The Prospect for Health and Wealth in the Caribbean
(St. Kitts/Nevis)**

Mr. Prime Minister of St Kitts/Nevis, Mr. President of the Caribbean Development Bank, Members of the Board of Governors, Distinguished guests, Ladies and gentlemen.

First, let me thank the President of the Caribbean Development Bank, Professor Compton Bourne for the invitation to deliver this William Demas Memorial lecture. I am fortunate in my choice of topic not only because of the interest Mr. Demas showed in health as an instrument of Caribbean development, but also I am privileged to deliver the lecture with Prime Minister Douglas in the chair. Prime Minister Douglas combines in one person the attributes of a physician and a politician, and let me pay tribute to his work as the Prime Minister responsible for the health portfolio in CARICOM. I am fond of quoting to my politician friends a famous statement by a distinguished German physician-Rudolf Virchow who said “medicine is a social science and politics is nothing more than medicine on a large scale”. I do not know if the Prime Minister’s experience bears this out.

I also know from his recent pronouncements that Professor Bourne shares with me the conviction that the Region ignores the health of the people at its peril. This refers not only to the constitutive value of health and its humanitarian face, but also because of its patent instrumental role for us especially at this stage when we are considering all aspects of what I refer to as our human development.

William Demas came to the University College of the West Indies in its early days as I have seen photographs of him with the pioneers of the Institute of Social and Economic Research but I never met him then, and I only heard of him as a brilliant economist who concentrated on Caribbean issues. However, in the 70’s I began to follow his writings more closely as his arguments gave substance to my own naive and rather green ideas about the viability of Caribbean integration and my dreams of a Caribbean destiny. I was attracted to his articulation of the view that the Caribbean people could not only survive, but thrive in a world that really owed us nothing.

* Pan American Health Organization, Pan American Sanitary Bureau, Regional Office for the Americas of the World Health Organization.

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The sheer simplicity of his propositions and the logic of the argument for Caribbean integration resonated loudly with me and many of my generation who were Caribbeanized in the early days in the vale of Mona. Of course he emphasized economic growth and integration as the basis for the people power which he envisaged as being a pre-requisite for the effective sovereignty or independence that he proposed as our true aim and not the mere trappings of the formal sovereignty or independence. The way out of dependent underdevelopment occupied much of his thinking and he saw it as a relic or consequence of our small size and our external economic dependence. The former is a fact of geography over which we have no control, but he showed how the disadvantages of both could be mitigated, compensated for or overcome by focused attention on our advantages which he posited were not inconsiderable. Of course like most economists of his era in which welfare economics had not gained the stature it now enjoys, he saw development as being synonymous with economic growth.

I was pleased to note that in his later years he dwelt more on the other aspects of development and in one of his speeches entitled “Men, Women and Children in Development” he focused on our human resources as the vital capital for our economic progress. He regarded human resource development as an end in itself and also a lever for growth and referred especially to health and education as two critical inputs into the formation of the human resource or as we might say now, the human capital that is essential in any society.

Quite naturally this concern for the ingredients of, or shall I say recipe for Caribbean economic growth and wealth creation has been a constant concern of Presidents of the Caribbean Development Bank. Professor Bourne as a practicing economist was responsible some twenty years ago for pointing out some of the key steps that the Region had to take if it was to survive and flourish in the twenty-first century. Under the heading of policy continuity he laid stress on the need for long term investment in human capital.

The first President, Sir Arthur Lewis in his inimitable style frequently set out his thoughts on the prospects of enhancing national wealth. In his annual address to the Bank given thirty years ago, in which he analyzed the reason why the Caribbean economic growth was inhibited he paid particular attention to our lack of entrepreneurship. He did this in the context of the historical development of economic thought. He said:

“Economists have been asking since the seventeenth century what is the cause of a nation’s wealth. The mercantilists said that it was the possession of gold, and urged the direction of trading policies to acquire more gold. The Physiocrats said that the foundation of wealth was the land. Adam Smith in the mid-18th century thought that it was the opportunities for specialization opened up by free trade. At the beginning of the nineteenth century the classical position was that labour was the foundation of wealth. Karl Marx, writing in mid century and after, also gave lip service to this proposition, but his candidate was really capital, which he thought could now release mankind from the bondage of poverty.
By the end of the nineteenth century the American philosophers, echoed by Marshall in England, and by Schumpeter on the continent, were putting the emphasis on business enterprise, whose willingness to innovate was the engine driving the economy forward. Recently, emanating from the United States we are told that the real solution lies in education”.

Thus Lewis perhaps in that last sentence hinted at what Demas made more explicit in indicating the critical role of human capital in wealth creation. I am certain of Demas’ later orientation, as it was when he was Governor of the Central Bank of Trinidad and Tobago that he invited me to give the Eric Williams Memorial lecture fourteen years ago on the topic “Health and Development in the Caribbean” and we discussed how it should be possible to find the policy levers for improving health not at the individual, but rather at the population level as a motor of our economic growth. Demas needed no convincing of the forward linkage of health to wealth and the question was more what could be done to convince policy makers who usually fixed on the immediacy of individual care and the services to provide it. He took the point I made then that if indeed the health of the people is an essential good, then certainly public health expenditure should be counter-cyclical and be protected in times of economic crisis. The passage of years has made me even more convinced of the relevance of this connection between health and wealth for our Region.

The notion of health being essential for our wealth was captured beautifully by the Heads of Government at their meeting in Nassau in 2002 when they recognized formally the role of health by declaring “The Health of the Region is the Wealth of the Region”. They were particularly concerned with the problem of HIV/AIDS that could impede development “through the devastation of our human capital”. But they also saw health in a wider context, as the declaration was perceived as being “Consonant with the goals of the Caribbean Community to promote the improvement, well-being and security of our peoples”.

I will attempt to follow Demas’ line of thinking and the declaration of the Heads of Government by sketching the prospects and trends in health in the Caribbean and show how these will impact on our wealth or our possibility of growing economically. I will not dilate on the prospects for wealth creation outside of health partly because of my own limitations and also because economic prognostications are notoriously difficult even for the economic cognoscenti. I also propose to address the gaps in our knowledge that should be filled if our leaders are to make the policy decisions necessary to give effect to the Nassau Declaration and speak briefly about the role of the Caribbean Development Bank.

Let me clear that I am not so biased or arrogant as to imply that health is the only or most important ingredient in wealth creation. Discussion on the drivers of economic growth has produced a voluminous literature but I believe that there would be general agreement that beside investing in human capital, there is a need for a foundation of law, a policy environment that embraces macroeconomic stability, a good physical infrastructure, means for protecting the physical environment and also care and protection
of the vulnerable in the society. I will not even go so far as to say that health and human capital in the Caribbean outweigh all the other inputs into our actual and potential wealth, although I have been intrigued by calculations which estimate that personal wealth is predominantly the present value of the returns to human capital in the economy over the span of productive life.

The two most important considerations in terms of the stock of human capital and its effectiveness in contributing to wealth are its quantity and its quality. Extension of life through attention to the prevention of illness and the cure or rehabilitation from illness will increase the productive capacity of a people, given of course that there are conditions for the optimum use of that capital such as providing employment opportunities. In cross country studies that examined the effect of longevity on growth, Bloom and Sachs demonstrated that an increase of 1% of life expectancy in 1965 could represent an increase in per capita GNP of some 3% per year during the following 25 years. And in similar studies the conclusion is reached that a five-year advantage in life expectancy between countries will add to an advantage of 0.3 to 0.5% in per capita income and raising life expectancy by 10% can increase economic growth by as much as 0.4% per year for the subsequent decades. These represent large gains and the prospects for such gains in life expectancy are not outside the realm of possibility.

There is clearly complementarity between the major ingredients of human capital. Extension of healthy life increases the time in which the returns to other investments in the human capital can be maximized. The period of formal education is a relatively short one and increase in life expectancy optimizes returns to the investment in education. In addition there is good evidence that ill health in the formative years impairs cognitive development and therefore learning capacity.

In this almost idyllic setting in which some of the natural beauty of St. Kitts is shown at its best, it may be difficult to convince any one that there are health problems in the Caribbean. We quite properly project an image of a healthy people living long in a healthy environment and in large measure this is true. Gone are the days such as those Sir Cuthbert Sebastian described in his book on 100 years of medicine in St. Kitts. We no longer have the massive infections with hookworm that debilitated our children and adults. Yaws and malaria are diseases of the past in most countries as it is only in Belize, Suriname and Guyana that the latter is a health problem. The picture of children swollen or emaciated because of malnutrition is a rarity in our clinics and hospitals. The last outbreak of poliomyelitis was seen in 1982 and measles that is a major killer of children worldwide, accounting for some 800,000 deaths in 2000, has not been diagnosed in the Caribbean since 1991. Indeed the Caribbean was the first region in the Americas to undertake successfully a campaign to eliminate measles.

The standard health indicators show how we have progressed. The infant mortality rate is currently about 25 per 1000 live births and it has fallen 30 percent in the past 15 years, and indeed, the mortality from communicable disease in children 1-14 years has fallen by almost 70 percent in the same period. The Caribbean child born today can expect to live to about 73 years, and because of these favorable indicators we
anticipate that in the year 2025 fully 17 percent of the Caribbean population will be over the age of 60 years, and this region shows one of the fastest rates of growth of the elderly population. The Caribbean is well into the demographic transition that we have seen in the industrialized world. There has been a fall in child mortality, a rise in life expectancy and a fall in the rate of population growth. This fall in child mortality that inevitably precedes the fall in the fertility reduction which leads to a decrease in population growth has consequences for the health services, but also is relevant to the economic potential of countries. These health improvements represent a remarkable achievement of the public health services and are a tribute to the health workers of the Caribbean, prominent among whom are the public health nurses.

This increase in healthy life increases the potential productive capacity of the Caribbean people. The demographic transition through which the Caribbean has passed or is passing represents a potential demographic dividend that only occurs once. The female fertility in the Caribbean fell after the reduction in child mortality as is seen in other countries and this sequence leads to a bulge in the young adult productive population of working age. The spectacular economic performance of the South-East Asian countries has been attributed in part to the growth of this segment of their population. I must repeat however that the opening of this demographic window by itself without the other infrastructural elements that allow the population to be productive does not allow countries to benefit. The relationship of our demographic changes to our economic performance is one of the areas that merits further study.

There has been a long standing argument that improved health which leads to increased productivity per worker and increased life expectancy may not contribute to national wealth as long as there are high levels of unemployment. Especially in societies in which manual unskilled labor is the predominant activity, the ill workers are easily replaced if there is excess labor supply. This argument does not take account of the cost of the illness to the individual and the community as a whole. Also as countries such as those in the Caribbean develop and move predominantly to service-based economies and depend on offering more sophisticated technical services, that argument becomes less valid.

There is considerable quantitative evidence now of the economic benefits to be derived from health and nutrition especially in the area of the labor market returns to good nutrition. Much of the economic growth of the southern United States at the turn of the last century has been attributed to the elimination of hookworm infestation which was known as "the germ of laziness" Even closer to home we have the experiments of George Giglioli in Guyana who could demonstrate in 1924 that treatment of anemia in bauxite mine workers allowed them to shovel more ore.

The economic historians have shown that over a long sweep, improved health and nutrition of the population increase wealth. Fogel estimates that the improvement in health and nutrition between 1780 and 1979 could account for 50% of the economic growth of Great Britain. Days of illness or the self-perception of state of health bear a close relation with individual earnings. Persons who reported themselves to be in good
health not only have higher incomes but their income continues to increase at a rate faster than those persons who report themselves to be in poor health. As one author put it graphically, healthy bodies lead to thick wallets.

It is not only the reduction of illness and good nutrition in the adult that are important, as one of the most vulnerable periods of life may be in utero and early childhood. In one study that I helped to initiate it could be shown that the earnings of adults could be correlated with their caloric intake in their first 36 months of life. I suspect that studies of infants who are malnourished in utero, in addition to demonstrating increased proneness to some chronic diseases may well have reduced earning capacity as adults. Winston Churchill would never claim to be a nutritional scientist but he was perhaps more correct than he imagined when he said” There is no finer investment for any community that putting milk into babies”.

So what are the health problems that will decrease the quality and the quantity of the stock of human capital in the Caribbean and what is being done about them? The infectious diseases have always been and will always be with us. There are still occasional outbreaks of typhoid fever in some countries as a result of inadequate sanitation. Unfortunately tuberculosis seems to be on the rise and because of our inability to control the Aedes Aegypti mosquito there are about ten thousand cases of dengue fever every year.

But the infectious disease that is of greatest concern to us all is HIV/AIDS. You have heard on repeated occasions that the greater Caribbean is the most severely affected region in the Western hemisphere and has an incidence second only to that found in sub-Saharan Africa. It is estimated that there are about half million HIV infected persons in the Caribbean and about twenty five percent of these are in the CARICOM countries. The disease is now firmly established with a heterosexual mode of transmission and there is no evidence that the epidemic has matured and is plateauing. Our young people, particularly women constitute the most vulnerable group of the population, and in 1999 some 70% of new cases were reported in the age group 15-44 years. CAREC reports that young women aged 15-24 years have an HIV prevalence rate 2-4 times higher than any other female age cohort.

I am sure that you are all aware of the actual and potential economic damage that results from the epidemic. The destruction of the most economically productive sector of society is a grim prospect. The various models that have been applied here and elsewhere to measure the burden of illness give data for the impact on national wealth, but often do not capture the true social cost of the epidemic. One of the great fears in sub-Saharan Africa is that AIDS by killing the teachers can lead to the collapse of the educational system with horrible consequences for the future generations. The strong social forces driving the epidemic include poverty, discrimination and the unequal distribution of power between the sexes which makes it difficult if not impossible for females to determine with whom and under what circumstances they will engage in sexual relations.
Although the effects of the infectious diseases are often dramatic we must not forget that the non-communicable diseases are still responsible for most of the mortality in the Caribbean, and this is not simply a result of the increased life expectancy.

Cardiovascular disease has been the leading cause of death for years and the hypertension that occurs in approximately one quarter of the adult population contributes to this as well as to the strokes that are a significant cause of chronic disability. Diabetes mellitus is a major contributor to heart disease and unfortunately prevalence rates are increasing. About one of six older adults in Jamaica and Barbados is diabetic with rates being higher in females. Cancer is the second leading cause of death with cancers of the prostate and breast being the commonest in men and women respectively. For reasons as yet obscure, the incidence of cancer of the prostate is particularly high in Jamaica. No description of chronic disease would be complete without mention of mental illness and the increasing prevalence of substance abuse which are recognized as being significant health problems, but there is a regrettable paucity of data on the actual extent of the problem although there is no dearth of plans and strategies for mental health.

I will comment only on selected aspects of the response to these health problems. The Heads of Government placed tremendous emphasis on the region finding a response to the HIV/AIDS epidemic and Prime Minister Douglas can describe the formation of the Pan Caribbean Partnership against HIV/AIDS in which a wide range of agencies from within and outside the region seek to work cooperatively. We have seen progress in the preparation of national and regional plans and strategies. We have seen negotiations for the reduction of prices for the anti-retro viral drugs that have changed the face of the disease in the rich countries that can afford them, and even now the prices are falling still further. We have seen Guyana embark on a bold venture for producing its own anti retroviral drugs, and countries such as Jamaica and Barbados have indicated their commitment to confronting the epidemic by entering into loan arrangements with the World Bank. The countries are making great efforts to fulfill the commitments they made two years ago at the Special United Nations General Assembly that dealt with HIV/AIDS and indeed in some places there has been significant progress in areas such as a dramatic reduction in the transmission of the disease from mother to child.

But Mr. Chairman, there is one area in which there has not in my view been enough progress. There has not been the focused high-level approach to reducing the stigma and discrimination that attends the disease. We have not seen enough officials at high levels address seriously the homophobia that is rampant in the Caribbean, contributes to the stigma that drives the epidemic underground and frustrates many of the appropriate public health measures to contain its spread. I must emphasize that the disease in the Caribbean is spread mainly by heterosexual contact, but there is no doubt about the importance of the stigma both against persons suffering from AIDS and those who are presumed to be homosexual that leads to difficulty in tracing contacts and reluctance to come for counseling. This will not change unless there we have the courage to address the problem at all levels of our societies and perhaps modify some of the legislation that facilitates the perpetuation of the stigma and discrimination.
There is another epidemic that is less dramatic, but is having and will continue to have severe effects on Caribbean health. The Caribbean populations are becoming more and more obese and the poor nutrition practices plus physical inactivity are major causes of the epidemic that predisposes to the non-communicable diseases such as heart disease and diabetes mellitus. Data from the Caribbean Food and Nutrition Institute (CFNI) show that almost 60% of Barbadian women are overweight and about 30% are frankly obese. In males the figures are 25% and 15%. The tragedy is that the situation is worsening steadily and a similar pattern is found in all Caribbean countries from which we have data.

The principal way to address this is through a careful look at the whole problem of food and nutritional security viewed as combining food availability, access and the interplay between nutrition and health outcomes. There is little evidence of a close relationship between agricultural policy and the concern for the nutritional and health consequences of one or other policy. A series of social and other changes have resulted in the Caribbean spending over one billion US dollars annually on food imports and the tragedy is that the imports for the fats and sugars are higher than we need and for the complex carbohydrates lower than is good for us. This pattern of consumption of excess fats, sugars and refined carbohydrates and less of the complex carbohydrates is just the one to contribute to obesity and consequent chronic diseases.

This is one of the areas in which the CDB might be more active in terms of stimulating the harmonization of some agricultural and health policies or at least ensuring that the policies of one sector are not inimical to the other. Lack of physical activity also contributes to the obesity epidemic as in some countries at least half of the adult population is almost completely sedentary as a result of increasing urbanization and different styles of living often induced by images and practices that are not indigenous to the Region.

It is a constant source of concern whether countries can afford their health expenditures and the stronger the feeling that health is a consumption item and not productive, the greater will be the temptation to reduce expenditure in health in times of hardship. Health expenditure in the CARICOM countries averages 4.94 percent of GDP and the greater fraction in almost every country is public expenditure. There are cross country data to show that public expenditure has very little effect on an indicator such as child mortality. But the more relevant datum for us is the clear demonstration that while this may be so for a large group of countries, public expenditure has a marked effect on the health of the poor.

Poverty reduction is of overriding concern in the Caribbean and the CDB has been in the forefront in supporting the necessary analysis and definition of policy options. This figures prominently as one of the main thrusts and initiatives in the CDB’s annual report for 2001 that recommends the targeting of its efforts and resources “to the most critical areas for effecting social change in which CDB enjoys comparative advantage and synergy in its activities, or in which it can influence key stakeholders to increase support to underserved areas”.
Four years ago, the Pan American Health Organization (PAHO), CARI COM and the United Nations Development Program (UNDP) initiated a study on the possible effects on the poor of the health sector reforms that were being undertaken in the Caribbean. The study showed that the poor were disadvantaged in terms of access to health care and used the services less than the non-poor. One of findings that struck me was the fluctuation in the numbers of the poor with time. This seemed to indicate that people were going into and out of poverty, or to express it differently there were significant numbers of persons teetering on the borderline of poverty. Ill health with the attendant loss of wages and especially the expenses that fall on the individual or family because of illness can combine to drive families into poverty. This phenomenon known as the poverty trap has been well documented, and is one of the more unfortunate linkages between health and the opposite of wealth-poverty.

The Caribbean countries are more vulnerable than many other developing ones and this can be traced to factors which include the environmental and ecological characteristics that make them prone to natural disasters, their limited land resources and possibilities of economic diversification, as well as the high transactional costs that are a natural result of their economic and population size. There are also social vulnerabilities that derive from such factors as the increasing poverty and many of the health problems I have described above. I wish us to consider in this context the vulnerability to health shocks that may plunge individuals and families into the poverty trap or prevent them escaping from it.

The answer to this problem lies not only in maintaining the population healthy and providing good services, but perhaps in one of the recommendations of the study that advocated for national health insurance with prepayment and resource pooling as a basic mechanism for protecting the poor. Numerous attempts have been made to establish such schemes with universal coverage in the Caribbean, but the major stumbling blocks have usually been the lack of the necessary resources and in the case of the smaller states, the size of the risk pool. There has been some success in the case of Jamaica that has implemented a National Health Fund that has at its core the provision of a basic benefits package which covers mainly drugs for chronic diseases. But no country as far as I am aware has so far put in place a scheme so comprehensive as to prevent the poor from falling into the poverty trap as a result of catastrophic illness.

In order to follow up on their Nassau Declaration, the Heads of Government called for the formation of a Caribbean Technical Regional Task Force on Health and Development “to advocate, review and help to propel health to the centre of the development process”. This is very much in keeping with the recommendations of the Commission on Macroeconomics and Health chaired by Jeffrey Sachs that set out clearly the need for increased attention to and investment in health if many developing countries were to have any chance of escaping from poverty. I hope that this Task Force will develop more fully some of the areas for which more evidence is needed to inform policy.
One such area is the readiness of the Caribbean health services to deal with the changing epidemiological profile of the Region. The decision to address one or other problem and fund the relevant services is usually based on the advocacy skill of the involved physicians or the political imperative of the moment. I am not aware of any systematic cost-effectiveness analysis being done before the introduction of new technologies, and certainly this type of analysis has not preceded the provision of identical services in many countries that may indeed have benefited from some form of sharing. The increased availability of information from the internet and television will create pressures for providing services that on the basis of cost effectiveness analysis may not be priorities for the expenditure of scarce resources.

I hope this Task Force will examine again the possibilities of trade in health services as an income source. I referred briefly to this issue recently and identified two possibilities that in the GATS terminology are referred to as consumption abroad and the presence of natural persons. The former refers mainly to the treatment of persons abroad and falls into the category of health tourism. Tourism is our major product and I have commented elsewhere on the reciprocal links between health and tourism, but it is tourism for health and mainly health care that must be explored more. There are strengths and weaknesses in our health systems that have been identified, but I believe that this area has potential but will advance only when there is enough private entrepreneurship to undertake it.

The presence of natural persons encompasses the migration of health personnel. During the decade of the fifties large number of nurses migrated to North America and Great Britain. The flow has increased again, this time helped by active recruitment from those countries. I believe that instead of wringing our hands and bemoaning the brain drain, the Caribbean must be positive about taking advantage of the natural benefit that derives from our geography and our language. Unfortunately my idea of human resources as an exportable product does not sit well in some quarters, but I believe we must be gathering the data on our capacity to produce nurses, for example, the potential of the foreign market, the level of remittances that can be projected from this source and think seriously of marketing this resource.

Mr. Chairman, if anyone wished a reminder of the role of health in a country’s economy, the recent epidemic of SARS is indeed a grim one. The epidemic has demonstrated dramatically the impact of a disease on the economy of large countries that are nowhere as vulnerable as ours. The salutary lesson to the Caribbean and economies like ours is that globalization does not only mean financial inter-connectedness, but also implies that the threats and realities of plagues old and new are problems for all of humankind without reference to national boundaries or distinctions.

The CDB as with any other bank must lend for projects that have potential for both social and financial returns. I believe, perhaps naively that it is for that reason it is called a development bank. The Annual Report for 2001 shows that the health sector accounted for 2.8 percent of the loans approved between 1970 and 2001, and I was pleased to see that this figure had risen to 10 percent for the 2001 I hope that the obvious
interest of the president in health as instrumental for the other aspects of human development augurs well for the institution increasing or maintaining its health lending and examining how health concerns can be considered when loans are made in other sectors. Can loans for education for example, include a component for addressing HIV/AIDS? Also, I hope it will be possible to dedicate some of the financial and highly skilled human resources in CDB to assist in carrying out the mandate of the Heads of Government in their Nassau Declaration.

Mr. Chairman, I hope I have shown to your satisfaction that the health of our Region is indeed the wealth of our Region and you will understand my ignoring any possible Delphic interpretation of the Nassau Declaration and focusing predominantly on the contribution of our health to our wealth. I have no doubt that we can face and overcome the challenges to our health that I have outlined because I share the conviction expressed by Demas in one of his lectures when he said:

“We West Indians are a gifted and versatile people and can apply ourselves to the most formidable and demanding task when we choose to” And he went on to identify the essential task as ..”the creation of a decent, humane and united society of self-respecting and respected West Indian people”.

I thank you for your attention and hope you will agree that health has a significant role in the society of which William Demas dreamed.