

Health financing options for Fiji's health system

Abstract: Fiji is currently implementing health care reforms with the first phase of reforms focusing on decentralization of the health system. Part of this effort focuses on looking at financing options. Some options for financing health care include private health insurance, social insurance, community financing, user-pays system (out-of-pocket), health savings accounts, government taxation and subsidies, and overseas loans and aid funding. This paper addresses all these options in detail and provides an analysis into each of these options relevance to Fiji and in some instances to other nations in the South Pacific region. Given the relative small populations of Fiji and its neighbouring nations, a regional approach to financing could prove more viable in the longer term, however political, social, economic, legal and cultural issues will need to seriously explored. (Pacific Health Dialog 2003, Vol. 10 (2); Pg 129-140)

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Introduction

'Today many countries in the [Western Pacific] Region are exerting efforts to reform their health systems and respond to their needs in rapidly changing economic, social and political situations. Health care financing is the backbone of achieving short, medium and long-term objectives set within the health system reform process...stable and effective health care financing mechanism that ensures access by all to good quality health services is the most important and common goal for all the countries in the WHO Western Pacific Region' (www.wpro.who.int. 2003). World Health Organisation (WHO), in its World Health Report 2000, argues that when focusing on performance of health systems, a key dimension for its determination is the fairness of its health financing.

Fiji is currently implementing health care reforms under the guidance of Australian Aid (AusAid), with the first phase of reforms focusing on decentralization of

the health system (Ministry of Health, 2002). Part of this effort is also focused on looking at financing options. Like many other developing nations, Fiji is faced with the challenge of how to fund the acquisition and delivery of quality health care to its populations. The experiences of other developing countries like the Philippines, Vietnam and certain African and Asian countries provide Fiji with the opportunity to choose carefully what might suit its populations without having to learn from entirely new, untried and risky alternatives. This provides advantages as well as disadvantages as will be discussed later in the paper.

There are many health care financing options that have been formulated and tried in many developed and developing countries. Some of these include private health insurance, social insurance, community financing, user-pays system (out-of-pocket), health savings accounts, government taxation and subsidies, and overseas loans and aid funding (www.wpro.who.int. 2003; Akal & Harvey, 2001; Buividas & Richards, 1987). This paper will address all these options in detail and provide an analysis into each of these options relevance to Fiji and in some instances to other nations in the South Pacific region.

Fiji

Fiji is a multiethnic and multicultural society. Some interesting statistics include:

- Total population (estimate): 821 000 (rate of growth- 1.2%)
- Fijians: 50.8% (1996 census); current estimates: 432 000
- Indians: 43.7% (1996 census): current estimates: 333 000
- Others: (Chinese, Part Chinese, Europeans, Part Europeans, Rotumans, others including Pacificans): 5.5% (1996 census); current estimates: 56 000
- Crude birthrate/1000 (1999): Fijians 26; Indian 16
- Crude death rate/1000 (1999): Fijian 5; Indian 4

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- Major income earners: Tourism, Sugar and other food items, Beverage and Tobacco, Gold.
- Labour force (2000 estimates): (42%) 342 000; Unemployed: (12%) 98 500 (Fiji Bureau of Statistics, 2002/2003)

Fiji has had several political problems in the past (1987 and 2000) that has affected its image, economy and social fabric. These problems have led to significant consequences from the international community in terms of sanctions, reduction in income earning capacity, and most significantly to migration of skilled workers (Pacific Beat Focus, 2002). Government and other stakeholders seem to be struggling with some of these especially how to stop the ever-increasing 'brain drain' (Pacific Islands Report, 2002).

Fiji's Health System

The Fiji Ministry of Health: Corporate Plan 2002, states that the Ministry of Health (MOH) is committed to 'providing quality services to the people of Fiji through an integrated and decentralized health system to foster good health and well being...the overall aim being to build a healthier nation whereby improving economic growth'. Some key result areas that the MOH hopes to improve its performance in include (ibid):.

- Health promotion and public health
- Health protection through curative services
- Restructuring/Reforming of health system
- Human resources management
- Standards and quality
- Financial management
- Management information/health and information system
- Health care financing
- Public relations/Internal communications and coordination

Many of these key areas are similar to the challenges faced by other developing nations in the Pacific and other areas of the world. In Fiji, it is envisioned that properly supported primary health care (PHC) system has the potential and capacity to meet 90% of the health care needs among the rural populations, however for this to happen there needs to be better accessibility to health facilities, improved availability and affordability of health services, and more culturally appropriate health interventions (Fiji Bureau of Statistics, 2002). Through the current Health Management Reform Project being implemented in Fiji, the three geographically different

Divisions, namely Central/Eastern, Western and Northern, have been decentralized from the MOH headquarters in Suva. The aim here is improve the delivery of health care by empowering the three Divisions to make decisions in line with national objectives at the divisional level rather than at headquarters level (Ministry of Health, 2002). The time-consuming decision-making process of the past was seen as a hinderance to the better management of the health system. This particular Reform has installed a new organizational structure with the introduction of new positions and amalgamation of previous job descriptions to tackle some of the key result areas. It is still early to determine if this new organizational design is going to deliver. However, the new structure has implications for health financing because

budgeting and other financial management issues have become the primary responsibility of each of the Divisions. Should majority of the objectives for each of these strategic areas be accomplished, than an improved health system will be evident.

Fiji's Health Expenditure

According to the Fiji Bureau of Statistics (2002/2003), Fiji Government spent a total of F\$109million (M) on health, approximately 8.5% of total expenditure in 2002. For 2003, F\$116M has been budgeted for, approximately 9% of the total expenditure of F\$1.295Billion. For the year 2003, \$67M (58%) was spent on salaries and wages for established and unestablished health staff. Another \$21M (18%) was used to purchase medical resources and services. For capital construction and purchases, \$8M (7%) has been allocated, with \$7M (6%) for travel and communications, maintenance and operations, grants and transfers, and special expenditures (health promotion and prevention programmes). Approximately \$13M (11%) was paid back into government coffers as Value-added Tax (VAT). Total aid from donors is expected to be approximately \$14M (Fiji Bureau of Statistics, 2002/2003).

The recently announced budget for 2004 (Fiji Times, Nov. 8th 2003), has increased the allocation for health to F\$121M (9% of total expenditure), with a marginal increase of F\$4.7M (4% increase). This increase is earmarked for up-grading rural health facilities (F\$2.7M); purchasing bio-medical equipment for sub-divisional hospitals (F\$1.2M); and for preventative health programmes (F\$1.8M). According to former assistant Minister for Health, Dr. Gunasagan Gounder, 'to really improve our health services we need an increase of around F\$14-15M' (Fiji Sun, Nov 8th 2003). There is also

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speculation that Government may present a supplementary budget sometime next year to seek extra funds to health and other expenditure.

It should also be noted that other Ministries and institutions like Ministries of Labour, Industrial Relations and Productivity (OHS compliance), Multiethnic affairs (scholarships), Education (health education and promotion), Local Government, Housing, Squatter Settlement and Environment (housing and squatters), Women, Social Welfare and Poverty Alleviation (welfare for the poor, advocates for reduction in domestic violence), Youth and Employment (youth issues including STIs, improving income earning capacity), Agriculture, Sugar and Land Resettlement (promotion of good farming practices and nutritional issues), Fisheries and Forests (sustainable development and use of natural resources) and other institutions like the Fiji School of Medicine and Fiji School of Nursing are making both direct and indirect contributions to the well-being and health of our populations. These contributions are essential in preventing disease and illness, promoting healthier lifestyles, and sustaining and appreciating the direct efforts of the MOH in improving the health status of our people. Thus the actual budgetary contribution towards health is greater than as stipulated by the MOH's budgetary allocations.

Fiji and the Western Pacific Region

The Western Pacific Office (WPRO) of WHO looks after 36 member countries divided into 4 categories based on economic development. These categories and their listed countries include (www.wpro.who.int. 2003):

- Developed Economies (DE): Australia, Japan and New Zealand
- Newly Industrializing Economies (NIE): Brunei, Hong Kong, Macao, Malaysia, Republic of Korea, Singapore and Philippines
- Transitional Economies (TE): Cambodia, China, Laos, Mongolia and Vietnam
- Pacific Island Economies (PIE): American Samoa, Cook Islands, Fiji, French Polynesia, Guam, Kiribati, Marshall Islands, Micronesia, Nauru, New Caledonia, Niue, North Mariana Islands, Palau, Papua New Guinea, Samoa, Solomon Islands, Tokelau, Tonga, Tuvalu, Vanuatu, and Wallis and Futuna.

The highest and lowest per capita gross national product GNP and per capita health spending (HS/C)

respectively, for each of the categories is as follows (ibid) (In US\$):

- DE: Japan- \$37925 (HS/C \$2244); New Zealand- \$16716 (\$1159)
- NIE: Singapore- \$ 26264 (\$792); Philippines- \$1089 (\$32)
- TE: China- \$573 (\$34); Cambodia- \$314 (\$16)
- PIE: American Samoa- \$26264 (N/A); Kiribati- \$740 (\$47) FIJI- \$2250 (\$82)

It should be noted that the per capita earnings for many countries in this Region is affected by their population. For example China has a population of 1.2 billion with \$573-GNP/C; \$34 HS/C, whereas one of the least populated nation is Niue with 1900 people has \$3002-GNP/C, \$ 328 HS/C. According to the WHO WPRO 2003 data, Fiji is ranked 12th in terms of per capita GNP and an approximate rank of 15^h for per capita health spending in the PIE category. The irony is that certain countries like Micronesia, Tonga and Tuvalu have a lower per capita GNP but a higher per capita health spending with size of population being a factor.

Fiji is a member of the 'Council of Regional Organisations in the Pacific' more recently known as CROP (Secretariat of the Pacific Community, 2003). This 'Council' comprises intergovernmental organisations of all the nations of PIE, including Australia France, New Zealand, USA and UK, as advisory and donor agencies. Recent additions have been the Fiji School of Medicine and the South Pacific Board for Educational Assessment. The main aim of CROP is to exercise an advisory function on key policy and operational issues of importance to the region and regional organisations...it seeks to take advantage of opportunities that stem from sharing or pooling of the region's resources (ibid). CROP and its member organisations have tremendous potential for combining efforts for the benefit of all Pacificans.

Options available for health financing

Before policymakers and other stakeholders embark on an enormous task such as identifying the right option(s), it is important to have a good set of data. This should include information on:

- organizational design
- the range of services being provided
- the personnel involved in delivering these services
- accurate account of all financial (expenditure statements)

- physical resources (health centers, medical equipment and supplies, support equipment (transportation, office equipment, etc)
- demographic spread of populations
- epidemiology of as many common health problems
- household spending of target population (actual and potential income earners) and
- other social factors that may have an impact on decision-making.

Currently there are many options for financing available, however a thorough analysis of the current system of expenditures is necessary to determine the need for increased funding.

User-Pay System

User-pays system is referred to in many different terms like user fees, out-of pocket payment, and prepayments (Creese, 1997; Buidivas et. al., 1987). The aim of this system is to get the patient/public to pay partial or full costs of the expenses incurred in delivering a health service (ibid). The main motivation behind this system is either cost recovery or revenue generation (Akai & Harvey, 2001). However there are other advantages and disadvantages of this system.

There are other reasons given 'for' and 'against' having a user-pays system. Some of these include:

- people with ability-to-pay (ATP) should bare some of the health costs;
- increase financial resources for health; improve efficiency by moderating demand and containing costs;
- it can be costly to implement, and income based exemptions in particular have proven difficult to manage;
- it can become a political strategy to shift health care costs from the better off to the poor and the sick;
- it can become an obstacle to the really poor and sick from seeking medical help which later culminates into increased intensity in the form of longer or more expensive treatment episodes;
- it has proved to be blunt and of limited success and has the potential for serious side effects in terms of equity; (Creese, 1997; Creese, et. al., 1995; Shaw & Griffen, 1995; Akin, et. al., 1987; Evans, et. al., 1993; Manning, et. al., 1987; Wagstaff, ?; E-Interviews, 2003).

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The WHO WPRO recommends that Fiji give priority to health insurance development along with user charges and privatization (www.wpro.who.int. 2003). The MOH in its Corporate Plan (2002), states its goal for health financing as 'to generate revenue care system' with objectives 'to generate funds for the health system through the introduction of user pay system/cost recovery and revenue generation'. However there seems to be little relationship shown between current levels of service provision, implications of improving management of current financial and other resources, and the need to increase funding through alternative financing systems. Fiji currently does charge a minimal fee for dental care, inpatient care, some laboratory diagnosis, circumcisions, and quarantine services (E-Interviews, 2003).

The current WHO recommended methods for assessing the financial protection and fairness of financial contribution (FFC index) of individual countries has come under criticism from research groups within the World Bank who argue that 'the FFC index does not capture, and does not purport to capture- how fair a financing system is in terms of its impact on the distribution of access to and utilization of health services...it is unable to distinguish between progressive and regressive payments, and is also unable to distinguish between cases where households on different incomes pay different shares of their income in health care payments [vertical inequity] and cases where households at the same income pay different amounts for health care [horizontal inequity]' (Wagstaff, 2003). It is the lack of such information (household spending on health) and inadequate research that could lead policymakers to make wrong choices.

A leading clinician and academic at the Fiji School of Medicine (FSM), Professor Moulds, comments that 'I don't think we are in danger of over-servicing in Fiji, which would be the main argument in favour of introducing charges' (E-Interviews, 2003). Andrew Creese (1997), a Health Economist, reports that [user-fees] is recommended in two situations; when total health spending is falling or when (paradoxically) health expenditure is high and increasing fast. In the case of Fiji, it does not seem that we are totally fulfilling either of the criteria; the total health expenditure has slightly increased and remains stable (Fiji Bureau of Statistics, 2002/2003; Fiji Government Budget 2004). So is it desirable to introduce a user-pays system given that a strong case for its implementation is yet to be made?

If user-fees were to be introduced than what form would it take? According to a diverse range of public

health and primary care practitioners and academics at FSM, 'there should be a charge for all investigations [including the issuing of] sick sheets and any other medico-legal documents excluding any social welfare forms, for providing professional health advice, for drugs, for special medical check-ups, physiotherapy, and for certain surgical procedures. The charges recommended range from 5-20% (E-Interviews, 2003). The main reason often sighted by health professionals for having user-fees is to deter over-use of facilities and resources, however *overuse or unnecessary use* is yet to be proven in Fiji. Most commentators on user-fees observed that instead of moderating the use of services, it instead led to underutilization of health services which in the long run proves to be even more expensive for the health system (Creese, 1997; Creese, et. al., 1995; Shaw & Griffen, 1995; Akin, et. al., 1987; Evans, et. al., 1993; Manning, et. al., 1987; Wagstaff, 2003). There are many other complex issues that need to be addressed before such a system can be implemented like,

- What health services will be affected?
- Who is going to pay?
- How are they going to pay? (At the point of treatment, prepayments, or a combination of payments options)
- How much should be paid? (Partial or full amount, or a combination of the two)
- **How will the system be administered?**
Who is going to pay for those who cannot pay? (Social safety nets)
- How is the revenue collected going to be used?
How will this affect the accessibility and equity of health service delivery?
- How will user-fees affect household income and expenditure?

Before decisions are made in relation to expanding the user-pays system in Fiji, more research on its feasibility and viability, consultation and agreement among all stakeholders on related issues, and huge amounts of resources will be required.

Health Insurance

A working definition of Health Insurance (Chawla and Berman (1996)) is:

A group of persons contributing funds to a common pool, usually held by a third party. These funds are then used to pay part or all of the costs of defined set of health

services for the members of the pool. This third party can either be a governmental social security, a public insurance fund pool, employer-sponsored pool, or a private insurance fund pool'.

The emphasis of this definition is that most insurance programs only cover for a limited range of health services and also many of the funds only meet part of the costs as opposed to all of the costs (Akal and Harvey, 2001). There are two major types of health insurance, namely social and private health insurance. Each has a different emphasis to health care financing, different implications for the health system, and different entitlements for its members.

Social Insurance

WHO is a strong advocate for this type of funding for health systems in many developing countries including Fiji (www.wpro.who.int. 2003). The Permanent Secretary for Health (Fiji), Luke Rokovadra (2002), said that a national social/health insurance scheme was a potential source of revenue for our health system. The World Bank advocates social insurance scheme but with focus that such financing should lead to 'diversity and competition in the delivery of health services' (Abbasi, 1999). Even a local financial expert and academic agreed that people should pay for health services rendered (Personal interview, 2003). Some public health practitioners also agree that if we do charge for the services we provide than we may be able to compete, and that competition could lead to '*appropriate use*' of services, clients will have a choice, public health system may be able to provide very similar service at a much lower cost, increased revenue that could be directed towards improving human and other resources for health, and has the potential of improving current infrastructure and quality of service (E-Interviews, 2003). However, the downside of competition could lead to a distorted and distracted public health system, possible loss of a safety net for poor people, under-the-table payments whereby the poor are affected, and unnecessary hassles for the health system (ibid; Akal and Harvey, 2001).

Social health insurance is a:

'mechanism for pooling contributions from a whole population to meet the costs of providing defined health services or to reimburse individuals for all or part of the costs of the services that they use...it is usually compulsory and universal...the premiums are based on ability to pay (rich pay more than the poor and very poor make no payments for insurance cover)... and the

premiums are not risk stratified- they are not based on the health of the individual or on the expected use of services (Akal and Harvey, 2001).

The favoured method for getting financial contributions for a social insurance scheme is through formal government taxation. This taxation should apply to all those in employment including salaried public sector (all civil servants), salaried private sector, self-employed and informal sector, however the coverage of the scheme will be universal, that is, all members of the population including handicapped people, the very poor who cannot pay, children, and legal dependents of all members of the population will have access to **health services** (Bayarsaikhhan, 2002). 'These contributions [taxes] are often based on national minimum wage, the poverty income, politically agreed basis, and the ability to pay' (Akal & Harvey, 2001; Bayarsaikhhan, 2002).

Among other benefits, WHO (2000) envisions, that a social insurance scheme could increase public spending on health; help adjust and adapt to decreasing external support; decrease user-fees and out-of-pocket payments; provide financial protection for the poor; and increase efficiency in allocation and utilization of financial resources.

According to WHO (Bayarsaikhhan, 2002), a well-designed social insurance scheme will have:

Family coverage with dependents rather than individual coverage;

- Affordable contribution for majority of the population;
- Comprehensive health care benefits that include ambulatory and inpatient care, essentially drugs;
- Capitation as the major provider payment with minimal fees for service;
- Separate administration.

One way of deciding who pays how much is through the principle of ability-to-pay. WHO (2000) recommends that contributions should be made based on a person's ability to pay, however like Wagstaff (2003), argues that 'though many policymakers appear to support the application of the ability-to-pay principle to health care finance, rarely, if ever, do policies and policymakers specify the appropriate degree of progressivity (in order to achieve vertical equity, progressive payments are necessary; for horizontal equity payments could be proportional to ability-to-pay, which sometimes can be regressive whereby the poor are paying a greater

proportion of their income for health)'. WHO (Bayarsaikhhan, 2002) goes further to say that prepayments is the most suited method for the collection of this form of finance so that payment is not required at the point of treatment, ensures greater risk sharing and fund pooling, and provides financial protection for the poor and vulnerable.

People living in poverty in Fiji has increased substantially over the last few years with different organizations claiming anywhere between 40-60% of the population either living in poverty or on the edge of the poverty. Government estimates 25% of the population is in poverty, but a recent Asian Development Bank survey shows that poverty is almost double- 50% (Fiji Times, 8th November, 2003). If this figure is anything to go by, then those with the ability-to-pay will be

required to pay ever so more to cater for the poor. Also the burden on government will increase to support a social insurance scheme on behalf of the poor and those with no ability-to-pay. With a modest income and ever increasing demands on government expenditure (Fiji Bureau of Statistics, 2002/2003), Fiji government would need careful financial planning and management to sustain such a scheme.

The administration of any health financing system is always a concern. According to Akal and Harvey (2001), 'the costs of collecting contributions for social health insurance is relatively low because they can usually run parallel with existing systems'. Examples from countries that have implemented a social insurance scheme (Mongolia, Laos, Philippines, and Vietnam), show that existing government structure were used to administer the scheme (Bayarsaikhhan, 2002). The universality of the scheme, and exemption of the poor are often factors that contribute to the complexity of the scheme. 'If the poor are given exemptions from user fees this can increase the cost of administration, but the size of the cost will depend in part on exactly how the exemptions are given, and how the services are organized and paid for' (Akal and Harvey, 2001).

In the case of Fiji, there exists the Fiji National Provident Fund (FNPF), which collects contributions from employees and employers, for a saving scheme that also acts as a retirement fund for its members. This is a compulsory savings scheme where employee contributes 8% of their salary to this fund, with the employer (government and private sector) contributing a minimum of 8% towards the employees account (Fiji Bureau of Statistics, 2002/2003). This Organisation and/

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or other government bodies could easily administer a social insurance scheme, without introducing to many new administration costs. However, proper legislation should be introduced to clearly demarcate administrative roles and responsibilities.

If the process of introducing, financing, and managing a social health insurance scheme is successful, then Fiji stands to benefit in terms of:

- Strengthened health care financing (mobilization of additional resources, increased participation and commitment, and sustainable financing mechanism);
- Promotion of equity (equitable contributions, equity access to health care, same benefits for all insured);
- Financial protection (low financial burden on individual people, predictable prepayment that would help rationalize household expenditure, reliable financial protection for the poor and vulnerable population);
- Promotion of health service development (planned use of revenues to strengthen primary, secondary and tertiary care and improve quality, increased efficiency and effectiveness of health spending focusing on disease prevention and health promotion, and effective management of facilities and referrals). (WHO, 2000; Bayarsaikhan, 2002)

It would require tremendous resources and expertise to achieve all of the above, hence the increased need to make more informed decisions based on accurate, reliable and relevant information.

Private Health Insurance

According to Akal and Harvey (2001), Private (risk-rated) health insurance is a:

'mechanism for pooling contributions from a group of individuals who have similar characteristics that are expected to be related to the use of health services, and for paying for of all defined health services costs incurred by members...the insurance then pools the contributions within these risk-stratified populations... within each risk pool, premiums are the same for all persons regardless of income or ability to pay'

Even though premiums are risk based (family size, health status, age, employment, and lifestyle) and not on ability-to-pay, the actual affordability of private insurance is based on ability to pay. 'Poor people often have larger families, and worse health that do higher

income people; private health insurance premiums for the poor are likely to be higher than for the rich. The effect of this is to exclude the poor from private health insurance' (Akal and Harvey, 2001).

In the case of Fiji, private health insurance seems to be quite extensive, with public servants having the opportunity to afford it through the efforts of the Public Service Commission (PSC), government's human resources recruitment and development arm. However, as was noted at a MOH (Fiji) sponsored Health Financing Workshop, 2002, The PSC sanctioned private insurance scheme was not doing so well because the number of claims for health benefits from its members was exceeding the revenue it generated, the conclusion being drawn that either premiums be increased or other forms of funding be proposed. Since then changes have taken place to address the issues involved.

Recently, Fiji Care, a private insurer, said that Fijian and Indo-Fijian male were dying at the age of 49 and 52 respectively while the life expectancy is 65 and 64 respectively (1996 census, Fiji Bureau of Statistics, 2002/2003). The implications of this finding will have an effect on the premium levels being charged to members. However, private insurance will remain possibly the only option for access to many specialized tertiary health care, and only to those who have the ability-to-pay.

Community Financing

According to Chawla and Berman (1996), community or cooperative financing, and its advantages are:

'... Established by the common will of the people rather than the market forces, these programs permit a variety of resource mobilization methods, such as payment in cash or kind, payment in part or full, payment in form of labour contribution, idle land, etc. This flexibility in the community-sponsored plans has been useful in limiting the effects of seasonal income fluctuations on access to care in some countries in sub-Saharan Africa'.

It can be argued that Fiji has benefited tremendously from community finance through the development of schools, places of worship, cooperative stores, and public facilities such bus settlers and health centers. In terms of health, 'community [health] schemes usually focus on primary care, especially drugs, but also may include referral services and often have a broad community development orientation- eg community

schemes in Guinea-Bissau, Taiwan (China), Vietnam' (Careese and Bennett, 1997). However, community financing is seen as having limited potential unless supported by other financing mechanisms because certain poor communities just don't have any extra cash or resources for such schemes.

With increased poverty in Fiji, such schemes should not be seen as an alternative to current arrangements; eventhough stakeholders should explore its full potential. According to Preker, A. et. al. (2002), government can support community schemes for rural and poor people through: 'increased and well-targeted subsidies boosting the health insurance contributions of low-income populations; insurance for protection against fluctuations in expenditure; reinsurance to enlarge the effective size of small risk pools and cover catastrophic events; prevention and case management techniques to limit expenditure fluctuations; technical support to strengthen the management capacity of local schemes; and the establishment and strengthening of links with formal financing and provider networks'. This is a very resource intensive exercise and Fiji government has placed an emphasis on rural development projects.

Health Savings Account

Health savings accounts scheme is another mechanism for health financing. This provides incentives for or compel, people to pre-pay for their future health expenses, and the program allows people to build up credit for health care when they are well to help cushion or cover the increasing cost of care in old age (Akal and Bennett, 2001). This could be run as part of national insurance scheme.

This is arguably a new way of looking at the relationship between individual health, access to health, and equity issues in health with strong emphasis on promotion and prevention of certain health conditions by living healthy. However, as other options, this also needs to be considered from the viewpoint of the poor. Akal and Bennett (2001), note that 'unless there are subsidies from taxation to the poor and the sick, the poor would be unlikely to be able to contribute sufficiently to Health Savings Accounts to provide for any reasonable level of protection against health care costs'.

In the case of Fiji, this could be an option but may be very resource intensive for the government. Fiji would

need a significantly lower level of poverty, and reduced incidence of lifestyle diseases (diabetes, hypertension, stroke) before such a scheme may be feasible. 'Health savings accounts are an inequitable way of funding health services, and if the poor cannot contribute they would receive no benefit at all' (ibid).

Tax Financing

By far tax financing is the World's greatest financial contributor to health. Towards the end of the last century, tax-finance contributed almost a third (\$1 Trillion) of total spending on health that was \$3 Trillion (Bayarsaikhan, 2002). In Fiji, the government contributes a greater percentage of the total health expenditure (Fiji Bureau of Statistics 2002/2003). Most governments allocate a portion of income tax, tax on sale of goods and services (VAT), tax from restricted items such as tobacco and alcohol, and other areas like from profits generated by businesses (capital gains tax) towards financing health.

In Fiji, there is the potential to derive direct funding from all the above especially funding generated from consumer goods and services that are seen to have harmful effects (tobacco, alcohol, kava) on individual and community health. A environmental health expert and academic, Navi Litidamu, comments that there is a whole

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To safeguard the poor from being burdened with extra tax burden, taxes on food items should be limited to allow for increased ability to purchase healthier foods. It has been noted (Akal and Harvey, 2001), that poor often spend a greater portion of their income on food than the rich. Tax on food items is seen as being regressive. On the other hand increasing tax levels on capital gains is seen as progressive because these taxes generally fall heavily on the rich that on the poor, since the rich gain a much higher proportion of their total income from these sources.

In Fiji, these options are yet to be fully explored to increase funding for health. It can be strongly argued

that transparency and accountability in the use of public funds is a more pressing issue. Without proper accountability it would be difficult to monitor government expenditure, and thus hindering proper financial planning.

The Fiji government also spends a substantial amount on educating and training health professions, but migration of health workers affects its ability to provide the expected level of care. The loss of skilled workers through migration also affects the economy through reduction in domestic expenditure, and the increase costs of finding replacements namely expatriate workers. The introduction of expatriate workers is only a short-term solution and often proves to be relatively expensive when comparing to locally-produced skilled labour. Government spending also has to address working conditions of the workers, and tax income generated from consumption of goods and services (among other sources of revenue) that could be used towards improving working conditions.

According to Akal and Harvey (2001), 'tax financed services are generally seen as the most equitable way of raising funds for the provision of services to the poor [because] it is generally considered that taxation revenue is raised according to the ability of individuals to pay'.

According to The World Bank:

Health, Nutrition and Population Sector Strategy Paper (2000), countries with per capita income in the range of US\$300-\$800:

'may need to mobilize additional funding from community sources and international donors to pay for public health interventions with large externalities and essential programs for the poor (i.e. over and above the financing)'.

In relation to the above, Fiji boasts a per capita income of US\$ 2250 (www.wpro.who.int. 2003), however this does not necessarily translate into solutions for health financing. Other issues such as debt repayments, and import tariffs on items essential for survival have an effect on household disposable income, from which most health costs are met. Fiji has the potential to generate sufficient income through its export capacity in tourism, sugar, garment, gold, fisheries, and other sectors (Fiji Bureau of Statistics, 2002/2003). This income can be supplemented by direct and indirect tax income. However, political stability together with law and order and investor confidence are key to maximizing income generation. More income should mean increased capability to cater for the poor and the needy.

Overseas Funding

Overseas funding comes in many forms-international loans, foreign aid in cash and in-kind. Over the years many most countries in the South Pacific region have received substantial amounts of foreign aid to supplement government expenditure in the area of education, infrastructure development, fisheries and agriculture development, and in areas of health (CROP, 2002). In Fiji, approximately F\$14Million was received as aid for health for 2003 (Fiji Bureau of Statistics, 2002/2003). However, WHO notes that there is a decreasing trend in external support (Bayarsaikhan, 2002). The challenge in aid funding is the sustainability of programs that were introduced with aid money, but require internal funding in the long-term (Akal and Harvey, 2001). Hence aid donors are encouraged to work with governments and various stakeholders to ensure sustainability in the longer run.

On the other hand, government borrowing stands at 46% of GDP, with domestic borrowing at 40.9% (F\$1.8Billion) and external borrowing at 5% of GDP (F\$218Million)...with government trying to reduce

[external borrowing] by reducing capital expenditure (Jayaraman, 2003). In the long run such policies could cause problems such as bulk of the expenditure going into operational costs and very little

for capital development. The challenge however 'relates to the capacity of a country to repay the debt at the same time as raising additional funds for [health] on a sustainable basis (Akal and Harvey, 2001).

In terms of overseas funding for health care, Fiji remains dependent on donors mainly for development funds that may offset its reduction in capital expenditure (previously achieved through internal and external borrowing). However, as mentioned earlier, sustainability of programs and the ability to pay external lenders will determine the significance of overseas funding in health and Fiji's economy generally.

Policy Direction for Stakeholders

From the discussion above, it is clear that in the very near future, Fiji will need to seriously address its health financing options to sustain and also improve its current range and delivery of health care. Most commentators on health financing recommend that developing nations should focus on social insurance combined with a user pay system as the option. The social insurance scheme will provide financial protection and a safety net for the poor, while the user pays system will ensure that those

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with the ability-to-pay contribute either in part or in full for the health services that are rendered.

Recommendations for policymakers and stakeholders based on the above analysis of health financing options include:

The immediate focus to be on collecting the appropriate information needed for decision-making. This may require the setting up of a research team made up of social scientists, health professionals, health economists, and some other professionals. Arguably, informed decisions have a greater chance of success. The MOH has already started this process, however details of progress are to be determined. Government should make public its intentions so that people and the various stakeholders have an opportunity to contribute to the dialogue on the issue. Many change processes have failed because of inadequate communication between the sponsors of change, agents of change, advocates of change, and most importantly the recipient of change;

Improving resource planning, organizing, controlling and overall management of finances, infrastructure, medical equipment, office equipment including the use of communication services, and support resources like support personnel, and transportation. The aim should be to increase accountability and transparency for the sake of improving effectiveness and efficiency of health service delivery;

Exploring the possibility of a social insurance scheme. This would include looking at possible premium rates, coverage of ability-to-pay. contributions required from government, legislation to regulate the scheme, administrative issues, procedures for the people to qualify for exemptions, and sustainability issues. In its initial form, it should not be a very complex system of rules and procedures; simplicity should be the focus of a trial period of approximately 5 years;

Exploring the possibility of expanding the user pays system. This would include compiling a comprehensive list all health services being provided, examining current charges, doing a cost analysis of each or a desired set of health services (very important), consult relevant stakeholders, researching household spending, and matching ability-to-pay with user fees. Since MOH has already decided that its focus is going to be on revenue generation and cost recovery, the policymakers will need to decide which of the two is more appropriate for initial implementation. It is argued that cost recovery would be a better option because revenue generation may distort the operations of the public health system. Also the user pays concept may be easier to sell to the public and

other stakeholders. Cost recovery may focus on recovering part or the full cost of all resources (excluding human resources) used in a health procedure. This cost should be matched to the disposal income of populations to determine who pays the fee. There should not be too many different levels of fees as this may increase administration costs. It is also argued that the income generated during the trial period should be used to retain and attract quality health professionals. Even the World Bank recommends that developing nations should invest in human development (Abbasi, 1999);

Exploring the potential of other financing options such as community finance, private health insurance, health savings accounts, and overseas funding as sources of revenue for supporting health expenditure. Their potential should be investigated in assisting government initiatives.

Finally it is argued that the expanded or revised user pays system should not be introduced before any form of social insurance scheme is in place. The rationale is that first and foremost the general public should not be seen as being burdened with another cost in times of substantial poverty; secondly, a social insurance scheme in place say six months prior to the introduction of the user pay system will allow for pooling of resources, ironing out teething administrative problems, testing of the contribution system, education of all personnel involved from the health professionals to the administrative staff, education of the public and other stakeholders, and for addressing of any other uncertainty that may arise. An expanded user pays system is going to be introduced soon or later; however if no financial protection is proved to the poor and needy, than we will be faced with increased inequities in health, which is not one of the aims of any health system (Akal & Harvey, 2001; Abbasi, 1999; Creese, 1997).

Strategic Direction

From the viewpoint of strategic management, and sustainability of the recommended financing option, an increased regional approach should be taken. The fact that most PIC's have very small populations, economies of scale can be very difficult to attain. It is thus suggested that members of CROP may wish to combine resources that would have a more synergistic effect – the sum of parts being greater than the whole. Health is an area where this idea can be experimented. In Fiji, a new drug storage facility is being constructed with the assistance of Japanese aid. The aim of this project is to purchase drugs for local consumption as well for selling to small Pacific states like Kiribati, Nauru, Niue, Tokelau, and certain others at minimal mark-up prices. This has been calculated to be cheaper than these Nations going and

purchasing drugs on their own (Personal Interview, 2003). This could be the beginning of a more comprehensive collaboration between like-minded PIEs' to achieve better value for their individual resources by combining them into a greater pool to purchase other types of health resources, to provide for health care that is currently not available in any of the small Pacific nations, to improve staff retention, to have a country to country exchange programme for health professionals so that they are they appreciate the different working environments and which may also act as an incentive to stay in the system, and to achieve economies of scale in the long-term. It can be also argued that this collaboration might be inevitable, however, appropriate research needs to be done into its scope and limitations before its potential is fully utilized.

Conclusion

This paper has tried to identify viable health financing options for Fiji's health system. Most commentators on the issue agree that cost of providing health care is increasing, and that governments need to find alternative sources of finance is necessary. In the case of Fiji, social insurance scheme combined with a user pays system is recommended. However as this presentation has shown that much work needs to be done before any option or combination of options can be confidently stated as being *the one*. This research has also attempted to suggest policy direction and the work required for making an informed decision. In all of this the government of the day has a major role to play commencing with initiating dialog on the issue, and allocating appropriate resources for essential research before the second phase of implementation is justified.

Given Fiji's political history, the suggested recommendations could prove to be a political minefield, whereby politician may be reluctant to commit to any such option for the fear of losing any political advantage they may have. The danger in this is procrastination whereby delaying necessary activities and decision-making to such a point when uninformed decisions are taken in haste only to prove futile in the near future. For the benefit of government, other stakeholders and the public, meaningful work and consultation must start now if informed decisions on health care financing are to be.

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A man who fears suffering is already suffering
from what he fears.

(Michel de Montaigne 1533 - 1592)