



GRENADA HEALTH SYSTEMS AND PRIVATE SECTOR ASSESSMENT 2011



May 2012

This publication was produced for review by the United States Agency for International Development. It was prepared by Laurel Hatt, Danielle Altman, Slavea Chankova, Carol Narcisse, Donna-Lisa Peña, Pamela Riley, Jordan Tuchman, Taylor Williamson, and Andrew Won for the Health Systems 20/20 Project and the Strengthening Health Outcomes *through* the Private Sector Project.

Health Systems 20/20 Mission

The Health Systems 20/20 **cooperative agreement**, funded by the U.S. Agency for International Development (USAID) for the period 2006–2012, helps USAID-supported countries address health system barriers to the use of life-saving priority health services. Health Systems 20/20 works to strengthen health systems through integrated approaches to improving financing, governance, and operations, and building sustainable capacity of local institutions.

SHOPS Mission

The Strengthening Health Outcomes *through* the Private Sector (SHOPS) Project is a five-year **cooperative agreement** (2009–2014) with a mandate to increase the role of the private sector in the sustainable provision and use of quality family planning, HIV/AIDS, and other health information, products, and services.

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DISCLAIMER

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CONTENTS

- Acronyms..... ix**
- Acknowledgments..... xi**
- Foreword xiii**
- Executive Summary I**
- I. Assessment Methodology..... II**
 - 1.1 Framework for the Health Systems And Private Sector Assessment Approach II
 - 1.2 Assessment Process..... II
- 2. Health Systems Profile and Background 13**
 - 2.1 Overview of Grenada..... 13
 - 2.2 Political and Macroeconomic Environment..... 15
 - 2.3 Health System Overview 17
 - 2.4 Key Actors in Grenada’s Health Sector..... 19
 - 2.5 Health Systems Strengthening Capacity 21
 - 2.6 International Donors 21
 - 2.7 Public-Private Partnerships..... 22
- 3. Governance..... 25**
 - 3.1 Overview of Governance in Grenada..... 26
 - 3.2 Policy, Legislative, and Regulatory Framework..... 26
 - 3.3 Government Structures 29
 - 3.4 Citizen Voice, Responsiveness, and Transparency 30
 - 3.5 Recommendations 32
- 4. Health Financing 35**
 - 4.1 Resource Mobilization and Revenue Collection 35
 - 4.2 Risk Pooling and Financial Protection 40
 - 4.3 Resource Allocation and Purchasing..... 43
 - 4.4 Recommendations 48
- 5. Service Delivery 51**
 - 5.1 Structure of the Service Delivery System..... 51
 - 5.2 Continuity of Care 53
 - 5.3 Community Outreach and Health Promotion..... 53
 - 5.4 Priority Service Areas..... 53
 - 5.5 Service Delivery Access, Coverage, and Utilization..... 55
 - 5.6 Quality of Care..... 56
 - 5.7 Recommendations 57

6. Human Resources for Health	61
6.1 HRH Profile of Grenada.....	61
6.2 Human Resources for Health Policy	63
6.3 Human Resources Management.....	65
6.4 Human Resources Development.....	66
6.5 Recommendations	67
7. Management of Pharmaceuticals and Medical Supplies... ..	69
7.1 Pharmaceutical Policy Framework.....	69
7.2 Regulatory Issues	70
7.3 Procurement, Storage, and Distribution	72
7.4 Rational Use	74
7.5 Financing for Medicines and Supplies	74
7.6 Recommendations	75
8. Health Information Systems.....	78
8.1 Organization and Structure of the Health Information System.....	78
8.2 Processes and Resources for Data Collection, Reporting, and Analysis.....	81
8.3 Use of Health Information.....	82
8.4 Recommendations	83
9. Private Sector Contributions to Health	86
9.1 Governance and Policy Environment.....	87
9.2 Private Health Service Delivery.....	89
9.3 Private Sector Role in the Supply Chain	89
9.4 Private Financing for Health	91
9.5 Contributions of Private Companies to Health	91
9.6 Public-Private Engagement.....	92
9.7 Recommendations	92
Annex A: Health Financing Indicators	95
Annex B: Health Systems Strengthening and HIV in Grenada ..	97
Annex C: Validation and Prioritization Workshop Summary....	99
Opening remarks and presentation of findings.....	99
Validation of findings and recommendations	99
Prioritization of recommendations.....	101
Next steps and closure	103
Annex D: Bibliography.....	111

LIST OF TABLES

Table 2.1: Demographic Indicators in Grenada Compared with Latin America and Caribbean Regional Average.....	14
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Table 2.2: Reproductive Health Indicators in Grenada Compared with Latin America and Caribbean Regional Average.....	14
Table 2.4: Economic indicators in Grenada Compared with Latin American and Caribbean Regional Average.....	16
Table 2.5: Key Actors in Grenada’s Health Sector	19
Table 2.6: Overview of Health Systems Strengthening Capacity in Grenada	21
Table 2.7: Recent International Donor Support for Health in Grenada	22
Table 2.8: Illustrative Examples of Public-Private Collaboration in Grenada	23
Table 3.1: Worldwide Governance Indicators: Grenada	26
Table 3.2: Key Health Legislation in Grenada.....	27
Table 4.1: Comparison of Select Health Indicators between Grenada, LAC Region, and Upper-Middle-Income Countries.....	43
Table 4.2: Grenada’s Distribution of Health Budgets	44
Table 5.1: Hospital Beds in Grenada and Carriacou	53
Table 5.2: First Place Visited for Medical Attention by Quintiles	56
Table 6.1: Number of Health Workers per 10,000 Population	61
Table 6.2: Staff at Public Sector Community Health Facilities in Grenada and Carriacou.....	63
Table 6.3: Number of Grenadian Students Enrolled in Advanced Health Training Programs, 2009.....	66
Table A1: Basic Health Financing Indicators for Grenada, 2000–2009...	95

LIST OF FIGURES

Figure 2.1: Map of Grenada.....	13
Figure 2.2: Organization of the Public Health System.....	18
Figure 4.1: Per Capita Total Expenditure on Health.....	36
Figure 4.2: Total Expenditure on Health as a Percentage of GDP	36
Figure 4.3: General Government Expenditure on Health as a Percentage of Total Government Expenditure.....	37
Figure 4.4: Out-of-Pocket Expenditure on Health as a Percentage of Total Health Expenditure.....	39
Figure 4.5: Budgeting Process for the Ministry of Health	46

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
BAICO	British American Insurance Company
CAREC	Caribbean Epidemiology Center
CARICOM	Caribbean Community
CDC	Centers for Disease Control and Prevention
CHART	Caribbean HIV/AIDS Regional Training Network
CLICO	Colonial Life Insurance Company
CPU	Central Procurement Unit
CSO	Civil Society Organization
DfID	U.K. Department for International Development
DPA	Department of Public Administration
EC\$	Eastern Caribbean Dollar
E-GRIP	E-Government Regional Integration Programs
EIU	Epidemiology and Information Unit
GARFIN	Grenada Authority for the Regulation of Financial Institutions
GDP	Gross Domestic Product
GMA	Grenada Medical Association
GTM	Guyana-Trinidad Mutual
HIS	Health Information Systems
HIV	Human Immunodeficiency Virus
HMN	Health Metrics Network
HRH	Human Resources for Health
HRSA	Health Resources and Services Administration
HSA	Health Systems Assessment
HSS	Health Systems Strengthening
IFC	International Finance Corporation
IMF	International Monetary Fund
I-TECH	International Training and Education Center for Health

LAC	Latin America and the Caribbean
M&E	Monitoring and Evaluation
MOF	Ministry of Finance
MOH	Ministry of Health
NAC	National AIDS Council
NAD	National AIDS Directorate
NCD	Noncommunicable Disease
NGO	Nongovernmental organization
NHA	National Health Accounts
NIDCU	National Infectious Disease Control Unit
NIS	National Insurance Scheme
OECS	Organization of Eastern Caribbean States
PANCAP	Pan Caribbean Partnership against HIV/AIDS
PAHO	Pan American Health Organization
PEPFAR	U.S. President’s Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PPP	Purchasing Power Parity
PPS	Pharmaceutical Procurement Service
PRISM	Performance of Routine Information Systems
PSA	Private Sector Assessment
RN	Registered Nurse
SGU	St. George’s University
SHOPS	Strengthening Health Outcomes <i>through</i> the Private Sector
STI	Sexually Transmitted Infection
TAMCC	T.A. Marryshow Community College
UNAIDS	Joint United Nations Program on HIV/AIDS
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
USAID	United States Agency for International Development
USAID/EC	United States Agency for International Development/Eastern Caribbean Mission
US\$	United States Dollar
VAT	Value-Added Tax
WHO	World Health Organization

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- Government: Prime Minister’s Ministry, Ministry of Health, National Infectious Disease Control Unit, Ministry of Finance, Ministry of Legal Affairs, Ministry of Tourism, Ministry of Social Development
- Public sector health facilities: General Hospital, Princess Alice Hospital, Mt. Gay Psychiatric Hospital, Grand Bras Health Centre, Bellevue Health Centre, Grand Anse Medical Station, Good Hope Medical Station
- National Insurance Scheme
- Private hospitals
- Doctors in private practice
- Private pharmacies
- Private insurance companies
- Private businesses
- Grenada Medical, Nurses, Dental, Public Health, and Pharmacists Associations
- Nongovernmental and civil society organizations
- St. George’s University and T.A. Marryshow Community College
- Private laboratories

This assessment report was prepared collaboratively by the members of the assessment team. Laurel Hatt drafted the Health Financing chapter and edited the full document; Danielle Altman drafted the Management of Pharmaceuticals and Medical Supplies chapter and edited the full document; Andrew Won drafted the Health Systems Profile and Background chapter; Donna-Lisa Peña and Taylor Williamson drafted the Governance chapter; Carol Narcisse drafted the Human Resources for Health chapter; Slavea Chankova drafted the Health Information Systems chapter; Jordan Tuchman drafted the Service Delivery chapter; Pamela Riley drafted the Private Sector Contributions to Health chapter; and Clara Knausenberger drafted the HIV brief (Annex B).

FOREWORD

In 2009, the United States government supported a process to develop the United States-Caribbean Regional HIV and AIDS Partnership Framework 2010–2014 (Partnership Framework) together with 12 Caribbean countries: Antigua and Barbuda, the Bahamas, Barbados, Belize, Dominica, Grenada, Jamaica, St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines, Suriname, and Trinidad and Tobago. Development of the Partnership Framework involved participation from ministries of health, national AIDS programs, regional organizations such as the Pan Caribbean Partnership against HIV and AIDS (PANCAP) and the Organization of Eastern Caribbean States (OECS), and nongovernmental and private sector stakeholders. The Partnership Framework is aligned with national strategic plans and the PANCAP Caribbean Strategic Framework.

A major goal of the Partnership Framework is to move the region toward greater sustainability of HIV/AIDS programs. Obtaining results in this area will be challenging, given that most country governments currently provide limited national budget resources to their own HIV/AIDS programs, relying to a large degree on external aid. While there are six U.S. government agencies supporting implementation of the Partnership Framework, USAID/Eastern Caribbean (USAID/EC) provides support for health systems strengthening (with particular emphasis on health financing) and private sector engagement. Both these efforts are closely linked to sustaining the HIV response in the region.

As a part of the Partnership Framework, USAID/EC asked the Health Systems 20/20 and Strengthening Health Outcomes *through* the Private Sector (SHOPS) projects to conduct integrated health system and private sector assessments in St. Lucia, Grenada, St. Kitts, Antigua, Dominica, and St. Vincent and the Grenadines. The assessments identify opportunities for technical assistance, which are aimed at improving the capacity of these countries to effectively lead, finance, manage, and sustain the delivery of quality health services, including HIV prevention, care, and support.

USAID/EC has requested that the SHOPS project, USAID's global flagship private sector engagement project, establish a baseline of private sector engagement in HIV/AIDS that will inform future regional and country support for maximizing contributions from this sector in the Eastern Caribbean. USAID/EC has asked Health Systems 20/20, USAID's global flagship health systems strengthening project, to determine opportunities for improving health financing systems, ensuring the sustainability of funding for the HIV/AIDS response, and strengthening financial tracking and management procedures in the region. The integrated health system and private sector assessment approach is specifically used to pinpoint areas where the private sector can be leveraged to strengthen health systems, sustain national HIV responses, and contribute to improved health outcomes.

The assessment methodology is a rapid, integrated approach, covering six health systems components: health financing, pharmaceutical management, governance, health information systems, human resources for health, and service delivery. Special emphasis is placed on the current and potential role of the private sector within and across each health system building block. An extensive literature review was conducted for each country, and in-country interviews with key stakeholders were used to validate and augment data found in secondary sources. The assessments are guided by an intensive stakeholder engagement process. Following the preparation of a draft assessment report, preliminary findings and recommendations are validated and prioritized at in-country stakeholder workshops. Stakeholders interviewed and engaged throughout the assessment process include government representatives,

development partners, nongovernmental organizations, professional associations, health workers in the public and private sector, civil society organizations, and private sector businesses.

The assessments have been conducted in close collaboration and cooperation with the Pan American Health Organization (PAHO), the Health Resources and Services Administration (HRSA), the International Training and Education Center for Health (I-TECH), and the Caribbean HIV/AIDS Regional Training Network (CHART). Representatives of these organizations joined assessment teams, contributed to the assessment reports, and have assisted with identifying opportunities for technical assistance. Health Systems 20/20 and SHOPS wish to express gratitude to these organizations, to ministries of health in participating countries, and to all in-country stakeholders for their intensive engagement and contribution to the assessments.

EXECUTIVE SUMMARY

PURPOSE OF THE ASSESSMENT

Grenada is one of 12 Caribbean countries joining efforts with the United States Government in the United States-Caribbean Regional HIV and AIDS Partnership Framework 2010–2014 (Partnership Framework). The United States Agency for International Development (USAID) is working through two projects, Health Systems 20/20 and Strengthening Health Outcomes through the Private Sector (SHOPS), to provide a variety of health systems strengthening technical assistance to countries in the eastern Caribbean, as part of this Partnership Framework. To identify priorities for this technical assistance, the two projects conducted an integrated health systems and private sector assessment. Additional partners in this effort included the Pan American Health Organization (PAHO), the International Training and Education Center for Health (I-TECH), and the Caribbean HIV/AIDS Regional Training Network (CHART). The assessment described in this report is a first step toward improving the capacity of Grenada to effectively lead, finance, manage, and sustain the delivery of quality health services, including HIV prevention, care, and treatment. Inherent in the country's capacity to carry out these roles is better understanding and catalyzing private sector contributions to health. While the functioning of the broader health system is the focus of the assessment, particular attention was paid to sustaining the country's HIV response.

COUNTRY OVERVIEW

Grenada is an upper-middle-income country in the eastern Caribbean, with a population of approximately 104,000, of which 30 percent live below the poverty line. Fertility is now low (2.26 births per woman), but the population is young, with about 60 percent under the age of 25. Public sector health services are delivered through four hospitals, six health centers, and 30 medical stations. There are also three small private hospitals and more than 30 private physician practices in Grenada. Although 65 percent of the population lives in rural areas, there is good geographic coverage of public health services. Basic reported health indicators, such as births attended by a skilled health care worker and immunization coverage, are excellent. Chronic and noncommunicable diseases (NCDs) now account for the majority of reported health problems in Grenada, with diseases of the circulatory system among the leading causes of morbidity and mortality in adults. In recent years, there have been significant improvements in treatment, care, and support services for people living with HIV (PLHIV). However, stigma and discrimination issues persist, and evidence suggests that some PLHIV in Grenada do not access care and treatment services until HIV is at an advanced stage.

METHODOLOGY

Health systems and private sector experts from the SHOPS and Health Systems 20/20 projects, as well as I-TECH and PAHO, conducted an integrated rapid assessment of Grenada's health system according to the "building blocks" of the World Health Organization (WHO) health systems strengthening framework: governance, health financing, service delivery, human resources for health, pharmaceutical management, and health information systems. Examination of the current and potential role of the private sector in the health system was incorporated into this approach. In an effort to

promote efficiency, an extensive review of the literature pertaining to the health system, and HIV/AIDS services in particular, was conducted prior to the team's arrival in country. Existing information was then validated and expanded upon through interviews with over 90 key stakeholders representing the public, non-profit and for-profit sectors, and spanning the health system areas.

KEY FINDINGS AND RECOMMENDATIONS

The assessment team concluded that while the health system in Grenada functions well, there are key areas that could improve the delivery of health care. Addressing these challenges holistically will result in positive and sustained impact, and contribute to a more effective health system in the long term.

Overall, the assessment team identified the following key cross-cutting themes:

- Availability of and capacity to use data for strategic, evidence-based policy, planning, and advocacy;
- Resource constraints and need for sustainable financing for the health sector;
- Coordination and collaboration between the public and private health sectors; and
- Improving community-level primary health care (PHC) service delivery and quality.

We present below selected findings and recommendations for strengthening the health system for each of the WHO health systems building blocks. Full findings and recommendations (presented as short-term and longer-term) are presented in separate chapters for each health system area, as well as a summary chapter on private sector contributions to health.

Governance

Effective health governance is the process of competently directing resources, managing performance, and engaging stakeholders toward improving health in ways that are transparent, accountable, equitable, and responsive. Grenada has a National Strategic Health Plan 2007–2011, but the plan is in draft and it ended in 2011. A new strategic plan is needed to address issues such as the new tertiary hospital, dual employment policies, user fees, and provider payment mechanisms. Civil society organizations (CSOs) and media are highly engaged in Grenada's health sector. However, formal mechanisms for citizen engagement are weak, and consumer feedback systems are ad-hoc. Ministry of Health (MOH) capacity for evidence-based planning and budgeting could be strengthened. Developing and disseminating an analytic, user-friendly annual MOH report would significantly improve transparency of statistics on health system usage and disease patterns.

Key findings and recommendations in the area of governance are as follows:

Findings	Recommendations
<ul style="list-style-type: none">• The development of a new strategic health plan presents an opportunity for a new, evidence-based, inclusive strategic planning process.• The MOH engages regularly with civil society and the media on health issues.• Basic health system information, such as service utilization rates and health legislation, is not easy to access.• Mechanisms for citizen feedback are weak, especially for service delivery concerns.• The regulatory framework governing the management of General Hospital is unclear and outdated.• Health planning and budgeting capacity at the MOH could be strengthened.	<ul style="list-style-type: none">• Begin development of a new strategic plan (2012–2017) using a collaborative, multi-stakeholder process.• Strengthen MOH capacity for evidence-based health planning, budgeting, and monitoring and evaluation.• Continue to engage CSOs proactively and strategically as advocates and educators on health issues.• Strengthen information availability.• Develop consumer feedback mechanisms for service delivery issues.• Revise and/or clarify key components of the legislative and regulatory framework for health, including for the General Hospital.

Health Financing

Financing of the health system – specifically mobilizing, pooling, and allocating funds to cover the health needs of the population – is a critical element to ensuring access to quality health care. Grenada’s total health expenditure as a percentage of GDP was estimated at around 7.4 percent in 2009, similar to other countries in the region. However, public sector budget shortfalls pose an ongoing threat to the health sector. Also of concern is Grenada’s very high and growing reliance on out-of-pocket payments to finance health care, accounting for an estimated 48 percent of total health spending in 2009 according to the World Health Organization. This reflects increasing use of private health care providers as well as off-island care-seeking, and implies that many families may be at risk of burdensome health care costs. The country is again moving forward with discussions of a national health insurance scheme, which could help ensure better financial protection and access to services for many families – especially lower- and middle-income families who cannot afford or access private health insurance. While a proposed new tertiary hospital could reduce the need for off-island care, careful planning will be needed to ensure that it is adequately financed and does not draw resources away from community-level primary care services. Gathering more comprehensive health expenditure and service utilization information – especially about the private sector – will be essential as plans for insurance and the new hospital are developed.

Key findings and recommendations in the area of health financing are as follows:

Findings	Recommendations
<ul style="list-style-type: none"> • Grenada prioritizes health in its national budget, but its economy is very vulnerable and recent budget shortfalls pose a severe challenge to the public health sector. • There is good access to public sector PHC services. • Broad fee exemptions, weak billing systems at public facilities, and uneven collection of fees mean that many who could pay receive free care. • According to the WHO, Grenada relies more heavily on out-of-pocket spending than any other country in the Caribbean region. • The MOH urgently needs data that links health spending, utilization, and outcomes to support evidence-based planning and budgeting. 	<ul style="list-style-type: none"> • Build capacity for stronger public financial management at the MOH; consider drawing upon existing Ministry of Finance expertise. • Conduct a National Health Accounts (NHA) estimation and institutionalize capacity for NHA, so that expenditure information is routinely available for evidence-based planning. • Strengthen billing systems and revise exemption system at public facilities to recoup costs from private insurers and patients with ability to pay. • As part of a 2012–2017 strategic health plan, develop a health financing strategy to reduce rising out-of-pocket spending, increase efficiency and quality, and explore a national health insurance scheme. • Plan carefully to ensure that a new tertiary hospital with teaching facilities does not drain funding of national health priorities. • Within the context of an overall financing strategy, develop a financial sustainability plan for HIV/AIDS programming.

Service Delivery

Service delivery systems should aim to ensure access, quality, safety, and continuity of health care. Grenada has good coverage of and access to primary and basic secondary health care, though secondary facilities are often overcrowded with primary care-seekers. The largest share of health services in Grenada is delivered through public facilities. Some Grenadians, however, access private facilities as their first source of medical care (46 percent according to the *2007-8 Country Poverty Assessment*). HIV/AIDS counseling and testing services are integrated into PHC service provision, but treatment services are centrally located and stigma around PLHIV remains an issue. The key gaps in the service delivery system are in the areas of continuity of care, quality assurance, and strategies to address the growing burden of NCDs.

Key findings and recommendations in the area of service delivery are as follows:

Findings	Recommendations
<ul style="list-style-type: none">• There is an overutilization of hospitals for PHC. A clear system for referral and case management will be essential for managing chronic conditions such as HIV and cardiovascular diseases.• MOH leadership express strong commitment to the revitalization of PHC.• Maternal and child health and infectious disease indicators are very strong. There is a pressing need for a more cohesive national strategy for chronic disease prevention and treatment.• There is a need for a more systematic approach to Quality Assurance and Improvement that harnesses financing mechanisms and includes the private sector.• There are ongoing challenges with stigma and discrimination among clinical staff (HIV/AIDS, mental health, etc.)	<ul style="list-style-type: none">• Fast-track technical assistance to the PHC Revitalization Steering Committee to build capacity around planning, change management, and stakeholder engagement.• Conduct a chart review to evaluate the adequacy of NCD treatment and care while also creating an evidence base for strengthening quality of care.• Engage technical assistance to better integrate HIV/AIDS services at the primary care level. This could help both to increase access to HIV and related services and reduce stigma associated with the disease.• Develop provider education approaches to improve provider behaviors toward patients.

Human Resources for Health

Human resources for health (HRH) impact the availability, cost, and quality of health service delivery. A sufficient number of general medical practitioners and nurse-midwives support the current service delivery system in Grenada. However, the planned revitalization of PHC and the country's disease burden will require an increased number and range of medical and nursing personnel. In addition, there are vital posts in the public health sector which have not been approved or established; some important positions are filled by staff on contract, which has implications for retention and security of tenure; and some key posts are vacant. Grenada has a good foundation for professional regulation and oversight. This foundation can be strengthened by expanding the capacity of regulatory bodies, by increasing the number of supervisory level staff, and by improving systems for monitoring and evaluation. There is a major need for comprehensive HRH planning and management, including for training and succession.

Key findings and recommendations in the area of HRH are as follows:

Findings	Recommendations
<ul style="list-style-type: none">• Grenada’s health system has a relatively stable workforce for its present services, with an adequate number of general doctors and nurse-midwives and a relatively good range of specialists.• There is no comprehensive HRH plan. The MOH has limited HRH planning capacity.• There are shortages of key medical and nursing specialists needed to enable the health system to adequately respond to changing epidemiological trends, and to shift resources toward primary health care.• Several initiatives now underway, in particular the intended revitalization of primary health services, have major implications for HRH which urgently need to be planned for.	<ul style="list-style-type: none">• Obtain approval and funding to recruit a Human Resources Director at the MOH, to provide the capacity needed to prepare and implement a comprehensive HRH plan.• Fast-track technical assistance to strengthen HRH planning capacity at the MOH.• Establish and strengthen linkages with nongovernmental organizations, the private sector, and other partners to improve pre- and in-service training, recruitment, and other elements of HRH development and management.• Increase the use of technology (such as telemedicine) for HRH development and management, for economies of scale.• Strengthen the capacity of the professional councils to implement and enforce provisions mandated in the Health Practitioners Act and other legislation.

Management of Pharmaceuticals and Medical Supplies

Grenada benefits from cost-savings by participating in the OECS Pharmaceutical Procurement Service (PPS). Public sector stock-outs and wastage are nonetheless common in Grenada, as a result of the lack of public sector funds, the use of manual forecasting, and weaknesses in inventory management. There is a vibrant private pharmaceutical sector in Grenada, which many consumers turn to when there are stock-outs in the public sector. There is also strong informal collaboration between the sectors, particularly when stock-outs occur. A key opportunity for the health system is to formalize such collaboration, in order to increase access to medicines. There is strong leadership and political will within the MOH to improve the regulation of pharmaceuticals and medical supplies. However, the lack of staff for pharmaceutical management impedes the ability of the government to enforce the law and to regulate both the public and private pharmaceutical sectors. Grenada can more actively participate in the PPS pharmacovigilance system by encouraging and institutionalizing the wider use of PPS adverse drug reaction forms in public pharmacies. Updating and improving pre-service education for pharmacists will contribute to improving the quality of pharmaceutical services overall.

Key findings and recommendations in the area of medicines and medical supplies are as follows:

Findings	Recommendations
<ul style="list-style-type: none">• There is strong leadership and political will at the MOH to improve regulation of the public and private pharmaceutical sectors.• Stock-outs and wastage in public sector facilities are common. Public sector stock-outs are primarily due to lack of funds.• A strong private pharmaceutical sector engages in informal collaborations with the public pharmaceutical sector to fill gaps when stock-outs occur.• There is a lack of capacity at the MOH to enforce regulations surrounding pharmaceutical importing, licensing, and rational prescribing practice.• Pharmacovigilance efforts are in need of strengthening.	<ul style="list-style-type: none">• Expand pharmaceutical sector management capacity at the MOH to improve regulation.• Appoint 1–2 additional pharmacy inspectors.• Formalize mechanisms for public pharmacies to source drugs from private pharmacies, to mitigate stock-outs and rationalize costs.• Encourage adverse drug reaction reporting through using the regional pharmacovigilance system.• Update, innovate, and strengthen pre-service and in-service training for pharmacists.

Health Information Systems

A well-functioning health information system (HIS) produces relevant, timely, and high quality information to support transparent and evidence-based decision making in the areas of planning, budgeting, resource allocation, and quality assurance. In Grenada, data collection, reporting, and use at public health centers for planning and monitoring is well-established, but there are important gaps in HIS processes at the central level. There is little use of data at the central level for planning, budgeting, and quality improvement. Hospital data available to the MOH is incomplete and private providers do not report into the system. This results in a partial picture of the health system, thus reducing the ability to plan effectively. Lack of data on household health expenditures and cost of health services limits the MOH's ability to plan for adequately funded, efficient, and equitable service delivery. At the central level, gaps in capacity for analysis, interpretation, and publication of data can be strengthened through targeted training and technical assistance. The implementation of the electronic national health information system (which was in the planning stages at the time of this assessment, although without confirmed funding) would improve efficiency in data collection and management at all levels.

Key findings and recommendations in the area of HIS are as follows:

Findings	Recommendations
<ul style="list-style-type: none">• Abundant data are collected from public health facilities through well-established processes.• Incomplete hospital data and lack of data from private providers results in a partial picture of the health sector.• Implementation of the electronic national health information system would improve efficiency in data collection and management at all levels.• Lack of data on household health expenditures and cost of health services limits the ability of the MOH to plan for adequately funded, efficient, and equitable service delivery.• An adequate number of staff collect and process data at all levels of the MOH system, but capacity for analysis, interpretation, and publication of data at the central level needs to be strengthened.	<ul style="list-style-type: none">• Conduct strategic planning for HIS as part of the next national health strategic planning process.• Prioritize implementation of the electronic national HIS.• Prepare and publish the annual MOH report on health outcomes and service utilization. In the long term, develop and implement a plan for systematic routine health information dissemination.• Identify training needs for data analysis, data quality, and information use, and prepare a plan for securing technical assistance for such training.• Establish routine private sector data collection, particularly for disease surveillance and key service utilization statistics.

Private Sector

Harnessing the private health sector can relieve constraints in delivering essential health services and result in increased efficiencies in resource utilization. The private health sector increases the scope and scale of services available in Grenada in important ways, such as by reducing overcrowding in public facilities and filling gaps when public sector drugs and supplies are unavailable. Private sector contributions in such areas have not been quantified. In terms of oversight, the recently enacted Health Practitioner's Act imposes new registration and licensing regulations for all medical, dental, and allied health practitioners, and addresses many weaknesses in current private sector oversight. Initiatives that would strengthen private sector contributions to the overall health system include: putting in place dual employment policies with clear requirements and sanctions; providing privileges for private providers at public hospitals in exchange for help in defraying costs; and introducing mandatory reporting of data from private providers to track overall health expenditures. Grenada has a long tradition of public-private stakeholder councils, committees, and alliances to foster cooperation with civil society for developing strategies to address health needs. However, outreach to the corporate sector is not well coordinated. This has diluted the potential to tap into the marketing resources of Grenada-based companies willing to support national health campaigns, and to invest in the health of their employees and customers.

Key findings and recommendations in the area of the private sector are as follows:

Findings	Recommendations
<ul style="list-style-type: none">• The private sector plays a large role in Grenada’s health care system, with more than 30 private doctors, 10 nurses, 33 pharmacies, and 3 labs.• Few data exist to quantify the scope, characteristics, or costs of these contributions.• Senior leaders within the MOH support leveraging public-private partnerships to improve access to health care.• Grenada’s CSOs (unions, non-profits, foundations, faith-based organizations, professional associations) play an active advocacy role and regularly participate in public-private councils to address social issues.• Corporate social responsibility contributions from Grenada-based companies are made on an ad-hoc basis.	<ul style="list-style-type: none">• “Map” the private sector to form a baseline regarding the private sector’s contribution to health care in Grenada, and collect routine private sector service delivery data.• Launch a multisector social marketing campaign to address wellness and prevention of chronic disease.• Pilot-test contracting with the private sector to alleviate critical public sector shortages.• Develop and enforce guidelines on dual practice in the public and private sector.• Implement public-private agreements to reduce stock-outs.• Support more formal engagement with private businesses; this could provide companies desired visibility as health partners tap into their strengths in marketing, and increase the impact of their support on critical health needs.

RESULTS FROM VALIDATION AND PRIORITIZATION WORKSHOP

The assessment team returned to Grenada in April 2012 to host a participatory workshop during which approximately 50 stakeholders validated the report’s findings and prioritize recommendations. This final draft of the report incorporates suggestions made by participants in that workshop. Annex XX includes the full workshop report, including suggested edits and additional recommendations as well as action plans for priority recommendations.

Stakeholders prioritized the following recommendations for urgent action:

- Implement the electronic Health Information System (HIS).
- Fast-track technical assistance for the PHC Revitalization Committee & launch a multi-sector wellness and prevention program.
- Update key health sector legislation and regulations and develop a new National Strategic Plan for Health.
- Strengthen capacity for Human Resources for Health (HRH) planning, and establish an HRH

Unit.

- Implement health financing studies and reforms (such as NHA and costing studies, and improvements to billing systems) in preparation for launch of National Health Insurance.

I. ASSESSMENT METHODOLOGY

I.1 FRAMEWORK FOR THE HEALTH SYSTEMS AND PRIVATE SECTOR ASSESSMENT APPROACH

Health Systems 20/20 and the Strengthening Health Outcomes *through* the Private Sector (SHOPS) projects, in collaboration with the Ministry of Health (MOH), used a combination of the Health Systems Assessment (HSA) and Private Sector Assessment (PSA) approaches to undertake a rapid assessment of Grenada's health system. The HSA approach was adapted from USAID's *Health Systems Assessment Approach: A How-To Manual* (Islam 2007), which has been used in 23 countries. The HSA approach is based on the World Health Organization (WHO) health systems framework of six building blocks (WHO 2007). The standard PSA approach has been used in 20 countries and SHOPS is currently developing a how-to guide for future assessments.

The integrated approach used in Grenada covered the six health systems building blocks: governance, health financing, service delivery, human resources for health (HRH), pharmaceutical management, and health information systems (HIS). Special emphasis was placed on the current and potential role of the private sector within and across each health system building block. Additionally, the health system's ability to support the HIV response was examined throughout each dimension.

The objectives of the assessment were to:

- Understand key constraints in the health systems and prioritize areas needing attention
- Identify opportunities for technical assistance to strengthen the health system and private sector engagement to sustain the response to HIV
- Promote collaboration across public and private sectors
- Provide a road map for local, regional, and international partners to coordinate technical assistance

I.2 ASSESSMENT PROCESS

I.2.1 PHASE I: PREPARE FOR THE ASSESSMENT

During the preparation phase, the assessment team worked with the MOH and the National Infectious Disease Control Unit (NIDCU) to build consensus on the scope, methodological approach, data requirements, expected results, and timing of the assessment. Recognizing the importance of building strong partnerships among the government, donors, private sector, and nongovernmental and community organizations, team members held a pre-assessment workshop in conjunction with the MOH to meet with stakeholders. The objectives of the half-day workshop were to (1) explain the methodology to be used, (2) identify key issues for further investigation during data collection, and (3) clarify expectations for the assessment.

A team of technical specialists for priority areas identified in the stakeholder meeting was assembled. These priority areas included health financing, governance, and HIS. The team of seven consisted of representatives from Health Systems 20/20, SHOPS, the International Training and Education Center for Health (I-TECH), and the Pan American Health Organization (PAHO).

I.2.2 PHASE 2: CONDUCT THE ASSESSMENT

The majority of health systems data were collected through a review of published and unpublished materials made available to the team by the MOH and development partners and obtained online. Team members produced a literature review for each of the health systems building blocks to develop an initial understanding of the system and identify information gaps. Semi-structured interview guides were developed for each building block based on the noted information gaps, standard PSA interview guides, and the indicators outlined in the HSA approach. A local logistics consultant assisted the team in preparing a preliminary list of key informants and documents for the assessment process, as well as arranging interviews.

Key stakeholders in both the public and private sector were invited to participate in key informant interviews to provide input and validate what had been collected through secondary sources. Key informants also provided additional key documents and referred the team to other important stakeholders. During the one-week data collection period, the in-country assessment team interviewed over 90 stakeholders. Interviewees included representatives of government, professional associations, health training institutions, nongovernmental organizations (NGOs), private businesses, health providers, pharmacists, and many professionals from the MOH. Site visits in urban and rural areas were conducted to verify data from key informants. These visits included public hospitals and health centers, private providers' offices, private labs, and private pharmacies. Responses were recorded by the interviewers and examined for identification of common themes across stakeholders while in-country. The team presented a preliminary overview of the emerging findings and recommendations to the MOH prior to the team's departure.

I.2.3 PHASE 3: ANALYZE DATA AND PREPARE THE DRAFT REPORT

Following the in-country data collection, the assessment team transcribed the responses of the stakeholders and reviewed the additional documents collected. The lead for each building block and the private sector lead drafted a summary of the findings and recommendations for their respective areas. The team lead, together with input from the rest of the team, identified key findings and cross-cutting issues and further developed recommendations. The results were compiled in an initial draft and submitted to quality advisors in the Health Systems 20/20 project and USAID for review. A final draft was submitted to the MOH for review and approval.

I.2.4 PHASE 4: DISCUSS FINDINGS WITH LOCAL STAKEHOLDERS

The assessment team used the findings in this draft report to conduct a workshop in April 2012 at which the MOH and key local stakeholders discussed and validated assessment findings and prioritized the recommendations. Special emphasis was placed on looking at the strengths and weaknesses of the health system and the recommendations to strengthen it and the role of the private sector. The team used the results of the prioritization to identify areas of technical assistance for USAID. Annex XX contains the full summary of this validation and prioritization workshop.

2. HEALTH SYSTEMS PROFILE AND BACKGROUND

This chapter provides an overview of Grenada's economic and health status performance, in order to capture the context in which the health system operates. Topics covered in this section include political organization, epidemiological profile, political and economic context, business environment, an overview of the service delivery system, and a snapshot of the key stakeholders and institutions in Grenada's health system.

2.1 OVERVIEW OF GRENADA

Grenada lies at the southern end of the Windward Islands and comprises three sister islands: Grenada, Carriacou, and Petit Martinique. The country's total land area covers 133 square miles. The country is divided into six parishes, and over two-thirds of the population lives in rural areas. However, the island is small enough for people to work or conduct their business in the capital, St. George's, without living in the city. Grenada is an upper-middle-income country with a GDP of US\$6,009 per capita (World Bank 2011), and tourism and agriculture are the main industries. About 30 percent of the population lives below the poverty line (CIA 2011).

FIGURE 2.1: MAP OF GRENADA



2.1.1 DEMOGRAPHICS AND POPULATION DYNAMICS

About 89 percent of Grenada's population is of African descent. Approximately 8.2 percent are of mixed East Indian, African, and/or European ancestry, reflecting Grenada's history of African slaves, East Indian indentured servants, and European colonizers. In 2009, the estimated population of Grenada was 104,487 (World Bank 2011). The median age is 28.6 and about 60 percent of the population is under the age of 25 (U.S. Department of State 2011) (Table 2.1).

TABLE 2.1: DEMOGRAPHIC INDICATORS IN GRENADA COMPARED WITH LATIN AMERICA AND CARIBBEAN REGIONAL AVERAGE

Health System Indicator	Grenada	Year of Data	LAC* Average	Year of Data	Source of Data
Population, total	104,487	2009	19,520,385	2008	World Bank 2011
Population growth (annual %)	0.37%	2009	1.10%	2009	World Bank 2011
Rural population (% of total)	69.0%	2008	36.9%	2008	WHO 2011
Population ages 0–14 (% of total)	27.6%	2009	28.1%	2009	World Bank 2011
Population ages 65 and above (% of total)	7.2%	2009	6.8%	2009	World Bank 2011

Sources: World Bank (2011); WHO (2011); Health Systems 20/20 (2011).

*LAC=Latin America and Caribbean

2.1.2 REPRODUCTIVE HEALTH TRENDS

Until the 1960s, Grenada had high fertility rates and relatively high mortality rates. Since the 1960s, fertility rates have declined significantly to the current replacement rate of about 2.26 births per woman (see Table 2.2). The decrease in the fertility rate can be attributed to delaying of first pregnancies as a result of increased education for women, increased family planning interventions, and increased socioeconomic status. While teen pregnancy rates have decreased significantly over the years, they remain a challenge for the country. In 2009, the adolescent fertility rate was 39.6 births per 1,000 women aged 15–19, which is below the Latin America and Caribbean (LAC) average of 72.5 but still above the average 28.6 births per 1,000 for upper-middle-income countries. Grenada is to be commended for its extremely low maternal mortality ratio,

TABLE 2.2: REPRODUCTIVE HEALTH INDICATORS IN GRENADA COMPARED WITH LATIN AMERICA AND CARIBBEAN REGIONAL AVERAGE

Health System Indicator	Grenada	Year of Data	LAC Average	Year of Data	Source of Data
Contraceptive prevalence (% of women ages 15–49)	54%	2006	54%	2009	World Bank 2011
Total fertility rate (births per woman)	2.26	2009	2.2	2009	World Bank 2011
Pregnant women who received 1+ antenatal care visits (%)	100%	2005	95%	2009	UNICEF Childinfo
Maternal mortality ratio (per 100,000 live births)	None reported	2008	103	2008	IHME 2010; World Bank 2011

2.1.3 HIV AND AIDS

Grenada's HIV/AIDS epidemic is considered generalized. In 2009 the estimated prevalence rate was 0.57 percent (United Nations General Assembly Special Session on HIV/AIDS [UNGASS] 2010). By the end of 2009, a cumulative total of 403 HIV/AIDS cases had been confirmed in Grenada since the first case was reported in 1984 (UNGASS 2010). However, stigma and discrimination against people with HIV

remain strong in Grenada, and this limits testing rates as well as hampering prevention and outreach efforts. More males have been affected, with a cumulative male-to-female ratio of 1.8:1. The mode of transmission is predominantly via heterosexual intercourse though men who have sex with men. There is no known case of transmission through intravenous drug use and no record of transmission via blood transfusion. In 2008 and 2009, there were 56 newly diagnosed HIV positive cases, most of which had been identified through provider-initiated testing (UNGASS 2010). Recent statistics provided by Grenada’s NIDCU reveal a total of 54 persons with advanced HIV disease currently receiving antiretroviral therapy (ART). Six HIV-infected pregnant women received antiretroviral (ARV) drugs during this period for the prevention of mother-to-child HIV transmission (PMTCT).

2.1.4 CAUSES OF MORBIDITY AND MORTALITY

Life expectancy for Grenadians is 75.49 years (World Bank 2011) (Table 2.3). Infant and under-five mortality rates are very low. Chronic noncommunicable diseases (NCDs) now account for the majority of reported health problems in Grenada. Diseases of the circulatory system are among the leading causes of morbidity and mortality in adults (Government of Grenada 2005). These trends reflect a shift in epidemiological diseases pattern from communicable diseases to NCDs. This is driven by factors such as an aging population and sedentary lifestyles, as well as dietary habits.

TABLE 2.3: MORTALITY INDICATORS IN GRENADA COMPARED WITH LATIN AMERICA AND CARIBBEAN REGIONAL AVERAGE

Health System Indicator	Grenada	Year of Data	LAC Average	Year of Data	Source of Data
Life expectancy at birth (years)	75.49	2009	73.59	2009	World Bank 2011
Infant mortality rate (per 1,000 live births)	9.0	2009	18.9	2009	World Bank 2011
Under-5 mortality rate (per 1,000 births)	11.1	2009	22.6	2009	World Bank 2011
Maternal mortality ratio (per 100,000 live births)	None reported	2008	103	2008	IHME 2010; World Bank 2011

Sources: World Bank (2011); WHO (2011); Health Systems 20/20 (2011), IHME (2010).

2.2 POLITICAL AND MACROECONOMIC ENVIRONMENT

Grenada gained independence from the British in 1974, and is a member of the British Commonwealth. It is a parliamentary democracy, and has had a stable political environment since 1983. The Parliament is responsible for making laws and has two chambers. The House of Representatives has 15 members, elected for a five-year term in single-seat constituencies. The Senate has 12 appointed members, 6 appointed by the government, 3 by the leader of the opposition party, and 1 each by the Trade Union Council, Chamber of Commerce, and Farmers’s Association.

Grenada is a member of two major regional bodies, the Caribbean Community (CARICOM) and the Organization of Eastern Caribbean States (OECS). These entities play a vital role in developing government policies, including health policy, and are often the recipients of resources or assistance for the region. CARICOM, established in 1973, reflects a vision for common political, economic, and legal policies, although the organization does not have supranational political powers. It now includes 15 member countries. The OECS was formed in 1981 by the six smaller English-speaking island nations of

CARICOM which desired greater integration: Antigua and Barbuda, Dominica, Grenada, St. Kitts and Nevis, St. Lucia, and St. Vincent and the Grenadines. The OECS has successfully created a common currency and central bank and it regulates banking and securities, telecommunications, and aviation. It has developed common foreign, defense, and security policies. The organization has also created common strategies to deal with regional concerns such as education, health, agriculture, tourism, and the environment (IBRD 2010).

The economy of Grenada is based primarily upon agricultural production (nutmeg, mace, cocoa, and bananas) and tourism. Agriculture accounts for more than half of merchandise exports, and a large portion of the population is employed directly or indirectly through agriculture. Since the construction of an international airport in 1985 tourism has also been a main source of foreign exchange. Reliance on agriculture and tourism has made Grenada highly vulnerable to global economic downturns and natural disasters. Two natural disasters, Hurricanes Ivan and Emily in 2004 and 2005, were economically devastating, and the public health sector incurred high costs in damages. Grenada has recovered substantially since these catastrophes but is now saddled with the debt burden from the rebuilding process. The public debt-to-GDP ratio is nearly 110 percent, leaving the government limited room to engage in public investments and social spending. More than 70 percent of the public debt is owed to external creditors (commercial and multilaterals) who look for fiscal restraint. Grenada's debt relief, supported by the IMF, calls for public spending to not exceed 40 percent of GDP, and the MOH budget is fixed at about US\$20 million for the next few years. Strong performances in construction and manufacturing, together with the development of tourism and an offshore financial industry, have contributed to growth in national output; however, economic growth was stagnant in 2010 after a sizeable contraction in 2009, because of the global economic slowdown's effects on tourism and remittances (CIA 2011) (Table 2.4).

TABLE 2.4: ECONOMIC INDICATORS IN GRENADA COMPARED WITH LATIN AMERICAN AND CARIBBEAN REGIONAL AVERAGE

Indicator	Grenada	Year of Data	LAC Average	Year of Data	Source of Data
GDP per capita (current US\$)	\$6,009	2009	\$7,196	2009	World Bank 2011
GDP growth (annual %)	-1.12%	2009	-2.00%	2009	World Bank 2011
Per capita total expenditure on health (PPP Int\$)	\$620	2008	\$788	2009	WHO 2011
Private expenditure on health as % of total expenditure on health	49%	2008	43%	2008	WHO 2011
Out-of-pocket expenditure as % of private expenditure on health	98%	2008	69%	2009	WHO 2011

Sources: World Bank (2011); WHO (2011); Health Systems 20/20 (2011); Kairi Consultants Ltd. (2008).

Grenada is classified as an upper-middle-income country by the World Bank and ranked “high” on the human development index, but national averages hide inequities. A Caribbean Development Bank-funded Country Poverty Assessment in 2007/08 found 38 percent of the population was living below the national poverty line of EC\$5,842 (US\$2,150) per adult per year, and 2.4 percent were deemed to be indigent. In addition, in 2008 it was estimated that the national unemployment rate in Grenada stood at 25 percent, and among the poor that number was at 35 percent (Kairi Consultants Ltd. 2008). These

figures are likely higher now given the economic crisis. In addition, the cost of goods and services is often much higher in Grenada due to small economies of scale and heavy reliance on imports.

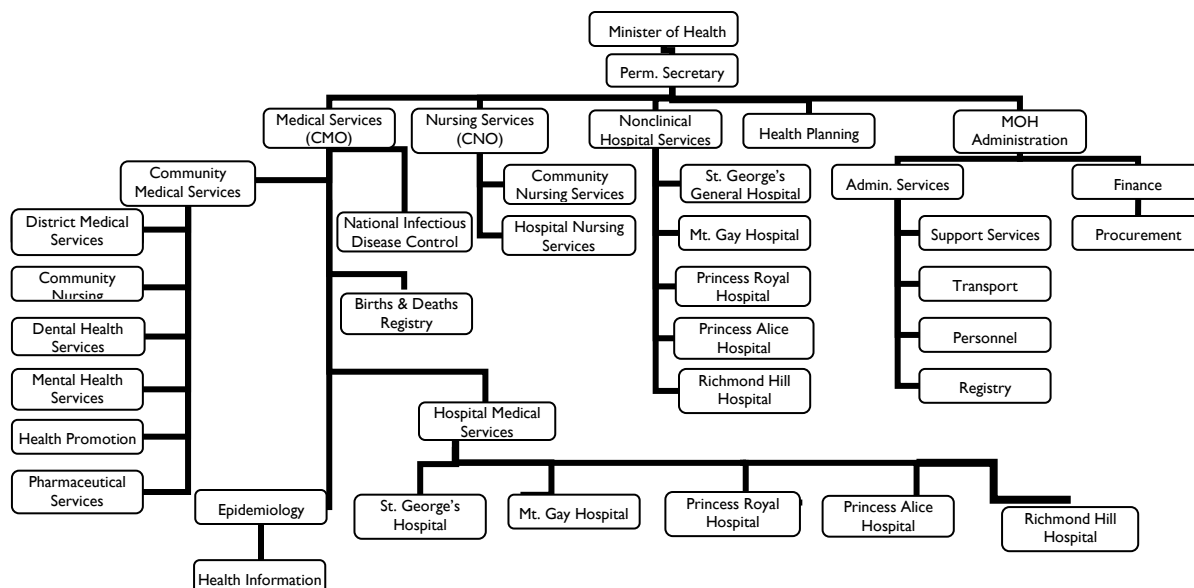
The general macro-environment in Grenada has been conducive to investment. However, Grenada still lags behind some of its OECS neighbors in terms of broad socioeconomic development and faces challenges in its efforts to attract further investment. Among other factors, the most serious constraints to doing business in Grenada include its susceptibility to natural disasters, the lack of a highly skilled well-qualified labor force, the high cost of and lack of access to finance, and high tax burden (FIAS et al. 2004).

2.3 HEALTH SYSTEM OVERVIEW

2.3.1 GOVERNMENTAL INSTITUTIONS INVOLVED IN THE HEALTH SECTOR

The MOH manages the public health sector in Grenada. It is divided into three main areas: Administration, Hospital Services, and Community Health Services (see Figure 2.2) and also is responsible for environmental health as well as the registry of births and deaths. The MOH creates policy, enforces regulation, and provides programmatic guidance. The MOH also oversees health statistics, health expenditures, health care-related inventory, and the health workforce. The Ministry of Finance (MOF) has authority to determine overall expenditure levels. The Department of Human Resources (housed under the Prime Minister's office) approves all public sector staffing, and the Public Services Commission determines the terms of appointment and employment for all staff. Health facilities do not have decentralized control over budgets, human resources, and strategic decisions; these are managed at the MOH level.

FIGURE 2.2: ORGANIZATION OF THE PUBLIC HEALTH SYSTEM



Source: Government of Grenada (2005).

CMO = Chief Medical Officer

CNO = Chief Nursing Officer

2.3.2 PUBLIC SECTOR HEALTH CARE FACILITIES

Primary health care in Grenada is delivered through a network of 30 Medical Stations and six Health Centers. There are six health districts in Grenada, each of which is managed by a District Medical Officer. Three district hospitals provide secondary care, and General Hospital in St. George's is the main referral hospital. In addition, Mt. Gay Hospital serves as Grenada's mental hospital. Health facilities are located throughout the islands such that every household is within a three-mile radius of the nearest point of care. Chapter 5 (Service Delivery) provides more details on these facilities.

2.3.3 PRIVATE SECTOR HEALTH CARE FACILITIES

The private sector plays a large role in Grenada's health care system, with more than 30 private physician practices and three laboratories. There are four private health facilities (St. Augustine Hospital near St. Georges, Grenville Medical Services in St. Andrews, Old Trafford Medical Center in St. Georges, and Marryshow's Hospital in St. Georges) each with diagnostic facilities and laboratory services. The private sector serves as the sole provider of CT scans, dialysis, and digital x-rays. There are an estimated 30–40 licensed private pharmacies in Grenada currently in operation. See Chapter 9 (Private Sector Contributions to Health) for further details.

2.3.4 HIV/AIDS SERVICES

Until 2009, the National AIDS Directorate (NAD) coordinated Grenada's multisectoral HIV program. This entity was dissolved following the end of World Bank funding for HIV prevention and control in 2009. Currently, the NIDCU manages implementation of HIV programming as a stand-alone unit under

the auspices of the MOH. The NIDCU's clinic provides counseling, testing, treatment, and care and support services, and is located on the campus of the General Hospital. This clinic is the only public sector site for HIV treatment services in Grenada, including ARV drugs. Community-level health facilities in the country offer HIV/AIDS counseling and testing during once-weekly clinics. Health centers offer some care and support services. ART is provided to all eligible HIV-positive clients at no cost, as are ARV drugs for PMTCT.

2.4 KEY ACTORS IN GRENADA'S HEALTH SECTOR

Table 2.5 provides an overview of key actors involved in major aspects of Grenada's health sector, including actors in the public, private, and NGO sectors.

TABLE 2.5: KEY ACTORS IN GRENADA'S HEALTH SECTOR

Health Services	Role and Relationship
<p>Public</p> <ul style="list-style-type: none"> Ministry of Health Ministry of Finance Department of Human Resource Management, Prime Minister's Office Public Services Commission 	<p>MOH creates policy, enforces regulation, and provides programmatic guidance. The MOH also oversees health statistics, health expenditures, health care-related inventory, and the health workforce. The government is the primary provider of health care.</p> <p>Performs revenue planning and budget review; disburses funds; coordinates international donor support.</p> <p>Approves all public sector staffing.</p> <p>Determines terms of appointment and employment for public staff.</p>
<p>Private</p> <ul style="list-style-type: none"> Private hospitals Private physicians and nurses Private pharmacies Private laboratories 	<p>Numerous doctors work in dual public/private practice. There are three private hospitals each with diagnostic facilities and laboratory services. The private sector serves as the sole provider of CT scans, dialysis, and digital x-rays. There are an estimated 30-40 licensed private pharmacies in Grenada currently in operation, with as many as 20 additional practitioners dispensing medicines without a license. Eight wholesale distributors sell pharmaceuticals directly to private pharmacies and doctors.</p>
Medical Education Institutions	Role and Relationship
<p>Public</p> <ul style="list-style-type: none"> T.A. Marryshow Community College Schools of Nursing and Pharmacy 	<p>Provide Associate's degree-level training in nursing and pharmacology. Coordinate with off-island universities for Bachelor's-level training.</p>
<p>Private</p> <ul style="list-style-type: none"> St. George's University 	<p>Medical education institution that caters primarily to foreigners. Offers 10 scholarships per year to local candidates.</p>
Medical Insurance	Role and Relationship
<p>Public</p> <ul style="list-style-type: none"> Social Security (National Insurance Scheme) 	<p>Social Security provides medical coverage for employment-related injuries.</p>

<p style="text-align: center;">Private</p> <ul style="list-style-type: none"> • Sagicor • GTM Mutual • BAICO • CLICO 	<p>There is limited uptake of private medical insurance in Grenada (estimated at around 9% of the population). Sagicor is the main health insurance provider mainly through its plan for civil servants (offered through the Public Worker’s Union). BAICO and CLICO are currently under government receivership in all OECS countries. As a result, there is great uncertainty in the insurance marketplace.</p>
Civil Society	Role and Relationship
<ul style="list-style-type: none"> • Medical Associations • Dental Association • Pharmacists' Association • Grenada Planned Parenthood Association • Grenada Red Cross • Grenada National AIDS Council • National Chronic Non-Communicable Disease Commission • Kidney Foundation • Trades Unions 	<p>Various NGOs and civil society organizations (CSOs) are active in health promotion, education, and policy advocacy. The Grenada Medical Association (GMA) includes 80 members from both the public and private sectors. The National AIDS Council (NAC) of Grenada is responsible for coordinating oversight, policymaking, guidance, and accountability for the National HIV/AIDS Program.</p>
Industry	Role and Relationship
<ul style="list-style-type: none"> • Various large employers 	<p>Health insurance is made available to employees of several large companies in the financial, tourism, and manufacturing sectors. Some ad-hoc corporate contributions are made to support health services. A small number have sponsored employee awareness programs particularly related to HIV/AIDS.</p>

2.5 HEALTH SYSTEMS STRENGTHENING CAPACITY

The success of health systems strengthening (HSS) activities depends in part on the capacity of implementing organizations. Having the ability to deliver health care services does not always mean that the capacity for HSS is present; appropriate leadership, research, technical assistance, training, and advocacy are also essential. In Grenada, one of the major challenges is shortages of human resources at all levels. The MOH has the commitment to take on HSS and private sector initiatives but insufficient human resources to do so. Leveraging regional networks has been, and will continue to be, an approach that will allow the MOH to guide health system improvements. Table 2.6 demonstrates the challenges the MOH faces in gaining support in-country for HSS efforts.

TABLE 2.6: OVERVIEW OF HEALTH SYSTEMS STRENGTHENING CAPACITY IN GRENADA

Role and Function	Organization
Leadership to set direction, align stakeholders, mobilize resources, set standards, and monitor implementation	There is strong leadership and political will at the MOH but somewhat weak capacity for evidence-based planning. MOH public servants play multiple roles and are stretched thin.
Research to provide evidence for health system changes	Grenada can leverage its memberships in the OECS and CARICOM to benefit from the work of PAHO, Caribbean Health Research Council, and Caribbean Epidemiology Center, among others. Internally, capacity for data analysis needs strengthening.
Technical assistance to address specific problems	Grenada does not have a local pool of consultants, NGOs, or universities to rely on to provide technical assistance in HSS. St. George's University provides some resources to support medical facilities but does not provide strong support in research. NGOs and other CSOs lack the numbers and capacity to provide strong technical support.
Training to develop professionals with expertise in strengthening health systems	Regionally, there are capacity building opportunities via the University of the West Indies and PAHO's supported e-governance programs. On-island opportunities are limited.

2.6 INTERNATIONAL DONORS

In monetary terms, Grenada currently receives relatively little foreign assistance for health. There are a number of international donors who support the health sector, but this funding constitutes only 1–2 percent of health financing per year (see Chapter 4 [Health Financing] for more details). Many donors give financial support to regional entities, and do not have representation in Grenada itself but in regional offices located in Barbados. Some provide technical rather than financial support. The MOF coordinates relations with foreign donors across all sectors. Table 2.7 summarizes recent donor support to Grenada.

TABLE 2.7: RECENT INTERNATIONAL DONOR SUPPORT FOR HEALTH IN GRENADA

International Donor	Type of Support
Global Fund to Fight AIDS, Tuberculosis and Malaria	<ul style="list-style-type: none"> • Round 3 grant for prevention, care, and treatment in OECS (ended in 2010). • Round 9 Pan-Caribbean Partnership against HIV and AIDS (PANCAP) grant to provide free ARV drugs (ends December 2012).
United States Government (President's Emergency Plan for AIDS Relief)	<ul style="list-style-type: none"> • Supports laboratory strengthening, improved surveillance, enhanced HIV prevention efforts, stigma reduction, and HSS.
World Bank	<ul style="list-style-type: none"> • Ongoing e-Government for Regional Integration Program, to harmonize regional e-government frameworks in OECS, including health. • Loan-funded HIV/AIDS Prevention and Control Project (ended in 2009).
Pan American Health Organization	<ul style="list-style-type: none"> • Supports health information systems, primary health care, monitoring of Essential Public Health functions, quality of care, health financing, National Health Accounts, national policy for the elderly, health reform, environmental health, health promotion, disease prevention, and providing other technical assistance.
United Nations Children's Fund (UNICEF)	<ul style="list-style-type: none"> • Support for health and family life education policy.
Caribbean Development Bank	<ul style="list-style-type: none"> • Reconstruction of community health facilities, hospital management, and other initiatives.
United Nations Development Fund for Women (UNIFEM)	<ul style="list-style-type: none"> • Strengthening counseling services. • Mainstreaming gender analysis in HIV/AIDS.
Joint United Nations Program on HIV/AIDS (UNAIDS)	<ul style="list-style-type: none"> • Currently providing support for developing the next National Strategic Plan for HIV/AIDS.
Government of Venezuela	<ul style="list-style-type: none"> • Retrofitting of General Hospital.

Sources: Government of Grenada (2011), UNGASS 2010; PAHO (2007).

2.7 PUBLIC-PRIVATE PARTNERSHIPS

Grenada has a tradition of fostering public-private collaborations between the government and councils, committees, and alliances to develop strategies that address national health needs. Opportunities to strengthen partnerships exist, as weak coordination among the various groups has resulted in duplication of effort and diluted impact. Table 2.8 provides illustrative examples of public-private partnerships in Grenada. Many more are not captured here.

TABLE 2.8: ILLUSTRATIVE EXAMPLES OF PUBLIC-PRIVATE COLLABORATION IN GRENADA

Private and non-profit partners	Activity
Caribbean Broadcast Media Partnership on HIV/AIDS	Coalition of major Caribbean commercial and public broadcast companies; outreach and social marketing on HIV/AIDS
Scotiabank	Sponsors annual HIV testing days
Bryden & Minors	Donations for General Hospital
St. George's University	Donates medical equipment funding to the MOH, provides scholarships
Grenada Red Cross	Advocacy, community mobilization
Grenada Planned Parenthood	Advocacy, service delivery
Grenada Electricity Services Ltd. (GRENLEC)	Support for eye clinic and laboratory at General Hospital; support for Queen Elizabeth Home Rehabilitation

3. GOVERNANCE

Key Findings

- The health system is in need of an updated strategic plan.
- The MOH engages with civil society organizations and the media on health issues but this could be done in a more systematic, structured way.
- Mechanisms for citizen engagement are weak. Feedback mechanisms for the health system are ad hoc and based on direct contact with MOH officials, or public forums such as radio call-in shows.
- Legislation governing the General Hospital has been passed by the Grenadian Parliament, but has not been implemented, leaving an unclear regulatory framework.
- Health planning and budgeting capacity at the MOH could be strengthened.

Effective health governance is the process of competently directing resources, managing performance, and engaging stakeholders toward improving health in ways that are transparent, accountable, equitable, and responsive to the public (Islam 2007). Sustainable health interventions require that all of these processes are in place, as they are dependent on each other. Three primary sets of actors have responsibility for ensuring that these processes result in a strong health system: the state, health providers, and citizens (Brinkerhoff 2008). This Health Systems and Private Sector Assessment seeks to explain how effectively each of these health system actors interact with one another to achieve good health governance. In many countries, international organizations and donors present a fourth actor that can have significant influence on other actors and health system performance.

State actors include politicians, policymakers, and other government officials. Together, they develop, implement, and enforce the rules and regulations that govern the health system, provide policy leadership and oversight, organize state-managed insurance schemes, and determine financing for significant parts of the health system. State actors are also responsible for responding to citizen “voice,” as expressed in elections or advocacy efforts.

Providers are public and private sector health care staff and facilities and the organizations that support service provision. Their main role is to deliver services to clients and provide information to politicians and policymakers on performance and health indicators. They also lobby state actors in support of their own interests.

Citizens are consumers of health services. Citizens’ interests in health extend to the societal benefits of health services, not just their impacts on individuals. Citizens can interact with providers as individuals, or through organizations that represent their interests. Citizens influence policy formulation and service delivery by advocating for change, providing feedback to providers, and demanding performance from both providers and governments. They also contribute financing for the system through taxes, premiums, and out-of-pocket payments.

This assessment seeks to understand how these actors interact in Grenada, how formal and informal structures reinforce or inhibit these linkages, and how they influence the ability of the health system to meet performance criteria.

3.1 OVERVIEW OF GOVERNANCE IN GRENADA

The World Bank’s Worldwide Governance Indicators (World Bank 2011) are composite indicators that draw on a wide variety of sources to create scores of six different elements of overall governance. Data sources include document reviews and quantitative and qualitative surveys, such as interviews with think tanks, NGOs, and international organizations. The percentiles in Table 3.1 show the percentage of countries in the world that scored lower than Grenada on the selected indicators. These indicators give an overall picture of the strength of governance structures in Grenada.

TABLE 3.1: WORLDWIDE GOVERNANCE INDICATORS: GRENADA

Governance Indicators	2000	2005	2010
Voice and Accountability	66.8	67.8	72.0
Political Stability	77.9	63.5	66.5
Government Effectiveness	66.3	63.4	61.2
Regulatory Quality	65.2	61.8	63.2
Rule of Law	59.3	58.9	59.7
Control of Corruption	71.2	73.2	69.9

The Worldwide Governance Indicators for Grenada are firmly within the range that would be expected for an upper-middle-income country, though they also show a leveling off or even decline from 2000 to 2010. For example, Political Stability, Government Effectiveness, and Control of Corruption have all shown moderate declines in the last 10 years. On the other hand, a significant improvement in Voice and Accountability indicates that Grenadian society is becoming more open over time. The Rule of Law indicator reflects some weaknesses in contract enforcement, property rights, and judicial system effectiveness.

3.2 POLICY, LEGISLATIVE, AND REGULATORY FRAMEWORK

3.2.1 NATIONAL HEALTH SECTOR STRATEGY

Grenada developed a draft National Strategic Plan for Health covering the period 2007–2011. This plan was intended to provide the overarching framework for the management and implementation of health programs; however, the draft plan was never finalized and expired at the end of 2011. As many health policy-related developments are taking place, such as a rethinking of the PHC delivery system and the development of a new tertiary hospital, it will be critical to prioritize development of the next strategic plan in order to ensure a seamless transition. Widespread consultations within the MOH, and with external partners such as NGOs and other ministries, will ensure that programmatic priorities across the health system contribute to shared goals. A new strategic planning process will also help the MOH to better focus its priorities in light of a constrained budget situation.

The 2007–2011 draft plan was based on five key guiding principles that place emphasis on health as a development issue, encourage an understanding of the determinants of health and their role in health outcomes, promote the concept of value for money, and recognize the role of national stakeholders in advancing health in Grenada. The Strategic Plan for Health identifies five priority areas which include:

- **Health Issues:** NCDs, Communicable Diseases, Reproductive and Child Health, Health Care of the Elderly, Accidents and Injuries, and Occupational Health.

- **Health Service Issues:** Quality of Care, Community Health Services, and Hospital and Specialist Services.
- **Management and Health Systems:** Health Systems Structure, Management of Public Health System, Legislative Framework, Health Planning, and Procurement and Inventory.
- **Resources for Health:** Health Financing, Human Resource Management and Development, Information Systems, Acquisition and Maintenance of Equipment and Infrastructure.
- **Determinants of Health:** Environmental Health Issues and Environmental Protection.

In addition to the goals outlined in the draft strategic plan, the revitalization of PHC is one of the key strategic priorities of the MOH. The MOH recognizes that the current model of PHC, which emphasizes broad geographic access to basic services through a network of 36 medical stations and health centers, requires some fundamental changes to ensure that problems with quality, efficiency, and sustainability are addressed. (For more discussion on proposed changes to the service delivery structure, please see Chapter 5 [Service Delivery]). The MOH has put in place a multisectoral Primary Health Care Revitalization Steering Committee to recommend and oversee changes to the current model. Improving PHC structures will remain a strategic health priority into the next strategic planning period.

3.2.2 LEGISLATION

The health sector is governed by several key pieces of legislation, summarized in Table 3.2.

TABLE 3.2: KEY HEALTH LEGISLATION IN GRENADA

Legislation	Date Enacted
Health Practitioner’s Act	2010
Nurses and Midwives Registration Act	2003
Hospital Authority Act	1998
Hospital Act	1953
Public Health Act	1990
Drug Abuse (Prevention and Control) Act	1992
Pharmacy Act	1988
Medical Officers Act	1903
Grenada General Hospital (Fees) Rules	1988
Medical Products Act	1995
Mental Hospitals Act	1885

The first two pieces of legislation mandate the registration of health providers, including doctors, nurses, midwives, dentists, and allied health professionals in Grenada. They outline certification requirements and give broad powers to profession-specific councils (such as the Medical, Dental, and Nurses and Midwives Councils) to investigate complaints, manage disciplinary proceedings, and enforce training standards (such as Continuing Medical Education requirements). The Public Health Act gives the MOH its statutory authority and outlines broad roles and responsibilities. These pieces of legislation are common throughout the Caribbean, and show relatively recent updates to take into account new

thinking on disciplinary procedures and registration, especially for doctors. In this regard, Grenada is ahead of many of its OECS counterparts.

There remains confusion around the Hospital Authority Act and the Hospital Act. In 1998, the Hospital Authority Act was passed in order to update and clarify the regulations for the General Hospital. A stand-alone Hospital Authority, external to the MOH, was to be developed. However, the regulations to outline the implementation of this piece of legislation were never written and put into force of law, and the legislation contained a provision that all regulations under the previous Hospital Act would remain in force until new regulations were written. Political opposition to this “executive agency” model, including from unions, meant that the experiment did not last. On paper, the Hospital Authority Act is currently the governing legislation, but the regulations that enforce the 1953 Hospital Act are still being followed (Office of the Director of Audit 2007). The Office of the Director of Audit developed a comprehensive review of the legislation, regulations, and policies concerning the General Hospital in 2007 that outlined other legislative and policy gaps, including fee schedules that were not adhered to, weak regulations related to use of the private ward, and the lack of a full-time Medical Director to approve operational policies.

A key strength within health governance in Grenada is the willingness of MOH leadership to update and formulate new policy and legislation. While political will for improving the legislative framework is strong, MOH leadership indicated that lack of staff capacity was a limiting factor in updating outdated laws and formulating new legislation.

3.2.3 REGULATION OF THE PRIVATE HEALTH SECTOR

Grenada’s recently enacted Health Practitioner’s Act (2010) imposes new registration and licensing regulations for all medical, dental, and allied health practitioners in the public and private sector, and addresses many prior weaknesses in private sector oversight. The enactment of this legislation is a first step toward stronger stewardship and governance of the private health sector. Representatives from the Medical and Dental Associations are optimistic that the act will improve standards and oversight of health professionals, and are anticipating implementation of some key provisions. For instance, members of the newly established Medical and Dental Council, sanctioned with enforcement functions, were appointed in March 2011. Once their names are published in the Gazette, the council will be empowered to enforce regulation. While there is evident political will to strengthen enforcement of the private health sector through the council, a key concern is whether funding to support the council is adequate to ensure investigation and oversight. In addition, while the new council will regulate and license providers, health facility regulation remains a gap.

Aside from registration of health practitioners, the private sector in Grenada is self-regulated. There are insufficient resources for identifying and enforcing unlawful or unethical practices. However, few informants raised quality concerns about private physician or pharmacy practices, and a number of private providers spoke with pride about their personal professional standards, hygienic practices, and voluntary use of WHO treatment guidelines and other web-based resources. With no nationally sanctioned standards of care or routine oversight, quality of care in the private sector is largely unknown.

During this assessment, private sector stakeholders raised concerns about the business impact of weak government regulation – for instance, the unfairness of competing with unlicensed pharmacies, or with doctors who misuse public prescription pads for private clients. Several informants suggested that patients would be better served by mandatory continuing medical education for all health practitioners.

As pointed out by one private provider, the lack of resources available to the MOH limits the vigilance which can be applied to enforce quality in the private sector.

Grenada adopted an anti-corruption bill in 2007; however, weak enforcement remains a challenge. An ombudsman was appointed in 2009.

Private sector stakeholders highlighted the following regulatory issues as priority areas for attention:

- **Facility regulation:** Aside from private provider licensing requirements, there does not appear to be active oversight of private physician practices, medical offices, dental offices, or pharmacies. None of the providers interviewed were aware of any regulations regarding the operation of health care facilities. One major private hospital has been operating without an operator's license since its establishment in 1998, because no person of authority has conducted an inspection.
- **Dual practice policies:** Dual employment in the public and private health sectors is legally sanctioned in Grenada and widely practiced. Doctors appointed to the public service through the Public Service Commission are granted private practice privileges through their Letter of Appointment. Regular scheduled hours are required at public facilities, but key informants reported that absenteeism is a problem, as some doctors may prioritize their private practices. This is also alleged to lead to overuse of hospitals since patients are often unable to see doctors at the primary care level. Doctors who opt to practice in both sectors cite poor public sector working conditions, the lack of supplies, and low salaries as reasons for maintaining a private practice. Dual employment policies should be incorporated into broader HRH planning and strategy, with the adoption of clear requirements and sanctions, processes for performance evaluation and supervision, authorization to discipline those in noncompliance, and incentives to reduce abuses by rewarding public service. The right to dual practice should be maintained in order to retain physicians.
- **Access to hospital privileges:** Doctors practicing solely in the private sector reported that the greatest impediment to quality of care was the inability for them to obtain hospital privileges at General Hospital. At the same time, the auditor's 2007 report on hospital management reported an "unwritten agreement" between doctors and hospital management allowing publicly employed physicians to use the operating theater facilities free of cost for their private patients, "in compensation for low salaries and allowances paid to them" as well as in the hopes of retaining expatriate specialists. Under the current system, private doctors referring patients to the hospital write up their assessments and diagnoses, and send these along with the patient. General Hospital accepts these referrals but there are no communication channels to track patients, confer with the hospital staff, advise on treatment, or otherwise offer continuity of care. These are areas ripe for policy reform. The hospital privileges desired by private doctors could be granted in exchange for formalized private sector contributions to defray hospital costs, or for pro bono services to alleviate staff shortages. Formalization of these arrangements is important for transparency and accountability, as well as cost recovery.

3.3 GOVERNMENT STRUCTURES

As indicated in Chapter 2, the public sector health system in Grenada includes 30 medical stations and six health centers which are organized in six health districts. These facilities mainly provide health services; budgets, human resources, and strategic decisions are made at the MOH level. Each health district does have the responsibility to report to the Community Health Services Division on service use

statistics and disease patterns within their catchment areas. They can make suggestions about areas of need, such as staffing or equipment shortages, but do not have the ability to make decisions about these items. Additionally, Community Health Services develops a short annual report that highlights their areas of need for review during budget development.

The General Hospital has a Hospital Management Team comprised of three members, each of whom has responsibility for different areas of the hospital.

- The Medical Director, who is responsible for medical services, oversees the work of the physicians on staff.
- The Director of Nursing Services, who is responsible for all nursing services, prepares statistical reports and maintains records.
- The Director of Hospital Services is in charge of all administrative and financial functions of the hospital, including oversight of the orderlies, financial management, and maintenance.

The Director of Hospital Services officially oversees this team, as well as all services at the Princess Alice and Princess Royal Hospitals. Concerns about this management structure were not emphasized during on-site interviews.

In addition to the health care provided by these public sector hospitals, health centers, and medical stations, Grenada also has a vertical HIV program that is managed by the NIDCU within the MOH. This program is guided by the draft National HIV & AIDS Strategic Plan 2009–2015 (Government of Grenada 2009b) which focused on prevention, reducing stigma and discrimination, and scaling up treatment, among others. With the end of World Bank funding in 2009, finalization of a new strategic plan was put on hold, but UNAIDS recently provided funding to support development of the next plan (Bynoe-Sutherland 2011).

According to the 2010 UNGASS country report, the NIDCU is using the concepts from this draft strategy and is measuring progress against the indicators set out in this plan, even though the strategy was never finalized. Currently, the NAC provides a multi-stakeholder forum for determining priorities and needs regarding HIV; the NAC also provides strategic direction to the NIDCU for the HIV program. The MOH supports the NAC with secretarial support and meeting space. In the past, the NAD managed the HIV program, but this was structure dissolved with the loss of World Bank funding and the responsibility fell to the NIDCU.

The MOH embraced the political declaration of the 2011 UN High Level Meeting on HIV/AIDS in favor of an integrated approach to leadership and service delivery, but little movement has been made to integrate HIV into other health service programs.

3.4 CITIZEN VOICE, RESPONSIVENESS, AND TRANSPARENCY

3.4.1 CIVIL SOCIETY ENVIRONMENT

CSOs working in the health sector in Grenada are driven by the dedication, engagement, and personal relationships of their leaders. CSOs have engaged with the MOH on numerous occasions and across a wide range of areas. For example, following the end of World Bank funding in 2009, the NAC was disbanded. With leadership from the Minister for Health, the NAC was resurrected in 2010 to ensure a forum for civil society and government coordination on issues and services relevant to improving HIV services. The MOH provided funding for a part-time secretariat and meeting space.

The NAC is not the only forum that brings together government and external stakeholders around a common cause. The MOH also supports a National Chronic Disease Council that was launched in 2010. This commission was formed to provide input to the MOH on NCD policy and to guide health promotion efforts by CSOs and the MOH, especially during health fairs. The commission is made up of representatives from government, civil society, higher education institutions, and health care providers. Other civil society forums are convened on an ad-hoc basis, typically around specific pieces of legislation, policies, or strategic planning.

The MOH recognizes that many civil society leaders and organizations have great technical expertise on various health topics. Interviewees noted that CSOs were often asked to participate in consultation meetings, comment on draft policies, and even develop first drafts of legislation. Advocacy efforts are often based on personal relationships with high-level government officials, such as parliamentarians, ministers, and heads of department. The MOH regularly partners with organizations that are hosting health events, by providing MOH staff in an advisory role, speaking at events, and providing health promotion materials for church or community gatherings.

Media relationships are cultivated by both CSOs and the MOH. The Grenada National Organization of Women frequently goes onto radio shows to discuss HIV-related topics and answer questions. They are also in the process of writing a drama series on gender awareness and developing public service announcements. The MOH, in collaboration with a private sector hardware company, produces a weekly radio program on NCDs that invites experts to discuss treatment and prevention of diabetes, hypertension, and obesity. Questions from callers tend to focus on disease-specific issues. This radio program is a good example of a private sector partnership that the MOH has explored; the company pays for the airtime and gets a marketing benefit, while the MOH is able to improve knowledge of NCDs.

Organizations that represent health providers, such as doctors, nurses, pharmacists, and dentists, are also present in Grenada. These organizations have varying levels of engagement with the government and different abilities to influence policy and legislation. Interviewees from the Grenada Medical Association (GMA) noted that they would like to become more involved in policy development, mentioning for instance that there was not enough consultation with the GMA during the drafting of the Health Practitioner's Act. The GMA also conducts policy-relevant research for presentation to MOH officials. It recently held a series of town hall meetings to determine patients' willingness to pay for certain health services, and concluded that there was significant willingness, as long as quality improvements accompanied the increased cost. The GMA also noted that people with insurance and tourists were also willing and able to pay, but that the General Hospital has no mechanism to recoup costs from them. Provider organizations also noted that they focused on training and advocacy to increase funding levels for specific services. Common challenges for provider organizations include reconstituting their membership after years of dormancy and negotiating the challenges of party politics.

3.4.2 GOVERNMENT RESPONSIVENESS AND TRANSPARENCY

A draft Freedom of Information Bill was prepared in 2007, but has not yet been enacted into law. Health sector CSOs did not see the lack of a Freedom of Information Act as a major barrier to getting information; rather they noted that the MOH often does not have or produce the types of information that they need. Interviewees, both in civil society and within government noted that in many cases health system information was incomplete or did not exist, limiting transparency. While the MOH has plans for developing an annual report, the last such report was published in 2005 according to interviewees. Developing and disseminating an annual report would significantly improve transparency of statistics on health system usage and disease patterns.

In addition to health statistics, another way to look at transparency and responsiveness is the ease of accessing government documents, reports, and legislation. By this measure, Grenada has made recent progress. A number of government documents have been published on the government's official website (www.gov.gd). While the research team was unable to get access to many pieces of health legislation in Grenada in June 2011, as they were available only in hard copy that could not be removed from the government library, this has changed recently with online publication of legislation.

While engaging with CSOs is important, direct responsiveness to patients is also of key importance. During this assessment, we were unable to identify existing "citizen-provider committees" or other structures that might facilitate local-level engagement between citizens and providers, in order to improve services at health centers and medical stations. The complaint system at the General Hospital is weak; patients take their complaint to a nurse who forwards it up to the Director of Nursing Services. Interviewees noted that complaints are rarely tracked to ensure resolution and that the Quality Improvement Coordinator is not informed of complaints. Patients with complaints will often call radio stations in order to voice their grievances.

3.5 RECOMMENDATIONS

3.5.1 SHORT-TERM RECOMMENDATIONS

Begin development of a new national strategic plan for health (2012–2017).

As the current strategic plan remains in draft form, the most logical course of action would be to begin from scratch to develop a new strategic plan for health. Interviewees noted that the last strategic planning process incorporated extensive external stakeholder involvement, and the next planning process should be no different. As the political challenges faced by the previous strategy derailed its official adoption, steps should be taken to ensure that the new strategic plan is broadly representative of all stakeholders, as apolitical as possible, and reflective of the technical priorities of the MOH.

Continue to engage CSOs proactively and strategically as advocates and educators on health issues.

There are numerous opportunities for partnerships with CSOs and the media, particularly as partners in advocacy and to promote awareness of health issues in Grenada. Information sharing and policy dialogue between the public sector and CSOs is currently strong, but it may be useful to create a mechanism within the MOH for engaging civil society, facilitating two-way communication on issues of mutual concern, and to serve as a contact point for community alliances. A recently identified MOH focal point for coordinating with CSOs is a step in the right direction.

3.5.2 LONGER-TERM RECOMMENDATIONS

Strengthen information availability.

While Grenada currently has only a draft Freedom of Information Bill, openness and transparency of government data did not seem to be a major challenge for interviewees. Rather, the major challenge is that health system data are not easily accessible, nor are they collected or disseminated in a timely manner. The MOH recognizes the need to develop and disseminate an annual report in order to improve transparency and should be supported in this process. The recent initiative to post legislation electronically is an excellent step.

Develop mechanisms to directly engage citizens on health system issues.

Grenada does not currently have strong mechanisms for eliciting individual citizen feedback on service delivery problems. No citizen-provider committees exist at the primary care level, nor is there a clear system for registering complaints at hospitals. Instituting formal mechanisms for citizens to engage with health providers and government officials would strengthen citizen feedback. Additionally, developing a formal complaint mechanism at the General Hospital, with an intermediary such as an ombudsman to better track and process complaints, would both improve citizen engagement and increase feedback on service quality issues. Finally, as people often use radio call-in shows to provide feedback on the health system, the MOH could consider creative ways of using that medium to invite comments on broader health system issues, such as making the Chief Medical Officer available to radio programs, developing press releases on health information, and inviting radio journalists to dissemination meetings.

Reduce uncertainty around relevant health system legislation.

As noted by the Office of the Director of Audit, there are various concerns about how the General Hospital is managed. Even though the Hospital Authority Act is the relevant legislation, its provisions are unenforceable, due to poor clarifying regulations. While disagreements with worker unions complicated the implementation of the legislation, engaging in discussions around a politically feasible resolution would help to clarify the status of the hospital. Additionally, the Medical and Dental Council should take up its responsibilities under the Health Practitioners Act as soon as possible.

Strengthen capacity for evidence-based health planning, budgeting, and monitoring and evaluation.

The assessment team heard that health planning, budgeting, and monitoring and evaluation (M&E) skills were weak across the MOH. Health planning comprises a range of activities that contribute to improvements in health outcomes and facilitates the creation of actionable links between needs and resources. With the upcoming review of the National Health Plan and the development of a new five-year strategic plan, building the skills of health staff involved in planning, budgeting, and defining the strategic direction of health programs should be prioritized.

4. HEALTH FINANCING

Key Findings

- Grenada prioritizes health in its national budget, but its economy is very vulnerable and recent budget shortfalls pose a severe challenge to the public health sector.
- There is good access to public sector PHC services, most of which are provided free and funded through general tax revenues.
- Broad fee exemptions, weak billing systems at public facilities, and uneven collection of existing fees mean that public subsidies support many who would be able to pay.
- According to the WHO, Grenada relies heavily on private out-of-pocket spending to finance health care – more than any other country in the Caribbean region (an estimated 48% of total health spending).
- The MOH urgently needs data that links health spending, utilization, and outcomes to support evidence-based planning and budgeting.
- The MOH is considering two proposals that could either drastically worsen or potentially improve efficiency and equity: construction of a new tertiary hospital and national health.

This chapter presents an overview of health financing in Grenada. The WHO defines health financing as the “function of a health system concerned with the mobilization, accumulation and allocation of money to cover the health needs of the people, individually and collectively, in the health system.” It states that the “purpose of health financing is to make funding available, as well as to set the right financial incentives to providers, to ensure that all individuals have access to effective public health and personal health care” (WHO 2000).

Health financing has three key functions: revenue collection (raising sufficient money for the health system), risk pooling (combining funds raised so that individuals are protected from catastrophic costs and the burden of health spending is distributed equitably), and purchasing of services (allocating funds efficiently and effectively to health service providers). This chapter addresses each key health financing function in turn.

4.1 RESOURCE MOBILIZATION AND REVENUE COLLECTION

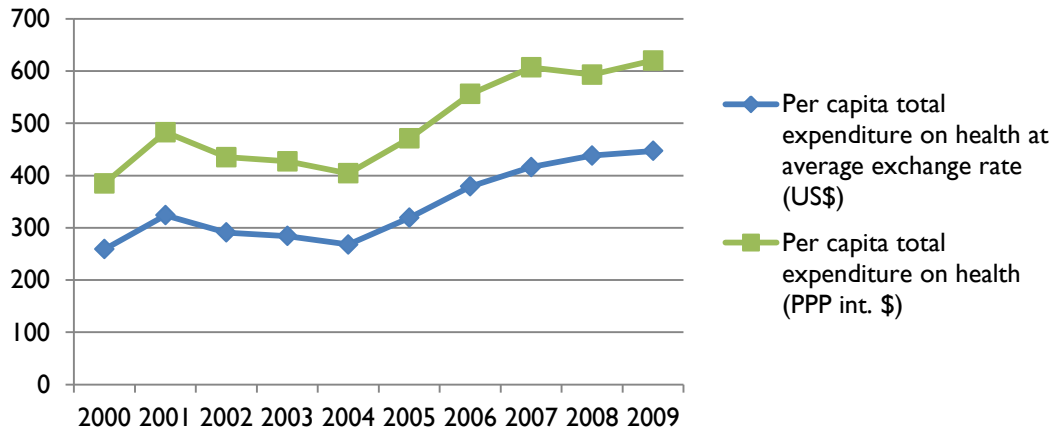
Grenada has never conducted a formal National Health Accounts (NHA) estimation. This means that health expenditure indicators reported by the WHO’s Global Health Observatory (reported below) are estimates, based on government reports, broad assumptions about private sector spending, and WHO calculations. The figures reported below should therefore be treated with caution. Annex A summarizes trends in these indicators over the past decade.

Total health expenditure per capita was estimated at US\$447 in 2009; this is equivalent to \$620 per capita in international dollars. There has been a relatively steady increase in total health spending per capita since 2004 (Figure 4.1). Because Grenada uses the Eastern Caribbean dollar – which has a fixed exchange rate with the U.S. dollar, thus keeping inflation low – this upward trend over the past few years represents a real increase in the resource envelope for health. The global economic crisis that

began in 2008 may decrease that resource envelope going forward, both through decreases in public budgets and through reduced spending by households on private health providers.

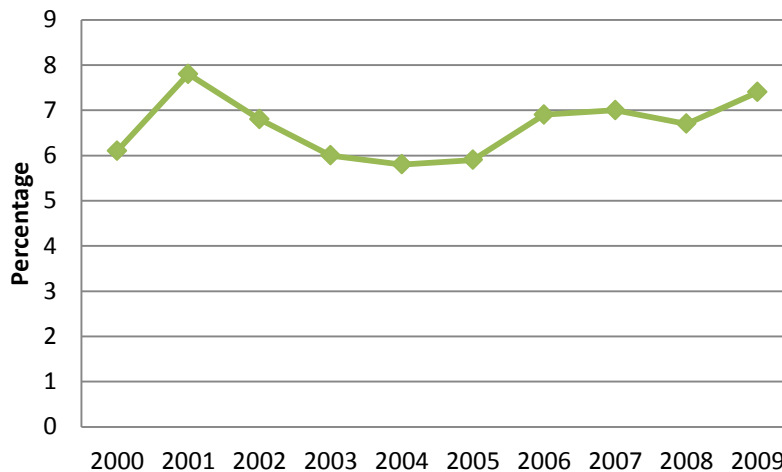
Grenada's **total health expenditure as a percentage of GDP** was estimated at 7.4 percent in 2009. This is more than the average for countries in the LAC region (6.7 percent) and upper-middle-income countries globally (6.6 percent) (Health Systems 20/20 2011). This indicator has been rising gradually since 2004 (Figure 4.2). Its growth is consistent with the country's positive income growth, which often correlates with increased health spending, and an increasing burden of chronic diseases, which are costly to treat.

FIGURE 4.1: PER CAPITA TOTAL EXPENDITURE ON HEALTH



Source: WHO (2011).

FIGURE 4.2: TOTAL EXPENDITURE ON HEALTH AS A PERCENTAGE OF GDP



Source: WHO (2011).

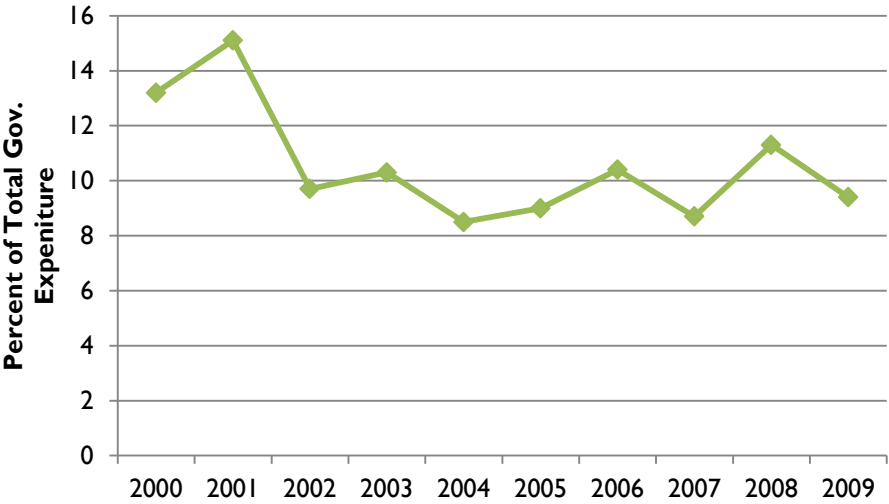
Government health spending in Grenada was US\$228 per capita in 2009 according to the WHO's indicator database. This level had been holding steady since 2006, and had almost regained the country's 2001 peak level of government spending (US\$232 per capita). However, preliminary government

expenditure estimates indicate that government spending decreased by more than 15 percent in 2010, to less than US\$20 million or US\$190 per capita (Government of Grenada 2010). This was a dramatic shock, likely due to the global economic crisis and decreased government revenues.

In relative terms, government spending is estimated to constitute 51 percent of total health expenditure in 2009. The true level of private spending on health is unknown because private health spending data are not collected through surveys or routine information systems. However, a 2008 survey found that more than 46 percent of the population first sought services from the private sector, either domestically or overseas. Even poorer groups sought care in private facilities (14 percent of the poorest quintile and 53 percent of the next-poorest quintile). While government health spending in absolute terms has been rising since 2004, its relative share has been declining from a high of 71 percent in 2001 as household spending has risen.

The government’s share of health spending is primarily generated from general tax revenues. The country allocated 9.4 percent of its total government budget to health in 2009 (WHO 2011) and 9.8 percent in 2010 (Government of Grenada 2010). This share has remained relatively stable since about 2002 (Figure 4.3), varying from 8.5 to 11.3 percent of the total budget. The proportion is comparable to budgetary allocations to health in St. Vincent and the Grenadines (9.5 percent), and less than those in St. Lucia (11.8 percent), Antigua and Barbuda (11.0 percent), or Barbados (10.8 percent).

FIGURE 4.3: GENERAL GOVERNMENT EXPENDITURE ON HEALTH AS A PERCENTAGE OF TOTAL GOVERNMENT EXPENDITURE



Source: WHO (2011).

During this assessment many stakeholders expressed concerns about Grenada’s economic situation and the strong budgetary pressures faced by the public sector. As noted in Chapter 2, the country’s economy is extremely vulnerable – as are all the small-island Caribbean states – to downward global economic trends, natural disasters, and the nation’s very high debt burden (110 percent of GDP). MOF interviewees noted that the economic crisis has resulted in shortfalls in projected revenues and serious cash flow problems in the past year.

Some public sector revenue is collected directly from health care consumers in the form of small **user fees** charged at health centers, hospitals, labs, and pharmacies. Fees are charged for minor and major

surgeries, laboratory tests, x-rays, and prescription drugs. In an attempt to generate additional health sector revenue, an updated fee schedule was instituted in April 2010. However, one hospital administrator estimated that fees only recoup between 5 and 20 percent of actual costs incurred, and noted that variations in fees charged are unrelated to variation in actual costs. Government budget estimates indicate that fee revenues collected were equivalent to 4.5 percent of total government health expenditure in 2010 (Government of Grenada 2010), totaling approximately US\$8.50 per capita.

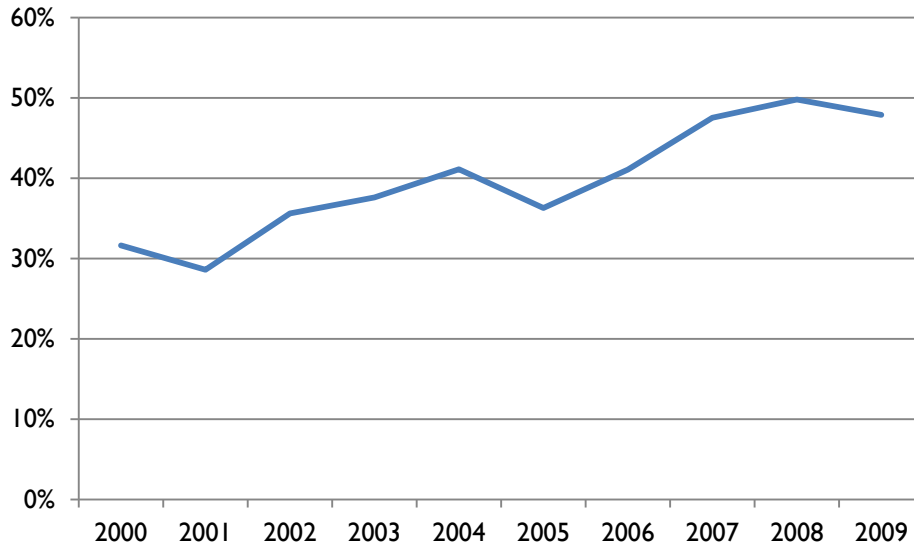
To promote access to services for vulnerable population groups, children under 17 and adults over 60 are exempted from all user fees, as well as individuals considered “indigent.” Several stakeholders interviewed expressed the opinion that many people who are able to pay are nonetheless exempted from fees. User fee revenue is not kept at health facilities, but must be returned to the Treasury, so facilities have little incentive to strengthen fee collection. Moreover, public sector facilities lack the billing systems necessary to recover costs from private insurance companies, so privately insured patients are able to receive publicly subsidized free care at hospitals and health centers. The MOH listed one of its priorities for 2011 as “Strengthen Mechanism for the Collection of Fees” (Government of Grenada 2010) and indicated that PAHO had offered to provide support for modernizing admissions and billing systems in the coming year. Information on PAHO’s assistance was not available at the time of this assessment.

While only a small portion of public sector health funds are raised through direct fees to consumers, nearly all other health spending – coming from sources other than the government (including employers, insurance, and households) – is estimated to be paid by households **out-of-pocket** at the time of using health services or purchasing medicines. The role of out-of-pocket spending to finance health care is suspected to have increased dramatically in Grenada over the past decade, rising from about one-third to nearly one-half of total expenditures on health (Figure 4.4). By 2009, out-of-pocket spending is estimated to have accounted for 48 percent of total health spending, and this share likely increased further in 2010 given the decline in public sector health spending noted above. If WHO estimates are accurate, *the 2009 out-of-pocket share in Grenada was higher than any other country in the Caribbean and similar to Haiti’s ratio of out-of-pocket financing (47 percent).*¹ It was also substantially higher than in the LAC region overall (34 percent), and among upper-middle-income countries worldwide (29 percent).

If confirmed, this trend should be a source of concern to policymakers in Grenada. Private out-of-pocket spending occurs in an unplanned, uncoordinated manner. High levels of out-of-pocket spending imply limited financial protection in health for many consumers and the risk that families could be impoverished by catastrophic costs. They also imply possible financial barriers to accessing high-quality care for substantial segments of the population. The share of Grenadians’ GDP being allocated to out-of-pocket health spending appears to have nearly doubled over the past decade (from 1.9 percent to 3.6 percent [author’s calculations]).

¹ Comparable ratios of out-of-pocket spending in other OECS countries in 2009 were: St. Vincent and the Grenadines (43 percent), St. Kitts and Nevis (38 percent), St. Lucia (32 percent), Dominica (30 percent), and Antigua and Barbuda (22 percent).

FIGURE 4.4: OUT-OF-POCKET EXPENDITURE ON HEALTH AS A PERCENTAGE OF TOTAL HEALTH EXPENDITURE



Source: WHO (2011).

As a percentage of the total health resource envelope, **international donor** funding currently constitutes only a small fraction of health financing in Grenada (approximately 1 to 2 percent per year on average). This is unlikely to change in the near future, given Grenada's upper-middle-income status and the global economic downturn. Disaster relief funding to rebuild the health sector after Hurricanes Ivan and Emily was provided by USAID, the U.K. Department for International Development (DfID), and the World Bank, among others. PAHO and the U.S. government (through agencies such as USAID, the Centers for Disease Control and Prevention [CDC], and the Health Resources and Services Administration [HRSA]) provide some technical assistance to the health sector. In addition, the government of Cuba has provided some bilateral support in health. A more comprehensive list of donors working in Grenada's health sector is included in Chapter 2.

4.1.1 RESOURCE MOBILIZATION FOR HIV/AIDS PROGRAMS

Currently, there is limited information on the impact of Grenada's HIV/AIDS response to date, how to make the response more cost-effective, and how the country will sustain its response after external assistance ends. Direct donor funding for HIV/AIDS-related activities has largely ended in Grenada. The World Bank credit-funded HIV/AIDS Prevention and Control Project ended in 2009, having disbursed US\$2.6 million to Grenada between 2003 and 2009. Along with the other OECS countries, Grenada also benefited from a multi-country Global Fund Round 3 grant (totaling US\$8.3 million across the six countries) that ended in 2010. The grant was used for prevention, care, and treatment, with a particular emphasis on voluntary counseling and testing as well as behavior change campaigns. The country continues to receive free ARV drugs through the OECS Pharmaceutical Procurement Service (PPS), with funding from a multi-country Global Fund Round 9 grant to PANCAP. Phase I of this funding is slated to end by December 31, 2012.

Grenada is a member of the United States–Caribbean Regional HIV and AIDS Partnership Framework, a five-year collaborative effort of the government of the United States and 12 Caribbean countries. The Partnership Framework is meant to facilitate efforts by U.S. government agencies and the 12 countries

to combat HIV and AIDS, with funding from the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). PEPFAR funding mainly supports the provision of technical assistance for laboratory strengthening, improved surveillance, enhanced prevention efforts, stigma reduction, and health systems strengthening.

According to Grenada's progress report to UNGASS for 2010, Grenada spent approximately US\$487,000 in 2008 and US\$196,000 in 2009 on its HIV/AIDS program – funding which largely came from external donors. The government's domestic contribution to the HIV/AIDS program was not reported, and its current spending level is unknown. The national budget does not have a line item for the HIV/AIDS program, either in the MOH budget or in other line-item budgets. The only reported estimate of purely domestic spending was included in the UNGASS report for 2006 and 2007 (approximately US\$100,000) (UNGASS 2008). A respondent from the NIDCU in Grenada (the MOH unit that provides care for sexually transmitted infections [STIs] including HIV) reported that the NIDCU does not separately track spending on HIV programs.

The NIDCU also indicated that the end of World Bank funding in 2009 has meant “doing more with less” for HIV/AIDS programming. The previous functions of the National AIDS Directorate were absorbed into the NIDCU. Without external funding, several staff had to be laid off, including the NAD Director, a PMTCT coordinator, and an administrative assistant. The government is now responsible for funding outreach efforts, including costs for staff time, gasoline, and communications materials; there are fewer outreach efforts in general, and greater reliance on volunteers. Programs in line ministries other than health have slowed down or stopped. While ARV drugs are funded by the PANCAP Global Fund grant, the government covers the cost of medications for opportunistic infections. A public-private partnership with Scotiabank supports free voluntary HIV testing and counseling days each year at sites around the country.

It is unlikely that domestic spending on HIV/AIDS will be able to replace donor funding at its previously high levels in the near future. Nonetheless, respondents did not express great concern about financial sustainability for HIV/AIDS programming going forward. The assessment team's impression was that Grenadian leaders are concerned about general financial constraints facing the country and the health sector as a whole. The growing burden of NCDs may be contributing to this shift in focus.

4.2 RISK POOLING AND FINANCIAL PROTECTION

In Grenada, risk pooling mainly happens *de facto* through tax-funded service provision at government health facilities. PHC services at health centers are generally provided free, and children, the elderly, and the indigent are exempt from all fees as noted above. Modest fees are charged to working-age adults for medicines, lab tests, x-rays, and surgeries.

Grenada has a mandatory social security scheme, known as the National Insurance Scheme (NIS), which provides old-age pensions, stipends for those unable to work due to disability or sickness, funeral and survivors' benefits, and employment injury compensation. Some medical coverage is provided for those injured on the job, including off-island evacuation if needed. The NIS is funded through a 4 percent payroll tax on employees and a 5 percent payroll tax on employers (with 1 percent allocated to the employment injury fund).

Currently, there is no national health insurance scheme in Grenada. The topic of national health insurance has been discussed for many years (see for instance PAHO 2002; PAHO 2007), with few notable developments. The draft National Strategic Plan for Health (2006) and the 2011 Ministry of Health Corporate Plan both listed exploration of national health insurance options as an important

national priority. In early 2011, the Committee for National Health Insurance was re-commissioned in an attempt to revitalize these efforts – a positive sign given the country’s worrisome reliance on out-of-pocket spending to finance health. The committee was asked to meet monthly and prepare a position paper on national health insurance before the end of the calendar year. Its members include one senator, senior leaders from the MOH, and representatives of the NIS. Some ideas being considered included organizing the scheme around the existing NIS; initiating health benefits for NIS contributors first and then scaling up coverage to other population groups; and starting with a small, tailored benefits package rather than trying to comprehensively cover a wide range of services.

Several topics will need to be considered as Grenada moves forward with the process of establishing insurance:

- What design is most appropriate?
 - Is a payroll tax-based model best? Payroll tax systems have the advantage of setting aside a dedicated funding stream for health that cannot be appropriated by other sectors. However, they represent a tax on labor and may exacerbate tax avoidance or incentivize employers to hire workers on a temporary basis (World Bank 2004). It will also be difficult to cover the portion of the population that is outside the formal sector (such as unemployed or informally employed workers, migrants, and children). This population is in the lower income quintiles and at risk for catastrophic health expenditures given relatively high use of private providers (14 percent in the poorest quintile and 53 percent in the next poorest). Another challenge is the estimated 25 to 30 percent unemployment rate in Grenada.
 - Would a “mixed” insurance model work? This would combine general tax revenue-financed care for priority groups (elderly, children, unemployed) with a payroll tax-financed health fund, and private insurance as an optional top-up.
- Will the scheme include private providers in its network? Without including private providers, the insurance will not address the problem of high out-of-pocket spending.
- How will providers be reimbursed for care provided? Fee-for-service reimbursement without careful cost control and utilization management mechanisms is known to result in cost escalation over time. Is capitation or global budgeting feasible?
- What benefits package can Grenada afford? What would this cost? What cost control mechanisms will be used to ensure financial sustainability?
- What are Grenadians willing to pay for health? Some respondents in this assessment expressed concern that Grenadians feel entitled to free health care, and will not be interested in paying more than they currently do.
- Who will be the “champion” for national health insurance? Who will “own” the insurance development process and keep momentum going? Should the MOF be engaged early given the country’s high debt? Foreign creditors or the IMF may demand a thorough financial feasibility analysis. Given the many stakeholders involved, clear leadership is essential.
- Could efforts to design a Grenadian health insurance system be linked with efforts to establish regional health insurance for the OECS?

Historically, moving from generalities to specifics and achieving consensus among varied political constituencies has been very challenging in countries moving toward universal health coverage. Much work will be needed to arrive at a workable, politically feasible, economically sustainable model.

Relatedly, the assessment team observed that the Committee for National Health Insurance does not include any representative of a private health insurance company. This is recommended for several reasons: to tap into expertise related to insurance administration in the private sector; to ensure open communication with a politically important interest group; and to ensure that the future relationship between public and private insurance schemes is carefully thought out. At least one private insurance representative interviewed for this assessment expressed great enthusiasm for a public insurance scheme, noting that it would likely be complementary with private insurance. The respondent had several quick suggestions for the design of the scheme (such as the importance of making it mandatory, marketing it well, and being careful not to overpromise an unaffordable benefits package) and expressed willingness to participate in future discussions on this topic.

In all the eastern Caribbean small-island countries, one particularly burdensome category of health care costs is off-island care. Certain advanced tertiary care services (such as some cardiac surgeries and advanced cancer treatment) are not available in Grenada. Individuals needing such care must seek services elsewhere in the Caribbean or in the United States, incurring higher treatment costs as well as travel costs for themselves and family members. Families are typically left to foot the bill themselves, unless they have private insurance coverage. Very limited financial support for off-island care is provided by the MOH in Grenada; in 2010, approximately US\$81,000 was allocated (MOH 2011). This funding is intended for those who are in urgent need and who cannot afford to pay, and is almost certainly far less than what is needed. Official guidelines for eligibility indicate that applicants must be in need of critical care to survive, unable to afford this care, and not currently covered by any health insurance. Applicants undergo a needs assessment including a home visit and must be referred by a certified practitioner. The existence of official eligibility guidelines implies some level of transparency in the allocation of this subsidy. The Government of Grenada has also established memoranda of understanding with other countries (Cuba, Trinidad) and organizations to provide off-island services.

As noted in the section above, there is little risk pooling of spending in the private health sector – most private health spending is out-of-pocket. Reliable figures for the percentage of Grenadians who have private health insurance coverage are not readily available. The WHO Global Health Observatory estimated that private insurance accounted for 0 percent of health expenditures in Grenada in 2009 (WHO Global Health Observatory 2011) – certainly an underestimate and likely reflecting a lack of data. The *2007–08 Grenada Country Poverty Assessment* reported that 7 percent of respondents had private health insurance, ranging from 1 percent in the poorest quintile to as many as 19 percent in the wealthiest quintile of the population (Kairi Consultants Ltd. 2008). As in other countries, individuals with private insurance are typically formally employed higher-income earners whose insurance premiums are partially subsidized by their employer or trade union. The wealth disparity in private health insurance coverage translates to inequitable access to health care services: those with insurance can afford to stay in the private ward of the General Hospital, access care from private health care providers, and obtain care off-island when needed. Those without private insurance are typically unable to do so.

Sagicor is the main private health insurance provider in Grenada. British American Insurance (BAICO), Colonial Life Insurance (CLICO), and Guyana-Trinidad Mutual (GTM) Insurance also provide some coverage. The seven largest unions in Grenada (including the Public Workers Union, Teachers Union, and Allied Workers Union) have negotiated with Sagicor to offer a health insurance plan to approximately 10,000 union members. The government of Grenada contributes 50 percent of the premium costs for those civil servants who voluntarily enroll in the union-sponsored plan. Workers can also pay to obtain coverage for their spouse and dependents. For approximately US\$28 per month, the group plan offers quite comprehensive benefits, including coverage for consultation fees, medicines, lab tests, private room fees, and off-island care. However, there is associated coinsurance (usually 20 percent of the total cost), deductibles, and lifetime maximum benefits. Patients typically must pay out-of-

pocket up front and submit a claim for reimbursement. There may be opportunities to expand access to group private insurance coverage through the labor movement in Grenada, which has the highest percentage of unionized workers (over half) in the Eastern Caribbean region (IMF 2004).

Key informants in the insurance industry stated that they have little to no interaction with the MOH, and that there is relatively little government regulation of private insurers. The Grenada Authority for the Regulation of Financial Institutions (GARFIN), established in 2007, is responsible for regulating this sector and has reportedly been paying more attention to the timeliness of quarterly reporting since the recent regional financial failures of BAICO and CLICO. These highly publicized failures have left many individuals with financial losses, and suspicion of private insurance companies has intensified. However, GARFIN's regulatory oversight mainly focuses on the financial health of the companies. It licenses the insurance companies annually and must approve the insurance products they offer, but does not conduct any direct monitoring of service quality or get involved in health insurance product details.

Information on the incidence of catastrophic expenditures was not available during this assessment.

4.3 RESOURCE ALLOCATION AND PURCHASING

In this section we look at how health sector money is being spent in Grenada, including resource allocation patterns, the process by which resource allocation decisions are made, and how payments are transferred to health care providers. These topics get at *efficiency* and *cost-effectiveness* in the use of scarce resources.

In broad terms, Grenada is achieving health outcomes superior to the LAC region at a similar total cost; and achieving health outcomes on par with other upper-middle-income countries, but at a significantly lower cost (Table 4.1). The priorities for health financing are increased efficiency given the country's debt crisis, equity and financial protection given the rise of out-of-pocket expenditures, and improved service quality (e.g., referrals, continuity of care, prevention) in the face of rising NCDs.

TABLE 4.1: COMPARISON OF SELECT HEALTH INDICATORS BETWEEN GRENADA, LAC REGION, AND UPPER-MIDDLE-INCOME COUNTRIES

Indicator	Grenada	LAC	Upper-Middle Income	Year of Data	Source of Data
Per capita total expenditure on health at average exchange rate (US\$)	\$438	\$383	\$552	2008	WHO 2011
Per capita total expenditure on health at international dollar rate	\$619	\$602	\$814	2008	WHO 2011
Life expectancy at birth, total (years)	75.32	72.89	72.02	2008	World Bank 2011
Mortality rate, infant (per 1,000 live births)	13.10	20.52	15.18	2008	World Bank 2011
Births attended by skilled health personnel (%)	98.80	94.42	97.28	2007	World Bank 2011
DTP3 immunization coverage: one-year-olds (%)	99.00	88.59	91.41	2008	WHO 2011
Pregnant women who received 1+ antenatal care visits (%)	100.00	96.09	96.23	2005	UNICEF Childinfo
Contraceptive prevalence (% of women ages 15–49)	54.00	54.03	55.17	2006	World Bank 2011

4.3.1 RESOURCE ALLOCATION PATTERNS

Grenada’s budget allocations to various health care categories are presented in Table 4.2.

TABLE 4.2: GRENADA’S DISTRIBUTION OF HEALTH BUDGETS

Category	2010 Actual	2011 Estim.	2012 Planned	2013 Planned
MOH Administration	13%	15%	15%	15%
General Hospital	52%	49%	49%	49%
Mt. Gay Psychiatric Hospital & Richmond Home	9%	10%	10%	10%
Princess Alice Hospital	4%	4%	4%	4%
Princess Royal Hospital	2%	2%	2%	2%
Community Health Services	20%	20%	20%	20%
TOTAL (%)	100%	100%	100%	100%
TOTAL (USD)	\$19,640,324	\$21,430,264	\$21,501,447	\$21,501,447

Source: Government of Grenada (2010)

The General Hospital absorbs approximately half of the nation’s health budget each year, and hospital services overall account for about two-thirds of recurrent spending. One-fifth of the budget is allocated to community health services, which includes funding for community-level medical stations and health centers, health promotion, environmental health, and dental health. This allocation to primary and preventive health care seems low, given the growing burden of NCDs in the country, although the portion of hospital spending on PHC and prevention is not known. In any case, it seems to contrast with the country’s stated emphasis on PHC services (listed as a budget objective in the 2011 Estimates – “Renewed integration of PHC approach at the centre of delivery of Health Care Services” – and emphasized during interviews with senior health policymakers). Leaders may wish to consider whether reallocating funds towards primary care might better contribute to those objectives. Since budgets for primary care and secondary care are separately allocated, providers at each level have little financial incentive to track their patients and ensure continuity of care between the levels.

Wages, salaries, and allowances absorbed a relatively high share of the recurrent health budget in 2010 (70 percent). Spending on consumables (drugs and supplies) constituted another 18 percent, while maintenance services received 0.9 percent. This distribution was more or less replicated in the 2011 estimates, with a slight increase in the allocation for drugs and supplies. A worrisome trend is that shortfalls in projected revenues have limited the country’s ability to procure needed items in 2011; there has been an increasing number of “unpaid claims” (bills) in the Treasury, as well as frequent need for “special warrants” or mid-year requests for budget increases. The most critical late payment issues relate to the OECS/PPS. In 2010, Grenada and St. Vincent and the Grenadines had the highest levels of debt to the PPS, according to key informants, and the PPS in 2011 threatened to cut off Grenada’s supply of drugs if payments were not made in a more timely fashion. Respondents in this assessment also expressed anxiety about rising pharmaceutical prices and the increasing share of the budget these inputs are likely to consume. It is not considered politically feasible to reduce spending on wages, especially during a time of economic contraction, though if there are stock-outs of drugs and supplies in public facilities patient out-of-pocket costs may rise as patients seek care in the private sector.

To improve efficiency and cut costs, the MOH is reviewing whether some of the 30 medical stations and/or six health centers might be consolidated under the Revitalization of Primary Health Care initiative. There may be too many facilities given low utilization rates in some areas, and the cost of allocating medical staff to those areas is reportedly very high.

4.3.2 BUDGETING AND PLANNING PROCESS

Grenada's MOH uses historical budgeting, rather than planning based on the population's health needs and estimates of resources required to meet those needs. According to MOF interviewees, there is no "scientific" method used to determine the budget allocation to the MOH. Previous spending levels, especially on staff, are the primary determinant of future spending levels. MOH respondents corroborated this perception, noting that a stronger interface between health information systems and the health planning process would be useful.

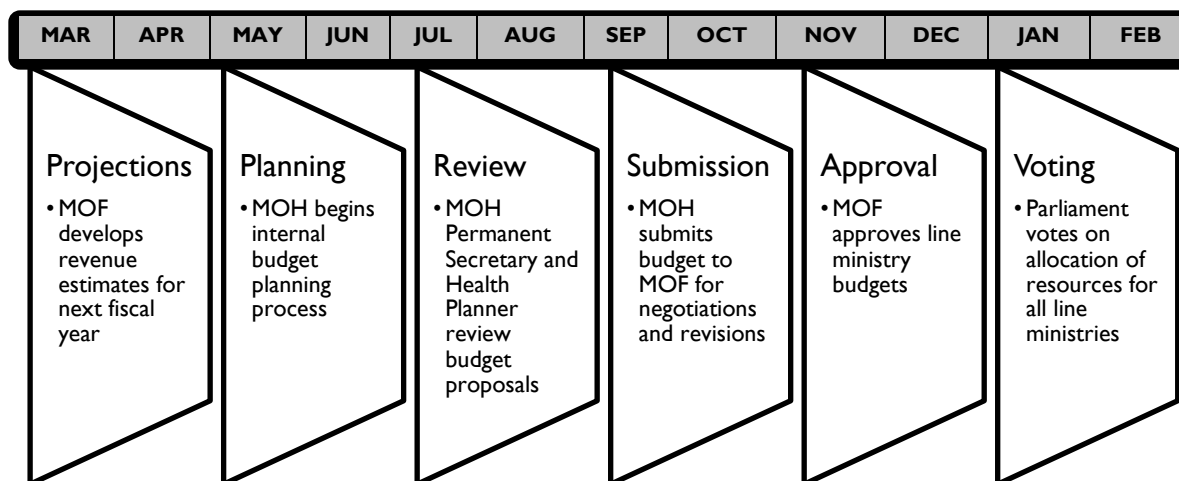
For the 2011 fiscal year, Grenada initiated a three-year "rolling forward" budget process. This was an attempt to improve the country's fiscal discipline, both through prospective setting of budget constraints and through allocation of resources in accordance with agreed-upon priorities (CARTAC 2010). Each ministry was asked to prepare three years of estimated budgets in advance. The objective was to increase the predictability of funding from year to year, ensure more "strategic" planning, and reduce the need for detailed oversight of each ministry by the MOF. Reportedly, the MOH was the only line ministry that failed to submit budgets for the two out-years, instead rolling over the projected 2011 budget. Respondents at the MOH explained that the rationale for three-year budgeting was not clear and staff did not understand what was expected of them; the process proved to be more difficult than expected. A training workshop was held in 2011 to better prepare staff for the next budget cycle.

The MOH's budget does list a series of program objectives, output measures, and outcome measures for each functional division (Government of Grenada 2010). This is a positive sign that the MOH hopes to move toward program-based budgeting over time. The budgetary categories, however, are still institution-based rather than program-based (e.g., Administration, General Hospital and other hospitals, Community Health Services). Specific objectives within a particular division are not linked with defined funding streams.

Grenada's fiscal year runs from January to December. The recurrent budgeting process begins with the MOF, which in the spring produces a forecast of the country's general revenues, grants, and loan revenues for the upcoming year. A budget envelope is set and shared with each ministry based upon the revenue projection and the previous year's budget. In May/June, each ministry is asked to begin preparing its budget within this envelope. Within the MOH, the finance team first estimates the funding needed to cover staff on payroll, including travel costs and per diems, and then estimates the cost of supplies, medications, and overhead. National budget consultations are then held with wide stakeholder participation including line ministry representatives and the MOF, during which the line ministries justify their proposed budgets including any requests for increased funding or additional staff. The MOF often requests additional detailed information at this point and (reportedly) almost always negotiates downward. The line ministries make revisions to draft budgets; drafts are presented to the Cabinet; final revisions are made; and the budgets are typically presented to Parliament in December or January for debate.²

² In December 2011, the government announced that the presentation of the FY2012 budget to Parliament would be postponed until March. The reasons for the delay were not articulated, but media articles speculated that it was due to the country's US\$30 million budget gap. ("Government seeking to allay concerns over delayed budget," *Antigua Observer.com*, Dec 11, 2011.)

FIGURE 4.5: BUDGETING PROCESS FOR THE MINISTRY OF HEALTH



One concern expressed by senior officials during this assessment was weak capacity for evidence-based planning in Grenada, and the absence of information on the real costs of services provided free through the public sector. This makes it difficult to project the likely benefits of a particular health program investment, to demonstrate to policymakers that the amount allocated for health is or is not “enough” to meet the population’s health needs, or to plan for major policy initiatives such as national health insurance. To make informed resource allocation decisions, health planners need to be able to link information about costs with information about utilization and health outcomes. As was also noted in the introduction to this chapter, NHA data are not routinely collected or analyzed in Grenada. PAHO has previously provided some training on NHA, but the process has not been institutionalized.

There is also a worrisome gap in information related to the private health sector. In essence, no one knows for certain how much money is being spent on privately provided health services. Information is lacking on service utilization patterns in the private sector (such as: which illnesses treated? which providers visited? which services provided? who is seeking care?), as well as the clinical outcomes of privately provided care. Given the very large estimated role of out-of-pocket spending for health care in Grenada as estimated by the WHO – the bulk of which is likely spent on private providers and off-island care – this absence of information should be of urgent concern to policymakers in Grenada. Not only is there potential for better, more coordinated policymaking and planning if the private health sector is considered explicitly and engaged proactively, but understanding the current role of the private sector is essential in any discussion of national health insurance that might cover private sector care.

During this assessment, senior policymakers at the MOH made reference to plans for constructing a new tertiary hospital in Grenada, to replace the General Hospital. The current hospital’s physical location on the edge of a cliff creates many logistical challenges and safety hazards for health workers and patients. In addition to improving the quality of care provided to the people of Grenada, it is envisioned that the new facility would be a teaching hospital, thus enhancing the medical education program offered by St. George’s University (SGU), and that it could attract significant medical tourism to the island. The hospital would be built with co-financing from the MOH, SGU, and the International Finance Corporation (IFC) as well as other private financing. According to interviewees, a technical planning committee has been established, with representation from each of these entities. The committee will review options for long-term financing, the appropriate number of beds, staffing, and other issues.

Planning for the new facility is still in its early phases, but the government of Grenada should proceed cautiously and deliberately with this proposal, given its enormous potential importance for the health system as a whole. Investing public funds in a tertiary facility bears the risk of drawing funding away from community-based, primary care services – especially over the long term as the costs of advanced care escalate. An emphasis on tertiary care would stand in contrast to the goals of the MOH’s Revitalization of Primary Care Initiative, which focuses on improving the efficiency, quality, and availability of services at the community level. Currently, senior officials recognize that there is overuse of the General Hospital for basic care in part because patients feel assured of seeing a doctor there, and hence obtaining better quality care, than they can at community facilities. Yet inappropriate use of higher-level services is wasteful and drives cost escalation. The opening of a new hospital might be likely to drive *additional* patients to seek more advanced care than they truly need, and result in higher system costs – a particularly worrisome risk if Grenada is having difficulty meeting its current budgetary obligations.

Another concern is patient safety. Tertiary care usually refers to specialized, complex conditions and procedures. There is a growing body of evidence that a high volume of cases is associated with better outcomes across a wide range of procedures and conditions (Halm et al. 2002). Given Grenada’s small population, it might be challenging to achieve sufficient volumes of these procedures to ensure adequate quality.

In addition, the potential revenue that can be generated through medical tourism should be carefully reviewed. Grenada should coordinate its planning with other eastern Caribbean countries also considering this revenue-generation approach, as the services offered by neighboring countries could dramatically affect demand for Grenada’s care.

4.3.3 PROVIDER PAYMENT AND PURCHASING

Provider payment refers to transferring funds to health service providers, ideally in a way that incentivizes efficient, high-quality, cost effective service provision. As examples, health care providers may be paid a fixed salary; they may receive a fee for each service provided; or they may receive a fixed payment per month for providing treatment to a particular population group, adjusted for the characteristics of that group. Public sector entities may contract with private providers to provide a particular set of services for a fee. Various performance incentives, both financial and nonfinancial, may be employed to stimulate provision of certain high-priority services, to ensure that services are provided in a high-quality manner, or to encourage outreach to particular vulnerable population groups.

Currently, no innovative public or private purchasing methods are employed to promote efficiency or quality. Public sector health care workers in Grenada receive a salary. Some specialist doctors from other countries (such as Cuba) are engaged through memoranda of understanding to fill human resource shortages. Private health care providers (and public employees who work in dual public-private practice) charge fees directly to their clients and sometimes to private insurance companies. Aside from these payment mechanisms, the assessment team did not observe “innovative” provider payment mechanisms being applied. As discussed more extensively in chapters 3 (Governance) and 9 (Private Sector Contributions to Health), some dual practice doctors make free use of public hospital operating theaters to treat their private clients, without paying any fees for this privilege.

Given the threat of health sector cost escalation, and especially as plans for national health insurance are developed, Grenada should consider alternatives to fee-for-service and salary-based payment to providers. As discussed above, the design of a national insurance system presents an opportunity to introduce payment methods such as capitation or global budgeting, which can create incentives for efficiency and quality. Salaries do not incentivize high-quality or highly efficient provider performance,

while fee-for-service payment incentivizes overprovision of services and is frequently associated with cost escalation. Contracts with private providers may allow the public sector to finance certain high-end services more cost-effectively (if private provision is more efficient, and if the private sector is better able to maintain equipment or retain specialized staff). Contracting out might also free up the public sector to focus on better managing high-impact public health programs.

4.4 RECOMMENDATIONS

4.4.1 SHORT-TERM RECOMMENDATIONS

Engage technical assistance to conduct and institutionalize NHA estimation.

This internationally accepted methodology is the most comprehensive, accurate estimation approach for identifying the sources of health spending (including household out-of-pocket spending) and how funds are spent. It is an informational foundation for health sector planning and is invaluable in supporting evidence-based policymaking, including advocacy for increased health sector budget allocations, shifts in the distribution of funds to different end uses and levels of the health system, and design of large health financing reforms such as national health insurance. NHA is a key input to a realistic health financing strategy. Regional and international sources of technical assistance, such as PAHO, the University of the West Indies (UWI), and USAID, could be tapped to build capacity for the process so that it can be institutionalized for routine implementation.

Strengthen billing and collections processes at hospitals in preparation for transition to national health insurance program.

User fees at public sector health facilities will never contribute more than a fraction of total health system costs, and they should not be utilized to generate substantial revenue because they are regressive. However, the targeting and application of fees in Grenada could be greatly improved, and if done appropriately, could increase equity as well as shifting service utilization patterns in desired ways. Also, if facilities were allowed to retain user fees, they would have an incentive to improve collection and could use a portion of the user fee revenue to address staff issues such as absenteeism and reward staff for customer-focused behavior. Grenada should modernize its public sector billing systems, especially at the General Hospital, so that private health insurance can be billed appropriately for public services provided to privately insured individuals. This will necessitate service unit cost studies, so that appropriate fee schedules can be developed for private insurance reimbursement. User fee structures should be revised to deter primary care-seeking at secondary hospitals, in concert with improvements to the quality of services at primary-level health centers. But fee exemptions should also be targeted and applied more systematically, so that those who do have the ability to pay are required to contribute. Finally, General Hospital should be staffed so that it can collect fees at all times, not just from 8am to 4pm.

Build capacity for stronger public financial management at the MOH.

Continued training on program-based budgeting, forecasting, and budget management would help the MOH move toward more strategic and evidence-based long-term planning. There was reportedly some confusion at the ministry about the three-year planning process now being used, and additional training might help demonstrate the value of this approach as well as facilitate its implementation. While the global economic crisis is to blame for Grenada's budget shortfalls in recent years, training to support better financial management would also help the ministry avoid frequent "special warrants," line-item reallocations, and unpaid claims.

Proactively plan for reduced external HIV/AIDS funding.

Grenada should develop a financial sustainability plan for the HIV/AIDS program, now that World Bank funding has ended. The MOH should conduct a projection analysis of available domestic and external funds going forward, and plan proactively to absorb the cost of ARV drugs after Global Fund support ends.

4.4.2 LONGER-TERM RECOMMENDATIONS

As part of developing a new health sector strategy for 2012–2017, prioritize developing a health financing strategy that would emphasize increasing efficiency given constrained resources, improving equity and financial protection given the rise of out-of-pocket expenditures, and improving service quality. The health financing strategy should include the following recommendations:

Carefully assess the feasibility of national health insurance, supported by technical assistance.

Grenada's WHO-estimated level of out-of-pocket spending on health was the highest in the Caribbean region in 2009, and its true level is unknown. The country should prioritize expanding insurance coverage to ensure good financial access to care and protect families from the risk of catastrophic health expenditures. Since health spending in the private sector and off-island are key drivers of these expenditures, any comprehensive insurance mechanism must address these sources of care.

Given the many stakeholders and the high political stakes involved, clear leadership and ownership of the insurance development process are essential. Identifying a “champion” for the process might be useful, as would including a representative from the private insurance industry. Managing the politics of national health financing policy development is often as challenging as the technical details, as is evident from the years-long discussion around national health insurance in Grenada. The country could draw from the ample experiences of other countries in scaling up insurance coverage in the Caribbean and elsewhere, and should avail itself of regional and international technical resources to address the myriad design and implementation challenges. In addition, an inclusive national discussion on this topic seems necessary before the government can consider collecting additional revenues from households; a technocratic “behind closed doors” approach is risky, especially if constituents may be asked to pay a new tax.

Develop routine facility-based electronic systems for tracking health care costs and expenditures, and linking them with service use and outcomes.

As Grenada builds a new electronic HIS (see Chapter 8 [Health Information Systems] for more details), systems to track the costs of providing services should also be put in place. Again, this would facilitate better evidence-based planning and resource allocation.

Plan carefully to ensure that proposed construction of the new teaching hospital contributes to and does not jeopardize national health priorities.

Opening a new tertiary hospital could increase on-island access to advanced health care services. However, there are numerous risks for Grenada at this juncture: the potential financial risk to the country if an ongoing financing stream is not established; the potential to promote cost escalation through a tertiary care emphasis; risk to patient safety if complex services are done at a low volume; and potential risks of staff being pulled away from community-level health services into tertiary care (in direct opposition to the PHC revitalization effort). Careful epidemiological, economic, and staffing analyses are critical. Ideally, the planning for this facility should be done in conjunction with plans to

develop a national health insurance scheme, since that might be tapped as the recurrent funding stream for the hospital.

5. SERVICE DELIVERY

Key Findings

- Maternal and child health and infectious disease indicators are very strong in Grenada. There is a pressing need for a more cohesive national strategy for chronic disease prevention and treatment.
- There is an overutilization of hospitals for PHC, and no clear system for referral and case management. There is strong commitment to the revitalization of PHC, but there are challenges in developing and rolling out the strategy.
- There is a need for a more systematic approach to quality assurance and improvement.
- There are ongoing challenges with stigma and discrimination among clinical staff (HIV/AIDS, mental health, etc.)

The WHO defines service delivery as the way “inputs and services are organized and managed, to ensure access, quality, safety, and continuity of care across health conditions, across different locations, and over time” (WHO 2007). Health service delivery is the most visible aspect of the health system because it is often where users interface with the health system.

The largest share of health services in Grenada is delivered through public facilities. Nearly 45 percent of respondents in a 2007 survey, however, noted that their first source of medical care was a private doctor, dentist, or hospital, either in Grenada or abroad (Kairi Consultants Ltd. 2008). A growing private sector provides additional, and often specialized, health services.

5.1 STRUCTURE OF THE SERVICE DELIVERY SYSTEM

In the MOH system, community-level PHC is delivered through a network of 36 health facilities within six health districts. The health facilities fall into two categories: medical stations (30) and health centers (6). A range of primary services are provided via these facilities and an organized home visit program, including maternal and child health, family planning, pharmacy, and nutrition (Government of Grenada 2005). Each health district has a health center which acts as a hub for between four and eight medical stations and provides more specialized services such as pediatrics, dentistry, and psychiatry. Health facilities are strategically located throughout the islands such that every household is within a three-mile radius of the nearest point of care. Public hospitals offer outpatient and emergency room services that are overused for PHC. Less than 5 percent of cases at hospital emergency rooms are true emergencies.

As noted in previous chapters, the MOH has stated an objective of revitalizing PHC services. The revitalization, which falls under the auspices of the newly formed Primary Health Care Revitalization Steering Committee, may include the consolidation of some facilities, the merging of some health districts, and a redeployment of health staff.

Grenada’s main public referral centers for secondary care are the 198-bed General Hospital in St. George’s, the 54-bed Princess Alice Hospital in the rural parish of St. Andrews, and the 40-bed Princess Royal Hospital on the island of Carriacou that also serves the residents of Petit Martinique island. There is currently a pressing need for several specialists at the General Hospital, and in Grenada in general,

notably in the fields of oncology/hematology, radiology, internal medicine, and emergency medicine. This lack of specialty staff, equipment, and facilities contributes to use of off-island medical services. The MOH set aside approximately US\$81,000 in 2011 – likely an insufficient amount – for Grenadians who were in urgent need of life-saving treatment and could not afford to pay.

St. George's is also home to the government-run Richmond Hill Institutions which include an 80-bed, long-stay mental health facility (Mt. Gay Hospital); a 20-bed acute psychiatric unit (Rathdune); a day-treatment substance abuse center (Carlton House); and a home for the elderly (Richmond Home). There are two additional geriatric care facilities and eight elderly care homes.

The number of doctors who serve clients in the private sector is unknown. Doctors are not required to identify themselves as dual practitioners or solely privately practicing physicians when they register with the Medical and Dental Council, so it is also unclear how many public sector doctors have private practices. Twenty-four private doctors are listed in the Grenada yellow pages. Stakeholders estimated that there are approximately 30-40 doctors actively serving private clients. A small number of nurses and nursing assistants are employed by private physician practices as well.

There are several private health facilities in Grenada: St. Augustine Hospital near St. George's, Grenville Medical Services in St. Andrews, Old Trafford Medical Center in St. George's, and Marryshow's Hospital in St. George's. St. Augustine is the largest, with 12 beds and a staff of 27, including one full-time doctor. All provide lab services including ultrasound, sonograms, electrocardiograms, mammograms, hematology, and x-rays. These services are also available at the public hospital, but the wait times are reportedly much longer. It was reported that some individual private practitioners have invested in lab equipment and services. The private sector serves as the sole provider of CT scans, dialysis, and digital x-rays. There is a perception among many Grenadians that the private sector provides higher-quality services, has shorter waiting times, and affords patients a greater degree of confidentiality than public facilities.

Public sector laboratory services in Grenada are highly centralized, with one public lab in the country. The three private hospitals have laboratory and diagnostic capabilities as well.

The non-profit Grenada Planned Parenthood Association provides reproductive health and family planning services via two private clinics and rural outreach teams. No NGOs offer inpatient care, though some engage in limited health promotion and community mobilization activities. There is not much evidence of employer-based health care programs. Scotiabank partners with the MOH, PANCAP, and the Caribbean Media Broadcast Partnership to support an annual HIV Testing Day.

Private facilities reported underuse of their operating theaters, medical equipment, and outpatient services, while the (public) General Hospital suffers from severe overcrowding and long waiting times. Clients who may have the ability to pay for the use of hospital services take advantage of free or subsidized public services, overburdening public facilities which could be positioned to provide services to the poorest who have no other options. Private facilities expressed interest in exploring contractual arrangements with the public sector. This might potentially be a way to reduce public costs if private contractors could provide services more cheaply. One respondent gave the example of tele-radiology services, which are available in the private sector and could address the severe shortage of radiologists in Grenada. In response to the lack of specialists on-island in the areas of hematology, cardiology, oncology, and x-ray technicians, several respondents commented that private providers might invest in identifying, hiring, relocating, and training foreign doctors with needed specialized skills if the public sector were willing to contract for these services. This would serve to fill the urgent need for clinicians to address the growing prevalence of NCDs.

The assessment team estimated that there are 304 hospital beds in Grenada and Carriacou (Table 5.1), or 29.2 beds per 10,000 population. This is an increase from the Global Health Observatory’s 2009 estimate (24) and more than the average in the LAC region (20.6), but less than the average for upper-middle-income countries worldwide (34.9) (WHO 2011).

TABLE 5.1: HOSPITAL BEDS IN GRENADA AND CARRICOU

Hospital	Public or Private	Number of Acute Care Beds
General Hospital	Public	198
Princess Alice	Public	54
Princess Royal (Carricou)	Public	40
St. Augustine	Private	12
Total		304

5.2 CONTINUITY OF CARE

In Grenada, there is no formal system for managing referrals, which poses significant challenges for ensuring continuity of services, case management, and tracking patients in general. Referrals are not uncommon, however – from primary to secondary levels and from public to private sector and vice versa – and are typically accomplished via handwritten notes and/or phone calls. For a small number of urgent off-island tertiary care referrals subsidized by the MOH, there is a more formal system, organized through a social worker at the MOH. A very small annual budget (usually less than US\$100,000) is available to assist those needing treatment abroad. Bilateral arrangements, especially with Cuba, have helped to facilitate access to off-island care in select cases.

5.3 COMMUNITY OUTREACH AND HEALTH PROMOTION

To cope with the escalating costs of providing chronic disease care as well as acute and rehabilitative care services, the MOH has placed greater emphasis in recent years on primary prevention through health promotion and educational activities. The role of the Health Promotion Department within the MOH is to coordinate these activities and liaise with other MOH departments (i.e., community health, environmental health, and mental health) to build the capacity of their staff to carry them out. Periodic workshops are held with clinicians on conducting needs assessments, designing priority actions, and implementing them. Other recent activities have included health screening programs, awareness campaigns, and school-focused outreach. In addition, special clinics for chronic disease management, dentistry, and mental health are periodically offered at the community level.

According to respondents, the MOH lacks an official health promotion policy. Such a policy would ideally lay out standards and norms to follow for the promotion of healthy behaviors to ultimately improve health outcomes and reduce the incidence of chronic diseases.

5.4 PRIORITY SERVICE AREAS

5.4.1 HIV/AIDS SERVICES

Most community-level public health care facilities in the country offer HIV/AIDS counseling and testing during weekly clinics. HIV treatment and care and support services, however, remain highly centralized, with one treatment site at the General Hospital and six care and support sites throughout the country.

A population survey conducted in 2007 found that more than 75 percent of respondents thought HIV services were not sufficiently available in their community (HIV and AIDS in Grenada 2007).

As noted in Chapter 4 (Health Financing), ART is made available to all HIV-positive clients at no cost, as are ARVs for PMTCT and ARV prophylaxis for infants born to HIV-positive women.

HIV/AIDS services in Grenada are not fully integrated into the wider health system. Services are coordinated and provided by the NIDCU, a stand-alone unit within the MOH. One challenge with offering voluntary counseling and testing at weekly clinics is that this arrangement can discourage testing: at-risk individuals may seek to avoid the stigma associated with arriving on HIV testing day. Concerns have also been raised as to the effectiveness of patient-initiated testing as a means of finding new HIV cases. For instance, in 2008/09, only 13 out of 5,963 people who volunteered to be tested in the country were found to have HIV. Over that same period, there were 56 diagnosed cases (UNGASS 2010).

There are also challenges with encouraging those tested to return to access their results. In 2005, 1,547 people between the ages of 15–49 reported having been tested for HIV in the previous 12 months; yet only 9.6 percent of them accessed their results, with women more likely than males (6 vs. 13 percent) (HIV and AIDS in Grenada 2007). All blood draws must be sent to the central laboratory at the General Hospital and it can take from one to two weeks to receive a result; confirmation of positive results used to be done by the Caribbean Epidemiology Centre (CAREC) in Trinidad but now is reportedly done in country. A pilot program will be launched in the near future that seeks to address a number of these issues, by better integrating HIV services into PHC. Key informants also noted that, by the end of 2011, rapid testing for HIV will be piloted in three sites and accompanied by an increased availability of mobile testing.

In the last few years, there have been dramatic improvements in treatment, care, and support services for people living with HIV (PLHIV) in Grenada. Some evidence suggests, however, that some PLHIV do not access care and treatment services until HIV is at an advanced stage (HIV and AIDS in Grenada 2007). Some of this delay in care-seeking may be due to concerns about stigma or gender-related barriers. However, discriminatory provider behaviors towards PLHIV contribute to reluctance to seek health services. There exists a need to address stigma and discrimination among clinical staff, while generally fostering a more patient-friendly environment for all users of the health system.

5.4.2 CHRONIC AND NONCOMMUNICABLE DISEASE SERVICES

As the burden of NCDs increases in the coming years, strengthening chronic disease management is a key challenge facing Grenada's health system. The MOH's approach to address NCDs largely centers on clinical care and treatment. Monthly chronic disease clinics are conducted by medical staff at community health facilities, emphasizing management of diabetes and hypertension. Some facilities have reported, however, that interest in these clinics remains low. The planned revitalization of the PHC system should better integrate NCD services into routine basic care provision and facilitate more comprehensive NCD management for both providers and patients, as should the recently established Chronic and Noncommunicable Diseases Commission.

The Health Promotion Unit of the MOH plays a small but complementary role in addressing NCDs by using education and health promotion as tools for prevention. There exists a need for even more attention to prevention, including behavior change counseling in the communities by nurses and doctors, and a sharper focus on nutrition and wellness programs in schools. The lack of clear information, education, and communication on the determinants of NCDs poses a significant threat for Grenadian society, and inadequate data on NCDs and their determinants complicates the situation further.

5.4.3 MENTAL HEALTH SERVICES

Mt. Gay Hospital is the main provider of acute mental health services, including psychiatric and other therapies as well as counseling services. Community mental health services are offered at five of the six health centers in the country, including follow-up and reevaluation of patients. There are mental health services available on Carriacou and Petit Martinique on a monthly basis. A review of mental health status and services was conducted in 2005, after which a Mental Health Policy was developed, aiming to improve the quality services and integrate community mental health services into primary care. To date, however, mental health services have yet to be mainstreamed into primary care and remain under the administration of Mt. Gay.

Health workers and non-profit associations have expressed concerns about the current state of mental health services in Grenada. Insufficient funding, inadequate staffing, and significant overcrowding at Mt. Gay – more than 130 patients in an 80-bed facility – are the most salient issues that need to be addressed. With mental health services not organizationally integrated into the primary care system, case management and follow-up of patients is inadequate. Stigmatization of patients by health care workers, society at large, and the families of patients hinders efforts at reintegration into society. Opportunities to raise awareness around mental illness and address stigma and discrimination should be prioritized. PAHO has recently been providing some training relating to mental health issues, and there is reportedly draft mental health legislation being prepared.

5.5 SERVICE DELIVERY ACCESS, COVERAGE, AND UTILIZATION

Geographic coverage of public health services in Grenada is good, as noted above. However, there is limited verifiable information on the utilization of both public and private health care facilities in different areas, including standard indicators such as outpatient care visits. Basic reported health indicators, such as births attended by a skilled health care worker (100 percent [World Bank 2010]) and immunization coverage (99 percent coverage of DTP3 [PAHO 2010]) are very good.

Primary care facilities are open from 8am to 4pm, mainly on weekdays, with doctors present at least four to eight hours per week. These hours, coupled with a high degree of physician absenteeism, present a formidable barrier for clients needing convenient, accessible, high-quality services in the public sector. Evidence also points to overutilization of secondary care facilities for primary care, with less than five percent of cases at hospitals due to emergencies (Kairi Consultants Ltd. 2008). There are currently few disincentives to discourage this behavior, as non-emergency patients are not turned away nor encouraged to visit a community-level facility; the Accident and Emergency Department is open 24 hours a day, and doctors are always available at the hospital. Some concerns were raised about overcrowding with occupancy rates approaching 100 percent at General Hospital and Princess Alice Hospital.

Table 5.2 illustrates where Grenadians first accesses health services, according to quintiles of socioeconomic status, based on a Country Poverty Assessment conducted in 2007/08. More than 46 percent of the population first sought services from the private sector, either domestically or overseas. While poorer groups were more likely to seek medical attention from a public facility, a considerable percentage sought care in private facilities (14 percent of the poorest fifth and 53 percent of the next-poorest fifth). Approximately 42 percent of those in the wealthiest quintile receive subsidized care in the public sector. Some of the most cited reasons for selecting a given facility to visit were proximity to one's home, faster service and attention, and better service and attention (Kairi Consultants Ltd. 2008).

TABLE 5.2: FIRST PLACE VISITED FOR MEDICAL ATTENTION BY QUINTILES

Place First Sought Medical Attention	Per Capita Consumption Quintiles (Percent)					
	Poorest	II	III	IV	V	Total
Public hospital	12.9	17.0	12.9	11.6	15.6	13.8
Public health center	64.6	30.1	49.4	29.6	26.5	36.9
Private domestic doctor/dentist/pharmacist	14.3	36.6	28.4	34.3	32.4	31.1
Private overseas doctor/dentist/hospital	0.0	16.3	6.8	20.7	21.9	15.1
Not stated	8.2	0.0	2.4	3.8	3.7	3.2

Source: Kairi Consultants Ltd. (2008).

Private physicians' practices are typically not plagued by overcrowding or long waiting times, and patients use the private sector to cover for gaps at public facilities (e.g., limited availability of specialists and NCD drugs), greater confidentiality, and a perception of better customer service. For instance, rapid HIV tests are available in the private sector, and laboratory results are returned within 24 hours; in public facilities, results may take several weeks as noted above. However, private sector consultation fees can be prohibitive or burdensome; this encourages some patients to utilize services only when their conditions are already advanced.

5.6 QUALITY OF CARE

According to key informants, quality of care is mentioned by patients, providers, and MOH leaders as an area needing improvement. An officer within the Quality Improvement Unit at the MOH is responsible for designing and implementing Quality Assurance and Quality Improvement activities for the government-run health system. The General Hospital has its own separate quality improvement coordinator for nurses, who reports to the Director of Nursing. There is no direct line of reporting or communication between these two quality improvement managers.

Both units face similar challenges, including inadequately defined budgets, limited institutional support, and no direct decision-making authority to ensure quality of care. Numerous small quality improvement initiatives occur on an ad-hoc basis (such as periodic workshops, clinical teaching, and health chart audits) but there is no overarching strategy in place for continuous improvement or quality monitoring. A complaint made against a nurse at the General Hospital, for example, would be handled first within the individual ward, after which it could be escalated several levels upward to the Director of Nursing Services; it would not at any point make its way to the Hospital's Quality Improvement coordinator. There are no formal mechanisms through which a patient or a member of the community can lodge a complaint or make a suggestion to a clinician or facility administrator. A proposal has been put forth by the MOH Quality Improvement Officer to set up a customer service desk at the General Hospital. Similar mechanisms, like regular client satisfaction surveys or suggestion/complaint boxes, could provide an opportunity for beneficiaries to play an active role in improving quality.

Customer service by clinicians has been referenced both by patients and other providers as an area of significant concern (HIV and AIDS in Grenada 2007). Patients report being treated poorly due to their HIV status, sexuality, or mental illness and note breaches of confidentiality by clinical staff. Incorporating customer service and interpersonal communication skills into in-service or technical refresher trainings is recommended.

Significant concerns around the quality of community health services have been identified by both staff and patients. These include long waiting times at clinics, lack of coordinated and integrated care, and a general lack of confidence in community services, resulting in clients seeking care at the General Hospital or private clinics (Government of Grenada 2005). Although patients tend to have fewer complaints about private providers, little is known about the clinical quality of care as the private health sector is largely unregulated. The 2010 Health Practitioners Act sought to address this issue by creating a Medical and Dental Council to oversee professional licensing, ethics, and quality of care of doctors and dentists, both private and public. The council will also be responsible for setting clinical guidelines and quality assurance monitoring. Additionally, key informants noted that nursing policy was recently updated and changes would be introduced in the coming months.

Although several key informants reported that physicians and nurses in Grenada are generally perceived to provide a decent standard of care with the resources that are available, many quality challenges clearly remain. While there are guidelines for treatment and care for most conditions in Grenada, many are either out of date or unavailable to clinical staff. Some health center staff reported never having seen policies, procedure manuals, or protocols in their facilities. The Quality Improvement Coordinator at the General Hospital has carried out audits of health charts and discovered poor documentation and inappropriate treatment and care, so room for clinical improvement is evident. Moreover, key informants reported that conditions in many public sector facilities are neither patient- nor worker-friendly and are not conducive to supporting high-quality care. Poor physical infrastructure, frequent stock-outs, and limited equipment and supplies were mentioned by health care workers as posing significant challenges. As noted in Chapter 4 (Health Financing), there are ongoing discussions to build a new hospital in St. George's to replace or complement the General Hospital. Both Princess Alice and Princess Royal hospitals need basic equipment (e.g., operating room and x-ray machine) to be considered full-fledged secondary care facilities. Maintenance of existing equipment is an issue as well, as maintenance staff are concentrated primarily at St. George's and have limited knowledge of advanced medical equipment.

5.7 RECOMMENDATIONS

5.7.1 SHORT-TERM RECOMMENDATIONS

Fast-track technical assistance to the Primary Health Care Revitalization Steering Committee.

The revitalization of PHC has been a stated objective of the MOH for several years. The emergence of NCDs presents a strong financial incentive to improve preventive health care, and shortages of trained staff at primary care facilities offer further motivation. The overcrowding and misuse of hospitals, lack of referral system, and limited continuity/integration of service levels suggest that the Steering Committee consider broadening its scope beyond PHC to include secondary care. The revitalization strategy calls for the merging of some health districts and zones; greater integration of services; and the shifting of decision-making authority to district-level entities. The impact of these changes on secondary facilities should be considered. These changes will present significant challenges for the MOH, and the government of Grenada in general, in the areas of planning, change management, and stakeholder engagement. Fast-tracking technical assistance to the Primary Health Care Revitalization Steering Committee could help to strengthen the ministry's capacity in these areas and support further development of strategies to address them. Assistance would be particularly invaluable in articulating linkages between PHC revitalization and health facility consolidation. Referral linkages between primary and secondary providers also merit explicit attention to foster a more effective continuum of care for users of the health system.

Engage technical assistance to better integrate HIV/AIDS services at the primary care level.

The PHC revitalization strategy calls for a shift from offering services at stand-alone clinics (in a vertical fashion) toward a greater degree of integration. In terms of HIV/AIDS services, this could mean offering HIV testing on any day a patient would like, which would help address the stigma inherent in arriving to a facility on HIV services day. Patients could also use their local facility to access treatment instead of having to journey to St. George's. Greater local availability of HIV services, and the corresponding provider education that would be required to deliver them, could also engender a greater degree of HIV awareness in the community. Implicit in HIV integration are a number of steps that must be taken to prepare facilities. Targeted technical assistance can be utilized to transition smoothly to integration and ensure that staffing is appropriate; capacity for counseling and testing is adequate; guidelines and protocols are updated and available; infrastructure meets standards; and referral networks and monitoring systems are in place.

Conduct chart review of select NCD treatment and care.

Poor quality of care has been increasingly mentioned as an issue affecting health service delivery in Grenada. While many actors within the health system, including both providers and patients, have vocalized their concerns about poor quality of services, there is little quantifiable evidence to substantiate their claims. The Quality Improvement Coordinator at the General Hospital has carried out audits of health charts and discovered poor documentation and inappropriate treatment and care. These reviews, however, have been done sporadically and have not formed part of a broader quality improvement strategy. At the same time, NCDs have emerged as the biggest burden to the health system, and similarly there is no cohesive strategy to address their present and future impact. A chart review of NCDs would serve a dual purpose. Adequacy of care and treatment could be evaluated, while creating an evidence base for strengthening quality of care in general and laying the foundation for a culture of quality. To achieve the latter, chart review feedback to clinicians must be done carefully to instill a culture of learning, teamwork, and continuous improvement; not one of embarrassment and punishment. In the short run, it may be better to select the top two or three NCD conditions for chart review to establish an effective process.

5.7.2 LONGER-TERM RECOMMENDATIONS

Develop approaches to improve provider behavior toward patients.

Patients and providers have raised concerns about poor customer service at health facilities. Specific attention has been called to discrimination based on HIV-positive status, sexual orientation, and mental illness, although problems with interpersonal communication skills have been observed throughout the health care system. A World Bank-sponsored workshop was held a few years ago to address these concerns. While it was deemed a success in helping providers to foster more patient-centered delivery approaches, there is a need for longer-term solutions. Technical assistance to the MOH could be instrumental in developing and institutionalizing provider education approaches for pre- and in-service trainings or as components within clinical procedure manuals.

Other creative approaches that could be considered include: (1) allowing health facilities to retain user fees and use a portion of the revenue to reward staff for customer-focused behavior; (2) incorporating customer satisfaction measures as a component of performance-based financing; or (3) having nursing students pretend to be "mystery patients" who assess the quality of care, including provider behavior.

Develop policy options for addressing absenteeism.

Absenteeism of workers at health facilities, especially doctors, has been identified as an issue that adversely affects the quantity and quality of health services delivered in Grenada. It is important to note the lack of data on health worker productivity (actual staff time and actual utilization rates), and the degree of dual practice, which would inform development of effective solutions. Along with closing underutilized facilities, the PHC Revitalization Initiative should seek ways to consolidate staffing and reduce absenteeism at remaining facilities. Again, allowing facilities to retain user fee revenue and use a portion of the revenue to reward staff for attendance would be one approach to consider.

Factors that may contribute to provider absenteeism include lack of incentives and accountability, but absenteeism may also be symptomatic of broader weaknesses within local institutions and governance structures. In light of the fact that most health workers do not earn high wages, the MOH should look to design human resource policies that address work-related conditions. These could include staff allowances and other indirect benefits as well as amenities that less available in remote areas. Simultaneously, internal control measures could be enhanced at facilities such as installing staff attendance registers and increasing the frequency of supervision visits. Civil society partners could be engaged as well as to support community supervision and contribute to management of facilities.

Explore performance-based incentives.

While working with the same overall aim as traditional input-based systems – providing high-quality and equitable health services to a population – output- or performance-based systems have shown encouraging results in producing better health outcomes as well as greater efficiency, quality, and equity of services (Meessen et al. 2011). Performance-based incentives, when employed correctly, can address a variety of issues like physician absenteeism, data quality, and facility-level governance. The MOH would continue to determine which services to provide and establish the desired quality. Health facility staff, however, would develop the strategies and specific facility-level approaches to achieve those results. If facilities or individual workers receive appropriate incentives for attaining targets, they may be more likely to show up for work, deliver better quality of care, and/or increase productivity. Because performance-based incentives require the payer to review and verify routine data that is the basis of the incentive, the system can improve data quality. In addition, data quality and timeliness can be one of the rewarded targets.

6. HUMAN RESOURCES FOR HEALTH

Key Findings

- Grenada’s health system has a relatively stable workforce for its present services, with an adequate number of general doctors and nurse-midwives and a limited range of specialists.
- There are shortages in key medical and nursing specialists needed to enable the health system to adequately respond to current epidemiological trends and shift resources toward PHC.
- There is no comprehensive HRH plan in the MOH, which has limited HRH planning capacity.
- Several initiatives now underway, in particular the intended revitalization of primary health services, have major implications for HRH which urgently need to be planned for.

A critical component of a comprehensive health system assessment is an examination of the human resources engaged in the health care delivery process, as well as the strengths, weaknesses, and opportunities for improving the HRH situation. This assessment sought to examine the current status of HRH in Grenada and make actionable recommendations. The assessment was guided by the WHO definition of HRH as “all people engaged in actions whose primary intent is to enhance health” (Islam 2007). This includes those who promote and preserve health as well as those who diagnose and treat diseases; health management and support workers; and those who educate health workers.

6.1 HRH PROFILE OF GRENADA

Grenada’s health system has a relatively stable workforce with an adequate number of general doctors and nurse-midwives. Table 6.1 compares the health worker-to-population ratio for key cadres in Grenada to the averages for the LAC region and for upper-middle-income countries.

TABLE 6.1: NUMBER OF HEALTH WORKERS PER 10,000 POPULATION

Health Worker Cadre	Source	Grenada		LAC Regional Average		Upper-Middle-Income Average	
		Density	Year	Density	Year	Density	Year
Physicians	WDI 2010	9.8	1998*	10.58	2000	36.68	2007
Nursing and midwifery personnel	WHO 2011	39.8	1998	9.98	2002	69.42	2007
Pharmacists	WHO 2011	8.4	1998	4.86	2000	5.04	2007
Lab technicians	WHO 2011	--	--	--	--	3.17	2004

*Note that data from 1998 are the most recent published by the WHO.

Though limited in number, there is a relatively good range of types of specialists, especially at the tertiary level. However, there are some gaps. For example, there have reportedly been periods of up to a year when there was no radiologist on-island; some oncology services are provided by a visiting Grenadian specialist based in the United States; and there is one internal medicine specialist currently on the island. A bilateral agreement with Cuba facilitates access to specialists.

During the assessment, stakeholders expressed concern that established medical and nursing posts in the public sector have remained the same for several years and are not keeping pace with changes in services; with what may be needed to respond to epidemiological trends; or with the model of health delivery that is envisioned by the MOH going forward. It is important to bear this context in mind when assessing the complement of the health workforce.

General Hospital

At the level of the general hospital, the majority of approved, established posts are filled. The 2011 Estimates of Expenditure (Government of Grenada 2010) indicated that 14 percent of the 478 posts were vacant (the same percentage as were vacant in 2010). The vacancies included several for House (Medical) Officers; an ophthalmologist; and surgeon specialists.

Posts which are not yet approved and established include those for intensive care and emergency room physicians and endocrinologists. Twenty percent of the physicians at General Hospital are employed on contract, in posts not yet approved by the Cabinet. Unlike their established colleagues, contracted staff do not have security of tenure or pension benefits. Contract positions allow greater flexibility in hiring and salary determinations, but less job security for the employee.

According to senior leaders at the MOH, medium-term plans are being made to build a new tertiary-level hospital to replace the General Hospital. In addition to improving the quality of care provided to the people of Grenada, it is envisioned as a teaching hospital that would generate medical tourism, and would be financed through a public-private partnership with SGU as well as external loans. Successfully managing such a facility will require careful consideration of additional human resource needs and costs, especially given the potential drain on existing human resources including those at the primary care level. Consideration will be needed of potential public-private and regional partnerships, and possible recruitment within the Grenadian diaspora.

Mt. Gay Psychiatric Hospital

The Mt. Gay Psychiatric Hospital, which is currently handling 130 patients in an 80-bed facility, faces severe human resources challenges. It has only three social workers and one psychiatrist, who in addition to the hospital must also serve the prison and attend to community mental health needs across the islands. The post of Psychologist has been vacant for many years. Contract psychiatrists from Cuba sometimes supplement the cadre serving on one- or two-year contracts, along with one House Officer (general practitioner). Most of the nine senior nurses at the hospital have psychiatric nursing training and the majority of the nursing staff are Nursing Assistants.

Thus, while the overall complement of technical staff is barely able to provide adequate services for the hospital based on its current model of custodial care, it is inadequate to support a community-based mental health and psycho-social rehabilitation model.

Community Health Facilities

Doctors are present at PHC facilities for only four to eight hours per week, but there is reportedly a high degree of physician absenteeism, presenting an obstacle for clients needing physician-level services in the public sector. Table 6.2 details the relatively small number of staff in place to provide community-level public sector care across Grenada and Carriacou.

TABLE 6.2: STAFF AT PUBLIC SECTOR COMMUNITY HEALTH FACILITIES IN GRENADA AND CARRIACOU

Category	Number of Approved/ Established Posts
Senior Community Health Nurse	2
Community Health Nurse	10
Family Nurse Practitioner	4
District Nurse	37
Nursing Assistants	45
District Medical Officer	11

At the 30 medical stations and six health centers on the islands, there is a more than adequate number of generalist nurse-midwives but significant gaps in the number of specialist-trained nurses in areas such as nephrology, psychiatry, gerontology, anesthesiology, and oncology.

As reported by the Chief Nursing Officer, an analysis of nursing needs across the system was carried out in 2010 and resulted in the Cabinet's approval for an additional 70 posts for Staff Nurses and approval for the creation of a new staff category in the system – that of Registered Nurses (RNs). A total of 153 RN posts have been approved but are not yet established. A process is now underway to develop job descriptions and define career paths for this nursing group. Once these new posts are established, funded, and filled, the additional staff will strengthen the ministry's efforts to achieve the revitalization of PHC. In anticipation of the new RN cadre, the ministry should encourage and identify support for needed nursing specializations to be pursued.

While the number of doctors who serve clients in the private sector is unknown, it is estimated that more than 30 doctors (many of whom also work in the public sector) operate private practices. About 10 nurses are employed by private physician practices. There are also 17 dentists in private practice. An unknown number of pharmacists serve in 33 private pharmacies. There are also specialists who work in private laboratories.

6.2 HUMAN RESOURCES FOR HEALTH POLICY

The MOH has a clear, strategic vision for reorganizing and revitalizing PHC delivery. The assessment found that the MOH has done an effective job of communicating this vision to stakeholders. Interview respondents articulated the revitalization of PHC as the focus and direction of the MOH.

Nonetheless, Grenada does not currently have a comprehensive HRH plan in place. The National Strategic Plan for Health 2007–2011 identified major cross-cutting HRH issues, including:

- Lack of a continuous approach to human resource development

- Inadequate working conditions – no job security, inadequate benefits/career planning
- Inadequate provisions for retirement
- Effects of migration
- Poor succession planning
- Continuing education
- Licensure

However, there is only limited detail in the document, and the plan remains a draft to date. As policymakers consider drafting a new strategic plan, it would be an opportune time for the MOH to ensure that there is capacity for developing and incorporating an HRH plan. In addition, the multi-stakeholder Primary Health Care Revitalization Steering Committee recently completed a draft plan, and a carefully thought-out HRH plan will also be key to the success of this initiative. As noted in Chapter 5 (Service Delivery), recommended changes to the delivery of PHC include:

- Merging some districts, upgrading some facilities, and closing some underutilized facilities
- Offering a range of integrated services each day instead of specialized clinics on specific days
- Shifting decision-making to district-level management structures comprised of technical personnel and citizens

These changes have significant implications for personnel. Revitalization will require a process for staff consultation and buy-in; plans for staff recruitment, deployment, and redeployment; and plans for in-service training initiatives.

At the time of this assessment, a human resources audit was being implemented by the Department of Public Administration (DPA) in five ministries, including the MOH. The results of this audit will provide much-needed information. However, the audit should inform rather than preclude a comprehensive HRH planning process.

Strong provisions for professional standards and regulation are important aspects of HRH policy. Grenada has a good foundation for effective professional regulation and oversight in the new eight-member Medical and Dental Council, formed in March 2011 as a result of the Health Practitioners Act passed in 2010. This is in addition to a Pharmacy Council and General Nursing Council. Continuing education, licensure, registration, and re-registration are legislated requirements of the 2010 act. However, interviewees in this assessment still reported confusion about continuing education requirements. This suggests a need for increased dissemination of information on the legislated requirements and for enforcement of the provisions. The institutional capacity of the councils also needs to be prioritized for strengthening.

Dual employment in the public and private health sectors is another HRH policy and planning issue that key informants highlighted as important. Dual practice is legally sanctioned in Grenada and widely practiced. Doctors appointed to the public service through the Public Service Commission are granted private practice privileges through their Letter of Appointment. Regular scheduled hours are required at public facilities, but key informants reported that absenteeism is a problem, as some doctors prioritize their private practices. This is also alleged to lead to overuse of hospitals since patients are often unable to see doctors at the primary care level. Doctors who opt to practice in both sectors cite poor public sector working conditions, the lack of supplies, and low salaries as reasons for maintaining a private practice. Dual employment policies should be incorporated into broader HRH planning and strategy,

with the adoption of clear requirements and sanctions, processes for performance evaluation and supervision, authorization to discipline those in noncompliance, and incentives to reduce abuses by rewarding public service. The right to dual practice should be maintained in order to retain physicians.

6.3 HUMAN RESOURCES MANAGEMENT

The MOH has responsibility for HRH management and oversight. However, recruitment for approved, established positions is the purview of the Public Service Commission on the request of the ministry. Posts are approved by the DPA. The Public Service Commission selects, appoints, and determines terms and conditions of employment. Interview panels are convened for middle-level to senior administrative and technical posts and MOH representatives are part of such panels.

Frustration was reported with the pace at which posts are approved and funded. Stakeholders acknowledged that requests for staff are typically made when the national budget is being prepared, tend to be hurried, and generally do not have requisite data to indicate the rationale or substantiate the request. This was said to be a significant obstacle that hampers the DPA in determining the justification for requests.

The MOH has been delegated authority to hire ancillary staff and to contract with persons for posts that have been approved but are not established – for example, with the newly created posts for RNs. The ministry may also directly contract retired personnel, and has been delegated authority to assign nurses. Other assignments are determined by the commission. The ministry may move staff laterally within their post but all other movement of staff (promotion, etc.) is the responsibility of the commission.

This assessment found that there is need for greater consultation and collaboration among the entities involved in ensuring that human resource needs in health are met. The planned revitalization of the primary health system and rationalization of secondary and tertiary care services offer an opportunity for such collaboration. An interviewee at the DPA, for example, reported that the agency had put together a compendium of reform initiatives in the public service and is therefore able to advise on potential linkages and overlaps. The department's interviewed representatives indicated they would be open to being brought into the planning process of the ministry at an early stage as this would further sensitize the department to the needs of the health system.

Professional and practice standards in health require regular updating. This aspect of human resources management needs to be strengthened. While annual and semi-annual performance appraisals were reported to be done, the general public service tool is used, and there are specific health professional standards that are not likely to be captured.

Nurses' job descriptions are subject to periodic review and were last revised in 2009. The nursing policy and procedures manual also underwent a process of review which was completed in early 2011, and reflects the new nursing functions. The manual and job description may or may not be consistent with each other; consistency should be ensured by the nursing leadership.

The quality of supervision is affected by limited staff, especially at the community health level where there is one nursing supervisor for three districts. This supervisor is able to visit clinics only once monthly. In general, quality assurance across the system is reported to be inadequate, as described in further detail in Chapter 5 (Service Delivery).

6.4 HUMAN RESOURCES DEVELOPMENT

Grenadian students mainly access Bachelor's- or higher-level health training at the following regional and national institutions: UWI in Jamaica and Trinidad; the School of Nursing in Jamaica; the University of Technology, School of Pharmacy in Jamaica; the University of Guyana's Pharmacy School; and SGU in Grenada, which caters mainly to students from off-island but provides 10 scholarships to Grenadian students annually. Medical training is also accessed in Cuba, the United States, and other nations.

Details of students enrolled in Bachelor's- or higher-level health training programs in 2009 are given in the 2009 PAHO Core Data report, as shown in Table 6.3.

TABLE 6.3: NUMBER OF GRENADIAN STUDENTS ENROLLED IN ADVANCED HEALTH TRAINING PROGRAMS, 2009

Area of Study	UWI	Cuba	MSU	CUNY	St. George's	TOTAL
Medicine	1	11	1*	0	6	19
Public health	0	0	0	0	1	1
Nursing	2	0	0	0	0	2
Psychology	5	1	1	2	0	9
TOTAL	8	12	2	2	7	31

*Includes one radiology specialist

Source: PAHO (2009). MSU=Michigan State University, CUNY = City University of New York

On-island training in nursing and pharmacology in Grenada is provided by the T.A. Marryshow Community College (TAMCC), where 175 nursing students are currently enrolled. For nursing, TAMCC offers three levels and types of qualification: Certificate (Nursing Assistant, General Nursing), Associate's degree (General Nursing, Pharmacy), and Post Basic Certificate (Midwifery).

About five years ago, the TAMCC School of Nursing was moved from the jurisdiction of the MOH to the Ministry of Education, so that it could eventually be upgraded to granting a minimum of a Bachelor's degree as mandated by the Regional Nursing Council. However, the School of Nursing currently has limited capacity for meeting the Bachelor's degree granting status. The majority of current staff themselves have undergraduate qualifications. The school operates in a very small space with limited laboratory and library resources. Students receive a government stipend of EC\$700 per month and while enrollment is high, there are challenges with student retention and a falling rate of passes on the regional qualifying examination, now reported to be at 61 percent. While the training program includes some laboratory work, there is only limited exposure to a clinical practicum. The school does not have capacity for offering training in specialist areas. Nursing training at the Bachelor's degree level can currently be accessed through UWI, which offers an online three-year Bachelor's program combined with clinical supervision at Grenada's General Hospital. Prior to 2007, credit was not given for prior study to the Associate's degree level, and perhaps as a result only a small number of Grenadian students had utilized this resource. Interviewees reported that six persons graduated in 2010.

The TAMCC School of Pharmacy offers a three-year Associates Degree program, which enables matriculation to Jamaica's University of Technology (UTECH) one-year Bachelor's degree program in pharmacology. The School's enrollment capacity is thirty students. Grenadian students pay fees of EC\$1,184 per year. TAMCC also has memoranda of understanding with the UWI St. Augustine campus in Trinidad and with the University of Guyana for higher-level pharmacology training. Like the TAMCC School of Nursing, the School of Pharmacy does not currently have the complement of faculty sufficiently degreed to be able to deliver a Bachelor's degree program.

Through technical cooperation between the European Union, PAHO, and the WHO in the area of medicines (2004–2010),³ a Caribbean Network on Pharmacy Education was spearheaded in 2008. TAMCC has been active in this network which has been working on the harmonization of curricula and entry requirements, development of a Caribbean pharmacy policy, regional practice protocols, and registration requirements. PAHO hosts an online facility for meetings.

Some in-service training is available to health professionals in Grenada. The MOH, PAHO, SGU, and professional associations are among some of the institutions that offer training. Hospitals and clinics carry out in-house training as well. Online training is also utilized by professionals. Stakeholders expressed a need for more training in public health, integrated health care, M&E, quality assurance, and customer service.

Grenada would benefit from organizing a higher education council to support planning and rationalization of the island's advanced health worker training capacity. There is also a need to arrive at a national consensus on the role which the SGU can play in meeting the country's undergraduate and graduate degree training needs in health. One promising opportunity is that the University has online training capacity and is a member of the Caribbean Knowledge and Learning Network. This network is supported by the European Union and the Caribbean Development Bank, which are helping to introduce a high-speed fiber-optic network linking regional universities. Along with other electronic resources, this network could support both pre-service and in-service training in Grenada and the wider OECS.

6.5 RECOMMENDATIONS

Strengthen the HRH planning capacity of the MOH.

The ministry should fast-track procurement of technical assistance to assist corporate planning and other relevant units and committees to develop a comprehensive strategy for HRH recruitment, succession, professional development, and retention. The HRH strategy should be in line with the ministry's strategic plans and based on empirical data – including data gathered from epidemiological surveillance as well as the recent human resources audit – which can inform the needed mix of human resources cadres, skills, and competencies. Such a strategy should include elements for:

- Establishing and/or strengthening linkages with regional initiatives and partners for pre- and in-service training, recruitment, and other elements of HRH development and management. Linkages could be established or strengthened with the Caribbean Knowledge and Learning Network's online platform, PAHO's "20 Goals for HRH 2007–2015," and the CARICOM-PAHO initiative for harmonizing regional pharmacy training.
- Increasing the use of technology for economies of scale, such as online training materials, video-conferencing, tele-medicine, and other e-resources. UWI, SGU, TAMCC, and other regional and international institutions are potential partners for such initiatives.
- Establishing frameworks and mechanisms for partnerships with local NGOs and businesses to meet HR development, health promotion, service delivery, and other needs. Partnerships could be sought with the private sector, professional associations, and training institutions such as UWI, St. Georges University, TAMCC, and other regional and international institutions.
- Expanding partnerships with the Grenadian diaspora with appropriate incentive strategies to

³ See: http://www.who.int/medicines/areas/coordination/Caribbean_Pharm_Policies_Factsheet.pdf

encourage their contribution of skills, or other needed support, to strengthen the health system.

- Public-private partnerships to provide student loans and strengthen scholarship programs.
- Facilitation of stakeholder consultations to encourage ownership of the changes going forward. Specifically, there will be a need to strengthen “change management” skills and processes as PHC revitalization unfolds.
- Strengthening capacity of existing Quality Assurance officers to develop and implement strategies for fostering a “culture of quality” and strengthening system-wide quality assurance implementation and M&E.

Strengthen the capacity of the professional councils.

The capacity of the professional councils to implement and enforce the provisions mandated in the Health Practitioners Act and other acts will determine the effectiveness of the legislation. As such, the MOH may seek to:

- Ensure capacity development of the professional councils (Medical and Dental, Pharmacy, and General Nursing) to support their effective functioning; their ability regulate, enforce, and implement legislation; their ability to raise awareness of laws and regulations among the relevant professionals; and the functioning of their leadership role and their relationships with relevant professional associations. The councils are authorized by law to hold income-generating activities such as continuing education, and this should be encouraged.

Obtain approval and funding for, and recruit, a Human Resources Director for the MOH.

A comprehensive HRH plan, and capacity in the ministry to manage the implementation of the plan, will be critical factors in the success of the planned revitalization of primary health and other initiatives. It is recommended that the ministry therefore seeks to obtain Cabinet and relevant public service bodies’ approval for the post, funding, and recruitment of an experienced human resources director for the MOH. The human resources director should lead a coordinated HRH management and planning team which includes nursing, medical, and allied technical officers and the Quality Assurance Officer.

7. MANAGEMENT OF PHARMACEUTICALS AND MEDICAL SUPPLIES

Key Findings

- Stock-outs and wastage in public sector facilities are common. Public sector stock-outs are primarily due to lack of funds.
- There is a strong private pharmaceutical sector, which engages in informal collaborations with the public pharmaceutical sector in order to fill gaps when stock-outs occur. Formalizing this type of public-private interaction is a key opportunity for the health system.
- There is lack of capacity at the MOH to enforce regulations surrounding pharmaceutical importing, licensing, and practice.

Medical products encompass medicines, vaccines, test kits, related commodities, and equipment. They are a core component of health services because their monetary value is generally substantial and the systems for managing these products are often faced with political and managerial challenges. Pharmaceutical management represents the whole set of activities aimed at ensuring the timely availability and appropriate use of safe, effective quality medicines and related products and services in any health care setting.

7.1 PHARMACEUTICAL POLICY FRAMEWORK

Grenada does not have a national medicines policy that establishes and monitors medium- to long-term objectives in the public and private pharmaceutical sectors. The primary objective of such a policy would be to ensure access, quality, and rational use of medicines and medical products. The Caribbean Pharmaceutical Policy, currently in draft form, is intended to guide OECS countries in developing national medicines policies. Stakeholders in Grenada indicated they would welcome more regional cooperation and guidance in strengthening the policy framework surrounding pharmaceuticals and medical products. However, the lack of human resources within the pharmaceutical division at the MOH poses a challenge to developing a national medicines policy.

The pharmaceuticals division at the MOH is composed of the Chief Pharmacist, the Pharmacy Inspector, and the junior and senior pharmacists. The Pharmacy Council falls under the supervision of the CMO. Members of the council include the Chief Medical Officer, the Chief Pharmacist, two pharmacists from the Pharmacists Association, one pharmacist from the private sector, two physicians, one agriculture representative from the Ministry of Agriculture, and one lawyer. The Pharmacy Council, after being dormant for a number of years, was reactivated in the spring of 2011. The existence of the council and the presence of private sector representatives on the council are key strengths of the pharmaceutical sector in Grenada. The continued revitalization of the council is crucial to strengthening the policy and regulatory framework for pharmaceutical management in the public and private sectors; and for

improved enforcement of regulations. The Pharmacists Association, which was recently revitalized and represents both public and private pharmacists, is also well-positioned to support the eventual expansion of the policy and regulatory framework.

7.2 REGULATORY ISSUES

7.2.1 REGULATORY FRAMEWORK

The regulatory framework for medicines and medical products is limited in Grenada. There is no Medicines Regulatory Authority, nor is there registration of pharmaceutical products.

Three pieces of legislation govern the pharmaceutical sector in Grenada: The Pharmacy Act (1988, amended in 1992 and 1995), the Medical Products Act (1995), and the Food and Drug Act (1986). According to key informants, pharmaceutical legislation is in need of updating in order to strengthen the regulatory framework. There is political will within the leadership at the MOH and within the pharmaceuticals division at the MOH to update the legislation. The Pharmacists Association indicated in interviews conducted for the assessment that updating the legislation is a top priority for the sector. The Pharmacists Association could play an advocacy role in this area.

A key challenge in adequately regulating the pharmaceutical sector is the shortage of available MOH staff. There is political will and support from MOH leadership to strengthen regulation and enforcement, but the lack of staff to undertake this work is a limiting factor. A government-wide hiring freeze and budgetary shortfalls constrain the ability to hire additional staff. Stakeholders indicated that following a human resources audit (ongoing at the time of this assessment), it will be possible to advocate for the creation of two positions which have been deemed the highest priority. The MOH is in support of creating these positions. First, a registrar will be established who can license pharmacies and pharmacists. Secondly, an additional Pharmacy Inspector will be appointed. The creation of these two positions will enhance licensing, inspection, and enforcement functions that are mandated under current legislation.

7.2.2 PRODUCT REGISTRATION, LICENSING, AND INSPECTION

Currently, the Pharmacy Inspector licenses pharmacists and pharmacies in both the public and private sectors. As of the end of 2011, there were 82 licensed pharmacists, 19 of which are established public sector pharmacy posts; four posts are filled by contract workers. Pharmacists working in community health services are assigned to visit different facilities on specific days to dispense medications to patients. There are 36 sites where medicines are dispensed outside of the major hospitals.

The Pharmacy Inspector is also responsible for inspecting public and private facilities and by law has enforcement power over facilities. The Pharmacy Inspector also monitors the importation and distribution of pharmaceuticals and medical products to the public and private sectors. While inspections of facilities should occur once or twice a year, inspections do not happen as often as they should as a result of capacity constraints. The Pharmacy Inspector is also responsible for licensing local importers that distribute to the private sector. One concern raised during this assessment is that the current Pharmacy Inspector does not have the Instrument of Identification to effectively perform her duty.

The private sector is a major player in Grenada's pharmaceutical sector. However, aside from licensing and inspection, the private pharmaceutical sector is unregulated in Grenada. There are eight licensed distributors and 33 licensed pharmacies. It is unclear how many pharmacists are currently practicing in the private sector. The Pharmacists Association, which includes public and private pharmacists, currently

has around 50 active members. One source estimated that about 20 private pharmacists may be practicing without a license, although this was disputed by another source. The number of retail outlets (which distribute only over-the-counter drugs) is unclear, as these are not mandated to be licensed under existing law.

It is also common for doctors to dispense medications without a pharmacy license. This is a conflict of interest, and is reportedly a major issue impacting quality of care and patient outcomes. Pharmacy stakeholders interviewed also expressed concern that when doctors dispense without a license, it takes business away from private pharmacies.

The MOH faces a number of challenges in terms of licensing and inspection. First, there is only one Pharmacy Inspector to license and inspect public pharmacies, private facilities, and private distributors. The lack of capacity for inspection and enforcement limits the MOH's ability to regulate pharmaceutical practice, as well as its ability to collect and update data on the number of private sector pharmacies and pharmacists. Relatedly, the lack of electronic record keeping systems poses a challenge to collecting and updating data, tracking licensing, and collecting licensing fees. Moreover, certain aspects of senior ministry officials' jobs – such as issuing letters to pharmacies or pharmacists that have fallen behind on paying fees – could be automated, thus reducing the administrative burden on senior-level staff. Third, the Permanent Secretary is currently functioning as the Registrar, and is the only person that has the power to license pharmacists and pharmacies. Given the Permanent Secretary's many other responsibilities, this lengthens the licensing process. Fourth, although the Pharmacy Council and the Pharmacy Inspector are mandated to regulate both the public and private sectors, the Pharmacy Inspector is not currently appointed to the Pharmacy Council. Appointing the Pharmacy Inspector to the Pharmacy Council will ensure that the council is aware of key regulatory, inspection, and enforcement issues facing the sector in general. Finally, while the MOH has recently been making strides in collecting unpaid fees from pharmacists and pharmacies, the amount charged for licensing fees is outdated and thus well below current economic realities. Pharmacists pay EC\$100 (US\$37) per year to keep their license up to date, and pharmacies pay EC\$150 (US\$56) per year.

7.2.3 QUALITY CONTROL AND MEDICINES ADVERTISING

Grenada does not have its own national quality control laboratory and it does not regulate the advertising and promotion of medicines. Some standards are monitored by the Bureau of Standards.

7.2.4 PHARMACOVIGILANCE

Pharmacovigilance is the tracking of adverse drug reactions. In both the public and private sectors, an informal pharmacovigilance system operates, in which pharmacists refer patients back to their physicians if a patient reports an adverse reaction to a medicine. Grenada's public pharmaceutical sector participates in the OECS pharmacovigilance system. Public sector pharmacists are supposed to record any adverse reactions to medicines obtained through the OECS/PPS on a form issued by the PPS. They are then supposed to submit this form to the Central Procurement Unit, which will then forward the report to the PPS. The assessment found that some pharmacists are not aware of this form, do not commonly use it, and are not aware that they are supposed to submit this form to the MOH (instead of directly to the PPS). Stakeholders indicated that with the current understaffing of the pharmaceuticals division at the MOH, it would be a challenge to create and implement a pharmacovigilance system at the national level.

7.3 PROCUREMENT, STORAGE, AND DISTRIBUTION

7.3.1 PUBLIC SECTOR PROCUREMENT AND DISTRIBUTION

Public sector procurement is centralized in Grenada. The CPU within the MOH secures medicines and medical supplies and distributes them to all public facilities. The CPU is responsible for forecasting order quantities; processing requisition orders; storage; preparing packing slips; conducting a formal inventory twice a year, and informal inventories as needed; issuing reports on outstanding order lines; tracking expiry dates; conducting batch tracking; and reporting on products out of stock.

The CPU faces challenges in relation to forecasting, storage, and inventory. The unit uses both manual and electronic record keeping. With support from the PPS, Grenada uses ORION Software with regular technical support. Inventory management is a weaknesses in the public sector. While individual pharmacists may have a clear picture about what drugs are available in their pharmacy, there is no process to monitor current pharmaceutical stock across the country. Therefore, if one pharmacy has a large supply of certain drugs, but another is experiencing a stock-out, there is no official mechanism for tracking this or for redistributing drugs from one pharmacy to another. Additionally, a computerized monitoring system would greatly facilitate better stock management. It would allow the CPU to see which drugs are available in every pharmacy in the country, develop PPS orders, and resupply pharmacies, as necessary.

Storage capacity at the CPU is somewhat limited, with corridors being used to store items when large quantities of supplies are in stock. Human resource shortages sometimes pose a problem, with the CPU composed of a staff of 10. Despite the limitations, management and control of inventory at the CPU was reported to be stronger than the control and management of inventory at the facility level.

Grenada procures about 80–90 percent of its pharmaceuticals through the PPS, though its record of making late payments to the PPS has recently jeopardized this arrangement. The CPU procures items that are not available through the PPS from other sources on a somewhat regular basis – usually if Grenada’s line of credit with the PPS has been overextended and the government is unable to promptly settle outstanding credit, or if a certain product is needed urgently. The MOH prefers to procure from the PPS, as it is much cheaper. Procuring from the PPS is one of the key strengths of Grenada’s pharmaceutical sector, and current MOH leadership is committed to improving its payments to the PPS. However, low budgetary allocations for pharmaceutical procurement will continue to hamper the ability of the public sector to keep drugs in stock until more funds are secured.

It is not possible to procure some reagents or medical products through the PPS. For items not procured through the PPS, the CPU purchases from a wide range of suppliers. In some cases, once a relationship with a supplier has been established to procure a certain product, the CPU may begin to sole-source from that supplier. For instance, some laboratory supplies are now sole-sourced through established suppliers.

The public sector distribution system operates on a “pull” system: facilities submit monthly requisitions to the CPU. The distribution system for medicines and medical products is fully integrated, with the exception of ARV drugs for HIV and oncology medicines.

Requisition is done manually. The CPU provides pharmacies with pre-printed requisition forms (MOH 2010). Supplementary requisitions can be submitted during the month if stocks run low. Pharmacists forecast need for the upcoming six weeks based on historical usage, using pre-issued cards which track usage over the past few years. At one pharmacy visited during this assessment, pharmacists had trouble

locating the cards used for forecasting. Pharmacists indicated that the lack of an electronic forecasting system was a challenge; and that the forecasting and requisition process was time-consuming. They indicated that creating electronic forecasting and requisition systems would greatly improve the distribution process. They also reported that it takes the CPU from two to three weeks to fill a requisition, and indicated it was common for shipments to take longer than three weeks. Shipment times that extend beyond three weeks contribute to stock-outs.

The largest challenge facing the public pharmaceutical sector is stock-outs (discussed in more detail below). Stock-outs are common in public pharmacies, and occur most often for chronic disease medicines. At one public sector pharmacy visited, two of nine WHO infectious disease tracer drugs were out of stock and two of seven WHO chronic disease tracer drugs were out of stock.

7.3.2 PRIVATE SECTOR PROCUREMENT AND DISTRIBUTION

As noted above, there are eight licensed private sector distributors in Grenada. At times, if local distributors do not have a commodity in stock, private pharmacies will purchase directly from overseas suppliers based in Barbados, Trinidad, the United Kingdom, or other countries. They typically do not like to do so, as international suppliers charge a mark-up of EC\$2–4 per item.

Agents for local distributors visit private pharmacies monthly to fill orders. Manual forecasting, record keeping, and inventory are common at private pharmacies, though electronic databases for dispensing and labeling are becoming more common.

7.3.3 STOCK-OUTS AND INVENTORY MANAGEMENT

Public sector stock-outs are common. Informants largely attributed stock-outs to the lack of sufficient public sector funds to procure pharmaceuticals, and delayed or lack of payment to the PPS. Manual forecasting and storage and inventory issues at pharmacies also contribute to stock-outs and wastage. Public pharmacies reported dumping expired medicines. Both public and private pharmacies reported being “taken off guard” by stock-outs as result of the lack of electronic inventory management systems. Public and private pharmacies expressed a desire to have electronic access to CPU stock lists in order to conduct better forecasting.

Multiple interviewees for this assessment confirmed that the private sector fills the gap in the market when public sector stock-outs occur. As a result, public sector stock-outs will often trigger private sector stock-outs. Stock-outs do occur in the private sector for other reasons as well, such as the lack of solid forecasting systems and the lack of stock at the wholesale level. As in the public sector, chronic disease medications are the most likely to be out of stock in the private sector. When a private pharmacy is out of stock for an item, they will call other private pharmacies to see if they can refer the patient elsewhere. If they learn that other pharmacies do not have the product, they will tell the client to return to their doctor to ask for a prescription for something else.

Patients move fluidly between public and private sector pharmacies to access needed medications. Price shopping between private pharmacies is common. At some private pharmacies, about half of the prescriptions filled were on public prescription pads (even though patients could in theory have filled the prescription at a public pharmacy). As a result of the global economic crisis, and the much lower cost of pharmaceuticals in the public sector, interviewees noted that increasing numbers of patients are attempting to first fill prescriptions at public pharmacies. If patients are turned away from public sector pharmacies as a result of stock-outs, they will then go to private pharmacies. If private pharmacies stock-out they turn first to local distributors and then to international suppliers for emergency procurement, which is more costly than going through local agents. The public sector also turns to last-minute

procurement from suppliers outside the PPS when stock for needed medicines is depleted, increasing costs. The supply chain has thus evolved in a way that negatively affects access to medicines for the poorest, and drives prices up for procurement in both the public and private sector.

It is likely that some patients who are able or willing to pay for pharmaceuticals at private pharmacies are utilizing public pharmacies. Some public pharmacies will fill private prescriptions, particularly if they are familiar with a patient or their economic situation, but will turn away private clients if stock is running low in order to protect stock for public clients. At one public pharmacy, about 15 percent of prescriptions filled were private. A related issue is the lack of enforcement of dual practice regulations. Some doctors may see private clients, and provide them with prescriptions on public pads.

Private and public pharmacies engage in informal favors and sharing of stock to fill gaps in stock on a regular basis. In addition, private pharmacies will sometimes fill half-prescriptions for indigent patients when there are public sector stock-outs, or provide a small discount. There is a key opportunity to formalize some of the informal collaboration that already exists between the public and private sector. Leadership at the central level should drive this engagement, in order to mitigate challenges – for instance, some private pharmacies expressed feeling as though the public sector merely wanted to “use” them. In addition, the private sector is wary of entering into contracts with the public sector in which they may be owed outstanding payments for long periods of time.

7.4 RATIONAL USE

7.4.1 STANDARD TREATMENT GUIDELINES AND ESSENTIAL MEDICINES LIST

The OECS/PPS has developed an essential medicines list and treatment guidelines to guide the procurement and use of medicines in the member countries. Grenada has adopted this as its national essential medicines list from which it procures medicines and medical products for the public sector.

7.4.2 PROMOTING RATIONAL USE OF MEDICINES

WHO defines the rational use of medicines as follows: "Patients receive medications appropriate to their clinical needs, in doses that meet their own individual requirements, for an adequate period of time, and at the lowest cost to them and their community" (WHO 2002). Irrational drug use can lead to poor patient outcomes and adverse drug reaction, and can exacerbate antimicrobial resistance. Grenada's MOH recognizes the importance of actively promoting rational use through a national rational use policy, but is not currently promoting rational use through a national rational use policy. The Grenada Pharmacists Association positions continuing medical education initiatives, including the promotion of rational use, as one of its top priorities. The association could also play an advocacy role for organizing public education campaigns, potentially funded through public-private partnerships. Strengthening the association and its role on the Pharmacy Council is key to promoting rational use at all levels.

7.5 FINANCING FOR MEDICINES AND SUPPLIES

In the public sector, the cost of medicines and medical supplies are funded through budgetary allocations. Medicines listed in the OECS formulary are included. Clients between 16 and 60 who have a public prescription and go to a public pharmacy are charged a flat fee of EC\$4 for any drug that is less than EC\$4. Any drug that costs over EC\$4, the patient pays that price at cost, rounded to the nearest dollar. Patients under 16, over 60, who have been declared indigent, are mentally or physically disabled, are veterans, or in the military do not pay for medicines. Pharmacists and doctors will sometimes treat

clients as indigent and exempt them from paying regardless of whether they have been officially declared indigent.

Clients who fill private prescriptions at public pharmacies are charged the cost of the drug plus 50 percent. This pricing system provides an incentive for patients with private prescriptions to attempt to fill prescriptions at public pharmacies first, as drugs are marked up even more in private pharmacies. The pricing system, and the lack of enforcement of pharmaceutical and dual practice regulations, have implications for patients' ability to access drugs and the equitable distributions of medicines, and create a challenging business environment for private pharmacies.

In the private sector, prices are unregulated. Private pharmacies benefit from VAT exemptions for certain drugs, mostly for chronic diseases.

7.6 RECOMMENDATIONS

7.6.1 SHORT-TERM RECOMMENDATIONS

Expand pharmaceutical sector management capacity at the MOH to improve regulation.

The existence of strong leadership and political will within the pharmaceuticals division at the MOH to improve regulation of the public and private pharmaceutical sectors is a key strength that should be capitalized on. Expanding the number of staff within the division will improve enforcement of regulations surrounding licensing and pharmaceutical practice in both the public and private sectors. In addition, current staff and structures should be empowered to enforce regulations that exist under current laws. Finally, the Pharmacy Council should continue to be strengthened, so that it can steer efforts to improve regulation. The MOH should consider:

- Appointing 1–2 additional pharmacy inspectors.
- Appointing a Registrar to register facilities and license pharmacists.
- Providing official documents needed for Pharmacy Inspector to perform enforcement functions.
- Updating and enforcing license and registration fees, in order to reduce quackery and unlicensed providers.
- Continuing efforts to revitalize and strengthen the Pharmacy Council, including appointing the Pharmacy Inspector to the Pharmacy Council.

Formalize mechanisms for public pharmacies to source drugs from private pharmacies, to mitigate stock-outs and rationalize costs.

Pharmaceutical stock-outs in the public system erode confidence that the public system is equipped to play its role in the health system. They also deprive patients of needed medicines. A memorandum of understanding could be developed between the public and private sector, and a price schedule could be agreed upon. The Pharmacy Council and the Pharmacists Association can help steer the process of developing the memorandum of understanding and the agreed-upon price schedule, as both entities have representation from the public and private pharmaceutical sectors.

Encourage the use of OECS/PPS adverse drug reaction reporting form at pharmacies.

Stakeholders interviewed for the assessment indicated that participating in the PPS is a major strength for Grenada's public pharmaceutical sector. As there is a shortage of human resources for

pharmaceutical management within the MOH in Grenada, deepening engagement in regional pharmacovigilance efforts is crucial. Ensuring that adverse drug reaction reporting is covered in pre-service and in-service training efforts is something that the Pharmacist Association can advocate for. The MOH should ensure that PPS adverse drug reaction reporting forms are available and being used in pharmacies.

7.6.2 LONGER-TERM RECOMMENDATIONS

Update, innovate, and strengthen pre-service and in-service training for pharmacists.

Training, for both the public and private sectors, should include training on pharmaceutical legislation and regulation; rational use; and pharmacovigilance. Pharmacists in both the public and private sector expressed a desire for improved education and professional development, and noted that improved educational opportunities are necessary for major issues surrounding regulation, irrational use, and pharmacovigilance to be resolved.

- As noted in Chapter 6 (Human Resources for Health), Grenada would benefit from organizing a higher education council to support planning and rationalization of the island's advanced health worker training capacity. If this process were to take a place, it would be a key opportunity for updating and strengthening pre-service and in-service training for pharmacists.
- In addition, SGU has online training capacity and is a member of the Caribbean Knowledge and Learning Network. This network is supported by the European Union and the Caribbean Development Bank, as part of an effort to introduce a high-speed fiber-optic network linking regional universities. Along with other electronic resources, this network could support both pre-service and in-service training for pharmacists in Grenada and the wider OECS.

8. HEALTH INFORMATION SYSTEMS

Key Findings

- Abundant data are collected from public health facilities, and compiled predominantly manually. Implementation of the electronic national health information system would improve efficiency in data collection and management.
- There are important gaps in data collected at the central level:
 - Incomplete hospital data available to the MOH
 - No data from private providers
 - Lack of data on household health expenditures and cost of health services
- There is need for strengthening the analysis, interpretation, and publication of data.
- Data are used effectively for results-based planning and monitoring at health centers, but there is little coordinated use of data at the central level, especially for planning, budgeting, and quality improvement.

A health information system (HIS) is defined as a “set of components and procedures organized with the objective of generating information that will improve health care management decisions at all levels of the health system” (Lippeveld et al. 2000). The ultimate goal of an HIS is to facilitate transparent, evidence-based, high-quality decision-making for the health sector. Therefore, the objective of the HIS is to produce relevant and quality information to support decision-making (WHO 2008b).

An HIS has four functions: (1) data generation, (2) data compilation, (3) data analysis and synthesis, and (4) data communication and use (WHO 2008b). An HIS should collect data from the health sector and other relevant sectors; analyze the data and ensure their overall quality, relevance, and timeliness; and convert the data into interpretable information for health-related decision-making. HIS data are the basis for M&E of public health programs, and also provide early warning systems (via surveillance), support service delivery and health facility management, inform planning, and permit global reporting (WHO 2008b). In addition, a well-functioning HIS should be supported by appropriate policies and adequate resources (human, technical, and financial) for generating, processing, and using health information.

This rapid assessment builds on the findings from two recent assessments of the public sector HIS in Grenada (Holder 2009; MOH 2010). The reports from two other recent HIS assessments – based on frameworks by the Health Metrics Network (HMN) and the Performance of Routine Information Systems (PRISM) – were not yet available when this assessment was conducted.

8.1 ORGANIZATION AND STRUCTURE OF THE HEALTH INFORMATION SYSTEM

Grenada’s national HIS includes the following components:

- Routine service delivery information system (including patient records)

- Epidemiological surveillance system
- Vital registration
- Census of the population
- Research and M&E

This section describes the overall organization and flow of data associated with each component of the system, while the following sections provide a more detailed analysis of issues related to resources, quality, dissemination, and use of health information.

8.1.1 ROUTINE SERVICE DELIVERY INFORMATION SYSTEM

Routine service delivery information is managed by the Epidemiology and Information Unit (here abbreviated EIU) of the MOH. This unit is responsible for collecting, analyzing, and disseminating service delivery statistics from the two levels of the public health system, community health services and hospital services. The NIDCU is responsible for compiling HIV-related statistics. Service delivery data are not collected from the private sector.

Community health services: Individual patient files and a number of registers are kept at each health center and medical station. A set of standard monthly reports are submitted to the EIU by each of the six health districts. The Community Health Nurse in charge of each district compiles the reports from the health centers and medical stations in the district. Reports cover prenatal and postnatal care, child health (including immunization), and adult health (including anemia and obesity screening, chronic diseases, cancer). The Health Information Officer at the central EIU enters all of the monthly individual district reports in an Excel spreadsheet monthly, in preparation for producing the annual Community Health Services report. None of the 30-plus private physician practices submits any data to the EIU, except a few private providers who submit surveillance reports for select communicable diseases.

Hospital services: In each of the public hospitals, individual patient files are kept at a Medical Records Department and loaned to the wards for the duration of a patient's hospital stay. The Medical Records Unit at the General Hospital compiles monthly inpatient statistics on admissions, discharges, and bed occupancy rates for the different wards, based on individual patient discharge records. Mortality rates disaggregated by diagnosis (using ICD-10 codes), as well as sex and age groups, are also compiled. The clerk in charge of compiling these statistics uses Excel to enter the data on an ongoing basis. The General Hospital submits the monthly inpatient utilization reports to the EIU, which does not conduct any further processing or analysis of the data. At Princess Alice Hospital, a medical records clerk manages patient files and collects daily ward data on bed occupancy, but does not compile or submit any routine service delivery reports to the EIU. Similarly, no service delivery reports are submitted to the EIU by the Princess Royal Hospital. The reasons for the lack of reporting by the two community hospitals appear to be a combination of lack of staff capacity at the hospitals to compile such reports, and lack of clarity about lines of responsibility and official requirements to submit routine reports to the EIU. Admissions and discharge data from Mt. Gay Psychiatric Hospital are compiled and reported to the EIU but reports do not include breakdown by diagnosis. None of the private hospitals submit data to the EIU.

HIV/AIDS data: All HIV-related data are collected and processed by the NIDCU. The unit receives voluntary counseling and testing reports gathered during antenatal care or general health care visits from public sector facilities around the country. Individuals are assigned a unique code to preserve their confidentiality. The paper-based forms are entered electronically in *Epi Info*, which generates automated reports. Private providers do not routinely report HIV testing statistics to the NIDCU, but typically

refer HIV-positive clients for follow-up counseling and services. The NIDCU also maintains an HIV patient monitoring and treatment database (provided by PAHO), which also has automated reporting functions. The NIDCU submits statistical reports to the EIU and, upon request, to the Central Statistics Office at the MOF (e.g., when the Central Statistics Office needs data for an international report).

Private sector: Encouraging provision of timely and accurate data by the private health sector to the MOH is a challenge. Private providers interviewed for this assessment reported that they find many of the forms required by government too cumbersome and time-consuming. In many cases, the government requires submission of the data via fax, which private sector providers rarely use.

8.1.2 EPIDEMIOLOGICAL SURVEILLANCE

There is active surveillance (mandatory routine reporting) for vaccine-preventable and other communicable and infectious diseases, using standard PAHO forms and processes. Surveillance reports are prepared weekly by the Community Health Nurses overseeing each health district, nurses at the hospitals, and at the Surveillance Nurse at the NIDCU, and sent to the Surveillance Officer at the EIU who submits a consolidated report for the country to CAREC. Only a few private providers submit surveillance reports to the EIU, based on an informal/goodwill relationship with the unit. Since many patients prefer to seek diagnosis and care for STIs from private providers (where confidentiality is perceived to be better than in the public sector), it is likely that a substantial portion of notifiable STI cases do not make it into the official surveillance statistics.

8.1.3 VITAL REGISTRATION

Official individual records of births and deaths are kept by the Registrar General's Department of the MOH. The department produces the *Registrar General's Annual Report* which includes statistics on births and deaths by parish, sex, and age group; and death statistics by cause of death.

The entire records system of the department is paper-based, and all data are compiled manually. This makes the statistics compilations prone to errors and results in substantial delays in the production of vital statistics reports. A computerized database for deaths is in place but not in use because of missing data entry fields; the database was provided by the Organization of American States (OAS), which has not responded to requests for modifications that would make it consistent with Grenada's vital registration records.

The Central Statistics Office uses the births and deaths registration data from the Registrar General's office to produce birth, mortality, and population growth rates, as well as life expectancy estimates. The Central Statistics Office publishes the number of births and deaths, and disaggregates the data according to various parameters, but the last publication was from 2005/06 and no data are published online.

8.1.4 CENSUS OF THE POPULATION

The 2011 Population and Housing Census was being conducted by the Central Statistics Office at the time of this assessment. The census was conducted as scheduled, and no major problems with the field work were reported at the time of this assessment. The complete questionnaire included about 100 questions, including sections on fertility, infant mortality, disability, chronic diseases, and health insurance. The overall content of many sections of the questionnaire is very similar to the standard Demographic and Health Survey developed by USAID.

8.1.5 RESEARCH, MONITORING, AND EVALUATION

There is no specific MOH department that oversees or conducts health sector program M&E according to standard international guidelines. Results-oriented work planning is in place for community health services: health centers prepare annual work plans with priority activities and related indicators, and monitoring progress against set targets is reportedly part of their regular management meetings. The performance indicators that were selected by the health facilities visited for this assessment appeared to be appropriate.

Occasional health sector studies are conducted by outside researchers (e.g., SGU students) in collaboration with the MOH. An example is a recent survey to identify reasons for late antenatal care-seeking, which was a collaboration between the MOH Community Nursing Division and SGU Department of Public Health and Preventive Medicine. However, a systematic health system research agenda is not part of the MOH's work plan or strategy.

Lack of data on the cost of health services was one notable gap identified by the assessment. No data on the cost of health services are collected by MOH or any other government agency, which limits the ability of leadership to allocate adequate resources and prioritize coverage of cost-effective services when funding is limited. Furthermore, there are no data on household out-of-pocket health expenditures, and thus any estimates of total health expenditures in Grenada are really just "guesstimates." A household income and expenditures survey conducted in 2007/08 as part of the Country Poverty Assessment (Kairi Consultants Ltd. 2008) included questions on health expenditures. However, the results on out-of-pocket health expenditures were not published or readily available.

8.2 PROCESSES AND RESOURCES FOR DATA COLLECTION, REPORTING, AND ANALYSIS

The components of the HIS managed by the MOH are almost entirely paper-based, with some minimal use of computers for data aggregation and analysis tasks at the General Hospital, the NIDCU, and the EIU. As mentioned earlier, the entire births and deaths registration system and resulting statistical analyses are paper-based. All facilities maintain individual patient files on paper only, which puts the files at risk of damage or permanent loss (e.g., due to termites in storage rooms, floods, or hurricanes) and requires a considerable amount of space and staff time to manage.⁴ In community health facilities, patient files are typically kept in filing cabinets that can be accessed by all staff at the facility (i.e., files are not locked or subject to restricted access). A multitude of registers are kept at primary care facilities, and reporting requirements involve some duplication, contributing to an already substantial reporting workload for the community health nurses.

There are plans to introduce a pilot electronic Health Management Information System in public health facilities, and preparatory steps have already been taken in this direction. As noted in the introduction to this chapter, several HIS assessments have recently been conducted (the HMN and PRISM assessments, as well as a detailed systems assessment conducted by the MOH). The World Bank-funded Electronic Government for Regional Integration Project (E-GRIP), which aims to harmonize regional e-government frameworks and applications by automating and pooling resources across the OECS countries, supported a consultancy to select an appropriate operating platform for Grenada's new electronic system. The next steps in the planning process include the establishment of a steering committee and technical working groups to guide the design of the electronic HIS (envisioned for 2011), with an

⁴ For example, retrieving a patient's file in the General Hospital is a multi-step process that involves locating the patient's file number using an index-card system, and then retrieving the file from a room of files, often in another building.

intention to start rolling out the pilot system in 2012–2013. However, financing for the new system is likely to be a challenge: the development of such a system was not on the list of the health system priorities announced by the Minister of Finance in his speech to Parliament upon presentation of the 2011 budget. Some E-GRIP funding may be available for this new national HIS.

The number of staff responsible for data collection and processing at all levels of the MOH system appears to be adequate. Community health services and surveillance reports are submitted on a timely basis, and the staff producing these reports appear to be adequately trained for the task. While the General Hospital appears to have adequately trained data management staff to compile utilization data, this does not seem to be the case in the community hospitals (particularly Princess Royal). In general, there is no formal, routine data quality assurance process in place, although community health nurses review facility data reports and identify potential data errors during the routine facility supervision process. Overall, the content and quality of the limited number of data-based publications produced by the MOH indicate that there is room for strengthening data analysis and presentation skills across the MOH units tasked with such duties. This would help ensure that reports contain accurate, relevant, and useful indicators and analyses. For example, many of the demographic indicators included in the 2009 Registrar General's Annual Report did not correspond to standard international definitions⁵ and some of the reports produced by the EIU could benefit from greater analysis and a streamlined presentation of results. There is a chronic discrepancy between the number of births and deaths compiled by the MOH Registrar General's office and the Central Statistics Office, for reasons that likely include errors in the manual aggregation of the data.

Grenada's HIS lacks key standard products, most importantly an Annual Report of the MOH and a health statistics profile or a similar publication by the Central Statistics Office. The last MOH Annual Report was published in 2005, according to informants. At the time of this assessment in 2011, the EIU was in the process of completing the 2008–2009 Community Health Services Report. Accordingly, timely and readily available data on health outcomes or health system performance are not available, for use by MOH leadership or the general public. The reasons underlying this lack of reports may stem from a combination of factors that are linked to both the supply of data (i.e., capacity/ability to produce relevant analyses and reports) and demand for data (i.e., low prioritization or value placed on data).

8.3 USE OF HEALTH INFORMATION

Community health nurses and district nurses have received training in result-based planning, and are putting it to use: health centers prepare annual work plans with priority activities and related indicators, and facility management meetings include comparing implementation to established targets, as well as routine review of the data in the service delivery and surveillance reports. Similarly, managers at the General Hospital review service utilization reports from the hospital at routine management meetings. However, this is not the case at the community hospitals, where use of utilization data for decision-making at the facility appears to be lacking.

At a system-wide level, the absence of the key HIS reports discussed above has two major implications for the governance of Grenada's health system.

- With a few exceptions, MOH leaders do not use health information for decision-making on programs, policy, and budgets. This means that the allocation of resources is likely unresponsive

⁵ For example, the report includes an indicator "neonatal death rate (per 1,000 population)" instead of per 1,000 live births, and a "fertility rate (live births per 1,000 females 15–49)" which is given as 68.3% (683 births per 1,000 women is clearly an overestimate).

to actual population needs (e.g., what types and amounts of services are required in a given facility) and resources may be wasted or used inefficiently. This also constrains the ability of the MOH to advocate with the MOF for adequate budget allocations. Finally, the lack of evidence-based decision-making limits the ability of MOH leadership to demonstrate measurable results stemming from their health system investments.

- Secondly, the lack of routine and timely reports on health sector performance limits the ability of CSOs to effectively participate in the dialogue on health care policy. The lack of readily available compiled data summaries, and the gaps in the data that MOH collects routinely, leave advocacy groups at a disadvantage when weighing in on national priorities and funding for health.

8.4 RECOMMENDATIONS

8.4.1 SHORT-TERM RECOMMENDATIONS

Conduct strategic planning for HIS as part of the next national health strategic planning process.

This HIS strategic planning process should prioritize the implementation of an electronic HIS, and build on the preparatory work already done by the MOH. As part of the design and planning of the new electronic HIS, there also should be some further review of (1) the health data needs at various levels of the health system, (2) reporting processes, and (3) the choice of health indicators. One or more technical working groups could be convened to guide this review process and provide strategic planning for improvements in these three areas, including identification of relevant training needs.

Technical assistance from external partners could be sought for the design, costing, and roll-out of the electronic HIS (including necessary training). It is important to involve private health providers in the planning process for the electronic HIS to ensure their buy-in to the new system.

Prepare and publish an annual MOH report on health outcomes and service utilization.

This comprehensive report will not only be a valuable tool for decision-making by MOH leadership, but will highlight the power of data, and inform the dialogue on health policy among government decision makers, CSOs, and the public at large. The EIU should take the lead on this task and could consider collaborating with the SGU public health program and/or seeking technical assistance for the completion of the first such report (which will help establish a report template, and could assist with capacity building for specific complex analyses). Examples of comprehensive annual MOH reports from other countries in the region could be considered to guide the contents and type of analyses to include.

Identify training needs across the health system on data analysis, data quality, and information usage, and prepare a plan for securing technical assistance for training.

Developing a training plan should be a collaborative activity between the EIU, MOH staff in key positions who require data for decision-making, and the Central Statistics Office staff in charge of health statistics. Some MOH units (such as the EIU) already prepare training needs plans as part of their annual work planning process; but other MOH units need HIS-related training (e.g., on how to use data for planning) as well. If a technical working group is convened to guide the design and planning of the electronic HIS, its scope of work should also include identifying training needs. Specific HIS areas that emerged in this assessment as priorities for capacity building include:

- Statistical analysis and information presentation skills for health sector data.

- How to effectively use data for evidence-based decision-making (for senior leadership and technical leads).

Include a health sector research agenda as part of the MOH annual work plan.

- Identify potential partners outside of government (e.g., universities, PAHO, USAID) that could support or conduct the research, and involve them in the process of preparing the research agenda together with the technical leadership of EIU and the Central Statistics Office.
- Prioritize key health system topics such as the costs of health service provision, household health expenditures, and the quality of chronic disease management.

8.4.2 LONGER-TERM RECOMMENDATIONS

Develop and implement a plan for systematic routine health information dissemination.

This plan should be under the leadership of the EIU, in collaboration with other MOH divisions and the Central Statistics Office staff in charge of health sector statistics, and could include the following activities:

- Create communications materials for sharing data on topical health issues (e.g., a quarterly newsletter on current health issues) and disseminate these information products to government and private sector employees and to the public.
- Improve the functionality of the MOH page on the government website and regularly post current data, reports, and other information products.

Incentivize routine private sector data reporting, particularly for disease surveillance and key service utilization statistics.

To generate interest from private providers in data sharing, consider the following steps:

- Initiate a public-private dialogue on what data are needed and how these data could be used.
- Highlight the value of comprehensive health sector data for efficient service and resource coordination across both sectors – e.g., select a few service delivery categories and collect utilization and service cost data from both sectors to showcase how such information can be used for effective, evidence-based decision-making. This data could be collected through a small survey implemented in collaboration with SGU researchers, for example.
- Ensure that the reporting burden for private providers is minimized, by involving them in the process of developing the reporting forms and procedures they would use as participants in the electronic HIS.

9. PRIVATE SECTOR CONTRIBUTIONS TO HEALTH

Key Findings

- The private sector plays a significant role in Grenada's health care system, with more than 30 private physician practices, 10 nurses, 3 hospitals, and 33 pharmacies.
- Few data exist to quantify the scope, characteristics, or costs of these contributions.
- Senior leaders within the MOH support leveraging public-private partnerships to improve access to health care.
- Grenada's CSOs (unions, non-profits, foundations, faith-based organizations, professional associations) play an active advocacy role and regularly participate in public-private councils to address social issues.
- Corporate contributions from Grenada-based companies are made on an ad-hoc basis. More formal engagement would offer companies desired visibility as health partners, tap into their strengths in marketing, and increase the impact of their support on critical health needs.

The role of the private health sector is often not explicitly conceptualized in a health systems framework. Harnessing the private sector can relieve constraints in delivering essential health services. It can also result in increased efficiencies in management and resource utilization, a broader market for health promotion messages, and greater responsiveness to consumer preferences. The private health sector increases the scope and scale of services available in Grenada in important ways, such as by reducing overcrowding in public facilities, and filling gaps when public sector drugs and supplies are unavailable.

This chapter uses a private sector lens to identify ways to improve the availability, affordability, access, equity, and use of health services in Grenada. The objective is to identify factors to improve the environment enabling private sector participation in health, to ensure more equitable access and sustainable quality care for all Grenadians.

BOX 9.1: GRENADA'S PRIVATE HEALTH SECTOR AT A GLANCE

Private physician practices

It is estimated that 30–40 doctors actively provide private services. Dual practice in the public and private sector is reportedly common among physicians, although dual practice is not formally tracked. A small number of private doctors employ nurses or nursing assistants as well.

Private clinics and hospitals

There are four small private health facilities, each with diagnostic facilities and laboratory services and one with inpatient beds. The private sector serves as the sole provider of CT scans, dialysis, and digital x-rays.

Pharmaceutical supply

There are an estimated 30–40 licensed private pharmacies in Grenada currently in operation, with as many as 20 additional practitioners dispensing medicines without a license. There are eight wholesale distributors who sell pharmaceuticals directly to private pharmacies and doctors.

Non-Profit Sector

NGOs are not engaged in the direct provision of medical care, other than family planning and reproductive health services offered by the Grenada Planned Parenthood Association. NGOs are active in health promotion, education, and policy advocacy.

Industry

Health insurance is made available to employees of most large companies in the financial, tourism, and manufacturing sectors. Some ad-hoc corporate expenditures are made to support health services through corporate social responsibility contributions. A small number have sponsored employee awareness programs, particularly related to HIV/AIDS.

9.1 GOVERNANCE AND POLICY ENVIRONMENT

Grenada's recently enacted Health Practitioner's Act (2010) imposes new registration and licensing regulations for all medical, dental, and allied health practitioners, and addresses many prior weaknesses in private sector oversight. The enactment of this legislation is a first step toward stronger stewardship and governance of the private health sector. Representatives from the Medical and Dental Associations are optimistic that the act will improve standards and oversight of health professionals, and are anticipating implementation of some key provisions. For instance, members of the newly established Medical and Dental Council, sanctioned with enforcement functions, were appointed in March 2011. Once their names are published in the Gazette, the council will be empowered to enforce regulation. While there is evident political will to strengthen enforcement of the private health sector through the council, a key concern is whether funding to support the council is adequate to ensure investigation and oversight.

Aside from registration of health practitioners, the private sector in Grenada is self-regulated. There are insufficient resources for identifying and enforcing unlawful or unethical practices. However, few informants raised quality concerns about private physician or pharmacy practices, and a number of private providers spoke with pride about their personal professional standards, hygienic practices, and voluntary use of WHO treatment guidelines and other web-based resources. With no nationally sanctioned standards of care or routine oversight, quality of care in the private sector is largely unknown.

During this assessment, private sector stakeholders raised concerns about the business impact of lax government regulation – for instance, the unfairness of competing with unlicensed pharmacies, or with doctors who misuse public prescription pads for private clients. Several informants suggested that patients would be better served by mandatory continuing medical education for all health practitioners. As pointed out by one private provider, the lack of resources available to the MOH limits the vigilance which can be applied to enforce quality in the private sector.

Grenada adopted an anti-corruption bill in 2007, and appointed an ombudsman in 2009. However, weak enforcement in this area remains a challenge.

Private sector stakeholders highlighted the following regulatory issues as priority areas for attention:

- **Facility regulation:** Aside from private provider licensing requirements, there does not appear to be active oversight of private physician practices, dental offices, or pharmacies. None of the providers interviewed were aware of any regulations regarding the operation of health care facilities. Pursuant to the Health Practitioners Act of 2010, a committee was to have been created to oversee regulation of private providers, but does not appear to have been established. One major private hospital has been operating without an operator's license since its establishment in 1998, because no person of authority has conducted an inspection.
- **Dual practice policies:** Dual employment in the public and private health sectors is legally sanctioned in Grenada and widely practiced. Doctors appointed to the public service through the Public Service Commission are granted private practice privileges through their Letter of Appointment. Regular scheduled hours are required at public facilities, but key informants reported that absenteeism is a problem, as some doctors may prioritize their private practices. This is also alleged to lead to overuse of hospitals since patients are often unable to see doctors at the primary care level. Doctors who opt to practice in both sectors cite poor public sector working conditions, the lack of supplies, and low salaries as reasons for maintaining a private practice. Dual employment policies should be incorporated into broader HRH planning and strategy, with the adoption of clear requirements and sanctions, processes for performance evaluation and supervision, authorization to discipline those in noncompliance, and incentives to reduce abuses by rewarding public service. The right to dual practice should be maintained in order to retain physicians on the island.
- **Access to hospital privileges:** Doctors practicing solely in the private sector reported that the greatest impediment to providing high-quality care was their inability to obtain hospital privileges at General Hospital. At the same time, the Auditor's 2007 report on hospital management reported an "unwritten agreement" between doctors and hospital management allowing publicly employed physicians to use the operating theater facilities free of cost for their private patients, "in compensation for low salaries and allowances paid to them" as well as in the hopes of retaining expatriate specialists. Under the current system, private doctors referring patients to the hospital write up their assessments and diagnoses, and send these along with the patient. General Hospital accepts these referrals but there are no communication channels to track patients, confer with the hospital staff, advise on treatment, or otherwise ensure continuity of care. These are areas ripe for policy reform. The hospital privileges desired by private doctors could be granted in exchange for formalized private sector contributions to defray hospital costs, or for pro bono services to alleviate staff shortages. Formalization of these arrangements is important for transparency and accountability, as well as cost recovery.
- **Mandatory private sector reporting:** There is little data available on private sector health services in Grenada, and lack of surveillance data from private providers increases health risks for the whole population. These issues can be partially addressed through adopting national treatment guidelines and policies affecting rational use of medicines, and requiring mandatory reporting of adverse drug events.

9.2 PRIVATE HEALTH SERVICE DELIVERY

The number of doctors who serve clients in the private sector is unknown because registration lists maintained by the Medical and Dental Council are not routinely updated. Doctors are not required to identify themselves as dual practitioners or solely privately practicing physicians when they register, so it is also unclear how many public sector doctors have private practices. Twenty-four private doctors are listed in the Grenada yellow pages. Stakeholders estimated that there are approximately 30–40 doctors actively serving private clients. A small number of nurses and nursing assistants are employed by private doctors as well.

There are three private hospitals in Grenada: St. Augustine near St. George's, Grenville Medical Services in St. Andrews, and Marryshow Hospital in St. George's. St. Augustine is the largest, with 12 beds and a staff of 27, including one full-time doctor. All provide lab services including ultrasound, sonograms, electrocardiograms, mammograms, hematology, and x-rays. These services are also available at the public hospital, but the wait times are reportedly much longer. In some cases individual private practitioners have invested in lab equipment. The private sector serves as the sole provider of CT scans, dialysis, and digital x-rays. There is a perception among many Grenadians that the private sector provides higher-quality services, has shorter waiting times, and affords patients a greater degree of confidentiality than public facilities.

The perception of businesses interviewed for this assessment is that the public sector could do much more to recognize and benefit from private sector contributions to health care delivery. Private health providers suggested that the public sector could greatly benefit from engaging their services. Private facilities reported underuse of their operating theaters, medical equipment, and outpatient services, while the (public) General Hospital suffers from overcrowding and long waiting times. Clients who may have the ability to pay for the use of hospital services take advantage of free or subsidized public services, overburdening public facilities. Private facilities expressed interest in exploring contractual arrangements with the public sector. This might potentially be a way to reduce public costs if private contractors could provide services more cheaply. One respondent gave the example of tele-radiology services which are available in the private sector and could address the severe shortage of radiologists in Grenada. In response to the lack of specialists on-island in the areas of hematology, cardiology, oncology, and x-ray technicians, several respondents commented that private providers might invest in identifying, hiring, relocating, and training foreign doctors with needed specialized skills if the public sector were willing to contract for these services. This would serve to fill the urgent need for clinicians to address the growing prevalence of NCDs.

The Grenada Planned Parenthood Association, via two private clinics and rural outreach teams, provides reproductive health and family planning services. No NGOs offer inpatient care, though they do engage in health promotion activities. As in other countries, Scotiabank partners with the MOH, PANCAP, and the Caribbean Media Broadcast Partnership to support an annual HIV Testing Day.

9.3 PRIVATE SECTOR ROLE IN THE SUPPLY CHAIN

The private sector is a key contributor to pharmaceutical supply in Grenada. Through informal processes, the private pharmacies serve as a stop-gap for public sector stock-outs. People commonly seek drugs first from public pharmacies where they are free or much lower priced, and then turn to the private pharmacies if public pharmacies stock out. There is an informal segmenting of the market going on with reports of public pharmacies "saving" scarce drugs for their poorest clients and directing others to private pharmacies. The size, structure, and oversight of the private pharmaceutical sector is also covered in Chapter 7 (Management of Pharmaceuticals and Medical Supplies).

9.3.1 WHOLESALER DISTRIBUTION

There are eight licensed wholesale distributors of pharmaceuticals who sell directly to private pharmacies and doctors. Given the small size of the Grenadian market, pharmaceutical manufacturers contract with local distributors as their agents rather than establish direct offices. There has been some consolidation of the market as the larger wholesale companies have acquired smaller distributors. All major global suppliers are represented and there has been a substantial increase in the number of generic suppliers importing as well in the past three years. Some pharmacies interviewed acquire products directly from supplier representatives in Barbados and Trinidad.

Wholesalers are licensed by MOH, and are prohibited from dispensing directly to the public. Respondents for this assessment described import processes as straightforward with minimal bureaucratic delays, and had no complaints about the business regulatory environment. There are price controls on the amount wholesalers and retailers can mark up prices on imported drugs and supplies, but these are not enforced. Most essential medicines are exempt from the VAT. Some informants made reference to a small number of unlicensed importers and agents active in Grenada. Other concerns expressed by distributors included:

- Oversupply of private pharmacies with many falling into financial trouble, and closing after a few years.
- Inability to accurately forecast demand because of unpredictable run-ups on products when the public sector stocks out.
- Burdensome process for bidding on public tenders for medicines outside the PPS process, with one company stating that it had stopped bidding because of poor payment practices by the government.

9.3.2 RETAIL PHARMACIES

According to the MOH, Grenada has 33 licensed private pharmacies. However, the actual number is unknown due to limited oversight of the pharmaceutical sector in recent years. As confirmed by the Pharmacy Inspector, some of the licensed private pharmacies have closed, and some are operating without licenses. There are 22 private pharmacies listed in the Grenada phone book, although one wholesaler estimated there are closer to 30 on the island.

Numerous stakeholders agreed that there was an oversupply of private pharmacies on the island. The licensing process is not burdensome, but several private physicians mentioned closing their private pharmacies due to low demand, inability to retain credentialed pharmacists, and chronic limitations in supply. Smaller pharmacies in particular had trouble ensuring reliable supply, noting that several wholesalers owned large pharmacies and ensured their own shelves were full before filling orders from others. The larger private pharmacies visited during this assessment appeared to be clean, busy, well stocked, and well managed.

Pharmacists interviewed noted the increasing and chronic shortages of popular medications in private pharmacies, including hypertensives, antibiotics, diabetes medications, opiates, and psychotropic medications. These shortages occur following stock-outs in the public sector, which drive patients to private pharmacies. When local private distributors run out, pharmacists may contact off-shore suppliers directly, though the prices will be higher. When there are stock-outs, the pharmacists confer with prescribing doctors to identify the best alternative available. Reagents and medical supplies are not procured through the PPS, and there are shortages of both in the public and private sectors.

Regulation of private pharmacies is weak. Pharmacies are registered by the MOH, but inspections or investigations to ensure safe and ethical practices are very limited as a result of the lack of human resources at the MOH to carry out enforcement functions. The Pharmacy Act should be updated with clear requirements for licensure, inspections, a funding mechanism for enforcement, and authority for imposing sanctions. The recently revitalized Pharmacy Council should continue to be strengthened, so that it can steer efforts to improve regulation.

9.4 PRIVATE FINANCING FOR HEALTH

There is limited information on out-of-pocket expenditures on health, or the percentage of Grenadians who have health insurance. A Country Poverty Assessment conducted in 2007 found that 7 percent of respondents reported having health insurance (Kairi Consultants Ltd. 2008). As noted in Chapter 4 (Health Financing), private insurance is available through some employers and unions with Sagikor providing the dominant share of private health insurance. The seven largest unions in Grenada (including the Public Workers Union, Teachers Union, and Allied Workers Union) have negotiated with Sagikor to provide a health insurance plan to all 10,000 union members. The government of Grenada contributes 50 percent of the premium costs for public civil servants. Benefits include deductibles and lifetime caps, and are subject to reasonable and customary charges as established by Sagikor. Premiums (which include union dues, health, dental, vision, and some life insurance) start at US\$27 per month, which may be out of reach for many workers.

Health insurance is also made available by some large employers. Two large companies interviewed for this assessment offer their employees self-funded insurance plans which include air transport to other Caribbean islands for specialized care. These companies expressed strong support for a regional plan to improve access to specialists in cardiology, oncology, endocrinology, and other common chronic conditions.

The Communal Cooperative Credit Union of Grenada offers a novel private sector contribution to health financing by channeling corporate social responsibility funds into direct grants to union members for medical bills. Funded directly from the credit union's company dividends (2 percent) generated by union deposits, a special Health Committee has been created to establish criteria, review applications, and make donations to defray health expenses. This committee was developed in response to increasing requests from union members for loans to cover health care costs for ill family members.

Commercial lending to the private health sector is not widespread in Grenada. Health is seen as within the realm of development banks with investment measures focused on social rather than financial returns. This leaves private providers with limited access to capital for expansion or improvement of their facility.

9.5 CONTRIBUTIONS OF PRIVATE COMPANIES TO HEALTH

SGU contributes funding (approximately US\$240,000 in 2010, according to government estimates) to the MOH's budget each year for the purchase of medical equipment. Companies throughout Grenada make regular contributions in cash and in-kind donations to public health facilities, charities, and causes, but aside from the SGU example there are no data available on total corporate social responsibility expenditures for health initiatives. Examples include Scotiabank's annual sponsorship of HIV/AIDS testing days, Coyaba Beach Resort's contributions to the BelAir Home for Children through guest donations, and Bryden & Minors donation to construct steps leading to General Hospital. Companies consistently reported that there has been no outreach from the MOH regarding priority health needs, requests for targeted corporate contributions, or efforts to coordinate corporate support in health promotions. This

is an area ripe for more structured public-private partnerships to better leverage the willingness of Grenada-based companies to invest in the health of their employees and customers.

Through the outreach and resources of the NAC (with funding from the now-expired World Bank loan for HIV prevention and control), a number of corporations took advantage of employee education workshops on HIV. One business interviewed, for instance, invited the Council to conduct a one-day session for its 130 employees in 2010, and reported that this was very successful in sensitizing its workforce to the issues of stigma, discrimination, prevention, and resources. The large hotels in Grenada are active members of the Employers Federation and the Caribbean Hotel Association, both of which offer trainings and human resources development. More can be done to integrate publicly sponsored health education programs into these private sector trainings.

9.6 PUBLIC-PRIVATE ENGAGEMENT

Grenada has a tradition of broad public-private stakeholder councils, committees, and alliances to foster cooperation and develop strategies to address health needs, distinguishing Grenada from countries in which the public and private sectors have minimal interaction and distrustful relations. In fact, several stakeholders noted that their time is diluted across so many public-private coalitions that it is hard to maintain attendance and effective contributions to all. Examples include the Coalition for the Rights of the Child, the Steering Committee for the 2007–2011 draft National Health Strategy, the National Chronic Disease Commission, the Sustainable Development Council, the Committee to Revitalize Primary Care, and the Grenada NAC (reconstituted in May 2010). Each of these bodies included representation from the MOH, non-profits, professional associations, consumers, foundations, advocacy organizations, statutory bodies, Chamber of Commerce, and/or other civil society entities. There is weak interaction and coordination among these organizations, however, resulting in duplication of effort and diluted impact.

The GMA includes 80 members from both the public and private sectors. It is active and engaged in policy consultation, although members reported that they do not necessarily feel that consultations with the MOH and legislators give sufficient weight to their recommendations. As one example of their input, GMA has sent letters to the MOH documenting detailed lists of essential supplies missing from public hospitals (e.g., gauze, gloves, IV lines, amoxicillin) to express their alarm and seek solutions to the stock-out problems that prevent practitioners from providing care. The Grenada Dental Association similarly seeks to address critical shortages in basic supplies, resulting in informal stocking of public clinics with stock from private practitioners. The recently revived Pharmacists Association, which includes public and private sector pharmacists, could become a resource to drive needed reforms in the pharmacy sector.

The NGO sector is strong, with leaders actively involved in advocacy and community mobilization. NGOs involved in health advocacy, outreach, screening, counseling and referrals include the Grenada Red Cross, Grenada Council of Churches, Grenada National Organization for Women, Grenada Save the Children Organization, and many others. Several NGOs mentioned specific pieces of legislation that they had helped draft and shepherd through the legislative process.

9.7 RECOMMENDATIONS

9.7.1 SHORT-TERM RECOMMENDATIONS

Launch a multisector social marketing campaign to address wellness and prevention of chronic disease.

Numerous private sector actors expressed interest in collaborating with the MOH on a campaign to promote behavior change for diabetes and hypertension prevention. Building on the mission of the Council on Noncommunicable Disease and the findings of the Essential Public Health Functions 2011 report, the MOH should tap key corporate leaders who have expressed openness to working collaboratively to address these health challenges. Technical assistance could be solicited to, for instance, convene a Corporate Health Roundtable and develop sponsorship commitments (both cash and in-kind contributions such as donated media spots) in exchange for corporate visibility as campaign partners. Other partners – including health advocacy organizations, social service organizations, and community charities – could mobilize their volunteers to provide coordinated health education messages and outreach to the hardest to reach.

Grenada is well positioned to create more structured public-private partnerships, to better leverage the social responsibility mission of Grenada-based companies that are ready to invest in the health of their employees and customers. A critical requirement for engaging these private sector partners is the establishment of measurable goals and returns on their investment. Private partners are well positioned to lead in this area, by creating metrics to evaluate the reach, acceptability, impact, and cost-effectiveness of marketing campaigns.

“Map” the private sector to establish a better understanding of its role in health.

Data are needed about the private sector’s contribution to health care in Grenada. Understanding the private sector’s current role is a first step toward developing future formal arrangements with private sector actors that could ease the burden on the public sector, protect the poorest, and make better use of existing national resources. A local consultant could conduct an inventory within a short time frame to document the number of private providers, their specializations, services offered, diagnostic equipment available, staffing, and location.

Establish routine private sector data collection.

The MOH should mandate collection of data from private health care providers regarding the scope and costs of their services. A technical working group comprised of public and private stakeholders should be convened to review national data needs and agree on standard indicators and reporting processes. To incentivize high participation rates from private providers, routine reporting could be mandated through the Medical and Dental Council as a condition of licensing, and by making the process less onerous by instituting a simple process of electronic reporting. Buy-in from private providers will be strengthened if results are shared regularly with them and the public at large. Improved use and dissemination of data will provide opportunities for improved relations between the sectors and greater ability to leverage the strengths of each.

Pilot-test contracting with the private sector to alleviate critical public sector shortages.

Contracting with private sector providers could make more efficient use of private sector capacity, reduce the strain on tight public sector capital budgets, and alleviate long waiting times for patients. In particular, the MOH should consider negotiating formal agreements with private laboratories to secure more economical terms for purchasing than under existing informal arrangements, with clearly defined procedures and M&E plans. Technical assistance could be sought from agencies with global experience in public-private contracts; such experts could support the MOH in designing a pilot, assessing policy requirements, conducting costing studies to support price negotiations, and developing performance-based terms. Data from such a pilot test would support MOH planning and resource allocation as it works to address shortages in equipment, reagents, and lab technicians, as well as equipment repair.

In addition, a pilot program to permit contracted private provider use of public hospital facilities could reduce public sector clinicians' excessive caseloads, improve continuity of care, and reduce costs. Consultants could be engaged to identify best practices in other countries, assess concerns of hospital management and private providers, and broker trial agreements to build the groundwork for long-term policy change.

9.7.2 LONGER-TERM RECOMMENDATIONS

Stimulate a national dialogue on improved equity in health care.

As Grenada works toward comprehensive systemic changes to improve health care, the public must be sensitized to the need for more sustainable cost-sharing models. In town hall meetings throughout the country conducted last year by the GMA, there was strong public support for the concept of modest fees for use of public services to improve quality and availability of services. As part of the discussion on national health insurance, these consumer forums should be convened to build awareness of the true costs of health care, the burden on the neediest, and the need for wise and fair solutions.

Develop and enforce guidelines on dual practice in the public and private sector.

As part of its HRH planning, the MOH should address some of the factors which may have contributed to distorted provider incentives, which have encouraged the prioritization of private patients at the expense of public patients. These factors include weak oversight, weak performance standards, lack of performance evaluation or sanctions, and issues related to compensation, working conditions, and training. Technical assistance could help facilitate negotiation of acceptable private practice privileges between the MOH and the professional associations to strengthen drafting of and compliance with dual practices guidelines.

Implement public-private agreements to reduce stock-outs.

Shortages of private sector pharmaceuticals are directly related to stock-outs in the public sector, with large run-ups in private pharmacies when public supply is depleted. Private distributors need access to public sector inventory data in order to supplement supply for essential drugs. Technical assistance to the government to improve forecasting and budgeting for essential medicines should include engagement with private suppliers to ensure adequate supply, and segmenting of users and adoption of new price structures to reduce the current gap between free public drugs and market-based private supply. Such arrangements may include new waivers for private sector duties and fees, high-volume discounts, and smaller dealer mark-ups.

ANNEX A: HEALTH FINANCING INDICATORS

TABLE AI: BASIC HEALTH FINANCING INDICATORS FOR GRENADA, 2000–2009

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Gross national income per capita (PPP int. \$)	5,910	5,680	5,820	6,460	6,090	7,580	7,650	8,120	8,430	--
Total expenditure on health as a percentage of gross domestic product	6.1	7.8	6.8	6	5.8	5.9	6.9	7	6.7	7.4
Per capita total expenditure on health at average exchange rate (US\$)	259	324	291	284	268	319	379	416	438	447
Per capita total expenditure on health (PPP int. \$)	385	483	435	427	404	471	556	607	593	620
Per capita government expenditure on health at average exchange rate (US\$)	177	232	187	177	158	197	217	213	214	228
Per capita government expenditure on health (PPP int. \$)	263	345	280	267	238	292	319	310	290	316
General government expenditure on health as a percentage of total expenditure on health	68.4	71.4	64.4	62.4	58.9	61.9	57.4	51.1	48.9	51
Private expenditure on health as a percentage of total expenditure on health	31.6	28.6	35.6	37.6	41.1	38.1	42.6	48.9	51.1	49
Out-of-pocket expenditure as a percentage of private expenditure on health	100	100	100	100	100	95.2	96.4	97.2	97.4	97.7
Social security expenditure on health as a percentage of general government expenditure on health	0	0	0	0	0	0	0	0	0	0

Private prepaid plans as a percentage of private expenditure on health	0	0	0	0	0	0	0	0	0	0
External resources for health as a percentage of total expenditure on health	0	0	10.3	0	1.4	1.1	1.9	1.7	2.4	0.8
General government expenditure on health as a percentage of total government expenditure	13.2	15.1	9.7	10.3	8.5	9	10.4	8.7	11.3	9.4

ANNEX B: HEALTH SYSTEMS STRENGTHENING AND HIV IN GRENADA

The government of Grenada has made significant progress in addressing the challenges of HIV/AIDS over the last decade, but weaknesses in the health system threaten these successes. A Health Systems and Private Sector Assessment conducted in June–July 2011 examined these challenges, including weak integration of HIV into the broader health service delivery system, stigma and discrimination, and the lack of sustainable financing.

Background on HIV in Grenada

The Caribbean region has the second-highest HIV prevalence in the world after sub-Saharan Africa. HIV prevalence in Grenada is estimated at 0.57 percent, and the most common mode of transmission is through heterosexual intercourse (UNGASS 2010). The epidemic is believed to be concentrated among certain high-risk populations, including men who have sex with men, sex workers, prisoners, and young women. However, there are very few data on most-at-risk populations in Grenada, making it difficult for the government to determine the size, determinants, and distribution of the epidemic, and target an appropriate response.

Strengths of Grenada’s HIV/AIDS Health Care System

The government of Grenada, civil society organizations, and the private sector are committed to limiting the effect of HIV on Grenada’s health and development. The Ministry of Health’s National Infectious Disease Control Unit (NIDCU) implements the national HIV response. The NIDCU collects and processes HIV-related data from public sector facilities; maintains an HIV patient monitoring and treatment database; and is responsible for providing HIV/AIDS care, treatment, and support. The NIDCU is guided by the draft 2008–2012 National Strategic Plan for HIV/AIDS which focuses on prevention, reducing stigma and discrimination, and scaling up treatment. While the plan was never finalized, the NIDCU is measuring progress against the indicators set out in this plan.

Grenada benefits from strong civil society and private sector commitment to improving HIV services and awareness of HIV. The National AIDS Council (NAC) serves as a forum for government and civil society to coordinate priorities for the national HIV response, and provides strategic guidance to the NIDCU. For instance, the NAC has engaged a number of corporations to provide employee education workshops on HIV. Scotiabank sponsors free voluntary HIV testing and counseling days each year at sites around the country.

Treatment, care, and support services for people living with HIV have improved significantly in recent years. Funding from the World Bank; the Global Fund to Fight AIDS, Tuberculosis and Malaria; the Pan American Health Organization; and the U.S. President’s Emergency Plan for AIDS Relief has supported the expansion HIV services. Antiretroviral therapy is free for all HIV-positive clients, as are antiretroviral drugs (ARVs) for prevention of mother-to-child transmission. At the community level, health facilities offer HIV/AIDS counseling and testing during weekly clinics. Improving primary health care is currently a

major health priority in Grenada, and primary health care revitalization efforts will provide a key opportunity for strengthening the HIV response in the public sector. Rapid HIV tests are available in the private sector, as are counseling and some ongoing care and support.

Challenges Faced

The Ministry of Health has stated its commitment to an integrated approach to leadership and delivery of HIV services. However, HIV has not been effectively integrated into other health service programs. While there is good geographic coverage of health services in general, and HIV/AIDS counseling and testing services are available at the primary care level through weekly clinics, a recent survey found that more than 75 percent of respondents thought HIV services were not sufficiently available in their community. Treatment, care, and support services are only offered in one public sector secondary hospital. Referral and case management systems are weak, making it difficult for health workers to closely manage chronic conditions such as HIV.

Stigma and discrimination surrounding HIV persist in Grenada, negatively impacting health outcomes and quality of care. At-risk individuals may fail to seek testing at primary health centers because of the stigma associated with arriving on HIV testing days. Evidence also suggests that people living with HIV in Grenada do not access care and treatment services until HIV is at an advanced stage, partially as a result of stigma. Private sector facilities have a reputation for greater confidentiality, and a perception of better customer service. However, private consultation fees can be prohibitive or burdensome, encouraging some patients to utilize services only when their conditions are already well advanced.

The sustainability of the HIV response is also a concern in Grenada. World Bank funding for HIV prevention and control ended in 2009, and current Global Fund support that provides free ARVs is slated to end in 2012. It is unlikely that domestic spending on HIV/AIDS will be able to replace previous levels of donor funding. The lack of information about HIV costs limits strategic planning and budgeting going forward. In addition, Grenada relies heavily on out-of-pocket spending for health care, accounting for an estimated 48 percent of total health spending in 2009. Overall public sector budget shortfalls pose an ongoing threat to the health sector, and may have consequences for the equitable provision of HIV services.

Health Systems Recommendations for the HIV Response

- **Proactively plan for reduced external HIV/AIDS funding.** Within the context of an overall financing strategy, Grenada should develop a financial sustainability plan for the HIV/AIDS program. Conduct a projection analysis of available domestic and external funds going forward, and plan proactively to absorb the cost of ARVs after Global Fund support ends.
- **Engage technical assistance to better integrate HIV/AIDS services at the primary care level.** Greater local availability of HIV testing and treatment, and the corresponding provider education that would be required to deliver this, could reduce stigma and engender greater HIV awareness in the community. Targeted technical assistance can be utilized to transition smoothly to integration.
- **Expand public-private partnerships to support the HIV response.** Partnering with the private sector can help expand availability of critical services and drugs by leveraging service delivery capacity in the private sector, thereby relieving some of the pressure on overburdened public sector systems. This can also improve the ability of the health system to respond to changes in volume or types of services needed.

ANNEX C: VALIDATION AND PRIORITIZATION WORKSHOP SUMMARY

This annex summarizes the workshop during which the assessment team validated the findings of the Grenada Health Systems and Private Sector Assessment and facilitated the process of prioritizing recommendations. The results of this workshop informed revisions to the draft report and the prioritization of technical assistance that USAID and other partners may provide in the region.

OPENING REMARKS AND PRESENTATION OF FINDINGS

Mr. Bill Conn, Regional Coordinator for the U.S.-Caribbean Regional HIV & AIDS Partnership Framework, opened the workshop by welcoming participants and thanking them for their engagement in the process. He introduced Mr. Bernard Link, U.S. Chargé d’Affaires in Grenada, who offered brief reflections on the partnership between the United States and Grenada in combating HIV and improving health systems. Both the Acting Permanent Secretary for Health, Mr. Isaac Bhagwan, and the Honorable Minister for Health, Senator Ann Peters, thanked participants for attending and noted the Ministry’s and the government’s commitment to the process of this health systems and private sector assessment. Senator Peters acknowledged the challenges of meeting the population’s health needs with limited resources, and expressed pride in the fact that Grenada is using scientific rather than “hit or miss” policy making. Some of the priorities she highlighted included succession planning for human resources in the health sector, moving rapidly to establish national health insurance, enhancing public-private partnerships for health, and quality improvement in service delivery.

Ms. Carol Narcisse served as facilitator for the two-day workshop, and she provided a quick overview of the proposed agenda. Following the welcomes, Dr. Laurel Hatt from Health Systems 20/20 highlighted the key findings and recommendations presented in the *Grenada Health Systems and Private Sector Assessment* report. The presentation discussed the findings and recommendations for topics including health governance, health financing, human resources for health, service delivery, pharmaceutical management, and health information systems. Within each topic, findings related to the private sector’s role were also discussed. Participants asked questions to clarify the findings and recommendations.

VALIDATION OF FINDINGS AND RECOMMENDATIONS

Following the presentation of the findings, participants were asked to discuss the report’s key findings and recommendations. Participants formed seven small topical groups based on their interests and specialties. The groups reviewed the report to verify if its findings matched their experience and to add any points that they felt should have been included. Participants reported that the findings were generally accurate and made suggestions for strengthening each module. One critique of the assessment process was that it had not included interviews with patients.

The small groups then discussed the assessment’s recommendations. The groups considered whether the recommendations addressed the key findings presented, if there were any concerns about the recommendations, and finally if there were any recommendations that were missing. The participants generally agreed with the recommendations listed and added or further specified some

recommendations. The following table summarizes the groups' feedback.

ADDITIONS AND EDITS TO FINDINGS AND RECOMMENDATIONS	
Health Financing	<ul style="list-style-type: none"> Grenada needs more accurate data regarding out-of-pocket health spending rate. The WHO estimates are based on unknown data sources and may be inaccurate. Links between the health information system and billing and collections systems at hospitals need to be made. Stronger HIS is a prerequisite to National Health Insurance. Grenada needs to address dual public-private practice and how providers are compensated. Recommend moving forward quickly with National Health Insurance; process has been too slow. Emphasize the importance of public consultation throughout the process. Recommend costing studies for short-term analysis of current health sector costs.
Human Resources	<ul style="list-style-type: none"> Rephrase key finding to state that Grenada has a "limited" range of specialists. At the time of the assessment, there was no position of HR Director within the MOH. This position has since been created and filled (September 2011). Specific corrections were suggested on established and vacant posts. Recommend building an improved nursing school. Recommend using epidemiological data for HRH planning.
Service Delivery	<ul style="list-style-type: none"> There is only one government geriatric care facility; others are privately owned but government associated. Grenville Medical Services is not a hospital. Old Trafford Medical Centre should be included in the list of private health care facilities. Confirmation of positive HIV tests is no longer done at CAREC; now done in Grenada. Mental health clinics are provided on Carriacou and Petit Martinique on a monthly basis. Some doctors are available at health centers up to 32 hours per week. Recommend providing free diabetes care to young people.
Governance	<ul style="list-style-type: none"> Need to mention that political will is necessary to drive governance improvements. Revise finding to state that the MOH engages with civil society and the media on health issues, but not regularly. Engagement needs to be more structured. Suggestions included better use of social media, development of MOH website, increased use of the press, etc. Recommend updating health sector legislation in general.
Health Information Systems	<ul style="list-style-type: none"> The Health Information Unit should officially be called the Epidemiology and Information Unit. The Health Information officer at the central HIU reports district data monthly- not once a year. Amend statement to "Private providers do not <i>routinely</i> report HIV testing statistics." NICDU submits statistical reports to the Epidemiology and Information Unit, not to MOF. Only NIDCU has a surveillance nurse; other hospitals do not. There is mandate for M&E in the health system; what is lacking is capacity. Need to emphasize that the collaboration between EGRIP, SGU, and MOH on the electronic HIS is a pilot project.
Pharmaceutical Management	<ul style="list-style-type: none"> Several corrections were provided in writing. These addressed membership of the Pharmacy Council, legislation governing the pharmaceutical sector, and the number of pharmacies and pharmacists. With support from OECS/PPS, Grenada uses the ORION Software, not LIMS. Rephrase as "It is not possible to procure <i>some</i> reagents or medical products through OECS/PPS." Correction: Public sector pharmacies/pharmacists do adapt a system of "first in, first out" for dispensing of medication. Recommend revisiting the possibility of private pharmacies procuring drugs through OECS/PPS. Recommend updating the Pharmacy legislation in its entirety.

Private Sector

- NGOs provide more than education and advocacy. They provide screening, counseling and referrals.
- Contracting out to private providers should be moved to a short-term recommendation, not long-term.
- More mention is needed for the dialysis crisis, and how the private sector could relieve the critical inadequacies in the public sector.
- Recommend exploring contracting out laboratory services with the private sector.

PRIORITIZATION OF RECOMMENDATIONS



Participants prioritize recommendations from the governance group.



Voting on recommendations for health financing.

After agreeing on additions and changes to the findings and recommendations, the participants in a plenary session discussed criteria for prioritizing the recommendations. The group agreed that priorities would be based on whether the recommendations were 1) of high importance, 2) feasible, 3) affordable, 4) impactful, and 5) low-risk.

In small groups, participants reviewed the recommendations in their thematic area. Using the criteria, each small group identified its top three priority recommendations to be addressed and posted them on flip charts. At the end of the first workshop day, the flip charts with top recommendations were displayed around the room. Each participant was given five stickers and asked to “vote” with their stickers for the top priority recommendations across thematic areas. The following recommendations were prioritized:

Topic	Top Small Group Recommendations	Final Votes
Health financing	Conduct National Health Accounts estimation & costing studies	12
	Strengthen billing & collection systems at hospitals	7
	Fast track process for developing national health insurance	5
Governance	Develop a new strategic plan for health	16

	Update legislation for the health sector	13
	Develop consumer feedback mechanisms for health facilities	0
Private sector	Launch a multi-sectoral campaign to address wellness & prevention of chronic disease	22
	Pilot-test contracting with the private sector to alleviate critical public sector shortages.	11
	Map the private health sector to inventory services, human resources, and costs	4
HRH	Strengthen HRH planning capacity in the Ministry of Health	16
	Establish the HR Unit [new]	6
	Strengthen the capacity of professional councils	3
Service delivery	Fast-track technical assistance to PHC Revitalization Committee	22
	Develop approaches to improve provider behavior towards patients	5
	Explore performance based incentives to improve service delivery quality	0
Pharmaceuticals	Update pharmacy legislation	20
	Increase # number pharmacy inspectors and hire Registrar	1
	Establish standard treatment guidelines [new]	0
Health information systems	Implement electronic HIS	29
	Training and capacity building for HIS staff	3
	Produce annual health sector report	1

On day two of the workshop, participants reconvened to discuss the leading priority recommendations and articulate concrete next steps. The facilitator helped the group come to consensus on whether the top vote-getters were the “right” recommendations to focus on. After some additional discussion in plenary, the selection of key priorities was consolidated and revised as follows:

- Implement electronic Health Information System (HIS)
- Fast-track technical assistance for the PHC Revitalization Committee & launch multi-sector wellness and prevention program
- Update key health sector legislation and regulations and develop a New National Strategic Plan for Health
- Strengthen planning capacity for Human Resource for Health (HRH), including establish an HRH Unit
- Implement health financing studies and reforms (such as NHA and costing studies, and improvements to billing systems) in preparation for launch of National Health Insurance

Participants then broke into small groups again and worked together to develop action plans for each priority recommendation. Using a template provided by the project teams, the groups worked to address the following questions:

- What ongoing initiatives already support this priority area? (e.g. MOH, PAHO, others)
- What action steps have already been proposed?
- Who will “own” (lead or champion) the next steps?

- What resources are needed? What external resources could be mobilized?
- What additional concrete next steps are needed?

The tables on the following pages summarize the action plans developed by each group.

NEXT STEPS AND CLOSURE

After the presentation of action steps by each group, Health Systems 20/20 and SHOPS thanked participants for their engagement in the validation and prioritization process. Health Systems 20/20 and SHOPS used results of the workshop to revise the assessment report. The final report with priority recommendations highlighted will be shared with USAID's implementing partners in the region, as well as other US government agencies working in the region, PAHO, the OECS, and UNAIDS, to further align technical assistance with the country's needs.

Acting Permanent Secretary Isaac Bhagwan closed the workshop, thanking participants for their enthusiasm and USAID for creating the opportunity to discuss priorities.

PRIORITY RECOMMENDATIONS AND ACTION STEPS

Strengthen planning capacity for Human Resource for Health (HRH), including establish an HRH Unit

What ongoing initiatives already support this priority area? (e.g. MOH, PAHO, others)	What action steps have already been proposed?	Who will “own” (lead or champion) the next steps?	What resources are needed? What external resources could be mobilized?
<ul style="list-style-type: none"> • MOH created and filled an HR Officer position • PAHO-initiated regional HRH roadmap • PAHO/Grenada biennial workplan • New National Strategic Plan for Health • PAHO 20 Goals baseline on HRH (conducted in 2010) • PAHO HRH core dataset activity (conducted in 2009) • PEPFAR regional partnership framework (Grenada workplan) • HR module of SmartStream 	<ul style="list-style-type: none"> • MOH HR Director position • PAHO Technical Assistance • Recommendations from Human Resource audit (2011) • I-TECH/CHART are in process of organizing a workshop to strengthen HRH planning and management in OECS • OECS HAPU to hire an HRH technical advisor to OECS members, supported by I-TECH/CHART 	<ul style="list-style-type: none"> • MOH PS and designate with authority to lead process (possibly MOH HR or Quality Assurance Officer) 	<ul style="list-style-type: none"> • Technical assistance to guide MOH in development of HRH unit • Resources and TA could be mobilized by PAHO, OECS, EU, I-TECH, CHART, World Bank, CARICAD, UWI, private sector • Funding for positions, seminars, workshops, assignments • Time and commitment by team members
<p>What additional concrete next steps are needed?</p>			
<ul style="list-style-type: none"> • Schedule internal MOH meeting to get ministry endorsement of strategy to strengthen HRH planning capacity • Schedule key stakeholder meeting between MOH, MOF, MOE, DPA (Department of Public Administration), PSC, trade unions, PAHO, I-TECH/CHART, OECS HAPU, private sector representatives to come to agreement on way forward and map out timeline • Establish team (see “owners”) (e.g., PSC, DPA, MOH, MOF, MOE) • Develop planning timeline • Train key team members in HR planning and management • Develop/acquire tools for HRH planning • Review existing data and ongoing initiatives to inform HRH Development plan (e.g., HR data from SmartStream, 20 Goals Baseline, Core dataset, etc.); solicit input from all levels of workers that contribute to the health and well-being in Grenada • Consultation sessions with stakeholders • Develop HRH Strategic Plan 			

Implement Electronic Health Information System (HIS)

What ongoing initiatives already support this priority area? (e.g. MOH, PAHO, others)	What action steps have already been proposed?	Who will “own” (lead or champion) the next steps?	What resources are needed? What external resources could be mobilized?
<ul style="list-style-type: none"> • Paper-based system • Community clinical services statistics (reported monthly to HC- MOH) • Communicable Diseases reported weekly (MS-HS-MOH) • Hospital Surveillance Data (data weekly) • Steering Committees: 1) EGRIP (equipment), SGU (consultants), MOH 2) MOH HIS • PAHO developed framework for Regional Caribbean HIS System • Health Metrics Network, PRISM (Performance of routine information system management) assessment • SGU-developed PMMHS using PERC software 	<ul style="list-style-type: none"> • Procurement of Equipment for EHIS (EGRIP project funded) • Procurement of Consultant to implement the customized the EHIS (SGU) • Development of Implementation Plan • Expansion of Pilot to all Health Facilities • The Integration of private sector data into the EHIS as mandatory 	<ul style="list-style-type: none"> • Chief Planner with support from Medical Officer and MIS Officer 	<ul style="list-style-type: none"> • Funding
What additional concrete next steps are needed?			
<ul style="list-style-type: none"> • Dedicated IT Team/Department within the MOH • Combination of the two steering committees • Preparation/Development of proposal for funding (technical assistance to help develop proposal) • Coordination with the legislative activities (information needed from labs, private clinics, etc.) • Procurement of licenses (cache license -\$40,000) 			

Fast-track Technical Assistance for PHC Revitalization Committee & Launch Multi-sector Wellness Prevention Program

What ongoing initiatives already support this priority area? (e.g. MOH, PAHO, others)	What action steps have already been proposed?	Who will “own” (lead or champion) the next steps?	What resources are needed? What external resources could be mobilized?
<ul style="list-style-type: none"> • MOH establishment of national PHC team • PAHO-team visited to understand Dominica PHC Integration • Establishment of National Wellness Committee • MOSD, Legislative Aide & Counseling • UNICEF • National Chronic & Non-Communicable Diseases Commission 	<ul style="list-style-type: none"> • Integration of services • Increase access, multi-sectoral campaign, sensitization of public and staff • Public involvement/ Community Participation • Building capacity with civil society • Monitoring and Evaluation 	<ul style="list-style-type: none"> • Chair of PHC • Health Service Manager (District) 	<ul style="list-style-type: none"> • Financial • Human/Material • Technical Assistance • USAID, PAHO, PEPFAR, PACAP, DIASPORA, SGU, Mt. Sinai Univ., NYU
What additional concrete next steps are needed?			
<ul style="list-style-type: none"> • Situational Analysis of each district/ Mapping of private sector • Building capacity with civil society • Strengthen National Wellness Committee & collaborate with District Wellness Team • Involvement with private sector and other governmental sectors • Research into existing cooperation to which Grenada is signatory 			

Update Legislation and Regulations and Develop New Strategic Plan

What ongoing initiatives support this priority area? (e.g. MOH, PAHO, others)	What action steps have already been proposed?	Who will “own” (lead or be the champion) the next steps?	What resources are needed? What external resources could be mobilized?
Regulation of Medical Laboratories			
<ul style="list-style-type: none"> • Draft document submitted to MOH 	<ul style="list-style-type: none"> • There must be legislation for the implementation of ISO standards for labs with the aim of accreditation 	<ul style="list-style-type: none"> • Director of Laboratory Services 	<ul style="list-style-type: none"> • Technical Assistance- Consultative meetings with all stakeholders, compilation, modification, adoption
New Mental Health Act			
<ul style="list-style-type: none"> • 1st draft prepared • consultation meetings took place, comments were collected 	<ul style="list-style-type: none"> • Separation had to be made as to what falls under policy or regulation • Comments need to be addressed as right now held up in legal dept. • After comments addressed policy department will make final decision 	<ul style="list-style-type: none"> • Health Services Administrator-Mental Health 	<ul style="list-style-type: none"> • Technical Assistance for staff and public sensitization
International Health Regulations			
<ul style="list-style-type: none"> • Draft bill by PAHO currently in Legal Affairs Dept. • Consultation with stakeholders • Legal personnel reviewed it 		<ul style="list-style-type: none"> • Chief Medical Officer • Chief Environmental Officer 	<ul style="list-style-type: none"> • Technical Assistance for further consultation on the draft
Public Health Act			
<ul style="list-style-type: none"> • Review current Pharmacy Act (PAHO) • Consultation with stakeholders 		<ul style="list-style-type: none"> • Chief Environmental Officer 	<ul style="list-style-type: none"> • Technical Assistance for staff and public sensitization
Pharmacy Act			
<ul style="list-style-type: none"> • Pharmacy act is to be updated • PAHO has a draft policy for the OECS – Caribbean Pharmaceutical Policy 	<ul style="list-style-type: none"> • Need improved regulations that make act more effective • Amendment proposed 	<ul style="list-style-type: none"> • MOH Chief Pharmacist 	
Strategic Plan			
<ul style="list-style-type: none"> • On MOH agenda for review 	<ul style="list-style-type: none"> • Use HSA/PSA Assessment in formulating new Strategic Plan 	<ul style="list-style-type: none"> • MOH Chief Planner 	<ul style="list-style-type: none"> • Technical Assistance- Consultative meetings with all stakeholders, compilation, modification, adoption, etc.

What additional concrete next steps are needed?

Regulation of Medical Laboratories- Take the draft document to parliament for final approval

New Mental Health Act – Heavy public and staff sensitization

Pharmacy Act- Need extensive consultation, corrections, and adaptations to current act to make it more effective

Strategic Plan- submit proposal for new strategic plan to PAHO

Conduct health financing analyses and reforms (NHA, costing studies, improvements to billing systems) in preparation for launch of National Health Insurance

What ongoing initiatives already support this priority area? (e.g. MOH, PAHO, others)	What action steps have already been proposed?	Who will “own” (lead or champion) the next steps?	What resources are needed? What external resources could be mobilized?
<ul style="list-style-type: none"> • Prefeasibility study on National Health Insurance was conducted by UWI • Electronic HIS is intended to include a billing module eventually • Government NHI steering committee has been established, supports process • USAID-supported regional NHA initiative is ongoing 	<ul style="list-style-type: none"> • Pre-feasibility study results to be presented to Cabinet and the public • New studies have been proposed to guide implementation 	<ul style="list-style-type: none"> • Ministry of Health and Ministry of Finance jointly (Permanent Secretaries as champions) 	<ul style="list-style-type: none"> • Support from PAHO, IFC, or USAID to conduct needed studies • Technical Assistance from USAID on NHA, costing, and insurance design • IFC could support technical consultations on insurance
<p>What additional concrete next steps are needed?</p>			
<ul style="list-style-type: none"> • Committee on NHI should develop work plan, expand membership to be more inclusive. Cabinet should give guidance on next steps. • Additional data collection -- Obtain unit cost information for hospital services, conduct willingness-to-pay studies • Obtain commitment of MOH to participate in regional NHA program • Engage GARFIN, private insurers, trade unions, providers, public in consultations about NHI. Prepare change management and communications plan. • Explore linkages with SGU/Department of Public Health on possible support & other agencies 			

ANNEX D: BIBLIOGRAPHY

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