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PROSPECTS FOR CARIBBEAN HEALTH**
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Mr. Chairman. This Conference deals primarily with U.S.-Caribbean relations and in speaking of Caribbean health in this context I will begin by recalling two vignettes related to the U.S., the Caribbean and health. So much of the traffic and aid is from North to South, sometimes it is good to know of some reverse flows.

In 1765 one Dr. John Morgan persuaded the worthy burghers of Philadelphia to found a medical school in the College of Philadelphia. This was the first medical school in America and is the case with most young institutions faced very lean times in its early years. It was quickly appreciated that the rich cousins of the West Indies were a likely source of income, so in 1772 Dr. Morgan armed with a deed of Authority set out to raise money in the Caribbean

This deed of Authority begs in the most elegant manner and speaking of the Trustees of the College, says

and while they look around them for help, they cannot but turn their eyes towards their neighbours in the West India Islands, a people blest with opulence and known to delight in acts of liberality and kindness

In spite of a hurricane in Jamaica, Dr. Morgan came back with the princely sum of £860. Such is West Indian liberality and kindness

This is the 200th anniversary of the first vaccination by the English physician Jenner and it is appropriate that my other vignette relates to vaccination. George Washington stayed in Barbados in 1751 and contracted smallpox there. He was treated locally and developed the immunity which insured his resistance to the epidemic that swept his army. He used his Barbadian experience and had his troops inoculated with pus from the pox. How history might have been different if Washington had succumbed to smallpox! But enough of history and vignettes.

There is a general perception that the health status of the Caribbean is excellent and that image is portrayed in the brochures used to advertize that area as a destination. And indeed, the Caribbean countries have much to be proud of as regards their current health status. As a group

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of countries, they have indicators of health intermediate between those of their neighbours of the north and those of the south. I have referred elsewhere to a popular perception that for their levels of economic performance island states tend to have better health status.

I have sometimes thought of the Caribbean as passing through the various stages of the epidemiologic transition which represents the changes in patterns of health, disease and demography that have consequences on the state of populations. These stages cannot be separated rigidly, but are a good approximation of trends.

The first stage — the age of pestilence and famine pretty much describes the situation in the Caribbean for much of its existence and probably up to the first part of this century. There was high mortality and fertility rates, low life expectancy and the population suffered from malnutrition, and infectious and parasitic diseases resulting from deplorable environmental conditions. This was in general due to the social neglect consequent upon a *laissez-faire* style of colonial government and in some measure a reflection of the discrimination by one group against another that it considers different and inferior. I say this without any sense of recrimination. These are simply facts of life or death. At the home I was born, for example, I had about 30% chance of seeing my first birthday and it was nothing short of a miracle that the seven children of my parents survived to adulthood.

The second stage which is sometimes called that of receding pandemics saw mortality decline and infectious diseases brought under control. I experienced that stage as I saw malaria disappear from the Caribbean. My memories of malaria as a medical student are very real, but subsequent generations of students did not experience these kinds of diseases. It is postulated that fertility started to decline subsequent to the reduction in mortality and population grew. This phase of Caribbean health probably lasted until the 1950's.

Most of the Caribbean is firmly in a third stage — that of degenerative and man made diseases. The current life expectancy for males averages about 69.6 years and for females about 74.6 years. This level of life expectancy which is good for developing countries is due to improved social conditions and the application of health technologies that have been shown to be effective. Infant mortality rates are another commonly used indicator of health status and here again the Caribbean shows that it is well placed in comparison with countries at similar levels of wealth. These rates range from 46/1000 live births in Guyana to 12 in Montserrat. The impressive statistic is not only the change, but the rapidity of the fall which started in the 1960's in most countries. I have speculated elsewhere that these changes have been due not only to changes in medical technology, but have been closely related to the political changes that took place for the better in the Caribbean countries.

This stage of the degenerative diseases shows itself in the high prevalence of diabetes, hypertension, cancer, the notable presence of obesity and the marked increase in costs that attends the treatment or rather attempted control of these health problems. Cancer is particularly troublesome. The death rate for cancer of the cervix is several times higher than in North America and Barbados has the dubious distinction of having the highest death rate from cancer of the prostate in the Americas.

But the apparent progress made as shown by infant mortality rates and life expectancy is no cause for complacency as there are other countries in our Region apart from these in North America that boast of health statistics better than the Caribbean. It is not that I wish to establish any order of countries, but the difference shows what is yet to be achieved. We must also remember that even in small countries like those of the Caribbean these averages hide differences that exist among groups of persons and families and among different parts of countries.

Let me repeat again that the health workers of the Caribbean can take pride in its health status. The Caribbean was not affected by the epidemic of cholera that came to the Americas in 1992 after an absence of almost a century. There have been no confirmed cases of measles in the past 4 years — a tremendous achievement, and many other countries of the Americas are following the Caribbean example in eradicating this childhood disease. The Caribbean can boast of some fine health establishments and the health care workers are second to none.

But in spite of these indicators and these achievements, there is a wide spread perception that the health services are deteriorating and there is a fear that the Caribbean is likely to see the return of diseases and problems it had forgotten. There is some truth in these claims and it is a fact that the social conditions have had a negative impact on the health care facilities, and an increase in poverty is likely to show itself in a reversal of health indicators. We saw that during the period of economic stringency all countries while initially making efforts to maintain spending in health, eventually had to give in to the economic pressures. The capital and recurrent budgets fell and this was shown in the reductions in staff and deterioration of physical plant. We saw isolated outbreaks of disease associated with the environmental deterioration consequent on economic stringency. In spite of these problems, the general indicators of population health remain good. The major issue is attention to the person, and the majority of complaints arise in relation to deficiencies in the personal care services. It is claimed that the maintenance of the indicators of population health in the face of deteriorating personal care services derives from the inertia in the change of these indicators and also the lack of effect of care services on general health.

Let me look now at the major challenges facing the health sector now in the Caribbean countries. Perhaps the most prominent is their almost universal rush to health sector reform. With the need for financial stringency there was a universal call for a reexamination and reduction of public sector spending within a program of reform and the health sector has not escaped. This is driven by the ideal of increasing efficiency and equity and at the same time reducing the burden that health care makes on the public purse. There is the temptation to rush to address the issue of health care financing and the introduction of some sort of user fee is common — to the chagrin of some politicians who would continue to believe that a state can satisfy all the health care demands of its citizens — which of course is impossible. Fortunately, some countries are approaching reform in a more logical way — determining the kind of systems and services needed and then consider the financing.

Of course, there is some political drive behind the reform in many countries. Health reform is part of public sector reform and in addition there is genuine concern that the cost of care services is rising faster than any minister of finance likes to contemplate. Also, given the prospects of economic recovery in some countries and the established notion that income

elasticity of public sector spending is greater than unity there is good reason to be worried about the cost of health services to the State.

Fortunately, at least in some countries there is appreciation of the steps to be taken in the reform process and in particular a great deal of attention is being paid to involving the public and the profession in the decisions. It is also gratifying to note that in one country — Trinidad and Tobago, the change in government did not mean the dismantling of all that was done to structure a health reform process. The focus on decentralization, rethinking the role of the central ministry and provision of some basic package of services for all citizens have all been retained.

Everyone knows of the disease profiles and the threats they pose to our way of life, but few appreciate the health effects of the growing epidemic of violence in the Caribbean. Jamaica takes pride of place where some 40 percent of all crimes are violent and over 200 murders occurred in 1995. There are 38 murders per 100,000 population in Belize compared with 27 in New York and 2.5 in London. Data we have for Barbados showed that the main causes of death in the age group 15-44 years were associated with violence. Violence accounts for 10-25% of hospital admissions in some countries.

Why should violence be regarded as a health problem? First because of the effect on the health services of the effects of violence. The crowding of casualty departments and hospital wards with victims of violence diverts attention from other needy cases. But in addition, it is now clear that the approach to the problem cannot be left solely to the justice system. Public health can use the tried and true epidemiological approaches to determine some of the causes of violence and possible interventions. In addition the mental health problems that figure in the perpetrator and sometimes the victims are enormous, but are rarely addressed. I must mention here my special concern for violence against women.

I have mentioned before the chronic diseases and the burden they represent to the services. One of the most effective interventions that can be made in many of these is to have an effective program for elimination of tobacco use. I have yet to see vigorous efforts by governments to address this problem.

I should not end this section without mentioning HIV/AIDS. By the end of 1994 some 6.5 thousand cases had been reported. The frightening aspects do not only relate to the absolute numbers and the inevitability of death, but the epidemic is continuing. The change in the male/female ratio shows the entry of the disease into the heterosexual population. The Caribbean countries are adopting the standard approaches of education and addressing those areas in which definitive action can be taken to interrupt transmission — for example, ensuring a safe blood supply.

Why should Caribbean health be important to you here, apart from the human aspect and the natural concern for the suffering of fellow human beings? I believe that many of you think about returning home and wish to think that you will be cared for if the need arises. One other reason is that it is linked very much to Caribbean economic growth and you are all interested in the economic health of the region. I propose that investment in health contributes to countries future economic growth and the Caribbean should be no exception. While I accept that

reduction of poverty depends on economic growth, I do believe that investment in health and education of course, contribute strongly to a country's economic potential. Also, investment in health may be a contributing factor in reducing the income inequality that is the tinder box of social instability in small societies.

There is yet another reason. The health of the region and the health of its people are part of the tourist attraction that bring visitors. Visitors are shy of unhealthy places and peoples. I will not discuss here one of my favourite topics — health and tourism and the potential of the Caribbean attracting tourists for health reasons.

Finally, I wish to address very briefly the aspect of U.S.-Caribbean relations in health. There is the obvious aspect of tourist health to which I referred earlier. I have no data on human resources and can only allude very generally to the migration of health personnel from the Caribbean to the U.S. I have often entertained the argument as to whether this has been detrimental to Caribbean health at all. I honestly doubt that migration of Caribbean physicians has made any real difference to health care or public health in the Caribbean. The case of nurses may be different, but it has been argued that their remittances more than compensate for any inconvenience in the services and it is not only outward migration that affects the shortage of nursing in the Caribbean.

I can point to specific grant support from U.S. institutions to the Caribbean and bewail the reduction in USAID funding for health projects in the region. I can speak positively of U.S. support for one of the more successful projects in the Caribbean — the Eastern Caribbean Drug scheme which is a cooperative venture among those countries that allows them to purchase drugs at a considerably reduced price. But the more fundamental question as to whether the changes in U.S.-Caribbean political relationships affect health is unanswerable.

The most potent U.S. influence on health in the Caribbean is through the media. The perception of health care gained from television is distorted and distorting. It leads to public clamour for therapies and procedures that are outside the capacity of the Caribbean countries.

Finally, I wish to address very briefly the aspect of U.S.-Caribbean relations and the possible relation to health. I would divide these relations into three broad categories. There are the formal diplomatic relations that are played out at high governmental levels. These derive in part from the place of the Caribbean in the context of issues and places that are of geopolitical importance to the U.S.A. There are others here much more competent than I am to describe the future of these kinds of relations.

There are trade or commercial relations that may or may not be linked to and follow the above. There is no doubt that these are determined predominantly by self-interest and hopefully the Caribbean can identify areas in which there is mutuality of this interest. Finally, there are the cultural relations that are heavily influenced by the ties and connections that bear little relevance to the two above. There is the strong influence of the diaspora on both those who left and those who stayed.

These relations have both direct and indirect effects on Caribbean health. The most obvious field in which this is played out is in tourism. These relations have tremendous impact

on the movement of people and we must also note that health impacts positively or negatively on the movement as well. It is not only the visitors who are passive recipients, they also transmit diseases to the people visited.

But the relations are also seen in the area of health and to the Caribbean. Changing political orientations have led, for example, to a reduction in health support from USAID to the Eastern Caribbean. This has been disconcerting, given the very positive impact of this aid to the Caribbean. The Eastern Caribbean Drug Scheme through which the OECS countries purchase drugs jointly resulting in reduced costs was begun with USAID support. The Caribbean Epidemiology Center has benefitted from US support in order to help it deliver a high quality of technical cooperation to the countries of the region.

I am often asked about the movement of Caribbean health professionals as one aspect of the brain drain. First I have no good data on such movements, but I do know that this movement is becoming less as market forces here play themselves out. I always make the point, however, that health professionals are only one societal group and do not exhibit social responsibility any different from the other groups. There is also the view that professional movement is of economic advantage to the Caribbean because of the significant remittances, but I have no data to make a judgement as to the net benefit that may or may not accrue to the region.

I have no doubt that physical proximity will ensure that there is always some effect of U.S. Caribbean relations on Caribbean health. I would be flippant and say that relations would be much improved if we got back the interest on the £860 that we contributed 224 years ago.

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