Centre for International Health

Health Reforms: A Case Study of Fiji

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Certificate of Authorship

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Included Publications and Manuscripts

1. Aumua A, Lewis JA & Roberts G. 2009. Fiji's Health Management Reforms: (1999-2004) A Case Study. *Pacific Health Dialog* 15(2): 13-20.

2. Aumua A & Hodge N. 2012. Pacific in crisis: The urgent need for reliable information to address non-communicable diseases. *Pacific Health Dialog: Special Edition on HIS* 18(1): 191-192.

3. Walker S, Rampatige R, Wainiqolo I & Aumua A. 2012. An accessible method for teaching doctors about death certification. *Health Information Management Journal* 41(1): 4-10.

Conference Presentations

1. 2009. *Fiji's Health reforms 1999-2004*. Fiji Health Research Council: Conference on Health systems Research. Suva, Fiji.

2. 2009. *Fiji Health Reforms: the policy experience.* Pasifika Medical Association Conference. Auckland, New Zealand.

3. 2011. *Fiji Health Reforms: A case study.* World Health Organization, Country and Staff training workshop. Suva, Fiji.

4. 2012. *Experience of Fiji Health Reforms 1999-2004: Implications and learnings for Fiji and the region*. World Bank Flagship Course / Harvard School of Public Health. Nadi, Fiji.

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List of Abbreviations

AMC	Australian Managing Contractor
ATL	Australian Team Leader
AusAID	Australian Aid
CEHS	Central East Health Service
CO	Central Office, Ministry of Health, Suva
CRC	Constitutional Review Commission
CWMH	Colonial War Memorial Hospital
FHMRP	Fiji Health Management Reform Project
FHSIP	Fiji Health Sector Improvement Programme
FLMP	Front Line Management Reform Project
FMIS	Financial Management Information System
FSM	Fiji School of Medicine
FSN	Fiji Nursing School
GCC	Great Council of Chiefs
GDP	Gross Domestic Product
GoA	of Australia
GoF	Government of Fiji Islands
GSD	Government Supplies Department
HFA	Health for All
HISA	Health Information System Advisor
HMA	Health Management Advisor
HRM	Human Resource Management
LMIC	Low and Middle Income Countries
MIS	Management Information System
MOF	Ministry of Finance
MOFP	Ministry of Finance and Planning
MOH	Ministry of Health
NGO	Non-governmental Organisation
NHP	National Health Plan
NPM	New Public Management
NHS	Northern Health Service

NZPTC	New Zealand Pacific Training Centre
OECD	Organisation for Economic Cooperation and Development
PCC	Project Coordinating Committee
PD	Project Director
PDD	Project Design Document
PMA	Pasifika Medical Association
PSC	Public Service Commission
PSH	Permanent Secretary for Health
PWD	Public Works Department
QA	Quality Assurance
SELP	Senior Executive Leadership Programme
STA	Short Term Advisor
TA	Training Advisor
TAFE	Technical and Further Education
TAG	Technical Advisory Group
TCHP	Taveuni Community Health Project
WHO	World Health Organisation
WHS	Western Health Service

Glossary of Fijian Terms

Adi	Title for Indigenous female chief
Itokatoka	Related groups of clans
Matanitu	Large political unit, made up of villages
Mataqali	Groups of several families
Ratu	Title for Indigenous male chief
Sevusevu	Traditional Gift
iTaukei	Landowners, original inhabitants
Vanua	Groups of villages that form for strategic purposes
Vakaturaga	Chiefly ways
Vulagi	Visitor or guest, stranger, foreigner
Yavusa	Clans groupings of people related or associated by history

Abstract

Globally there have been important advances in health care; however developing nations have been challenged with problems of increasing prevalence of disease, changing and rising demands of services and problems of cost containment in managing their health systems generally (OECD, 1994, World Health Organisation, 2005). In the face of these difficulties and with significant influence from the international policy arena developing nations began to identify the need for change across all aspects of their systems (Smith, 1997). The past thirty years have seen more than a third of the world's developing nations undertake some form of health restructuring activity (OECD, 2004, Schou and Haug, 2005). The reforms have varied in content and scope from country to country, but most share common features such as changes in the institutional configuration of the health care systems, health financing and the role of the public and private sector in health care delivery (Berman and Bossert, 2000).

Developing countries in the Pacific have faced the dilemma of a growing burden of diseases and the weakening of the post-colonial health system infrastructure. The introduction of health reforms globally throughout the 1980s created a wave of new ideological thinking of how post-colonial health systems could be strengthened and reconstructed (Litvack et al., 1998). This study examines Fiji as a specific case study of health system reform from 1999 to 2004 and focuses on reform implementation concerns.

The review is complemented by 55 interviews with senior public servants, health minsters, academics and medical and health system bureaucrats and traditional chiefs involved in the reform experience. Context of the reforms is provided by in depth interviews and literature and government reports. Considine's (Considine, 1994) public policy framework helped guide the approach of the study and the methodological design of the research was intrinsic case study (Yin, 2012a).

Understanding the policy implementation experience for developing countries is essential, as much of the reform literature and written experience have focused on

developed nations. Key areas of focus in this thesis include a study of the behaviour of political institutions and actors in the reforms and the context in which the reforms took place and how these factors affected the implementation process.

Analysis of the qualitative data highlights a poor understanding of both political and contextual knowledge of Fiji as well as a lack of understanding by reformists of the effect of Fijian culture on change management processes. Attitudinal factors associated with leadership, power and culture are determinants of the reform process. Awareness of reform processes and the importance of stakeholders' support and engagement in the implementation of a reform activity are not well understood. This study identifies the importance of understanding a country's political history and its societal values, when considering a shift in the political landscape of change. Reform approaches based on global experiences highlights their limited effectiveness and use in developing island nation settings are important finding of this study.

The review of the implementation process of the reforms highlights that Fiji's Ministry of Health does not have sufficient capacity to reform its system. There is little systemic capacity to develop, plan and implement reforms during a period of continuous political instability. Strengthening a country's ability to analyse and design health system change, particularly in developing country settings where a culture of health policy making is weak and a strong culture and traditional mandate of the people remains, is challenging. The importance of health policy analysis (Walt and Gilson, 1994) and its use in the development country settings is paramount to the success of policy implementation success and an important outcome for this study.

Chapter 1: Introduction and Overview

1.0 Introduction

This thesis identifies, describes, analyses and discusses the policy implementation experience of Fiji health reforms which took place between 1999 and 2004. It is the first in depth study to be carried out on the Fiji health policy experience (Aumua et al., 2009). The study examines the relationships and links between political institutions, policy actors, the political environment, and the values and culture that existed within the public policy making system in Fiji. The research identifies and examines the importance of these multiple issues and the inter-related experiences of each of these issues in the reform process. The culmination of analysis of these key issues is intended to help explain what happened in Fiji during the health reforms.

This chapter introduces the study by providing the background and rationale for the study. It introduces the specific research objectives and explains in brief the conceptual framework that guided the project. The significance of the study is explained and an overview of the thesis and its limitations are described.

1.1 Background of the Study

My research interest in this project started in 1998 while working in a policy role in the New Zealand Health Ministry. I took both a professional and personal interest in the health reform activity. As the Fiji reforms rolled out, I became a committed observer . In 2004, in the final year of the reform programme, the Fiji Ministry of Health (MOH) presented a paper at the Pasifika Medical Association (PMA) Conference in Fiji on the progress of the Fiji Health Management Reform Project (FHMRP), which drew attention to several key issues related to the implementation of the reforms. These related specifically to the challenges within the wider policy environment as well as concerns around the capacity of the MOH in Fiji to implement the reforms.

The 2004 conference provided a platform that brought together policy makers in the region to discuss, reflect and gauge how well the Pacific region as a whole was

managing the implementation of in-country reform programmes. From this point, my interest grew into more formal discussions with donors, academics and ministries of health in the region and eventually evolved into a PhD research project in 2007.

Further impetus for the study came also after the release in 2007 of work undertaken by Gill Walt and colleagues at the London School of Hygiene, who released a series of papers derived from a workshop on health policy analysis. The results of the workshop concluded with a series of recommendations for the 'future directions' of health policy analysis in development country settings (Buse, 2008).

The workshop recommendations called for a stronger focus on research on health policy analysis, including the following recommendations: (Buse, 2008)

- A more explicit focus on the methods for doing policy analysis by increasing the methodological diversity within policy analysis by drawing more extensively on experience from other fields while paying greater attention to the benefits and limitations of different methodological approaches.
- Enhancing reflexivity in relation to both the relationships between researchers and policy actors and the manner in which the findings from policy analysis are used to engage with policy actors.
- Better use of the existing, but often descriptive, body of policy analysis through:
- Synthesis of existing case study material using theoretically robust and well-structured approaches to synthesis of findings;
- Collation of lessons learnt from country case studies that have a common topic focus or common framework;
- Collation of lessons learnt from all the health policy analysis studies carried out in a single country.

These recommendations formed the underpinning basis and ideas of some of the key objectives and questions that have driven this research project.

Prior to committing to the research project, I undertook a more formal process of discussions with a range of key stakeholders to scope the level of importance,

interest and support for a study of this kind, including several consultations with AusAID (the funder of the reforms) and Aus Health International (Australian managing contractors), who were involved in the reform design and implementation,[1] as well as with the MOH of Fiji. These discussions helped me to identify a range of preliminary issues that the study could cover.

AusAID officials encouraged me to consider an evaluation of the reforms, in particular their role in the reform project. This was a serious consideration; however, after discussions with other keys stakeholders, it was decided this was not a priority for Fiji. Australia's role is nevertheless highlighted in various aspects of the study. Fijian ministry officials, on the other hand, signalled their concerns with regards to reforms processes and encouraged me to consider certain questions in the study. These questions and issues have naturally manifested themselves in the data analysis process.

Consulting with stakeholders early in the project before the development of the study's design assisted me in gathering some ideas around key issues and gaps in information that would be useful to Fiji. Assessing how the MOH in Fiji might view the project and its relevancy and usefulness early in the development of the study was a strategy that helped me over the entire project period and ensured political and cultural safety, not only for the project but for myself. This approach from the researcher's perspective is an appropriate method in case study research (Darke et al., 1998) and confirms the study's potential contribution to improving Fiji's health policy environment by having all stakeholders consulted at the outset of the study (Aumua et al. 2009).

1.2 Republic of Fiji

Fiji is categorised as a developing nation (World Bank, 2012) and has the largest and most extensive health system in the Pacific region, excluding Papua New Guinea. It has, like many other small island nations in the region, struggled over the past three decades to deliver health services to its population, who are spread over a large

[1] Australian managing agents for the FHMRP

geographical region and include outer and remote islands and rural village-based populations. Providing a responsive and appropriate health service in a country of significant geographical difficulties is one of Fiji's many health system challenges. Other problems have included the management of limited resources, fragmented health services, reduced workforce numbers and a powerful centralised administrative system (World Health Organisation, 2011, Government of Fiji, 1996). Between 1999 and 2003, the Government of Fiji, as part of a series of wider public sector reform initiatives, implemented a programme of health reforms entitled FHMRP, with the purpose 'to improve health system performance and delivery through the restructure and decentralised Fiji's health management system'.

1.3 Aim and Objectives

The overarching aim of this research project was to synthesise a coherent description of the policy implementation process of the Fiji health management reforms (FHMRP, 1999 to 2004).

This is a study of policy; it is concerned with examining key areas within the policy making environment that influenced the policy implementation outcomes. The project's primary focus is the architecture of Fiji's health policy system and how health policy was developed and implemented in Fiji during this period. To achieve this aim, the study explores numerous issues and factors that affected the implementation of the FHMRP. These issues have been captured in the design of the research objectives.

The study is underpinned by Considine's (1994) framework of policy processes (Figure 1).

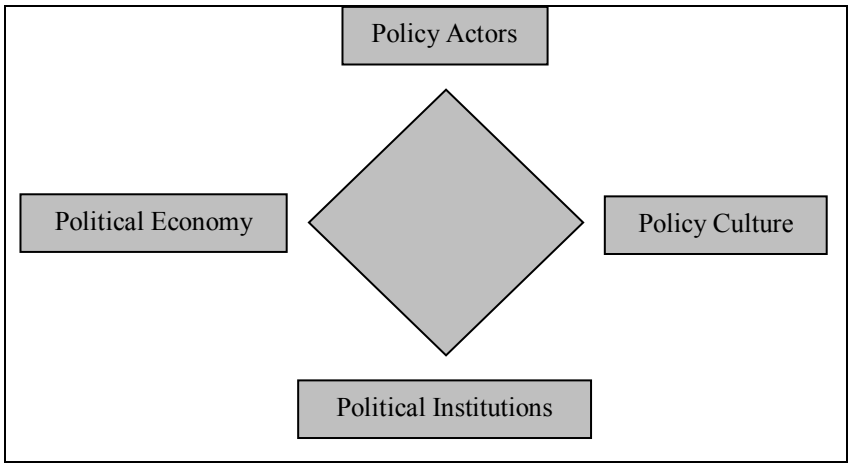


Figure 1 Structure of policy systems diamond (Considine 1994; pg 9)

The specific objectives of the research were:

1. To investigate the role of the key stakeholders, their relationships and the extent of their influence in shaping the development and implementation of the FHMRP.
2. To analyse the role of the various policy institutions and their influence on the reform implementation process.
3. To investigate the role and nature of the political, economic and social environment and its influence in shaping the design and implementation of the reforms.
4. To determine the importance and role of culture and values in the development of policy during the reform process.
5. To identify the process of implementation of the reforms.

The ***first objective*** relates to the experience of key policy actors and stakeholders in the Fiji policy system, which included individual actors, professional associations, industrial unions, academic institutions and groupings of actors. This objective answered the questions surrounding how actors used their power and influence to develop strategies which they used as individuals and as groups to 'get what they wanted' in the policy process. An analysis of the actors and their behaviour was an important and revealing contribution to the case study.

The ***second objective*** examined the role of policy institutions and is focused on the agency and institutional level. This included examining processes and relationships between the organisations that held institutional and legislative power within the policy making process. This objective sought to understand how institutions laid the pathway down which the policy had to travel. An analysis of the legislative arrangements, policy and governance legacies and the history of institutions that directly influenced what happened within a policy process was fundamental to answering this objective. Key institutions included MOH, the Public Service Commission and the Ministry of Finance. Questions were posed to these agencies that revolved around their policy authority, their relationships with each other and their role in the reform process.

The ***third objective*** examined the policy culture in Fiji during the reform period. This objective is a consideration of the policy values and knowledge of the various stakeholders and the tension they brought to bear on the policy process. Further, it sought to understand why policy actors and institutions struggled to control what they held as important and how this influenced behaviour and preferences. An analysis of the culture of Fiji's public service and Fijian culture in relation to power within the public service was an important inclusion. These elements provided the study with important evidence in relation to the implementation of the reforms.

The ***fourth objective*** examined the political economy of Fiji's health system and the reforms. An analysis of the health systems resources, infrastructure and decision making processes was necessary to understanding the broader context of Fiji's public policy processes. An examination of Fiji's societal values and their influence on Fiji's governance and traditional structures were part of this analysis. Data from reports and archival matter together with interviews with leading politicians, senators and public servants on these issues provided a perspective on the wider political and environmental issues during the reform period.

The ***fifth objective*** was an examination of the process of the reforms. This included an analysis of project documentation, historical reports and archival data together with evidence from interviews with key stakeholders involved in the planning of the

reform process. Its importance lay in the reality of 'what really happened' versus what was 'intended and planned', and why.

1.4 Significance and Contributions of the Study

There is a notion that health systems, particularly those in low and middle income countries (LMIC), are in urgent need of reform to improve systems development and efficiency and population health outcomes (Cassells, 1990, Mills, 1990, Mills, 1997, Cassels, 1995b). The majority of reform policies used for restructuring health systems in developing countries have tended to be along the lines of decentralisation (Bossert et al., 1998, Mills, 1997). Decentralisation as a concept has been firmly entrenched in health reformist thinking and has been espoused by global organisations who have promoted health system reforms as part of their development agenda (World Bank, 2000, OECD, 1994).

However, two to three decades of health sector reform experiences in many countries, including the Pacific region, appear to have done little to improve the stated problems of health system effectiveness, efficiency and responsiveness (Berman and Bossert, 2000). A semi-formal evaluation of the Fiji decentralisation experience has taken place (Mohammad, 2011). An end-of-project report by the reform consultants was completed in 2004 and noted the key milestone achievements of the project (Aus Health International, 2004a). The reports were viewed with some scepticism by Fijian authorities as they were presented as a reflective review of the consultant organisations' achievement of the project's milestones.

More recently, it has been reported that the Government of Fiji in 2006 and more recently recognised a number of key problems that have stemmed from the reform process that warrant a fuller review of the effectiveness of the health reform project (Australian Agency for International Development, 2006). This study, therefore, goes some way to assisting Fiji to better understand what happened during the reforms. In particular, it highlights the importance of policy knowledge and processes when introducing administrative system changes.

The project is important for Fiji. From a research perspective, the importance of having appropriate and trustworthy, researched information available to policy makers will assist in building greater confidence in those responsible for using the information (Ritchie and Spencer, 1994). Second, at a policy level, the study will have implications for improving the development of health policy in Fiji as a country that has struggled in recent years to formalise a whole health sector policy framework focused on health system strengthening (Oconnor, 2001). A major priority for the research was the study of the reform process, which included aspects such as the influence of the political, social and economic environment and the distribution of power and influence between stakeholders and the state. The results of this analysis are important for Fiji policy makers and policy institutions, who often fail to take account of the extent that environmental and contextual issues influence a change process (Schneider et al., 2006, Buse, 2008)

At a government level, the research is important for politicians and government leaders who are ultimately responsible for policy development and achievement. Information regarding the complexity of reform process as a government-wide strategy and the issues associated with reform development and sustainability will be important for Fiji as it continues the implementation of health system changes and public sector reforms.

At the institutional level of policy making, issues of institutional relationships and their role within reform programmes were examined. The study will highlight the challenges of institutions and their capacity to implement the reforms. At a community level, key issues in the research have been drawn out that will benefit the wider health sector such as non-governmental organisations (NGOs), industrial unions, international aid and donor agencies and other government donors, in particular, the recognition of their power and ability to influence a government change process.

Finally, at a regional level, the study will benefit other Pacific nations who have embarked on reforms in recent years who have similar public service structures and culture- and value-based tensions within the policy making environment. Further,

international organisations who have promoted health reforms and who have contributed to both policy development advice and funding of reform initiatives in the Pacific region will observe with interest the findings of this study.

Methodologically, the case study contributes to the qualitative research gap in health reforms (Buse, 2008). There is need for better qualitative data, in particular, more in depth knowledge on reform experiences in developing nations. Case study methodology is a method that entails the intensive collection of data on all aspects of this case. It is a methodology that has traditionally not been utilised well enough in the study of health policy analysis (Buse, 2008).

The study will further contribute to the body of knowledge regarding health policy analysis and implementation of health policy in developing countries. The challenges of implementing a reform programme in small island nations that are reliant on external resources to support their development are also highlighted. Transferability of the reform experience to other small island nations in the region such as Tonga, Vanuatu, the Solomon Islands and Samoa is linked with many of these elements.

From a Fijian Indigenous woman's researcher perspective, this project is important. A 2003 report noted that more than 80 per cent of research undertaken and published about Fiji health issues is researched and written by non-Fijians (Finau, 2003). Research by Pacific researchers on the Pacific remains one of the Pacific's most challenging and significant shortcomings (Thaman, 2002). Finau's report further notes the lack of female Indigenous researchers working in the Fiji health system (Finau, 2003).

1.5 Contextual Challenges for the Study

Political Tension

The period during which this research project was carried out was a politically unstable period in Fiji (Lal, 2006). Several political coups had ensued and there was emerging political and ethnic tension across the public sector. The environment was not particularly conducive for open and frank discussions with public servants. Anxieties were reflected in the way the participants of the study responded to the

research process and manifested in their cautious responses to questions. Respondents were concerned that answers should not be misinterpreted or misconstrued. This level of cautiousness did not always allow for a free flow of information with some participants and was constraining from the researcher's viewpoint. Furthermore it affected how individuals responded given their need for anonymity.

Timing

While undertaking the data collection aspect of the study, I was living in Perth, Western Australia. I was only able to travel intermittently and not for long periods of time. At the time when the bulk of the interviews were undertaken, the MOH was undergoing an internal management restructure,[2] adding another level of stress to the participants and their work environment and to the already sensitive political tensions within the MOH.

Cultural Responsiveness

While my own set of beliefs and values guided the way I went about the research process, the importance of knowing my cultural place was key and guided the way I managed the study. As an Indigenous Fijian female researcher, it was important for me to ensure that I understood the multiple roles I played when working in Fiji. Ancestral obligations, perceptions, reactions, attitudes and responses were part of the research process.

It was necessary for me to remain within a culture- and gender-sensitive framework when speaking and gathering information from individuals. It was important to maintain respectful recognition of participants' ages, clan membership and social status. As a Fijian, this can often be a confining situation, particularly when attempting to gather information that could be seen as not in my realm of relevance from a cultural and gender perspective. I managed these limitations as best I could while assuming a posture of cultural recognition of my role as well as my cultural and gender limitations in this process.

[2] In 2008 the MOH in Fiji was recentralised

Cultural Reciprocity

As an Indigenous Fijian health worker, I have a natural concern and affinity with all things Fijian and, in particular, with issues that affect the health status of the people of Fiji. In choosing the FHMRP as my research project, I found an opportunity to contribute to the development of the country's health system while living outside of Fiji. This project allowed me to utilise years of knowledge and experience gained in a field in which Fiji has limited capacity. The concept of reciprocity is an important Fijian cultural principle. The act of returning what you have taken or returning what you have enjoyed or benefited from for the good of more than just yourself is of cultural and personal importance. It is customary and expected to give back. This principle has been at the heart of what has driven this research. This thesis is what I take back to my Fijian community after spending many years away.

The learning from this study is my returning gift, it is my *tabua* (whale's tooth)[3] and it is intended that the benefits of this learning will not only benefit the Fiji health system but will go some way to assist in improving the health of the people of Fiji and my own tribal clan. These concepts embody my personal and cultural responsibilities to my community and have been the underlying motivation of this work. The improvement of the health of the people of Fiji has remained the most important motivating factor in choosing this case.

1.6 Overview of the Thesis

The structure and design of this study is based on what Yin (Yin, 2012a) calls a linear analytical structure. The thesis is an explanatory case study. Chapters 1 to 4 provide the necessary information and background to the project. Chapters 5 to 6 are the analysis chapters. Chapter 7 discusses the findings and makes recommendations for further exploration.

This present **Chapter 1** provides the background and rationale for the study, and introduces the research objectives and issues.

[3] In Fijian culture, the symbolism of a whale's tooth is the highest and most sacred gift that one can give to another

Chapter 2 reviews the literature relevant and necessary to the current study on health reform implementation and explores why there is lack of success of health reforms worldwide and why, in particular, health reforms have been unsuccessful in developing nations. The literature review makes a case for using broad contextual policy analysis to analyse the challenges of policy implementation in a developing country.

Chapter 3 introduces the research methodology and methods. Considine's (1994) theoretical framework is discussed and the three qualitative data collection methods are described. The usefulness of case study methodology and qualitative methods as appropriate tools in the analysis of policy are examined.

Chapter 4 provides background information on the Republic of Fiji, its people, its colonial history and the challenges and problems in Fiji's health system that prompted the need for the FHMRP. The reforms objectives and approach are also outlined in this chapter.

Chapter 5 introduces Fiji's political institutions and their role in the policy making environment in Fiji. It discusses the role of the three main political institutions involved in the reforms. It highlights the importance and centrality of policy institutions and their influence on the policy implementation process and the role of Fijian culture in the political institutional process.

Chapter 6 provides an examination and analysis of some of the actors, and the issues that mobilised them during the reform implementation. It examines the role of medical power and its influence on the reform process. The role of external technical advisors was part of this analysis.

The final discussion, conclusions and limitations related to the findings are found in **Chapter 7**. This chapter includes a discussion on health policy theory processes that helps explain what happened in Fiji. Also included are recommendations to meet the challenges and constraints in implementing health policy in Fiji.

Chapter 2: Literature Review

2.0 Introduction

The purpose of this review is to place this current study in its context. The first part of the review reports on the subject of global health reforms and its history and importance, is followed by a discussion on health policy analysis and key ideas and challenges within the existing body of knowledge. The second part of the review discusses health policy analysis and its importance in health policy reform implementation. This thesis is concerned with understanding the importance of issues and ideas related to implementing health policy and the importance of factors such as politics, context and culture.

The case for undertaking policy analysis has been made by a number of scholars and practitioners. However, there is very little guidance on how to undertake health policy analysis in low-income countries (Walt et al., 2008). (Walt and Gilson, 1994) argued that health policy analysis was central to health reforms. They assert that there is very little attention to how countries should carry out reforms, much less who is likely to favour or resist such policies. Reforms are therefore likely to fail because very little analysis is undertaken to assess who will support the implementation of policies without taking into consideration factors that affect implementation (Gilson et al., 2008, Walt and Gilson, 1994).

In the search for relevant literature, there were a number of broad areas of enquiry (Table 1). Accordingly, a number of different search strings were used. These are highlighted in Table 2. In online searches of library-based catalogues and databases, search stings were utilised in both title and abstract fields.

Table 1 *Literature Search and Strategy*

Literature Category	Method
Published literature such as books, peer-reviewed articles in journals and other scholarly papers and reports.	Curtin University library catalogue. Curtin University 'Gecko' collection of databases, including those under 'Health Sciences', 'Humanities' (includes public policy) and 'Public Health' categories. Manual searches of the reference lists of relevant book chapters, articles and reports. Internet search, including 'Google Scholar' and 'Google'. Scanning of the websites of major relevant organisations, such as the United Nations, Secretariat Pacific Community South Pacific Forum, World Health Organisation (WHO) and the governments of Fiji, Samoa and Tonga, Vanuatu, Papua New Guinea
'Grey' or not publicly available literature, e.g., technical reports from government agencies and reports or working papers from research groups, consultancies or committees.	Direct contact and enquiry with relevant authors and organisations. Scanning of ongoing work announced in relevant organisations' newsletters, websites or email lists.

Table 2 *Literature Search Strings*

Area of Enquiry	Search Strings Utilised
The history and practice of health policy and policy analysis in the field of public health.	(‘public health’ OR ‘ health reforms’ OR health ‘policy analysis’ AND ‘reforms’) (‘history’ OR ‘practice’ OR ‘health policy theory*’ OR ‘strategy*’ OR ‘method*’) (‘public health’ OR ‘public health policy’ OR ‘health reforms’ AND ‘health’ OR ‘policy*’ OR ‘*’policy analysis’ OR ‘implementation of policy*’ OR ‘reforms*’).
The health system in Fiji	‘Fiji*’ AND ‘health’.
History and culture of the Republic of Fiji.	‘Fiji’ AND (‘history’ OR ‘culture’ OR ‘society’ OR ‘social’ OR ‘tradition*’ OR ‘custom’).
The health system in Fiji.	‘Fiji’ AND (‘politics’ OR ‘health policy*’ OR ‘decentralisation’ OR ‘health systems’ OR ‘politics*’ OR ‘History*’).
The governmental structure of Fiji.	‘Fiji’ AND (‘govern*’ OR ‘parliament*’ OR ‘constitution*’ OR ‘legislation*’).

2.1 Global Health Reforms

Health reforms are a political and development tool that have been imposed upon under-developed, developing as well as industrialized nations for more than 30 years (Walt, 1998, Litvack et al., 1998). Much of the literature available on the subject has been written by international organizations and funding agencies who have had an interest in the political implications of health reforms as well as by leading academics and economists interested in the debate of fiscal responsibility in health

systems (Litvack et al., 1998, OECD, 1994, Berman and Bossert, 2000, Peckham et al., 2005, Figueras et al., 1997).

There is no clear definition or universally accepted definition of what constitutes health sector reform (Figueras et al., 1997, Cassels, 1995b). They further suggest that health sector reform is a "process concerned with defining priorities, refining policies and reforming the institutions through which those policies should be implemented." This definition is useful as it captures the broad range of activities that go on within the context of health reforms. There is consensus in the literature that reforms are typically understood to be political concepts which involve a "top down" process of structural and organizational change (Figueras et al., 1997, Saltman et al., 1998).

Much of the reform work in developing countries in the past two decades has centered around four main concepts and principles. These have included 1) the separation of financing and provision of health services 2) the introduction of cost effectiveness analysis to establish policy priorities, 3) resource allocation and the introduction of user fees, and health insurance, and 4) the growth of the role of private sectors in areas previously considered the exclusive jurisdiction of the state (Smith, 1997).

The bulk of health reform literature points to the lack of cohesive evidence and detail regarding the success of health reforms in developing countries (Rondinelli and Shabbir, 1983, Hutchinson and LaFond, 2004). According to Cassels (1995) two to three decades of health sector reform experiences in many countries appear to have done little to improve the stated problems of health system effectiveness, efficiency and responsiveness (Cassels, 1995b). Furthermore the literature does not point to one defining issue responsible for the lack of success, rather various studies point to a mixed bag of reasons for poor outcomes in health reforms (Cassels, 1995b, Bossert, 2000, Gonzalez-Rossetti and Bossert, 2000).

Issues range from the inadequate capacity of policy reforming institutions, health worker issues, political and economic instability of the reforming country, the role of

policy makers, stakeholders, donor agency influence, the complexity and design of reform models used in developing countries and in particular the lack of understanding of policy implementation processes (Litvack et al., 1998, Walt, 2006). However, the one consistent feature in the literature linked to the debate of policy reform failure is the recognition that much of the health reforms discourse is reflected by a preoccupation of rhetoric and ideology centered around health economics and market oriented interventions (Walt et al., 2008, Gilson et al., 2008, Lister, 2005, Buse, 2008).

According to (Berman and Bossert, 2000, Buse, 2008) this is highlighted throughout the literature by the over emphasis of reformists focusing on system infrastructure and the economic and technical aspects of health systems. He suggested that the abundance of economic evaluations cited in the literature reflects the primacy of financial issues for policy makers and the political pressure to demonstrate improvements in fiscal performance by countries under reform. Berman (2000) agreed and argued that the lack of recognition and understanding of the social and cultural dimension of policy systems in the implementation of reform programmes pose serious problems for health reformists. Subsequently he suggested there is a need for more qualitative research in order to understand how reform initiatives have affected the organizations and stakeholders involved in the reform process and the influence of the wider environment on reform implementation (Berman and Bossert, 2000).

Berman (2000) argued that the most significant determinant to successful reform processes is the recognition of the reforms being “purposive” he asserts that reforms must be designed to achieve “policy objectives”. Numerous country studies reviewed allude to the problem of poor results due to the lack of shared understanding by reforming countries of what health reform agendas might be and the lack of clarity around the reform purpose. Bossert (2000) suggested that this lack of shared understanding by all policy stakeholders is reflected in the way reforming nations have struggled with defining problems and subsequently identifying solutions that were successful. Policy theorists on the other hand suggest that it is the lack of knowledge of “policy processes” as well as the limited recognition and importance of

the economic, social and political elements within the environment that affect policy formation which are not considered by reformists when undertaking reform programmes (Considine, 1994, Colebatch, 2002). The creation of new organizations and the endless modifications of systems demonstrate the belief within health reform literature that the development of new formal arrangements of any system will mistakenly solve all health system problems (Gilson, 2003). Subsequently health reforms have not been viewed successfully as part of a global push to improve the strengthening of health systems (Lister, 2005).

Reform efforts have historically focused on the development of the content of the reform package, neglecting the process of reform and the difficulties of implementing and managing change (Walt and Gilson, 1994). Policy analysis can contribute to meeting health objectives by revealing the many other key and complex issues that underpin the process of change (Walt and Gilson, 1994).

2.2 Health Policy and Analysis

Health policy analysis is a central strand of health policy systems research. It is sometimes understood as technical work that underpins the development of new policies or the central element of their evaluation (Gilson and Raphaely, 2008). It can include epidemiological analysis, risk factor analysis, targets for health interventions and cost effectiveness, which can help identify the various possible interventions to address a particular health problem and which provides the best value for money.

Literature on health policy analysis in LMIC has demonstrated that politics, process and power must be integrated into the study of health policies and the practice of health system development (Gilson and Raphaely, 2008). Developing nations bear the bulk of the world's disease burden and its negative effects such as weak health and financing systems and low numbers and capacity of health workers. Although there have been dramatic improvements in disease management over the years, there is still a notion that health systems, particularly those in LMIC, are in urgent need of reform to improve system development, efficiency and population health outcomes (Cassels, 1995b, Mills et al., 2001). The case for undertaking health policy analysis

has been made by various scholars who have argued that appropriate policy analysis is central to health reform success (Walt et al., 2008, Walt, 1994, Parsons, 1995).

Health policy analysis is cited as important in health reform success for two reasons (Walt et al., 2008). It helps explain why certain health issues receive political attention and others do not, such as identification of stakeholders who may support or resist policy reforms and why. It can also identify potential and unintended consequences of policy decisions, as well as the barriers that undermine policy implementation and so jeopardise national and global goals for health improvement (Gilson et al., 2008, Gilson and Raphaely, 2008, Buse et al., 2007). Historically, policy literature has tended to focus exclusively on general public policy that specifically relates to health; however, there has been a growing interest in applying general policy knowledge and principles to the concerns of the health sector.

This research project is interested in health policy analysis and is concerned with policy process (not policy content), which is according to some arguably the biggest problem with the global phenomena of health sector reform for policy makers (Saltman et al., 1998, Reich, 2002, Collins et al., 1999). The context in which health policy is now formulated and implemented has changed dramatically over the years from a policy domain characterised primarily by consensus health policy development to an environment of conflict and uncertainty now characterised within developing countries (Walt et al., 2008). New paradigms of thinking need to be applied to the health sector to understand the factors that influence the effectiveness of policy change (Walt and Gilson, 1994). It has been further suggested that the lack of success in health reform experiences in developing nations such as the neo-liberal reform experience in Latin America (Homedes and Ugalde, 2005) and district planning reform in Africa (Oyaya and Rifkin, 2001) are directly linked to the problem of inadequate prospective health analysis by health policy researchers and reformists (Walt and Gilson, 1994).

Policy is the process by which governments, institutions or organisations translate their political vision into programmes and actions to deliver outcomes. Policy can be

a single statement or a set of laws, regulations or, more vaguely, guiding principles brought to manage a particular health issue or resolve a fundamental health problem. The term health policy means the consideration of policy with an overarching concern for the health sector (Walt 1994, p. 214). Health policy can be understood as the:

> Courses of action (and inaction) that affect the sets of institutions, organisations, services and funding arrangements of the health system. It includes policy made in the public sector (by government) as well as policies in the private sector. But because health is influenced by many determinants outside the health system, health policy analysts are also interested in the actions and intended actions of organisations external to the health system has an impact on health (Buse et al. 2005; p 25).

Health policy analysis is a multi-disciplinary approach to public policy that aims to explain the interaction, links and communication between institutions, interests and ideas in the policy process (Walt et al. 2008). It has been defined as the approaches, methods, methodologies and techniques for improving discrete policy decisions within a country's health system (Dror, 1993) Policy analysis draws on concepts from various disciplines such as economics, political science, sociology, public administration and history (Walt & Gilson 1994).

Policy analysis considers the role of actors who influence policy change at different levels, the influence of power relations, institutions and ideas over health system operations and policy as well as political economy issues. It can be conducted retrospectively, to understand, evaluate and improve past experience; it can also be used prospectively to support health policy change and health system strengthening (Walt and Gilson, 1994). Reich's case study on the introduction of an essential drugs policy in Bangladesh highlights the importance of the use of prospective analysis to formulate policy (Reich, 1995b). Until the 1990s, very little knowledge existed in the academic literature on health policy analysis. More recently, however, it has become an area that is broadly acknowledged and recognised as an important aspect of health systems strengthening that can assist countries to better understand and

improve health outcomes (Walt and Gilson, 1994, Buse et al., 2007, Gilson and Raphaely, 2008)

Today, health policy analysis is an established research and academic discipline in the industrialised world. In the developing world, however, its application has been limited and neglected (Walt and Gilson, 1994). From the mid-1990s, much more interest in the developing countries experience with health analysis has emerged and a recent literature review by Gilson (Gilson et al., 2008) highlights that although policy analysis in developing countries is still in its infancy, there is increasing knowledge and recognition of its increasing importance. Historically, the literature has tended to focus on policy specifically related to health, however, as Gilson and Raphaely (2008) and Ham (Ham, 1990) point out, there is now a growing interest in applying general policy knowledge and principles to the concerns of the health sector (World Health Organisation, 2013).

2.3 Approaches to Health Policy Process

There exist several frameworks, models and theories of the policy process. The most commonly known public policy framework is the '**Stages Heuristic Framework**' (Laswell, 1956). This approach divides the public policy process into four stages: agenda setting, formulation, implementation and evaluation. Agenda setting is the issue sorting stage, during which a small number of the many problems societies face rise to the attention of decision makers. In the implementation stage, governments carry out these policies, and in stages heuristic for presuming a linearity to the public policy process. This approach is more commonly known as the Top Down approach as it is driven by Government with a focused staged approach to implementation.

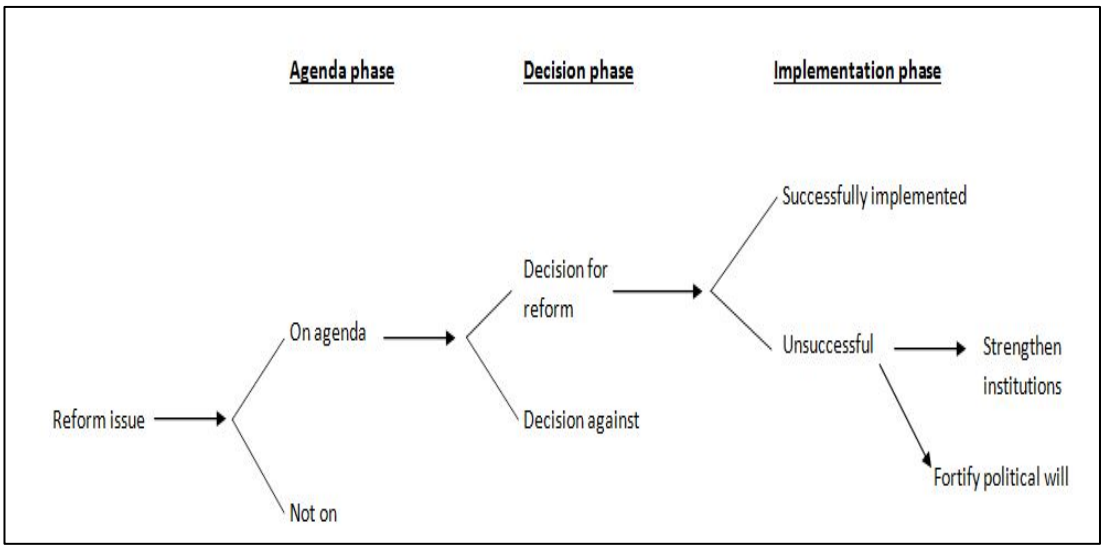


Figure 2 Linear /heuristic model of policy making (Grindle and Thomas 1990; pg 7)

The **Heuristic approach** reflects the rationalist and scientific ideal, which according to some theorists, views society as a collection of autonomous rational decision makers who do not recognise the contribution of a wider circle of community players (Stone, 1998). It assumes that the policy process can be designed and implemented in a straight line (Sabatier, 2007). Considine (1994) notes that to accept this view of policy making is too instrumental, that is to say, policy development in this way blocks any understanding of what happens in the field, and it does not allow for asking questions related to the bigger social and contextual issues within a policy environment (Considine, 2005).

Theorists such as Sabatier (Sabatier, 2007) suggest that linear/heuristic model (Figure 2) is not a realistic framework for policy development as the stages that it postulates do not exist in reality and the neat demarcations between stages are blurred in practice. One of the key challenges of this approach is that it suggests that public policy is the result of a political process (Colebatch, 2002). It recognises that policy is essentially a product that is seen as an action or a decision, which employs governmental authority to commit resources in support of a preferred value (Howlett and Ramesh, 2003, Lindblom and Woodhouse, 1993).

This approach focuses on the content of policy as it analyses more specifically than other approaches how policy making should be done. It is viewed as a problem solving process methodology and comes from the evidence-based movement and is

focused on considering the efficiency and effectiveness of policy (Lewis, 2005). Those interested in the analysis of policy and concerned with how the policy process is structured use this approach, as it helps to ask questions about how a policy process works and is concerned with political institutions and policy making capabilities of government machinery.

As Walt et al. (2008) suggest, however, the linear/heuristic model does offer a useful and simple way of thinking about the entire public policy process, and helps researchers situate their research within a wider framework and offers a 'simple way of thinking about the policy process'. Walt in the same discussion asserts that this approach has been responsible for capturing much of the health policy debate in recent years. However she further notes that this methodology has also been responsible for distracting policy analysts to focus on the content of policy and reform and neglect the role of actors involved in policy change and implementation (Walt et al., 2008).

Theorists such as Walt, Gilson, Rapahaely (Walt and Gilson, 1994)and others opposing the linear approach suggest that it fails to recognise the importance of the wider political community as participants in the policy process and their struggle with ideas. They suggest the approach is not ideal as it fails to explain why decisions are made and what drives policy from one stage to the next, and it subsequently fails to embrace the complexity and reality of policy making processes (Considine, 2005, Stone, 1998).

The **Behaviourist or Interactive (*bottom up)* Approach** (advocates the importance of paying more attention to the process and the context in which policies are developed and implemented (Gilson and Raphaely, 2008). The *bottom up* view of the implementation process is that that implementers often play an important function in implementation, not just as managers of policy handed down from above, but as active participants in a complex process that informs those higher up in the systems.

This behaviourist or interactive perspective suggests that policy making and policy analysis does not assume a single decision maker addressing a clear policy problem,

rather it focuses on a range of participants in the policy arena, the diversity of their understanding of the situation and the problem, the ways they interact with each other and the outcomes. This view suggests that policy is an on-going process of negotiation and influence (Considine, 2005). The central claim is that policy emerges from identifiable patterns of interdependence between actors, communities and institutions. In a sense, everything in the policy world is about process, the movement of people and programmes around common problems. Peoples' views and their values do not remain fixed; they keep moving and changing. According to Considine (1994), we cannot afford to view policy as just a study of decisions. The following table captures the different approaches used by the two disciplines of thought.

Table 3 *Top-down and Bottom-up Approaches to Policy Implementation* (adapted and expanded from Sabatier 1986; Buse et al. 2007)

	Top Down Approaches	**Bottom Up Approaches**
Initial Focus	Central Government	Local implementation actors and networks
Identification of major actors	From top down and starting with government	From bottom up, including both government and non-government
View of the policy process	Largely rational process, proceeding from problem identification to policy formulation at higher levels to implementation at lower levels	Interactive process involving policy makers and implementers from various parts and levels of government and outside in which policy may change during implementation
Evaluative criteria	Extent of attainment of objectives rather than recognition of unintended consequences	Much less clear possibly recognizes that policy process takes into account local influences

Overall focus	Designing the system to achieve what central/top policy makers intend - focus on structure	Recognition of strategic interaction among multiple actors in a policy network. Focus on agency

The difference between the rationalist and the behaviourist approaches to health policy analysis is that behaviourist outcomes are evolutionary; they are not fixed, rational or logical. They rely heavily on understanding the political, social and cultural aspects of policy making and it is these issues they suggest should lead to the best choice of strategies for implementation (Sabatier, 2007, Jenkins, 1978, Hogwood and Gunn, 1984). The behaviourists argue that it is much more important to pay attention to the process while the rationalist approach relies heavily on understanding the content of policy from a perspective of efficiency and effectiveness, and disregards the context and environment in which the policies are developed or will be implemented. The behaviourist approach enables a way of understanding why policies are not implemented effectively and why health policies do not achieve what they set out to achieve (Jenkins, 1978, Walt and Gilson, 1994).

There is a tendency to split policy making and implementation in the heuristic/linear model. That is the decision making is all about politics and implementation is all about administration (Grindle and Thomas, 1992). The interactive model however sees the policy process as one integrated process. Other policy frameworks most commonly identified in the literature include Kingdon's (1984) agenda setting (Kingdon, 1984)(e.g., Klugman's 2000 study of NGOs)(Klugman, 2000) and actor network theory (e.g., Walt and Gilson's 1994 work on health sector reform and Schneider and colleagues' 2006 (Schneider et al., 2006) work on health systems and disease programmes). The most commonly used overarching framework is Walt and Gilson (Walt and Gilson, 1994).

Other models of the policy process include the **Incremental Model**. This model enables policy makers to look at a small number of alternatives for dealing with a problem and tend to choose options that differ only marginally from the existing policy. This view does not suggest an optimal policy decision but rather suggests that

a good policy is one that all participants agree on rather than what is best to solve the problem (Lindblom and Woodhouse, 1993). This model suggests that major changes occur through a series of small steps, each of which does not fundamentally "rock the boat". The policy process is one of disjointed incremental steps or "muddling through" (Lindblom and Woodhouse, 1993).

The **Mixed Scanning Model** covers a middle ground between the linear and behaviourist models (Walt, 1994). It involves the policy maker in taking a broad view of the field of policy. The rational/linear model implies an exhaustive consideration of all possible options, and the incremental approach suggests looking only at options which are known to exist. In contrast a mixed scanning approach suggests taking a broad view of possible options and looking further into those which require a more in depth examination.

This research project is concerned with understanding the process and context in which policies are formed. The study intends to go beyond the content of policies and give greater attention to the behaviour of health policy actors, their processes of decision making and the actions they take, or their lack of action and unintended actions, the influence of content on those actions, and the context that influences and is influenced by these behaviours (Walt and Gilson, 1994). Furthermore the focus of the study is the importance of all these factors and the impact that they have on implementation.

2.4 Implementation

There is near universal consensus in the literature on how little is known about the process of implementing policy. Research on public policy implementation is scarce (Sabatier, 2007). Multiple implementation theories have been dominated by a discourse as to whether decision making is top down or bottom up or a synthesis of the two (Sabatier, 2007). A key issue in the literature focuses on the gap or the deficit between policy objectives and actual implementation (Walt et al., 2008, Hill and Hupe, 2002). Two schools of thought emerge in the literature. The first views implementation as an administrative function, the other views it as a political function. The administration model represented by the works of (Pressman and

Wildavsky, 1984) see implementation as a "top down model: which focuses on putting policy into effect through communication and control. The seminal work *by* Pressman and Wildavsk, Implementation: *How Great Expectations are Dashed in Oakland* (Pressman J and Wildavsky, 1973) considered to be founding fathers of implementation research. Their starting point is policy formulation, and implementation, the writers suggest that the goals of this policy approach might be achieved. The emphasis been on compliance rather than performance.

This approach is strongly supported by politicians and bureaucrats. The "bottom up model" as described and evolved by Lipsky (1980) who published *Street Level Bureaucracy, Dilemas of the Individual in Public Service* suggests that policy implementation is driven by those who control the actions and carry out the policy goals (Hill and Hupe, 2002 pg 53). Lipsky is considered the founding father of the bottom up approach. He provided a perspective and a shift away from a focus on top down policy input and looked at what actually happens at the implementation level. Others see policy implementation as political process. A process of interaction and negotiation between those seeking to put policy into effect upon whom action depends (Considine, 2005, Walt, 2006). The political model views implementation as a bottom up process based on negotiation and compromise. Performance rather than conformance is the focus of the political model. Saetren (2005) in his review of policy implementation of published literature concluded that while most studies focused on health and education, they predominantly focused on high income countries (Saetren, 2005).

A key concern in the health reform literature has dealt with the issue of the timing and implementation of health reforms. Walt et al (1994) note that global reform efforts have tended to focus on the development of the content, neglecting the process of reform and the difficulties of implementing and managing change. Reform failures often have little to do with the merits of the program but rather reflect the inadequate understanding of the many social and actor issues related to implementation. A range of contextual factors including the socio political environment and societal values influences the implementation of reform in a specific country. The process of implementation is directly affected by the system of

government and the distribution of authority as well in which the process itself is conducted (Walt and Gilson, 1994b) Contentious issues related to implementation have been the pace of implementation and the merits of a big bang approach (Klein, 1997) versus the incremental approach (Lindblom and Woodhouse, 1993). In addition actors and stakeholders play a significant role in the determinants of policy change. Subsequently health reforms have not been viewed successfully as part of a global push to improve the strengthening of health systems (Lister, 2005).

A key issue highlighted in the literature puts the barrier of effective implementation directly on the uniform failure of governments to plan for implementation of policies they develop. Planning for execution is seen as a critical component of implementation success (Sabatier, 2007, Hill and Hupe, 2002). Paradoxically, policy makers assume that implementation is self-executing and neglect to plan for it. Typically, their concept of implementation is to assign a budget and a time limit to the legislation and consider their jobs completed. The rest in their view is up to the local program people and bureaucrats responsible for the implementation of policy (Considine, 2005, Dye, 2001, Pressman and Wildavsky, 1984).

2.5 External Influence and Development Ideology

Although external assistance is not always a major source of funding in many developing countries, it is never the less influential in shaping policies and programs and therefore an important factor in the analysis of health sector reforms. Much of the criticism of donors involved in this process has centered on the concern of certain agencies to promote specific strategies, (notably user charges, community financing and greater reliance on private care rather than taking a more country specific view and assisting recipient countries to analyse the implications of different options for reforms (Cassels, 1995a, Walt, 1994). Ideological convictions, national experience and the need of some agencies to maintain an identifiable niche in the market for public and donor support are the key drivers for donor positions (Cassels, 1995b). Reform experiences in Latin America and in Europe highlight that many reforms experiences have been seen as imposed from the outside (Reich, 1995b, Thomas and Gilson, 2004). A World Bank report on policy implementation suggested that

negotiations on policy were often seen as coercive exercise designed to impose the donor philosophy (World Bank, 2000).

2.6 Methods and Tools of Analysis of Reforms

Undertaking health reform is a highly political process and will never be in everyone's interest and cannot be promoted by rational argument alone (Gonzalez-Rossetti and Bossert, 2000). A range of tools and strategies are available to analyse health sector reform strategies, these include packages of services, such as burden of disease analysis and cost effective analysis (Murray, 1995, OECD, 1995), health financing and social health insurance, (Schneider et al., 2006). Further various national studies have been carried out in Mexico using tools such as political feasibility analysis (Frenk, 1995). Other approaches such as National Health Accounts as a tool for describing health care expenditure and flow of funds also exist (Klein, 1997). A computer based tool, for political mapping developed such as the one by Reich and Cooper (Reich and Cooper, 1996) and Stakeholder analysis tools such as the one developed by (Trader -Leigh, 2002). Although an assortment of tools have evolved to support health sector reform there is no single strategy for health sector reform. Countries inherit systems that impose advantages and constraints that must be incorporated into reform efforts as such all reforms look inherently different.

According to Murray (1995) analysis of health sector reforms will always remain challenging and difficult, as health sector objectives are difficulty to articulate and quantify. Defining a single overarching goal for reforms is not straightforward (Murray, 1995). Most public health practitioners are happy with the objective that the goal of the health sector is to improve the health of the populations or maximize appropriate health measures (Lister, 2005). Most economists are more comfortable defining health sector objectives in terms of welfare maximisation rather than in terms of health status maximisation (Murray, 1995). Health reform implies however significant change. WHO report of 1993 reported that reform requires changing both policies and institutions (World Health Organisation, 1993). Acknowledging that more is needed than just a reorientation of goals and intentions.

2.7 Decentralisation as a Health Reform Strategy

Of interest to this study is the concept of decentralisation. Decentralisation takes many forms and has several dimensions and can mean different things. The difficulties in discussing decentralisation are illustrated by the following quotation:

Decentralisation may mean the transfer of authority over public enterprises from political officials to a relatively autonomous board. The transfer of administrative functions downwards in the hierarchy, or by the establishment of legislative units of smaller size, or the transfer of responsibility to sub-national legislative bodies. The assumption of control by more people, the hope for a better world to be achieved by more individual participation (Mills et al., 1990 pg 32).

Saltman et al (2007) describe the logic of decentralization as based on an intrinsically powerful idea. It is, simply stated, that smaller organizations, properly structured and steered, are inherently more agile and accountable than are larger organizations. In a world where large organizations control wide swaths of both public and private sector activity, the possibility of establishing more locally operated, locally responsible institutions, holds out great attraction (Saltman et al., 2007).

There are four types of decentralisation commonly found in practice: de-concentration, devolution, delegation and privatisation (Rondinelli and Shabbir, 1983). These reflect both different degrees of decentralising of government authority and different approaches to decentralisation.

1. De-concentration is applied to the handing over of some administrative authority to locally based offices of central government ministries.
2. Devolution is the creation or strengthening of subnational levels of government that are substantially independent of the national level with respect of a set of functions.
3. Delegation involves the transfer of managerial responsibility for defined functions to organisations that are outside the central government structure,

4. Privatisation involves the transfer of government functions to voluntary organisations or to private profit making or non-profit making enterprises (Rondinelli and Shabbir, 1983).

Implementation of decentralisation in developing countries has had mixed results. According to Litvak and others (1998), designing decentralisation policy is difficult because decentralisation can affect many aspects of public sector performance and generate a wide range of outcomes. He notes that it is particularly difficult in developing countries because institutions information and capacity are all very weak. The cross cutting nature of decentralisation, the importance of local institutions influencing the impact of decentralisation and the limited empirical evidence on what works and what does not make the design and implementation of decentralisation a considerable challenge (Litvack et al., 1998).

2.8 Developing Nations and Health Reforms

Many developing countries have faced the need to transform their large and highly inefficient health systems, which have been operating along the same policy lines for 50 years following their founding in the early post-war period (Gonzalez-Rossetti and Bossert, 2000). Developing nations have also been challenged to consider reforms for various reasons and many developing countries face a variety of obstacles in addressing their many health problems. Most common among these obstacles are extremely limited and often inequitably distributed resources, shortages of institutional and or human capacity, inadequate accountable mechanisms, absence of risk pooling strategies and inefficient and frequently wasteful service delivery. Further, developing countries have had to deal with issues such as the need for better rural and or divisional outreach services, poor health infrastructure, shifting patterns of disease and in the poorer nations a prevailing lack of economic development.

These issues were reiterated in the 2001 and 2010 WHO reports, which confirmed that the majority of public sector health systems in developing countries were poorly designed and did not respond to the needs of their populations. These same developing nations have been targeted by international development organisations and funding agencies who have been responsible for promoting health restructuring

and reform concepts (Litvack et al., 1998, Berman and Bossert, 2000). There has been a tendency in public health to portray policy reform as a technocratic or economic process. Both economists and health policy analysts tend to provide detailed prescriptions on what has been done without clear instructions on how to do it and without good explanation of why things go wrong (Reich, 1995a, Walt et al., 2008). Health system reforms have until recently tended to focus primarily on structural change (Scott et al., 2003). Many of the global reforms have been formed from strong economic theoretical underpinnings that have been driven by mechanistic and technical ideas, rather than sector wide holistic ideas around government process and human dynamics (Gregory, 1999, Parsons, 1995).

Criticism of health sector reform and the new public management concepts relate to the focus on standardised packages of technical and structural interventions based on simplistic assumptions about human behaviour and what (Gregory, 1999) has termed economic and reductionism and technocratic structuralism. As Blaauw et al point out, the debate is not new and the dominant discourse in health systems research and health sector reform still reflects a preoccupation with the infrastructure technology and economics of health systems rather than its human, organisational cultural and social dimensions (Blaauw et al., 2003).

Reforms that have been carried out around the world have varied in content and scope from country to country, but most share common features such as changes in the institutional configuration of the health care system, health financing, and the role of the public and private sector in health care delivery (Berman & Bossert 2000; (Hsiao, 2007, Buse, 2008). The variation of systems and problems within countries described in the literature suggests that many of the reforms planned and carried out globally demonstrates that there is an ongoing search for better ways of improving health systems and health services.

In 2000, a WHO report noted that 29 countries grouped in the OECD accounted for 89% of total world expenditure on health, leaving the vast majority of the world's population to share the remaining 10%. The same report highlighted that 84% of the world population shared just 11% of global health spending, but suffered 93% of the

world's burden of disease (WHO, 2000, Institute for Health Metrics and Evaluation, 2012, World Bank, 2012). These statistics demonstrate the widespread disparity between global population and health spending and the scale of inequality that has been generated by the current mix of systems and policies. In particular, these statistics point to the problem that global health care spending is almost completely inversely proportional to the global burden of disease. These statistics have led health academics and economists to propose that fundamental changes are required in health systems around the world if they are to be equipped to meet the challenges of the twenty-first century (Agyepong and Adjei, 2008, Berman and Bossert, 2000, Lister, 2005).

Surprisingly, however, after years of investments in health reforms, there still remains inadequate evidence of the effectiveness of health reform policies and initiatives not only in those countries and agencies championing these policies but also by those countries at the receiving end (Figueras et al., 1997). As such, successive rounds of reforms have rolled out unevenly across developing countries with considerable evidence of limited progress and poor results, leaving the health systems strengthening agenda largely unfinished in many countries (Roberts et al., 2008).

The past 30 years have seen more than a third of the world's developing nations such as countries in South America (Chile, Boliva) (Berman and Bossert, 2000, Bolger, 2005), Papua New Guinea (Kolehmainen-Aitken, 1991) and Thailand (Green, 2000) undertake some form of health restructuring activity (OECD, 1994, Schou and Haug, 2005). The discussion of health policy and health policy analysis and its importance and relevance to health reforms and health systems improvement has only recently emerged as an important issue related to global health systems improvements. In the past decade, there has been an expansion of literature that has reflected the growing interest in health reforms and health policy analysis (Berman and Bossert, 2000, Walt et al., 2008, Walt, 1998).

2.9 Health Reforms in the Pacific Region

Over the past 10 years, several countries in the Pacific region, Tonga, Samoa, Vanuatu, Papua New Guinea and Fiji (Rabukawaqa, 2006, World Bank, 2003) have undergone health system reforms. The central catalyst for many of the reform initiatives has been the result of investments by donors, through bi-lateral or multi-lateral specific aid programmes, which have enabled countries to undertake restructuring programmes. Tonga, Vanuatu, Fiji, Solomon Islands, Papua New Guinea and Samoa were most notably subsidised by the Australian government (Rabukawaqa, 2006, Soakai, 2006, World Bank, 2003, Aus Health International, 2004b, Australian Government, 2004, Ministry of Health Tonga, 2004, Bolger, 2005).

A 2008 review of global literature, which identified 391 health policy analysis articles concerning LMIC over a 13-year period, noted that none focused on the Pacific (Gilson and Raphaely, 2008). Globally, evidence-based policy making is becoming more complex. Poor health information systems and the limited ability of many countries in the Pacific to collect, and monitor information for decision making is poor, as such evidence for policy making is limited (Aumua and Hodge, 2012).

The WHO (World Health Organisation, 2005, Buse, 2008) highlights the strength of development partners, asserting: 'not only do these partners have the power to fund, or not to fund, given projects, they also have the power to influence, if not control, policy making agendas'. Reich et al note: 'policy making in global health has become a multi-stakeholder process … with competition and confusion both globally and nationally' (Reich et al., 2008 pg 18). The fact that the Pacific is the most heavily aid-assisted part of the world per capita only adds to the challenge and importance of health policy analysis (Australian Agency for International Development, 2009). Markus et al further note in their recent multi-country study on fragile states and health systems that, "when a country has significant portion of external aid it diminishes the power of local decision making" (Markus and Hill, 2012 pg 12). This suggests that donor dependency is linked directly to the lack of ability for a country to manage its own decision making process and ultimate determining its own health systems outcomes.

The intimate involvement of international aid organisations such as the World Bank in health reform programmes as described in the literature and evidenced in-country reform reports has created tensions over health reform processes and has led to problems such as reform design, implementation and reform sustainability (Kolehmainen-Aitken, 1998, Cassels, 1995b, Berman and Bossert, 2000, Romeo, 2003). Although very little evaluative work has been done on Pacific reforming nations and their success, there is evidence that health reforms in the region have not been successful (Rokovada, 2006, Soakai, 2006).

2.9.1 Health Reforms in Fiji

In 1999, Fiji commenced a series of health reforms, which were part of a wider reform programme aimed at restructuring the MOH (Government of Fiji, 1999b). Although Fiji's health system infrastructure has re-oriented itself at various stages since the system's inception in the early 1900s, the 1999 FHMRP was the first significant major attempt at restructuring the entire management of the health system. In 2004 Fiji continued its reform program with phase two of the FHMRP, and in 2009 the Government of Australia and Fiji established the Fiji Health Sector Improvement program which continues until today. To date, no formal evaluative work has been undertaken on the 1999 Fiji health management reforms.

2.10 Why is Health Policy Analysis Important?

The literature highlights numerous areas that relate to the importance of health policy analysis. Its overall importance is that:

> It can help explain why certain health issues receive political attention, and others do not, such as by enabling identification of which stakeholders may support or resist policy reforms, and why. It can also identify the perverse and unintended consequences of policy decisions, as well as the obstacles that undermine policy implementation and so jeopardize national and global goals for improved health. In these ways, policy analysis supports more realistic expectations about the timeframes and nature of policy reform, 'can assist' in enabling successful policy development and implementation, and can support the use of technical evidence in these processes (Buse et al., 2007)

Establishes Policy Objectives

Health policy analysis assists in understanding how public policy makers set objectives and make decisions on health priorities and actions. Health policy analysis can help explain why certain issues receive political attention in a political environment and why others do not. For example, the Kingdon (1984) model is often used to test the criteria of an issue making it onto a government agenda. The Hall model of analysis can be used to ascertain whether an issue and likely response would be high in terms of its legitimacy, feasibility and support and meeting all three criteria, and Kingdon's three stream model can be used to understand the perceptions of problems as public matters requiring government action and efforts of government to act on an issue.

Further and most importantly for this study is that the role of policy analysis can assists policy makers better understand how a government sets a policy agenda and what role stakeholders play in supporting (or not supporting) governments to implement their agenda (Gilson & Raphaely 2008). The journey of getting tuberculosis on the policy agenda and formulating the DOTS policy provides a good example of the use of health policy analysis as a tool for advocacy and negotiation (Ogden et al., 2003).

Helps Understand the Policy Process

Health policy analysis can help in understanding important stages of the health policy process such as:

- Agenda building
- Policy formulation
- Planning
- Monitoring and evaluation
- Assisting in understanding which factors affect processes and how researchers can influence policy.

The latter includes considering whether and why routine practices differ from, and may even contradict, formal policies, and generate an implementation gap between

policy intentions and routine practice (Gilson and Raphaely, 2008). This particular aspect of health policy analysis is important to this project.

For improving evidenced-based policy, the usefulness in health policy analysis lies in the opportunity in these processes to include much more technical evidence into the policy development process. Ultimately, policy makers through this process will have a more realistic understanding of policy success. It helps explain aspects of the policy making process, such as the roles of actors who influence policy change at different levels—from individual, organisational, national to global—and their interests in a country (Gilson and Raphaely, 2008). Studies undertaken by Thomas and Gilson (2004) on actor management in South Africa help explain the complexities of actors' behaviour and their influence on reform implementation.

Further, the study by (Green, 2000) on the role of policy actors in health sector reforms in Thailand shows that the policy formation processes can only be successful when there is critical support from policy actors in the system. These types of studies describe the environmental and contextual factors that affect policy processes and its health outcomes (Walt, 1994). Although health policy analysis can be used to increase our knowledge of the complexity of the health policy process as a tool, it has remained underdeveloped and subsequently has limited application in LMIC (Gilson and Raphaely, 2008).

Helps to Understand the Role of Power and Politics in the Policy Process

There are many ways in which people can participate in the policy process and therefore influence governments to promote the policies that they want. Power can often be seen to be only in the hands of a few (Walt, 1994) and policy can often be decided by a small group of elites within government or outside of government. Health policy analysis can assist policy makers to:

- Better understand the influence of power relations, institutions (the rules, laws, norms and customs that shape human behaviour) and ideas (arguments and evidence), over health system operations and policy change within them

- It can also help us to better understand the global political economy issues that influence the policy making processes (Gilson et al., 2008).

Impact on Implementation

Health policy analysis can be used as a tool to identify the obstacles that undermine policy implementation. An important aspect of health policy analysis is that it can:

- Assist with identifying which stakeholders who will support policy reform or those who might reject it
- Assist policy makers to develop strategies to improve the prospects of a new policy change activity
- Help identify barriers to the policy implementation process
- Assist in creating a smoother pathway for policy.

2.10.1 Health Policy Analysis and Developing Countries

In many developing countries much of the international and global health agenda, such as Health for All (HFA) and Primary Health Care (PHC), initiatives have struggled to achieve their goals and targets. These initiatives have not succeeded and failure has been attributed to the lack of knowledge around factors such as health policy content, context and processes (Walt et al., 2008, Gilson et al., 2008). Over the past several decades, international agencies have tried to improve population health by merging international health programmes with national health policies. In developing countries, the policy process is different, for example, the relationships' and interaction between policy makers, decision makers, and public servants influence the implementation process and affect the way a policy is developed and implemented. Many of the traditional policy process such as the heuristic approach cannot be used to guide developing countries experiences, given that the political economic and social and cultural contexts in which the policies take place in the developed world is vastly different than in developing countries (Gilson and Raphaely, 2008).

Much of the theory from health policy analysis to date has come from high income countries and has usefully informed research in those areas; however, transferring

such concepts to developing nations needs to be undertaken with caution (Walt et al., 2008). Health policy environments in high income countries differ from those in low-income countries. Much of the learning that has emanated from studies in developed (Stone, 1998) countries are not useful in developing countries. Health policy environments in middle and high income countries also differ from those in low-income countries, where, for example, there are weaker regulations, regulatory capacity and monitoring systems, lack of purchasing power as a leverage to influence types and quality of services delivered, more patronage in political systems, and more reliance on external donor funds, among many other differences.

The importance of understanding the unique aspects and nature of health policy, in particular, for LMIC according to (Walt et al., 2008) lies in the importance of generating an understanding of the factors that influence the experience and results of policy change. Health policy analysis can inform action to strengthen future policy development and implementation. The same review further highlights that the issues of politics, process and power were necessary and essential key considerations in the study of health policies and practice of health system development (Gilson and Raphaely, 2008), an area that has according to (Walt et al., 2008) been seriously neglected. Further, there is little knowledge and experience of the issue of power and its role in developing countries in health reforms. Gilson and Raphaely's (2008) review noted that there are very few explicit or formal assessments of the practice of power and policy change in LMIC. From an implementation perspective, there is little consideration in the literature on the role of institutions, rules and laws that shape actor behaviour (Parsons, 1995).

2.10.2 Key Issues in the Literature of Health Policy Analysis

Up to 1990, much of the literature on the topic of health policy analysis has been framed around the traditional policy frameworks that have been couched in both rationalist and behaviourists' models of analysis. Traditionally, health policy analysis has been located in the area of technical and economic analysis and centred on industrialised and advanced economies. Prior to 1990, the majority of health policy literature focuses on the policy process that emanated from the theoretical frameworks of the rationalist approach to policy analysis (Buse, 2008).

This has now been highlighted as a problem as those models have not necessarily been helpful in understanding what and why health policies succeed in being implemented in the developing countries. As noted earlier, these frameworks have not taken account of some more complex elements such as processes, power, institutions and the effect of actors on health policy, and recent research has highlighted that these concepts are necessary to understand the policy making environment. Walt and Gilson (1994) have argued that much health policy in recent years has wrongly focused on the content of policy and reform and has neglected actors involved in policy change. In the late 1990s, policy analysts recognised that current approaches to health policy and health policy analysis were not helpful in understanding or explaining the experiences of health policy analysis in developing countries. As such, new ideas emerged as demand grew to better understand 'how and why' certain policies seemed to succeed and others did not.

In 1994, Walt and Gilson developed a policy analysis framework (policy triangle) specifically for health. The framework emerged from their recognition that health policy research has focused largely on the content of policy, neglecting actors, context and process (Walt, 1994, Buse, 2008). In the development of the framework, Walt took account of both rational and behaviourism approaches as well as consideration of the context. The policy triangle is grounded in a political economy framework and has been used extensively since its development in health policy research, including the analysis of health sector reforms (Gilson and Raphaely, 2008, Considine, 1994).

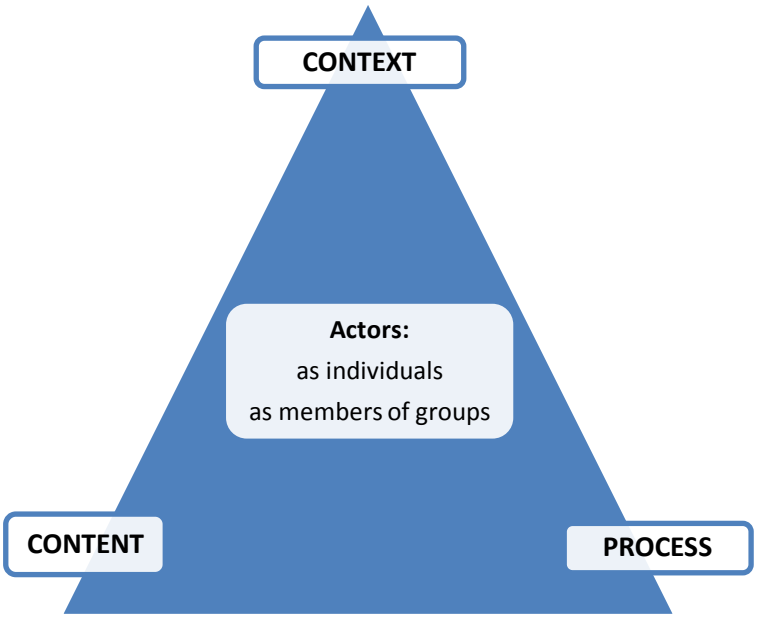


Figure 3 Model for health policy analysis **(Walt, 1994)**

Mark Considine (1994) similarly developed a generic framework for the study of public policy. It is an approach based on a combination of both behaviourist and rationalist principles called the diamond framework. This includes policy culture, actors, institutions and political economy (figure1). The methodology used to answer the research questions in this thesis is guided by Considine's framework. In developing countries, there is now much more recognition that policy processes are important in order to understand how and why policies succeed or do not. More importantly is recognising that the theories and models of Kingdon (Kingdon, 1984) and Sabatier (Sabatier, 2007) are not appropriate for developing countries. Rather, a combination of both the rationalist and the behaviourist approach is more suited to ask questions around policy implementation practices. The majority of policy analysis lessons come from developed country experiences (Gilson and Raphaely, 2008).

Gilson and Raphaely's (2008) literature review on health policy analysis shows that out of the 130 articles they reviewed five articles sought to explain or describe successes in policy outcomes, including: differences between countries examples include HIV AIDS experiences (Gauri and Lieberbman, 2006, Allen and Heald S, 2004), family planning programmes outcomes (Lee et al., 1998), equity effects such

as a the Bamako initiative (Gilson et al., 2001) and safe motherhood outcomes (Shiffman and Garces de Valle, 2006).

Studies were inductive in nature rather than deductive, and were often focused on testing a theoretical application. Many of them focused on describing what has happened in a particular setting rather than explaining 'why' it was the case. Despite the central role that health policy analysis should play, the reviewers argued that much of health policy analysis work has not been reported in the key medical journals and, given the considerable difficulties in undertaking rigorous policy analysis research; the limited knowledge of the field is understandable. It is imperative therefore for developing countries to undertake their own research so as to better understand the complexities that relate to poorer economies with limited health systems development and different epidemiology and political economy and policy infrastructure (Gilson and Raphaely, 2008).

Recent global discussions on sustainable health development, universal health coverage and equity, captures some of the learning from previous policy approaches that may assist in improving health policy outcomes (World Health Organisation, 2011). Policy analysis theorists have advocated for some years the problem of insufficient evidence in the current body of knowledge on the subject of health policy processes and implementation in LMIC (Sabatier, 2000, Walt et al., 2008). Much of the current research knowledge has been generated from higher income countries, where health policy analysis has had a much stronger and longer recognition in the academic field of practical relevance. As a result, health policy analysis research and knowledge is still in its infancy and remains an area of underdeveloped work in low and middle income settings (Buse, 2008).

The first ever review of literature analysing the health policy process of LMIC carried out by Gilson et al. (2008) highlighted that much of the knowledge and literature in this area was limited, small, fragmented and descriptive and had limited understanding of policy change processes. It noted that much of the learning stemmed from case studies dominated by authors from the northern hemisphere (Berman and Bossert, 2000, Bossert and Wodarczyk, 2000, Glassman et al., 1999,

Grindle, 2000, Klugman, 2000). The review highlighted that no studies had been undertaken in the Pacific region (Gilson and Raphaely, 2008, Gilson et al., 2008).

Analytical Weakness

There is concern about both the depth and quality of data presented and collected in studies and potential analytical weakness. Gilson (Gilson and Raphaely, 2008) note that many of the studies are a cross sectional descriptive analysis and exclude any assessment of the historical influences over experience and many of the studies fail against basic criteria of rigour, validity and authority. Gilson explains that many of the articles in their recent literature review asked what happened, but not enough explained what happened. Subsequently, they suggest this has led to a weak foundation for informing future policy action. Despite various studies, the existing body of knowledge published on health policy analysis is small with the majority analytically weak. The quality of the literature varies enormously in intellectual rigour, theoretical perspectives and descriptive accuracy (Marmor et al., 2005)

Limited Use of Policy Analysis Theory in Health Policy Studies

Very little is known about the research methods and research designs and theories that best lead to understanding how to undertake health policy analysis (Walt et al. 2008). There has been a gap in the literature on the methodological challenges for research studying health policy analysis. The lack of methodological thinking in the study of health policy analysis has created an imbalance in the literature that has traditionally focused on methods, designs and theories on how to do policy analysis and not necessarily on why we should do it. Many studies are not appropriate because the political, economic, social and cultural aspects of the policy process in the developed world are vastly different for developing nations. In developing countries, health policies need different but comprehensive approaches (Walt, 1994).

Limited Understanding of the Importance of Power

Different groups of actors have different resources and reserves of power and hence varying abilities to influence political contests (Lewis, 2005). Policy making is shaped by actors who use the resources at their disposal to have their concerns taken seriously. The power of actors and their influence opens up a whole new way of

thinking about policy analysis. Understanding how these actors use their power and shape the policy debate is key to recognising the role of power in the health policy debate (Walt and Gilson, 1994).

2.11 Conclusion

Recent health policy literature recognises that there is limited knowledge and understanding of the social, cultural and political aspects of policy systems as well as knowledge of the role of actors within the policy environment and their influence on health reform implementation and effectiveness (Considine, 2005, Lewis, 2005, Walt and Gilson, 1994). They have suggested that this limited knowledge base now poses serious problems for health reformists and health reform research. Subsequently, the call for health policy analysis is becoming more important and reformists are beginning to recognise the need for more research in areas such as the role and influence on implementation of stakeholders and policy actors, power and institutions in the policy areas that have not been well considered by policy analysts (Gilson and Raphaely, 2008).

The existing body of knowledge in the area of health policy analysis is largely inadequate and currently does not sufficiently help policy practitioners better understand the key challenges and issues that relate to improving health policy implementation in LMIC. Recognition that the majority of current studies focuses on content rather than process and therefore the importance of building a greater knowledge in this area relates to integrating concerns regarding politics process, power and analysis into the study of health policy. The study of health reform implementation and its success requires an understanding of the factors that affect policy. This study looks at the health reform experience of the Fiji health system during 1999 to 2004. The following chapter describes the methodology of the study.

Chapter 3: Methodology

3.0 Introduction

This chapter introduces the case study methodology and the theoretical framework that was used to the guide the study. The methods used to collect, manage and analyse the data are described and discussed. The criteria used in the study and the ethical considerations of the study are also outlined.

3.1 Case Study Methodology

A case study is an empirical inquiry that investigates a contemporary phenomenon within its real life context; it is a method that is useful especially when the boundaries between the phenomenon and context are not clearly evident (Patton (Patton, 1990). Case study is a research methodology that comprises covering logic of design, data collection techniques and specific approaches to data analysis (Yin, 2012a).

Until the 1990s, approaches to health policy analysis were entrenched in economic and rationalist approaches to health policy development theory (Reich, 1995a, Walt et al., 2008). Health policy analysts recognised that this type of approach and analysis could not explain how and why certain policies succeeded and others failed, nor did it assist policy makers and mangers to make strategic decisions about future policies and their implementation. Gilson and Raphaely (2008) suggest that this traditional approach has led to a weak foundation for informing policy action.

A literature review by Gilson and Raphaely (2008) highlighted several key concerns relating to the quality of health policy analysis studies in recent years. First, the authors suggest that many of the studies lacked real methodological rigor, meaning there was poor analysis of data. They further suggest that many of the studies also lacked a strong explanatory focus in the research, meaning that research focused on answering what happened rather than why. They also note that much of the literature and the studies in health policy analysis lacked use of health policy analysis frameworks and policy analysis theory. Fourth and most importantly, analytical weakness within the studies was concerning.

Gilson and Raphaely (2008) concluded that the policy analysis field would benefit from more reflection on the use of different research approaches, in particular, *case study methodology*, which would enable a depth of data as well as the rich historical analysis of country experiences that has been lacking in current studies. Further case study methodology would enable the use of theoretical frameworks and allow for the assessment of both historical political and policy as well as systems knowledge. The authors note that many of the studies undertaken in this area did not demonstrate clarity or describe analytical approaches and commentary on how they added to the existing empirical evidence base. These issues accordingly have led to a weak foundation for informing future policy action. A case study approach allows the researcher to find answers to questions in the area of decision making, in particular, a case study illuminates why particular decisions were made and why they were taken and how they were implemented (Schramm, 1971). This is the essence of case study and one of the one of the reasons why case study was selected as the preferred methodology for this project.

3.2 The Fiji Case

The Fiji health management reforms 1999 to 2004, is an intrinsic case study and is bounded by that period. Intrinsic case study according to Stake (Stake, 2006, Stake, 1995) is undertaken because first and last the researcher wants a better understanding of the particular case, not because the case represents other cases or because it illustrates a particular problem, but rather because in all its particularity and ordinariness, this case is itself of interest. Yin affirms (Yin, 2012a, Yin, 2009) that case study research is appropriate when studying process, and suggests that when process issues are involved together with multiple sources of evidence, case studies offer a holistic perspective allowing for a fuller exploration of the issues in question. A case study design in this instance has been used to gain an in depth understanding of the situation and meaning for those involved. The interest has been in the process rather than in the outcomes in the context, or a specific variable (Yin, 2012b, Stake, 1992).

3.3 Theoretical Framework used for the study

Yin (2004) highlights the importance and necessity of developing a theoretical framework within case study research. This is congruent with Gilson (Gilson and Raphaely, 2008), who suggest that policy analysis research needs to be underpinned by a theoretical framework. Case study methodology is more effective if the research design includes a specification of the data to be obtained from the case and can be integrated with the key design tasks (George and Bennett, 2005). Further, without a theoretical framework all these choices can be difficult and hamper the development of a rigorous case study (Yin 2009, p 223). Without a theoretical framework, the case study researchers are in severe danger of providing description without wider meaning. Considine's (1994) diamond public policy framework has guided the design of this study's data collection and its analysis.

After an assessment of other key policy frameworks such as Walt and Gilson's (1994) diamond framework, which captures the broader contextual and process issues of policy analysis, Kingdon's (1984) agenda setting framework, as well as the stakeholder holder analysis framework by Varvasovszky (Varvasovszky and Brugha, 2000), Considine's (1994) framework was found best suited to guide the study. Considine's public policy diamond was chosen because of its broader perspective on the use of culture and cultural issues related to policy. Walt and Gilson's framework would not sufficiently capture some of what Duncan (2011) calls the Pacific's '**below the iceberg' factors**, such as beliefs, culture and values; power, authority and social patterns and relationship (Duncan, 2011).

Considine's framework was utilised to study the policy reform experience in Fiji and is shown in Figure 1. The framework was used to develop the theoretical proposition and to guide and determine the priorities of the data collection and analysis process. The key areas that guided the study were Fiji's policy culture, institutions, actors and the political economy of Fiji's health system.

1. **Policy Culture** is defined as the value or the emotional environment that existed within the policy system. An analysis of the culture of the policy system that existed in Fiji during the reforms is important as it becomes a means to examine shifting and contesting patterns of belief and definitions

about what was valuable to those engaged in the policy making process (Considine, 2005). The concept of culture was further extended in this project to include an analysis of issues that related to Fijian culture and traditional power.

2. Policy has always been seen as an **expression of governmental authority** and traditionally it has always been defined by key politicians and bureaucrats who had command of the institutions. Considine (Considine, 1994) however, describes policy makers as any individual group or institution who are able to take action on a public problem or issue. An analysis of policy actors from within a policy process is important as it helped identify who and how the policy processes were influenced.

3. **Public policy** is the achievement of actors making use of institutions and being shaped by them (Considine, 1994). Policy institutions refer to the machinery of government as well as other institutions, which control the authority and resources needed to initiate and sustain policy. These institutions not only impose constraints on policy systems, they also lay down pathways for action and send signals to actors about how to move forward. Understanding the behaviour and influence of policy institutions in the policy making process highlights how institutions can control and influence the policy design and implementation (Morone, 1994).

4. All policy systems have been defined by a **Particular Political Economy**, which has been inherited from the past. The political economy of a system has been defined as the relationships between the many actors within the policy system (Considine, 1994). These relationships included the way the policy institutions, communities, networks and individuals inter-related. The concept of political economy further draws attention to the importance of the use of labour and resources and their importance in the reform planning process.

3.4 Research Methods

Four qualitative methods to study Fiji's reform implementation experience included document and archival collection and in depth interviews and focus groups. The three sites, Suva, Lautoka and Labasa, were the locations where interviews and focus groups were completed. All data collected via documentation collections, interview and focus groups were transcribed and triangulated together**.** Figure 4 summarises how the methods were used.

Objective	
A	To investigate the role of the key stakeholders, their relationships and the extent of their influence in shaping the development and implementation of the Fiji Health Management Reform Project
B	To analyse the role of the various policy institutions and their influence on the reform implementation process
C	To investigate the role and nature of the political, economic and social environment and its influence in shaping the design and implementation of the reforms
D	To determine the importance and role of culture and values in the development of policy during the reform process
E	To identify the process of implementation of the reforms

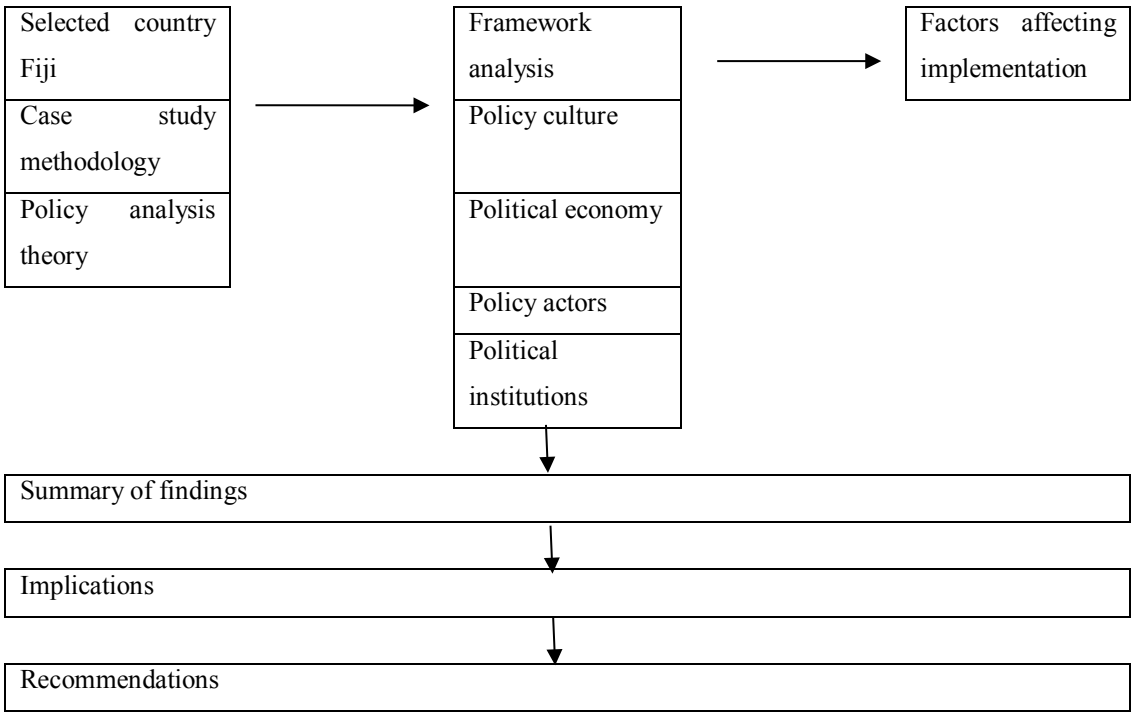


Figure 4 Overview of research methods

3.5 Stages of the Research

There were 10 stages identified as part of the case study approach:

1. Development of a case study database
2. Document analysis (preliminary background reading)
3. Key informant interviews
4. Development of case study protocol
5. Data collection preparation
6. Data sources
    a. Data sources 1
    b. Data sources 2
    c. Data sources 3
7. Data management and analysis
8. Analysis
9. Quality criteria
10. Reflexivity.

3.5.1 Stage 1: Establishment of Case Study Database

The establishment of a case study database was important for two reasons. First, within case study research the distinction between a separate collection of information and the case study is important so that the case study report and the critical reader would be able to have a sense of recourse, should they want to inspect the raw data that led to the case study's conclusions. Second, the case study database allowed the researcher to return to various points in the study and track the process of decision making as well as having the ability to return to various points in the study. This process adds another level of reliability to the entire case (Yin, 2012a, Yin, 2009). The development of the database ultimately allowed me to organise all my field notes, data from interviews, draft reports, documents and diary, and I was able to track my decision making points. The collection of data within the case study database enabled me to draw on critical findings that added to the case study's conclusions.

3.5.2 Stage 2: Preliminary Document Analysis

Becoming familiar with the background and context of a case is essential. Yin (Yin, 2012a, Yin, 2009) highlights the importance of understanding the theoretical and policy issues prior to commencing a study so that analytical judgments can be made throughout the data collection phase. Yin has suggested that without a firm grasp of the issues, one can easily miss important clues and would not know when a deviation was acceptable or even desirable. A preliminary document analysis and key informant interviews made up the two background activities necessary for me to become more directly familiar with the context and policy issues of the case.

An initial analysis of key planning documents and reports that were prepared by the Australian government (AusAID) and the consultants contracted to plan, design and implement the reforms (AusHealth) were analysed. This preliminary assessment of information was useful in identifying the boundaries of the case (i.e., the time frames in which particular activities took place), and the development of a preliminary set of issues that emerged from the documents. The reports that were identified for this exercise were '**milestone reports**' and were written by the reformists at the various points that implementation of the project were analysed. From these reports emerged a preliminary list of key issues that contributed to the key thematic areas for the structured interviews. Further, from this process I was able to identify key stakeholders and actors in the reform process.

3.5.3 Stage 3: Key Informant Interviews

The first seven interviews carried out were key informant interviews for the sole purpose of gathering information and background from a contextual view point. Key informants came from the Office of the Prime Minister, an ex-Minister of Health, a senior manager from the department of planning and a senior official from the Public Service Commission, two NGO community leaders and the first AusHealth project manager of the project. The results of these interviews added further to the development and refinement of the case study protocol and themes, which guided the questions and topics used in the open-ended interviews.

3.5.4 Stage 4: Development of Case Study Protocol

The development of a case study protocol is seen as essential in case study methodology (Yin 2009, p 224). It assists in increasing the reliability of the case study design and is intended to assist the investigator in carrying out the data collection. As part of my preparation for the data collection phase of the project, I completed four tasks: 1) An analysis of key documents; 2) A series of key informant interviews; 3) The development of a case study protocol; and 4) The establishment of a case study database, which held all the key documentation. All of these approaches are recommend by Yin (2009, 2012) as part of the training required for case study researchers. These activities further assisted in enabling me to become familiar with key issues in the project and identify further case informants (Yin 2009, p. 224). Yin cautions against the lack of preparation in case studies and notes that if it is not done well it can jeopardise the entire case.

The development of a case study protocol after the completion of the document analysis and key informant interviews enabled me to develop a set of key themes, issues and questions that were important to the study. The protocol enabled me to keep track of issues and assisted me to think through how I would manage other sources of data as well as ideas for arranging the data. More importantly, the protocol allowed me think through the structure of the case study report early on in the data collection process and helped me to clarify my theoretical framework prior to commencing the data collection process. What emerged from the design of the protocol was a timeline of key events and decisions that I used as part of my interview process to jog the memory of interviewees and to confirm events and decision activities. The protocol also included my introductory and background information to the study as well as the ethics permission documentation. I used this daily during the interview period to guide my actions and behaviour.

3.5.5 Stage 5: Data Collection

Case study is not merely a matter of recording data in a mechanical fashion. One must be able to interpret the information as it is being collated and to know immediately for instance if several sources of information contradict one another and lead to a need for additional source of evidence (Yin 2009, p 224). Three qualitative

data collection methods were utilised: document and archival analysis, in depth interviews and focus groups.

3.5.6 Stage 6(a): Data Source 1 (Document and Archival Documentation)

Archival Data

Archival data is defined as taking the form of computer files and records, service records, organisational records, maps, charts, survey data and personal records such as diaries (Yin, 2012). The collection of archival records from MOH, the Public Service Commission, the Fiji Government Archives, WHO and the Fiji National University (previously known as the Fiji School of Medicine) relevant to the case commenced early in the study and was a major source of the background information. Archival data was identified based on a study of the documents from AusAID and AusHealth and the MOH over the period 1998 to 2005. From this, a systematic search for documents important to the study was undertaken in these three databases. An initial review of all the documents held in the databases enabled me to collect and copy documents that related to the establishment, development and implementation of the project. Most of the archival records were produced for a specific purpose and a specific audience and these conditions were taken into account when interpreting the usefulness of the archival records.

Documents

Documentary information is defined as including letters, memos, minutes of meetings, written reports and agendas(Yin, 2012) It. Key reports written by the contract Australian consulting company Aus Health were accessed with permission and forwarded to me by their senior office staff. Other key documentation included Fiji government documents, interim reports on progress, legislative reports, memos, newspapers articles, academic reports and archival documents from the government archives library. The majority of this information was already in the public domain and approval was given for the information to be used as background information only.

Permission was given by AusAID to collect all relevant information relative to the project and this enabled me to access specific project information from both Suva

and Canberra AusAID offices. A number of senior health officials within the health sector also lent me key reports that they had kept in their personal filing system. These proved to be invaluable and not available on the public databases. The WHO Pacific regional office library identified further historical documents relative to the project and these were made available and copied for me .

Assessment of Archival and Documentary Evidence

The collection and assessment of documentary evidence was carefully collated. As many of the documents and reports analysed were written and designed for specific communication, it was important to take account of possible bias in the documents. Many of the reports were written by consultants as part of their reporting, and other reports were reviews of activities by monitoring and audit teams. I used a framework to assess the meaning and evidentiary worth of the documents and reports to help me interpret the meaning and significance of what was written (George and Bennett, 2005). As part of this process, it was necessary to consider who was speaking in the reports, to whom and for what purpose and under what circumstances when assessing the evidence.

The bulk of the documentary evidence retrieved were reports written for the funder of the project and were designed to provide information related to budgetary and contractual requirements of the project. Determining the usefulness and validity and accuracy of the documents was part of the research process. The AusHealth milestone reports proved most useful and were used to corroborate and augment evidence from other sources (Yin 2009). Various interviewees mentioned articles and reports during their interviews and the corroboration of events and issues were substantiated in this process.

Yin (Yin, 2012a), however, does caution against the extensive use and over reliance of documents and reports and suggests that they should not be accepted as literal recordings of events that have taken place but are useful and give a study broad coverage. The usefulness of the reports lay in the extraction of specific facts and events that related to the reform policy planning, development and implementation process. They assisted me to develop an understanding of the many issues that

related to the wider contextual nature of the reforms (Merriam, 1988). Documentary evidence further gave richness to the analysis of the data collected from the interviews.

3.5.7 Stage 6(b): Data Source 2 (Open-ended Individual Interviews with Three Groups)

Interviews: Informal and In Depth

Interviews were essentially the main source and arguably the primary data source for this explanatory case study. It is through the interviews that the researchers can best access case participants' views and interpretations of actions and events. Interviewing is a research method that allows one to explore what is in and on someone else's mind, to access the perspective of the person being interviewed and to find out from them those things we cannot directly observe (Patton, 1990).

Good interviews are those that provide an opportunity for respondents to tell their stories and allow the participants to share their feelings, thoughts, knowledge and experiences (Patton, 1990). I used a semi-structured interview process to accommodate a flexible approach to the interviews, which provided me with a wider scope to probe responses. I used the case study protocol to ensure that key topics were discussed with all interviewees, though none of the themes or issues were investigated in the same order or in the same depth. I relied on generating a sense of spontaneity, which helped to bring about a natural flow of interaction between myself and the respondent.

Forty days was allocated to all the interviews and the three focus groups over a period of two months. This spread allowed for unexpected cancellations, postponements and other possible interferences and delays. I completed one interview per day, allowing me ample time for each interview as well as time to write up my notes directly after the interview and to listen to my interview recording, ensuring it was audible and that interview notes were clear. This process helped ensure my data was as near to accurate as possible (Patton, 1990). It also allowed me adjust the style of my questions if I needed and identify emergent themes.

Interviews were conducted in English and recorded and transcribed by me. English is the language of the public service in Fiji and was the comfortable choice of most of the respondents. Further, Fijian was not the native language of all of respondents and my Fijian vernacular was not good enough in formal situations.

Where respondents did use Fijian language to describe something, I would translate their meanings in English during the interview to ensure that I had interpreted what they were attempting to convey correctly. Interviews commenced with ensuring that the consent forms were completed and that the respondent was clear on their rights during the interview process. Signatory consent required in depth explanations to most interviewees as I needed to repeat explanations regarding the privacy and confidentiality of the research consistently. Given the sensitivities in the political environment in Fiji at the time of the study, this was to be expected and anticipated. All interviews allowed for small talk and banter, this made for a more relaxed setting, including the appropriate protocol and engagement of '**cultural jibing**' that is acceptable among Indigenous Fijians of different tribal affiliations (Nayackalou, 1975).

Depending on whom the interviewee was, and his or her role in the health sector or wider community, their status and title, the meeting would commence with recognition of their position and the importance of their contribution to the study. If the individual was connected to me via traditional or mutual clan affiliation, this was also recognised and affirmed at this point.

In cultural settings such as this, it was important for me to prepare well by gathering information on the potential interviewee and their cultural background so that I could locate my traditional place and status in relation to theirs prior to exchange of information. This ensured the balance of power and position in a situation particularly when it was necessary to interview senior politicians who held traditional chiefly titles. Ensuring the cultural protocols were complete and assessing the appropriateness of when it was acceptable to start the interview was a necessary action and showed respect to the interviewee so that they felt that interviews were not hurried and they themselves were important as individuals not just what they

could contribute to the study. A significant amount of time and emphasis was taken prior to the conducting of some of the interviews to ensure comfort and protocol safety was necessary with some respondents. For some interviews the exchange formal greetings and acknowledgment of clan histories and place often took up to forty minutes before the start of an interview.

The concept of cultural respect meant that priorities were different when talking to both Indigenous and non-Indigenous Fijians. Often, when speaking to male Indigenous Fijians, I was more restrained and less informal. Interviews with Indigenous Fijian women were less restrictive and more informal. The concept of 'Fiji time', meaning that life is taken at a very leisurely pace, further allowed for many of the interview times to be changed at short notice or interview appointments never started on time nor did they finish on time. All interviews included refreshments, which I provided whether in the respondent's home or their office place. Refreshments were recognized as a *sevusevu*[4] (welcoming gift) (Ravuvu, 1987).

Identification of Informants for Interviews

There were 39 separate individual in depth interviews, five focus groups and seven key informant interviews. In total, the project had 70 informants. The following table identifies the stakeholders, the number of interviews, data collection method and category of the respondent (Yin, 2012a, Yin, 2009).

4 *Sevusevu* is a traditional welcoming ceremony and normally would include the presentation and drinking of Kava and gifts

Table 4 *Categories, Numbers and Methodology of Key Stakeholders Interviewed* (data collected from October 2007 to March 2008)

Stakeholder	Number of Units	Category	Data Collection Method
Senior MOH officials	10	Planners and implementers	In depth
	3	Implementers	Focus group
	3	Implementers	Focus group
Australian reform consultants	4	Planners and implementers	In depth
Senior public sector officials	5	Implementers	In depth
Ex-ministers of health	2	Planners	In depth
Donors	3	Planners	In depth
Academic institutions	3	Observers	In depth
Nurses	4 (Central)	Implementers	In depth
	4 (Lautoka)	Implementers	Focus group
	4 (East)	Implementers	Focus group
Doctors	6	Implementers/ Observers	In depth
Health managers	11	Implementers	In depth
Professional associations	2	Observers	In depth

Unions	2	Observers	In depth
Traditional leaders	2	Observers	In depth
NGO	2	Observers	In depth
Ex-politicians	1	Observers	In depth

Identification of participants for interviews came via two processes. One was through the analysis of reports and documentation, where individuals were identified as part of their roles and tasks in the reform process. Second, there was personal referral of senior policy staff within the MOH who had knowledge of individuals and their involvement in the reforms. Respondents who were interviewed from NGOs, academic institutions and professional associations came from referrals from my Fiji-based supervisor and from colleagues of mine located in various sectors of the community. Other respondents included public health officials, health managers, public servants, ministers of government, traditional leaders and ex-politicians. In identifying key public servants for the interviews, I was mindful to not only interview officials who were 'high in the hierarchy' of policy making or had 'too close' an involvement in the reform process, but purposefully selected a cross-section to obtain multiple views at several levels.

I recognised throughout the process that often it is the lower level officials who have worked on everyday issues who often have stronger recollections of how policy was decided than senior officials who actually made the decisions. High level policy makers are often only focused on the issues in question and only intermittently, and subsequently do not often have the full and wide range of knowledge of many of the middle managers who were interviewed. Further, given that middle managers and officials did not have complete accounts of what happened, it was important to interview other policy actors in the system who often had different views from those who were intimately involved in the process.

A review of the information and my own knowledge of the case enabled me to gauge the point of saturation where I felt that I had collected and explored a wider range of experiences by those involved in the reforms to meet my research objectives, at which point I stopped collecting interview data. Saturation can be dictated by issues such as project design sample size and therefore saturation might be achieved earlier or later depending on these factors . Given the time limitations of the study and availability of many of the participants, I did not have the luxury of funded research or an open ended amount of time. Ensuring that I had sufficient data and that I felt I have exhausted all avenues of information possibilities (Morse, 1994). The point of saturation was difficult to identify (Charmaz, 2006). However, it is important and necessary according to Yin (2012) for the researcher to make judgments about continued data collection; it depends mostly on the level of new knowledge that emerges from on-going interviews, which are relevant to the case. Three groups of interviewees were identified as potentially those who would provide the most information on the case.

Group 1 (Planners)

Individuals in this category were those who had been identified in the various reports studied as part of the documentary evidence process. They were identified by their role in the project and specifically by their involvement in the pre-planning work, development, design and negotiation of the reforms. Stakeholders included Aus AID, Aus Health, MOH officials and WHO. These groups were specifically involved at the front end of the reforms and their stories reflected the early stages of the development of policy work.

Group 2 (Implementers)

These were identified stakeholders from within the MOH and the broader public reform process (policy managers). Respondents included health leaders inside the MOH, health managers and ministers of government, and senior public servants from within the MOH. Officials of the Public Service Commission, the Ministry of Finance, Prime Minister and Cabinet's Office, representatives of other public sector agencies and AusHealth consultants were also included. This group reflected experiences on the implementation management aspects of the reform policy.

Group 3 (External Observers)

Open-ended interviews were held with a series of individuals who represented organisations and institutions within the health sector but not directly or intimately involved in the planning or implementation of the reforms. Informants included organisations such as industrial unions, academic institutions, traditional Indigenous chiefs and leaders and community leaders, health sector representatives outside of the MOH and international NGOs. Information gleaned from this group added to the wider contextual knowledge of the reforms and provided a perspective on implementation issues outside of the policy process.

3.5.8 Stage 6(c): Data Source 3 (Focus Groups with Reform Implementers)

Focus Groups

The focus group approach has been defined as 'group discussions organised to explore a specific set of issues' (Kitzinger, 1994). According to McDaniel and Bach (McDaniel R and Bach, 1996), such discussion takes place in a social setting moderated by a group leader, so as to generate descriptive or explanatory information. Other researchers simply refer to it as a process of group interaction that serves to generate data for analysis (Stewart and Shamdassani, 1990, Patton, 1990). Patton (1990) further states that the focus group is an interview and not a discussion nor a problem solving session. He suggests that groups can be used to examine what people think, how they think, why they think in specific ways and their understandings and priorities in a given subject area.

The focus group approach was used to interview health workers in three sub-divisional hospitals who were involved in the implementation of the health reforms. Four focus groups were completed. Each was separated by gender and profession to allow a much more open and culturally safer and intimate sharing of information to take place. Gender separation mostly related to doctors (males) and nurses (females) and minimising power and gender cultural issues within the interviews. The purpose of using the focus group approach in this study was to explore a specific set of issues (Kitzinger, 1994). The smallest group numbered 7 participants and the largest group numbered 12 participants. Mixed focus groups were considered in particular mixing

both doctors and nurses group together as it was recognized that the different and dynamic discussions between both groups would have produced valuable dialogue.

The interview structure and format used allowed for contentious (Lincoln and Guba, 1985) issues raised to be more fully examined. More importantly, it allowed for members of the group to express what they thought and why they thought it more freely. This was consistent with fundamental qualitative research assumptions that advocate the insider's standpoint or 'emic' perspective. On reflection, I felt that the focus group interviews drew me into the issues with a bit more intensity than the individual interviews and I found myself much closer to research topic and better understood the issues of the actors involved (Clarke, 1999, Buse, 2008)).

In particular, I found that fuller explanations of sensitive issues were easier for participants than in the individual interviews. Hence, the most important aspect of the focus group exercises was the ability of respondents to validate issues that arose from the interaction of the members within the focus group. Often a member of the group would raise an issue of sensitivity and immediately other members would support or comment on the issue. This type of validation as expressed by Stewart and Shamdassani (1990) would not have been possible to ascertain in face to face interviews.

Planning the Focus Groups

The organisation of focus groups was the most challenging aspect of the data collection activities. In each sub-divisional hospital it was intended that two focus groups would be conducted. This did not eventuate as coordinating health workers in their workplace proved too difficult. Focus groups that were planned in Suva were much easier to organise than the other two sub-divisional hospitals. I had preliminary conversations with all the focus group participants prior to inviting them to gauge whether they were able to make a contribution to the case. I asked questions about their role, tasks and their comfort to participate in the group. It was also at this stage that time and dates were negotiated and confirmed verbally.

It was important to have focus groups take place during their time of work as outside working hours was not appropriate, as most interviewees saw this exercise as related to work and therefore not a conversation to have outside of the work place. In all three hospitals, all those who were invited attended. Adopting a strategy of over recruiting for the focus groups proved useful as not everyone who was invited attended. Stewart and Shamdassani (1990) highlight the merits of over-recruiting to focus groups, suggesting that it is likely that at least two potential participants will not turn up, subsequently it pays to over invite. This strategy was adopted in recruiting participants for the subsequent groups.

Conducting the Focus Group

Focus group participants were provided with written material on the aims and objectives of the study. In order to maximise the accuracy of the data, the discussions were tape recorded. I recruited a student researcher to assist with note taking and the operation of the recorder and gave the assistant both ethical and translation guidelines and training for this exercise. Both these tactics had the effect of enhancing the validity of the data analysis (Patton 1990, p. 171). All participants gave consent to this method of recording interviews. At the outset, it was necessary to ensure that all participants felt welcome and comfortable.

Having explained the purpose of the focus group, I then reassured them all that their involvement would not adversely affect their work and that all their responses would remain confidential to the study. While each group began with general questions, I was able to probe further with more specific questions until all respondents got an opportunity to express their views. The sessions ended with a summary of the discussion and seeking verification from all the participants on the issues discussed. In particular, the focus group processes resulted in a consideration of the many voices of those who were involved at the forefront of the reform process.

3.5.9 Stage 7: Data Management and Analysis

Case study documents were collected prior to the field work and throughout the duration of the study. This resulted in a large collection of documents. All documents were registered in Endnote® and categorised as primary reports or secondary reports

depending on their usefulness. The purpose of this process was to make documents readily retrievable for later perusal. In instances where the documents had been relevant to specific interviews, the documents and interview were cross-referenced so that the interview notes cited the document.

The creation of a case study database assisted me to keep information collated and orderly and allowed ease of referencing to support the evidence of the study. At the end of the project, the case study database had 147 entries, these included reports, memos, letters, emails, cabinet memos, AusAID reports, AusHealth reports and both Australian and Fijian government official documents.

Narratives as Evidence

(Carter, 1993, Buse, 2008) calls for letting the case 'tell its own story'. This study highlighted the importance of storytelling as personal experiences were important to the emergence of themes and issues that were relevant to the completeness of the case study. The data therefore was in the form of the participant's own words, including direct citations from documents and added to the evidence and support of the findings of this study. Storytelling in the interviews provided a way of capturing the respondent's view of how things happened and what they experienced. This provided a much more real understanding not only for the respondents but also for the researcher. The data from the interviewees were used to support the themes and ideas that had emerged from the document and archival analysis process (Lincoln and Guba, 1985).

Note Taking as Evidence

Most interviews took longer than 1.5 hours. All interviews were recorded. During the interview, substantial notes were taken to ensure I captured what Patton (1990) calls 'tracking of key phrases, major points, key terms or words in quotation that capture the interviewees own language'. The notes took on a variety of forms but mostly were handwritten and then typed. They eventually were collated and formed part of my diary and the case study database. Entire interviews were transcribed by me, allowing for a more controlled interpretation of the interview and further allowed for double checking against my case study notes that were taken during the interview.

3.5.10 Stage 8: Analysis

The importance of analytical strategies in case study analysis is highlighted by Yin (Yin, 2012). The theoretical framework helped focus my attention on certain data and evidence. Using an inductive approach, I merged indexed and coded data together using NVIVO® (QSR International Pty Ltd, 2008). All the data (from the various sources) were triangulated to provide an in depth analysis of the FHMRP. The relationships between the four major research objectives, the instruments and the data collection strategies are shown in Figure 4 as part of the research methodology diagram.

Thematic Analysis and Interpretation

Thematic analysis is a method for identifying, analysing and reporting patterns of themes within data (Braun and Clarke, 2006). This study utilised thematic analysis. According to both Braun and Clarke (Braun and Clarke, 2006) and Attride-Stirling (Attride-Stirling, 2001), the process of thematic analysis starts when the researcher begins to notice and look for patterns of meaning and issues of potential interest in the data. As part of the analysis of the data, Braun's six steps were used to guide the analysis process. These included data familiarisation, generating codes, searching and reviewing, defining themes and explanation building (Braun and Clarke, 2006).

Familiarisation of the Data

In order to become familiar with the raw data, I read all reports, documents and archival materials numerous times. From this process emerged a preliminary list of key issues and ideas being identified. I read and re-read transcripts several times checking for accuracy against the audio recordings. This process brought another level of understanding of the data and further added to the list of key issues and ideas being identified. Interview notes and other case study background notes were also scrutinised. Becoming familiar with the raw evidence, according to Braun and Clarke (Braun and Clarke, 2006), is vital so that the researcher is familiar with the depth and breadth of the content. Further, they note that repeated readings of the data in an active way strengthens the search for meaning and patterns (Braun and Clarke, 2006). At the conclusion of the familiarisation process, more than 135 issues and ideas wereidentified that were of interest.

Generating of Initial Codes

According to Boyatzis (1988), codes identify a feature of the data that appears interesting to the researcher and refers to the most basic segment or element of the raw data or information that can be assessed in a meaningful way regarding the phenomenon. Further, the process of coding as described by Miles and Hubermann (Miles and Huberman, 1994) is part of the formal process of analysis as in order to organise data into meaningful groups. I used NVIVO®, a computer software specifically designed for qualitative research (reference), to collate and categorise my data. The software tools assisted me to explore, manage and shape the unstructured bulk of the data collected. Tools within NVIVO® included sorting, classifying, and arranging the research into categorised themes. I systematically worked through the entire data set and gave full and equal attention to each data item. Handwritten notations and the use of highlighters and coloured pens were used at this stage to identify initial themes and patterns. I used NVIVO® to collate, sort and file the codes.

Second, I moved through the entire data once again set asking specific questions that were relative and linked to Considine's (1994), framework and proceeded to code the data around four key issues (policy actors, policy culture, policy institutions and political economy). From this dual process emerged two separate types of coded data. One set that was coded for ideas and themes and another set that was cross coded with framework.

This process allowed me to code and identify as many themes and patterns as possible. It assisted me to capture potential and future issues that specifically did not relate to the theoretical framework but issues that I felt were important to the case. I coded extracts of data inclusively so as to keep a little of the surrounding data where relevant to ensure that I did not lose the context of the quotation (Bryman, 1989). Where I identified key issues that did not fit into this initial framework, these were separately coded so that I did not lose their value or possible future importance.

Search for Themes

Once all the data had been coded and collated and I had a list of codes, I began the process of identifying themes by sorting through the codes. This process focused me at the broader level of the themes rather than the codes and resulted in the identification of a range of themes, which I was now able to collate with relevant coded data extracted within the identified theme. I drew a series of maps, one for each theme, and organised the codes into themes this way using NVIVO®. This process concluded with a collection of main themes and sub-themes and all the extracts of data that were coded in relation to them. Codes that did not belong were retained separately

The case study approach allows for the investigation of information that revolves around themes. According to Braun and Clarke (Braun and Clarke, 2006), a theme captures something important about the data in relation to the research question and represents some level of patterned response or meaning with the data set. Braun and Clarke (Braun and Clarke, 2006) further suggest that a theme is not necessarily dependent on quantifiable measures but rather on whether it captures something important in relation to the overall research question. This definition was used to define and interpret the themes in this study.

Reviewing the Themes

I approached this phase in two stages. ***First***, I reviewed themes by revisiting the level of the coded extracts and decided whether they appeared to form a coherent pattern. Returning to analyse the extracts and the evidence was necessary to ensure all the themes were coherently supported by the extracts. In some instances, I found that some themes were too big and were better separated and, in other instances, it became evident that some themes were not themes at all as there was insufficient data to support them. There were a range of themes that did not fit and the extracts that supported them better supported other themes.

The ***second*** stage in this process of review and as suggested by Braun and Clarke (2006) was the consideration of the validity of all the individual themes in relation to the data set. For this process, I re-read the entire set for two purposes. First, to

ascertain whether the themes worked in relation to the data set and second to code any additional data within themes that I had missed in earlier coding stages. According to Braun and Clarke (2006), this is necessary as the need for re-coding is an ongoing organic process. As part of this process, I laid out all the themes on a whiteboard and attached to them the coded data that supported the theme. This process was helpful as it helped refine the themes further and I was able to visually see all of my data quickly. This process concluded with a thematic map of my data and 25 themes were identified at this stage.

Defining and Naming the Themes

The next stage in this process as suggested by Braun and Clarke (2006) is necessary to ensure the final themes are refined. At this point, I returned to the collated data extracts and systematically checked the themes and the data for internal consistency, further ensuring that my themes were true to the data and what I was interpreting as evidence. Returning to the collated data extracts was necessary to ensure the themes were internally consistent with the result theme. This process also required me to identify what was of interest about them and why.

For each theme I ended up with the identified theme and an accompanying narrative, a process made easy by NVIVO®. I then wrote a detailed analysis of the theme and how it linked to the greater aspect of the analysis and the broader story in the data in relation to the key objectives of the research. As I moved through this process, it naturally progressed into a process of refinement and I was able to identify further sub-themes that warranted further analysis, which added to the development of the structure of the story. This process was completed with the identification 16 key themes that related to the research objectives.

3.5.11 Stage 9: Quality Criteria in the Study

Tests to establish the validity and reliability of qualitative data are important to determine the stability and quality of the data obtained. However, there is no single, coherent set of validity and reliability tests for each research phase in case study methodology (Andreas M. Riege, 2003). The approach taken in this study enables the examination of various criteria for judging the quality of the method and it allows

for the highlighting of various techniques which can be used to address objectivity and rigor relevant for the case study. Using standard measures of validity I have also included for other measures such as credibility and authenticity.

Case study research is difficult because the rigor of the process used to arrive at the results and the validity of the findings and the conclusions reached need to be established (Yin 2009). Four tests have been commonly used to establish the quality of any empirical social research and as case studies are one form of such research, the four tests are also relevant for this project (Judd et al., 1991). I used the following case study methods to ensure rigor in the study (Table 5).

Table 5 *Case Study Methods to Ensure Rigour of the Study*

Tests	**Case Study Methodology Practices**	**Research Phase**	**Methods**
Construct validity	Use of multiple sources of evidence	Data collection	Archival, historical documents, reports, interviews, focus groups
	Establish a chain of evidence	Data collection	Timeline development, case study diary
Internal validity	Explanation building	Data analysis	Peer briefing with supervisor
	Feedback workshops	Data analysis	Delivery of two workshops to respondents in the study
External validity	Use of theory research in single case study	Design phase	Health policy analysis theory
Reliability	Use of case study protocol	Data collection	Design of study protocol part of preparation of data collection
	Develop case study database	Data collection	

Construct Validity

Construct validity as defined by (Judd et al., 1991) asserts the necessity of establishing correct operational measures for the concept being studied. In this study, two different methods were utilised to ensure that the study captured data that related

to the objectives of the study. The ***first*** was the use of multiple sources of evidence, which allowed for convergent lines of inquiry, which as described earlier is a process of triangulation. Various sources of data allowed for testing and confirmation of ideas from various sources not a single source. This approach allowed for a stronger validation of the data. The ***second*** method used was the collation of evidence (chain of evidence). This included timelines, historical evidence and recording and filing of reports and use of the case study database. The maintenance of a chain of evidence enabled for an identified pathway from the case study questions, to the case study protocol, to citations in the evidence through to the database and the eventual writing of the report. The collection of case notes, interview evidence and other factual elements would enable an observer to trace the process of evidence (Yin, 2009, Yin, 2012a).

Internal Validity

Guba and Lincoln (Lincoln and Guba, 1985) and Klenke (Klenke, 2008) used the concept of 'credibility' of internal validity and described it as an attempt to establish the match between the constructed realities of respondents and those realities as represented by the researcher. Patton asserts that validity is replaced by authenticity and credibility and that the ultimate test of a report is the response of the information users and readers to that report. In order to ensure the validity and authenticity of my work, two techniques were used. First, I undertook a peer debriefing with my supervisor and colleagues who worked in the Fiji health sector. Peer debriefing is recommended by Guba and Lincoln (1989) as an important strategy to enhance credibility. I was mindful that there were many instances where I inferred that particular decisions were made or I assumed that a particular result could be directly the result from some earlier occurrence based on interview or documentary evidence.

Peer briefing allowed me to account for these assumptions and gave my data a level of protection from my own self-assumptions. These threats to validity were treated in the study by the process of explanation building. Critical insights established during the analysis phase of the study particular in areas such as public policy processes and health policy analysis were tested in this manner. This process enabled me to stipulate a set of causal links and make initial theoretical statements or propositions

about health policy and Fiji. What eventuated was a gradual building of explanations and the refining of ideas (Yin 2009, p 230). As I became more confident with theoretical statements, these were tested by my supervisors and with my peers.

A second test of internal validity was the hosting of report back workshops, which were used to gain feedback from those who were involved in the focus groups and the individual interviews. This process allowed for critique and discussion between myself and interviewees and resulted in the emergence of other issues that added to the process of alternative explanation building. Equally important from a researcher's view, the workshops allowed for the return of the information to those who actually owned it. This is also an important element of cultural reciprocity.

External Validity

External validity is concerned with the extent to which the findings of the study can be applied to other situations or generalised beyond the immediate case study (Merriam, 1988). In traditional experimental research, researchers are interested in research situations in which a sample can be readily generalised to a larger universe. This is not the intention of case study methodology. Case studies rely on analytical and theoretical generalisation, where the researcher is striving to generalise a particular set of results to some broader theory. The theoretical proposition that led to the study of this case was based on the lack of knowledge of health policy analysis theory and limited experiences of health policy in developing countries. This proposition or gap in the knowledge has been reflected in my theoretical framework and research design and shaped how I collected my data (Yin, 2009).

Reliability

Reliability is concerned with the stability of data over time or the extent to which findings may be replicated (Merriam, 1988, Lincoln and Guba, 1985). Merriam (1988) suggests that the use of an audit trail is essential to increase reliability. An audit trail is a process that is established, trackable and documentable so that the analysis of the collected data can be confirmed (Lincoln and Guba, 1985). To ensure dependable results, the study used two tools to ensure reliability: a case study protocol and a case study database (Yin, 2012a, Yin, 2009).

Triangulation

A case study is known as a triangulated research methodology and triangulation can happen with data methodologies and theories (Patton, 1990). The concept of data triangulation is when the researcher looks for the data to remain the same in different contexts. This is also a form of assuring reliability. The use of multiple sources of evidence in case studies according to (Yin, 2009) allows an investigator to address a broader range of historical, attitudinal and behavioural issues. This is one of a case study's major strengths.

Yin (2009) argues that when process issues are involved, multiple sources of evidence and case studies offer a holistic perspective, allowing for a fuller exploration of the issues, and that the use of multiple sources of evidence far exceeds that in other research strategies such as experiments, surveys or histories. The ability for case studies to have multiple perspectives triangulated gives a study a multi-dimension of the case study experience and is an important feature of case study methodology, which was an important aspect of this project's design.

3.5.12 Stage 10: Reflexivity

My own set of beliefs and cultural values guided the way I went about the research; my cultural position affected the way I collected the data. As an indigenous Fijian woman, who has spent a significant number of years outside of Fiji, I had two challenges. First, recognising my own cultural values and the constraints that this put on the research process, and second, as an outsider to my own culture and the acceptability of validity of my personage in this process and how I conducted the interviews and my role within the interview process. Remaining in a cultural framework while carrying out interviews and while speaking and gathering information was an important aspect of the research and data collection.

During the analysis phase of the project, I was conscious that my cultural knowledge and beliefs as well as my extended knowledge of the health sector in Fiji through years of association with the system influenced some of my judgments. My knowledge of the health sector also affected the way I analysed the data. Both the

feedback workshops and the peer briefing exercises created opportunities for me to test my cultural biases and assumptions.

Positionality

As a health policy analyst and researcher it is important to state that one of the key issues facing health policy analysts is how they are viewed or situated as researchers their institutional base, and perceived legitimacy and involvement in policy communities (Walt et al., 2008). This project was personally an important and meaningful experience, and was strengthened by the opportunity provided to me to access the policy environment as both a researcher and also as a practitioner. I not only had the opportunity to conduct the research but also I was able to engage with the policy and political elites, a necessity when investigating sensitive political issues (Walt et al., 2008). I had what Merriam describes as "positionality", the ability to be both the insider and the outsider (Kobayashi, 2003).

I commenced the research as an outsider so I had the advantage of curiosity and was unfamiliar with many processes within the Fiji health systems. I was seen as neutral but understanding and safe and more importantly not aligned with any of the stakeholders. Towards the end of this study I commenced working for World Health Organization in the Pacific Regional office based in Suva Fiji. In this role I worked closely with the MoH in Fiji and was part of central MoH policy team. I shifted from an outsider to an insider and this allowed me to continue to discuss my findings and learning's and ask more meaningful questions. As the analysis progressed I was able to describe better an understanding of the reality in which the health sector operated. According to Buse and others studies that include both insiders and outsiders as members of research teams yield the richest and most comprehensive understanding of the policy process (Buse et al., 2007). The benefit of this position I would hope would allow me to deliver better and relevant policy conclusions and new theoretical and methodological understandings in the policy analysis space.

3.6 Chapter Summary

This chapter has described the theoretical framework and methodology used to answer the study's five research objectives. The chapter introduced case study

methodology and the key elements of case study research. Considine's (1994) theoretical framework was introduced and discussed and highlighted how the framework has guided the entire study. The project's research issues and the research method were introduced and discussed. Data collection techniques and the management of the data and thematic analysis were also highlighted. The importance of quality and validity in the research was discussed and the chapter concluded with introducing the concept of explanation building and how it has related to the overall development of the report, its analysis and its conclusions. The next chapter introduces country and background information on the Republic of the Fiji Islands.

Chapter 4: The Republic of Fiji's Socio-political Context in 1999

4.0 Introduction

It is now well accepted that an understanding of policy processes needs to be grounded in analysis of the context within which the policy dynamic occurs (Walt & Gilson 1994b). This chapter introduces key background information necessary to understanding the environment and context and highlights issues important to understanding the environment in Fiji up to and prior to the 1999 reforms. It has been structured in three parts.

The first part introduces Fiji and its people and provides a brief discussion on the early history and migration of the Fijian people. This discussion is important because it helps put in context the role of indigenous leadership and Fijis social structures and the importance of this in relation to the influence of Fijian culture on the reform process. Understanding Fiji's history and the formation of its political system and its colonial past helps to provide context to how Fiji has formed its political identity today, recognition of the formation of Fiji's early political institutions and the role of ethnic protectionism. Part two discusses Fiji's health system, its challenges and its problems. This discussion intends to highlight key issues that were seen as major drivers for the reform process prior to 1999. Part three discusses the Fiji health reform project and its governance structure and the role of the donor.

4.1 The Republic of Fiji

Fiji is a sub-tropical nation made up of more than 520 islands and islets and two larger volcanic islands, Viti Levu and Vanua Levu (Figure 5). The total land area of 18,343 square kilometres is scattered over 650,000 square kilometres. The country is approximately 1,700 miles north-east of Sydney, Australia, and is centrally placed among the island territories and states of the South Pacific.

Figure 5- Map of the Fiji Islands (Gravell 1979)

4.1.1 The People

There are several views on the origins of the indigenous people of Fiji. Historians have provided a variety of explanations on the arrival of Fijians based on historical, emigration and language patterns, which suggests that Fijians travelled the oceans and sea currents for thousands of years out of Africa, stopping in Asia and then eventually dispersing throughout the Pacific (Gravell, 1979).

The most common and considered ***oral traditional story*** of early migration of the Fijians is the Kaunitoni migration story ((Geraghty, 1977 p 77{Government of Fiji, 2006 #1038, Buse, 2008)}. The Kaunitoni myth describes the journey of Fijians from the Middle East through the Red Sea to Ethiopia and to settlement in Lake Tanganyika. According to this story, upheld in oral history today in Fiji, all indigenous 'Fijians are the descendants of Chief Lutunasobasoba, who led the expedition. Today, the Kaunitoni story has become intrinsically part of Fijian history and tradition (Tuwere, 2002). Anthropological authorities have suggested that people migrated into the Pacific from South-East Asia via the Indonesian islands. Polynesian, Melanesian and African blood are traceable, and there have been recent archaeological discoveries that have suggested that there have been South American influences (Gravell, 1979).

Fijians that are dark-skinned, of Melanesian origin, predominate in the western part of Fiji. However, Indigenous Fijians of the eastern islands of Fiji come from Polynesia and are mainly of Tongan descent. The 1996 Census numbered Fiji's population at 775,077, which made it the largest of all Pacific Island nations in the region excluding Papua New Guinea (Government of Fiji, 2006).

Two major ethnicities, Indigenous Fijians[5] and Indo-Fijians, make up the greater part of Fiji's population. Fiji's Indo-Fijian[6] population originally came from India between 1879 and 1916, as indentured workers for the British and all other plantation owners. During the 1960s and prior to independence in 1970, the Indo-Fijian population grew to outnumber the Indigenous Fijian population. In 1975, the Indo-Fijian population represented more than 55% of the population of Fiji. Indo-Fijians migrated from Fiji in large numbers after the first political coup in 1990, and for the first time since independence did not represent the majority population (De Vries, 2002). In 1999, Indo-Fijians represented 37.5% of the population, with Indigenous Fijians comprising 58.6% of the population. Chinese, Rotuman and other Pacific ethnicities made up the rest of the population at 3.9%.

The bulk of Fiji's population lives in urban centers, namely, Suva, Nadi, Lautoka and Labasa. Small groupings of populations mainly in villages are spread through rural areas on the two main islands, with also smaller groupings of villages scattered throughout the various small-inhabited island groups. Fiji promotes itself as a Christian nation; the majority of the Indigenous Fijians belong to Christian religious denominations with the Fiji Methodist Church being the most sizeable. The majority of the Indian population practice Hinduism, with a quarter of them followers of Islam. The official languages are Fijian and English, but Hindi is also spoken widely among both the Indigenous Fijian and Indo-Fijian population.[7]

4.1.2 Early History

Dutch navigator Abel Tasman was the first known European visitor to Fiji in 1643. Captain James Cook visited the islands in 1774(Gravell, 1979). It was not until 1789,

[5] Commonly referred to as *itaukei*
[6] More commonly now known as Fijians
[7] The 1997 Constitution of Fiji names the three main languages of Fiji as English, Hindi and Fijian

however, that the islands were charted and plotted, when William Bligh, the castaway captain of the HMS *Bounty*, passed the outer island of Ovalau and sailed between the main islands of Viti Levu and Vanua Levu en route to Batavia, in what is now Indonesia. Bligh Water, the strait between the two main islands, is named after him, and for a time, the Fiji Islands were known as the Bligh Islands(Gravell, 1979). The first Europeans to settle among the Fijians were shipwrecked sailors and runaway convicts from Australian penal colonies. In 1804, the discovery of sandalwood on the south-western coast of Vanua Levu led to an increase in the number and frequency of western trading ships visiting Fiji. The 19th-century further brought other European traders in search of *beche de mer* (sea cucumbers); other settlers arrived in search of land and the first Christian missionaries arrived in search of stray souls.

Early tribal wars and politics in the middle of the 19th century played a significant role in the establishment of Fiji's early political structures. There were tribal wars between chiefs, *Ratu* Seru Cakobau and the great Tongan chief Ma'afu, who fought over the right to rule and the domination of various geographical parts of Fiji. Years of fighting temporarily halted when Cakobau accepted Christianity and during this period of calm an agreement was reached between the chiefs to establish a confederacy of native kingdoms(Geraghty, 1977).[8]

4.1.3 Establishment of the Fijian Indigenous Administration System

Fiji was ceded to the United Kingdom on 10 October 1874. The first Governor, Sir Hercules Robinson, established a formal colonial administrative system, which carried out the day-to-day affairs of ruling the country. In addition to the colonial administrative system, a traditional system of administration was also established by the colonists to help order the affairs of the Indigenous Fijians (Figure 6).

The British, as part of their programme of colonisation, purposefully designed policy within the new infrastructure based on upholding principles of Fijian supremacy and interests over and above the interests of any other racial or ethnic group. A system of indirect rule, similar to that used by the British in India (Etherington, 1996), was

[8] The three confederacies were Burebasaga, Kubuna and Tovata

achieved by taking the existing authoritarian Fijian chiefly structures and using them as way to organise by law some of the activities of the Fijian people for their own social and political development (Nayackalou, 1975). The main institution established in this process was the Great Council of Chiefs (GCC), which provided advice on Indigenous and leadership issues to the colonial government and enabled Fijians to oversee and participate in colonisation decisions (Nayackalou, 1975)

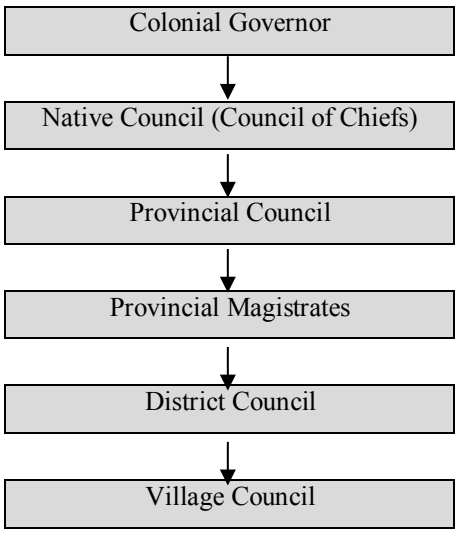


Figure 6 Traditional administration structure

The two additional institutions that were established as part of this process were the Native Land Trust Board, an institution that promoted the safe guarding of native lands for Indigenous people, and the Native Regulation Board, which allowed Fijian chiefs to control policies and laws only for Indigenous Fijians based on the concept of protectionism (Gravell, 1979). Both the GCC and the Institution of the Native Regulation Board, which was renamed the Fijian Affairs Board, made up the higher echelons of the system of Fijian administration and directly supported the colonial administrative processes (Figure 6). The new infrastructure further enabled indigenous Fijians to establish separate policy and infrastructure for self-management, including a separate system of law (Ravuvu, 1992).

Fijian provincial magistrates were employed to solve conflicts at the provincial level, while traditional chiefs continued to resolve conflicts at the village level or within their *Vanua* boundaries. While Fijian magistrates operated within the modern rule of law and handed out rulings, which became 'legal' through the colonial state, the

rulings of the traditional chiefs derived validation from customary practices and from the traditional authority that had been bestowed on them by the predecessors of the people within a *Vanua*.[9]

The indigenous socio-political system that evolved in this process, combined with the traditional legal system, became the colonial version of an indigenous rights system. This is a system that has been described as a 'state within a state' and justified in terms of protecting the interests of Indigenous Fijians (Laramour and Qalo, 1985), a justification that in recent years has become the motivating claim for supremacy of Fijian interests in modern day politics (Lawson 1991). The 'traditional' chiefly elite supported British rule in return for continued control over Indigenous Fijian society. It was intended that these new structures would preserve Fijian indigenous rights and the Fijian way of life (Nayackalou, 1975). Early concerns about various aspects of the system led to a major reorganisation in 1944 and a further review in 1985. The overarching concerns in these early days related to the distribution of rents derived from land leases of native land, a concern which illustrates the underlying traditional cleavage between chiefs and commoners and the increasingly bureaucratic nature of the system. The presence of traditional Fijian structures has continued to infiltrate the behaviour of political institutions and politics to this day (Lawson, 1996).

Towards Self Rule: 1964 to 1970

Fiji's early political history has its roots in the transfer of political institutions in various stages of colonisation to independence. After nearly 60 years of colonial rule, Fiji held its first elections in 1967, signalling the emergence of modern party politics and Fiji's first step towards independent rule (Mataitoga, 1992). As independence drew closer, Fijian politics began to coalesce around ethnically based parties. The Alliance Party was formed by Fijian chiefs and the National Federation Party was supported by Indo-Fijian sugar farmers and workers.

The Alliance Party won the first election and Fiji's first cabinet system of government was formed in 1967, with *Ratu* Sir Kamese Mara, a high-ranking Fijian

[9] *Vanua* is the term used to described a person's tribal clan affiliation

chief, becoming the first Chief Minister (Lal, 2006). In 1970, Fiji's Legislative Council agreed on a timetable to transition Fiji to independence and on 10 October 1970 Fiji became an independent country and a member of the Commonwealth (Lal, 2006). The colonial government recognised the process of transition from colonial dependency to Independence was difficult for Fiji given the growing ethnic tension between Indigenous Fijians and the fast growing Indian population. The Governor of Fiji at the time cited the following:

> Seldom can a country have prepared for independence with such aplomb. The diverse people of Fiji do not yet think of themselves as a united nation. (Governor of Fiji 1970)(Mataitoga, 1992, Buse, 2008)

Although the British colonial government actively supported the transition, they were concerned at this early stage that Fiji was not prepared fully for the implications of independence.

4.1.4 Fiji's (*iTaukei*) Socio, Community and Political Structures

The Indigenous Fijian (*iTtaukei*)[10] communal and traditional system or way of life represents to the Fijians the highest form of human value within in their lives, and is reflected in how Fijians live within their customs, traditions and their material achievements (Bole 1992). The Fijian chiefly system embraces the entire indigenous Fijian people and is at the heart of the Fijian political and social economic systems. It draws its strength and cohesiveness from a well-defined hierarchy of groups and sub-groups with clearly specified roles. These roles have their roots in history and tradition (Bole, 1992). Cultural and social society is highly hierarchical and authoritarian. Chiefs generally have a defined status within communities and society over commoners. There are also divisions of gender and age (males versus females and elderly over youth). These lines of differentiation are an important factor when considering what happens in Fiji society and its interface in all forms of society.

[10] Today, *iTaukei* refers to Indigenous Fijians.

The concept of Vanua[11] (behaviour, knowledge, values land, lineage and traditional customs) is at the heart of all things. *Vanua* represents all things that are paramount to Fijian identity. It provides a sense of identity and belonging and is an extension of the concept of the self (Bole, 1992). Every *iTaukei* belongs to a clan called a *Mataqali* and a sub-tribe called an *Itokatoka*, which belongs to a *Yavusa* (clan comprising several *Mataqali* or several tribes), that is part of a *Vanua* (bigger social and political unit). Each sub-group has a leader or chief chosen from its members.

In a *Vanua*, *Yavusa* or *Mataqali*, (Figure 7) these leaders know their responsibilities with regard to members of the sub-group as defined in custom and tradition (Bole 1992). As such, all Indigenous Fijians live within a tension that ensures that they keep their *Yavusa* and *Mataqali* values alive so that their relationships remain intact and preserve their way of life (Nayackalou, 1975). It is the proper performance of these responsibilities with regards to members of the sub-group that confers mutual respect between members and their chiefs. In this system, the chiefs and the people are indivisible. Neither can exist independently of the other. This bond between chiefs and people is traditionally linked by their interdependence for survival and reinforced by blood ties (Bole, 1992).

[11] *Vanua* is an essential concept of indigenous Fijian culture and society. It is generally translated in English as 'land', but *Vanua* as a concept encompasses a number of inter-related meanings. According to Fijian academic Asesela Ravuvu, a correct translation would be 'land, people and custom'. *Vanua* means 'the land area one is identified with'

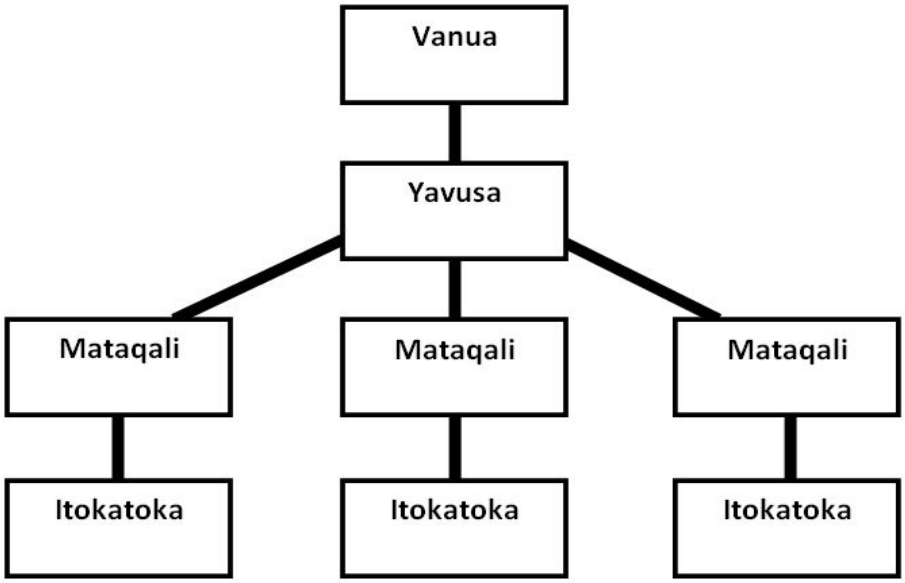


Figure 7 Fijian socio-political structure

The Fijian social system, of which the chiefs are an integral part, remains a virtually unaltered structure impervious to new political influences (Bole, 1992). The persistent survival of its structure has provided a strong basis of political self-reliance for the Fijian people. In other words, through their own traditional social structure, the Fijian people already have a system that they can utilise for political purposes. Customs and traditions still regulate the lives of individuals in many parts of Fiji from the moment of birth until death. This kinship system is the structure that holds Fijian communities together and the relationships among the groupings is governed by adherence to recognised codes and customs. Fijian culture and its highly valued place in Fiji society is the cornerstone of Fijian peoples' identity and is a powerful force in the political, socio and economic relationship of people (Bole, 1992). In more recent days Fijian culture and traditional structures have been dismantled challenged as part of an overall focus for the current Bainimarama Government. These policies have been recognized as direct attacks of the foundation of Fijian society(Lal, 2007).

4.1.5 Paramountcy and Protection

The concept of paramountcy and protection is a principle that demands that the interests of Indigenous Fijians should always remain paramount and protected. It was introduced by the colonial government in the early years of the 20th-century as a

strategy for the protection and position of Indigenous Fijians within the colonial processes. The first British Governor to Fiji in 1865 noted that the necessity of paramountcy was a temporary protection to stabilise Indigenous society (Lal, 2006). The suggestion that Fijian indigenous society needed protection was related to the idea of Indigenous Fijians managing their own political protection and destiny; however an opposing view is cited in Lawson (1991) that Indigenous paramountcy was more to do with opposing European political and land claims.

Post-independence, the concept of Indigenous paramountcy and protection moved from the idea of paramountcy as a protective principle of privilege for indigenous chiefs to paramountcy as a right. According to Lal (2006), paramountcy became a principle to deflect the growing demand for political representation for Fijian Indians (Lawson, 1996). Fijian academics, chiefs and leaders begun to equate paramountcy with political control and entrenched this view within the first constitution of the country in 1970. The same notion has infiltrated current political discourse and until recently continued to be an uncontested part of Fiji's political landscape (Lal, 2006).

The differing views of paramountcy and its interpretation in the electoral system has been the basis of much of the political tension in modern day Fijian politics. The concept has been challenged in recent years as its practical implementation within legal frameworks in Fiji such as the constitution and public policy legislation and institutions has caused ethnic backlash with the Indo-Fijian population. Horscroft's study of paramountcy showed that the concepts of Paramountcy throughout Fiji's political history has detrimentally affected and exacerbated race tensions in Fijis political structures (Horscroft, 2012).

Throughout the Twentieth Century, ideologies of Indigenous paramountcy and individual equality have competed in Fiji's political dialogue. They represent different conceptions of political rights for ethnic groups and individuals; differences not yet resolved into a conception of common national citizenship with wide acceptance. The ideology of paramountcy and its ostensible incompatibility with equality has structured the rhetorical shape of military and civilian coups

overthrowing democracy in 1987 and 2000. This political instability has severely impeded Fiji's social, political and economic development (Horscroft, 2012)

Following British colonisation in 1874, Fiji has struggled to resolve contests played out in political dialogue between claims to paramountcy by Indigenous Fijians and claims to equality by Indo-Fijians. In his definitive history book "Broken Waves (Lal, 1998) Lal writes: The problem of reconciling these competing, indeed, incompatible, interests – paramountcy for Fijians, parity for Indians, and privilege for Europeans – is a central theme of the history of Fiji in the twentieth century.

4.2 Fiji's Constitutional Crisis and Politics of Exclusion

Since independence, Fiji has suffered a history of political instability. Commentators suggest a variety of reasons for this: the inheritance of Fiji's colonial imported political system, the formation of the traditional and Indigenous systems that stemmed from the establishment of the traditional administration established by the British, issues of Indigenous leadership, Fijian paramountcy, and growing ethnic tensions between Indigenous Fijians and the Indo-Fijian population, as well as problems related to the constitution (Lal, 2006). For Fifty years, Indo Fijians were the largest ethnic group, a demographic feature which has fuelled perceptions of a "threat of Indian domination" (Lal, 2006).

Ethnic tensions have manifested in both political and economic dimensions of Fijian society between Indigenous Fijians and Indians born in Fiji (Indo-Fijians) who were brought to Fiji under the indentured Labour system in the late 1800s. By 1916, a total of 60,000 Indians had immigrated to Fiji from India (Gravell, 1979). A series of compromises and accommodations among community leaders during the 60s and 70s ensured a delicate balancing of ethnic interests for two decades (Lal, 2006).

Conflict began to emerge between the Indian population and Indigenous Fijians during the colonial era. By the time of independence, ethnic tensions had escalated. There were tensions directly related to the perceived dilution of democratic principles promised after independence during the negotiation process by colonial administrators (Lal, 2006, De Vries, 2002). The efforts by Indigenous Fijians to

ensure control over the political landscape and public service through the continued promotion of paramountcy and protection policies and by policies that advanced Indigenous Fijians in both economic, employment and educational opportunity were the basis of many of emerging tensions (Lal, 2006).

The threat of Indian domination has been the fundamental cause of Fiji's political problems according to one academic is its obsession with race and its entrenchment in the political and public policy process. The result of this preoccupation is that every issue is seen through the prism of ethnicity as opposed to national interest. Ethnic fears and prejudices are cynically exploited for political gain during elections (Lal, 2006). Although Fiji's growing tribal structures and the historical ethnic tensions have always been viewed as the basis of the political tension in Fiji, it is also important to note that the growing emergence of a class structure in Fiji where interests are been increasingly defined by the role in the capitalist division of labour has also played a part in the political tensions. The increasing unequal division and distribution of power through class has been hidden because of the overt focus on racial issues. Indians are no better off than indigenous Fijians as both groups have suffered under the political system which has concentrated power in the ruling class.

At independence in 1970, Fiji established its first constitution. Its framework reinforced the social and political divisions of Indigenous protection instigated under the colonial period (Lal, 2006). In May 1987 Ratu Sir Kamasese Mara the head of the indigenous led conservative party that had been in power since Independence lost the elections to Dr Timoci Bavadara who led a multi-ethnic party primarily supported by Indian Fijians. Indigenous traditional leaders viewed his election as a threat to indigenous control and authority (Lal, 2006). What followed were two military coups in quick succession led by Military Commander Sitiveni Rabuka. The second coup resulted in Fiji been removed from the Commonwealth and the establishment of Fiji as a Republic.

Political unrest prompted the review of the 1970 Constitution. Indigenous political leaders became concerned that indigenous Fijians were been compromised, asserting

that the 1970 constitution did not go far enough to protect Indigenous Fijians.[12] The result of the review was the creation of new 1990 Constitution, which was primarily motivated by the desire to exclude permanently any possibility of Indo-Fijian parties forming a government. Unhappiness ensued with the 1990 constitution again on the part of Indo Fijians who again felt disadvantaged.

The Constitution was once again reviewed in 1995 by the Fiji Constitutional Review Commission (CRC). The results of the review and report, entitled, *The Fiji Islands: Towards a United Future*, raised two key issues which commanded the most attention and linked to the question of Fijian paramountcy and political representation. The results of the review noted that Indigenous leaders agreed that some form of multiracial politics was necessary to secure the country's economic and political future (Sherlock, 1997). The issue of representation is on the one hand, the desire to continue to entrench Fijian political supremacy and on the other, the wish for fair and adequate representation for all ethnic communities. Between 1992 and 1997 the mood of public debate shifted from testy defensiveness, aggression, and disdain of most Fijian Leaders, and bitterness and rebuke from their Indian counterparts to an optimistic accord (Norton, 2000).

Subsequently, in July 1997, the Parliament of Fiji passed the *Constitution Amendment Act* to move Fiji away from the discriminatory constitution of 1990. The new constitution was a partial move towards a multiracial government. The process of Fijis constitutional reform highlight the dilemma of reconciling a principle of indigenous Fijian paramountcy with an imperative to shape a multi ethnic nation for which non-Fijian particularly Indian, contributions have long been crucial.

A paragraph in the Constitutional review report explains further the discourse that existed in Fiji during the review of the Constitutions in 1995 some years before the commencement of the FHMRP:

[12] The principles that framed the Fiji Constitution of 1990 were that the interests of indigenous Fijians could be protected only if Fijian leaders were guaranteed political ascendancy, a formula based on the effective political exclusion of the Indo-Fijians: 'to assure that the interests of the Fijian race are safeguarded and a guarantee be given that Fiji is to be preserved and kept as a Fijian country for all time' (cited in Lawson 1991, pg 59)

> Fijians have always categorised the inhabitants of the country, or of any locality or village, into two main divisions: a person is either a taukei (indigenous owners) or a vulagi (visitor or foreigner) in any place… The Taukei are normally at the forefront of decisions making. The vulagi are allowed to participate but they must not be domineering or forceful… Whilst they are welcome to stay and enjoy the fruits of their labour… they need to be reminded time and time again of this fact… The taukei and vulagi concept host/guest relationship, continues to be challenge and upset by the human rights concept in which all are considered equal (Constitutional Review Committee, 1995 pg 27-29)

Fiji's Methodist church has also been a vehicle for the promotion of Fijian paramountcy. Preserving ethnic dominance is a central theme of the church: "God made Fiji for Fijians". The Fiji Methodist church note in their submission on the constitutional reform processes:

> Whilst we appreciate the democratic arguments of equal rights, we also realise that such a liberal tradition will gradually take away our ownership and governance rights… The paramountcy of Fijian interests is an issue that Fijians cannot be made to apologise about... It does not mean that Fijians will impose their own way of life or religion on the non indigenous (Constitutional Review Committee, 1995 pg 45)

Fiji's electoral system has been described within the constitutional debate as discriminatory (Swastika, 2008, Lal, 2006). Ethnic-based constituencies have been a key feature of Fiji's electoral system since independence, while also prior to independence all elected seats in the legislative council were based on ethnic allocations. Voters could only elect the same seats from specific population groups. Although the system changed slightly in 1966, ethnic candidates and roles remained (Swastika, 2008). The 1970 constitution retained ethnic rolls. Under this constitution, the House of Representatives compromised 22 Indigenous Fijian, 22 Indo-Fijians and eight other races. The constitution of 1970 provided for a parliament composed of seats reserved for the various ethnic communities, as well as non-communal

'national' seats. The 1990 constitution, which was developed after the 1987 coups, further guaranteed Fijian dominance of parliament.

The system has enabled the further entrenchment of racial based politics in Fiji. Subsequently, Fiji's electoral system has been a mechanism in which the concepts of paramountcy have been promoted. One might argue that the entire constitutional and electoral process in Fiji over the past 30 years has been based on the necessity to ensure Fijian paramountcy and Indigenous protectionism, as various commentators suggest that Fiji's political instability is directly related to the ethnic-based electoral system in Fiji (Head, 2001, Lal, 2006).

4.2.1 The Role of Chiefs in Political Integration

The management of ethnic conflict has been seen and favoured by both leading chiefs in communities and the institution of the Great Council of Chiefs, which was established during the colonial period. Both were rallying points for Fijian ethnic unity in oppositions to Indians (Norton, 2000). Norton further suggests that community chiefs' long term leadership and contribution in the national political arena has not been to guide Fijian communities and society at large but have by their position obstructed a solution to the problem of establishing a viable democratic polity (Norton, 2000 pg 35).

Fijian chiefs deepening sense of conflict with the growing Indian population, especially during the last thirty years of colonial rule reinforced the chiefs identify as ethnic group protectors. Up to 1999 the Great Council of chiefs had operated as both an important constitutional and symbolic institution with legislative authority, reaffirming the role of Fijian indigenous traditional leaders in Fiji's political landscape.

4.3 Fiji's Economic Landscape, 1999

In 1999 Fiji was recognised as a developing nation and not considered a poor country by world standards. It is the largest and most resource-rich nation in the central South Pacific (excluding Papua New Guinea). It was known as the unofficial leader of the Pacific region, with its strong social system and a recognised well-established

health and education system (Asian Development Bank, 1999). Its main sources of revenue are tourism, sugar, mining and agriculture and bottled water. Over the past three decades, Fiji, like most developing countries, has undergone profound economic policy change.

While the 1970s has been described as the 'decade of independence' for the Pacific, the 1980s were substantially the 'decade of big government'. Government expenditure in the region as a percentage of gross domestic product (GDP) grew to one of the highest in the world, assisted by high aid inflows (Asian Development Bank 1999, p 63). Typical of developing countries, post-independence, Fiji adopted an economic strategy largely based on protection of domestic industries and a large public enterprise sector. Stabilisation policies were developed primarily to contain and correct the inflationary consequences and macro-economic imbalances of the oil crisis and other causes of destabilisation inflation in the late 1980s.

Economic progress in Fiji over the 1980s and 1990s remained slow and the protectionist approach and focus by government in the 1980s, with poor revenue, led to a build-up of inefficiency in both the public and private sectors (Reddy et al., 2004b). The widespread failure of this approach to deliver a growth rate sufficient to match the increasing domestic demands caused both policy makers and development banks to re-examine the country's growth strategy from the early 1980s. Fiji subsequently moved to focus on open market oriented policies (Reddy et al., 2004b). Furthermore the end of the Ninety nine year sugar land leases in 1997 leading to the deterioration of the sugar industry added further to poor economic outlook for Fiji during late 1990s. (Lal et al., 2001, World Health Organisation, 2011) The sugar industry was the main commodity export earner for Fiji, directly contributing about 22% of the national GDP and supporting over 25% of the country's active labor force. Fiji's sugar exports relied heavily on preferential access to the European Union (EU) and the USA, and bilateral contractual arrangements with countries such as Malaysia and Japan. Fiji exports 80% of its sugar production, earning on average of $250-300 million in foreign exchange annually.

The end of the leases and the slow deterioration of the sugar industry saw the loss of the significant level of income to the Government of Fiji. It has been suggested that much of Fiji deteriorating health system issues have been a directly linked to the reduction of government resources towards health(World Health Organisation, 2011). Of the 97,046 hectares of land under cane, 63% is leased from indigenous Fijians who own about 83% of some 1.8 million hectares of land in Fiji. In 1996, there were over 12,500 sugar cane growers farming over 60,000ha of Native land.

In 1999, Fiji's economy had a strong export focus with manufacturing and tourism making up more than 35% of Fiji's GDP at the time. The challenge for Fiji's economic management during the 1990s in the area of public finances was the problem of low growth due to mismanagement and corruption in the public sector (Reddy et al., 2004a). The government ran consistent budget deficits between 1993 and 1996 totalling 4.9% of GDP. While public finances did began to improve during this decade, there was the discovery of fraudulent behaviour and mismanagement in the state-owned National Bank of Fiji, the largest domestic commercial bank, and the accumulated bad debts of more than F200 million (Reddy et al., 2004a). The effect of the government's financial rescue on the budget deficit was enormous and reached 9.2% of GDP in 1997 (McMaster, 2002). By 1999, the country was still in a cycle of low growth with an export-driven, fiscally weak economic situation.

4.3.1 Fiji's Public Sector Reforms

Public Sector reforms have been a part of the discourse on management in the public sector for three decades in Fiji. Since Independence, Fiji's public sector has developed under the post-colonial model of socio economic development and nation building characterised by policies and heavy reliance on the public sector to generate growth. Fiji's public sector therefore has for many years grown into a large ineffective machine. In 1985 a move towards public sector reforms saw the Government of the day introduce a wage freeze as its first substantive step in the direction of public reforms, a process that was seen to be part of a process required to improve efficiency and reduce burgeoning costs in the civil service.

The coup of 1987 disrupted plans of the government to continue restructuring plan. Political uncertainty continued and lasted till after the 1992 elections and the distractions of the ethnically biased Constitution of 1990. From 1994 through to 1996 at the commencement of the FHMRP Fijis public sector went through a period of unpredictability in public policy. Principles of good governance were rapidly compromised and where bribery, corruption, lethargy and poor performance by civil servants was alarming (Lal, 2006). Public sector reform and public sector efficiency was not considered a primary objective for the Government (Appana, 2007). However between 1996 and 1999 the Government under Sitiveni Rabuka introduced a range of structural adjustment policies which centered on private sector and public sector reforms were again finally a priority.

The reforms promised to do several things. First, reduce the size of the public service that had burgeoned out of control under the fiscal economic policies of protectionism discussed earlier (Vallance, 1996). Second, the reforms intended to introduce a new public management performance mechanisms for permanent secretaries who led public sector agencies and by this introduce a new performance management culture across the public sector. The reforms were heralded as visionary and a new way forward for Fiji (Sharpham, 2000). In introducing the reforms, Prime Minister Rabuka in (1994) is quoted as saying that they were implemented:

> To counter a tradition of nepotism and poor performance by public servants. The government's vision as part of the reforms is to introduce a new performance management system for senior managers and CEOs in the public service. One which hold them more accountable for their performance and where the criteria for promotion and progress and reward would be solely on merit (Sharpham, 2000).

It was intended that these reform actions would increase efficiency, decrease public spending and therefore reduce the national debt but also incentivise public servants to improve their performance (Lal, 2006). The reforms were also positioned to create a new culture of service within the public service, where agencies would be more

responsive to community needs and be more accountable to both government and communities. In introducing the reform programme, Prime Minister Rabuka stated:

> We must co-operate, minsters and administrators to build a public service that is efficient accountable, and dedicated in properly managing and administering the operations of government (Sharpham 2000, p 35).

In 1999 the public sector reforms enabled the enactment of the *Public Service Act 1999* and the *Finance Management Act 1999*, both critical to the implementation and alignment of the FHMRP(Government of Fiji, 2001). Sixteen government departments and statutory bodies were reorganised during the period of 1996 to 1999. In May 1999 (six months after the start of the FHRMP), the Rabuka government lost the elections. In the first 100 days of the new incoming Chaudhry government, the public sector reforms, including the review of key legislation necessary to the reforms were halted whilst an interim administration took over for 12 months before democratic elections ensued. Public sector reforms continued after the 2001 elections, and then was again halted and then rolled back. In 2002 the reforms recommenced.

4.4 Fiji's Health System and Summary of System Changes

In 1999, Fiji's health system was based on a three-tiered structure that provided an integrated health service between primary, secondary and tertiary care, a system inherited from the British colonial administration. Prior to 1999, the system had undergone small improvements. The 1999 reforms, however, were the most significant proposed modifications since Fiji's independence in 1970 (World Health Organisation, 2011). In 1999, the Fiji MoH's stated goal was to promote the health and wellbeing of the population through the provision of a range of primary, preventive and curative services (Government of Fiji, 1999a). The national health system was delivered through 16 provincial hospitals, three specialist hospitals, three divisional hospitals in the main cities (Suva, Lautoka and Labasa) three nursing homes, 74 health centres, three area hospitals, one hundred nursing stations and 17 community nursing stations. Health centres and nursing stations serviced suburban and rural areas, including the outer islands (Table 6). The combined number of beds

across all health facilities in Fiji at this time numbered 1,600 and every inhabited island had an airstrip that allowed for medical and emergency evacuations.

Table 6 *Number of Health Facilities in Fiji, 1999*

Institutions	Central	Western	Northern	Eastern	Total
Divisional hospitals	1	1	1	-	3
Specialised	3	-	-	-	3
Sub-divisional	4	5	3	4	16
Area hospital	1	-	-	2	3
Health centres	18	24	18	14	74
Nursing stations	20	26	21	33	100
Community nursing stations	5	3	2	7	17

Prior to the reforms, the MoH central responsibilities included planning, policy and service delivery. All key decisions related to service improvements and financing were managed at the central and national level of the system. The senior management team of the MoH managed the operations of the three major hospitals and their divisions from the centralised arm of the ministry. The MoH was led by the Permanent Secretary for Health (PSH). The Minister of Health oversaw the MoH and its services. The service delivery structure of the Fiji health system was based on the traditional structures of primary and preventive health care and curative health care services. Both these two programmes and their respective disciplinary areas determined the organisational structure of the MoH.

The structure of the MOH pre-reforms consisted of four divisions with four national directors each with different responsibilities (see Figure 8) and three divisional directors for each of the three sub-divisions. The three divisional directors located in Suva (Central Eastern Division), Lautoka (Western Division) and Labasa (Northern Division) reported to the Director of Primary and Preventive Health and were located in the MOH headquarters. (Divisional positions but centrally located) Directors were responsible for the delivery of divisional health services. Hospitals were directed by the medical superintendents in a framework of centralised control and were responsible to the Director of Hospital Services, who was also located in the MOH headquarters.

Medical officers working with one or two nurses managed health centres and provided first level of referral for nursing stations and were generally staffed by one nurse who conducted outreach visits to communities in a designated nursing area. Community nursing stations complemented and functioned like stations except that they were built and funded by the community themselves (Negin et al., 2010). In 1999, Fiji's private sector consisted of a less than 20 private GPs, 10 private dentists and one private hospital (Government of Fiji, 1998).

Fiji's health system has always been financed by general taxation, with the Fiji government providing 98% of the costs of Fiji's health services. Established early through the colonial administration, medical treatment has always either been free, or inexpensive. A small fee is charged at hospitals and some medical centres. Reports have shown that the government budget for health has increased each year, since 1985, but has remained stagnant in relation to GDP.

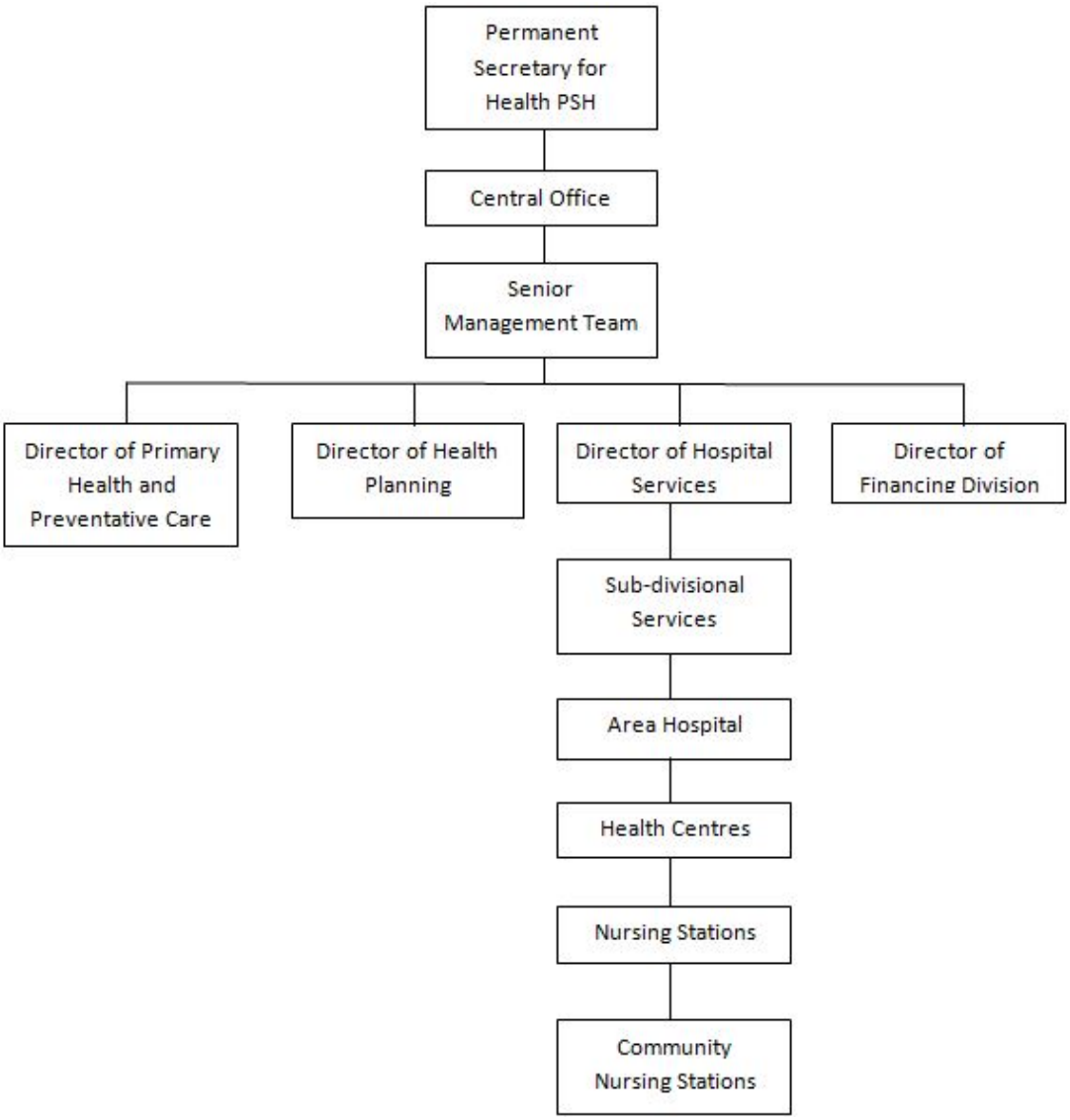


Figure 8 *Pre-reform structure of the* MoH (1999)

However, government budget allocations for health remained constant from 1985 to 1999, despite the increasing demand and cost for health care. Over the period 1995 to 2004, the government allocated between 9% and 11% of its total yearly public expenditures to health, except in 1999 when it hit a low 7.6% (World Health Organisation, 2011) Total health expenditure has always been around 3% of GDP and was capped to a maximum of 3.5% of GDP. This is one of the lowest rates among Pacific Island countries (WHO 2011) (see Table 7).[13] It is suggested that the

[13] Health expenditure as a percentage of GDP for other Pacific countries: Papua New Guinea 3.2%, Niue 17.9%, Nauru 15.2%, Solomon Islands 5.3%, Tuvalu 9% (WHO 2011)

explanation for Fiji been at the lower end of health spending levels compared to other Pacific countries is related not only to political commitment but also the inability of the Government of Fiji to invest in its health system at greater levels (World Health Organisation, 2011 , World Health Organisation, 2014) Fiji made considerable progress in improving its key health indicators up to 1990, with increases in life expectancy and decreases in maternal and infant mortality, but since then progress has stalled (Carter et al., 2010, World Health Organisation, 2011).

Table 7 *Comparative Figures for Per Capita Health Expenditure, Pacific Island Countries*, 1999

Country	Per Capita Health Expenditure (USD)
Cook Islands	264.8
Fiji	54.7
Kiribati	93.7
Marshall Islands	85.0
Federated States of Micronesia	143.4
Niue	364.7
Palau	236.5
Papua New Guinea	32.7
Samoa	49.0
Solomon Islands	-
Tokelau	98.9
Tonga	55.6
Tuvalu	69.8
Vanuatu	36.6

The maternal mortality rate, for example, fell from 156.5 per 100,000 live births in 1970 to 53.0 in 1980 and 26.8 in 1990; it then rose to 67.3 in 2005 to fall again in 2007 to around the 1990 level. The infant mortality rate, which was 16.8 per 1,000 live births in 1990, was higher, at 18.4, in 2007; under-five mortality showed a similar flat trend. (Government of Fiji, 1994, Government of Fiji, 1999a). Progress against key indicators such as maternal mortality ratio has increased worryingly since 1990 (Negin et al., 2010).

Like most developing countries in the region during this period, health system challenges related to the continued management of communicable diseases and emerging issues around non-communicable diseases. The Carter et al., (2010) study looked at routine mortality in Seven Pacific Islands countries highlights that Fiji's declining health status has been a trend for some years now. Life expectancy at birth declined from 72.9 years in 2000 to 67.8 years in 2005 (Ministry of Health, 2005) with women living on average five years longer than men. The study looked at health data over the past 20 years and concluded that adult mortality in Fiji is higher than in Australia and New Zealand and showed high levels of premature mortality due to non-communicable diseases (Carter et al., 2010). It's important to note that the majority of data in the Pacific is based on WHO estimations (Naidu et al., 2013). It has only been in recent years 2011 onwards that doctors in Fiji have received adequate training to improve their capacity to certify deaths correctly and therefore improve the accuracy of mortality data (Walker et al., 2012).

4.5 Culture of Policy Development

Since independence in 1970, and up to the commencement of the 1999 reforms, no formal national health policy framework has guided Fiji's development of its national health system.[14] An analysis of all health policies in the MOH in 2004 highlighted that the majority of health policies in the MOH were disease focused policies (M Fong, 2004). In the 1980s, Fiji chose to pursue a 'village-based approach to primary health care' in line with its existing rural health programme and along the lines of the Alma Ata Declaration (Negin et al., 2010). Since then the progression of concepts of community health and health sector priorities has moved from PHC to health promotion (Roberts et al., 2008) to Healthy Islands and the Yanuca Declaration[15] and to health sector reform. A lack of a formal policy framework in Fiji has resulted in a consortium of different policy responses without a national plan or a strategic approach to national health system development. Rather, Fiji's health system over the past 30 years has developed under a series of ad hoc, informal,

[14] The Alma Ata Declaration and a focus on primary care has been the most substantial health policy focus throughout the 1970s and 1980s. In the 1990s, health promotion and village-based PHC became a central focus.

[15] Healthy Islands is a policy initiative of the Pacific Health Ministers (1995) Its focus proposes an ecological model of health promotion emphasizing the environment and advancing the concept of Healthy Islands.

donor-driven and disease-specific policy development experiences. The culture of evidence-based policy making has not been part of Fiji's health sector development prior to 1999 (Aus Health International, 2000).

4.5.1 Centralisation as a key Concern in the Fiji Health System

The structure was based on a centralised administrative system, where planning, service delivery decisions and key financing and budgetary decisions were made at the center of the system. The sub-divisional health system delivering the core services to the majority of the population and over the years had struggled to ensure not only a level of adequate services but also maintain resources necessary for the ongoing provision of basic services. A series of reports from 1979 to 1997 highlighted Fiji's health system challenges, noting that the system was under duress and struggling to deliver services for its growing population (Coombe, 1982, Dunn, 1997, Auditor Generals Office of Fiji, 1996, Senate Select Committee, 1997). The report further suggested that Fiji's health system had evolved into an unmanageable uncoordinated administrative system, struggling to deliver core health services in a sensible and planned manner (Dunn, 1997).

A WHO consultant report more commonly known as the Dunn Report (1997) and the Auditor General Report (1996) included an assessment of the structure and functioning of the MoH. Its conclusions highlighted that the highly centralised policy, planning and service arrangements did not provide the necessary synergy nor structural ease between primary and preventive health services and curative services at the sub-divisional level (Dunn, 1997, Auditor Generals Office of Fiji, 1996). Other key concerns in the same report noted that the system had problems of service co-ordination and resources issues both at the central and at the health facility level, resulting in the growing discontentment of communities who perceived that the health system was deteriorating (Auditor Generals Office of Fiji, 1996, Dunn, 1997). Inadequate numbers of health workers plus the poor availability of health supplies were key indicators in the demise of many of the rural health facilities. Fiji's health system was constructed to purposely serve the rural communities, hence this deteriorating situation was now of concern (Asante and Hall, 2011).

A report by the Senate Select Committee (1997) was prompted by community agitation at the poor quality of rural health facilities. Concerns were levelled at the failing quality and access of services (Senate Select Committee, 1997). Concerns regarding the management and delivery of services of the three divisional hospitals were further reflected in criticism by the Auditor General in 1996 and the Senate Select Committee review (Auditor General's Office of Fiji, 1996). The culmination of various reports provided the impetus for the FHMRP (Figure 9).

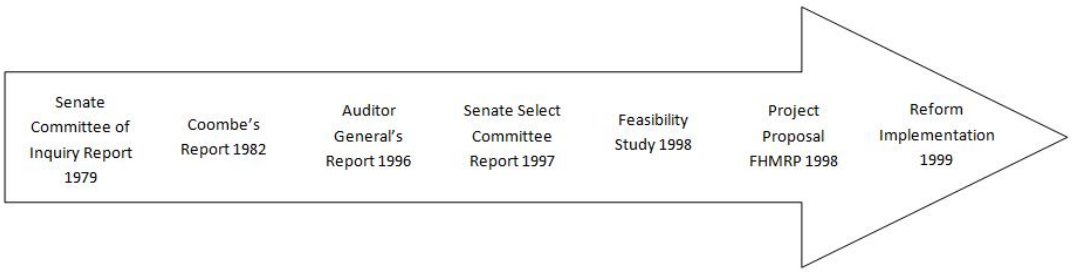


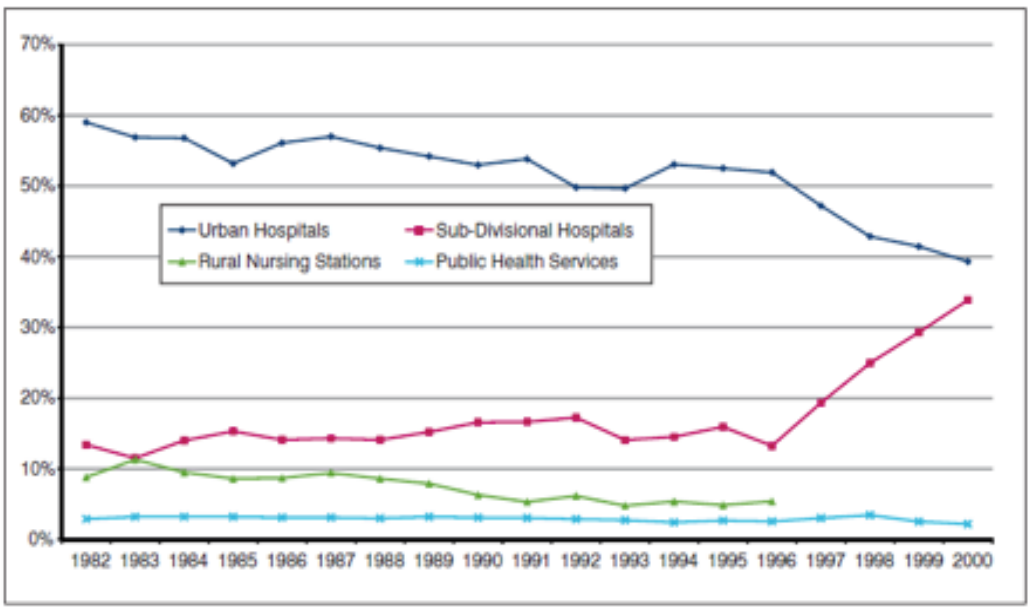
Figure 9 Key health reports that have provided the growing impetus for the FHMRP reforms

4.5.2 Rural and Urban Health Services

Fiji's health system comprised of three Divisional Hospitals, sixteen Sub-divisional hospitals and more than 100 nursing and community health facilities (see Table 6). The rural health services were the mainstay of Fiji's health system. Rural health services however were the most challenging of the system to maintain with few doctors and nurses and supplies (World Health Organisation, 2011).. Between 1985 and 1995, the MoH received more than 1,000 complaints from patients and consumers related to the quality of health services (Senate Select Committee, 1997). Issues, in particular, concerned long waiting times, lack of beds, inadequate treatments, poor health worker attitudes, lack of doctors, insufficient drugs and pharmaceuticals in rural health centres (Kudrani and Tuisuva, 2004).

Communities who live in the outer rural areas often have not had adequate access to sufficient services compared to those who live closer to the urban-based facilities and who have access to a broader range of services. The outcome of these problems and arrangements resulted in communities losing confidence in sub-divisional level services and actively by-passing sub-divisional facilities and going directly to

divisional hospitals in the major urban areas who were unable to cope (Aus Health International, 1998c). A leading primary care practitioner and Fijian academic noted that patients were happy to travel to the urban centres because 'at least they would be assured of a week's supply of medicines even if the consultation was agonisingly slow' (interview data). Urban drift as well as the increased movement by the population to the city as a result of expiring land leases further increased the urban facility burden. The reducing level of government investment into urban based facilities and increasing investment into sub divisional based highlights the growing use of rural health facilities as shown in Figure 10.



Note: Data for 1997 were not available and were estimated.
Source: MOH 1994; 1996; 1998; 1999; 2000

Figure 10 *Government provision for health by category, 1982-2000*

Rural health officials noted that these frustrations related directly to the problem of centralised management arrangements that prevented them from been utilised to maximum potential (Coombe, 1982). An analysis of the resource allocations in the health system in 1998 highlighted an emerging shift of resources away from primary care towards the larger curative-based services (AusHealth International 1998). Divisional hospitals, because of their specialist infrastructure, were the most expensive point of health service delivery and drew most of the health budget. In addition to these challenges, the MoH faced problems related to the internal

management of their health budget. Dr Sharma (2003) further comments as part of his interview for the study

> Unfortunately, with a centralised administration, we have paid a heavy price in terms of poor planning, inappropriate resource/finance management a very high attrition rate of health care providers. Primary care has not been given its due and we see nursing stations and health centres without funding and resources, particularly medicines (Dr Neil Sharma ex academic and current Minister of Health 2013,)

4.5.3 Inability to Control Health System Resources

A central concern of the MoH prior to the reforms related to the lack of control of the MoH to manage its own human and financial resources. Prior to the FHMRP, government legislation did not give authority to the MoH to manage these key health system inputs, which were mandated through legislation to the Ministry of Finance (MoF) and the Public Service Commission (PSC). This structure hindered the MoH's ability to make timely and appropriate investments both in human resources and services, at the right levels of their health system.

The MOH was required on an annual basis to submit its annual plans and these were funded on the basis of agreement with cabinet. There was little possibility of change or movement or control for the MoH in these processes. This rigid funding methodology did not allow the MoH to respond to the divisional and sub-divisional challenges in both services improvement and resources. All hospitals were centrally budgeted on the basis of their salaried personnel, which accounted for a substantial proportion of hospital budgets, often leaving very little resources for service and resources improvements (Aus Health International, 1998c).

4.5.4 Declining Workforce

Fiji has for many years been committed to training large numbers of health workers within their system. The challenge for Fiji has been the problem of retaining doctors and nurses (see Table 8) in the system. The most significant loss has been doctors and nurses. There are a number of factors related to this, namely, migration, political

instability and issues related to poor career opportunities, pay structure issues such as overtime rates, long hours of work in the system and lack of transparency of processes for promotion in the system (WHO, 2001). A MoH unpublished survey on health workers noted that between 1987 and 1999, a total of 510 doctors and 600 nurses left the Fijian government health services, the majority emigrating to New Zealand, Australia and Canada (WHO, 2001).

Retaining staff at the divisional and sub-divisional level of the health system had its separate challenges. Career opportunities for both nurses and doctors were perceived to only exist at the central level of the system and not the divisional or sub-divisional level. Health workers at the divisional level were often considered second class health workers and felt they were often overlooked; they perceived that their careers were compromised by serving at the divisional level; hence many of the sub-divisional facilities could not attract highly skilled staff (Aus Health International, 1998c). Both public and private institutions have been severely weakened by human resources loss through accelerated emigration of skilled workers. The emigration of over 13% of the population since 1987 can be considered a state of disintegration (Naidu and Pillay, 2004). It has been suggested that the disparate rates of workforce attrition in the various fields are the consequences of post coup ethnic tensions.(World Health Organisation, 2011)

Table 8 *Workforce figures, Fiji MOH, 1997-1999*

Category	**1997**	**1998**	**1999**
Doctors	396	299	271
Dentists	36	28	32
Pharmacists	61	59	51
Nurses	1,622	1,622	1,500
Health managers	-	-	3
Assistant nurses	70	66	72
Other para-medicals	250	395	355
Other health personnel	96	87	80

4.6 Fiji Health Management Reform Project 1999

The Fiji health reforms were based on two well-understood principles: that health services, health and ultimately health outcomes can be improved with a more effective management of resources, both human and physical, and that decision making should occur as close to the point of implementation of that decision as possible (Aus Health International, 1998c). The theoretical philosophy that underpinned the reforms were based on the idea of decentralisation as and managerialism would deliver a more focused, responsive and efficient system. The reform approach was based on the transfer of authority from the centre of the health system to the sub-divisional health system. The assumption been that more control by people making decisions closer to the point of service delivery would improve the health outcomes of the Fiji people.

The objectives of the FHMRP project were to design, develop and implement a new management structure that would enable an improved and responsive resource, planning and effective decision making at the sub-divisional levels of the health system. The intention of the decentralised management structure was to separate the responsibilities of the MoH central office of policy and planning so that the divisions could focus more on development and implementation and service improvement. It was intended that the MoH central division would then be able to focus more on centralised planning, national health policy and standards and monitoring of the health sector (Aus Health International, 1998c).

The purpose of a feasibility study undertaken by Australian consultants in 1998 was to consider the political and health sector support environment for 'readiness' for the reforms (Aus Health International, 1998b). The feasibility study concluded that the reforms would benefit Fiji at this time and that the sector and community were supportive of the proposed reform agenda.[16] The FHMRP project commenced in February 1999 and had a five-year duration with the bulk of changes and activity intended to be made in the first three years. The main implementing agency of the

[16] The feasibility study did not take account of the economic feasibility of the reforms from a cost perspective nor did it consider technical capability and personnel of the MOH to implement the reforms or an assessment of the political risks of implementation. It was based purely on whether the reforms were necessary and timely and would be supported by the various stakeholders

reforms was the Ministry of Health. The reform objectives who co jointly identified by both the GoA and GoF. The redesign of the system was conceptually designed by the HMA but the bulk of the implementation of the reforms was the responsibility of the GoF.-The project intended to achieve several goals (Aus Health International, 1998b);

- A decentralised and professional health management system that provided a cost effective and quality service for the people of Fiji.
- A strengthened primary health care system would be preserved and enhanced, leading to improved attendance at sub-divisional facilities and the development of appropriate referral patterns.
- The MOH headquarters would be restructured with a stronger focus on planning health services, developing policy, equitably allocating resources, setting standards and monitoring and evaluating the delivery of health services.
- Divisions would be managed by a CEO who would report to the Permanent Secretary and be responsible for the total management of integrated hospital and community health services. Appropriate authority, responsibility and accountability would be decentralised to all levels of management. The three divisional hospitals would function as referral institutions catering for the needs of patients referred from sub-divisional hospitals and would provide outreach services to smaller hospitals.
- Hospitals would be managed by a General Manager, leaving doctors free to carry out professional services.
- The MoH would be characterised as 'Learning Organisations', in which knowledge would be readily acquired, shared and utilised.
- The new organisational structure would provide for increased health management career development opportunities.
- One hundred and five milestones guided the implementation of the initiative.

4.6.1 Governance of the FHMRP

In 1998 the Government of Fiji requested the assistance of the Government of Australia to support Fiji to carry out a health reform program. The impetus of the

request came directly from the permanent secretary of the Ministry of Health to the Senior Aus Aid officials in the Fiji country office. The reforms were intended to be based on the establishment and creation of a new health management system structure.

The management of the project would sat between the GoF and GoA, through the managing contract agent, AusHealth International, an Australian management contractor with a speciality in health systems and health reform management. In country the AMA team was led by a project team leader and project director. The governance structure of the reforms is shown in Figure 11. The GoA and GoF were responsible and accountable for the development and planning of the reforms through their various committees and working teams with the primary holder of responsibility been the MOH of Fiji. The GoA established an independent Technical Advisory group that provided independent technical advice throughout the program. The total costs of the Reform program funded by Aus Aid, was Australian Dollars $9,259.449.16.

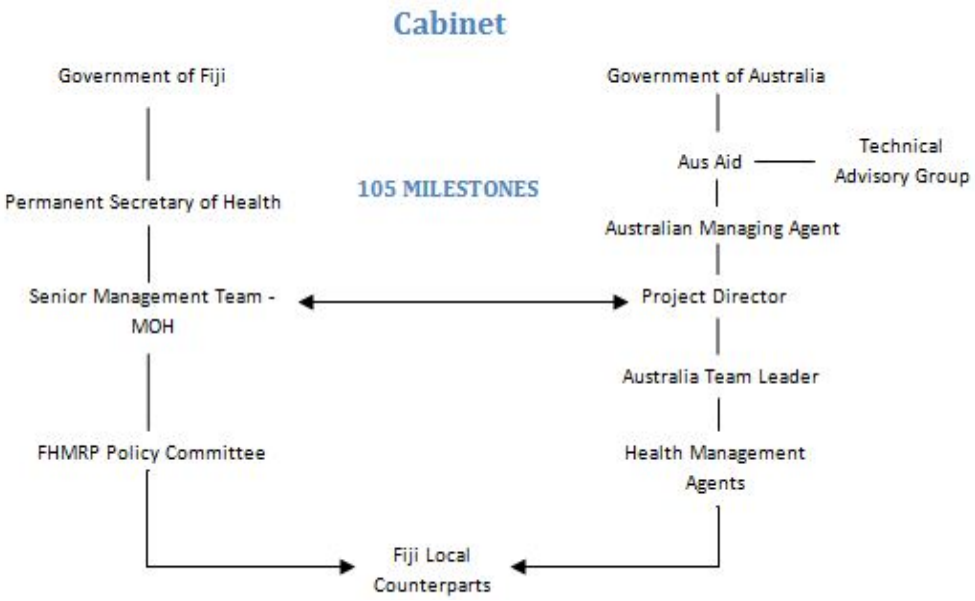


Figure 11 Structure of relationships between the Government of Fiji and the Government of Australia

Australia has played a central role in the aid and the health sector in Fiji since the 1980s. Australia's support continues through their investment through the Fiji Health Sector Support Program 2004-2015 (Australian Government, 2013). Today Australia remains the largest single donor to Fiji and Fiji's health sector: a total of FJD $97.9 million dollars (AUD $53.8 million) (Australian Government, 2013). Approximately 40% of this total amount goes into the health and social sector.

Walt and colleagues (1999) discuss the concept of systemic issues which govern aid contributions to developing countries and how health sectors have been subject to differing reforms which have affected the manner in which is aid is managed. Aid coordination between donors is a critical challenge and often a barrier to smooth implementation of health sector changes and reforms in developing countries (Walt et al., 1999). In the case of FHMRP Australia was the only donor involved. They funded the entire reform initiative with the Government of Fiji (GoF) contributing less than 1% from its health sector budget. This placed Australia as a donor in a position of power and dependency within the reform program, a situation that tended to often-undermine the recipient Government. As Fiji, in particular was a cash strapped Government with weak technical expertise, the analysis shows that they tended to defer to donor expertise without really identifying their own priorities for aid. There is a tendency for poor developing countries to develop an over reliance on the donor in such cases (Van de Walle and Johnston, 1996).

Table 8 (a) Key Stakeholders involved in the Reforms

Stakeholder	Definition	Resources	Perceived Attitude towards the reforms	Impact of reforms on actor
Minister of Health	Elected Minister of Health	Political	disengaged	high
Minister of Health	Appointed	Political	Supportive/disengaged	low
Interim Minister of Health	Appointed	Political	Supportive /disengaged	low
Interim Minister of Health	Appointed	Political	Supportive/disengaged	low
Permanent Secretary of health (PSH)	Senior Public Servant	Political and Institutional	Advocate	high
Senior Health managers and directors in the MOH	Senior public servants, health bureaucrat	Institutional	Followers/and blockers	high
Senior doctors in the MOH	Senior Public Servants	Institutional/ medical power	Followers/ blockers	medium
Mid level managers	Public servants	Institutional	Followers /blockers	medium
Nurses	Public servants	Institutional		high
Senior public servants of other public agencies	Public servants	Institutional and cultural	Blockers/ indifferent	medium
Health Management Agents (HMAs)	Consultants	Institutional and policy	Advocates	low
AMA, Australian Managing Agent	Appointed	Institutional, policy, financial	Advocates	low

4.7 Chapter Summary

This chapter provided a social and political context to this study. It has given a brief review of the political history of Fiji, as well as an explanation of the key social and cultural issues that make up Fijian society. It has asserted that Fiji's colonial history has to a large extent influenced the political landscape of Fiji; in particular, Fiji's troubled political, constitutional and ethnic challenges have overshadowed the political landscape. The chapter also introduced the concept of protectionism and paramountcy, two key principles that have influenced the political environment and policy institutions.

The establishment of Fiji's early colonial structures has played a significant role on how Fiji's traditional and political structures operate today. Twenty years of unpopular reporting highlighted the key concerns for the Fiji health system, which provided the impetus for a review of the system and ultimately became the basis for the proposal for the Fiji health management reforms of 1999 to 2004. The chapter concludes with a brief overview of the objectives, outcomes and structure of the intended reform process. The discussion includes a table on the various key stakeholders who participated in the reform activities. The role of the stakeholders and the issues they advocated within the reform implementation is further explored in the following two chapters. . The following chapter examines the role of Fiji's political institutions in the reforms.

Chapter 5: Political Institutions

5. 0 Introduction

Reform programmes in the Fiji public sector have suffered from the existence of inappropriate and under-performing public institutions (Reddy et al., 2004b). Political institutions are defined as organisations supported by the government that create, enforce and apply laws; that mediate conflict; make (government) policy on the economy and social systems. Their importance according to Lewis (Lewis, 2005) is related to understanding how they can determine the future course of policy. According to Considine (2005), the importance of evaluating the role of policy institutions within the public policy process requires an understanding of the history of the institutions, recognition of how legislation is formed within a political system, what regulatory roles particular institutions play, how institutions use their legislative power to implement rules and what constraints they put in place to ensure rules are followed (Considine, 2005).

This chapter examines and discuss a range of issues related to the behaviour of political institutions in the FHMRP. It seeks to answer question two and four of the research objectives by analysing the role of three institutions involved in reforms. How political institutions in Fiji utilised their powers during the reform process, how they affected the policy implementation process and what tensions they brought to bear on the reform pathway is examined.

Ideas of authority and capacity are discussed, as they were critical features of Fiji institutions, both of which had a major effect on the ability of any government to make and implement policy (Howlett and Ramesh, 1995). In this context, authority means the ability of government institutions to be able to independently control a policy process; capacity refers to the ability of the government system to make and implement policy. This analysis is essential as it explains how institutions can provide a context within which policy making can occur (Lewis, 2005)

5.1 Fiji's Political Institutions

The three central political institutions involved in the FHMRP and responsible for supporting and facilitating the legislative pathway for implementing the new structural and policy changes necessary for the reforms were the Public Service Commission (PSC) the Ministry of Finance and Planning (MOFP) and the Ministry of Health (MOH). While a MoH is instrumental in policy formulation, often other agencies or bodies are responsible for policy implementation (Walt, 2006).

5.1.1 Ministry of Health

The MoH was governed in 1999 by the Public Health Act of 1970, and was the lead agency in the reform process, with its key role in the development, planning and implementation of the central policy actions. It was charged with advocating and negotiating support of the reform policy programme with other key political institutions such as the Public Service Commission (PSC) and Ministry of Finance and Planning (MoFP). A central role of the MoH was the provision of the policy and strategic leadership as well as dissemination of information and communication across the public sector as part of its overall accountability to report on the reform's progress. A key priority of the MoH was the oversight and guidance of the necessary amendments to the legislation to enable the MoH to perform its new functions within the reform structures (Aus Health International, 2004b).

5.1.2 Public Service Commission

In 1999, the PSC was governed by the *Public Service Act* of 1999. The PSC was the most legislatively powerful institution[17] in the public sector involved in the reforms. The PSC was the central human resource agency for the public service. Its legislative responsibilities included the recruitment, retention and career management of all public servants. At the time of the commencement of the reforms, the PSC was the central employer of all professional staff for the public service and was responsible for the training and career development of 75% of the public service. Further, the PSC under the Public Service Act of 1999, had the mandate for setting regulations regarding salary control and promotion of public servants' careers, as well as for

[17] The original *Public Service Act 1974* was established at the time of independence. In 1999, the act was reviewed for the first time since its establishment

enforcing the public sectors values and the code of conduct and behaviour regulations for public servants. Its key responsibility was the implementation of the legislative authority for the establishment of the new structure and new positions in the MoH, including the new role of the PSH and the proposed new senior divisional director positions within the MoH. This critical function of the PSC required close collaboration with the MoH in designing the necessary authorities.

5.1.3 Ministry of Finance and Planning

In 1999, the MOFP was governed by the *Finance Management Act* of 1994 and the *Finance Amendment Act* of 1998. Its central role within the public service was the maintenance of the vision and financial planning goals of the government. It was charged to manage the financial accountability of the public sector, and controlled the government's budget spending and financial management of all public institutions within the public sector. The central role of the MoFP in the implementation of the FHMRP was the devolution of financial delegation and authority to the MoH through amendments to the *Finance Act* 1998, thus enabling the MoH to have the authority to manage its own financial resources. This action necessitated close collaboration with the MOH. The majority of public servants are indigenous Fijians. In describing the context of the institutions it is important to also note that institutions are also represent the traditional indigenous actors whom Fijian custom and tradition is given a central place in the wider public sector. For them constitutional recognition of Fijian custom and tradition is essential

5.1.4 Institutions and the Reforms

The central role of the PSC and MOFP in the reform process was the devolution of authority of powers to the MOH. It was intended this process would be managed in four stages (see Figure 12). The delegations to the MoH would allow them to recruit, employ and manage their own staff, set salary and employment contracts and to manage their own budgets. Further, the devolved powers would enable the PSH to transfer these tasks to newly established divisional directors who would then become responsible for managing their own human and financial resources (Government of Fiji 2001, p 60).

Agencies	Cabinet →	Ministry of Finance and Planning →	PSC →	MOH PSH →	MOH Divisional Directors
Legislation	Approval between GOF and GOA	Amendment to the Finance Amendment Act 1999	Amendment to the PSC Act 1999	Public Hospital Dispensary ACT	
Proposed Timeline	1988	1999	1999	2001	2003
Actual Timeline	1988	2001	2001	2003	2006
Outcome	Memorandum of understanding	Devolved authority to the PSC	Devolved authority to the Permanent Secretary for Health	Devolved authority for planning, service delivery and budgeting the newly established sub divisional directors	Authority to recruit HR personnel and budgeting

Figure 12 Process of the flow of authority

The MOF and the PSC controlled the legislative authority and had the power necessary between them to enable the advancement of the reforms, making them the two most critical institutions outside of the MoH with legislative authority.

Implementation of the FHMRP necessitated amendments and changes to 14 key pieces of legislation. The three critical pieces of legislation requiring immediate action and necessary for the reforms were the *Fiji Public Finance Management Act* 1999, the *Public Service Act* 1974 and the *Public Health Act* 1970 (Figure 12). Fiji's public sector reform program which had been underway for sometime was the driving impetus for these legislative changes. Although all three legislation Acts were necessary for the FHMRP, the Financial Management Act (1999) amendments were the most critical as it intended to harmonise the finance legislation with the *Public Service Act* 1999 and the *Public Service Regulation Act* of 1999 (Government of Fiji 1999)[18,19] and enable agencies such as the MOH to take on budget responsibilities. In 1999, the Cabinet had approved amendments to all three pieces of legislation.[20]

The task of the institutions was therefore to implement the legislative changes within the FHMRP timelines. The *PSC* Act and the *Finance Act* had been enacted early in

[18] In the exercise of its powers under this section, the PSC must have regard to the need to synchronise and harmonise its functions with the provisions of the *Public Finance Management Act* 1999 (Government of Fiji 1999)

[19] The public sector reform programme had been underway for some years prior. The initial reform programme had focused on economic reform, labour reform and public sector service (Reddy et al. 2004)

[20] Alignment of the public sector reforms with the FHMRP never eventuated

1999, however, the *Public Hospitals and Dispensaries Act* needed reviewing and changing to enable the MOH reform changes to take place.

Both the MoFP and PSC signalled that these changes would be forthcoming and that the respective agencies would start reviewing the legislation to accommodate the MoH reform programme. As such, the MoH was encouraged to press forward with their planning. Positive institutional signals (by the PSC and MoFP) to proceed gave the MoH the mandate it was seeking to commence reforms. This process involved political institutions granting permission for the proponents of a new initiative. However, for the first three years of the reforms, the legislative changes were not forthcoming, with both political institutions intentionally delaying clearance of the legislation. An examination of the data shows that between 1999 and 2002, both the PSC and the MoFP purposely resisted devolving authority to the MoH (Aus Health International, 2004b). Data suggest that the reasons for withholding authorities related to public agencies' concerns regarding threats to governance, paramountcy and leadership and capacity. These issues are discussed in the following sections.

5.2 Threat to Traditional Governance and Paramountcy

A central issue related to the resistance of political institutions to support the reforms can further be explained by understanding how the principles of paramountcy (as described and explained in 4.1.5) were interpreted in the political institutional environ. As described in the previous chapter, the identity and values in Fiji's political institutions were shaped by their colonial establishment and experience. Post-independence, these same ideals of Indigenous control and paramountcy were transferred into the modern day political and policy environment. Fiji's public sector and Fiji political institutions have always been the mainstay of Fiji's political environment and the promoter of these ideals (Reddy et al., 2004a). Further, high-ranking chiefs remained part of the many public institutions' legacy.

The protector of paramountcy in the public sector was mandated via the constitution to the PSC.[21] The PSC through its legislation was granted by Government to be the

21 Public Service Commission Legislation

primary promoter and protector of Indigenous power in the public sector through the control of PSC recruitment processes. The PSC bureaucrats took these responsibilities seriously and interpreted the pending devolvement of human resources power (a key and essential aspect of the reforms) to the MoH as a direct contradiction of its legislation and traditional authority empowered to them via the constitution. The PSC interpreted the reforms as contradictory to the spirit of the PSC legislative mandate, as suggested in the following comment.

> If we opened up public sector management and handed over our legislative responsibilities and control to the MOH … it would be a disaster … Our job is to control the human resources entering the public sector … We cannot give that authority away … They (the MoH) would recruit inappropriate people, you know what I mean they would not be Fijians but other races. The PSC has always had control of the personnel of the PSC and our legislation allows us to retain this control (Senior PSC official).

In this instance, control referred to Indigenous control of the public sector and Indigenous preference for public servants in the public service. The promotion of these concepts lies at the heart of the PSC legislation and constitution. However, much more than just protection and safety in the public service, the concept of Fijian protectionism is linked to political and economic stability, and the understanding that the Fiji public services and government is only safe in the hands of indigenous Fijians (Government of Fiji, 1982, Buse, 2008). The idea that protectionism is related not only to indigenous authority in the public sector but also linked to the economic wellbeing of the nation gives this concept collective strength across the wider public sector.

A long standing politician explains the resistance of the PSC:

> If you look closely at the PSC legislation, you will see that the power of that institution is what holds the Fiji public sector together and it enshrines in it the power of control over all Fijian authority in the public service … So really why would they change it … This entrenched power also tells you why

> we have never changed the legislation of the PSC for two decades (Ex-Senator, Fiji government).

Understanding how the PSC interpreted its traditional role of protection explains one aspect of cultural authority; the other aspect of cultural authority and a reoccurring theme in the data was the concept of the role of chiefly leadership in the political institutions.

5.3 Chiefly Leadership and Resistance

The placement of traditional chiefly leadership at the top levels of the public institutions was a strategy to protect traditional governance structures by the British. The colonial regime strategically trained Fijian chiefs, who were people of towering personalities and influence, to assume power when Fiji became independent (Lal 2006). Post-independence has seen the reign of Fiji and Fiji political leadership continue to fall to traditional high-ranking indigenous leaders across political institutions within the public service.

These same leaders have advocated that only an indigenous Fijian-dominated government would protect their heritage and rights after colonisation and that it is this cultural authority that gives Fijians a sense of political and economical comfort and safety (Lal, 2006). Fiji's Constitutions (1970, 1999) have also reflected this preference of ethnic loyalty with reservations of the highest political posts in the land retained only for indigenous Fijians (Lal, 2006).

The analysis shows that the health management reforms (in particular the devolution of powers from the PSC to the MOH) were viewed by institutional leaders as a strategy to reduce the control of Fijian traditional structures within the public sector, therefore challenging traditional governance in the system. Institutions viewed and interpreted the reforms as a new model of governance for the MoH that contradicted public sector values and furthermore would have reduced the control of the PSC . The introduction of legislation that allowed human resource and financial control to move away from the PSC and MOFP was viewed as a threat to traditional structures, as described by a senior official in the PSC.

> We could see the MoH leadership wanted more control of resources and decision making but this was not aligned to traditional public sector structures. They were pushing for something different and we could not allow that to happen (Senior official, PSC).

A similar experience is also described by academic Dr Mahendra Reddy et al in his assessment of the implementation challenges related to the financial management reforms in Fiji during the 1990s, who notes that the biggest resistance to implementing the financial reforms was the unresponsive political institutions and the difficulty he suggests lies in the problem of reorienting value laden and complex agencies (Reddy et al., 2004a).

In attempting to explain the limited success of governance reform in the Pacific more broadly and, in particular, in Fiji, Ron Duncan (2011), a Pacific expert in governance, notes that the challenges related to the political aspects of Pacific culture, specifically concepts of leadership and obligations within political hierarchies, have remained since colonial times. Many Pacific Island leaders and other influential members of politics grew up in pre-independence times and their values and actions are guided by the norms and expectations of the Pacific political culture (Duncan, 2011). As such, many of the cultural values that were in place before colonisation remain in place and heavily influence governance of the economies. Recognition of this helps explain the resistance of traditional leaders to the shifting of power in any kind of reform activity.

Sensitivities in this regard were further heighted by the loss of the 2000 election, (one year after the start of the reforms) resulting in a shift from the traditional Fijian power base of leadership to a non-chief and non-Indigenous Fijian leader. Outgoing Prime Minister Sitiveni Rabuka lost the 1999 election, and Fiji acquired its first Indo-Fijian Prime Minister, Mahendra Chaudhry, and Leader of the Labour Party. This transition of Fijian indigenous power to Indo-Fijian power exacerbated the

already growing tension in the public sector over paramountcy.[22] In May 2000, a year after the election and 17 months into the implementation of the FHMRP reforms, Prime Minister Chaudhry and his entire cabinet were taken hostage by coup leader George Speight in the name of indigenous power. A senior official in the Prime Minister's Office at the time shared the following:

> Unfortunately our traditional leaders felt very threated during this period …the reforms unfortunately started during a time when our country was not interested in public policy debates over health or other social sector issues, we were a country really under siege with political instability and multi-racial problems .

Comments such as these highlight the challenging environmental context during the implementation of the health reforms.

5.4 MoH as a Low Level Political Institution

Relationship challenges between the public institutions were further compounded by disparaging attitudes within the public sector agencies towards the MoH. Exploring this issue with interviewees revealed that the PSC and MoFP viewed the MoH as an agency with no significant political authority nor any formal legislative power (had no power to create independent policy) and therefore a public agency with no 'real grunt' in matters of public sector policy making. As a senior PSC official suggested,

> The MOH is a weak ministry legislatively … so what can it do? It really has no authority to tell us what to do (Senior PSC official).

According to Buse and colleagues (2007), this is a common perception of MOHs in developing countries, where they are often referred to as 'low lying agencies'. Buse et al. explain that the concept relates to understanding where a MoH sits in a hierarchy within a public sector setting. A common perception particularly in low-income countries is the MOH is often seen as low down in the hierarchy of public

22 The 1999 Elections were fought tested the new constitution and issues of ethnic and indigenous issues

agencies and well behind the MOF, and is often described as the Cinderella among ministries (Walt, 2006). Similarly, in Fiji, this view had been established and ingrained as part of Fiji's colonial history where legislative and political power has always sat with the PSC and MoFP, and confirmed by the senior PSC official quoted above. Further probing of this idea with interviewees revealed that the perception of political weakness was related to the MoH not having constitutionally based authority nor being a holder of traditional and cultural authority.[23] Both these opinions further validated the concept of the MoH as having low lying agency status.

5.5 Synchronisation with Public Sector Reforms

A central and key issue advocated by the PSC and the MOFP as part of their rationalisation for not supporting the reforms related to the timeliness of the Fiji reforms. The Fiji Public sector reforms, as described in Chapter 4, were halted in 2000 after the Labour Government came to power. Concerns by the PSC in particular related to the perceived push by the MOH to keep advancing the reforms and outside the synchronisation of the rest of the public sector reform program. This described by an official of the PSC:

> Why is it that the MoH should keep pushing its reforms along a timeline that is not supported by the rest of the public sector… what makes them so special, that they don't have to conform like the rest of the public service… the Public sector reforms are in limbo and have been halted by Government but the MOH keeps pressuring us to support their timelines…

Comments such as this suggest that the MOH viewed their reforms as sitting outside of the main public sector reform program and timelines. This idea was confirmed by interviewee data by senior health officials who suggested that the health reforms were **not** perceived to be linked to the rest of the public sector reforms as the funding for the health reform program was independently funded by Aus Aid and not by the Government of Fiji. This gave the MoH a false sense of agency independence as it did not need to rely on resources from within its own system that might require cabinet or government approval (Aus Health International, 2004b).

23 The PSH of MOH was not a traditional chiefly leader.

5.6 Strategies to Delay Reforms by the PSC and MOFP

A key and significant deterrent to the successful implementation of the reforms was the delay of the approvals and authorities from the PSC and the MOF to the MoH. At the heart of the agencies' resistance to devolve power to the MoH was the recognition that the health reform policies would ultimately affect and decrease their own institutional power base. Public agencies admitted that they attempted to delay the reforms through a range of tactics, such as refusing to attend meetings or not showing up for meetings, or attending meetings with no information, forcing MoH officials to become frustrated with the repetition of information and data. Dispersing low level staff to meetings who had no power or influence to make decisions was a common strategy by the PSC. The same institutions admitted they purposefully delayed and created barriers to the reform process by banding together to slow it down. The rationale for the behaviour they suggested was a lack of confidence in the MoH reform processes to deliver the anticipated outcomes, but also a fear of the loss of their own institutional power and the perceived threats to paramountcy, highlighted in the following comments by public sector officials.

> We had no confidence that the MoH leadership understood what it was they were attempting to do and the impact that it would have, they gave no thought to how their reforms would impact the protection of their own Ministry long term. So we tried to delay their process (MoFP official).

> We also knew that what they were trying to do did not fit the general public sector framework, they were way ahead of themselves … so we tried to slow them down (PSC official).

> We didn't trust them, they didn't share the detail of what they were trying to do…(MoFP official).

The analysis shows that the attitude of both the PSC and MoFP was viewed by MoH bureaucrats as territorial jealousy. Health officials note that the resistance by these

agencies to support the reform process was essentially related to power and loss of authority. As one health official shared:

> We understood the PSC and the MoFP position but we didn't anticipate their reaction. In reflection it was really about power for them…..

What developed from within non health agencies was a 'non-caring' attitude towards the MoH and resulted in the agencies not prioritising MoH reform actions in their work plans and delay tactics used to respond to MoH concerns. This is a common response by agencies whose policies can affect health, but to which they give no priority and consequently prefer to remain absorbed within their own policy space (Walt, 2006). Other external Fijian public sector agencies viewed the lack of information sharing by the MoH as a strategy to purposely withhold information from them, creating an environment of mistrust and reduced confidence in the MOH and their reform approach.

5.7 Capacity of the MOH to Implement the Reforms

Interviewee data and reports analysed indicate that many of the concerns related to process, and implementation challenges were NOT just related to external political institutions issues as described above but key implementation challenges additionally sat within the realm of responsibility of the Ministry of Health. The management of the health reform strategy by the MoH has been a central concern. Ministries of health in middle and low-income countries have a reputation for being the most bureaucratic and least effectively managed institutions in the public sector (Bossert et al. 1998).

5.7.1 Changing Role and Culture of the Ministry

Fiji's MOH was established during the colonial period and up to 1999 had developed as part of its responsibility the operation of financing a large rural and urban extensive hospital and primary health care system (Coombe, 1982). The role of the MOH as the central political institution in the reform process was to provide the strategic leadership for the health sector in the development and implementation of the health reforms. Central to this role, according to Bossert and colleagues (1998), is

the **necessary development** of capacity in several key areas, such as public sector management, analysis and planning capacity, leadership and management.

Further, and a most critical role of bureaucracy in this instance, was to recruit allies to the reform process. Equally important was the need to convince opponents and ensure that blockages among stakeholders, such as delaying the operationalizing of decisions they did not support, did not occur (Considine, 2005).

The reforms required the MOH to reorient its functions from a large centralised health service bureaucracy to an institution with a stronger policy mandate and focus on policy planning regulation and monitoring. It required the development of new functions both at the centralised arm of the MOH system and at the sub-divisional level (Ministry of Health Fiji, 2001). It was necessary therefore to develop new ways of working between divisions in the MOH, both internally and across the wider health sector. Interviewee data suggest that the MOH struggled to internalise the new functions and develop a new culture and way of doing things. Reports analysed together with interview data found that the MOH was challenged to deliver on these core and central functions and struggled to build the necessary capacity to oversee the management and implementation of the reforms.

5.7.2 Constraints to Changing Culture and Capacity in the MOH

Inability of the MOH to Frame the Policy Dialogue

Effective and open communication is essential in a reforming organisation. (Bossert et al., 1998). Hogwood and Gunn (Hogwood and Gunn, 1984) discuss the importance of clarity of understanding and agreement on reform objectives as an essential pre-determinant of the success of implementing reforms. MOH and interviewee data suggest that the biggest deterrent to winning the support and engagement of stakeholders in the reform process in the MoH, was the inability of the MOH to present the reforms in a clear, coherent and transparent way or as described by Bossert (1998; pg 18) ‘the lack of ability to frame the policy dialogue’.

A recurring theme in the analysis suggests that staff within the MoH had very little knowledge about the purpose, and objectives of the reform and further had little

understanding of how the reforms would affect them and their role in the system. Framing the policy dialogue among staff is a critical imperative in implementation of reforms, that is explaining how the policy problems are defined, analysing specifically what is included and excluded from consideration (Apthorpe and Gasper, 1996). Bossert and colleagues (1998) discuss the importance of reform objectives as critical for a transforming a MOH:

> A health system needs to demonstrate that it is clear about where the inefficiencies are in its system and that any changes related to its structure will not burden or drain resources from other sectors or use public funds. Most importantly a MOH must be able to articulate these goals and gain a broad consensus from its stakeholders (Bossert et al., 1998 p18).

The lack of ability for the MoH to develop and convey clear objectives caused both internal and external confusion with stakeholders. A critical impact was the delayed agreement and understanding on an agreed reform model. As such the reform model evolved in a fragmented and incoherent staged process, changing many times and going through numerous stages. The lack of clarity and coherence in the process further created an air of suspicion and scepticism around the reforms.
A MoH official shared the following:

> I remember looking at version 22 of the health reform model … We had a very confusing process, we really didn't know what we were doing. Were we decentralising, devolving powers or were we just creating new structures and doing business as usual?

The lack of clarity of reform objectives is evident in the following comment from a doctor in the CWM Hospital:

> I never knew if the reforms would give me more bedpans, more surgical gloves or it would give nurses more money that they deserved or if it was really about new jobs for managers.

A senior nurse shared the following:

> From day one right to the end of the reform period … I had no idea what the reforms were about and what changes I could expect with my job (Senior sister, CWM Hospital).

These comments highlight the different levels of understanding and confusion around the reform purpose and goals.

Reform Model

The analysis suggests that the reform design was essentially driven by the timetable and donor milestones of the contracted outputs and outcomes designed by the Australian management agents. The HMAs who led the reform internally within the MoH were contracted to deliver 105 contracted milestones developed as the key deliverables that guided the implementation of the consultants work plans. In reflection MoH bureaucrats recognized that the technical gap and capacity in reform modelling within their own system created a skills gap, and thus enabled the milestones and accountability framework used by the HMAs for their contract with the Government of Australia to become the reform design and framework. In essence the Terms of Reference of the consultants' contracts became the reform model. A health official shared the following:

> The consultants couldn't identify what really the reform design was, it kept changing over a period of two years, eventually what happened was the reports and the milestones designed by the donors to monitor the consultants became the blue print for the reform design.

This comment suggests that the reform model ultimately was developed by the donors and the HMA with very little local MoH input. According to Grindle (2000), this is a common practice in developing countries that do not have the internal technical capacity for reform modelling. The over-emphasis on the contractual outputs of the donor as a design tool for the reforms added further to the confusion about what the reforms were trying to achieve. The risk for Fiji in this was that the

reform model was based purely on what the donor was trying to achieve and not based on the needs of Fiji's health system.

An analysis of the consultants work plans highlights that the GoA was interested in contracting for things that they viewed were controllable and demonstrably attributable, suggesting that the funders wanted to buy outcomes that they could control. This meant that for Fiji donors were fixated on outputs and HMA's had very little flexibility or room to incorporate outcomes that might have been identified by the local counterparts as part of the reform process. The data analysis suggests that the 105 milestones and outputs were ideologically oriented towards 'decentralisation concepts' rather than an assessment of the problems the reforms were trying to fix. Reports identified (Coombe, 1982, Senate Select Committee, 1997) as key documentation that provided the impetus for the reforms emphasised that the health sector's concerns related to problems of health service delivery and the stifling of management resources at the centre of the health system.

However a review of the feasibility study undertaken prior to the reforms to test feasibility and suitability of the reforms intentions noted no formal diagnosis of the health sector was completed prior to the reform commencing (PW Associates Pty Ltd, 1998) nor were the contracted milestones related to a formal diagnosis and assessment of the health systems problems (Aus Health International, 1998b).

On reflection, reform designers noted that the diagnosis of these issues was not well enough tested and that further analysis should have taken place to enable stronger analysis to reveal causes of poor performance. As one senior official reflected:

> We should have worked backward and we should have kept asking why until we discovered why we had a problem … also I think we had evidence but we didn't use it when formulating our plans … I think we weren't smart enough here…(MoH official).

Furthermore the approach to identifying or diagnosing Fiji health systems challenges were not taken seriously, as much of the discussion related to reform design and

approvals had already been completed during negotiations between the MOH and the donor (which explains how the 105 outputs were negotiated before the reforms commenced). Interview data revealed that the need to establish "real evidence for the reforms appeared to not be a priority as the decision to reform was already politically endorsed by the donor and the need for diagnosis and evidence was less important.

The analysis of reports and interviewee data suggests that the lack of ability to get clear on the reform design was related to the MOH's inability to first assess what the problems were and then agree on how they would fix them. Exploring this issue further suggests that the MOH was not clear at the outset about which performance problems to focus on, which suggests that the diagnosis of the health system issues may not have been accurately assessed (Grindle, 2000). Diagnosis is referred to as the first key step in figuring out the causes of a health system's performance (Roberts et al., 2008). The overt influence of the 105 milestones further confused the diagnosis, design and assessment stages of the reforms.

The data highlighted that many of the reform model discussions held within the MOH during the start-up period had a strong technical focus. Vallis and Tierney (Vallis and Tierney, 1999, Gilson et al., 2008) discuss how the role of technical information and its dominance in reform planning processes is problematic and that it has the capacity to dominate and distract reform development by its focus on technical infrastructure discussions rather than on the process work. Without clear diagnosis of the health system's problems, poor clarity of reform objectives and a lack of a clear reform model and plan for implementation, it was impossible for the MOH staff to understand what effect the reforms would have on them as individuals and as an institution.

Delayed clarity resulted in a range of other poor decision making processes by the MoH and delayed their ability to plan future human resource investments and other key health system inputs. A senior health official shared:

> Unfortunately, throughout the reforms we never really knew what we were doing, each day new information would come to the various parts of the MoH. We had to think on our feet most of the time.

Formulating a cohesive vision of the change process was impossible and subsequently disallowed any success of the MoH to work towards developing a new culture of change, furthermore the role of the HMA who played the key role of reform design also warrant taking some of the responsibility for the failure of the reforms.

5.8 Relationship Failure with External Agencies

5.8.1 Communication

Successful implementation of the reforms relied on the ability of the MoH to negotiate the reform vision and changes through the policy and legislative frameworks with the PSC and MOFP. Central to this negotiation was the management of relationships between institutional bureaucrats. A recurring theme highlighted in the analysis and directed at the MOH was their lack of ability to engage with the agencies in a timely and consultative manner. The MoH failed to formalise the relationships with the two key agencies and struggled to get a joint understanding and agreed approach to the work programme and legislation timelines. Reports suggest that the MOH presented with an attitude of information **'sharing'** rather than approaching the agencies in a spirit of '**collaboration and consultation'** (Aus Health International, 2004b). A senior public servant in the PSC shared the following:

> When the MOH came to talk with us about the reform plan, they told us what they wanted us to do, they didn't discuss it nor seek our views. They didn't come with any information that assisted us to understand the purpose of the reforms … they showed us the structure of the new organisation and asked us to sign it off before they even consulted us … they really didn't understand our role.

Agencies were concerned at the attitude of the MoH in this regard. Further relationship management was not helped by the fact the MoH appeared to be disorganised, meetings were planned last minute, often with poor information distributed at the meetings, and with no coherent strategy from the HMAs regarding processes and timelines. As one MoPF official noted:

> We were invited to poorly organised meetings where nobody seemed to know what was going on.

Inadequate and clear communication further aroused suspicion by public agencies who felt that the MOH's lack of clear communication was due to their inability to articulate the reform process suggesting that the MoH 'did not know what it was doing'. A senior official from the MoFP shared the following:

> We saw that very little thought and planning had gone into the design of the implementation of the reforms and the staging of the legislative changes … sometimes they (MOH) did not speak confidently about what they were doing … We felt that this was the reason they didn't communicate well with us.

The issue of communication and relationship management by MoH during the reform period is noted in a report carried out by Fiji National University (2004). Researchers interviewed public agencies on their understanding of the reform process. The report highlighted that both the MoH and other external agency officials 'felt in the dark' on reform processes and suggested that poor communication was a key factor in the lack of support by the institutions (Kudrani and Tuisuva, 2004). Lack of confidence by the PSC in the MoH reform processes became further apparent when the agency questioned the technical soundness of the reform plan in a confidential memo to Prime Minister's Office in June 2001 and noted in a report by the Technical Advisory Group [24] (AusAid Review Team, 2006)

[24] The TAG or Technical Advisory Group were was a team of experts who monitored the implementation of the project externally

Interviewee data analysis and reports suggest the effect of communication mismanagement resulted in reduced credibility of the MoH (Aus Health International, 2004b). The MOH struggled to overcome the resistance by the agencies to build collaborative and sustaining relationships throughout the project. The MOH did not develop what (Bossert and Wodarczyk, 2000) describe as the necessary bargaining influence essential for the reform process. Inability to manage these relationships resulted in a tense and unhelpful atmosphere between the PSC and MOFP throughout the five-year reform period.

5.9 Effect of Delays on MOH

The delay of the legislative and formal authority by the PSC and MoFP for the establishment of the new sub-divisions worked against embedding the new change management culture. Delays caused confusion about processes, structures and responsibilities; further, it created a culture of sluggishness and reduced interest in the reforms. Limited capacity to make decisions on issues related to the reforms, forced a culture of non-accountability and non-management in the MoH and enabled the same old practices in the MoH to continue to operate under its old objectives. Cassels (1995), in his assessment of institutional challenges for MOH in developing countries, notes that the issue of capacity for a MoH to make strategic and operational decisions is often constrained by the fact that no one is in overall charge due to the absence of clear management structures. A senior medical officer in the newly formed sub-division noted:

> I knew I was supposed to have some authority to make some decisions but my counterparts in the central office continued to act as if they were still in control.

For the first three years of the reform, the MoH struggled to align its organisational structure and its human resources with the new roles and functions that the reform was proposing (Aus Health International, 2004b).

5.9.1 Lack of Analytical Capacity

Bossert (2000) and others (Gilson et al., 2008, Varvasovszky and Brugha, 2000) suggest that a critical and necessary skill for any MOH to have while reforming is the essential capacity to undertake both political and policy analysis. At the commencement of the reforms, the MoH had no formal health policy or health policy analysis trained human resources (Aus Health International, 1998a). Health policy focus in the MoH over the years had been on developing vertical disease programmes. An analysis of the MoH health policies prior to 1999 reveals that the MOH did not have a substantial history or developed culture of health policy development or have established health policy framework that guided the system (M Fong, 2004). A report by a WHO Consultant in (2001) also confirms that the MOH did not have a track record of health systems strengthening policy (O'Connor, 2001) . Much of the MoH historical policy experience in recent years focused on primary health care and health promotion policy (Negin et al., 2010).

During the reform process, the MOH needed key data such as regulatory and legislation knowledge, human resources information on supply and availability, data on service utilisation and budgetary analysis. It further needed information on monitoring and evaluation as part of the improvement of their health information systems.[25] The necessary skills and information needed to support decision making and planning for the reform process was not built up nor available in the MOH during the reform period and compromised the ability of the MOH to make timely and responsive decisions. A report written in 2001 by WHO[26] midway through the reforms recommended that the MOH establish a policy analysis capacity unit under its own direction and not under the direction of reform consultants (Oconnor, 2001). The establishment of such a unit (which did not eventuate during this period) would have enabled the MoH to develop capacity to increase its ability to collect and use information for the policy process as well as identify the necessary training and capacity needed to ensure the success of the reform program.. An interview with a senior official of the MOH at the time revealed the following:

[25] A component of the health reforms was on health information systems but its focus was ICT and not information for policy and planning (Aumua et al. 2009)

[26] Discontentment of the MOH at reform processes forced them to seek technical assistance from the WHO

> A lot of the technical knowledge was needed. It was something we didn't appreciate at the time … we didn't know our workforce numbers, we didn't know real costs of services and we didn't really know much about health reforms and we needed to take control of our own information.
>
> Not establishing some kind of unit was a big oversight on our part, we needed different competencies at all levels of the system. We did not understand what skills decentralisation would need and we didn't understand how to develop those skills. Unfortunately no one thought that in spite of the reform there were going to be more people and more skills needed (Senior health official).

At the end of the five-year reform plan, the MOH was left with very little reform and institutional capacity.

5.9.2 Stakeholder Management as a Political Strategy

A central and key skill necessary as part of the MOH's capacity to build a culture of change and ensure the safe pathway for the reform process was the analysis needed to understand the political nature of its stakeholders in the environment. According to (Gilson and Raphaely, 2008), knowledge of the political context includes understanding what is important to the stakeholders in the environment and the ability to recognise and anticipate how they might react to the reforms is crucial to reform management.

The political analysis of stakeholders is an essential element of any health reform and a necessary consideration. These are critical capacity issues and necessary to have for reforming institutions (Bossert and Wodarczyk, 2000, Buse et al., 2007, Varvasovszky and Brugha, 2000). While the MOH was the primary institutional leader in the process of implementing the reforms, the PSC and the MOFP were also a central part of the 'task network'. As noted earlier, the relationships between the agencies remained tense throughout the five years. The lack of management of these relationships raised key issues related to the ability and capacity of the MOH to

develop political strategies to respond to the issues raised by their counterpart institutions.

The MOH lacked political analysis knowledge that would assist them to not only identify the relevant groups and individuals that were important to the reform process. The MOH did not understand the relative power of the stakeholders over the reforms, nor did they have the capacity to evaluate stakeholder positions on the proposed policies, including the level of their commitment or their underlying interests. A significant failure by the MOH was the inability to anticipate which stakeholders had influence to shape the policy discussions, what resources they had and what interests they were advocating. As one senior health official stated:

> We didn't anticipate the level of opposition to the reforms by some of the stakeholders… we couldn't understand their reaction and poor support.

The lack of recognition by the MoH of the power of stakeholders highlights the MoH's limited understanding of policy processes and context as described by Walt (1994).[27]

Part of the MoH struggle to grasp with the importance and necessity of developing political strategies showed in their inability to build and lead consensus building both internally with MoH staff and outside of the MoH walls.

The data point out that that the MoH leadership was more focused on trying to "**win the authority war"** with its stakeholders and focused on the **positions** that unsupportive agencies took on the reform work, rather than trying to understand what was at the heart of the resistance. The inability of the MoH to develop bargaining skills to influence and shift the power positions of the political institutions outside of the MoH was a testing and disappointing outcome for the MoH (Aus Health International, 2004b).

[27] Throughout the study the term MOH is used to reference the health Ministry and not the Government of Fiji.

For the first three years of the reform programme, the MoH failed to deliver a win-win situation for all involved. A negative tone ensued early on in the agency's negotiations with the PSC and MoFP, resulting in a stand-off between the agencies for the first three years of the reforms. The use of power by both the PSC and MoFP to achieve their own desired outcomes was not understood nor anticipated by the MoH. The MoH were not able to influence at any level, nor develop strategies to sway the stakeholders. Subsequently, the lack of ability of the MoH to analyse the political and contextual environment in which the reforms were taking place resulted in their limited ability to manage and control the policy dialogue and provide a strong policy context in which the reform programme could progress (Bossert and Wodarczyk, 2000, Lewis, 1999). Institutions need to interact with the outside world, and the main modality for interacting with external stakeholders, as Lewis et al describe, **has to be with a carrot, rather than a stick**, through steering rather than control and processes.

5.9.3 Political and Institutional Leadership

The political instability of the environment in which the reforms were taking place has been explained earlier (4.2). Berman and Bossert (Berman and Bossert, 2000) highlight the importance of stable political and bureaucratic leadership in a period of reform change. They state the orientation of any MoH needs sustainable and effective leadership. A recurring theme in the data suggests that much of the MOH inability to drive the MoH institutional reorientation and keep safe the reform pathway during its implementation was related to the lack of political ownership by the Government of Fiji.[28]

Lack of visible political support of the reforms during the five-year period limited the opportunities of the MoH to canvass the reforms outside of the walls of the MoH. The analysis highlighted that very few political health ministers understood the real nature of the reforms and therefore did not champion the reforms and provide important political leadership for them (Aus Health International, 2004b). Examining

[28] Since independence, Fiji has had nine elections, 14 governments, including a combination of two military governments, interim, coalitions and democratically elected regimes and four military coups

how the reforms got on the political agenda helps explain why the reforms were never entrenched in the political environment.

The analysis reveals that the agreement to undertake the reforms by the Government of Fiji was declared in a MOU signed in 1998 as a declaration of support by the GoF and GoA. It was declared that the MOU was sufficient endorsement to enable the start of the reforms and that it was not necessary for the proposal to go through a cabinet process or be debated in parliament (PW Associates Pty Ltd, 1998). The MOU and the agreement protocols of the reforms were therefore managed at the level of the Permanent Secretary.

The senior official in the Prime Minister's Office at the time of the reforms confirmed this in his interview and noted that the reason for this was primarily because the reforms were not reliant on Fiji government public funds, but were funded by AusAID and were directly funnelled into the MOH. He further noted the government cabinet process in 1998 was a declaration of support rather than the result of rigorous public policy debate. It is likely, he further stated:

> .. the majority of government ministers did not know the detail regarding the reforms nor were involved in any of the discussions between the MOH and the GoA. The reforms started under the parliamentary radar, there was not much visibility from where I sat…

Health officials reflected that the lack of formal and visible public policy debate at the early stages of the reform did not give the reform programme the political visibility it needed to canvass the reforms more publicly. At the time, this was not seen as problematic as there were many other distracting factors within the environment such as the impending elections, however and as Grindle (2000) notes, in many developing countries reform initiatives are more commonly started at the level of the executive and not at the political level (Grindle, 2000).

It was recorded that every Government of Fiji between 1999 and 2004 endorsed the reforms. Further investigation into these reports highlights that ministers of health as

individuals endorsed the reforms as part of ministerial tasks but the reform programme was never submitted to the government as a formal process until 2002.

An interview with an ex-senator of Fiji's parliaments sheds light on why there was poor visible parliamentary debate on the reforms.

> Politicians in Fiji are ex public servants, they do not know how to have policy development discussion, they don't have the training and they are inept in this regard. This is why we don't have good public policy dialogue in any of our sectors (ex-Senator of Fiji Parliament).

Considine (1994, 2005) affirms this dilemma; he notes that the policy-making role of ministers in parliamentary institutions is distinctive. The fact that their recruitment, from among the ranks of different aspects of the legislature, makes them more apt to be policy generalists than specialists. He further notes that the generalist background of ministers makes them even more heavily dependent on the bureaucracy.

The test of the Fiji Government's commitment to the reform process was seen in their lack of intervention on behalf of the MOH during the stand-off period (1999-2003) with the MOFP and the PSC. In exploring this issue further, MOH stakeholders suggested a possible explanation for the lack of government support was related to the government's general lack of interest in the health sector. Other commentators have suggested that the political attention of government before and during the reforms was solely focused on the issues of the new constitution, stabilising government amid the rising ethnic tensions, the upcoming elections and political coup included, and therefore common public policy work was ignored. A hands-off approach by political leaders is a common practice during periods of political instability (Considine, 2005).

5.10 Health Ministers' Engagement

Berman (1995) highlights the importance and need for leadership at the highest levels both at the political and civil service levels in order to provide consistency over the lengthy period's necessary for reforms to be implemented. For 20 years

prior to 1999, the Fiji health bureaucracy as not recognised as having strong policy leadership within the health sector (O'Connor, 2001). There appears to be only three periods up to 1997 in which a genuine widespread discussion of national policy and development of new directions took place: the introduction of primary health care around the time of the Alma Ata Declaration in 1977; the introduction of health promotion policy and ideas in 1989; and again in 1997, the era of health promotion and Healthy Islands (Pacific Island Health Ministers Forum, 1980). In each of these phases there appears to be strong bureaucratic and political leadership (Negin et al., 2010). As such, Fiji political leadership has historically not had a strong presence in the health sector.

During the period of the reforms Ministers of health came to power by democratic election and or by interim government appointment. (1 elected, 3 appointed) A central role of health Minsters in a reform activity includes championing, promoting and protecting reform dialogue and processes. Interviewee data suggest that the various (four) health Minsters during the reform period were not actively engaged in advocacy activities or in encouraging public policy debate with stakeholders (in particular, the resistant stakeholders). Interview data with three health ministers during the reform period further affirm that the health agenda was not a priority during the period of political conflict.

> The interim and military governments were preoccupied with the development of the new constitution and managing a political landscape of ethnic tensions. We didn't have time then to be concerned with policy debates … this was a very politically difficult time (Ex-health minister 2000).

Interviewee data with the individual ministers who held posts during the reform period confirm this conclusion. Interviewees further confirmed that the only time that the health reforms discussion made it to the cabinet agenda was when the PSC raised its concerns regarding the reform agenda. This reflects Walt's (2006) observation that it is unlikely that health appears on executive cabinet agendas except at a time of crisis (Walt, 2006).

Further, interview data with four ex-health ministers highlighted that during the reform process the various Ministers appeared to not be able to form a view of what they wanted the reforms to achieve and were vague in their articulation of the outcomes. Subsequently they generally felt they that were persuaded by others to agree to the processes. An interview with one health minister during the period revealed the following:

> There were times admittedly when I was Minister that I felt I didn't know a lot about the reforms but I trusted the bureaucracy and the AusAID consultants to manage this … what could I add, I was put there as Minister (Ex-health Minister).

An analysis of cabinet papers during the period 2000 to 2004 reveals that the reforms were not formally discussed in cabinet until 2002, three years after the commencement of the reforms. The cabinet paper referenced in 2002 was the first formal endorsement of the FHMRP.[29] An ex-health minister commented:

> In my short time as health minister, I was never asked nor required to report on the progress of the health reforms (Ex-health minister).

The lack of political leadership and protection was a failure on the part of the Government of Fiji. A senior public official shared the following:

> I felt sorry for the health sector as their reform programme stayed under the political radar for the entire five years. I always thought that the ministers of health were probably the biggest single deterrent of the reforms because of their lack of commitment to the reform programme (Secretary to the Prime Minister's Office).

The lack of political commitment and the political disruption of the reforms by several changes of Government and a coup ultimately resulted in much of the

leadership of the reform efforts falling to the bureaucracy and the Permanent Secretary of the MoH to manage the policy dialogue at all levels within the sector.

The downside of this is that the MoH became exposed to constant criticism that the reforms were driven and championed only by bureaucrats and that **therefore the reform efforts were most likely to be only about improving the 'lot' of bureaucrats**. The shifting responsibility of the success of the reforms fell to the MOH bureaucracy and therefore the benefits of the reforms were perceived to be associated with the MOH leadership. Comments such as the following were common:

> "The reforms are all about new jobs for the directors in the health sector … the reforms are about seven new jobs for seven new directors" (Senior academic FNU).

Suspicion in the public sector regarding the motivation of the Ministry's bureaucratic leaders was perceived as "attempts by them to create a new and strengthened policy base through the reforms. Furthermore the PSC which controlled the employment pay scales and promotion policy for the public sector were concerned that the efforts by the MoH senior bureaucrats to advance the reforms was motivated by their desire escalate their careers, and an attempt by senior health officials to work around the PSC employment regulations. This view of MoH officials became a constant sticking point throughout the reforms and adding to the perception that the reforms were not necessarily about improving the system but as Green (2000) describes '**improving the lot of bureaucrats'**.(Green, 2000, Buse, 2008)

The effect of the poor political leadership of the reforms is highlighted by the difficulties the MoH had in managing the policy dialogue within the public sector. The fact that no political champion supported or advocated on behalf of the MoH with external stakeholders further inhibited the MoH to maintain its reform timelines. Maintaining a high level of political commitment due to the constant changes in political leadership over the period of the reforms was difficult. The essential

institutional capacity needed by the MoH to implement the reforms and identification of key challenges is summarised in the following table.

Table 9 *MoH institutional capacity and challenges*

Essential Institutional Capacity of the MoH	Problems in the MoH
Analysis capacity: human resources needs.	Policy analysis and political strategic analysis knowledge lacking. No fixed infrastructure or unit to create the space for analysis capacity building.
Clarity of reform goals.	Confusion over reform goals and objectives. Result of poor diagnostic analysis of health sector problems.
Environment of change.	No anticipated political strategies to manage unstable political environment.
Sector leadership and management: ability to provide leadership for sector and enable consensus building both internally and externally to the MOH.	MOH Permanent Secretary showed strong commitment to the reforms. Unable to provide either internal or external leadership to the reform. Consensus never reached during the five-year period on reform objectives, both internally and with external stakeholders.
Participation incentives.	Recruitment of new senior level positions provided some incentives for engagement by senior doctors.

5.11 Limited Public Policy Dialogue

The importance of public policy discussions during a reform process to test its acceptability is a critical aspect of policy dialogue (Bossert, 2000). According to Considine (2005), the electoral system is undoubtedly the most formal institutional framework that has the most effect on policy making. Elections are normally the most obvious window of opportunity so far as policy making is concerned; once an election is called a wide variety of policy proposals receives attention.

As noted elsewhere (Section 4.2), two elections were held during the five-year period of the health reforms. An analysis of political party manifestos for both the 1999 and 2001 elections highlighted the absence of any political parties promoting the importance of the health reforms.[30] In 1999 Rabuka's Government and the initiator of the public sector reform program did advocate the continuation of the reforms if successfully elected. As noted elsewhere Rabuka's Government lost the election. An assessment of the 19 political parties that stood for election in the 2001 election noted that only one party mentioned the health reforms as part of their political agenda.[31]

The importance of analysing manifestos according to Considine (2005) is that the manifesto becomes an authoritative document, which future governments can wield in parliament; commitments made in manifestos therefore take on great significance. As such, the 2001 elections never provided a health policy platform to test governments' commitment to health and the health reforms.

5.12 Institutional Resistance to Change

The set of relationships called the policy system in Fiji is composed of several different kinds of actors and institutions. Their joint identity as a system is defined as a pattern of dependency between actors and organisations (Considine, 1994). The most important means for providing structures between actors is through institutional legislation and procedures. When these procedures are applied to policy making and implementation we see these regulations in more formal terms (Considine, 1994).

The governing institutions in Fiji were central to the policy implementation process. Their role to provide a regulated structure through which the policy proposal was to travel. Institutions are able to confer advantage on policies or they can restrict others (Lindblom and Woodhouse, 1993, Considine, 2005). Ascertaining the support of the Public Service Commission and the Ministry of Finance and Planning in the case of Fiji was necessary, however due to reasons discussed in the above chapter the institutions imposed constraints on the policy process, which impacted on the functioning of policy system. By withdrawing support of the policy process the

[30] Nineteen political parties registered in the 1999 elections
[31] The party was not successfully elected

institutions signalled to the wider public sector a different pathway was been developed for the reforms. They applied "brakes" to the process and subsequently forced actors to follow the same patterns.

This response by institutions, according to Considine (1994), creates potential problems for policy makers. The regulatory role of a political institution is mandated through the parliamentary processes and via its legislation lays downs the codes for which the policy proposals are structured. The long histories of both these institutions gave them their own sense of power and independence to define their own action pathways. The policy system with which they operated gave them many advantages and they used the power in their organisational history as well as their legislative authority to enable them to judge the reforms as a threat. The regulatory mechanism and the cultural mandate carried by the institution offered them an opportunity to carry past practices into the reform discussion. As Considine (1994) suggests, an institutions' 'accumulated intelligence' allows it to express itself as it feels appropriate.

Trader-Leigh (2002) discusses the idea of a '**pathology of resistance'** to implementation strategies in the public sector. She describes the importance of developing the case for change and that public sector managers unlike the private sector managers are much more likely to resist change. She notes that public sector managers and bureaucrats are much more difficult to convince and that strong cases for change need to be developed as part of a change strategy (Trader -Leigh, 2002 p142). In the case of Fiji the lack of analysis on purpose and clarity of reform intensions must be strong so that institutions can see the benefits of change. When this type of analysis is not available, organisation designs for major changes often result in failure or a struggle between forces supporting change and those institutions resisting change, followed by long and bitter implementation battles, change she suggests is a bit like warfare. Lindblom agrees and suggests initiating change introduces hostile activity.

An examination of Fiji institutions and their resistance to the reforms is better understood by reviewing and assessing the process of the stages and development of

the new legislation. As in most reforms, the majority of policy initiatives involve new or revised legislation and it is typical that the MoH as the central policy makers push and cajoled together with their counterparts to bring the policies into action. According to several theorists (Theodoulou and Cahn, 1995, Sabatier, 2007, Peter, 2012), four important stages are required to implement legislation: initiation, clearance, consideration and decision.

1. Initiation

The first stage of this process is referred to as the initiation of new legislation or amendment of legislation which was first proposed and completed under the broader public sector reforms program in 1999. At this stage of policy initiation in Fiji, it is important according to Stone (1998) that a detailed analysis should be completed on the level of opposition that the proposal might attract by other agencies. The reason is to gauge an evaluation of alternative means could be identified should the existing proposal not meet all the requirements (Stone 1998), and identify if interested players have any concerns. Importantly also to gauge commitment to the policy if at any stage an election or budget occurs and political priorities change (Howlett and Ramesh, 2003, Considine, 2005). The reason being is that it is necessary at this early stage to assess whether interested players have any concerns and to enable a significant and lasting commitment to the policy if at any time an election or budget occurs and the commitment could evaporate.

As noted in Section 5.2, the MOH did not have the capacity to carry out this kind of analysis nor was it considered. There was no formal strategic analysis on the impact of the policy and the views of key policy stakeholders. A feasibility undertaken prior to the reforms identified that the reforms would be welcomed if they resulted in system improvements and improve access for consumers (PW Associates Pty Ltd, 1998). Resources to implement the policy were not required at this stage from Government of Fiji as the donor through its bilateral arrangements with Fiji, had committed to funding ninety per cent of the costs of the reform program, subsequently at this stage of the initiation no financial assessment of the reforms was carried out (Aus Health International 2004).

2. Clearance

The second stage of consideration concerns the vetting of proposals in order to obtain permission or clearance to proceed further (Colebatch, 2002). No matter what agency or authority initiates a proposal for new legislation there is always a demand that other authority holders to be given an opportunity to check modify or veto new policy. In the case of Fiji it was at this stage of the vetting that the PSC and MOFP did not clear the policy process. Also important at this stage is the identification of policy resources and involvement of the MOFP (or treasury). It was at this juncture that the MOFP in particular became concerned at the capacity of the MOH to manage the resources that would come with devolved authority.

Reviewing the policy at a broader governmental level to ensure that that government philosophy and strategy are consistent, and to check that the policy initiative is still seen as a Government priority is critical (Stone, 1998, Considine, 2005). It is standard at this stage that policy committees of Government might also assess the policy's validity (Considine, 2005). In the case of Fiji, these processes were not adhered to. At no time did the policy proposal developed by the consultants with the MOH go to Parliament or to cabinet for review and checking. As such the policy was not protected by the broad government processes but rather kept within the confines of the PSC and MOFP policy process, who used their own internal institutional processes and powers to review the policy.

3. Consideration

The third stage involves consideration of the new legislation and sees Ministers deciding whether or not to grant permission for the proponents of the new initiative to proceed with the policy. It is at this stage that the proposal is checked to see if the initiative will actually work in practice and to make sure that there is no major opposition from inside the government. Media reaction to the initiative is likely to be at this stage. This stage also involves elaborate policy consultation and wide community consultation. Further it is likely at this stage of the process that attempts at forecasting the impact of the proposal takes place. In the case of Fiji this process took place after the completion period of the reforms in 2004. It was also at this stage of the processes that the PSC and MOFP who had been resisting the proposal

were forced to offer some form of cooperation. The data shows that at no point during the five year reform period was there any substantial debate by the media on the reforms.

4. Decision

This point is reached when the proposal is framed as a Bill or an Act. It is at this stage the Minister responsible for the proposal is able to call upon his or her party colleagues to vote the measures through. For Fiji the decision point was reached in 2004 when the transfer of authorities moved from the PSC and MoFP to the MoH. The analysis highlights that the FHMRP policy proposal sat at clearance stage (stage 2) of the process for the entire five years of the reform program.

5.13 Authority Transfer

In September 2002, three years after the commencement of the formal reform period and after a period of various delays caused by the institutional resistance the 1999 election and the 2000 coup, and the reinstatement of the public sector reform program, the MOF finally approved partial devolution of financial powers to the MoH (Aus Health International, 2004b). Three months later in December 2002, the PSC devolved partial human resources power to the MoH. The PSC retained the power to approve job descriptions as well as authority to appoint senior health officials, but devolved to the MoH power to recruit their own medical staff.

Following the delegation by the PSC of HR powers to the PSH, the MoH prepared a detailed listing of proposed HR sub-delegations to the health services and finalised it in February 2003. The proposed sub-delegations were then submitted to the PSC for approval in March 2003. The achievement of this output was dependent on the support of the MoF.

These two central policy decisions enabled the MoH to formally establish the new divisional structures and commence advertising the new divisional positions (AusHealth International 2004a). The MoH completed its necessary documentation for the devolvement and recruitment process in March 2003. Approval by the PSC to advertise positions did not come until June 2003, adding further delays to the MoH

reform timelines (Aus Health International, 2004b).[32] The PSC reported that director positions would be processed and completed by the end of July, and general manager positions by the end of August. In December 2003, four years after the commencement of the reforms, the PSC approved the appointments of three directors of health for the newly formed divisions (see Figure 13).

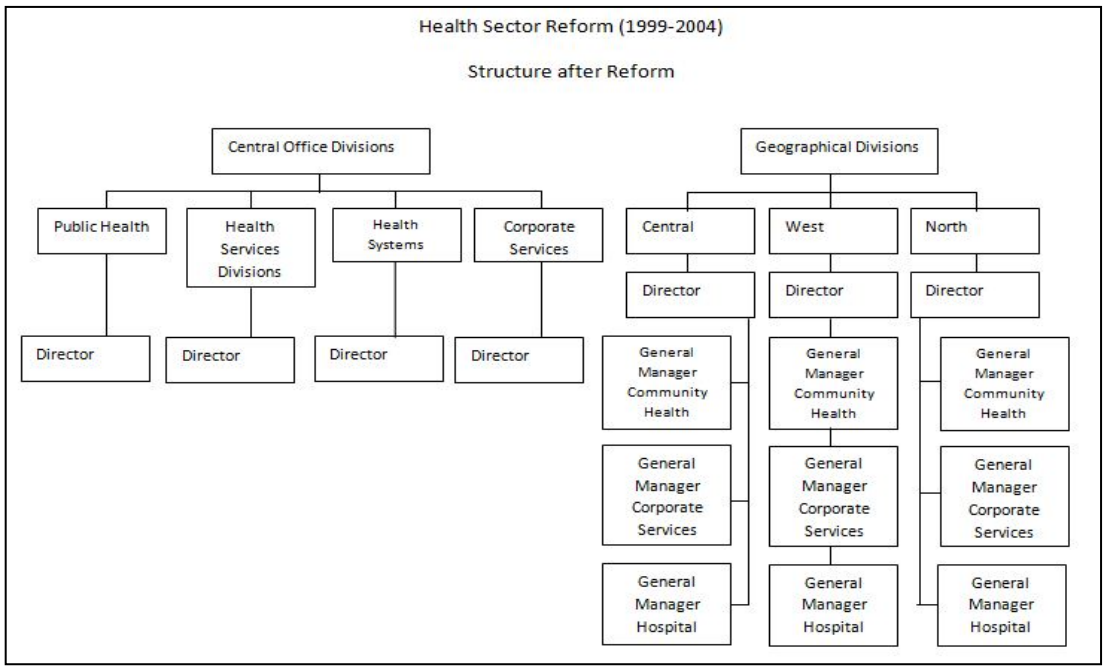
The development of policy and divisional guidelines, new job descriptions and roles was a significant part of this work. Central to this was the legal framework, in which the delegation of powers could be transferred to the newly established divisions, from the PSH to the new divisional structures. The process of consultation and negotiation to get to this point took more than 12 months. Detailed organisational designs for the divisional health services were completed in 2001, however, the legislative amendments to support the establishment of the divisional health services were not passed in parliament until August 2002 and the PSC did not delegate powers to the PSH until November 2004, nearly five years after the commencement of the project.

At the end of the reform period in 2004, the final report on the reform outcomes notes that the delegations from the MoF to the MoH '**remain inadequate'** to successfully complete the reform implementation successfully (Aus Health International, 2004b). A senior health official describes the following:

> The FHMRP finished in December 2003. The major areas started but not completed are wide and varying in size. Some of the key changes are still only in the planning stages, whilst others are a little bit further along. I don't think people will view this process as successful. As a follow on we are pleased that the Australian Government will continue to fund phase two (Rabukawaqa, 2006)

Figure 13 *Completed health system restructure, 2006*

[32] In addition there were further delays caused by public service staff freezes would result in the new senior health managers not being appointed until mid-2003 (AusHealth International 2001b)



5.14 Chapter Summary

This chapter highlighted the challenges of the three main political institutions involved in the reform activities. The analysis showed that the two key and central political institutions, the PSC and the MoF, actively derailed the reform process by delaying the devolvement of authority to the MoH. The analysis further highlighted that the legislative processes related to the approvals were not adhered to and subsequently the MoH proposals "got stuck" in bureaucratic processes rather than Government and legislative processes. Reasons such as paramountcy and protection, lack of confidence in the MoH and relationship failure were the key determinants that contributed to the delays in this health reform process.

The MoH also had both technical and human resource issues, which affected the ability of the MoH to reorient itself as a serious policy institution. I further argued that a key challenge for the MoH was the limited political support it received from central government and the various ministers of health during the same period. The lack of political visibility of the reforms kept the MoH reform programme under the political radar.

Chapter 6: Actors, Issues and Strategies

6. 0 Introduction

The study of a country's political context, the culture of policymaking and its institutions do not account for all that occurs within a policy system. Subsequently, an analysis of policy actors and their relationships with each other and their behaviour is necessary (Considine, 2005). The concept that Considine advances is that policy is the result that emerges from the interplay of individuals and groups who seek to alter and confirm the rules and the programmes organised by government or a bureaucracy (Considine, 1994; pg 37). There is no policy system without participants, so policy must be viewed as the accomplishment of real people and actual groups. Policy is primarily a joint action among a complex range of actors (Considine, 2005, Gilson et al., 2008).

This chapter considers the role of actors and stakeholders using evidence and information gathered through interviews and documentary data. It examines several key issues that emerged in the analysis related to actor behaviour. Actors acting on these issues affected the implementation of the reforms. An analysis of the strategies of actors and the issues that mobilised them has been identified from careful analysis of interview data outlined in the methods section. The research identifies various categories of actors who engaged in the reform process. Two themes are examined: the role of the medical authority (between doctors and nurses) and the role and effect of the external technical authority on the implementation of the reform process.

An actor is an individual or organization that has an interest in the reform and has some power to affect the policy's progress (Walt and Gilson, 1994). Although numerous actors were involved in the reforms, the following discusses the key themes in relation to four groupings of internal MOH stakeholders: doctors, nurses, health bureaucrats and HMAs.

Doctors and Nurses

Doctors and nurses in Fiji's MOH are employed by the state and they are public

servants. There were two groupings of doctors in the system: medical managers and mostly located in the centralised arm of the MOH and clinicians who worked in the hospitals and in the sub-divisional health service. Doctors were not grouped together in a formalised network in the system, but came together over common concerns related to the reform structure and processes. Nurses in the Fiji health system make up the largest part of the health sector workforce.[33] Nurses did not hold senior health management posts. The Director of Nursing position was the only senior nurse position at the time of the commencement of the reforms.

Health Management Agents (HMAs)

HMAs were technical advisors employed by the managing agents to lead, design and support the implementation of the reform processes. The recruitment of HMAs to act as technical advisors was part of the identified reform implementation model (Aus Health International, 2000). Advisors were selected from a pool of Australian development consultants, based on their knowledge, skills and expertise and worked in Fiji either for the duration of the project, or short term 3-6 months. Over the period of five years, 20 different HMAs were involved in the reform project. Their technical skills included, health financing, health information, IT, nursing, policy and management and workforce training.

Health Bureaucrats

Health bureaucrats in this discussion include all health workers in the MoH that were not part of the clinical workforce. These included planners, service directors and non-medical divisional directors, office clerks, corporate service employees.

6.1 Power and the Influence of Actors

Various commentators agree that actors bring varying degrees of power and influence to the policy making and implementation process (Lewis, 2005, Walt, 2006). The power and influence of the different actors (nurses, doctors, health bureaucrats, public sector officials and community leaders, politicians) in Fiji during the reforms highlights the importance of this critical element in the policy making process and underlines why actor behaviour is important to analyse. The data

[33] In 1999, there were 1,570 nurses employed by the MoH (MoH Annual Report 2000)

identified that several categories of actors wielded significant influence during the reforms. The study has been guided by Lewis's definition of influence below:

> Influence is defined as a demonstrated capacity to do one or more of the following: shape ideas about policy, initiate policy proposals or veto others proposal, or substantially affect the implementation of policy in relation to health. Influential people are those who make a significant difference at one or more stages of the policy process (Lewis 2005; pg 61).

While those in the top political and bureaucratic positions are highly visible and central, there are other actors in the policy process who had extensive influence. Linking actors with issues helps examine how the health policy agenda can be shaped by the confluence of influential actors and their concerns (Considine, 2005). An emphasis on analysing connections, combined with the notion that actors cannot be divorced from their preferred issues, produces a way of understanding the impact of actors on policy process.

6.1.1 Medical Power

The role of the medical profession in any reform activity holds special interest and the medical profession is important as it plays a number of different key roles (Lewis, 2005, Walt, 2006). Health and policy formulation requires medical knowledge and expertise, doctors and physicians as well as nurses are the frontline workers and their practices often determine how well a policy would perform. If the medical profession holds a common view on a health policy, it can have a direct channel to policy makers, which can be used to further the profession's interests. Consideration of the role of doctors in the reform process and how they acted to protect what they valued forms part of the following discussion (Lewis, 2005).

Fiji's health policy system has evolved from a colonial base where the power and influence of the medical sector has been at the centre of its system. This is not an unusual scenario given that most developing nations' health systems have historically developed on the availability of medical professionals and their contribution to health systems and services (Bossert et al., 1998). They have in the

past acted as health managers, health service directors, hospital managers, corporate managers and practitioners. The analysis shows that during the reforms the doctors responded over several key issues, discussed in the following section below.

6.2 Creation of a New Cadre of Health Managers in the MoH

A key feature of the reforms was the establishment of a centralised and strengthened policy and health management capacity in the MoH. It was recognised that the creation of this capacity in the MoH required the establishment and training of a new cadre of health and policy managers into the system.[34] The removal of doctors from management roles therefore was a key aspect of the establishment of the new policy and management culture to make way for the new cadre of health managers (Aus Health International, 1998a). Further exploration of this issue with actors and stakeholders highlights that MoH stakeholders recognised and were concerned at the overt influence of doctors in the management of the health system. A senior member of the planning team shares the following:

> The majority of the management decisions made in our system were made by doctors. Our senior management team was mostly doctors. I can see the reform needs a different kind of skill and our doctors don't have it (Planning officer MoH).

Equally concerning for many stakeholders was not just the need or desire to remove doctors from senior management roles but the urgent need to put doctors back into clinical practice. As one health official describes,

> We need our doctors to be working with patients, that's what they are trained for, not running the health system….. they are hopeless at management. They are wasting their skills here when we need them in the hospital

It was a common perception that doctors were in administrative roles so they could influence decision making and resources allocation. Comments typically heard include the following by a nurse:

[34] In 1999, at the commencement of the reforms, the majority of health managers in the MOH were medically trained staff (Aus Health International 1998b)

> Many of our doctors they know where the real power is, they seem to have forgotten what they were trained for (Senior nurse in the MoH).

Comments such as this suggest that doctors should be actively working in the hospital and managing patients and not meddling with health management politics, nor should they be associated with political and management roles.

The reform's intentions to remove doctors from senior level positions and described in the reform proposals as part of the management restructure,[35] were firmly rejected by the medical doctors. The analysis showed that doctors were, first, concerned with the proposed structure and the planned reduction of their power and influence at the senior health management level and, second, concerned with the lack of capacity of the MoH to replace them with the 'new management capacity'. A senior doctor on the MoH management team shared the following:

> We understood that the reforms wanted to remove us (doctors) from the administration of the system but we did not view this as a reality as there were no real health managers in the MoH. We are still the most important and knowledgeable in the health system and it would be impractical and risky to try move us out at the top of administration … what and who would you replace us with? … These folks don't know how to run a health system (Doctor on senior management team in the MoH).

Comments such as these demonstrated that doctors in senior levels of the health system believed they were well suited for the management of systems and their reactions revealed the tension between doctors and non-medical managers and bureaucrats.

[35] The FHMRP proposal to restructure the centralized MOH unit was based on removing doctors from management roles and returning them to hospital duties.

6.3 New Paradigm of Health Care

The devolvement of authority and decision making to the newly established sub-divisions and part of the new decentralised reform structure, was a move to take health decision making closer to communities, and an important and critical part of the reform strategy and a key aspect of the reform design (Aus Health International, 1998a). The devolvement was based on the release of authority by the central arm of the MOH to the new sub-divisional directors (Aus Health International, 2001a). Implementation of this model meant that many of the responsibilities held by the senior management team and medical staff at the centre of system would be removed or reduced. Decisions related to service delivery and outreach and community services would, in the new structure, be within the jurisdiction of the newly formed sub-divisions and not retained at the central level.

Doctors at the centre of the health system who held control and authority of resources did not support the approach. The contention for doctors was that the new structures would give medical and administrative divisional staff more power than their counterparts. Further exploration of this issue with doctors highlighted that underlying the tensions was a resistance by medical doctors at the centre of the system towards policies (such as the reforms) that were moving away from a medically centred approach of care towards a community centred model. A doctor from the centralised arm of the MoH shared the following:

> I'm not sure our medically trained staff in the sub-divisions realize the full impact of this policy … they will have to think about how they deliver their services differently. It seems they will have to talk to their communities more … I don't think this is their role here.

The doctors reaction to the intended reforms is understood better in the context of understanding how Fiji's health system was established and has evolved within a bio-medical model of health care. In the bio-medical framework as discussed by Starr (1982) in his work, *The social transformation of American medicine*, he states that disease is an individual condition to be cured by individual action (Starr,

1982).[36] The medical profession has significant control over health care through its autonomy and authority and by shaping societies beliefs about health problems and how they should be managed. Lewis (2005) notes that the structure of health systems is indicated not only by bio medicine and the associated authority of the medical profession, but also by the range of other interests that rely on a continuation of disease focused and curative service policies, such as medical equipment manufacturers, pharmaceuticals companies and providers of care to people with acute and chronic illnesses (Lewis, 2005).

The Fiji health reform policies were based on a shift towards socially based models of health care with stronger community and public health principles and a move away from the bio medical approach to health service development. Socially based models of health care which locate disease within the wider environment, challenge the models of bio medicine by emphasising the importance of societal factors in determining health and illness and, subsequently, challenge and at times reduce the authority of the medical profession (Lewis, 2005).

Policy initiatives that have a strong shift away from the bio medical focus have often caused negative responses by doctors as they can be perceived as directly undermining the medical profession's credibility in health care. Lewis (2005) further explains that this type of approach is also likely to threaten the authority of medical influence and reduces the perception of the autonomy of medicine, threatening the profession. A doctor concerned about the proposed policy shift shared the following:

> I don't have confidence that my medical counterparts at the sub-divisional level will know how to handle the new environment … we are doctors, not community workers (Senior medical superintendent in the CWM).

> I understand that there is belief that communities should be more involved in community health decisions, but at the end of the day it is the doctor who treats the patients that makes the decisions about the health of the patient…..

[36] Although the bio medical view of health has changed over the past twenty years, the idea of medical power and authority remains a strong influence in the Fiji Health system.

These types of comments suggest that doctors in Fiji feared not only the loss of management influence and control in the system but also felt threatened at the reduced influence and role of their own profession.

6.4 Strategies by Doctors

The attitude of senior doctors with regards to the reform intentions of the removal of doctors from management roles and their professional demise as part of the reform policies orientation resulted in doctors strategising to retain their positions and power within the system. The majority of the senior medical staff sat on various committees responsible for the oversight, decision making and implementation of the reforms. The committees were recognised as being the central decision making mechanism of the reforms (Aus Health International, 2004b).

Behaviour such as non-attendance at critical meetings, withholding information from committees, withholding approvals for activities related to change management processes and the use of delay tactics such as purposefully losing information resulted in slowing processes needed for the smooth implementation of the reforms. A senior planning officer shared:

> We would wait for Dr … and Dr … to attend these meetings, which were critical to the reform roll out. They always sent their apologies to the most important meetings, knowing full well we couldn't proceed without them.

A common strategy by doctors is described by one of the sub-divisional medical superintendents.

> Sometimes we found out that doctors in the central office would make decisions that would be to their advantage and push through decisions … then these decisions would come to the meetings and we were required to sign them off … there was no consultation.

A senior divisional manager shared the following:

> Many times we were called to meetings to just rubber stamp whatever the central medical divisional officers had already agreed behind closed doors … I found this very frustrating.

These actions contributed to the delay of the reforms and resulted in anger and confusion at all levels of the system. A sub-divisional planning manager shared the following:

> I could see what was happening at the central level of the system, the doctors were behaving badly, it was frustrating for us in the sub-divisions, we couldn't get a decision on time for anything.

Confusion regarding responsibilities and delays for decisions were also a direct result of the behaviour of strategic play by the medical doctors at the centre of the system. As the senior medical officer in charge of a sub-divisional hospital noted:

> I was always left unsure what responsibilities and authority I had during the five-year reform. I did recognise that for some of our senior medical staff in Suva … it was hard to let go of some of the their responsibilities and I felt it made it hard for us in the divisions … Some days I knew what I had authority to do but most days I didn't … even when I thought I had the power to make decisions, I know I really didn't have it.

Comments such as these were a telling example of the confusion and power struggle between MOH officials and medical counterparts and resulted in a tension that existed throughout the five year period. Further the delays imposed by the PSC and MoFP on the reform roll out impacted on the delay of the recruitment of the new health managers (new cadre of health workers) planned to replace many of the

medical managers. These delays played to the advance of the medical strategy to resist change in the MoH.[37]

The FHMRP challenged the medical profession because it was viewed by doctors that their privileged status might be eroded, they also viewed the reforms as introducing more control and monitoring in the system and these would impact on patient practices.

> The reforms are supposed to free up doctors to do more medical work but all I see is more monitoring and less resources.

> I see the reforms as increasing more managers in the system… this means more reporting and more paper work…and more time spent writing reports than on looking after patients…. How does this help?

Comments such as above highlight that doctors were concerned that the reforms was would reduce their medical authority in the system but viewed the reforms as increasing control over their profession and clinical freedom.

6.4.1 Increasing medical authority in the MoH

Overriding concerns by nurses and other internal MoH stakeholders was the push by medical doctors to retain their medical and management influence in the MoH. The interview data suggested that the strategies by doctors to keep the reforms from succeeding were successful. The overt push by doctors was not only about retaining their level of influence at the management level but it was also about increasing their influence. As many stakeholders described the doctors' strategies were to increase the medicalisation in the MoH; that is, increase the power of medical power in the system, rather than reduce it as part of the reform's intentions. Doctors within the MoH who had senior roles were very vocal and strategic about retaining their level of control of the administrative power and were able to keep safe and protect their positions at the senior level of the MoH during the reform process. By the end of the reforms, there was an increase of six medical doctors at the senior management team level of the health system. Their ability to increase their hold at the highest level of

[37] At the beginning of the reforms, the MoH had one formally trained health manager

the system was viewed negatively by the MoH non-medical staff. A senior nurse shared the following:

> I felt … doctors in the management team actively sabotaged the reform ideals … They sat around the decision making table and were able to advocate their issues and keep safe their positions better than anyone else in the system

> I felt the doctors were very smart…. They used the reforms to gain an advantage and yet we thought the reforms were about removing the doctor's (Senior nurse in the MoH)

6.4.2 Relegation of Nurses

An examination of the position of nursing in the Fiji health reforms provided useful insights into not only the power of the medical profession but also the position of nurses in the health system. The central concern of nurses during the reform period related to the behaviour of doctors to entrench their medical position in the MoH. Nurses were further concerned at the lobbying of doctors and others to reduce the nurses' leadership position and capacity in the MoH system. Nurses were also concerned that their credibility to actively have a voice in the reform processes was marginalised.

Tension between doctors and nurses emerged in the early days of the reform during the planning process and over the reform structure. The new reform model proposed the removal of the Director of Nursing position and the nursing division from the top level infrastructure of the MoH.[38] In the pre-reform structure, the Director of Nursing was located at the most senior level of the MoH management system (equal role to the senior doctors in the management team). The position gave nurses not only health system leadership profile but also enabled nurses to have a voice in the management of the overall system.

[38] The Director of Nursing was a member of the senior management and executive team that worked under the leadership of the PSC. The position was considered the highest nursing leadership role in the system

The Director of Nursing had sole responsibility for the recruitment, retention, training, promotion, supervision and career development of all nurses in the MoH (Aus Health International, 2000). The proposed relegation of the Director of Nursing position from the senior management team[39] was supported by doctors who made it clear that the Director of Nursing role was 'ill fitted' to sitting around the senior management team table, as one senior doctor described it.

> The Director of Nursing position should be concerned with the work of nurses, their role and their support of the medical teams, it makes no sense that the Director of nursing is at the senior level of the health system … nursing issues are a human resources issue not a management issue.

The position of doctors towards nurses during the reform process can be explained further by their fear of loss of authority, but also by what Lewis (2005) calls the need for doctors to control the definitions around health. The above comment reflects the attitude that doctors had regarding the role of nurses and their contribution to the health care model. Nurses should be concerned about only supporting doctors and their roles not about management issues. Nurses became concerned at the push by doctors to relegate the nursing director's position outside of the senior management team structure.

A nurse in the hospital shared the following:

> We were not sure what the real intentions of the reforms were. We were shocked at the suggestion to remove the nursing director's role. We felt the doctors in the system were supporting this. I know many of my medical colleagues believed that nurses should stay under the medical director's position. I know many of them thought we should not even have an independent nursing director.

One nurse recounted:

> You know, we are the largest workforce in this sector, the nurses make this system work … yet we were not regarded well in this reform (Nurse CWM Hospital).

[39] The senior management team consisted of five doctors, one non-medical manager, a female Director of Nursing and the Permanent Secretary

Another nurse described the reforms were a 'slap in the face' for the nursing profession. An unpublished report written by an external consultant on the role of nurses during the reform period notes that 'nurses were on a slippery downward slope' (Shields, 2003). The unpublished report suggests that the Fijian nursing profession was at risk of losing its 'true vocational identity'. The report further suggests that reforms had intentionally ignored the role of nurses in the restructuring process signalling their disregard as serious policy contributors.

Nursing was viewed as on a lower hierarchy within the system because the doctors within medical profession placed themselves at the top of the hierarchy. An extract from a report completed by a nursing consultant during the reform period that highlighted the tensions between doctors and nurses noted the following:

> The focus of health management change has been on the medical superintendents. Their issues, their needs and driven by them. As part of this push there has been some strategic oversights along the way the most obvious of which is nursing. The reforms have paid little or no attention to nursing, a function in our Ministry that employs 75% of our total professional of staff (Shields, 2003; pg 17).

Nurses viewed the position of doctors towards them as a direct attack on nurses and the nursing profession, further enforcing the perception that nurses were not an important factor in the policy discussions. The PSC of Health at the time described in his interview that the nurses were central to the reform discussion but unfortunately the influence of the doctors made it difficult for them to assert their positions (Rokovada, 2006). According to Lewis (2005), this is a common perception that although nurses can wield significant power through the sheer numbers of their workforce, the power is not the same as that required to be able to contribute to health policy agenda setting. Their major contention was their lack of visibility in the reform programme and the push by doctors to grasp for more power.

Nurses in the MoH did not vocally or publicly agitate their concerns regarding the proposed reform changes in nursing leadership. A senior nurse noted the following:

> We didn't make a public fuss internally; it wasn't our way (Senior nurse in CWM).

In exploring this position of non-confrontation and silence with the nurses further, they conveyed that they were aware that moves by doctors to strengthen their role in the MOH and to reduce the power of nurses was related to power and gender. A senior nurse suggested that their silent response could be explained by the traditional and cultural position that women normally take when confronted by men in change processes, suggesting that women in a strong cultural male environment needed to be careful about how they managed their relationships so as not to upset the balance of social hierarchy.

Varani-Norton (2002) in her study on Fijian culture and women, affirms this idea of social balance:

> Fijian women will be inhibited by two concerns: a desire not to lose their time-honoured role as conservators of the status quo, and a fear of disrupting social harmony by challenging what they still see as men's proper role as initiators of change (Varani-Norton, 2002; pg 22).

The policy process, Lewis (2005) explains, is a result of nursing still being seen as female and therefore subordinate to medicine and the male profession. Furthermore, Lewis and others suggest that women nurses particularly struggle to find a voice in the health policy debate because of the highly gendered nature of the professions (Lewis, 2005, Sperling, 2001) and policy is often oriented to male concerns (Sperling, 2001). Power issues between nurses and doctors within the MOH were not explicitly referred to as nurses were sensitive about being seen as griping about the professional tension. However, their responses to the removal of nursing within the leadership structure brought forth an underlying tension regarding doctors in the senior management levels who were perceived to have supported the decentralisation of nursing's power.

Quietly and strategically, nurses conveyed their concerns through the Fiji Council of Nurses.[40] They communicated their concerns also to the Prime Minister's Office (interview with the Secretary to the Prime Minister's Office). Political lobbying was a key political and legitimate strategy by the nurses who used this approach to gain support. Nurses viewed themselves as holding very little power and were in a weak position during the reform years, and remained concerned at the reforms throughout the five-year period.

Both the nursing and medical professions are an integral part of the architecture of Fiji's health policy system both as part of the institutional arrangements of health and as interest groups. They were also a focal point in understanding the politics of health. The medical professional has always had significant control over health care through its autonomy and authority of other health occupations. The primary concern of medical managers and doctors in the Fiji health system was whether medicine's position in the system was losing power and if so what impact this would have on them. Nurses on the other hand were on journey in this process to have their expertise respected and their voice and opinions incorporated into the institutions policy frameworks, as one senior nurse shared:

> We need to be heard and taken seriously, we are tired of just been the workers, when it comes to policy and serious health discussions, they… seem to forget we exist.

Fiji Nurses were perceived by doctors to be pushing the boundaries and this was viewed as challenging medical authority in the system. Nursing provides a contrast to the medical authority when analysing the various ways in which culturally gendered professions relate to reform policy programmes. Non-medical groups tend to remain peripheral to health policy debates. Their ability to promote their own ideas on health and policy has been constrained by the dominance of medicine (Starr, 1982).

[40] The nursing union that represents all nurses in the public service

Ultimately both nursing and the medical profession had very important roles in the policy process and were key institutional players. Although the data highlights that the nursing voice was hard to decipher in the debate they did demonstrate they had a strong ability and influence to negotiate. The power of medicine wielded significant influence.

6.5 Bureaucratic Power and the Role of the Public Servant

Walt (2006) notes that the role of MOH bureaucrats is recognised as having the most extensive influence in policy processes and they need to be visibly active. An examination of the behaviour of health bureaucrats is important as it helps to explain the reality of translating policy into practice (Considine 2005). The seminal study of Michael Lipsky's (1980) 'street level bureaucrats' highlights that policy implementation in the end comes down to people who actually implement it, the bureaucrats, in particular, how they shape their responses to their understanding of the reform issues (Lipsky, 1980, Hill and Hupe, 2002, Considine et al., 2009).

6.5.1 Role of the Public Servant

In Fiji, MOH bureaucrats consisted mostly of Indigenous Fijians who were career public servants (Ravuvu, 1992). [41]Civil servants in Fiji have always been held in high regard and high-ranking traditional chiefs have often held the majority of bureaucratic positions in Fiji's public service. In the Fijian context, senior civil servants have led the way in the public discussion of controversial policy issues of the day. The engagement and support of health bureaucrats in the FHMRP was seen as a central and essential aspect of the safe implementation of the reforms. The data suggest that the relationships between health bureaucrats and the technical health management advisors needs examination in order to understand the various issues that affected the implementation of the reforms.

6.5.2 Role of the Health Management Advisor

The role of HMAs in the reform programme was seen as a critical and important aspect of the reform model. Their role was to provide the technical and strategic

[41] Although most senior civil servants were Indigenous Fijians , the reforms were proposed a merit based recruitment process that would enable non indigenous Fijians opportunity to apply for senior positions

leadership and guidance under which the reforms would progress. An analysis of the role of the behaviour of bureaucrats in this study cannot be explained without a focus on the role of the HMAs. HMAs were located across the various divisions in the MOH,[42] depending on the role they were performing. It was intended that the international consultants would bridge the gap and fill the missing and necessary capacity that the MOH needed to support the reform planning and implementation.

6.5.3 Control of the Technical Dialogue

Throughout the analysis a reoccurring theme by internal MOH stakeholders was the lack of confidence of the bureaucracy in the HMAs' abilities to carry out the technical and strategic leadership of the reforms. Concerns related to the HMAs' on-going inability to get clarity on technical aspects of the reform model, implementation plans and sequencing of technical inputs, timelines and processes was seen by the bureaucrats as a key failure and left the MoH with little confidence that HMAs were technically capable for completing the tasks allocated.

A health official offered the following:

> We never knew where we were up to with the reforms, sometimes I felt the plans changed daily … and the HMAs kept changing their minds on everything. They did a lot of their thinking on their feet, the reform model was never agreed with any certainty … and it kept changing each week. I remember being very frustrated with the HMAs we had as we couldn't understand their processes…

The analysis further highlighted that bureaucrats felt that arguments developed by the HMAs were technically poor, highlighting their lack of understanding of the contextual issues in Fiji. The example highlighted by many in the analysis referred to the collapse of relationships with their public sector colleagues in the PSC and

[42] The international consultants were delegated local counterparts to work with but due to relationship difficulties the transfer of knowledge by consultants to local counterparts was poor

MoFP.[43] I felt that the HMAs did not know how to frame the policy issues properly so that we could convey the issues well to stakeholders.

A senior health bureaucrat noted:

> I didn't expect the HMAs to understand everything about how our system works, but I did expect that they would know about politics and policy.

Interview data confirmed that external stakeholders were concerned that the MoH bureaucrats seemed detached and not fluent with the reform processes nor fully conversant with reform issues. A MoH official shared the following:

> The reform model kept changing so much, I was too afraid to go to any outside meetings in case I was questioned about what was going on … I didn't know anything.

Some years later a review of reforms by the Australian government acknowledged the problems of technical errors and problems of interpreting the political landscape and the effect of those on the reform programme (Australian Agency for International Development, 2006).

A central issue in the data and an area of concern was the problem of what one health official called **undeserved** power and position allocated to the HMAs in the reform process to control the technical and the policy dialogue. Health bureaucrats felt they were forced to rely on the expertise of HMAs because of their appointed roles in the reform programme. As one divisional director noted:

> The reform efforts depended entirely on the consultants … the team was perceived as the experts… but they should have facilitated the process, not led it.

[43] The MoH failure to convince the PSC and MoFP to support the reforms was detrimental and a failure blamed on the HMAs

The data suggest that bureaucrats felt that the authority and leadership granted to HMAs during the reform period was not justifiable, not only from a technical perspective but because MoH counterparts felt that they were purposefully disempowered and isolated from the decision making and had no real technical voice in the reform process. The concern was that the HMAs used their technical expertise to gain autonomy in the technical debate and to isolate bureaucrats from being much too involved in technical discussions. Their expertise enabled them to endorse their own plans and they used their technical knowledge to justify their processes. Interview data suggested that HMAs assumed a special role in the reforms which gave them position to exclude health bureaucrats.

The control of the policy dialogue further gave the impression that the reforms were driven and owned by the consultants and not by the MOH. As one bureaucrat shared:

> The reforms are all about the HMAs, they are the real beneficiaries of this exercise … not us.

A senior health official described the relationship in the following way:

> The reforms belong to the consultants, this is their thing, we have nothing to do with it. They think all the work in reforms is at the top level, and we at the bottom are not qualified enough or important enough to understand what was going on. This reform is about them not us.

These comments suggest the underlying and tense feelings that the bureaucrats carried towards the HMAs. Further, bureaucrats were concerned for their own reputations in this process within the broader public sector and among their colleagues. Their isolation from technical processes and lack of control of the processes made them look inept among their colleagues in the other sectors. As one MoH official shared:

> I felt embarrassed at times because I was so far removed from the technical discussions in the MoH, my colleagues seemed to question the integrity of my position … I felt awkward.

The effect of these delays affected the credibility of the MoH to engage confidently and publicly with external stakeholders and agencies who were outside of the MOH; subsequently, external colleagues developed the impression that the MoH bureaucrats had little technical knowledge of the reforms.

6.5.4 Technical Capacity of HMAs

At the heart of the many concerns of the MoH was the issue of the technical capacity of the HMAs. Interview data suggested that this caused the most concern for the MoH officials. An observation by a MoH manager noted:

> Our consultant didn't know what he was doing, he didn't know the technical detail needed to help us … We needed skills to help us understand our new legislative and regulation roles, how to deal with our stakeholders and how to communicate to our colleagues, our consultant was not able to help us with this (MoH manager).

A member of the independent Technical Advisory Group (TAG) reported that consultants recruited for the project were not well matched to their specific roles as the recruitment process was based on availability of consultants (mutual friends and associates) rather than technical fit . As one member of the project review team noted at the completion of the reforms:

> A number of the consultants were a complete mismatch between the tasks that were needed and the skills that were necessary for the reform process (Member of TAG).

The project leader at the commencement of the reforms revealed that the consultants '**were cobbled together'** as a team to provide the technical support of the reforms

and subsequently were not selected under rigorous scrutiny but rather recruited on availability.

6.5.5 Capacity Building

A central outcome of the reforms and a key role of the HMAs was the importance of transferring technical knowledge to the local counterparts in the MoH (Aus Health International, 2001b). The concept of skills transfer was a new "championed idea" by the donor (Soakai, 2006) and strongly supported by the MoH of Fiji. Given the views of the bureaucrats towards the Health Management Advisors (HMAs), the outcomes of these intended arrangements were not achieved. Internal stakeholders shared that the HMAs did not 'reach out' to work with them; rather, their approach was to carry out the majority of the technical tasks on their own without the support of local counterparts. Further exploration into this issue highlights that HMAs felt under duress to manage timelines and reporting and compliance activities, which often did not leave them time for working in a collaborative style with the local counterparts.

As one HMA noted:

> We had 105 milestones to deliver on over five years, I never felt I had adequate time to really do the job well … I felt all I did was write reports.

HMAs revealed that compliance reporting and managing up was a burdensome task that often took them away from the day-to-day work of the reform programme. Preoccupation with over-reporting was perceived by health bureaucrats as not only distracting, but gave them the perception that the HMAs role and the reforms were a desk exercise rather than a real exercise in system change. Counterpart interviews further reaffirmed this frustration:

> They were always busy managing their reporting milestones … rather than supporting the MoH to deliver the reform outcomes.[44]

[44] The 105 milestones were required to be reported on during the five-year reform programme

The final report by the Australian government notes that the 'burden of delivering on a 105 milestones' and the over compliance in reporting on the project was challenging as well as distracting to the initiative (AusHealth International 2004b).

Interview data revealed that very few counterparts felt that they learnt anything from HMAs over the five-year period. Bureaucrats suggested that this was not a priority for HMAs; rather their focus was on **rapid results versus long term capacity development**. A sub-divisional director in the MoH noted:

> Our HMA was focused on quick wins and I needed to stay focused on the longer goals … I was going to be here longer than him … I needed to make sure we had good processes…. So we didn't agree on many things.

The concerns were that the HMAs did not feel a strong sense of accountability to Fiji nor to the MoH, and were focused on managing their internal compliance obligations, and therefore focused more on their own responsibilities. This particular issue also suggests that the HMAs operated in a mode of "box ticking" outcomes rather than being focused on building longer term capacity and systems development needed for the reform program. The combination of these issues impacted on relations between HMAs and the MoH officials.

6.6 Relationship Failure

The collapse of relationships between HMAs and internal health bureaucrats created a significant barrier to the implementation of the internal reform changes in the MoH. Bureaucrats were unsupportive of the reforms and did little to avail themselves of the processes. Lack of support by bureaucrats is captured in a comment by a HMA:

> Throughout the entire five-year period we had a disconnect between us and the internal health bureaucrats. We couldn't communicate and our relationships were tense. We couldn't win the hearts and minds of those inside the MoH to the goals of the project.

HMAs did not share the same perspective of the internal health bureaucrats; rather, they suggested that the reasons that internal reform processes struggled was the lack of technical capacity by the counterparts. The end of year report written by a consultant and HMA noted:

> Our counterparts couldn't internalise the technical information, they didn't want to read the information, they didn't appreciate the technical detail of the reforms (Aus Health International, 2004b).

A HMA shared the following:

> Communicating with internal staff was a problem … we just couldn't get it down to people and more often than not … people wouldn't read the stuff anyway.

A HMA reform planner noted:

> Changing people's mind-set and creating a new environment of change proved difficult because not everyone felt part of the process.

HMAs described feelings of isolation and distancing by internal MoH staff, not only technically in the work but also as colleagues in the same working environment. Interview data with HMAs confirmed the tension between themselves and the local counterparts but they struggled to understand and interpret it. A comment made by one HMA reflects the confusion of the behaviour of counterpart colleagues. As one HMA noted:

> The entire three-year period I was there, not once was I invited to a local home or to a colleague's residence; it was like we were the untouchables. Our work didn't make it easier. They had this kind of respect for us because of what were charged to do that sometimes turned into loathing (Senior HMA).

The attitude of the bureaucrats in this regard is better understood by examining cultural and social values in the Fijian context. HMAs experienced the discontent of officials but were not able to understand nor interpret why health bureaucrats remained distant or aloof during the processes. Fijian societal concepts of respect and keeping face are related to this. Concepts of *Vulagi* (the visitor) and *iTaukei* (the host) are cultural concepts of respect. The treatment of visitors in Fiji is held in high regard. HMAs were viewed as *Vulagi* and therefore they were not to be disrespected. Maintaining respect for the *Vulagi* and ensuring their dignity is maintained is essential (Ravuvu, 1987, Ravuvu, 1992). This cultural concept requires a Fijian to not offend and ensure that the visitor maintains dignity. The cultural positioning of Fijians in the system was not an overriding value but does explain some of the behaviours of some counterparts who disengaged in processes for fear of been rude and breaking the rules of *Vulagi*.

A low level manager expressed that culturally he didn't feel it was appropriate to openly criticise a white consultant:

> I didn't really understand or care what the consultants did, I knew when they left we would do what we wanted. It wasn't our place to tell them or to advise them … I didn't feel I could tell them much because they are not Fijians and probably would not understand some of our Fijian ways.

Fijian bureaucrats were careful not to offend but they also did not encourage or foster collegial relationships or friendships outside of the MoH with external consultants as this went against their understanding of traditional etiquette.

Ravuvu (1992) explains the problem of culture and misinterpretation. Fijians are well known for being courteous, respectful and self-effacing. Their world is imbued with concepts such as *vakaturaga* (chiefly values). This explains why health bureaucrats did not openly challenge the HMAs regarding the process, but rather kept silent about their disenchantment in order to maintain cordial respectful working relationships. In face to face contacts, such principles of social engagement translated into particular styles of interaction: soft spokeness: avoidance of eye

contact, care not to cause offence and indirect, subtle, nuanced or elliptical ways of addressing sensitive issues (Ravuvu, 1992). For those not schooled in these ways especially foreigners, the scope for misinterpretation and misunderstanding are considerable.

These norms of social behaviour are especially not open to critical inquiry or debate; subsequently HMAs were never given the opportunity to discuss these key issues. These socially sanctioned modes and conventions are widely understood only by Fijians. Disagreement therefore is resolved in private, rather than in public, consensus and quiet diplomacy is preferred over an adversarial style, and criticism is muted. The impact of social behaviour and norms according to Ravuvu (1992) does not allow for critical thinking and expression of independent thought and the development of skills of argumentation, and therefore helps explain why health bureaucrats during the reform process, were perceived to be supporting the reforms by the HMAs because of their muted and silent responses.

The combination of all these issues left MoH counterparts and stakeholders feeling isolated from the various processes and resulted in MoH staff disengaging from reform activities. The consultants' inability to recognise the importance of cultural context of management change in the MoH and their lack of appreciation of the cultural values that existed in the system hindered their inability to work alongside many of the internal MoH stakeholders, subsequently creating a 'them and us culture'. These issues resulted in resistance towards not only the HMAs and a lack of confidence in their ability but also a resistance towards the reform programme by internal MoH staff.

Disengagement from the reform processes caused difficulty for HMAs. Subsequently, the MoH failed to bring about a whole of organisation **'buy in' to the reforms.** The introduction of the reforms, planning, conceptual and strategic discussions and ideas were not internalised throughout the MoH. The diminished technical role of the bureaucrats affected their public service credibility. They felt unable to discuss the reforms publicly and therefore unable to maintain what they viewed as their key role as public policy leaders in the discussion.

6.6.1 Strategies of the Bureaucrats

In examining the interview data and reports that described the activities of internal bureaucrats, a number of strategies were used to derail communication activities and implementation processes. The most common practice of health bureaucrats during the reforms was their purposeful disengagement from discussions with HMAs and internal processes. Disengagement with external stakeholders was also a strategy used by bureaucrats. Bureaucrats felt unable to hold technical discussions with external counterparts, due to their limited technical knowledge of the processes. Interview data showed that internal stakeholders removed themselves.

6.7 Actor Resistance to Change

The intensity of policy resistance to the reform initiative for some actors in Fiji was reinforced by their desire to ensure that other actors were not empowered by changes. Doctors did not want to lose power and neither did the bureaucrats. Doctors did not want nurses representation advanced in the system and bureaucrats wanted to retain the status quo within the system. Many of the tactics used by the actors had traditionally been used in the system and it was not necessarily a case of developing new strategies by actors but rather escalating their behaviour at various time and intensity. The nature of policy resistance was partly driven by a legacy of the history of bio medical culture and many of tactics used by doctors used to resist the reforms had been practiced throughout the systems at various times. The resistors exploited all their options available to them.

Lindblom (1994) notes that while it is possible to is to find policies or changes that benefit everyone in policy reform, changes ordinarily benefit some actors or institutions by injuring others, particularly where change is feared and members of the organisation are not made to see its possibilities. In the Fiji case doctors resisted the change but also stopped the flow of communication in committee meetings (Section 6.4). Lindblom et al (1994) suggests that halting communication by stakeholders who resist change is the best way to block change because it renders people unaware of change possibilities. He suggests that those who are most affected by policy change often will use communication less for exposing others to the possibilities and more for maintaining control (Lindblom, 1994).

Where the reforms were able to advance and actors reduced their resistance, was through processes of negotiation for example the removal of the nursing directors' position was reinstated after political lobbying and discussions. The reinstated role however did not have the full powers of its previous position. The various actors in the Fiji system had different resources at their disposal, the nurses used political non-confrontational lobbying and had access to high level political leaders, whilst doctors were much more explicit in their responses and involved the Fiji medical Association to support their position. Health bureaucrats on the other hand used the strategy disengagement from processes had an immediate and compelling impact on the reform process. Disengagement was also an expression of power by the MOH officials, it symbolised authority.

Actor resistance to change was an obstacle to the smooth implementation of the Fiji health reforms (Table 10). Recognizing the determining influence of actors over policy development and implementation, much attention has been given to stakeholder analysis (Reich and Cooper, 1996, Varvasovszky and Brugha, 2000) and actor management (Thomas and Gilson, 2004). Public policy literature sheds light on the complexity of the implementation of change and the role of actors and their resistance to change (Grindle, 2000, Sabatier, 2000, Thomas and Gilson, 2004).

There is some evidence to suggest that the deliberate management of actors is a key factor in driving reforms (Glassman et al., 1999). Governments need to become better managers of sector change and therefore develop an ability to negotiate with stakeholders (Reich, 1995b). In the case of the Fiji study it was difficult to identify where the Governments took on this role, rather it was a case of where Government actor management was mostly absent.

Change management literature focuses on the skills managers require in order to deal with the unpredictability, resistance, practical difficulties and disruption to personnel arrangements that change can bring about (Argyris, 1994, Trader -Leigh, 2002). In the case of Fiji there was none or very little of the management of actors as a strategy to respond to emerging resistance. Change management theorist (Trader -Leigh,

2002) suggests that people react against change for a wide range of reasons, including fear of the unknown, lack of information, threat to status, there being no perceived benefits, fear of failure, low trust in the organisation, strong peer groups norms and being bound by custom (Table 11).

Table 10 *Actor strategies and the impact on the reform process*

Actors	**Positions within the reform**	**Strategies they used**	**Impact on the reform process**
Doctors in management positions	Non-supportive	Sabotage Withholding information Silence	Forced delays on the process
Doctors in hospitals	Supportive	Disengaged as reforms didn't seem relevant to them	Neutral
Nurses	Not supportive	Silent	Disempowered
Sub-divisional directors	Supportive		
Technical advisors (HMAs)	Leadership	Technical isolation	Could not engage support of bureaucrats and stakeholders
Health bureaucrats	Non-supportive	Disengagement	Caused delays
Nursing council	Anti-reforms	Political intervention/ vocal	Mobilised strike
Senior medical bureaucrats	Not supportive	Sabotage Attempts to remove nursing from management structure Separate conversation across the MoH	Delayed approvals processes

As Glassman and colleagues note, actors in health reforms are often more satisfied with the status quo rather than with change (Glassman et al., 1999). Furthermore, Mauer et al. (1996) suggest that in order for actors to move in any direction they must feel that there is a strong case for change. Actors must recognize the

purposefulness of the changes and see the benefits of the change primarily for themselves. Many of the actors in the Fiji system did not perceive that these changes would result in advancements. Rather actors (doctors, nurses and health bureaucrats) felt that the results of the reforms would result in the redistribution of benefits away from them. Doctors further were concerned that the redistribution of power and authority throughout the reforms impacted on their role and their social and expert standing in the system.

Table 11 *Factors associated with actor resistance and actor issues in the Fiji Reforms (adapted from Trader Leigh 2002)*

Factor	Doctors	Nurses	Medical Managers	Health bureaucrats
Self-interest: Individuals will only buy into change if to a degree their interests are met	Opposed the reforms as they couldn't see how the reforms would benefit them and could not see how their interests would be advanced	Wanted the reforms to strengthen their visibility and power	Retain status quo	Retain status quo
Psychological impact: Relates to job security, social status and compromise of expertise of the individual	Doctors felt compromised by lowering of status of medical expertise	Nurses expertise status compromised Job security concerns	Job security concerns	Felt at risk around job security and changing roles
Threat to historical ways of working	Doctors felt threatened with new ways of doing things. Loss of power	Nurses wanted to retain traditional power in the old system	Escalate profile	Resisted new ways of working

Redistributive factor: Loss of control of power, funding , policies	Doctors did not want to lose power nor redistribute power to sub division	Felt threatened at loss of leadership power at the senior level of the system		Resisted push by consultants to control policy and decision making power
Culture compatibility: New approach to resource management and decision making	Doctors didn't like new rules of accountability	Opposed increased medicalization of power of doctors	Loss of power to sub division resisted	Didn't like new ways of working imposed by HMAs/ Estranged from policy formulation distanced from implementation

6.8 Chapter Summary

This chapter has brought together information and analyses of issues related to four categories of actors involved in the implementation of the reforms. There was an analysis of issues that were of concern to them, how they reacted to the issues and the strategies they used to influence the reform outcomes. The perceived loss of medical influence and power for doctors was a significant barrier to the reform implementation as well as a range of other factors culminated in a wall of resistance for change. Further, capacity issues within the MOH made it an ineffective implementation agency for the reforms (Niedeggen et al., 2012). The data analysis has suggested that the reform implementation model used by Fiji did not enable strong stakeholder involvement from the start of the reforms through to implementation further impacting on lack of actor engagement and support throughout the reform period.

Chapter 7: Synthesis, Discussion, Recommendations and Conclusion

7.0 Introduction

The study analyzes the implementation process of the Fiji health reforms between 1999 and 2004. Fiji is recognized as a developing country and the largest Pacific Island nation in the region besides Papua New Guinea. This chapter brings together research findings, observations and theory from previous chapters in order to synthesize a coherent description of the reform implementation challenges in Fiji. This study has suggested that when health policy analysis precedes or accompanies policy development, the chance of effective implementation is greater. Data collection for the study was guided by Considine's (1994) public policy framework. The study showed that the execution of policy is an integral part of the policy process.

7.1 Synthesis and Discussion

In the collection and analysis of all the interview data, reports and documentation, one key issue was considered as central to this investigation. That is: what were the challenges of implementing the FHMRP? The analysis examined implementation challenges from several perspectives, institutions, actors, political context and culture and values. This was achieved through the discussion of the analysis of the data, interviews and documentation.

The research study examined the following key issues, the role of:

- Key stakeholders in shaping the development and implementation of health reform in Fiji.
  Institutions.
  Political economy.
  Culture and values.

Initiating policy change requires thorough understanding of the context and careful management of the process. The study highlights that the importance of local

context, historical, political and social cultural aspects of a system need consideration when initiating policy change. For Fiji the greatest lesson has been the influences of the past as the most dominant force affecting health policy change.

7. 1.1 The role of Stakeholders and Actors

The research identified that the role of stakeholders in the reform implementation was critical to shaping the end result of the policy. Key actors included not only health bureaucrats, ministers and politicians, nurses and doctors, but also public servants who sat outside of the health bureaucracy. The research highlighted that a range of issues mobilized the various actors (Section 6.1). The research showed that actors reacted and responded to the reforms in various ways (Sections 6.3, 6.4). The influence of doctors who resisted the reforms for various reasons described in Section 6.2 highlights the continued role and power of the medical elite in developing country settings and their ability to shape the end result of a policy process.

The important role of bureaucrats particularly those who worked in agencies with traditional and strong legislation, was highlighted and showed that the influence of their behavior had significant implications on the reform process. The study highlighted that the role of the donor as an influential actor through the management of their consultants impacted on the design and implementation of the reform to a large extent, creating a negative "quick win" atmosphere within the reform project, rather than a strategic longer term capacity building environment.

The Fijian traditional cultural and societal system played an important aspect in understanding the behavior and actions of the actors and stakeholders. The role of chiefs, leaders and the unique cultural principles related to respect to visitors and outsiders highlighted that the management of relationships with outsiders within the policy system had implications for the process.

7. 1.2 The role of Institutions

Institutional restructuring presented significant changes for Fiji (Section 5.1.4). The advantages of restructuring were perceived by Fiji to be long term benefits and

during the reform process, it became difficult to observe the tangible outcomes causing a sense anxiety within the health sector. For the bureaucracy the restructuring was feared because it was centrally about the redistribution of power and resources, and threats to job security (Section 6.10). A key issue highlighted in the data was the over arching impression that the structural institutional changes were perceived to be about change for change sake rather than the reforms been a necessary change for improving the real health outcomes of the population. The fact that many of the actors suggested that the structural changes, job descriptions and roles change, were merely facets of the process, but in reality it was mostly "business as usual".

In analysing the role of institutions in the reform process the study highlighted that three central institutions played different roles in the reform process and each one of them was central to the other and their progress was implicit on support from each of the institution. The PSC and MoFP, Fiji's two most important political institutions outside of the health sector, controlled the legislative authority to enable the reforms to progress. The study documented that for various reasons the institutions resisted approvals (Section 5.11). The study highlighted that no political analysis took place prior to the reforms hence the reaction and level of resistance by the institutions were unanticipated.

Resistance by institutions impacted the timelines and the final shape of the policy whilst internal stakeholders in the MoH purposefully delayed the policy progression (Section 5.11). The study further emphasized that the Ministry of Health as the central political institution responsible for leading the reforms struggled to develop the necessary political and technical capacity to ensure the safe formulation and development of the reforms (Section 5.8.1). The lack of political advocacy and leadership by Ministers impacted on the ability of the MoH to protect and safeguard its pathway.

7. 1.3 The role of Culture and Values

In analysing the role of culture and values in the reform process, the study indicates that the cultural and societal values of indigenous Fiji communities played a role in

influencing the behavior of actors on the policy process. The interpretation of institutional and cultural and traditional values by actors impacted on their behavior and engagement with the policy process. Furthermore institutions such as the PSC interpreted their cultural and historical mandate in promoting and protecting paramountcy values within the public sector as central to the institutions functions (Section 5.1). The loss and threat of these traditional values and responsibilities mobilized institutions to protect and keep safe those values.

The importance of Fijian societal values were further highlighted in the study as a key factor in the management of relationships between indigenous health bureaucrats and external health management consultants (Section 6.7). The study showed that the clash of interpersonal relationships between these actors was due to cultural misinterpretation of actions and cultural norms which operate at the heart of Fijian society (Section 6.1).

The study revealed that the MoH failed to understand the importance of developing clear objectives for the reform not only for the purposes of guiding the reform process and communicating to stakeholders the reform goals, but the MoH missed the opportunity in this processes to advocate explicit institutional values and describe what was important to them and what it wanted to achieve with the reform program (Sections 3.1, 5.1). The study noted that a major distraction for the MoH was the internal "authority wars" between the MoH and the other key public sector agencies. These distractions and delays impacted on the ability of the MoH to define the reform goals it was trying to advance.

A clash of values was highlighted in the study through the analysis of the behavior of medical managers, non-medical managers, doctors and nurses and bureaucrats. Doctors felt the need to protect the medical value base of the health system whilst also protecting their expertise. Nurses felt that their position in the health system and their contribution to the reform process was compromised, whilst bureaucrats fought hard to retain control of their positions and authority in the system.

The reform model as discussed earlier was recognized to be in policy terms a "big bang" reform strategy rather than a strategy with "small incremental" steps. The choice of the reform design is strongly associated by the sway of the donor who were influenced at the time by ideas around global reforms advocated in the 1990s including the 1993 World Bank Report (such as decentralization and increased roles of the private sector in health) (Section 2.1). Furthermore Fiji was heavily influenced by ideas generated in the Fiji public sector at the time related to the New Public Management (NPM) ideas (Appana, 2007).

The study has also noted that development aid values and emerging ideas related to the health sectors functioning played a significant part in influencing the reform design and implementation. The study showed that prior to the 1999 reforms, that the Government of Australia and Fiji enjoyed a strong donor relationship, with Australia enjoying a priority position as a central funder of the health sector. Australia's interests therefore were well entrenched in many of the already existing donor initiatives in the country. Australia's role was further strengthened by the control of the initiative through the management contractor and the health management advisors.

In the case of Fiji, policy makers did not consider the assumptions of the values that lay behind the chosen policy options nor did they anticipate the reaction of stakeholders who championed the retention of the old system. According to Walt (1994) value systems are seldom explicit or take into account when policy implementation is considered (Walt, 1994). There was considerable conflict in values between policy makers, the professional and other stakeholders in Fiji. Where values clashed with reform objectives there was resistance to executing policies such as the doctors' resistances to release decision making power to the sub divisions and institutional resistance to release human resource authorities to the Ministry of Health. Assuming that the entire Fiji Health Sector was committed to change was a false assumption.

7. 1.4 The role of political Context

In analysing the political policy context of Fiji during the reforms, it was shown that the unstable political environment which preceded the reforms and during the reform period impacted on the reform implementation. Political unrest coupled with rising ethnic tensions, changing roles of traditional leadership and power, removal of Fiji from the world commonwealth community in 1990 and the subsequent review of Fijis constitution all made for a difficult context and environment for public policy making (Section 4.2)

The frequency of the change of governments during the same period resulted in lack of sustainable political support by health ministers for the reforms. The distractions of ethnic tensions, constitutional issues related to paramountcy and protection of indigenous Fijians did not allow for a political focus on public sector reforms. There were four changes of government and one coup during the reform period. Strong and stable governments are not only a necessary determinant for successful implementation but important for implementation and sustainability (Walt, 1994).

The 1999 elections were the first political test of the reconfigured 1990 Constitution known as the 1997 Constitution Amendment. The Act signaled a move towards a broader equitable political balance between indigenous Fijians and Fijian Indians. The results of that election gave Fiji its first Indian Prime Minister and a year later a military coup overthrew the Indian leadership. From 2000 to 2001, Fiji was led by an interim Government and the public sector reforms were halted. These vital events created a de-stabilising environment for the implementation of the reforms (Section 4.3.1). Fiji was also recovering from substantial economic setbacks and a growing large and inefficient public sector (Section 4.3). Furthermore and most importantly there was evidence that the Fiji health system was struggling to respond to the growing burden of disease on its growing urban population, impacting on the ability of the system to function well (Section 4.4).

The study highlighted that the MOH was shown to be a “low lying” agency with little political power and legislative authority to undertake the reforms. It was viewed within the public sector as an agency of “little importance”. As such the MOH

struggled to develop the necessary respected and credible leadership and failed to convince the wider public sector of its capacity to sustain the reform momentum. Strong bio medical focus of the health system (Section 6.1.1) and a nursing sector that was discontent with its professional status within the system (Section 6.5.1) was also an influencing feature of the reforms. An environment of discontented health workers and a high volume of migrating doctors and nursing during the same period was also a key element of the reforming health system (Section 4.5.4).

7. 1.5 The role of Policy process and implementation

In analysing the health policy process the study showed that the important stages of the health policy process (such feasibility, agenda building, advocacy, diagnosis, agreement on objectives, planning, and implementation) were not well understood and therefore affected the formulation and the implementation process. The study suggests that limited data and evidence was used to diagnose the health sector problems were not clearly identified or articulated and therefore the problem identification stage of the policy processes floundered.

Analysis also highlighted that the process in which the health reforms then made it onto the policy agenda was without formal political support. At the policy formulation stage the study suggests that very few stakeholders, community and actors were involved in the consultation of reform objectives nor contributed to the reform design. Critical to this stage of the reform model development is the importance of communication with stakeholders and as the study showed, poor communication across the entire five year period on the reforms was problematic and directly destabilized the implementation process. Arguably implementation is the most important phase of policy making. The study documented that at the various stages necessary, for policy formulation and implementation were not well defined. Subsequently, implementation of the reforms were diverted and often changed, impacting on overall success of the reform process.

7. 1.6 The role of the Policy Context

An analysis of the data suggests that the reforms proposed for Fiji were technically difficult and complicated and therefore were not easy to implement. The least

technical a policy design according to Walt the easier it is to implement (Walt, 1994). In the case of Fiji the conditions for analysing the reform model and the changes it necessitated both legislatively were not available. Three agencies were involved in the key changes, and technical features of the reforms required substantial legislative changes as well as the orientation of the Ministry of Health from a service provision organisation to a policy, planning and monitoring organization (Section5.6.1). These were not marginal changes but whole of sector and system changes. The complexities of the reform model placed the importance of technical information at the centre of the decision making process, causing distractions and an over emphasis of its role in the process.

This according to Bossert (1998) is problematic and is a rejected concept in policy making decisions (Berman and Bossert, 2000). The study further highlighted the importance and emphasis that policy makers put on the role of technical information to try to gain legitimacy and to persuade actors to support the reform model. The over-reliance on legislation and technical activities in the reform program highlighted the belief of the policy makers that the legislation changes would be sufficient catalyst for reform success. The study showed that whilst central to the reform implementation, numerous other factors (such as actors and the political context) were equally as important and critical to the success of the program. The study further showed that there was no technical consensus to the reform model during the reform period (Section 5.6.2).

Implementation has been defined as, "what happens between policy expectations and (perceived) policy results". As discussed in the methodology chapter early theoretical models perceived policy making as linear with a clear division between policy formulation and policy execution (Buse et al., 2007). Most of these models suggest that policy formulation is political and concerned with what governments should do and implementation is concerned with management and administrative (Walt, 1994). In the case of Fiji, the reform initiative is described as a decentralisation reform (Aus Health International, 1998c). This study does not cover what decentralisation means and its content. However analysis of both

documentation and interview data suggests that the reform model and the significant restructuring of the system was not what the MOH expected or anticipated.

The study suggests that the overly technical approach of formulating the reform model used by the consultants was a purposeful strategy because it was easier, and appeared to be more efficient to define decisions as technical rather than political. In other words it was easier for them to advocate technical designs and defend policy decisions rather than to engage in the political discussions of reform development. As the study highlights: reform and health systems change require both political and technical leadership.

The reform leaders were as much as possible technically qualified but were not aware of the political implications of the reform option chosen. Furthermore, the MoH was not prepared for analysing and managing the highly political dimensions of the reform process nor prepared for identifying strategies to manage the various stakeholders. Policy analysis capacity within the MoH would have assisted in organising political data in the system that would have assisted in risk management.

7. 1.7 The role of Leadership and Ownership of the Reforms

The leadership vacuum during the reforms made the overall reform process difficult. Four changes of Government and four different health ministers, two elections and one coup, did not allow political stability or consistency of progression of the reform program, even with stable bureaucracy leadership.[45] Health sector change requires the full commitment of Governments and political leadership, the credibility of the Government, political timing and recognition of the political effects of the reforms (Glassman et al., 1999). Given the political vacuum, much of the leadership fell to the bureaucracy and to the technical teams located across the MoH, of which neither groupings had the knowledge or capacity for political strategic assessment to manage the political costs and benefits of reform especially in relation to the stakeholders in the MoH and the PSC and the MoFP (Section 5.9).

[45] The Permanent Secretary for Health remained the same throughout the entire five year reform period

The challenges of adopting the reforms were due to lack of ownership of the changes by the MoH and by the Government. The dilemma identified was that the various Governments that came to power during the reform period were not committed nor engaged in the health sector reform debate and therefore did not take political ownership of the reforms to a large extent. There were no efforts to raise ownership with the various governments in power (through for example multi partisan ownership) because of the political turmoil within the country at the time. Rather minister driven ownership was the only approach and the only political strategy available to the MOH and as the analysis showed this was not a successful strategy.

7. 1.8 Political Timing of the Reforms

The feasibility of reforms is affected by political timing (Glassman et al., 1999). The Government who initiated the FHMRP remained in power for five months after the commencing of the reforms. Although policy reformists were concerned at the impending elections, very little political strategizing could have prevented the temporary halt by the new Government of the legislation process. Subsequent Governments such as military and interim governments 2000-2001 did not have the political will or mindset for continued public policy development. In 2001 after a democratic election the reforms progressed more slowly (Chapter 4, Appendix 1).

7.2 Recommendations from the Study

Analysis of data gathered and a review of literature in this thesis point to a series of efforts that could be made towards a greater understanding of health policy implementation in Fiji and for Pacific countries in the region. This section proposes specific recommendations in this regard for a range of relevant stakeholders who have an interest in this regard.

7.2.1 Recommendations for the Government of Fiji

That the Government of Fiji ensures coverage of *a comprehensive approach to building knowledge and capacity* in health policy development, analysis and practice as identified in Chapters 3 and 4 by:

1. **Establishing a central health policy unit that builds and harnesses the historical context and intelligence in the Ministry on health policy development and analysis.**

This recommendation was shared discussed with the Minister of Health in Fiji in 2011. In 2012 the MoH established a health policy unit. The learning form this thesis has contributed to a number of discussions held in the MoH as part of the scoping of the new policy unit.

2. **Developing a comprehensive and resourced workforce strategy which identifies the recruitment of and growth of health policy analysis and strategic planning of human resources.**

The study argues that much of the implementation challenges for Fiji are due to the lack of capacity in the health system to understand health policy formulation processes and its impact on implementation. The project highlighted the lack of technical knowledge by MoH staff in this area has resulted in poor policy judgments and lack of proficiency to anticipate and plan for successful implementation activities. Recognition of the importance of policy analysis has been part of this recognition. The need for Fiji to articulate and describe a comprehensive workforce plan that includes, health policy analysis training and the investment of health policy research would be a major step in advancing Fiji's capacity.

In particular, it is observed that Fiji MoH failed to recognize and develop political and strategic responses that would have enabled wider public sector issues and issues of key stakeholders to be better understood in the implementing stages of the health policy reform. Furthermore, the development of MoH own policy analysis unit would strengthen its ability to counter inappropriate external advice and pressure from donors and other development partners who don't have full knowledge of contextual and political challenges in health policy processes.

As discussed in Chapter 4, responsibility for implementing health policy is not always or solely that of the Ministry of Health. External Government agencies and

health sector NGOs and workforce unions have extensive responsibilities to ensure the smooth flow of health policy decisions in Fiji. Furthermore, the establishment of a focal point of health policy in the MoH will enhance a greater profile of policy expertise for the public sector within the MoH and for the health sector providing provide a greater confidence in health policy matters for both external and internal stakeholders. Specifically it will escalate the importance and credibility and practice of the culture of health policy making (Chapters 4, 5).

3. **That the Government of Fiji promotes a *shared responsibility* for health policy formulation and implementation through both the public sector and the health sector.**

Chapter 3 highlights that the MoH struggled to convince stakeholders to share the responsibility in health policy formulation and implementation. The MoH struggled to advocate the importance of health policy within the broad policy dialogue. Understanding how the health sector can broaden and advocate the importance of health systems strengthening as much more than a health sector issue is key to advancing this important responsibility. A central role for the MoH should include a key advocacy role but also opportunities need to be explored with the broader public sector on engagement in public policy advocacy and processes.

4. **That the Government of Fiji ensures a *consultative* approach with all those associated with the development of new health policy: includes cabinet, political ministers, senior politicians NGOS, academics and broad public sector agencies and the community more broadly**.

Discussion of the need to account for *advocating a culture of policy for evidence* is identified throughout Chapters 3 and 4. Policy culture refers to a habit of using evidence for policy making, fostering processes and creating an enviornment of information for decision making. Specific consultative processes require a broader understanding and buy in of change in a health reform environment. The thesis has identified that a poor culture of information and information sharing existed within the MoH and across the public sector. Consultation is likely to provide a catalyst to

improve communication and therefore engagement and empowerment in the policy process by policy implementers. More importantly consultation is likely to also identify potential barriers to policy implementation and more importantly assist the MoH to agree reform objectives but also provide clarity on the impact of the reforms on stakeholdres and the broader community.

5. **That the Government of Fiji specifically *gather commissions information and research* in public health policy in Fiji in regard to implementation success factors.**

The study highlighted that there is poor understanding of implementation success factors. It would be important to ensure that the findings of this commission are documented in order to provide guidance to other developing nations in the Pacific. This thesis has observed that the body of research in this area is relatively small for developing countries in particular Pacific countries that have similar colonial histories and public sector structures.

6. **That the Government of Fiji requests the *technical assistance* of the WHO, and/or bilateral donors such as the Australian Government and the World Bank to build stronger and more sustainable health policy capacity in the Fiji Health System.**

International assistance in the area of health reforms and health policy needs to take greater account of capacity building as part of the broader health systems strengthening approach for countries. That donor ideology needs and donor driven outcomes should not be at the centre of health reforms objectives and outcomes, but rather focused on what the country is trying to achieve and assisting the country to build that capacity to ensure long term sustainability. WHO has a central role in supporting this approach as they are the countries key technical advisors in health systems strengthening and capacity building and they should play a role in assisting the Ministry of Health in this area.

7. **That technical assistance is provided in a capacity-building manner through training and mentoring.**

The study highlighted that the role of the donor and Technical Assistance played an important role in the formulation, planning and implemenation of the reforms.

Key questions that development partners should consider when funding initiatives similar to this should include assessment of the following issues:

- **Assurance that key personnel are culturally and technically competent**
- **Human resources available in the country to support the assessment, formulation, and planning and implementation adequate and sustainable**
- **Is the donor formulating the plan or is the country?**
- **Is there an agreed understanding between all stakeholders of what the plan will do with the country?**
- **Is there already a process in place for planning within the country system?**
- **How does a country analyse its context?**
- **How does the planning process recognize and take account of in-country policy processes, institutional and legislative arrangements (i.e. complexity of the country's system)?**

Based on a synthesis of this combined information, a range of factors have been argued to be key requirements for success in the development and implementation of health policy in developing nation settings. Furthermore what this study has also attempted to support is Gilson and colleagues assertion that health policy analysis is not only of practical importance in public health, but also a legitimate area of academic inquiry (Gilson et al., 2008). In short, despite ten years of calls for more health policy analysis which elucidates the determinants of policy change, the field remains in its infancy and is failing to deliver what it potentially could (Gilson et al., 2008).

7. 3 Limitations of the study

This study has provided a background to the process of health policy implementation in Fiji, and has focused on the key areas of resistance to implementing the Fiji Health Management reforms. The study was not able to cover all the issues that emerged in the data analysis, further a number of limitations were also identified in the medthods and scope of the study.

Literature review: The area of health policy analysis is not well documented except for a handful of specialists and experts in the developed world. No literature was available on studies on health policy experiences in the Pacific and with Pacific island nations.

Methodology: Besides the document analysis, open ended interviews with numerous stakeholders including international and donor agencies of which were central to the research study. The approach of conducting interviews with actors involved in the policy process, sharing personal knowledge was a culturally sensitive and new experience for many of the interviewees. Convincing stakeholders that they can make a meaningful contribution to improving health systems was challenging. During the data collection phase Fiji's MOH was once again restructuring. Furthermore, the fragility of the political environment made it difficult for interviewees to speak freely about their feelings for fear of repercussion.

Health information and data in Fiji is poor (Aumua and Hodge, 2012); accessing information from within the MoH system of reports was challenging. When data was not available but necessary to validate themes that were emerging in the interviews, I would not use the information. Information that I could only verify was used and resulted in me not using a large proportion of information. I was questioned several times as to why the study was necessary given it was the first time a study of this kind had been carried out in Fiji and that the information I needed was not available. A large part of the study was focussed specifically on understanding reform implementation challenges. Interviewees were often uncomfortable judging and commenting negatively on their experiences because of the cultural constraints in which they operated. Cultural loyalty is an important value in Fiji.

Scope: Initially, the scope of the study seemed to capture the critical areas of focus. However, during the data analysis phase it became clear that the area of the study was just a small step into a large research area and it was not possible to investigation every emerging issue and theme that was generated in the data. Choosing which themes to continue to investigate was difficult as there was so much important questions that needed to be answered.

7.4 Suggestions for Future Research and Implementation of Health Reform Policy in Developing Countries

7.4.1 Potential Key Areas of Future Research

The role of health policy analysis theory in developing countries

The existing body of knowledge of health policy analysis in LMIC is weak (Walt et al., 2008). Health policy theory and its usefulness has been evolved and developed from the basis of developed country settings experiences and knowledge. The interface between policy making and research in low income countries is complex (Hyder et al., 2007). The Literature highlights that there is very little research or learning on how health policy analysis models have been used or understood within development country settings (Walt et al., 2008). To advance health policy analysis, more research is needed in the use of existing frameworks and theories. As Gilson and others have highlighted what is needed are many more studies that test a theory's application.

Deepening and extending this body of work requires a much more focused approach to understanding politics, process, and power and needs to be integrated into the study of health policies. In particular the concept of power remains under researched in health policy analysis (Gilson et al., 2008) Further attention on Pacific Island countries and experiences is needed as the reality is that policy analysis is only emerging and has yet to establish its legitimacy as a field within developing countries (Buse, 2008).

Understanding the centrality of actors in health reforms (developing country experience)

Actors are essential to consider when analyzing health policy and each grouping of actors have a critical role to play. There is a growing realization between researchers and decision makers that research can improve the management decisions of actors in national health systems. However there is a lack of scientific knowledge on the mechanisms to promote such engagement and their level of success, especially in low-income countries. There is a need to better understand why actors and policy decisions makers behave as they do. Understanding their values and interests and identifying who have the potential to block or subvert policy development and implementation.

An added dimension of this important discussion relates also to what Gilson and colleagues (2008) describe as the importance of enhancing reflexivity in relation to both the relationships between researchers and policy actors and the manner in which the findings from policy analysis are used to engage with policy actors. It is in this vein and in the context of LMIC that the role of actors in limited resource settings needs further exploration. A significant learning in the study has been specifically my role as an indigenous Fijian woman and the use of reflexivity principles throughout the research and how this concept enabled me to be central to the research knowledge process.

Building health policy capacity in developing countries

Health policy capacity refers to both institutional and individual capacity but also individual capacity and competencies necessary for reforming developing countries. Much is already known about training and development of health policy analysts, however more research is needed to understand further the development of strategies to enhance and strengthen institutional policy capacity. How can countries strengthen and prioritize decisions that relate to building and investing in institutional health policy analysis. How can countries learn about program sustainability? This single and most important issue is responsible for the limited success of health systems changes and improvements in the Pacific region.

Implementation Theory and its role in development countries

Policy implementation studies have found that while there has been a trend in the growth of academic literature about implementation of public policy, there has been no theory that has commanded general agreement and researchers continue to work from diverse theoretical perspectives, do not agree on the outlines of a theory of implementation, or on the key determinants to success (Trader-Leigh, 2002). Adding further to theoretical challenges is the complexity is the limited knowledge of implementation theory in developing countries. A critical aspect of these investigations should focus on institutional resistance to policy change.

7. 5 Significance of the Study

An understanding of the broad range of factors that affect implementation of health reform, change and policy is growing; however, much of the learning has been accrued from developed country experiences. Absent from the published literature is research and knowledge on health policy on the region of the Pacific, and in particular small island nations with poor public policy development infrastructure.

- This study is the first to provide an in-depth detailed such a discussion of health policy implementation in Fiji and one of a few on health policy in the Pacific region.

- This study also collected data related to the health policy implementation experience from a variety of stakeholders. There has been no other data available in Fiji to date to explain health policy process.

- While data has highlighted that health policy formulation and implementation are difficult processes, it has also identified other issues related barriers of implementation. These findings require further investigation, although the current research has identified, political institutions, actors, values and context much more research is required to better understand them. This project therefore provides the first evidence based information on health policy implementation in Fiji.

- The research has identified that in a country that has limited formal policy formulation and implementation experience, a history of colonial influence on its political institutions, a health sector that is weak with human resources and limited technical knowledge, and an unstable political environment, the likely hood of successful policy implementation is difficult.

- The thesis has discussed the importance of health policy analysis to assist in strengthening policy implementation and it has identified the challenges of implementation.

- The study highlights that implementation studies need to examine the relationships between the authority responsible for policymaking, the policy objectives and policy implementation.

- The recommendations proposed in this thesis provide practical suggestions for overcoming these challenges. Most importantly it proposes a call for research to test health policy analysis theory in development country settings.

7.6 Conclusion

Health Policy in Fiji has traditionally focused on responding to supply side issues such as supply of hospitals, services, and human resources. During the 1990s and prior to the reforms Fiji had also developed a policy focus on disease prevention and health promotion (Negin et al., 2010). Health Systems strengthening or health management strengthening prior to the 1999 reforms had not been a policy focus. The reforms as discussed elsewhere challenged the centralized and bio medical focus of the system. The reforms shifted power from centralized health decision making structure to various devolved health structures. The reforms also instigated a shift in power form a centralized control center of Government to the Ministry of Health.

Health policy analysis is important for Fiji as it helps identify what has been the experience of implementation of the Fiji reforms and for developing countries. Policy analysis means different things to different people, for some policy analysis mainly concerns policy content, while others argue it is more to do with policy

context and process (Walt and Gilson, 1994b).

In developed countries, policy structures and process are much more sophisticated with formal procedures and actors and stakeholders are much more organized. Democratic procedures hold these processes in place. In developing countries the policy process is different, and the interaction between institutions and actors can influence the implementation process much more than in developed country settings. Policy structures are not often well organized and policy processes and stakeholders groupings are not well formed.

In developing countries such as Fiji the political environment, unstable governments, poor institutional capacity in reforming organisations, the cultural values of society and its history are often much more influencing factors (Bossert, 2000, Gilson et al., 2008, Gilson and Raphaely, 2008). In analysing the implementation of the reforms the study highlights that the lack of understanding of the important stages of the policy process, such as agenda building, policymaking, planning and implementation was evident. The involvement of all stakeholders in the development of reform objectives and broad engagement of stakeholders in the implementation was low. The challenges which affected the implementation, was the control and influence of the centre of the system, medical power, reluctance to move towards community health models of care, shortage of key trained staff, and difficult and unstable political environment. Implementation was further influenced of the social cultural context of Fijian society such as paramountcy and protection.

Traditionally, there are two approaches to policy analysis, the "rationalist approach" and the "behaviorist" approach. The rationalist approach assumes that the policy process can be designed and implemented in a straight line and that policy can be implemented in a series of rational steps (Sabatier, 2007). The behaviourist approach on the other hand suggests that policy implementation is much more interactive and not linear but rather a process that is "bottom up" and not "top down".
What has been learnt in this study is the understanding that the theory that undermines policy choices and processes is critical to the success of a reform activity. The more important a country pays attention to the processes and context

with which its policy is been developed the more likely the success of the policy been formulated and the greater identification of the appropriate reform model. Additionally, the more a country undertakes policy analysis activities the more effective its policy implementation.

Considines (1994) public policy model used in this study to guide the collection of data and analysis is s associated with the behaviorist approach of policy development and implementation. Its usefulness to this study of Fiji was that it called for a broader description of the role of culture and values in policy making

The model utilised by Fiji to formulate and implement the reforms is closely aligned to the linear or top down approach (Figure 2) (Sabatier, 2000), which implies that once a policy decision is made, implementation of the decision happens automatically. This model assumes that the role of actors is not central to the success of the reform implementation; rather it is fixated on processes rather than actors. A major drawback of the linear model is its failure to consider the complexities of the implementation process, and what eventuates is a situation in which the practical working out of the policy may be very different from the policy originally planned (Chapter 3). Policy leaders in the Fiji context did not recognize that Policy implementation is an ongoing, non-linear process that must be managed (Grindle and Thomas, 1991) and required consensus building, participation of key stakeholders, conflict resolution, compromise, contingency planning, resource mobilisation and adaptation.

The interactive model of implementation would have been a far more effective model for Fiji to use, as its focus would have been to generate the policy from within the policy community with which it would have been implemented (Grindle and Thomas, 1992). This approach argues for an 'actor-perspective', emphasizing the need to take into account the opinions of individuals, agencies and social groups that have a stake in how a system evolves. The approach promotes an interaction and sharing of ideas between those who make policy and those who are influenced most directly by the outcome. As seen in the case of Fiji one of the most important effects of the division between policy-making and implementation is the possibility for

policy makers to avoid responsibility. 'The dichotomy between policy-making and implementation is dangerous. That is because it separates the 'decision' from the 'implementation' and thus opens up 'escape hatches' through which policy makers can avoid responsibility (Sutton, 1999).

The approach taken by Fiji fell short of achieving its intended results. This study has intended to show the importance of policy analysis in prospective policy making. Its focus has been on understanding the importance of process for policy formulation and implementation and not on the content of the policy. Policy analysis has been used in this study to retrospectively understand Fijis past experience. The study has intended to highlight why health policy analysis is important to understanding health reforms success (Walt et al., 2008). The study has helped explain why certain health issues received political attention and others did not. It assisted in the identification of stakeholders who supported as well as resisted policy reforms and helped identify The study identified both potential and unintended consequences of policy decisions, as well as the barriers that undermined policy implementation and jeopardise the overall national objectives for the overall reform goals (Gilson et al., 2008, Gilson and Raphaely, 2008, Buse et al., 2007).

However it should also be used prospectively in the future for policy development as Fiji continues to move towards further reform and policy changes to strengthen its system and enhancing health services for its population.

A model for health policy development and implementation with the following stages can be considered by Fiji and possibly developing countries:

1. **Defining the context**- an assessment of the politics, economics and the culture of their health system, social pressures including their national culture and values, and priorities. This will enable Fiji to put its health system in context and therefore form the basis for health policy analysis.

2. **Stating the problem**- an assessment or clear definitions on the health problem. Although problem definition is critical, what we have learnt in

health policy analysis is that problem definition becomes clearer the more we review our empirical and conceptual understanding of the problem. The process of policy analysis helps to make sure that the problem will be successfully targeted.

3. **Evidence of the problem**- Assembling the evidence of the problem. Collecting data that can help identify the features of the policy. Health policy analysis will assist at this stage in identifying significant features of the policy problems under study and how it might be solved or mitigated.

4. **Identifying policy options**- once the evidence has been compiled, and policy options have been constructed for solving the problem, it is at this stage that the importance of health policy analysis becomes critical and where linkages to the contextual factors, (identified in stage 1) become important. Once policy options have been considered, health policy analysis instruments for implementation should be considered such as:
   - analyzing conditions for facilitating change process,
   - identification of technical features of the policy change and assessment ease of policy change,
   - reviewing the underlying values within the chosen policy options
   - undertaking stakeholder analysis, reviewing interest groups who are likely to resist or support the policy- options for mobilizing support
   - analysis of the financial and technical and managerial support to facilitate the policy change, training issues, salary levels, information systems , workforce capacity
   - consideration of how strategic implementation process might work, such as how to involve planners, managers, research , and the analysis needed to execute the policy, promoting public awareness, advocacy etc. *It is at this stage that policy makers might review their own analysis of the policy problem and the policy options.*
5. **Impact Analysis or projecting the policy outcomes –** Policy makers will at this stage should be concerned with the outcome of the proposed interventions (i.e. what conclusions will they arrive at if they chose option A

over option B) The answers to these questions should emerge from health policy analysis undertaken at stage 4. The role of health policy analysis at stage 5 should be on implementation analysis and utilizing the information collected at stage 4.

6. **Making the decision to implement –** At this stage the decisions regarding which policy option to pursue that will give the maximized outcome and have the greater success of implementation should be clear.

Fiji, like many other developing countries around the world is intent on improving the health of its population whilst challenged with limited financial and human resources and with an increasing burden of disease. These challenges place significant stress on its health system. However, Fiji is a country of great optimism and its dedicated health workforce are admired for their tenacity and commitment. Ensuing population health and enhancing the Government's capacity to improve health is now a priority for Fiji. Health policy analysis offers Fiji an important opportunity to strengthen the health systems approach to population health.

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Appendices

Appendix 1: Key Dates and Reform Timeline

1970	Fiji becomes Independent from United Kingdom under a new Constitution
1979	Report of the Select Committee of Inquiry into the Health Services in Fiji
1982	David Coombes Report on the Administration of Fiji's Heath System
1985	Public Sector reforms introduced with Public Sector Wage Freeze
1987 May	Fiji's First Military Coup by Rabuka
1987 September	Fiji's second Coup (Fiji is evicted from the Commonwealth)
1987-1992	Fiji Ruled by a military Interim Government Rabuka
1992	Fiji General Elections/won by SVT
1990	New Constitution developed
1994	General Elections won by SVT
1994	Start of Civil Service Reform Programme under Rabuka
1996	Economy and Efficiency Review of the Colonial War Memorial Hospital
1997	Constitutional Amendment Act
1997	Report of the Select Committee on the Fiji Health Service
1997	WHO Mission Report on Divisional Hospital Management
1998 February	Pre-Feasibility Study completed on Reforms
1998 April	AusAid Issues and Proposals Paper for Management Reform of Sub Divisional Health Services
1998 October	Final Project Design completed
1998 December	MOU signed between GOA and GOF
1999 February	Appointment of AMC
1999 February	FHMRP commences Project Implementation (Minister of Health Navuca)
1999 January	Public Service Act Reviews – its purpose to improve public sector accountability in CEO's

1999 January	Public Finance Management Act passed but not implemented due to elections and new incoming political party
1999 June	Finance Management Act suspended
1999 November	Cabinet endorses the proposed changes to MOH HQ and the establishment of Divisional Hospitals. (FHMRP)
Duration of project	Six-monthly TAG reviews
1999 April	Eve of elections , Nursing strike by Fiji Nurses Association over salary disputes
1999 May	Elections of government in Fiji/ Rabuka Government lost the elections to Mahendra Chaudhry (Fijis first Indian Prime Minister) Labour Coalition Government New Minister of Health, Mr Isimeli Cokanasiga
1999 July	All public sector reforms halted including legislation development necessary for the FHMRP
2000 March	MOH submits to Cabinet the devolution structure, the creation of the divisional health boards and the creation of Chief Executives as administrative heads of each division.
2000 April	First Annual Plan of the FHMRP
2000 May	Speights Coup/Labour Coalition Government overthrown and new Minister of Health, Mr Pita Nacuva Fiji Constitution Suspended
2000 June	Finance Management Act suspended
2000 November	Constitution Restored
2001 April	2 additional HMA positions (from the original HMA position at CEHS), added to the project – by the creation of HMA positions in Lautoka (WHS) and Labasa (NHS)
2001 July	Tavenui Community Health Project Opened PATIS introduced into the Northern Division
2001 August	Installation of an elected government for the first time since the May 2000 Coup
2001 September	Democratic Elections Prime Minister Qarase elected
2001 September	New structure organisation submitted to PSC and approved
2001 December	PSC approval of the proposed decentralised structure for the MOH
2002June	Infection Control Guidelines launched

2002 July	Establishment of Divisional Health Offices in the 3 Divisions
2002 September	Dr Lepani appointed Temporary Director of Health. PSC approved temporary position in new environment
2002 October	Decentralisation Task Force disbanded
2002 November	First Meeting of the National Executive Committee (supreme decision making for MOH).
2002	FHMRP introduced as a KRA
2002 December	Government announced a freeze on recruitment to all vacant public service posts. Medical and nursing positions were exempt.
2003 February	Division of Health system standards renamed to include Nursing.
2003 March	Draft instrument of delegation (transferring responsibility and accountability to the proposed Divisional Directors' positions of the 3 Health Services) submitted to the PSC for approval
March 2003	PSC published the formal transfer of staffing establishment from PWD to the MOH
2003 May	Financial Information System launched
2003 September	Government lifted freeze on recruitment of public service posts
2003 October	PSC approval of the delegation, with the exception of those powers considered to be granted to the PSC by the Constitution
2003	The strengthening of the Decentralised system noted Annual Report as KRA
2003 December	Permanent appointments made to positions of Director, for each of the 3 Health Divisions
2004 January	Project Completion –
2006	Full devolution of powers completed
2006	Fiji Government Elections

Appendix 2: Key individuals and organizations who participated in the case study research

Total of 92 participants, 55 individual interviews and three focus groups.

Individual	Institution	Title	Why was this person chosen
1	Fiji School of Medicine	Leader/ Director	Involved in Medical education and health policy education
1		Senior researcher	Involved as a member of the HMA team
6		Senior researcher	Involved in Reform evaluation
1		Senior Researcher	Employed at the MOH during the period of the reforms
1		Senior researcher	Policy and planning manager during the reforms
3	Ministry of Health	Ex Ministers of Health	
10	Central Division	Senior MOH Clinical Officials	Involved in the reforms both planning and implementation
4		Senior Nursing Leaders	Involved in planning, development and implementation
1	MOH	Member of MOH Corporate services	Part of planning team in the MOH
1	MOH	Member of the senior management team	Ex Director Planning
1	MOH	Senior Clinician	Decentralization Task Force

Individual	Institution	Title	Why was this person chosen
1		Senior Clinician	Divisional leader
1		Senior Clinician	Epidemiologist
1		Senior Health Planner	Health reform manager
1		Health Researcher	Researcher in the MOH
5	Eastern Division	Nurses	Active nurses in the reform period
5	Western Div	Senior health officials	Involved in reform implementation
3	Central Division	Senior health managers	Involved in reform implementation
3	Northern Div	Senior Members MOH	Reform implementers
4	Outreach Nursing Station	Nurses	Effected by reform
2	Fiji School of Nursing	Senior Lecturers and manager	Involved in lobbying MOH and nursing strike
4	Public Service Commission	Senior officials	Involved in legislation and reform planning and discussions
3	Dept PM Cabinet	Senior officials	Oversight of reforms Monitored progress
3	Min Finance & Planning	Senior officials	Key stakeholder, control of legislation
1	Dept of Public Works	Senior official	Responsibility for asset management for the MOH

Individual	Institution	Title	Why was this person chosen
1	Parliamentarian	Senator	Member of Parliament during the reforms
1	Fiji Womens Rights Movemen	CEO	NGO in women's health and advocacy
1	Soqosoqo Vakamarama	Senior official	NGO for Fijian women
1	WHO	Country Head	Technical Advisor to MOH
2	Aus Aid	Country Head	High level oversight of reforms
		ex first secretary	Key advisor involved in reforms
1	JIKA	Country Head	Observer
1	Fiji Med Assoc.	Member of MA and ex Minister of Health	Stakeholder/actor
1	Suva Private Hosp/NGO	Director	Stakeholder/actor
1	Aus Health	Senior official	Lead implementing agency
1	Aus Health	Health Management Advisor	Team Leader for Project
1	Aus Health	Health Management Advisor	Manager Health reform team
1	Aus Health	Health Management Advisor	Technical advisor policy and planning

Individual	Institution	Title	Why was this person chosen
1	Aus Health	Health Management Advisor	Hops technical advisor
1	Aus Health	Health Management Advisor	Institution reform technical advisor
2	Great Council of Chiefs	Traditional Leader	Observers

Appendix 3: Themes that guided discussion with stakeholders

Interviews structured around a framework of themes and questions which varied depending on the position of the individual been interviewed.

Theme 1 Reform model and personal understanding

Background knowledge of Fiji's health sector

Knowledge of key problems

Knowledge of purpose and goals of reforms

Understanding of reform design and reform content

Process on which reforms were communicated to the recipient/ how did they come to know about the reforms.

Involvement in actor networks/groups etc.

Theme 2 Institutional Focus

Individual role in the institution

How long in institution

How did they as individuals engage in the reform process

How did the reforms become internalized in their respective institution

Institutional legislation issues

Public service issues/ role and environment

Capacity and technical issues in their institution that related to the reforms

Explore other issues related to institution and other public sector agency relationships

Theme 3 Implementation

Individual role in implementation

How active individual in implementation process

Role in governance policy process

Individual observations regarding infrastructure and processes

Key observations regarding barriers and challenges

Observations regarding actors and networks involvement in implementation

Theme 4 Context

Individual views regarding political landscape,

Explore tensions/leadership /cultural and other broader socio political issues

Explore key issues in the environment that impacted on reforms

Perception of relationships, key roles in sector.

Appendix 4: Consent Form

CONSENT FORM

Thank you for agreeing to be part of this research.

The research is being conducted as part of a PhD with the School of Public Health, Curtin University.

As part of this research you will be interviewed about your experience and role in the implementation of the Fiji Health Management Reforms Project (FHMRP)

Participation in the interview is voluntary. You may terminate your participation in the interview at any time.

The interview will be recorded on audio tape. It will then be transcribed verbatim into a document file so that the content may be analysed using NVIVO software. When the interview is transcribed, all names will be omitted and the file identified by a number only.

The content of the interview will remain confidential to the researcher, Audrey Aumua and the transcriptions of the interviews will not be shared with any other person except that needed to meet the requirements of writing the research report. The results of the research will be reported in aggregate terms only. Any direct quotes from the interviewees used in the thesis will not be identified by name, either of the person, their job title , their location in the health agency or sector in which they are employed.

At the completion of the research, the audiotapes will be destroyed. The transcripts of the interviews will be retained in an electronic version in the archives of the School of Public Health, Curtin University for five years.

I have read the above and agree to participate.

Signature_____

Name _____

Date_____

Appendix 5: Information Sheet

Division of Health Sciences

Curtin University of Technology

School of Public Health

GPO Box U1987
Perth Western Australia 6845

Telephone +61 8 9266 7819
Facsimile +61 8 9266 2958
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CRICOS Provider Code 00301J

21 May 2007

Dr Jona Senilagakali
PO Box 2223
Government Buildings
Suva
Fiji

Dear Minister
Ni Sa Bula Vinaka

Audrey Aumua is a Doctoral candidate in the School of Public Health here at Curtin University. She is currently completing her research proposal and candidacy application. The focus of her research will be the Fiji Health Reforms 1999-2004 and will consider the policy challenges in implementing these reforms.

It is anticipated that the proposal will be placed before the Ministry's Research and Ethics committee in next few months.

The purpose of this letter is to respectfully inform you and your officials of the proposed study. It is planned that this study will be carried out over the next 18 months. Audrey is in Fiji for a few days visiting family and would be happy to brief you with further details of the project.

Should you need any further information from myself please do not hesitate to contact me.

Yours truly,

.....

Dr Janice Lewis
A/ Health of School
School of Public Health

Appendix 6: Participant Consent Form

Dear.....

Re: Case Study on the Fiji Health Reforms (1999-2004)

I am writing to you to invite you to participate in a study that is being undertaken by myself and the School of Public Health Curtin University Perth, Western Australia.

The aim of the research project is " to synthesize a coherent description of the process of implementation of the Fiji Health Management Reforms" (FHMRP) that took place in the Ministry of Health between the years 1999-2004.

The research project intends to analyse the events during this period when the Ministry of Health implemented a series of reforms that affected its organisational structure. The project is particularly interested in analysing the policy process of implementing the reforms. The research considers both the role of humans and the political environment and its interaction and influence in the policy making and implementation process.

You have been identified as someone who may be able to contribute to the study. I would be happy to discuss this further with you should you need further information and clarification on the project.

Should you wish to participate I attach a consent form for your consideration.

I look forward to meeting you.

Yours sincerely.

Audrey Aumua
School of Public Health
Curtin University

Appendix 7: Fiji Ethics Approval form

MINISTRY OF HEALTH
88 AMY STREET, SUVA.
BOX 2223 GOVT. BLDGS.
SUVA. FIJI ISLANDS
PHONE: 3221424 FAX: 3318227

15th March 2007

Mrs. .Audrey Aumua,
PhD Candidate
Curtin University
Australia.

I am pleased to advise that the National Health Research Committee has endorsed the following proposal submitted to the committee in February 2007.

Fiji Health Reforms
Researcher: Mrs. Audrey Aumua

It is your responsibility to ensure that all people associated with this particular project are made aware of what has actually been approved.

You must submit an annual report on this project at the end of the study or, at the conclusion of the project if it continues for less than a year.

If you have any further queries on these matters, or require additional information, please do not hesitate to contact me on telephone number (+679) 3221424 or email: ravi.reddy@health.gov.fj. On behalf of the National Health Research Committee (NHRC), I wish you well in your research.

Yours sincerely

Ravi Reddy

Secretary – NHRC
for
Chairperson – NHRC

Appendix 8: Curtin University Ethnics Approval Form

memorandum

To	Dr Janice Lewis Public Health
From	A/Professor Stephan Millett, Executive Officer, Human Research Ethics Committee
Subject	Protocol Approval **HR 111/2007**
Date	31 October 2007
Copy	Dr Graham Roberts, Public Health Audrey Aumua (44 Buttercup Crst High Wycombe) Graduate Studies Officer, Division of Health Sciences

Curtin University of Technology

Office of Research and Development

Human Research Ethics Committee

TELEPHONE 9266 2784
FACSIMILE 9266 3793
EMAIL hrec@curtin.edu.au

Thank you for your application submitted to the Human Research Ethics Committee (HREC) for the project titled "*Case Study Fiji Health Reforms*". Your application has been reviewed by the HREC and is **approved.**

Please note the following:

- You are authorised to commence your research as stated in your proposal when a response is received and approved by the Executive Officer.
- The approval number for your project is **HR 111/2007.** *Please quote this number in any future correspondence.*
- Approval of this project is for a period of twelve months **02-10-2007** to **02-10-2008**. To renew this approval a completed Form B (attached) must be submitted before the expiry date **02-10-2008**.
- If you are a Higher Degree by Research student, data collection must not begin before your Application for Candidacy is approved by your Divisional Graduate Studies Committee.
- The following standard statement **must be** included in the information sheet to participants:

  This study has been approved by the Curtin University Human Research Ethics Committee (Approval Number HR 111/2007). If needed, verification of approval can be obtained either by writing to the Curtin University Human Research Ethics Committee, c/- Office of Research and Development, Curtin University of Technology, GPO Box U1987, Perth, 6845 or by telephoning 9266 2784 or by emailing hrec@curtin.edu.au.

Regards,

A/Professor Stephan Millett
Executive Officer
Human Research Ethics Committee

Appendix 9: Pacific in crisis: the urgent need for reliable information to address non-communicable diseases

Available to view online at http://www.uq.edu.au/hishub/pacific-health-dialog (full copy is provided with the PDF version of this document).

Appendix 10: An accessible method for teaching doctors about death certification

Available to view online at http://www.ncbi.nlm.nih.gov/pubmed/22408110 (full copy is provided with the PDF version of this document).

Appendix 11: Fiji's health management reforms (1999-2004). A case study

Available to view online at http://www.pacifichealthdialog.org.fj/Volume%2015/v15no2/Original%20Papers/Fijis%20Health%20Management%20Reforms.pdf (full copy is provided with the PDF version of this document).