SENATE

Tuesday, April 17, 2012

The Senate met at 1.30 p.m.

PRAYERS

[MR. PRESIDENT *in the Chair*]

LEAVE OF ABSENCE

Madam Vice-President: Hon. Senators, I have granted leave of absence to Sen. The Hon. Anand Ramlogan SC, Sen. The Hon. Kevin Ramnarine and Sen. Dr. Rolph Balgobin who are all out of the country.

SENATOR'S APPOINTMENT

Madam Vice-President: Hon. Senators, I have received the following correspondence from His Excellency the Acting President, Timothy Hamel-Smith.:

"THE CONSTITUTION OF THE REPUBLIC OF TRINIDAD AND TOBAGO

By His Excellency TIMOTHY HAMEL-SMITH, Acting President and Commander-in Chief of the Republic of Trinidad and Tobago.

/s/ T. Hamel-Smith
Acting President.

TO: ARCHBISHOP BARBARA BURKE

WHEREAS Senator the Honourable Kevin Christian Ramnarine is incapable of performing his duties as a Senator by reason of his absence from Trinidad and Tobago:

NOW, THEREFORE, I, TIMOTHY HAMEL-SMITH, Acting President as aforesaid, in exercise of the power vested in me by section 44(1)(a) and section 44(4)(a) of the Constitution of the Republic of Trinidad and Tobago, do hereby appoint you, ARCHBISHOP BARBARA BURKE, to be temporarily a member of the Senate, with effect from 17th April, 2012 and continuing during the absence from Trinidad and Tobago of the said Senator the Honourable Kevin Christian Ramnarine.

Given under my Hand and the Seal of the President of the Republic of Trinidad and Tobago at the Office of the President, St. Ann's, this 13th day of April, 2012."

OATH OF ALLEGIANCE

Sen. Archbishop Barbara Burke took and subscribed the Oath of Allegiance as required by law.

Madam Vice-President: Hon. Senators, we do have two other instruments, so we will return to item No. 3 as soon as we do receive the instruments for the other Senators.

PAPERS LAID

1. Report of the Auditor General of the Republic of Trinidad and Tobago on the Financial Statements of the Tobago House of Assembly for the year ended September 30, 2004. [*The Minister of Public Utilities* (*Sen. The Hon. Emmanuel George*)]
2. Report of the Auditor General of the Republic of Trinidad and Tobago on the Financial Statements of the Tobago House of Assembly for the year ended September 30, 2005. [*Sen. The Hon. E. George*]
3. Annual Report and Annual Audited Statement of Accounts of the Central Bank of Trinidad and Tobago for the year ended September 30, 2011. [*Sen. The Hon. E. George*]
4. Ninety-Fifth Report of the Salaries Review Commission of the Republic of Trinidad and Tobago. [*Sen. The Hon. E. George*]

COMMITTEE OF PRIVILEGES
(SEN. FITZGERALD HINDS)

Madam Vice-President: Hon. Senators, leave is granted under Standing Order 26(2) to the Leader of Government Business to raise a matter as a question of privilege.

The Minister of Public Utilities (**Sen. The Hon. Emanuel George):** Thank you, Madam Vice-President.

"Dear Madam Vice-President,

Privilege Motion

In accordance with the provisions of Standing Order 26, I seek your leave to raise the following matter as a question of Privilege.

At a sitting of the Senate held on Tuesday, March 27, 2012, Sen. Fitzgerald Hinds during his winding up of a debate on a Private Member's Motion asking the Senate to take note of the strengths and weaknesses of the Trinidad and Tobago police service said the following:

"Talking about that, the police almost had to be called out in Philippine... She did not see the headline where the neighbours in Philippine, the Prime Minister's immediate neighbours want to flee... It is about disturbance in the neighbourhood night and day, Monday, Tuesday, Wednesday, Thursday, 'is fete after fete after fete after fete'.

To make matters worse, three o'clock two… o'clock in the morning, 'the helicopter coming and making noise to disturb everybody, while it is wine, woman, man and song…"

Sen. Hinds: And four too.

Sen. The Hon. E. George: Madam Vice-President, it is a matter of public record that the Hon. Prime Minister, holds high level meetings of officials of State and Government at her residence in Philippine, and for Sen. Hinds to mischaracterize newspaper report to portray any activities taking place at that location in the manner he has done is demeaning of the conduct and character of the Hon. Prime Minister, Head of Government and Member of the House of Representatives; libelous and calculated to bring the Prime Minister and, by extension, the Government which she leads into ridicule, disrepute and odium.

Hon. Senator: Take your seat!

Sen. The Hon. E. George: What is worse is that this was done under the cloak of parliamentary privilege afforded Sen. Hinds as a Member of this Senate.

Sen. Hinds: Titled.

Sen. The Hon. E. George: The foregoing statement by Sen. Hinds purported to inform the Senate of the contents of a newspaper report written by Miss Susan Mohammed and carried by the *Daily Express* of March 27, 2012. A copy of the article is appended to this letter.

The article in the *Daily Express* reported an alleged complaint by one Mr. Leon Achilleous, an immediate neighbour of the Hon. Prime Minister, Mrs. Kamla Persad-Bissessar SC, at her residence at Philippine, south Trinidad.

The following are extracts from the article as reported in the *Daily Express*:

"They have complained about late-night parties, the sound of hovering helicopters, and the recent construction of a chain-link fence that replaced the razor wire."

The article continues:

> "Achilleous said he and his family are also fed up of excessive music and noise emanating from a nearby restaurant and bar.
>
> Sometimes there is music until four o'clock in the morning on weekdays and when kids have to go to school. It has been a real headache. I have been trying to come to terms with that, but it really is a big intrusion with noise. It's an intrusion when at night you want to relax. It's mainly on weekends now, but it used to be every night before."

While settled parliamentary practice dictate that to constitute contempt, a slander upon a Member must concern the character or conduct of a Member in that capacity, I submit that any reflection, imputation or other indignity offered on the holder of the high office of Prime Minister can be held as a contempt, as it would tend to bring the Prime Minister, the Government of which she is head and, by extension, the Parliament into odium and disrepute.

It is also a settled practice that to constitute a breach of privilege the Member making any such statement must be aware that the statement is false, and he must make the statement wilfully, deliberately and knowingly. If this Senate is to be the guardian of its privilege and dignity, it ought not to permit any Member to deliberately, and premeditatedly make allegations which reflect on and impugn the conduct of a Prime Minister without reference to any cogent evidence in support of that statement.

Further, for a Member of this Senate to deliberately mischaracterize a newspaper report to reflect adversely on the conduct of the Prime Minister is a violation of the Member's sacred privilege of freedom of speech in Parliament. Such conduct can only lead to a diminution of the dignity of this Senate in the eyes of the national community, thereby bringing this Senate into ridicule and odium.

Hon. Senator: Waste of time!

Sen. The Hon. E. George: Such conduct…can only lead to a diminution of the dignity of this Senate in the eyes of the national community, thereby bringing this Senate into ridicule and odium.

Sen. Al-Rawi: "You doing that by yourself".

Sen. The Hon. E. George: I submit that Sen. Hinds has committed a contempt and request that this matter be referred to the Committee of Privileges of this Senate. I so move. [*Desk thumping*]

Sen. Hinds: What are you doing about this? [*Senator holds up a newspaper clipping*] What is the Government doing about this?

1.45 p.m.

Madam Vice-President: Hon. Senators—Sen. Hinds, thank you—after careful consideration and based on the details of the matter presented, and in accordance with Standing Order 26(4), it is the ruling of this Chair that a prima facie case has been made, and this matter is subsequently referred to the Committee of Privileges.

Sen. Hinds: What is the Government doing about this? [*Newspaper in hand*] [*Desk thumping*]

REGIONAL HEALTH AUTHORITIES (AMDT.) BILL, 2011

Order for second reading read.

The Minister of Education and Acting Minister of Health (Hon. Dr. Tim Gopeesingh): Madam Vice-President, I beg to move,

That a Bill to amend the Regional Health Authorities Act, Chap. 29:05, be now read a second time.

Madam Vice-President, I consider it a distinct honour and a great privilege to be piloting this amendment to the Regional Health Authorities Bill in this august Chamber, having been here for the first time in this session of Parliament to make a presentation, and I feel very gratified that I was here in 2001 in the Sixth Parliament. In the Seventh Parliament there was no Parliament. In the Eighth Parliament, I was here from 2004—2007, and now in this Tenth Parliament, I feel very honoured and privileged to be able to be amongst distinguished Senators [*Desk thumping*] on all sides, despite the behaviour of Sen. Hinds. [*Desk thumping*]

Madam Vice-President, allow me to share the overall purpose of this Bill before us, which is an important and essential piece of legislation for the effective functioning of our health care system. The Regional Health Authorities (Amdt.) Bill, 2011 seeks to amend section 20 of the Regional Health Authorities Act—the Regional Health Authorities Act, Chap. 29:05 has 35 sections—by inserting a new section which will enable the Regional Health Authorities, all five, to procure goods and services collectively where it is economically expedient to do so. These are very important words in the whole amendment, "where it is economically expedient to do so". The other issue is to procure goods and services collectively. [*Crosstalk*]

Madam Vice-President, I think the country knows very well the history of the Regional Health Authorities Act. We go back to 1994 when the then Minister of Health, Mr. Eckstein, was able to bring this Regional Health Authorities Act,

despite the kicking and the frantic cries and protestations of the labour movement, at that time, headed by Miss Jennifer Baptiste. She was Jennifer Baptiste then and not Primus.

I remember those times when there was the move to have these four Regional Health Authorities, because the country felt, and the people responsible for health also felt, that the country's health care system was not improved at all, and there was the concept of bringing health care closer to the people. So, the creation of these Regional Health Authorities, by having four in Trinidad which Minister Eckstein at that time said he felt that would bring health care closer to the four corners of Trinidad and one in Tobago. And, therefore, despite the protestations that we should consider having two in Trinidad and one in Tobago, the four authorities were formed.

There was the discussion then of the issue of having the same type of organizational structure and organizational functioning replicated four times in Trinidad and one in Tobago. So that in any organization when you have a finance department, a human resource department, an administration department, legal and regulatory department and communication, et cetera, it would be replicated in all four Regional Health Authorities and that was one of the issues that came to the forefront. So here you were bringing the Ministry of Health which had one set of people in an organizational structure, and creating the same set of organizational hierarchal structure and repeating it four times as had occurred over the period of years.

Whether it is working well or not at this time, or whether the situation of the creation of these Regional Health Authorities has benefited countries worldwide, there were examples of it in the United Kingdom where they created about 60 or 70 Regional Health Authorities in the 1990s. After a while they found they had to be reducing the number of authorities and they whittled down to, I believe, about 12 after one time, and then they converted these Regional Health Authorities into hospital trusts. So, therefore, they moved from more than 80 to about 12 and now to a small number of regional trusts. [*Crosstalk*] No, the British system is still a free system under the national health insurance system.

If you look at the Canadian model as well and what they experienced, at one time in the 1990s, Ontario was spending more than 35 per cent of its GDP on health care and they began to think about doing something similar to that, but they never went ahead and did it.

In the United States of America, colleagues would remember, Mrs. Hillary Clinton was given the opportunity in 1991 to examine the health care system in the United States of America and determine in what way forward the United

States of America could improve its health care system, because we all know that forms a major area of concern and discussion in all elections of presidential candidates in the United States of America election upon election.

It was found that the United States of America system had a preponderance of specialists as opposed to generalists and, therefore, the recommendation was that they should increase the number of general practitioners in the United States of America to meet the demands of the wider population of more than 250 million people. They went ahead to do that, and to some extent the United States of America health care system began to improve.

At one time there were 18 million people without any health insurance in the United States of America, and this is why President Obama moved with alacrity, during this term, to move the health care agenda forward despite it might have received negative connotations at times, but he was brave and he has decided to move with it.

When this Regional Health Authorities Act came into Trinidad in 1994 under the then PNM administration, the UNC administration which came into being in 1995—it was over just one year old—made the decision to move with it and carry the responsibility of something that was new. Attached to that was a US $200 million IADB health sector reform plan, which would have assisted the reform that was needed, at that time, in the health care system from infrastructure to organizational restructuring and institutional strengthening, and also the movement of workers from the public service to the Regional Health Authorities.

There was a very slow movement of workers from the public service to the RHAs and they were given three options. One of the options was you second across to the Regional Health Authority, and the second option was that you resign and take up employment with the RHAs. One of the critical factors was that people who had been working in the RHAs for a long time did not see for themselves the issue of the gratuity and pensions being transferred across to the Regional Health Authorities. So, therefore, there was a slow move of workers from the public service to the Regional Health Authorities.

The gratuities and pensions issues took a long time to be dealt with and, therefore, there were people working as public servants in the institutions which were held by the Regional Health Authorities, and which were owned by the Regional Health Authorities, and that caused another problem. Many of the medical personnel indicated how could they be working in a RHA hospital, owned by an RHA, when they are public servants, and there were legal cases that were brought before the court that, I believe, up to today, have not been settled.

Anyway, the then UNC administration demitted office—well, power was taken away from the UNC in 2001. You all will remember that, when the President moved to have the PNM administration into power when they were in Opposition, despite the fact that the United National Congress had the majority at that time. Nevertheless, the PNM administration ran the Regional Health Authorities from 2001—2010, nine years later.

So there have been weaknesses in the system and there have been strengths, and the Regional Health Authorities are there to stay unless the citizens of Trinidad and Tobago demand that we do a stakeholder consultation to determine the way forward on it. So while it still exists in the present form with all its strengths and some weaknesses, we have to continue to make it much more efficient and effective in the delivery of health care.

So, what are some of the areas that would help to strengthen the delivery of health care for the Regional Health Authorities? One that was considered by this administration that required some degree of change is what is before us in the Parliament today. I guess Sen. Hinds is now comfortable with the fact that—[*Crosstalk*]—you had been there for a very long while yourself.

So, Madam Vice-President, in addition, pursuant to section 6 of the Regional Health Authorities Act, the powers and functions of a Regional Health Authority include: to provide efficient systems for the delivery of health care. You know that a public hospital, let us say for example, the Port of Spain General Hospital, has about 32 different silos. There are different departments, as many as 32, and they all have to be interacting with each other to ensure that there is smooth and efficient functioning of the authority.

For instance, the hospital will have accident and emergency, operating theatre, orthopedics, ear, nose and throat, general surgery, neurosurgery, internal medicine, dermatology, X-ray and ultrasound; a whole heap of areas, 32 OBGYs, as Sen. Wheeler knows very well. To make these systems work, you have to be able to integrate them very well. For instance, a person gets into an accident, reaches the accident and emergency department at the general hospital via ambulance or by a vehicle, who has to come into play there? The nurse and the doctor at the emergency and the team, and then you may need an X-ray, an ultrasound or a CT scan and, therefore, the technicians are called out, and the specialist doctors are then called out if they are there. You need transport from the emergency department to that department. If the patient necessitates urgent surgery you have to take the patient to the operating theatre, and then you have to

get the operating theatre staff arranged—the nurses, the scrub technicians and everybody. So, just a simple process like this brings into play, at least, 15 or 16 different departments and systems.

2.00 p.m.

Therefore, to provide efficient health care, all the systems working in the hospital have to be functioning effectively, like a chain all linked together, and no weak links must be in that chain.

The powers and functions of the authority also include to operate, construct, equipment, construct, infrastructure, furnish—machines, ultra sound, X-rays, maintain, a biomedical type of maintenance for equipment and physical maintenance of the institution; manage strong, administrative capacity, hospital administrators, et cetera; secure and repair all its property. That is just another of the powers and functions.

The other is to facilitate new systems of health care. Are we going about providing health care in the same old way or do we look for new modes in the management and provision of health care? Recently, the hon. Minister of Health, whom I have the privilege of representing today—he is away on the business of Government related to health, and I am very grateful that the Prime Minister saw it fit for me to represent him, and therefore have the ability to pilot this Bill. [*Interruption*]

Sen. Hinds: I hope he carried his credit card.

Hon. Dr. T. Gopeesingh: Leave the boy alone; leave him alone; behave yourself. We all have so many, do not worry.

Sen. Hinds: He can use it abroad, you see.

Hon. Dr. T. Gopeesingh: Yes, he can. Anyway, Madam Vice-President, I will not take on Sen. Hinds this afternoon. I will take him on outside. [*Laughter*] To facilitate new systems of health care—I was making the point that the hon. Minister of Health was able to secure recently the concurrence of Cabinet in the decision to have a private sector/public sector partnership in a new system of health care, so as to facilitate private entrepreneurs, private citizens, organizations and firms, wanting to set up systems of health care in Trinidad and Tobago which would redound to the benefit of the citizens. He was able to get Cabinet's approval. It is now possible that any group or organization, whether it is national, regional or international can come to Trinidad and Tobago and work with us here to set up systems for the provision of specialty cardiac services, transplant

surgery, retinal surgery, hip and knee replacements, tertiary health care and a number of other areas. With a public sector/private sector partnership, it may be cost effective.

In doing so as well, there would be the possible creation of Trinidad and Tobago becoming a hub for effective and efficient tertiary health care, thereby bringing about our nation as a country where you have health sector tourism, where, when it is very costly to do these same procedures internationally, they could come to Trinidad and Tobago and have it done at a cheaper cost.

If we compare the cardiac services being run in Trinidad and Tobago under the private system, the cost of that, even though it is still high for cardiac surgery, it is still cheaper than in metropolitan countries. Even though the cost is about $120,000—$150,000, because of all the instruments, postoperative care and so on, for patients in intensive care, internationally that would cost you between TT $300,000—$400,000 equivalent.

So here you have the cardiology services. Cardiac surgery is being done; hip and knee replacements and even renal transplants are being done in Trinidad and Tobago at a cost that would facilitate the creation of health tourism here. A Regional Health Authority has the power and function to facilitate new systems of health care, which would be of tremendous benefit to the people.

Another area is to do all such things incidental or conducive to the attainment of the objectives of the authority. Of particular note, Madam Vice-President, is section 20(1) of the Regional Health Authorities Act which provides inter alia:

> "For the purpose of any transaction, contract or covenant a Board may, on behalf of the Authority for which it was constituted—invite, consider, accept or reject offers for the supply of goods or the undertaking of works or services necessary for carrying out the objects of the Authority."

At the moment:

> "…a Board may, on behalf of the Authority...invite, consider, accept or reject offers for the supply of goods or services necessary for carrying out the objects of the Authority."

Further, it is material to note section 20(2) of the Regional Health Authority Act which provides that:

> For the purpose of this section, the provisions of the Central Tenders Board Ordinance shall not apply.

In other words, the Regional Health Authorities are empowered to follow their own rules when purchasing goods and services. The Central Tenders Board Ordinance does not apply in the Regional Health Authorities Act. The RHAs are empowered to follow their own rules when purchasing goods and services. The rules and regulations are stipulated in the Regional Health Authorities Act.

Madam Vice-President, in this regard, the Regional Health Authorities Contracting for Goods and Services Regulations were passed in 1995 subsequent to the passing of the Act. These regulations detail the entire procurement process which an authority must follow in inviting, considering, accepting or rejecting offers for the supply of goods or the undertaking of works and services necessary for carrying out the objects of the authority. So the Contracting for Goods and Services Regulations passed in 1995 govern the procurement process, because you do not have the Central Tenders Board process governing the Regional Health Authorities.

The fact of the matter is that in exercising its powers and functions, the Regional Health Authorityies often require the same goods and services. What are some examples? Pharmaceuticals—I do not say "drugs", that is another word—for all five RHAs. All five RHAs would require the same type of pharmaceuticals. The National Insurance Property Development Company Limited (NIPDEC) has been the contracting agent to purchase the pharmaceuticals for all five RHAs, and through C40, the distribution of pharmaceuticals takes place today. So they are bought in bulk, which makes them more cost effective and facilitates a number of improved services in the purchase of pharmaceuticals.

What about other areas? As far as I could think of, that is the only area where there is a commonality of purchase for all the regions. The other regions have to purchase other goods individually. What are goods and services? The regulations under the Act clearly define in the interpretation that:

> "Goods means materials, products, implements, tools"—tools are surgical equipment in this situation with medical things—"devices, machinery, equipment, plant and articles of all kinds."

Those are goods. Most of these things have to be bought by individual RHAs, and sometimes they need them in all four, the same common things needed in all four. But they have to be purchased on an individualized Regional Health Authority basis.

Why can they not be purchased collectively by all the RHAs coming together and saying, "We need this," and agreeing that they would purchase collectively, which would be economically cost effective? So this is what this amendment to the Regional Health Authorities Act is. The Government is asking for support in the passing of this piece of amendment to the RHA Act.

With regard to services:

> "service includes assistance in doing things or getting things done, and includes professional or consultancy services."

So the human resource element across all four RHAs is critically important. Let me give you just one example where it is actively needed at this time. Let us take for instance neurosurgery as a service to save lives. My distinguished colleague from Tobago, Sen. Dr. Wheeler, would understand the depth of what I am saying. I am sure all my colleagues in this Senate understand as well.

At the moment we have just a few neurosurgeons in this country, a great shortage, and so many accidents occur on a daily basis. So an accident occurs on the highway going to south, and somebody has brain injury, unconscious. They will be taken directly through if the ambulance—may I take this opportunity to say how I feel about the whole issue.

When people get into accidents, we see their family and friends waiting for an ambulance to come. Well the ambulance system is improving day by day, year by year, and as we get more ambulances the time for reaching a particular accident will be shortened. When we had about 30 or 35 ambulances, the time to reach a victim case would be about 10 or 15 minutes. Now it is about 15 to 20 minutes. The Minister of Health is getting Cabinet's support to purchase more ambulances and improve the management of the ambulance service. The waiting time would be shortened again drastically.

In the old days, when something happened to someone, you would put him in a vehicle and take him to the hospital. I still think that people should consider that, to some extent, because the time you are waiting, your family member's life could be lost just waiting there. With a little internal bleeding, reaching the hospital five or 19 minutes before could save that person's life.

The general citizenship must take into cognizance that where there is the possibility of transferring a victim in a quicker time, they must do so on their own, at times, when it is possible or feasible.

Sen. Hinds: I witnessed accidents that you have just described, and citizens are now reluctant even to move the body from one position to the next, with a concern that maybe with a broken bone they could do further damage. How do you respond to that, in light of your recommendation?

2.15 p.m.

Hon. Dr. T. Gopeesingh: Well, there are situations, this is a major concern by all citizens, whether by moving someone you will dislocate, probably if someone has a fractured vertebrate on the cervical spine or fractured vertebrate on the back area, you can cause spinal cord jury. But when someone is basically sitting up, and you know that there is no such type of—they are in an accident site, and you can deal with them, and you can know that there is no possible fracture that will, on movement—it is difficult for the ordinary man to do that, to understand that, but in situations where it is feasible, they should consider it.

I was making the point about the neurosurgery; so they would go down to San Fernando Hospital where there is a shortage of neurosurgeons. Port of Spain General Hospital has two neurosurgeons; Eric Williams Medical Sciences Complex—that is the North Central Regional Health Authority, I think has one, but there are about five or six neurosurgeons, privately, who are not working in the system, not working in South West Regional Health Authority nor North Central Regional Health Authority, and only two in Port of Spain in North West Regional Health Authority.

If there is a commonality amongst the Regional Health Authorities for contracting services of the neurosurgeons, collectively, about eight of them, and they are able to share their skills and their resources across the four regions in Trinidad and Tobago, particularly the three, central, south and north, the eastern generally comes to Mount Hope, is it not better that these services contracted together as one, benefit all three or four Regional Health Authorities, rather than having services provided by North West in two, none in south-west, south east or South Regional Health Authority, and one in central? That is just one example. You know how many lives would be saved? By having to transfer a patient from down south back to Eric Williams Medical Complex or Port of Spain General Hospital to receive neurosurgery attention that can be disastrous.

This is what the Minister of Health is asking for the support of this honourable Senate, to facilitate—allowing the Regional Health Authorities to come together, so that they can contract services together, once they agree amongst themselves, and share the services amongst themselves, so that they can develop an efficient system for the provision of neurosurgical services in Trinidad and Tobago.

There are many more examples of that; neurology, which is another shortage, that is the medical aspect of neurologic diagnosis and so on, there is a shortage of that. Therefore, in the provision of services, laboratory, well, X-ray specialists,

particularly CT and MRI, if they can contract a group of citizens or doctors to work together as a team to provide the services for MRI and CT scans, rather than Eric Williams Medical Complex having a whole heap, north-west having a few, and south having a few, provide a service for a group of them, so that they can arrange amongst themselves to be in the different regions, and to be able to efficiently deal with it.

So, this is one of the areas that the Bill, the amendment, seeks to cure, and to effect and to bring about efficiency in the provision of services. So contracting of goods and services includes assistance in doing things, and consultancy services. I have just given two little examples of provision of services which will redound to the benefit of the citizens of Trinidad and Tobago, where all four regions in Trinidad and even the region in Tobago, can benefit from a collective responsibility of purchasing, once it is economically feasible to do so. And there is no question, if you bring a group of consultants together, and work out a package for them, it would be more cost-effective and cheaper than having to pay them individually. The health care system is so difficult to manage that anything you can do to bring about greater efficiency, we should consider and support. I just gave two examples.

What about equipment? Each one of the regions now has to have MRI and CT scan because they are a part of life now in medicine. So each region now wants to purchase an MRI, a CT scan, X-ray machines, an ultrasound, an echocardiography machine, and all these sophisticated equipment; anaesthetic machines for the operating theatre.

As it is at the moment, each one of these authorities has to go through a tendering process, as put forward in the subsidiary legislation for the Regional Health Authorities contracting for goods and services. Each one of them has to go through the tender process to purchase this equipment.

You have to have a group of personnel who are specifically trained, and who understand what it is about to sit on tenders committee. So, in four regions in Trinidad and Tobago you have four groups of individuals sitting to purchase an MRI or CT scan for their own regional authority, so you need 15, 20, 24 different personnel spread across the four regions in Trinidad. Why can the personnel, four or five with the technical expertise, on the support of all the Regional Health Authorities, not come together as one tenders committee, and make a determination in the purchase of MRI machines for all the Regional Health Authorities or CT machines or ultrasound or echo machines, whatever? You know the benefit of that, Madam Vice-President, and colleagues—the additional

benefits—you have one supplier, and therefore, the training for the use of these machines becomes easier. Instead of having a Philips CT scanner, a Siemens CT scanner, and a GE CT scanner in the three different regions—each one having its own idiosyncratic type of process, and for training, they all have to go through different training methodologies, therefore, why can you not purchase the best, and to be used by the four different regions. So you decide that GE is the best at the moment or Siemens or Phillips, you purchase that, one training company, training all the people throughout Trinidad and Tobago, one biomedical company for maintenance, and one team of workers for maintenance throughout the country. It is cheaper to maintain, you will get it cheaper in cost, easier to use. That is another example of where this amendment to the RHA Act would facilitate greater improvement, efficiency and effectiveness.

Works—because it is good, services, works.

> "'works' means activities, equipment and other resources related to construction, maintenance and refurbishment of buildings, equipment, plant and facilities of all kinds."

I think I have touched on that. Therefore, the commonality exists for not only pharmaceuticals as we have by Nipdec purchasing all the pharmaceuticals, but we would have the ability to purchase goods and services, collectively, where it is economically feasible to do so, and the economies of scale would obviously benefit the nation as a whole, and there are economies of scope as well. So economies of scale and economies of scope would facilitate greater efficiency and effectiveness in the delivery of health care.

In this regard, Madam Vice-President, it is the Ministry's view, that there are immense, undisputed benefits to be derived from the procurement of goods and services, collectively, such as, it is cheaper to purchase in bulk, and even in our homes, with the advent of bulk purchasing—you know that if you purchase a particular item and you buy six of it, the unit cost will be cheaper. You see it in the groceries when you go and you see something attached to one other item, you purchase that, and you get the item cheaper. You just transfer that across to the purchase of things in the Regional Health Authorities, transfer what you do in your everyday life thinking to what is required and desired for the Regional Health Authorities.

It is less time-consuming to purchase in bulk because four Regional Health Authorities have to do the same thing. It involves a lesser number of personnel in the procurement process. Four groups of personnel with the specialties have to get

together four times, in four different regions. There can be a pooling of resources, as I just mentioned, since the evaluation process only involves highly specialized officers who do not always work in one regional authority. So if the regional authorities are permitted to procure collectively, the evaluation team can be drawn from the different authorities, so service agreements become easier, management of equipment becomes easier, training of personnel becomes easier and more cost-effective.

Therefore, this Bill will allow goods and services to be purchased in bulk, where it is economically expedient to do so, and same to be distributed amongst the respective Regional Health Authorities according to their individual needs .

Madam Vice-President, just to reiterate, clause 2 of the Regional Health Authorities (Amdt.) Bill, 2011, introduces a new section 20(1A) to the Regional Health Authorities Act and provides as follows; it says:

> "Notwithstanding subsection (1), and where it is economically expedient to do so, a Board may—
>
> (a) pursuant to an agreement with any other Authority;"

So they have to agree amongst themselves.

> "(b) in accordance with regulations made under this Act for the purpose of this subsection;"

The regulations are here in the Act, Madam Vice-President, the subsidiary legislation, Regional Health Authorities Contracting for Goods and Services Regulations.

> "(c) acting on behalf of its Authority, and an Authority referred to in paragraph (a),"

which is any other authority, any of the other three or four in Trinidad and Tobago. They may:

> "invite, consider, accept or reject offers, and enter into contracts for the supply of goods or the undertaking of works or services necessary for carrying out the objects of the respective Authorities."

Madam Vice-President, and colleagues, I wish to remind this honourable Senate, that the People's Partnership Government's vision for health is taking health care to the people, from conception to exit. To achieve this vision, the framework for sustainable development identifies seven key pillars, and one of the key pillars identified is people-centred development.

In this regard the Ministry of Health has developed its five-year strategic plan to support this pillar, and to achieve the Government's vision. The Ministry's five-year strategic plan is developed to respond to the following broad strategic lines of action as outlined in the framework for development: first-class health care for the people, this is what we are striving to achieve.

Members know that health and education are the cornerstones and fundamental pillars of any civilized society, therefore, it is imperative for any government, and it is imperative for our Government, and which we are doing, putting into place a first-class health care for our people.

We have difficulties throughout the world, no system is perfect, and everyone knows that health care is a bottomless pit; you put more and more money into it, and it is like falling through a bucket, but you have to work to make sure that the systems are put into place, so that whatever money you have, you can still provide the best health care.

Another important pillar for health in people-centred development is the support for patients' rights. Far too long patients in the country are kept subservient to the system, are not able to understand and have the knowledge about their own health care system; even when they go to hospitals, and to doctors, they must be told what their problem is, and it has to be discussed; they know their rights. Their rights are that they must know what is happening to them, and this is what we are trying to ensure as a People's Partnership Government under the Minister of Health.

2.30 p.m.

We have to improve physical infrastructure of public health care facilities, and I would just make some small mention of that subsequently, if time permits. Lifelong commitment to health—is it about an hour? How much time again do I have?

Madam Vice-President: Thirteen minutes.

Hon. Dr. T. Gopeesingh: Thank you very much, Madam Vice-President. We, as a Government are committed to ensuring that the health of every citizen of Trinidad and Tobago from conception to exit is our life, and every citizen of Trinidad and Tobago under our regime is treated with the respect and the dignity with which that person's life ought to be treated, and no one must be left without health care in our country.

So, we have a lifelong commitment to the health of our citizens and we are responding to the issues of chronic diseases, cardiovascular diseases, cancer, diabetes and HIV/AIDS. Seventy per cent of our hospital population is as a result of complications related to the non-communicable diseases of diabetes and hypertension. Emerging from obesity and diabetes which has a genetic predisposition as well, amongst the East Indian population, a high incidence of diabetes, and with complicated diabetes not being treated properly you get the complications of heart disease, heart attacks, death, strokes, renal failure, blindness and amputations. And in the Afro-Trinidadian population a predisposition to hypertension, which, in a lot of our young Afro-Trinidadian men, who are stockily built and strong and do not even recognize the fact that they do have hypertension, end up with renal failure when they do not even know that they have the problem of hypertension.

So, we are moving expeditiously to educate the population on these non-communicable diseases of diabetes and hypertension. So the poor Afro-Trinidadian man in his 30's—could you imagine in the late 30's having renal failure and have to have renal dialysis because the hypertension was not diagnosed early to be treated and not told about losing weight and exercise, and the Indo-Trinidadian person's diet is very bad, not exercising, smoking and dying in their 30s from sudden heart attacks and deaths. These are the issues facing us in this country, and not only Trinidad and Tobago alone. This is why the hon. Prime Minister ensured, through Prof. George Alleyne, the former head of PAHO in the Western Hemisphere—he was so enthusiastic that Caricom would take this issue of non-communicable diseases to the United Nations. The hon. Prime Minister, Mrs. Kamla Persad-Bissessar, took the whole issue of non-communicable diseases to the United Nations, now, where it is one of the major issues in the health care reform around the world; even in OAS recently, the 34 countries, that was discussed to some extent as well. So, we are moving to take care of our population by prevention, early detection and management.

Well, HIV/AIDS, we need to do a lot more work and the hon. Prime Minister had decided that the management of HIV/AIDS would come under one coordinating body, and each one of the Ministries of Government now has been asked to ensure that they have one person with the strength, the capacity and the calibre to be able to move the whole process of the management of HIV and AIDS. So, it is out of the Prime Minister's office but decentralized to other areas as well.

Responding to the mental health crisis. We have a serious problem in Trinidad and Tobago on mental health, but the problem is worsened because of the fact that we have more than 60 to 70 per cent of the inpatients at St. Ann's who do not need to be there in the first place. [*Interruption*] They are like long-staying inpatients and

they could be managed as outpatients, but we have to move now, and which the hon. Minister is moving, to ensure that we have community-based health care systems for mental health where they can get the mental health care out into the communities. Not everybody is mad. There is about a 6 per cent or 8 per cent depression.

Sen. Deyalsingh: You said it, no need to admit it—[*Desk thumping and interruption*]

Hon. Dr. T. Gopeesingh: Yes, he has admitted it by stamping the desk. [*Interruption*] [*Crosstalk*]

Hon. Senator: "Do not speak too loudly, eh!"

Hon. Dr. T. Gopeesingh: Madam Vice-President, the question of depression, internationally is about 6 per cent of the population; Britain it is rising to about 8 per cent of a population of about 60 million, that is about 4.8 million people. Eight per cent of Trinidad and Tobago is about one-twelfth, which is about 100,000, do experience some form of depression one way or the other. So, the Minister of Health is looking very strongly at the question of management of this mental health situation in this country, and it is a matter of having more psychiatrists, more clinical psychologists and many other people to be working in the mental health system. [*Interruption*] We now have a shortage of male mental health nurses. [*Interruption*] Yes, we have females, but generally you need many more male mental health nurses and assistants. [*Interruption*] You need many, many more, and for years the resource has been falling. So, we are working to see how we could motivate more and more men to come into the system for mental health nursing care.

So, the Ministry's overall strategy is value based, focused on achieving operational excellence, efficiency and effectiveness in its operations while paying close attention to meeting the diverse needs of its customers or its patients from the Regional Health Authorities and other health-sector providers in the general public.

Madam Vice-President, permit me to outline some of the initiatives the Ministry of Health is undertaking at the moment, and also some of our medium term and long-term measures, namely:

- the conduct of a national health needs assessment—critically important for us to determine where we are going in the provision of health care;

- the implementation of an information technology driven health information management system—and this is where the Minister of Science, Technology and Tertiary Education, Sen. The Hon. Karim, is working with the different Ministries now to help to improve the information technology, particularly, in the health care system as well, and in education;
- human resource planning and development for the entire health sector—the entire health sector has close to about 15,000 workers, about 2,500 professionals, doctors, nurses, paramedical professionals; so we are moving to ensure that there is human resource planning and development.

For instance, nurses training: we are now going to be actively pursuing nurses training at an advance stage at the Tacarigua—

Hon. Senator: El Dorado Nurses Training Academy.

Hon. Dr. T. Gopeesingh:—the El Dorado Nurses Training Academy. You know, your administration had stopped the training of nurses in the early 80s and early 90s, and that is one of the reasons we had a shortage of nurses. Today we have about 1,500 nurses less than we should have and we have close to 300 doctors less than we should have, particularly the consultants, who they had sent out with the voluntary separation and they moved out of the hospital, now we need them back in the hospitals, so all these things are going on.

The establishment of a National Emergency Ambulance Authority to manage and operate the National Emergency Medical Ambulance Service, and rationalization and re-engineering of the Ministry's vertical services, all the blood bank services and all the things that need to go hand in hand with the provision of health care.

Madam Vice-President and colleagues, it is envisaged that our health-care system will be an integrated system with a strong primary care sector and an efficient hospital sector supported by modern hospital physical infrastructure. This includes the implementation of the Ministry's primary health care physical infrastructure development strategy over a three-year planning period. Between 2012 and 2015, the Ministry would undertake construction of a number of primary health care centres like Chaguanas District Health Facility, Sangre Grande, Palo Seco, Carenage, San Fernando, et cetera.

We are now opening our health care centres beyond the normal time of up to four o'clock, now up to 8.00 p.m. in some of the health centres. We are now making efficient the district health facilities, about seven or eight of them in Trinidad, which is the intermediate institution between the primary health centre, which is

about 105 in Trinidad, and the hospitals, namely—we have 10 hospitals in Trinidad and at least 10 very good private nursing homes and so on. So, we are moving to focus a lot on primary health care and the district health facilities, ensuring that patients can get ultrasound, X-ray, blood test, stay overnight in these seven district health facilities, and therefore, preventing overload in the general hospitals, and much more.

The physical infrastructure of the hospitals—we intend to complete the Point Fortin Hospital. [*Desk thumping*] You just saw us open the Scarborough Hospital, which the previous administration promised for years, from since 2001 and they were unable to complete it. We completed it. [*Desk thumping*] The cost then was $120 million in 2001; it has ended up costing the taxpayers close to $800 million. They spent $100 million on the National Oncology Centre and today there is grass growing, not even the foundation completed. They promised the Point Fortin Hospital from since 2001; we are going to build it. We have turned the sod for the central hospital for the children and the burns unit. [*Desk thumping*] We are going to make sure that the Arima Hospital is completed; the Sangre Grande Hospital and the Port of Spain General Hospital is also done. We continue to take special care of our people, all our children throughout the length and breadth of Trinidad and Tobago—[*Interruption*]—and our elderly as well.

So, Madam Vice-President, in order to fully complement this primary and secondary care services and our plans and initiatives, this People's Partnership Government recognizes the need to undertake a programme of institutional strengthening across the RHAs to improve the management and the delivery of health care services. This is what we are doing. This amendment is just part of it.

In this regard the Ministry has already implemented certain key enablers such as the annual service agreements, to ensure that the authorities do the work for which they are contracted to do by the annual services agreements—and purchasing intention agreements with the RHA. So, we would give them a certain amount of money, they are supposed to provide this type of health care for you, to ensure transparency and accountability of the services being delivered. These agreements clearly define the role of the Ministry as the purchaser of services from the RHAs which are the delivery arms, and ultimately achieving greater value for money with the limited resources.

In light of the above, the Ministry recognizes that there must be reform of the procurement practices to ensure an effective implementation of the care and hospital physical infrastructure strategy. Presently, all of the RHAs procure separately for similar goods and services, and this is highly inefficient,

unnecessary and unwarranted, and it often leads to misuse of resources, both financial and human resource. This Government is of the view that cost-effectiveness and an improved delivery of the health services are priorities, and the Regional Health Authorities (Amdt.) Bill, 2011 seeks to do exactly that and we seek your support.

I beg to move, Madam Vice-President.

SENATOR'S APPOINTMENT

Madam Vice-President: Hon. Senators, before I propose the question I which to revisit item No. 3 on the Order Paper, "Announcements by the President" I have received the instrument for a temporary Senator to be sworn in.

Madam Vice-President: Hon. Senators, I have received the following correspondence from His Excellency the Acting President, Timothy Hamel-Smith.:

"THE CONSTITUTION OF THE REPUBLIC OF TRINIDAD AND TOBAGO

By His Excellency TIMOTHY HAMEL-SMITH, acting President and Commander-in Chief of the Republic of Trinidad and Tobago.

/s/ T. Hamel-Smith
Acting President.

TO: MR. KEVIN BHAGALOO

WHEREAS Senator ANAND RAMLOGAN is incapable of performing his duties as a Senator by reason of his absence from Trinidad and Tobago:

NOW, THEREFORE, I, TIMOTHY HAMEL-SMITH, Acting President as aforesaid, in exercise of the power vested in me by section 44(1)(a) and section 44(4)(a) of the Constitution of the Republic of Trinidad and Tobago, do hereby appoint you, KEVIN BHAGALOO, to be temporarily a member of the Senate, with effect from 17th April, 2012 and continuing during the absence from Trinidad and Tobago of the said Senator the Honourable Anand Ramlogan.

Given under my Hand and the Seal of the President of the Republic of Trinidad and Tobago at the Office of the President, St. Ann's, this 17th day of April, 2012."

OATH OF ALLEGIANCE

Sen. Kevin Bhagaloo took and subscribed the Oath of Allegiance as required by law.

2.45 p.m.

REGIONAL HEALTH AUTHORITIES (AMDT.) BILL, 2011

Question proposed.

Sen. Faris Al-Rawi: Thank you, Madam Vice-President, and thank you hon. Senators. It is very good to have the hon. Dr. Tim Gopeesingh, Minister of Education here with us this afternoon if I do say so myself, holding the fort for the Minister of Health.

Madam Vice-President, we are here on a very serious issue of debate today. The Bill before us is deceivingly simple in the manner in which it is stated. It is proposed that we amend the Regional Health Authorities Act, Chap. 29:05, by the mere inclusion of a paragraph into section 20 of the Act. The wording is set out—simple language without any definition provided to some of the language which I would come to in a short while. Before us, if one were to appreciate the tone—very complimentary tone by my learned colleague, the hon. Minister of Education, but he advanced for this Senate this afternoon all of the reasons why Trinidad and Tobago ought to be concerned about the state of the health care system which the Government of Trinidad and Tobago provides for its citizens. On that we have absolutely no issue. I do not think that any Senator here this afternoon, or any member of the national community could ever disagree that we are in a united purpose to achieve the very best form of health care for our citizens. We are after all in a very fortunate situation of being able at present to afford the position.

The Ministry of Health receives $3.6 billion per annum, roughly, if one were to take the last figure of estimates in the last budget. That is a serious portion of money. And what this Bill really drives to, and which regrettably, my learned colleague, the hon. Minister of Education failed to address—and I do not mean to be impolite to him—at all in any meaningful way, is the issue of procurement.

Madam Vice-President, this is the seventh occasion on which the Regional Health Authorities Act is going to be debated. It is No. 7. We had 1994, where Act No. 5 of 1994 was introduced by then Minister of Health, John Eckstein. We had November 24, 1994, when we dealt with further amendment; we had amendments in July 1999; we had amendments twice in the year 2000; we had an amendment by Act No. 73 of 2005; and today we are seeking by this House of Representatives Bill, No. 23 of 2011, to amend the law again.

The hon. Minister of Education told us, and he is very clever. He said that the hon. Minister of Health, John Eckstein when he piloted this Bill was met with fierce Opposition and he called the names. He said Jennifer Baptiste—she was not Primus yet, on behalf of the public servants, the trade union which represented the public servants—but he forgot to tell us that the loudest protestors against the Regional Health Authorities creation, that model, was the United National Congress (UNC). I spent several days reading every single page of debate for the last six occasions on which this Act was amended.

The People's National Movement (PNM) piloted the legislation in 1994 and the United National Congress dealt with every single one of the amendments, save for the 2005 point, Madam Vice-President, which was a very innocuous point. And most spectacularly, when the Regional Health Authorities legislation was put in for debate in 1994 by John Eckstein—in fact, he spent three hours in the Senate in piloting that Bill then—the loudest protestors to be found against everything possible including most importantly the concept of procurement, was the United National Congress, Madam Vice-President, loud voices.

Sen. Wade Mark as he sat in Opposition in 1994 is on record in the *Hansard* as saying he disagrees with the concept of decentralization as brought. He insisted upon classic devolution as he called it, being distinct from the type of decentralization which was being proposed. He said that not enough attention to vertical decentralization was being given. He complained bitterly about the Minister of Health's involvement to intervene in the procurement process, to amend schedules, because, Madam Vice-President, the schedule by which we operate here today, the subsidiary legislation which we are guided by and that is by Act No. 4 of 1995, the rules and procedures by which this Regional Health Authorities system is bound, those things are brought in with the Minister's involvement. There was bitter complaint by the United National Congress. In fact, they abstained on the vote.

We now come 2012, nice and fuzzy concepts about, you know we need to do better, and we need to be more efficient, et cetera. But Madam Vice-President, absolutely no attention has been offered by way of explanation in piloting this Bill, as to the most critical thing, that is the rationale, why this particular methodology now proposed by this Government is the correct one to be followed. It is not, and nobody here would disagree that we need a better, more cost-effective and better value for money system. It is not that. We care, all of us about patients' rights. As difficult as it might seem on the Government's part at times, we care about patients' rights. We care about health delivery. We agree that

money being poured into the health sector is a proper subsidization of our people, but nothing by way of particulars has been brought to this Senate to tell us why this is the only way to do it. That is where we have a problem, Madam Vice-President. Our problem lies insofar as, we are in the middle of a procurement discussion at a national level.

Secondly, we are in the middle of procurement debacles under the management of the United National Congress partnership. We are in the middle of extremely difficult economic times ahead of us and the need for frugality, the need for proper and well-thought-out reform is left begging for an answer. You see, present today in the Senate, there are no less than six Members of the Joint Select Committee on Public Procurement. Sen. Abdulah is here; Sen. The Hon. Dr. Bhoendradatt Tewarie is here; Sen. Dr. Armstrong is here; Sen. Helen Drayton is here; I am here; the hon. Attorney General is a member and the hon. Minister of Education is a Member. If the Attorney General were here, there would be seven persons present who are participants in the joint select committee.

Let me at the very outset make this abundantly clear, I had cause to read the *Hansard* contribution of the Leader of the Government Business in the Lower House, Dr. Roodal Moonilal, Minister of Housing and the Environment. And most spectacularly he in the wind up on behalf of the Minister of Health, he had to say, "The Opposition has come here and say this whole thing is a procurement debate, ah, ha! section 22 Central Tenders Board Act does not apply."

I was staggered that he could even have said that, when the joint select committee appointed to look at procurement is to deal with two bits of legislation before it. One is a legislative proposal for public procurement and disposal of property, and the other is a repeal of the Central Tenders Board Act. And in the first legislative proposal, we are specifically looking at the concept of procurement of bodies such as the RHAs. How could he possibly, as a serious intelligent Member of the Government as he ought to be, say something like that? It makes me believe that there is absolutely no form of consultation between the Members of Government.

Madam Vice-President, without going into the business of the joint select committee, which six of us came from sitting this morning, it was staggering to also find out that the Ministry of Finance is involved in a separate discussion on procurement from the committee. [*Interruption*]

Hon. Dr. Gopeesingh: Point of order, Madam Vice-President. I think the learned Senator knows that matters related to the joint select committee—unless the entire matter is brought before the House—[*Interruption*]

Sen. F. Al-Rawi: Agree, agree.

Hon. Dr. Gopeesingh:—you ought not to discuss matters related to it. So I think he is going in that direction.

Sen. F. Al-Rawi: I have not gone that far, I am sure you would agree. I have made a point and my discovery is one which is properly in the public domain as I understand, and I do not intend to go any further. That is why I gave the cavaet to not get too antsy. I have seen the Leader of Government Business quite content to bring stale-dated issues of privileges when he knows or ought to know that things should be dealt with expeditiously. I have seen the hon. Minister of Transport studying hard the Standing Orders here this afternoon. I have seen the Minister—I have seen the Leader of Government Business fumble with Standing Orders over and over again. I certainly would never be one to fumble on Standing Orders, not me. [*Desk thumping*]

My point is that there is a solid discussion afoot in the national community, one which has achieved public note, because the Opposition walked out by way of protest from a joint select committee participation because of our bitter complaint demonstrated by the foul behaviour of Members of the Government that they could not be trusted to adhere—[*Interruption*]

Hon. Dr. Gopeesingh: Madam Vice-President—[*Interruption*]

Sen. F. Al-Rawi: Madam Vice-President, I called no single person.

Hon. Dr. Gopeesingh:—unparliamentary language. Carry on.

Sen. F. Al-Rawi: My learned colleague knows the Standing Orders better than that. I may be new to Parliament but I am not insincere in my study of what is permitted, Madam Vice-President.

3.00 p.m.

I am saying that the Opposition has absolutely no faith at all by the very behaviour of the Government Members opposite that they can be trusted with anything to do with procurement. [*Desk thumping*] And I do not think it is a personal intention on their part. I want to be charitable and say that I think that it is from bungling. It is from lack of communication. I will leave the more insincere motives to others in this Parliament. But I am saying if you factor the position relative to procurement, and you factor this Government's stout, stubborn and steadfast refusal to provide answers—for instance, in relation to the Invaders Bay project, questions have been asked; we are told that there is advice floating somewhere in relation to procurement, but we are not permitted the privilege of seeing it. That remains a very curious thing.

Sen. Dr. Tewarie: Madam Vice-President—

Sen. F. Al-Rawi: Madam Vice-President, I am not giving way unless it is a point of order.

Sen. Dr. Tewarie: The hon. Senator is misleading the House.

Sen. F. Al-Rawi: What is the point of order, Madam Vice-President?

Sen. Dr. Tewarie: He is misleading the House.

Sen. F. Al-Rawi: I am not giving way, so have a seat! [*Desk thumping*]

Madam Vice-President: I would ask that all Senators—Minister, if you have a point of order, I would like to hear the point of order. Until then—but, please, Senator, you spoke about being charitable, I think in the Motion moved before, Senators of the Opposition, or a Senator of the Opposition did ask to simply give way. I think it is only fair; up to you, but proceed.

Sen. F. Al-Rawi: Thank you, Madam Vice-President, for your reminder of gentlemanly conduct, but, regrettably, this is going to be a very uncomfortable issue for the Government, so they ought to get comfortable in their chairs as it warms to fever pitch and learn to take the pressure. [*Desk thumping*] The Members of the Government need to understand that they have to learn their Standing Orders—basic parliamentary rules.

Anyway, the point is, the Attorney General, in whose conduct it is to actually draft the regulations—first of all, let me backtrack. The hon. Minister had to say, in piloting this Motion, just before he concluded, that the Ministries viewed—I am not sure if he understood what he said. He said at about 2.24p.m.—is my note—that we have the regulations here.

You see, Madam Vice-President, the Bill before us says that section 20 is to be amended by the insertion of a new clause, and that new clause reads as follows:

"Notwithstanding subsection (1) and where it is economically expedient to do so, a Board may—

(a) pursuant to an agreement with any other Authority;

(b) in accordance with regulations made under this Act for the purposes of this subsection; and

(c) acting on behalf of its Authority and an Authority referred to in (a),"

It is conjunctive by the use of the word, "and" in the paragraph split out as (a), (b) and (c). It cannot be that the regulations that comprise the subsidiary legislation attached to this Act at present, could govern this process, because the clauses do not lend themselves as drafted to support the kind of legislative amendment that is being proposed now. Dare I say that if the regulations were to lay unamended, it would constitute a ridiculous proposition of law that we should look for guidance in the regulations.

Let me tell you why. The parent Act is extremely important—and I have not left the Invaders Bay project, Madam Vice-President; I am going to come back to it, so let Senators not rest too easily. This particular parent Act is very important in considering the amendment before us. Number one, I ask the Senate to take careful note of several sections of the legislation.

Firstly, section 4 of the Act is important in this context. It deals with the concept of creating a body corporate. Section 6, as the hon. Minister took us through, deals with the powers of Regional Health Authorities, which are very wide powers. This resembled the old memoranda and articles of incorporation under the old Companies Act where you had to specify every power, and if you did not specify a power, you could not perform it at law. It changed with the passage of the Companies Act where you could just do anything as a natural person.

Section 7 provides for the constitution and procedure of the board of directors and makes specific reference to the Second Schedule of the Act. Section 9 provides for an immunity of the board of directors in good faith. Section 10(6), the board of directors may delegate to the CEO anything within its power. Section 13, the board may delegate to a committee any of its functions. Section 16, the RHA may have dealings in property subject to the approval of the Minister. Section 20 is the one that we now seek to amend, which deals with aspects of procurement. Section 25(4) requires audited accounts and third-year detailed accounts to be laid in Parliament. Section 26 deals with transfer of employees. Section 35 allows you to make the very regulations which I have referred to, the subsidiary legislation. The Second Schedule, sections 4 and 9 of that—section 4 permits that the board of directors may regulate its own procedure and section 9 mandates that conflicts of interest must be declared.

Under the subsidiary legislation, which is the procurement rules by which these institutions are governed, section 13 says that the CEO—wherever goods or services are required to be procured, they must be tendered. Section 20 provides for an evaluation committee. Section 22 provides for a strict form of contracts.

Madam Vice-President, when you look at these provisions as a collective whole, it must be that if you propose that the authorities ought to negotiate collectively, we will have to amend the regulations to provide for exceptions to the conflict of interest provisions; to provide for the manner in which procurement is to be dealt with when one authority is dealing without the benefit of the other authority's full involvement, because it will dilute the immunity clauses offered inside of the Act.

So the devil is in the details. [*Desk thumping*] But do you know what details we have in this Parliament? Absolutely nothing! We are told by the hon. Minister of Education, with the greatest respect to him—he is my good friend and he knows that. We are told that the Ministry of Health says so. Absolutely no report; no form of statistical reference; no form of analysis. Now, factor that on what I just pointed out to you: audited financials to be put forward; reports to be put forward; public meetings of the RHA and their board of directors. No form of statistical information as to why this is the only way that the type of procurement that we are looking at can be performed, because if you look at the conjunctive effect of section 13 of the parent Act with the existing section 20—let me explain that. The fact that you may delegate anything, and the fact that procurement is dealt with under section 20, then you turn to the regulations.

The regulations which set up the requirement for tenders committees is not mandatory. It uses the word "may". The word "shall" is not used. So if you look at a proper construction of the legislation as it exists, one may argue that you may deal with the type of procurement that you seek to do now without amending the Act. And why should we consider that? We should consider that out of an appreciation of the fact that procurement discussions are going on now. We should factor that.

In the course of the run-up to the election, this Government, big on its position on procurement, said specifically to the nation, "We will implement procurement forthwith." I will take some blame that the Opposition had to protest, and we protested on very strong reasons of the requirement for policy, because there is none; no statement of policy in the Lower House debate of this Bill. [*Desk thumping*]

The Member for Diego Martin Central begged for policy. The Leader of Government Business, much like the Leader of Government Business here, had nothing to say in answer to him. "Why do you need public policy? We do not need to tell you about policy." It is axiomatic that policy is the first prescription before you get into procurement modification. You must have a statement of policy.

Now, even if you do not want to accept that my reading of the legislation is that you can, in fact, undertake procurement without amending the Act to be more cost-effective, but more importantly to get better value for money—because that does not mean that you have to get the cheapest; you want the best value for money for our patients and citizens—then how do you explain the dichotomy which exists right now where Nipdec, through C40, is allowed to procure in bulk on behalf of all the RHAs without an amendment to the legislation? Were they acting ultra vires? Is it unlawful? How do you explain that? Why do you need it now when you have the ability to transfer and second?

You see, Madam Vice-President, it is so disingenuous and unintelligent to stand and say, "you need to do this now", without explaining how it is being done now with respect to pharmaceuticals for all the RHAs. How? Why no legal challenge to date? Why no declaration of being ultra vires for the donkey's years that it has been done? Why? Do you know why? Because the Act provides for the Minister to have authority for procurement beyond certain limits. The Minister has that authority. So under the People's National Movement, we dealt with procurement in a blocked scale basis by allowing the Cabinet to make a decision as to Nipdec's procurement on behalf of the RHAs.

That is still a mechanism permitted and open to this Government to utilize, not because their intention is wrong, but because in the context of the public procurement debate which is ongoing and which we so desperately required—and dare I say, which the PNM called onto itself; the People's National Movement called for a commission of enquiry into the construction sector. It paid the ultimate political price because citizens felt that they could not support things which came out of the PNM's own call. But we called it! And the Uff Commission Report recommendation still has to be implemented. Two and a half years later, silence relative to implementation! Staggering silence!

So you have Nipdec able to procure on a bulk scale basis; why not now? Why not explain to the nation why you did not obtain legal advice as to whether you could procure via the same route of Cabinet's position, particularly when procurement is of two types under the regulation: selective tendering process and open tendering processes, where there are limits with respect to matters under $50,000 and over $50,000; where there is a limit in the existing rules that matters of procurement over $1 million must have ministerial approval?

This resembles the very form of debates that we have had before on other Bills—poorly thought out. Poorly thought out! Inexplicable logic offered! Absolutely no detail! If I were the Leader of Government Business sitting here, I

would be ashamed to say that I put this on the Order Paper. Ashamed! Rather than jumping up to move stale-dated Privileges Motions, he should be ashamed of laying something like that on the Table. Yes, Madam Vice-President, I will be cautious not to go much further on his personality. I am talking about the policy of bringing forward ill-prepared legislation.

Sen. George: My back is broad; I could take it.

Sen. F. Al-Rawi: Back broad and thin-skinned.

Sen. George: You go ahead, man.

Sen. F. Al-Rawi: There you go. [*Desk thumping*] So, Madam Vice-President, it is critically important that we have explanation from the Government as to where the legal opinions lie—

Madam Vice-President: I am going to warn you, Sen. Al-Rawi, that your reference to people who are thin-skinned, et cetera, please, do not make such statements and they are not considered parliamentary in this Chamber.

3.15 p.m.

Sen. F. Al-Rawi: Thank you, Madam Vice-President. I am thin-skinned and I can say that. If I have offended the hon. Leader of Government Business, I humbly apologize and I withdraw the remark, but I am thin-skinned. [*Interruption*]

Hon. Dr. Gopeesingh: You better take care of your health.

Sen. F. Al-Rawi: Thank you, honourable doctor. [*Laughter*] So in the face of this inexplicable dichotomy of procurement en bloc via Nipdec through C40 with respect to pharmaceuticals and others, why now come to say you absolutely need to do this in this way when there is another mechanism? The other mechanism is by way of framework agreements by the Government to some institutions.

Madam Vice-President, members of the World Bank have told us that the devil is in the details with respect to framework arrangements—it is called, whole of government procurement. When we look for positions as to explanation, when we look to the best form of advice, when we look as parliamentarians to do the very best for our citizens, we must have reference to the full gamut.

In 1994, 1999 and 2000, when we had debates relative to amendments on the RHA Act—in 1994, in particular, the extent of information provided to the Parliament was spectacular. Every single form of consultation that could have happened, happened. The hon. Minister of Health, in 1994, was permitted three

hours in the Senate to explain the rationale in piloting the Motion, then, which became the law. The UNC, which became Government later, reneged on its position as they are accustomed to doing. No problem in eating their own words. In private, I have asked a couple of them how do they feel as parliamentarians in their experience with volunteering a position now that is so radically different from the one which they articulated in Opposition. But, Madam Vice-President, when you look to the PNM's record of debate on this Act itself—I have genuinely looked at it—there is not one instance of word eating. [*Desk thumping*] You could stand today and say you said the same thing then.

Now, I think it is absolutely important that we reform the procurement procedures as they prevail in the RHAs now—absolutely important. I think it is critical for the Government to explain why this is the only way for this to be done. I think that we must have national conscious reflection upon the recent history of the United National Congress as it relates to public procurement, and I wish to reflect on two aspects of public procurement because it affects. If we are to say trust the Government now on this procurement cycle, even though you are going to end up in an absolute conflict in terms of management, how do you hold people accountable when something goes wrong?

RHA No. 1 procures for RHA No. 2, No. 3 and No. 4. RHA No. 1 makes a decision and there are procurement rules—the hon. Minister said the rules exist now. I tell you that they need to be amended. The rules provide that you must declare interest; you must have regard to certain things; that there is immunity for directors, et cetera, in relation to these things. What happens when a conflict comes; how do we hold people accountable? It is a legal nightmare. So, on two points I should add a third point of public procurement. Let us look at their recent history as to whether we ought to trust them. [*Interruption*]

Sen. Hinds: No!

Sen. F. Al-Rawi: The three points that I would deal with are: one, the Invaders Bay project; two, the procurement of health services in relation to the St. Ann's health facility; and the third, the procurement of lands as they relate along the highways for the Point Fortin Highway. Why? Because it is germane to this debate. How is it germane to this debate? It concerns procurement. How does the procurement affect us here today? The Government is telling us, in the absence of the information, trust us; the Ministry of Health has said that. We, as a responsible Opposition, need to pay attention as to whether we can rely on that now in deciding whether to passage this Bill.

So relative to the Invaders Bay project, on the Invaders Bay project we have had a debacle. [*Crosstalk*] The debacle is that the hon. Attorney General, in whose Ministry the responsibility to draft the regulation amendment for this Bill resides, has steadfastly refused to provide the advice in relation to why the Central Tenders Board Act does not apply to that disposition of state land. [*Desk thumping*]

Madam Vice-President, why is that important, because the advice ought to have been given relative to this Bill? Why is it that this is the only amendment that can be done? Now, mind you, it must lie as a conspicuous thought that the hon. Members of the Government have been at pains to waive every bit of advice that they get when it suits them, but are holding close to their bosom and not showing us advice which we have asked for on a serious matter of public procurement, when persons such as the Joint Consultative Council for the construction sector comprising the TTMA, the Surveyors Association, the Architects Association, the Construction Association—all of these people—have complained in the public domain as to why they cannot be given an explanation, because explanations relate to transparency and transparency relates to procurement in this very bit of legislation that we are looking at.

So point No. 1, steadfast, stone face, cold silence on the rationale for public explanation, for transparency on the process. We have an opinion and it is good thus far. Those are the words of the hon. Attorney General in the No Confidence Motion. Those are his words: "We not telling yuh. It is good thus far." He did not say we are not telling you. He said it is good thus far. My interpretation after asking is that he is not telling me.

Secondly, we have an issue skipping over the St. Ann's issue because the St. Ann's issue—St. Ann's was mentioned in every single debate in 1994, 1997, 2000 and 2005. Every single debate had an issue with St. Ann's at the same time. Do you know what? History is true to itself; repeating cycles. There is another issue of St. Ann's in the public domain. In 1994, there was the throttling and strangulation of a patient. Later on—[*Interruption*]

Hon. Dr. Gopeesingh: What about the eggnog?

Sen. F. Al-Rawi:—there was the eggnog incident. Thirteen people died over that incident. I am thankful to the hon. Minister of Education.

So, Madam Vice-President, what do we have today? It seems we have a procurement of patients for the St. Ann's Hospital, but that aside, that bit may be

sub judice so I would not go there. What have we done to the doctors, hon. Leader of Government Business? [*Crosstalk*] What have we done to the doctors?

Sen. George: [*Inaudible*]

Sen. F. Al-Rawi: I will tell you. I will tell you exactly. I am grateful that you repose confident that I know what I am saying. So the point is what have we done to the doctors? We have exposed the doctors to risk of malpractice, to breach of the very patient's rights.

The hon. Minister in his presentation raised, for us, the Patient's Charter of Rights. The Patient's Charter of Rights is a document published on the SWRHA website. There is a Patient's Charter of Rights. From their website the Patient's Charter of Rights reads:

- Access to treatment
- Respect
- Privacy and confidentiality
- Refusal of treatment offered

Things mentioned by the very Minister sitting opposite us today who piloted this. But what have we done when we are looking to procure services for persons to replace those who are likely to be prejudiced by recent actions of the Government? We have put them in jeopardy because we have not thought out the processes carefully.

There are procurement aspects inside of there. When we come to negotiate services for neurosurgery, or for neurology, or for mental health administration, if we are looking to do this en bloc—one authority for others—how do we provide the immunity of contractual relationships inside of there when there are risks of the type that happened under the very, very, very unfortunate incident of Cheryl Miller? That is a genuine example of a risk which the doctors face. Badly managed! Silence from quarters that I never believed could have been silent on the issue. Silence! Not a word!

But, it applies here when we come to create contracts across authorities. How do we deal with it?

3.25 p.m.

Now, I am glad that the hon. Minister mentioned neurology. He said to us in this debate, "Take my word that the Ministry of Health has said that this is a good

thing." Let me tell you, Madam Vice-President, why I feel no comfort in that; not that I would disrespect those persons at the Ministry of Health.

On January 20, 2012, we had the Ninth Meeting of the Joint Select Committee of Parliament, public enquiry, with members of the Ministry of Health in attendance chaired by my learned colleague, Sen. Corinne Baptiste-McKnight. I raised a very important issue which is directly related to this Bill and I have raised it with Dr. Anton Cumberbatch. I asked him with respect to the thousands of radiology reports that are in backlog in the system, what was being done. Here is what Dr. Anton Cumberbatch had to tell us at page 46 of the Minutes of that particular day. He said, in answer to my question:

> "Well, I would answer the first part of it in terms of the response to the backlog let me just indicate from where I sit, the backlog that has been presented to us is not in the thousands but substantial."

I then asked: "How substantial?"

He said: "Hundreds." I said: "How many hundreds?" "It is not only…" and then he went into an explanation—the Ministry of Health, well-appointed persons ought to be able to speak for the Ministry. Later on, Dr. Ramroop stands and says that he is a consultant radiologist at the NCRHA and that the backlog is 5,000 MRI cases.

Sen. Hinds: Yes, I remember that.

Sen. F. Al-Rawi: The source of that, Madam Vice-President, is the Ninth Meeting of the Joint Select Committee on Parliament, Group I, appointed to enquiry, January 20, 2012, 9.27 a.m., publicly televised.

My point is, Madam Vice-President, when I asked for further particulars in relation to that, do you know what I got? Because I said, look, go back and research the issue. I asked Dr. Ramroop to repeat that to Dr. Cumberbatch.

Sen. Hinds: Yes.

Sen. F. Al-Rawi: Dr. Ramroop told him thousands. I said, how many? I could not believe that the headman could say hundreds and somebody else directly under him, in charge of backlog clearing exercises of the very neurological and radiography reports that we are talking that we wish to procure broadly—number one: it turns out that they are being solved by a joint procurement exercise without—[*Interruption*].

Hon. Dr. Gopeesingh: That proves its point.

Sen. F. Al-Rawi: Yes, it proves the point—without amendment to the Act. That proves the point! [*Desk thumping*]

Next, we had tabled before us, on March 16, 2012, written responses to my direct questions. Do you know what the number turned out to be? Madam Vice-President, 9,920 reports. [*Desk thumping*]

Madam Vice-President: Hon. Senator, I am going to ask that we all look at Standing Order 74 seeing that you are quoting directly from statements that were made during the session of the Joint Select Committee and any publication thereof. As Standing Order 74 says:

> "The proceedings of, and the evidence taken before any Select Committee and any documents presented to and decisions of such a Committee shall not be published by any member thereof or by any other person before the Committee has presented its Report to the Senate."

In light of that Standing Order, I am going to ask that you desist from referring to proceedings of the Joint Select Committee any further.

Sen. F. Al-Rawi: I am guided. In the event that you rule that it may be struck off, I will just say, I am informed and verily believe that the report is in the thousands—[*Interruption and crosstalk*]

Hon. Dr. Gopeesingh: You cannot quote from that source.

Sen. F. Al-Rawi: Listen, let us not play semantics. We are talking about procurement—

Madam Vice-President: I am going to ask, for semantics purposes, that the statements, *Hansard*—any statements that reflected the proceedings of the Joint Select Committee will be struck off from the *Hansard* recording as they are not considered to be part of, and please, let us not—

Sen. F. Al-Rawi: May I ask for your guidance?

Madam Vice-President: Yes, but please do not reflect on any of the proceedings of the Joint Select Committee.

Sen. F. Al-Rawi: May I ask for your guidance on a very, very important point of Parliamentary privilege and that is the right to speak in Parliament. For your guidance, insofar as there is public televised play of the Joint Select Committee, public enquiry, at which members of the public are invited, would you, please, guide me, if I were to quote that on the television when I watched it later from my source on that day, would I be running afoul of the rule?

Madam Vice-President: How can you quote verbatim from the televised version? Were you taking notes? Is that—

Sen. Al-Rawi: I can tell you my source.

Madam Vice-President: If it is that you refer to what you heard via television; that is fine; or if you have some sort of photographic memory, but do not refer to proceedings taken out of the Joint Select Committee.

Sen. F. Al-Rawi: Thank you, Madam Vice-President; it is proof that I can think outside of the box. [*Crosstalk*] Yes, with the help; we are here to help about the truth, hon. Leader of Government Business. [*Desk thumping*] Do not be afraid of the truth, hon. Leader of Government Business.

So, Madam Vice-President, I am quoting from the televised play of comments made on the Parliament Channel that the report is over 9,000 strong, and a fortiori to the argument that I have already presented, the backlog exercise is being cleared by way of a system without amendment of the Regional Health Authorities Act in the manner in which we now seek to do.

Hon. Dr. Gopeesingh: There are other areas.

Sen. F. Al-Rawi: I accept what the hon. Minister of Education is saying across the floor; there are other areas. My question is this: in light of the timing of the Joint Select Committee on public procurement, the national debate, is this really the right time? Now, he would be very correct to tell me, as Sen. Ramkhelawan often says, we ought not to let the horse starve while the grass is growing. That is a commendable argument. How do we deal with this whole concept of providing an interim solution relative to a long-term problem, bearing in mind that procurement is an ongoing exercise of reform? I accept that. My point is whether we need to do it this way.

I respectfully beg to argue forcefully, Madam Vice-President, that it is my humble view, that the Minister has the authority right now, under the regulations—I hope you are giving me some injury time, Madam Vice-President, while you look for the time. [*Madam Vice-President nods*] Thank you. That the Minister has the authority right now to form a procurement arrangement by way of framework arrangement, by way of whole of Government or part of Government position. [*Interruption*] Could I crave your indulgence to ask for protection from the Leader of Government Business for interruptions? [*Desk thumping*]

Madam Vice- President: You would have protection from all the Senators who are talking across the floor. Proceed.

Sen. F. Al-Rawi: Thank you, Madam Vice-President. He is, after all, the Leader of Government Business; I must be respectful, and he is persisting—[*Interruption and crosstalk*] Thank you, Sen. Hinds, for your assistance. If I could say that it is

my view that the current legislation allows the hon. Minister that authority. It is evidenced by the playout of the NIPDEC situation through C40 in procurement. It is evidenced by the very radiographer backlog clearing exercise that the Regional Health Authorities are engaged in at present. Very important evidence before us that we need to look at this thing in the face. I would be happy to be persuaded by my learned colleague if some facts were brought forward. I feel, as if I would abdicate my duty to the citizens of this country if I were to lend support to something that is not properly interrogated or presented.

Madam Vice-President, I wish to raise a few more issues broader in the debate relative to procurement. Specifically, I raise these issues on behalf of a very heavy cry of certain citizens. The hon. Minister of Education told us today that the Government was proud to enter into—

Madam Vice-President: Hon. Senators, the speaking time of the hon. Senator has expired.

Motion made: That the hon. Senator's speaking time be extended by 15 minutes. [*Sen. Shamfa Cudjoe*]

Question put and agreed to.

Sen. F. Al-Rawi: Thank you, Madam Vice-President. I would not be much longer but there are a couple of issues that deserve ventilation before the hon. Senators present. The hon. Minister of Education told us a while ago that the Government was proud to say that it had moved in the direction of creating a health tourism market particularly by the encouragement with respect to private/public assistance.

I am aware that private institutions in this country that wish to invest in specialist medical diagnostic equipment have, in fact, been refused permission for the waiver of duties, specifically customs and VAT, by—[*Interruption*] Okay, well, I am not beating; I am asking for assistance here. I am saying—I know that I will get none from certain people but I am sure that I am falling on fertile soil here. The point is that I am aware that the Government has refused—Cabinet specifically—waivers made by the private sector for public participation with respect to VAT and customs. I am humbly asking the Government, the Cabinet of this country, many of their Members sit here, to reconsider that position for two reasons.

One: the economy is flat and health tourism would do well. [*Desk thumping*] Public/private participation and ventures would do well. There is a short supply of diagnostic equipment in this country. The best way to regulate something—if you are going to give a guy a benefit, make him serve the public as part of the

concession. But, Madam Vice-President, in 2006, the PNM Cabinet specifically agreed, by way of Cabinet Minute, to the exemption of customs and VAT duties, and I am humbly asking—[*Interruption*]

Hon. Dr. Gopeesingh: For what? For what?

Sen. F. Al-Rawi: For medical equipment being imported for use in conjunction in public/private.

Hon. Dr. Gopeesingh: But the public would benefit?

Sen. F. Al-Rawi: Yes, the public would benefit. I am humbly asking the hon. Minister—and I will provide him with details after—to lend assistance if he can.

The second thing that I wish to make a great deal of plea on is the request for pain management medication. Madam Vice-President, there is a bitter, bitter, bitter shortage of pain management medication for our dying patients. The procedure is, in fact, regulated by the WHO and by the United Nations relative to quantities of narcotics for pain medication that you can import. If Trinidad and Tobago is to become a health tourism destination, we cannot be treating people with bare amounts of pethidine or watered-down versions of morphine and pethidine because of drug concentration issues.

I am aware, Madam Vice-President, for instance of the most excellent altruistic work done, philanthropic work done, by the Vitas House. They have been the champion of the cause for pain management medication. I am aware that they have to go out and get that medication from overseas, in Barbados, to bring it in here. Patients dying of cancer cannot have any form of help. I know I am falling on fertile ground here with the hon. Minister and I am, please, begging for him to take attention of the issue.

I believe that this is an issue which has spanned successive Governments. It is not his Government alone; it may be successive Governments. I am told, and verily believe, by persons well placed, that the issue has to do with agitation for the United Nations and WHO quantities. I am imploring the hon. Minister to carry the message back to the Cabinet of Trinidad and Tobago to bring relief for these citizens.

Madam Vice-President, the hon. Minister left us with a great deal of room for debate. My colleagues plan, I am sure, on stimulating the discussion before us, sometimes it may be a little bit heated, but I want to make it abundantly clear, this is so that we ensure the best programme for procurement. Procurement is not only about cost-saving. Procurement is a management tool. Management to be

effective must be capable of measurement and accountability. The measure before the honourable Senate today is not associated with management, or with measurability, or with accountability. It may, in fact, be the case if the regulations are brought.

Madam Vice-President, I wish to join solidly with Sen. Wade Mark when he sat as an Opposition Senator in 1994, when he said that it was incumbent in the climate then, for the regulations to be brought with expedition. In fact, the regulations which form subsidiary legislation under this Act were brought immediately, and there was public consultation and there was participation in relation to it.

3.40 p.m.

No sooner than the November/December debates were done, No. 4 of 1995, the subsidiary legislation was put in the Parliament. The discussion was ongoing at the same time with the creation of the legislation. Why then has the titular head of the Bar, the hon. Attorney General, who has immense ability to bring subsidiary legislation for consideration as to how the measurability and accountability and inter-articulation facets are going to work, not tabled it at the same time with this Bill? It may have caused for much shorter debate.

I notice that the Members of the Government said: "Let us do this Bill because it is a short debate." I said to myself: "Surely, they are not being serious. Hopefully they are trying to be optimistic that the commentary will be short." The issues are deep and important.

I think it is incumbent upon the Government, through the Leader of Government Business, as he sits there, to make sure that the parliamentary agenda is well explained and when he is bringing legislation, he brings legislation which is well thought out. Poor examples, by way of assistance to him, existed in previous debates recently under the very Leader of Government Business' own hand. Fortunately, he did provide, to his credit, explanations and the Senate was warm to have them then. We need that assistance from him now. We need that existence now to explain how this thing is going to be measured; how it is going to be performed; how does the accountability rack up against the procurement exercise, which we wish to modify; why this is the only route available to us; what is the legal opinion, in relation to that; why is it that the Minister's discretion cannot prevail now; and why is it that sections and 20 and 13 of the Act cannot inter-articulate now together with the subsidiary legislation to avoid dynamic difficulties. They need to explain that now.

I beg the hon. Senators to consider carefully their response and this time to actually make mention in their closing remarks of what the answers to those questions are. I have a long list—I am giving them notice—of questions asked and that remain unanswered. It is serious debate. It is serious law. We are here as a Parliament debating for our citizens, the best form of process possible and I wish the Government to step up to a higher standard.

Thank you, Madam Vice-President. [*Desk thumping*]

Sen. Dr. Victor Wheeler: Thank you, Madam Vice-President, for allowing me to contribute at this time. I have to also thank my colleagues on the Independent side for affording me the opportunity to lead off in this debate. [*Desk thumping*] It is not something that I am accustomed to but I would certainly enjoy the moment, however few and far between it is.

I would also like to welcome the acting Minister of Health, Hon. Dr. Gopeesingh, to this Chamber. Thank you for leading off the debate by moving that Bill. [*Desk thumping*] It is a very important Bill because it affects the delivery of health care in Trinidad and Tobago.

This Bill amends the Regional Health Authorities Act, Chap. 29:05. First of all, I would like to give some background information to the Regional Health Authorities as were set up. As Hon. Minister Dr. Gopeesingh has said, the RHAs were formed in 1994, by the introduction of the RHA Act, No. 5 of 1994 and this was under the PNM administration led off by Minister Eckstein.

The RHA Act was actually introduced as part of the Health Sector Reform Programme, which was being discussed in the late 1980s and funding was sourced from the Inter-American Development Bank (IADB) which eventually agreed to fund the programme. But part of the requirement for funding this programme, it seems, is that the delivery of the health-care system which was previously managed by the Ministry of Health should be decentralized, broken up into different regions, so that the care is brought closer to the communities. There was a debate at the time whether there should be two RHAs in Trinidad versus four. Eventually, there was the agreement that there would be five RHAs, four in Trinidad and one in Tobago.

The actual introduction of the RHA (Amdt.) Act in 1994, was strongly criticized by the then President of the Public Services Association, Jennifer Baptiste. Part of her criticism of the Act is she wanted to negotiate when the public servants moved to the RHAs, under the Ministry of Health, the Public Services Association was the recognized majority union for the workers. She tried

to get, if you are moving workers from the Ministry of Health to the RHAs, she would like her union to have automatic recognition to represent these workers. This is something that was not agreed to. Hence, her serious opposition right up until I think she demitted office. She did not go up for the election. As a result of this opposition, from 1994 to, I think, 2009, the health system was run by employees of the RHAs and also employees of the Ministry of Health who were public servants. This, in effect, was a dual-track arrangement of employment.

The rationale for introducing the Regional Health Authorities in 1994 was because there were problems with the provision of health care by the Ministry of Health. The Ministry of Health was the funder of health care and also the provider of health care. The concerns raised then were shortage of staff, both of doctors and nurses; old infrastructure; malfunctioning equipment; shortage of equipment; slow response of the Ministry of Health to dealing with various problems in the health sector. Many of these items were also pointed out in the Gafoor Report, which was the Commission of Enquiry into the Health Sector.

When the RHA Act was passed in 1994, funding was not released by the IADB until 1996, but the Government went ahead and introduced the different Regional Health Authorities. The intention of the Regional Health Authorities was to—I would point it out here—return service delivery and management to the Regional Health Authorities whereby the Ministry of Heath will contract services for the provision of health care by them. They were also supposed to provide cost-effective balance of public and private services within a global budget. The RHAs were supposed to have developed human resource strategies, which included a new funded pension plan for all RHA staff to achieve appropriate skill mixes and staffing levels. The RHAs were all supposed to rationalize the health services and infrastructure, emphasizing preventive and promotive services and strengthening primary care. I would come back to this later on. The RHAs were supposed to develop a comprehensive financial strategy for the sector, including evaluation of user charges and also a national health insurance system as a potential financing mechanism for the RHAs.

Along with the introduction of the RHAs in 1994, the public servants who were formerly the employees of the Ministry of Health were supposed to either, as the Minister said, transfer to the RHAs, second to the RHAs or resign and be employed by the RHAs. As I have said the PSA strongly resisted this, because of the issue with the representation, and as the acting Minister of Health pointed out, you actually had specialist public service doctors leaving the public health system because, while the issue of transfer, secondment and resignation was being

challenged by the union, there were those specialist public service doctors being asked to work in buildings that were managed by the RHAs. There was a famous anaesthetist out of Port of Spain who actually refused to work in that building. He would go to work every morning, sign the register and go home. [*Interruption*]

Hon. Dr. Gopeesingh: It is still pending.

Sen. Dr. V. Wheeler: I understand there was a legal challenge to that. There were several other doctors in this instance. There were also one or two paediatricians who were also acting in that way for justifiable medico-legal concerns, because when they asked the question: "If as a Ministry of Health employee I were to work in an RHA building, managed by the RHAs and a problem arose with respect to the care of a patient, who would be responsible for protecting me? Who would be looking after my interest?" They were not given a clear answer to that. As the Minister intimated, still not.

With respect to paediatrics, all the senior paediatricians left the Port of Spain General Hospital and the paediatric services were transferred to the Eric Williams Medical Sciences Complex. The effect was that Port of Spain General Hospital, which is supposed to be a general hospital, did not offer paediatric care. I am actually surprised that Port of Spain General Hospital can still be called a general hospital. The only service it offers is really for newborn babies and when those babies are—that is only if they have a problem they are admitted to the neonatal intensive care—are discharged from that unit they are sent to the neonatal clinic. Port of Spain General Hospital right now, to this day, does not have a paediatric department.

With respect to Tobago, I would touch here, VSEP was offered in Trinidad in 2009, and finally it was offered in 2010. Even though VSEP was offered in Tobago in 2010, you still have about 20 to 30 THA employees working in the RHA-controlled hospital, who had requested transfer to the TRHA and their issues still have not been addressed. I am not certain what is happening with them. Even though VSEP has occurred for Trinidad and Tobago, you still have the dual-track system in place and this is causing challenges to the RHAs' ability to manage the health sector.

I should also mention here that at the time the RHAs were introduced, I came back to Tobago in 1996, after specializing abroad, and at that time part of the IADB funding was financing to improve management system, HR system and finance system. There were many different projects and courses that both RHA personnel and Ministry of Health personnel were supposed to go on. There would

be a project where there would be both RHA staff and Ministry of Health staff, the project is started and all of a sudden you were supposed to have a meeting, the Ministry Health employee would not be there and you would see someone else in that person's place. Why? It was because that person was either sent on leave or promoted and a replacement would come in with no handover. The RHA, at that time would not be informed that the Ministry had planned to approve leave for this person so, therefore, many of the projects that were embarked upon during that time had the serious challenges for completion and implementation. Obviously, you would see that would have an adverse effect on the ability of the RHAs which were supposedly given responsibility for health care, but not really given true authority to manage all the staff. That will, of course, pose some challenges in their delivery of health care.

As I have said, the RHA Act resulted in five different RHAs. Section 4(3) of the Act states that each RHA will establish its head office in such a place as the Minister approves. Whereas the Ministry of Health had one office, and the Minister referred to this, all the five RHAs now had to have five head offices, which means they had to rent or purchase five buildings. They had to have five sets of head office staff, five CEOs, five HR departments, legal departments, finance departments, quality departments. Automatically you had a multiplication of the administrative cost of health care, dramatically, but there was no similar reduction in the Ministry of Health cost because the Ministry of Health still had their administration stuff to do because they still had Ministry of Health employees that they needed to manage. This went on throughout.

3.55 p.m.

Section 6(a) of the RHA Act states that:

"The powers and functions of an Authority are—

(a) to provide efficient systems for the delivery of health care;"

This is what we are being told, that this Act is hoping to improve some of the deficiencies in the health care, but after 18 years of existence of the RHAs it is still not clear whether the efficient system for delivery of health care has really been approved.

With the introduction of the RHA, I spoke about the five head office staff whom RHAs would employ, they also employed in some instances their own clinical personnel to carry out functions which public servants who were there in the same hospital may or may not be carrying out. Actually, when the RHA came

into being there was a fairly antagonistic approach towards the public officers, because the RHA hierarchy thought sooner or later, "if you do not come and work for me, you will no longer have a job, because we are going to make your position redundant;" that occurred from 1995, 1996 and 1997. By 1998 when the RHAs realized that the public servants were still there, they realized they had to now see how they could work with the public servants in the system and a more conciliatory approach developed. I think from that year maybe into the mid 2004-2005, there may have been some improvement in the relationship, but the Public Services Association was still snapping at their heels.

As a result, many of the challenges that the Regional Health Authorities had in the provision of health care were then primarily HR challenges. The senior staff of all the RHAs—there was lack of job security, because all CEOs and all the senior management were on contracts. Whereas in the Ministry of Health, the senior hierarchy of the provision of health care, the Permanent Secretary, Chief Medical Officer, County Medical Officer of Health, Hospital Medical Director under the public service, these positions were permanent and protected by the Public Service Commission. But under the Regional Health Authorities, the CEO and all the senior managers were on contract, which meant there was no security of tenure. When you have a situation where the Board of Directors of the RHAs are political appointees by the Minister of Health, not necessarily appointed based on application, interview and competence, but just because they are appointed by a particular party you, therefore, had the hierarchy of the RHAs being subject to political interference and political control. The result of this would obviously be in—this lack of job security would result in—Tobago, for example, over the past 18 years had seven different boards of directors. In Tobago over the past 18 years you actually had 12 different CEOs, each CEO as you know when they come into an organization as the senior administrative person would want to bring their own management style to the organization. So it is not surprising with all of this uncertainty at the top, you would have low staff morale, lack of commitment and dedication to the job and you would also have a loss of valuable institutional knowledge.

The other HR problems that the RHA would have would be questionable recruitment practices. Section 10(1) of the RHA Act states that:

> "A Chief executive officer shall be appointed by the Board, on such terms and conditions as the Board with the approval of the Minister may determine."

I work in Tobago so I am more familiar with the Regional Health Authority in Tobago, and we have seen where a former board of director in Tobago, actually in the process of recruiting a chief executive officer for the Regional Health Authority, removed all the academic qualifications for that post, and employed

someone to lead the Regional Health Authority who did not even have a first degree. That individual tried his best, he did not employ himself, but the controversy resulted in him demitting office after about 18 months or so; he resigned.

You could imagine what would have transpired during that time, and remember this was the Tobago Regional Health Authority preparing to move into a new hospital, which completion dates were changed every year, until finally it was partially opened last month, and I have to commend here the current Minister of Health—[*Desk thumping*]—the current Government, the Secretary for Health of the THA, previous Governments, previous administrations; everyone certainly played an important role in having partial delivery of the hospital services. [*Laughter*] It is still to be quantified what portion of it has been delivered.

Hon. Senator: So it is incomplete?

Sen. Dr. V. Wheeler: No, it is not complete—[*Interruption*]

Sen. Deyalsingh: Serious!

Sen. Dr. V. Wheeler:—but at least we have access to—[*Interruption*]

Sen. Cudjoe: A part! A part!

Sen. Dr. V. Wheeler:—a building that is quite well built, and everyone who is there is actually happy. At least the outpatient services have started, some radiology services have started, and we are very happy for that. However, given the background of what transpired before with HR, there are still major human resource challenges that the Tobago Regional Health Authority is facing, and from what I have heard from colleagues in Trinidad, there are similar HR challenges.

Another HR problem that the RHAs face is a delayed and in some instances, a failure to address outstanding disciplinary matters. Some employees of the Regional Health Authorities feel that they can do whatever they want, there is no real accountability, and in particular when that employee is closely aligned to a board member, or a politician, they feel they can do no wrong.

There are other employees who raise concerns about various matters affecting health care and if they are on the other side of the political divide not of the national politics, but the local politics within the health institution, they might find themselves victimized. These are real challenges that are now occurring in the Regional Health Authorities and these are things that need to be addressed, because they are adversely affecting the ability of the RHAs to provide efficient, quality health care to the population.

Another thing I will come to is privatization. Since the introduction of the RHA in 1994, there has actually been a mushrooming of private health institutions in Trinidad and Tobago. And part of this, as I would have mentioned before when the RHA came into being and some of the senior specialists chose not to work for the RHA, some of them set up their private institutions and as I said there has been that mushrooming. I am not certain if this may have been the reason for some of the shortages now in the health sector, but it is certainly a factor whereby there is a shortage of neurosurgeons as Minister Gopeesingh mentioned, and there is also a shortage of ICU care, even though I know the Minister when he was in charge of North West Regional Health Authority, expanded the IC Unit in the Port of Spain General Hospital, and this had an impact. But with the increase in road accidents now, and other heart diseases—you know there has been an explosion of lifestyle diseases, there is a greater and greater demand for specialist services, in particular ICU care.

Now, we have already been told that there is a shortage of neurosurgeons and if this Bill is passed today, it will facilitate the four or five private neurosurgeons coming together to offer their services to the RHAs. As I have mentioned, there has been an increase in the private health institutions in Trinidad and Tobago since 1994, and I wonder if there is some plan to gradually privatize health care in the country, because if this Bill were to be passed, you might find other specialists potentially leaving the RHA employment, going privately, forming their own private company and then offering their services to the RHAs.

I hope this is something Minister Gopeesingh would watch out for, because this Bill might actually encourage it, because if they know they can offer their services rather than being employed by a hospital, form a private company, a group of them get together and offer it to all the Regional Health Authorities, the income they will make that way is far greater than if they were to just confine themselves to one. So I hope—I am a gynaecologist, a specialist myself, we are not in short supply, so you have no fear of us—[*Laughter*]—doing that.

But neurosurgeons, ophthalmologists, neurologists, plastic surgeons, you have some specialists, anaesthetists also, because some of the hospitals are crying out for anasethetists. I hope this does not encourage those who are still in public service to leave, to get further financial benefits.

Another area I want to touch on, which you had mentioned was the waiting list/surgical programme. Part of the problem the public hospitals faced before the RHAs came in to being was the long time to wait for surgery, since the RHAs have come into being this problem has not really been reduced. Some years ago under

the previous administration they introduced a waiting list initiative whereby if, for example, you had—well, we certainly heard the example of the need for reporting on the MIR scans, but you also had a long waiting list for hernia operations, cataract surgery, fibroid surgery, all of those things. What would happen is that you would identify one or two private practitioners and have them perform that surgery at a cost to the Ministry to assist the public hospitals.

What was worrying to me in that process was that you would sometimes have the same doctors working in the public institutions, being paid privately to do the same things that they should normally be doing at the hospitals, sometimes using the public institutions for this private work. When I first heard about that some years ago, I was always very uncomfortable with it, and I am still uncomfortable with that process, because that particular doctor might open himself to being accused of facilitating a long waiting list knowing that he would be paid to do something privately that he would ordinarily be doing in the public system. But the reality is that even with the introduction of that waiting list initiative, there are still some procedures where you have to wait months or sometimes years to have them performed.

At the end of the day, there has been a significant increase in expenditure by the previous Government and this Government on the health sector. But to say that the overall care to the patients has actually been improved, this is something the Ministry of Health, I would challenge, they really do proper statistical analysis to compare what was happening before with what is happening now.

Also, I want to suggest that the RHA system as it is now, be properly reviewed, because the questions were asked then as they are being asked now, has the inception of the RHAs really brought value for money? Has the increased expenditure to have the RHAs increase their administrative cost, has that really translated into improved care? The reason I ask those is that all of us in the health sector, be you Minister of Health, Permanent Secretary, chairman of a board, we have to realize if we do not already, that everything we do must be translated into some benefit for the patients who come for care.

4.10 p.m.

And that is important because there are some people in the system who, I believe, do not fully appreciate that. If you are working in the health sector and you are not able to say, okay, this is my job today, and this is how a patient would benefit, then you really need to re-examine what you are doing, and why you are doing it.

The RHAs, in my opinion, are not being really held accountable for the vast amount of money that they are being given to spend. The only reporting that takes place right now is an annual public accountability session. This just really is a public relations exercise that they do boasting about maybe some new services that they have introduced. [*Desk thumping*] There is really no critical analysis of their function, even when they lay reports in the Parliament; it is just a financial statement with absolutely no relation to the service that they are supposed to have been providing.

This is also reflected in the budgeting exercise because part of the funding that was provided with the IADB loan was to improve the quality systems in the delivery of health care, it was to improve the performance of clinical audit, it was supposed to improve our record keeping. So that each RHA should be able to say, "I have been given $100 million this year"—what has been provided with it; how many operations have been provided; how many diabetics have been treated; how many amputations have been saved.

Also, the RHAs were supposed to address a problem of prevention and screening in the primary care setting. Now, the acting Minister of Health said that they have built some new health centres and they have extended the hours for people coming to the primary facility if they need acute care. But sadly lacking are efforts in screening, for example, screening in the various cancers. We have heard about the national oncology centre that has been a stalled project for a number of years, a lot of money spent, but that oncology centre was supposed to go hand in hand with the development of a national screening programme for cancer on the whole in the country. That screening programme, for example, making sure that all women over 21 who are sexually active have pap smears, all the men over 45 have their prostate checks.

Right now we know that diabetes, obesity and hypertension are big problems. All persons in the public are supposed to be having regular height, weight, blood pressure checks, blood sugar checks, cholesterol level done. These types of screening activities, I believe, are where the emphasis should be right now.

I am not aware if the passage of this Bill will assist this screening activity unless if you want to purchase point-of-care testing in bulk to facilitate health centres; nurses and doctors do point-of-care testing, that may be a way in which this Bill can facilitate that.

I would certainly like to see a greater emphasis on primary care in screening and prevention activities. I know the Minister of Health has launched an attack on obesity by encouraging exercise and also launched efforts to change persons' eating habits, but this must also be combined with the population being activity

checked and screened to ensure that—"okay yuh exercising and yuh eating better"; but has this translated into a reduction in weight? Has it translated into better control of blood pressure? Has it translated into better control of the diabetes? This is where I believe the emphasis should be.

Now, specifically coming to the amendment, the Bill seeks to amend section 20 of the RHA Act. The Bill is said to be a procurement Bill. I will leave the aspects of procurement to my other colleagues who are more versed in that area but it deals with contracting for goods and services and is intended to allow one RHA to act for another RHA, or all the other RHAs in the procurement of goods and services so that bulk goods and services can be obtained at a cheaper cost.

Now if the other problems that I have mentioned, HR problems and other problems, are not addressed, I am not certain that the passage of this Bill will have the true effect that it could have if we had the RHAs functioning properly. In a system where the RHAs are properly functioning, this Bill would be very useful, but I think, Minister, you can use your influence to encourage a proper review of the functioning of the RHAs.

We have already heard there is a system in place for bulk purchases of medication and some non-pharmaceutical items that have achieved cost savings for economies of scale. And this is Nipdec procuring some drugs and other supplies by the RHAs.

Nipdec, however, has suffered from two things: one, sometimes they do not get enough funding to purchase all the needs of all the RHAs, hence, if they only purchase 50per cent of the needs, the RHAs are going to complain that they do not have enough supplies.

The other problem Nipdec has is actually with the suppliers of drugs. So even though a company may be awarded a contract to purchase one million doses of insulin, sometimes those companies do not deliver as promised and that can result in some shortages.

Now, I do not know if as an alternative to the passage of this Bill the Government had considered a system similar to that as Nipdec in procurement of some of the other items. I do not know but, at least Nipdec does have its use in purchasing some items.

With respect to the examples that the Minister had made, for example, CT scan or MRI machines—and you did mention that some of the hospitals, for example, the new hospital in Tobago, the Scarborough Hospital, has a Siemens 16-slice CT

scanner; I believe Port of Spain General Hospital has a GE 64-slice scanner, and Eric Williams Medical Sciences Complex has a 16-slice scanner. The reason I am going into that detail is that not every CT scan machine is alike.

Hon. Senator: What is the difference?

Sen. Dr. V. Wheeler: The difference is in the ability to—one slice will only give you limited view of the internal organs, whereas a 64-slice—the higher the slice, the greater the accuracy; of course, the higher the slice the greater the cost of the machine.

Sen. Baptiste-McKnight: So then, buy five 64-slice one time?

Sen. Dr. V. Wheeler: [*Laughter*] The reason I mentioned that is that the Scarborough Hospital is a general hospital. A place like—

Sen. Baptiste-McKnight: Is that not what this is about?

Sen. Dr. V. Wheeler:—Eric Williams Medical Sciences Complex is a tertiary level institution where you have cardio care, orthopaedics, neurosurgery, all those types of surgery. So a CT scan for Scarborough—you do not need a 64-slice where you do not plan to do cardiac surgery, you do not plan to do neurosurgery.

Some place like Sangre Grande which is similar to Tobago, you do not need a very complex and advanced scanner. So for this to make sense it is only if the items being purchased are exactly the same in all the regions. Also—

Hon. Dr. Gopeesingh: Orthopaedic equipment.

Sen. Dr. V. Wheeler:—it is useful, orthopaedic equipment, certainly in gynaecological surgery, but CT scan machines and MRIs, I do not know that that would be the best use of this Bill because with the Scarborough Hospital just having a new CT scan machine, we are not likely to need one for a number of years. I hope it would not be a case of what happened when equipment was purchased under the IADB loan where there were several mammogram machines purchased about 15 years ago.

One of them was to go into Tobago, but at the time Tobago was not capable of doing it so it was held in storage. I hope you do not go down the road of: you need to purchase an MRI machine and you buy five. You may not need it at this time but we still buy it, put it aside, and wait until you need it. [*Crosstalk*]

Sen. Baptiste-McKnight: It would be cheaper now than five years down.

Sen. Dr. V. Wheeler: But I am hoping that that does not happen now because it can. It did and I hope it does not.

Hon. Dr. Gopeesingh: It must not.

Sen. Dr. V. Wheeler: The reason I am raising it is that you take safeguards that it does not happen because one of these machines bought and put down, when you are ready to use it in five years' time it is likely to be outdated, it is likely to be not functioning.

The current CT machine in Tobago, even though it is new and well advanced, is still not functioning up to mark.

Sen. Baptiste-McKnight: They are using that on people?

Sen. Dr. V. Wheeler: No. There are certain types of scans it can perform, but it does not have all the various parts to perform all the scans it was purchased to perform. Remember the hospital was only opened last month, but that CT scan machine was acquired a couple years ago. You will have these issues if there is intention to bulk purchase items—An RHA may not need it at the time, you do not have proper storage for the item and when the RHA is ready to use it you have problems with it. So this is something I raise, and I hope that steps will be taken to prevent it. The other thing that it would require is that all the RHAs, the clinics using whatever tools you bulk purchase would need to have the same clinical protocols operating in the same way. In the past, this has been very difficult to achieve in Trinidad and Tobago. All doctors behave as if they—some, myself excluded—know it all and some have resisted the introduction of standardized clinical protocols of health care.

For us to improve the delivery of health care in this country, you need to have standardized procedures by which you operate so that you can be measured on what you are doing, you can be compared from one region to the other and it is only by doing that that you can truly improve the care that you deliver. We will then, by having standardized ways of operating, be able to compare ourselves with the places abroad in which that is a norm, we would then be able to improve the quality of the care.

So if the effect of this Bill is to force regions to have their care and services standardized then that would be a good thing. That would be a requirement for this Bill to really make sense and to be truly beneficial.

Madam Vice-President, one other area I would like to touch on, as was mentioned by the Minister of Health, is the issue of the five star specialist medical centres. At the Cabinet briefing on March 8, 2012: the Minister of Health said that:

> "There are plans for public and private medical partnerships to build five-star specialized medical centres in Trinidad and Tobago. The land will be provided by the Government and the private investors will bid for the design, financing and construction of these centres of excellence.
>
> Government will pay for health care services at these centres at agreed to reduced rates, and these rates can be negotiated for 20-to 30-year periods."

Now I am just wondering if these five-star specialist medical centres would be providing the same care that the Regional Health Authorities provide. And if they are providing—now I know the aim t is to invite foreign partners, you will have universities coming, you will go into medical tourism and so on. If this is to be financed by reduced rates, is it the Ministry of Health that will be directly paying for these centres or are these centres going to be accessed by the regional health authorities, and then the regional health authorities will pay for them because this is going to be an additional cost?

4.25 p.m.

Again, I have already mentioned that there has been a slow but steady privatization of the health sector. So, I am actually a little concerned about what this means, having persons coming in. We have probably had a tripling or quadrupling of the private institutions in Trinidad already, and this is going to introduce five new medical centres. I am not certain if this is to facilitate the provision of care to the public; I am not certain if this increased, additional expense will bring value for money, if it means the money being channeled out into these institutions will be taken from the Regional Health Authorities budgets, because we know already there is a challenge in getting staff.

If you have five new private facilities, you are going to find the young doctors, when they graduate from medical school, they might look to seek employment in these institutions rather than the public institutions. You might find experienced specialists, who are needed in the current public institutions to train the younger doctors looking to leave to go private, and already there have been accusations and consequences to unqualified doctors performing surgeries on patients in the public sector, and efforts are being taken to correct that. I just have a little concern with the direction that we are going, because, to me, it seems to be really privatizing the care.

Finally, I would just like to make some comments with respect to the Tobago Regional Health Authority. Section 5(2) of the Regional Health Authorities Act states that in the exercise of its powers and functions, the board of the Tobago

Regional Health Authority is subject to the provisions of the THA Act. Now, when I looked at the Tobago House of Assembly Act it does not mention the TRHA at all. This is something I have mentioned before when there was an earlier debate. The only place where the THA Act mentions health is in the Fifth Schedule, No. 23, where it states the THA is responsible for health services. Yet, under the responsibility of Ministers, the TRHA is placed under the Ministry for Tobago Development and this, obviously, was a big problem last year—

Madam Vice-President: Hon. Senators, the speaking time of the hon. Senator has expired.

Motion made: That the hon. Senator's speaking time be extended by 15 minutes. [*Sen. S. Ramkhelawan*]

Question put and agreed to.

Sen. Dr. V. Wheeler: Thank you, Madam Vice-President. I am surprised I went beyond 45 minutes. In practice in Tobago, it is really the Ministry of Health and not the Ministry of Tobago Development that really supports the TRHA. The Minister of Tobago Development does assist Tobagonians whenever she can when it comes to certain health care needs, but this pales in comparison to the assistance and service that the Ministry of Health actually provides.

In fact, I commended the Minister of Health for his enthusiasm to have the hospital open to some level of service. Right now, even at the Medical Imaging Department, the Ministry has provided a senior radiographer to assist the X-ray Department in being operational. I hope this type of arrangement would continue. I am not aware that it is at any cost to the TRHA.

Also, when patients at the Scarborough Regional Hospital are in need of specialist care in Trinidad, this care is provided at Port of Spain General Hospital, Eric Williams Medical Sciences Complex and sometimes at the San Fernando General Hospital free of cost to the TRHA, and I think this needs to be pointed out, because in its current state and in the near future, the THA is just not able to be truly responsible for health care at this point in time, because it just does not have the capacity to satisfy all the needs of the people of Tobago in respect of health care services. So whatever discussions are taking place with respect to constitutional changes, I hope that this will be borne in mind.

Madam Vice-President: Hon. Senators, it is now 4.30 p.m. and we will take the tea break and resume at 5.00 p.m. This sitting is now suspended until 5.00 p.m.

4.30 p.m.: *Sitting suspended.*

5.00 p.m.: *Sitting resumed.*

Madam Vice-President: Hon. Senators, before we took the tea break, Sen. Dr. Victor Wheeler was on his legs. By my count, Dr. Wheeler, you have 12 minutes remaining. [*Desk thumping*]

Sen. Dr. V. Wheeler: Thank you, Madam Vice-President. As I was in the process of wrapping up, this amendment to the RHA Act that is being proposed by itself is well intended, but without addressing some of the serious problems affecting the RHAs at present, it is unlikely to have the desired effect of truly improving the cost efficiency of health care.

I strongly suggest that it is time to seriously review the Regional Health Authorities since their creation, to determine if they have really achieved what they were intended to achieve, which is, value for money. We know that there have been significant increases in administrative costs. We also know that they have, certainly, acquired some equipment and have done some renovations to health centres and have built new hospitals, but what we truly need to find out is, has all of this translated into better care for the patients who go to the various public institutions for care?

Value for money should be our watchword. We should be performing clinical audits. We should be focusing on outputs rather than just focusing when we are budgeting on new services that we want to introduce. When new equipment is being acquired, we need to know how is this new equipment or how is this new building or how is this new hospital going to translate into improved care for the patients who come.

If all of us in the health sector and the Government who certainly seem to want to address some of the health issues—every decision we make we should be able to say, how does this action that we have taken translate to improve care for the patients. I think if we have that as our focus, we should make a dent in it.

Right now, the RHA system needs serious review and I would have preferred if the amendment would have been after proper analysis of what is going on now and what happened at the beginning, so that when we truly assess the RHAs, we will have some hard figures by which we would be able to make a judgment.

Madam Vice-President, I thank you. [*Desk thumping*]

Sen. David Abdulah: Thank you very much, Madam Vice-President, for allowing me to participate in the debate on this Bill to amend the Regional Health Authorities Act, Chap. 29:05, which, as the hon. Minister of Education, Dr. Tim Gopeesingh, described so clearly, has a very specific purpose which is to enable better management of resources by the RHAs by way of enabling one or more of the RHAs to collaborate where it may be economically expedient to procure various goods and services for the benefit of a better health care delivery service. I want to congratulate Sen. Dr. Victor Wheeler for a very, very, thoughtful and thought-provoking contribution [*Desk thumping*] as he took us through not only some of the history of the development of the RHA and some of the twists and turns and experiences of these various creatures of legislation and new institutions that arose therefrom, but also gave many experiences of problems, and described issues and challenges pertaining to the delivery of good health care in Trinidad and Tobago.

For those who would have listened to his contribution outside of this hon. Chamber, I am sure they would have been tremendously edified by his contribution. It was good that he went first up, and he did very well, indeed, for all of us. [*Desk thumping*] I contrast that to Sen. Faris Al-Rawi who reminded me of the advocate who had a very weak case and substituted thoughtful, careful and reasoned argument for a lot of bravado and other forms of dramatics. [*Desk thumping*]

Sen. Al-Rawi: Nice try.

Sen. D. Abdulah: Nice try? Well, yes, it obviously struck home. So, sometimes the bravado and the theatrics substitute for when the cases are weak and, therefore, difficult to argue.

Madam Vice-President, I think that both the hon. Minister in piloting this Bill, as well as Dr. Wheeler, described very well the torturous experience of the RHAs brought about by legislation in 1994 by the then PNM Government, and as it has been said, it was intended—as was the public argument in favour of it—to bring about decentralized health care. But, rather than decentralizing health care, we created new bureaucracies.

So instead of one bureaucracy which was no doubt fraught with problems, maybe in the Ministry of Health in the delivery of health care, we then had five bureaucracies together with the Ministry of Health which remained as a bureaucracy, and the conflicts that continued as had been described and so on, which continued between the central bureaucracy of the Ministry of Health and

the various RHAs, compounded the delivery of health care services. Sen. Dr. Wheeler was making the point that the administrative costs of the RHAs were not insubstantial and, therefore, money voted for the delivery of health care may very well have gone into the support of bureaucracies of administrations which, as we all know with bureaucracies, could be very self-serving and very self-seeking and may lose complete sight of the real object for which they were created, which is to provide quality service to citizens.

Madam Vice-President, I am reminded that the policies of Mr. Manning's governments—he presided over as Prime Minister at various times—had one core objective, which was really to undermine the public service of Trinidad and Tobago. And so, I think, we need to remind ourselves that when we speak of the public service, it really is an excellent phrase to describe what ought to be taking place, namely that through the public service, the Government by way of policy measures and so on—and the public service implementing those policy measures—are able to provide quality service whether it is in health care, education or the range of public services that are required in the country.

The RHAs, therefore, by creating these institutions for the delivery of health care sought to obviate the public service, and I want to come back to that in terms of some of the observations made by Sen. Dr. Wheeler with respect to privatization and so on, which has emerged over time since the creation of the RHAs.

5.10 p.m.

The point was made as well about various human resource and industrial relations issues. I remember those matters quite clearly, because although the Public Services Association was clearly in the forefront of articulating the issue, with respect to the problems that their members would have had in a transition from the public service to the RHAs and the loss of recognized majority union status that would have accrued to the PSA—which I will come back to in a moment—other trade unions were also very active in mobilization on this question of the RHA. We raised philosophical issues about some of those same points I made, not about the decentralization of health care delivery, but rather the creation of new bureaucracies and so on, the issue of privatization and who was driving the agenda, because as we mentioned, it was funded by the IADB.

At that time the IADB was very aggressive, together with other institutions in the early 1990s, with what was known as the second generation reform process; the first generation coming about in the 1970s and 1980s, with respect to orthodox

structural adjustment, and the second generation having to do with further reform of the State and Government and the ways in which that should take place, whether it be with respect to pension reform or health care reform or education reform. Therefore, questions were also raised at that time about what was driving the process, and what was the thinking behind it.

A number of us were very, very involved. I recall as well engaging discussions. There were discussions in the medical profession. There were many, many debates and discussions in the medical profession publicly about this issue and about how best to address the issue of health care in the country, the same issues of primary health care versus the very high cost of tertiary health care in the hospital system, the issue of the Mount Hope Hospital or the Eric Williams Medical Sciences Complex. I remember discussions by the medical profession about that huge complex which in the early 1990s was virtually unutilized in terms of capacity. There were very intense and important debates and discussions that were taking place. I am sure that the current Minister of Education would have recalled some of those discussions that I myself would have taken part in on behalf of my own trade union.

One of the specific issues that the PSA raised in terms of human resource was that in the original Act it was explicitly provided that the union which represented the hourly and daily paid workers would in fact continue. I am referring to Part VII of the original Act, section 34(a)(3), which says:

> Subject to the Industrial Relations Act the majority trade union which immediately prior to January 1st 2000 represented the daily rated workers who were employed in health care facilities and in respect of whom the Chief Personnel Officer was deemed to be the employer under the Industrial Relations Act shall continue to represent such workers.

So the National Union of Government and Federated Workers, which would have been the union representing the daily paid workers in the health care sector and whose employer was the CPO, continued to represent those daily paid workers under the RHAs.

But that same provision was not extended to the Public Services Association which represented monthly paid workers, including at that time doctors, nurses and other monthly paid workers, clerical workers and so on. That clearly was unfair and unjust. The law ought not to have made provision for one group and to exclude another group within the same employment and in the same sector. That was one of the problems that never got fully resolved. The very long transition

that was mentioned in terms of workers leaving the Ministry of Health and eventually going to the RHA, which took more than 10 years, created many challenges and problems for the human resource management within the health care sector.

Quite apart from that, of course, there was also subsequently the fact that a number of medical doctors in some of the RHAs then sought to have their own union, the Medical Practitioners Association of Trinidad and Tobago (MPATT), represent them, and there were issues with respect to recognition. I believe they are recognized by just one RHA at this point and maybe a second one to come.

So the process of reform introduced in 1994 with the RHA Act and the creation of the Regional Health Authorities was a process of reform that had not been, prior to the legislation coming on the books, properly worked out and planned. Had it been carefully thought through, carefully worked out and planned, then many of the issues and problems which we are still experiencing today would not have happened. As a result of the absence of proper planning, proper organization and proper thought going into the RHA system, the people who suffered were really those who needed health care in our public institutions: the ordinary people and the poor who would not have been able to afford private medical care. It is really regrettable that so many people have suffered as a result of policy decisions that were not well thought out and well planned and well executed.

I want to say, Madam Vice-President, that with respect to the issue of this particular amendment to the RHA Act, and with respect to procurement, that one of the issues of creating institutions outside of the public service—and it is an issue that has been ventilated in the public domain by many over the years—institutions that are parallel to or to replace the public service, which public service would have been governed by the procurement processes under the Central Tenders Board, that you then enable public procurement to be outside of a legally regulated environment. And certainly we have had many examples of runaway horses in that regard.

It is interesting that the RHA Act, as has been referred to by Sen. Al-Rawi and others, in section 22 it explicitly states:

For the purpose of this section, the provisions of the Central Tenders Board Act shall not apply.

That was explicitly stated. Fortunately, to buffer that or to balance that, there were the regulations that formed part of the legislation, and those regulations did set out very clear processes by which procurement should take place by an RHA. So there was regulation of the RHAs, in that regard.

But the very notion of establishing these institutions to supposedly expedite matters in a way that would obviate the Central Tenders Board, has been a cause of concern in this country for quite some time. It emerged more particularly as has been stated in the Uff Commission of Enquiry, which is precisely why this Government made a commitment to deal with procurement legislation and to bring proper procurement legislation to the law books of Trinidad and Tobago, to ensure that we do have a system of procurement which covers and makes sure that all public money in this country is not only accounted for in a transparent way, but that it is spent in a way where there is, not only value for money, but also in a way that is free from the kinds of allegations of corruption that certainly circled around institutions such as UDeCott sometime ago.

That is why, listening to Sen. Al-Rawi this afternoon—and yes I know what the rejoinder would be, that we are now in Government so we are supposed to deal with it. But one cannot help but think—well, I certainly cannot help but think—as we just came out of the Easter season—of some of those movies that have been reruns on television every year for the last 40 years. Those who are a little older might remember going further back than I can of the *Passion of the Christ* and things like that. One gets reminded of Pontius Pilate.

Sometimes when I hear those on the other side speak, it almost reminds me of Pontius Pilate—they pretend that they could wash their hands somehow clean of all sin. I really think we need to move beyond that and say that we all have a responsibility for what takes place in this country. People have a responsibility, whether it was when they were not specifically in office, but the party of which they were a part had a responsibility, and they must take responsibility for the sins of the past. You cannot come here like Pontius Pilate and simply wash your hands and pretend the past did not exist.

In that regard, yes, the issue of a legislative framework for public procurement is very much taking place, and there is a Joint Select Committee. Given the fact that it is sitting, I am not going to run afoul of your ruling, Madam Vice-President, with respect to speaking about matters of a Joint Select Committee. But let me say that the Government's position with respect to policy was enunciated in the debate in the first and second reports of the Joint Select Committee in the previous session.

In those debates we made it clear that we were seeking to arrive at a consensus position with respect to this legislation, that Government could take one approach to bringing a policy and then have the Opposition oppose it, and we go backwards and forwards. But as something as fundamental as public

procurement, which deals with public money, it therefore is in the interest of every single citizen—regardless of party, race, religion, where they were born, gender, age—who ought to be concerned about the issue of public procurement. Therefore the ideal approach to it really was to have a national approach, one that crossed the lines or the floor of this Senate, so to speak, and sought to involve everyone, so that all ideas could have been put on the table in order that the best possible legislation could have emerged.

So it is a little difficult sometimes to hear Members opposite suggesting that there was a dragging of the feet with respect to bringing this particular legislation to the Senate, when they were part of the process of developing that legislation from scratch, from the ground floor, and also were part of the reason it has taken an extra seven months, because they withdrew from the process earlier this year, and therefore abdicated their responsibility in that regard. I wanted to make that point, because it is important that not just Members of this Senate, but citizens generally be aware of where the Government stands on the issue of public procurement, and the approach that we have taken in order to ensure that we have the best legislation possible coming to the Senate.

One does take the point that Sen. Dr. Wheeler made, that the amendment being proposed to the RHA Act is good, but would have been ideal or better, in terms of its efficacy, had it come in the context of a review and reform of the RHAs themselves. In other words, that you can improve the tools by which an institution can function, but if the institution itself is not capable of making use of those tools, then the outcome is not going to be any better than it is now. I think that point is well taken. I am sure as part of the overall review of health care delivery in the country, the Minister of Health would take careful note of what Sen. Dr. Wheeler said in that regard.

In terms of legislation, Madam Vice-President, I think we also have to take the point that while one can legislate for improvements in systems, whether it be holistic, public procurement legislation or whether it be specific amendments as we are doing here with this particular Bill, to enable more efficient procurement by the RHAs, one cannot legislate—I know Sen. Beckles-Robinson has made this point as well—necessarily for the behaviour of individuals. That is an important point.

So I too want to join with Sen. Dr. Wheeler in saying that I hope there are not some persons who are looking to stand just inside the six-yard box, waiting for the ball to be crossed into the area to score a goal on their own behalf, in their own self-interest. In other words, waiting for a system like this to be established

in order to then outsource their services to the RHAs, and therefore to make money out of it. I certainly hope that is not going to be the unintended outcome of a piece of legislation like this.

5.25 p.m.

It raises therefore the issue of one of the elements of—what I believe, and this is my own personal view—the problems of the health care sector. Yes, $3.5 billion is a significant amount of money to spend on health care, and I suppose if we add to that, by the Government, coming out the Government's budget, the amount spent by private individuals through health insurance plans, and private visits to hospitals and doctors and so on, that the total amount expended on health care in the country may approximate, I am not sure, just over $5 billion as the case may be, which is still less than what I think the international or recognized norm for expenditure as a percentage of the GDP ought to be, if you are to get your health care system up to standard, which is probably about 8 or 9 per cent of GDP, and right now we are probably about 4 to 5 per cent of GDP expenditure on health care.

So, we do have to increase the absolute amount spent on health care as a percentage of GDP, but quite apart from that, there is also the need to ensure that that which is spent, is spent in a way that delivers health care. One grew up listening to stories about famous members of the medical profession in years gone by and so on, who really worked very, very long hours, and I am not casting aspersions on any current members of the health profession, but let me just say that you heard these stories of persons working very, very long hours for, in many cases, little or nothing. They would treat patients who were poor, and did not have money, and not charge, and maybe the patient in the rural areas would bring some fruit or some produce from the land to pay, but there was no cash being paid because doctors, nurses and others would have seen what they did as a privilege, first of all, to have obtained the education to do medicine as the case may be, and then secondly, they saw their role really as providing service.

In this globalized world these days, Madam Vice-President, the culture of many of our younger people is not about service, it really is about the acquisition of material benefits for themselves, and therefore, a profession is not seen sometimes by some of them as something noble, but rather a means to an end, a means to their own personal end. That could perhaps explain why we have this duality in our system of the private and the public, and persons working in both. I heard Sen. Dr. Wheeler speak about that a moment ago, and we have heard those stories about some persons who are less than ethical in terms of referring patients in the public sector to their private institutions.

So, we also have to address I think the whole debate about—and this is not necessarily a debate on health care—but, in the national debate on health care and on the issue of how do we have the best possible system of delivering quality health care, I certainly think that it also has to do with the values that are inculcated by our professionals, and for them to see their role as contributing, in a significant way, to national development, and to the well-being of others.

If we walk through various parts of Trinidad and Tobago, Madam Vice-President, and I have had the very good fortune of walking in different parts of this country, there is not one Trinidad and Tobago, there are different Trinidad and Tobagos, and there are parts of this country where the condition of life of thousands of our citizens is something that we ought to feel collectively very sad, sorry and ashamed about, given the significant wealth that the country has benefited from over the years, and our relatively small population. There is no need for so many of our people to be living in conditions of terrible poverty, and therefore, also experiencing problems when they have to go to hospitals and to the health centres, and are unable, for the lack of the investment in those resources, to have a bed in the hospital as the case may be.

I know that the Minister of Health is working in San Fernando, for example, to transform that monstrosity on Chancery Lane that was built as a multistorey skyscraper in San Fernando, totally out of character with the skyline of San Fernando. I am sure Sen. Al-Rawi would agree, having been a San Fernando person himself, that the Chancery Lane Complex is really a sore thumb in the context of the architecture and culture of San Fernando. But the Government now is seeking to make use of that to be part of the San Fernando Hospital, to create the space to provide more beds so that patients who require hospitalization can at least be hospitalized in decency and with a modicum of comfort that is required of any civilized society, and we certainly hope that takes place very, very soon.

It is that issue of priorities that we have to get right, in terms of the allocation of resources, and how we procure goods and services. Those who are responsible in the bureaucracies of these RHAs, as they have this particular tool that would be provided by this amendment, have to recognize that they are custodians of public money, and therefore, need to engage in procurement on the basis of priorities that have at their root the best possible care and treatment of citizens of Trinidad and Tobago who access and need the public health care system of this country.

I just wanted to make two more points, Madam Vice-President, because you know the particular amendment is just a one-subsection amendment, and therefore, does not in my view require an extensive contribution on it. I wanted to make two more

points: one is that, the hon. Minister of Education in presenting the Motion, made the point that the Point Fortin Hospital is going to be built. That is a very important statement, Minister, because the people in the deep south of the country have been in extreme pain for lack of a proper hospital in Point Fortin. There was a famous statement, made by a former Prime Minister, that Trinidad ends at Point Fortin, and therefore, Cedros and Icacos were not counted. But someone who lives in Cedros and Icacos and who has to access tertiary medical treatment, and has to get to San Fernando, takes several hours to get to San Fernando, and that is a very difficult proposition indeed.

Therefore, one certainly looks forward, and I was down in Point Fortin just last week and that was the cry of the people in Point Fortin, that they need that hospital very urgently, and all the years—I do not know how many years of budget speeches by the last Government, when listed under capital expenditure, Point Fortin Hospital, and in the next year—[*Interruption*]

Dr. Gopeesingh: 2001.

Sen. D. Abdulah:—from 2001, thank you, Minister. I am sure if you go before that to the 1990s, you would have probably seen it then. So that Point Fortin Hospital is something that really has to be delivered for that community of the south-west peninsula. It is very, very important to the well-being of a community which has produced a tremendous amount of the wealth of this country in terms of the oil industry, and one does not want to see that item linger any longer.

In closing, there were issues about patients' rights and all kind of matters related to that, and I was going to go back in time but perhaps I thought that I would go back as far as the BWIA issue many years ago in the 1970s when a patient's record was read in the Parliament.

Dr. Gopeesingh: Hernandez.

Sen. D. Abdulah: A BWIA captain's record was read out in the Parliament, totally violating the patient's rights, but the younger Members of the Senate may not recall that particular issue, I certainly do.

Sen. Deyalsingh: We are not going to be political today. [*Crosstalk*]

Sen. D. Abdulah: I did not say who read it, so that is why I am not being political; I did not say who read it. I just wanted to close by saying, Madam Vice-President, we have to, I think, recognize—[*Interruption*] [*Crosstalk*]

Sen. Karim: Do not be distracted.

Sen. Deyalsingh: Do not provoke me today.

Sen. D. Abdulah: Provoke "yuh"? [*Crosstalk*] Well, one hopes that those who are provoked will respond with thoughtful reason and rational arguments [*Laughter*] [*Desk thumping*] and not with a lot of emotional rhetoric, noise, sound and fury, signifying nothing, but that is when persons try to distract me, they suffer the consequences of that.

I want to close by saying that systematic reform is certainly necessary, both at the micro-level, when it reaches the institutions in terms of procurement of the RHAs, whether it is in terms of overarching public procurement legislation, systematic reform is absolutely necessary. We also need to address the issue of institutional structures and how those structures work, and reforming of some of those structures is also very, very important. But, in addition to that, and I always think that this is important, we also have to address the culture of institutions, and the culture of how we do things, and therefore, when you have a system as Sen. Dr. Wheeler mentioned, where you have 15, I think, CEOs in the space of 10 or 12 years or something like that of an RHA, you cannot go forward. There is no way, regardless of who that CEO is or is not or how qualified they may be, the institution will not move forward if every nine months you are changing a board or CEO; that cannot work in a small society such as ours with very limited capacity in terms of managing the health care system. We also have to address the issue of culture change.

So even as I rise to support this particular amendment, I do also want to say that the amendment by itself will not necessarily give us the best outcome, unless those who are charged with the responsibility of managing the affairs of these institutions do so with the culture of service to their fellow citizens. Thank you very much.

Madam Vice-President: Before Sen. Deyalsingh begins his contribution, under Standing 32(6), leave was granted to Sen. Deyalsingh to refer extensively to his notes. [*Desk thumping*] [*Laughter*] [*Crosstalk*]

Sen. Terrence Deyalsingh: Thank you, Madam Vice-President, for allowing me to contribute on this Bill, "An Act to amend the Regional Health Authorities Act, Chap 29:05".

Sen. Al-Rawi, as young as he is, [*Laughter*] he is my junior chronologically, I am older than him but I consider him—[*Interruption*]

Sen. George: Not by much.

Sen. T. Deyalsingh: —a mentor of sorts, and having been sitting next to him for the past year and a half, I have learnt a lot from him. I take from him his passion for his profession, which is that of law, and although the Government Ministers and sometimes I myself, am taken aback by his contributions during the committee stage. His driving force is always that of the law, and passing the best possible law. In that regard he defends his position.

5.40 p.m.

I intend to follow a similar path by learning from him and as a clinical pharmacist myself, in making a contribution to a Bill which deals with health, to also contribute in a manner which will elevate the profession and not bring the health services into disrepute, so I intend to stick to my word. However, when we are discussing matters of health—in any case, two wrongs do not make a right—and Sen. Abdulah referred to an incident which happened in the Parliament, I think, back in the 1970s, and my reminder to him, is that your Government has repeated the same error in 2012. So where is the learning, when one of their colleagues could pick up the medical file of someone in 2012 and say, I have the file in front of me and I agree with the diagnosis of a particular individual? How is that different in 2012 to what the hon. Minister just referred to? And I am referring specifically to the Minister of Health of this Government. [*Desk thumping*] I need not call the name of that person so affected because it is before the courts, but he is in the newspaper, saying, he has the person's medical file in front of him and he agrees with the diagnosis. I say no more.

Madam Vice-President, in one of my earliest contributions to this Parliament in the Red House building when the former Minister of Health, then Sen. Therese Baptiste-Cornelis, was the Minister of Health, I rose to, not defend her on one occasion, but to explain to the national community, because she was being faced with a very serious situation at the San Fernando General Hospital, if colleagues would remember—no need to go into the details, the details are irrelevant—and I made the point to the then Minister of Health and I said, "Minister—she sat directly opposite me in those days—you have one of the most thankless jobs in the world". Any Minister of Health or secretary of health is going to be a whipping boy, because human nature is such—

Hon. Senator: Or girl.

Sen. T. Deyalsingh: Or girl—that in the deliverance of health services we always focus on the cases that go wrong or where you do not have the desirable outcome, but we never focus on the millions and thousands of millions of medical miracles

that take place every day in hospitals around the world. It is a thankless job! It is a thankless job, and I feel sorry for any Minister of Health of any government in any country in any part of the world.

The only time those miracles get exposure is when somebody pens a letter to the Editor and it is printed in the editorial pages. But let one thing go wrong, it is front page news. Editorial ink is spilt by the gallons, very often portraying the events wrongly—as a case in point, in in a recent case of murder or homicide, where certain claims were made, splashed in the media, only to be determined differently. So, I make my defence of health services, that, even though things will go wrong, and they will go wrong—we are going to die, children will die, we are human beings—doctors are human beings; nurses are human beings; but it is not to say that we cannot prosecute cases of gross incompetence and malpractice. We must and we should!

So, Madam Vice-President, I just wanted to open with that statement. The hon. Minister of Education, in piloting this Bill, spoke about diabetes and so on, and Madam Vice-President, I have in my possession a document, "The Diabetes Epidemic in Trinidad and Tobago", August 03, 2010, "Attacking a burdensome disease with conventional weapons", by Dr. Kenwyn Nicholls, and I had sought your leave to read extensively—[*Interruption*]—yes, but it is about Trinidad and Tobago. The reason I spend a lot of time on diabetes today is that as the hon. Minister said, "The Ministry of Health or health services is like a bucket without a bottom", you can pour as much money as you want into health services, it will always be absorbed in something, and unless Trinidad and Tobago and countries around the world get serious about primary health care we will continue to pour money into that bucket with no bottom.

Dr. Gopeesingh: Agreed.

Sen. T. Deyalsingh: I read, Madam Vice-President, page 17 of that report:

> "According to IDF's Diabetes Atlas. Third Edition…there are 102,100 persons in T&T with prediabetes"—not full-blown diabetes—"this number is projected to go to 130,500 by the year 2025."

I go on—

> "The Economic Burden of Diabetes in Trinidad and Tobago:
>
> "The IDF Diabetes Atlas also cites health expenditure in Trinidad and Tobago for diabetes to be $US35.377 million in 2007."

That is a lot of money. I go on—

> "Economic Burden on the Family Pocketbook:
>
> Since in T&T out-of pocket spending outweighs all other forms of health expenditure…the burden on the individual family's pocketbook is likely to be crippling as the patient copes with expenses associated with doctors visits, hospitalization, meds, labs, and the like—direct costs."

Finally from that document, Madam Vice-President:

> "There is unanimous agreement that diabetes self-management is of critical importance…"

Madam Vice-President, a second document that I would like to quote from is taken from the Postgraduate Medical Journal, and it is time that Trinidad and Tobago with its particular demographic profiles. We wake up to the triad of diseases which a Ministry of Health is going to spend hundreds of millions of dollars on—occupied bed space, whether it is in San Fernando, Port of Spain or Mount Hope, and that triad of diseases is diabetes mellitus, dyslipidemia, high cholesterol levels and hypertension, and the fourth one—if you want to add a fourth, cancer.

Trinidadians over the years have been too flippant with their health. Much too flippant, and then the State has the burden of providing tertiary health services for them at astronomical cost—[*Interruption*]—when, if we take the steps to self-management of health at early stages we can prevent a lot of traumatic experiences, and I quote from an article written by Drs. Teelucksingh, Michael Ramdass, et all, called "The slipping slipper sign"—the SSS—"a marker of severe peripheral diabetic neuropathy and foot sepsis."

Diabetics in Trinidad and Tobago and the world over have to understand the signs of diabetes, and this slipping slipper syndrome is one—which is basically that some diabetics, because they lose sensation in their legs due to neuropathy, their nerves do not pick up the sensations. They do not realize that when they are walking their slippers fall off, and you say, "Pa, whey your slippers?" And he looks back and there it is 10 feet behind him. The slipper has fallen off the person's foot, and because he has diabetic neuropathy he does not realize it. If you have diabetic neuropathy and you go outside to garden, plant your little whatever, and you get a cut on your foot, gangrene starts. You do not feel the pain. That is why we advise diabetics to look at their feet every day, and if they cannot look at them, have someone look every day. It says here:

> "The study included 105 diabetic outpatients without active foot problems, 40 diabetic inpatients with active foot sepsis, and 69 other patients with neither diabetes nor active foot sepsis as negative controls.
>
> Results: No control subjects had a positive SSS"—that is slipping slipper sign—"in contrast, 64 of 145 diabetic patients had severe neuropathy of whom 53 had a positive SSS."

Therefore, 53 people had the slipping slipper sign, a marker for future amputations.

Madam Vice-President, building on the issue of amputations I go to another article, authors: Dr. Rahaman, Stewart et all—title: Lower limb amputations in Trinidad, analysis of 576 cases:

> "Major lower limb amputation remains one of the commonest operations done by the general surgeon and carries the highest mortality of all operations at the Port of Spain General Hospital."—carries the highest mortality, meaning you die—"While vascular insufficiency is the main indication for amputation in Great Brattain and the United States, we had a clinical impression that the diabetic septic foot was more important in our population."

Meaning Trinidad and Tobago. I go on:

> "Overwhelming sepsis and 'multiorgan failure' (54 per cent), ischaemic heart disease (76 per cent), cerebro-vascular accident"—stroke—"(11 per cent) and pulmonary embolism (9 per cent) were the major causes of death."

And this is a problem a Ministry of Health will face. It goes on:

> "The average hospital stay was 51 days."

You are a severe diabetic, you go in and you have sepsis, you stay there 51 days. You occupy a bed for 51 days; you multiply 51 by the cost of having you there and you get hundreds of thousands of dollars.

> "Diabetics (57 days) stayed longer than non-diabetics (35 days). The high amputation rate, mortality rate and prolonged hospitalization suggest that urgent measures be taken to improve the outcome for patients with ischaemic or septic feet. We recommend an extensive education programme in foot care..."

Hon. Minister, even though you are a Minister of Education, you are a medical practitioner, and I am glad that you are piloting this Motion today, and I will return to the issue of education later. Madam Vice-President, I think people

have the picture now, so I would not bother to go into the fourth and fifth documents that I would like to read from. However, I would like to alert citizens to some information which I got from the Helen Bhagwansingh Diabetes Educational Research and Prevention Institute. Helen Bhagwansingh as you know is one of our most successful business women—philanthropist, social worker, donated some serious money—so to say—I think, in 2009. I think this institute is about three years old. You are on the Board?—[*Inaudible*]—Great, so I got some information from the Helen Bhagwansingh Diabetes Education Research and Prevention Institute. It is nice to come to the Parliament for a change and quote statistics from a local organization, because often we quote statistics from the United States, Germany, England, but it is a pleasure, Madam Vice-President, to come to this Parliament today and quote some information and statistics from a local institution. So in speaking to one of the prime movers behind this institute, I got the following data: diabetes affects 20 per cent or one in five people between the ages of 15 and 64.

5.55 p.m.

Hypertension: one in four people. Dyslipidemia or high cholesterol, one in two, and the mortality rate for people so affected is about 50 per cent. Fifty per cent of all these people would die before their time and probably die horrible deaths because of the complications of diabetes, high cholesterol and hypertension. So I do not want to be flippant and say "the RHA" so I could link it back to the Bill. I think by now you get the gist of what I am trying to say, so I am not going to say, "Port of Spain General Hospital" or "San Fernando", but in case a Standing Order is raised I will.

Sen. George: I was just about to. [*Laughter*]

Sen. T. Deyalsingh: Yes, 35(1). The institute tells us that it is the leading cause of death; it is the leading cause of kidney failure; it is the leading cause of non-traumatic amputation and the leading cause of blindness in Trinidad and Tobago. This is what Ministries of Health and Ministers of Health over the years in Trinidad and Tobago have to grapple with. It is an unenviable task, it is a thankless job.

But what is the future for diabetes in Trinidad and Tobago, Madam Vice-President? I would tell you what. It is not nice. In this country—and the two eminent gynecologists, my learned colleagues, can probably bear me out here, the institute estimates that 10 per cent of pregnancies in Trinidad and Tobago—10 per cent of those women would develop gestational diabetes—diabetes because they

are childbearing. The chance of a woman having birth trauma is a twofold increase. The chances of that child having to go to an ICU—there is a threefold increase. There is a fourfold increase for caesarean sections if you have gestational diabetes and an eightfold increase of fetal abnormalities. Then who knows, the fold increase for the child of a woman with gestational diabetes becoming diabetic in early years. And what the institute also tells us, which is shocking, is that 30 per cent of our children are now obese. Trinidad and Tobago—[*Interruption*]

Hon. Dr. Gopeesingh: Most are overweight, about 50 per cent overweight and obese.

Sen. T. Deyalsingh: Good, overweight and obese. We in Trinidad and Tobago have to take stock of this scenario because there is going to be a cost to be paid 10—15 years from now, which the State might not be able to afford, Madam Vice-President.

Madam Vice-President, the cost associated by any Ministry of Health for both direct cost and indirect cost are humongous. The direct costs are easily quantifiable: medication, dialysis and transport. But what we never factor in or is difficult to factor in, is the indirect cost, and the trauma families have to go through to care for people who have strokes, heart disease, severe diabetes, amputations—the trauma, and blindness. What I discovered in speaking to officials from the Helen Bhagwansingh Institute is that all the statistics we are quoting, are only statistics gathered via the public health system. Apparently, we do not gather or there is no legislation to empower the Ministry or to compel private institutions and private doctors to report on incidences of diabetes and so on.

So therefore, what I am saying is that everything I have said so far is quite possibly a gross underestimation of the problem, because it does not trap what goes on in the private institutions, it does not trap what goes on at the private physicians' offices. So the problem we are faced with is like the iceberg, we see 10 per cent but the real problem is there. So maybe the time has come to make some of these conditions reportable, the same way we have it for dengue. I think, hon. Minister, if you have dengue and you go to a private physician, I think by law he has to report it so that we can trap the data. I believe so.

Hon. Dr. Gopeesingh: I am not sure.

Sen. T. Deyalsingh: I believe so, I believe so. But, Madam Vice-President, that is something I throw out for the country to look at so we can understand the

size of the problem and as the management experts would tell you if you cannot measure it, you cannot manage it.

What is more alarming about these diseases, and let me link it to the Bill—people who have to go to Mount Hope which falls under the North/Central Regional Health Authority; people who have to go to the new Scarborough Hospital which falls under the Tobago Regional Health Authority; people who have to go to the San Fernando General Hospital, so they have to go to the San Fernando Regional Health Authority—what is really sad about this epidemic that we face in Trinidad and Tobago is that it impacts more on the lower socio-economic groups in Trinidad and Tobago. Because the burden of these diseases, if you do the analysis, you would see people of the lower socio-economic groups have a higher incidence of diseases like uncontrolled diabetes because they either lack the education or the understanding or the money to pursue treatments. So these diseases trap poor families and pauperize them even more and then the State has to pick up the burden. It is a real, real problem.

So what are some of the solutions? The hon. Minister when he was piloting he said that the hon. Prime Minister took something to the United Nations, I believe.

Hon. Dr. Gopeesingh: [*Inaudible*]

Sen. T. Deyalsingh: Good. In 2007—and let us forget the politics, and I refer now, Madam Vice-President, to a document from the Caribbean Community Secretariat:

"DECLARATION OF PORT-OF-SPAIN:

UNITING TO STOP THE EPIDEMIC OF CHRONIC NCDs"

NCDs are non-communicable diseases.

> "We, the Heads of Government of the Caribbean Community (CARICOM), meeting at the Crowne Plaza Hotel, Port-of-Spain, Trinidad and Tobago on 15 September 2007 on the occasion of a special Regional Summit on Chronic Non-Communicable Diseases (NCDs)…" said, "so and so".

The point I am making, this type of initiative, CARICOM-wide, has been on the table since 2007.

> "Inspired by the successes of our joint and several efforts that resulted in the Caribbean being the first Region in the world to eradicate poliomyelitis and measles;"

So they are using the eradication of polio and measles as a model to tackle this epidemic of diabetes, hypertension and dyslipidemia.

> "Affirming the main recommendations of the Caribbean Commission on Health and Development which included strategies to prevent and control heart disease, stroke, diabetes, hypertension, obesity and cancer in the Region by addressing their causal risk factors of unhealthy diets, physical inactivity, tobacco use and alcohol abuse and strengthening our health services..."

So, Madam Vice-President, there is this initiative, but hon. Minister these types of initiatives, CARICOM-wide or the UN, I think you and I know that they have limited success unless there is the political will to implement it. I think, and I floated this idea with a couple of specialists in the field and they sort of see where I am going. I want to throw out to the national community via you, Madam Vice-President, that maybe the time has come in our 50th year of Independence, when we start to look at ourselves seriously, and take away, divorce this issue of the management of these non-communicable diseases from the political directorate and probably move the education process of managing these diseases into some sort of commission or body that would survive changes in regime.

There are two models I can look at. We have the Centres for Disease Control (CDC) out of Atlanta, the United States. In Trinidad and Tobago we have our own CAREC. If we leave the management of these diseases to politicians and individual Ministers of Health—and that is why at the start of my contribution I said, like Sen. Al-Rawi who protects his profession of the law, I am protecting my profession as a health service provider. I honestly feel that this issue is to important and too big, and maybe the time has come to set up some sort of agency to continually monitor, gather data, educate people and start to influence Trinidadians and Tobagonians as to how they eat, how they live, how they consume alcohol and so on. I honestly believe that. In speaking to two senior doctors in the field, they seem to back the idea.

What that would do, Madam Vice-President, instead of having the Helen Bhagwansingh Institute on onehand, you have the Diabetes Association on the other hand, you have the Ministry of Health doing their own things, it brings everybody under one umbrella. You get a certain degree of critical mass to move the thing forward, you get cross-fertilization of ideas instead of everybody working in silos and not sharing information.

I think if I could direct my next comment, Madam Vice-President, through you, to the hon. Minister of Planning and the Economy—because the Central Statistical Office has a serious role to play in this. So we have to have legislation to compel the private providers to share data. We have to have the CSO collecting the data and this is why on many occasions every time I have an opportunity in

this Senate, to float the idea, with the approval of my political leader who agrees with me, that the CSO should be taken out of political control and be set up as an independent body.

We are now in 2012, 50 years of independence. Again, like the commission I am suggesting, it would survive administrations, and the CSO which has to be the main collecting agency in Trinidad and Tobago has to be separated. So I float it again.

Madam Vice-President, in continuing my contribution I make brief reference to the Draft Estimates of Development Programmes for the Financial Year 2012. On pages 100 and 101 we talked about, under heading:

Sub-head 003—Special Programme—Renal Dialysis. The actual figure in 2010, expenditure was $18.1 million; 2011 estimate was $20 million; the revised estimate for 2011 was $20 million, but this is where I got a little bit concerned, the 2012 estimate is $14 million, a drop from $20 million to $14 million. That is almost a 30 per cent drop. If we agree that diabetes and renal failure is an increasing problem, this drop in the estimate from $20 million to $14 million gives me some cause for concern.

As I spoke recently about the development of a communications programme to alert people, under Heading 230 Communications Programme—I am going back to 2010, this would be under the last administration, there was no actual figure, but there was an estimated figure of $30,000; 2011 Revised Estimate none; 2012 estimates $30,000. Woefully inadequate to alert the population of the dangers of what I am speaking. That is why I am saying that we need to have a concerted consistent communications method to alert people as to what we are doing.

6.10 p.m.

Madam Vice President, I turn to the Details of Estimates of Recurrent Expenditure for the financial year 2012, and on page 208 of that we see that the Ministry of Health has a total allocation of $3.656 billion. That was the 2012 estimate, and it represented a 1.2 per cent increase over the 2011 revised estimate. Just about $44,618 was added; just about a 1.2 per cent increase.

When I looked at those figures and I related it back to the Medium Term Policy Framework, on page 54—and I am sorry my good friend, former Sen. Rabindra Moonan is not here, because the last time I referred to this document "he tell meh how ah colour it up". You all remember that? Right? But I am really sorry.

Hon. Senator: "He watching yuh."

Sen. T. Deyalsingh: He said, "Ah only colour it." Right?

Hon. Senator: "He watching yuh on TV."

Sen. T. Deyalsingh: "He watching meh on TV."

Hon. Senator: "He just send a message for yuh."

Sen. T. Deyalsingh: "Yeah, yeah. Ah colour it up."

Sen. Al-Rawi: "He colouring by numbers where he is."

Sen. T. Deyalsingh: Madam Vice-President, it is glad to know the Members of Government are actually listening to me.

Hon. Senator: Because "yuh making sense".

Sen. George: "Ah waiting tuh see where yuh going. Ah timing yuh on 35(1). [*Laughter*] Ah give yuh leeway, buh ah timing yuh."

Sen. T. Deyalsingh: "Yuh" really want to invoke 35(1), or 46(1)?

Sen. George: No, 35(1). Go ahead. "Ah timing yuh."

Sen. T. Deyalsingh: Madam Vice-President, referring to the "budget" that Minister Gopeesingh spoke about and I referred to, the provision of health services is one which gives budgeters problems. Many countries are judged by what percentage of GDP they put into health, education and so on, as a standard, as their benchmark, and the Medium Term Policy Framework talks about increasing for the health sector over the medium term beyond the current 6 per cent of GDP. However, it does not say to what level.

I think what we should be doing, instead of having an open-ended statement: "increased funding to the health sector over the medium term beyond the 6 per cent of GDP", what are we increasing it to? To what percentage, and what do we hope to get out of it? Because as I said, health is a ministry, is a bottomless pit, and until we take the bull by the horns, we could be spending 100 per cent of GDP; it could go up to anything.

That is why I am saying; I am advocating; I am imploring, through this medium, that we take these diseases in control so that future governments will have less expenditure. Because these RHAs—

Sen. Dr. Tewarie: Who will pay for that?

Sen. T. Deyalsingh: Who will pay for that? Good question. It is better you take a hard decision now and help to change people's lifestyles now so that you have the savings 10 years from now.

Sen. Dr. Tewarie: If you will give way, just to ask you to elaborate on something.

Sen. T. Deyalsingh: Sure.

Sen. Dr. Tewarie: I only asked the question, Madam Vice-President, through you, because you said it will basically shift the financial burden from the Government, and that is why I asked you the question, who will pay for it.

Sen. T. Deyalsingh: Thank you, Madam-Vice President—

Sen. Dr. Tewarie: It is not that I am opposed to the position.

Sen. T. Deyalsingh: Madam Vice-President, I do not think it is about shifting the financial burden; I think it is more about having a paradigm shift in Trinidad and Tobago, to the shifting of attitudes and behaviours. It is about shifting attitudes and behaviours, not necessarily a shifting of a financial burden. It is about making a decision now in 2012 that we take this thing, put some resources behind it so that 10 to 15 years from now we do not have to come back and say in the budget that we have to spend 25 per cent of GDP to treat a cohort of people who, if we had taken action 10 years ago, would not be presenting to the hospital to stay for 51 days per person. That is the kind of paradigm shift I am hoping for.

Sen. Dyer-Griffith: From tertiary to primary.

Sen. T. Deyalsingh: Correct. As Sen. Nicole Dyer-Griffith is saying, some focus needs to be shifted from tertiary health care back to primary, because we already have five regional health authorities, and we need to devolve authority to them, because this Bill is about centralization.

The Northwest Regional Health Authority covers St. Ann's, Port of Spain and St. James. You have about 17 health centres. The North-Central Regional Health Authority, you have two tertiary teaching hospitals, four health care facilities and 12 health centres. Eastern Regional Health Authority covers Sangre Grande, Mayaro, with 15 health centres. Southwest Regional Health Authority: San Fernando, Point, Princes Town, Couva, with 33 health centres, and Tobago, 18 health centres and now one hospital.

The point I am making, the coverage of health facility seems to be good. The problem is delivery. If we go back to centralization, which is what this Bill wants to do—[*Interruption*] I am coming to that. To the provision of centralization to the

procurement, my question is: how effective is that going to be? I raise this for the hon. Minister's consideration. If we take all of these regional health authorities that I have just called out, the Eastern Regional Health Authority is probably one of the most efficient and has been for a while.

Let us ask ourselves why. What it is that the Eastern Regional Health Authority has been doing over the years, over administrations that make it efficient, that make it responsive to the population that it serves? What best practices have they implemented that the other regional health authorities could look at, whether it is procurement or staffing? That is why the issue I am raising today, hon. Minister, is it that the panacea you are looking for is centralization? Or is it that we are trying to use legislation to address a management issue? What are the management failings that currently go on at these regional health authorities? I will give you an example.

Last year in the papers there was a big hue and cry about pigeons in one of the hospitals. Now, pigeons in a hospital, in my view, do not require the attention of a Minister of Health. That is a management issue. It is up to the managers of the hospital, but it became a big hue and cry and a Minister had to step in. If that is the culture we have in these regional health authorities, we are wasting time.

Sen. George: In the country we have that culture.

Sen. T. Deyalsingh: Change it. Start.

Hon. Dr. Gopeesingh: Accountability is the problem.

Sen. T. Deyalsingh: That is the point. Unless we start to hold people in these regional health authorities accountable for their failings, no legislation is going to solve the issue, hon. Minister. That is the point Sen. Al-Rawi was making in his contribution. Let us see the regulations.

Hon. Dr. Gopeesingh: I told him that we have it.

Sen. T. Deyalsingh: But we need to see it.

Hon. Dr. Gopeesingh: All right. You will give way?

Sen. T. Deyalsingh: Sure.

Hon. Dr. Gopeesingh: Thank you, hon. Senator. I appreciate your giving way for me to make an intervention. Madam Vice-President, it is only when the Bill is passed we will be able to put in the regulations governing the Bill. We have the regulations that are made already, and we ask the support for the passage of this Bill so that we can bring the regulations into Parliament by negative resolution or

affirmative resolution, whichever, but the Act itself says negative resolution. So we have all the regulations there already. Let me just remind them, it was being done by one of the former Ministers of Education. He liked the idea of bringing all the things to be purchased together, but he was advised that it was against the law and they sought the attention of the then Attorney General, John Jeremie, and he indicated that you needed regulations to govern the change, and the regulations have been made by the hon. Minister and it is available for Senators to see.

PROCEDURAL MOTION

The Minister of Public Utilities (Sen. The Hon. Emmanuel George): Madam Vice-President, before Sen. Deyalsingh continues, I beg to move that this Senate continue to sit until eight o'clock this evening.

Question put and agreed to.

REGIONAL HEALTH AUTHORITIES (AMDT.) BILL

Madam Vice-President: Senator, I will give you an extra one minute for the intervention.

Sen. T. Deyalsingh: Thank you, Madam Vice-President. Hon. Minister, the issue you have raised about the regulations is one that we have raised on this side on many occasions. Sen. Al-Rawi raised it today in relation to this Bill. We have had other occasions to raise the same issue where Bills are brought before the honourable Senate and we do not see the background work; we do not see the regulations and so on, especially for important Bills, for instance, the Biological and Weapons Bill; I think there was an issue when we were debating the vesting of properties under the postal corporation. We had to literally beat it out, but we only got it after it was raised.

The point is, when we are debating these sort of Bills, it will be nice, in the spirit of cooperation and consultation if you treat this side with a little more courtesy. That is the only point. So let us leave it at that. [*Desk thumping*]

Hon. Senator: "We does do that all the time."

Sen. George: "But we doh get it reciprocated, yuh see."

Sen. T. Deyalsingh: You see, Madam Vice-President, they want me to get political, you know, but—

Sen. Beckles: "Do leh dem provoke yuh."

Sen. T. Deyalsingh: —they are not going to provoke me today, Madam Vice-President. Peace is in my heart today; peace and love today.

Sen. George: And the Standing Orders, because I have not moved 35(1) yet. [*Laughter*]

Sen. T. Deyalsingh: Peace and love. You see, Chanderpaul almost made a century today—peace and love.

Hon. Senator: Ohh, all right.

Hon. Dr. Gopeesingh: Senator, they said you are under a calming influence today.

Sen. T. Deyalsingh: Of course.

Hon. Senator: Because of him.

Sen. Beckles: We need the Minister of Education up here—

Sen. T. Deyalsingh:—a little more often. As we press on, I said earlier, hon. Minister, that maybe the solution to the issues surrounding the RHAs— and I relate it to the pigeon in the hospital issue—is a management issue, and whether the last administration held nobody accountable, or yours, let us forget that. There has to be a starting point in Trinidad and Tobago where we start to hold people accountable, because the issues of these RHAs, it is too important to have these RHAs being managed as personal fiefdom and people get away literally with bloody murder.

Hon. Senator: That is what we had before.

Sen. T. Deyalsingh: Regardless. And Sen. Al-Rawi raised the point: do we need this legislation of centralization because we already have Nipdec purchasing drugs in bulk. And I will make the point again. You can have an overarching policy, because the regulations give the Minister the authority to do this. You raised the issue of the purchasing of scanners and MRIs. Do we really need to purchase MRIs the way this Bill envisages?

We are saying, have your overarching policy; leave the RHAs as they are; improve the system; look at the Eastern Regional Health Authority; see what best practices they have. We do not have to reinvent the wheel, but the solution may not be legislative change. That is the position that we are articulating.

Sen. Al-Rawi: If it is, tell us why.

Sen. T. Deyalsingh: Exactly. And if it is you need legislative change, why? What is the rush? Why now? So as I come to a close—and I really do not need the extra one or two minutes—I just want to encapsulate what I have been saying for the past half an hour or so, that Trinidadians and Tobagonians need to take stock of

themselves, one; two, I am recommending to the national community the development of some sort of body, some sort of commission to drive the process of education on a continuous basis that spans political change. I am advocating that the incidences of diabetes and so on, that go to the private sector be trapped and fed into the national grid of data. I am again appealing to the Government to consider the taking of the CSO to an independent footing. And with those very few words, I thank you. [*Desk thumping*]

6.25 p.m.

Sen. Helen Drayton: Thank you, Madam Vice-President. This Bill definitely goes to the heart of procurement, and let me open by saying that change is a necessary part of life, and I certainly believe that at this juncture, it is absolutely necessary that the systems and procedures that govern the way we deliver services to the public need to be changed if we are to become more efficient, effective and bring greater value to the citizens. So, I certainly see the need for some hybrid or matrix system that would create flexibility in the way the regional health authorities purchase or acquire their goods and services.

Let me say, Madam Vice-President, I, too, have a grey area, and that is, I am trying to understand exactly how this piece of legislation is necessary to effect that change. Now, I heard that you mentioned that certainly, if we need to bring in a container of pharmaceuticals for distribution throughout the health sector, that can be done. I imagine that if we had to purchase beds—we need to bring in 100 beds—I would imagine that could be done, and certainly, if we need to bring in prosthesis, certainly that could be done.

So, I have been trying to put this Bill in a certain context, and I saw it very much in the context of a deepening of the private/public sector delivery of health services. I see it making a great deal of sense in that context at this juncture. But, of course, I do not know exactly what those policies are or what framework the Government has in mind in the context of deepening that process, because I simply cannot understand why the need to rush this piece of legislation at this point in time outside of a broader, robust framework. We all know that there is a committee working on procurement; I am not going to go into that. But, suffice to say that any public procurement system will make it mandatory for government agencies to comply with a specific set of operating principles, objectives and guidelines. And certainly, for it to be effective, it will be sufficiently flexible to allow for joint transactions. So, I just cannot understand the need for the legislation outside of the context.

I certainly do not want to be critical of change; as I said, we need change; it is necessary. But, there are positives and there are many negative implications outside of a proper framework, particularly if you are seeking to deepen a public/private sector process in the delivery of health care. The collaboration among agencies, that has its advantages, but, outside of a proper regulatory framework, it could snuff out small local suppliers; it could also run against fair-dealing, ethics and competition—three critical pillars of effective procurement.

So, the question that I want to raise in order to avoid this—yes, I heard that regulations will be in place, but would all the appropriate standards exist for undertaking by parties for joint transactions. I say this in the context of two things. I recall—it is a report probably about four years or five years old, and I think it is a report of the World Health Organization or it was a report of the World Bank. What was significant about that report to me is this: it said that citizens, generally, are all concerned about corruption or alleged corruption in public affairs, but we tend to think about it in the context of big construction projects That report said, specifically, that the greatest amount of corruption actually takes place in the acquisition of essential goods and services, and it made reference to the health sector and also the education sector, particularly because, usually, given the nature of these sectors, there is a greater need for flexibility so that the regulatory framework is usually very weak.

So, you see, it is not just a question of us, and I think it is necessary that we take these global situations into consideration when we are looking at our legislation, and how we can improve our systems to standards that would certainly lend themselves to scrutiny and transparency, particularly as the Government indicated its desire with respect to deepening the public/private sector partnership.

So, I ask the question about accountability for oversight in the absence of robust legislation, but legislation or regulations that are sufficiently flexible that would cater, you know, to the nature and the exigencies of the public health sector. I ask this for two reasons: one, and I stated this last week in a different way, and that is that government departments, agencies and enterprises, over the years, have been making a mockery of the process of parliamentary oversight, a mockery of the law that governs them and also the Constitution by extension—simply because there is no scrutiny because there are no proper accounts which one could look at to assess the level of management when it comes to the public funds.

Sen. Dr. Wheeler mentioned financial statements but the law is quite clear in the context of what has to be submitted to the Auditor General, and which the Minister is supposed to deliver to Parliament. Just to give you an idea. According to the research that I have done with the library of Parliament, the last report tabled in this Parliament for the North West Regional Health Authority was for 1998 in 2005. That is a generation. The last report for the Tobago Regional Health Authority, a vast improvement, that was for 2009 and it was delivered in 2011. The report for the Eastern Regional Health Authority, that was for 2006 and delivered in 2010, and the report for the South West Regional Health Authority was submitted in January2012. I stand to correction.

When you look at the regulations that govern the affairs of the Regional Health Authorities in the context of procurement, it really is a non-entity; it is very weak. There is virtually no oversight with respect to the use of public funds in the health sector given the fact—I think, Sen. Deyalsingh just mentioned a budget of $3.2 billion. When I checked that, I think it was $4.2 billion, but, even so, let us just say, it is $3 billion on average over the past five years. That is $15 billion, the bulk of which is spent by the Regional Health Authorities, and there is absolutely no accountability other than the end of the year when you see a budget that says this was the expenditure and this is the estimate for the new year and that is the reality.

Now, the role of the line Ministers and, by extension, Central Government in that regard is clear because the law makes it clear with respect to who, when and where it has to be delivered, so that the Minister has full accountability in that regard. We all know about the issues of manpower, but how long would that continue to exist?

Let me also mention another observation and that is by the Uff Commission with respect to the UDeCott matter or, I should say, the Commission of Enquiry into the construction industry and also other bodies such as the World Bank, and this basically is what was said: amendments to procurement regulation have led to off budget arrangements and activities not covered by legal and regulatory framework. That applies to this particular amendment.

We hear that regulations would be forthcoming but we are mindful of the fact that the current regulations governing the conduct of the authorities—that is very weak.

Then, when you read what the Act actually says under section 4 and it was referred to earlier on. The Act says that the:

> "Board may"—appoint—"a Tenders Committee for the purpose of inviting, considering, accepting or rejecting offers in excess of fifty thousand dollars for the supply of goods"—and—"services…and for the disposal of surplus or unserviceable goods."
>
> "May". So that the board does not have to appoint a tenders committee to acquire goods and services because the law is not mandating it to do so. So that in the context of that piece of legislation, the chairman of another regional authority, Mr. "X", could call up the chairman of another regional authority, Mr. "Y", and says, "well, I want to purchase 'x', 'y' and 'z'. I have a supplier here but if I could do it jointly and get a bulk order, then of course, I could get a better price."

So, the question I would ask: in the context of this very simple piece of legislation, where would collaboration end and collusion begin? Who would ensure oversight of that process? So the current legislation is weak; I do not see how you could bring regulation in the context of this amendment and it would be any better since the law does not mandate a tenders committee.

It is very easy to say that all we are asking here is for the Senate to approve a Bill that would, if it becomes law, that the health sector would be in a position to achieve economies of scale and economies of scope, and therefore, greater efficiency. It is not that easy. If that was all it was doing, I am 100 per cent in support of the Bill and I am in support of the change. Quite frankly, any change that we could bring to the public service has got to be better than what we have now. So that, you know, one is pretty much predisposed to a new viable direction.

So that all I am saying is that I am not taking issue with this Bill in principle. I am taking issue with the fact that it is being rushed when the Government is eager to get legislation that is on the brink of being ready at this point in time, and that unless there are proper mechanisms, the efficiencies and the value that you are looking for will not be there.

I will tell you why: because competition is a check on cost and efficiencies and this has the potential to snuff out competition outside of a proper framework.

6.40 p.m.

In closing, I want to reiterate that change is necessary if we are to move forward on a continuum and not in circles and worse yet, do nothing to improve our systems. We need to improve our systems.

I ask the hon. Minister to clarify exactly why this cannot wait to be placed in the context of the legislation that this Government has said that it is determined to bring forward as soon as possible, which is your procurement legislation. I would ask: Is there a system to measure performance? It was mentioned that, in order to achieve the economies that you are looking for and the value that you are looking for—I am not even going to talk about cost because you are dealing with health and, to some extent, it is not always a question of cost. Standardization underscores that type of procurement. And, therefore, is there a system of standardization or standard ways of operating to give effect to joint transactions?

The last question I would raise, because I think it is necessary in the context of what the Minister mentioned, which is a Patient's Charter of Rights, and it is this: With respect to the Patient's Charter of Rights, when will the patients and their families see the report on the matter of calibration of the linear accelerators at the Brian Lara Cancer Society? I close and thank you, Madam Vice-President.

Madam Vice-President: Hon. Senators, before the next speaker, it is indicated that Sen. Nicole Dyer-Griffith had requested that she would refer again, extensively, to her notes and such leave has been granted.

Parliamentary Secretary in the Ministry of Foreign Affairs and Communications (Sen. Nicole Dyer-Griffith): Thank you very much, Madam Vice-President, for affording me the opportunity to contribute to this Bill to amend the Regional Health Authorities Act, Chap. 29:05.

Accordingly, this Bill would seek to amend, as was mentioned by many of the Senators who went before, section 20 of the Regional Health Authorities Act, by inserting a new subsection (1)(a), which would enable the regional health authorities to procure goods and services collectively, where it is economically expedient so to do.

Before I get into the substantive areas around the Bill, there were a number of issues that were raised throughout the debate by various Senators and I would like to touch on a few of the issues because many of them I do support and many of them, I believe, would be further expounded upon by the hon. acting Minister of Health, in his closing.

Sen. Drayton and other Senators who went before mentioned the issue of oversight and the authority of Ministers from a regulatory framework as well as the issue of Nipdec and whether Nipdec could procure goods outside of pharmaceuticals. The hon. acting Minister of Health has advised that he will touch on those issues and seek to answer those questions and provide responses in his winding-up, so that you can have a clear idea of what is the policy of the Government and his response moving forward.

Mention was made about the Patient's Charter of Rights, again. I am very happy to note when the hon. Minister was piloting the Motion earlier, he mentioned the political will of this Government that ensured that the Patient's Charter of Rights, which was highlighted in the Gafoor Report since 2007, has been placed on the table and the People's Partnership Government has been giving active consideration to the implementation of the Patient's Charter of Rights and the Patient's Bill of Rights.

With respect to the Nurses Training Academy, that was also raised by the hon. acting Minister of Health, I would like to take this opportunity to congratulate Sen. The Hon. Karim for ensuring that the Nurses Training Academy will be opened soon. This is welcome news. As a registered nurse myself, I recall many times in the hospital scenario where—[*Desk thumping*] Well hon. Senator, whilst I was sitting here listening to the many contributions, it struck me that there are so many hon. Senators in this Senate who are very much au courant with the parameters of this RHA Bill that it—[*Interruption*] well, except one, perhaps. The actual tone of the contributions thus far has been quite intellectually stimulating and provided, I think, good fodder for us moving forward and, perhaps, this should be the tone that we would seek to employ moving forward.

Actually, I take this opportunity to recognize Sen. Deyalsingh, because I think this was one of his best contributions ever. Sen. Deyalsingh, staying away and steering clear of the politics, gave very solid points, even though many times you wondered about relevance to the Bill, Standing Order 35(1), we allowed it to pass because he was going so very well. Well done, Sen. Deyalsingh, well done.

I was speaking about the Nurses Training Academy. That is welcome news. I recall the days, and I would refer to it when I make the substantive contribution, when as a registered nurse sometimes you would be on a ward and you would be the sole RN on that ward with "40-something" patients with one or two nursing assistants. That is absolutely incredible when you have to try to provide acrobatics, in order to manage that scenario. Such an academy certainly is welcome news.

Sen. Dr. Wheeler spoke about the standardization of the protocols of care and service. Sen. Dr. Wheeler, I absolutely agree. I believe that the Minister of Health is actively working on ensuring that we do have the standardization of these protocols of care and service, because in some ways it ties into the Patient's Charter of Rights of having a specialized standard of care. Of course, you will have to have a standardization of those protocols in order to evaluate effectively the standard of care across the board.

Sen. Abdulah raised the issue of the Point Fortin Hospital. I remember not too long ago, before my grandmother had passed on, I had to accompany her to the Point Fortin General Hospital. The only thing I did not do at that time was just break down. It was not only as a result of that emotional experience, but it was also as a result of looking at what patients in the southern part of the country had to undergo. The conditions in the Point Fortin Hospital are absolutely deplorable. [*Interruption*]

Sen. Karim: Neglect.

Sen. N. Dyer-Griffith: After years and years—I do not want to go there—of neglect it is unacceptable. So, it is welcome news, again, that we have demonstrated that this Government is delivering—[*Desk thumping*] and will continue to deliver.

I touched on Sen. Deyalsingh's contribution. There are some areas he mentioned which I do agree with. Sen. Deyalsingh mentioned something around the issue of mandatory reporting to select lifestyle diseases, where you offered an opinion that, perhaps, consideration should be given for the capturing of that data. I do agree. I think it is an idea that is worth merit and I am sure that the hon. Minister of Health would take it into consideration.

You also mentioned the movement of NCDs into the realm of agency-based management. I believe that there is a modicum of good thought in that. However, I do not believe and I do not support that it should be removed from under the umbrella of having a political will that pushes it forward. I believe the hon. Prime Minister, in her raising of the awareness from a Caricom perspective, did an excellent job and you need to have that strong political will in order to push the agenda forward.

Sen. Deyalsingh mentioned the bucket and immediately, not only did the calypso "Bucket" come to mind, but it also reminded me of the bucket of millions of dollars that was dropped into the Scarborough Regional Hospital where it started from $135 million and ended to where?

Sen. Karim: Over $1 billion.

Sen. N. Dyer-Griffith: Over $1 billion. Those thoughts came to mind when you hear about the bucket and the limitless resources when you speak about health care.

Sen. Deyalsingh also spoke about shifting resources from the tertiary level to the primary level of intervention, which he believed would redound to the benefit of the population. That is scientifically proven. If you provide services and you put more resources from the primary level health care, which speaks to education so that it does not result in secondary and tertiary-level health interventions, then you tend

to save more from a financial perspective. I do support that perspective. I do support that point. As I mentioned, the other areas that were highlighted, the hon. acting Minister of Health will take into consideration when he is winding up.

It is important to note that even though, to us, this is a simple amendment, it has significant implications pertaining to the services within the health sector. Part of the significance has to do with the way in which we define goods and services.

Accordingly, in piloting this Bill, the hon. acting Minister of Health had inferred "goods" to mean products, implements, tools, devices, machinery, equipment, et cetera, under the umbrella of goods, and "services" to include assistance in doing things or getting things done, which also include the issue of professional and consulting services.

When the hon. acting Minister of Health spoke and he made reference to the issue of limited resources from the neurosurgical perspective, it immediately brought back other memories. You would find I would be going in and out of references from my experience within the hospital system. I recall, as a direct result of the lack of that service many years ago as a student nurse in and around the early 1990s, the loss of the life of one of our patient/ clients as a direct result of a lack of that specialized service. When the hon. Minister, in piloting this Bill, spoke to that, it resonated with me at a number of different levels that you can actually have an impact on the loss of patient/client lives when we speak to that part of the services aspect of the amendment to the Bill.

Madam Vice-President, the concept of joint purchasing or regional pool procurement is nothing new and it has been tried, tested and proven to be an efficient and effective model of procurement management for many years. I have with me, a document entitled European Commission Green Public Procurement (GPP) Training Toolkit, which was done by the EU. It is a joint procurement fact sheet. I would like to quote from it, where it states:

> "Joint procurement' (JP) means combining the procurement actions of two or more contracting authorities."

In this instance, of course, you will have four or five authorities, meaning our RHA authorities.

> "The key defining characteristic is that there should be only one tender published on behalf of all participating authorities. Such JP activities are not new—in countries such as the UK and Sweden public authorities have been buying together for a number of years—"

The document goes on to identify some very clear benefits for contracting authorities engaging in this joint procurement engagement.

The reason I want to lift this is that we need to have some baseline of credibility for the actual amendment and to demonstrate the best practices moving forward that were done, tried, proven and tested in other jurisdictions. So, in this particular jurisdiction, the clear benefits for contracting authorities engaging in the JP arrangement would redound in lower prices.

"Combining purchasing activities leads to economies of scale."

—as the hon. Senator would have mentioned and, of course, economies of scope.

> "This is likely to lead to more attractive offers from suppliers. Particularly for small contracting authorities these advantages can be quite significant."

Our particular scenario, you will have the different sizes of the RHAs because the NWCRHA would be a different perspective to the Central Regional Health Authority and so on.

> "Administrative cost savings—The total administrative work for the group of authorities involved in preparing and carrying out one rather than several tenders can be substantially reduced."

6.55 p.m.

Now, we have heard it mentioned time and again, the bureaucratic HR administrative nightmare that evolved as a result of hosting five RHAs, you heard about 15 CEOs, five different HR departments, administrative departments and so. In the case of joint procurement, the total administrative work will be reduced so as to eradicate the confusion in terms of having it done five times over.

> "Skills and expertise—Joining the procurement actions of several authorities also enables the pooling of different skills and expertise between the authorities"

Madam Vice-President, this clearly outlines some of the key benefits from the JP perspective or the perspective of Joint Procurement. Even closer to home there is another document which outlines a best practice. Now, before I actually read from the document, it outlines a best practice where over nine Ministries of Health from regions within the Organization of Eastern Caribbean States (OECS), decided that instead of doing procurement from an island-wide perspective, they would do it from a joint perspective.

So nine countries from within the OECS came together and developed the OECS/PPS Procurement Model, where they decided to procure their pharmaceuticals in the first perspective, and then their other large-scale machinery from a health perspective, this document is from the World Health Organization (WHO). They utilized this model as a best practice in pooled procurement. It is entitled: "Reducing cost through regional pooled procurement," and it goes:

> "Financial constraints have made it increasingly difficult for developing countries to adequately finance the supply of drugs to health facilities. The countries comprising the Organisation of Eastern Caribbean States (OECS) have recognised that improving the use of existing resources could be achieved by efficient procurement practices. Of the four areas of drug supply management cycle efficient procurement provides the greatest opportunity for cost-savings."
>
> The core function of the OECS/PPS"

And this is the group which the nine Ministries of Health across the OECS countries came together to form.

> "is the pooled procurement of pharmaceuticals and medical supplies for the nine Ministries of Health (MOHs) of the OECS countries..."

Madam Vice-President, I know it is difficult to see, [*Holds up document*] but one of these graphs demonstrates the percentage savings that were accrued to each one of the member countries of the OECS over the years as a direct result of the pooled procurement: the joint procurement. In Grenada, they experienced a 50 per cent level of savings from their pharmaceutical perspective; in Anguilla you had a 50 per cent savings; Montserrat, 45 per cent savings and it goes across the board. It gives an idea of the percentage of savings across the board, which range from 35 to 38 per cent, all the way up to 55 per cent to each one of these countries which participated in the joint procurement process.

> "The Pharmaceutical Procurement Service operates a centralised, restricted tendering system in which all approved suppliers are pre-qualified by a vendors registration questionnaire. Pre-qualification is necessary to assess the quality standards, technical competence and financial viability of competing suppliers."
>
> Recognizing the success"

This is where it goes on to state that they tried the model simply for purchasing their pharmaceuticals, and as a direct result of the success of this model for the purchase of the bulk pharmaceuticals, the:

> "OECS/PPS has rapidly expanded its product portfolio to include medical supplies, contraceptives and x-ray consumables. The Service has now been mandated to explore the feasibility of purchasing dental and laboratory supplies."

This speaks to the question of looking at a best practice with our neighbours that has worked and continues to work. It responds to the question of: do we have any examples and what is the model for best practice moving forward?

Madam Vice-President, in that document mention was made of some of the measures for oversight and accountability in their procurement process. And I wish to link this statement of procurement efficiencies to what I understand the hon. Minister of Health is undertaking at the Ministry, by bringing this amendment where he has ensured that a number of these processes are in train, including the evaluation process; the checklist for questions from the evaluation committee; background checks of persons who would be tendering/utilizing this process; the undertaking of a Cost Benefit Analysis (CBA), moving forward; maintenance and service agreement, and a number of other areas which the hon. Minister had mentioned in passing that will be carried out as a result of strengthening these procurement processes.

The correlation here demonstrates that the hon. Minister of Health is clearly on the right track as it pertains to his vision for effective management of the health system in Trinidad and Tobago. And according to the document from which I just quoted, recognizing the success as I mentioned of the pooled procurement, you will find the OECS would have moved from just the purchase of pharmaceuticals to an expanded portfolio of purchasing, which I suppose is one model that can be utilized very, very well as we move forward to make the amendment to conduct a similar practice.

The OECS model also quotes some ideas and items that were keys to the success of this model, and the decision to go the route of pooled procurement where the amendment that we are proposing will currently or likely guide us into. And some of these other areas which demonstrated and underscored the success of that OECS model were that of political will and financial commitment, and that underscores the political will of our Minister of Health and, of course, that was demonstrated by the Acting Minister of Health for bringing this amendment forward to ensure that we can continue to underscore and increase the efficiencies of our health care services.

Participatory decision-making which, of course, is what we are participating in right here in this honourable Senate. One of the other very important key factors in ensuring that a similar JP or regional pooled procurement model works is that of careful selection of suppliers, coupled with prompt payment of these suppliers.

Madam Vice-President, and hon. Senators, I know the question will be asked and it has been asked, as to the effective management of this JP procurement process, and I heard it mentioned here and I cannot recall which one of the honourable Senators mentioned it. The Ministry of Finance recently produced a document entitled: "State Enterprises Performance Monitoring Manual. "Improving the Corporate Governance Framework for State Enterprises."

Even though this document does not pertain specifically to the RHAs, I have heard it mentioned before, time and again that we are not seeing the documentation, we are not seeing the guidelines, and we are not seeing this and that, but the Ministry of Health took the opportunity to develop this document, and I will be more than happy to share it with the hon. Senators—[*Interruption*]

Hon. Senator: Ministry of Finance.

Sen. N. Dyer-Griffith: Ministry of Finance, sorry. I will be more than happy to share it, it demonstrates—[*Interruption*] Sorry?

Hon. Senator: All state enterprises?

Sen. N. Dyer-Griffith: Yes, the document is produced for state enterprises, it is called: "State Enterprises Performance Monitoring Manual." As I mentioned, even though it is not specific to the RHAs, it provides some guidelines to the thought process moving forward. In the section entitled: "Ethical Procurement Standards," I would just like to read here:

> "It is important that employees conducting procurements on behalf of the Company avoid improprieties, as well as the appearance of such improprieties. The integrity and credibility of the procurement system requires the Company employees to be impartial, fair and free of any relationships that may cause them to be unduly partial to any Vendor or product."

Madam Vice-President, you—[*Interruption*]—sorry?

Hon. Senator: [*Inaudible*]

Sen. N. Dyer-Griffith: It is updated? Yes, it is an updated version I am being advised by my Senator colleague.

Sen. Al-Rawi: It is on the Ministry's website.

Sen. N. Dyer-Griffith: Yes, yes, thank you. You recall earlier in my contribution I mentioned that this amendment held great significance as it related to the definition of goods and services. I can relate to both of these concepts because the example I gave of my tenure within the regional health authority system, where you had one nurse with a number of patients, it was a very difficult scenario to manage.

It was said here time and again—I believe Sen. Dr. Wheeler and the hon. Acting Minister of Health would have given an overview of the history of the RHAs. From my perspective, I recall in and around 1991 or so, and then in 1994 with the implementation of the RHAs, I do recall the HR implications and the brouhaha that surrounded the implementation, because at that point in time as a student nurse attempting to practise nursing in the way in which we are supposed to, because they had adopted the British system to train my batch, my batch was BN5, and as a result—and then you had the introduction of the RHA system where there was some difficulty in introducing this system into our local context, so you had that to deal with. Then you also had to deal with the RHA system in Britain at that time or what they had introduced across there at that time was contracting, because they found after different types of analyses it was not working as efficiently and effectively as it should have been.

In Britain as the hon. acting Minister of Health would have identified, the system had contracted from approximately 40 or 50 NHAs to 12. So you had a contraction of that system in Britain as a result of the non-functionality of it, and it was now being introduced in the Trinidad and Tobago context. So there were a number of areas which led to the—even though the introduction of the RHAs under the PNM administration was done to increase efficiencies and effectiveness, after a while it was very clear that it was not necessarily tuned towards a system that was being managed under a Ministry of Health, because you had the Ministry of Health and then you had the RHAs, and there was a confusion as to who reports to whom, if something happens in an RHA, what takes place, if a Ministry of Health employee were to go across to the RHA, who would be held responsible and accountable for certain things, so there were a number of things which were taking place at that point in time.

The Minister of Education, and Acting Minister of Health, mentioned that the UNC took over thereafter and they had undertaken some type of evaluation of the system, and felt that they would give it a try, because you know it is said that many times you come in, you see something and dismantle it and you do not give it a try.

The UNC administration at that time came in and decided the RHA system was there, they would give it a try and throughout that period things started to work, even though as the hon. Senators mentioned, we have reached the point where we really need to undertake a full-scale evaluation of the model to ensure that we move forward for a system of effectiveness, during that time under the UNC administration, had begun to put things in place to make it work.

Madam Vice-President, as I spoke to—[*Interruption*]—yes, yes, it did—as I spoke to some of the experiences, I recall many times where we would not even have—the hon. Minister of Health mentioned that during that period and up to now we have a deficiency of over 1,500 nurses. I still believe that in this system we do still have that deficiency, and perhaps Sen. Dr. Wheeler can bear me out, if the deficiency is still around 1,500 registered nurses in the system and around 300 doctors—so that at that point in time and during—[*Interruption*] yes, yes—[*Interruption*] What is that, sorry?

Sen. Al-Rawi: It is much less, in the most recent reports.

Sen. N. Dyer-Griffith: Yes, it is much less because of what has been taking place under the People's Partnership Government. [*Desk thumping*] So I would like to thank the Senator for pointing out it is much less as a result of the aggressive recruitment drive which was undertaken [*Crosstalk*] by the People's Partnership Government.

Sen. Al-Rawi: In one day it happened, May 24, 2010, it miraculously happened.

Hon. Senator: That was two years ago.

Sen. N. Dyer-Griffith: Madam Vice-President, [*Laugher*] Thank you very much, hon. Senator. I am aware that there will be some concerns raised pertaining to the introduction of this amendment as has been raised throughout the debate, and we do understand and recognize there are merits in those concerns. I have heard some of those concerns raised in the other place, so I would just like to speak to one or two of those areas.

The first concern is that of the RHAs functionality and effectiveness as a whole pertaining to the issue of procurement management. And the other issue I have heard is procurement as it relates specifically to this Bill. The issue of the RHAs—we had it ventilated throughout this debate, so I do not think there is need to get into the history of the RHAs any further in terms of who would have introduced the concept, because we all know it was introduced under the PNM administration

in 1994 and then under the UNC in 1995, they undertook the review of that and made it feasible, so there is no need to go into that. I would just like to recognize the work then, which had started under the Minister of Health at that time, I believe it was Dr. Hamza Rafeeq and then the current Minister of Health was the junior Minister of Health, who took the reins of the RHA which they met and really streamlined it into something you could make feasible.

7.10 p.m.

And in doing so utilize what we call the nursing system which you have a referral as made, and then you create a diagnosis of what you have met, you create a plan, you implement your plan, and then you undertake an evaluation of that plan.

You know, Madam Vice-President, I am surprised that I have not heard about—well that is in the past, and why is it you are bringing that up—because usually when you speak to these things, and you speak to some of the things we would have met, you hear about it being spoken about as something that is in the past. So I am glad that we have not heard that—[*Crosstalk*] [*Desk thumping*]

Hon. Senator: Good point!

Sen. N. Dyer-Griffith:—because I was prepared to state that Bob Marley said: "in this bright future you cannot forget your past". [*Desk thumping*] [*Laughter*] Of course, Madam Vice-President, the past in this case is instructive for all of us as parliamentarians, in this august House, to be frank with, and to utilize our past as a beacon in shaping our future. That is for Sen. Faris Al-Rawi. [*Desk thumping*]

We cannot deny what went on. [*Crosstalk*] And we must bring it to the forefront, acknowledge the deficiencies, and collectively decide on a way forward. I believe that this is what has been taking place particularly today in this debate.

Sen. Al-Rawi: COP.

Sen. N. Dyer-Griffith: Of course, the second issue I heard being mentioned is that of procurement. [*Crosstalk*] You know, Madam Vice-President, it is not often that the Opposition is commended. I would say this again because the Opposition is not listening. I said it is not often that the Opposition is commended, so I would like to take this opportunity to commend the Members of the Opposition who form part of the joint select committee. I would like to commend them for recognizing that it is important to underscore the lead of the Government in recognizing how you need to be responsible in moving forward, and responsible in responding to the needs of the national community.

You have followed the lead of the People's Partnership and come back to the table, and I congratulate you for that. [*Desk thumping*] [*Crosstalk*]

Hon. Senator: Do not walk out again.

Sen. N. Dyer-Griffith: I congratulate you most sincerely for taking that very adult and mature position, and I look forward to such positions continued to be taken in the best interest of the national community. [*Desk thumping*]

I mentioned the success of the OECS/PPS model of regional and pool procurement, and I would like to highlight just another experience that shares similar benefit, and this a situational analysis and feasibility study on regional pooled bulk procurement of essential medicines and other health supplies in East African community partner states. This one says:

> The East African community, in January2007 requested the assistance of the WHO of the technical cooperation for essential medicines to conduct a situational analysis and feasibility study for implementing regional pool procurement of medicines as part of their efforts to address issues of accessibility and availability of essential medicines in the region.
>
> Pool procurement otherwise known as joint purchasing—which I had mentioned before—is increasingly being regarded globally—Now this is important. I mentioned regional in the perspective, but this document by the WHO said—as an efficient strategy to resolve challenges as high medicine prices, poor quality and other bottlenecks generally associated with procurement and supply chains of essential medicines.
>
> A number of sub-regional and regional blocs as well as global initiatives have adopted the pool procurement mechanisms with success stories to share. The Gulf States who have been carrying out pool procurement for over 25years—

So, Madam Vice-President, in this contribution I have already mentioned at least three or four different areas in the world that have gone the route of joint or regional procurement.

> —reported that it had reduced cost and made millions of dollars in savings, whilst the East Caribbean islands—as I mentioned before—reported an average cost savings of over 57 per cent for selected items over a five-year period. Other successful pool procurement initiatives include a WHO Pan American health organization strategic funds, and a WHO global drug facility for TB medicines have shown significant achievements in lowering medicine prices, improving procurement processes and quality of medicines.

Madam Vice-President, in 2005 a Commission of Enquiry into the Health Sector was commissioned with the terms of reference including, but not limited to, enquire into the operations of the delivery of public health care services and the adequacy of such services. In the summary of those findings under the headline of inefficient and ineffective management—now I know the question will be asked under which Government was this, also I would leave that open-ended because I am sure anyone could guess—including the absence of a single policy governing the purchase of equipment, goods and services.

Consequently, in many instances equipment purchases were inadequate or had failed to meet the necessary requirement.

I vividly recall myself in the 2007 elections calling for the implementation of the recommendations of the Gafoor Report. Because you recall that there was a report of the Commission of Enquiry into the Operations and Delivery of Health Care Services, the Gafoor Report where there were a number of recommendations that were brought to the fore.

Again, I would like to congratulate the hon. Minister of Health for taking these recommendations by the horns and ensuring that they are implemented with a view to increasing the efficiencies and effectiveness of the health care services. So, I would like to join the chorus of those who have recognized the hon. Minister of Health, and of course, the Prime Minister's fervent desire to ensure the completion or at least the completion to a basic level of services of the Scarborough Regional Hospital. [*Desk thumping*] And to state to those who may say, but we started it, that it matters not who started the race, but what matters is who completed the course. With those few words, Madam Vice-President, I thank you. [*Deskthumping*]

Sen. Dr. Lester Henry: Thank you. I thank you, hon. Leader of Government Business. As I rise to make a somewhat brief contribution to this debate, I take it that we have heard a lot of what we have to grapple with in the health system from previous speakers, so I would not want to repeat a lot of what was said before. When we talk about health and in terms of procurement and spending on health I would start by looking at the international perspective and then come down to our regional health authorities and speak to the Bill directly in terms of that set of institutions that we all seem to acknowledge have quite a bit of problems that we need to sort out in this country.

When we talk about health and spending—and many other speakers before talked about the amount of money that we spent including Sen. Abdulah, and so on, on health care—we have to realize that spending on health care is a very serious matter and is one of the areas of major expression of inequality on a global level

that countries tend to spend very disproportionately on health care, some spend a lot of money and some spend a very little. The point is, there is no direct correlation between how much you spend on health care and the actual health of your population which is why we see some very strange numbers—well I guess it is not as strange because many people may know about it. But if you look at per capita spending, on a global level, we find that many of the rich countries in terms of life expectancy the one major indicator of how well your health care system is actually functioning in terms of keeping people alive, living longer and more fruitful lives. We see that the country with the highest life expectancy as recently reported by the University of California's site that I got this information from they had Japan listed as the country with the highest life expectancy with over 81 years on average, very, very high. Their spending per capita was roughly about 2,000 international dollars. What they call international dollars are dollars adjusted for purchasing power and they do some kind of weighed average, and they make it sort of comparable across countries. So that was about $2,000. If you go across the second country San Mariano, Monaco, Switzerland, Australia, Sweden, these are the countries with the highest life expectancies.

Of the top 30 countries in terms of life expectancy the only one from what we might call a developing country perspective is Cuba. Cuba came in a life expectancy around 77 years. Strangely enough, if you look at their per capita spending by the same measure was less than about $200.

Hon. Senator: Serious?

Sen. Dr. L. Henry: Yes. [*Crosstalk*] That was about $2,000 for Japan. The United States came in—regardless of which site you look at or which data—as the number-one country for spending on health care in absolute and capital basis by those same international dollars spent $4,500 per capita.

So in some statistics, the United States spends as much as 16 per cent of their GDP on health care. But if you look at the other aspect, life expectancy, it is right next to Cuba, it is actually almost identical. Of course, when you think about America one of the caveats is that—well it depends on who you are in America because the life expectancy if you just take rich white people it might go up 80 on the same level with Japan, if you take my race, African Americans, life expectancies is about the same thing as Trinidad and Tobago at 70.

Canada was here at about close to 80 as well in terms of life expectancy. So what we see is that even though the Americans spend so much money on a per capita basis on health care their life expectancy is no better than Cuba which

spends very, very little by comparison. So what does that tell us? It tells us that money without any uncertainty is not the only solution to having proper health care. So throwing more money at a particular problem—I believe one of the previous Senators made reference to it, I think it was my colleague Sen. Deyalsingh, that if you just think that we could buy some more equipment, hire a few more doctors, spend a little more money on training, that it is not necessarily going to solve your problem.

Unfortunately, in this country many of us, in the past and hopefully not in the future, adopted that kind of approach towards health care and trying to solve our problems. So what it really points to is life expectancy and proper well-being can be dealt with relatively modest spending if you target the spending properly in the right areas. If you channel those into more preventative medicine rather than waiting till people get sick in advanced stages and then trying to spend a lot of money taking care of them.

7.25 p.m.

So, again, some of the speakers before made mention of educational projects and so on to try to get the population aware in terms of proper habits like exercise and diet, and also taking care of primary medical needs, and that is critical.

Now, just before I get to the RHAs and our situation, in one set of data that I have here, in 2008 Trinidad and Tobago ranked 45th on spending per capita. So we are not so bad. We could be somewhere in the upper quarter of countries in the world. If you think about 200 independent countries in the world we are somewhere up there but, what we need to do is to spend wisely and, clearly, that is the moral of the story when it comes to expenditure on health. It is not quantity but quality in terms of spending your money wisely.

Now, I turn to our situation with the RHAs and so on. One of the problems that I have come to understand with the RHAs in terms of planning and how we spend money and so on, is that they have not really implemented studies or what we might call health needs assessment, to know exactly what the country requires on a given basis. So, in other words, for planning purposes, you need to have a stock taking and say, "Well, okay, what is it out there that we have to contend with today and what we will be contending with tomorrow, the day after or a year or two down the road?"

So, in other words, without proper health needs assessments based on data and solid research, what we have is the RHAs basically shooting in the dark, and basing their procurement and policies just by whim in terms of, "Well, this is what we had last year, so we might expect this much this year and then, perhaps, next year

too", and that is apparently how they operate rather than being on a more scientific basis by looking at the communities and assessing, what do we really need to put in place and what can we expect that will come our way in the way ahead and, perhaps, later on. So, we must have a proper plan as to what our health needs are based on—solid research and proper health needs assessment studies.

Another problem that I have come to understand is that there is a move afoot to implement modern health care information systems in our public health systems, and there is quite some concern about whether the RHAs are equipped to handle and manage this, even if the financing and all the equipment are put in place by the Government through the Ministry of Health, the RHAs themselves would have to be responsible, at the end of the day, for taking care and managing the system.

Given what we have seen within the RHAs in terms of the staffing and performance, we could have potential problems there as well. It is all well and good, as many of us know, from past experiences with computerization in the public service in many parts and even in some private businesses, you could put the best equipment there and spend a lot of money, but if the people do not buy into it and operate the system to the degree that is required, then you are just wasting money.

So, in many instances, we know that in the past when you computerized a particular department, sometimes the people go back and write everything down on paper as though the computers are not even there, and we have had that experience, and that is what causes a lot of wages and, of course, the people never bought into it and they never really learn to appreciate the use of the information technology.

Now, one of the major issues that has come up again and again, and it came up in the Lower House, that affects the functioning of the RHAs and our health care system—we cannot hide from it even though it is a very ticklish kind of issue, but it is a reality that we must confront and we must change—is the practice of having doctors in the public sector also maintaining their private practice. That is something that has to stop. I am saying it unequivocally.

I have heard many people argue that we cannot stop it, but I am certain that it has to stop, because what you are doing there—when you allow that, regardless of the reasons. I have heard some of the reasons advanced for doing so, and one of them being that if we only restrict specialist doctors and so on to work in the RHAs, then we would have to pay them an exorbitantly high salary for them to only work there. In other words, we will have to pay them something comparable to what they would have made in private practice otherwise they would leave.

My understanding of how things go right now is that there is so much wastage in the system based on how it is set up now. We pay many specialists just to be on call, and many times these specialists that we are paying this basic salary, which I understand is not small, but it is reasonable, many times they are not there and they just do not show up. They are at their private practice or they are somewhere else, and we call them in if there is a troublesome case or whatever. Very often, what happens more often than not is that they send the junior doctors to take care of people in the public hospitals and they take care of people in their private clinics.

Now, added to that, our taxpayers' money financed the payments of the private practice of these same doctors. How is that not the classic moral hazard problem? That is as big a moral hazard as you could ever get and it is clear cut. Apparently, what happens is that these doctors will say, "Well, okay, we do not have enough of this equipment or that equipment at Mount Hope Hospital or at the Port of Spain General Hospital and, therefore, we have to send the patient to a private clinic which, by chance, he might happen to have a part ownership in, just by accident, of course, and then the RHAs or the Ministry of Health foots the bill for the patients.

Now, how could you have something such as that? I mean, we know it exists and it has been in existence for a long time so it is nothing new that I am talking about. The point is, as I have said in many of my contributions, I am not really interested in who started it, but I am interested in ending the practice. So, in other words, what you have is a system where there is an incentive for the doctors to underperform in the public sector.

Based on the current contracts, they are paid whether they perform 10 surgeries or none. That is my next point. Apparently, they have never really implemented any performance criteria for doctors in the RHAs. It was supposed to be done in the switch-over from the Ministry of Health to the RHAs, but it has never been implemented. So, in other words, the specialist doctor shows up—in fact, sometimes he does not even show up—and he still gets paid the same amount.

At the end of the month, there is no accounting to say, "Well, okay, did you see a minimum of 200 patients or one or five?" How many surgeries did you do? There is nothing like that. So, the absurdity of that system cannot be ignored, and the people who argue that we cannot change that need to really look at it very carefully, because you cannot have the dual loyalty system continuing forever, it has to be stopped.

In all of the countries where we admire their public health systems like the Nordic countries—the Denmarks, the Swedens and Finlands and so on—this would not be allowed. If you are paying someone in a public hospital they have to be there, they cannot be somewhere else. That will never be allowed in all the countries we always boast about and say that we admire, and they have such wonderful health care system and we want to be like them. That would never be allowed.

If you are paying someone, especially the specialist, he or she has to be present and has to deliver. There must be some kind of performance-based criteria. Why would we, as a country, call for performance criteria for the police, teachers and everybody else and then exempt doctors from it? Does that really make any sense?

In fact, I was even informed that there was a clause in the doctors' contract that if someone was ill in his or her private practice while they were attending to someone at Mount Hope Hospital, they could leave and attend to their patient in the private sector. This was actually in the contract. I heard that for the first time when I looked into this matter. So, this is the kind of absurdity that exists in the system.

What you have, in addition to that, is that the junior doctors are the ones who you would see on the wards in Mount Hope Hospital and Port of Spain General Hospital and you hardly see the seniors. They will send them and say, "Okay, you go ahead and take care of the patients, and you have my cellphone so give me a call if you have a little problem there" and they are getting the big salaries. So you demotivate the juniors in the process as well. What happens frequently is that the juniors get fed up and they leave because the senior specialists, the senior doctors, block them from advancement and collect all the big money. So we have a problem within the system now.

Now, if you train the junior people and offer them proper salaries—now what I am saying is that if you keep them and restrict their trade to strictly working in the public hospital, of course, you must pay them more than what obtains now—you must pay them a reasonable level of compensation—but that could be arranged if we cut down on the wastage and the absenteeism of the senior doctors.

When you look at it, I am sure a lot of that $3-plus something billion that some of the speakers before mentioned that is spent in the health system, a lot of that goes on wages, and I would guess a significant amount to the senior doctors but, what do we get? Do we have any proper measurements of the RHAs? How do

they measure output? Do we say, okay, we spent X amount and we took care of X amount of patients this month and so on? If we put that in place then somebody will have to answer. I think Sen. Dyer-Griffith talked about proper management and so on, and that is one of the problems that continuously comes up in our debates when we talk about our national institutions lack of proper management.

7.40 p.m.

Madam Vice-President, when you put persons in management positions that are weak or have no performance evaluation criteria applied to them, then they sit back and just allow everything to happen.

If you look at the international setting, in the same countries with the high life expectancy and the proper health care systems, you put people to manage a hospital, they have to show results. Of course, the American system is somewhat brutal, in that those HMOs when they manage a hospital they do not play. You do not come up with the right numbers and you are out. Even big doctors that are highly qualified, and with tremendous experience, will get the boot, if they do not perform a minimum amount of operations. There must be proper guidelines.

From my understanding we are not getting the kind of output from our highly paid senior specialists. I am not saying that these people are necessarily bad or evil people. They are working in the system as they see it. It is allowed. There is no law to stop them as we frequently hear. In fact, they are not committing any serious violation. In fact, like I said, it is actually in their contract that they could do these things. I am saying that we have to change that. We have to get the strength and the will to deal with that problem, and pay specialists who will be resident on site in the hospitals to take care of patients, [*Desk thumping*] and not only allow them to be called up in cases of emergency.

From what I understand there could even be a reduction in the number of specialists required, if we go that way, and that is where the savings would come in. So you do not have to pay 20 people to be on call if you have one or two persons fully paid up, properly compensated, on site. So you might actually reduce your costs by going that way, contrary to what some people told me when they said, "We cannot change the system as it is, because we would have to pay these highly qualified doctors too much money to keep them in the public service."

Of course, the central problem is that they have an incentive to underperform. They would direct the patients to their private clinics. It is a classic case of having your cake and eating it too: you clean up on both sides. You get your steady

paycheck from the RHA and you make your mint on the side as well. Whether they are bad people or not, we do not care. The point is, as a country, successive Governments have not seen it fit to carry out the policy of changing that system, but at some point it has to be done. There is no way that could be sustained, absolutely not. Like I said, it is bad; it costs us a lot of money, and we have no proper measurement of output.

With these few words, I thank you.

Sen. Prof. Harold Ramkissoon: Madam Vice-President, fellow Senators, I am indeed pleased to take part or make a contribution to this debate on this Bill, which seeks to give permission to the RHAS to collectively purchase goods and services, if it is expedient and economical to do so. For a Bill that seems so simple, so straightforward, and so benign, I must admit the debate has been extensive, lively and interesting. My contribution will, by the way of an example, illustrate the need for us to be careful about the interface between the public and private sector.

This Bill is all about the purchase of goods and services, and that would involve partnership between the public and private sector. As I said, I want to illustrate the need for us to be very cautious when we have this kind of partnership. I ask for some latitude, Madam Vice-President, because I would probably stray from the topic from time to time, not very often. As my example, I want to focus on the area of cancer treatment. The goodly Sen. Deyalsingh focused on diabetes; I will focus on cancer.

Cancer is of great concern to all of us. It is perhaps ranked as the No. 4 killer in the country today. I have figures for the period 2003 and 2007 from the Cancer Registry, but they do not seem to have very updated figures. The number of cases for that period 2003—2007 is over 10,000: 10,724 cases. The number of deaths due to cancer in that period is over 6,000: 6,815 deaths. The numbers, I suspect, are on the increase. I have every reason to believe that the numbers are on the increase; so there is great concern about that.

Of equal concern, Madam Vice-President, is the lack of facilities and the lack of modern technology, modern machines and equipment to deal with the treatment of cancer. As far as I know, the major public treatment centre is the St. James Radiation Centre. My enquiries indicate the following: One, the staff at that centre are very hard-working, very dedicated, doing yeoman services very much against the odds. Two machines are outdated, overused and archaic, and anybody who has gone there would tell you this. The ratio of patients to doctors is extremely high; in other words, hundreds of patients on a regular basis and a handful of doctors.

The waiting time on any given day could be several hours, and many of the patients who go there are senior citizens. The seating accommodation is limited. I have been told that many have to stand for periods, and some of these are senior citizens who come from afar in the country. It is unbelievable that in this day and age records at that centre are still being kept manually. In this day and age, the information and technology age, we have a major centre keeping records manually. I was hoping that this Government would set a deadline by which all Government departments in the country would be computerized. If they have not done this yet, I think they need to set a deadline to ensure that all our public offices are computerized.

I know there are other centres that help with respect to the treatment of cancer: the San Fernando General Hospital, Sangre Grande General Hospital and also Tobago. They focus on chemotherapy. But we need, I believe, to set up some more oncology centres to take away the heavy load from the St. James Radiation Centre. So my recommendation is that we need to probably have one oncology centre in every regional health authority. I now want to move on to another centre.

Let me make the statement, preface my remarks by saying, that as a people we are not going to progress if we do not learn from the mistakes of the past. And now I move on.

Some of the patients from the public hospitals are referred to the Brian Lara Cancer Treatment Centre by the Government. I think they pay US $8,000 for each patient going to that centre. I shall refer to that centre in future simply as the Brian Lara Centre. I do not know if Brian Lara still wants that centre to be named after him, or if he wants to have his name removed from the centre.

Hon. Senator: "De stadium and all!"

Sen. Prof. H. Ramkissoon: I was intending, at some point in time when I had my first grandson, to call him Brian Lara, but I am having second thoughts about that.

So let us get back to the Brian Lara Cancer Treatment Centre. There is an arrangement for patients from the public sector or public institutions to go there at a cost to the taxpayers, which I think is about US $8,000. It does not seem to be too much. I do not know if that is a basic cost and you have to add to that. [*Interruption*] Per treatment, I have been told.

This is a case where you have the private sector providing health services for the Government. We all know of the case where 223 patients were over radiated at the Brian Lara Centre. According to the latest reports on the newspaper, the *Express* of last Sunday, out of those 223 patients, 91 of them have died, which is over 41 per cent.

For the sake of the public, I want to relate the sequence of events leading up to that which I call embarrassment. First let me say that radiation therapy is the treatment of cancer with the use of radiation emitting machines. The one at the Brian Lara Centre is a linear accelerator; in short it is called "linac". There is another one in the country, so there are two such machines in the country. These machines emit large amounts of radiation, the equivalent of 100,000 times the radiation from an X-ray. That gives you an idea of the exposure of radiation. It is therefore extremely important that we make regular checks on these machines on their calibration, to make sure everything is in order. It is imperative that we do this. The International Atomic Energy Agency insists that we do it every year. What went very wrong at the Brian Lara Centre?

In-depth, exhaustive annual checks on the calibration were supposed to be done annually at the centre. The machine was commissioned in 2007. In 2008, the annual rigorous check was done. In 2009, no such tests took place—case No. 1 of gross negligence. There is another test, and this is a less rigorous test. It is carried out by the International Atomic Energy Agency. This is the procedure: they send you a test system; you expose it to radiation from your machine, a specified amount and then you take that and you send it to the centre in Vienna and they verify if in fact that was the amount they received. This is how it works.

In 2009, through PAHO—we could not do it ourselves, because Trinidad and Tobago is not a member of the International Atomic Energy Agency; and I will come to that again.

7.55 p.m.

So, through PAHO a sample was sent. In 2009, PAHO facilitated the exercise, and it was found that there was an overdose of 15 per cent. The error was 15 per cent on the plus side. There is an error limit of plus or minus 5 per cent. What this says is that the radiation was in excess of somewhere between 10 per cent and 20 per cent. If you take the limit of 20 per cent, in terms of X-rays, it meant that it had an equivalent effect in terms of radiation of 20,000 X-rays; that was the extent of the overexposure of over radiation. In 2010, the centre then carried out the rigorous test, and it was in fact discovered that there was a miscalibration.

So, there were three, what I call, cases of negligence: the first one was no testing was done in 2009; the second one was when it was sent through PAHO and a less rigorous test was done; and they found the error, and the Brian Lara Centre ignored the warning.

The procedure at the International Atomic Energy Agency is the following: if you do a test and there is something to worry about, something to concern people about, they send another test, and that is expected, and ask you to repeat the test. So, they sent a second test system to the Brian Lara Centre, and you know what happened? They ignored the second test system, they did not simply carry out the second test. So, there were three major areas of negligence.

In 2010, when the second rigorous test was done—the first was done in 2008, none in 2009, and then the third one was done in 2010—when that was done, and it confirmed what the IAEA suspected, you know what they did to the person who was in charge, or who carried out the test for them locally? A highly trained medical physicist; you know what they did, when he confirmed the errors? They ignored the message and they shot the messenger; they fired the gentleman. They fired the gentleman.

Madam Vice-President, the deaths of those 91 people under these circumstances, borders on criminal negligence. In any other country you know what would have happened? They would have revoked the licence of the Brian Lara Centre. That licence was given by the Ministry of Health who should have been supervising the centre very closely. In any other country the Brian Lara Centre would have lost its licence, and the director and board members would have had to face criminal charges. [*Desk thumping*]

Hon. Senator: Who were the directors and consultants?

Sen. Prof. R. Ramkissoon: Due to public pressure, the Government requested help once more from the highly respected International Atomic Energy Agency in 2011. They sent down a team of five specialists to carry out an investigation with a narrow frame of reference. [*Crosstalk*] Yes, Madam Vice-President, as I was saying, the Government approached the International Atomic Energy Agency and asked that the team of specialists be sent down to look into this matter. A report was made available to the Trinidad and Tobago Government in January 2012, and that report is yet to be released officially by the Government.

ADJOURNMENT

The Minister of Public Utilities (Sen. The Hon. Emmanuel George): Madam Vice-President, we had agreed that we would conclude this debate this evening at eight o'clock, and while regretfully I stand to interrupt my colleague, the goodly Senator, I think that my advice is that if we want to go beyond eight o'clock I will have to move another Motion, which I do not want to do.

With due apologies to my colleague, Sen. Prof. Ramkissoon, I beg to move that this Senate do now adjourn to Tuesday, April 24, 2012 at 1.30 p.m., when the Senate will debate the Motion brought by Independent Senator Corinne Baptiste-McKnight, regarding the establishment of tangible memorials in recognition of the work and contribution of former Prime Ministers and Presidents of the Republic of Trinidad and Tobago. Thank you.

Madam Vice-President: Hon. Senators, just for note, Sen. Prof, Ramkissoon, you do have 28 minutes remaining of your original time when we resume the debate.

Question put and agreed to.

Senate adjourned accordingly.

Adjourned at 8.02 p.m.