Health reform in Trinidad and Tobago: lessons for the Pacific islands?

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Introduction

Trinidad and Tobago (T&T) is a two island country with a population of 1.4 million (with about 50,000 people residing in Tobago). It is the southernmost Caribbean state with approximately 5 miles, at the closest points, separating it from the east coast of Venezuela. The country enjoys the benefits of having a petroleum based economy.T&T has maintained a relatively stable economic base and is considered an upper middle income country in terms of development status.

It was a British colony until 1962 and has a Westminster style Parliamentary system despite taking republic status in 1976. The entire public sector is governed by regulations.This centralised civil service system worked when there was a stable predictable environment with limited capacity in the private sector. However, with the rapid pace of change over the last years, there has been a prevailing sense of continuous crisis management as the bureaucracy has failed, and continues to fail, to respond in a timely manner. This is particularly apparent in the health sector where the public sector plays a dominant role in health service delivery and in which there have been significant changes in the factors that affect health and health status.

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In response to almost two decades of analysis of the health sector, the country has embarked on a comprehensive programme of reform following successful negotiation with the InterAmerican Development Bank (IDB) for a 7 year loan which will finance 70% of the costs of the programme. The main thrust of the programme is to address the institutional constraints that have frustrated many of the previous efforts at improving health care delivery in the public sector. It was recognised, however that a 7 year programme must support some ongoing infrastructure investment given the poor state of some of the public sector facilities - and so the programme comprises of a mixture of institutional strengthening (software) and infrastructure (hardware) components.

Are there lessons for the Pacific?

The Pacific shares many common geographic, political and economic features with T&T. If there are relevant issues in any health sector reform experience from country to country, they exist not only because the countries are either islands or continents or developed or developing economies, but because there is a perceived need for countries, donors and health sector financiers to:

- understand the interrelationships of the problems in the sector;
- to gauge what is politically and technically feasible in the short term; and
- to agree what must be done in order to address the more difficult institutional issues in the medium and longer term.

The following analysis of the health sector was based on the work in T&T and has been substantiated by the work done on health sector reform (HSR) by the Institute for Health Sector Development (IHSD) in other countries and regions over the last two years. The approach taken was to frame the problems and interventions required in such a way that readers could develop or strengthen national health sector reform initiatives by tailoring the analysis to their particular situations and political reality. It therefore takes a broad organisational view so that the interrelationships among the various issues can be explored, and in a case study fashion uses examples from the work done in the T&T Health Sector Reform Programme (HSRP).

The challenges facing the health sector

The major challenges facing the health sector are listed in Figure 1. They are grouped under five main headings for this

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Figure 1. The main challenges facing the health sector

Changing demographic profile
aging of the population (the adult and elderly population will grow to about double their size in the next 25 years)
greater proportion of the population living in urban communities
higher literacy rates and education levels
Changing epidemiological profile
control of EPI communicable diseases and falling IMR
leading causes of morbidity and mortality are related to chronic diseases like heart disease, stroke, diabetes, cancer and accidents
leading causes of morbidity and mortality in under 15 year age group are accidents and behavioural problems
new communicable disease problems like HIV/AIDS
Rapid changes in technology
advances in ambulatory care - day surgery and minimal invasive procedures
advances in telecommunications and computer technology
more and more can be done in the doctor's office
introduction of new expensive drugs
blurring of specialty boundaries - who does what
Growing inability of the public health sector to meet the demand for health services
shrinking national health budgets in real terms
lack of capacity to identify the medically indigent
lack of management capacity and authority
limited coordination with other sectors and providers
National policies to introduce market based incentives
liberalisation of currency and trade policies
dismantling government monopolies, encouraging the growth of the private sector
improving consumer protection mechanisms
remodeling of tax collection systems
strengthening of the 'safety net' in the social sector(s)

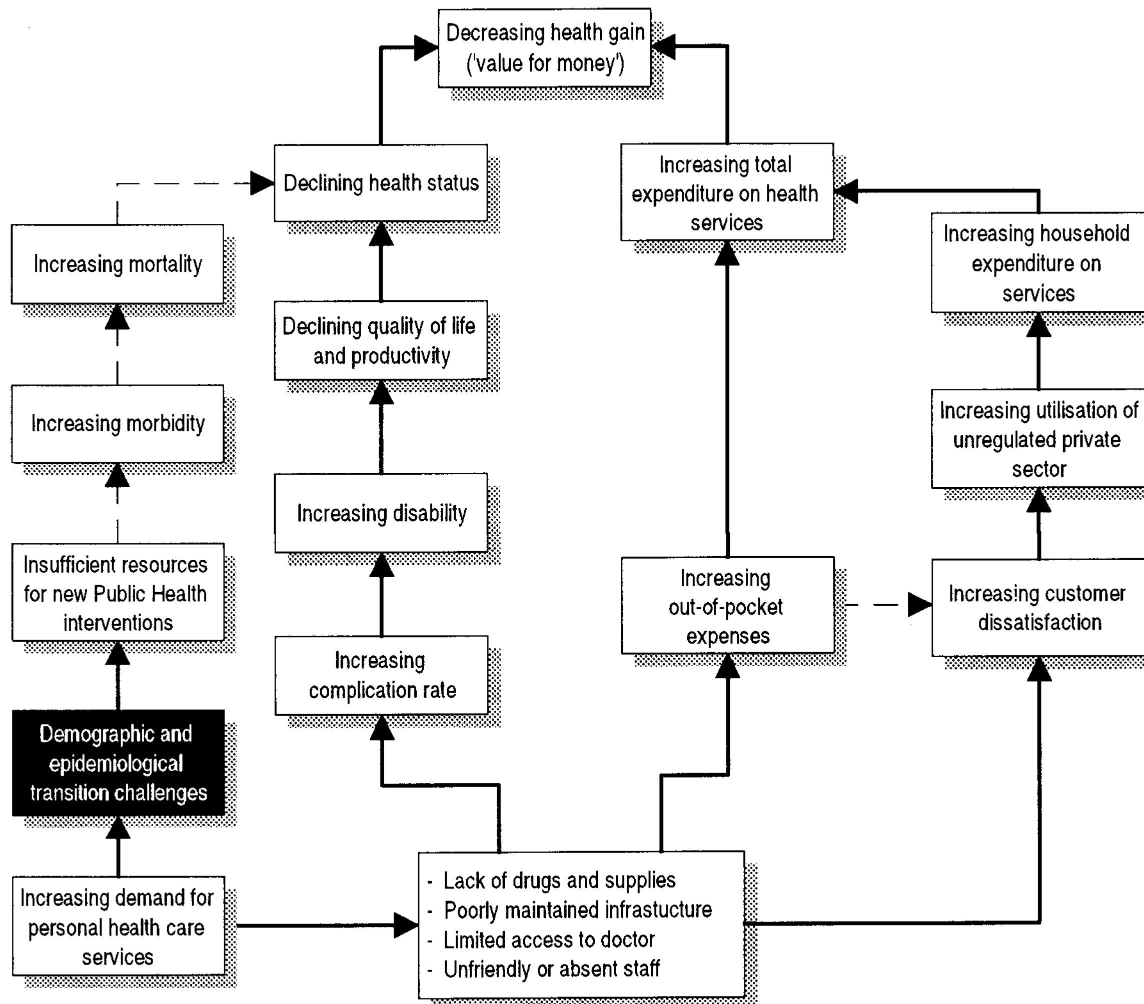
analysis and include some of the general macro economic changes affecting the entire Government system.

The last group consists of national initiatives aimed at making T&T more competitive in the global market and therefore introducing market based incentives - this has major significance for the health sector since:

- health care is perceived as a right of an individual regardless of the ability to pay;
- the health care market is imperfect in its relationships between demand and supply and between costs and prices;
- T&T has a delivery system which is heavily dependent on public sector provision.

If one can define these national initiatives as 'pull' forces for consumers of services towards the private sector, and that the problems in the public sector are 'push' forces, then the status quo shows a clear direction towards the private sector. This direction in itself should not present a problem however there is little regulation of the private sector and huge difficulties in restructuring the public sector - hence instead of providing the consumer with more choice and better care, the thriving unregulated private sector is also:

Figure 2. The effects of the main challenges in the health sector (Level I)



- stimulating demand in the public sector for more expensive services;
- creating perverse incentives for doctors to provide unnecessary volumes of services ('churning');
- duplicating capacity across the public and private sectors;
- increasing national expenditure on health care without any evidence of improving outcome.

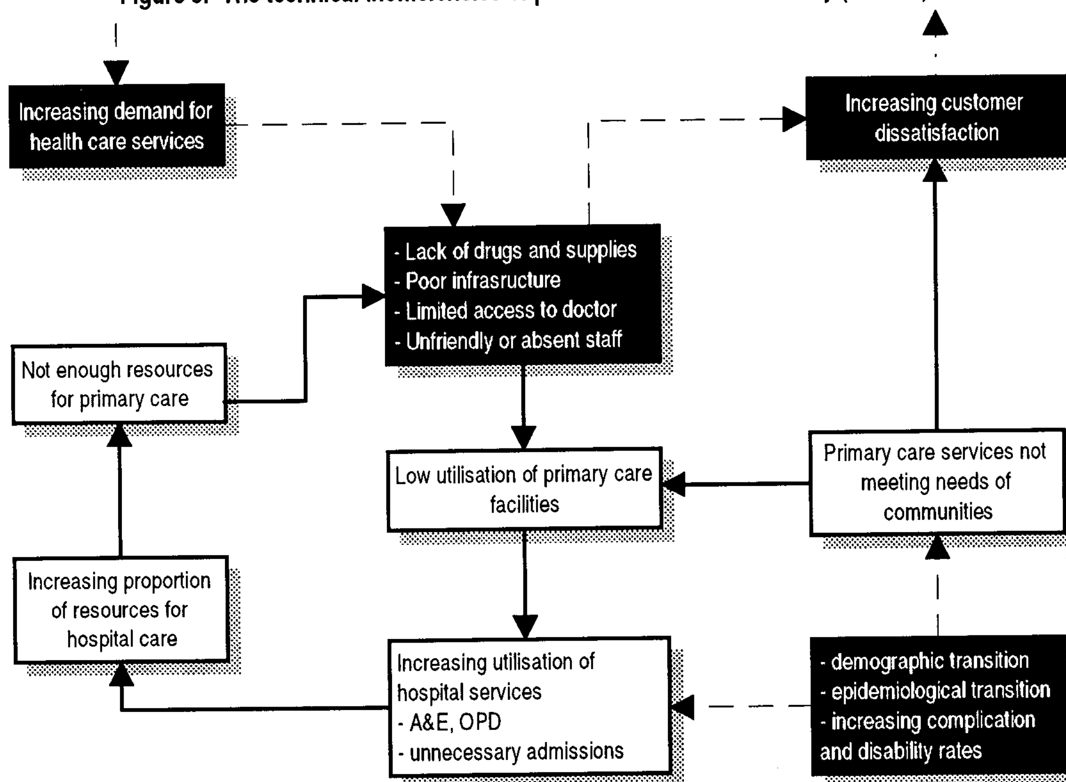
It can be debated which is pull and which is push; what is the challenge and what is the solution; but in management terms, the solution often lies in the opportunity that change presents. The public health sector would be unwise to ignore the national trends towards privatisation – the opportunity here is for T&T is to design incentives and interventions which minimise the waste and duplication across public and private sectors. If, however, this does not happen then national expenditure on health care will continue to increase without real improvement in health status and ultimately less benefit or value for money spent on health.

The effects of the main challenges

There has been significant achievements in terms of increased life expectancy at birth, control of endemic and infectious diseases, control of nutritional deficiencies -which in fact is why the country is facing the challenges from its demographic and epidemiological transition. The progress could be attributed, based on international experience, on the investment made in the water and sanitation system and the primary care system in the 1960s to the 1980s.

In terms of the effects of this transition on the health sector, the main one has been an increasing demand for personal health care services, both at the primary and hospital levels (this is illustrated in Figure 2). The response of the health sector has been to try and provide 'more' and during the economic boom of the 1970s and early 1980s, much of the resources were introduced in terms of more infrastructure, more equipment, more drugs and even more pay. However, these did not result in the desired effect of satisfying demand in the medium to longer term because much of it was more of the same – this did not take into account that the demand

Figure 3. The technical inefficiencies of public health service delivery (Level II)



Note: black boxes represent connections to Figure 2

was not only increasing but also changing due to some of the factors listed in Figure 1.

These new resources were also usually added through a project or capital investment and at the end of the project, the system was unable to cope with the recurrent expenditure aspect of the investment. As a result, buildings were not maintained or even commissioned and budgets were not adjusted for the new consumables or staff – the problems of inadequate infrastructure, drugs and staffing persisted.

Further, by the mid 1980s, T&T was facing a significant economic recession because of the fall in petroleum prices, the failure to diversify the economy during the boom, and also high recurrent expenses in the health sector due to the expansion described above. Whereas the Government continued to finance the health sector at constant prices, there was a shrinking of the budget in real terms because of inflation and currency devaluations and the problems described were accentuated.

In addition to the declining capacity to meet the increasing demand for personal health services, another big effect was the lack of funding for new programmes, particularly in the areas of health promotion, non-communicable disease control, accident prevention and environmental protection.

Many of the effects described above have implications for the general economy and productive capacity of the population. These are illustrated in Figure 2. They have perhaps resulted from the inability of the system to manage change rather than the fact that any of the challenges are inherently good or bad. There is also the growing realisation that this relative chaos may be a sign of our times and efforts should be channeled towards developing systems that can cope with this pace rather than to try to re-create stability.

It is also evident that even for a country like T&T which was able to find 'more', there is an ever increasing dissatisfaction both on the side of the consumer and the provider. The public providers have been held responsible for delivering more services within the same or diminishing envelope of resources. They do this through a system of implicit rationing, either by decreasing volume and/or quality of the services, informal user charges and/or shifting work to the private sector. Neither method is professionally nor personally satisfying and despite some commendable efforts, staff in the public health sector are generally perceived as lazy and unfriendly due to high levels of absenteeism and demotivation.

On the other hand, services in the private sector are perceived by the public as more user friendly and responsive to the customer need. There is little evidence that it is any more effective or efficient than publicly provided services. There are also problems and complaints associated with

inconsistent standards, doctor shopping, excessive treatments, 'cherry picking' and 'quack' providers.

The consumers do not seem to get the value for money or the quality care either from the public sector or the unregulated private sector. Even for those who use the 'free' public sector services, out-of-pocket expenditures are increasing in order to get the drugs or diagnostic tests prescribed. For those who use the fee-for-service private sector, expenditure is limited by the ability to pay and even then the outcome is uncertain in terms of complication and disability.

Figure 4. The problems of centralised control in the public health sector - administrative or managerial inefficiencies (Level III)

Overcentralised control
Central level bogged down with operational details
Little strategic planning at central level
Little regulation of the private sector
Allocative inefficiencies
Not able to shift resources from hospital sector
Costs not well known
Financing of public health sector inadequate
Limited managerial capacity
Not enough training
Low salaries
Lack of management information systems
Limited authority at local levels
Little planning at local level
Limited community involvement in assessing health needs

Whereas lack of access to quality services has been touted as the cause of increasing morbidity and mortality, the growing body of evidence-based medicine and effectiveness research indicates that services in themselves have little effect on these rates. Of more relevance is the lack of resources that is being made available for public health and social sector interventions. This may be due to the diversion of available resources to providing more services but it may also be due to the lack of an active advocate function with the responsibility for improving the allocation of resources to these other determinants of health status.

The problems of service delivery

Much of the progress in analysing the problems of health service delivery in the public sector has come from recognising that there are gross inefficiencies even with the existing resource base which needs to be addressed if and when more resources become available - otherwise they will continue to frustrate interventions in strengthening the delivery system and continue the spiral of diminishing return.

Figures 3-5 lists some of the key problems in health services delivery and aim to show that the interrelationships are not simple linear cause and effect but rather one of multiple levels of causes and therefore spiral or reinforcing effects.

At various points in time, T&T has tried to improve the technical inefficiencies (illustrated in Figure 3) by adding new infrastructure and more staff. Neither effort has been sustainable, and over the last 2 decades, there has actually been a significant decrease in the proportion of recurrent expenditure going to primary care compared to hospital care. In addition, the pattern of primary care service delivery has not changed significantly and whereas maternal and child health programmes are relatively well managed, services have not been developed to serve the needs of working adults and the elderly who require care.

Many of these technical and operational difficulties were then ascribed to the lack of planning and management capacity at the facility or community level. Significant resources were invested in establishing County units lead by a doctor with training in public health and improving hospital management skills. The community teams were given the responsibility for developing and implementing programme plans and managing the health centres; and a hospital administrator or medical director was given management responsibility for each of the hospitals.

In addition, different management arrangements were explored in terms of relationships between the County and hospital management units and the central Ministry of Health (MoH). However, by the beginning of the 1990s, it was acknowledged that whereas these units had been given the responsibility - they lacked the autonomy and authority over financial and human resources on which to act. The link was therefore made between the service delivery problems and the underlying issues of overcentralised control and decision making (Figure 4), or lack of, as the case may be.

The country then developed a plan for administrative decentralisation through the establishment of autonomous Regional Health Authorities (RHA), governed by statutory non-executive boards and each with their own executive management teams. The RHA were vested with the physical assets of the services within their boundaries and will be responsible for the delivery of services from these units. Staff were to be transferred to the RHA or be seconded (loaned) from the public service. Budgets would be given from Central Government to the RHA, in the short term based on historical expenditure, with plans to move towards some form of cost based or population based allocation.

Public Health and Vertical Programmes were to remain within the MoH until there was a clearer view of the role and function of the central Ministry. Many of these programmes have important regulatory functions and a plan was needed

to revise their governing legislature and to develop the appropriate mechanisms to ensure control. One of the main problems that plagued these programmes was the duplication of effort and capacity not just within the Ministry but also across Ministries and the emerging private sector.

The political will to address these administrative inefficiencies was strong but before long it was recognised that another level of issues existed. Negotiating with professional and unions groups in ensuring the smooth transfer of staff to the RHA revealed that staff were generally unwilling to leave the security of tenure with the public services - despite their obvious dissatisfaction with the status quo.

This will be a major issue for many countries, like T&T, who have tried or are trying to decentralise. Human resources usually represent 75% to 90% of the health sector's budget - whether this is inappropriately high is yet to be proven but it is now perceived as a problem because of the difficulties in managing these resources. Within this reality, if the RHA or any other body does not have authority over their human resources then they will not have real authority over its budget.

Authority over the human resources means that either the power to manage these resources (recruit, reward, discipline and retire) can be devolved to this unit or that staff are directly employed by the Authority. It is perhaps this issue in human resources, not merely providing more training or better management systems, that requires wider political support that has traditionally been needed for change in the health sector - the need for forging new alliances outside the health sector should not be underestimated.

Acknowledgment of these institutional related issues (listed in Figure 5) furhter facilitated the discussions about the role of an RHA in ensuring the health of a geographical population rather than the custodian of services. As a custodian, the incentive for the RHA was to hold on to as many assets as possible under the guise of ensuring access to services - without the incentive to find the right mix of services within available resources, whether they were located in the public or private sectors. The development of a National Health Services Plan based on agreed norms of service provision was a key tool around which these discussions could be held and over the period of the HSRP, it will serve as the key mechanism to control infrastructure investment in the public sector across RHA.

Figure 5. The institutional issues underlying limited managerial capacity (Level IV)

Weak central role and function
Limited capacity for regulatory role (policy and legislature)
No strategy for involving private sector
No control of introduction of technology
No advocacy for public health
Ineffective performance mechanisms
Resources allocated on historical patterns - what exists
Rigid financial regulations
Lack of management information systems
Limited authority over human resources
Rigid personnel regulations
Pension issues
Industrial relation/union issues
Lack of HR management systems
Limited incentives for performance
No local needs assessment
Not customer focused
No system of rationing or prioritisation

Through this type of analysis, T&T was able to build a consensus for an integrated approach - not just one intervention - which places an increased emphasis on the underlying institutional constraints that operate in the public health sector (Level IV). The resulting T&T HSRP has as its main areas for intervention (which broadly addresses the levels of problems shown in Figure 2-5):

- Strengthening the role of Health Promotion and Public Health (Level I)
- Strengthening Health Services Delivery (Level II)
- Building Management Capacity (Level III)
- Institutional and Financing Reform (Level IV)

The institutional reform issues

Within this integrated approach to HSR, the major change that is needed in the interest of sustainability is the assumption of new roles and functions by the different players in the sector. The change will involve shifting authority and responsibility from both central to local and from local to provider unit levels. New partners or alliances may emerge with the private sector or non-governmental sector in terms of providing services and new ways of working with communities and individual users of the services will be required.

The four main roles (key functions in parentheses) in the health sector include:

- Regulator (Policy formulation, legislation and advocacy)
- Financing (Collection and allocation)
- Purchasing (Assessing Need, planning and commissioning or buying services)
- Providing (Delivering the services, customer interface)

Figure 6 shows these major roles and functions and provides at the broadest level an analysis of which player is doing these presently in T&T and ideally within the principles of managerial autonomy, who should be doing it in the future. Realigning of these roles in the past has been more about

Figure 6. Roles and functions in the health sector - present and future

Role	Function	Responsibility	
		Present	Future
Regulation	· Rector - protect/advocate · Set standards for quality · Monitor health gain · Formulate Policy · Set priorities nationally · Establish formula/basis for equitable resource allocation · Define 'basic' package · Control introduction of technology	Ministry of Health	Ministry of Health
Financing	· Collect funds for health · Ensure solidarity and equity in financing through allocation mechanisms · Finance health care in keeping with national policy	Ministry of Health /Ministry of Finance	Ministry of Health
Purchasing	· Assess health needs of local population · Ensure effective application of resources to those needs · Ensure coverage of high risk population · Ensure financial accountability · Manage people · Community involvement	Ministry of Health	RHAs
Providing	· Deliver services · Manage the customer interface · Community involvement	Ministry of Health /RHAs	· Primary Care Units · Hospitals · Private Sector

assigning responsibility without the commensurate authority - resulting in high levels of frustration and demotivation among the staff at all levels.

Much of the regulating and financing functions are not done because the Ministry is busy trying to do the purchasing and providing functions for all the people with varying needs and environments. Further, much of the authority to carry out these functions are held by other Ministries e.g. Finance, Works or Education.

At the RHA level, there is a big pool of managerial resources who are very aware of what needs to be done both for the staff and the communities but who have not been empowered to match the use of resources to their needs. For service delivery to be improved, RHA staff will also have to be encouraged to push autonomy as far down as possible to the provider unit level.

Who can help?

The resistance to change should not be underestimated, despite the obvious logic for assuming these new roles and functions. Managing the transition is not only about finding the right structure(s) and accountability mechanisms but also about harnessing the energy that is consumed by resisting the change - and/or the persons who represent that change - and channeling it as productively as possible. A balance must be made among the technical/managerial content of the changes with the emotional and political content.

The issue of leadership for institutional reform is a critical one. The most 'uncomfortable' participants in the reform process are the senior administrators and technical officers in the central MoH. Whereas discussions at the centre tend to focus on preserving control - the operational levels, in spite of their personal concerns see the benefits of autonomy more easily, and in many cases are eager for it.

During the design and pre-implementation phases, technical and managerial leadership were supported through national counterpart staff and consultants (national and international). Critical support was provided by the Public Service Reform Programme (PSRP) in the Office of the Prime Minister - without this, it would have probably been impossible to move as far forward in terms of thinking out the fundamental institutional reform issues, for example, ensuring pension security through the establishment of a RHA Pension system.

The IDB facilitated the review of the proposals through their economic and technical analyses of the loan documentation and request - this input is often misunderstood and underestimated but is yet another resource that could be utilised more productively. The Bank's involvement and analyses also focussed the participation of the Ministry of Planning and Development and the Ministry of Finance (MoF), since many of their questions about the HSR allowed these key ministries to see their roles more clearly in terms of providing leadership and facilitating decision making on cross cutting public sector issues like pension funds and sector financing.

However, the issue of sustainable leadership in the health sector remains problematic. PSRP initiatives, aimed at a generic approach to all Ministries, lag behind the HSRP and is much more heavily influenced by the political climate. Lack of understanding of the complexities of the health market, including the influence of doctors on the demand for health services, oversimplified some of the assumptions about health sector reorganisation and financing issues.

The Programme attempts to address these weaknesses by maximising capacity building **within** the new institutions - rather than by complex project implementation units and reporting - and appointing long term advisors, for at least the first 3 years, in key technical and managerial areas within the MoH. Based on the experience of the pre-implementation stage, it will also be important that key alliances continue to be strengthened outside the MoH, particularly to the political level, PSRP and the Ministry of Finance, so that for some of the inevitable difficult decisions, support will be readily provided with the appropriate authority.

How to continue to build political will to move forward with institutional reform and to encourage the politicians to allow the new managers to get on with managing with minimal interference will be major challenges. Perhaps this need to find the right political lever within the context of HSR will provide a new perspective for 'community empowerment'.

Acknowledgement

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References

Available from the author on request ☐

To prepare for the changing world,
we must be prepared to invest in our children.

Honorable Bikenbeu Paeniu,
Prime Minister of Tuvalu (33rd SPC Conference, 1993)