

Primary health care in Fiji

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Fiji is an archipelago of some 300 islands in the tropical South Pacific. Some 240 islands are still uninhabited. Being centrally located it serves as a hub for the various groups of other island countries. Traditionally a trading post, it boasts an agricultural based economy. There are rich deposits of gold, fish and oil in our trade and economic zone. Fiji today, is also an important trade, telecommunication and tourism destination.

The population is approximately 800 000 with 60% urban based. Great cultural diversity, tourism, travel exposure, turbulent politics and rapid urbanization pose new meaning to the planning and delivery of primary health care.

The primary health care system

Primary care is provided by the Fiji Ministry of Health and is modeled on the World Health Organization three tier system of primary care aimed to provide divisional, sub divisional and area based health care facilities. This is complemented by the urban based general practitioner community under the aegis of the Fiji College of General Practitioners.

The three tiered system is manned by specialist, generalist and primary providers. The latter include basic medical graduates, medical assistants, nurse practitioners and nursing graduates. The aim was to keep medical care decentralized and primary focused.

Problems and improvements

This well intended strategy has produced practical difficulties due to a centralized administration. Poor logistical support, inadequate pharmaceutical supplies and manpower shortages have resulted in inadequate peripheral care. Limited financial resources and lack of health planning are contributing to deteriorating primary health care delivery. The need to upgrade equipment plus basic and technological supplies is a

constant need. The rural dwellers and periurbanites head to the base hospitals, perceiving them as centers of excellence, while the primary health centers remain under used. At the base hospital, elective work becomes almost impossible and effective primary care, mere wishful thinking.

Nonetheless, Fiji improved in areas of child and maternal health. Morbidity and mortality statistics are better. Immunization, nutrition, contraception usage and longevity statistics improved. This is a direct result of the contribution by the three tiered health care delivery. Greater strides are needed to control the non-communicable diseases including diabetes, cardiovascular disease and cancer quality of life issues for the patient, their family and the community in general.

The Fiji College of General Practitioners

This was established in 1993 and still awaits formal recognition as an act of parliament. It remains a voluntary, primary health care organization aimed at providing ongoing vocational education and training for the general practitioner community. This involves journal clubs, peer groups, clinical audit groups, mini seminars, and annual conferences for the 100 odd members. Well over 200 professional development and continuing medical educational activities were organized in the last fiscal year. A bi-monthly newsletter keeps members in touch, while a quarterly journal provides an avenue for publishing local research.

Accreditation and reaccreditations of college membership is currently continuing medical education based and plans are in place to establish a vocational career pathway for new graduates. The College of General Practitioners is affiliated to the Fiji School of Medicine, which is the Regional Medical Training Institution. Three members are senior honorary lecturers in primary care/general practice. Four others have been appointed lecturers for undergraduate attachments throughout the academic year. The undergraduate program is now fully established and students receive an improved bird's eye view of general practice.

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Accepted for publication 18 March 2002.

Developing a postgraduate program is an important aim of the college. In striving for excellence in primary health care training, education, research and service delivery, a localized program of study is being formulated in affiliation with the school of medicine and the regional university of the South Pacific. Franchising a postgraduate study program and making sure it stays internationally recognized will need collective input. Attracting the current lot of general practitioners will be another task as interest levels vary due to work and political pressure.

The ministry of health's recognition of the Fiji College of General Practitioners' international links, outreach community programs and undergraduate/vocational ongoing training schemes have paved the way to a formal memorandum of agreement for setting up a computerization program in general practice. This exercise will assist in bilateral transfer of statistics and surveillance data, as well as placing the Ministry of Health in a better position for fund sourcing.

Practicing in primary care

Most general practitioners are urban based, initially working in the public system as a registrar in one of the hospital based disciplines. They are mostly in solo practices. Newer developments see integrated practices with various practitioners with postgraduate diplomas in dermatology, pediatrics, obstetrics and gynecology, travel, aviation and dive medicine. There is a sprinkling of specialists in the private sector too. These include anesthesia, obstetrics and gynecology, cardiology, internal medicine and surgery. A fee for service, capitation, integrated capitation and a mixed payment system remunerates the general practitioner.

The public sector physicians are salaried, although specialists in the public sector are allowed some after hour consultation. Well over 65% of hospital based and public primary care doctors are expatriates from China, Cambodia, India, Nigeria, Pakistan, United Kingdom, New Zealand and Australia. Expatriates and a small number of locals provide the teaching staff at the regional medical school. The general practitioner community are largely locals with a few expatriates who have taken Fiji citizenship.

Dealing with a changing medical workforce

There has been a massive loss of manpower following the coups (see Viewpoint, this issue). Over 30 general practitioners and a sizeable number of teaching staff at the school have left. This is all to the detriment of primary health care. We are also losing well-trained nurses to New Zealand, Australia, England, Marshall Islands and Palau. A small outflow of technologists is anticipated as well.

With the Australian based (Mayne–Nickless) sponsored Suva private hospital, we see the entry of managed care in Fiji, although not everything appears as it should. Monopolies have resulted in unilateral fee hikes within a year, unscrupulous over servicing and competition with the general practitioners has become an issue, which needs the attention of both management and the College of General Practitioners. Suva private hospital, a 40 bed establishment, does however, provide a breath of fresh air for the community. Local inpatient care for those who can afford executive health schemes, against overseas evacuations may be of great benefit. However, a national health scheme remains a major missing link in the chain of social development.

A challenging future

The Fijian political instability has resulted in increased poverty. Over 50% of the population now lives below the \$6000 per annum income (Fijian dollars). There is changing diseases patterns in primary health care. We are seeing more internal displacements in the community; periurban squatter settlements; anemia's; and water, contagious and air borne diseases. There is an increase in sexually transmitted diseases. Social problems associated with political instability are more obvious. The most vulnerable in society suffer the most – woman, children and the elderly. Primary health care providers suffer with them.

The challenge to primary care is to continue providing quality care in the face of a rapidly changing disease profile with increased professional attrition and still be astute enough to keep focusing on primary prevention.