Social Protection in Action: Building social protection floors for all

Country Brief: Fiji

December 2021

Extending Social Health Protection in Fiji: Accelerating progress towards Universal Health Coverage

1. Introduction

In the Republic of Fiji, an upper middle-income country with an approximate population of 896,000 in 2020 (World Bank n.d.), the right to health is enshrined in the Constitution. Legally, the state "must take reasonable measures within its available resources to achieve the progressive realization of the right of every person to health, and to the conditions and facilities necessary to good health, and to health care services, including reproductive health care". [1] The State's responsibility for social health protection is reflected in the architecture and financing of the health system in Fiji, which relies primarily on government revenues to provide essential health services for free or at a low cost to all residents (WHO 2011). The Ministry of Health and Medical Services (MHMS) has recently adopted a Strategic Plan (2020–2025) outlining a strategy to achieve universal health coverage (UHC), and provide the quality of health services necessary to ensure health for all (Fiji Ministry of Health and Medical Services 2019).

However, Fiji is facing challenges in the effective provision of services. In 2017, the health service coverage index for Fiji was only 64, compared to the average health service coverage index of 75 among upper-middle income countries. This has been attributed primarily to weak management of non-communicable diseases (NCDs). Furthermore, while health services in Fiji are provided for free or at low cost for all residents, a low level of funding and allocative inefficiencies hinder effective coverage for all. The geography of Fiji, as well as social and cultural factors also impede access to services, which ultimately impacts utilization. As a result, life expectancy among the Fijian population is lower than in many Pacific Islands (67 in Fiji compared with 70, 71 and 73 in Vanuatu, Tonga and Samoa, respectively), which suggests that the capacity of the national health care system to deliver effective services remains limited (WHO n.d. a).

To address these challenges, the Strategic Plan (2020–2025) envisages a broader "collaboration with partners for a more efficient, innovative and higher-quality health system" (Fiji Ministry of Health and Medical Services 2019). Moving

[1] Constitution of the Republic of Fiji, article 38 (1).

forward, the MHMS intends to pursue "whole-of-government" and "whole-of society" approaches to national policy and legislative interventions to address risk factors and social determinants of poor health outcomes.

2. Context

Fiji inherited its health system from the British colonial administration. It provides social health protection to its population through tax-funded services. In the late 1990s, the Government of Fiji attempted to decentralize its health system through the creation of geographical divisional structures. This involved a transfer of considerable power and responsibility to these structures, coupled with the development of stronger institutional and managerial capacity (WHO 2016). However, due to political instability and a lack of support from central management, the reform was largely unsuccessful. In the late 2000s, the health system was partially recentralized, although divisional structures remained in place in the form of Divisional Health Offices. Decentralization efforts were renewed in 2009 in the subdivision of Suva (Fiji's capital), and the process of reforms is currently ongoing, with a focus on promoting primary health services, including prevention.

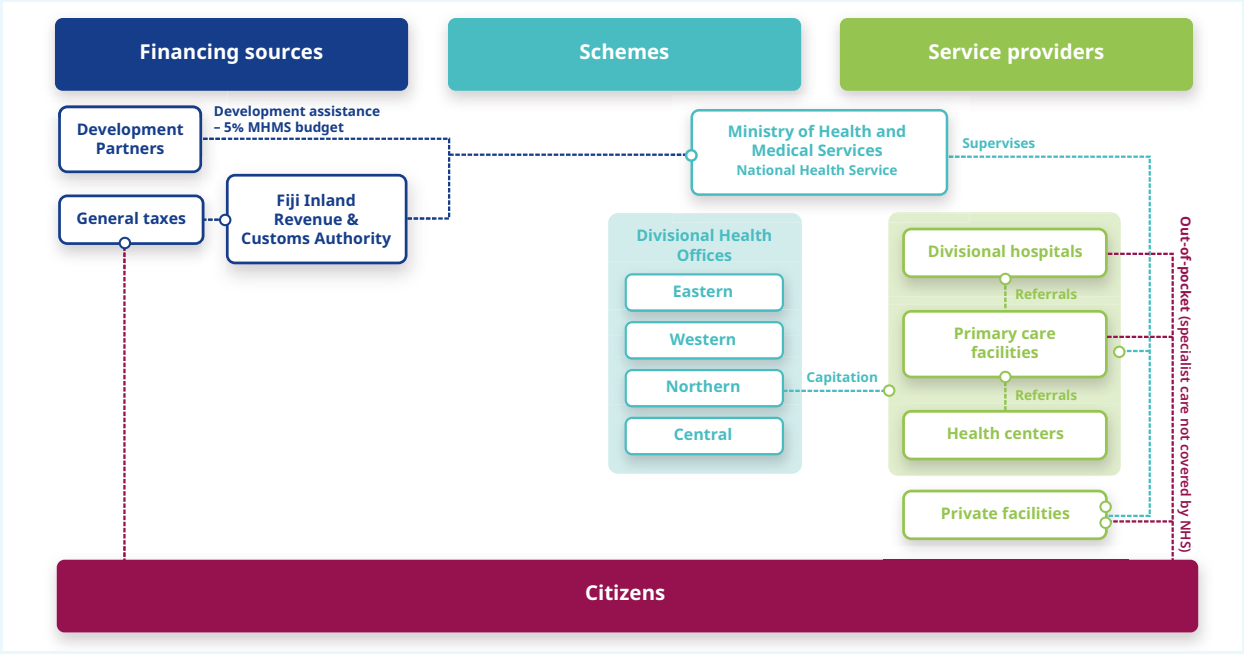
3. Design of the social health protection system

- Financing

Access to health services is predominantly funded by the Government budget. Between 2000 and 2018, domestic general government expenditure on health increased by more than 2.7 times in absolute terms. However, there has been a decrease in relative terms, reducing from around 2.6 per cent of GDP in 2000 to around 2.3 per cent of GDP in 2018 (WHO n.d. a). The share of domestic general government spending on health as a share of general government spending also decreased from 10.6 per cent to 7.2 per cent over the same period (WHO n.d. a), indicative of low prioritization of health in the general budget. Nonetheless, tax revenue mobilization has increased drastically in the last few years, rising from 19 to 24 per cent between 2010 and 2018 (Kubasta et al. 2020). This has created additional fiscal space to be mobilized for social spending.

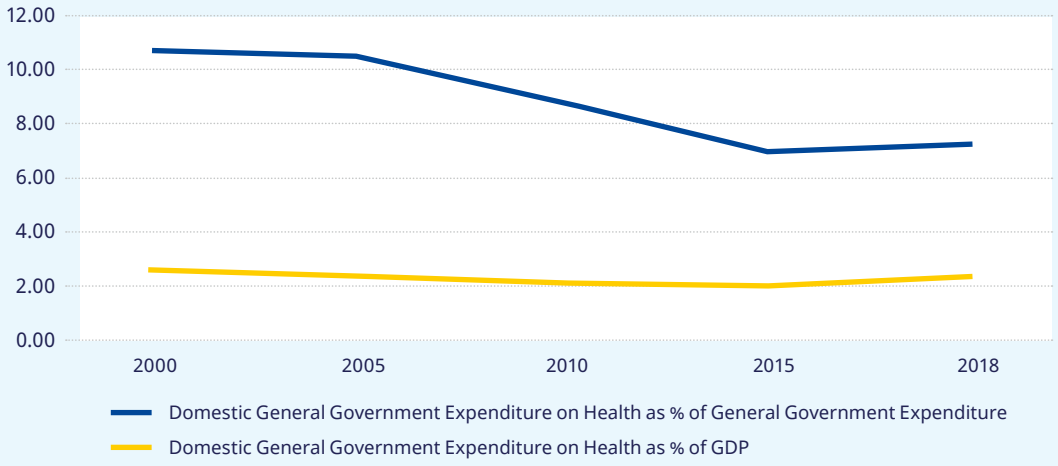
The financing flows of the health protection system are schematically presented in figure 1.

Figure 1. Overview of main financial flows of the social health protection system in Fiji



Source: Authors.

▶ **Figure 2. Domestic General Government Expenditure on Health, 2000 to 2018**



Source: Adapted from WHO Global Health Expenditure Database.

- Governance

Fiji has a decentralized health system of integrated primary, secondary and tertiary care managed by the MHMS. The system is administered through four Divisional Health Offices (DHOs), each responsible for one of the four regions: Eastern, Western, Northern and Central. The DHOs are led by Division Medical Officers (DMOs), who manage a network of sub-divisional hospitals, health centres and nursing stations (WHO 2011). DMOs are responsible for developing their own business plans and enjoy considerable financial authority to ensure more effective resource distribution at local level (Gilbert et al. 2019).

The Minister of Health is responsible for administering the work of the health system, and reports directly to Parliament. The MHMS coordinates and supervises the work of DHOs, sets standards, regulates the provision of services and manages financial planning for the overall health system. Much of the work of the MHMS is undertaken through Fiji Medical and Dental Councils. The two Councils can register or deregister the licence of health care practitioners in the country, as well as issue codes of practice and professional guidelines, investigate complaints, and take disciplinary actions.

- Legal coverage and eligibility

The government funded national health service is a universal scheme that provides coverage to the entire population of Fiji (WHO 2014; 2011). The Public Hospitals and Dispensaries Act of 1955 stipulates the provision of services to both Fiji citizens and foreigners, meaning that legal coverage extends to all residents of Fiji.

- Benefits

The health services offered by the public sector include both primary level services offered by primary health care facilities and in-patient and out-patient services offered at clinics and hospitals (WHO 2011). The latter include general medical services, specialist referral services, sub-specialist referral services and high-cost complex referral services (WHO 2011). The general package of services is defined in the Public Hospitals and Dispensaries Act of 1955. Among the specialized services included in the package are general diagnostics (including radiography, X-ray scans, ultrasound and ECG) and common dental care services. The Act established a zero-cost policy for a range of general medical treatments and diagnostic procedures for children.

Medicines are either provided for free or at a subsidized cost. In addition, since 2015, the Government of Fiji has run the Free Medicines Programme initiative which aims at improving access to essential pharmaceutical products for lower-income households (Fiji Ministry of Health and Medical Services 2014). Under the programme, all eligible Fijians can access medicines prescribed by a licensed medical practitioner free of charge from any government hospital pharmacy, dispensary or selected private retail pharmacy. To become eligible, a patient needs to demonstrate that s/he has an annual income of less than 20,000 Fijian Dollars (FJD) and

is required to provide a Tax Identification Number or Social Welfare Number (Fiji Ministry of Health and Medical Services 2014).

On the whole, public services in Fiji are mostly geared towards curative care. However, the MHMS runs a range of primary level programmes aimed at health promotion to achieve better health outcomes and to contain increases in curative care costs. For example, a Wellness Unit was established in 2012 to help reduce the negative effect of NCDs on the Fijian population through provision of wellness services (Fiji Ministry of Health and Medical Services 2019).

- Provision of benefits and services

Most of the health facilities in Fiji are public. According to the MHMS, in 2016, there were 207 government health facilities, including 97 nursing stations, 86 health centres, 19 sub-divisional and three divisional hospitals, as well as two specialized hospitals (Fiji Ministry of Health and Medical Services 2016). Financing and providing the majority of services, the Government acts as both purchaser and provider (WHO 2014). Public hospitals and clinics receive funding from the MHMS on the basis of line-item budgets (human resources, services, capital investments, purchase of pharmaceuticals and so on) (WHO 2014).

Providers within the national public health system are organized into primary, secondary, and tertiary levels. In principle, primary health care practitioners (community health workers and nurses) act as the first point of contact within the health system, with a referral system as follows:

- Community health workers and nursing stations are the first point of contact, and refer patients to higher-level health facilities. They are tasked with delivering the most basic health services and preventive care (including immunization).
- A more comprehensive primary health care package is delivered at health centres, which serve larger populations and areas, and have more personnel and equipment.
- Secondary care is provided by sub-divisional hospitals, which have much greater diagnostic capacity and offer a range of in-patient and out-patient services.
- Finally, the most advanced and specialized care is offered by the country's divisional hospitals, which are the largest hospitals in the country and act as national domestic referral centres (Asante et al. 2017).

The private health sector has expanded in recent decades, but remains smaller than the public sector, with nearly all of the private providers in the country concentrated in urban areas. Currently, there are four private hospitals that have a comparatively low bed capacity. This includes the recently established Children's Heart Hospital. However, there is a considerable number of private practitioner clinics, estimated to number around 160. [2] These clinics are largely day clinics and provide general outpatient services (Asante et al. 2017).

Co-payments are in place to access some specific health care services and certain medicines. These are detailed in a special annex to the law (Schedule 1), which was last updated in 2013. These co-payments are charged at a fixed rate, depending on the type of in-patient or out-patient service provided. However, in accordance with Regulation 49 of the Act, these co-payments only apply to patients seeking services at public hospitals who were referred by a private health care provider.

▶ 4. Results

- Coverage

As previously noted, all Fiji residents (both nationals and foreigners) are entitled by law to access health services without hardship. According to news reports, in August 2018, there were 31,000 beneficiaries of the Free Medicine Programme (DEPTFO News 2018), which corresponds to around 3.5 per cent of the Fijian population. Regarding the rights of migrants in Fiji, who were estimated to account for around 1.5 per cent of the country's population in 2017 (WHO 2018), with around 600 refugees in Fiji in 2019 (UNHCR 2020), gaps may exist. While the Public Hospitals and Dispensaries Act of 1955 does not distinguish between regular and irregular residents, it is not clear whether access for migrants is determined by their status. It is likely that undocumented migrants face challenges in accessing certain procedures. For example, challenges could arise for undocumented

[2] Information sourced from telephone Interview with the President of the Fiji College of General Practitioners.

migrants in applying for exemption from fees that are charged for specific services, which require the completion of a form signed by a local authority, in accordance with the Regulation 20 (3) of the Public Hospitals and Dispensaries Act.

- Adequacy of benefits/financial protection

Overall, the Fijian social health protection system provides a good degree of financial protection. As outlined above, most consultations, admissions, and laboratory and radiological examinations are provided for free at public health facilities (Asante et al. 2017; Irava 2015; WHO 2011). WHO assessments suggest that the population of Fiji is not exposed to the risk of expenditures related to informal/illicit payments to health care providers (WHO 2014).

As a result, out-of-pocket (OOP) spending remains at a low level, representing 14 per cent of health expenditure in 2018. However, this figure should be interpreted with caution due to potentially low utilization of public health services. It was estimated that only around 3 per cent of OOP health spending was related to the use of public health services in 2015 (Irava 2015), with most OOP payments resulting from the use of private health services. Overall, research confirms that government health funding in Fiji is pro-poor, favouring lower-income households (Asante et al. 2017). Indeed, around 61 per cent of public spending for nursing stations and 26 per cent of spending for government hospital inpatient care were directed to services provided to the poorest 20 per cent of the population (Asante et al. 2017).

- Responsiveness to population needs

    o Availability and accessibility

According to a survey conducted in 2017 in collaboration with the Fiji Bureau of statistics, only 70 per cent of men and 60 per cent of women reported having received some form of health care when they last required treatment (Fisk and Crawford 2017). This may be due to geographic and social factors that adversely affect conditions for accessing health benefits in Fiji. For example, there is evidence that patients from remote communities need to travel long distances to receive diagnosis and treatment, which is particularly challenging for patients with chronic conditions (Fisk and Crawford 2017; WHO 2016; 2014). Additionally, certain population groups face social barriers to accessing services due to stigma, cultural norms, poorly-informed social perceptions and lack of public dialogue (Pūras 2019; WHO 2011). Specifically, it has been found that discriminatory attitudes among health care workers impede access to maternity and family planning services for women in certain communities and areas (Pūras 2019). Notably, a 2017 survey involving 325 women in Suva found that fewer than half of the participants had a good level of knowledge of family planning (Lincoln, Mohammadnezhad, and Khan 2018). Based on findings from a 2017 study conducted with the Fiji Bureau of Statistics, gender-based inequalities were also evidenced in relation to a range of other health issues (Fisk and Crawford 2017).

Persons with disabilities also face challenges in accessing health services in Fiji. Health infrastructure and medical care are often not tailored to people with special needs, such as those with communication disabilities (Hopf and McLeod 2015) and persons with psychosocial, cognitive and learning disabilities (Pūras 2019). In certain cases, patients have to rely on support provided by civil society organisations and charities, as there is a significant gap in services for persons with disabilities delivered by the health system (Pūras 2019).

In terms of the availability of health personnel, a 2017 study found that six out of 15 provinces in Fiji fall short of the recommended threshold of 2.3 health workers per 1,000 people (Wiseman et al. 2017). This issue is partly due to the outbound migration of the health workforce and re-location to urban areas (WHO 2011). For example, in 2006, the combined number of Fiji-born health practitioners in New Zealand and Australia was greater than the total number of public doctors in Fiji (W Irava and Prasad 2012). There are also some inequalities in the distribution of the workforce within the country, but these have been found to be less acute than in many other low- and middle-income countries.

    o Quality and acceptability

Issues related to quality stem from the lack of a qualified health workforce in Fiji, which affects the capacity of the system to deliver services in a timely manner. The majority of health workers are employed by the MHMS or other government institutions and the Government pays out fixed salaries which are not dependent on performance (WHO 2014). This has been highlighted as an issue by some observers as a practice that is not conductive to improving efficiency or quality

(Rannan-Eliya, Irava, and Saleem 2013). However, separating purchasing from provision (including some degree of autonomy for providers and the adoption of strategic payment) is difficult to implement, as it would require substantial technical capacity and resources to effectively develop, manage and monitor, both at facility and management level, which Fiji has not yet attained (Rannan-Eliya, Irava, and Saleem 2013).

A global overview of health care access and quality published in 2018 ranked Fiji at 131 out of 195, indicating that the country performed below the international average (Fullman et al. 2018). Perceived low level of quality of some public services has led to an increase in the utilization of private services (Wayne Irava 2015; Singh 2011; WHO 2016; 2011). To address quality concerns, on its official website, the MHMS encourages the public to register any complaints "as close as possible to the source of the issue" by following the complaint process at a given health facility (Fiji Ministry of Health and Medical Services 2020). The website also has a generic form that can be used to send a complaint or leave feedback electronically. The Fiji Human Rights Commission also has a dedicated service on its website to allow for the submission of complaints on any issues related to human rights, including the right to health (Fiji Human Rights and Anti-Discrimination Commission n.d.).

In the context of the high burden of NCDs in Fiji, the allocation of funding and distribution of services do not match the levels necessary to improve the quality and availability of services, leading to a failure to respond effectively to the increasing health care needs of the Fijian population (Asante et al. 2017; Negin, Roberts, and Lingam 2010; WHO 2011). For example, in 2015, about 62 per cent of government spending on health in Fiji was allocated to hospital services, whereas only around 18 per cent was allocated to primary care facilities (such as nursing stations and health centres), and 7 per cent was allocated to providers of preventive care (authors calculations based on Fiji Ministry of Health National Health Accounts from 2017).

Overall, the provision of health services remains underfunded, with an insufficient number of qualified personnel and insufficient scale of outreach and health promotion activities (Negin, Roberts, and Lingam 2010). Despite the existence of a referral system, a 2011 WHO assessment concluded that the gate-keeping system in Fiji is not well-defined and that patients can bypass the primary level, in practice (WHO 2011). The weak gate-keeping function of primary-level care may further negate efforts to promote healthier lifestyles through primary health care interventions at community level.

Moreover, the Fiji health system has been found to be vulnerable to medicine shortages (Walker et al. 2017). For example, in March 2020, public health facilities ran out of stock of major drug used for blood pressure control that was included in the Free Medicines Scheme list (Deo 2020). The lack of high quality medical services is partly mitigated by the existence of special oversees referral programmes (for example, to Australia, New Zealand and India) based on eligibility criteria and visits by individual specialists and teams sponsored by government, donors and charitable organizations (Fiji Ministry of Health and Medical Services 2014).

5. Way forward

While the Republic of Fiji already provides comprehensive legal social health protection coverage to its citizens, further efforts are needed to boost the utilization of services and improve effective coverage. Increasing and rationalizing funding, as well as improving efficiency in spending towards primary level of services, will be key to sustain access for all. Accordingly, the Government has acknowledged the existence of funding gaps which impede the right to social health protection. As such, in 2015, a proposal was endorsed to increase total government health expenditure to at least 5 per cent of GDP with the express aim of expanding access to quality services (Asante et al. 2017). However, as highlighted above, further efforts are needed. One possible solution being considered for mobilizing additional resources for health is the introduction of earmarked taxes on products that are known to adversely impact health. Notably, in Fiji, taxes on tobacco remain below the WHO-recommended level and the prevalence of tobacco consumption is high, estimated at 22 per cent (WHO 2018).

Broadening access to services also remains a priority in Fiji. In 2018, the Government announced that the population would gain access to private general practitioners (GPs) by making them free of charge at the point

of service. The new policy, when finalized, is expected to include incentivising GPs to settle directly in Fijian communities, including in peri-urban areas, towns, local communities and rural and remote parts of the country. In order to fund this initiative, the Government has chosen to set up a dedicated trust fund. As the legislative basis of this initiative, Act No. 30 of 13 July 2018 amends the Fiji National Levy Order 1988, with half of the levy collected on employers being earmarked "for the purpose of facilitating public access to private medical services." However, it remains unclear which payment mechanism will be used for private practitioners, and how the use of funds will be balanced between private and public providers.

The issue of health workforce shortages is reflected in the MHMS Strategic Plan 2020–2025 (Fiji Ministry of Health and Medical Services 2019). The Government of Fiji has taken steps to tackle this by mitigating outbound health workers' migration, and attempts have been made to retain qualified health workers by increasing their salaries (Pūras 2019). A migration of the workforce from the public to the private health sector has been observed in the past, with the share of professionals employed in the private practice reaching 25 per cent of the total medical workforce in 2008 (Negin, Roberts, and Lingam 2010).

To address pharmaceutical shortages, a more effective procurement mechanism needs to be established, informed by better stock forecasting and supply tracking mechanisms (Walker et al. 2017). Up until now, FMI medicines were supplied to private retailers for free by the Government. However, the Government is now considering reforming the Free Medicines Initiative, whereby private pharmacies would have to procure the medicines on the FMI list from the central warehouse themselves, and charge a dispensing fee to the Government ex-post. This poses a potential threat to the financial sustainability of the scheme.

6. Main lessons learned

- Ensuring adequate quality of health services is crucial to improving effective coverage. Low quality of public health services at primary level is partly due to underfunding and allocative inefficiency. Negative perceptions among the population encourage bypassing the primary level and directly accessing expensive secondary and tertiary services, as well as using private health services.
- Social health protection strategies must incorporate responses to social and financial barriers to access. The health care system in Fiji has achieved a degree of vertical equity in financing and is predominantly pro-poor. Despite the policy of free services at the point of entry, health access is hindered for certain population groups, due to discriminatory practices of providers and financial barriers related to transportation and accommodation costs. These obstacles should be addressed as part of national expansion of social health protection efforts.
- Financing strategies of the social health protection system must rely on sustainable domestic funding sources. Because the social health protection system is highly dependent on government general budget allocations, the low prioritization of health as part of the general budget has had a direct detrimental impact on access to health. Moving forward, strategies including the introduction of earmarked resources appears as promising stable source of funding, with potential to partially fill the funding gap.

References

Asante, Augustine D, Wayne Irava, Supon Limwattananon, Andrew Hayen, Joao Martins, Lorna Guinness, John E Ataguba, et al. 2017. "Financing for Universal Health Coverage in Small Island States: Evidence from the Fiji Islands." *BMJ Global Health* 2 (2).

Deo, Dhanjay. 2020. "Enalapril Medicine out of Stock at Major Government Health Facilities." *Fijivillage*, 17 March 2020.

DEPTFO News. 2018. "Free Medicine Scheme Benefits More than 31,000 Fijians". *Fiji Sun*, 13 August 2018.

Fiji Human Rights and Anti-Discrimination Commission. n.d. "Complaints Form", available at: http://www.fhradc.org.fj/.

Fiji Ministry of Health and Medical Services. 2014. "Free Medicine Program", available at: http://www.health.gov.fj/fiji-free-medicine-program/.

——. 2016. *Ministry of Health and Medical Services of Fiji: January–July Report 2016*.

——. 2019. *Strategic Plan 2020–2025*.

——. 2020. "Public Health Services", available at: http://www.health.gov.fj/health-services/.

Fisk, Kylie, and Joanne Crawford. 2017. *Exploring Multidimensional Poverty in Fiji: Findings from a Study Using the Individual Deprivation Measure*. International Women's Development Agency.

Fullman, Nancy, Jamal Yearwood, Solomon M. Abay, Cristiana Abbafati, Foad Abd-Allah, Jemal Abdela, Ahmed Abdelalim, et al. 2018. "Measuring Performance on the Healthcare Access and Quality Index for 195 Countries and Territories and Selected Subnational Locations: A Systematic Analysis from the Global Burden of Disease Study 2016." *The Lancet* 391 (10136): 2236–71.

Gilbert, Katherine, Kunhee Park, Corinne Capuano, Taniela Sunia Soakai, and Beth Slatyer. 2019. "Achieving UHC in the Pacific, a Closer Look at Implementation: Summary of a Report for Pacific Health Ministers." *Health Systems & Reform* 5 (1): 83–90.

Hopf, Suzanne, and Shaynne McLeod. 2015. "Services for People with Communication Disability in Fiji: Barriers and Drivers of Change." *Rural and Remote Health* 15 (3).

Irava, W, and R Prasad. 2012. *A Case Study on the Public and Private Mix of Health Services in Fiji*. Centre for Health Information Policy and Systems Research, Fiji National University.

Irava, Wayne. 2015. *Universal Health Coverage Assessment Republic of the Fiji Islands*. Global Network for Health Equity (GNHE).

Kubasta, Celeste, Richard Neves, John Short, and Kris Kauffmann. 2020. *Fiji Public Expenditure and Financial Accountability (PEFA)* Assessment. International Monetary Fund.

Lincoln, Jay, Masoud Mohammadnezhad, and Sabiha Khan. 2018. "Knowledge, Attitudes, and Practices of Family Planning Among Women of Reproductive Age in Suva, Fiji in 2017." *Journal of Women's Health Care* 7 (3).

Negin, Joel, Graham Roberts, and Dharam Lingam. 2010. "The Evolution of Primary Heath Care in Fiji: Past, Present and Future." *Pacific Health Dialog: A Publication of the Pacific Basin Officers Training Program and the Fiji School of Medicine* 16 (2): 13–23.

Pūras, D. 2019. *Preliminary Observations by the UN Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health Following the Visit to Fiji, 28 November to 5 December 2019*. United Nations Human Rights Office of the High Commissioner.

Rannan-Eliya, Ravi P., Wayne Irava, and Shanaz Saleem. 2013. *Assessment of Social Health Insurance Feasibility and Desirability in Fiji*. WHO and the Fijian Ministry of Health and Medical Services.

Singh, Gurmeet. 2011. "Healthcare Service Delivery and Customer Satisfaction: Insight from Government Hospitals in Fiji." *International Journal of Services, Economics and Management* 3 (3): 323–35.

UNHCR (United Nations Human Rights Office of the High Commissioner). 2020. "Refugee Data Finder- Key Indicators", available at: https://www.unhcr.org/refugee-statistics/.

Walker, Josephine, Betty B. Chaar, Numa Vera, Alvish S. Pillai, Jessy S. Lim, Lisa Bero, and Rebekah J. Moles. 2017. "Medicine Shortages in Fiji: A Qualitative Exploration of Stakeholders' Views." *PLOS ONE* 12 (6).

WHO (World Health Organization). 2011. *The Fiji Islands Health System Review. Health Systems in Transition.*

——. 2014. *Fiji Living HiT Update*. Health Systems in Transition. Asia Pacific Observatory on Health Systems and Policies.

——. 2016. *Fiji Living HiT Update*. Health Systems in Transition. Asia Pacific Observatory on Health Systems and Policies.

——. 2018. "Fiji Celebrates 40 Years of Primary Health Care towards Universal Health Coverage", available at: https://www.who.int/westernpacific/about/how-we-work/pacific-support/news/detail/07-04-2018-fiji-celebrates-40-years-of-primary-health-care-towards-universal-health-coverage.

——. n.d. a. "Global Health Observatory Data". Available at: https://www.who.int/data/gho. Accessed 19 March 2020.

——. n.d. b. "Global Health Expenditure Database". Available at: https://apps.who.int/nha/database. Accessed 19 March 2020.

Wiseman, Virginia, Mylene Lagarde, Neha Batura, Sophia Lin, Wayne Irava, and Graham Roberts. 2017. "Measuring Inequalities in the Distribution of the Fiji Health Workforce." *International Journal for Equity in Health* 16 (1).

World Bank. n.d. "Population, Total - Fiji", *World Bank Data*. Available at: https://data.worldbank.org/indicator/SP.POP.TOTL?locations=FJ. Accessed 26 October 2021.

Supported by LUXEMBOURG AID & DEVELOPMENT

This profile was prepared by Mathilde Mailfert (ILO) with the support of Roman Chestnov, Sven Engels, Nga Leopold and Christine Lohse (ILO). It benefited from the review, inputs and quality assurance of Nii-K Plange (Fiji National University).

The Editor of the series is Valérie Schmitt, Deputy Director, Social Protection Department.

This country brief is extracted from and one of 21 country profiles published in the ILO's report: "Extending social health protection: Accelerating progress towards Universal Health Coverage in Asia and the Pacific".

Contact information

International Labour Organization
Social Protection Department
Route des Morillons 4
CH-1211 Geneva 22
Switzerland

ILO Regional Office for Asia and the Pacific
United Nations Building
Rajdamnern Nok Avenue
Bangkok 10200
Thailand

T: +41 22 799 7239
E: socpro@ilo.org
W: www.ilo.org/asia
www.social-protection.org

ISBN 9789220359280 (print)
ISBN 9789220359297 (PDF)