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Fiji

A Context-Specific Approach to Primary Care Strengthening in Fiji

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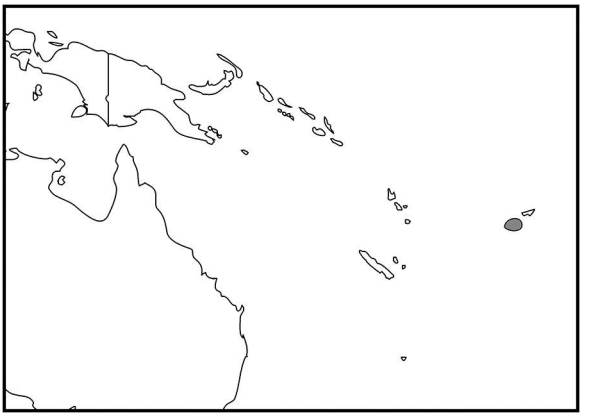

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Background

Two major healthcare reforms have been attempted in Fiji. The reforms differed significantly in both approach and outcome. The first was radical and ambitious, but failed to be supported by Ministry of Health (MoH) personnel and was eventually abandoned. The second, more successful, reform, was

tailored to local context (i.e., context specific). It adopted a more gradual and circumscribed approach involving incremental strengthening of community-based health centers and refocusing of ambulatory hospital services.

Universal healthcare in Fiji is mainly provided by the MoH through four divisions (Central, Eastern, Northern, Western) and their subdivisions that deliver healthcare to nearly 1 million people across 332 islands (Ministry of Health and Medical Services [Fiji], 2015a). Each division delivers healthcare through nursing stations (basic care only), health centers (comprehensive primary care), and subdivisional and divisional hospitals (ambulatory and inpatient care at all levels).

Starting in 1979, a series of critical government and external reports highlighted community dissatisfaction with healthcare and declining health outcomes. Criticisms that the MoH did not effectively delegate responsibility, authority, and planning to regional divisions, were related to poor staff morale, high turnover, shortages of staff and drugs, and a mismatch between population changes and staffing levels (Coombe, 1982; Dunn, 1997; Government of Fiji, 1979, 1996, 1997; Ministry of National Planning [Fiji], 2009). Recommendations were for a more responsive healthcare system with improved accessibility (Mohammed et al., 2016a,b; Australian Agency for International Development [AUSAid], 2008). In response, the MoH initiated two periods of reform through decentralization: the first from 1999 to 2004, and the second from 2009, with a brief period of recentralization between.

The first far-reaching reform involved a collaboration between the Fiji government and the Australian Agency for International Development (AUSAid). The reforms involved strengthening healthcare delivery in the four geographic divisions and developing management capacity, reflective of the approaches used in other Pacific countries. However, political instability, coupled with a lack of support from MoH personnel (who viewed the reform as being driven externally by AUSAid), hindered the establishment of the devolved structure (Mohammed et al., 2016a). By the end of the 5-year implementation period, only limited delegation, along with some restructuring of the delivery and organization of services, had been achieved. These changes, however, fell far short of the reform goals (Mohammed et al., 2016a,b).

In 2009, a less ambitious decentralization program was initiated, aiming to improve access to primary care through the strengthening of health centers in the Suva subdivision (one of five in the central division), accounting for approximately one-quarter (217,597 persons) of Fiji's population. This initiative addressed reports that lower-level services were often bypassed by users who self-referred to divisional hospitals, which they perceived as providing better care, indicating that health center resources were underutilized, while divisional hospitals were being used inappropriately (AUSAid, 2008; Ministry of Health [Fiji], 2010; Roberts et al., 2011; WHO, 2000). Over a period of 2 years, services at the six health centers in the Suva subdivision were

expanded, enabling the divisional hospital outpatient service to be closed to self-referrals, and designated a tertiary hospital, by February 2011.

This reform initiative followed a *coup d'état* in 2006. A priority of the new government was to improve physical and financial access to healthcare (Ministry of National Planning [Fiji], 2009). With the goals of decentralization widely perceived as benefiting the population, the reform was given some support by both MoH personnel and the general public.

Globally in resource-constrained health systems, there is strong support for expanding primary healthcare to encourage the utilization of lower-level health services and reduce inappropriate utilization of expensive hospital services (Feeney et al., 2005; Kruk et al., 2010; WHO, 2000). The failure of the first healthcare reforms strongly influenced the approach to the second initiative, recognizing the importance of incremental reform in a politically unstable and fragmented society. In light of the documented failure of the first prescriptive approach to radical healthcare reform, this exemplar has been chosen to examine a contrasting approach, whereby health reforms were undertaken using an incremental, context-specific approach.

Details of the Success Story

Fiji's constitution guarantees a right to health, which is reflected in universal health coverage with an emphasis on primary healthcare (see Figure 51.1). Primary healthcare strengthening is thus central to Fiji's health reforms and to the aims of achieving accessible, responsive, and quality outcomes, as well

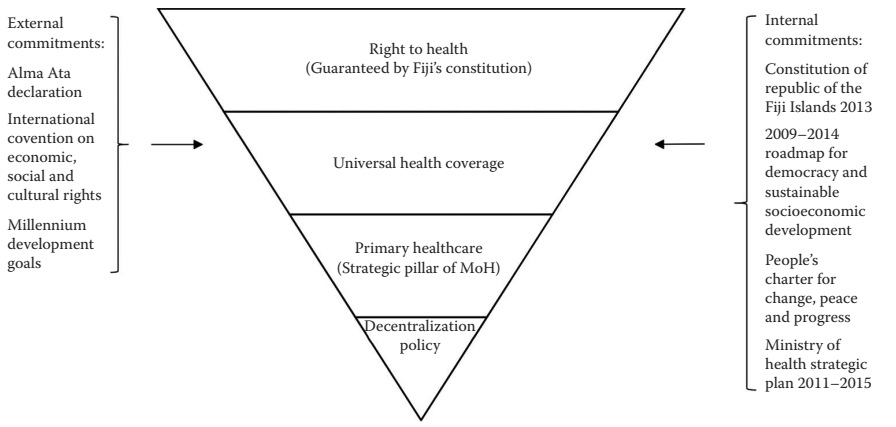

FIGURE 51.1
Framework for primary healthcare in Fiji.

as universal health coverage (Government of Fiji, 2013; Ministry of National Planning [Fiji], 2009).

Starting in 2009, first-contact care was decentralized from hospital outpatient services to the six health centers in the Suva subdivision in order to enhance both access to health services and the responsiveness of primary healthcare, and to encourage the use of outpatient services (Ministry of Health and Medical Services [Fiji], 2016).

Implementation was deliberately incremental, involving the closure of ambulatory hospital services as health centers were expanded. The first three health centers were strengthened in early 2009, then the remaining three in early 2011, after which the divisional hospital ceased accepting self-referrals (Ministry of Health [Fiji], 2011a). Health center strengthening involved upgrading infrastructure and equipment, increasing pharmaceutical and consumable supply, and introducing limited diagnostic services. This was made possible through an increased allocation of government health expenditure to central division health centers following decentralization (from 4.7% in 2008 to 9.2% in 2014; see Table 51.1) (Ministry of Health and Medical Services [Fiji], 2015b). While a centrally defined basic package of health services ensured the delivery of essential health services in all health centers, larger health centers with space were upgraded to provide basic diagnostic services including blood tests, x-rays, and basic scans (Ministry of Health [Fiji], 2010). Access to first-contact healthcare was enhanced by extending hours of operation from 8 to 16 hours per weekday and 8 hours per weekend day (Mohammed et al., 2016b) Health centers underwent structural improvements to cater for increased numbers of users and staff.

During implementation, continuous monitoring allowed for feedback from health centers to MoH planners, and for problems and deficiencies—such as the inadequate supply of pharmaceuticals—to be

TABLE 51.1

Government Current Health Expenditure Allocated to the Central Division, Including Suva Subdivision (2008–2014)

Year	Central division		
	Divisional hospital	**Subdivisional hospitals**	**Health centers**
2008	29.4%	6.1%	4.7%
2009	29.6%	5.5%	5.0%
2010	29.2%	5.7%	5.3%
2011	33.5%	4.2%	6.1%
2012	30.1%	4.2%	7.9%
2013	26.9%	4.8%	10.3%
2014	24.4%	5.5%	9.2%

Source: Fiji Health Accounts National Health Expenditure (2011–2014). *Note:* These figures reflect both decentralized and non-decentralized health centers. Of the total divisional population, 58% live in the Suva subdivision.

identified and remedied. Incremental upgrades to equipment at all health centers—none of which met even the minimum standard equipment requirements prior to decentralization—were made before and after decentralization. Human resources needs, deemed key to the success of the decentralization policy, were continually revised throughout the decentralization process. The number of medical officers and nurses employed in the six health centers increased by 44% and 30%, respectively, following decentralization. New posts for laboratory assistants and radiographers were created at larger health centers to introduce diagnostic services (Ministry of Health [Fiji], 2010, 2011b).

Details of the Impact of the Success Story

In the Suva subdivision, decentralization has resulted in increased utilization of health centers, reflecting the increased availability of community-based services and removal of divisional hospital self-referrals (except after-hours). Comparisons of utilization rates prior to decentralization in March 2008, and following the closure of hospital outpatient services in March 2011, reveal an average increase in utilization of 150% at the six health centers (range 98–225%) and a decrease in utilization of hospital outpatient services by 21% (Ministry of Health [Fiji], 2008, 2011c, 2011d). A close inspection of the first three decentralized health centers shows that the most significant increases in utilization occurred following the closure of hospital outpatient services (see Table 51.2).

TABLE 51.2

Utilization Rates at the First Three Health Centers to be Strengthened

	Health Center A		Health Center B		Health Center C	
	Outpatients seen	Percentage change	Outpatients seen	Percentage change	Outpatients seen	Percentage change
Baseline month	3525	—	4061	—	2429	—
One month post-decentralization	4124	16	6239	54	2568	6
Six months post-decentralization	6703	90	5275	30	3196	32
One month post-closure of divisional hospital to self-referrals	7116	102	7658	89	6135	153

Implementation: Transferability of the Exemplar

Internationally, there has been a marked shift in approaches to reform, involving a move away from a prescribed set of common elements to taking a more context-specific approach (Green et al., 2007; Healy et al., 2006). An incremental approach to health reform is not unique; however, primary care reforms in the Suva subdivision show that reforms need to be context specific. In Fiji's case, changes were gradual and progress was monitored carefully, thus ensuring greater responsiveness to any problems encountered. In addition to MoH support, the harnessing of local "ownership" and engagement from health professionals at lower levels was essential to the reform's success. The approach is transferable not only to other divisions within Fiji, but also to neighboring Pacific island countries that have experimented with prescribed approaches to health reforms but have failed to achieve intended outcomes. Like Fiji, many of these countries are remote and sparsely populated, have centralized administrative systems, and have limited funding and skilled personnel.

Prospects for Further Success and Next Steps

Utilization rates—which provide the MoH's only measure of success—have limitations, in that they do not provide insights into whether visits are first, repeat, or follow-up. Users have no choice but to utilize health centers; further studies are needed to examine whether primary healthcare is acceptable to users. Such studies could examine issues such as waiting time, other barriers to access, whether the type or scope of primary health services are appropriate for users, and why some people opt out of the public health system (Goddard and Smith, 1998). Penchansky and Thomas (1981) offer a possible framework for such an evaluation, which considers personal, financial, and organizational factors in the utilization of healthcare.

Conclusion

Two separate attempts at decentralizing Fiji's health services, each employing a different strategy, indicate that a context-specific, incremental approach has been more successful than a prescribed approach to reform. The first, a major prescriptive reform approach, failed to be supported by MoH

personnel and was abandoned. The second more gradual and circumscribed approach, has allowed the MoH to respond to feedback and apply lessons learned as decentralization has been implemented. Wider acceptance and support for the reforms, ensuring local ownership and drive, has, in Fiji's case, accompanied context-specific approaches.