Leadership and management

A REVIEW OF HEALTH LEADERSHIP AND MANAGEMENT CAPACITY IN FIJI

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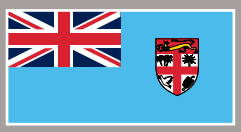

Fiji

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ACRONYMS

AUD$	Australian dollar
AusAID	Australian Agency for International Development
FJD$	Fiji dollar
GDP	gross domestic product
GoF	Government of Fiji
HRH	human resources for health
IT	information technology
Lao PDR	Lao People's Democratic Republic
MAKER	Managers taking Action based on Knowledge and Effective use of Resources
MDG	Millennium Development Goals
MoH	Ministry of Health
PPP	purchasing power parity
PSC	Public Service Commission
PSH	Permanent Secretary of Health
RAMSI	Regional Assistance Mission to Solomon Islands
SDHS	Sub-Divisional Health Sister
SDMO	Sub-Divisional Medical Officer
UN	United Nations
UNDP	United Nations Development Programme
UNSW	University of New South Wales
USD$	United States dollar
WHO	World Health Organization
WPRO	Western Pacific Regional Office

A note about the use of acronyms in this publication

Acronyms are used in both the singular and the plural, e.g. MDG (singular) and MDGs (plural).
Acronyms are also used throughout the references and citations to shorten some organisations with long names.

EXECUTIVE SUMMARY

The Ministry of Health is Fiji's largest provider of health care, but a **growing private sector and a significant number of non-government organisations** also provide particular services to the public.

This review describes the current situation of health leadership and management capacity at the sub-divisional level in Fiji. Fiji is a lower middle-income country ranked 86 out of 169 countries on the UNDP[1] human development index. With a gross national income per capita of USD$4,304 in 2007, Fiji's economy is among the most developed of the Pacific Island countries. However, the economy contracted by 2.5% in 2009, representing the worst performance in more than a decade.

Fiji has a good standard of health with about 70–80% of the population having access to Primary Health Care. Life expectancy at birth is around 70 years, similar to most Pacific Island countries. Infant mortality has declined over recent years from 21 per 1000 live births in 2005 to 13 per 1000 in 2008.

Fiji now faces significant challenges with increasing rates of non-communicable diseases and injuries from accidents. Non-communicable diseases such as diabetes, heart disease, high blood pressure, respiratory diseases and cancers, have replaced infectious and parasitic diseases as the principal causes of mortality and morbidity in Fiji.

The health system of Fiji is the most complex and developed among the Pacific Island countries. The Ministry of Health (MoH) is Fiji's largest provider of health care, but a growing private sector and a significant number of non-government organisations also provide particular services to the public. In 2010, the MoH had an approved establishment of 3,452 employees, 17% of whom were medical or dental cadres, 57% nursing, 15% other health professionals and 9% administration and information technology (IT) support.

Government health spending as a proportion of gross domestic product (GDP) was 2.6% in 2008. This was relatively lower than allocations in neighbouring Solomon Islands and Tonga, which were between 4–5% of GDP respectively. The Fijian Government expenditure on health represented about 71% of total national health expenditure in 2008. In general, donors finance less than 5% of health activities in Fiji, making the health system one of the least donor-dependent in the region.

Fiji is divided into four divisions and 15 provinces. Health services are delivered in the four divisions but through 19 sub-divisions, all of which have health centres and nursing stations and 16 have a sub-divisional hospital. There are 19 sub-divisional medical officers (SDMOs) working as clinicians at the sub-divisional level who also have responsibility for the day-to-day management of the health system. Their managerial competencies vary according to the level of management preparation. While all are medically trained, only four of the 19 reportedly held a Master of Public Health Degree in 2010, in which they had studied basic management. The MoH and the Public Service Commission (PSC) and donors periodically provide short management training courses and workshops.

In conforming to MoH, PSC and Ministry of Finance process, the degree of management flexibility is limited. The MoH itself has undergone periods of decentralisation and recentralisation in the past three decades which has significantly altered management flexibility in the divisions. Key management support systems at the divisional and central levels give variable support to SDMOs.

Sub-optimal systems, such as the supply of essential drugs, have periodically required high level management reviews instigated by the Minister. SDMOs have managerial flexibility in managing their interaction with the local community. Effectiveness in this domain depends on the ability to balance roles while also motivating community leaders to undertake preventative measures, such as early referral, improved sanitation and non-communicable disease risk factor control. Role definition, staff team building and community development competencies require further strengthening as Fiji accelerates its progress towards achieving the Millennium Development Goals (MDGs).

[1] United Nations Development Programme

SNAPSHOT: FIJI

BASIC DEMOGRAPHIC AND SOCIO-ECONOMIC DATA

Population in 2007
0.8 million

GDP per capita (PPP USD$) in 2007
$4,304

Life expectancy at birth in 2007
68.7 years

Under age 5 mortality in 2007
18 per 1,000 live births

Maternal mortality in 2005
210 per 100,000 live births

Nursing and midwifery density from 2000 to 2007
20 per 10,000 people

Doctor density from 2000 to 2007
5 per 10,000 people

Key to acronyms

GDP	gross domestic product
PPP	purchasing power parity
USD$	United States dollars

(Adapted from UNDP 2009, WHO 2009)

INTRODUCTION

Despite recent improvements in health status, Fiji, like other Pacific Island countries is **undergoing an epidemiological transition, and is now faced with a triple burden of disease:** communicable and non-communicable diseases and injuries and accidents.

Fiji consists of about 332 islands of which 110 are inhabited. It is the largest population among the Pacific Island countries (excluding Papua New Guinea). Nearly 30% of its 837,271 inhabitants are under the age of 15 years. Much of the country's population is concentrated on the two largest islands, Viti Levu (where the nation's capital Suva is located) and Vanua Levu (Fiji Islands Bureau of Statistics 2008).

Fiji is classified by the World Bank as a lower middle-income country and ranked 86 out of 169 countries on the UNDP human development index (UNDP 2010). Its economy is among the most developed of the Pacific Island economies. However, the economy contracted by 2.5% in 2009, representing the worst performance in more than a decade (World Bank 2010). Sugar remains the key foreign exchange earner, providing about 30% of domestic export earnings and employing over 13% of the labour force (Fiji Ministry of Finance and National Planning 2004). The economy is also dependent on tourism and remittances from Fijians living and working overseas. Remittance inflow is estimated at about 3.4% of GDP (UNDP 2010).

The Fijian health system is the most complex and developed among the Pacific Island countries (UNDP 2006) and has undergone significant change in the last decade. AusAID supported a two-stage health sector improvement program between 1999 and 2009. The first phase (1999–2003) was a management reform program designed to improve decision making by supporting a new model of decentralised management. The second phase (2004–2009) aimed to improve governance, health systems performance, clinical outcomes and supported public health and infrastructure initiatives at the divisional level (WHO WPRO 2008). The next stage of AusAID's health sector support to Fiji is more specifically targeted to achieving MDGs and reducing non-communicable disease prevalence and is currently in the planning stage.

The MoH is the largest provider in the health sector, but there is a growing private sector and a significant number of non-government organisations also providing services to the public (Sutton et al. 2008). The MoH has recently signed Memorandums of Understanding with a number of private providers to deliver certain services. As an example, in 2007 the MoH signed one with the Kidney Foundation of Fiji for the establishment of the Haemodialysis Unit to serve kidney-failure patients (Government of Fiji 2007).

Fiji has a good standard of health with life expectancy at birth around 70 years. This is due, in part, to improved health service delivery which has seen a significant decline in mortality and morbidity. After little change in the 1990s the infant mortality rate declined over three years from 20.76 per 1,000 live births in 2005 to 13.1 per 1,000 in 2008 (Government of Fiji 2009b).

Despite recent improvements in health status, Fiji, like other Pacific Island countries is undergoing an epidemiological transition, and is now faced with a triple burden of disease: communicable and non-communicable diseases and injuries and accidents (WHO WPRO 2008). Non-communicable diseases such as diabetes, heart disease, high blood pressure, respiratory diseases and cancers, have now replaced infectious and parasitic diseases as the principal causes of mortality and morbidity in Fiji. Around 82% of deaths in Fiji in 2007 were due to non-communicable diseases and 10% due to communicable diseases (WHO WPRO 2009).

PURPOSE AND APPROACH

The purpose of this review is to describe the current situation of health management and leadership capacity at the sub-divisional level and to analyse issues that affect the performance of sub-divisional managers and the administrative staff that support them.

Among other case studies it is intended to inform the development of policy recommendations for improving management and leadership performance in six AusAID priority countries – Cambodia, Fiji, Lao PDR, Papua New Guinea, Solomon Islands and Timor-Leste.

The review was conducted through desk review of both published and grey literature and discussions with key informants. The first six sections provide a brief description of key aspects of the health system of Fiji and the last five assess management and leadership capacity using a modified version of the WHO MAKER[2] framework (WHO 2007).

Key components of the framework include the number and distribution of managers, managerial competency, the management working environment, management support systems and the socio-cultural context in which managers operate. A summary of key points on management and leadership in Fiji has been provided at the end of this report. Detailed analysis and discussion of the issues identified will be available in a separate paper that brings together all the issues identified from the six countries. This synthesis will be available at **www.hrhhub.unsw.edu.au**

[2] Managers taking Action based on Knowledge and Effective use of Resources.

ACCESS TO HEALTH CARE

At the community level, **non-salaried village health workers in Fijian villages and community health workers** in other rural areas provide basic first aid and coordinate referrals to nursing stations.

Access to quality health care remains a challenge in Fiji, as in other Pacific Island states. It is believed that about 70–80% of the population has access to primary health care but only about 40% has access to quality health services (Jerety 2008).

Ministry of Health policy asserts the right of every citizen of Fiji, irrespective of race, sex, colour, creed or socio-economic status, to have access to a national health system that provides a high quality health service (Government of Fiji 2006b). The vast majority of the population receives health care through the public system. In general, health services have delivered 124 nursing stations, 3 area hospitals, 76 health centres, 16 sub-divisional hospitals, 3 divisional hospitals and 3 speciality hospitals (WHO WPRO 2008).

At the community level, non-salaried village health workers in Fijian villages and community health workers in other rural areas provide basic first aid and coordinate referrals to nursing stations. Limited secondary-level clinical care is provided at the sub-divisional hospital level while tertiary care is only available at the divisional level. Access to health care is hindered by geographical, transport and financial constraints. Primary health care and outreach initiatives have a long history of successful coverage in Fiji but were wound back to some degree for logistical reasons and, in part, due to the new emphases placed on health promotion in the 1990s and on other reform agendas (Negin et al. 2010).

FINANCING THE HEALTH SYSTEM

Managing within a financially constrained system is another difficult challenge. In 2008, about FJD$150 million was allocated to the health sector, representing around 2.6% of the GDP (Lingam and Roberts 2009). For the last decade government expenditure on health has not exceeded 4% of GDP (Government of Fiji 2009a).

Total government health expenditure since 1995 has ranged between 2.5% to 3.5% of GDP, lower than many of Fiji's Pacific neighbours, although per capita spending is among the highest in the region. The Solomon Islands and Tonga, for example, spend between 4–5% of GDP on health annually, while Vanuatu spends around 3% (UNDP 2008)[3]. Figure 1.4-1 shows GDP per capita in United States dollar purchasing power parity and government health expenditure as a proportion of GDP for 1990 and 2000–2004.

While there was a small but steady rise in GDP per capita, government health expenditure has been fluctuating, with a fall in 2003 and a sharp rise in 2004. The rise may be due, in part, to the resumption of aid to Fiji by the European Union in November 2003 following a freeze of aid after the coup of 2000 (European Commission 2004).

The AusAID-funded (AUD$25 million) Fiji Health Sector Improvement Program between 2003 and 2009 also brought additional funding to the health sector. Government health expenditures in Fiji are almost exclusively financed through tax revenue, although the MoH receives funding from donor agencies to supplement MoH activities in specific areas.

A limited amount of revenue (approximately 1% of expenditure) is raised internally through user fees but these have not kept pace with cost increases and, as they accumulate in Government of Fiji consolidated revenue accounts, are not retained by the MoH (Lingam and Roberts 2009) nor available to hospital managers. The Fijian health system is essentially publically funded with a small proportion (about 3% in 2008) of the overall budget provided by development partners. Government expenditure accounted for 71% of the total national health expenditure, as shown below.

[3] Despite the relatively low proportion of GDP spent on health, the health status of the population in Fiji compares well with other Pacific Island nations according to WHO (WHO WPRO 2009)

HUMAN RESOURCES FOR HEALTH

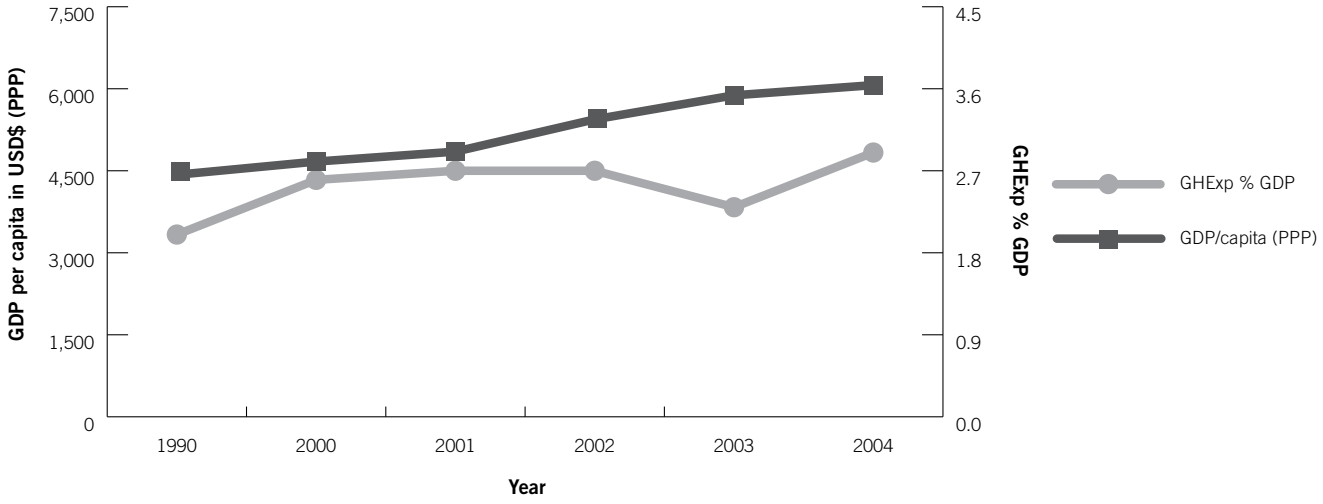
In 2010, the MoH staff establishment approved by the PSC was 4,955 employees, comprised of 3,452 'established' and 1,503 'unestablished' general staff (Government of Fiji 2010). Among the established staff 14 positions (<0.5%) were senior executive posts and 327 (9.5%) were administrative, accounting, IT and other management support staff. These 327 positions include MoH headquarters administrators and those at divisional and sub-divisional levels, all of whom are employed by the PSC. SDMOs and Sub-Divisional Health Sisters (SDHSs). are counted among the medical (12%) and nursing (57%) cadres respectively.

As at January 2010, six senior executive posts (43%) and 25 medical officer posts (6%) were vacant, as were 81 administrative posts (25%; Asia Pacific Observatory on Health Systems and Policies 2011). The potential to fill these positions with suitably qualified and experienced people is constrained by PSC demands in other areas and a lack of health management training programs in Fiji. Programs offered at the University of the South Pacific in the 1980s and at the Fiji School of Medicine in recent years have been difficult to sustain, have not attracted strong academic staff and have not resulted in a trained health administration cadre. Senior executive positions are filled by professional staff, many having studied health management as a component of a Master of Public Health Degree at the University of New South Wales; and the PSC periodically provides training programs on government procedures. In 2002 and 2003 the Fiji Health Management Reform Project supported 80 MoH staff to attend a frontline management training course provided through the New Zealand Pacific Training Centre in Suva, although this hasn't continued.

As SDMOs and SDHSs manage the sub-divisional health system, the problem of improving management is linked to the difficulty in retaining clinical staff in rural areas. Emigration and a limited annual number of medical and nursing graduates has resulted in the employment of expatriate doctors at the sub-divisional level, the creation of a cadre of nurse practitioners and the need to increase medical training output. Little effort has been placed on providing management training to expatriate staff, some of whom experience language difficulties, while Bachelor of Medicine, Bachelor of Surgery graduates are exposed to basic management theory in their degree and learn the systems of government 'on the job'.

FIGURE 1. GDP PER CAPITA AND GOVERNMENT HEALTH EXPENDITURE IN FIJI AS A PROPORTION OF GDP, 1990 AND 2000–2004

(Adapted from UNDP 2000 to 2007/2008)



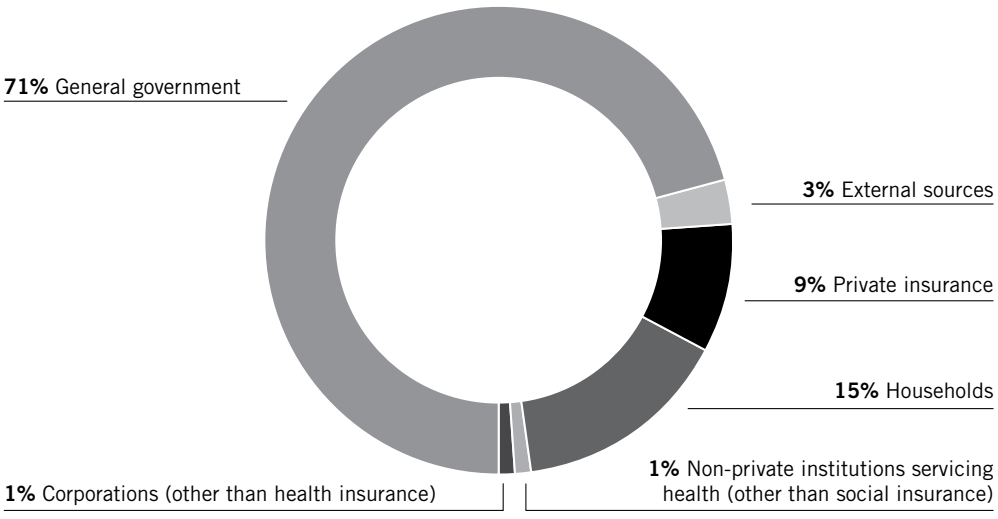
	1990	2000	2001	2002	2003	2004
GDP/capita (PPP)	4,427	4,668	4,850	5,440	5,880	6,066
GHExp % GDP	2.0	2.6	2.7	2.7	2.3	2.9

Key to acronyms in Figure 1

GDP	gross domestic product
GHExp	government health expenditure
PPP	purchasing power parity
USD$	United States dollars

FIGURE 2. SOURCES OF HEALTH EXPENDITURE IN FIJI, 2008

(Adapted from Government of Fiji 2009a)



HEALTH MANAGEMENT STRUCTURE

The MoH has implemented several reforms in the last decade that have impacted significantly on management. The AusAID-supported Fiji Health Management Reform Project from 1999 resulted in delegation of management responsibilities from central agencies of the Ministry of Finance and the PSC to the Permanent Secretary of Health (PSH); and decentralised from the PSH to the three divisional directors (who had the title of Chief Executive Officer), and also opened up management positions to non-medically trained managers[4]. The three divisions were Northern Health Service, Western Health Service and Central/Eastern Health Service (Rokovada 2006). However, in 2010 the Central and Eastern Divisions separated, taking the total number of divisions to four.

The intent of the reform was to address long standing issues of poor health management identified by a Senate Select Committee[5] and others by decentralising management operations, improving management, planning and policy capacity in the MoH headquarters and divisional offices, updating health legislation, developing management and health information systems, developing standards and guidelines for management and improving asset management and maintenance systems.

The new management structure was approved by the PSC in 2001 but was not fully implemented until 2003 due to funding constraints. These arose again and in 2008 the short-lived decentralised management structure was recentralised, and responsibilities delegated to divisional management reverted to the Permanent Secretary, while and those delegated to the Permanent Secretary reverted to the PSC and Ministry of Finance.

The roll-back of responsibilities was received in different ways by the MoH staff. Many who had accepted new delegations at the divisional level felt the benefit of shortened lines of decision making and welcomed the changes that had empowered them to make improvements to the local delivery of health services (Mohammed 2010). While the withdrawal of responsibilities was driven by centralist concerns, the impact on newly emerging managers was adverse, as they reverted to their prior roles and limitations and referred their decisions centrally.

The AusAID-supported Fiji Health Management Reform Project from 1999 resulted in **delegation of management responsibilities from central agencies of the Ministry of Finance and the Public Service Commission to the Permanent Secretary of Health.**

[4] Prior to the reforms, management positions within the MoH were held largely by medical officers at the central level. However, as part of the reform such positions were opened to non-medically trained managers with three out of the seven management posts going to people with no medical training (Rokovada 2006).

[5] Government of Fiji 1979

NUMBER AND DISTRIBUTION OF SUB-DIVISIONAL MANAGERS

The Census of Population and Housing divides Fiji into four divisions and 15 provinces as shown in Table 1. The MoH is managed from its headquarters office in Suva, through the four divisions and 19 sub-divisions, 16 of which have a sub-divisional hospital. The three urban sub-divisions of Suva (the capital), Labasa and Lautoka/Yasawa are within the catchment areas of the three divisional hospitals, however, they manage and provide the full range of community health services through health centres and nursing stations within both urban and peri-urban areas.

For the purposes of this review, the management situation facing the 19 SDMOs and their administrative support staff are considered. The SDMOs and administrators are responsible for managing an integrated health service within the sub-division; managing the hospital and health centres, coordinating public health services delivered by public health nurses, health inspectors, dentists, nutritionists and other health cadres in the sub-divisional establishment (Government of Fiji 2006a).

Administrative staff are based in the sub-divisional offices, usually at the hospital, and conduct general administration, oversee budget processes, procurement, travel, information systems and manage the general staff. These administrative positions are common cadre positions filled largely by employees of the PSC. Good performing health administrators at the divisional and sub-divisional levels may be transferred to the MoH headquarters or to other ministries, such as Foreign Affairs (In-country reviewers 2010).

In 2009, in response to fiscal pressures the PSC reduced the retirement age from 60 years to 55 (Amosa et al. 2009). The MoH lost about 331 experienced senior personnel, including 15 doctors and 97 nurses and support staff (Sharma 2009). A number of strategies to deal with the sudden loss of senior staff with corporate memory are in place, such as re-engaging retired staff on contracts, undertaking internal redeployments and out-sourcing certain services (Sharma 2009).

Good performing health administrators at the divisional and sub-divisional levels may be **transferred to the MoH headquarters or to other ministries, such as Foreign Affairs.**

TABLE 1. DISTRIBUTION OF HEALTH PERSONNEL AND FACILITIES BY DIVISION AND PROVINCE IN FIJI, 2007

(Adapted from Source: Fiji Bureau of Statistics 2008 and Sutton et al. 2008)

DIVISION	PROVINCE	POPULATION	HEALTH FACILITIES*	HEALTH PERSONNEL^	HEALTH WORKER PER POPULATION (RATIO)
Central Division	Naitasiri	160,760	7		
	Namosi	6,898	12		
	Rewa	100,787	14		
	Serua	18,249	9		
	Tailevu	55,692	5		
	Subtotal	**342,386**	**47**		
Eastern Division	Kadavu	10,167	10		
	Lau	10,683	21		
	Lomaiviti	16,461	15		
	Rotuma#	2,002	3		
	Subtotal	**39,313**	**49**	**1,049+**	**1:364**
Northern Division	Bua	14,176	8		
	Cakaudrove	49,344	20		
	Macuata	72,441	15		
	Subtotal	**135,691**	**43**	**331**	**1:411**
Western Division	Ba	231,760	33		
	Nadroga/Navosa	58,387	15		
	Ra	29,464	10		
	Subtotal	**319,271**	**58**	**660**	**1:484**
Total		**837,271**	**197**	**2,040**	

Key to symbols

* Health facilities include divisional hospitals, sub-divisional hospitals, area hospitals, health centres and nursing stations.

^ Health personnel include only doctors and nurses.

Rotuma is usually included in Eastern Division for administrative purposes but it has a dependency status. Note, the populations above are of divisions and provinces, not Ministry of Health sub-divisions.

\+ Figure includes health personnel in the Central Division.

COMPETENCE OF HEALTH MANAGERS

In addition to the consistent findings of the Senate Select Committee 1979 , the Coombe Report 1982 and the Senate Select Review Committee of 1997 highlighted issues of the complex MoH organisational structure, the unmanageable span of control and lengthy chain of command. The findings also noted that the MoH did not have much autonomy in matters of finance and personnel (Mohammed 2010).

Prior to the Fiji Health Management Reform Project all senior management functions within the health system were carried out by medical and nursing staff, few with professional management training. Sutton et al. (2008) reported that over the past 10 years there had been a slow but steady development of a pool of clinicians with some basic training in management within a Master of Public Health Degree, although in 2010 only four of the 19 sub-divisional medical officers reportedly held this degree.

The Fiji Health Management Reform Project, initiated in 1999 in anticipation of a policy of decentralisation, placed a considerable focus on capacity building of senior and middle-level management.

About 80 MoH staff members, largely middle-level managers, undertook a frontline management program in 2002 and 2003. Similarly, 24 senior executives participated in a 12-month on-the-job, experiential learning, senior executive development program.

In 2005 the Fiji Health Management Reform Project also provided an opportunity for management training of frontline managers in the divisions, and funded the establishment of a fully equipped training centre for the Northern Health Services (Government of Fiji 2006b).

The Fiji School of Medicine offers a postgraduate Diploma in Health Services Management and some undergraduate courses with a basic health service management component. James Cook University in Australia offers a Bachelor of Nursing Science and post-basic nursing certificates in Fiji that seek to build management and leadership skills and knowledge among potential leaders in nursing (Stewart et al. 2006).

Sutton et al. (2008) observed that the quality of management within the MoH would be enhanced if the PSC created formal classifications of professional health service managers, and if

Prior to the Fiji Health Management Reform Project all senior management functions within the health system were carried out by **medical and nursing staff, few with professional management training.**

a professional body were created with minimum acceptable qualifications and experience, similar to such professional associations in Australia and New Zealand.

[6] Government of Fiji 1979
[7] Coombe 1982
[8] Government of Fiji 1997

MANAGEMENT WORKING ENVIRONMENT

The environment in which Fiji's SDMOs and health managers are working has been subject to dynamic political and policy changes over the last 10 years. For the decade prior, the policy environment had predominantly favoured decentralisation, yet the strictures of central government control over finance and human resources have remained.

The health system was extensively re-organised between 1999 and 2003 when management responsibilities were decentralised to the divisional level (Rokovada 2006), but lasted only four years until the formal reinstatement of centralisation in 2007. This was followed by the merging in 2007 (and then de-merging in 2009) of the MoH with the Ministry of Women, Social Welfare and Poverty Alleviation. The MoH has had two Ministers and three Permanent Secretaries since 2003.

Soon after the 2006 military coup, the PSC introduced austerity measures which effectively reduced salaries by 20% and took staff morale to a new low. The government imposed a 10% cut in personnel in 2008, with the MoH being able to achieve only 5%. A number of those affected were in management positions at the divisional level (Government of Fiji 2008).

In 2009, the government's new retirement age policy resulted in experienced staff leaving the health service at age 55. Furthermore, low salaries have been cited by emigrating health personnel as one of the key factors influencing their decision to leave (WHO WPRO 2008). All of these factors have significant implications for the management environment and the potential for effective management.

Supportive supervision, including on-the-job training and mentoring, is a challenge to local management. As part of its ongoing efforts to build management capacity, the MoH had appointed management advisors to assist senior and middle managers in key management areas. The advisors assisted managers in reviewing policy and procedures, formulating alternative strategies and establishing sound management practices (Rokovada 2006), however, this strategy has not continued.

FUNCTIONING OF MANAGEMENT SUPPORT SYSTEMS

Procurement and supply

SDMOs are responsible for managing their public sector pharmacy outlets. The inefficiencies, wastage and leakages in the pharmaceutical and biomedical services represent a serious challenge to the Fijian health system (Sharma 2009). Sutton et al. (2008) observed that the limited availability of essential drugs contribute to sub-optimal patient care and to patient dissatisfaction and frustration with the system. Facilities rarely received their full order on time, leading to frequent stock-outs, so people travel to more central facilities. The AusAID-supported Fiji Health Sector Improvement Program and ministerial intervention has improved the situation, although more is yet to be done. The Health Minister announced in July 2009 that a new system has been devised to better monitor stock levels at hospital, health centre and nursing station level and to ensure on-time delivery and more accurate placement of orders.

Management of health information

The large task of collating information centrally and translating it into information for policy input is made more difficult by a lack of human resources and technical capacity (Sutton et al. 2008), resulting in limited use of information for operational management. Information exists in the health system for strategic planning and management at the national, divisional and sub-divisional levels, but it is largely based on case presentations to public facilities and used for monthly and annual reporting. Population based information is available but its collation and use is not well coordinated. The information system is biased towards calculating morbidity and mortality rates, rather than providing information to improve management. Indeed, the largest data base PATIS was developed to improve the MoH's capacity to plan and manage its resources (Government of Fiji 2008; Kerrison 2004; Rokovada 2006), although it is essentially used as a medical records system. This bias reflects the absence of a cadre of health administrators, resulting in the most critical indicators of systems performance and management being neglected.

Finance

Limited funding for improvements influences managerial effectiveness. The Fijian health system is one of the most under-funded health systems in the world. The percentage of GDP spent on health has reduced progressively from about 4% in 1993 to 2.6% in 2009. Health workers receive minimal additional incentives to perform additional work or serve in rural and remote areas.

SOCIO-CULTURAL CONTEXT

Issues in the socio-cultural setting that potentially affect health leadership and management at the local level in Fiji include ethnicity and gender. Fiji comprises three main ethnic groups – Fijians (57%), Indians (38%) and other groups including Europeans and Chinese (5%) (Fiji Islands Bureau of Statistics 2008). Historically perceived legitimate roles of ethnic Fijians and Indo-Fijians in government and government service, although not absolute, have constrained the careers of many competent officers. However, government policy is now non-discriminatory[9] and officers are appointed and promoted on merit.

Traditional chiefly notions of leadership grounded in the concept of one's rank in society persist in the Fijian community, but they are not significant as far as health management and leadership are concerned. Indeed, these traditional rankings are largely ignored in the public sector (In-country reviewers 2010), although they may subtly affect interpersonal behaviour through the concern not to be disrespectful.

Many of the most senior director positions have been held by female professionals. The current PSH is female. Rokovada (2006) observed that there were two women (with the likelihood of three) holding seven of the directorship positions created by the MoH during the health management reforms. Government of Fiji equal opportunity policy excludes gender as a criterion for election, nonetheless, women in Fiji still lag behind men in many respects.

After the 2006 election, only eight out of 71 seats in the House of Representatives were held by women (11.3%), and women hold only 13.6% of all Parliamentary seats (AusAID 2008). Despite the disparities, the situation in Fiji, in terms of women participating in public life, compares well with other Pacific-Island countries and it is consistent where women are allowed to assume leadership roles. This may encourage more women within the MoH to aspire to management and leadership positions (McLeod 2008).

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[9] Protection of Fundamental Rights and Freedoms of the Individual Decree. No. 12. Fiji Republic Gazette, 1988-01-29, Vol. 2, No. 6, *p. 119-30.*

SUMMARY

Access and utilisation of health care

- The Fijian health system was constructed to serve a rural population but is now under pressure to modify itself in response to urban migration. Fiji is now 51% urbanised. Urban migration applies to the professions as well, so it has been difficult to retain staff at the sub-divisional level.
- About 70–80% of the population has access to primary health care but only about 40% has access to quality health services due to population dispersal.

Financing the health system

- The Fijian health system is essentially publically funded with a small proportion (about 3% in 2008) of the overall budget provided by development partners. The proportion of GDP allocated to health is among the lowest in the world and lower than many of its neighbours.
- Sub-divisional health staff manage health activities within budgets and according to prescribed processes, having little flexibility other than to conform to scheduled activities. However, the degree to which they can mobilise communities to apply their own resources to health improvements depends on their willingness to engage with community leaders.

Human resources for health

- SDMOs are responsible for day-to-day management of the local health staff within Public Service Commission systems, and act on central Ministry of Health decisions on deployment and access to training.
- In rural areas, SDMOs and SDHSs coordinate and supervise health centre and nursing station staff, including overseeing them in screening and team programs (such as school visits). Retaining staff in rural areas requires SDMOs to engage in team building.

Health management structure

- The Fijian health system has undergone a short period of decentralisation and then recentralisation with significant changes to management roles and systems and to the career expectations of health managers in the divisions. The recentralisation has again lengthened lines of communication and broadened the span of control.

Number and distribution of managers

- All health administration personnel are employed by the Public Service Commission and may be transferred to another Ministry if required. A small number of specialist health administrators and accountants have developed their careers within the Ministry of Health.
- At the sub-divisional level 19 SDMOs and 19 SDHSs manage the integrated hospitals, health centres, nursing stations and community health services.

Competence of sub-divisional health managers

- No sub-divisional medical officer has acquired a management qualification, although a small number have been exposed to management training in Master of Public Health programs, and others to Public Service Commission or donor-provided short programs.
- Health administration training programs have been difficult to sustain despite several attempts. Consequently a cadre of professional health administrators has not been developed.

Management working environment

- An unstable working environment and dissatisfaction among Fijian health workers due partly to lack of sufficient opportunities for promotion, heavy workloads, inadequate supportive supervision and poor remuneration, reduce the appeal of a health management career and feed emigration.

Functioning of management support systems

- Purchasing and supply systems (particularly of pharmaceuticals, consumables and technical equipment maintenance) require specialist management to ensure supply. Sub-divisional medical officers are responsible for managing public sector dispensaries in their areas.
- Health system information flows towards the centre, but little returns to the periphery to assist with operational management. Information systems are biased towards disease rates rather than management indicators.

The socio-cultural context

- Government anti-discrimination policy has replaced a history where ethnicity had the potential to limit career opportunities. In addition, female managers are well accepted in Fiji and many of the most senior Ministry of Health positions are currently held by females.
- The health system is available to all ethnic groups without distinction. However, the use of the health system varies with ethnicity.

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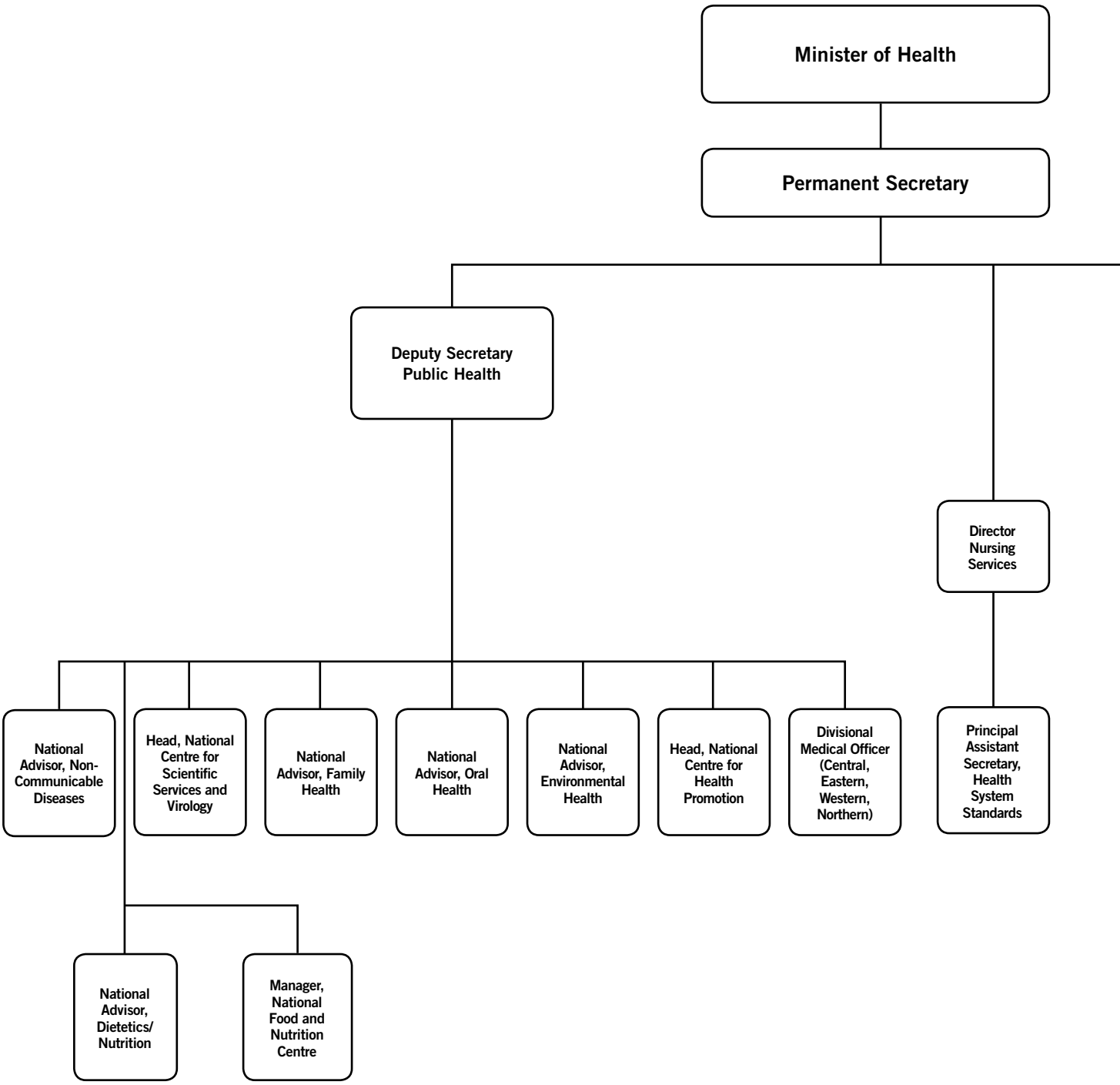
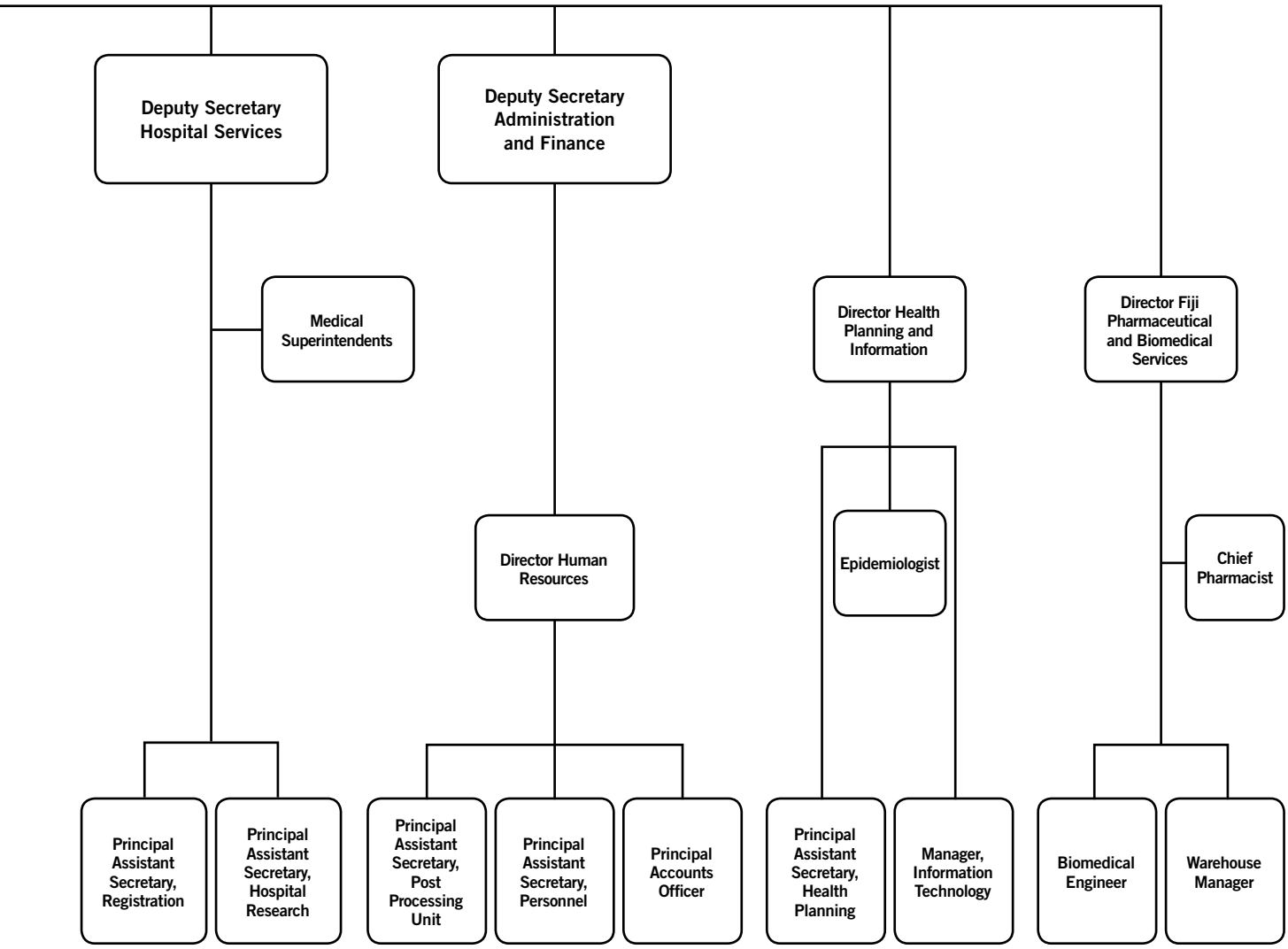
APPENDIX

ORGANISATIONAL STRUCTURE OF FIJI MINISTRY OF HEALTH

(Adapted from WHO WPRO 2011)

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Deputy Secretary Administration and Finance
Director Health Planning and Information
Director Fiji Pharmaceutical and Biomedical Services
Medical Superintendents
Director Human Resources
Epidemiologist
Chief Pharmacist
Principal Assistant Secretary, Registration
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University of New South Wales

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Health Information Systems Knowledge Hub,
University of Queensland

Aims to facilitate the development and integration of health information systems in the broader health system strengthening agenda as well as increase local capacity to ensure that cost-effective, timely, reliable and relevant information is available, and used, to better inform health development policies.
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