ANALYSIS OF HEALTH SECTOR REFORM
IN THE ENGLISH-SPEAKING CARIBBEAN COUNTRIES*

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ORGANIZATION AND MANAGEMENT OF HEALTH SYSTEMS AND SERVICES

DIVISION OF HEALTH SYSTEMS AND SERVICES DEVELOPMENT

PAN AMERICAN HEALTH ORGANIZATION

I. MONITORING THE HEALTH SECTOR REFORM PROCESSES

By the mid 1990s almost all the Latin American and Caribbean countries (LAC) had initiated, or were considering to set in motion health sector reforms (HSR).[1] The definition of what constitutes Health Sector Reform is, and continues to be, a subject of contention.[2,3] In the Americas, an international meeting held in 1995 to discuss HSR defined it as *"...as a process aimed at introducing substantive changes into different health sector entities and functions. The purpose is to increase equity of benefits, efficiency of management, and effectiveness of actions, thereby, meeting the health needs of the population."*[4]

The *"Methodological Guidelines for the Preparation of Health Systems and Services Profiles for LAC*", which includes a section on Monitoring and Evaluating Health Sector Reforms in LAC, have been implemented by the Division of Health Systems and Services of the PAHO/WHO since 1997.[5 6] Tthe Guidelines are intended for use even in countries where sectoral reforms are not being implemented. This holds true for countries where the changes, while being noteworthy, are often referred to as something other than "reform". Given the continued debate on what should legitimately be considered as constituting HSR, it is therefore not surprising that the monitoring and evaluation of HSR presents methodological and conceptual problems that are far from being resolved.[7,8]

Based on the information included in the Monitoring and Evaluation section, a first version of an analysis of the *dynamics (stages and principal actors)* and of the *contents* of the health sector reforms in the English-speaking Eastern Caribbean countries was prepared. The country profiles of *Anguilla, Antigua and Barbuda, Barbados, British Virgin Islands, Dominica, Grenada, Montserrat, Saint Lucia, and St. Vincent and the Grenadines*, were reviewed and included in the analysis. The document was presented at the *Eastern Caribbean Health Systems and Services Profiles Workshop* held in Barbados, June 5-7, 2002. The comments, observations, and suggestions from the workshop participants were incorporated. The profiles for *The Bahamas*, *Turks & Caicos,* and *St. Kitts and Nevis* are to be included in the analysis once finalised by the country teams. Subsequently, the information included in the *Guyana, Jamaica, Trinidad & Tobago, and Suriname* profiles was incorporated into the analysis that follows.

MONITORING THE DYNAMICS

Origin of the Reform

Most of the English-speaking Caribbean countries were initiating Health Sector Reforms in the early 1990s. This is not to say, that reforms were never previously initiated. Indeed, some countries such as *Jamaica* and *Trinidad & Tobago* report the development of initiatives related to HSR in the 1970s and 1980s and there is some evidence of reform initiatives as early as the 1950s/1960s. One such example is the Julian Commission in Trinidad and Tobago.[9]

While it is true that the analysis revealed the existence of a number of common factors influencing HSR, upon closer examination of the country profiles there is some indication of differences in the significance of the factors across countries. That is, the profiles suggest that the ***origin of the reform*** among the countries varies. Structural adjustment measures and public sector reform triggered the reform in *Barbados, Grenada, Saint Lucia and Suriname*. The reformulation of the role of the MOH, financial sustainability, quality assurance and equity prompted the reform in *Jamaica*. Natural disasters, such as volcanic activity and hurricanes initiated the reform process in *Dominica and Montserrat.* The development and strengthening of Primary Health Care strategies and infrastructure are mentioned as generators for HSR in *Anguilla*, *Dominica and Trinidad & Tobago*. The need to improve management at all levels of the health system was identified as the key factor eliciting the reform in *Guyana*. Most countries reported some degree of externally driven influence by donor and development assistance agencies for HSR.

ORIGIN OF THE REFORMS

- Most of the English-speaking Caribbean countries were initiating Health Sector Reforms in the early 1990s. Some countries report the development of HSR initiatives since the 1970s and there is evidence of even earlier initiatives, for example the Julian Commission in Trinidad and Tobago.
- The main generators of the reforms include:
  - Structural Adjustment Measures
  - Public Sector Reform
  - Natural Disasters
  - Fostering of Primary Health Care strategies
  - Management Improvement
  - The search for Financial Sustainability of the Health System
  - Quality Assurance and Equity concerns

Barbados, Dominica, Guyana, Jamaica, Saint Lucia and Suriname were among the countries reporting that the ***opinions and demands of the population*** were taken into account at the time the reform was proposed. As part of the process to develop their national strategic health plan, *Barbados* intends to hold a national consultation process involving stakeholders from the public and private sectors.

In all countries, with the exception of *Antigua and Barbuda*, the existence of ***an explicit agenda for sectoral reform*** with specific objectives was confirmed. However, its content varied by country. Common objectives pointed out include the following: (i) equity in access to health care in *Anguilla, Barbados, Grenada, Jamaica, Saint Lucia, Suriname and Trinidad & Tobago*; (ii) improvement in the overall quality of care in *Anguilla, Barbados, Dominica, Jamaica, Saint Lucia, and Trinidad & Tobago*; (iii) strengthening the steering role of the Ministry of Health (MOH) and decentralisation schemes in *Guyana*; (iv) alternative methods of health care financing in *Anguilla, Barbados, Dominica, Grenada, Guyana, and Saint. Lucia*; (v) performance indicators to monitor effectiveness and delivery of services in *Barbados, Dominica, Montserrat, Suriname, Trinidad & Tobago;* (vi) Environmental Health strategies *in Grenada, Montserrat, and Saint Lucia;* (vii) Primary Health Care *in Anguilla, Grenada, Montserrat, and Saint Lucia;* and (viii) Health Promotion in all countries as a result of the Caribbean Charter for Health Promotion declared in 1993.

Health Sector Reform has been ***incorporated into the plans and programs*** for modernization of the State in *Dominica, Grenada, Guyana, Montserrat, Saint Lucia and Suriname*. The eligibility of *Guyana* for debt relief under the Highly Indebted Poor Country Initiative (HIPC) made possible the allocation of funds for health and poverty alleviation programmes. In the case of *Suriname* the structural adjustment program provided the framework for the HSR. In *Dominica* in 1996 the Government launched a new phase of public sector development aimed at providing an impetus to reform within the public sector, which eventually included the Ministry of Health.

DYNAMICS OF THE REFORMS

- *Barbados, Dominica, Guyana, Jamaica, Suriname, Saint. Lucia* reported that the opinions and demands of the population were taken into account at the time the reform was proposed.
- An explicit agenda for sectoral reform with specific objectives was prevalent in most countries although the objectives varied by country. The strategies of the Caribbean Health Promotion Charter have been accepted as an overall approach to health reform in all countries.
- In most cases Health Sector Reform has been incorporated into the plans and programs for modernization of the State.

Design of the Reforms

The Ministries of Health were ***responsible for the design of the reform*** in all countries with the exception of Montserrat. Nonetheless, the Canadian International Development Agency (CIDA); the Department for International Development (DFID) of the United Kingdom Government, the Dutch Government; the European Union (EU), the French Technical Cooperation Agency, the German Technical Cooperation Agency (GTZ); the Inter-American Development Bank (IADB), Japan; the Organisation of Eastern Caribbean States (OECS) Secretariat, the Pan American Health Organization (PAHO), the United States Agency for International Development (USAID), and the University of West Indies (UWI) were instrumental in providing technical and financial support to the process in some countries. For example, in Montserrat DFID and the Government of Montserrat Executive Council were the primary actors involved. In Jamaica, *Saint Lucia* and St. Vincent and the Grenadines, a Health Sector Reform Committee was established within the Ministry of Health and included stakeholders from outside the MOH. In *Anguilla*, a Health Authority Project Board is being instituted. In *Suriname* and *Guyana* the Ministry of Health and the IADB were primarily responsible for the design of the reform.

DESIGN OF THE REFORMS

- The Ministries of Health have had the leading role in the design of the reforms.
- International agencies, such as CIDA, DFID, the Dutch Government, the EU, the French Technical Cooperation Agency, GTZ, IADB, Japan, OECS Secretariat, PAHO, USAID, as well as academic institutions, such as the University of West Indies have been instrumental in providing technical and financial support to the Health Sector Reform processes.

Negotiation of the Reforms

In *Barbados, Guyana, Jamaica, Saint Lucia, and Trinidad & Tobago* negotiations were held with health care workers, trade unions, regional/local authorities, other Ministries, NGOs, the media and the private sector to determine the objectives and content of the Health Sector Reform Project. In *Guyana, Jamaica, Suriname, and Trinidad & Tobago* the Ministry of Health exerted the leadership role in the negotiation process. In *Saint Lucia*, for example the Health Sector Reform Committee of the Ministry of Health played the lead role in the negotiation process. As a result, proposals regarding quality and control of services as well as a mechanism to receive and facilitate complaints from the general public were developed. In *Barbados*, the Ministry of Health is currently preparing a national consultation process regarding their national strategic health plan with expectation that the consultation(s) will involve stakeholders from the private and public sector.

Implementation of the Reforms

An ***action plan*** with goals and responsibilities for the implementation of the reform was identified in *Anguilla, Barbados, Dominica, Guyana, Jamaica, Saint Lucia, Suriname, and Trinidad & Tobago*. Most countries have moved into the implementation stage with some being in a more advanced stage of implementation than others. In the case of Trinidad and Tobago, a major initiative under the HSR was the creation of Regional Health Authorities (RHAs). The RHAs have been established since January 1994. In the case of Dominica, initiatives have been implemented to strengthen the role of the primary health care network as the gatekeeper in the system

Evaluation Criteria of the Reforms

With the exception of *Jamaica*, none of the countries presented evidence that evaluation criteria or monitoring mechanisms for the reform process were included at the outset. However, studies by MOH personnel and by local and international consultants are performed to evaluate the progress and impact of various components of the health sector reform program.

NEGOTIATION, IMPLEMENTATION AND EVALUATION CRITERIA OF THE REFORMS

- Negotiations on Health Sector Reform with country stakeholders have taken place in six countries.
- More than half of the countries have action plans with goals and responsibilities for the implementation of the reform. Some countries have moved into the implementation phase.
- Only *Jamaica* defined evaluation criteria or monitoring mechanisms for the reform process at the outset.

Conclusions

In most cases, the Health Sector Reform processes in the Eastern Caribbean English-speaking countries were **initiated** in the early 1990s. However, other countries such as *Jamaica* and *Trinidad & Tobago* report the development of initiatives related to HSR in the 1970s and 1980s.

The main **issues** that were identified as **triggers of the reforms** were the structural adjustment measures, public sector reform initiatives; reformulation of the role of the MOH, financial sustainability; quality assurance and equity; the need to improve management at all levels of the health system; natural disasters, such as volcanic eruptions and hurricanes; and an emphasis/reorientation of the health system towards primary health care strategies.

In most cases, the Health Sector Reform processes have been incorporated into the plans and programs related to the **modernisation of the State**. On the whole, the Ministries of Health have had the leading role in the design of the reforms. However, **development cooperation and financial agencies**, such as CIDA, DFID, the Dutch Government, EU, the French Technical Cooperation Agency, GTZ, JAPAN, the IADB, PAHO, and USAID as well as academic institutions such as UWI have been instrumental in providing technical and financial support to the processes. The **opinions and demands of the population** have been taken into account at the time the reform was proposed in at least six countries.

An explicit **agenda for sectoral reform** with specific objectives was prevalent in most countries although the objectives varied by country. The strategies of the Caribbean Health Promotion Charter have been accepted as an overall approach to health reform in all countries.

In all cases, the Ministry of Health played a central role in the HSR process. Moreover, **negotiations** on the reform with country stakeholders have taken place in at least six countries.

More than half of the countries have **action plans with goals and responsibilities** for the implementation of the reform and many countries are now in the implementation phase.

Only in Jamaica were evaluation criteria or monitoring mechanisms for the reform process been defined at the very outset.

MONITORING THE CONTENT

Legal Framework

Changes have been ***introduced to modify the Constitution or the health legal framework*** in some of the English-speaking Caribbean Countries. In the case of *Jamaica* legal changes introduced are related to decentralisation, the Mental Health Act and the National Health Insurance Program. In *Guyana* and *Trinidad & Tobago* the most significant legislation is related to the creation of Regional Health Authorities. *Suriname* envisions changes to the law on the import of drugs and law on tariffs on health care. In *Barbados* there is awareness that development of new legislation must take place to ensure implementation of the Strategic Health Plan. Over the next two years the Ministry of Health in Barbados also plans to introduce legislation related to the Mental Health Act; the Continuous Quality Improvement Programme; the Nursing Homes and Senior Citizens Homes legislation; Health and Environmental Protection; Port Health Services; and Cremation Regulations. Although in *Dominica* constitutional amendments in support of health sector reform have not been proposed the new User Fee System was effected through the amendment of existing legislation.

CHANGES IN THE LEGAL FRAMEWORK

Changes have been introduced to modify the Constitution or health legal framework for Health Sector Reform in some of the English-speaking Caribbean countries.

The Right to Health Care and Health Insurance

Health care is considered to be a fundamental right for all citizens *in Anguilla, Antigua and Barbuda, Barbados, Dominica, Grenada, Guyana, Jamaica, Montserrat, and Suriname.* In *Trinidad & Tobago*, although the right to health care is not stated explicitly in the Constitution, it is implied by legislative mandates. In the case of *Saint Lucia* the Health Sector Reform envisages that the right to health care is to be guaranteed through increased access to health services, anti-discriminatory legislation, equitable financing arrangements, a Basic Package of Health Services, and regulation/licensing of health care providers. In many cases, a direct spin-off from this principle has been that health care in

the public sector is basically free at the point of delivery for all citizens (or in those cases in where charges are in place, such charges are minimal).

Barbados, Dominica, Grenada, and Saint Lucia reported increased coverage as an integral goal of their Health Sector Reform Strategy. In *Dominica*, increased ***coverage*** has been attained through the establishment of an island-wide primary health care programme. A ***Basic Package of Health Services*** for the primary level has been defined in *Antigua, Dominica, Montserrat and Trinidad & Tobago.* In *Dominica*, the *Basic Package of Health Services* includes medical care for common infectious and chronic diseases, maternal and child health services including family planning, delivery and immunisations, health promotion and prevention, and dental care. Among the HSR proposals in *Suriname* is the development of a Basic Package of Health Services.

In *Jamaica*, as in many of the other English-speaking Caribbean countries, a ***National Insurance/Social Security System*** is in place. However, as in the case of most of the countries it only includes a limited retirement program and some provisions for sick leave and reimbursement for selected services. Currently there is no basic set or plan of health benefits to which all citizens are entitled.

RIGHT TO HEALTH CARE AND HEALTH INSURANCE

- In the totality of the countries health care is reported to be a fundamental right of all citizens.
- Three countries reported increased coverage as an integral part of their Health Sector Reform strategy.
- One country has implemented a limited version of a *National Health Insurance System*. The rest of the countries have begun discussing the design of National Health Insurance System. With the exception of one country, none of the Eastern Caribbean countries have moved to the implementation stage. At least three countries intend to include a Basic Package of Health Services in the National Health Insurance Programme.
- At least three countries have defined a Basic Package of Health Services for the primary health care level.

The rest of the countries have begun the discussion process in regards to a *National Health Insurance.* However, with the exception of *Antigua and Barbuda,* where a Medical Benefits Scheme was implemented in the late 1970s, no other Eastern Caribbean country has moved to the implementation stage of NHI.[10] In *Grenada, Saint Lucia*, and *Trinidad & Tobago*, the *National Health Insurance System* envisions the inclusion of a *Basic Package of Health Services.* Interestingly enough, Suriname has had a Health Insurance in operation for many years now and the National Insurance in Guyana provides limited health care coverage under the National Insurance System.

Steering Role and Separation of Functions

The MOH has been reorganised to strengthen its steering role in *Jamaica* and *Trinidad & Tobago*.

The steering role function in health is presently under review in *Anguilla, Barbados, Dominica, Guyana, Montserrat, Saint Lucia and Suriname,* but no steps have been implemented.

The Ministry of Health of *Barbados* will undertake shortly a detailed assessment of its various administrative and organizational practices, which affect decision-making in the health sector. In *Anguilla*, the Project Board is in the process of developing draft proposals for the organizational structure and activities, for itself as well as relationships with the Ministry of Health.

Only in *Trinidad & Tobago* does HSR provide for separation of the roles of regulation from service delivery.

STEERING ROLE AND SEPARATION OF FUNCTIONS

- Two countries have reorganised their MOH as to strengthen their steering roles.
- Seven countries are presently reviewing the steering roles of their respective Ministries of Health.
- Only *Trinidad & Tobago* has separated the functions of regulation from services delivery.
- Recently the health authorities of the English-speaking Caribbean countries evaluated the eleven Essential Public Health Functions defined in the corresponding performance assessment instrument put forward by the PAHO/WHO.

During the first semester of 2002 the Ministries of Health of the English-speaking Caribbean countries evaluated the eleven Essential Public Health Functions defined in the corresponding performance assessment instrument put forward by the PAHO/WHO. These include: (1) Monitoring, evaluation and analysis of the health situation; (2) Public health surveillance, research, and risk/harm control in public health; (3) Health promotion; (4) Social participation in health; (5) Development of policies and institutional capacity for planning and management of public health; (6) Strengthening of the institutional capacity for regulation and enforcement in public health; (7) Evaluation and promotion of equitable access to necessary health services; (8) Development of human resources and training in public health; (9) Quality assurance of personal and population based health services; (10) Research in Public Health; and (11) Reduction of the impact of emergencies and disasters in health. [11]

Modalities of Decentralization

The three basic types of decentralisation identified are *Devolution, Delegation, and Deconcentration*.[12] In *Dominica* the framework for decentralization was implemented prior to the reform process. In *Saint Lucia* devolution of power from the CMO to the Medical Director took place in order to abide with the reform proposals for decentralisation of the health and public services. However, transfer of responsibilities, authority and resources to sub-national levels has not come about.

In *Jamaica* and *Trinidad & Tobago* decentralisation has been achieved through the establishment of Regional Health Authorities (RHA). The RHAs primarily manage the delivery of health services although resources are centralised.

In *Grenada*, the government announced the intention to introduce an Executive Agency, a hybrid system that embraces elements of delegation to manage acute care institutions. In *Guyana* and *Suriname* the administrative levels of the health system are being reviewed to decentralise health services; however, these efforts are not necessarily linked to other efforts to decentralise public administration.

MODALITIES OF DECENTRALIZATION

- Devolution, delegation and deconcentration of health care delivery public institutions are the most common decentralisation modalities identified.

Social Participation

In *Jamaica* the HSR has promoted social marketing and participation entities and mechanisms to encourage the participation of a wide range of members of society. In the case of *Trinidad & Tobago* multiple initiatives to promote social participation have been implemented, such as public consultations, creation of web sites, and involvement of NGOs. In *Suriname* social participation is stimulated through presentation of study results and policy options to civil society.

In *Dominica* social participation has been implemented through the inclusion of the public and civil society in the planning and evaluation of health services. However, the Ministry of Health is exploring different mechanisms to facilitate meaningful participation, such as reorganization of health

committees, and working with local government authorities, and other community-based organisations.

In *Saint Lucia*, social participation is an explicit objective of the reform. Meetings were held with health workers and other stakeholders to sensitise them to reform and provide them the opportunity to give feedback on key policy issues.

In *Barbados*, the Ministry has proposed to provide training and leadership skills to communities to enable them to manage community health programs. In *Montserrat*, social participation was not an explicit objective of the reform process.

SOCIAL PARTICIPATION

- In seven countries Social Participation was included as an explicit objective of the reform.
- Four countries have implemented Social Participation and Control through the inclusion of the public and civil society in the planning and evaluation of health services. Moreover, new modalities of social participation are being explored.
- Plans to implement social participation strategies were identified in three countries.

Financing and Expenditure

In *Trinidad & Tobago* the HSR process has promoted the development of a financial information system and the design of a National Health Insurance Scheme. *Jamaica, Guyana* and *Suriname* have developed proposals to modify the composition of the financial regulations and financing. The need to strengthen information systems for financing and expenditures is recognised in the latter three countries.

During the early 1990s, the Organisation of Eastern Caribbean States (OECS) established the Health Care Policy Planning and Management Project, which conducted a number of studies toward designing a strategy for health financing reform in the Eastern Caribbean.[13] The Caribbean Regional Health Study stated that each country would need to pursue one or a combination of health financing mechanisms, placing emphasis on a strategy that "provides an adequate level of cash flow, shares the burden of payments equitably among different groups, encourages efficiency in resource use and is sustainable, is relatively easy to administer, and is generally acceptable.[14] A PAHO/UNDP/CARICOM policy document[15] focused on the importance of designing and

implementing a health care financing policy based on a sound assessment of the respective financial mechanisms. As part of a process of continued Technical Cooperation from the Office of Caribbean Program Coordination PAHO/WHO to Eastern Caribbean countries, the Office established in 2000 a Working Group on Health Financing Reform for Barbados and Eastern Caribbean countries to support and successfully advance health financing reform in Barbados and the Eastern Caribbean. The major focus of the Working Group is to contribute to the necessary co-ordination to successfully move forward on a five-year plan of action for health financing reform for Barbados and Eastern Caribbean countries. The components are: (i) Improvements to Health Financing Models; (ii) Development of a Set of Health Benefits; (iii) Modifications to Provider Payment Mechanisms; (iv) Skills Development in Health Economic Analyses; and (v) Improvements in Health Financial Management Systems.

Considering both the complexity and specificity of health reform processes, the Plan of Action is mainly oriented to foster regional or inter-country activities. This regional approach, centred on the development of regional guidelines, concept papers, and technical papers is viewed as the most appropriate means to provide support to countries to carry out situational assessments as well as to design, implement and monitor reform processes in health financing. The components are best thought of as a package; they are closely related and mutually reinforce each other. The successful implementation of this Plan of Action is dependent upon national commitment and that not every country will be involved in each activity under the Plan of Action as each country may be at a different state of readiness to initiate the health financing reform activities under the Plan of Action. However, all countries have agreed that no reform should run contrary to the Plan of Action and that the "ideal reform" would be one in which substantive changes have been introduced in all activities by the end of the process.

In 2001, the *Development of National Health Accounts in the Caribbean Initiative* was launched in the Caribbean. A training course *Development of National Health Accounts in the Caribbean* was held. This training course was largely a development and training exercise to assist country teams to begin the process. *Barbados, Dominica, Guyana, Jamaica, St. Vincent and the Grenadines, Suriname, and Trinidad and Tobago* are participating in Phase I of this Initiative.

Policy makers expressed the need to have a frame of reference to assess the pertinence of national health insurance proposals. In response to this need and as part of a process of continued Technical Cooperation, the Office of Caribbean Program Coordination PAHO/WHO undertook the initiative to develop a guidebook designed to assist Eastern Caribbean countries in the process of decision making about introducing National Health Insurance. This guidebook "*National Health Insurance in the Eastern Caribbean: A Guidebook for Appraisal and Design, Working Document"* was disseminated to Barbados and Eastern Caribbean countries as well as other Caribbean countries in May 2002.[16]

In *Dominica*, low acceptance of a national health insurance scheme led to the implementation of a User Fee System. However, an assessment of the User Fee System found gross under collection, negative impact on access to care, over-priced services, and significant public dissatisfaction. This led to the implementation of a schedule of reduced fees with exemption for certain categories.

In *Saint Lucia*, plans are underway for a review of the entire financing mechanism of the health sector. Plans for a National Health Insurance Scheme are being discussed.

In *Barbados*, the Ministry of Health is exploring the feasibility of implementing an appropriate mix of financing mechanisms including private insurance, user fees, and social insurance.

In *Montserrat*, the Ministry of Health has identified the need to improve its information systems on financing and expenditure and it is a priority area in the hospital information system currently being developed.

FINANCING AND EXPENDITURE

- Different strategies to modify the mix of the existent financing mechanisms are being planned or have been introduced in various countries.
- The design and implementation of a system of National Health Accounts is reported in some countries.
- Plans and discussions to design a National Health Insurance Scheme are taking place.
- The need to improve the financing and expenditure information system was identified.

Services Delivery and Management Model

In regards to ***services delivery*** in *Trinidad & Tobago* there are plans to increase the number and range of primary level and community services including ambulatory care, day surgery programs and home care programs, with a particular emphasis on primary level management of chronic diseases. The development of integrated referral systems is planned to ensure continuity of care between institutions. In *Jamaica* promoting the integration of care between the primary and secondary care levels will modify delivery of public health services. In *Guyana*, there is an expressed goal to make Primary Health Care the focus of the reforms, but there has been no realignment of the resources and services to reflect that goal. Equally, the need to strengthen the referral system has been recognised

and is one of the activities of the reform process. In *Suriname* efforts to strengthen primary care are underway. Moreover, several programs are being developed to increase service delivery to vulnerable groups, such as mother and child programs, adolescent sexual and reproductive health programs, nursing homes for the elderly, among others.

In regards to the ***management model*** in *Trinidad & Tobago* the development of new institutions such as the Health Sector Quality Council, and new instruments such as health facility accreditation, annual service agreements, and annual business plans provide the foundation for the new management model. In *Jamaica*, changes are being discussed and introduced in the management model in the relationships between the protagonists. For example, the RHAs have become operational and the MOH head office has been reorganised. In *Guyana*, changes to the management model for public health facilities are centred in making the Regional Health Authorities be responsible for service delivery, and to work closely with the private sector in the provision of health care. In *Suriname*, it has been proposed that the different stakeholders in the health sector be organised in a formal National Health Council. Management contracts/commitments in the public health system already exist between payers and providers.

In *Montserrat*, the Ministry of Health has identified the need to redefine the model of care by strengthening primary care and prioritising vulnerable groups. The strategies identified in the Caribbean Health Promotion Charter 1993 will be used for the planning and program development of all services and the Government intends to improve health services delivery for chronic diseases.

SERVICES DELIVERY AND MANAGEMENT MODEL

- Services Delivery models are being modified in all countries.
- Modifications to the existing model include strengthening primary care, prioritising vulnerable groups, same day and outpatient surgeries, and the use of health promotion as the main strategy for the delivery of all health services.
- Modifications to the health care delivery model have been proposed for the three levels of care, changes have been applied only at the secondary level.
- Plans to modify the management model are taking place.

In *Saint Lucia*, modifying the delivery of services has been proposed for services offered at the primary, secondary and tertiary levels of care. Same day and outpatient surgeries are performed in greater numbers at both acute general hospitals. Also, some changes have been introduced in the existing management model.

Human Resources

The centrality of human resource development (HRD) in health systems and services in the Caribbean has been recognized by Governments in the subregion and endorsed as one of the priority areas in the Caribbean Cooperation in Health (CCH II), a mechanism that promotes collective action and resources on common regional priorities in health and identifies practical target areas and approaches in addressing these priorities.

The four-year project, Human Resources Training and Development in Health Information Systems for the English-speaking Caribbean, mounted at the Barbados Community College (BCC), represented a major achievement in human resource training and development. The project was successfully completed in February 2001 and is now regarded as a model for successful partnerships between PAHO and other funding agencies.[17]

The continued emphasis on human resource development in the health sector of the sub-region was reflected in the signing of a three-year agreement between the Government of France and the OECS in support of the implementation of a Health Sector Reform Program. This agreement allows for Human Resource Management and training.

Harmonization of curricula for basic nursing and family physician training programs was completed and a regional registration examination, previously established, now qualifies nurses to practice in any country in the Caribbean. Harmonization of the programs supports the CARICOM single market economy initiative and facilitates free movement of professionals and skills in the Caribbean region.

The movement for a single, standardized approach to medical registration evolved when the region's National Medical Councils persuaded PAHO and the CARICOM Secretariat, to assist them in developing this approach. This gained added momentum at a special meeting of the Conference of Ministers of Health in 1997, when the ministers endorsed the Caribbean Association of Medical Councils (CAMC) initiative as an integral part of the health care reform process in the sub-region. This action resulted in the creation of the Caribbean Association of Medical Councils (CAMC) as the regional mechanism for the registration and monitoring of the practice of all categories of health personnel. Each National Medical Council has since launched marketing and information campaigns in their respective countries, explaining the new registration process and increasing general awareness about expected improvements in community health care. By the year 2004, all medical personnel in the Caribbean, including UWI graduates, will be required to pass the test in order to practice in the sub-region.[18]

The problem of nursing shortage in the Caribbean is a major challenge to the delivery of safe, effective and efficient health services, and is likely to be intensified by imminent political developments such as the advent of the Free Trade Area of the Americas (FTAA). An implementation team was appointed comprising delegates representing 12 English-speaking Caribbean countries and several non-governmental organizations, institutions and national associations. At its first meeting, the implementation team reviewed the status of the Managed Migration Program and prepared an action plan that included a marketing drive aimed at enlisting the services of qualified young, mature, male and female nurses. Another strategy identified was a mentorship program designed to prepare senior nursing staff to provide an environment that promoted professional growth, and enhanced staff and client satisfaction.[19]

In *Trinidad & Tobago* a major change arising from the HSRP is the transfer of the staff from MOH to the RHA. New programs are being developed to address the health status and health service needs of the population. In addition the HSRP provides for training in a large number of areas to facilitate the massive changes arising from the program.

In *Jamaica*, there is a human resources unit in the Ministry of Health. Modifications in human resources education have been designed and introduced to respond to the needs created by sectoral reform. For example, teaching programs have been consolidated into a few universities and departments. Their objectives are accreditation, greater operational efficiency and compliance with global professional standards. Changes in labour laws have been introduced.

In *Guyana*, some modifications have been made in human resources education to include areas such as health promotion. Mechanisms are being formulated for the certification of health workers mainly through Caribbean sub-regional initiatives. Increased financing to upgrade the salaries of workers in the public sector so that they can approach the salary levels of the private sector is being allocated.

In *Suriname*, some modifications to the general practitioners education program to better reflect the need for strengthening preventive care are being introduced. A proposal has been introduced to improve the performance of general practitioners in the public sector. It consists of offering a bonus to the general practitioner if a predefined target for preventive care services for the patient population is reached.

In *Saint Lucia*, health personnel have been trained in health planning, health information and medical demography to strengthen existing capacity in Health Information and Planning, a priority area of the Health Sector Reform Process.

In *Dominica*, human resource development in relation to Health System Reform has not been emphasized. However, consistent with public sector reform a system of financial incentives based on performance appraisal has been introduced.

Barbados plans to develop human resources management and development policies in 2003. Human resources will be strengthened initially in rehabilitation, mental health, hospital services, and oral health.

In *Montserrat* no changes have been introduced in human resources planning and management. Training of health workers is done as the need arises and as finances allows. There is continuing education and in-service training for all categories of workers, but done in ad hoc manner.

HUMAN RESOURCES

- More than half of the countries reported changes in human resources development to respond to the needs of Health Sector Reform.
- Modifications in human resources development were reported in the field of health planning, health information, medical demography, community health, dental health, community nursing, and administration.
- The introduction of a system of financial incentives based on performance appraisal to comply with the public sector reform process was reported.

Quality and Health Technology Assessment

In *Trinidad & Tobago* quality of care is a major focus of the HSR process as evidenced by the establishment of a Directorate of Quality Management, mandated with development of systems to support improvements in quality of care. It includes a system for accreditation of both hospital and primary health care facilities and the development of clinical audit systems. Moreover, it includes a plan for development of health technology assessment and management capacities and systems.

In *Jamaica* procedures for the accreditation of health establishments and programs are being created or reformulated. HSR initiatives in the areas of technical quality and perceived quality have focused on only public hospitals at this time. Proposals have been drafted to develop mechanisms to evaluate health technology before it is introduced.

In *Guyana* the HSR includes initiatives in the area of technical quality or perceived quality for the different levels of care. Among them is the development of a Value Improvement Programme, the establishment of a Health Complaints Authority, and the Health Sector Quality Council.

Suriname has included accreditation of health care facilities and initiatives in the area of improved technical quality in the HSR programme. Perceived quality of care of the households and patients is included in the data collection activities of HSR.

PAHO has developed and initiated training in Continuous Quality Improvement (CQI) in health plans and programs for national coordinators. Those already trained and also future trainees in CQI leadership are expected to provide guidance to interdisciplinary teams and task force members responsible for effecting continuous quality improvement in the plans and programs of their respective health care organizations, and in effecting user satisfaction with the services provided.

In *Barbados*, a Continuous Quality Improvement Programme (CQI) was instituted and a feasibility and sensitisation study in five institutions of the Ministry of Health undertaken. The main recommendation was the development of educational programmes within institutions to foster a culture of quality. Quality coordinators and quality teams have been identified and trained.

In *Montserrat* there are no quality improvement programmes in place except in the laboratory, which is part of the quality control mechanism with CAREC and in the pharmacy with the OECS/PPS. A study to audit the quality of care in the treatment of diabetes and hypertension as part of the DFID/PAHO/GOM project will begin shortly.

In *Saint Lucia*, the proposed procedures and/or institutions for the accreditation of health establishments and programs have not been created. However, a Health Technology Assessment Committee, comprising both technical and lay persons, will be appointed. Equally, a Technology Assessment and Continuous Quality Improvement Programme will be developed.

QUALITY AND HEALTH TECHNOLOGY ASSESSMENT

- Most countries are developing Quality Improvement Programs with a strong capacity-building component.
- Proposals have been drafted to develop mechanisms to evaluate health technology. One country reported the intention to appoint a Health Technology Assessment Committee.

Conclusions

Changes have been introduced to modify the Constitution or health ***legal framework*** for Health Sector Reform in some of the English-speaking Caribbean countries.

In the totality of the countries health care is reported to be a ***fundamental right*** of all its citizens.

Three countries reported ***increased coverage*** as an integral component of their Health Sector Reform strategy.

Some countries have begun discussing the design of a ***National Health Insurance Scheme***. Three countries intend to include a ***Basic Package of Health Services*** in the National Health Insurance Scheme. Two countries have reorganised their MOH as to strengthen their steering roles. Seven countries are presently reviewing the ***steering roles*** of their respective Ministries of Health. Only one country has separated the functions of regulation from services delivery.

Devolution, delegation and deconcentration of health care delivery public institutions are the most common ***decentralization modalities*** identified.

In seven countries ***social participation*** was included as an explicit objective of the reform. Four countries have implemented Social Participation and Control through the inclusion of the public and civil society in the planning and evaluation of health services. Moreover, new modalities of social participation are being explored. Plans to implement social participation strategies were identified in three countries.

In regards to ***financing and expenditures*** different strategies to modify the mix of the existent financing mechanisms are being planned or have been introduced in various countries. *Barbados, Dominica, Guyana, Jamaica, St. Vincent and the Grenadines, Suriname, and Trinidad and Tobago* are participating in Phase I of the *Development of National Health Accounts in the Caribbean Initiative.* The design and implementation of a system of National Health Accounts is reported in all countries. Plans and discussions to design a National Health Insurance Scheme are taking place. Moreover, the need to improve the financing and expenditure information system was identified.

Services Delivery models are being modified in all countries. Modifications to the existing model include strengthening primary care, prioritizing vulnerable groups, same day and outpatient surgeries, and the use of health promotion as the main strategy for the delivery of all health services. Modifications to the health care delivery model have been proposed for the three levels of care,

changes have been applied only at the secondary level. Plans to modify the ***management model*** are taking place.

The centrality of human resource development (HRD) in health systems and services in the Caribbean has been recognized by Governments in the sub-region and endorsed as one of the priority areas in the Caribbean Cooperation in Health (CCH II), a mechanism that promotes collective action and resources on common regional priorities in health and identifies practical target areas and approaches in addressing these priorities. Thus, more than half of the countries reported changes in ***human resources*** development to respond to the needs of Health Sector Reform. Modifications in human resources development were reported in the field of health planning, health information, medical demography, community health, dental health, community nursing, and administration. The introduction of a system of financial incentives based on performance appraisal to comply with the public sector reform process was reported.

Most countries are developing ***Quality Improvement Programmes (QIP)*** with a strong capacity-building component. Proposals have been drafted to develop mechanisms to evaluate health technology. One country reported the intention to appoint a ***Health Technology*** Assessment Committee.

II. EVALUATION OF RESULTS

Most countries report that implementation of the process is either moving slower than expected or is in its initial stages. Thus an evaluation of the results is not feasible at this time. In the case of *Montserrat* a preliminary evaluation is to be completed and a report with recommendations expected. However, *Trinidad & Tobago* and *Jamaica* report preliminary results as follows:

Equity: In *Trinidad & Tobago* several facilities have extended hours of service and increased the range of services available particularly in primary care facilities. The decision has been made by the Government to implement a national health insurance system to guarantee access to a basic package of health services based on need rather than ability to pay. Also to reduce the waiting lists in public hospitals for common procedures, both decisions have the potential to reduce disparities in health status among population groups. In *Jamaica*, there is no evidence that HSR has had an impact on equity.

Effectiveness and Quality: In *Trinidad & Tobago* a legislative framework and a draft Health Services Quality Act have been prepared, and a Health Sector Quality Council has been put in place to guide and monitor improvement of quality of health care. Quality improvement committee structures have

been developed within each of the RHAs. In *Jamaica*, all public hospitals have quality assurance committees. Yet the percentage of hospitals that have a fully functioning quality assurance committee is unknown. In general, user satisfaction with the health services has increased.

Efficiency: In *Trinidad & Tobago* resources continue to be allocated primarily on a historical basis, however, several mechanisms are being developed to improve financial allocation. Among them is a health needs assessment, annual service agreements between the Ministry of Health and RHAs. In *Jamaica*, allocation of resources has not changed under the HSR. Decentralisation became fully operational in 1999 and may have an impact on resource allocation. However, no data is available.

Sustainability: In *Trinidad & Tobago* several challenges exist to the sustainability of the HSR program. Among them is acceptance of the stated objectives of the HSR, credibility of the RHA, the ability of the MOH to self-reform, and the development of a viable health care financing strategy.

Social Participation and Control: In *Trinidad & Tobago* mechanisms used to increase social participation have included use of consumer representation on committees and councils and public meetings by the RHAs. In *Jamaica*, HSR has contributed to an increase in social participation and control in the health system through the decentralisation process.

EVALUATION OF RESULTS

- Most countries report that implementation of the process is either moving slower than expected or is in its initial stages. Thus an evaluation of the results is not feasible at this time.
- Only Trinidad & Tobago reports a slight effect on *equity*.
- To improve *efficiency* several mechanisms have been developed to improve allocation of financial resources.
- Mechanisms to ensure the *sustainability* of the reform processes are very limited.
- *Trinidad & Tobago* has included consumer representation on committees and councils and public meetings by the RHAs to increase *social participation*. In *Jamaica*, the decentralisation process has contributed to an increase in social participation and control.

Conclusions

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*Dr. P. Rivas-Loria, Organization and Management of Health Systems and Services, Division of Health Systems and Services Development, PAHO/WHO prepared the analysis. The document was peer-reviewed in two stages. The first stage was completed for the Eastern Caribbean by eleven country participants** at the Eastern Caribbean Health Systems and Services Profiles Workshop held in Barbados, June 5-7, 2002 where they received peer-review training. The second stage was completed by Dr. Althea La Foucade, Health Economics Unit, Department of Economics, The University of the West Indies, St. Augustine, Republic of Trinidad and Tobago. Ms. Marilyn Entwistle of the PAHO CPC Office in Barbados collaborated in completing the document final review.

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[9] In 1986, Heads of Government approved the Initiative, in which seven priority health areas were identified. Later in 1996, the CARICOM Conference of Ministers responsible for Health mandated a re-definition and re-formulation of the Caribbean Cooperation in Health Initiative. In 1997, the Caucus of Ministers responsible for Health approved its eight health priority areas and then in 1998, its goals and targets for 1999 to 2003. CCH-II applies, as appropriate, the six strategies of the Caribbean Charter for Health Promotion to all the priority areas thus utilising health promotion as a strategic approach to health development.
The Extraordinary Meeting of the CARICOM (Caribbean Community) Conference of Ministers Responsible for Health Reform was held in 1995 to achieve a clear understanding of the context and elements of health sector reform and to develop processes of collaboration for exploring reform. In terms of decentralisation the meeting recommended that reform plans must be preceded by a needs assessment. National goals and targets should be established for the reform including a restatement of the priority place of primary care. There should be a clear definition of roles and functions at all levels. Ministries of Health should change their focus to policy formulation, regulation, and evaluation. Community building should be a pillar of the process and all stakeholders should be fully involved.
CARICAD (Caribbean Centre for Development Administration) convened two Caribbean Regional Symposia - "The Management of the Social and Health Services at the Local Level" held in Jamaica in May 1996 and "A Policy Forum on Health Sector Reform: Management and Performance" held in Trinidad and Tobago in April 1998. Both symposia were convened to discuss policy and broad issues, the wider Commonwealth and developed world experiences. The discussions presented opportunities for the assessment and reporting on where the respective countries were in respect to the reform process with particular attention to context, content and process – the latter to include change management process and the political, managerial and technical processes. Several recommendations emerged from the fora with much emphasis being placed on achieving progress in the areas of financing, the quality of health services, and decentralisation in the context of the role of the Ministry of Health.

The theme of the 12th Commonwealth Health Ministers' Meeting held in Barbados in November 1998 was "Health Sector Reform in the Interests of Health For All". Representatives of thirty-nine Commonwealth countries, three British Overseas Territories, relevant international agencies, regional bodies and non-governmental organisations attended the meeting. Thirty-two delegations were led by Ministers and three by Deputy Ministers in two committees, plenary sessions and four roundtables. The Ministers approved a number of recommendations to be acted upon by governments, Commonwealth regional bodies and other organisations, and the Commonwealth Secretariat.

The PAHO/UNDP/CARICOM project "Managing and Financing Health to Reduce the Impact of Poverty in the Caribbean", completed in 1999, identified how best to implement decentralisation and financing strategies while protecting the poor.

The workshop "Health Sector Reform: Implementation Strategies for the Eastern Caribbean" was held in Saint Lucia in May 1999. The workshop was in response to the offer of the PAHO Director at the first meeting of the OECS Ministers of Health in 1998 to host a forum for the Ministers of Health in the OECS member countries to specifically address health reform implementation strategies for the Eastern Caribbean. Later in October 1999, as a follow-up to the May 1999 meeting, the OECS and PAHO hosted a meeting to further refine the critical areas under a health reform framework for Barbados and the Eastern Caribbean Countries. Besides selected parties working in health (e.g. PAHO, OECS Secretariat, CAREC, the University of the West Indies), country representatives who helped finalise the summary report of the May 1999 Workshop attended. Participants at this meeting agreed to the following as the five components under a health reform framework for Barbados and the Eastern Caribbean Countries for 2000 to 2004. Programming elements cross-cutting all components include institutional strengthening, information systems, human resource development, research, social communication, and community participation. (1) Strengthening the steering role of the Ministry of Health; (2) Re-orienting systems to emphasize health promotion and the priority health issues identified in the CCH-II; (3) Developing/strengthening quality improvement and assurance programs; (4) Establishing a sustainable financial base for the health sector;and (5) Defining and implementing a "minimum package of health services"

[10] PAHO/WHO, Office of Caribbean Program Coordination*: "National Health Insurance in the Eastern Caribbean: A Guidebook for Appraisal and Design,"* Barbados, 2002.

[11] In collaboration with the Latin American Center for Research in Health Services (CLAISS), and the Centers for Disease Control of the United States (CDC). PAHO/WHO, CDC, CLAISS: Instrument for the Performance Assessment of Essential Public Health Functions, May, 2001.

[12] Three basic types of decentralisation are identified within the Caribbean experience: Devolution – in which sub-unit functions as an incorporated state agency with independent power to implement health programs agreed to in its charter. ***Delegation*** – in which a sub-unit functions as an unincorporated state agency with no charter of its own, but has functions assigned by a central authority to coordinate an agreed set of programs and projects. ***Deconcentration*** – in which a local organisation without independent power is designated by the central authority to carry out specific health functions. Some countries, however, have adopted a hybrid form of decentralisation by combining the delegation and deconcentration models, in which the decentralised unit has functions designated by the central authority to coordinate an agreed set of health programs and projects. This type of decentralisation in Barbados shifts responsibility for the day-to-day management and operational functions of the health system from the highly centralised mode to autonomous regional and/or hospital boards. The experience in Grenada, St. Vincent and St. Lucia shows that because the Government transfers functions to hospital boards with varying degrees of regulation, it permits them to combine public and private roles. In some of the smallest states, such as Montserrat and Anguilla, traditional concerns generated by the effects of highly centralised structures do not apply. In these cases, decentralisation is operationalised as the creation of mechanisms to facilitate public participation in decision-making while maintaining their administrative and physical structures. See PAHO/UNDP/CARICOM: *"Managing and Financing Health to Reduce the Impact of Poverty in the Caribbean"*, Washington DC, August 1999.

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[14] Pan American Health Organization/World Health Organization and Inter-American Development Bank. Caribbean Regional Health Study Report, Washington, D.C.: Pan American Health Organization/World Health Organization and Inter-American Development Bank, May 1996

[3] PAHO/UNDP/CARICOM Project. Managing and Financing Health to Reduce the Impact of Poverty in the Caribbean: Implementing Decentralization and Financing Strategies while Protecting the Poor, Policy Document. Washington, D.C. August 1999.

[16] It is intended to facilitate the process of decision making where the first decision to be made is based on a financial, technical and political feasibility appraisal. The guidebook does not provide the answers to whether a

country should introduce National Health Insurance; rather, it offers a path to an informed decision making process.

[17] Administered by the CPC Office, the project was funded by the W.K. Kellogg Foundation, amounting to approximately US$500,000. This technical cooperation initiative facilitated training in health information systems, their management and health informatics. Fourteen countries benefited from the training and participants were drawn from the various disciplines, work settings and programs of Ministries of Health in their respective countries.

[18] Health and health-related training opportunities, including in-country training-of-trainers, continued to be provided through the PAHO fellowship program, consistent with the national priorities of the various member Governments. In 2000 the leading areas of study for those from Barbados and the Eastern Caribbean were Nursing, covering Community Health Nursing, Post-Basic Psychiatry, Public Health, Rehabilitation Therapy and Family Nurse Practitioner; and Health Information Management. In 2001, there was an increase in the number of nationals trained in Nursing, specifically Clinical Teaching in Nursing/Midwifery, followed by Community Care of the Elderly. Training was also provided at the Masters level in International Health and in Public Health. The program also facilitated Medical Laboratory Technology and Ophthalmic Technology training in the United States, and the Masters in Health Management and the B.Sc. in Infection Control, in the United Kingdom.

[19] Other key strategies agreed on included the publication and distribution of an information pamphlet to all CARICOM countries; and lobbying for continued program support from their Governments at a meeting of Commonwealth Health Ministers held in New Zealand in November. In addition, consultations were held with the Ministers of Health, who were specifically asked to acknowledge the critical nature of the problem caused by migration of the nursing workforce and the impact on the countries' ability to deliver quality health care to the public. They were also encouraged to endorse the Managed Migration Program advanced by the nurses; provide the necessary support for its implementation at the national level; and mobilize additional resources to support the program activities. Nursing bodies, in the meantime, acknowledged that there were positive aspects to migration. It was affirmed, based on a thorough assessment of costs and benefits from the migration pattern of nurses over an 18-month period that the region had realized the benefit of nurses trained in one Caribbean country being able to work in others with clear gains to the entire region. Migration from the region also contributed to the quality of service in the countries to which regional nurses migrate, and remittances to the Caribbean from nurses' resident abroad contributed in many instances to the support of family members in the home countries.