The Turks and Caicos Islands: A Public Private Investment Partnership For an Integrated Health System

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This paper outlines the model and captures the experiences thus far, of the Turks and Caicos Islands (TCI) Public-Private Investment Partnership (PPIP). The PPIP delivers a new integrated health system for the people of TCI and serves as a catalyst for broader health systems strengthening. This PPIP is unique in that, as well as building and managing facilities, it includes management of a wide range of primary care, outpatient and hospital services; and uses capitation to pay providers. Further, it links PPIP development with implementation of a national health insurance plan that provides long term financial sustainability for the PPIP and the country's health system.

I. Introduction and Background

Health is not just the mere absence of disease, but is a relative state of physical, social and psychological well-being. It is a harmonious adjustment to the environment, together with an attitude that regards it not as an end in itself, but as a means to richer life as measured in constructive service to mankind. The health system is responsible for assisting man to meet his needs so that he will be able to maintain an optimum level of wellness and make constructive contributions to his society.

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The Turks and Caicos Islands (TCI) is a UK Overseas Territory in the West Indies, with a Governor appointed by the Crown and an elected ministerial government. TCI lies southeast of the Bahamas and its territory consists of eight large islands and many smaller cays and islets. The islands are scattered over a large area, which presents a challenge for governance and often results in duplication of essential government services such as health (Figure 1).[i]

Figure I: Turks and Caicos Islands Territory

[1] The authors are advisors to the TCI government in their health sector reform.

During the past 20 years, TCI has experienced significant economic growth. In 2001, its Gross Domestic Product (GDP) per capita was approximately $11,500; while in 2007 it exceeded $23,000.[ii] This rapid economic growth has led to an equally dramatic increase in population, largely through the migration of workers from neighboring Caribbean countries and Asia, to support TCI's tourism and construction sectors. In 1980, TCI's population was 7400; as of 2007 it reached 35,000.[iii] Roughly two thirds of the population is immigrant workers and expatriates; while 11,000 are natives (called "belongers').

While the population growth has placed a strain on TCI's basic health services, the economic growth has allowed the TCI Government (TCIG) to continue to offer comprehensive health services virtually free, to all its residents. This includes committing significant resources to fund health care overseas, through a generous treatment abroad program (TAP). The government spent an estimated 6.8% of GDP (approx. $1100 per capita) on health care in 2008; 63% of this was for TAP.[iv] Private health spending through private insurance and out-of pocket payments is estimated to be 0.8% of GDP.[v]

The Ministry of Health is responsible for the provision of all preventive and curative services on the Islands. Primary healthcare clinics are located on each of the six main islands, while the two largest islands, Providenciales (Provo) and Grand Turk, have hospitals offering secondary care.

Though private providers exist, they are limited to providing outpatient services in Provo, and cover mainly general practice and limited specialist care. As in the UK, doctors are allowed to work in both the public and private sectors and some do so. As in many systems with public financing and provision, explicit regulation tends to be weak in TCI, with the Ministry of Health serving as payer, provider and regulator.

This paper describes the health sector reforms being undertaken by TCIG. The first section provides a background for the reforms; sections II and III describe these reforms in more detail; while sections IV and V outline lessons learned and conclusions.

Impetus for Change

Several factors in the past few years have made it increasingly difficult for the government to provide the level of quality and access to health care that its population requires and expects.

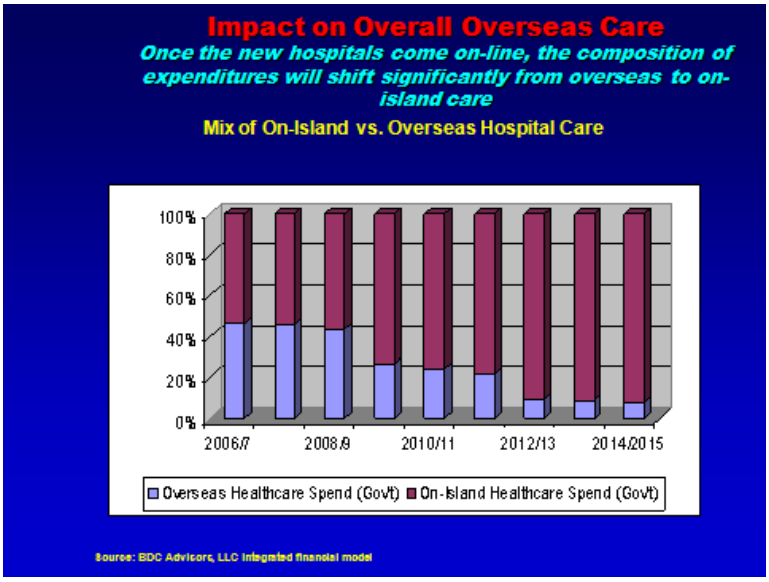
First, the basic infrastructure of the current hospitals is not adequate to meet the needs of the population, with a limited number of beds and outdated clinical facilities. As a consequence, most specialty services are sent off the Islands through TAP. The costs of this program, which allows coverage for services in the very expensive US market, have escalated dramatically. With higher incomes, the native population increasingly demands treatment in the US for services that may be provided on TCI, but are not considered to be of adequate quality. In some cases this includes deliveries, where the program covers travel to the US for the mother and accompanying family members, and

sometimes extended stays at expensive hospitals and hotels. TAP costs rose from $8.9 million in 2005 to almost $32 million in 2007. Even with TCI's high economic growth rate, this is clearly unsustainable.

Second, rapid population growth and the demographics of this growth, have placed competing demands on the health sector. On one side, the rising immigrant worker population, with over 47 multinational and multicultural groups, has changed the country's disease profile and brought with it communicable diseases that were uncommon in the native population. On the other side, TCI has become a popular tourist destination and has seen rapid growth in the purchase of vacation homes and properties by wealthy Americans, including retirees, who demand a new standard of quality and availability of health services.[vi] For this population continued foreign investment may be dependent on the level of health care the Islands are able to offer, particularly for an aging expatriate community.

Third, TCI residents do not pay any general income tax or VAT. All government expenditures are funded through import duties and land transfer taxes. These taxes cannot be expected to keep pace with the growing fiscal demands of the health sector.

Based on these considerations, in 2004, TCIG commissioned a strategic plan for the health system, which showed that by expanding the scope and quality of services on the Islands, it could significantly reduce TAP expenditures and provide greater access to quality health services. (Figure 2).

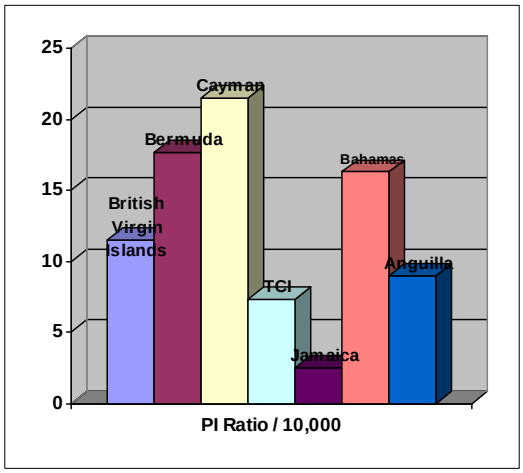


However, the plan also indicated that it would be difficult to scale up government services due to a shortage of qualified managers and staff. Figure 3 shows that TCI ranks second to the bottom for physicians/10,000 population compared to its neighbors.[vii] The small population makes it difficult to attract high quality specialist care; and like countries in Africa, the Caribbean is grappling with a brain drain of health personnel to richer countries.

To address the needs identified in the Plan involved the construction of expanded healthcare facilities on TCI. The government decided to pursue building its new infrastructure through a Private Finance Initiative (PFI) model for the reasons that many countries decide on this arrangement: to undertake large capital expenditures, while maintaining prudent balance sheet management. This has allowed TCIG to spend its limited capital on hard infrastructure projects, such as roads and airports, and to invest

in education and training for its people; while it accessed external debt and equity through the PFI, to finance its health system.

Figure 3: Physicians per 10,000 Population for Selected Caribbean Countries



TCIG, decided to take the project to a new level, by bringing in world class expertise to both design, build and manage its new facilities, and to provide healthcare services in those facilities. By investing in its social infrastructure, TCI is ensuring that the reform will not simply result in new buildings, but will fundamentally change the quality and delivery of health services on Islands.

In 2005, the government approached the international private healthcare market to commission the building of two new hospitals for TCI, and to procure the provision of health care and facilities management services at the hospitals, for a period of 25 years. The three objectives of TCIG in its procurement were to:

a. Achieve value for money.
b. Maintain financial viability and affordability for overall government spending.
c. Follow an equitable and transparent bidding and selection process.

The government chose the European procurement process which specifies guidelines for open and transparent competitive tendering. This proved to be critical for political acceptance of the program, and encouraged the participation of high quality health providers, by reassuring international investors.

The project was advertised in August 2005, to gather an expression of interest. A pre-qualification questionnaire was sent to interested providers in November of that year, followed by an Invitation to Negotiate in May 2006. In August 2006, Interhealth Canada Limited ("ICL") was appointed as preferred bidder. The project achieved financial close in January 2008, roughly 18 months from selection of ICL as preferred bidder.

While this length of time is not long compared to other PFI and PPIP projects, the fact that the project was breaking new ground in its scope added to the complexity of the funding and legal arrangements. The resulting health reform has three parts which work together to create the new integrated health system for TCI.

1. A PPIP which includes:

a) Construction and maintenance of two state-of –the-art complexes offering a wide range of primary, secondary and tertiary care.

b) Management of clinical, ancillary and support services on the Islands.

2. The establishment of a Health Regulatory Authority for monitoring and regulating quality and access to care for the entire health sector.
3. The implementation of a National Health Insurance Plan to ensure financial sustainability for the health system.

These are described in more detail in Section II.

II. Towards a New Integrated Health System

Integrated Health Services Delivery

The new healthcare system, which will be fully operational in early 2010, separates funding from provision and explicitly develops the role of the government as regulator of the entire health sector, not just publicly provided services. Hospital care, and an increasing range of specialty services, will be provided through two new healthcare complexes at Provo and Grand Turk. ICL will be responsible for building and operating the hospitals and providing a full range of clinical services (primary through tertiary), for a period of 25 years. At the end of this period, the infrastructure will revert to TCIG. The government can choose at that time to extend the contract with ICL (for a further five years) for the management of all or a part of its clinical care, partner with a different provider, or bring these services under direct government control.

At the outset, a critical consideration for TCIG was to ensure that the majority of staff, including physicians, at the existing hospitals would transfer to ICL once the new hospitals were built. ICL agreed, where possible, to provide extensive training to staff to upgrade their skills and build long term capacity on TCI. Any additional staff ICL requires for the operation of the hospitals will also be recruited from the existing population of TCI whenever possible. The intent of both parties is to build on-Island capacity and potentially pass management responsibilities to the government before the end of the contract, if this is deemed appropriate.

In addition to training current staff, ICL will bring-in international specialists both on a permanent and rotational basis to expand the scope of services offered on-Island. Because ICL's investors include a major university hospital in Canada it has ready access to experienced clinicians. In later stages of the project, telemedicine will be brought-in to link TCI to Canadian high tech facilities.

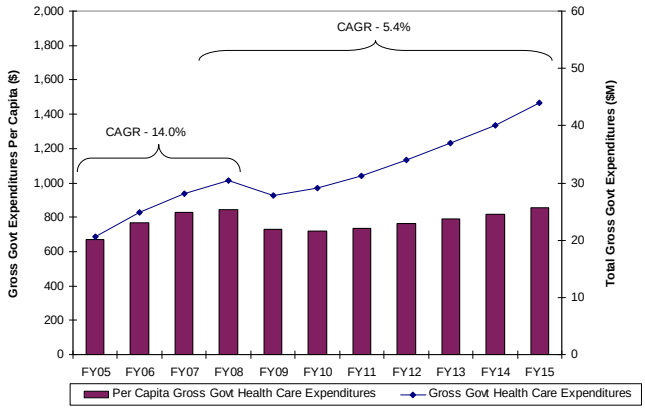
The new healthcare system is also seen as a way to encourage health tourism to TCI. To ensure that the people of TCI benefit from this new industry, both parties have agreed that profits from health tourism activities will be shared equally.

The National Health Insurance Plan

While the new system of provision represents a major evolution in the level of quality and capacity on the Islands, the government continues to be committed to allowing universal access to healthcare regardless of ability to pay. These objectives come with a price tag that is prohibitive for the government to sustain from current revenue sources, even with continued high economic growth. To finance its new delivery system, the government examined several options, including introducing a general income tax, mandating the purchase of private insurance by employers and individuals, introducing a social health insurance system funded by payroll taxes, and legislating other hypothecated taxes such as VAT or tobacco taxes. For a number of reasons, including an existing payroll-based pension scheme and high formal sector employment, TCIG has chosen to introduce a mandatory social health insurance system, called the National Health Insurance Plan (NHIP) which will cover all residents and immigrant workers. This will be implemented prior to the opening of the new health facilities to ensure that it has accumulated sufficient reserves for sustainability.

Funding for the NHIP will come from a combination of employee/employer, individual and self-employed contributions. These will be augmented by government payments for the poor, elderly and vulnerable populations, pensioners, and others who cannot afford to pay. The implementation of NHIP is expected to slow the rate of growth of the government's share of health expenditures from its current compound annual growth rate (CAGR) of 14% to a more affordable, 5.4 % (Figure 4).[viii]

Figure 4: Projected TCI Government Health Care Expenditures



Source: BDC Advisors, LLC integrated financial model

The government will not increase or decrease its projected expenditures for health, but will shift monies from paying for its current health system, including overseas care, to providing on-island services. This will also support the Islands' economy and expand employment opportunities.

Creating a new health system with expanded and modern facilities is essential to the political acceptance of payroll taxation for the NHIP. Initial focus groups show that the

public's willingness to pay is high because the new system will meet Canadian accreditation standards and raise the level of service on the Islands.

III. What Is Different about this PPIP?

The design of the health system and the partnership between TCIG and ICL has a number of unique elements, which are highlighted below:

- *Full Spectrum of Care*

  The first major difference between this and other projects is that provision of clinical services is part of the contract in addition to designing, building and facilities management services. The reform goes further, by having the provider manage the full spectrum of health services, across primary, secondary and tertiary levels, not just hospital care.[2] This will ensure better continuity of care, allow the health system to adapt to changes over time, and help to manage healthcare costs. Since ICL is responsible for all services, it can decide the most cost effective and appropriate means of provision, and adapt its delivery model to meet the changing needs of the population. It also means that TCI is not locked into hospital care at the expense of primary and community based services.

- *Aligned Incentives*

  To support ICL's investment in developing cost-effective, community based and patient-centered services, payment for clinical services will be on a capitated formula, which provides a single payment to the provider to cover the full range of clinical services for the population. This is an important component of the design of the system, since it aligns the incentives of the provider and the government, and provides opportunities for both parties to make changes to health services delivery as they occur, minimizing perverse incentives to continue to hospitalize patients when they can be treated at home, or to devote unnecessary resources to curative care. Capitation provides a good foundation for a long term partnership because it can adapt to changes in practice patterns, technologies, epidemiology and care modalities, which will inevitably occur during the course of the arrangement.

  With limited historical data on costs and utilization, the provider was reluctant at first, to assume full capitation risk for clinical care. A methodology was jointly devised to pay ICL on a direct cost basis (actual costs plus an agreed upon margin) for the first two years of operations. During this time, utilization and cost data will be gathered and a shadow capitation system will operate to allow both parties to become accustomed to capitation without actually shifting risk to ICL. After two years, an actuarial study will be commissioned to determine the

[2] Primary care at the smaller islands will still be provided by the Ministry of Health.

appropriate capitation payment going forward. A full review process will take place at specified intervals during the life of the contract to recalibrate the capitation amount considering changes in epidemiology, demographics, and treatment patterns.

- *Quality Assurance and Monitoring*

  Developing a contract for clinical services requires a detailed risk and responsibilities matrix specifying which party is accountable for particular services, with established standards of quality, access and availability. While ICL will provide all secondary care, selected tertiary care on-island, and primary care for the populations of the two islands on which it has facilities; the government retains control of public health services (e.g. immunization campaigns, health education), and primary care on neighboring islands. Where ICL has facilities, these government provided services will be co-located on the ICL complex.

  The clinical services contract specifies a comprehensive list of key performance indicators (KPIs) based on international standards, with payment subject to deductions for non-compliance. It is important to note that deductions are not intended to penalize the provider severely, but to ensure that the provider is focused on the performance indicators that the government feels are important. For example, a KPI on access indicates that waiting times for patients needing urgent diagnostic tests cannot exceed 5 working days. If they do, a financial deduction will be made to ensure prompt access. Performance deductions are based on the severity and frequency of non-performance, ranging from $40-$100. Deductions are progressive, so that if the same problem is reported multiple times, the amount the government can deduct is much higher than when the problem is initially reported. Continued poor performance may trigger a service investigation and can ultimately lead to termination of the clinical services contract.

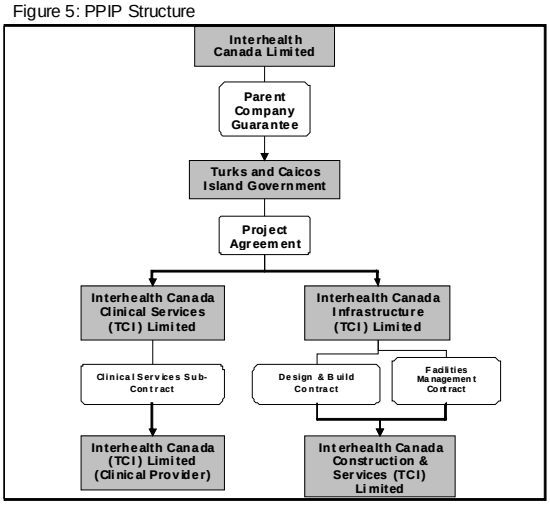
  The contract requires that the Canadian Council on Health Services Accreditation accredit ICL facilities. Maintaining accreditation is a prerequisite for payment, and loss of accreditation for any period of time would allow TCIG to terminate the agreement.

  The government will also provide ongoing monitoring of quality and access through the creation of a Health Regulatory Agency (HRA) to monitor the public and private health sectors on the Islands. The introduction of this body will prompt the development of sound quality of care and service standards, and has resulted in a complete updating of healthcare regulations.

- *Structure of Contract*

While funders have considerable experience with the construction of facilities and understand the risk they undertake in financing these projects, few are willing to assume long- term risk for management of clinical services because they are unfamiliar with this aspect of the health sector. This may change as more PPIPs are created.

Figure 5: PPIP Structure



In the case of TCI, ring fencing funders' risk, led to the creation of two separate special purpose vehicles (SPVs or subsidiaries) for the PPIP. One is responsible for designing and building the new facilities, providing equipment and technology, and covering basic facilities management services such as cleaning, estates and catering services over the life of the project; while the second SPV will manage clinical services and maintain medical equipment and information systems. The first SPV has the greatest capital outlay and is funded by a consortium of banks; the second is funded by ICL and its subsidiaries. This arrangement is also useful in that termination of the clinical services would not of itself void the whole contract.

As is normal in PPIPs it was ICL's responsibility to obtain financing for the project. Construction and facilities management services are funded by a consortium of banks which have made monies available to ICL during the construction phase. ICL starts to receive payment from TCIG once the hospitals are built and, at this point, ICL will be required to begin repayment to the consortium. TCIG will begin full payments to ICL only when both hospitals are operational.

Two separate payment streams are specified in the contract. A unitary payment is intended to recompense ICL for the construction of the hospitals, the provision of facilities management services and the purchase of initial equipment. The unitary payment will be paid in monthly installments by TCIG over the 25 year life of the contract once the hospitals are built. If the performance of facilities management services is poor during any one month TCIG is entitled to make deductions from that month's unitary payment in accordance with the established performance monitoring and payment mechanism. Clinical services will be paid as described earlier, through capitation. Again, payment will commence only when services are operational.

TCIG has built excess capacity into the hospital design to accommodate continued population growth. Because the unitary payment is fixed, it will decrease on a per capita basis as the population grows. Clinical services, paid by capitation, will increase as the population grows. To ensure that clinical services costs remain competitive, a value testing mechanism is specified in the contract which involves benchmarking costs against other countries and the region.

The combined payments for building, equipping, maintaining, managing, and providing clinical services are projected to be approx. $1200 per capita in the initial years of the contract. If capital costs are not included, this figure comes down to approx. $650 per capita. With the anticipated reduction in spending for overseas care, the PPIP should result in an overall decrease in government per capita expenditures for health.

IV. What Have We Learned So Far?

Both TCI and ICL are breaking new ground in this project, which is now entering post-Financial Close Implementation. For a period of two years until the health system is operational (April 2010), intensive work will be required by dedicated teams from ICL and the government to manage the complexities of construction, facilities management, information systems, new clinical procedures and protocols, upgrading quality, access and service standards; training and transferring staff; creating a Healthcare Regulatory Authority with detailed standards and regulations; designing and implementing the NHIP; as well as managing a myriad of other unanticipated issues which are bound to arise. ICL is managing these processes on the ground, in partnership with the Government to ensure that activities are coordinated and the transition to the new system is smooth. It is important to note that TCIG will have no payment obligations to ICL during this transition period. Government payments will start when hospitals are built, with full payments commencing only when the new health system is operational.

While the program is still in its initial phases, a number of lessons so far may be useful for other PPIPs.

- ***Political stability, and high level participation and commitment by Government are essential.***

The Project Director in TCI, the Honorable Royal Robinson, is a senior politician and recognized leader on TCI, who reports directly to the Deputy Premier, Premier, and House of Assembly. During the development phase, this allowed him to personally address a number of obstacles, any one of which could have derailed the project. He was able to call on policy makers to provide input at critical junctures which demonstrated to the private partner that the government was serious about the partnership. Senior officials, including the Ministers of Health and Finance, and the Attorney General, attended key meetings and were personally committed to ensuring the program's success.

- ***Building a market requires effort.***

Before a deal can be structured, it is necessary to have high quality, well financed and managed providers, who will undertake the challenge of building and operating healthcare facilities in emerging markets. There are many companies willing to enter OECD countries, or to build and manage hospitals for the rich paid for on a fee-for-service basis in developing countries. There are only a handful that have the expertise and capital to invest in the developing world and are committed to providing care for the broader population through a government partnership. Even with an open bid process, ensuring a choice of providers for TCI involved targeting potential bidders based on personal contacts. For providers to invest the time and money it takes to prepare a bid for a large infrastructure and services project, required that the process be perceived as open, fair and transparent which was achieved by closely following European public procurement, which is recognized as a robust model.

- ***Encouraging market development may require managing and limiting provider risk.***

Before financial close and prior to the operation of the facilities, the provider is responsible for all outlays, including borrowing costs. The government's first payments begin when the hospitals are built, which will be several years after initial bid submission. This is obviously advantageous to the government, but limits the willingness of private operators to enter this line of business. The risk to the provider is greatest before financial close, during which time, the contract may not be finalized for a variety of political and economic reasons which are beyond the control of the bidder. In rich country markets, the costs of failed bids can be recouped in future government contracts. This is less of an option in developing countries. A change of government is also a risk. This was not a problem in TCI, which has a stable government, but elections in the midst of the financial close process, caused some sleepless nights. Ways to limit provider risk should be considered, such as interim payments, incentives to close, or underwriting a portion of the losing bidders' costs or financing.

- ***It takes time and money to close the deal…***..

Considerable time and expert resources are required to manage the details of negotiating a PPIP contract. It is fair to say that both parties underestimated the time and money needed to achieve financial closure. Dedicated, preferably full time teams, on both sides could shorten the time required to close a project. These teams could also prepare for post-financial close to build public capacity through the multi-year launch of the new health system. Shortening the time to financial close will reduce risk for both sides and help to sustain political commitment and public interest. Hopefully the lessons learned from the TCIG model can assist in shortening the process for subsequent projects.

Depending on the scope of the reform, PPIP projects require the government to access international expertise in the fields of PPP law, health services financing and delivery,

commerce and banking, clinical services management, information technology, health regulation, and health insurance. This expertise is needed to ensure that the government gets the best value possible and has experts who can match the well developed negotiating skills of the private sector. Expert advice comes at a cost which lower- income countries may find unaffordable. This is an area where international donors and lenders can play an important role in funding project design and providing financial support to access technical advisors.

- ***…but it's better to get it right in the beginning.***

Private finance projects and PPIPs are often criticized for the time and resources they require to become operational. However, spending time upfront to explicitly identify the "devil in the details' avoids much greater cost down the road by reducing the need for change orders, and preventing failed projects after considerable political capital has been expended. As Belani notes[ix], one of the advantages of PPPs is that the presence of external funders forces a rigor into the design of health programs that is easy to avoid when funder, provider and manager roles are all played by the government. Funders expect issues and risks to be identified early in the process and resolved before they are willing to make a financial investment. There is then less likelihood that projects will be abandoned mid-stream or that facilities will sit empty.

- ***PPIPs mean new roles for Government that are not always comfortable.***

PPIPs bring with them roles for government which are unfamiliar, and ways of working that require new skills, new processes and new attitudes. Two of these, 'the government as a partner' and the 'government as an active purchaser and regulator', are particularly critical to the success of PPIPs.

Government as partner

Governments aren't often accustomed to acting as 'partners' but learning to manage jointly is absolutely essential to the success of PPIP ventures. Long-term partnership is a 'marriage' that requires a high degree of trust, and a deep understanding of, and appreciation for, the incentives and motivations of the other party. In countries where the public and private sectors are wary of each other, merging the two cultures is a challenge that must be explicitly addressed. Managing cultural differences is complicated by the fact that the private partner may be from a different country than the government , and lack an understanding of how the particular public sector environment operates in the host country. Health ministries can address some of these issues by looking at government partnerships in other sectors, and finding lessons from mergers and acquisitions within their own country.

In the case of TCI, its long history of public/private partnerships in other sectors (tourist operators, real estate developers) made the partnership with ICL easier to create. ICL also brought experience from other international markets and was sensitive to learning the nuances of the Islands' culture.

Government as an active purchaser and regulator

The separation of purchasing and provision, the management of large, long-term PPIP contracts and the introduction of the NHIP, require the TCI government to expand its role to become a purchaser of care, and regulator of the health sector. This will require building contract management skills, monitoring quality, cost and accessibility of health services delivery, developing the ability to pay providers, and creating insurance risk management expertise. TCIG has begun the process of identifying the skills needed to perform its new roles. It is starting now to bring the necessary international expertise to build its capacity in these areas, but this will be an ongoing investment that the government must factor into its expenditures. One may argue that these capabilities are an intrinsic part of what governments should be doing in the health sector in their roles as stewards, regardless of how care is financed and provided.

- ***Evaluating Value for Money includes considering the cost of risk transfer, as well as understanding the counterfactuals.***

TCIG believes that this project has achieved value for its health sector dollar. Unlike PPIPs in the developed world, the investors' cost of capital is at or below TCIG's borrowing rate because of the country's small size and emerging economy. ICL also brings international expertise in the construction and management of healthcare facilities that the government does not have, and would find difficult and very expensive to purchase on a strictly consulting basis. This is even more true for the provision of clinical services since payment for clinical care is on an open-book cost basis for the first two years. If the government could, theoretically, recruit the expertise needed to manage a high level of clinical care, its additional costs under the contract are only for the providers' margin, which is strictly defined.

The government estimates that it will pay a premium of 5-10% over actual costs for using the PPIP model. This is a small price given the cost of risk being shifted to the private provider. The counterfactual is also useful to consider. If the government decided to upgrade its health system to meet Canadian (or other international) accreditation standards, it would involve a long term commitment to education and training of clinical and ancillary staff supported by intensive international consulting in all aspects of health services construction, management and delivery. It would also require changing civil service guidelines and recruitment procedures to attract the right level of talent. The Ministry of Health would need to commit scarce managerial resources over an extended period of time to support this endeavor. The Medical Director of Health Services on TCI believes that bringing in a provider that already meets international standards will allow the Ministry of Health to focus on its role as steward of the health system, to ensure better health for the entire population.

V. Conclusions

TCI is still early in the development of its PPIP and the broader health systems reform that it is undertaking. There will be many opportunities for successes and failures along the way. There are factors that make this reform easier than in other emerging

countries, such as a strong economic base and high growth; and a stable political system. Other factors make it more difficult such as proximity to the very costly US health system, the vagaries of small island economies, and the difficulty in providing health care to small populations over large geographic distances.

Long term evaluation of the reform will take many years and, given the complexities and interdependencies of the health sector, it will be difficult to definitively unravel the causes and consequences of each aspect of the change. To better understand how this PPIP evolves, it would be very useful at this stage to establish an external evaluation which collects both qualitative and quantitative data to inform future decisions within TCI which can be shared throughout the Caribbean Region, and with the broader international community.

The government of the Turks and Caicos Islands has embarked on a bold and innovative path to reforming its health sector. Ultimately, for the people of the Turks and Caicos Islands, the rewards of a successful partnership will be the creation of a high quality healthcare system at an affordable cost – a significant achievement for any country.

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