Chapter 6: Principal Health Reforms

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References
6.1 Section summary

Fiji made considerable progress in advancing health outcomes of its citizens from the 1950s to 1970s. However, this progress has been stalled since the 1980s with little or no headway being made in improving health outcomes (World Health Organization, 2013). Additionally, a series of reports outlined growing user dissatisfaction with health services (Coombe, 1982, Dunn, 1997, The Government of Fiji, 1996, The Government of Fiji, 1997, The Government of Fiji, 1979, World Bank, 1993). As a result, Fiji attempted two waves of reforms: the first between 1999 and 2004; and the current from 2009 (see Box 6.1). This section provides an overview of the two waves of reform and describes their impact on service organization and planning, financing, human resources, and service delivery.

The first wave attempted to improve health service delivery by devolving health services. However, a devolved structure could not be successfully achieved due to political instability resulting in a coup d’état; four changes in government during the reform period; resistance from senior health officials; and a lack of management capacity to support divisional structures. As a result, the reform project was revised to a delegation of health services. The first wave of reform created geographical divisions, facilitating the delivery of public and clinical service delivery within these divisions. However, the Ministry of Health (MoH) budget was not adjusted to accommodate the divisional structures until the end of the implementation period. Additionally, due to a lack of control over its human resources, the MoH was unable to redeploy staff to key positions within divisional structures.

The current wave of reform began in 2009, with the aim to improve physical and financial access to good-quality health services. As a pilot project, this wave deconcentrated adult outpatient health services from the Colonial War Memorial (CWM) Hospital to the six health centres in the Suva subdivision. This involved the following key changes:

1. Service organization and planning – The six health centres in the Suva subdivision were strengthened to accommodate decentralized health services. This strengthening took place over a two-year period, extending the hours of operation from eight to 16 hours per day on weekdays and opening for eight hours a day on weekends. To facilitate the extended hours of opening, upgrading of infrastructure, consumables, medications, equipment, transport and administration were undertaken. As a result of the strengthening, the CWM Hospital ceased the provision of adult outpatient services. Planning was consolidated under three key areas: hospital services; public health; and administration and finance; and resulted in the segregation of planning for clinical and public health services, with coordination ensured through an overall strategic vision.

2. Financing – Financial allocations to decentralized health centres were increased slowly while strengthening activities were undertaken, but these were greatest following the closure of adult outpatient services at CWM Hospital.
3. **Human resources** – The Fijian health system has an average of four doctors per 10,000 population, falling far below WHO’s recommendation of a minimum of 23 doctors per 10,000 population. Shortage of human resources continued to affect the MoH during this wave of reform and despite staffing to decentralized health facilities being increased, a shortage has persisted. This affected the delivery of a full range of services during the extended opening hours.

4. **Service delivery** – Following decentralization, health centres in the Suva subdivision have become the first point of contact for users, with higher-level services only accessible through referrals. Service delivery hours at the six health centres were extended, resulting in an average increase in utilization of 150% at the six health centres. However, this caused increased workloads for medical officers in these six health centres resulting in a corresponding decrease in time spent with users.

**Box 6.1 Summary of decentralization efforts in Fiji**

<table>
<thead>
<tr>
<th>Reform effort</th>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wave 1: Fiji Health Management Reform Project (FHMRP)</td>
<td>February 1998</td>
<td>FHMRP pre-feasibility study</td>
</tr>
<tr>
<td></td>
<td>February 1999</td>
<td>Implementation of FHMRP commences</td>
</tr>
<tr>
<td></td>
<td>May 1999</td>
<td>New government elected</td>
</tr>
<tr>
<td></td>
<td>October 1999</td>
<td>FHMRP team seeks ‘buy-in’ from new government</td>
</tr>
<tr>
<td></td>
<td>November 1999</td>
<td>New government endorses changes</td>
</tr>
<tr>
<td></td>
<td>March 2000</td>
<td>Cabinet Subcommittee convened to review alternative to decentralized structure proposed by Prime Minister</td>
</tr>
<tr>
<td></td>
<td>April 2000</td>
<td>FHMRP Project endorsed by Cabinet Sub Committee as the way forward. Health Services Bill to be forwarded to Cabinet by June for approval</td>
</tr>
<tr>
<td></td>
<td>May 2000</td>
<td>Coup d’état removes elected government and halts progress of FHMRP</td>
</tr>
<tr>
<td></td>
<td>February 2002</td>
<td>3-year implementation period of the FHMRP ends</td>
</tr>
<tr>
<td></td>
<td>February 2004</td>
<td>Planned completion of FHMRP</td>
</tr>
<tr>
<td></td>
<td>March 2008</td>
<td>Rollback of Health Sector Reform</td>
</tr>
<tr>
<td>Recentralization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wave 2: Decentralization of Adult outpatient services in the Suva Subdivision</td>
<td>August 2008</td>
<td>People’s Charter for Change, Peace and Progress endorsed, highlighting the need to improve users’ access to health care. This is incorporated in the key government national planning document: Roadmap for Democracy and Sustainable Socio-Economic Development 2009–2014</td>
</tr>
<tr>
<td></td>
<td>March 2009</td>
<td>Decentralization of outpatient services in Suva subdivision begins (Valelevu and Makoi health centres first to be decentralized)</td>
</tr>
<tr>
<td></td>
<td>April 2009</td>
<td>Raiwaqa Health Centre decentralized</td>
</tr>
<tr>
<td></td>
<td>January 2011</td>
<td>Lami, Samabula and Nuffield health centres decentralized</td>
</tr>
<tr>
<td></td>
<td>February 2011</td>
<td>CWM Hospital ceases provision of outpatient services</td>
</tr>
</tbody>
</table>

Abbreviation: FHMRP, Fiji Health Management Reform Project

*Source: Mohammed et al., 2016a*
6.2 Analysis of recent major reforms

Health sector reform, taking the form of decentralization, has been attempted in Fiji since the late 1990s (Roberts et al., 2011). This chapter provides an overview of Fiji’s reform attempts: the first between 1999 to 2004; and the current from 2009, separated by a brief period of recentralization, as outlined in Box 6.2 (Mohammed et al., 2016a, Mohammed et al., 2016c). The first reform attempt has been discussed in The Fiji Islands Health System Review, and this update should be read in conjunction with the initial report (Roberts et al., 2011). This update provides a critical overview of the two waves of reform and describes their impact on service organization and planning, financing, human resources and service delivery.

Box 6.2  Major health care reforms and forms that it has taken

<table>
<thead>
<tr>
<th>Date</th>
<th>Key reform</th>
<th>Form of decentralization undertaken</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999–2004</td>
<td>Wave 1: Fiji Health Management Reform Project (FHMRC)</td>
<td>Devolution, i.e. the creation or strengthening of subnational levels that then deliver a set of functions through geographical structures (Rondinelli et al., 1983, Mills et al., 1990). Delegation, i.e. involves the transfer of decision making and administrative authority for a specific set of functions from the central ministry to structures the ministry has indirect control over (Rondinelli et al., 1983, Mills et al., 1990).</td>
</tr>
<tr>
<td>2008</td>
<td>Recentralization</td>
<td></td>
</tr>
<tr>
<td>2009-Current</td>
<td>Wave 2: Decentralization of Adult outpatient services in the Suva Subdivision</td>
<td>Deconcentration, i.e. transfer of some workload from the central ministry to subnational levels (Rondinelli et al., 1983, Mills et al., 1990).</td>
</tr>
</tbody>
</table>

6.2.1 Wave 1: Fiji Health Management Reform Project (FHMRC) [1999–2004]


The FHMRP aimed to improve health service delivery by strengthening the structure of the MoH, redefining and focusing roles, building management capacity, reinforcing health information systems and addressing intersectoral issues (AUSHealth International, 2000). This was to be achieved by devolving the delivery of health services to strengthened divisional structures, which have legal powers to plan, manage health facilities, control their budget, raise revenue and address specific health needs of their population (The Government of Fiji, 1990). However, political instability resulting in Fiji’s third coup d’état, four changes in government during the reform period, resistance from senior health officials, and a lack of management capacity to support divisional structures, meant the reform project could not achieve a devolved structure (AUSHealth International, 2000, Mohammed et al., 2016a, Mohammed et al., 2016c). As a result, the reform project was revised to a delegation of health services to divisional structures.

**Service organization and planning**


**Figure 6.1 Organizational structure prior to decentralization (1998)**

Following decentralization, health service delivery was streamlined through the redefinition of roles, institutional capacity strengthening and restructuring of the delivery of health services (AUSHealth International, 2000). This led to the creation of three geographical divisional structures, focusing on the delivery of health services, and coordinated by a central office supported by central office divisions (Rokovada, 2006, Mohammed et al., 2016a). The central office divisions were restructured to focus on four key areas: public health; health services development; health systems standards; and corporate services. The geographical divisions were
created to deliver devolved health services under three divisions: Central/Eastern (known as CentEast), Western; and Northern, as illustrated in Figure 6.2.

Figure 6.2 Organizational structure following ‘first wave’ of decentralization (1999–2007)

These geographical divisions, led by a director and supported by three general managers, were to have autonomy to plan and coordinate health service delivery in their respective divisions. However, this did not eventuate as the proposed legislation intended to transfer legal autonomy to devolved structures over human resources, financing, supply and purchasing and maintenance, was not tabled in Cabinet in June 2000 due to a coup d’état in May (Mohammed et al., 2016a). This resulted in a devolved health structure not being achieved. However, a delegated structure was achieved, whereby some decision-making over planning of health service delivery was transferred to divisional levels. This was evident in the combined planning of clinical and public health services at divisional levels (Australian Agency for International Development, 2008).
**Financing**

Under FHMRP, each division was to be delegated financial responsibility from the central office. Proposed legislation would have given each division responsibility over their approved budget and the ability to set its own user fees. However, financial management reforms as part of government-wide reforms, which began prior to the reform project, were halted with a change in government. These reforms intended to give the MoH central office greater control over its finances. However, with financial management reforms halted, the Ministry of Finance (MoF) retained control over finances (Mohammed et al., 2016a, Mohammed et al., 2016c). As a result of four changes in government during the reform period, the MoF did not adjust the MoH budget to accommodate the decentralized structure until 2003 (see Figure 6.3) (Mohammed et al., 2016a). This meant the decentralized structure was poorly resourced, affecting the achievement of FHMRP objectives.

**Figure 6.3  Health budget as a percentage of the national budget (1998–2005)**

![Graph showing health budget as a percentage of the national budget (1998–2005)](image)


**Human resources**

Delegation of human resources was an integral part of the reform process. Government-wide reforms prior to the FHMRP resulted in the Public Services Commission (PSC) delegating responsibility to the MoH to manage its own human resources. However, a change in government reversed PSC delegations, weakening the ability of the MoH to redeploy existing staff in a decentralized structure (AUSHealth International, 2000). A subsequent agreement was reached between the MoH and the PSC to work together to transfer staff to divisional structures. However, migration of skilled personnel as a result of political instability meant that there were only three managers in the MoH who had the training and experience to be considered health service managers (AUSHealth International, 2000, Australian Agency for International Development, 2008). This hindered the MoH’s ability to fill key positions within divisional structures to oversee the implementation of the reform process.
Service delivery

The overall aim of FHMRP was to improve health service delivery by devolving health services. Decentralization focused the delivery of health services around three divisional structures, allowing for strengthening activities to be carried out. Clinical services were consolidated under one umbrella, and divisional structures were strengthened to deliver clinical services (Mohammed et al., 2016a). A key change was the integration of public health programmes and clinical services at the divisional level. This facilitated a greater focus on public health, increasing financial allocations made to public health programmes over the reform period (see Figure 6.4). However, much of the changes under FHMRP was limited to policies, guidelines and standards. Political instability hindered further progress, which meant that community dissatisfaction with health facility deterioration, waiting times and falling standards of service and cleanliness was not resolved (Mohammed et al., 2016a).

Figure 6.4  Percentage of health budget by health function (1998–2005)


6.2.2  Recentralization [2008]

The FHMRP faced a number of challenges following implementation. It was seen to be externally driven and did not have the support of senior managers at the MoH (Mohammed et al., 2016a, AUSHealth International, 2000). Additionally, the FHMRP commenced in an election year, with uncertainty in terms of commitment, ownership and support, if a new government came into power. A change in government resulted in precisely that. The reform project had to renegotiate support and commitment from the government, resulting in the first year outcomes not being achieved (AUSHealth International, 2000). Ultimately, the FHMRP team was able to renegotiate government support for the project 18 months into the
project, but faced another significant challenge when the government was removed through a *coup d’état* in May 2000. The combination of these challenges, meant that the FHMRP was not able to achieve a devolved health structure, instead achieving a limited delegation.

Following a fourth *coup d’état* in 2006, the GoF began a process of reforming the public services to improve efficiency. This resulted in a 10% reduction in the public services to be achieved by reducing the retirement age from 60 to 55 (The Ministry of Health, 2008, Freeman and Sutton, 2010). This amounted to a loss of over 300 staff from the MoH (World Health Organization and The Ministry of Health, 2012). These challenges, compounded by the PSC and MoF reversal of delegations for human resource management and finance respectively, left the MoH with limited control over human resources and finance needs of divisional structures. As a result the MoH encountered difficulties in implementing public health programmes within decentralized structures (The Ministry of Health, 2008). This led to the ‘roll-back’ of health sector reform, with MoH reverting to centralized structures that existed prior to the FHMRP.

Under the recentralized system, planning was coordinated by the central office under seven key areas: corporate services; health programmes and training; health systems standards; health information, planning and infrastructure; pharmaceutical and biomedical supplies; primary health services; and curative health services, as illustrated in Figure 6.5.

**Figure 6.5  Organizational structure following recentralization (2008)**

![Organizational structure following recentralization (2008)](image)

*Source: Mohammed et al., 2016a*

While divisional structures continued to exist after ‘roll-back’, planning for clinical and public health services was separated (Mohammed et al., 2016a). Hospital services became part of curative health services and planning was carried out by the general manager of each hospital in collaboration with the director of curative services. Similarly, planning for public health services was carried out under the division of primary health services by the divisional and subdivisional medical officers in collaboration with the director of primary health care services (Mohammed et al., 2016a).
6.2.3 Wave 2: Decentralization of adult outpatient services in the Suva subdivision [2009-current]

In 2008, the GoF recognized that Fiji was not on track to achieving its obligations under the Millennium Development Goals (The Government of Fiji, 2008a). It further noted public dissatisfaction with community-level health services resulting in users bypassing lower-level services (Australian Agency for International Development, 2008, World Health Organization and The Ministry of Health, 2012). The MoH, in response to calls from the government to improve physical and financial access to good-quality health services, initiated a pilot process of decentralizing adult outpatient health services in the Suva subdivision (Mohammed et al., 2016a, Mohammed et al., 2016c, The Ministry of National Planning, 2009, The Government of Fiji, 2008a). This second wave of reform was characterized by decentralization taking the form of deconcentration, i.e. the transfer of some workload to lower levels of the organization (see Box 6.2 for more details).

As a pilot project, the second wave had a more focused aim, i.e. improving users’ access to health services in the Suva subdivision only. This involved strengthening of the six health centres in the Suva subdivision, which serve a quarter of Fiji’s population (Mohammed et al., 2016c). Strengthening took place in terms of extending the hours of operation from eight to 16 hours per day on weekdays and opening for eight hours a day on weekends (The Ministry of Health, 2011b). It also included upgrading infrastructure and increasing consumables, medications, equipment, transport and administrative services (Mohammed et al., 2016c, Nand, 2012). Strengthening of the six health centres was undertaken over a two-year period, commencing in March 2009, resulting in the cessation of adult outpatient services at the CWM Hospital in March 2011 (Office of the Prime Minister, 2012).

Service organization and planning

Under the second wave of decentralization, changes were made to the execution of planning and organization of health services. An examination of the organization structure reveals a consolidation of planning under three key areas: hospital services; public health; and administration and finance (see Figure 6.6) (Mohammed et al., 2016a). Reform of the structure resulted in the segregation of planning for clinical and public health services, with coordination ensured through an overall strategic vision managed by the central office (The Ministry of Health, 2011c, The Ministry of Health and Medical Services, 2016). At the lower levels, each subdivision devised their own business plans which were linked to divisional business plans, allowing the central office to harmonize divisional planning activities with national strategic directives.
A baseline study informed the needs for decentralization, and identifying utilization along with resources held by each health centre. Following implementation, continuous monitoring provided feedback from the health centres to the central office, allowing adjustments to be made to infrastructure, consumables, medications, equipment and transport needs (The Ministry of Health, 2010b, Mohammed et al., 2016c). This facilitated the delivery of a consistent package of health services across the decentralized health centres. Decentralization further facilitated the divisional hospital to focus on the development of tertiary-level care through a three-phased development of the CWM Hospital, resulting in improvements to accident and emergency services, referral and diagnostic services, surgical capacity, inpatient and intensive care.

While the separation of planning for clinical and public health services has facilitated the development of community-level and hospital services, it has limited the divisions’ ability to coordinate and allocate resources between the two activities (Australian Agency for International Development, 2008).

**Financing**

Under the second wave of decentralization, the function of finance remained centrally administered, with the MoF releasing a yearly budget allocation to
respective ministries (Mohammed et al., 2016a). These budget allocations were based on historical expenditure and involved consultation with the central office. In turn, the central office used business plans from each division and subdivision to determine the MoH budget needs. While health centres had no specific budget allocation, they could request funding from their respective subdivisions (Mohammed et al., 2016a, Mohammed et al., 2016c).

An examination of the National Health Budget during the second wave of decentralization reveals that allocations to the MoH did not increase during the first two years of decentralization (see Figure 6.7). In fact, the overall budget allocation to the MoH decreased during the same period (The Ministry of Health, 2010a, The Ministry of Health, 2009, The Ministry of Health, 2011a). An increase in the allocation was expected as the six health centres underwent strengthening during this period. However, budget allocations were increased following the closure of outpatient services at the CWM Hospital (The Ministry of Health, 2013, The Ministry of Health, 2014, The Ministry of Health and Medical Services, 2015). With limited financial data recorded at subdivisional levels, an examination at the divisional level reveals an increase in the current government health expenditure to central division health centres from 4.7% in 2008 (prior to decentralization) to 9.2% in 2014 (Mohammed et al., 2016b). These increases were the greatest following the closure of outpatient services at CWM Hospital, and reflective of an increased allocation to the MoH budget from 2012. However, limited increases during the first two years when strengthening activities were carried out, resulted in considerable issues in delivering quality health care (The Ministry of Information, 2011, Luke Rawalai, 2014b, Naleba, 2014b, Swami, 2013, Swami, 2014). These issues are highlighted under the service delivery subsection.

Figure 6.7  Health budget as a percentage of the National Budget (2008–2014)

Human resources

The MoH recognized that the success of decentralization was linked to adequate staffing of decentralized health facilities to facilitate extended hours of operation and increased utilization (The Ministry of Health, 2011b). MoH requests to PSC to increase the number of medical officers and nurses prior to and following decentralization resulted in increased staff establishments. As a result, medical officers and nurses employed at the six health centres increased by 44% and 30% respectively following decentralization (Mohammed et al., 2016b). However, this was still seen to be inadequate and meant ancillary services could only be provided for part of the extended opening hours. This was attributed to high vacancy rates for health professionals, particularly doctors (28%), nurses (6%), laboratory staff (7%), radiographers (8%) and pharmacists (21%)\(^1\). An additional allocation of FJ$ 8.1 million to the health sector was made in 2014 by the GoF to recruit an additional 200 nurses, 150 doctors and 91 allied health workers to address this shortage (Devi, 2014, Repeka Nasiko, 2014). The result was an extension of pharmacy opening hours at larger health centres (Pratap, 2014). However, laboratory and radiology services continued to be provided only at larger health centres and only for part of the extended opening hours.

Shortage of medical officers within the public health service meant that the MoH entered into public-private partnerships with private general practitioners to work at public health facilities in order to provide health services during the extended hours of operation (The Ministry of Health, 2010b). The shortage of nurses had to be managed internally, with zone nurses having to cover shifts at outpatient clinics, affecting the delivery of public health programmes. Additionally, a maldistribution in the deployment of staff has resulted in overstaffing at some health facilities (Australian Agency for International Development, 2008).

As a guide, the World Health Organization (WHO) recommends a minimum of 23 doctors and nurses each per 10 000 population for the effective functioning of health systems and to achieve adequate coverage rates (World Health Organization, 2010). The Fijian health system falls far below this recommendation with an average of 4 doctors per 10 000 population.\(^2\) A closer examination of the six decentralized health centres, which serve a quarter of Fiji’s population, reveals a grimmer situation with the six health centres having closer to one doctor and nurse each per 10 000 population (see Table 6.1).

<table>
<thead>
<tr>
<th>Health facility</th>
<th>Doctor: population ratio</th>
<th>Nurse: population ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lami Health Centre</td>
<td>1:13 927</td>
<td>1:3482</td>
</tr>
<tr>
<td>Samabula Health Centre</td>
<td>1:8149</td>
<td>1:2716</td>
</tr>
<tr>
<td>Raiwaqa Health Centre</td>
<td>1:9826</td>
<td>1:2948</td>
</tr>
<tr>
<td>Nuffield Health Centre</td>
<td>1:21 887</td>
<td>1:5472</td>
</tr>
<tr>
<td>Valelevu Health Centre</td>
<td>1:8365</td>
<td>1:3137</td>
</tr>
<tr>
<td>Makoi Health Centre</td>
<td>1:6226</td>
<td>1:10 959</td>
</tr>
</tbody>
</table>

Source: Ministry of Health 2011b

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1 Figures are for 2014
2 Figures are for 2010
Service delivery

The second wave of decentralization has been the most significant change to the delivery of health care in Fiji, affecting how users access and receive health care. Following decentralization, health centres in the Suva subdivision have become the first point of contact for users, with higher-level services only accessible through referrals. To accommodate increased utilization at decentralized health centres, the MoH extended hours of operation from eight to 16 hours per day on weekdays and opened for eight hours a day on weekends. This resulted in an average increase in utilization of 150% at the six health centres (range 98–225%) and a decrease in utilization of hospital outpatient services by 21% (Mohammed et al., 2016b).

Comparisons of medical officer workloads prior to and following the closure of outpatient services, reveal an increase in workload from an average of 39 users (range 23–52 users) to 191 users (range 123–299 users) at the six health centres (Mohammed et al., 2016b). Alarmingly, the time spent with users has decreased considerably, from an average of 12.5 minutes (range 4.4–33 mins) to 4.8 minutes (range 2.8–6.7 mins) at the six health centres (Mohammed et al., 2016b).

A significant change under this reform period was the introduction of user fees for those referred to public health services from private providers (The Government of Fiji, 2012b, The Government of Fiji, 1976, The Government of Fiji, 2012a). However, those accessing health facilities directly continued to enjoy free health care.

A number of issues have affected service delivery. Increased utilization of decentralized health centres has resulted in lengthy waiting times for users, particularly during the day-shift when all services are available (Naleba, 2014b). A lack of ambulances within the public health service has led to long waiting times for referrals between health centres and the divisional hospital (Luke Rawalai, 2014a, Delaibatiki and Cava, 2014). Additionally, the decentralized health centres have faced consistent shortages of pharmaceutical products. The MoH notes that 80% of medications on the free medicines list are available consistently throughout the month and aims to increase this to 90% (The Ministry of Health, 2011c, The Ministry of Health and Medical Services, 2016). However, a major problem that has affected the decentralization initiative is the lack of availability of all services for the entire extended opening hours. While users can receive medical consultations for the full 16 hours a day, they only have access to pharmacy, laboratory and radiology services for eight hours a day. Following user complaints two of the six decentralized health centres have begun to provide pharmacy services for the full 16 hours a day since October 2014 (Naleba, 2014a). However, other ancillary services continue to be provided for only part of the extended opening hours.

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3 Figures are based on a comparison of utilization rates in March 2008 prior to decentralization and following decentralization in March 2011
4 Figures are for 2010 prior to closure of outpatient services at CWM Hospital, and March 2011 following the closure of outpatient services at CWM Hospital
6.3 Future developments

The MoH Strategic Plan 2016-2020 outlines two strategic pillars for growth and development for the next five years. The first focuses on the delivery of health services while the second focuses on health systems strengthening (The Ministry of Health and Medical Services, 2016). The MoH views decentralization as a way to improve users’ access to health services and respond to the health needs of the population. It identifies the extension of opening hours at health centres as a key goal to achieving this (The Ministry of Health and Medical Services, 2016).

Deeming the decentralization of outpatient services a success, the MoH plans to roll-out the decentralization policy to the other divisions (Mohammed et al., 2016a, Mohammed et al., 2016c, Mohammed et al., 2016b, The Ministry of Health, 2011b). The measure of this success is based on user utilization rates. However, utilization rates have limitations. They do not distinguish between first visits, or repeat and follow-up visits (Mohammed et al., 2016b). Additionally, utilization rates only reveal the usage of each health centre and do not reveal the quality of care provided.

Given that preliminary work has been undertaken to build new and upgrade existing health centres in the Western Division, this may indicate that Lautoka subdivision will be the next subdivision to be decentralized (Mathewsell, 2013, The Government of Fiji, 2013a). However, health facility strengthening based on lessons learnt from the Suva subdivision pilot is needed to ensure health centres in the Lautoka subdivision have the infrastructure and capacity to provide extended outpatient services (The Ministry of Health and Medical Services, 2016).

The roll-out of decentralization would align well with the MoH’s priority of strengthening primary health care services to ensure continuum of care and improved quality of services (The Ministry of Health and Medical Services, 2016). However, as no evaluation of the decentralization initiative has been carried out, further studies are needed to evaluate the pilot project prior to roll-out, ensuring decentralized health facilities are sufficiently resourced to cater for increased utilization. An understanding of the pilot project will facilitate the MoH in adapting lessons learnt from the pilot project to other divisions.

Acknowledgements

This Living HiT update was written by Jalal Mohammed.
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