 | 2017-18 | 2018-19 | 2019-20 | 2020-21 |
|---------------------------------|---------|---------|---------|---------|---------|
| Curative care | 138.5 | 175.2 | 184.7 | 190.9 | 201.4 |
| Inpatient curative care | 57.2 | 65.2 | 81.9 | 66.6 | 71.2 |
| Outpatient curative care | 81.3 | 110.0 | 102.9 | 124.2 | 130.3 |
| Rehabilitative care | 7.0 | 6.3 | 10.3 | 6.3 | 7.2 |

| | | | | | |
|---|--------------|--------------|--------------|--------------|--------------|
| Long-term care (health) | 0.1 | 0.0 | 0.0 | - | - |
| Ancillary services (non-specified by function) | 2.6 | 5.1 | 16.5 | 16.6 | 3.3 |
| Medical goods (non-specified by function) | 3.1 | 1.0 | 0.0 | 0.7 | 1.0 |
| Preventive care | 68.4 | 78.0 | 77.7 | 79.6 | 89.9 |
| Governance, and health system and financing administration | 13.5 | 20.4 | 21.6 | 18.1 | 23.2 |
| Other health care services not elsewhere classified (n.e.c.) | 0.4 | - | - | - | - |
| Total | 233.6 | 286.0 | 310.8 | 312.1 | 326.0 |

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.

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

| Preventive care | 2016-17 | 2017-18 | 2018-19 | 2019-20 | 2020-21 |
|---|----------------|----------------|----------------|----------------|----------------|
| Information, education and counselling programmes | 16.5 | 17.4 | 18.6 | 17.8 | 21.3 |
| Immunisation programmes | 10.9 | 11.3 | 16.8 | 10.8 | 12.2 |
| Early disease detection programmes | 12.2 | 13.3 | 13.4 | 16.2 | 20.6 |
| Healthy condition monitoring programmes | 10.4 | 12.1 | 10.1 | 11.1 | 11.2 |
| Epidemiological surveillance and risk and disease control programmes | 9.1 | 13.2 | 9.9 | 15.0 | 15.2 |
| Preparing for disaster and emergency response programmes | 9.3 | 10.8 | 8.8 | 8.7 | 9.4 |
| Total | 68.4 | 78.1 | 77.7 | 79.6 | 89.9 |

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 6-5.

Table 6-6 provides the Government expenditure on medicines since 2016-17.

Table 6-6 Government drugs expenditure

| Year | 2016-17 | 2017-18 | 2018-19 | 2019-20 | 2020-21 |
|---------------|----------------|----------------|----------------|----------------|----------------|
| FJ\$ m | 25- | 46.7 | 41.5 | 46.2 | 50.2 |

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\$110.9m in 2016-17 to FJ\$220 m in 2020-21 (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, 2016-17 to 2020-21

| Description | 2016-17 | | 2017-18 | | 2018-19 | | 2019-20 | | 2020-21 | |
|--|-----------------|-------------|-----------------|-------------|-----------------|-------------|-----------------|-------------|-----------------|-------------|
| | Amount (FJ\$ m) | Share (%) | Amount (FJ\$ m) | Share (%) | Amount (FJ\$ m) | Share (%) | Amount (FJ\$ m) | Share (%) | Amount (FJ\$ m) | Share (%) |
| Voluntary prepayment | 47.4 | 42.7% | 53.3 | 33.7% | 49.4 | 32.8% | 65.0 | 33.9% | 71.9 | 32.6% |
| Voluntary prepayment from individuals/households | 12.7 | 11.5% | 16.4 | 10.4% | 14.7 | 9.8% | 52.4 | 27.4% | 57.1 | 25.9% |
| Voluntary prepayment from employers | 34.7 | 31.3% | 36.8 | 23.3% | 34.5 | 22.9% | 12.6 | 6.6% | 14.8 | 6.7% |
| Other voluntary prepaid revenues | | | | | | | 116.1 | 60.6% | 135.7 | 61.6% |
| Other domestic revenues n.e.c. | 63.5 | 57.3% | 104.9 | 66.3% | 101.4 | 67.2% | 114.1 | 59.6% | 129.9 | 59.0% |
| Other revenues from households n.e.c. | 55.0 | 49.6% | 86.1 | 54.5% | 96.5 | 63.9% | 2.0 | 1.0% | 5.8 | 2.7% |
| Other revenues from corporations n.e.c. | 6.9 | 6.2% | 12.2 | 7.7% | 4.0 | 2.7% | 3.8 | 2.0% | 4.7 | 2.1% |
| Other revenues from NPISH n.e.c. | 1.6 | 1.4% | 6.5 | 4.1% | 1.0 | 0.6% | 6.7 | 3.5% | 7.9 | 3.6% |
| TOTAL | 110.9 | 100% | 158.1 | 100% | 150.9 | 100% | 191.6 | 100% | 220.2 | 100% |

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 59% % of PCHE in 2020-21. 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 2016-17 to 2020-21

| Schemes | 2016-17 | | 2017-18 | | 2018-19 | | 2019-20 | | 2020-21 | |
|---|----------------|-------------|----------------|-------------|----------------|---------------|----------------|---------------|----------------|---------------|
| | 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 | 47.4 | 42.7% | 53.3 | 33.7% | 49.2 | 32.7% | 65.0 | 33.9% | 71.9 | 32.6% |
| Employer-based insurance (other than enterprises schemes) | 20.6 | 18.6% | 36.8 | 23.3% | 34.5 | 22.9% | 52.4 | 27.4% | 57.1 | 25.9% |
| Other primary coverage schemes | 26.8 | 24.2% | 16.4 | 10.4% | 14.7 | 9.8% | 12.6 | 6.6% | 14.8 | 6.7% |
| Household Out-of-pocket (OOP) | 55.8 | 50.3% | 86.1 | 54.5% | 96.5 | 64.0% | 116.1 | 60.6% | 135.7 | 61.6% |
| Out-of-pocket excluding cost-sharing | 55.8 | 50.3% | 84.3 | 53.3% | 90.0 | 59.7% | 114.1 | 59.6% | 129.9 | 59.0% |
| Cost sharing with third-party payers | 0.0 | 0.0% | 1.8 | 1.2% | 6.5 | 4.3% | 2.0 | 1.0% | 5.8 | 2.7% |
| NPISH schemes | 1.6 | 1.4% | 6.5 | 4.1% | 1.0 | 0.6% | 3.8 | 2.0% | 4.7 | 2.1% |
| Enterprise financing schemes | 6.1 | 5.5% | 12.2 | 7.7% | 4.0 | 2.7% | 6.7 | 3.5% | 7.9 | 3.6% |
| TOTAL | 110.9 | 100% | 158.1 | 100% | 150.7 | 100.0% | 191.6 | 100.0% | 220.2 | 100.0% |

7.3. Private Current Health Expenditure by Providers

Retail and other providers of medical goods accounted for the 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, 2016-17 to 2020-21

| Providers | 2016-17 | | 2017-18 | | 2018-19 | | 2019-20 | | 2020-21 | |
|-----------|----------------|-----------|----------------|-----------|----------------|-----------|----------------|-----------|----------------|-----------|
| | Amount (FJ\$m) | Share (%) | Amount (FJ\$m) | Share (%) | Amount (FJ\$m) | Share (%) | Amount (FJ\$m) | Share (%) | Amount (FJ\$m) | Share (%) |
| Hospitals | 22.0 | 19.9% | 42.3 | 26.8% | 41.2 | 27.3% | 49.0 | 25.6% | 67.2 | 30.5% |

| | | | | | | | | | | |
|---|--------------|---------------|--------------|---------------|--------------|---------------|--------------|---------------|--------------|---------------|
| Pvt Medical practices | 26.8 | 24.2% | 22.6 | 14.3% | 18.7 | 12.4% | 19.4 | 10.1% | 21.7 | 9.9% |
| Dental Practice | 3.5 | 3.1% | 4.8 | 3.1% | 5.5 | 3.7% | 6.0 | 3.2% | 5.8 | 2.6% |
| Eye Care | 4.9 | 4.4% | 6.4 | 4.0% | 2.8 | 1.9% | 3.6 | 1.9% | 3.7 | 1.7% |
| Ambulatory health care centres | 0.0 | 0.0% | 0.0 | 0.0% | 0.0 | 0.0% | | 0.0% | | 0.0% |
| Providers of ancillary services | 1.1 | 1.0% | 17.0 | 10.7% | 12.6 | 8.4% | 3.3 | 1.7% | 3.0 | 1.3% |
| Retailers and other providers of medical goods | 40.6 | 36.6% | 51.0 | 32.3% | 55.4 | 36.8% | 85.5 | 44.6% | 94.0 | 42.7% |
| Providers of preventive care | 0.0 | 0.0% | 3.2 | 2.0% | 0.2 | 0.1% | 1.2 | 0.6% | 1.2 | 0.6% |
| Providers of health care system administration and financing | 0.0 | 0.0% | 0.1 | 0.1% | 0.0 | 0.0% | 1.7 | 0.9% | 1.6 | 0.7% |
| Rest of the world | 12.0 | 10.8% | 10.7 | 6.7% | 14.2 | 9.4% | 22.0 | 11.5% | 22.0 | 10.0% |
| TOTAL | 110.9 | 100.0% | 158.1 | 100.0% | 150.7 | 100.0% | 191.6 | 100.0% | 220.2 | 100.0% |

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 2020-21 inpatient care was 46.4% whilst outpatient was 53.6% 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, 2016-17 to 2020-21

| Functions | 2016-17 | | 2017-18 | | 2018-19 | | 2019-20 | | 2020-21 | |
|---------------------------------|----------------|-----------|----------------|-----------|----------------|-----------|----------------|-----------|----------------|-----------|
| | Amount (FJ\$m) | Share (%) | Amount (FJ\$m) | Share (%) | Amount (FJ\$m) | Share (%) | Amount (FJ\$m) | Share (%) | Amount (FJ\$m) | Share (%) |
| Curative care | 56.2 | 50.7% | 68.6 | 43.4% | 70.7 | 46.9% | 98.3 | 51.3% | 118.5 | 53.8% |
| Inpatient curative care | 18.8 | 17.0% | 26.0 | 16.5% | 11.2 | 7.4% | 48.8 | 25.5% | 55.0 | 25.0% |
| Outpatient curative care | 6.6 | 5.9% | 42.6 | 26.9% | 59.5 | 39.5% | 49.5 | 25.8% | 63.5 | 28.9% |
| Rehabilitative care | 0.0 | 0.01% | 0.0 | 0.01% | 0.0 | 0.01% | | 0.00% | | 0.00% |

| | | | | | | | | | | |
|---|--------------|---------------|--------------|---------------|--------------|---------------|--------------|---------------|--------------|---------------|
| Ancillary services (non-specified by function) | 8.2 | 7.4% | 28.8 | 18.2% | 19.5 | 12.9% | 3.3 | 1.7% | 3.0 | 1.3% |
| Medical goods (non-specified by function) | 44.3 | 39.9% | 55.5 | 35.1% | 58.3 | 38.7% | 87.1 | 45.5% | 95.7 | 43.5% |
| Preventive care | 2.2 | 1.9% | 5.1 | 3.2% | 2.3 | 1.5% | 1.2 | 0.6% | 1.4 | 0.7% |
| Governance, and health system and financing administration | 0.0 | 0.0% | 0.1 | 0.1% | 0.0 | 0.0% | 1.7 | 0.9% | 1.6 | 0.7% |
| TOTAL | 110.9 | 100.0% | 158.1 | 100.0% | 150.7 | 100.0% | 191.6 | 100.0% | 220.2 | 100.0% |

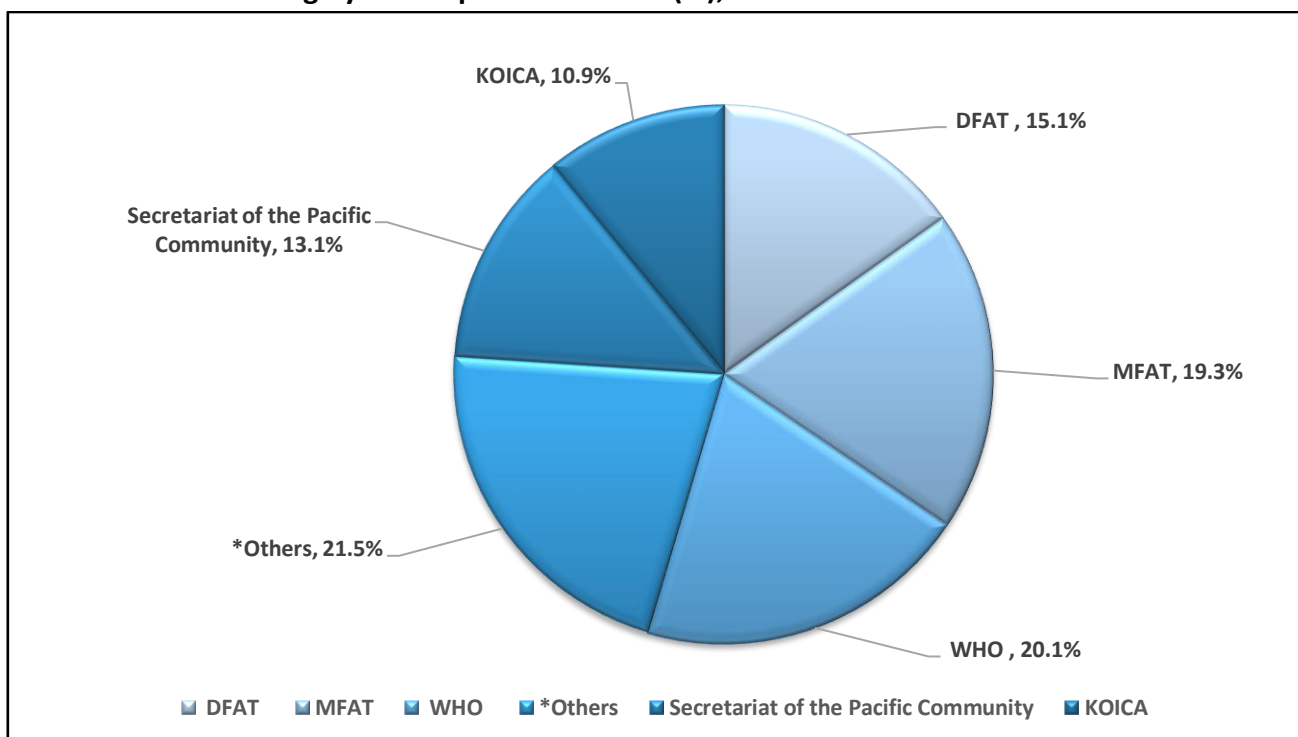
8. Development Partners (Rest of the World)

In this area, development partners also make reference to the SHA 2011 classification of "Rest of the World."

The Ministry of Health & Medical Services (MHMS) continues to seek assistance in the form of ad hoc financial grants, aid-in-kind (technical expertise, supplies, and equipment), and direct (cash grants) from its bilateral and multilateral partners.

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 2020-21.

Figure 8.1 Share of funding by Development Partners (%), 2020-21



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 2016-17 to 2020 -21. 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)

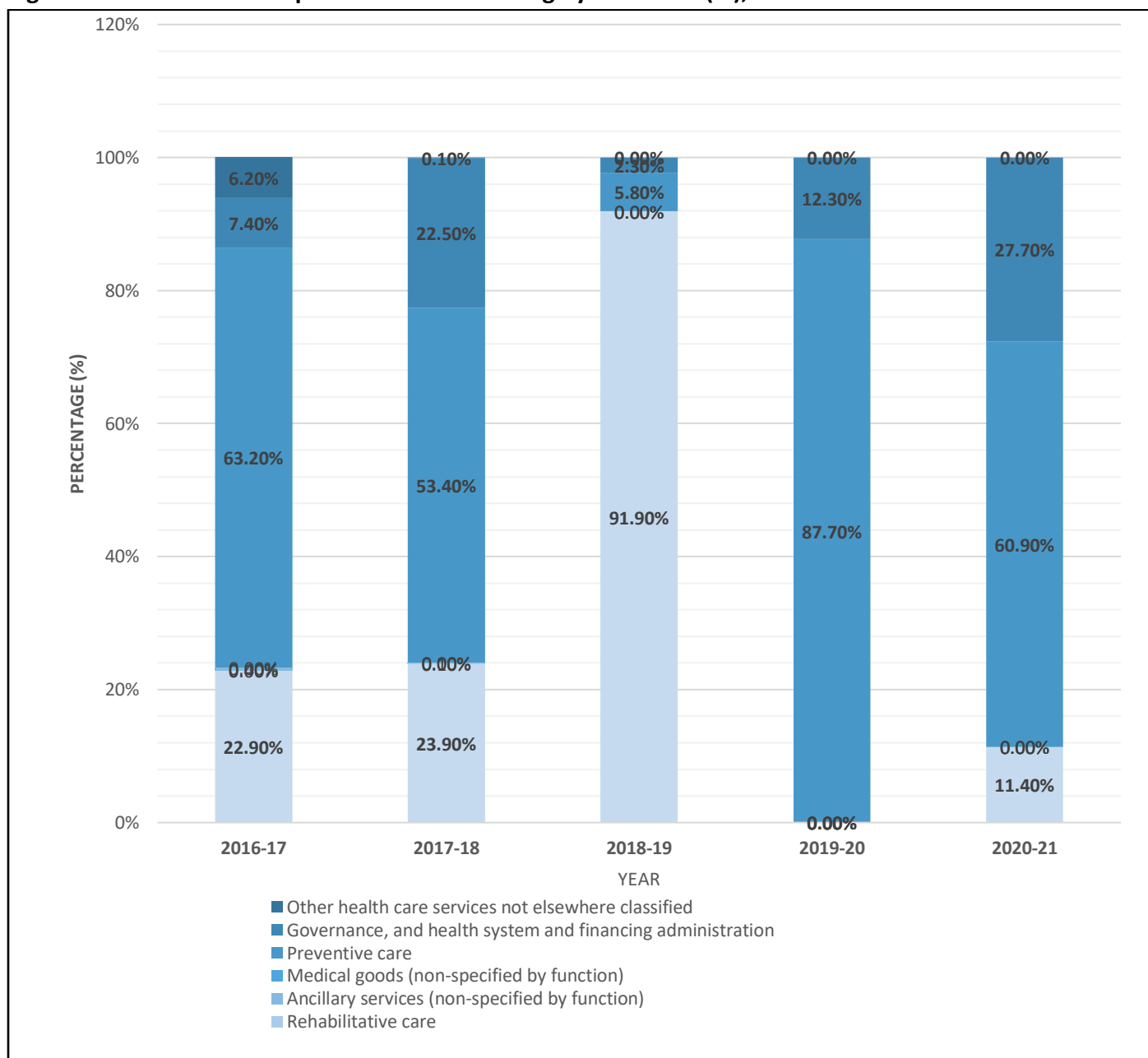
| Development Partners | CHE | | | | | HK | | | | | Total Contribution | | | | |
|---|-------------|-------------|-------------|-------------|-------------|----------|------------|----------|------------|------------|--------------------|-------------|-------------|-------------|-------------|
| | 2016-17 | 2017-18 | 2018-19 | 2019-20 | 2020-21 | 2016-17 | 2017-18 | 2018-19 | 2019-20 | 2020-21 | 2016-17 | 2017-18 | 2018-19 | 2019-20 | 2020-21 |
| DFAT | 2.0 | 7.3 | 38.1 | 5.2 | 7.1 | - | - | | | | 2.0 | 7.3 | 38.1 | 5.2 | 7.1 |
| WHO | 0.9 | 3.1 | 1.5 | 16.0 | 9.5 | - | - | | | | 0.9 | 3.1 | 1.5 | 16.0 | 9.5 |
| Japan | - | 1.5 | - | 0.0 | 0.8 | - | - | | | 0.4 | - | 1.5 | - | 0.0 | 1.2 |
| China | - | - | - | | | - | - | | 1.1 | 1.0 | - | - | - | 1.1 | 1.0 |
| NZAid | - | - | - | | | - | - | | | | - | - | - | - | - |
| Global Fund | 2.8 | 3.7 | - | | | - | - | | | | 2.8 | 3.7 | - | - | - |
| UNFPA | - | - | 0.4 | | 0.1 | - | - | | | | - | - | 0.4 | - | 0.137 |
| UNICEF | 1.5 | 0.2 | 0.1 | 1.563 | 3.5 | - | - | | 0.0 | 2.9 | 1.5 | 0.2 | 0.1 | 1.602 | 6.4 |
| UNAIDS | - | 0.0 | 0.037 | 0.032 | 0.1 | - | - | | | | - | 0.0 | 0.037 | 0.032 | 0.1 |
| KOICA | 2.9 | 2.0 | - | 3.2 | 4.7 | - | - | | 0.2 | 0.4 | 2.9 | 2.0 | - | 3.4 | 5.1 |
| ROC (Taiwan) | - | - | - | | | - | - | | | | - | - | - | - | - |
| UNDP | - | - | - | | | - | - | | | | - | - | - | - | - |
| Other | 3.1 | 3.2 | 1.1 | | 1.3 | - | 0.9 | | | | 3.056 | 4.1 | 1.1 | - | 1.3 |
| MFAT | - | 13.0 | 0.7 | 2.4 | 9.1 | - | - | | | | - | 13.0 | 0.7 | 2.4 | 9.1 |
| Secretariat of the Pacific Community | - | 0.2 | 0.1 | 0.1 | 6.2 | - | - | | | | - | 0.2 | 0.1 | 0.1 | 6.2 |
| Total Donor Contribution | 13.1 | 34.2 | 42.0 | 28.6 | 42.5 | - | 0.9 | - | 1.3 | 4.7 | 13.1 | 35.1 | 42.0 | 29.9 | 47.1 |

Note: USD Conversion: average of the FY. 2021 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 and again in 2019-20 and 2020-21 it is again preventive care (Covid -19).

Figure 8-2 Share of Development Partners funding by Functions (%), 2020-21



Source: Table 8.2

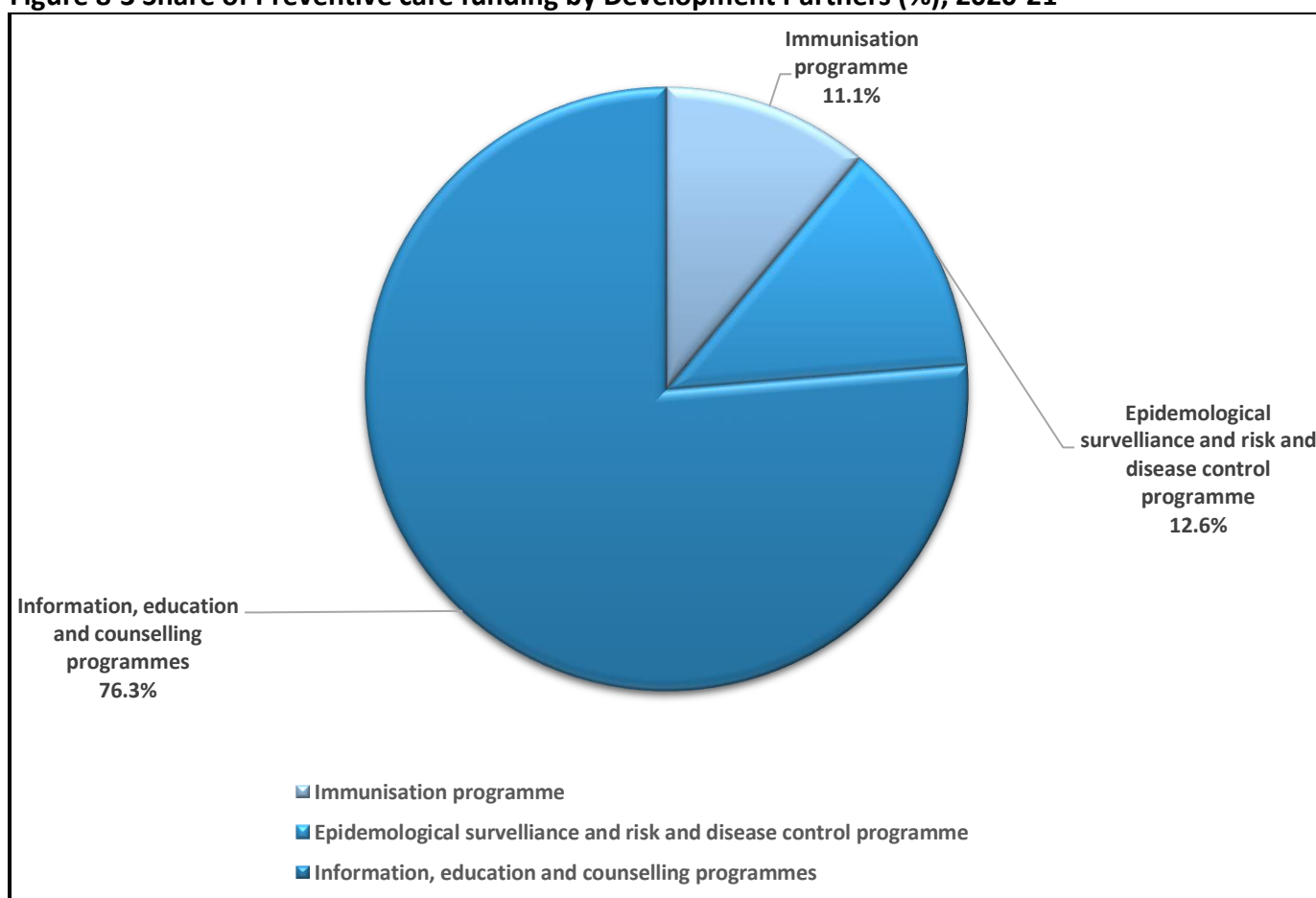
Preventative care and Governance, health system, financing and administration combined reflected around 90% of development partner investment in health sector.

Table 8-2 Financing contributions by Development Partners by Functions (%)

| Description/Functions | 2016-17 | 2017-18 | 2018-19 | 2019-20 | 2020-21 |
|--|---------------|---------------|---------------|---------------|---------------|
| Curative care | 22.9% | 23.9% | 91.9% | 0.0% | 11.4% |
| Rehabilitative care | 0.0% | 0.1% | 0.0% | 0.0% | 0.0% |
| Ancillary services (non-specified by function) | 0.4% | 0.0% | 0.0% | 0.0% | 0.0% |
| Medical goods (non-specified by function) | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |
| Preventive care | 63.2% | 53.4% | 5.8% | 87.7% | 60.9% |
| Governance, and health system and financing administration | 7.4% | 22.5% | 2.3% | 12.3% | 27.7% |
| Other health care services not elsewhere classified | 6.2% | 0.1% | 0.0% | 0.0% | 0.0% |
| Total | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |

Figure 8-3 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 (%), 2020-21



9. Capital Expenditure

According to SHA (2011), capital expenditure (HK) is a crucial part of health spending that goes toward providing healthcare services. The HK data aids in assessing the appropriateness, deficiency, and excess of the service delivery within the health systems production capability.

The capital expenditures for the production of services by the government, the private sector, and development partners are broken down in this chapter along with the services that have been rendered. The data on development partners and the private sector that is displayed has been combined from survey replies.

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 2016-17 to 2020-21.

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

| | 2016-17 | 2017-18 | 2018-19 | 2019-20 | 2020-21 |
|---|--------------|--------------|--------------|--------------|--------------|
| Capital Account | Amount FJ\$m | Amount FJ\$m | Amount FJ\$m | Amount FJ\$m | Amount FJ\$m |
| Infrastructure | 26.4 | 19.2 | 26.0 | 26.6 | 15.6 |
| Residential and non-residential buildings | 26.4 | 19.2 | 26.0 | 3.0 | 3.1 |
| Other structures | 0.0 | 0.0 | 0.0 | 23.6 | 12.5 |
| Machinery and equipment | 10.1 | 18.7 | 9.0 | 10.2 | 20.5 |
| Medical equipment | 9.4 | 16.6 | 7.7 | 7.4 | 8.0 |
| Transport equipment | 0.2 | 0.6 | 0.3 | 0.5 | 0.4 |
| ICT equipment | 0.5 | 1.5 | 1.0 | 1.1 | 1.4 |
| Machinery and equipment | | | | 1.3 | 10.8 |
| Intellectual property products | 0.7 | 0.7 | 0.6 | 0.9 | 0.9 |
| Computer software and databases | 0.7 | 0.7 | 0.6 | 0.9 | 0.9 |
| Non-produced non-financial assets | 0.2 | 0.3 | 0.1 | 0.6 | 0.7 |

| | | | | | |
|---|-------------|-------------|-------------|-------------|-------------|
| Non-produced non-financial assets | 0.1 | 0.0 | 0.0 | | |
| Land | 0.1 | 0.3 | 0.1 | 0.6 | 0.7 |
| Memorandum items | 0.0 | 0.0 | 0.0 | | |
| Education of health personnel | 0.0 | 0.0 | 0.0 | | |
| Unspecified gross fixed capital formation (n.e.c.) | 0.0 | 3.0 | 0.6 | 0.3 | 0.3 |
| Total | 37.4 | 42.0 | 36.3 | 38.7 | 38.0 |

9.2. Capital Expenditure by Sectors

Table 9-2 shows the contribution of Capital Expenditure by each sector for the years 2016-17 to 2020-21. 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 2020-21 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

| | 2016-17 | 2017-18 | 2018-19 | 2019-20 | 2020-21 |
|-----------------------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| Sector | Amount FJ\$m | Amount FJ\$m | Amount FJ\$m | Amount FJ\$m | Amount FJ\$m |
| Government | 29.5 | 24.96 | 27.4 | 27.97 | 23.8 |
| Private | 7.9 | 16.14 | 9.0 | 9.37 | 9.5 |
| Development Partners | 0.0 | 0.91 | 0.0 | 1.34 | 4.7 |
| TOTAL | 37.4 | 42.0 | 36.3 | 38.7 | 38.0 |

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 the 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 2020-21, Government was largest by (55%) followed by Private (37.0%) and Development Partners (8.0%).

Figure 10-1 Share of expenditure by Factors of Health Care Provision by CHE (%), 2020-21

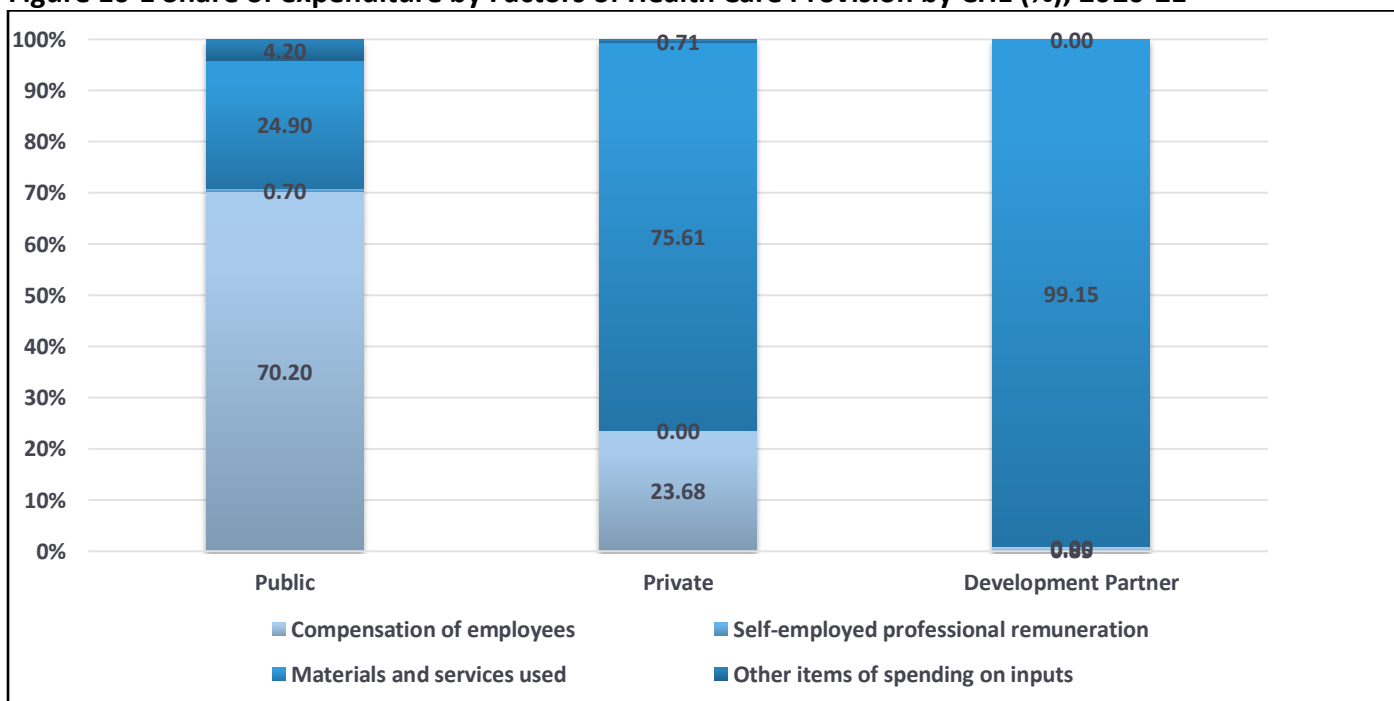


Figure 10-1 shows that Government had very high input costs in the production of health care services to maintain and sustain the level of service delivery.

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

Table 10-1 Factors of Provision by GCHE

| Category | 2016-17 | | 2017-18 | | 2018-19 | | 2019-20 | | 2020-21 | |
|---|---------------|-------------|---------------|-------------|---------------|-------------|---------------|-------------|---------------|-------------|
| | Amt (FJ\$m) | Share (%) | Amt (FJ\$m) | Share (%) | Amt (FJ\$m) | Share (%) | Amt (FJ\$m) | Share (%) | Amt (FJ\$m) | Share (%) |
| Wages and salaries | 170.94 | 73.2% | 171.02 | 59.8% | 198.4 | 63.8% | 174.84 | 56.0% | 206.76 | 63.4% |
| FNPF | 12.24 | 5.2% | 16.12 | 5.6% | 18.3 | 5.9% | 15.93 | 5.1% | 10.21 | 3.1% |
| Wages and Salaries - Allowances, OT, Relieving etc | 9.33 | 4.0% | 6.61 | 2.3% | 4.0 | 1.3% | 26.95 | 8.6% | 11.89 | 3.6% |
| Self-employed professional remuneration | 0.00 | 0.0% | 3.31 | 1.2% | 4.9 | 1.6% | 2.41 | 0.8% | 2.29 | 0.7% |
| Laboratory & Imaging services | 0.00 | 0.0% | 1.28 | 0.4% | 5.8 | 1.9% | 10.56 | 3.4% | 11.37 | 3.5% |
| Health care services | 8.93 | 3.8% | 8.03 | 2.8% | 10.6 | 3.4% | 11.16 | 3.6% | 22.70 | 7.0% |
| Vaccines | 0.00 | 0.0% | 0.05 | 0.0% | - | 0.0% | 3.38 | 1.1% | | 0.0% |
| Contraceptives | 0.00 | 0.0% | 0.00 | 0.0% | 0.0 | 0.0% | 0.00 | 0.0% | | 0.0% |
| ARV | 0.00 | 0.0% | 0.00 | 0.0% | - | 0.0% | | 0.0% | | 0.0% |
| Pharmaceuticals (Drugs) | 0.31 | 0.1% | 46.62 | 16.3% | 18.2 | 5.8% | 10.67 | 3.4% | 13.92 | 4.3% |
| Diagnostic Equipment | 0.00 | 0.0% | 0.00 | 0.0% | 0.0 | 0.0% | 0.69 | 0.2% | | 0.0% |
| Other health care goods | 10.49 | 4.5% | 3.20 | 1.1% | 9.6 | 3.1% | 6.61 | 2.1% | 9.25 | 2.8% |
| Training | 0.44 | 0.2% | 0.28 | 0.1% | 0.1 | 0.0% | 0.02 | 0.0% | | 0.0% |
| Technical Assistance | 0.00 | 0.0% | 0.00 | 0.0% | - | 0.0% | | 0.0% | | 0.0% |
| Indemnity | 0.00 | 0.0% | 0.07 | 0.0% | - | 0.0% | | 0.0% | | 0.0% |
| Operational research | 0.00 | 0.0% | 0.00 | 0.0% | - | 0.0% | | 0.0% | | 0.0% |
| Indemnity | 0.00 | 0.0% | 0.00 | 0.0% | 0.2 | 0.1% | | 0.0% | | 0.0% |
| Non-health care services | 9.97 | 4.3% | 3.46 | 1.2% | 5.4 | 1.8% | 0.06 | 0.0% | 4.01 | 1.2% |
| Non-health care goods | 6.01 | 2.6% | 7.71 | 2.7% | 8.7 | 2.8% | 8.49 | 2.7% | 5.16 | 1.6% |
| Other materials and services used (n.e.c.) | 0.00 | 0.0% | 8.47 | 3.0% | 6.4 | 2.1% | 25.88 | 8.3% | 14.77 | 4.5% |
| Taxes (VAT) | 1.95 | 0.8% | 6.45 | 2.3% | 6.8 | 2.2% | 6.54 | 2.1% | 4.97 | 1.5% |
| Other items of spending | 2.64 | 1.1% | 3.35 | 1.2% | 13.5 | 4.3% | 8.10 | 2.6% | 8.72 | 2.7% |
| Unspecified factors of health care provision (n.e.c.) | 0.32 | 0.1% | 0.00 | 0.0% | 0.0 | 0.0% | 0.00 | 0.0% | 0.00 | 0.0% |
| Total | 233.56 | 100% | 286.01 | 1.00 | 310.79 | 1.00 | 312.26 | 100% | 326.01 | 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 2016-17 was 233.5 FJ\$m and in 2020-21 was 326.01 FJ\$m. The major increase is in HR, Laboratory and Imaging, healthcare services and pharmaceuticals. 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

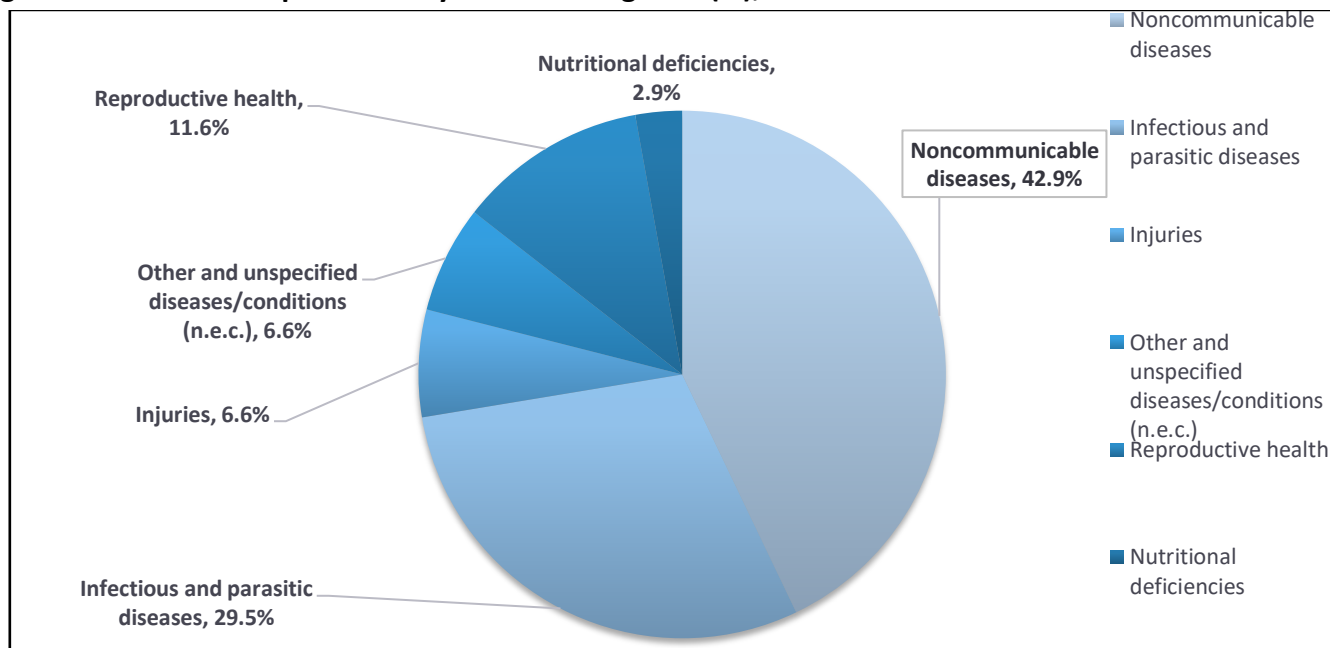
Table 11-1 shows the distribution of total CHE across the disease categories. NCDs account for the most expenditure and represents 42.9% of total CHE. Within the NCD category, cardiovascular diseases were the most dominant illness.

Table 11-1 Expenditure by disease categories (FJ\$m), 2016-17- 2020-21

| Classification of diseases / conditions | 2016-17 | | 2017-18 | | 2018-19 | | 2019-20 | | 2020-21 | |
|---|----------------|-----------|----------------|-----------|----------------|-----------|----------------|-----------|----------------|-----------|
| | Amount (FJ\$m) | Share (%) | Amount (FJ\$m) | Share (%) | Amount (FJ\$m) | Share (%) | Amount (FJ\$m) | Share (%) | Amount (FJ\$m) | Share (%) |
| Non-communicable diseases | 127.9 | 35.8% | 189.6 | 39.6% | 191.1 | 38.0% | 235.8 | 44.3% | 252.4 | 42.9% |
| Infectious and parasitic diseases | 106.9 | 29.9% | 168.4 | 35.2% | 165.2 | 32.8% | 142.09 | 26.7% | 173.73 | 29.5% |
| Injuries | 61.2 | 17.1% | 46.6 | 9.7% | 27.3 | 5.4% | 29.3 | 5.5% | 38.7 | 6.6% |
| Non-disease specific* | 18.9 | 5.3% | - | 0.0% | 0.0 | 0.0% | | 0.0% | | 0.0% |
| Other and unspecified diseases/conditions (n.e.c.)** | 14.6 | 4.1% | 16.7 | 3.5% | 66.2 | 13.2% | 29.5 | 5.5% | 38.7 | 6.6% |
| Reproductive health | 19.7 | 5.5% | 33.7 | 7.0% | 24.9 | 4.9% | 79.0 | 14.8% | 68.3 | 11.6% |
| Nutritional deficiencies | 7.0 | 1.9% | 16.6 | 3.5% | 21.1 | 4.2% | 16.8 | 3.2% | 16.8 | 2.9% |
| Long-term care | 0.0 | 0.0% | 0.2 | 0.0% | 0.0 | 0.0% | | 0.0% | | 0.0% |
| Rehabilitative Care | 1.3 | 0.4% | 6.6 | 1.4% | 7.7 | 1.5% | | 0.0% | | 0.0% |
| Total | 357.5 | 100.0% | 478.4 | 100.0% | 503.5 | 100.0% | 532.5 | 100.0% | 588.6 | 100.0% |

** 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 (2020-21) as presented in Table 11-1.

Figure 11-1 Share of expenditure by disease categories (%), 2020-21



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), 2020-21

| Classification of diseases / conditions (FJ\$m) | Public | Private | Development Partners | Total | Share (%) |
|--|--------------|--------------|----------------------|--------------|-------------|
| Infectious and parasitic diseases | 90.8 | 51.3 | 31.6 | 173.7 | 29.5% |
| Reproductive health | 61.3 | 6.7 | 0.3 | 68.3 | 11.6% |
| Nutritional deficiencies | 5.4 | 11.2 | 0.2 | 16.8 | 2.9% |
| Non communicable diseases | 119.2 | 127.6 | 5.6 | 252.4 | 42.9% |
| Injuries | 33.6 | 5.1 | 0.0 | 38.7 | 6.6% |
| Other and unspecified diseases/conditions (n.e.c.) | 15.7 | 18.3 | 4.8 | 38.7 | 6.6% |
| Total | 326.0 | 220.2 | 42.5 | 588.6 | 100% |

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 (%), 2020-21

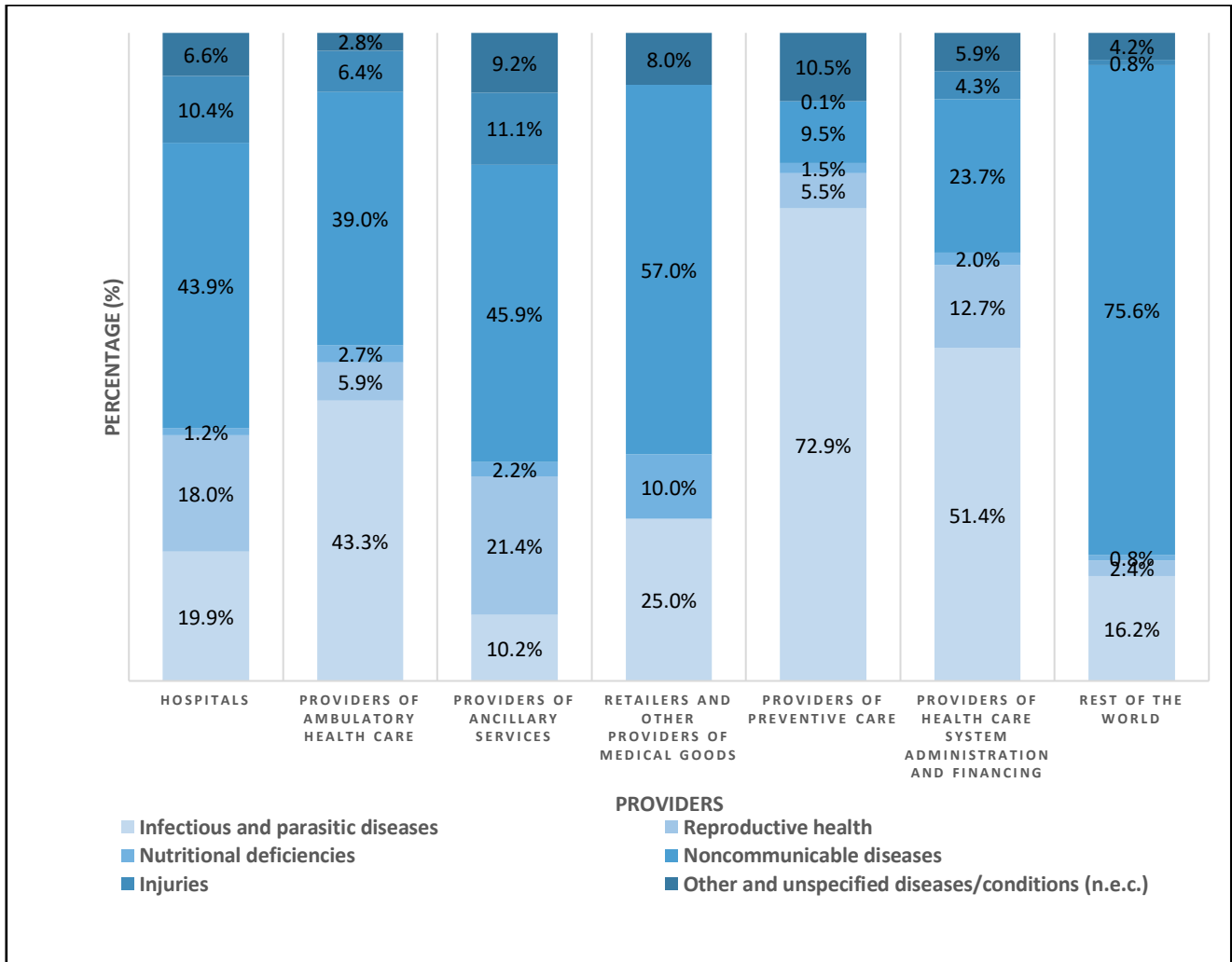


Table 11-3 shows the disease distribution across the functional classification. Again, *Noncommunicable diseases* were highest amongst all patients seeking curative care (both inpatient and outpatient) in 2020-21.

Table 11-3 Disease expenditure by Functions (FJ\$m), 2020-21

| Classification of diseases / conditions | Curative care | Inpatient curative care | Outpatient curative care | Rehabilitative care | Ancillary services (non-specified by function) | Medical goods (non-specified by function) | Preventive care | Governance, and health system and financing administration |
|--|---------------|-------------------------|--------------------------|---------------------|--|---|-----------------|--|
| Infectious and parasitic diseases | 50.2 | 22.9 | 27.3 | 0.4 | 0.6 | 23.7 | 80.0 | 18.7 |
| Reproductive health | 54.3 | 25.6 | 28.7 | | 1.3 | | 8.0 | 4.6 |
| Nutritional deficiencies | 3.2 | 1.8 | 1.4 | | 0.1 | 9.5 | 3.3 | 0.7 |
| Noncommunicable diseases | 161.3 | 72.0 | 89.3 | 3.7 | 2.9 | 55.8 | 19.9 | 8.6 |
| Injuries | 33.1 | 4.5 | 28.6 | 3.1 | 0.7 | | 0.2 | 1.6 |
| Other and unspecified diseases/conditions (n.e.c.) | 22.6 | 4.1 | 18.5 | | 0.6 | 7.6 | 5.8 | 2.2 |
| Total | 324.8 | 131.0 | 193.8 | 7.2 | 6.3 | 96.7 | 117.2 | 36.5 |

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 systems, 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)¹. 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 in Fiji is defined as expenditure on outpatient care (curative as well as Long term care, excluding Specialized outpatient care and outpatient care at Divisional Hospitals), home based care (curative as well as long term care), medical goods (100% of the OTC and 80 % of total of other medical goods), preventive care and Health system Governance and administration (30 % of HC.7.1).

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

| | 2019-20 | | 2020-21 | |
|----------------------|--------------|---------------|--------------|---------------|
| | FJ\$(m) | % | FJ\$(m) | % |
| Government | 124.8 | 48.4% | 134.0 | 47.0% |
| Private | 104.0 | 40.3% | 121.7 | 42.7% |
| Development Partners | 29.1 | 11.3% | 29.4 | 10.3% |
| Total | 257.9 | 100.0% | 285.1 | 100.0% |

¹As 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

| | 2019-20 | | 2020-21 | |
|--|--------------|---------------|--------------|---------------|
| | FJ\$(m) | % | FJ\$(m) | % |
| Hospitals | 86.0 | 33.3% | 81.1 | 28.4% |
| Providers of ambulatory health care | 47.4 | 18.3% | 62.6 | 21.9% |
| Providers of ancillary services | 0.0 | 0.0% | 0.0 | 0.0% |
| Retailers and Other providers of medical goods | 75.3 | 29.1% | 82.8 | 29.0% |
| Providers of preventive care | 43.0 | 16.6% | 48.0 | 16.8% |
| Providers of health care system administration and financing | 7.0 | 2.7% | 10.9 | 3.8% |
| Rest of the world | 0.0 | 0.0% | 0.0 | 0.0% |
| Total | 258.7 | 100.0% | 285.5 | 100.0% |

The PHCE by providers gives an idea about how the gate keeping is successful in the health system. In Fiji in 2020-21 the major providers of PHCE were Pharmacies followed by hospitals, and ambulatory care providers.

Government Health Expenditure on Primary Care

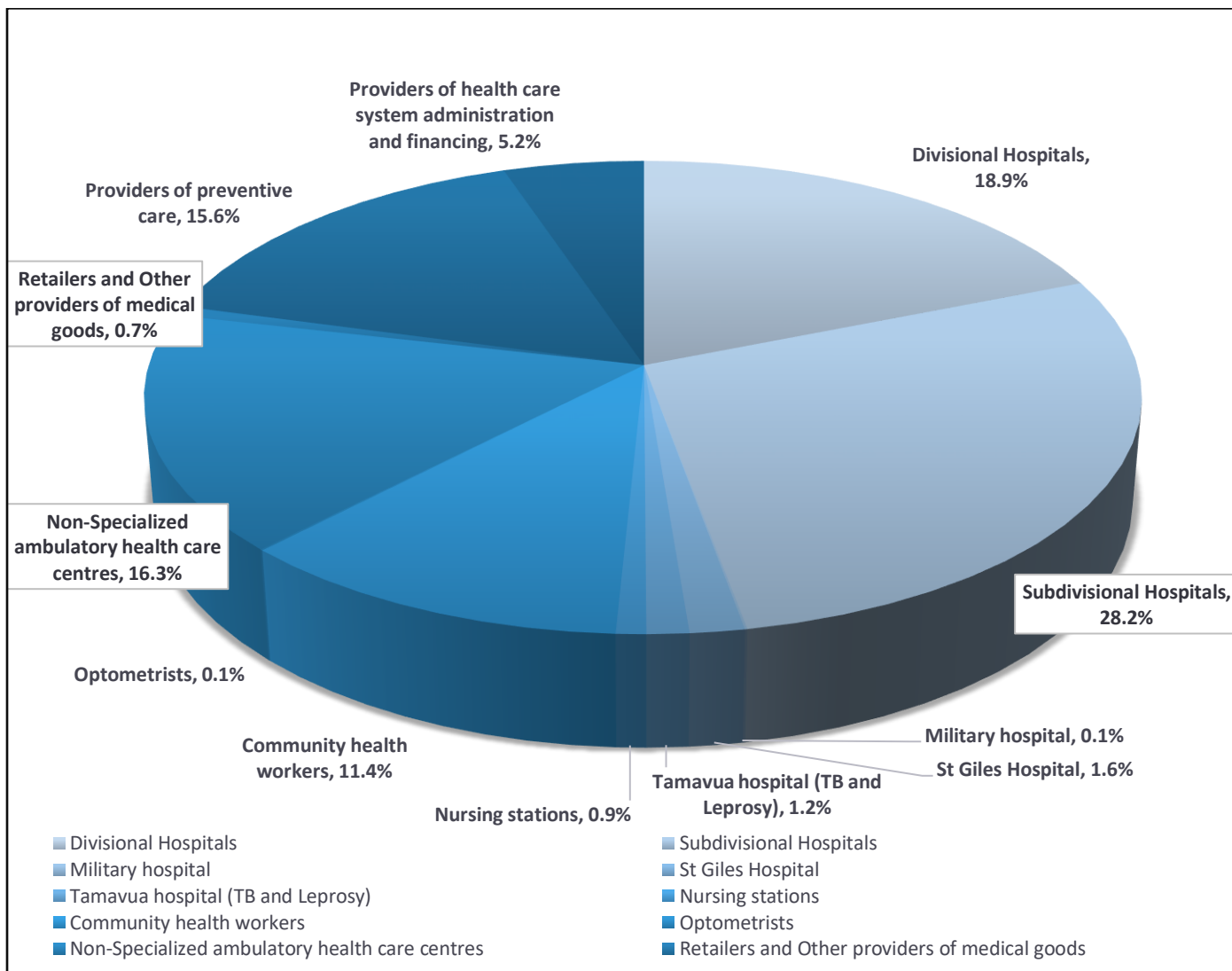
Fiji health system is three tier system where the Divisional hospitals provides mainly tertiary and secondary care, the sub-divisional hospitals are tasked with primary and secondary care and rest of the facilities provides primary care (except for specialized hospitals).

Table 12- 3 Government health expenditure on primary health care by providers (FJ\$(m) and %

| Health care providers | FJ\$(m) | Percentage (%) |
|--|---------|----------------|
| Divisional Hospitals | 25.4 | 18.9% |
| Subdivisional Hospitals | 37.8 | 28.2% |
| Military hospital | 0.1 | 0.1% |
| St Giles Hospital | 2.1 | 1.6% |
| Tamavua hospital (TB and Leprosy) | 1.6 | 1.2% |
| Nursing stations | 1.1 | 0.9% |
| Community health workers | 15.3 | 11.4% |
| Optometrists | 0.1 | 0.1% |
| Non-Specialized ambulatory health care centers | 21.8 | 16.3% |

| | | |
|---|-------|--------|
| Retailers and Other providers of medical goods | 0.9 | 0.7% |
| Providers of preventive care | 20.9 | 15.6% |
| Providers of health care system administration and financing | 6.9 | 5.2% |
| All HP | 134.2 | 100.0% |

Figure 12-1 Government health expenditure on primary health care by providers %



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

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 2016 to 2020-21 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 2016 to 2018-19 may differ from those 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 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 2020-21. 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 at 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 2020-21 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 2020-21. 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 disposal 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 13- 1 Response rates of surveys of the private sector

| Name | Surveyed population | | | | Response Rates (%) | | | |
|---|---------------------|---------|---------|---------|--------------------|---------|---------|---------|
| | 2017-18 | 2018-19 | 2019-20 | 2020-21 | 2017-18 | 2018-19 | 2019-20 | 2020-21 |
| General Practitioners | 106 | 91 | 75 | 75 | 66 | 55 | 45 | 45 |
| Private Dentist | 39 | 37 | 34 | 34 | 72 | 68 | 59 | 59 |
| Retail Pharmacies | 71 | 62 | 76 | 76 | 83 | 55 | 66 | 66 |
| Private Hospitals | 5 | 4 | 4 | 4 | 80 | 75 | 100 | 100 |
| Private Employers | 12 | 4 | 19 | 19 | 33 | 50 | 95 | 95 |
| Private Laboratory and X-Ray | 5 | 4 | 9 | 9 | 60 | 25 | 67 | 67 |
| Private Insurance | 4 | 2 | 4 | 4 | 75 | 0 | 25 | 25 |
| Private Optometrists | 17 | 14 | 2 | 2 | 71 | 86 | 0 | 0 |
| Development Partners | 14 | 10 | 10 | 10 | 57 | 60 | 80 | 80 |
| NGO's | 12 | 7 | 6 | 6 | 33 | 57 | 50 | 50 |
| Overall response rate across all health providers surveyed | | | | | 68 | 58 | 60 | 60 |

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 13- 2 Revenue estimations of private sector surveys

| | |
|------------------------|---|
| Daily revenue | Calculated using average fee per patient multiplied by total number of patients seen in a year |
| Weekly revenue | 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 |
| | |
| Monthly revenue | Average revenue reported per month multiplied by 12 months |
| Annual revenue | 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 2021 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 9 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 be extended 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 be documented 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 were employed in past productions of NHA.
- The mapping of raw financial data to the SHA-2011 classifications was not straightforward. 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

| 2018-19 Matrices | Page Numbers |
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Table 1: Financing schemes (HF) by Revenues of health care financing schemes (FS), 2020-21

| Fiji Dollar (Millions) | Transfers from government domestic revenue (allocated to health purposes) | Transfers distributed by government from foreign origin | Voluntary prepayment from individuals/households | Voluntary prepayment from employers | Other revenues from households n.e.c. | Other revenues from corporations n.e.c. | Other revenues from NPISH n.e.c. | Direct foreign transfers | All FS |
|---|---|---|--|-------------------------------------|---------------------------------------|---|----------------------------------|--------------------------|--------------|
| Government schemes and compulsory contributory health care financing schemes | 326 | 1.3 | | | | | | 0.2 | 327.5 |
| Employer-based insurance (Other than enterprises schemes) | | | 2.9 | 54.2 | | | | | 57.1 |
| Other primary coverage schemes | | | 14.8 | | | | | | 14.8 |
| NPISH financing schemes (including development agencies) | | | | | | 3.9 | 0.8 | 14.3 | 19 |
| Enterprise financing schemes | | | | | | 4.9 | 2.9 | | 7.9 |
| Out-of-pocket excluding cost-sharing | | | | | 129.9 | | | | 129.9 |
| Cost sharing with government schemes and compulsory contributory health insurance schemes | | | | | 5.8 | | | | 5.8 |
| Rest of the world financing schemes (non-resident) | | | | | | | | 26.7 | 26.7 |
| All HF | 326 | 1.3 | 17.7 | 54.2 | 135.7 | 8.8 | 3.7 | 41.1 | 588.6 |

Table 2: Health care providers (HP) by Revenues of health care financing schemes (FS), 2020-21

| <i>Fiji Dollar (Millions)</i> | Transfers from government domestic revenue (allocated to health purposes) | Transfers distributed by government from foreign origin | Voluntary prepayment from individuals/households | Voluntary prepayment from employers | Other revenues from households n.e.c. | Other revenues from corporations n.e.c. | Other revenues from NPISH n.e.c. | Direct foreign transfers | All FS |
|---|---|---|--|-------------------------------------|---------------------------------------|---|----------------------------------|--------------------------|--------|
| HP.1 Hospitals | 239 | | 8 | 22 | 29 | 4 | 3 | | 306 |
| HP.1.1.1 Divisional Hospitals | 159 | | 0 | 0 | 6 | | | | 165 |
| HP.1.1.2 Sub divisional Hospitals | 70 | | | | | | | | 70 |
| HP.1.1.3 Military hospital | 0 | | | | | | | | 0 |
| HP.1.1.4.1 Private Hospitals | | | 8 | 22 | 24 | 4 | 3 | | 61 |
| HP.1.2.1 St Giles Hospital | 4 | | | | | | | | 4 |
| HP.1.3.1 Tamavua hospital (TB and Leprosy) | 4 | | | | | | | | 4 |
| HP.1.nec Unspecified hospitals (n.e.c.) | | | | | | 0 | 0 | | 0 |
| HP.3 Providers of ambulatory health care | 39 | | 2 | 7 | 20 | 1 | 0 | | 70 |
| HP.3.1.1.1 Private medical practices (GPs) | | | 2 | 7 | 11 | 1 | 0 | | 22 |
| HP.3.2.2 Private dental practice | | | 0 | 0 | 5 | 0 | | | 6 |
| HP.3.3.1 Nursing stations | 1 | | | | | | | | 1 |

| | | | | | | | | | |
|--|------------|----------|-----------|-----------|------------|----------|----------|-----------|------------|
| HP.3.3.2 Community health workers | 15 | | | | | | | | 15 |
| HP.3.3.4 Optometrists | 0 | | 0 | 0 | 3 | 0 | 0 | | 4 |
| HP.3.4.9 All Other ambulatory centres | 22 | | | | | | | | 22 |
| HP.4 Providers of ancillary services | 3 | | 1 | | 2 | | 0 | | 6 |
| HP.4.1 Providers of patient transportation and emergency rescue | 3 | | | | | | 0 | | 4 |
| HP.4.2 Medical and diagnostic laboratories | | | 1 | | 2 | | 0 | | 3 |
| HP.5 Retailers and Other providers of medical goods | 1 | | 3 | 6 | 85 | 1 | | | 95 |
| HP.6 Providers of preventive care | 21 | | | | | 1 | 0 | 26 | 48 |
| HP.7 Providers of health care system administration and financing | 23 | 1 | | | | 2 | | 10 | 36 |
| HP.9 Rest of the world | 0 | | 3 | 19 | | | | 5 | 27 |
| All HP | 326 | 1 | 18 | 54 | 136 | 9 | 4 | 41 | 589 |

Table 3: Health care providers (HP) by Health care functions (HC), 2020-21

| Fiji Dollar (Millions) | Inpatient curative care | Day curative care | Outpatient curative care | Unspecified curative care (n.e.c.) | Rehabilitative care | Ancillary services | Medical goods | Preventive care | Governance, and health system and financing administration | All HC |
|--|-------------------------|-------------------|--------------------------|------------------------------------|---------------------|--------------------|---------------|-----------------|--|--------|
| Hospitals | 103.7 | 14.1 | 133.9 | 7.2 | 7.2 | | | 39.6 | | 305.7 |
| Divisional Hospitals | 42.5 | 13.9 | 84.2 | 7 | 3.7 | | | 14.1 | | 165.4 |
| Subdivisional Hospitals | 25 | | 20.2 | | 2.5 | | | 22.7 | | 70.4 |
| Military hospital | 0.1 | | 0.1 | | 0 | | | 0.1 | | 0.2 |
| Private Hospitals | 32.5 | | 28 | | | | | | | 60.5 |
| St Giles Hospital | 2.1 | 0.2 | 1.2 | | | | | 0.9 | | 4.4 |
| Tamavua hospital (TB and Leprosy) | 1.5 | | 0.3 | | 0.9 | | | 1.6 | | 4.4 |
| Unspecified hospitals (n.e.c.) | | | | 0.2 | | | | 0.2 | | 0.4 |
| Providers of ambulatory health care | | | 38.6 | | | | 1.7 | 29.6 | | 69.9 |
| Private medical practices (GPs) | | | 21.7 | | | | | | | 21.7 |
| Private dental practice | | | 5.8 | | | | | | | 5.8 |
| Nursing stations | | | 0.2 | | | | | 0.9 | | 1.1 |
| Community health workers | | | | | | | | 15.3 | | 15.3 |
| Optometrists | | | 2 | | | | 1.7 | | | 3.7 |
| All Other ambulatory centres | | | 8.8 | | | | | 13.4 | | 22.2 |
| Providers of ancillary services | | | | | | 6.3 | | | | 6.3 |

| | | | | | | | | | | |
|---|------|------|-------|-----|-----|-----|------|-------|------|-------|
| Providers of patient transportation and emergency rescue | | | | | | 3.6 | | | | 3.6 |
| Medical and diagnostic laboratories | | | | | | 2.7 | | | | 2.7 |
| Retailers and Other providers of medical goods | | | | | | | 95 | | | 95 |
| Providers of preventive care | | | | | | | | 48 | | 48 |
| Providers of health care system administration and financing | | | | | | | | | 36.5 | 36.5 |
| Rest of the world | 27.2 | | | | | | | | | 27.2 |
| All HP | 131 | 14.1 | 172.5 | 7.2 | 7.2 | 6.3 | 96.7 | 117.2 | 36.5 | 588.6 |

Table 4: Health care functions (HC) by Revenues of health care financing schemes (FS), 2020-21

| Fiji Dollar (Millions) | 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 |
|---|---|---|----------------------|--------------------------------|--------------------------|--------------|
| Curative care | 201.4 | | 62.1 | 56.4 | 4.8 | 324.8 |
| Inpatient curative care | 71.2 | | 41.9 | 13.1 | 4.8 | 131.0 |
| Day curative care | 14.1 | | | | | 14.1 |
| Outpatient curative care | 115.0 | | 20.2 | 37.3 | | 172.5 |
| Unspecified curative care (n.e.c.) | 1.2 | | | 6.0 | | 7.2 |
| Rehabilitative care | 7.2 | | | | | 7.2 |
| Ancillary services | 3.3 | | 1.1 | 1.9 | | 6.3 |
| Laboratory services | | | 0.8 | 1.1 | | 1.9 |
| Imaging services | | | 0.3 | 0.5 | | 0.8 |
| Patient transportation | 3.3 | | | 0.2 | | 3.6 |
| Medical goods | 1.0 | | 8.7 | 87.0 | | 96.7 |
| Preventive care | 89.9 | | | 1.4 | 25.9 | 117.2 |
| Information, education and counselling (IEC) programmes | 21.3 | | | 0.0 | 19.7 | 41.0 |
| Immunization programmes | 12.2 | | | | 2.9 | 15.0 |
| Early disease detection programmes | 20.6 | | | | | 20.6 |
| Healthy condition monitoring programmes | 11.2 | | | | | 11.2 |
| Epidemiological surveillance and risk and disease control programmes | 15.2 | | | 1.4 | 3.3 | 19.9 |
| Preparing for disaster and emergency response programmes | 9.4 | | | | | 9.4 |
| Governance, and health system and financing administration | 23.2 | 1.3 | | 1.6 | 10.4 | 36.5 |
| All HC | 326.0 | 1.3 | 71.9 | 148.3 | 41.1 | 588.6 |

Table 5: Factors of health care provision (FP) by Revenues of health care financing schemes (FS), 2020-21

| Fiji Dollar (Millions) | 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 |
|--|---|---|----------------------|--------------------------------|--------------------------|--------|
| Compensation of employees | 228.9 | | 14.4 | 37.9 | 0.4 | 281.6 |
| Wages and salaries | 206.8 | | 14.4 | 37.9 | 0.4 | 259.5 |
| Social contributions | 10.2 | | | | | 10.2 |
| All Other costs related to employees | 11.9 | | | | | 11.9 |
| Self-employed professional remuneration | 2.3 | | | | | 2.3 |
| Materials and services used | 81.2 | | 56.9 | 108.8 | 40.8 | 289 |
| Health care services | 34.1 | 1.3 | 37.1 | 11.5 | 4.9 | 88.9 |
| Health care goods | 23.2 | | 18.5 | 88 | 2.8 | 132.5 |
| Non-health care services | 4 | | 1.3 | 9.3 | 33 | 47.7 |
| Non-health care goods | 5.2 | | | | | 5.2 |
| Other materials and services used (n.e.c.) | 14.8 | | | | 0.1 | 14.8 |
| Other items of spending on inputs | 13.7 | | | 1.6 | 0 | 15.2 |
| Taxes | 5 | | | | | 5 |
| Other items of spending | 8.7 | | | 1.6 | 0 | 10.3 |
| All FP | 326 | 1.3 | 71.4 | 148.3 | 41.1 | 588.1 |

Table 6: Classification of diseases / conditions (DIS) by Revenues of health care financing schemes (FS), 2020-21

| Fiji Dollar (Millions) | 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 | 90.8 | 1.3 | 16.5 | 34.8 | 30.3 | 173.7 |
| HIV/AIDS and Other Sexually Transmitted Diseases (STDs) | 2.8 | | 0 | 0 | 0.1 | 3 |
| HIV/AIDS and Opportunistic Infections (OIs) | 2.6 | | | | 0.1 | 2.7 |
| HIV/AIDS | 2.6 | | | | 0.1 | 2.7 |
| TB/HIV | 0 | | | | | 0 |
| Unspecified HIV/AIDS and Other STDs (n.e.c.) | 0.2 | | 0 | 0 | | 0.2 |
| Tuberculosis (TB) | 2 | | | | 0 | 2 |
| Unspecified tuberculosis (n.e.c.) | 2 | | | | 0 | 2 |
| Malaria | 0.2 | | | | | 0.2 |
| Respiratory infections | 13.4 | | 2.3 | 2.4 | | 18.1 |
| Diarrheal diseases | 10.4 | | | | | 10.4 |
| Neglected Tropical Diseases (NTDs) | 3.2 | | | | 0.2 | 3.4 |
| Vaccine preventable diseases | 13.3 | | | | 0 | 13.3 |
| Emergencies / outbreak / surge (e.g. Ebola, Avian flu) | 1.2 | 1.3 | | 0.2 | 15 | 17.7 |
| Disease from coronavirus 2019-nCoV (COVID-19) | 1.2 | 1.3 | | 0.2 | 15 | 17.7 |
| Other and unspecified infectious and parasitic diseases (n.e.c.) | 44.4 | | 14.2 | 32.2 | 14.9 | 105.7 |
| Reproductive health | 61.3 | | 3.2 | 3.5 | 0.3 | 68.3 |

| | | | | | | |
|---|--------------|--|-------------|-------------|------------|--------------|
| Maternal conditions | 44.3 | | 1.1 | 0.8 | | 46.2 |
| Pregnancy | 0.6 | | 0.4 | 0.1 | | 1.2 |
| Other Maternal conditions | 43.6 | | 0.7 | 0.7 | | 45 |
| Perinatal conditions | 3.8 | | 0.4 | 0.1 | | 4.3 |
| Contraceptive management (family planning) | 0.1 | | | | | 0.1 |
| Unspecified reproductive health conditions (n.e.c.) | 13.1 | | 1.7 | 2.6 | 0.3 | 17.6 |
| Nutritional deficiencies | 5.4 | | 1.6 | 9.6 | 0.2 | 16.8 |
| Other Nutritional deficiencies | 5.4 | | 1.6 | 9.6 | 0.2 | 16.8 |
| Noncommunicable diseases (NCDs) | 119.2 | | 45.5 | 82.1 | 5.6 | 252.4 |
| Cancers | 2.5 | | 1.3 | 0.7 | 2.4 | 6.8 |
| Endocrine and metabolic disorders | 22.9 | | | 0 | | 22.9 |
| Diabetes | 1.7 | | | | | 1.7 |
| Other and unspecified endocrine and metabolic disorders (n.e.c.) | 21.2 | | | 0 | | 21.2 |
| Cardiovascular diseases | 11.1 | | 12.6 | 3.9 | 1.9 | 29.5 |
| Hypertensive diseases | 1.7 | | | | | 1.7 |
| Other and unspecified cardiovascular diseases (n.e.c.) | 9.5 | | 12.6 | 3.9 | 1.9 | 27.9 |
| Mental & behavioural disorders, and Neurological conditions | 11.9 | | 0.8 | 0.3 | 0.3 | 13.3 |
| Mental (psychiatric) disorders | 0.1 | | | | | 0.1 |
| Behavioural disorders | 0.1 | | | | | 0.1 |
| Neurological conditions | 5.3 | | 0.4 | 0.1 | | 5.8 |
| Unspecified mental & behavioural disorders and | 6.4 | | 0.4 | 0.1 | 0.3 | 7.2 |

| | | | | | | |
|---|------|-----|------|-------|------|-------|
| neurological conditions (n.e.c.) | | | | | | |
| Respiratory diseases | 6 | | 6.7 | 11.6 | | 24.2 |
| Diseases of the digestive | 4.2 | | 3.4 | 1.1 | | 8.6 |
| Diseases of the genito-urinary system | 5 | | 0.8 | 0.3 | | 6.1 |
| Sense organ disorders | 10.1 | | 2.4 | 4 | | 16.5 |
| Eye conditions | 5.9 | | 0.3 | 3.4 | | 9.5 |
| Ear nose throat conditions | 0.6 | | 0.8 | 0.3 | | 1.7 |
| Skin conditions | 3.6 | | 1.3 | 0.4 | | 5.3 |
| Other Sense organ disorders | 0 | | | | | 0 |
| Oral diseases | 15.1 | | 0.2 | 5.6 | | 20.9 |
| Other and unspecified noncommunicable diseases (n.e.c.) | 30.4 | | 17.4 | 54.7 | 0.9 | 103.4 |
| Injuries | 33.6 | | 2.2 | 2.8 | 0 | 38.7 |
| Other and unspecified injuries (n.e.c.) | 33.6 | | 2.2 | 2.8 | 0 | 38.7 |
| Other and unspecified diseases/conditions (n.e.c.) | 15.7 | | 2.9 | 15.4 | 4.8 | 38.7 |
| All DIS | 326 | 1.3 | 71.9 | 148.3 | 41.1 | 588.6 |

Table 7: Capital Account (HK) by Institutional units providing revenues to financing schemes (FA), 2020-21

| Fiji Dollar (Millions) | Government | Corporations | Rest of the world | All FA |
|--|------------|--------------|-------------------|--------|
| Gross fixed capital formation | 24 | 9 | 5 | 37 |
| Infrastructure | 13 | 3 | | 16 |
| Residential and non-residential buildings | | 3 | | 3 |
| Other structures | 13 | | | 13 |
| Machinery and equipment | 11 | 5 | 5 | 21 |
| Medical equipment | | 4 | 4 | 8 |
| Transport equipment | | 0 | | 0 |
| ICT equipment | 1 | 1 | | 1 |
| Machinery and equipment n.e.c. | 10 | | 0 | 11 |
| Intellectual property products | | 1 | | 1 |
| Computer software and databases | | 1 | | 1 |
| Non-produced non-financial assets | | 1 | | 1 |
| Land | | 1 | | 1 |
| Unspecified gross fixed capital formation (n.e.c.) | 0 | 0 | | 0 |
| ALL HK | 24 | 9 | 5 | 38 |

Table 8: Health care providers (HP) by Financing schemes (HF), 2020-21

| Fiji Dollar (Millions) | Government schemes and compulsory contributory health care financing schemes | Voluntary health insurance 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 |
|--|--|------------------------------------|---|--------------------------------|--|------------------------------|---------------------------------|--|-------------|
| Hospitals | 238.9 | 30.4 | 23.1 | 7.3 | 4 | 3.2 | 29.4 | | 306 |
| Divisional Hospitals | 159.6 | 0.4 | 0.4 | 0 | | | 5.8 | | 165.8 |
| Subdivisional Hospitals | 70.4 | | | | | | | | 70.4 |
| Military hospital | 0.2 | | | | | | | | 0.2 |
| Private general hospitals | | 30 | 22.8 | 7.3 | 3.9 | 2.9 | 23.6 | | 60.5 |
| Mental health hospitals | 4.4 | | | | | | | | 4.4 |
| Specialized hospitals (Other than mental health hospitals) | 4.4 | | | | | | | | 4.4 |
| Unspecified hospitals (n.e.c.) | | | | | 0.1 | 0.3 | | | 0.4 |
| Providers of ambulatory health care | 38.8 | 9.5 | 7.6 | 1.9 | 0.4 | 0.9 | 20.2 | | 69.7 |
| Private medical practices (GPs) | | 9 | 7.3 | 1.7 | 0.4 | 0.7 | 11.4 | | 21.5 |
| Private dental practice | | 0.2 | 0.1 | 0.1 | | 0.1 | 5.5 | | 5.8 |
| Nursing stations | 1.1 | | | | | | | | 1.1 |
| Community health workers | 15.3 | | | | | | | | 15.3 |
| Optometrists | 0.1 | 0.3 | 0.1 | 0.2 | 0 | 0 | 3.3 | | 3.7 |
| Primary health care centres | 22.2 | | | | | | | | 22.2 |
| Providers of ancillary services | 2.9 | 1.1 | | 1.1 | 0.3 | | 1.6 | | 5.9 |
| Providers of patient transportation and emergency rescue | 2.9 | | | | 0.2 | | | | 3.1 |
| Medical and diagnostic laboratories | | 1.1 | | 1.1 | 0 | | 1.6 | | 2.7 |

| | | | | | | | | | |
|---|--------------|-------------|-------------|-------------|-------------|------------|--------------|-------------|--------------|
| Retailers and Other providers of medical goods | 0.9 | 8.5 | 5.7 | 2.8 | | 0.9 | 84.5 | | 95 |
| Providers of preventive care | 20.9 | | | | 4 | 1.2 | | 21.8 | 48 |
| Providers of health care system administration and financing | 24.7 | | | | 10.2 | 1.6 | | | 36.5 |
| Rest of the world | 0.3 | 21.9 | 20.2 | 1.7 | | | | 4.8 | 27.1 |
| All HP | 327.5 | 71.4 | 56.6 | 14.8 | 19 | 7.9 | 135.7 | 26.7 | 588.1 |

Table 9: Health care functions (HC) by Financing schemes (HF), 2020-21

| Fiji Dollar (Millions) | 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 | 201.8 | 70 | 50.8 | 10.8 | 4.5 | 3.9 | 48.1 | 4.8 | 324.6 |
| Inpatient curative care | 71.3 | 44.6 | 36.3 | 5.3 | 1.7 | 1.3 | 10.1 | 4.8 | 130.9 |
| Day curative care | 14.1 | | | | | | | | 14.1 |
| Outpatient curative care | 115.2 | 25.2 | 14.5 | 5.5 | 2.7 | 2.5 | 32.1 | | 172.4 |
| Unspecified curative care (n.e.c.) | 1.2 | 0.2 | | | 0.1 | 0.1 | 5.8 | | 7.2 |
| Rehabilitative care | 7.2 | | | | | | | | 7.2 |
| Ancillary services | 2.9 | 1.3 | | 1.1 | 0.3 | | 1.6 | | 5.9 |
| Laboratory services | | 0.8 | | 0.8 | | | 1.1 | | 1.9 |
| Imaging services | | 0.3 | | 0.3 | 0 | | 0.5 | | 0.8 |
| Patient transportation | 2.9 | 0.2 | | | 0.2 | | | | 3.1 |
| Medical goods | 1 | 9.7 | 5.7 | 2.9 | 0 | 1 | 86 | | 96.7 |
| Prescribed medicines | 0.3 | 3.4 | 2.1 | 1 | | 0.3 | 30.4 | | 34.2 |
| Over-the-counter medicines | 0.3 | 3.4 | 2.1 | 1 | | 0.3 | 30.4 | | 34.2 |
| Other medical non-durable goods | 0.1 | 0.9 | 0.5 | 0.3 | | 0.1 | 7.6 | | 8.5 |
| Therapeutic appliances and Other medical goods | 0.1 | 0.9 | 0.5 | 0.3 | 0 | 0.1 | 8.3 | | 9.3 |

| | | | | | | | | | |
|--|--------------|-------------|-------------|-------------|-------------|------------|--------------|-------------|--------------|
| Unspecified medical goods (n.e.c.) | 0.1 | 1 | 0.6 | 0.3 | | 0.1 | 9.3 | | 10.4 |
| Preventive care | 90 | 5.5 | | | 4 | 1.4 | | 21.8 | 117.3 |
| Information, education and counselling (IEC) programmes | 21.3 | 0.7 | | | 0.7 | | | 19 | 41 |
| Immunization programmes | 12.2 | 0 | | | 0 | | | 2.8 | 15.1 |
| Early disease detection programmes | 20.6 | | | | | | | | 20.6 |
| Healthy condition monitoring programmes | 11.2 | | | | | | | | 11.2 |
| Epidemiological surveillance and risk and disease control programmes | 15.2 | 4.7 | | | 3.3 | 1.4 | | | 19.9 |
| Preparing for disaster and emergency response programmes | 9.4 | | | | | | | | 9.4 |
| Governance, and health system and financing administration | 24.7 | 11.8 | | | 10.2 | 1.6 | | | 36.5 |
| All HC | 327.5 | 98.2 | 56.6 | 14.8 | 19 | 7.9 | 135.7 | 26.7 | 588.1 |



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