ARUBA

GENERAL SITUATION AND TRENDS

Socioeconomic, Political, and Demographic Overview

Aruba is an island in the Antilles located 24 km from the northern coast of Venezuela. It is the smallest (194 km^2) and westernmost of three Dutch islands. Aruba is divided into eight regions: Noord/Tank Leendert, Oranjestad (West), Oranjestad (East), Paradera, Santa Cruz, Savaneta, Sint Nicolaas (North), and Sint Nicolaas (South).

The official language is Dutch, which is used in the school system and civil service. Papiamento, which is spoken on Aruba, Bonaire, and Curaçao, is the language of the Parliament and the mass media. English and Spanish are mandatory languages taught in the upper grades of primary school and are widely spoken.

As an autonomous entity within the Kingdom of the Netherlands since 1 January 1986, Aruba is responsible for its own political affairs and administration, with the exception of defense, foreign affairs, and the Supreme Court. Its constitution provides for free and democratic elections every four years to elect the 21 members of Parliament. The Cabinet, headed by the Prime Minister, consists of a maximum of nine ministers. Officially, the head of state is the Dutch monarch, represented by a Governor.

The service sector—especially tourism—is the mainstay of the economy, although the oil refinery has reopened and several small industries, notably construction, are developing.

The per capita gross national product (GNP) in 1993 was US$ 12,900. In 1994, the gross domestic product (GDP) was US$ 16,630. This index makes Aruba more similar to Western Europe and the United States of America than to other countries of the region; nevertheless, these numbers should be viewed with caution because they were calculated for a relatively short period and are estimates. A study is currently under way to determine the GNP; preliminary data indicate that it probably represents 60% of the GDP. The inflation rates in 1990, 1993, and 1994 were 7.1%, 6.0%, and 4.7%, respectively.

Between the census of 1991 and the Labor Force Survey (LFS) of October 1994, the population of the island grew from 66,687 to 79,837, an increase of almost 20%. This growth has affected employment and unemployment in Aruba. Proportionally, in 1994 the number of non-Aruban employees was higher than it was in 1991. According to the LFS, of the 2,722 persons employed in 1994, 28% were not from Aruba. Between 1991 and 1994, employment increased more among women than among men.

After the LAGO refinery was closed, unemployment levels climbed to 28% in 1985. Since then, the Government has adopted a series of measures aimed at improving the national economy. In particular, it has promoted strengthening the tourism industry, whose growth, together with that of parallel activities in the construction and service sectors, has helped to bring down unemployment. The growth of tourism led to a 6.5% increase in the transient population between 1994 and 1995. In the latter year, the number of visitors to the island totaled 618,915, which is 7.3 times the population of Aruba.

According to the 1994 LFS, Aruba's total unemployment rate was 6.4%. Among women the rate was 7.8%, and among men it was 5.3%.

The estimated population in 1995 was 83,652. Of that number, 41,592 (49.7%) are male and 42,060 (50.3%) are female. The population density was 445 inhabitants per km^2. Oranjestad, with approximately 20,045 inhabitants, is the most densely populated region.

The highest registered population growth rate (9.35%) was in 1993. In 1994 the rate decreased to 3.03%, and in 1995 it was 4.13%. These fluctuations basically are due to migration. Net migration between 1984 and 1987 was negative, with values ranging from –264 in 1984 to –501 in 1987. Net migration became positive in 1989, with a value of 586 for that year, and since then it has risen steadily, reaching a high point in 1993

(5,734). According to the 1991 census, immigrants made up about 23.9% of the resident population of Aruba.

The total fertility rates for the years between 1993 and 1995, respectively, were 6.7, 6.5, and 6.8 per 1,000 women 14–44 years of age. No figures on age-specific fertility are available. The crude birth rate in 1995 was 17.0 per 1,000 people; this rate has remained relatively stable since 1991. In 1991, life expectancy at birth was 77.1 years for females and 71.0 years for males.

The population of Aruba is mainly urban and can be considered predominantly young—55.2% of the inhabitants are under 35 years of age. The population over the age of 65 represents 6.6% of the total.

Mortality Profile

The crude death rate ranged from 5.2 per 1,000 inhabitants in 1993 to 6.0 per 1,000 in 1995.

The five leading causes of death in the period 1987–1993 were diseases of the circulatory system; malignant neoplasms; endocrine, nutritional, metabolic, and immunological disorders; external causes; and diseases of the respiratory system. In 1993, the last year for which figures on causes of death are available, of a total of 402 deaths, 25.6% were attributed to ill-defined causes. Of the deaths from defined causes, 138 (46.1%) were due to diseases of the circulatory system; 47 (15.7%) to malignant neoplasms; 30 (10%) to endocrine, nutritional, metabolic, and immunological disorders; 30 (10%) to external causes; and 12 (4%) to infectious and parasitic diseases.

Conditions that originate in the perinatal period are the leading cause of death among children under 1 year old. Among males aged 1–44 years, external causes are the leading cause of death. Heart disease is the primary cause of death for both sexes over the age of 45.

For the 1991–1993 period, the leading specific causes of death were diseases of pulmonary circulation and other forms of heart disease, ischemic heart disease, diabetes mellitus, cerebrovascular diseases, and malignant neoplasms of the breast and stomach.

SPECIFIC HEALTH PROBLEMS

Analysis by Population Group

Health of Children

The child health service of the Department of Public Health seeks to promote the well-being of and provide care for children and adolescents aged 0–12 years. The physicians employed by the service provide medical care through the Yellow and White Cross Foundation and administer vaccines to schoolchildren.

Mortality among children under 1 year old has decreased since 1991, when 10 deaths were certified. Between 1993 and 1995, four, five, and one infant deaths, respectively, were registered. All four deaths in 1993 were attributed to conditions that originated in the perinatal period; two (50%) were due to intrauterine hypoxia and birth asphyxia.

In the 1–4 age group, in 1991 one male child died of a malignant neoplasm, no children died in 1992, and one died in 1993 due to an unspecified accident. In the group aged 5–14 years old, four deaths were certified in 1991—three from diseases of the respiratory system and one from an accident. No deaths occurred in this age group in 1992, and in 1993 there was only one death, which was due to infectious disease.

Health of Adults

The Family Planning Foundation, created in 1970, aims to promote parental responsibility, bearing in mind the cultural and religious traditions of the population. The Foundation provides contraceptive services through the Aruban Family Planning Clinic. According to data from 1994, the most widely used methods were oral contraceptives (41.7%), condoms (41.1%), sterilization (5.7%), injectable contraceptives (5.2%), intrauterine devices (4.8%), and others (1.4%). Although there are no data on coverage, it is known that the number of women coming to the Foundation is on the rise: 5,005 visits in 1988 and 7,178 in 1994, an increase of 43%.

Aruban women can opt to receive care during pregnancy and childbirth from a general practitioner, a midwife, or an obstetrician/gynecologist, but in practice this choice is somewhat limited. Women who have private health insurance and those who are employed in the public or private sector have the greatest freedom of choice. Those who have PPK ("propaupere kaart"), a special card for persons of limited economic means, are required to use the services of a midwife. To prepare for the birth, women may take a prenatal exercise course. The Yellow and White Cross (community nursing service) also offers a full range of parenting courses for future mothers and fathers, teaching them about diet and nutrition for mother and baby, growth and development of the fetus, hygiene, nursing, labor and delivery, and postnatal care. Delivery usually takes place at the General Hospital, although women may elect to give birth at home.

Premature births are relatively rare, but when it is suspected that one may occur, the mother is transferred to Curaçao (Netherlands Antilles), where the necessary services are available. If a premature birth does occur on Aruba, the infant

is transferred to Curaçao as soon as his/her medical condition permits.

Abortion is a crime prosecutable under the Aruban Penal Code. No data on abortion are available.

No maternity deaths were recorded for the period 1991–1993.

Health of the Elderly

The most frequent causes of death in the group 65 years old and older are diseases of the circulatory system and malignant neoplasms, which account for 51% and 15% of all deaths, respectively. Sixty-five percent of the deaths attributed to ill-defined causes occur in this age group, which has grown considerably as a proportion of the total population over the past three decades: in 1960, persons 65 and older made up 3.1% of the population; in 1991, 7%; and in 1995, 6.6%.

According to the 1991 census, the employed population who were older than age 60 years decreased from 1,187 (5% of the employed population) to 887 (3%). At the time the census was conducted, 13% of the population aged 60 and over was working. This proportion is considerably less than the numbers registered in the 1981 census (20.5%). One possible explanation is the recent decision (1 July 1992) to reduce the age at which persons are eligible to begin collecting their pensions, from 62 to 60 years. Aruba has an officially regulated old-age pension program designed to ensure a minimum income for the elderly.

Stichting Algemene Bejaardenzorg Aruba (SABA), an organization that provides services for adults aged 60 and over, manages three residences for the elderly with a total capacity of 236 beds, which is insufficient. The Government subsidizes the personnel costs of foundations that provide social assistance services to elderly persons in the community.

The Yellow and White Cross Foundation at the district level offers home care for the elderly. There are also two day-care centers that provide services only in the mornings; their programs are mainly recreational.

Workers' Health

A public-sector service provides pre-employment medical examinations for workers as well as monitoring and following up on sick workers. This service also is responsible for prevention and control of occupational risks, health education for workers, and management of data on occupational accidents and illnesses.

In 1995, 40% of all workers in the public sector were women, and this percentage has been increasing. Participation in the labor market by people under the age of 20 has declined dramatically as the number of years spent in school has increased, and currently the percentage of employed young people under 20 is quite small. In the group aged 20–24 years, the rate of participation is considerably higher (70.2% for males, 62.7% for females).

Studies of the years 1994 and 1995 reveal that the causes of morbidity that lead to the greatest absenteeism among workers are colds and flu, digestive disorders, and headaches.

Health of the Disabled

According to data from the 1991 census, the prevalence of disability (including both physical and mental disability) was 5.5% (3,700). The most frequent form of disability was impairment of a limb (28.7%), followed by motor and visual impairments (18.3% and 13.2%, respectively). Disabilities were slightly more frequent in males (5.7%) than in females (5.4%).

Analysis by Type of Disease or Health Impairment

Communicable Diseases

In May 1995 the first case in an eight-month dengue outbreak was reported. A total of 67 suspected cases were reported (57 in 1995 and 10 in 1996) and 45 were confirmed through serological testing, in which serotype 2 was isolated. No deaths or cases of hemorrhagic dengue were reported. This dengue epidemic is the second that has occurred in Aruba; the first occurred in 1984–1985 and affected 24,000 persons. There were two deaths. Serotype 1 was isolated in that epidemic. No other cases of vector-borne disease have been reported.

Aruba has had no reported cases of poliomyelitis or acute flaccid paralysis, diphtheria, whooping cough, or tetanus. Four cases of measles were reported in 1994, none in 1995, and four suspected cases in 1996; serological studies of the latter four cases revealed that three were rubella, and measles was ruled out in the fourth case. Another five cases of rubella were reported during 1996. One case of mumps was reported in 1994, two in 1995, and none in 1996.

There are no consolidated data on vaccination coverage, but estimates indicate 80% coverage with vaccines against diphtheria, tetanus, and pertussis, (DTP), and against poliomyelitis for 1.5-year-old children and 100% coverage for 6-year-olds.

Three cases of hepatitis B were reported in 1994, one in 1995, and one in 1996.

The island has had no cases of cholera. Between 1981 and 1996, the number of cases of shigellosis ranged from 10

(1981) to 89 (1990). During the past three years the numbers have fallen from 24 (0.3 per 1,000 inhabitants) to 20 (0.2 per 1,000 inhabitants) to 13 (0.1 per 1,000 inhabitants), but this reduction is attributed to underreporting. During the same period, the number of reported cases of intestinal infectious diseases caused by other salmonella organisms ranged from 23 (1985) to 116 (1989).

Data from the period 1981–1996 indicate that the highest incidences of tuberculosis were registered in 1992, when seven cases occurred, and in 1995, when eight cases were reported, and most of those were foreigners. No drug resistance has been detected, and no association with AIDS has been found. Aruba had only one case of leprosy, which was diagnosed in 1994.

Although there is no information on the number of medical visits for acute respiratory infections (ARIs), it is estimated that they are a major cause of morbidity; a review of hospital discharge records for 1994 reveals that the likelihood of being hospitalized for a clinical picture consistent with ARI was 2.9 per 1,000 inhabitants. Children aged 1–4 years and adults aged 65 and over were three times more likely than other age groups to be hospitalized for ARI.

During the 1987–1996 period, 25 cases of AIDS were reported, 18 in males and 7 in females; 22 people have died. Epidemiological studies indicate that 94.4% of the males were infected through sexual transmission and 5.6% (one case) through blood that was probably infected (as a result of intravenous drug use). All HIV-positive individuals who report to the Division of Infectious Diseases receive medical and psychological counseling following detection. In addition to counseling and clinical care for HIV-infected patients, control measures include education and screening, especially of prostitutes, patients with sexually transmitted diseases, and blood donors. During the 1986–1995 period, blood testing for HIV detected one seropositive case in 1986, three in 1987, and one in 1995. There were no positive tests in the other years. Approximately 50% of the seropositive individuals were immigrants who had applied for work permits. Most returned to their native countries, which made it impossible to determine how many later developed or died from AIDS.

The number of physician-reported syphilis cases ranged from 14 (the highest number reported) in 1990 to 7 in 1995. In 1996, it was decided that laboratories would be asked to submit information on seropositive cases directly and 86 cases were thus detected, which suggests that the previous numbers reflect a significant degree of underreporting.

There is also underreporting in the case of gonorrhea; the highest number (53 cases) was reported in 1990. In 1996 only three cases were detected.

No cases of rabies or any other zoonoses were reported.

Noncommunicable Diseases and Other Health-Related Problems

A nutritional survey conducted in 1991–1992 (Kappel/Kock) indicated that 67% of the Aruban population was overweight, with a body mass index (BMI) of 25 or more, and 52% of the population had a BMI of more than 27. The mean BMI found among persons aged 22–64 was 27.8. Overweight affects both sexes equally. Significantly higher BMIs were found in low-income than in upper-income groups. The BMI among persons aged 50 and over was 28.5, while among younger adults aged 21–34 it was 27.

In 1995–1996, first- and fifth-graders were screened for overweight and the results were compared with screening results obtained in 1994–1995. It was found that the percentage of overweight among first-grade children had declined from 13.4% to 12.0%. Among fifth graders, an increase from 26.1% to 29.4% was observed. No data are available on protein-energy malnutrition among children under the age of 5.

Aruban authorities have not established an official policy on promotion of breast-feeding. In practice, many mothers do breast-feed their children, although they generally use bottle-feeding as a supplement.

The 1990 National Health Survey was a descriptive study of the general population aimed at obtaining information on health status, alcohol consumption, demand for medical services, and degree of satisfaction with those services. The results of the survey indicated that 66% of the population felt healthy and that hypertension and diabetes were the most prevalent diseases (affecting 9.8% and 4.3%, respectively, of the population).

Hospital admissions for diabetes mellitus were more frequent among females than males, which may indicate that the disease is more prevalent among females. The risk of requiring hospitalization for this cause increases with age and is three times higher in the group aged 65 and over than in the 45–64 age group. Diabetes mellitus was the fourth leading cause of death during the 1987–1993 period, and the rate has tended to remain stable. In 1993, the risk of dying from this cause was twice as high among females.

Ischemic heart disease ranked first or second as a cause of death in the 1991–1993 period.

In 1989, a study of a sample of the population aged 15–74 yielded information on the prevalence of coronary risk factors. The prevalence of arterial hypertension was found to be 17% with no significant differences associated with sex, nor were cholesterol levels significantly different in the two sexes (12% of males and 11% of females showed seriously high cholesterol levels, and 23% of males and 28% of females had moderately high levels of 5.2–6.4 mmol/l). The study showed the prevalence of diabetes to be 6% and that of smoking to be 32% among males and 13% among females. Overweight was

detected in 60% of the sample; 35% were moderately overweight and 23% were severely overweight. Significantly more females than males were overweight.

Malignant neoplasms were the second leading cause of death during the period 1987–1993. The most frequent tumor sites were the stomach and breast. A decline in mortality from this cause was noted between 1991 and 1993, which may be due to the fact that a high percentage of deaths was attributed to ill-defined causes in the latter year. According to anatomopathology reports for 1995 and 1996, in 100% of the cases of cervical cancer diagnosed, the carcinoma was in situ, but of 49 cases of breast cancer, 45 (92%) had progressed to an invasive stage at the time of diagnosis.

During the 1987–1993 period, accidents ranked third as a cause of death. In 1993, the only death in the 1–4 age group was attributable to this cause. Among males aged 15–44, accidents (specifically, motor vehicle accidents) were the leading cause of death. The only death among females aged 15–24 years was due to a violent cause (homicide). According to hospital discharge records, at least 8 of every 1,000 persons required hospitalization each year as a result of an accident, a number 2.8 times higher than the rate of hospitalization for acute respiratory infections.

With regard to behavioral disorders, during the 1995–1996 school year, the Drug Abuse Foundation carried out a survey among secondary school students. Of a sample of 625 students, a response rate of 98% was obtained. Of those who responded, 25% admitted using legal or illegal drugs. Of those who admitted to drug use, 19.3% indicated they drank beer, 16.5% drank wine, 12.2% drank rum or whiskey, 9.1% smoked cigarettes, 5.6% used marijuana, and 0.4% used cocaine. The students were more aware of the harmful effects of legal than of illegal drugs. The latter most often were obtained on the street, in discotheques, and at friends' houses.

With respect to oral health, in 1990 the School Oral Health Division of the Department of Public Health conducted a study of oral health among schoolchildren aged 4, 6, 9, and 12 and found that 66% had dental caries, while 34% were caries-free. The average DMFT (decayed, missing, filled teeth) index for the sample was 2.9. Dental caries were the most frequent oral health problem found, followed by extractions. Of the 37 schools surveyed, 17 had a DMFT index below 2.9, 6 had an index of 2.9, and 14 had an index above 2.9. Both the extent and the seriousness of caries were greater in Santa Cruz and Sabaneta than in other parts of the country. Oranjestad, the capital, was where the dental caries problem was least severe. The DMFT index was lower among females than males. Higher percentages of deficient oral hygiene were found in Sabaneta.

As for emerging and re-emerging diseases, no cases of meningococcal meningitis, hantavirus, or Venezuelan equine encephalitis have been reported.

No natural disasters or industrial accidents have been reported.

RESPONSE OF THE HEALTH SYSTEM

National Health Plans and Policies

The current Government is committed to reorganizing public health services, ensuring efficient and coordinated management of health activities, distributing financial resources appropriately, providing information to the population about the importance of preventive medicine, and maintaining and improving medical and paramedical care.

Reorganizing the public health sector means revising existing laws; applying the general insurance law, the aim of which is to reduce and control medical costs; inventorying and coordinating the areas related to public health; promoting good health and accentuating health education, including primary, secondary, and tertiary prevention; and introducing a system of inspection of public health services.

The Public Health Law (1952) comprises a set of general laws—also known as organizational regulations, which deal with matters relating to organization and supervision of health services as well as promotion of health—and specific laws, grouped according to whether they concern the health professions—mental health, sanitation, diseases, health inspection of animals and plants, meat inspection, livestock and marketing of meat products, and burials and cemeteries. The specific laws were enacted between 1917 and 1969.

Health Services and Resources

Organization of Services for Care of the Population

The Department of Public Health of Aruba is responsible for promotion of public health, mental health, and psychiatric care; administration of the public laboratory; and application and enforcement of laws relating to public health.

Health Promotion. The Department of Public Health makes information available to the population via radio and television. Its Public Relations and Health Promotion Section distributes informational materials (posters, pamphlets, brochures, and stickers). Other services within the Department provide information to the general public, including schools, about various health-related topics.

Disease Prevention and Control. The Youth Health Service performs physical examinations of all first- to fifth-grade students each year, and also provides vaccinations.

Vector control is the responsibility of the Department's Vector Control Division, which monitors all dwellings on the island for *Aedes aegypti.*

The Animal Health and Veterinary Public Health Division of the Department of Public Health conducts research and analysis in the field and in the veterinary laboratory. These activities are regulated by veterinary law.

The Communicable Diseases Division ensures epidemiological surveillance of communicable diseases through a reporting system in which the health services participate. This service regularly provides consolidated information to the Division of Epidemiology and Research. Reporting of communicable diseases is required by law. Nurses from the Communicable Diseases Division are responsible for patient monitoring and follow-up. This division also monitors and counsels patients with HIV.

Aruba has a public health laboratory, which makes diagnoses for surveillance purposes. Internal and external controls ensure the quality of laboratory tests.

Water Supply and Sewerage Systems. Drinking water is supplied on Aruba by the Water and Energy Company (WEB), which serves some 26,000 homes. Average per capita consumption of water in 1995 was 9 metric tons a month. Drinking water is produced by desalinization of sea water. WEB Aruba obtains more than 31,000 metric tons of desalinated water per day, which represents a total of about 11 million metric tons per year. On the basis of the water-quality standards of the World Health Organization, Aruba's water is one of the best in the world; chemical and bacteriological tests are performed monthly at 20 sites on the island to ensure water quality.

Wastewater is treated through both individual systems—including cesspits, septic tanks, and direct drainage into the ocean—and the collective system, which may be by central cesspit, purification of wastewater, and drainage into the ocean.

Municipal Services for Management of Solid Waste, Including Hospital Waste. For disposal of solid waste, there is a 12.5-hectare refuse dump located in Parkietenbos. Different types of waste are taken to this site (refuse from homes, offices, industry, hotels, restaurants and cafes, construction and demolition sites), but no documentation is available regarding the exact amounts. Hospital waste also is transported and disposed of in the municipal dump. Infectious waste is burned in an incinerator, which may pose operation and maintenance problems.

Food Safety. The Communicable Diseases Division tests food-handlers every six months for shigella, salmonella, and tuberculosis. Food samples are collected regularly and sent to the laboratory for testing.

Organization and Operation of Personal Health Care Services

Everyone who legally resides on the island has access to medical care. Individuals may obtain insurance privately or through their employers. The unemployed, the elderly, and the disabled are eligible to receive a PPK card, which entitles them to receive care from government physicians. The Government also furnishes any drugs that PPK cardholders require.

The main hospital on Aruba is the Doctor Horacio Oduber Hospital, which is a private, nonprofit institution managed by a foundation. It has 253 beds for inpatients and 26 beds for psychiatric care. In 1994 the hospital had 9,970 admissions, with an occupancy rate of 87.2%. The hospital possesses radiology equipment and performs 2,000 imaging studies and 40,000 X-ray studies annually. Other services provided include internal medicine, surgery, urology, gynecology and obstetrics, pediatrics, otorhinolaryngology, ophthalmology, neurology, psychiatry, and rehabilitation. The emergency room operates 24 hours a day and in 1994 attended 25,293 patients, of whom 2,516 (9.9%) were tourists.

The Dr. Rudy Engelbrecht Medical Center is centrally located in Sint Nicolaas to provide medical care for the city's residents as well as those from Savaneta, Pos Chiquito, Brasil, and Cura Cabay and the inmates of the Correctional Institute. The Center provides mainly primary care. It has an emergency room that operates 24 hours a day under the supervision of a general practitioner. Except for pregnant women in labor, who may be admitted by their general practitioners, only patients referred by a specialist are admitted.

As of 31 December 1996, Aruba had 32 general practitioners, 50 specialists, 20 dentists, 15 pharmacists, 4 veterinarians, 4 psychologists, and 3 midwives.

Human Resources

Most physicians receive their training in recognized institutions in the Netherlands or, to a lesser extent, in Colombia, Costa Rica, the United States, or Venezuela. The Hospital has a school of nursing, which trains practical nurses. Nursing degrees are usually obtained from schools on Curaçao or in the Netherlands.

Health research is considered an important activity for the development of public health. In 1996, the Public Health Department budget allocation for research development was US$ 29,000.

Investments

Equitable and sustained economic growth is clearly an objective of Aruba's public spending policy. For example, a spe-

cific objective of the Sasaki Development Plan and many other public investment projects is to promote sustained and equitable economic development. Public investment plays an important role in the formation of both human and physical capital. Public investment in basic infrastructure is also an essential requirement for the accumulation of wealth in the private sector.

Investment is one of the factors that has allowed Aruba to experience rapid growth. Total investment increased from around US$ 95.3 million, or 20% of GDP, in 1986 to US$ 436 million, or 31% of GDP, in 1991; however, it fell to around 24% of GDP in 1993, but subsequently rose again to approximately 27% of GDP in 1994–1995, a level consistent with the macroeconomic policy objective of 5% real growth in the GDP.

Three distinct trends can be identified in the period 1980–1995. Between 1980 and 1985, there was a decline in investment and in related economic growth, coupled with a significant rise in unemployment; during the period 1985–1990 investment increased to an annual average rate of 31.5%, with the highest rate (32.2%) occurring in private investment, which provided a strong impetus for the economy and, more importantly, fueled a recovery of economic growth, which had stagnated during the crisis years. In the period 1990–1995, investment increased only slightly, with slow economic growth.

Analysis of available statistical data shows that the contribution of private investment to overall growth of the GDP has been considerable and that there has been an increase in capital formation efforts in the past 10 years. In January 1991, average private investment as a percentage of GDP reached a high of 27%, subsequently declined to 20.8% in 1993, and then recovered in 1994, rising to 24.4% of GDP in 1995. Throughout the period, private investment exceeded public investment. Access to foreign capital was a key factor in the increase of the gross investment rate. The Government stimulated investment through a combination of fiscal incentives. These measures had a significant impact on private investment, which became the principal motor of economic growth.

During the period 1986–1995, average public investment reached 3.8% of the GDP and 12.8% of total government spending. Both, however, began to decline in 1987, which affected public investment in the social sectors, especially education and health. The drop in public investment was linked to two main factors: a salary increase in the public sector and relatively low tax revenues. Public investment—including foreign aid provided through the Dutch Development Cooperation Program, administered by the Cabinet of the Netherlands Antilles and Aruba—which decreased to a relatively lesser extent than private investment, underwent significant changes in terms of prioritization. These changes favored state-run companies, especially in the energy sector. The negative effects included a decrease in capital outlays, spending on operations and maintenance, and investment in social programs (education and health, in particular).

Investment began to rise in 1995 and continued to do so into the first half of 1996. Public investment is expected to increase considerably during the period 1996–2000, especially as a result of early application of the Sasaki Development Plan.

With regard to planned investment in health for the next period, the Ministry has assigned high priority to the construction of a psychiatric hospital with 60–80 beds by the end of 1996. The objective is to link the psychiatric hospital to a small general hospital (70 beds) so that they can share services such as laundry, laboratory, technical maintenance, and food service.

Under the present plan, the general insurance system will be implemented in phases. During the first two years, health expenditures will probably increase, but then they are expected to decline. It is also expected that the reorganization of health services, with an emphasis on prevention, will lead to a reduction in health care spending. In this connection, the activities of the Yellow and White Cross Foundation are seen as very important, and it is considered necessary to enhance and intensify them. Home health care, which is becoming increasingly prevalent, should also be expanded so that it becomes a truly viable option.