the Australia and New Zealand School of Government

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Challenging the health process - fixing the hurts in St Vincent and the Grenadines (A)

When Mrs Verlene Saunders, Permanent Secretary in the Ministry of Health, opened the memo on 26 November 2002, she was dumbfounded. Nothing in her outstanding public service career had surprised her more than the note indicating that the Cabinet had decided to proceed with health sector reform by January 2005 and, within three months, required a plan of action. Milton Cato Memorial Hospital (MCMH) was to be organised as a quasi-commercial operation, run by a separate Hospital Authority, as a first step in the reform process. As Mrs Saunders contemplated her options, she pondered on the many issues that must be addressed. Could she handle the long-standing issue with the doctors and their largely unregulated fees? And what of establishing a code of conduct to ensure quality care to the public? She became very despondent as she thought about what was required to successfully transform the operations of the MCMH. The plan would require commitment from a number of stakeholders but how could a workable win-win solution be reached?

The country

St Vincent and the Grenadines (SVG) is a small multi-island nation in the Eastern Caribbean. It is located between the Caribbean Sea and the Atlantic Ocean, not far from the South American mainland, with a population of about 109,022. Seventy-nine percent of the country's population is 15 years and older. The country has a democratic system

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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 has been prepared as a basis for class discussion rather than to illustrate either effective or ineffective handling of a managerial situation. The assistance of Mrs Verlene Saunders is gratefully acknowledged.

of government with the Governor-General as head of state representing the Queen. It is a small open economy mainly dependent upon agriculture, tourism and financial services.

In 2002 the Gross Domestic Product grew by 1.98 percent and the GDP per capita income was estimated at EC $7,468[1]. While 95 percent of the population had access to good quality drinking water, 38 percent lived below a poverty line defined as $88.53 per household monthly.

The health services sector

The SVG government spent just over four percent of GDP on health, amounting to $39.8 million in 2001 and $40.3 million in 2002. Health spending accounted for between 12 and 13 percent of the annual budget. The medical workforce per 10,000 people consisted of 6.9 physicians, 19.8 trained nurses, 1.4 dentists, 1.1 laboratory technicians, 2.5 pharmacists and 1.1 environmental health officers. For every 1000 people, there were 5.3 hospital beds.

Specialist health care was delivered through the government-owned MCMH Hospital, five rural hospitals, and 39 health clinics spread over nine health districts.

The MCMH, situated in Kingstown the capital of St Vincent, was the major health care institution for the country. As the single entity with the largest number of staff, it used the largest portion ($13.9 million or 34.4 percent in 2002) of the Ministry's recurrent, operations and capital budget.

Recurrent Budget

Ministry of Health Budget	Hospital Expenditure	Percentage Use
2003 – $41.7 million	**$14.6 million**	**35%**
2002 - $40.4 million	**$13.9 million**	**34.4%**
2001 - $36,6 million	**$11.8 million**	**32.2%**

Assisted by health interventions such as high vaccination coverage (85-100 percent in the 0-5 years age group of the population during the last fifteen years), life expectancy had steadily increased in SVG. From 58 years in the 1960s and 70s it grew to 65 years in the 1980s and 90s and seventy-three years in years 2000, to 2002.

The average national mortality rate over the last five years was recorded at seven per thousand. This compared favourably with similar countries in the Eastern Caribbean, Grenada also being 7/1000, Dominica 5, St Kitts 4, St Lucia 1 and Barbados 2.

At the same time, infant mortality rates had been markedly reduced, from 60 per thousand live births in the 1980s to 18/1000 in 2002. Live birth rate recorded a gradual decline

[1] All figures in EC dollars: approximately 4 EC dollars to the $US.

from 30/1000 in the 1980s to 24/1000 in the 1990s and by 2002 had further declined to 19 per thousand.

Issues in the health sector

Despite its successes, there were many new difficulties facing the health care system. Non-communicable diseases such as cancers, diabetes, hypertension, heart disease and their complications had escalated to become major public health issues, as many people resorted to sedentary life styles, with diets high in fats, sugars and salts.

For the last ten years, non-communicable diseases had been the five leading causes of death in SVG, except for the year 2000 when HIV/AIDS emerged as the third leading cause of death.

These factors increased demand for specialist, hospital-based health care. However, for a number of years there had been rising public concern about the cost, quality and accessibility of health services.

Within the health system, there was increasing frustration with pay rates, which were the lowest in the East Caribbean region, and employment conditions, including some extremely demanding shift patterns. Staff turnover was continual, with many migrating to better-paid positions in the US, UK or Canada.[2] The MCMH fought a losing battle to fill available staff positions, and to retain specialist consultants.

At the MCMH, the Hospital Administrator and the Hospital Medical Director reported to the Administrative Head of the Ministry of Health. The central Public Service Commission made the majority of staff appointments to the MCMH, as it did for other departments, so a specialist might have no say over who was in an operating theatre team.

In 1999 the government of the day proposed a comprehensive reform of the health sector, intending to introduce it along with a new National Health Insurance scheme. The reforms included a proposal for the MCMH to be managed by an autonomous Hospital Authority (See *Exhibit 1)*.

Twelve different reports were prepared as background for the reform. The reports covered everything from economic and social predictions to cost calculations and possible provider payment mechanisms. Almost all the reports highlighted in some way the problems created by the relationship between private and public health delivery.

Public and private services

All public hospital services were subject to specified user fees, to be paid directly to the hospital. However, some specialist consultants were allowed to admit and treat private

[2] The St Vincent nurse training was highly regarded. A typical recruitment package for the US offered to pay for further training, pay for sick days, sponsorship and insurance coverage for the family, and a salary equating to $EC 180 to $240 an hour.

patients at the public hospital. The payment for these services was unregulated since the fees were paid directly to the consultants in their private offices. Both patients and health professionals were concerned at aspects of this.

A main concern for the public was the difference in quality of care offered by consultants to their private patients compared to the public patients. There had been complaints to the Minstry of Health that public patients seeking treatment at the MCMH had been asked to pay unreasonable fees to medical practitioners. On some occasions, it was said, patients were told that medical attention would not be given unless the fees that were demanded were paid. Some persons reported that they had to remain in the hospital for several days and were forced to pay the fees before any treatment was given.

Within the health system, consultants were concerned about what they saw as an inequitable and inconsistent approach to permitting private practice. As far back as 1984, they had made recommendations to address the problem, but nothing had been progressed. Over the years, a number of specialists had resigned, citing frustration that Ministry of Health bureaucrats seemed unable to bring in an equitable system for private practice across the board.

The new Minister of Health

When the new government of SVG came into office in 2001 it established several accountability and reporting mechanisms to assess the current state of affairs in all state entities and ministries, particularly that of health, where the Health Sector Reform Committee was set up.

The Honorable Minister of Health, Dr Douglas Slater, committed himself to the implementation of the Government's policy regarding health sector reform. The general public was assured that the issues of accessibility, affordability and quality in the health care system would be addressed.

The MCMH presented the gravest challenge. The Minister was acutely aware of the widening operational deficit at the hospital and the fact that with the low levels of productivity, increasing expenditure and low levels of revenue growth for the last seven years, the quality of health could not be sustained.

Dr Slater knew only too well what would be the outcome if the implementation of reform was not done well and if all of the players were not happy with the changes to be implemented.

The Minister recalled the year 2000 and the days of the "sick out"[3] by the nurses, and he mentioned the increasing rate of their migration to the United States and England. He also noted the departure of many consultants, some of whom were Vincentians, who were very aggrieved with the public/private issue. He was determined to fix this problem

[3] Industrial action by taking sick leave

Dr Slater himself had been employed as Medical Officer of Health at the time when a system of user fees was implemented. He had witnessed firsthand the reaction of the public. As Minister of Health, he had everything at stake and was determined that the plan of action must bring results.

His government had decided against a wholesale implementation of health sector reform, incorporating the introduction of a new National Health Insurance Programme.
The first step in the reform and repositioning of the country's health sector, to meet the growing needs of the country's population with high quality, timely and affordable services, would be to strengthen hospital services.

The Permanent Secretary for Health

Mrs Verlene Saunders had worked for thirty-two years in the Government public service. Her initial education, in Canada, was in the field of public administration and she attended many in-service training courses in related disciplines. She had a stint in the SVG Department of Treasury in the Ministry of Finance, but worked for most of her career at the Ministry of Health handling administrative issues.

Her new position was very challenging. As Permanent Secretary, she not only had responsibility for the MCMH and its attendant facilities, but for the nursing staff, School of Nursing, the Mental Hospital, the Sanitation Department, the Senior Citizens' Home, medical stores, community health services and for the full accounting system of all the above entities.

In addition, she represented the Ministry of Health on regional and international health committees and served as the country's representative at the Pan American Health Organization and the World Health Organization and liaised with other agencies on behalf of the Minister and the Ministry.

In her post as assistant secretary, which she held for seven years before becoming permanent secretary in 2002, she had very few encounters with the senior personnel at MCMH and only dealt with few of the issues that were impacting the hospital. As Permanent Secretary, she would have to confront them all.

The Milton Cato Memorial Hospital

MCMH had many roles. It was a general acute care facility which served as the referral hospital for all other hospitals, health clinics, and other health care agencies in the country. It also had facilities for teaching, providing ongoing support for medical and nursing students (training between 20 and 50 each year), and offering them practical training. It gave high school students interested in a medical career the chance to spend time in specific departments, to confirm their area of interest prior to pursuing their university studies.

The hospital had a bed capacity of 209 and provided specialist services in medicine and surgery. 8,849 admissions were recorded in 2000 with an average length of stay of 4.7 days and a 56.3 percent occupancy rate. One third of admissions were in maternity, 58 percent of admissions were to accident and emergency. Services at the hospital were provided at subsidised costs through a system of user pays for patients.

Over the past 20 years, the hospital had been expanding its services, responding to the demands of physicians and patients. This expansion was not matched with a corresponding expansion in staff numbers. Between 1996 and 2002, there was a three percent increase in the number of available positions, bringing the establishment to 502.

A number of established vacancies had not been filled, and staff turnover was high. The MCMH had a budgeted staff complement of 120 nurses and 40 doctors. In 1999 and 2000 the hospital had lost 32 percent of its registered nursing population, mainly to migration. Of the 120 positions there were 24 vacancies.

Although this trend was well known, there had been little forward planning for the workforce. With chronic staff shortages, the hospital could not bring the key human resource up to a satisfactory level for the benefit of patients and the satisfaction and motivation of the staff. This had an ongoing effect on service quality and delivery.

The Public Service Commission's central role in staff appointments, and the hospital organisation itself, restricted career development and even horizontal mobility.

The Hospital Authority

In an effort to improve the operational efficiency of the MCMH, the government had agreed to reform the current governance structure of the hospital, with a view to increasing the level of autonomy, and improving service delivery and financial sustainability.

The proposal was to create an independent Hospital Authority, with a board of directors nominated by Cabinet comprising public, private sector and independent persons with requisite skills.

The finance subcommittee of the Health Sector Reform Committee was asked to put forward proposals, possibly based on overseas examples, for ways the Hospital Authority could be structured to operate effectively.

But first, it was to assess the financial operations of the hospital over the last seven years, mainly to address the declining situation in the level of collection of user fees from patients at the hospital.

The financial situation of the hospital

The committee, with membership from the banking and private sector, as well as representation from hospital specialists, reviewed data for the period 1996-2002 *(Exhibit 2)*.

This showed that between 1996 and 2002, the hospital's operating deficit had increased by 50 percent, reaching $12.13 million in 2002, from $8.67 million in 1996. Annual spending had increased by 34 percent while revenue had declined by 22 percent over the period under review. Revenue as a percentage of expenditures also declined during the seven-year period. In 1996 user fees recovered 9.5 cents out of every dollar spent. By 2002, the recovery rate fell to 5.5 cents out of every dollar spent.

The data also indicated there was a slight shift in the structure of the expenditure at the hospital. In 1996, approximately 81 cents out of every dollar was spent on personnel. This increased to 86 cents by 2002. This meant that the growth in personnel costs outpaced the growth in expenditure in other areas.

The committee identified one of the main causes for the loss at the hospital as the current relationship between the public and private system, where private patients paid directly to their private doctors even though the services were rendered at the public hospital.

Outdated and inefficient record-keeping and other systems allowed for wastage and little accountability. Although there were user fees for most hospital services, weaknesses in the billing and collection mechanisms meant that patients might access services without being billed. Current user fees were outdated, and needed to be brought in line with the actual cost of providing the services; MCMH lacked a comprehensive system for costing for its various services to inform the level of user fees.

Strategies for the new structure

The committee was challenged to identify appropriate strategies which could alleviate these problems. Varying options from Canada, United States and United Kingdom were assessed, and after careful consideration, the following three propositions were advanced:

- Firstly, a commercial operation, with no National Health Insurance: In this model, the hospital authority would operate on a strictly commercial basis. This would necessitate the development of a more effective structure. In this option, no government financial support was envisaged. The hospital would have to generate sufficient revenue to meet its operational costs.

- Secondly, a subsidised or quasi-commercial operation: In this option, the Hospital Authority would have nominal user charges with the shortfall made up from the Government's budget.

- Thirdly, as a commercial operation within the context of a National Health Insurance Programme (NHIP). In this case the NHIP would be the main source of financing for the Hospital Authority.

The committee carefully considered the options and their anticipated consequences. It recommended adopting option two as a transitional arrangement, while the NHIP was being reviewed for implementation.

The challenges to be overcome in order to fix the system

Mrs Saunders now knew which structure she must plan for. The challenges were numerous and also included drafting regulations to govern the contracting of goods and services, developing the internal audit policy, establishing financial guidelines, reviewing and regulating admissions, billings and collection procedures, preparation of a public relations policy, developing the human resource policy plan and implementation strategy and finally addressing the issue of unfilled vacancies.

She reviewed her mandate and noted that she was authorised to co-opt the necessary expertise. She wondered if the budgeted amount of $300,000 would be sufficient for the work allocated. She knew that it was possible to receive technical assistant from the Pan-American Health Organization, but that assistance was limited. Convincing the Ministry of Finance to allow her to seek additional funding would be a significant challenge.

As Mrs. Saunders made her to-do-list, she realised that the first page of the note pad she kept with her jottings was almost full and there was no mention of the round of consultations that she must hold with the Trade Unions and Associations representing the doctors, the nurses, and the non-established workers.

How were the efficiency issues to be addressed given the magnitude of the prevailing problems? Which of the issues should be given priority? Should matters of governance and accountability be handled first? The task seemed insurmountable and she only had three months to complete all negotiations and draft the plan. She wondered aloud “where do I begin?”

Exhibit 1

Proposed Hospital Authority
Statement of Operations
(EC Dollars)

	2000	2001	2002	
REVENUE	624,391	599,637	711,646	
EXPENDITURE				
Personnel Expenses	11,009,918.	11,279,453	12,604,090	
Material and Supplies	5,340,866	5,224,069	6,980,066	
Operating and Maintenance	311,179	299,903	391,741	
Utility Charges	704,807	597,728	425,510	
Other Expenses	41,880	66,804	87,112	
	17,408,650	17,467,957	20,488,519	55,365,126
Surplus/ (Deficit)	(16,784,259)	(16,868,320)	(19,776,873)	

RATIOS			
Cost Recovery Percentage	3.6%	3.4%	3.5%
Number of Employees	571	574	587
Revenue Growth	-5.6%	-4.0%	18.7%
Expenditure Growth	2.0%	0.5%	17.2%
Personnel costs as % of Total Expenditure	63%	65%	62%

Note: This statement consolidates the operations of the four (4) programmes mentioned.

Exhibit 2

MILTON CATO MEMORIAL HOSPITAL
REVENUE & EXPENDITURE STATEMENT 1996 – 2002
(EC Dollars)

	1996	1997	1998	1999	2000	2001	2002
REVENUE	914,147	831,697	706,163	661,403	624,391	599,637	711,646
	914,147	831,697	706,163	661,403	624,391	599,637	711,646
EXPENDITURE							
Personnel Expenses	7,798,880	8,279,663	8,779,492	9,212,581	9,636,958	9,906,817	11,042,285
Material and Supplies	984,835	960,503	929,602	958,713	1,006,295	1,056,055	1,046,200
Operating ant! Maintenance	304,269	347,546	423,705	235,343	290,077	281,089	370,701
Utility Charges	467,834	467,860	457,822	555,875	576,000	488,274	298,830
Other Expenses	26,566	27,755	43,411	223	41,658	65,404	87,112
	9,582,384	10,083,327	10,634,032	10,962,735	11,550,988	11,797,639	12,845,128
Surplus/(Deficit)	(8,668,237)	(9,251,630)	(9,927,869)	(10,301,332)	(10,926,597)	(11,198,O02)	(12,133,482)

RATIOS							
Cost Recovery Percentage	9.5%	8.2%	6.6%	6.0%	5.4%	5.1%	5.5%
Number of Employees	486	484	490	487	489	492	502
Revenue Growth		-9.0%	-15.1%	-6.3%	-5.6%	-4.0%	18.7%
Expenditure Growth		5.2%	5.5%	3.1%	5.4%	2.1%	8.9%
Personnel costs as % of Total Expenditure	81.4%	82.1%	82.6%	84.0%	83.4%	84.0%	86.0%