

LETTER OF TRANSMITTAL

**THE COMMISSION TO REVIEW THE TERMS AND CONDITIONS OF
EMPLOYMENT OF MEDICAL PRACTITIONERS AND NURSES**

Address:

Date:

The Cabinet Secretary
Office of the Prime Minister
Saint Lucia

Dear

We have the honour to present our Report in fulfillment of our Terms of Reference as set out in the Cabinet Conclusion No. 115 (d) of 2004 and dated February 16th, 2004.

Our Review was conducted under the authorisation conferred by that Instrument.

Yours truly

.....
Sir Richard Haynes
(Chairman)

.....
Mrs. Jennifer Astaphan
(Deputy Chairman)

.....
Dr. Barbara Johnson

.....
Mr. Cletus Springer

**REPORT OF THE
HEALTH REVIEW COMMISSION**

ACRONYMS

| | |
|-------------------|--|
| CARICOM | Caribbean Community and Common Market |
| CEO | Chief Executive Officer |
| CMO | Chief Medical Officer |
| CNO | Chief Nursing Officer |
| CSA | Civil Service Association |
| CSME | Caribbean Single Market and Economy |
| DMOs | District Medical Officer |
| ED | Executive Director |
| EMT | Emergency Medical Technician |
| ENT | Ear, Nose and Throat Specialist |
| FNPs | Family Nurse Practitioners |
| HRM | Human Resource Management |
| MDA | Medical and Dental Association |
| NWU | National Workers Union |
| OVI s | Objective-Verifiable Indicators |
| PPS | Pharmaceutical Procurement Service of the OECS |
| TORs | Terms of Reference |
| PAHO (CPC) | Caribbean Office of Programme Coordination of PAHO |
| SLNA | Saint Lucia Nurses Association |
| SALCC | Sir Arthur Lewis Community College |
| UHC | Universal Health Care |
| UHCC | Universal Health Care Committee |
| VH | Victoria Hospital |
| WHO | World Health Organisation |
| SLMDA | St. Lucia Medical and Dental Association |

ACKNOWLEDGEMENTS

We, the members of the Health Review Commission would like to place on record our sincerest appreciation to the many persons and organizations that appeared before us and gave us the benefit of their experience and advice.

We are also grateful to the Minister of Health for his demonstrated keen interest in the progress of our work and for helping to clear the administrative hurdles that surfaced from time to time.

We acknowledge the contribution of the Permanent Secretary, Mr. Fidelis Williams, Deputy Permanent Secretary, Mr. John Husbands, Assistant Secretary, Mrs. Beatrice Mc Donald, and Chief Medical Officer, Dr. Stephen King for meeting with us and for facilitating our access to relevant documentary evidence as well as our meetings with the medical and nursing staff at the various health facilities on the island.

We would also like to acknowledge with sincerest thanks, the tremendous contribution of the administrators, doctors, nurses, programme managers and maintenance personnel who took time from their busy schedules to share with us their unique perspectives on the health situation, in person and/or in writing.

Our task was greatly facilitated by the pivotal support of the officers of the Ministry of Health, Human Services, Family Affairs and Gender Relations. We would like to make special mention of the efficient and highly professional support given by Mrs. Jacinta Butcher, who in addition to performing her regular duties as Administrative Secretary to the Minister of Health, provided us with incisive notes of our numerous interviews and supervised the myriad logistical aspects of our work. The Commission is of the view that without Mrs. Butcher's dedication and outstanding work it would have been impossible for the Commission to complete its Review in an expeditious manner.

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EXECUTIVE SUMMARY

INTRODUCTION

On February 16th, 2004, the Cabinet of Ministers of Saint Lucia approved the Terms of Reference (TORs) of the Commission to Review the Terms and Conditions of doctors and nurses employed in the Government Health Services. The members of the Commission were:

| | |
|------------------------|-----------------|
| Sir Richard Haynes | Chairman |
| Mrs. Jennifer Astaphan | Deputy Chairman |
| Dr. Barbara Johnson | Member |
| Mr. Cletus Springer | Member |

The Task

The Commission was required to:

- (a) to review the system of remuneration and other conditions of service of doctors and nurses employed in the Government Health Service;
- (b) to determine the extent to which this system has impacted the quality of medical care available to the people of Saint Lucia;
- (c) to identify any deficiencies in the system and the extent to which such deficiencies have contributed to the dissatisfaction of patients, their relatives and the general public with the standard and quality of medical care delivered to patients at public institutions;
- (d) to inquire into the exercise of private practice by doctors employed in the Government Health Service, with particular reference to desirability, organization, management and effects on the performance of hospitals and other health institutions;
- (e) to review the existing structure (legal and administrative) of the medical services in light of the planned construction of the new hospital complex;
- (f) to make recommendations:
 - a. to ensure that existing incentives within the system achieve the declared objectives in the provision of better patient care;
 - b. for the cost effective delivery of health care by doctors and nurses employed in the Public Service to public patients;
 - c. for the enhancement of the capacity of doctors and nurses to deliver such care;
 - d. for effective monitoring, management and organization of the exercise of private practice by doctors employed in the Government Health Service;
 - e. for the elimination of any contentious disparities in the system of remuneration and privileges accorded to doctors in the Government Health Service;

- f. for the enhancement of the legal and administrative structure of the medical services.

The Commission was also required to take into consideration:

- a. the prevailing social and economic conditions of Saint Lucia;
- b. the terms and conditions of service of doctors and nurses employed in the Government Health Service of other OECS and CARICOM States;
- c. the declared health priorities of the Government of Saint Lucia in the health sector.

Interpretation of Our Mandate

The Commission interpreted its mandate as requiring it to review the *system* of remuneration of doctors and nurses and not the *level* of remuneration that is paid to these professionals. This interpretation is supported by the fact that levels of remuneration are determined through well established collective bargaining processes between the Government and the Saint Lucia Medical and Dental Association (SLMDA); the Nurses Association (SLNA); the Civil Service Association (CSA) and the National Workers Union (NWU) respectively. Indeed the Commission considered this distinction to be important enough that it sought from the outset to assure representatives of those organizations that appeared before it that it would do or say nothing that could be construed as usurping the collective bargaining process.

The Commission accorded high priority to cost-effectiveness and operational efficiency in the public health care system. Accordingly, the Commission decided to focus on those aspects of its TORs that required it to examine and report on all relevant matters affecting the functioning of doctors and nurses; to identify any deficiencies which compromise the capacity of doctors and nurses to provide satisfactory levels of health care to patients and to make recommendations to:

- correct any existing deficiencies in the governance and management of the public health service which militate against effective delivery of health care by doctors and nurses;
- correct any deficiencies in the system of remuneration which have led to the problems identified in our TORs;
- strengthen institutional arrangements to remedy any shortcomings;
- restructure the system of remuneration to eliminate any contentious issues under the present system and to provide for equity and transparency in the system of remuneration;
- strengthen the management, monitoring and organization of the exercise of private practice by doctors employed in the government service; and

- enhance the capacity of doctors and nurses in health care delivery.

The Commission took into consideration the proposed construction of a new secondary/tertiary care hospital in arriving at its conclusions and recommendations regarding the future utilization of existing secondary care institutions.

Methodology and Approach

The Commission's work was carried out in the Conference Room of the Ministry of Health, Human Services, Family Affairs and Gender Relations (hereinafter referred to as the Ministry) on the second floor of the Sir Stanislaus James Building on the Castries Waterfront.

At its first meeting, the Commission decided to adopt the following procedure:

- (a) to invite via the media, written submissions from members of the public;
- (b) to invite all interested persons and organizations who wished to make representations to the Commission to attend its hearings and to assure them that all information received will be treated in the strictest confidence;
- (c) to hold community consultations in key population centres served by Hospitals;
- (d) to visit as many health facilities as possible so as to gain a first-hand appreciation of the physical conditions of work;
- (e) to interview as many health professionals as possible;
- (f) to request the Ministry of Health to commission a User Expectation and Satisfaction Survey among a representative sample of users of the health services of Saint Lucia;
- (g) to request the Ministry of Health to obtain details of the remuneration of doctors and nurses in Dominica, St Vincent and the Grenadines, Grenada, and Antigua and Barbuda.

Over 150 persons interacted with the Commission through formal interviews and community consultations. Interviews were conducted with about 100 health service personnel employed at primary and secondary health facilities. A list of interviewees is carried at Appendix 1 to this Report.

Community consultations were planned in Babonneau, Castries, Vieux-Fort, Soufriere, Gros-Islet and Dennery. It soon became apparent to the Commission that the promotion and advertisement of these events, which were supposed to have been done jointly through the Ministry and the Ministry of Social Transformation, were not effective. Consultations were

held only in Babonneau, Dennery and Soufriere, where the turn-out averaged 12 persons. The Consultation in Vieux-Fort did not take place as no one showed up. The Commission had little reason to believe that the attendance in the other communities would increase to meaningful levels. Accordingly, the Commission decided, most regrettably, to cancel the consultations planned for Castries and Gros-Islet.

Up to the time of preparing this report, the User Survey had not been conducted. The Commission considers this survey to be a useful tool that could yield valuable information about the policy, structural and organizational changes that are required in the health service. The Commission recommends that this survey be executed as soon as circumstances allow and that it be repeated at regular intervals.

The Commission perused reams of consultancy reports, and policy proposals on various aspects of the management of Saint Lucia's Health Sector. A more complete listing of these documents is provided at Appendix 2 to this Report. Among them are:

- The Report of the Task Force on Universal Health Care.
- The Report on the Primary Health Care system by Mr. Peter Carr and Dr. Barry Wint.
- The Report on Paying Health Care Providers in the Caribbean by Macide Pinto and Brent Anderson.
- Legal instruments governing the provision of public health care.
- Submissions relating to the system of remuneration of doctors and nurses in Dominica, St. Vincent and the Grenadines, Grenada, Antigua and Barbuda.
- The Report of the Chief Medical Officer of Saint Lucia (2001 – 2002).
- Health Sector Reform Proposals, Saint Lucia (March 2001)
- Report of the Commission of Inquiry into the exercise of Private Practice by doctors employed in the Government Health System – Jamaica 1996.
- Such information as was available relating to accounting, and financial matters, including the levels of remuneration achieved by doctors and nurses under the present system.
- The Report on the Managed Migration Problem (PAHO/CPC Office, Barbados).

We found many of the recommendations in these documents to have continuing relevance and usefulness. Our observation is that many of these recommendations have not been acted upon.

The Commission received several valuable written submissions from doctors and nurses in particular. No written submissions were received from

members of the public and no member of the public appeared before the Commission, except at the community consultations, despite invitations carried via advertisements in the local print and broadcast media.

Visits were made to the Victoria, Golden Hope, St. Jude, Dennery and Soufriere Hospitals where the Commission met with various categories of doctors, nurses, administrators and other personnel from these institutions. The Commission also visited the Castries Health Centre and the Gros-Islet Polyclinic.

As a matter of policy the Commission met with representatives of several organizations and institutions within and without the health service. These included:

- The Saint Lucia Medical and Dental Association
- The Saint Lucia Medical Council
- The Saint Lucia Nurses Association
- The Saint Lucia Nursing Council
- The Saint Lucia Chamber of Commerce
- The Saint Lucia Civil Service Association
- The Public Service Commission
- The Sir Arthur Lewis Community College
- The National Insurance Corporation
- The Saint Lucia National Council of and for Persons with Disabilities
- The Saint Lucia Pensioners Association
- The Saint Lucia Council of and for Older Persons
- The Saint Lucia Fire Service
- EDF/Programme Monitoring Unit
- Officers from several Ministries of the Government of Saint Lucia

The Commission is satisfied that it gave all who wished to appear before it and/or make submissions, the opportunity to do so and wishes to thank all who made such a valuable contribution to its work.

Summary of Findings, Conclusions and Recommendations of the Commission.

The Commission's findings, conclusions and recommendations are contained in twelve chapters of its report.

Chapter 1 focuses on the capacity of the Ministry to effectively: (a) design and implement national health policies and plans in general and in particular, the policies governing the system of remuneration of health personnel; (b) manage the human resources within the health service; (c) manage the system of compensation and benefits; (d) perform employee evaluation and control functions; and (e) manage its financial resources.

The Commission found systemic weaknesses in all of these areas. In particular, the Commission found:

- a highly insular approach to the design and implementation of health policy, which is a departure from Government's stated desire to ensure that " ...health policies are consistent with developmental, educational, socio-economic and health promotion concepts;"
- The absence of a comprehensive, integrated health policy document, that articulates a sufficiently clear vision and accompanying objectives for the health sector; that is informed by solid epidemiological data; that is supported by a strategy outlining clear roles and responsibilities for internal and external stakeholders; and that outlines the programme and organizational linkages that must exist with the economic, social and environmental sectors.
- The absence of a detailed, integrated, transition plan identifying the human resource requirements and other "soft" aspects of the establishment of the new General and Psychiatric Hospitals.
- the lack of standard human resource management policies and procedures to govern proper recruitment, selection, training and development, and deployment of staff;
- widespread dissatisfaction among staff at the various health institutions with the overall governance and management of the Ministry;
- a compensation and benefits system that is in disarray;
- the lack of enforcement of procedures for employee evaluation and control including performance appraisals, disciplinary systems and grievance procedures;
- a health system afflicted by wastage and a lack of adherence to sound financial management principles.

The Commission realised that the Ministry does not have full control over many of the areas listed earlier especially those relating to human resource management. It is our view that a contractual system that requires the intervention of four different parties at varying times (the Hospital's ED, the Ministry of Health, the Ministry of the Public Service and the Public Service Commission) is totally inappropriate in situations where the exigencies of the service usually require that a post be filled expeditiously.

The Commission recommends that:

- (a) the Ministry must assume the responsibility as the employing authority to determine the standard for the employment of doctors and more particularly for the employment of consultants;
- (b) there is an urgent and immediate need to strengthen the leadership cadre at the policy level;
- (c) the contractual process employed by the Ministry and VH

- must be urgently addressed and responsibility must reside at the policy level to ensure consistency in the practice pending a decision on the future governance of VH;
- (d) the existing generic contract documents be revised to include all relevant conditions and terms of employment including job functions;
 - (e) the Ministry of the Public Service should be engaged in discussions aimed at developing a reclassification plan for medical personnel that is sufficiently flexible to allow for employment of various categories of junior doctors within the budgeted allocation;
 - (f) there is an urgent need for a policy formulation and strategic planning exercise to be conducted to coordinate the vision and plans for the health sector in general and to define and plan for the proposed New Hospital and its support institutions;
 - (g) priority attention is given to human resource needs, training and succession planning to build the institutional capacity needed for hospital management;
 - (h) new Job Descriptions and Job Specifications should be prepared for all posts;
 - (i) a Training Needs Assessment of the Ministry should be conducted and its results used to plot a Career Development Path for each officer;
 - (j) the Ministry should adopt the Management-by-Objective approach, which should involve the preparation of Annual Work Programmes, with realistic goals, measurable objectives and objectively-verifiable-indicators (OVIs);
 - (k) a Disciplinary Committee should be established within the Ministry;
 - (l) the Health Complaints Act should be enforced as soon as possible;
 - (m) a Handbook of Administrative Policies and Procedures should be prepared with input from staff of the Ministry and the Ministry of the Public Service;
 - (n) Heads of Institutions be exposed to regular training programmes in management and team building;
 - (o) urgent action be taken at the national and sub-regional levels to preserve the integrity of the OECS/PPS;
 - (p) the Office of the Chief Pharmacist be strengthened to allow it to perform a stronger role in monitoring the importation and dispensing of drugs within the public and private health system;
 - (q) the formulation of a National Drug Policy and the drafting of Regulations for the 1993 Act be accelerated and the post of Drug Inspector provided for under that Act be activated as soon as possible; and

- (r) the Standards Bureau be invited to establish clear standards for the importation of all drugs.

CHAPTER 2 of the Report examines the problems relating to doctors in the public health service as the basis for assessing the extent to which the current payments system has contributed to these problems. The impact of public/private sector relationships on the health system is also assessed.

The Commission found a long-standing payments system, the basic element of which is the payment by the State of a salary and other allowances to doctors, while some categories of doctors are also permitted private practice in order to augment their earnings. While this arrangement worked reasonably well in the past, various pressures generated by changed expectations, economic circumstances and costly investments in infrastructure in private practices appear to have created a new dynamic in this payments system. In the view of the Commission, the failure to respond to the new developments with appropriate changes has not only fuelled the development of the private sector of medicine but has had an overall negative impact on the delivery of health care by doctors in the public sector, who are permitted to engage in private practice.

The Commission found that while many of the problems are attributable to the system of payments, there are other issues that compound the situation. These relate to strong perceptions of conflict of interest especially among doctors engaged in public and private practice; lack of participation by doctors in the governance and management of the health services; a poor physical environment in many instances; lack of equipment and other necessities for effective patient care; and a pervasive sense of helplessness to effect change for the better.

The arrangements whereby doctors are appointed to the public service at salary levels which are based on a presumption that they can increase their earnings through permitted private practice has operated very much to the disadvantage of the efficient delivery of care in the public sector.

The Commission received a large number of complaints by and about **some** doctors in the secondary health system, including:

- breaches of hospital regulations by doctors who charge and collect fees in their offices for procedures done at VH;
- manipulation of “on-call” and “call-out” allowances to enhance incomes;
- special arrangements which result in marked differences in remuneration among Consultant staff;
- misuse of the hospital to increase earnings;

- failure of senior doctors to give proper direction to and respond to calls for help from junior doctors and nurses;
- failure to see patients, often for over a week, who have been admitted to hospital under their care;
- chronic indiscipline and no response to complaints about the conduct of doctors towards nurses and patients;
- an almost complete absence of doctors at VH in the afternoons, except for those in Accident and Emergency and junior doctors on emergency duty;
- patients seen for the first time by doctors when they are on the operating table;
- patients requiring urgent emergency procedures are kept waiting until the doctor is free from his private practice obligations in the evening;
- inappropriate invasive interventions in patient care;
- no sanctions against doctors, no matter how serious the complaints.

Complaints were also made by and about **some** doctors in the Primary Health Care System. Generally, the DMOs felt that their salaries are inadequate and do not reflect the critical work that they perform. Other complaints include:

- priority given to private practice;
- inadequate assessment of patients;
- inadequate documentation of findings by some doctors;
- difficulties in getting doctors to do home visits;
- absence of a system of rotation of doctors through various communities, some of whom have been assigned to the same community for decades;
- an inconsistent supply of drugs;
- lack of confidence in the professional acumen of some doctors;
- delayed responses to emergency calls;
- infrequent clinics leading to overcrowding;
- re-direction of patients to private offices;
- non-specific contracts which do not spell out the obligations of doctors;
- no monitoring of the performance of doctors;
- lack of punctuality in attending clinics and unacceptable speed in disposing of patients in order to get to their private offices;
- schedules for clinics that do not place the interest of the patient first;
- absence of a proper patients-based records system except at the Gros-Islet Polyclinic;
- high fees for post-mortem examinations;

- lack of involvement of DMOs in the community.

The Commission found that the overall influence of doctors on the management of the health services to be minimal and outlined steps which should be taken to correct this, not only in the context of proposed statutorization of some entities but in respect of all elements left under the management of the Ministry.

The Commission also found the status of consultants to be under grave danger of compromise due to the practice of according the status of "Consultant" to persons who may have developed some post-graduate experience and additional qualifications, which are not normally recognized as those required of Consultants.

On the issue of public/private sector relationships the Commission is of the view that the State should seek to provide a satisfactory level of health care that on medical grounds, gives patients an equal choice to determine whether they wish to access private or public care and be guaranteed an appropriate standard of care in the public sector.

The evidence presented to the Commission suggests that many doctors leave or elect to have minimal contact with the public sector of medicine because of a deep sense of frustration, alienation, lack of professional fulfillment and inability to effect change and progress. The task therefore must be to restore confidence and create the best possible conditions for doctors in the public service to realize reasonable expectations, professional and otherwise.

The Commission supports the formulation of a Health Sector Policy which includes: (a) a general recognition that the private sector has an important role to play in the delivery of care for those who wish to access private medical services; and (b) a regulatory framework to ensure adequate standards. The Commission urges that investment by individuals in the health sector should not automatically be considered a conflict of interest, especially when this is done by those doctors in the public sector who are permitted private practice. The Commission believes that it is the responsibility of the governors and managers of public entities to ensure that there is no conflict of interest in the functioning of doctors.

The issues raised by full time doctors who are, for the most part, junior doctors in the secondary health care system without access to private practice, were dominated by the lack of supervision and direction by their seniors who, in pursuing their private endeavours, devote little time to this aspect of their work. At present there is a complete absence of mechanisms to remedy this situation. The contracts of employment are vague; there are no job descriptions; there is no management system; there is no

enforcement of discipline; and doctors are left to determine their own schedules of private practice, often at the expense of commitments to public duties.

The Commission identified many undesirable developments in medical practice in Saint Lucia which are the direct result of deficiencies in the regulatory process. There is a need to address these deficiencies aggressively and to implement the remedies identified by the Medical Council.

Recommendations

Among the recommendations advanced by the Commission to deal with the issues relating to doctors are the following:

- (a) the establishment of a Board to govern the operations of VH;
- (b) the removal of VH from the rigid system of payments in the wider public service to facilitate the changes proposed by the Commission;
- (c) the involvement of doctors and nurses in the management of the health system through appropriate Committee structures;
- (d) the implementation of a sustained public relations exercise to assist Saint Lucians in better understanding the role of Consultants in the public health service;
- (e) the adoption of a “no compromise” policy in setting the qualifications for the post of “Consultant”;
- (f) the removal of any differentials in the basic remuneration of Consultants paid by the Government;
- (g) all legal remedies should be vigorously enforced against doctors who collect fees from patients in their private office in breach of the Hospital Fees Regulations.
- (h) all reports of failure to respond to calls for assistance by nurses and junior doctors be fully investigated and appropriate action taken;
- (i) better monitoring of the system of on call/call out allowances to reduce abuse;
- (j) the introduction of a protocol whereby all patients admitted to hospital must be seen by a Consultant on the day of admission or, at the latest, the day following admission;
- (k) adequate ward rounds by Consultants based on a schedule approved by the Medical Director;
- (l) no priority be given to patients admitted from the private offices of Consultants, except in cases deemed to be genuine emergencies;
- (m) an effective disciplinary process be put in place to deal with all complaints relating to the conduct of doctors;
- (n) steps be taken to ensure there is an adequate presence of

- doctors at VH at all times;
- (o) delays in treatment of emergencies as a result of doctors' involvement in the private offices should be investigated, whenever they occur;
- (p) the scheduling of private practice by doctors on the day on which they are on emergency duty at the hospital should be avoided;
- (q) better supervision of out-patient clinics by Consultants;
- (r) a full review of the functioning of DMOs be undertaken, which should include the scheduling of clinics, the time spent at clinics, record keeping, home visits and delays in responding to emergency calls;
- (s) contracts of employment should be more specific and job descriptions should accompany all contracts; and
- (t) early resolution of the issues surrounding the accreditation of doctors trained in Cuba.

Chapter 3 of the Report addresses several issues raised by nurses including their empowerment, remuneration levels, working conditions, mobility prospects, education and training, and recognition of specialty qualifications. The Commission found that, while some of these issues had some bearing on remuneration, professional fulfillment was of equal if not greater significance. The Commission was impressed by the high quality of nurses in management positions in the primary and secondary sectors of the health services and regretted that these talents are not being fully utilized to the benefit of the service.

Nurses considered the present governance and management arrangements at the Ministry to be devoid of transparency and identifiable leadership direction, and believe that the appointment of a Chief Nursing Officer (CNO) with appropriate post-graduate qualifications and extensive experience in HRM will fill a major gap in the system of health care delivery by nurses. The Commission is supportive of these suggestions and is of the view that legislation establishing Boards of Governance should provide for the Director of Nursing Services to be:

- (a) An ex officio member of the Board;
- (b) A member of the Senior Management Team
- (c) The Chairperson of a legally-constituted Nursing Staff Committee
- (d) A member of a Patient Care Committee.

The Commission discovered that the efficiency of all sectors of the public health service is being seriously undermined by a shortage of nurses. This situation has not only de-motivated existing staff who are already overworked, but has also impaired work attitudes and encouraged the migration of many nurses from Saint Lucia. The Family Nurse Practitioner

(FNP) programme which, by all accounts has been quite successful is now headed for a serious crisis, due to the absence of a sufficiently aggressive programme of training of a new cadre of FNPs.

The lack of adequate support Staff has forced many nurses to perform many non-professional duties which can be readily done by support staff. This aggravates the problems facing trained nurses in the system.

Nursing Assistants complained that, although they received additional training and were promoted to the rank of Staff Nurses, they do not receive equal treatment even in situations where they demonstrated their ability and capacity to function efficiently in sub-specialty areas.

There were many representations on behalf of the Nursing Aides who perform a valuable service in the primary health care sector. The Nursing Aides are of the view that they deserve better remuneration and some means of assistance with travelling to avoid having to walk long distances.

The Commission concluded that the growing problem of migration of Nurses is linked to problems in obtaining continuing nursing education, inadequate recognition of specialist nursing training, poor working conditions in physical facilities which are frequently poorly maintained, and with inadequate equipment and supplies. The Commission urges that emphasis be placed on increasing the number of trained nurses and by creating the best possible conditions for retention of those trained and entering the system.

The Commission examined the laws governing the nursing profession and supports the call for a review of the legislation aimed at amending the administrative structure of the Council to ensure inter alia, that the Chairperson is a Nursing professional and to redefine the advisory and regulatory role of the Council in keeping with current trends and changes in the profession.

Recommendations

The Commission recommends that:

- (a) the post of CNO be filled as soon as practicable and that the CNO be involved in all matters relating to nurses employed in the public sector;
- (b) a policy of decentralisation of the management of entities in the primary health care system be actively pursued;
- (c) urgent steps be taken to empower nurses in the management of all sectors of the health care system;

- (d) in respect of VH and/or its successor (when it is transferred to the governance of a Board) the Director of Nursing Services should:
 - be an ex-officio member of the Board
 - be a member of the Senior Management Team
 - be Chairperson of a Nurses Staff Committee
 - be a member of a Patient Care Committee
- (e) an urgent programme for the training of Psychiatric Nurses and FNPs be designed and implemented;
- (f) a programme to ensure that more nurses in the Community Health Service receive training in Public Health be implemented;
- (g) an urgent recruitment programme be pursued to attract more young persons into the nursing profession;
- (h) the appointment of Nursing Aides in the secondary care system as support personnel for nurses;
- (i) the size of the nursing establishment be increased;
- (j) former Nursing Assistants who have become Staff Nurses should not be subject to any form of discrimination;
- (k) a special programme of assistance be introduced to facilitate scholarships/study leave for nurses seeking training in approved areas;
- (l) sub-specialties be recognized as appropriate routes for promotion similar to Midwifery and Administration;
- (m) a legal framework to ensure that statutorization of segments of the public nursing service does not compromise lateral and vertical mobility of nursing staff;
- (n) appropriate rewards for nurses who satisfactorily complete post-graduate training and return to the service;
- (o) closer attention be paid to the physical conditions under which nurses work;
- (p) greater transparency in the process by which nurses are selected for training and promotion;
- (q) an adequate number of senior personnel be deployed to ensure effective supervision of Staff Nurses on night duty;
- (s) an efficient and effective mechanism for handling complaints be established;
- (t) improved allowances for nurses on night duty;
- (u) where appropriate, travel allowances for Community Health Nurses and Nursing Aides should be provided.

Chapter 4 deals with the payments system for doctors and nurses; the system of payment by patients; the fee collection mechanism and the remuneration of consultants. Much of the analysis in this Chapter is based on the Commission's findings and conclusions in earlier Chapters.

The Commission found that while the basic salaries were relatively uniform there were enormous disparities in the annual payments to Consultants depending on their contractual arrangements and capacity to earn fees under the present Hospital Fees arrangements. Moreover, the methodology and designation of awarded allowances to achieve a given level of remuneration, varied from contract to contract.

Further, the Commission found clear evidence indicating that the payments system has been contaminated by the sometimes conflicting arrangements for the payment of doctors who are engaged in public and private practice. The Commission feels that the present arrangement where doctors are paid a percentage of fees charged by the hospital, whether or not the hospital is paid by patients, is unsatisfactory and should be abolished. In the opinion of the Commission, the present Hospital Fees Regulations are highly discriminatory against Consultants whose discipline does not involve operative procedures, a hang-over from another age. The Commission considers that a new set of Hospital Fees Regulations would be mandatory to remove this discrimination and to provide for related matters.

The Commission recommends that:

- (a) a policy objective of full-time doctors to man the health services be pursued;
- (b) consultants be full-time employees but with provision for payment in lieu of private practice or an allowance of sessions to pursue private practice;
- (c) a policy of employment of some Consultants on a sessional basis be adopted;
- (d) provision be made in the new hospital for geographic private practice and for the accommodation of private patients;
- (e) the present system of payments by patients seeking medical care at public institutions be abolished;
- (f) the proposed new method of financing the health services be put in place as soon as possible;
- (g) the present system of the hospital charging fees and paying fees to Consultants be abolished;
- (h) the current Hospital Fees Regulations SI No. 68 of 1992 be repealed and replaced by new Regulations;
- (i) all Consultants be paid the same basic remuneration;
- (j) a fixed percentage of their salary be paid for on call/call out duties;
- (k) a fixed percentage of the salary of Consultants be paid in lieu of private practice, where relevant;
- (l) an award of sessions for private practice for those who opt to pursue private practice;
- (m) the retention of housing, telephone and travel allowances where appropriate;

- (n) the abolition of all other allowances which were designed to overcome the limitations inherent in the public service salary arrangements;
- (o) legal provisions be introduced to allow VH to bill and collect fees for the services it provides for private patients;
- (p) doctors to bill and collect fees for the services they provide to private patients.

Chapter 5 of the Report identifies major problems at VH, most of which could and should have been ameliorated by dedicated leadership which is manifestly lacking at this time. The morale of all staff at VH is very low; staff meetings are extremely rare; there is no evidence of any systematic attempt to ensure staff performance in relation to either professional or contractual obligations; no protocols for quality assurance or for managing patient complaints exist; the accounting system is chaotic with large sums outstanding that may never be collected.

Whatever efforts had been made to resolve the numerous problems affecting the operation of the surgical theatres, they have been manifestly unsuccessful. There is no organized maintenance programme for the physical structure and equipment; sometimes an entire surgical list has had to be cancelled because the autoclave is “down”; the engineering department often does not know that a particular piece of equipment is in the hospital until the equipment has broken down; contracts for supplies often go to those who can offer credit for the longest period; the equipment in the radiology department is described as “deplorable” and there is no trained radiologist on staff; the dietetics department cannot plan menus because of unpredictability in the availability of supplies; and complaints by staff are usually ignored or put through a process which usually ends with no remedial action.

We also received strong complaints about the inadequacy of the security arrangements at the Accident and Emergency Department of the Hospital.

Recommendations

The Commission supports the policy of the government to improve the governance of VH by putting in place a Statutory Board but cautions that by its composition, structure and the authority with which it is legally vested, the establishment of the Board must send a powerful signal to the entire community that it is empowered to achieve the following:

- (a) the elevation of the care of patients as the first priority for the existence of the hospital;
- (b) the elimination of inappropriate partisan political interventions which, whether real or perceived, have sapped

- the vital sinews of the institution over decades;
- (c) an end to chronic indiscipline at all levels;
 - (d) an end to misuse and abuse of the institution for personal financial gain by some;
 - (e) respect for staff at all levels;
 - (f) the empowerment of doctors, nurses and other professionals in the management and decision-making processes;
 - (g) the promotion and enshrinement of the rights of patients;
 - (h) the removal of any concerns that the Board can become yet another hurdle to overcome in the decision-making process;
 - (i) sound financial management of the affairs of VH with due regard to laws governing the use of public funds;
 - (j) the involvement of civil society in the governance of the institution;
 - (k) the preservation of the constitutional rights of all staff currently employed as civil servants at the institution.

In pursuit of these objectives the Commission recommends that:

- the Minister be authorized to appoint only a minority of Board members in his own discretion, including the Chairperson;
- the Medical Director, Nursing Director and the Executive Director be ex-officio Board members;
- all other Board members be nominated by national organizations representing doctors, nurses, workers, the church, the private sector, the academic community;
- no employee of the hospital except as indicated above should be eligible for membership of the Board;
- no person should be appointed to the Board who has not demonstrated an interest in the public welfare and competence in his chosen field of endeavour.

The enabling legislation should clearly set out the functions of the Board and any limitation in its authority. Similarly, the legislation should indicate the restrictions on the Minister to general policy directives, and more specifically to matters such as the relationship of VH to other health institutions and services such as Polyclinics, ambulance services, inter alia and facilitating arrangements for the lateral and vertical movement of staff within the health system, without loss of any accumulated rights and benefits.

The Commission's recommendations for improving the management of VH prior to the establishment of a Board include:

- (a) an in-depth management audit of the operations of VH;

- (b) the senior managers should constitute themselves as a formal senior management team under the chairmanship of the ED and should meet at least once a month;
- (c) the Engineering Department should be upgraded and its Head invited to participate in all decisions affecting it;
- (d) a programme to strengthen middle management, especially in the ancillary and support services be put in place;
- (e) the process of effective empowerment of professional staff be implemented by the establishment of functional medical and nursing staff committees.
- (f) putting in place procedures for handling complaints and acting on them expeditiously.

The Commission also strongly recommends that:

- (a) the legislation for a Board for VH be put in place as soon as possible;
- (b) an appointed day be set for the change-over to a Board;
- (c) the Board be appointed well in advance of the take-over date, which ideally should be at the beginning of a financial year;
- (d) all outstanding liabilities should be for the account of the Government;
- (e) the budget for first year's operation of VH under a Board be settled well in advance of the appointed date of take-over;
- (f) the members of the Board become fully familiar with the relevant issues and their role as governors, rather than as managers, before the appointed day;
- (g) the Board be empowered to put its senior management staff in place on the appointed day;
- (h) all matters relating to staff involved in the change over to a Board be settled before that day;
- (i) the Board be empowered to make regulations under the Act for the good governance of the institution;
- (j) such regulations should provide for the establishment of:
 - A Senior Management Committee
 - A Medical Staff Committee
 - A Nursing Staff Committee
 - A Patient Care Committee
- (k) given the corrosive and insidious atmosphere that engulfs VH, the functions of these committees be spelt out in legislation.

Chapter 6 of the Report examines the governance and management of St. Jude Hospital and its long-term future following the commissioning of the new general hospital.

The Commission determined that St. Jude remains relatively free from the negative cultural influences affecting VH. Fewer complaints were received about its operations from the general public and staff and there were many comments that indicated a user-friendly atmosphere at the facility. However, problems were identified with the recruitment of medical staff, especially volunteers; the collection of fees from Government agencies with respect to services delivered to persons who are exempt under the Hospital Fees Regulations, such as prisoners, nurses, police officers and firemen; and the poor physical condition of the facility.

The Commission found that while the use of temporary volunteers from overseas appears to have worked well in the past, there are justifiable concerns about an over-reliance on this arrangement. Volunteer doctors were usually not conversant with the socio-economic realities in the country and tended to prescribe expensive drugs.

In addressing the long-term future of St. Jude, the Commission took into consideration its aged physical plant, the number of beds to be provided at the new hospital, trends in occupancy levels at hospitals on the island and in medical care, and the human resource requirements for maintenance of an effective, efficient and affordable health service. The Commission noted that trends in medical care were such that in the future, more and more health care at the secondary care level will be delivered on an out-patient basis.

While the Commission was not insensitive to arguments based on distance, demography and geography, it could not find compelling medical reasons for the retention of St. Jude in its current configuration and function. The Commission noted that patients from all over Saint Lucia came to St. Jude for medical attention, including patients from the Castries and surrounding areas, a development which undermines arguments about distance.

Recommendations

Having regard to medical, planning, quality and cost-efficiency considerations, the Commission is strongly of the view that the wishes of the people for better health services can be better met by converting St. Jude Hospital into a facility which combines the functions of an upgraded Polyclinic sharing the specialist services at the new hospital, with the provision of an Accident and Emergency Department capable of stabilizing serious cases, supported by an efficient ambulance service and a limited number of beds.

The Commission further recommends that:

- (a) St. Jude be gradually phased out as a secondary care hospital and that it be converted into a facility providing mainly

- out- patient care at the primary and secondary levels on a 24-hour basis;
- (b) an upgraded accident and emergency facility be sited in this complex;
 - (c) only a limited number of in-patient beds be retained;
 - (d) an organized system of transfer of patients to the new hospital by means of a well-equipped ambulance service be put in place;
 - (e) the full range of specialist services available in Saint Lucia be provided at this major Medical Facility on an out-patient basis;
 - (f) The management should continue to be performed through a Statutory Board.

In the event that it is decided to maintain St. Jude as a secondary care hospital, the Commission recommends:

- 1. a reduction in the number of beds, depending on the number of beds available at the new hospital;
- 2. an amalgamation of the clinical departments with those at the new hospital;
- 3. a sustained effort to avoid costly duplication in other areas.

Chapter 7 of the Report reviews the management of Golden Hope Hospital. The physical condition of the facility, shortages of staff, especially trained psychiatric nurses, inadequate security, paucity of equipment and general neglect were the principal concerns of the management and staff of the hospital. Against this background, the Commission welcomed the decision of the Government to construct a new Psychiatric Hospital.

Recommendations

The Commission recommends that the authority to manage the Golden Hope Hospital should remain with the Hospital Administrator and that a Board for Golden Hope Hospital should not be put in place at this time but in the future.

In addition, the Commission recommends that:

- (a) there be full involvement of staff in the design of the new Psychiatric Hospital;
- (b) the issues of shared governance and management be deferred;
- (c) a thorough analysis of the difficulties involved in shared services be done;
- (d) a major effort be made to restart a training programme for psychiatric nurses and recruit trained nurses;
- (e) urgent attention be paid to security issues.

Chapter 8 of the Report deals with Dennery and Soufriere Hospitals.

The Commission found that the two institutions share a common status and face the same core problems, including: a dramatic reduction in occupancy levels; inadequate supplies of drugs and essential materials; an unsatisfactory physical environment; inadequate staffing; inadequate financial support; delays in response by doctors “on call” particularly on the weekend; and difficulties in accessing ambulance services.

Recommendations

The Commission recommends that:

- (a) Soufriere and Dennery “hospitals” be replaced by 24-hour polyclinics with a few beds for observation;
- (b) the ambulance services be upgraded;
- (c) the supply of drugs and materials be given urgent attention;
- (d) adequate facilities be provided to treat minor emergencies and for the stabilization of more serious emergencies prior to transfer to the new hospital;
- (e) The governance of these institutions and all other primary care institutions remain with the Ministry of Health with progressive decentralisation of management.

Chapter 10 analyses the rate of bed utilization at VH, St. Jude, Dennery, Soufriere and Golden Hope Hospitals. The Commission found that the occupancy rates at VH (59.3%) and St. Jude Hospital (44.3%) do not support a case for two acute secondary care hospitals. The occupancy rates for Dennery (1.7%) and Soufriere (6.3%) confirm that these two institutions have fallen largely into disuse as hospitals. The Commission believes that these occupancy figures will decline further as better out-patient services are made available, including day-care surgery and the establishment of an infrastructure which leads to more rapid diagnosis and treatment of in-patients.

Recommendations

Against this background, the Commission recommends that a detailed audit of bed utilization be conducted. This should include reasons for admissions, factors affecting length of stay in hospital and other relevant data. Such an audit will not only produce useful information for planning but allow for the development of protocols for use by junior doctors in making decisions about admission.

Chapter 11 of the Report deals with the physical conditions at primary and secondary health facilities. Here reference is made to the repeated complaints of doctors about:

- the absence of basic facilities such as a staff canteen, a desk and chair from which they can work; the absence of a facility where they can speak to patients and relatives in private; the lack of facilities in the hospital for doctors on night duty;
- the lack of facilities for consultants to conduct their activities following ward-rounds;
- the lack of facilities for geographic private practice; and
- the lack of functioning equipment

The Commission observed that with the exception of the Gros-Islet Polyclinic, which is a fairly new facility, physical conditions at other primary health care facilities are generally unsatisfactory and in the case of the Castries Health Centre are depressing. The Commission was informed that a programme of upgrading of primary health care facilities is in the early stages of implementation and has urged that this programme be accelerated.

Recommendations

The Commission recommends that:

- (a) immediate steps be taken to correct the physical deficiencies at VH and at primary health care facilities;
- (b) the future role of primary health care facilities be taken into consideration in reaching decisions about the bed complement at the new General and Psychiatric Hospitals;
- (c) The Ministry should consult with the Ministry of Physical Development, Environment and Housing on: (i) the ideal location for health centres, that takes into consideration the demographic, settlement and socio-economic trends in Saint Lucia; and (ii) the design of a model health centre that supports the goal of creating an efficient and effective primary health care system.

Chapter 12 assesses the current and future role of the Ambulance Services. The Commission believes that the enhancement of Ambulance Services represent by far the most cost-effective approach to the delivery of an efficient health service by the Dennery and Soufriere Hospitals in particular.

The Commission further believes that Saint Lucia has a well conceptualized basis for an effective ambulance service through its linkage with the Fire Service, which it regards as a disciplined organization with a culture of professionalism. This relationship between the Fire Service and the Health Services exists in a somewhat embryonic form and should be developed to its maximum potential in order to overcome any problems arising from geographic considerations. Our interview with the Assistant Divisional

Officer left us in no doubt that in the Fire Service there is a clear vision of the potential of this relationship. However, we are unsure whether those responsible for policy development in relation to the ambulance services share this vision.

Recommendations

The Commission recommends that:

- (a) the rationalization of the roles of St. Jude, Dennerly and Soufriere Hospitals in the secondary health care system should be accompanied by the enhancement of the ambulance service;
- (b) a policy and a plan be developed to integrate the ambulance service fully into an effective system of emergency care with efficient deployment of manpower and equipment and with a clear understanding of the crucial importance of training of personnel;
- (c) the number of ambulances should be increased;
- (d) the difficulties in maintenance be addressed;
- (e) an effective training programme for ambulance personnel be put in place;
- (f) a promotional stream be introduced for EMTs within the Fire Service;
- (g) better communications systems be established;
- (h) a more formal and functional relationship be established between the Accident and Emergency Service at VH and the Fire Service;
- (i) the current system of payment for ambulance services by the public should be abandoned.

Chapter 13 focuses on a transition plan to facilitate the smooth and effective implementation of the Commission's recommendations. The Commission believes that the management of the process of transition will be of vital importance and therefore has proposed in this Chapter that the following structures be put in place to achieve a smooth outcome.

1. A Board of Governance

Mindful that the establishment of a Board to govern VH will inevitably raise concerns among public officers about their constitutional rights, especially in the area of job security and pension entitlements, the Commission advises that draft legislation of a Board be completed as soon as possible, after which discussion with interested parties should commence. The language of the legislation should be explicit in confirming the preservation of the rights of public servants and great care should be taken to ensure there is no conflict with the Constitution of Saint Lucia.

2. New Financing Arrangements

The introduction of a new method of financing the health services under the Universal Health Care Programme should be timed to coincide with the start of a new financial year and with the establishment of the Board with responsibility for VH. All available financial resources should be directed towards improving the public health sector.

3. New Payments System for Consultants

The new payments system to be used by private patients admitted to VH and by Consultants should ideally take place at the same time. The de-linking of payments to the hospital and to the doctors will require a temporary method of identifying private patients, from date of admission to date of discharge from the Hospital, until such time as private facilities are available for private patients in the new hospital. This can be achieved via appropriate administrative arrangements.

4. New Hospital Fees Regulations

Consultants should be intimately involved in the preparation of the new fees structure which should come into force at the same time. Provision should be made in the new regulations for the Hospital to act as agent for billing and collecting fees on behalf of doctors who so wish and for a percentage of fees to be retained by the Hospital for this service.

5. Remuneration Levels for Consultants

The Commission did not consider it appropriate to specify the exact salary that should be paid to Consultants as there is a negotiating process in place which deals with these matters and which should not be compromised.

6. Redress of Financial Concerns of Nurses

There are several issues pertaining to Nurses which require immediate attention and resolution. These have been addressed in the Report. We suggest that resolution of these issues be part of the package offered in negotiating the transfer of nurses to a statutory board.

7. Capital Programme

The Commission recommends that beginning in the fiscal year 2005/2006, there should be a 7 year Capital Programme which would encompass its recommendations in respect to Dennery, Soufriere and St. Jude Hospitals as well as the rationalization programme for health centres recommended by the Carr and Wint Study. Our recommendation in relation to St. Jude

Hospital should not be implemented until the new General Hospital is commissioned, adequately equipped and staffed.

Timely consideration should be given to the future use of the present VH buildings after the new Hospital is commissioned. There is a strong case for closure of the Castries Health Centre and reconfiguring and redeveloping part of the VH structure as a 24 hour polyclinic. The possibility of using another section of the facility for long stay patients requiring minimal care and rehabilitation should be explored. This could help to relieve any pressure for beds at the new Hospital.

Apart from the new Psychiatric Hospital and the new General Hospital, there are other modest capital developments which can be completed over a seven-year period. It may be appropriate to finance these proposed developments partially by way of a transfer of assets within the public health sector by selling the assets vacated by the Golden Hope and the Castries Health Centre and re-investing these funds in new facilities.

8. Agents for Change

The Commission suggests that the following entities be established to speed up the implementation of those of its recommendations that are approved by Cabinet:

- a team to bring the already conceptualized new financing package to fruition including the necessary legislative action;
- An Action Committee to prepare the legislation for a Board for VH;
- A Hospital Fees Advisory Committee to prepare the new Fees Regulations.

9. Primary Health Care Sector

The Commission recommends that a plan be put in place early to effect the transition to a service manned principally by full-time doctors. It is anticipated that a significant number of doctors will be returning to Saint Lucia over the next five years and an appropriate programme should be devised well in advance of their return

Conclusion

The Committee notes that the implementation process will require a high degree of coordination as there are many discrete elements which need to be addressed simultaneously. Consequently it is necessary to have persons in place who can ensure that all these elements are addressed in a timely and appropriate manner.

MAIN DOCUMENT

CHAPTER 1: THE MINISTRY OF HEALTH, HUMAN SERVICES, FAMILY AFFAIRS AND GENDER RELATIONS - AN OVERVIEW

The Ministry was the natural start point of our review as it this Ministry which has primary responsibility for managing the system of remuneration of health care professionals; for determining the conditions of service within the health sector; and for providing quality health care to all the people of Saint Lucia.

The Ministry's Mission Statement is "...to provide leadership and direction in the creation of an environment in which empowered institutions can be created, guided and nurtured for the provision of holistic health and services to the entire population." In pursuit of this Mission, health care is delivered at the Primary (Community) level at 33 Health Centres, 1 Polyclinic and 2 district hospitals, while secondary level care is delivered at 2 acute General Hospitals, 1 Psychiatric hospital and 1 substance abuse rehabilitation centre. A significant amount of primary health care takes place at the Acute General Hospitals in response to the demands of patients.

We are of the view that the structure, role and function of the Ministry have been adequately addressed in recent consultancy reports including the Carr/Wint Report of 2002. In this Chapter we have chosen to focus on the Ministry's capacity to effectively undertake the following:

- (a) the formulation and implementation of national health policies and plans in general and in particular, the policies governing the system of remuneration of health personnel;
- (b) the management of the human resources within the health service;
- (c) the management of the system of compensation and benefits;
- (d) employee Evaluation and Control; and
- (e) the management of financial resources.

Corporate Direction and Leadership

The Policy Environment

The Government of Saint Lucia endorses the World Health Organisation (WHO) concept of health as not merely the absence of disease or infirmity, but as a state of physical, mental and social well-being. It also regards good health as a fundamental human right and seeks to ensure that health policies are consistent with developmental, educational, socio-economic and health promotion concepts (Wint/Carr, 2002).

The Commission has been presented with a suite of policy statements that reflect Government's commitment to:

- (a) improve the health system using the primary health care approach while simultaneously increasing the quality and availability of secondary care;
- (b) gradually decentralize the management of the secondary and tertiary health institutions while strengthening the regulatory and oversight functions of the Ministry and other agencies within the health sector;
- (c) allocate a major part of the national health budget to improving the health services;
- (d) construct a new General Hospital and a new Psychiatric Hospital on the same site, thus allowing for a system of shared services between these institutions;
- (e) introduce a System of Universal Health Care as a means of:
 - a. maximizing the use of health resources and create a more efficient system capable of providing quality health services in the most efficient manner;
 - b. reducing the impact of poverty by making health care affordable and accessible to all in need of care;
 - c. reducing the resource gap in health to allow for more comprehensive coverage of health needs;
 - d. focusing more resources on priority health needs and incorporating appropriate incentives and accountability frameworks into all provider and health worker agreements to ensure value-for-money (National Health Insurance Task Force, 2003).
- (f) Apply the principles of human rights in the management of HIV/AIDS and collaborate with other agencies in the prevention and control of the disease;
- (g) Utilize cost-effective approaches to the use of technology, medical supplies and drugs;
- (h) Develop and retain a cadre of highly trained, committed, motivated, professional, administrative and technical staff;
- (i) Develop a management system that is accountable, progressive, communicative and functional where service productivity is the objective;
- (j) Give priority to the provision of health services to specific vulnerable-at-risk groups like the poor, expectant and nursing mothers, the elderly, chronically ill and disabled persons and persons infected with communicable diseases.

Saint Lucia's health policy environment is also influenced by the Caribbean Cooperation in Health Initiative (CCHII) which encourages Caribbean Governments to focus on the following priority areas:

- Reproductive Health
- Child and Adolescent Health
- Environment Health
- Food and Nutrition
- Violence and Injury Mitigation
- Communicable and Non-Communicable Diseases
- Mental health and Substance Abuse
- Oral Health
- Eye Health and Disabilities
- Emergency Services and
- Health Promotion

Health Policy Design and Implementation

The Commission found a highly insular approach to health policy formulation and implementation which is at variance with Government's stated desire to ensure that "...health policies are consistent with developmental, educational, socio-economic and health promotion concepts." The fact that health underpins and traverses virtually every area of physical, human and economic development has not been fully appreciated and internalized within the national decision-making process with the result that health policy and planning are regarded as being the responsibility of the Ministry alone. Also, the fact that health is affected by policies that often have nothing to do with health care or services (such as environmental pollution, insecurity and instability, whether caused by poverty, unemployment or violence, economic regulation or deregulation, contaminated water and poor sanitation) dictates that health policy formulation and implementation must be broadened to include at least the major actors in the social, economic and environmental spheres.

The Commission did not find a comprehensive, integrated health policy document that contains a sufficiently clear vision and accompanying objectives for the health sector; that is informed by solid epidemiological data; that is supported by a strategy outlining clear roles and responsibilities for internal and external stakeholders; and that reflects the programmatic and organizational linkages that must exist with the economic, social and environmental sectors.

The Commission notes however that such a national health policy can only emerge in an environment that is characterized by close inter-institutional collaboration and a team ethic especially in the area of planning. The team approach that we advocate, involves a lot more than management meetings. It will require significant, focused and sustained investment in Human Resource Management (HRM) and in health systems management. These investments will need to be supported by a change in the traditional

structure and operations of the Ministry from a Department-based approach to a Programme-based approach. We were advised by the Chief Medical Officer (CMO) that such a change is under active consideration of the leadership of the Ministry. We strongly support this shift as it will allow Programme Leaders to assume greater control of the design and implementation of their respective programmes and in the process encourage deeper and broader integration among and between programmes.

The Commission recognizes and applauds the enthusiasm being exhibited by the new Chief Medical Officer (CMO). It is clear to us, that from a medical standpoint, the CMO possesses many of the core competencies and skills required by the post. However, we are mindful that the post of CMO also requires strong organizational management and planning skills, which can best be acquired through formal training in management.

The enthusiasm and competence of the CMO, notwithstanding, the Commission received compelling written and oral testimony which suggests that the concerns of many health professionals over his dual (public/private) status is likely to seriously challenge his efforts at building a team approach to planning and management within the health service. The Commission suggests that the goal in the future should be to find someone with similar qualities who is a full-time officer. This is particularly important in order to avoid any perceptions of conflict of interest, especially in an atmosphere where there is public concern over the relationship between private and public sectors of medical care in Saint Lucia.

A major related concern of the Commission is the likelihood that the design of the new secondary care institutions is likely to be compromised in the absence of a National Health Policy and Strategy. The Commission noted the widely differing responses from personnel of the Ministry of Health on the number of beds that will be provided in this new facility as well as the target date for its commissioning. The Commission's own preliminary view is that the number of beds proposed for the new Hospital is likely to be inadequate. It would be a serious error to build a new hospital which does not have an adequate complement of beds. Therefore, we feel that this new hospital should not be less than 185 beds.

The Commission strongly encourages the urgent development of a detailed, integrated, transition plan which should include the human resource requirements and other "soft" aspects of the new General Hospital and the new Psychiatric Hospital. The Commission was made aware of PAHO/CPC's willingness to support the preparation of a National Health Policy. We wish to encourage that this offer be accepted and that urgent steps be taken to complete this critical policy instrument as early as possible.

Further, the Commission recommends that a Health Policy Advisory Committee be established under the chairmanship of the Minister of Health to assist in the formulation of policies relating to the delivery of services by medical personnel in the public health service. Its membership should include representatives of doctors engaged in Primary/Secondary care, and in the Private sector as well as representatives of the Saint Lucia Medical and Dental Association, the Saint Lucia Medical Council and the Saint Lucia Nurses Association.

HRM within the Health Service

We see our TORs as demanding an assessment of HRM arrangements within the Ministry. Effective HRM involves the process of first placing the right people with the right skills, in the right place at the right time, with the right motivation in order to accomplish an organization's goals. The oral and written evidence received by us, coupled with our own observations and findings, suggest that the Ministry has not been effectively executing its HRM role. This view is encouraged by:

- (a) the lack of standard human resource management policies and procedures to govern proper recruitment, selection, training, development and deployment of staff;
- (b) the loose management of contracts;
- (c) the absence of quantifiable performance targets for health institutions and personnel;
- (d) the absence of sanctions for non-fulfillment of contracts;
- (e) the general laxity in the system of management at VH.

Some of these weaknesses are addressed in greater detail later in this Report. For the moment, it is important to note that the evidence received suggests that the Ministry does not enjoy the trust and respect of health professionals. Staff at the various health institutions expressed dissatisfaction with the overall governance and management arrangements and frequently expressed the view that the administrative staff at the Ministry was not sufficiently sensitive and responsive to the situation "on the ground".

Human Resource Planning

We found little evidence of any conscious effort by the Ministry to determine the staffing requirements necessary to attain its corporate vision and its goals. This weakness did not surprise us, especially given our earlier observation regarding the state of the policy environment. A related deficiency is in the area of Job Analysis and Design. This is reflected in the mismatch that exists between the responsibilities and duties of some jobs (job description) and the skills, knowledge and abilities needed by the person (s) performing the job (job specification). In Chapter 2 of this report,

we cite concrete examples of this deficiency relating to various posts within the medical profession. Our review of a random set of job descriptions has prompted us to recommend that a qualified consultant be commissioned to review and redesign all existing job descriptions based on an in-depth assessment of the specifications of these jobs.

We are mindful that the Ministry does not have full control of the HR Planning process and that this and other aspects of HRM are shared with other public sector agencies, including in particular, the Ministry of the Public Service, and the Public Service Commission. However, we believe that the Ministry can do a lot more to influence sound human resource planning, by amongst other things, preparing a long-term strategic plan.

The Commission recommends that on the completion of this plan, that dialogue be held between the political and administrative leadership of the Ministries of Health, Public Service and Finance respectively, to agree a joint action plan for addressing the HR planning needs of the Ministry.

The Recruitment and Selection Process

The analysis, observations and findings in subsequent chapters confirm systemic weaknesses in the recruitment and selection process managed by the Ministry. We found that the process was being approached in a disjointed and opaque manner, especially in connection with the appointment of medical personnel at VH. We were left with the distinct impression that a sufficiently conscious effort is not being made to match applicants to available jobs.

The Commission is conscious of the many factors (such as labour market conditions, the preferences of job applicants and the Government's ability to pay) that affect the Ministry's ability to recruit and retain suitable applicants. We would argue however that is precisely because of these limiting factors that greater care should be exercised in the recruitment and selection process.

A clear policy decision is required on *who* should recruit and *how* this should be done. We do not support the continuation of the current practice where decisions regarding the recruitment and selection of medical staff at VH are taken solely by the ED. Rather, we encourage the establishment of a Recruitment and Selection Committee to oversee the process, comprising the ED, the Medical Director, a senior Consultant and the Hospital's HR Manager. The process should allow adequate time for conducting the appropriate background checks on a candidate and for internal processing of contracts, physical examinations, professional registration procedures and orientation. The initial treatment of potential applicants is extremely important, as applicants can and have formed a negative impression of the

health service when they feel they are being treated unfairly or casually. The recruitment and selection policy should mandate that whenever it is practicable and affordable, face-to-face interviews are an integral part of this process, especially for top-level personnel.

Management of the Contract Process

The Commission is of the view that the entire contract system used by the Ministry and in particular by the ED of VH left much to be desired. We learnt of several instances where doctors were hastily engaged from overseas and put in financially compromising situations. Such situations arose when doctors arrived in Saint Lucia expecting to be handed contracts setting out salaries and other agreed terms of service, which would have allowed them to settle in quickly, secure loans for cars and to meet their personal commitments. We were advised that very often contracts are not completed for several months. We were also advised of several occasions where doctors were offered and accepted jobs at a certain grade and salary, only to be placed at a lower grade and salary on their arrival. In our view, this practice which has reportedly resulted in considerable hardship and frustration among the affected doctors, is not consistent with the conduct and behaviour of a Ministry of Government. Not only does it leave the Government vulnerable to costly litigation for alleged misrepresentation and for breach of contract, but it also generates bad publicity which compromises the ability of the Government to recruit competent doctors in the future.

Of concern to the Commission is the effect which the practice can have on the mental disposition of affected doctors and on the quality of health care that they provide. A doctor who is distressed because he/she is unable to meet his/her financial commitments due to delays in processing a contract of service is unlikely to be in the right frame of mind to deliver proper health care. At least two doctors, who were unable to purchase motor cars because they were unable to submit signed contracts to their bankers, told the Commission of the difficulties which they encountered when “on call” and when transportation is not available. One doctor reported having to walk from his home to the VH twice within a four-hour period to respond to emergencies.

It is our view that a contractual system that requires the intervention of four different parties at varying times (the Hospital’s ED, the Ministry, the Ministry of the Public Service and the Public Service Commission) is totally inappropriate in a situation where the exigencies of the service usually requires that a post be filled expeditiously.

We have reviewed the contracts that are issued and also concerned about their vagueness as well as the fact that they are not legally tight. In many

cases, the contracts are not tied to the job descriptions and do not expressly commit the doctors to observe the policies, rules and regulations of the health service. These deficiencies could make it impossible for the Government to seek legal redress against doctors who breach the terms of their contract.

Contracts for Goods and Services

The management of contracts for the procurement of goods and services leaves much to be desired. At VH there seems to be little appreciation of the value of cost efficiency in this area and we are advised that, not infrequently, contracts are awarded principally on the basis of the capacity of the supplier to extend credit for the longest period. While we have some sympathy with the hospital authorities, who attribute this to delays in accessing funds voted for this purpose, it must be recognized that this practice must inevitably lead to higher costs.

A procurement plan should be put in place at the beginning of each financial year in order to effect efficiencies and reduce costs.

The Procurement and Distribution of Pharmaceutical Supplies

Responsibility for the procurement and distribution of drugs rests with the office of the Chief Pharmacist (CP) while the dispensing of drugs is done by a complement of 14 pharmacists, 6 of whom are assigned to Victoria Hospital.

Saint Lucia has benefited immensely from its participation in the OECS Pharmaceutical Procurement Service (PPS), which has made available generic drugs at greatly reduced costs. A clear indication of the overall dependence of Saint Lucia's on the PPS can be gleaned from the fact that 80% of all drugs used in the country is purchased through the PPS and that 65% of the drugs purchased by the Government is utilized at VH. The PPS also performs an invaluable role in assuring the quality of the drugs that it supplies. However, the evidence that we have received suggests that the integrity of the PPS is under threat as a result of the late payment of suppliers, which in turn is due to the late settlement of invoices to the PPS by OECS Governments. Urgent and concerted action is needed to preserve the integrity of this vital service and to enable the PPS to move into the planned procurement of specialized medical equipment.

Urgent attention should also be given to strengthening the role and function of pharmacists in general and in particular the Office of the CP. Pharmacists working in the primary care sector are being underutilized, especially in facilities where DMOs operate on a part-time basis. Our recommendation that DMOs should be made full-time should help to address this problem.

Further, we think it is critical that the operations of the pharmaceutical service be computerized.

Presently, the main focus of the CP is on the public health service. However, the CP also has a critical role to play in monitoring the entry and use of the 20% of drugs that are not purchased through the PPS. During the community consultations, members of the public complained to the Commission about the importation of drugs from non-English speaking countries. In many cases, the accompanying literature relating to the use of these drugs is in a foreign language, thereby placing the users at some risk of illness if and when they have to rely solely on the contents of the accompanying literature.

We understand that measures are being taken to strengthen the policy framework for the procurement and dispensing of drugs, including the formulation of a National Drug Policy and the drafting of Regulations for the 1993 Act. We urge that these measures be accelerated. We also urge that: (a) the post of Drug Inspector provided for under that Act should be activated as soon as possible; (b) the drug formulary be reviewed and (c) the Standards Bureau be invited to establish clear standards for the importation of all drugs.

Training and Development

Training and development constitute perhaps the most critical activities in any organization. It is mainly through continuous training that an employee develops the specific job-related skills that will ensure effective performance and help the employee to grow, not only in his/her career but also as a person.

One positive feature of the HRM arrangements within the Ministry in particular and the health services in general is the fact that officers in the managerial and administrative streams are well qualified and have been exposed to formal and informal training in their respective fields. However, elsewhere in this Report we document the strident complaints of nurses and other health personnel about the lack of formal and informal training opportunities. Further, there is no evidence that a comprehensive Training Needs Assessment has been done for the health service. We urge that this be done as a matter of urgency.

The lack of succession planning is of particular concern to the Commission. This is reflected in the intended retirement or loss by attrition of five Family Nurse Practitioners (FNPs), whose training takes two years, with no arrangements for their replacement. One of the two (2) trained Psychiatric Nurses is due to retire shortly and there no other nurses in training.

We are ever mindful of the financial constraints which limit the investments that Governments in small island states can make in training and development. Also, we are aware of the precipitous decline in the number of scholarships offered by external agencies and of the growing migration of nurses. However, we take the view that training and development are of such vital importance to the delivery of quality health care that creative ways must be found to raise the money to sustain an effective training and development programme within the health service. Without this investment, the commissioning of the new secondary care hospitals will be severely affected as the old, negative behaviours and cultures will be transferred to the new facilities.

Indeed, we would go further to recommend that the cost of training and development be included in the mandate of the Universal Health Care Committee (UHCC). While we are aware that financing for training and development is among the issues being addressed by the Commission on Health and Social Development recently established by CARICOM Ministers, we still urge that a Task Force be established to devise a national strategy for addressing training and development. Further, we recommend that the Ministry be given greater autonomy in addressing its training and development needs. A full-fledged Health Training Centre should be established to allow for a continuing employee training and development.

The Management of the Compensation and Incentives System

Very early in our work we concluded that the compensation and benefits system is at the heart of many of the problems afflicting the health service. Clearly the system is in disarray. Some of the weaknesses are internal and are linked to failings within the Classification and Pay Plan for the wider Public Service and the way in which the system is being administered within the Ministry. Other weaknesses are external in nature and are linked to market compensation and benefit conditions; collective bargaining; Government's ability to pay; and perceptions of employee equity in terms of salaries. These weaknesses are addressed in greater detail in subsequent chapters of this Report

We fully appreciate and strongly support the need for a compensation and benefits package that reflects the relative importance and responsibility attached to a job and that adequately rewards performance. Also we appreciate that there will be situations when market forces and the exigencies of the health service will prompt consideration to be given to the payment of salaries and benefits outside of the approved Classification and Pay Plan, as was done in the case of the ED of VH.

We feel impelled to note however, that this decision has caused considerable disquiet among health professionals. We are concerned about the problems

that it can pose when acting appointments have to be made for this post as, strictly interpreted, the rules of the Public service provide that a person appointed to act in a higher position should receive at least the difference in his/her basic salary and the minimum of the scale of the higher post.

We have also found instances when doctors have been able to negotiate compensation and benefits that are outside of the Plan. However, we prefer to interpret such deviations from the Classification Plan as evidence that the Plan is out of tune with market realities and needs to be overhauled.

The Commission also received several complaints especially from nurses about the non-payment of increments. Mindful of the assurances that we have given that we will not comment on issues that are normally the subject of the collective bargaining process, we can do no more than point out that of all the elements in the current compensation package, only increments have any strong motivational value. It is difficult to use the typical benefits such as retirement benefits, paid vacations, paid holidays and sick leave to influence motivation, as they are provided regardless of an employee's performance.

Accordingly, the Commission strongly recommends that the Classification and Pay Plan for the Public Health Service be reviewed as a matter of urgency and that a systematic job evaluation be undertaken based on revised and up-to-date job descriptions and specifications.

Employee Evaluation and Control

If done properly, Performance Appraisals can be of considerable assistance not only in controlling performance but also in influencing motivation and setting and communicating goals as part of the planning process. Disciplinary systems and procedures are intended to enable employees to air their grievances. They are supposed to provide policies, rules and procedures for use in appraising performance, enforcing discipline and handling grievances.

The Commission found that procedures for employee evaluation and control including performance appraisals, disciplinary systems and grievance procedures are not being enforced within the Ministry. In particular, we were unable to detect any organised effort by the Ministry to ensure that doctors employed in the Health Service fulfill the conditions of their contracts. The number of and seriousness of some of the long-standing complaints and allegations of abuse and non-performance levelled against some doctors, led us to conclude that the performance appraisal and disciplinary systems have broken down.

The Commission is particularly puzzled by the Ministry's failure to institute disciplinary action against a doctor who launched an unprovoked verbal assault on some nurses, despite having clear evidence of the assault as well as the damaging effect which it has had on the health of at least one nurse.

The Commission notes that the Ministry has not been moved to use the various disciplinary instruments contained in the Staff Rules and Orders, in the grievance procedures outlined in the Collective Agreement between the Ministry and the various bargaining agents, and in legislation governing the disciplinary and grievance provisions contained in the Registration of Nurses and Midwives Ordinance No. 12 of 1966 and in the Registration of Medical Practitioners Act No.12 of 1967. The former Act at section 13 (1) provides for the cancellation or suspension of the registration of any person, "...upon proof to the satisfaction of the Nursing Council of professional dishonesty, negligence or conduct that does not conform to the generally recognized standards of the profession of nursing, or that is unbecoming to a nurse; or willful refusal to obey a lawful order given in the course of his/her professional duty or fraud or misrepresentation in obtaining registration."

The provisions contained in the Registration of Medical Practitioners Act relating to doctors are not as forthright. Nonetheless, they do provide for a practitioner to be struck off the Register if he/she is convicted of a felony or misdemeanour or if he/she is "...adjudged to have been guilty of infamous conduct in any professional respect."

In addition, health service users and workers can have complaints addressed under the Health Services (Complaints and Conciliation) Act No. 34 of 2001 which provides inter alia, for the establishment of a Commission with the following functions:

- (a) to investigate and make recommendation on complaints relating to health services;
- (b) to conciliate between users and providers of health services;
- (c) to investigate any matter relating to the health services referred to it by the Minister; and
- (d) to review and to identify the causes of complaints and to make recommendations on ways of minimizing or removing those causes.

We are impressed by the fact that this Act allows for any aggrieved person, including a user or health service worker to lodge a complaint with the Commission against a health service provider or another health service worker, on the grounds that a health service provider has acted unreasonably:

- by not providing a health service to a user;

- by denying or restricting the user's access to records kept by the health service provider and relating to a user;
- in the manner of providing a health service to a user;
- in disclosing a user's health records;
- or by not properly investigating or taking proper action upon a complaint made to a health service provider by a user about a health service provider's action.

We interpret these provisions to mean that the Ministry is leaving itself open to charges that it did not take prompt action on complaints brought before it. The Commission considers the totality of these laws to provide an adequate framework for managing a disciplinary system and recommends that these laws be enforced by appropriate bodies without fear or favour. We recommend that urgent consideration should be given to strengthening these laws.

The Financial Management System.

Presently, health care delivery is financed primarily from the Consolidated Fund and from fee payments at primary and secondary health care facilities by users and/or by private health insurance companies. These sources are augmented from time to time via grants and donations averaging EC\$3 million annually from the National Insurance Corporation (in the case of Victoria Hospital) and via philanthropic donations from foreign individuals and corporations (in the case of St. Jude Hospital).

It is a simple, indisputable fact that health care delivery is, by its very nature, a very costly endeavour. In small island developing states like Saint Lucia with extreme vulnerability to external economic shocks and limited development options, high levels of unemployment, under-employment and poverty, it is imprudent, if not impractical to think in terms of cost recovery within the health sector as a significant source of revenue.

However, as unchallengeable as these facts may be, we do not interpret them to suggest that Governments should adopt a fatalistic attitude regarding health care financing or to conclude that cost-effective health care delivery is impossible.

Almost from the outset of our review, it became clear to us that the health system is afflicted by wastage and a lack of adherence to sound financial management principles. These symptoms have their roots in weaknesses in governance, HRM, procurement, and maintenance.

For example, we received evidence of the wrong equipment being purchased; of equipment lying idle for want of maintenance; of equipment being purchased but allowed to remain in Customs for long periods before it is cleared and commissioned; of supplies intended for VH being spirited away; and of patients who can afford to pay not being required to pay.

The figures provided in Table 1 below confirm that expenditure on Saint Lucia's health sector has been increasing steadily over the past five years, from EC\$49.1 million in Financial Year (FY) 1999/2000 to EC\$53.2 million in FY 2003/2004. Over half of recurrent expenditure has been consumed by VH and St. Jude Hospital. The combined recurrent expenditure at these two institutions increased from \$24.2 million in FY 1999/2000 to \$27.7 million in 2003/2004. By contrast, expenditure on Primary Health Care remained fairly constant rising only marginally from \$5.6 million in 2000/2001 to \$5.7 million in 2003/2004.

Table 1: Comparison of Recurrent Expenditure (2000-2004)

| | 2003/04 | 2002/03 | 2001/02 | 2000/01 | 1999/00 |
|---------------------|------------|------------|------------|------------|------------|
| Estimates MOH | 53,218,736 | 52,501,549 | 53,090,177 | 51,260,279 | 49,198,980 |
| VH | 19,217,282 | 18,407,944 | 18,329,631 | 18,321,565 | 17,122,034 |
| St. Jude's | 8,578,163 | 8,295,663 | 8,200,000 | 7,350,266 | 7,122,034 |
| Soufriere | 892,958 | 903,144 | 931,296 | 935,073 | 910,830 |
| Dennery | 653,741 | 653,464 | 670,786 | 645,107 | 645,486 |
| Golden Hope | 2,512,471 | 2,519,974 | 2,490,501 | 2,356,083 | 2,041,100 |
| Turning Point | 422,444 | 454,117 | 492,695 | 452,707 | 469,251 |
| Primary Health | 5,725,762 | 5,721,155 | 5,707,886 | 5,627,757 | N/A |
| Gros-Islet P/Clinic | 714,186 | 577,063 | 750,506 | 0 | 0 |
| Citizens Home | 555,791 | 573,504 | 609,291 | 635,859 | N/A |
| Substance Abuse | 241,686 | 0 | 0 | 0 | |

Source: Ministry of Health

The expenditure levels at Victoria Hospital, especially in capital works is not readily reflected in the present state of its physical infrastructure.

Our analysis of the revenue figures supplied by the Ministry revealed that only a small percentage of the money spent on the health system in FY 2001/2002 and 2002/2003 was recovered through a combination of hospital fees, confinement fees, medical fees, laboratory fees, user charges and the sale of drugs. Nearly 70% of the total budget of the Ministry is taken up in personal emoluments.

The Commission believes that the overall financial situation and in particular the situation at VH warrants an in-depth review ideally through a comprehensive Management Audit to determine inter alia, the failings in the way the hospital is managed and the way in which the finances of the institution have been utilized and managed. The Commission is of the view that unless the situation is clearly assessed the same culture will be transferred to the new hospital.

Recommendations

The Commission recommends that:

- (a) The Ministry must assume the responsibility as the employing authority to determine the standards for the employment of doctors and more particularly for the employment of consultants;
- (b) There is an urgent and immediate need to strengthen the leadership cadre at the policy level;
- (c) The contractual process employed by the Ministry and VH must be urgently addressed and that responsibility must reside at policy level to ensure consistency in the practice pending the transfer of responsibility to a Hospital Board;
- (d) The existing generic contract documents be revised to include all relevant conditions and terms of employment including job functions;
- (e) The Ministry of the Public Service should be engaged in discussions regarding the reclassification of positions for medical officers and that the new classification system should be sufficiently flexible to allow for employment of various categories of junior doctors within the budgeted allocation;
- (f) There is an urgent need for a policy formulation and strategic planning exercise to be conducted to coordinate the vision and plans for the health sector in general and to define and plan for the proposed New Hospital and support institutions;
- (g) Priority attention should be given to the human resource needs, training and succession planning to adequately prepare for institutional capacity strengthening;
- (h) New Job Descriptions and Job Specifications should be prepared for all posts;
- (i) A Training Needs Assessment of the Ministry should be conducted and its results used to plot a Career Development Path for each officer.
- (j) The Ministry should adopt the Management-by-Objective approach, which should involve the preparation of Annual Work Programmes, with realistic goals, measurable objectives and objectively-verifiable-indicators (OVIs);

- (k) a Disciplinary Committee should be established within the Ministry;
- (l) The Health Complaints Act should be enforced as soon as possible;
- (m) A Handbook of Administrative Policies and Procedures should be prepared with input from staff of the Ministry and the Ministry of the Public Service;
- (n) Heads of Institutions be exposed to regular training programmes in management and team building;
- (o) urgent action be taken at the national and sub-regional level to preserve the integrity of the OECS/PPS;
- (p) the Office of the Chief Pharmacist be strengthened to allow it to perform a stronger role in monitoring the importation and dispensing of drugs within the public and private health system;
- (q) the formulation of a National Drug Policy and the drafting of Regulations for the 1993 Act be accelerated and the post of Drug Inspector provided for under that Act be activated as soon as possible; and
- (r) the Standards Bureau be invited to establish clear standards for the importation of all drugs.

CHAPTER 2: DOCTORS

Introduction

Our mandate required us to review the system of payments to doctors employed in the public health service and to determine the impact which this system has on public health care delivery. In pursuit of this objective it was necessary to examine the problems relating to doctors in the public health service and then make an assessment as to the extent to which the current payments system has contributed to these problems.

The system of payments was the genesis of many of the issues raised by doctors, or by others in relation to doctors, and many of the complaints and suggestions made to us have their origins in the payments structure. The present payments system has been in effect over many years and is an integral part of traditional practices not only in Saint Lucia but throughout the Caribbean. The basic element of the payments system is the payment by the State of a salary and other allowances to doctors while some categories of doctors are also permitted private practice in order to augment their earnings and provide a service to patients who prefer private medical attention. This arrangement worked reasonably well in the past but various pressures generated by changed expectations, economic circumstances and costly investments in infrastructure in private practices have created a new dynamic in this payments system. The failure to respond to the new developments with appropriate changes has not only fuelled the development of the private sector of medicine but has had an overall negative impact on the delivery of health care by doctors in the public sector, who are permitted to engage in private practice.

Many of the serious issues raised with the Commission in interviews and written submissions reflect the intrinsic contradictions in the system and efforts to fix the symptoms without addressing the root causes will not be successful. We were impressed by the competence, commitment and frankness of many doctors whom we interviewed. They did not hesitate to speak out against any shortcomings of some members of the medical profession and they made positive suggestions regarding the functioning of doctors in the public service. This is a hopeful sign as Saint Lucia has a solid core of skilled and experienced doctors who have the capacity to assist in leading the public health service in the right direction.

However, it was disturbing to note that all of the infelicities mentioned in this Chapter are well known to those empowered to address them and nothing has been done for decades.

The doctors made many submissions over the years, both at the individual and institutional levels, with no positive results. This inaction has led to all

sorts of suspicions and allegations relating to the influence of partisan politics, family connections, and the like.

We do not need to import these considerations into our deliberations. There is enough in the system to account for the behaviour of some individuals and the lack of responsiveness of those responsible for the governance and management of the system.

While many of the problems are attributable to the system of payments there are other issues that compound the situation. These relate to strong perceptions of a conflict of interest especially among doctors engaged in public and private practice; lack of participation by doctors in the governance and management of the health services; a poor physical environment in many instances; lack of equipment and other necessities for effective patient care, and a pervasive sense of helplessness to effect change for the better.

The Commission recognized that it would be reneging on its duty to the Government and people of Saint Lucia if it failed to document the complaints and issues communicated to it and the positive suggestions coming from committed persons. Out of an abundance of caution we have elected to document those complaints embraced and articulated by others as well as by the doctors. Other complaints have not been disregarded and, where we were satisfied that they were not without merit, they were given appropriate consideration in our deliberations.

Perceptions of Conflict of Interest by Doctors

During our review continuing and persistent concern was expressed over the relationship between public and private health entities and the apparent conflict of interest which arises when individuals employed in the public sector are permitted to engage in private practice. The focus of our attention has been on the extent to which such developments affect the public sector of medicine.

The arrangements whereby doctors are appointed to the public service at salary levels which are based on a presumption that they can increase their earnings through the permitted exercise of private practice has operated very much to the disadvantage of the efficient delivery of care in the public sector. Indeed, many doctors identified the negative impact that this is having in specific areas. Other health personnel have confirmed to us the extent of these practices and steps must be taken to redress this situation.

The Commission was informed of:

- unauthorised removal of medical equipment from VH to use elsewhere;
- priority given to patients admitted to hospital from private offices;
- inappropriate influence on patients to use private laboratories in which doctors have a financial interest;
- out-patient clinics often left to junior doctors to manage while senior staff are in their private offices;
- ward rounds conducted by telephone and other instances of hurried rounds by doctors eager to leave for their private offices;
- collusion with some nurses to obtain priority treatment for private patients;
- Unavailability/inability of doctors to respond to urgent calls because of commitments to private practice, even when they are “on call” for emergencies at the hospital.

There is an abundance of evidence which allows us to conclude that some doctors employed in the public service devote as little time as possible to their public duties and seek to maximize their earnings in the private sector. This is an issue which concerns most Saint Lucians, especially those who cannot access private medical care and are subjected to what they consider as sub-standard care in the public sector.

Our remit did not include a review of the functioning of private medical practitioners in Saint Lucia but we are convinced that the State needs to exercise its regulatory role in relation to several developments in the private sector. At the very least it should ensure that doctors who hold themselves out to be in possession of various competencies have the requisite qualifications; that private diagnostic facilities meet required standards; and that the people of Saint Lucia are assured of sound practices. These concerns are very relevant in an era where the merchandising of medicine has become the primary objective of some medical practitioners.

Complaints By and About some Doctors in the Secondary Health Care System

The Commission received a large number of complaints by and about doctors in the secondary health system, which include:

- breaches of hospital regulations by doctors who charge and collect fees in their offices for procedures done at VH;
- manipulation of “on-call” and “call-out” allowances to enhance incomes;

- special arrangements which result in marked differences in remuneration among Consultant staff;
- “double salaries” paid to some Consultants;
- misuse of the hospital to increase financial earnings;
- failure of senior doctors to give direction to and respond to calls for help from junior doctors and nurses;
- failure to see patients, often for over a week, who have been admitted to hospital under their care;
- chronic indiscipline and no response to complaints about the conduct of doctors towards nurses and patients;
- an almost complete absence of doctors at VH in the afternoons, except for those in Accident and Emergency and junior doctors on emergency duty;
- patients seen for the first time by doctors when they are on the operating table;
- patients requiring urgent emergency procedures are kept waiting until the doctor is free from his private practice obligations in the evening;
- inappropriate invasive interventions in patient care;
- no sanctions against doctors, no matter how serious the complaints are.

Complaints By and About some Doctors in the Primary Health Care System

There were also complaints by and about some doctors (DMOs) in the Primary Health Care System. Generally the DMOs felt that their salaries are inadequate and do not reflect the critical work that they perform. Some DMOs are disenchanted over the fact that they are placed at the same grade as Nurse Supervisor within the Classification and Pay Plan (Grade 14). Other complaints include:

- priority given to private practice;
- inadequate assessment of patients;
- the practice by some doctors of writing prescriptions while the patient is coming through the door to see them;
- inadequate documentation of clinical findings by some doctors;
- difficulties in getting doctors to do home visits;
- absence of a system of rotation of doctors through various communities, some of whom have been assigned to the same community for decades;
- inconsistent supply of drugs;
- lack of confidence in the professional acumen of some doctors;
- need for continuing education of doctors in the community health sector;

- delayed responses to emergency calls;
- infrequent clinics leading to overcrowding;
- re-direction of patients to private offices;
- non-specific contracts which do not spell out the obligations of doctors;
- no monitoring of the performance of doctors;
- lack of punctuality in attending clinics and unacceptable speed in disposing of patients in order to get to their private offices;
- schedules for clinics not organized to put the interest of the patient first;
- absence of a proper patients-based records system except at Gros-Islet Polyclinic;
- shortages of drugs and materials;
- high fees for post-mortem examination;
- lack of involvement of District Medical Officers in the community.

These complaints and suggestions, though by no means representative of the total picture presented to us, capture many of the factors and influences which have combined to undermine efforts to deliver quality health services to the people of Saint Lucia. The fact that these allegations are coming from multiple sources, including professionals themselves, indicated that they warranted serious consideration by the Commission. However, we wish to stress that these complaints do **not** apply to **all** doctors.

Participation by Doctors in the Governance and Management of the Health System

The governance of the health service rests with the Ministry of Health. The CMO and his limited medical staff in the Ministry represent the extent of participation by the medical profession at the level of governance. This is unfortunate because the leadership in the development process will inevitably fall on the shoulders of the medical profession working closely with other critical professionals and administrators in the public health service.

We have had the benefit of many valuable contributions and submissions from doctors in relation to public health policy. Many of these proposals have been articulated over many years, but fell either on deaf ears or in a kind of vacuum which has defied change for the better. There is clearly a need for empowerment of the doctors at the level of policy making, especially at the level of complex secondary/tertiary care institutions. Similar considerations should apply in relation to the Community Health Services especially when a policy of effective decentralization and later regionalization is put in place.

The overall influence of doctors on the management of the health services is minimal and steps should be taken to correct this not only in the context of proposed statutorization of some entities, but also in respect of all elements left under the management of the Ministry of Health. Appropriate Committee structures should be put in place to achieve this objective. This divorce between management and the medical profession must be corrected. It is a contentious issue and should not be allowed to fester to the disadvantage of patient care.

Consultants

At present there is a grave danger of serious compromise of the status of the “Consultant.” This status should be accorded only to persons having the requisite qualifications and experience. This is not a matter of professional snobbery but is very relevant to matters such as recruitment of staff, training of junior staff, and international accreditation.

By and large VH has maintained accepted standards but, elsewhere, there is evidence of undesirable compromises. The Public Service must set the example and refrain from according the status of “Consultant” to persons who may have developed some post-graduate competence, experience and additional qualifications that are not normally recognized as those required of Consultants. Rather, these persons should be accorded the status of Senior Registrar. In exceptional circumstances persons without the requisite qualifications may be designated “Honorary Consultant,” recognizing competence and experience, as distinct from the award of “Honorary Consultant cum laude” for those who have served with distinction and on retirement retain hospital privileges. These are issues which should be addressed by the Medical Council, the SLMDA, and the Ministry.

Staffing at Consultant Level

Apart from those appointed to the Public Service, there are other well-qualified Saint Lucians who should be given the opportunity to participate in the public health system at Consultant level. These persons should be offered sessional work in the Department of their specialty and should come under the administrative direction of the Head of the particular Department and the Director of Medical Services. Their privileges should be uniform in the system and their obligations clearly set out in contractual obligations.

The task is to retain and bring on board available talent at Consultant level, the corner stone for the development of the medical services.

Aspects of the Payment of Remuneration of Consultants

Elsewhere in this report we noted the dissatisfaction caused by differentials in the levels of remuneration enjoyed by Consultants. We have reviewed the varying levels of remuneration, the exceptions made and the underlying reasons for these exceptions and the consequences. This system is based more on expediency, and the need to overcome the constraints inherent in the general public service systems of payments. In fact different mechanisms have been used to arrive at a desired result. These differentials run counter to a fundamental principle that all Consultants are equally obligated to function at the level of Consultant in the system and should have the same basic remuneration structure in respect of their public commitments.

Another aspect which is a matter of concern is the payment of on-call/call out to Consultants and the manner in which it is done. Consultants are responsible for patients admitted under their care throughout their stay in hospital. The method of operation of the on call/call out payments to Consultants diminishes in some measure the status of Consultants who should be in a position to assist in regulation of the operations of this system in respect of other categories of staff.

Public/Private Sector Relationships

We do not subscribe to the notion that the State should seek to discharge some of its health functions through private sector efforts. Such a policy can only facilitate the transfer of human and financial resources to situations over which the State has no control and lead to further deterioration in the public sector of medicine. In fact, it is the deterioration in the physical plant and the environment for the practice of medicine, the lack of equipment and the chronic indiscipline in the public sector which has led to the growth of the private sector, and which invites unfavourable comparisons by users of the public health services. The Commission is strongly of the view that it will not serve the public good for the State to enter into financial arrangements using public funds which reinforce and accelerate a process which must be reversed.

The embedded negative contractual arrangements which operate against the efficient delivery of patient care in the public sector must be revisited. An environment which leads to professional growth and satisfaction in the public sector must be established.

The aim must be for the state to provide a satisfactory level of health care which, on medical grounds, gives patients an equal choice to determine whether they wish to access private or public care and be guaranteed an appropriate standard of care in the public sector.

Decisions to seek private care should be based on convenience, personal choice, and similar factors, not on a justifiable belief that better medical care will be delivered. As Saint Lucia develops and incomes improve and health insurance possibilities expand there will be further expansion of the role of the private sector. Such developments are welcomed as much as the investment in private entities. However none of these should be at the expense of or to the detriment of efforts by the state to provide health care for all.

Saint Lucia has a sufficiency of doctors and other personnel committed to these ideals. What is needed is a combination of clarity of policy, the will, and the financial support to achieve them. Each doctor has his own motivations and expectations for a successful career. The majority strive to achieve a healthy balance between their professional, social and economic ambitions. The doctors of Saint Lucia are no different from those anywhere else. It is our judgment that many doctors leave or elect to have minimal contact with the public sector of medicine because of a deep sense of frustration, alienation, lack of professional fulfillment and inability to effect change and progress. The task therefore must be to restore confidence and create the best possible conditions for doctors in the public service to realize reasonable expectations, professional and otherwise.

It is a major error to assume that all doctors abandon or opt for minimal involvement in the public sector solely for economic reasons. There are many professional reasons why some doctors would wish a deeper and continuing involvement with the public sector but would wish to work in a more satisfactory environment, characterized by discipline, opportunity to influence development, better staff relationships, adequate working equipment, an appropriate physical structure, sensitive and efficient management and a culture which places the interest of the patient first.

It is tempting for the state to embark on a policy which relies increasingly on the private sector to meet the needs of its citizens. Such a policy would be ultimately disastrous. The appropriate policy is for the state to provide quality medical services for all its citizens, and finance these services in a manner which does not compromise access or outcomes.

The Commission supports the formulation of a Health Sector Policy which includes:

- (a) a general recognition that the private sector has an important role to play in the delivery of care for those who wish to access private medical services;
- (b) a regulatory framework to ensure adequate standards.

However, the Commission urges that:

- caution be exercised in entering into financial arrangements which could accelerate the flow of financial and human resources from the public sector to the private sector;
- investment by individuals in the private health sector be not automatically considered a conflict of interest when this is done by those doctors in the public sector who are permitted private practice.
- it is the responsibility of the governors and managers of public entities to ensure that there is no conflict of interest in the functioning of doctors;
- the efficiency and standards in the public sector be brought to a level where patients who choose private care do so for reasons other than the quality of care obtained in the public sector.

Suggested Remedies

There were many suggestions offered by interviewees and persons making submissions. These included:

- (a) prosecuting persons who collect fees from patients in their offices in relation to procedures performed at VH;
- (b) stopping the abuse of the “on call/call out” system;
- (c) lowering the rate of “on call/call out” allowances paid after 10 claims in any month;
- (d) paying the same basic remuneration to all Consultants;
- (e) increasing the salaries of Consultants and District Medical Officers;
- (f) designating all Consultants as full-time officers;
- (g) paying an allowance to Consultants in lieu of private practice;
- (h) offering sessional work to Consultants who are in private practice to bring more skills to bear on the operations at VH;
- (i) providing hospital facilities for geographic private practice by Consultants;
- (j) improving supervision of junior staff by Consultants;
- (k) allowing DMOs the opportunity for further training in their field;
- (l) increasing the number of junior staff at VH;
- (m) recruiting more full time DMOs;
- (n) transferring the management of VH to a Statutory Board which should include representation by the Medical and Dental Association;

There can be no question that the current system of payments to doctors, which is rooted in the concept of inadequate salaries and provision for

augmenting incomes by way of private practice, has contributed significantly to the present unsatisfactory situation.

In contrast the issues relating to full time doctors without access to private practice were of a completely different character. These doctors are for the most part junior doctors in the secondary health care system and the issues raised by them were dominated by the lack of supervision and direction by their seniors who, in pursuing their private endeavours, have little time to devote to this aspect of their work. This is yet another example of the deleterious influence of unregulated private practice by doctors employed in the public service.

At present there is a complete absence of mechanisms to remedy this situation. The contracts of employment are vague; there are no job descriptions; there is no management system; there is no enforcement of discipline; and doctors are left to determine their own schedules of private practice, often at the expense of commitments to public duties. From this, it can readily be seen that part of the problem is a direct result of a failure to manage the system.

The proposed statutorization of the secondary health care system must be accompanied by the necessary changes which should be put in place by the Board while the CMO should be responsible for the functioning of doctors in the primary health care system since this segment will remain under the management of the Ministry.

Laws Relating to the Practice of Medicine in Saint Lucia

During our interviews the issue of the role of the Medical Council in relation to the discipline of doctors in matters concerned with their contractual obligations surfaced on several occasions. The Commission noted that the Medical Council has no role to play in matters of a contractual nature unless there is associated professional misconduct.

As required by its Terms of Reference the Commission reviewed the laws governing the practice of medicine in Saint Lucia and interviewed the President of the Medical Council. The principal legislative instruments regulating the medical Profession are:

- The Registration of Medical Practitioners Act. No. 13 of 1967.
- The Registration of Medical Practitioners (Amendment) Act. No. 10 of 1970.
- The Registration of Medical Practitioners (Amendment No.2) Act. No. 26 1970.
- The Registration of Medical Practitioners Act No. 10 of 2002.

These laws expressly prohibit anyone from engaging in the practice of medicine without being registered. However, we heard of several instances in which medical practitioners were recruited by the State and allowed to work prior to the necessary registration process being fulfilled.

The Commission was informed by the President of the Council that the necessary amendments to the current legislation had been identified to allow inter alia for aspects such as annual registration of medical practitioners, linked to continuing education, provisional registration for Interns, temporary registration of specialists and for registration of CARICOM nationals in keeping with the spirit of the Caribbean Single Market and Economy (CSME).

The treatment of Cuba-trained doctors needs to be satisfactorily resolved as soon as possible. The evidence suggests that current accreditation arrangements, some of which were agreed at the regional level are ineffective. We understand that a fairly large contingent of these doctors is scheduled to return to Saint Lucia over the next five years. Many, if not all of these doctors will have taken out substantial loans to finance their education. It is critical that action is taken at the level of the OECS and/or CARICOM to ensure that the region can retain and utilize the skills and competencies of these doctors.

Other issues such as the process for handling disciplinary matters brought to the attention of the Council need to be addressed. We support the view of the Medical Council that the existing Act should be repealed and replaced by more relevant legislation which addresses the new and complex issues relating to registration, specific disciplinary processes and an appropriate regime of penalties.

Recommendations

The Commission recommends:

- the establishment of a Board to govern the operations of VH;
- the removal of VH from the rigid system of payments in the wider public service to facilitate the changes proposed by the Commission;
- the involvement of doctors and nurses in the management of the health system through appropriate Committee structures;
- the implementation of a sustained public relations exercise to assist Saint Lucians in better understanding the role of Consultants in the public health service;

- the adoption of a “no compromise” policy in setting the qualifications for the post of “Consultant”;
- the removal of any differentials in the basic remuneration of Consultants paid by the Government;
- all legal remedies should be vigorously enforced against doctors who collect fees from patients in their private office in breach of the Hospital Fees Regulations.
- all reports of failure to respond to calls for assistance by nurses and junior doctors be fully investigated and appropriate action taken;
- better monitoring of the system of on call/call out allowances to reduce abuse;
- the introduction of a protocol whereby all patients admitted to hospital must be seen by a Consultant on the day of admission or, at the latest, the day following admission;
- adequate ward rounds by Consultants based on a schedule approved by the Director of Medical Services;
- no priority be given to patients admitted from the private offices of Consultants, except in cases deemed to be genuine emergencies;
- an effective disciplinary process be put in place to deal with all complaints relating to the conduct of doctors;
- steps be taken to ensure there is an adequate presence of doctors at VH at all times;
- delays in treatment of emergencies as a result of doctors’ involvement in the private offices should be investigated, whenever they occur;
- the scheduling of private practice by doctors on the day on which they are on emergency duty at the hospital should be avoided;
- better supervision of out-patient clinics by Consultants;
- a full review of the functioning of DMOs be undertaken, which should include the scheduling of clinics, the time spent at clinics, record keeping, home visits and delays in responding to emergency calls;
- contracts of employment should be more specific and job descriptions should accompany all contracts; and
- early resolution of the issues surrounding the accreditation of doctors trained in Cuba.

CHAPTER 3: NURSES

Introduction

Nurses play a vital role as members of the health team and are involved in all aspects of health care in Saint Lucia. In keeping with our TORs, we considered it essential to obtain a thorough understanding of all the factors affecting the nursing profession in order to determine what improvements can be made to enhance the ability of nurses to function more efficiently in the health care system. We interviewed and met with nurses who are employed in the primary and secondary health systems at various levels. We also interviewed representatives of the Nursing Council and the Nurses Association and visited with nurses in their working environment.

The issues raised were substantive, well articulated and, not infrequently, there were positive suggestions from the nurses as to the appropriate way to deal with them. Very early in our interviews it was apparent that salary levels were not the principal concerns of the nurses. While some of the issues raised by nurses with the Commission such as promotion and recognition of specialty qualifications would have some bearing on remuneration, it is our judgment that professional fulfillment was of equal if not greater significance.

Empowerment of Nurses

We were impressed by the high quality of nurses in management positions in the primary and secondary sectors of the health services. It is a matter of regret that these talents are not being fully utilized to the benefit of the service.

We assume that after the statutorisation of the secondary care institutions the Ministry of Health will have continuing responsibility for the governance of the primary health care system. This emphasizes the vital importance of the filling of the post of the Chief Nursing Officer (CNO). This officer, located in the Ministry will be of critical importance in policy formulation in relation to the primary health care sector. The failure to fill this post for many years has sent a powerful signal to nurses that there is considerable insensitivity in the Ministry of Health to their desire for a level of empowerment which bears some relation to the extensive role they play in the system and their ability to participate at that level in policies affecting the nursing profession.

Nurses consider the present practices to be devoid of transparency and identifiable leadership direction, and are of the view that the appointment of a suitable person to this post will fill a major deficiency in the system of health care delivery by nurses. The holder of this post should have post-

graduate qualifications and should have extensive experience in human resource management.

The present policy of a “de facto” centralization of the management of entities in primary health care sector is highly inefficient and a policy of decentralization must be put in place. This will empower nurses and managers to bring about greater efficiencies and improvements in the level of care offered to patients and make better use of the administrative talents of the nurses in charge of the polyclinics, district hospitals and health centres. When we consider the geography and historical developments of the primary health care sector of Saint Lucia we have no difficulty in supporting the notion of regionalization in the context of decentralization to promote greater efficiencies within the management system but decentralization of smaller units must come first and regionalisation later.

Nurses in hospitals do not feel empowered to play a role in the governance and management of these institutions. They do not feel an integral part of the Health Team and some complain that Medical Staff appear to disrespect them. One suggestion which could help in this regard would be to ensure that Directors of Nursing at hospitals become *ex officio* members of any Hospital Board appointed and so participate regularly in Board Meetings and decision making. Another suggestion would be the formation of Nursing Staff Committees. Meetings should be chaired by the Director of Nursing and should be held regularly.

We are supportive of these suggestions and are of the view that legislation establishing Boards of Governance should provide for the Director of Nursing Services to be:

- (a) An *ex officio* member of the Board;
- (b) A member of the Senior Management Team
- (c) The Chairperson of a legally-constituted Nursing Staff Committee
- (d) A member of a Patient Care Committee.

Chronic Nursing Shortage

Over the years Saint Lucia has put together an impressive infrastructure for Community Health Care, the performance of which depends heavily on the contribution of nurses. The efficiency of all sectors of the public health service has been seriously undermined by a shortage of nurses. This situation has not only de-motivated existing nursing staff who are already overworked, but has also impaired work attitudes and encouraged the migration of many nurses from Saint Lucia.

The causes of the chronic shortage of nurses in the public health system are complex, but we were left in little doubt that the conditions under which the

nurses work are far more important to them than levels of salaries. There are unfilled vacancies in the system and there is a need to bring more nurses into the system.

At the level of the Ministry there is an awareness of the problem as it relates to numbers but we did not discover a concrete programme of action to address this critical matter and this can be seen in the inadequacy of training programmes at all levels. For example, Golden Hope Hospital which has 162 beds is manned by two (2) trained psychiatric nurses, one of whom is due to retire shortly. Plans are underway for a new Psychiatric Hospital and unless urgent action is taken it is almost inevitable that there will be only one (1) trained nurse at that institution.

The Family Nurse Practitioner (FNP) programme in the primary health care sector which has been quite successful is now headed for a serious crisis. Information available to us indicates that there is not a sufficiently aggressive programme of training of FNPs. Of the small number available five (5) are scheduled to retire soon. There is no programme in place to address this situation. We were also informed that 96 per cent of Community Health Nurses currently on the job have had no additional training in Public Health. This is an untenable situation and needs to be speedily addressed. Generally nurses in the primary health care sector feel that the part-time employment of some DMOs is limiting their effectiveness. They believe they can be of greater help to patients if DMOs are engaged on a full-time basis.

Support Staff for Nurses

The decision to offer additional training to Nursing Assistants and appoint them as Staff Nurses created a vacuum for support staff for nurses. As a result, the Staff Nurses find themselves in a situation where they are required to perform many non-professional duties which can be readily done by support staff. This aggravates the problems facing trained nurses in the system. The nurses are of the view that the appointment of support staff will significantly relieve the problems occasioned by nursing shortages. We are advised that a proposal has been submitted to the Ministry to trade four (4) Staff Nurse posts for additional Nursing Aides posts. We believe that this proposal merits earnest consideration.

Nursing Assistants

Nursing Assistants complained that, although they received additional training and were promoted to the rank of Staff Nurses, they do not receive equal treatment, even in situations where they demonstrated the ability and capacity to function efficiently in sub-specialty areas. There is a strong perception among them that they are being discriminated against in matters

related to further professional development such as promotion and further training.

Remuneration of Nurses

A significant finding was the relatively low level of complaints by nurses about the salaries they are paid, even when invited by us to comment on them. However, while nurses were far more concerned about other conditions of service, we think it would be wrong to infer that they are generally satisfied with their current salaries. Indeed, Staff Nurses at VH intimated to us that their salary do not allow them to meet the borrowing requirements of financial institutions, especially for educational purposes. We believe that these salaries should be kept under active review.

There were many representations by and on behalf of the Nursing Aides who perform a valuable service in the primary health care sector. The Nursing Aides are of the view that they deserve better remuneration and some means of assistance with traveling to avoid having to walk long distances. In addition there were some concerns expressed which could impact the level of remuneration and these include:

- the allowance of \$1.00 per hour for night duty which some nurses consider an insult;
- the non-payment of a travel allowance for Community Health Nurses;
- infrequent increments despite favourable performance appraisals.

Education and Training

Nurses cited the difficulties that they experience in obtaining scholarships and/or study leave as yet another source of their dissatisfaction. They complain about having to compete with other members of the Civil Service for the few scholarships which are available. They point out that their salary levels do not allow them to meet the borrowing requirements of the banks. Not infrequently they have had to finance their training from their own pockets. Avenues for promotion are limited to the traditional routes of Administration or Midwifery. However there are many non-traditional areas in which nurses have been or wish to be trained - for example, Intensive Care, Operating Theatre, Paediatrics, Otolaryngology (ENT) and Ophthalmology. Nurses complain that even when such training has been obtained there is no prospect of promotion or retention in the specialty of their choice.

Mobility Prospects

In small societies such as Saint Lucia opportunities for lateral and vertical mobility of nursing staff will always be somewhat compromised. However, there is a systemic problem in the structure of the nursing profession due to the failure of policy makers to recognize the changing needs of medicine and nursing and make appropriate adjustments in response to them. Saint Lucia already has the capacity for sub-specialty development in the areas mentioned above and others, but, quite evidently, there is no structural nursing response to this situation, either at the level of training or human resources allocation.

Doctors complain that after spending much time and effort to contribute to the development of nurses in their specialty, these nurses are transferred to other areas and they have to start the process all over again. Some nurses who, by their own efforts or by scholarship, have achieved a high level of competence in their chosen field find themselves being supervised by seniors who have no training in their specialty, and without prospects of promotion except by way of administration; and, not infrequently, no recognition in terms of remuneration for their efforts to improve themselves professionally and advance the goals of the profession.

It should be noted that the impending statutorization of a significant segment of the public health service could lead to a further contraction of the lateral mobility for nurses, **unless** arrangements are made for movement between the statutorized entities and those remaining under the Ministry of Health **without** the loss of accrued benefits, especially in the area of pensions.

Migration of Nurses

The growing migration of Nurses remains a vexed and recurrent problem not only in Saint Lucia but in most other Caribbean states. The reasons adduced for migration are multi-factorial. Surprisingly, unattractive salaries, increments and allowances were not the reasons advanced by nurses themselves as the main causes of migration. Instead, important factors identified as causes of migration include, absence of Human Resources Development, difficulties in obtaining continuing nursing education, and inadequate recognition of specialist nursing training. Migration is also closely related to working conditions in physical facilities which are frequently poorly maintained and without adequate equipment and supplies.

In a free democratic society no restrictions can be placed on the movement of any group who seek to improve their situation by migration. The emphasis must therefore be on increasing the number of trained nurses and

creating the best possible conditions for retention of those trained and entering the system. The nurses who appeared before us made the following recommendations to increase the number of persons entering the nursing profession:

- An increase in the number of student nurses;
- The provision of a small stipend during the period of training;
- An active programme for the recruitment of nurses

The nurses also advocated a number of things that could be done to assist in the retention of nurses, many of which are described elsewhere and include:

- improvement of the physical conditions under which they work;
- the provision of a staff canteen at the major hospitals;
- the provision of a nurse's sick bay or rest room, a library, and day care nursery;
- greater transparency in the recruitment and selection process, including adequate advertising of posts to be filled;
- greater transparency in matters relating to promotion;
- stronger emphasis on quality assurance practices;
- written policies and protocols to be followed by all;
- more nursing supervisors on duty at night at VH to improve nursing care at night.

Some nurses have expressed the view that the consequences of the shortage of nurses may be temporarily alleviated by the following measures:

- More flexible working hours
- the creation of a pool of sessional nurses which would include retired nurses
- adjustment of the age of retirement of nurses to age 60.

These suggestions were welcomed by the Commission and are indicative of the contribution which the nurses would like to make if given the opportunity.

Nurse/Doctor Relationships

At the level of the primary health services there were no complaints by doctors about nurses and rather few complaints by nurses about doctors. In general, there seemed to be better relations between doctors and nurses at the primary health care level than in the secondary health care system.

The complaints of nurses about doctors were identical to those of the public and were directed towards the availability and attitudes of some DMOs and may be summarised as follows:

- inadequate clinical examination of patients;

- overcrowded clinics as a result of the limited amount of scheduled medical clinics;
- priority given to their private practices to the detriment of their public duties
- poor response to legitimate requests for house visits when made by nurses.

At VH there are many outstanding issues between some Consultants and the nursing staff. There are numerous cases where nurses have been humiliated and abused by some Consultants, especially some nurses working in the operating theatres. The complaints by the nurses were numerous and very little has been done to address this situation.

Laws Governing the Competence and Conduct of Nurses

The nursing profession is governed by the following laws:

- (a) The Health Services (Complaints and Conciliation) Act. No. 34 of 2001;
- (b) Registration of Nurses and Midwives Ordinance No.12 of 1966.
- (c) Registration of Nurses and Midwives (Amendment) Act No.1 of 1993.

The Commission was informed that a request had been made by the Nursing Council to the Attorney General's Chambers for a review of the legislation dealing with the Registration of Nurses, Midwives and Family Nurse Practitioners. Both pieces of legislation provide, inter alia, for the establishment of a General Nursing Council, the appointment of its members, regulation of the profession and the Council's responsibility to advise the Minister on matters related to Nursing.

At Part IV of the Act provision is made for the maintenance of a Roll of Nursing Assistants and matters related to that category of nurses. The Act further provides for the making of Rules by the Council to give effect to the Ordinance. The Council is empowered to suspend or cancel the registration of nurses and midwives and the Act institutes offences and penalties for "unauthorized practice by nurses and midwives".

The Commission supports the call for a review of the legislation aimed at amending the administrative structure of the Council to ensure that, inter alia, the Chairperson is a Nursing professional and to redefine the advisory and regulatory role of the Council in keeping with current trends and changes in the profession.

Our attention was drawn to the provisions of the Registration of Nurses and Midwives (Amendment) Act No.1 of 1993, which specify a wide range of serious medical conditions which an FNP is authorized to treat. We have examined the legislation and have concluded that urgent attention should be paid to this issue to avoid any problems in the future.

The guiding policies to be followed in improving the working conditions of nurses are well captured in the following Declaration emanating from an International Conference of Nurses held in Barbados on February 24, 2004:

“We urge all relevant authorities in the Caribbean Region to scale up their actions to recognize value and strengthen nursing in several key areas by taking the following actions:

- (a) improve the recruitment and retention of Nurses
- (b) improve the terms and conditions of work for Nurses
- (c) improve the education and training of Nurses
- (d) improve the utilization and deployment of Nurses
- (e) improve the value and recognition of nurses and nursing
- (f) improve the management practice and policy contribution of Nurses.

Recommendations

The Commission recommends that:

- (a) the post of CNO be filled as soon as practicable and that the CNO be involved in all matters relating to nurses employed in the public sector;
- (b) a policy of decentralisation of the management of entities in the primary health care system be actively pursued;
- (c) urgent steps be taken to empower nurses in the management of all sectors of the health care system;
- (d) in respect of VH and/or its successor when it is transferred to the governance of a Board the Director of Nursing Services should:
 - be an ex-officio member of the Board
 - be a member of the Senior Management Team
 - be Chairperson of a Nurses Staff Committee
 - be a member of a Patient Care Committee
- (e) an urgent programme for the training of Psychiatric Nurses and FNPs be designed and implemented;
- (f) a programme to ensure that more nurses in the Community Health Service receive training in Public Health;
- (g) an urgent recruitment programme be pursued to attract more young persons into the nursing profession;
- (h) the appointment of Nursing Aides in the secondary care system as support personnel for nurses;

- (i) the size of the nursing establishment be increased;
- (j) former Nursing Assistants who have become Staff Nurses should not be subjected to any form of discrimination;
- (k) a special programme of assistance be introduced to facilitate scholarships/study leave for nurses seeking training in approved areas;
- (l) sub-specialties be recognized as appropriate routes for promotion similar to Midwifery and Administration;
- (m) a legal framework be created to ensure that statutorization of segments of the public nursing service does not compromise lateral and vertical mobility of nursing staff;
- (m) appropriate rewards for nurses who satisfactorily complete post-graduate training and return to the service;
- (n) closer attention be paid to the physical conditions under which nurses work;
- (o) greater transparency be introduced in the process by which nurses are selected for training and promotion;
- (p) an adequate number of senior personnel be deployed to ensure effective supervision of Staff Nurses on night duty;
- (r) an efficient and effective mechanism for handling complaints be established;
- (s) improved allowances for nurses on night duty;
- (t) travel allowances be paid for Community Health Nurses and Nursing Aides, where appropriate.

CHAPTER 4: THE PAYMENTS SYSTEM

Policy Issues

Any changes in the system of payments to doctors and nurses should be anchored in a policy framework which addresses the needs of the service and available resources. The critical decision to be taken is the extent to which the service should be manned by full time officers. It is our judgment that the best arrangement would be a system whereby the services are manned primarily by full time officers and supplemented by officers employed on a sessional basis.

In the secondary health services all doctors should be full time with provision made for regulated private practice by Consultants. No doctors below the level of Consultants should be allowed private practice. Consultants employed on a sessional basis would normally have their private practices and be paid only for sessional work. This should be the basic arrangement which would provide for a central core of full time doctors, supplemented by sessional doctors.

The term “full time” should be properly construed as it applies to Consultants with the privilege of private practice. Contracts for these officers should stipulate:

- the basic salary;
- an allowance in lieu of private practice for Consultants who elect not to exercise the option of private practice;
- the number of sessions allowed per week for private practice for those who opt for the privilege of private practice. Assuming there are ten 4-hour sessions in a 5-day week a maximum of 3 sessions should be allowed for private practice.

Earlier in this report we indicated that the system of on call/call out allowance for Consultants should be abolished. The present system should be replaced by a fixed allowance by way of a percentage of salary. There are other allowances available at present such as housing, telephone, etc. These should all be reviewed in a new contractual dispensation.

In the new hospital geographic private practice should be encouraged since this helps to keep those Consultants exercising the privilege of private practice on the premises.

At least one consulting suite should be available which could be shared by several Consultants who will be required to pay the rent and the salaries of staff, etc. Provision should also be made for a number of private beds for

patients. Patients should be allowed the option of choosing private facilities and be treated by the Consultant of their choice. Fees would be payable by such patients to the hospital for services it provides and to the Consultant for his/her services. These private facilities should be so arranged that private patients are readily identified for ease of administration and avoidance of any confusion in the future.

The Primary Health Care System

The policy decision should be to gradually replace part-time doctors with full-time officers, and the principle of anchoring the medical services with full-time doctors, supplemented by sessional employees should apply. For full-time employees an appropriate package of remuneration should apply and this should include salary, travel allowances, housing allowance, and any other relevant allowances. Sessional workers should be paid a fixed amount per 4-hour session.

The transition to this longer term policy objective should be carefully managed in order to retain the services of those experienced DMOs who currently do not abuse the system and provide dedicated service.

Payments by Patients

At present there is a policy in place which requires patients to pay for services in the public health system. There is a list of approved exemptions by categories of persons. In addition there is a process involving the social worker that seeks to determine who should be exempted and who should not.

We received repeated complaints that some persons are able to obtain exemption status without going through the established process. There were also repeated concerns expressed by the public that children, the unemployed and disadvantaged persons are not exempted automatically. We were advised that at VH there are approximately twenty-three (23) Clerical Officers involved in this process. The evaluations occupy a significant amount of the time of the solitary social worker as well as Staff in the Accounts Department who work on the billing and collection process.

While we have no doubt that persons who can afford to pay sometimes succeed in beating the system, the primary concern must be the difficulties encountered by the genuinely poor and sick in meeting these charges and/or being subjected to this evaluation process. People who are ill must have access to medical care and there should be no financial barrier erected in the public health service.

When one considers all these factors including the fees paid to doctors and others out of this “pool” and the high level of arrears which will never be collected, it is very doubtful whether there is any significant net contribution to the public purse. This system of payments has no place in a policy environment which declares an objective of Health for All. It should be replaced by a policy of access by all Saint Lucians to health care in the public sector without payment at the point of delivery of such care.

The Government’s policy of seeking to finance the health services by other mechanisms is a step in the right direction and should be implemented as soon as possible.

Other Aspects of the Payments System

The present arrangement where doctors are paid a percentage of fees charged by the hospital is unsatisfactory and should be abolished. We were surprised to learn that these fees are paid to doctors **whether or not the hospital is paid by patients**. These fees are charged under the existing Hospital Fees Regulations which are highly discriminatory against Consultants whose discipline does not involve operative procedures, a hang-over from another age. A new set of Hospital Fees Regulations will be mandatory to remove this discrimination. These new regulations should provide for the hospital to bill and collect for the services it delivers to private patients and doctors to bill and collect for the services they provide for private patients, in the context of a schedule of fees permitted by new Hospital Fees Regulations. A sustained education programme should accompany this policy shift to protect patients from abuse.

Remuneration of Consultants

While our mandate is to review systems of payments rather than actual salaries and other payments to doctors we found that our review would be incomplete without a careful examination of the levels of remuneration of Consultants in respect of their duties at VH. The years of review were fiscal year 2002 – 2003 and fiscal year 2003 – 2004. We also reviewed the special contractual arrangements with various doctors.

While the basic salaries were relatively uniform there were enormous disparities in the annual payments to Consultants depending on their contractual arrangements and capacity to earn fees under the present Hospital Fees regulations. Moreover, the methodology and designation of awarded allowances to achieve a given level of remuneration varied from contract to contract. It is therefore not surprising that considerable discontent and confusion surround these issues. Hence we find the call for transparency and equity to be highly appropriate.

In the proposed restructuring of private practice arrangements remuneration from fees earned by doctors in private practice at VH will not be a consideration in relation to payments by the hospital for services rendered by Consultants. The core elements to be considered will be:

- (a) salaries;
- (b) payments in lieu of private practice;
- (c) payments for on call/call out
- (d) other allowances such as housing, travel, telephone as now exist.
- (e) payments in lieu of private practice and for on call/call out should be a fixed percentage of salary.
- (f) housing and other allowances should be uniform.

When a statutory Board is in place there will be no need to overcome the constraints which now exist in relation to paying appropriate salaries and arriving at a satisfactory level of remuneration for Consultants. We have focused heavily on payments to Consultants and payments by patients, since this is where the main problems exist and where reforms are required.

In relation to non-consultant staff the issues raised centred around levels of salaries, delays in obtaining contracts and placement in jobs at lower salary levels than indicated in the original letters of job offer. We considered these as administrative problems and matters for negotiation with their representatives. There is no need to change the system of payment in relation to junior medical staff.

Special Allowances

Any additional special allowance should be rare and should be dictated solely by the exigencies of the Service. There should be no personalised arrangements and in every instance the concurrence of the Medical Director and the Medical Staff Committee should be sought. Equity and transparency should be the watchwords in variations of this nature.

Fee Collection Mechanisms

The payment of Hospital Fees is governed by the Hospital Fees Regulations SI No.68 of 1992. The Commission found these regulations to be outdated and not truly reflective of the current cost for services.

The accounts at VH are in such a bad state that the Commission is reluctant to quote exact figures and prefers to make judgments on the basis of trends. We examined the annual amounts received under the broad head of medical fees and annual disbursements to doctors under a similar head. There is an inescapable conclusion that more money is paid out than is received. This view is reinforced by the observation that while arrears of

payments by patients to VH amount to several million dollars we found nothing to suggest that there are significant arrears in payments by the hospital to doctors.

It will therefore be necessary to establish a new set of Hospital Fees Regulations and the legislation establishing a BOARD should confer this authority on the BOARD. In our proposed new dispensation for private practice the main purpose of Hospital Fees Regulations would be to:

- (a) avoid abuse;
- (b) accord due recognition to the value of work done by Consultants whose discipline does not involve operative procedures;
- (c) establish a clear separation between billings and collections by the hospital for the services it provides and billings and collections by doctors for the service they provide;
- (d) put an end to a situation where the hospital pays fees to doctors, whether or not it collects such fees from patients.

The Payment Systems in other OECS Countries and Barbados

With the assistance of the Ministry, the Commission obtained information on the system of payments of doctors and nurses in Antigua and Barbuda, St. Vincent and the Grenadines, Dominica, and Grenada. The Commission found the basic payment system in these countries to be substantially similar to what obtains in Saint Lucia, with some minor variations from country to country.

However, Barbados has a different system in that all doctors in the primary health system are full-time with the exception of two doctors who perform sessional work. In the secondary health care sector all doctors are full time, except for a limited number of sessional consultants. All other Consultants are full time with the privilege of either private practice on a limited scale during normal working hours or payment of a percentage of salary in lieu of private practice. It is to be noted that Barbados' payment system evolved over the years from what exists in many OECS states.

Recommendations

The Commission recommends:

- (a) a policy objective of full-time doctors to man the health services;
- (b) Consultants be full-time employees but with provision for payment in lieu of private practice or an allowance of sessions to pursue private practice;
- (c) a policy of employment of some Consultants on a sessional basis;

- (d) provision be made for geographic private practice in the new hospital;
- (e) facilities for private patients in the new hospital;
- (f) the present system of payments by patients seeking medical care at public institutions be abolished;
- (g) the proposed new methods of financing the health services be put in place as soon as possible;
- (h) the present system of the hospital charging fees and paying fees to Consultants be abolished;
- (i) the current Hospital Fees Regulations SI No. 68 of 1992 be repealed and replaced by new Regulations;
- (j) all Consultants be paid the same basic *remuneration*;
- (k) a fixed percentage of salary be paid for on call/call out duties;
- (l) a fixed percentage of salary be paid in lieu of private practice, where relevant;
- (m) an award of sessions for private practice for those who opt to pursue private practice;
- (n) the retention of housing, telephone and travel allowances where appropriate;
- (o) the abolition of all other allowances which were designed to overcome the limitations inherent in the public service salary arrangements;
- (p) the hospital to bill and collect fees for the services it provides for private patients;
- (q) doctors to bill and collect fees for the services they provide to private patients.

CHAPTER 5: Victoria Hospital

Governance Arrangements

The governance and management of Victoria is proscribed by:

- (a) The Public Hospitals Management Act No. 5 of 1973.
- (b) Public Hospitals Management (Amendment) Act, No.8 of 2000.
- (c) Hospitals Regulations No. 68/1992.

Although the main Act pertaining to the management of VH is about 30 years old and out-dated it makes provision for the establishment of a Hospital Board. In submissions made to the members of the Commission by persons who at one time or another had been appointed to the VH Board, they all complained of the inability of the Board to function independently and effectively due to micro-management by the Ministry.

The Commission's attention was drawn to the Public Hospitals (Management) (Amendment) Act, No. 8 of 2000, which effectively makes special provisions for the administration of VH. By section 3 of the Act the Hospital Board is created as an Advisory Board and that management structure excludes the CMO from responsibility for the medical administration of VH. The Act expressly provides for the appointment of a Medical Director under the supervision of and reporting to the ED who in turn reports to the Permanent Secretary in the Ministry.

In March 2004 during the time of the sitting of the Commission efforts were underway to appoint a Medical Director and to constitute a Medical Services Committee as provided for under the Act. The Commission was apprised of the great difficulty this posed both in operation and cooperation.

We consider the settlement of the issue of governance to be fundamental for the rescue of the VH and vital to the preparation for governance of the proposed new hospital. Unless this issue is addressed without delay, the same attitudes, the same culture and the same disabilities will be transferred to a new institution and the investment in a new hospital would be severely compromised.

We have taken note of all the comments of those appearing before us in relation to a change of governance of the institution. We believe that the composition of the Board should overcome any hesitation based on past experience while achieving an appropriate degree of autonomy and functional independence for the Board within the context of constitutional responsibility and authority of the government.

We are therefore generally supportive of government's policy of "statutorization" but we consider it of critical importance to have a clear notion of what this process entails and what it is intended to achieve.

Specifically, we see the establishment of a statutory board not as an end in itself or an automatic cure for the deeply ingrained cultural, professional and other broad-based infelicities which now engulf the institution, but as the beginning of a process which can lead to lasting improvements and put in place structures and systems which can be transferred to the proposed new hospital.

By its composition, structure and the authority with which it is legally vested, the establishment of the Board must send a powerful signal to the entire community that it is empowered to achieve the following:

- (a) the elevation of the care of patients as the first priority for the existence of the hospital;
- (b) the elimination of inappropriate partisan political interventions which, whether real or perceived, have sapped the vital sinews of the institution over decades;
- (c) an end to chronic indiscipline at all levels;
- (d) an end to misuse and abuse of the institution for personal financial gain by some;
- (e) respect for staff at all levels;
- (f) the empowerment of doctors, nurses and other professionals in the management and decision-making processes;
- (g) the promotion and enshrinement of the rights of patients;
- (h) the removal of any concerns that the Board can become yet another hurdle to overcome, in the decision-making process;
- (i) sound financial management of the affairs of VH with due regard to laws governing the use of public funds;
- (j) the involvement of civil society in the governance of the institution;
- (k) the preservation of the constitutional rights of all staff currently employed as civil servants at the institution;
- (l) respect for the inalienable right of government to give general policy directions.

In pursuit of these objectives the Commission recommends:

- the Minister be authorized to appoint only a minority of Board members in his own discretion, including the Chairperson;
- the Medical Director, Nursing Director and the ED be ex-officio Board members;
- all other Board members be nominated by national organizations representing doctors, nurses, workers, the church, the private sector, the academic community;
- no employee of the hospital except as indicated above should be eligible for membership of the Board;
- no person should be appointed to the Board who has not demonstrated an interest in the public welfare and competence in his chosen field of endeavour.

The enabling legislation should clearly set out the functions of the Board and any limitation in its authority. Similarly the legislation should indicate the restrictions on the Minister to issue general policy directives, and more specifically to matters such as the relationship of VH to other health institutions and services such as polyclinics, ambulance services, inter alia and facilitating arrangements for the lateral and vertical movement of staff within the health system, without loss of any accumulated rights and benefits.

In light of the fact that Parliament and the Minister of Finance are ultimately responsible for all public funds, the legislation should address matters such as the role of the Auditor-General, the laying of financial statements in Parliament, permitting the practice of virement, retention of savings by the Board, the charging of fees for services, the receiving of gifts and donations, the establishment and management of a Hospital Trust, the capacity of the Board to borrow, the vesting of assets in the Board, the pledging of the assets of the Board, the preparation of budgets for approval, a financial code for the hospital, the assumption of pre-existing liabilities by the government and other matters of this nature, including a charter of patients rights.

Accordingly, we strongly recommend that:

- (a) the legislation for a Board for VH be put in place as soon as possible;
- (b) an appointed day be set for the change-over to a Board;
- (c) the Board be appointed well in advance of the take-over date which ideally should be at the beginning of a financial year;
- (d) all outstanding liabilities should be for the account of the Government;
- (e) the budget for first year's operation of VH under a Board be settled well in advance of the appointed date of take-over;

- (f) the members of the Board become fully familiar with the relevant issues and their role as governors, rather than as managers, before the appointed day;
- (g) that the Board be empowered to put its senior management staff in place on the appointed day;
- (h) that all matters relating to staff involved in the change over to a Board be settled before that day;
- (i) the Board be empowered to make regulations under the Act for the good governance of the institution;
- (j) such regulations should provide for the establishment of:
 - A Senior Management Committee
 - A Medical Staff Committee
 - A Nursing Staff Committee
 - A Patient Care Committee
- (k) given the corrosive and insidious atmosphere that engulfs VH, the functions of these committees be spelt out in legislation.

Management Arrangements

VH has a senior management structure which includes an ED, Medical Director, Nursing Director, Financial Controller and Human Resource Manager. There is no evidence that this team, led by the ED, has had any significant impact on the functioning of the Hospital. We are advised that Management Meetings are infrequently held. In 2003 only 2 meetings were reportedly held and at May 2004, the team had not met.

In several submissions before the Commission there were numerous complaints about the frequent absences of the ED which appeared to be affecting the proper functioning of that institution.

On the basis of our own observation, and drawing on oral and written submissions it has become clear to us that there are major problems at VH, most of which can and should have been ameliorated by dedicated leadership which is manifestly lacking at this time. The morale of all staff at the hospital is very low; staff meetings are extremely rare - the last one was held 2 years ago; there is no evidence of any systematic attempt to ensure performance of staff in relation to either professional or contractual obligations; doctors are seldom introduced to nurses following their appointment; no protocols for quality assurance or for managing patient complaints exist; the accounting system is chaotic with large sums outstanding and there is grave doubt whether any of this money will ever be collected.

There are also numerous problems affecting the operation of the surgical theatres and there has been no effort to resolve the problems in this critical area. Further, there is no organized maintenance programme for the physical structure and equipment; sometimes an entire surgical list has had to be cancelled because the autoclave is “down”; the maintenance department finds itself in a situation where it does not know that a particular piece of equipment is in the hospital until the equipment has broken down; contracts for supplies often go to those who can offer credit for the longest period; the equipment in the radiology department is described as “deplorable” and there is no trained radiologist on staff; the dietetics department cannot plan menus because of unpredictability in the availability of supplies; and complaints by staff are usually ignored or put through a process which usually ends with no remedial action.

We also received many complaints about the inadequacy of the security arrangements at the Accident and Emergency Department of the Hospital. Nurses complain that their lives are often under threat especially during the treatment of patients with gun-shot wounds incurred during acts of gang-violence. On more than one such occasion the intervention of the Special Services Unit (SSU) of the Police Force had to be sought.

We are of the view that many of the problems affecting the hospital can be ameliorated by efficient management, even in a situation where the governance of the institution is largely devoid of any serious sense of vision, mission or strategy. The defects in management do, however, impact the performance of doctors and nurses, and must be cured and not carried over to the new hospital.

Our mandate does not require us to conduct an inquiry into VH. However, notwithstanding Government's decision to build a new Hospital, we feel obliged to make some recommendations in relation to its management which can be implemented now and pave the way for the management structure which will be introduced by legislation under a Board.

Accordingly the Commission recommends:

- (a) an in-depth management audit of the operations of VH;
- (b) the senior managers should constitute themselves as a formal senior management team under the chairmanship of the ED and should meet at least once a month;
- (c) the Engineering Department should be upgraded and its head invited to participate in all decisions affecting it;
- (d) a programme to strengthen middle management, especially in the ancillary and support services be put in place;
- (e) the process of effective empowerment of professional staff be implemented by the establishment of functional medical and nursing staff committees.
- (f) putting in place procedures for handling complaints and acting on them expeditiously.

CHAPTER 6: ST. JUDE HOSPITAL

Introduction

This 88 bed hospital, formerly a private hospital, was taken over by the Government and is now being managed by a Statutory Board within the context of St. Jude Hospital Act No. 7 of 2003. The Hospital serves a population catchment of approximately 40,000 persons in the south-east and southwest-regions of the island. It provides a 24 hour out-patient clinic and a 24 hour Accident and Emergency Department.

We visited the institution, met with the Chief Executive Officer, the Director of Nursing services, senior doctors and the Director of Medical Services. It is our view that the physical plant will require substantial upgrading if it is to become capable of delivering quality secondary care services to the people of Saint Lucia at the level envisaged for the new hospital in Castries. A considerable amount of money is being spent on maintenance and repair of age-related defects in the Hospital's physical plant.

Management Arrangements

The oral evidence received by the Commission suggests that St. Jude remains relatively free from the negative cultural influences described in relation to VH. We received fewer complaints about its operations from the general public and staff. Indeed, there were many comments which indicate that a "friendlier" atmosphere exists there as far as the users are concerned.

The Commission noted that the approach to the management of St Jude was far more business-like and commercial in nature than that of VH. Unlike the Public Hospitals Act governing the management of VH, the St Jude Hospital Act circumscribes the functions of the Hospital's Chief Executive Officer and prohibits him from holding any appointment or engaging in any activity which may interfere with his proper performance or which may be "prejudicial to the interests of the hospital".

Recruitment of Medical Staff

St. Jude relies heavily on temporary volunteers from overseas to augment its medical staff. While generally, this arrangement appears to have worked well in the past, the evidence presented to the Commission points to understandable concerns about an overdependence on volunteers. Other related concerns put to the Commission include:

- a lack of predictability in the availability of doctors at the hospital;

- volunteer doctors not conversant with the socio-economic realities in the country;
- the tendency of volunteer doctors to prescribe expensive drugs;
- doctors not receiving discharge summaries about their patients to facilitate continuing care.

Financial Management Arrangements

In the FY 2003/2004, St. Jude received a subvention of EC\$8.2 million from the Government which is used primarily to pay the salaries of medical and other staff. In that year, the Hospital raised \$6.7 million in revenue, including \$4.2 million from hospital fees. The balance of the Hospital's operational budget (approximately \$4 million) is met through a vibrant volunteer programme. A perennial problem for that institution is the difficulty in collecting fees from Government agencies and/or persons receiving services on behalf of Government such as prisoners, nurses, police officers and firemen.

Fee Collection System

No Regulations as required by the St Jude Hospital Act were available to the Commission and it would seem that no regulations were effected under the Act. Notwithstanding the fact that the Act provides for Regulations to be made "with respect to the fees to be charged for the services of the Hospital" it is noted that the Hospitals Regulations No. 68/1992 also applies to any hospital declared by Cabinet to be a hospital for the purposes of section 3 of the Hospitals Ordinance.

Nonetheless, the Commission noted that the fees charged by St Jude differed from those charged at VH and in fact in many instances were quite higher for the same services. This factor, along with better collection methods and greater compliance by patients explains the higher revenue generated when compared with VH.

The Commission was advised that the Hospital is also struggling to deal with Consultants employed at the Hospital who are allowed to engage in private practice and are in direct competition with the hospital for patients.

The Long Term Future of St. Jude

The Commission is aware of the "two hospitals" recommendation by the authors of the 2001 Health Sector Study (HERA), who made it clear that their recommendation was not primarily based on "planning, quality or

efficiency arguments.” The Commission does not enjoy the luxury of ignoring these considerations which are central to its mandate.

The number of beds at the new hospital will be a critical factor in determining the long term future of St. Jude Hospital. At the time of preparation of this report there has been no final decision as to the number of beds which will be available at the new hospital. During the period of our review we were advised initially that a total of 185 beds were being contemplated but the most recent figure communicated to us was 146 beds. It is our understanding that the reduction is due to funding issues. It is our firm view that every effort should be made to achieve a bed complement of 185 beds.

We have listened carefully to all the arguments advanced in support of two secondary care institutions in Saint Lucia serving a population of only 155,000 people. In 2002, the occupancy rate at St. Jude Hospital was 44.3% for a complement of only 88 beds. We have noted that the occupancy rate of all hospitals in Saint Lucia is relatively low. The highest occupancy rate is at Golden Hope.

The present trends in medical care are such that in the future, more and more health care at the secondary care level will be delivered on an out-patient basis. Predictable ratios of out-patient to in-patient activities will be in order of 70% to 30%. That figure of 30% will decline if there are adequate facilities for geriatric care and expanded day care surgical facilities.

We have also taken into account the available human resources in the secondary health care sector and the qualifications and experience of those delivering such care at Consultant level and have concluded that it is unwise to duplicate the deployment of these resources between two institutions. VH is significantly under-funded, when one examines what is left after paying personal emoluments. Significant sums of money will be required to convert the aged physical plant at St. Jude into a modern hospital consistent with reasonable expectations in the 21st century.

The main argument for the retention of St. Jude as a secondary care hospital relates to the wishes of the people in the area and distance from Castries. Neither of these are compelling medical reasons. However, we are not insensitive to arguments based on geography, demography and other matters. Still, it was of interest to us that on several occasions we were told that patients from all over Saint Lucia come to St. Jude for medical attention, including patients from the Castries and surrounding areas. In our view, this does not give strong support to the argument about distance.

Recommendations

Having regard to medical, planning, quality and cost-efficiency considerations, the Commission is strongly of the view that the wishes of the people for better services can be better met by converting St. Jude Hospital into a facility which will combine the functions of an upgraded Polyclinic sharing the specialist services located at the new hospital, and with provision of an Accident and Emergency Department capable of stabilizing serious cases – which are only a small percentage of those presenting at *any* Accident and Emergency Department – and supported by an efficient Ambulance Service, the infrastructure of which is already present through the linkage with the Fire Service.

The Commission further recommends that:

- (a) St. Jude be gradually phased out as a secondary care hospital and that it be converted into a major Medical Facility providing principally out-patient care, at the primary and secondary levels on a 24-hour basis;
- (b) an upgraded accident and emergency facility be sited in this complex;
- (c) only a limited number of in-patient beds be retained;
- (d) an organized system of transfer of patients to the new hospital by means of a well-equipped ambulance service be put in place;
- (e) the full range of specialist services available in Saint Lucia be provided at this Medical Facility on an out-patient basis;
- (f) the management should continue to be effectuated through a statutory board.

These recommendations are designed to:

- (i) address the needs and expectations of the people now served by the hospital;
- (ii) improve the services offered to the community;
- (iii) address a more efficient utilization of human and financial resources;
- (iv) respond to the changes in the delivery of medical care, driven by new technologies, and which are already taking place in Saint Lucia.

If the decision to maintain St. Jude as a secondary care hospital stands we suggest:

- a. a reduction in the number of beds, depending on the number of beds available at the new hospital;
- b. an amalgamation of the clinical departments with those at the new hospital;
- c. a sustained effort to avoid costly duplication in other areas.

The Commission wishes to emphasize that this alternative is not a cost-efficient solution to the secondary health care problems of Saint Lucia.

CHAPTER 7: GOLDEN HOPE HOSPITAL

Introduction

The Golden Hope Hospital, in addition to the management of in-patients, also manages the Community Mental Health Service and provides assessments and other professional services for Turning Point. The governance of this institution resides in the Ministry of Health, while the day-to-day management rests with the Hospital Administrator.

We visited this institution and were very concerned about its physical condition. We were informed that the present in-patient population was 107, and that the new Psychiatric facility which is scheduled to be completed at least one year before the new General Hospital would cater for 104 patients. We concluded that the decision to construct a new Psychiatric Hospital has not come too soon.

We interviewed the Administrator, the Principal Nursing Officer and the Psychiatrists and also met members of the nursing staff. It is our view that the institution is grossly understaffed. Only 10 of its 18 registered nurse positions are filled; One post of Psychiatric Social Worker is vacant and 1 qualified Psychiatric Nurse is due to retire by September 2004.

The physical condition of the facility, shortages of staff, especially trained psychiatric nurses, security, paucity of equipment and general neglect were the principal concerns of the management and staff of the hospital. We received no complaints about the doctors or other members of staff.

Recommendations

We are of the view that the authority to manage the Golden Hope Hospital should remain with the Hospital Administrator. Clear policies dictating a timely and effective disciplinary process are required to deal with abuses against patients.

The Commission is of the view that a Board for Golden Hope Hospital should not be put in place at this time but in the future. Further, the Commission recommends that proposals for shared management with the new General Hospital be deferred until such time as the Board and management of the new hospital are able to demonstrate that they have the capacity to take on additional responsibility. While we are of the view that it would be premature to put in place a hospital board at present, the legislation establishing a Board for VH should be drafted in such a way as to provide for other institutions to come under its jurisdiction at the appropriate time.

In addition the Commission recommends that:

- (a) there be full involvement of staff in the design of the new Psychiatric Hospital;
- (b) the issues of shared governance and management be deferred;
- (c) a thorough analysis of the difficulties involved in shared services be done;
- (d) a major effort be made to restart a training programme for psychiatric nurses and recruit trained nurses;
- (e) attention be paid to security issues.

CHAPTER 8: OTHER SECONDARY CARE INSTITUTIONS

Introduction

The fact that Dennery and Soufriere Hospitals share a common status and face the same core problems has encouraged us to treat them together in this Chapter. The governance of these institutions resides in the Ministry of Health. The physical structures are old and in urgent need of replacement.

Soufriere Hospital

The Soufriere Hospital has a capacity of 32 beds. The occupancy has fallen from 16% in 1999 to 6.3% in 2003. The total number of admissions has declined from 470 in 1999 to 170 in 2003. The number of deliveries has dropped from 54 in 1999 to 24 in 2003. The reasons articulated by the residents for this sharp decline include poor physical facilities, lack of diagnostic equipment, and easier access to St. Jude and VH as a result of road improvements.

The overwhelming majority of the service provided at this hospital is on an out-patient basis and much of it is of a primary care nature. The casualty section is not equipped to deal with emergencies other than those of a minor nature and the hospital does perform some element of stabilization for the more serious cases prior to transfer to VH or St. Jude.

The casualty area is not conducive to efficient emergency care. Inadequate staffing was raised as one of the problems but more specifically it was evident to members of the Commission that the cadre of staff was demotivated, unhappy and demoralised. The Soufriere property can lend itself to a temporary upgrade but ultimately should be replaced.

Dennery Hospital

Dennery hospital has a capacity of 21 in-patient beds with an average occupancy rate of 1.7% in 2002. The Commission was reliably informed that a fair number of these patients are referred from Victoria Hospital for some element of continuing convalescent care. Like Soufriere, Dennery provides a wide range of primary health care, but very little secondary health care. Its casualty department can only cater for minor emergencies and the stabilization of more serious case before referral to VH or St. Jude.

The staff at Dennery is seriously concerned about having to service the medical needs for the new Bordelais prison. They were especially worried about their own security when providing medical care to potentially violent persons as well as having to share the limited supplies with Bordelais. They were also concerned about the state of the access road leading to the

hospital and advocated for a new facility with road improvement at that site or a new facility located on more favourable terrain.

We found the building at Dennery to be in worse shape than the one at Soufriere. We share the views of the people of Dennery that it should be replaced by a new structure with better vehicular access. To us it is undesirable that persons seeking emergency care at the Hospital must travel along such a hazardous access road.

Common Concerns

The principal concerns of the doctors, nurses, administrators and the public at both Hospitals centred around the following:

- Inadequate supplies of drugs and essential materials;
- Unsatisfactory physical environment;
- Inadequate staffing;
- Inadequate financial support;
- Loss of confidence in the quality of medical care;
- Delays in response by doctors on call, particularly on the weekend;
- Difficulty in attracting young persons from the area into the nursing profession;
- Difficulties *in* accessing ambulance services;
- The lack of diagnostic facilities

Recommendations

We recommend that:

- (a) the Soufriere and Dennery “hospitals” be replaced by 24-hour polyclinics with a few beds for observation;
- (b) the ambulance services be upgraded;
- (c) the supply of drugs and materials be given urgent attention;
- (d) adequate facilities be provided for the treatment of minor emergencies and for the stabilization of more serious emergencies prior to transfer to the new hospital;
- (e) The governance of these institutions and all other primary care institutions remain with the Ministry of Health with progressive decentralisation of management.

CHAPTER 9: BED UTILIZATION AT HOSPITALS

The following table sets out the bed utilization figures for Victoria, St. Jude, Dennery, Soufriere and Golden Hope Hospitals.

UTILISATION OF HOSPITAL BEDS - 2002

| Hospital | Bed Complement | Occupancy Rate % |
|-------------|----------------|------------------|
| Victoria | 164 | 59.3 |
| St. Jude | 88 | 44.3 |
| Soufriere | 32 | 6.3 |
| Dennery | 21 | 1.7 |
| Golden Hope | 162 | 69 (at present) |

Source: Report of the Chief Medical Officer 2001-2002.

The logic behind these figures is self-evident. Dennery and Soufriere have fallen largely into disuse as hospitals for a variety of reasons articulated elsewhere in this report.

The occupancy rates at Victoria and St. Jude Hospital do not support a case for two acute secondary care hospitals with all the negative consequences to both. A new hospital to replace Victoria will need adequate staffing at all levels and it can serve the medical needs of St. Lucia with the kind of supportive institutions which we have outlined in chapters dealing with specific hospitals.

These occupancy figures will decline further as better out-patient services are made available, including day-care surgery and the establishment of an infrastructure which leads to more rapid diagnoses and treatment of in-patients.

The occupancy rate at Golden Hope can be significantly reduced if an effective Community Health Care programme is put in place.

During its visits to these institutions, the Commission noted that there were many patients in hospital beds who were there for social rather than medical reasons and this tended to increase the occupancy rates recorded.

In-patient hospital care represents the most expensive aspect of health care delivery and health policies, rooted in cost-efficiency considerations, should be directed towards more out-patient and less in-patient care.

Recommendations

The Commission recommends that a detailed audit of bed utilization be conducted. This should include reasons for admissions, factors affecting length of stay in hospital and other relevant data. Such an audit will not only produce useful information for planning but allow for the development of protocols for use by junior doctors in making decisions about admission.

CHAPTER 10: PHYSICAL CONDITIONS

Conditions at Secondary Health Care Facilities

Doctors complained bitterly about the physical conditions under which they work and which compromise their ability to function with appropriate levels of efficiency in the public sector. Among the complaints are:

- the dilapidated state of sections of the physical plant of the health services;
- the absence of basic facilities such as a staff canteen, a desk and chair from which they can work;
- the absence of a facility where they can speak to patients and relatives in private;
- the lack of facilities in the hospital for doctors on night duty;
- the lack of facilities for consultants to conduct their activities following ward-rounds;
- the lack of facilities for geographic private practice.

Whatever the future usage of VH these facilities should form an integral part of its physical plant and that of the new hospital. It is most undesirable to have a situation where as one Consultant described “my office for my work at VH is the back seat of my car.” Minimal requirements include individual office space for the Director of Medical Services, Heads of Departments, one shared office for Consultants in each Department and one shared office for junior medical staff. Each Department should have the support of at least one Secretary.

When doctors are not actively engaged in the clinical care of patients there is other work to be done. If there are no facilities, the obvious temptation would be for them to leave the hospital and seek to occupy their time more productively. This is especially so at the level of the Consultant who must have facilities available to him in order to function effectively in that capacity. It will be recalled that some, but by no means all of the criticisms directed at Consultants stem from a lack of appreciation of the role of the Consultant in a hospital setting which includes but is not limited to:

- ultimate responsibility for the care of patients under his charge;
- supervision and contribution to the development of junior medical and other staff;
- discipline;
- administrative responsibilities;
- all matters relating to the efficient functions of his unit;
- contributing to the overall development of the hospital;
- training and research, where appropriate;
- development of protocols for patient care;
- the maintenance of ethical practices.

Quite evidently these functions cannot be discharged in the absence of appropriate facilities. The present system, which is a hang-over from the days of the visiting specialist is highly inappropriate for a situation which has changed considerably and is moving relentlessly towards one of a central core of full-time staff, supplemented by sessional participants at the level of Consultants.

In order to function effectively doctors must have at their disposal the tools with which to work. The lack of functioning equipment drastically reduces the capacity of Consultants to perform at the level expected of them and this applies to all sections of the infrastructure of the hospital. These are factors which have an important bearing on the attitudes and motivation of Consultants and must be corrected without delay.

Conditions at Primary Health Care Facilities

With the exception of the Gros-Islet Polyclinic, physical conditions at primary health care facilities are generally unsatisfactory. The situation at the Castries Health Centre in particular is depressing. There is strong case to be made for relocating this facility away from a dust-ridden arterial road and the unsanitary conditions that exist in the immediate vicinity.

While we were impressed with the general working conditions and overall appearance at the Gros-Islet Polyclinic, we could not readily appreciate the rationale for the layout of this facility. On the day of our visit to the facility we were told that there was considerable overcrowding and inadequate waiting area for patients. We were advised that the overcrowding is partly due to the fact that the Polyclinic receives patients from as far away as Choiseul and Soufriere. We advise that the lay-out of this facility not be repeated in the design of other polyclinics

The Commission was informed that funding has been received to implement a programme of upgrading of primary health care facilities on the island. While not aware of the details of this programme, the Commission believes that ideally such a programme should be informed by a National Health Policy that inter alia, outlines a clear vision for primary health care along the lines recommended in the Carr/Wint Study. The Ministry may wish to follow the lead of the Ministry of Education, Human Resource Development, Youth and Sports, and agree on the design of a model Health Centre from which a full suite of preventative health care programmes and activities can be implemented.

Recommendations

The Commission recommends that:

- (a) immediate steps be taken to correct these physical deficiencies at Victoria Hospital and at primary health care facilities;
- (b) the future role of primary health care facilities be taken into consideration in planning for the new General and Psychiatric Hospitals;
- (c) The Ministry should consult with the Ministry of Physical Development, Environment and Housing on: (i) the ideal location for health centres, that takes into consideration, the demographic, settlement and socio-economic trends in Saint Lucia; and (ii) the design of a model health centre that supports the goal of creating an efficient and effective primary health care system.

CHAPTER 11: AMBULANCE SERVICES

Our recommendations in relation to St. Jude, Dennery and Soufriere hospitals will require considerable enhancement of the ambulance service. They also represent by far the most cost-effective way in the delivery of service by these institutions while creating an opportunity for more efficient health services for Saint Lucia.

It is most important not to confuse an ambulance service designed to deal with emergencies with a routine patient transport service which should be located at institutions delivering health care. This misunderstanding often leads to overuse of ambulances for purposes for which they were not intended.

Saint Lucia has a well conceptualised basis for an effective ambulance service through its linkage with the Fire Service. The Fire Service is a disciplined organisation and its culture emphasises professionalism, rapid responses and execution. This is the ideal environment for the location of an ambulance service in Saint Lucia.

This relationship between the Fire Service and the Health Services exists in a somewhat embryonic form and should be developed to its maximum potential in order to overcome any problems arising from geographic considerations. Our interview with the Assistant Divisional Officer left us in no doubt that in the Fire Service there is a clear vision of the potential of this relationship. We are unsure whether there is a shared vision with those responsible for policy development in relation to the ambulance services.

The following concerns were expressed:

- an inadequate number of ambulances
- difficulties in maintenance
- under-financing of the service
- no planned retirement and replacement of vehicles
- inadequate response times at some locations
- inadequate training of personnel
- inadequate numbers of certified EMT instructors
- no system for promotion and career advancement except by way of leaving the ambulance service and absorption into the promotion stream of the Fire Service
- the system of payment for ambulance services causes considerable distress to poor people.

In our recommendations for a Board for VH we specifically indicated that the Minister of Health should have authority for the direction of relationships between the Board and other institutions. The VH will be under a statutory board of governance while the Fire Service will be under the governance of central government (Ministry of Home Affairs). The main emergency services will be located at the Accident and Emergency Department of Victoria where the medical expertise in dealing with serious emergencies will be concentrated.

Doctors involved in emergency care medicine at Victoria can be of considerable value, with good communications, in directing the pre-arrival care of emergencies and assisting in the training of ambulance personnel in an integrated emergency care system. With the development of new medical technologies, effective care can be delivered by non-medical personnel prior to arrival and many lives can be saved.

Recommendations

The Commission recommends that:

- (a) the rationalisation of the roles of St. Jude, Dennery and Soufriere Hospitals in the secondary health care system should be accompanied by the enhancement of the ambulance service;
- (b) a policy and a plan be developed to integrate the ambulance service fully into an effective system of emergency care with efficient deployment of manpower and equipment and with a clear understanding of the crucial importance of training of personnel;
- (c) the number of ambulances should be increased;
- (d) the difficulties in maintenance be addressed;
- (e) an effective training programme for ambulance personnel be put in place;
- (f) a promotional stream be introduced for EMTs within the Fire Service;
- (g) better communications systems be established;
- (h) a more formal and functional relationship be established between the Accident and Emergency Service at VH and the Fire Service;
- (i) the current system of payment for ambulance services by the public should be abandoned.

CHAPTER 12: IMPLEMENTATION CONSIDERATIONS

The management of the process of transition will be of vital importance and it is essential to put in place structures and persons to achieve a smooth outcome. There are key elements which form the pillars on which the transition will rest and considerable care must be exercised in their execution.

1. A Board of Governance

The establishment of a Board to govern VH will inevitably raise concerns among public officers about their constitutional rights, especially in the area of job security and pension entitlements. We advise that draft legislation for a Board be completed as soon as possible. After the draft has been completed discussion with interested parties should commence. In this way, the discussions will be focused and specific responses can be given to the issues raised. The language of the legislation should be explicit in confirming the preservation of the rights of public servants and great care should be taken to ensure there is no conflict with the Constitution of Saint Lucia.

2. New Financing Arrangements

The introduction of a new method of financing the health services under the Universal Health Care Programme should be timed to coincide with the start of new financial year and with the establishment of the Board with responsibility for VH. All available financial resources should be directed towards improving the public health sector.

3. New Payments System for Consultants

The new payments system to be used by private patients admitted to VH and to consultants should ideally take place at the same time. The de-linking of payments to the hospital and to the doctors will require a temporary method of identifying private patients, from the date of admission to the date of discharge from the Hospital, until such time as private facilities are available for private patients in the new hospital. This can be achieved via appropriate administrative arrangements.

4. New Hospital Fees Regulations

New Hospital Fees Regulations should come into force at the same time. Consultants should be intimately involved in the preparation of the new fees structure. Provision should be made in the regulations for the Hospital to act as agent for billing and collecting fees on behalf of doctors who so wish and for a percentage of fees to be retained by the Hospital for this service.

Under no circumstances should payments be made to Consultants before fees are received by the Hospital on their behalf.

5. Remuneration Levels for Consultants

The restructuring of the remuneration of Consultants, as recommended in Chapter 4, will require an appropriate increase in the basic salary of Consultants to replace those allowances which will be discontinued. This matter will naturally be subject to negotiation and should be introduced when a Board is in place.

It is our judgement that in a structured environment characterized by proper systems of evaluation and control that there would be sufficient justification to consider, within a framework of negotiations, a basic salary for all Consultants in the range of \$108,000.00 to \$120,000.00.

6. Redress of Financial Concerns of Nurses

There are several issues pertaining to Nurses which require immediate attention and resolution, which have been addressed in the Report. We suggest that resolution of these issues be part of the package offered in negotiating the transfer of nurses to a statutory board.

7. Capital Programme

There is evidence that the Government of Saint Lucia understands the need for a well-organised Capital Programme for the health services. The building of a new secondary/tertiary hospital and a new Psychiatric Hospital are major steps in the right direction.

There are many recommendations emanating from various studies regarding the capital investments needed in the primary health sector. The Gros Islet Polyclinic is a useful start to this process. We suggest that beginning in the fiscal year 2005/2006, there should be a 7 year Capital Programme which would encompass our recommendations in respect to Dennery, Soufriere and St. Jude Hospitals as well as the rationalization programme for health centres recommended by the Carr and Wint Study.

Our recommendation in relation to St. Jude Hospital should not be implemented until the new General Hospital is commissioned and adequately equipped and staffed.

Timely consideration should be given to the future use of the VH buildings after the new Hospital is commissioned. There is a strong case for closure of the Castries Health Centre and reconfiguring and redeveloping part of the VH structure as a 24 hour polyclinic. The possibility of using another

section of the facility for long stay patients requiring minimal care and rehabilitation should be explored. This could help to relieve any pressure for beds at the new Hospital.

Apart from the new Psychiatric Hospital and the new General Hospital, there are other modest capital developments which can be completed over a seven year period. It may be appropriate to finance these proposed developments partially by way of a transfer of assets within the public health sector by selling the assets vacated by the Golden Hope and the Castries Health Centre and re-investing these funds in new facilities.

8. Agents for Change

Assuming that the recommended changes are scheduled to take place at the start of the next financial year, there is considerable urgency in getting this infrastructure in place. No single agency will be able to achieve this in six months. We therefore suggest that the following entities be established:

- a team to bring the already conceptualized new financing package to fruition including the necessary legislative action;
- An Action Committee to prepare the legislation for a Board for VH;
- A Hospital Fees Advisory Committee to prepare the new Fees Regulations.

9. Primary Health Care Sector

In the primary health care sector, a plan must be put in place early to effect the transition to a service manned principally by full-time doctors. It is anticipated that a significant number of doctors will be returning to Saint Lucia over the next five years and an appropriate programme should be devised well in advance of their return.

The implementation process will require a high degree of coordination as there are many discrete elements which need to be addressed simultaneously and it is necessary to have persons in place who can ensure that all these elements are addressed in a timely and appropriate manner.

APPENDIX 1

PERSONS INTERVIEWED

| NAME | DESIGNATION | INSTITUTION | DATE INTERVIEWED |
|---------------------------------|---|-----------------------------|-------------------------|
| 1. Dr. Stephen King | Chief Medical Officer | Ministry of Health | March 29, 2004 |
| 2. Mr. Cosmos Andrew | Hospital Engineer | Victoria Hospital | March 29, 2004 |
| 3. Mr. Arthur Edwin | Bio Medical Technician | Victoria Hospital | March 29, 2004 |
| 4. Ms. Bernadette Bobb | Senior Executive Officer | Soufriere Hospital | March 30, 2004 |
| 5. Mr. Keith Weekes | Chairman | Public Service Commission | March 30, 2004 |
| 6. Mrs. Bernadette Springer | Administrator | Gros Islet Polyclinic | March 30, 2004 |
| 7. Ms. Georgis Taylor-Alexander | Senior Crown Counsel | Attorney General's Chambers | March 30, 2004 |
| 8. Ms. Suzanna Jolie | Principal Nursing Officer | Community Nursing Service | March 31, 2004 |
| 9. Mr. Stewart Smith | Executive Director | Victoria Hospital | March 31, 2004 |
| 10. Ms. Gillan French | Chairperson | Medical Council | March 31, 2004 |
| 11. Mr. Renny Biscette | Procurement Officer | Victoria Hospital | March 31, 2004 |
| 12. Mr. Fidelis Williams | Permanent Secretary | Ministry of Health | April 01, 2004 |
| 13. Mrs. Elvina Raveneau | Departmental Sister (Medical Social Worker) | Victoria Hospital | April 01, 2004 |
| 14. Jennifer Clauzel | Nurse in Charge | Denney Hospital | April 01, 2004 |
| 15. Ms. Sybil Philip | Principal Nursing Officer | Victoria Hospital | April 01, 2004 |

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| 16. Ms. Sybil Edward | Senior Physiotherapist | Victoria Hospital | April 01, 2004 |
| 17. Mr. Allansworth Hughes | Senior Radiologist | Victoria Hospital | April 01, 2004 |
| 18. Mr. Paul Meroe | Chief Executive Officer | St. Jude Hospital | April 02, 2004 |
| 19. Dr. Sylvestre Francois | Medical Director | St. Jude Hospital | April 02, 2004 |
| 20. Mr. Cuthbert James | Maintenance Officer | St. Jude Hospital | April 02, 2004 |
| 21. Mr. Lambert Charles | Assistant Divisional Officer | St. Lucia Fire Service | April 02, 2004 |
| 22. Ms. Henrietta Vaval | Nursing Director | Victoria Hospital | April 02, 2004 |
| 23. Mr. Isaac Anthony | Director of Finance/Chairman, Central Tenders Board | Ministry of Finance | April 02, 2004 |
| 24. Mrs. Vernamay Louisy | Human Resource Manager | Sir Arthur Lewis Community College | April 19, 2004 |
| 25. Ms. Celestine Emanus | Financial Analyst | Ministry of Health | April 19, 2004 |
| 26. Dr. Elizabeth Lewis | Medical Director | Victoria Hospital | April 19, 2004 |
| 27. Mr. Wilfred Pierre | National Authorizing Officer | EDF/Programe Monitoring Unit | April 19, 2004 |
| 28. Mr. Randall Alexander | Financial Controller | Victoria Hospital | April 19, 2004 |
| 29. Sharon Philips | Accountant | Victoria Hospital | April 19, 2004 |
| 30. Mr. Claude Griffith | Representative | National Insurance Corporation | April 20, 2004 |
| 31. Ms. Xysta Edmund | Chief Planner | Ministry of Health | April 20, 2004 |

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| 32.Dr. Kenneth Louisy | District Medical Officer | Castries | April 21, 2004 |
| 33.Dr. Thadee Alexis | District Medical Officer | Soufriere | April 21, 2004 |
| 34. Dr. Olusina Adesanya | District Medical Officer | Vieux Fort | April 21, 2004 |
| 35. Dr. Roger Herelle | District Medical Officer | Vieux Fort | April 21, 2004 |
| 36. Dr. Sylvia Wilson | District Medical Officer | Dennerly | April 21, 2004 |
| 37. Dr. Muniy Appa Parashuram | District Medical Officer | Dennerly | April 21, 2004 |
| 38.Dr. M. Aguilar | Obstetrician/Gyn | St. Jude Hospital | April 26, 2004 |
| 39.Dr. Jorge Valdez | Pathologist | St. Jude Hospital | April 26, 2004 |
| 40.Dr.T.Ramachandra | General Surgeon | St. Jude Hospital | April 26, 2004 |
| 41.Dr. L. Lashley | Radiologist | St. Jude Hospital | April 26, 2004 |
| 42.Dr. Ndidi Dagbue | Orthopaedic Surgeon | St. Jude Hospital | April 26, 2004 |
| 43.Dr. G. C. Mallik | General Surgeon | St. Jude Hospital | April 26, 2004 |
| 44. Dr. Charles Maresh | Consultant, Internal Medicine | St. Jude Hospital | April 26, 2004 |
| 45. Ms.Jennifer Clauzel | Principal Nursing Officer | Dennerly Hospital | April 26, 2004 |
| 46. Ms. Kerthney Surae | Community Health Nurse | Dennerly Hospital | April 26, 2004 |
| 47.Ms. Gertrude Gustave | Community Health Nurse | Dennerly Hospital | April 26, 2004 |
| 48.Mrs. Thecla Deterville | President | Chamber of Commerce | April 27, 2004 |
| 49. Ms. Linda Bruno | Departmental Sister, Head of Medicine | Victoria Hospital | April 27, 2004 |
| 50.Ms. Paulina Isaac | Departmental Sister/ Head of Ob/Gyn | Victoria Hospital | April 27, 2004 |
| 51.Ms. Laura Stanislas | Departmental Sister/ Head of Paediatrics/Eye Ward | Victoria Hospital | April 27, 2004 |
| 52. Ms. Martha Paul-Charles | Departmental Sister/ Head of Operating Room Theatre | Victoria Hospital | April 27, 2004 |

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| 53. Ms. Merina St. Rose | Departmental Sister/ Head of Continuing Education | Victoria Hospital | April 27, 2004 |
| 54. Ms. Francisca Prospere | Departmental Sister/ Head of Medical Social Services | Victoria Hospital | April 27, 2004 |
| 55. Justina Timothee | Departmental Sister/Head of Surgery | Victoria Hospital | April 27, 2004 |
| 56. Matilda Jervais | Departmental Sister/Head of Accident and Emergency | Victoria Hospital | April 27, 2004 |
| 57. Mrs. Bernadette Springer | Administrator | Gros Islet Polyclinic | April 27, 2004 |
| 58. Ms. Marylene Paul | President | St. Lucia Nurses Association | April 28, 2004 |
| 59. Ms. Janetha Walker | Ward Sister/ Theatre Nurse | Victoria Hospital | April 28, 200 |
| 60. Ms. Beverly Lansiquot | Coordinator | Department of Health Science, Sir Arthur Lewis Community College | April 28, 2004 |
| 61. Mr. Francis Raphael | President | St. Lucia Civil Service Assn. | April 28, 2004 |
| 63. Ms. Lucia Lee | Chairperson | St. Lucia General Nursing Council | April 28, 2004 |
| 64. Dr. Horatius Jeffers | President | St. Lucia Medical and Dental Assn | April 29, 2004 |
| 65. Dr. Ira Simmons | Consultant Paediatrician | Victoria Hospital | April 29, 2004 |
| 66. Dr. P.A.W. St. Rose | Consultant Ob/Gyn | Private | April 29, 2004 |
| 67. Mr. John Husbands | Deputy Permanent Secretary | Ministry of Health | May 17, 2004 |
| 68. Mrs. Elaine Nicholas | Chief Pharmacist | Ministry of Health | May 17, 2004 |
| 69. Dr. Martin Didier | Consultant Physician | Private | May 17, 2004 |
| 70. Dr. Leonard Surage | Consultant Otolaryngologist | Public/Private | May 18, 2004 |

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| 71. Dr. David Bristol | Consultant Surgeon | Private | May 19, 2004 |
| 72. Dr. McDonald Chase | Consultant Ob/Gyn | Private | May 19, 2004 |
| 73. Dr. Romel Daniel | Consultant Physician | Public/Private | May 19, 2004 |
| 74. Mr. Trevor Brathwaite | Permanent Secretary | Ministry of Finance | May 19, 2004 |
| 75. Ms. Christiana Matthew | Staff Nurse | Victoria Hospital | May 24, 2004 |
| 76. Ms. Pelagia Leon | Staff Nurse | Victoria Hospital | May 24, 2004 |
| 77. Ms. Aloysia Bynoe | Staff Nurse | Victoria Hospital | May 24, 2004 |
| 78. Dr. Leslie St. Rose | Chief Dental Surgeon | Ministry of Health | May 24, 2004 |
| 79. Dr. Alphonsus St. Rose | Specialist Internist/ Gastroenterologist | Private | May 24, 2004 |
| 80. Ms. Harriette Smith | Family Nurse Practitioner | Ministry of Health | May 24, 2004 |
| 81. Andrina Seriuex | Family Nurse Practitioner | Ministry of Health | May 24, 2004 |
| 82. Mary Charlery | Family Nurse Practitioner | Ministry of Health | May 24, 2004 |
| 83. Dr. Richardson St. Rose | Orthopaedic Surgeon | Ministry of Health | May 24, 2004 |
| 84. Mr. Patrick Lammie | Principal Nursing Officer | Golden Hope Hospital | May 26, 2004 |
| 85. Ms. Bibiana Baptiste | Nursing Director | St. Jude Hospital | May 26, 2004 |
| 86. Ms. Carol Llyod | Nurse Midwife | Castries Health Centre | May 26, 2004 |
| 87. Ms. Claudius Desir | Public Health Nursing Supervisor | Castries Health Centre | May 26, 2004 |
| 88. Dr. Parasam Ramraj | Senior House Officer ENT/Ophthal/ Surgery | Victoria Hospital | May 26, 2004 |
| 89. Dr. James Ugbo | Senior House Officer/ Surgery | Victoria Hospital | May 26, 2004 |
| 90. Dr. Ingrid Cox | House Officer/ Paediatrics | Victoria Hospital | May 26, 2004 |
| 91. Dr. Luana Freeman | House Officer/ Paediatrics | Victoria Hospital | May 27, 2004 |

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| 92. Dr.Oukayode Somorin | Senior House Officer | Victoria Hospital | May 27, 2004 |
| 93. Dr. Mark Devonish | Senior House Officer | Victoria Hospital | May 27, 2004 |
| 94. Dr.Mershack Naawu | Senior House Officer (A & E) | Victoria Hospital | May 28, 2004 |
| 95. Ms. Isabelle Pierrot | Staff Nurse | Victoria Hospital | May 28, 2004 |
| 96. Ms. Angella Antoine | Staff Nurse | Victoria Hospital | May 28, 2004 |
| 97.Ms.Veronica Joe | Staff Nurse | Victoria Hospital | May 28, 2004 |
| 98. Ms. Pelagia James | Staff Nurse | Victoria Hospital | May 28, 2004 |
| 99. Ms. IrmaJames | Staff Nurse | Victoria Hospital | May 28, 2004 |
| 100. Rita Mason | Staff Nurse | Victoria Hospital | May 28, 2004 |
| 101. Dr. Emsco Remy | Consultant Ophthalmologist | Private | June 24,2004 |
| 102. Dr. James Fletcher | Cabinet Secretary | Head of the Civil Service | June 24, 2004 |
| 103.Dr S. S. Kumar | Psychiatrist | Golden Hope Hospital | June 28, 2004 |
| 104. Dr. E.S. Aleman | Psychiatrist | Golden Hope Hospital | June 28, 2004 |
| 105. Ms. Lena Harry | Staff Nurse | Golden Hope Hospital | June 28, 2004 |
| 106. Mr.Desmond Philip | Administrator | Golden Hope Hospital | June 28, 2004 |
| 107. Ms. Beatrice McDonald | Assistant Secretary | Ministry of Health | June 28, 2004 |
| 108. Mr. Mark Louis | Director, Public Sector Reform | Prime Minister's Office | June 28, 2004 |
| 109. Ms Lancia Isidore | Executive Director | National Council for the Disabled | June 30, 2004 |
| 110. Mrs.Martina Mathurin | President | Pensioners Association/ Project Officer, National Council of and for Older Persons | June 30, 2004 |

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|----------------------|-------------------------|---|--------------------------------|
| 111. Hon. John Odlum | Parliamentary Secretary | Ministry of Health, Human Services, Family Affairs and Gender Relations | August 20 th , 2004 |
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APPENDIX 2
DOCUMENTS REVIEWED

| | |
|---|---|
| Carr, P & Wint, B | Assessment of the Current Structure and Operations of the Primary Health Care System in Saint Lucia - 2002 |
| Government of Jamaica | Report of the Commission of Inquiry into the Exercise of Private Practice by Doctors Employed in the Government Health System – 1996 |
| Government of Saint Lucia | Universal Health Care: Report of the National Health Insurance Task Force 2003 |
| Government of Saint Lucia (Ministry of Health) | Health Sector Reform Proposals, Saint Lucia March 2001. Report of the Chief Medical Officer of Saint Lucia (2001 – 2002). Collective Agreement between the Saint Lucia Mental and Dental Association (April, 1995 to March 2001). Conversion Manual, Reclassification and Pay Plan: Guidelines, Policies and Procedures , 1993 Registration of Nurses and Midwives Ordinance, 1966. Registration of Medical Practitioners Act No. 13 of 1967 Registration of Medical Practitioners (Amendment No. 2 Act, No 26 of 1970. Registration of Medical Practitioners Amendment Act No 10 of 1970 Public Hospitals (Management) Act, NO. 5 of 1973. |

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Aide Memoire: Terms of Reference for
Commission on Payment Mechanisms for
Health Providers in Saint Lucia, 2003.

Pinto, M. & Andersson, B:

Paying Health Care Providers in the
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