DRAFT REPORT

STRATEGIC PLAN ON HEALTH AND RELATED SOCIAL SERVICES IN THE CARICOM

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THE CARIBBEAN COMMUNITY

The Caribbean Community, CARICOM, consists of 15 full member countries with a total population of about 15 million people. There are 5 associate member states with a total population of about 164,000. These populations are of different sizes and are diverse in people, language, skills and levels of development - economic and social (TABLE 1, FIGURE 1).

In general, the Caribbean is disadvantaged with respect to their small size and small economies that limit resources and investments. Also the Caribbean frequently suffers from natural hazards, such as flooding and hurricanes that not only places a strain on the economies and health sector but also slows down development and causes setbacks.

As the Caribbean economies become increasingly global and competitive, both inter-regional and intra-regional, and as the implementation of the provision of the CARICOM Single Market and Economy (CSME) around free movement of persons continues, the main advantage will be the ability to continue to leverage cooperation in health as well as other social and economic developmental areas. The CSME brings new challenges but also enables the region to become more competitive in global developments.

TABLE 1: OVERVIEW OF CARICOM MEMBER STATES WITH SELECTED KEY DATA [1], [2]

PROFILE OF CARICOM MEMBER STATES		Demographics					Health Indicators			Economic Indicators		
								Life expectancy (2008)				
State	Membership	Land Area sq. miles	population	Language	Date Independence	Date CARICOM Membership	Infant mortality rate / 1,000	male	female	Currency	GDP per capita EC$	unemployment level
Antigua and Barbuda	full	442	76,482 (2002)	English	1-Nov-81	4-Jul-74	21.8 (2007)	70.3	75.2	EC$	25,449 (2002)	7% (2000)
The Bahamas	full	5,382	312,000 (2002)	English	10-Jul-73	4-Jul-83	17.6 (2007)	71.0	76.7	Bah $	44,223 (2002)	6.9% (2001)
Barbados	full	431	270,800 (2002)	English	30-Nov-66	1-Aug-73	14.2 (2005)	74.6	80.0	BDS$	25,905 (2002)	9.9% (2001)
Belize	full	8,867	265,200 (2002)	English	21-Sep-81	1-May-74	17.2 (2007)	73.3	79.3	BZ$	9,699 (2002)	9.1% (2002)
Dominica	full	290	71,079 (2002)	English	3-Nov-78	1-May-74	12.5 (2000)	72.4	78.4	EC$	9,639	11.7% (2001)

[1] CARICOM – our Caribbean Community an introduction. CARICOM Secretariat 2005
[2] Pan American Health Organization, Health Situation in the Americas. Basic Indicators 2008

Grenada	full	133	102,638 (2002)	English	7-Feb-74	1-May-74	11.0 (2007)	67.1	70.5	EC$	10,559 (2002)	11% (2001)
Republic of Guyana	full	83,000	774,800 (2002)	English	26-May-66	1-Aug-73	22.0 (2005)	64.6	70.3	G$	2,530 (2002)	9.1% (2001)
Republic of Haiti	full	10,714	8,357,000 (2000)	French and Creole	1/1/1804	2-Jul-02	57.0 (2006)	59.4	63.2	Gourde	1,534 (2000)	70% in informal sector
Jamaica	full	4,244	2,641,200 (2002)	English	6-Aug-62	1-Aug-73	19.0 (2001)	70.1	75.3	J$	8,743 (2002)	15% (2001)
Montserrat	full	40	4,501 (2002)	English		1-May-74	0 (2002)	76.9	81.5	EC$	22,808	12.1% (2001)
Federation of St. Kitts and Nevis	full	104	46,710 (2002)	English	19-Sep-83	26-Jul-74	12.5 (2001)	70.1	76.0	EC$	20,396 (2002)	5% (1998)
Saint Lucia	full	238	159,133 (2002)	English	22-Feb-79	1-May-74	15.0 (2007)	72.0	75.8	EC$	11,612 (2002)	16.4% (2000)
St. Vincent and the Grenadines	full	150	109,164 (2002)	English	27-Oct-79	1-May-74	26.2 (2006)	69.7	74.0	EC$	8.931 (2002)	28.2% (1999)
Republic of Suriname	full	63,251	504,257 (2006)	Dutch	25-Nov-75	4-Jul-95	19.1 (2006)	67.2	73.7	SRD	10,260 (2006)	12.3% (2006)
Trinidad/Tobago	full	1,980	1,276,000(2002)	English	31-Aug-62	1-Aug-73	16.5 (2004)	68.2	72.1	TT$	19,736	10.8% (2001)

PROFILE OF CARICOM MEMBER STATES		Demographics					Health Indicators			Economic Indicators		
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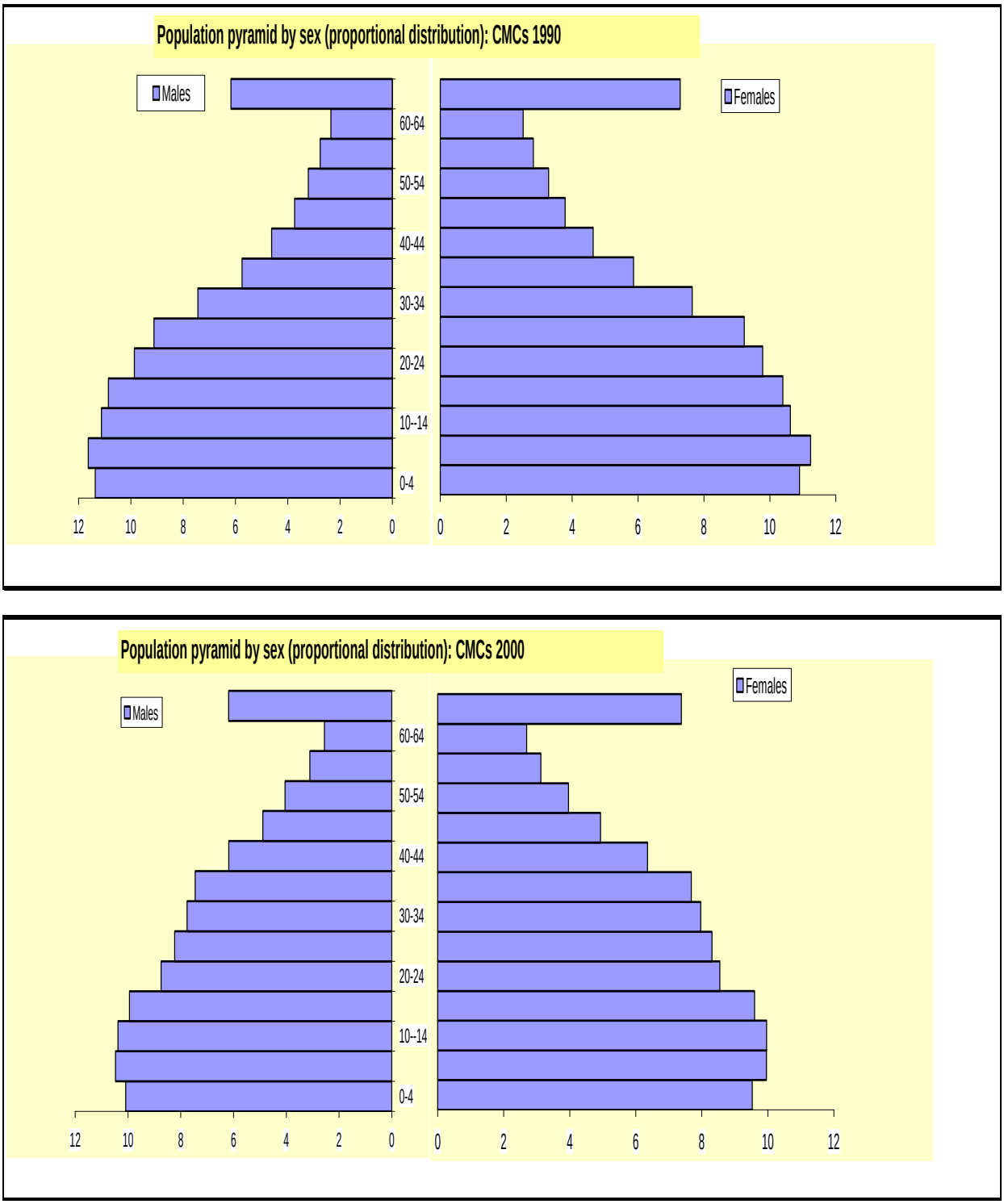
State	Membership	Land Area sq. miles	population	Language	Date Independence	Date CARICOM Membership	Infant mortality rate / 1,000	male	female	Currency	GDP per capita EC$	unemployment level
Anguilla	Associate	35	12,200 (2003)	English		4-Jul-99	5.6 (2002)	78.0	83.1	EC$	20,094 (2002)	7.8% (2002)
Bermuda	Associate	21	63,960 (2002)	English		2-Jul-03	4.0 (2001)	76.2	80.5	EC$	147,031 (2001)	3.0% (2000)
British Virgin Islands	Associate	59	23,500 (2002)	English		2-Jul-91	3.0 (2002)	75.9	78.3	US$	100,500 (2002)	3.6% (2002)
Cayman Islands	Associate	102	42,800 (2002)	English		13-May-02	1.6	77.7	83.0	KYD	36,419 (2002)	5.4% (2002)
Turks and Caicos Islands	Associate	193	20900	English		2-Jul-91	8.3 (2002)	72.9	77.6	US$	29,637 (2001)	9.7% (2001)

FIGURE 1: POPULATION PYRAMID CAREC MEMBER STATES (CMC), (1990 AND 2000)



HEALTH SITUATIONAL ANALYSES

In the second half of the 20th century the Caribbean has made great advancements in health as can be measured by the classical indicators of population health. The data compare favorably with other countries of the world that are at similar levels of wealth and have similar geographies[3]. This is a result of government policies that have emphasized water and sanitation, nutrition and the essentials of primary health care. The Caribbean has one of the best vaccination programs in the world and this has significantly contributed in improving the overall health status.

The health status in the Caribbean can be considered to be good according to health indicators but the challenge is to sustain the current health status and to continuously improve health in an environment of new threats, globalization, increasing cost and increasing demands.

The Caribbean has made great progress in the last decades in health, especially the vaccination programmes have paid off, and the Caribbean has one of the best vaccination coverage's in the world. The possibility exists that if this progress can be sustained CARICOM countries will reach the set Millennium Development goals.

In general the Caribbean is disadvantaged with respect to their small size and small economies which limit the resources and investments. Also the Caribbean frequently suffers from natural hazards, such as flooding and hurricanes that not only places a strain on the health sector but also slows down development and causes setbacks.

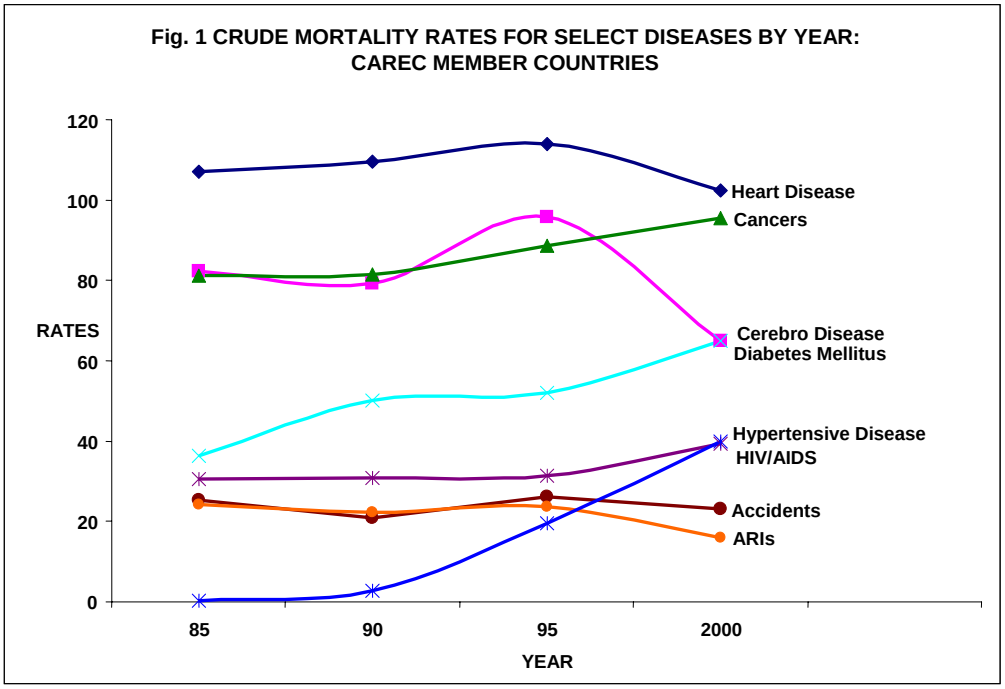
[3] Report of the Caribbean Commission on Health and Development (CCHD), 2006

Within the CARICOM there is not much difference in the health trends, the main causes or death (mortality) and disease (morbidity) are mainly commonly shared[4]. Exceptions are in general Haiti and Guyana that struggle with higher rates of infant mortality and HIV/AIDS. These two countries also have the lowest life expectancy in CARICOM. The average life expectancy in CARICOM is comparable to the average of the other Latin American countries but lower than the Northern American countries (Bermuda, Canada and USA).

The main causes of mortality in all Caribbean countries are first heart and vascular diseases followed in no particular order by cancers, Diabetes, violence and injuries, and HIV. For all CAREC (Caribbean Epidemiology Center) member countries. A mortality analysis for the years 1985, 1990, 1995 and 2000 showed a consistent trend in which over the period, Heart diseases, Cancers, Cerebrovascular diseases, and Diabetes constituting the four leading causes of deaths. Of note is that in 2000, HIV/AIDS climbed to 5th position (from 8th position in 1995), FIGURE 2.

FIGURE 2: CRUDE MORTALITY RATES PER 100,000 POPULATION FOR SELECTED DISEASES BY YEAR: CAREC MEMBER COUNTRIES: 1985, 1990, 1995, 2000

[4] Report of the Caribbean Commission on Health and Development (CCHD), 2006.



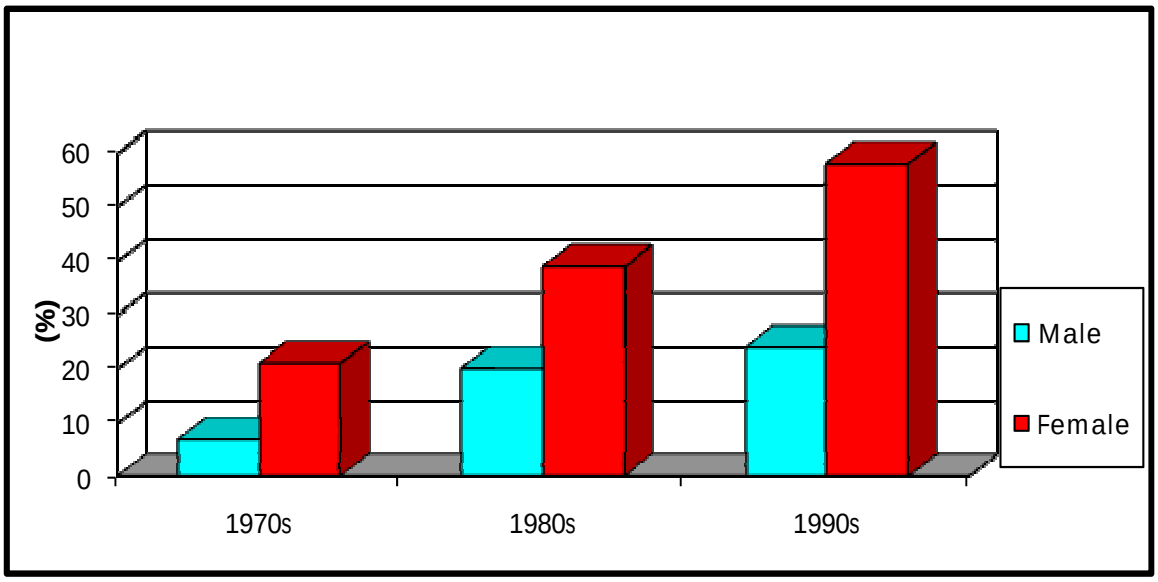
The group of Non Communicable Diseases (NCD's), hypertension, heart, disease, cancers and diabetes, are the cause for the highest mortality and morbidity in the CARICOM. The common risk factors of these diseases, overweight, smoking and lack of exercise are evident in our region. Especially, overweight has dramatically increased since the 1970's (FIGURE 3).

Of concern are the high mortality rates from violence and injuries. This is more of a problem in countries like Jamaica, Trinidad and Guyana. The annual cost of violence and injuries in Jamaica is estimated at 0.7% of GDP.

Overall there is great concern about the HIV/AIDS epidemic that seems to be leveling of in 2003 but is not yet on the decline[5]. The Caribbean is the second most affected region for HIV/AIDS in the world and affecting young people this does not only has an economic impact on the region but also results in loss of production capacity. Table 2 displays the a stable crude death rate and a decrease in under 5 mortality rate, but we see an increase in working years of life lost, this is mainly a result from the increase in HIV/AIDS in the region.

[5] Analysis of the Caribbean HIV/AIDS epidemic 1982-2002. Status and trends. Caribbean Epidemiology Center (CAREC)/PAHO, 2004.

Figure 3: percentage of population being overweight in the Caribbean



The direct cost of diabetes and hypertension for Bahamans, Barbados and Jamaica are estimated on USD 560 mln. per year [6] .

TABLE 2 gives an impression of the impact of mortality and morbidity in society.

Table 2: Selected Regional Death Rates per 100,000 population, CAREC Member Countries: (1985, 1990, 1995, 2000).

	1985	1990	1995	2000
Crude Death Rate per 100,000	636.2	601.6	667.9	640.1
Under 5 Mortality Rate per 100,000	568.5	458.0	489.8	421.6
Potential Years of Life Lost <65 years	511235	446035	541985	529705
(Rate per 1,000)	(89.9)	(79.0)	(89.6)	(84.1)
Working Years of Life Lost 15-64 years	223730	216990	310230	326660
(Rate per 1,000)	(63.1)	(60.1)	(77.8)	(76.6)

[6] CARICOM Secretariat / PAHO; Report on "Study on the Economic burden of Diabetes and Hypertension in the Caribbean. Tropical Metabolical Research Institute (TMRI)University of the West Indies, Mona, Kingston, Jamaica. March, 2006.

ACCESS TO HEALTH AND HEALTH FINANCING

In order to provide health to a population there should be an infrastructure that is available all over the country and should be equitably accessible for everyone to receive equitable prevention and treatment. In some CARICOM countries the infrastructure is not everywhere available, especially in countries with a hinterland and large rural areas. On the other hand given the small size of the population, specific, specialized services are usually not available in the smaller countries. Most Caribbean countries should be able to provide good quality primary and prevention health services but there is a trend that the infrastructure is declining in the Caribbean[7].

The region is also challenged by the migration of health personnel, especially nurses. The Caribbean loses about 300 nurses per year at a loss of investment of USD 17mln [8].

Factors that influence organization, management, and financing in order to improve equitable access in health are the relative high poverty rates in the Caribbean and the existence of a large informal sector.

The government usually pays for the poor and a large part of the informal sector. A burden that the government cannot continue to uphold and therefore important investments in the health sector are being delayed resulting in deterioration of services.

A countries' ability to provide services geographically spread over the whole country can be evaluated by reviewing the vaccination coverage in that country, especially in certain areas, and to review the proportion of pregnant women attended by trained personnel during pregnancy and delivery. TABLE 3 and 4.

[7] Caribbean Regional Health Study. Inter-American Development Bank (IDB)/PAHO 1996
[8] Managed Migration of skilled nursing personnel. Jean Yan. PAHO-CPC office Barbados. April 2004

Another performance indicator used is that of the levels of the Essential Public Health Functions (EPHF). FIGURE 4.

Vaccination coverage for Guyana, Jamaica and Suriname are rather low. (no data on Haiti). Proportion of pregnant women attended by trained personnel during pregnancy shows improvement in 2002 when compared to 1999. Similarly, proportion of deliveries attended by trained personnel indicates improvement in 2002 when compared to 1999 for seven countries; four countries sustained their 1999 performance and three countries showed slight decrease as shown.

The results of the Essential Public Health Functions (EPHFs) exercise provide guidance for strengthening the steering role of a Ministry of Health. The health sector reform initiatives in most countries have resulted in a trend toward the separation of management functions in the health system. These circumstances demand greater institutional capacity on the part of Ministries of Health to manage, regulate and conduct EPHFs. The analysis in the English Speaking Caribbean countries' performance of the Essential Public Health Functions (EPHF) identified strengths and weaknesses of Ministries of Health and laid the foundation for concerted institutional development efforts to improve public health practice.

With regards to health systems and services, based on an assessment of essential public health functions, countries in the Caribbean exhibited adequate performance (exceeds 70%) for the function of reducing the impact of emergencies and disasters in health (EPHF 11). Countries exhibited a high-intermediate performance (51 – 70 %) in the function related to evaluation and promotion of equitable access to necessary health services (EPHF 7); public health surveillance, research and control of risks and threats to public health (EPHF 2); monitoring, evaluation and analysis of health status (EPHF 1); health promotion (EPHF 3); and development of policies and institutional capacity for planning and management in public health (EPHF 5). Countries exhibited low-intermediate performance (41- 50%) for social participation in health (EPHF 4); human resource development and training in public health (EPHF 8); strengthening of institutional

capacity for regulation and enforcement in public health (EPHF 6). Countries of the Region exhibited their lowest performance in public health research (EPHF 10) and quality assurance in personal and population based health services (PHF 9).

TABLE 3: IMMUNIZATION COVERAGE FOR CARIBBEAN COUNTRIES, 1997 AND 2003

Country	*Proportion of population immunized against poliomyelitis [%]* *(less than 1 year)*		*Proportion of population immunized against measles [%]* *(less than one year)*		*Proportion of population immunized against diphtheria, pertussis and tetanus [%]* *(less than one year)*	
	1997	**2003**	**1997**	**2003**	**1997**	**2003**
Anguilla	99	99	92	96	99	99
Antigua and Barbuda	91	99	93	99	99	99
Aruba	...	79	...	90	...	79
Bahamas	86	93	94	90	87	92
Barbados	96	90	92	90	96	89
Belize	85	95	98	96	86	96
British Virgin Islands	96	99	99	99	99	99
Cayman Islands	96	92	93	83	95	92
Dominica	99	99	99	99	99	99
Grenada	95	98	92	99	99	97
Guyana	88	91	82	89	88	90
Jamaica	90	81	88	79	90	81
Montserrat	99	99	99	99	99	99
Saint Kitts and Nevis	99	99	97	98	99	99
Saint Lucia	98	91	95	90	98	90
Saint Vincent and the Grenadines	99	99	99	94	99	99
Suriname	81	74	78	71	85	74
Trinidad and Tobago	91	91	88	98	90	91
Turks and Caicos	99	96	99	91	00	96

Source: Pan American Health Organization, Division of Vaccines and Immunization Expanded Program on Immunization. Based on Country information. 2004

Pan American Health Organization, Health Situation in the Americas, Basic Indicators 1998

TABLE 4: PROPORTION OF PREGNANT WOMEN ATTENDED BY TRAINED PERSONNEL DURING PREGNANCY AND PROPORTION OF DELIVERIES ATTENDED BY TRAINED PERSONNEL, 1999 AND 2002

Country	Proportion of pregnant women attended by trained personnel during pregnancy [%]		Proportion of deliveries attended by trained personnel [%]	
	1999	2002	1999	2002
Anguilla	...	...	100**	100
Antigua and Barbuda	82*	92	100*	99
Aruba	98*	100	99	96
Bahamas	87	93.6	99	99
Barbados	89	100	91	100
Cayman Islands	99	98.8	100	100
Dominica	99.9	...	99.9	100
Grenada	90*	99	99	100
Guyana	90	...	94*	93.8***
Jamaica	98.4	...	95.9**	98.5***
Montserrat	...	100	...	100
Saint Kitts and Nevis	...	100	99.4*	99.6
Saint Lucia	47.8**	...	100**	98
Saint Vincent and the Grenadines	91.8	99	99.3	100
Suriname	91*	...	90.6**	...
Trinidad and Tobago	93	...	99**	...
Turks and Caicos Islands	82	100	88.2	...
Virgin Islands (UK)	100**	100	100	100

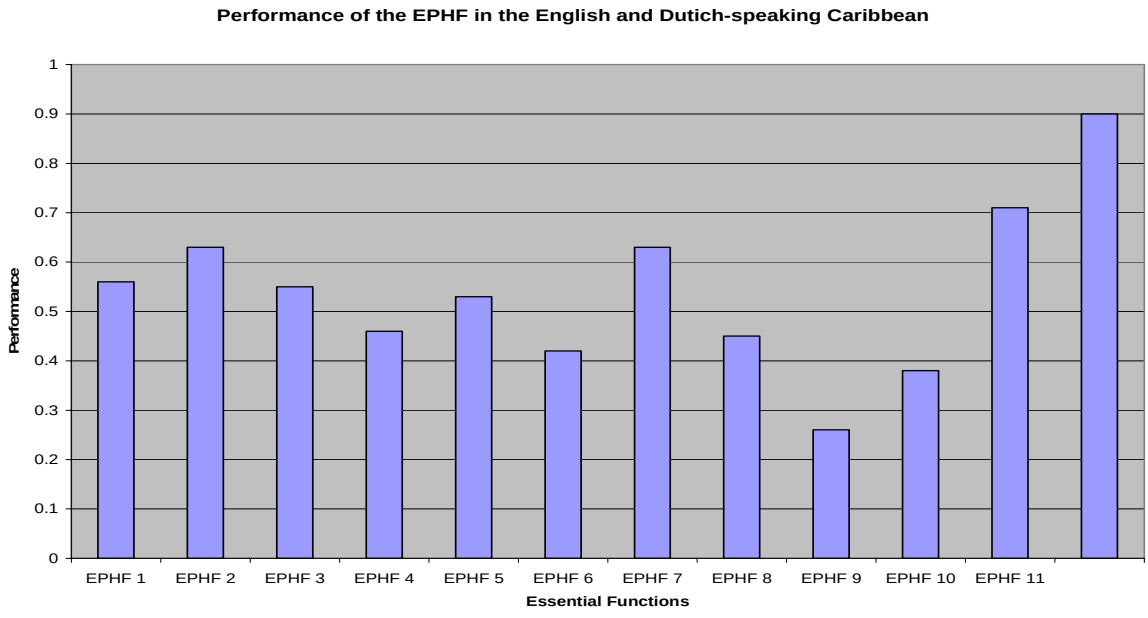
SOURCE:

Pan American Health Organization, Health Analysis and Information Systems Area. Regional Core Health Data Initiative; Technical Health Information System. Washington DC, 2003.

Symbols

-	* 1998
0	** 1999
...	*** 2001

FIGURE 4: PERFORMANCE OF THE EPHF IN THE ENGLISH AND DUTCH-SPEAKING CARIBBEAN, 2002-2003 (CAREC)



Health cost is ever increasing, also as a result of increasing demands of the population for more specialized services. The treatment of the diseases responsible for the main burden of disease is expected to increase because of increased prevalence, and their economic impact, especially when not treated, will be very costly[9]. For the OECS it is estimated that long term health cost as a percentage of GDP will increase by 50% in 2035 and that the cost of treating diabetes will double in 2030.

[9] Universal health care 101: Lessons for the Eastern Caribbean and Beyond. IMF working paper. March 2009.

CARICOM HEALTH EXPENDITURES

The economic capacity for expenditures differs from country to country. An overview of several indicators is presented in TABLE 5. Suriname, Jamaica, Saint Vincent and the Grenadines, and Barbados spent the highest percentage of their GDP on health.

Per capita expenditures in USD is highest in Bahamas followed by Barbados and Antigua. Out of Pocket expenditures are high in Belize, Trinidad, and Bahamas. The high out of pocket expenditures, directly to health services providers, indicate that there is little of a safety net and health insurance. Private health expenditures are high in Trinidad and Tobago, Jamaica, Bahamas, and government expenditures are high in Dominica, Grenada, Saint Kitts, Barbados and Saint Lucia, Saint Vincent and Antigua. Is it that the governments mainly cover the cost for the poor and near poor that can explain such a large part of the expenditures being paid for by the government?

Linking health expenditures to health outcomes is interesting as to evaluate if only the level of expenses result in better health. TABLE 6 and 7. Table 6; High expenditures per capita (Bahamas) still have lower life expectancy, but has already resulted in lower infant mortality and crude death rate, likely for life expectancy to rise. Trinidad with high per capita spending has relatively poor infant mortality and crude death rates in average life expectancy.

TABLE 5: HEALTH EXPENDITURES OF CARIBBEAN COUNTRIES. AVERAGES IN THE PERIOD 1997-2001*

Indicators	Ant	Bah	Bdos	Bel.	Dom.	Gren.	Gya	Jca	SKN	SL	SVG	Sur #	TT
THE%GDP	5.4	5.6	6.1	5.0	5.9	4.9	5.0	6.4	4.8	4.3	6.1	8.5	4.3
PHE%THE	39	43	34	51	27	31	17	49	34	36	37	41	55
GHE%THE	61	57	66	49	73	69	83	51	66	64	63	55	45
GHE%TGE	14	15	12	5.5	12	12	9.3	6.2	11	8.5	9.1		6.6
ERH%THE	3	--	4	4	2	--	4	3	7	0.6	1.5	3.9	4
SSHE%GHE	--	--	--	--	--	--	--	--	--	24	--	16.5	--
OOP%THE	39	43	26	51	27	31	17	34	34	36	37	20.0	48
THE pc US$	487	798	562	147	200	223	48	178	344	188	167	332	239
THE pc $PPP	540	1029	844	251	292	372	191	229	515	257	324		367

* WHO World Health Report 2004

THE----Total Health Expenditure

PHE---Private Health Expenditure

GHE—Government (Public) Health Expenditure

ERH—External Resources for Health

OOP—Out of Pocket Expenditure

SSHE—Social Security Health Expenditure

data 2006. National Health Accounts

TABLE 6: HEALTH INPUTS AND OUTCOMES IN CARIBBEAN COUNTRIES 2001*

Country	GDP p.c. US$	THE p.c. US$	THE% GDP	Life Expect. (years)	Infant Mortality Rate Per 1000 life births	Crude Death Rate per 1000
Antigua	9055	497	5.5	71.3	16.1	5.6
Bahamas	16249	1069	6.6	67.2	12.7	8.2
Barbados	9444	734	7.8	77.3	14.7	7.7
Belize	3145	198	6.3	71.4	21.2	5.3
Dominica	3697	252	6.8	74.1	19.8	7.0
Grenada	3881	198	5.1	64.5	17.6	7.5
Guyana	943	50	5.3	63.4	54.0	9.0
Jamaica	2982	191	6.4	75.9	19.9	5.7
Montserrat	8070	436	5.4	78.4	8.0	7.3
St Kitts	7451	425	5.7	71.6	21.0	8.9
St Lucia	4184	204	4.9	72.7	16.7	5.9
St Vincent	3112	190	6.1	74.2	19.2	5.8
Suriname (2006)	3800	332	8.5	70.4	19.1 (2006)	6.2 (03-05)
T'dad & T'bgo	7068	432	6.1	71.1	21.1	7.6

(Life Expect.—Life expectancy; IMR—Infant Mortality Rate; CDR—Crude Death Rate)

* Report of the Caribbean Commission on Health and Development, CARICOM Secretariat and PAHO, 2006

Table 7; In general de data suggest that higher expenditures result in higher healthy life expectancy (age until you can be considered healthy without any disabling disease), and lower probability of dying under 5 years and between 15-60 years.

TABLE 7: INTERNATIONAL COMPARISON OF HEALTH EXPENDITURES AND OUTCOMES, 2001*

Country	THE per cap. (I$)	THE%GDP	Healthy Life Expectancy	Probability of Dying under 5 years per 1,000	Probability of dying 15-60 years per 1,000
Caribbean Countries					
Antigua	614	5.6	61.9	20	160
Dominica	312	6.0	63.7	13.5	163
Grenada	445	5.3	59.2	23	242
Monts.	436	5.4	--	--	--
St Kitts-Nevis	576	4.8	61.5	22	177
St Lucia.	272	4.5	62.7	14.5	178
St Vin	358	6.1	59.9	23	211
Belize	278	5.2	60.3	39	156
Bahamas	1220	5.7	63.3	12	201
Barbados	940	6.5	65.6	16	146
Guyana	215	5.3	55.2	56	251
Jamaica	253	6.8	65.1	15	142
T&T	388	4.0	62.0	21	200
Suriname (2006)	332	8.5	58.8	31	223
Other Countries					
Cuba	229	7.2	68.3	8	114
Costa Rica	562	7.2	67.2	11	101
Mauritius	323	3.4	62.4	17	169
US	4887	13.9	69.3	8	112
UK	1989	7.6	70.6	7	87

* WHO World Health Report 2003

Human Resource issues, especially in the smaller countries, remain critical with insufficient personnel, quality of the work force, and problems with retention of trained personnel. Shortages exist in a number of health professions including nurses, epidemiologists, health informatics, etc. In several instances, staff must function in multiple areas. The situation has led the Caribbean Chief Medical Officers to conclude that Public Health Workforce and Leadership Capacity Building is urgently needed to address contemporary health challenges and to provide visionary leadership to the health sector.

Human resources (physicians, nurse and dentist per 10,000 population) for Non-Latin Caribbean [nlc] (the countries in this analysis plus the French Department of the Americas and U.S. Virgin Islands but minus Belize and Bermuda) showed an increase in all categories from 1980 to 2001 - the number of physicians increased from 4.7 to 9.4, nurses from 17.3 to 25.8 and dentists from 0.8 to 1.3. When compared to Latin America and the Caribbean, Non-Latin Caribbean had less physicians and dentists but more nurses – this holds true for 1980 and 2000 as shown table below.

TABLE 8: HUMAN RESOURCES (PER 10,000 POPULATION) 1980 AND 2001

Sub-Region	Physicians		Nurses		Dentists	
	(Per 10,000 population)					
	1980	[c] 2001	1980	[c] 2001	1980	[c] 2001
Latin America and The Caribbean	**9.1**	**18.3**	**4.2**	**8.42**	**3.3**	**5.7**
Non-Latin Caribbean	**4.7**	**9.4**	**17.3**	**25.8**	**0.8**	**1.3**

[nlc] Anguilla, Antigua and Barbuda, Aruba, Bahamas, Barbados, British Virgin Islands, Cayman Islands, Dominica, French Guyana, Grenada, Guadeloupe, Guyana, Jamaica, Martinique, Montserrat, Netherlands Antilles, Saint Kitts and Nevis, Santa Lucia, San Vincent & the Grenadines, Surinam, Trinidad and Tobago, Turks and Caicos Islands, US Virgin Islands

Source: Pan American Health Organization, Special Program for Health Analysis. Health Situation in the Americas: Basis Indicators 2002, Washington DC 2002.

However, shortages exist in a number of health professions including nurses who are actively and aggressively recruited by Agencies in North America, the UK and Netherlands. In several other areas staff must function in multiple areas, for example, the epidemiologist also functions as the Medical Officer of Health and in some cases also has privilege for private practice. Generally, decisions related to human resource management are made at Ministries of Establishment or Public Service Commissions and not by the Ministries of Health. CARICOM has adopted a policy of freedom of movement for professionals between member states and it is expected that it will be fully implemented. This policy has implications for the preparation and recruitment of staff. The foremost need includes the preparation and retention of a good cadre of public health professionals with leadership potential. The availability of persons to fill posts of Chief Medical Officers is presenting a major challenge to several governments as these posts do not usually allow private practice and require good management skills.

A comparison of human resources (physicians, nurses, dentists) per 10,000 population between 1997 and 2001 (2002 for physicians) indicates a maintenance of the status quo for all categories in 10 countries (Barbados, Bermuda, Dominica, Grenada, Montserrat, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Turks and Caicos, and British Virgin Islands). Changes were seen in Anguilla - decrease in physicians and nurses, Antigua & Barbuda - decrease in physicians and increase in nurses, The Bahamas – increase in physicians and slight increase in nurses and dentists, Belize – increase in physicians, nurses and slight increase in dentists, Cayman Islands – increase in physicians, Guyana – increase in physicians and slight increase in nurses, Jamaica – decrease in physicians and increase in nurses with slight decrease in dentists, Suriname – increase in physicians and nurses and slight increase in dentists, Trinidad and Tobago - slight decrease in dentists. (TABLE 9).

TABLE 9: HUMAN RESOURCES BY 10,000 POPULATION IN THE CARIBBEAN

	Physicians		Nurses		Dentists	
	1997*	c 2002**	1997*	c 2001***	1997*	c 2001***
Anguilla	17.5	9.0	36.3	31.3	1.3	1.3
Antigua & Barbuda	11.4	10.5	32.2	33.2	2.2	2.2
Aruba	12.8	12.8	...	...	2.2	2.2
The Bahamas	15.2	16.3	23	23.8	2.5	2.5
Barbados	13.7	13.7	51.2	51.2	1.9	1.9
Belize	5.3	10.2	8.0	12.3	1.0	1.3
Bermuda	17.7	17.7	89.6	89.6	4.2	4.2
British Virgin Islands	11.5	11.5	33.0	33.0	2.0	2.0
Cayman Islands	19.4	21.5	53	53.0	3.9	3.9
Dominica	4.9	4.9	41.6	41.6	0.6	0.6
French Guiana	13.9	13.9	86.0	86.0	3.0	3.0
Grenada	8.1	8.1	19.5	19.5	1.1	1.1
Guadeloupe	13.8	13.8	29.9	29.9	3.1	3.1
Guyana	1.8	2.6	8.4	8.6	0.4	0.4
Jamaica	14	8.5	6.5	16.5	0.9	0.8
Martinique	19.7	19.7	56.8	56.8	3.1	3.1
Montserrat	1.8	1.8	29.1	29.1	0.9	0.9
St Kitts and Nevis	11.7	11.7	49.8	49.8	2.0	2.0
Saint Lucia	5.8	5.8	22.6	22.6	0.9	0.9
Saint Vincent & the Grenadines	8.8	8.8	23.9	19.8	0.5	1.4
Suriname	2.5	5.0	15.6	22.8	0.1	0.8
Trinidad and Tobago	7.5	7.5	28.7	28.7	1.1	0.9
Turks and Caicos Islands	7.3	7.3	19.3	19.3	0.7	0.7

[c] = circa

* Pan American Health Organization, Special Program for Health Analysis (SHA), . Health Situation in the Americas:

Basic Indicators 1998

** Pan American Health Organization, Area of Health Analysis and Information Systems (AIS), Health Situation in the Americas:

Basic Indicators 2003

*** Pan American Health Organization, Area of Health Analysis and Information Systems (AIS), Health Situation in the Americas:

Basic Indicators 2004

INTRA-REGIONAL MIGRATION PATTERNS

Migration of people is an ongoing phenomenon and more long term movement of people intra-regional and extra-regional are part of Caribbean life. There is no universally accepted definition of a "migrant" nor of minorities [10]. Migrants usually have few rights under domestic law and the Caribbean Governments still have to ratify the International Convention on the Rights of Migrant Workers that came in to force in July 2003. But the ILO convention no. 111 provides an opportunity when facing discrimination in employment and occupation.

Historically, most 20th century migration was towards Europe and North America, over the course of the century an estimated 6 million people. In the early 20th century thousands of Caribbeans, especially, Jamaicans and Barbadians worked on the Panama Canal, which opened in 1914. Also large migration to the banana operations in Central America (1920's – 1930's). Cane cutters from the Eastern Caribbean and Haiti moved the Dominican Republic and other countries. The evolving oil industry in Trinidad, Venezuela and Curacao attracted another stream of migrants in the 1970's. The independence in the 1960' and 1970' temporarily slowed down extra-regional migration but the need for skilled personnel abroad, especially in health and education has opened new windows[11].

The pull factors for migration in the Caribbean are economical growth in other areas, frequently from USA investments that create labour shortages and in recent years the growth of the tourism and service industry in the Caribbean, diversifying from more traditional industries as sugar. Push factors are mainly poverty, lack of opportunity, overcrowding and land shortages. The diversification of the economies has also resulted in more migration of females in recent years.

[10] Migration in the Caribbean: Haiti, the Dominican Republic and beyond. James Ferguson. Minority Group International, 2003.
[11] Migration in the Caribbean – What do we know? Expert group meeting on international migration and development in Latin America and the Caribbean. ECLAC. Port of Spain , Trinidad and Tobago, January 2006.

It is estimated that over the last 40 years intra-Caribbean migration has been at 500,000 people, with the main sending countries being Haiti, the Dominican Republic, Guyana and Jamaica. The main receiving countries are the Bahamas, the Virgin Islands (British and USA) and the Turks and Caicos Islands (TCI).

In the Caribbean the largest of migration takes place from Haiti, Estimated numbers of Haitians are in the Dominican Republic (500,000-700,000), the Bahamas (40,000-75,000 20% of the population), TCI (6,000 30% of the population). In Guyana and Suriname there are tens of thousands of Brazilians working as illegal gold miners (garimpeiros).

Migration can take place in an official manner with a work permit and legal residence. This form of migration is usually welcomed as it provides qualified professionals and skilled workers. Still documented migration is rare as Caribbean countries are still protective of their labour markets. Activities to open up the migration of professionals are within the Global Agreement on Trades and Services (GATS, especially mode 4) and the prepared legislation on domestic regulations for the CARICOM which is in line with the launched CARICOM Single Market and Economy (CSME) in 2005.

In most cases undocumented, illegal migration takes place and these migrants are more likely to be poor, unqualified and less educated. These people are mainly used as cheaper labour, sometimes exploited, do not pay taxes, and frequently become a burden on the health system.

While undocumented immigration, being from within or from out of the Caribbean can provide a cheap labor source, it places a strain on society and on the health system. In most cases these migrants cannot afford health insurance or pay for health services, and the government has to provide.

When considering a Regional Health Insurance Scheme it are the documented migrants, mostly professionals and skilled personnel that could be covered by insurance. The numbers of these migrants should be evaluated as they are not

readily available. It should be taken into account that embassy personnel or personnel covered by diplomatic status are not officially registered in the host country as a resident.

POLICY FRAMEWORK

CARICOM REGIONAL HEALTH POLICY

The CARICOM has identified health as a priority area as Heads of Government in their Nassau Declaration in 2001 declared "The Health of the Region is the Wealth of the Region", stating that health is also important for economic development.

Because of the known mortality and morbidity in the region the CARICOM Heads of Government have identified HIV/AIDS, Non Communicable Diseases and Mental as being the health priorities in the region.

The regional agenda of health development is coordinated and guided out of the directorate of Human and Social Development of the CARICOM Secretariat, department of Health Sector Development. The Directorate of Human and Social Development reports to the Council for a Human and Social Development (COHSOD).

The regional priorities and planning is set out in the Caribbean Cooperation in Health (CCH) that since the 1980's has seen a phase I and phase II. Phase II was evaluated in 2005 but up till now the CARICOM Secretariat has failed to produce the CCH III, despite the extensive discussions and improvements recommended. CCH III should focus on the three priorities of the Heads of Government and supporting factors such as Human Resource Development, Health Information Systems and Health promotion and education (the three H's).

For HIV/AIDS the CARICOM has established a separate unit, the Pan Caribbean Partnership Against HIV/AIDS (PANCAP) that has grown into a full scale

organization with access to tens of millions of USD in grants over the last years and soon with a staff of about 24 personnel.

CARICOM heads of government are very concerned with the burden and impact of Non Communicable Diseases that they held a special meeting in Port of Spain on September 15, 2007. This was the very first meeting of Heads of Government about NCD's in the world. The Heads of government issued the declaration of Port of Spain; "Uniting to stop the epidemic of chronic NCD's [12].

Mental health is also a priority for the heads of government. However, data on the prevalence of mental diseases are difficult to come by. It was estimated that for depression and schizophrenia the cost for Jamaica are USD 600 mln per year. With support of PAHO a mental health policy and action plan was developed but is very slow in implementation because of a lack of capacity and funding[13],[14]. There has been a mental health study of best practice in Jamaica by the CARICOM Secretariat which needs to be expanded to other Member States.

Despite the fact that NCD's are the highest contributor to the burden of disease in the CARICOM there is little effort from the CARICOM Secretariat in mobilizing resources of NCD's. A first regional NCD plan was developed in 2001 with PAHO[15] and later in 2003 a more extensive plan with a budget of USD 1 mln. Which was never implemented because of a lack of funds. With the meeting of the Heads of Government in 2007 there finally came more focus on NCD's but a clear updated plan and necessary funding is still not available.

All the focus in health is on HIV/AIDS which is in the center of attention. All of the funding of the projects in health are depending on grants. This makes the region very sensitive to external direction of policy and actions. The lack of a funding source from the region itself, even for the use as seed funding to get a project

[12] Declaration of Port of Spain; Uniting to stop the epidemic of chronic NCD's. Heads of Government, September 15, 2007.
[13] Mental Health in the Caribbean. Caucus Caricom Ministers for Health. PAHO September 2001.
[14] A proposal to the Caribbean Ministers of Health. "SUPPORTING THE IMPLEMENTATION OF MENTAL HEALTH POLICIES, THE REVIEW OF LEGISLATION AND THE PROTECTION OF THE HUMAN RIGHTS OF PERSONS WITH MENTAL DISORDERS IN THE CARIBBEAN REGION". September 2003.
[15] Non Communicable Diseases in the Caribbean. Caucus Caricom Ministers for Health. PAHO September 2001.

started, will place the region in a better negotiating position for grant funding and influence the direction and activities in programme and project execution.

HUMAN RESOURCE REQUIREMENTS

For any health system to provide quality services an integrated balanced composition is required of physical infrastructure, equipment, logistics, information and communication, and skilled personnel en management. Of the worldwide health workers, two thirds are actually involved in directly providing health services and one third in supportive, administrative and management services.

Although the World Health Organization (WHO) does not provide a universal norm or standard for Human Resources in Health density in any given country[16], it has been estimated in the World Health Report of 2006, those countries with a density of fewer than 2.28 per 10,000 physicians. Nurses and midwives generally fail to achieve a targeted 80% coverage rate for skilled birth attendance and child immunization.

TABLE 8 and 9, shows the number of physicians, nurses and dentists per 10,000 population. The non-Latin Caribbean has significantly more nurses than Latin America, where there is a much larger number of physicians and dentists.

The number of health personnel in the Caribbean is in general lower than average of what is generally required, but the advantage is that In the Caribbean we usually deal with small countries and populations where the distances are usually not great. Despite these factors, countries like Guyana and Suriname are on the low side for physicians. However, most countries have improved over the past years.

In the CARICOM there is a shortage of health care workers. Training institutions in the CARICOM do not train enough health care workers such as doctors, nurses,

[16] Establishing and monitoring benchmarks for human resources for health: the workforce density approach. Spotlight, issue 6, on health workforce statistics, November 2008.

midwives and public health leaders. The capacity of the institutions is not optimally utilized, frequently due to a lack of training leadership and insufficient support to increase the number of students.

On the other hand the Caribbean faces the challenge of migration of health workers, mainly nurses. It is estimated that the Caribbean loses USD 20 mln. and 200 nurse a year[17]. The managed migration approach of the CARICOM has not resulted in agreements with other countries willing to invest in the Caribbean to train more nurses of which some for migration. Despite promises of destination countries the migration continuous. Unless, the Caribbean pushes for training agreements with investments from the destination countries this situation will only worsen as the need for nurses in the destination countries only increases.

More use and more useful application should be made of CARICOM institutions such as the Caribbean Accreditation Authority for education in Medicine and other health professions (CAAM-HP) and the Caribbean Association of Medical Councils.

These institutions regulate and monitor the quality of education and services of health professionals for the CARICOM.

[17] Managed migration of skilled nursing personnel. PAHO 2004

LEGISLATIVE FRAMEWORK - HARMONIZATION

Within the revised treaty of Chaguaramas and the CSME policy has been established regarding legislation and harmonization. The free movement of people in the CARICOM for certain groups has been agreed upon. In health, specific legislation, the draft bill on domestic regulations has been drafted. This bill provides the minimal requirements for the organization of the health professions in countries and also the guidelines to establish minimal CARICOM requirements for registration and licensing for health professionals.

Other legislation related to harmonization that should be developed are legislation for the regional registration of pharmaceuticals. Just a few countries in the CARICOM have legislation for the registration of pharmaceuticals. A regional registration would be beneficial for the CARICOM as a larger market and would not require importers and producers to register separately in each country of the CARICOM.

Also the CARICOM should develop a regional position on the Trade Related Intellectual Property Rights (TRIPS) and establish clear policies on governments orders and possible compulsory licensing for the production of pharmaceuticals for the CARICOM, even by other countries.

Challenges regarding legislation in the Caribbean are e.g. the laws again buggaring in the certain CARICOM countries. This hampers the response to sexually transmitted diseases and HIV/AIDS as the response cannot officially target the vulnerable group of men having sex with men (MSM).

FINANCING THE SECTOR'S NEEDS

Financing the health sector is a continuous challenge as the patients always want more and higher level care which is expensive. Health care cost also increase more that the consumer price index.

In the financing of the health sector the flows of funds can be divided in the sources; central government (Ministry of Health), out of pocket payers, private companies – financing intermediaries; insurance companies, government health institutions, and – providers; hospitals, physicians, laboratories etc. This approach is being applied in the descriptive studies on the flow of funds in the health sector known as the National Health Accounts.

Three big groups in the health field are the financiers the providers and the patients. In the Caribbean the patients usually are not well organized and have little input as a stakeholder in policy development and implementation. Between the patients and the providers there should be clear understanding on what to expect from the delivery of services, between the financers and the providers there should be clear agreed payment mechanisms.

A separate responsibility is that of the public health goods and services that is a direct responsibility of the government, such as vaccinations, disease surveillance, vector control, standards and regulations.

Based on the experiences in the CARICOM the general guideline for governments is to spend at least 7.0% of GDP on health or at least 60% of the total health expenditures, including the public health goods. It is not only the amount of funding put also the system of fund utilization that results in the impact on health (see Table 7).

Health financing should first of all be focused on creating a system of equitable access and delivery of health basic health services to the whole population. Financing the health system should also be equitable and for increased coverage of the population there are specific challenges in developing countries and the CARICOM. The specific challenges for the CARICOM are in general poverty (those people that cannot or can only partly pay) and a large informal sector. Equitable contribution to health financing means contributing according to ability to pay. With the additional challenges of poverty and an informal sector a National financed system based on insurance has become more attractive in the recent years. People that cannot pay or only partly pay can be identified through targeting techniques, e.g. the poor and near poor in Suriname with the Ministry of Social Affairs.

In certain instances countries have chosen to finance disease related costs such as the National Health Fund (NHF) in Jamaica and the Chronic Disease Assistance Programme (CDAP) in Trinidad and Tobago. These programmes only cover medical costs for certain diseases and do not cover preventive measures, monitoring and follow up by physicians and medical specialists.

With the already significant and increasing morbidity of chronic diseases it is expected that the long term health care cost as a percentage of GDP will double in most Eastern Caribbean countries. Especially, the increase in the treatment of diabetes will increase dramatically[18].

The CARICOM and Caribbean countries frequently rely on grants and special loans from the IDB and the World Bank that have many conditionalities in the allocation and implementation of the funds that there generally is little ownership, purposefulness and effectiveness of the programmes and projects. Even though loans from the commercial banking sector demand higher interests, governments should consider such loans for specific programmes and should also consider seed funds for programmes as a start for seeking additional funding.

[18] Universal Health Care 101: Lessons for the Eastern Caribbean and Beyond. IMF working paper, March 2009.

Public private partnerships can be applied in several instances where revenue can be generated through health services and these opportunities should be explored more often.

Aiming to centralize health financing and improving health coverage and quality of health services, worldwide, several countries have introduced National Health Insurance (NHI) Schemes. In the Caribbean several countries are exploring the possibilities for National Health Insurance.

NHI should mandatory cover every citizen and should also have a system for the for the contribution of everyone, including the informal sector, to ability to pay, while also covering the poor. Such a social health insurance system[19],[20] should be achievable in the CARICOM countries for a basic package of services.

[19] Social Health Insurance. A guidebook for planning. C. Normand, A. Weber. WHO/ILO, 1994
[20] Good practices in health financing, lessons learned from reforms in low- and middle-income countries. P. Gottret, G. Schieber, H. Waters (editors).The World Bank 2008.

Incentives in health usually are related to improvement of quality of health services or to motivate health workers to work in unpopular (remote) areas. Incentives can be given to health workers reaching certain targets as a form of a bonus, e.g. reaching a certain level of vaccination coverage, screening of target groups of patients[21],[22].

Depending on the provider payment mechanisms it may wise to include incentives, e.g. in the case of salaries or capitation fee where there is less of a motivation for efficiency and quality when compared to other payment mechanisms, TABLE 10.

Other incentives that can support the development of health are to provide incentives for large investments in health. These incentives can be provided for the private sector when they support the policy of the Ministry of Health and a priority in health. The government should promote and support the development of public private partnerships in health. Such investments could be for health tourism, where an internationally renowned institution can open a clinic in the Caribbean with regional/local partners.

[21] Paying health care providers in the Caribbean, Matilde Pinto, Bernt Andersson. PAHO, April 2001
[22] Performance-based contracting for health services in Developing Countries. A toolkit. Benjamin Loevinsohn, The World Bank, 2008.

TABLE 10: DIFFERENT PAYMENT MECHANISMS WITH HEALTH CARE SERVICES PROVIDERS, PRO AND CONS

Payment Mechanisms							
Mechanisms	Incentives for efficiency	Incentives for volume	Impact on increasing system wide costs	Impact on improving quality	Information required to construct the mechanism	Administrative complexity	Potential for billing fraud
Salary	- - - -	- -	0	- -	+	+	+
Global Budgets	- - - -	- -	+	- -	+	+	+
Fee-for-service	- -	+ + + +	+ + + +	+	+	+ + +	+ + +
Fixed fee per hospital day	- -	+ + + +	+ + + +	+	+	+ + +	+ + +
Payment by packages of care	+ +	+ +	+	0	+ + +	+ +	+ +
Primary care capitation	-	- -	+ +	+	+ +	+	+
Full capitation	+ +	- -	- -	+ +	+ +	+	+
Capitation adjusted for enrollee risk characteristics	+ +	- -	- -	+ + +	+ + + +	+ +	
Bonus	+ + + +	depends on circumstances	- -	+ + + +	+ + +	+ +	0
Withholds	+ + + +	depends on circumstances	- -	+ + +	+ + +	+ +	0
Mixed models	depends on circumstances	depends on circumstances	depends on circumstances	depends on circumstances	depends on circumstances	depends on circumstances	depends on circumstances

In CARICOM there should be discussion on a CARICOM trade policy related to food, e.g. discussion and decision on making the CARICOM transfat free, marking food products for the healthiness (e.g. contents on high fructose corn syrup etc.). In upcoming trade negotiations the CARICOM could have a position on these trade issues.

CARICOM should also invest in the flexibilities of the Trade Related Intellectual Property Rights (TRIPS) in order to guarantee access to affordable medicines. The TRIPS has now for years been a hot issue in the WHO and countries are struggling to deal with the difficult legal aspects of it.

INSTITUTIONAL REQUIREMENTS

The current regional institutions are providing decent health support to the CARICOM countries. With the increasing health challenges and changing environment the organizational structure and services of these institutions need a serious review to anticipate to the changing needs of the CARICOM.

A first step in this direction was provided with the review of the Regional Health Institutions that has lead to the recommendations for changing the government structure and now to the establishment of the Caribbean Public Health Authority (CARPHA).

Another increasing need in the region is the need for highly specialized medical services such as cardiac surgery, cancer treatment and radiotherapy, certain types of neurosurgery and orthopedic surgery etc. These services are scarce in the Caribbean and there is a certain level of sharing of these services from other countries in the Caribbean. Still significant number of patients is send abroad for treatment. Given our relatively small populations the investment in these high level services in a National level is in most cases not cost beneficial. The official establishment of CARICOM Medical Centers of Excellence is becoming a greater need. In CARICOM it can be agreed which country would concentrate on certain highly specialized services for the region. This would increase the patient population, rationalizing the investment and sustainable availability of services, attract Caribbean specialists from abroad to return to the region and of course reduce the number of patients sent abroad for treatment.

With the increase in diabetes and hypertension the region has experienced a great increase in kidney dialyses and these costs cannot be supported any longer by insurance companies that are limiting their coverage. A need for the CARICOM in this area is to establish a regional kidney transplant programme.

SUSTAINABLE EDUCATION

Human Resources in Health need special attention in the CARICOM as there is a shortage of health workers and migration of health workers. For the education of the health workers to be more sustainable regional trainings programmes should be strengthened (e.g. public health leadership programmes) and related to availability of scholarships and study loans.

On the National level health workers in which the government invests in their training should be tied to contracts after graduation to prevent early migration.

The CARICOM should approach destination countries in a more commercial way to discuss training for export with the investment of destination countries.

CROSS SECTIONAL LINKAGES

ENHANCING COMPETITIVENESS WITHIN AND AMONG SECTORS

Some competitiveness in health is required to stimulate quality of services and to reduce cost. However, reducing cost can impose on the quality of and access to health services and this should be avoided at all times.

Competition can be created for countries to bid for and develop a plan for CARICOM Medical Centers of Excellence for the regional super specialized services. Services as cardiac surgery, neurosurgery, radiotherapy and cancer treatment, and a kidney transplantation center.

Another area for where competitiveness can play a role is the operation of a regional emergency medical service and trauma center. This could be beneficial for the Eastern Caribbean to have a professional OECS medical emergency organization and trauma center. With tourism as a significant source of income such a service provides confidence in emergency health services.

RECOMMENDATIONS

POLICY ACTIONS

1. Develop strategies to sustain the health gains in the Caribbean. Especially our vaccination coverage and explore the introduction of underutilized vaccinations.

2. Finalize the programme for the Caribbean Cooperation in Health III (CCH III), with links to responsibilities of the Regional Health Institutions (RHI's) and budgets. The CCH III should at least have the core of priorities set by the Heads of Government (NCD's, HIV/AIDS and Mental health) with cross sectional supporting policies in Human Resource Development, Health Information Systems, and Health promotion. The RHI's can separately provide input for policy regarding priorities in their area of responsibility.

3. Strengthen the management and monitoring of the CCH process, especially strengthening of the CARICOM health Desk.

4. The CARICOM Secretariat should reserve a budget for supporting the CCH III, even as a manner of seed funding.

5. CARICOM countries should commit, as a priority, to the Essential Public Health Functions (EPHF).

6. Planning the establishment of CARICOM Medical Centers of Excellence.

7. Total health expenditures should spend at least be 7.0% of GDP and the government health expenditures about 55-60% of the total health expenditures.

8. Develop basic guidelines for Caribbean countries for the development of National (social) health financing policies.

9. Perform National Health Accounts on a regular basis.

10. Develop regional and national policies to increase the number and diversity of health personnel while also including arrangements to reduce migration.

11. Develop a more commercial approach to migration of health personnel, negotiate with destination countries to invest in Caribbean trained professionals for export.

12. Speed up the process for implementation of the domestic regulations and the minimal requirements for professionals related to the free movement of professionals.

13. Intensify the role of the Caribbean Accreditation Bodies, especially CAAM-HP with clear status of graduates from accredited institutions.

14. Establish a CARICOM registration for pharmaceuticals and a regional policy to utilize the flexibilities in the Trade Related Intellectual Property Rights (TRIPS).

15. Establish professional emergency response systems with a trauma center in the CARICOM.

DATA GAPS

1. Surveillance of chronic disease risk factors
2. Health financing information is lacking
3. Lack of a database on health personnel and the training pool
4. Lack of data on the mental health burden of diseases

LEGISLATIVE CHANGES

1. Elimination of legislation that forbids beggaring
2. Regional legislation on the quality of imported foods, e.g. making the Caribbean transfat free
3. Develop regional legislation for accreditation, registration and licensing of health professionals
4.