

CARIBBEAN CENTRE FOR DEVELOPMENT ADMINISTRATION

(CARICAD)



A POLICY FORUM

HEALTH SECTOR REFORM: MANAGEMENT AND
PERFORMANCE

PUBLIC - PRIVATE SECTOR FORUM

Trinidad and Tobago
April 1998

A POLICY FORUM
HEALTH SECTOR REFORM: Management and Performance

I THE CONTEXT

Health is a quality of life issue, a resource for every day living needed to achieve our life goals.

1. Background & Introductory Remarks

In her opening remarks, **Dr. Karen Sealy, CPC Director, PAHO** pointed out that the Caribbean's Health Sector Reform (HSR) process, (which could be traced back to the mid-eighties), predates the current global focus on health reform. The Special Meeting of the Caribbean Community on HSR in November 1995 had crafted a vision for the health services in the subregion for the year 2020. At that Meeting critical areas were identified in which joint action was needed to complement individual national programmes. **Dr. Barry Wint, Programme Manager, Health, CARICOM** pointed out that early structural adjustment programmes in the region focused on the productive sector. However, it was now recognised that productive sector growth was not attainable without social sector growth. In recognition of this fact, the CARICOM had recently replaced the Conference of Health Ministers with the Health and Human Development Council and identified the Caribbean Co-operative Initiative in Health with eight focal areas for action including Health Sector Reform (HSR).

Some of the major issues of HSR in the region included:

- the needs/demands of an aging population on our Health Care Services HCS;
- the impact of deteriorating socio-economic circumstances (such as increasing incidence of teenage pregnancies and substance abuse,) on the HCS;
- the adequacy of quality and scope of the services at the primary and secondary levels;
- perception versus reality about the quality of health care offered within the public and private health systems;
- the migration of clients to the private sector health care systems (HCS);
- equity and access to effective HCS for all particularly the poor;
- the increasing proportion of disposable income and government revenues which must be spent on health care including drugs;
- changing epidemiological profiles;
- increasing urbanisation;
- inefficient allocation of resources;
- inappropriate institutional arrangements;
- outdated management practices and bureaucratic inertia which characterised the HCS.

Dr. P.I. Gomes, Executive Director, CARICAD, emphasised the importance of pursuing a solutions-oriented approach, building on the good that has been achieved and moving forward. **Mr. Wendell Kellman, President of CMDA** reiterated that the CMDA would continue to support the reform process and had as its members, the people with the skills necessary to forward the process of reform and improved social development.

Senator the Honourable Wade Mark, Minister of Public Administration & Information, Trinidad & Tobago urged perseverance of effort despite the skepticism of some towards the reform process.

Dr. The Honourable Hamza Rafeeq, Minister of Health, Trinidad & Tobago outlined the significant progress made in Trinidad & Tobago with HSR and underscored the need for behavioural change in addition to the organisational/functional changes made through the reform effort. Dr. Rafeeq pointed out that there was no single applicable model of HSR, however there was a rich variety of solutions to be found from different communities for similar core issues of financing, purchasing and delivering HCS. The considerable body of knowledge now available from around the world and within the region provided a rich resource for learning how other countries had dealt with the many hurdles to be overcome in the process of HSR and Dr. Rafeeq welcomed the opportunity provided by the Policy Forum to do so.

2. Policy Opportunities

Partnerships For HSR to succeed it was vital to gain the support of the stakeholders. Partnerships offered the opportunities for successful HSR. Partnerships between: the government and its social partners; between communities and the health services; public and private sector, doctors and health administrators, doctors and nurses, ministers and permanent secretaries. The current exploration of social partnership and SMART partnership approaches within the regional and global community was a timely opportunity for the HSR process.

Wellness Programmes Health is a quality of life issue, a necessary resource for achieving our life goals. Health education and the teaching of lifestyles for wellness in the school environment and the encouragement of back yard nutrition gardens in schools and in the community were important strategies in a wellness programme.

Community-based programmes Integral to the use of the partnership strategy and the implementation of wellness programmes is the community-based health service. Community-based programmes also complemented the decentralisation of the HCS as a strategy for improving access, equity, efficiency and effectiveness in the delivery of services.

Increased Trend Towards Healthy Life Practices In the region and globally there was a growing trend towards the adoption of a healthy lifestyle which meant that many people were increasingly receptive to information about health issues. However there were differing levels of awareness and on-going public education was important. Dr. Duane Adams, Director, Saskatchewan Institute of Public Policy, Canada urged: "Give the public hard factual scientific information, not emotional arguments. They understand it."

Leadership Development Leadership development was another key for HSR success - nurse leadership development in particular as nurses had a vital role to play in the HCS and its reform.

Nurses in the Community Nurses play a major role in community based services as care providers and also as advocates, enablers, mediators for the promotion of a healthy lifestyle.

Partnership between nurses and teachers, nurses and farmers, nurses and private sector organisations were vital to achieving the goals for the improvement of health and health practices.

In this context, nurse leadership development was particularly important. It was opined that nurses tended to be the most objective in terms of the welfare of the patients. Nurses were concerned about their jobs but their economic interest tended not to be as strong as that of the doctors. Consequently, developmental, institutional and capacity building programmes for the nursing body were opportunities which strengthened the process of HSR.

3. Policy Threats

The real constraints to wellness and reform were poverty, malnutrition, lack of awareness, distrust deteriorating housing and services, under-education, unemployment. The barriers to access to health services were level of income, prices, population demographics vis a vis the location of services.

4. Policy and Legal Framework for Restructuring Health Care Services

The overall objective of the HSR is to improve the quality of health care provided in a manner that imposes no additional financial burden on the state. Key policies underpinning the overall objective include:

➤ EQUITY: All persons in a society should have an equitable chance of achieving a given desired health standard.

HSR must not exacerbate the paucity of health opportunities for the poor; and in fact targets the poor with a view to reducing the gap between the rich and the poor

➤ ACCESS: HSR must ensure the affordability and facilitate the physical availability of HCS for all, particularly for the poor and vulnerable within the society.

➤ HEALTH PROMOTION: Collaborative fora and methodologies must be established and used for intersectoral policy and program formulation. For example, within and between the social and productive sectors; public and private sectors.

Community involvement must be extended to develop informed clients as the basis for designing and delivering customer-driven HCS.

New kinds of health professionals with health promotion skills and a new vision for what will comprise the network of health facilities should be the foundation of a reformed HCS.

The health of workers at the workplace should be as important as the health of children in the school.

➤ STRENGTHENING
PUBLIC HEALTH:

The overall standard of health and wellness of the public should be strengthened and prioritised as a fundamental human right and primary indicator of the socio-economic well-being of a nation.

➤ CARIBBEAN
COOPERATION
IN HEALTH:

Agreed measurable objectives, joint action and shared services would form the basis for joint planning, financing and implementation of selected services within the region as opposed to the current practice of individual countries independently building slightly oversized facilities and then inviting other counties to use the national facilities.

➤ PUBLIC/PRIVATE
MIX:

The public /private mix of services within the HCS must include greater participation by the private sector in health promotion and preventive services.

A shared responsibility for the design and development of a supporting financial mechanism is required for sustainable delivery of a high quality HCS.

➤ FREE MOVEMENT
OF GOODS, SERVICES
& SKILLS:

A common method and standard of registration of health care providers and professionals must be established to faci

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- SUSTAINABILITY: A non-partisan consensus-building approach to reform should be adopted and maintained so that changes in administration do not frustrate the HSR process.

The public sector should perform a dual role with increased capacity for effective financial administration, operating as an effective mechanism for the allocation of resources and the monitoring of expenditure against results achieved.

A shared responsibility between public and private sectors for the design and development of a supporting financial mechanism which includes cost sharing and the implementation of a sound social insurance approach to financing the HCS.

The use of cost-effective and affordable medical and information technologies and the appropriate number and mix of human resources to address the needs of providing a quality HCS at an affordable cost.

➤ ENGENDERING
HEALTH:

The national plan for the HCS should incorporate the principles of the Commonwealth Gender Management System to ensure the adequate attention to gender specific health and wellness needs.

➤ VULNERABLE
GROUPS:

Particular care must be taken to identify and address the specific needs of the elderly, disabled and the youth, especially the adolescent male within the HCS.

➤ LEGAL
FRAMEWORK
FOR HSR:

The hurdles of revising the legal framework to support decentralisation of the HCS and delegation of authority for human and financial resources management should be addressed through collaborative consultations which involve the various stakeholders. This should comprise the HCS's management and staff representatives (including public and private sector, professional and administrative) and their unions, the public service commissioners, ministry of health officials, regional health authority officials, constitutional/legal expert advisers, with the facilitation of trained conflict resolution mediators.

The legal framework must seek:

- to protect the right of the public to have equitable and accessible quality health care services and wellness programmes;
- to protect the rights of health sector workers affected by changes to the HCS;

- to provide for the effective monitoring and accountability for the use and expenditure of resources against the results gained.

II STRATEGIES, LESSONS & FINDINGS OF HSR FOR THE CARIBBEAN REGION

1 The Vision, Objectives and Strategies of HSR

Vision

The vision for the Caribbean Health Sector Reform is to have societies that are brimful of healthy people living healthy lifestyles. We see the provision of health services as a regional matter and an issue of regional access. We would like to know that wherever we go in the region that we have our Caribbean health insurance card and can have access to health services in any member country of the region. We envision a health care service which is equitable, accessible and efficient operating effectively in every member country of the region.

Broad Objectives

HSR is about change and improving the health status of populations. The health status of the poor and socially disadvantaged must be recognised as a key determinant of the health status of a country.

We need to be clear about our mission and objectives. Is our mission, one of health sector reform or is it delivery of health care reform? A lot of emphasis has been placed on upgrading the institutions in the health sector without due attention to the work needed to develop the community and to prepare the community on preventive issues. It is necessary to ensure the quality of health service delivered to end users and communities whilst strengthening the institutions and capacity of our health care providers and administrators.

The overall objective of the HSR is to improve the quality of health care provided in a manner that imposes no additional financial burden on the state. HSR is not about cost-cutting. We have a commitment for HSR to achieve the highest level output for the lowest possible cost of resources.

Equity and accessibility has to be the guiding criteria for HSR.

- Health care must be affordable to ensure access of all to adequate health care.
- We need a system that foremost is equitable and accessible, and then secondly is efficient.

Broad Strategies for Implementation

- ***The Partnership Strategy was strongly endorsed as the essential, most effective and dynamic approach to the successful implementation of HSR.*** This entailed government and its social partners working together on a national and regional basis. The key involvement of the health professional workers, particularly the nurses and doctors, the communities being served, and the trade unions was emphasised. The value and role of the internal workers and the unions were underlined as a force that could stop reform or ensure its success.

Additionally, **Ministers and Permanent Secretaries (PSs) together must determine and implement change of policy and practice. PSs and followers must guide and push and influence leaders to do the things that are necessary.**

Private sector partnerships were another vital and valuable strategy in the process of HSR. One cannot deal with public sector reform in the health sector and not deal with private sector reform as well.

- **On-going public education programmes** on the objectives, issues and progress of HSR was mandatory. **The need to communicate and repeat the message over and over could not be over-emphasised.**
- There needs to be a clear and explicit framework with **clear rules for equity and efficiency of service delivery and access to a range of programmes** - including wellness, primary, secondary and tertiary HCS. Precise policies are very important to ensure that equity was protected. We can no longer assume that because our HCS was public that it was automatically equitable.
- **Wellness programmes** need to be developed further in support of the vision for healthy people and healthy lifestyles. The planning, development and provision of Health Services are based on the assumption that the client population is ill. Whereas, wellness programmes focus on the preventive measures and the maintenance of overall well-being. These complementary approaches have different implications and options for the issues of equity, access and financing of health services.
- The will and **attitudes** of persons driving or involved in the process of Health Sector Reform is pivotal to its success or failure. In this context, **leadership development is critical.** Attitudes and mental models need to be re-defined and changes arising from the process of HSR must be effectively communicated or else the system will subvert itself. The shell may be changed, but the core remains the same.
- The standard of health care being provided now for the monies taken from the population must be examined. The quality of health care being provided by both public and private services must also be monitored as there were real and perceived variances in the standard of care offered. **A measureable and desired standard of HCS must be defined and better use made of the amount of money now being collected/spent before we identify any need for additional resources.**
- The financial strategies required **needed to move away from the heavy dependence on fiscal financing and focus more on cost sharing approaches and social insurance.** Improvement in the controls used to manage existing resources was imperative so that a greater level of output could be achieved from the existing level of financial resources invested in the HCS.

- ***Location of the services*** were another key issue. If all services were centralised in the urban areas this would be a disservice to the rural population. Therefore, strategies for decentralisation needed to be carefully examined, selected and implemented.
- Effective strategies for the management of our human resources within the health sector was a pre-requisite of successful HSR. ***Creating new kinds of jobs, re-training and developing new kinds of compensation packages, including re-location packages, were required. HSR was not about cost-cutting and should be seen as cost neutral.***
- ***Damage control*** was also critical, especially where commitments made were withdrawn. It was advisable to conduct, in advance, ***sensitivity-analyses*** to the most critical worst-case scenarios and to identify strategies for addressing them or for reducing vulnerability to them.
- ***Breakthrough strategies change the way we do business. A breakthrough result is a position or result which right now is not possible for you/ the organisation. The leaders and stakeholders of HSR must grasp the courage and commitment to envision, plan, develop and implement breakthrough strategies for the HCS of the region.***

2 Policy and Implementation Lessons Learnt From the Region

Latin America and Bolivia - Technical Cooperation in the Region

The conference was advised that Latin America (LA) and Bolivia in particular were leading the world in HSR and supporting global and regional statistical information was presented. There were 2 key policies underlined:

- Decentralisation of services
- Financing of Health Care

The driving goal was Managing HSR for Poverty Alleviation and the key strategy was to increase efficiency whilst ensuring equity. It was pointed out that equity was poorly measured and the data available was underutilised, therefore, the region needed to produce more information and ensure that it was better used. Notably, more experiences from the global community on health equity issues were being shared/extended to benefit LA countries. It was imperative for the member countries of the Caribbean and Latin American region to capitalise on the increasing opportunities for TCC (technical cooperation) which existed in the region.

Tobago House of Assembly (THA) - Partnership Approach

THA has experienced various levels of reform, along with various legislation and memoranda of agreement. As the region embarked on various strategies of HSR, the key issues raised were: to what extent have we involved the other sectors in the process; to what extent were the political directorate committed to the process; the access to, and sustainability of, funding.

In response to these issues, working together with NGOs and village councils has been the approach adopted by the Tobago Regional Health Authority (TRHA). Also there were private sector partnerships to provide island paradise convalescent care services for visitors. Through the partnership approach, a training centre for providing primary support and geriatric care was being

developed. Notably, there were plans to earn money from these strategies for the community for Tobago. These revenue earning strategies were critical as the accessing of funding for HSR was an important issue for Tobago.

Barbados - Programme Budgeting Approach

Barbados has adopted a programme budgeting approach as the basis for establishing an annual services agreement between the MOH and the RHAs which outlines the services expected from the regions in any one year. This mechanism allowed for equity and access issues to be addressed. It was recognised that whilst resources must be increased to close the financial gap, the resources had to be more efficiently used and the allocation process had to address the needs of the disadvantaged.

Grenada - Statutorisation & Secondment

In Grenada, the decision was taken to statutorise the general hospital and second public sector employees to work at the hospital. However, it was subsequently determined that such secondment was unconstitutional and the union and workers withdrew their support from the previously accepted proposal. The impasse remained unresolved at the time of the forum, however, the attitude of the public sector trade union leadership and the commitment of the parties to finding a win-win solution was a lesson in itself that the region should note. The conviction expressed by the NUPW President, Lauret Clarkson was that: ***“Grenada will become the model on how it should work.”*** **Job security and the quality of delivery of services was the concern of the workers. There was no problem with the policy on statutorisation if it improved the quality of service delivery and protected the tenure and benefits of workers. A win-win solution was required, the dialogue continued and lessons were being learnt.** Primarily, there had not been enough discussion and information sharing throughout the decision-making process coupled with an assumption that all levels understood what was happening.

The option was recommended to Grenada that they advertise the jobs being offered by the statutorised hospital and interview those who responded and let the job applicants decide to abide by the new terms and conditions of the new positions.

3 Human Resources Issues

The Population, Communities and End Users of the HCS

The availability of services was not sufficient if the public was not aware of what was available, or could not get to the care facilities. In response to this issue of access, it was agreed that a public education programme must be put in place as a major component of reform. Also, the movement of resources into community-based services was proposed as the alternative to the hospital-doctor complex which were often centralised in urban areas.

The development of community-based services as a response to community health needs required greater involvement of the communities. ***The Partnership process, by which communities are involved in planning the change that will affect them, should be adopted. This would entail an intensely consultative approach with as many stakeholder groups as possible involved in***

the decision-making and prioritising process. Establishing common goals and trust would create the strong links needed between the community and the health services. The effectiveness of this approach was demonstrated by the experience of the Saskatchewan community-based health service in Canada. The Saskatchewan community consultation allowed the voices of women, the disadvantaged, aboriginal, and average people to be heard. There was transparency about what was being done with the health care services and the reason for it.

HSR and the Human Resource Management of Health Professionals and Rights of Workers

If you want people to change their jobs then you must provide incentives for them to do so. *HSR strategies typically involve statutorisation, privatisation, decentralisation, rationalisation, down-sizing, relocation of workers, transfers of public sector workers to the private sector, all of which entailed fundamental changes to the status quo of the health sector workers.*

The major issue was how to deal with workers and the retention of their rights. Options included secondment, voluntary retirement and rehiring, severance, guarantee of pension and rehiring. Another issue was the scarcity of opportunities for re-employment. Ideally, one would give workers all severance rights whether re-employed or not, or preserve/ transfer all their rights, however there were seldom enough funds to support this solution.

It was suggested that advertising jobs in the public domain would give public sector and private sector workers the option to decide to give up their existing job and its benefits for the new jobs and their attendant terms and conditions of employment. The sentiment was expressed that we must rid ourselves of the job-for-life syndrome in the public service.

Role and Position of the Unions

Mr. Kingsley St. Hill, President of the Caribbean Public Services Association (CPSA) stated that public sector trade unions in the region have agreed that a holistic approach to PSR, including HSR, was required. However, the concern was expressed that Privatisation often meant that services were not provided where they did not make economic sense and the unions would always be opposed to that. On the matter of Labour Productivity issues, the unions were opposed to the downsizing of the labour force. It was opined that if displaced labour was redeployed then productivity could still be achieved.

4 Financial & Capital Investment Issues

Quality of care was very important, not just the quantity of care.

The mandate for access to quality health care required extensive financial and capital investment in the HCS. Physical and financial resource constraints created problems of health care delivery, especially to rural communities. The view was expressed that additional clinics, polytechnics and hospitals would assist if they were appropriately located. Otherwise, a poorly conceived location strategy would result in the waste of scarce resources. Also, in a small country, it should not be overlooked that one important and less complex response to this issue was to provide for improved ambulance services.

Globally and regionally, there was the trend for an increasing percentage of GDP being spent on health care. Caribbean countries have been dependent on fiscal financing which is reflected in the fact that an average 45% of health expenditure in the region was public. This was difficult to maintain and resources for the HCS were always inadequate. Consequently, this system was not sustainable and did not provide the desired level of access to health care. It was imperative that more efficient use be made of existing resources. There were inadequate controls and leakages in the system which, if resolved, would allow increased services for the same level of resources.

Dr. Karl Theodore, Health Economics Unit, UWI informed the forum that there were four pillars by which health care was financed in the region: from Government revenues, private insurance, social insurance, and out of pocket payments. A diagram of the framework was presented entitled: HEALTH FINANCING & ACCESS TO HEALTH SERVICES. It was necessary to determine an appropriate mix of options to arrive at adequate financing of the health sector. Moving from a heavy dependence on fiscal financing towards insurance financing of health care had implications for equity and access and the HSR had to deal with this challenge. The use of National Health Insurance and the fee for service basis of some operations were amongst the strategies to be considered. It was also proposed to deepen the collaboration with NGOs as there were situations in which they could provide services more cheaply and more effectively to the disadvantaged sectors of the population than the public services. Whatever financing instrument was used must ensure access of the population to health care services. It was noted that user charges can create an access and equity barrier however small the fee may be.

Notwithstanding the non-government options being proposed, shrinking our government sector did not always improve our social services. Instead stakeholders needed to get the government and the social services sector to do their job better - that is, by getting equity right. The view was expressed that more reliance should be placed on the social insurance system which was biased towards increasing access. The government should contribute on behalf of those who were not working and those who worked should pay social insurance. The purpose of government expenditure was to ensure access through strategies that addressed prices, income levels and location of services.

In Trinidad & Tobago, when the Decentralisation policy was adopted, was a strategic error made by not advancing the financing mechanism at the same time. There was a need for more funds to be injected into the system. Give managers the funds and the flexibility to manage and to respond in the way that they deemed necessary to varying circumstances. Don't ask people to manage and then put stumbling blocks in the way.

5 Organisational & Management Issues

Partnerships are an end in itself as well as a means to an end. They are essential to any reform effort.

Managing the Process of HSR

Separate management and performance. The process we are engaged in and the outcomes or objectives to be achieved must be clear. We can focus on the process at the expense of really

achieving the desired results. In this respect, the experiences of other countries should provide us with some of the tools necessary to avoid some of the errors made elsewhere.

HSR takes time and the social marketing must be done effectively. This required a good quality change team with the marketing and public relations skills to ensure that the change process was sold and constantly being sold to the public and stakeholders. ***The necessity for systematic and frequent accurate information repeated over and over again could not be over-emphasised.*** “Give the public hard factual scientific information, not emotional arguments. They understand it.” (Quoted from Dr. Duane Adams, Director, Saskatchewan Institute of Public Policy, Canada).

Experiences shared from Canada’s HSR revealed that resistance to change/HSR came from local politicians and from some interest groups, including the doctors, many of whom tended to cloak their economic interest in quality of care rhetoric. Support came from many NGOs. The single most important group to be committed were the front line workers - firstly the nurses, and secondly the doctors. Also, the support of the union groups was needed. Benefits needed to come through quickly as people were quick to criticise and politicians became nervous for positive results.

Decentralisation

The major issues of decentralisation as a strategy for HSR were: the Approach to Decentralisation; the Quality of Health Service Delivered; and Protection of Workers Rights.

The questions to be answered and communicated to the stakeholders included: “What did it mean to statutorise?” “Was it the same as to privatise?” “Would decentralisation improve the quality of service provided.” “How would you ensure that poor people were not disadvantaged.” And, as noted previously, “how would you deal with workers and the protection of their rights?”

The terms ‘privatisation’ and ‘statutorisation’ were being used inter-changeably and the distinction needed to be defined. It was clarified that Privatisation and Statutorisation were two different things and these and other strategies of decentralisation and reorganisation for HSR were defined.

- ***Commercialisation*** included various strategies for decentralising and reducing cost to the state. This entailed the contracting of services to parties/entities organised for commercial gain, whilst control was retained by the state;
- ***Privatisation*** entailed the outright sale of the service to private entities, with no retention of control by the state except through usual regulatory powers;
- ***Statutorisation*** entailed the enactment of a statute to create a legal profile which operated the service. Although the minister retained control the statute allowed a significant degree of autonomy from the ministry;
- ***Executive Agencies*** were another type of public entity which were completely autonomous but came under the control of the government.

The Role of Government & the Social Partnership

The role of government in the provision and management of health care services and in the development of HSR needed to be re-visited. Some questions to be considered were: “Should governments be in the business of running hospitals.” “Who is going to run the national insurance, will they run it like how they run the health services.” “Will we achieve the level of efficiency required.” “What if we privatise all HCS for the next 10 years then evaluated the results?” “Are our fears of privatisation well founded? Or are we revisiting our fear of the privatisation of the telephone services?” (which are now *fait accompli* and functioning well despite concerns about the power of monopoly).

The new role emerging for government was that of catalyst and pivotal player in a Social Partnership approach. It was not practical to minimalise the role of government nor sufficient to distinguish and limit its role to creator of the environment and that of the private sector, unions and other NGOs to producers of goods and services - they needed to do the job together.

The state and the private sector and all social partners together should be creating the environment and producing the goods and services. This would entail the public and private sectors together designing solutions and creating the value added within the society - that is, health practitioners and administrators, communities and ministries together designing, developing and implementing solutions.

Another important area for shared responsibility was in the area of Public Education. Although, primarily the responsibility of government, yet communications from governments were often inadequate and needed to be bolstered by the efforts of the social partners to ensure adequate awareness of the public and other stakeholders on the issues, objectives and progress of HSR and the availability of HCS.

What about the politics of the Partnership solution? Would there be a controlling board loaded down with political appointees or would there be a genuine involvement of community and stakeholders? In such situations it was advisable to prioritise the supporters needed and get them on your side and to empower stakeholders. Unions were another important fact of life and workers representatives on boards were advisable.

Within the above context it was important and pragmatic to accept and manage the inter-relationship between government and politics. Politicians would always be there and whenever there was a change of government there would always be a need for re-education of the new players. This was an on-going responsibility which required the active involvement of the Social Partners.

A Process for Establishing Partnerships

Establishing trust and respect and maintaining two way communications were mutually supportive foundations of a sound partnership. A sound partnership also required the ability to manage conflict and to sustain a “Win-Win” philosophy and practice. Within the framework of the partnership, the following definition for communication was offered: ***the basic function of all communication was to control the environment in order to realise certain physical, economic, social and emotional rewards.*** Parties controlling or contributing to the provision of rewards of

others and parties requiring those rewards would therefore need to interact and learn to negotiate with one another. Successful negotiation required knowing the other person and understanding what they wanted; whilst knowing what you wanted and what you were prepared to give up in order to get what you wanted.

Within the process of HSR and organisational change, who are the stakeholders who need to be included in the Partnership. The most important were the internal people, that is, the people inside the organisation. People functioned in little groups and need face to face communications in little groups; and within each group there was an 'expert', a leader or opinion-leader, with whom communications and negotiation were vital. People affected by such changes or planned changes fear for job security, and relocating - moving and the loss of power were the greatest barriers to change and these perceptions had to be managed. People would ask themselves: "Do I have control over my work, my environment, do I know what is happening do I feel involved in what is happening?" Communications was one of the greatest motivators in these circumstances. People were propelled by self-interest and change agents or champions needed to ensure that the people to be partnered supported the new directions by re-defining their self-interest.

III SUMMARY OF RECOMMENDATIONS

Health of the community should reflect the quality of life of the nation.

1. **HEALTH POLICY**

What is Health? Health is the social, physical and mental well-being of people. This requires the understanding of the concept of wellness which does not focus only on physical limitations such that a physically disabled person can also be well; also, an understanding of health promotion and disease prevention; in addition to the treatment of disease or health problems ***Accordingly, health policy should address both wellness and the care of the problem/ disease.***

Government's policy for health and for HSR should be in a context of a real understanding of the importance of health in development - health as a criteria for general economic development and sustainable human development. For example, the business of tourism which was the fastest growing economic sector globally, was affected if a destination was considered to be unhealthy or experiencing an epidemic.

HSR has become a global reform industry, and the capacity and opportunity exists for the development of an indigenous Caribbean health sector reform industry for research and information gathering and development of solutions for ourselves. This would enable us to analyse the system and the indicators of whether the system is working and to be able to communicate hard data to the community about the status and developments in the HCS. For example, the public would understand and be interested in information on whether waiting time in health clinics has decreased.

Health services should be accessible by all and the designed health package should be guaranteed by the state.

What does all of the above mean for each sector? All sectors have a role to play to achieve and sustain the good health of people. ***A multi-sectorial approach to health is required to provide: clean water, air, environment, housing, agriculture, education, etc.*** The need to address all areas, the social as well as the economic context of ***health therefore requires community involvement in the design, development and delivery of services.***

2. HUMAN RESOURCE MANAGEMENT POLICY

Workers rights and benefits should be recognised in any reform process and redeployment of existing staff be adopted in preference to termination. The major stumbling block is the resistance to changes that have to be made. Therefore, a strong partnership strategy is needed between the managers for the HSR process and the unions that represent the workers.

3. FINANCIAL STRATEGIES

Financial mechanisms should be sustainable and not compromise equity and should reward quality. Decentralisation and financing were closely related and a framework should be defined that focuses on the inter-connectedness of policies within HSR. A clear shared vision should be defined - one which was as complete and whole as possible.

Health packages that were required should be defined first then the financing determined; instead of allowing the financing to determine what health system would be provided.

External sources of financial support must be identified to shift the burden from fiscal financing of the HCS to one of social insurance and user fees whilst maintaining affordability, access and equity.

A regional social insurance scheme should be explored.

4. MANAGEMENT SYSTEMS

What drives reform? Quality of service must be examined, the management of the performance of personnel, leadership and institutions, the management of time and money, transparency and accountability. Management systems and structures must build in flexibility while ensuring accountability, creating efficiency and aligning responsibility with authority. The focus on administrative changes and organisational review should be managed without losing focus on the purpose of the HSR. The establishment of hospital boards should be based (amongst other criteria) on a sharing of approaches and experiences as more than one country seeks to implement the same strategy.

Systems should be designed to achieve measurable outcomes and thereby allowing the creation of standards. The measurement of performance based on standards and targets

that are shared and agreed are critical. There is also the need to address professional regulations.

5. GOVERNMENT AND THE SOCIAL PARTNERSHIP STRATEGY

HSR process should institutionalise community participation in health to ensure wide consultation with stakeholders prior to implementation. Who are the major stakeholders? Government, private sector, NGOs, health professionals, the unions, the end users including the captive audience of children in schools.. We need to develop committed partnerships amongst stakeholders based on trust. The process of implementation for HSR must be clarified especially the process of gaining consensus and regaining it when people turn around on previous agreements. It must be clear that consultation or dialogue does not mean telling or talking to, but true participation in the decision-making and implementation process.

The role of the various partners needs to be clarified, especially that of government. The shrinking size or role of government whether as provider or purchaser of health services must retain a strong effective regulatory role: establishing and promoting the required HCS standards; licensing and registration of health professionals and the hospital authorities; leading on policy formulation and informing on policy and monitoring health care services generally. The expanded role of private sector in health, particularly in the provision of health care and of financing the HCS must be clearly defined within a framework of policies and standards. There needs to be recognition of the fact that health care providers include the pharmacist, chiropractor, and herbalist.

The Partnership philosophy and strategy must include regional collaboration and a design for regionalisation and harmonisation of health services with other territories which includes the private sector and addresses private/ public sector collaboration at the regional level.