SENATE

Tuesday, November 18, 2014

The Senate met at 1.30 p.m.

PRAYERS

[MR. PRESIDENT *in the Chair*]

LEAVE OF ABSENCE

Mr. President: Hon. Senators, I have granted leave of absence to Sen. David Small, who is out of the country.

SENATOR'S APPOINTMENT

Mr. President: Hon. Senators, I have received the following correspondence from His Excellency The President, Anthony Thomas Aquinas Carmona, S.C., O.R.T.T.:

"THE CONSTITUTION OF THE REPUBLIC OF TRINIDAD AND TOBAGO

By His Excellency ANTHONY THOMAS AQUINAS CARMONA, O.R.T.T., S.C., President and Commander-in-Chief of the Armed Forces of the Republic of Trinidad and Tobago.

/s/Anthony Thomas Aquinas Carmona O.R.T.T., S.C.
President

TO: MR. TAUREL SHRIKISSOON

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

NOW, THEREFORE, I, ANTHONY THOMAS AQUINAS CARMONA, President as aforesaid, in exercise of the power vested in me by section 44(1)(a) and section 44(4)(c) of the Constitution of the Republic of Trinidad and Tobago, do hereby appoint you, Taurel Shrikissoon, to be temporarily a member of the Senate, with effect from 18th November, 2014 and continuing during the absence from Trinidad and Tobago of the said Senator David Small.

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 November, 2014."

OATH OF ALLEGIANCE

Senator Taurel Shrikissoon took and subscribed the Oath of Allegiance as required by law.

CONDOLENCES

(MR. MICHAEL MANSOOR)

Mr. President: Hon. Members, as you are aware the former Sen. Michael Mansoor passed away on November 11, 2014. Tributes will be paid to him later in the proceedings, following which we will have one minute of silence.

APPOINTMENTS TO JOINT SELECT COMMITTEES

Mr. President: Hon. Members, I have received the following correspondence from the Speaker of the House with regard to the appointment of members of Joint Select Committees.

"November 11, 2014

Sen. The Hon. Timothy Hamel-Smith

President of the Senate…

Appointments to Joint Select Committees

At a sitting held on Friday November 7, 2014, the House of Representatives agreed to resolutions for the appointment of Members to serve with an equal number from the Senate on the following Joint Select Committees:

1. The Joint Select Committee on Public Administration and Appropriations:

Mr. Wade Mark, MP	Chairman
Mrs. Carolyn Seepersad-Bachan, MP	Member
Mr. Rudranath Indarsingh, MP	Member
Dr. Keith Rowley. MP	Member
Miss Marlene Mc Donald, MP	Member

2. The Joint Select Committee on National Security:

Mr. Errol Mc Leod, MP	Member
Mr. Prakash Ramadhar, MP	Member
Mr. Collin Partap, MP	Member
Dr. Keith Rowley, MP	Member
Miss Donna Cox, MP	Member"

I am advised that members of those committees will decide who will be the chairman along with the others. The first appointment really is a fixed appointment as to chairman.

"3. The Joint Select Committee on Energy Affairs:

Mr. Stephen Cadiz, MP	Member

	Mrs. Carolyn Seepersad-Bachan, MP	Member
	Dr. Delmon Baker, MP	Member
	Dr. Keith Rowley, MP	Member
	Mr. Colm Imbert, MP	Member
4.	The Joint Select Committee on Foreign Affairs:	
	Mr. Winston Dookeran, MP	Member
	Dr. Surujrattan Rambachan, MP	Member
	Mrs. Vernella Alleyne-Toppin, MP	Member
	Mrs. Paula Gopee-Scoon, MP	Member
	Mr. NiLeung Hypolite, MP	Member
5.	The Joint Select Committee on Human Rights, Diversity, the Environment and Sustainable Development:	
	Mr. Nizam Baksh, MP	Member
	Miss Ramona Ramdial, MP	Member
	Mr. Rodger Samuel, MP	Member
	Mr. Fitzgerald Jeffrey, MP	Member
	Ms. Alicia Hospedales, MP	Member
6.	The Joint Select Committee on Parliamentary Broadcasting:	
	Mr. Wade Mark, MP	Chairman
	Dr. Roodal Moonilal, MP	Member
	Mr. Chandresh Sharma, MP	Member
	Mr. Terrence Deyalsingh, MP	Member
	Ms. Joanne Thomas, MP	Member
7.	The Joint Select Committee on Government Assurances:	
	Mr. Wade Mark, MP	Vice-Chairman
	Dr. Tim Gopeesingh, MP	Member

Dr. Lincoln Douglas, MP	Member
Dr. Amery Browne, MP	Member
Mrs. Patricia Mc Intosh, MP	Member

8. The Joint Select Committee on Election Campaign Financing:

Mr. Wade Mark, MP

Dr. Roodal Moonilal, MP

Mr. Prakash Ramadhar, MP

Mr. Clifton De Coteau, MP

Mr. Colm Imbert, MP

Miss Marlene Mc Donald, MP

9. The Joint Select Committee appointed to consider the Legislative Proposal entitled, "The Draft Houses of Parliament Service Authority Bill, 2014":

Mr. Wade Mark, MP	Member
Ms. Nela Khan, MP	Member
Dr. Rupert Griffith, MP	Member
Mr. Colm Imbert, MP	Member
Miss Marlene Mc Donald, MP	Member

At that same sitting, the House of Representatives also agreed that Mr. Jairam Seemungal, MP, be appointed to serve as a member of the Public Accounts Committee.

Accordingly, I respectfully request that you cause this matter to be placed before the Senate at the earliest convenience.

Respectfully,

Hon. Wade Mark, MP

Speaker of the House"

PAPERS LAID

1. Annual Audited Consolidated Financial Statements of the Petroleum Company of Trinidad and Tobago Limited for the year ended September 30, 2013. [*The Minister of Finance and the Economy* (*Sen. The Hon. Larry Howai*)]
2. Annual Report and Audited Financial Statements of the Regulated Industries Commission for the year ended December 31, 2011. [*Sen. The Hon. L. Howa*i]
3. Annual Report and Audited Financial Statements of the Regulated Industries Commission for the year ended December 31, 2012. [*Sen. The Hon. L. Howa*i]
4. Audited Financial Statements of Export Centres Company Limited for the financial year ended September 30, 2010. [*Sen. The Hon. L. Howa*i]
5. Audited Financial Statements of Export Centres Company Limited for the financial year ended September 30, 2011. [*Sen. The Hon. L. Howa*i]
6. Consolidated Financial Statements of the National Gas Company of Trinidad and Tobago Limited for the year ended December 31, 2013. [*Sen. The Hon. L. Howa*i]
7. Annual Audited Financial Statements of Caribbean New Media Group Limited for the year ended December 31, 2012. [*Sen. The Hon. L. Howa*i]
8. Annual Audited Financial Statements of Caribbean New Media Group Limited for the year ended December 31, 2013. [*Sen. The Hon. L. Howa*i]

9. Annual Audited Financial Statements of National Schools Dietary Services Limited for the financial year ended September 30, 2010. [*Sen. The Hon. L. Howa*i]
10. Report of the Auditor General of the Republic of Trinidad and Tobago on a Special Audit of the School Nutrition Programme managed by the National Schools Dietary Services Limited. [*Sen. The Hon. L. Howa*i]
11. Second Report of the Auditor General of the Republic of Trinidad and Tobago on the Financial Statements of the Chaguaramas Development Authority for the year ended September 30, 2000. [*Sen. The Hon. L. Howa*i]
12. Audited Financial Statements of the Tourism Development Company Limited for the financial year ended September 30, 2011. [*Sen. The Hon. L. Howa*i]
13. Annual Administrative Report of the Livestock and Livestock Products Board (LLPB) for the year October 2008 to September 2009. [*The Minister of Food Production* (*Sen. The Hon. Devant Maharaj)*]
14. Annual Administrative Report of the Livestock and Livestock Products Board (LLPB) for the year October 2012 to September 2013. [*Sen. The Hon. D. Maharaj*]
15. Annual Administrative Report of the Arima Borough Corporation for the year October 2012 to September 2013. [*The Minister of Local Government* (*Sen. The Hon. Marlene Coudray*)]
16. Administrative Report of the Penal/Debe Regional Corporation for the period October 2007 to September 2008. [*Sen. The Hon. M. Coudray*]

17. Administrative Report of the Penal/Debe Regional Corporation for the period October 2008 to September 2009. [*Sen. The Hon. M. Coudray*]
18. Administrative Report of the Penal/Debe Regional Corporation for the period October 2009 to September 2010. [*Sen. The Hon. M. Coudray*]
19. Administrative Report of the Penal/Debe Regional Corporation for the period October 2010 to September 2011. [*Sen. The Hon. M. Coudray*]
20. Administrative Report of the Couva/Tabaquite/Talparo Regional Corporation for the period October 2009 to September 2010. [*Sen. The Hon. M. Coudray*]
21. Administrative Report of the Couva/Tabaquite/Talparo Regional Corporation for the period October 2010 to September 2011. [*Sen. The Hon. M. Coudray*]
22. Administrative Report of the Couva/Tabaquite/Talparo Regional Corporation for the period October 2011 to September 2012. [*Sen. The Hon. M. Coudray*]
23. Administrative Report of the Couva/Tabaquite/Talparo Regional Corporation for the period October 2012 to September 2013. [*Sen. The Hon. M. Coudray*]
24. Ministerial Response to the Fourteenth Report of the Joint Select Committee appointed to inquire into and report to Parliament on Municipal Corporations and Service Commissions on a Review of the Administration of the San Fernando City Corporation. [*Sen. The Hon. M. Coudray*]
25. Response of the Public Service Commission to the First Report of the Joint Select Committee appointed to inquire into and report to Parliament on Municipal Corporations and Service Commissions on

an evaluation of the Service Commissions. [*The Vice-President* (*Sen. James Lambert*)]

1.45 p.m.

26. Response of the Police Service Commission to the First Report of the Joint Select Committee appointed to inquire and report to Parliament on Municipal Corporations and Service Commissions on the Evaluation of the Service Commissions. [*Sen. J. Lambert*]
27. Response of the Public Service Commission to the Fifth Report of the Joint Select Committee appointed to inquire and report to Parliament on Municipal Corporations and Service Commissions on a re-evaluation of the efficiency and effectiveness of the Public Service Commission. [*Sen. J. Lambert*]
28. Administrative Report of the Tobago House of Assembly for the year 2013. [*Sen. The Hon. G. Singh*]
29. Trinidad and Tobago Millennium Development Goals Report 2014. [*The Minister of Planning and Sustainable Development (Sen. The Hon. Dr. Bhoendradatt Tewarie)*]

JOINT SELECT COMMITTEE REPORTS

(Presentation)

Ministries (Group 2) Statutory Authorities and State Enterprises

Sen. Dr. Victor Wheeler: Mr. President, I have the honour to present the following reports as listed on the Supplemental Order Paper in my name:

National Commission for Self Help Limited

Sixteenth Report of the Joint Select Committee appointed to inquire into and report to Parliament on Ministries (Group 2) Statutory Authorities and State Enterprises on the Administration and

Operations of the National Commission for Self Help Limited.

Trinidad and Tobago Blind Welfare Association

Seventeenth Report of the Joint Select Committee appointed to inquire into and report to Parliament on Ministries (Group 2) Statutory Authorities and State Enterprises on the Administration and Operations of the Trinidad and Tobago Blind Welfare Association.

PUBLIC ACCOUNTS COMMITTEE REPORTS

(Presentation)

Sen. Dr. Dhanayshar Mahabir: Mr. President, I have the honour to present the following reports as listed on the Supplemental Order Paper in my name:

Regulated Industries Commission

Fifth Report of the Public Accounts Committee on the Audited Financial Statements of the Regulated Industries Commission (RIC) for the years ended September 30, 2008—2010.

Trinidad and Tobago Electricity Commission

Sixth Report of the Public Accounts Committee on the Audited Financial Statements of the Trinidad and Tobago Electricity Commission (T&TEC) for the years ended September 30, 2008, 2009 and 2011.

ORAL ANSWERS TO QUESTIONS

The Minister of the Environment and Water Resources (Sen. The Hon. Ganga Singh): Mr. President, thank you. With your leave, the Government is in a position to answer questions Nos. 1, 2 and 3 and we ask for a deferral of question No. 18 for two weeks.

The following question stood on the Order Paper in the name of Sen. Avinash Singh:

Vehicle Management Corporation of Trinidad and Tobago
(Details of Management Positions)

18. With respect to the Vehicle Management Corporation of Trinidad and Tobago, could the hon. Minister of Transport please advise this Senate on:

(a) whether the CEO contract at VMCOTT was terminated by the new Chairman of the Board; if so, on what basis was it done;

(b) whether the Chief Operating Officer position at VMCOTT was in existence prior to 2010;

(c) whether the Chairman of VMCOTT is an Executive Chairman; and

(d) whether the Managers at VMCOTT met the minimum qualifications for their positions?

Question, by leave, deferred.

Agricultural Development Bank Buildings
(Details of)

1. **Sen. Camille Robinson-Regis** asked the hon. Minister of Food Production:

As it relates to buildings occupied by the Agricultural Development Bank (ADB), would the Minister indicate:

(a) the number of buildings used by the Agricultural Development Bank (ADB) for administrative purposes, and their locations;

(b) whether the ADB is the owner of this/these buildings;

(c) if the answer to part (b) is in the negative, would the Minister indicate the number of such buildings occupied under lease agreements, their locations, when leased, the lease rent in each case and whether the ADB is in occupation;

(d) whether the ADB has any plan or has taken any decision to sell any of its real estate assets, and if so, which such assets;

(e) in respect of (c) has the ADB spent or is spending any money to render any leased property fit for the purpose for which it has been leased; and

(f) if the answer to (e) is in the affirmative, how much has been spent in each case and how much more is expected to be spent in each case?

The Minister of Food Production (Sen. The Hon. Devant Maharaj): With regards to part (a), there are five buildings that are currently occupied by the ADB for its administrative purposes. These include the head office at 87 Henry Street, Port of Spain; the central branch office at 29 Ramsaran Street, Chaguanas; the east branch office, LP No. 917 Eastern Main Road, Sangre Grande; the south branch office at No. 7 Cipero Street, San Fernando; and Tobago branch office, Corner Young and Robinson Streets, Scarborough.

Part (b), the ADB is the owner of two of these buildings which are the head office and its Tobago branch office.

Part (c), the number of buildings occupied under lease arrangements are four—three, sorry. They are: the central branch office, 29 Ramsaran Street, Chaguanas; It was leased on August 25, 2009; the lease rent is $23,460 and it is occupied. The east branch office at Sangre Grande; March

19, 2009, $26,000l; and it is occupied. The south branch office at Cipero Street, San Fernando on July 01, 1985; $14,000; and it is occupied. There is no plan or any decision to sell any of the ADB real estate.

Part (e), in terms of spending money to lease and so on, does not apply and, similarly, part (f).

Thank you very much. [*Desk thumping*]

Agricultural Development Bank

(Details of Loans)

2. Sen. Camille Robinson-Regis asked the hon. Minister of Food Production:

A. Would the Minister indicate whether the Agricultural Development Bank has granted any unsecured loans for the period 1st November, 2010, to the present date?

B. If the answer to (A) is in the affirmative, could the Minister indicate:

(i) the total amount of the unsecured loan portfolio and the number of loans?

(ii) whether any such loan has been granted for non-agricultural purposes and if so, how many?

(iii) could the Minister indicate whether any of these unsecured loans are in arrears and by how many months?

The Minister of Food Production (Sen. The Hon. Devant Maharaj): Mr. President, with regard to the ADB granting unsecured loans for the period 2010 to the present date, in August 2011, the bank approved a loan product by the name of Reaping Opportunities Loan, hereafter called ROL. The loan was developed and approved as an unsecured loan to a maximum value of

$50,000, and was a short-term loan up to the maximum of 36 months which was geared towards individuals involved in farming who were members of a major farming association and were economically challenged. Security was a promissory note.

Individuals were required to submit a letter of recommendation from the major farming associations, that is, the Agricultural Society of Trinidad and Tobago, the National Food Crop Farmers Association and the Tobago District Agricultural Society. The product was launched on a pilot basis and has since been discontinued to assess its performance and address any shortcomings.

The total amount of unsecured loan portfolio and the number of loans: there is a principal balance outstanding of $3,179,629 and 104 Reaping Opportunities Loans were issued. These loans were secured by a promissory note as indicated above.

All loans were agricultural related as a key element of the loan and recommendations and monitoring from the main farming associations. Fifty-three of these loans are in arrears and are aged as follows:

seven loans, 1 to 30 days;

seven loans, 31 to 60 days;

seven loans, 61 to 90 days;

four loans, 91 to 180 days;

four loans, 181 to 270 days; and

24, over 270 days.

Thank you.

Sen. Robinson-Regis: Supplemental, please, Mr. President. Minister, would you be able to indicate when this was discontinued and also if the

assessment has been completed?

Sen. The Hon. D. Maharaj: The loan was discontinued earlier this year, so that is 2014, and the assessment is continuing right now. We have looked at the value of the aged loans that are in arrears, and we have a total value of approximately $812,973 in arrears in terms of the loans I just indicated, but that includes loans that fall under the 1 to 30 days and 31 to 60 days.

Sen. Robinson-Regis: Further supplemental, please, Mr. President. Minister, would you be able to indicate whether a system has been put in place, given that an assessment is taking place to recoup these loans?

Sen. The Hon. D. Maharaj: Yes, Mr. President, the bank is taking all the necessary steps, including legal avenues to recoup the loans, but the loans that are under 90 days are normally paid within a reasonable point in time, given the type of crop that is involved.

The assessment process is ongoing because we have to look at the utilization of the loan because we have had reports of one or two persons, not the majority, as you indicated. You would have seen that a overpayment of over $3.1 million, we have a loan arrears of $800,000. Some of the loans were used for—while it was applied for agriculture, it may have been utilized otherwise, and this forms part of the assessment.

Agricultural Development Bank
(Details of Administration)

3. **Sen. Camille Robinson-Regis** asked the hon. Minister of Food Production:

With regard to the administration of the Agricultural Development Bank (ADB), could the Minister kindly indicate to this Senate:

(a) whether a Board of Directors of the ADB is now in place;

(b) whether the ADB has a full complement of managerial staff in accordance with the ADB's most recent Human Resource Structure/Establishment plan and whether they are all in active service;

(c) if the answer to (b) is in the negative would the Minister indicate why not, and whether there are plans to rectify this situation?

The Minister of Food Production (Sen. The Hon. Devant Maharaj): With regard to the ADB board, yes a board of directors is in place and is duly constituted with seven members inclusive of the chairman. The bank does not have a full complement of managerial staff in accordance with its most recent human resource establishment structure. The bank does not have a full complement of managerial staff due to resignation of two members. However, the bank is in the process of rectifying this situation by advertising the vacancies, and the recruitment process to select a suitable candidate to fill these positions is ongoing presently.

In the interim, two managers within the respective departments are currently acting in the positions to ensure continuity.

Thank you.

Sen. Robinson-Regis: Supplemental please. Minister, would you be able to indicate what are the two vacancies?

Sen. The Hon. D. Maharaj: Yes. The two vacancies are: the Corporate Manager, Finance and IT; the person resigned on September 25, 2014. And the position of Corporate Manager, Human Resources, the person resigned on April 25, 2014.

STATEMENT BY MINISTER

Waste Water Rehabilitation Project

The Minister of the Environment and Water Resources (Sen. The Hon. Ganga Singh): Thank you, Mr. President. [*Desk thumping*] Mr. President, it gives me great pleasure to address this honourable Senate after having witnessed the signing ceremony yesterday for two major contracts worth TT $1.3 billion, part of the multiphase waste water rehabilitation loan from the Inter-American Development Bank to be executed by the Water and Sewerage Authority.

Mr. President, with your permission, I would like to delve into this historic matter for a brief moment. Governments of countries which were parties to the UN Millennium Declaration are focusing on the development of water supply and sanitation sectors, which translate to the "Right to access potable water and sanitation services".

This People's Partnership administration, under the leadership of the hon. Prime Minister, Kamla Persad-Bissessar, consistent with the UN millennium development goals, has articulated in its manifesto, "Water Security, Protection of Water and Catchment Sources and Protection of the Environment".

2.00 p.m.

The Water and Sewerage Authority, through its line Ministry, the Ministry of the Environment and Water Resources is the responsible agency for executing the Government's mandate in the water and waste water sector towards fulfilling the Government's vision. In 2010, when this Government took office, the national coverage for waste water was 30 per cent of the population—had access to centralized waste water systems, while only 18

per cent of the population in Trinidad had a 24/7 water supply. Today, under this People's Partnership Government, significant strides have been made in the area of water services with new water sources being developed, a national transmission grid being constructed, as well as the rehabilitation of existing pipelines, water treatment plant and extension of distribution pipelines.

Mr. President, over 110 kilometres of transmission pipelines were laid over the last four years, including Navet, Hollis, and the dualling of the Caroni South Trunk Main. Over 800 kilometres of distribution pipes have also been laid throughout the past four years, and I am advised that 69 per cent of the population in Trinidad is now receiving a 24/7 water supply as against a mere 18 per cent in 2010 when we assumed office. Seventy per cent of Tobago's population is currently receiving a 24/7 water supply.

Mr. President, over the last four years, Trinidad and Tobago has made significant strides towards achieving developed-nation status. Development may be defined as good infrastructure, universal education, reliable communication, access to health care and sanitation services and, most importantly, the development of a workforce with managerial, technical and vocational skills. This Government is working for the benefit of the people of Trinidad and Tobago holistically, with works being done all over the country. This development includes the expansion of our road network, including highways and secondary schools, houses are being built for both middle and low income groups, new hospitals and training facilities and schools are under construction, and water and waste water services are being expanded—just to name a few of the sectors where works are very visible.

Mr. President, development requires astute leadership, both at the

political and institutional levels, and creative and out-of-the-box thinking. This Government understands the concept of building a developed nation, and not only has established sustainable plans, but focuses on a balanced and equitable allocation of resources across the east, south, north, west and Tobago, and has permitted and supported institutions to seek funds from other sources where possible.

Mr. President, it must also be noted as well that proper sanitation and sanitation services is of key importance to the Government of Trinidad and Tobago as articulated in its manifesto, "Framework for Sustainable Development: Initiatives for a Secure, Prosperous and Sustainable Nation". Consistent with Government's pledge, a consultant was engaged under a technical cooperation agreement with the Inter-American Development Bank and the following catchments were identified as priority areas based on technical, environmental, economic and social considerations: Port of Spain, Maloney, Malabar, San Fernando, Chaguanas, Couva, South West Tobago and Scarborough.

It is to this end that on January 19, 2013, this Government entered into an agreement with the Inter-American Development Bank for phase one of a multiphase waste water rehabilitation loan in the amount of US $246.5 million. This loan is multiphased with a total value of US $546.5 million. Complete new waste water systems will be constructed in Malabar and San Fernando. Maloney has also been identified for major works under another loan from the IDB. The Water and Sewerage Authority as the executing agency has satisfied all the IDB conditions in record time for this first phase leading up to the award of these works contracts, and, as a result, the IDB has increased its lending portfolio with a US $120 million loan for drainage

works in Port of Spain.

Mr. President, this multiphase waste water loan represents the single largest loan disbursement in the English-speaking Western Hemisphere by the IDB and the single largest investment in waste water in the history of Trinidad and Tobago. [*Desk thumping*] Over 200,000 persons will benefit from improved waste water services in the Malabar and San Fernando catchments on completion of this programme. It must be noted that no other Government in the history of Trinidad and Tobago has provided such a concrete commitment to the preservation and development of our water and waste water sector, and our environment.

This major initiative must be seen in the context of this Government's overall development plans for all sectors of the country, benchmarking the services to the best in class in the developed world. Looking back to the water sector in 2010, this Government inherited an aged and leaking transmission and distribution network, deteriorating water treatment plants with low operating efficiency, the lack of an aggressive leak management plan and an unfavourable habit of little investment in development of new water sources and little or no investment in waste water services.

As I indicated, Mr. President, there was low sewer coverage of 30 per cent and a minimum investment in expansion and maintenance of existing sewer network. There was a massive deterioration of critical sewer pipelines and key waste water treatment plants in San Fernando, Arima and Scarborough. There was no policy on the development of waste water treatment plants which led to over 200 waste water facilities, meaning over 200 facilities being abandoned by private developers, posing a serious threat to the environment and public health.

In 2010, WASA was overstaffed with 17 employees per 1,000 paying customers as compared to five to eight in efficient water institutions, while it was stuck with an operating deficit of $1.23 billion. Fast-forward to present day, Mr. President: through astute local leadership over the past four years, WASA is the best-performing institution in the Caribbean in satisfying loan conditions for accessing IDB loans and was rated seven out of 10 by IDB in working towards meeting the criteria for lending. [*Desk thumping*]

Mr. President, customer service levels at WASA continue to improve. WASA has achieved 97 per cent of its mandate to provide all customers connected to the network with a water supply of a minimum of two days per week. The authority's initiatives to improve customer care resulted in the MORI poll showing in May/June, 2011, a 67 per cent customer satisfaction rating. [*Desk thumping*] This is a 30-percentage-point increase over the comparative period. The poll showed us 56 per cent reduction in negative reporting on WASA and an overall 33 per cent drop in media reports mentioned on a negative side. This is indicative of an improvement in the authority's programme of delivery.

However, over the years priority has been given to water supply services by previous Governments and waste water development was neglected, but, Mr. President, today, this People's Partnership Government, under the leadership of our hon. Prime Minister, Kamla Persad-Bissessar, is committed to shifting that paradigm for Trinidad and Tobago towards sustainable development and eliminating years of inertia and stagnation. To this end, two major contracts under phase one of a multiphase waste water rehabilitation loan in the amount of US $246.5 million were signed on Monday, November 17, 2014: one, for the construction of the Malabar waste

water treatment plant and collection system at a total cost of TT $620 million with Sinohydro Corporation of China; secondly, for the construction of the San Fernando waste water treatment plant and collection system at a total cost of TT $654 million with a joint venture comprising Acciona Agua SAU and Atlatec SA.

Mr. President, throughout the procurement process for these contracts, the Inter-American Development Bank procurement guidelines were followed, including prequalification and tendering. The evaluation was done by a core multifunctional voting team and present were non-voting members, including a consultant financed by the Inter-American Development Bank. Transparency and objectivity were of paramount importance and a no-objection had to be received from the IDB at various stages of the procurement cycle, including procurement for those services described below.

The supervision contract to AECOM to the aforementioned works. Secondly, Deloitte Touche as the financial auditors. Thirdly, SAFEGE, the lead firm; Corporate Solutions Consulting Limited, a partner; and Aquatech Engineering, sub-consultant for the provision for corporate governance services. Fourthly, General Earth Movers Limited for the construction of an access road and bridge at the site of the San Fernando plant.

Mr. President, with this historic contract signing on Monday, November 17, 2014, this Government has pledged its commitment to constructing modern waste water systems in San Fernando and Malabar, and the continuation of waste water development which we initiated some 15 years ago in a previous incarnation. When all three phases of the IDB multiphase waste water rehabilitation loan are completed over an eight-year

period, it is projected that the population connected to centralized systems will increase from 30 per cent to 44 per cent, and, more so, meet and exceed the stringent Water Pollution Rules set by the Environmental Management Authority for effluent discharges.

Mr. President, in keeping with the best-practice sustainable development, the multiphase waste water rehabilitation loan has also provided for the institutional strengthening of WASA by virtue of training in contract management for outsourced services, operations and maintenance, and environmental management and development of corporate governance services at the Water and Sewerage Authority. WASA's corporate governance development is aimed at development of comprehensive governance policies, improvement of the current information management policies and disclosure practices, training on risk management and controls systems, an establishment of a financial statements team to strengthen auditing and internal control practices, and a corporate governance structure aimed at a new corporatization model of self-reliance and policies that will attract investors and encourage strategic alliances and partnerships.

Another key action is the improvement of commercial management services by supporting the purchase, installation, integration and implementation of a new billing system. Mr. President, all of the above expresses the confidence which the Inter-American Development Bank has both in WASA and in the People's Partnership management of the water and waste water sector. It is noteworthy that under this Government, projects would benefit persons not only in Port of Spain and environs, but across the nation in keeping with our manifesto theme of sustainable nation-building.

The collective effort of all these initiatives is that the population can

look forward to improved standards of living and the protection and enhancement of the environment and public health. Mr. President, with these few words, I thank you. [*Desk thumping*]

CREDIT UNIONS BILL, 2014

Bill to provide for the regulation of the financial business activities of all credit unions and secondary bodies carrying on the business of a credit union and for matters related thereto [*The Minister of Finance and the Economy*]; read the first time.

CO-OPERATIVE SOCIETIES (AMDT.) BILL, 2014

Bill to amend the Co-operative Societies Act, Chap. 81:03 [*The Minister of Finance and the Economy*]; read the first time.

Mr. President: The Leader of Government Business.

ARRANGEMENT OF BUSINESS

The Minister of the Environment and Water Resources (Sen. The Hon. Ganga Singh): Thank you, Mr. President. Mr. President, notwithstanding Standing Order 20(2), I beg to move that the Senate consider Private Business instead of Government Business.

Agreed to.

Mr. President: Sen. Dr. Victor Wheeler. [*Desk thumping*]

REGIONAL HEALTH AUTHORITY SYSTEM
(COMPREHENSIVE REVIEW OF)

Sen. Dr. Victor Wheeler: Mr. President, I beg to move the following Motion standing in my name:

Whereas prior to the introduction of the Regional Health Authorities it was recognized that the centralized approach to the management of

the public health sector had resulted in allocative inefficiencies, limited managerial capacity and limited authority at the local level;

And whereas in 1994, the Government of Trinidad and Tobago introduced a comprehensive health sector reform programme to address the institutional constraints that have frustrated many of the previous efforts at improving the delivery of public health care;

And whereas these reforms resulted in administrative decentralization of the health sector through the establishment of autonomous Regional Health Authorities governed by statutory non-executive boards supported by executive management teams;

And whereas in spite of significant increases in annual expenditure in the health sector, there still remains numerous problems with the delivery of health care;

Be it resolved that the Senate call on the Government to take immediate steps to conduct a comprehensive review of the Regional Health Authority system in the delivery of health care in Trinidad and Tobago.

2.15 p.m.

Mr. President, I just want to give a background of the state of delivery of health care, prior to the introduction of the Regional Health Authority system.

Prior to 1994, the Ministry of Health was responsible for the delivery of health care. In the hospital there was the position of the Hospital Medical Director, who was usually a doctor who was in charge of all the services in the hospital. He was responsible for the doctors, the nurses, the laboratory, X-ray, all the clinical services. There was also a position of Hospital

Manager that reported to the Hospital Medical Director, and the hospital manager was responsible for the plant: the building itself and also the staff that was responsible for maintaining the hospital: the daily paids, engineering staff, maintenance staff and cleaners, also the kitchen and the attendants. Those staff reported to the Hospital Manager and he reported to the Hospital Medical Director.

With respect to the community services, that is the health centres, it was the position of County Medical Officer of Health, another senior doctor who had all the various persons in the local health centre and the community services reporting to him or her. So you had county health visitors, district health visitors and medical officers. The County Medical Officer of Health was also responsible for public health, and there were also some other services such as dental services and HIV. During that time, before the Regional Health Authority system, there was one union representing the health workers, the Public Services Association.

Why was it necessary to change the provision of health care? This was really because there were problems identified under the centralized control of the Ministry of Health. I refer to a document here, Health Reform in Trinidad and Tobago: lessons for the Pacific islands? Pacific Health Dialog, Vol. 4. No. 1, where some of these problems in the delivery of health care in Trinidad and Tobago prior to the introduction of the Regional Health Authority system were identified, I will just list some of them: over centralized control; the central level was bogged down with operational details; there was little strategic planning at the central level; there were allocative inefficiencies; not able to shift resources from one hospital to the other sector. The cost during that time, even a simple thing as what was the

cost of health care, was not known.

During that time as well, this is prior to 1994, the funding or the financing of the public health sector was inadequate. With respect to those in charge of the health sector, Hospital Medical Director, County Medical Officer of Health, there was not enough training that was being done then in health management. At that time the complaint was the wages were low, there was lack of management information systems and there was also little planning done at the local level.

The effect of this, Mr. President, was that there was poor planning in the execution of projects. For example, a decision would be made to start a service in a new building; the capital expenditure would be made, the equipment would be purchased, staff hired, but there was no consideration for consumables. So you would have the service start, and then when the supplies that were purchased with that capital expenditure was finished, the service ended or it could not be sustained because there was not a consideration for recurrent expenditure and consumables during that time. During that time, again this is prior to 1994, there was inadequate infrastructure, there were staffing problems and there was a shortage of drugs. As I go through these complaints then, there are some similarities to what is taking place now in 2014.

Another problem then under the Ministry of Health, was a difficulty to discipline underperforming workers, and this was because they were all in permanent jobs with a union, and there was inadequate performance management systems. So persons who were not performing well, it was very difficult to have them improve their performance.

Another factor which could not be ignored, as I mentioned, was that

the position of Hospital Medical Director was in charge of all the services in the hospital, and he had a very wide span of control and, therefore, could not cope with all of that. I say all of this in the context of the late 1980s where we had just entered a recession. There were falling oil prices; there was also a consequence of a failure to diversify the economy, because during the oil boom years of the 1970s and early 1980s, there was very little effort to diversify.

There was also an increase in recurrent expenditure during the time, as a result of the oil boom years. Equipment was purchased, staff were hired and people were paid a little more. I just have to remark that those conditions seem similar to what is happening now with our oil prices falling.

At that time it was recognized that the problems of the health sector were as a result of over centralization and, in an effort to revamp the health sector, the Government of the day sought help from the IADB. They obtained a loan to improve the health sector, but one of the conditions of that loan was they were told that they must decentralize. The funding from the IADB was actually tied to a decentralizing process, and that was the birth of the RHA system. Then you had the Regional Health Authority Act of 1994 that was passed.

The introduction of the RHA system was, in fact, a good intention. There was intention for it to have planned administrative decentralization by creating these autonomous RHA-governed non-executive boards—and I repeat the word "non-executive" boards. These RHAs were supposed to have their own executive management teams, and they were supposed to have the legal status of a statutory body. I refer to section 6 of the RHA Act, which outlines the powers and functions of the authority, and these are—and

I will just point them out briefly:

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

(b) to collaborate with the University of the West Indies and any other recognised training institution, in the education and training of persons and in research in medicine..."et cetera—

(d) to operate, construct, equip, furnish, maintain, manage, secure and repair all its property;

(e) to facilitate new systems of health care;"— and other things such as:

"(h) to do all such things as are incidental or conducive to the attainment of the objectives of the Authority."

Mr. President, the aim of the health sector reform programme was really to strengthen the policy planning and to strengthen the implementation capacity in the health sector, but it was also to promote primary care and focus on the preventative aspects, because at that time lots of people were coming to the hospital directly for care, and it was felt that the cost of hospital care was much more expensive than if you were to prevent a problem from recurring. So there was supposed to be an emphasis on primary care so as to reduce the demand for hospital care. As a result of that, all the physical assets of the Ministry of Health were vested with the Regional Health Authorities. In the case of Tobago, the Tobago Regional Health Authority was said to be subject to the Tobago House of Assembly Act.

This change in the way health care was provided in Trinidad and Tobago during that time was to introduce a purchasers/provider model, where the Ministry of Health would be one that purchases the health care,

and the provider would be the Regional Health Authorities, but also it was the intention for the private sector to be part of the provision of health care. That was to be done through the implementation of a national health insurance scheme which, almost 20 years later, has not really come into effect.

Under the RHA system the staff were supposed to be transferred to the RHA or seconded to the RHA. Those persons who were providing public health were to remain under the Ministry of Health, and there was some vertical services such as dentistry and a couple other services that were supposed to remain under the Ministry of Health.

In Tobago, the Tobago House of Assembly was supposed to fund the Tobago Regional Health Authority, and the THA staff, that is the public servants working in the Division of Health and Social Services, were supposed to be either transferred or seconded to the TRHA. Mr. President, this transfer never took place, because it was not well planned, it was not well thought out, and there was also no agreement with the union at the time, the Public Services Association led by Jennifer Baptiste. This is because the union wanted, if you are going to transfer my officers from the Ministry to the Regional Health Authority system, they wanted to have the recognition to represent these workers when they moved across.

The problem with the workers, however, was that you were asking workers who had permanent employment with the Ministry of Health to be transferred to a system with the Regional Health Authority, where they were all supposed to be on contract. So you were asking them to give up their permanent, secure jobs until retirement and go to a system where you are given contracts, where there was a fear that you will get the first contract,

which would have been from one to three years, but after that contract was finished you would be removed. Because of this fear, no one in the public service wanted to be transferred. There are a few who took secondment—in fact, like myself, I took secondment because in secondment you would still remain a public servant. You would be loaned to the RHA, you would enjoy all the terms and conditions of the RHA, but in case things do not work out, you could have always gone back into the public service where you had your permanent job.

So what did the RHAs do? At that time, 1995, 1996, because there was no mass transfer of public health workers to the RHA system, the Regional Health Authorities were then forced to employ their own staff. They were forced to employ their own doctors, their own nurses, their own administrative staff, and this was the beginning of the dual track system of employment, whereby in the health sector from 1996 for the next 10 to 15 years, you had two parallel organizations existing as one. You had those under the Ministry of Health, public servants who were still reporting to the Hospital Medical Director and the County Medical Officer of Health and, at the same time, you had the Regional Health Authorities with their own RHA workers: RHA doctors, RHA nurses and so on, but with the RHA workers in the hospital there was an arrangement where they would still report to the public service hospital medical director, and in the community they would still report to the public service County Medical Officer of Health. In my opinion that was the beginning of a waste of resources being spent in the health sector.

By June 2003, I am referring here to a document that says:

"Government of the Republic of Trinidad and Tobago and United

Nations Development Programme

Project Title: Institutional Strengthening and Support to the Ministry of Health

Starting Date: 1 June 2003

Expected Ending Date: 31 May 2006"

The Minister at the time was Colm Imbert. The UNDP representative was Inyang Ebong Harstrup:

"The objective of this technical assistance is to assist the Government of the Republic of Trinidad and Tobago to further enhance the delivery of health care services."

That required the recruitment "of one hundred requisite medical doctors" that were volunteers from the UNDP programme. The reason these doctor were required was because at that time, 2003, there were 200vacancies existing mainly at the level of specialist medical professionals, general practitioners, health service managers and technical personnel.

2.30 p.m.

In 2003, the system, the health sector in Trinidad and Tobago, was characterized by other sector-wide problems such as unnecessary hospital admissions, excessive self-referrals to larger hospitals, scarcity of doctors in the public health centres, weakness in curative primary care services, excessive length of stays, administrative inefficiency, ineffective quality of control mechanism, and weak health services management. This is almost 10 years after the RHA system was introduced. The amount of funding for that project was US $12.316 million.

So when these doctors came on board, you would have had the Ministry of Health which previously was supposed to be a purchaser of

services, but as I have said before, because the personnel did not transfer, the Ministry remained purchaser of services and also provided services. And then when this group of doctors that came from the UNDP, they did not report to the RHA, so you had a third category of worker that had their own reporting relationships. In fact, some had used the term "triple track", because you went from dual track—RHA, Ministry of Health—to triple tracked with these UNDP workers. Now that arrangement started in 2003, and was supposed to end in 2006. It actually was renewed after the first three years to another three years, so you had that existing for six years in all, from 2003 to 2009. All this meant is that the Regional Health Authority, which was supposed to be responsible for providing health care in the country, they really did not have control of the provision of services.

Now, having pointed out all of these problems in the health sector, there have been many good things that have occurred since the introduction of the RHA system. For example, one of the things was the significant increase in employment in the health sector. Because of the RHA system and the mushrooming of administrative personnel in the RHA system, lots of people found employment doing all sorts of things in the health sector now. But you also had the expansion of services free to the public.

There were persons who, at that time prior to the introduction of the RHA system, if you needed a CAT scan, you had to get that privately. If you needed an MRI, that had to be obtained privately. The RHA system, at least, allowed a facility where members of the public could have had these investigative procedures done free of charge in the public health system; either it would be done in a public health system, or it would be done privately and the Government would pay for it.

You also had expansion of laboratory testing. There was also improvement in treatment of various conditions. You had eye conditions that were not previously treated for free, now being treated in the public health system. You had cardiac surgery being done for free. Renal dialysis was expanded; renal transplantation in surgery. You had the advent of keyhole surgery or laparoscopic surgery which is now widely available in the public health system.

You also have orthopaedic surgery, knee replacement, hip replacements. There was the expansion of the ICUs in virtually all the hospitals; San Fernando, even Tobago now has an ICU, an expansion of neonatal intensive care. There were lots of infrastructural improvement that took place over the time that the RHA has come into being; and one example is the new hospital in Tobago; the new hospital in San Fernando; and there are also new health centres that were built. You also have new services that were introduced that were not there before. There are walk-in services to the public.

So it is not now only Casualty that you can go to during the day or after hours to get emergency care; that service is provided in several health centres. There is also improvement in cancer treatment, improvement in radiotherapy in St. James. But generally speaking, the advent of the RHA system allowed patients to access care that previously was only available privately. Some of those patients are actually accessing care in the private sector, but paid for either by the RHA or the Ministry of Health. So there have been good things that have happened.

However, the reality is that the dual tracks that the RHA had to contend with remained until 2008 in Trinidad when VSEP came, and in

2010 in Tobago when VSEP was introduced in Tobago. I should point out that when the Regional Health Authority Act was first passed, the VSEP was not an offer in the beginning, but when it was realized that the workers are just not transferring, and they were not retiring fast enough, the option of Voluntary Separation of Employment was introduced.

Now as I had mentioned, the dual track did cause some problems for the health sector. One of the biggest problems was in human resource management because you had two sets of employees who were reporting to two different employers. And what was worse is that there was no performance management system in place. Even to date, there is still not a proper performance management system in place in the RHA. And what that meant is that persons who performed well and above and beyond the call of duty, they were not rewarded, and bad performance was also not dealt with.

This was exactly the same as what occurred under the Ministry of Health. However there was a difference. Because many of the workers in the Regional Health Authority system were on contract, the environment for victimization flourished, and the introduction of the RHA system in Trinidad and Tobago brought a lot of uncertainty and instability, certainly among the medical profession, and also other categories of workers, and I will give an example. Prior to the introduction of the RHA system, you had someone go to medical school, they did their internship in a hospital. When that internship was finished—after that internship was finished on June 30 1993, on July 01, if that was a Monday, you started working in the Ministry of Health as a house officer.

You were a house officer—you were not given permanent

appointment then, you were on a sort of probation, and after a few months to a year, you would have your medical, then you would be given your letters of permanent appointment. So, you would then become a permanent public officer in the health sector. And as you passed your exams and you got more experience, you would be promoted to registrar consultant and so on, and in some cases, hospital medical director.

Under the RHA system, that same intern, when he finishes his internship, now has to apply for a job with the Regional Health Authority. After he applies, there is no guarantee when that interview will take place. So, it was not uncommon over the past few years for interns to finish their internship and be unemployed, hoping that you will get employment in an RHA where they will give you a contract. This was the beginning of the instability, certainly in the medical profession.

Then, when you got employment, it was a contract varying from maybe one to three years. Even though it was the intention of the RHA that when you were given your first contract, if you performed satisfactorily, the next phase would be to give you permanent appointment, but the manner in which permanent appointment was given to health care personnel did not demonstrate any logic or basis by which some people were given permanent employment, and others were not.

Also, because of this uncertainty it led some doctors to think that, if you were not in favour of those in the hierarchy of the health system, you were not going to get permanent employment, you are just going to remain on contract, and the renewal of your contract would be subject to good performance, and in some respects, a renewal of contract was not necessarily based on good performance and good output.

The other thing that plagued the RHA is the board appointments. Even though the RHA Act allows a board to be appointed for up to five years, most times the boards are appointed for a period of two years; same thing with the chief executive officer. The chief executive officer in the RHA Act can be appointed up to a period of five years, but in reality they are given contracts varying from one to three years. So, as a result, since the RHA was introduced you probably had in Trinidad about maybe nine or 10 different boards of directors being appointed, and the same amount in Tobago.

The position of chief executive officer on contract, the position of medical chief of staff which replaced the position of HMD—contract. All the senior management in the RHA system—contract. Whereas under the Ministry of Health before, the chief medical officer, who was the most technical officer in the health sector, is somebody who was permanent. Hospital medical director under the public service was permanent. You therefore have persons in the position of chief medical officer who would rise to that position, very experienced, many years in the service. Hospital medical director, the same thing, would have usually been one of the most senior specialists in the hospital who would have been in that post; he would have headed the departments.

So, therefore, when these people attained these positions, there is a natural respect that they would have earned, and when they make decisions these decisions would have been coming from a position of authority, confidence and seniority.

Under the RHA system whenever the government changes, the board changes. So, you can have someone who was appointed to a board today,

elections are called in six months' time, if the government changes, that person's appointment is terminated. Usually—[*Crosstalk*]

Sen. Hadeed: Not this time around.

Sen. Dr. V. Wheeler: It is not unusual when the board changes that the CEO also changes. So that the CEO—that is supposed to be the only employee of the board and the most senior person in the health sector—there was a level of instability even at that level.

As a result of all of these there were major HR issues, and in both Trinidad and Tobago appointments that should be made based on qualification, training and experience, there are other factors that are introduced to make these appointments. So, now you would have, for example, someone who might have a position of a chief executive officer who may not necessarily be someone who is very senior and experienced. You also had examples where boards changed the requirements for credentials. And I have a copy of an advertisement for a chief executive officer in 2009.

> Credentials and experience: minimum of 10 years' progressive experience in senior capacity. Extensive experience in strategic planning processes and functions, as well as equivalent combination of training and experience is considered an asset. A compelling track record of success as a senior manager in a complex environment.

Three or four more lines of things like that. There was no requirement for a postgraduate degree. And here it is you are looking to employ a chief executive officer who will have general managers with graduate degrees, and postgraduate degrees reporting to him or her, and that is something that was happening in the health sector.

I have recent advertisements for a chief executive officer, 2014. Credentials and experience—one of the first things identified: postgraduate qualifications in health administration or related discipline from an accredited educational institution. A minimum of 10 years' progressive experience at a senior management level in a health care or similar complex organization experience—rest of other things.

This is the same RHA when on one hand you look to employ a CEO and there is no requirement to have a post-graduate degree, and in another hand things return to normal.

2.45 p.m.

Let us look at the position of Medical Chief of Staff: Education, Post Graduate Medical Specialist qualification from an accredited educational institution.

CredentialS and experience: a minimum of 10 years progressive experience in a senior capacity or in a similar or related job function.

Now I had said before, the advent of the RHA meant that persons were appointed to positions where there were other criteria other than qualification and experience used to select those persons. I would like to challenge the Minister of Health and the Tobago House of Assembly to review the persons in those senior positions right now, to see if they actually have those minimum qualifications and experience, because I am not certain.

You also had since the advent of the RHA—because I had said there were problems with human resource—the hiring of HR consultants, finance consultants, communication consultants. In 2014, almost 20 years after the RHA has come into being you have the need for the RHA to hire these consultants in these various capacities.

Mr. President, I want to now look at the allocation or the spending in the health sector. In 1994 the budgetary allocation for health was $653,943,546, out of a total budget of $10,163,998,778; IT was 6.4 per cent. In 2013 that figure rose to: health allocation, $4,233,426,325, out of a budget of $56-plus billion, 7.5 per cent. When you compare the allocation from 1994 to 2013, the allocation in the health sector had increased by 647 per cent. I mean, some people have been arguing that the Government is not spending enough money and the health sector money is not being spent. Over the years Governments have been increasing allocations in the health sector, so allocation of funds cannot be the reason why we are having problems.

I try to look, because if you have this big expenditure in health then we have to say, okay, well, we had a 600-plus top 100 increase in expenditure, but what was the outcome? What was the data to justify this massive increase? Or, has the delivery of health care improved comparative to this over 600-plus per cent allocation? And, now, I must declare—which I should have done in the beginning—I am an employee of the RHA. The information that I am presenting was obtained as if I am an average person seeking information on the net. I did not use any personal contacts, that I had access to, to seek information, so I am not speaking about anything that is not in the public domain and a member of the public cannot access. I just want to make that clear.

Now, I looked on the Ministry of Health's website and there is a category that says statistics and I pulled up Ministry of Health Annual Statistical Reports that started in 1994/1995. Unfortunately those reports ended 2004/2005. No reports have been available for 2006 to present. But

just looking at those reports so far, in 2005 the allocation in the health sector was $2,826,616,071. That represented a 432 per cent increase over 1994. So, what statistics did the Ministry of Health produce then? Let us see how that compares to the 400-plus per cent increase in allocation, and I looked at something: Maternal mortality for example, which is something that is very recent and very topical, mothers dying during childbirth and pregnancy.

In 1994 the rate was 57.1, which means for every thousand women who gave birth 57 of those would die in Trinidad and Tobago. In 2005 the figure fell to 52.2 per cent, which really represented about—

Sen. Ahmed: What per cent?

Sen. Dr. V. Wheeler: 52.2, which is 52 women per 100,000 deliveries. It fell by 5 per cent in the 10 years. Neonatal mortality rates: this is the number of neonates that died for every 1,000 births. In 1994 the figures were 13.9; in 2005, 13.5. Stillbirth rates: there was no figure recorded for 1994, but for 2004 the figure was 14.0. Infant mortality rate, that is the number of infants over one month of age that died for every 1,000 babies that were born. The figure in 1994 was 17.5; in 2004, 16.5.

Life expectancy male: 1994, that is if you were born in 1994 on average you were expected to live to the age of 68.4; 2005, life expectancy 68—sorry, 2000, 68.2. So it looks like after six years you are likely, if you were born in 2000, to live for 68.2 years as opposed to 1994 you would live for 68.4 years on average. Life expectancy female: females always live longer than males. 1994, 73.2 and 2000, 73.7. Death rate from AIDS and HIV, 1994, 13.5 and in 2005, 7.9. The only statistic between 1994 and 2005 that showed any significant improvement was actually death rate from AIDS and HIV.

Now, as I said I went on the Ministry of Health website to get that information. But I also went on the website of the World Health Organization to see if they would have any information about Trinidad and Tobago, and there it is in their 2014 World Health Statistics, I looked under maternal mortality and I see figures for Trinidad and Tobago for 2013 and for 2012 in some instances. There are three figures quoted: 1990, 2000 and 2013. If you were to look for Trinidad and Tobago for maternal mortality rate. That is, as I said, the number of mothers who died as a result of childbirth or pregnancy for every 100,000 live births.

Trinidad and Tobago 1990, 89; 2013, 84. So, it meant over a 23-year period—now, in between, as I had said, the Ministry of Health figures had showed 1994 it went down to 57.1; 2000 there was a little increase to 59; 2005 it had gone down to 52, but between 2005 and 2013, there was a big jump again in maternal mortality. If I were to look at our Caribbean neighbours, for example, Grenada. In 1990 Grenada's maternal mortality rate was 34. That is for every 100,000 live births in Grenada in 1990, 34 women will die. In 2000 that figure fell to 29; and in 2013 that figure fell to 23. So, I found it very embarrassing because our smaller, less wealthy Caribbean neighbour to have performance in health delivery to their population that far supersedes what happens in Trinidad and Tobago.

In fact, the rates for Grenada for 2013, maternal mortality rates, 23; Trinidad and Tobago 52, it is actually less than 50 per cent. If you we look at Dominica—well Dominica did not produce any figures at all. If we look at Barbados, Barbados started in 1990 with a maternal mortality rate of 120. Reasonably high as compared to Trinidad at the time when we were at 89. But in 2000 Barbados' maternal mortality rate fell to 42, in 2013 it increased

slightly from 42 to 52. Barbados, who has been going through some serious financial strife over the past few years is still able to say to themselves, if a woman goes to Barbados and gets pregnant she is less likely to die as a result of pregnancy and childbirth compared to if she was to have come to Trinidad to have that child. Very embarrassing to us who are spending billions of dollars.

Another category that we could look at, is infant mortality rates. Trinidad and Tobago, World Health Organization figures for 1990 and 2012: 1990 infant mortality rate, meaning for every 1,000 babies that were born, this number that you are given is the number that would die over the age of one month and before one year. In 1990 the figure was 29; in 2000 the figure fell to 25; and in 2012 the figure falls further to 18. So, in 2012 the World Health Organization figures showed that for every 1,000 babies that were born alive, 18 of them would die between the age of one month and under one year.

Again, when we compare with our Caribbean neighbours, Barbados 1990 figures 16, whereas we were 29; 2000 figures 16, we were 25; 2012 figures 17, an increase slightly, we fell to 18. Grenada, infant mortality rate, that is number of infants who die for every 1,000 live births, and that is the infants more than a month and less than a year. Grenada 1990, 18; 2013, 2012, 11. Grenada outperforms us every year. Jamaica, who is the larger island but also in financial straits. Jamaica's infant mortality rates in 1990 was 25, we were at 29; in 2000 it fell to 20, ours fell to 25; in 2012 Jamaica fell to 14, and ours fell to 18. Jamaica also outperformed us. There is one other figure I would just call just to verify—part of the reason why the World Health Organization puts out these data is so that countries can

compare themselves to see whether you are improving, whether you are not doing so well, and I think it is important.

Neonatal mortality rates: Trinidad and Tobago 1990, 22. That is, neonatal mortality rate refers to those babies that died from seven days to one month of age for every 1,000 babies that were born alive. And in 1990 the figure was 22 for Trinidad and Tobago; 2012 it fell to 15.

3.00 p.m.

Again, look at our neighbour, Grenada. It was 10. Grenada's neonatal mortality rate is less than 50 per cent of our rate. In 2012, it fell to seven, single digit. Dominica neonatal mortality rate was 12, almost half of our rate. In 2012, it fell to nine. In Barbados it was nine, 1990; 2012, it increased slightly to 10.

Now, part of the reason I am going through all of this is to show that there has been massive increase in expenditure in the health sector, but this has not really translated into the kind of improvement in quality of care that one would have expected. And when one considers the context of the millennium development goals that we all signed on to, I will just mention some of them.

> "Target 4.A Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate"

I did mention that figure.

> "Target 5.A Reduce by three quarters, between 1990 and 2015, the maternal mortality"—rate.

We are certainly not going to achieve that.

> "Target 6.B Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it"

I think it is fair to say that as far as HIV/AIDS and treatments and deaths, the country has done fairly well because right now anyone who is diagnosed will have access to free medical care if they choose to go to the public health system. At this point, I would just like to commend Prof. Bartholomew of the Medical Research Centre and Dr. Ray Noel in Tobago for the work that they have been doing.

So, we have had the data that shows that there has been a massive increase in expenditure in the health sector. The data regarding delivery of health care does not reflect this massive increase. So where has the money really been spent? There is a view that this may have been due to a massive increase in administrative cost. It may be that the money was spent on big-ticket items that did not necessarily translate into improvements in the provision of health care, but that analysis is what I am hoping—if the Senate supports my Motion in having this done, and if the Government does undertake it—to give us some answers as to where that money was really spent.

If we look at section 6 of the RHA Act:

"The powers and functions of"—the—"Authority…—

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

Now, based on the amount of complaints that we have currently: long waiting times for treatment in accident and emergency; long times for clinic; in some instances, long times for surgery. You go to the hospital, the doctor seeing you to be admitted and there are no beds. Sometimes you have to buy drugs. So as far as the public is concerned, the RHA has certainly not been providing efficient systems.

If you look at complaints from staff—in fact, I got a whole list of complaints from doctors when I tried to canvass opinions and input into this Motion. The junior doctors—that is, interns, house officers—complain of long working hours with no meal breaks. For example, it is not unusual for a doctor to be on call and have to be physically in the hospital from eight o'clock on Monday morning to four o'clock on Tuesday afternoon, which is 32 hours in a stretch. This person is on duty—the accommodation for him when he is there is unsatisfactory.

At Port of Spain, you have a big common room where you might be lucky to get a chair to sleep on. In Tobago, at least with the new hospital, the accommodation is a little bit better. San Fernando, I have been told with the new hospital there are some accommodation rooms which I think are quite good. But Mount Hope, Eric Williams, Sangre Grande, not up to mark. [*Interruption*]

Mr. President: Just drawing to your attention that you have another 10 minutes of time.

Sen. D. V. Wheeler: All right. There is shortage of basic supplies, old instruments, complaints of no overtime payments. With the new hospital in San Fernando there are some concerns about the length of time, the distance taken to walk from where the wards are to the laboratory, X-rays and so on, that has been a concern.

With respect to doctors working in the department of O&G, there is a chronic shortage of blood that exists in the public health system. Now, this is a national problem where sometimes you have to perform an emergency caesarean section, when you call the blood bank there is no blood. In fact, some of us, when you are going to do that surgery with no blood, you have

to pray to make sure that nothing happens, because the day something happens and there is an adverse event, "the people coming for your neck" and you might be so unfortunate to be referred to the DPP.

There is also a shortage of midwives; shortage of foetal monitors; you know, doctors right now are working at 2008 salarries. The system clearly is not efficient. But in spite of all of these problems, I should state that there are many committed personnel in the health sector. There are many committed doctors, nurses and midwives who will still perform above and beyond the call of duty, and they are given little recognition for this.

With respect to the other powers of the RHA—operating, construct, maintain equipment—this certainly has been substandard. It is not adequate even though the construction of new hospitals will help this.

Mr. President, the decentralization that is under the RHA, the decentralization system was a good idea at the time, but the implementation was poor. We have in 2014 new hospitals being built, when currently, for the hospitals that are in existence we have a shortage of specialists, shortage of nurses, shortage of midwives, shortage of lab managers, shortage of staff. My concern is, when these new hospitals that are planned to be built are opened, I am just wondering where we are going to get the staff from.

Mr. President, I just want to spend a little bit of time, well the last few minutes commenting on Tobago. Tobago, the RHA Act, section 5, subsection (2) 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 Tobago House of Assembly Act."

When you look at the THA Act, the TRHA is not mentioned

anywhere. In fact, the only mention of health is in respect to the Fifth Schedule where it says Tobago is responsible for health services. In fact, some have wondered if you really need to have an RHA in Tobago because in the decentralized efforts to create the Tobago House of Assembly, health was already decentralized to the THA. There are some concerns swirling around right now with respect to the TRHA, the Chairman resigned recently and there was a very public conflict with the secretary for health, and as someone from Tobago I am very concerned about this.

There was also the concern of the issue of payment of allowances to the board of directors. I just want to read the Second Schedule, subsection (2) of the RHA Act where it simply states that:

> "Remuneration. 3. (1) A Board shall pay its members such remuneration as the Minister approves."

The Ministry of Health should also have a role to play into what has happened, because the Ministry of Health was supposed to be performing a monitoring function, and this was to be done through the annual services agreement, but this annual services agreement is very inadequate and it really needs to be revamped.

Now, even though the focus was on the RHA, the Ministry, I think that we the general public do need the take cognizance of our responsibility. You cannot have someone driving drunk and get into an accident and causing death, injury. That is irresponsible behaviour. When we do not exercise when we are supposed to exercise, that behaviour is irresponsible. When we overeat and smoke, that is irresponsible behaviour. So we, the members of the public, should also take some responsibility.

What really is the way forward in this? I believe there should be a

total review of all the systems of the RHA. From what has happened recently, I believe there should be a forensic financial audit taking place. There should also be a human resource audit. People in senior management positions need to be qualified and experienced for the positions that they hold. The annual services agreement needs to be revamped. There should be an effort to hire experienced, qualified staff. The question of whether— do we need four RHAs in Trinidad and one in Tobago? I believe we may have to consider reducing the number of RHAs, potentially, to have one RHA and look at some other management arrangements for the hospital. We need to have proper performance management systems in place. We need to have clinical audits being done.

Mr. President, the RHA concept was a good idea at the time, but in my opinion, it is not working and needs a major overhaul. I do hope that I will get the support of this Senate in achieving this. I thank you. [*Desk thumping*]

Sen. H. Drayton: Mr. President, I beg to second the Motion and reserve my right to speak at a later stage.

Question proposed.

Mr. President: Senators wishing to contribute to the debate may do so now.

The Minister of Health (Hon. Dr. Fuad Khan): Thank you very much, Mr. President. First, let me start by congratulating the Independent Senator, Dr. Wheeler for a very strong presentation and we will look at the Motion based on what is occurring now, and historically what had occurred then. Now, first let me start by saying that the Regional Health Authority came about in 1994 as a result of looking at the health sector prior to that and a lot

of work went into it between 1991 and 1994. What caused this Regional Health Authority to move forward in 1994?

Looking at the English system and the health authorities in the English system, we tried to mirror that by looking at the Health Sector Reform Programme and they came up with the deficiencies after looking at the consultations throughout Trinidad and Tobago. The consultant came about with the idea of it. We needed to have separate entities as autonomous bodies, statutory bodies in the sector to develop what?—one simple thing, service to the people of Trinidad and Tobago. So I think what occurred at that time was, the word "service" to Trinidad and Tobago, and Trinidadians and Tobagonians—that was not occurring as the result of the public service health sector. So we ended up now with the Regional Health Authorities. It started off with, leaving at the Ministry of Health, certain services and deploying to the Regional Health Authorities other services for general use.

3.15 p.m.

I just want to say that at the Ministry of Health there was something called the vertical service index. These were services that stayed on at the Ministry of Health, together with the administrative function of the overall health sector. We had the Chemistry Food and Drugs, the Population Programme, the School Health Programme, Insect Vector Control Division, Nutrition and Metabolism, National Organ Transplant Unit, Dental Services, Emergency Services and Disaster Preparedness Coordination Unit, the Expanded Programme on Immunization, the Schools of Nursing, the National Oncology Programme, the National Blood Transfusion Service, the Veterinary Public Health Service, the Medical Library Services, the Health Education Services, the Trinidad Public Health Lab, the Queen's Park

Counselling Centre and Clinic, the National Surveillance Unit, the HIV Coordinating Unit, the Public Health Inspectorate and now the NADAPP.

You see, Mr. President, what I am trying to indicate here, a lot of the services that stayed on at the Ministry of Health were sort of broad-based services, looking at the structure and working the structure of the health sector itself. At the RHA level it was hoped that by putting the system in place where you had the boards of directors together with management services, that will deliver health services to Trinidad and Tobago: primary health care services; secondary health care services and also tertiary health care services. The public service part of the system, which was the primary health care service, with the health offices and that part of it, was governed by the Chief Medical Officer at the Ministry of Health and the county medical officers of health at the different jurisdictions. They also had medical officers of health, et cetera.

That still stands in some form or fashion today, where we have the Chief Medical Officer and the county medical officers of health working in the public health area, and in the Regional Health Authorities we have the general managers of primary health care, and there is an overlap in who manages what in those health offices, and that type of delivery service.

Now, Dr.Wheeler indicated that the sector spent quite a lot of money, and he is right. With inflation, you do have to spend quite a lot of money, and are we getting value for money. Since becoming the Minister of Health I have been looking at the system and trying to figure out how best we can deliver services to the people of Trinidad and Tobago, make it simpler and make it more effective.

Yes, we have an explosion of chronic and non-communicable diseases

and we have a lot more demand for the services, such as secondary and tertiary services, as well as primary health care services. So we have taken on board at the Ministry of Health, the annual service agreements and the development of utilization of the health sector, and the Ministry of Health in the RHAs—as you say, the implementation part of the Ministry of Health—how do we use the annual service agreements to develop service and also efficiency at that level?

Before 2010, the annual service agreements were service agreements made in such a manner that they were a sort of a recipe list of what was necessary without any outcomes, et cetera. We have started to look at the annual service agreements and indicated that we will cut down the shopping list of what was necessary for the Regional Health Authorities, make them more broad-based with performance indicators. When I first went in the Ministry of Health, there were not many systems that had, what they call performance bench-markings, so outcomes, as Dr. Wheeler said, were very difficult to establish. Now, when we look at the Regional Health Authorities Act, and the powers of the Regional Health Authorities, as said by the previous speaker, the powers of the health authority and the functions of the health authority are very broad-based. The Regional Health Authorities Act, Part II, at section 6 states:

"The powers and functions of an Authority are—

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

That is taking into consideration primary health care, secondary health care and tertiary health care:

"(b) to collaborate with the University of the West Indies and

any other recognized training institution, in the education and training of persons and in research in medicine"—et cetera.

And it goes through, "dentistry, pharmacy":

(c) to collaborate with and advise municipalities on matters of public health;

(d) to operate, construct, equip, furnish, maintain, manage, secure and repair all its property;

(e) to facilitate new systems of health care;

(f) to provide the use of health care facilities for service, teaching and research;

(g) to establish and develop relationships with national, regional and international bodies engaged in similar or ancillary pursuits; and

(h) to do all such things as are incidental or conducive to the attainment of the objects of the Authority."

Mr. President, we have been looking at the actions of the Regional Health Authorities and what they are doing right now is, basically, not acting as separate implementation statutory agencies. How they have been acting—and this, as a result of inheritance over the period of time—they are acting as five different public service bodies. Why do I say that? You have a board of directors who was supposed to be, according to this, a non-executive board of directors, and most of the boards of directors prior to this have been acting as executive boards of directors. You have a management structure that is supposed to be an executive management team that is supposed to develop the Regional Health Authorities, however, the

executive management team waits on the board of directors to do anything based on—rather than implementation policy directions, they implement activity—which is implementation activity.

You see, Mr. President, one could speak a lot about how much money was spent in the Regional Health Authorities and how much you are supposed to obtain. Most of that expenditure is recurrent expenditure—staff expenditure. Now, the Regional Health Authorities Act gives the Minister the strength to determine salaries and also to determine a level of salary that —after $150,000 per annum—a Minister could determine the salary arrangements based on need.

What has happened prior to our coming into office in 2010, you had a ministerial activity—back to a public service activity—that determined and constrained any movement in the Regional Health Authorities. So here you are saying, "We are allowing you to move your hands forward, but we are tying them behind your backs". This is what we are trying to unravel at the Ministry of Health, to allow the Regional Health Authorities to work as separate bodies and hold them responsible for certain performance outcomes. But the historical aspect of it is, we gave them a Regional Health Authorities Act but with the constraints of the public service, and that is what has been going on, like two-tier systems, three-tier systems, et cetera.

Now I am not making excuses for the Regional Health Authorities. I am coming to another point. How do you expect to attract the best in any system when you do not pay them well? The Regional Health Authorities, the constraints of salary and salary negotiations, are under the purview of the CPO, which was never supposed to be so. When you look at the Act, at the end of the day you are looking at an Act that says, "You all are separate.

Determine your movement. Give me service and I will just hand you an annual service agreement. Should you not do the agreement properly this year, next year you will pay the penalty." That does not occur. The mechanism goes on but the system does not allow it.

So we are in the process of determining how best we could allow the Regional Health Authorities the autonomy to do what they are supposed to do, which is to develop health care in this country, [*Desk thumping*] at the same time making sure that they do not run riot and run as runaway horses. How do you do that? You do not constrain them and then allow them to run. It is impossible to do both actions at the same time.

I am going to give an example. San Fernando had no neurosurgeons when we came into office—absolutely none for about—how much?—five years or more? And I inherited a bill from one institution of approximately $35 million to $40 million from San Fernando for neurosurgical services being outsourced to that institution. Everyone, every consultant and every system has a salary benchmark, as consultants, registrars, house officers, et cetera. It makes no difference if there is any shortage, or if there is anything, you cannot attract somebody that may be willing to come.

Mr. President, for approximately a year and a half—two years, we tried to source neurosurgeons, at the salary range that was determined by the CPO, in the Regional Health Authorities. It was only when I took it upon myself as a Minister and discussed with the Cabinet, and said, "Okay, I am going to go out and offer a little more, based on a sort of consultancy services", we got neurosurgeons in San Fernando. So while we were paying for one patient, sometimes, $1.5 million to an institution because of neurosurgical services and ICU care, we were able to get neurosurgeons for

a higher salary than was obtained, but doing six and seven surgeries a week. [*Desk thumping*] And at present, as I speak, we have the Chinese delegation doing, as they say, state-of-the-art surgery in San Fernando—intracerebral coiling. Intracerebral coiling, Mr. President, normally I used to pay $300,000 for one patient on the outside. Now it is free because the Chinese neurosurgeons are training—[*Desk thumping*] they are training our young neurosurgeons how to do it and they are utilizing the cath lab in Mount Hope.

Now, when I came into the office in Mount Hope, the cath lab in Mount Hope was run by one person and, as Sen. Wheeler said, they were allowing external providers to utilize the system on contract agreements, but there was not much performance, as you say, benchmarking and outcome appreciation. So what we did? Because of that system where intensive care cost factors on the RHA were going sky-high before 2010/2011—the intensive care external surgeries, MRI, you name it, everything was going outside. All you had to do was to go into the system, somebody signs a form and you go outside: cardiac services, everything.

Mr. President, what I did when I first came in, I saw the bill—$35 million for neurosurgery before 2010; so much millions for this, so much millions for that; every single sector, and what was supposed to be done in the public sector was being done in the private sector, and Sen. Wheeler says the Regional Health Authorities and the system allowed it. But what it did not allow for was for us to do it in-house.

The first thing I did was to stop all outsourcing—no outsourcing. [*Desk thumping*] If you wanted to outsource something, you had to make sure that you could not do it in the public institutions, and also it was of a

nature that needed something specialized outside. Mr. President, we went from here, [*Demonstrates with hand*] of outsourcing, to almost next to nothing. But of course, the little changes in between where people said I am crazy, I cannot do it, but they were able to do it.

Intensive care beds in the Eric Williams Medical Sciences Complex, there are about, I think 11 to 12—even 14 beds, I cannot remember offhand. But six of those beds are being utilized because the nurses, I want to say, are working one on one—one nurse to one bed. In Port of Spain, one nurse sees about two patients, so we are able to get more activity done in intensive care in Port of Spain rather than Mount Hope. So what we did, we brought in Cuban nurses, intensive care nurses, as well as Indian intensive care nurses and they were trained as intensive care—they were already intensive care nurses and we opened up the intensive care in Mount Hope. So that was a saving cost because intensive care costings in the different private institutions were extremely high, and that is the result of the pay for service, as the agreement that the RHA did.

Not only that, what we set out to do also—and under the regime of 2002 to 2010, although you had the RHA Act and although the RHA Act was being, as they say, utilized in whatever direction—two-tier system, et cetera—there was also the development of something called a waiting list initiative where most small activities were outsourced. We were able to increase the amount of surgery services and systems in the public institutions because of allowing the increase in the amount of operating theatre time. Once you increase the operating theatre time, you will get more service. And how did we do that? By bringing specialized medical practitioners, surgeons, cardiologists, et cetera, from Cuba and different countries.

So, you see, Mr. President, although the RHAs have been—it is a system that really and truly needs to be tweaked a little differently, they are working.

3.30 p.m.

Now, the North West Regional Health Authority, they had a cardiac programme going on, the cardiac programme has continued, but at the end of the day, they had what they called a good ophthalmological centre with cataract surgery and eye surgery, et cetera. Because of the RHA Act and because of the system that is allowed, we are able to attract, as I said, private ophthalmologists, et cetera, as well as the Cuban ophthalmologists that we have brought in to do cataract surgeries in the hospitals themselves. So, too, in Eric Williams, but there is a bit of inefficiency there. Sangre Grande has pioneered the way of cataract surgeries based on the RHA system, paying somebody who does cataract surgery a little more based on the consultant-type system. So if the Act was not there, we would not be able to do it utilizing the public service activity.

The same thing in Tobago. They have been getting a lot of activity because of the Act. Had the Tobago Regional Health Authority not have the Act to allow them to move forward, what would have happened? You would have a public service system, public service movement, the salary system would be the same and they would be out of the box—you would not be able to go out of that box of attracting other specialization, and Dr. Wheeler could attest to that because I think he is in Tobago, dealing there.

So, although you speak about the amount of money being put in the system, in 1994—some figures were called, I think it is about two-something or 100 million, I do not have the figures here and we have a lot more now.

But when you compare and contrast, one, the level of services in 1994 to now, the amount of people entering the system, the volume of patients that come through the casualty and go on to the beds, et cetera, in all the regions: eastern, north central, north-west, Tobago, as well as San Fernando, when you look at the amount of patients that go through those regions, you realize that they have gone from, let us say, X to about 100 times X patients, so you obviously will get a higher expenditure.

We also have a large amount of specialized services. In 1994, we did not have the utilization of much cardiac services, we did not have much neurosurgical services, everything was at a minimum—haematological services. Now, each region has that. What about MRIs? Let us talk about MRIs, let us talk about CT scans. I remember in 1994, a CT scan was something that you got only after you did all the X-rays and then you might have sent somebody for a CT scan, it was expensive; that was in 1994. Now, there are CT scans in every single institution. In fact, you name an institution, that is a regional institution, there are CT scans there, so you will get a higher expenditure.

So, if we go on like that, the disposables of a lot of minimal invasive type of activities, surgery, the disposables are expensive. So instead of somebody getting an operation, let us suppose it is to open the belly and whatever it may be and repair what is inside, and then you lie down there for not less than two weeks or three weeks, depends on how the healing process goes, you have what they call minimal invasive surgery where you make three holes in a laparoscopic port, you do the surgery inside, and the patient is out the next day. That is gall bladder surgery, out the next day. But with it comes a special amount of disposables which are expensive.

So, instead of having somebody sitting and lying down for two to three weeks for healing for a large cut and tubes, et cetera, you have minimal invasive surgery and they are out within a day or two. So, too, with prostate surgery; before you had to open up, cut and everything else. So what I am saying, the cost factor goes up depending on the service that is available [*Desk thumping*] and we have been trying—not just trying, we have done and moved the health system into what they call a higher level system where there is a lot of minimal access surgeries, minimal invasive surgeries and a decrease in the amount of hospital stay. [*Desk thumping*]

Now, you are going to ask me how come we do not have enough beds. Now, I will tell you why we do not have enough beds. The volume of people that are—well, let me first say, I want to say, Mr. President, that the San Fernando Teaching Hospital, I think the hon. Prime Minister said, is the first hospital that has been opened—in how many years? Twenty years? Fifty years—thanks. We were able to open a hospital in Trinidad in 50 years. The Scarborough Hospital, we opened it when I came into office. The Scarborough Hospital was opened by the People's Partnership Government and the hon. Prime Minister indicated to me and directed me to make sure that hospital was opened. So we got that done.

So, at the end of the day, Mr. President, I am going back to the cost factors and why there are no beds, why people complain about beds. When you have the staff, doctors, not discharging patients appropriately, they will not discharge a patient on a Saturday, Sunday. A patient lies down there, let us say Friday night, Saturday, Sunday even though they could go home, and Monday, they come and make the ward rounds. So you have somebody remaining and blocking spaces that could be utilized over that period of time

so it backs up. That is one problem, and we have done studies to show it whoever wants to see the studies, I can show it to them. The amount of discharges over the weekend, Friday, Saturday and Sunday, drops remarkably and on Monday, it shoots up. So between Monday, Tuesday, Wednesday, Thursday, you get beds; Friday, Saturday, Sunday, there is a backup.

But then again, we go to something else. If we have to depend on a public service type of approach to remunerate the doctors and the nurses, because the nurses have to do pool work and some of them give their services in the private sectors. Why? To compensate for the small income that they are getting, I am not ashamed to say it. Because we are looking at a system right now, and we have it before the Cabinet, where we are increasing the ancillary medical staff which are nurses, ultrasonographers and radiographers, about 15 per cent—increasing their salaries by 15 per cent. [*Desk thumping*] That is before the Cabinet. And, Mr. President, you know I am talking the truth when the Minister of Finance and the Economy walks in when I make that statement. [*Laughter*]

We also have the negotiations between the doctors and we are working on a system and offers have been countered back and forth. That should be dealt with very soon. So when Sen. Dr. Wheeler said about working for 2008 salary, you are right. They are working for 2008 salaries and we are trying to address that. But you had 2008, 2009, 2010, we looked at it and we are trying our best to give them a package. You may have heard over the last year or so when I started to speak about the two-year internship. The reason behind that, we want the doctors, the doctors in the system, rather than running to their private practise, what we wanted to do was to

develop a system where the doctors in our country will be better trained, because a lot of them come out of internship, go into private practice and are not really capable as yet, so we open a two-year internship. But that fell flat a little bit because the University of the West Indies attacked it very strongly. But we are still of the opinion and, in fact, I offered the opinion to the Medical Officer, et cetera, that our doctors who are running into private practices and full registration, after one-year internship, is not desirable because people are affected.

So what we were looking at—and I am giving why the negotiations delayed a little bit. We were looking at developing a cadre of medical specialists who, as consultants, would teach these doctors full-time. Now full-time means all the time, no private practice, and you would be there in the system, whenever, doing research, writing papers, academic and research training, as well as being full-time. Rather than doing one operating theatre or one clinic a week, you might do about two or three, and teach the students who are coming in. So we were going to give a salary that is much higher than what is available now. That is what we are negotiating with the Minister of Finance and the Economy and so too the Registrar and so too the house officers.

We are also looking at a system where those who are moving up the ranks from House Officer, et cetera—one, two, three, four—into specialist areas and writing their exams would get much more money, salaries, as a result of moving up for their education needs versus those who are stagnating and moving up this way. We had the plan of visiting consultants who would come in and do something. Visiting, as they say, specialists who would come in and work, and move out—part-time specialists. So all that

was taken into consideration to change the system.

As I talk about doctors, the same thing would be for nurses. We have now the category of the PSC nurse, [*Desk thumping*] the specialist nurse, we have the cardiac nurse, the intensive nurse, and also I am proud to say, and I see Sen. Lambert is knocking quite hard, that the Nurses and Midwives Registration (Amdt.) Act was passed here with the help of the Opposition and Independents, and I thank you because it is going to see the system—the movement of an advanced practice nurse. [*Desk thumping*] So we are categorizing the staff remuneration on the kind of staffing and the hope that we get for the future.

However, and quite rightly so, people became a little impatient, so what we are doing as of now is working the system with the Ministry of Finance and the Economy and also the Ministry of Public Administration and the RHAs to try our best to give a proper remuneration; one, for the basic salary. I would not call the percentage here because it is still in negotiations. Two, with a grant for studying, a grant for continuing medical education, proper phone allowances, a higher amount of housing allowances, travelling allowances, so it is going to be a good package. And that package is going to go up to like say 2015 and I am hoping, together with the Ministry of Health officials, to still develop the system that I was speaking about where we have the different categories of doctors, so we could now look at training our—it is all about training and education.

Now, cost, we were talking about cost. The RHAs, let us take north-west. North-west, when we came they had what we call the Cobalt machines. There was no breast clinic, there was no, as they say, other clinics that had a specialized nature in the St. James Radiotherapy Unit but

there is now. There is a breast clinic, a woman's clinic. There is a cancer clinic that is run by specialist surgeons, et cetera. The chemotherapy drugs are more expensive. There has been outsourcing of most amount of the radiotherapy needs. So what do we have to do? The cost factor goes on to that institution.

So what we are doing, we are putting a linear accelerator into St. James; we are putting also a Gamma Knife in neurosurgical radiotherapy in St. James; [*Desk thumping*] we are putting an MRI in St. James to control that; we have a CT scan for that, so you will find the cost will go up in St. James. When you look at cancer drugs, and cancer drugs are costing what? One shot of a drug could cost you $10,000 to $15,000 an ampoule, one ampoule. So when you are looking at that, the cost factor of pharmaceuticals will go up but we are dealing with it.

And I will walk straight into the oncology centre. We have opened the second cath lab in north central. We are looking at a cath lab in San Fernando which is for cardiac services and also for an MRI in Port of Spain. We are also looking at what they call the first diagnostic centre in the Eastern Regional Health Authority. You will have two CT scans, MRIs, ultrasounds and everything into a diagnostic area in one hospital. So there is also the ECU unit which is the orthopaedic centre with all the pharmaceuticals, et cetera, going to be opened there.

In San Fernando, we have started the work of putting a cath lab and we have the MRIs and everything already. But I am proud to say, although the Tobago hospital is under the THA and Dr. Wheeler could attest to that, we are putting in an MRI in Tobago, as well as a proper cath lab from the Ministry of Health, for Tobago, and by the way, right now, it is being built.

3.45 p.m.

So, I was approached by the Secretary for Health and she was wondering about—we were putting a cath lab inside—what will happen and who will use it. I have indicated to her that we will be getting our specialist cardiologist as well as cardiologists from Cuba. I am also working with a memorandum of understanding from Uganda because they are British-trained and they will be sending cardiologists. So we will do work in Tobago.

The whole development aspect of it is—what we are trying to do—to bring Trinidad and Tobago to a level so that we could have what they call the so-called medical tourism. You cannot have medical tourism unless you have the facilities to give proper medical services and surgical services.

We have also started and we are doing what we call accreditation of institutions and programmes. The Accreditation Bill will come here soon but in the meantime, the Accreditation Authority of Trinidad and Tobago, we are working with them. We have a consultant on board the Ministry for the accreditation of the health institutions. We are going to review the system, because right now there are no hospitals or no programmes in Trinidad and Tobago that are internationally recognized or accredited. So you will not get anybody coming here for medical tourism unless they come from a country that does not have any health facilities. We want to attract people from developed countries to come to Trinidad and Tobago for health treatment as well. [*Desk thumping*] So we have to accredit our institutions.

I also want to speak about the oncology centre that is being put up in the Eric Williams Medical Sciences area. The oncology centre will have state-of-the-art equipment, state-of-the-art everything, it is ongoing, as well

as a cyclotron unit; the only one in the Caribbean region. What that is going to do is produce its own radiopharmaceuticals for export as well as for use here.

Sen. Ramnarine: It will expand.

Hon. Dr. F. Khan: You will get that. You want to expand on the cyclotron. Now the cyclotron is a device that produces radiopharmaceuticals so we could do our own nuclear scanning here without importing radiopharmaceuticals to do it. We are also going to have a PET/CT Scanner in that area. We are going to have what they call a CyberKnife, a knife that moves up and down, well a radiotherapy unit that moves up and down with the body as it moves. So, when you look at those systems that I am speaking about, you are looking at increased costs.

I also want to indicate that—and I neglected to mention—not only are we working on specialized areas, recently I had discussions with the ophthalmologists and what we are going to do is to produce an eye centre that is similar to Bascom Palmer Eye Centre and we are going to try to link with the University of Utah and the Moran Eye Centre to do that. So, we will have what they call specialized centres of excellence, as well as the secondary and primary health care system.

Sen. Lambert: That needs an extra five years. [*Desk thumping*]

Hon. Dr. F. Khan: Thank you Sen. Lambert. Sen. Lambert has hit the nail on the head because we must make sure that these programmes continue. [*Desk thumping*] And I hope we let them continue, Sen. Lambert.

Mr. President: Hon. Members, the speaking time of the Minister of Health has expired.

Motion made: That the hon. Minister's speaking time be extended by

15 minutes. [*Hon. G. Singh*]

Hon. Dr. F. Khan: Thank you very much. Mr. President, when I started speaking, I looked across on the other side, my good friend, Sen. Shamfa Cudjoe, I just want to make certain that she looks extremely nice. She looks very nice. Radiant! And when I further looked at her I realized that she is wearing the colours of the People's Partnership/UNC and I thank you for that. [*Desk thumping*] Sen. Cudjoe, may I say something of a nice nature? I see you are following the weight loss programme of the Members of this side and you are looking rather nice. "Faris doh get jealous yuh know." [*Laughter*]

Okay, Mr. President, back to the real work and business. You are quite rightly aware that we are putting up a hospital in Couva, a new hospital, called the Couva Children Hospital, that has 180 beds for adults with 70 beds for children. [*Desk thumping*] It is going to be a state-of-the-art hospital with specialist services for children, as well as some specialized services for adults. There will also be the burns unit and the trauma unit and an accident and emergency unit. But that is not all, Mr. President. That hospital is going to be the first digitalized hospital in the Caricom region. [*Desk thumping*]. It is going to be a paperless hospital where people would be moving around like they are in the outer space area as are seen in parts of the world, in developed countries, where there will be no paper. Everything will be done on iPhones. It will be done on systems in such a manner, computer systems, where, as you see, electronic medical records, X-rays, PSCS systems and everything else would be in that hospital moving out, and all the records could be accessed anywhere internationally and that is what we are going to be doing. [*Desk thumping*] It is going to be the prototype of

the future of hospitals in this country. That is what the prototype is going to be.

You see, Mr. President, the days of paper, as I say, are passing and we are working also throughout the system for what we call the health information management system where electronic medical records and electronic systems will be placed in every single health institution in this country. Right now, iGovTT has passed it, passed what we are doing, and we are now in the process of implementing the electronic medical system. So when you walk into an institution, you will have the card, hopefully the health card that we will be giving out by April/May next year because we would be signing the contract for it today or tomorrow. We are going to have that health card in place and on that health card, not only would you have pharmaceutical systems, et cetera, as checks and balances, you are also going to have the card to be used for your electronic medical records. So you walk into a system, you skate your card, everything comes up, based on the security aspect of what level you are at. We are placing everything on that system, the digitalized system. It goes into a cloud where everything is stored in a security area.

If you do an X-ray, you do a CT scan it goes unto the system, the doctor or whoever it is, internationally would be able to swipe that card and see your X-rays, your CT scans, your results, even the pictures, everything on board. So you will not be able—you would not find a system where you do not have records, you do not have this. If you go abroad you have to call up, et cetera. You would not have that again, Mr. President.

Sen. Lambert: That is in April?

Hon. Dr. F. Khan: Hopefully. It is going to start in April. Mr. President,

we firmly believe in moving forward with technology. That health card movement is part of the technology movement of what we intend to do.

Right now, what we are also doing—we are in the process of putting what we call the patient archive computer system in all the health offices. Once you have an X-ray facility in that area, if you take an X-ray, let us suppose in Toco, or you take an X-ray, let us say in Mayaro, and you do not have a radiologist to read it but you go in there for emergency services, what are you going to do? That X-ray is going to be sent via digitalization to a central area where the radiologist would read it, look at it and send back the report so you could be treated at the external area. If, however, you need to be seen by a specialist doctor we are putting in telemedicine areas where you could visualize it from a camera unto the system. So you could be examined, as they say, electronically. That is what we are working on, Mr. President.

I also want to talk a little about the ambulance service. As know, quite rightly, Mr. President, I have been attacked on the blogs for the half hour/hour—[*Interruption*]

Sen. Ramnarine: KFC.

Hon. Dr. F. Khan:—KFC of the ambulance services. I just want to indicate to the population of Trinidad and Tobago, the ambulance service is what we call a vertical service in the Ministry of Health but also we have ambulances in the Regional Health Authorities. There are much more ambulances. Recently we bought 10 ambulances, I think, for North/Central. I think we distributed around the area. The ambulances—there is an ambulance policy and a new ambulance board that we have placed in the system. What is supposed to happen, there are two sets of systems, the ambulance system

that works in the hospital and health centre areas and there is what we call the GMRTT system that works on the emergency aspect. The ambulances need to be increased. The number of ambulances are going to be increased. We have passed in Cabinet a Note where the Central Tenders Board is going to determine exactly the provider and how the provider is going to develop their systems, increase the amount of ambulances, et cetera. We are hoping that it could be in a public/private partnership where we pay for service and they pay for the ambulances, et cetera, and the upkeep.

Right now they are called emergency medical technicians. We are developing a training system for paramedics. At the site of an accident or a disaster, the paramedics would be taking over and dealing with the patient on the spot, rather than minimal treatment and transport. So what we are doing is major treatment on the spot with telemedicine, et cetera,with ECG and defibrillation, IV lines, et cetera, at the site of the accident. So, the system is going to change where development of ambulance and emergency service are going to be married together as one unit. I think it is going to auger well for the system. But as everything else, it takes time and we are working on that.

Now, the ambulance system is one part of it. Now we are looking at the development of the health office system. The Palo Seco Health Office is being built right now. We also have the Carenage Health Office being built right now. The Sangre Grande enhanced health facilities, the sod has to be turned. The Arima Health Facility, this is under the North/Central Regional Health Authority, right now, if you go to Arima you would see there is a new block, a block E we call it, that we are going to utilize for more services in Arima. If you are driving down the bus route and you look at the Mount

Hope Women's Complex you will see on the left-hand side, there is activity going on and that is going to be a two-storey structure for women's care, children's care as well as colposcopy units, pharmaceuticals and clinics to be linked to the main sector.

We also have in plan and it is being done right now, a neonatal intensive care unit. So when Sen. Dr. Wheeler speaks about the infant mortality rate and the maternal mortality rate yes, there have been blips up and down. It normally goes like that. We have had some adverse events in San Fernando, as you know, and that raised the maternal mortality rate (MMR) to some extent, based on the quantum of deaths. They are being investigated and systems were put in place. Because of the maternity comprehensive system, the report, et cetera, we utilized that report to put systems in place and it has decreased over the last two years. It has decreased. Those figures would come up later.

The infant mortality rate, what I found out—I spoke to the UNICEF people when they came here. They had a consultant and I asked him to look into why there was such a discrepancy. What we found out was Port of Spain Hospital counted it differently to North/Central to South to Eastern. Some people counted 24 weeks and 500 grammes or less. Some people counted 28 weeks and—it was a whole different system. There was no standardization of counting. Stillborns—somebody who came with a stillborn and 14 weeks, you know 14 weeks is not a count but they were counted as deaths. So you got stillborns and they were counted as deaths. We have put in a system now to have accurate counting of whatever the definition of infant mortality. The definition is, I think, 24 weeks and 500 grammes. That is it. If you are under 24 weeks you are not counted. If you

are under 500 grammes you are not counted because viability is not—you cannot have viability under those things. So you cannot count something that is not viable as being viable. So that is why the counts you find fluctuated. I think in the next year or two when those counts come out in a proper manner, we would have a drop in the infant mortality rate and it will be not because the infant had died, it was a statistical error. [*Interruption*]

Mr. President: Minister, may I intervene a minute? I seem to have mistaken your original time. I robbed you of 10 minutes, and therefore, I took a four for a five, not a six for a nine, and in fact 4.13 will be your ending. [*Desk thumping*]

4.00 p.m.

Hon. Dr. F. Khan: Mr. President, thank you very much. I know I was speaking fast, but not that fast. [*Laughter*] Thank you very much, Mr. President, for allowing me that extra time.

You see, I just want to indicate that there are certain other programmes being introduced into the Regional Health Authority system, such as, one, the Child Assessment Units. We have found out when we went into the Ministry, that there are really and truly no place, no areas, nothing really and truly, for child psychiatric problems or psychological problems, there is nothing, nothing of any great amount, and I see Minister Ahmed is here. So what we have done, we have put a system in place that we are developing Child Assessment Units throughout all the Regional Health Authorities, where children with psychological and psychiatric problems, could go to and also be treated in those areas.

We spoke about trauma centres which are psychological trauma centres; those are being developed. We are looking at different health

offices, one in north, one in south, to put the Children Psychiatric Development Centres, so we could determine and make use of those health offices that are not being fully utilized, and that is one system that is being done. We are also looking at the autism—children with autism, and parents with autism. We are trying to put up an autism house in north and south. So that cost will go on to the RHAs.

There is a smoking cessation programme. We have the NCD Programme, there are extended opening hours at the health centres. I have seen here the vaccination programmes. Our Government is the first Government which started off giving HPV vaccination. We are one of the few countries in the world that has the HPV vaccination for girls to allow [*Desk thumping*]—the increase is cancer of the cervix. So we are doing that.

Also there is a lung cancer programme, the bone study is being done. We have created the chronic disease wards, and if you noticed that recently we opened the Palliative Care Ward in Caura. So in the Sangre Grande Hospital, there is the expansion of the dialysis unit, there is the expansion of the lab, the clinical services and also there are biopsy services. So what we are looking—[*Interruption*]

Sen. Ramnarine: Very good hospital, Sangre Grande.

Hon. Dr. F. Khan: Yes, Sangre Grande is excellent.

Sen. Ramnarine: Excellent hospital.

Hon. Dr. F. Khan: Now, we have started also increasing the time in all the health facilities. So you could go in some health facilities at eight o'clock in the night, some nine o'clock, some ten o'clock and some 24 hours. So that is a cost factor that will be taken up by the RHAs.

We are also refurbishing all the health centres, et cetera, utilizing both

in-house and external, CEPEP as well as URP, to assist us in developing that, [*Desk thumping*] so that is another cost. Now, we could go on and on about it, but not only are we doing all of that, but every single RHA has moved on to the Healthy Lifestyle Programme, the Fight the Fat Programme, the Love Yourself Programme, and also community programmes where they go to schools; give lectures.

Sen. Ramnarine: You are leading by example.

Hon. Dr. F. Khan: Yes, of course—and so too are many on our side. [*Desk thumping*]

Now, we have looked at the whole health sector, and I agree with Sen. Dr. Wheeler, that although we are doing a lot of work in the RHA system, I have always been the firm believer, in fact, when the RHA system was in 1994, we were part of the medical association that was looking at it. We did come to some, as they say, some negative movement at the time when we tried to indicate that the RHA system as it is, is not a very functional system. Because one, there are too many RHAs in Trinidad and Tobago, there are four in Trinidad and there is one in Tobago.

An RHA system, and we are looking at it, there was a Note to Cabinet, but we are trying to look to see how best we could develop the policy, and look at the plans. It would be nice because right now the RHA system disallows, well, according to the Act it allows, but according to the people, it disallows, where somebody working—I have somebody who is living in Guayaguayare, working in Port of Spain hospital, could you imagine that, every day, and would like a transfer to eastern, but to get that transfer, she has to resign from Port of Spain and reapply in Sangre Grande to get a position, which is nonsense, and that is what the RHA system has

done.

In Mount Hope, there are about 16 anaesthetists who are doing work according to—like three and four in a team. Some of them doing a lot of work you know, but in San Fernando there are about four or five, three antitheists the last count, let us say, four now. I wanted anaesthetists from Eric Williams which is overloaded to go to San Fernando to do some work, because San Fernando had a paucity of anaesthetists. Guess what? "Dey say dey not going", because their contract only said they are working north/central. Now, when you look at that, you say to yourself, you cannot transfer to any great extent. There is somebody in San Fernando who wants to be transferred to Port of Spain. Guess why? He moved to Port of Spain, he got married and he cannot move to Port of Spain, because he is working in San Fernando. So the RHA system is devoid of any human elements when you think of where the staff is concerned. We have to bring that back, the human element, to allow people to work where they want to.

Sen. Lambert: Bring legislation to amend the Act.

Hon. Dr. F. Khan: Now, the legislation is almost—you know, it takes a while. What I am looking at—and Sen. Dr. Wheeler is right, what the RHA was born to do was service, service to what, both staff as well as the population of Trinidad and Tobago; service. So what the RHA has to do is to develop service in its whole boundary. If you have one RHA in Trinidad, and one RHA in Tobago, you decrease the amount of executive board members and make them non-executive. So you have one set of board members in Trinidad and one set of board members in Tobago, linked by the Ministry of Health, but at each level you have the managerial structure at the bottom, and each region. So nobody will lose anything, nobody will lose

any of their jobs. The only thing that will happen, it will have less boards at the top. So the transferability, the movement in the system, will be much easier.

A Minister of Health or an RHA board, could ask the RHA board, we need a neurosurgeon in Mayaro hospital, kindly send one. So we could end up having specialist clinics in Mayaro, instead of people leaving Mayaro at two o'clock in the morning to reach a specialist clinic in San Fernando or elsewhere. We could have that type of system, aid to easy access and easy utilizable. So looking at that, I have recommended to the Cabinet that we should, we will look at the RHA system. So it speaks to the last part of it:

> "…to conduct a comprehensive review of the Regional Health Authority system in the delivery of health care in Trinidad and Tobago."

So we are addressing it. It is not to say that we are looking—[*Desk thumping*] I want to say to Sen. Dr.Wheeler, thank you. I commend you for bringing this Motion. This Motion speaks to the health sector of Trinidad and Tobago. You and I have come from almost the same era, and we understand where the RHA came from, and the deficiency. England has recognised it and they have decreased the number of RHAs. In fact, they no longer have what they call Trust, they have decreased that and they might call it something else now. They have gone from here to here, [*Hon. Dr. F. Khan indicates with his hands*] because they understand the manageability and the movement.

When we talk about contract work, when I was in England, and you were in England, when you have to go for a job, you are given a contract, sometimes three years, sometimes six months, sometimes something. If you

are not working well, guess what? They would not renew your contract and you have to move to another area. So you have people moving around the system all the time, those who are permanent are those who they want to keep. At the end of the day, I think the system here needs to be such a manner because performance appraisals in this country, should not even be looked at, because people who are bad workers have good performance appraisals, and people who are good workers have good performance appraisals.

Until we get it right and people are held responsible—I have a union gentleman here. Mr. Lambert is here and I told him about it. I said, I tried to get some workers disciplined, some escorts who were not working at all, not going to pick up patients, and guess what? The union rep came and said, but they have good performance appraisals. So it is not just our fault. It is a fault of the system—[*Desk thumping*] so we have to look at that.

Also what I am looking at, because of the number of medical mishaps that are taking place, it has come a time for us to start looking at medical defence insurance, for doctors to be specific to themselves, and the Ministry may decide to take up half of the cost. So you make the doctors and the nurses responsible for their actions. Right now how it goes, a doctor makes a mistake, a nurse makes a mistake or anybody makes a mistake, it is thrown on to the Ministry of Health and the Attorney General. So guess what? Nothing happens. However, if you had your medical defence and as they do abroad, you are responsible for it. I think people would take much more care with what they are doing. So we are looking at those aspects of it.

It is not hard and fast, it has the policy developed by the Cabinet—sorry, policy by the Ministry of Health, and also approved by the Cabinet.

These are things we are looking at to make it safer for the people of Trinidad and Tobago to increase the amount of research and development—depends on the different categories of staff, and hopefully, the change that started off with the RHA, because we had to have a change from the public health system. The change that has started off with the RHA will metamorphosize into something that is way different down the road. You and I might not be here.

So, Mr. President, I want to thank you very much for giving me the extra 10 minutes. I thank you for doing it. [*Desk thumping*]

Sen. Camille Robinson-Regis: [*Desk thumping*] Thank you very much, Mr. President. I am very pleased to be given the opportunity to speak on this Motion, especially since the health system is a system that affects all of us in Trinidad and Tobago. The objective really is to see this system work effectively. We know that in 1994, the objective was to ensure that the RHAs brought a level of management and accountability to the system of health services. And clearly from what the mover of the Motion said, and even to some extent what the Minister said, this is not being achieved. Interestingly, Mr. President, concomitant with the growth in the expenditure in this system, is a growth in the level of dissatisfaction by the public, in the system of health care in Trinidad and Tobago. [*Desk thumping*]

It is passing strange that the Minister has stood here and talked about so many things happening within the health care system, and each day if you listen to the call-in programmes, there is always a complaint about the health care system in Trinidad and Tobago that has continued without let or hindrance. And despite the fact of what the Minister has said that they have spent money doing this, and bringing extra beds in the ICU and so forth, the

system is not serving the people of Trinidad and Tobago effectively. Mr. President, that is what needs to be dealt with, the management in the RHAs needs to be dealt with effectively.

I would like to ask the Minister of Health if he speaks with his own colleagues in the Cabinet, because one of his own colleagues has complained bitterly about what is taking place at the Eric Williams Medical Sciences Complex, in terms of the ICU Unit. I would like with your permission, Mr. President, to refer to a Ministry of Health/Regional Health Authority's comment form, from the hon. Suruj Rambachan. Have you seen it, Minister? The address, well, I would not give out the address and so on, but I think this comment form adequately indicates the kind of pain and suffering that members of the public have to endure when they go to the hospitals.

And really, if we listen to the Minister alone, we would be of the view that everything was hunky-dory in the health system, but his colleague, Suruj Rambachan, has another opinion. The document has 12 lines for comments, however, Minister Rambachan goes on to make 30 comments. This comment form is dated January 01st it looks like, 2014.

I would just like with your permission to read some of the comments:

1. Keep public toilets clean with liquid soap and toilet paper
2. Replace old bins
3. Fix broken tiles on all floors
4. Fix service elevator by ICU adult
5. Keep garbage areas outside clean and clear regularly and sanitize

4.15 p.m.

6. Get TVs for working areas, especially visitor areas.

7. Repaint hospital in brighter colours.
8. Check equipment for functionality on wards on a scheduled basis.
9. Pave roads and car parks.
10. Fix clocks which are not working.
11. Have more serious guards on ground levels.
12. Review contract of Magic Mist; underpaid workers.
13. More sanitary or hygienic workers at Rituals.
14. Medical staff need more support from procurement.
15. Replace all the furniture in working areas where necessary.
16. Do some public relations on patient care.
17. Shake up human resources—doctors disgruntled; medical staff disgruntled.
21. Get a properly qualified or experienced CEO in hospital management.
22. Spray doors on wards to avoid creaking, especially at night.
23. More visits by MOH officials—quality team to review and correct practices.
24. Deal with nursing shortage; go to Kerala, India.
25. Commission all ICU beds; get nurses.
26. Launder drapes in the waiting rooms; they are old and dusty.
27. Have a prayer room for families.
28. Have CROs walk the floors to sample patients.
29. Introduce employee surveys on a semi-annual basis to motivate change.
30. Your mission statement should be: A Better Quality Health

Care Facility.

Now, Mr. President—

Sen. Singh: He should be given a management consultancy contract.

Sen. C. Robinson-Regis: We will give him that when we get back into office.

Mr. President, this memorandum from Minister Suruj Rambachan is received on January01, 2014. On January 24, the North Central Regional Health Authority sent a report into the concerns listed by Dr. Rambachan and they went through each and every concern that was listed and they also took photographs of the state of the hospital and the photographs really indicate a hospital that is in a state of disrepair; a hospital that clearly, from what the Minister says and from the photographs that are here, needs to be attended to effectively by the RHA and perhaps even by the Ministry of Health.

It is passing strange that there are so many issues in this one complaint by Minister Rambachan that the Minister seems to be oblivious to what is actually taking place on the ground. This is not the only area of concern with regard to the health care system in Trinidad and Tobago.

There have also been complaints—and I hear the Minister talking about ensuring that beds have been purchased and that people are much more comfortable than they have been before, but by memorandum dated October 31, 2014, there is a complaint from the head of the Adult Emergency Department where the complaint talks about—

Dr. Khan: What region?

Sen. C. Robinson-Regis: North Central. I said that. North Central Regional Health Authority. And it says, "Overcrowding in Adult

Emergency Department—Legal Implications". And I quote:

> This is my first letter to you on this subject, but Dr. Helmer Hilwig, Head of the Adult Emergency Department, had written the legal department in the past.
>
> As you are well aware there is a serious overcrowding issue in the Adult Emergency Department with boarding of admitted patients in Adult Emergency Department for up to four days in some instances due to lack of ward beds.
>
> The implication of this is that critically ill patients are sometimes left in waiting rooms on chairs instead of trollies or beds; seizure patients on trollies without sidebars—and I repeat—seizure patients on trollies without sidebars; cardiac patients without monitors and several other critically ill patients left in substandard condition.

This is October 31, 2014.

> Examination rooms designed to house one patient are now housing six patients resulting in patients' privacy and confidentiality being compromised, as well as exposing patients to risk of cross infection. And the legal issues that have come up, the purpose of this letter is to get a written document from your office regarding the legal implications of this situation, bearing in mind that adverse events will occur—and this is in bold, Mr. President.
>
> I would be pleased to have the following legal questions answered in your reply:
>
> 1. Does Adult Emergency Department have the legal obligation not to accept new patients once our capacity is maxed out?
> 2. Could any Adult Emergency Department member of staff be

sued and proven legally liable for any adverse event emanating from this situation?

3. If the answer to question 2 is yes, would NCRHA take full responsibility for the legal defence of such staff member?

I eagerly await your prompt reply to this memorandum since I am desperately seeking legal guidance on the way forward.

This is signed by Dr. Malachi Ojuro, Head, Adult Emergency Department and copied to Dr. Shehenaz Mohammed, Chairman of the Board of the NCRHA. It is also copied to the CEO; it is copies to the Director of Health Services and several other persons.

Mr. President, I believe that the Minister is burying his head in the sand. [*Desk thumping*] It is not just a situation like this. There is also a growing situation with regard to the availability of pharmaceuticals. As you are well aware, under People's National Movement, we started the Chronic Disease Assistance Programme and that programme had been running quite well, but I have here a list of pharmacy services and the availability of drugs, dated October2014 and it has as a matrix, A, for available drugs; LA for limitED availability; NA for not available; and R for restricted.

- Under antibiotics, oral, tablets and capsules: there are 15 possible drugs; eight are unavailable, out of 15;
- antibiotics, oral suspensions: of 10, there are five unavailable;
- antibiotics, topical: of nine, seven are unavailable—seven out of nine;
- antibiotics injectables: of 21, 13 are unavailable;
- antibiotics injectables, continued: of eight, six are unavailable;

- antihistamines: of 12, six are unavailable;

Mr. President, these are drugs that deal with chronic situations in both adults and in children and, in the main, they are either unavailable or have very limited availability. [*Interruption*] No, this is generally.

I do not have any region attached to it. I just have "Pharmacy Services, Availability Listing". As far as I understand, the drugs are available from a central location because I see the Minister had told regional authorities to start purchasing their own drugs and I do not think that has actually begun, so it refers generally.

The Minister spoke about the cardio situation. With regard to cardiovascular drugs, of 33 possible drugs, 24 are unavailable. Again, of 20 possible drugs, 13 are unavailable and that is cardiovascular care.

It is highly disturbing that the Minister would come and tell us about hospitals that are being built and hospitals that will be built and the basic requirements in hospitals are not available. Beds are unavailable; drugs are unavailable; medical services are generally unavailable. [*Desk thumping*]

In terms of respiratory systems agents, and that is mainly for persons who have asthma, of 22 drugs, 16 are unavailable. In the Ear, Nose and Throat, again mainly for asthma and other types of infections of that nature, of 31 possible drugs, 23 are unavailable, Mr. President, and it is the same thing in gastrointestinal and that would deal with the issue of acid reflux. There are certain drugs that have been set aside for the CDAP and, in the main, they are unavailable.

With regard anaesthetics, of eight possible drugs that could be used, six are unavailable In many instances persons have allergies to certain drugs

and that is why you have a variety of drugs you can use, so that you would not want someone to have an allergy to a particular drug and it is just unavailable.

4.30 p.m.

Mr. President, I know by agreement we said we would end at 4.30 and, I really look forward to saying some more on the health system that is not serving us effectively. [*Desk thumping*]

Thank you, Mr. President.

The Minister of the Environment and Water Resources (Sen. The Hon. Ganga Singh): Mr. President, by agreement with the coordinator of the Independent Bench and the Leader of the Opposition minority, we agreed that we would have tributes paid to former Independent Sen. Michael Mansoor at this point in time. Dr. Bhoendradatt Tewarie, Minister of Planning and Sustainable Development would lead the tributes from the Government side.

CONDOLENCES

(MR. MICHAEL MANSOOR)

The Minister of Planning and Sustainable Development (Sen. The Hon. Dr. Bhoendradatt Tewarie): Thank you very much, Mr. President. Mr. President, Trinidad and Tobago has lost a loyal son and a dedicated citizen in Michael Mansoor, and it is only fitting that this Senate should take note of his passing and mourn his loss.

Mr. Mansoor served in this Senate for several years between 1987 and 1995 as an Independent Senator and always conducted himself with dignity and decorum, just as he always anchored his presentations to this honourable House in substance.

Michael Mansoor was indeed a man of substance. His disposition was always to be thoughtful, deliberate, well-prepared and as objective and as professional as possible, but he was also a doer and a high achiever. He tended to be task oriented and was propelled towards the achievement of objectives. He set high standards for himself as well as for others, and he believed in hard and dedicated work to get the job done.

Michael Mansoor was an accountant by profession, and as so many of the better ones in that profession, he was a stickler for detail. He practised his profession for many years and built a reputation as a thorough professional, a thoughtful advisor and a man of high ethical conduct. He rose from this realm to become a corporate leader and institution builder.

Many would remember him as Managing Director of the Ansa McAl Group from 1990 to 1998. He did yeoman service there; helped to strengthen structures and systems and set high standards of performance and for accountability for performance. Up to recently, he continued to be involved in the Ansa McAl Foundation.

Others will remember him in his leadership roles in CIBC where he served as executive chair for a decade. He made a big difference in that bank; both in Bridgetown and in Port of Spain. Mike Mansoor liked finance and banking and he enjoyed his job as a banker. Although the establishment and growth of this bank during the time that he served presented formidable challenges, but he did the best job he could before he took retirement.

But I remember Michael Mansoor most for his public service. He served as chairman of T&TEC during a troublesome period 1996 to 1998, because of the legacy left him by those who preceded him, and he wanted to think through some issues that required that business, financial and political

considerations, all be taken into account.

I was serving at the time as Executive Director of the Institute of Business, now Arthur Lok Jack Graduate School of Business. We had several discussions until he worked things through towards the required solutions. That is another thing about Michael Mansoor worth noting. He always sought out solutions. He always believed that a problem was there to be solved and that any problem could be solved.

When I became Principal of the St. Augustine Campus of the University of the West Indies, I asked him to serve as chairman of the campus council. He had enough work and he really did not have the time, but he agreed to serve. I would like to think that at least part of the reason he agreed to serve was out of personal consideration for me, and the cordial mutually respectful relationship we had developed over time.

We worked well together, he as chairman of the campus council and I as principal, during the period of our tenure, as we pursued the path of massive construction on the UWI campus, strategic planning, information communications technology infusion and acts of curriculum reform and the introduction of little things that would make a difference now taken for granted, such as the shuttle service and the evening university. He received an honorary degree of laws in 2012 from the University of the West Indies.

On occasion, Mike Mansoor and I would have discussion on personal matters. He was always about family: his wife, his children, his grandchildren. He loved them, he worked for them, he worried about them. There was light in his eyes whenever he spoke about them. He would also on occasion speak about our country Trinidad and Tobago, and about things like productivity; the effective harnessing of talent; the combative and

acrimonious nature of the politics, building momentum for higher national objectives and a fuller realization of Trinidad and Tobago's potential.

Trinidad and Tobago has lost a good citizen. The business world has lost a decent, understated humble leader. His family has lost a husband, father, grandfather who loved them all. On behalf of our Government team, let me say that we mourn his loss.

May God grant him peace.

Sen. Camille Robinson-Regis: Thank you very much, Mr. President. Mr. President, I join with the Government and my other colleagues in this Senate to pay tribute to Michael Mansoor.

Mr. President, I served during the time that Michael Mansoor served as an Independent Senator in this Senate. He served from 1987 to 1995, and I served in this Senate from 1992 to 1995, and it is really good and necessary for us to pause and remember and offer tributes to Michael Mansoor.

To have met Michael was to learn that he was much more than a respected Independent Senator and businessman. He was much bigger than that. We have all been reminded of his stellar scholarly achievements, and the business community of the entire Caribbean continues to sing praises for his untiring, inspiring and the kinds of contributions that he made in shaping the business sphere, particularly in the establishment of First Caribbean International Bank and, of course, his leadership within the Ansa conglomerate and, Mr. President, he made a significant contribution as an Independent Senator to the people of Trinidad and Tobago.

What really captivates me about Michael Mansoor is that I remember him as being someone whose leadership style, and indeed his style in the Senate was one that was calm and pragmatic. And as a—I was going to say as a

young Senator at the time, but then I would probably be dating myself, and seeing that I am still a young Senator [*Desk thumping*] I would say, as a younger Senator at the time, he was someone from the Independent Bench that we could really look to for leadership, for calm and for pragmatism. And as decision makers and deliberators on matters that would influence the lives of many, we could each take example from Michael Mansoor's style.

Mr. President, to be pragmatic is to be practical, to be logical, to be relevant, to base our course of action on the realities that surround us and to articulate our positions in as calm and composed a manner as possible. Michael Mansoor did that in each of his contributions to the Senate, and in his contributions to the development of Trinidad and Tobago.

Mr. President, in William George Jordan's discourse on *The Majesty of Calmness*, he says:

> "Calmness is the rarest quality in human life. It is the poise of a great nature, in harmony with itself and its ideals. It is the moral atmosphere of a life…self-reliant, and self-controlled. Calmness is singleness of purpose, absolute confidence, and conscious power,—ready to be focused in an instant to meet any crisis."

That describes Michael Mansoor as I knew him in this Senate.

Mr. President, when the day comes for us to depart this phase of life, we, too, will be remembered for how we influenced this space and how we influenced one another. Michael Mansoor influenced not only this space, but many throughout Trinidad and Tobago and throughout the Caribbean region. He was a great example for us, and I trust that there are some young men and young women growing up in our country thinking: "I would like to be a person of calm, integrity and pragmatism." He was a good template for

all of us; he was a good template for me.

I am trusting that Michael Mansour's legacy will endure, but ours is the challenge as citizens of Trinidad and Tobago to take it forward.

I extend heartfelt sympathy to his family, to his friends and to the people of Trinidad and Tobago.

Mr. President, thank you very much for this opportunity. [*Desk thumping*]

Sen. Helen Drayton: Mr. President, on behalf of the Independent Bench, it is my honour to say a few words in tribute to a gentleman, Mr. Michael Mansoor. In so doing, we extend our deepest condolences to his beloved wife Maureen Mansoor, his loving son and daughter, Allan and Natalie, and to the rest of the Mansoor family.

It was the Pulitzer Prize winner Ernest Hemingway who said:

> "There is nothing noble in being superior to your fellow man; true nobility is being superior to your former self."

Meaning, of course, a person's status prior to their continued growth and achievement. It was Michel de Montaigne, one of the most influential French writers of the French Renaissance who said:

On the highest throne in the world, "we still only sit on our"—behinds.

Now, whether writers like Hemingway or de Montaigne or revolutionaries like Gandhi, Mandela or philosophers like Immanuel Kant who saw reason as the source of morality, there are a couple of values that most people who become inspirations to their fellow citizens have in common, and they are humility and compassion.

The passing of Michael Mansoor is a light gently extinguished leaving us at

a time when we need lights of humility, of civility of maturity marked by our ability to skilfully negotiate and mediate societal problems, for Michael Mansoor was a skilful negotiator and a skilful mediator. Here was a man, husband, a gentleman, father, grandfather, friend and colleague of many who epitomized professionalism, modesty and diplomacy.

Now, his personal life was pretty much like his professional life. And I understand from his family, of course, he was a very humorous and fun-loving person. He loved Carnival, he loved to play mas, he loved pan and, of course, he loved to collect art, especially local and Caribbean art.

4.45 p.m.

He lived a philosophy that Gandhi espoused when Gandhi said, "It is unwise to be too sure of one's own wisdom", and "It is healthy to be reminded that the strongest might weaken and the wisest might err." So he, Mr. Mansoor, understood human frailties. He did not wield power to convey self-importance though he enjoyed a powerful status in business, in academia, as well as in social communities. He did not think himself as a brainy intellectual but, clearly, this was a person who was decent and whose intellect had evolved to a high level of astuteness and enlightenment that is very, very unique on the board of leadership today, and, no doubt, it was his humbleness that facilitated such tremendous personal growth and love of his fellow men.

Here we had amongst us another patriot who shared much of himself in the interest of national service, also his company, his profession, and the welfare of employees and customers. He believed deeply in youth development and he once told university students, "You can take the first job that comes your way, you can decide that Trinidad and Tobago is the centre

of the universe and not pursue opportunities to work in a highly competitive world, and you can choose to insulate yourself from world-class competition". He saw the usefulness of Caricom. He understood that the social and economic problems of Caricom partners must affect us and how we treat with them benefits either our progress or our detriment.

He anchored this view in his knowledge of Caribbean history and regional success in the professions in academia, in arts, sports, athletics and business. He was proud of the successes of the region and, namely, he mentioned Trinidad's petrochemical sector and its light manufacturing industries. He mentioned the tourism of St. Lucia, Jamaica and Barbados, and the international financial services of the Cayman and The Bahamas. He was proud of Caribbean bands. He was proud of Bob Marley, Carib, Red Stripe, Sandals, the "Mighty Sparrow" and Brian Lara, just to name a few. In his own words he believed that the time and the tide are running against us, and he said it is up to our young graduates to transform and advance the Caribbean societies to flourishing democracies and economic prosperity.

He said there is potential for our youth to become shining examples of professionalism and hope, and they could harness and convert intellectual capital into real income and real jobs. He also advocated seizing opportunities to contribute to green energy, to make agriculture and food production an axis of future prosperity. He once asked students of a graduating class, "Why, for example, do we have a world famous Cocoa Research Unit with the world's most famous International Cocoa Genebank and we rank nowhere in the top cocoa producers of the world?" He said further, "Consider the myriad opportunities in the technology sector". He also asked another question, he said, "Have we thought about the impact of

having now, people who are dependent on unemployment relief programmes, exchanging their 10-day assignments for the higher paying jobs in the information industry?"

So what Mr. Mansoor was projecting here was that we should not place boundaries on the human potential because of their social or educational circumstances, nor to let our prejudices blind us to the creativity and will of the nation's human capital. He saw the promise that exists in the twin island of so much beauty, raw talent and creativity, and he brought this out in his Senate debates when he spoke about labour, the economy, strengthening the Judiciary indiscipline as evident by the way we litter with impunity, and the need for the law enforcement in a just and timely manner.

So as we pay tribute to the memory for this distinguished person, how many excellent contributors to the growth and development of this country we have lost in recent times, and we stand here, we speak of their contributions and their virtues that endeared them to us, but what are we going to do about that legacy? How are we going to use their exemplary stature to infuse our discourses with integrity and dignity? How are we going to use their exemplary corporate behaviour to infuse business across the landscape with ethical professionalism? And how are we going to use it to inspire young people? Well, he too was a person of academia, had his dreams. We have five universities, should a collective framework be established for producing comprehensive leadership profiles and case studies of local and regional luminaries to complement the stock of foreign case studies used by students in relevant university subjects? Most discussion in academia or leadership traits and styles focus on foreign entrepreneurs and foreign country leaders. That is fine, but would not such a project be

tremendously useful in deepening our socio-economic history and culture?

Is this not an excellent way to keep the tremendous contributions of Michael Mansoor and other leaders alive and relevant in the minds of our young people? Would it not give them a sense of history and depth of our local civilization? Would we not be better off for such a project? I close by saying, thank you Mr. Michael Mansoor for your wisdom, your grace and guidance that you have given to business and the community of Trinidad and Tobago. May you rest in peace. [*Desk thumping*]

Mr. President: Hon. Members, if I may follow on together with the tributes that have preceded me in terms of Senators' statements relating to the late Senator, Michael Kelvin Mansoor, who served with distinction as an Independent Senator, and, as I do so, I certainly would like to support the proposal put forward by Sen. Drayton.

Michael's passing on November 11, 2014, represents a great loss both to the corporate world and to Trinidad and Tobago itself. His was a life of dedicated service. He was an outstanding exemplar who was able to role model to many of us. Michael was one of the most honourable, ethical and distinguished gentleman with whom I have had the pleasure and honour to work.

Michael stands out in my mind as a true patriot of Trinidad and Tobago. All of his efforts, in whatever his field of efforts, were dedicated to the development of the institutions and the people of Trinidad and Tobago. When I think of Michael, the image that comes to me is one of a rock. Michael was a rock among us and you know that in his company, when he was chairman, the question of failure was not an option. Michael would always live up to any challenge in order to find a solution to meet the

challenges that always come to each one of us and, therefore, there was that sense of abiding confidence whenever you were in the company of Michael.

This dedicated and humble servant of Trinidad and Tobago was a product of Saint Mary's College where he won the open national scholarship for languages in 1966, but more outstanding in his intellectual brilliance was Michael's ethical and principled approach to every aspect of his work and service. These qualities form part of the fabric of Michael's being, and for this grounding we can be thankful for the quality of his family life, his teachers at Saint Mary's College, and his mentor when he was there, Father Toba Valdez. To his wife Maureen and his children Allan and Natalie, his grandchildren and all the members of his family, this Senate extends our sincere and heartfelt condolences. May the soul of Michael rest in peace and should he hear those words telling him, come forth, good and faithful servant.

I also wish, at the end of his tribute, to make another announcement. At this point we intend to have one minute silence in honour of Michael Mansoor.

The Senate stood

Mr. President: Thank you. Leader of Government Business.

ADJOURNMENT

The Minister of the Environment and Water Resources (Sen. The Hon. Ganga Singh): Thank you, Mr. President. Mr. President, I beg to move that this Senate do now adjourn to Tuesday, November 25, 2014, at 1.30 p.m. when we will deal with a Bill entitled, "An Act to establish a Council for Urban and Regional Planners and to provide for the regulation of the urban and regional planning profession and other matters incidental thereto".

PRESS BRIEFING

Mr. President: Before I put the question, hon. Members, I just want to make an announcement of a press briefing. I was asked to remind members of the media that the Chairman of the Joint Select Committee, Group 2, will be holding a press briefing in the J. Hamilton Maurice room after this Senate is adjourned. Senators and members of the public who are present may also attend that press briefing.

Question put and agreed to.

Senate adjourned accordingly.

Adjourned at 4.58p.m.