the Australia and New Zealand School of Government

CASE PROGRAM 2006-58.2

Challenging the health process, fixing the hurts in St Vincent and the Grenadines (B-Sequel)

Mrs Verlene Saunders, Permanent Secretary in the Ministry of Health of St Vincent and the Grenadines (SVG) had been given three months to plan the transformation of the Milton Cato Memorial Hospital (MCMH) as a quasi-commercial operation, run by a separate Hospital Authority. This would be the first stage in a comprehensive health system reform process. Among the most pressing issues were conflicts between the public and private uses of the hospital, and problems in attracting and retaining specialist staff.

Mrs Saunders' first actions included bringing in a consultant to provide more detail on the human resources issues at the hospital (see *Exhibit 1)*, and consulting with the Medical Association on professional issues including the public/private relationship. As the February deadline approached, she had a number of options to consider.

Options proposed to remedy the situation

Mrs. Saunders paid careful attention to the options proposed to remedy the situation. The first was that a case load mix between public and private patients be adopted. Under this option the hospital management would be allowed to monitor the number of public to private patients on operating lists and ensure that it was maintained within acceptable levels.

This case was written by Reginald Thomas for the Centre for Management Development, University of the West Indies, with supervision from Dr Richard Norman and editorial assistance from Janet Tyson, Australia and New Zealand School of Government. It is a sequel to case 2006-58.1.The use of teaching materials is restricted to authorised persons. The assistance of Mrs Verlene Saunders is gratefully acknowledged.

The second concerned the sale of time for use of the operating theatre. This option would involve identifying a block of theatre time, which would be costed and sold to surgeons/specialists. This would allow government to ensure full recovery of the cost of its services even if the fees were paid to consultants in their private offices.

She referred to the comments of the Medical Association regarding the options and took account of the fact that the association supported their implementation. However, she knew she would be challenged to implement the following key recommendations which were necessary to support any course of action:

- A code of conduct for regulating the procedure for private practice as part of the regulatory framework for clinical practice.
- Development of supporting manuals which should form the basis for the conduct of private practice
- Establishment of a standard of private fees for surgical procedures
- Establishment of a ratio of 3:1 public/private patient
- Building of a separate private wing at the hospital
- Establishment of formal clinical departments
- Educating the general public on the use of hospital facilities for private patients.

As Mrs Saunders reviewed this list, she recalled that the final draft of the proposed implementation plan was still to be reviewed. She had one week in which to accomplish this. Mrs Saunders summoned her team to her office so that they could review the draft and prepare the presentation to be made to Cabinet.

She was encouraged following the presentation, when the Cabinet accepted the implementation plan and approved the recommendations regarding the new governance structure for the Milton Cato Memorial Hospital.

Would she now be successful in implementing the code of conduct and the procedure to regulate private fees?

Exhibit 1:

Human resources issues identified by the Consultant

The majority of managers who were interviewed by the consultant indicated their concern with the level of indiscipline among staff, resulting largely from the fact that the Hospital Authority had responsibility for service but no authority to handle disciplinary matters. The Chief Personnel Officer whose responsibility it was to deal with such matters did not do so in a timely manner.

Other major human resource issues, which were reported, included:

1. A shift system which allowed nurses to work from 7:00 p.m. to 7:00 a.m. in the night compared to the 7am to 2pm or 2 pm to 7pm in the day was perceived to be unfair by the nurses. The effect of this system was felt particularly at nights where the patient-nurse ratio was unacceptable

2. Low salaries paid to nurses and doctors were a major concern. The salaries paid were the lowest in the OECS[1] sub-region. The salaries paid to skilled clinical and technical professionals were also very low, and in no way compensated for the level of expertise, responsibility, and risk that came with the job. There was a visible level of dissatisfaction among staff, especially among those that did not have additional means to complement the salary they received. A number of resignations had attributed to this factor, and it was believed that more individuals would leave in the very near future in order to earn better salaries elsewhere. A few staff members talked about the freezing of salaries some years ago, and anticipated that the re-classification exercise that was presently taking place in the Public Service would address the salary problem.

3. The number of unfilled posts in many of the critical care areas affected the utilisation of the Operating Theatre. This was the sentiment strongly expressed by the Medical Director of the hospital, and the Operating room Sister. However the efforts to improve the workload, and bring greater efficiency and effectiveness to the Operating Theatre services could not be realised, due to the shortage of operating room nurses. Currently the operating theatre started work at 8:00am and ended at 4:00 pm. It was not regular to have elective cases going later than 4:00 p.m. Emergencies attracted a twenty-four hour service. It was the norm to have one theatre nurse on duty working between the two functional operating rooms, and preparing day cases in an area adjacent to the operation rooms. In addition, other vacancies included:

4 positions - Laboratory	24 positions - Staff Nurse
3 positions - Radiology	5 positions - Pharmacy
3 positions - Medical Records	8 positions - Medical Dept.
2 positions - Physiotherapy Dept.	1 position - Dietary Dept.

4. The limitation of the current establishment:
   The Dietary Department had one Dietitian on the establishment. The position was vacant; a Nutritionist was also on loan to the hospital.

[1] Organisation of East Caribbean States

In addition, the establishment did not address the need for social services in the hospital. There was one medical social worker on staff who provided services to the hospital and to the Geriatric Hospital.

The social worker was unable to attend to all the patients who required her services. This placed her in the unfortunate position of having to prioritise according to how critical the patients' need would be at the specific point in time.

Secretarial services were greatly lacking at the hospital. The Medical Director's Secretary was shared with other Hospital Management, and a number of other persons. She performed the duties of a mini-Librarian, and helper to the Medical Interns and Medical Students. Other areas such as the laboratory, radiology, pharmacy, and Medical Records were without a secretary.

5 The absence of procedural manuals:
The absence of procedural manuals was evident in a number of areas, with the exception of the nursing administration. This was indicative of an institution that did not take seriously the implications of providing service without the necessary guidelines, to ensure quality, safety, and security of the patients, and the staff in a high-risk environment.

6. Inadequate materials management:
The hospital had very little control over the management of supplies. There was no materials management department or unit within the hospital. The hospital Administrator assumed the tasks of ordering some items and the major supplies. The Deputy Administrator assisted by ordering the other supplies. This was in addition to the many other tasks they had to perform on a daily basis.

The procurement function was somewhat duplicated. A major part of the supplies for the hospital was done by the Senior Pharmacist at the Central Medical Stores. The approval for supplies to the hospital resided with the Ministry of Health, and the Ministry of Finance. Documents were passed between these two institutions at a pace that did not enhance the efficiency of the process. A steady, adequate, and consistent source of supply was not always available to the hospital. Hence the hospital at times found itself short of very critical supplies.

The overall result of all this was that the quality of care was not at the standard that should be expected of such a hospital. Patients experienced long waiting hours in some out-patient services and at times drugs were not easily accessible at the hospital.

The hospital's progress was stifled as a result of the ad hoc way in which decisions were taken, and the lack of appreciation for timely performance. Staffing of the operating room was poor and there was no provision for nursing personnel to establish a fully operational out-patient surgery.

The salaries paid to nurses and doctors were the lowest in the East Caribbean region. The salaries paid to skilled clinical and technical professionals were also very low, and in no way compensated for the level of expertise, responsibility and risk that came with the job.

Each year, large numbers of staff, specialists and consultants left for better-paid positions overseas; other resignations were caused by frustration with the system, inability to change it, and lack of career opportunities.

This resulted in a major shortcoming of the hospital being, the inability to bring the key human resource in short supply up to a satisfactory level to the benefit of the patients, the hospital and to the satisfaction and motivation of the staff.

In addition, there were inefficiencies in the clinical department which affected the delivery of particular service e.g. radiology, unacceptable level of service provided by the pharmacy, chronic staff shortages in the areas of physiotherapy, dietetic, records and unwarranted transfers of unsuitable staff to the hospital.

The hospital organisational structure did not allow scope for staff development and upward or even horizontal mobility. This resulted in frustration and a sense of loss among both professional and non-professional staff. The system was closed due to the control of central bureaucracy of the public service. There was no opportunity for the creation of a stimulating environment that challenged the creativity, and innovativeness of the professionals in the hospital system.