REGIME CHARACTERISTICS AND HEALTH POLICY REFORM IN THE POST-COLONIAL STATE:

A comparative case study of the influence of regime characteristics on health human resources policy and policy reform processes in Guyana, Jamaica and Trinidad and Tobago: 1970-1990.

being a Thesis submitted for the Degree of
Doctor of Philosophy (Ph.D.)

by

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July 1998
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List of Abbreviations and Acronyms

CARICOM  Caribbean Community
CAREC  Caribbean Epidemiology Centre
CAST  College of Arts, Sciences and Technology (Jamaica)
CCMRC  Commonwealth Caribbean Medical Research Council
CFTC  Commonwealth Fund for Technical Cooperation
CHA  community health aides (Jamaica)
CCHM  Conference of Caribbean Health Ministers
CHW  community health worker (Guyana)
CMJ  Caribbean Medical Journal
CMO  chief medical officer
DMTMPF  Draft Medium-Term Macro-Planning Framework (Trinidad and Tobago)
EAN  enrolled assistant nurse (Jamaica)
ECLAC  Economic Commission for Latin America and the Caribbean
EWMSC  Eric Williams Medical Sciences Complex, also referred to as the Mount Hope Medical Complex (Trinidad and Tobago)
FHS  Faculty of Health Sciences (University of Guyana)
GAHEF  Guyana Agency for Health, Education and Food Policy
GNP  gross national product
GOG  Government of Guyana
GOJ  Government of Jamaica
GOTT  Government of Trinidad and Tobago
HFA  health for all 2000
HRH  human resources for health
IBRD  International Bank for Reconstruction and Development (the World Bank)
IDB/IADB  Inter-American Development Bank (regional office of the World Bank for the Americas)
IMF  International Monetary Fund
JLP  Jamaica Labour Party
MAJ  Medical Association of Jamaica
Medex  Medical Auxiliary (Guyana)
MOH  ministry of health
NAC  National Advisory Council (Trinidad and Tobago)
NAJ  Nurses Association of Jamaica
NAR  National Alliance for Reconstruction (Trinidad and Tobago)
NIHERST  National Institute for Higher Education, Research, Science and Technology (Trinidad and Tobago)
NPA  National Planning Agency (Jamaica)
ONR  Organisation for National Reconstruction (Trinidad and Tobago)
PAHO  Pan American Health Organisation (regional office of the World Health Organisation in the Americas)
PHC  primary health care
PHN  public health nurse
PNC  Peoples’ National Congress (Guyana)
PNM  Peoples’ National Movement (Trinidad and Tobago)
PNP  Peoples National Party (Jamaica)
PPP  Peoples’ Progressive Party (Guyana)
RN  registered nurse
TTMA  Trinidad and Tobago Medical Association
UG  University of Guyana
UWI  University of the West Indies
UNC  United National Congress (Trinidad and Tobago)
WIMJ  West Indies Medical Journal
UNICEF  United Nations Children’s Fund
USAID  United States Agency for International Development
WHO  World Health Organisation
WIC  West Indian Commission
Acknowledgements

I would like to express my deepest gratitude to my supervisor Prof. Andy Alaszewski of the Institute of Health Studies for his continuous support, availability, consultations and enormous patience throughout this process, for his help in illuminating the PhD process, and in guiding me through what was an extremely underdeveloped, though challenging interest of mine. I would also like to thank the University of Hull for its financial support through the post-graduate studentship and Wilberforce scholarships, respectively, that were awarded in pursuit of my research. Similarly, I would like to thank the British Council for its award of a Chevening scholarship which also helped enormously. I would further like to thank a number of Caribbean colleagues helped shaped my initial ideas including Professor C.Y. Thomas of the Institute of Development Studies, University of Guyana; Dr. Satnarine Maharaj at the Department of Social and Preventive Medicine, also at the Mona Campus of the UWI; and Stanley Lalta of the Institute of Social and Economic Research, UWI, Jamaica. Thanks also to Dr. D. Alissa Trotz; and finally Ms. Marilyne Trotz in Guyana and Drs. Brian Meeks and Patsy Lewis-Meeks in Jamaica for welcoming me into their homes, which facilitated my data collection.

I would also like to thank all of the interviewees in Guyana, Jamaica and Trinidad and Tobago who took time off from their busy schedules to share their knowledge and experiences of health policy issues. Four of these particularly stand out: Gail Tesheira, the current Guyanese minister of health; Dr. Emanuel Hosein, the former health minister of the National Alliance for Reconstruction (NAR) regime in Trinidad (1986-1990); Dr. Steve Smith, a senior doctor at the San Fernando General Hospital in Trinidad and Ms. Margaret Smith, the Director of Planning at the health ministry in Jamaica. I would also like to express my gratitude to staff and former colleagues at the Caribbean Community Secretariat in Georgetown, Guyana for their considerable logistical assistance. I also wish to thank all my friends for their much-appreciated moral support including Dorothy, Francis, Emma, Naoko, Dematee, Lavern and particularly, Sico.

Finally, I wish to thank my brother Takoor who supported me financially for much of this period, my mum, Samdaye Ramnath, my other brothers and sisters; and Simon, for everything, especially putting up with my preoccupation over the last two years. This study is ultimately dedicated to the memory of my late father whom I know would have been proud of my effort. Responsibility for this dissertation, including any shortcomings remains of course entirely mine.

K.R.

CHAPTER ONE

REGIME CHARACTERISTICS, POLICY REFORM AND THE DECOLONISING STATE:
HEALTH POLICY IN GUYANA, JAMAICA AND TRINIDAD AND TOBAGO: 1945-1970

1.1 INTRODUCTION

In this dissertation, I examine and compare the influence of the following regime characteristics -
strength, stability, ideology, democracy and survival/maintenance - on post-colonial health human
resources policy processes within one sub-region: the Commonwealth Caribbean; with special reference to
Guyana, Jamaica and Trinidad and Tobago (hereinafter called Trinidad) between 1970 to 1990. As I want
to comparatively assess the role of these characteristics in post-colonial policy processes, I shall in this
chapter place my study within the context of colonial regime characteristics, society and reform processes,
assessing its possible influences on post-colonial political developments. This forms the basis of my
analysis of policy within these three 'post-colonial' states during the 1970s and 1980s. Section One
describes the paradox of health and health human resources status in the Commonwealth Caribbean during
the 1970s and 1980s. In Section Two, I describe the area under study. In Section Three, I examine
possible linkages with the nature of power and reform under colonial regimes. In Section Four, I analyse
the influence of regime characteristics on policy processes by assessing health policy outcomes of post-
war reform. I begin with an examination of the contradictory status of Commonwealth Caribbean health
and health human resources development in the 1970s and 1980s.

1.2 CARIBBEAN HEALTH HUMAN RESOURCES: THE POST-INDEPENDENCE
PARADOX

Health human resources policy processes are an integral part of health policy action and processes, and
therefore cannot be analysed without recognition of wider health developments. In order to explain the
paradox facing health human resources in the Commonwealth Caribbean post-colonial state in the 1990s
therefore, I first outline and recognise the achievements, to date, of these governments.

Caribbean health achievements: outcomes and inputs

There are good grounds for recognising the generally impressive achievements of Commonwealth
Caribbean regimes in health development. This is reflected in both activities at the policy level, as well as
outcomes. In terms of outcomes, the health status of the region ranks among the best in the developing
world, comparing more than favourably with other frequently-cited examples such as Kerala State (India),
Costa Rica and Cuba. Demographically, the region's population has increased relatively slowly, with
fertility rates falling steadily over the last fifty years - the result of successful population programs: the
estimated figure for 1985 was just over 5.5 million and is projected to reach 6.9 million by the year 2000
(Alleyne and Sealey, 1992: 4). The percentage of persons under 15 is also expected to fall with a
concomitant rise in older age groups. Infant mortality has declined steadily in all Commonwealth
Caribbean countries except Guyana. Life expectancy at birth has increased steadily in all of these
countries. The average as at 1992 was 72.4 years, which ranks between the Latin American and North
American average (Alleyne and Sealey, 1992). In terms of physical and technical infrastructure, the
region has numerous hospitals and other secondary and tertiary health facilities both public and private,
most of which possess high-technology capacity. By the end of the 1980s then, the outcome of this
Generally progressive commitment to health was remarkable even by developing country standards with action based at both national and regional levels. Communicable diseases such as malaria and yellow fever were confined to the hinterlands of Belize and Guyana, both on the mainland. Other tropical diseases such as hookworm occurred less frequently, as did childhood infectious diseases such as poliomyelitis, diphtheria, and whooping cough. With the exception of Belize, there was no Commonwealth Caribbean country in which parasitic diseases were among the three main causes of death (Alleyne and Sealey, 1992).

In the case of health human resources outcomes, equally impressive attempts were also made at the regional and national levels to develop and maintain a high quality of health personnel throughout the region which also contributed to the relatively good health status. Cooperative efforts in medical training have been established since 1948. Nursing examinations were regionalised in the 1980s. Additionally, considerable efforts have been made at producing most categories of professional and technical and paramedical personnel through national and regional efforts - thus steadily eliminated the (costly) necessity to travel abroad. Indeed, the region's medical, nursing and paramedical professions rank quite favourably with the rest of the developing world, and is also quite impressive when compared with North America and Latin America. For example, in 1984 the Commonwealth Caribbean had fewer doctors, nurses, dentists and health auxiliaries that the USA, however it had more nurses, fewer doctors and about the same numbers of nurse auxiliaries than Latin America (Alleyne and Sealey, 1992: 22).

All of these achievements reflect sustained policy activity or inputs in health at both the national and regional levels within the Commonwealth Caribbean region. At the national level these inputs included active involvement of health ministries, health 'academics' and politicians and the significant role of health in the developing state political process. Historical factors were also important inputs. The persistence of British colonial professional links, whatever the faults and criticisms, enabled the development of high training standards in medical, nursing and other professional categories. As we shall see later in this chapter and indeed the study itself, the maintenance of essentially colonial public health structures, organisations and institutions, whatever the faults, did provide a framework for public health development which in most cases persisted well into the 1980s and which was not all entirely bad at least in the case of public health itself.

In terms of regional cooperation, health has been one of the more successful areas of policy endeavour through the initiation, in 1986 of the Caribbean Cooperation in Health (CCH) programme, a direct policy outcome of activities at the regional health level under the aegis of the Conference of Ministers responsible for health, established under the Caribbean Free Trade Association (CARIFTA) in 1969, and subsequently brought under the Caribbean Community (CARICOM) under the Treaty of Chaguaramas of 1973. This policy signalled a turn towards 'primary health care' well before it was placed firmly on the international agenda in the 1970s. Nevertheless, it has been given greater significance in the post-1978 Alma Ata period, when adherence to primary health care was adopted by all of these states. Although reliant on various organisations, including the World Health Organisation's sub-regional office in the Americas: the Pan American Health Organisation (PAHO) for technical support, the Caribbean 'Cooperation in health' Initiative was a manifestation of national commitment by governments to health policy development in a number of areas including inter alia, health human resources development (Boyd, 1977). Other important regional policy actors have been the University of the West Indies medical school which has undertaken considerable curricular policy reforms to reflect both a Caribbean reality as well as a primary care focus. In the case of the nursing, the reality of 'Caribbean' nursing examinations reflected an increasingly progressive regional-level cooperation in health not only at the regional governmental level, but also at the level of teaching institutions as well as professional associations.

Comment: In sum then, this generally impressive nature of the region's health development more than favourably compares to other developing areas at both ends of the spectrum, from sub-Saharan Africa on the one hand, to Latin American and South Asia on the other. It has been due to a combination of factors, including rising incomes, a commitment to basic public health measures, literacy, public awareness of health matters, and the emergence of national commitment on the part of health professionals. and their
demonstration of the feasibility of health development on the basis of modest national resources (Cumper, 1983: 1983). Most if not all of these factors point to national political/governmental influences. However, in addition to the commitment of newly emerging governments, the role of other regional and international organisations have been also critical. Many of the above achievements have been realised with considerable post-war and post-independence financial support from organisations such as the World Bank (through the funding of hospitals and health centres) and the World Health Organization (through largely technical support).

Despite various militating factors then, the political commitment of most Commonwealth governments to health as part of the drive for self-determination has been central. Good access to health facilities combined with effective and sustained public health programmes were developed in tandem within political developments, and regional governments have consistently maintained progressive views on the importance of the health sector in national development. However, this generally favourable situation was threatened by a variety of factors which threatened to reverse the gains made in the post-war and post-independence periods. This will now be examined.

The paradox of the 1980s and 1990s

A Shift in health status: Two paradoxical trends occurred during this period with grave implications for both health status and health services: a rise in ‘affluence’ related chronic diseases, and the re-emergence of ‘poverty’ related infectious diseases. There was a steady rise in the incidence of chronic non-communicable diseases in the 1970s and 1980s, which became the leading causes of morbidity and mortality. Approximately 40% of the total mortality in the Commonwealth Caribbean was due to cardiovascular diseases and diabetes during this period (Le Franc, 1988: 38-39). In 1989 for instance, Trinidad ranked highest in the Americas for heart diseases among women and second, for men (“Chronic diseases in Trinidad and Tobago: cause for alarm”, Trinidad Express, 28/8/89: 3). Even the downward regional trend in infectious diseases, reported in the mid-1970s, was being reversed by the early 1980s, with diseases such as dengue, typhoid, tuberculosis, leptospirosis, scabies and gastro-enteritis making ominous returns. In addition, increased incidences of malnutrition were registered. Further, even the steadily declining infant mortality rates since the 1950s - a good indicator of the effectiveness and accessibility of health services as well as nutritional status - actually increased over this period (Alleyne and Sealey, 1992: 5; Le Franc, 1988: 38-39). Rises were recorded in Guyana, Jamaica and Trinidad among others.

Human resources losses: In the case of health personnel, the increased demands on health services as noted above added to the pressures on national resources, including health human resources throughout the region. While migration has been a persistent feature of the Caribbean experience, in the 1980s many Caribbean health professionals - mainly doctors and especially nurses - either left the public health services for the private sector, or moved to North America and the Gulf States in search of better opportunities. The loss of these professionals - most of whom were trained at considerable government expense under progressive and consistently-articulated government health policies after independence - was a particularly severe blow. Most governments typically responded to the migration problem by training even more personnel, while others suspended training programmes due to scarce resources, where it was determined that there were too many numbers of certain professional categories. None of these policy responses addressed the problem as migration persisted alongside both economic and political contributing factors. We first look at the economic explanation of policy failures.

Contributing factors

Economic crisis and structural adjustment: In the case of communicable diseases, the main cause was undoubtedly the increased poverty resulting from the economic crises from the mid-1970s, and the subsequent implementation of harsh structural adjustment policies by governments which had extremely limited room for manoeuvre (Le Franc, 1988: 2). As Le Franc noted of the relationship between economic factors and health:
"...economic difficulties and policy responses of the 1980s, have only served to bring these complexities more sharply into focus, and to make even more urgent, an understanding of the relationship between illness patterns and socio-economic growth and development... an economic recession will in all likelihood lead to a deterioration in society’s health status..." (1988: 14).

Studies on economic adjustment in Central America and the wider Caribbean have underscored the vulnerability of the region’s economies during this period (Thomas, 1988; 1989; Pantin, 1986). Regional government responses have ranged from reductions in food subsidies, to mass lay-offs of state employees, and to reduced expenditure in the social sector, particularly in the health sector. Economic crisis also generated increased social demands on the state, particularly in terms of health services utilisation by both the poor, but also by the 'new' middle classes (Le Franc, 1988; Musgrove, 1986; Boyd, 1988; Taylor, I, 1990; Theodore, 1993). In the case of health then, Commonwealth Caribbean government policies, like that of many developing areas, were caught between balancing the demands of international financial institutions for greater fiscal restraint in these states’ social sectors, on the one hand, and fulfilling their commitments to providing universal health care, free at the point of delivery at a time of increased demand, on the other. The lack of confidence in deteriorating national health services displayed by migrating health professionals undoubtedly contributed to the overall health declines, but was also itself an outcome of the pervasive economic crisis. Most health personnel expressed frustration at both conditions of work and remuneration and inflation. In the case of nurses, career prospects also contributed, with their persistent problems of status in relation to their non-classification as health professionals. Guyana, Jamaica and Trinidad in the 1980 all experienced increased various levels of health personnel industrial action and ultimately migration to the private sector, and overseas. The outcome of this economic impact for health human resources was thus one of depleted skills combined with even less available resources.

Middle ‘classization’, the media and high-technology demands: Other explanations for the health paradox in Commonwealth Caribbean in the 1980s include the steady ‘middle-classization’ of these states, the increasing incidence of the new ‘lifestyle’ diseases, and hence the increased demand for the latest expensive technologies. In the case of these diseases, the proximity of North America and its influences, combined with a general increase in the standards of living, means that the outcomes of the middle-classization explanation of Commonwealth Caribbean societies also has some explanatory power Macdonald, 1986; Le Franc, 1988). 1 There are however, in addition to middle classization, other important, related social factors. One of the more important has been the role of the media. This new trend has resulted in demands for new technologies by both medical professionals and the general public, which have the ability to absorb a considerable chunks of entire health budgets. The combined effect of both middle classization and media influences are reflected in Henry’s concerns about:

"...the current aggressive cultural penetration by the electronic media in our countries and the consequent exposure of our citizens to the latest advances at the frontiers of medicine which are taking place only hours away from our shores..." (1988: 21).

The AIDS and drug addiction crises: Two other important social factors are the rise in incidences of AIDS and drug addiction throughout the Commonwealth Caribbean region. The sudden emergence in the late 1980s of acquired immuno-deficiency syndrome (AIDS) and AIDS-related illnesses throughout the region placed an added burden on already over-stretched state health services (Alleyne and Sealey, 1992; Henry, 1988). Similarly drug addiction - both ‘hard’ and ‘soft’ - in the 1980s escalated into full-blown crisis in most Commonwealth Caribbean states, some of which, like Trinidad, Guyana and Jamaica, found themselves on direct narco-trafficking routes to North America and Europe. Increased drug addiction, like AIDS thus added to the demands being placed on regional health services already reeling from economic crisis.

Comment: Health human resources policy development in the Commonwealth Caribbean cannot be examined without reference to wider health trends within and outside the region. Three sets of

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1 ‘Middle classization’ simply means the steady rise in the numbers of the Anglo-Caribbean middle classes. The term is used by Macdonald (1986) to describe developments in Trinidad and Tobago. However, it is also applicable to varying degrees, of course, to the rest of the region during the period under study.
simultaneously-occurring paradoxes have been observed since the 1970s: 1) increases as well as falls in health status indicators; 2) the co-existing rise in the incidence of both diseases of affluence and poverty; and 3) increases in both health professional production and migration. While not unique to the developing world, these paradoxes point to a number of explanations. The most obvious ones are economic, social and environmental factors. Prior to 1980, Caribbean states experienced generally favourable health status on most counts: infant mortality, the reduction in communicable diseases and longer lifespans. This was generally attributed to considerable resource allocations at both the national and international programme levels, as well as the commitment of governments to improving the health of their populations, with initiatives co-ordinated at both the national and regional levels. In the case of health human resources, this resulted in increases in numbers of trained personnel as well as the quality of such training compared with other countries in the Americas.

After 1980 however, a new trend emerged: one of declines in areas previously recording successes, and the advent of new 'lifestyle' - as well as the 'old' infectious diseases. A number of reasons have been advanced for this new, paradoxical development. The most obvious one has been the harsh social impact of the economic downturn and subsequent adjustment policies adopted during the 1980s. In the case of chronic diseases, this explanation is more attributable to increased affluence and developed country 'lifestyle' influences in the region, despite the downturn. Economic downturn and structural adjustment policies however had severe effects on the ability of health services to cope with the rise in demand for the care of both chronic and infectious diseases. The economic factor also explains part of the motivations of migrating health human resources in the 1980s and 1990s, i.e. better salaries and career opportunities.

While supporting the economic and other environmental explanations, my central argument in this study is that these influences do not wholly explain a number of other issues relating to the state of the Caribbean health sector. Economics, for instance, cannot wholly explain those problems that hint more at organisational and political issues as I observed in my study of the three states. My argument in this study is that the direct and indirect influence of political factors - including political inaction as reflected in the failure to administratively reform - also need to be considered, if only to complement economic and social factors in revealing a more accurate picture of the diversity of developing states' policymaking responses and experiences. Realistic policy analyses in both developing and developed states, then, cannot ignore the political. I now turn to examine the defining features of the Caribbean region.

1.3 THE COMMONWEALTH CARIBBEAN: BACKGROUND

Defining the Caribbean

There are various definitions of 'the Caribbean'. Geographically, the 'wider Caribbean' region is made up of those territories - continental, archipelagic and island - which rim, or share the common waters of the Caribbean Sea. The Caribbean archipelago stretches approximately 2,500 miles from the larger and northern-most islands of Cuba, Jamaica, Hispaniola (shared by Haiti and The Dominican Republic) and Puerto Rico which all lie relatively close to the North American mainland, to the smaller Eastern Caribbean island chain which straddle the Atlantic-Caribbean divide on the eastern side: from Antigua to the north, to Trinidad and Tobago, the most southerly of the island chain. Trinidad and Tobago, like Aruba and Curacao, are located immediately north of the South American mainland. There are however paradoxes, even with geographical descriptions. The Central and South American states which rim the Caribbean Sea to the west and south can all be considered 'Caribbean' in the broader sense though they are usually not defined this way. This area incorporates south-eastern Mexico (the Yucatan Peninsula which demarcates the boundaries of the Caribbean Sea and the Gulf of Mexico), Belize, Guatemala, Honduras, Nicaragua, Costa Rica and Panama in the Central American isthmus, to Colombia and Venezuela on the South American mainland. Interestingly, states such as The Bahamas in the north, Guyana on the South American mainland and Barbados in the east are not washed by the Caribbean Sea but are typically defined as 'Caribbean' countries.
Historical and/or cultural descriptions are more relevant to this study in defining the Caribbean according to particular colonial influences. In this regard, the ‘Commonwealth Caribbean’ simply describes those former British colonial Caribbean territories. These include Jamaica, the smaller eastern Caribbean islands of Antigua and Barbuda, Barbados, St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines, Grenada, Trinidad and Tobago, the Bahamas, Belize and Guyana (formerly British Guiana). Anguilla, the British Virgin islands, Montserrat and the Turks and Caicos islands are also defined as Commonwealth Caribbean although they remain British colonies. We now turn to examine the three countries under study: Guyana, Jamaica and Trinidad and Tobago.

Describing Guyana, Jamaica and Trinidad and Tobago

Geography: Guyana (formerly British Guiana), Jamaica and Trinidad are the largest of the Commonwealth Caribbean territories. However there are important geographical differences. Guyana is approximately 83,000 square miles in area. It is situated on the north-eastern coast of South America, bounded on the north by the Atlantic Ocean, on the east by Suriname, on the south and south west by Brazil, and on the north-west by Venezuela. Guyana has a coastline, approximately 210 miles long, and a ‘depth’ into the South American mainland of about 450 miles. About 35% of the country lies within the Amazon Basin. The name “Guyana” derives from an Amerindian word meaning “land of many waters” which aptly describes the country’s extensive network of rivers and its large numbers of waterfalls. Guyana’s population, despite its huge size, has the smallest population of the three countries under study with a total of 755,937 persons. About 68% of the population is located in the rural areas and/or concentrated mainly along the narrow coastal strip and waterways. Jamaica and Trinidad, by contrast are small island states. Jamaica is located at the north-western corner of the Caribbean Sea, about 100 miles south of Cuba, and about 900 miles from Guyana. It has a land area of 4,400 square miles which makes it about sixteen times smaller than Guyana. Jamaica’s population is approximately 2.5 million people, roughly 50% urban and 50% rural. The islands of Trinidad and Tobago, with a combined area of 2,318 square miles (about 1/35th the size of Guyana and about half the size of Jamaica) are located five miles off the north-eastern tip of Venezuela, and about 136 miles from Guyana. They are the most southerly of the Eastern Caribbean island chain. Trinidad is geologically part of the South American continent, while Tobago is markedly similar to the eastern Caribbean islands. Trinidad’s population is approximately 1.3 million, approximately 69% of whom are located in urban and semi-urban areas.

Historical background: Guyana, Jamaica and Trinidad share a common British colonial background which is reflected in their political, economic and socio-cultural features. Jamaica, though claimed for the Spanish Crown by Columbus on his fourth voyage to the ‘New World’ was captured by the British and remained a British territory for over 300 years, from 1655 to 1962. The common British background does not fully apply to either Guyana or Trinidad. Guyana is essentially an agglomeration of three former British colonial territories on mainland South America: Demerara, Essequibo and Berbice which were ceded by the Dutch in 1803 after the Anglo-Dutch War. Both Dutch and English settlers had occupied the area as early as 1621. The three territories were united under British rule in 1831, just three years before the abolition of slavery in the British Caribbean, to form what would be known until Independence in 1962 as British Guiana. Trinidad by contrast remained a Spanish colony until 1797 when it was captured by the British, and becoming in 1802, the first British crown colony until full Independence in 1962. Tobago’s history is even more colourful, being a virtual pawn in the various imperial enterprises during the 17th and 18th centuries. It was ruled variously by the Dutch, the British and the French, finally becoming a British crown colony within the Windward island group in 1814. In 1889, it was administratively joined to Trinidad, both later becoming a joint Crown Colony in 1899. The basis of the all three territories under colonialism was the plantation, although it must be noted that Trinidad’s experience of the slave plantation system was relatively short, given its general neglect under Spanish colonisation. Jamaica by contrast, remained a British slave colony from the late 1600s to emancipation in 1834: well over 150 years.

Economic base: The economies of Guyana, Trinidad and Jamaica, like many other Caribbean colonies (including Spanish and French) were based on sugar production. The plantation economy of
both the pre-and post-emancipation periods as well as the activities of transnational corporations over the last hundred years have both left their legacies on economic activity in these countries. After the initially futile ‘gold rush’, the major part of the 17th and 18th centuries was focused on sugar cultivation which became the ‘backbone’ of each territory’s economy. Gold was eventually found in Guyana, but European demand for sugar greatly influenced both society and economy. However, the discovery of oil in Trinidad in the 1880s and bauxite in Guyana and Jamaica saw a slow shift away from agriculture in the first half of this century. Production of these commodities were in foreign hands until the post-Independence, 1960s period, when governments sought state ownership of these concerns. While sugar production still constitutes an important social and political part of these territories, each state is dominated by distinct economic concerns. Jamaica’s economic base is characterised by tourism, along with bauxite and manufacturing. Guyana’s is focused on extensive forestry exploitation, agriculture, as well as gold mining, and Trinidad and Tobago’s is dominated by oil exports, alongside manufacturing and tourism.

**Socio-demographic background:** The impact of the plantation system on demographic patterns is also distinctive to the region and has had important implications for political party formation and national political characteristics in the post-colonial era. The engine of development was the sugar plantation. The exploitation and decimation of the Amerindian populations in early colonial Trinidad and Jamaica resulted in the beginning of the British Caribbean slave trade which provided an extremely cheap and reliable source of millions of African slaves until emancipation in 1834. The end of slavery was linked to economic decline which in turn had profound political consequences for both British colonial rule and the future wealth of planters and plantations (Williams, 1969). The acute labour shortage that followed the abolition of slavery in 1834 saw planters begin the search for alternative sources of labour from among other areas, Madeira, China, eventually, settling upon India, a decision which irrevocably changed the socio-political landscape of both Guyana and Trinidad. After slavery, the rural-urban shift of free blacks began so that by the late 1800s and early 1900s, each country’s urban population underwent rapid growth. Jamaica’s rural urban shift was arguably the most profound, as many former slaves chose to work on the plots given them after emancipation. Many others however remained as paid labour on the sugar estates. In Guyana and Trinidad, the experience was somewhat different as acute labour shortages saw planters rapidly turn towards Indian indentured labour.

Between emancipation in 1834 and 1917, more than a half million Indians were brought to the region to meet the needs of the labour-deficient plantations. The descendants of these indentured immigrants constitute over one million, most of whom live in Guyana and Trinidad, a significant proportion of both countries’ populations. In Guyana, Indians account for about 49.6% and Africans 30.4% of the population (MacDonald, 1986). There are however important minorities: mixed race (14%), and Amerindian (5.3%). Trinidad’s ethnic composition is 40% Africans, 41% Indian, and the rest made up of mixed, Chinese, European and Syrian and Lebanese. Tobago’s population of approximately 40,000 is more homogenous, with an almost 98% Black population. These ethnic differences in Guyana and Jamaica have polarised politics, as we shall see later, along ethnic lines, with potentially serious developmental consequences. This movement of East Indian labour to meet the needs of European-controlled agriculture mirrors similar experiences in Surinam or Dutch Guiana, Fiji, Mauritius, and Malaya, with similar ethno-political cleavages. In Jamaica by contrast, the population is almost 76% African, with 16% mixed race, and the remainder made up of Chinese, Indian, European and Lebanese peoples. Although predominantly African, the population is nevertheless stratified along colour and class lines rather than the strong Indian-African cleavage that define both Guyana and Trinidad. A large proportion of Afro-Jamaicans remain at the base of the society with the other groups generally dominating business and professional life, though this is slowly changing (Edie, 1989; 1991). The socio-economic, socio-cultural situation changed considerably, with most blacks in Trinidad moving into urban areas or the oilfields which opened in the early 1900s as Indians replaced them on the sugar estates. Class hierarchies are also dominant in Guyana and particularly Trinidad. However racial cleavages are more distinctive, and hence significant in these two societies (Hintzen, 1989; MacDonald, 1986; Ryan, 1991). After completing their bonded periods, most Indians chose to remain in the Caribbean and have retained their links with the sugar industries in both Guyana and Trinidad to the present day.


Political systems - race, class, power and ‘regime’ formation: The dominant political parties from as far back as the 1940s, to the present have all been based on a mixture of class, race and clientelist support. In Guyana and Trinidad, the race factor has been predominant, with the main parties throughout the period dominated by the African and Indian segments of the population respectively (Premdas, 1993; 1994; Hintzen, 1989; 1994). In Trinidad, Eric Williams and his Peoples National Movement (PNM) party, were identified as representatives of the Black segment of the population, while the opposition Democratic Labour Party (DLP) were seen to represent the Indians. The nature of the ethnic cleavages were not lost on the British authorities who noted the difficulty of forging ‘healthy political conditions’ given the Indian presence (Bahadoorsingh, 1971). Nevertheless the first elections under universal adult suffrage in 1956 in Trinidad, and 1953 in Guyana, and almost all of the elections since, have been defined by the ‘race’ issue (Bahadoorsingh, 1971).

Political party formation in Guyana, Jamaica and Trinidad also had its roots in the anti-colonial struggle, usually based on middle class interests, but with strong working class support. Most of the Commonwealth Caribbean territories, like much of the developing world during the 1950s were dominated by independence movements and the coalescing of political parties along class, ideological and racial lines. Many of the leaders of these movements, the well-educated middle classes, forged alliances with trade unions and other political groupings. In the Caribbean, charismatic leaders such as Eric Williams, Alexander Bustamante, Norman Manley, Cheddi Jagan and Forbes Burnham commanded overwhelming support among their respective constituencies. While there was a common cause and a shared vision of the potential benefits that could accrue to the entire Commonwealth Caribbean through a ‘political federation’, the attempt, which started in 1958, nevertheless failed within four years and Independence was almost immediately gained in its aftermath by the two main contentious parties: Jamaica and Trinidad. Williams never forgave the conservative Bustamante-led JLP government in Jamaica for undermining the effort. With a Jamaican referendum voting against the idea. Both countries gained independence in 1962.

In the case of Guyana, political troubles saw elections only granted in 1966 under Forbes Burnham. While developments followed a similar pattern to Trinidad, there were clear differences, the main one being externally-engineered instability. Active as well as covert action by both the British and American government saw the Marxist Indian-based Peoples Progressive Party under Cheddi Jagan variously outmanoeuvred and deposed from power twice in a decade (in 1953 and again in 1963), given the unhappiness of both governments with his Marxist leanings. His chief political rival, Burnham, though ‘socialist’ was seen as the lesser of the two evils of socialism, which resulted in active support from both powers. In Trinidad, Williams was also able to win colonial support and eventual political power by shoring up his anti-Communist, pro-business, pro-American credentials in exchange for British-instigated constitutional and electoral boundary changes that effectively guaranteed his party dominance in the 1961 electoral vote, which was followed by full independence in 1962 (Hintzen, 1994: 64). Compared with the Guyanese situation however, Trinidad was much less volatile, and external involvement much less blatant though certainly there. Nevertheless, the fact that the two main attempts to destabilise the country were based more on working class, urban disaffection than inter-ethnic problems and its general stability despite these events reflects a somewhat different reality from the Guyanese situation.

In terms of political systems, Jamaica has been closest to a Western style two-party liberal democratic system, although retaining the Queen as head of state. Guyana and Trinidad have both had various levels of powerful central rule for much of their post independence periods. Trinidad and Tobago became a republic in 1976. Guyana became a co-operative socialist republic in 1970, becoming independent only four years earlier in 1966. Both Jamaica and Trinidad nominally use a Westminster-style two party, ‘first past the post’ system of liberal democracy, although in practice there is much to distinguish each from the other as well as from that being practised in Britain. In Jamaica and Trinidad, power is concentrated in the hands of an ‘executive’ Prime Minister, although other branches of government such as the judiciary are relatively independent. At the administrative level, the institutional legacy of British colonialism is still deeply embedded in public sector administration of each country in spite of constitutional differences. Despite its republican status, Trinidad’s presidential system is however as symbolic as Jamaica’s retention

8
of a governor. This presidential power of the first Trinidadian Prime Minister, Eric Williams, and electoral violence in Jamaican politics aside, both countries have had a fairly democratic post-colonial period in the Westminster 'first-past-the-post' of the term.

The Guyanese system by contrast is framed on a republican representative system, with a strong presidency and a limited degree of regional autonomy, born out of Forbes Burnham’s authoritarianism in the 1970s and 1980s. The president appoints the prime minister and cabinet members, not all of whom are members of the National Assembly. The cabinet, which is normally chaired by the president formulates policies and plans and is responsible to the National Assembly. The Head of State is the president, who is the leader of the party which commands the largest number of seats in the National Assembly. The Assembly is unicameral, with 53 of its 65 members elected directly under proportional representation and the other 12 from regional assemblies, and sit for five year terms. The Guyanese system for much of its post-Independence period has been dominated by the non-democratic rule of the African-based Peoples National Congress (PNC) regime under Burnham.

Comment: There are many differences as well as similarities between and among Guyana, Jamaica and Trinidad which we need to recognise as important in a contextual appreciation of post-colonial health policy developments. Jamaica and Trinidad share a largely British common colonial background, although there are important differences that are significant. Historically, Jamaica remained British for well over three hundred years; Trinidad only became British in the late 18th century and British Guiana only emerged under British rule in the 1830s. The economies of all three colonies were based on sugar production, and though still important by the time of independence, Guyana and Jamaica were also producing bauxite, while Trinidad had been producing oil from the early 1900s. Socio-culturally, Guyana and Trinidad share a similar African-Indian ethnically plural society, while Jamaica’s population is largely African. Politically, Guyana and Trinidad are also stratified along ethnic lines. In the case of Jamaica, clientelism and class, more than race have played a more important role (Edie, 1989; 1991). The main parties in all three states have however had close ties with unions representing their respective clientele, and without exception have been largely led by middle class professionals. However, Guyana has a proportional representative, and strong presidential system; Jamaica has essentially retained the Westminster model; while Trinidad and Tobago' political system is somewhere between the two, following the Westminster model, but having republican status, albeit a symbolic one. The authoritarian nature of the Guyanese system and the relative democracy and legitimacy of the Jamaican and Trinidadian system need to be considered as important defining elements. However, again, the authoritarian rule of Trinidad’s prime minister Williams especially during the 1970s are a key focus in this study, despite Trinidad’s relative legitimacy.

Before we examine the significance of the health policy paradoxes outlined earlier and its possible connections to national politics in the 1970s and 1980s, we first need to begin by examining the relationship between the colonial state and health policy reform.

1.4 REGIME CHARACTERISTICS AND COLONIAL HEALTH POLICY

The negative effect of colonialism on health, regardless of coloniser, has been well-documented (Doyal, 1979; Navarro, 1982; Fanon, 1965; Turshen, 1977). In her Marxian analysis of this impact on British colonial Tanganyika (now Tanzania), Turshen noted that:

“...the health sector has been subject to the same limitations and distortions under colonial rule as other sectors of the political economy. Widespread ill-health and essentially chronic malnutrition are not primarily internal problems...just as continuing poverty is not. These are the products of colonial history...and changed social relations of production...” (1977: 32-33).
Much the same was true for other colonies including those under French rule. Fanon (1965), for instance, describes the role of medical care in promoting French military goals in Algeria. Similarly, Lasker notes of French colonial health policy in the Ivory Coast:

"...survival and conquest were the most important goals of colonial rule...the military and civilian administrators of the colony developed medical services as one of the main means for achieving these goals..." (1977: 281).

This distortion and limitation is not however confined to the colonial state. Navarro (1976) has pointed to the link between health services development and class structure in his study of American health policy, suggesting that the capitalist system was organised to serve the dominants interests in society: much like health under colonial rule. To assess the politics of health and health reform in with specific reference to British Caribbean plantation society, we first turn to an examination of regime characteristics within the slave colony and its impact on policy and policy reforms.

*Regime characteristics and Caribbean slave society (the late 1500s to 1834)*

The influence and importance of regime characteristics to the Caribbean plantation economy is critical in explaining post-colonial health developments. The raison d’être of British Caribbean colonialism under the ‘old representative’ system of government was the plantation economy and its profitability for both planters and the tax-conscious British Colonial Office. Power and strength thus lay in the hands of the planters on the one hand, and the governors and their colonial administrators, on the other. The basic aim was wealth extraction from sugar production for the benefit of both planter and, ultimately, Crown. The main objective therefore was the exercise of power and control in order to maintain a stable system which satisfied these aims. Under the Caribbean slave system therefore, a curious blend of autocratic rule combined with mercantilism, within a formally ‘Christian’, slave-owning society prevailed. In the case of colonial administration, while the governor commanded overall considerable power, ‘day-to-day’ power was effectively exercised by bureaucrats. As Jones points out under British colonialism in the Caribbean:

"...the colonial polity was essentially bureaucratic...the governmental process was dominated by the British Secretariat whose representatives combined administrative and political power...bureaucrats defined the rules of the social system, determined the exercise of official violence and dictated the pace and direction of political change..." (Jones, 1981: 14).

This system was eventually replaced by the crown colony system in which expansion of local members of the council were instituted. However power remained with the planters and the colonial authorities. Under both systems, power remained effectively in the hands of planters, propertied classes and the governor, with appalling health conditions and little chance of political reform. The result for health care, given the aims of the plantation economy was a general legitimisation of the system, while at the same time preserving the raison d’être of the colony.

*The colonial regime, the ‘legitimising’ medical profession and health policy*

One Marxian interpretation of Caribbean health development in the post-emancipation period of the late 19th century - a time also of rapid global imperialism - is reflected in Habermas’ notion of legitimation. Applied to colonial health care, legitimation essentially means the use of medicine and social welfare to pacify the oppressed, and hence ‘legitimise’ capitalist penetration of underdeveloped societies (Manderson, 1987: 94-95). The ultimate aim was preservation and survival of the status-quo be it colonialism, capitalist development or the medical model. Manderson, in her study of British Malaya illustrates the role of legitimation through public health ‘policing’ measures and medical services provision as mechanisms to establish superiority of colonial knowledge of aetiology and therapy over local non-western systems. *Legitimation* is not confined to colonialism and health. Navarro for instance
demonstrates the ‘legitimising’ role of welfare programmes in contemporary America in integrating alienated sectors of the population (Navarro, 1976: 135-169; Habermas, 1979; Manderson, 1987: 94-95). Nevertheless, under colonialism, the links between the colonial plantation economy, legitimisation and health care was exemplified by the important role of the British colonial medical profession. Here, Turshen’s analysis of the dual legitimising roles of colonial medicine in Tanganyika - pacification and cure - could well be applied to the British Caribbean:

“...in the age of imperial expansion, colonial medicine was put at the service of the British Empire: British physicians and surgeons, firmly in control of the medical professional by the end of the 19th century, inevitably urged and won the adoption of the curative approach in the colonies...the rudiments of a system of public health and medical services were transferred from Britain...during the period of colonial rule. Determined and designed in the metropolis rather than the colony, the colonial medical system was responsive to the needs of the rulers than the ruled...” (1977: 8).

Both the objectives of the colonial system, and medical legitimation were thus important in shaping colonial health care under the slave system. Medical practitioners provided care for white planters, other expatriates and the local ‘mixed’ or mulatto population. It was, however, in the economic interest of the planter to provide some form of rudimentary health care for slaves along with food and other necessities to ensure this profitability, although at the height of the slave trade, slaves were cheap enough for planters to simply buy more to replace those expiring or ill from over-work. Public health was generally ignored, partly due to the mores of the time, but also due to the fact that elites lived in cordon sanitaires, away from the masses (Gish, 1979: 205). European ignorance in the 17th century of public health, sanitation and disease thus also extended to the colonies, with epidemics of yellow fever, typhoid, typhus, cholera and smallpox, as well as dysentery and other diseases killing thousands in both the pre- and post-emancipation periods (Parry, Sherlock and Maingot, 1983).

In terms of health personnel under colonialism, most planters employed largely British-trained private medical practitioners for their plantations, who were aided and supplemented by black traditional midwives. Despite the fact that the professional qualifications of doctors, privately contracted by individual plantations varied, they constituted the focus of colonial health care (Sheridan, 1985). However, missionaries, along with the nurses, traditional midwives as well as other categories were also important components of the prevailing colonial personnel system, with their specific concern for slave welfare. One interpretation is that this ‘caring’ presence offered a legitimising force in plantation society regardless of coloniser - a credible interpretation, especially before emancipation (Gouveia, 1971: 21; Lasker, 1987). There were also professional differences based on historical factors.

In sum, then, the role of the colonial regime in British Caribbean colonial society, like that of successive British governments in the 16th, 17th and 18th and part of the 19th centuries was ensuring and securing the survival of the plantation economy, based an authoritarian slave society. Under this prevailing state of affairs then, the balance of power was clearly skewed in favour of the colonising power and the planter, with the medical profession playing a legitimising role and reform clearly off the agenda as long as the slave system persisted.

Regime characteristics, the ‘crown colony’ system, and health (1838-1930s)

Health policy reforms under early colonialism was brought about by a sequence of crisis and reform, starting with the abolition of slavery itself. Following abolition 1838, politics, society and health provision in the post-emancipation era were conditioned by three main developments: 1) labour attrition from plantations; 2) the importation of indentured labour mainly from the Indian sub-continent to replace slave labour; and 3) the establishment of a crown colony system of government as a means of the colonial authorities assuming more responsibility for social conditions. Labour attrition from the plantations saw the planters and the British colonial authorities cooperate in the importation of indentured labourers, mainly from India to solve the shortage. Crown colony rule formalised political control under the British
Crown on the following grounds: to improve public services and administration; to act as arbiters between conflicting classes, and the protection of ex-slaves (Augier, 1971: 72-73). In Jamaica, the direct impact of social dissatisfaction resulted in the Morant Bay rebellion which was the primary reason for the transition to the crown colony system. Between 1865 and 1930 Jamaica was ruled under the crown colony system. Trinidad, being the first crown colony started much earlier in 1802, while Guyana only became a British Crown colony in 1928. As Augier notes, the British also saw the crown colony period as a temporary transition to full self rule “...as soon as the society had learnt the arts of responsible government...” (1971: 72-73).

The implication of these reforms for governance, health and social welfare were mixed. While not much had changed, there were now the beginnings of a public health service by the colonial regime largely due to planter unwillingness to provide health care for ex-slaves. Given the labour attrition from the plantations, planters instead focused their attention and resources towards indentured labour. Planters and colonial administrators squabbled over who was to provide health and welfare services for the ex-slave. As their fortunes waned, planters, who still controlled the public purse, were more concerned to spend their money on immigration and sugar estates rather than welfare and education (Augier, 1971: 72-75). This social 'gap' thus forced the colonial administrators to accept some level of responsibility, given the objectives of the crown colony form of governance. Colonial administrators became very active in public health given their new mandate under the crown colony system, for instance, spending public resources on the cholera epidemic in Jamaica in 1865. Still as Augier notes, the British Caribbean colonial regime barely acknowledged its responsibility for universal health care provision. Consequently, the health of freed slaves did not drastically improve during the post-emancipation period, despite these stated concerns. Crown colony legislatures were at first praised for their education policies. When this system ended in the British Caribbean in the 1930s however, it left education and health effectively in the hands of voluntary associations and missionaries, in the absence of any official colonial action (Augier, 1971: 72-73).

In addition to the reforms brought on by emancipation and planters’ refusal to provide care for ex-slaves, two health-related developments influenced the development of an embryonic health sector in the British Caribbean crown colonies: 1) the 1848 British public health act and the 1869 Sanitary Commission report; and 2) the continued rise of the western medical model of doctor-dominated health care. The development towards a form of organised health care in the British Caribbean colonies started with the implementation of 1848 Public Health Act in Britain which made public health the concern of the state. The Colonial Office was obliged to replicate health developments in Britain within the colonies. Similarly, the improvement, through the 1869 Sanitary Commission, of water supplies in order to prevent epidemics was translated in various forms to the colonies. Quarantine regulations were established, and water works installed and/or improved, which saw a reduction in the incidence of yellow fever and typhoid. The foundation of public health services was thus laid during these years (Quamina, 1988). At the curative level, hospitals were also built in main towns during the mid 1800s, while medical services were established in the late 1800s, with various complements of doctors and nurses.

The 'success' of the Indian indentureship system in rehabilitating the sugar economy in the British Caribbean, particularly in Trinidad and Guyana, ensured the persistence of the three-tier health care system, but resulted in a new form of slavery. While entitled to health care and housing under the indenture system, the poor working and living conditions of indentured labourers, their powerlessness, the abuse of power by the estate managers made their situation comparable to slaves (Jayawardena, 1963). In Trinidad and Guyana, estate health dispensaries served the Indian indentured labourers both during and after their bonded contracts. This three-tier level bears remarkable similarity to other plantation societies including former British colonies such as Mauritius (Parahoo, 1986); Ghana (Twumasi, 1981; Akwasi Aidoo, 1982); British Malaya (Manderson, 1987); Kenya (Mburu, 1981a; 1981b); and (Tanzania (Turshen, 1977) as well as in French colonies such as the Ivory Coast (Lasker, 1977). In Trinidad, Guyana and Jamaica district medical services were also established under crown colony rule. In Trinidad and Guyana, this was linked to concerns in India about the welfare of Indians on the sugar estates. In Trinidad in 1921, the public health ordinance was amended to provide for district medical officers
In 1870 a plan was formulated by the chief medical officer for the medical care for the poor as well as the siting of hospitals close to estates (Quamina, 1988; Gopaul, 1970: 83-86).

In the case of health human resources after full emancipation in 1838, there were a number of significant developments including migration of expatriate doctors and consolidation of medical professional power which had important effects. First the mass emigration of expatriate doctors after emancipation - Jamaica for instance had 217 doctors in 1834; by 1850, this had dropped to 90 - paved the way for the emergence of black doctors who learned by doing (Wilkins, 1989: 27-32). By 1846, with Trinidad well into British crown colony rule, the relationship between categories such as apothecaries and midwives was being managed by the increasingly powerful local medical profession and its parent body the Royal College of Physicians (Harnarayan, 1977). The colonial authorities recognised this power and tried to bring the medical board under control, which was strongly resisted (Harnarayan, 1977). The medical board also controlled midwives, though not nurses. All three territories adhered to the British tradition. Trinidad was initially different due to the persistence of Spanish style-administration even after British conquest. For instance, as regards doctors, the local 'cabildo' or assembly was empowered by Spanish colonial laws dating back to the Spanish code of law of the Indies in 1680 administered from Caracas, to inspect and approve qualifications of physicians, surgeons, and apothecaries, and organise against disease epidemics. The Medical Board in Trinidad was formed relatively early in 1814 to manage entry into medical practice in the colony (Harnarayan, 1977).

Comment: The crown colony experiment was effectively a crisis-driven reform response of the colonial formerly slave-owning state. It was partially successful in terms of some health policy reforms in the British Caribbean colonies. However, drawbacks included: 1) the continued power wielded by the planters; 2) lack of democratisation; and 3) the existence of discriminatory categories of health and welfare services for the masses. First, despite the intermediary position of the colonial administration, effective power was often wielded by the planters. Secondly, the British adhered to the principle that a crown colony could have all the services its revenues could afford, but left it to the discretion of governors and the colonial secretariat to allocate available resources which resulted in increased centralisation of power. While the increasingly visible public health profile of the British Caribbean colonial authorities was also a result of genuine concern to address public health threats, the ideas of crisis-driven reform, legitimisation and the power of the colonial state does nevertheless have considerable explanatory power when applied to this period. Under crown colony rule, the health services of post-emancipation Caribbean colonial state continued to be characterised by its authoritarian environment, polarised along ethnic and class lines, but now inclusive of indentured labour. The medical profession was part of this system legitimisation process, controlling both the practice of medicine and the management of early public health services that were to eventually constitute health ministries under self-rule, although they were also part of the struggle for self-rule and democratisation in the late 19th- and early 20th centuries.

Placing reform on the colonial agenda: the Moyne report, self government and health reform (1945)

The main reforms in the Commonwealth Caribbean only began in the immediate post-war period and had direct implications for health services organisation and provision. These reforms sprang from widespread protest movements and riots in the inter-war period, driven by poor economic and social conditions as well as the increasing desire for political self-determination. The demise of sugar, and increasing unemployment as a result of the economic crisis saw successive waves of Jamaican and other Caribbean workers migrate to build the Panama canal in the early 1900s as well as to Cuba and Central American coast of what is now Nicaragua, in addition to the USA. Growing discontent in the 1920s had initially resulted in the visit to the West Indian colonies of the British government-appointed Wood Commission, which presented its report in 1921. This report regarded the colonies as unprepared for self-government because the nature of West Indian society made it too hazardous, with Trinidad and Guyana said to pose particular problems because of the ethnic problem (Proctor, 1971). The Wood report instead favoured an incremental approach. The general slowness of reforms resulted in further riots between 1934-1939 throughout the region, often violent, and marked a turning point in the drive towards self-government. Another commission led by Lord Moyne was sent to the British Caribbean in response to
these riots. Reflecting developments both within the colonies and in Britain, the pattern of health services development in Guyana, Jamaica and Trinidad and Tobago in the inter-war years had remained largely unreformed with the exception of the embryonic colonial central and district health services.

The appointment of the Royal West India (or Moyne) Commission was the response of the Colonial Office to the crisis. The issue of health reform comprised a significant part of the Moyne report. This report was unambiguous about widespread poverty being the main ‘health’ problem: poverty of individuals, health facilities in rural areas; poverty of medical departments and of the colonial governments. As the report noted, the rapid population increases, which began at the turn of the century and which had been brought about by a decline in the death rate through marginal improvements in public health, placed enormous pressures on public and social services which contributed to the rising unemployment and unrest and migration. This report also found that the health of British West Indians, while generally better than in some other British colonies, was still unsatisfactory. On the issue of health policy however, lack of finances, poor administration, curative bias and bad social conditions were identified as the main problems. While focusing on the poverty-related manifestations - high infant mortality and general morbidity, deplorable housing, sanitation and poor diets - the report expressed concern that the cure of disease received much more attention than had been given to prevention as Table 1.1 below demonstrates. It noted in this regard that “...little improvement in the health of the people can be expected, however extensive the hospital facilities - until these serious defects are remedied...” (Moyne Commission Report, 1945). Lack of coordination and effective administration as well as research deficiencies were also identified. In the case of health human resources, the report cited the shortage of non-medical health categories as a major problem, noting that “...the number of well-trained personnel of the subordinate medical staff is everywhere low in proportion to the numbers of fully qualified doctors...” (Moyne, 1945).

The Commission’s most important political recommendation recognised the need for transitional self-government under a federal system as the main way forward for these states. In terms of administration, political reform was vital. The need to speed up process of decentralisation and dissolve the old colonial secretariat system, the creation of ministries, were all necessary for decisions to be implemented. The implications for political governance were far-reaching as general recommendations included the unification of the territories under a federal system.

**TABLE 1.1:** Health spending on preventive and curative care in Guyana, Jamaica and Trinidad and Tobago in 1945

<table>
<thead>
<tr>
<th>Country</th>
<th>% medical expenditure to total expenditure</th>
<th>% preventive to total health expenditure</th>
<th>% curative to total medical expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>British Guiana (Guyana)</td>
<td>10.2</td>
<td>12</td>
<td>88</td>
</tr>
<tr>
<td>Jamaica</td>
<td>9.8</td>
<td>18</td>
<td>82</td>
</tr>
<tr>
<td>Trinidad and Tobago</td>
<td>9.2</td>
<td>18</td>
<td>82</td>
</tr>
</tbody>
</table>


In the case of health care and health services generally, the Moyne Report’s recommendations included the unification of the medical services, the decentralisation of medical institutions, the re-organisation of services and the development of long-term health policies, including training. In terms of medical training, the regional thrust of the report was reflected in its recommendation that consideration be given to the eventual establishment of a medical “college” as a faculty of “...a West Indian university...” (Moyne Report, 1945). The Jamaica Legislative Council had made such a request two years earlier. This request was subsequently supported by the Asquith Commission on medical education for the Caribbean colonies, which recommended the establishment of a faculty of medicine under University of London supervision. In 1946, the decision was made to establish the medical school in Jamaica, with other Caribbean territories pledging financial support. Independence bought the
university's full charter, with the University of London granting it full independence of operations in 1962 alongside Jamaican (and Trinidadian) political independence (Theobalds, 1993: 8-11). This decision had a major impact on medical training for the entire region. At the hospital level, attempts were made to reform nurse training programs throughout the region, with particular attention paid to local training. The nursing profession, like other disciplines up to this time was still dominated by administrators and senior nurses trained mainly in the United Kingdom or Canada.

The key problems in the case of colonial health services were however administration and a curative bias (Segovia, 1976). In the case of administration, the three tier-system persisted, with a private (largely urban) sector for the ruling elite, the voluntary agencies and the new colonial hospital system for the urban poor, and the industrial or estate-based health services for the indentured labourers. The blatant discriminatory system which developed, for instance, in Kenya - where Europeans were designated 'medical officers'; Asians: 'Asian medical officers' and Africans: 'assistant medical officers' - may not have been implemented in the plural societies of Guyana, or Trinidad. However, a two-tier system of expatriate, and 'colonial' or native doctors, the latter in several cases being discriminated in terms of promotions and appointments persisted was similar to that identified by inter alia, Mburu in Kenya (Commissiong; 1968; Mburu, 1981a; 1981b). In relation to Trinidad and Guyana, the separateness of the two major ethnic groups, the Blacks and Indians - spatially and in health care - added to the alienation of both groups, with and as Hezekiah has noted in the case of Trinidad, accounted for the absence of Indians in nursing and medicine in the late 1800s and early 1900s (1989: 83).

In terms of curative bias, in the newly emerging public health services, the authorities concentrated most of their financial, human and material resources on hospital services located in capital cities and centres of production and commerce. Despite the fact that separate arms of public and curative health services were developed, health care at the level of the estate, the voluntary sector and the private services respectively all focused almost exclusively on curative medical care. In terms of distribution, the missions and voluntary agencies focused largely on the remote areas. In the case of funding in the 1920s and 1930s, financial problems in the British West Indian territories during this inter-war period resulted in cuts to public health expenditure. The overall situation was nevertheless marginally better than, for instance, the French-ruled Ivory Coast, which never focused on prevention-based health care in the first place (Lasker, 1977). The problems however remained the same in the case of health human resources under both French and British colonial rule: the dominance and control of all aspects of medical education by the profession by virtue of the profession's status and prestige; and the unwillingness -largely due to medical professional opposition - to produce auxiliaries and prevention-trained personnel (Twumasi, 1981; Mburu, 1981a; 1981b). The curative focus in the British Caribbean colonies had another side-effect in addition to the neglect of prevention, in the case of health training processes. The status, prestige and resources that accrued to the urban-hospital-based system was the main outcome of this skewed system.

**Outcomes:** Some of Moyne's were implemented, the main one in the case of health human resources, being the establishment of the University of the West Indies. However, little effort or headway was made in the case of the curative bias, and the formulation of policies. The primary reason was clearly the fact that the period between 1945 and the 1960s was characterised by considerable political manoeuvring as parties consolidated themselves in the runup to independence. This process was fraught with problems. Of the three territories, Guyana faced the greatest threat to its stability. This fear of instability in the newly emerging states thus meant therefore the imposition by the colonial regime of incremental, as against radical political, economic and social reforms. In the case of the social services, this meant tinkering with the edges of the colonial system. The report itself was arguably an incremental, transitional document, which was not concerned about radical change. Even political independence was to follow an orderly, incremental process. While fine for political stability, the incremental path would bedevil post-colonial health and social policy development, since a comprehensive reform of much of the old colonial system, and not a simple tinkering at the edges was urgently needed.

Beyond awareness of the above health issues then, the main outcome of the incremental Moyne report was a heightened awareness of political, economic and social reform. There was increased recognition of
the central role of political power transfer and the democratisation of political institutions within colonial society to realise these aims. The colonial regime policymakers opted to effect the incremental transfer of power without jeopardising either British political, or multi-national and other business interests. In doing so the management of the reform process was essentially incremental, and ‘modernisation’ rather than ‘development-oriented’ (Mills, 1973a; 1973b; 1974). During the post war era then, this Report served nevertheless as the ‘blueprint’ for the formulation and implementation of general development policy and policy reform (Lutchman, 1989: 298). In the case of overall development - political, economic and social - the Report arguably started the process of political, social and economic decentralisation as the way forward for progressive development. As Lutchman notes of the value of this report to the health sector:

“...it established norms and certain minimum standards...it emphasised an integrated approach in attempting to solve social, economic and political problems. Thus according to its conceptualisation, health problems were intimately connected and related to educational, economic, labour, and even political factors...” (1989: 298).

The first decade of independence and health

Economically, the decade of the 1960s was characterised by the implementation of industrialisation-by-invitation policies which while initially successful saw worsened economic and social conditions by 1970 due to the failure of this ‘Operation Bootstrap’, US-inspired strategy, as well as a rising population. Politically, a Westminster-style ministerial system was already in place in Guyana, Jamaica and Trinidad, with permanent secretaries of ministries vested with powers of supervision and administration, subject to the control of ministers generally along British lines. In the case of health, the old central boards of health under colonial rule formed the core of these new ministries of health. Meanwhile, most newly-independent Commonwealth Caribbean governments focused on infectious disease eradication and control with Pan American/World Health Organisation (PAHO/WHO) assistance. Similarly, national health plans were also formulated with such assistance. However as Quamina (1988: 36) notes in the case of Trinidad, technical reforms were not followed by administrative reforms, which were essential to effect the implementation process. Such plans nevertheless formed the basis of considerable physical infrastructural development in the 1970s as sectoral planning gave way to project development including, the negotiation of World Bank loans for various levels of health sector support, including the building of nurse training schools, health centres, improvements in maternal and child health policy and family planning.

By the end of the 1960s, then, most Commonwealth Caribbean countries had a two-tiered health system, covering comprehensive curative and preventive health services. Curative health was delivered through community district services as well as various hospitals offering both general and specialist services. Preventive services ranged from general environmental concerns to the various levels of physical facilities in the community, ranging from health centres to health posts in outlying areas, the latter particularly critical for health services provision for example in the vast hinterland of Guyana.

The evolving structure of health service systems in Guyana, Trinidad and Jamaica was by the end of the 1960s then similar to that of many other developing countries, divided into a state-run free public health system and a private health care system, with external agencies providing considerable technical support in policy formulation and implementation. The Pan American Health Organisation, the sub-regional office of the World Health Organization; the Inter-American Development Bank, sub-regional office of the World Bank as well as a number of other agencies including the United States Agency for International Development (USAID). The private medical sector provided services for those who could afford it at both the community and secondary levels, while public health care provided the bulk of health services at the tertiary/curative level. There were however a series of complex interrelationships between these subsectors. In the case of health human resources, many private medical practitioners worked for the governments on a contractual basis, due to the perennial shortage of doctors, while many public doctors moonlighted in the private sector to supplement their earnings.
Comment: The transition period before full Commonwealth Caribbean self-rule was conditioned by both international and national political economic and social factors and processes. Internationally, Fabian-influenced social welfare thinking in Britain inevitably triggered a similar concern with the plight of the poor social, economic and political conditions of the inhabitants of the British colonies. The advent of universal adult suffrage and the adoption of declarations on human rights, health, economic and social issues at the United Nations meant that interest in the development and modernisation of the newly-emerging colonies was on the agenda. At the national level, the decolonisation process within most Commonwealth Caribbean states, excluding Guyana, was one of almost peaceful transition, compared with the bitter struggles that characterised other states’ independence struggles. In terms of politico-administrative preparation for self-rule, for most former British colonies the process was therefore essentially an evolutionary one with universal suffrage happening alongside the formation of multi-party systems, strong trade unions, the creation of ministerial system of government and cabinet systems modelled on the British system with colonial power being eventually ceded to representative government in the 1960s (Mills, and Jones, 1989).

At the social policy level, the critical need for reform, in particular administrative and institutional reform was highlighted by the findings of the 1945 Moyne Report. Event the incremental Moyne report however recognised however that there was need for considerable reform of the old colonial administrative structures and institutions if progress was to be achieved. In the case of health, planning during the 1960s was heavily promoted and supported by the Pan American Health Organisation (PAHO) in terms of appropriateness of service provision within available resources as well as the elimination of the prevention-curative dichotomy by promoting the integration and rationalisation of health services especially given the scarce resources of Caribbean states during this period. Changes during this period were therefore evolutionary in an effort to preserve stability. In doing so, important frameworks for future policy implementation such as bureaucratic reform were neglected, which left serious work to be done in the post-independence period in all three states.

By the end of the 1960s then, all three countries - Guyana, Jamaica and Trinidad - experienced generally similar problems in the case of health, but understandably chose to tackle the most serious physical infrastructural problems first. Thus health policy during the early years essentially comprised such basic issues as the building of facilities and the implementation of mass immunisation programmes. Of the three, there was little attempt in Trinidad to reform administrative structures at this stage due to the emergence of Williams’ authoritarian-style of politics. Guyana was also similarly about to pursue an authoritarian path in the 1970s under the illegal Burnham regime. Both Guyana and Jamaica, unlike Trinidad and Tobago were also about to pursue radical developmental agendas that constituted significant shifts from the status quo, and which also had potentially important outcomes for health policy, including health human resources development in the post-independence period.

Caribbean politics and health policy: the neglected dimension

One of my main concerns in exploring the health policy process in the post-colonial Caribbean developing state was partly to address the relevance of political explanations for the paradoxes raised earlier, given the groundwork laid by the 1945 Moyne Report. Despite the lack of contemporary studies on the politics of health in the Caribbean colonial state, indirect evidence of political impact can be gleaned in studies of Caribbean public administration (including health management) (Mills and Jones (1989); Segovia, 1976) and political sociology (Stone, 1986; Hintzen, 1989). The role of national politics is extremely relevant as I found in my fieldwork. A cursory review of the numerous consultancy reports as well as press reports of health related industrial action throughout the period for instance, points to health services neglect and mal-administration by successive governments as one important factors alongside economic factors such as resource scarcity in both declining health status and professional dissatisfaction. Yet contemporary Caribbean social policy studies have consistently relegated, even ignored the importance national politics, focusing almost exclusively on economic factors, thus leaving this most important area are of inquiry unexplored. Without such explanations, it is exceedingly difficult to question various explanations of policy processes, including economic and political factors.
The health paradoxes raised earlier are not unique to Caribbean states. In the Pacific region for instance, problems relating to the health transition i.e. the change from infectious to lifestyle diseases as the primary cause of illness; political centralisation and its negative effects on health administration, the proximity to developed health care societies which not only emphasise medicalised health training, but the non-return of trained islanders mirrors the Commonwealth Caribbean post-war and post-independence development experience (Taylor, 1990). According to an economics-based interpretation of policy, policy processes in developing states are hindered largely by resource scarcity. A 'politics-oriented' explanation of policy processes in these same states might find that while resource scarcity is an important factor, the situation is much more complex with explanations heavily conditioned by both political and social context and content, in addition to economic factors and processes. The logical extension of this argument is that the role of national government and politics in the post-colonial policy process needs to assessed alongside other contributing factors such as economic, social and environmental influences. Thus Emmanuel's assertion of the importance of the political can be applied to almost any other state, developed or developing:

"...a proper treatment of issues of governance and democracy in the Commonwealth Caribbean must needs be undertaken on the basis of an identification of what constitutes the essential properties of the region’s political systems, as well as the character of relationships between these political systems and their contextual social and economic systems..." (1991: 1).

1.5 SUMMARY AND CONCLUSIONS

In this chapter I have attempted to set the context for the study by describing the country under study, the regional context, an importantly an examination of the politics of policymaking in the colonial policy arena, its evolution and its implications for policymaking in the post-colonial period. We began this chapter by noting the paradox of Caribbean health improvements and declines in the 1980s. While historical and contemporary economic influences must be considered in any explanation of post-colonial policy development, I have tried to show the importance and relevance of colonial political patterns of development to post-colonial colonial policy reform processes: namely 1) the continuation of a curative bias; 2) the retention of authoritarian patterns, with the exception of Jamaica in the post-colonial period despite full independence and 3) the crisis-reform pattern of political and policy reform.

Assessing British colonial health policy in India, Jeffrey has noted that "...it makes little sense to see imperial medicine in India solely as either social control or humanitarian concern. The picture is more complex. Both aspects are important and were often closely intertwined..." (1986: 79). The same could be said for the British Caribbean. The colonial regime was strong and autocratic enough to exert its will, bowing to social reforms only under periodic crises, dating back from slave emancipation in 1834 to the riots in the 1930s which triggered further, and more far-reaching reforms. After the war, political reforms dominated the agenda to the negation of social reforms as political parties jostled for power. On the one hand, health reform was incrementally introduced because of humanitarian factors, and mirrored developments in Britain at the time. However, like other colonies such reforms were also introduced for economic self-interest after crisis periods, giving credence to the idea that incentives for change and reform only occurred at such politically-opportune periods. Colonial regime characteristics were thus influential in the both the development and underdevelopment of health in the colonial Caribbean as in other regions.

This chapter has attempted to show the historical political (and economic) links between health policy and the post-colonial Commonwealth Caribbean state. Given the overwhelming influence of economic, as well as social and environmental factors on national health policies in the post-colonial state, the search for alternative explanations such as national-level political influences runs the risk of underestimation of these other important factors. Additionally, the question of apportioning both praise and blame in post-colonial state policymaking is also problematic. It is, for instance, relatively easy to link positive health developments to progressive governance on the part of regimes. It is however both theoretically difficult, even unfair, to blame third world regimes for health status declines given the negative impact of
externally-imposed structural adjustment programmes. Not surprisingly therefore, much of the literature on Caribbean health has focused on the impressive policy gains of regional governments, and the negative economic impact of structural adjustment programmes on these gains. Explanations for policy failures that are limited to economic arguments do little for our understanding of the both the complexities of the developing state policy context, and the abilities of third world policymakers, as pointed out by Grindle and Thomas (1991), Walt and Gilson (1994) among others. My aim in this study is to examine and question the role of national politics in post-colonial policy processes and its relationships with other determining factors such as economic factors. My central contention is that individual meta-level explanations that might incorporate a variety of explanations must be striven for, indeed, must be addressed as a matter of good objective social science. Such an integrated approach enriches knowledge of the developing state policy process by looking beyond economic deterministic answers to more complex answers, while simultaneously retaining some level of ‘generalizeability’.
CHAPTER 2

REGIME CHARACTERISTICS AND ‘LOW-POLITICS’ POLICY REFORM PROCESSES IN THE POST-COLONIAL STATE: A ‘STRUCTURATED’ APPROACH

2.1 INTRODUCTION

Because I want to illustrate the role, influence and relevance of the following characteristics - regime strength, stability, ideology, democracy and regime survival - to developing state social policies, I shall in this chapter examine evolving theoretical perspectives about the role and importance of the developing state and developing state political actors in policymaking specifically. To support this argument, I shall draw from, and assess the contributions from the various theoretical debates in the fields of political science, development studies, sociology and comparative policy analysis on the role of national regime actors in developing state policy processes. In the first section, I shall review the literature on the relationship between regime characteristics and developing state policymaking. In the second section, I shall briefly examine the lessons from the development theory impasse in the 1980s that can be applied to developing country policy on the role and relevance of national actors, particularly the most dominant of them all: the regime. In the third section, I shall review and discuss the main themes emerging from both the state- and society-based approaches to policymaking in analysing policy actors and their motivations as well as their actions, inaction and/or non-decisionmaking as policy. In the fourth section, I analyse of the policy literature assessing, among others, the perspectives of Hall, Kingdon and Grindle and Thomas on the policy and policy reform process in the developing state. In the final section, I shall state the case for the usefulness of regime characteristics as a determinant of social policy processes in the developing state.

2.2 REGIME CHARACTERISTICS AND POLICY MAKING IN THE DEVELOPING STATE

Regime characteristics and policy

Regime types and characteristics have been frequently used to analyse policy processes in developing states (Anderson, 1967; Ayers, 1975; Remmer, 1978; Stepan, 1971; Thomas, 1984). One of the more important recent discussions of the relevance of regimes types and characteristics to health policy is Bossert’s cross-comparative case study (1983) of the impact of regime characteristics on primary care policy adoption and implementation in Central America. He analysed regime type across four of these states and across the following four dimensions: 'strength', 'stability', 'ideology' and 'democracy'. He covered a range of issues including degrees of centralisation, integration of policy, degree of community participation, funding levels and the role of international assistance. He explained his underlying hypothetical logic as follows:

"...Strong regimes will have the capacity to adopt and fund innovative health care programs because they will be able to extract sufficient resources and distribute those resources to non-dominant sectors of society. Stable regimes will be most able to implement these policies because they allow more continuity in the bureaucracy. Progressive [or reformist] regimes will pursue more social welfare policies [than status-quo conservative regimes]. Democratic regimes will give more voice to lower class beneficiaries and therefore be more responsive to their demands..." (Bossert, 1983: 426).
In his testing of these hypotheses, Bossert did not find any simple relationships between regime characteristics and policy adoption (1983: 427-424; Reich, 1994: 425-426). Both stable (Costa Rica) and unstable (Guatemala and Honduras) regimes adopted the policies, as did reformist (Costa Rica and Sandinista Nicaragua) and 'status-quo' (Guatemala and Honduras) regimes. Bossert did however identify several complex 'contingent' relationships among the variables (1983: 426). 'Status-quo' regimes that are threatened with instability have a greater incentive to adopt reforms as an effort to co-opt support and prevent opposition: Without that threat, stable, 'status-quo' regimes (like pre-Sandinista Somoza) had little incentive to adopt such reforms (1983: 436). The other 'status-quo' regime that was unstable - Guatemala - was indeed one of the first in the world to adopt primary health care reforms (1983: 436). Bossert reached similarly complex conclusions about implementation. Weak and unstable regimes (Honduras and Guatemala) showed a lack of centralisation and integration - two important variables for successful implementation, in contrast to the strong and stable regime of Costa Rica. He suggested however that weak, unstable regimes might not design policies that could be effectively implemented because the potential threat that a successful program would pose to political and economic elites. Moreover, when weak states did design primary care policies they were more likely to depend on foreign funding (Guatemala) in contrast to strong states (Costa Rica) that could allocate available resources to rural areas (1983: 436). The lack of clear findings in this study suggests two things: first, the need to move beyond hypothesis-testing in policy analysis in order to capture individual complexity, diversity and detail, and secondly, the importance and relevance of regime characteristics to the low-politics health policy process. For a definition of low-politics policy, see page 37; also Walt, 1994: (42-43).

Other studies focus on one or more of these regime characteristics. Diamond et al (1989) in their study of Latin American regimes, for instance, acknowledge the importance of stability and democracy in analysing the developing state context. They define a stable regime as one that is deeply institutionalised and consolidated, making it likely to enjoy a high level of popular legitimacy. They identify partially-stable regimes as those that are neither fully secure nor in imminent danger of collapse. The institutions under such regimes, according to this view, have acquired some measure of depth, flexibility and value, but not enough to ensure the regime safe passage through severe challenges. Finally, they note that unstable regimes are by definition highly vulnerable to breakdown in periods of acute uncertainty and stress. New regimes, including those that have recently restored democratic governance, tend to fall into this category (Diamond et al, 1989: xviii). In the case of democracy, they argue that regimes have to fulfil three essential conditions to be labelled democratic and legitimate: 1) meaningful and extensive competition among individuals and organised groups (especially political parties) for all effective positions of government power, at regular intervals and excluding the use of force; 2) a highly inclusive level of political participation in the selection of leaders and policies, at least through regular and fair elections, such that no major (adult) social group is excluded; and 3) a level of civil and political liberties - freedom of expression, freedom of the press, freedom to form and join organisations - sufficient to ensure the integrity of political competition and participation. They acknowledge that no one country broadly satisfies these criteria perfectly, and most do so to varying degrees (1988: xvii). All three conditions, then, according to Diamond et al: multi-party competition in a non-violent arena; democratised decision making and participation and full civil and political liberties - are essential to progressive policymaking and implementation. As noted above with the Costa Rican and Guatemalan examples, this is not always the case. Nevertheless, the importance of both regime stability and democracy to progressive policymaking and implementation is underscored in this study.

The relationship between regime power, instability and policy reform is another interesting angle that is addressed by Grindle and Thomas (1989; 1991). They assert that developing state regimes do exert considerable power, through their domination and control of the state apparatus vis à vis other national actors but have very little incentive to instigate reforms. They relate this to the problems posed by persistent political vulnerability and instability:

"...power over the state apparatus does not necessarily ensure the strength of the regime...developing country governments are frequently very vulnerable to challenge...in the absence of established systems and traditions, constitutional or other, reinforced by adherence over time, that regulate political competition and
changes of power, the legitimacy of state actions is always open to dispute. Challenges to the right of regimes to remain in power can emerge easily. The view that coups take place with great regularity in developing countries is probably overblown, but it is based on the record of vulnerability of these regimes...” (1991: 57).

In the case of regime ideology and democracy, most analysts also recognise the complex findings that can emerge. On the one hand, political ideology is intimately associated with reformism and a commitment to progressive policymaking (Bossert, 1983; Goldsworthy, 1988). This reformism refers to “...the general orientation of the regime towards an active governmental role to the benefit of wide segments of society...” (Bossert, 1983: 432). Bossert, for instance, found that ideologically-progressive regimes were more likely than status quo regimes to adopt progressive policies such as primary care and community participation. On the other hand, the relationship was also a complex one. As he admitted, regime ideology, like other regime characteristics did not operate on a single dimension but interacted with other actors and processes in complex ways that needed to be taken into account (1983: 438). Sloan’s findings (1989) in his study of Colombia, Chile, Brazil and Mexico in the case of education and health policies and regime characteristics are as complex as Bossert’s. One the one hand, he noted that the record of democratic regimes such as Colombia in policy areas such as education and health were as poor as the authoritarian Brazil, Chile and Mexico. Costa Rica was the only democratic exception. Additionally, systems of such distributive justice in democratic states varied widely, from high (Costa Rica) to low levels (Colombia). On the other hand, he however found that democratic regime were on balance much better for progressive policy adoption and implementation than authoritarian regimes. The trend towards democracy in Latin America and the policy evidence indicated that democratic regimes had better policy capabilities to achieve a variety of developmental goals, without suffering the high levels of repression of authoritarian states. They could therefore achieve both distributional justice and economic growth (1989: 125-6). He concluded that in terms of the policy capabilities of regime types, the flexibility of democratic regimes was largely positive in shifting priorities and achieving moderate progress towards a variety of developmental goals.

Comment: The studies of Bossert (1983), Diamond et al (1989) and Sloan (1989) all point to the relevance of one or more of the regime characteristics that I focus on in this study. Given the complexities that need further examination and comparison in policy analysis - a point recognised by these studies - we can make two main general conclusions at this stage: first, the importance of regime strength, stability, ideology and democracy; and second, that the relationship between regime characteristics is much more complex, intricate and interlinked than single-level hypotheses can meaningfully reveal. It is therefore worthy of further analysis, if only to explore these intricacies by applying them to other developing states. While these are the four main characteristics that I wish to apply to Caribbean health human resources policy processes, I also want to assess the relevance of regime maintenance as an important sub-category. In the next section, I briefly examine the issue of regime maintenance, which deserves separate examination, even though it is closely linked to all four regime characteristics types, particularly regime democracy.

'Maintenance' or 'survivalism' as a regime characteristic

Regime maintenance or survival is not new to the political sciences literature, although it has been relatively unexplored in the policy literature. It can be broadly defined as the use and allocation of the values and resources of the state by regimes to satisfy the needs of client groups with the goal of remaining in power and retaining state control. Simply put, regime maintenance means the use and allocation of patronage and other values to retain and control power (Ames, 1987). Two of the main proponents of the regime survival thesis in developing state theory are Joel Migdal and Percy Hintzen.

The 'survivalist (strong society-weak state) state' thesis: the Migdal and Hintzen approaches: Migdal (1988) and Hintzen (1989) both advocate the survivalist thesis in relation to certain types of developing states. According to Migdal’s argument, the main reason why some developing states continue to be weak given all the resources and agencies at the disposal of their leaders, is that they face the classic political
dilemma: balancing their need to survive with their promotion and support of the development of complex organisations and state institutions. The choice of political survival at the expense of "...enhancing state capabilities..." thus accounts for failure to implement reform and policy changes (1988: 236). According to this view, weak developing states have historically had a tenuous hold on society. This is compounded by the unhelpful balance between strong societies in these countries (characterised by ethnic, caste, tribe, and religious bonds) on the one hand, and weak states (with leaders willing to do anything to retain power, including using the military). The key issue for Migdal is the impact of pluralism on survival politics, and the impact of survival politics on development policy. Using the examples of racially-plural Guyana and Trinidad, this point is taken up by Hintzen, who also notes that in plural developing states, the pressures on regimes to retain support while satisfying collective social needs can under certain conditions also lead to the practice of the politics of regime survival which can straddle both ends of this spectrum. Hintzen notes in this regard:

"...if it is to ensure its own survival, a regime might find itself with little choice but to allocate resources and to satisfy the accumulative demands of powerful individuals and groups in ways which render the realisation of the collective needs of society highly unlikely. To deal effectively with the consequences of this, a regime might be forced to employ the state for coercion and control, and surveillance to contain the effects of social, political and economic crisis and to prevent destabilising anti-regime mobilisation..." (1989: 166-167).

Hintzen, like Migdal, cautions that he is not denying the emergence and/or existence of leaders in less developed countries who have been, and are genuinely committed to the collective needs of their populations. What he stresses is that many regimes in such plural developing states often have little choice but to support their patron groups to retain power. Depending on how this is carried out, it can affect the wider development process. He thus notes that these regimes:

"...might find themselves with no option but to give way to the demands of powerful interest groups in order to survive for any appreciable period. If they do not they might find their control of the state quite tenuous and marked by endemic political and economic trauma. Thus regime survival can, and usually does, come at the cost of the satisfaction of the collective needs of society..." (1989: 166-167).

The implications for regime survival as an important regime category need to be considered separately, if only to confirm or deny Hintzen’s and Migdal’s assertions about the developing state policy arena. However, one can presume that regime survival must have quite serious effects, and hence relevance to the policy process of developing states polarised by particularly problematic race, caste, and class divisions. In the case of regime type, Bossert’s study hinted at the influence of political survival noting that while both conservative/status quo and radical/reformist regimes were able to adopt primary health care, they did it for different reasons: for radical regimes, it was more for ideological reasons; while for the status-quo regimes, it was for co-opting support and political survival. However the interrelationships between regime survival, on the one hand, and the other characteristics, on the other, cannot be ignored even here. Scarpaci’s study of health policy in Chile (1989), as well as Feinsilver’s (1993) and Navarro’s (1972) studies of Cuba seem to confirm this complexity. They all suggest some linkage between regimes’ survival needs and their allocation of social (in both cases health) policy resources and values regardless of ideology. However even here, regime ideology is muddled with survivalist reasons that encompass both national and international level explanations. Cuba’s adoption of a generally progressive health policy was ideologically-rooted, but was also based on both political and national self-sufficiency and survival in the face of sustained US aggression. Chile’s authoritarian Pinochet regime, with its US-supported conservative agenda, offered a minimum level of medical care for the poor and the working class in order to co-opt them and thus enhance the regime’s legitimacy and survival (see also Sloan, 1989). Even here however, the need to move beyond single-level explanations is clear as Scarpaci’s interesting, but complex findings show. He found for instance that even though both the Pinochet and Castro regimes were ideologically poles apart, there is one influence common to both: they both heavily emphasised access to curative services for all, paying far less attention to preventive
care. In sum then, even the value of regime survival explanations have to be related to the influence of other regime characteristics in any analysis of the politics of developing state policy.

Comment: Given the above, one can conclude that despite complex interrelationships, the following regime characteristics: strength, stability, ideology and democracy and regime survival and maintenance - are not only extremely relevant to developing state policy, but need to be further fleshed out and explored, given the preliminary studies by Bossert, Diamond et al, Sloan, Scarpaci and others. In addition, the issue of regime survival needs further exploration as it relates to policy adoption and implementation. Regime survival; was alluded to in Bossert’s study, but really developed in the political sciences field by Hintzen, Ames and Migdal. These studies confirm the negative implications for policy adoption and implementation of ‘survivalist’ policies in weak, unstable, developing states riven by caste, class, ethnicity and tribal divisions where policies are used as patronage for favoured groups. This is probably no different to developed countries where lobbyists for dominant interests and politicians also engage in patronage and ‘pork-barrel’ politics. However, it seems obvious to assume that patronage and political survival would take on a rather different meaning when transferred to the under-resourced, socially-fragmented post-colonial state policy environment.

Nevertheless, despite no simple relationships in the literature between regime characteristics and policy and policy reform processes, four broad conclusions are evident from this review. The first is that the complexity of the relationship between regime types and policy adoption suggests that policy experiences are as much unique to individual states as broad geographical regions, and must be assessed and compared in this way, as the diversity of the findings within the Latin American region illustrates. The second is that although the relationships remain complex, on balance, progressive policies seem to stand a better chance of getting on the agenda and being implemented under democratic, reformist regimes than status-quo regimes. Third, even though they have little incentive to adopt progressive policy reforms, situations of crisis and threats to survival can trigger policy reforms in status-quo regimes. Finally, the overall conclusion is that regime characteristics do affect how policy processes are played out in the national arena whether resources are available or scarce. My objective in applying the relationship between regime characteristics and policy processes to the Caribbean health human resources development policy process thus supports Bossert’s overall conclusion of the usefulness for both policy analysts and policymakers:

"At the very least this study suggests that advocates of policy changes take into account regime characteristics when they design strategies for the adoption and implementation of preferred policies..." (Bossert, 1983: 438).

In the next two sections, I justify my focus on regime characteristics by examining both the strengths and weaknesses of development theories as well as policy approaches, and assessing the theoretical ways forward in both instances for comparative policy analysis. I begin with the theories of development by examining firstly the development theory impasse and the usefulness of Giddens’ concept of structuration to developing state policy analysis.

### 2.3 THE DEVELOPMENT IMPASSE AND STRUCTURATION

Developing state policy processes are implicitly concerned about progressive development. The main debates in the ‘development’ field thus need to be briefly examined to assess the implications for policymaking. I begin this section by defining development. I then examine the relevance of the key debates between agency and structure that are at the heart of developing country policy analysis. This is followed by an assessment of the possible contribution to this debate offered by Giddens’ structuration thesis as the bridge between actor-and structure-based analyses in explaining developing state policy.
Defining ‘development’

The most common definition of development, as applied to the post-colonial state encompasses the notion of ‘progressive change’ at all levels - political, social and economic. The concept has its origins in the establishment of capitalist society where it was assumed to be the natural state of affairs in Eurocentric enlightenment thought. The only question that was asked was “...how far and how fast...” until, at least, the post-war period when the emergence of the rapidly decolonising ‘third world’ presented new dilemmas for the newly emerging ‘international community’ (Hadjor, 1993: 98). In general though, the definition of development as ‘the process of being developed’ as it relates to the progressive social, political and economic advancement of people and societies in developing states is the one used in this study. This interpretation needs to be placed into the context of the two dominant strands of post-war, post-colonial development thought: modernisation and dependency which are extremely relevant to developing state comparative policy analysis as we shall see.

The modernisation and dependency approaches to development

Two broad sets of approaches to ‘third world’ development have dominated the post-war debate: the modernisation (or neo-evolutionary, stages of growth) approaches, and the neo-Marxian ‘dependency’ approaches. The emergence of both approaches during this period was at a time when most of the former territories of the colonising European powers gained their independence, with questions being asked from both sides of the ideological divide about the ‘development’ prospects of these states. The modernisation approach was essentially the conservative prescription for development, while the dependency approach, a variant of Marxism, was articulated by the Latin American ‘left’, but represented the concerns of many within these newly-emerging states. We begin with the modernisation approach.

Modernisation: The ‘modernisation’ view, popularised by Rostow and Myrdal among others, was primarily concerned with economic growth, seeing ‘development’ as an evolutionary process with Western states at the apex of modernity. It borrowed heavily from social theories, particularly Weber’s ‘protestant ethic’, as well as Parson’s structural-functionalism, in underlining the imperative of the compatibility and interrelationship between economic, social, political and cultural structures to explain why development was not occurring in post-colonial states (Rostow, 1960; Myrdal et al, 1968; Hoogvelt, 1978: 186)1. Prior to the two world wars, ‘development’ was thought unable to happen in ‘backward’ colonial societies. However, after 1945, these opinions could no longer be sustained as newly independent third world countries were themselves increasingly exploring various economic development strategies (Hadjor, 1993: 100). Western ‘modernising’ theorists saw development as primarily economic growth occurring in progressive stages with strategies and societal constructs that modelled the Western approach. Development was therefore equated with progressive industrial capitalism. Essentially, the argument went that former colonies lagged behind because of ‘backward’ peoples, traditions and values - factors that were not conducive to development. Developing countries could however ‘evolve’ and ‘develop’ as long as ‘modern’, Western liberal-democratic cultural values, along with technology, expertise and capital were diffused into their societies on a sustained basis with the active participation of local Western-educated elites. The ‘modernisationists’ argued that the movement towards devolution of powers away from authoritarianism to highly specialised bureaucracies and government agencies was critical to development. This factor, together with changes in social conditions through communications and education would generate a complexity in developing state political systems that would be able to satisfy, in the long run, as many different political interests as possible and in doing so further the development process (Robertson, 1985: 213). In essence then, the modernisation argument stressed that incremental change, characterised by ‘modern’ western, liberal-democratic values was the only way forward for these new states, that would satisfy both the drive for democracy after colonial rule, while simultaneously promoting ‘modern’ development.

1 For a comprehensive literature review of both approaches, see Hoogvelt, 1978, and 1982.


Dependency: The main approach to the criticism of this hitherto generally-accepted development strategy in post-colonial societies came in the 1960s from the Latin American neo-Marxian/dependency school. Like classic Marxism, these theorists criticised the modernisation concept for its total ignorance of the role and influence of national and international class and power relations, particularly the role and influence of imperialism and ‘dependent’ development. Far from being a natural state of affairs that would eventually happen to other states who rigidly followed it, Gunder Frank and others argued that Western economic growth and development was the outcome of a progressive system, not of development, but of power domination and exploitation of the peripheral regions by the core, rapidly industrialising countries. They essentially saw, then, development and underdevelopment as opposite ideas of the same process: development in one region was occurring at the expense of underdevelopment in another (Harrison, 1988: 150). In order to escape such perpetual underdevelopment, according to this perspective third world countries, accordingly had to become socialist and then either ‘go it alone’ or develop links with other socialist countries (Harrison, 1988: 151).

The main failure of both approaches was that neither could claim to explain the totality of ‘third world’ experiences in the post-war period, since they essentially ignored each others main tenets. For instance, the modernizationists, on the one hand, ignored the international web of power relationships exemplified by the ‘core-periphery’ nature of dependent capitalism, and with it, the pervasiveness of historical/colonial factors. The dependency theorists, on the other, ignored the persistence of capitalism, the problems with existing socialist models, and most importantly perhaps, in the case of policy processes in post-colonial states, the capacity for self-willed action - both good and bad - by developing state regimes, and political actors within these societies. In addition, dependency theorists could not explain the evident growth and rapid development of the South-East Asian former colonies. These problems with both approaches led to an impasse in the development debate, and was further heightened by the continued economic failures throughout the third world apart from the few South East Asian cases after the 1960s (Booth, 1994; Harrison, 1988; Manzo, 1991). This impasse led to a renewed interest in the role of actors and processes at the national and sub-national levels as possible clues to explaining both the occurrence of development and underdevelopment. These criticisms, acknowledged in the post-impasse debates of the 1980s, were first, an exclusive focus on the ‘third world’ to the exclusion of the cyclical, changing nature of external (international) factors and their influences. The second main critique was the ignorance of societally-specific historical processes as well as ‘ad-hoc’, unplanned events and an excessive focus on the national and international levels to the exclusion of the local or sub-national issues (Buttel and Mc Michael, 1994: 48; Booth, 1994: 7-8). The outcome of these failures was encapsulated, thirdly, in the excessive tendency to generalise about or across the ‘third world’ in the search for ‘universal’ theoretical explanations about the development process. As Buttel and Mc Michael warned:

"...the empirical realities of state-economy relations are distinct across time and space; developmental theory that collapses these distinctions in striving for universal validity across the Third World is...inconsistent with these realities..." (Buttel and Mc Michael, 1994: 48).

The contribution of 'structuration' theory to the agency/structure impasse

One of the main contributions to a possible solution to the ‘actor-structure’ impasse, albeit at a general political-sociological level, is Anthony Giddens’ structuration thesis. Although the ‘agency-structure’ critiques in development studies really started in the early to mid-1980s, its origins in political sociology can be traced to the 1970s in Giddens’ development and popularisation of ‘structurationist’ theory. Unsatisfied with the polarised interpretative writings of Weber and Durkheim on the one hand and the deterministic and equally polarised Marxist studies on the other, he proposed structuration theory as an inclusive approach, set against the separate “empire-building endeavours” of the pluralists and structuralists/elitists respectively (Giddens, 1977: 2). Structuration theory, as proposed by Giddens,

2 For an excellent critical summary of Giddens’ development of structuration theory, see Cloke et al (1991)
sought to recognise the importance of both agency and structure. This realist or dualist approach, incorporated the essential strengths of both perspectives: first, the important recognition of human beings as capable actors, and not as "...cultural dupes of structural determinism..." while simultaneously recognising, secondly, the equal importance of structural/societal factors such as power struggles within organisations and its influences on interest group articulation (Cloke, et al, 1991: 95; Giddens, 1977: 2).

After criticisms from both humanists and structuralists, two other interesting ideas were incorporated into structuration theory which are also useful to policy analysis and policymaking. The first was the 'time-space' factor within which social life takes place, and an important issue in policy analysis (Hoogerwerf, 1990). Secondly was the 'core-periphery' concept of actors and processes. This is the view that 'core' actors have established their power and control over resources, while, as the name implies, 'peripheral' actors are outside of this power structure. Another useful concept for policymaking and policy analysis in structuration theory is 'regionalisation', or 'zoning'. For example, in its application to human geography, main city districts could be described as 'front zones', at the front-line of developments, and the centre of attention (Cloke et al, 1991: 114-115). These front zones, according to Giddens' thesis, operate on a different level of interaction with specific rules and resources. This is contrasted to those 'back zones' for example neglected, decaying docklands and inner cities which are usually unsightly, underdeveloped, with little or no resources for regeneration. There is room in Giddens' formulation however for movement from one 'zone' to the other on the 'time-change-space' continuum (Cloke et al, 114-115).

The relevance of 'structuration' to policymaking

Given the issues raised earlier about the role and importance of political versus economic factors, as well as the impasse in development theory in the 1980s and 1990s, structuration has much to offer post-colonial state policy analysis. The parallels and relevance to policy analysis are clear. It raises issues about policy timing, power relations of actors within states as well as states themselves, the nature of the policy context and perhaps its greatest contribution, the absolute necessity to relate and recognise actors to their inhibiting or facilitating structures, for more meaningful and accurate interpretations. Structuration also has much resonance in existing social theories of power such as Alford's structuralist 'dominant', 'challenging' and 'repressed' policy actor categories used in his analysis of the dominance of the medical profession and the medical model (Cloke, 1991: 109-115; Alford, 1969; 1975). At the international actor level, this 'core-periphery' analysis can also be applied to explain the dominance of developed states and para-statal institutions and their level of influence in post-colonial state' development and underdevelopment processes. It is an analytic model that also therefore has much in common with the 'core-periphery' idea at the heart of the dependency approach to development.

Finally, both Giddens' regionalisation and time-space explanations have quite a lot of resonance in recent comparative policy analyses in developing states, particularly Grindle and Thomas' study (1991) of the role and influence of policy elites in explaining policy reform. According to Grindle and Thomas, the influence of power (and who holds it) is as critical to agenda-setting and eventual implementation as resource availability. Therefore, policy areas - such as economic policy - where the stakes are higher and more resources are involved, will naturally command more attention from both bureaucratic and political elites, than those, such as health and education policy where much less stakes - power and resources - are involved. Additionally, Giddens' idea of the possibility of one policy moving from the 'back zone' to the 'front zone' at both the agenda-setting and implementation levels, sometimes against great odds also enhances its relevance to policy analysis. On the issue of the time-space policy continuum, regimes and leaders are as much subject to changing circumstances (the loss of elections, death, new external constraints) as the subjective environments in which they operate. To ignore the time-change factor in policy therefore is to ignore the 'dynamic' element that characterises and defines policy, a fact recognised by Grindle and Thomas, (1989: 231) among others.

Comment: The main reason for the development theory impasse was largely a failure to balance grand theorising with the consideration of other deeper and ultimately more meaningful levels of explanations, hence the value of approaches such as structuration. The relevance of structuration to my case study of the politics of the Caribbean health policy process is that I wanted to find such a balance by focusing on
the important, but under-explained politics issue without ignoring the important structural, contextual issues. The strong interrelationship between actor and structure as underscored by Giddens' study means that both must be recognised and accommodated in comparative policy analysis. The development impasse testifies to this. My concern was that the focus has been heavily skewed - for justifiable reasons - on the militating national economic as well as external and international political and economic factors, to the detriment of other explanations, particularly the role of national politics. Giddens thesis thus offers for the developing country policy analyst, the chance to make interpretations that are cognisant of both levels while not detracting from particular focus or interest in either one or the other meso- or macro-levels of analysis.

My main focus in this study is on the role and influence of national regime actors on post-colonial state policy, within specific structural contexts and within a specific time period, characterised by much change. In adopting an integrative, structurationist approach to frame my study, I hope to partially redress the current imbalance by recognising the capacity for action by at least one dominant national actor: the regime. In doing so however, I also hope to show that explanations for developing state policy action must ultimately be sought from both levels: in this case, the national actor-based variables such as the behaviours and characteristics of governing regimes, as well as the prevailing structural influences that can potentially retard or promote development policy. In the next section, I further underline the case for regime characteristics analysis using an integrated, structurationist approach by showing how the need for some level of commensurability across paradigms, as seen in the development debate, also needs to be applied to the various policy analysis perspectives, particularly in their applicability to developing state policy environments.

2.4 STATE AND SOCIETY-BASED APPROACHES TO POLICY ANALYSIS

In this section, I examine the two broad approaches to policy analysis: the state- and society-based approaches - in order to assess their respective merits to analysing the relationship between regime characteristics and policy processes in developing states. I begin by examining the relevance of the state-based approaches to my study.

State-based’ approaches to policy analysis

The main state-based approaches are the rational actor-; the bounded rationality-; the bureaucratic politics- and the state interests approaches.

First, the rational actor approach focuses on the innate rationality of state policy actors making rational policy choices for the whole of society. After assessing various courses of action based on accumulated information, the rational actor chooses the best option based on his 'rational' preferences and prospective societal benefits (Walt, 1994: 4; Grindle and Thomas, 1989: 219). The main problem with this approach is that neither optimal information nor fortuitous timing are always available in the real world, a fact applicable to both developed and developing states. Neither is there such a thing as a value-free or non-contextually-determined decision (Grindle and Thomas, 1989: 220; Walt, 1994: 46-48). The 'bounded rationality/satisficing/incrementalist' approach is, by contrast, a much more realistic approach to explaining how decisions are generally made in both developed and developing states. Originating from March and Simon's (1958) notion that organisations and institutions operate on the basis of 'bounded' or 'limited' rationality, the argument is essentially that:

"...because of the complexity of perfectly rational choice and its cost in terms of time and attention, decision-makers (whether individuals or organisations) do not usually attempt to achieve optimal solutions to problems, but find ones that satisfy their basic criteria for an acceptable alternative or ones that meet satisfactory standards..." (Grindle and Thomas, 1989: 220).
In terms of applications to developing country political environments, the *middle approach* of the bounded rationalists is more realistic for both analysts and policymakers alike, than the ‘wish-list’ nature of rational decisionmaking (Allison, 1971; Killick, 1976). As Walt notes:

"...the point is that one model is really an ideal model of policy making (how it ought to be made and the other is describing what actually happens in the policy process (how policy is made). Both have validity, one as a normative prescriptive model, the other as an explanatory or descriptive model... " (1994: 51).

The *bureaucratic politics approach* focuses exclusively on the relationship between different groups of bureaucratic actors within the state system and their relative influences over policy goals and outcomes. This approach credits bureaucrats with much power in the way they use their positions, expertise, knowledge and resources to influence policy choices in their favour. The best example of the conflicting roles of different divisional bureaucracies for policy, albeit in a crisis situation, is Allison’s account (1971) of the evolution of American foreign policy during the Cuban missile crisis. The advantage of this model is that it offers insights into the workings of the different arms of the state bureaucracy, which not only implements but helps shape the technical features of policy. This may well be influenced by any number of factors prevailing in the bureaucratic context. The main problem with this approach is that again it sidelines, if not ignores, the importance of societal factors as important influences on policy choice that are arguably more important than the micro-decisionmaking process within small developing state bureaucracies. As Grindle and Thomas note, it was primarily developed by Allison to explain a foreign policy crisis situation, but in the more drawn-out, ‘politics-as-usual’ arenas where long-standing problems of policy reform have been extensive and prolonged, it offers little insight by its singular ignorance of the societal factors that are also usually responsible (Grindle and Thomas: 30). More importantly, its method was devised specifically for the bureaucratic/organisational study of a developed country’s internal crisis-driven policy making process. This approach can however be a potentially useful pointer to regime behaviour and characteristics. Although important, powerful policy actors within developing states, bureaucracies have remained, until recently relatively unreformed, ineffective relics of colonialism which politicians have either used or sidelined according to their needs at the time. However, its overall use as noted above in the small Caribbean post-colonial state context, though insightful, would be limited given both the size factor, as well as generally different political ‘assumptive worlds’ of the developing state policy environment.

Finally, the *state interests approach* posits that the state (and its policy elites) is an autonomous actor that is capable of recognising and defining problems and developing appropriate policies to remedy these situations. Among the interests of the state, according to this approach, are the achievement and maintenance of its own hegemony *vis à vis* other societal actors, the maintenance of social stability, the pursuit of national development as defined by policy elites representing particular regimes and the particular interests of regime incumbents in retaining power (Grindle and Thomas, 1991: 30-31; Stepan, 1985; Nordlinger, 1987; Skocpol, 1985; Migdal, 1988). The importance of this ‘state autonomy’ approach to understanding policy choice is that state actions may lead to policies that may not necessarily please powerful elites and other societal groups. The main problem with this approach is that the state’s capacity to act autonomously can be constrained by factors such as timing, circumstances and, arguably more important, party politics including regime characteristics and behaviour (Migdal, 1988, Skocpol, 1985). Nevertheless, this approach does offer the possibility of self-willed state action which has much relevance to the core of my thesis.

*Comment:* State-based approaches are very useful in underscoring the fact that policies are actually made daily in developing states, despite considerable economic and other constraints and limitations. However these approaches negate questions of *power* and *political motivations* of policy elites when they make or try to influence policy. The fact that influential policy actors including politicians, bureaucrats, and special interests can either directly manipulate outcomes by exercising various levels of power is not discussed or considered. Equally we cannot ignore the fact that motivations can be both positive as well as negative. Bounded rationality and the state interests approaches do offer, on the one hand, a sound view -essentially rational - of policy making through examination of both the micro- and macro- levels of
policy. We need however to balance these approaches by incorporating the role of power and power-based motivations in the process if we want to have a realistic, balanced explanation of policy successes and failures and general experiences in the developing state. We now turn therefore to examine the other broad perspectives that places power at the centre of their analysis: the ‘society-centred’ approaches.

Society-based approaches

Society-based or power-centred approaches largely comprise the pluralist- and the elitist- or neo-Marxian perspectives.

The pluralist/public-interest/incrementalist approach has linkages to early development (modernisation) theory and is different from other society-based approaches in that while recognising the influence of power on decisions, it sees this power as divided equally among the various interests in society. Lindblom, its main proponent argued that developed countries like the United States comprise interest groups that were equally able to defend their interests through a process of ‘muddling through’ incrementally within such ‘plural’ societies (1959). The motivation element, at least according to Lindblom’s early pluralist theory, was the common good, with no interests entirely ignored. The pluralist then, according to this view, sees public policy outcomes in such societies as more or less equitable outcomes arising out of a process of conflict, bargaining and coalition formation or ‘partisan mutual adjustment’ among a potentially large number of societal groups (Grindle and Thomas, 1991: 23). These groupings may be based on regions, ethnic groups, religion or shared values (including ideology) among other issues. The state is thus a neutral arbiter for the competing interests. This process is called bounded pluralism as no one elite dominates decisions and different groups compete and policy outcomes are in the public interest (Walt, 1994: 4). Through partisan mutual adjustment, issues are resolved, while the system of dispersed power enabled more values to be protected than a system of centralised co-ordination.

The elitist/neo-Marxian response:

Elitists such as Etzioni (1967: 387) and Harrison et al (1990) challenged the ignorance of the power/dominance question within this perspective, arguing that 1) partisan mutual adjustment favoured the well-organised partisans and worked against the underprivileged in society; 2) that it was not necessarily mutual; 3) that incrementalism neglected the issue of innovation and the fundamental questions which bring about change; and 4) that incrementalism was also present in totalitarian societies. Lindblom (1977: 346) later acknowledged the power issue recognising that partisan mutual adjustment was biased in favour of certain groups, such as big corporations. As Ham and Hill point out however, in resisting the idea of central planning, and opting instead for “greatly improved strategic policy making”, both analytical and interactive, Lindblom virtually concedes the inequality of power distribution among partisans in developed society policy arenas (Ham & Hill, 1993: 96).

The main response to pluralism came from the neo-Marxist elitist school. The Mills/Dahl ‘elite domination’ school, whose chief proponents are C. Wright-Mills and Robert Dahl criticised the pluralists, noting that far from being a neutral arbiter, liberal democratic states such as the USA were governed by a ‘power elite’ comprising big, business, the military and state institutional interests. As Dahl put it in his famous ‘who gets what and how’ thesis: “A has power over B to the extent that he can get B to do something that B would not otherwise do” (1957: 203). Dahl’ was in turn criticised by the chief advocates of the ‘the non-decisional’ approach, Bachrach and Baratz.

The main point of the Bachrach/Baratz ‘non-decision-making’ school was that non-decisions were also effectively decisions. They argued that power does not simply involve examining key decisions and actual behaviour: “...power is also exercised when A devotes his energies to creating or reinforcing social and political and institutional practices that limit the scope of the political process to public consideration of only those issues which are comparatively innocuous to A...” (1962: 948). As Ham and Hill note, this approach encompasses the notion of mobilisation of bias: “a process which confines decision-making to safe issues” as well as Easton’s idea of “...gatekeepers who regulate the flow of demands in the political arena...” though these gate-keepers are more concerned with system preservation and political stability.
(Ham & Hill, 1993: 67-68; Easton, 1953; 1965). It raises also the idea of the two faces of power argument: one ‘face’ operating at the level of overt conflicts over key issues, the other operating through a process of ‘nondecision-making’ to suppress conflicts and prevent them from entering the political process (1993: 67-68). They also points to the need to explain how and why political systems can themselves 'control inputs into the system, rather than inputs determining political action (1993: 42). The nondecision-making argument is essentially that demand regulation is not neutral but “...operates to the advantage of the powerful and against the less powerful”, with power being less plural than Dahl and the pluralists maintain (Ham and Hill, 1993: 68).

In response to the pluralist critique that nondecision-making was unresearchable, Bachrach and Baratz (1970: 44) stated that nondecisions lay in researching “...covert grievances and the existence of conflicts that do not enter the political arena...”. According to them, if no grievances are uncovered, then nondecision-making has not occurred. One of the more widely cited studies of nondecision-making is Crenson’s comparative analysis of air pollution policy in two American cities: Gary, Indiana and East Chicago, Indiana. Crenson found that while East Chicago had passed a law controlling pollution in 1949, Gary did not act until 1962, largely because of the domination and power of a single US company US Steel in the latter. Despite its obvious advantages in explaining non-decision-making power in liberal democracies, this approach also had its non-pluralist critiques, the main one being Lukes.

The Lukes ‘third dimension of power’ school took the non decisionmaking power argument a stage further by advocating the idea of 'latent conflict', which occurred when “...A exercises power over B, when A affects B in a manner contrary to B’s interests...” (1974: 27). Lukes contribution to the debate was that the presence of consensus did not rule out the “...possibility of false or manipulated consensus by definitional fiat...” (Lukes, 1974: 24) Thus, Bachrach and Baratz’s thesis on non decision-making was deemed inadequate because it did not address the possibility that power could be used to prevent even covert conflict and potential issues emerging on the agenda. Clegg extended this third dimension thesis by focusing on the diffusion of values. He argued that power could also be expressed in “...the prevailing set of values...[and]...works systematically through its expression in the organisation, to the advantage of some individuals or groups, rather than others...” (1981:136). In the case of health policy, this view has some resonance in Alford’s study of the dominant, challenging and repressed categories in the health sector (Ham, 1985; Alford, 1975). The main difference between the ‘third dimension’ and the ‘two faces’ approaches to power therefore lies in assertion of the former that power can be used to manipulate peoples’ interests and preferences.

Comment: Issues of power and its various manifestations, as noted in the above neo-Marxian elitist models are particularly important for policy analysis of both developing and developed states (Walt, 59-60; Leichter, 1979: 7). Leichter suggests that public policies and policy decisions are for the most part merely statements of governmental intent. He notes that the fact that actors have proclaimed their desire to do something does not guarantee that any steps will actually be taken in that particular policy direction. He also adds that policy impact is often complicated by the fact that the consequences of a policy may be intended as well as unintended. Unintended outputs may be both positive and negative and might even create political instability. Walt’s broad definition of policy similarly incorporates these ideas of ‘intent’ and ‘inaction’ noting that policy can be seen as “...a series of more or less related activities and their intended and unintended consequences for those concerned...” (1995: 40-41). As she noted, this can be refined, in the case of government policy to incorporate all levels and combinations of action: from intended-, to actual- and ‘ad-hoc’ actions, as well as inaction. In terms of inaction as policy, one often-cited example is American health care policy, where until the 1960s, when stronger demands for the reduction of inequalities were placed on the mainstream public agenda, US health policy was “...defined largely by an absence of interference with private enterprise in stimulating and meeting a growing demand for health care...” (Heidenheimer et al, 1990:5; Walt, 1994: 41). In such a scenario, according to this view, the issues raised by Bachrach and Baratz, Lukes and others dominate the policy agenda. As Heidenheimer et al see it:

“...government inaction, or non-decision becomes a policy when it is pursued over time in a fairly consistent way against pressures to the contrary...it is never easy to
say just when passivity begins to assume the characteristics of a public policy, but the growth of controversy is one good clue...what matters for purposes of identifying “policy in repose” is that the issue be perceived by at least some major participants as being on the political agenda. At that point it becomes possible to compare meaningfully one government’s ‘hands-on’ approach to another’s ‘hands off’ approach to the same issue...” (Heidenheimer et al, 1990: 5).

The negative outcomes in the early 1990s of President Clinton’s proposed health reforms, despite following on the heels of his popular re-election, given the power of his main opponents - the medical, pharmaceutical and health insurance lobbies - bears testament to the role of power-induced inaction as policy. This is by no means confined to developed states. Although the context is considerably different, the power of the medical lobby in developing countries to influence action and inaction must be factored into any policy analysis.

Another society-based perspective is the ‘new right/public choice/private interest’ approach. It takes the ‘agency/capacity for action’ argument to its extreme in advocating ever more shrinkage of the state from society. It sees society composed of organised groups and interests. However, unlike the pluralist approach, it sees the state as one of these self-interested ‘rent-seeking’ actors; not as a neutral arbiter. According to this view, the state competes alongside private interest actors, forging alliances and making decisions which may or may not necessarily be in the public interest (Walt, 1994: 4; Grindle and Thomas, 1991: 24-26). There is, accordingly, a mutually-rewarding, power-based relationship in this self-interested state. Interest groups use money, expertise, political connections, votes and other resources to extract benefits from governments. Elected officials and governments are fundamentally concerned with maintaining power and are rewarded from their patrons in various ways, the most obvious being political and financial support (Ames, 1987: Grindle and Thomas, 1991: 24). This complementary and mutually-rewarding relationship, according to Grindle and Thomas, answers the question of “…why reasonable men [sometimes] adopt public policies that have harmful consequences for the societies they govern...” (Grindle and Thomas: 24; Bates, 1981: 3).

The strength of this approach is that it explains why policies in the public interest are not always implemented. It thus acknowledges the influence of corruption, “…the importance of the power-seeking motivation of decision-makers...” and their regime maintenance instincts (Grindle and Thomas, 1991: 26). The main criticism of this model is its profoundly negative, right-wing and cynical view of politics that does not allow public officials some level of independent judgement that rises beyond personal and professional interests and does not countenance the existence of public officials “…who may adopt goals that transcend the interests of many particular group...” Grindle and Thomas (1989: 245). Toye similarly agrees that: “…to attribute individual self-interest as their exclusive motive to politicians in developing countries is to deny their sincerity, their merit and, ultimately, their legitimate right to govern...” (1993: 135-136). In addition, as Grindle and Thomas have noted, public choice approaches reveal little about how such motivations are developed or changed over time (1989: 245). Both positions are valid. The fact that there are many honest elected officials throughout the developed and developing world striving to improve the lives of people through their roles as public policymakers, does not invalidate the equally relevant fact that many elected officials in both types of states also act in their own interests, and oftentimes, to the detriment of national development. Similarly, the idea that the private sector is universally bad and the public sector good, is much too simplistic, hence the need for developing state public policy analysts, in particular, to approach policy development in a balanced way.

Comment: Three broad themes emerge from this review of the state-and society-based approaches, which, although formulated for developed states, have much to contribute to the analysis of developing state policy arenas and experiences. The first is that there is no such thing as a rational, value free decision. Most policymakers use a ‘bounded rational’ approach to decide upon what they consider the best use for the best of available resources, given available knowledge. The second theme is the role and influence of power within any power and its relatively unequal distribution among actors. In this regard, the contributions of the elitist school in the contribution of Mills and Dahl are very important. Similarly, the importance of nondecision making highlighted by Bachrach and Baratz, and its further development
by Lukes and others make this a pertinent policy issue worthy of investigation for the developing country policy analyst. Finally, what emerged, particularly from the society-based approaches is role of the self-interested actor, be it the state or regime, the bureaucracy, professional and other interests, and possible implications for policymaking: another issue of concern in developing states. This is very often negated or ignored in development policy dialogues. In sum then, the societal-based approaches, through their focus on the power issue, are extremely relevant to developing state policymaking, although the state-based approaches also have explanatory value.

A realistic understanding of the policy process should recognise that developing as well as developed country politicians and policy elites are at least as interested in surviving politically - maintaining their jobs, power and influence - as they are in developing progressive policies for their societies. However, there is the equal need to recognise that this balance for developing states is heavily dependent on contextual factors, the main one usually being resource scarcity. Finding out how far agency and structure each influence developing state policy processes thus depends on deeper comparative examinations of the national level. These approaches illuminate the various strengths and weaknesses of approaches to policy analyses. As Ham and Hill and others have emphasised however, these strengths and weaknesses make it imperative to "...draw on ideas from a number of academic disciplines, particularly political science and sociology..." (1993: 11). In striving for an integrative approach, we need therefore to consider issues such as development country regime and non-action, as well as the role of regime characteristics within specific national policy contexts. Only by doing so can we cover both the macro-level big picture (such as historical and structural factors) and the micro-level close-up shots referred to by Etzioni (1967). These issues are further explored in the next section where I assess the policy process itself.

2.5 ANALYSING THE POLICY PROCESS IN THE DEVELOPING STATE

In this section, I first examine the various definitions of policy. This is followed by a critically examination of Easton’s political systems analysis model.

**Defining policy and policy reform**

Policy and policy reform are essentially about the power and processes involved in making choices and/or changing decisions, within specific contexts (Walt, 1994: 1). The term ‘policy’ originates from the Greek term ‘politeia’ meaning government or citizenship (Scruton, 1982: 358). Most formal definitions of policy incorporate a ‘dynamic’, power-based, multi-decisional element. According to Scruton, policy can be defined as "...the general principles which guide the making of laws, administration and executive acts of government in domestic and international affairs..." (Scruton, 1982: 358). Hall and Kleckowski similarly define it as a statement of intent or direction that provides institutions and individuals with guidelines for action (1978: 301). Anderson describes a policy decision as a single binding act by an authoritative entity "...that authorises or gives direction and content to public policy actions..." (1975: 3). However, the multi-actor, multi-decisional nature of policy is key, as he also states that it is "...a purposive course of action followed by an actor or set of actors with a problem or matter of concern..." (Anderson, 1975: 3). Easton suggests that a policy "consists of a web of decisions and actions that allocate values..." (1953: 130). Jenkins similarly posits that policy is "a set of interrelated decisions...concerning the selection of goals and the means of achieving them within a specified situation” (1978: 15). Given these definitions, it can be deduced that policy is also about power and the motivations, incentives and power-related contexts that influence can influence a variety of policy actions and responses. Scruton defines power as "...the ability to achieve whatever effect is desired, whether or not in the face of opposition..." (1982: 366). He goes on:

"...power is a matter of degree; it can be conferred, delegated, shared and limited. The power of a charismatic leader may be based in consent, while that of a tyrant usually is not...power may be exercised through influence or through control...because power (unlike authority, legitimacy and right) is an indisputable fact, as such, because it seldom exists without also being exercised...there have
arisen various power theories of politics, which see power as the substance, of which politics is the form... “ (1982: 366).

Scruton’s definition conveys the indisputable and substantive characteristics of power as well as the various levels to which it can be exercised. It does not however explain power motivations or covert power. One of the key questions in addressing policy making in developing countries is the extent to which power relations in these societies differ from developed country variants. Much of policy theory acknowledges actors’ motivations (Jenkins, 1993) or assumptive worlds (Ham, 1982; 1985). Jenkins notes that the way to explain and analyse the relationship between policy processes and outcomes is to:

“...establish some conceptual grasp of motivation and behaviour. Without such a grasp, responses to policy can be neither understood or anticipated. To assume individuals or organisational elites behave rationally (perhaps the most elementary behavioural model) is often an oversimplification. An understanding of behaviour and motivation is central to an understanding of policy outcomes and impact...” (1978: 42).

In addition to power, motivation, dynamic processes and any number of actors, policy is also about timing and contextual relevance. Indeed ‘process’ implies a time-space continuum. In the case of time, Anderson states that “...policy making typically involves a pattern of action extending over time and involving many decisions...” (1975: 10). Minogue adds that:

“...the policy analyst...cannot ignore the overall policy process which is created by the interaction of decisions, policy networks, organisations, actors and events. Nor can he avoid the broader environment within which the public policy process is located; that is, he must pay due regard to the interaction of society and economy, in the effort to understand the political consequences of this interaction...” (1993: 11).

Policy is also about non-decisions as we have noted in the previous section. Heclo states that “...a policy may usefully be considered as a course of action or inaction rather than specific decisions or actions...” (1972: 84). Finally, on the issue of reform, the concept of reform itself implies a change from the status-quo, which essentially is at that heart of all policymaking.

Comment: Policies can range from a written statement of intent to legislative material. It can also be gleaned from action, words and deeds as much as non-action and limited action. It can involve one decision taken by a single actor, or a series of decisions taken by a number of actors, or any other permutation of actors and decisions thereof. It also involves a specific time element, and related to this a dynamism that are part of both policy and context. Finally, policy encompasses dynamic networks of political, socio-cultural, economic action and interaction at various levels: sub-national, organisational, national, international, and regional. The above definitions are about policy, but equally apply to power and process in policy reform processes. This applies to both developed and developing states. Policy reform is conditioned by the power of actors, their motivations in exerting such power. It is also influenced by the content of the prospective reforms as well as the wider policy context that influences any policy action. My study focuses on this power and motivation in relation to national political actors within the Caribbean post-colonial state - as reflected in their ‘regime’ characteristics: regime strength, stability, ideology, democracy and regime survival or maintenance. Having assessed both the state- and societal theoretical approaches to analysis, as well as the above definitions of policy, we need to see how a hypothetical policy system works. This will be examined in the next section.
The Easton model

One of the best hypothetical models of policy is Easton's systems model. In this section, I first examine and critique this model, after which I explore some more realistic approaches that address the issue of regime characteristics - as manifested in power and motivations - that is at the heart of this study.

Easton's systems model outlines, in a biological/organic way, the consensual character and functions of the policy making system (1953, 1965). Political activity is explained as a biological system containing a number of processes, based on the 'authoritative allocation of values' for society. Like a biological organism, the political 'system' must remain in balance if it is to survive. The three key processes that need to be balanced are 1) **inputs**; 2) the 'black box' of government decision making; and 3) **outputs**. Inputs are the demands, support and resources. Demands involve actions by individual and groups seeking allocation of those resources from the authorities. Support includes, inter alia, voting and obedience to the law (Walt, 1994: 16). Resources enable the governments to satisfy the demands being made on the system. These feed into the 'black box' of decision-making or 'conversion process' and produces outputs, namely the decisions and policies of the authorities. Outputs, according to this approach, are distinguished from outcomes which are the effects on citizens (Ham and Hill, 1993: 15).

While an easily understood model of the main elements of policy, the main problems with the Easton model are: 1) its almost exclusive focus on the value-free 'neutrality' and consensus of government activity rather than power conflicts and even manipulation of policy; and 2) its static nature which does not contemplate content or contextual-related policy changes. First, in the case of power, Ham and Hill warn of need to recognise that:

"...policies may be intended to improve social conditions, but this should be part of the object of enquiry, rather than the assumption of research...through the manipulation of language and the creation of crisis, the authorities may impose their own definitions of problems and help to frame the political agenda" (1993: 15).

This point is particularly pertinent in the typical developing state policy environment where the political system is relatively underdeveloped in terms of active participation by interests groups at all levels of society. In such an environment, the agenda can be easily controlled and manipulated by dominant political actors, such as regimes, and their supporting elites. In relation to the time factor, they note that:

"Yesterday's statements of intent may not be the same as today's, either because of incremental change adjustments to earlier decisions or because of major changes in direction...this is not to say that policies are always changing, but simply that the policy process is dynamic rather than static and that we need to be aware of the shifting definition of issues..." (1993: 12).

The timing factor, in addition to supporting Giddens' argument of its inherent importance, also incorporates Hogwood and Gunn (1984) and Hogwood and Peters (1983) idea of much of policymaking being essentially concerned with policy termination or policy succession. Finally, Ham and Hill's critique of the systems model, as reinforced by Bachrach and Baratz, Lukes and others, like Heclo (1972) also recognises the importance of 'non-decisions' or 'inaction':

"the concept of non decision-making has become increasingly important in recent years, and it has been argued that much political activity is concerned with maintaining the status quo and resisting challenges to the existing allocation of values..." (1993: 12).
Comment: Easton’s systems model gives an essentially good general outline of the functioning of the political system that can be broadly applied to the policy analysis in developing countries. It examines political inputs, outputs, the environment in which ‘demands’ evolve and feed back into the system. However as we have noted on our definitions above, as well as in the critique above, the power issue needs to be incorporated, given its ‘static’ illustration of the process, as well as its unrealistic view of governments as neutral, value-free arbiters rather than as occasionally prone to ‘manipulation’ (1993: Ch. 1). Before addressing these issues further, we first need to examine the importance of ‘context’ and ‘content’ and their relevance to policy making, policy reforms in developing states and indeed the analysis of such policy. We begin by examining context.

Analysing the developing state contexts and policy

‘Context’ is about the “rightful role of the state” in policy making (Walt and Gilson, 1994: 361). It is important in explaining reforms and non-reforms, and recognises, among other things, those macro-contextual factors which influence policy and the extent to which it conditions state participation in policy making. As Minogue notes:

"...The [policy] ‘system’ cannot be understood without reference to particular areas of policy; areas of policy cannot be understood without reference to specific decisions and actions; specific decisions and actions may be interesting in themselves but have no meaning beyond themselves except to the extent that they contribute to understanding of the policy area within which they are located, and to the general policy system which provides the context for both decision and policy..."
(Minogue, 1993: 11).

One of the simpler ways of analysing contextual factors (both internal and external) and their influences on policy is Leichter’s ‘accounting scheme’ which he used in his analysis of health policy in four developed countries (1979: 41; Walt 1994). This scheme categorises ‘context’ into situational, structural, socio-cultural and environmental variables (1979: 39-41). Leichter’s model is itself adapted from Alford’s contention that “...decisions, policies and government roles can be explained by a combination of situational, structural, cultural and environmental factors...” (1969: 2). According to Leichter’s schema, situational factors are those relatively transient conditions and/or events that have a significant impact on policy making. These variables range widely from violent events such as global and civil wars and natural disasters, to economic depression and booms, and also to technological change. It also encompasses other political events and conditions such as political status change (e.g. political independence), political regime change, ideological shifts, political reform, political corruption and leadership change.

Structural contexts also have a critical bearing on policy and include political, economic social and socio-cultural influences. At the political level, influencing structural factors include regime type (e.g. military or civilian, socialist or capitalist), political organisation type (federal or unitary), form of government (parliamentary or presidential), group activity (number, strength and legitimacy of interest groups) political processes (e.g. executive-legislative-bureaucracy relationships) and policy constraints. Economic-based structural factors include the overall economic system, economic base, national wealth and income and geographic location. Socio-demographic contextual factors include population composition (geographical distribution, migration levels, and education and health levels). The degree of urbanisation, the availability of natural resources and geographic location are also important variables. In relation to cultural contextual factors, national heritage, political norms and values, formal political ideology, religion and traditional social values. Liddle for instance focuses on culture as an important variable in policy making in Indonesia (1992). Finally, Leichter lists the international political environment (e.g. the cold war), policy diffusion, and international agreements, obligations and pressures as the main environmental contextual variables. In the case of the latter, the role of international affiliations including international financial obligations are most influential (Leichter, 1979: 41-42).
Comment: Thus far in this section, we have seen the complexity of definitions of policy and policymaking, analysed the workings of the basic Easton model, and examined the relevance of 'context'. In the case of the latter, the main problem with Leichter's accounting scheme of contextual factors is its implied rigidity. It neglects the dynamic relationship between and among all four sets of contextual factors, a point recognised by Leichter (1979: 40-42). Nevertheless, this 'scheme' is extremely valuable to policy analysis as it categorises the variety of factors that can influence and shape policy. It locates the influence of 'regime characteristics' - my interest in this study - as a structural factor, though as can be inferred from the four categories above all are interrelated to varying degrees. We now turn to need to examine policy content and its influence on process.

The relationship between content and various stages of the process

In the rush to explore the role of policy context, content cannot be ignored. The interrelationship between 'content', contexts and processes are extremely relevant to explanations of policy. Content can be basically assessed by the extent of a policy's deviation from the status-quo - whether fundamental, incremental or negligible; progressive or regressive. Cleaves study (1980) on policy implementation cites a number of influential content-related factors. These again include the timing factor, but also note the importance of level of technical complexity within these policies, level of deviation from the status-quo, nature of goals (ambiguous or clearly stated) and one actor or multi-actor objectives. Cleaves study also emphasises the idea of a convergence of factors, akin to Kingdon's 'three streams' approach to policymaking (Kingdon, 1984). He basically found that policies with poor timing, high levels of technical complexity, greater deviation from the status-quo, ambiguous goals and many actors involved, tend to have a high failure rate at implementation. One can surmise that this is probably also true for the earlier stages of policy such as agenda-setting and decisionmaking.

In the case of the policy process itself, this interaction of actors, contexts and processes can be broadly analysed along its four main stages: agenda-setting, decision-making, implementation and evaluation or outcomes (Grindle and Thomas, 1991; Walt, 1994).

Agenda-setting, decisionmaking and implementation and the 'high-politics/low-politics' approach:
The main contribution here has been the adaptation of the high-low characteristics of policies from the international relations literature to the social policy arena (Evans and Newnham, 1992: 127; Walt, 1994: 42; Grindle and Thomas, 1989; 1991). The policy agenda can be best defined as "...the list of subjects or problems to which government officials and people outside of government closely associated with those officials, are paying some serious attention at any given time..." (Kingdon, 1984: 3; Walt, 1994: 53). The main characteristic of policy agendas is that they can be broadly divided into two levels: high-level issues such as political stability, the economy, and various related crises; and low-level, routine sectoral issues such as education, agriculture or health policy making. Movement between the two though infrequent, nevertheless occurs. For example industrial action in either of these sections, taken to an extreme level can elevate such policies to the top of the agenda.

High-politics policy issues can also be defined as macro-level issues since they are basically concerned with "...the maintenance of core values - including national self-preservation - and the long term objectives of the state..." (Evans and Newnham, 1992: 127; Walt, 1994: 42). In the case of issues such as policy reform implementation, the meaning of high-politics can be extended to 'crisis-ridden' or 'high-risk policies': essentially issues that depart considerably from the status-quo, involve a lot of risks including regime instability and face considerable difficulty in being placed on the agendas and/or being implemented, a fact not unique to developing states (Grindle and Thomas, 1989; 1991). Policy issues which can be considered high-politics-oriented include decentralisation, public service reform and economic adjustment. As both Walt and Grindle and Thomas note, participation and hence agenda-setting in 'high-politics' issues are often limited to, and controlled by high-level officials and the political elite (1994: 43).
Of greater relevance to this study are those 'low politics' policy issues not involving "...fundamental or key questions relating to a state’s national interests, or those of important and significant groups within the state..." (Evans and Newnham, 1992: 184; Walt, 1994: 42). These include areas such as health and education policies where the risks to regime and state stability and survival are relatively low. The main proponents of this approach are Grindle and Thomas. In the case of policy reform, they refer to these as 'politics-as-usual' policies (1989; 1994). Because of their low-risk nature, more participation can theoretically occur in such policy processes (Walt, 1994: 42-43). They also emphasise the importance of circumstance, by examining: 1) whether the policy issue is crisis-ridden or politics as usual; 2) the stakes involved in both situations for politicians, beneficiaries and potential losers; 3) the status of the decision-makers (i.e. their political hierarchy); 4) whether the decision required is an innovative or incremental one; and finally 5) the influence of timing on policy for example under positions of crisis (1989).

In their two most relevant case studies, Grindle and Thomas also found simple, very locally-grounded relationships between policy implementation and low politics which were not wide enough to be conclusive. In the case of a non-crisis, policy issue - a USAID-funded health project in Mali whose objective was to develop low-cost care through the training of village health workers and the establishment of village dispensaries - the failure of the project seemed to be due to its low level nature, and requisite low level political involvement, though bureaucratic self-interested motivations were also influential. In the second 'low-politics' case, bureaucratic reorganisation in Kenya - bureaucratic self-interest, low levels of political involvement as well as the perceived imposition of overseas management models were the main obstacles to reform (Grindle and Thomas, 1989: 233). Again this raises the complexity of issues even in relation to low-politics issues, although, the political interests and incentives in specific policy issues such as health seem to play a rather prominent role. The setting of the policy agenda as well as actual decision-making and implementation in developing states can be also understood in the Hall and Kingdon models of policy.

'Legitimacy, feasibility and support': the Hall et al approach: This model devised by Hall et al (1975) in their study of change, choice and social policy in Britain, though fairly similar to the high- and low-politics approaches used the concepts of 'legitimacy, feasibility and support to explain the 'hurdles' through which issues have to pass through before they get to the policy agenda. Legitimacy "...refers to issues which governments feel they should be concerned and in which they have a right to intervene..." (Walt, 1994: 54). Some issues may be high on the legitimacy scale while others might be lower down the order. Feasibility refers to the potential for implementing the policy. These may include concerns such as shortages of staff, insufficient technological capability and capacity of implementing systems. Finally, support refers to "...the rather elusive, but important aspect of public support for, or public trust in government..." (Walt, 1994: 54). As Walt notes:

"If [the government] has high legitimacy (government has the right to intervene), high feasibility (there are sufficient resources, personnel, infrastructure) and high support (the most important interest groups are positive - or at least not negative), then the issue may well come onto the policy agenda and fare well, once enunciated as policy... (1994: 56)."

She notes however that:

"...sometimes governments will put an issue onto the policy agenda because they wish to make a statement about it, to show they have a position - but they do not expect it to be translated from policy into practice because it has low support, or low feasibility..." (1994: 56).

In the case of low politics issues such as health, legitimacy, feasibility and support also seem to relate to both the nature of certain policies issues as well as the idea of incentives for regime involvement and support as noted earlier. Low-level political involvement in issues such as health thus means professional
domination of the policy agenda, even though Walt alludes, regimes may well wish to the issue move beyond agenda-setting (Ugalde, 1979; Walt, 1994).

The ‘three streams’ approach: the Kingdon model: This model also underscores much of the dynamism, timing and circumstances as well as the complexities discussed earlier, and the necessary confluence of actors and circumstances that move policy from agenda-setting to decisionmaking. This approach sees the process as comprising three streams: the problem stream, the politics stream and the policies stream, with policies only emerging when simultaneous windows of opportunity open up in each stream (Walt, 1994: 56-57). The problem stream as the name implies relies on ‘feedback’ from the community alerting the authorities to the existence of problems. This broadly corresponds to Hall’s legitimacy hurdle in that issues emerge that demand attention to varying degrees. The politics stream is where visible participants (organised interests) attempt to get issues on the agenda and hidden participants (bureaucrats and consultants). The hidden participants - resonant of Bachrach and Baratz and Lukes’ ideas of non decisionmaking - can both influence issues that do get on the policy agenda and propose alternatives for those that do not (Walt, 1994: 57). Finally, in the policy ‘stream’, policy makers choose from the options available, based on both contextual conditions such technical and other information as well as values, public and political receptivity (Walt, 1994: 57).

Comment: This model has shades of a ‘bounded rationality’ approach for policymakers. However for policy analysts, it does not adequately consider the politics of power, specifically, how the unequal distribution of power within all societies can exert considerable influence on both high and low politics issues in favour of dominant interests. This approach nevertheless offers the hope for developing states that there are favourable windows of opportunity through a confluence of timing, progressive policies and policymakers and resources that can have a positive impact on both prospects and outcomes. It is this issue that makes this a valuable analytical tool for the study.

The policy cycle, timing, crisis-driven ‘room for manoeuvre’ issue

One of the more interesting ideas re-introduced into policy studies on developing states is the notion that crises do in fact bring about change, by bringing issues to the top of the policy agenda. This goes back to the idea in the early development literature of ‘crises’ and ‘sequences’ in the development process (Ilchman and Uphoff; 1971; Nordlinger, 1968; Horowitz, 1989: 210). It has contemporary resonance in Kingdon’s three streams coming together. Horowitz concurs with this noting that “…paradoxically perhaps, some of the most important events in a political system - major policy departures - occur when the system is not functioning as it usually does…” (1989: 205). While not analysing regime characteristics, even Grindle and Thomas assert the possibility of reform stalemate under non-crisis situations:

“...they may also be without the pressured political environment that can act as a stimulus for change. Thus under conditions of perceived crisis, the likelihood of change occurring may be greater than when the policy reform is a matter of routine...” (1989: 232).

Both the Grindle and Thomas and Horowitz perspective are particularly interesting since they effectively confirm that policy reforms placed on the agenda but not implemented under non-crisis situations, do actually stand a better chance of succeeding under crisis situations as a ‘pressured political environment can act as a stimulus for change” (Grindle and Thomas, 1989: 232). Horowitz however warns against the idea that policy reform as a one-off, unilinear event along the time-space continuum, supporting Hogwood and Gunn’s notion of policy succession:

“...policy has a life cycle, and at some times the possibilities are far more open-ended than at others. When these occasions have passed, policy can also be made but under different conditions, much less conducive to broad departures, less hospitable to new ideas, less likely to involve elites acting alone, without interest groups or affected bureaucrats having a significant say...policy making is not a one-
shot venture; there are always further decisions to be made, especially for those major departures that come in times of crisis. In routine times, they will have to be fleshed out, pruned, amended and adjusted; some branches of the policy will be expanded, but others will not be. By the time this happens, the conditions that facilitated the major innovation may have changed...” (Horowitz, 1989: 205).

One of the commonalities shared by the Kingdon and Grindle and Thomas perspectives respectively in relation to agenda-setting is this timing factor. The Kingdon model asserts that the process is not a linear one, but that issues may be around for a long time before “...the three streams come together and are propelled onto the policy agenda...” (Walt, 1994: 72). The Grindle/Thomas perspective similarly identifies the timing of policy responses as alterable by ‘circumstance’ such as under crisis conditions when the control over policy decisions are affected (1989: 233). Under politics-as-usual circumstances, there was more time to study the implications for change and then proceed to implement when the time was right. If circumstances however changed, they would place the issue on the ‘backburner’. They note as an example that institutional reforms in Argentina, Colombia and Kenya were “...shelved for long periods of time when little political support was available for pursuing them...” (1989: 232). Horowitz sums up a holistic view of policy analysis, incorporating this time element when he notes that:

“...Clearly it becomes necessary to take conceptions of the life-cycle of policies much more seriously and to follow policy - not merely to study implementation, but to trace how a policy works out more broadly, how it is altered, how it lapses, how it intersects with other policies at various stages...” (1989: 210).

Issues of specific concern to low-politics policy processes in developing states

The developing country policy literature has identified several characteristics that indicate the existence of a ‘third world policy process’ (Horowitz, 1989; Grindle, 1989, 1991). Horowitz, for instance, notes some of these distinguishing characteristics:

“...First, the legitimacy of many Third World regimes is in question. Second, policy concerns do not match those that predominate in the West. Third, the state structures of developing countries whatever their weaknesses are still relatively powerful vis à vis their societies. Fourth, the capacity of Third World’ states to make and effectuate policy is, in several respects, more imperfect than that of their counterparts in the West. Fifth, participants in the policy process are fewer than in developed states than in the West, and some sectors of the society are hardly participants at all. Sixth, the channels for participation are less well established and less clearly prescribed in developing countries. Seventh, information for policy making is much scarcer in Asia, Africa and Latin America than it is in advanced industrial countries. Eighth, foreign models [frequent reliance on foreign experts] are therefore much more common...” (Horowitz, 1989: 199-200).

Although Horowitz’ list is not exhaustive, it does point to some of the major determinants of and (deterrents to) developing country policy reform. We first examine regime power.

**Regime power:** In terms of impact and relevance to policy, the role of power and particularly state and governmental power is particularly important. The state, at least up to the end of the 1970s was generally the biggest employer and in some cases the largest owner of national resources in many developing states. This is why, according to Gish, important questions about developing states should not confine themselves to normative issues such as the ‘urban-rural’ divide, as these are frequently only euphemisms for “...who gets what” and, also why “...under most circumstances, those who already have are likely to get even more than those who do not...” (1987: 178). Developing state regimes inherit, and have retained much of their powerful roles from autocratic colonial systems which I noted in Chapter One, and which explains their unwillingness to reform such assumed roles in the post-colonial period. Any
examination of the role of regime power and other characteristics in post-colonial policy making therefore has to be measured against the power, role and influence of actors, structures in the colonial state and the former's attempts to reform the status-quo. Most of Horowitz's assertions about 'third world' state power and participation can be traced back to the aims and objectives of the colonial system. The basic aim was to extract resources from the colony for the benefit of both the planters and ultimately the mother country, through, inter alia, taxation. The objective was to provide and/or maintain a smoothly-functioning, highly-centralised institutional structure - administrative, political, economic and social - that fostered a stable environment for this goal to be achieved. This started at the position of the colonial governor who had strong and extremely concentrated decision making powers. Under this strategy, entrenched animosities based on race, caste and tribal differences were exploited for colonial political survival. This helped to create 'weak states' which severely retarded the prospects for social, political and economic progress in the post-colonial era. This happened both in the Carribean (Williams, 1969) and much of Africa (Migdal, 1988). Migdal, for instance, highlights the negative impact of British 'divide and rule' policy in Sierra Leone where various 'strong-men' were co-opted, a process which has fractured and undermined post-colonial development to the present day. Migdal concluded that the British had "...induced a fragmentation of social control, an environment of conflict, during that historical window of opportunity when the population sought new strategies of survival..." (1988: 141).

The limited participation of interests (with the exception of dominant interests) are also an important feature of the post-colonial state policy arena and also explains strong regime power. The links to colonialism are also evident. Jones (1987: 4) notes that the highly centralised, authoritarian and generally undemocratic political structures of colonialism "...discouraged popular participation in the processes of development and public management...". In addition to the governor, considerable power was also consolidated in hands of planters and other dominant classes who "...manipulate the state machinery in favour of their parochial interests..." In the case of the Commonwealth Caribbean for instance, the British colonial system institutionalised a non-bargaining culture in colonial Jamaica, with bargaining limited to dominant groups. This led to popular distrust, agitation and violence by excluded or 'challenging' groups. This type of group action, according to Jones, was mirrored in the post-independence period era of paternalism, and the co-optation of groups and their leaders who threatened the status-quo in order to reduce the activities of the 'challenging' groups in society.

Bureaucratic power and influence: The role of bureaucrats in colonial society also mirrors the reality of the post-independence era. In relation to the dilemmas of low-politics policy development in developing states, problems stemming from bureaucratic inertia and survival are also potential deterrents to reform. Jones study of Jamaica is instructive of the policy inertia created by bureaucrats geared towards system maintenance rather than reform-based development. British colonies such as those in the Caribbean, strong bureaucracies were cultivated under crown colony rule which were strong at protecting their interests and implementing colonial policy, but were weak for the demands of independent development due to their largely unreformed status. Unlike politicians, bureaucrats are generally divorced from both national and international political pressures, and their power lies in their political and administrative capacity to influence and even manipulate both the institution and its resources, - due to their command of information. Jones, in his study of Jamaican bureaucrats emphasises their ability to "...mute or de-emphasise issues relating to social accountability..." (1981: 129). Jones concludes that this overall capacity, together with their "...proximity to political power..." helped them to secure personal as well as professional gains from the system, and led to their "...resistance to change...". The resulting power-based tension between bureaucrats and politicians are important to understanding post-independence development policy processes and outcomes. After independence, Caribbean governments addressed the bureaucratic problem in one or more of the following ways: by undertaking limited reform; co-optation; or worse, total neglect.

International economic actor power: Other than the state, the two main actors in the international economic arena: the World Bank and the International Monetary Fund (IMF) are arguably the most powerful players in the policy reform arenas of most-developing states. This means that their power to influence shape and affect social life in these states cannot be underestimated (Payer, Walt, 1994; Nelson, 1990; Caulfield, 1997). In the case of the IMF, the majority of developing states have concluded
structural adjustment agreements with this organisation. The effects of IMF loan conditions have been debilitating and damaging socially, economically and in many cases politically. The World Bank's increasing visibility has been particularly noticeable in the case of health policy reform in developing countries where its support for private sector involvement has not entirely been welcomed by health experts (World Bank, 1980; 1987; 1993; Buse, 1994). This international visibility commenced in the 1980s with its health sector policy papers and culminated in 1993 with its 'Investing in Health' policy document. Even though it has always been involved in country level health projects, the 1980s and 1990s marked the first time that it outlined its global health policy thinking. Both organisations and their relative power therefore have to be considered in any analysis of policymaking and reform, particularly since 1980. I now turn to those issues of particular concern to the health sector.

**Issues of particular concern to developing state health policy reform processes**

*The role of medical power and dominance:* The power of the medical profession is undeniably linked to common historical processes shared by post-colonial/developing states as noted in Chapter One. Navarro's Marxist studies on health underdevelopment (1982: Ch. 1) illustrates the impact of Rostowian' stages of growth theory on health and health human resources underdevelopment, through the negative effects of cultural, capital, educational and technological 'diffusion in developing societies. He notes that development in such societies was channelled and stimulated through metropolitan-style enclaves in developing countries resulting in dual health systems, like dual economic systems. Using the examples of Latin American countries, he argues that the misuse (through inter alia, external repatriation, educational systems, consumption patterns) rather than scarcity of resources is the key issue for these states. He sees problems such as health professional migration as the logical outcome of medical dominance, depriving poor countries of their valuable human resources in the process.

This medical domination cycle, according to Navarro is perpetuated by cultural and technological diffusion under dependent capitalism. He concludes that the main beneficiaries of this type of "highly-skewed" development are minority capitalists, the medical profession and international capital. In the case of health human resources, this means the continued deprivation of access to appropriate health care personnel. Navarro's earlier study (1972) cited revolutionary Cuba which promotes equitable distribution of health human resources. However, he later recognised the internal medical bias, even of the Cuban medical system, which resulted from an active policy of training more doctors in response to medical migration, but which once again underscores the power of medical dominance. This dilemma is also noted by Bossert (1984) in the case of revolutionary Nicaragua, where a combination of factors, including demands for curative care, which resulted in a more costly resort to such training and services to the underdevelopment of primary health care, which was more sorely needed.

Jones notes the problems of colonialism as the relate to the Commonwealth Caribbean health sector. He points out that in relation to Jamaica, the professional groups in late colonial society - the medical, teaching and legal professions - were 'natural community leaders', with many at the forefront of independence movements. In the case of health policy, the dominant medical lobby "...perceived themselves as some kind of support wing to the formal colonial establishment and mostly pressed claims and opposed policies and practises in a manner always perfectly motivated by self-interest..." with few exceptions (Jones, 1987: 79). Deriving much of their power and status on relationships to medical institutions in the 'mother country', doctors were able to vigorously promote their medical ideology in the colonial state, to the exclusion of traditional healers who were labelled quacks. The profession was most concerned to retain its unique professional position in post-colonial society. Thus the major demand of this lobby was for "...the institutionalisation of procedures which would ensure their continuous influence (at the executive level) over all facets of colonial medical policy..." (1987: 79). As Jones notes:

"Government dependence on them for the management of community health policies...was an effective sanction...their formal and informal linkages with the official circle also constituted an important political resource...reinforcing these levers of influence was the fact that they had the responsible and powerful support of the London-based BMA..." (1987: 80).
Maru (1983) also demonstrates the power of medical interests in health human resources development policy reforms within the developing state, prevailing against even popular government policy intentions. He found, for instance that power of the populist Congress party which dominated politics for much of India's post-Independence history, was blunted against the powerful medical profession in that government' attempts to pursue a more integrative health human resources in a poor developing state. The resulting outcomes for India's health policy was wasteful doctor overproduction, urban bias and unemployment with lack of access to basic health personnel by a significant proportion of the country's population, a reality which persists to the present day.

The role of international health policy actors: While in practical terms the World Bank's activities in the developing country health sector enables it to be increasingly categorised as a major health policy reform actor in its own right, the main technical policy actor in the case of the health sector has been the World Health Organisation through its various sub-regional offices. The policy role of the WHO, has been especially critical to developing countries health policy directions. However, its own organisational problems, in addition to its deeply ingrained medical ideological ethic has been the source of its main problems (Walt, 1993; Godlee, 1994). Its high point was undoubtedly the 1978 Alma Ata Conference, jointly sponsored with UNICEF where the policy goals of primary health care were formally adopted, and later followed by the somewhat more ambitious Health For All 2000. While it performs independently, its remit is to assist in the role, guidance and involvement of national policy in WHO member states. Although its role has been superseded by the Bank's, for these and other reasons, and despite its medical ethos, its technical support to developing states without basic planning facilities and know-how also needs to be considered in analysing policy processes, which opens up a whole new area of inquiry, for example, the quality and appropriateness of technical advice. Other important agenda-setters for reform - include three of the main social policy arms of the United Nations: the World Health Organisation and its various sub-regional offices, one of which is the Pan American health Organisation; as well as the United Nations Children’s Fund (UNICEF) which also focuses on health issues and the United Nations Population Fund (UNFPA) (Walt, 1994,1993; Godlee, 1994).

The media: The role of the media needs also to be included in the search for the origins and influences on policy. Walt notes the role of the media as an important agenda setter for reform the especially in the case of crisis policy issues, "...drawing attention to issues and forcing governments to act..." (1994: 72). As Walt note, this role and influence seems most effective in high-politics issues. It can thus play a role when normally low-politics issues such as health policy becomes a crisis-ridden area, as in the cases of the BSE and salmonella policy trajectories in Britain. In developing countries, the role of the media can be a two-edged sword for regimes: on the one hand its can give them free publicity for their prestige projects such as hospitals; on the other, bad headlines can trigger calls for ministerial resignations and other forms of regime action just as in developed countries. Finally, the role of non-governmental organisations in developing country health also need to be considered. While more primarily concerned with health delivery, they can influence overall policy reforms. In developing states, particularly small states, the role of national universities and their medical and health faculties and departments can play an influential policy role, particularly in training policies, determining the extent of shifts from status-quo to reformist policy positions, for example the level of shifts from curative- to preventive approaches in health training.

Comment: While there are other organisations that help to shape health policy in developing states, I have limited this discussion to the main ones of particular interest to my study. Of these actors operating/or influencing developing state national and sectoral policy and policy reform agendas, the power of international financial actors cannot be denied. However, we can see from all of the other national-level actors, that the regime is still the pre-eminent state actor within this arena. While severely constrained by a variety of structural influences - including the activities of these international financial agencies, regimes wield considerable power in the developing state arena. In the case of low-politics policies, even if there are little or no incentives to reform policies, decisions are still taken by ministers and their bureaucrats on a day to day basis in the health sector which constitute health policy. These need to be examined to determine, despite the low-politics status of health, whether or not policies and policy reform efforts are being adopted and implemented or not, and whether regime-related reasons are
influential in this regard. In the next section, I make the case for the usefulness of regime characteristics in analysing low-politics policy issues such as health.

The case for analysing regime characteristics and the ‘low-politics’ health policy process

Quite a few studies have been done on the direct influences of regime characteristics on high-politics public policy. Most of these point to the relevance of regime maintenance as an important motivation in maintaining the loyalties of, and ‘strategic coalitions’ with important pressure and client group, and hence influencing policy. In the case of regimes and high-politics policy, Kaufman’s comparative study of the politics of implementing crisis-ridden economic adjustment in Argentina, Brazil and Mexico, found that 1) decisionmaking was in the hands of a small insulated policymaking elite; 2) decisions to relax or sustain austerity measures were closely correlated to the scheduling of mid-term elections in each country and 3) in the case of the influence of regime type on policymaking, differences within democratic and authoritarian categories were arguably as important as distinctions between them. He also noted that the desire to maintain power under such crisis circumstances was as much heavily influenced by national as by international factors; with regimes ‘...impelled to move in converging directions by domestic and cross-national pressures over which they had little control...’ (1989: 412). (1989: 411). Kaufman also saw economic development policy making as a balancing act among competing interests, “a process of conflict-resolution in which social tranquillity and the maintenance of power is a basic concern...” Even Horowitz admits the role of regime maintenance as a prime motivation in policy making generally, noting that “...there is plenty of opportunity for unintended consequences, including some that may threaten the regime itself...” (1989: 206).

While more evident in high-politics policy issues, Bates’ study of agriculture in Africa interestingly suggests that some low-politics policy issues can also threaten regime survival (Ames, 1987; Kaufman, 1989; Killick 1976: 176 Lindenberg, 1988; Bates, 1981; 1988). Grindle and Thomas, (1991: 100-101) equally concede in their own non-regime study that policy elites (including relevant politicians/ministers) have to take account of concerns about the political support available to the regimes they represent or to its leadership:

"...the fragility of the coalitions that support incumbent regimes in many developing countries and...the limited legitimacy...makes them vulnerable to the performance expectations of supporters... “ (1991: 101).

As a result, how particular decisions will sustain the regime in power is a prime concern in crisis-ridden policies. Ames (1987) and Lindenberg (1988) have demonstrated how regime maintenance can affect some policies and not others. Ames in particular demonstrates the influence of political ‘pork’ in maintaining power through the sustenance of ‘strategic coalitions’ in Latin America. Others such as Haggard and Bates similarly show how regime actions are employed as payoffs to maintain the loyalty of important groups or interests. Bates’ study of African agriculture policy (which incidentally shows how ‘low-politics’ issues can become high-politics, and ‘crisis-ridden’) notes that regime maintenance becomes the single most important factor in explaining how governments can get away with the perpetuation of economically-irrational development policies. According to Bates, the logic is simple:

"...governments want to stay in power. They must appease powerful interests...and people turn to political action to secure special advantages...” (1981: 4; 1988).

Thus while the case for the need to explore relationship between regime survival and crisis-ridden ‘high-politics public policies in developing states seems quite convincing, for understandable reasons, the case for regime survival and low-politics policies seems less clear, limited to Bates’ study of African agricultural policy processes. Health policies do not threaten regimes. And yet, there is a lot of explaining to do in the case of regime characteristics and low-politics public policies in developing states as the helpful, though inconclusive studies by Bossert and others so clearly show. The fact that there have been very few attempts in the 1990s to ‘return to the regime’ as a source of analysis of developing states makes such attempts all the more timely. Developed country environments allow sophisticated analyses
of government policy. However, other than for high-politics policies, developing state policy arenas as Horowitz and others have demonstrated, operate under quite different circumstances, particularly in terms of the simpler power structures, the influence of historical factors, the scarcity and apathy noted by Cleaves, and even the basic lack of data to make policy. All of these negate the role of regime characteristics in low-politics policy. Nevertheless the state and its chief actors, the regime and the bureaucracy are still pre-eminent, rivalled only by the increasingly prominent international financial agencies on the one hand, and the entrenched professional power of local medical interests on the other, with other groups and interests including the private sector lower down the power-influence ‘ladder’. This reality means that power is being exercised within the small developing state policy arena which needs to be explained by relating it to the context and the outcomes for the health sector in the Commonwealth Caribbean state.

My ultimate argument then is that the state is the most powerful actor in developing countries. Whether it is a force for progressive or regressive policies is not all due to colonialism and the IMF and World Bank, dominant though they may be. There is some room for manoeuvre in making progressive policies. Two questions need to be asked: first, to what extent do states/governments use the room that they actually have, given these constraints, to make progressive policy. The second and equally important question, ignored by much of the development literature is what happens in terms of low politics policy reform when states do have room to manoeuvre. The lack of incentives in low-politics reform may go some way to answering this question, though it cannot explain why progressive reformist policies are implemented by regimes who have little incentives to gain from undertaking such reform. These and related questions can only be answered through case-specific analyses of regime characteristics - regime strength, stability, ideology, democracy and maintenance - and their influences on the reform process. In the next section, I briefly examine the main problems associated with regime analysis.

The pitfalls of ‘regime’ analysis

There are a number of problems with regime characteristics as the source of policy which need to be noted. In the first place, as noted earlier, structural, historical and economic factors remain pervasive, conspicuous only by their negative effects. In addition to the inconclusiveness of the some of the earlier mentioned studies, the main problem with regime characteristics analysis is its adherence to rigid lists of characteristics that are analysed separately. One cannot emphasise enough the need to view these characteristics as not only related, but changing over time as well. A regime for instance may shift ideologically or even democratise while in office. Such changes need to be accounted for and incorporated in terms of effects on policy processes and outcomes. On the issue of power and regime maintenance and survival also, there is even more strident criticism. Liddle (1992) for example, criticises the assumption that the drive for power and survival is decisive and central to politics:

“...[first], it is too centred on the top leadership and their most basic policies, thus failing to distinguish between policy issues where the decision-makers’ survival is genuinely at stake and those where it is not, and between policy issues settled at the top of the system and those decided further down. The implication from this point is that for any given policy issue, the motivation to attain or maintain power should be treated as a variable, not a constant or assumption...[second] there is less than meets the eye to the analytical reach of the ‘power-as-overriding-motive’ assumption for many strategies may be compatible with this from Hitler and Stalin, to Kohl and Gorbachev, to Marcos and Suharto. The power motive therefore while useful as a conceptual foundation, is still less than satisfactory...” (Liddle, 1992: 797).

Liddle by contrast argues that regime maintenance analysis denies the existence of the capacity for autonomous, progressive action by politicians and regimes. These criticisms must be therefore be borne in mind as I have already noted. He does conclude however that the analysis of power relations and its practice in terms of policy is essential in any balanced approach to examining both progressive and regressive behaviour on the part of regimes. He even concedes that, used ‘sensitively’, regime analysis is
"...can carry us some way in understanding why one policy is chosen rather than another in specific situations..." (1992: 796).

Comment: The analysis of regime characteristics as a source of low-politics influences, used wisely can potentially illuminate our understanding of health policy processes in the developing state. The impasse in development theory occurred precisely because there is has been much grand-theorising that only tells part of the story, with less culture- and societally-specific analysis. I address this central question in my regime characteristics analysis, by locating my societally-specific case studies within wider trends, even though they are grounded in national and subnational detail. Regime characteristics, as even Liddle agrees can provide some richer and ultimately beneficial insights about developing country policy processes.

2.7 SUMMARY AND CONCLUSIONS

My aim in this chapter has been to examine the relative merits of exploring the relationship between regime characteristics and low-politics policy processes in the developing state. I began this task by examining the dilemma of the development process itself, through an examination of modernisation, dependency and Giddens’ structuration approaches as a useful way forward. Modernisation and dependency approaches to development have variously dominated the post-war development and development policy debate. The polarisation of both approaches however led to an impasse because of their respective shortcomings. The modernisationists could not explain persistent underdevelopment in most of the third world, while dependency theorists could not explain development in South-east Asian countries. Gidden’s sociological concept of ‘structuration’ is one of the more interesting and influential theoretical constructs that can be applied to this explanatory gap within development theory. Giddens essentially advocates the need for a balanced, integrative and dynamic approach to actors and structures in sociological analysis which pays due attention to the specificity of time/space issues. Giddens justifies this approach by noting that only such an integrative approach can explain diversity and specificity at the micro- and meso- levels, along with some amount of structural uniformity and pattern: effectively the prime objectives of social enquiry. The relevance of this impasse to policymaking is evidently the new opportunity it presents for taking a balanced look at developing state policy processes. At the next stage of my discussion, a number of themes recurred in this overview of the policy process: power, content, context, process, timing, and interrelationships at a variety of levels. Policy is about power and its influence on process, hence Dahl’s famous assertion that politics is about ‘who gets what’ and ‘why’. Power in policy making is about national and international actors, elites and interest group influences all affecting the decisions that affect the national policy arena. I have tried to show that in addition to international actors and contexts, national actors and contexts are also important. In the case of policy making in the post-colonial state, power is the product of a number of situational, structural, socio-cultural and environmental actors and contexts that vary from territory to territory, conditioned by historical power arrangements which have persisted into the post-independence period.

I also went on to discuss the nature of policymaking as a product also of the particular characteristics of policies themselves. The influence of these contextual factors cannot be seen in isolation. They influence and interact with each other to shape and influence policy to produce various outcomes at specific moments in time. The policy literature has established the general difference between ‘high-politics’ policy processes such as economic adjustment and other major policy reforms, and the ‘low-politics’ characteristics of health policymaking and reform. High politics policies are usually made at the senior political and bureaucratic levels and are risky and potentially threatening to regime maintenance. ‘Low-politics’ policies by contrast usually involve lower level policy elites and do not normally threaten regime maintenance. The policy literature has also strongly established the direct links between regime maintenance or survival and the adoption and implementation of high risk, potentially risky policies. In the case of regimes and low-politics issues such as health, however, the situation is rather more complex. Grindle’s study of health policy in Mali showed that lack of powerful, high-level support can result in policy failure, although this is not always the case, as Bossert’s Central American examples of primary health care implementation showed. The fact that the often crisis-based urgency of high-risk policies and their immediate environment are absent from low-politics issues are as important differences that must be borne in mind when considering developing state health policy experiences. However this does not negate
the need for studies of the influences of regime characteristics and relevance on low-politics processes and outcomes. Another possible contention that needs to be questioned is the issue of accounting for the successes and failures in policy and the culpability of agency- versus structure-based factors in this regard.

The logic of the Mali example is that such policies stand very little chance if there is no high-level political support. However, even Grindle and Thomas have strongly emphasised the capacity of developing state policymakers to formulate and implement progressive policies against tremendous odds - an assertion which does make the case stronger for further investigation of regime characteristics analyses of policy. A further issue to bear in mind, is the indirect effects of high-politics policy decisions - in areas such as economic reforms for instance - on low politics policy issues. As stressed earlier, low politics policies such as health - like any policy for that matter - do not occur in a vacuum. One can therefore only assume that there is considerable intersection and interaction between the two, thus resulting in the interesting, though very real idea of high level policymaking affecting low politics policy trajectories and outcomes. In the 1980s, many developing states at the behest of the international financial organisations were implementinglow-politics reforms as part of the macro-economic reforms. This needs to be considered in regime characteristics analyses.

The second theme is 'process' as it relates to the influence of regime characteristics on the decisions and non-decisions that they make in relation to actual 'low-politics' policy processes. Legitimacy, feasibility and support of policies are important in terms of room for manoeuvre in setting policy agendas, making decisions and implementing policies. However, until recently development theory literature has been reluctant to countenance the fact some regime characteristics do also affect policy outcomes. Bossert and others have found that regimes that are usually undemocratic and authoritarian-leaning, by both their direct and indirect actions can hinder policy development. This can happen through both 1) the implementation of policies are seen to be inappropriate, unpopular and have more to do with the assumptive world of the regime; and 2) or not act in areas where other interest groups are threatened. One has to explore the role of regime characteristics on symbolic policy symbolic policy, that is where progressive policies have been formalised and implemented but their outcomes are hampered by factors related to the behaviour and characteristics of regimes themselves, rather than structural-related factors as resource availability and even other actors in the policy arena.

In conclusion, Dye has described policy analysis as "...finding out what governments do, why they do it, and what difference it makes..." and that all policy analysis is concerned about the same thing - "the description and explanation of the causes and consequences of governments actions..." (1976: 1). This chapter has attempted to critically examine the role, influence and relevance of regime characteristics in post-colonial state policy reform processes. Health policy is widely regarded as a 'low-politics' type of policy, as it does not threaten a regime' stability or survival, and consequently may not command the amount of political attention (and resources) that would otherwise be allocated to 'high politics' policy issues. My main reason for examining regime characteristics is essentially through recognition of the limits posed by structural explanations of health policy, pervasive though they may be. As in other fields, the health literature recognises the role of politics but, as Reich notes, many usually consign it to a line or two about the relatively meaningless 'political will' at the end of such studies (Reich, 1991). The lack of commensurability across disciplines is especially regrettable. The health economics literature recognises the importance of political processes in developing country health care, but pays far less attention to it, focusing instead on abstract notions of supply and distribution, the influence of wages and remuneration on worker retention and productivity without attempting to ground them, at least partially, in political explanations (Lee and Mills, 1983: 216-217). The health manpower economics literature likewise ignores discussions of politics (Ferster and Tilden, 1983). However all is not lost. The planning literature by contrast, recognises the importance of political factors (Hall and Kleckowski, 1978; Green, 1995). Similarly, the primary care implementation literature has also given much room to political power and influence of politics (Bossert and Parker, 1984; Segall, 1983). While all of this may seem obvious, they do reflect the failure to see the value of integrative approaches to health policy. The need for an integrative approach that places politics at the centre of analysis, but importantly links and relates it to other factors is needed, if only to support a fundamental belief in the primacy of power and politics.
Although it is nearly impossible to use a rational approach to developing country policymaking that considers all the possible determinants, it is nevertheless clear from the preceding review that an integrated approach that focuses on actor-based approaches within their structural constraints is at the very least a potentially useful analytic method. This chapter has broadly advocated two things, first, the need to recognise an explanatory role for regime characteristics in the developing state low-politics policy process; and secondly, the need to also recognise the importance of aiming for a balanced, non-determinist theoretical approach in comparative policy analysis that considers objectively both sides of the agency-structure divide. This structurated approach, therefore, may well be the only accurate way to identify and realistically appraise the effects of specific policy phenomena.
CHAPTER 3

STUDYING REGIME CHARACTERISTICS AND LOW-POLITICS POLICY AND POLICY REFORM: INTEGRATING GROUNDED THEORY WITH COMPARATIVE CASE STUDIES

3.1 INTRODUCTION

The following chapter describes the method that supports this comparative analysis of regime characteristics and health policy processes in Guyana, Jamaica and Trinidad. Its aim is to examine the evolutionary methodological process that led to my focus on the role of regime characteristics and their influence on the policy process in the decolonising state, and the subsequent choices of focus for my study of health human resources. It is divided into four sections. In the first section, I describe the background to the study. This is done in three progressive stages: preliminary interest; preparation; and data collection and analysis. It traces the initial personal observations and questions raised by various studies on the relationship between regime characteristics and public policy processes in the post-colonial state. In the second section, I describe the general methodological approach that framed the study. I outline the integrated method that I adopted using grounded theory and comparative case study. I then describe my application of Bossert's concept of regime characteristics within this comparative case study/grounded theory-oriented approach. The role of theoretical sampling of concepts and the link between grounded theory and comparative analysis is then discussed in order to assess the relative merit of the integrated method of comparative analysis and grounded theory. In the third section, I describe my method. I conclude with a discussion of the limitations of this integrated method.

3.2 BACKGROUND TO THE STUDY

The discussion of methodology is important to any study because it is the framework or 'conceptual lens' through which data is collected, presented and analysed. It guides the researcher throughout the entire process and the logic of its design will inevitably influence the validity of the findings. Issues such as appropriateness, justification, replication and ultimately 'good science' are therefore of utmost importance. To be useful, appropriate and innovative at the same time, the chosen method needs reflect the relationship between the objectives of the study and the actual methodological tools used for collecting and analysing the data. One therefore needs to justify the approach, based on its stated merits in preference to other possible approaches. Another important issue in relation to the conduct and role of social science inquiry is that of innovation and/or contribution. Innovation and contribution in the case of social science inquiry does not always mean a paradigm shift in terms of method. It more often than not entails a more realistic examination of data in different or 'innovative' ways. For example, the manipulation of existing methodologies can yield new, richer and potentially more realistic insights regarding a phenomenon. The limitations of such an approach however, together with (potential) uses in the area of social inquiry also needs to be explicit. Only then can one assess whether the methodological 'innovation' was useful and by extension, whether any contribution was made. In most qualitative research, the choice of method is influenced by the subject matter. The subject matter is progressively refined as is the research process itself as more and more data is collected and analysed. This evolution of both subject and method therefore occurs at different stages; from the initial planning to the collection and evaluation stages. As Becker points out, the natural history of research involves:

"...presenting the evidence as it [comes] to the attention of the observer during the successive stages of his conceptualisation of the problem..." (Becker, 1958: 660).
This study was the product of such an evolutionary method based on a combination of observations and experiences in the Commonwealth Caribbean. These experiences prompted me to question the way in which policies were determined. I also wanted to know by whom, how, the influence of changes and with what consequences in and for the region, especially during the difficult decades of the 1970s and 1980s. It is with these broad questions in mind that I approached this study of the politics of the human resources policy process in Guyana, Jamaica and Trinidad and Tobago. In the following sub-sections, I describe and discuss the evolution of the study and the method.

Getting started - preliminary interest

My interest in the study of the role of politics in policy-making and in the specific area of human resources policy in the public health sector of the Commonwealth Caribbean had its genesis in two experiences. These experiences shaped the evolution of both the central focus on regime characteristics and public policy as well as my choice of Guyana, Jamaica and Trinidad and Tobago (hereinafter referred to as Trinidad) as the countries that I wanted to study. The first experience relates to my background and interest in Caribbean politics and social policy-making since Independence. I studied politics at the University of the West Indies in Mona, Jamaica from 1986 to 1989 at a time when Jamaica was experiencing the severe ‘aftershocks’ of tough International Monetary Fund (IMF)-ordered structural adjustment policies. The negative impact was very clear in relation to social conditions: drastic cuts in state expenditure including cuts in social expenditure and job losses, increases in poverty-related illnesses, and increasing poverty due partly to higher unemployment. The concept of ‘independent development’ was itself under question. It seemed evident that whatever limited level of national ‘agency’ or ‘ability to act’ that had been gained from political independence was slowly being eroded by these new externally-derived policies.

In Guyana, much of the same was occurring. Trinidad, which had escaped the worst of the 1970s recession by virtue of its oil-exporting status began to experience similar economic problems as prices fell in the early 1980s. The International Monetary Fund was also approached by the Trinidad government and the first structural adjustment package approved in 1988. By the end of the 1980s, all three countries had therefore adopted some form or other of Fund-prescribed adjustment policies, which meant among other things, significant reductions in social expenditure. Another important component of the ‘conditionalities’ was the ‘rationalisation’ of the public sector. The main objective of this rationalisation was administrative reform through decentralisation (and even some measure of deregulation) of public services including health. However, another underlying objective was greater efficiency in the public sector, which while laudable, also meant severe social impact in terms of, inter alia, public sector cuts in resources and job losses. Trinidad’s oil-based economy boomed in the middle of the 1970s while Guyana’s and Jamaica’s dependence on oil imports saw them slide into recession. The net effect of ‘fiscal discipline’ in the 1970s and 1980s in all three states (at varying periods) was social, economic and political tensions. In terms of economic policy, the devaluation of national currencies in all three states brought with it the inevitable negative social impact. In Jamaica, this manifested itself directly and indirectly in, inter alia, industrial unrest and relatively sustained political/electoral violence. In Guyana, there was also industrial unrest and more significantly, the heightening of the call for democratic elections. In Trinidad, industrial action by among others public sector workers, rising crime and unemployment as well as political crisis and change characterised the period. One of the more ‘visible’ consequences of these ‘adjustment policies’ was in the area of human resources in the health sector. The numerous instances of industrial action was the most obvious evidence of the fact that working conditions for health sector professionals had deteriorated considerably. The health sector unrest in Trinidad formed at least one component of the socio-political backdrop to the almost-successful attempt by Muslim extremists to topple the democratically-elected Robinson government. The continued expenditure on a new medical school at a time of scarce resources was another. Migration to the metropoles from all three countries of thousands of professionals (with nurses forming a significant proportion) was one of the more popular and non-violent outlets and was the essentially the end-product of the difficult economic conditions in the region at that time as well as the seeming inability of national governments to address the problems facing the health sector.
The second experience which influenced this study relates to my short stint as a research officer in the Caribbean Community Secretariat (Caricom) in Guyana from 1991 to 1992. One of the principal aims of this regional body (in addition to closer integration of member states) is to foster functional co-operation in social policy in such fields as health and education, among others. From my own preliminary readings, observations, experiences as well as discussions with colleagues, I discerned a generally low priority being accorded to health policy issues, particularly human resources development at the regional level which made me question the state of national health policy processes. Despite some successes for example in implementing a Caribbean regional nursing examinations policy, the policy reorientation towards primary health care and its impact on the medical school curriculum of the University of the West Indies, human resources development in the health sector still seemed to be a rather neglected area. I was particularly surprised at what seemed to be the relegation of nursing policy issues at the various ministerial and technical meetings. Indeed many of the health ministers were themselves medical practitioners who seemed more interested in the concerns of their own professional group. I wondered whether or not this was a symptom of events and indeed reality at the national political and policy levels.

Such ‘apathy’ seemed quite surprising since, as noted in chapter one, health has always been in most senses one of the major success stories for Commonwealth Caribbean governments. Health issues (including expenditure) have always been a top national-level priority for the vast majority of these states. The commitment by Caribbean governments to universally accessible health care evidenced by innumerable speeches, party manifestos and legislative instruments seemed clear enough. This commitment was cemented in the post-1978 period in the adoption by member states (including the Caribbean Community) of the UNICEF/World Health Organisation-sponsored 1978 Declaration on primary health care, and a few years later, the related adoption of the health for all 2000 objectives. The high rankings of Caribbean Community member states (excluding Guyana) in the annual global health statistical tables only served to confirm the high status of health and indeed primary health care itself in the region. Despite all of these positives however, problems in the health sector persisted throughout the 1980s and early 1990s. I was convinced that lack of financial resources must be the main problem, a conclusion which did not answer the entire question satisfactorily. I also wondered whether regional governments were really concerned about the loss to the region of expensively trained human resources at a time when nurses seemed to be either engaged in industrial action or migrating en masse to the United States, Canada and even to Saudi Arabia on contract. There seemed to be no policy initiatives or directives on this most important of issues.

I had therefore observed two paradoxical events. On the one hand, there were the excellent rankings in the international health tables; on the other there appeared to be a somewhat apathetic situation with what appeared to be poor utilisation of policy space at the national and regional levels. In the case of human resources, this manifested itself in nursing and junior doctor industrial action, nurse migration, apathy at the regional level and a general disenchantment by the citizenry about the state of health care within these countries. I wanted to find out firstly whether these paradoxical events and state of affairs could be explained only and adequately by economic factors. If not, I wanted to find out whether the national political arena, and in particular regime politics, could shed any further light on the problem. I wanted to find out whether plausible relationships or linkages could be made between non-economic variables and developments in the human resources policy process that I had observed. The difficult policy choices faced by the governments or ‘regimes’ in each country during that period seemed clear enough in terms of the impact of external (and to some extent internal (economic) impact on social policy-making during the 1970s and 1980s. These conditions had limited the financial resources and by extension the policy choices available to governments.

As a student of Caribbean politics however, I felt that this explanation, pervasive though it might be, was much too deterministic even in small, vulnerable states like Guyana, Jamaica and Trinidad. I believed that alternative explanations had to be sought, examined and assessed at other levels if only to prove or disprove the overwhelming view about the importance of economic factors which was itself being questioned in the development literature (Booth, 1985; Seers, 1981; Harrison, 1988; and Schuurman, 1993). For this study, I wanted to focus on the national policy arena. I was particularly
interested in exploring government or regime policy space and requisite use/non-use of that space in relation to the human resources policy process. I also wanted to examine policy impact when regimes changed. In terms of day-to-day policy-making, varying levels of financial and other resources are continually allocated by even the most cash-strapped governments or regimes in all developing states. This factor almost instantly empowers these regimes within the context of the national public policy arenas, vis à vis other actors in society. Indeed, regimes are undoubtedly the most dominant policy actors, with somewhat limited policy challenges from the relatively underdeveloped interest groups, with the exception of the general trade unions and some traditionally-powerful interest groups such as the medical profession. In the case of health, the public health sector still largely dominates the health care system of each country and is therefore the dominant purchaser and provider of services. It must be concluded from these facts that national governments/regimes in developing states are important policy actors, arguably the most important policy actors within their national boundaries. I was essentially curious to discover the outcome of a study of Caribbean policy-making if one controlled the economic variables and focused exclusively on those political factors that influenced regime behaviour in the national policy-making arena.

On the question of the evident diversity as well as commonality between and among the three countries, I wanted to examine the extent to which regime characteristics were viable explanations of policy action and inaction, given the varying contexts. In order to apply the concept of regime maintenance to human resources policy, I needed to look for evidence of ‘policy-space availability’, its use, and its relationship to regime-based factors such as strength, stability, ideology and democracy. This had to be balanced against mitigating structural factors such as resource availability and institutional characteristics. I also had to ‘discover’ from the field which particular regime characteristics were relevant to the study. The influences and consequences of ethnicity and ethnic politics on general development, particularly in relation to Guyana and Trinidad, have been the focus of much research (Hintzen, 1989; Premdas, 1993; 1994; Ryan, 1972). Hintzen’s study (1989) of the influence of regime survival and political control in Guyana and Trinidad prompted me to question whether it could be logically extended to policy analysis. Hintzen’s findings on the role of regimes and racial mobilisation in each state was particularly significant. I was not interested in the direct role of racial factors in public policy. Rather, I was interested in the study of the implications and outcomes for social policy making within such potentially divisive political arenas. The dominance of racial groups in the various health professions, or health care provision in geo-ethnic regions of Guyana and Trinidad would undoubtedly make for interesting studies. However this was not my interest in particular study. I wanted to analyse the linkages between (as well as the consequences of) regime power and action (and indeed inaction) in the planning, training and management in relation to doctors and nurses.

Comment: These questions formed the basis of my initial conceptualisation of the study. I wanted to apply them to human resources development in the Commonwealth Caribbean health sector for two reasons. The first already highlighted earlier, was my basic interest in trying to find explanations and linkages for my initial observations in Guyana, Jamaica and Trinidad. The second was that virtually no non-technical, policy-based research had been done on Commonwealth Caribbean health policy using a political economy approach that borrowed from political sociology as well as broader concepts of political theory. I believed that adequate qualitative data existed to enable applied, comparative policy studies to be undertaken in analysing - what appears to be at first glance - an obscure and irrelevant link between regime survival and health policy processes. In the next section, I discuss briefly the evolution of my preparatory work.

Preparation

My choice of Jamaica, Guyana and Trinidad as the ‘policy arenas’ under focus was therefore informed by familiarisation as well as observation of policy evolution in the three states. While I did briefly contemplate including a non-Commonwealth Caribbean developing state for further interesting outcomes, limitations of time and money meant that I had to confine myself to this region. I was also familiar with the obvious similarities in general development experience which characterised them. There are however important differences in political systems and regime characteristics that have significantly influenced each country’s overall political and policy development. I therefore decided that I wanted to compare and
contrast their policy-making experiences in the post-Independence period based upon the broad concepts outlined earlier. I was particularly existed in the post-1970 period because for all three states, this was their second decade of self-rule after what seemed to be a relatively unsuccessful developmental decade of the 1960s. In terms of background research, there existed few comprehensive comparative policy studies on the specific area of human resources development in the health sector in developing countries. As far I was aware, there was none on the Caribbean region, with the exception of numerous technical consultancies. This made it a potentially daunting task in terms of searches for previous references despite my belief that it could be done.

According to Marshall and Rossman (1995: 5-6) researchers who conduct qualitative research face at least three challenges one of which is 'want to do-ability' - that is, the researcher's engagement with the topic. My experiences as undergraduate politics student in Jamaica, my stint at the Caribbean Community Secretariat as well as my own interest in health policy provided the personal commitment to undertake the study. I applied to and was accepted by the University of Hull to pursue studies leading to the M.Sc in Health Services Research in October, 1992. Having settled into the course I decided to undertake a qualitative study of the politics of the health policy process with specific to English-speaking Caribbean countries. After the first term of study, I was upgraded after discussions with my course director, now supervisor, to a Ph.D in health policy administration. I informed him of my interest in regime influence and its impact both directly and indirectly on policy-making for health professionals - in terms of planning, production and management - in the three countries that I had chosen to study. I had to decide with the help of my supervisor which was the best method or combination of methods that would help me to carry out the aims and objectives of my research. He urged me carry out an initial literature review of the area and prepare a proposal as well as an itinerary for the field-work.

During the first term, I carried out an initial survey of the general area of health policy in developing states. This was largely confined to journal articles which examined health policy experiences in post-colonial Africa, Latin America and a few island states, such as Mauritius and those of the South Pacific as well as a literature search of Caribbean health policy which, in spite of a few notable exceptions (Cumper, 1986; Cumper, G.E., 1983; 1993; Hezekiah, 1989) was markedly deficient. Second, I found that the available 'health' and health policy literature seemed to negate the politics of the policy process, while paradoxically the field of health economics rapidly expanded in the aftermath of the 1980s adjustment period as demands for such quantitative information increased. Even the approaches were different. Navarro (1982) and Doyal (1979) among others used Marxist and dependency approaches in their respective examinations of the politics of health in developing countries. These studies helped enormously in forming an important part of the context for conceptual development of the study. I found however that economic determinism limited their usefulness for my study. They helped me however to focus on those issues common to the developing state experience in the case of health policy. This equally applied also to my own readings and prior knowledge of the Caribbean political, social and economic environment. The structural-functionalist approaches to health and social policy analysis were also important sources. Of these studies, Heidenheimer, Heclo and Adams (1990); Ham (1980); Hill (1993) and the cross-national aggregate approach of Leichter (1979) were the most detailed. The focus of these studies on 'developed world' social policy processes though somewhat inappropriate, were nevertheless extremely helpful, given the dearth of relevant comparative policy literature in the initial conceptual development of the research proposal.

In addition to engagement with the topic, Marshall and Rossman (1995: 5-6) also pointed to another important challenge for the social researcher: 'should do ability' or, the need to develop a conceptual framework for the study that is thorough, concise and elegant. I had decided to examine the concepts 'regime characteristics' and 'policy space availability' while controlling for economic factors. I needed therefore to find a method that would enable exploration of those particular 'regime characteristics' that were most influential in determining the use of that 'policy space'. I therefore needed to develop a suitable and methodologically-sound framework that would analyse available data in a systematic way that at least partly allowed a 'non-determinist' look at events/happenings. Theory development in the field would only occur if I found and linked repeated evidence of those observations that were not sufficiently accounted for by dependency theory. The second issue that I wanted to highlight was the 'process'
variable. This I believed, could be done by comparing regime influence and its composites on policy. Comparing the decades of the 1970s and the 1980s would also address the ‘time/transition’ element of this question.

The third of Marshall and Rossman’s challenges is ‘do-ability’ or the feasibility of planning a design that is systematic and manageable, yet flexible. In terms of ‘do-ability’ the fact that human resources policy analysis in Guyana, Jamaica and Trinidad, and indeed health policy analysis generally, was relatively under-researched meant that I needed a flexible method which would incorporate the limitations of data collection ‘in the field’ as well as time and money constraints. The choice of national policy ‘arenas’ as well as the focus was informed by the need to explore, uncover and attempt to fill the research gap on human resources policy processes. It was equally informed by familiarisation, observation of policy evolution and the similar developmental experiences between them. There were also, however, important differences in political systems and regime characteristics that had significantly influenced each country’s overall political and policy development. I wanted to compare and contrast these differences and similarities in relation to policy action and process in the post-Independence period. I was uncertain as to whether method(s) existed in the social sciences that would give me the necessary flexibility, especially given the fact that I was uncertain as to the quality and accessibility of data on Jamaica, Guyana and Trinidad in relation to human resources development in the health sector. I expressed my concerns to my supervisor. He suggested that I consider an ‘open approach’ to the study which would allow theoretical categories to emerge, rather than a more closed approach on which categories were imposed. Strauss and Corbin (1990: 176) described this method as “...theoretical sampling on the basis of concepts that have proven theoretical relevance to the evolving theory....” I agreed to adopt this approach as the most suitable way to operationalise the study at this stage. I wrote letters of introduction to the ministries of health in each country and gained approval to collect data from their respective documentation centres and libraries and also interview selected personnel from their respective ministries. I then prepared and submitted my initial proposal and gained approval for the following itinerary from my supervisor:

Table 3.1: Itinerary

<table>
<thead>
<tr>
<th>Period</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>September, 1993-October,</td>
<td>Undertake preliminary analysis of secondary sources in Hull and the</td>
</tr>
<tr>
<td>1994</td>
<td>Caribbean</td>
</tr>
<tr>
<td>October, 1994</td>
<td>Visit Guyana: data collection</td>
</tr>
<tr>
<td>November, 1994</td>
<td>Visit Jamaica: data collection</td>
</tr>
<tr>
<td>January-August, 1994</td>
<td>Trinidad and Tobago: data collection</td>
</tr>
<tr>
<td>September, 1995</td>
<td>Return to Hull to complete write-up</td>
</tr>
</tbody>
</table>

Comment: I decided to begin the ‘open approach’ by first re-establishing my initial contact with colleagues and acquaintances as well as health sector personnel in each country. This was to be complemented by extensive documentary analysis on site in each country at both the broad political level as well as the actual technical/policy level. My initial observations of the concepts of ‘regime characteristics’, ‘policy space’ and ‘policy action and inaction’ were just that: initial observations of broad concepts. The next step was to begin the simultaneous tasks of data collection and theoretical sampling in Guyana, Jamaica and Trinidad in order to find out whether these observations had any foundation.

Collecting and analysing the evidence

Using the ‘open’ approach, I decided that a two-pronged method of unstructured, open-ended interviews, coupled with extensive documentary evidence would allow theoretical concepts or ‘categories’
to emerge. I would then analyse records of incidents and events relating to production, planning and administration/management policies. The next step for my research would then be to explore the potential leads and linkages that I hoped to find by assessing the evidence for them, against my already collected data on regime variables. I returned to Trinidad in September 1993 to begin the open-sampling process. I started with a broad analytical review of the available data on politics, development and health policy in general and specifically human resources development in the Caribbean. The objective was threefold. First, I had to review all of the political concepts that had been used in Caribbean political analysis with specific reference to the state and public policy. I then had to identify from this data, those concepts that could be deemed significant. Significance would be determined by the repeated presence of a phenomenon in the literature.

Finally, I had to make a pragmatic judgement, based on the above sampling, as to which of these significant concepts had direct as well as indirect linkages to the planning, production/training and administration/management policy processes in the health policy processes of each country. Equally important for the meaningfulness of the research, I needed to know that adequate supporting data for these significant concepts could be found. Linkages would then be sought and developed between these 'political' concepts and the human resources policy process. In relation to the main political themes generated by Caribbean researchers since the 1960s, I found that regime-related variables comprised a significant proportion of the focus of analysis. Though not the only area under study, it was clear that regime variables were emerging as a factor in Caribbean policy. In terms of the Caribbean as a whole, regime-related issues covered general politics (James, 1962); the development of regime typologies (Stone, 1980); the impact of regime policy on public administration and bureaucracy (Mills, 1970; 1973 and 1981 and Jones, 1974b; 1981), authoritarianism (Thomas, 1984; 1988); local government (Singh, 1972) and most interestingly to me, regime survival (Hintzen, 1989).

Specific country-based studies ranged from the influence of regime ideology and race relations in Guyanese and Trinidadian national politics (Premdas, 1970, in Payne and Sutton 1993) to regime ideology and development policy in Trinidad (Sandoval, 1983); Guyana (Thomas, 1984; 1988) and Jamaica (Stephens and Stephens, 1983; Kaufman, 1985; Payne, 1976; Edie; 1991 and Mandle, 1977). Stone's analyses of regime democracy in Jamaica (Stone, 1976; 1980; 1983 and 1986) as well as Greene's study of democracy in Guyana (in Henry and Stone, 1983) further highlighted the importance of regime variables for Caribbean political researchers. Of these Caribbean studies, I was particularly interested in the studies by Stone, Thomas, Edie and Hintzen. In Stone's (1980) typology of Caribbean regimes, both Trinidad and Jamaica were classified as competitive party systems, while Guyana (before its first fair elections in 1992) was categorised as a one-party dominant system. Most of the above researchers however use the broad regime categorisations that I have used in this study to describe Guyanese, Jamaican and Trinidadian politics in the 1970s and 1980s. I decided that I wanted to apply these broad regime categories across the three states over the period between 1970 and 1990. The question of authoritarianism raised both in connection between Burnham's Guyana and Williams' Trinidad presented the opportunity for a promising comparison, given Trinidad's classification as a competitive party system. This had potentially good prospects for the explaining the relationship between health policy and regime characteristics.

In addition to the above, I was also interested the issue of public policy inaction raised various Caribbean public administrations studies in terms of its direct and indirect implications for human resources development (Mills, Jones, 1974b; 1981; Jones and Mills, 1976; 1989; Mills, 1973a; Mills and Slyfield, 1987). The question of governmental centralisation was a recurring complaint in the literature in terms of its negative impact on policy formulation and implementation. The concepts of 'inaction' and 'limited action' at the bureaucratic level seemed to reflect a general lack of attention paid to public and indeed health service reforms since the 1950s. It was thus an issue that had some potential linkages with regime characteristics. I was using the 'open approach'. I therefore wanted to see whether ample evidence existed for validity of these conclusions in the public administration and human resources data. The justification for selecting the regime as a conceptual variable was therefore grounded in existing research on the region. I next had to decide which regime variable had overall proven theoretical relevance. The two studies that pointed 'the way forward' were Bossert's (1983) study of regime characteristics and
primary health care in Central America and Hintzen’s study of the influence of regime political survival on politics in Guyana and Trinidad. I wanted to explore the feasibility of incorporating Bossert’s typologies with Hintzen’s ‘regime survival’ as a potential framework in explaining both policy action and inaction. I wanted to analyse the extent to which regime-based analysis could explain and compare policy processes in 1) ethnically-plural, undemocratic Guyana; 2) ethnically plural, democratic Trinidad, and 3) the class- (rather than race-) divided two-party, democracy in Jamaica, where an extensive patronage system was nevertheless entrenched along class- rather than ethnic lines (Edie, 1991).

I also wanted to incorporate into this potentially useful framework, the concept of ‘process’. I wanted to examine the determinants of the different stages of policy making and reform: from agenda-setting, to decision-making and implementation. This aspect of the analysis would underline the importance of policy ‘flow’, ‘transition’ and succession (Hogwood and Gunn, 1984). It would also explain the transaction that defined policy analysis, i.e. the relationships between the actors in the policy arena. In terms of the time factor, it would also enable me to compare and contrast the influence of the regime typologies, especially ideology and democracy, in each country across two decades and also afford cross-country comparisons of any ‘discovered’ relationships. If regime characteristics were found to be important determinants of policy that encompassed to varying degrees Bossert’s typologies, I also needed to examine the impact (if any) of regimes changes on policy outcomes. It was only by including an analysis of the ‘process’ question that I believed that I could either establish or diminish the role and importance of the post-colonial regime and its characteristics as important sources of policy.

In relation to health human resources development, I adopted the World Health Organisation’s re-definition of health human resources development (formerly the politically-incorrect health manpower development) as the production, training and management of health workers (Simmonds, 1989). Again I used an ‘open approach’ to determine both the importance and categorisation of incidents and concepts. They either had to be repeatedly present or absent in the data that I would collect from both my interviews and more important, the available documentary analysis. Attempts to determine whether conclusive linkages existed between these concepts/incidents/events and regime variables would then be made. Only then could I proceed to further detailed sampling.

Another issue was the categorisation and actual ‘grounding’ process, that is, the relating of policy actions and inaction to regime characteristics. During my fieldwork, I discovered evidence of ‘action’, ‘limited action’ as well as a significant level of ‘inaction’ in human resources policy at all three levels of health human resources, that is, in the planning, production/training and management/utilisation processes for health professionals. At this stage, I could only speculate about the possible relationships between regime variables and their probable influence(s) on policy outcomes as well as the dimensions of those outcomes. The question of ‘inaction’ was particularly interesting as I found evidence of this during my preliminary reading. I found in Trinidad, for instance, no formal written health human resources development (or health manpower) policy. I wondered whether the same applied to Guyana and Jamaica. The implications of this for my research was also problematic, though I recalled that inaction and by extension absence of formal policy could itself be considered a policy action (Bachrach and Baratz, 1963; Lukes, 1974). I accessed the necessary finances that allowed visits to Guyana (four weeks, October 1994 and Jamaica (five weeks November/December 1994). I conducted a limited number of open-ended interviews with senior officials at the Ministries of Health and Public Services respectively in Jamaica, including the director of health planning. In Guyana, I requested and subsequently gained interviews with both the current and past ministers of health as well as the head of the Pan American Health Organisation (PAHO) mission. I also interviewed a former minister of health in Trinidad. I tried without success however to gain interviews with health ministers, present and past, in Jamaica. I discovered from these interviews and documents evidence of action, limited action as well as inaction in all three countries.

While in Guyana, I made extensive use of available documentary material/data including technical consultancies at both the Pan American Health Organization office as well as the Caribbean Community Secretariat in Georgetown. In Jamaica, I established contact with a lecturer in public health at the University of the West Indies’ School of Public Health, who introduced me to other senior public health
academics. I also managed to access pertinent documentary data on human resources development in Jamaica from the Pan American Health Organization in Kingston, in addition to establishing contact and carrying out interviews with some senior ministerial officials in the health human resources field. Because of the relative short stays (six weeks each) in Guyana and Jamaica, I knew that I had to carry out most of the analysis and corroboration on the ground because my financial situation precluded any return to these two countries.

I collected and analysed pertinent data in both countries at various locations, mainly those already mentioned. Based on the information in these documents, I arranged interviews with the relevant sources (authors, consultants and health policy officials). The open sampling approach also meant that the process was essentially a cyclical one. Most of the interviewees guided me towards more richer documentary sources of data as well as other potential interviewees. Due to various reasons, the main ones being unavailability and limited resources, I was not able to meet every potential interviewee on my list. In Guyana, I carried out interviews with seven of the (10) that were on my original short-list. While in Guyana, however, I met four Amerindian midwives who were able to shed considerable light on past and present government policies in relation to the rural hinterland. In Jamaica, the response was much the same with six (7) actual out of ten (10) potential interviewees, though I did meet three additional interviewees through recommendations. Table 3.1 below lists the designations of the interviewees. I collected and analysed as much data as I could from these sources (both interviewees and documents) in the first two weeks of my visit. The final two weeks in each country was reserved for further examination of the collected data. I basically had to find supporting or negating evidence (by examination of events, processes, incidents) for the linkages between regime categories (strength, stability, ideology and democracy) and regime maintenance; and specific aspects of human resources development policies (planning, production and administration and management) and processes. I also had to find and account for the type(s) of action (positive action, limited action, non-action). The preliminary 'open' approach thus had to give way to a much more detailed and focused approach.

<table>
<thead>
<tr>
<th>Category</th>
<th>Guyana</th>
<th>Jamaica</th>
<th>Trinidad</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ministers of Health</td>
<td>2</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Senior HRH officers</td>
<td>2</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Senior doctors</td>
<td>-</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Nurses</td>
<td>-</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>HRD consultants</td>
<td>4</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Student nurses</td>
<td>4</td>
<td>-</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Overall Total</td>
<td>36</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Interviews with senior officials in both Guyana and Jamaica provided a range of data as well as their own views about the state, causes and consequences of doctor and nurse planning, production and management. The data that was accessed, although uneven, yielded valuable information on the role of the developing state regime in the following areas of these categories:
I had also 'discovered' this pattern in my preliminary fieldwork in Trinidad. I therefore decided to use these specific areas as the second stage of my fieldwork to guide the study. I spent the last two weeks of my fieldwork examining documentary sources and conducting second interviews to get more details on particular incidents pertaining to these categories. The information that I gained in the time available in both Guyana and Jamaica was enough to assure me that analysis was possible in relation to each category. On my return to Trinidad, I continued the analysis of the collected data from Guyana and Jamaica. I also conducted further second interviews and additional documentary searches at the Ministry of Health, the University of the West Indies and the Pan American Health Organisation's country office. As the categories unfolded, I decided to further explore the data relating to the Williams' government's policy decision to build the medical school in Trinidad and its possible relationship to regime politics. In the process of doing so, I managed to collect a wealth of information - documentary, newspapers, consultancies and national reports - supported and supplemented by the interviews while there, as was the case in the other two countries. The good quality of the data on this particular policy was demonstrated by the fact that I was able to trace the main phases of the policy process, from formulation to implementation and outcomes/consequences. This was done by cross-comparing data from a wide variety of sources including cabinet notes and newspaper reports with unstructured interviews. This technique enable me to uncover the regime-based political elements which I then subjected to further cross-comparison for factual accuracy. I reported this to my supervisor who pointed out that this data could be used most effectively in a case study. Financial problems, together with the late collection of data precluded an early return to Hull. I however secured British Council funding to assist with the write-up period, returning to Hull in late 1995. The analysis of the data and the final write-up were however interrupted by personal problems in February 1996. I did not return to Hull again until November 1996 to complete the final write up.

Comment: My particular interest in this study was to explain the role and influence of regime characteristics and behaviour on policy action and inaction in the post-colonial state. My empirical knowledge of the area suggested that ideology and democracy were particularly significant determinants. Hintzen's analysis of regime survival, in particular, convinced me that if added to a wider examination of regime characteristics generally - done along Bossert's four regime characteristics sub-categories - might be the best way to synthesise and analyse the data. As I started the collection and analysis process, what emerged was a relatively complex process of action and interaction that pointed to their usefulness as analytic tools in developing state policy processes. I adopted the World Health Organisation definition of human resources development as the planning, production/training and management and utilisation of health workers and professionals. I limited my human resource 'professional' categories to doctors and nurses simply because these are the main health human resource categories. However, in the case of Guyana, I included two other categories: community health workers and medex - both being the result of important government policy strategies which were introduced during the period under study. Similarly in the case of Jamaica, I also included data on community health aides - the equivalent of the Guyanese community health workers, and also an important social policy plank of the democratic socialist Manley regime. I also limited the study to the public health sector, since lack of basic data on the private health sector precluded any exploration of linkages, though they clearly existed. I now turn to the formal methodological approach used in the data analysis.
3.3 THE GENERAL METHODOLOGICAL APPROACH

I defined the objective of my research as an examination of the influence of the post-colonial regime on the human resources policy processes in Guyana, Jamaica and Trinidad in the 1970s and 1980s. Using theoretical sampling, I had discovered evidence, including incidents and events relating to planning, production and management - the three broad components of health human resources development. I needed to further refine this ‘open approach’ into an analytic method. I had to search for and analyse possible relationships by comparing categories and their similarities and differences at the dimensional level. I also needed to find a method that would integrate the ‘open’ approach to theory building with a cross-comparison of cases at both the national and conceptual levels. In this section I shall discuss the two-pronged methodological approach that guided my research, beginning with the grounded theory approach.

**Grounded theory**

Grounded theory was developed by Glaser and Strauss for medical-sociological studies of death and dying (1965; 1967). Its further application to policy analysis was however developed by Strauss and Corbin (1990). Strauss and Corbin note that ‘concepts’ are the basis of grounded theory research and that all grounded theory procedures are aimed at identifying, developing and relating these concepts (1990: 177). The approach can be best described as ‘hypothesis-generating’ or ‘hypothesis-creating’, where the researcher is actively involved in selection, analysis and interpretation. The predominance of economic explanations in the national policy arena of developing states left little room for alternative explanations. I wanted to examine possible linkages within this ‘limited room’ between human resources policy and regime characteristics using the ‘open approach’. I would then make a determination as to whether regime politics constituted a significant (or insignificant) influence on human resources policy action and inaction. In doing so, I hoped to answer the ‘how’, ‘why’ and ‘with what consequences’ questions for both health human resources specifically, as well as the wider questions about, and implications for development.

Grounded theory is described by Strauss and Corbin (1990: 23) as a general methodology that is “...inductively derived from the study of the phenomenon it represents...”. Accordingly, the theory that develops is grounded in data that has been systematically gathered and analysed. It evolves during the actual research through continuous interplay between analysis and data collection with the central feature of the method being constant comparison of data. Glaser also describes the method of “...generating theory and doing social research [as]... two parts of the same process...” (1978: 2). The researcher therefore has to perform three different but related types of analysis or coding in grounded theory. The first, open coding is described as the process of breaking down, examining, comparing conceptualising and categorising data (Strauss and Corbin, 1990: 61). The second is axial coding, where the ‘broken-down’ data, having been categorised, is then put back together to make connections or linkages between categories. This is carried out using the paradigm model. In this model, one specifies a category phenomenon in terms of the causal conditions that give rise to it; the context (its specific set of properties) in which it is embedded; the action/interactional strategies by which it is handled, managed, carried out; and the consequences of those strategies (Strauss and Corbin, 1990: 97-99). According to Strauss and Corbin, these specifying features of a category or phenomenon gives it precision, and therefore can be termed sub-categories. Causal conditions are defined as events, incidents, happenings that lead to the occurrence or development of a phenomenon. The phenomenon or core category is defined as the central idea, event, happening, incident about which a set of actions or interactions are directed at managing, handling, or to which the set of actions is related. The context relates to the specific set of properties that pertain to a phenomenon; that is, the location of events or incidents pertaining to a phenomenon along a dimensional range. Context represents the particular set of conditions within which the action/interactional strategies are taken. The intervening conditions are defined as “...the structural conditions bearing upon action/interactional strategies that pertain to a phenomenon...” which either facilitate or constrain the strategies taken within a specific context (Strauss and Corbin, 1990: 99). The action/interaction category incorporates strategies devised to manage, handle, carry out, or respond to a
phenomenon under specific sets of perceived conditions. Consequences are basically the outcomes or results of action/interaction.

The third or selective coding stage describes the process of selecting the core category, systematically relating it to other categories, validating those relationships, and filling in categories that need further refinement and development. Here the core category is the central phenomenon around which all the other categories are integrated. The core category is in essence the conceptualisation or storyline; the narrative about the central phenomenon under study (Strauss and Corbin, 1990: 116). A later innovation of grounded theory was the 'conditional matrix', which essentially enables the analyst to both distinguish and link levels of conditions and consequences at the sub-national, national, regional and international levels with many and usually include the various sub-organisational components found even within these levels (1990: 158). It basically traces the theoretical/conceptual storyline of the study through these various levels. This is done by examining the interactive nature of events through the tracking of an event, incident or happening from action/interaction through the various conditional and consequential levels, and vice versa, in order to directly link them to the central phenomenon or core category.

In terms of similarities with other methods, grounded theory is an interpretative and redefined method with interpretations sought for understanding the actions of individuals or collective actors being studied. Additionally, sources are basically the same, for example, interviews and document reviews. In relation to sampling of incidents, Strauss and Corbin (1990: 176) point to the importance of theoretical sampling, dimensionalised differences and similarities and flexibility. They stress the importance of 'proven theoretical relevance' in this regard:

"...concepts [that are] are deemed to be significant because they are repeatedly present or notably absent when comparing incident after incident, [and] are of sufficient importance to be given the status of categories..." (Strauss and Corbin, 1990: 176)

Comment: Grounded theory methodology is used in qualitative policy studies to examine issues such as context, influences at various levels and consequences or outcomes. While solving at least one part of my research objectives, I was however only able apply the hypothesis-generating element to my study, given the aforementioned constraints of the study. Similarly, while not interested in high-levels of hypothesis-generating which I did not think was fully applicable to a complex area such as policy analysis, I was nevertheless more concerned to use grounded theory in order to critically re-examine the more pervasive theoretical norms in Marxist and neo-Marxist approaches to development. In doing so, I hoped to find enough support, through proven theoretical relevance of the linkages between the various components of regime characteristics and health human resources policies in the developing state. One such tenet was the negation of national level political action and inaction -whether positive or negative. In terms of using theoretical sampling in a cross-national comparative study, the usefulness of grounded theory is therefore obvious. Theoretical sampling of 'policy action' and 'inaction', the dimensions of such action and their relationship to specific regime characteristics provided the methodological link to comparative analysis for my research. To summarise then, I applied only one half of the grounded theory approach - the hypothesis-generating element for its usefulness a non-deterministic 'open' approach to the study of the post-colonial politics, that did not either fully accept or reject existing theories, but rather questioned them. In addition, I decided that hypothesis-testing in the comparative policy field, at least for this study would be less useful, than an application of the broad techniques of this component of grounded theory to the data. I shall next discuss the comparative method.

The comparative case study method

Comparative policy analysis can be basically described as a cross-national study of public policy, where public policy comprises "...a series of goal-oriented actions taken by authoritative usually governmental actors..." (Leichter, 1979: 3). This definition emphasises state activity, with public policies usually contained in legislative enactments including budgets, executive and administrative orders and decisions, judicial decisions, among others (Leichter, 1979: 3). Typical methods used in the early days of
comparative policy analysis included cross-national aggregate analysis. Leichter himself used cross-national aggregate analysis in analysing health policy across four developed countries. However, such studies have been criticised for not developing sufficiently complex descriptions of regime characteristics (Bossert, 1983: 419). Heidenheimer et al (1990) trace the origin of 'cross-cutting' or comparative perspectives from Aristotle to Macchiavelli in the 16th century, noting that the systematic comparative study of public policies emerged only in the last thirty years or so. In contrast to its ancient ancestors, it is pointed out that the modern field of inquiry took as its starting point the nation state and the intellectual framework of 20th century social science. In supporting the usefulness of integrated approaches, they note the increasing shift away from single factor deterministic theories and acceptance of the need to integrate diverse perspectives in order to produce plausible accounts of policy development (Heidenheimer et al, 1990: 9). This view is shared by those grounded theory proponents, Strauss and Corbin who also see the need for plausible relationships among concepts and sets of concepts as the prime conceptual components of theory (1990). On the issue of means and methods in comparative case study analysis, Heidenheimer et al pointed to five problematic issues: 1) finding truly comparable measurements; 2) appropriate indicators; 3) 'collinearity' of variables; 4) the dynamic quality of public policy development and 5) uniqueness (1992: 9-12). Though they emphasise the need to see similarities and underplay differences, I thought that differences also had to be explained and hence incorporated into any meaningful analysis.

In terms of case studies, Hakim (1992: 61) points out that this method can take as its subject one or more examples of actors or relationships which can then be analysed using a variety of data collection techniques. The usefulness of the case study approach lies in its provision of rich detail to substantiate observed patterns and processes. In terms of multiple case study, Hakim adds that these are done either to replicate the same study in different settings or to compare and to contrast different cases. The flexibility and diversity of case studies in dealing with either actor-related or event/relationship, interaction-type studies as well as its well-established reputation in international comparative studies of national government (1992: 65-72). Hakim also adds that relationships, events, roles and interactions are a more diffuse category of case study, highlighting the role of the interviewee in case studies as both respondent and informant (1992: 73). She further pointed to the importance of prior knowledge of the subject area as an important starting point for such studies. Case studies often involve specialised interviewing of informants, professionals, and organisational or public role-holders which is quite different from standard research interviewing. Hakim concludes that the criteria that informs any study influences its rigour between descriptiveness, on the one hand, and the rigorous test on the other. However, as this study focuses on the influence of regime characteristics on the policy process I wanted to be neither too descriptive, on the one hand (which would not yield valuable insights), nor too hypothesis-oriented (which as I have already noted, would have been, in my opinion, too rigid for this type of study).

This method thus specifically focuses upon comparisons between initial expectations and actual outcomes which are frequently different or sometimes altogether "unforeseen, undesirable and unintended..." (1990: 3-4). Importantly for my work, the limitations involved in studying this little-analysed and relatively unresearched area, Heidenheimer et al noted that what mattered for comparative policy analysis was not so much identification of this or that decision and how it was made but "...the string of decisions that add up to a fairly consistent body of behaviour sanctioned by governmental authority..." (1990: 5). They added that there must be some underlying logic in and justification for the choice of cases. Therefore, configuration of 'movement' and 'activity' are crucial when analysing policy, guided by a central concern for the larger general trend. The fact that comparative policy analysis draws from many different disciplines is also recognised in the Heidenheimer et al approach. They state that because of this it can never become a self-contained discipline, since the how question often draws heavily from the fields of comparative government, public administration, political science generally, as well as political theories of development in the case of this study; the why question veers into areas such as political sociology, history, social psychology and political economy, among other fields; and the to what effect element covers the field of implementation analysis, economics and "...ultimately, when one evaluates results in terms of the kind of society we would like to live in, social philosophy..." (1990: 6). However, as Geertz noted about the overall advantages of comparative political analysis:
"...It is through comparison (and comparison of incomparables) that whatever heart we can get to can actually be reached..." (1983: 233).

Comment: The usefulness of integrating the comparative case study approach with the hypothesis-generating element of grounded theory allowed the most suitable approach to my analysis, given both the nature of the study and its inherent limitations. Leichter has stated that because public policy had several dimensions, the study of public must include:

1. an analysis of the intended purpose of state activity;
2. the steps taken to enforce these intentions and related explanations; and
3. measures of their consequences (1979: 8).

He added that there was no one inherently superior analytic approach to such studies. For Heidenheimer et al however, there are good reasons for engaging in comparative policy research, the prime one being to gain a deeper understanding of how government institutions and political processes operate as they deal with concrete problems. They point to the fact that comparative policy analysis occupies the middle ground between 'pure' and 'applied' research, noting the following advantages:

"...it broadens our understanding of particular policy problems and the lessons to be derived from experience. It helps us to test general theories and hypotheses by exposing the varied nature of policy decision-making as it confronts concrete issues and it also illuminates the various and subtle ways in which politics works to produce choices of a collective or social nature. Accordingly, sensitivity to that process helps us to begin seeing beneath the surface of political events in our rapidly changing and inter-dependent societies..." (1990: 2).

Heidenheimer et al also noted the importance of the fundamental tenets of comparative policy, namely the conceptual distinctions between the how, the why, the to what effect and the courses of action and inaction (1990: 3). They emphasised the need to address the specific issues surrounding how governments chose to act and the various structures and processes which framed such actions and/or inactions. Beyond this, they emphasised the need to examine the influence of the:

"...constellation of interest groups, public opinion, program beneficiaries...the ideas of policy makers present, which, no less than the power they seek to exercise, constitute the raw materials for explaining why policy similarities and differences occur..." (1990: 3).

Qualitative studies of the policy process in the developing state also demand a certain level of flexibility and innovation in both framing the study and accessing the rich data that exists but is not catered for in some of the more inflexible and deterministic methods. Grounded theory with its raison d'être as a theory building method gives precisely this flexibility, albeit within specified structures for data collection, breakdown and re-configuration to yield new insights. It focuses on the tracing of a phenomenon through its context, action/and interaction and consequences. It also enables the utilisation of existing theories where the are found to be adequate, and new smaller theories are then built to fill the existing theoretical gaps. In terms of actual policy there is however basic agreement about the importance of action and process in comparative study. Heclo (1972), like Leichter acknowledges that "...a policy, like a decision can (also) consist of what is not done...". Heidenheimer et al (1990: 1-3) are more specific in defining comparative public policy as "...the study of how, why and to what effect different governments pursue courses of action or inaction...". The role of inaction as a policy decision was particularly significant to my study of Caribbean policy-making, as I wanted to analyse whether this was a significant policy outcome of regime politics or simply the absence of adequate resources. Policy comprises both action and process. Comparative analysis - whether by country, by regime by decade -
enables analysis of similarities and variations in action. It also encapsulates the ‘process’ and ‘time-space’ factors which are vital to any attempts at policy theory-building. As Strauss and Corbin put it:

"...Knowledge is after all, linked closely to time and place. When we carefully and specifically build conditions into our theories, we eschew claims to idealistic versions of knowledge, leaving the way open for further development of our theories..." (Strauss and Corbin, 199: 276).

To summarise, then, the insights from grounded theory, when combined with the comparative case study method offered the breadth, variety and contrast that are useful in comparing policies both within and across nations and regions. The advantage of the hypothesis-testing element of grounded theory is that it allows one to find and establish theoretical linkages in a non-predetermined way that can be applied both within and across country policy. The advantage of the comparative case, in contrast to single case studies is that it also allows one to examine selected dimensions of policy across states, enabling patterns of both similarities and differences in action, interaction and consequences to be observed

3.4 MY RESEARCH METHOD

Before, explaining my actual method, I outline, in Table 3.4 below, the main characteristics of the regimes under study. These categorisations are generally underscored in the Commonwealth Caribbean political science literature. However, it must be noted that the concept of changing circumstances, for example, the change from boom to bust within a short period, is difficult to replicate in a table. Nevertheless, Table 3.4 lists the regimes under study in the 1970s and 1980s. In the data chapters to follow, I outline the specific regime characteristics for each decade.

Table 3.4: Regimes under study by country, year and political party

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>YEAR</th>
<th>REGIME</th>
<th>POLITICAL PARTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guyana</td>
<td>1970-1986</td>
<td>The Burnham regime</td>
<td>Peoples National Congress (PNC)</td>
</tr>
<tr>
<td></td>
<td>1986-1991</td>
<td>The Hayte regime</td>
<td>Peoples National Congress (PNC)</td>
</tr>
<tr>
<td></td>
<td>1980-1989</td>
<td>The Seaga regime</td>
<td>Jamaica Labour Party (JLP)</td>
</tr>
<tr>
<td>Trinidad and Tobago</td>
<td>1970-1981</td>
<td>The Williams regime</td>
<td>Peoples National Movement (PNM)</td>
</tr>
<tr>
<td></td>
<td>1981-1986</td>
<td>The Chambers regime</td>
<td>Peoples National Movement (PNM)</td>
</tr>
</tbody>
</table>

In my research, I applied the dominant regime characteristics listed in the two main data chapters - Chapters Four and Five - from the political sciences data for the specific years as shown above - to the health policy data, based on theoretical sampling of policy incidents/events. This process led to the development of the study at three levels. These comprise first, a general three-way comparative case study of health human resources planning, training and management policy processes generally under successive Guyanese, Jamaican and Trinidadian political regimes in the 1970s and 1980s. The second level is also a three-way comparative case analysis of regime responses to doctor and nurse migration which also focuses on the 1970s and 1980s. Finally, the third, and most detailed of the levels is a single case study which compares regime characteristic influences within one country on one policy issue.
medical training. This level focuses on the role and influence of regime maintenance on the Williams regime’s policy decision to build the medical school in Trinidad.

'The general three-way comparative case study: planning, production and management in Guyana, Jamaica and Trinidad in the 1970s and 1980s compared'

At this level, my primary concern was to undertake a comparative analysis of the influence of regime characteristics and change on the human resources policy process generally across the three states and across two decades: the 1970s and 1980s. The aim was to explain similarities and differences at the cross-national level in line with my hitherto unsubstantiated assertions. The focus was therefore on the influence of regime characteristics on selected policies related to planning, training and administration in the 1970s and 1980s for which data could be accessed. In the case of planning, my research concentrated on available health plans, the existence of policies, the speeches of politicians and senior level bureaucrats.

In terms of training and production, I examined and assessed the relative influences of regime characteristics and medical influence on established training and 'training innovation' policies for doctors and nurses. The focus here was both on the role of the medical influence in training, as well as the attempts by regimes to reform the traditional medical curative bias. It also focused, in this regard, on appropriateness in regime responses to the goals set out in each country in relation to the United Nations/World Health Organisation's guiding principles on primary health care. 'Process' is also incorporated by comparing the policies and policy responses of successive regimes in the 1970s and 1980s. In the area of administration and management, I focused on policy action and inaction at two levels: the sectoral or health ministerial level; which I related to the second level, i.e. the context of reform efforts (or non-efforts) at the national administrative level. In the case of the first, I limited my interpretation of the term 'management' to mean the politics involved in managing and/or administration of the health professionals after training. In this section, I progressively examined the following issues: the influence of regime variables (including regime change) on migration; regime responses (by characteristics) and approaches to retaining health professionals, including methods such as post-graduate and post-basic training, job incentives and creation of new professional categories; and the successes, failures and consequences involved. In terms of the second, I focused on the state of national administrative reform processes, particularly regime actions with regard to decentralisation, as well as independent assessments from the development administration policy literature in relation to the three states.

The three-way comparative case study of migration: doctor and nurse migration in Guyana, Jamaica and Trinidad in the 1970s and 1980s

This section was developed as a comparative case study, by regime and country of nurse migration in the 1970s and 1980s. Policies relating to nurse migration in the Caribbean has been explained at two levels: first as a social safety valve and as a symptom of underdevelopment (Duany, 1994: 95-122). The second relates to the rights of health workers to migratory freedom which inevitably favours the developed countries (Fulop and Roemer, 1982: ix). The costs incurred by developing countries of health professionals are enormous, therefore it is critical that explanations of the problem assume a balanced approach. The argument for such an approach is qualified by the very limited and limiting available data for doctor and nurse migration in the region. Nevertheless, the dominance of this issue in the health field in the Caribbean as well as my success in progressively accumulating more relevant detail through theoretical sampling in each country was an important factor in its selection for the single level case study. Migration by its very nature can be also both a determinant and output of policy processes, so I had to distinguish between these two factors in the analysis. There are a number of key issues here that were considered. These included:
The relative role and influence of regime characteristics on nurse migration in the 1970s and 1980s within the three countries and their respective regimes;

The context of health professional migration - as both an international phenomenon and as an output of national/sub-regional policy processes; and

Action/interaction/inaction and policy responses generally at various levels; national, regional and international - and the wider implications for future policy development.

The single country case study: the medical school complex policy in Trinidad

This level of analysis was the most detailed of the study, its major aim being to analyse the influence of regime characteristics on the decision to build a medical school in Trinidad. Using theoretical sampling, I found that questions over the democracy of the regime itself, as manifested in the authoritarian nature of leadership of Prime Minister Eric Williams was very conspicuous by its recurrence in the political science literature. The analysis thus traces the events, leading up to the decision to establish a medical school in Trinidad in the early 1970s, the actors involved, their interactions, the levels of interaction (national, sub-national, international) and the output and consequences of such decisions, actions, and interaction for health human resources development in Trinidad. In addition to this regime 'power/characteristics' component, the 'process' issue was also pertinent to the analysis as it applies to regime change and its influence on policy. In this section, I also examine and assess the influence of regime characteristics on the decisions made by the successor Chambers and Robinson regimes in the 1980s to proceed with this policy.

Comment: I used the integrated method, based on theoretical sampling of policy incidents/events which led to the development of the study at three levels. These comprised first, a general 'three-case, comparative analysis' of human resource policy action, inaction, initiatives, processes and outcomes in Guyana, Jamaica and Trinidad during two specific time periods: the 1970s (in Chapter Four), and the 1980s and part of the early 1990s when fundamental policy reforms began to be implemented (in Chapter Five). The second level is a 'three-case, comparative analysis' which discusses the relevance of regime characteristics to doctor and nurse migration in the three states from 1970 to 1990 in Chapter Six. Finally, the 'single country case study' compares the role and influence of regime characteristics in the decision to build and commission a medical school in Trinidad by examining the actions of the three main regimes involved in the process between 1970 and 1990 in Chapter Seven.

Collecting and analysing data: documentary analysis

As mentioned earlier, primary data in the form of interviews and secondary data in the form of documents constituted the main sources of my data. This data - accessed from documentary analysis and open-ended, unstructured interviews - was then subjected to progressive and inter-linked theoretical sampling. These two methods proved quite useful in the collection and analysis process. As noted earlier, this was because the absence of human resources policy studies made it a somewhat difficult area to corroborate. Few studies had been done in this area in the Caribbean or in relation to Jamaica, Guyana and Trinidad. Where such research existed, most were Pan American Health Organisation-generated technical reports, commissioned by the national governments and their respective ministries of health. I therefore had to use interviews as well as documentary as a means of both eliciting and corroborating information on lead concepts against each other. Additionally, human resources policy in the health sector was often seen as not actual 'health care' policy, despite its central role in health.

Pertinent information in line with the goals, aims and objectives of my study thus had to be collected, analysed and extracted using both these methods. This was done using theoretical sampling which incorporated both my own prior knowledge as well as documentary sources and interviews. As I collected the information, I discovered and allocated categories based upon both frequency and absence of incidents. Categories were also allocated in accordance with their level of relevance to regime (characteristics) influences, both direct and indirect as noted in the findings in Table 3.3. In relation to
other sources of documentary evidence, I relied heavily on newspapers from the period, especially in relation to the single case study of the medical school project in Trinidad. I also relied heavily on official documents (published and unpublished) such as consultants reports, many commissioned by regional and international organisations such as PAHO which proved extremely useful in terms of data quality. Other important documents collected, reviewed and analysed included annual reports of the three ministries of health which provided information - both statistical and analytic - of human resources policy issues such as staff numbers, posts, vacancies, and policies being adopted or followed by regimes/governments. The other sources included various issues of the Caribbean and West Indies Medical Journals which provided me with important leads on most aspects of the human resources policy issues or sub-categories. These were particular helpful in the area of production of health professionals, particularly their obvious concern for doctors as an interest group. In relation to nurses, I relied on the International Nursing Review which contained articles on nursing development in the region.

**Interviews**

In the course of this study I conducted interviews (some of them follow-ups) with thirty-two (32) persons, all of whom were connected in some direct or indirect way to health and human resources policy in Guyana, Jamaica and Trinidad. The interview process did not always follow a set pattern since a significant amount of cross-comparison of sources had to be done. The integrated approach of grounded theory and comparative case study also implied a considerable amount of on-going analysis of the data provided by interviewees and the secondary data to ensure both accuracy and cogency. Table 3.1 earlier noted the categories of personnel interviewed. My interview technique was essentially based on lead questions, at two broad levels to which the interviewees were asked to respond.

*The first level:* The ‘first-’ or ‘open-sampling’ level was designed to search for concepts that had some proven theoretical relevance; the second, to explore those issues that had proven theoretical relevance. The ‘first-level’ questions were generally along the following lines:

1. How would you describe the state/status of health policy in your country?; good?; poor?; neglected?; mixed?; Explain.
2. How would you categorise/rank the different influences on health policy in your country generally and who or what are they?;
3. How would you categorise in order of importance these influences (international and national economic, political, social, organisational factors) and combinations of influences?;
4. Which national group(s) in your opinion exert considerable impact (or dominate) health policy in your country (doctors, politicians, bureaucrats, non-governmental organisations, multi-lateral organisations?); and
5. Have governments used resources wisely and generally done as best as the can in developing health human resources given various adverse factors: colonialism, resource scarcity, the IMF etc?

Most of the respondents expressed the view that international and to some extent national economic factors were quite powerful actors in small developing states. However, there was general agreement that there existed some level of national policy space that varied from country to country that could be used by national actors. The main user of this space was stated to be the regime or national governments of these states.

Other than the debt crisis, colonialism and third world underdevelopment, the other key concepts that emerged during this preliminary process (and common to all three countries) centred upon the politics of regime action, inaction and limited action. In terms of incidents, almost all of the respondents mentioned the concept of poor planning of regionalisation and administrative reform and the ‘mixed’ experiences of regimes in relation to health generally. At the national level, the medical school issue was recalled again
and again in Trinidad in terms of its 'political' origins and its relevance, as did the migration issue. Incidents relating to the ideological influences of the Manley and Seaga regimes on health policy emerged in Jamaica. In Guyana, the key incidents that surfaced seemed to be contradictory: on the one hand, decentralisation and other 'progressive' formal policies in relation to health, on the other, authoritarian and corrupt regime influence that seemed to have negative effects on health status, health policy and the overall quality of life of the population, irrespective of the 'scarce resource' factor, which was undeniably important. I needed to subject incidents and concepts such as these to further analysis.

The second level: This level of sampling was basically relational and variational sampling of the emerging concepts: the politics of regime action, inaction and limited action and the consequences of such action. As the name implies, the aim was to discover relations and variations in these dimensions. Strauss and Corbin's 'paradigm' model which essentially traces the contextual or causal conditions, the actions and interactions and their consequences thus influenced my questions as well as the supporting documentary analysis. In Trinidad, this on-site sampling and analysis process occurred at different periods since I was based there. In Jamaica and Guyana however, it occurred in the course of the same interviews. Although the precise content of the questions varied according to the hierarchy of the interviewee in the health field as well as the country, questions like the following, based on what I had gleaned earlier, were asked:

**Question** How would you describe the role of national regimes in Guyanese/Jamaican/Trinidadian health human resources policy processes after independence when compared with other factors (historical, national political, economic, socio-cultural, environmental)?

**Question** How would you describe the relative influence of the following broad regime characteristics on health human resources policy: strength, stability, ideology, democracy and regime survival/maintenance in the policy process in your country (the Caribbean generally); what is the level of significance compared with other actors, contexts and processes including economic problems?; and

**Question** Have these regime variables positively/negatively influenced health human resources policy action and processes in your opinion? If so How?; Were these policies/actions beneficial or regressive? Mixed? Strategies and consequences? Give examples.

From these questions, the following are just three samples of interviewees' responses which generally seemed to confirm that while economic factors and colonialism were uppermost in their minds, many were concerned to note that national governments had not acted as responsibly as they should have in placing health reform on the agenda. This assertion of course varied from country to country and from regime to regime. Nevertheless, the recurrence of concepts related to 'neglect' and 'inaction' were as commonly used (to varying degrees of course) in all three countries as were the terms 'innovation', 'policy reform', though to be sure, the recurrence of 'debt crisis' and IMF and World Bank power was an equally-dominant theme during the course of my interviews.
Response

...While I accept the reality of the generally negative influence of international and national structural factors, particularly the importance of structural adjustment policies in the 1980s, there cannot be any doubt that national political processes and political party characteristics have also influenced health human resources policy action, limited action and inaction after independence. Manley's democratic socialism was doomed but his regime's emphasis on community and preventive health policies proved very effective. (Senior health human resources manager, Jamaica).

Response

...The role of regime type and characteristics is obviously very important. We in the Caribbean have been generally successful in achieving quite impressive health statistics, but when you look at the individual countries, the politics of policymaking begins to emerge. For instance, Guyana's experiences cannot be solely due to lack of resources, but also to [President] Burnham's and the PNC's authoritarian political practices...It is shocking that under colonialism at least the colonial authorities had implemented a decent public health policy...after the Burnham years, we are worse off in health than when we started..." (Economist, Guyana).

Response

...Trinidad's recent experiences in health policy need to be placed not only in the context of the oil boom, but also in the context of the PNM politics behind the use of the windfall and in the case of the health sector, its implications for the development of a sustainable health service...the PNM squandered the wealth of the country and the NAR were too busy pleasing the IMF to deal with the health crisis..." (Hospital medical doctor, Trinidad and Tobago).

In the case of Trinidad, the domination of one particular aspect of health human resources policy for much of the 1970s and the 1980s - the medical school project - meant that I was particularly interested in the responses of the medical profession to this particular policy. My question to Trinidadian interviewees was along the following lines:

Question

How would you describe the policy decision by the Williams government to build the medical school; can it be linked to party politics?; Williams' own motivations; the oil boom; underdevelopment; how would you categorise these and other factors in order of importance?

This question yielded somewhat different responses from the medical profession, based not surprisingly on those involved in implementing decisions taken by the previous regime and those outside of it, but nevertheless harbouring deep reservations about it:
Response  ...We had no choice. The decision was made long before we assumed office. I did not like it at the time but there were no feasible alternatives but to go through with the implementation process..." (former NAR minister and medical doctor).

Response  ...This policy was (Prime Minister) Williams' 'baby' along with that of those institutional doctors who wanted a fancy place to practice their hi-tech medicine. Under the NAR, instead of spending some of the already scarce resources on reforming health services, they chose to spend it on this much-hyped institution, which is of questionable value to Trinidad's health problems currently...we at this hospital have to deal on a daily basis with the failure of successive governments' health policy failures - the medical complex epitomised this failure. The IMF's structural adjustment policies just make matters worse. The new government was in a positions to act but did not have the courage to fight the medical lobby and curtail the project..." (Hospital medical doctor).

These sample findings proved just how divergent the views were even about this particular policy. In the case of migration, responses also varied from economic to political. However, the one theme that resonated was that of poor working conditions due to lack of any meaningful reform of the colonial system. This criticism was heard more in Guyana and Trinidad, it has to be said, than Jamaica, a finding which furthered my interest in whether there were any regime characteristics-related reasons for this, as economics did not explain it adequately.

Comment: These and other questions were intended to serve two main purposes. The first objective was to provide more detailed information on the context, causes, actions/interactions and consequences of policies (and non-policies). The second objective was to get pointers towards more detailed information on the relative levels of importance of regime characteristics - strength, stability, ideology, democracy and regime maintenance - as well as the dimensions or level of impact of policy for example, explanations for types of policy actions, and their effectiveness, as well as reasons for limited action and inaction. Based on the information collected and analysed at the first two levels, I re-visited documentary data pertaining to migration, training policy and administrative reform of the health service in each country. In Trinidad, I also re-interviewed three of the original interviewees on these issues in addition to returning to some of the relevant documentary evidence. I also checked newspapers to corroborate the facts as well as the processes.

Delimitations and limitations

In terms of delimitations, human resources development covers quite a broad area. I however wanted to focus specifically on the possible links between regime characteristics and the three main areas of health human resources development - planning, training or production and administration or management in a cogent manner, the choice of which was to be based on theoretical sampling. I knew that there would also be variations in the data which were totally dependent on the quality and quantity of data that I collected. I thus limited the study to the influence of regime characteristics and change on administrative reforms (or lack of); the migration issue; and finally the allocation of scarce resources to (and the resultant impact on health human resources development of) the building of the medical school in Trinidad. I believed that this was a rational delimitation, given the data, finances and time available as well as the requirements of the dissertation. I also kept my cross-comparisons down to three states and two decades which I believed was adequate for the objectives I had set out the study in consultation with my supervisor. I was initially concerned about the number of regimes to be cross-compared: seven (7) across two decades. However, I believed that the sampling process using grounded theory served as a conceptual guide to both eliminate unnecessary data and afford greater conceptual detail and focus.
Limitations

In relation to limitations, the main limitation is obviously and regretfully my inability, due to reasons of time and money, not to mention the nature of the PhD process, to also do the ‘hypothesis-testing’ element of the research, which would have involved essentially testing out my findings for the Caribbean region within another developing area or combinations of developing countries. While not undermining the study, it makes my findings heavily subjective, although, as I try to show throughout the study, there are pertinent examples within both developed and developing states that support some of my conclusions. In addition, have already mentioned the limitations of money that precluded a follow-up collection of data in Guyana and Jamaica. This was the other major limitation of the study. It prevented me from following up leads and potential interviewees who might have provided richer information for the study. It also precluded the follow-up examination of some areas such as migration. Having said that, I think that the delimitations helped since I scaled down and refined my aims and objectives as the collection and analysis progressed. Overall then, despite these two limitations, my belief is that the essential aims and objectives of the study were not compromised by either the methodological limitations or the actual data collection and analytic procedures of my actual fieldwork although further follow-up work in the future is clearly necessary.

3.5 SUMMARY AND CONCLUSIONS

According to Macridis, comparative analysis is an integral part of policy analysis and its function is to:

"...identify uniformities and differences and to explain them. Explanations require the development of theories in light of which similarities and differences come, so to speak, to life..." (1955: 1-3).

Social science researchers have at their disposal a number of broad approaches to social inquiry. The choice of approach is inextricably bound up with a number of important factors. Qualitative approaches are most suitable for policy-behavioural related research where context, action and outcomes, among other things have to be measured in an analytical as opposed to statistical way. To examine and compare the impact and influence of variable factors on a phenomenon, the most suitable method must be chosen. Suitability has to be conditioned naturally, by the aims and objectives of a study. I adopted an analytic approach which integrated elements of grounded theory methodology and comparative case study to examine whether regime characteristics and regime change influenced human resources development in the health sector in the 1970s and 1980s. This method had four related advantages: first, it enabled me to be both systematic and flexible in my collection and analysis of data, given the lack of previous research in the Caribbean on human resources. Second, it enabled me to analyse three progressive levels of human resources policy processes in Guyana, Jamaica and Trinidad in the 1970s and 1980s, based on data type and availability. Thirdly, it provided a rich variety of cross-comparisons of the independent variable of regime influence manifested in four characteristics. This approach was used at three levels. At the most general level, I compared specific policies relating to human resources policy across the various regimes in the three state using Bossert’s regime characteristics, but augmented by my introduction of regime survival as an important explanatory variable in Guyana and Trinidad as noted by Hintzen (1989). At the second level, I selected one policy issue: migration which I also cross-compared by regime characteristics over the same time period across the three states. At the most detailed level, I examined the influence of regime characteristics and regime change by tracing one human resources issue across three regimes in Trinidad in the 1970s and 1980s - the role and influence of regime characteristics in the policy decision to build of a medical school.

The flexibility of grounded theory with its in-built allowances for on-site collection, theoretical sampling of concepts and analysis was quite useful, given the very obvious limitations relating to time, finances, accessibility to research sites, limited material and previous policy research in the field. Comparative analysis gave the study a decisive advantage in terms of realistic applicability in its cross-comparisons of policy in similar states within this one geographical region. I believe therefore that the
essence of the broad human resources policy processes in Guyana, Jamaica and Trinidad was effectively captured and analysed using this method. My use of comparative study, much like my use of grounded theory evolved from the collection and open sampling of data from the three countries. In addition to ‘discovering’ the more pertinent categories through the data coding process, theoretical sampling constituted the direct link between the two methods. In terms of the former, the core category of regime characteristics was already ‘discovered’ in Bossert’s study of Central America, while regime survival or maintenance was also already ‘discovered’ in various studies, including, pertinently, Hintzen’s 1989 political study of regime survival in Guyana and Trinidad. My preliminary analysis of the data showed that there was adequate level of applicability of these sub-categories to Jamaica, Guyana and Trinidad. I thus decided to use them to ‘discover’ possible ‘variations’ in the relationship between regime characteristics and health policy formulation and implementation in the Commonwealth Caribbean state.

In terms of comparing cases and finding categories, the process was somewhat complex since I was comparing regime influences across three countries as well as across three broad sub-components of human resources development. I was also incorporating the concept of ‘process’ by analysing successive regimes in two successive decades (the 1970s and the 1980s). I therefore chose to focus primarily, though not exclusively, on the regimes of each country - two in Guyana, two in Jamaica and three in Trinidad which governed during this particular period. In relation to the actual sub-components of human resources policy, my preliminary data analysis pointed first to the role of regimes in health services reform and its impact on human resources development as an important issue. The area of production of doctors and nurses was the second major area and undeniably a core area of human resources policy in the health sector. In terms of migration, the same logic applied. The data pointed to this issue as both a symptom and sign of regime action and inaction in managing human resources policy in the health sector, as much as a product of economic crisis. The interrelationships among the three however needed to be clarified. The question of the availability of room to manoeuvre by developing states and the role and influence of regime strength, stability, ideology and democracy also warranted further clarification through the progressive analysis of these sub-components.

I then had to address the question of levels of analysis, based on the types and levels of detail that I had collected and subjected to preliminary analysis. As pointed out earlier, the dominance of the medical school policy issue in Trinidad in the 1970s and 1980s, and even in the 1990s warranted a special case study of policy making at the national level. There was also adequate documentary data on the specific issue of migration that would allow a cross-comparison on this particular issue. However, I did not manage to access - either in Guyana or Jamaica - the type of information that I got in Trinidad relating to the medical school. This factor influenced my decision to adopt three levels of analysis in my approach. It should be noted finally that I deliberately ignored the question of size and smallness in this study, which although a useful concept, questions still remain about whether a country’s size retards development, with Singapore being often cited as an exception to this ‘rule’. Given my focus on national-level policy action and responsibility in the post-colonial state, in conclusion, then, the guiding rule in my decision upon methodology is in line with Schahczenski’s conclusion (1990: 69) about small, developing state that “...any government, no matter how small does have some capacity for autonomous action...”.
CHAPTER 4

COMPARING REGIME CHARACTERISTICS AND HEALTH HUMAN RESOURCES UNDER THE BURNHAM, MANLEY AND WILLIAMS GOVERNMENTS IN GUYANA, JAMAICA AND TRINIDAD AND TOBAGO THE 1970s

4.1 INTRODUCTION

In this, the first of my four data chapters, I examine the influence of regime strength, stability, ideology and democracy and political survival on the post-colonial state policy process. This is done by examining and comparing health human resources policy within the three Commonwealth Caribbean states during the 1970s. I examine the context of policy action and processes in Guyana, Jamaica and Trinidad under the Burnham (1970-1980), Manley (1972-1980) and Williams (1970-1981) governments respectively. The 1970s was an important 'developmental' decade for small post-colonial states, like Guyana, Jamaica and Trinidad, which had gained independence the previous decade, and which were now formulating and implementing a variety of public policies as fully-independent states. I critically examine and compare whether regime characteristics can realistically explain the policy action, limited action, and non-action (with specific reference to health human resources policy) that ensued, given constraints and limitations exerted at other levels, particularly the economic and historical. The chapter is divided into two main sections. The first examines and compares the contexts and characteristics that shaped health and health human resources policies in Guyana, Jamaica and Trinidad in the 1970s. The second section assesses the relevance of regime characteristics in the policy process, given the influence of these other factors.

4.2 REGIME CONTEXTS, CHARACTERISTICS AND HEALTH HUMAN RESOURCES POLICY REFORMS IN THE 1970s

In this section, I examine the influences regime characteristics by applying Bossert's characteristics, discussed in Chapter Two, to the Caribbean region. I analyse the dominant characteristics of these regime as illustrated in Table 4.1 below. I begin by examining the Burnham regime in Guyana.

<table>
<thead>
<tr>
<th>Regimes</th>
<th>The Burnham regime (Guyana)</th>
<th>The Manley regimes (Jamaica)</th>
<th>The Williams regime (Trinidad)</th>
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<tbody>
<tr>
<td>Characteristics:</td>
<td></td>
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<tr>
<td>Strength</td>
<td>Weak</td>
<td>Weak</td>
<td>Strong</td>
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<tr>
<td>Stability</td>
<td>Unstable</td>
<td>Stable-Unstable</td>
<td>Stable</td>
</tr>
<tr>
<td>Ideology</td>
<td>Cooperative-socialist/Reformist</td>
<td>Democratic-socialist reformist</td>
<td>State capitalist/status quo</td>
</tr>
<tr>
<td>Democracy/</td>
<td>Non-democratic/authoritarian/maintenance-oriented</td>
<td>Democratic/non-maintenance-oriented</td>
<td>Democratic/authoritarian/maintenance-oriented</td>
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<tr>
<td>survivalist</td>
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Policy context: The policy environment of the 1970s in Guyana was dominated by the authoritarian and illegal nature of the Burnham government, within a crisis-ridden economic context. Politically, Guyana in the 1970s was governed by the weak, unstable Peoples' National Congress (PNC) under prime minister Forbes Burnham. Like many socialist states, it was characterised by both ideologically-reformist and authoritarian, survivalist tendencies. In 1970, Burnham declared Guyana a cooperative socialist republic which set Guyana on a distinct road to non-democratic, authoritarian rule unlike the rest of the Commonwealth Caribbean region. Guyana's electoral politics, like that of Trinidad was based on a similar pattern of Indian-African polarised ethnic pluralism. However, the implementation of a proportional representation system of government, as well as the fact that the regime had assumed power through rigged general elections in 1968 differentiated Guyana not only from Trinidad, but also from Britain's other former Caribbean colonies. Effective power was thus in the hands of an authoritarian prime minister. Economically, the negative effect of the oil shock in the post-1973, in addition to poor commodity prices saw the government forced to adopt unpopular measures, including drastic cutbacks in recurrent and capital expenditure which resulted in massive retrenchments of state employees and the removal of food subsidies and consumer essentials (Hintzen, 1989: 68). Balance of payments deficits forced cutbacks on imports, leading to severe shortages of essentials. The cumulative effective of these and other economic conditions, not only affected the ability of the state to deliver basic services including health care, but when added to the politics of the regime, created an untenable social, economic and political situation for the Guyanese population.

Ideologically, the government had announced in 1975 its adherence to the concept of party paramountcy within its new cooperative-socialist ideology. Party paramountcy established the supremacy of the party over the state - the hallmark of authoritarian rule. Cooperative socialism was advocated as the ideological framework for achieving economic, political and social development under 'paramountcy'. Burnham underlined his determination to make Guyana a 'cooperative republic' where the main goal was "...the organisation of our human and material resources through the co-operative movement, with government providing financial assistance, management, training and administrative direction..." (Spinner, 1984: 136). Under this ideological direction, all Guyanese were urged to "...grasp the value of coming together as a group, of pooling...physical, material and human resources..." (Spinner, 1984: 137).

The impact of cooperative socialism was immediate and contradictory. The bauxite industry, a mainstay of the economy, was nationalised as were all other major foreign economic assets, excluding banks and insurance companies. In the 1970s, the Burnham government also managed to maintain what within the cold war context, a rare, but rocky foreign policy achievement of being friendly with Cuba, while maintaining links with the USA. In 1972, diplomatic relations were established with Cuba, a decision which was to prove particularly beneficial to Guyana in relation to human resources development in the health sector over the next two decades in terms of the contracting of Cuban doctors to the Guyanese public health sector. As American impatience grew with Burnham's increased friendly relations with Cuba and other socialist states, as well as his authoritarianism in the late 1970s however, the regime would become increasingly isolated. Even the ideals of cooperative socialism were undermined by party paramountcy, resulting in generally negative outcomes. In the case of public policy reform, according to Mars, party dominance resulted in governmental priorities and decisions being "...usually initiated and promulgated within the decision-making framework of the paramount party, before they are legitimised or implemented as government policy..." (Mars, 1990: 3). Party paramountcy constituted a de facto declaration of authoritarian and non-democratic rule by the government. As the respected Guyanese historian, Walter Rodney somewhat cynically noted:

"...paramountcy is one of Burnham's fancy words. He announced the doctrine of PNC paramountcy or domination over parliament, the courts, the press, everything else. In fact, 'paramountcy' was the official statement that a minority party which was growing smaller and smaller intended to maintain dictatorial rule..." (1979: 8).
Diplomatic relations between the Burnham regime and his original benefactors, the USA and Britain, though still friendly for much of the 1970s, had now begun to cool. This factor coupled with the claim on a significant part of its territory by Venezuela influenced a vigorous foreign policy and presence by the government at international 'socialist' forums, like Jamaica, during the 1970s. Part of the reason for this diplomatic thrust, it has to be said, was also to achieve legitimacy and support from other countries, both within and outside the region. The country was not only financially and institutionally weak, but riven by race-based politics, making it quite unstable. Burnham's authoritarian tendencies and his desire to cling to power resulted in considerable political and policy turmoil in the 1970s.

Regime characteristics and health and health human resources policy responses: It was within this national context that attempts were made to reform the health system. The government, despite its illegality, began reasonably well in attempting to outline its health policy and policy reforms. In 1969, a full-time planning unit was established in the Ministry of Health, under the direction of the national planning commission to develop a ten-year plan for the sector. This plan, *A Blueprint for Action*, completed in 1970, contained the broad principles of universal coverage and access to health services, similar to those principles developed by other Commonwealth Caribbean states (Harry/PAHO, 1989: 6). Developed with technical support from the Pan American Health Organization (PAHO), it provided for the principles of regionalisation, given Guyana's size, through the definition of five levels of care, ranging from primary through to tertiary care. Though the majority of Guyanese lived in urban and/or accessible areas, levels one and two were aimed at providing primary care services through health posts and clinics for the country's small indigenous population who lived the vast hinterland of this 82,000 square mile country, while levels three, four and five provided for care at the secondary and tertiary/urban levels (Sagala et al, 1990: 32; Government of Guyana/Ministry of Health, 1970: 60).

To achieve these goals, the plan noted that administrative reform was needed at both the national and sectoral levels, given the still-pervasive colonial bureaucratic structure. The ministry and government thus recognised the need for comprehensive administrative reform as a priority. These reforms, according to the health plan, would incorporate cooperative socialist principles, with decentralisation, relevance and self-sufficiency as the guiding strategies for program formulation and implementation. In line with the five health levels, the plan also proposed the creation of two administrative levels - the central and the regional - as the way forward for the health reform process. The country would be divided into five (5) health regions to facilitate the implementation process. These two levels of administration were duly created. At the central level, the Minister would be supported by a national health board, which would include a chief medical officer, the chairmen of the five (5) regional boards, technical consultants from the ministry and a representative of the central planning office. According to the plan, the central level would be regulatory and policy-making in terms of its overall function and would provide general direction, interpretation of government policy consistent with the government's ideological objectives. It would provide national planning and evaluation of health activities throughout the country. Human resources development in the health sector was identified as one of its most important priorities. It was envisaged that the regional administration would administer day to day health services, within this newly decentralised system. In terms of expressing socialist ideals, the plan could be considered very enlightened and quite impressive (Mars, 1990:1). It placed equal value on both the preventive and curative aspects of health care. According to the Ministry, the aim of the health administrative reform process was to reduce the preventive-curative division within the health services by integrating them wherever possible. It also aimed to provide egalitarian access to health facilities throughout the country and committed the government "...to the task of bringing the benefits of modern medical knowledge to the greatest number of people..." (1970: 3).

In order to assess the role and relevance of regime characteristics in Guyanese health human resources policy action and processes in the 1970s, we need to first examine the health human resources process and policies espoused or taken during this period. The Burnham regime emphasised the importance of health human resources development in all sectors within its new developmental 'path'. The nature and extent of the task ahead was reflected in the health plan's assertion that:
"...the most striking deficiencies in the health services are caused or aggravated by quantitative and qualitative lack of human resources. Priority must be given to recruitment, education, training, deployment and supervision of health manpower..." (Government of Guyana/Ministry of Health, 1970: 60).

Planning: In terms of health human resource planning, among the key strategies outlined in the plan to remedy these existing problems was the creation in 1970 of a health planning unit to "...provide leadership in the training and development of staff and to co-ordinate all training programs..." (1970: 60-61). The fact that this plan was never fully implemented was a sad indictment of the Burnham regime’s priorities. The government was clearly focused more on enhancing its own security, with the already limited resources available, than on health policy reform or other social policies. The health planning unit was disbanded the same year, so that for the ensuing nineteen year period (1970-89) when one health planner was finally appointed, there was no health planner employed by the Guyanese government. Economic problems and the resultant scarcity of disposable resources for the health and education sectors was definitely a causal factor. However, policy non-implementation was also due to the politics of survival and neglect which dominated the regime’s behaviour within the national policy arena. Both overall health and health human resources policy formulation and implementation had no guiding policy other than the draft plan. Thus, both continued to be, like the rest of the health sector, un-reformed, 'ad hoc', 'numbers and ratios' oriented, highly centralised, and based on highly unreliable statistics. Even a Pan American Health Organisation (PAHO) commissioned report, the Neal Report of 1982 had to admit by the end of the 1970s that health human resources development was:

"...still being conducted without any clear policy strategies and had not been planned or controlled to produce adequate numbers or types of health manpower responsive to the nation’s needs. As a general rule, manpower development is still conducted independently of actual requirements of health programs and without response to projections of needs or coordination between existing vertical programs..." (Pan American Health Organisation /Neal, 1982: 6).

To summarise, then, planning by the end of the 1970s was basically non-existent due to a combination of economic problems and policy reform neglect by a regime preoccupied with its own survival and perpetuation of its undemocratic rule.

Training: In the case of training, Guyana’s fortunes in the 1970s were somewhat better, though still mixed, with some notable successes in spite of the failure to implement the health plan in its entirety. In small developing states like Guyana, Jamaica and Trinidad, the government largely assumes the costly financial responsibility for training health personnel. Hence allocation of training resources is quite important. Training fell under on two broad categories however: first the almost automatic, though less than satisfactory maintenance and support of the still intact colonially-based nurse training system; and secondly the innovation of ‘new’ policies in an ad-hoc manner. In keeping with the government’s new ideological direction, as well as global trends in the 1970s, the health plan explicitly stated that health human resources would be developed through "appropriate" training programmes. Consequently, the training and use of auxiliary personnel were to be emphasised alongside the traditional professional categories, with subsequent deployment throughout the country in order to "...help achieve the aim of providing some form of basic medical care to every situation..." (1975: 61). In 1977 and 1979 respectively, the regime’s high point in health human resources was the implementation of quite progressive training programmes for the medex and community health worker (CHW) categories of auxiliary workers for assignment to rural areas. This will be discussed in more detail in the next chapter on the 1980s, the period when the programmes were fully implemented. The medex (from the French: ‘medecin extension’, literally extension to the physician) training programme was introduced into Guyana in 1977, and enacted in 1978, was pioneered at the University of Washington in 1969, and developed and refined at the university of Hawaii in 1970s for application to rural areas in developing countries. The problem with this ‘ad-hoc’ implementation was the lack of adequate organisational and other support for these categories and goes back to the generally chaotic planning and coordination situation. The ministry
requested from the central government substantial increases in budgetary allocation for both the training and salaries of both auxiliary and professional staff. Having started late in the 1970s, these programmes understandably had little to show the end of this decade, and hence cannot be fully assessed until the next chapter.

In the case of the two main categories - doctors and nurses - the policy situation was grim. In the case of nurse training, government policy could be defined as the continuation of the status quo, which, in an environment of political and economic crisis and the urge to migrate, was short-sighted. Thus, nurse training programmes continued under the ministry of health, like other Commonwealth Caribbean states, with the private sector (in the form of private hospitals) training for their own needs. The health plan had proposed that nurse planning, training and discipline be retained at the central ministerial level “...to provide professional direction at the regional level...” (1970: 61). However, there was little change here. In the case of physician training and supply, the situation was more problematic. The main policy seemed to focus on overseas recruitment and training of limited numbers of Guyanese medical students. Plans were also outlined to attract overseas doctors. Guyana produced no doctors and depended almost entirely on sponsoring, at full cost, the training of medical students at the University of the West Indies medical school (which it chose not to be a part of) and in North America and the UK. Many however failed to return, given the poor working conditions, salaries and lack of other incentives. Places were extremely limited in Jamaica, so the government engaged itself in funding limited numbers of medical students and contractually binding them to the ministry for set periods as well as soliciting scholarships to the former Eastern ‘bloc’ as well as Cuba for Guyanese medical and dental students. The ministry acknowledged the doctor shortage and its primary causes:

“...the need to improve the doctor-population ratio by active recruitment of doctors, preferably Guyanese. This may be done through active encouragement of medical education and improved conditions of service. It is unrealistic to expect good doctors to work satisfactorily under present conditions...” (Government of Guyana/Ministry of health: 81).

Comment: Like planning, training problems at the three main levels remained unresolved by the end of the decade. The auxiliary programmes started too late to be significant at this point in time. Nursing standards remained high by developing world standards but poor salaries and living and working conditions forced many to migrate in search of better rewards. Problems at the medical training level stemmed from the Burnham regime’s unwillingness to be part of the UWI system, the reasons for which - medical dominance and costs - though understandable, meant that it was itself deprived of doctors. The country’s health system suffered as a result, having to solicit, instead, funds from Eastern Bloc countries. While economic factors were instrumental in this state of affairs then, they were intertwined by political choices and decisions as well that, though partly understandable, disregarded the needs of the majority of Guyanese and was compounded by regime survival.

Administration and management: A number of political problems were identified at the administration and managerial levels within the ministry of health, one of which was coordination. The Neal report (1982) noted the failures at all three categories of the human resources development process: planning production and management/utilisation, adding that no coordinating unit was set up “...to develop human resources in order to provide an adequately staffed health service, both quantitatively and qualitatively....” (1982: 6). Another major political problem was bureaucratic politicisation and the increasingly debilitating problem of migration for a combination of both political and economic reasons. The lack of support by the regime for public sector non-party supporters who were committed to the health development process, coupled with declining economic conditions made migration a sensible option for such professionals. The majority of the emigrants consistently stated that their dissatisfaction with the national policies of the PNC regime and dissatisfaction with the political situation in Guyana were major factors influencing their decision to stay abroad (Hope, 1985: 38). As Hope observed, if high-level and sufficient manpower was not available then there could be no lasting and significant process of growth and development. Bureaucratic politicisation through excessive regime patronage was, not
surprisingly, another regime 'characteristic-influenced' reason for the failure to implement the health plan and consequently human resources development policy reform and rationalisation. As Hope noted of the character of the Guyanese bureaucracy under Burnham's tenure:

"...The situation in Guyana is one where politics is centred on individuals. Personal loyalty to politicians therefore plays an important part in the process of political identification and decision-making. Administration under such leadership cannot remain wholly impersonal. The bureaucrat is nurtured more in the politics of agitation than in concepts of nation-building..." (Hope, 1985: 112).

Inefficiencies and incompetence therefore became a hallmark of bureaucratic professional life which made even the most laudable of policy efforts by the government in the area of human resources development seem 'ad-hoc' and 'crisis-ridden'. The ministry's positive efforts in implementing the PAHO/Caricom-designed auxiliary program and the subsequent placement of the medexes and community health workers in the late 1970s thus has to be seen within the context of an overall health and developmental policy vacuum during this period. These workers would eventually be called upon in the 1980s to undertake duties (many times without payment) that, under normal conditions would have been carried out by primary care nurses in a fully-reformed and resourced health system. Instead, as the decade closed, and the Burnham regime was focusing more on its own survival given the economic crisis, than on adequately supporting such programmes, administrators along with many doctors, but especially nurses either migrated overseas or into the local private sector.

'Party paramountcy' thus extended to and permeated the bureaucracy. The ensuing patronage resulted in the further ascendancy of the political apparatus over the state bureaucracy. Under these conditions, politicians were able to use the political apparatus and state machinery to foster a growing personalisation of political power. This created, according to Hope, a "...highly centralised system of administration and sycophantic policy-making..." on the part of senior civil servants, which led to inefficiency in the administration of national development while at the same time making it costly (Hope, 1985: 35). Any attempts at greater coordination at the systemic level were resisted by this vested political interest (1985: 34-36). Hope noted in this regard the following:

"...civil servants in Guyana lack a sense of purpose and commitment to their responsibilities. They do not believe that they are serving anyone else but their PNC bosses and themselves and they exploit their positions for personal gain..." (1985: 37).

There was therefore widespread pessimism about the future of the overall post-independent development management process, as the permeation of party politics continued. As Hope concluded of the problems within the Guyanese bureaucracy:

"...of primary importance among the factors affecting the bureaucratic machinery is that of the lack of the leadership's support and commitment for increasing the efficiency of the administrative system. The political leadership can, in the same manner in which they inspire political allegiance, inspire the bureaucracy to higher levels of performance. Additionally, government functions are generally dispersed among an excessive amount of ministries and agencies. Since independence, new agencies ...have been superimposed without a prior review of costs and benefits...administrative leadership then tends to be lacking. It has been replaced by politicised and centralised decision-making at the party and cabinet level. This centralised nature of the bureaucratic machinery contributes to the destruction of the channels of communication and tends to immobilise the administration of national development. The ultimate result of all these manifestations is a lack of coordination of policies among departments and a lack of dissemination of information for effective decision-making...The effect is, necessarily, either procrastination and long delays and/or inadequate and inept policies..." (1985: 38).
Comment: The Burnham regime’s time, policy efforts and resources were therefore, throughout the
1970s increasingly concerned with its own survival, and based on ‘party paramountcy’, not policy
development within a democratic society. As economic conditions worsened in the late 1970s so did the
authoritarian policies of the regime, thus aggravating the already considerable exodus of administrators
and professionals. There was little mention of health in the national budgets speeches of 1977 and 1978.
The latter mentioned the formation of a state planning commission as the key to planning and monitoring
the entire economy, “...an essential step towards the goal of rational application of human, natural and
financial resources...” under the government’s stated policy of cooperative socialism (1978 Budget
Speech, Minister of Finance). Self-reliance and cooperativism was emphasised in the 1980 budget speech
by the then economic development minister Desmond Hoyte as a response to the increasing economic
crisis. However little or no mention was made of the health sector crisis or attempts to remedy the health
situation.

The role of Cuban and other assistance: The establishment of diplomatic relations with Cuba in
1972, followed by the Soviet Union and Eastern European states was a boon to the faltering health human
resources process during the mid to late 1970s. These relationships proved particularly beneficial to the
training of doctors with a number of scholarships offered to Guyanese medical students by these states.
Cuba also played a particularly critical role in filling Guyanese public health sector vacancies with Cuban-
trained Guyanese doctors comprising a significant proportion of medical staff during, and since the 1970s.
Teams of Cuban doctors also held periodic clinics throughout the country. In 1978, Cuban medical
workers treated over 200,000 patients during a fifteen-month stay in Guyana (Feinsilver, 1993: 162).
Significant numbers of contracted Cuban doctors thus manned the Guyanese health services during this
period providing the vast majority of specialists for the public sector: a situation that continued well into
the next two decades. However, this strategy still represented an ‘ad-hoc’, short-term, 'stop-gap' policy
response at a time when some room for state action existed, but was being occupied and set by ‘political
survival’ rather than development. By its very nature, there was little or no political incentive to
adequately support and reform ‘low-politics’ policy issues such as health, given this context.

This ‘ad-hoc’ approach was also evident in the heavier than usual reliance by the ministry of health on
PAHO’s technical assistance and support as ‘de facto’ health policy formulator and implementer than
obtaining on other countries. Like the Cuban policy, PAHO’s assistance though quite laudable, was in
effect providing short-term, crisis-based solutions to what was essentially a national policy situation
thwarted by the regime’s illegality and its desire to cling to power. Other forms of assistance had little
impact on the on-going human resources situation. In 1979, with a US$9.2 million grant from the Inter-
American Development Bank (IDB) and technical support from PAHO, the ministry of health adopted a
new plan to reform and “strengthen” the health care system to accommodate an emphasis on primary
health care in line with the Alma Ata objectives agreed at the international level a year earlier. The
project was designed to train, inter alia, nurse administrators and other categories of workers and to
develop both local and overseas training programs. This programme was a response to the crisis situation
of the late 1970s by the government in collaboration with the two international organisations to prevent
the total collapse of the health system. However, a PAHO team in 1980 found that planning
methodologies for even this new plan had not yet been designed, and that activities were being carried out
without a systemic, comprehensive, integrative character (PAHO/Lopez,1980: 1).

In relation to human resources, the team also found that programmes had not been developed in the
priority area of training and management/utilisation. Inter-sectoral co-ordination and rationalisation of
administration remained ‘ad hoc’ at best, while the formulation of an integrated human resources
development plan was still non-existent. The report strongly urged the Burnham regime to prioritise both
planning and programming, as well as the development of human resources within an overall policy of
regionalization (PAHO/Lopez, 10-15). However, the increasing preoccupation with regime maintenance
being practised by the regime limited, if not precluded, any positive action on these issues.
The conclusions and recommendations of the Lopez report were supported by the 1982 Neal report - which itself lamented the lack of adequate numbers of doctors, nurses and auxiliaries needed to serve at key posts in the proposed referral (five-tier) system contained in the first health plan (Neal/PAHO, 1982: 6-7). The report similarly painted a gloomy picture of health policy neglect, concluding that the failure of the 1979 initiative was due to the continued absence of a written policy. It noted also problems including the failure to rationalise training programs for all categories of nurses; the irrelevance of curriculum design; limited opportunities for upward mobility; and falling nursing standards. This report also pointed to the negative influence on health planning of the continued lack of reliable basic statistics on the health care system. In the case of politics, the report was uniquely blunt, describing the policy process as one which stressed ‘who one knows’, and the Guyanese situation as one which had resulted in “...a stifling stultification of individual initiative and consequently low productivity...” (1982: 46). The report cautioned the government that:

“...formulation of manpower development plans must take into consideration the short-run investment required and long-range dividends in achievement of improved human performance, increased worker satisfaction and increased commitment...”

(Oh/Neal, 1982: 47).

Consequences by the end of the 1970s: As in other Commonwealth Caribbean former territories, health care reform in Guyana had been designated a priority by the Burnham regime at the end of the 1960s because of the failures associated with the colonial health system. Health conditions, though stabilising in the early 1960s then deteriorated considerably making the need for action urgent as well as comprehensive in scope. Like other Caribbean territories, doctor and nurse migration had started in the late 1950s, and steadily increased during the political crisis period of the early 1960s. The chronic shortages of these two major categories of health professionals that followed were also instrumental in plan formulation.

The formulation of the 1971-1980 health plan which noted the importance of human resources development in the health sector, was an acknowledgement of the problem. Despite this however, the Burnham focused instead, not on plan implementation, but on allocating much of its scarce resources for its own short-term political survival goals. Thus, while the ideological underpinnings of cooperative socialism seemed initially progressive and reform-driven, the policy arena as well as the agenda was dominated by the politics of survival and not development, as Burnham had pledged in 1970. By the end of the 1970s therefore, the health sector and its human resources, like much of Guyana’s other sectors was in a state of crisis. The intention of the new regime was clear: the maintenance of power, despite the considerable developmental cost. The process of co-optation and control of the state through patronage left little or no room for development policy (Hintzen, 1989: 65-70). Military and policing expenditure rose steadily in comparison to the social sectors, so that even scarce financial resources which should have been going towards the development effort were being used for political survival and control (Greene, 1983; Hope, 1985; Thomas, 1988).

Even on the administrative front, the hallmarks of regime characteristics were clear. According to the government’s own health bureaucrats, the health services in Guyana in the 1970s suffered progressive deterioration due to excessive centralisation, lack of planning, lack of adequate and reliable data for planning, poor co-ordination, lack of managerial capabilities, lack of inter-sectoral co-ordination and a general lack of procedures (Sagala et al, 1992: 33). The consequences were therefore predictable by the end of the decade. Reports that nursing care by the end of the 1970s was being provided mainly by nursing students rather than qualified nurses cannot be confirmed. However, given the situation by the end of the decade, this is hard to dispute given the increased nursing shortages caused by migration which progressively worsened as economic and social conditions deteriorated. Political harassment, discrimination and continued lack of democratic governance also contributed to the outflow, which seems to confirm this generally less than satisfactory state of affairs.
One ironic by-product of the use of socialist medical scholarships offered the regime in the 1970s was some level of deterrence in migration of such personnel. For instance, most of these newly-qualified doctors returned to Guyana, unlike many others trained in the traditional countries. Although some subsequently migrated, many stayed in the public sector, but partly because of their contractual commitment to the government, and partly because their qualifications were not generally recognised in other Caribbean and non-Caribbean countries, and in some cases by their own 'western' and/or West Indian-trained private sector colleagues in Guyana (Singh, 1990: 10-16). However availability and access to public sector personnel still remained appalling by Commonwealth Caribbean standards. The power of the professions were muted by the emerging health situation in Guyana. Most doctors worked in the private sector, while some straddled both sectors. The evidence suggests a limited impact in terms of the power of the profession. However, the medical bias was still clearly evident, particularly given the growing resort to the private sector by the population. Relations with the medical and nursing associations were also influenced by the political situation, which in turn influenced the level and quality of participation in the process. Mass migration of many members of both of these groups meant that those who remained tended to be either strong supporters of the regime. Those who could not migrate for various reasons or (especially in the case of doctors) those who were able to secure employment in the mushrooming private hospital sector given the decline of the public services during this decade. The political and policy influencing roles of both professions as pressure group action was evidently limited, given the increasingly 'hustling' nature of the society as poverty increased.

Numerous problems thus remained by the end of the 1970s. An assessment of the quality and appropriateness of medical qualifications and nurse training standards in Guyana in the 1970s is difficult to judge, though the available evidence suggests that conditions were worse, even when compared to conditions under late colonial rule. Despite the adherence to the principles of Alma Ata, the system continued to be heavily curative and urban-oriented, with questions even raised about the excessively curative training of the Cuban trained Guyanese doctors (Singh, 1990: 10-16). Similarly in terms of nurse training, there seemed to be no evidence of any studies commissioned on the quality of nurse training both in the public sector and especially the private sector. Guyana's nursing training used to be of a similar standard to that of the rest of the region. However it is difficult to imagine that the circumstance of the 1970s, including migration - due to both political and economic oppression did not affect the quality of nurse trainers as well as the availability of other essential resources, a reality confirmed by the Neal Report among others.

The parlous state of the health system at all levels - human, physical and material - by the end of the 1970s therefore reflected not only economic circumstances, but a clear case of neglect and lack of commitment to policy implementation by the regime. This neglect was partly understandable given the economic as well as political predicament facing the regime at that time. The postponement of elections due in 1978 and the rigging of elections again in 1980 were manifestations, according to Thomas, of "...the extent to which authoritarianism had become entrenched in Guyana..." (1988: 354-355). Attempts at developing and implementing a comprehensive human resources policy for the health sector under these conditions were therefore limited and ad-hoc at best, and both negligible and negligent at worst.

Comment: 'Weak, unstable, socialist, authoritarian, survival-oriented' regimes and policy: In the case of regime characteristic influences, the co-existence of weakness, instability, formal adherence to socialist principles, authoritarianism and 'survivalism' seems to have contradictory outcomes for policy implementation in the post-colonial state. The state under Burnham was weak at extracting and allocating resources for areas such as health, yet strong at doing so for its own security and survival like so many other post-colonial authoritarian states. It was also weak in terms of its 'negative politicisation' of the bureaucracy. The state was also unstable, yet there was little incentive for it to fundamentally reform health administration for political reasons. Even where this was done, it was not only uncoordinated, but political cronyism affected its functioning. The undemocratic, survivalist state was willing to use various means to retain power, despite enormous social problems. Although regime strength can be directly linked to economic circumstances, the other factors are clearly political and did have a great effect on the functioning of the health sector. Even economic decline was, arguably, partly due to regime
mismanagement and corruption. The fall in commodity prices was undoubtedly influential, as was the weakness of interest group articulation which resulted in either non-participation or cooption. However, given the above evidence, the influence of regime characteristics is clearly evident. The resort to ad-hoc, crisis measures such as reliance on Cuban doctors was one symbol of the overall deterioration of health planning, training and administration of human resources for much of the decade and well into the 1980s under the Burnham regime.

The Burnham regime's weakness, instability, and authoritarian/survivalist nature thus negatively affected its policy performance in the case of the health sector. Aided by a favourable American foreign policy during the cold war period, although a 'socialist' state, the regime still struggled to achieve the democratic legitimacy required of its Commonwealth Caribbean counterparts - such as Jamaica - and also required of the development process, given the regime's increasing authoritarianism. The Burnham regime's 1970 five year health plan was a reasonably impressive document outlining the importance of primary, decentralised care at a time when it was not yet fully on the international agenda. Yet this plan was not fully implemented by 1980. The regime also began implementing a decentralisation policy that would in turn extend to the health sector. However, health, like health human resources depends on a complex degree of interactions at varying levels. The regime's increased authoritarianism and coercion of opponents, as well as its excessive use of patronage affected not only the quality of life and job opportunities in the country, leading to mass disaffection which will be discussed in greater detail in Chapter Six, but also affected health human resources planning, training and management prospects. The underlying feeling of the Burnham years in the 1970s was that despite the praiseworthy and progressive nature of state and even some implemented policies, the regime itself was undermining the very outcomes of these policies through its actions in the political sphere, notwithstanding the admittedly difficult economic problems it faced.

To summarise then, the policy process under a weak, unstable, socialist undemocratic, survivalist regime, given the Guyanese experience of the 1970s, seems to have essentially contradictory policy implications, with idealist, socialist goals on the one hand, which actually made it to the implementation stage, but which were greatly undermined by the other characteristics particularly regime maintenance. We now turn to the Manley regime in the 1970s to compare health human resources experiences with another 'socialist' state within the Commonwealth Caribbean: Jamaica.


Policy context: Like Guyana, Jamaica was also financially and institutionally weak in the 1970s, despite a decade of growth in the 1960s. Jamaica was however characterised by reasonably democratic, legitimate, and stable rule which had persisted from the partial self-rule period in the mid 1940s, despite an extensive party-based patronage network with related inter-party electoral cycle violence. Although not affecting the legitimacy of electoral outcomes, this violence affected the country, worsening according to the severity of economic problems particularly by the mid-1970s (Edie, 1989). However, it was confined to the electoral cycle. The main developmental problem for Jamaica, like Guyana and other post-colonial states, was the urgent need for comprehensive administrative reform to provide the support for policy implementation. The increased popularity of the Peoples' National Party (PNP) at the end of the 1960s, coincided with disenchantment at the failure of former prime minister Hugh Shearer's conservative, but weak Jamaica Labour Party (JLP) government to arrest economic and social decline through its industrialisation by invitation policies.

In 1972, the democratic socialist People's National Party (PNP) under Manley assumed power in relatively free and fair elections. As in the case of the Burnham regime in Guyana, the Manley government's democratic socialist principles were also influenced by 'cold war politics', given the tensions between the United States and the many 'leftist' liberation movements in Latin America, particularly Cuba, just ninety miles to the north of Jamaica. The subsequent establishment of full diplomatic relations with Cuba, and the considerable assistance received from Cuba saw the resulting heightening of tensions with the USA which was to become a major source of problems for the Manley
government by the end of the decade (Kaufman, 1985: 88). This is contrasted to Burnham’s friendly relations with the Americans, in spite of his illegal regime and his party’s socialist ideology. As Thomas points out, the main difference between the two states that could explain this policy was that Guyana’s main opposition party was Marxist, while that in Jamaica, Seaga’s JLP were conservative and market-oriented (Thomas, 1984). Nevertheless, Manley’s promise to bring ‘good government’ and social reform, coupled with his reputation and charisma played decisive roles in the party’s 1972 electoral victory (Kaufman, 1985: 71). In terms of general policy reforms, between 1972 and 1974, the government undertook a limited reform agenda, limiting nationalisation of public utilities, and carefully nurturing its relationships with the business and middle class (Kaufman, 1985: 73-75). By late 1974 however, the regime had shifted further to the ‘left’, outlining the broad formulation of the principles of ‘democratic socialism’ during the mid-1970s.

Like the Burnham regime’s cooperative socialism, Manley’s democratic socialism emphasised an increased role for the state in the economy and society and community ‘grassroots’ participation along broad socialist lines. Unlike the Burnham regime however, the Manley government’s legitimacy was unquestioned. The possibilities of this legitimate, democratic-socialist ‘third path’ thus received considerable international attention and support from developing states through the publicity generated from Manley’s own high profile for much of the 1970s in the Non-Aligned Movement (NAM) and Socialist International. Despite his party’s clear socialist rhetoric, Manley was committed to the principles of a two-party democratic state. Overall, government policy thus stressed self-reliance, and the optimising of appropriate human resources through education and community participation as critical social elements of democratic socialism.

Economically, the 1970s was an “unmitigated disaster” for Jamaica (Stone and Wellicz, 1988: 83). Between 1973 to 1980 real gross domestic product (GDP) declined by 18% an overall decline of 23%, leading to a general collapse of the economy (Stone and Wellicz, 1988: 83). This led to migration at all levels, especially by professionals taking advantage of a more generous US immigration changes (Stone and Wellicz, 1988: 80). Some of this migration was due to the government’s increased socialist rhetoric, though rapid economic decline was probably closer to the truth. Jamaica was one of the first recipients of the IMF structural adjustment medicine, with Manley’s PNP government forced to negotiate a ‘standby-facility’ at the end of 1976. In July 1977, a US$ 79.6 million loan was made available. However, Jamaica failed to pass the IMF’s performance test in 1977 and the loan agreement was subsequently abrogated. This decision was however partly due to American influence in an effort to pressure the increasingly radical Manley regime. In 1978, a US$ 240 million was eventually signed with the IMF which called for comprehensive structural reforms, devaluation, taxes rises, wages ceilings, and spending cuts. As Stone and Wellicz note, this agreement effectively called for the abandonment of the PNP’s entire development policy thrust. The Manley government’s failure to fully conform to the agreement saw the IMF suspend this facility in 1979, with negotiations finally broken off by the government in 1980. Manley lost the general elections in 1980, with at least 800 people killed in the ensuing electoral violence. Although this electoral violence was due to the nature of the political process in Jamaica, its severity was nevertheless due to a combination of the regime’s own mismanagement, but more important, American political pressure and the high demands exacted socially by the economic crisis.

This ‘third path’ was formulated because ‘industrialisation by invitation’ development strategies implemented in the region in the 1960s, had failed to achieve significant social and economic progress. Although reasonably successful, it had not improved living conditions for the majority of Jamaicans by 1970. The Manley government’s democratic socialist principles encompassed a ‘mixed’ approach where nationalisation and abolition of ‘exploitation’ were merged with a policy of private sector cooperation, despite the evident contradictions. As Kaufman has noted, the term ‘democratic socialism’ was itself “...rich in ambiguity...” and “...was usually defined by the political conjuncture and the audience being addressed...”(1985: 78-79). Nevertheless, the Manley government’s democratic credentials, its legitimacy and its relative stability were remarkable given the economic crisis of in the latter half of the 1970s, and negative American influence at international financial level. In the case of health human resources, despite problems, including the economic situation and US foreign policy, the regime’s democratic
socialist ideology and its strong commitment to democratic-led development held out possibilities for progress in policy development and reform.

**Regime characteristics and health and health human resources policy responses:** The Manley government outlined its health policy proposals for discussion in 1974 - two years after assuming office - in a ‘green’ paper, titled ‘The Health of the Nation - Proposals for a National Health Service’ (Government of Jamaica, Ministry of Health, 1974). Given the arduous preparatory process involved, it was nevertheless doubtful whether the ministry of health anticipated that the plan would only be formulated and adopted until three years later!. Nevertheless, the discussion paper acknowledged both the ‘ad-hoc’, crisis-driven nature of the planning and policy processes in the past along with the limitations posed by the lack of “…a clear political commitment, adequate data, financial resources and health manpower…” (Government of Jamaica, 1974: 1). The regime accused the previous JLP government in the 1974 document of patronage in the allocation of resources and outlined the need for development of “…a systematic and orderly approach to the establishment of priorities and the development of priorities…” without which “…no action can hope to achieve long range social and economic objectives…” (Government of Jamaica, 1974: 1). The actual health plan was not published however until another three years, in 1977, with the intervening period seeing the PNP’s re-election to power in 1975. The plan offered a similar ‘wish list’ type vision of socialised health care to the Guyanese plan in its stated health policy. It was based on health as a fundamental right, on intersectoral co-ordination with other sectors including private sector providers, and on a health service that balanced preventive with curative health through increased focus on community participation. In this regard, the role of decentralisation was seen as key to health improvement. This was in line with the prevailing context of the Jamaican (and the Commonwealth Caribbean) tradition of universal health care, and also within the context of the thrust towards primary health care at the global level, adopted one year later. As Mitchell noted of the heightened reformist anticipation of the implemented plan:

“...the PNP had been in power long enough to be aware of the intrinsic and extrinsic health problems of Jamaica, to have some awareness of where the roadblocks to change lay, and some appreciation of the effects, and the limitations of the politics of change...” (1981: 464).

Despite these criticisms levelled by Mitchell and others relating to inconsistencies between goals and objectives, the general consensus was that the policy agenda was now firmly set by the Manley government’s democratic socialist credentials, and buoyed by its renewed mandate from the electorate. The explanatory power of regime characteristics on specific health issues such as human resources policy implementation, though important, as we shall later see, has to be balanced by other explanations. The government’s hopes for the implementation of the plan assumed a position of economic strength and socio-political stability. However, the changed circumstances of the late 1970s and the relative absence of these two factors threatened both the government’s survival and the implementation of its health policy plans and programmes.

The need for health human resources reform in Jamaica was recognised within the wider context of post-colonial reform well before independence. This ranged from both wider administrative as well as narrower health sectoral reforms. After independence in 1962, the conservative Jamaica Labour Party (JLP) regime under Prime Minister Hugh Shearer in its 1963-1968 development plan had acknowledged the serious human resources problem facing Jamaica’s health sector, given the inadequate numbers of professional staff and high migration levels. The Shearer government also recognised that the high cost of training doctors, combined with limited financial resources would constrain any short-term growth in the areas of need (Barrett, 1979: 66-67). Limited action by this government saw its own ‘ad-hoc’ proposals within the national development plan on planning, training and utilisation/retention of doctors and nurses remained largely undeveloped up to 1972. Action was however concentrated up to this period, as in many post-colonial states on physical infrastructure. One major human resource achievement before independence from a regional perspective of particular benefit to Jamaica was establishment of the of the medical school at the Mona Campus of the University of the West Indies (UWI) in the late 1940s, and its
fully accredited status by the 1960s. The Shearer regime’s successes in health human resources were thus were limited both in terms of its reform aims as well as in achievements.

Addressing medical shortages it pledged to expand the Commonwealth Caribbean-funded medical school in order to double medical intake. In relation to nurse training, a second nursing school was established. It was also recommended that the successful ‘enrolled assistant nurse’ course, introduced in the late 1960s be expanded (Barrett, 1979: 66-67). However, a comprehensive health policy had not been formulated during that government’s tenure within which a health human resources policy could itself be defined. Administrative problems hindering the overall functioning of the health system were identified but reforms never undertaken. The government also failed to establish a proper ‘bonding’ system which aggravated the external migration flow that was brought about by declining economic and social conditions. Like Guyana, data unreliability proved a major problem in formulating human resource policy. To give an example of this problem: the number of doctors registered to practice in 1973 was 1,254. However, the national planning agency (NPA) data suggested a total of about 490 practising physicians in 1972, a figure which may be incomplete but closer to the real number. In relation to nurses, the Pan American Health Organisation reported that in 1973 there were 7,287 general nurses on register. However, the NPA reported only 1,437 nurses and 666 assistant nurses practising in public sector health facilities for the same year.

By 1972 therefore, health human resources development and indeed the health sector as a whole was in urgent need of reform primarily through the definition of a clear, comprehensive policy. This challenge was recognised by the Manley government on assuming office in 1972, although it was two years before it published its ‘green’ discussion paper, the Health of the Nation. In relation to the medical profession, the paper identified a curative-based training system, mal-distribution of services and a chronic shortage of doctors and nurses due to steady migration as the main problems facing the health sector. The regime’s big ideological challenge in the case of the health sector was transforming the inequitable and ineffective status-quo a into truly socialised public services including health care. This challenge was recognised in the 1974 ‘green’ paper. In relation to medical training, the Health of the Nation expressed the government’s unhappiness with the curative orientation of the university medical school’s curriculum, and underlined the need for community health reform as an integral part of the training process. The ‘green’ paper bluntly stated in this regard that those older physicians trained in North America and the UK were “ill-equipped” to provide for the health needs of Jamaica, and proposed to implement a system whereby Jamaican medical students would be required to serve for a set period in rural areas before receiving their degrees. The paper also recommended a one-year mandatory period of service by doctors in community medicine, which together with re-allocation of doctors from health districts to health centres would put more doctors into the community. The need to upgrade physical infrastructure in an effort to both retain local staff as well as to recruit, on a part-time/notional basis, private sector doctors was also identified. Finally, the 1974 Health of the Nation document advocated external recruitment, like Guyana, in order to meet the existing and anticipated shortfall.

The regime made a good start in relation to a community-oriented approach to health human resources. The political support by the Manley government for a primary care approach to human resources planning, production and utilisation was evident in the regime’s advocacy of a more integrated, community-based approach for the nursing profession. The Health of the Nation paper urged greater dialogue with the nurses association in Jamaica (NAJ) in plan formulation. No similar call was however made in relation to the medical association, an omission which would later lead to a breakdown in relations between the government and the profession with negative consequences for the health care system in the 1970s. By contrast it actively courted the nurses by proposing in the Health of the Nation document to establish a permanent committee consisting of inter-ministerial nursing personnel and representatives of the nursing association. The government was particularly interested in nursing development for ideological reasons, given the fact that nurses comprised the largest professional group as well as the profession’s utility, flexibility and cost-effectiveness within a community-based health care approach. Plans were thus outlined for, inter alia, the expansion of the profession through the development of a new nursing category, the nurse practitioner. This programme was developed in 1971 by the Nurses Association of Jamaica (NAJ) and was accepted enthusiastically by the receptive PNP
regime, and in particular the health ministers, Dr. Kenneth McNeill, and later, Douglas Manley (Seivwright, 1982: 22).

In terms of overcoming the anticipated nursing shortfall in the mid 1970s, the paper also reflected government concern and intention to act. It alluded to a proposed program of local and overseas recruitment, estimating that over six thousand Jamaican nurses in training and in practice abroad might be willing to return home “...if proper nursing opportunities consistent with their experience and status exist...” (Government of Jamaica, 1974: 29). The two main nursing schools, the Kingston school of nursing (government-funded but independently run) and the UWI’s nursing school together produced 200 registered nurses each year with the Kingston School also producing 150 enrolled assistant nurses (EANs). The government hoped that with the commencement of training at another regional hospital, this number of nurses would increase by 50 more, and by 1975 to a total annual production of approximately 600 nurses.

Other health human resources policies in relation to nursing were proposed in the ‘green’ paper included the additional expansion of the assistant nurses category which was expected to fill the gap left by the better utilisation of the registered nurses. It was also asserted that the health planning process would also be based on the proper staffing of the health service and was to be phased in within a period of three years at which time it was hoped that the service personnel would be 75% full strength. (Government of Jamaica, 1974: 29). Local recruitment for training, according to the paper, would not be a problem since there were usually long waiting lists. To support its community health program, the ministry also pledged its full and expanded support for the community health aide (CHA) programme which was eventually implemented in collaboration with the university in 1973. Finally, in order to achieve all of these aims, the government recognised in the green paper, the need for urgent reorganisation of the administration and management system, a position restated in the 1978-83 health plan. The ‘green paper’ was essentially the Manley regime’s framework for an eventual comprehensive health plan within which its human resources development programme could be implemented.

The contextual conditions for implementation of these policies were however not good during the mid to late 1970s, despite the democratic re-election of the Manley government in late 1977. Worsening economic conditions, political violence and an ideological struggle with the ‘left’ of the party over future development strategy created a climate where rational, coherent long-term planning was very difficult. Nevertheless, the achievements of the government's first term between 1972 to 1975 yielded favourable results that could be directly linked to regime characteristics as we shall now see. The implementation of the 1978-83 by the Manley government three years after the ‘green paper’, though late for political and other reasons, was generally welcome by all, except some members of the medical lobby. This was also the period when attention was focused on primary health care influenced the government to this commitment, even though it must be said that this had framed the regime’s policy actions since 1972. Nevertheless, the new plan committed the government to primary health care and the ‘health for all’ (HFA 2000) strategies. The emerging international consensus on primary care was thus seen as a vindication of its own radical, community-based approach to the health policy process.

In line with the aims and aspirations of the health plan, some important policies were implemented in the case of nurse training in the 1970s. The first was the training of greater numbers of general and enrolled assistant nurses. In terms of training reform, the nursing curriculum was revised within the context of the new approach as well as resource constraints. In its 1977 policy statement the government noted that:

"...we must continue to ensure that the skills of all health workers are constantly upgraded to make maximum use of health manpower resources...no health worker should perform tasks which a lesser-trained member of the health team could do equally well...the training of health workers must be relevant to health needs...” (Government of Jamaica/Ministry of Health, 1983: 3-4).
The Manley regime and the Jamaican nurse practitioner programme: By far though, the Manley’s government’s biggest achievement in the case of appropriate training - and a direct outcome of its ideological orientation - was the formulation and implementation of the nurse practitioner policy in 1977. It was developed as a joint program between the government, the Nurses Association of Jamaica (NAJ) and the advanced nursing education unit of the university. Selected registered nurses and certified midwives who had developed clinical competence undertook the one-year basic course, with further training in their area of specialisation. They were not intended as substitutes for the doctor, but trained to assist the doctor and to reduce workload by carrying out certain functions under specific guidelines (Barrett, 1979: 114). These nurse practitioners would, upon completion of the intensive training program, be posted throughout the country in line with the government’s economic and ideological justifications: it was appropriate to developing country needs, and the cost of training the number of doctors needed to keep pace with health care demand was impossible to sustain in the longer term.

There were however problems during the health implementation process which although not questioning the government’s ideological commitment to the programme, reflected its difficulty in grappling with sectoral as well as wider bureaucratic reform. Problems relating to supervision, remuneration, and especially legal status threatening the programme within its first two years. In terms of supervision, the nurse practitioners were found to prefer doctors rather than nurses as their supervisors, which reflected more an attempt to define a professional status above that of nurses than regime negligence (Akintunji, 1979). In addition, remuneration and incentives did not reflect their new skills and duties, clearly an economic problem, given the government’s financial problems after 1977. The lack of legal status to prescribe even antibiotics threatened to curtail the programme, as pharmacists refused to honour their prescriptions. The omission/neglect of these policy details, were thus partly economic and partly political naivety in relation to the importance of administrative factors and resulted in delays in fully legitimising, and thus implementing the program well into the 1980s (Cumper, 1986; Akintunji, 1979: 130). Nevertheless, such events while not entirely dispelling the notion of administrative ‘ad-hocism’ that characterised the policy implementation process in Jamaica after 1978, did not dent the morale among nursing staff and students about the benefits of the programme (Seivwright, 1982: 58).

The health plan was under greater pressure because of the strained relationship, noted earlier, between the government and the medical profession since 1974. The medical profession was firstly, not happy with its exclusion from the policy formulation process about primary care inclusion in medical training. A confrontational tone had been set by the government when the ‘green paper’ noted that:

"...the unfortunate characteristic of most discussions about training of primary care physicians is the acceptance of the medical school as the proper seat of learning for this type of practitioner. It is assumed that the medical faculty can be persuaded to revolutionise itself to achieve a focus antithetical to its own history and its own interest in hospital based practice...no establishment is in the business of dis-establishing itself... if and when the revolutionary changes come about in medical care, the forces for change will tend to come more from outside than from within...”

(Ministry of Health, Jamaica 1974: 21).

The government, in its effort to provide a more socially and preventive-oriented health service saw the profession’s curative ‘bias’ as anathema to its plans. It thus reacted to what it thought was a irreconcilable conflict of interest by excluding the profession form the plan’s formulation. Instead, the main actors in the process were committees and sub-committees comprising technical officers from the ministry of health (which included the ministry’s own doctors), the nurses association and other health-related ministries. At the regional level, technical advisors from the University’s school of public health, the Caricom Secretariat and the Pan American Health Organization were the main actors in the formulation process (Carr, 1984: 19). This exclusion, though understandable, given the agenda and the economic circumstances, was nevertheless a risky and counterproductive strategy since the profession’s cooperation and presence was necessary for successful implementation. Primary care was, after all an integrated ‘three tier’ approach in which all professional categories played a role. Despite the good intentions of the
government, and even though it stated that it had no problems with private practice, this covert policy of exclusion of the medical profession from the process succeeded in alienating many doctors, particularly those directly affected in the public health sector. Deteriorating doctor-regime relations also extended to administration and management. The proposed administrative reform process under health decentralisation, whereby doctors, the traditional heads of regional health districts, would function under area health administrators was highly unpopular. The Jamaican Medical Association (MAJ) pointed out that the proposals represented a threat to the independence of the profession as well as the right to private practice (Barrett, 1979: 89-90). Doctors were essentially resentful of reporting to administrators in interventions which directly affected the care of their patients (Mitchell, 1979).

The Manley government's expressed policy contracting overseas health personnel, mainly Cuban doctors and nurses, also attracted criticisms from the profession and added to the strained relationship. This was one of the policies emerging following Manley's 1972 visit to, and the subsequent establishment of full diplomatic relations with Cuba. In 1976, the government recruited fifteen (15) Cuban doctors, which was increased to fifty (50) by the end of the decade (Feinsilver, 1993: 162). The medical association was not consulted, and expressed its concerns about the qualifications and competence of these doctors as well as their eligibility for registration under the laws governing medical practice in Jamaica. In spite of the controversy, which escalated into press exposés and investigations, the government maintained its position though the profession's intervention forced the government to screen and orient new and potential Cuban recruits (Barrett, 1979: 90). At least a quarter of these doctors provided service at the regional hospital level (Feinsilver, 1993: 162). Whatever the concerns, the services of the Cuban doctors and nurses were important in supporting the health sector during the crisis period of the late 1980s, particularly at the regional primary and secondary levels, and hence constituted a vindication of the Manley government's ideologically progressive policy thrust in health human resources. Despite disputes with the profession, the government did however manage to achieve important policy goals in relation to medical education, with the medical school faculty eventually endorsing the need for curricular reform process to include the primary care approach, a long advocated policy. It has to be said however that international health trends in reforming medical education in developing countries was as influential as governmental pressure in effecting the change, as predicted in the 'green paper'.

In terms of the government's second priority, administrative and management reform, the regime's achievements in its second term, 1975-1980, were also severely limited by both economic and political constraints. Fundamental administrative reform was identified as an early 'first-term' target, but had mixed results. The establishment of a ministry of the public service was intended to reform administrative practice. However the central bureaucracy failed to respond "...effectively, expeditiously and sensitively..." to changed internal and external environmental conditions which had ripple effects on the functioning of public sector health administration (Jones and Mills, 1989: 113). The continued excessive centralisation of power within the three core institutions with direct relevance to health policy - the ministries of finance and the public service as well as the public service commission - imposed serious constraints on sectoral ministries, such as the ministry of health. Slow and weak decision-making, cumbersome procedures, structural rigidities, shortages in funding and staff shortages in critical administrative areas therefore continued to characterise the bureaucracy by the end of the 1970s. Because of the IMF-ordered budget cuts, decision-making by heads of department and permanent secretaries were being taken on an 'ad-hoc', 'day-to-day' and 'crisis-ridden' basis within a now under-resourced and semi-reformed (at best) public health sector (Jones and Mills, 1989: 114; Mills and Slyfield, 1987: 395-412).

Politically the Manley government was still committed to fundamental reform. However, because of the crisis situation, feasibility was increasingly questioned and there was greater unwillingness to tackle a bureaucratic system still dominated by colonial tendencies, given the crisis-driven pressures being exerted by the International Monetary Fund and World Bank (Mills and Slyfield, 1987; Carr, 1977: 83; Stone and Wellicz, 1988). Caught in the middle of wanting to implement its development programmes, the economic problems constraining such action, bureaucratic resistance, and its own internal ideological wrangling at the time, the Manley government seemed incapable of acting effectively during its second term. Despite its achievement in actual health policy then, the health bureaucracy, linked as it was to the central bureaucracy remained therefore virtually unchanged well into the 1980s with the colonial style of
management and administration still dominant and little or no sign of inter-sectoral co-ordination. This had negative consequences even for the government’s progressive policy achievements (Carr, 1977: 134-136). As Carr noted about the conservatism of the Jamaican bureaucracy in contrast to the radical Manley regime in the 1970s:

"...civil servants are very often inadequately informed on the issues before them...even where informed, because they have been conditioned by the bureaucratic environment to think in incrementalist terms, and to maintain the existing power structures within the society, any policy suggestions tend to be aimed at adding to what already exists rather than at making any fundamental change..." (1977: 83).

Accounting for regime-based influences and health human resources policy under Manley: The economic problems facing the Manley government was a major factor in its policy failures. The 1970s was an “unmitigated disaster” for Jamaica as the economy rapidly declined (Stone and Wellicz, 1988: 83). This had a grave effect on the largely economically-driven mass migration of nurses and doctors in the late 1970s, who were simultaneously taking advantage of American immigration changes which gave professionals a better chance of naturalisation, explored later in Chapter Six. Yet, the government’s health human resource achievements were all the more remarkable given this situation, which were largely to due to its characteristics. Its power to extract and allocate its scarce resources for health human resources policy implementation, though diminishing by the end of the decade was still impressive. Its socialist ideology as well as its democratic credentials were clearly influential factors in this regard. By the end of the 1970s, the Jamaican health human resources policy, despite the growing resources problem, was well on the way to officialising an integrative approach, emphasising primary health care within its health sectoral planning, training and management processes, in spite of the economic crisis.

The comparisons with the Burnham regime are instructive. Both governments had experienced similar economic problems during the decade. The major problem facing Guyanese health human resources policy other than resource scarcity and debt was regime illegitimacy. The other problem constraining the Manley government in addition to resource scarcity and demands for reduced spending by the International Monetary Fund was the slow pace of administrative reform and to a lesser extent the antagonism of some elements of the medical profession. The Manley government underestimated the importance of fundamental bureaucratic reform as a basic pre-condition of the policy development process (Carr, 1977, 134-136). Strong and sustained support for the policy process was thus very difficult under such conditions. Both regimes managed to formulate policies that were eventually implemented in the 1970s: the community health worker and medex in Guyana; and the community health aide and nurse practitioner programmes in Jamaica. Both also suffered from health sector migration in the late 1970s, Jamaica, largely due to economic factors, Guyana, to political as well as economic factors. The defining difference however was regime democracy and survival which was reflected in the divergent outcomes for both countries. The Manley government was democratic; the Burnham regime, undemocratic, and interested in retaining power by whatever means. This factor, coupled with mismanagement and corrupt practices explains Guyana’s worse plight in the case of health human resources compared to Jamaica’s, despite that country’s own political and economic problems, by the end of the 1980s. Finally, in terms of pressure group activity and influences in Manley’s Jamaica, the evidence indicates both considerable nursing influence and hence positive reforms for both that profession as well as the primary health policy thrust in the 1970s, which was largely due to the policy aims of the regime. Although an independent, regionally-governed institution, even the shift in the medical school curriculum towards a more preventive approach was due in part to the regime’s own policy goals during this period. Despite alienating some in the medical profession, then, health care outcomes in the area of health human resources development was still impressive given the mitigating circumstances.

Comment: weak, stable, socialist, democratic, non-survival-oriented regimes and policy: The above evidence from the Manley government’s health human resources policy experiences in Jamaica in the 1970s demonstrates the possibilities as well as the pitfalls of progressive policies by democratic regimes in the post-colonial state. On the one hand, it suggests that weak, even unstable, but democratic, ideologically progressive regimes can achieve far better results in policy formulation and implementation. Despite financial and bureaucratic weakness, it was able to use its limited resources progressively to
support social policy implementation. Unlike survivalist regimes, like Burnham’s in Guyana, policymaking can be undertaken as resources are not being diverted for questionable and/or regime maintenance policies, despite a shared ideology. Compared with Guyana therefore, adherence to democratic, non-survivalist principles seems to be the main difference.

On the other hand, there are other policy influences to consider. Jamaican example in the 1970s demonstrates that external political pressures cannot be ignored, given the might of American political and economic pressure exerted on the regime for its relationship with Cuba in the 1970s, a punishment not exerted on the Burnham regime for largely strategic reasons. This makes the Manley regime’s achievements all the more impressive. In terms of the actors within the policy process itself, the evidence suggests that participation by challenging interests such as the nursing profession, actively championed by ideologically progressive, democratic regimes resulted in considerable policy innovation and change in achievement of human resources development goals, medical antagonism and despite regime weaknesses at the resource and bureaucratic capability levels (Abel-Smith, 1988: 88-90). Before any serious comparative assertions can be made about the post-colonial state policy process in the Commonwealth Caribbean in the 1970s, we need, finally, to examine the Williams regime’s policy experiences in the 1970s.


**Policy context:** The Eric Williams government which governed Trinidad from self-rule in 1956 through to 1981 presents some interesting comparisons and contrasts to both the Burnham and Manley governments. The Williams regime began the 1970s economically and politically weak. However, the 1974 Arab oil embargo saw Trinidad’s oil economy rapidly expand for the rest of the decade, and with it the fortunes of the ruling party. The government was therefore not only strong for most of the 1970s, even lending to its Commonwealth Caribbean neighbours, but was also able to proceed on its developmental path in a way that the weaker Guyana and Jamaica could not envisage, given their oil-importing status and increasing debt problems. Given Trinidad’s wealth and the regime’s longevity, the regime was quite stable in the post-boom period. Williams political ideology was essentially ‘non aligned’. However, given its strength in the 1970s and its subsequent decision to develop along a capitalist-based ‘third path’, rather than socialism as in Jamaica, it can best be characterised as ‘state capitalist’ (Sandoval, 1983). In terms of democracy and regime maintenance instincts, the lack of parliamentary opposition for the first half of the decade, coupled with Williams personalised and centralised rule saw the government continue along the survivalist politics mapped out by Williams in the early 1970s in the aftermath of the black power riots and attempted military overthrow of the government.

The black power uprising and attempted military coup resulted partly from the failed ‘industrialisation by invitation’ development strategy followed by the Peoples National Movement (PNM) regime like its other Caribbean counterparts. The failure of the ‘strategy’ by the early 1970s which had been incorporated in the government’s two preceding five-year development plans since independence, had resulted in rising cost of living, unemployment and considerable migration from all social classes and races. Like Guyana and Jamaica in the early 1970s, a continued decline in social, and particularly health conditions reflected not only the need for a new economic development strategy, but also the need for fundamental reform the colonial administrative system into a development-oriented one. The ensuing social unrest culminated in the failed coup attempt and forced the Williams to search for another development and reform strategy. The rocketing oil prices in the post-1973 period however precluded these difficult tasks.

In 1976, the Williams government received a fresh mandate based on the oil boom. Between 1973, when the boom started, and 1978, when it reached its peak, central government revenues increased five-fold (Sutton, 1984: 50). With this strength however came a form of ‘presidential’ government (Sutton, 1984: 60). The prime minister’s distrust of even some of his own ministers and the bureaucracy, or conversely the incompetency of both groups was one cause (Ryan 1981; Emmanuel 1991, Hintzen, 1989; Sutton, 1984: 59-60). This led to the creation and concentration of decision-making powers by Williams himself, in tandem with new supra-national, policy groups that appropriated power from the bureaucracy.
and whom were wholly responsible to the prime minister personally (Macdonald, 1989: 192). One of these organisations, the National Advisory Council (NAC) was created in 1976 and charged with, inter alia, defining policies for almost all sectors including health. Regime survival was thus key. As Samaroo notes, the "...PNM's obsession with political survival and the maintenance of power at all cost; a situation which has resulted in the alienation of large sections of the population..." meant that reform was needed through democratic participation in the decisionmaking process through decentralisation and administrative reform (Samaroo, 1985: 164).

**Regime characteristics and health and health human resources policy responses:** The Williams government’s plan, the ten-year national health plan (1967-1976) was prepared by the Ministry of Health with technical support, like Guyana and Jamaica, from the Pan American Health Organisation (PAHO) during the early 1960s. The document underscored the need for fundamental administrative reform, with the health ministry recommended to be reorganised along three levels of authority: policy decision, policy formulation and policy implementation. This was not the first attempt at reforming the health system under self-rule. At the start of partial self-government in 1956, a commission of inquiry set up by the Williams government into the poor state of health care services resulted in the 1957 Julien report. This report found that the causes of dissatisfaction by hospital-based doctors and nurses were largely due to poor working conditions that urgently required decentralisation, rationalisation and integration of the health sector. This report was however not implemented by the new government for economic reasons, but also political factors, since there was little enthusiasm for decentralising power by Williams, as the countries largely symbolic, impotent local government system aptly demonstrated in the post-independence period (Ragoonath, 1991).

Like the two other countries, an outline of a universal health care system was at the heart of the Williams regime’s policy. It consisted of three other components: assessment of the health situation including the technical and administrative problems of the health service; the criteria for establishing priorities; and the implementation of plans that were defined under three major programs - integrated health care, environmental health and epidemiology (Government of Trinidad and Tobago, 1967). In relation to the first priority, plans were outlined, for example, for the integration of curative and preventative services, including the reorganisation and relocation of the existing district services, thus decentralising services to the regional level (Hezekiah, 1989: 87-88). Both bureaucrats and health advisers emphasised the importance of decentralised-based reform. Decentralisation and policy definition were integral parts of the health plan. The ministry of health’s performance was affected by the concentration of power and decision-making, a situation that could not be improved without "...breaking the circle: through decentralisation and effective delegation of authority..." (PAHO, 1963: 19-20).

However, as in Guyana, and to a lesser extent in Jamaica, the first national health plan was never implemented. The government’s own ‘health bureaucrats’ admitted that the plan was at best implemented selectively, with no fundamental administrative reform of the health sector as recommended (Jordan, 1979, Quamina, 1984). Quamina justifies this by noting that much change occurred simultaneously: change in administrative structures, change in the attitude of senior bureaucrats who were not convinced of the need for it; and importantly, changes/reshuffles of ministers and permanent secretaries which itself confirmed the nature of the regime’s authoritarianism. All of this, she conceded, resulted in confusion as well as stasis (1984: 3). The causes of partial and ad-hoc implementation, then, go far beyond Quamina’s assertions, since policy action so heavily depended on an facilitating political environment, including Williams’ willingness to decentralise power and clear indications that his government was willing to do so. However, this was lacking, given the political and economic context of Trinidad after 1970. The omens were not good for health. Other sources of policy also gave cause for concern. There was also no mention of the health sector in the PNM party’s general election manifesto of 1971. Subsequent manifestos in 1976 and 1981, aside from pledges to universal and primary health care, also remained silent on health policy and administrative reform as possible solutions to the health crisis (PNM, 1971: 16). It was not altogether surprising therefore that the sector suffered from selective, and hence non-effective implementation of the plan during this decade by those committed bureaucrats due to the non-reformist, centralising tendencies of the Williams government.
Comment: The ‘state capitalist’ stable, democratic, yet ‘authoritarian’ Williams regime in Trinidad was shaped by two main factors: the attempted ‘revolution’ in 1970 which saw Williams exert ‘presidential’ control over the party and the state in the 1970s, and the 1973 oil boom (Sutton, 1984). Both of these factors heavily conditioned the national political and policy process in Trinidad and Tobago for the rest of the decade, and beyond. In discussing Williams’ political authoritarianism, the question has to be one of relativity. It can hardly be equated with the dictatorships of Pinochet’s Chile or Moi’s Kenya. Nevertheless, political confidence and power gained from the oil boom in Trinidad in the 1970s coupled with the reality of the political problems of the early 1970s triggered the creation of a personalised, ‘presidential’ form of rule by Williams that had serious implications for post-independence policy reforms, including health and human resources development (Sutton, 1984). Aside from the 1957 Julien report and the 1967-76 health plan both of which strongly recommended health sector decentralisation and appropriate training, there were numerous other reports that alluded to the sources of Trinidadian health and health human resources problems in the subsequent years. The problem, then, was known by the Williams government long before independence in 1962. The 1967-76 health plan had noted that “…the greatest single obstacle to successful implementation of this or any other health plan is the shortage of trained personnel…” (Government of Trinidad and Tobago, 1967: 62).

Even the 1967-76 health plan itself contained no detailed proposals for health human resources within a decentralised health sector, other than the moderate incrementalist goals of reiterating the need for more ‘in-service’ training and a revision of the terms and conditions for all categories of staff - a fact that reflected both the enormity of the need of reform as much as the neglect of health human resources (Government of Trinidad and Tobago/Hansard, 1965: 587-608). In its own survey of nursing needs in 1968, the health ministry noted that the increasing migration problem was hindering attempts to provide adequate health services. This report also highlighted problems stemming from acute shortage of teaching staff at the schools of nursing, an imbalance in institutional/district nursing allocations, unbalanced training needs and job instability (Government of Trinidad and Tobago/Ministry of Health, 1968: 46). These findings confirmed that the problem was as much related to management and planning factors as it was financial. The absence of clear policy on both general health policy and human resources development 1973 however made any improvements impossible in the short-term.

The issue was not really one of instability, although this was an important contextual factor. Health sector reform was a ‘low-politics’ situation which would not have threatened the government. Yet, the government was still recovering from the political events of 1970, and with it, the increased concerns about centralising power and control by Williams himself. Without the much-needed reforms to the sector, due to the prime minister’s growing distrust of the other actors in the public policy arena, the ministry continued to function along colonial lines with only superficial reforms implemented on an ‘ad-hoc’ basis. Hints at nursing and medical policy reform were usually advanced in parliamentary statements expressing concern about ‘on-going crisis’ situations, the migration problem, the need to train more staff and the need to recruit foreign nurses. By 1973, this policy vacuum saw migration increase, resulting in both nurse and doctor shortages. During the pre-1973 period, government policy in relation to health human resources amounted to providing scholarships for study abroad and financial support for the medical campus in Jamaica. In the case of nurses, policy continued along colonial training structures and institutions with little emphasis on preventative care. In terms of medical education however, regime policy seemed decidedly active on another front, its further discussions with the World Bank over that organization’s willingness to fund a medical school for the Eastern Caribbean, to be located in Trinidad. This is fully discussed in Chapter Seven, but the increasing preoccupation with this project mirrored the neglect of the more important and immediate organizational and policy problems not being addressed the government, as much as it did medical professional influence on the prime minister and antagonism with the Manley government at this time. In sum then, the first three years of 1970 saw little or no concerted action to implement long-outstanding policy due to Williams presidential hold on power. This resulted in an all-but-abandoned ten year plan, and with it the necessary reforms which might have curbed if not prevented health personnel migration.
Comment: The 1967-76 health plan was essentially short on detail, contained no clear sense of the aims and objectives of the state health system other than a generalised recognition that the situation needed to be improved, and was on hold or neglected because of Williams unwillingness to decentralise any type of power, even for the health sector. Assuming that it was essentially a framework document, the lack of policy detail in the plan, given the recommendations of both the planning team and the government’s own pre-plan ministerial report, was noticeable. This even led to a less than satisfactory position by the admission of the ministry’s own technical officers of partial implementation and undeveloped details. It became instead a ‘framework’ document that broadly guided health services in a country without a clear, written policy: a situation that would persist well into the 1980s under PNM rule.

The health human resources recommendations of the 1978 National Advisory Council: By 1976, the Williams government received a fresh mandate on the strength derived from the oil boom, and, correspondingly, Williams own presidential authoritarian style of government, even in relation to his own ministers increased (Sutton, 1984: 60). Policy decisions remained in his hands, but were prepared by his select group of favoured technocrats on the National Advisory Council (NAC). The limited planning attempts in the 1960s were thus replaced by a cash-driven, physical infrastructural boom (including hospital and health centre construction and repairs) that was centrally managed and controlled by Williams personally, and executed by his small select groups of technocratic advisers. The government embarked upon numerous grandiose projects, all cash-intensive, and quite a few questionable including the medical school and complex project. Still, no basic written health or health human resources policy existed for the country at this point. The gains for the health sector were mainly physical and technical improvements, which though good, still did not address the core organisational and management-related problems facing both health personnel and the health services that might have been forthcoming in such a policy. Instead, ad-hocism at the policy level and crisis management at the institutional and district levels, dominated, and were usually solved by financial allocations rather than organisational reform. Trinidad however was not alone in this situation. One concerned doctor asserted:

"...at the root of all accomplishment lies the definition by each country of a health policy that takes account of its own circumstances and sets out concisely the priorities and the precise objectives of the health services...Hardly any Caribbean country has written such a policy..." (Massiah, 1975: 44-45).

Reporting to the National Advisory Council on the health sector, the consultancy report by Peat Marwick and Mitchell was critical of the poor conditions of the health sector at a time when vast amounts of resources were being allocated to the medical complex. It noted that medical professionals were in scarce supply, not because of training shortages, but because current methods of compensation tended to aggravate the problem. It also significantly added that one of the main problems was that the health care system was highly medicalised with emphasis being on cure rather than prevention and that as a result, programmes and activities were being adversely affected by this “inappropriate emphasis” (Peat Marwick Mitchell Report, 1978: 15). In this regard, it questioned the dominance of medical professionals in the health ministry (Peat Marwick Mitchell Report, 1978: 15).

In relation to human resources development, the final NAC report recommended, and the government agreed, to the establishment of postgraduate facilities at the proposed medical complex from its inception. It also proposed to increase scholarships for medical specialisation. In relation to nurses, the government had already initiated the NAC’s recommendation to increase the number of nursing posts in the establishment. In addition, a strengthened administrative framework with the creation of a nursing division with a chief nursing officer and two sub-officers responsible for policy formulation and implementation in relation to institutional and community nursing was recommended. Though praiseworthy, these recommendations were ad-hoc, limited, curative-oriented and did not solve the main, political/organisational problem. This failure to address this problem emerged in various crisis-ridden forms, including migration overseas and to the private sector by both doctors and nurses, as well as innumerable protests and other forms of industrial action. Another was the examination failures of a large number of nursing students in 1977, which forced the government to order a commission of inquiry into
the profession. The remit of this commission suggested that only crisis situations would yield urgent
government attention away from its numerous prestige projects in the throes of the oil boom. The regime
was strong and stable, yet had little short-term political incentive in reforming the health services. Hence
attention was paid to ‘showpiece’ projects such as the medical complex, to the detriment of smaller, more
community health oriented policies - which the government persistently claimed was its central policy.
Policy failure however such as the nurse practitioner issue which will now be examined and compared
with the Jamaican situation support the criticisms of government policy.

**The failure of the nurse practitioner policy:** The failure of the nurse practitioner policy issue in
Trinidad was due to a combination of influences and cannot be blamed entirely on the government, which
in fact introduced the issue to the health agenda in the mid 1970s. Like Jamaica, implementation of the
nurse practitioner policy would not have solved problems like nurse migration, poor salaries or
deteriorating working conditions. However, it would have certainly helped to promote the profession’s
status in a country, like Jamaica that was producing a significant number of highly trained nurses annually,
but seemed incapable of retaining many of them. It was first introduced, ironically, in the health
minister’s 1975 address to the Trinidad and Tobago Medical Association (TTMA), where he outlined the
government’s intentions to introduce the category to the health sector. Nurses were obviously the main
supporters, though some progressive doctors did support adoption and implementation (Massiah, 1982:
40).

Given this support, the government requested the National Advisory Commission to consider the
merits of introducing this professional category and the role of such nurses in relieving medical officers of
certain routine functions of the profession in this regard. The question would also crop up again in the
remit of the 1981 Toby Commission on public health reform. The continued failure of this policy to make
it beyond the agenda-setting stage, despite political support, implied covert medical influence to
undermine the policy. The recommendations of both commissions - both with medical professionals it has
to be said - were generally unsympathetic, a fact which was also confirmed in the course of my interviews
(La Touche, S 1994, interview). The final 1978 NAC report suggested increased posts, better
remuneration, and a modest lowering of the entry requirement for prospective students to remedy nursing
shortages. On the nurse practitioner issue however, it was silent. The 1981 Toby report however went a
step further, noting that it was a good idea. However, this report recommended that the policy should not
be considered in the short term. No justification for this decision was given. The fact that Toby himself
was a doctor may itself be instructive.

Like Jamaica then, the Trinidadian situation reflects a pattern of regime willingness to consider policy
implementation. However, unlike Jamaica, the Trinidadian policy lacked adequate support from a wider
variety of important actors, including the persuasive powers of the state. Equally important, the issue of
regime characteristics was also important as the Williams government seemed unable to follow through,
due both to a lack of ideologically-driven goals like the Manley government, and the government’s own
limited understanding and appreciation of the possibilities of nurses in policymaking. It has to be noted
however that the less than satisfactory lobbying efforts of the nurses associations also played a role.
Added to this was medical professional dissatisfaction with the policy to an extent that was significant
enough to preclude policy adoption and implementation. In this case therefore, regime characteristics
seemed as equally important as nurse apathy and medical influence in preventing the policy issue from
making it past the agenda-setting phase.

By Williams death in 1981, the economic situation had already begun to change. The human resource
policy costs of the government’s failure to adopt and implement progressive policies were now being
counted. The ministry of health’s annual report in 1981 noted, for instance, that community health
nursing had suffered from its failure to implement the policy of providing primary care nurses in the
community. This was said to be due to shortages, lack of staff and poor research data on needs
(Government of Trinidad/Ministry of health,1981: 7). In terms of relationships between the regime and
the medical profession in the 1970s, there was barely-disguised mutual distrust. The health minister,
Kamaluddin Mohammed continually berated the profession for not performing its duties in the public
interest, while the profession resented his confrontational, 'ad-hoc' style and seeming inability to grasp the need for comprehensive reform of the sector. In 1979, relations between Mohammed and the TTMA worsened when he threatened to restructure the medical board to include government members: a suggestion dismissed by the association as a joke (Thomson, 1979: 66-67).

Accounting for regime characteristics-based influences and health human resources policy in Trinidad in the 1970s: The main question in attempting to explain the determinants of Trinidadian health policy at the end of the 1970s was essentially how a financially strong, reasonably democratic, and reasonably stable regime could squander such a golden development opportunity. The problems associated with post-colonial states, namely colonial institutions and structures, as well as corruption are part of this explanation. The state was reasonably democratic and stable, yet it had emerged out of the attempted overthrow in 1970 with a prime minister more concerned about securing his hold on power, than on attempts at rational progressive policymaking. Effective power was in the prime minister's hands, and decisionmaking delegated to a small group of trusted bureaucratic advisers and cabinet ministers.

However, the seeming unwillingness of the regime to reform basic state institutions and instead impose advisory group type policymaking which did not necessarily address needs was clearly observed in the health and health human resources sectors. The policy chaos that ensued included contradictory policies as well as questionable justifications for those policies. The medical complex absorbed considerable funds while conditions declined. Ironically enough, it was the increased funding of existing health systems rather than fundamental reforms that prevented further deterioration. While an effective tool in the boom years, as the debt crisis mounted in the early 1980s, and resources were no longer available, one justifiable conclusion was that even if one accepted some level of misuse of public funds - a reality of public policy in both developed and developing states - the Williams regime seemed to have clearly squandered its policy reform 'window of opportunity' to a great degree.

As Ehrensaft pointed out in 1968, before the oil boom, the incrementalism of the Williams government in its maintenance of the status quo at all costs, rather than the search for progressive change was detrimental to development. He noted that the regime's recourse to weak or 'pseudo' planning to spur development was bound to create problems in the long term. By reacting to 'short-run' pressures as against changes for the long term and the need for political mobilisation, it was stated that the country would not be able to harness its developmental potential (Ehrensaft, 1968: 373-374). The authoritarian and status quo characteristics of the regime were thus clearly instrumental. To be fair, however, the problem though largely one of mismanagement, was not entirely due to this factor in the case of health human resources development. The medical profession dominated ministerial policymaking as well as 'advisory group' policymaking in Trinidad throughout the 1970s, despite ill-founded concerns about them yielding power to other professionals such as administrator/managers (Quamina, 1976). The profession also scuppered the nurse practitioner policy, aided by a weakly articulated position from the nursing profession, despite the regime's willingness to move the issue beyond the agenda-setting stage. In light of these realities, Quamina's statements rang somewhat hollow. International financial agencies were quick to sense an opportunity in the boom years. Hence, various loans from the World Bank and other lending institutions were entered into by the regime. The Inter-American Development Bank (IDB) in 1974 funded the constructing health centres throughout the country, while the World Bank funded a family planning programme, driven by the Bank's own policy priorities at that time. The World Bank also funded a significant proportion of the medical complex.

Calls for reform by many doctors and nurses nevertheless remained unanswered. In the last three years of the health plan, from 1973 to 1976, the government's 'health policy' was concentrated almost exclusively on the building of health centres, upgrading of hospitals as well commissioning the feasibility study for the expansion of the Mount Hope hospital into the medical 'complex'. While the concerns of the professions were noted, there was no coherent attempt, during the entire duration of the plan to act on these concerns, which traced its origins back to 1957. What was most needed, and what the government steadfastly refused, was to formulate and implement a clear health policy, listing the priorities for the country based upon an integrated, primary care-oriented, decentralised and ultimately reformed system.
In the case of health, the ten year plan (1967-76) signified a positive start by the regime in addressing the problems facing the country in the late 1960s. However, political as much as economic factors precluded the implementation of the plan and its main recommendation, the reform of the health services. Though not surprising given the same government’s reluctance to heed similar recommendations in the Julien report as far back as 1957, the failure of this attempt was to prove particularly frustrating for both committed health bureaucrats and professionals alike. Ehrensaft’s assertions were much in evidence therefore, by the end of the 1970s in relation to human resources development in the health sector, especially by 1980 when the oil boom was about to turn into an oil ‘bust’.

Comment: Strong, stable, authoritarian-democratic, state capitalist, survival-oriented regimes and policy: The above evidence suggests that regime characteristics exert influences on post-colonial state policy processes even where regimes have considerable resources for implementation. This suggests two things, firstly, that like two other cases, there was little incentive to implement such low-politics policy reforms; and secondly; that despite the nominal adherence to democratic norms, when regime leaders exhibit undemocratic, authoritarian tendencies the implications for low politics policies tend to be negative. Rather than reforming antiquated institutions, policymaking is left to small groups of trusted advisers who may or may not be ignorant of the public need, and biased towards one type of policy ideology to the detriment of long-term policy. The Williams government unlike Burnham in Guyana and Manley in Jamaica was financially strong enough to undertake the type of policy reforms that would have had considerable long term benefits. However, due to political events in 1970 and Williams subsequent authoritarian, ‘survivalist’ style, ad-hoc, short term, grandiose, capital intensive, prestige policies seemed to dominate within this brief window of opportunity. These choices had negative ‘ripple’ effects on low-politics policymaking generally.

Much-needed policy reforms such as decentralisation of the health sector and reduction in medical dominance within the health planning process and training process were needed. Instead the colonial bureaucracy remained unreformed as in Jamaica and Guyana, health policy remained centralised and heavily curative and health personnel, particularly nurses as will be seen in Chapter Six, continued to migrate. Medical interests, exerted considerable influence on the policy process, dominating the health ministry senior bureaucracy as well as policy advisory groups, while nurses appeared less organised and able to lobby effectively to further their concerns as shown by the failure of the nurse practitioner policy. In sum then, the Trinidadian experience suggests a complex picture, like both Guyana and Jamaica on the issue of regime characteristics influence. Regime characteristics exerted considerable power on policy, arguably more so in the affluent post-colonial state especially in determining the allocation of abundant resources. However the evidence also suggests that the unequal power of interest groups as well as the persuasive role of international financial actors in unquestioningly funding ‘elephantine’ tertiary projects in developing states where simpler solutions might be both necessary and appropriate are also contributing factors

4.3 SUMMARY AND CONCLUSIONS

In this chapter, I have examined the role of regime strength, stability, ideology, democracy and regime maintenance or survival on the health human resources policy process under three post-colonial regimes in three Commonwealth Caribbean states in the 1970s. All three regimes experienced mixed policy outcomes that indicated a general pattern of influence of regime characteristics. The Burnham regime was weak, unstable, nominally ideologically progressive, but undemocratic and interested primarily in its political survival. While the causes of weaknesses were primarily economic, there was also bureaucratic co-optation, which undermined those ideologically progressive policies such as the community health worker programmes, as well as the workings of the health ministry. Regime maintenance, as enunciated in ‘party paramountcy’ however seemed to be the most influential regime characteristic in the 1970s. In undermining democracy, it affected every aspect of social, political and economic life, which made life for even the most committed professionals extremely difficult. The paradox of progressive policies occurring simultaneously with deteriorating living conditions as Burnham’s oppression increased by the end of the 1970s thus cannot be omitted from any explanation of development policy in Guyana in the 1970s, and, as we shall see in Chapter Five, for most of the 1980s as well. Not even considerable
American political and economic support could solve what was essentially a question of regime legitimacy and democracy.

Health human resources policy in Jamaica under the Manley regime in the 1970s provides some similarities with the Guyanese situation and points to both the possibilities as well as the pitfalls facing post-colonial regimes. The Manley regime also espoused a socialist path and also governed within the context of a weak, declining economy and an unreformed bureaucracy, with urgent reforms necessary for smooth and effective implementation. The Manley regime also, like the Burnham regime in Guyana, formulated and implemented progressive policies in the case of health human resources. In addition to supporting the medical school and influencing university thinking on curriculum changes to reflect its preventive approach for both doctor and nurse training, the regime also implemented its two other impressive achievements in the 1970s: the nurse practitioner and community health aide policies. The fall in bauxite prices on the global markets in the mid-1970s affected resource availability. This made it impossible to increase wages and improve general conditions that might have stemmed deteriorating working conditions and, ultimately migration. The Manley regime’s resort to the International Monetary Fund and the harsh conditions attached to these loans, and the political and economic pressures being exerted by the American government because of the regime’s friendly relations with the Cuban government, only compounded matters. It also makes the government’s attention to policies such as the nurse practitioner policy, and other allied health programmes, and its continued training of the traditional categories all the more remarkable. The Jamaican example of the 1970s suggested that explanations for health human resources policy must take into account the “democratic” socialist, non-survivalist characteristics of the Manley regime. Any doubts about the role of the regime in radically reforming perceptions of health care was demonstrated in its support of nurses and its impatience with the conservative medical profession in forcing the profession to consider policies such as the nurse practitioner issue. Although this proved influential in some doctors’ decisions to migrate, the main problem in the case of both doctor and nurse migration, as well as the limited achievements on health sector decentralisation were related to economic factors and priorities in Jamaica at that time, rather than questionable regime characteristics as in Guyana.

The Williams regime’s authoritarianism tendencies in the early 1970s, resulting from political instability, an operating within the context of political legitimacy, was nevertheless harmful for the health human resources development process. The Williams regime’s unwillingness to reform the state machinery for development purposes left it totally unprepared when the oil boom occurred. It was essentially faced with the post-colonial politician’s dilemma. On the one hand, it faced the question of whether to support sustainable, relatively unglamorous policies such as health sector decentralisation which though not threatening its survival, could set a precedent in the reduction of central policy control. The alternative was physical infrastructural ‘prestige’ projects that had much political - if not policy - utility. The outcome was a complex mix of regime platitudes about primary health care, especially after Alma Ata, coupled with the huge allocation of resources towards the medical school policy. The regime chose to avoid the state machinery and adopt and implement policy helped by trusted special advisers. One argument can be advanced that reform was not a short-term issue for a regime eager to proceed with the development process. The problem with this view is that the eventual decisions that were actually taken and implemented were ad-hoc, with little consultation from the wider society, and dominated by interest articulation from the medical profession in the case of health and health human resources. Even worse, these plans had to be eventually integrated into national goals and policies, which were not written at this time. The failure to reform at this critical juncture was to have even worse consequences for the policy process in the impending decade of structural adjustment for all three countries as we shall see in the next chapter. The considerable policy ‘window’ provided by the oil windfall was thus effectively squandered by 1980.

Bossert’s 1983 analysis of regime characteristics alluded to the need to consider regime-based explanations in policy analysis. My examination of policy-making found that while there was a significant degree of similarity in terms of context and problem definition, different approaches to the policy process were made. These were influenced by, among other factors regime characteristics. I introduced to Bossert’s original typology the characteristic of regime maintenance or regime survival. I found that this
regime characteristic also had some explanatory power in two of the three cases examined, with Guyana, under Burnham exhibiting the strongest influences in this regard. However, it interacted with other regime influences such as democracy and ideology as well as non-regime factors such as economics. I found in the case of Guyana in the 1970s that under conditions of non-legitimacy, authoritarianism and limited resources, the urge to maintain control of the state results in the allocation of resources for regime survival. This in turn has the effect of negating and undermining the nominal progressive ideological policies being espoused in the policy arena, leading to policy neglect, 'ad-hocism' and underdevelopment. Policy 'ad-hocism' and neglect characterised the policy development process in Guyana in the 1970s, as significant amounts of the state's scarce financial resources were directed towards regime survival. The resultant poor conditions for the rational planning, training, management and utilisation of health professionals thus triggered a sustained level of migration of health professionals and a marked decline in all aspects of health.

By contrast, in the case of the Manley government in Jamaica in the 1970s, I found that under given conditions of regime legitimacy and progressive ideology, and some level of political will - despite Reich's critique - and room to manoeuvre can be found in making and implementing policies, even under militating internal economic conditions and external political pressures (Reich, 1994). Regime characteristics such as ideology were found to be more important than regime maintenance. Hence, the main problem for the Manley government was economic, despite the occasional lapses as we saw in its poor relations with the medical profession. Inexperience, the size of the task, its failure to effect the required administrative reform as a precondition for implementation, a chronic lack of resources due to a sustained economic problems, also added to its problems. Importantly, even though the government's own increasingly radicalised political agenda was a symptom of its tenuous situation, it never made any moves that constituted a wish to retain power undemocratically. This legitimacy along with its ideological commitment to preventive, community-based care was its greatest contribution to policymaking for the health sector, although its hands were effectively bound by IMF dictates.

Finally, in the case of the Williams government in Trinidad, I found that under conditions of personal authoritarian, any strong desire to centralise power for regime survival had deleterious effects for reforming implementing institutions of the state in preparation for development policy despite nominal democracy and legitimacy. This tendency became quite strong with grave consequences for long-term policy and development processes even when favourable 'intervening' conditions in the form of unexpected resource acquisition have created policy windows of opportunity for policy reform. For the 1970s at least, then the role of regime characteristics was influential to varying degrees in each country, though economic factors, professional interests and international economics and politics were also very important. In the next chapter, we assess and compare these developments with those in the 1980s.
CHAPTER 5

STRUCTURAL ADJUSTMENT, REGIME CHARACTERISTICS AND HEALTH HUMAN RESOURCES POLICY AND POLICY REFORMS IN GUYANA, JAMAICA AND TRINIDAD IN THE 1980s: THE BURNHAM AND HOYTE (GUYANA), SEAGA (JAMAICA) AND CHAMBERS AND ROBINSON (TRINIDAD) GOVERNMENTS COMPARED

5.1 INTRODUCTION

In Chapter Four I examined the influence of regime characteristics on health human resources in the 1970s by examining the policy trajectory of the main policy issues placed on the agenda in Guyana, Jamaica and Trinidad. I found that while the incentives for reform and continued support of low-politics policies such as health remained limited, and while economic, historical and medical dominance factors were critical, the levels of action of the three regimes in Guyana, Jamaica and Trinidad also reflected the varying influences of individual regime and leadership characteristics. I found, for instance, that while economic boom and crisis as well as medical interests conditioned the various stages of the process, regime strength, stability, ideology, democracy and political survival also exerted varying degrees of direct and indirect influences on agenda-setting, choices made and ultimately implementation. Different regime influences also seemed to influence different phases of the process. Regime ideology, for instance, seemed important in policy formulation, but was conditioned by regimes’ democratic status at the implementation stages. The differences between the socialist Burnham and Manley regimes were marked in this regard given their different positions on the regime maintenance question. Policy outcomes by the end of the decade had therefore been affected to varying degrees by regime characteristics, despite the importance of economic and ‘medical interest’-related factors.

In this chapter I analyse and compare those policy actions and outcomes with that for the decade of the 1980s to determine first, whether these influences which persisted during the 1970s were as important in the 1980s, given the advent of regime change/succession within an equally changing economic context during this decade; second, whether (and how) regime attention to health human resources policy changed given the new even more serious national and international economic context of the 1980s; whether the usual ‘crisis-reform’ pattern of development occurred in the case of health human resources; and fourth, whether reform outcomes yielded by the end of the 1980s were compatible with national health policy aims and objectives, and the influence of regime characteristics in this regard. As in Chapter Four, I underline the need for a balanced, integrative approach to explaining individual developing state policy processes. I acknowledge that unique historical factors, resource scarcity and medical dominance do exert limitations on what developing state regimes and their policymakers can and cannot do in relation to health human resources policy, regardless of regime typologies. I however argue three things: first, that the unique influences of regime political characteristics in low-politics policy need to be grounded in particular local experiences; second, that these unique regime influences and circumstances need to be integrated with other contextual factors in attempting to realistically explain developing state policy actions, processes and outcomes; and third, that sometimes even low-politics policy issues such as health can assume high-politics features which can in turn influence regime survival. The chapter comprises three main sections. In Section One, I compare and contrast the influence of regime characteristics on health human resources policy in the first half of the 1980s. In Section Two, I examine and compare influences on policy developments in the second half of the 1980s. In the third section, I briefly examine developments in the 1990s. In the final section I conclude by assessing the main findings for health policy in the 1980s and developments in the first half of the 1990s.
5.2 POLICY CONTEXT, REGIME CHARACTERISTICS AND HEALTH HUMAN 
RESOURCES POLICY IN THE FIRST HALF OF THE 1980s

During the first half of the 1980s, all three countries experienced sustained deterioration in economic conditions, but also experienced political/regime changes. Burnham remained Guyana's president until his death in 1985, followed by his successor Desmond Hoyte until 1992. In Jamaica, Manley’s PNP was heavily defeated by Edward Seaga’s Jamaica Labour Party which remained in power for from 1980 to 1989. In the case of Trinidad, Williams death in 1981 saw a new prime minister, George Chambers lead the PNM to victory in the general elections later that year. The PNM under Chambers was heavily defeated in the 1986 general elections by the reformist NAR coalition led by A.N.R. Robinson. In this section I apply the broad regime characteristics listed below in Table 5.1 to explain regime influences during this period, beginning with policy under the last years of the Burnham regime.

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Regime characteristics and health human resources policy reforms in Guyana in the first half of the 1980s: the Burnham regime (1980-1986)

Policy context: Guyana’s unfeasible and non-facilitating policy context was due as much to the Burnham regime’s authoritarian as it was other factors. When combined, these factors meant that meaningful policy reform was difficult in the early 1980s (Premdas, 1994: 54; Spinner, 1984). First in relation to economics, falls in commodity (sugar and bauxite) prices saw approaches by the Burnham regime to the International Monetary Fund (IMF) between 1978 and 1981 (Thomas, 1988: 263; Spinner, 1984: 206). The devastating impact of both cooperative socialism and the economic environment was evident. An Inter-American Development Bank (IDB) report noted the fact that since 1970, no economic growth had occurred in eight of the nine years of nationalisation of the main industries under cooperative socialism (Spinner, 1984: 184). By 1982, Guyana’s most basic of foreign exchange needs could not be met, which, when added to declining productivity, a soaring national debt and a generally poor all-round economic performance resulted in even fewer resources for policy implementation. Renegotiating Guyana's loans with the World Bank and the International Monetary Fund in 1982, the Burnham regime agreed to concede a larger role for the foreign and national private sectors. Meanwhile, education and health conditions declined considerably. A team of Yugoslav experts even urged the regime to undertake bureaucratic and economic reform but was ignored (Spinner, 1984: 201). An IMF team visited Georgetown in April 1983. The regime rejected their loan conditions and strikes and shortages continued well beyond the mid-1980s. The government was bankrupt. The IMF declared Guyana ineligible to receive further loans because of failure to meet its performance criteria. The cost of living spiralled upwards, followed by continued emigration of skills. Guyana became a remittance economy as the “...underground economy stepped in where cooperative socialism had failed...” (Premdas, 1993: 118).
Economic crisis was however complemented by increased regime authoritarianism, which was equally not conducive to progressive policy development. A new constitution was promulgated by the PNC regime in 1980, inspired by cooperative socialism and party paramountcy, which effectively legislated for the regime's survival. The paradox of cooperative socialism was that on the one hand the 1980 constitution included what could be considered a progressive policy of regionalisation and decentralisation of administration. On the other however, it entrenched the position of the executive president thereby ensuring Burnham's own absolute control over the party, the state and the society which undermined such developmental potential. Under party paramountcy, the army swore allegiance to the ruling party, not the state. There were increasing calls for political democracy in Guyana in the late 1970s as social conditions worsened. A series of industrial strikes and the increased agitation by opposition parties and citizens' groups for a restoration of democracy was seen by the government as a threat to its grip on power. It responded by failing to hold elections due in 1978, the ban on general strikes by trade unions, the use of the state's coffers for the reinforcement of security apparatuses, the use of terror, thuggery and violence and the intimidation of critics (including the media) were just some of the methods used to ensure regime survival (Premdas, 1994). Even the rapid promulgation of the 1980 constitution was part of this survival strategy (Spinner, 1983: 182). The fraudulent nature of both the hastily-called referendum on the constitution in 1978 and following that, the 1980 elections, added to the belief that Burnham and the inner party elite had chosen regime maintenance over progressive policy development (Hintzen, 1989). The regime's complicity in the murder of the prominent historian and opposition politician Walter Rodney in 1980 also demonstrated the extent of this resort to 'survival politics. To add to the political crisis, Burnham was also engaged in a battle for control of the PNC party with his main rival, Hamilton Greene. In the midst of increasing national and international condemnation of its human rights record in the late 1970s, the Peoples' National Congress (PNC) regime intensified its campaign against a growing opposition.

International politics was, like in the 1970s also influential, as we saw in the last chapter with both Guyana and Jamaica in the 1970s. However, even this context was changing. American foreign policy shift also played an important role in Guyana's policy context. The ending of the 'cold war' saw the Americans lose interest in their onetime ally, which had serious effects on both Burnham regime's economic and political prospects. The Reagan administration's response in blocking an Inter-American Development Bank (IADB) loan as well as severely curtailing its aid program was therefore as much due to the decreasing communist threat especially after the 1983 Grenadian invasion, as it was to the State Department's concern about Burnham's increasingly authoritarian and 'radical-leftist' behaviour (Thomas, 1988: 263). Prior to 1980, the regime had managed to receive the highest per capita aid in the world from Washington for various sectors including health (Spinner, 1984: 184). However, in the early 1980s, even these funds had been considerably diminished. Burnham shifted ideologically from left to right as it suited him, despite the continued rhetoric about cooperative socialism and party paramountcy (Premdas, 1993: 117). He had alternately courted both the socialist bloc and the American government. However, his failure to criticise the 1983 Soviet downing of a Korean airliner brought the wrath of the Reagan administration on his regime with the USAID's Georgetown branch closed and Guyanese applications for loans from the multilateral agencies blocked. This had serious repercussions on policy and policy reforms. Even a 1983 US State Department report on Guyana was forced to admit that "...since independence, the political scene has been marked by fraudulent elections, wholesale emigration, frustration of the educated and politically aware middle class, and repression of the political opposition..." (Spinner, 1984: 211). As the Latin American Bureau noted of the Burnham years:

"...Guyanese politics over the past three decades has revolved around the rise and consolidation in power of Forbes Burnham. The beneficiary of constitutional irregularities and political fraud, of inept opposition and timely international support, Burnham has turned all to his advantage. By adopting the most convenient ideological posture of the moment... he survived a series of crises. He insisted not on governing but on governing absolutely... ambitions of Burnham and those around him could not be contained within the framework of a democratic constitution, so they took the ultimate step of writing a constitution around their ambitions..." (Latin American Bureau, 1984: 88).
Between 1980 and 1985 then, economic and geo-strategic problems, was compounded by the oppressive and negative constitutional and other political responses of the Burnham regime. This meant that regime power was “...firmly rooted in coercion and control...” with less opportunity for effective policy reform as long as political freedoms were denied (Hintzen, 1989: 190).

Impact of regime survival on development policy reform: This chaotic political and economic context made policy reform unfeasible, though as noted in chapter two, crisis conditions can trigger fundamental reforms of low-politics policy even by survivalist regimes. The negative impact on the policy process of the diversion of already scarce resources to coercion and control was however apparent everywhere. The deterioration of basic public infrastructure such as water and electricity supplies, basic medical care, malnutrition, rising unemployment and impoverishment increases, though due in part to Fund (IMF) -influenced retrenchments were also due to the regime’s desire to retain power by non-democratic means. Education deteriorated as the regime concentrated on ideological indoctrination rather than training. Guyanese students scored worst in regional secondary examinations. No development plans were formulated to replace the unrealised 1972-1976 development plan, despite the establishment of a state planning commission in 1979.

At the national bureaucratic level, one initially progressive policy reform which had direct implications for the health sector was national decentralisation. Under the new decentralised system enshrined in the constitution and implemented in 1980, decisionmaking was devolved to ten semi-autonomous regions. Each region had its own administrative council and administrative centre. Regional chairmen were chosen by the central authorities, while an overall governing body, the regional democratic council, and all subject ministries and certain agencies were to be represented within the regional administrative councils, including health. These regional administrative councils were meant to operate independently of the ministry, preparing and submitting their own budgetary proposals, deciding on staff requirements and receiving their funds directly from the treasury. In the case of health, the councils were to have a central role in ensuring the effective operation of the health delivery system, as yet still centralised. In each of the regions, a regional health officer was to be responsible for the ‘day-to-day’ management of the health sector, supported by a staff of district health officers who would monitor and supervise the various health facilities (Sagala et al, 1992: 32; Mars, 1990: 3).

While this national decentralisation policy was implemented in 1980, not without some problems, many problems also arose, both administratively and politically with the process as it related to the health sector. First, there was general delay and confusion as the ministry of health was decentralised five years after the rest of the administrative system, but was still expected to effectively coordinate the regional administrative councils. Second, the regional administrations were not held accountable to either their local populations or to the ministry of health. Third, a complete breakdown of the public auditing system meant that regional administrators could not be held financially accountable to the central government. Fourth, funds allocated for the regional health service were being diverted to cover both expenditure in other sectors as well as corrupt practices. Finally, spending on health in the regions was determined by the regional health officer’s negotiating position (and often political allegiances) within the regional administration. All of these factors made it difficult to plan and budget for the regional health system, and the ensuing systemic problems aggravated the already poor effectiveness of public health services provision (World Bank, 1993; Sagala et al, 1992; S. Gordon, interview).

Regime characteristics and health policy responses: In the case of direct health policy reforms, similar contradictions were evident. On the one hand the regime tried to reinforce its ‘socialist’ credentials by enunciating its overall health policy in support of primary health care in 1982, with a planning and programming process instituted, “...at least nominally...” in the following year (Drayton and Caleb, 1993: 4). On the other hand, progressive cuts were being simultaneously made to already small and shrinking health and education budgets, as resources were diverted for political survival (Spinner, 1984: 174). In 1980, for example, at a time of severe resource constraints. 10% of the budget was
earmarked for the security forces, while only 5% was designated for health needs (Spinner, 1984: 184). The ‘cause and effect’ cycle during the period was evident as these cuts in government health expenditure resulted in increased doctor and nurse migration. This was in turn exacerbated by the continued lack of co-ordination between training, planning and management agencies as noted earlier, high levels of inefficiency, persistent equipment and drug shortages and the fragmented and neglected organisation of the sector.

**Regime characteristics and health human resources responses:** The combined influence of economic weakness, instability, ideology and non-democratic, survival-based rule was also seen in the human resources development process. As conditions worsened, a group of doctors wrote to the health minister expressing grave concerns about their deteriorating working conditions, pointing out that “…the shortage of basic drugs, medical supplies, surgical dressings, and antiseptics make meaningful health care difficult, if not impossible…” (Spinner, 1984: 202). In the case of nurse training, the failure to reform nurse training meant that highly-skilled professionals were being produced but were highly unlikely to remain in Guyana as both political and economic conditions deteriorated. As Drayton and Caleb (1993: 7) noted, the professional group that suffered the most during this period were nurses, resulting in the fact that “…in some cases, “production” just could not keep pace with losses due to migration...”. The impetus to migrate was strong as those who remained in public institutions faced a deteriorating work environment, coupled with poor remuneration, which compounded the crisis situation.

Even those positive policy reforms implemented by the regime in the late 1970s and fully ‘coming on stream’ in the early 1980s to address the paramedical skills problem - the community health worker (CHW) programme; the Medex (medical extension) programme as well as other new non-medical auxiliary categories such as the health service management programme - all ideologically progressive and cost-effective regime responses to health human resource needs, were undermined by a combination of regime characteristics and economic crisis as we shall now see.

**The Community Health Worker (CHW) program:** This programme was implemented in 1980 along the lines of other similar programs such as the Chinese ‘barefoot doctor’ and the Jamaican community health worker programs. Unlike the Jamaican programme however, the Guyanese programme was targeted mainly at the isolated Amerindian population in the Guyanese hinterland. Community health worker trainees were nominated by their communities and/or village captains. The three-month training period was mainly ‘on the spot’ with tutors travelling from the capital, Georgetown to these communities. A number of non-regime, logistical-related factors limited the effect of the program during implementation, for instance the Amerindians’ migratory lifestyle within the Amazonian hinterland. However, the major problem remained the long-standing regime neglect of the needs of this almost 30-40,000 strong indigenous community in policymaking. The often late and variable payment of paltry stipends to these workers, which the government initially insisted should be paid by the poverty-stricken communities themselves was symptomatic of neglect as much as the country’s economic woes. The eventual agreement to pay the workers by the communities themselves was driven by their own urgent health needs. Many years of neglect and a general mistrust of central government had given rise to community self-reliance. In the case of health, this meant either the reliance on traditional medicine as well as informal strategies such as the use of health facilities in northern Brazil by the border Amerindian communities (K. Davis, interview, 1994).

By 1984 however, this negative regime policy changed, with the decision to establish sixty (60) community health worker posts in the health establishment and to be paid a small salary for the first time. In addition, the existing training program was increased from three to four months. Most of the workers were evaluated and found to perform effectively despite political, economic, social, educational and geographical constraints (K. Davis; S. Gordon, interviews, 1994). However political mismanagement affected the programme. Poor supervision and the lack of refresher courses due to lack of funds - the direct result of political confusion at the central level about the role and status of the training agency, GAHEF, was responsible for the policy stalemate and lack of support (G. Tesheira, interview, 1994). The
general consensus therefore was that though progressive - a direct result of the regime's socialist ideology - it could have been potentially more effective because of its community health orientation, with more government attention and resources. The indirect effect of the mismanagement and corrupt practices of some regional administrations was particularly important in this regard, despite the best efforts of committed trainers and community health workers alike. This combination of low-politics policy neglect of its own policies, added to the regime's economic weakness and the channelling of limited resources towards political survival also affected the medex programme to which we now turn.

The medex program: 'Medex' or 'medical auxiliary' workers training started in 1979 as a USAID-funded and University of Guyana-certified programme, devised by the University of Hawaii and adopted and implemented by the Burnham regime as a major policy response to the continuing doctor and nurse shortage throughout the country. In 1978, legislation was introduced and approved to provide for the registration of medexes to provide primary health care as auxiliaries to medical practitioners, and employed by the government (Lutchman, 1989: 303). A 1979 PAHO-commissioned report on the planning of a regional health system outlined a number of policy recommendations to ensure quality and utility of the programme, given Guyana's circumstances. It was first recommended that every medex should be a qualified nurse, which was accepted. The regime was also urged to consider either the additional training and upgrade of medexes or, alternatively, to replace the medex category with public health nurses and upgrade the existing public health nursing program, which, it also noted, "...does not equip nurses adequately to carry out assessment, diagnostic and treatment skills..." (PAHO/Burke, 1979: 30-35). The 1979 report also recommended that the medex and public health nurse programs be merged into a 'nurse-medex' classification after five years. Although the programme continued, these latter recommendations remained underdeveloped and affected by political and economic chaos within the context of the Burnham regime's survival politics. Even the medex training and management processes were thus similarly affected by regime survival politics as the following account demonstrates:

One medex's experience: training:

"...I was in the first batch of medex trainees. At that time there was a general nursing strike in connection with meal allowances. Midway through the medex courses, the trainees were ordered to fill in for striking nurses. We medex trainees however supported our nursing colleagues. We were also unhappy because the course had been interrupted, having only recently started. We were sent to Camp Madewini and Camp Timehri during the strike for ideological training and political awareness courses, run by the party machinery. About 50% of the course was strongly political. The vast majority of the medexes felt that it was totally unrelated to their work. The general feeling was that we were being victimised for standing up for our fellow health workers. We were lectured about the 1975 Sophia Declaration as the government tried to rally political support for its policies. While no attempt was made to directly coerce us students, it was strongly implied that party policy should be followed. During this six-week period, we were rigorously taught the goals of the party and shown Soviet films, while hanging over our heads was a heavy political atmosphere of indoctrination and coercion. Workers did not speak out for fear of being victimised. The senior health minister (Hamilton Greene) was a good listener and action-oriented. However, there was a general feeling that he was responsible for interrupting the training of the medexes and imposing this action. Another problem was that about five of the initial twenty-six trainees could be said to be under-qualified and were allowed in the course for political reasons. In addition, given the political climate of the time, attempts were also made to kill the co-ordinator of the course [Dr. Frank Williams] who was a leading opposition party member..." (Interview with a former medex).
The post-training working environment:

"...Once trained, the medex was basically on his own, with little contact with the doctor, performing a variety of tasks: delivering babies, dental extractions, giving health education talks in schools and villages, home-visiting as well as mobilising hinterland communities for the arrival of the health visitor. Medexes who were not members or supporters of the ruling party were often sent off to the hinterland (for longer periods) while party supporters tended to remain in urban areas. Some party supporters managed to stay almost always in the urban/settled areas of Georgetown, Essequibo and Berbice with letters of recommendation from the party. Additionally, there were many problems between the medexes and the regional councils mainly related to shortages of supplies and late arrival of salaries and allowances. The medex totally depended on the regional councils to provide these necessities, as the ministry of health had re-directed this function through the new system. Thus problems at that level affected us. In addition, the USAID program had supplied vehicles specifically for the programme. However, PNC-dominated regional councils used them for political and personal purposes. The councils also tried to manipulate the use of radio sets which was a vitally important tool for the largely rural-based medexes...." (Interview with a former medex).

In the case of physician supply, one controversial policy placed on the policy agenda by the regime, and arising out of the existing shortage was the medical practitioner training programme.

The medical practitioner programme: As in Trinidad, the Guyanese medical school strategy similarly reflected the 'ad hoc' nature of the post-colonial state decision-making process. There was little doubt that doctors were needed, given the major migration problem. The provision by the Guyanese government, since 1974 of full-cost scholarships to five (5) students to attend the UWI medical school in Jamaica - (Guyana had opted out of the regionally-funded university) in addition to offering overseas scholarships to Guyanese students, was by the early 1980s deemed insufficient and ineffective for the country's needs (PAHO/Guyana, 1982). The question of whether the implementation of a full medical school by Guyana alone was the most feasible way forward, a question that was still not fully answered in the late 1990s (Drayton, 1997). The decision was nevertheless taken by the government to build Guyana's own medical school. This policy was driven as much by need as by the self-sufficiency, 'we can go it alone' cooperative ideology of the socialist regime, in spite of calls for the government to join the University of the West Indies system. It was initiated by the government with the collaboration of the University of Guyana and the Pan American Health Organisation, with some cooperation from the University of the West Indies as well as Cuban technical assistance. The plan seemed sound in its objective of producing locally relevant community doctors. In 1980, visits were made by a university-government team to Colombia, Cuba, Mexico and Canada where 'locally-adapted' programs were observed as potential models. A report was then submitted to the ministry of health in 1983 and work initiated on project development with a mandate from the regime that medical training should become a part of the programme of the University of Guyana's Faculty of Health Sciences by September 1985 (Dr. C. Charles, interview). However, even this policy eventually began to suffer from political as well as economic events at the national level, with questions raised about lack of staff, and inevitably, standards (Drayton, 1997). While laudable in one sense then, the policy still required considerable resources from an overstretched treasury for effective implementation. It was not helped either by the chaotic political context of the early 1980s.

Comment: The above cases illustrate the fact that despite extremely progressive health policies, regime factors were as much responsible as economic crisis for the difficulties experienced at the planning, training and management states. These policies were based on legislative provisions for the right to health, which linked civil and political rights with social and economic rights under the new 1980 'socialist constitution' (Lutchman, 1989). However, the cycle of deteriorating working conditions, lack of basic supplies and equipment, health worker dissatisfaction, poor salaries, staff shortages, migration,
overwork of remaining staff and unsupported, though progressive, programmes was clearly linked to both sets of factors. Preventive care was, in the main, limited to immunisation and maternal and child care, both of which were supported in part by international organizations; but poorly-resourced public health and health education programmes which depended almost solely on the state’s coffers (World Bank, 1993; Hintzen, 1989: 173). The effects of political and economic factors on the entire health system - including health human resources - by the mid-1980s was very evident in the extremely low quality, understaffed state-funded health care services available at the lower primary and secondary levels. This meant that people bypassed them, in Georgetown, in the hope of accessing better services and available staff, though this was not always the case. 1 In general, then, health policy became one of crisis management during Burnham’s last five years. In distorting the system, regime survival and economic problems had reduced equity of access especially for poor rural people who were unable to travel to Georgetown or afford private care, and who typically delayed treatment until seriously ill. Those who could afford it used one of the seven private hospitals operating in the country. Occupancy rates were very low at the poorly-supported and managed public regional hospitals. The regime’s commitment to health by 1985 was now more questionable with actual expenditure declining from 5% in 1982, to 4.6% in 1983 and 4.5% in 1984 - a fact which as Lutchman notes was not only bound up with economic and social factors but also the politics of the Burnham regime (1989: 311).

The weak, unstable, socialist/survivalist regime and low-politics policy

Regime characteristics such as economic weakness as a result of resource scarcity undoubtedly undermined government health policy reform intentions and outcomes. However, the evidence presented above shows a clear pattern of the negative influence of the political environment on even the best ideologically-progressive policies. The Burnham regime’s record in relation to health sector expenditure and policymaking between 1980 and 1985 continued to be full of contradictions, as it was in the 1970s, conditioned as it was by an attempt to implement progressive policy within this undemocratic, resource-scarce context. The limited resources -human, material and financial - available to those (remaining) committed bureaucrats in the ministry of health and the training agencies undoubtedly impeded the ability to effectively formulate, implement and provide continuing support for even their most progressive policies. But these factors were also inextricably linked to Burnham’s desire to retain political power. The limits placed by scarce resources such as poor working conditions and lack of basic equipment and supplies were, if anything, worsened by the lack of democracy, political harassment and mismanagement. The mass migration of one third of the population overseas during this period thus included skilled professionals such as doctors and nurses which the country could least afford to lose (Thomas, 1983). Guyanese health human resource policy, then, though full of innovation on the one hand, was severely affected by the internal political and economic policies of the Burnham regime, as by external economic and political developments and national historical factors. Lutchman thus rightly concluded that despite its radical departure in 1980, the health model followed in Guyana still reflected, like the rest of the Commonwealth Caribbean, a combination of a historical medical model, but placed under great pressure in the 1980s by not only economic, but also political factors:

"...in Guyana, the ubiquitous presence of the state in the health field (which is attributed to the adherence of a socialist ideology) is likely to impact both positively and negatively on rights..." (1989: 310).

For the rest of the period which culminated in Burnham’s death in 1985, the effectiveness of efforts on the production side continued to be dogged by stagnation and neglect in the face of survival politics. Thus, even laudable efforts such as the medex and community health worker programs were harmed by the regime’s desire to maintain power. Nursing also continued to be hindered at both the production levels, by an unreformed and duplicated training system; and at the management level by high levels of migration due to the impact of regime politics. In the case of the medical school policy, the problem was

1 a good review of the legal rights to health in Guyana and the rest of the Commonwealth Caribbean and Latin America is found in Fuenzalida-Puelma and Scholle-Connor (1989).
essentially one of long-term feasibility based on a political decision which was questionable even at this
stage, given the country's extremely limited resources (Drayton, 1997). The policy itself was
praiseworthy, but the fact that linkages were not established with other institutions at the Caribbean level
saw it suffer problems of quality and sustainability. This issue was still not resolved in the late 1990s as
we shall see later. I next examine and compare the experiences of the Seaga regime in Jamaica.

*Regime characteristics and health human resources policy reforms: the Seaga regime (1980-83)*

**Policy context:** The 1980 Jamaican general election was won by the conservative Jamaica Labour
Party (JLP) under Edward Seaga. After the progressive social policies of the 1970s, even under
tremendous constraints, given US foreign policy at that time, the possibilities for policy development and
reform under the US-leaning Seaga regime were hopeful. Jamaica, like Guyana was in considerable
economic and political turmoil in 1980, despite the democratic transfer of power in the former. Seaga’s
overwhelming victory over Manley’s now discredited (at least by its ideological critics) ‘third path’
radical development model signalled another radical turn, this time towards conservative market-led
policies. Despite electoral violence, both the main Jamaican political parties - the PNP and the JLP to
their credit, remained committed to the democratic process in the run-up to and aftermath of the elections
(Payne, 1991: 45). Nevertheless, Seaga’s market-led policies had dire social effects on the Jamaican
society. The new regime’s popularity during its first three years in office was increasingly threatened
given the slow pace of economic recovery under stringent IMF conditions. By April 1983, there were
civil service strikes protesting wage ceilings and rising food prices. As the regime faced increased
difficulties at home, one external event restored its waning fortunes: the October 1983 US-led invasion of
Grenada, in which Jamaica under Seaga played a leading role. Taking advantage of this new-found
popularity, and fearing that new austerity measures which the regime was forced to adopt would erode
government support, Prime Minister Seaga called and subsequently won a snap election in December
1983, two years before it was due (Stone and Wellicz, 1988: 105). This election was boycotted by the
PNP which accused the Seaga regime of electoral impropriety, thus enabling virtual ‘one-party’
governance for the next five years.

The Seaga government’s adherence to a conservative, US-leaning market ideology saw its sustain its
reform efforts and in so doing, reversed many of the policies of the previous Manley government. By
early 1984, the IMF-instigated reform process was well underway with bureaucracy cuts the first
‘condition’ implemented (Mills and Jones, 1989: 127). The impact of the stabilisation policies forced
onto a reluctant, but powerless Manley regime in the late 1970s by the IMF were particularly damaging to
the health sector and largely contributed the victory of the Jamaica Labour Party regime. However,
Seaga’s assumption of office was accompanied by the almost immediate consideration of similar austerity
measures. The health budget was thus cut in line with newly negotiated agreements with the IMF on terms
more lenient than the Manley regime was able to acquire, with the active support of the Reagan
administration (Edie, 1991: 118). During its first three years in office, the Seaga regime also received an
amount equivalent to 65% of all American assistance to Jamaica in the previous 30 years (Thomas, 1988:
232-233). Despite this evident generosity by the grateful Americans, the Jamaica exchange rate and the
economy continued to decline, while the national debt grew. Living standards predictably fell with a
simultaneous rise in the incidence of malnutrition. The health sector-particularly at the regional
primary/community level suffered badly. Many smaller regional hospitals were closed and staff cuts
implemented. These cuts and closures were part of the conditions attached to the IMF loans. Their
effects led even the market-reformist Seaga government to protest to the IMF as a fifth of the country’s
entire public sector workforce was laid off within a one year period between October 1984 to October
1985 (McAfee, 1991: 128). As Stone and Wellicz noted, the country had come full circle by the mid
1980s (Stone and Wellicz, 1988: 105). The outlook for progressive policy reforms, including support for
the previous Manley government’s progressive health policies especially during this time of rising social
and health needs was thus not hopeful.

*Regime characteristics and health policy responses:* The Seaga government, to its credit, started well
in terms of its health aims and objectives. In 1984, it outlined its health policy in a programme that was
similar in many respects to that of the Manley regime. The document retained much of the previous regime’s progressive rhetoric about linking health with development, noting the paradoxical problems facing Jamaican health services by so-called modern ‘lifestyle’ diseases co-existing with traditional health problems such as malnutrition. In terms of management reform, it noted its intention to establish a national health committee to co-ordinate inter-sectoral action in health. Policy reform was also outlined in relation to general health administration as the country was to be divided administratively into four (4) health areas, and ten (10) regional health boards. The regional health boards were to be legal entities responsible, inter alia, for hospital administration and community health with ministerial support (Government of Jamaica/Ministry of Health, 1984: 3-4). However there were even more far-reaching reforms. In addition to the principle of universal access to health care, the statement outlined for the first time the regime’s commitment to private sector involvement in public health services. It noted that efficiency and cost-effectiveness in the health services through public and private health sector cooperation would boost efficiency and productivity, given were the country’s dwindling resources, an overburdened health system and increased demand (Government of Jamaica/Ministry of Health, 1984: 1-2). Although public-private cooperation was not altogether diabolic within the Commonwealth Caribbean region, having been an integral part of the overall health services system for decades, both public sector preventive and curative services - but particularly the former - suffered as government attention focused inordinately on facilitating such ‘market-led’, ‘IMF-driven’ health reform programmes. Between 1981 and 1985, total Jamaican government per capita spending on health fell by 33% (Government of Jamaica/Ministry of Health, 1983; 1984). As a consequence, health capital stock and equipment deteriorated. Patient care generally deteriorated, with patients often asked to take their own linen and food to the hospitals. The regime had very limited policy space to manoeuvre in health care partly due both structural adjustment, but also due to its own political/ideological position. The targeting for ‘rehabilitation’ (cuts) in programmes at the primary and secondary levels of the system revealed a regime following both its own ideological principles which hardly questioned the socially damaging IMF loan conditions.

Regime characteristics and health human resources policy responses: The main problem facing the regime in the case of health human resources continued to be the “severe drain of health manpower form the island; nurses, doctors and to a lesser extent other health professionals...” (Government of Jamaica/Ministry of Health, 1983: 11). Migration is fully discussed in Chapter Six. The government responded with policy strategies for both doctors and nurses. For instance, an aggressive recruitment campaign to fill the many vacant posts of physicians and other health categories in both primary and secondary care was implemented. Importantly, the government also committed itself the upgrading of salaries and fringe benefits for both doctors and nurses (Government of Jamaica/Ministry of Health, 1983: 4). Migration overseas and to the local private sector was driven, unlike Guyana, largely by poor remuneration, with the real incomes of doctors, nurses and other health personnel unable to keep up with inflation (Government of Jamaica/Ministry of Health, 1984). In terms of improving on the policy lapses of the Manley regime, legislation was finally prepared and enacted to regulate nurse practitioners and nurse anaesthetists who were found to be particularly effective in the regions/parishes and the community (Cumper, 1986). In the case of allied/auxiliary health training, the regime stated its intention of forging closer links with the University of the West Indies and the College of Arts, Sciences and Technology (CAST) “...to facilitate and expand manpower training...” (Government of Jamaica, 1984: 15-16). In relation to midwives, innovative policies - including the targeting and training of midwifery students straight from high school, so that, lacking a registered nurse qualification, they would be less likely to emigrate, and their training, like doctors, would be tied to a contract - were suggested (Mitchell, 1981: 483). In terms of the overall improvement of health professional status, the government accepted that health manpower policy needed be strengthened “...to provide the necessary staff, which in addition to recruitment would also mean constant upgrade of skills through a variety of ‘in-service’ and other programs...” (Government of Jamaica, 1984: 15-16). Although there was no development in the document of any specific, detailed plans and programs the fact that these issues were being discussed was generally positive.

On another front, given the medical profession’s poor relations with the Manley regime, the Seaga government was urged to review and change the situation by developing parallel structures in the
reorganisation of the system so that doctors no longer reported to their peers. According to this view, Jamaica would never halt out-migration if doctors were made subordinate to non-professionals in other fields. The only viable route was the co-optation of the profession into working with managers in a consensus way. The regime and the bureaucracy were urged to appreciate and empathise with the doctors, "...or change will never mean movement towards the desired goals..." (Mitchell, 1981: 484). As Mitchell noted further:

"...Political change always brings administrative change. Whether one concurs with it or not, doctors deeply resent being forced to report to administrators, and to having decisions which they feel directly affect the care of their patients being made by non-medical personnel, whether these decisionmakers reside locally or in Kingston. To alleviate the current medical disenchantment with the administration, it may be necessary to reorganise the health care system even if means creating parallel structures...doctors will work long and hard despite old, inadequate facilities if they know that these are truly unavoidable. They will not tolerate non-medical interference with patient care. Nor would any patient want them to...the route to lasting success, is to co-opt the medical profession into working with management, getting them to see for themselves the other side of the coin and then jointly working out a consensus for action within the administrative structure...there will be a few medical die-hards but the majority of caring physicians will respond to this approach. If the die-hards occupy strategic positions, then some way must be found to promote them out of harm’s way...for those politicians and bureaucrats wrestling with the politics of change, this may seem like the last straw. But it must be borne. Just as the physician must come to understand, to appreciate and to empathise with their patients...so politicians and the bureaucrats must come to understand, appreciate and empathise with their professionals, in this case the physicians...this approach is always good politics, it is an essential strategy for an emerging nation seeking to change..." (Mitchell, 1981: 484).

This view was a middle solution to the problem, compared with the socialist Manley’s regime’s somewhat more confrontational policy of pursuing alternative human resource strategies. Both approaches had their flaws. Seaga’s approach, shaped albeit by structural adjustment and a recognition of the need to provide incentives for both professions, was effectively to return to curative care type policies added to active private sector collaboration, compared with the Manley regimes approach of searching for community-based, alternative methods of care that could be economically achieved, and made financial sense, given the continued migration of highly skilled health personnel. The need for reform then of the Jamaican health sector was heavily influenced by Seaga’s market-based ideology, which although incorporating decentralisation as a major plank, also ran the risk of undermining much of the Manley regimes’ real health human resources achievements.

Comment

The health human resources policy window available to the weak, stable, democratic, non-survivalist Seaga government, like its predecessor, the Manley government was severely restricted by structural adjustment policies as well as its own strong market-led ideology which triggered both positive as well as negative regime responses in the case of health human resources reforms. The problems that faced Jamaican health care in the early 1980s thus largely emanated from both IMF action as much as from the government’s own ideological position on the need for radical market-led reforms of the public services including the health sector. Curative-dominated health care policy persisted at a time of both primary health care neglect, despite its emphasis in official policy as well as increased doctor and nurse migration - both of which were problematic for the Jamaican health services by the mid-1980s. The government sought to address the migration problem in the case of the medical profession by mending fences in the 1980s noting in its 1984 health manpower policy document that "...the involvement of professional associations in the setting of standards and the monitoring of professional performance will be encouraged..." (Government of Jamaica/Ministry of Health, 1984: 23). In the case of nurses, the eventual
legalising of nurse practitioner categories were partly effective. The government also recognised and made efforts to improve salaries and working conditions for health professionals. However, despite both adherence to the primary health care rhetoric and expressed concerns about the social impact of adjustment, the regime continued with its market-led, though IMF-driven reforms. For the health services and health professionals alike, the policy message was clear as the closures, staff cuts and continued migration demonstrated. The increased funding of the health services and the implementation of a comprehensive national health service were policy responses that were needed but not considered in this market-led reform policy response (Omatovale (1982: 14). The overall picture for health human resources policy and policy reforms in the early 1980s, given these policies was generally negative for health human resources, with the main exception of its remedying of the nurse practitioner legislative issue. The policy focus however remained a confusing 'mix', complicated by deteriorating economic and political conditions. Both thus exerted negative effects on policy over the Seaga’s final five years in office as we shall see later. We now turn to compare developments in Trinidad after Williams death in early 1981, and the appointment of the new PNM prime minister, George Chambers.

Regime characteristics and health human resources in Trinidad and Tobago in the first half of the 1980s: the Chambers regime (1981-86)

Policy context: The appointment of George Chambers as Prime Minister after Williams death in 1981 was smooth and democratic, and a direct contrast to the continuity and illegality of the Burnham regime during the first half of the 1980s in Guyana. In terms of policymaking, Chambers’ much-vaunted technocratic style after almost thirty years of Williams’ presidential politics signalled the possibility of a move from authoritarianism and towards more democracy and openness in public policy development. His declarations of “what is wrong must be put right” and “the fete over, now its back to work” indicated a recognition of the need for reform at all levels of government, given the now-falling oil prices - still the backbone of the Trinidadian economy (Sutton, 1984: 65; MacDonald, 1986: 200). The halting of two of the Williams’ government’s more controversial projects - a racing complex and a housing project - as well as various pronouncements on decentralisation and public service reform were signs of this new approach.

In the case of low-politics policy under the Chambers regime’s tenure however, the first half of the 1980s in Trinidad turned out to be one of policy stasis and inaction despite the government’s main policy reform initiative: the commissioning of the Demas Report on national development and reform strategies. Attention was now increasingly focused on the crisis-driven management of the declining oil economy. Economic and political problems had set in almost as suddenly as petroleum prices fell in the early 1980s. High petroleum prices in the 1970s had helped to postpone economic crisis in Trinidad, unlike Guyana and Jamaica, the Commonwealth Caribbean region’s only producer of substantial amounts of oil and natural gas. There were also persistent questions of corruption (MacDonald, 1986). In addition to economic decline and policy stasis, then, the PNM regime continued to be dogged by accusations of corruption and mismanagement of the oil windfall. The visit by a joint IMF/World Bank ‘team’ in mid-1982 to advise the government on financial management and control in the midst of a general decline in most sectors including education and health revealed the gravity of the economic situation. Despite winning a snap election in November 1981, the problems facing the Chambers regime mounted as social and economic conditions deteriorated. As it sought to control the national budget, the Chambers government’s popularity declined sharply within a year of the 1981 general elections as local government elections. One outcome of the combined effect of political and policy stasis under the Chambers years was the formation of both a new coalition of opposition parties - the National Alliance for Reconstruction (NAR) - united mainly by the need to defeat the PNM. To be fair to the regime, in addition to its appointment of the Demas Committee on national, its other major asset was its adherence to democratic principle, which although not perfect, was significantly different from his predecessor, and a far cry, of course from Burnham’s Guyana (MacDonald, 1986: 209). While the prognosis for democracy remained good however, the same could not be said for policy making and reform as it was effectively sidetracked by the economic crisis and political survival, given the almost certain political defeat facing an increasingly unpopular regime after almost thirty (30) years in office (MacDonald, 1986: 207-208). Like Guyana and Jamaica, the need for administrative reform and accountability was a major call not only from the
international financial institutions but also from bureaucrats and citizens alike, fed up with a deteriorating situation and a regime paralysed by the new economic reality of the post-boom period.

Faced with impending crisis, the Chambers government's main attempt at beginning policy reform in Trinidad was the appointment of a group of local experts, the Demas Task Force, in 1983 to prepare a long-term development plan for the country, including the health sector, for the period 1983-1986, (MacDonald, 1988: 207-8). Much of the country's economic resources had been wasted in the previous boom years both short-term amelioration and/or political projects and long-term, ultimately unfeasible projects. This precluded the possibility of any rational approach by the Williams regime to policy reform and development. Little attempt was however made by the Chambers regime in this immediate post-Williams period to consider policy issues such as health reform, in addition to the long-term impact of contentious policy issues such as the medical school programme.

Regime characteristics and the health policy reform response: The regime's main health policy concern for its entire period in office - in typical crisis-driven mode - was the need to maintain health services at an acceptable, tolerable level. However, the appointment of the Demas Committee at least signalled its intentions to introduce health care reforms, as it also pondered the future of the medical school and complex. As economic problems worsened, the Chambers government's decision to continue with Williams' medical complex policy, as planned and agreed by the previous regime had more to do with the fact that the contract was already signed. However, the regime's unwillingness to re-open the issue was evident in the beginning of construction in 1981 in the middle of the economic crisis was questionable to say the least. Questions now increasingly dogged the feasibility and scale of the project. However the role of political calculation through a combination of influences - the medical academic lobby, the reality of a signed contract, the work already 'on the ground' as well as the potential benefits both for health care and for the party's reputation as a caring government undoubtedly contributed to the final decision. Though a difficult policy decision for the regime. the fact that the project was now underway and absorbing a significant percentage of the country's revenue (as well as governmental policy attention) when compared to the existing situation of increasingly cash-strapped, antiquated health service was not however lost on either the population, or striking health professionals at the country's health institutions. As the president of the medical association noted:

"...efficiency is the watchword and accountability to the public can be demanded...it is a poor record for the ministry of health when the population can only hear the truth when doctors strike..." ('Facts behind doctors protest', Dr. R. Thompson, Pres. TTMA, Trinidad Express, 7/5/81: 4).

This need for urgent health reform was supported by most health staff. One doctor - a prominent critic of government' health policy priorities at this time - noted in 1983 that "...compared to other third world countries, health services in Trinidad and Tobago are fairly good, but will be much better if administration was efficient with the great amount of money being spent..." (Welch, Trinidad Express, 18/10/83: 36). By 1984 however, the Chambers regime was so convinced that its policies were still not being recognised by a critical public, that the extremely low-profile minister of health, Dr. Neville Connell noted the need to "...speak of the good as well as the bad..." (Trinidad Guardian, 16/3/84: 3). As the expensive complex neared completion in 1983, the government continued to insist that primary health care was its guiding principle. In light of the existing reality of an under-funded, still unreformed and essentially colonial health system, even senior ministers were prone to making such contradictory policy statements. Finance minister Anthony Jacon's admonition, for instance, to a national primary health care workshop at a time when millions of dollars were being spent on the expensive medical complex only underscored the gap between the policy rhetoric and reality of the Chambers regime:

"...unless scarce national resources are carefully husbanded and allocated to bring about the maximum possible gain, development cannot proceed, and without development, the goal which is now within our grasp may become an illusion..." (Government of Trinidad and Tobago/Primary Health Care Workshop, 1983: 5).
The most serious indictment of health development under this government was that despite a broad, and quite avidly-stated adherence to the goals of Alma Ata and universal health, it had by end of its tenure in 1986 still not produced a single document that could be called Trinidad’s health policy. This policy lapse was underscored by the Demas Task Force report which was itself part of the response to this underlying problem, and which noted that the two main problems hindering effective health systems development were the absence of clear policies and the failure to implement and adequately support the first national health plan (Government of Trinidad and Tobago/Demas Committee Report, 1983). In light of the health crisis and the regime’s persistence with the medical school policy, calls increased for decentralised-based health sector reform. These calls, as noted in Chapter Four, had started well before full independence with the 1957 Julien report, which was followed by a series of reports in the late 1970s and early 1980s including the National Advisory Council report (1978), the Toby report (1981) and the Holiday Inn Report (1983). These reports had all recommended fundamental health reform of Trinidad and Tobago’s health services system. The politics of the failure to reform by this stage was not lost even on the health ministry’s own technocrats. In an indirect criticism of the both the past and present regimes, the Holiday Inn Report and subsequent reports suggested that political will and resistance to change were among the key factors hindering health services reform (Holiday Inn Report, 1983; Drayton, H and D. Ray, 1987: 1). The 1983 Demas report recommended, inter alia, the creation of three separate health boards for the country’s three main hospitals, with the ministry of health focusing exclusively on policy-making, monitoring and evaluation. This view was supported by the 1983 Holiday Inn Report. In terms of the way forward in health policy, the Demas Report recommended, like those health sector reports before it, the adoption of primary health care with emphasis on health promotion and inter-sectoral linkages among the various levels including policy formulation, community participation, the reorganisation of the ministry of health and some form of decentralisation, where hospital boards, on the one hand and county medical officers of health on the other, were given various levels of autonomy and administrative support.

The recommendations of the Demas report were largely neglected by the Chambers regime in its preoccupation with the looming general elections in 1986, despite the appointment of a new ‘management-oriented’ health minister. Health conditions meanwhile worsened for both health professionals and the population as the economic decline and policy stalemate continued. During a senate debate on the 1985 budget, one independent senator and former doctor concluded that administrative problems were no different (and in some cases worse) than they were under colonial rule (‘Health problems even worse’, Harnarayan, Trinidad Guardian, 24/1/85: 1). He criticised the previous underperforming minister of health Dr. Neville Connell and his successor during the last two years of the PNM regime, John Eckstein for the lack of clear policy. He also criticised the PNM government’s poor decisionmaking and management in relation to the medical complex policy, noting that: “...if we do not pay attention to the problem now, a lot of money would be wasted on the Mount Hope Medical Complex...”. He warned, in this regard, of the consequences for the rest of the health system of too much emphasis on “this institution” (‘Health problems even worse’, Harnarayan, Trinidad Guardian, 24/1/85: 1). Addressing doctors in early 1986, Connell’s successor as health minister, John Eckstein, also questioned why the health services were attracting such increasing criticisms at a time when medical staff were being “...highly trained both at home and abroad...” and especially when Trinidad had moved into the “...expensive, hi-tech field of tertiary health services...” (Address to 9th medical update, Trinidad Express 11/1/86: 3). The criticism, he noted, could not be about expenditure, when compared to other developing states, or the technical competence of doctors and nurses. He added that the health surcharge introduced by the government to meet the funding shortfall had yielded TT$100million (US$ 33.5 million) in 1986 out of a total health budget of TT$ 600 million (US$ 142 million). By March 1986 however, the press concluded that the new philosophy outlined by the former management consultant, was effectively an admission that the ministry had been unable to provide an efficient health service.

**Health human resources policy responses:** In relation to the medical complex, the ‘face-saving’ approach and its political utility in this regard was evidently the main justification for its continued popularity with the government. The minister insisting that the imminent opening in December 1986 represented:
"...a tremendous opportunity for the development of our health services, a tremendous opportunity...since it brings strengthened university presence to the health services of Trinidad and Tobago and stimulates continuing medical education and research..." (Trinidad Express, 4/12/86: 1).

In addition to its support for the medical school policy, the Chambers government was also cognisant of other health human resource policy concerns. A 1981 report of a committee to study the health ‘manpower’ needs of Trinidad alluded to the reality of government policy neglect particularly in relation to migration. This report also alluded to the fact that the host of planning and production problems, including the need to redress the balance between community health nurses and curative nurses were also due to the absence of reform as well as resource scarcity (Government of Trinidad/Ministry of Health, 1981). In terms of management, other problems stemming from economics, as well as lack of health reform, included the low morale among doctors, nurses and other staff, personnel shortages, inadequate incentives, cumbersome bureaucracy and inflexible recruitment procedures, and employment practices all of which made it impossible to attract and retain much-needed health professionals. The lack of provision for nurses in particular to be recruited at appropriate levels commensurate with academic training and experience was, according to the 1981 report, particularly problematic, given the chronic staff shortages throughout the 1980s. In addition, insufficient in-service and external post-graduate training, the sub-optimal use of human resources, the inability to regulate private practice privileges, in addition to the insufficient support for highly qualified personnel all contributed to the crisis in health services in the early 1980s. The report stressed the need for improved health human resources planning, an intensification of the recruitment process, both locally and abroad to fill vacant posts, and the need for local in-service training programmes, with emphasis on management and planning and the development of a reformed personnel system to facilitate rapid recruitment and discipline in addition to responsiveness to employee needs.

These recommendations were accepted in principle, but in practical terms ignored as the Chambers regime responded by doing little by way of implementation, given the impending elections. In the meantime it was pre-occupied with the ‘ad-hoc’, ‘day-to-day’ crisis management of policy, which included the active courting of the electorate, including public sector employees. Doctors and nurses were among the first to protest at the declining conditions (both infrastructural and remunerative) at all levels of the health system. However, on the eve of the 1983 local elections, public servants were awarded huge pay increases of approximately 57% that, although welcomed by these workers, helped push government expenditure up by 76%. This, at a time also when the country’s balance of payments went from US$283 million surplus to US$ 909 million deficit between 1981 and 1983 (MacDonald, 1986: 206). Again then, the exigencies of regime maintenance were placed before the interests of policy reform and development. Despite this electoral ‘sweetener’ however, health professionals - especially nurses - remained unhappy about an unreformed and neglected working environment and poor professional and status-based rewards.

In terms of general health policy, the Chambers government had reiterated that a multi-sectoral primary health care approach to health was being implemented. The reality however was that there was little evidence, other than the consideration of the 1983 reform proposals as it became more and more preoccupied with its own survival. By late 1986 nevertheless, health reform, based on the broad thrust of the Demas report recommendations was placed on the national policy agenda, partly under international financial pressure, and partly also due to the new health minister’s own recognition of the need for reform. In his last statement just before the PNM were defeated by the NAR coalition, Minister Eckstein noted that proposed the hospital authorities would be the beginning of the decentralisation process, and would eliminate ‘red tape’ with these authorities functioning with the ministry focusing on policy formulation (Trinidad Express, 4/12/86: 1). In supporting the reform process, he noted that between 1981 and 1986, despite the severe economic recession and subsequent attempts to adjust to lower public expenditure, funding of the health sector was still generous. He recognised that the main problems facing health included management as doctors had to act as managers thus encroaching on their working hours, and stated in this regard that professional managers would be recruited as well as lay administrators.
However, regime survival would also impede developments on this front by the time of elections in December 1986.

The Chambers years then can be explained as transitional, with a recognition of the need for reform, given economic conditions, but aware of its own need to survive politically as the oil resources dwindled. One the one hand its appointment of the 1983 Demas task force on development reform - though much of the final report was effectively ignored - was far-reaching in terms of an overall recognition of the need for urgent health care reform in the post-Williams era. Falling oil prices in the early 1980s impeded implementation, but also saw the government curtail many of the Williams regime's oil boom 'mega-projects', with the notable exception of the medical complex policy, which though still being supported by the treasury, was now effectively on hold after construction as the government was financially-unable to commission. Its health-related political symbolism was exploited for electoral purposes. Its use in both the local elections in 1983 and in the runup to the general elections in 1986 (despite being uncommissioned) as a symbol of the regime's care and commitment to public health, and a modernised one at that. In the case of both the wider population and disgruntled health professionals working within the public health service however, this symbolism was lost, being seen more as wastage, despite the award of huge pay increases to them on the eve of local elections. By ignoring the basic problems outlined in the Demas report and resorting instead to 'ad hoc' strategies such as training ever more personnel, recruiting nurses from abroad and using the complex for political purposes as a response to questions about its record on health services, the Chambers regime demonstrated that it too, like the Williams regime was concerned more about its short-term survival than any rational, concerted approach to the reform agenda. Although without the structural adjustment pressures facing both the Burnham and Seaga regimes in the early 1980s, the decision by the now weak and unpopular, though stable, democratic and still relatively non-survivalist Chambers government to spend its way out of the crisis - including continued funding of the now 'on-hold' medical school/complex - was to have serious consequences for the new NAR policy reform opportunities in 1986.

Comment: Compared to the 1970s, regime characteristics influences in the first half of the 1980s is less clear as economic factors assumed greater importance given the crisis. In tandem with these influences, however, was the continuing effect of regime weakness, instability, ideology and political survival on the policy reform trajectory. The first half of the 1980s can be seen as the start of a transition period for Commonwealth Caribbean health human resources policy with the recognition by all three governments - excluding the Burnham regime - of the need for political/administrative as much as economic reforms. This recognition was due both to international financial adjustment conditions, as well as a recognition at home of the failure of centralised policies in the previous decade. In some states, particularly Guyana, and to a lesser extent Trinidad, policy reform was however jeopardised by the exigencies of political survival. In Guyana for instance, the Burnham regime's authoritarianism was actually enhanced during this period as economic problems worsened. This was an extension of its behaviour in the 1970s. The result was increased neglect and undermining of its own theoretically progressive health policies by mismanagement and co-optation of resources for its survival. Regime neglect was thus both evident the lack of support for implemented administrative structures as well as political interference in training and management policies such as the medex and community health worker programmes and its effects felt in the decision to proceed with the questionable medical school policy (Drayton, 1997). Williams’ death and the appointment of Chambers, saw reform action in Trinidad initiated with the appointment of the 1983 Demas task force. The need for health and health human resources policy reform was recognised through a number of preceding reports. However, little was done, with the exception of the policy decision to continue funding the medical school programme, and the continuation of the training status quo in relation to doctors and nurses. This was due as much to the waning political fortunes of the PNM, which in itself was due both to the fall in oil prices as it was the mismanagement of the ensuing oil windfall for political survival.

In Jamaica, there was also strong evidence of the impact of intervening economic conditions on policy along the lines of Guyana and Trinidad. The Seaga regime enjoyed both the active support of the Reagan administration especially after the 1983 Grenadian invasion and maintained its democratic credentials in
the aftermath of the snap December elections boycotted by Manley's PNP in late 1983. Despite its national popularity, and buoyed by American support, the health policy reform dilemma facing the Seaga regime in this period remained essentially similar to that facing the other two regimes: how to balance development reform with political survival at a time of economic crisis. Timing, coupled with the economic crisis militated, in all three cases, against reform. However regime characteristics, particularly ideology and political survival played critical roles. Despite signalling its policy intent of public-private sector partnerships and better management of health services, the Seaga regime's 'market-led' ideology considerably undermined both community health services and the personnel charged with delivering these services in addition to economic factors. However, unlike Guyana, it retained its democratic credentials, as did the Chambers regime, which although unpopular, also turned away from blatant authoritarian governance.

The recognition of reform within all three countries' health services was evident in varying levels of regime health human resource policy responses in the 1980s. Each government responded based on not only historic, economic and international contexts, but also on their individual regime characteristics. As economic conditions worsened, policy windows of opportunity were severely limited, there was nevertheless room for meaningful organisational and technical policy reform. To summarise then, while increasing economic problems made policy reforms more difficult, the role of national political/regime characteristics continued to be influential. As in the 1970s, policy inaction and neglect was still a favoured choice in the case of health human resources policy agenda-setting, formulation and implementation, although economic climate, medical interests, and the preoccupation of government with crisis-ridden, potentially destabilising issues also contributed to the failure of the reform issue to get on the agenda, and, in the specific case of specific policies for health human resources policy, the curtailment of spending. In sum then, a combination of economic and political/regime influences was evident in the case of health human resources in the first half of the 1980s. We now to analyse the second half of this decade to see whether these trends persisted.

5.3 HEALTH HUMAN RESOURCES IN THE SECOND HALF OF THE 1980s: THE HOYTE, ROBINSON AND SEAGA REGIMES COMPARED

Given the findings of the previous section, I examine and compare, in this section, the determinants of health human resources policy action, inaction and reforms in the second half of the 1980s when regimes changed in Guyana, and Trinidad, but remained the same in Jamaica. I examine policy responses during this period, then, under the Hoyte regime in Guyana, the Seaga regime in Jamaica and the Robinson regime in Trinidad. I begin with the Hoyte regime.

Guyanese health human resources policy in the second half of the 1980s: the Hoyte regime (1986-1992)

Policy context: President Burnham's sudden death in August 1985 signalled a potential end to regime maintenance politics in Guyana by presenting for the first time in decades the possibility of democratic politics and with it progressive policy reform and support that would improve health human resources at the planning, training and management levels. This expectation was however dashed when his successor Desmond Hoyte oversaw yet another rigged election in December 1985 (Premdas, 1994: 55). As the support of the socialist bloc - excluding Cuba, at least at this stage - dissipated, Hoyte's hold on his illegally-acquired power faced sustained pressure from the United States, the PNC's sometime external sponsor, for democratic reform. Guyana also continued to suffer severe economic problems in the mid-1980s: serious trade deficits, balance of payments problems, lack of foreign exchange, high inflation, and inability to meet production levels in the major sectors of the economy. The devaluation of the Guyanese dollar added to further impoverishment and poor working conditions. This in turn led to high levels of mass emigration, particularly of skilled and professional personnel. The Hoyte regime launched its Economic Recovery Program (ERP) in 1988. By the end of the PNC's term in office in 1992, much of the reforms requested by the International financial institutions were in place, but with extensive negative social impact. The Inter-American Development Bank estimated that in 1989, 67% of the Guyanese
population was living in poverty although official calculations put the figure closer to 86% (World Bank/Guyana, 1993: 73).

**Regime characteristics and health policy reforms:** The effect on the health sector was particularly severe. The World Bank country report noted the decline of the health sector in the 1980s and the impact of the shortages of staff, equipment and basic drugs on the already quantitatively and qualitatively poor services being offered. The report attributed this to severe shortages of resources, fragmented organisation of the sector, lack of coordination between relevant agencies and "...lack of accountability of agencies to client populations..." (World Bank/Guyana, 1993: xv). It also recognised the need for a major increase in public sector wages along with a significant increase in health expenditure in the medium term, as well as greater cooperation with the private sector. The mismanagement of the Burnham years, though not mentioned underpinned these criticisms. In the case of actual policies, despite severe economic problems and continued lack of democracy, the regime proceeded with its three main policies: decentralisation, the establishment of the medical school in 1985 and the creation in 1988 of the health training institution, the Guyana Agency for Health Science Education and Food Policy (GAHEF). The decentralisation of the health sector, implemented in 1985, five years after the other ministries, was one sign of the unexpected progressive policy development and transition under Hoyte. Under the new PAHO-supported policy, responsibility for most health functions were passed directly to the newly created regional administrations. The ministry of health remained largely a central quality control unit whose function was to formulate policy, monitor conditions and ensure that equal standards of care were provided across the regions, as well as retain responsibility for preventive health. Despite this newly-implemented health system however, the Guyanese health service continued to deteriorate over the next four years, given the combination of poor economic performance and utilisation of much of the limited resources for political survival. By 1989, for example, the country’s chronic drug shortage was being ‘remedied’ by an illegal trade in (often expired) drugs from Venezuela and Brazil (Tesheira, interview, 1994). Hoyte’s recognition of such problems along with the reality of an overall deterioration of the quality of life for Guyanese, coupled with increasing regional and American political pressure meant that the days of undemocratic rule were numbered. By April 1989, the government had negotiated an IDB-financed US$27.9 million loan for its Health Care II project to meet the cost of physical infrastructure and medical supplies for the health service. While most of this money was targeted at the Georgetown Hospital, the health transitional process had begun, aided by the democratisation process being pushed by Guyana’s Caricom neighbours as well as the Atlanta-based Carter Centre - founded by the former US president to foster democratic governance (Daily Chronicle, 4/4/89). In sum, reforms began because the Hoyte regime had limited room to manoeuvre either politically or economically.

**Health human resources responses:** Although no fundamental reforms occurred initially under the Hoyte regime, the impact of this new scenario was reflected in the regime’s responses to health human resources policy. In the case of training, the medical school programme was implemented by the state-run university with PAHO and Cuban government support. Though it remained problematic, the medical school was seen to be potentially useful for the country. In terms of training outcomes, collaboration with regional institutions such as the British-oriented University of the West Indies (UWI) medical school remained cordial during this period with some technical support. However, the active involvement of PAHO, with heavy reliance of Cuban and North Korean expertise were its main support. This lack of full cooperation with the UWI medical school, combined with the cost of training doctors at this Guyanese university were found by some to be unjustifiable given the state of the economy and the attendant qualitative and quantitative risks involved (Drayton, 1997). The argument was essentially that even if the policy could be considered visionary in attempting to solve the doctor shortage for poor developing states like Guyana, the long-term feasibility of the programme, coupled with the sustainability of quality controls must be questioned in terms of whether this was the most feasible use of Guyana’s scarce resources, given Caricom-level regional training capability at the Jamaican medical school.

In the case of day to day medical care provision, Cuban medical foreign policy coupled with active PAHO technical and financial assistance and support continued to be important components of Guyanese health policy under the Hoyte regime. The ratio of physicians for example, increased slightly in 1990 due
to the recruitment of Cuban medical interns on short-term contracts. In terms of overall Cuban health human resource aid, the numbers of doctors had also grown from 15 in 1972 to 54 in 1988. By 1990, the Cuban medical brigade totalled 120 professionals serving six regions of the country, effective forming the backbone of the public health system (Cotman, 1993: 156).² Given the heavy reliance on Cuban and other expatriate medical staff, the Hoyte regime discouraged these physicians from setting up private practice and prohibited them generally from working outside the public sector.

Another human resource problem that was compounded in the late 1980s, by regime politics as much as economic crisis was the ‘disassociation’ or separation of the production sub-system (the university) from the policy-making, planning and management component (the ministry) (Drayton and Caleb, 1993: 7). Under both Burnham and Hoyte, no genuinely systematic co-ordination mechanisms were established to complement the needs of both health personnel and the demands of the population, which reflected the continuing confusion at the heart of the health system under the new regime (Drayton and Caleb, 1993: 7) Health was thus effectively split into three levels: the ministry of health, the regions, and the main Guyanese training agency, GAHEF, with the ministry, GAHEF as well as the University of Guyana all carrying out their own training programmes without any inter-sectoral coordination. Additionally, the Ministry was responsible for allocating staff to the regions but had no say on these staff once allocated. The failure to recognise these and other problems and their effects simply meant more of the same with the government’s response continuing to be the training of ever more nurses to keep pace with migration. According to the state-controlled Daily Chronicle, the policy being followed was one of “...not too much or too little...” as an allocation of G$120 million (approx. US $1 million) was made for increasing the training programmes for nurses, nursing assistants, midwives and community health workers (Daily Chronicle, 26/4/89). The regime’s ‘official’ policy nevertheless remained one of emphasising the familiar PAHO/WHO cries, i.e. the need for inter-agency co-ordination for the production and management of health personnel, support for the concept of different human resource ‘mixes’ and appropriate curricula for Guyana’s health needs (Chin, W, interview).

Meanwhile as programmes were formulated with these goals in mind, the management component was undermined by regime political survival as much as economic and environmental context. Inter-sectoral coordination remained a major problem for the Hoyte regime, particularly the need to build into the policy process a direct link between production and need, within the context of scarce resources. In the case of health human resources, a 1987 PAHO consultancy on the decentralisation process noted this lack of clarity in relation to the regime’s new primary health care policy A general confusion was found between some of the roles of the primary health care team. Physicians did not understand the role of the medex. The medexes and health visitors, when placed together, had competing roles in terms of community outreach. Regional differences also meant that the role of each class of personnel might be different (PAHO/Zakus/Guyana 1987: 29; Drayton and Caleb, 1993: 13). In terms of the medex policy in the mid 1980s, conditions remained much the same with little or no policy incentives such as the rotation of workers. While medexes tried to be flexible, adapting and improvising as they went along, working conditions remained poor and complaints almost impossible without a representative union or a professional association (K. Davis, interview, 1994). There were also continuing disputes over professional and managerial seniority between medexes and public health nurses ‘in the field’. While these problems were more managerial and economic than political, they revealed still reflected the chaotic policy situation that also bore the hallmarks of regime action, inaction and neglect. Regime characteristics’ influences was also evident in the creation in 1988 of the main training institution,

² Cuban medical aid throughout the 1970s and 1980s often included free medical care in Cuba, particularly for complex procedures in particular those requiring hi-tech medical equipment and facilities. In 1983 for example, Cuba agreed to provide hospital treatment for a specific number of Guyanese during that year, as well as to extend for another two years, the terms of the 24 doctors already serving in Guyana. Later agreements called for the continued treatment of Guyanese children in Cuba between 1986 and 1988. Cuba also assisted in the construction and staffing of the medical school (Feinsilver, 1993: 164-168). The ratio of nurses however declined.
Policy formulation was placed with GAHEF, while responsibility for employment and management of health workers remained with the ministry of health: a move which was seen as politically motivated and opportunistic (G. Tesheira, interview; Drayton and Caleb, 1993: 7).

In general then, the overall breakdown of the health system due to both political and economic mismanagement as well as factors outside the regime’s control was increasingly apparent. This in turn affected professional productivity. For instance, doctors especially at the country’s regional hospitals were often under-utilised because of the low occupancy rates, as patients chose to go to the main hospital in Georgetown instead, because of the anticipated lack of basic equipment and drugs and staff. By July 1987, a opposition motion urging the government to remedy the critical deficiencies in health services and specifically the staffing and supplies/drugs crisis in the rural health centres was defeated by the government. The health minister (and Burnham’s son-in-law) Dr. Richard Van West Charles denied the charge, pointing to the new regionalised system, and the new health worker categories created by the government. Despite these claims, the working conditions for all Guyanese health personnel at the end of the Hoyte regime’s tenure was described as "...bad beyond belief..." (Working Peoples Alliance Manifesto, 1992: 65). Various consultants, including the World Bank continually noted the non-facilitating political as well as economic environment for policy reform. Opposition parties such as the Working Peoples Alliance, in addition to calling for free elections also urged the regime to improve wages, working conditions and training facilities for health workers as well as the adequate teaching, supervision and material resources for medical students (Working Peoples Alliance Manifesto, 1992: 65). The unsatisfactory nature of the overall situation was reflected in the ministry’s own figures for 1990 which showed a general staff vacancy rate of approximately 40% (World Bank/Guyana, 1993: 80).

The Hoyte regime had taken some limited steps but the continued combination of extremely poor working conditions - despite the ambitious decentralisation program - and regime illegitimacy continued to encourage large scale emigration of trained and qualified health manpower (1993: 80). As the government’s own health technocrats noted of the state of the Guyanese health service in 1992 after more than two decades of PNC rule, there was a general weakness in evaluation systems for both programmes. Quality assurance was not only attributed to geographical peculiarities and manpower shortages, but also to the tendency by regional organisations to take politically-influenced decisions without taking into consideration the views of health workers (Sagala et al, 1992: 36). Similarly, management weaknesses, which led to the high attrition rate among all categories of health workers, were also attributed to a combination of political and economic factors, with Sagala et al noting that: "...until we can come up with some genuine solution to enable to help retain the personnel, the problem is bound to multiply..." (Sagala et al, 1992: 36). Another ‘management’ problem that persisted by the end of Hoyte’s tenure was the poor relationship between the ministries of health and the regions, and the related inability to do anything about local level health systems-building until the other issues were resolved. The questions also hinted at the

Interestingly, the Guyanese health minister, Gail Tesheira linked regime characteristics, particularly political survival with health policy responses and outcomes in my interview with her. She noted first that the creation of the Guyana Agency for Health Education and Food Policy (GAHEF) was President Hoyte’s way of "getting rid of” the former Minister of Health (and Burnham’s son-in-law) Dr. Richard Van West Charles. After Burnham’s death, Dr. Van West Charles was shifted to the Ministry of Education. Another minister Dr. Noel Blackman, a clinician assumed office, but did not have a primary health care focus and focused his energies on physical infrastructure. His “fall from grace” resulted in Hoyte’s chief rival for the party leadership, Hamilton Greene assuming office. Greene did not however physically occupy his offices at the ministry, leaving the ministry under a non-performing junior minister, Jailall Kissoon. Tesheira asserted that the ensuing power struggle between President Hoyte and Greene, combined with the cuts to the health budgets and other conditions imposed by the IMF loan resulted in the health sector being “ravaged” by the late 1980s, and early 1990s. The impact, she noted, was worse on the poorer and middle classes who relied on the public health services. She also linked the increased incidence of communicable diseases including malaria and tuberculosis, to regime neglect, and inaction and its failure to acknowledge Guyana’s AIDS problem until 1992. The high infant and maternal mortality rates, she asserted, were also denied as data was “doctored” to shore up the regime.
regime context and remained well after democratisation and concerted policymaking efforts as we shall see later (Drayton, 1997: 18-20).

Comment: Despite considerable IMF constraints, Guyana’s poor health and health human resources situation was not only due to economic problems, but regime illegitimacy and survival in what was effectively a continuation of Burnham-styled undemocratic rule by the weak, authoritarian though reformist Hoyte regime. An important factor in this regard was the regime’s mismanagement of public funds to retain power. The net result was a further deterioration in already bad services as many health workers including doctors and nurses migrated or moved into the private sector. The introduction of new health worker categories such as medex and community health workers was commendable. However, the influence of politics even on these programmes, as I have shown, was palpable. While the Hoyte government showed its recognition of reform by decentralisation of services including health, albeit five years after it was announced by the previous regime, it nevertheless still intended to retain power in the traditional PNC way: by undemocratic means. There is also another factor here. American foreign policy, given its linkage to IMF financial packages is arguably the least best option to foster democracy and trigger much needed political and policy reform given its history in the Latin American and Caribbean region - including Guyana. However, this linkage in the post cold war era between political democratisation and economic assistance was good for Guyana politically and socially in presenting the Hoyte regime with a clear policy choice: either democratisre or suffer the economic as well as political consequences at the national and international level. These extremely limited options severely discouraged the PNC regime’s favoured option of regime maintenance in the Burnham tradition. The eventual choice of the regime in the late 1980s to reform and democratise and the implications of this decision for health policymaking, including health human resources policy has to be seen within this no-win political, economic and developmental context (Premdas, 1994: 56). The limited room for policy manoeuvre, brought on by international level factors, as well as political and economic pressures nationally were important influences on the Hoyte regime’s moves towards gradual political reforms. This had important implications for the implementation of health human resources policy reforms by the time the new Jagan regime assumed office as we shall see later. In the next section we examine the influence of regime characteristics on health human resources policy during the final term of the Seaga government and compare it with the Guyanese situation.

Regime characteristics and health human resources policy reforms in Jamaica: the Seaga regime 1983-1988

Policy context: Like Guyana under Burnham, Jamaica under Seaga also enjoyed the lucrative benefits of a cold-war generated relationship when it suited the American administration. However, like Guyana also, such benefits lasted for a short period, but the problems of development in the post-cold war developing world remained the same. In spite of considerable US assistance as reward for its the support of the 1983 Grenadian invasion, Jamaica was no better off in 1986 as it was in 1980 (Thomas, 1988: 232-233). The Seaga regime’s administrative reform program was initiated in 1984 with the goal of improving the performance of the public service. Like their contemporaries in Guyana and Trinidad and indeed many similar developing countries, the lack of effective decentralisation, duplication of services, skills scarcity and low employee morale were just some of the problems that faced the Jamaican government and its technical policy formulators. The prime minister, as chairman of this committee was actively involved in the reform process. In the case of health policy, the ministry of health’s 1984 policy statement essentially outlined the government’s need to balance policy maintenance with policy reform in a declining economy. This policy balance however proved hard to achieve as policymaking slid into crisis management mode rather than rational development, compounded by situational factors ranging from the end of the cold war to the devastating effect of Hurricane Gilbert in 1988. Nevertheless, 1986, the restructuring process was implemented within the ministry of health focusing mainly on management systems reform and a rationalisation of facilities in line with new primary and secondary health care functions, with the assistance of financial agencies such as the Inter-American Development Bank (IDB), the Pan American health Organisation (PAHO) and the USAID-supported Project Hope for medical training. By 1988, the reform process was continuing with the launch of a programme to restructure social services including health systems as well as an increased emphasis on the role of the private sector in
health services delivery. However, Hurricane Gilbert in 1988 devastated the island in September 1988 and forced national health priorities to be turned to disaster response.

The net effect of the last five years of the Seaga regime was mixed for health policy generally. On the one hand, the curative focus severely curtailed the emphasis on primary care, though it certainly existed. Several clinics and regional hospital wards were closed or downgraded, while the remaining facilities were ostensibly up-graded and rationalised. Hospital beds declined from 6408 in 1984 to 5,753 in 1985. However, this rationalisation program was implemented without sufficient warning and forward planning, and the remaining facilities whether rationalised, upgraded or not, frequently lacked the most basic supplies with many being poorly staffed - ironically part of the rationalisation programme. New fees imposed in 1984 and some existing one for all public health facilities under the terms of the World Bank loan to achieve "...a more efficient delivery of services, and optimum utilisation of health facilities..." compounded the situation (Levitt, 1991, 51). The government later exempted disadvantaged groups, children, the elderly, food aid beneficiaries from the rationalisation programme. However, by now the situation had returned to the worst conditions of the late 1970s. By October 1987, even the monetarist Seaga regime was forced to admit that despite "the necessity" of the structural adjustment programme, the social costs were extremely high for Jamaicans. As the government's social adjustment policy paper noted in 1987:

"...The strategy adopted by the government of Jamaica has been based on the stabilisation and adjustment of the economy so it can better cope with changing economic conditions and maximise the benefits from the resources available to the country. In the early 1980s, the government gave high priority to stabilisation and structural adjustment policies in recognition of the importance of the severe financial constraints imposed on the country by the prolonged internal and external disequilibria; [and] secondly, the realisation that long-term welfare gains can only be obtained from a solid economic foundation. The high priority given to adjusting the economy during Phase I however does not mean that the social/human dimension of the Jamaican problem was completely ignored. The government of Jamaica recognises that adjustment policies must have positive and negative effects; positive in terms of stabilisation; and negative in terms of certain by-products..."


A health sector initiatives consultancy also urged the government to contemplate concepts such as means testing, fees for service, private insurance and contraction of services as possible policy responses to the funding and management crises after 1986.

Regime characteristics and health human resources policy responses: In the case of health human resources in the latter half of the 1980s, policy statements continued to acknowledge these adjustment 'by-products' at all levels of the process: training, planning and management. In the case of management, the 1987 document expressed particular concern about the migration problem, outlining a progressive strategy that focused on the needs of both community based and curative-based personnel, within the context of its reform programme for wider public sector (Government of Jamaica/Ministry of health 1984). The situation actually worsened as the harsh consequences of adjustment (including migration) continued with widespread retrenchment of health workers and the abolition of several nursing posts. As Levitt noted of the Jamaican health service in the late 1980s:

"...We now have a situation where there are posts which the ministry is unable to fill and areas where there are not enough posts to accommodate all the available personnel. The ministry itself is deficient in human resources, particularly in planning, evaluation and supervision because it is unable to attract and retain suitably qualified and technically competent personnel. The deterioration in the health service has undermined the capacity of the sector to provide quality health
care and has adversely affected the poor, who are the main users of public health facilities...” (Levitt, 1991: 51).

The 1987 social adjustment paper noted that special attention would be focused on planning, training and overall health human resources policy process, given the increasing crisis in this area. The “by-products” mentioned in the 1987 paper however included the health sector and its personnel who were now enveloped in a cycle of deteriorating physical, material and financial working conditions, coupled with increased demands on the system due in large part to the social effects of the adjustment process (Boyd, 1988). However, the influence of adjustment was pervasive as was management-based problems such as the confusion in the linkages between the training and management levels of the local system as we noted in the case of Guyana. The training of nurses, though intermittently stopped, continued throughout the reform period of the mid-1980s, without being costed and assessed against needs as well as the retention factor. The report added that training would be centralised and that the intake of registered nurse, enrolled assistant nurse and midwifery trainees would be increased with a view to training, inter alia, 100 registered nurses and 100 enrolled assistant nurses annually. The document further stated that the regime would make available to the ministry of health “...incremental resources for training and filling existing vacancies on the establishment...” which it noted would make for a “...more efficient service providing quality care based on established norms and procedures (Government of Jamaica, 1987: 25).

In spite of these pledges however, structural adjustment conditions combined with the government’s ideological stance saw contradictory developments occurring. Nurses were needed, and were being trained, but were also migrating in significant numbers once trained. Thus, even the ad-hoc cutting of a number of nursing posts as part of the entire civil service reform process in the middle to late 1980s were not helpful at this crisis stage. The result was a large drift of new graduates overseas - after training at considerable government expense - from state-funded schools as well as into the local private sector (La Touche, interview). Many other trained nurses meanwhile went into the local private health and general insurance industry. Active recruitment of nurse trainees was intermittent, stopping occasionally. The ministry cut back its training from 200 to 100 nurses per year in the mid 1980s. While the civil service was bloated, it was hardly the case that nursing posts were over-staffed. As a result of this contradictory policy situation of cuts in numbers trained as well as posts, parish hospitals and health centres were also scaled down considerably with severe consequences for primary and secondary health care (La Touche, interview). One reason for this confusing situation was resource scarcity. However, as Carr noted, the non-utilisation of a draft health manpower plan was also a problem (PAHO/Carr/Jamaica, 1987: 47-48). Other programmes were likewise affected, particularly at the community level. The hitherto successful community health aide (CHA) complement, introduced by the Manley regime was reduced by approximately 50% (Ennever, 1988).

All was not however gloomy in the case of the primary care approach, increasing acceptance and integration into policy. Public health nurses (PHNs) were given higher salaries, had access to a vehicle and in the normal course of their duties did not do night work. Additionally the nurse practitioner programme continued to be supported by the regime despite the threat of abolition by the medical lobby. However, despite these two areas, the general (and unsurprising) trend was one of steady decline at all levels of the system. In 1989 a nurse manpower proposal developed for the ministry of health by PAHO consultants confirmed that this decline was due to the weight of IMF driven policies adding, inter alia, that the government was unable to supply the quantity of nurses needed to meet health service demands. As the report noted “...such shortage has jeopardised the quality of even the basic level of care...” (PAHO/Jamaica, Adair et al, 1989: 6). This report, as did others preceding it, also reiterated the familiar problems of posed by nurse migration, shortage of well-qualified students, weaknesses in education and physical infrastructure and resources; and the imbalances in nursing categories. However, the regime's unquestioned acceptance in implementation of some of these areas, given its ideological position, was also a contributing factor.

Comment: A early as 1983, the initially strong, but now weak, though still democratic and market-reformist Seaga regime had begun to lose legitimacy in eyes of the Jamaican population (Edie, 1991:
The perceived deception of the country deeply undermined the government with Seaga's technocratic and insensitive response to the labour protests in 1985 Seaga's being limited to a speech stating that the adjustment period had to be endured (Kaufman, 1985). Later in the same year, the general strike led to the regime's downward spiral. By 1989, the country reeling under adjustment, re-elected Manley to office. According to some analysts, internal factors such as the regime clientelist political structure in Jamaica had a similar negative effect to the ethnic factor in Guyana and Trinidad in impeding policy and policy reform through diversion of resources for political survival (Edie, 1991: 141). It is however hard to believe that policies such as the community health aide programme would be cut by 50% because of the regime's need to survive politically in the face of economic crisis. The undeniable fact was that the structural adjustment policies affected and undermined the ability of government to implement and support policy, as Seaga, as well as the returning Manley regime and his successor, P.J. Patterson found in the 1990s. Like the first Manley government in the 1970s, and like other regimes in post-colonial states including Trinidad and Guyana, Seaga justifiably blamed the international financial actors, especially the IMF. The limited policy room available to manoeuvre even saw Manley's PNP forced to re-think its ideological approach to the development process in this new globalised order, like many other developing states. By the late 1980s therefore, much of the policy room for manoeuvre made available to Jamaica, due the US's generous politically-motivated aid policy had eroded, due as much to Seaga's policy failures as it was Jamaica's inability, like so many poorer developing states, to control its destiny in a post-cold war, adjustment-oriented and rapidly globalising world (Fauriol (1988: 124). In the case of Jamaica then under the last term of the Seaga government, while regime ideology continued to be significant, the effect of the structural process was debilitating to say the least, and mirrors that of other developing states during this period. We now turn to see how the new NAR government under ANR Robinson tackled the problems left by both the PNM and structural adjustment.

Regime characteristics and health human resources policy reforms in Trinidad in the second half of the 1980s: the Robinson regime (1986-1991)

Policy context: The politically strong, democratic reformist though financially weak National Alliance for Reconstruction (NAR) won power on a tide of discontent with the performance of the PNM regime under Chambers that even managed to bridge for the first time the African-Indian ethnic divide, a defining feature of Trinidad's, like Guyana's politics. Its pledge to bring back morality and equity into politics was a very popular one. The regime however almost immediately found itself with very limited room for policy manoeuvre for both political and economic reasons. The regime's lack of economic options meant that it had to continue with the IMF-imposed economic austerity measures started by the Chambers regime, this time negotiating Trinidad's first IMF adjustment 'package' in 1988. Like many regimes in developed and developing countries, the NAR's political strategy comprised the implementation in the first few years of the 'harsh' adjustment policies. According to the stated government strategy in its 1988 Draft Medium Term Macro-economic Policy Framework paper, by the eve of the next elections due in 1991, an anticipated improvement in economic, fiscal and administrative conditions would enable huge spending on social projects including health. The regime justifiably blamed its policy predicament on thirty years of PNM rule, and which would, of course, ensure its re-election. The NAR regime effectively had limited room to manoeuvre even at this early stage. However, in addition to the financial crisis, it added to its own political woes by jettisoning the important, majority Indian-based Alliance component of the governmental coalition within only five (5) months of assuming power. This expulsion left the party extremely politically vulnerable from the start as it continued on its adjustment path (Hintzen, 1994: 70).

In terms of development policy formulation, the Robinson/NAR government outlined its main national policy and planning document, the Draft Medium Term Macro-Economic Policy Framework in 1988. This policy document explicitly justified the regime's strategy of harsh but necessary adjustment reforms as a precursor to improved social conditions. In line with this strategy, a series of adjustment-based measures were imposed. The currency was devalued twice within three years. Many state-funded projects were curtailed, abandoned or privatised. Utility rates were increased and many subsidies were eliminated, while a 15% value added tax (VAT) was imposed on most goods and services. Government workers'
(including public sector nurses and doctors) salaries were cut by 10% while many others - including temporary and special projects workers - were retrenched at a time when the unemployment rate was already close to 23%. These measures were compounded by various food shortages and price increases. The outcome of these successive measures over a three year period included rising poverty in this once oil rich economy, almost continual industrial unrest and the increasing unpopularity of the regime. The NAR government was seen by many as the instrument of the international financial institutions, since many of its efforts seemed confined to creating the conditions for debt servicing through a program of structural adjustment rather than social and economic development (Ryan, 1989: 318-342; Hintzen, 1994: 70; S. Smith, interview, 1994).

Regime characteristics and health human resource policy responses: In the case of health human resources development, despite the existence of the 1983 Demas recommendations on overall public sector and ministerial reform which were supposed to be the framework of a new health policy, the health system remained had remained unreformed, while policy remained ill-defined during the Chambers period (Harewood, 1984). Instead, during the post-1983 period the Chambers regime, as noted earlier, was preoccupied with achieving some political utility - mainly status - from the completion of the medical complex in time for the celebrations of the 10th anniversary of the republic in September 1986, but with an eye on the impending elections just three months away. The fact that the electorate read the symbolism of both events differently reflected the mood of disenchantment which led to the Chambers/PMN regime's defeat. The sad reality post-Chambers, in the case of health, was that the first national health plan (1967-1976) was still being used a guide in the 1980s in the absence of any comprehensive contemporary health policy. By the time the NAR regime assumed office, there was no single formal document that could be considered Trinidad's health policy - it had to be found in various speeches and scattered sources - which, in many cases, followed the format of a stated adherence to primary health care, followed by statements of programmes, such as physical infrastructure-building or the increased training of categories of staff. Nevertheless, a 1987 health ministry mission statement contained a basic commitment to a universal, modern, community-based health care system reflecting the need of the primary, secondary and tertiary levels with emphasis on primary health care and preventive medicine. This document however also warned of the potential implications of the recessionary period for health policy, noting that:

"...a strategy for HFA 2000 cannot be thoroughly addressed without examining the economic situation in any country especially since recession is a global problem. As a consequence, we in Trinidad and Tobago anticipate shortcomings with regard to the implementation of some of our planned health programs. Our new government has inherited severe budget deficits from our predecessors, thereby making it rather difficult to project our anticipated programs of development of which health is paramount...." (Mission statement, Ministry of Health, Trinidad and Tobago, 1987).

The NAR government's policy pledge in 1987 was to monitor the economic situation "...so as not to create any imbalances in the promotion of [the] nation's welfare..." which would jeopardise Trinidad and Tobago's favourable health record vis-à-vis the developed world (Government of Trinidad/Ministry of health, Mission statement, 1987). The overriding goal, it noted, would be 100% access to health services (Mission statement, 1987). The 1988 publication of the Draft Medium-Term Macro Planning Framework document also raised the possibility for the first time of a new comprehensive health policy complemented with a reform action plan and timetable. The report firstly articulated the new regime's overall policy commitment to universal health care as well as preventive and promotive health care based on the primary health care and 'health for all' strategies, pointing to the problems associated with heavy traditional reliance, and consequently, diversion of a greater proportion of resources to tertiary care. The document however pointed to the need for harsh but necessary administrative reform, stating that:

"...particular emphasis will be placed on promoting efficiency in the management and use of resources thereby securing greater cost effectiveness in the delivery of health services so that health care costs can be minimised..." (Government of
This new management ethos was also outlined in the regime's support for reform in order to counter implementation-related problems at the primary level (Government of Trinidad and Tobago/Draft Medium Term Framework, 1988: 73-89). One issue highlighted in this regard was policy imbalances between primary, secondary and tertiary care, for instance, the limited opening hours of health facilities and the consequent resort by the public to either expensive private care or the free emergency health services at hospitals. This practice, it was noted, not only affected the poor, but demonstrated how inefficiencies at the primary health level could negatively affect the entire health system. In order to solve these and other problems, the document noted that primary care would be given more direct resources. Although no details were presented in the document, it nevertheless reflected a clear commitment by the new NAR regime to reforming the health system. The NAR regime, and its health minister, Dr. Emanuel Hosein were clear about the priority of health reform. Under continued attack throughout 1989, the minister restated his commitment to effective health services management reform through decentralisation and the introduction of user charges. Both of these, he noted, had been neglected during the boom years. The biggest policy dilemma however facing the regime in addition to implementing fundamental decentralisation was whether to commission the 'frozen' medical school. The minister reiterated his regime's position that proper management and cost recovery was the best decision for all concerned, despite his evident dislike of the options placed before him, having previously been a vocal critic of the policy as we shall see in Chapter Seven. Nevertheless, this was to become the main goal for the NAR regime, given the time factor and the losses through continual funding for its upkeep in its uncommissioned state (Trinidad Guardian, 5/4/89: 1). The NAR's policy dilemma in the case of the medical school/complex as well as wider health policy, given the political and economic context was an unenviable position for the government, and especially in the case of the medical training complex, revealed the rise of health policy to a high-politics issue, eventually contributing to a volatile environment that led to the attempted overthrow of the regime.

Even though the draft national health plan had been completed for the period 1987 to 1991 and its policies and strategies included in the draft 1989-95 Medium Term Macro Planning Framework, time factors, as well as the political crisis meant that health policy reform was not implemented, though the NAR, to its credit did start the process. The government's political crisis was thus inextricably linked with health in the period preceding the attempted overthrow. The minister's somewhat unfair nomination by a national newspaper as 'non-achiever of the year' somewhat unfairly ignored both the PNM legacy and the impact of economic circumstances. The emergence of AIDS and drug addiction as major health problems that needed health human resources responses also added to its problems. However, the general feeling in Trinidad was that the regime had not only broken its policy promises but seemed incapable of manoeuvring within its limited policy space (Sunday Guardian, 24/12/89: 11). Hosein was even quoted as saying that the objective of the regime was "...to move the public health care system out of the public service sector and into the private sector..." which did not help his popularity with health workers or the population (Hosein, 1990: 8). His eventual failure to give interviews to the press at this stage because of his fear of misinterpretation did not remove this perception. For many, the biggest irony in terms of health human resources policy was the fact that the health minister claimed its biggest future achievement would be the phased commissioning of the PNM-formulated medical complex which he had previously criticised. The spectacle of funds being allocated for the complex, while the rest of the health sector was languishing was not likely to win much support. The years 1987 and 1988, the worsening economic situation saw a fall from 11% to 9.7% fall in public health expenditure (PAHO/Nicholls, 1989: 7). This response negatively affected Trinidad's relatively modest health budget which was never more than TT$550 million anyway. Given the active efforts made almost simultaneously to commission the medical complex which required an estimate recurrent expenditure of TT$ 200 million alone, Nicholls noted that:

"...these figures indicate the financial implications of the medical sciences complex venture, especially in view of the fact that over the past two decades, between 60-65% of annual expenditure was for hospital care-secondary and tertiary..." (PAHO/Nicholls, 1989: 7).
Health policy was thus contributing slowly to the unpopularity and eventual downfall of the NAR regime. In a move calculated to win popular support for his religious group, the leader of the Jamaat al Muslimeen, Yasin Abu Bakr offered the government in December 1989 medical assistance in the form of drug supplies as well as the provision of five (5) visiting doctors in medical caravans from the World Islamic Call Society, of which the Jamaat was a local affiliate to operate throughout the country (Trinidad Guardian 15/12/89: 1). This offer was subsequently refused by a regime now under unmitigated pressure to ease the burden of adjustment. The implementation, instead by the government of its social amelioration programme, targeted at the poor and including the removal of VAT on some basic food items was seen to be piecemeal, and did little to alleviate either the health situation or the government’s unpopularity, despite its popular mandate less than five years earlier. In an attempt to harness this mood, the Jamaat al Muslimeen engineered a coup on July 27, 1990. On the issue of stability however, despite the widespread unpopularity of the regime, there was virtually no popular support for this attempt at destabilising democracy - an ironic fact which despite Trinidad’s two attempts at destabilisation in two decades, still renders the stability argument not entirely feasible. Equally surprising was that when the Prime minister and seven members of his cabinet, including the Minister of Health were held as hostages in the parliament building for six days while their freedom was negotiated, there was very little sympathy from a population reeling under five years of difficult adjustment after the prosperous years of the 1970s (Hintzen, 1994: 71). While stability returned to the country very soon thereafter and a newly-chastened, but severely traumatised NAR government - without the resigned, though not entirely disgraced health minister - completed its last year in power, the administration reform process, including that for the health sector - already formulated by the Robinson government - was subsequently implemented by the new PNM regime under Patrick Manning in 1992.

Regime characteristics and health human resources policy responses: The 1988 Draft Medium Term document outlined the new NAR regime’s policy goals of making available the full complement of doctors, nurses and pharmacists at all health centres during clinical hours, along with the provision of improved management and supply systems. It also pledged to implement, through effective human resources management, a new system which would inform decision-making and coordination in relation to education and training of personnel and the establishment of a staff development unit responsible for coordinating the training for all categories of personnel, including management training for doctors and nurses. Interestingly, the document also expressed the NAR’s intention to reintroduce the nurse practitioner policy - mooted in the mid-1970s by the PNM under Williams in the draft policy document, stating that:

"...manpower planning will address the issue of optimal use of trained personnel...as a result, consideration will be given to the introduction of new categories of personnel, such as pharmacy aides and nurse practitioners and a re-thinking of traditional roles will be encouraged..." (Draft Medium Term Macro Planning Framework, 1988: 188).

This issue is further explored in the next chapter. However, suffice it to say that the policy was to be effectively undermined yet again by a combination of medical lobbying and the somewhat questionable belief of the minister himself that Trinidad did not need such a category (La Touche, S; Hosein, Dr. E; interviews, 1994). In the case of doctors, the main question facing the government at this stage, given the un-commissioned status of the medical school, was whether there was a shortage or an oversupply in Trinidad. The draft document pointed to shortages in a number of categories of staff including doctors (Draft Medium Term Macro Planning Framework, 1988: 73-89). However, this directly contradicted the findings of a health manpower consultancy a year earlier. Two Pan American/World Health Organisation (PAHO/WHO) consultants commissioned by the health ministry to study the five-year health human resource needs of Trinidad found that in addition to the total lack of health planning, the actual number of doctors grew from 723 in 1980 to 1103 in 1986, contradicting both the 1988 Draft report as well as a 1980 ministerial report which had also suggested a shortfall by 175 doctors by 1985 (Drayton and Ray, 1987: 1-4). Drayton and Ray pointed out that their findings were supported by another ministerial report in 1986 which had warned of the potential for oversupply. This 1987 report also cautioned that since the
avenues for emigration of doctors were gradually closing, due, inter alia, to US government restrictions on medical immigration, the need to act in preventing oversupply was vital. The consultants had also noted the potential problems that might be experienced in placing the 35 Trinidadian doctors graduating annually from the medical school in Jamaica, in addition to those graduating from outside the region, given the low attrition rate and the advent of the new medical school. They concluded that "...if at all contemplated, (the medical school] should take into consideration demand and ability to pay..." from overseas students (PAHO/Drayton and Ray, 1987: 11). These findings undermined much of the justification for the medical school policy and by extension the government's health and health human resources policy).

The 1987 report was even more sceptical about the need for a dental training school - also a part of the medical training complex - noting that in order to improve the supply of dentists in the country, no more than 5 or 6 were needed annually which could be easily funded at overseas institutions: "...the establishment of a dental school in the Eric Williams Medical Sciences Complex appears to be an extremely expensive solution..." (Drayton and Ray, 1987: 4). They concluded that any feasible policy or plan must give "...highest attention to the resource constraints..." given the fact that the health budget was estimated to be shrinking by 3% (PAHO/Drayton and Ray, 1987: 11). They noted by contrast the need for lower categories of health personnel, adding that the number of public health nurses was woefully inadequate if community health was to be emphasised, and that in spite of the government's commitment to primary health care, spending on secondary and tertiary care was still outstripping spending, and indeed policies, on primary care. The consultants added that while acute, there was no need for extensive numbers of public health nurses to be trained. They recommended, in this regard, the switching vacant institutional posts to the community health services. They finally urged the government to consolidate all training under one agency and to implement a proper information system to assist in the training, planning and management of health personnel. In relation to nursing assistants, they urged the minister to delay restarting this programme which had been suspended in 1984 and 1986. Drayton and Ray also recommended in this regard that a steering committees be implemented to oversee the training of each category of health personnel, while the follow up discussion workshop two years later recommended that a manpower planning commission be appointed to formulate and implement human resource policies and the need to move away from "...simply adding more people to the service..." towards a more qualitative, community-based system (PAHO/Nicholls: 7).

In 1989, a PAHO-commissioned workshop convened to discuss the above progressive proposals echoed similar sentiments. This workshop report identified a number of other chronic organisational problems including the absence of personnel planning and information systems resulting in continued reliance on 'ad-hoc decisions' in training and management. In addition, optimal staff utilisation was found to be hampered by shortages of staff at the personnel level, the absence of procedural manuals, the lack of clarity in terms of institutional and health staff functions, the lack of evaluation methodologies, and finally an unsatisfactory referral system due to poor co-ordination between community health services and hospitals (PAHO/Nicholls 1989: 7).

At the human resource management level, problems identified included poor work organisation and utilisation of health personnel, inappropriate training and lack of co-ordination between the employer (the ministry) and the trainers (the institutions). In addition, the lack of promotional prospects by merit due to the continued use of the seniority system and the lack of opportunities for continuing education and research and its impact on deteriorating medical and nursing skills and knowledge were also mentioned (PAHO/Nicholls, 1989). This poor state of affairs plaguing such basic areas of support services in the post-boom era revealed the somewhat misplaced policy priorities of the Robinson government in the late 1980s, but moreso, that of its successive PNM predecessors. Some of the above recommendations were implemented. However, the overall tone of both the report and workshop suggested a chaotic, unreformed policy context by the end of its tenure with training, planning and management based on tradition rather than need, and with the NAR regime preoccupied with the dilemma of the already built but uncommissioned medical, dental, veterinary and pharmaceutical training schools. As one health human resources advisor noted:
"...the fundamental challenge continues to be the absence of a clearly-thought-out and articulated health policy in order to outline the decision-making and execution of health care consideration, including health manpower planning. Linked directly to this lack of a national health policy is the failure or neglect to implement the stated commitment of primary health care. This failure is currently being highlighted by the opening of the [medical complex] which unfortunately is being perceived as being put into operation at the expense of the rest of the health care system and the health of the nation. This conflict is clear, for despite the stated commitment to primary health care, the scale continues to be tipped in favour of institutionally-based health care. Approximately 60% of the health care budget is being allocated to secondary and tertiary health care. This figure is more than likely to increase, given the escalating costs of putting the complex on stream...The challenge then is to make secondary/tertiary care work for primary health care by effecting closer and more direct linkages between both systems..." (PAHO/Bryan, 1989: 16-17).

The economy, of course, conditioned the regime’s entire period in office. While health jobs had generally been preserved during the regime’s first three years in office, 10% civil service salary cuts in line with the ubiquitous IMF adjustment loans common to all three countries during this period which severely affected the morale of doctors, nurses and other health categories. However, like Seaga in Jamaica, one of the main critiques of the Robinson tenure was its uncritical implementation of IMF policies, although evidence questioning the formulation and application of these policies to Trinidad persisted (S. Smith, interview). Health worker morale was further affected by the absence of drugs, basic equipment and routine maintenance. By the time of the attempted coup in July 1990 then, protest action by nurses and doctors against a backdrop of deteriorating conditions could be explained by a combination of previous policy decisions by successive PNM regimes in the 1970s and first half of the 1980s.

The rising commissioning costs of the medical complex - the NAR’s stated health human resource priority - at a time of limited public resources and declining health care posed a major policy dilemma for the regime. This dilemma was made even more difficult by criticisms of the complex’s questionable status and usefulness from local doctors and international technical advisers alike. Like the Chambers regime before, the reasons for the Robinson’s government’s pursuit of this policy’s implementation was based partly on the predicament facing the regime. The minister clearly disliked the choices placed before him, given his sustained criticism of the entire project even from his party’s stint in opposition. An urgent decision needed to be made, within a short time period given the situation ‘on the ground’. Added to this was the NAR regime’s desire to rehabilitate its battered image as an uncaring government as well as its need to re-create a political identity for itself through the achievement of a successful commissioning process. It was therefore arguably a ‘no-win’ policy situation for health policy, but seen to be worthy, nevertheless, for the regime’s image as we shall see further in Chapter Seven. However, the fact that the financially weak, but market-reformist seemed preoccupied with the programme - which came to dominate health sector spending and priorities throughout the 1980s - to the exclusion of much of the rest of the health service - not only undermined these goals but reveals how health policy can assume the characteristics of a high-politics character based on regime motivations, such as survival, but which can paradoxically threaten this very regime survival.

Comment: Health human resources policy reform and progress in the 1980s continued to be influenced by a combination of political, economic, environmental and situational factors, with regime characteristics still quite influential, but giving way to global realities. The beginning of the end of the cold war after 1983 saw diminishing American interest in the region, and the emergence of good governance and democratisation as the new political/developmental canons. In the case of health policy, the advent of the global primary health care focus in 1978 was also a significant policy development, and saw considerable efforts to incorporate this policy goal into all aspects of health policy though not without problems. Thus, on the one hand, economic factors were particularly powerful determinants of change and reform, which held out better prospects for the 1990s than the previous two decades. Developing country regimes - even
those survivalist ones like the Hoyte regime- had little choice but to reform if they wanted further loan
guarantees and assistance from international financial organisations. Without such external pressure the
progressive policies of the Burnham and Hoyte regimes in Guyana - which were already failing due to
political and economic mismanagement - the chances for the success of health human resource policies
such as the medex, community health worker and even the medical and nursing programmes were slim.
However, on the other hand, the contradiction with the new adjustment-driven status quo was such that
even the primary care approaches and responses were now under direct attack, given the perception of the
anti-public sector bias of the new policy thrust, and worse an uncritical questioning of these policies. As
the Seaga regime’s second term and the policy dilemmas facing the Robinson regime in Trinidad show,
the problem of balancing wider reforms with the pursuit of progressive health policies was a problematic
one: heavily conditioned by economic circumstances, but, although partly unfair given the PNM legacy,
also just as heavily conditioned by the political choices made by the NAR during this period. In the next
section, I briefly assess and compare developments in the first part of the 1990s.

5.4 REGIME CHARACTERISTICS AND HEALTH HUMAN RESOURCES POLICY
DEVELOPMENTS SINCE 1990

The main attempt to remedy the parlous Guyanese health human resources situation came after the
October 1992 elections when Guyana elected its first democratic government after 27 years of PNC
regime rule. The Peoples Progressive government under Cheddi Jagan had been ousted twice in the 1950s
and 1960s for its orthodox Marxist credentials which was seen by the American and British governments
to be worse than that of his rival, Burnham. However resource scarcity threatened even this newly-re-elected
democratic regime in the 1990s. In 1994, the World Bank urged the Jagan government to cut staff in all
sectors, but health and education (‘Government must cut back on personnel’, Sunday Chronicle,
17/4/1994: 1). The years of political instability, mismanagement and political survival were partly to
blame for Guyana’s ranking as the 16th poorest country in the world with a GNP of only US$ 250 in the
United Nation’s Development Programme’s (UNDP) Human Development Index by the early to mid-
1990s.

The advent of a new democratic era raised the hopes of improved public health administration and
management by the new regime, given the decades of either limited or non-effective action. Guyana’s
first comprehensive health policy document under democratic rule was presented in 1994 by the new
minister of health Gail Tesheira, whose personal pro-active style raised the status of health within the
government during the first half of the 1990s. In relation to health human resources, the neglect of
previous years was evident. The new ten-year national health plan noted that while there was no general
shortage of medical staff, there remained nevertheless a heavy reliance of overseas personnel: over 90% of
the specialist staff in the public sector continued to be either Cuban or North Korean (Guyana Health Plan,
1993: 63-66). While vitally needed to support the system, these expatriates were seen as not necessarily
committed to training and managing of Guyanese health human resources in the longer-term (Tesheira,
interview, 1994). They found also it very difficult, according to the minister, to discipline young interns -
mainly Guyanese who were basically doing much of the work. Discipline, motivation and attitudes of
health professionals were among the biggest constraints to improved health services provision and
efficient operation of the Guyanese health system (Tesheira, interview, 1994). The plan also recognised,
among other things, that low salaries and a poor working environment (for example, deteriorated
infrastructure, shortages of drugs and medical supplies) made it very difficult to attract and retain staff to
work in Guyana’s public health care system (Guyana Health Plan, 1993: 63-66). The disincentive
of public sector salary levels to newly-graduated nurses saw most of them, including other health sector
personnel ‘buying off’ their contracts and migrating either to the rest of the Caribbean, or overseas. These
responses were however predicted in the Plan which noted that given the limited opportunities for upward
mobility offered in the public health sector, the temptation to migrate would continue to be great in the
1990s.

There were also problems identified in the case of training. The 1994 plan pointed to the fact that
some training programs, such as nursing, which had been previously over-subscribed, were in the early
1990s experiencing considerable difficulty in attracting applicants. Because of the decline in education over the 1970s and 1980s, many applicants could not meet course entrance requirements. This was a major problem, particularly for applicants from hinterland regions, who did not have the same educational opportunities as people from coastal areas. The plan also noted the continuing problems due to poor intersectoral co-ordination between the ministry of health and the other training institutions: GAHEF and the University of Guyana, which resulted in duplication and wastage of scarce resources. The new minister responded by establishing a ‘tripartite working committee’ as a co-ordination mechanism, but by the mid-1990s, the body was yet to work effectively or efficiently. The Jagan/PPP government also reintegrated the training institution GAHEF into the ministry of health as part of this overall reform process, where ‘...training, curriculum development and staff placement would then be the responsibility of one institution...’ (Guyana Health Plan, 1993: 65). Another continuing problem was the shortages of various categories of teaching staff and management expertise, which also complicated the policy responses of the government. The minister could however count on some early health human resource successes. One such success was the negotiation with a hostile nursing council that led to the basic training in midwifery procedures of 16 of the 130 mainly Amerindian community health workers as a precursor to the full professional programme within two years (Tesheira, interview, 1994). This policy ensured the reach of skilled midwifery services to these neglected hinterland communities, demonstrating in the process that all of Guyana’s problems were not solely due to economic factors.

Many problems however remained, much of it related to previous years of neglect as well as economic crisis. One political obstacle was that the Hoyte regime had extended the life of the PNC-dominated public service commission for another year. This, the minister noted, made it extremely difficult for the new regime to immediately tackle staff incompetence and other related matters (Interview, 1994). Guyana also continued to have a high maternal mortality rate compared to the rest of the Caribbean region due to both poorly trained and/or lack of adequately trained staff. Additionally, by 1994, the government was counting that most if not all of the 24 Guyanese doctors due to return to the country from government scholarships abroad - 19 to the ministry of health would ameliorate the shortage (Tesheira, 1994). Living and working conditions though marginally improving in terms of activities on the ground, were still appalling given the both PNC legacy and the debt crisis, hence precluding too much optimism about such returns. In the case of the oppressive debt, President Jagan blamed these for the underpayment of, inter alia, health workers: the minister of health in the 1994 budget debate noting, for instance, that nursing assistants after 18 months training received just US$33 per month; professional nurses after four years training, US$ 44; and professional midwives US$ 41 (Jagan, “Consider our plight”, Daily Chronicle 17/4/94: 16-17). Guyana’s mental care services also suffered from lack of adequate human resources: the country’s lone psychiatric institution for instance had only one psychiatrist whose time was spent on general medicine. Of the 180 nurses and nurse aides in mental health services, only 4 had undergone psychiatric nurse training (Tesheira, interview; “Mental health in Guyana”, D. Wintz, Stabroek News, 1/5/94: 12-13). Despite these and other problems, the general feeling in the 1990s was that improvements were being made with the transformation to democratic rule, given the ideological commitment of the reformist, though still socialist-leaning PPP regime and its dynamic health minister to effect reforms after years of authoritarian rule. The implications for political instability, given this situation revealed itself in early 1998, although political manipulation by the now opposition PNC under Hoyte was also agitating the situation, thus ensuring limited optimism, despite the good start in the 1990s.

In the case of Trinidad, the reform process, was well underway in some areas by the late 1980s, despite the predicament of the NAR regime. One important policy outcome of the concerted efforts of local health bureaucrats, PAHO/WHO as well as the Ministry of Health was the integration of nurse training under one body, NIHERST through the establishment of a College of Nursing in 1990 as recommended by Drayton and Ray in 1987. There was also some collaboration with the university medical school, but the new college became an autonomous tertiary institution in its own right, offering, inter alia, a basic nursing degree which reflecting the need for locally-grounded health education reform while maintaining the some of the strengths of the traditional nursing programme common to the other Commonwealth Caribbean programmes. By 1996 four such programmes had been completed in collaboration with the nursing council, the registered nurses association and the ministry of health. The early 1990s however revealed continuing hitches in planning, training and management intersectoral
coordination with the lack of employment for many of these nurses. However, despite these problems, this particular reform provided nurses with somewhat better career improvement prospects within the country, especially given the new opportunities available with the eventual 1994 implementation of the health sector regionalisation and reform programme by the PNM/Manning government which succeeded the NAR/Robinson government. While short on detail on health human resources policy, this development was a major step forward both organisationally, politically and policy-wise, despite understandable concerns about health worker tenure (Phillips, 1994). The document noted that policy and funding would be driven by need rather than the historic patterns of resource allocation and would be cost effective with higher quality services as the outcomes. The ministry of health would be limited to a coordinating role while the planned five regions would be given jurisdiction for the daily operations of health services. This was the first comprehensive policy document in Trinidad since 1967 the National Health Plan (1993-1998). Despite severe criticisms also about lack of adequate consultation with health personnel in its preparation, there was general relief and optimism that the health sector reform process was finally underway almost forty years after the Julien report was presented to the country’s then chief minister, Eric Williams.

Problems remained with the new reform efforts as well as the maintenance of a basic health care service. The costing of the reform objectives identified to remedy the human resources problem - a strengthened ministerial administrative capacity in terms of policy development, training and management; the establishment of minimum health manpower standards, the development of criteria for health human resources shortage areas and the improvement of quality of staff through well developed training curricula - remained undone as late as February 1997 (Drayton, 1997: 18-21). The country’s health human resource situation by the 1990s then was still somewhat paradoxical. The country’s single post of forensic pathologist remained vacant in a country of 1.3 million people at a time when the expensive medical school was producing 65 medical graduates a year, over half of them overseas students, with the locals supported by 50% state subsidies, in addition to the government’s continued -though now considerably reduced - subventions. In addition, nursing assistants were being called upon to assume registered nurse duties, because of the numerous vacancies -in spite of nursing vacancies - contravening nursing regulations in the process. This situation culminated in the 1993 ‘egg-nog’ incident at the country’s lone psychiatric hospital, where fourteen patients died after ingesting contaminated eggnog, directly linked by the investigating Hyatali Commission to chronic staff shortages and the performance of nursing duties by nursing assistants (“22 negligent”, Trinidad Guardian, 22/5/93: 1). The press reacted by blaming nurses as slackers (“No more going the extra mile”, Sunday Express, June 6, 1993: 8). However such episodes demonstrated both the failings of past neglect by successive regimes and the necessity for fundamental reforms. Although problems persisted into the 1990s, the fact that fundamental reform of the health services was finally on the agenda after a forty-year wait was cause for some optimism.

In the case of Jamaica, the health reform echoed to varying degrees the efforts being pursued in the 1990s in the other two states, as well as many other developing states. The health mission statement of the new PNP regime under Manley and later after his resignation, P.J. Patterson in the early 1990s thus retained the idea of a continuation of the reform process within the primary health care approach with the goal of HFA 2000 started by the Seaga regime. The government’s main priority as set out in its five year plan (1990-1995) included the general upgrading of health management systems with a US$ 70.5 million dollar loan from the World Bank, which in the case of health human resources ominously found that the government’s human resources development was “found to be compatible” with the government’s wider economic restructuring and public sector investment program (PAHO/WHO, Report of the Director, 1990: 80; World Bank, 1990: 5). The health ministry outlined its intention to also continue those policies of the Seaga regime, including health promotion with the collaboration of the private sector, in an effort to ensure effectiveness and accessibility at all levels of the system. In line with these reforms, the government noted the need for mechanisms to ensure a high level of quality assurance in both sectors as well as the need for rationalisation of all resources through inter alia decentralisation. In the case of health human resources, the government stated that systems would be put in place to recruit, train and retain health professionals and acknowledged the gravity of the migration problem, in particular nursing. In this regard, attempts to attract nurses back into the profession and prepare potential recruits to enter nursing schools through non-traditional means (PAHO, 1990: 80). Regime proactiveness was evident in these
innovations, reforms, programmes and policy thrusts. However, as noted earlier, the positives of these new reform efforts in the 1990s in the case of the health sector and health human resources development, were balanced by the continuing negative resource-based influences and spending constraints placed on the developing state social sector, which continued to undermine the effectiveness of the very policies both agencies and regimes were trying to promote.

5.5 CONCLUSION AND SUMMARY

In this chapter we have examined and compared the influence of regime characteristics and health human resources in the 1980s. In Guyana in the first half of the 1980s, the ideologically progressive policy initiatives such as the medex, community health worker and even the medical practitioner programmes continued to be undermined by the Burnham regime’s undemocratic rule and intention to hold on to power. By his death in 1985, an unsympathetic international environment and a deteriorating political, economic and social context meant that the room available for policy was not expanded without fundamental reform. To his credit, Hoyte began the reform process, and ceded power gracefully in 1992. The achievements of the new Jagan regime in the case of health human resources policy give much cause for optimism of desperately needed improvement in health status. However, economic and political problems, as noted in the previous section, persist. Any explanation of the appalling health conditions in Guyana since independence, including health status, health policy development and health human resources development while acknowledging the role of economic factors, thus has to recognise the role of regime characteristics in underdeveloping health in the 1970s and 1980s in the cause of PNC political survival.

In the case of Jamaica in the 1980s, explanations of the balance between regime characteristics and economic and other factors in determining health policy and would fall more favourably on the Seaga regime’s side given the poor state of the economy after Manley. Nevertheless, his regime’s free-market credentials were also much in evidence during the 1980s, and with devastating effect in the case of health human resources when combined with the IMF’s loan conditions. While even Seaga himself came around to questioning these conditions, the damage - in the case of nurse and doctor migration, including staff and post cuts, elimination of community health aide posts, hospital closures and spiralling inflation that made increased public sector pay packets useless - had already been done. Unlike Guyana, there was never any question of regime survival or undemocratic rule. Explanations of Jamaican health human resources policy in the 1980s however must incorporate a number of factors at various levels and dimensions including the regime’s free market ideology, as well as its limited bargaining position vis à vis the IMF at a time of severe economic crisis and declining US financial support. In terms of outcomes, the price paid by the Jamaican health sector and its professionals was arguably bad, though a quick comparison to the Guyanese situation which was greatly-defined by the added influence of political authoritarianism makes it seem marginally less traumatic.

In Trinidad, the health situation was not significantly or greatly improved or even qualitatively better in the post-boom, recessionary 1980s -a great irony given the vast resources that passed through the country’s coffers. By the time the Chambers regime assumed office, recession had already hit. Under these last five years of PNM rule, the country changed from a creditor to a debtor nation. Health human resources policy, like the other two countries during this period was subsumed to crisis-driven needs, although the Chambers government had also recognised the need for reform. Its inability to act and the questionable nature of the previous PNM’s regime under Williams’ persistence with the medical complex made this policy all the more questionable in the 1980s when after being used for electoral purposes, it could not be commissioned as planned. This policy also came to dominate the tenure of the Robinson regime in the mid 1980s, when it had to decide on short notice what to do. The eventual choice of a phased commissioning and the subsequent resources allocation at a time when the health sector could least afford it, as we shall see in Chapter Seven, contributed in part to the image of an uncaring government and the eventual the 1990s coup attempt, as well as the government’s massive loss at the 1992 general elections. The medical school policy not only symbolised the backlash of NAR regime policy, but of the arguably bigger policy failure of the previous Williams regime - for largely political reasons since the
1950s - to implement fundamental decentralisation of the health sector. The implementation of these reforms by the new Manning regime in 1994 signalled a new start for the health sector and particularly for health planning, production and management. However, like the other three countries in the 1990s, the role of the new economic and international policy context of IMF-driven reforms were also had their own negative implications for the rest of the decade.

The role and relevance of regime characteristics in the 1980s and the early 1990s varied from by country and individual regimes. The situation in this decade however are not as clear cut for regime characteristics influences as in the 1970s, largely because of the pervasive and largely negative influence of economic crisis and the accession to, and fallout from structural adjustment policies adopted by all three countries - starting with Jamaica as early as 1977. However as we have seen throughout this discussion, regime political factors are intertwined even given these factors. In short then, while economic factors dominated policy non-achievement explanations across all the regimes in the three countries, the role of politics is clearly evident in the examples outlined throughout this chapter. In order to deepen the analysis, in the next chapter - the first of two case studies, I assess this structure-versus-action, regime characteristics-versus-resources scarcity' argument by looking at the issue of doctor and nurse migration.
CHAPTER SIX


6.1 INTRODUCTION

In this first case study, I compare and assess the influence of regime characteristics against other factors in regime policy responses to professional migration from the post-colonial state. My aim is to compare and assess its role and relevance as a push factor in health professional migration from the three countries in the 1970s and 1980s, given other influencing structural factors. The chapter is divided into six sections. In the first section, I examine the historical context of Commonwealth Caribbean migration, with specific reference to the post-war period. In the second section I briefly analyse the regional and international context and determinants of doctor and nurse migration in the 1960s. In the third section, I examine and compare the influence of regime characteristics on physician and nurse migration during the 1970s in Guyana, Jamaica and Trinidad. In the fourth section, I examine these effects in the 1980s. In the fourth section, I briefly examine developments in the first half of the 1990s. In the fifth, I conclude with an assessment of the role and relevance of regime characteristics in health migration from the Caribbean developing state since independence.

6.2 CARIBBEAN MIGRATION: THE HISTORICAL CONTEXT

In this section I examine the national and international context of migration, the policy context of health migration and the role of regime characteristics in health migration in the 1960s.

The international and national dynamics of the Caribbean migration process

Any study of the role of national politics in physician and nurse migration has to be placed within the broader historical context of Caribbean migration. Undoubtedly the movement had picked up over the last two decades. Of the nearly two million Caribbean emigrants who have migrated to the USA since 1820, nearly one half arrived in the 1970s and 1980s (Pastor, 1985: 2). The roots of such regional movements therefore go back a long way and though sporadic, has been nevertheless consistent. Between the immediate post-war years and the end of the 1970s, emigration from Jamaica and Trinidad increased almost tenfold, with Guyana also registering significant increases (Pastor, 1985: 6). This pressure to emigrate from the Caribbean in the post-war era - especially in the 1960s, 1970s and 1980s - can be explained by internal social and economic as well as political crises, but also by periodic overseas demand for skilled and unskilled labour. Blackman (1985: 262-4) has identified four historical phases in Caribbean migration which helps explain the linkage between these push and pull factors. Phase One comprised migration from the smaller islands/colonies to the larger ones, as well as the immigration of contract workers into the Caribbean region from Europe and Asia from the 1830s through to the early 1900s to satisfy labour needs after British slave emancipation. Phase Two began with severe unemployment brought on by the collapse of sugar prices in the 1880s and the ensuing economic depression which reduced intra-Caribbean migration flows and introduced a new outward movement that lasted until the end of World War I. This resulted in substantial emigration between 1890 and 1920 from
the British West Indies to Cuba, the UK and the USA. Other outlets included South American countries, particularly Panama with the building of the Canal and Costa Rica with railroad construction.

Phase Three began in the inter-war years and was marked by the gradual reduction in opportunities for migration and by the return of a large number of migrants following the 'crash' of 1929 which was followed by global economic depression, a slump in the Cuban sugar industry in the 1920s and the implementation of controls by many formerly receiving governments. Despite the opening of opportunities within the region, for e.g. the Trinidad oilfields, the employment situation deteriorated in most countries, given the shrinkage of these migration outlets. Phase Four starts at the outbreak of World War II which provided new avenues for outward migration, with many Caribbean people leaving for Britain, while the construction of US naval bases in the region, including Trinidad attracted considerable skilled and unskilled labour. Meanwhile, the USA and UK met their labour gaps (due to the war effort) by recruiting large numbers of contract workers from Jamaica, the rest of the Caribbean and the Asian sub-continent (in the case of the UK), and mainly the entire Caribbean and Latin American region (in the case of the USA). To this categorisation might be added a Phase Five, which broadly incorporates post-war migration, in two main 'waves': the first, of skilled and unskilled workers in the 1950s and 1960s and the second, and more recent 'wave' of large numbers of both skilled and unskilled workers in the period under study - the 1970s and 1980s - which both satisfied labour demands abroad, and eased the economic and social situation at home. Table 6.1 illustrates this rising and persistent trend in the case of population movements from the Commonwealth, as compared with the Commonwealth Caribbean to the USA in the post-independence period.

Table 6.1: Legal emigration by country of birth from the Commonwealth Caribbean to the USA: 1960-1987.

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<tr>
<td>Selected Commonwealth Caribbean States:</td>
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<tr>
<td>Bahamas</td>
<td>n.a.</td>
<td>n.a.</td>
<td>n.a.</td>
<td>1628</td>
<td>1602</td>
<td>556</td>
<td>3786</td>
<td></td>
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<tr>
<td>Barbados</td>
<td>2377</td>
<td>7312</td>
<td>7878</td>
<td>13070</td>
<td>6204</td>
<td>4797</td>
<td>1665</td>
<td>43303</td>
</tr>
<tr>
<td>Guyana</td>
<td>1434</td>
<td>5760</td>
<td>14320</td>
<td>33211</td>
<td>25782</td>
<td>27310</td>
<td>11384</td>
<td>119201</td>
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<tr>
<td>Jamaica</td>
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<td>62676</td>
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<td>80550</td>
<td>61815</td>
<td>58340</td>
<td>23148</td>
<td>357649</td>
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<tr>
<td>Trinidad/Tobago</td>
<td>2598</td>
<td>22367</td>
<td>33278</td>
<td>28498</td>
<td>11287</td>
<td>8622</td>
<td>3543</td>
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<tr>
<td>Non-Commonwealth Caribbean States:</td>
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<tr>
<td>Cuba</td>
<td>84979</td>
<td>180073</td>
<td>110691</td>
<td>290886</td>
<td>28045</td>
<td>64047</td>
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<tr>
<td>Haiti</td>
<td>10820</td>
<td>27648</td>
<td>27130</td>
<td>41786</td>
<td>223886</td>
<td>32670</td>
<td>14819</td>
<td>178759</td>
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<tr>
<td>Dominican Republic</td>
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<td>58744</td>
<td>67051</td>
<td>80965</td>
<td>57729</td>
<td>73109</td>
<td>24858</td>
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Source: Selected from R. Pastor. 1985: (introduction).

The interrelationship between 'push' and 'pull' factors must be understood in any study of developing state health migration, including that of the Caribbean. Poverty and unemployment combined with the need by the British government for both skilled and unskilled labour during the post-war 'rebuilding' years were both responsible for the high level of migration to the United Kingdom in the 1950s (Pastor, 1985). Britain of course also remained, for colonial reasons, the major destination of choice for most Commonwealth Caribbean people in the 1950s and early 1960s. However, by the mid-1960s there was a major shift away from Britain to the United States and Canada as a result of two factors.
Firstly, the implementation of the 1962 British Immigration Act curtailed immigration from the Commonwealth. The second was the 1965 amendment to the 1952 US Immigration and Nationality Act which abolished discriminatory quotas based on national origin, and instead authorised the recruitment of temporary unskilled agricultural and industrial labour from the hemispheric region where American workers could not be found. These developments triggered a shift in Caribbean migration - both skilled and unskilled in the post-1965 period from Britain to the United States and later, Canada (Blackman, 1985). This ability to manipulate both human resources had a tremendous impact particularly on the nursing sector, in the case of health by reinforcing a cycle of skills shortage and ultimately underdevelopment.

At the national push level, two other ideas have been offered to explain Caribbean migration: the safety valve and comparative advantage theses. Blackman (1985: 262) and Duany (1994) among others have noted that successive developing countries have actively encouraged, along with the receiving states, the migration of large numbers of skilled and unskilled workers to relieve social and political pressures (the safety valve thesis). Blackman in particular has also noted that Caribbean countries have long had a comparative advantage in producing skilled workers such as doctors and nurses which though bad for these countries, has been good for the receiving mainly developed states in terms of saved training resources expenditure. These two issues are particularly crucial in terms of problems posed and responses offered by Caribbean governments in the 1970s and 1980s as we shall see later. However there are also other special explanations for health migration at the global health policy level.

The international ‘health policy’ context of physician and nurse migration (1945-1970)

One factor that explains to some extent health professional migration from developing states like the Commonwealth Caribbean is the nature of western medical development in colonial societies. As noted in Chapter One, this followed a strict colonial Western pattern, which although no bad thing, created by its very western nature the enabling conditions for out-migration particularly under periods of economic and social crisis. Improvements in health in the post-war era were due to a number of factors including the international agenda set by the United Nations and its affiliated bodies for the promotion of progressive social policies including the concept of health, together with access to food, clothing and shelter as a universal human right in both developed and developing countries. In international health circles, the post-war period was characterised by increasing recognition of both the dominance of the ‘medical model’ and the many social causes of ill-health. By the 1950s and 1960s, many former colonies (and colonies) already had colonial health services modelled on the ‘mother country’ long before independence. ‘Left-wing’ ideology was no barrier to western-style medical dominance as evidenced by the dominant role of the medical profession even in revolutionary Cuba (Feinsilver, 1993; Navarro, 1972). As technological advances occurred, the increased medicalisation of health care continued, especially in developing countries with the mushrooming of developed country modelled-medical schools and the resultant acceleration in the rise in status and power of the profession in the protection of its professional interests in these countries. Three important confluences thus emerged during this period: 1) the production of generally high quality professionals in these countries; 2) the inability of ‘home’ countries to reward and retain these workers, especially during crisis periods and 3) the increasing demands for medical and nursing services by the richer, more developed countries.

Physician and nurse migration: Physician and nurse migration lies quite close to the core of the health problems facing developing states. In the case of physicians, according to World Bank figures, 56% of all migrating physicians in the early 1990s were from developing countries (World Bank, 1993). Abel-Smith (1994, 92-105) criticised developing countries for their role in sustaining this pattern in what he called ‘...a wastage of developing country resources...’ by their surplus physician production which fitted in with the emerging ‘developing-developed’ migratory pattern. The pattern, he acknowledged however, had deep roots in both sending and receiving countries’ social, political economic and health contexts. The 1950s and 1960s saw large scale doctor emigration from the Indian sub-continent to Britain as many British physicians who failed to become specialists emigrated to the US, Canada and Australia (Abel-Smith, 1994). Additionally, as Abel-Smith has noted, for many years the United States welcomed
physicians from all over the world provided that they could pass its licensing examinations specially designed for emigrating doctors. By 1972, over half the candidates for state licensing exams were foreign-trained doctors. Part of the reason for this emigration was financial, but some doctors and nurses also emigrated because they could not find specialist work for which they had been trained in their own countries (Abel-Smith, 1994). Indeed, many Caribbean doctors and nurses who migrated in the 1950s to the USA and the UK had also done so to obtain further qualifications (Richmond and Mendoza, 1990: 74). Developed countries were thus, according to this view, effectively 'robbing' less developed countries of physicians, trained usually at government expense and who were badly needed at home. (Pujadas/Unitar, 1971; Abel-Smith, 1994). Abel-Smith (1994: 92) summed up this developing-developed world physician migration pattern as effectively ‘...a vast subsidy from the developing world to the developed, not fully mitigated by the considerable remittances from these doctors to their families at home...’.

The international migration of nurses has been less-well quantified as that of physicians but was as serious a problem in the 1950s and 1960s. However, the pattern was, if anything, worse as the numbers of overseas nurses practising, for e.g., in the oil-exporting countries increased by 110% between 1965 and 1980 largely owing to migration from India, Pakistan, and the Philippines and Korea (Bankowski and Fulop 1987: 27). Nurses also moved in large numbers from the Caribbean to firstly Britain, and then the US between 1950 and 1970 leaving their countries of origin with acute shortages during this period. This situation was finally recognised well into the 1960s and 1970s at the international health policy level by the United Nation’s main health- and development-related bodies, the World Health Organisation and the United Nations Children’s Fund and culminated in the Alma Ata agreement in 1978 - the watershed in the drive for a more non-curate, preventive primary care approach. Both organizations were at the helm of this and other related global health policy reforms (Walt, 1993; Godlee, 1994). A decade later however, physician overproduction in developing countries was still proceeding apace (Butter and Mejia, 1987: 494-499). However a start had been made in addressing issues such as societally-relevant training of doctors nurses and auxiliaries as part of the primary care approach. However as we shall see in the next section the role of such historical and economic influences were also complicated by the realities of politics in the newly developing state.

Comment: In this section we have noted a number of issues. The first is that Commonwealth migration is almost as old as the region itself. The second is that migration is usually driven by push and pull factors - the former a result of poverty, unemployment and economic and even political crises, the latter, the manipulation of immigration rules historically by developed states to satisfy their own skilled and unskilled labour demands. A variant on these themes - and of particular importance to my study of regime characteristics and health migrations - had been the safety valve and comparative advantage theses. The safety valve thesis, essentially states that politicians and governments from developing countries loosen controls deliberately to relieve themselves of potentially difficult political problems, given the high unemployment typical of such states. The comparative advantage argument is that developing states can produce at lower cost, highly skilled workers such as nurses and doctors than developed states. Thus migration, according to this view, is inevitable as these workers seek better opportunities abroad. The drawback is the health care deprivation when such migration occurs and the cumulative costs to the training and sending country. A related argument is that the nature of developing state health training itself- westernised and highly curative-oriented is also part of the explanation for health migration to developed states. The relative merits of both the safety-valve and comparative advantage theses and their implications for the role, responsibility, and indeed ability of developing states to retain their highly-skilled professionals will be assessed as we now turn to briefly to developments in the 1960s, before moving to the 1970s and 1980s.

6.3 REGIME CHARACTERISTICS AND HEALTH MIGRATION IN GUYANA, JAMAICA AND TRINIDAD THE 1960s

To explain whether national political/regime characteristics play a role in the Commonwealth state health migration problem, I now examine the role of regime characteristics and health professional migration in the 1960s, beginning with Jamaica.
In Jamaica, medical migration was not a major problem in the 1960s. A study of the movement and location of medical graduates of the University of the West Indies (UWI) between the years 1954 and 1965 revealed that only 28 of the 98 Jamaican graduates had migrated (Goldson, 1972: 67). This finding correlates with one of the early international comparative studies on health human resources migration which concluded, inter alia, that a sizeable number of Jamaican medical students who trained abroad did in fact return to the country in the late 1960s (Mejia, Pizurki and Royston, 1979: 312-315). Of those graduating from the University of the West Indies medical school in 1966, 72% were still in the country by 1968 while 21% had migrated. Indeed, the absorption of a further 44 graduates from other Caribbean territories meant that Jamaica was on balance a net recipient rather than a donor of physicians during this period. Mejia et al (1979) however found cause for concern. Many of the Jamaican medical graduates were young, many were among the first batches trained at the regionally-funded medical school and many were in search of post-graduate training in Canada and the USA. Many preferred Canada because racial tensions were considerably less than in the USA, along with easier access to teaching hospitals. The West Indian community in Canada was also rapidly expanding. However, the case of Jamaican nurses in the 1960s was clearly evident, particularly after the change in US immigration rules. A sharper dichotomy was evident, with big increases in migrating nurses registered after the 1965 abolition of the American quota system. Figures for this period estimate that the number of nurses who migrated each year was equivalent to 1.2% of Jamaica’s domestic stock (Mejia et al, 1979: 314). Meanwhile many nursing students continued to go to the UK. The best estimates of Jamaican nursing students in the UK were that there were about 800 by 1970, with not many expected to return (Mejia et al, 1979: 314).

Mejia et al found that the main problems for doctor and nurse migration in the 1960s were mainly economic and socially-related: inadequate compensation; poor information, personal and family reasons, unavailability of jobs in specific areas and local economic and social conditions and attitudes (Mejia et al, 1979: 315). These reasons are understandable. Jamaica’s economic performance in the 1960s was impressive but as Anderson notes, this first decade of independence was characterised by very little social advancement for the mass of the population. The prevailing pattern of dependent, high-import, capital-intensive growth pursued in the 1950s and 1960s of bauxite/alumina export, manufacturing, and tourism had few spin-offs for the fast growing population (Anderson, 1988: 99). Despite some level of political unrest in Jamaica during the late 1960s, the country remained basically stable and the government democratic throughout the decade. There was heightened political activity as Manley’s radical PNP party mobilised mass support in the run-up to the 1972 general elections as social conditions including health and unemployment worsened. However, there were few explicit political/regime-related problems serious enough to trigger mass doctor and nurse migration during this period. The main political factor affecting policy during this period was essentially an inability - due to insufficient resources - of the conservative JLP Shearer regime’s to respond adequately and speedily to the doctor and nurse migration problem. The explanation for Jamaican skilled migration in the 1960s therefore had more to do with the regime’s economic weakness lack of administrative reform during this first decade of independence than political factors. As Jamaica’s first five year development plan recognised in 1963:

"...were it not for the considerable migration of nurses to countries where the conditions of work...are better than they are in Jamaica, the numbers trained would be adequate to meet the needs of the country...it is...essential...that conditions in the nursing service be improved in order to stem the migration of nurses..."  

Comment: The power of both push and pull factors were evident in the increased migration of health personnel - particularly nurses - from Jamaica in the 1960s. Both reflected the reality of the underdeveloped post-colonial state. However, in the case of Jamaica, there was little evidence of political
factors triggering health emigration. The causes were largely socio-economic. We next examine health migration experiences in Trinidad in the 1960s.

**Trinidad and Tobago**

Like Jamaica, studies on health migration from Trinidad and Tobago are hard to find. The only substantial study of the country was carried out in 1970, and underlines the nurse-dominant trend observed in Jamaica. This Pujadas/UNITAR study noted that of the 10,912 professional and skilled workers who migrated between 1962 and 1968, 143 (1.3%) were doctors and 679 (7.5%) were nurses (Pujadas/Unitar, 1971: 42-66). It also alluded to the potential losses for Trinidad, noting that in both cases (doctors and nurses), those who ought to have returned home was larger than the gross addition to the country’s stock made in the period from all non-Caribbean sources. In the case of Trinidadian nurses, the study showed that between 1960 and 1964, 269 nurses out of a total of 459 who graduated or 57% had emigrated, with well over two thirds going to the USA, Canada and the UK attracted, like Jamaican nurses by both the pull factors implemented in both countries, as well as the economic and social problems at home. Other reasons such as cheaper air travel and family ties were given. There were however push factors also operating that have some relation to national politics. The main ones seemed, like Jamaica to be organisational and socio-economic-related, including low salaries; lack of professional opportunities; the under-utilisation of professional skills; an increasing population and “general underdevelopment in the widest sense” (1971: 46). These explanations revealed not only a tone of political and administrative neglect, but also the dominant behaviour of the medical hierarchy within the Caribbean health sector. As early as 1969, one physician noted that the reason for non-return of trainee doctors was the singular failure of the government to reorganise the health services, and that junior doctors were:

“...overworked dogsbodies thrown into casualty for 118 hours a week, [becoming] very discouraged with the working and financial conditions...the consultants or Grade A men are the lords who control government beds and equipment. Others will not attempt to compete and leave in disgust...” (‘Tackling the problems that trouble our doctors’, Richardson, Dr. E, Trinidad Guardian, 18/8/69).

As noted in previous chapters, the personal authoritarian style of rule by Williams and the PNM regime was not oppressive as in many genuinely ‘authoritarian’ regimes for e.g. in Latin America. However, his presidential style proved quite inflexible in the face of demands for political devolution as way of fostering much-needed post-colonial reforms - a fact which must partly explain the health migration problem in Trinidad in the late 1960s. As economic and social conditions deteriorated the prime minister concentrated decisionmaking in his hands. The attempted coup in February 1970 was the outcome of frustration with the Williams regime’s management of the first decade of independence. His unwillingness to undertake more rapid reform in the 1960s was also revealed in the prevailing institutional inertia and a continuation of the old colonial bureaucratic ways. The relationship between this factor and the problem of doctor and in particular nurse shortages was only officially recognised after 1968 with the Pujadas/UNITAR report. Indeed, before 1968, as the study itself noted, there were few references to any overall shortage of skills. It concluded that although the Williams regime had finally recognised the overall problems created by the outflow of trained manpower and had expressed concern, “...specific policies towards the problem have been partial and conditional...” (Pujadas/Unitar, 1971: 59). The main recommendations of the Pujadas study included the expansion of the education system, manpower planning, restrictions on the employment of foreigners and salary adjustments.

The role of increased (and newly available) training opportunities was stressed as the main regime response to the problem. Some action was taken by the Williams regime. Specific measures were adopted, including tax reductions in 1968, which had as its specific objective the retention of skilled persons and the expansion of training opportunities. In the case of manpower planning, the Williams regime’s second and third five year national development plans had emphasised the need to co-ordinate manpower planning needs with the structure and numbers of those graduating from the educational
system. However not much was achieved as health workers remained unhappy. In July, 1970, nurses presented nineteen (19) proposals to the health minister relating to salary increases, promotional opportunities, improved training and working conditions, nursing tutors’ qualifications and the persistent problem of doctors passing on responsibilities to nurses. Around the same time, the Dolly Report on wider public service reform urged the government to take “earliest possible action” to improve the terms and conditions of employment of health professionals in line with the policies outlined in the 1967-76 First National Health Plan formulated during this period. The Dolly report was highly critical of the Williams government’s health human resource inaction, noting the lack of trained personnel, the demand for more services; shortages and rapid turnover in middle management; the rigidity of controls; and the “acute” shortage of public health doctors causes (‘The Dolly report: call for action in health’, Trinidad Guardian, 20/7/70: 1). It also stated that the recruitment policy for both doctors and nurses was counterproductive since the few recruited were generally followed by those who left. The additional demands on serving doctors due to acute staff shortages, administrative delays in making appointments and promotions and inadequate housing and poor working (physical) conditions were identified as the main causes (‘The Dolly report: call for action in health’, Trinidad Guardian, 20/7/70: 1). The minister of health, Dr. Max Awon acknowledged both the findings of the report and the grievances expressed by the nurses and doctors. However he told them that the government could not possibly afford to pay nurses metropolitan salaries (‘Let a nurses life be at least tolerable’, Trinidad Guardian, 11/6/70).

Health personnel emigration continued in Trinidad therefore without much regime action. The Williams regime made some impressive strides in health care, but these were largely ad-hoc and/or physical infrastructure-related: achieved without the implementation of the fundamental reforms outlined in the national health plan. While the Pujadas study could justifiably conclude, then, that ‘underdevelopment’ was the primary cause of migration “…when it is expressed in terms of low salaries, compared to abroad, a salary structure which discriminates against skills and unsatisfactory conditions of work”, there was some element of political neglect about the Williams regime’s unwillingness to effect the political and sectoral reforms that were urgently needed and could potentially have solved at least a part of the problem (1971: 59). The Pujadas study concluded somewhat despairingly of the ineffective government action and the power of the pull factors that:

“...On this basis, it appears that the official measures employed to stem emigration have been less effective than those which operated to induce emigration. It is doubtful whether national action alone, short of repressive measures which are unacceptable nationally, would suffice to counter the pull of the developed countries in this period of mass communications...” (Pujadas/Unitar, 1971: 59).

Comment: Socio-economic factors also figured highly alongside administrative factors in Trinidad’s inability to stem the migration flow, in spite of the implementation of tax breaks and a government policy which committed the regime to focus on health human resources retention policies. However, although little could be done given the socio-economic climate, the regime characteristics of the Williams regime, particularly his unwillingness to countenance policy reforms already prepared but unimplemented by the end of the 1960s was directly linked to his new presidential/authoritarian style of government, which though not blatantly authoritarian, nevertheless undermined any idea of reform.

Guyana

Unlike the doctor and nurse migration studies on Jamaica and Trinidad in the 1960s, there exists no similar study for Guyana. However both push and pull factors were operative, although the former assumed a level of importance well beyond that obtaining in Jamaica and Trinidad. Guyana suffered most compared with the other two countries, from doctor and nurse migration in the post-Independent late 1960s, given its chaotic political and economic situation, and the implications for social conditions. Economic factors were undoubtedly critical as the Guyanese bauxite- and sugar-based economy experienced considerable problems. However, the impact of national politics, as outlined in Chapters Four and Five, was arguably as important as the poorly performing economy in pushing thousands of
Guyanese to seek a better life abroad. In the case of skilled professionals such as lawyers, teachers, doctors and nurses, the pull factor was also operative as Britain, Canada, the USA and even the other more ‘affluent’ Caribbean territories such as The Bahamas, Trinidad, Jamaica and Barbados were the main beneficiaries. Guyana, like Jamaica and Trinidad trained its own nurses to similar high British-based standards, despite the obvious constraints. Once trained, the choice of staying in poorly paid jobs with little or no prospects in dilapidated, under-resourced hospitals and health centres, added to the socio-political oppressiveness of Burnham’s already illegal and undemocratic regime meant that migration was a most popular option. The magnitude of the exodus, though unknown, is clearly reflected in Drayton and Caleb’s assertion that during the decades between independence in 1966 and the 1980s,

"...disequilibrium in the health manpower development/human resources development system has become even more critical, as a result of the massive emigration of trained health staff-physicians, and allied health workers, but especially nurses. In some cases production just could not keep pace with losses due to migration!..." (1993: 7).

The influence on migration of the hopelessness and impoverishment brought on in large part by sixteen years of the Burnham regime’s authoritarian rule was also illustrated by Spinner who noted of Guyanese migrants in the latter half of the 1970s that "...many left reluctantly, not because they were seduced by higher salaries in wealthier countries, but because they had lost all hope..." (Spinner, 1984: 170).

Comment: By the end of the 1960s, there was little doubt that the problem of doctor and nurse migration (particularly the latter) was on the increase in Jamaica, Guyana and Trinidad. The causes ranged from pull factors including as British policy and American legislative reform, and push-type structural factors, such as individual national economic, political and social characteristics and events. The combined effect of these factors thus operated to varying degrees in each country during this decade, impeding progress in health human resources development and social development generally during this first period of full self rule. The sad paradox was that although highly qualified skilled personnel were being trained, the inability of these states to reform adequately or pay adequate salaries to retain these workers meant that the room for manoeuvre was extremely limited by economic factors, the in-built dynamic of a western-style medical training programme and the politics of reform. One area which could have potentially given these regimes room for manoeuvre was a political decision to effect the reform process as soon as was feasible, given the problems posed by the still-antiquated system. However, regime politics deterred reforms, especially in Guyana and Trinidad, but more so in the former. In sum then, health migration in Guyana, Jamaica and Trinidad, in the 1960s can all be explained to varying degrees by structural or underdevelopment-related factors. However, there are differences among the three which can also be explained by regime politics, particularly in relation to Guyana and Trinidad.

Comment: Of the three countries in the 1960s, only Guyanese physician and nurse migrants, already under the authoritarian Burnham regime for the first four years of independence could claim political repression as a genuine determinant, in addition, of course, to the other common factors. In Shearer’s Jamaica and Williams Trinidad, physicians and nurses were not fleeing the type of regime authoritarianism that prevailed in Guyana, or the more excessive degrees of dictatorship practised in other third world countries. The economic structural and historical factors were the common denominators. In all three countries, migrants left behind unreformed colonially-structure societies and economies where there was little impetus after the initial enthusiasm of independence to implement required reforms. The apparent regime apathy towards addressing the fundamental institutional problems was most apparent in health services even where politically and economically feasible policies plans had already been designed, in some cases even prior to independence such as in Trinidad. Doctor and nurse migration even at this stage, therefore, has to be seen as much within the context of both the failure of regimes to respond consistently and adequately to the ‘low politics’ field of health, as it did economic and other factors (Grindle and Thomas, 1991; Walt, 1994). To see whether this pattern persisted in the 1970s, we now turn to this decade in the next section.
6.4 REGIME POLICY RESPONSES TO THE MIGRATION QUESTION IN GUYANA, JAMAICA AND TRINIDAD AND TOBAGO IN THE 1970s

In this section, I begin my analysis of the relevance of regime characteristics to health human resource migration in the 1970s by briefly examining the regional and international context of the migration of Caribbean physicians and nurses during the 1970s.

The regional and international policy context of the 1970s

Commonwealth Caribbean governments in the 1970s faced, like many other developing regimes, the dilemma of how to develop economically, socially and politically in order to satisfy the needs of rapidly growing, and increasingly politically-aware, demanding populations, and cognisant the general economic/developmental failures of the previous decade. The choice of ‘alternative paths’ to development were explored within the region as seen in Chapter Four, with Jamaica and Guyana presenting the most radical deviations from the liberal democratic model which was being followed to varying degrees by the other newly-independent Commonwealth Caribbean territories. Among the contentious issues facing the region’s health services in the 1970s however, in addition to economic problems, limited resources and political apathy in reforming the health sector were other factors. Among these was the decision in the mid-1970s by the Gairy regime in Grenada to allow the establishment of a private, offshore private US-owned medical school in Grenada which placed the issue of regional health human resources education on the agenda for the first time since the Moyne recommendations in 1945. Commonwealth Caribbean health ministers, echoing their medical professions (indeed many were doctors themselves), expressed the fear that the traditional Caribbean British-oriented medical training system was under threat from an inferior brand. Another, more positive, development which set the policy context for the late 1970s was the advent of the primary health care approach which saw regional health ministers declaring their commitment to managerial reform, preventive health as well as “…the education, training and retention of health personnel, and especially those involved in the delivery of primary health care…” They also noted the need to “…review and revise the measures that are needed to combat the ‘brain drain’ in the health profession…” (Caricom Secretariat, 1978b: 16-17; 1978a).

Arguably the three biggest influential factors on progressive health policymaking at the international level in the 1970s were 1) the beginnings of the international debt crisis in the mid-1970s; 2) the ongoing geo-politics of the ‘cold war’; and 3) the Alma Ata declaration in 1978 on the central role of primary health care in the health systems of all countries. The first severely limited many developing states’ resource allocation abilities in social infrastructure by the late 1970s. The debt crisis and cold war situation only served to heighten the problem, and threatened to undermine the impressive health status gains of Commonwealth Caribbean states. The second saw many third world countries divert social development resources to the military sector. Another main defining factor shaping the Caribbean health and health human resource policies in the 1970s was the ongoing cold war and the alliances forged between Cuba and the socialist regimes of both Guyana and Jamaica. The adoption of primary health care was essentially a response to the fact that preventable diseases (including many ‘lifestyle diseases) continued to account for high levels of mortality and morbidity in both developed and developing countries, partly due to colonial/historical and situational factors such as civil wars and military and other forms of authoritarian rule that were with few exceptions, committed to regime maintenance rather than social justice.

Comment: These regional and international contextual factors form the backdrop against which health policy processes within the region was played out in the 1970s. Economic and regime characteristics-based factors were influential in policy processes during this period, and not surprisingly resulted in different outcomes in each state. We begin with Guyana and the Burnham regime.

Policy response: The context of the 1970s has been discussed in 1970. Nevertheless, the 1970 declaration by Burnham’s Peoples’ National Congress (PNC) party of a co-operative socialist republic meant the legalisation of Burnham’s authoritarianism. The impact of this blatant form of regime maintenance on the continuation of the 1960s migration process, which, although not well documented was nevertheless confirmed by the evidence of Guyana’s rapidly declining health status indicators. Despite Burnham’s stated support for human resources development, the migration of both skilled and unskilled persisted throughout the 1970s (Spinner, 1984: 137). Economic problems and the resultant scarcity of disposable resources for the health and education sectors was a major causal factor. However, policy non-implementation was also due to a preoccupation with regime maintenance and policy neglect which dominated the regime’s behaviour within the national policy arena. Relations with the medical and nursing associations were also influenced by the political situation, thus impacting on the level and quality of participation in the process. Mass migration from both professions meant that many of those who remained tended to be either supporters of the regime or (in the case of both doctors and nurses) those who were able to secure employment in the mushrooming private hospital sector given the decline of the public services. The lack of support by the regime for public sector non-party supporters who were committed to the health development process, coupled with declining economic conditions made migration a sensible option for such professionals. Many pointed to a dissatisfaction with regime politics and dissatisfaction with the political situation in Guyana were major factors influencing their decision to stay abroad (Hope, 1986:38). As the PAHO/Neal Report noted in 1982:

"...still being conducted without any clear policy strategies and had not been planned or controlled to produce adequate numbers or types of health manpower responsive to the nation’s needs. As a general rule, manpower development is yet conducted independently of actual requirements of health programs and without response to projections of needs or co-ordination between existing vertical programs..." (Pan American Health Organisation Neal, 1982: 6).

Both regime- and non-regime factors therefore explain Guyana’s migration predicament. The regime effectively undermined its already limited options by resorting to political coercion and neglect. The only viable option left for health personnel was migration. The 1982 PAHO/Neal report noted the failures of health human resources at all levels: planning production and management/utilisation. The ministry’s positive efforts in implementing the PAHO/Caricom-designed auxiliary programme and the subsequent geographic placement of the medexes in the late 1970s have to be seen within the context of an overall health and developmental policy vacuum. Both the PAHO-commissioned Lopez and Neal reports, discussed in Four and Chapter Five, alluded to the push factors, driving Guyanese doctors, but particularly nurses away from Guyana ((PAHO/Lopez,1980: 1; PAHO/Neal, 1982: 6-7). As in other Commonwealth Caribbean former territories, health care reform in Guyana had been designated a priority by the Burnham regime at the end of the 1960s because of the failures associated with the colonial health system. Health conditions, though stabilising in the early 1960s then deteriorated considerably making the need for action urgent as well as comprehensive in scope. Like the other territories, doctor and nurse migration had started in the late 1950s, and steadily increased during the political crisis period of the early 1960s. The chronic shortages of these two major categories of health professionals were recognised in the national health plan formulation process. The process of co-optation and control of the state by the Burnham regime however left little or no room for development policy as the Burnham regime sought to tighten its control of the Guyanese state (Hintzen, 1989: 65-70; Green, 1983: 257-280).

As noted in Chapter Five, the consequences of neglect and regime maintenance were predictable by the end of the 1970s also in the case of health worker migration with doctor and nurse shortages progressively worsening as economic and social conditions deteriorated. In many cases, nursing care in the 1970s was being provided by nursing students rather than qualified graduates. Political harassment,
discrimination and continued lack of democratic governance contributed to the outflow. Bilateral arrangements signed with a number of socialist states in the 1970 for the training of Guyanese medical students, of which the most significant was with Cuba, began to produce results at the end of the 1970s. Most of the newly qualified doctors returned to Guyana, and though some subsequently migrated, many stayed partly because of their contractual commitment to the government and partly because their qualifications were not generally recognised in other Caribbean and non-Caribbean countries, and in some cases by their own colleagues in Guyana (Singh, P, 1990: 10-16). Guyana also became largely dependent on contracting Cuban, North Korean and other socialist state doctors to remedy the medical migration problem. In the case of nurses, its response was to train ever more nurses in the established British-modelled way, many of whom continued the migration trek after training as political, economic and social conditions worsened throughout the 1970s.

Comment: Like many developing states, the Burnham regime was rather powerless to retain its skilled health personnel given its economic predicament in the 1970s. However, the mismanagement and/or misappropriation of available scarce resources for political survival meant that the regime’s progressive statement committing itself to developing human resources was also considerably undermined by its own actions. The poor state of the health system at all levels - human, physical and material - by the end of the 1970s therefore reflects as much on the persuasiveness of regime characteristics as it does economic factors. We now turn to the Manley government.


Policy context: Migration has long been a feature of Jamaica’s demographic history (Anderson, 1988: 101). Between 1943-60, net migration was estimated at 195,000 in total, or nearly 1/3 of the natural population increase over the period. During the 1960s however, the net outflow reached 280,000 or 53% of the natural increase (Anderson, 1988: 101). On assuming office in 1972, the Manley regime was acutely aware of this fact, as well as the influencing role of contextual factors. Jamaica was seriously affected by the brain drain and as a result was “...hard put to move ahead in providing the necessary services for a people whose rising expectations, and reasonably modest demands, need to be satisfied...” (Mejia et al, 1979: 68). Not surprisingly therefore both push and pull factors were luring nurses to the USA and the UK in greater numbers in the 1970s, while doctors were increasingly drawn to the USA where they usually remained after completing their residency programmes (Anderson, 1988).

Policy responses: A variety of policy responses were implemented ranging from bonding agreements for nurses, to implementation of new training programmes. In 1973, the new Manley regime had implemented a bonding agreement for nurses graduating from the Kingston school of nursing in line with a similar two to five- year agreement for physicians implemented in the late 1960s (Mejia et al, 1979: 68). The Manley regime in active collaboration with the largely state- and regionally-funded UWI medical school also continued its efforts to train additional medical personnel. One of the most important policies implemented by the Manley government was the availability of free university education to all Jamaican medical students. Additionally, the post-graduate medical education programme was implemented in 1972, given the problems outlined earlier. The regime was also innovative in both urging the university to focus on preventive and community medicine as well as implementing its own policy to retain doctors who were interested in community health by offering the new post-graduate training opportunities for those doctors who served for a year in a rural area (Mejia et al, 1979: 322).

Another significant policy response by the Manley government was the assistance received from the Castro regime under revolutionary Cuba’s medical foreign policy initiative (Feinsilver, 1993). As a last resort, other policy response tried by the Manley regime with some success included the recruitment of overseas professionals from the UK, the USA, Korea, Cuba and India among others - either on contract appointment or for full-time service. None of these policy responses could however stem the losses through migration, which worsened as the Jamaican economy deteriorated. In the case of training, among the government’s most impressive policy responses was its strong support for the nurse practitioner and
community health worker policies in the 1970s. Both were fully implemented under Manley’s tenure and were testimony to the regime’s commitment to searching for viable human resource policy alternatives given the accelerating ‘brain drain’ of health professionals. However, by the late 1970s, the better educated, including physicians and nurses continued to leave in greater numbers Mejia et al (1979: 316-7). By the end of the 1970s, more than three-fifths of all Jamaican migrants were professionals in the 1970s.

Again the pattern for the 1970s in Jamaica, like the other two countries, saw the influence of a combination of political, economic as well as other factors. Economic factors explain much of the doctor and nurse migration process and the inability of the regime to respond adequately, despite some very progressive initiatives. Political factors in the case of the government’s deteriorating relationship with the medical profession was also a possible cause. Related to this was the political/ideological destabilisation factor noted by Stone (1985; 1986) who related migration during the Manley years to the political hysteria about the ‘communist threat’ created by orchestrated accusations of the opposition JLP, as well as a hostile, reactionary local and North American mass media, the local business class and a vocal minority among the professional business class (Anderson, 1988). Others non-economic factors relate simply to proximity and familial ties as in the 1950s and 1960s, though the economic motive was strong. In a 1977 poll, Stone (1982) reported that 60% of Jamaicans saying that given the chance they would migrate to the USA for better mainly for better job opportunities.

The underdevelopment-related pull factor has been a popular explanation of Jamaican health migration, with many seeing health migration as developed states ‘creaming off’ developing country skills (Stone and Wellicz 1988: 133). This view had some credibility. However there is an alternative view in the case of Jamaican health migration which questions the role of governments in developing states, particularly progressive, democratic regimes like Manley’s. According to this view, successive Jamaican governments actively encouraged the exodus of both the skilled and unskilled. As Logan noted, “...sometimes indeed, excess production of professionals was deliberately planned with a view to exporting manpower....” (Logan (1980:121). Barrett shares this view, noting that the Manley regime actively proposed exploring “new migration outlets”, a policy which unwittingly helped the brain drain of skilled health personnel (Barrett, 1979: 68-75). This argument has some merit when applied to the unskilled or poorly-skilled. However, Logan’s argument seems rather implausible in the case of health professionals as it is hard to imagine a conscious decision taken by a socially-progressive regime to export much-needed doctors and nurses, trained at considerable state expense, while at the same time having to face the political fallout of understaffed health institutions and resorting to importing overseas doctors for its own needs, thus incurring twice the expense. An alternative and more plausible view is Anderson’s (1988: 112) and Cumper’s (1993) argument that the absence of effective demand within Jamaica for the quantity of doctors and nurses being trained by the state and its inability to adequately reward these highly-skilled professionals were both responsible for health worker migration in the 1970s and early 1980s. Anderson’s and Cumper’s conclusion was that better planning was need to curb some programmes, by targeting scarce resources rather than wastage on too many highly skilled professionals many of whom migrated anyway. There is much to be said for this approach in the Jamaican situation, and given what we have seen of the Jamaican and Guyanese situations, other countries also, though to varying degrees. Nevertheless, this argument points to poor planning and mismanagement common to so many developing state governments, rather than to blatant survival politics, at least in the case of Jamaica.

Other reasons (and combinations of reasons) have been forwarded as explanations of Jamaica’s health migration problems. Mejia et al (1979: 316-7) have posited that Jamaica’s status as both an importer and exporter of doctors during the 1970s could be explained by the wider tradition of mobility, coupled with economic crises. In the case of nurses the export (no imports occurred) could however, according to them, be explained by the high number of female-headed households. These views are also valid in explaining Jamaican migration. However they dismiss one of the prevailing assumptions of medical migration: that physicians in developing countries being taught developed country medicine will want to migrate to find suitable work. They stated, in this regard, that even in the late 1960s and early 1970s Jamaica’s disease pattern already resembled a developed country, with lifestyle diseases already
accounting for the principal causes of death. While a valid point, it is naive to assume that developed world concepts of ill-health, medical training and tradition did not influence norms and values, and by extension, demands on health services and traditional types of service providers. This returns us to the relevance of the structural argument, i.e. the powerlessness of developing state regimes, and their limited ability to act in spite of progressive credentials given the effects of economic conditions. Even though the Manley regime in the 1970s experimented with a number of progressive policies, the fact remained that largely curative-orientated institutions were producing highly skilled professionals many of whom then migrated as economic conditions worsened, and as demands for their services abroad increased, with government policy - though progressive - failing to react adequately to stem the tide, with due regard of course to familial and other reasons.

Comment: Both push and pull factors exerted varying levels of influence on health human resources migration in the 1970s then, albeit with some evident level of regime mismanagement of the national policymaking policy process, both generally, but also as it related to this specific issue. The combined impact of economic crisis, public service shortages and poor management practices and their direct effects on the Jamaican public sector has been well established (Nunes, 1974; Mills and Robertson, 1974, Mills and Slyfield 1987; Mills and Jones, 1989). In the case of medical and nursing migration specifically, the main reasons seemed to be the outcome of both push factors: poor economic and social conditions, lack of effective demand in retaining doctors and nurses; and pull factors: the lucrative foreign job packages and related opportunities (Anderson, 1985; Pastor, 1985). Only this combination of factors could explain why Jamaican doctors were increasingly migrating in the 1970s while the legitimate and non-coercive Manley government had to resort to among others, Cuban medical brigades as a stop-gap policy (Cotman; 1993; Feinsilver, 1993). The regime’s inability to act given the nature of both the economic and professional constraints shows the reality of many a developing state progressive regime. What Jamaican experiences in the 1970s represented in the case of health migration then, was the relative inability and powerlessness of developing state regimes to resolve the existing national and international ‘disequilibria’ in health human resources training, planning and management policy. When combined with economic crisis, the situation was bad, though not as debilitating, it must be repeated, as tin Guyana under Burnham. With institutional reform itself delayed, and the Jamaican economy going into freefall in the late 1970s, it is not difficult to understand why the exodus of both the skilled and unskilled continued well beyond Manley’s electoral defeat in 1980. We now examine Trinidad’s migration problems and policy responses in the 1970s under the Williams regime.

The Williams regime in the 1970s: state capitalism, the oil boom and policy responses to the doctor and nurse migration problem (1973-1981)

Policy context: There is little reliable information on the exact numbers involved in the physician and nurse exodus from Trinidad during the 1970s. However, the concerns of the Williams regime expressed in the case of chronic shortages in both categories meant that the problem was much more serious than the 1960s. Despite these concerns, the regime’s perception of the problem was different to that held by the doctors and nurses themselves. In the case of physician supply, the Williams government believed that the number of Trinidadian students graduating annually from the university medical school in Jamaica (about 30-35) were too small for Trinidad’s needs. This belief, though partly true, ignored the feeling of many in the service that the pressure for reform of the health services was not strong enough at this stage. In 1978, the same year that the national advisory council (NAC) presented its report on health services, the Williams regime appointed a task force to hasten the establishment of medical school within a relatively short period of time. The Peat Marwick Mitchell report commissioned by the advisory council, as mentioned earlier, noted the basic problem: the absence of a clear health policy. This manifested itself in a number of planning and management problems: poor co-ordination between training institutions and the ministry, poor staff utilisation and gross inefficiency which in turn led to frustration and high staff turnover levels (National Advisory Council/Peat Marwick Mitchell report, 1978: 15). The report additionally noted that health care remained - in the year of Alma Ata - highly medicalised. Together with poor salaries, all of these factors contributed to the apparent shortage of public sector doctors in the 1970s. This factor, coupled with the sudden availability of resources enabled the regime and its advisers both at the national and international levels to draft what it considered its main, viable, and suddenly now
feasible policy response to both migration and perceived health worker shortage: the medical school and complex.

**Regime policy responses:** The decision to implement the medical school policy, which was later expanded to build training facilities for, inter alia, advanced nurse training could be seen as the Williams regime's main policy response to the doctor and nurse health migration problem. However, as noted before and also in the next chapter, the role of regime motivations, calculations and characteristics, along with other factors such as medical interests also influenced the decision. Other responses to migration included overseas recruitment of doctors and nurses and creation of new posts. However even here there were problems. In 1977 for instance, 415 new nursing posts were created. However, in this the year preceding the Alma Ata conference, all except 21 of these posts (of district health visitor) were bound for the three main hospitals. In addition, the government announced the recruitment of 112 nurses from the UK most of whom were nationals who had migrated for both training and better employment conditions. None of these responses could however adequately solve what was essentially a political problem. During the 1970s, the health minister whose ad-hoc, confrontational stance did not exactly endear himself to health professionals, continually reminded them of government’s other (cheaper and easily implemented) policy option of overseas recruitment of both doctors and nurses where local staff could not be found. This was in effect an admission, as in Jamaica, that the wider problems facing the health system were not going to be comprehensively addressed when such ad-hoc, stop-gap and less politically risky measures were available. Reflecting the view of many in the health sector, one opposition member of parliament (and doctor) however criticised this approach, accusing the Williams regime of incompetence. His view that under-utilisation and underdevelopment of human resources, rather than overseas recruitment was the main problem was widely shared (‘Poverty and health services’, Sampath, M, Dr, Trinidad Guardian, 18/10/75).

However neither of these policy responses solved the problem. In the case of the nurse practitioner programme, plans never got off the ground as noted before, the main reason being not regime support, but medical profession opposition. The failure to engage both the nursing and progressive members of the profession and lack of effective lobbying by nurses to counter this opposition could also explain the failure of the policy (Trinidad Guardian, 18/10/75: 1). The recruitment of overseas nurses also failed to be implemented and was seen to be unfeasible. Trinidad’s ‘de facto’ health and health human resources policy in the post-boom 1973 period was thus dominated by the medical complex project to the exclusion of discussion of pressing problems such as health migration. The Williams regime, and Williams in particular, undoubtedly calculated that the medical complex policy would yield long-term solutions to chronic physician, nurse and other professional shortages. However, the problem lay more in his government’s unwillingness to reform and decentralise national power, which gives regime characteristics some validity in this case. After the 1970 attempted coup, Williams’ increased authoritarian style made the placing of reform on the policy agenda very difficult. This was compounded by the oil boom in 1973 which enabled him to effectively spend his way out of developmental problems - including health, without incurring unnecessary political risks. The road to reform was potentially dangerous politically, even for a ‘low politics’ issue like health human resources which might have curbed if not prevented migration. However Williams was not prepared to comprehensively do so for a low-politics issue such as health development. There was even less incentive to do so after the oil boom.

**Comment:** The search for development alternatives began in earnest with the three regimes pursuing alternative development paths. One of the persistent realities of the Commonwealth Caribbean has been migration - driven by socio-economic crises, family ties and developed world manipulation of immigration laws to satisfy their own labour demands. In the case of Guyana and Jamaica in the 1970s the reality of the weak, resource scarce developing state was a major cause. However, this did not apply in the case of Trinidad where ample resources were available in the post-1973 period. However, rather than being used for long term fundamental reforms which might have at least helped to retain some health personnel, was spent instead on training ever more personnel in the traditional way. This policy was not unique to Trinidad alone with Guyana and Jamaica also culpable. This constituted a waste of national resources that none of these states - even Trinidad - could afford to lose. The oil boom factor enabled the state capitalist Williams regime to signal its new status in the region. The major problem with this focus
however was that it overshadowed the very real structural problems facing the Trinidadian health system that were forcing physicians and nurses to migrate in the first place.

Regime maintenance thus manifested to some extent in presidential behaviour which had a bad if not altogether devastating effect on the health reform impetus, and which hastened the migration of dissatisfied professionals. Jamaica and Guyana also revealed the complexity of the determinants of health migration under socialist regimes. In Guyana, regime maintenance and political coercion was more highly influential, along with economic factors. In Jamaica, the economic factor was dominant. However a number of other factors, ranging from active regime collusion to lack of effective demand for doctors and nurses were also valid. The difference between Guyana and Jamaica was that two was that blatant survival politics was not practised in Jamaica, despite its political problems. The similarity for both ultimately was that they each suffered considerably from the oil shock in the 1970s (unlike Trinidad which gained from it) which considerably worsened the health migration situation and somewhat limits political factors. However, if politics were not applicable to Jamaica, given this point, it was definitely so in the Guyanese case. We now turn to analyse developments in the 1980s.

6.5 TRANSITION AND REGIME RESPONSES TO THE PHYSICIAN AND NURSE MIGRATION PROBLEM IN THE 1980s

The economic context

The financial crisis that affected almost all Commonwealth Caribbean countries in the late 1970s extended to the early 1980s, resulting in the subsequent implementation of fiscally prudent, but socially damaging structural adjustment programs as conditions for loans from the IMF and the World Bank. The resultant impact on the social development gains of the past as well as the risk to existing policies and programs was extremely debilitating (Stone and Wellicz, 1988; Manley, 1987; Thomas, 1988; Pantin, 1986). In the case of Caribbean health, this impact included a general decline in health status and services (Musgrove, 1986; Boyd, 1988; Levitt 1990; Theodore, 1993; Phillips, 1994).

The international health human resources policy context: Successive rises in oil prices in the 1970s resulted in important changes in international physician and nurse migration. The newly-rich Arab countries became doctor importers on a large scale (Abel-Smith, 1994: 94). But from the 1980s, other countries, including Britain and the United States became more restrictive in the admission of foreign medical graduates, partly due to pressure from both their own medical graduates, and to political pressures to restrict the admission of every type of emigrant, but partly due to an increasing recognition of the harm being done to developing state health services (Abel-Smith, 1994: 94). As Britain expanded its medical schools, plans were set for the replacement of foreign graduates as they retired with doctors trained at home. The United States also became more restrictive in the case of physicians. As Abel-Smith, Cumper and Anderson among others have pointed out, these developments happened simultaneously with reduced economic prospects which made developing countries unable to employ all the doctors they had trained. On the nursing question, the position was markedly different, largely due to the mushrooming demands of the American health care system. As demand for private medical and nursing care grew the 1980s, the USA addressed its own shortage by amending its legislation, making it relatively easy for nurses wishing to come to the US to obtain a visa in the 1980s (Abel-Smith, 1994: 94). This selective migration policy was to have a profound effect on a number of neighbouring countries such as Mexico, but also the already short-staffed Guyana and Jamaica, and even Trinidad. In the next section, I examine responses to migration in the 1980s by looking firstly at Guyana under the Burnham and Hoyte regimes.

Co-operative socialism and policy responses to the migration problem in Guyana: the Burnham and Hoyte regimes (1980-1991)

As noted in the two preceding chapters, the limited information available on Guyana’s health human resource situation as well as my interviews suggest that the health migration problem worsened
considerably during the 1980s. By President Burnham’s death in 1985, one of the more substantial assessments of human resources development concluded that both nursing and medicine were in crisis, noting also that there was “...little or no evidence of commitment of health professionals - especially doctors - to the education and training processes” (Drayton/Collado/Ray, 1987: iii). The study concluded similarly, in the case of student nurses, that nursing training was being used as a tool to facilitate easier migration to other Caribbean territories as well as the metropolitan countries, a conclusion also applicable to Jamaica, as Anderson and others have noted (Anderson, 1988; Henry and Johnson, 1985). The importance of deteriorating economic and social conditions similar to those affecting Jamaica, and to a lesser extent, Trinidad cannot be overstated. Low wages could not match rising inflation and poor working conditions as a direct consequence of the even more limited resources available for the public health sector.

**Policy recommendations and responses:** The 1987 Drayton et al report recommended a number of policy strategies to the Hoyte regime to improve the system in order to stem the doctor and nurse migration flow (PAHO/Drayton/Collado/Ray, 1987). These included the formulation of a comprehensive policy, which would, inter alia, define goals and priority areas, as well as the identification of long- and short-term strategies to achieve these goals. On the management side, these recommendations covered the configuration and functions of the ‘health team’ concept, the integration of production with management and the development of ‘career paths’ particularly for Guyanese nurses. The 1987 report reiterated the importance of “...adequate provisions be made to support the system with the development of a strong infrastructure...” (1987: 1). This report concluded importantly however that without political change, these recommendations would remain just that. In formulating policies in support of its ideology of co-operative socialism in the first half of the 1980s, the Burnham regime did not entirely ignore health human resources development. Indeed, some of the ideas were very radical and progressive by traditional Commonwealth Caribbean health training standards, and similar in terms of its change from this Caribbean status-quo with Jamaica’s nurse practitioner and community health aide programmes. The development of the community health worker, medex and medical practitioner programmes as discussed in Chapter Five were innovative responses in large part to the doctor and nurse shortages in the public sector. However, regime/national politics, meant that the effectiveness of these programs was considerably undermined.

**Consequences:** By 1990, a serious human resources shortage in the public health sector was predicted to continue, given these conditions, and, consequently, the public health sector’s inability to attract and retain health professionals (PAHO, 1990b). Not surprisingly, the continued preoccupation with regime survival by Burnham’s successor Hoyte combined with economic crisis impacted negatively on the ability of doctors, nurses and other health workers to stay in the public health services. The continuation of regime-influenced health human resource migration thus contributed, as did economic factors, to a poor health delivery system, which in turn resulted in the progressive decline in the health status of the Guyanese people. Even though they were among the hardest workers, nurses remained among the lowest paid health workers as well as having the least prestige and status. Nursing was particularly badly affected, accounting for at least 88 of the 105 health personnel who resigned over the 1988/9 period (Harry/PAHO, 1989: 5-7). Doctors terms of employment and working conditions were similarly bad. The decision to establish a medical school was an important, though criticised policy response (Drayton, 1997). Though somewhat understandable, the question of better allocation of scarce Guyanese public resources persisted well into the 1990s (Drayton, 1997).

Unlike Trinidad, the Burnham regime had long chosen the decentralisation path as a path to health services improvement. Laudable though this decision was, the fact remained that it was implemented on an ‘ad-hoc’ basis, and under conditions of undemocratic, cooperative socialist- and party paramountcy-based rule which had their own ramifications for public policy policymaking. Additionally, even after implementation in the mid 1980s, regime maintenance factors were significantly contributing to the underdevelopment, not only of the health sector and working conditions, but the living conditions for all Guyanese. These push factors during the 1980s simply meant an increase in doctor and nurse migration, both externally as well as internally into the private sector. In the case of nurses then, despite a fairly
steady student intake since 1988, a no-fee system, and output of 120 nurses annually by the four publicly-funded nursing schools, severe staffing problems still remained well into the 1990s, nurse migration, not surprisingly perhaps, persisted (World Bank/Guyana, 1993: 80). Wages were extremely low for all categories, as seen in Table 6.2. Like all health sector personnel, physicians, nurses and other categories’ salaries were fixed according to central government pay scales. Most physicians earned between G$991 (US$85) and G$11,437 (US$99) per month in 1993, but declines in the real value of salaries between 1985 and 1991 were greatest for all qualified staff. As the opposition Working Peoples Alliance (WPA) party manifesto noted in 1992, Guyana’s poor health situation - undermined by decades of PNC rule - encouraged health migration particularly among the female-dominated nursing profession:

“...our hospitals are slums, overcrowded and falling apart. Essential drugs, bandages, cleansers and equipment for routine medical work are scarce and very expensive. Doctors, nurses, technicians, administrators and aides, assistants and health workers generally are in very short supply. The number of physicians per 10000 of the population is less than one-fifth of that for Trinidad and Tobago, and one-half for that of Jamaica. The number of nurses per thousand of the Guyanese population is less than one-third that of Trinidad and Tobago; and these are concentrated in urban areas. The working conditions for health care personnel, the bulk of whom are women, are bad beyond belief...” (Working Peoples’ Alliance Manifesto, 1992: 65).

Table 6.2: Salary differentials for Guyanese health human resources for the years 1985 and 1991 (US$)

<table>
<thead>
<tr>
<th>Category</th>
<th>1985 monthly salary (US$)</th>
<th>1991 monthly salary (US$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>217</td>
<td>128</td>
</tr>
<tr>
<td>Registrar</td>
<td>168</td>
<td>103</td>
</tr>
<tr>
<td>Med Officer</td>
<td>99</td>
<td>98</td>
</tr>
<tr>
<td>Med Intern</td>
<td>99</td>
<td>85</td>
</tr>
<tr>
<td>Medex</td>
<td>55</td>
<td>45</td>
</tr>
<tr>
<td>Ward sister</td>
<td>54</td>
<td>47</td>
</tr>
<tr>
<td>Staff Nurse/midwife</td>
<td>42</td>
<td>44</td>
</tr>
<tr>
<td>Nurse</td>
<td>41</td>
<td>43</td>
</tr>
<tr>
<td>Midwife</td>
<td>31</td>
<td>27</td>
</tr>
<tr>
<td>Assistant Nurse</td>
<td>29</td>
<td>25</td>
</tr>
<tr>
<td>Nurse Aide</td>
<td>24</td>
<td>22</td>
</tr>
</tbody>
</table>


Comment: The political survivalism practised by the Peoples National Congress (PNC) regime under first Burnham, then Hoyte immeasurably worsened living conditions for most Guyanese including health workers who migrated en masse to other Caribbean states, the USA, the UK and Canada. In an already difficult environment of limited resources - human, material and financial - even those committed bureaucrats in the ministry of health and the training agencies could not effectively formulate, implement and provide continuing support for even their most progressive policies given the persistence of regime politics. The limits placed by scarce resources were thus worsened by the lack of democracy, political harassment, mismanagement and poor working conditions. As noted in chapter five, factors such as administrative problems, misallocation of health resources within the regions, late payment of salaries made it difficult to ensure the development of a health system that would encourage nurses and doctors to remain in the public sector, and indeed, the country (World Bank, 1993; Sagala et al., 1992; Drayton and Caleb, 1993; S. Gordon, 1994, interview. The end result was high levels of migration from all classes in society, but mainly the skilled and the educated - including doctors and nurses - whom the country could least afford to lose. As the then chief medical officer concluded by the end of the 1980s: “...by far the most intractable human resources problem is that of staff retention...” (Harry/PAHO, 1989: 5-7). Economic crisis in the Guyanese case was thus worsened by national politics which resulted in a collapse
in health services by the time the newly elected democratic regime assumed office in 1992. This reality underscores the need for a balanced approach to explaining Guyanese developing state policy by incorporating the regime characteristics argument. We now turn to the Seaga regime in Jamaica in the 1980s.


The policy context: As noted in Chapter Five, by 1986, Seaga’s favourable status within the geographic sphere of influence declined as the cold war threat rapidly diminished. Despite the government’s faithful implementation of IMF policies, the Reagan government was disillusioned with his regime’s “statist attitudes” (McAfee, 1991: 128). By 1988, Jamaica was no longer an American foreign policy priority (McAfee, 1991: 128). Despite the considerable aid and loan packages, Jamaica however was now in a worse condition economically, socially and politically than when the regime assumed office. At the end of Seaga’s term in 1989, the gross domestic product was no larger than it had been in 1980. Its debt servicing ratio, like Guyana’s was very high, but its overall debt remained at US$4.4 billion, one of the highest, per capita in the world, more than half of which had been accrued by the Seaga regime. In the aftermath of Hurricane Gilbert in late 1988 and the harshness of the IMF’s policies, even the USAID was forced to admit of Jamaica in 1988 that it was characterised by:

"...a crippling debt burden...distribution of wealth and income is highly unequal...shortages of key medical and technical personnel plague the health system... physical decay and social violence deter investment..." (McAfee, 1991: 139).

The combined impact of the disequilibrium of health human resources, the debt crisis and the role of regime ideology, though not survival was most evident in Jamaica in the post-1980 period. Despite the good intentions of the Manley regime, the fact remained that severe economic problems forced many Jamaican professionals including physicians and nurses to search for better job opportunities abroad, rather than the regime’s politics (Anderson, 1988). A Jamaican health policy paper noted that emigration during the latter half of the 1970s had considerably reduced available technical and professional staff in the health ministry (Government of Jamaica, 1984: 11). This situation continued during the first half of the 1980s. Despite the advent of the laissez faire Seaga regime and its US government-, IMF- and World Bank-endorsed policies the process continued to deteriorate. Even the very real progressive achievements of the Manley regime were considerably undermined by the adjustment programmes in the 1980s, and with it, the aspirations of those committed primary health care and policy reform in the health sector.

Policy responses: The Seaga government’s early attempts to implement its primary health care strategy with regard to health human resources was described as “initially gratifying” (Carr, interview, 1994). These attempts were however, like other reform policies, severely hampered and/or undermined by adjustment policies (Carr P, interview, 1994). Staffing requirements were not being adequately met due to the devaluation of the Jamaican dollar, low wages, poor working conditions, and importantly, the increasingly ‘open’ US health market were some of the main mitigating factors. These served to enhance the existing Jamaican ‘brain drain’ well into the 1980s. They also affected the ability of the health ministry to actively recruit expatriate staff, especially doctors, who were often transient (Holding-Cobham et al, 1985: 26). Inevitably, Jamaica’s much-vaunted training system suffered as it could not keep up with the high attrition rates and resultant chronic under-staffing of facilities at all levels of the health system (Holding-Cobham et al, 1985: 17)

All of these effects on the health sector were endured in a society already struggling under the wider social strains of adjustment. Health care was absolutely critical at this time of increased use of public care...
facilities. However, the Seaga regime acceded to IMF pressures at the height of the social crisis by imposing a 12.5% reduction in nursing personnel. The government also added to the restriction of access to public hospitals to the poor by imposing fees for service. In the case of doctors, in 1988, the number of medical posts in the Jamaican public service was 547, but the number filled was only 376. Of even greater concern was the fact that of the 4,312 posts of registered nurse, only 2,663 by the end of 1988 (or 62%) were filled (Gallimore, interview, 1994). The effects of push and pull factors were thus both being experienced. The situation seemed to be a contradictory one of government inability to pay for such posts to be filled - a point noted by Cumper (1993) and Anderson (1988) - although the need for health services, at all levels of the system was clearly there. These vacancies for both categories persisted well into the 1990s as a result of a combination of Seaga’s monetarism, the IMF’s adjustment conditions, and the still curative bias prevalent in resources - human, financial and organisational at this time. A study of registered nurse migration for the period 1974-1984 found that the major “push factors” in Jamaica were: poor salary, lack of professional development opportunities and poor working conditions (Reid, 1985). The ‘pull factors’ abroad, as noted in other reports, were increase in salaries, better working conditions and professional development opportunities. The Reid study also found that staff shortages led to overwork and fatigue of remaining staff and poor interpersonal relationships. The most disliked factors on the job were staff shortages, equipment and supplies shortages, unsatisfactory working conditions and lack of material benefits. This confirmed the importance of non-economic factors and expressed in the contention by Mejia et al that:

"...whilst income differentials between donor and recipient countries play a role in the sense that they determine the directions of migration, low income per se does not seem to constitute a push factor...” (Mejia, Pizurki and Royston, 1979: 402).

As noted in Chapter Five, the Seaga government did manage to implement some progressive policies in response to the nurse migration crisis. The most important were firstly, improved conditions for the retention of primary health nurses including car provision, no night services and higher salaries than institutional nurses. Secondly, the enrolled assistant nurse (EAN) programme was implemented, essentially as a stop-gap measure to counter the migration of registered nurses. Organisationally, the impressive performances of the rural health team approach was vindicated the new government’s continuation of the Manley regimes’ policy. However, serious problems continued at the tertiary level (La Touche, G; interview). Under the administrative reform programme started in the mid 1980s, nurses continued to be trained, despite the 50% cut in the training budget. However, because of the 12% cut in the number of registered nurse posts, these nurses could not find jobs, given the lack of demand, so went to the private sector (including the insurance industry) and abroad aggravating already severe shortages (Reid 1985: vi). Between 1984 and 1988, it is estimated that 609 nurses left the system, driven by low wages and the proximity of lucrative jobs in North America (Holding-Cobham and Bowen-Wright, 1985: 17-26; La Touche, interview). Table 6.2 below illustrates the gravity of the nursing problem during this time and its continuation of trends from the 1970s:

Persistent under-funding driven by adjustment policies meant that funding of the health sector continued to be a problem, with the 5% spending target recommended by the UN not matched by the regime’s average of 2.9%. As a result, entire hospital wards were closed down. Where rises in budgetary allocation were recorded this was primarily due to inflation and the decreased purchasing power of the Jamaican dollar. A significant proportion of the government’s income during this entire period went into debt servicing. Successive consultancy reports on nursing shortages due to migration recommended that better utilisation of staff, better career opportunities, the need to utilise ‘return flows’ of Jamaican nurses were integral elements to curb nurse migration (Reid, 1985; Government of Jamaica/Ministry of Health, 1993). Nevertheless, the developed countries remained the major benefactor of nurse migration with the USA receiving 63%, Canada 7%, the UK 2% and other Caribbean countries, 2% of migration by 1985 (Reid, 1985). The overall result for health human resources development by the end of Seaga’s tenure in 1989 was the persistence both push and pull factors which undermined Jamaica’s health services considerably.
TABLE 6.3: The movement of Jamaican public sector nurses: 1976-90

<table>
<thead>
<tr>
<th>Year</th>
<th>No. of nurses admitted to the public sector</th>
<th>No. of nurses resigning from the public sector</th>
<th>No. of nurses admitted to the USA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1976</td>
<td>305</td>
<td>107</td>
<td>106</td>
</tr>
<tr>
<td>1977</td>
<td>275</td>
<td>71</td>
<td>143</td>
</tr>
<tr>
<td>1978</td>
<td>303</td>
<td>117</td>
<td>167</td>
</tr>
<tr>
<td>1979</td>
<td>293</td>
<td>151</td>
<td>205</td>
</tr>
<tr>
<td>1980</td>
<td>211</td>
<td>148</td>
<td>N.A.</td>
</tr>
<tr>
<td>1981</td>
<td>308</td>
<td>119</td>
<td>N.A.</td>
</tr>
<tr>
<td>1982</td>
<td>245</td>
<td>135</td>
<td>186</td>
</tr>
<tr>
<td>1983</td>
<td>246</td>
<td>80</td>
<td>N.A.</td>
</tr>
<tr>
<td>1984</td>
<td>244</td>
<td>80</td>
<td>158</td>
</tr>
<tr>
<td>1985</td>
<td>245</td>
<td>133</td>
<td>175</td>
</tr>
<tr>
<td>1986</td>
<td>243</td>
<td>143</td>
<td>175</td>
</tr>
<tr>
<td>1987</td>
<td>248</td>
<td>120</td>
<td>174</td>
</tr>
<tr>
<td>1988</td>
<td>142</td>
<td>202</td>
<td>182</td>
</tr>
<tr>
<td>1989</td>
<td>115</td>
<td>270</td>
<td>170</td>
</tr>
<tr>
<td>1990</td>
<td>217</td>
<td>189</td>
<td>186</td>
</tr>
<tr>
<td>TOTAL</td>
<td>3640</td>
<td>2065</td>
<td>2027</td>
</tr>
</tbody>
</table>


A joint PAHO/WHO/Ministry of Health report concluded that the government was unable to supply the quantity of nurses needed to meet even basic health service demands (PAHO/WHO/Ministry of Health, Jamaica, 1989: 6). Undoubtedly, structural adjustment was the prime factor. However, one cannot ignore the interrelated role and influence of both push and pull factors. As the report concluded:

"...the continuing shortages of nurse manpower due to migration, low remuneration, inadequate facilities, poor professional development in all categories of professional and non-professional nursing staff have created a deficit in the delivery of health care and have reduced the Government's capacity to meet the health care demands of the country. This shortage of nursing personnel...is severely affecting the quantity and quality of the delivery of health services and care received by users of the health sector...the pull factors to the metropolitan markets are caused by a dynamic marketing strategy by these markets targeted at the Caribbean...Other pull factors are attractive and fringe benefits schemes, better conditions of service and work, better educational opportunities and career mobility." Among the push factors are low salaries, and fringe benefits, poor conditions of service and work, and the low status of the nurse..." (1989: 1-6).

Comment: Unlike the Manley regime's relatively radical policy agenda and its many opponents in the 1970s, the initial outlook for the Seaga regime in the 1980s in sustaining the gains of the previous regime and promoting new policies was good. The confluence of factors was in its favour in the early to mid 1980s: the support of the US after its own political backing of the Grenada invasion and the initially 'good reports' from the international financial agencies. Some achievements were laudable, such as the incentives for primary care nurses and the creation of the enrolled assistant nurses (EAN) programme. However, structural adjustment meant that there was little room for manoeuvre at the national level resulting in an underfunded service, and a dismantling some of previous regimes' more progressive policies, like 50% cut in the community health aide (CHA) programme in the mid-1980s. The effect was essentially a worsening of the migration problem. The cumulative effects of IMF-imposed adjustment
policies saw cuts in nursing staff and the nurse training budget, poor salaries and the imposition of a cess/fee for Jamaican medical and nursing students at the University effectively drove both nurses and doctors abroad. Despite continuing inter-party strife throughout the 1980s, the limited choices available to the albeit monetarist Seaga regime in the 1980s suggest that, as with the previous Manley regime, the IMF prescriptions (debt servicing and adjustment policy) rather than active pursuit of power were more critical to nursing and physician exodus than regime politics in Jamaica, although regime factors were also instrumental in health human resources outcomes by the end of Seaga’s two successive terms in office.


The PNM regime under Chambers (1981-1986): As oil prices fell, the once-booming Trinidadian petro-dominated economy of the mid-1970s was severely affected. Between 1983 and 1988, the country’s per capita income had dropped by 50% while unemployment doubled (McAfee, 1993: 17-18). Trinidad’s external debt reached US$ 2.4 billion in the same year, equivalent to 57% of the country’s gross domestic product (GDP). The annual debt bill was equal to a quarter of the country’s export earnings. In a desperate effort to cope with the debt burden in the mid 1980s, the new NAR regime negotiated a series of IMF loans, beginning in November 1988, as the country’s debt increased to more than US$3 billion (McAfee, 1993: 17-18).

Regime responses: Criticising what was effectively the failure of the Williams government’s nursing policy in the 1970s, a 1981 report on health manpower needs of “...present and projected health services...” stated, inter alia, that nursing services had not kept pace with the increasing and changing demands, that the creation of new nursing posts lagged behind population growth, that there was a dearth of nursing personnel in specific areas like psychiatric care, and that no provision was being made to implement the national health policy of providing primary health care by nurses in the community (Government of Trinidad/Ministry of health, 1981 a). Economic factors were clearly important. The 1981 report had pointed to the importance of economic conditions. However even this report noted that it was not the only factor forcing nurses to migrate. The other factors alluded to were essentially poor working conditions. Drugs and equipment shortages made actual work close to impossible. In terms of the work environment, a lack of proper facilities for staff, the lack of security in a social environment of rampant drug addiction and increasing criminal activities featured prominently as a secondary reason for the departure of nurses.

Under Chambers’ tenure, a new minister of health, Neville Connell assumed office from the long-serving Kamaluddin Mohammed, but this made little difference especially the new economic climate and the diversion of resources for day to day service maintenance. In 1982 and 1983, the country was in the middle of a nursing crisis. Connell acknowledged the crisis, noting the government’s response would be to fill vacant posts (Trinidad Guardian, 15/9/83: 1). Another response was the amendment of nursing council regulations to encourage the return and utilisation of overseas-based nurses equipped with specialised skills. One year later however, the failure of these ‘ad-hoc’ strategies and the failure to address the core problem of health reform was acknowledged both by the ministry and the minister (Holiday Inn Report, 1984; ). The paradox of the first half of the 1980s was that while nursing output was relatively steady, the inability to absorb these nurses in the public service, despite the numerous vacant posts reflected policy stagnation and inaction as much as financial problems. Ministerial allocations remained fairly steady even as the downturn was occurring. As resources began to diminish, even the ministry of finance and planning noted that the lack of a single clear-cut health policy was hampering the improvement of the existing human resources and sectoral financial/developmental resource allocations (St Cyr, E, Holiday Inn Report, 1984). Trinidad and Tobago by the end of the Chambers regime’s tenure also had yet to ratify the International Labour Organisation’s working conditions for nurses. Protest action by nurses and doctors, mainly the overworked junior doctors, continued throughout the 1980s as economic problems worsened well until the new regime assumed office in 1986.
Comment: The outcome of the Chambers years was little discernible shift in resources from secondary and tertiary care almost a decade after Alma Ata. Community health nurse numbers were woefully inadequate. In addition, in 1987 the training of primary health nurses seemed to have been suspended (Drayton/Ray, 1987). The paradox of oversupply and lack of effective or affordable demand was evident in the nursing sector. Those graduating in the late 1980s had no effective demands for their services, despite the shortage, because of lack of resources to fund these appointments. The only option left for unemployed nurses was migration. This disequilibrium constituted therefore a tremendous waste of resources (Anderson, 1988; Abel-Smith, 1994). Migration increased as the cost of living declined in the recessionary economy. In the case of doctors, then, the issue was also one of potential oversupply. However, the government, rather than addressing the chronic problems driving away existing public sector doctors in the first place stuck to the Williams plans for the medical training complex.

Regime change and NAR policy responses to health migration (1986-1991)

By the time the NAR under new prime minister Robinson assumed office, the rapid decline in economic and social conditions saw the shortage of health professionals escalate into crisis proportions. Within weeks of assuming office, the NAR regime and minister Emmanuel Hosein, in particular, were urged by nurses and doctors to improve the conditions that would retain nurses in the public health sector. Proposals in the case of nurses included the absorption of unemployed nurses in a temporary capacity at hospitals, the reduction in long shifts, better management in minor staff matters, the need to allow opportunities for study leave, greater recognition for trained nurses, and promotion based on performance rather than tenure (‘Nurses turn to Hosein for help’, Trinidad Express, 12/1/87: 3). The minister responded by commissioning a WHO consultancy on health human resources development in early 1987. A number of ‘old’ issues were identified in this report including the central one of a continuing lack of clear policy.

In the case of doctors, the chaotic policy, planning and management situation was clearly reflected in the fact that far from an anticipated shortfall of 75 physicians by 1985, the numbers had actually increased from 723 in 1980 to 1103 in 1986 with the medical school yet to be commissioned (Drayton/Ray, 1987: 3). The Drayton report warned the health minister and the government that since the avenues for physician were gradually closing through externally-generated action, government policy needed to recognise this factor in order not to exacerbate the supply. It urged the regime to give the highest attention, in current and future plans, to resource constraints rather than needs, given that the health budget was estimated to be shrinking by 3%, by the late 1980s as economic conditions worsened. It was recommended that given the present difficult financial situation, the resources for some of the unfilled posts in the hospitals could be shifted to community health services. In the case of nurses, the report stated that even in those categories where shortages most acute: mainly primary health nurses especially in mental health, none really needed extensive numbers to be trained. Further, the ministry was advised that before embarking on training, the government needed to ensure that posts could be provided for graduates so that the public sector could absorb them. One suggestion in this regard was that the government could, for example, rationalise by switching vacant institutional posts into community posts. Another was to keep nursing assistant training on hold until a need could be established. Finally, the report emphasised the need to consolidate all training under one agency. In the case of the medical complex, the report urged the government to ensure that relevance, appropriateness and national self-reliance were observed. Further, the government’s stated adherence to a primary health care approach was also being undermined by the continued imbalance between primary and tertiary human resources in the health sector.

Neglect of the nurse practitioner policy: By far the biggest failure for nurses under the NAR was their neglect in implementing the nurse practitioner policy, almost a decade after it had been similarly considered but not implemented by the Williams regime. The continued failure of successive regimes to implement the nurse practitioner program despite numerous supportive statements was the most glaring example of the low status and neglect of nurses within the Trinidad health system, compared even to their counterparts in Jamaica. The PNM despite minister Mohammed’s commitment - in the late 1970s had
been unable to implement the policy largely due to medical professional influence. Under Chambers tenure, the PNM continued to neglect the policy even though it was mentioned in the 1983 Demas report. This was partly due to preoccupation with economic crisis and the continued resistance of the medical profession, but also due to a weak health minister. Under the NAR, there was a possibility for change. A policy commitment to implement was stated in the new government's draft development policy, the 'Draft Medium Term Macro Planning Framework (1988: 188). There was widespread support for the programme. A report on the Tobago health situation noted the potential use in that island of nurse practitioners, given the inability to recruit doctors there (Nalder, 1988: 34-43). The Draft report called for nursing practice legislation to be reviewed and consideration given to the introduction of the program, as practised in Jamaica, in order to, inter alia, "...maximise limited physician time in clinics..." (DMTMPF, 1988: 7). Even a former medical professor at the regional university questioned whether Caribbean countries could afford to produce, then pay the salaries of highly qualified doctors from national resources "...on which there are increasing pressures, and which are being rapidly eroded by low productivity and inflation..." (Cruickshank, 1989: 7). He urged the government and the medical profession to look towards the nurse practitioner as "the obvious answer":

"...so much simple diagnosis and treatment is already undertaken by the nurse receptionist in practice, the casualty sister and the health centre home visitor - and yet this is done unofficially and without giving formal training...a year of clinical training could produce an efficient, practical clinician as is done with the midwife. The nursing profession is well-established and has the support of the public. All that is needed is recognition of their potential by the medical and nursing professions, and the public could be educated to accept the nurse instead of demanding to see the doctor for all their wants. Much of health centre practice could be handled by them and I'm sure they could take on the responsibilities of at least half of junior hospital doctors. If the will were there on all sides, it could be done..." (Cruickshank, 1989: 7).

Unfortunately, the situation remained the same, despite the optimism surrounding the policy. This view was a minority in the medical profession, and certainly reflected the unwillingness of the Trinidadian medical profession to work in partnership with nurses. The failure by the NAR to force through and implement the policy also reflected the health minister's misgivings about the use of the nurse practitioner as an effective retention strategy and the regime's lack of political will to improve the status of nurses vis à vis that of the dominant medical profession. Contrary to the recommendations of many in the health sector, and government stated policy, the reason given by minister Hosein, himself a medical doctor, for non-implementation was that there was no demand for this category in Trinidad, and hence no need for such a post (Interview, 1994).

The nursing exodus thus accelerated in 1988, having started the previous year, due to a combination of regime neglect and economic crisis. An average of four nurses were leaving every month for the USA as American private hospital officials and nursing recruitment consultants stepped up their drive within the Caribbean region. Those recruited went to either the USA or Saudi Arabia, with starting salaries of between US$1000 and US$5000 per month plus perks, three times the Trinidadian nursing wages being offered. One report noted that 100 nurses had flown into Barbados during one weekend to write the American entrance examinations. Another report stated that more than 500 hundred nurses had signed up to a Saudi recruitment agency ('Nurses exodus', Trinidad Guardian, 13/4/88: 1; 'Exodus to the gulf', Trinidad Guardian, 15/5/88: 1). While the veracity of these press reports could be questioned, the fact that senior nursing officials were being quoted gave cause for alarm. Ironically, one of the government's flagship IMF adjustment-originated policies, the voluntary termination of employment (VTEP) programme, meant to cut staff in the public sector, was used by these migrating nurses to their own benefit. It also coincided with both the economic downturn and the activities of the recruitment agencies. This made the decision to leave the service even more lucrative. By 1989, the registered nursing association president confirmed that 600 nurses had left the service in just two years (Trinidad Express, 27/6/89: 46).
Other administrative causes for dissatisfaction and migration included the fact a nurse had to wait for approximately twenty years before becoming a head nurse. Indeed, many were ‘frozen’ in ‘temporary at short notice’ posts, with little or no chance of appointment (Bryan, 1989: 8). Five hundred nurses who graduated in 1983 were still receiving student and trainee nurse salaries in 1988. Many continued to be temporary after seven years despite the vacant posts, at both the primary and institutional levels due to government inability to fund these posts (Trinidad Express, 15/5/88: 1). Bryan asserted that nurses worked under the same unsatisfactory conditions as doctors, but without the accompanying financial remuneration or job prestige. The net effect of the sudden nurse exodus was instant chaos as doctors expressed frustration at the disruption in schedules. In addition, the nurses union, the Public Services Association (PSA) alleged that the ministry was retaining community and district nurses to meet the institutional shortfalls at the main hospitals, and that training policies essential for promotion had not occurred for years, which they warned would result in crisis (‘Hospitals hit by shortage of nursing staff’, Trinidad Guardian, 14/8/81: 1). The pragmatic choice made to commission the medical complex held little meaning for both health personnel and a general public told of limited resources, especially at a time when the government eager to commission the complex managed to find and allocate over TT$ 127 million for equipment in preparation for imminent opening in the 1989 budget. Better conditions were needed for health personnel, particularly junior doctors and nurses. In 1989, the nurses association again urged the NAR government to make them a reasonable offer noting that “...in the light of the current circumstances in the health field, nurses must evaluate their present position professionally and personally...” (‘Nurses to government: make us an offer’, Trinidad Guardian, 13/9/89: 14). Even the president of the nurses association, announcing the departure of another 40 nurses to the UK and Saudi Arabia, noted that:

“...it is most unfortunate that developed countries, with their financial resources to train people should come to developing countries with their sever economic problems and take experienced personnel...” (‘Flight of nurses form Trinidad and Tobago continues’ (Trinidad Guardian, 12/1/90: 12).

The NAR regime’s response given the national context was to only promise that things would get better, a response that did not entirely satisfy health professionals as the migration process accelerated. Hosein’s perceived unsympathetic manner did not help matters either. He told nurses to make up their minds whether they intended to remain in the country or “...migrate to greener pastures...”, adding that the terms and conditions of nurses would be adjusted soon and that “...those who have left will be eating their hearts out...” (‘Better deal for nurses’, Trinidad Express, 5/4/89: 1). He further added that the government was not begging anyone to stay. In terms of plans to address the problem, he announced a number of reform initiatives. In the case of training, he announced the resumption of the nurse training programme which would be run by NIHERST, the newly-created higher education body, instead of the health ministry. Additionally, training in advanced nursing would be implemented by the UWI and nurses would also benefit from the modern technology of the medical complex. In terms of improvement of conditions, he detailed plans to encourage retired nurses to re-apply for jobs in order to meet the shortfall. He also noted that nurses would take home more pay with a reformed tax system, and that a health insurance scheme would be introduced. He promised nurses, finally, that their terms and conditions would be adjusted for the better and called for them to administer the service which the population needed, and not envy their colleagues who “...abandoned their responsibilities to the nation...” (Trinidad Express, 5/4/89: 1). Other policy responses to the nurse migration problem were announced by the NAR regime during the 1990 budget debate when Hosein stated that nurses trained at the UWI must enter into a three year contract with the government. He added that they would receive a monthly stipend but that they would have to pay for their uniforms and books. As if to reassure, he added that conditions were not as bad, given similar problems in Jamaica and the USA (‘Three-year contract for UWI-trained nurses’, Trinidad Express, 4/1/90: 5). He also reiterated the government’s policy of overseas recruitment.

Most of these policies had little effect as economic conditions and the political and social climate worsened. The attempt to lure nationals from home and abroad proved fruitless, due both to poor salaries, because of devaluation, and the continued poor working conditions. Many doctors and nurses also
criticised this approach as cosmetic without addressing the real question of health sector reform. As Bryan (1989:13), noted, the health human resources situation in Trinidad and Tobago at the end of the 1980s gave reason for great concern. The economic situation, government's voluntary termination programme, and the acute shortages in health manpower in metropolitan countries combined to push valuable health manpower out of the country. The opening of the medical complex added further stress to a system already in disequilibrium. Responding to the crisis, the acting minister of health Herbert Atwell announced what was effectively an ‘ad-hoc’, crisis-driven ‘action plan’ for the health service, which included funds for equipment, physical upgrade and funds for the training of 270 nurses in 1990 (TT$ 30 million action plan for ailing health sector, Trinidad Guardian, 30/6/90: 1).

Consequences: None of these policies seemed to placate health professionals or stem the tide. Instead, by February 1989, the paradoxical situation of both public sector doctor and nurse vacancies rose -even though training policies were still at traditional-, in some cases, like nurses, even increased levels - as both working and living conditions worsened. In the case of doctors, the public sector shortages continued, many migrating to the local private sector. As Hosein had himself noted as a medical student in 1974, over 40% of medical graduates migrated from the Caribbean on average mainly because of financial security - low salary, bad housing, heavy workload, and inadequate facilities. He added somewhat prophetically:

"...as well as reflecting on the attitudes of students, this is also an indication for action on the part of those responsible for the medical programme, and the politicians of the region who have for too long done nothing to prevent medical graduates from going abroad..." (Hosein, E. et al, 1974: 193).

In the case of nurses, by 1989 and 1990, there was a virtual “stampede” out of the country (‘Appreciating the value of TT’s nurses’, Grayson, J, Trinidad Guardian, 7/9/91). The majority of nurses leaving were institutional, so that hospitals suffered considerably. As noted before, in addition to the traditional destinations: the USA, Canada and the UK, many, like nurses in other developing and developed countries left to take up lucrative appointments in Saudi Arabia. Many strategies for emigration were used, some genuine, many however were simply a means of escape. Postgraduate training was highlighted as one reason, Senior nurses opted for early retirement under the new voluntary termination of employment (VTEP) policy. Many also applied also for unpaid study leave but were prepared to leave even without its approval. Others used the archaic ‘grounds of marriage’ regulation for early retirement. Yet more left on vacation and/or sick leave, and never returned (Bryan, 1989: 9). Many nurses who had graduated in 1986, had left by 1989. Those graduating in 1989 and had not already left were merely waiting for their results before leaving (Bryan, 1989: 9). In 1983, 18% of Trinidadian nursing posts were vacant. By the end of 1989, only 2500 nurses remained in the system, out of total of 3277 posts, a shortfall of 777 nurses or 24% (Grayson, J, Trinidad Guardian, 7/9/91).

This shortfall had also increased from 199 to 266 from both two main general hospitals. The total number of resignations, though not necessarily departure increased from 146 in 1988 to 320 in 1989. By 1991, despite the addition of well over 250 new posts, the nurse vacancy figure had increased to over 40% (Ministry of Health, 1994). In the case of doctors the available figures for 1991 showed a 29% vacancy rate (1989: 9). Of the 320 nurses who left in 1989, 21 left Mt Hope hospital, many specialty nurses, their departure especially felt since it took twice as long and was three times as costly to train them. The result of these departures made conditions for remaining nurses worse with ‘doubling up’ resulting in greater stress. The ministry responded by training in specialties such as geriatric care, oncology, midwifery and neonatal medicine. However, the losses were still severe. Many of the migrants were managers and trainers, so that even some of these innovative responses could not be adequately implemented because of reduced staff. Equally hit was the still neglected public health nurses at a time when greater use was being made of community health facilities (Nicholls/PAHO, 1989). For nine weeks prior to the July, 1990 coup attempt, health workers led by nurses marched in northern Trinidad to protest deteriorating conditions. After the coup attempt, negotiations with the government’s chief personnel officer was accelerated, although by now the situation was rapidly changing with the advent of regionalisation. In a final twist to the Trinidad nurse migration paradox in the late 1980s, it emerged that the newly incorporated Mt. Hope
Complex Authority was actively lobbying at nursing fairs in England, Scotland and Ireland to recruit British and Irish nurses, aided by a brochure entitled ‘Work and Play in Trinidad and Tobago’, and by salaries offers which were more twice that earned by local nurses (‘Mt Hope woos nurses in UK’, Trinidad Guardian, 10/10/91: 1). The outlook was not good.

Comment: The question facing the policy analyst in the case of Trinidad is whether market reformist characteristics or structural factors - agency or structure - influenced the policy choices the NAR regime in relation to the migration issue on assuming office in 1986. The fall in oil prices was undoubtedly a mitigating factor. It triggered a drastic fall in revenue, which in turn led to a balance of payments problem and the eventual implementation of IMF adjustment programmes and limited the policy room, as did the PNM thirty year legacy. The result in the case of the health sector was a gradual reduction in resource allocation. With devaluation came both a decline in the real value of wages, as well as a general decline in working conditions. In a sense the regime was unlucky. Though committed to health reform, it had to now govern within the context of economic crisis alongside the guiding hands of the World Bank and the IMF: agencies not known for their widespread sympathy of the critical social role of the state in developing countries. The chain effect of economic crisis was that other than rationalisation programmes, it could only manage ad-hoc policy measures during its tenure which did not address the main concerns of the professions, excluding salary increases. On the other hand the regime could be blamed for persevering with a relatively modified, phased medical complex policy implementation to the detriment of other areas. In addition the regime continued to train nurses, given IMF commitments, although it seemed unable to employ them. While the IMF conditions could be held responsible for this state of affairs, the NAR’s lack of attention to nursing policy was a serious miscalculation. The end result was the paradoxical effect, like Guyana and Jamaica where nurses were badly needed for the public services, and were being produced, but ended up instead in the US, Canadian, British and Saudi health systems because of limited resources to effectively employ and keep them at home, which returns us to Anderson’s (1988) Cumper’s (1993) thesis of lack of effect demand.

The strong, and in most cases, debilitating influence of economic structural factors is probably the single most powerful factor that influenced the health migration problem and regime responses to the problem in Guyana, Jamaica and Trinidad in the 1980s. However, I have tried to show that to accept this simple explanation is to deny the complexity of the policy process even within developing states. In Guyana in the first half of the 1980s, economic problems were compounded by Burnham’s party paramoncyn and survivalism, which helped to undermine his government’s own policies including health, as well as the confidence of human resources in the health sector, which hastened, inter alia, doctor and nurse migration during this period. In the second half of the 1980s, after Burnham’s death, his equally non-democratic successor President Hoyte had little economic and political room for manoeuvre and hence had to begin the political and economic reform process. This was achieved partly due to political pressures linked to IMF and other forms of financial assistance. While migration continued unabated and regime responses were limited, the advent of elections and regime change in 1992, signalled the hope of improved conditions and reforms which would stem the tide. In Jamaica the situation was clearly one of economic adjustment, given the lack of financial support at the end of the cold war, though evidence pointed to poor mismanagement of resources.

As economic crisis deepened, more Jamaican nurses and doctors - but particularly the former - left to search for jobs and better rewards. In Trinidad by contrast, the availability of funds in the 1970s had disappeared in the 1980s with serious consequences for the health sector. As the Chambers regime battled, like those in the other two countries to maintain basic services, the only policy that received sustained support was the medical complex project. This was rightly viewed as an example of the regime’s misplaced priorities at the time. The Chambers regime’s options were limited in the case of health migration. So was its successor regime, the NAR. The example of the neglect and lack of support for the nurse practitioner programme by the end of the 1980s reveals both successive regime neglect and medical influence, given the fact that implementation would have cost much less than the billion dollar medical complex. By the end of the 1980s then, although the negative effects of adjustment programmes were being felt and heightening the health migration process, national governments in all three states were
now fully on the road to reform after years of ignoring it for lack of political incentives to do so. The only problem was that such reforms were not totally in the interests of health workers as we shall see in the next section.

6.6 REGIME CHARACTERISTICS DEVELOPMENTS IN GUYANA, JAMAICA AND TRINIDAD IN THE FIRST HALF OF THE 1990s

Two factors helped to ease medical and nurse migration in the 1990s. The first was the restriction of entry to doctors and nurses in the UK and the USA. The second was the implementation of fundamental health reforms within these developed states. In the case of the former, while not banning entry, the restrictions were partly a recognition of the unfairness of the global health migration phenomenon. Regime characteristics were superseded by economic factors in the 1990s as political democratisation was no longer a major issue, with the focus increasingly on administrative and sectoral policy reforms. Nurse migration in particular persisted, though in Guyana, this slowed with the new democratically-elected government. Nurse migration thus remained a serious problem. The steady attrition to private sector and overseas saw the near collapse of the health system at all levels (Carr, P; Tesheira, G. interviews, 1994). The legacy of the past two decades meant that instant solutions were unrealistic. However the national health reforms, although part of adjustment conditions, offered a new start and with it, the hope of curbing health migration. With Guyana still one of the world’s heaviest per capita debtors by the mid 1990s, the prospects were still gloomy.

Jamaica fared did not fare much better in terms of economic conditions, although active policy responses to remedy the prevailing system in the early 1990s gave cause for hope. The newly elected Manley (later to be succeeded by P.J. Patterson) PNP regime abandoned its socialist rhetoric and, like many developing countries in the 1990s embraced the ‘free market’. Some health professional improvement was due to unlikely sources. For instance, in 1990, the number of Jamaican doctors actually increased; due to the establishment of Trinidad’s medical school. This meant that approximately 92% of the medical staff required was now being satisfied. However, the number of shortages among other groups especially nurses persisted. The government’s own economic and social report for 1991 gave as the consequence of this chronic shortage, a continued rationalisation programme which saw the closure of more wards and/or amalgamation of wards, which were unmanned by nursing personnel on evening or night shifts; reduction in the numbers of elective surgery; unattended deliveries; high incidence of absenteeism and low morale among nurses and poor quality nursing care (Government of Jamaica/Economic and Social Survey, 1991: 20.1).

Noting that nursing vacancy rates of approximately 45% was a major cause for concern, the regime announced a number of measures to reduce the manpower shortage through a variety of programmes (Government of Jamaica/PIOJ, 1991: 100-101). They included training to fill approximately 60% of vacancies over the 1991-1996 period, including the restart of the enrolled assistant nurse (EAN) programme suspended since 1980 by the Seaga government; the provision of incentives to retain staff, particularly those trained at the government’s expense; the establishment of new health human resources categories; renewed support for the community health aide (CHA) programme, which had been cut by approximately 50% under the Seaga government; and even negotiating with private medical practitioners to do sessions at public hospitals as a stop-gap measure. A package of incentives designed to retain staff was also announced, including salary increases for nurses above the 12.5% wage guidelines; increased allowances for key hospital staff; and better access to housing for all health workers. (Planning Institute of Jamaica, 1991: 100-101). Attrition of nurses had however slowed considerably when compared with previous years: in 1991, 80 nurses had resigned, compared with an average of 375 over the previous four years, although 112 were recruited (35 from abroad). However, despite these noteworthy attempts at policy reform, the impact of structural adjustment continued to exert a great impact on the decision of nurses to migrate. Even though all nurses were bonded according to the cost of their fellowships, the migration problem persisted well into the 1990s (G. La Touche, interview). Even the World Bank’s 1993 policy paper on health reform highlighted the impact of nurse migration on Jamaica’s health development.
process, noting the nearly 50% vacancy rate, and the fact that the 111 registered nurses who resigned form the government service in 1990 took with them nearly US$1.7 million in government investment in training and education (World Bank, 1993: 141).

In the case of Trinidad, the migration problem in the 1990s was similar for nurses, though, as predicted by Drayton and Ray in 1987, there was now also the danger of a glut of Trinidadian doctors with the commissioning of the medical school. Many overseas-based doctors thus returned home in the late 1980s and early 1990s, given the changes in UK and US policy. Many returned home but the state of public sector work environment forced many into the private sector. Given the paradox of a doctor ‘glut’ in the country in the 1990s, after the expenditure of considerable resources since the 1970s together with the persistent dissatisfaction of those working in the public sector health, the general feeling was that health policy priorities were still confused, despite the implementation of the decentralisation policy in 1994. Economic factors and low status continued to be the main problems. In the case of nurses, the chief nursing officer of the ministry of health noted the relationship between lack of status and the difficulty of retaining nurses:

"...a nurse will endure and remain in a situation where they have the tools to do the job; it is when they are without these, that they lose hope...it is not just a matter of increasing the supply of nurses, but ensuring that nurses have the tools to work and that they have a say, and are not just a presence in policy-forming decisions..." (Grayson, J, Trinidad Guardian, 7/9/91: 1).

The chief nursing officer pointed out that 1991 was the first year that a nurse was on the traditionally-medical dominated Trinidad’s delegation to the World Health Assembly annual meeting. The fact that this was considered a significant achievement by Trinidadian nursing professionals showed the extent of the extent of exclusion from the policy process. However Bryan underscored the complex interrelationship between these influencing factors:

"...nurses comprise the single largest category of health manpower and thus the major providers of the country’s health care. Yet [they] are subjected to some of the most debilitating and frustrating effects of the health care system. The policy decisions, made without nursing participation, have created confusion in the implementation programmes, and have hindered efforts of health care delivery...lamentably nine years later, this statement can be accurately repeated...it is of particular concern that nursing manpower, both the largest provider of health care, and the most important element in the primary health care thrust, is being the most quickly depleted. Economic conditions are indeed a critical factor, but overall unsatisfactory and substandard working conditions are also significant contributing factors..." (Bryan, 1989:14).

Comment: The joint and interrelated impact of regime neglect economic factors, poor working conditions, poor status, medical dominance as seen in the nurse practitioner issue in Trinidad, contributed to health migration. Hence, like Guyana and Jamaica it is inaccurate to say that only economic factors were influential, although arguably the most dominant. Regime characteristics also along with the other factors, played important roles that cannot be neglected. Although migration continued into the 1990s, given the persistence of poor economic conditions, there was a general feeling that the adoption of national health reforms -some off which were arguably not in the nest interests of national health care -offered on balance for all three countries an improvement in the ‘policy neglect’ status-quo of the past by finally placing health sector reforms on the agenda.

6.7 SUMMARY AND CONCLUSIONS
In assessing the role of *regime characteristics as a push factor* in health migration in the 1970s and 1980s and government responses to the situation, one needs to first recognise the pervasiveness and generally negative effects of the *main push factor*: the structural economic, political and social influences explained by development theory. The key conditions of International Monetary Fund (IMF) adjustment policies such as wage restraints, reductions in government spending and elimination of government subsidies undermined the standard of living of all workers and enhanced migration. Other elements such as devaluation and increased indirect taxation also worsened social and economic conditions. IMF pressure, for example, to cut government spending had a disastrous effect on the provision of social services, so that hospitals and schools were partially or totally closed, or forced to operate with drastically reduced budgets. The inability by organisations such as the IMF, for example, to recognise the social impact of the above factors on skilled, middle class worker retention, as well as the elimination nursing posts for example at a time of structural adjustment where social conditions had deteriorated rapidly is surprising to say the least, although the World Bank's recognition of these problems must be acknowledged (World Bank, 1993).

However, as I have argued here and throughout this study, agency-based factors or push factors: namely, the national regime characteristics and political calculations are important to any explanation of health human resources policy in the Commonwealth Caribbean state since they were also to blame for the health migration through both errors of omission and commission. The neglect of health policy under the illegal, undemocratic and coercive rule of Guyana's undemocratic coupled with poor economic performance throughout the period resulted in a situation of policy apathy and neglect. Political persecution as well as economic factors were therefore triggered all migration including health professional migration. In Jamaica in the 1970s, the explanation was somewhat different, again the distinguishing feature being regime characteristics. Although a radical socialist party like the Burnham regime, the Manley regime in the 1970s was democratic. In Jamaica in the 1970s then, the explanation was dominated more by economic than political characteristics-based factors, although these were also influential, along with other factors such as medical dominance. In Trinidad there is similar interrelation between economic, political and other factors. Sudden economic wealth in the 1970s contrasted with the problems for Guyana and Jamaica as a result of the same event - the 1973 'oil shock' - but surprisingly had similar grave implications for health migration. There was less pressure and incentives for the survivalist, though still democratic Williams government to instigate political change and much-needed public sector reforms, including that for the health sector. The 'oil bust' less than six years later revealed the extent of the public sector neglect. It forced national and low-politics health policy reform onto the agenda of succeeding regimes in the 1980s which gave these regime limited policy room for manoeuvre in both avoiding the reform issue, or conversely, finding adequate conditions to implement.

Far from being separate influences, I have also however argued in this chapter that the interrelated impact of these agency and structure-based influences are critical to understanding the Caribbean migration process. In the 1980s, structural adjustment programmes undermined policy in all three countries in the 1980s. However, this alone could not adequately explain the failure of successive Trinidadian governments to pursue inexpensive policy reforms as the PNM and NAR experiences with the nurse practitioner policy revealed. The influence of other nationally-based causes of nurse migration such as medical dominance, and low status of nurses, in spite of the popularity of the primary care approach also contributed to what was effectively a pattern of neglect and/or ineffective, piecemeal action. Although the regimes in all three countries in the 1980s recognised the need for reform, they delayed, for as long as was politically feasible, consideration of public sector reform until the late 1980s when IMF-driven reforms not only placed health sector reform on the agenda, but forced regimes to take far harsher action, than might have been necessary, had for instance, persistent calls for decades by doctors and nurses for health care reforms been heeded. The economic reforms had a negative impact, culminating in increased migration by the end of the 1980s. However, health sector reforms, finally implemented in the early 1990s offered some hope of improved working conditions in terms of stemming the migratory flows, despite concerns about the role of IMF and World Bank involvement in the process (Phillips, 1994).
In terms of external pull factors in the 1980s and 1990s, the impact of the demands of the adjacent and vast US health care system, together with its highly inflated wages was another decisive factor for Caribbean nurse migration also need be to included in an explanation of policy action and structure in the case of health migration from the developing state. The demands of even the distant Saudi health system proved attractive, despite restrictive conditions when compared to the low wages and poor conditions due to the almost intractable combination of politcally- and apathy-based regime neglect, and a real inability to act within these states. The migratory trend which had changed in the 1960s, from the UK and towards the new destinations was therefore well-established by the early 1990s. Despite the personal gains for Caribbean health workers and their remittances to these countries then, the ability of the US system in particular to manipulate its legislation to attract skills from resource-deprived developing states remained a significant problem and represented a recurrent cost to the development process (Pastor, 1985).

Regime characteristics and motivations then cannot be ignored. It has been stated that Caribbean migration is deeply rooted in “...powerful structural-geographic, economic, familial and psychological reasons...” and attempts to study the region without an appreciation of this phenomenon cannot be plausible (Pastor, 1985: 22). However, given the above, there is some sympathy with the suggestion that “...governments have been reluctant to even consider policies on the subject...” (Blackman, 1985: 267). Pastor’s conclusion (1985: 22) of migration that “...communities that have experienced heavy out-migration are generally stagnant...” could well be applied to the Guyanese situation after Burnham and Hoyte regime policy in particular (Pastor, 1985: 259). While economic factors were pervasive, national health sector reform initiatives which did not necessarily involve the disbursement of scarce resources would have helped, but were either not implemented or considered. As Pastor notes, the prudent use of human resources and self-reliance is critical to development (Pastor, 1985: 259). In all three countries, the lack of coordination between planning, production and management went well beyond a bureaucratic, administrative issue and well into the realm of the political as we have seen to varying degrees in each case. This co-culpability, inaction, and lack of innovation at the national level to the migration problem was even noted in the regionally-appointed West Indian Commission’s 1992 report whose remit included the health sector:

“...governments have recognised that they cannot indefinitely produce trained personnel which are acceptable to markets in which shortages exist and then complain of lack of staff. It is possible to contemplate training persons to fulfil specific local needs without regard to any mythical international standard, with the knowledge that these persons cannot leave. Too many Caribbean countries refuse to take such actions, however and continue to train along traditional lines while bemoaning the loss of those individuals once they are trained. We do not believe that given the significant differential in financial benefits between the Caribbean and North America, the Caribbean will ever be able to solve its manpower shortages, especially in nursing, by offering greater financial incentives...” (1992: 22).

On the issue of migration as active government policy, Duany has noted that Caribbean governments cannot indefinitely rely on migration as a safety valve on both humanitarian and political grounds, as “...a development strategy that expels thousands of workers abroad is morally flawed and ideologically committed to preserving the status quo...” (1994, 114). Palmer (1990: 14) similarly points out that policy responses to the migration problem have only dealt with the effects rather than the real causes of the problem, which though structural, allowed some limited amount of opportunity for manoeuvre for developing states, and which was in many instances either ignored or neglected. In terms of the pervasiveness of both pull and push factors then, Logan’s summary of the Jamaican nursing position in 1980 can well apply to developing state health human resources policy migration dilemma in the 1990s:

“...Insofar as there are some countries which consider they need more health manpower and can pay for it, there will always be “pull factors” somewhere in the world. So, countries with “push factors” will always be at risk and should attempt...”
To eliminate them if they wish to curb migration... national administrations concerned about outflow will therefore need long-term planning involving revision of policies regarding supply and distribution, productivity and utilisation of manpower... action is needed; action at the national level... the need for national nurses associations to get involved in the policy process, through collaboration with governments in assessing the extent of movement and devise measures to modify patterns of nurse migration in desired ways... the international flow of nurses and indeed of health manpower is currently unpredictable and largely uncontrolled, and seems to alter quite rapidly in terms of size and direction. It is the result of an interaction between "push" and "pull" factors. The policy implications at the national level for both donor and recipient countries are clear. Only well-calculated policies and plans can control the flow in desired ways..." (Logan, 1980: 121).

To summarise then, my findings in this comparative case study suggest first, that the economic and political as well as a number of other factors influence the process, to a complex extent that deserves further study to elucidate. Nevertheless, there is adequate evidence for the influence of regime legitimacy and democracy as important push determinants in the nature and extent of the health migration process, especially in its interaction with other influencing factors. Economic factor and environmental factors are, of course, critical, even overwhelming in some cases. However, equally important at the national level are the presence of apathy and inaction as well as miscalculation in terms of assessment of health human resources needs for various categories, leading to expensive solutions such as Trinidad’s medical school.

Regime responses to health migration in Guyana, Jamaica and Trinidad were probably more influenced by regime characteristics - particularly regime strength, ideology, democracy and maintenance - in the 1970s; and by economic factors in the 1980s. However to apply this simplistic, one-dimensional assertion to these countries is to deny the complex interaction of both economics and national government action with each other across the two decades, as well as with other important situational, structural, socio-cultural and environmental factors in the process which also need to be explained in any accurate analysis. As we saw in chapters four Trinidad was strong, while Guyana and Jamaica were economically weak, given the onset of the oil boom. Guyana and Jamaica were espoused variants of socialism which conditioned both countries’ health and development policies for the rest of the decade. Both were relatively unstable. However the Burnham’ regime’s undemocratic, survivalist rule compared unfavourably with the Manley regime’s democratic socialism. The impact on health migration then was bound to be conditioned by these factors. I therefore found that while both experienced serious health personnel migration problems in the 1970s, the reasons, in the case of Guyana, were also complicated by Burnham’s survivalist, undemocratic rule, and the channelling of scarce resources for survival. Henry and Johnson’s (1985) observation that education and training have always been viewed as a passport to geographic and social mobility applies to all three states - as well as to other low-to middle income developing states. The pervasiveness of economic and other factors is also a continued reality to be borne in developing state policy responses to migration. However, my findings reveal that policy responses are conditioned as much by national political/regime calculations as well as by national and international economic and professional factors. In short, this means that solutions to the migration problem must, at the very least, be addressed at all of these levels.
CHAPTER 7


7.1 INTRODUCTION

In this second case study, I examine the context, determinants outcome of the policy decision in 1971 to establish a medical school in Trinidad and Tobago. Examining the initial policy decision by the PNM/Williams regime and the follow-up actions and decisions taken by its successor regimes - the PNM/Chambers and the NAR/Robinson governments in post-independence Trinidad - I compare and assess the extent to which regime characteristics, particularly political survival influences low-politics policy issues such as health, given other influences including economic, factors, medical interests and environmental factors. A secondary interest in this chapter is to examine this influence of regime politics on the developing state low-politics policy trajectory when 'room for manoeuvre' exists within a specific time period. In doing so, I assess the relevance of regime characteristics, particularly survival, on outcomes, compared with other influences in low-politics policymaking and reform particularly where a policy's legitimacy, feasibility and support has not been clearly established, although the regime is strong, given sudden resource availability. I further examine the influence of regime change on policy reform when enabling conditions suddenly change. Finally, I examine the consequences and implications for developing states and developing state regimes of low-politics policy choices influenced by regime characteristics, particularly survival. The chapter is divided into five sections. In Section One I examine and compare the confluence of political and other factors at the regional and international levels - including regime characteristics and timing - which influenced the Williams government to build a medical school. In the second section, I examine and compare the influence of regime characteristics and medical dominance in the implementation process, particularly in expanding and changing the policy, beyond its original remit. In the third section, I examine the influence of regime change, the choices facing the two new regimes, and the bases of their eventual decisions, given their limited room for manoeuvre. In the final section, I analyse the implications of the original and successive policy decisions for Trinidadian health and health human resources development, and by extension, the developing state.

7.2 POLICY CONTEXT: AGENDA-SETTING, DECISIONMAKING AND REGIONAL DEVELOPMENTS

In order to understand the developments leading to the decision to establish a medical school/complex in Trinidad and Tobago in the 1970s, we first assess the three main 'political' elements of the policy context: regional health politics; the prime minister’s personal interest; and the perceived threat of private ‘offshore’ medical schools and political conflicts - as sources of the policy.

Regional politics in the post-federation era and the case for a second Caribbean medical school

As noted in the in Pujadas report on Trinidadian migration in Chapter Six, there was a real doctor shortage problem due inter alia to non-return of medical students. However, as this and other reports, including the Dolly report, pointed out the issue was not so much a training problem, but more one of poor planning and management, utilisation and non-reform (Dolly, 1992; Pujadas/UNITAR, 1971). Although economic factors, were influential in terms of effective demand and adequate remuneration, the years of unwillingness of the Williams government to effect public sector reforms also contributed to the
public sector health human resource shortage. Despite the graduation of about 30 Trinidadian doctors per year by 1971 (a figure deemed sufficient for the country’s needs by the Pan American Health Organization) at the Mona Campus in Jamaica, chronic shortages were attributed almost entirely to lack of a Trinidadian medical school rather than the equally, if not more justifiable explanation of regime neglect of health services reform.

The origins of this perception that a medical school was the solution to this problem go back to the politics of Commonwealth Caribbean tertiary education. The establishment of the University of the West Indies was an important element of the integrationist thrust that swept the region in the post-Moyne period. Funded by all Commonwealth Caribbean governments excluding Guyana, its main aim was to provide higher education for Caribbean nationals, hence saving member states enormous overseas training costs for all categories of tertiary education, while at the same time fostering the training and development of home-grown, and hopefully more appropriate human resources. Prior to the opening of the regional medical school in Jamaica, most medical students undertook their training mainly in the UK, Ireland and to a lesser extent North America. After the failure of political integration, the university represented one of the few areas that sustained the regional ethos. However inter-territorial rivalry was inevitable in the allocation process. The three campuses of the university were allocated the teaching of the main disciplines under the university arrangement: Barbados (law); Trinidad and Tobago, (engineering and agriculture); and Jamaica (medicine, pre-clinical and clinical). In the case of medicine, the regionally-funded university financed the medical school, while the Jamaican government largely funded the teaching hospital. Clinical training was also provided in Trinidad and Barbados, with their main general hospitals designated teaching hospitals to satisfy nationals of eastern Caribbean states who wished to continue their clinical training closer to home. While no contributing state was entirely happy with these arrangements, the economic and developmental benefits far outweighed the costs.

Contributing to this situation was the inter-territorial political/ideological rivalry between Williams and Manley in the 1970s. The tensions between Jamaica and Trinidad go back to the days of Jamaica’s undermining of the Commonwealth Caribbean federal experiment. Williams’ personal bitterness at the failure of the West Indian Federation experiment in 1962 - due to Jamaican misgivings about these plans for regional economic and political integration - was an ongoing feature of his relations with that country. There were however other factors. Williams also wanted to carve out a more influential role for Trinidad (and himself) in the region, especially after the 1970 attempted coup, and especially after the 1973 windfall as a result of rising oil prices. In wanting to do so, he found himself increasingly at odds with the newly-elected and democratic socialist Manley regime. Williams openly engaged in dialogue with both Cuba and the USA, but remained steadfastly non-aligned. Manley on the other hand, although a committed non-aligned leader, never concealed his pro-Cuba sentiments. Manley also had an international political profile. His model of democratic socialism attracted considerable attention throughout the developing world, and was actively promoted through his high-profile involvement as a possible ‘third path’ model for development. While these factors did not directly influence the medical school policy, the fact that the region’s medical school was located in Jamaica, and the Williams government’s perception that the country was not adequately benefitting, from its financial outlay, given the number of Trinidadian doctors trained, (which marginally less than Jamaicans) helped to focus the government’s interest in a new medical policy.

Given, the above, another influential factor that paved the way for the medical school policy was first Williams personal support that gave legitimacy to the policy in tandem with the Inter-American Development Bank (IDB) which was to financially support this idea, and hence give it feasibility.

The interrelated role and influence of Williams and the IDB: The Williams government appointed its own team of experts including two representatives of the clinical medical faculty in Trinidad to examine the possibilities of expansion of the hospital into a medical school, which happened simultaneously with the University of the West Indies own examination of the feasibility of the project (Williams, 1976: 39). The regime’s perception of the problem was thus conditioned by its politics and was a dominant factor. Williams was personally, by this stage, fully convinced by the argument for a
medical as well as dental school, as a status-building health human resources option over the less glamorous, and potentially risky and dangerous loss of power through decentralised reform which was the only other alternative to address the concerns about health personnel shortages. In 1971, an Inter-American Development Bank (IDB) 'special committee', consisting of the University Council of the West Indies, medical 'academics' as well as representatives of the Bank presented a report to Caribbean Health Ministers at their annual regional conference, on the feasibility of the expansion and/or duplication of the Faculty of Medicine, as well as dental training and general bio-medical research facilities (Government of Trinidad and Tobago, Hansard (House of Representatives), 1978: 1164-6).

The report essentially confirmed the Bank's, and Williams' enthusiasm for the policy. The IDB Committee recommended that a new university medical centre should be established to cater for the needs of the Eastern Caribbean, and that this new teaching school be established in Trinidad where IDB was funding at that time, the establishment of a maternity hospital and a number of health centres throughout the country. The regional Caricom health ministers and the university council accepted in principle the Bank's recommendations for pre-clinical facilities to be centralised in Trinidad. The Committee emphasised however that when established, the school should produce doctors cognisant of the particular needs of the Caribbean. In the interim, the 1971 report recommended and, the policy was subsequently adopted by the University Council and medical faculty, that an increase in the Jamaican-based medical school's intake from 50 to 110 students was necessary, of which Trinidad's quota would be 30 students as noted above, which was generally supported (Williams, 1976: 39). The original idea for the medical school was Williams' ('Medical complex idea was sown by Williams', Trinidad Guardian, 27/9/91: 5; Williams, 1976). Indeed, as Williams himself noted at a regional medical research conference in 1976: "...I myself in my personal connection with the University in the earlier days, participated in those discussions which led to the report of the Special Committee..." (Williams, 1976: 39). However the support of the Bank during this pre-oil boom period was important in further enhancing the perception that a second Caribbean medical school was necessary. Another helpful influence, which helped to underline the Williams' government's perception was the offshore medical school which emerged in the mid 1970s.

The 'offshore medical school' justification

At the regional level a study was commissioned by the Caribbean Community on the establishment of medical American universities in the smaller islands, including Grenada. Reporting to the Fourth Conference of the Caricom Ministers of Health in Saint Lucia in 1978 on the perceived 'threat', the Bahamian health minister spoke for most delegates when he asserted that:

"...from the national standpoint, there is little doubt that an educational institution should be meant to service the needs, hopes and aspirations of the country and region in which it is located. It should pay attention to the problems of the society and social aspirations of its people..." (Caricom/Charles, 1978: 13).

This investigation concluded that existing and planned facilities in the Caribbean for the training of medical manpower requirements in the Commonwealth Caribbean - including the school in Trinidad- were adequate and could be extended to meet future needs without the presence of any 'offshore schools (Caricom Secretariat/4th Conference of Health Ministers, 1978). The view was one which undoubtedly reinforced the Williams government decision. As if to justify the policy decision, Trinidadian health Minster, Kamaluddin Mohammed stated that an offer had also been made to the Trinidad government by one such American school to provide TT$100,000 per year to the Trinidadian medical services if they were allowed to operate in Trinidad. Mohammed concluded that there was no valid justification for such development, in the region, of these "...profit-oriented entrepreneurs with little or no experience in medical education, to attract principally US students who have failed to secure admission to an American medical school..." and that "...participation in the establishment of such medical schools has already generated unfavourable publicity which can be ill-afforded by the countries of the English-speaking Caribbean..." (Mohammed, 1978: 1). There is little doubt that this sudden development alarmed the
Ministers of Health (many of whom were doctors themselves, and/or with doctors as their chief advisers) and reinforced the Williams government's decision.

Comment: Reports of doctor shortages in Trinidad, the location of the regionally-funded medical school in Jamaica; the rivalry between the Williams and Manley regimes on the regional stage; the perception that Jamaica was benefiting more from the regionally-funded medical school than Trinidad - the other main contributor; and the support of Williams own idea of establishing a Trinadian medical school to solve the problem - at the regional level by Caricom, and the international financing level by the Inter-American Development Bank - were all important factors that moved the issue swiftly beyond the agenda-setting stage to an informal policy decision by 1971. The subsequent establishment of American offshore medical schools in the Caribbean reinforced the government's policy position. In addition, the high cost of studying medicine in developed countries for those Trinadian and other West Indian students was also an determining factor. There were however problems with this logic. While some level of doctor shortages existed, due mainly to migration to the private sector as well as to the more developed countries in search of better wages, conditions of work and post-graduate training, solutions had been offered in the same IDB recommendations on the training front. Despite a regional agreement that the number of Trinadian medical students be increased to 30 at the Jamaica-based UWI medical school in 1971 (a figure deemed sufficient for the country's needs by the Pan American Health Organization) chronic shortages and migration overseas and the local private sector still persisted, and with it the regime's belief that a medical school was the only solution. The Williams government thus interpreted this as a training problem. While economic and training factors were part of the problem, equally important was the unreformed state of the Trinadian health services more than a decade after the calls for health sector reform in the 1957 Julien report, as we have noted in previous chapters. Thus, the decision was clearly taken by Williams, with these other factors simply underlining the need for the school. The government and Williams personally, then, were essentially convinced by this logic over the less glamorous, and potentially damaging loss of power through decentralised-based reform as we shall see in the next section. Meanwhile, the lack of resources for such a project was in 1971 the main problem, but not for very long.

National level influences

In this section I examine the influence of the two main national factors: first the political impact of the attempted overthrow of the government in 1970 on Williams refusal to countenance alternative devolution-based policies and the 'oil shock' of 1973, both of which directly influenced the policy.

The impact of the 1970 coup attempt and regime characteristics: As noted in previous chapters, the Williams regime's credibility was severely tested by its attempted, but unsuccessful overthrow 1970. The crisis, which had its roots both in the 'radical' politics of the period was also enhanced by the harsh social and economic context. Having retained the critical support of the army, and with the Westminster model still intact, the move towards the prime minister's distinct style of authoritarian government grew as a result and was cemented through a number of measures on the political front, such as his heavy reliance on select groups of policy advisers and lack of trust even of his own cabinet (Sutton, 1984). This authoritarianism was enhanced with the boycott in 1971 of the general election by the Indian-led opposition party with the regime gaining all 36 seats in Parliament, an event which saw the prime minister effectively assume total power, at least as far as the constitutional framework allowed. The administrative system inherited from colonialism was in urgent need of reform. Institutions needed to be nurtured and built up in order to translate social sector development policies into programmes of action. This, however, did not happen in quite the rational manner expected of the government, despite the regime's advocating of public service reform as a major concern (Sutton, 1984: 44). The bureaucracy, like others in the Commonwealth Caribbean, remained essentially the same, albeit with a new political master (Jones, 1974a; Mills and Jones, 1976). The practice of 'survival politics' was becoming entrenched. Power was effectively with Williams who refused to heed the calls from various elements in the society for fundamental reforms through inter alia, de-concentration of power and the active support of developmental institutional capability and processes.
Williams and the PNM in the immediate post-1970s period therefore faced a negative political fall-out as a direct consequence of the attempted revolution, the cause of which were largely the failure of the government's development strategies. The impact on development policy of these events was largely negative. Development plans for various sectors, including health were formulated but not implemented, due both to the ongoing economic crisis and Williams' fear of political reform. Administrative reform was however, urgently needed, having been endorsed by the numerous commissions of inquiry prior to and after independence. In the case of health, the point was recognised as early as 1957 in the Julien report, commissioned by the then Legislative Council (of which Williams was chief minister just prior to independence) that fundamental reform was urgently needed. The main goal, according to the Julien report was decentralisation of health services away from the excessive hospital-based, curative focus that existed (The Julien report, 1957). The Julien report was indeed itself a crisis-driven response to poor hospital conditions including staff shortages during the immediate pre-independence period: a type of response that would continue to dominate health policy decision-making processes throughout the post-independence era. The health situation had deteriorated considerably in the late 1960s and early 1970s given, inter alia, the economic crisis. The alternative and arguably more feasible option available to the regime was health service reform. The ability to improve salaries for doctors and other professional staff in most developing states was hardly a realistic option in an environment of limited resources. The option of fundamentally reforming the still colonially-structured health services through decentralisation would have yielded a marked improvement in working conditions of doctors and nurses, as the Julien report of 1957. Reform, then under the Williams regime, was effectively on hold, but became even more sidelined in favour of ad-hoc policymaking in the aftermath of the 1973 'oil shock'. Between 1973 and 1978, total government revenue increased almost six times. The 1973 boom provided the PNM regime and the prime minister in particular with an opportunity to reinvent themselves at both the national and regional political levels (Sutton, 1984). Williams' and the PNM's political fortunes recovered as dramatically as the oil prices, as he and his group of trusted ministers and advisers set about planning and implementing a wide variety of industrial and social projects, which were implemented. In the case of the medical school policy, like many of the other grand projects formulated by the government and its advisers, it was now fully on the implementation agenda.

Comment: Politically, Williams' popularity by 1973 had declined, and his 'benign' authoritarianism had increased as a consequence, helped by the fact that between 1971 to 1976, due to an opposition boycott of elections, Trinidad was virtually a one-party state. Despite this, Williams was on the verge of departing from office when the dramatic change in fortunes occurred that would enable him to implement his unique and 'ad-hoc' type of development strategy for the country. His practice of 'survival politics' through, inter alia, centralisation and authoritarianism in decision-making after 1970 would have grave implications for the subsequent boom-driven developments in terms of this and other mega-projects that the government undertook in the aftermath of the rise on 1973 of oil prices. The main reason for the doctor shortage was more migration than limited places at the medical school. Many doctors indeed consistently blamed maladministration among their main reasons for leaving the public sector. The regime however refused to entertain this power devolution-based reform alternative to solving the shortage and migration problems. This inability to implement these highly-recommended and feasible management-based alternatives can be traced to the prime minister's own distrust of the civil service and its 'leaders' whom he saw as a threat to his power, his unwillingness to devolve power given his presidential-style authoritarian rule after the attempted overthrow. The oil boom placed the medical school/complex policy back onto the implementation agenda by 1975.

7.3 REGIME CHARACTERISTICS, THE BOOM, MEDICAL 'ACADEMIA' AND THE DECISION TO IMPLEMENT THE POLICY

Even though the policy was back onto the agenda in the wake of the oil boom, it was about to be fundamentally transformed and expanded. First, Williams himself had stated as early as 1971 that the government also wanted to establish both a dental school and an advanced nursing school. While a case could be made for the latter, the dental school was a particularly controversial addition, given the country's need of only 5 trained dentists per year (PAHO/WHO estimates) as well as the recurrent costs of running such an institution. Despite the existence of a medical research facility in Trinidad - the
regionally-funded Caribbean Epidemiology Centre (CAREC), some effective lobbying by the Commonwealth Caribbean Medical Research Council (CCMRC) was rewarded when the Prime Minister announced that medical research would be an integral part of the new ‘complex’ (Williams, 1975). With the country awash in oil dollars, consultations with a variety of health professionals including veterinarians, dentists, pharmacists and nurses saw these disciplined added to the original medical school project. The medical school policy was transformed in a short space of time into the medical complex policy.

Comment: As if to elicit support for the proposed project, the health minister Kamaluddin Mohammed continually registered his concern at various forums - including medical association meetings - about the shortage of health personnel, especially doctors. In doing so he outlined the PNM government’s health human resources strategies including changing legislative procedures - which was actually implemented in 1975 - to allow American and Canadian-trained doctors to practice. On the positive side, in a move towards primary health care, he urged the university and other training institutions to immediately re-orient training to suit Caribbean needs. He also outlined the desire of the government to introduce new categories of staff “...in line with present day thinking on the composition and function of the health team” and noted that policy would be based on intersectoral coordination and integration. He also urged doctors to be more community-oriented (Mohammed, 1975: 28-35). These statements reflected international policy trends at the time. However, the inability of the minister and the regime to identify and address the bigger problems facing the health service which forced many doctors to migrate in the first place which was creating the on-going crisis situations and the imminence of the medical ‘complex’ implementation process placed these policies and admonitions into perspective.

The medical research lobby was duly rewarded. Addressing the 21st meeting of the Commonwealth Caribbean Medical Research Council on April 21, 1976 both the prime minister and his health minister pledged that medical research would be a very significant component of the ‘medical complex’ project, with Mohammed stating without irony that “...a key word in this decision-making process is social relevance...” (Mohammed, 1976: 40-41). Williams’ friendship with the then head of the CCMRC was also a central factor in the decision to focus on medical research, despite the existence of an existing research institution, CAREC. Referring to his budget speech on December 12, 1975, Williams stated that both the medical faculty and the university council were still supportive of the policy, funding the teaching hospital, while the government would fund the rest of the project. To implement the policy, he also announced in 1976 that the Trinidad government had established a new committee, the Barsotti Committee under the chairmanship of the finance ministry’s permanent secretary and comprising senior technical officials from this ministry, as well as the health ministry in addition to two representatives of the university medical faculty branch in Trinidad (Williams, 1976: 39). This commission was charged with considering the procedures and arrangements for the establishment of the medical school as well as the feasibility of establishing dentistry, veterinary, pharmacy and nursing teaching facilities.

Regime characteristics and the decision to underwrite the ‘complex’

Funding was now the main issue. The Barsotti Committee urged the Cabinet to consider approaching international lending agencies, including the IDB given the ever-increasing funds needed. In addition, they acknowledged that the poor economic situations in other Caricom countries indicated that the Trinidadian government would be required to meet all or most of the cost associated with the project. In addition, disputes developed between the Trinidad government and the University Council, on financial responsibilities for the project. As a consequence of the boom, Williams decided to bear the full cost of constructing and equipping the teaching hospital and the medical school. In addition, he also expanded the policy, announcing that the schools of dentistry and nursing would also be established. Both would be run under a new tertiary education organisation, the National Institute for Higher Education (NIHERST) and would be integrated with the medical school (Williams, 1976: 40). A paediatric hospital would also be built and be the responsibility of NIHERST, but incorporated into the university teaching school structure under terms and conditions agreed by regional member governments. In relation to the capacity of the medical school, the government on the basis of technical advice decided on an annual intake of between 60-70 students (Mohammed, 1976).
These developments, including the development of NIHERST were undoubtedly influenced by the oil boom and the government’s lack of confidence in the ability of the regional university to deliver adequate health manpower to Trinidad. His intention was to demonstrate that Trinidad and Tobago could go it alone. Policy as political imagery and symbolism thus replaced any sense of bounded rationality in dealing with the real causes of the doctor shortage problem. In his 1976 budget speech, the Prime Minister justified his decision to establish all of the schools, noting in particular the importance of dental and paramedical training in the program. His stated intention was to implement a ‘two-track’ approach, with the medical school accounting for professionals and a second approach that would see the training of paramedical/auxiliary staff to satisfy Trinidad’s health needs. The establishment of NIHERST was to focus on the latter. By June 1976, the University of the West Indies’ University Council had fully accepted the recommendation that a medical school be established at Mount Hope, Trinidad on the site of the newly constructed maternity hospital.

Comment: Williams style of party governance impacted on the decisions being made during this stage. The initial IDB-funded and formulated maternity hospital, had thus grown to encompass the medical school, and the dental, pharmaceutical, advanced nursing and veterinary schools all within a short space of time. This type of ‘ad-hocism’ in the policy process showed a distinct lack of prioritisation, reflecting as much the effects of the oil boom and the presidential politics being practised by Williams himself, as it did regional politics; the perceived need for a medical- as well as other schools; the IDB’s interest in the project, and the offshore school programme. It also reflected the influence of the medical academics and researchers. This situation is not unique to Trinidad, as Ugalde’s study of the influence of the medical profession health policy-making in Colombia illustrates (Ugalde, 1979). However, three factors are also operative here: Williams, support; the oil boom; and the increasingly powerful role of medical academics. The pro-active personal support and involvement of the prime minister, and his regime’s strength on the back of the oil boom were evident. In the case of medical interests, what was different was the increasing involvement of ‘medical academics’ - as distinguished from the general medical profession - who seemed to have the greatest influence on policy, and upon whose technical knowledge the project was heavily reliant. Although a small group, they exerted considerable influence given the nature of the policy. The confluence of all of these factors were thus influential. The decision to underwrite the medical school - now complex - policy was based on the PNM regime’s strength given the oil boom. The resulting ad-hoc, symbolic, snowball effect policy process that ensued, also reflected a need for power, higher status, popularity and electability by Williams personally and his ruling party, though the power and status argument can also apply to the medical academics now sensing their opportunity for a slice of the country’s largesse. While the government’s stated tertiary/auxiliary approach to health human resources was a nominally good move by the regime, the inevitable outcome of a focus on the former meant that not only was the original policy objectives vastly different, but their absorption of resources meant that little resources and attention was paid to the paramedical and other innovative health human resource approaches. Worse, little attention was being paid to the fundamental sectoral reform question.

Implementation

On Friday 6th April, 1978, Trinidad and Tobago’s minister of health Kamaluddin Mohammed formally announced in Parliament, the PNM regime’s decision to establish the medical complex for the training of health professionals in medicine as well as dentistry, veterinary science, pharmacy and postgraduate nursing. A number of reasons were given which informed the Government’s decision. The first was the government’s stated recognition of the limited numbers of Trinidadian medical students admitted to the regionally-funded University of the West Indies (UWI) medical school at Mona, Jamaica. Coupled with this were the severe restrictions placed upon the admission of overseas students to medical schools and universities in metropolitan countries. The minister expressed the government’s determination “...to ensure that the Mount Hope medical school would be of high repute, acceptable to international standards...” with facilities for the teaching of the areas outlined above as well as facilities for biomedical, applied and operational research in health and other related matters (‘Mt. Hope Medical Complex’, Hansard, House of Representatives 1978/9: 1164-6). Mohammed justified the policy decision noting that Trinidad had only 700 doctors in 1975 and with rapidly expanding services would need more. He noted, somewhat ominously however that the medical complex would alone need a staff of 300 doctors when
fully operational, while the expansion of health services - through the building of health centres - throughout the country would mean the need for another 450 doctors by 1989 ('Mt. Hope Medical Complex', Hansard, House of Representatives 1978/9: 1164-6). The offshore school justification was again used for the medical school policy in the parliament. It was informed that the complex would meet the health human resource needs not only of Trinidad, but also the smaller islands of the Eastern Commonwealth Caribbean countries, as initially discussed between the government and the University seven years earlier. The establishment in Grenada of a private 'offshore' medical school, and the possibility of more such schools in the other smaller territories meant, according to the health minister, that "...the urgent need to train health personnel to the highest professional level to man our expanding health services..." was necessary given the "dubious antecedents" and "questionable standards" of these schools ('Mt. Hope Medical Complex', Hansard, House of Representatives 1978/9: 1164-6).

The initial Barsotti Committee was disbanded, according to the minister, and a new task force, chaired by medical researcher and Commonwealth Caribbean Medical Research Council (CCMRC) member, David Picou was appointed in 1978 with special terms of reference relating to the implementation of the Mount Hope Medical Complex project. These included visits to medical schools abroad, and liaising with the University of the West Indies (UWI), Government departments, and statutory and other related bodies. The members of the Task Force, at least half of whom were medical academics and professionals of the various disciplines were to report to a ministerial review committee, chaired by the Energy Minister Errol Mahabir and including eight other senior ministers. Concerns about the 'blank-cheque' given this task force to implement the project would later be raised by many, including the future health minister who would inherit the completed physical infrastructure himself less than a decade later (Hosein, interview, 1994).

Government Members of Parliament were unstinting in their praise and support of the medical complex project. Supporting the motion, one Member of Parliament, the minister's brother, Sham Mohammed noted that "...it is good to see that the thinking in the medical field in the Caribbean is to put the emphasis on primary health care..." (Hansard, 1978/9: 1217). This was either a response to the plans for curricular reform in light of Alma Ata, or else a grave misunderstanding of the primary health care approach. He commended the medical fraternity for its educational objectives which he understood to be to be the production of doctors:

"...who possess attitudes to prevention and to social action that result in their practising a truly comprehensive approach to medicine...[able to]...apply techniques of health promotion, prevention and the treatment of illness and to pursue lines of research appropriate to the needs and priorities of the Commonwealth Caribbean...." (Hansard, 1978/9: 1215).

The medical school policy was thus being 'sold' both as a high-tech as well as preventive/community approach to medical training. However, even though such curricular reforms were eventually adopted at the school in the early 1990s, it continued to be conceptualised as potentially the best high-technology hospital in the Caribbean in numerous political speeches. Moving the motion of support, Sham Mohammed reflected the general acceptance of the 'big is better' logic common to many developing state regimes, curiously linking it, like the minister, to community health and "the local environment" added that:

"...it is going to be the largest single building complex of its kind in the Caribbean...far reaching in terms of improving the quality of our health service and the skills and knowledge of health personnel...it expected that with the provision of medical education at Mt. Hope, a doctor would be more oriented in work in the local environment and more acutely aware of the health needs of the community in which he serves...." (Hansard 1978/9: 1226-1229).
The minister added that the government was searching for, and had received applications from academic staff “of high calibre”, nationals from home and abroad, and that “several eminent persons” had already applied for work (Hansard, 1978/9). Supporting the motion, another government MP, Winston Williams expressed a similar ‘third-worldist’, colonial type of medical logic as referred to in Chapter One, giving due regard to the work (including the ‘invaluable’ foreign visits to medical schools) undertaken by the Task Force, and asserting that considerable savings would accrue to the country as a result:

“...This is the type of thing we are looking forward to: saving space, money and manpower. With a project like this, one can begin to feel what real independence means...I feel every doctor should try to specialise in some area. Many doctors would have liked to do that, but because of lack of facilities are unable to do so...medicine in the big countries has gone a long way. Many of our doctors find it not only more profitable but more satisfying to work in the foreign countries where there are facilities to meet their type of training...the cost of the medical complex is very high so the task force went on the journey to bring back the sort of information to reduce the appalling cost of medical tuition...” (Hansard 1978/9: 1226-1229).

The decisionmaking process at this critical stage was now confined almost totally to the Task Force which reported directly to the Cabinet on the project, with little or no consultation with the non-academic medical profession or any other group or even the totally-sidelined technocrats at the ministries of health and education. Despite impressions given, there was surprisingly little real involvement of the ministries of health (with the exception of the minister, the chief medical officer and the permanent secretary) or education (whose permanent secretary was also on the Task Force) in the policy formulation process, as power was exclusively in the hands of the Task Force. Dr. Emmanuel Hosein, who would a decade later become the health minister confirmed this, noting that in his capacity as a member of the public accounts committee of Parliament in the mid 1980s, the permanent secretary of the education ministry had been unable to answer even simple questions about the Task Force’s operations, even though the complex was being implemented as an education project (Hosein, interview, 1994). Many doctors were also sceptical, even at this stage about the feasibility and need for the project. The Trinidad and Tobago Medical Association (TTMA) expressed its concern at not being consulted in relation to the policy. The chief medical officer addressing their annual meeting nevertheless told doctors that:

“...my sincere wish is that the TTMA will seek to be actively involved in these developments...it is fit and proper that those responsible for the delivery of health care should participate in determining this type of medical graduate product...” (Quamina, 1977: 31).

Meanwhile, on a somewhat positive side, in an effort to demonstrate intersectoral coordination, she also noted that the government had decided, based on the decisions of Caribbean Health Ministers (CCHM) in 1973 and a 1977 Conference convened by the Caribbean Community (CARICOM) and the Commonwealth Fund for Technical Cooperation (CFTC) to formalise linkages between the UWI medical faculty and the Ministry of Health. The University, it was pointed out, was initially reluctant to entertain the idea until 1977. The then chief medical officer admitted of this radical attempt at coordination that “...to what degree of success only time will tell...” (Quamina, 1977: 31). However, given the increasing disquiet about the rapidly expanding project, even this progressive policy initiative seemed insignificant. The government nevertheless claimed that the project enjoyed widespread approval, with the health minister again justifying it with the somewhat spurious logic that:

“...this is why we have dealt with the Pan American Health Organization (PAHO), the World Health Organization (WHO) experts and professors in the United Kingdom, Canada and the United States, all of whom have the approval of the international organisations concerned...” (Hansard 1978/9:1203).
This however was not a simply a question of overseas experts or the PAHO/WHO or the IDB, but one of a deliberate policy choice being implemented without exploring less expensive and more effective alternatives by Williams and the PNM. As for the recurrent costs required for the project, the Minister had to admit that "cost-wise we do not yet know..." which basically summed up the 'blank-cheque' approach to policy formulation and implementation that was to dominate subsequent developments, at least until the recession hit in the late 1970s and early 1980s. (Hansard 1978/9: 1203).

Comment: The policy implemented in 1978 was thus vastly expanded from the original 1971 remit. The government used a number of justifications, including the offshore school, which itself did not explain the expansion into other schools: largely Williams' ideas, supported by leading (and eager) professionals from each sector. In the case of the medical school policy, the government continued to insist that its new policy would solve the medical shortage crisis, and not only that, would help the overall community health system. These somewhat questionable views were supported by government politicians which, in the context of the authoritarian politics of Williams and the PNM were not exactly objective about the use of this fortuitous 'policy window' available to the country. Decision making was confined to the task force reporting to cabinet, with even health professionals, particularly doctors. Many of these doctors were not surprisingly opposed to the policy for a variety of reasons, the main one being the continued neglect of health sector reform, even during this oil boom period. As the government and the health minister continued to justify the policy, there were further concerns raised from different quarters.

Other policy concerns

The National Advisory Council (NAC) recommendations on health human resources: There were important gaps in the policy logic being used by the regime, as policy implementation proceeded apace. The government seemed to have largely ignored the main findings of a consultancy commissioned in 1978 by its principal national policy advisers, the National Advisory Council (NAC) which questioned the goals and logic at the heart of the government's health and health human resources policy position at this time, particular in relation to the medical school policy, i.e. the production more medical staff to remedy the existing chronic shortages. In April 1978, the Peat Marwick Mitchell consultancy firm presented its recommendations to this Advisory Council in a report, titled "A strategy for improvement of health services: an interim report". The Council's remit in the case of the health sector was a review of proposals for the expansion of medical education in Trinidad including the training of health auxiliaries and to formulate projections for manpower needs in the medical field among other areas. The Peat Marwick Mitchell group report to the Advisory Council identified a number of problems the health services which confirmed the recommendations of the 1957 Julien report and subsequent reports, while voicing concerns over the 'medical complex' policy. These findings included, inter alia: 1) poor utilisation of trained staff; 2) an absence of properly structured staff development programs; 3) an absence of effective supervision; 4) general inefficiency and frustration of committed personnel; and 5) high staff turnover. Highlighting the glaring lack of a health policy during this boom period, the report also noted that the health ministry needed a policy determination, development and evaluation group to assist in determining its overall direction; 2) a planning program development division for ensuring that programs are developed in response to specific needs; and 3) an adequate information system needed to assist managerial staff in the decision-making process (Peat Marwick Mitchell report, 1978:15).

On the specific issue of health human resources development, the Peat Marwick Mitchell group noted a number of other influencing factors. It stated that medical professionals were in scarce supply largely because current methods of compensation tended to aggravate the problem. It also added significantly - for an accountancy firm - that one of the main problems was that Trinidad's health care was highly medicalised with emphasis being on cure rather than "prevention" and "care", and that as a result, programmes and activities were being adversely affected by this "inappropriate emphasis" (Peat Marwick Mitchell group report, 1978:15). This factor, the report opined, was probably due to medical technical dominance within the health ministry (Peat Marwick Mitchell group report, 1978:15). Noting the need for health reform, it criticised the lack of flexibility in the ministry against the fact that the concept of health
was a dynamic one, adding that there was a conflict between administrative and technical staff and little community involvement in health services. It finally stressed that a goal-oriented programme approach to health development be adopted and the need for collaboration with other pertinent ministries as well as communities (Peat Marwick Mitchell group report, 1978:15). The problems of health manpower were effectively blamed therefore on the absence of health reform and need to encourage more effective use of inter alia, human resources. The significant implication of this report for government policy generally, as well as for he medical complex policy specifically, was that the government was approaching policy in a high-tech manner when less sophisticated, infinitely more cheaper solutions such as a primary approach to training as well as fundamental organisational reform were really needed

The Inter-American Development Bank's Caricom health policy concerns: Additionally, at the regional level, here were also indirect concerns about the Caribbean policy implementation process, expressed by the IDB, that seemed to be alluding to the Trinidadian policy predicament. In 1979, the Inter-American Development Bank presented a report to the Caricom Health Minister’s meeting on the feasibility of expanding and/or duplicating the faculty of medicine hinted at the neglect of Caribbean health services by regional governments (Caricom/IDB, 1979). This report criticised the lack of activity on the reform front of member states. Echoing the recommendations to the Trinidadian National Advisory Council, this report blamed the absence of sound health planning and inappropriate balance as the main problem from which all the other problems emanated. It noted that in most Caribbean Community states, a high proportion of national health budgets being spent were being spent on hospital services; that rural health facilities were understaffed, and that hospitals were also understaffed but overcrowded. The report further noted the emerging gap in health provision, where, in these relatively poor countries, more than half of all patients were being forced to pay for private care; that while many practitioners are paid by the governments to give public care, they were devoting a great part of their attention to private practice; that certain types of badly-needed, but more sophisticated care management for diseases that are very common such as hypertension, diabetes and health disease are available, but only to a limited, ‘better-off’ segment of the population. This report, echoing the Peat Marwick Mitchell report also noted that there was an excessive curative focus; and that because of the absence of a systematised approach to teamwork, there is a grave lack of effective utilisation of paramedical and auxiliary personnel. These concerns while directed at all member states of the Caribbean Community, were thus particularly resonant in the case of Trinidad, given the ad-hoc nature of the medical complex policy.

The fact that Trinidad of all thirteen Caribbean Community member states was the only oil producer simply made the failure to address the health reform question at all, all the more inexplicable. One former Caribbean medical professor, addressing a Commonwealth medical meeting in 1978, seemed to be articulating a popular Trinidadian concern about the Williams/PNM government’s policy and wider concerns about the possibilities for health human resources development in the post-colonial state when he noted that:

"... with increasing affluence, large new [teaching] hospitals still continue to spring up in some developing countries and...regarded almost as national status symbols. This commonly entails the draining off of both material and personal resources from community centres and rural programs...it also leads to the production of graduates who have a disproportionate bias towards institutionalised care. Medical schools themselves also need to re-examine their roles...too often they lay great emphasis on excellence as defined by the more developed countries than on appropriateness in the context of their own...” (Stuart, 1978: 4).

Despite these criticisms and concerns, the project continued with the medical faculty of the university establishing its own ‘steering committee’ to liaise with the Trinidad government in preparing the expansion plan and as well as curriculum details. The Task Force visited a number of “modern teaching hospitals” in the US, Canada, France as well as one in the French Caribbean: Guadeloupe (Hansard, 1978: 1183). A number of veterinary and dental consultants were also enlisted, while eight representatives from the Mona Campus of the University of the West Indies (UWI) visited Trinidad and assisted the Task
Force in examining the designs, which were subsequently modified. They completed and submitted their report in June 1977.

Comment: The gap between the reality of the need for health services reform action at both the ideological and political levels, on the one hand, and the proactive, curative, cash-intensive medical complex policy, on the other, revealed a number of influences including: the role of the oil boom; the role of regime politics; and the role of medical influence on the process. The government was effectively ignoring the advice of its own appointed council that reform was needed, on the one hand, while proceeding with a policy that though having the support of the cabinet and government, medical academia and the Inter-American Development Bank (which voiced its own concerns at the regional level about the lack of administrative and ideological health reform), seemed to be rapidly losing support even from the broader, non-academic medical profession as a way of tackling the real reasons for doctor shortages in the country. The 1978 National Advisory Council (NAC) itself concluded from the Peat Marwick group recommendations that first, major and complex policy issues had to be resolved before any strategy for improvement could be proposed and that a wide variety of views existed within the medical profession and the health administration about the approach to any of the issues. The Advisory Council’s recommendations essentially supported both the calls for sectoral/administrative reform of the health services, and the equally urgent need for a clear primary health-focused national health policy statement from the government. The only action that was taken however in relation to the recommendations of these report was the establishment by the Ministry of Health of a policy planning committee as well as two units: a policy determination, development and evaluation unit, and a program planning and budgeting unit. These were however implemented within the context of an unreformed ministry, as the government continued to neglect a grand reform policy/plan for the health sector, as well as other sectors it must be pointed out, in favour of its showpiece and ‘ad hoc’ medical complex project. Implementation however was interrupted by Williams death and the onset of recession.

Oil ‘bust’, PNM leadership change and policy stasis: the Chambers regime (1981-86)

Two major developments affected the PNM’s implementation plans in the late 1970s and early 1980s: Williams death in 1981 and the almost simultaneous onset of economic recession in Trinidad as successive oil price falls began to rapidly convert the country from credit-rich to debt-ridden status. The physical construction process experienced a number of delays and eventually commenced on January 1, 1981, at a time when the economic downturn had already started. Prime Minister Williams died exactly three months later. As oil prices fell however, the petro-dominated economy was severely jolted. The Chambers regime allowed the project to be continued since the contract had already been signed. However, the constraints of the economic situation also limited further policy movement under the new regime. From its start as a maternity hospital costing approximately 11.9m dollars, the Complex had by 1985, and even before the commissioning process had started, absorbed well over half billion dollars of Government funding as it rapidly expanded and also due to the persistent delays, industrial disputes, corruption and contractual claims and counter claims (‘Mt. Hope baby chalks up $1/2 billion bill’, Trinidad Express, 1/2/87:15). Dr. Neville Connell, the Health minister for most of the next five years under the new Chambers regime was largely silent about health policy issues generally, but more so about the role and future of the project after its physical completion. He did try however shore up the beleaguered project, as well as the University of the West Indies’ gradual policy change towards the production of a more community-oriented doctor at the Mount Hope medical school in light of the 1978 Alma Ata Declaration, noting in 1983 that medical schools had:

"...for too long divorced themselves from the responsibility for meeting the needs of the health service it supplies with doctors. The medical profession with its absolute insistence on educational freedom has ignored its responsibilities to society by producing too many doctors who are educated to work in hospitals. In the Caribbean, the UWI has set out to produce a Caribbean doctor of excellence..."

This upbeat assessment did not however dispel the feeling that the new Chambers government not only had limited room to manoeuvre but was, not surprisingly, unsure about its next move once the project was completed and handed over. As the Chambers government became increasingly unpopular, given the
crisis, and its lack of direction, it sought to extract some political mileage - in order to increase its popularity - by praising the completed physical infrastructure as the legacy of a caring political party. The physical infrastructure of the project was finished in November 1985: seventy (70) buildings on 135 acres, and a total cost, at the time of its hand-over to the government, of TT$657,422,000 (approx US$ 160 million). A lavish party was held on the grounds of the complex as it was handed over to the government, carefully timed to coincide with Trinidad’s 10th anniversary as a republic in September 15, 1986, and the impending general elections, and named (some might say more than appropriately) the Eric Williams Medical Sciences Complex in honour of the man who had conceived of the initial idea. Mahabir also outlined the possibilities as well as, without irony, the potential problems, when he stated at the handing over ceremony of the still unfinished complex that:

"...This unique complex is large by any standards and represents a great challenge to the government and the people of Trinidad and Tobago. Its operation and maintenance will require vast human and financial resources, but it is a challenge to which we must rise for there is tremendous potential in this complex, not only for the people of Trinidad and Tobago but for the region as a whole...." (‘Medical complex idea was sown by Williams’, Trinidad Guardian, 27/9/86: 5).

Noting that the complex was carefully planned and executed with the best of Trinidadian expertise, including medical expertise, Mahabir stated that, "...apart from expert advice received from abroad, the scope and functions of the complex were defined with the full participation from our professors of medicine, our doctors, our educators, our dentists, our nurses, health planners, architects and engineers..." (Trinidad Guardian, “Medical complex idea was sown by Williams”, 27/9/86:5). The celebrations were shifted at late notice to the Complex site, in an attempt to shore up a now increasingly unpopular government, but the imagery of wastage and mismanagement was more evident (Trinidad Guardian, “Medical complex idea was sown by Williams”, 27/9/86:5). Despite these efforts however, the fortunes of the Chambers regime declined almost as dramatically as the oil prices. Although trying to spend its way out of the crisis, all that resulted was Trinidad's slippage from credit-rated to debtor nation. Many public sector workers including doctors, migrated either to the private sector or overseas. The medical school/complex project was still incomplete but continuing to absorb maintenance costs until the PNM’s crushing defeat at the polls in December, 1986, leaving the options for the new regime severely limited.

Comment

The window of opportunity for Trinidad’s health policy development, like its wider development process, seemed to be closing as the 1980s recession hit. Williams’ successor, George Chambers could do no better than say that ‘the fete is over. Now its back to work’ as oil prices dramatically fell on the world markets in the early 1980s (Sutton, 1984). Public disaffection with the Peoples National Movement (PNM) and the desire for change even saw the tradition of ethnic politics being bridged as the increasingly popular opposition coalition National Alliance for Reconstruction (NAR) party encompassed both major racial groups. While the PNM was to succumb to its worst defeat ever less than six months later, the fact that the NAR coalition had formed, constituted a political milestone for Trinidad’s political system in terms of the possibilities of overcoming the traditional regime survival-based politics being practised. In the case of the medical school policy itself, the role of regime characteristics in the post-boom, post-Williams era on the policy is balanced by the economic and political dilemma facing the regime. On the one hand, economic recession had weakened the Chambers government, which although maintaining some elements of Williams survivalism, was committed to the democratic process. The new NAR government seemed interested in technocratic management and reform given the new economic situation. The impact on the medical school policy under the Chambers regime then, seemed to be a balance between having little choice but to continue, given that it had already started in light of the sudden economic constraints, and a dilemma about what to do when it was finished. The Chambers regime itself, then, reeling from a string of scandals, accusations of widespread corruption (some senior-level interviewees also noted that the Complex was not untouched by such allegations) and a general economic downturn, was massively defeated in the general elections of 1986. The overriding paradox of the Chambers decision now that the oil boom was over was that the continued quest for the best high-tech medical school and complex that could hold its own with those in developed countries, was in stark contrast the reality of a badly-managed,
unreformed health service in a country still without a written health policy. Successive PNM health ministers speeches had continued to include references about following a primary health care and community health care-based policy in spite of evidence to the contrary. The health services deteriorated as resources continued towards pay for the project and maintaining it until improved economic conditions eventually improved the chances for full commissioning. There was little political mileage for the Chambers regime then, even from the hand-over of the complex, as its last-ditch effort to attract some praise and status, given the crushing defeat in December 1986 by the National Alliance for Reconstruction (NAR).

This second regime change in the country’s history, but the first non-PNM succession saw the medical school dilemma still at the top of the health policy agenda. The PNM’s successor, the new Robinson/NAR regime was now faced with this policy issue. In December 1986, the National Alliance for Reconstruction (NAR) under A.N.R Robinson was elected on a wave of public disaffection with the corruption, scandal and mismanagement that, exaggerated or not, had certainly tainted the PNM regime’s tenure during the ‘oil boom’ years. The economic recession of the early 1980s undoubtedly also played a major role in this massive unpopularity. As early as 1982/3, the failure of most of the government’s grand petro-led and high-spending projects exposed the hollowness of the PNM’s policy development strategies and processes, which included the medical complex. In the next section, we examine the NAR/Robinson government’s policy choices and its influence on the policy’s trajectory.


Between 1983 and 1988, the country’s per capita income dropped by 50% while unemployment doubled (McAfee, 1993: 17-18). Trinidad’s external debt reached $US2.4 billion in 1988, equivalent to 57% of the country’s gross domestic product (GDP), according to World Bank figures. The annual debt bill was equal to a quarter of the country’s export earnings. In a desperate effort to cope with the debt burden, the Trinidad government negotiated a series of IMF loans, beginning in November 1988, as the country’s debt increased to more than US$3 billion. The new National Alliance government’s health minister, Dr. Emmanuel Hosein was faced with a policy dilemma: should scarce public funds in a recessionary period be used to maintain and improve existing health services, or should some also be allocated for the medical school policy, inherited from their PNM predecessors. The other choice was of course to abandon the project altogether, with the existing infrastructure utilised for other purposes. The new minister was, from the start, extremely critical about the entire project from the start, stating that the Complex constituted an enormous wastage of public funds, costing over a billion dollars. He also called it “...a sinkhole of funds...” with estimated operating costs of over US$200 million a year which was close to a third of the average Trinidadian health budget (“Hosein: there is much to be done in health services”, Trinidad Express, 16/2/87: 19). He criticised the previous PNM regimes for neglecting health generally and for creating the policy dilemma facing the NAR government in the first place (Interview, 1994). Immediately upon assuming office, the minister stated categorically that he was not prepared to pay for the project when 45% of UWI-trained doctors were annually going abroad. The minister knew however that a rapid decision was needed, recognising, despite his own concerns, that some level of phased commissioning was needed if only to prevent further waste of the infrastructure. In addition, the NAR/Robinson government was increasingly convinced that it might be able to prevent a loss of face by actually achieving implementation giving the enormous constraints, thus creating its own identity as a serious, responsible political party and government given its massive mandate.

The government thus took the position that a successful commissioning or implementation of the project would help the party’s credentials and its reputation as a ‘can-do’ government especially at a time of economic difficulty, and in light of the enormity of the political change, given the PNM’s defeat. In one of his first interviews as minister, Hosein criticised the former government for its lack of planning, policymaking and reform over the preceding decade, noting the dilemma this posed for government health policy (Trinidad Guardian, 21/6/87: 1). He labelled the policy a classic example of the lack of health human resources planning under the PNM regime. He added that there was no primary health care focus by the previous PNM regimes, noting that contrary to the assertions of former PNM ministers of health, there was no evidence of any budgetary reallocation to primary health care and his intention to remedy such a situation. He admitted
however that the job facing him and the NAR government was not going to be an easy one, but emphasised the regime's intention to formulate and implement health reform in a review of the entire system (Trinidad Guardian, 21/6/87: 1). In the case of the complex, he noted at this point that if commissioning were to occur, the emphasis would be on the training of allied health workers and nurses. The focus of Mount Hope would thus be on training of lower-order staff, including paramedical workers (“Scandals in health”, Trinidad Guardian, 29/1/87: 1). In this, effectively his first policy speech after the elections, the new minister noted that the broader goal of the new Robinson/NAR government was to ensure “...coverage and utilisation of health services where 100% of the population will have access to acceptable health care services...” (Trinidad Guardian, 29/1/87: 1). This statement was to change, however, as the actual logistics of implementation got underway. Allied health and nurse training under the NAR was now charged under the newly formed NHHERST training organisation. The medical complex policy would revert back to its original goal: medical training. The decision to incrementally implement was therefore both an assessment of the existing economic as well as political context and the extremely limited choices given the regime, even though the policy already seemed to be reverting to the medical school and complex focus, and away from any connection with primary care training.

The decision to 'incrementally implement'

The NAR/Robinson government decision to proceed with the commissioning process was a pragmatic choice, given its existing economic predicament, the policy situation ‘on the ground’, and the potentially useful political benefits of successful implementation. The minister had thus changed his views, though the reasons given were partly due to the policy parameters set him by the two previous PNM regimes. He thus stated that the phased commissioning of the complex was his main objective, noting that “...in pure economic terms it is an investment...if we don’t activate it, we will lose it...I’ll certainly feel proud if I can get it off in 1987....” (“Hosein: there is much to be done in health services”, Trinidad Express, 16/2/87: 19). He added that the new National Alliance regime would engage in discussions with the Inter-American Development Bank (IDB) with a view to funding the refurbishment of the complex. (Trinidad Express, 16/2/87: 19). He emphasised however, his commitment to provide training programmes for allied health human resource categories at Mount Hope such as physiotherapy, medical technology and dental nursing, noting that these additional programmes would contribute to the maximum utilisation of the institutions as well as the main professional groups: doctors and nurses.

While the minister and the government had to ultimately and rationally decide upon the best course of action, the medical academic lobby had no such doubts. After the decision was taken to commission, the Pan American Health Organization offered assistance by funding the return visits in December, 1987 of a ‘review team’ from the Missouri-Columbia Hospital of the United States to prepare a pre-feasibility study for the launch. Arising out of this visit, the NAR/Robinson government decided to appoint a Commissioning Team made up, at least initially, of former members of the original implementing Task Force including the medical ‘academics’ who had, in effect, developed and implemented the policy to this stage after Williams’ initial formulation, and retaining considerable technical control especially after his death in 1981. The Commissioning team was charged with the responsibility of implementing the recommendations approved by the new Cabinet. Among its main functions was to devise a progress report of the complex’s expenditure, including the possibility of future self-financing. Links were forged between this group and the Missouri-Columbia review team. As the government’s popularity waned however early in its tenure, given its expulsion of the members of its main coalition, and the continued economic crisis, so its judgement in implementing the commissioning phase began to be seriously questioned from a variety of quarters.

The battle for the future of the policy, and its juxtaposition alongside deteriorating, un-reformed health services and increasingly migrating health workers, started in early 1987 with striking staff almost as soon as the NAR government assumed office in late 1986. Most of these were junior doctors and nurses criticising poor working conditions and inadequate remuneration and career opportunities in the public health sector. The government was criticised by these groups for its decision to incrementally implement the commissioning policy to what was seen as the detriment of the rest of the health services. However, as
the Task Force deliberated over the final form of the new commissioning policy, the battle for and against the policy was also played out in the national media, which played a particularly important role. Among the first were the supporters of the policy, somewhat predictably perhaps, were three medical professors. In March 1987, in an attempt to swing both the government-appointed inter-ministerial committee and the general public towards the benefits of full implementation, the medical academics pointed to what they termed seven main misconceptions about the complex ('The case for the complex', Drs. Coore, Cross and Richards, Sunday Guardian, 6/3/87: 9). They noted 1) the medical complex was not a "grandiose" pipe dream of the oil boom, but was proposed by the 1971 UWI Committee and sponsored by the IDB, and was also geared towards providing more spaces for Jamaican medical students by the 35 extra spaces reserved for Trinidadian medical students at the Jamaican medical campus; 2) that it was not only to train doctors but paraprofessionals; 3) that teaching would not detract from the Complex's service role; 4) that its research would be locally-appropriate: 5) that its high-technology focus was because "...Trinidadian citizens expect to receive hi-tech medicine and in many cases are prepared to pay for it abroad, producing a drain on foreign exchange..."; 6) that "...inferior secondary and tertiary care will be unacceptable to citizens..." given the capital and human resources involved at the complex; and 7) finally, that while the cost would be "astronomical", the citizenry would be "gaining" five human resources training institutions - medicine, dentistry, advanced nursing, pharmacy and veterinary science ('The case for the complex', Drs. Coore, Cross and Richards, Sunday Guardian, 6/3/87: 9).

While some of these points were accurate, the entire effort was an accomplished, blatant attempt to justify full, rather than phased commissioning: the government's favoured middle approach. These professors also missed the essential point of the main critics of the policy: implementation of the policy would be to the detriment of the bigger priority - the maintenance and support of collapsing essential services especially at this time of crisis and a fundamental reform of health services based on the government's still-strongly voiced objective of a primary care approach. The momentum against the commissioning was however building. As one doctor pointed out a few days later:

"...the Trinidad and Tobago economy is facing serious fiscal constraints; the time when 'money is no problem' has long gone. The physical structure of the [Eric Williams] Complex is now completed and [the fact that] the medical academicians of this country who have a vested interest in this project are planning at tax payers expense to open [the various schools]...ignores our present economic situation. Professional schools are not one of our present priority areas. The Ministry of Health should re-evaluate this project. The present panel should be dissolved and a new multi-disciplinary team should make clear [the Complex's] opportunity cost...." ('Primary health care more important than this grandiose white elephant', Dr. Harry Singh, Trinidad Guardian, 8/3/87: 2.)

Of the medical 'academics' on the medical faculty's 'steering team' (also called FAST), the doctor commented:

"...these men are quite able and honourable in the field of medicine but this does not automatically equip them with expert knowledge in health planning and economics needed to advise the government to spend our limited financial resources on such a grandiose dream. If our present government continues to undertake the financing of these professional schools, it will create a serious fiscal strain in our economy which we cannot afford in our nation-building. The [Eric Williams Medical Sciences] Complex should open as a hospital and be part of the training of medical, nursing, pharmacy as well as auxiliary studies of the University of the West Indies. The training of 30 medical students [as obtained in previously in Jamaica] is adequate for our needs; after Trinidad and Tobago has crippled itself to train 65 medical students, they will most likely migrate to Europe and North America..." (Trinidad Guardian, 8/3/87: 2).
Even some medical academics who had initially supported the idea and been part of the original policy process, were now objecting to the PNM regime’s decision. In January 1985, one former member of the initial Barsotti task force, Dr. Courtney Bartholomew had warned the previous Chambers regime that it was ‘creating a monster’ and an ‘ivory tower’ (Trinidad Express, 1/2/87: 19; Dean, 1991). Ten years earlier, responding to the suggestion that dialogue and cooperation could be enhanced with the private medical schools operating offshore at the time, Bartholomew’s confidence in the soundness of the government’s policy, and one which he himself was a part of, was categorical:

“...my business, like the rest of my colleagues is to ensure that the Mt. Hope medical complex will be a school of national pride and international reputation and recognition...good business that is our charge...the government has expressed its commitment. The gauntlet is thrown The stakes are almost incomprehensible. The opportunities are almost mind-boggling. Those of us who are involved in the planning process of this new medical school have exciting years ahead of us...this is an expensive commitment [but] health is getting a piece of the action. The Mt. Hope hospital will be THE teaching hospital of the Eastern Caribbean ” (Caribbean Medical Journal, 1977, 38, (4): 4-9).

He had now changed his mind. The NAR minister, Emmanuel Hosein was however still trying to justify the decision - finding it difficult - pointed out to the critics of phased commissioning that:

“...it is no secret that the debate was long and often contentious, but after wide-ranging and searching discussions, and after consultation with a reputable firm of accountants, having due regard to the financial position of our country, we have at long last come to the point where Cabinet has confirmed its approval for the phased utilisation of the Mt. Hope Medical Sciences Complex...despite financial constraints, we are committed to a modern health care system that is community-based and committed to the provision of primary, secondary and tertiary care in the service of every citizen in the country, with emphasis on primary health care...” (Hosein 1988: 7).

Even the IDB - the project’s chief loan financier/guarantor - was now concerned with the process, if not the policy. The Bank which had been involved since the policy formulation stage voiced its unhappiness with the commissioning process, particularly the incompetence of the members of the commissioning team. In 1988 an IDB Committee headed by Walter Reddel reported that the commissioning team itself lacked the necessary qualifications, expertise and leadership to meet the requirements of commissioning a project the size of the complex. Criticising the NAR government, the Reddel report added that up to October 1988, the government had made no serious attempt to determine the recurrent operational costs of the complex (the Bank’s own estimate was US$72 million a year). Other criticisms included:

“...the emphasis on an academic university-based oriented staff;...too many trips and short-stays; certain non-relevant experiences [and] no exposure to government-run or foreign medical health systems could be a problem...” (‘Mt. Hope: a ‘complex’ complex’, J. Babb, Trinidad Guardian, 20/8/89: 1).

It also criticised the wastage of a proposed TT$8 (approximately US$1 million) consultancy to an American academic to determine the project’s feasibility. The report concluded that the complex could pose major problems for Trinidad and Tobago, and recommended that the governing board be reviewed since it was too heavily oriented towards doctors. It further stated that proper patient care should be the main consideration, and that teaching should not interfere with the commissioning process. The report concluded however that even though “...the small team is doing their best...they do not have the qualifications to commission a complex of this size and magnitude...” (‘Mt. Hope: a ‘complex’ complex, Babb, Trinidad Guardian, 20/8/89: 1). The commissioning team now headed by Trevor Romano, a local
management consultant rejected these charges outright, only accepting the recommendation of a ‘team approach’. Even the commissioning team itself had not been entirely ignorant of the policy pitfalls involved in the process. In its own report to the Inter-ministerial committee in July 1988, the team had acknowledged that

"...the commissioning of the Complex is a complex exercise...its end product has a high potential for political and emotional response. In general, it is fraught with potential for long-lasting effect of current wrong-decision-making. It is also an extremely costly project..." (Government of Trinidad and Tobago/Status report of the Commissioning Team to the Inter-Ministerial Committee, July, 1988: 3).

It nevertheless strongly recommended the need for the university to be fully involved in planning for implementation, given the approval, in principle by the government, of the University’s proposal to establish a self-financing medical education scheme. The Team also recognised the need to “…minimise recurrent costs for the government...[adding that]...the philosophy of excellence must permeate both the planning and operation of the complex...[and]...the need to be realistic and flexible and to balance comprehensiveness with incrementalism...” (Government of Trinidad and Tobago/Status report of the Commissioning Team to the Inter-Ministerial Committee, July, 1988: 3).

Comment: A difficult policy dilemma faced the NAR/Robinson regime: whether to implement the policy incrementally during a time of economic crisis and potentially reap some political rewards and status from a successful implementation, or to not implement and cut the government’s losses. Given the prevailing context, both choices must have been appealing to a certain degree. In the event, the regime opted for what was a ‘bounded rationality’ type decision based on what they saw to be the best option give the situation ‘on the ground’: phased or incremental implementation, beginning with the medical school. Before this decision was reached, the lobbyists for the programme: largely the medical academic fraternity felt compelled to consistently argue for the continuation of the policy. To its detractors, including former supporters and the media, the policy decision was the wrong one given the country’s collapsing and unreformed public health system and its lack of a written comprehensive health policy. However, either way, a compromise decision had been made that reflected more the failings of the past PNM regimes - including their regime characteristics and motivations - than any blatant fault of the NAR ‘phased implementation’ decision. However, given the interaction of political and economic crisis in the wider national context of 1988, the government did not exactly lend itself easily to sympathy from a population now being told that structural adjustment was the only way out of the crisis.

Structural adjustment, policy continuation and the political consequences for the NAR/Robinson regime

As this paradoxical situation continued, the medical school/complex health human resources policy was slowly being transformed into high-politics status under the NAR government - a development that was to contribute to the regime’s eventual demise. Events in 1988 almost ruined the NAR government’s hope for a successful outcome as both economic factors, and with it the government’s political fortunes worsened. More funds were needed for the process but less was available given the high interest rates of the international loans that funded the complex. The government was however - still partly justifiably perhaps - convinced of the need to persevere with the policy, being imminently close to implementation. The health minister noted that more funds were needed and would be allocated (US$ 55m) by the NAR regime to complete the process, in addition to the then estimated annual running costs of US$ 72 million (IDB figures). The government was convinced that Trinidad was “…poised to take a quantum leap forward...” in health care with the project (Trinidad Express, 13/7/88: 2). Commissioning was expected by the middle of 1990. To make matters worse for the NAR, the minister noted that services might have to be paid for either by a fee for service payment by the public, or a national health insurance plan in order to recover some of the past costs incurred (Trinidad Express, 13/7/88: 2). To compound matters, economic conditions worsened. By July 1988, the health sector, like social and economic conditions at the time, was in a state of depression if not crisis. The NAR regime was now in engaged in the unenviable process of implementing a questionable IMF structural adjustment programme that entailed, inter alia, massive cuts in public sector social expenditure. Other reform measures in the process
of being formulated included administrative reform and health services decentralisation, which, after more than three decades after it had been first recommended, was now virtually forced onto the policy agenda. To add to his woes in relation to the health sector, Hosein, acknowledging the negative impact of his government’s cut in health budget for 1988 - in line with the IMF programme - noted that lay-offs were a real possibility, adding that the ministry’s development budget will have to be ‘cut to the bone.’ (Trinidad Express, 13/7/88: 2). As economic problems worsened, the minister warned for the first time that his government would have to look at the possibility of curtailing expenditure on the project.

The picture that emerged by late 1989 in Trinidad, then was one of increasing mismanagement, misplaced priorities, and ad-hoc policy making and above all health and social crisis. In addition to controversies such as allegations of corruption in the drug supply process at the national hospital management company, which the minister ordered to be wound up in October 1988, the financial crisis also extracted its toll on general health services. By November 1988, the press was awash with health horror stories. The shortage of money, food and drugs and staff at the nation’s main hospitals, with nurse migration in particular reaching critical levels. The Government, making its own political prospects worse, allocated in its 1989 budget, a total of TT$127 million in capital expenditure for health sector. However, most of this money ended up being used to buy equipment for the soon to be commissioned Complex, while the Cabinet decided that it would go ahead with phasing in the dental and veterinary teaching programmes - a questionable decision at this stage - in addition to the medical school programme slated to begin operations in October 1989 (“Doctor: government has priorities mixed up”, Dr. Steve Smith, Trinidad Express, 9/1/89: 2; Taylor, 1990: 16). The government’s policy decision on this issue however continued to be defended as the NAR’s Draft Macro Planning Framework in 1988 noted that the commissioning of the medical school and teaching hospital, brought into operation on a phased, self-financing basis was the most sustainable policy and best for the country, given both the project and health human resources realities ‘on the ground (Government of Trinidad and Tobago/Draft Macro Planning Framework, 1988).

By January 1989 however, there was even more criticism about the necessity for the Complex and its components: the medical school, the other tertiary training schools and hospitals and the sizeable research facilities. Hosein in y interview, expressed his disgust with the research component in particular, four years after leaving office, blaming both medical academic/research influence as well as the Williams and Chambers governments for enabling them to exert such influence by giving them a virtual ‘carte blanche’ to create and formulate policy as it suited their individual and professional needs (Interview, Dr. E. Hosein, 1994). He added in this regard that the amount of physical space allocated for medical research at the Complex was both unconscionable and out of all proportion, when compared to the space allocated for treating patients. Nevertheless, during his period in office, the minister increasingly came under attack from almost every quarter except medical academics: the press, the main trade unions, prominent members of the medical profession, the Trinidad and Tobago Medical Association and the public. Questions persisted about the need for the various schools, including medicine, to the detriment of public sector health services, and the need for decentralisation and reform, as well as about the imminent medical ‘glut’, given the restrictive US and UK health professional immigration laws implemented in the late 1980s. Many critics would have agreed with one newspaper’s critical editorial that the “glow of triumph” surrounding the imminent commissioning of the medical school was paradoxical as there was:

‘...very little sense to be creating more doctors to join those already frustrated because they lack the tools to carry out their jobs...should we be proceeding to expand our stock of doctors when existing professionals are in a state of rebellion about the conditions under which they work?’ (“Paradox in medicine”, Editorial, Trinidad Guardian, 18/1/89: 8).

One doctor reminded of the central position given the Complex policy by successive governments - both PNM regimes and the NAR to the detriment of policy reform, and its imagery to the rest of the population as one of the main sources of the crisis:

‘...changes in this decade had its roots in the previous administration’s preoccupation with the Medical Sciences Complex as its major and only goal to the
detriment of the entire health service. The rest of the service was a coat of paint here, refurbishing there, and occasionally pre-election ideas such as cardiac surgery with expenditure of large sums of money on one hand, and equipment that went to waste. The problems in our health system were predictable, but no one took the trouble to sort them out as we were able to buy our way out of any problem as it cropped up. What we need urgently is a rapid assessment of the problems and to apply possible inexpensive solutions. We need to restart the nurse training program and investigate the problems faced by front line health staff and the organisation that is designed to support them in this era of dwindling resources. We cannot expect gimmicks to replace serious planning.” (‘Decentralisation needed for service...’ Dr. P. Harnarayan, Trinidad Guardian, 3/6/89: 9).

He however reiterated, in a balanced analysis, that it was dangerous to blame Hosein for existing problems one of which was a total breakdown in public administration and management, like the rest of the country’s public administration system. Harnarayan however was not the only doctor speak out against the rapid deterioration due to the NAR’s excessive focus on the medical complex to the detriment of policy-making and reform. One interesting development in Trinidad at this time was the formation of a coalition of ‘concerned citizens’ opposing the commissioning of the complex in response to the commissioning process. This ‘Citizens Welfare Committee’, comprising a number of medical doctors and ‘concerned’ citizens who stated that their intention was to inform the public about the consequences of the Complex policy, while also trying to convince the government, even at this late stage to change its policy course. This committee asserted that some of the IDB’s 1988 technical assistance recommendations that were not “…consistent with its [the Commissioning Team’s] self-serving agenda...” had either been circumvented or ignored by the Team (‘Mt. Hope: a threat to health care’, Reyes, C. Trinidad Express, 14/8/89: 1). As one member of the group noted of the Commissioning Team:

“...it is they who possess the administrative and technical expertise to facilitate and frustrate the implementation of policies favourable or otherwise; it is time for the government to wake up and realise that it cannot afford to gamble away its dwindling political fortunes. The Mt. Hope controversy is one which affects every citizen. It is a life and death concern which must not be left in the hands of bungling bureaucrats...the Eric Williams Medical Sciences Complex is a picture of inefficiency...what is disturbing about this whole affair, that threatens the quality of our health, was that it could have been avoided...” (‘Mt. Hope: a threat to health care’, Reyes, C. Trinidad Express, 14/8/89: 1).

Three medical doctors linked to the activities of this new pressure group also embarked on a press campaign against what was seen as the government’s immorality in implementing the project. Through a series of articles in the Trinidad Guardian, this group was also very vocal in its criticism of questionable need in Trinidad and Tobago of this “elaborate edifice” (‘Critical look at Mt Hope Medical School’, Trinidad Guardian, 10/7/89: 9). They added that much of the teaching and research could have remained at the Mona campus in Jamaica and at the other existing research institutions within the country and the Caricom region. They also criticised as unworkable and unsound the plans for the proposed self-financing of the Complex, noting that suggested earnings from private overseas medical students did not warrant “…this level of additional expenditure...” by the government. They recognised however that “…that there are already vested interests in the establishment of the facilities at Mount Hope and that several reputations, including political reputations are at stake...” (‘Critical look at Mt Hope Medical School’, Trinidad Guardian, 10/7/89: 9). This view was also supported by the trade union movement, with one unionist stating that “…a group of technocrats and the minister himself seem to have gone off on Mount Hope. They are completely taken up with the exciting prospect of practising/and or administering this ‘hi-tech’ megabucks complex. The country does not need a veterinary school. The running costs are much too expensive...” (‘Peoples’ health comes first’, D. Abdullah, Trinidad Express 24/7/89: 9). He predicted that “…the school would become an ‘offshore school’ offering places to US students with sub-standard qualifications...” a statement which was to prove partly prophetic by 1995 (‘Peoples’ health comes first’, D. Abdullah, Trinidad Express 24/7/89: 9). The NAR’s policy process was by now coming full circle,
given the role of the offshore medical schools issue as a contributing factor by the Williams government and its advisers in the first place.

In the Houses of Parliament the criticisms were equally forthcoming. In a Senate debate on the status of the Complex, one Independent senator questioned why the board of the new Eric Williams Medical Sciences Complex Authority - the management body for inter alia, the various schools - needed twenty-five (25) directors when some of the largest companies in the world seemed to manage with no more than ten (10) ('Government told to explain delay in complex', K. Bahadoorsingh, Trinidad Express 15/6/89: 48). He noted that it was even larger than the country's cabinet, and was more 'a herd of elephants' than a 'white elephant'. He warned the government that it was entering into a 'debt trap' with the Complex. The bill establishing the management to run the Complex was however eventually passed in the Senate, with a number of senators walking out of the chamber unconvinced that it was in the best interest of the people of Trinidad and Tobago ('House passes Bill,' Trinidad Express, 28/6/89: 2). The health minister however continued to defend the Complex, noting that its training capability would foster and encourage the principles of primary health care and that it would provide secondary care for its catchment area in addition to tertiary care for the whole country and the wider Caribbean ('Hosein: more resources for health care', Trinidad Guardian, 3/4/89: 3). Earlier in that year, he admitted though that even though the medical complex might be seen as a symbol of third world extravagance as one opposition MP had suggested in the Parliamentary debate, the fact was that it was a 'fait accompli', inherited by the National Alliance for Reconstruction regime, that something had to be done about it, and as such, that it could be used as a device for improving health care in the country should lessen such criticisms. Some did sympathise with the choices facing the health minister, even at this late stage, noting that the government had 'taken the plunge' at a time of limited resources and urged the government "...not to adopt halfway measures which would leave it a white elephant..." ('Milestone or white elephant?', Trinidad Express editorial, 29/6/89: 8). Support was also forthcoming from medical academia, with one professor stating, not surprisingly that:

"...we can't afford not to have Mount Hope. Nobody ever said health is cheap. There is no point saying to me that you can't afford it; you have to afford it to produce a community which can cope with the health problems in the year 2000..." ('Why we need Mt. Hope says UWI professor', Trinidad Guardian, 17/7/89: 10).

Criticisms however continued to dog the minister and the government by late 1989 with grave implications for both the regime, in the short-term, and the sectoral development process, in the longer term. The potential distortion of the health services in particular, resulting from the policy being followed was also pointed out at a Pan American health Organisation-convened Caribbean forum on health human resource policy (Bryan, 1989:6). Bryan noted that the curative slant inherent in the policy was:

"...a practice which validates and reinforces the system of social stratification inherited from the colonial period, and which contradicts concepts of egalitarianism so crucial to serious nation-building...in addition, the Eric Williams Medical Complex is perceived as 'cannibalising' financial resources, planning and other energies, which should at best be shared with the community health centres, given the primary health care thrust on which the government has verbally embarked...It is easy to see then why deficiencies and neglect in primary health care systems are directly linked to massive expenditures in the curative health area, and appear to be in direct competition with the rest of the system. In addition, doctors are perceived as tremendous power wielders who know how to get what they want. It is also perceived that a 'high-tech' modern complex serves their career interest, since it affords the opportunity to practice in an impressive environment, to sharpen their skills, and to develop their specialities and sub-specialities to a greater extent than the preventive care approach of primary health care would afford. This should be an area of great concern, since there is the perception that the Eric Williams Medical Complex will skim off the cream of medical personnel, thus aggravating the demoralisation and frustrations of medical personnel not employed with the Complex..." (Bryan, 1989: 7).
The Complex, however, despite such criticisms, continued to absorb funds, adding to the destabilisation of the health human resources, health services delivery and, threatening to add to the other factors that could potentially destabilise the regime. Another related development was the voluntary termination of employment programme. A main component of IMF-induced administrative reform, this VTEP policy was meant to trim the public sector. Like other civil servants, however many nurses - including those hired by the Complex authority from other public health institutions - took up this offer mainly to take up the lucrative jobs offers in the USA and Saudi Arabia. However, many nurses were also attracted by the new teaching hospital instead, given the much higher wages, which added to the feeling that a dual public health system emerging which would harm existing health services ('Mt. Hope Complex gets `green light' Trinidad Guardian, 20/5/89: 1). Welch suggested - more than half-seriously that the government should ‘...stop the medical school, ‘integrate’ the already hired university medical staff within the existing Eastern Caribbean medical scheme, cease further employment of university staff at the Complex and apologise to the existing applicants and the university...' (Trinidad Guardian, 27/8/89: 1). Many of the nurses who had gained voluntary retirement from the government’s programme were applying to the Mount Hope complex which alone needed 558 nurses and 172 doctors, and whom, according to the Authority’s regulations, would be allowed to practice privately including the specialists and consultants, thus aggravating the health human resources imbalance and the crisis in the health sector policy process. Criticisms thus persisted, given the ever worsening health and wider economic context, as the government also instituted other unpopular policies at this time, including a drastically restricted public expenditure which involved the loss of cost of living allowances and merit increases, a 10% wage cut and in addition the voluntary termination of service program. In the health sector, the feeling of crisis was palpable. The government seemed unable to afford to recruit and retain nurses and other health professionals such as pharmacists and radiographers. Most linked these developments in the health sector to poor political and policy judgement, given the context. As Welch noted:

"...Government expenditure on the health services has fallen over the last few years, and the accompanying rise in the cost of drugs and other supplies makes the impact on services all the more notable. It is in the midst of this reality that the establishment of a hospital at Mt. Hope would increase government’s expenditure on health by TT$150-200 million or 40% of the existing budget for the entire health services of the country...[in relation to the medical school]...the consequences of the establishment of a medical school at Mt. Hope along with the Mt. Hope Hospital may well have disastrous consequences for the health services..." ('Will Mt Hope destroy our health services?', Welch, W, Trinidad Guardian, 18/7/89: 9).

The outcome of the medical school element of the policy in the mid 1990s, then, was not totally unpredictable, and a salutary lesson for health policymakers in the developing state. To remain viable, by making room available for 50% foreign fee-paying students, the medical school ended up restricting the numbers of Trinidadian students to thirty-five (35): the revised number being trained in Jamaica in the first place, after the IDB Special Committee recommendations two decades earlier! This in itself rendered the entire policy tragic. The NAR’s policy commitment that the entire complex should be viable, meant therefore that the remaining thirty (30) places were reserved for US dollar-fee paying students from the USA, Canada, Australia, the Philippines, Britain and other countries. In 1996, this policy was extended as the medical school was ‘twinned’ with India’s Manipal Education and Medical Group to undertake training of Indian medical students during their clinical years. (‘Mt. Hope’s twin delivers an international flavour’, Trinidad Guardian, 18/9/96: 8). Though the end result was this paradoxical situation, the policy dilemma facing the NAR government was, admittedly, not an easy one. The government had made its decision. Now it was reeling under the consequences, not only at the sectoral level, but more important, in relation to its own political survival, as it was now being seen as an uncaring government.

Comment: While the NAR government was a market-reformist one, its decision to incrementally implement the medical school and complex were driven more by economic and policy circumstance that it inherited ‘on the ground’, than any great desire for the project itself. Indeed, the health minister was opposed from the start, though forced to reluctantly opt for phased commissioning, given the two unpalatable choices placed before him and the government: full implementation, or no implementation. The eventual decision then while controversial, was also a middle-ground bounded rationality one, given
the inaction of the Chambers regime, and the instigation of the policy years earlier by the Williams regime. The room for manoeuvre for the NAR regime was extremely limited. Timing its decision to commission the medical school at a time of political and economic crisis and a collapsing health service, brought on inter alia by IMF conditions, was a politically difficult, though rationally understandable option. However, its very nature of the policy to open a medical school, at a time when there was an increased feeling that one was not needed, coupled with the massive allocation of funds for the medical school and wider Complex, though trimmed substantially, was politically dangerous at a time of health services shortages at all levels. The feeling of much of the country was that the government and specifically the health minister were ‘uncaring’. Many perceived that the minister was focusing excessively on project completion, while neglecting the needs of the rest of the services, especially as images and ‘shock’ stories of people dying in wards due to lack of staff and drugs dominated the press. Importantly, this perception was to have a major impact on both the coup attempt, as well as the citizenry’s relatively nonchalant reaction to the plight of government ministers, including the health minister, when they were held hostage by the Jamaat al Muslimeen group in the Parliament building just over a year later in the country’ second attempted coup in two decades. Hosein however continued to robustly defend himself and the complex against critics, promising more resources for the other areas of what was now a chaotic and chronically under-funded health service. The government however continued to have the support of medical academics, as well as the local representative of the local PAHO/WHO described the Complex as “fantastic” and dismissed the ongoing human resources crisis as a economics-related, a view reflecting lack of understanding of both the context, as well as the primary health care, although her organisation was the co-sponsor of the primary health care approach (Sunday Express, 8/7/90: 5).

On the positive side, in terms of pure ‘rational’ achievement then, given the goals the NAR government set itself, it could feel justifiably proud to the extent that the policy had actually been reformed and implemented, despite major problems, given its inheritance from successive PNM regimes. However, on the negative side, the overriding sense of this achievement was of its irrelevance to the real health needs of the country at a time of serious economic and social crisis. The minister also seemed to have dismissed cheaper and potentially more beneficial - both cost wise and policy wise - alternative options such as the nurse practitioner policy, which, as we noted in the last chapter was seen by him as irrelevant to the country’s needs. Regime survival was influential, exerting influence to the extent that the regime was in a weak position, but wanted to salvage some praise/status form this situation. Ideologically, some criticised the regime for implementing the past regime’s policy without questioning it adequately. As the political situation lurched towards a climax in mid 1990, one can justifiably say that medical school/complex policy process, started by the Williams regime, implemented by the Chambers regime, and passed onto the NAR regime for commissioning now contributed to the regime’s unpopularity and threatened its survival. This meant that normally-low politics issues such as medical training, for most states, had now assumed high-politics characteristics that threatened the government. In the interim, economic crisis, coupled with the dilemma posed by inherited policy seem more accountable for the policy process in this once windfall state. Regime characteristics played a role to the extent that it had to rely heavily and unquestioningly on medical academia, like its predecessors because of the nature of the policy. This could be construed as regime neglect. However, economic and historical factors seem more influential at this stage of the process.

7.5 SUMMARY AND CONCLUSIONS

The Trinidadian medical school policy is both typical and atypical of the developing state government dilemma. It is typical to the extent that it represents another example in the long line of examples of doctor-dominated curative oriented health policies adopted and implemented by states and leaders in instances where cheaper, more simpler forms of policy action and reform may be really needed to address real health human resources problems. In Trinidad, like many other developing states, this was fundamental and meaningful policy reform, which itself demanded the decentralisation of power. The policy is however also atypical to the extent that while most developing states are resource-deficient, a fortuitous event, the oil crisis or boom in Trinidad’s case in 1973 saw a significant amount of policy opportunity become available to the government to pursue its development strategies. Not many developing states had been this lucky. The medical policy as one of Williams personal priorities was
suddenly on the agenda, aided by the IDB Special Committee in 1971, but actively supported by the
government and the prime minister personally, who was in turn lobbied effectively by medical academic
interests, as distinct from the wider, more sceptical medical profession.

However, the premise for the policy was questionable, and reflected the lack of understanding of the
problem, due in part to both political and economic factors, as well as a of adequate data information
systems: an indictment of the PNM regime's failure to either implement such policies or reform the health
system. As we have seen in this and previous chapters, the doctor shortage which triggered the policy in
the first place had not clearly been established. Even if it were, the main reason why doctors were leaving
Trinidad in the late 1960s and 1970s was the singular failure of the increasingly authoritarian Williams
regime to address the health reform and decentralisation issue recommended to him as far back as 1957
when he was chief minister of the then British colony. While external factors, particularly the pervasive
phenomenon of 'south-north' migration of health human resources development explains to some extent
Trinidad's dilemma, this level does not address events at the national level as we have seen. My findings
suggested that regime characteristics played a more important role under Williams in the 1970s than the
other succeeding regimes in the 1980s, where economic problems and the inheritance of the policy as
developed by the government's medical advisers exerted greater influences the policy actually threatened
regime survival. Undoubtedly however, interactions between the various influences and interactions: regime
characteristics, regional organisations such as the Caribbean Community Secretariat, the University-based
medical academics, the formation of pressure groups both for and against the policy as well as the
constantly changing socio-political and socio-economic context and international finance all contributed
to the process and eventual outcomes. In this chapter, I attempted to explain how and why this particular
policy evolved, given the following influences: 1) the failure by the Williams government to effect
national institutional and sectoral reforms as important pre-conditions for effective and progressive policy-
making; 2) the sudden appearance of a policy 'window of opportunity' in the form of the oil 'windfall'
and the resultant possibilities for 'developmentally-beneficial' policy-making through considerable
resource availability; and 3) the roles and influence of the medical academics and researchers who were
most likely to benefit from the particular policy and finally 4) the role of regime characteristics itself.

The fact that developing country actors at various levels do make important policy decisions and
choices (by both their action and non-action) on a 'day-to-day' that impact, both positively and negatively,
on their countries' development processes has been increasingly acknowledged in the policy analysis
literature (Grindle, 1980; Grindle and Thomas 1991; Liddle, 1988; Ugalde, 1998 Walt, 1994). I have, in
this chapter, argued that there was room for policy action, but that the ensuing action, though partially
understandable in the case of the options facing the NAR regime, was not only heavily biased, the goals
and objectives were unclear and ill thought out, but very expensive and multi-goal multi-actor oriented -
all of which detrimental to successful implementation (Cleaves, 1980). I therefore detailed the influence
and consequences of the failure to properly and effectively use 'policy windows' that appear fortuitously
in the post-colonial state. The policy context just prior to the oil boom - political, economic and social -
especially the prime minister's authoritarianism and adherence to survival politics saw a reluctance to
delegate and devolve power and build institutions and institute the reform process. This particular failure
had grave consequences when the regime sought to take advantage of the windfall provided by this policy
window for the development of the country. The provision of a 'carte blanche' by the Williams' regime
thus gave this professional generous leeway in creating and developing policy to shape its own needs. By
the time of economic recession in the 1980s, the policy choice was faced by a newly elected regime which
had to weigh the costs for and against implementation, with little room for manoeuvre, but to go for a
phased implementation. By opting for phased implementation, the National Alliance regime and the
Minister in particular opened themselves up to criticism as uncaring and out of touch, given the increasing
health crisis. Though not a direct cause of the coup attempt on the National Alliance regime, the medical
complex policy process nevertheless heavily influenced the public perception prior to and the reaction in
the aftermath to this destabilisation attempt.

In attempting to explain the apparent paradox of why some developing states remain weak despite the
access by regimes and state leaders to adequate resources and supporting agencies, Migdal (1988: 236)
arrets that such states typically face the dilemma of:
"...continued fragmentation of social control [which] has led them to a political style and policies: the politics of survival - that have prevented the state from enhancing its capabilities by not allowing the development of complex organisation in state institutions...."

In the case of the medical school - later expanded to become 'Complex' - policy under Williams then, Migdal’s analysis of the role and influence of the politics of survival, in light of the evolution of this particular policy, is a somewhat depressing example of how the politics of survival and status through benign' authoritarian politics can result in states that are blessed with the chance of a 'policy window' for making progressive strides, doing almost irretrievable harm to the development process over the medium to longer term, burdening future governments, as we saw with the Chambers and to a greater extent the NAR regimes. In political terms, the Williams government had the biggest policy window in health human resources development. His subsequent choice of the complex, along with other dubious policies and development actions, in addition to limiting development prospects, also limited the room for manoeuvre for the successor regimes, particularly the NAR, but also the PNM Chambers regime. The fact that simpler options were eschewed in favour of the more expensive alternative, while espousing contradictory policy platitudes says as much for interest groups, as it does for the heavy reliance by developing country politicians on short term political gains over institution-building and reform.

The art of balancing the two main goals: political stability and economic development, according to Migdal, may be less demanding for leaders of oil - producing states for example, where wealth is generated relatively easily, and state agencies remain viable through such wealth. He compared this situation with that of 'non-rentier' states such as Egypt and India, where leaders had to promote the building of complex organisation which could either enhance production on the one hand but might also enhance political dangers to their rulers on the other (Migdal, 1988: 236-237). Migdal concluded that an environment of fragmented social control results in "...a particular, pathological set of relationships within state organisation itself, between the top state leadership and its agencies.." which "...shape the very nature of state insinuations into society...” Migdal’s paradox assumes important significance in light of the oil boom experienced in that country in the mid 1970s. The state suddenly had at its disposal in the 1970s an adequate supply of financial resources for putting its development plans and policies into action. Mindful of the fact that Williams' authoritarianism cannot be equated with Burnham’s ruthless, oppressive and cynical version, there was nevertheless a fair amount of coercion, manipulation and corruption in the utilisation of this oil bounty in the post-1973 for political purposes. Williams' concentration of power in his own hands, especially after the attempted destabilisation in 1970 had grave implications for his regime’s capacity to effectively formulate and implement policy when resources suddenly became available. The fact that this instability happened before the oil boom also supports lends credibility to Migdal’s thesis.

The role of medical academic interests also cannot be ignored in this policy process - a point as true for developing as it is for developed countries. Analysing the relationship between the medical ‘academics’ and government on this particular policy does resemble to some extent that identified by Eckstein in his study of the relationship between the Department of Health and the British Medical Association (Eckstein, 1960). In terms of Alford’s (1975) structural delineation of the power equation, the dominant interest was clearly in this particular case the medical academics, with the active support of politicians, despite the important role of the regional political context. The ‘challenging’ interest were elements of the medical profession and citizens groups formed to counter further development. The repressed were the citizens who were left with the prospect of IMF-originated reform policies in response to their elected leaders inability to experiment with alternative policy options in the health human resources process. Even ideology is not a major factor as Navarro found with much-vaunted, but highly-medicalised, curative Cuban health human resources system, Navarro (1972: 415). He warned of the dangers of a medicalised health policy, even though in Cuba’s case it was done to counter the medical brain drain after the revolution, by not substituting them with paramedical and nursing personnel, but more medical doctors. Trinidad’s medical complex managers, by contrast, were mooting over the issue of making the facility both a potential money spinner from medical tourism as well as from overseas
medical students, using their comparative advantage over the American health care system (Trinidad 
Guardian, "Medical tourism could earn $8m TT per year", Trinidad Guardian, 14/10/93: 3). Even Cuba, despite its considerable problems, still had a socialised, free health service, despite its evident medical bias.

On the issue of medical production and balancing the ‘health team’, given scarce resources, Butter and Mejia (1987: 494-500) have also warned against training ever more doctors in developing states, given both the contraction in overseas recipient countries and economic downturn in donor states, as well as the overall waste. Ironically, Caribbean medical as well as nursing education by the late 1980s, like health care generally in many developing states were moving rapidly toward an innovative approach started in the 1970s that formulated a mixed preventive-curative curriculum to suit the needs of the Caribbean, which though not new with the existence since 1972 of the West Indies School of Public Health, was now moved to the centre of the medical training agenda (Wray, 1981; 1986; Cruickshank, 1989; Standard, 1985

To summarise then, the phased medical complex policy both influenced, and was influenced by regime survival, as well an interrelated array of actions and changing contexts. It was the direct result of the Williams regime’s choice of political survival over reform-led development. In the case of the policy, its technical nature also led to considerable dominance of the policy trajectory by medical academics, though the regime ultimately triumphed by approving phased commissioning. Opinions on the consequence of the policy were mixed by the 1990s. The NAR on the one hand, had limited choices but also made poor decisions that jeopardised and, ultimately caused its own demise. Even former PNM ministers were divided, with some like the health minister in the 1960s, Max Awon calling it “...a monstrosity that should never have been...the crux of our present health problems...a bottomless pit that will continue to gulp a superabundance of scarce public funds...”, while Kamaluddin Mohammed under whose ministerial tenure the policy was formulated and implemented calling those who criticised it as “prejudiced” ...” (‘Bright vision or bad dream?’, Sunday Express, 29/9/94: 4). Clive Pantin, the NAR health minister for three months after Hosein’s resignation after the 1990 coup attempt called it “a magnificent structure standing next to a dilapidated health service...” (‘Bright vision or bad dream?’, Sunday Express, 29/9/94: 4). Dean, writing in the Lancet was equally sceptical, noting that the incremental implementation outcome was a “messy compromise”. He asked somewhat rhetorically:

“...how a government as sharp as Trinidad’s could have proceeded with such a project...the story is not a new one for the third world, but it remains no less sad for that” (Dean, 1991: 1593).

If blame had to be apportioned, one cannot ignore the essential fact that the policy went back to Williams presidential survival politics, and his resulting blatant neglect of public sector and health reform, which, when added to the oil boom, made the incentives for reform unnecessary. Twenty five years, more than a billion dollars- and various health crises later, the greatest indictment of the Trinidadian medical school policy of particularly the Williams regime was a government decision in the early 1990s that thirty-five (35) Trinidadian medical graduates per year was adequate for the country’s needs after all, which would have been produced in Jamaica in the first place. Medical interests were responsible. International finance and structure also undoubtedly shared responsibility. In a major international health policy document published in 1993, titled ‘Investing in Health’ the World Bank uncharacteristically admitted, among other things, that international assistance can “...frequently exacerbate the problem of unsustainable health investments...” (World Bank, 1993: 139). This report also acknowledged that donor assistance, “...particularly for tertiary facilities and teaching hospitals, has sometimes been provided even if the incremental recurrent costs from these investments are too high...” (World Bank, 1993: 139). This is undoubtedly true of the IDB’s role in the Trinidadian medical school policy. Nevertheless, the role of regime characteristics - particularly survival - at both the first implementation stage, , and also at the second commissioning stage was also influential, and raises important questions not only for the health human resources development and reform process in the suddenly ‘affluent’ developing state, but for the very concept of development itself.
8.1 INTRODUCTION

In this conclusion, I shall concentrate on two broad levels: first I briefly discuss my theoretical and methodological approach, given the aims and objectives of the study. Second, I assess the main findings of the data, including the strengths and weaknesses, given both these approaches.

8.2 AIMS, OBJECTIVES AND METHOD OF THE STUDY

My central aim in doing this study was to analyse and assess the role, influence and relevance of Bossert’s regime characteristics - strength, stability, ideology and democracy, in addition to the concept of regime maintenance or survival - given other important structural influences on the policy process of the post-colonial state. The objective I set myself was to apply this analysis to health human resources policymaking processes and outcomes in three Commonwealth Caribbean states: Guyana, Jamaica and Trinidad and Tobago in the 1970s and 1980s. In terms of these aims and objectives I set myself, theoretically, I was particularly interested in the relevance of the ‘agency-structure debate in the development literature as it applied to the Commonwealth Caribbean region, particularly within the countries I had selected. Policy-wise, I was interested in applying social science techniques to a study of Caribbean post-independence health and health human resources policy experiences, given my own initial interest and observations over periods of time spent in the past in all three countries. I decided to use the 1970s and 1980s as the main focus of the study for two reasons, first, these were the two main decades of independent development after independence at various periods in the 1960s, and second, the evident contrasts of experiences and influences both within and from outside the region in these two decades, offered enough justification for a comparison across the two decades.

In terms of my methodological approach to these aims and objectives, after discussions with my supervisor, I decided upon a comparative case study-based approach, using the insights of the theory-generating techniques of grounded theory. Comparative case study and grounded theory techniques were best, in my judgement, to achieve the right balance between the rigour of the hypothesis-testing approaches, on the one hand, and descriptiveness, on the other. In the case of policy analysis within the developing state policy environment, the paucity of previous studies and data on the area, as well as statistics, meant that the search for policy trends and patterns should be my main focus. In this way, I could actually collect as much information that I could during my fieldwork, then analyse and search for trends with countries, by comparing regimes actions, and also across the three countries. The techniques used for data analysis were also conditioned by these factors. Where data availability was patchy and uneven, as in Guyana, I relied heavily on interviews, particularly with a range of senior-level officials, including politicians, as well as consultants, academics and health workers themselves. In Jamaica and Trinidad, where the data collection was more fruitful, I also relied on interviews to corroborate the secondary data findings on health human resources. Subjecting the collected data to grounded theory hypothesis-type testing, I decided to analyse the study across three levels. At the first level, I would analyse, given the overall data, general trends by regime-based comparison, across the three states. At the second level, I selected health personnel migration for deeper cross country, and cross regime analysis. Although the available statistics had to be gleaned from a combination of reports, including from the press, and was uneven - especially in the case of Guyana - I felt confident that I had achieved a ‘critical mass’ for a special case study as various patterns were revealed in my subsequent analysis. Similarly, at
the third level, applying my grounded theory approach to the data I had accumulated on the Trinidad medical school policy process, I found that the breadth and depth of the data was more than adequate for another case study in order to assess the role and influence of regime characteristics across the three regimes involved in the process from formulation in the early 1970s to eventual implementation in the late 1980s.

The main limitations of the study, as I see it are, centred around the limited time (six weeks) spent within each country, and probably more important, financial constraints. In terms of time and money, these precluded deeper analysis as well as further follow up of leads long after I left the countries. Where interesting patterns were found, especially to corroborate such emerging trends. Data limitations especially access to senior personnel, especially in Trinidad was a major problem, for variety of limitations to do with timing, availability and willingness to participate in interviews. Despite these main weaknesses, I believed that adequate data had been found, interesting patterns revealed and adequate corroboration found for my findings, through return interviews during fieldwork, as well as from a wide variety of documentary sources, as well as interviews with a broad cross section of persons (including politicians and policymakers grappling with day to day issues, or recounting their experiences, or doctors and nurses 'on the ground') - one of the strengths, I believe, of the study. I now turn to the main findings of the study, which incorporates a summary and critique of my theoretical approach.

8.2 THE MAIN FINDINGS

My main findings of the role and influence of regime characteristics on the developing state are along three main themes: first, recognition at the general level of the value of the structurated approach: the interrelationship between both actor- and structure-based determinants - as the best way forward in explaining and accommodating in a non-deterministic way, patterns, including policy trends or trajectories, as well as similarities and differences in developing state policy processes and outcomes; second, the clear, but variable influence of regime characteristics: strength, stability, ideology, democracy, and regime maintenance on low-politics issues such as health human resources policy development at the planning, training and management phases; and thirdly, and perhaps most significantly, the influence of regime survival in occasionally transforming low-politics policies, in the developing state, such as health policy into high-politics issues, in collaboration with other factors, which can threaten political survival. I begin with my findings on structurated or integrated actor-structure influences on policy.

'Structurated' or actor/structure influences and the post-colonial state policy process

The definition of development as 'the process of being developed' as it relates to the progressive social, political and economic advancement of people and societies in developing states has been the one used in this study. Given the developing state 'development' dilemma, modernisation and dependency the two main approaches to developing state comparative policy analysis offer contrasting views on the role agency or self-willed action, and structure. The 'modernisation' view, popularised by Rostow and Myrdal among others, was primarily concerned with economic growth saw development as evolutionary with Western states at the apex of modernity. Prior to the two world wars, 'development' was thought unable to happen in these 'backward' societies. However, after 1945, these opinions could no longer be sustained as newly independent third world countries were themselves increasingly exploring various economic development strategies. Western 'modernising' theorists saw development, as noted earlier, primarily as one of economic growth with strategies and societies that modelled the Western approach. Development was therefore equated with progressive industrial capitalism. Essentially, the modernisation argument went that former colonies lagged behind because of 'backward' peoples, traditions and values - factors that were not conducive to development. Developing countries could however 'evolve' and 'develop' as long as 'modern', Western liberal democratic values, technology, expertise and capital were diffused into their societies on a sustained basis with the active participation of local Western-educated elites. The basic modernisation argument was therefore that the movement towards devolution of powers away from the all powerful authoritative posts to highly specialised bureaucracies and government agencies was critical to development. This factor, together with changes in social conditions through communications and education would generate a complexity in political systems in developing countries
that would be able to satisfy, in the long run, as many different political interests as possible and in doing so further the development process.

The main criticism of this approach came in the 1960s in the form of a neo-Marxian response by the Latin American ‘dependency’ theorists. Like classic Marxists, they criticised the modernisation concept for its total ignorance of the role and influence of national and international class and power relations, particularly the roles of imperialism and ‘dependent’ development. Far from being a natural state of affairs that would eventually happen to other states who rigidly followed it therefore, Gunder Frank and others argued that Western economic growth and development itself was the outcome of a progressive system of power domination and exploitation of the peripheral regions by the core, rapidly industrialising countries. They saw development and underdevelopment as opposite ideas of the same process: development in one region was occurring at the expense of underdevelopment in another (Harrison, 1988: 150). In order to escape such perpetual underdevelopment, third world countries, accordingly had to become socialist and then either ‘go it alone’ or develop links with other socialist countries (Harrison, 1988: 151). As we have seen in both the 1970s and 1980s, political and policy development in Guyana, Jamaica, and Trinidad and Tobago were influenced by the dependent development and the pervasiveness of structural factors. This influence was dominant at two main levels: 1) in strengthening the idea of the political, economic and social structural status quo, with incremental change as the way forward; and 2) the negative impact of economic crisis situations in the 1970s and 1980s on developing states’ abilities to implement progressive policies for their populations. These ‘situational’ crises were the manifestations of a number of factors, the main one being the inherited colonial, capitalist form of dependent development.

Applying the dependency theoretical approach to my study health and health human resources policy, I found that the impact of dependent development extended to the socio-political as well as the economic realm as noted by Navarro, Doyal, Turshen and others. The main economic problem was the lack of resources. As we saw in Chapter Four, in Guyana, Jamaica, and Trinidad, the web of international capitalist relations meant that commodity prices were subject to the vagaries of ‘the market’. As prices rose so, the room for policy manoeuvre and the chances for successful policy implementation increased. Without adequate resources, policy development for the planning, training and management of health personnel could not be implemented or indeed reformed. With this influence an almost permanent feature of post-independence development in Guyana and Jamaica, any findings that exposed lack of policy action on the part of these and other similar states could well be forgiven. Without adequate financing, health policies and plans remain essentially that. This pattern was repeated in the 1980s, as global recession hit developing countries particularly hard, including oil-producing ones like Trinidad. These countries had to resort to international finance with its attendant harsh conditions that not only set back progressive reforms, but also jeopardised past achievements.

As Chapters Four, Five, Six and Seven showed, in the case of health human resources the impact was particularly felt in Guyana and Jamaica of the three countries studied. Progressive policy reform responses, for example, the Burnham government’s medex and community health worker policies, as well as Jamaica’s community health aide programmes were severely undermined, given both the recessionary situation and the externally-driven austerity measures. In addition the production of traditional categories such as doctors and nurses were also undermined due to a basic lack of financial resources. Guyana’s medical school, although targeted to meet community medicine needs, although a controversial policy, was also undermined by economic forces and circumstances beyond the control of successive governments. Undoubtedly, the structural economic problems and the adjustment programmes forced on developing states in the 1980s posed the greatest threat to any semblance of progressive health and health human resources development policies. One of the problems was the inability to fund existing vacant posts of staff on health service establishments. While cuts might have been necessary for non-technical posts in the regional civil services, the forced elimination of particularly nursing and auxiliary health posts reflected the negative effects of the structural influences continually faced by developing states.

One of its other major effects of dependent development was seen in Caribbean health human resource migration. As noted in Chapter Six, Caribbean health migration, though grounded in long-standing
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One of its other major effects of dependent development was seen in Caribbean health human resource migration. As noted in Chapter Six, Caribbean health migration, though grounded in long-standing

Navarro (1972; 1976; 1982), Doyal (1979), Turshen (1977)
migration patterns since the late 19th century nevertheless developed a momentum largely its own by the 1950s, heavily influenced by two levels of structural factors: the pull factors: including the manipulation of immigration laws to encourage skilled and professional migration from the cheaply-produced pools of labour in the developing world; and the push factors: the poor economic and social conditions that force many, including developing country skilled workers and professionals to migrate in search of a better quality of life, including better job opportunities and rewards for their skills. Given its inherent unfairness to developing states, efforts have been made by the major receiving countries to stem this ‘tide, for example in the USA and United Kingdom through immigration reforms. However, this does not preclude the option that given existing shortages they cannot reform their rules again. In the 1970 and 1980s, Caribbean governments - particularly Jamaica, Guyana and Trinidad were unable to prevent this already - developed and entrenched trend, losing literally millions of dollars of investment in the training or these personnel to the richer, more developed ‘North’. By the end of the 1980s, new opportunities for migration opened up particularly with the burgeoning American private health sector, especially in the East Coast and in the retirement havens of Florida, less than two hundred miles from a Jamaican health service unable to adequately pay its highly competent public sector doctors and nurses. The result was also migration to the also lucrative internal private sector. However, the decision to migrate to the USA and later to Saudi Arabia was the option of choice for many, including other Caribbean nurses. Caribbean governments were practically helpless to do anything about the wages and benefits being offered by the increasingly active agents on behalf of health institutions in these developed countries. These trends simply increased as economic conditions progressively worsened. The outcome was not only an understaffed public health service in Guyana, Jamaica and Trinidad, but also a deterioration in training standards, already reeling from ‘economic rationalisation’ but now affected in the late 1980s and early 1990s by the migration of the trainers as well as the trained.

Structural problems also extended to the socio-professional realm of developing state human resources policy processes. As many including Abel-Smith, Doyal, Navarro, Illich and others have pointed out the professional culture of health development as an almost exclusive medical/curative construct was imparted to the colonial state, and remained intact well beyond independence. Within this policy environment, the doctor through professional control of his skills was able to exercise control and dominance not only over medical, but nursing and paramedical training and practice in patterns modelled after independence on the developed countries. Thus, issues such as appropriateness and access to adequate care were undermined by what was essentially a power issue as underscored by Alford, Freidson, Eckstein and others in developed states, but just as appropriate to the developing state. In Trinidad for instance, research reports found that the dominance of medical technocrats within the health ministry was a major constraint on the developing and reforming health policy away from a curative approach - a significant finding which confirmed a situation found in other developing states, by among others, Ugalde in his study of health professional dominance in policymaking in Colombia (Peat Marwick Mitchell group report to the National Advisory Council, 1978; Ugalde, 1979).

While not all doctors were not guilty of excessive focus on curative, care, the regional pattern was nevertheless entrenched. By the late 1970s and 1980s, the regional medical profession came around to recognising the usefulness of an integrated primary health care approach with important changes medical training. As Mitchell (1981) has noted, such professional changes usually had to come from within. Despite these important changes, coming out of the 1978 Alma Ata Declaration and its acknowledged impact on Caribbean health policy processes, community health training, planning and management was still heavily influenced by medical dominance, both theoretically and in real terms. Two clear examples of this were seen the Chapters Four, Five and Six in the demise of the nurse practitioner policy in Trinidad, and the resistance of the Jamaican medical profession to government policy in the 1970s. The outcomes of this dominance on nurses frustration and their resulting migration is thus not hard to understand. This dominance thus retarded change at critical junctures for both nurses as well as the wider health system. When this factor is added to the economic crisis, one can also understand why nurses and even junior doctors - consigned to worked excessively long hours as part of the hierarchical tradition - resisted and sought new opportunities abroad and in the local private sector after qualifying to practice their skills.

There are of course other related structural factors. As Horowitz has pointed out, policy concerns do not match those that predominate in the West. State structures in developing countries whatever their

weaknesses are still relatively powerful vis à vis their societies. The capacity of Third World states to make and effectuate policy is, in several respects, more imperfect than that of their counterparts in the West. Participants in the policy process are fewer than in developed states than in the West, and some sectors of the society are hardly participants at all. The channels for participation are less well established and less clearly prescribed in developing countries. Information for policy making is much scarcer in Asia, Africa, Latin America and the Caribbean than in advanced industrial countries. Finally, given all the above, the resort to foreign models and frequent reliance on foreign experts is common (Horowitz, 1989: 199-200). Cleaves (1980) also raised the issue of apathy as a result the prevalence of these conditions.

And yet, given all of these militating structural conditions at various levels, one would be forgiven for thinking the developing state policy processes, including that of the health sector - have been totally paralysed, neglected and in crisis since independence. This is not totally the case in the Commonwealth Caribbean. As shown in Chapter One, the region -with the exception of Guyana - has justifiably been proud of its achievements, which have enabled it to be rank well above most developing states. Traditional indices such as life expectancy, infant and maternal mortality rates, population growth rates, doctor and nurse ratios bear this out especially since independence was achieved. These were considerably affected by structural adjustment policies, in the late 1970s (in the case of Jamaica) and 1980s which revealed the crisis situation for the first time.

These proactive and progressive developments by both political actors and bureaucrats nevertheless revealed the central problems of an over-reliance on deterministic approaches to policy development in the developing state. Like south-east Asian economic 'miracles', Caribbean leaders have gained a lot of attention for their health achievements from other developing states, in what is by any standard a quite remarkable achievement, in a short space of time, and especially given the economic crisis situation. This effectively revealed the existence of national power and the capability, ability (agency) to act, by the low-to middle income Caribbean developing state. As Grindle and Thomas (1991) and others have found, developing state health policy actors are also involved in considering issues continually on issues of concern to the health sector, and involved in a wider range of activities, including considering (and influencing) items on the policy agenda; decisionmaking, implementation, and assessing and evaluating outcomes. While conditioned by structural factors, this ability is nevertheless there to varying degrees. The biggest actor has, by far been the state and specifically the ruling parties or regimes. Yet explanations at this level by most Caribbean researchers has been ignored until recently for largely ideological reasons. The ability to explain this paradox of ability to act or not act in the face of structural factors, however runs the risk of making generalisations about the Commonwealth Caribbean as a whole. As I have found in my study of regime characteristics and health human resources policy, policy changes, choices and outcomes reveal the complexity of the development policy process even within this relatively small region. Even when one considers the negative effects of structural factors, the effects of political factors, and their uniqueness with specific developing country policy environments reveal enough to recognise that this factor cannot be ignored in policy explanations.

The influence of regime strength, stability, ideology, democracy and survival on low-politics policy

The role of the regime in Caribbean health and social policy has to be traced back to the colonial era. In Chapter One I examined the relationship between health and the colonial regime with specific reference to former British colonies of the Caribbean, to determine whether linkages could be made between the power relations and policy objectives of the colonial state and the power relations and its impact on policy in the post-colonial state. Power under colonial rule was concentrated at the political level: in the hands of the colonial governor and bureaucracy. Power was also concentrated at the economic level: in the hands of the planters and the evolving international mercantile system. Health care was used to legitimise the colonial system. In the post-slavery, crown colony period, power remained in the hands of these two groups, with the newly emancipated being the powerless. Given this situation, policy responses to health, after the economic crisis brought on by emancipation, colonial administrators were forced to step to fulfil the health duties once carried out by the planters. The reasons for this vary though a combination of self-interest (to prevent epidemics, for instance) as well as some genuine level of interest in the social welfare of the freed blacks also contributed.
In those territories like Guyana and Trinidad, crown colony rule saw the importation of thousands of Indian indentured labourers - a phenomenon which added a further level to the social and health policy strata. Separate health systems - based on provision of doctors by the planters also reinforced the social and racial 'apartheid' within the colony. The planter and expatriate classes received the best quality care available, the freed blacks depended on the development of new hospitals and missionary-based health care, and the Indians received rudimentary care from the plantation. In the 1930s, riots in the region protesting lack of employment and poor social conditions - did hasten the reform process by the still powerful, but gradually weakening colonial regime. The Moyne recommendations that extended from political and economic reform, to social and health care reforms were a part of this crisis-reform mode. The relationship between colonial power and health services delivery was thus a power-centralised one based on enlightened self-interest and driven by crisis-based reform. Much of this behaviour was adopted by post-colonial regimes to the detriment of health services as I found to varying degrees in Guyana, Jamaica and Trinidad and Tobago particularly in the 1970s.

The 1970s marked a new phase in Caribbean politics with the search for new strategies of development and new models of political organisation in what was effectively the second decade of independence (Payne, and Sutton, 1995: 13). Applying Bossert’s regime characteristics typology to the Caribbean in the 1970s, the Burnham, Manley and Williams regimes shared similarities though characterised by important differences that must be understood in accurately interpreting policy outcomes. Manley’s PNP shared a similar socialist agenda with Burnham’s PNC, though the latter’s resort to survival politics through its non-democratic hold on power contrasted with Manley’s adherence to the democratic process. The Williams regime was essentially non-aligned, cultivating cordial relations with both the Americans, and even the Cubans eventually. However, the oil boom after 1973 made these relationships less important than they were to the other two by empowering the regime to formulate plans and policies which lending agencies such as the World Bank were willing to offer seemingly unlimited funds.

I used Bossert’s typology of regime characteristics - strength, stability, ideology and democracy to which I added regime maintenance or survival which I found was also relevant to the discussion of regime democracy (1983: 429). Guyana under Burnham exhibited the strongest influences in this regard. However, it interacted with other regime influences such as democracy and ideology as well as non-regime, structural factors such as economics. I found in the case of Guyana in the 1970s that under conditions of non-legitimacy, authoritarianism and limited resources, the urge to maintain control of the state resulted in the allocation of resources for regime survival rather than health policy. This in turn has the effect of negating and undermining the nominal progressive ideological policies being espoused in the policy arena, leading to policy neglect, ‘ad-hocism’ and underdevelopment. Policy ‘ad-hocism’ and neglect characterised the policy development process in Guyana in the 1970s, as significant amounts of the state’s scarce financial resources were directed towards regime survival. The resulting poor conditions for the rational planning, training, management and utilisation of health professionals thus triggered a sustained level of migration of health professionals and a marked decline in all aspects of health.

By contrast, in the case of the Manley government in Jamaica in the 1970s I found that under given conditions of regime legitimacy and progressive ideology, and some element of political will, room to manoeuvre can be found in making and implementing progressive policies, even under militating internal economic conditions and external political pressures. Regime characteristics such as ideology were more important than regime maintenance. Hence, the main problem for the Manley government was economic, despite the occasional lapses as we saw in its poor relations with the medical profession. Inexperience, the size of the task, its failure to effect the required administrative reform as a precondition for implementation, a chronic lack of resources due to a sustained economic problems all contributed. Importantly, even though the government’s own increasingly radicalised political agenda was a symptom of its tenuous situation, it never made any moves that constituted a wish to retain power undemocratically. This legitimacy along with its ideological commitment to preventive, community-based care was its greatest contribution to policymaking for the health sector, although its hands were effectively bound by IMF dictates. Finally, in the case of the Williams government in Trinidad, I found that under conditions of personal authoritarian, any strong desire to centralise power for regime survival will have deleterious effects for reforming implementing institutions of the state in preparation for development policy
nominal democracy and legitimacy. This tendency can become quite strong with grave consequences for long-term policy and development processes even when favourable ‘intervening’ conditions in the form of unexpected resource acquisition have created policy windows of opportunity for policy reform. For the 1970s at least, then the role of regime characteristics was influential, though economic, professional interests and international economics and politics were also very important.

While resource availability is arguably one of the most important determinants of policy implementation, even this factor could not adequately explain how ‘resource-deficient’ Jamaica in the 1970s was able to formulate and achieve what was on balance a more progressive approach to reform and innovation specifically relating to health human resources policy, when compared to equally ‘resource-deficient’ Guyana, and the resource-rich Trinidad in the 1970s. More surprisingly, the Manley regime’s own achievements in health human resources policy development at a time of severe economic problems were arguably on par with, and in terms of innovativeness, decidedly more progressive than that of newly ‘oil-rich’ Trinidad under the Williams regime: a fact which could not be adequately explained by either colonialism or economics. I therefore found evidence to support Hintzen’s assertion of the generally negative influences of ethno-based ‘survival politics’. The experiences of the Burnham and Williams regimes in the 1970s in relation to health human resources policy illustrated the secondary status of progressive development policy processes in favour of ‘survival politics’ and therefore supports Hintzen’s basic argument. Specific examples of this neglect included a heavy reliance on ad-hocism, an unwillingness to implement internally-generated and recommended reform (in some cases made by various commissions appointed by the regimes themselves) and the general neglect of other policy actors and institutions. I also found that even when policy ‘windows of opportunity’ were available, the ‘survival politics’ approach to governance often generated risky, ‘crisis-driven’ responses to those unresolved, wider systemic problems that the regime seemed unwilling to address, due to a combination of apathy and the perception of threat to its own survival. This ‘policy-as-crisis’ approach thus undermined not only the need to develop and nurture relationships with other policy actors and institutions. I also found that even when policy ‘windows of opportunity’ were available, the ‘survival politics’ approach to governance often generated risky, ‘crisis-driven’ responses to those unresolved, wider systemic problems that the regime seemed unwilling to address, due to a combination of apathy and the perception of threat to its own survival. This ‘policy-as-crisis’ approach thus undermined not only the need to develop and nurture relationships with other policy actors (including the bureaucracy), but also the medium-term prospects for systematically developing (through reform and integration) an appropriate and effective policy system at the main levels: agenda-setting, formulation and implementation (Grindle and Thomas, 1991).

The health human resources data for the 1980s also revealed both positive and negative trends and processes in the role of regime characteristics in the developing state policy process. Compared to the 1970s, there were strong differences among all three countries’ regimes. While the 1970s was characterised by radical type policy departures that produced both progressive policies and regressive actions by some regimes to maintain power, the 1980s ushered in a reform phase which had both positive and negative policy implications. On the positive side, countries such as Guyana in particular, despite the last five years of the Burnham regime was forced to democratise after 27 years of PNC regime rule, given a changed global and hemispheric context. The choices were limited for this survivalist regime. In choosing reform, the chances of improvement of health policy processes and indeed health status were greatly improved. On the negative side, in the case of Jamaica and Trinidad, the role of regime characteristics seem less relevant though not totally absent, when compared with the influence of economic factors. The Seaga regime in Jamaica, like the Chambers and Robinson regimes were not only democratically elected but also market-reformist governments - the former, a free-marketeer, the latter two forced by circumstances. However, also common to both -along with Guyana of course - was the economic crisis of the 1980s which limited policy windows to fundamental structural and economic reforms.

In the case of Jamaica in the 1980s, explanations of the balance between regime characteristics and economic and other factors in determining health policy and would fall more favourably on the Seaga regime’s side given the poor state of the economy after Manley. Nevertheless, his regime’s free-market credentials were also much in evidence during the 1980s, and with devastating effect in the case of health human resources when combined with the IMF’s loan conditions. While even Seaga himself came around to questioning these conditions, the damage - in the case of nurse and doctor migration, staff and post cuts, elimination of community health aide posts, hospital closures and spiralling inflation that made public sector pay packets useless - had already been done. Unlike Guyana, there was never any question of regime survival or undemocratic rule. Explanations of Jamaican health human resources policy in the 1980s however must balance the regime’s free market ideology with its limited bargaining position vis a vis the IMF at a time of severe economic crisis and declining US financial support. In terms of outcomes,
the price paid by the Jamaican health sector and its professionals was arguably bad, though a quick comparison to the Guyanese situation with the added influence of political authoritarianism makes it seem marginally less traumatic.

In Trinidad, the situation was bad when compared with its own former strength and status in the oil-rich 1970s. By the time the Chambers regime assumed office, recession had already hit. Under these last five years of PNM rule, the country changed from a creditor to a debtor nation. Health human resources policy, like the other two countries during this period was subsumed to crisis-driven needs, although the Chambers government had also recognised the need for reform. Its inability to act and the questionable nature of the previous PNM’s regime under Williams’ persistence with the medical complex made this policy all the more questionable in the 1980s when after being used for electoral purposes, it could not be commissioned as planned. This policy also came to dominate the tenure of the Robinson regime in the mid 1980s, when it had to decide on short notice what to do. The eventual choice of a phased commissioning and the subsequent resources allocation at a time when the health sector could least afford it contributed in part to the image of an uncaring government and the eventual the 1990s coup attempt, as well as the government’s massive loss at the 1992 general elections. The medical school policy not only symbolised the backlash of NAR regime policy, but of the arguably bigger policy failure of the Williams regime - for largely political reasons since the 1950s - to implement fundamental decentralisation of the health sector. The implementation of these reforms by the new Manning regime in 1994 signalled a new start for the health sector and health planning, production and management. However, like the other three countries in the 1990s, the role of the new economic and international policy context of IMF-driven reforms were also had their own negative implications for the rest of the decade.

In my case study of doctor and nurse migration and its relationship to regime characteristics, my findings suggested that regime legitimacy and democracy played a varied role but important role in the nature and extent of the health migration process, especially in its interaction with other influencing factors in all three states. Economic factors and environmental factors were, of course, critical. However, equally important at the national level were the presence of government apathy and inaction as well as well as miscalculation in the case of migration of expensively-trained health sector human resources. The pressure to change only arose out of the negative consequences in the early 1990s which later triggered new and innovative approaches to the problem within the context of health reform programmes. Regime responses to health migration in Guyana, Jamaica and Trinidad were probably more influenced by regime characteristics - particularly regime strength, ideology, democracy and maintenance - in the 1970s; and by economic factors in the 1980s. However to apply this simplistic, one-dimensional assertion to these countries is to deny the complex interaction of both economics and national government action with each other across the two decades, as well as with other important situational, structural, socio-cultural and environmental factors in the process which also need to be explained in any accurate analysis.

As we saw in Chapter Four, Trinidad was strong, while Guyana and Jamaica were economically weak, given the onset of the oil boom. Guyana and Jamaica were espoused variants of socialism which conditioned both countries’ health and development policies for the rest of the decade. Both were relatively unstable. However the Burnham’ regime’s undemocratic, survivalist rule compared unfavourably with the Manley regime’s democratic socialism. The impact on health migration then was bound to be conditioned by these factors. I therefore found that while both experienced serious health personnel migration problems in the 1970s, the reasons, in the case of Guyana, were also complicated by Burnham’s survivalist, undemocratic rule, and the channelling of scarce resources for survival. Henry and Johnson’s (1985) observation that education and training have always been viewed as a passport to geographic and social mobility applies to all three states - as well as to other low-to middle income developing states. The pervasiveness of economic and other factors is also a continued reality to be borne in developing state policy responses to migration. However, my findings revealed that policy responses were conditioned as much by national political/regime calculations as well as by national and international economic and professional factors. In short, this means that solutions to the migration problem must, at the very least, be addressed at all of these levels.

In my second case study of the decision by the Williams government to build a medical school and the decision of the successor NAR government to commissioning it, I found that the explanation was bounded by both time and financial constraints, but equally important by regime characteristics and motivations.
particularly on the part of the Williams' regime. The main reasons for the policy included a medical doctor shortage. Yet the evidence suggests that while this may have been the case, a combination of other factors including resource availability, the regional politics behind the prime minister's personal interest in the project and other situational factors such as the offshore medical school problem saw intensive lobby action by medical academic interests for the adoption and implementation of the policy. The dilemma that faced the NAR regime in 1986 given the stalemate of the Chambers years was essentially the least worst option and clearly a bounded rationality approach. International financial involvement and support of the project was also a legitimising determinant from the start, a policy that has now been criticised by among others the World Bank in the 1990s (1993: 139). The clear implication from my findings is the need for an integrated approach to developing state policymaking as much as to developing state policy analysis.

The transition of low-politics to high politics, crisis-ridden policy

Chapter Seven of this study identified what was perhaps the most interesting overall finding in this study of regimes and Caribbean low-politics health policy processes. I found that such policies, give what Kingdon (1988) might call a confluence of contextual and content-related 'streams', can assume high-politics, crisis-ridden characteristics that can actually threaten regime survival. This is amply demonstrated in the Robinson/NAR's predicament in the late 1980s of whether, and how to proceed with a medical school (which had graduated to a 'complex' of schools and research facilities by the time of its physical policy implementation) given the legacy left by successive PNM governments, but particularly the Williams regime that placed the issue on the agenda in the first place. A number of interesting points emerge, in this regard, that are particularly instructive to third world politicians engaged in policymaking. One is that despite considerable special interests (in this case the medical academics) involvement and cooptation (through the control of technical influence) on low-politics processes, the fall-out from the process ultimately had political consequences, as politicians and ruling parties, and not technocrats have the most to lose - particularly their political futures, given their ultimate responsibility in policymaking. Another is that the causes for such predicaments are to be found, in a combination of structural factors - including historical and economic factors - as well as agency-based factors, for instance, the Robinson/NAR regime, although making a sound bounded-rational approach to policy, compared to the inaction and non decisionmaking legacy of the Williams and Chambers years on this issue, it also committed its own errors that must be added to the structural explanations of this particular policy trajectory. Jeffrey's (1986) example of the role of the family planning issue in undermining the Indira Gandhi regime also illustrates the role reverse, and transformed role of regimes being influenced and worse, politically threatened by their low-politics, health policy decisions. Even here however, such illustrations of the power content of policies themselves need to be seen within power and process contexts at the structural level, which returns us to the middle-ground' value of the structurated approach to low-politics policy issues such as health.

The case for the structurated approach

Gidden's sociological concept of structuration is one of the more interesting and influential theoretical constructs that can be applied to this explanatory gap within development theory. Giddens essentially advocates the need for a balanced, integrative and dynamic approach to actors and structures in sociological analysis which pays due attention to the specificity of time/space issues. He justifies this by noting that only such an integrative approach can explain diversity and specificity at the micro- and meso-levels with along some amount of structural uniformity and pattern: effectively the prime objectives of social enquiry. In Chapter Two, a number of themes recurred in our discussion of policy: power, content, context, process, timing, and interrelationships at a variety of levels. Policy is about power and its influence on process, hence Dahl's famous assertion that politics is about 'who gets what' and 'why'. Power in policy making is about national and international actors, elites and interest group influences all affecting the decisions that affect the national policy arena. National and international actors and contexts are particularly critical in this regard. In the case of policy making in the post-colonial state, power is the product of a number of situational, structural, socio-cultural and environmental actors and contexts that are vary form territory to territory, but are nevertheless conditioned by power arrangements in colonial society.
The analysis of both national and external power is critical to analysing and explaining low-politics processes like health and health human resources policy processes. Migdal’s ‘strong society-weak state’ thesis has similarly contributed to the agency-structure debate by acknowledging the use and negative consequences of political survival on the development process in poor to middle income states. In his study of policymaking in Indonesia, Liddle (1992: 793-807) criticised dependency theory for placing most of the blame on structural factors, noting the importance of political and socio-cultural factors in the process. He added that in their search for deeper roots, analysts did not address the question of the causes of policy at all, or did so only obliquely. Even where they did, they tend to look at an overly abstracted state without examining the power factor, that is those who control and direct the activities of state agencies. He also added that these researchers tended to tend “...to paint with too broad a brush, rendering monochromatic what might in reality be a rainbow of factors...” Liddle (1992: 793-807). Liddle concluded that these approaches were almost invariably locked into a positivist framework of hypothesis testing and the search for generalisation, which though not bad in itself for policy analysis, got in the way of the basic objective of development policy analysis: which is to solve the problems facing the economy and society. He asserted that the prodigious capacity for self-willed action of human actors as policy makers or in other political roles, individuals and groups often acting against analyst’s expectations must be analysed if there was to be balance:

“...Any approach to the study of the causes of development policy that does not take this simple but powerful truth into account loses much of its diagnostic and prescriptive potency. What is sacrificed is the sensibility necessary to appreciate the range of possible actions a decisionmaker might in fact take, and with it the range of variables or combinations of variables that might influence his or her decision For the problem solver, the ability to respond to flexibly to the unexpected can often make the difference between a win and a loss in the policy game...” (Liddle, 1992: 794).

Bates has similarly noted that scholars should pay more attention to the capacity for autonomous action on the part of local actors, both public and private, and give greater weight to the importance of these choices in shaping the impact of external environments upon the structure of the local societies... (Bates, 1981: 8). I could have analysed the material collected using a solely deterministic, dependency approach that examined the negative impact of external political and economic factors on policy processes. Using this approach the ideas associated with the dependency and indeed much of the development literature would have provided adequate theoretical support for the negative influence of these factors on attempts by post-colonial regimes in Guyana, Jamaica and Trinidad and Tobago to further their development. However, I found that this was unsatisfactory for two reasons: first, much supporting research has already been done in this area; but second, and more importantly, an exclusively dependency-based approach did not explain some of my preliminary observations as well as subsequent findings about policy experiences in these states. Thus, a dependency approach would have explained some, but not all of post-colonial state policy reality ‘on the ground’.

It would have, for instance, explained the real financial pressures facing the Jamaican and Guyanese regimes in the 1970s and 1980s in particular, but would not have explained that the Guyanese regime was undemocratic, more interested in its own survival than policy implementation, and even its progressive policies, were in reality undermined by manipulative regime politics which forced many Guyanese, including hundreds of health personnel to flee the country. The nurse practitioner program which was implemented in 1977 was undoubtedly the government’s most innovative and ambitious human resource strategy. In the case of management capability the role and influence of national regime characteristics and motivations was also clear. In the case of Guyana, the gap between the admittedly progressive constitutional and legislative provisions pertaining to health, on the one hand, and its “meaningless” reality “...in terms of the actual delivery of health services and health care to the citizen...” on the other, was also a by-product of a combination of regime characteristics, particularly regime survival (Lutchman, 1989: 309).

The question of whether regime characteristics or structural factors has played a crucial role in health human resources development policy cannot elicit straightforward, single level answers. Marxian and
neo-Marxian explanations of dependent development are as valid as the agency exhibited by the post-colonial state in its attempt to better itself. Jeffrey's (1986) study of Indian health policy supports my argument for a balanced, integrated approach that includes an appreciation of both structural forces, including medical dominance on the one hand, with the very real positive (and negative) actions that can emanate from developing state governments. On the negative influences of regime characteristics, and indeed its risks for political survival, Jeffrey noted the politically motivated 1975 sterilisation policy decision the 1975 and its negative political fall-out for the Congress Party under Indira Gandhi, as well as, of course, for family planning policies and programmes in India. On the positive side, he points to the role of political democratisation and health policy achievement in the comparative cases of Pakistan and India, both of which gained independence at the same time.

To make generalisations about the influences on the health policy process - particularly health human resources trajectory, given these regime ideological characteristics, however - is to ignore the other important influences of regime power, level of democratisation and desire to hold on to power as equally important factors in the developing state process. Undoubtedly, the relationship between regime characteristics and the policy choice available in the case of health human resources development in Guyana, Jamaica and Trinidad and Tobago between 1970 and 1990 was heavily conditioned by structural factors - a situation common to developed as well as developing states. However the conditions of the developing state are particularly unique. The lack of a preparatory ideology, the unreformed political and bureaucratic structures, the nature of regional and international political, economic and social processes in the 1950s, all managed in their own way to retard the post-independence reform process, while promoting an incrementalist, bounded rationality model of development policy that while promoting stability managed to ignore this fundamental need for a decentralisation-based reform of power relations in order to foster development (Mills and Jones, 1989; Rondinelli 1984; Rondinelli et al 1989).

Structural factors are important, but even economists recognise the value of political factors. Questioning whether IMF agreements led to revolutionary upheavals in the third world, Pantin has noted of Trinidad that while the economic foundations of the political crisis of 1990 did not help, the main problem was a continued regime failure to transform the country’s rentier economy (heavy reliance on oil revenue), and hence the state and society. Examining role of good governance in the Caribbean in the post-1983 period, Musgrove (1986: 156) criticised wasteful investment projects, the lack of reform and an overstaffed state sector as key determinants to the health situation in 1981-84. The political and policy motivation question is also acknowledged by economists. As Lee and Mills note:

"It may...be a myth to believe that governments allocate resources to the health sector solely in order to improve the health of their populations, and even more of a myth to believe that governments are universally committed-above all else-to health improvement (Lee and Mills, 1983:226)."

Abel-Smith’s (1976) also notes the wider prevalence of dilemmas faced in what are commonly termed developing state problems:

"A powerful politician may have promised to secure a hospital for his constituency and he is likely to get it. Any theoretical distributional aim may be modified by short-term political pressures. These are the realities of life in any society..." (1976: 180).

The role of political factors has been recognised in the Caribbean public administration literature. Khan’s (1993) list of the major problems facing the Caribbean public sector, are therefore extremely applicable in the case of health and health human resources policy because they concur with my findings in this study. The lack of clear national strategic plans identifying priorities as well as short-medium and long term objectives including the fundamental reforms needed to implement such a plan; organisational inertia, resulting, inter alia, from over-centralisation; the over-centralisation of decision-making which manifests itself in an over-reliance on cabinet decisions without which little significant action is initiated; the lack of delegation of authority; the lack of coordination; the ad-hoc attempts at organisational reform and the resulting mobilisation of forces to block such attempts; many of which had come from
prescriptions of external consultants are all relevant in the case of the health human resources process that may have some relation to resource scarcity, but more to do with regime mismanagement and failure to reform.

Khan’s conclusion that these “constraining” forces have resulted in significant levels of turnover from the public sector, with those who leave doing so through disillusionment resonates in Chapter Six on the doctor and nurse migration problem. The outcome of these departures, as he points out, provides an excuse for not embarking on any meaningful human resources planning since the view prevails that planning in the context of uncertainty regarding the quantity and quality of available human resources is seen to be a meaningless exercise “...since those who benefit from such efforts are more often than not the same ones who leave the public sector...” (Khan, 1993). While a profoundly pessimistic view this reflected much of the reality of the health sector throughout the 1970s and 1980s. Considerable improvements have been made in the 1990s, the most important one being the implementation of health policy reform programmes. However, many of these basic problems remain, thus emphasising the need to recognise that the problem is one of both actors and structures, and can only be solve if addressed at both levels (Simmonds, 1989). Given, these views which confirm the need for an integrated structured approach to health policy analysis in the developing state, I now turn to the prospects for the rest of the decade and beyond.

The implications of the findings for the future of Caribbean health human resources

A number of implications arise of this study that are potentially disrupting in the health and health human resources policy process in the 1990s and beyond. Structural factors such as resource scarcity, the debt crisis and structural adjustment are undoubtedly the biggest problems impeding the ability to implement policies that are in the interests of national populations. The capacity of international financial institutions to undermine national policies and development plans through the conditions attached to urgently-needed loans cannot be underestimated, a fact which the Manley regime eventually recognised to its political as well as its policy cost (Barrett; 1979; Carr, 1977: 166-170). In the case of the debt crisis, Caribbean debt doubled to nearly US$1 billion US between 1980 and 1988. In 1991, Jamaica had to use 31% of its US$ 2.4 billion export earnings to service its debt. Both Guyana and Jamaica have suffered from the consequences of the debt crisis more than Trinidad. Jamaica was actually the first country to be given a structural adjustment package, and so has been under a much longer indebted period, but without any relief in sight. The fact that Jamaica’s GNP per capita is marginally higher than Guyana’s, has seen the latter placed on the ‘Group of Eight’ shortlist for debt forgiveness. Policies such as this threaten to undermine Jamaica’s tremendous social and health gains since independence (Pastor and Fletcher, 1993: 267). Trinidad is also indebted but its oil revenue continues to offer a brighter future for the funding of the public health services. However the country still has not fully recovered from the spending spree period of the 1970s under the Williams’ regime. As Stone noted of the ‘windfall developing states’:

"...Countries like Nigeria and Trinidad and Tobago where a weak state in the first case and poor management of the windfall gains in the second created economic crisis and chaos rather than real progress are interesting examples of how windfall benefits can hurt rather than help development..." (1991: 99).

In the case of the impact of structural adjustment and health policy reform in Trinidad in the early 1990s, there was concern about the possible negative effects of the World Bank-supported health decentralisation programme (Phillips (1994:144). There was the feared impact of regionalisation and decentralisation for staff job security and tenure, with the autonomy shifted to the regions and the private sector. Phillips noted that the new roles and structure superseded the functioning of the public service commissions and was to the disadvantage of the employee. However views like this, while valid, have to be seen in the context of the status quo prior to reform. One cannot deny the considerably negative effects of World Bank and IMF policies on social development in the ‘third world’ (Feder, 1983; Burkett, 1991; Caulfield, 1997). However this is a reality that should serve as a reminder the developing state governments to act responsibility in the long-term health interests of their citizens, despite that fact that it was attributable to both international banks and developing states.
However, events in developing countries including Commonwealth Caribbean states in the 1990s give some cause for concern in this regard, particularly the increasing role of privatisation. In the case of this ‘public-private’ mix for health human resources, Frenk (1993) defended it on the grounds that it can “correct the imbalances” in the health sector by drawing from the best of both sectors, given public sector mismanagement and the contradiction in so many developing states - the co-existence of unserved populations with under-utilised human resources. In the Caribbean, privatisation has also been supported by some, although this support is still in the minority (Grell, 1993: 3). Jamaica has been ahead in this regard with private sector involvement in an investment climate study in that country’s health sector. However, in terms of the future and the role of privatisation in the 1990s, as Borzutsky has noted (1993: 255-6) despite the widespread enthusiasm for privatisation generally, as recent demands for national health insurance in the USA have indicated, there are definite limits to the role of the private sector in the context of declining economic conditions. As she noted: “…some functions will always have to be performed by the state.” (1993: 256). She added however that the pressures for “expanding and improving…health policies and services are likely to increase as democratisation continues.” (Borzutsky, 1993: 256). The connection to democratisation as we have seen in the case of Guyana has been a welcome one. There is a prevailing sense on the one hand in the region that a good balance will be reached, and that adjustment policies and even some privatisation of non-care services, and other reforms including better management will strengthen and preserve these health systems in the long run. However, there is the prevailing fear of further private sector incursions into the public health sector. The answer to this is that private sector has always operated side by side with Caribbean public health systems. This is not to say however that the public health system cannot be improved and maintained in these small, developing states.

Aside from economic factors, the most important concern and priority for the rest of the 1990s and beyond is an action-oriented one: better planning. One of the key issues as we have noted repeatedly in this study is poor information. Even the information available during this course of the study reflect my central argument about the role of regime characteristics. The implementation of regular health manpower statistics surveys in Jamaica, strongly supported under the Manley regime meant that I was able to access reliable data, which though not always detailed and perfect, was reasonably systematic. In the wealthier Trinidad by contrast, the poor health planning unit at the health ministry could not supply basic data on vacancies by categories of health staff for the period under study which reflected badly on among other things, the Williams boom years, and the neglect of the bureaucracy. On the more relevant issue of planning for a balanced health manpower work force Abel-Smith (1994:104) has concluded that:

“…planning the health professions, the mix of different grades, and where those that have been trained will practice are all critical for health service planning. If this is all but left to market forces, any health system will become inequitable, unnecessarily expensive and unresponsive to health priorities. Moreover, there are important international ramifications which can damage the best intentions of national planners. The developed countries have a responsibility not to allow their own special needs to obstruct health progress in the developing world...”

Better planning has to be both integrated into other elements of the system and within the common health goals of primary health care. Simmonds (1989: 194) has pointed in this regard to the relative absence until recently of the integration of management component of human resources development with the planning and production elements, and especially the need for better systemic knowledge especially in the case of nurses which, she asserted, would uplift their status as managers and better articulators (like doctors are) of their problems. Here again, the issue of effective demand in Caribbean states must be considered (Cumper, 1993; Anderson, 1995). Ferster and Tilden similarly argue that health human resources planning, training and management needs to be synchronised with other human resources “…to ensure that demand for people with different levels of education are congruent with their supply, and that the plans of one sector are not hampered by those of another...” (1983: 116-117). The importance of cost-effectiveness in health then, while not only relevant to developing states, is however even more vital in an environment of scarce resources. There exists therefore the need to explore options for ‘anomalies’ where for example highly trained professionals such as doctors are used for tasks that could be handled by less qualified personnel such as nurses (Abel-Smith 1984:88-90). Abel Smith noted that the most logical way forward was to plan for a “…correct balance of types of available service and trained manpower necessary.
...the rule is still the medical professional as platonic guardian setting standards which - given available resources - necessarily limit access, and also treating attempted patient, politician or other professional criticism as either ignorant folly or 'malpractice'...some medical professionals do believe radical changes are needed...in the end however, it is often necessary for politicians to pluck up the courage to say (and to act) that health is too important and too complex to be left totally in the hands of doctors..."
1979. In most countries, unemployment has increased, poverty has struck new
groups, austerity policies have been implemented, and government health
expenditures have been reduced. Increased malnutrition, famine, and deteriorated
health conditions have become realities in many countries. The health manpower
system could not be immune from such turmoil. New trends have emerged,
challenging some of the conventional ways of thinking which were "a la mode" in
the early 1970s. It seems that the prime task today is to build up systems able to
adjust themselves quickly and safely to changing adverse conditions..." Doan,

The West Indian Commission noted in their 1992 report that while the entire region had fewer doctors
and more nurses than Latin America, it nevertheless recorded massive migration of health workers,
especially nurses with their numbers steadily declining in the larger countries such as Guyana, Jamaica
and Trinidad (West Indian Commission, 1992: 22). The Commission expressed concern at the Seaga
regime’s cutbacks in health staff including nurses and community health aides in the 1980s. There is also
cause for concern about the role of international financial and non-financial institutions as de facto
policymakers in developing states. In the case of the increased visibility of organisations such as the
World Bank and USAID, and even UN organisations such as the WHO and UNICEF one critic has
questioned the increasing level of influence of these organisations in dictating health programmes and
reforms in developing countries, as the “principles of ‘equity and ‘health for all’ [become] distorted by the
ideologies of Western market forces health care...” (Lob-Leyt, 1990: 86). Buse (1994: 98-99) has pointed
to the major realignment in global health policy and the now increasingly influential role of the world
bank in the health sector, and its overwhelming agenda-setting policy role and leverage as lender to
developing states. The role of national actors, particularly national governments in framing debates,
according to Buse is critical in this regard... There was however enough cause for optimism in the
Commonwealth Caribbean as Pastor and Fletcher (1993: 257) noted was the continued faith in the
democratic process in the region and its promise for future development:

"...politically and socially, Caribbean hopes have been commendable. The region
has wanted democracy, independence and stability for its nations and justice and
equality of opportunity for its citizens. Although the English-speaking Caribbean
has serious economic and social problems, by and large, it has retained its
Independence within a democratic framework that has promoted peaceful change.
This is a remarkable achievement in the developing world..."

The debate on whether there is a specific third world policy process is answered by Horowitz who
came to the following conclusion:

"...On the one hand, it is clear that the systemic frameworks of policy -the
institutions, participants, resources, the weight of the state relative to the society,
and the capacity of the state to work its will-all vary between developing and
Western countries. The same is true for the scope of policy activity, the
configuration of issues, and the actual content of policy. On the other hand, the
policy process - the constraints, the ripe moments that produce innovation, the
tendency of policy to have unanticipated consequences, and so on - appears to
display regularities that transcend the categories of Western or Third World state"
(1989, 197).

It is an underestimation to say that developing countries - including those in Guyana, Jamaica,
Trinidad and the rest of the Commonwealth Caribbean are faced with difficult challenges in their health
and health human resources policies in the decades ahead. For far too long there has been a blinkered,
softly-softly approach in the literature towards the roles and responsibilities of developing states in their
policy actions, processes and outcomes. While highly justifiable given economic developments over the
last two decades, such a blinkered view does a disservice to those committed governments and
policymakers who have through their actions made huge improvements to the quality of health care within
their countries. Dependent development theory may be an overriding factor given the continued
globalisation trends. However, state and regime action are still relevant and are still going to be shaped
and conditioned by a variety of factors, including enlightened self-interest, as in the colonial period. In an era of accountability and good governance however, the possibilities for mismanagement and political graft, at least in the Commonwealth Caribbean, seem less important than the need to strive for efficiency and better management of limited resources. Although there is much to criticise about these institutions in the case of health care, one wonders whether efficiency and better management would be on the agenda in the first place, one totally relied on the political will of prime ministers and health ministers in developing states. This goes back to Reich’s (1994) negation of the idea of ‘political’ will as significant. The fundamental question then remains, as Reich, Walt (1994) note, not so much one of political will but rather the influence of power on process even in ‘low-politics’, yet non-directly-linked ‘crisis-ridden’ issues like health policy and policy reform. According to Reich the more important focus should be on:

“...how governments act as the agents of private interests, how governments act to retain power... markets become instruments of political organisation...and how the international political economy impacts on national health policy and health conditions...”

Implications for further research

Given the limitations of time, money and method that conditioned this study, future research in this area to fulfil the other half of grounded theory - the hypothesis-testing element - by examining policy processes in other similar, as well as dissimilar developing states is clearly necessary, to compare, even corroborate some of the findings. Within the Caribbean region, such studies, for instance, could examine and compare the developments in the smaller micro-states; while it could also be applied to the former Spanish, French, and Dutch Caribbean countries. Other studies could for instance question whether economic factors are more significant by comparing regimes and countries according to economic levels - for instance middle-range economies as against low-income economies, which Trinidad and Jamaica, on the one hand, and Guyana, on the other, also to some extent symbolise. These are just some general ideas. The worthwhile nature therefore, of such studies is that they would contribute to our understanding of both diversities and similarities in policymaking experiences across developing states.

8.3 SUMMARY

In this dissertation, I have examined the role, influence and relevance of the following regime characteristics first used by Bossert (1983) - regime strength, stability, ideology, democracy to which I added regime maintenance and survival, given my data findings - on health human resources development in the post-colonial state, using three states in the Commonwealth Caribbean, Guyana Jamaica and Trinidad and Tobago for my comparative case study. Unlike Bossert’s study, my intention was not to test any single level or multi level influence of the these characteristics on health human resources policy. Rather, I wanted to examine the available evidence for conclusive trends of the existence of such influences in these three states between 1970 and 1990. I found evidence for the pervasive influence of structural factors - colonial structures, economic political, and socio-cultural factors, as well as international factors on policy process. However, like Grindle and Thomas and other researchers concerned with the capacity of the developing state to act, I found that ample evidence was available for positive, progressive action, negative, regressive action, inaction, limited action, pragmatic policymaking based on available choices as well as non-pragmatic decisions that had dire consequences. My main finding - if there is one- is that one set of determinants cannot be examined without relation it to the other. In effect, my basic finding was that to structure-based factors must also be added those national-level policy choices (both progressive and regressive) that certain regimes have actively and consciously made in the past (and in some cases continue to make), and which are based inter alia on variety of reasons ranging from genuine interest to enlightened self-interest to blatant political or regime survival. Essentially this is what Giddens’ termed structuration. While structural factors, may dominate the policy equation, the essential finding of this study is that to ignore actors and their actions at the national level, the contexts within which they make decisions within the international context rather than outside the international context is to miss the central goal of social inquiry, that is to determine deviation and diversity within more generalizable and justifiable theoretical patterns. Structuration-based approaches thus offers the developing state policy researcher a fresh, ‘mixed-scanning’ type look at the developing state policy process, which is what in the final analysis is needed to move knowledge forward in the policy sciences.
Comparative policy analysis has long been used to examine the influence of regime characteristics on developed state high-politics national policy processes, yet its application to low-politics issues such as health has been problematic, the most obvious being the pervasive and largely negative influences of structural factors. The impasse in development theory in the 1980s and the influence of Giddens' structuration or agency-structure theory revealed the need to integrate deterministic explanations of developing state policymaking, with analyses of individual political, economic and socio-cultural contexts, dominant actors, their motivations, diversity of experiences, and the resulting potential implications for policy action, inaction and limited action within a changing, though still heavily-skewed global environment.

Using an integrated grounded theory-comparative case study methodology, I examined and compared the influence of regime characteristics on health human resources policy in the post-colonial state, using three Commonwealth Caribbean states: Guyana, Jamaica and Trinidad and Tobago as my case studies. I used as my framework Bossert's regime characteristics: regime strength, stability, ideology and democracy - to which I added the phenomenon of regime survival or maintenance, applied by Migdal, Hintzen, Ames and others in the developing state political sciences. My findings like Bossert's 1983 study of Central American health policy, were similarly complex. At the broadest level, a reasonably clear relationship was found between regime ideology, democracy and maintenance and health human resources trajectories and outcomes particularly during the 1970s when regimes in each country pursued various development paths, some of them radical; and the 1980s, when structural adjustment programmes limited action and even undermined policies.

The most significant findings for development country health policy studies were nevertheless: 1) that regime characteristics do invariably affect low-politics policy processes; 2) conversely, that low-politics issues such as health can also occasionally become high-politics and crisis-driven to the extent that they can in turn affect regime survival under particular and unique confluences of content- and contextual factors that go beyond resource scarcity explanations; 3) that structural adjustment policies seriously impeded, indeed undermined existing and newly-implemented programmes; and 4) interestingly, that while structural adjustment policies were largely and unsurprisingly negative for non-crisis-driven, low-politics issues, in one they proved 'positive' by returning the issue of political and administrative reform - critical to public policy development, and neglected for various reasons, including regime survival - back onto the developing state policy agenda of the Caribbean developing state. The evident complexity of these findings only underscores the need for developing state health policy analysis to focus more on integrated actor-structure-based approaches in order to effectively explain the diversity of low-politics policy actions and processes and experiences within such states.
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Ms. J. Timberlake, Health Planner, Ministry of Health.
Mr K. Davis, Community Health Worker Tutor, GAHEF.
Mr P. Carr, PAHO/WHO Representative.
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