HOUSE OF REPRESENTATIVES

Friday, January 14, 1994

The House met at 1.45 p.m.

PRAYERS

[MR. DEPUTY SPEAKER *in the Chair*]

PETITION

Greater Malabar Christian Centre

Mr. Cyril Rajaram *(Pointe-a-Pierre):* Mr. Deputy Speaker, I have the honour to present the petition on behalf of the members of the Greater Malabar Christian Centre of Malabar Phase IV, Arima.

I now ask that the Clerk be permitted to read the petition and that the promoters be allowed to proceed.

Petition read.

Question put and agreed to, That the promoters be allowed to proceed.

PAPERS LAID

1. Report of the Auditor General on the accounts of the Structural Adjustment Loan No. 3152-TR and the Exim Sal to Trinidad and Tobago Loan Agreement between the Government of the Republic of Trinidad and Tobago and the International Bank for Reconstruction and Development and the Export-Import Bank of Japan for the year ended December 31, 1992. [*The Minister of Finance (Hon. Wendell Mottley)*]

2. Report of the Auditor General on the accounts of the Board of Industrial Training of Trinidad and Tobago for the year ended December 31, 1989. [*Hon. W. Mottley*]

3. Report of the Auditor General on the accounts of the Board of Industrial Training of Trinidad and Tobago for the year ended December 31, 1990. [*Hon. W. Mottley*]

4. Report of the Auditor General on the accounts of the National Insurance Board for the year ended June 30, 1991. [*Hon. W. Mottley*]

5. Report of the Auditor General on the accounts of the National Insurance Board for the year ended June 30, 1992. [*Hon. W. Mottley*]

6. Report of the Auditor General on the accounts of the Victoria County Council for the year ended December 31, 1987. [*Hon. W. Mottley*]

7. Report of the Auditor General on the accounts of the Victoria County Council for the year ended December 31, 1988. [*Hon. W. Mottley*]

8. Report of the Auditor General on the accounts of the Victoria County Council for the year ended December 31, 1989. [*Hon. W. Mottley*]

9. Report of the Auditor General on the accounts of the Victoria County Council for the year ended December 31, 1990. [*Hon. W. Mottley*]

Papers 1 to 9 to be referred to the Public Accounts Committee.

10. US $125 Million Eurobond Issue. [*Hon. W. Mottley*]

11. Annual Report of the National Insurance Board for the year ended June 30, 1993. [*Hon. W. Mottley*]

12. Ombudsman of Trinidad and Tobago—Special Report No. 1/94. [*The Minister of Local Government and Minister in the Ministry of Finance (Hon. Kenneth Valley)*]

13. Road Improvement Fund—List of Main Roads by District, 1994. [*The Minister of Works and Transport (Hon. Colm Imbert)*]

ORAL ANSWERS TO QUESTIONS

Bagasse Plant (Functioning of)

18. Mr. Raymond Palackdharrysingh (*Caroni Central*) asked the Minister of Agriculture, Land and Marine Resources:

Would the Minister state:

(a) Whether the bagasse plant at Brechin Castle is functioning?

(b) If it is not, what plans has he for the operation of the plant?

(c) If there are no plans for its operation, would the Minister state whether the plant would be leased or sold to our nationals?

The Minister of Local Government and Minister in the Ministry of Finance (Hon. Kenneth Valley): Mr. Deputy Speaker, Trinidad Bagasse Products Limited ceased operations on June 30, 1981, at which time the company had accumulated losses of $31,687,052. From June 1981 to the present, Caroni (1975) Limited has been responsible for the safekeeping of the assets at a cost of $2,391,576.

1.55 p.m.

Given Government's policy for the rationalization of the state sector and the insolvency of Trinidad Bagasse Products Limited, a decision was taken by creditors in June 1993 to wind up the company. Subsequently in July 1993, Mr. William Lucie-Smith of Deloitte & Touche was appointed liquidator of the assets of the company. The liquidator has since ceded title to the Trinidad Bagasse plant and machinery to Caroni (1975) Limited in full and final settlement of their claim against the company.

Caroni (1975) Limited has carried out an assessment of the facility and has determined that the plant and machinery are worthless. Caroni is considering selling the assets as scrap and reusing the land and building for other projects.

Mr. B. Panday: A monument to inefficiency!

Sport and Culture Fund

20. Mr. Raymond Palackdharrysingh (*Caroni Central*) asked the Minister of Sport and Youth Affairs:

Would the Minister state:

(a) What is the status of the Sport and Culture Fund?

(b) The names of sporting and cultural groups that were facilitated by the fund for the years 1990, 1991, 1992 and 1993?

(c) What other activities have been facilitated by the fund for the period 1990, 1991, 1992 and 1993?

The Minister of Sport and Youth Affairs (Hon. Jean Pierre): Mr. Deputy Speaker, the Sport and Culture Fund was established in 1988 by Act No. 31 of 1988. Prior to December 1991, the fund was under the purview of the Ministry of Youth, Sport, Culture and Creative Arts. Following the election of 1991, responsibility for sport and culture was divided between two portfolios, namely the Ministry of Sport and Youth Affairs and the Ministry of Community Development, Culture and Women's Affairs; hence it became necessary to amend the Act.

The Minister of Sport and Youth Affairs wishes to inform this honourable House that an amendment to the Sport and Culture Fund Act No. 31 of 1988 was presented and passed in the Lower House on Friday, October 15, 1993.

This amendment sought to designate the responsibility to a single authority and to re-designate a new management structure to conduct the affairs of the fund. The Amendment Bill was passed in the Upper House on Tuesday, November 16, 1993.

Audited accounts of the fund for the year ending December 31, 1991 indicated a balance on the account in excess of $5 million.

The Minister wishes to inform this honourable House that beneficiaries of this fund for the period 1990 to 1993 are listed in an appendix, a copy of which can be made available to the hon. Member.

The Minister wishes to inform this honourable House that only one additional activity was funded during the period in question: the sum of $76,432.00 to cover the 1993/94 commitment in respect of the four-year scholarship awarded to Ms. Sherma Andrews in 1990 to pursue a course of study in Music (Commercial Arranging) leading to a BA Degree at the Berklee College of Music, Boston, USA.

Thank you.

Mr. T. Sudama: Question 30 to the Minister of Energy and Energy-based Industries.

Hon. K. Valley: Mr. Deputy Speaker, of the 12 questions on the Order Paper today, the Government will be answering 10. Question No. 30 is one of the two questions for which we will be seeking a deferral. The other one is question No. 39. I request a deferral of two weeks.

The following questions stood on the Order Paper in the name of Mr. Trevor Sudama (Oropouche):

Pointe-a-Pierre Refinery Upgrade Project

30. Could the Minister of Energy and Energy-based Industries state:

(a) How many phases of the Pointe-a-Pierre Refinery Upgrade Project, undertaken with a loan from the Inter-American Development Bank have to date been completed and what has been the expenditure incurred?

(b) Whether this expenditure will be recovered from the increased revenue accruing to refinery operations as a result of the upgrade and, if so, what are the projections for increased revenue over the next 10 years in the light of falling oil and refined product prices?

(c) What are the remaining phases of the Refinery Upgrade Project to be completed and at what cost?

(d) Whether, after the completion of the whole upgrade project, the operation of the Pointe-a-Pierre Refinery would be a financially viable proposition?

Scholarship
(Tertiary Level)

39. Could the hon. Prime Minister provide the following information with respect to the scholarships currently tenable at the tertiary level of education awarded by the Trinidad and Tobago Government:

(a) The names of the recipients;

(b) The respective fields of study;

(c) The respective institutions at which studies are being pursued;

(d) The total length of the period of study inclusive of more than one award to the same recipient;

(e) The total expenses incurred by the Government on each recipient and his or her family?

Mr. Sudama: Mr. Deputy Speaker, before you put the question to the House, may I with your leave make a comment? These questions were filed over two months ago, and we have come to this House and have had deferral after deferral. This House has been in recess for about a month now, and I would have thought that this Government if it was doing anything at all, and obviously it was doing nothing, would have had ample time to come here and answer these questions which are not new.

Here I have two questions in my name—I do not know whether I am being singled out in this House—which have been on the Order Paper for a very long time and today the Government is coming here to ask for a further deferral of these questions. I want to protest.

I believe it is a subversion of this Parliament and the work of this Parliament, and it is gross contempt to the Members on this side to have these continued

[MR. SUDAMA]
requests for deferrals. It also betrays the gross incompetence and inefficiency of this Government; and if it cannot rule, get out and let somebody else take over the reins of the administration of this country. Members opposite are doing such a shoddy job that this society is deteriorating by the hour. They cannot answer a simple question in this Parliament. I want to make my protest, Mr. Deputy Speaker.

Dr. Rowley: Has the Member finished?

Hon. K. Valley: I just want to make the point that the Government is answering in excess of 90 per cent of the questions on the Order Paper today. Two questions, and I understand there is one more, question No. 49.

Mr. B. Panday: That is an improvement on 20 per cent.

Hon. K. Valley: Mr. Deputy Speaker, you will see that they require quite a bit of information, hence the reason that those questions cannot be answered today.

Questions 30 and 39, by leave, deferred.

Mr. Deputy Speaker: Do I take it that you will also be asking for question No. 49 to be deferred?

Hon. K. Valley: Yes, that is for a written answer.

WRITTEN ANSWER TO QUESTION

Air Caribbean (Terms and Conditions)

The following question stood on the Order Paper in the name of Mr. A.N.R.. Robinson (Tobago East):

49. Will the Minister of Works and Transport:

(a) State the precise terms and conditions under which Air Caribbean operates on the route between Trinidad and Tobago?

(b) Identify the document or documents in which those terms and conditions are contained?

(c) Lay the documents referred to on the Table of this honourable House?

Hon. K. Valley: Mr. Deputy Speaker, we seek a deferral of two weeks.

Question, by leave, deferred.

ORAL ANSWERS TO QUESTIONS

Local Government Authority (Scavenging Costs)

32. Mr. Sahid Hosein *(Siparia)* asked the Minister of Local Government:

Will the Minister indicate to this honourable House the following:

(a) The highest cost paid for scavenging per area in each local government authority?

(b) The lowest cost paid for scavenging per area in each local government authority?

(c) Will he identify the area and the specific local government authority in respect of (a) and (b)?

Hon. K. Valley: Mr. Deputy Speaker, the areas with the highest scavenging costs at the local government authority are as follows:

With respect to the Port of Spain Corporation, scavenging is all done in-house so the question does not apply to Port of Spain.

With respect to San Fernando, the area with the highest cost is Area 45 which comprises Marabella Market, Market Street and so on, and the cost is $829.00 per day. The lowest cost in the San Fernando area, San Fernando City is Area 33, Marabella East, at a cost of $419.00.

The Borough of Arima, the scavenging is done in-house so the question does not apply here.

In the case of Chaguanas, the highest cost is Area 29, Charlieville, Pierre Road, et cetera, at a cost of $724.00 per day, and the lowest cost is Chaguanas Main Road, market and abattoirs at $460.00 per day.

Point Fortin Borough, highest cost Area A, Guapo and Gonzales; also Area B, Techier, Mahaica, and so on, and Area E, all with a similar cost of $345.00 per day. The lowest cost is Area G with the market and abattoir and so on.

2.05 p.m.

Couva/Tabaquite/Talparo Corporation—highest cost of $628, Area 12, Calcutta South; lowest cost, Area 19, Flanagin Town/Caparo.

San Juan/Laventille Corporation—highest cost of $4,497 per day, Area 16, San Juan market and abattoir, Mt. Hope Hospital, et cetera; lowest cost of $4,200, Area 15, St. Ann’s, Cascade, Belmont North.

[HON. K. VALLEY]

Mayaro/Rio Claro Corporation—highest cost of $555 per day, Area 10, Guayaguayare; lowest cost of $450 per day, Area 2, San Pedro.

Princes Town Corporation—highest cost of $674 shared by Area 4, St. Croix, Cipero, Oropouche; Area 5, Moruga Road North; Area 6, Moruga Road South; and Area 8, Torrib/Tabaquite Road; lowest cost, Area 12, Naparima/Mayaro Road, Princes Town North/Central.

In the Diego Martin Corporation, highest cost of $5,600, Area 12, North Post Hills, St. Lucien Road, Blue Range Junction, West Covigne Road, Bagatelle Road; lowest cost of $3,800, Area 11, Blue Range, Four Roads, Cameron Road, Sierra Leone Road.

Sangre Grande Corporation—highest cost of $614 in Area 6, Coalmine, Jurasingh, Nestor, Guaico Tamana and also Area 9, Sangre Grande; lowest cost, Area 2, Upper Sangre Grande.

Tunapuna/Piarco Corporation—highest cost of $3,300, Area 6, Tacarigua North Five Rivers; lowest cost of $650, Area 11, Paria and Blanchisseuse and Area 12, La Filette, Las Cuevas.

Penal/Debe—highest cost of $1,425, Area 11, Penal market and abattoir, Assim Avenue, Penal Junction, Batchyia Road; lowest cost, Area 12, Penal market and abattoir compound.

Siparia—highest cost of $684, Area 13, Pepper Village, Fyzabad Main Road, Siparia Old Road and surroundings; lowest cost, Area 15, Oropouche.

Water Rates
(Criteria)

37. Mr. Raymond Palackdharrysingh *(Caroni Central)* asked the Minister of Public Utilities:

Would the Minister state:

(a) Whether water rates are charged on properties where there are no houses but where there are water mains?

(b) Whether this rate applies to state lands and lands of state enterprises in a similar situation?

(c) What criteria are used to determine the rate?

The Minister of Public Utilities (Hon. Morris Marshall): Mr. Deputy Speaker, the Water and Sewerage Authority has indicated that its water customers

can be categorized into five main types, based on how they obtain water from WASA. These are as follows:

(1) Residential	A1 Domestic Standpipe
	A2 Domestic Yard Tap
	A3 Domestic Internal Serviced, No Meter
	A4 Domestic Internal Serviced, Metered
(2) Charitable	A5 Churches
	A6 Other Charitable organizations
(3) Industrial	B3 Industrial Non-Metered
	B4 Industrial Metered
(4) Commercial	C3 Commercial Non-Metered
	C4 Commercial Metered
(5) Agricultural	E3 Agricultural Non-Metered
	E4 Agricultural Metered

It is important to note that based on Order No. 83 of the Public Utilities Commission dated December 15, 1993, service to customers who conduct VAT-registered businesses on domestic premises or conduct businesses in structures which are partly used for business and partly used as domestic premises, is to be defined as Cottage Service to which specific rates are to be applied.

WASA has advised, further, that all customers within 400 metres of a standpipe are considered to have access to potable water and accordingly are charged water rates. WASA has pointed out that customers served at properties where there are no houses but where there are water mains are categorized as A1—Residential Domestic Standpipe—and are accordingly charged water rates.

The Water and Sewerage Authority has advised that water rates are applicable to state lands and lands of state enterprises in a similar situation as explained earlier.

The Minister of Public Utilities wishes to advise this honourable House and the wider national community that the criteria used to establish tariff rates are determined by the Public Utilities Commission. The PUC has indicated that the rate is calculated to allow the utility to earn a certain level of revenue from a particular class of customers, based on the cost of providing this service by WASA.

Children's Death
(Tobago)

43. Mr. A.N.R. Robinson *(Tobago East)* asked the Minister of Health:

Will the Minister tell hon. Members what he knows about the case of the two young children who died in mysterious circumstances in the village of Canaan in Tobago earlier this year and to whom reference was made in this honourable House in the previous session?

The Minister of Health (Hon. John Eckstein): Mr. Deputy Speaker, the Minister of National Security has been advised that two children, Willan Bain, four years old, and Willis Bain, three years old, were found dead on a bed at their home at Douglas Street, Canaan, on Monday, May 17, 1993.

As a result of enquiries conducted by the police into the deaths, post-mortems were conducted on both bodies by the forensic pathologist at the Tobago County Hospital on May 18, 1993. He subsequently submitted certain organs for further analysis to the Forensic Science Centre in order to determine the cause of death.

The Director, Forensic Science Centre, has recently concluded the analysis of the organs and has forwarded a forensic report to the Commissioner of Police for action as may be appropriate in the circumstances.

Mr. A.N.R. Robinson: May I say the question was, "What does the Minister of Health know?" What he has told us is what somebody else has done—a report sent to the Minister of National Security. Is it that the Minister of Health knows nothing?

Pipe-Borne Water Supply
(Penal Rock Road)

45. Mr. Sahid Hosein *(Siparia)* asked the Minister of Public Utilities:

(a) Is the Minister aware that the residents of Penal Rock Road between the 6 mm and 9 mm have not been in receipt of pipe-borne water for this year?

(b) If the answer is in the affirmative, will he indicate when the situation is going to be rectified?

(c) Can he also indicate whether those residents affected will have their bills adjusted accordingly?

Mr. S. Hosein: Let me state in part (a), the third line, "for this year", the year in question is 1993.

The Minister of Public Utilities (Hon. Morris Marshall): Mr. Deputy Speaker, the team co-ordinator of the Water and Sewerage Authority has advised as follows:

Penal Rock Road receives its supply from the Navet Waterworks via a dual transmission system off the Navet Trunk Main. The supply is then boosted by the Clarke Road Booster into the distribution system.

2.15 p.m.

The distribution system terminates at the 8¼ mm along the Penal Rock Road. Areas between the 6½ mm and 8¼ mm are scheduled to receive a weekly pipe-borne water supply between 6.00 a.m. on Thursdays and 6.00 a.m. on Fridays.

This schedule, however, is not maintained and the areas up to the 7 3/4 mile mark have been without a pipe-borne supply for most of l993. The poor supply has resulted from the following:

The 100 mm diameter cast iron pipeline along the Penal Rock Road is now undersized due to encrustation and it is also corroded, resulting in frequent leaks.

The Clarke Road Booster, which supplies the area, generally operates during the night period only. As such, the effective schedule period is 12 hours (rather than 24 hours). This situation developed due to deterioration of the transmission pipeline and having to take it out of service.

The pipe-borne supply to Penal Rock Road can be improved by undertaking the following works:

Replacing the cast iron main along the Penal Rock Road between the 5 1/4 and 8 1/4 mm. The estimated cost is $1.08 million.

Repairing and reinstating all damaged sections of the transmission pipeline at an estimated cost of $227,500.00

Extending one of the transmission mains along New Colonial Road from Papourie Road to Rochard Douglas Road, that is, approximately 2.2 km of 300 mm diameter pipe at an estimated cost of $770,000.00.

The Authority is seeking to obtain funds to upgrade and rehabilitate the transmission and distribution systems and, when obtained, the works outlined would be undertaken.

Mr. Hosein: Mr. Deputy Speaker, the Member did not answer part (c) of the question.

Hon. M. Marshall: Mr. Deputy Speaker, in response to part (c), what is necessary is that the consumers concerned write officially to WASA and they will address that particular matter.

MF Panorama

46. Miss Pamela Nicholson *(Tobago West)* asked the Minister of Works and Transport:

Could the Minister inform this House:

(a) If he is aware that the *mf Panorama* has been off the Tobago run for over two months now?

(b) What steps are being taken to put the *mf Panorama* back on the route in the shortest possible time?

The Minister of Works and Transport (Hon. Colm Imbert): Mr. Deputy Speaker, the Minister of Works and Transport wishes to advise this honourable House that:

(i) The *mf Panorama* has been out of scheduled service since August l993 to allow for the carrying-out of repairs, dry-docking and refurbishment.

(ii) Prior to the dry-docking of the vessel, which is mandatory, the Port Authority has been engaged in effecting extensive repairs to the vessel.

These include:

(a) Overhauling and repairing of all four engines;

(b) Replacing of three clutches with new ones acquired for this project, and servicing of the fourth clutch, which was acquired earlier in l993;

(c) Rebuilding of one of the two generators and servicing of the other;

(d) Changing of the seals on the hydraulic cylinder of the stern ramp;

(e) Repairing, reconditioning and servicing of the air-conditioning system by changing seals on three compressors, realigning motors, cleaning, repairing and repainting ducting and servicing fan motors;

(f) Overhauling of the Sewer Evac System by emptying tanks, servicing pumps and overhauling valves for the toilet systems;

(g) Renewing and modifying of fairlead rollers and guards for spring and bow lines of the vessel;

(h) Repairing of hanging car deck rails;

(i) Overhauling of the bilge pump system.

The necessary funds to undertake the dry-docking and to complete the refurbishment of the *mf Panorama* to enable its return to the ferry service have been sourced through a bond issue. It is anticipated, therefore, that the *mf Panorama* will now be dry-docked in January l994.

Miss Nicholson: Mr. Deputy Speaker, could the hon. Minister tell us where it would be dry-docked? Has the port gone through the necessary procedures? It has been off since August and up to now we do not know where it is going to be dry-docked. Would it be in Port of Spain, Curacao? The people of Trinidad and Tobago want to know.

Hon. C. Imbert: Mr. Deputy Speaker, the funding required to dry-dock the *mf Panorama* is approximately $8 million. This is the reason the *mf Panorama* has not been dry-docked to date. The question of where it will be dry-docked is engaging the attention of the Port Authority and I anticipate within the next week recommendations would be made as to exactly where the *mf Panorama* will be dry-docked.

Princes Town Car Park
(Rental of)

47. Mr. Mohammed Haniff *(Princes Town)* asked the Minister of Works and Transport:

Would the Minister state:

(a) (i) What sum of money and other benefits did the Traffic Management collect at the end of the original contract for the rental of the Princes Town Car Park for Fantasy Land?

(ii) For what period was the original contract?

[MR. HANIFF]

(iii) Whether the period for the original contract was extended and, if so, for what period?

(b) Is the Minister aware of the serious inconvenience caused to motorists by taking away the parking facilities?

(c) Does the Minister intend to continue to rent out the car park?

The Minister of Works and Transport (Hon. Colm Imbert): Mr. Deputy Speaker, the rental arrangement for the car park entered into by the Traffic Management Branch earned a total of $6,000, that is, $4,000 from the original agreement and $2,000 from the extension. The rental of the car park was a beneficial arrangement in that it afforded the following:

- generation of revenue to undertake infrastructural work to the car park itself;
- enhancement of the environment;
- a social and economic turnover to the business and transit operators.

The original contract was for the period September 17, 1993 to October 17, 1993. This contract was extended for the period October 18, 1993 to October 31, 1993.

The Minister is not aware that the temporary arrangement has caused any significant inconvenience to the motorists. In fact, considerable dialogue has been taking place between the Traffic Management Branch and the appropriate agencies in the traffic-related operations namely, the fire services, the police, the Princes Town Regional Corporation, et cetera, and no complaints have been received with respect to the use of the site of the car park.

The rental arrangement was concluded on October 31, 1993 and the Traffic Management Branch does not have any existing plans to continue the rental of the facility beyond the stated period, but it is nevertheless envisaged that the Traffic Management Branch may be required to adopt other similar innovative approaches to provide its services efficiently.

Khalay Village
(Status of Residents)

48. Mr. John Humphrey *(St. Augustine)* asked the Minister of Housing and Settlement:

With respect to the residents of Khalay Village on lands acquired by the state for housing from the late Bhadase Sagan Maharaj known as the Pasea Estate, would the hon. Minister please state:

(a) The present status of residents?

(b) What progress has been made by Government in regularizing tenancies?

(c) What terms and conditions will be offered to residents in the said regularization?

The Minister of Housing and Settlement (Dr. The Hon. Vincent Lasse): Mr. Deputy Speaker, the lands in question known as Pasea Estate comprise approximately 480 acres and were acquired by the state for public purposes on August 11, l960 (*Royal Gazette*, page 654). Some occupants of the lands were given probationary tenancy agreements of three-year duration. These tenancy agreements have since expired and have not been renewed by the Ministry of Agriculture, Land and Marine Resources. Residents who were not granted these agreements are categorized as squatters on state lands. These squatters have been in occupancy of these lands prior to l991.

With respect to the regularization of tenancies, the Ministry of Agriculture, Land and Marine Resources has completed the surveying of the entire area and its division into parcels for agricultural purposes. Completion of this exercise is dependent on the finalization of payment by the agricultural occupants. It is to be noted that the area is also earmarked for the construction of the Macoya Interchange and the Southern Link Freeway which is to be undertaken by the Ministry of Works and Transport. Completion of the regularization exercise in the area must also await a final decision on these projects.

2.25 p.m.

The National Housing Authority would have to await the outcome of discussions among the Ministry of Works and Transport, the Lands and Surveys Division of the Ministry of Planning and Development and the Ministry of Agriculture, Land and Marine Resources before any work can be commenced on the regularization of residential squatters.

The Lands and Surveys Division has indicated that once given instructions from the Ministry of Agriculture, Land and Marine Resources, standard agricultural leases would be provided to those who occupy agricultural holdings, as long as these are consistent with the planned highway improvements.

The terms and conditions which will apply to residential squatters have not yet been finalized. In this connection, it is to be noted that the Regularization of Tenure (State Lands) Act No. 20 of 1986 is currently being amended.

Thank you, Mr. Deputy Speaker.

ROAD IMPROVEMENT FUND

The Minister of Works and Transport (Hon. Colm Imbert): Mr. Deputy Speaker, you would recall that in the budget speech delivered by the hon. Minister of Finance in this honourable House on Friday, November 26, 1993, the Minister indicated that the Government proposed the establishment of a Road Improvement Fund to be financed directly through the imposition of a road improvement tax on motor vehicle fuels.

The measure was to take effect on the publication of the Provisional Collection of Taxes Order and was estimated to yield approximately $50 million annually, to be used solely for the repairs, maintenance and improvement of roads throughout the country. Since that time, the Government has finalized measures for the operation, administration and utilization of the fund so that the necessary financing can be made available for the repair and improvement of specifically identified roads throughout Trinidad and Tobago which previously could not be undertaken because of the limited resources available to the Government.

I, therefore, wish to advise this House of the preparatory work done so far and the proposals for utilization of the Road Improvement Fund. With regard to the establishment of the fund, as indicated by the Minister of Finance during the budget debate, the Government carefully considered this matter and decided that a special account should be opened in the Central Bank in the name of the fund, to which deposits would be made and against which expenditure would be incurred.

In this regard, I wish to apprise the House that all legal work to facilitate this matter has been completed and the special account will be opened by the end of next week. In the interim, the proceeds of the tax are being deposited and secured in a temporary account in the Treasury.

It was also decided that the proceeds of the fund should be applied solely to the repair, maintenance and general improvement of roads throughout Trinidad and Tobago. The fund, therefore, will be under the control of the Minister of Finance, and disbursements for the purposes of the fund will be certified by the Minister of Works and Transport, who is to be advised by a management committee comprising representatives of his Ministry—who will chair the committee—the Ministry of Planning and Development, the Ministry of Finance and the private sector. The Minister of Works and Transport would report to Parliament on a half-yearly basis on the operations of the fund.

The Government is of the view that taxpayers and the travelling public will be satisfied if the payment of the road improvement tax results in an increased level

of comfort to users of the roads, in addition to savings in travel time and reduction of vehicle operating costs. Expenditure from the fund must, therefore, be properly managed to ensure prompt and efficient allocation of resources. For this reason, the management committee referred to has been established, and comprises the following persons:

The Director of Highways, Ministry of Works and Transport	-	Chairman
The Deputy Director of Budgets, Ministry of Finance	-	Member
The Assistant Director, Planning and Reconstruction Division, Ministry of Planning and Development	-	Member
Mr. Everard Medina, Representative of the Trinidad and Tobago Chamber of Industry and Commerce	-	Member

In determining the most appropriate allocation of resources from the fund, a number of construction and development options have been considered. These options include the following:

- a major road repair and road patching programme;
- a major road resurfacing programme;
- repairs to landslips affecting roadways;
- protection of coastal roads;
- improvements to major intersections and highways;
- improvements to bridges and culverts.

After careful consideration, and in view of the unsatisfactory condition of several roads in the country at present, it has been decided that in the first year of implementation of road improvement work under the fund, a major national programme of road repair and road patching should be undertaken. The objective is to bring a significant proportion of the country's roads and highways up to acceptable standards by the end of 1994.

In 1995, and continuing thereafter, the programme will be expanded to include some of the other road construction options previously referred to.

[HON. C. IMBERT]

A list of main roads and highways to be rehabilitated throughout Trinidad and Tobago has thus been developed using a number of well-established criteria. These criteria include the cost-benefit ratios of the repair work for the particular roads, the volume of traffic on the roads, and the existing condition of the roads. In preparing the list of roads, use was made of the findings of the first phase of a comprehensive highway maintenance study funded by the Inter-American Development Bank, which was recently conducted by consultants on behalf of the Ministry of Works and Transport. This study examined the condition of every main road and highway in Trinidad and Tobago, and made wide-ranging recommendations for road repair and improvement.

This initial list of main roads to be upgraded was laid in this honourable House earlier today, and represents a wide geographical spread throughout the country.

In the first half of 1994, the Road Improvement Fund will be utilized to repair and improve only those main roads listed in the paper laid in this honourable House. In the second half of 1994, however, a number of secondary roads will be included in the programme after consultation with the various local authorities and approval by Cabinet. The approved list of secondary roads will be laid in Parliament by June 1994.

It is estimated that at present there is a seven-year backlog of road repairs. It will, therefore, take some time to rehabilitate all of our roads. Nevertheless, the roads that will be repaired in the first year of the programme include most of the country's major arterial roads, and as a result, significant improvement in the condition of the roads used by the majority of the travelling public in conducting their daily business is anticipated by the end of 1994.

The Government considers the establishment of the Road Improvement Fund to be an innovative mechanism designed to ensure that the travelling public can reap tangible and early benefits from the payment of the Road Improvement Tax. The funding for road resurfacing, materials and equipment under the fund is more than six times the average annual allocation for goods and services for these items in the Ministry of Works and Transport. It is expected, therefore, that, through this fund, which is to continue on an annual basis, the conditions of the nation's roadways will be significantly improved over time.

2.35 p.m.

The programme of road improvement work is scheduled to begin in just over one week's time, on Monday, January 24, 1994, throughout the country, and is yet

another demonstration of the Government's commitment to improve the quality of life for all our citizens.

As we move towards the 21st Century, we are confident that through innovative and creative mechanisms such as this fund, we shall continue to upgrade the physical infrastructure throughout Trinidad and Tobago to standards which all citizens will enjoy and of which we can all be proud.

I thank you.

Mr. Mohammed: Will the hon. Minister indicate whether the works will be executed by his ministry or by contractors?

Hon. C. Imbert: Mr. Deputy Speaker, it will be executed in the first half of 1994 largely on the basis of contracts, but there will be a mix of allocation of resources.

Mr. Sudama: Mr. Deputy Speaker, by way of clarification, in Victoria West there are two main roads which are not listed. I am just trying to find out from the Minister whether that is an oversight or whether the status of these roads has been changed. They are Dumfries Road, for which the Ministry of Works and Transport has responsibility, and Philippine Road for which it also has responsibility.

Secondly, is this listing provided in the order of priority in which the Ministry will undertake these road repairs?

Hon. C. Imbert: Mr. Deputy Speaker, the listing is not in order of priority. The Road Improvement Programme will be done throughout the country, throughout the year. The roads were selected based on the criteria which I have referred to: the cost-benefit ratio, the volume of traffic on the roads, the conditions of the roads; and they were generated by the comprehensive highways maintenance study as being the first set of roads that should be rehabilitated. Other roads will come into the programme in due course.

Mr. Sudama: Your "other roads" will be secondary roads?

Hon. C. Imbert: Other main roads and secondary roads will come into the programme in due course.

Mr. B. Panday: On a point of clarification. Would the hon. Minister state what mechanisms have been put in place to ensure proper accountability for these funds, and what provisions are being made to prevent waste, mismanagement and corruption with respect to the spending of these funds?

Hon. C. Imbert: Certain financial controls have been put in place which I have referred to: the setting up of a special account and the establishment of a management committee, the certification of the disbursements from the fund by the Minister of Works and Transport.

In addition to that, there will be other management controls within the ministry, and the Minister of Works and Transport will report on a half-yearly basis on the amount received, the operations, the efficiency, productivity and all of the matters relating to the output from the fund. It will be a report to Parliament on a half-yearly basis.

Mr. Haniff: Thank you very much for your clarification.

Mr. Deputy Speaker, when the hon. Minister informed this House during the debate about the Road Improvement Fund, he suggested that there would be consultation.

Can the Minister say whether Members have been consulted? I wish to further inform the Minister that 13 roads in the Princes Town constituency have been left out of this listing; two of those roads are officially closed because of landslips and they are not included. As a result, I cannot understand the criteria which is being used.

ISLAMIC CHILDREN'S HOME (INC'N) BILL

Question put and agreed to, That a Bill to provide for the incorporation of the Islamic Home for Children and for matters incidental thereto, be now read the first time.

Bill accordingly read the first time.

REGIONAL HEALTH AUTHORITIES BILL

Order for second reading read.

The Minister of Health (Hon. John Eckstein): Mr. Deputy Speaker, I beg to move,

> That a Bill to provide for the establishment of Regional Health Authorities and for connected matters be now read a second time.

Sir, hon. Members are aware that all is not well in the state of the health sector. The public is not happy, and complains of staff attitudes, long waits, poor facilities and lack of drugs among other things. The staff is not happy, and complains of frustrations in the work place, inadequate facilities and equipment, lack of maintenance, interference and constraints exerted from central levels, and, generally, of not having the freedom to manage properly.

Many talented health workers have left the public sector frustrated with trying to practise good medicine in the tangled web of bureaucracy that constitutes the public health service.

Many members of the public, though they can sometimes ill-afford to do so, have also abandoned the public health sector. The health services must change and this change must result both in better services for the public and in better conditions for staff. The two are inexorably intertwined.

The Regional Health Authorities Bill, which the Government now introduces, is part of a comprehensive package of improvements and reforms; some already are on the way; some for implementation in the future; but all forming part of an essential package of measures to reform our health sector. Let me give you an indication of what this package entails:

1. Upgrading of the physical infrastructure and equipment on a selective and phased basis.

2. Decentralization of service delivery and management via the creation of five autonomous and corporate regional health authorities. These will assume the operation of primary, secondary and tertiary care services.

These authorities, operating in accordance with policy directions of the Minister of Health, will hire their own staff, will be able to sub-contract both clinical and support services and will have a priority focus on primary health care.

Emphasis will be placed in such areas as the screening and prevention of diabetes, hypertension, coronary heart disease, which are among the main causes of morbidity and mortality in the country.

3. Reorganization and strengthening of the Ministry of Health to facilitate its policy-making, planning, surveillance and regulatory roles, devolving at the same time current operational responsibilities on the new authority. This will imply a more sharply focused ministry but more importantly, one devoted to effective sector leadership rather than at present to the management of health facilities and delivery of services.

4. Rationalization and upgrading of hospital and ambulatory care, among other things, the concentration of specialized outpatient and diagnostic services of polyclinics.

The expansion and creation of accident and emergency facilities and the creation of a network of community-based primary health care workers.

Finally, the creation and phased introduction of a national health insurance system in sequence with the decentralization, rationalization and service upgrading components described earlier.

2.45 p.m.

The health insurance system would be national in scope and coverage. It will finance a basic package of preventive, primary, secondary and tertiary services, and will establish clear incentives and controls, promoting preventive and primary health care through both public and private providers, as well as the rational use of specialist and hospital services, diagnostic resources and pharmaceuticals.

Firstly, let me discuss the upgrading of the physical infrastructure. By now, every citizen of this country must be aware of the tremendous improvement taking place in the facilities.

Mr. Sudama: Where?

Dr. Rowley: Do not worry. Carry on.

Hon. J. Eckstein: Plant and equipment within the Ministry of Health. It has been two years of unrelenting efforts that have seen improvements in all our hospitals and many of our health centres; also nurses' quarters in very remote areas and this work will continue into 1994.

I wish to place on the record of this House a status report on the work done during the first two years (1992 and 1993) of this Government in the Ministry of Health. I really would have preferred to give some details as part of my contribution, but I know from experience that the other side's tolerance level for good news is extremely low.

Mr. B. Panday: How would we know? We have never heard anything from that side.

Hon. J. Eckstein: Mr. Deputy Speaker, this document contains so much good news that it would give rise to gastrointestinal problems of such a magnitude that they would never recover. And being the charitable man that I am, I would save them that problem.

Miss Bhaggan: Like the eggnog.

Hon. J. Eckstein: I also need their support in the legislation.

The document now forms part of the official record of this House.

Miss Nicholson: He met it going on, that is why he is going on.

Hon. J. Eckstein: These physical improvements would all come to nothing if at the same time we do not put in place the structure and system that would make proper and effective use of the upgraded health centres and hospitals, and maintain them. Achieving that happy state of affairs requires fundamental and structural reforming of health services.

Decentralization of services and management is the basis of that reform. The new regional health authorities are the vehicles proposed for achieving decentralization and enabling our staff to get on with the job effectively. Regions would have much autonomy which would allow them to solve their own problems without undue interference from central bureaucracy. This is entirely consistent with international trends in modern management that put decision-making power into the hands of those at the right levels. Working within their defined levels of authority and defined budgets, managers at all levels must be free to solve their problems, as only those with the right technical and local knowledge can.

I want to give seven basic reasons why the Ministry of Health has chosen to decentralize the health services:

(1) Decentralization allows services to be run by those on the spot, who can see the problem and the opportunity for solution.

(2) Decentralization means that those running the services are closer to those utilizing them. Services would become more responsive to the consumer as a result.

(3) Decentralization allows flexible responses by managers including shifting resources from one area to another, within their overall budgets.

(4) Decentralization avoids the managerial albatross of the bureaucratic public service, that burden to modern management requiring approvals and procedures for trivial things, slowing down action and response and demoralizing staff.

(5) Decentralization puts decision making into the hands of managers at all levels. It involves them in their work and for the first time it would enable them to see that effort and initiative would get results.

(6) Decentralization creates cost-awareness. It is only if staffs manage their own budgets, would they realize the connection between cost and value for money.

(7) Central planning and management are discredited all over the world. Even Central and Eastern Europe have seen the ultimate folly and

> futility of central planning by distant, ill-informed, uninterested and often, uncaring bureaucrats—who bear no responsibility for the decisions they take.

Decentralization can cure the disease so aptly referred to in an editorial in one of the Sunday newspapers, as the disease that has infected our public service to make it costly and yet unable to deliver the goods.

There are several models of decentralization. The Ministry of Health has chosen the regional model and for the following reasons: Regionalization assumes the rational use of all the health services in geographic areas of the country, where health centres, clinics and district or regional hospitals are closely articulated within the specific area.

The basic principle of regionalization is that whenever possible, health care should be offered by the lowest possible level in the system. It provides more efficient ways to distribute personnel and equipment among facilities, to co-ordinate central and satellite activities, and to facilitate the referral of patients, the flow of medical records and the consultation of specialists with general practitioners.

Regionalization implies the mandatory integration of services in order to improve the conditions in which comprehensive health care is provided to communities. It also ensures that health care workers are part of the continuum of service, rather than part of isolated units. It would, therefore, allow an easy interchange of staff among the various units within the region; for example, specialists at hospitals becoming a part of and providing services at health centres.

This would promote both increased convenience to the population and knowledge about health services; it would encourage improved accessibility to these services; higher quality of care and increased efficiency at lower cost.

I want to assure this House that the Government has embarked on a well-conceived and well-thought-out scheme which has support both within and without the Ministry of Health, both nationally and internationally. This Bill is informed by and is the culmination of recommendations of several commissions, the earliest dating back to 1957, and Ministry of Health workshops, seminars and retreats, in one form or another, for the decentralization of the ministry.

Let me give you some of the history. The Julien Commission of 1957 recommended a statutory board of governors with executive powers; regional, medical and public health boards and hospital management committees, the object

being to establish a regional command system involving hospitals and health centres.

In 1978, the National Advisory Council in its report recommended the establishment of a two-tiered system, a national hospital authority with overall responsibility for all the health institutions, save the Complex which should have its own Authority. These recommendations were accepted by the then Cabinet, but never implemented. I believe that the then Minister of Health did not have the testicular fortitude with which this present Minister is so generously endowed. *[Laughter]*

2.55 p.m.

The Toby Commission of 1981 recommended a national health authority, a company under the Companies Ordinance, Chap: 31:01, with powers enabling the corporation to deal with personnel, procurement of equipment, plant maintenance, security, and so on.

In 1983, an inter-ministerial committee suggested a health services commission and the establishment of three separate boards for Port of Spain, San Fernando and St. Ann's, the management of the operations of the institutions to be by qualified hospital administrators reporting to boards of governors, and the Minister of Health retaining responsibility for policy formulation, monitoring and evaluation.

These recommendations demonstrate that whenever and over whatever period the problems of the Ministry of Health are considered objectively and dispassionately by people competent to do so, the inescapable conclusion is that the ministry has to be decentralized.

What is the thinking today the world over about the manner in which public health systems ought to be organized? This is a pertinent question and I believe that the answer is extremely instructive.

The authority for the following statements is a report published by the World Health Organization. It is the eighth report put out by that body, and the most recent of its reports on the world health situation. It covers the period 1985 to 1990. Based on this five-year review, the report identifies certain ingredients assessed to be critical to achieving success in developing health systems. It identifies certain criteria felt to be absolutely critical to achieving any measure of success in the development of a health system. Among these ingredients, the following have been identified by the World Health Organization:

(1) Government, political, social and financial commitment.

(2) Strong management capabilities for implementation.

(3) Well-oriented, trained and committed health personnel.

(4) Decentralization to district and local levels.

The report went on to review what was happening in this decentralization strategy throughout the world. I am quoting from that report:

> "In a majority of African countries, emphasis has been laid on the decentralization of the managerial process, which is gradually being introduced by all African member states...
>
> In many countries of the Americas, reforms aimed at decentralization of authority have accompanied the democratization process...
>
> A number of countries in the Middle East have reviewed and tried to strengthen and reorient their health information systems, to solve management problems. Oman, for example, is on the way to having a regional health information system to support regionalization of its health system.
>
> A number of countries in the Far East and the Pacific, (American Samoa, Kiribati, Malaysia, Philippines, Solomon Islands, Tonga, and Vanuatu) are making efforts to improve their managerial process by strengthening the planning component. The common feature of these countries is that the responsibility and accountability for resource utilization have been delegated outside the central level.
>
> In some European countries, for example, Sweden ... there has been a widespread trend towards decentralization in health management from the centre to regions, provinces and districts. The common feature in some of these countries is that responsibility and accountability for resource utilization have been delegated to the district level."

In concluding this section, the following portion is given in the report:

> "Weak management at the district level was not always improved by the creation of district management teams or similar action. Unless full responsibility and accountability are given to the programme managers at the delivery level, any improvement in this area may not have the desired effect."

To continue with the expression of views of the international community, I will just give you two more. I had the privilege of attending, as the representative of the Trinidad and Tobago Government, the World Health Assembly meeting last

year. The Canadian Minister of Health speaking at the World Health Assembly stated:

> "Our provinces which have the responsibility for the management and delivery of our health care system are increasing their efforts in decentralizing services down to the regional and local level. All these are efforts to ensure that services address the priority health needs of the population."

The Minister of Health from the UK said:

> "The key element in our reform has been a greater delegation of authority to the local level. The leadership which demands control over every facet of the service can never be wholly effective. It is important to create a framework and an environment in which authority can be exercised and decisions taken close to the point of delivery where they can more easily respond to local conditions and needs.
>
> The emphasis on reform in the UK has been to devolve responsibility to make the service more responsive to the needs of the population."

I want to come back to Trinidad and Tobago and I want to give a feel for how several actors in the health sector think about administrative decentralization. Through the Permanent Secretary in the Ministry of Health, we sought the views of a number of organizations and they responded as I shall show you. The Chest and Heart Association, by letter dated February 12, 1992 said:

> "The Association fully agrees with, and supports the concept of decentralization of the administrative functions of the Ministry. The Association also supports the proposal for the management of hospital services by incorporated authorities or boards with full executive powers, but responsible to the Minister in respect of broad policy matters. Moreover, the boards must clearly appreciate that all the activities carried out by them must be within the framework of stated government policy."

The Trinidad and Tobago Registered Nurses Association, by letter dated February 11, 1992 said:

> "The Association has agreed to the concept of administrative decentralization of the Ministry of Health and the establishment of incorporated authorities to achieve this goal.
>
> We support the view that vesting of the responsibility for the running of individual hospitals in local boards or authorities will facilitate the management of these institutions and improve the quality of service provided to the public."

The Trinidad and Tobago Medical Association said:

"The Association wishes to convey to you its agreement, in principle, to the concept of administrative decentralization of the Ministry of Health. We would like to reiterate, however, that while the concept of decentralization is very dear to our hearts and is something that we have been advocating for two decades as the only remedy for the ills of the system, we strongly recommend the setting up of regional health authorities. These would encompass the feeder health offices and centres and the area hospitals".

The Society of Radiographers, by letter dated February 7, 1992 said:

"The Society agrees in principle to the concept of administrative decentralization and we look forward to collaborating with you in working out the details of the system to be adopted."

3.05 p.m.

With respect to letter dated January 29, 1992:

"The Tobago House of Assembly welcomes this approach to the management of the health services throughout the country. Your intervention then is very timely, and the concurrence and support of the assembly is assured."

The Public Services Association:

"The Public Services Association had no disagreement in principle with the introduction of boards for health institutions, but they would continue to operate under the aegis of the Public Service Commission."

The Diabetes Association of Trinidad and Tobago:

"Our association agrees in principle with the concept of administrative decentralization and the establishment of incorporated authorities for improvement to the management system in the health services."

Mr. Deputy Speaker, you will recall I laid in Parliament a policy document on administrative decentralization; this document was widely circulated and comments were received.

The following is the opinion of the then Vice Dean, now the Dean of the Faculty of Medical Sciences of the University of the West Indies, Prof. G. N. Melville. He says:

"The Ministry of Health has dealt with all aspects that are ingredients for a successful decentralization."

(1) Community Involvement.

(2) Political Goodwill and so forth.

He concludes:

"It is the route to go in the 21st century if efficiency, effectiveness and equity are to be achieved, and barring slight refinements here and there, the Faculty should support it."

Prof. Rolph Richards of the Faculty of Medical Sciences wrote as follows:

"(1) The Boards of Authorities must have the authority and ability to recruit and hire its own staff and to terminate contracts as it sees fit.

(2) The Authorities must, and should be given their own budgets to utilize as dictated by the authority or finance committee thereof, including the purchasing of equipment, chemicals, computer hardware and software."

He has gone a little too far.

A sub-committee of medical consultants of the Faculty of Medical Sciences at the University of the West Indies was asked to comment and it responded as follows:

"The Paper served as a useful introduction to the question of administrative reform. The philosophies and concepts which are addressed are praiseworthy, but the document is full of generalities, lacks specificity in some areas, and the exact *modus operandi* by which proposals will be implemented are not stated."

This was followed by some very useful and instructive comments which assisted us in preparing the draft Bill. Their paper concluded as follows:

"Thus, in summary, we do agree with the need for administrative reform and decentralization in the health sector. However, the systems to be adopted to effect this have to be specifically spelt out. The comments given above are done in an effort to develop a functional policy so that a healthier future for our children and grandchildren can be envisaged."

The Public Services Association have more recently responded, more or less reiterating their earlier position; mainly they agreed in principle, but preferred to maintain the *status quo*.

This analysis would not be complete without entering into the records, the thinking of the major political parties of the day on the subject of administrative

decentralization of the health services. The former administration left a Note in the Cabinet records; it is dated October 7, 1991. In paragraph 4 the Note identifies a series of deficiencies in the Ministry of Health, and in paragraph 10, the Note reads as follows:

In order to remove the present deficiencies in the system it is proposed:

"…that hospital health care services, be delivered to the country's population through hospitals managed and run by incorporated authorities which are answerable to the Minister of Health in respect of broad policy matters only. The Ministry of Health also proposes as part of the new framework that the responsibility for, and control over staff and property be vested in the incorporated authorities themselves, if not immediately on their incorporation, then on a phased basis over a period of transition."

The recommendation in the Note is as follows:

"The Minister of Health recommends and Cabinet is asked to agree to the proposal, that as a matter of policy, the Port of Spain General, San Fernando General and St. Ann's Hospitals be managed by autonomous incorporated authorities responsible to the Minister of Health."

My ministry considered this Note very carefully; we have sought to improve on it as any administration would do. Unfortunately, the administration—it is a fact that they did not have the opportunity to implement it, but I think they need to be congratulated on having moved in the right direction. *[Applause]*

This is what the UNC manifesto—*[Interruption]* which I trust reflects the position today of that august party:

"It is essential that we have a Health Service which provides an efficient and high standard of care for the ill and the ailing."

And—

"In order to advance these concerns the UNC will implement…" *[Interruption]* If elected, that is a big problem. *[Interruption]*.

Mr. B. Panday: You are a minority Government; do not forget that. *[Interruption]*.

Hon. J. Eckstein: Mr. Deputy Speaker, could I ask for some—*[Interruption]*

Mr. Mohammed: You are provoking people; go on with your presentation. [*Interruption*]

Hon. J. Eckstein: Okay, I am sorry. I humbly apologize.

Mr. Mohammed: You are going good man, present your case!

Hon. J. Eckstein: To continue:

"In order to advance these concerns the UNC will implement:

(4) Efficient district medical services managed by Regional Medical Boards including efficient emergency and outreach facilities.

(9) Establishment of effective financial, administrative and management systems."

Their proposals more closely resemble the Bill which is now before the House—*[Laughter]* than the PNM's proposals, because we modified our proposals on the basis of consultation and by advice from technical officers and we came closer to their position. The original position of the PNM is to be found in its election manifesto. This position was somewhat modified, as I have just explained, and laid in this Parliament and is now operationalized in this Bill.

3.15 p.m.

Finally, as I mentioned before, on a daily television feature called "The People Meter", 81 per cent of the respondents to a question on decentralization expressed the view that the Ministry of Health should be decentralized. These polls may not be 100 per cent accurate but I think this result can be taken as reflective of public opinion, that an overwhelming proportion of the population supports decentralization.

Let me give two examples: one in the clinical area, the other in housekeeping, to demonstrate why we must move with expedition to free the health institutions from the central bureaucracy of the public service and vest the authority to manage in those who have the responsibility for the services.

First the clinical area. These details are taken from a report prepared by the hospital administrator of the Port of Spain General Hospital. The name Debra Yearwood, in case hon. Members have forgotten, was featured in three articles in the *Sunday Guardian* of October 3, 1993. Debra presented at the Accident and Emergency Department of the Port of Spain General Hospital on Friday, August 20, 1993 at 10.10 a.m, with a letter from a specialist medical officer acting at the San Fernando General Hospital, requesting that she be admitted to Ward 22 of the

Port of Spain General Hospital. Reported in the medical officer's handwriting on the patient's record was that the matter was discussed with the relevant specialist medical officer at the Port of Spain General Hospital. So the patient presented at 10.10 a.m.

At 10.20 she was seen by a house officer attached to the Accident and Emergency Department and registered in accordance with the request of the officer in San Fernando for admission to Ward 22, which is a female surgical ward. At Ward 22 she was seen by an intern who redirected the patient to Ward 15, an ear/nose/throat ward. The patient was attended to by a house officer on Ward 15, who requested and received blood for the patient, which was transfused to the patient late Friday evening and through the night.

On Saturday 21, the house officer again, on behalf of the patient, requested blood which the patient received. On Sunday 22, it is recorded in the notes that the patient was to be reviewed by the specialist medical officer, general surgery. That officer was then contacted by the Registrar, Ear/Nose/Throat Department and agreed to take over the management of the patient. The patient was then transferred to Ward 22, which was the original recommendation, at 4.15 p.m. on the Sunday.

On admission to Ward 22, the patient was not seen by the specialist medical officer but by a medical intern who recorded in the file that the patient was to be reviewed by the specialist medical officer.

On Monday 23, another intern noted in her file that the patient should be reviewed by a senior.

At 7.00 p.m. on the same day the patient expired. When the family and the media enquired they were told that she died because the hospital did not have a drop of blood—an outrageous, self-serving falsehood, which the media, without bothering to check, I presume, reported.

I do not pretend to know the cause of Miss Yearwood's death, but what is clear from the reports I have received, however, is that she died without the benefit of the best technical expertise for which the Ministry of Health is paying. I am not contending either that she would not have died had the technical expertise been brought to bear on her case, only that she did not get it. Such is the experience of many who seek to avail themselves of the health care offered at the government-financed, owned and operated public health care institutions.

Miss Yearwood spent from Friday, August 20, 10.10 a.m. to Monday, August 23, 7.00 p.m. at the hospital, where, according to the hospital records, she was

cared for mostly by house officers and interns. She eventually died and never got the attention or the kind of expertise that had the best chance of making a difference in her case.

This is not an isolated case; it was the same with the young boy, Shahadath Boodram, who died, having reported with gastro at the San Fernando General Hospital.

The fact of the matter is that the bulk of the medical work at hospitals is done by house officers and interns. This is not to say—and I want to make this very clear—that there are not specialist medical officers and registrars who evince and conscientiously discharge a sense of responsibility to the patients in their charge. These individuals are to be complimented, but their efforts notwithstanding, the fact is that the vast majority of the expertise residing in the system is often elsewhere pursuing, very legitimately—I hasten to add in the case of the consultants—private practice. The result is an almost complete absence of medical administration, in that the young inexperienced house officers and interns are left to fend for themselves, resorting often to despairing and futile notes in patients' records calling, as in the instant case, vainly for help. The quality of care is, of course, severely compromised, and the public pays a heavy price.

The root of the problem is a decision of the Industrial Court given in a judgment dated September 22, 1978 as follows:

> "With effect from October 1, 1978, until September 30, 1983, a Registrar who is qualified to be appointed a Consultant shall be allowed private practice."

It would be quite wrong to attach any blame to the Industrial Court for this judgment, for the court in the said judgment had this to say:

> "We did not discover the rationale behind the grant of private practice to government medical officers. On the face of it also, there appeared to us to be some inconsistency in a claim on the one hand for increased pay to doctors to compensate them for unconscionably long hours of work..."

The bulk of this judgment dealt with compensating doctors for unconscionably long hours of work, as a consequence of which they received institutional allowance, sessional rates, compensatory time off. The court was saying that there seemed to be some inconsistency in a claim on the one hand for increased pay to doctors to compensate them for unconscionably long hours of work—

"and a claim on the other hand that these same doctors should in addition be allowed to work at private practice. Fortunately, a concession made by the Personnel Department during the hearing saved us the necessity of making a full-scale enquiry into these matters."

So, the matter before the court was between the Chief Personnel Officer and the Public Services Association, and the court was saying that a concession by the Personnel Department saved them the trouble of having to investigate a matter in which they saw considerable inconsistency.

But the fact that the CPO so readily conceded the association's claim should not come as a surprise. This is a direct consequence of giving a central agency of government the authority to make a determination in a matter, the implications of which it cannot possibly appreciate.

Had the CPO any understanding of the disastrous consequences of this decision for the delivery of health care; had the CPO to be held accountable at the bar of public opinion for it, the concession would not have been made so lightly. Rather, it would have been exercised with such circumscription that opportunity would not have been provided for the unscrupulous, in pursuit of their narrow self-interest to so easily subvert the primary focus of the public health care system, which is to provide quality health care to the people of Trinidad and Tobago. So, the matter of private practice has to be revisited.

3.25 p.m.

I do not want to give the impression that I am against private practice. Under the new dispensation which the passage of this Bill promises, it will be a matter for determination and agreement between the hospital administration, which will be vested in law, and the relevant authorities and the PSA, or whichever union represents the doctors. Any agreement on private practice has to begin by first defining in law what is meant by private practice.

In Britain, where we copied this concept from, private practice is permitted. All the arrangements relating to private practice can be found in the laws; and clearly we start with the definition of the expression "private practice" in these terms and conditions of service which includes—"(a) a diagnosis or treatment of patients by private arrangement;" and it defines exactly what private practice means. There is no ambiguity. The employer and employee know what it is. In our system nobody knows. One can do "private practice"—it is nowhere defined in anything.

This document sets entitlements to undertake private practice. It sets out those categories of staff who can, and under what conditions. It sets the limitations on

private practice. It says here: "a whole-time practitioner"—you see, we have copied the concept of private practice from Britain, but we did not bring with it the regulations, the baggage, and so on.

Mr. Maharaj: I wonder if the hon. Minister could answer a question. Since we are copying this also from Britain, could he tell us what mechanisms have been put in place to have the standard and cost of health care monitored?

Hon. J. Eckstein: Does the Member want that now? *[Laughter]*

Mr. B. Panday: No, next year will do.

Hon. J. Eckstein: Limitations on private practice. It says:

(a) "A whole-time practitioner…"

It distinguishes between different categories of staff—

> "…in one of the career grades must certify annually (by the production of fully audited accounts) that his gross income from private practice does not exceed 10 per cent of his gross salary.
>
> (b) Where a whole-time consultant's…certified private practice income exceeds 10 per cent of his gross salary for two consecutive years, his contract will automatically be deemed to be a maximum part-time contract and his remuneration adjusted accordingly. "

The arrangement of your duties will be such as may be agreed between the employer and the relevant union. It is agreed that—

> "any private practice you may undertake whether limited or not by the terms and conditions of service will in no way diminish the level of service that may be expected from you by the authorities in carrying out the duties specified above."

So that, it is not that I am against private practice. Far from it. What I am saying is that the arrangements that we have, need to be dealt with by an agency that has the direct responsibility, the authority, and which is accountable to the country and the people of Trinidad and Tobago for the decisions that they make.

Mr. B. Panday: Accountable to the country how? That is one of the major points. Show me how in this Bill they are accountable to anybody.

Hon. J. Eckstein: In the meantime, we all, especially if we cannot do better, have to live with the present system. Unfortunately, many like Miss Yearwood and Mr. Boodram have not been so lucky.

Mr. Maharaj: PNM is responsible for that. They created the system.

Hon. J. Eckstein: I said I would give two examples; that is one of them. The other one is in the housekeeping area. This is a decision, or rather, it is in the terms of settlement between the CPO and the NUGFW in relation to a particular matter; and the terms of the settlement are as follows.

"It is hereby agreed between the parties as follows:

(i) that the Letter of Dismissal dated May 13, 1993 issued to the worker is withdrawn";

This is the CPO and the NUGFW. A worker was dismissed and the dispute is now being settled.

"(ii) that the worker will resume duty on September 7 in his former substantive post at the Hospital; and

(iii) that the period May 7 to September 6 while the worker was off the job shall be treated as a period of suspension without pay."

This very seriously upset the administration at the hospital and they penned the following letter to the CPO. It reads as follows:

"I refer to your Memorandum of Agreement dated September 9, 1993 between the CPO and the NUGFW reinstating a worker of this hospital with effect from September 7, who was dismissed on May 15 on the grounds of job abandonment.

I have accepted the decision of the CPO and submit for your certification the time cards of this worker for the periods September 7-20, 1993 and September 21 to October 4, 1993, so as to facilitate payment to this worker.

I cannot certify payment to this worker for the following reasons:

1. It was my opinion then, as it is now, that this worker is unfit for continued employment and his very presence is inimical and counter-productive to our stated mission and purpose.

2. His truancy, tardiness, inertia, poor performance and conduct have deteriorated over the past years.

3. As the Accounting Officer for the General Hospital, I cannot in good conscience justify the expenditure of public funds to pay this officer, when he has not and is not performing up to standard.

> In view of the above, I am forwarding this officer's time card to you for certifying. Since it was your decision to reinstate the officer, I have assumed that you know this officer's strengths and weaknesses and work ethic, and therefore you are in a position to assess his capabilities, supervise his work and therefore certify his card for payment…
>
> When I reviewed the decision of the Personnel & Industrial Relations Officer III and the Assistant Administrator to terminate the services of the worker, I was of the view that this case was *prima facie*, very clear and straightforward and the decision arrived at was non-prejudicial and in the best interest of the organization, and very consistent with the terms and conditions of the officer's employment.
>
> Clearly, by your overturning of this decision, I was very wrong…."

If you remember the Memorandum of Agreement did not say anything as to why the decision was reversed. The letter continues:

> "I understand from the P&IRO III that the reason given by the CPO for this worker's reinstatement was that 'he has children'. If this is a reason then clearly performance is no longer a criterion for employment.
>
> Are we therefore, in future, before pursuing disciplinary action against a worker, to conduct a domestic needs assessment? And if yes, should this be done by us or should we refer the case to the Social Workers' Department, so that it would carry professional credibility?
>
> The decision of the CPO has completely emasculated and undermined the authority of this administration and proven its disciplinary mechanism ineffectual and useless. Your decision has resulted in a total loss of respect for the administration of this hospital.
>
> Last year, the CPO again overturned another decision of this Administration…
>
> My position here is both difficult and sensitive, in terms of my effectiveness in managing this cadre of staff. I am now wondering if by the CPO's decisions, the message being sent is that the Hospital Administration should now refer all disciplinary matters to the CPO for a pre-evaluation so that we may know the outcome in advance therefore saving us the time, money and extensive human emotional and psychological input which go into resolving a disciplinary matter.

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3.35 p.m.

Two (2) trained and experienced Hospital Administrators and a senior and very experienced P&IRO III make a decision, which is corroborated and endorsed at Head Office by an Administrative Officer IV, Industrial Relations, on behalf of the Permanent Secretary, Ministry of Health, and is overruled by the Chief Personnel Officer, not apparently on technical or professional grounds, but apparently for domestic reasons.

You would not be unaware of the negative publicity that plagues our health care service, in particular our General Hospitals. Issues such as unkempt grounds and corridors, smelly (urine) and stained staircases, unscrubbed steps, 'stinking' mortuaries, untimely delivery of meals, etc. These are separate and distinct from the negative clinical publicity."

How is this administrator ever going to run this hospital? He goes on to say that his authority has been completely "on ninth street". He continues:

"The following is a characteristic day in the life of running a General Hospital, which I hope will give you a sense of what I face each day as I enter the hospital.

On October 1, 1993 at 11.00 a.m., I made a spot check on the mortuary of my Hospital, a practice I regularly do. The mortuary's odour could best be described as fetid, a combination of decomposing bodies and stale blood. The floor was soiled and dirty. There were three trolleys covered in blood and other body fluids, and blood-stained, soiled linen which once wrapped the bodies were strewn on the floor and overflowing from the bin provided for disposing of such linen.

With hesitation and anxiety I entered the autopsy room. In there were the Pathologist and the Mortuary Attendant in the process of doing an autopsy.

I enquired, or at least sought to, from the Mortuary Attendant, why the mortuary was in such a condition at 11.00 a.m. He shouted back at me, 'But I clean here yesterday'. I continued that 'I am not speaking about yesterday. I am talking about today, now.'

With great indignation and gesticulation of his hand—holding the scalpel, which is very sharp—voice raised, obviously quite displeased that I was interrupting his work, he proceeded to let me know in no uncertain terms, that he could not understand my problem, as the mortuary was cleaned the day before. Clearly a case of stupidity on my part. This discourse in futility lasted about ten minutes.

At that point in time, I left the mortuary in frustration, achieving absolutely nothing and knowing fully well how powerless I was to do anything.

Reporting the matter to you was clearly out of the question."

I do not mean to you, Mr. Deputy Speaker; I mean to the CPO.

"As I returned to my office in the heat of the day, my sense of despair was real. I sat in my chair, silent, for a considerable length of time."

And listen to this; this is extremely critical:

"I have since written to the Permanent Secretary, Ministry of Health to have this worker transferred from this institution. I inherited this worker as a result of a scandal that made the press concerning the 'selling of bodies' from the mortuary of another hospital."

This is the extent of the power that the authorities have: somebody misbehaves here, he or she is transferred there and that is it. Full stop!

Mr. B. Panday: That is the practice you developed in the PNM. You promote them when they are corrupt. That is your system that you are talking about.

Hon. J. Eckstein: Mr. Deputy Speaker, Members of the Opposition have said that we created this system. As I indicated earlier, we are now adopting the system that they have suggested and which we are now presenting to them for their consideration.

Mr. B. Panday: We say to deal with public servants like that. That is what we said.

Hon. J. Eckstein: The letter concludes:

"I have chosen to give this matter wider coverage because of the broader implications which go to the core of the 'responsibility versus authority' conundrum that managers in the public service face and its implications for public finance."

Mr. B. Panday: You are reaping the whirlwind! You have sown the wind!

Hon. J. Eckstein: Mr. Deputy Speaker, it has been alleged in certain quarters that there has not been consultation with respect to the Bill and that people are unaware. This comes as a surprise to the ministry. I made a statement here in

Parliament on March 20, 1992. I indicated the number of organizations that we have been in touch with on this matter. I made a statement in Parliament giving a progress report on Government's initiatives designed to improve the Ministry of Health and in that statement the promise was to improve the management of secondary health care institutions through a system of administrative decentralization. At that time we still had not as yet adopted the regional approach.

However, by July 24, following intensive discussions and consultations, the policy was modified and I made a statement in Parliament setting out Government's policy on administrative decentralization. A policy document was distributed to every Member opposite, to all members of the media and to all health sector organizations, including administrators and medical chiefs of staff at all hospitals. That was on July 24, 1992.

Subsequent to the passage of the legislation, I met with the Public Services Association on November 23, December 28 and January 4. Their position, as I indicated to you, is that they are not generally supportive of the thrust and they are very concerned about the job security and tenure matters of their members, and with every justification. Theirs were very legitimate concerns. We have sought in the legislation to address each one of them.

We feel confident that the legislation does not threaten anyone in any way, but they were not comfortable, and in the course of those long hours of meetings, they suggested a number of amendments to the legislation and the vast majority of those amendments have now been cast in law and circulated to Members. These amendments came out of the discussions and the recommendations following discussions with the trade union. We have not accepted all their recommendations but we have accepted the vast majority of them.

I met also with the NUGFW, the other union which represents workers in the health sector, and I want to give the assurance to health workers that no one in the health sector will be dismissed as a direct consequence of the passage of this legislation. No one!

In addition to that, Mr. Deputy Speaker, we have had continuous discussions within the Ministry of Health. We have had on May 21, a meeting to discuss an overview of decentralization as a key strategy of health sector reform. This was attended by all the technical and administrative heads, the hospital administrators, the consultants, EWMSC representatives, the county medical officers of health.

3.45 p.m.

The Ministry of Health had a retreat for six days for its senior technical officers and the target group was technical and administrative heads at head office, hospital administrators, the CO from the complex, representatives from the CPO, DPA, O&M Division, the consultants, the public service reform team—six days of consultation. That is September 7, 8, 16, 17, 28 and October 13; all of them dealing with what a Ministry of Health would look like under a decentralized arrangement. Because that is something we have to look at. The Ministry of Health has a different mandate now. It is now the leader in the sector. It is not engaged in operational activities again; it is going to do policy formulation, regulation monitoring, and so on. What would a new Ministry of Health look like in this new dispensation?

On November 23, December 14, 21, we had another retreat for senior technical and administrative officers. There were medical chiefs of staff, research officers, district registrars, CMOHs, area administrators, SMOs, Insect Vector Control Division, nutrition and metabolism, Hansen's disease. We have been having now, specifically with respect to the Bill, a series of discussions. These things are ongoing. Yesterday I met with some of the consultants from the Port of Spain General Hospital and they raised certain concerns which we sought to address.

Mr. B. Panday: "We sought to address", where? What does that mean? Because we have a note from them after the meeting.

Hon. J. Eckstein: We sought to address; we sought to allay their fears. We do not always succeed, but we try.

As I move to wind up my presentation now, let me provide some more detail on the proposed regional health authorities. As I have said, regions will have a great deal of autonomy, allowing them to solve their problems, without undue interference from the central bureaucracy. There will be four regions for Trinidad and one for Tobago. Their boundaries will be coterminous with those of the municipal corporations. Each region will be formed by combinations of whole municipalities.

Hon. Members will demand accountability from these new regions, and rightly so, and we shall have it. The Bill before us clearly retains the accountability of regions to this House through the Ministry of Health. Like statutory authorities, regions remain under the Exchequer and Audit Act controlling their financial dealings. The Bill retains ministerial control through

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directives to the regions. I emphasize, however, that this is intended as a safeguard measure, not as a device for unnecessary interference in a region's day-to-day affairs. This power of directives allows the Minister to define annual reporting arrangements for the regions and to demand proper income and expenditure projections annually.

The most fundamental changes are that the regions will be the main providers of health care services. Regions will own our hospitals and health care centres and will employ our health personnel. To avoid any misunderstanding on this issue, I emphasize that regions are statutory authorities accountable to the Government. No state assets are being privatized.

The role of the ministry becomes that of setting the policy, the health priorities, the specific performance targets and the budgets of regions. No longer having to operate services directly will enable the ministry to concentrate on using the policy and financial control mechanisms to steer regions towards quality and value for money. The regions will be run by small boards. Non-executive board members will be selected for their leadership qualities and their practical experience in relevant fields, financial control, management, law, health, for example. Executive management will be achieved with a small group of senior managers, with responsibility for the whole of the region, covering primary and secondary care.

Regions will be responsible for providing primary care for their populations and for operating the hospitals within their areas. But the hospitals are national resources, accessible to all patients on the basis of need, not only to the population of the region operating them. Regions will be able to agree to arrangements with private sector doctors to provide some of the primary care services needed for their public sector patients.

When I earlier discussed the business about private practice, one of the things we did not allow in the Government service is private practice within public health care institutions. That is, again, something we have to correct. There is absolutely no reason why, properly regulated, doctors cannot do their private practice in the Government's hospitals. It has to be regulated. In Britain, there is a large set of rules: "Management of Private Practice in Health Service Hospitals in England and Wales." It sets out the whole framework within which they can do the private practice within the hospitals without in any way affecting their commitment to the hospital and the Government workers.

Regions will prepare their annual plans and action programmes on the basis of the policy and priorities set by the ministry. Finance will pass to the regions on

the basis of those plans, as agreed with the ministry. I believe the Representatives for Couva North and South were asking earlier how the ministry exercises control over its regions and how they are accountable to the Parliament.

Mr. B. Panday: Not Parliament, the country.

Hon. J. Eckstein: Regions will commit to an agreed volume of primary and hospital services to meet the defined quality targets and to an annual budget. Actual performance against this contract will be monitored by the ministry. Contracts for subsequent years will be modified by experience gained. As regions come into existence, staff in the hospitals and health centres will transfer their employment to these new legal entities. There will be no loss of employment as a result of this transfer. Staff will join regions on terms and conditions comparable or superior to those they enjoy under the ministry's employment. Pension rights will be preserved.

There is also provision for ministry staff to be seconded to regions. Over time, and as the regions start to achieve the desired shift towards priority health programmes, there will be opportunities for staff to receive appropriate training to take on new roles. New skill mixes will be required to support the emphasis on primary care. Nurses, for example, will be encouraged to take on new functions.

In terms of overall costs, regionalization itself will not require additional recurrent financing. The objective is that regions will squeeze the present inefficiencies out of the system to make more effective use of the money we now spend. This is a first priority. In due course, it is intended that more funds will be channelled through the regionalized system by a national health insurance fund, but only when the restructuring of the health service is in place and will prevent that extra money causing cost inflation.

3.55 p.m.

Of course, structures, systems and financing are not everything; they all exist to improve the health of citizens and to improve the health care they receive as patients. A vital part of the latter concerns the attitude of staff toward patients, and I believe that improving those attitudes starts with improving the structures and facilities within which staff are asked to do their jobs.

It is the structure that dictates the amount of time staff can spend with patients; the effectiveness with which they can bring their skills to bear on a patient's problem; and the tools they have on hand for diagnosis and treatment. Not being able to meet a patient's proper needs gives no satisfaction to health care staff; it simply creates yet more frustration for them. By being near to the action,

regions would become more responsive to consumer needs and to the specific local opportunities for solving problems and meeting those needs. At the same time, the ministry would ensure that its contracting relationship with regions includes considerations of quality, as well as quantity of services; and measure of quality would include the views of consumers.

Whilst structural reform is not a sufficient condition for better health care, it is a necessary one. The regional health authorities and the principles of decentralized management that will be set up by this Bill are essential steps on the path to better services.

I have embraced the opportunity given me by fate, I am sure, to move this momentous piece of legislation in this House. I certainly see it, without question, as the defining moment of my political life—*[Applause]*

Mr. B. Panday: Which will soon come to an end.

Hon. J. Eckstein: For it is to me, a far better thing that I do than I have ever done before.

I have characterized this opportunity as one given to me by fate, for I can assure you that there was a time when the possibility of my standing here today, moving the second reading of this, or any other Bill, appeared highly improbable. How well I remember my first entry into the Ministry of Health in 1985, when very quickly it became apparent to me that responsible management, vested in the necessary legal authority was the key ingredient—missing in the institutions—if the Ministry of Health had to improve the health care delivery system.

Back then, I immediately set about the task of correcting this identified structural deficiency, and in a few short months, upon my recommendation, the Cabinet agreed to create the position of Hospital Administrator in the major hospitals, and to the establishment of management advisory committees to oversee the operations of the major hospitals. These committees did not have legislative authority, and were seen as only forerunners to hospital authorities, which it was my intention to approach Cabinet to have constituted under appropriate legislation in due course.

Then came the run-up to the general election of 1986. I recall as if it were yesterday, the present representative for Tobago East—then Chairman of the Tobago House of Assembly—proclaiming stridently to the national community that I was unfit to hold public office.

Mr. B. Panday: He did not mean that; do not hold that against him. *[Laughter]*

Hon. J. Eckstein: The election came, I lost, and was banished for five years to the political wilderness, as Mr. Ferdie Ferreira recently commented in a letter published in the press.

Mr. B. Panday: You see, he was right then. *[Laughter]*

Hon. J. Eckstein: As much as I thank Mr. Ferreira for his kind words about my ministerial performance, he could not begin to understand the extent of that banishment, and, perhaps, the less said about it the better. *[Laughter]*

Suffice it to say, that it was by frequent recourse to the soothing, comforting and reassuring words of the 23rd Psalm that I sustained myself during that period; but I am back, the Government of which I am a part is back, and we have had two really outstanding years in the Ministry of Health, notwithstanding the major structural difficulties this Bill addresses.

Only recently, Mr. Keith Smith of the *Daily Express*—let me take this opportunity, on behalf of the Government, to extend condolences to him and his family on the death of his father—took his "On the Road" column to St. Ann's and so impressed was he by what he saw there that he felt moved to write. I do know that one of the ways one judges the worth of a society is the way in which it treats the helpless and the hapless. What we are doing in St. Ann's may get us some of the points we need to acquire if we are to get to heaven, or paradise, if you will.

I was not surprised. I too, quite recently, on the occasion of the commissioning of a refurbished ward for females at St. Ann's, experienced such a sense of euphoria at the work taking place in my ministry that, forgetting for a while my natural reticence and the precariousness of political office, I returned to my favourite psalm, this time for celebration and rejoicing, and in front of a large audience spoke quite shamelessly as follows: "My cup runneth over, surely goodness and mercy shall follow me all the days of my life—*[Laughter and applause]*

Mr. Robinson: Mr. Deputy Speaker, I was merely about to say that I am happy I delivered the shock treatment that he deserved. *[Laughter]*

Hon. J. Eckstein: Mr. Deputy Speaker, I would be no more than two minutes. The achievements of the Ministry of Health over the past two years, as well as my previous stewardship—not recourse to the courts, as I was advised—are my answer to those who have questioned my fitness to hold public office. As I have said before, these physical improvements, impressive as they are, will soon come to naught if we do not change the system by which our health care services

are administered. The Government cannot and is not prepared to continue to preside for a day longer than is necessary over a service that is clearly not serving the best interests of its people.

I, therefore, call upon Members opposite, to support this Bill. In the case of the United National Congress, I ask them to be faithful to their manifesto pledge, the basis on which the people of Trinidad elected them for the office they now hold. *[Laughter]*.

In the case of my good friends the Members for Tobago, I ask them to be faithful to the policies they proposed but did not have the opportunity to implement while they were in Government.

To the Member for Couva North, to him personally, my erstwhile political leader—

Mr. B. Panday: To be once again.

Hon. J. Eckstein: —really, the inspiration for my first venture into the political arena, I call upon him, Sir, to join hands with his former charge—*[Laughter]*—in supporting a measure that captures the essence of what I am sure, we still believe—unselfish service to all the people of Trinidad and Tobago.

Mr. Deputy Speaker, let us all open our hearts to this measure and lend a willing hand. Let us, by our action show the lonely, and the poor, that God is in this land.

Thank you.

ADJOURNMENT

The Minister of Local Government and Minister in the Ministry of Finance (Hon. Kenneth Valley): Mr. Deputy Speaker, in moving the adjournment, I wish to inform you that I have informed the Chief Whip, that debate on this Bill will continue on January 28 and that on Friday 21, the Government will be introducing the Maxi-Taxi (Amdt.) Bill.

I beg to move that this House do now adjourn to Friday, January 21, 1994 at 1.30 p.m.

4.05 p.m.

Deferment of Debate
(Request for)

Mr. B. Panday: May I ask that the hon. Leader of Government Business do reconsider the position of having this Bill debated two weeks from now.

I say that because we held a very hurried discussion with the people who are going to be directly affected by this Bill. We spoke to the Nursing Concil, the Pharmaceutical Board, the Mount Hope Consultants, the PSA, the Public Health Inspectors, and the Medical Association.

As the Minister rightly said, “in principle”; the Bill is supported in principle, but there are many things to be ironed out. I do not think that two weeks is going to be enough time for consultation. Consultation was the theme that ran through the meeting we had with these parties.

I was wondering. Having regard to what was said by the Minister of Health, that they held consultations and people are still unhappy, maybe it means that the Minister cannot consult. Would the Minister consider the setting up of that joint select committee so that real consultation could take place between those parties and an opportunity be given to everybody?

The law is going to succeed only to the extent that it has public support. He is right that the Bill is agreed upon in principle, but there are many questions to be ironed out. Do you think two weeks is going to be sufficient time? Would you consider the idea of a joint select committee so that all the persons who are involved would have an opportunity to voice their opinions? I put forward that suggestion.

Hon. K. Valley: Mr. Deputy Speaker, as you know, at the second reading the Bill can go either to a committee of the whole House or to a select committee.

At that stage obviously, one would put in that decision as to what is the appropriate entity to send the Bill.

Mr. T. Sudama: Mr. Deputy Speaker, on the last occasion of this House I had a Motion on the Adjournment and the Government decided not to debate it. It got this House to pass a Motion to defer the Motion on the Adjournment to the next sitting of the House.

I wonder what I did in this House?

Mr. Deputy Speaker: I do not have that in front of me so I would have to ask that this be taken up at the next sitting of the House.

Question put and agreed to.

House adjourned accordingly.

Adjourned at 4.09 p.m.