Health Care Reform: Policy Content and Process in the Caribbean, study no. 1

The Historical Development of the Health System in The Bahamas

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Commonwealth of the Bahamas

COUNTRY PROFILE

PEOPLE

Population (1995)	0.3 million
Population distribution	Over 50% population in New Providence
Population density	11.8 per km^2
Ethnic groups	Afrocentric 95%, Caucasian 5%
Principal languages	English

GEOGRAPHY

Area	13,935 km^2. One island, Andros 3701 km^2
Topography	3000 islands, covering 460,934 km^2 70 inhabited, 22 island groupings 97km East of Miami, Florida
Capital	Nassau, New Providence Population: 171,542 (1990) Freeport, Grand Bahama Population 24,423 (1980)

GOVERNMENT

Party	Free National Movement
Local divisions	North, Central and South Islands
Active troop strength	900

ECONOMY

Services	Tourism, financial services (50%GNP)
Industries	Trans-shipment, petroleum refinement, steel pipe, pharmaceuticals, salt, rum, shellfish production
Minerals	Not significant
Electricity production (1998)*	1.246 billion kilowatt

FINANCE*

Monetary unit	Bahamas dollar (US1:1Bahamas dollar)
Gross Domestic Product (GDP), purchasing power parity (1998 est.)	$5.58 billion
GDP per capita, purchasing power parity, (1998 est.)	$20,000
Imports (1998)	$ 1.74 billion
Exports	$ 362.8 million
National budget (1997/8)	Revenues $766 million Expenditure $845 million

COMMUNICATIONS*

Television sets per 1000 population (1997)	227
Radios per 1000 population	720
Telephones (1994) mobile (1993)	77,000 (mobile 2400)

HEALTH

Life expectancy at birth (1996)	73.2
Birth rate per 1000 population	18.2
Death rate per 1000 population	5.2
Population growth (1995-2015)	1.3%
Infant mortality	1960: 50. 1996: 19.

HEALTH SERVICES

Physicians per 10,000 population (1994)	15
Nurses per 10,000 population (1994)	40
Ratio of private/public physicians (1994)	227 private/293 public
Hospital beds per 10,000 population (1995)	38.9

EDUCATION

Literacy (1993)	93%
	Compulsory education ages 6–16 years

* Central Intelligence Agency -The World Factbook 2000 –The Bahamas

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ABBREVIATIONS

AIDS	Acquired Immunity Deficiency Syndrome
BMA	Bahamas Monetary Authority
CAREC	Caribbean Epidemiology Centre
CIDA	Canadian International Development Agency
CME	Continuing Medical Education
CMO	Chief Medical Officer
CMOH	County Medical Officers of Health
DLP	Democratic Labour Party
EMC	Executive Medical Committees
FNM	Free National Movement
GDP	Gross domestic product
IADB	Inter-American Development Bank
IMF	International Monetary Fund
IMR	Infant Mortality Rate
MOH	Ministry of Health
NAR	National Alliance for Reconstruction
NHS	National Health System
PAHO	Pan American Health Organisation
PLP	Progressive Liberal Party
PMH	Princess Margaret Hospital
Rand	Rand Memorial Hospital
RHA	Regional Health Authority
SRC	Sandilands Rehabilitation Centre
TAP	Technical Assistance Procurement
UNC	United National Congress
US	United States
USAID	United States Agency for International Development
UWI	University of the West Indies

INTRODUCTION

This profile of The Bahamas is one of four country studies produced as a result of the first phase of the research project, **Health Care System Reform: Policy Content and Process in the Caribbean** (ERBIC18CT970247) funded by DG XII of the European Commission. The remaining subjects of research are The Bahamas, Martinique and Trinidad & Tobago. Institutions and lead individuals participating in the project are the London School of Hygiene and Tropical Medicine (Anne Mills and Gill Walt); Erasmus University, The Netherlands (Frans Rutten and Ruud Lapre); the University of the West Indies (Edison Haqq); the University of Suriname (Ronnie Antonius and Marcel Tjon Jaw Chong); the Centre de Recherche sur les Pouvoirs Locaux dans la Caraibe, Martinique (Justin Daniel); and the Ministry of Health, Bahamas (Hannah Gray).

The aim of the project is to compile, review and analyse data relevant to health sector reform in the Caribbean, with a view to enhancing health reform initiatives and collaborative efforts between related national, regional and international institutions. The study provides an understanding of the evolution of health reforms in four countries/territories which share similar climatic and geographical features and historical background but, by the nature of the diverse styles of colonial administration, have developed very different health systems, mirroring former colonial systems. Their differing colonial histories have also resulted in a degree of isolation between the countries. The research has been undertaken to shed light on the triggers which lead to the conception of health reforms, the conditions necessary for their introduction and problems encountered in their implementation and ability to be sustained. The overall picture can provide a clearer understanding of the climate and conditions necessary for health reforms to be successfully integrated into diverse health care systems.

Reference sources consisted of published and unpublished literature on The Bahamas, official documents of the Ministry of Health and other governmental and non-governmental agencies, and include other less official records and reports. Limitations to the study arise from the limited availability of data. Interviews were held with key players in the health services to complement and expand on the data available to produce a more comprehensive overview[1].

It is interesting to note that the frustrations faced by each of the core team members included finding the time for the full discussions, guidance and scope for in-depth analysis to maximize the potential of this exercise. This, together with the fact that, over the course of the exercise, research assistants had to be replaced a number of times, limited the coverage and speed with which the work was completed. These experiences in themselves demonstrate one of the findings of this research which show that health policies sometimes do not work, or have the level of impact desired, simply because of the difficulties in identifying or maintaining the appropriate human resources. The pool of available skilled resources in small states such as The Bahamas invariably is a limiting factor when strides for expansion and development are undertaken.

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[1] Readers are referred to the sister document to this report, which was prepared as the preliminary phase to this project and is available from the authors or from Anne Mills, LSHTM. It was presented at the first project meeting held in Trinidad and Tobago in 1998 in preparation for the current work. Particular attention is drawn to the overview of the health sector reform strategies undertaken in The Bahamas. This reference frees the current report, to an extent, from providing details on some of the more recent reform initiatives of the Government of the Bahamas for which the process analysis, here, is undertaken.

The first chapter in each study provides a background into the political, economic and epidemiological developments that have shaped the present climate for health reforms. This is followed by a description of the current health sector and its evolution, in Chapter two. In the third chapter a more detailed analysis is presented to include the development of health policy within the health system, health financing policy, and policy developments in health human resources. A case study is presented of an innovative approach to public private partnerships in health. The final section summarises the authors' conclusions and presents editor's observations in relation to the other three studies.

While it is recognised that constructing arbitrary time periods in which to describe a series of events must cause some inaccuracies, in this study four eras have been identified within which developments can be described. The periods are the *Colonial period* (pre 1964), *Period of Self-rule* (1964-1972), *Post-Independence era* (1973-1991) and the *Recent situation* (1992-1999).

CHAPTER 1. POLICY CONTEXT

Background

The Bahamas' history has a pattern of socio-economic development that can be directly linked to its geography. Its chain of some three thousand islands, small cays and rocks stretching over 100,000 sq. miles of warm turquoise seas with white sandy beaches and a balmy climate in the centre of the region of the Americas has, on the one hand, served as an economically viable attraction for the illicit movement of goods during all eras. The profits of pirates, bootleggers, sailor-loving prostitutes, drug traffickers, gun dealers and money-launders have often brought benefits to the Bahamas economy. Unfortunately, the wares of many of these traders have themselves resulted in too many instances of social upheaval. Alcoholism, crack cocaine addiction, Acquired Immune Deficiency Syndrome (AIDS) and gun-shot injuries have become leading causes of morbidity and mortality in the country. On the other hand, its geography has provided the catapult that has made the Bahamas a number one tourist destination throughout the world. Tourism and tourist related commerce constitutes by far the main economic activity of the country and accounts for over 50% of the Gross Domestic Product (GDP) and 60% of the employment.

Only about 70 of the islands and cays of the Bahamas are inhabited, forming 22 island groupings. Some areas consist of just one island e.g. San Salvador, while others comprise a number of islands and/or cays like the Berry Islands. The total land area is 14,000 sq. kilometres with the largest of the islands (Andros) having an area of 3,701 sq. kilometres. The wide geographic dispersion of the Bahama Islands presents the government with many logistic problems for the organisation and delivery of services including health care services. The islands are characterised by uneven development and distribution of resources. Most economic activity is carried out in the two major population centres of New Providence and Grand Bahama. The majority of the small islands[2] enjoy varying levels of economic development, with those at the lower end of the spectrum being merely subsistence economies.

Political Developments

The stability of the political system of the Bahamas has been lauded internationally and fosters its secure economic growth and development. It became a British Crown Colony in 1729, gained internal self-rule in 1964 and Independence on 10th July 1973. Key political and economic milestones from 1945-1997 are summarised in Table 1.1.

As an independent unitary state within the British Commonwealth of Nations, The Bahamas is governed as a parliamentary democracy based on the Westminster/Whitehall model. A Governor General represents the British Crown. There is a bicameral legislature including an elected House of Representatives and an independent judiciary. Those responsible for the drafting of policies and programmes and their subsequent implementation are the Cabinet of Ministers, headed by a Prime Minister who is also a member of the legislature. Government business is carried out by Ministries, headed by Ministers (political) and Permanent Secretaries (administrative) and by quasi-governmental institutions. Executive commissions deal with the public service, police and judiciary and a court of appeal was set up in 1965. Initially only males and property owners were eligible to vote with women voting for the first time in 1962. The ' one man one vote' policy effected a change in the internal political system with the

[2] Formerly known as *Out Islands* and more recently referred to as the *Family Islands*.

advent of party politics.

Described as the next greatest political advance in the country since the first General Assembly met in Nassau (New Providence) in 1729, the 1964 Constitution made provision for a Premier and Cabinet of Ministers who were responsible for the day-to-day affairs of the country. The Governor's powers became limited constitutionally to external affairs, defence, internal security, police and the prerogative of mercy for convicted criminals.

The general election of 10th January 1967 ushered in black majority rule under the Progressive Liberal Party (PLP). After 25 years this Government was changed following elections in 1992. The new government, the Free National Movement (FNM), was voted in and returned to power in 1997.

Economic Developments

The Bahamas has evolved from a plantation economy into a tourism based and financial services economy. After World War II, the tourist industry emerged as a result of the vast improvements in air transportation that made the Bahamas easily accessible to the United States (US) market. Vibrant promotional advertising was undertaken by the Development Board, which became the Ministry of Tourism in January 1964 and The Bahamas today has become the number one tourist destination in the world, on a per capita basis. The attraction for foreign capital has extended beyond tourism to banking, insurance and other financial services. The Bahamas is a global financial centre with over 400 registered offshore and commercial banks and trust companies. With its Bank Law Secrecy Act, and a currency pegged to the US dollar, it has become a premier international tax haven for investors.

These major foreign currency earnings cause the economy of the Bahamas to be highly dependant on the economic climate of the US. Indeed, joint efforts with the US in controlling the illegal transportation of cocaine and marijuana, accompanied by a decline in tourism, resulted in a general recession in the Bahamas which was associated with a general economic decline in the US in the late 1980s.

Of late, according to labour force and household surveys by the Department of Statistics, employment levels have been significantly improving. The general improvement in the economy and the expansion of the construction and tourism industry have reduced the unemployment rate to its lowest level since 1973. The hotel industry has been rejuvenated as a result of an $800 million investment by Sun International over the five year period commencing 1992. The investment in the Paradise Island Hotel Resort increased available hotel rooms by 1200 new rooms and expanded the market by some 2000 new permanent jobs. Latest statistics from the Central Bank indicate that for 1998, real economic growth was 2.5%-3%, tourism expenditure reached $1.4 billion and hotel room and occupancy rates increased by 8.7% and 2.9%, respectively over the pervious year. The Bank also reported that external reserves reached record levels during 1998. At the end of the year external foreign reserves were of the order of $330 million, more than $100 million over 1997 levels and more than double external reserves at the end of 1992. During the fiscal year 1997/98 the Government's overall deficit was reduced by more than one half to $51.7 million from $139.8 million as economic growth generated robust revenue gains of 13.2%[3] [4].

In terms of formal social safety nets, there has been a non-contributory means-tested old-age

[3] New Year's Address to the Nation by Prime Minister Ingraham, Commonwealth of the Bahamas, January 1999.

[4] In view of the fact that The Bahamas serves as the home of rich winter residents from Europe and North America, statistics on per capita income are inflated.

pension programme in The Bahamas since 1956. The National Insurance Act of 1972 provided for a three-part programme, beginning in 1974, with a National Insurance scheme for employed persons, along with the inclusion of the elderly under the Old-age Pensioners' Act and the transfer of responsibility for paying pensioners. In 1976 the self-employed were included and by the end of 1980 industrial benefits, including free medical care for industrial injuries, were introduced.

Health care, particularly for children, is in high demand. In 1990 the demand for child health services for children of non-Bahamian parents ranged from 13% to 72% of users in clinics in New Providence. The burden was equally great on the education system where more than 7% of the students enrolled in the public school system were of non-Bahamian parentage. The social and economic implications of immigration gradually became more evident as the economic crises of the mid-nineties intensified.

Table 1.1. Summary of key political and economic milestones, The Bahamas, 1945-1997

Year	Milestone
1945	End of World War II
1949	Hotels Encouragement Act followed by tourist boom. Tax and customs concessions resulted in surge of foreign investment, building construction and real estate development
1953	Formation of Progressive Liberal Party (PLP)
1955	Granting of 50,000 acres to Great Bahamas Port Authority. Hawksbill Creek Agreement and Act guaranteed exemption from income, capital gains, real estate and property tax until 1985 and excise duties until 2054. Attracted scores of enterprises. By 1966 Freeport was flourishing
1958	General strike leading to major labour reform. Labour Board and post of Labour Liaison Officer established
1959	Secret ballot elections in New Providence. Property qualification and plural voting were abolished. Huntingdon Hartford bought Hog island for $10,000,000, re-named it Paradise Island and began the development that changed the island into a glittering offshore resort
1960	Women given right to vote and to sit in legislature Houghton report on Education and Hughes report on Medical services recommended major reforms Bahamas becomes biggest single dollar earner in British Empire as major world financial centre
1964	Internal self-rule gained
1965	Symbolic action of PLP throwing the Speaker's mace out of the window of the House of Assembly, in protest over constituency boundaries issues.
1966	Decimal currency introduced on par with US$
1967	PLP won General Election, ushered in black majority rule
1968	Constitutional conference in London effected changes that strengthened the government's hand: Defense, police and internal security placed under a Cabinet Minister (Imperial government retained control of Foreign Affairs) Government given the right to negotiate trade and migration agreements with other governments "Bahamian Belongership" status abolished in favour of a less equivocal citizenship definition The Colony of the Bahama Islands renamed the Commonwealth of The Bahamas
1969	Bahamas Monetary Authority (BMA) created, with control over currency, exchange regulations and the operation of banks and trust companies, a forerunner of the Central Bank (formed in 1974). The foremost achievement of the BMA was the setting up of machinery whereby the Bahamian dollar was not only shifted out of the less stable sterling bloc but, through a clever juggling act, sustained at par with the US$
1970	Famous speech of Premier Pindling threatening to 'break' the regime at Freeport if it would not 'bend'
1971	Unexpected collapse of Bahamas Airways with loss of 800 jobs

	Defection of eight parliamentary members of the PLP at the end of 1970
1972	Subsequent formation of the Free National Movement (FNM)
1973	White paper on Independence/ Independence constitution agreed to
1975	Independence achieved on 10th July
1976	Bahamas Marine Defense Force created
1980	Military attack by Cuba on Bahamas ship arresting Cuban fishing vessels for poaching
1983	Entire government accused on national television of involvement in 70% of all illegal drug trafficking
1984	Subsequent Commission of Inquiry report into drug trafficking submitted
1988	Preparation for the establishment of a National Health Insurance Scheme
1992	In General Elections FNM gains majority. First change of government for 25 years Local Government introduced on Family Islands Family Island Economic Encouragement Act.
1997	General Elections - FNM stays in power. PLP retained only 6 of the 40 seats

Demographic and epidemiological factors

As in the rest of the Caribbean, for most of its history the population growth of The Bahamas has been characterised by the ebbs and flows of migration. Repercussions from the American Civil War, the Two World Wars, the expansion of the Florida citrus industry and the development of Freeport in Grand Bahama, for example, can be seen in the size and make up of the population today. The first two decades of the 20th century were a period of mass migration out of The Bahamas. Thousands of Bahamians migrated to Florida in response to the construction boom in Miami, and by the census of 1921 the population growth rate was a negative 0.5% per annum. In 1921 the US congress sharply restricted immigration and this halted the exodus from The Bahamas. Since then, The Bahamas has been a receiving country with migration into the islands peaking at 39,301 in the period between the censuses of 1953 and 1970. The population growth rates from 1953 until the last census in 1990 have shown a continued decrease (Table 1.2).

Table 1.2. Inter-census population growth rates, The Bahamas, 1953-1990

Time period	1921	1953-1963	1963-1970	1970-1980	1980-1990
Growth rate Population	0.5%	> 4% 1953= 86,659	3.8% 1970= 170,000	2.2% 1980= 210,000	2.0% 1990= 255,000

Although the rate of immigration may have slowed in the 1980s, the demographic impact of a sustained period of migration into the islands is quite evident. The greatest impact is on fertility rates, which are higher in non-nationals. When the demands on the social and economic services of The Bahamas were examined, the impact of immigration was more pronounced.[5] A large number of illegal immigrants are living in sub-standard housing, concentrated in areas that quickly become slums, negatively affecting the small, sparsely populated island.

The way of life of the people of The Bahamas has been changing rapidly in the second half of the twentieth century. As in many other countries, underlying causes include a lower birth rate, longer life expectancy, a higher divorce rate, widening educational opportunities, technical progress and a higher standard of living.

[5] Reporting to the Nation, New Year's Address to the Nation by Prime Minister Ingraham, Commonwealth of The Bahamas, January 1999.

Population composition

Current demographic patterns are indicative of an ageing population. Between 1943 and 1963 the population aged under 15 increased by 6% from 38% to 44%, while the population age 15-64 years decreased by the same margin. After 1963, these trends were reversed and by the census of 1990, the population under four years accounted for only 32% of the population while more than 63% were between the ages of 15 and 64 years. It is estimated that in the last decade more than 199,000 persons (65%) were between the ages of 15 and 64, with large numbers entering the labour market and reproductive life. During this same period the population over 65 years have maintained a more-or-less constant proportion of the population. It is, however, estimated that by the year 2000, persons over 65 years of age will make up 5.2% of the population, an increase of 1% over the past twenty years. In absolute numbers this represents a rise from 8,700 to 15,600, an increase of 6,900 or 79% in the numbers of elderly persons. Increases in life expectancy combined with falling birth-rates have led to an increase in the median age of the population from 19.7 to 23.6 in 1990. The projected median age for the year 2000 was 27 years.

The Bahamas has limited racial ethnic diversity. The population is predominantly Afro-centric (approximately 85%), descendants of 17th and 18th century slaves. Caucasians, the other major ethnic group, (approximately 15%) are mainly descendants of British Loyalists.[6]

Health status

The health status of the slaves during the pre-emancipation era was described as favourable compared to those in other plantation colonies (Saunders 1985). The reasons for this were given as:

- more favourable working conditions - the Bahamas was not a sugar colony and in the agriculture islands of the Bahamas, labour was less intensive - cotton needed one slave for every five acres compared to sugar which needed one slave per acre
- a sea food diet rich in fish and conch - low fat and high protein
- the absence of endemic diseases such as malaria and yaws
- a temperate climate — "the healthiness of the air induces many of the sickly inhabitants to retire to them (the Bahamas) for the recovery of health".

Furthermore, slaves by tradition and culture employed local home remedies and bush medicine.

This favourable health status changed in the 1800s as Nassau became an important sea-port and The Bahamas a tourist industry. Nassau was vulnerable to periodic visitations of cholera, yellow fever and other epidemics imported by foreign visitors and incubated in crowded unsanitary conditions. In their historical account of the Beveridge report of the health services in 1926, Craighton and Saunders (1986) noted a resident population with a high prevalence of preventable disease, largely eradicated elsewhere – tuberculosis, sexually transmitted diseases, pellagra, worms, neonatal tetanus and, at the time, there was an outbreak of typhoid. The population of the Bahamas since this time has been experiencing improvements in many areas of health. Life expectancy at birth has steadily improved, rising from about 60 years in the period 1950-1955 to approximately 73 years in 1990-1995 (76 years for females and 69 years for males).

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[6] There are no known descendants of the first Bahamians, the Lucayan Indians, the island inhabitants discovered by Christopher Columbus in 1492; they were displaced to other Spanish territories as slave labour.

In 1997, the total fertility of women in the Bahamas was 1.9 per 10,000 women of child-bearing age. Comparison of recent age-specific fertility rates with those of the 1970s and 1980s show that fertility is lower now than in the earlier years among all age groups, though the rate for 35-39 year olds has increased in the 1980s (Table 1.3).

Table 1.3. Fertility rate in age categories, The Bahamas, 1976,1983 and 1991

Year	**Number of births per 1000 women of child-bearing age.**						
	15-19	20-24	25-29	30-34	35-39	40-44	45-49
1976	125	214.1	165.9	123.9	70.6	24.8	3.3
1983	65.3	164.7	169.1	106.6	43.2	12	1.4
1991	65.7	129.6	129.5	94.5	52.8	11.8	1.5

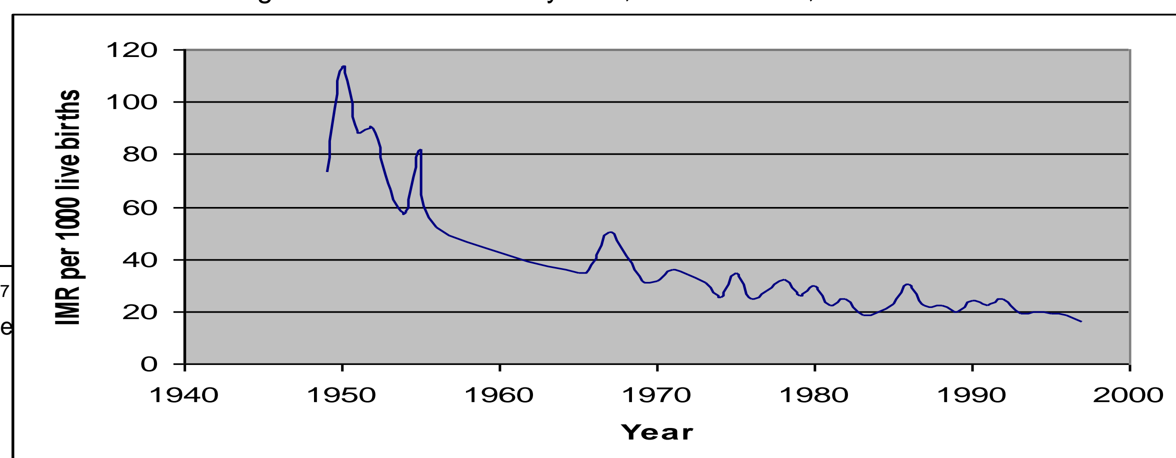
Source: Vital Statistics Reports, Department of Statistics, Census of Events, Health Information & Research Unit

Teenage pregnancy is a continuing problem in the country: 14% of all births in The Bahamas are among mothers under 20 years of age.[7] In The Bahamas, in 1990, non-nationals accounted for 11.5% of the population but produced 17.2% of the births for that year. There were 80 births per 1000 Bahamian women age 15-49 and 120 per 1000 among foreign-born women of the same age.

The records of the Board of Health and the early Ministry highlight diseases such as influenza/pneumonia and tuberculosis as leading causes of mortality. More recent records reflect that, in the overall population, heart disease and cancer ranked either as the first or second commonest cause of death throughout the 1970s and 1980s. At present chronic, non-communicable diseases influenced by lifestyle choices such as heart disease, strokes, diabetes, cancers and injuries are major causes of morbidity and mortality. They account for approximately 50% of all deaths in the country. A recent health survey has found that in the population of 15 to 64 year olds the prevalence of diabetes and hypertension is approximately 11% and 13.3% respectively (see Appendix).

Early reports of the Chief Medical Officer from the 1930s indicated that Sexually Transmitted Diseases posed a major problem in the islands, which to date has never been solved. Not surprisingly therefore, the advent of AIDS in The Bahamas in 1985 had a major impact and it became the second most common cause of death in the 1990s. During the most productive years of life, AIDS is the leading cause of death in both males and females, accounting for 47% and 41% of the total deaths among males and females respectively. In these age-groups twice as many males as females die from AIDS, and trauma is the second commonest cause of death in males whereas for women, this is malignant neoplasms. Other diseases and conditions of particular concern in The Bahamas include alcoholism, which has been a long standing problem from the 1950s and 'crack cocaine' addiction, which was identified to be of epidemic proportions in 1985, and is an offshoot of the cocaine trafficking problems throughout the islands.

Figure 1.1 Infant Mortality Rate, The Bahamas, 1949 -1997



In recent times, the Infant Mortality Rate (IMR) in the Bahamas has shown unacceptably high rates although the trend has been declining. Between 1975 and 1979 the IMR averaged 29.1 per 1000 live births annually. Until 1993 the rates remained above 20. There has been a consistent decline from 19.7 in 1993 to the preliminary estimation of 14.0 for 1998 (Figure 1.1).

In comparison with the other territories in the research project, the Bahamas exhibits a high GNP per capita but a lower than expected life expectancy, which is comparable to both Trinidad and Tobago and Suriname (Table 1.4). According to WHO statistics, the probability of dying under 5 years in the Bahamas is considerably higher than in Trinidad and Tobago, a much poorer country, though lower than in Suriname. Trinidad and Tobago's IMR is also lower than that of the Bahamas.

Table 1.4. Comparison of population characteristics, Martinique, The Bahamas, Trinidad and Tobago and Suriname

Country	**Population density (per km^2)**	**GNP per capita (1997)***	**Life expectancy***	**Probability of dying under 5 years per 1000***	**Top causes of death**
The Bahamas	11.8	US$11,830	67.0 males 73.6 females	24 males 21 females (1999)	CVD^ Cancer Diabetes
Martinique	338	US$12,000 (1996)	74.4 males 81.8 females	n/a IMR 14 per 1000 live births (1998)	CVD (33.4%) Cancer (22.3%) Trauma (8.5%)
Suriname	2.7	US$1,320	68.1 males 73.6 females (1996)	34 males 27 females (1999)	CVD (25.9%) Old age/ unknown (14.5%) Trauma (12.1%)
Trinidad and Tobago	250	US$ 4,250	68.7 males 73.4 females	10 males 7 females	CVD Cancer (13.3%) Diabetes Trauma

^Cardio-vascular disease
* data from Human Development Report
** data (except Martinique) from World Health Report 2000; Health systems: improving performance, WHO Geneva 2000

CHAPTER 2. THE HEALTH SECTOR

This section describes the evolution of the health sector in the Bahamas and details the composition of the present health system into which health reforms were introduced.

Background

At the dawn of the twentieth century, the Bahamian economy was vibrant. The local Development Board made significant capital investment in infrastructure to attract tourism. By 1925, the city of Nassau had modern water and sewage and electrification systems, paved streets for internal transportation and the harbour was dredged to accommodate passenger cruise ships. As a public relations exercise, the Bahamian Parliament requested a national health status report via the British Colonial Office. The result was the *Beveridge* report of 1927 which, contrary to expectations, reported substandard housing, overcrowding, and lack of cleanliness. These deficiencies were attributed to a combination of public indifference, poverty, and ignorance (Beveridge, 1927).

During this period,government health care services were primarily provided for those who were incapable of caring for themselves. The first *Poor house* was opened in 1809. The local residents used home remedies and bush medicine, those who could afford it sought private medical care and the very affluent sought care abroad. Health budgetary allocations at this time were very modest; evident in the significant shortages of health care personnel, services and drugs.

Private sector health care was equally limited, with a few private general practitioners and specialists, all primarily based in Nassau. There was one private hospital, owned and manned by an army-trained surgeon, Dr. Meyer Rassin. The health care available to the Family Islands residents was very limited.

Records of the Chief Medical Officer (CMO) in the 1950s and 1960s reflect a much simpler system for health care delivery than today. There was still one private hospital in Nassau and a handful of private physicians practising in the Bahamas. The public sector was operated under a Health Board with a Chairman who was usually a Member of Parliament. The CMO functioned as the Chief Environmental Officer. The two senior officers reporting to the CMO were the Hospital Secretary and the Chief Health Inspector.

In 1954 the Hospital Secretary was responsible for three hospitals:

- The *Bahamas General Hospital* {later renamed the *Princess Margaret Hospital* (PMH)}, with 200 beds and 12 nursery cots included private accommodation of the nursing home type, general wards for surgical, medical and maternity cases and a children's ward.
- A psychiatric hospital with facilities for a total of 147 patients.
- The leprosarium with a total patient count of 14 at the end of 1950 .

The Public Health Department, under the Chief Health Inspector, was responsible for health inspections, vector and pest control, water sampling, infectious diseases investigations, school health services and 'Out island' services.

A new private hospital, the *Rassin Hospital* was established in 1955 consisting of 20 beds. In 1986 this hospital was purchased by a group of physicians and was renamed *Doctor's Hospital*. There was significant expansion in diagnostic and therapeutic services. In 1992, a new 72

bedded hospital was built on the existing premises. Only those financially endowed Bahamian residents had access to modern and quality health care in North America.

During the 1970s and 1980s there were significant changes in out-patient services in both the public and private sectors. In the public sector, the government's building programme intensified with the construction of a new out-patient department in the PHM and numerous community clinics throughout the islands. In addition, the range of services offered was extended to include dentistry, radiology, dispensary and overnight stay. The number of government health clinics increased from 55 in 1973 to 113 in 1998.

In the early 1980s, the Ministry of Health and Environment developed and implemented a new structure to allow for a multidisciplinary team approach to the management of health services. Executive Management Committees (EMC) were formed beginning with the Princess Margaret Hospital and the Rand Memorial Hospital and later including Sandilands Hospital.

The Present Health System

The organisation of the current health services comprises of a number of sectors with overlapping responsibilities. The public sector comprises Hospital Services, Primary Health Care, a Preventative Health and Disease Control Programme, a number of National Health Programmes paying attention to government health priorities and Environmental Health Services. These are complemented by private health services.

The Permanent Secretary is responsible to the Minister of Health for five health departments, Health Services and Management, Nursing Affairs, Medical Affairs and Population Health, Planning and Administrative Support. Within these departments are a number of units with specific responsibilities.

Public Sector Health Services

Hospital Services: The public sector operates three hospitals, two in New Providence and a smaller one in Freeport, with a total of 518 beds for acute services and a further 482 for care of the elderly and mentally ill (Table 2.1).

Table 2.1. Public hospitals in The Bahamas

Hospital	Location	Specialities	Number of beds
Princess Margaret Hospital (PMH)	New Providence	Acute care (general) Specialised services	436
Sandilands Rehabilitation Centre (SRC)	New Providence	Mental health care Care of the Elderly	352 130
Rand Memorial Hospital (Rand)	Freeport	Acute care (general) Specialised services (limited)	82

Primary Health Care: In the area of Public Health, services are delivered through community health clinics in New Providence, Grand Bahama and the 'Family Islands' as well as through community-based programmes such as school health, dental health, home and district nursing. Out-patient attendance at community health clinics over the islands was more than double that of the three main hospitals combined in 1995 (442,446 in the community clinics compared with 198,199 in the main hospitals).

Prevention and control: This arm of Public Health is responsible at a national level for epidemiological surveillance including contact tracing, food safety, port health and environmental safety, the Expanded Programme on Immunisation and the Notifiable Disease Register.

Environmental Health Services: Environmental concerns of the country are managed by the Department of Environmental Health Services whose prime responsibility is to provide for the management, control and conservation of the Bahamian environment. These functions are conducted through three divisions: The Health Inspectorate, Vector Control and Solid Waste Collection and Disposal.[8]

National Health Programmes: Efforts to address priority health concerns of the country are typically structured under separate operational secretariats responsible for the planning, development and co-ordination of all relevant agencies and groups. In 1998 eleven areas of health services were given priority (Table 2.2). Secretariats have been established for Maternal & Child Health, Family Planning, Adolescent Health, HIV/AIDS, Drug Abuse, Oral Health and Health Promotion and Education.

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[8] In 1997, this Department was placed under the Ministry of Aviation and Consumer Welfare.

Table 2.2. Current priority programmes and projects, 1998

Area of intervention	Specific programmes/initiatives
Health Education and Health Promotion	
Maternal and Child Health	Infant mortality reduction Early Childhood Initiative Early youth / adolescent health Birth registration improvement
Reproductive Health/Family Planning	
Control of Communicable Diseases	Disease surveillance-organisational strengthening HIV/AIDS Immunisation Port health Food safety
Control of Non-Communicable Diseases	Establishment of cancer registry Development of cancer programme Injury surveillance system Reactivation of National Committee for Prevention of Trauma National nutrition programme National diabetes/hypertension programme Community based rehabilitation
Mental Health Programmes	Substance abuse Community mental health services
Dental Health Programmes	
Care of the Elderly	
Disaster Preparedness	
Health Sector Reform	Devolution of hospitals Establishment of local health systems First responder programme Selective privatisation Establishment/strengthening of national systems for professional and service/ facilities standards Integration of programmes for human and social development
Strengthening of Infrastructure	Strengthening of information systems National pharmaceutical services Upgrading physical plant NIB clinical programme Human resources development Strengthening of statutory provisions

Private health care

There are two private hospitals in The Bahamas, both located in New Providence. One is the *Doctor's* Hospital with 72 beds and the other is the *Lyford Cay* Hospital with 12 beds. These are supplemented by a number of private practices with facilities for in-patient care. There are an abundance of 'walk-in' clinics, private medical and dental clinics, pharmacies, and a myriad of allied health specialists such as Optometrists, Physiotherapists, Podiatrists, Dieticians, Chiropractors and Acupuncturists. Recent legislation has empowered the government to develop systems for the licensing and regulation of these professionals.

The ratio of physicians working only in the private sector compared to those employed by the government (who may also be involved in private practice) has increased since 1992 from 140 (private) against 233 (government) to 227 (private) against 293 (government) in 1998. Private dentists have almost doubled in number from 1992 to 1998 while government-employed

dentists have remained relatively stable, even falling in number between 1997 and 1998 (Table 2.3).

Table 2.3. Trends in private and public employment of physicians and dentists, The Bahamas, 1992 – 1998

Profession	1992	1994	1995	1996	1997	1998
Government employed physicians	233	238	235	230	261	293
Private physicians	140	161	182	192	192	227
Total physicians	373	399	417	422	473	470
Government employed dentists	19	21	21	20	22	16
Private dentists	39	57	59	63	67	70
Total dentists	58	78	80	83	84	89

Health care professionals

Until 1820 there was reference to only four doctors in the Bahamas. Nurses cared for the very young and were aided by older slaves. The older slaves tended infant children and the sick. Midwives were those women slaves who helped other females in childbirth (Saunders 1985).

The Medical Act was introduced in 1906. This allowed unqualified doctors, invariably ministers of religion, to practice medicine but not to perform major surgical operations, which was the responsibility of the qualified doctors. In 1921 there were only three qualified doctors to serve the 42,000 'Out Island' inhabitants. Only 5,000 of these residents actually lived in the districts served by the doctors, the remainder either went to Nassau for treatment or depended on the unqualified practitioners.

The development of the health services infrastructure in the 1950s was accompanied by a parallel growth in the number of health professionals and support staff. This was due to an aggressive effort over the years to address a scarcity of certain skills in the health sector. However, the majority of physicians and nurses were deployed in the main hospitals, showing a bias to hospital versus community care (Table 2.4).

Table 2.4. Bahamas public sector health manpower distribution: Hospitals vs Community Health Services, The Bahamas, 1994-1998

Year	Physicians		Registered Nurses		RN's and TCN's	
	Hospitals	Community	Hospitals	Community	Hospitals	Community
1994	202	35 (15%)	491	154 (24%)	869	225 (21%)
1995	197	37(16%)	522	149 (22%)	912	223 (20%)
1996	195	34(15%)	527	136 (21%)	925	198 (18%)
1997	214	45 (17%)	542	139 (20%)	937	198 (17%)
1998	253	48 (16%)	533	148 (22%)	923	227 (20%)

There are, at present, 309 physicians, 159 Registered Nurses (RN), 551 Trained Clinical Nurses (TCN) and 20 dentists. Almost 50% of the physicians have post-graduate training and reflect all relevant medical and surgical specialities. There has been a significant growth in the classical groupings of professions such as optometrists, podiatrists, radiographers, laboratory technicians and physiotherapists, complemented by the addition of professional health administrators and other health systems experts. The majority of allied professionals are trained abroad, predominantly outside the region.

The Bahamas has not experienced the out-migration of skilled personnel, as commonly occurs in developing countries, and 60% of physicians employed in the government services are expatriates on fixed term contractual agreements.

Finance and expenditure patterns

In the 1997/98 recurrent budget of the Government of the Bahamas, $122,151,783 was allocated to the Ministry of Health and the Department of Environmental Health Services. This represented 14.4 % of the total government expenditure budget. A review of trends in the proportion of government spending allocated to health indicates that, prior to 1973, this rate of allocation never exceeded 11.9% and then, every year until 1983, the rate fluctuated between 14.0 and 14.9 percent. The highest level was reached in 1986 (15.7%) with the median percent government budget spent for health in the period 1984-1991 of 15.15% dropping to around 14% every year after 1993. Personnel emoluments account for 82% of the Ministry of Health's budget with less than 5% appropriated for capital.

Comparison of the three study countries

On the basis of the WHO analysis of health systems performance, The Bahamas health system, in comparison with Trinidad and Tobago and Suriname, ranks much higher on responsiveness but relative to Trinidad and Tobago ranks lower on fairness of financial contribution (Table 2.5). The latter may be explained at least in part by the existence of sizeable private out of pocket expenditure. Performance on health levels was considerably worse than the other two countries, resulting in an overall ranking which was better than Suriname but worse than Trinidad and Tobago. This assessment confirms the impression that Bahamas has excellent quality health services in the main islands but faces major difficulties in combating chronic diseases, HIV, and conditions affecting under-five mortality.

Table 2.5. Comparison of Health System Performance in The Bahamas, Suriname and Trinidad and Tobago, 2000

	Bahamas	Suriname	Trinidad and Tobago
Population x 1000	301	415	1.289
Responsiveness of health system			
level (ranking 1-191)	18	87	141
distribution (ranking 1-191)	6	79	108
Fairness of financial contribution Ranking 1-191	138	172	69
Overall health system attainment Ranking 1-191	64	105	56
Performance on health level (DALE) ranking 1-191	137	77	79
Overall performance ranking 1-191	94	110	67

Source: World Health Organization, The World Health Report 2000; Health systems: improving performance, WHO, Geneva, 2000

CHAPTER 3. HEALTH POLICY, PLANNING AND MANAGEMENT

The previous two chapters have provided a description of the health system and given an account of its evolution. In this chapter factors that can explain the development of the health sector as it now stands are discussed. The first section provides a general analysis of health policy, planning and management, which is followed by sections devoted to health financing and development of human resource policies.

Background

The Sir Wilfred Beveridge report on Public Health and Medical Conditions in New Providence, Bahama Islands of 1927 defined the health policies of the Bahamas under the Colonial Authority and described succinctly the health organization, health care status and delivery of care as a National Directive (Beveridge 1927). Beveridge praised Nassau's new waterworks and sewage system then under construction, though he deplored their limited extension. He had some good things to say of the efficient and cleanly way in which the police barracks, prison, poorhouse and parts of the hospital were run. Many teachers and nurses did the best they could, though he believed that they were 'under-trained, overworked, and disgracefully ill supplied, serving in schools that had space for only half the eligible children and a hospital that those who could afford to avoided like the plague'. Other parts of the report were grimmer - almost a horror story. Lepers were not isolated in a proper leprosarium, and in the aptly named isolation ward of the 'Lunatic Asylum', the so-called wards consisted of dark, bare rooms in a dilapidated building. Each room was devoid of hospital equipment beyond in some cases a bedstead and small table. The door of every room was secured on the outside. There was no visible sign of any attempt being made for the comfort of the patients. Overall, Beveridge was horrified by the combination of public indifference, poverty, and ignorance that had led to such substandard housing, overcrowding, and lack of cleanliness. The sanitation clauses of the 1914 Health Act were obviously ineffective.

This vivid account of the health status of the Bahamas in the early 1900's underscores the philosophical basis for and the nature of health care policy guidelines for the Bahamas under the British Colonial Authority. Health care was perceived to be the responsibility of the individual, the Colonial Government provided care for the indigent, the mentally insane and the incarcerated. This philosophical approach remained relatively unchanged in the first half of the century and throughout the pre Independence era. The lack of government defined health care policies initially was reflected in the health status of the Islanders. In spite of the advantages of the Bahamian slaves over other colonies regarding climate, diet, endemic diseases, working conditions and availability of traditional health care, the population suffered from diseases associated with poverty and poor access to health care.

As steamships became the predominant mode of travel globally, and the Bahamas the shipping lanes of the New World, Government policy turned to address the health issues arising from this contact with the wider world. It was not surprising that the first recorded health related Act in the Bahamian legislature was the Quarantine Act of 1905.

One year later the Medical Act was introduced in a half-hearted attempt to eradicate medical quacks.[9] Government health initiatives were dictated as health issues emerged and many felt that crisis management became the health reform vehicle.

During the Second World War the first recommendations were made for a Regional medical school to be established in the Caribbean. The venture resulted in the opening of the University of the West Indies (UWI) in 1948 consisting of a Medical school in Jamaica, Agricultural and Engineering faculties in Trinidad and the remaining faculties in Barbados. The Bahamas did not participate in this arrangement initially but by 1974 the majority of physicians were trained in and recruited from UWI.

Interest in the Health Services was apparent in 1960 by the commissioning of a study by the Colonial Office. The result was a report, known as the Hughes report, the impact of which is still felt in the Bahamas today. The main recommendations of the report were (Hughes 1960):

- To establish a Hospital Management Committee to relieve the workload of the Board of Health and Chief Medical Officer.
- To establish Nursing, Finance, Public Health, Buildings and Welfare Committees.
- To segregate the Department of Health from the main hospital.
- To appoint a Minister of Health for the whole of the Bahamas to work alongside a new post of Nursing Officer[10].
- To improve services to the 'Family Islands', known then as 'Out islands', by recruiting more health personnel and introducing a flying doctor service in the Islands.[11]
- To raise nurse morale, reported as being at a low ebb, by improving accommodation for nurse training.
- To regulate charges to private patients and encourage private nurses to join the Nurses Federation.
- To extend ties with Jamaican hospitals to relieve staff shortages.

In his report Hughes suggests that there would be a need to rely on expatriate doctors for a long time to come until conditions and work interest is improved.

Self rule (1964 to 1973)

In January 1964 The Bahamas gained complete internal self-rule and three years later the election of 1967 ushered in black majority rule under the PLP. The new government placed highest emphasis on a policy of 'Bahamianization'; which meant that Bahamians would have first priority to opportunities for employment and other economic advancement. While the booming economy and new political regime provided unprecedented prospects in the public service and private sector for the black majority, the inadequacy of the Bahamian educational system, was blatant.[12] Less than 10% of school-leavers attained the minimum requirements for clerical employment. In the health sector this deficiency was accentuated as health professionals required an even higher standard of education. Not surprisingly, the predominant professionals were expatriates. The significant policy initiative for health care, therefore, would have been the government's investment in providing secondary and tertiary education opportunities that were never before available.

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[9] The number of qualified physicians in the colonies were so few, relative to the population size, that it would not have been feasible for a more effective policy to be introduced at this time

[10] Created in order to allow Miss Bouwen, the first UK trained Bahamian nurse, to gain more access to policy development and implementation.

[11] Established to replace the costly system of transferring patients requiring more complex medical help to the main islands by commercial flights.

[12] The Health Minister for Trinidad and Tobago reported the same observations following Independence

Another significant health policy in this era was the establishment of the Mental Health Act in 1969, which made provisions for the care and treatment of mentally disordered persons. The landmark event was the launching of the Mental Health Association in 1967 with over 200 inaugural members. The initial aims of the association were twofold, firstly, the education of the public on all matters pertaining to mental health and, secondly, to sponsor an in-depth study of the problem of alcoholism in The Bahamas. A report in 1971 suggested alcoholism was the number one health problem in The Bahamas (McCartney 1971). As a result a council on alcoholism was set up and an alcohol dependency treatment centre established.

While reports of the Chief Medical Officer until the 1960s reflected the emphasis on public health in line with the global health trend of the time, a steady increase in the emphasis on curative medicine became obvious by the early 1970s. Two reports prepared by the Pan American Health Organisation/ World Health Organisation were published as a result of government concern at this emphasis. The major recommendation regarding the health sector was

> *...reorganizing and reorienting it to provide a more comprehensive personal and community health service as well as create and maintain optimum environmental conditions consistent with the development of a concept of "Positive Health" as an integral and important aspect of the Government's social and economic plan"*

The recommendation called for the establishment of a Programme Implementing Level within the Ministry, responsible for direction and supervision of field operations on a national scope through the establishment of two parallel operational divisions: (a) Personal Health Services Division, and (b) Environmental Health Services Division.

Post independence (1973-1992)

The appointment of a Director of Personal Health Services was made through PAHO/WHO in July 1973. The Environmental Health Division was organised from the existing Sanitation Unit of the Public Health Service and the post of Director of Environmental Health Services was eventually filled in 1975. The concept of a separate division or department for environmental health has since been maintained in all subsequent restructuring of health services.

The plan, however, for a Personal Health Services Division for managing hospitals and community clinic services has not been sustained. This original concept called for Personal Health Services to be regionalised. A Northern Region with the Rand Memorial Hospital should serve as the hub for all existing and future health facilities in the islands to the north and a Central and Southern Region with Princess Margaret Hospital, along with Sandilands Rehabilitation Centre, being the central resource for facilities and services in New Providence and the islands at and below this latitude.

A major issue that impeded the implementation of this plan was the magnitude of the institutional problems at PMH. These problems were given priority attention by the Director of Personal Health Services over the development of the community-oriented components of the health care delivery system (McCartney, 1971)[13] in spite of the global emphasis on Health for All. In addition, the national transport and communication systems were not designed to facilitate this type of operation. The hub for all air and sea movement is the capital.

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[13] When the original contract came to an end in 1977, the post of Director of Personal Health Services was never filled.

Executive Management Committees: In 1979, the Ministry had acquired the services of a PAHO Management Consultant, beginning as a two-year full-time in-country placement. This led to a comprehensive evaluation of the management structures and systems throughout the organisation. The lack of co-ordinated management within the institutions was identified as a major problem, resulting in disjointed service delivery, inefficiencies, and abridged outcomes. To remedy these deficiencies the Ministry of Health and Environment (MOH) developed and implemented a new structure to allow for a multidisciplinary team approach to the management of health services. Executive Management Committees (EMC) were formed, beginning with Princess Margaret Hospital and the Rand Memorial Hospital and later Sandilands Hospital. The new management team approach comprised of the Hospital Administrator, Medical Staff Co-ordinator, Principal Nursing Officer and (at a later point) Financial Controller (as applicable). The original plan called for the chair of the committee to be rotated between the team members. The Chair was in effect the most senior in terms of responsibility and representing the institution. Well before this time, the system was noted to have put in place professionally trained Health Administrators who were ready to assume their "rightful" place in the planning and management of health services. In only one instance was there a time when the Administrator was not the Chair.

The concept of EMC was not introduced without resistance. Basically it provided difficulties for the Chief Technical Officers at the Ministry Headquarters who were pushed into a completely different relationship with their counterparts at the institutional level. With time, the Ministry Headquarters gradually withdrew from the direct management of these services to a policy-making, monitoring, regulatory and advocacy role, with direct control of capital development.

Establishment of the post of Systems Analyst: The establishment of the post of Systems Analyst in the Ministry of Health has its significance in the study of key actors in the system who initiate and drive reform processes. This post also resulted from the recommendations of the PAHO management consultant and afforded another level of decision-making within the organisation. Through this office, leadership was provided in the development of a health policy document (Ministry of Health, 1980). Other major developments initiated under this officer included the development and implementation of the first major information system application in the hospitals and the initiation and co-ordination of the Bahamas Health Project.[14]

National Health Programmes: Health Minister Norman Gay played a major part in the establishment of health programmes to change the focus from curative to non-curative heath care services. This policy initiative was fuelled by both regional and global policies and priorities, e.g. Measles Free Caribbean by the Year 2000 and Family Planning Programmes supported by PAHO. The advent of AIDS on the islands triggered the introduction of programmes for reduction in the demand for psychoactive substances. This was undertaken by Consultant Psychiatrist, David Allen and policies for prevention and control of AIDS were led by Infectious Disease Consultant, Perry Gomez and Community Nurse, Rosamae Bain.

Local Health Systems: Local Health Systems developed as a result of the efforts of one Hospital Administrator, Michaela Storr, who had served as Administrator in each of the three hospitals and was based at Rand hospital in Grand Bahama for many years. The aims of the systems were:

- To reduce problems associated with resource deficiencies, maintenance and upkeep of physical infrastructure
- To improve management of materials

[14] The officer responsible for this project, Mrs. Veta Brown, moved through the system in health as First Assistant Secretary, Deputy Permanent Secretary, and Under-secretary. In 1990 she was employed by the Pan American Health Organisation, becoming the first Bahamian professional in that organisation and was recently promoted (June 1999) to Caribbean Programme Co-ordinator, based in Barbados.

- To extend relief staff coverage
- To integrate the fragmented services to residents
- To co-ordinate the different levels of service.

Initially Grand Bahama maintained ten public health clinics that were managed by the Central Offices for Public Health and Community Nursing Services in Nassau. The Administrator, who became increasingly involved in diffusing issues in the clinics, arranged for the Public Health, and later Personnel, budgets for Grand Bahama to be transferred to the hospital so they could be managed locally. In 1985 the situation was formalised and the role of the Management Committee responsible for the Rand Hospital was expanded to a local Health Services Management Committee. The management team was expanded to include representation from Environmental and Public Health Services.

Local health systems were expanded to other pilot islands in 1992 but progress was slower than anticipated due to the heavy work-load of health co-ordinators.

Another major programme developed under the initiative of Storr was the *First Responder Programme* on the Family Islands and the development of the *Emergency Medical System* for the country.

Recent situation (1992-present)

A Maternal and Child Health Co-ordinating Unit was established in 1993 to identify contributing factors to high neonatal and infant death rates, to develop strategies to reduce infant mortality and to improve the quality of care to mothers and children. The multi-disciplinary technical advisory group involved in guiding and monitoring the programme activities introduced the *Adolescent Health Services*, the *National Nutrition Policy* and revised and strengthened the record keeping system. The quality of services provided was positively impacted by the process. In late 1996, the government implemented a policy to waive all fees for Maternal and Child Health Services offered in the public sector. The objective was to improve the antenatal and post-natal coverage.

At present in the Bahamas a number of reforms and general improvements are being introduced into the health sector. These include:
- the devolution of hospital services management to the *Public Hospitals Authority* with effect from July 1999;
- the construction of a new hospital beginning in January 2000;
- the ongoing development of local health systems;
- the legislated National Regulation of Health Professionals with the establishment of the related Council for Regulation in July 1999;
- the licensing and regulation of hospitals and health facilities with effect from July 2000.

The ongoing preparatory work for these initiatives involves the assessment of national needs for human resources and human resources development in health. The development and implementation of a human resource plan includes a comprehensive training and development plan, and the identification of opportunities for partnering with other institutions for staff training and development. It also involves the review, development and implementation of standardised management systems including a performance evaluation system and the identification and application of appropriate resources and information systems. The development of supporting regulations to relevant Acts passed in 1998 that monitor and control the practices of health professionals was required.

Health Financing Policy

The Chief Medical Officer, back in 1973, emphasised that, while there was no change in the system for financing the Health Services, there was "certainly developing an increasing awareness of the need for a more realistic fee-based approach in the provision of health services" (Ministry of Health 1973).

Options for a National Health Insurance scheme

In the light of escalating costs for health care, The Bahamas, over the past 10 years, has been considering and actively pursuing appropriate solutions to implementing other mechanisms for providing the recurrent and capital funds for the operation and development of health services throughout the public sector.

A working party, made up of persons drawn from the public and private sectors and representing a cross-section of the community, was formed in 1988 to develop a proposal to finance health care. After extensive research and great consideration, a proposal was prepared and submitted to the government following a period of extensive research. Specific recommendations (at that time) included:

- Compulsory contributions from the adult working population (15 - 65 years)
- Children (0-14 years) and the elderly (65 years and over) to be exempted from paying contributions
- The introduction of a health levy, paid on a ceiling of $26,000 annual income
- Cost for care of the indigent to be paid from the consolidated fund.

The plan, known as the National Health Insurance Plan, was to be implemented in stages with Phase I providing for In-Patient hospital care.

While the services covered by the National Health Insurance Plan appealed to the general public and allowed for private medical insurance plans, it was criticised strongly by the Medical Association of the Bahamas. The physician group contended

- that the numbers of individuals exempted from paying mandatory premiums were too large;
- there were no constraints to service utilisation and hence the costs of delivering the care would be exponential;
- it was unacceptable to exclude out-patient services as a covered benefit;
- the lack of remuneration for those health care professionals not included in the initial phase was unacceptable.

The Report of the Medical Association on the proposed National Health Insurance scheme resulted in formal discussions between the working party and the Association with the production of an *ad hoc* committee report. The government, as a consequence, agreed to cover outpatient services. However, with a change of government in 1992, the National Insurance Plan was shelved[15].

The Bahamas Health Project Policy paper indicated a need for alternative means of financing in support of decentralisation and the devolution of hospital services. These recommendations emphasised that funding of any devolved unit must be in accordance with national health priorities established by the Ministry of Health. These directions would be severely compromised unless a method was found that was both administratively and legally sound to

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[15] The implementation of a National Health Insurance Scheme was a prerequisite to securing a loan to build two new government hospitals in Nassau and Freeport. As the new government proposed to renovate and upgrade the existing facilities without a major capital outlay, the National Health scheme was shelved.

consolidate funding flows from the Health Insurance Commission, Deposits Fund and third party insurers, and distribute them to the devolved authority on a prospective global budgeting basis. As a result of these recommendations two optional frameworks were proposed. The first generally followed the administrative structures preferred by the working party of National Health Insurance while the second proposed changing administrative structures to bring the Health Insurance Commission within the responsibilities of the Ministry of Health. The Health Project succumbed to a similar fate as the National Health Insurance scheme. It was an integral part of the government's political platform and the newly elected government shelved the project.

In the Speech from the Throne 1999, the government announced the revisit of a National Health Insurance initiative through the National Insurance Board. The options of a national health plan along with other alternative means of funding health care are currently being evaluated by the Ministry of Health.

The role of the private sector

Given its proximity to the US, developments on medicine and health services are strongly influenced by the American model. There is a substantial private sector in The Bahamas, raising questions of what should be the appropriate relationship between public and private sectors. The case-study below outlines a partnership initiative that appears to have had significant benefits for both public and private partners.

Case study: Selective Privatisation

This case study describes the evolution of a unique partnership between the private and public sectors in health care and suggests reasons behind its successful integration into the health care system of The Bahamas.

Conception
The term *selective privatisation* was introduced by a group of physicians and the Executive Management Committee of the Princess Margaret Hospital. This was a unique concept in which the Ministry of Health agreed to enter into a partnership with a group of its physician employees to invest jointly in the delivery of select health care services in the Princess Margaret Hospital and share in any benefits and profits that would accrue. The evolution of this concept can be traced back to the 1990s. The need to provide state-of-the-art technology in the Princess Margaret Hospital became apparent as increasing numbers of trained Bahamian physicians returned home from their post-graduate training programmes, eager to utilise their acquired skills in diagnostic, endoscopic and minimally invasive procedures. State owned tertiary health care institutions lacked the required “high tech” equipment, supplies, and the capability to maintain and upgrade them. Furthermore, the limited capital budget of the Ministry of Health precluded timely purchase of the desired modem technology and the cumbersome bureaucracy of the Ministry further complicated the process.

Initiation
A group of physicians employed at the Princess Margaret Hospital formed a corporate entity, *Physicians Alliance Limited*, with the expressed purpose of providing the capital to purchase the desired state-of-the-art technology. *Physicians Alliance Limited* proposed a partnership with the hospital in which it would provide the capital fund for the technology, the required training of personnel and the maintenance of equipment as well as the management of the newly created services. The hospital, for its part in this partnership, provided the physical site, utilities and security and payment of the initial customs excise duties. *Physicians’ Alliance Limited* pledged to provide full accounting, transparency and responsibility in its management of the services. The Company proposed that, if any profits were generated in the provision of the services, they would be shared on a 50-50 basis with the hospital.

Ideology
Physicians Alliance Limited set out to ensure the affordability, accessibility and availability of quality health care services to both the private and public patients in the hospital. It proposed to charge nominal fees comparable with the *Gazette* fees for both public and private sector patients. Consistent with the Government philosophy of health care for all regardless of their ability to pay, the Company committed to guarantee that no patient would be denied access to its services.

The Company recognised the importance of maintaining and upgrading equipment and the training of the appropriate allied health care professionals to the success and sustainability of this venture, and made this an integral part of its proposal.

Priorities
In its initial proposal the company identified general diagnostic ultrasonography, non-invasive diagnostic cardiology, colposcopy and later minimally invasive endoscopic surgery, as the essential needs to advance medical care in the hospital. This first public/private partnership health initiative was inaugurated in 1991. It was aptly termed *Physician Alliance Diagnostics* and the service area was called *Diagnostics*.

During the renovations of the Private Wards in 1994 and 1995*, Physicians Alliance* made a proposal to capitalise and manage

the establishment of the private operating theatres and obstetric suites under a similar partnership agreement with the Ministry of Health as it had with the hospital in the Diagnostic Unit. In January 1995, *Physicians Alliance Limited* and the Ministry of Health signed a 'Memorandum of Understanding' setting out the terms of the partnership between them.

Expansion
After the successful completion of the private operating theatres and obstetric suites in April 1996, the hospital's administration, recognising the need to integrate all private in-patient care, requested the company to assist in the management of the private wards. This integrated private in-patient care became the Private Services of the Princess Margaret Hospital. The Directors of *Physicians Alliance Limited* incorporated *Physician Alliance Management Limited* to be the corporate entity for this arrangement.

In April 1997, the Government purchased all the diagnostic assets of *Physician Alliance Diagnostics Limited* in order to remove any legal ambiguity to *Physicians Alliance's* involvement in the delivery of care to public paying patients. Nevertheless, the partnership in the delivery of care to private patients in the private operating theatres and obstetric suites and the private wards remained intact.

Investment and sustainability
During the partnership in the Diagnostic Unit, the company contributed over $800,000 toward continuing education of physicians, nurses and allied health professionals, scholarships for ultrasonographic technicians, and assisted with the purchase of hospital equipment and supplies and unit renovations.

Physicians Alliance Management Limited has continued its commitment to advance and upgrade all aspects of health care delivery and the physical plant, and the allied health care providers. In addition to assisting in the overall improvement in the delivery of health care services in the public institution, in the year ending 28 February 1998 alone, the Company has contributed over $78,000 to improvements in the hospital, over $12,000 in education of nurses, physicians and allied health professional and over $20,000 to community service programmes.

The public/private health initiative between the Company, the Ministry of Health and the Princess Margaret Hospital has allowed physicians to have a greater input into the delivery of health care services in the Commonwealth of the Bahamas.

Human Resources

In this section the development of health human resources is described within two important categories of health professionals, nursing and medical staff. Problems related to human resources management are discussed.

Nursing Profession

In 1902, the Midwives Act provided for training, examination and registration of Midwives. Prior to this, midwifery was an active practice by the "grannies" or traditional birth attendants. These were women who were recommended by the Priest, Justice of the Peace, Commissioner or Teacher, based on reputation. The "grannies" were untrained but had acquired delivery skills through experience and observation of peers. The Act allowed midwives who had been granted certificates to work in any part of the Bahamas and licensed midwives, "grannies" and untrained midwives to work in certain Districts in New Providence or specific areas of the Family Islands.

The first record of formal training of health professionals in The Bahamas was in 1902 with the registration of four nurse/midwives in 1906. In 1957 a structured nurse training programme was introduced at the Princess Margaret Hospital (PMH). It has been suggested that the move to train black native Bahamians was the result of an escalating pressure from the newly formed Black majority political party to improve the health infrastructure and provide opportunities for the development of young Bahamians.

Hilda Bowen, the first Bahamian trained under the British Council's Colonial Nursing Scholarship, completed her six years of nurse training and experience in 1952. While she met the prerequisite for posting as a nursing sister at the Bahamas General Hospital, there was what seemed to be unnecessary delays in her appointment. In a report of an interview with Miss Bowen, Jeanne Gibson writes:

> *"In 1952, when she (Miss Bowen) wrote of her intentions of returning home, the replies she received from health authorities were negative and all sorts of excuses were found, such as no vacancies and more experience being necessary. Miss Bowen was determined to return home, however. Therefore she wrote to the Governor of the Bahamas, who took the necessary steps and one year later she returned home to The Bahamas, where she was destined to make a mark on the nursing profession in the Bahamas and somewhat revolutionize the delivery of health care on these islands"* (Nassau Guardian 1983).

The acceptance of a Bahamian nurse in the post of sister marked the beginning of a movement to raise the status of Bahamian nurses[16]. Several nursing positions were created including Principal Matron (1965), Chief Nursing Officer (1970) and Director of Nursing (1980)[17] which allowed Miss Bowen the opportunity to have a major impact on the nursing profession as its representative in the Ministry.

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[16] Nursing policy in the period of self-rule (1956-1973) was dominated by the desire to raise the status of Bahamian nurses while maintaining close ties with the United Kingdom nursing profession.

[17] Up until 1964, the most senior nurse was the Matron at PMH.

The first trained tutor was appointed from the UK in 1957 to facilitate the establishment of a school for nurses. As a pre-requisite for a reciprocal agreement for training with the General Nursing Council for England and Wales, the upgrading of the clinical areas was carried out and staffing levels reviewed and improved. The training of clinical nurses (the second level) was established in 1962. This level of personnel assisted in the delivery of basic nursing care under the supervision of the registered nurse, equivalent to the Enrolled Nurse in the UK. By 1964, the nurses trained in the Bahamas could apply to the General Nursing Council of England and Wales to further their training by completing the registered nurse programme (U.K.) in one year.

A number of post-basic nursing courses were developed in this period. Curricular were developed in keeping with the expected professional role of the nurse and the changing needs of the society. The courses included:

- The one-year post basic midwifery training (1971).
- The post-basic Community Health Nursing Programme (1972) (Prior to this period, nurses received in-service awards to pursue studies outside the Bahamas).
- A psychiatric programme for Trained Clinical Nurses (1974) with technical assistance from PAHO/WHO
- A post-basic nine month psychiatric programme for Registered Nurses (1983).
- A structured 6-month Maternal and Child Health programme for the Trained Clinical Nurse, which was conceived in 1984, designed and commenced in 1985 and completed in 1986.[18]

Although these efforts were made primarily to raise the status of nurses, the profession remained weak. This is evident from the extended period, 27 years, it took from the time it was recognised that nurse education would require a building of its own to the opening of the newly constructed, modern, School of Nursing facilities in 1987. Efforts made during this period included holding meetings and submitting position papers with the aim of convincing those in power of the need and the investment required for this venture.

The registered nurse (Diploma) programme continued with ongoing curriculum revision and a major change was made in 1988 when the block system was replaced by the semester system. This course was eventually phased out after the establishment of the Arts Degree in Nursing, which began in 1984 and was the first course in nursing to be conducted at the College of the Bahamas in the Natural Sciences Division. The initiative to include nurse education at College level originated from the WHO initiative, Health for all by the Year 2000, and is aimed to further raise the status of nurses. While the establishment of a nursing school took 27 years to be implemented from the first recognition of its necessity, the transferring of the nurse education to a higher education facility took only two years, reflecting the increased influence of the profession, and the weight given to international views on nurse training and practices in the US and UK.

Human Resources Management

Problems related to Human Resources Management were unveiled following an assessment resulting from the Bahamas Health Project in 1989. The conclusion of the assessment summarised the wide slue of concerns in this regard. Problems related to recruitment/appointments, classification/compensation, employee relations, manpower planning/career progression and training/development were identified. Typically, it was argued, the decisions the authority made and the action it took was too far removed from the work site in terms of both time and physical location. The overall conclusion was;

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[18] For some reason (not as yet uncovered) this programme has not been repeated.

> *"The systems and processes in place for Human Resource Management within the Ministry of Health, and the Government of the Bahamas generally, are systems oriented as opposed to people oriented, and are not effective"* (Ministry of Health 1989).

Decentralisation was recommended to address these concerns. These proposals were placed on hold in preparation for the elections of 1992 and were shelved following the subsequent change in government. The new Minister of Health came to the job with a wealth of training and experience as a retired educator and human resource specialist. She placed special emphasis on developing a modern comprehensive Human Resources Management system in the Ministry of Health. As a result a Human Resources Development Unit was established within the Ministry.

In general, as a result of the geographical and demographic features of the country, The Bahamas meets challenges with respect to the supply of professionals that are particularly acute for Nurses and Allied Health Practitioners such as medical technicians. We found it interesting to note, in comparing our national situation with some of the statistics provided in the literature, that while the Bahamas physician ratio of 1 per 613 population is in line with levels from developed countries, nursing numbers are well below the indicated standards. For example, in the Bahamas' public sector the number of hospital nursing staff per bed averages 0.55 nurses per bed (which is well below the 0.92 lower range for the U.K. or the 0.8 minimum proposed for Trinidad). While the number of physicians in the public sector increased by 27% over the last 5 years, our nursing stock increased by only 6.2% between 1994 and 1998 [19]. The Human Resources Management Policy addresses these challenges by recruiting health professionals, including physicians and nurses, from abroad on a contractual basis. Various initiatives used have been the recruitment of a pool of persons on contract from Barbados, commenced in 1997 with the support of the Barbadian government, and the cross posting of personnel between The Bahamas and Canada. This project allows for a nursing exchange programme that addresses the need for simultaneously supplying and training specialty nurses for neonatal intensive care.[20]

Compounding the human resources problems in The Bahamas is the competition for available staff from the private sector resulting in high attrition and moonlighting levels. Private sector health care is significant and is anticipated to grow even further. Therefore, the Bahamas' Health Services Plan being completed for 2000- 2004 is investigating the use of strategies for sharing the costs of health manpower training with the private sector and for the development of private/public partnership options.

Medical profession

Advances in the delivery of health care services in the Bahamas reflect the increasing number of Bahamian physicians who have returned home to practice medicine over the last 20 years. More than any other, Bahamian physicians have been the catalyst in initiating and shaping health care policies and health reform initiatives in both the private and public sectors.

There are several notable features of this group of health care providers:

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[19] The number of nursing graduates annually was very low, equalling 20, 15, 11, 36 and 40 between 1994 and 1998, respectively.

[20] This initiative, still conducted on an experimental basis, is proving to be very effective and is being evaluated for extension to other areas of need.

- *They were patriotic.* They are the direct products of the first majority rule government of the 1967 elections. As the first recipients of the academic scholarships issued by the new government, for studies locally and abroad, the returning physicians were charged with a patriotic commitment. They perceived themselves as instruments of change in advancing health care for the Bahamian people.
- *They were predominantly specialist trained.* The current profile of the Bahamian physicians indicates that 40% have completed specialist training from developed countries, principally Britain and North America. Hence the returning physicians agitated for "First World Medicine" - high level technology-based and consumer driven. Hence, the newly returning physicians were motivated to modernise medical services in the Bahamas.
- *The returning physicians were predominately medical graduates of the UWI.* The Bahamian government became a contributing territory to the UWI and as such medical education was accessible to all Bahamians. More importantly, the clinical training and Third World imprint contributed to their return to the Bahamas despite their postgraduate training in the developed countries. They were familiar with the health care system in the Bahamas and were prepared for the challenges of change in a developing country.

Underlying the above factors was the guaranteed market available for the Bahamian physician on his or her return. There was a need for physicians in general. The physician ratio in the Bahamas in the 1960s was in excess of one physician per 2000 population. Speciality trained physicians were scarce and there was a need for specialists in every discipline. Bahamian physicians, in particular, were few. In 1967, of the total physician population only 20% were native Bahamians.

In addition, the Bahamas was experiencing an economic boom at the end of the 1960s and the 1970s. Bahamians were being influenced by, and were rapidly developing, the American health culture of consumerism and 'high tech' medicine. As a result, Bahamian physicians training abroad focused on returning to the Bahamas. There was a market for doctors, in particular the native sons, and there was a viable segment of Bahamians who could afford to pay for their health care services. Hence, over the past thirty years there has been a continuing and increasing number of Bahamian physicians returning permanently to practice medicine.

The other notable feature of the profile of Bahamian physicians is the fact that the returning physicians have been employed in both the public and private sector. This applies particularly to specialists of whom 70% are employed in both private and public care. This involvement ensured that the advances in private health care were matched by similar changes in the public sector. Physicians were committed to minimise inequalities in health care delivery between their public and private patients.

Bahamian physicians were directly responsible for initiating, directing and sustaining government policies within the Ministry of Health. The following policies could be attributed directly to their efforts:

- *The establishment and sustaining of a faculty of medicine at the PMH*, thus formalising the status of the PMH as a teaching centre. The PMH as an academic centre improved the quality of medical care, expanded health services and provided an opportunity for Bahamians to undertake a medical education at home. The following sequence of events occurred:
  - 1989 The establishment of the PMH medical library as a community library of the University of Miami Medical library. This provided access and availability of a formal library facility at the PMH through the electronic media.
  - 1993 The establishment of the Office of Continuing Medical Education (CME) with a Director and full time administrator. A formal CME programme was scheduled with an annual calendar of events, integrated departmental lectures and a system for allocating

CME credits.

- 1995 The establishment of a clinical training program for the American University of the Caribbean to provide clinical training of medical students in their last two years of their undergraduate medical degree programme.
- 1997 The establishment of a Faculty of Medicine of the UWI at the PMH, to provide the final two years of clinical training of medical students in their undergraduate medical degree programme.
- 1999 The successful graduation of the first Bahamian doctors trained in the Bahamas.

- *The establishment of the PMH as an acclaimed medical research centre*. Hypertension research under the direction of Dr. John Lunn, AIDS research under the leadership of Dr. Perry Gomez and Anaesthesiology research led by Dr. Glen Beneby are conducted at the PMH.

- *The Selective Privatisation of the PMH services* (see earlier Case Study)

- *The establishment of the Medical Advisory Committee for the physician staff services and responsibilities regulated by physicians*. There was an increasing number of Bahamian physicians employed in the tertiary care sector including those specialists trained in North America. From this group a challenge was made to the traditional British hierachical system of physician deployment and guidelines. Rather than the British influenced consultant-longevity model, the physicians agitated for the North American residency staff-physician model. The system allowed for greater influence of physicians in hospital management and self-regulation at the hospital level as opposed to the bureaucracy of the Ministry of Health.

- *Creation of a National Health Promotion Programme*. The Medical Association of the Bahamas in collaboration with the Ministry of Health designed a ten week programme for Bahamians to incorporate healthy lifestyle behaviours. This national health initiative was called 'Here's to Your Health, Bahamas'. A nurse-physician health team evaluated participants for ten designated parameters of good health initially, and then at the end of the ten week period of health promotion and education involving mass media education programs, health walks, public seminars and lectures and a non-smoking campaign. Private and government businesses were invited to enrol their employees as a group and compete for the Healthy Company Awards. From 12 Bahamian Island communities 6,217 residents participated in the programme, and 35 companies registered for the Healthy Company Award competition. The national programme was self-funded: $75,331 US was generated from corporate sponsorship and company registration fees, thus balancing the projected budget. The programme showed that Bahamians are willing to undertake healthier lifestyles if so informed and educated, and the programme's success led to the formalisation of a health promotion unit within the Ministry of Health.

Summary of Health Policy Events

The following table chronicles a key (but not exhaustive) list of health policy events.

Table 3.1. A Summary of Health Policy Events, The Bahamas, 1952-1999

Date	Policy event
1952	Opening of the new Bahamas General Hospital. (Name changed to Princess Margaret in 1956)
1953	Return of Ms. Hilda Bowen, 1st Bahamian trained nurse under British Council's Colonial Nursing Scholarship. Returned to Bahamas as Nursing Sister
1955	Opening of the first private hospital "The Rassin Hospital". Dr Meyer Rassin was sole owner and it only served his patients. Mrs Rassin administered nursing care
1956	Opening of the new Sandilands Mental Hospital
1957	Nursing training became a structured programme with the first preliminary training of students in PMH
1960	Start of Flying Doctor Service to the Out islands (ended in 1978)
1961	Opening of the East Wing Extension of PMH, which comprised children's ward, eye wing and laboratory services
1962	Opening of the King George VI Memorial Chest Wing. Tuberculosis patients were transferred from Prospect Ridge Hospital
1963	Opening of the Catholic Clinic on Young Street (later renamed the Hardecker Clinic). It placed emphasis on teaching better health habits
	JAN 7, 1964 THE BAHAMAS GAINED COMPLETE INTERNAL SELF-RULE
1964	Establishment of a Ministry of Health under a Minister (as opposed to the Health Board under Imperial government). First minister was Peter Graham
1965	Opening of the new Geriatrics Hospital
1965	The Bahamas Nursing Body received reciprocity from the UK
1966	School Health Service Programme reorganized
1966	Health education of the general public was emphasized
1966	Formation of the Mental Health Association
	JAN 10, 1967 GENERAL ELECTION USHERED IN BLACK MAJORITY RULE UNDER
1967	Milo Butler became Minister of Health
1967	Escalated access to scholarships in Medicine and Nursing
1968	Trained Clinical Nurses Programme started
1969	Curtis McMillan became Minister of Health
1969	*Mental Health Act*: to provide for the care and treatment of the mentally ill, including those suspected of criminal acts while in such state
1971	Rand Memorial Hospital came under the responsibility of the Bahamas Government

1971	*Nurses & Midwives Act*: to provide for control of the training and practice of clinical nurses and midwives, for the registration of nurses and midwives and the enrollment of clinical nurses (revised 1974)
1971	Department of Nursing Education established (prior to this training came under PMH)
1972	Loftus Roker became Minister of Health
1972	National Insurance Scheme instituted on a purely contributory basis, though it did begin paying out small old age pensions and other non-contributory social benefits between 1974 and 1979 (by 1981 it could boast a fund of $122 million)
	JULY 10, 1973 INDEPENDENCE DAY
1973	Bahamas became a member of the International Council of Nurses
1974	Bahamas officially admitted to full membership in WHO and PAHO
1974	*Health Services Act* (created l914. Other revisions: 1920,1926, 1928, *1947,* 1962,1963,1964). Further revisions 1975,1976, 1987, 1998 Revised *Opticians Act* (created 1934, other revisions 1964 and further revisions 1987). Revisions to the act for the registration of Opticians, to regulate the practice of sight-testing (and in 1987, purposes incidental thereto)
1974	Revised *Dangerous Drugs Act* (created 1939, revised 1959, 1962, 1964, 1971) Revision to the act to regulate the importation, exportation, manufacture, sale and use of opium and other dangerous drugs
1974	Revised *Pharmacy Act* (created 1962, revised 1964, 1966) Revision to the Act for the licensing of Pharmacists and for the control of the sale and distribution of drugs and poisons
1974	Revised *Mental Health Act* (recreated 1969) Revision to the act to make fresh provision for the care and treatment of mentally disordered persons and with respect to their property and affairs and for purposes connected therewith
1975	*The Medical Act* An Act to make new provision for the practice of medicine and surgery, and for related purposes
1976	Official opening of the new ambulatory care department comprised of the outpatients department, accident & emergency department, specialist clinics and new modern radiological department
1977	Perry Christie became Minister of Health
1978	The Bahamas (and other WHO member states) adopted the Global Strategy for *Health for All by the Year 2000*
1978	Establishment of the Health Statistics Unit in the Ministry of Health
1981	Expansion of Primary Health Care
1982	Levingston Coakley became Minister of Health
1982	Establishment of Hospital Management Committees starting at PMH and Rand
1983	Establishment of National Drug Council
1983	Establishment of associate degree programme of Nursing at the College of the Bahamas
1984	Norman Gay became Minister of Health
1984	Construction of first set of modern polyclinics funded by the National Insurance Board
1985	Establishment of the NGO, Bahamas Family Planning Association

1985	Delegation of management of Community Clinic Services in Grand Bahama to hospital management
1986	Group of doctors purchased The Rassin Hospital. It was renamed *Doctors Hospital*
1987	Revised *Penicillin Act* (created 1948) Revision to the act to control the sale and supply of penicillin and certain other substances
1987	*Environmental Health Act* : to promote the conservation and maintenance of the environment in the interest of health, for proper sanitation in matters of food and drink and generally, for the provision and control of services, activities and other matters connected therewith or incidental thereto.
1988	Construction of present School of Nursing
1988	Preparation for the establishment of a National Health Insurance scheme
1989	AIDS Secretariat established
1990	Charles Carter became Minister of Health
1990	Establishment of post of Health Administrator for Public Health Department
1991	New management structure for Community Health Services

OCT. 1992 CHANGE IN GOVERNMENT (FIRST IN 25 YEARS)

1992	Ivy Dumont became Minister of Health
1992	New emphasis on strengthening national programs for Maternal and Child Health and start of Infant Mortality Reduction Project and Adolescent Health Programme
1992	Piloting of Local Health Systems based on UK model
1993	Pilot Health Promotion Programme – *Here's to your Health Bahamas*
1993	Eco-Tourism emphasis
1994	Establishment of Bahamas Environment Science and Technology (BEST) Commission
1994	Government gave support to the proposal for "Selective Privatization"
1995	Health Services Division created within the MOH, headed by a Minister of State, delegated responsibility for Hospitals and for Environmental Health Services
1996	Theresa Moxey-Ingraham became Minister of Health

1996 IMPLEMENTATION OF LOCAL GOVERNMENT IN GRAND BAHAMA AND FAMILY ISLANDS

1996	Establishment of National Reproductive Health and Family Planning Policy and programme (in tandem with the Bahamas hosting the Caribbean Population and Development Meeting: Follow-up to ICPD)
1997	Ronald Knowles became Minister of Health
1997	The Department of Environmental Health Services (including vector control, health inspectorate and waste management) moved to another ministry

MARCH 1997 GENERAL ELECTIONS

1997	Establishment of Bahamas location of UWI Medical School's Clinical Programme

1998	*Health Services Act*
1998	*Public Hospitals Authority Act:* to provide for the establishment of a Body Corporate to be known as the Public Hospitals Authority and for the functions relating to that Authority and to make provision in respect of matters connected therewith or ancillary thereto
1998	*Hospitals & Health Facilities Act*: to provide for the Licensing of Hospitals and Health Care Facilities and for matters incidental thereto
1998	*Health Professions Act*: to provide for the establishment of a Council for the regulation of health professions, the performance of services by members of those professions and for purposes connected thereto

CONCLUSIONS

This research project has crystallised an understanding of the scope of health policy evolution over the history of the development of the Bahamas, and provided insight into how health policies are formed in this country and the type of factors that impact their success. In particular we reflect on the change in ideology from Nationalism to Globalisation, recurrence of familiar policy themes, and suggest possible explanations that trigger the conception and more importantly the implementation of reforms into the health sector.

Nationalism and Globalisation

Most interesting (and perhaps somewhat ironic) in all this is to recognise that back in 1973 with Independence, the single most appealing concept of the then government of The Bahamas was the policy of *Bahamianisation*. While today, as the nation enters into the new millennium, without question, the overriding theme is one of *Globalisation*. In the early era, highest attention was placed on preparing Bahamians (and Bahamians alone) and providing opportunities for them to assume their full role at every level of the social and economic affairs of the country. In the health sector this policy translated into the expansive growth and development of the medical, nursing and allied health professions and professionals. Today, the Bahamas, like its sister Caribbean territories and its big brother regional and international nations, is just on the edge of major restructuring and revamping of policies and processes to bring them in line with the eminent globally-occurring developments for common markets and free trade. The challenge is to move away from insular to outward-looking deliberations and policies.

Recurring policy themes

Another observation from this exercise is the recurring nature of policy plans over time. We have seen this in the theme proposed for *Regionalisation* back in 1972. This theme is back on the drawing board in 1999 as a possible solution to the problems of manning, managing and strengthening the quality of health services in the face of the difficulties of remoteness. We also note that the theme of *decentralisation*, extensively developed back in 1989, has come full circle and is now taking hold in 1999. The concept of a *National Health Insurance Scheme* (which involved a ten-year process of development before the report of the task force for the scheme was presented in 1988) is now reaching the planning tables again as the government seeks alternatives to its health financing challenges.

Explanations/triggers

The question is to determine to what extent timing and the state of readiness (and other factors) play in policy implementation versus the argument that the most significant factor in government health care policy is the will of the government. With respect to the role of the state and changes to it, the experience does exist, even with the one turn over in government that this country has seen since independence, where policies on the drawing board or about to be launched were shelved with the new government.

The politicians, particularly in their capacity as government Ministers, have been the most influential. The political agenda was often directed at developing the physical plant, the immediately visible elements of the health care system, which would appeal more to a voting public. The legacy of the Minister was the unveiling of newly built public clinics, commissioning or additions to the hospitals, or showcasing new medical technology and equipment. In most instances the physical development preceded the human resource

requirement. There were insufficient numbers or inadequately trained health care professionals. In some instances turnkey operations remained closed for more than a year and unused equipment became obsolete. The political intent was transformed into wastage and inefficiency.

There are many different actors in policy formulation and implementation. The contributions and impact in initiating, directing and influencing health policies have come not only from government agencies but also individuals, non-government groups and in some instances the wider community.

From the health care professionals the policy directive can be "trickle up". This research has demonstrated a goodly number of instances where the movers and shakers of some very significant developments were the professionals in health including administrators, physicians, nurses and others. Administrators have single handedly introduced the integrated health systems approach to health care delivery, a model for advancing primary and community health care services. Our first Bahamian matron established a blueprint for nursing education that has propelled nursing education for almost fifty years. The physicians have emerged as in the vanguard of privatization in health and their current efforts may resuscitate previous initiatives for a National Health Insurance programme. Indeed private medicine overall in the Bahamas has thrived. The new Doctors Hospital, the 'walk-in' clinics, the comprehensive clinics and state of the art technology are testimonial to physicians shaping the culture of modern medicine in the Bahamas. These efforts have been recognised by the government as new legislation concerning health facilities, hospital devolution and the Medical Act for physicians dominated health politics in 1997 and 1998.

The proliferation of allied health professionals has not gone unnoticed. The Allied Health Professionals Act has emerged to regulate their status. The expansion of the health team will dictate yet again new policies for patient care. As traditional physician services are challenged and undertaken by non-physicians, health professional organisations will be strengthened and emerge as major lobbying groups. The status of nurses is rising as post-graduate nursing education is given higher priority and more nurses are sent to upgrade their management and clinical skills in the UK and the US. The evolution of health reforms in the Bahamas has shown that the role of individuals is likely to yield to professional groups becoming the dominant figures in initiating and directing health policies and government will assume more the role of setting standards and regulations.

The proximity of North America and its health care system and culture has indelibly influenced the Bahamians at large. Bahamians desire an American-style health care delivery system. The expectations of the Bahamian public has shaped the government's policy in health care. Health services readily accessible in Florida and the physical ambiance of their health facilities have become the bench mark of good health care for Bahamian health care workers to emulate.

Unfortunately the health profile of the Bahamian public reveal lifestyle related diseases are the major determinants of morbidity and mortality. Government budgetary allocations continue to favour tertiary care curative medicine as opposed to health promotion, education and prevention. The health promotion craze is yet to be established in the Bahamas, despite an initial national effort six years ago.

The educational investment by the Bahamas government has paid dividends: the Bahamian professionals returned after training abroad and they have impacted significantly in reforming health service delivery in the Bahamas. During the first 25 years of its Independence, the Bahamas experienced a positive growth in the number of all health care professionals, as opposed to the vexing "brain drain" that has crippled the development of most small nation states in the region.

EDITOR'S POSTSCRIPT

The authors have identified many influences in common with the findings of the other studies. Global influences identified have been the global trends for nationalism followed by globalisation and along with it the culture of health consumerism imported from neighbouring America. Health policy has also been influenced by tourism, world travel and the global economic climate and that of the US in particular. As the Bahamas' revenue through tourism and off shore investment rises and falls, funds available for health care fluctuate. Health policies in the Bahamas have been shown to be influenced by global trends in health policy and priorities e.g. public health, primary health care, regionalisation, decentralisation, national health insurance, private/public partnerships, which help to legitimise initiatives for policy implementation.

The study clearly demonstrates the role of dynamic individuals. Many names crop up throughout the study, all of whom have left a legacy on health policy in the country.

While the Bahamas is renowned for its stable government, it was noted that with one change of government, plans from the preceding one were shelved. This observation is consistent with those of Trinidad and Tobago, Martinique and Suriname. National political influences are apparent. As in Trinidad the high profile investment in health infrastructure favoured by Health Ministers preceded any investment in human resources, a less visible activity. The coming to power of the Black majority party had a very significant effect on health reforms in the Bahamas.

This study highlight areas in which the Bahamas stands out from the other research territories. A strong medical profession working *with* the government for the benefit of the people is the picture portrayed by the authors. This is displayed in the unique relationship between private and public health services, and the absence of a significant out migration of doctors. It can be argued, however, that the emphasis on curative services at the expense of heath promotion and primary health care programmes was influenced by the medical profession who favour high technology medicine, and this is perhaps one explanation for the relatively poor health status of the Bahamas population, relative to its income level.

The legacy of Colonial administration is more than evident. The English language has opened up the possibilities for international and regional ventures, unlike in Suriname and Martinique. Training of Bahamians abroad or in institutes affiliated with the UK have shaped the practice of medicine, and the more recent closer relationship with the US has contributed to an emphasis on curative and high technology medicine and a culture of health consumerism.

AUTHORS' POSTSCRIPT

By way of a final personalised word, we are compelled to evaluate the experience in undertaking this health research initiative in terms of what we see as a clear value to those among us that are active advisers and decision makers in the system in this country in the here and now. The value of having gone through the process of uncovering the information discovered and putting our minds to understanding it cannot be matched with the experience of only being able to read, evaluate and learn from a work completed by others. So much cannot be provided in a report because of time, sensitivities, articulation and other constraints. Yet so much is now highly relevant and will significantly impact conclusions to be reached in the ongoing practice of our professions.

A recommendation possibly imbedded in all this is for academic and professional research agencies to seek more opportunities to directly involve active leaders in public sector services in research endeavours.

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APPENDIX: BASIC HEALTH INDICATORS

DEMOGRAPHIC INDICATORS

Indicator (rate/000 pop.)	1975-79	1980-84	1985-89	1990-94	1994	1995
Annual av. Pop.	197	218	240	264	274	278
Estimate of annual av. Birth's '000	4806	5860	5888	6369	6104	6253
Crude birth rate	23.1	25.5	24.5	22.4	22.4	22.5
Crude death rate	5.3	5.5	5.7	5.6	5.6	5.7
Life expectancy Males Females	 63 71	 66 74	 68 75	 69 76	 69 76	 69 76

MORTALITY

	1975-79	1980-84	1985-89	1990-94	1994	1995
IMR*	29.1	23.2	23.8	22.1	19.7	19.0
Peri-natal mortality *	30.1	22.2	19.6	22.7	22.8	19.4
Neonatal mortality *	18.5	14.8	14.5	13.8	10.8	11.5
Still births*	14.1	9.2	15.8	10.9	12.9	10.7
Child mortality per 1000 children 1-4 years	1.0	1.2	1.1	0.9	1.2	0.4
Maternal mortality per 10,000 births	1.7	0.5	2.8	1.6	1.6	4.8

* per 1000 live births

REGISTERED DEATH RATES PER 100,000 POPULATION

Causes	1975-79	1980-84	1985-89	1990-94	1994	1995
Both sexes						
CVD	90.0	97.3	106	94.4	92.7	102.9
AIDS	-	-	17.2	62.2	88.3	97.1
Cancer	74.2	96.2	104.0	81.4	86.8	85.3
Trauma	65.0	69.4	71.4	53.3	65.2	39.8
Diabetes	15.1	16.8	29.5	28.3	34.8	36.2
Males						
AIDS	-	-	19.6	78.4	115.1	130.6
CVD	100.6	121.3	117.9	97.9	86.0	103.0
Cancer	79.3	110.8	119.6	87.9	96.4	91.4
Trauma	89.1	101.1	101.9	88.6	113.6	66.8
Diabetes	9.2	12.8	23.1	18.8	20.7	29.8
Females						
CVD	79.7	82.3	94.5	91.0	99.1	102.7
AIDS	-	-	12.9	46.5	62.5	64.5
Cancer	69.2	82.4	88.8	75.2	77.6	79.3
Trauma	41.2	37.6	32.8	19.5	18.7	13.5
Diabetes	20.9	21.0	35.2	37.4	48.1	42.5

Source: Department of Statistics