PARLIAMENT
REPUBLIC OF TRINIDAD AND TOBAGO

PAAC

THIRTEENTH REPORT OF THE

THE COMMITTEE ON

PUBLIC ADMINISTRATION AND APPROPRIATIONS

THIRD SESSION OF THE 11TH PARLIAMENT

INQUIRY

An examination into the Administration of Special Health Care Programmes in Trinidad and Tobago.

Public Administration and Appropriations Committee

The Public Administration and Appropriations Committee (PAAC) is established by Standing Order 102 and 92 of the House of Representatives and the Senate respectively. The Committee is mandated to consider and report to Parliament on:

(a) the budgetary expenditure of Government agencies to ensure that expenditure is embarked upon in accordance with parliamentary approval;

(b) the budgetary expenditure of Government agencies as it occurs and keeps Parliament informed of how the budget allocation is being implemented; and

(c) *the administration of Government agencies to determine hindrances to their efficiency and to make recommendations to the Government for improvement of public administration.*

Current membership

Mrs. Bridgid Mary Annisette-George	Chairman
Dr. Lackram Bodoe	Vice-Chairman
Ms. Nicole Olivierre	Member
Brig. Gen. (Ret.) Ancil Antoine	Member
Mrs. Ayanna Webster-Roy	Member
Mr. Clarence Rambharat	Member
Mr. Daniel Dookie	Member
Mr. Wade Mark	Member

Committee Staff

The current staff members serving the Committee are:

Ms. Keiba Jacob	Secretary to the Committee
Ms. Sheranne Samuel	Assistant Secretary
Ms. Rachel Nunes	Graduate Research Assistant
Mr. Brian Lucio	Graduate Research Assistant
Ms. Anesha James	Administrative Support

Publication

An electronic copy of this report can be found on the Parliament website using the following link:
http://www.ttparliament.org/committee_business.php?mid=19&id=232&pid=28

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Date Laid in HOR: January 11, 2019 **Date Laid in Senate: January 15, 2019**

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Members of the Public Administration and Appropriations Committee

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Chairman

Dr. Lackram Bodoe
Vice Chairman

Mr. Wade Mark
Member

Mr. Clarence Rambharat
Member

Mrs. Ayanna Webster-Roy
Member

Mr. Garvin Simonette
Member

Ms. Amrita Deonarine
Member

Mr. Daniel Dookie
Member

Brig. Gen. (Ret.) Ancil Antoine
Member

Ms. Nicole Olivierre
Member

EXECUTIVE SUMMARY

The Public Administration and Appropriations Committee commenced an inquiry into the Administration of Special Health Care Programmes in Trinidad and Tobago. Special Health Care Programmes are defined as programmes established and operational in the Ministry aimed at providing support based on unmet needs of the population due to limited capacity within the public health care system.

The objectives of the inquiry were to determine:

a. whether the funding allocated to special health care services in Trinidad and Tobago is adequate;
b. the administration of special health care programmes;
c. the benefits of special health care programmes across Trinidad and Tobago; and
d. whether improvements can be made regarding the administration of special health care programmes in Trinidad and Tobago.

This Report of the PAAC for the Third Session of the Eleventh Parliament contains the details of an examination of the Administration of Special Health Care Programmes.
In undertaking this inquiry the Committee sort to:

- determine how Special Health Care Programmes were administered in Trinidad and Tobago; and
- publicise pertinent information on the health care services readily available to the public.

The Committee employed two (2) mechanisms:

i. written submissions; and
ii. a Public Hearing.

The Committee made a call for written submissions to the stakeholders and thereafter focused on a review and analysis of the written submissions. Subsequently, the Committee conducted a Public Hearing with the Ministry of Health on May 9, 2018. The approach adopted by the

Committee took into account issues identified by the public and the written responses received. Post-hearing a subsequent request for additional information was made. The Committee's observations and recommendations are presented in Chapter 2.

1. INTRODUCTION

THE COMMITTEE

The PAAC of the Eleventh Republican Parliament was established by the revised Standing Orders to:

- examine current public expenditure, thereby capturing the full budget cycle by providing Parliamentary oversight of the implementation of the budget; and
- conduct a real time examination of the expenditure by Ministries and Departments.

Change in Membership

1. In the 11th Parliament the Members of the Committee were appointed by resolutions of the House of Representatives and the Senate at sittings held on Friday November 13, 2015 and Tuesday November 17, 2015 respectively.
2. By resolution of the Senate On November 3, 2017, Ms. Jennifer Raffoul was appointed as a Member of the Committee in lieu of Mr. Dhanayshar Mahabir.
3. By resolution of the House of Representatives on November 24, 2017, Brigadier General (Ret.) Ancil Antoine was appointed as a Member of the Committee in lieu of Mr. Maxie Cuffie.
4. By resolution of the Senate on November 28, 2017 Mr. Ronald Huggins was appointed as a Member of the Committee in lieu of Ms. Allyson Baksh.
5. By resolution of the Senate on November 27, 2018, Mr. Garvin Simonette was appointed as a Member on the Committee in lieu of Mr. Ronald Huggins.
6. By resolution of the Senate on November 27, 2018, Ms. Amrita Deonarine was appointed as a Member of the Committee in lieu of Ms. Jennifer Raffoul.

Chairman and Vice Chairman

By virtue of S.O. 109(6) and 99(6) of the House of Representatives and the Senate respectively, the Chairman of the Committee is the Speaker. At its First Meeting held on January 27 2016, Dr. Lackram Bodoe was elected as the Vice-Chairman.

Quorum

In order to exercise the powers granted to it by the House, the Committee was required by the Standing Orders to have a quorum. A quorum of three (3) Members, inclusive of the Chairman or Vice-Chairman, with representatives from both Houses, was agreed to by the Committee at its First Meeting.

1. METHODOLOGY

Determination of the Committee's Work Programme

At an in-camera meeting of the Committee held on Wednesday December 28, 2017, the Committee agreed to commence an inquiry into the Administration of the Special Health Care Programmes.

The Inquiry Process

The Inquiry Process outlines the steps taken by the Committee in its inquiry into the administration of Special Health Care Programmes. The following steps were taken:

a) Identification of entity to be examined – Ministry of Health;

ii. Preparation of Inquiry Proposal for the selected issue. The Inquiry Proposal outlines:
   - Description
   - Rationale/Objective of Inquiry; and
   - Proposed Questions.

iii. Consideration and approval of Inquiry Proposal by the Committee.

iv. Request for written responses was sent to the Ministry of Health on April 26, 2018. Responses were received from the Ministry on May 4, 2018.

v. Preparation of an Issues Paper by the Secretariat for the Committee's consideration, based on written responses received from the Ministry. The Issues Paper identified and summarised matters of concern in the responses provided by the Ministry;

vi. Based on the responses received and the issues identified, the Committee agreed to have a Public Hearing. The relevant witnesses were invited to attend and provide evidence on May 9, 2018.

vii. Following the Public Hearing, a request for further details was sent to the Ministry on May 11, 2018. The additional information was received on June 6, 2018.

2. ISSUES, OBSERVATIONS AND RECOMMENDATIONS

Special Health Care Programmes

In its initial written submission, the Ministry of Health defined Special Health Care Programmes as programmes established and operational in the Ministry aimed at providing support based on unmet needs of the population due to limited capacity in the public health care system. The Ministry fulfills its mandate in the provision of quality care through public-private arrangements. The programmes are managed by a Programme Administrator, External Patient Programme, and Ministry of Health. There were approximately 7000 patients accessing the various Special Health Care Programmes.

The following are the Special Health Care Programmes within the Ministry:

- External Patient Programme;
    - Treatment of Adult Cardiac Programme
    - Renal Dialysis
    - Waiting List Initiative
- Medical Aid – Financial Assistance for procedures that are not available at the public hospitals;
- Eyeglasses Project;
- External Radiation Treatment; and
- HIV/AIDS.

1. Challenges with External Patient Programme (EPP)

Officials identified a number of challenges in the administration of the External Patient Programme:

- patients not accessing the public health care system;
- patients approaching the Ministry directly rather than going to public health care institutions;
- the misconception that patients can go to private doctors and thereafter make claims for the Government to pay for any services rendered.

The Committee was informed that patients must be registered in the public health care system in order to access the programmes. Officials identified that many of the challenges stemmed from the issue of culture. The Committee questioned how the Ministry planned to improve the programme. Officials informed the Committee that the Ministry planned to conduct public awareness and education. It was stated that funding was a challenge over successive years. However, officials indicated that the programme was not meant to last forever, rather the programme is intended to fill the gap in meeting the needs of the public while building institutional capacity.

Recommendations:

- ***The Ministry of Health should embark on a public sensitization programme to educate and inform on the proper avenues to access the External Patient Programme.***
- ***The Ministry should submit a report to Parliament by February 15, 2019 on the programmes to be implemented, the timeline for implementation and the mechanisms to monitor and evaluate these programmes.***

a)Treatment of Adult Cardiac Disease

In its first written submission, the Ministry explained that patients requiring cardiac interventions were all treated at the public hospitals and were seen by a Cardiologist in the public sector. If any patient required interventions beyond the capacity of public hospitals, the patient was assessed by a Medical Social Worker and a public-private partnership was utilized to provide this intervention at either the Port of Spain General Hospital or the Eric Williams Medical Sciences Complex. The allocation for financial year 2018 for Treatment of Cardiac Disease was $20 million, as at the date of the Public Hearing (May 9, 2018) the Ministry spent all of the $5.05 million of the allocation received.

i. Non-Communicable Disease (NCD) Epidemic

The Acting Chief Medical Officer stated that Cardiovascular Disease (CVD)[1] was a significant and ever-growing problem that accounted for 30 per cent mortality among males aged 30 to 69 years and 28 per cent among females 30 to 69. Between 2000 and 2008, mortality was predominant among males 30 to 60 years and females 30 to 69 years. Of the cardiovascular diseases, the Ischaemic heart disease is the predominant cause of death. Ischaemic heart disease[2] was the cause of death in 55 per cent of the males and 46 percent females. Overall there were approximately 700 deaths annually as a result of CVD.

MOH Officials informed the Committee that the country was in the midst of an NCD epidemic. Work commenced on reducing NCDs since 2006, however, it was a Caribbean-wide phenomenon. The simple rationale provided was that it was a lifestyle disease and persons engaged in excessive smoking, alcohol consumption and unhealthy diets paired with limited exercise. The current NCD prevention and control plan was introduced in 2017. The plan emphasized the importance of health promotion, health maintenance and prevention rather than treatment.

ii. Public Awareness

In its second written submission, the Ministry indicated that there were outreach programmes educating the public on the prevention of cardiac disease. Through its network of non-government organisations, in particular the Trinidad and Tobago Heart Foundation and Heartbeat International, the Ministry conducted outreach programmes with a focus on the prevention of cardiac diseases.

Recommendation:

- ***The Ministry of Health should work with counterpart Ministries like Education, Agriculture, Trade and Industry, Sport and Youth Affairs, Family***

[1] *Cardiovascular Disease (CVD) is an umbrella term for a number of linked pathologies, commonly defined as coronary heart disease (CHD), cerebrovascular disease, peripheral arterial disease, rheumatic and congenital heart diseases and venous thromboembolism*

[2] *Ischaemic Heart Disease is also known as Coronary Artery Disease that is caused by the narrowing of coronary arteries, leading to inadequate blood supply to the myocardium.*

Services and others to embark on a public awareness campaign on NCDs within the current NCD prevention and control plan introduced in 2017.

- ***A report on the attempts made by the Ministry should be submitted to Parliament by February 15, 2019.***

b) Renal Dialysis

Patients diagnosed with end stage renal failure can access renal dialysis through the public hospitals. In the event that the hospitals cannot accommodate the volume of patients requiring dialysis, the Ministry utilizes public-private partnerships to provide the service. Patients accessing this service were financially assessed by a Medical Social Worker and thereafter recommendations were made for assistance through approved private service providers. Clinical oversight of the programme at the hospitals was done by the Nephrologists and contract management was overseen by the Ministry of Health. The allocation for financial year 2018 for Renal Dialysis was $24 million, as at the date of the Public Hearing (May 9, 2018) the Ministry spent $12.9 million of this allocation. As of May 2018, there were 1,187 patients receiving renal dialysis treatment. The barriers for entry into the renal dialysis market were low. The service was set up and offered quite easily. As a result there were 17 service providers.

c) Waiting List Initiative

At the Public Hearing, officials from the Ministry of Health explained that the Waiting List Initiative was for persons who had to wait an extended period of time for a CT, MRI or cataract surgery to have their procedure done at a public institution. Persons waiting for more than three months could apply to the County Medical Offices of Health (CMOH) or the Ministry. Officials clarified that in instances where a patient received an appointment for one year later, the patient must be present on that date. It was only in instances where the procedure could not be done on the date of the appointment then the patient was considered to be waiting. An officer would provide guidance and inform the patient of the requirements, which includes proof that the patient has been waiting for an

extended period. The Committee questioned whether it would be beneficial to communicate this initiative to the public since persons may not be aware of the initiative.

The officials indicated that special waiting list runs were conducted on weekends which allowed for as many as 50 patients being treated. These runs have been done for orthopedic procedures as well as cataract surgeries. The Committee questioned whether the runs could be done more frequently in an effort to reduce the number of persons on the waiting list. Officials indicated that it was something that could be considered.

Recommendation:

- ***The Ministry of Health should embark on a public awareness campaign to inform the public about the Waiting List Initiative. A report on this campaign must be submitted to Parliament by February 15, 2019.***
- ***The Ministry should assess the success of the Special Waiting List runs to determine a strategic schedule for frequent runs. A report on its findings should be submitted to the Parliament by February 15, 2019.***

2. Reporting

a) Late submission of Quarterly Reports

The submission of quarterly reports by Regional Health Authorities (RHA's) was pivotal for ensuring accountability and transparency in the use of public funds. RHA's are monitored through quarterly reports and through feedback from cardiologists in the respective hospitals. The Committee was informed that quarterly reports were not being submitted on time by the RHAs, however, the Ministry was taking steps to rectify the situation.

b) Monitoring of the RHAs

Officials also indicated that in the interim, verbal reports were being done at regular meetings with the Minister of Health, the Chief Executive Officers (CEO), and the Chief Medical Officer (CMO) in attendance. Furthermore, the Ministry advised that any adverse event or concerns about quality of care were submitted in writing to the office of the CMO for investigation and action.

c) Quarterly Assessments of Non-Profit Organisations (NGOs)

With regard to Non-Profit Organisations governed by Memoranda of Understanding (MOU), an assessment team, chaired by the CMO conducted quarterly assessments of these organisations. As a disciplinary mechanism for the non-submission of reports, the Ministry would withhold the organisation's subvention until the reports have been submitted.

Recommendations:

- ***The Ministry of Health should strengthen its oversight functions and its capacity to take a more proactive role in monitoring and evaluating the operations of all RHA's in Trinidad and Tobago, thereby ensuring the timely submission of reports and any other relevant documentation.***
- ***RHA's should take the necessary steps to develop and implement internal controls and processes to ensure the timely preparation and submission of reports to the Ministry of Health and other relevant authorities. A status report on the implementation of these internal controls and processes must be submitted to the Parliament by February 15, 2019.***

3. Public Awareness of Special Health Care Programmes and Services

The Committee learnt of a number of special health care programmes and services provided to patients within the Public Health Care System such as:

- Treatment of HIV/AIDS;
- Treatment of Cardiac Disease;
- Renal Dialysis;
- Joint Replacement;
- Cataract Surgery; and
- Cancer Care Services

The Committee sought to determine the extent of public awareness of these services.

Ministry Officials indicated the programmes are advertised through:

i. Health Centres across Trinidad;

ii. Ministry of Health website; and

iii. Ministry's Facebook page.

Officials further stated that they were discussing increasing the capacity in terms of increasing the shift system in public site facilities longer than 8.00 a.m. to 4.00 p.m. This was aimed to expand the scope to use the facilities in order to increase the capacity in the public system.

Observation:

- ***The Committee notes the initiatives of the Ministry of Health to educate the public on the available programmes.***

Recommendations:

- ***The Ministry of Health should ensure that the duties of the Customer Service Representatives at clinics and hospitals include educating patients and outpatients on the various special health care programmes and services.***

4. HIV/AIDS

HIV/AIDS Coordinating Unit (HACU)[3]

The HIV/AIDS Coordinating Unit is responsible for the monitoring and evaluation of the Health Sector's HIV/AIDS plan. It also provides an ongoing partnership, strategic framework, policy guidelines and protocols to improve the health status and delivery of health care to HIV/AIDS patients. At the date of the public hearing (May 9, 2018), there were 8476 patients receiving HIV/AIDS treatment.

i. Prevention Programmes

The Committee sought to determine whether active programmes were in place for citizens, as a form of prevention. The HIV/AIDS Coordinating Unit officials explained that the Unit collaborated with the National AIDS Coordinating Committee with regard to prevention programmes. The Unit also worked in conjunction with the Sexual and Reproductive Health Clinics on programmes as part of its prevention initiative. Officials

[3] The Ministry of Health website; accessed on July 13, 2018: http://www.health.gov.tt/sitepages/default.aspx?id=169

indicated that Prevention programmes existed for tertiary institutions but not for secondary and primary schools. Community-based programmes are conducted by the Unit within Prisons in Trinidad and Tobago. Additionally, the Committee learnt that outreach programmes to the general public is intensified on World AIDS Day and Caribbean Testing Day.

Observation:

- ***The Committee notes the programmes undertaken by the Ministry as a means of preventing the spread of HIV/AIDS.***

Recommendation:

- ***The Ministry of Health should engage in discussions with the Ministry of Education National Parent Teacher Association (NPTA)[4] on the possibility of developing prevention programmes suitable for the secondary and primary school levels. This discussion must be conducted by February 15, 2019.***
- ***A status report on the outcome of the discussion with the Ministry of Education should be submitted to Parliament by March 1, 2019.***

ii. HIV/AIDS Statistics

The Committee was informed that as at the end of fiscal 2017, the total number enrolled in HIV care was 8,530 patients. The number of children and adults as at the date of the public hearing, receiving Anti Retro-Viral medication was 6,693, with 746 being new cases. The Committee enquired about the statistics of the newly diagnosed cases over the past few years. Officials stated that in 2010 there were approximately 1,000 new diagnosed cases per annum in the country, however, as at 2016 there was a decrease to 492 new cases per annum. 59% of the newly diagnosed cases were male and 41% were female.

Observation:

- ***The Committee notes the decrease in new cases per annum in the country.***

[4]National Parent Teacher Association website; accessed on November 2, 2018; https://npta.tt/info/about_us

5. Regional Health Authorities

At the Public Hearing, during the discussions on the rescheduling of dates for CTs, MRIs and Cataract Surgery, the Committee learnt that each RHA operated with a different system for record keeping so it was often difficult to transfer patients between RHAs. Officials from the Ministry indicated that the RHAs were set up separately and over time they diverged in many different ways. As a result, the Ministry needed to find ways to coordinate and integrate the RHAs, although the legislation established each RHA separately. The Permanent Secretary informed the Committee that the Ministry was strengthening its Information Communication Technology (ICT) capacity as there was a recent Cabinet approval for additional positions for the Unit. The strengthened Unit would perform a central coordinating function for sharing information between the RHAs.

The Permanent Secretary informed the Committee that one of the projects on the Ministry's agenda was the Picture Archiving and Communication System (PACS) which was a medical imaging technology used primarily in healthcare organizations to securely store and digitally transmit electronic images and clinically-relevant reports. The Permanent Secretary could not provide a timeline for the implementation of PACS.

Recommendation:

- ***The Ministry of Health shall provide a status update on the implementation of the Picture Archiving and Communication System by February 15, 2019.***

5. CONCLUSION

During the Third Session of the Eleventh Parliament, the PAAC conducted an inquiry into the Ministry of Health with particular reference to the Administration of Special Health Care Programmes. During the course of the examination, the Committee noted the lack of controls to monitor Special Health Care programmes offered to the citizens of Trinidad and Tobago. Additionally, the Committee found that there was a lack of public awareness of the programmes offered to patients in the public health care system. Additionally, the Committee noted the decrease in new cases of HIV/AIDS and the increase in Cardiac Disease.

The Committee emphasises that in the context of the NCD epidemic as described by the Ministry of Health and the multi-year, multi-million dollar loan accessed by the Government of Trinidad and Tobago to deal with NCDs, the Ministry of Health should work with counterpart Ministries like the Ministry of Education, Ministry of Agriculture, Land and Fisheries, Ministry of Trade and Industry, Ministry of Sport and Youth Affairs and Ministry of Social development Family Services to embark on a public awareness campaign on NCDs within the current NCD prevention and control plan introduced in 2017. The Committee also emphasizes that in the context of the need to strengthen its oversight functions and its capacity to monitor RHA's in Trinidad and Tobago, RHA's must ensure the timely preparation and submission of reports to the Ministry of Health and other relevant authorities.

Finally, the Committee is of the view that the adoption of its recommendations contained in this report would lead to greater accountability and oversight in the use of public funds and greater efficiencies in the administration of Special Health Care Programmes.

This Committee respectfully submits this Report for the consideration of the Parliament.

…….	……
Mrs. Bridgid Mary Annisette-George **Chairman**	Dr. Lackram Bodoe **Vice-Chairman**
…….	……
Mrs. Ayanna Webster-Roy **Member**	Ms. Nicole Olivierre **Member**
…….	……
Brig. Gen. (Ret.) Ancil Antoine **Member**	Mr. Wade Mark **Member**
…….	……...
Mr. Daniel Dookie **Member**	Mr. Clarence Rambharat **Member**
…….	……..
Mr. Garvin Simonette **Member**	Ms. Amrita Deonarine **Member**

APPENDIX I

Questions to Entities

Questions submitted to the Ministry of Health

Special Health Care Programmes

General Questions:

1. Define what is a Special Health Care Programme?
2. Identify the Special Health Care Programmes within the Ministry.
3. How are the following programmes administered:
    i. Renal Dialysis;
    ii. Treatment of Adult Cardiac Disease
    iii. HIV/AIDS
4. Is there an External Patient Programme or a similar type of programme? If yes, how is it funded and administered?
    i. In particular, are there programmes for the provision of the following services:
        a. Joint Replacement;
        b. Cancer Care Services; and
        c. Cataract Surgery.
5. What are the intended objectives/benefits of these special programmes to health care users in Trinidad and Tobago? How is this measured?
6. Are frequency assessments conducted to determine the success level of these programmes?
7. When was the last assessment conducted on each Special Health Care Programme?
8. How is the expenditure for these programmes monitored?
9. How many persons have utilised each programme for fiscal 2017 and as at March 31, 2018? Provide in detail.
10. How does the Accounting Officer ensure transparency and accountability within the administration of these programmes?
11. Are there guidelines, processes or procedures are there with regard to the administration of these programmes? Provide details
12. Explain the process by which patients are selected for these programmes?
13. With reference to the Chronic Disease Assistance Programme (CDAP) provide the following information:

a. The sum spent on the programme for the period October 2017 – April 2018; and

b. Drugs currently available under CDAP.

14. Are there instances where the Private Sector utilizes Public Health Facilities and if so what are the arrangements to facilitate this?

HIV/AIDS

Questions:

1. What is the function of this programme? Provide a detailed explanation.
2. Can the Ministry indicate the reasons for the removal of funding for this programme in fiscal 2018?
3. How will this affect the users of this programme?
4. Provide information on the number of persons who have received (monetary/medical) assistance from the programme for the period November 2017 to March 2018.
5. Have there been any complaints by users of this programme?
    a. If yes please state the nature of the complaints and the action(s) taken by the Ministry to resolve it?
    b. What medium is used to make a complaint? Describe the complete process.
    c. How does the Ministry handle complaints by users of this programme?
6. Who oversees the expenditure of funds for this programme at the health institutions across Trinidad and Tobago?
7. What criteria is used to determine the persons who are to receive assistance from this programme?
8. How is this programme monitored to ensure accountability and transparency in Trinidad and Tobago?

Renal Dialysis

Questions:

1. What is the function of this programme? Provide a detailed explanation.
2. How does the Ministry monitor the administration of funds for this programme?
3. What is the criteria used to select the persons who are to receive assistance from this programme?
4. Provide information on the number of persons who have received (monetary/medical) assistance for the programme for the period November 2017 to March 2018.
5. Have there been any complaints by users of this programme?

i. If yes please state the nature of the complaints and the action(s) taken by the Ministry to resolve it?

ii. What medium is used to make a complaint?

iii. How does the Ministry handle complaints by users of this programme?

6. How is this programme monitored to ensure accountability and transparency in Trinidad and Tobago?
7. How many patients utilised this programme in Trinidad and Tobago for fiscal 2017?
8. Provide a list of external providers who are utilized by the MOH for the provision of renal dialysis services and also the criteria used for the selection of these providers.
9. For external providers, provide the following:
    a. List of suppliers
    b. Criteria used for the selection of these providers
    c. Process for contracting these providers
10. List of any complications experienced by patients utilising this programme.

Treatment of Adult Cardiac Disease

Questions:

1. What are the objectives of this programme? Provide a detailed explanation.
2. How does the Ministry monitor the administration of funds for this programme at each Regional Health Authority?
3. What criteria is used to select the persons who are to receive assistance from this programme?
4. How many patients receive assistance from this programme annually?
5. Provide information on the number of persons who have received (monetary/medical) assistance for the programme for the period November 2017 to March 2018.
6. Have there been any complaints by users of this programme?
    a. If yes please state the nature of the complaints and the action(s) taken by the Ministry to resolve it?
    b. What medium is used to make a complaint?
    c. How does the Ministry handle complaints by users of this programme?
    d. Who oversees the expenditure of funds for this programme at the health institutions across Trinidad and Tobago?

7. Can the Accounting Officer state how this programme is administered in Trinidad and Tobago?
8. How is this programme monitored in Trinidad and Tobago?
9. How many patients utilised this programme in Trinidad and Tobago for fiscal 2018?
10. Provide a list of external providers who are utilized by the MOH for the provision of renal dialysis services and also the criteria used for the selection of these providers.
11. For external providers, provide the following:
    a. List of suppliers;
    b. Criteria used for the selection of these providers;
    c. Process for contracting these providers.

APPENDIX II

The Inquiry Process

General Inquiry Process

The Inquiry Process outlines steps to be taken by the Committee when conducting an inquiry into an entity or issue. The following steps outlines the Inquiry process followed by the PAAC:

i. Identification of entity to be examined;

ii. Preparation of Inquiry Proposal for the selected entity. The Inquiry Proposal outlines:

   I. Description

   II. Background;

   III. Overview of Expenditure

   IV. Rationale/Objective of Inquiry; and

   V. Proposed Questions.

iii. Consideration and approval of Inquiry Proposals by the Committee and when approved, questions are forwarded to the entity for written responses;

iv. Issue of requests for written comment from the public are made via Parliament's website, social media accounts, newspaper and advertisements;

v. Preparation of an Issues Paper by the Secretariat for the Committee's consideration, based on written responses received from the entities. The Issues Paper identifies and summarises any matters of concern in the responses provided by the entity or received from stakeholders and the general public;

vi. Review of the responses provided and the Issues Paper by the Committee;

vii. Conduct of a site visit to obtain a first-hand perspective of the implementation of a project (optional);

viii. Determination of the need for a Public Hearing based on the analysis of written submissions and the site visit (if required). If there is need for a public hearing, the relevant witnesses will be invited to attend and provide evidence. There is usually no need to examine the entity in public if:

ix. the Committee believes the issues have little public interest; or

x. the Committee believes that the written responses provided are sufficient and no further explanation is necessary.

xi. Issue of written request to the entity for further details should the Committee require any additional information after the public hearing.

xii. Report Committee's findings and recommendations to Parliament upon conclusion of the inquiry.

APPENDIX III

Minutes of Meetings

THE PUBLIC ADMINSTRATION AND APPROPRIATIONS COMMITTEE – THIRD SESSION, ELEVENTH PARLIAMENT

MINUTES OF THE THIRTY-FIFTH MEETING HELD ON WEDNESDAY MAY 9, 2018 AT 1:39P.M.
IN THE ARNOLD THOMASOS (EAST) MEETING ROOM, LEVEL 6 AND THE J. HAMILTON MAURICE ROOM, MEZZANINE FLOOR, TOWER D, OFFICE OF THE PARLIAMENT,
INTERNATIONAL WATERFRONT CENTRE,
1A WRIGHTSON ROAD, PORT OF SPAIN.

Present were:

Mrs. Bridgid Mary Annisette-George	-	Chairman
Dr. Lackram Bodoe	-	Vice-Chairman
Mr. Wade Mark	-	Member
Brig. Gen (Ret.) Ancil Antoine	-	Member
Ms. Nicole Olivierre	-	Member
Ms. Jennifer Raffoul	-	Member
Ms. Keiba Jacob	-	Procedural Clerk
Mr. Brian Lucio	-	Graduate Research Assistant
Ms. Rachel Nunes	-	Graduate Research Assistant

Absent were:

Mr. Ronald Huggins	-	Member (Excused)
Mr. Clarence Rambharat	-	Member (Excused)
Mrs. Ayanna Webster-Roy	-	Member (Excused)
Mr. Daniel Dookie	-	Member (Excused)

EXAMINATION OF THE MINISTRY OF HEALTH – THE ADMINISTRATION OF SPECIAL HEALTH CARE PROGRAMMES IN TRINIDAD AND TOBAGO

5.1 The Chairman called the public meeting to order at 2:42 p.m., in the J. Hamilton Maurice Room, Mezzanine Floor.

5.2 The following officials joined the meeting:

MINISTRY OF HEALTH

Mr. Richard Madray	-	Permanent Secretary
Mr. Beesham Seetaram	-	Programme Administrator External Patient Programme (EPP)
Dr. Kevin Antoine	-	Director, HIV/AIDS Coordinating

		Unit
Dr. Jeffrey Edwards	-	Director, Medical Research Foundation of Trinidad and Tobago (MRFTT)
Mr. Lawrence Jaisingh	-	Director, Health Policy
Dr. Vishwanath Partapsingh	-	Chief Medical Officer (Ag.)
Dr. Rohit Doon	-	Health Advisor, Health Promotion

5.3 The Chairman welcomed the officials, members of the media and the public.

5.4 The Chairman outlined the mandate of the Committee and the purpose of the hearing. Introductions were then exchanged.

5.5 The following issues arose from the examination into the Administration of Special Health Care Programmes in Trinidad and Tobago:

HIV/AIDS

1. Clarification on the number of HIV/AIDS patients;
2. The rate of new infections per year;
3. Prevention programmes undertaken by the HIV/AIDS Coordinating Unit (HACU) to members of the public;
4. The body responsible for disseminating information to the public;
5. Outreach initiatives and its target market regarding HIV/AIDS;
6. Clarification on the subvention given to the Medical Research Foundation of Trinidad and Tobago (MRFTT);
7. The absence of the MRFTT under Non-Government Organisations in the 2017-2018 budget documents;
8. Monitoring of the expenditure allocated to MRFTT;
9. Details on the Memorandum of Understanding that govern the MRFTT and other Non-Profit Organisations;
10. Activities on the 2017-2018 HIV/AIDS work plan;
11. The number of tests conducted for HIV/AIDS in fiscal 2017-2018;
12. The number of patients confirmed with HIV/AIDS for fiscal 2017-2018;
13. Treatment provided for children with HIV/AIDS;
14. Details on the President's Emergency Plan for AIDS Relief (PEPFAR) Fund agreement and the funds received;
15. Monitoring of the disbursements of the funds received from the PEPFAR agreement; and
16. Details on the relationship between the National AIDS Coordinating Unit (NACC) and HACU;

Chronic Disease Assistance Programme (CDAP)

1. The total allocation for CDAP Drugs for fiscal 2018;
2. Reasons for the shortage of drugs at Pharmacies;
3. The amount spent on CDAP drugs for fiscal 2017-2018;
4. The comparison between the past stock and present stock of drugs in the country;
5. The reason for the lack of coverage of drugs specifically for persons with Autism under the CDAP programme;
6. The effects of the centralization of CDAP drugs;

7. Systems in place to prevent the abuse of the CDAP;
8. Status of the implementation of the Health Card;

Treatment of Cardiac Disease

1. Number of premature deaths of men and women in Trinidad and Tobago;
2. Number of men and women who die from Non-Communicable Diseases annually;
3. Causes of mortality in both men and women;
4. Procedures outsourced under the Cardiac Disease Programme;
5. Current waiting list figure for cardiac disease treatment;
6. Average waiting time for emergency an non-emergency diagnostic procedures; and
7. Collaborations with the Ministry of Education and the Ministry of Health to sensitize all levels of school children.

Renal Dialysis

1. The waiting time for patients to receive dialysis;
2. The number of renal dialysis patients for fiscal 2017-2018;
3. The number of renal transplant surgeries conducted;
4. Challenges faced with increasing the number of renal transplants conducted per year;
5. The number of service providers for renal dialysis;
6. Quality assessments conducted on service providers;
7. Details on emergency dialysis conducted in the Public Sector;
8. Public education system in place to sensitise person to become a transplant donor;
9. The status of the two proposed Renal Dialysis Centers;
10. Reasons for the withdrawal of service by the St. Clair Medical Centre;
11. The date of the last checks for calibration of dialysis equipment in public private health facilities;
12. Mechanisms in place for post-op patients in the event of a complication from outsourced service providers;
13. Standard used to measure service providers;
14. Details on the standard operating tools used for service providers; and
15. Functions and structure of the Inspection Teams and how often inspections are conducted.

External Patient Programme (EPP)

1. Clarification on the programmes that fall under the EPP:
2. The sum expended on the EPP thus far;
3. The number of patients who have benefitted from each programme under the EPP;
4. The challenges and successes of the EPP programme;
5. Improvements that can be made to the EPP;
6. The criteria needed to gain access to the programme;
7. Advertisements and awareness of the programme; and
8. The use of mechanisms to measure the impact of the services provided.

Waiting List Initiative

1. Details on the Waiting List Initiative;
2. The qualifications needed to be placed on the Waiting List;
3. The process time involved with the Waiting List Initiative;
4. Advertising and public awareness of the Waiting List Initiative;

5. Details on the Orthopedic Run conducted by the Ministry; and
6. Current number of patients on the Waiting List for emergency procedures and the necessary arrangements made by the Ministry;

General

1. The reasons that Tobago was not included in the submission with regard to Special Health Care Programmes;
2. The role of Tobago when setting policies for Special Health Care Programmes;
3. The development of an electronic central coordinating system for the health care system in Trinidad and Tobago;
4. The development of an ICT system within the health care system;
5. Impact analysis on all Special Health Care Programmes;
6. The costs incurred to provide Special Health Care Services;
7. Details on Diagnostic Procedures conducted in the Public Health Care System;
8. The waiting time for Diagnostic Procedures to be conducted;
9. Details on the Picture Archive and Communication System (PACS) project;
10. The rise in Non-Communicable Diseases;
11. An assessment of the performance of all service providers;
12. Standards used to engage service providers;
13. The ability of service providers to provide quality services to the public;
14. List of the private service providers for Joint Replacement Surgery, Cancer Care Services and Cataract Surgery;
15. Establishment of registers for Diabetics;
16. The plans to engage a qualified firm to develop Social Marketing;
17. The engagement of Medical Social Workers;
18. The availability of adequate Medical Social Workers at health institutions;
19. The procurement process of the Ministry of Health;
20. Reason for the large number of applicants pending approval for eyeglasses;
21. Clarification on the number of cataract surgeries conducted in fiscal 2017-2018;
22. Update on the North West Regional Health Authority investigation into mismatched implants for joint replacement surgeries;
23. The recent occurrence of defective implants for hip replacement surgery;
24. Oversight conducted by the Ministry on the expenditure of Non-Profit Organisations;
25. Means testing done for Renal and Cardiac disease to get into the Public Healthcare System; and
26. Mechanisms in place to treat with the loss of patients files.

5.6 The Chairman thanked officials for attending and they were excused.

[Please see the verbatim notes for the detailed oral submission of the witnesses]

ADJOURNMENT

9.1 The Chairman indicated that the Committee's next meeting would be held on **Wednesday May 16, 2018 at 1:30 p.m.** when the Committee would commence its inquiry into the Implementation of the Public Sector Investment Programme (PSIP).

9.2 There being no other business, the Chairman thanked Members for their attendance and the meeting was adjourned.

9.3 The adjournment was taken at 5:37 p.m.

We certify that these Minutes are true and correct.

CHAIRMAN

SECRETARY

May 09, 2018

APPENDIX 1

ADDITIONAL INFORMATION REQUESTED

RE: ADMINISTRATION OF SPECIAL HEALTH CARE PROGRAMMES IN TRINIDAD AND TOBAGO

Ministry of Health

Medical Aid

1. What type of procedures are covered under Medical Aid?
2. How does the Ministry determine who receives financial assistance under the Medical Aid programme?

Treatment of Cardiac Disease

1. Has the Ministry engaged in any outreach programmes educating the public on the preventions of cardiac disease?
2. What preventative measures does the Ministry plan to implement to decrease the number of patients accessing this service annually?
3. Is the criteria used in selecting service providers effective?
4. Describe the tender process used when choosing service providers?
5. How does the Ministry ensure the tender process is transparent?

Accountability and Transparency

1. Are quarterly reports submitted on time?
2. When was the last report submitted to the Ministry from each Regional Health Authority?
3. What steps are taken by the Ministry in the event of non-submission by the Regional Health Authorities?
4. How does the Ministry ensure accountability and transparency throughout the use of these providers?

Renal Dialysis

1. Can patients who are not in the "end stage renal failure" access this programme? If no, why not?
2. What is the status of the Ministry's attempts to build and develop its internal capacity to provide renal dialysis services?
3. How does the Ministry ensure that the process used to provide assistance (monetary/medical) is transparent?
4. How does the Ministry treat with service providers with faulty machinery?

Accountability and Transparency

1. In light of the high numbers of patients utilising the services stated on page 9 and 10 of your written submission, what preventative initiatives or outreach programmes does the Ministry plan to implement to decrease these numbers?

i. With regard to eyeglasses what are the reasons the pending approval of applications for fiscal 2018?
ii. How does the Ministry determine who takes precedence over who does not in the awarding of these services to patients?

HIV/AIDS

1. Under what sub-item is the subvention to the MRFTT covered?
2. What is the subvention received by the MRFTT for fiscal 2018?
3. Who monitors the expenditure of the MRFTT?
4. Who monitors the expenditure of the HIV and AIDS Coordinating Unit (HACU)?
5. What methods are used to monitor the expenditure of the MRFTT and the HACU?
6. What is the security risk at the MRFTT facility that needs to be reduced?
7. In light of the economic situation, are preventative measures being explored to decrease the number of patients that utilise this service?
8. Has there been any issues with the extension of the closing time at the clinic?
9. Has the time change proven to be successful due to the fact that most patients will attend after work over taking time off?

Accountability and Transparency

1. Who monitors and provides oversight for the HACU?
2. When was the last audited report submitted by the MRFTT?
3. What are the global indicators used for monitoring progress towards the achievement of goals?

Provide the following in Writing:

1. The reasons for the sudden increase in Renal Dialysis patients;
2. The number of Medical Social Workers on part time and full time;
3. The number of Medical Social Workers presently at each hospital;
4. The desired number of Medical Social Workers for each hospital;
5. A copy of the Memorandum of Understanding that govern the Medical research Foundation of Trinidad and Tobago and other Non-Governmental Organisations;
6. The 2018 work plan for HIV/AIDS;
7. Details on the relationship between the Ministry of Health, the Ministry of National Security and the HIV/AIDS Coordinating Unit;
8. The precautionary measures in place to prevent the Hip Replacement Surgery incident at the North West Regional Health Authority from reoccurring;
9. A list of the formalised Screening Programmes in Trinidad and Tobago;
10. The outcomes and outputs measured with regard to HPV and Cervical Cancer;
11. Further details on the status of the two Renal Dialysis Centres; and
12. A copy of the Statistical Report submitted to the Ministry on an annual basis with regard to HIV/Aids.

APPENDIX IV

Attendance

APPENDIX V

Verbatim

VERBATIM NOTES OF THE TWENTY-THIRD PUBLIC MEETING OF THE PUBLIC ADMINISTRATION AND APPROPRIATIONS COMMITTEE, HELD IN THE J. HAMILTON MAURICE ROOM, MEZZANINE FLOOR, OFFICE OF THE PARLIAMENT, TOWER D, THE PORT OF SPAIN INTERNATIONAL WATERFRONT CENTRE, #1A WRIGHTSON ROAD, PORT OF SPAIN, ON WEDNESDAY, MAY 09, 2018, AT 2.41 P.M.

PRESENT

Mrs. Bridgid Annisette-George	Chairman
Dr. Lackram Bodoe	Vice-Chairman
Mr. Wade Mark	Member
Brig. Gen. Ancil Antoine	Member
Ms. Jennifer Raffoul	Member
Ms. Nicole Olivierre	Member
Ms. Melissa Ramkissoon	Member
Ms. Keiba Jacob	Secretary
Ms. Rachael Nunes	Graduate Research Assistant

ABSENT

Mr. Clarence Rambharat	Member
Mr. Ronald Huggins	Member
Mr. Daniel Dookie	Member
Mrs. Ayanna Webster-Roy	Member

MINISTRY OF HEALTH

Mr. Richard Madray	Permanent Secretary
Mr. Beesham Seetaram	Programme Administrator

	External Patient Programme (EPP)
Dr. Keven Antoine	Director, HIV/AIDS Coordination Unit
Dr. Jeffrey Edwards	Director, Medical Research Foundation of Trinidad and Tobago (MRFTT)
Mr. Lawrence Jaisingh	Director, Health Policy
Dr. Vishwanath Partapsingh	Chief Medical Officer (Ag)
Dr. Rohit Doon	Health Advisor, Health Promotion

Madam Chairman: Good afternoon everyone, and welcome to the officials of the Ministry of Health and other health agencies, members of the media and members of the listening and viewing public.

My name is Bridgid Annisette-George, I am the Chairman of the Public Administration and Appropriations Committee of the Parliament.

The Committee of Public Administration and Appropriations has a mandate to consider and report to the House on:

(a) the budgetary expenditure of Government agencies to ensure that expenditure is embarked upon in accordance with parliamentary approval;

(b) the budgetary expenditure of Government agencies as it occurs, and keeps Parliament informed of how the budget allocation is being implemented; and

(c) the administration of Government agencies to determine hindrances to their efficiency and to make recommendations to the Government for improvement of public administration.

The purpose of this 23rd public meeting of the Public Administration and Appropriations Committee for the Eleventh Parliament is to commence an enquiry into the administration of special health care programmes in Trinidad and Tobago.

The Committee is desirous of hearing from the Ministry of Health to discover any challenges being faced by the Ministry regarding the administration of special health care programmes in Trinidad and Tobago. The Committee hopes that the meeting will be fruitful, that it will provide insight and workable solutions for the improvement of the administration of special health care programmes in Trinidad and Tobago.

This meeting is being held in public and is being broadcast live on the Parliament's Channel 11, radio 105.5 FM and the Parliament's YouTube channel, *ParlView*. Viewers and

listeners can send their comments related to today's enquiry via email to parl101@ttparliament.org, facebook.com\ttparliament and twitter @ttparliament.

I, therefore, now invite the representatives of the Ministry of Health and the other health agencies to introduce themselves to the Committee.

[*Introductions made*]

Madam Chairman: And the Committee today is being ably assisted by its Secretary, Ms. Keiba Jacob, and its Gradate Research Assistant, Ms. Rachael Nunes.

I would just like to start off the discussion with a general enquiry to the Permanent Secretary of the Ministry of Health, in that as I indicated, the discussion was about the administration of the special health care programmes in Trinidad and Tobago, and we have observed from the responses to our enquiry, that the responses were limited to Trinidad and, therefore, you know, for clarification, if maybe you can begin in making an opening statement, but also weaving into the context, where does Tobago fit in to all of this.

Mr. Madray: Madam Chair, Committee Members, the four PSIP programmes relate to the work of the Ministry in respect of our programmes to assist Trinidad. The Tobago House of Assembly is responsible for the management of its funds regarding the treatment of Tobagonians generally. However, from a policy perspective, the Ministry of Health sets policy initiatives for the nation.

Madam Chairman: Okay. So that will include Tobago?

Mr. Madray: Correct.

Madam Chairman: Okay. But, therefore, in terms of the responses to the questions with respect to how the programmes are administered, there was no reference to Tobago at all. So that how then, in terms of you setting policy, there is an absence of any reference to Tobago?

Mr. Madray: Well, I believe that we attempted to address the fact that the enquiry related to the Public Sector Investment Programme allocation of the Ministry, so we focused our response in that way.

Madam Chairman: Okay. Thank you very much. All right. So that I will now pass on to member Bodoe to begin the conversation as regard the specifics of the enquiry. Member Bodoe?

Dr. Bodoe: Thank you, Madam Chair. Good afternoon and welcome. I see

many familiar faces there, and a special welcome to you all. I just want to start the discussion, and if I could refer to page 1 of your response PS, and just for the clarification on the public side regarding these special health care programmes, I see we have listed under "Item 2", identified the special health care programmes within the Ministry. The External Patient Programme, can we get clarification? Does that just include the three listed under the External Patient Programme?

Mr. Madray: Mr. Seetaram will clarify.

Mr. Seetaram: Under the External Patient Programme, we managed specifically these three items. However, medical aid and the eye glasses project as well as the external radiation treatment is administratively managed under the programme.

Dr. Bodoe: All right. So in terms of listing, they would come under the External Patient Programme?

Mr. Seetaram: Administratively correct.

Dr. Bodoe: I just wanted clarification, so we could deal with all of these as a block. So PS, through you, if I could perhaps engage the Director of the EPP, and just to ask in terms of how much has been spent on the EPP so far in this financial year, can you give us an indication?

Mr. Seetaram: Under each line item we have different expenditures.

Dr. Bodoe: I just wanted a ballpark figure so that we will have an idea what sort of expenditure we are dealing with.

Mr. Seetaram: For adult cardiac, we would have spent $5.05 million; for renal dialysis, $12.9 million; for waiting list, we would have actually spent, $5.7 million. The other line items, I would have to get the figures for.

Dr. Bodoe: That is fine. So, Director, can you tell us approximately how many patients would have benefitted from this expenditure under this programme?

Mr. Seetaram: Under every line item we have varying numbers. For example, adult cardiac, it depends on the number of persons that present at the hospital. Renal Dialysis, currently we have 1,187 patients that are receiving treatment. The waiting list initiative is really based upon the number of persons that are awaiting the services at the public institutions as well, so that would be time based. Medically, it is based on the number of persons who apply and who are presenting to the public health care system. The eye glasses project, we would have provided a detail for fiscal 2018. We

have 300 applications that are being processed currently.

One of the things I would like to put on record is that all of these programmes are available to members of the public who present at public health care institutions.

Dr. Bodoe: Sure. All right. But in terms of a ballpark figure of the total number that would have benefitted under this expenditure, are you in a position to give us that?

Mr. Seetaram: A ballpark figure would be safely roughly 7,000 persons.

Dr. Bodoe: 7,000? Okay. So, if I may, there are some more specific questions I want to ask regarding the programmes themselves, but before I go into that, there are a few general questions I would want to ask regarding the External Patient Programme. Do you believe that the EPP has been able to achieve its target and objectives? Do you think the programme has been a success?

Mr. Seetaram: Thus far, yes. We have been able to meet the needs of the public. There have been some challenges in the past, and we continue to face challenges. However, we are able to meet all of the requirements of the public thus far.

Dr. Bodoe: Right. Could you, perhaps, maybe list some of these challenges that you mentioned?

Mr. Seetaram: One of the major challenges that we faced is basically persons presenting directly to the Ministry and not going through a public health care system. That is why I wanted to state from the onset that persons must belong to the public health care system.

The challenge we have is that there is a culture that needs to be changed, whereas persons feel as if they can go to a private doctor and then depend on the Government to pay for any service that they require thereafter. All of our programmes are geared towards persons who are within the public health care system and persons who have been treated there. So the major challenge is getting persons to actually access the public health care system.

Dr. Bodoe: Right. And that may be so, but in terms of someone seeking care at a private institution in an emergency situation and want the access the EPP, let us say, for example, with an acute cardiac situation, are you saying then that the patient has to go into the hospital system to be able to access the service?

Mr. Seetaram: Once the person presents at any one of our accident and

emergency centres throughout Trinidad and even Tobago, they are immediately the system kicks in, and we will get the request from the hospital and the person is transferred to a private centre to have the emergency surgery done, once you present at our accident and emergency.

Dr. Bodoe: So the public needs to understand that.

Mr. Seetaram: Yes.

Dr. Bodoe: Do you have any ideas, any suggestions, as to how the programme can be improved going forward?

Mr. Seetaram: In terms of going forward, possibly public awareness, education and, in essence, funding has always been a challenge throughout successive years, but these programmes are not meant to last forever. These programmes are meant to fill a gap and meet the needs of the public at this point in time while we build institutional capacity. So, in that interim, funding would be one of the things that would benefit us right now.

Dr. Bodoe: Do you have in place any mechanisms currently that can measure the impact of the EPP in terms of the provision of service?

Mr. Seetaram: One of the things we look at in terms of measuring impact is really the number of complaints. From 2014, going forward, the number of complaints of persons not being able to access any sort of service, we have been able to bring that number significantly down. So whereas in the past we would have had hundreds of complaints of persons not being able to access basic services such as CTs and MRIs, that no longer obtains. Once a person is made aware that this facility is available, they access the facility and, therefore, the complaints, we have seen a significant decrease.

Dr. Bodoe: Is this programme advertised publicly? How is the public made aware of this?

Mr. Seetaram: All of our CMOH offices have offices located there in which persons can go in and apply. All of our accident and emergencies at public health care institutions are aware of the programme. So patients, once they go in, they can get the information there.

Dr. Bodoe: So if I am to understand correctly, you have two situations: you would have acute situations where someone would present to accident and emergency, but you also have the waiting list initiative. Can you specify what that waiting list

initiative is about and what services it covers?

Mr. Seetaram: So, the waiting list initiative directly speaks to persons having to wait for extended period of time and not have any service. So we look at periods for about three to six months. So a person should not be waiting for a CT or an MRI or even a cataract surgery for more than that period. We try to absorb as many of them within the public sector, and those that we cannot get done within that period of time, we then try and get them done privately.

Dr. Bodoe: So, just to be clear, so the services are CT, MRI—

Mr. Seetaram: CT, MRIs, cataracts, yes.

Dr. Bodoe: Any other services?

Mr. Seetaram: Those are the main areas of focus. Correct.

Dr. Bodoe: So you are saying to public that if they have an appointment, for example, for an MRI at a public institution, longer than how long should they then try to access the programme?

Mr. Seetaram: Once they are waiting for more than three months, they can approach any one of our County Medical Officers of Health Office and apply or come directly to the Ministry of Health. We have an officer located waiting and ably ready to assist to provide any sort of guidance needed in order to tell them what needs to be done one, and what are the requirements, because we do not just say you have to go in privately. There must be some sort of proof and evidence that you have been waiting and these services are available to all citizens of Trinidad and Tobago.

Dr. Bodoe: I understand that you would not want to open the floodgates, but for those services, is any effort made to communicate to the public, besides the notices that the CMOH's office which generally patients may not visit on a regular basis, have there been any efforts to communicate that this assistance is available? I am speaking specifically in terms of advertising the programme outside of the CMOH's offices?

Mr. Seetaram: Currently, it is on our website and our Facebook page. So the information is out in the public domain.

Dr. Bodoe: Do you believe it might be of benefit, perhaps, to advertise otherwise? Has any consideration being given to that?

Mr. Seetaram: It is something that we are can consider moving forward, yes.

Madam Chairman: Thank you. Mr. Seetaram, just for me to understand. So

that a patient could be in the public health care system, a doctor there says you need to get a CT scan or an MRI, and you get an appointment for that to be done in the public health system for a year from today. That same patient can now go to a different office in the public health system and say that my appointment is a year down the line and, therefore, now, I want to be on the waiting list initiative? Is that how it works?

Mr. Seetaram: No, it is not. If a person has an appointment date, you must present on that date. If on that particular day the service is not rendered, then you start waiting. We ask persons who have been given extended appointment times or dates to actually write to us or call us. We try our best to bring updates. So whereas, yes, the facility is available to send persons privately to have procedures done—whether it be CT, MRI cataracts—we try to manage the system in such a way that we get the procedures done within our public sector.

Madam Chairman: So that after—well, I do not want to call it the waiting time—the expiration of the time between my being referred for the particular service and the appointed date, is only then I qualify for the waiting list initiative?

Mr. Seetaram: Correct.

Madam Chairman: Okay, because I think the public needs to understand that. When I am then now qualified, I then apply to be put on the waiting list?

Mr. Seetaram: Yes, correct.

Madam Chairman: Okay. How then does that impact—because I would think if my appointed time was a year down the road—so we are now in May of 2019, and I presented myself in May of 2019 and 1 did not have the procedure done, would I be automatically assigned a different time?

3.00 p.m.

Mr. Seetaram: If you present to the public hospital and your appointment is today, and you do not have the procedure done today, you are automatically given another appointment. At that point in time you can apply to us. However, you are given an appointment.

Madam Chairman: So I can apply to bring forward my appointment?

Mr. Seetaram: Yes.

Madam Chairman: Could you share with us what are the criteria to determine whether my appointment would be brought forward?

Mr. Seetaram: I beg your pardon, sorry.

Madam Chairman: Could you share with us what would be the criteria to determine whether my appointment would be brought forward, because I do not automatically get an earlier appointment than the appointed date?

Mr. Seetaram: So if it is you are given an appointment for one year and on that date the procedure does not happen, you write to us and you tell us exactly what the situation is, we then try to assist. Once there is a facility available within the public sector we utilize the facility. There are several reasons why it is some RHAs may be more efficient than others, and we utilize the system in such a way that we move patients from one area to another in order to get procedures done. So, for example, we would do waiting list runs. We did a waiting list run at Mount Hope a couple of months ago to have procedures done. That would deplete the list that currently exists right now.

Madam Chairman: All right. So that what you are saying is that I may have gotten a deferred appointment at a particular facility, but through the initiative I may get an earlier date at another facility? Yes? Can I ask why that could not be automatically done when my appointed schedule could not be met, because from the way I am understanding it, it is not through any fault of my own, the patient? This is maybe something with the facility. Why could it not be automatically be done at the time I am getting the deferred appointment?

Mr. Seetaram: So there are several reasons why appointments are deferred. It could be that the machines may malfunction, there may be staff shortages; there may be several reasons. Those are basically some of the reasons why the appointments are not kept.

Madam Chairman: And what I am asking is: Why at the time that my appointment cannot be kept for a matter that is outside of my control as the patient, why could I not then—why could it not automatically kick in?

We have technologies all being managed by one overarching entity, why could it not then look in terms of setting a date for me for the next available date throughout the system?

Mr. Seetaram: It does not kick in automatically because we have different RHAs and each operate independently of the other. What we are trying to do is to mesh the system in terms of service delivery. That is what we try to do, by moving patients from one RHA to another, and utilizing the services available by the other RHA.

Madam Chairman: But maybe I do not understand, and maybe I would give you an opportunity to clarify. I just heard that they were operating independently of each other, okay, but yet is being meshed by somebody, which I think is the Ministry of Health.

Mr. Seetaram: Yes.

Madam Chairman: So what I am asking is, I see that as something that can be done electronically. Am I wrong? And if it can be done electronically, why is it not being done?

Mr. Seetaram: Each of the RHAs operate with different systems in terms of recordkeeping, so the joining of the systems is something that has been looked at, but from an administrative point of view it is easier for us, at this point in time, to do that transfer or to help the patient get the service done at another institution; until all the systems that can correlate and speak to each other electronically, that cannot happen.

Madam Chairman: Can all the systems not speak to you?

Mr. Madray: If I may, so what we have found is that the—and I am just endorsing what Mr. Seetaram said—what we have found, precisely because the RHAs were set up separately, over time they have diverged in many different ways, right, and this is just one way in which it is an obvious example. So to a certain extent the Ministry of Health needs to find ways in which we can better coordinate and integrate those RHAs, despite the fact that the legislation was set up for the RHAs to be separate. So we take the point. I mean, it is an obvious point that you are making, we take the point with respect to the need to find a way for such integration. The IT

technologies is in fact one way. Of course, what we are doing through the EPP programme and Mr. Seetaram's office is in a way a work around.

Madam Chairman: A work around—

Mr. Madray: Work around for the time being. We are trying to achieve the integration or the service delivery, but without the technologies that support it.

Madam Chairman: Yes. And, therefore, I would ask then when do you, from what you know as the Permanent Secretary, see the assistance of the technology coming to aid this system?

Mr. Madray: We do have—all right, so this will be a programme of projects over a series of time. Introducing IT technology systems is always challenging, whether it is here or anywhere else in the world, and we can see what happened in the United States when they tried to implement their national health insurance scheme, their system went down for a period of time, even though they have access to all of the best resources. So it will be a challenge. We are doing two things. We are beefing up. We have advertised for positions in our ICT division, and recently Cabinet had approved additional positions for that unit. That will provide a central coordinating function once we get the kinds of expertise that we need. One of the projects that is on our agenda is a PACS system. I forgot what the acronym stands for, but basically it is a system to ensure that the screenings, the diagnostic imaging, and investigations can be shared from one hospital to another. If we can get that system it would be one phase of our programme of projects over a period of time. I cannot give you a timeline for that project as yet, but we are working on defining that project and finding a way to make it happen. But without the bodies in the ICT division to manage it, I think that is our first step.

Madam Chairman: So not putting you on the spot, what you would think is a reasonable timeline to get to there? What you would think is a reasonable timeline?

Mr. Madray: We are estimating from those who have been somewhat engaged in the project, about a one year to 18 months for the

PACS system. And, as I said, a prerequisite for that is in fact getting the human resources in place.

Madam Chairman: I know. But you said that is just one phase to where we want to get, that your system is being—in not necessarily the RHAs but being integrated with the Ministry of Health, because right now the Ministry of Health is doing something manually. I must come in and make a complaint, and so on. What I am really saying is if you are doing it manually, right—so we are not even talking about the RHAs being able to speak to each other, so to speak, but since you are providing that sort of overarching coordinating function, I am asking, one, whether technology, if there were, that you could speak to everybody, if that would not improve the process? Because I would feel that any patient who went to an institution having waited a year for their appointment, because I am sure I would be considering that, my waiting, and for whatever reason good, bad or indifferent, my procedure could not have been performed, it must have some kind of psychological impact on me. And then I am now being told I have to go somewhere and fill out a form, and wait for somebody to assess "meh" form for "meh" to go to some other place maybe when—so, you know, that alone may kill "meh" spirit, if I had any after a year. So one, I think the technology, if you could speak to everybody, meaning that you could see what everybody has available real time, that I could be, as a patient, sent automatically, rather than tell me I have to go somewhere else and pick up a form and fill it out, and then go—and that is what I am asking, how long do you feel you could bring that initiative? Because I understand what you are going to tell me about the technology and the systems, and they might not marry, and all of that. I am not technologically minded so I do not mean any disrespect, but I understand that there are problems. How soon you think a project like this—one, would you think a project like that makes sense? And, secondly, if, how soon do you think that something like that could realistically take place, so I do not have to go somewhere else and get a form and then come to you?

Mr. Madray: Let me say that anything that I can say here would be

a guess because the planning for this and the assessment of it has not been undertaken, but my estimate would be a normal cycle time for an IT project, all things being considered, may be somewhere around four years or so.

Madam Chairman: Four years.

Mr. Madray: But I also want to add that in fact there are some elements of IT solutions that are already in place for some services, and perhaps Dr. Antoine, now MRFTT, may wish to speak about the solutions that are in place for the HIV management.

Madam Chairman: Okay. So we will take that under HIV. I just do not want to dominate the conversation. I just wanted to ask Mr. Seetaram one other thing. When Dr. Bodoe asked you about achieving the objectives and so, what you said is that the system was working because you all are meeting the requirements of the public. Maybe I could ask you to share with us what that means?

Mr. Seetaram: So in terms of meeting the requirements of the public, we have been able to meet all of the requirements of the public. With respect to cancer care, we have no patients complaining of not being able to access external radiation. With respect to our cataract initiative, both within the public sector and the private sector we have been able to meet the demand. With our CTs and MRIs, when patients go to any one of our public institutions and they cannot get it done at Accident and Emergency, the request is electronically sent to us and it is dealt with, and the person gets the CT or MRI done within a matter of a day or two so that they can be diagnosed and treated. So we have had many success stories. Unfortunately, the success stories are drowned by the few negatives.

Madam Chairman: Okay. So maybe that goes back to what you said about public awareness and education. Member Raffoul.

Ms. Raffoul: Thank you, Chair. Thank you all for your work for Trinidad and Tobago and for the information you all submitted. I have a few questions, mainly about the objectives and the metrics for impact. Going through the submission I had not seen a lot of information on how the impact analysis is done. As an economist I know that in the past, in

general, worldwide, not just in Trinidad and Tobago, a lot of programmes had very qualitative objectives. So things like serving the population, as opposed to looking at numbers, like specific numbers and specifying a time frame, et cetera. I am wondering if you guys think that the metrics you all have and the objectives are adequate or if they need revision. That is one question. Before I forget this, a few others that I had, I did not see any financial references at all. I saw one note about the cost of the renal dialysis in the public sector provision as compared to the open market rate for private sector, compared to what you guys were able to negotiate. But from the eight programmes listed, that was the only reference I saw to financial projections in costs, and I did not see any costs for administration versus patient care, so my questions really are about objectives and metrics.

Madam Chairman: PS, I think that is a question for you.

Mr. Madray: Well, I am trying to divert it to Mr. Seetaram. So, let us see, rather between us we will respond.

Mr. Seetaram: In terms of the metrics, as I have stated before, each of the programmes speaks to a different category of patients. So, for example, external radiation treatment, our number of patients would come to us, all 100 per cent are treated. So there is absolutely no waiting time. For cataract surgeries, we try to keep the waiting time well below three months. In instances where it is beyond that, we make special attempts to bring that time period down. It is something we can look at from an economic perspective on how it has impacted our public sector and private sector, as well as our expenditures. With respect to expenditures we actually do have very competitive costs for all of our programmes. You are correct in terms of our reference to renal dialysis, but the same applies for all of our programmes. Our costings are well below market value, because we have negotiated the value down. So that even though you are getting the same service, probably better administered, because we have several checks and balances to ensure quality service at a lower cost to us. If you were to present as a private patient the cost would be probably two to three times more.

Ms. Raffoul: Okay.

Mr. Madray: So what has happened, for example, with respect to renal dialysis is that because the barriers for entry into the market are so low, people can set up services fairly easily as opposed to cardiac treatment. We have had a number of players entering the market and therefore that brings about competition. So the services are not just provided within the public health sector, it is also provided by the 17, I believe—17 current service providers that we have, and, therefore, through the tendering processes we are able to manage the costs there as one example.

Ms. Raffoul: Okay. As a follow-up question, can you provide the financial data, audited financial statements, and, specifically, the numbers of persons that have received treatment? I do know that the information provided had some numbers, but I did notice there were some discrepancies in the numbers for HIV and AIDS patients. One table had eighty-something thousand patients listed, and then a few pages later there was a reference to 8,900 patients and then seven thousand and something patients. So I was curious as to if that eighty-something thousand was a typo. Can you provide financial data going forward and accurate numbers?

Mr. Madray: Dr. Antoine will respond. I think I am hearing that it is a typo. The 87,000 is a typo, but perhaps you can provide clarification, Dr. Antoine.

Dr. Antoine: Eight thousand, four hundred and seventy-six.

Ms. Raffoul: Okay. Thank you. I have a few other questions—let me check the notes that I had made. Forgive me. If anyone wants to ask questions, I will come back with my questions.

Madam Chairman: Yes. Maybe I will ask member Olivierre, and then we go to Dr. Bodoe, and then come back to you.

Ms. Olivierre: Thank you very much. If we can go back to the waiting list initiative, in your earlier response you indicated that you periodically do a waiting list run, could you just elaborate on what that entails?

Mr. Seetaram: So in essence what we do is that we engage doctors

to do special runs. Late last year we engaged doctors to do an orthopaedic run at the Eric Williams Medical Sciences Complex and we are were able to achieve well over 50 patients over a weekend. So by engaging special runs such as these—and the Ministry has undertaken to do a cataract initiative, we have done it in Port of Spain, we are doing it in San Fernando—these are special runs that we do on weekends, and it is the same doctors that work in the public sector, and it brings the waiting time down.

Ms. Olivierre: Well, naturally, my follow-up question would be, I mean, is this something that can be done, say more frequently then so that you could eliminate the large backlog that go into a waiting list?

Mr. Seetaram: Coming out of the success of the recent runs is something that we are definitely looking at.

Ms. Olivierre: And if you can clarify, so the waiting list initiative, it only entails CT scans, MRI and cataracts, or are other facilities provided through that waiting list initiative?

Mr. Seetaram: Those are the major facilities that we provide because all the other services we tend to get it done at the public institutions.

Ms. Olivierre: Within a timely—

Mr. Madray: Within a reasonable timeframe. Yes, correct.

Mr. Madray: And we have found that those particular services are likely to have the greatest impact on the citizens.

Ms. Olivierre: Okay. But one of the major concerns of persons assessed in the public health care system naturally is the waiting list, having to wait that extensive period of time, and taken from the example that the Chairman would have drawn on earlier where you would go in and you would get an appointment for a procedure, and the appointment date is a year, hence, should the person really have to wait one year before they can access an accelerated period, or could you simply have a standard of response time that no one should wait more than perhaps three or four months and for a procedure, and then that would trigger the need to do a specialized run for that particular procedure? So it is really a form of

managing the provision of particular services throughout. So, perhaps if there is some automatic way of knowing that once appointment dates start being made for in excess of three or six months into the future, you start capturing that data to see what you can do to accelerate the provision of that service, because that would mean that the service is being requested at a more frequent rate than the facility is able to provide efficiently.

Dr. Partapsingh: Madam Chair, through you, I thank you very much, and your point is noted. I think that is exactly what happens in the system when a patient, or someone, a client interacts with a health care provider and a service is requested. That is the standard by which such a date is given, it is referenced based on a range of factors, their age—primarily the nature of the complaint, the nature of the investigation and the value of the investigation to the treatment or the management plan, and that is the target. The target is to try to have that done in the time frame that would make best sense for the management of the patient. Given that, and now we recognize—superimpose that on the context that we have, we have a situation where NCDs, the burden of NCDs has increased. The number of cases of NCDs have increased. The number of requirements for tests, the number of persons, that has increased, and it has increased dramatically over the last years. We have undergone—our population is also changing. We have undergone at stage four where we are contracted. So the population, being contracted at a lower range of the pyramid, we have more persons who are living longer lives, and with that, increase now of NCDs. So it is really a combination of factors that has allowed the system to now come to a point where—well, to become, where it is burdened. It is overburdened with the number of requests. But systems, plans are in place, and over the years we have managed to increase the supply of those tests. We have managed to do so by the increase of some equipment by services; there are other programmes. It is a work in progress. It is a system that is a reality that is not only limited to our context. It is limited across the world, and especially those countries having undergone that transition where you have moved away from the infectious

disease to the NCDs. It is a reality of the system. But the standards, we do try to maintain those standards. I do not know if that—perhaps that would answer your question. I mean, from the health care providers' perspective, I do know that it is an argument, a discussion that goes on within themselves, you know, what is the best time frame I can give this patient, and at the same time manage the resources that we have, the same time we know that we put in for increased resources.

Madam Chairman: Okay. Dr. Bodoe.

Dr. Bodoe: Thank you, Madam Chair. I wanted to address cardiac disease, but before I go there, PS—it is just a thought that I want to throw out, and it is a concept of machines that sleep from 4.00 p.m. in the evening to 8.00 a.m. the next morning. I know that the current working hours for ultrasound, CT, MRIs, and so on, the standard working hours would be eight to four. I know in some cases it might be extended. Has any consideration been given to utilizing these machines, perhaps adding a shift, say from 4.00 p.m. to 12.00 midnight to utilize these machines and use that as a mechanism to decrease the waiting list? And perhaps you could compare the cost of doing that initiative as opposed to what you would be paying a private provider. Is that something that has been considered? And not only on the weekdays, on Saturdays and Sundays as well, similar to the waiting list initiative you do on a Sunday.

Mr. Madray: You are right, I do know that some of these runs are being done over the weekend. I am not sure whether it is also being done on a shift basis, but it is a good point, and we will take it under consideration.

Dr. Bodoe: Yeah. I know you do not have control over the RHAs directly, but perhaps it is something that could come up in discussion when you all meet.

Mr. Madray: Yes, thank you for the point.

Dr. Bodoe: Thank you. If I could go back to page 8 and look at the adult cardiac programme, and Beesham you mentioned that about $5 million was spent to date this year, and I see 792 patients listed, and maybe I could

engage Dr. Partapsingh as well, just to give us an overview of the burden of cardiac disease, because I know it is one of the issues in Trinidad and Tobago that faces the population. Would you be in a position maybe to tell us in terms of numbers what the figures would be for cardiac disease?

Dr. Partapsingh: So I can start first with the figures and then in any supplements we can add in Mr. Seetaram.

Dr. Bodoe: Sure.

Dr. Partapsingh: When we looked at cardiovascular disease premature deaths, for example in 2000 and 2008 numbers, we see that for males, 30 to 60 year olds and females 30 to 69 year olds. The mortality, the contribution to mortality is 55 per cent of that from ischaemic heart disease for the men and 46 for women. Of the cardiovascular diseases, the ischaemic heart disease is the greatest contributor to premature mortality. Of all causes of mortality, as an expression or burden of disease, the cardiovascular diseases account for 30 per cent in the 30 to 69-year-old males and 28 per cent in the 30 to 69-year-old females. Of the NCD group, of the set of causes of mortality in these two age groups in the two sexes, NCDs account for 58 per cent in the males and 69 per cent in the females.

Dr. Bodoe: If I may—sorry to interrupt you—if we can translate that figure so that the public understands how many men would die per year from cardiac disease and how many women. What the numbers would be?

Dr. Partapsingh: Out of every 10 men within the age group of 30 to 69 years old, about six of them would have died from an NCD; of that six, three out of 10 would have died from a cardiovascular disease; of that three, about 1.5 would have died from ischaemic heart disease.

Dr. Bodoe: So your total numbers annually for Trinidad, roughly?

Dr. Partapsingh: Total numbers for premature deaths for men would have been 2,851, and this would be the 2008 figures. The reason why the figures are quoted there is because the registry data in terms of the death registry—an NCD premature death, 1,656 for men, and for females, 1,723. Total premature deaths and NCDs, 1,197. That is what I have right now for the NCDs. To break that down specifically by number for

cardiovascular disease, I do not have that with me at this point in time.

Dr. Bodoe: Okay. So you are saying that perhaps maybe 1,000 or 2,000 would die from cardiovascular diseases?

Dr. Partapsingh: So, I would say maybe about 800, 900 for NCD for men, and—no, no, about 400—400 for men, cardiovascular disease, and 250, 260, women.

Dr. Bodoe: Right. So we are looking at maybe about 700 people who die from cardiovascular disease per year in Trinidad and Tobago?

Dr. Partapsingh: We have some—sorry, say that again.

Dr. Bodoe: Sorry, you had some up-to-date figures?

Dr. Partapsingh: Yeah, 2015 figures are in the document. Dr. Doon can report to you with more recent 2015 figures.

Dr. Bodoe: I am only asking this because I want to look at the purpose of doing the EPP in terms of cardiac disease, so we need to know what we are addressing here.

Dr. Doon: Well, what you have got is a cardiac disease—2015 is the latest current data—heart disease, 2,673 persons died, a little more in men than women, marginal, which would account for 25 per cent of all deaths in the country. So that is a huge burden. And then from cerebrovascular diseases, which is another subset of cardiovascular disease, is just over 1,000, which accounts for about 10 per cent. So in all 35 per cent of all deaths recorded in the country would have been attributable to cardiovascular diseases.

Dr. Bodoe: Right. So we are looking at about 4,000 persons when you add heart disease and strokes—

Mr. Doon: Yes—3,700.

Dr. Bodoe: Okay. So the question I have then to follow up is that in terms of those patients, can you give us an idea of what procedures are outsourced under this adult cardiac programme? Perhaps you would give us a brief listing.

Mr. Seetaram: With respect to procedures we do, from basic angiograms, we do open heart surgeries, we do PCIs, we do mitral valve

replacements, we do aortic valve replacements—

Dr. Bodoe: What is a PCI? Remember the public is listening, you need to specify.

Dr. Doon: Stent.

Dr. Bodoe: Stenting.

Mr. Seetaram: Stenting, correct. So we do all of the services that are required by the public.

Dr. Bodoe: All right. Can you tell me, what is the current waiting list for these procedures, roughly?

Mr. Seetaram: The waiting list for any emergency procedure is less than a day. For all other patients can vary from five days to two weeks.

Dr. Bodoe: Right. Now you say the waiting list is less than a day, so somebody comes in on a Saturday morning with an emergency, how is that dealt with in terms of accessing the service?

3.30 p.m.

Mr. Seetaram: On a Saturday morning or a Sunday morning should there be an emergency, the Accident and Emergency Department of public health care system kicks in. They immediately inform the Medical Director's Office. They send the documents via email to my email address, and we send the patient off, making the arrangements with the private providers to have it done, even on the same day or the day after.

Dr. Bodoe: So you are saying that arrangement is in place 24/7 for emergencies?

Mr. Seeteram: That arrangement currently exists 24/7.

Dr. Bodoe: And the definition of emergency would be that defined by the doctor who is attending?

Mr. Seetaram: By the cardiologist, correct.

Dr. Bodoe: In terms of the diagnostic procedures like angiograms and so on, which is what you would use to base further treatment, what would be the average waiting time?

Mr. Seetaram: The average wait time for angiograms is between two to three weeks. If it is an emergency angiogram, it happens within probably one to two days.

Dr. Bodoe: Can you tell us whether any of these diagnostic procedures, like angiograms for example, are done within the public health system?

Mr. Seetaram: Within the public health system we do the angiograms, and all our procedures are done at Port of Spain General and Eric Williams Medical Sciences Complex. We have, however, engaged private providers to manage our cath labs there. However, we have started to do our angiograms at Eric Williams using skills, and for the capacity within Eric Williams—in Port of Spain we are now about to start that process.

Dr. Bodoe: So you are saying there is some sort of transfer of technology?

Mr. Seetaram: There is a transfer of technology and skill.

Dr. Bodoe: So they are being trained by the providers using the public facilities?

Mr. Seetaram: Correct.

Dr. Bodoe: Is there any plan to develop this further, for example, to spread to the other areas like San Fernando and so on?

Mr. Seetaram: It is something being looked at, because for example Southwest has gone out for tender for the construction of a cath lab. So the operation of that cath lab will be something that will come out of these training facilities.

Dr. Bodoe: Just before I leave cardiac services, we have heard of the operations of the Couva hospital, and perhaps the new arrangements that are going to be made. Is this one of the services that the Ministry will be looking to purchase from that operator? Are you in a position, perhaps PS, to answer that?

Mr. Madray: I cannot respond to that question at this time. We will know at some point.

Ms. Olivierre: I would like to—

Madam Chairman: On cardiac? What I would do is to open up the conversation. So member Olivierre I will take you back. Sen. Mark, I believe you have some questions to ask.

Mr. Mark: Thank you, Madam Chair. I would like to put this to Dr. Partapsingh. May I ask whether this number of 3,673 given by Dr. Doon, more or less, would you share with us whether with a population of 1.4 million citizens this could be deemed as one of crisis epidemic proportions, given the size of the population, in terms

of cardiovascular diseases? And when we look at international best practice and looking at countries of a similar size to Trinidad and Tobago, how would you describe our situation as it relates to this particular number that you have just provided to this Committee?

Dr. Partapsingh: Madam Chair, through you, member with your permission Dr. Doon actually is our lead for the NCDs, and if you wish he would be better informed to provide you with an answer, and then afterwards I can always supplement.

Dr. Doon: Thank you, Senator. It has long been recognized that we are in the midst of an NCD epidemic in this country. We have been experiencing this transition over a number of years, and we have started working on this particular issue since 2006, and then in 2007 we had the Heads of Governments meeting. So for the whole Caribbean it is a global phenomenon and a Caribbean wide phenomenon, and Trinidad and Tobago is no exception.

The reasons for it are that, as you well know, it is a lifestyle bunch of diseases, and we engage in too much smoking, alcohol abuse, unhealthy diets and not enough exercise. Those are the four main factors which drive all these NCDs we are speaking about: cancer, heart disease, diabetes and hypertension. And they are all co-morbidities. It is one influences the other and exacerbates the other, so they are not acting singularly in any one particular person. They are logarithmic in their effect on the human body.

So you are correct to describe it as we are in epidemic proportion status, and for that they have established an NCD Prevention and Control Plan last year. We published the plan, lodged the plan, and a number of activities we have begun to engage in that, and there are four major priority areas for us, but basically using a strategy and a philosophy of a whole of government, all of society approach. So we recognize in the Ministry of Health that we alone cannot deal with this issue, it is an issue for all of us.

The philosophy also re-emphasizes the importance of health promotion, health maintenance and prevention, rather than treatment. But what we have been talking about here all along are the downstream effects of what started many years ago. The epidemic did not start today, it started many years ago, and it starts in the antenatal period. Dr. Bodoe will know much about that. So that we are addressing concerns in the antenatal period, trying to prevent diabetes from occurring in pregnancy, because when it starts that early, people tend to get diabetes much earlier in the adolescent

years than in the adult years. So we have adopted the life course approach, so at every stage in our development we are going to be directing, and we are directing attention and resources.

One of the major factors in the country today is obesity, and particularly central obesity. I do not mean obesity from Chaguanas and so on, but around the abdomen. So central obesity drives this epidemic. So that is why we have identified that the prevention and control of childhood obesity is really going to make the biggest impact, because the population is already ageing and there you are going to have the bulk of disease. But we want to prevent and break the cycle of this epidemic, and so you have to start at the early childhood stage, and thus we have been directing a lot of the resources recently.

And as you know, recently we had the policy issued by the Government to ban sugar in schools, sugar sweetened beverages, et cetera. We have recently completed a BMI survey to assess the level of obesity in our school children. The results will be with us within the next week or two. So obesity control at this level is of particular importance, and our plan calls for, one, encouraging healthy diets in school and making sure the school environment is supportive for healthy diets, and also to increase activity in schools. Also we have some resources to build green gyms in schools where they do not have open spaces, and encourage the community to get involved in increasing activity and lowering the frequency of unhealthy diets. So that is in a nutshell the broad scope of approach.

Mr. Mark: Dr. Doon, could you advise, apart from the initiative taken to ban certain beverages at the school level: kindergarten, primary, even secondary, could you tell us, is there a policy approach on an education-wide basis that has been effected by the Ministry of Health, in collaboration with the Ministry of Education, to sensitize and to raise awareness and consciousness among the population at the school level, kindergarten, primary school level, secondary school level, so that this crisis could be captured and somewhat controlled in the coming period? What have we done to sensitize the population?

Dr. Doon: We have been working closely with the Ministry of Education in this regard. The health and family life education component of the curriculum in schools would contain elements of such advisories, and improving children skills and

knowledge about the link between improper diets and insufficient exercise and obesity and disease.

Recently we introduced in schools a lifestyle health reader, and that now is going to be embedded throughout all the primary schools, and we are going to be doing one, another reader for the secondary schools. We completed a healthy lifestyle quiz recently, about three months ago, and two schools in south got first prize, utilizing this healthy lifestyle reader.

So you are absolutely spot on there. We have started working with the school children, and our intervention there did not start this year. It started a few years ago. In the secondary school children we have not prepared any readers for them as yet, as specifically as we have done for the younger age group, the elementary school, so that that is coming on stream later on in the year.

We have also been engaging with the Parent Teacher Association, and educating the principals so they are all on board with us. So it is a national integrated effort between the Ministry of Health and the Ministry of Education. They are on board with us and we are on board with them, and we are working very closely.

Mr. Mark: My final question this round. May I ask the cost to the population and to the nation of Trinidad and Tobago, as it relates to the amount of resources in a period of scarcity that would have to be diverted toward this drive that we are all seeking to move towards more healthy lifestyles. But we are fighting against a serious battle; we are up against a wall.

On the one hand sometimes I wonder if ISIS or terrorists were to launch an attack here if they could get rid of close to almost about 3,673 citizens in one year, perishing because of cardiovascular diseases in Trinidad and Tobago. That is worse than, for instance, we having an invasion here. And I am asking the question, Doc: What is it costing Trinidad and Tobago's Treasury, the Consolidated Fund, in terms of foregone revenue that could have been diverted into some other measure in terms of health care advancement? That is what I would like to get clarification on.

Dr. Doon: We commissioned a study last year from the Inter-American Development Bank and they produced these figures for us. They said that they have estimated that the economic burden from diabetes and hypertension amounts to $36.7 billion. For example, the indirect cost for treating hypertension is about 58 per cent of

that $3.2 billion. The indirect cost is what you are talking about, that is productivity losses, and I see where you are coming from.

Actual treatment of the disease was 42 per cent, so it is just under half of $3.2 billion for hypertension. Diabetes' total cost is $3.5 billion annually. Again, it is roughly a little more than half in the productivity losses. So that is the framework in which we are operating. It is really an enormous burden on the Treasury and on the population, apart from the suffering and pain and loss of life, it is a serious economic burden. So we are very mindful of it; that is why we are very aggressive in the Ministry now. So that I do not think any country could sustain that burden for much longer.

Madam Chairman: Thank you, Dr. Doon. Therefore, I just want to ask Dr. Bodoe to just join the conversation at this stage.

Dr. Bodoe: Thank you, Madam Chair. Just to follow up in terms of the economic burden and to look at the issue of renal dialysis. If I could refer you PS to page 9. I am seeing here that we have a figure of 927 for October 2017 to March 2018. I just want to clarify, perhaps Beesham you could clarify. Does that refer to the number of patients or the number of cycles of dialysis? Cam we have some clarification on that?

Mr. Seetaram: This refers to the number of patients.

Dr. Bodoe: Now, in terms of the waiting time for dialysis, can you perhaps explain to us, the Committee and maybe the population, what happens here.

Mr. Madray: So therefore, it would be evident that what this is indicating is that this problem is escalating, because if for all of fiscal 2017, we had 927 cases, already we have had another 927 for this period. So it is an escalating problem. The BMI study for children is not yet out, but we do know that 25 per cent of our children are already obese. So the problem has been growing exponentially over the last 15 years or so, in tandem with the economic development of our country regrettably.

Dr. Bodoe: I noted that you have already spent $12.9 million on dialysis, and you would be presumably having to seek more funding for the rest of the year.

But I wanted to come back to the issue of emergency dialysis, Beesham. Perhaps you could give us an idea of how that is taken care of.

Mr. Seetaram: Once someone presents at the public health care institution and requires to be dialyzed, they are dialyzed. Over the weekend, for example, there was a patient who presented at San Fernando with end stage renal failure with creatinine of

23, I believe it was, and over the night to the next morning they were able to actually put in a temporary fistula and have him dialyzed on Sunday morning. So there are situations where we are able to do it in the public sector and treat with emergency cases.

Patients who require haemodialysis, once it is they go through the public system, they are dialyzed at all of our hospitals. Once the capacity is reached, we then start sending them privately. We are in the process of trying to expand all of our renal wards at our public hospitals to meet this growing demand, but at this point in time patients get access to service both at the public institution and the private sector.

Dr. Bodoe: Can you give us a sense of the capacity of the public sector in terms of the number of dialysis chairs that would be available at each of the major institutions?

Mr. Seetaram: I would have to provide that for you in writing.

Dr. Bodoe: Can you provide that? Can you at this point state which institutions would be providing dialysis?

Mr. Seetaram: Currently we provide dialysis at all of our major hospitals.

Dr. Bodoe: Would that include Sangre Grande as well?

Mr. Seetaram: That includes Sangre Grande as well.

Dr. Bodoe: So we are talking about Port of Spain, Mount Hope, Sangre Grande and San Fernando?

Mr. Seetaram: Yes.

Dr. Bodoe: So we spoke about end stage renal dialysis, and we know that sometimes the treatment for that CMO would be a renal transplant. Do we have any provisions for looking at a renal transplant? I know we have legislation in place for organ transplant and so on. Would you want to expand on that a little bit for the benefit of the public?

Dr. Partapsingh: Many thanks for that question, through you Chair, and many thanks Dr. Bodoe. Actually we were speaking about that just before, and I will direct it to Mr. Jaisingh who would give you the answers.

Mr. Jaisingh: Good afternoon Chair, member as well. Thanks for the question. To date in 2018 we have done six transplants to date. From the inception of the programme to now we have done 174. It is really about an average of 15 per year.

Dr. Bodoe: Over what period of time?

Mr. Jaisingh: Since 2006 to 2018. There is also a provision in the PSIP to

increase the scope of it as well, to look at more diseased type donors. So we are looking at that as well in terms of expanding that scope in the facility of providing equipment training. But the issue has always remained the donors basically.

Dr. Bodoe: What challenges are you facing specifically in terms of that?

Mr. Jaisingh: In terms of the communication strategy. In terms of how they source donors for the programme, and also building capacity within the programme as well to ensure that once you get the donors we have capacity built to ensure transplants take place. So it is really looking at the whole issue of increasing capacity to some extent, in terms of the demand and supply issue.

Dr. Bodoe: Is there any public education system or any system in place to educate, sensitize the public?

Mr. Jaisingh: Just through our website as well, there is probably during the forum on Facebook. But there is also discussion in the Ministry of increasing the capacity as you mentioned under cardiac for renal, in terms of increasing the shift system in our public site facilities as well, because there is a need to actually expand the scope, apart from 8.00 to 4.00, to use those facilities. So these are the discussions right now going on in the Ministry in terms of increasing that capacity in the public system.

Dr. Bodoe: So currently you are not in a position, for example, to do a transplant with a cadaver organ that might become available during the night or something like that?

Mr. Jaisingh: There is capacity in terms of that, but the assessment and also the referral side of it and the approval probably that should take about a couple of days. But again, I do not know CMO in terms of your knowledge of the timing of the transplant—I do not know if you know.

Dr. Partapsingh: I would not have that specific information at this point in time.

Dr. Bodoe: All right. I just wanted to ask with regard—now I know there were plans in place to build two renal dialysis centres, one in Mount Hope, one in San Fernando. Can you provide us with an update PS as to what is the status of these two proposed centres?

Mr. Madray: Sorry, I cannot comment on that because it is now a legal matter, so that is as much as I can say with respect to that.

Dr. Bodoe: Both centres are tied up in a legal matter?

Mr. Madray: Yes.

Dr. Bodoe: You are saying that both centres are tied up?

Mr. Madray: Yes, I am.

Dr. Bodoe: Fair enough. So there was one more issue and this is with regard to the providers that have been selected for renal dialysis, for outsourcing. PS you mentioned that the barriers to entry are low, and I am a little bit concerned about that because I know that some of the patients develop complications. So the question I want to ask is, first of all, whether there is something like a complication register that is kept at the Ministry and, of course, that would be populated. The data would come from the—if I understand it, after dialysis is done by outsourcing by a provider, the patient comes back to the hospital where they are dealt with by the in-house doctors. So do you have a system in place where any complications that occur as a result of outsourcing—I am not talking about in-house—are registered, and does that come to your attention?

Mr. Madray: Mr. Seetaram?

Mr. Seetaram: All complaints are sent to us and they are investigated. And you are correct, Member, the patients are seen at the public institutions and once there are any complications it is brought to our attention. What we try to do is manage quality. We have over the last few years tried to enhance and improve on all of our quality service delivery. So we actually engage in doing ad hoc site visits. We do planned site visits. We call patients randomly. We visit patients at the public hospitals as well as the private centers to try to get an understanding of exactly the quality of care that is being provided. All of our nephrologists within the public sector do report back to us and tell us exactly what their findings are. Should there be any sort of concern, it is escalated to us and it is dealt with.

Dr. Bodoe: So you are saying that there is a mechanism in place for the doctors in the hospital to report these complications directly to the Ministry?

Mr. Seetaram: Yes, there is.

Dr. Bodoe: So based on that, do you do an assessment—because you have several providers I noticed—quite a number of providers for a small country like ours, but I will not comment further on that—but in terms of identifying, are you able then to identify whether there might be shortcomings with particular providers? Do you do an

analysis at the end of maybe a six-month period or a nine-month period or even a three-month period, because waiting six months or nine months might be too long—if one provider is having unacceptable complications rates?

Mr. Seetaram: What we do is we actually do quality assessments of all of our providers within three to four months throughout the year. We include members of the RHA, members of our quality team, the nephrologist or a senior medical doctor, a dialysis nurse, as well as our county medical officers of health. What we try to employ is the same principles that apply for a private hospital, so that the quality of care is of that standard.

Dr. Bodoe: So the standard that you use to engage the providers, are they international standards in terms of renal dialysis? Could you tell us?

Mr. Seetaram: Yes, they are. We actually provide a standard operating tool for haemodialysis to all providers. Whether they provide to the Ministry of Health or they provide independently of the Ministry of Health, we provide the standards too that is provided. It is also available on the Ministry of Health's website.

Dr. Bodoe: On page 24 of your submission, you speak of the inspection teams. I may have missed it but did you mention what these teams comprise, who are the members of the team, and what they would look for when they do their inspection?

Mr. Seetaram: The teams actually include a nurse and a doctor within the specialist field. In this case, in renal dialysis, we ask for a nephrologist or a senior medical officer. We ask for a member of the quality team of the RHA, a biomedical technician from the RHA, a county medical officer of health. The team is in essence a membership of five to seven. They look at, not only the patient care, but they look at all logs, utilization, the machines. They try to encapsulate the entire process from beginning to end and then report back.

Dr. Bodoe: And these inspections are done how often?

Mr. Seetaram: The inspections are done mandatorily every year, and we try to do it at least two or three times apart from the mandatory time period.

Dr. Bodoe: And you spoke about the equipment being certified yearly. Who does the certification? Can you define what is meant by certified? Who does it? How is it done?

Dr. Partapsingh: I think the equipment that they would be using would be the

standard. The equipment that they would using would have to have met certain standards, and it is from that perspective, that is one of the elements of the standards that are applied and the certification that apply with the equipment. Those standards are set by the discipline. For example, if we do not have our own standards, we would adopt an international reference agency standard. So that is how they are benchmarked or they are reviewed based on those standards.

In terms of the maintenance of the equipment and making sure that they are calibrated, for example, that is the responsibility in-house of the facility, but when the team goes out that is what is inspected, to make sure that they would have complied with making sure that calibration would have happened and certification, if necessary.

Dr. Bodoe: I just wanted to let us look at the list on page 25 and 26. Two questions there. One, I noticed that St. Clair Medical Centre would have withdrawn their service in December 2017. Can you indicate the reason for that?

Mr. Seetaram: St. Clair Medical Centre would have withdrawn their services because of delayed payment for services rendered.

Dr. Bodoe: There was not any issue with standards and so on?

Mr. Seetaram: No.

Dr. Bodoe: So can you then give the public the assurance that the remaining 17 centres that provide dialysis to patients in Trinidad and Tobago meet all the standards as required by the Ministry, and meet international standards?

Mr. Seetaram: We continue to do checks. Actually, at this point in time we are going ahead and doing checks on all of our centres as well.

Madam Chairman: Might I just ask, when last was equipment checked for calibration?

Mr. Seetaram: All centres were checked at the beginning of January this year, between January and the end of February this year.

Madam Chairman: Were any found to be defective under the standard in default?

Mr. Seetaram: No.

Dr. Bodoe: So can I then have a straight answer to the question I asked before, as to whether you can give the public the assurance that all of these 17 providers meet their requirements?

Mr. Seetaram: Based on checks performed over the last couple of months, yes, and as we continue we will try to improve on the quality of care.

Dr. Bodoe: Thank you.

Madam Chairman: So, how many have been checked?

Mr. Seetaram: All have been checked.

Madam Chairman: No, you said up to January and you say you are currently in the process now. How many in this current cycle have you checked, of the 17?

Mr. Seetaram: Well, all 17 are being checked at the same time.

4.00 p.m.

Madam Chairman: Oh, so you have not completed the checks?

Mr. Seetaram: No.

Madam Chairman: So you could say as of January 2018, all have been compliant?

Mr. Seetaram: Yes. That is correct.

Madam Chairman: Okay. Member Raffoul.

Ms. Raffoul: Thank you. I really appreciated the information about NCDs and the cost thereof to the economy of Trinidad and Tobago and, of course, the quality of life and well-being. I am curious to learn more about the preventative methods that are being looked at. I do expect that that might be outside of the scope of this particular unit of the Ministry, but I am curious to hear the PS's perspective on what other programmes are being done by other units in the Ministry.

Mr. Madray: Again, I am going to point you back to Dr. Doon particularly with respect to the NCDs. But what we have done is that we have engaged on a project with the IDB which is a US $51 million project that is going to be focused over the next, well it is now about, the next four years on primary health care, but specifically within that, the control of the NCDs, and much of that is going to have to do with bringing about a culture change within our nation. Some of it, of course, will be determining the measures, doing benchmarks and baseline studies.

And Dr. Doon mentioned already that one of those studies will be a BMI study of the population, but there will be other studies and a range of projects will be devised over the period to bring that problem under control. It is really a black hole. The more

money you pour into it, the more money you need to pour into it if you try to deal with it at the end stage. So we have to try to get at it at the early stages, our children, teenagers and prevent the development of inappropriate behaviours and eating habits in particular at that age. But perhaps you would like to speak a little bit more about the projects.

Mr. Doon: Well, there are four broad priority areas that we have identified. One is risk factor reduction, and that is in its broadest scope at every level, and for all members of the population from childhood straight onwards to adult life.

As you know the risk factors for NCDs are very common, so when, if you could really reduce the frequency and prevalence of risk factors in the population, you are going to be able to reduce the prevalence of a bunch of diseases, namely cancer, hypertension, diabetes, heart disease. As I would like to call it and say, describe it, since we have bad eating habits and smoking and drinking, to me, NCDs are hand-to-mouth disease. So if you could control that access we will make a big impact.

And so behaviour change, as you know, is one of the mechanisms that we are working through, so we are going to be engaging shortly a firm to help us with social marketing, because we realize that the business community could market their products, these foods that, you know, we wish not to be consuming in the frequency and volumes that we use these unhealthy foods.

So the Ministry does not have the resources right now to go into a national social marketing campaign. So, we are addressing that, we are utilizing the settings approach, for example, the school setting, for example, the health centre being a healthy focus, community setting. So that is a broad thing for risk factor reduction.

The other major priority area with a number of activities would be surveillance and research, so the PS spoke about that, it is establishing a risk factor in the population, the prevalence of risk factors in the population in general. So that is for the adult population, we just finished in the school population. And for the adult population 18 years to 65, that will be conducted next year.

But judging from our previous studies and the risk factors in the population, we have observed—take, for example, over-weight or obesity. It is in the region of about 55.7 per cent in the general population, and it is more prevalent in women than men. Activity—inactivity is more prevalent in women than in men, but of course, smoking

and alcohol is more prevalent in the males than the females. So that is what we intend to track.

This study was done about 10 years ago, so we are going to track next year what is the prevalence of risk factors in the population. So, we will get an idea whether the interventions that we are making are working, how effective they have been over time. So that is one of the most important measures any country must work with.

The other main area in the research and the surveillance component is to establish registries for diabetes, you know, you could get data every year on time on how many heart attacks every year, how many strokes every year as it happens. That is not yet available because of the inability to establish electronic medical records in the country. So we have to do it the hard way by counting, using the paper base and manual data sets. So data is always going to be a few years late because of the environment in which we work in. So that is a major component.

The other major component is advocacy and policy. So we are creating policies. Obviously you are going to want to go into legislation and the no-smoking legislation, but you have a whole host of other legislation and policy instruments which need to be established. So we are working on that.

And then the fourth, yeah, [*Inaudible*] and the fourth major priority area is the health sector response. How do we improve what we do in the health sector? How do we deliver the service? And as Dr. Bodoe has been talking about with the failure to communicate. One of the side effects of the health sector reform has been, and it is not only in Trinidad, but throughout the Latin American and Caribbean region which is a PAHO conducted study, they have found out that fragmentation arose because of the decentralization and the unexpected and unanticipated side effects, bad side effects, as you see which has happened here, it has happened in every other country that engages in health sector reform. So those are the four main priority areas and a bunch of activities.

And as I mentioned before, it is a whole of Government, whole of society, so we are building partnerships with the private sector, building partnerships with the non-governmental organizations, and we do have a national NCD alliance formulated in Trinidad established last year which the Ministry started and engaged with them and now they are on their own. So it is all of us in this thing together—

Madam Chairman: Yeah. Thank you, Dr. Doon.

Mr. Doon:—parents, communities and individuals.

Madam Chairman: Dr. Doon, I do not really want to cut you, but I think what you have really presented us with is also some assurance that there are some risks reduction being looked at, because I think the point was made by the PS, that it is always good to take money and therefore, the more you put in front, the less you will have to at the end, and I think the initiatives you have spoken of suggest that that is well in tandem.

But having regard to our limited time, we could spend the whole day and believe me, I am sure that there are other questions that we are going to put to you even if not today, but in writing, but to give the other members— hear from the other aspects of the special health care, and opportunity to speak, I just really wanted to stare us in another direction. And, member Raffoul, I will come back to you. Might I just invite member Olivierre to join the discussion.

Ms. Olivierre: Thank you very much. In your response on the administration of the special health care programmes, particularly the adult cardiac disease and the renal dialysis programmes, you indicated that if a patient requires interventions that are beyond the capacity of the public hospital or the hospital cannot accommodate the volume of patients, you would engage a public/private partnership, but you would require the patient being assessed by a medical social worker. So my question is: Who engages the medical social workers? Is it the RHAs or the Ministry of Health? And do you have adequate medical social workers on staff?

Mr. Seetaram: To answer the second question first, yes, we do have an adequate number of medical social workers, and the doctors refer the patients to the medical social workers. They are actually located at all our four major hospitals. So the patients do not have to go very far to be assessed.

Ms. Olivierre: Okay. Who engages them, the RHA or the Ministry?

Mr. Seetaram: The RHA.

Ms. Olivierre: Now, as an elected member I do have constituents and a number of them would have engaged me because they have been made to wait an inordinately long time to get services by the hospital. And there are a number of cases, I mean, they are waiting for a review by the medical social worker, and from my understanding they

would tell me that the person comes once a month to the hospital.

So in a number of cases—I had a case of a young child maybe about seven years old who required surgery on his eye because there was silicone oil in his eye, and that case went on for about a year and a half before he was able to get the surgery, and the child, well practically went blind in that eye, had to miss school, the child's behaviour started deteriorating because of the lengthy time just to get that simple surgery, and in that year and a half the condition escalated, I mean, significantly. So the child finally, through the intervention of the Chairman of the South-West Regional Health Authority, I was able to get that done finally.

But the issue with the medical social worker was cited in that case, and it had another case of an adult male requiring some heart intervention over a year and a half now and that case still has not be addressed. And again, the medical social workers having to assess the patient and that person only being coming to the hospital once per month, so this is why I had to ask: Do you really have adequate medical social workers? These two cases would have been with the South-West Regional Health Authority and the San Fernando General Hospital.

Mr. Seetaram: Well, if I can answer the—well, the issue with the South-West Regional Health Authority, at the San Fernando General Hospital there are social workers there on a full-time basis. However, in Point Fortin they have medical social workers who go part time. That issue is being looked and being addressed to ensure that does not happen again.

Ms. Olivierre: Well, just for clarity, these two cases were at San Fernando not at Point Fortin. But the other question I would like to ask, well on the HIV/AIDS programme—can we move on to that now? If I may ask you about the administration of the HIV/AIDS programme: Who is responsible for education from a standpoint of prevention?

Mr. Antoine: The Ministry of Health through HACU is responsible for providing education information to the population.

Ms. Olivierre: Do you have any active programmes ongoing to enlighten the programme from an HIV/AIDS prevention standpoint?

Mr. Antoine: Yes. We have a number of programmes that are ongoing, and we also collaborate with the NACC as well, that is the National AIDS Coordinating

Committee with respect to our prevention programmes. We also work in conjunction with the sexual and reproductive health clinics on that particular programme with part of our—we collaborate with them as part of our prevention initiative.

Ms. Olivierre: All right. In terms your outreach initiatives what types of target markets do you have? Do you have a programme that targets like schools in particular? Or how do you decide when and where to launch your initiatives? Well the reason that I am asking is because, I am not aware of any large amount of HIV/AIDS prevention programmes in recent times. And HIV/AIDS is something that it is a latent epidemic in certain parts of the country, but it is something that is not spoken about, it is not in the public domain, and I am really not aware that there is any active prevention programme that it is currently undergoing. So in particular, I mean, are you targeting perhaps the schools or any other segments of the population for an education campaign?

Mr. Antoine: We do target, we have some programmes that are going on, not necessarily well at the level of the primary schools and secondary schools, no, but at the level of the tertiary institutions we would have some prevention programmes there. We would have community-based programmes, we would have at institutions such as the prisons, for instance, and we also have particular days like World AIDS Day, Caribbean testing day when we would heighten our programme to the general public.

Ms. Olivierre: So if an NGO or some organization would like to have a specific programme run, I mean, can we contact you to arrange something?

Mr. Antoine: You certainly can, and our function would be to, again, work in collaboration with NGOs as well that provide prevention initiatives.

Ms. Olivierre: All right. Thank you very much.

Madam Chairman: Member Mark.

Mr. Mark: Thank you, Madam Chair. Permanent Secretary Madray, in your submission you were told that there was this private/public partnership arrangement for joint replacement, cancer care services and even cataract surgery. Would you like to share with this Committee the state of the private service providers? In other words, who are these private service providers and what services do they actually provide given the three areas that you have outlined?—joint replacement, cancer care services and cataract surgery.

Mr. Madray: I can respond to our external radiation which is our cancer care

treatment. We utilize two service providers, the Brian Lara Cancer Treatment Centre and the Southern Medical Clinic. These are the only two private facilities in the country that can provide radiation therapy. With respect to the joint replacements and, what was the other?

Mr. Mark: The cataract surgery.

Mr. Madray: Perhaps you can respond, Mr. Seetaram.

Mr. Seetaram: With respect to the joint replacement, cataract surgery we actually do have several providers which I am willing to share with you in writing because there are several and they are spread across Trinidad.

Mr. Mark: All right. I am happy that you can provide us in writing. But may I bring to your attention that we had recent reports which were confirmed by the Chairman of the North-West Regional Health Authority in which there was an allegation, maybe you can confirm it, to the effect that an investigation was launched into what has been described as the mismatch between parts as it relates to joint replacement that caused some state of alarm. Could you provide this Committee with an update on this development?

Dr. Partapsingh: Madam Chair, through you, thank you very much for the question, member. The NWRHA is currently assembling the report, the final report on that matter, and we are awaiting the final report. However, what we would like to report to the Committee is that they have actually taken steps to strengthen their process or the procedures along the lines of how do you go about identifying suppliers and equipment. So for example, all suppliers for these particular equipment, they were asked to provide verification of the quality standards of their devices and to ensure that those standards would meet those of a recognized international body, for example, the FDA or one of equal standing. So that is one of the measures, and based on that now you can be assured of the standard of the devices that will be coming in by the suppliers.

They are also adopting an approach whereby the expression of interest that is also regulated, in a sense, they are an anonymity in terms of the NWRHA practitioners becoming involved in that process. And then they are engaging in a process to ensure declaration of conflicts of interest with the providers and suppliers, the practitioners and suppliers. So those are measures that will definitely strengthen the process to ensure the quality of the devices that are used in such procedures, but the report is currently

still being prepared.

Mr. Madray: More generally, the Ministry is engaged in a process, generally speaking, of strengthening the procurement process not just within the Ministry, but also the NWRHAs. So bringing practitioners together we are hoping, well, it will enhance that process.

Mr. Mark: Yeah. Would you want to also share with this Committee what would have been the situation involving, let us say, patients who may have undergone surgical procedures in the recent past, given that experience that we had at the North-West Regional Health Authority? And what mechanisms have you put in place to monitor those patients who might have been victims of mismatched parts? Let us assume that that were to take place. How are we monitoring to ensure that lives are not at risk?

Dr. Partapsingh: So they are. One of the measures which I forgot to mention is that they are actually doing that, they are reviewing those patients within a particular period of time—I do not have that particular period of time with me—who would have undergone procedures, and so following up to see whether there were any effects or complications with those procedures. So that is something that is ongoing right now, and the report and the assembly of that information I do not have right now to share, but it is a process that is being engaged in.

Mr. Mark: And could you indicate to us, what is the current state of hip surgeries? Have they been stopped since this exposé or have they continued? And what safeguards have we put in place to ensure that that incident that took place would never reoccur?—pending your report that is.

Dr. Partapsingh: Yeah. I would rather that we would provide that to you in writing to get the most recent information from the NWRHA, so you can get a specific answer to those questions.

Mr. Mark: May I, Madam Chair, as I am on this matter, may I just ask my colleagues here if they can share with us this whole matter of AIDS that was raised by my friend? Could you, there is an NGO that we need to get some clarification on. First of all, why is the Medical Research Foundation of Trinidad and Tobago not listed as one of the non-profit organizations in the budget documents? Why that body is not listed? And could you tell us at the same time, under what Sub-Item is the subvention

to this organization covered?—in terms of this AIDS programme, AIDS/HIV. Who can help us with that?

Mr. Madray: I am sorry. I am going to try to address the first question. I know, well I do not have the budget documents in front of me, but I do know that there is a section which the NGOs are listed that are receiving funding from PSIP under recurrent expenditure. So all the NGOs are there, but sorry, I cannot explain.

Mr. Mark: All right. Well, you can always—well, could you tell us, Mr. PS, what is the subvention that this organization would have received or is receiving in fiscal 2018? You should have that with you.

Mr. Madray: Mr. Jaisingh will respond with the precise figures.

Mr. Jaisingh: Thank you, member, for the question. Just to answer your initial question. Under special programme HIV, under PSIP, MRFTT was actually an item there, but what we tried do over the last two years with the Ministry of Finance was that—we locate MRFTT under non-profit organizations generally under recurrent expenditure, so to shift it during fiscal year 2018 from PSIP to Recurrent Expenditure.

The second question in terms of the amount of funding annually, it is $5.9 million per year. It is a three-year subvention basically that we initially got, and it is arranged through an MOU with the Ministry of Health and MRFTT through Cabinet approval, of course, and we recently got approval from Cabinet with all NGOs including MRFTT from 2017 to 2020.

Mr. Mark: And, Mr. PS, how does the Ministry go about monitoring the expenditure released to this organization and by extension, how is the accounting oversight role of the Permanent Secretary executed as it relates to subventions granted to non-governmental organizations?

Mr. Madray: With respect to MRFTT, as well as other NGOs there are memoranda of understanding that are signed with NGOs in which the services to be provided are laid out, and the amounts to be provided by the Ministry are also laid out. There are reporting requirements in each of those MOUs, the specifics of which can be further detailed by Mr. Jaisingh who is the director responsible for that particular function of monitoring.

Mr. Mark: Maybe you can provide us with just one or two of the specifics, and could you submit to the Chairman a copy of the MOU that you mentioned that govern

not only the MRTT, I think, MRFTT, as well as other NGOs? Okay?

Mr. Madray: Sure.

Mr. Mark: I do not know if it is one common MOU—

Mr. Madray: It is.

Mr. Mark:—or if you have separate MOUs with separate criteria for all of the NGOs along with the one that you originally mentioned?

Mr. Madray: It will be a general template, but there will be specific requirements for each of them.

Mr. Mark: Well, could you provide them to the Chairman—

Mr. Madray: Sure.

Mr. Mark:—on behalf of our Committee? And maybe our colleague could just give us one or two specifics ingredients contained in the MOU?

Mr. Madray: Sure.

Mr. Mark: Just one or two.

Mr. Madray: Sure. Mr. Jaisingh.

Mr. Jaisingh: Thank you, member. In terms of the MOU, the obligations side of it, quarterly assessments are being done on each NGO itself to an assessment team chaired by the CMO, and also there are reporting obligations and in the MOU there are specific criteria. If there is non-reporting of reports, we withhold the subvention until we get the actual reports. So that is one.

And we are not assessing not the financial side of it, but also the operational and management and HR capacity to deliver the service as well. So we have broadened the criteria not only from a financial, but non-financial area as well. And also, there are obligations in terms of the actual assessment of the service as well, and that is mainly the obligations from the NGO side in terms of meeting our criteria for assessment.

Mr. Mark: Thank you, Madam Chair.

Madam Chairman: Okay. Member Raffoul.

Ms. Raffoul: Thank you, Chair. I had a follow-up question about the prevention programmes. There is a financial instrument called Health Impact Bonds. They are like PPPs, public/private partnerships, but specifically health oriented, and I would just recommend that the Ministry looks into them. They are relatively new, they have only been around for a few years, but having really significant positive impact

internationally where they are being implemented. So there is a mechanism for cooperation between public sector and private sector that really defines targets beforehand, and it is all about results and achievement to the population.

Mr. Madray: Thank you for the suggestion and we will take it on board.

Madam Chairman: Thank you. Member Bodoe.

Dr. Bodoe: Thank you, Madam Chair. PS, just a quick follow up on the HIV treatment. In terms of the funding, I understand that there is an organization called PEPFAR that we get some funding from in Trinidad and Tobago. Can we have an update as to what is the status of that relationship? Maybe you can explain for the benefit of the public the entity that is involved and the funding that comes from that source.

Mr. Madray: Maybe the Chief Medical Officer will respond to that question.

Mr. Jaisingh: Through you, Madam Chair, currently we have entered into another agreement. We previously entered an agreement in 2010, and that ended in 2017, and so we are into a 2017—2022 agreement. We have engaged in the first two years of that agreement, 2017—2019. Fiscal year 2017/2018, we have managed to, the funding that was received for that was US $275,000. What is projected for fiscal year 2018/2019 is US $205,000. So first I will deal with 2017/2018. 2017/2018, we are still in that fiscal year. We have managed—there are three elements of it: there is a prevention work plan, a strategic information work plan and a laboratory work plan, and there is a set of activities under each of these work plans.

The prevention work plan activities are engaged in through the MRFTT, and that sum was US $125,000, and that sum was sent across to MRFTT. And Dr. Edwards can speak to specifics as to what those activities involved. And it comes back to member Olivierre's question about education and the focus and the focus to retain to over-testing and to retain patients within care, and the numbers that member Raffoul also spoke to. So, Dr. Edwards may shed some light on that.

The strategic information work plan and the laboratory component work plan they involve the recruitment of viral load coordinators, surveillance nurse, M&E officers, and that is a process, two of which have actually been directly engaged in. The M&E officers they are scheduled to come into being, the interviews are next, I think, 22nd May.

4.30 p.m.

Dr. Partapsingh: But that process is a transparent process. It is a process that includes the CDC, because the CDC is the donor through which we receive the funds, and so they are engaged in that process. It is a transparent process, as I said. Those bodies are to engage in doing laboratory strengthening, for example, and there are a range of activities under laboratory strengthening. In terms of surveillance, there is the surveillance capacity for HIV/AIDS case-base surveillance, a particular approach to surveillance for HIV, and the entire info to data surrounding, because some of the numbers that you saw in that table, 82,000 or so, if you look at the title, I think the title spoke to health care utilization. And one of the challenges that we have is the representation; there are is number of, for example, tests performed. One person may have multiple tests. So, harmonizing and trying to identify how many unique persons were tested as opposed to number of tests conducted. So, that is what the 2017/2018 work plan is about. The 2018/2019 work plan, the CDC Caribbean regional office came down to Trinidad and we had a joint meeting with the HIV/AIDS coordinating unit team and the CDC regional team, and we agreed on what would have been the activities under the 2018/2019 work plan.

Dr. Bodoe: Sorry, Doctor, perhaps maybe you could provide that in writing for us?

Dr. Partapsingh: Yeah, we can. We can share those for you.

Dr. Bodoe: I thank you for that. But just to clarify, this is a grant?

Dr. Partapsingh: Yes.

Dr. Bodoe: It is from the Centre for Disease Control? It is from the US?

Dr. Partapsingh: Originally it is from the PEPFAR fund and it is managed through the Centre for Disease Control.

Dr. Bodoe: Right. So, in terms of the disbursement and the monitoring of the disbursement of the fund, does that come under you, PS? In other words, how are those funds accounted for, and monitored, and disbursed?

Mr. Madray: Just noting that because of this arrangement with the US Government there is a particular interest in ensuring that the goals that are being laid out, which we share, are in fact achieved. The unit that is managing the arrangement

with MRFTT, or the units are both between policy, but primarily they are HACU division. So, the HACU will be monitoring whether those funds are being utilized and the results that we need to achieve in terms of—generally the goals are our 1990 goals.

Dr. Bodoe: And that would lead me to my next question, which would be: What is the relationship between the HACU, as you call it, and the National AIDS Co-ordinating Committee?

Mr. Madray: Can I ask Dr. Antoine if he can elaborate on how operationally those arrangements occur?

Dr. Antoine: Thank you. The National AIDS Co-ordinating Committee really coordinates a number of our multiple stakeholders in the national age response, of which the—

Dr. Bodoe: That is the unit that would have been moved from the Ministry of Health to the Office of the Prime Minister?

Dr. Antoine: To the Office of the Prime Minister. Of course, the HACU is one of those stakeholders that is responsible for the health response or the medical response.

Dr. Bodoe: And that has been working fine?

Dr. Antoine: You mean in terms of the relationship?

Dr. Bodoe: Yes, in terms of the relationship?

Dr. Antoine: Yes. Well it is a well-defined relationship that we have. HACU is responsible for that multi-sectoral response, and the Ministry of Health, through HACU, is in fact one of the stakeholders in that response.

Mr. Madray: I would just like to ask Dr. Partapsingh if he could add to that response, please.

Dr. Bodoe: Sure.

Dr. Partapsingh: So, to attend to the accounting, with regard to the accounting matter, there is an officer within the HIV/AIDS Coordinating Unit, HACU, who is dedicated to managing and doing the accounting. The relationship between MRFTT, HACU and CDC is an intimate one, that we meet regularly virtually, and in there, there are budget requirements, there are financial reports that need to be submitted every quarter. They are reviewed by myself and the PS. So, they are accounting, and the measures that are put in place to make sure that funds are used for what they are used—what they were targeted for, are there. The relationship with NACC and HACU—

HIV/AIDS, I mean, you know Dr. Bodoe, it is such a multi-sectoral, multi-disciplinary approach, and I think it is one of those that has historically been able to be assembled in Trinidad and Tobago. And I do not think any inactivity happens or takes place without interaction from NACC and HACU, whether it be by way, one initiating and the other following, or collaborating at the same time. But the relationship is an ongoing one. It is an evolving one, and it is one that is present.

Dr. Bodoe: Sure. Can you, CMO, give us an indication of perhaps the number of patients who are currently confirmed with HIV/AIDS in Trinidad and Tobago?

Dr. Partapsingh: Sir, I would defer to Dr. Edwards and Dr. Antoine. They can give you that. Just to note that, the MRFTT is the largest treatment site. We have treatment sites, there is one in San Fernando, Port of Spain, and MRFTT, and then there is a treatment site in Tobago. There are other testing sites which are larger in number. And the reason why MRFTT has been recognized is because of the success that we have been able to model. It is a model of care, and there are reasons why persons living with HIV come to the facilities. So, I would pass you over to Dr. Antoine and Dr. Edwards.

Dr. Antoine: Okay, so the Medical Research Foundation was founded by Prof. Bartholomew in 1997, and in 2002 the Government of Trinidad and Tobago commissioned the MRFTT to become the first HIV/AIDS site. Now, you know HIV/AIDS now is a chronic disease, so people live a fairly normal life. So, if you have HIV now your life expectancy is almost normal. And, the anti-retroviral drugs, the medication that we give what it does it suppresses the virus, and when the virus is suppressed you do not transmit. So, UN/AIDS has its goal of 90-90-90, whereby 90 per cent of persons should know their status, 90 per cent of those persons should be on medication, anti-retroviral therapy, and 90 per cent of those persons should have their viral load suppressed. And they expect if that has occurred, they could eliminate HIV/AIDS by 2030. So, HIV/AIDS, things have changed dramatically, and for the public HIV/AIDS is no longer a death sentence, you can live a normal life. And, at the Medical Research Foundation, what Dr. Partapsingh was talking about, we have extended hours at the clinic. We normally had clinic hours between 7.00 and 4.00, but we realized that a lot of people were not accessing therapy, so working in collaboration with the CDC we have extended the hours now to 7.00 p.m. so that people who are

working can come and access it. Because it is most important for people to take their medication to suppress the viral load so that they do not transmit.

Dr. Bodoe: That is good news, but any idea of the numbers?

Dr. Antoine: Total enrolled in HIV care at the end of December 2017 was 8,530 persons, and number of children and adults currently receiving ARVs was 6,693, of which 746 were newly enrolled by December.

Dr. Bodoe: If we were to go back 10 years, and I know you may not have the figures there, or perhaps you might in terms of where we have come from perhaps 10 years ago, can you give us some sense of that from a statistical point?

Dr. Antoine: We would have seen—well, in the early days, 10 years or prior to that, we would not have treated all positive cases. There were certain benchmarks, the CDC accounts had defined whether someone should be placed on treatment or not. I would say from 2016/2017 we have embarked upon a treat-all, so that you would have gradually seen a rise in numbers of persons who were being treated, and of course you also may have seen a rise in the number of persons enrolled in HIV care.

Dr. Bodoe: I just wanted to address the issue.

Dr. Antoine: I just wanted to clarify the 82,000. The 82,000 may not have been a typo, but I did not quite grasp the point that you were trying to make, and it would represent the total number enrolled in care plus those persons who have used our testing services.

Dr. Bodoe: If I may, just one more question with regard to—sorry.

Dr. Antoine: Which the point has already been made that our testing service, the numbers for testing are roughly 75,000. Of course, it does not represent persons but tests, and we are working currently to have a system where we are attempting to de-duplicate so that we can reduce tests to number of persons tested.

Madam Chairman: I know Dr. Bodoe has a number of questions, I just want to—member Antoine has been waiting for some time, do you still have the question to ask?

Brig. Gen. Antoine: Oh yes. [*Laughter*]

Madam Chairman: So, I will allow you in and then take member Olivierre. Member Antoine.

Brig. Gen. Antoine: In terms of cataract surgery I saw in fiscal 2017 you had

361 surgeries, but in fiscal 2018 you only had 91. Is there any reason for this drastic reduction?

Dr. Edwards: These were the numbers that would have been sent to private institutions, so the reduction is based on the fact that we are now ramping up our service. It is out of public institutions. So, as we increase our public capacity and our ability to provide the services in the public sector, the numbers would go down.

Brig. Gen. Antoine: So, these figures are for the private institutions?

Dr. Edwards: Private, correct.

Brig. Gen. Antoine: All right. In terms of eye glasses, in fiscal 2017 you had 632; 2018, 300 applications received pending approval. What is the reason for this pending approval for the eye glasses?

Dr. Edwards: The pending approval would be in the availability of funding. So, we have already requested funding to have these glasses purchased. Once we receive it, the process is less than five days for your glasses dispensed.

Brig. Gen. Antoine: So, the money is available now?

Dr. Edwards: We are sourcing money right now.

Brig. Gen. Antoine: Going back to the HIV, is there a reduction in the cases of HIV in Trinidad and Tobago? Because I saw recently they said that how—

Dr. Antoine: Newly diagnosed cases?

Brig. Gen. Antoine: Newly diagnosed cases.

Dr. Antoine: Yes. The trend has been towards a reduction in the number of newly diagnosed cases over the last 10 years.

Brig. Gen. Antoine: Because I read somewhere or heard on the news that it seems that men over 60 and young females seems to be a high incidence of HIV in Trinidad and Tobago. Is that factual?

Dr. Antoine: Yes, that is also correct, in terms of the age distribution of the number of cases as opposed to the number of newly diagnosed cases. So, in terms of the trends, there are trends towards a reduction in the number of newly diagnosed cases. That probably tells us that our prevention efforts are probably working very well. And in terms of the age distribution, we are seeing some significant numbers within that age group that you mentioned, 50 plus age group.

Dr. Antoine: Because people are living longer, so the age—

Brig. Gen. Antoine: Oh, that is what they tell you?

Dr. Antoine: Yeah.

Brig. Gen. Antoine: People living longer.

Dr. Antoine: Longer, so they are ageing with the HIV. Yes.

Brig. Gen. Antoine: Another question, a school mate of mine recently came to see me because his daughter is a graduate medical officer who has difficulty in finding employment. There is an article by the Minister, it says that part of the problem is in terms of location with the young graduates not wanting assignment in rural areas, as the case may be. What is the problem in terms of employment for young medical graduates in Trinidad and Tobago after they finish their internship?

Madam Chairman: Member, would this be in terms of maybe the programme? Because, remember our mandate here is with respect to the Special Health Care Programme. So that if you could maybe rephrase your question so it comes within the context of the mandate?

Brig. Gen. Antoine: Yes. So, can we absorb medical graduates in terms of the special programme to alleviate the problem in terms of employment?

Mr. Madray: Well, I will attempt to field it. The graduate doctors, what we tend to need for these specialist programmes are in fact specialist doctors, whether it is cardiac and specialist nurses, et cetera. Whether it is cardiac, cataract surgery, et cetera. So, until they are specialized.

Brig. Gen. Antoine: Okay. So in terms of this programme, it is mainly specialists?

Mr. Madray: Yes.

Brig. Gen. Antoine: Okay.

Madam Chairman: Member Olivierre.

Ms. Olivierre: Thank you very much. If we could just go back to the HIV/AIDS administration because you have just presented some interesting statistics, I am sure the population is probably abuzz with analyzing what you just indicated. Now, the question I wanted to ask is: What has been the rate of new infections that comes to your attention over the past few years? You indicated the trend has been reducing, do you have a percentage, and the rate of new infections per year?

Dr. Antoine: Yes, indeed. Thank you very much. The rate of new infections

has shown a general—the trend has been towards a decline, and—I am just looking for the numbers here—from about 2010 we were looking at roughly a thousand or over a thousand new cases per annum, and in 2016 the numbers would have been under 500 new cases.

Ms. Olivierre: Oh, well, that certainly is encouraging. Are you indicating the age distribution of persons living with HIV/AIDS? You indicated that it is among males the majority is over 60? Is that what you said?

Dr. Antoine: Not the majority. There may have been some insignificant numbers which were not expected in that age group, over 50, and that may be an indication that, one, persons are living longer with the disease so that—because of the treatment and care that they have received. And, it may also indicate they there may be new cause as well amongst that age group.

Ms. Olivierre: Would you have the statistics that indicate the new cases? Do you have that broken down in the age groups and gender?

Dr. Antoine: No, not at hand, but that can be provided.

Ms. Olivierre: If that can be provided in writing it would be interesting to see what the trends are for new infections, if there is any particular age group then that we need to target specifically for our prevention programmes? I am sure that information would be useful.

Dr. Antoine: Yes.

Ms. Olivierre: And thank you.

Madam Chairman: Member Mark.

Mr. Mark: Yes, thank you very much, Madam Chairman. I want to go to the issue of your CDAP programme. I saw where, between October 2017 to April 2018, you spent some $32 million. Would you care to share with this Committee firstly, what is the total allocation, Mr. PS, for CDAP drugs, pharmaceutical products that is, for fiscal 2018?

Mr. Madray: I have the figure for 2017, which is approximately $55 million, and I believe that the figure is approximately the same for 2018.

Mr. Mark: All right. Could you share with us, why it is there appears to be a persistent shortage of drugs, pharmaceutical products, on the market through these pharmacies, when the vulnerable, the poor in particular, really access those pharmacies,

the constant refrain, is: not available, not available, not available. Could you share with this Committee what is happening with crucial drugs that poor, vulnerable people require when they go to these pharmacies?

Madam Chairman: Member Mark, might I ask if you are relating this to the CDAP programme?

Mr. Mark: Yes.

Madam Chairman: You are talking about shortage of drugs that are covered by the CDAP programme?

Mr. Mark: Yes. Yes, exactly. CDAP drugs I am speaking about here.

Mr. Madray: I will first ask Mr. Jaisingh if he can begin the response and then Dr. Partapsingh will also collaborate.

Mr. Jaisingh: Member, thanks for your question. We have reviewed the entire system in terms of the inventory management side of it, and we realize, yes, there are some instances of stock out. What we have done as well is to look to see exactly what is the cause of this stock out, and the issue is really the procurement cycle. In terms of the fiscal year allocation versus the procurement of the actual items by suppliers. And while there are some shifts in the system in terms of our mis-link between the financial and the procurement of inventory, we are looking to improve the system. In the first instance we are looking at basically, there is a reordering of stock every two months by each pharmacy. We are looking to improve in that system, maybe to bring it down to one month at least, so that each pharmacy would have their minimum stock replenished in one month's time.

We realized they are stock out of certain key items. And also, from the procurement side, from the suppliers point of view, because we are a small purchaser we are at the last end of the replenish cycle, so therefore you might have stock out at some point in time. But also we are looking at alternative strategy to look at the PAHO fund, if we could source the pharmaceuticals quicker, faster and cheaper. We realize there are some cost savings at that end as well so we are looking to improve the procurement cycle period in alignment with the financial side of it as well, because in this instance, normally you look at a one-year cycle in terms of the fiscal year. So, we are looking at alternative strategies, how best we could match the funding availability with as well the inventory side of procuring the items as well. From my department, we have also

looked at a tool to actually capture exactly how is drugs procured, when it is procured, when stock outs take place, and we actually got the report up to the end of April. So, looking at the cover rate of really how you can reduce stock outs, and alternative mechanisms we could put in place to source the drugs accordingly. But, it is a procurement issue basically.

Mr. Mark: May I also ask, that under the listing that we received for CDAP drugs, I saw about between 10 and 11 major categories, including Parkinson's—

Mr. Jaisingh: Treatment areas.

Mr. Mark:—hypertension, among others. Could you share with this Committee whether there was more in the past, and what we have now is a reduction, or is this a consistent number in terms of category that you would have covered in the last, let us say, four or five years as the case may be? Or has there been a reduction?

Mr. Jaisingh: Well, in terms of the CDAP, how it evolved—

Mr. Mark: The CDAP drugs I am talking about.

Mr. Jaisingh: It evolved basically from 2004.

Mr. Mark: Just repeat for us?

Mr. Jaisingh: It evolved from 2003/2004, looking at a specific subset.

Mr. Mark: Yes.

Mr. Jaisingh: And this has evolved into different treatment areas, as you saw in our response. It covered about two to three treatment areas initially, then it actually increased further to the full 13 we have. So, looking from the last three to four years, it remained on the same 13 treatment areas.

Mr. Mark: Okay. Could you share with this Committee why autism, which is a very prevalent disease among young people, children in T&T, why it is not captured under the CDAP programme? Because I have not seen it. I do not know if I missed it. But, I have not seen a category called autism in terms of pharmaceutical products that would be required by these children and growing adults that would be suffering from that disease? Tell me if I am wrong? I am not too clear.

Mr. Jaisingh: Member, if I can pose the question to CMO, if possible?

Dr. Partapsingh: Through you, Chair. Member, thank you very much for the question. So, just to add to Mr. Jaisingh, to the response and the change in the number, change in number does not necessarily translate to less availability or less in the

interest. What we did is that we are strengthening the then list, the vital essential and necessary medicines, and we are doing so in alignment with what is the best practice? What are those that are recommended for the particular conditions?

So, for example, you might see there is a change in list of medicines for diabetes, and that would have a reflection on reviewing the literature, looking at the evidence, what are the recommended medicines for doing so. So, just bear that in mind that change in number does not necessarily translate to availability. In terms of the autism and—now, when the CDAP programme initiated it was Chronic Disease Assistance Programme, so you find that the evolution has been along the lines of the chronic diseases. Recognizing the duration of life with autism, notwithstanding that it is point to note, the burden of autism in terms of relevant to the other conditions, and relevant to prioritize the need for the resources, whether we want to have more centralized in terms of the service that is delivered for autism, and so the management of the medicines for those persons, those are discussions that are currently happening that are in evolution. So, that is the situation with regard to the autism.

Mr. Mark: Madam Chair, one final question. Centralization versus decentralization. We are looking at C40, which is the major warehouse located in the Western Peninsula of this country. Could you share with us whether the centralization of CDAP drugs, which is, I understand they have it as some C40 arrangement in terms of location, and its later distribution to various centres, North-West, North-Central, South, as the case may be. Do you think that, for instance, from the experiences that you have had, that that arrangement is generating more inefficiencies than efficiencies, and therefore the cost is one that is problematic given the experiences that we have had under the health care system? And maybe we could get some answers or clarification from the Ministry of Health on this particular question. And I am talking about CDAP drugs here in terms of what are we doing to generate greater efficiency levels in the distribution of these drugs to the various regional health centres in terms of cost.

Dr. Partapsingh: So, I think it might be a better starter—thank you very much, member, and through you, Madam Chair, for the question. That is a very philosophical question in the sense of not having looked at the efficiency measures in a true sense or a pure sense of efficiency. From the other end of it what we can say anecdotally, yeah, we have got the reports and the records of some challenges

experienced in the past. But when we look at what we have done over the past year to sort of address that, and I think that is why answering the question with a yes or no is not a right way to approach it, but the way to approach it would probably give it the opportunity to maximize on the potential that it has, and I think that is what the Ministry is engaged in. We have engaged in an activity to track the process tracing to see what are the steps for procurement all the way down to storage/distribution at the C40, that central level, at the regional health authority level, and at the end user level. So, the entire process.

And in doing so we have identified some of the challenges. And some of the challenges Mr. Jaisingh spoke to some of them, and so we are trying to address that start the procurement cycle even earlier so that you can really see the potential for the centralized system. There are merits to both, a centralized and a decentralized system. The centralized system allows for accountability, management, the tendering process, the review of the tenders, the review of the sort of control with regard to the vend list, to the buy essential list, the pharm and non-pharm items. You know, that itself is a central function, so it makes some sense, one can argue, for having that C40 still retain that function. I do not know if that answers you at this point in time.

5.00 p.m.

Madam Chairman: I just want to ask something. In terms of—I have seen it both in renal dialysis and, I believe, cardiac care—is there a question of means testing for people to be qualified?

Mr. Seetaram: Yes. Both for cardiac and renal dialysis there is a means test that occurs.

Madam Chairman: So, apart from being a Trinidad and Tobago citizen, to get into the public health system, there is a means test?—or to get the special health programme?

Mr. Seetaram: To get into the special programme, there is a means test.

Madam Chairman: And is there a qualifying financial criteria?

Mr. Seetaram: The medical social workers, after they assess you, they make recommendations to the Ministry based on your financials. So, there is a criteria. We are willing to share the criteria if you wish.

Madam Chairman: Thank you very much. Dr. Bodoe?

Dr. Bodoe: Thank you, Madam Chair. Just to go back to CDAP, PS, you know, one of the issues—we looked at the expenditure involved in these drugs on an annual basis, and one of the concerns I am sure you will have, PS, is that these drugs are dispersed appropriately to the correct patients in the right amounts, and so on. I am sure that you might be aware that there is a practice where—because some patients feel that there might be a shortage of drugs next month, or the month down—they have found innovative ways of collecting drugs, meaning that a patient might, you know, go to one doctor on Monday, get a prescription, collect some drugs. The same week on Thursday they might go to another doctor, collect a prescription, go to another pharmacy and collect drugs, and the following week do the same thing. My question is, really, what mechanisms are in place to ensure that patients do not fill the same, or similar prescriptions, at multiple pharmacies? So, in other words, what checks and balances are there to prevent this from happening? I ask this question— perhaps we can relate it. I know at one time, there was the suggestion of the implementation of a health card that would have dealt with this problem. So, maybe you can keep that in mind in terms of the answer, as we go forward.

Mr. Madray: Sure. Mr. Jaisingh will respond.

Mr. Jaisingh: Thank you, Member for the question. Indeed, yes, we are looking at the computerized system known as the health card part of it. Right now we are assessing exactly the reporting tool of that system. We are looking at the input, the inventory, and also looking at whether or not the system will fulfil the objectives—

Dr. Bodoe: That is the health card?

Mr. Jaisingh: Exactly.

Dr. Bodoe: But what is currently available? Until such time as that comes on board, what is currently available to deal with this issue? First of all, are we in agreement that this could be an issue?

Mr. Jaisingh: Well, definitely, in terms of the visibility across the

entire supply chain. In terms of the patients' encounter to the stock inventory and to the end patient side of it, definitely, there is room for improvement in terms of an electronic system, whether it be from EPP, CDAP—across the system itself. While the health card could serve some measure in terms of looking to see exactly how those objectives can be met in terms of transparency, accountability on the system itself, it is really driven by a manual system at this point in time, with minimal IT requirements.

Dr. Bodoe: I hear you. But, PS, you see, the question is that, in terms of the CDAP forms that are issued to medical practitioners, for example, is there some way of tracking where those forms are issued; where they go? And is there any mechanism to prevent a pharmacist, or to raise a red flag if the same patient comes to the same pharmacy, or a different pharmacy?

Mr. Madray: I am not aware of any manual processes that are in place. NIPDEC is not here, and they may have information that we do not have in terms of their interaction with the pharmacies with respect to the CDAP distribution. But I am not aware of this. I do know that we are trying to work with the health card system to get a better result out of it and—

Dr. Bodoe: NIPDEC may not be here, but you are paying the bill, PS—

Mr. Madray: I understand.

Dr. Bodoe:—on behalf of the citizens of Trinidad and Tobago. So, I am asking whether the Ministry, perhaps, can look at some mechanism in the interim until the health card comes on board. Has this problem been studied at all?

Mr. Madray: I will say that the problem that you indicated is not just that. I am sure that there are other ways in which—there are other situations in which we would have concerns, over whether persons are accessing the drugs, or whether costs have been incurred that should not be incurred. And the only way to really manage that carefully is either

through a manual system or an IT system. So, we thank you for the suggestion and we will look into it, along with NIPDEC.

Dr. Bodoe: Yes. Because at the end of the day you want to ensure the $32 million you spent is bringing value to citizens of Trinidad and Tobago.

Mr. Madray: Certainly.

Dr. Bodoe: I just want to ask one more question with regard to the treatment of HIV/AIDS, and that is with regard to the treatment of children, underage. I know in cases, where available, you would seek parental consent, but there might be situations where you may not be able to get the consent of a parent or guardian. How do you deal with those cases?

Dr. Antoine: With respect to cases of HIV, whether as children we—of course, the first attempt would be to obtain the consent of a parent. Where there is no parent, for instance, let us assume someone a little older, we would make all attempts to get the consent of the parent. But, eventually we would have to provide treatment because of the ethical issues associated with not treating someone with the disease.

Dr. Bodoe: In that case, do you have any obligation, legal or otherwise, to report this to the authorities—police, child protection unit, bodies like that?

Dr. Antoine: Yes, there certainly is.

Dr. Bodoe: So, this is done? And that is the normal policy—normal practice?

Dr. Edwards: A normal practice, yes. We do it. Also, remember, there are some children who are actually born with HIV too, eh.

Dr. Bodoe: Of course. That is what I am referring to. Yes.

Dr. Edwards: Yes.

Dr. Bodoe: I just wanted to go back to the External Patient Programme and the external radiation therapy and—Beesham, perhaps you may want to clarify that the National Radiotherapy Centre does provide radiation treatment. So, the 327 patients listed in the submission, are they

patients who are outsourced?

Mr. Seetaram: Correct.

Dr. Bodoe: Right. So what is the basis, then, for outsourcing these patients? How do you decide which patients can be treated at the National Radiotherapy Centre and who are outsourced?

Mr. Seetaram: The National Radiotherapy Centre is currently being upgraded to include a new linear accelerator because the equipment that currently exists can only treat a certain spectrum of cancers. The only ones we send externally, are ones that cannot be treated at NRC. So, this 300-plus patients, are patients who cannot be treated at NRC.

Dr. Bodoe: Okay. So those who can be treated at NRC, what is the waiting time for treatment? That is the next question.

Mr. Seetaram: There is no waiting time for treatment at NRC. If it is one area within the Ministry that there is absolutely no waiting time, it is cancer treatment.

Dr. Bodoe: So those who cannot be treated at NRC, what happens to those patients? Can you give me an idea?

Mr. Seetaram: I can actually give you a list of the criteria that we use, in order to send patients externally.

Dr. Bodoe: Right. Can you provide that list to the Committee?

Mr. Seetaram: That, we will provide in writing. Sure.

Dr. Bodoe: Right. In terms of the screening for cancer—because, of course, cancer, like the others, cardiac disease and renal problems, is a big burden on health care— in terms of screening programmes at CMO, can you, maybe, tell us a little bit about whether there are any formalized screening programmes for cancers in Trinidad and Tobago?

Dr. Partapsingh: So, from a women's health perspective, we can provide those to you in writing, if that would be best, from the Director of Women's Health. Most of the screening programmes are conducted—well, the screening programmes are primarily conducted through the RHAs—the Regional Health Authorities—because there is where the services are. The patient point of care happens—the opportunity to do opportunistic

screening happens there. The RHAs, in terms of having—they would—well, on a schedule they will help—you can get conducting Pap smear clinics for example—well, Pap smear drives, for example. But then, I know that there are services—Pap smear clinics—that actually are routinely scheduled within primary care health centres. So, that is one example, a routine schedule of Pap smear clinics within health centres.

Then, the outreach facilities with the mobile clinics where they will do the Pap smears, is another one. Breast examination is another one that is performed at the level of the primary care interaction with the primary care physician and the patient, or within the other patient/physician consultations. In terms of whether these fit within a defined cancer prevention programme or within a reduction programme, or a sort of very formal programme, I cannot tell you that at this point in time. I will have to get that information.

Dr. Bodoe: But can you undertake—because I know one of the remits of the Director of Women's Health—because I was involved in that at a different time—would have been to look at national cancer screening. So, maybe you can provide—I know the Director has been appointed for, perhaps, a year or so—

Dr. Partapsingh: Yes, and he has been very, very active in doing so, and there are lots of activities that engage him.

Dr. Bodoe: So, maybe you can provide a report to the Committee.

Dr. Partapsingh: Yes.

Dr. Bodoe: And also, if we can include in that, any study that would have looked at the impact of the HPV vaccine on cervical cancer. I know that that vaccination—is it still provided free of cost to the population?

Dr. Partapsingh: Yes. Sir, you are talking about locally conducted studies, or studies—

Dr. Bodoe: No, no. I am talking about the impact on the local population, in terms of what impact it has had, whether we have had studies to speak to that.

Dr. Partapsingh: Impact evaluation, with your permission, Madam

Chair, is a particular type of approach to measuring effectiveness of programmes. And I will see what we can assemble in terms of proxies for a formal impact evaluation, because a formal impact evaluation requires a particular process. So, we can see what we can assemble.

Dr. Bodoe: I would like to think that when the programme was being implemented—

Dr. Partapsingh: Well, effectiveness—

Dr. Bodoe:—that some attention would have been paid to an assessment.

Dr. Partapsingh: The outcome is what we can talk about. We can talk about the outcome, the reduction in number of—the change in cancers. We could talk about the number of persons who were vaccinated. In the true sense of impact evaluation, that requires a longer period of time to assess impact, but, we can definitely give you outcome and output in measures.

Dr. Bodoe: Yes, that would be fine. And just to close, would you want to just, you know, remind the population in terms of cancers, what are the common ones that face us as citizens in Trinidad and Tobago?

Dr. Partapsingh: So, in terms of breast cancer, breast cancer is one of the significant cancers that affect the population. Lung cancer and its relation to—cigarette smoking is another one of the risk factors, and severe smoking has been recognized as one of those. The key interventions—cessation of severe smoking to prevent lung cancer and to reduce the burden. Prostate cancer is another one, of significance for men. Colorectal cancer is another one that is of significance. And I think those would be the main ones that we see within—

Dr. Bodoe: Just one more question. In terms of children who may not be able to access, or who have been refused treatment by the Children's Life Fund, is there any avenue for those children to apply or to access any of these special health programmes by the Ministry of Health? PS, Director EPP?

Mr. Madray: Mr. Seetaram.

Mr. Seetaram: We have started discussions with the CLF to see how best the Ministry can support the work of the CLF, as well as provide the best care for all patients. We have been having discussions for a couple of months now, as to what we can do to supplement what the CLF does. So, yes, there is an avenue that is opening up for children who are unavoidably denied at the CLF.

Dr. Bodoe: How soon can we expect some pronouncement on that?

Mr. Seetaram: Very soon.

Dr. Bodoe: Thank you.

Madam Chairman: Just one question—I mean, there are several other questions we have here but we would send them in writing. There is one question, and I do not know if the PS is the person to direct this to. A lot of our discussions, really, have been centred on the more technical/professional side of the Special Health Programmes. One thing I know affects the ordinary man in the street who accesses these programmes, is the loss of their files. Okay? They go in, the file is lost. Has that really been identified as an issue? Because I know you all treat with complaints and you measure success by complaints. I call that customer care. I do not know if that is the real terminology. What mechanisms are we putting in place to treat with that?

Mr. Madray: Well, the answer refers to our earlier discussion where you were enquiring about the ICT system. Really, that is what is necessary. Because what is happening is that people are going from one hospital to another, and that is the other problem, and the same tests are being redone. So it is not just the loss of files, it is the expense that is being incurred by the country from having to duplicate the tests over and over again. So, I will take your question as a suggestion and I will ask our various divisions to engage with the RHAs to see whether there is a way in the interim that we can improve, at least on the process of the file management, because there is also the issue of simply—files getting lost within the system, within one hospital. So, we do need to manage in multiple ways.

Madam Chairman: I just want to say this, PS. While we are charged here in this Committee, on looking at the "money side", there is also a "big heart side", and for a sick person, you know, battling all the things they are battling—one has cancer and you are being treated and you go for treatment and they cannot find your file or they are reading somebody else's file, and you yourself might realize they are reading somebody else's file. You know, for us to sit here and talk just maybe about money—might seem heartless. I would like to think that all of us here have hearts and really hope that we do not have to wait until something that is heartless—ICT—to render some "heart" on our part.

Mr. Madray: What I am hoping to do is, within the next few months, engage resources directly under the Ministry to identify special projects, and this is quite likely a good example of one that may be simple to implement, but we need to identify what is causing the problem. Hopefully, it will be simple to implement, and get a resolution that could really benefit the patients.

Madam Chairman: Thank you. I am sure everybody is happy to hear that, and you know, Mr. Madray—

Mr. Madray: You will ask me the question—

Madam Chairman:—I will ask you about that. [*Laughter*]

Mr. Madray:—in two years' time.

Madam Chairman: No, no, no, no, certainly soon after the budget. [*Laughter*] Okay?

All right. So, I want to say: to the PS; to the Programme Administrator, EPP; to the Director, HIV; the Director, Medical Research Foundation of Trinidad and Tobago; the Director, Health Policy; the Chief Medical Officer; the Health Advisor, Health Promotion; and the State Counsel III, Acting; I want to tell you all, thank you for a very engaging discussion on a topic that really touches the hearts and comfort of our citizens. As I say, we have many questions still to ask, but we also have to have a heart in terms of the time, and therefore, I want to, at this stage, bring this part of our meeting to an end and suspend the meeting.

I want to thank the members of the media who stayed with us, and I want to thank the members of the listening and viewing public who have also stayed with us. I want to wish you all a safe journey home and, again, I thank you all.

This meeting is now suspended.

5.17 p.m.: *Meeting adjourned.*