

CAYMAN ISLANDS

2016/2017 Session of the

LEGISLATIVE ASSEMBLY

REPORT

of the

STANDING

PUBLIC ACCOUNTS COMMITTEE

on the Reports of the
Office of the Auditor General on
Cayman Islands Health System-January 2017 and
Ensuring Quality Health Care and a Healthy Population -
January 2017.

Laid on the Table of Legislative Assembly on this day of 2017

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REPORT OF THE STANDING PUBLIC ACCOUNTS COMMITTEE ON THE REPORT OF THE OFFICE OF THE AUDITOR GENERAL ON CAYMAN ISLANDS HEALTH SYSTEM – JANUARY 2017

SUMMARY REPORT

1. REFERENCE

The Standing Public Accounts Committee of the Cayman Islands Legislative Assembly, established under Standing Order 77(1), met to consider the following Report prepared and submitted by the Auditor General:

- ***Cayman Islands Health System – January 2017; and***
- ***Ensuring Quality Health Care and a Healthy Population- January 2017.***

2. DOCUMENT CONSIDERED

In accordance with the provision of Standing Order 77(3), the Committee considered the following Auditor General Report which was referred in the House of the Legislative Assembly:

- ***Cayman Islands Health System – January 2017; and***
- ***Ensuring Quality Health Care and a Healthy Population- January 2017.***

3. CHAIRMAN AND MEMBERS OF THE COMMITTEE

The following Members of the Legislative Assembly are the present Members of the Standing Public Accounts Committee – who dealt with these Report of the Auditor General:

- Mr D Ezzard Miller, MLA – Chairman
- Mr Roy McTaggart, JP, MLA – Member
- Mr Winston Connolly, MLA – Member
- Mr Joseph Hew, MLA – Member
- Capt Eugene Ebanks, JP, MLA – Member

4. MEETINGS OF THE COMMITTEE

The Committee held the Meetings(s) listed below to consider the Report:

(i) Wednesday, 1st February 2017 (Hearing)

(ii) Thursday, 2nd February 2017 (Hearing)

(iii) Friday, 3rd February 2017 (Hearing)

(iv) Thursday, 9th February 2017 (no quorum)

(v) Monday, 13th February 2017 (Hearing)

(vi) Friday, 17th February 2017

(vii) Round Robin, 21st March 2017

5. ATTENDANCE OF MEMBERS

The attendances of Members at the Hearing(s) are recorded in the Minutes of Proceedings which are attached to and form part of this Report.

6. PERSONS IN ATTENDANCE

In accordance with Standing Order 77(8), the following persons were in attendance at the hearing held with witnesses on Wednesday, 1st February 2017 in the House of the Legislative Assembly:

- Ms. Sue Winspear, Auditor General, CIG- Office of the Auditor General, Office of the Auditor General
- Mr. Martin Ruben, Audit Principal of Performance Auditing, CIG- Office of the Auditor General
- Ms. Angela Cullen, Director of Performance Audit – CIG- Office of the Auditor General.
- Hon. Kenneth Jefferson, JP, Financial Secretary and Chief Officer, CIG- Ministry of Finance and Economic Development

- Mr. Matthew Tibbetts, Accountant General, CIG- Ministry of Finance and Economic Development
- Ms Gloria Myles, Deputy Accountant General – CIG- Ministry of Finance and Economic Development.
- Mr. Julius Aurelio, Audit Manager, CIG - Office of the Auditor General
- Ms Ann Owens, Deputy Chief Officer – CIG- Ministry of Finance and Economic Development.

7. WITNESSES CALLED BEFORE THE COMMITTEE

In accordance with the provisions of Standing Order 77(4), the Committee invited public officers and members of staff of a non-Government organisation to give information and explanation to assist the Committee in the performance of its duties. The following persons appeared before the Committee to give evidence on:

Wednesday, 1st February 2017:

- Ms. Jennifer Ahearn, Chief Officer, CIG- Ministry of Health & Culture
- Dr. Darley Solomon, General Surgeon, Chrissie Tomlinson Memorial Hospital
- Dr. Sidney Ebanks, General Surgeon, Chrissie Tomlinson Memorial Hospital

Thursday, 2nd February 2017:

- Mr. Lonny Tibbetts- Chief Executive Officer (CEO), CINICO Management
- Mr. Frank Gallippi- Chief Financial Officer (CFO), CINICO Management
- Ms. Lizzette Yearwood– Chief Executive Officer, Health Services Authority
- Dr. Delroy Jefferson– Chief Medical Officer, Health Services Authority

Friday, 3rd February 2017:

- Dr. Ethel Elizabeth McLaughlin- Chief Medical Officer, CIG- Health Services Authority
- Mr. Jonathan Tibbets- Chairman, CIG- Health Services Authority
- Ms. Dorine Whittaker- Chief Officer, CIG- Ministry of Community Affairs, Youth & Sports
- Ms. Felicia Robinson - Director, CIG- Department of Children & Family Services
- Ms. Judith Seymour- Director, CIG- Department of Counselling Services
- Mr. Collin Anderson Medford– Chief Pharmacist, CIG- Cayman Islands Health Services

Friday, 9th February 2017:

- Mr. Mervyn Conolly- Director, CIG- Department of Health Regulatory Services
- Ms. Lyria Lawson-Josephs- The Registrar, CIG- Health Practice Commission

Monday, 13th February 2017:

- Mr. Mervyn Conolly– Director, CIG- Department of Health Regulatory Services
- Ms. Lyria Lawson-Josephs- The Registrar, CIG- Health Practice Commission

8. PRACTICE AND PROCEDURE OF THE COMMITTEE (S.O 77(6))

The Committee agreed that in accordance with the provisions of Standing Order 77(6), all meetings at which witnesses were invited to provide information should be held in an open forum. This decision was taken to promote openness and accountability in Government.

9. INTRODUCTION AND PAC COMMENTS

9.01 The Report of the Auditor General was carried out in Grand Cayman, Cayman Islands. The objective of the audit was to review the Health Services available in the Cayman Islands and to deliver the quality of a comprehensive Health Service System.

The Public Accounts Committee (PAC) fully supports the nine recommendations that were made by the Audit Office and finds it quite troubling that the Management Response was that the recommendations were "noted".

The PAC recommends that the Ministry re-assess the Report; and as well as carefully consider the nine recommendations and produce a plan to implement the suggested recommendations.

- The PAC is particularly troubled by the findings in the Report that identified the following:

    a. The perceived serious capacity shortages in the Ministry, the Department of Health Regulatory Services and the Health Services Authority (HSA).
    b. Interviews of Officials looking to the Ministry for decisions, assistance or guidance showed that they had concerns about the Ministry's responsive.
    c. The lack of a performance management and reporting framework that allows for regular monitoring of outcomes from policy decisions.
    d. The lack of medical systems administrative knowledge at the ministry level was clearly demonstrated during the hearings.

Therefore, the PAC strongly recommends, given the magnitude of the expenditures and the impact of these findings on the Health of the Country, that the Government address these concerns with some urgency.

- The Ministry of Health, with the advice of the HSA Medical Director, and in consultation with the Medical and Dental Council, should issue a policy on how to develop Caymanian Doctors, to Board certification level and provide a Grant to the HSA to fund these staff developments through proper training;
- The Ministry of Health in consultation with the Health Insurance Commission should review relevant legislation to enable private sector coverage into retirement;
- The Medical officer of Health should collect relevant health data from the private sector as well as the HSA in future and should report publically on both sets of data on a regular basis to help inform policy and decision making.

10. GOVERNMENT MINUTE

10.01 The Public Accounts Committee wishes to draw Government's attention to Standing Order 77 sub-order 7 which reads;

"The Government Minute shall be laid on the Table of the House within three months of the laying of the report of the Committee and of the report of the Auditor General to which it relates."

The PAC expects the Government to honour the requirements of this Standing Order.

10.02 The PAC expects that the Government minute will show how the resources to complete the implementation of these recommendations, by the Auditor General, is being provided in the 2016-17 budget.

ACKNOWLEDGEMENT

The Committee is most appreciative of the efforts of the Auditor General and her staff in presenting very fair, comprehensive and informative Reports and for the support, assistance and constructive advice given throughout its deliberations.

The Committee also thanks the staff of the Legislative Assembly for their administrative assistance.

REPORT OF THE COMMITTEE TO THE HOUSE

The Committee agrees that this Report be the Report of the Standing Public Accounts Committee to the House on the following Reports of the Office of the Auditor General:

- ***Cayman Islands Health System – January 2017***
- ***Ensuring Quality Health Care and a Healthy Population- January 2017.***

Mr D Ezzard Miller, MLA – Chairman

Mr Roy McTaggart, JP, MLA – Member

Mr Winston Connolly, MLA – Member

Mr Joseph Hew, MLA – Member

Capt Eugene Ebanks, JP, MLA – Member

Legislative Assembly of the Cayman Islands

THE STANDING PUBLIC ACCOUNTS COMMITTEE

MINUTES

Hearing held *with Witnesses*

Wednesday, 1st February 2017

9:00am

Minutes and verbatim transcript of the meeting of the Standing Public Accounts Committee held in the Chamber of the Legislative Assembly Building, Grand Cayman on Wednesday, 1st February 2017 at 9:00am.

Present:

- Mr D Ezzard Miller, MLA – Chairman
- Roy McTaggart, MLA - Member
- Mr. Winston Connolly, MLA – Member
- Capt. Eugene Ebanks, JP, MLA – Member

- Ms. Manesa Webb – Acting Clerk of the Public Accounts Committee

Apology:

- Mr. Joseph Hew, MLA – Member

Attendees:

- Ms. Sue Winspear, Auditor General – Office of the Auditor General
- Mr. Ruben Martin, Audit Principal of Performance Auditing – Office of the Auditor General
- Ms. Angela Cullen, Director of Performance Audit – Office of the Auditor General
- Hon. Kenneth Jefferson, Financial Secretary & Chief Officer – Min. of Finance & Economic Development
- Mr. Matthew Tibbetts, Accountant General – Min. of Finance & Economic Development

1. Reference

In accordance with sections 73(1) and 77(4) of the Legislative Assembly Standing Orders (2006) Revision, witnesses were invited to appear before the Committee to discuss various issues set out in the following Reports of the Auditor General:

a) *Cayman Islands Health Care System- January 2017*
b) *Ensuring Quality in Health Care & Health Population- January 2017*

2. Meeting to Order

There being a quorum present, the Chairman called the meeting to order at 9:30am.

3. Welcome

The Chairman gave a brief welcome to the Members of the Public Accounts Committee and the staff of the Office of the Auditor General and the Ministry of Finance and Economic Development.

PAC Member, Mr. Roy McTaggart, excused himself from sitting in the Hearings to avoid potential conflicts due to his recent appointment as the acting Minister of Home Affairs & Culture until the 16th February 2017.

The Chairman acknowledged this conflict and excused Mr. Roy McTaggart from all Hearings until his appointment end dates, 16 February 2017.

4. Report of the Auditor General: –

Cayman Islands Health Care System – January 2017

The Chairman invited the Auditor General to offer opening remarks on the above mentioned Report and the Hearing(s) commenced at 2:32pm. The Chairman then invited witnesses to the Chamber and asked them to state their names, the persons attending with them if any and department or organization they were representing. The Chairman then opened the floor for statements from the witnesses followed by questions from the Members of the Public Accounts Committee.

- *Ms. Jennifer Ahearn, Chief Officer, Ministry of Health & Culture*

At the conclusion of meeting with the witnesses the Chairman thanked the Members of the Committee and the staff of the Office of the Auditor General, Treasury Department and the Ministry of Finance for attending. The Hearing for this Report concluded at 11:30am.

5. Report of the Auditor General: –

Cayman Islands Health Care System & Ensuring Quality in Health Care – January 2017

The Chairman made an opening statement on the above mentioned Report and the Hearing(s) commenced at 1:30pm. The Chairman then invited witnesses to the Chamber and asked them to state their names, the persons attending with them if any and department or organization they were representing. The Chairman then opened the floor for statements from the witnesses followed by questions from the Members of the Public Accounts Committee.

The following persons listed below appeared in their named capacity as witnesses before the Committee for the Reports:

- *Dr. Darley Solomon - Chrissie Tomlinson Memorial Hospital*
- *Dr. Sidney Ebanks - Medical and Dental Council (MDC) Chairperson, Chrissie Tomlinson Memorial Hospital*

At the conclusion of meeting with the witnesses the Chairman thanked the Members of the Committee and the staff of the Office of the Auditor General, Treasury Department and the Ministry of Finance for attending. The Hearing(s) for this Report was suspended at 3:40pm.

6. Scheduling of next Hearing

The next Hearing was confirmed for:

- Thursday, 2nd February 2017 at 1:00pm.

7. Any Other Business

There was no other business.

8. Adjournment

There being no other business the meeting was adjourned by the Chairman at 3:45pm.

OFFICIAL VERBATIM TRANSCRIPT
STANDING PUBLIC ACCOUNTS COMMITTEE
WEDNESDAY
1 FEBRUARY 2017
9:30 AM

Meeting with Witnesses

"CAYMAN ISLANDS HEALTH CARE SYSTEM"
"ENSURING QUALITY HEALTH CARE AND A HEALTHY POPULATION"

Verbatim transcript of the Standing Public Accounts Committee meeting held 1 February 2017, at 9:30am, in the Chamber of the Legislative Assembly Building, George Town, Grand Cayman.

Present: Mr. D. Ezzard Miller, MLA, Chairman
Mr. Roy M. McTaggart, MLA, Member
Mr. Winston C. Connolly, Jr., MLA, Member
Capt. A. Eugene Ebanks, MLA, Member

Absent: Mr. Joseph X. Hew, MLA, Member

In attendance: Mr. Kenneth Jefferson, Financial Secretary/Chief Officer, Ministry of Finance
Mr. Matthew Tibbetts, Accountant General, Ministry of Finance

Audit Office: Ms. Sue Winspear, Auditor General
Mr. Martin Ruben, Director of Performance Audit
Ms. Angela Cullen, Acting Director of Performance Audit

Witnesses: Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture
Dr. Darley Solomon, President of the Cayman Islands Medical and Dental Society
Dr. Sidney Ebanks, Chairman of the Medical and Dental Council

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The Chairman: Good morning everyone. We now have a quorum present. I apologise for the slight delay in starting. We were just trying to get a few adjustment housekeeping matters in order. So, let me take the opportunity to thank the members of the Committee for coming, and the Auditor General's staff and the Civil Service representatives, the Chief Accounting Officer and . . . What is your title now, Financial Secretary or Chief Officer?

[Inaudible interjection]

The Chairman: Both. Okay. Thanks to the Financial Secretary/Chief Officer of the Ministry of Finance for coming.

Also, I want to express my gratitude and that of the Committee for the witnesses agreeing to come on short notice. We know that we were a day short on the requirement of the Standing Orders but we certainly appreciate the co-operation of the witness to come because the Public Accounts Committee would love to get all of its work done and cleared up and tabled in the last Meeting of the Legislative Assembly which starts on the 22 February. And the Standing Orders require that the item must be on the Business Paper prior to the start of the meeting in order for it to be accommodated in the meeting. So, we are grateful for all of those who are assisting us and we look forward to a very productive day.

Before we start the actual witness hearing on the health report, I want to express my disappointment and displeasure on the headlines in the *Cayman Compass* in Tuesday, January 31st which says, "AG Review Slams Public Sector Finances with Adverse Opinion". It is unfortunate that the newspaper would choose such a headline giving the report that they are referring to, because the Public Accounts Committee specifically invited the Auditor General to make that report public because we wanted to give credence, accolades, thanks and support for the civil servants who have brought their accounting so far forward in the last three years.

Just to give an idea, in the report that it is referred to, on the back pages for the 2012/13 audits, out of 40 audits, we had 13 qualified and 2 disclaimed. For the 2013/14 of the same 40 audits, we had 14 qualified and 0 disclaimed. For the 2014/15 audits, out of the same 40 audits, we have only 8 qualified and 0 disclaimed. And for the 2015/16 audits that have been completed which is out of the 40, there is only (counting – one, two, three) seven in progress? No, in pro-

gress (counting – one, two, three, four, five, six, seven, eight).

[Inaudible interjection]

The Chairman: They're all completed now? Okay.

So, we have 7 qualified and 0 disclaimers. Now, to me that represents and clearly demonstrates the amount of work that has gone into by the financial arm of government and the Auditor General's Office to bring this from where we were in 2009, and even further back, to where we are today. And I feel strongly that the civil servants who have achieved this should be congratulated, complimented for it, and we should appreciate the extra effort that both the Auditor General's Office and the Civil Service has put in to bringing us to this point, and I just think it is wrong when we move to this sensationalism that cannot really be supported in the body of the report that was tabled.

I now invite the Auditor General to make any comments on the headlines, if she so wishes.

Ms. Sue Winspear, Auditor General: Thank you, Mr. Chairman.

I agree the improvement in the financial audit statements that this Government has shown over the recent years has been phenomenal, I think, if we were to compare with any jurisdiction in terms of its exceptional nature.

Whilst individual entities have improved significantly on both timeliness and qualities you just clearly very evidences, we do still have an adverse qualification on the 2014/15 Entire Public Sector (EPS) accounts. There are some intractable problems there. And I would pay tribute to the two gentlemen behind in terms of the leadership that provide into the finance functions to try and address these cross-government issues, and in particular, we are hoping that the 2015/16 Entire Public Sector audit, when we come to review it, may have a move to a qualified opinion. Clearly, I can't prejudge that because we need to do the work. But we know that one of the big issues was that different entities across government had taken different approaches to the valuation of property plant and equipment and we know through Mr. Tibbett's leadership, this year, that we have had re-evaluation of all government assets. So, even with the remaining adverse opinion on the Entire Public Sector account which is not at all uncommon by international comparisons, I know in the UK we very recently moved to qualified from adverse.

There are significant improvements, so I also would like to pay tribute to those in the Civil Service on the leadership they have given. The Public Accounts Committee, of course, is well for absolutely highlighting the importance of this and the priority that has been given across government. So, I think the trajectory is very impressive and I remain positive about the future outlook, but, of course, that would be subject to whatever comes up through the annual audits.

Mr. Kenneth Jefferson, Financial Secretary/Chief Officer of Financial Services, Ministry of Finance: Thank you, Mr. Chairman. And good morning to you and, the Committee members and the Audit Office staff.

There is very little more that I can add to what has been said. We do acknowledge that whilst the 16 individual agencies within central government, their financial statements have improved significantly, it is at the consolidated level where the adverse opinion has been issued in respect of, and so we do know that there is more work to be done in order to improve the present adverse opinion on the consolidated accounts to a qualified opinion. So, we do acknowledge that there is some more work to be done. Often it will involve the Government of the day making policy decisions as to those particular items.

Just by way of perspective (and I won't belabour the point) to illustrate the Cayman Islands context in relation to the rest of the world, recently on the 12th of January, 2017, the US General Accountability Office, as an example, in respect of the American Consolidated Financial Statements for the year ended 30th September, 2016, the GAO in America actually issued a disclaimer of opinion on those particular consolidate accounts. And it is quite remarkable how some of the reasons for the GAOs disclaimer are actually present here as well. So, for example, the GAO opinions spoke about the difficulty with eliminating agencies within the American Government, eliminating those transactions. That was one of the reasons that we also got a disclaimer of opinion in the past and an adverse opinion now.

I will conclude shortly, Mr. Chair. But another reason, for example, for the Cayman Islands Government getting an adverse opinion on its consolidated accounts is that we have not included the Public Service Pension fund assets along with central government. We have not done that. The Audit Office has quite rightly said we believe that the definition of a statutory authority would fit the Public Service Pension Board and therefore it ought to be consolidated. We have taken a different view. We plan to do something in terms of legislation because we do genuinely feel that it is important to separate assets of pension funds from that of central government and to keep it separate.

I will conclude here by saying that if we then look at the UK example in respect of the United Kingdom's 31st March 2015 consolidated accounts, [Report] one of the reasons their Comptroller and Auditor General, Sir Amayas Morse, gave for issuing a qualified opinion for the UK was that entities such as the Royal Bank of Scotland have not been included in those consolidated accounts for the UK and the Auditor General there, obviously thought that they should

have been. So, there are remarkable similarities in the reasons for disclaimers and adverse opinions from one jurisdiction to the next. That does not at all mean, Mr. Chairman, that, we sit back and say that we can't do anything about it; that is certainly not the case. We intend to improve the opinion if we can and when we can. And I would like to again also thank the Auditor Office for their assistance and I am extremely pleased to say that the level of staffing in the Audit Office has improved and that will assist that office and the Entire Public Sector in improving financial reporting. Thank you, sir.

The Chairman: Does anyone from the Committee wish to make any comments?

Mr. Roy M. McTaggart: Thank you, Mr. Chairman. And good morning to colleagues and to the Auditor General's Office, the staff and the Ministry and staff as well from there.

Mr. Chairman, I too was very perturbed by the headline and to the story because it just ignores the true reality of what has been achieved in such a short time. And, you know, I am very familiar with the issues that continue to plague us with regard to the consolidated accounts. But I also do know that the Ministry has a plan to deal with them so that we can move from where we are to get to where these consolidated financial statements are far more reliable and that the country and, you know, whatever the case may be, users of financial statements can rely upon them. So, I don't know what the wrangle is coming from in a story like that yesterday, because everything is moving in the right direction, and to my mind sir, it is just a slap in the face to all the good people within government in the finance function for all the good work that they have done, the changes in mind-set and the desire, everybody moving lockstep in the right direction and we don't need distractions like this. Government just does not need it. And I just hope we can get more of a fair and better balance reporting than we see happening today.

The Chairman: Mr. Connolly.

Mr. Winston C. Connolly, Jr.: Mr. Chairman and colleagues, I echo those sentiments by the member and it is quite unfortunate that with all the work being carried out, somewhere it is not reported accurately about the efforts and I would hope that government information systems, Radio Cayman and other outlets could be used to tell the accurate story to counter the sensational headline. Because, I think when the people of the Cayman Islands appreciate what efforts have been made behind the scenes—and I know that your role is not to toot your own horn—I think given the headline, given the negative kind of tone of that headline, it is incumbent on the Government to set the record straight.

I would just like to congratulate everyone involved for the work that has been recognised by this Committee and kudos to everyone.

The Chairman: Okay, thank you all very much.

Before we move on the actual health care report, I think Mr. McTaggart you need to make a statement.

Mr. Roy M. McTaggart: Thank you, Mr. Chairman.

Mr. Chairman, for the past week and for the coming week I am actually Temporary Minister of Financial Services, Commerce and Environment. And in a couple of days I will also be taking on an additional role as Temporary Minister of Health and Culture. It is highly unusual for a sitting Minister to be a member of the Public Accounts Committee, but that is the position that I find myself in today. And so I feel that the conflicts of interest are too great to be mitigated and it is totally appropriate in the interest of transparency and good governance that I recuse myself from these hearing today and wish you all a very successful time in examining these reports.

I would also like on behalf of my fellow Councillor, Joey Hew, to say that he finds himself in the same position today, in that he is acting Temporary Minister of District Administration, Tourism and Transport and therefore he is unable to be here today for the same reasons.

So, with those statements I would take my leave from the Chamber and wish you all a successful hearing over the next few days. Thank you.

The Chairman: That is much appreciated. That is the perils of a small parliament. I guess the headline in the *Compass* next week will be that Ezzard Miller is advocating more seats in parliament.

So, without further ado, I would invite Ms. Jenifer Ahearn. I thought you had gotten married but anyway, I was not sure. Take your seat in the witness stand and at the same time I will invite the Auditor General to give the usual opening statement by her Office to frame the report for the general public that may not have had the opportunity to read it.

Ms. Sue Winspear, Auditor General: Thank you, Mr. Chairman, and good morning again to everybody.

Health care is something that affects every single person on these Islands and the spending on health care in the Public Service represents just under a fifth of total spending. So, for these two reasons we felt it was really important that we focused on a performance audit report on the health system.

There are two reports before the Committee today. The first is a Public Interest Report which simply and factually describes the Health Care System in place in the Cayman Islands— Report We felt this would inform the Members of the Legislative Assembly and the wider public about the system in place and

would provide really useful context for the Performance Audit Report which is the second report for you today— Report

We reviewed Government's roles and responsibilities in ensuring quality health care for the people of the Cayman Islands and in doing so, ensuring a healthy population. The provision of health care services is one of the fundamental areas of public sector responsibility throughout the world and in the Cayman Islands there is hybrid model where roughly 50 per cent is provided by the public sector and the remainder through practitioners and facilities in the private sector. Our work inevitably in the Performance Audit Report focuses more on the responsibilities and activities of the public sector.

We concluded through our work the improvements are inevitably necessary in Government's management of some of its roles and responsibilities to ensure that its stated aims of ensuring quality health care and a healthy population are better achieved going forward. Whilst many good things are happening day in and day out in the health system and our research found that health outcomes in the Cayman Islands compare well with health outcomes in other countries, there is little ready available information about the performance of the Cayman Islands health system due to the lack of a well-developed performance management and reporting framework. This is critical for public sector decision makers to understand the impact their policies and programmes are having on the population.

As we note in the report, effective oversight and regulation requires that realistic performance expectations be established and communicated, and that regular and reliable informational actual performance of the health system, in meeting those expectations, is available. When we looked at the relationship between the Ministry and the Health Services Authority and CINICO, we found that the ownership and purchase agreements lack any meaningful information that would help ensure they are delivering on government strategy.

With regards to information available from the private sector, we again identified a gap and generally that more needs to be done to improve how the Government communicates with these key partners in the overall health system.

We found that Government has not taken sufficient action to implement its own strategic plan developed in 2012 to identify significant opportunities to improve the system. And we also found some gaps in Government's role to ensure compliance with its laws. Whilst far from persuasive, and I want to emphasise that, we did find that some qualified practitioners are not fully registered and that not every facility providing health services is inspected and certified.

Our report includes nine recommendations which we believe that if implemented, would support the improvement of the health system and result in the Government ensuring quality health care and a healthy population in the Cayman Islands.

I have with me today, Mr. Martin Ruben who is the Director responsible for these two reports and who will support the Committee with the hearing today along with myself. Mr. Ruben will be leaving my office after eight years of service next week, so this will be his last series of appearances before the Committee. And to his immediate left I have with him Ms. Angela Cullen who is the incoming Performance Audit Director that will be taking over from Mr. Ruben and she started working in the office a couple of weeks ago.

Thank you, Mr. Chairman.

The Chairman: Thank you very much, Auditor General.

Again, I am in the mood for handing out kudos this morning, so let me congratulate Mr. Ruben and his team in particular for the public interest report on the Cayman Islands Health System. I think he did a remarkable job. I have some idea of the difficulties that you would have encountered in trying to collate the material because of the way things are currently managed. But I think it is good and I encourage everyone, particularly all of the professionals in the health care field to get copies of this report and read it.

It is acknowledged in your report that we compare favourably with OECD [Organization for Economic Co-operation and Development] developed countries and some of the standard indices by which the health of a nation is judged: life expectancy, mortality and other instances of disease. You also pointed out that it could be slanted because we have close to 50 per cent of the population that are expat transients who have to undergo medical screening before they come to Cayman. And they also are in that age group where we don't make large demands on health care between 25 and 45 or 50. And we are quite fortunate in Cayman that we don't have many of the indigenous diseases that affect people in those areas. But I think it would be interesting and certainly, I hope that the various agencies in government that are responsible for ensuring the quality which is the report that we are actually going to be dealing with today, to ensuring quality health care and a healthy population, take the time to read the report on the Cayman Islands health system because I think it brings to the forefront many of the issues that we have been ignoring for far too long.

So, I congratulate you and I also want to thank you for your service to the country. There are some people who describe you to me as a little pit bull. But in the areas that you deal with, I believe that that is almost an essential trait and I think that you have brought the process of performance auditing to a new level in Cayman over the years that you have been responsible for, and I wish you success in whatever your future endeavours may be.

Mr. Tibbetts.

Mr. Matthew Tibbetts, Accountant General, Ministry of Finance: Mr. Chairman, on behalf of the Treasury Department and the Ministry of Finance, we also would like to extend our thanks to Mr. Ruben for his keen insight into a number of matters. The performance audits have been very helpful in formulating a plan and figuring out what areas we can improve on. So, we really appreciate Mr. Ruben's contribution. Thank you.

The Chairman: Thank you.

Okay, I guess we can move on to the actual . . . the Committee is not going to spend a lot of time, Ms. Ahearn, on the Cayman Islands Health System. I think that is a factual report that will stand on its own. Our concern lies with the report "Ensuring Quality Health Care and a Healthy Population", and that is the report on which we will be questioning all of the witnesses in the next couple of days.

We thank you for coming at such short notice and I guess I will start off.

I guess my biggest concern and what jumps out at me most at the beginning is the management's response to the nine recommendations made by the Auditor General. And we will get into the body of the report and our concerns of what is included in the report. All except one, basically, the response is noted and, as a committee, we have no idea what "noted" means. So, we will give you the opportunity to explain to us what the management's response means when it says "recommendation is noted".

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Thank you, Mr. Chair.

As you pointed out, there were a few recommendations where the response was that it was noted. The first one was Recommendation 2; that the Government should proceed with a law review for the systematic updating of the health system legislative framework. Perhaps it would have been more accurate to say that we agree with the recommendation and that we do plan to implement it. You will note that we put a date of planned implementation for June of this year.

Similarly, with Recommendation 3 regarding strengthening relationships with private health care providers and the two-way communication, again, with the comment that you have made, perhaps we should have, instead of saying "noted", said "agreed" and that we will implement it.

Again, that is similar for Recommendation No. 4 regarding assessing our capacity. With the recommendations in the report we agreed that we will do that and we plan to undertake that with a view of having that ready for our Strategic Policy Statement submission. Sorry, I should have spelled it out—SPS for the 2018 Financial Year.

The other one where we "noted" was Recommendation 8, evaluating the design and performance of the CayHealth programme and as appropriate, extend it to cover a wider population. As the Auditor General noted in the report, the CayHealth programme is really one of best practice in terms of chronic disease prevention and management. We do agree with looking at the recommendation to roll it out to a wider population. And so, that is that comment there.

The Chairman: The same applies for 6, 7 and 9; "the recommendation is noted". The only one is No. 8 that says, "Recommendation is noted and agreed".

So, you are saying that in your response, "noted" is to be interpreted as "agreed" with the recommendation?

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: That is correct sir.

The Chairman: Okay, thank you very much.

I would like to deal a bit with the first recommendation which is the recommendation on the NHPP [National Health Policy and Plan] for the Cayman Islands 2012-17. Report by the Ministry. This report was laid with quite a bit of fanfare and a lot of expense in terms of the quality of the production. The Minister made some very strong statements when he tabled the report. So, it is particularly disappointing to the Committee to see that here we are in the final year of that plan which was for 2012-17, that there has been no implementation of any of it, no plan to implement it, no budgetary allocation for its implementation. So, we need to hear from you how that is possible and why did that happen.

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Thank you, Mr. Chairman.

As noted in the report, we did start some work on the implementation plan and the operational plans to implement the strategic directions in the health policy. One of the challenges that we have at the Ministry is in terms of our resources and the demands that we have, placed on us to deliver on the functions that we do have, as well as, we do have situations where we have identified a work plan and we need to amend that in response to changing priorities or changing conditions or issues that arise within the work of the Ministry. So, it is something that ideally, we really would have liked to have had costed operational plans and have an implementation schedule that we could then report on, in terms of monitoring and evaluation, but unfortunately we just haven't reached that point. It is a document that we do use to guide us and refer back to as we are embarking on new initiatives to make sure that we are working within the values that

are stated and helping to achieve the vision. And we had scheduled to review it in the latter half of this year because as you pointed out, this is the final year of the timeline for the policy.

The Chairman: Some of the nine things highlighted by the Minister in presenting the plan were:

1. Strengthening institutional capacity for leadership and governance.
2. Implementing an equitable and sustainable health financing model.
3. Enhance human capital to ensure an available, competent, responsive and productive health workforce to improve health outcomes.

Given that commitment in the plan, how do you explain that 10 Caymanian doctors at the HSA trying desperately to get funding to go on to board certification have received nothing with that statement about human capital and strengthening institutional capacity being the key points of the plan?

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Thank you, Mr. Chairman.

I assume that the doctors in question have applied for scholarships of funding through the Scholarship Secretariat which is the funding mechanism that the Ministry of Education has for post-secondary education. We haven't funded them, obviously, as you pointed out. I believe that the Scholarship Secretariat has been set up with that role and responsibility for post-secondary funding.

The Chairman: But certainly, your Ministry would be aware that the maximum that can be granted by the Scholarship Secretariat of US$20,000 is hopelessly inadequate for doctors to get board certification in a one year, 18 months, two year period. So, the idea that they should apply for a $20,000 scholarship to complete a post-graduate course which is probably—depending, unless they did it at the University of the West Indies (UWI)—going to cost $100,000 or more in one of the more developed countries like Canada, the United States or the United Kingdom. How could the expectation of the Ministry be, and confined your ability to develop human capital within the health system, particularly board certified positions, that they should apply for a scholarship?

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Thank you, Mr. Chairman.

I am not familiar with the policies or the figures that the Ministry of Education Scholarship Secretariat has in place in this regard, so I can't really speak to them, other than I have heard that the amounts available through the scholarship for post-secondary education, that the amount that they have maxed to that is not always enough, not only for physicians wishing to pursue specialisation but for other people looking at post-graduate.

The Chairman: Is it the common practice in the civil service that when Caymanians get a scholarship which takes them maybe to the BSC or Bachelor or Masters level, that when they come back, the development of that human capital in that area or across government, is certainly not that they are expected to go and apply for a scholarship?

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Thank you, Mr. Chair.

Again, I am not familiar with what the conditions are and the policies around the granting of scholarships by the Ministry of Education. I know that in the past there was a requirement that the recipient be bonded to government and that they must return to work with government. But I believe that that fell away some years ago. So I—

The Chairman: No, that is irrelevant. We are not talking about that now. What we are talking about is: What is the Ministry's plan, given that statement to develop its human capital beyond a government scholarship; that is, how do you invest in your chief accountant if you don't want to go down the doctoral to get their CPA or to get sufficient experience to be a competent chief financial officer in your Ministry? Do you tell them to go and apply for a scholarship to go and do their CPA exam?

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Sorry, Mr. Chairman, I'm a bit confused. My Chief Financial Officer is a civil servant who is an employee within my Ministry and the funding of her development would come out of our Ministry's training budget. I am struggling to make the connection between—

The Chairman: Well, the connection is that you are responsible, policy wise, and you have accepted and put it as one of the key items in the plan that was put together that development of human capital which are people that you already have working with you, not people coming out of school who want a scholarship to go and qualify for something. What is the Ministry's policy on developing human capital within the HSA? Is it simply because it is an Authority that you feel you have no responsibility, you don't have to offer any guidance and that is simply left for the board of the HSA to develop and implement?

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Thank you, Mr. Chair.

The human capital development plan of the HSA is an operational function of the Authority. The HSA has received funding from the Ministry in the form of an output for an internship training programme which they have done along with the Caribbean Association of Medical Councils (CAMC). So, there is some funding in place through that.

As has been highlighted in the Auditor General's report, the action plans for the implementation of the strategic directions in the policy have not been completed and so, at this point in time I can't speak to what we have in place regarding global human capital development in the field of health care because we have not reached that point in the work of the Ministry.

The Chairman: Do you accept that as the Ministry responsible for ensuring the quality of health care that you have some obligation to issue to the HSA, particularly when it is painfully obvious that they are not doing it, some guidelines which will allow them to develop their human capital to qualify Caymanians up to board certification in a specialty of their choice?

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Thank you, Mr. Chair.

I think there is definitely an argument to be made that there could be a role for the Ministry in terms of liaising with the Ministry of Finance for additional funding if there was a policy decision that we were looking to implement that kind of a programme to create a parallel programme to the scholarship programme focusing on board certification of qualified doctors. That would be something that I do see the Ministry of Finance, Ministry of Education and Ministry of Health working together on doing.

The Chairman: You keep going back to the scholarship thing.

Has any representation been made by the Ministry of Health to suggest to the scholarship authority that when they give Caymanians scholarships, particularly to do medicine, the scholarships should not end at their MBBS and becoming either provisional licenced or fully licenced at the HSA, but that it should continue until they are certified at board level in the specialty of their choice?

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Thank you, Mr. Chair.

No, we have not made that recommendation.

The Chairman: Would it be a recommendation that you would consider making?

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Yes sir, it would.

The Chairman: Okay.

The accounts of the HSA come to your Ministry and are reviewed by your Ministry on an annual basis. In reviewing those accounts, does it trouble the Ministry that there is no commitment for this kind of human capital development at the HSA for Caymanian doctors?

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Thank you, Mr. Chair.

We do receive the audited financial statements from the HSA as they are completed by the Auditor General's Office. The HSA will forward them on to us. I can't say that we have had a particular note of concern regarding an absence of the HSA's plans with regards to their human capital development. We don't receive their financials on a line item input basis. So, I think it would be difficult for us to ascertain from what we receive, exactly what is being spent on training and development.

Certainly, I think my understanding—and again I don't have operational authority for the HSA and I don't have the financials in front of me—is that the HSA does take steps to invest in their people to offer opportunities for their practitioners to get their continuing education hours through the services of the HSA. And, as I said, they did institute in partnership with CAMC, the internship programme. And there is also work they did regarding a family practice designation that they have offered to some of their practitioners as well.

The Chairman: Well, I can tell you that last night I had a cursory review of the 2015, 2016 accounts that are sent to me to be tabled this year and it clearly indicates there that even the money they allocated for training and staffing was not spent. I think if I remember the correct numbers, only like 60 per cent of it was spent. That money which was not spent could have easily sent at least two of those Caymanians to UWI to be board certified over the next 18 months, two year period that needs to be done.

You said in your opening remarks that the plan has been guiding the various bodies that it relates to which includes the HSA. What specific . . . and I know that you do not have direct line authority over the HSA but certainly my recollection of the law is that the Minister and the Ministry can issue guidelines to the HSA Board in the interest of public concerns with health.

Was the HSA Board asked by the Ministry to be cognisant of the NHPP and to use the recommendations, particularly these nine items, in making its decision on how to allocate its resources and how to manage the HSA?

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Thank you, Mr. Chair.

I am not aware that there has been a formal written directive to the HSA Board in that regard. It would be something that I guess would be assumed to be understood. But to your question, there has not been a directive issued under the law to the board in that regard.

The Chairman: How then does or did your Ministry without such formal recommendations—is that consistent with the Health Insurance Commission (HIC), the Health Insurance Regulatory Authority (HIRA) that it is has just assumed that they would pay cognisance to this document that we have invested so much resources in doing and it is left to their whims and fancies whether they do so or not?

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Thank you, Mr. Chair.

The Health Insurance Commission and the Health Insurance Practice Commission (HIPC) and the associated boards under the Department of Health Regulatory Services (DHRS) are governed by the statutes that guide them in their decision making, which is a different situation versus the operations of the Health Services Authority (HSA).

The Health Services Authority applies to central government for funding for their outputs and that is the funding that we give them in line with what we believe are the priorities or the needs that need to be addressed.

So, the regulatory boards, the legislation that governs them is in keeping with the stated aims and goals of the policy.

The Chairman: How do you know that, if you have not formerly instructed them to follow the plan and monitoring it?

Next question: How do you determine that they are doing that?

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: The HSA Board? Or the—

The Chairman: All of them because the HSA Board is also a creature of statute.

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Mm-hmm.

Mr. Chair, there is, as has been highlighted in the report, that there are not actioned plans or monitoring an evaluation metrics that is in place under the policy. So, there is not a framework right now to monitor the work of the HSA, the HSA Board or any of the regulatory bodies in terms of achievements of goals in the policy because those goals have not been arrived at or the metrics to measure them for the monitoring and valuation have not been reached or agreed.

The Chairman: The list of participants in developing this plan included people like the Director of the Department of Health and Regulatory Services. Are you suggesting that the assumption is made then that because they were party to the development of this policy, that they would have simply taken it upon themselves to abide by the policy?

Now, this is simply not an internal document that they may not know about. This was published through the Parliament of the Legislative Assembly as government policy. I will tell you that my disappointment at the time when I said so to the Minister was that there was no timeframe because there was no implementation plan included in the policy. We are facing this same thing now with the older persons' policy that has been developed with so much fanfare and stuff and nobody knows when or how it is going to be implemented. Is that what you are telling us?

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Thank you, Mr. Chair.

The Policy is a policy, a guiding document that outlines sort of the hopes, dreams and aspirations regarding in this particular case the areas of health.

The Chairman: No, no, no, no, no.

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Under the policy or falling out from the policy we have a framework that governs the conduct and the work of the regulatory bodies which are the laws and regulations. In the case of the Health Insurance Commission that is governed by the Health Insurance Law, the Health Insurance Regulations and the Health Insurance Commission Law. And in the case of the Health Practice Commission, the Medical and Dental Council (MDC), the Pharmacy Council (PC), the Council for Professions Allied with Medicine (CPAM) and the Nursing and Midwifery Council (NMC), they are governed by the Health Practice Law and Regulations. And those are the provisions of the law and the regulations will effectively trump the policy. But they are in keeping with each other.

The Chairman: But this particular document, I believe, rises a little bit above the dreams and aspirations of the people who put it together, in that it was tabled in this Legislative Assembly as Government's policy. When such a policy goes that route, it remains the policy of the Government until it is rescinded or replaced by this group. The policy itself refers to the need for certain legislative improvements. How does the Ministry expect, or how does it get the necessary

recommendations and input from these bodies to drive legislation changes which can be presented to parliament?

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Thank you, Mr. Chair.

There have been a number of legislative review committees that the Ministry put together in the last few years. We had a committee that reviewed the Health Practice Law and Regulations that led to the amendments in 2013. Similarly, we consulted with the Health Insurance Commission and other stakeholders, the Health Insurance Standing Committee and others, on amendments to the Health Insurance Regulations, the Health Insurance Law. We have feedback from the relevant registering councils regarding some amendments that they needed or would have requested both to the Health Practice Law and Health Practice Regulations. And those are the mechanisms that are generally done. As I said, we have embarked on some larger reviews of legislation with the stakeholder committees and other reviews have been done at the request or recommendation of, for example, the Health Insurance Commission.

The Chairman: What kind of reports if any, does the Ministry require from these various bodies in order to ascertain that they are functioning properly and in accordance with the law?

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Thank you, Mr. Chair.

We receive a monthly head of department report from the Director of Health Regulatory Services that outlines the work of the department as well as the work of the Health Insurance Commission and Health Practice Commission and the relevant councils. As was pointed out in the Auditor General's report, there is an opportunity to enhance the information and the level of detail that we get in that monthly report. And the Director of DHRS has started to add some additional detail in it and we will continue to refine it as we go forward.

The Chairman: One of the really concerning things in this report is the absence of legislation review in particular areas, for instance, the Pharmacy Law. Where is the new Pharmacy Law now? Is it . . .

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Thank you, Mr. Chair.

We have a draft bill which has been prepared by the Legislative Drafting in consultation with the Pharmacy Council. Unfortunately, we are not able to proceed with it at this time as some of the policy underpinnings are being reconsidered.

The Chairman: Those policy underpinnings which are being reconsidered, are they related to the practice, the monitoring, the requirement of the pharmacy profession? Or are they related to profit and ownership?

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Thank you, Mr. Chair.

The areas that are currently being reconsidered are touched on all of the things that you have identified.

The Chairman: The reason that the current draft has been rejected is because of conflicts of policy. Are those policies a part of this NHPP? Or are they policies that exist in other environments other than the NHPP?

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Sorry, Mr. Chairman, I am just trying to . . . the areas that are currently being revisited for discussion are not unique for provisions under the National Health Policy and Plan here in the Cayman Islands. The work that has been done by the Pharmacy Council and the Ministry and Legal Drafting has involved research into the relevant legislation in a number of jurisdictions as well as best practice used in the practice of pharmacy.

As has been pointed out in the Auditor General's report, the current Pharmacy Law that is in force, I think it is from 1979 and there was another one approved, I believe, in the early 90s but never commenced. So, obviously there have been some significant changes in the area of practice of pharmacy in the time that has passed since the initial legislation was approved.

So, as I said in my response to your earlier questions, some of the areas that are being reviewed are around the practice of pharmacy. They are around provisions for dispensing and those sorts of things, so it is not unique to provisions of the NHPP. It would move towards, you know, one of the goals of modernising our legislation and looking at things to ensure that we have got enhanced standards and scope of practice. And I think that it is commendable that we have been very fortunate to have a very professional level of practice in this jurisdiction in the area of pharmacy and all the other health care providers as well. But absolutely we do need to update that 1979 Law.

The Chairman: Now let me declare an interest. I am a pharmacist by profession. I was very much involved in the 1979 Law because one was needed. I was the Minister who brought the 1991 Law. I suspect that the conflicts that existed in 1991 which led to certain persons declaring they were willing to spend large amounts of money to get me kicked out of office because of that Law, are still the ones who are objecting to the legislation today.

Having said that, how similar is the current legislation which has been rejected by the Ministry, to the 1991 legislation that was passed into law but never commenced because of the political forces involved?

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Thank you, Mr. Chair.

Just to clarify the Law, the draft bill has not been rejected by the Ministry, nor has it been finally rejected by caucus or Cabinet. We had drafting instructions approved, the draft was prepared. We went back with the draft and there were some areas that were flagged as areas that they wanted to consider further or discuss further. And so it is not the situation that the Ministry has rejected the work of Legal Drafting or the Pharmacy Council, and there has not been a Cabinet decision rejecting either, but there were some things that we needed to go back and revisit; so, just to clarify that.

I don't have the Bill or the 1991 Law in front of me. I am not as familiar with the '91 legislation or even the 1978 one as I am with the Bill that we have been working on, and I haven't got a side by side comparison of the provisions. So, I am not really able to answer that question.

The Chairman: Okay, we will move on from that.

In part of what the Auditor General is reporting in the report concerning the National Health Policy is, and I quote: **"Ministry officials did note that the NHPP was often referred to whilst developing the Ministry's annual work plans. Officials noted as well that the Government's budgetary process and structure, with its focus on outputs rather than outcomes, does not easily lend itself to implementing the NHPP."**

Can you explain to the Committee what you see as a difference between an output and an outcome in relation to the NHPP and budgetary allocations to fund its implementation?

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Thank you, Mr. Chair.

An example would be . . . the output is the funding that we provide for unit measures of some sort and it does not always equate to an outcome. We have not got the framework in place through our budget process to look at outcomes as much as we do outputs. So, the indigent population, for example, we have an output HEA2 that we purchase from the Health Services Authority. We purchase that on a fee-for-service basis. They invoice us monthly through CINICO's claim adjudication process and we pay the HSA for those services. The output that we are funding is that of care. What we don't have through our budget process is something to identify what the outcome of that care is. Now we do have, as has been highlighted in the Auditor General's report, the CayHealth programme where the HSA has implemented with the population covered by HEA2, but the budget process does not look at if we spend X and we get this much care of, has it improved the health of that population.

It is a similar problem and this is not health related directly but with the MRCU funding they get funded for taking the plane up and spraying adulticide, and we report to say they've had 25 aerial sorties which is the unit we are using that we are funding from the output. But what we don't have in our budget process is something to look at, such as, when the plane went up, as to, did it kill any mosquitoes? Did it use the right insecticide? Did they spray the area where there were mosquitoes or did they just go send the plane up? So, that is a bit of disconnect in our process from an output versus an outcome.

The Chairman: But certainly that is management 101, in that there should be constant evaluation on the outcomes of your outputs, because how is it justified continuing the output if you have no idea whether it worked or not?

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Thank you, Mr. Chair.

I believe the comment that is in the report is to say that the current budget framework that we have, the way we put our budgets together and the framework we work in does not give us that ability directly through that process which isn't to say that it is not being considered but it is not in that process.

The Chairman: I accept that the budget is outputs, but certainly as the chief officer responsible for the administration and the management, you must have some way of determining whether a particular output receives an outcome. A good example as you used is MRCU. Did the GMI reduce the number of Aedes Aegypti mosquitos in the Island? They should know where they started and they should know where they finished. Certainly, the Minister requires that kind of evaluation of an output on a regular basis.

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Thank you, Mr. Chair.

To answer your question regarding the friendly Aedes Aegypti, yes, they have seen that the number of the population of the Aedes Aegypti has been reduced by that project. And they have demonstrated because they had a controlled area and the test area is the operational trial area that they have shown a significant difference between them.

The Chairman: So, the other statement by the Auditor General is that in the meantime it is not clear that the NHPP provides useful direction or coherence to the public and private sector stakeholders involved. Do you accept that as a fact?

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Yes sir, I think in the absence of the operational implementation plans it has not been used as a guiding document in the private sector.

The Chairman: Well, I am not too worried about the private sector; I am worried about the public sector because the obvious question is: What was the purpose of spending all of the resources that we did on the NHPP if that is an acceptable analysis of it five years later?

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Thank you, Mr. Chair.

The exercise to create the NHPP was done with a tremendous amount of technical support from PAHO [Pan American Health Organization] which we are very grateful for, and we continue to have a very good relationship with them. And at the time the exercise was embarked on it was to try to put in place a guiding document that we could use moving forward to be a bit more strategic in the approach to the work that is done.

It is not that it has, I don't think, been wasted necessarily. I think it is a document and the goals and the vision stated in it and the values in it are ones that as we move forward and respond to the needs for different work that we do, it is something that we make sure we are in keeping with and we are not doing something contrary to it. And it is also with the baseline that has been established now that we will be able to review in it later this year and look to see if that is still the vision of do we need to adjust the values; are there different priorities and different strategic directives that we need to focus on and move forward from there.

The Chairman: But I think the report clearly indicates that the opposite has happened and it is not being used as a guide at all. What are you going to review if you have not used it as a guide, you have not monitored or you haven't implemented any of it?

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Thank you, Mr. Chair.

We would review the vision, the values, the strategic directions and the objectives that are in the policy and have some discussion with the stakeholders around whether these need to be amended, whether they need to be completely replaced and whether this is still the direction that we want to go in, in the area of health for the Cayman Islands.

The Chairman: But in the absence of any implementation, basically that is going to be an arbitrary eenie-meenie-miney-mo. And what is the point of that exercise?

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Thank you, Mr. Chair.

The policy was initially drafted without any reference document like that in existence and it put together on the basis of . . . and I have to say and want to echo the comment that you made regarding the Public Interest Report that the Auditor General's Office has done. I think it is a tremendous resource that has been put together in one place, basically a situation analysis on the health system here. So, I do want to commend them for their work on that. And that would be a really useful resource for everybody in the areas of health to have. And it certainly would be something that feeds into the review process for the policy.

The Chairman: Okay.

Under the title "The Government's Authority and Capacity to Execute its Roles and Responsibilities" and I quote from page 14, section 37: **"Examples drawn to our attention of laws and regulations that are needed but that are not yet in place included legislation regarding the nursing profession and practice, blood banks, and human tissue transplants. We noted that the draft operational plans for implementing the NHPP included plans for early action on developing a law review schedule that would allow for systemic review and updating of the legislative framework."**

Any response to that in terms of what priority, or has any priority been placed on legislative changes?

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Thank you, Mr. Chair.

We have done the legislative amendments regarding the nursing profession and practice. Those have been done. We are working on . . . or we have just started working on the regulations for the human tissue transplant. As you know, the Law was passed in 2012 or 2013 but not commences, so we need to get the regulations done for that.

As I mentioned earlier in the response, we have undertaken and done fairly comprehensive reviews in 2010, 2011 and 2012 of a number of pieces of legislation. We updated the Mental Health Law and Regulations. We had the Mental Health Commission Law that was brought forward. We did a review of the Health Practice Law and Health Practice Regulations.

There was the fairly comprehensive review of the Health Insurance Law and Health Insurance Regulations. And we have also had . . . (sorry, I have just lost my train of thought). Quite often what happens is we identify a work plan in terms of reviews that we would like to undertake and other priorities come up. One recent example would be the legalisation of cannabis oil for importation and medicinal use. That was a work item that was not on our radar when we first set forward, but was one that came up and we had to deal with quite urgently and as a result we had to put some other work on hold. So, that is the situation we have in terms of legislative review.

The Chairman: And you said that you had an intensive review of the Health Insurance Law and the Regulations. Are you satisfied that those reviews and changes have addressed the problems with the financing of health care in the country as related to health insurance?

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Thank you, Mr. Chair.

No, it is not a situation where we believe we have solved it. We think that the amendments that were done in 2013 went a long way to addressing some of the problems in terms of the plan of benefits under the Standard Health Insurance Contract (SHIC) increasing the contributions to the segregated insurance fund that is put towards the cost of care for the indigents. But we have continued to make amendments to the Health Insurance Law and the Health Insurance Regulations as the need has arisen. And I think with legislation, that is just the nature of how it goes; you can undertake a comprehensive review and move forward with it but it is never perfect and that is why we have periodic amendments along the way.

The Chairman: It is four years since we have made any amendments—2013 and this is 2017.

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: To the Health Insurance Law and Regs? I think we have had . . . I don't have that in front of me but I believe we have done a few. I think there is one that is waiting to be dealt with at the current Sitting of the LA that we submitted in September. And there was a motion at the last House Sitting regarding an amendment to the Health Insurance Regulations that was done. It is something that we've had to do.

The Chairman: What drives health care legislation, economic rationale or quality of care?

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Thank you, Mr. Chair.

I would have to say that it is probably predominantly, depending on the legislation obviously, the quality of care would be governed in the Health Practice Law and the Health Practice regulations and amendments that have come through those. And then the Health Insurance Law governs the system of health insurance and its enforcement. It mandates the minimum level of benefits of health insurance that everybody in the Cayman Islands should have.

One of the major amendments put in place to the Standard Health Insurance Contract in 2013 was the introduction of a wellness benefit which was in keeping with some of the goals and values that we had in the NHPP regarding making sure that people take care of themselves and the emphasis on wellness and prevention. And one of the challenges that we saw at the time with the SHIC is that the outpatient benefit was limited to $100 a year, which clearly did not facilitate people taking things like annual check-ups and recommended screenings such as pap-smears or prostate exams and those sorts of things. So, one of the amendments to the Health Insurance Law in 2013 was to put that benefit embedded in the Standard Health Insurance Contract plan of benefits so that everybody who has health insurance has access to that benefit. And obviously, the benefit to the country, to the government's finances of having more people insured and having them better insured is that we hopefully forgo some catastrophic care costs that might end up on the government's lap, that we will see improved health of the population which will help lower those expenditures. So, it is not a situation necessarily where the thought processes is we have to save X dollars, let's find a way to do it; It is how can we put things in place to better facilitate the message of wellness of improved health and wellbeing, a preventative care or a primary care and those sorts of things.

The Chairman: Is the Ministry cognisant, paying any attention to what might happen to Obama Care and whether that is going to affect us here—that is, when the parent companies of many of the health insurance companies here will once again want to reject people with pre-existing conditions? Is any consideration being given? Is there anybody looking at what is happening?

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Thank you, Mr. Chair.

It is a situation that the Superintendent of Health Insurance, and I am sure, CIMA, because they issue the insurance licence to the insurance companies as well, so I am sure they are monitoring it.

There are provisions and these were part of the amendments in 2013 to the Health Insurance Law and regulations to put in place a process regarding people being deemed uninsurable and the things that health insurance companies must do when they are

considering insuring an applicant, including the removal of underwriting and a reduction in the timeframe for pre-existing conditions. So, there are already in the Health Insurance Law and regulations some things in place to hopefully guard against that happening, if that is the situation where the insurance companies decide on the direction of their parent companies that they need to start rejecting more people.

The Chairman: Would the Ministry be prepared to recommend that our legislation stays in place under those who don't want to comply . . . can't get a licence?

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Thank you, Mr. Chair.

Absolutely, if you are not prepared to operate within the legislative framework that we have here you should not be here operating. And we do have one of the amendments that we are bringing to the next [Meeting] of the LA. It is regarding the introduction of an approved insurer certificate which is issued and renewed on an annual basis through the Health Insurance Commission.

The Chairman: Another thread that runs through this whole report is the referral to the lack of resources. Is this an actual lack of resources or is this the management of the resources that you have accepting that there are certain lack of resources?

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Thank you, Mr. Chair.

I think that one of the things that the Auditor General highlighted as an example in the report was the Health Insurance Commission having three inspectors when they first formed however many years ago, and still having those three inspectors despite the growth and population that we now have that presumably they need to monitor and enforce on behalf of.

It is a situation where they have—and I have to commend the staff of the Health Insurance Commission, Department of Health Regulatory Services, and the Health Practice Commission—all done, I believe, a tremendous job of continuing to do the work that they do. And despite the fact that there have been increases in workloads, as, for example, we are seeing for the Registering Council more practitioners being registered so there is more files for the staff to deal with. They have continued to do, I believe, an outstanding job. But it is a situation where ideally I am sure if we could double the number of inspectors and the number of staff serving the Registering Council, they would all be very grateful for the additional support.

Similarly, at the Ministry level I am extremely fortunate in that I have a very capable and a fantastic team at my Ministry that I am very privileged to work with. They work very hard and they are just, you know, we are a small team. I think we are 13 people now and that includes our HR functions, our finance policy and admin. It would be fantastic to double the number of policy advisors or even triple because I really only have one in the area of health right now. But it has just not been a practical situation for us under the financial constraints that we have all faced over the past few years. Everyone is very aware of the restriction that the Cayman Islands Government has been under in terms of our budget and the FCO approvals that we needed to put in place and the headcount restrictions that we had. So, if all of those get lifted and the FS and the Accountant General are prepared to give me lots more money I would quite happily go out and hire a bunch of more people to do some of these jobs.

The Chairman: How many actual requests has the HIC made for additional staff and how often and who was it refused by? Was it your Ministry or by the Deputy Governor and the Finance personnel?

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Thank you, Mr. Chair.

When we get our budget targets issued to us the heads of departments do their best to stay within those targets. And it has been the situation over the past (I can't remember how many years now) but the budget targets have not allowed us to add additional staff. We have put in requests and I am very pleased to say that we have been given approval in the current financial year to add another post to the Health Insurance Commission which we are in the process of getting someone in place for that. And it is one of those situations where I am sure that the Ministry of Finance would love to be able to give us additional funds for additional posts but we are given targets and we make our submissions in line with those targets.

The Chairman: But you determine what your submissions are in line with those targets? Are you saying that every year, or how often since 2004 you asked for increased staffing at the regulatory board and it has been refused and you are getting one this year? Because you know everybody comes here to tell us that there is all of these restrictions on staffing but every time I pick up the newspaper there are ads for staff and some people seem to be getting all of the staff they want and I can't think of anything from where I sit, particularly with my background, that is more important than having the Health Regulatory Authority properly staffed. You can't tell me that an extra plane to Cayman Brac is more important than that.

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Thank you, Mr. Chair. And thank you for your endorsement of the importance of the staff for that department.

The process as I mentioned, we are issued with targets from the Budget Management Unit from the Ministry of Finance. Those targets are passed on to the heads of department and they submit their budget accordingly. When we go through the Strategic Policy Statement exercise we do come and present and say, *Here are some things, if we could get some additional resources we would like to add some staff in these areas.*

Just to speak to your observation about the number of ads that you see in the paper for recruitment within the Government, a lot of those are turnovers or they are contract renewals. I know, for example, my Ministry, we recently advertised one post and it is not a new post, it is an existing post that we have a contract holder and we are looking to recruit for. So, the number of ads is not really a reflective of an increase in headcount. I don't know the overall situation with regards to government's headcounts and where we have gone over the years. But yes, the director of the Department of Health Regulatory Services does regularly make . . . in his budget submissions he is on target. And through the SPS we go and say, *If you could give us some additional headcount or if you could give some additional funding, here is where we could apply it.* And we have been able over the years to get some additional staff for some of our departments and we are grateful for that, but I think like most government departments will tell you, they could still use additional resources.

The Chairman: So, you are saying that the Regulatory Authority has put forward adequate justifications and rationale for increasing their staff consistently and the Ministry of Finance and the Head of the Civil Service has refused to give them the resources they need? I don't think it is a matter of asking in a very casual way for staff increase. I know that is not what you are suggesting.

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: No.

The Chairman: But I just want to confirm that these additional resources that they need have been, from your point of view, as the person responsible for the Ministry, adequately justified and rationalised and there have been consistently refused?

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Thank you, Mr. Chair.

The director of the Department of Health Regulatory Services is very good at justifying his request and they are not made in a frivolous way. They are supported and the workload you have identified in this report has increased over the years. We have had some increase in their headcount over the last eight years. We have added to their admin staff. As I said, we are currently recruiting another member of the regulatory team for the Health Insurance Commission.

I can't say where the decisions ultimately get made and it varies from year to year in terms of that process. There may be some years that we get the budget target, we pass it on and the heads of department take it as, you know, gospel and that is going to be what they cast their budget in and that is the end of it. And if you were to go to them and say, *This is what we can give you but would you like some more*, I am sure that they would like some more. But it may be that, you know, we do have some years where we are told this is a hard target with the budget, this is the money that you are going to get. We have been able to fund one of the posts within that department by reallocating it from our Ministry. We gave up a post at our Ministry and gave the funds to DHRS in order to keep within our budget target. And obviously we don't have a lot of wiggle room around that across our Ministry.

There are other years where the target comes down during the SPS and we are invited to make submissions on whether we need additional headcount, additional funds and we make those submissions. Sometimes we do get the additional funding, whether it is for personnel or for products and services and other years we don't. And I can't say that there's . . . because it is not . . . it is different every year in terms of where that might come down.

Mr. Kenneth Jefferson, Financial Secretary/Chief Officer, Ministry of Finance: Mr. Chairman, sorry sir. If I could just elaborate to assist and I will be brief.

As you and the Committee know, that prior to the establishment of a budget for a particular fiscal year, there is a Strategic Policy Statement which, in past years, was due to be presented to the Legislative Assembly by the 1st of December and for the start of the fiscal year that would take place in the following calendar year, on the 1st of July. Obviously, that is a formal document of the Government of the day which is tabled here in the Legislative Assembly and spoken to by the Minister of Finance on behalf of the Government. But prior to the establishment of the Strategic Policy Statement and the financial expenditure limits that are contained within that document, annually there are generally meetings involving all ministries and portfolios in which they are invited to make presentations as to what their needs are, what they wish to do in an upcoming year. That would include both operating expenditures. So, any desired increase in staffing levels would be featured within those presentations. Any capital expenditure requirements and needs would be featured within the presentations.

Honourable Ministers, Councillors, Senior Civil Servants would be within the room hearing the presentations, seeing the presentations and leaving at the end of the day with a total request from the significant ministries, portfolios within the Government.

The Government of the day, having received those presentations, looks at the level of expenditures requested, considers whether it is desirable or sensible to have any increases in revenues to fund those expenditures. The financial restraints that the Government faces annually are well known—the Government obviously has to make an operating surplus so that its operating expenses have to be less than its operating revenues. It has to maintain a certain level of cash resources throughout the fiscal year. And so, having taken into considerations of do you want to change revenues; you need to maintain an operating surplus; you need to maintain a certain level of minimum cash; in the year you can't borrow, then the focus is back to the level of expenditure requested. And those initial presentations then with the requests in them, they get in most cases, paired down or reduced. It is pretty rare for a ministry or portfolio to come into the presentation. It is fairly rare to find that it is left intact. If anything, nine times out of ten it is going to be reduced.

So, that process involving a decision by Honourable Ministers, Councillors, particularly staff in the Ministry of Finance telling the Government of the day whether those projections we see as being in compliance with the demands placed on us, what level of expenditure we can proceed with, Mr. Chair, is a summary of the process by which the needs of ministries and portfolios are heard and ultimately it is a political decision as to what portion of those needs can be met. That is a fair summary sir.

The Chairman: Okay.

Mr. Martin, you wanted to say something?

Mr. Martin Ruben, Director of Performance Audit: Mr. Chairman, thank you very much.

In regard to the Financial Secretary's comments he has described fairly accurately the process that government uses to allocate resources.

In 2013, as a result of carrying out a fairly large audit of governance in the Cayman Islands Government, we identified gaps (if you wish) in that framework that you alluded to in some of your discussion here today and some of the comments made by the Auditor General with regard to the accountability framework that exist underlying all of that process.

In particular, while we understand that there is the SPS, the strategic plan, the linkages between that plan and the resource allocation process, we believe there are significant gaps as a result of missing performance information, and, as you have pointed out, the lack of ability to assess the impact programmes are having. And I will bring it right down to the report that we have written here. For example, if there is a reduction in the review and compliance area in the licensing for practitioners and facilities as a result of not having proper resources, there are no clear reporting mechanisms throughout Government to say, *Here are risks of reducing resources in this area and here is why if you do not allocate these resources, here are the consequences across the board.* And then, that would allow for clear decision making. I would argue by the Legislative Assembly in terms of the allocation of resources through the appropriations that are provided.

I understand that the process exist today because it works but we have identified where it can be improved significantly. We are not saying that it is not working. And again, I know, Mr. Chair, that, you know, you don't want to hear the auditors telling you that there are things wrong. But what we are saying is that these improvements are very important improvements in order to address some of the issues that you are discussing with the Chief Officer here today.

The Chairman: I agree with you but I still . . . the troubling thing for me in all of this, and I guess I am going to ask you a direct question: Have you as a chief officer received any political directives formally or informally to ignore the NHPP?

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: No, Mr. Chairman, I have not.

The Chairman: Have you received any political directives to abide by or implement the NHPP?

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: No, Mr. Chairman, I have not.

The Chairman: So, is it fair to say that in the absence of any political directives to implement the NHPP, it is a de facto a directive not to implement it?

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Now, Mr. Chair, no, I don't think that would be the correct conclusion.

The Chairman: Okay.

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: I certainly don't . . . I have never had any verbal or written comments to me that the NHPP should not be implemented or it should be ignored or any of those. I think it is a situation where it is an approved and tabled, as you mentioned, in the Legislative Assembly, a national policy. It is a guiding framework of a vision, values, some strategic directions and objectives under those. And as I mentioned earlier, it is a document that I believe if

you were to look at the work that we do in the Ministry, you would find that it is in keeping with the vision, the values. Maybe not directly drawing a straight line from the work to a strategic direction or an objective, but it certainly is a framework that guides us as we go forward. And because, as I said, it was the first one, the first policy that was put in place in this area and it embodies under it a number of pieces of legislation, programmes, work by different agencies and stakeholders that were already in train and continues to be in train. And I am not familiar with anything that is going on which is contrary to the provisions in that policy. And, as I said, the framework, the laws, the regulations and the work that we have done in reviewing those and updating those, I believe has been in keeping with what's in there. So, it is not that it has been ignored; it is not that I have been directed not to implement it. And, as I said, it is something that it is unfortunate that we don't have the action plans and the costed operational plans in place for it, but we were . . . even prior to this audit we had planned to review it this year because of the fact that the time horizon for it is up.

The Chairman: Here is the larger concern that I also have, particularly in your role as chief officer, the interaction with the political directorate. Mark Scotland was Minister for four years. This document was tabled in the last possible meeting of the Legislative Assembly under his tenure. We now a situation where you are suggesting to us that the current Minister is again, waiting until his departure or the end of his tenure to consider a plan for the health care sector. Is not this something that you should advise them that they need to do in the first six months or a year?

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Mr. Chair, I am not suggesting that the current Minister has said that this should happen next month or six months from now or five years ago. As I said, we have a ministry, we put a work plan together on an annual basis in consultation with our Minister, in consultation with the heads of department and in line with our finances and our budget, and how we proceed on that does get amended from time to time due to different things coming up.

Ideally, I would have liked to have commenced the review of this policy before the 2017 end of its timeline. It has not been done and we did take a decision in the Ministry that given the time that we have left running up to the election, the work that we are still trying to complete during that time, that it would make more sense to wait for the results of this report from the Auditor General's Office, to see what the elections brings and what the priorities of the Government of the day will be, to try and . . . because one of the challenges that we have had is that the NHPP and the prioritisation of the work that we do have not always been aligned. And I believe that there is an opportunity now because we have the Auditor General's Report and we have the Public Interest Report. The NHPP is coming up for the end of its time horizon in 2017, we do have an election, so we have an opportunity when we review it after the election to align it with the priorities that are agreed, and therefore, I think, increase the chances of us having the opportunity to be able to get to the level of costed operational plans to identify some of the metrics that we want to use to measure outcomes for monitoring and evaluation as well. So, it is not a situation that, at least, I am not aware of the current Minister saying he did or did not want to do it; it's not to do with a political direction.

The Chairman: This is an administrative decision and direction independent of the political arm?

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Thank you, Mr. Chair.

As I said, the work plan that we have for the Ministry is one that we review with the Minister and the Councillor for our Ministry in terms of identifying what the priorities are and where we might put it. So, I guess it in consultation with. And there are instances, which, as I mentioned, the legislation of cannabis oil was one fairly significant piece of work that we did not have on our work plan for last year but we were tasked with doing it, and as a result of that, and we had a discussion at the time, if we do this we are going to have to defer doing that. And that is how the discussion goes and the way the arrangements are done.

The Chairman: The . . . anyway, I'd better not go down that road.

I don't regard that as a very significant or time consuming exercise.

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Sorry?

The Chairman: I said I don't . . . let's move on.

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Okay.

The Chairman: Winston, did you have some questions?

Mr. Winston C. Connolly, Jr.: Thank you, Mr. Chairman, through you to the chief officer.

In the report we talk a lot about the weaknesses and the two-way communication between the Ministry and the private sector. Can you elaborate on what plans are in place to make that process better so that as a private citizen we know that the Government

is fully aware in what is going on in the private sector; the private sector is fully aware of what the obligations and expectations are from the Government; and how we can best mitigate any of the risks that are also involved in that lack of communication? Can you tell us more about what has gone since the audit and the recommendations?

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Through you, Mr. Chair.

The audit is quite recent so we haven't had the opportunity to formalise a plan in that regard, other than I would offer that, as I think I have said, we note the recommendation and agree we will take steps to make sure that there are more formalised opportunities for two-way communication with the private sector providers in all areas of practice.

We do have it on an informal basis through the councils and commissions and the board that we have on all of the . . . the Health Practice Commission, the MDC, the Health Insurance Commission and all of the boards there. There are practitioners there who will keep us in the loop and give us feedback on different things that are going on, but certainly there is not a formalised framework that is in place or formalised opportunities and it is something that we will take on board and put in place.

The Superintendent of the Health Insurance has regular meetings with the Health Insurance Standing Committee, so I know that there is quite good communication back and forth between them as well.

Mr. Winston C. Connolly, Jr.: Thank you.

I think the Chairman raised some issues about the capacity building efforts by the HSA, the Ministry and all parties involved, but can you address again some of the concerns in terms of nursing in the report with international benchmarks? And also, I guess, explain what or how Cayman is pegged in terms of doctors with specialisations and continuing professional development against the professions mentioned in this . . . sorry, the jurisdictions mentioned in this report. Are we at an international accepted . . . well, standard . . . where do we peg our doctors and their qualifications against some of those international benchmarks? And, how do we assure the public that this is a priority in terms of trying to get the best doctors, give them the best exposure continuously so that when they interact with the public there is that feeling that I don't have to worry about any of the qualifications and further continuing education because I know that the Government, the Ministry, the HSA, the various bodies involved are all doing it for me?

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Through you, Mr. Chair.

With regards to the issue of nursing, I am really pleased to be able to advise that the University College of the Cayman Islands (UCCI) has introduced a Nursing School to allow our local residents to undertake the study of nursing. Nursing is an area of health care where there are global shortages. I recall one meeting with PAHO where they projected that in ten years they would need a million nurses around the world, I think was the figure that they spoke about. So, it is something that is a problem in most jurisdictions. But UCCI along with Dr. Hazel Brown and some fantastic support from PAHO, we, as a country, have been able to have a nursing school introduced. And I believe the first set of graduates will be coming out this summer, so that would be the first four years. And it is a Bachelors programme. And the amendments to the Health Practice legislation regarding nursing that I mentioned earlier were done to facilitate the recognition and the registration of those nursing graduates to make sure that they are able to get registered.

On the issue of the question of qualifications of practitioners and how we are benchmarked against other jurisdictions, the Health Practice Law has provisions for full registration on the principal list that recognises seven jurisdictions. So, if you are qualified or eligible to be registered in one of those seven jurisdictions and have attended (I don't have the legislation in front of me, I apologise) UWI [University of the West Indies] to study medicine, I believe, if you are registered or eligible to be registered in one of those seven jurisdictions or have attended a course of study at UWI, if you demonstrate that you have sufficient experience and sufficient knowledge of English, you are of good character, it is in the public's interest, those are the provisions under the Health Practice Law and regulations which guide the registering councils in assessing the applications for registration of health care practitioners.

So, the benchmarks that we are using are those seven jurisdictions for registration on the principal list.

The registration on the institutional list is for practitioners who are registered to practice at an institution or facility designated to employ institutionally registered practitioners. So, their registration is tied to that facility and they are qualified in jurisdictions other than the seven that are recognised for the purposes of registration on the principal list, and they are assessed by the councils as well on a case by case basis. So, those are the measures that are in place in the legislation and the framework that we have which governs that.

The question about how we are making sure that practitioners are staying current and keeping up to date, there is a requirement on renewal of your practicing licence for each category of registration that

you submit evidence of having taken a number of continuing medical . . . or continuing education hours that have to be approved by the relevant council for that purpose. So, there is an active requirement in place for practitioners to make sure that they do keep up to speed.

I know that the Health Services Authority does facilitate those opportunities for their staff with some in-service units that they do. And I know that the Cayman Islands Medical and Dental Society (CIMDS) also work with some of the hospitals from the States and some other jurisdictions to have those sorts of things done. We have some NGOs (Non-profit Organisations) that also offer symposiums where practitioners are able to come and get some continuing education.

The Chairman: I just want to ask one question on the nursing programme.

It is my understanding that the persons in the nursing programme have to go, I think it is to the Bustamante Children Hospital in Jamaica in order to get the necessary experience in dealing with children on a paediatric level and there may be some complications in that the correct arrangements have not been made by the Ministry with the Government over there to grant them the sufficient visas to come and work at the Bustamante Hospital.

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Thank you, Mr. Chair.

I am not familiar with that. I know that there was some discussion about the appropriate exam for the nursing graduates to take, whether the RENR [Regional Examination for Nurse Registration] was going to be used and the arrangements for registration with Jamaica, but I am not familiar with the details on that issue raised by you.

The Chairman: The information I have is that that clinical experience is necessary prior to taking the exam.

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Mr. Chair, I would have to check with the people at UCCI in the programme to confirm that.

The Chairman: Can I ask that you please do? Thank you.

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Mm-hmm.

Mr. Winston C. Connolly, Jr.: Mr. Chairman, just following on in terms of the inspections and the certifications of the registered service practitioners and some of the institutions that were raised in the report; specifically the recommendation on page 18 and the observations in paragraphs 54-56. Again, looking at this from a public policy perspective and looking at the risks to patients in these institutions, can you tell us—and I understand it is a recent report, but are there things that were already going on before this report; things that you can explain to the listening public as to what kind of actions are being done to mitigate these unnecessary risks where there are no inspections and follow-up certification of these institutions and some of the practitioners there, please?

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Mr. Chair, through you.

On the issue of the practitioners that were not on the register, my understanding is that those practitioners have been vetted by the relevant council but not actually placed on the register because there is a clause. I can't remember if it is the law or the regs that say that you will be entered on the register once X, Y, Z and the necessary fee has been paid. So, it is not that the practitioners were not vetted. They have been vetted and approved but not entered on the register and I know that is the case with a couple of them. I am not familiar with all of the instances that the Auditor General discovered in their work. So, that is something that we are working to get some legal clarification on whether the fee waiver can be perceived as payment of fee and therefore they can be put on the register and is something that the DHRS is working on now.

With regards to the nursing homes and the other institutions that I think were flagged as not having been inspected, my understanding is that a decision had been taken previously that they would be governed by a separate set of guidelines for residential care facilities that have yet to be put in place. So, I think what I have discussed with the director of DHRS is that looking at making sure that these facilities in the absence of those standards not yet coming forward (I understand that is a piece of work that is proposed to be under the older persons policy that we mentioned earlier) that we are going to look at how we might address that within the DHRS framework now.

The Chairman: I am concerned by two recent articles in the press related to this licensure and thing. One is that somebody is proposing to be allowed to train doctors in an urgent care centre and another is a member of the public not medically qualified that is promoting to import cannabis oil and I wonder if either of those raises any alarm flags at the Ministry level.

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Thank you, Mr. Chair.

I saw the article in the *Compass* (was it yesterday or today?) about the importation of cannabis

oil. That is something that we are going to have to look into. The process that is in place with the amendments that were made and the provisions, you would be familiar with it as a pharmacist, the INCB [International Narcotics Control Board] importation process and needing to get a permit from the chief pharmacist in order to allow that importation to happen. I don't have the legislation in front of me but it defines an authorised person who would be eligible, both for the importation and dispensing and so on. So, we are now aware of that and will make sure the individual is made aware of the framework that is in place.

With regard to the training of doctors in the urgent care facility that is being proposed . . . Sorry, I didn't . . . did he say he was going to train practitioners in there or . . .?

The Chairman: Yes. The article that I read said that he thought that he should be able to train nurses and doctors and get them up to . . . obviously, I would assume that he feels that that is adequate clinical experience for somebody who has only completed their three years of academic part of medicine, and that such an institution should be accepted for providing the clinical experience needed for not only provisional licence but full registration.

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Right. That is something that would have to be discussed and agreed and approved with the Medical and Dental Council and the Ministry [of Health] and the Ministry of Education as well in terms of the educational component of it if he is proposing to train to award some kind of certificate or something. Again, something that we can make sure we reach out and make him aware of what would be involved.

Mr. Winston C. Connolly, Jr.: Mr. Chairman, through you.

Just looking at the various instances in the report where we are talking about increasing the overall cost of health to the government, including the growing unfunded liability of the [$]1.2 billion in 2013 and 2014; the bad debt allowance of the [$]95 million and then the 2014/15 total health expenditures of the [$]269 million, the trend is steadily rising as we all can see and know. Is there any efforts being made by the Ministry, Government, you know, the powers that be as to perhaps looking at things like captive insurance and self-insuring and doing things, I mean, some innovative ways? Or are we just kind of continuing to plod along and just do it on an annual budget by budget basis or an administration by administration basis based on priorities and personal view points? I mean, what strategic management is the Ministry and the senior civil servants possibly guided by the HSA and other practitioners looking to really tackle these rising costs, this unfunded liability and try to get it in control?

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Through you, Mr. Chair.

I think most of that is more in the realm of the FS in terms of the plan of attack on the unfunded liabilities and so on. I would say that I am aware that there is some work being done to look at, in particular, the health insurance benefit that civil servants and pensioners have and whether that needs to be revisited, revised.

One of the things that we have been looking to try and reinforce and encourage is the importance of prevention and wellness to try and forego catastrophic health care costs. You know, as I mentioned earlier, we have changed the Standard Health Insurance Contract plan of benefits to put the wellness benefit in place so that everyone in the country has the ability to use that benefit to get some preventative care. We've seen things coming online. Within the civil service we have the ongoing pedometer challenge that the Deputy Governor . . . well, the Deputy Governor has put a wellness committee in place with a view of how we are going to drive behaviour change.

One of the main things that need to happen in order to sort of stem the tide of . . . or the tsunami of seeing chronic non-communicable diseases is to change behaviours and to make people do the right thing before it is too late. The thing with chronic non-communicable diseases is that they are largely preventable and it is lifestyle changes and adopting healthy habits from early ages that will help in the long run to save the country a lot of money in health care costs as well as improving everybody's quality of life. And, you know, it noted that we do have an outstanding life expectancy as a country and I think we want to make sure that those years are healthy years. And so, the things that are being done by the Deputy Governor with the Wellness Committee, we have the pedometer challenge, the Deputy Governor's 5-K that he put into place that we have every year and have people coming out for that who have never done a 5-K before and this is their opportunity to do it. So, it is things like that.

We have the annual health care conference that we have had for the last few years that we have the speakers' gear their presentations, not to practitioners but to everyone. And we had the theme of that conference—I think it was 2000 and (can't remember which year it was) . . . 12 or 13—was looking specifically at chronic non-communicable diseases. And so, we are trying to make sure that the message gets out of the importance of driving that prevention.

The CayHealth programme that the HSA has done was with the view of looking at making that transition with that population. We were seeing at the time that they launched it, the number of specialist visits

were very, very high, and, of course, the cost of those visits is much higher than a general practitioner encounter. People's hypertension was not being controlled and their diabetes was not being controlled. And so, what we have seen with the implementation of that and the premise of it is that you are aligned with a primary care physician who takes responsibility for you as an individual and your care to make sure that you are checking your sugar, to make sure you are monitoring your blood pressure, you are losing weight, quitting smoking and doing the things that you need to do to hopefully prevent a catastrophic health situation. So, we saw with the initial introduction of the programme that the cost actually went up, the expenditure went up and we have now seen it normalise. The specialist encounters have decreased, the primary physician encounters have increased and the number of people whose diabetes is controlled, the hypertension is controlled, I believe has increased as well.

It is very difficult to say with any definite confidence what we have saved by having these people improve their health. We don't know with any level of certainty that ten of them would have ended up on dialysis with their diabetes. We can assume though that at least some of them would have and we have saved that amount of money. So, those are the sorts of things we are looking at to try and drive the message of behaviour change, drive the message of wellness and prevention.

Again, the benefit is, everybody is required to have at least the Standard Health Insurance Contract level of benefits. And embedded in everyone's insurance plan is a wellness benefit, so just to encourage and make sure that everybody knows that to remind people to use that benefit to get your wellness checked up. Make sure you get your screenings, your age appropriate screenings and take steps to take care of yourself.

The Chairman: Could you send a copy of the reports that demonstrate that to the PAC please, on the CayHealth programme?

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: You would like a copy of the reports on that?

The Chairman: Yes, that it shows that those things have happened.

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Sure, will do.

Mr. Winston C. Connolly Jr.: Mr. Chairman, just a follow-up question: In terms of the overall national programme that is a coordinated effort between education, health, you know, trying to get people in from, I guess, cradle to grave (so to speak), is that something under consideration where there is pegged throughout every government body, including the health system, the school system? Or is it simply what you have said so far that in different pockets there are efforts being made but it does not sound like it is something like a team across the board nationally where every aspect of, you know, government intervention and people's lives, be it pre-natal care, be it, you know, just drilled down to that degree?

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Mr. Chair, through you.

I think the idea of health in all policies and programmes is one that we really need to look at how we can achieve one of the action plans that we had started to look at. Under the policy there was a communication plan and a network to facilitate discussions among the stakeholders. There are so many people doing so much good work; the Ministry of Education, the Department of Education; a number of NGOs and the work that the Public Health is doing and so on. To your question, we don't have an overarching coordination mechanism in place to look at that, and that was one of the outcomes that we had envisioned with the implementation of the National Health Policy.

The Chairman: Any other questions from the Committee?

[No audible reply]

The Chairman: Okay.

I guess given the last question that we asked in that these plans are coming at the end of the terms for the political directorate, what confidence can we place in the projected timelines here?

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: For the review of the . . .?

The Chairman: For all of the stuff that you are planning to do in 2017 and 2018.

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Thank you, Mr. Chair.

I would offer that in addition to the advice that we would be able to provide to the Government of the day from the departments that we have in place, we now have this Auditor General's report and I assume the report of the PAC that will come out of it, that we will be able to use to reinforce the importance of proceeding with the work that has been identified.

The Chairman: Okay. Well, thank you, Ms. Ahearn, for your time.

We will take an early lunch and be back at 1 o'clock. Thank you all very much.

Ms. Jennifer Ahearn, Chief Officer, Ministry of Home Affairs, Health and Culture: Thank you, sir.

Proceedings suspended at 11:45 pm

Proceedings resumed at 1:30 pm

The Chairman: Let the record show that we have a quorum present and if I could, invite Dr. Darley Solomon to come into the Chamber please.

[Pause as witness enters Chamber]

The Chairman: Good afternoon, Dr. Solomon, and thank you for taking the time out of your busy schedule to come and lend us your expertise.

We are considering this afternoon the report of the Ensuring of Quality Health Care and a Healthy Population. And I believe I would probably be correct in saying that this is your first time appearing before the PAC, so I will give you an opportunity to give us a bit of background so that people will understand the framework from which your comments are being made.

Dr. Darley Solomon, President of the Cayman Islands Medical and Dental Society: My name is Darley Solomon and I am a general surgeon, born in Cayman, educated in the United States, I completed medical school in 1989 at Howard University. I went on to do an internship in preventative medicine and internal medicine at Albert Einstein Hospital, Bronx Municipal Hospital Centre in New York, and subsequently did a general surgery residency for five years at the University of Mississippi in Jackson, Mississippi prior to going into private practice in 2000. And I do have a continuing experience since then as an operating general surgeon.

In 2003 I came back and was chief of surgery at the Government Hospital. At that time I think Mr. McLean was the Minister of Health. Being at the Government Hospital I recognised, as the report says, a lack of capacity in our health care system in Cayman. Subsequently, I went back to the United States and obtained an Executive MBA while maintaining surgical practice in 2006.

I saw the landscape of medicine in the US and decided that the future of medicine in the US was not what it used to be, so I came back home in 2010 and quickly recognised that we were just blindly following the US model. And I felt like a conarium of mine trying to tell people that this is about the derail folks. Let's think outside the box, let's do something different.

At that time I also applied to be the Medical Director at the Cayman Islands Hospital which I guess was my first (that was about 2010, 2011) encounter with the Ministry and the mechanisms and the operations of the Ministry and I was never impressed even in 2003 when I was here, but subsequently I became less and less impressed.

They brought in a consultant from Deloitte and Touche out of Atlanta to interview me for the role of Medical Director. The CEO wasn't interviewed, the Chairman of the Board wasn't interviewed, the CFO wasn't interviewed but because they knew I was passion about health care and they felt that, you know, we best have an excuse to make sure that Dr. Solomon does not get in here and upset the applecart. Well, I don't know, I guess they thought I was going to go away.

I went on to be named the Chairman of the MDC [Medical and Dental Council]. During that period I started to improve the standards. I have to understand I am a general surgeon, I was trained in the United States of America, board certified. My standards are different. And I felt that the Cayman Islands as the fifth largest financial centre in the world should be recognised not only for its first world business but for first world medicine. So, my determination was to say- *Let's elevate health care in Cayman.* And so I set about initiating the increase in standards.

In the report it clearly states that we have a higher number of doctors per capita than the rest of the Caribbean. We don't have trouble attracting doctors. The mosquitoes are no longer killing cows, as my mother told me. So, why would we settle for anything less than the best? Why wouldn't we establish the standards that the UK have, that Canada have, and that the US have? And to me, meeting the opposition to raising those standards was confounding. I could not understand it. And, of course, making the waves I was quickly relieved of that job. Again, I'm Caymanian, I'm not going anywhere.

My next phase was to be president of CIMDS [Cayman Islands Medical and Dental Society]. Okay? That happened while we were in the process of providing information for the Mono Sueppel [PHONETIC] report and admittedly the doctors did not participate but to sentiments amongst doctors has been a mutual disrespect between the Ministry and private physicians which is embarrassing. It is actually shameful. How can you disrespect a major shareholder or stakeholder? So, as the president of CIMDS I took it personal. I said: *We as physicians will participate in this because I feel we were scapegoated with the Mono Sueppel report.* We're blamed after Government got a report, sat on it for a year, released it in public prior to even releasing it to the doctors and then basically said it was the doctors fault and they were not going to listen to the consultants. Who does that? To me it shows the lack of leadership, the lack of accountability, and "accountability" is a word that we need to throw around in the Cayman Islands a lot more.

We did participate for that and that helped to produce this report and I am glad that I have the opportunity to speak on it because I think there needs to be a change and I am not scared to say it. I am a surgeon. What I do is to identify problems and fix them. I've seen this problem in health care for years now. I think it has come to a point where we need to call a spade a spade. We need to recognise that things are not right in the Ministry and unless we do something about it we are going to continue to get the same thing.

Four of the most glaring ears that I can recall is the MDC trying to increase standards and the Government not getting on board. Quite the contrary, there is a forest of a group called Cayman Islands Health Care Association that is out there spreading propaganda that I am opposed to Caymanian doctors. How ridiculous is that? What I want is for Caymanian doctors to be trained so that when they come home there is no issue about them being substandard. We have doctors coming from all over the world to Cayman. I want to make sure that the Caymanians are adequately trained so that there is not a two-tier system like what exists in the legal profession where they are like, *Oh that is a Caymanian lawyer.* Not going to happen in medicine. Not going to happen in medicine. And so the fact that they would accuse me of being anti-Caymanian just irritates the hell out of me frankly.

Secondly, the lack of communication with the Ministry is unbelievable. When you have the Chairman of the Medical and Dental Council responsible for registering every physician and dentist on Island emailing the Minister, the Councillor, the Chief Officer and not getting a response in a town of 60,000? That's outrageous! How about if the President of the Cayman Islands Medical and Dental Society email them, would you expect a response? I have gotten to the point where I add a courtesy of response "It will be greatly appreciated" and they still ignore it. I wish I had the power, I would change the Ministry. I would change it.

You know one of my favourite sayings is and I have shared this with the Councillor. Actually, lest we forget the CarePay scandal when the Grand Court Judge, Mettyer (I think he was talking to a Mr. Moran [PHONETIC]) said: *Well, either somebody in the Ministry missed this parenthesis incompetent or was complicit.* Did we forget that? Somebody should have called the Ministry to task on that. It is unbelievable the conduct of forest. We have a national health policy and plan that is supposed to be inactive from 12 to 17 and the response is: *Yes, we will get to that next year.* That is embarrassing. That is embarrassing to my country. It is embarrassing to my profession. And somebody needs to step up and say it.

The Chairman: That is the purpose of these hearings because one of the things you would have observed, of course, running through the report, is the constant and repetitive claim of a lack of resources. We have tried to ascertain this morning whether it is an actual lack of resources or a lack of proper utilisation of the resources that we have, because what you have just intimated to us is that you at CIMDS and you at the Medical and Dental Council, and we have the existing Chairman of the Medical and Dental Council, Dr. Sidney, coming after you. So, it will be interesting to see if they have responded to him, not having responded to you when you were the chairman of the Medical and Dental Council.

So, how do you believe we could improve the communications between the private sector represented by CIMDS and the Ministry, and get an effective solution that improves the standards? Because, like you, I am an advocate for improving health care standards and I started at this in 1974. And I am seriously perturbed professionally by what has been ongoing in the last 5 to 10 years. But what do you think? Do you have any suggestions to the Committee as to what might be done?

Dr. Darley Solomon, President of the Cayman Islands Medical and Dental Society: As I told you, I am a surgeon. I identify problems and I deal with them. I think this has been going on long enough. Heads need to roll. It is unacceptable. Somebody has to be accountable.

Where does it stop? Where does the buck stop? We can't blame the politicians. They are going to say what they need to say to get elected.

The Chairman: Mm-hmm.

Dr. Darley Solomon, President of the Cayman Islands Medical and Dental Society: I've thought about this for a time. In my deliberations I come up with an answer. I don't know whether the people will agree with me or not.

The Deputy Governor is in charge of the Civil Service. They have to be accountable for the day to day progress of our Government. If they are not doing the job they need to be accountable. So, you have to hold the chief officers accountable and you have to hold the Deputy Governor accountable. And it is enough pussyfooting around. Let's get down to being a real country. We say we are the fifth largest financial banking centre in the world and conducting business like this? Business that involves people's health, lives? No, I am not that stupid. You misjudged me. It is wrong, it is unacceptable. No more!

The Chairman: Well, we had the—I don't know if we can call it a precedence but we had a similar, though different situation with the accounts and the financial statements of government for over a period of time and we have managed to get the Deputy Governor to put his foot down and the personnel in the Finance Department and we got them to work together and

have made a lot of progress. So, I agree with you that, I think, it is probably time now that we ratchet up the performance of the chief officer of Health to that of the Deputy Governor and question what kind of performance evaluation is being done of the chief officer particularly in relation to the management of the Health Care Portfolio.

Dr. Darley Solomon, President of the Cayman Islands Medical and Dental Society: I would be more tolerant if there was communication. You know . . . I don't feel like I am unapproachable. I am determined but I am determined that the health care of the Cayman Islands will be better. If you are not on the same page with that, then yes, we have differences. I have no apologies for that. But when we have senior management in the Ministry of Health that does not feel compelled or curious as to what the Chairman of the MDC or the President of the CIMDS thinks of health care, I know what I think of that situation. And, you know, that's why I decided to . . . you know, you have to be forthright. I know this is a small community, I understand that. But this is too big a problem for us to be pulling punches. Health care will bankrupt a society. It will bankrupt a society.

Their solution—I don't know how they thought it up because realistically they did not converse with me but they said, *Uh, health care expenditures are increasing, what can we do to stop that?*

Well, let's not give the doctors a 12.3 per cent raise.

Well, do your homework. Doctors' salary does little to stem the increase in health care expenditures. Do your homework. The fact that they thought that was going to affect something, shows me their ignorance.

The Chairman: Yes, I noticed.

Are you familiar at all with the NHPP or the first time you—

Dr. Darley Solomon, President of the Cayman Islands Medical and Dental Society: I vaguely remember maybe sitting in a hotel room and having the stakeholders meeting and we do that a lot in the Cayman Islands; stakeholders meetings and nothing ever becomes of it. So, I think I may have participated in it but obviously it didn't come to anything.

The Chairman: Yes, it appears to me that the CIMDS nor the Chairman of the Medical and Dental Council are not listed and I hope my dyslexia is not forcing me to skip over it.

Oh, I see at the time . . . oh yes, they did have the chairman of the Medical and Dental Council at the time, Dr. Joseph Marzouca, but I don't see as part of their committee—

Dr. Darley Solomon, President of the Cayman Islands Medical and Dental Society: That would not surprise me. There seems to be a total lack of respect. And I am sure you can sense the agitation in my voice, but it is just frustrating having trained in the US and participated in health care in the US to come home and see the way that the leaders in health care treat physicians. It is with disrespect. I don't know . . . well, I know they didn't treat them any better because I was at the HSA. So, it is not just a matter of relationship with private physicians.

The Chairman: Yes, it is kind of revealing that they have the Chief Executive Officer from the Chamber of Commerce. They have the Cayman Islands Civil Service Association (CICSA) representative but I don't see the Cayman Islands Medical and Dental Society representative and you are drafting a health policy.

Dr. Darley Solomon, President of the Cayman Islands Medical and Dental Society: Well, that sounds about right; let's draft the health policy but let's not get the Medical and Dental Society involved. That was sarcasm.

The Chairman: Oh, I know.

Dr. Darley Solomon, President of the Cayman Islands Medical and Dental Society: Sometimes people mistake my sarcasm for fact.

The Chairman: Well, I don't. Because again, besides the resources, there are comments by the Auditor General that although in his interviewing of the private sector he found some of the same sentiments that you are expressing; that is, the frustration in communicating with the . . . and it was not clear roles, for instance, in [paragraph] 33 it says: **"Several private sector practitioners we interviewed indicated that they were not clear about the Government's roles, responsibilities, policies or strategies for the health system. They were aware of the major efforts some years ago to develop the NHPP but not of any subsequent developments or outcomes. Most believed there was not enough communication or consultation between the Ministry of Health and the private sector, and that the Ministry has little information on what is happening in the private sector."**

Dr. Darley Solomon, President of the Cayman Islands Medical and Dental Society: I don't think . . . I started saying that I don't think they really care. I know that they feel more aligned with the concerns of the HSA, but even that they have done a piss-poor job at. Hell, they are running a $90 million deficit; maybe $10 million to be collectible. Should we talk about that? Come on, enough!

The Chairman: We were told this morning that they are going to review this document by September 2017 and hope to have an operational plan by March 2018.

Dr. Darley Solomon, President of the Cayman Islands Medical and Dental Society: Look . . . sorry for interrupting, I will let you continue.

The Chairman: No, I was finished.

The question I had was: What are they going to review? If you put together a plan with certain . . . or put certain priorities out but none of that has been implemented, what are you reviewing? Are you suggesting that your original identification of those priorities was bad enough that you need to revisit that to try to establish it before you can implement or . . .?

Dr. Darley Solomon, President of the Cayman Islands Medical and Dental Society: Well, I would respectfully ask you—what did the chief officer respond to that question?

The Chairman: That was her response; that they are going to review the existing document.

Dr. Darley Solomon, President of the Cayman Islands Medical and Dental Society: Oh. Well, I think they have had enough time. And the analogy that comes to my mind is if a patient has gangrene you've got some time to fiddle and faddle and play with it. Sometimes you don't. So, five years, I think that was enough time. Sooner or later you have to decide—*Am I going to let this gangrene continue to fester or do I need to amputate something?* I would contend that in the Ministry of Health and health care in the Cayman Islands in general, it's time for urgent action. The sore has been festering too long.

The Chairman: Do you have any concerns for . . . We have a number of Caymanians like yourself who are stuck in limbo in never-never-land, in that they want to continue their medical education, they want to get board certified like you but they don't have the means to do it because many of them are not as fortunate or unfortunate, depending on how you look at it, I guess, to have green cards or have access to being able to work in one of these places where they can get this kind of board certification. The response was that they should apply for a scholarship from the chief officer. Now, I find that wholly inadequate because you and I both know that if you want to become a surgeon or you want to become a cardiologist or you want to become an obstetrician and gynaecologist, US$20,000 for the year is not going to get you through the first course. What suggestions do you have, if any, that you believe we could recommend to the Government that would give these Caymanians a fighting chance to get the board certification that is needed in today's modern medicine?

Again, you and I will know that because of our background 25 years ago you came back from the University of the West Indies with a Bachelor of Medicine and a Bachelor of Surgery and you went into general practice and you did some appendectomies and other things and you got along pretty well.

Dr. Darley Solomon, President of the Cayman Islands Medical and Dental Society: Let me start by saying that it is a privilege to be a doctor. It is not a right; it is a hard earned privilege. It does not come easy. Anybody who thinks they can complete medical school and get out here and take care of lives, they are fooling themselves and worse yet, they are fools. It is impossible that with the explosion of medical knowledge it is disrespectful to think that you can do four years of medical school and then be entitled to take care of peoples' lives. Who does that? Who sets that standard?

These individuals . . . and again I take the opportunity to try to destroy the propaganda that is Cayman Islands Health Care Association, it's a forest. It's a forest. They don't have standards. Ask them what they standards are. Four years of medical school and a CAMC exam in Jamaica that I questioned as MDC. Did somebody give them the answer?

We had a Spanish speaker who could barely talk to me in English, take the test and pass it. I said, *How in the heck did he pass the test?* That's why I push for English as the IELTS [PHONETIC] test and a minimum score of 7 so that people who come here can at least relate to their patients. And even 7-ies can make errors. How many errors do you want to make when you are telling people about the medications that they need to take? Why, is that even tolerated?

The Chairman: I agree that—

Dr. Darley Solomon, President of the Cayman Islands Medical and Dental Society: So, it is . . . getting back to the drive and the motivation. First of all if you are a US citizen and you go to an offshore medical school you could not get into one on land. Let's set the record straight.

The Chairman: That's the reason you went—

Dr. Darley Solomon, President of the Cayman Islands Medical and Dental Society: That's the reason you went. Okay?

So, now that we have that out of the way, when you finish medical school—and I personally taught at St. Matthews. I happen to teach Dr. McField who was a bright student and I think, arguably, one of the better surgeons on Cayman at St. Matthews. So, I know there are some intelligent students that can matriculate through there, but you still need to do the training. He went on to the US, because of his scores

on the graduate level exams, got a residency. If you can't get a residency it is because you did not score well—point blank! They make exceptions for people from India to come. So, why wouldn't they give, I think it is a J1-visa to somebody from the Cayman Islands?

The residency programmes in the US, the first thing people need to do is if you don't get into a residency you need to start looking in the mirror and saying, *Well, is there something that I . . . was my standard not good enough?*

Now granted, I think the Government can do more. And we have to look and see why we are just talking about this in 2017. I mean, the Bahamas does not have a shortage of Bahamian doctors. Barbados does not have a shortage of Barbadian doctors. Why in 2017 that we are just looking at Cayman doctors? Where was the . . . I remember communicating with the chief officer and in one of my letters I said we need to think about manpower development and she chided me. She said, *Well, we have never talked about that.* Well, damn, maybe we need to have that conversation. Maybe we need to have that conversation and we would not be in the jam. In 2003 they were paying a neurologist a quarter of a million dollars for six months of the year. This problem has been going on for a long time ladies and gentlemen and it is time we fix it.

Now, what should have happened is that the Government should have invested in doctors and aligned themselves with some university, some training centre and say, *We will give you* . . . I don't know, in this day and age it is probably US$40,000 to US$50,000 per residency—*you train our doctors.* I want to know who in the Ministry has ever had that conversation.

We have a Caymanian General Surgeon, Neely Panton, who heads Vancouver General. I think he had an outreach. He was like, *Well, maybe I can take some.* Where did he go?

The Chairman: Mm-hmm.

Dr. Darley Solomon, President of the Cayman Islands Medical and Dental Society: So if you ask me, does the Ministry have the capacity? And I like that word. I'm a surgeon so I would have been more straightforward. But "capacity" is diplomatic. Do they have the capacity to manage health care? I think their track record says a resounding 'no'.

The Chairman: The other thing that is not mentioned in the actual report but it was identified in the supplementary documentation and that is the advent of Medical Tourism and what I call the barn door that was exploded into the whole regulatory regime for economic reasons to allow people to come in and work in what we call an institutional registration. And I would want to ask Dr. Ebanks in some more detail about that. But do you have any concerns of that advent? And what do you see that doing to the development of proper standards and the development of Caymanians in the medical field?

Dr. Darley Solomon, President of the Cayman Islands Medical and Dental Society: Again, we have to start back by how that came about. Certainly, I believe Dr. Marzouca was chairman of the MDC. He tells me he gave them input, the Ministry ignored it.

In the US where I trained there is only one standard. Either you are registered or you are not. So, to me when you start having these alternative pathways it leaves you open for creating a two-tier system. For example . . . and I want to be clear that I was the chairman of the MDC when Health City was opened. I had the opportunity to, I guess, be obstructionist at that time. I think the greater good of the country required that regardless of what my personal standing was, it would serve no good to the Cayman Islands to be obstructionist. But I did have concerns and I voiced those concerns to the Attorney General, Chief Officer, the Councillor of Health, and the Minister of Health about there being two separate and arguably unequal levels of medical professions. So, I was opposed to the way in which it was done. Now, I believe in good medicine, so regardless of who does it, that does not prejudice me.

I remember being at a CME [Continuing Medical Education] with the Paediatric Cardiologist of Health City. His name escapes me right now. And he showed how he had been doing interventional cardiology on kids and repairing valve septal defects and I got up and applauded him. Because hell, some places in the US in towns of 60,000 70,000, 80,000 don't have that capability. So, you have to appreciate good medicine.

The Chairman: Mm-hmm.

Dr. Darley Solomon, President of the Cayman Islands Medical and Dental Society: So, it was done wrong. Hopefully Health City is going to help us to increase our standards here. You know, they say that competition is good for business. So, I am hoping that health care will improve with the Health City here.

Certainly, I spoke to Dr. Jefferson a couple of years ago and I think that this report comes close to what I had explained to him about three years ago—Dr. Jefferson is the Medical Director of the HSA and I consider him a colleague and friend—that if you don't get your ship in order somebody will take it from you.

The Chairman: Are you concerned that the rationale used in making that decision, it was certainly sold to this Parliament? I was sitting here and I objected very strenuously to the changes to the legislation. I think I called it the worst piece of legislation brought to this Parliament in its history. But are you concerned that the rationale was that it was going to be medical tour-

ism and it was going to be a tertiary care facility and therefore assurances were given that it was not going to impact the Caymanian medical fraternity that already existed, particularly at the general practice level and some of the existing ones? Are you concerned that they may b at an advantage that other facilities in Cayman do not have?

Dr. Darley Solomon, President of the Cayman Islands Medical and Dental Society: Of course. Now I have to caution about that because again, I am US trained and you know, without hopefully sounding too arrogant—

The Chairman: A surgeon? Oh man, you could never be too arrogant to be a surgeon.

Dr. Darley Solomon, President of the Cayman Islands Medical and Dental Society: I maintain humility but I'm a straight shooter.

That preserves me some because you have a referral basis and when people understand your level of training and you've taken care of their patients appropriately, they appreciate that. They respect that and they can send them to you with confidence. And that preserves me. It may not be as threatening to me as it would be to some other physicians. But it should have been cause for concern but I think that horse has left the barn.

The Chairman: Well I tend to agree with you because my understanding of the agreement and the basis on which the concessions were granted was that it was not going to be in direct competition and it was going to remain a tertiary hospital. Yet, they informed the Auditor General and I quote: "HCCI is not limited in any way or form to providing just medical tourism; it can provide any health care services it chooses to the local population." [UNVERIFIED QUOTE] That was not what was sold to the public and what was explained in this Parliament.

Dr. Darley Solomon, President of the Cayman Islands Medical and Dental Society: I never thought that was the reality. I had spent enough time in the US to know that I didn't think anybody in the US was coming here to have open-heart surgery.

As a matter of fact, I met with the CEO of [INAUDIBLE] and the Medical Director about six months into it, and their question to me was: What can we do to get the local doctors on board? I don't know whether they saw the shock on my face or not, but I was like, *I thought this was medical tourism. What does that have to do with having the local doctors on board?* So, I never bought into it being medical tourism. At the start I knew that was not going to happen so it did not surprise me when they brought in a general surgeon that does lap-chole(s) [Laparoscopic cholecystectomy] on local folk. That does not surprise me.

What did surprise me in that conversation was that the CEO and the Medical Director, for a $2 billion company invested in medical tourism product, did not know about Baumgarten or didn't know about Apollo; two of the largest medical tourism businesses in the world. So, it made me wonder what kind of homework they did. And it gave rise to thinking of - *Well, is there something else that is going on here that is not for the public eye?* Because certainly, for them to come six months down, I would imagine they saw the revenue stream and said, *Hey, look, this ain't working, we got to do something different.* But the mere fact that they would come and ask about that and not have done their homework on medical tourism, somebody must have sold them a bill, because I looked at them like, *You guys run a $2 billion company?* I was flabbergasted.

The Chairman: My concern is like yours. I don't know how to regulate that kind of facility. When you say that you are only doing tertiary care and you are not going to compete, it is going to be very difficult. I mean, we were also told that there would be no such thing as walk-in patients. They would only treat Caymanians who were basically referred through the HSA for tertiary care.

My concern is also on the economic side of it, in that that institution is being allowed to compete with other institutions locally when they have the means to keep cost at an absolute minimum because of the way they employ their doctors.

Dr. Darley Solomon, President of the Cayman Islands Medical and Dental Society: Again, accountability.

So, if you are not going to give the local physicians or the local medical practice the same concessions, then at least keep accountable and value for money the concessions. Who is tracking that? Who is saying that for $800 million they have drawn down $100 million and this is the value for money that the country has gotten? I know there is no one doing that. It would surprise me if there is somebody doing that. So, is it just an open-ended blank check? Right now it is.

The Chairman: Mm-hmm.

Dr. Darley Solomon, President of the Cayman Islands Medical and Dental Society: And who knows? You know, I don't know. Have they spent $800 million yet? But I can't blame Health City. Please don't get—

The Chairman: No.

Dr. Darley Solomon, President of the Cayman Islands Medical and Dental Society: Any business

man worth his salt does what he can do to increase the bottom line. It's the Government to dot the, i's and cross the t's.

The Chairman: Mm-hmm.

Dr. Darley Solomon, President of the Cayman Islands Medical and Dental Society: The Ministry of Health, the Finance Ministry, where are they on this? Who's keeping accounting?

The Chairman: Well, on a different review on a different audit we brought all of those issues up and quite frankly they did not have answers that satisfied either the Auditor General or the Committee because everybody seems to be leaving it for some other agency to do. And again, the terminology over which the concessions are so ill-defined—you know, lifesaving equipment . . . well, that could be a hammer if you need to break the fire extinguisher. Right? It does not have to be a scalpel. And there is not a list that is attached to these benefits to which the Customs authority or other authorities in Government could rely on.

Dr. Darley Solomon, President of the Cayman Islands Medical and Dental Society: We can't give the Ministry of Health any more passes. No more passes. They have to be accountable. Not only the Ministry of Health; it happens in Education. I wrote a letter about the $110 million School. And one of the schools is saying that they don't have paper. Come on! We need to hold people accountable.

The Chairman: Would CIMDS be amenable to assist the Ministry of Health to put in place some of these standards, some of these criteria for which they could use to evaluate performance in order to hold people accountable? Because you can't hold me accountable if you haven't what your expectations and standards are that I have to meet; it's simply telling me that I can only spend $50,000 on a particular item and is not really giving me the information that I need to make sure that I am going to generate the outcome and there is this big tossing around between an output and an outcome, you know.

The budget realised by many experts, too heavily on outcomes and does not consider outcomes. But I proffer that the philosophy that *Yes, your budget might talk about outcomes but you as the administrator, as the manager, as the person responsible to the Deputy Governor to see that these things are done, should be in some respect monitoring and evaluating the outcome that the output that you asked for is supposed to do.* And they said no, kind of, so . . .

Dr. Darley Solomon, President of the Cayman Islands Medical and Dental Society: Lack of capacity.

The Chairman: Yes.

One of the things that we try to do as a committee is to get to a point where we can find a solution for the problem and then try and get the Government to respond in a government minute that yes or no, that is an acceptable solution and yes we are going to provide the resource to do it. We return then to the Audit Office six months, one year later and says, *Well, we made this recommendation to correct this problem, the Public Accounts Committee agreed with that recommendation to correct that problem, you responded in a government minute admitting that yes, it was a problem, yes, you would correct it, this is what you were going to do to correct it, these are the resources that we are going to provide to correct the problem,* and then, the Audit Office can come along and say, *Okay, you provided the resources, these are the things that were supposed to be implemented, how did it happen?*

Dr. Darley Solomon, President of the Cayman Islands Medical and Dental Society: I would be cautioned about throwing money at the problem. I would be very cautious about that. You know, I don't know the inner workings of the Ministry but give me more money or more people, I don't think that is the solution. What happens if you don't . . . let's say you don't have any more money, let's say you can't hire any more people. Now this is the problem: How are you going to fix it? Let's start by that. I wouldn't. No. Absolutely not! Ab-so-lute-ly not! Think outside the box. This is your problem, you've got finite money, you've got finite resources, now what do you do? If you can't do it we will somebody that can.

The Chairman: That is pretty straight and I agree with you. And this is where we are trying to get, because we agree with you in many respects that the evidence is here that they are not (certainly, in my personal view) utilising the resources that they have to ensure the outcome that the output is intended to produce. And I agree with you, giving them more outputs is not the answer to that problem. The answer to that problem is: What are you not doing with what you have as for the reason why you are not getting the outcome that you deserve? And that is what we are trying to get them to focus on.

Now, you may be right as a surgeon, we may need to amputate some people in order to get that done. But in what we have been discussing as a committee, that is where we would like to get to. Right? So, the question I am asking you is: Do you think giving that is where we want to get to, that the CIMDS would be willing in a proper environment to assist in any way that it could to try and get that sort of thing done?

Dr. Darley Solomon, President of the Cayman Islands Medical and Dental Society: As past presi-

dent, and I can't speak for the current President, there seems to be a commitment by the doctors to know that health care is changing, that the landscape of health care is changing and to want to participate and understand that unless you are sitting at the table having dialogue, the future may be shaped without your input. So, I would think that the CIMDS would welcome the opportunity to be involved with dialogue that is going to affect the health care of the Cayman Islands.

The Chairman: I think so too. I found it that way when I was minister of Health. I did not always agree or appreciate their input but it was always valuable and it was put in the mix of things, and many times it altered the solution that had been proposed by the Ministry because the dialogue in itself was a good exercise.

Dr. Darley Solomon, President of the Cayman Islands Medical and Dental Society: Absolutely!

Mr. Winston C. Connolly, Jr.: Mr. Chairman, through you. Good afternoon Dr. Solomon.

You mentioned a lot about the criteria and what we should be doing. Can you explain the journey that a doctor should take to be become fully competent in accordance with international first world standards?

Dr. Darley Solomon, President of the Cayman Islands Medical and Dental Society: Well, I am bias because I can only speak to my experience. I've heard about how training in the UK and certain other jurisdictions are but I am most familiar with the US standard, four years if undergraduate, followed by four years of medical school, and followed by a minimum of three years in residency to become a general practitioner or a family practice doctor. And at that point in time usually you can go and hang your shingle and say, *Yes, I am qualified to take care of people.*

Specialists require an additional minimum of one year for internal medicine. A surgeon may require another two to three years, depending on the specialty. And then, you never quit learning in medicine; never quit learning. It is a lifelong exercise. You know, I learn and I look up things every day. Even after I had gotten my surgical degree, I still practiced for about three years before I came home independently. So, when I came home I felt fairly confident that I could handle what was going to walk through the door. And I've written to, certainly, the Chief Officer and the Minister and the Councillor and explained to them that the most dangerous doctors are the doctors who don't recognise what they don't know. The diagnosis you miss is the one you don't think about. So, let's have some experience before you start . . . well, I'm like these are my relatives out here. My mother died in the Cayman Islands Hospital last year. You know, I want to make sure that the people taking care of Caymanians are adequately trained; that they are just not dropped off in the Cayman Islands because they could not get a local. What?

You know, too long we have had the reputation of sub-par doctors. That's why I take exception to the Ministry when I tried to increase the standards and then they would have the audacity to join some Facebook group that accused me of being anti-Caymanian—imbecile.

[Inaudible interjection]

Mr. Winston C. Connolly, Jr.: Dr. Solomon, just as a continuation, how does that compare to what actually occurs right now? And the reason why I am asking this is for the listening audience to basically see what, you know, to say a first world American standard is versus what is now being done and carried out in the Cayman Islands.

Part 2 of that is: In your opinion, do you think that that experience can be gotten in Cayman and if so, where? And if not, what is the alternative?

Dr. Darley Solomon, President of the Cayman Islands Medical and Dental Society: Let me be absolutely clear. There is no way at the present time that anybody can complete appropriate training in its totality in the Cayman Islands. The future may be different but at the present time there is no way that somebody can complete their medical training to include a residency in the Cayman Islands. This came to light with the good intention of the internship service at the HSA. I don't know whether that has been put to rest. I think it had good intentions but remember the road to hell is paved with good intentions. So, I admire the thought but getting back it would have been more constructive to establish a relationship somewhere where you could go and get adequately trained with proper volumes. Sixty thousand people are not adequate to train anybody. And the people who would say that it is, they are disingenuous. Be wary of them. Be very wary of them. Anybody who talks about training doctors in Cayman, at this point in time, at the present, I would not have too much conversation with them because I think they are starting on a premise that is false.

Mr. Winston C. Connolly, Jr.: So, what is the status quo right now in terms of being able under the law and the regulations to qualify in Cayman?

Dr. Darley Solomon, President of the Cayman Islands Medical and Dental Society: Well, there was a private member's motion brought by the chairman to increase the standards. The Ministry has been resisting to really endorse those. But there should be a minimum of—if you are on the US track and this is what I can speak to best. Dr. Ebanks can probably speak to the Jamaican and UK track a little better. But if you

are coming from a US based training, four years of medical school minimum, three years of residency, taking a CAMC exam and . . . okay . . . so, this is how ridiculous it is, that somebody would do four years of medical school, take a written exam that, remember I questioned the validity of that exam because somebody who could not speak English took it and passed it. So, either he got the answers or I don't know what happened but I questioned the validity of the exam, and then do an internship at the HSA where you were not even allowed to start IVs. You couldn't start IVs and then think that you are qualified to take care of people. That is unethical. That is unethical! They should start medical school again because they missed that class. They missed ethics 101.

The Chairman: I'll ask Dr. Ebanks a similar question. But when this idea came up about providing internships in Cayman, I asked many of the similar questions that you are asking now, and they were just brushed aside, in that it is my understanding that the reason we need to provide internships was because, for instance, at University Hospital in Jamaica where we were sending people, the classes have grown so big that they could no longer adequately supervise during the internship the volume of people that they would have to if they put the whole class in. So, some of the other countries like Barbados and Bahamas who had bigger populations and bigger hospitals started to provide some of theirs.

It was my understanding (and again it could be a misunderstanding on my part but I will clear that up with Dr. Jefferson when he comes), that what we were attempting to provide was one year of residency but we were still going to require the three years of residency, but we would provide one year locally and then we were trying to get other institutions, that is, the Bahamas or Barbados or some other place to provide the other two years of residency. And then the person would get a provisional licence so that they could work under supervision of a monitoring physician for a year before they would get full registration to go out and be able to be a physician unsupervised in the community. It seems like there has been a breakdown in that somehow. I don't know what has happened.

Dr. Darley Solomon, President of the Cayman Islands Medical and Dental Society: I think it is probably like the NHPP, a lot of talk, good ideas, no action.

Show me one email where somebody reached out to some university or some medical training hospital to say, *Would you allow us to pay you US$40,000 a year to train our doctors?* Show me one email, please, and then I will rethink, other than from Dr. Jefferson because I do feel like he has been at least trying. But show me something from the Ministry to say, *You know what? We would like to train more Caymanian doctors. How can we facilitate that?*

The Chairman: Well, I think it has come home because my understanding is that even for the nursing programme that we put in at UCCI to train local nurses, because of the size of the population and because of the volume of paediatric patients that they treat, before they would be allowed to take the, I guess, it would be the Jamaica State Board exam, they have to go to the Bustamante Children's Hospital to get the necessary clinical experience before they can even qualify to take the exam. Now, if we can't provide it locally for nurses, how are we going to possibly provide it for doctors, which have to be at a higher level?

Dr. Darley Solomon, President of the Cayman Islands Medical and Dental Society: There's no way that a doctor can be adequately and appropriately trained for the gamut of his training, and remember, that is to get to even a GP [General Practice] level here in the Cayman Islands.

The Chairman: When I was involved in going to school in the medical fraternity, the standards expected from a general practitioner then, is entirely different today because of all the legal connotations and everything else. Even general practice now is being converted to family practice and there is a certain kind of board certification that is required.

Dr. Darley Solomon, President of the Cayman Islands Medical and Dental Society: Standards have consistently improved and that is why it was so frustrating to try to improve standards in Cayman and be met by a Ministry that arguably wanted to lower standards. They wanted to lower standards.

The Chairman: Still wanting to, sounds like to me.

Mr. Winston C. Connolly, Jr.: Dr. Solomon, we heard earlier that funding is always an issue and budget constraints, et cetera, et cetera. In your mind again and your opinion, just as a member of the Council, how would we fund our young Caymanian doctors in terms of the internships and the specialisations, et cetera? How could we do that in association with government but not necessarily as a scholarship? Are there other ways so that budget won't be the argument against doing something like? Because I think and I'm not sure on this, but part and parcel of the creation of the internship and all of those things have to do with the cost of getting someone to be at that stage. But, I mean, surely this must have come up before in terms of how do we ensure that we get the best doctors but we find a way to pay for it?

Dr. Darley Solomon, President of the Cayman Islands Medical and Dental Society: Just thinking on my fee. Maybe think about the work permits for all the doctors we have. I forgot the last count. I think it is 380-something doctors. I think perhaps maybe some

of this work permit that bring doctors to Cayman, a portion of that could be set aside to say, *This is what we are going to use to train so we can eliminate foreign doctors.* I don't have any prejudice against foreign doctors, but hell, do I want to see Caymanian doctors? Would I like it that Neely Panton, the Chief of General Surgery of Vancouver General was here in Cayman? Or Rusty [PHONETIC] Bodden who is up in, I think, New Hampshire? Or Kevin McGann [PHONETIC] who is up in Louisiana? I'd venture to say we would have a different medical community and a different health care system, you know. And that is not to be smart. Anybody who comes here looking for a better life, it is just to say that where have we been trying to take care of our own. Where?

The Chairman: You see—

Dr. Darley Solomon, President of the Cayman Islands Medical and Dental Society: I hold the Ministry accountable for that and that does reflect a lack of insight.

Mr. Winston C. Connolly, Jr.: Well, it goes back to that whole capacity building, the succession planning, the fact that Caymanians feel like they have to go abroad to basically excel in their chosen career. Those are issues now opening up a whole can of worms. But in terms of what you are saying, you know, again some sort of fund that is financed through work permit fees, et cetera, those are solutions that we can come up with that would take our people that much further. That would be nation building; that would be getting them to that, again, out of that argument about two-tiers of doctors.

Dr. Darley Solomon, President of the Cayman Islands Medical and Dental Society: How about Government talks to one of the banks, CNB, local bank. How about we say, *Look, why don't we set up a revolving fund or some type where you will loan these people money, we will stand as guarantees? They will have to have some type of security.* And then they come back and they either work it off at the Government Hospital or they pay it off back to the bank.

To me, those are things that the Ministry should be interested in trying to create and that is the reason that I guess I am pretty critical of the Ministry but I feel rightfully so. I've had the opportunity to observe them for some time now and I don't think we can afford to kick the can down the road. As a country or as the Ministry of Health, we need to realise that accountability is the key. So, no I would say, *Well, what have you done? Show me.* Okay, you held shift fees neutral for ten years and the cost of medicine, health care still went up. Well, uh!

Well, we didn't give the doctors more money, so did health care keep going up? It does not take a genius to figure that formula out. I don't even know whether somebody has thought about that. And sadly to say, that is my take on the state of the Ministry of Health in the Cayman Islands today. I think this report is an indictment. It is a wakeup call and we can be gentle about it or we can de definitive but something needs to be done, in my estimation.

Mr. Winston C. Connolly, Jr.: Thank you, Mr. Chairman. That's all.

The Chairman: Dr. Solomon, we want to thank you for your insight and we hope that we will be in a position to make a report that will represent many of your concerns and the representation that you have made, and will provide people like yourself with the opportunity to be a part of the solution and certainly remove the stumbling blocks or bricks that are put in your way which are causing the frustrations to surface, because they are painfully obvious. And it is clear also to the Committee that your intentions are worthy and good and we need . . . I personally want to encourage you to keep pushing the envelope. By somebody who started to push it in 1974 and has been pushing it ever since, it needs to be done. And the only comfort I can give you is that the frustrations are there but the satisfaction and the respect that you earn in the process makes it, when we get to the end, somewhat worthy of the battles that you have fought.

Dr. Darley Solomon, President of the Cayman Islands Medical and Dental Society: Well, somewhere along the line I heard somebody say that if you want change, the key is to agitate, agitate, and agitate. And this is my effort to recommend that we need change. This topic is too important; peoples' lives are at stake. I'm not talking about bureaucracy and going to work from 9 to 5; I am talking about people dying—health care. So, when we keep that in context maybe we do a better job. This is not about pushing papers. And if we are not careful the country will go bankrupt.

The Chairman: If it hasn't already done that.

Dr. Darley Solomon, President of the Cayman Islands Medical and Dental Society: So, I appreciate the time.

The Chairman: Thank you very much for your time sir.

[Short pause as witness leaves Chamber]

The Chairman: Serjeant-at-arms, could you bring in Dr. Ebanks please?

[Short pause while witness enters Chamber]

The Chairman: Dr. Ebanks, thank you for spearing us the time to come to give us some insight into these

two reports. I think this is your first time before the Public Accounts Committee or any committee of parliament.

Dr. Sidney Ebanks, Chairman of the Medical and Dental Council: That would be correct, Mr. Chairman.

The Chairman: I will then invite you if you want to give a little bit of your personal background so that all the members can understand. I happen to know you very well, but a lot of people do not know your experiences. And so, the general public can understand the framework from which you are making your suggestions and recommendations.

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: Okay. Thank you for the opportunity to make these statements.

I currently serve as the Chairman of the Mental and Dental Council (MDC). Like Dr. Solomon, I am native Caymanian. I was trained in Jamaica at the University of the West Indies. I spent a total of 13 years in Jamaica before returning home to take up active general practice at the Chrissie Tomlinson Memorial Hospital where I remain to this day.

I would just once more like to thank you for the opportunity to appear here and give a few points of view on these two reports.

The Chairman: We are looking mainly at Ensuring Quality Health Care and a Healthy Population, and one of the perturbing things to me is the lack thereof and the claim that is a lack of resources why we don't have better performances from the MDC and the health regulatory function in government. And I am wondering what your response to that would be.

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: I can only speak from the MDC's viewpoint, certainly not the Department of Health Regulatory Services which is the administrative support of the MDC.

The MDC, as you know, is appointed by the Cabinet of five members and two, ex-officio. We meet every month. We have a rather packed agenda and we dispense things on a fairly brisk manner. So, from that viewpoint I think we are being as efficient as we can possibly be.

We have encountered some difficulties on occasion, primarily when we are trying to get legal advice on proceeding with some matters. That was initially a bit of a hiccup and that seems to thankfully have been sorted out at this point in time and is operating smoothly.

The Chairman: Does the Ministry of Health seek out your advice, recommendations on legislative improvements, regulatory improvements, monitoring improvements that could be done?

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: We have actually volunteered for recommendations which have not appeared to have gained much traction, but, as to whether we were approached and had our opinion actively sought, the answer to that would be no.

The Chairman: Because one of the things that they talk about here is the lack of reporting from the Health Regulatory [Services] is the format that would give the Ministry some comfort in making policy decisions. But what you are suggesting is that even when you give the advice it is not readily accepted and acted on?

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: Well, I believe the statement dealt with reporting metrics coming from the Department of Health Regulatory Services. And that department has its own director with his own remit and responsibilities which he must discharge to the Ministry. I can only speak to the Medical and Dental Council, which we do our best to ensure that we discharge our remit effectively and in a timely manner.

The Chairman: Let's move to the legislative framework that currently exists. Have you been asked to identify areas of the regulatory legislative framework specifically to the MDC that needs to be reviewed and improved in order to continue to raise the standards under which we operate?

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: No, we were not asked, we volunteered certain recommendations but we were not asked.

The Chairman: The recommendations . . . well, that is disappointing to hear that you were not asked because I would think that part of the discourse in appointing you chairman would be the development of a formal or informal methodology of communicating the problems that you see in the current legislation, because no legislation is perfect and with the changing times and advances and particularly in medicine, there is a reason for these things to be under constant review.

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: Mm-hmm.

The Chairman: Do you have opportunity to sit with the chief officer to proffer the difficulties that you see in the current legislation that need to be changing?

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: In June 2016 the Medical and Dental Council was summoned to appear before senior government officials, the Premier, the Chief Officer, the Attorney General and representatives from the policy making units of the Ministry of Health and Crown

Counsels. It was at that point that all members of the Council had an opportunity to ventilate concerns that they had relative to the Health Practice Law and Regulations, the limitations that we encountered and the difficulties that it posed with us attempting to ensure that we were licensing and registering high quality practitioners as prescribed under the Schedule pertinent to the Medical and Dental Council. Outside of that, we have had no meetings.

The Chairman: So there is no regular discourse?

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: No, there is not.

The Chairman: I noticed you are very careful in that you said you were summoned. Can I ask, having been summoned to appear, has there been any positive changes that came out as a result of that ventilation as you described and discoursed?

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: Out of that discourse recommendations to elevate the guidelines to the level of regulation were once again broached. As a matter of fact, that was a sentinel event that led to that meeting because there seemed to have been a fire storm ignited at the thought of us having the audacity to have our guidelines elevated to the level of regulation. So, those meetings were conducted with that and we received legal counsel on that matter. Amended guidelines were submitted which we believe are comprehensive and we believe to some degree, helped to reduce the ambiguity in the regulations and in the statute, because therein lies the danger. And I have always maintained that one of the difficulties of having one piece of legislation to govern a multiplicity of professions requires that piece of legislation to be written in such a sufficiently ambiguous manner that leaves areas open to exploitation.

The Chairman: I brought a similar motion here which the Parliament (I would describe as) grudgingly accepted and reading the body language it was fairly clear that it was not going anywhere. I was accused of having people draft stuff for me and other similar comments were made. Those regulations that you recommended have they actually been put in place at this point?

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: They have been submitted to the Ministry and we await feedback.

The Chairman: How long?

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: I believe that was completed in October.

The Chairman: Do you have any concerns that persons outside of the MDC membership may have, for whatever purposes or reasons, access to the Ministry that you are not facilitated with to influence legislation and decision?

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: I have email proof of that.

The Chairman: Pardon?

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: I have email proof of that. It revolves around a particular applicant whose application to be registered as a specialist dermatologist was refused. The Council has, in recent times, received an email from an individual stating that they were able to obtain an audience with the Ministry of Health and the Office of the Governor and they felt that based on that interaction the Medical and Dental Council was wrong in its decision. So, it is quite clear that individuals do have access to discuss matters which ought to fall within the purview of the Medical and Dental Council; that much is clear.

The Chairman: Were you able to get the necessary legal support to prevent that or to override that inference?

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: The email itself was an attempt to lobby the Medical and Dental Council to change its viewpoint by invoking reference being made to meetings with the Ministry and the Governor's Office. We have not changed our viewpoint.

The Chairman: I thank you for that. But this raises a very important concern to me, and certainly, some of the things that are referred to in this report in that it is difficult for me to understand why the Governor would give audience to someone who has application before a statutory body that is charged to enforce the law in that situation. And then, the person . . . has the Governor been made aware that this person is using that audience with them to try to lobby for a change of view?

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: We have not communicated with the Governor's Office.

The Chairman: Are you familiar with the NHPP?

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: That would be the National Health Policy Plan, yes. I would not say I am intimately familiar with it but I am aware of what it is.

The Chairman: I did not see you as one of the persons who assisted with the drafting of it. But that was laid before parliament with great fanfare by the Minister. I have some concerns which I have expressed to the chief officer of the timing because it was laid at the last possible opportunity of that Minister's term, and that it was laid in March 2013 and the House was dissolved a few days later. And here we have now, come back full cycle, where the current Minister has been there for . . . and he is coming to the end of his [term] and we are talking about reviewing a plan that was not implemented. But one of the big things highlighted by the Minister at the time was to enhance human capital to ensure an available competent, responsive and productive health workforce to improve health outcomes.

Have you had the opportunity as Chairman of the MDC to interact with the Ministry of Health where you could make recommendations, or have you been asked for recommendations on how we should be properly training Caymanian doctors? We had evidence earlier from Dr. Solomon and he talked about maintaining the standards for Caymanian doctors so that they are at a level that would be respected anywhere in the world. Have you had any opportunity for that?

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: I did a public presentation on the standards required and those power point slides have been included in the minutes of the MDC meeting and forwarded to the Ministry.

The Chairman: Any response?

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: To date, no.

The Chairman: Okay.

Dr. Solomon gave us his US experience in how what they regard as proper training and the timelines involved. He talked about a undergraduate degree, four years of medical school, minimum of three years internships and if you go on to board specialisation it is looking at another three or four years. What has been your experience and what would be your kind of pathway to properly certifying and qualifying doctors to a level at which you would be comforted as an MDC of (shall I say) sending your wife to one of them as a physician or a child?

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: Those are very good questions, Mr. Chairman.

One of the things that happened in medical education which has been an explosion of technology is that there has been an increase in the responsibility and the public expectations of the profession. And long gone are the days of four years of medical school, one year of internship and you can be a general practitioner. Those days are done, never to return.

Most jurisdictions now require in addition to completion of basic medical training, a minimum of two to three years to become either a family or general practitioner or pursue general internal medicine.

Obviously, the surgical specialties are longer in duration, typically four and a half to six and a half years, depending on the field that you enter.

I say all of this to articulate that someone who is not prepared to spend at least 12 years in formal medical education, quite frankly, is unworthy of being deemed a physician. I make no apologies for that.

The Chairman: We have a number of Caymanian doctors. Some of them I think have been practicing as physicians for 10, 11 years, maybe longer, that want to specialise but they are not getting the opportunity or the encouragement from either the HSA that most of them are working for, or the Ministry. I wonder how we can find a way to marry that lack thereof with this proclaimed intention to enhance human capital.

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: I think the difficulty, Mr. Chairman, is "operation in silos". I believe that this is a tripartite effort involving Health, Finance and Education and everybody has to be on the same page. The young doctors at the HSA who are sort of caught in a no-man's land (if you will), we must invest in them. We have got a moral obligation to ensure that their careers are enhanced and that they can ultimately assume their rightful place in their society. There are opportunities for them to be trained but it has to be funded. They cannot self-fund, they cannot do it on their own and there has to be political will.

I will frequently say that the Cayman Islands proudly parades its gross domestic product (GDP) and yet our sister Caribbean nations, many of whom have a much less GDP than we do, invest far more heavily in the development of their medical workforce. I believe we have been far too apathetic about it for far too long.

The Chairman: What would be your suggestion to the Committee as some of the ways that we could provide this opportunity for these young Caymanians because we were told by Dr. Solomon that, in his view, it is not possible to properly train a doctor, even to general practice level, through internships in the Cayman Islands?

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: Exclusively in the Cayman Islands, no. I believe we do need to have some overseas exposure for the simple reason that we do not have an adequate case volume or a case mix on a consistent basis to

attain the required level of competence within the prescribed time period.

Now, as to how we actually do this, we may very well have to look at public/private partnership. We may have to be very cautious about how liberal we are with duty concessions, realising that that represents lifeblood of our finances and perhaps offset those duty concessions being sought against the cost of this training. But certainly, it is a priority and I think it can't be ignored for any longer.

The Chairman: And time wise we would be looking in most instances at a minimum of one year in an overseas facility or up to three or four years depending on some of the specialties?

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: Well, one year in an overseas facility at this point in time really would not qualify you to be very much more than a very junior level physician.

Ultimately, the goal is to develop our Caymanian doctors so that they can rightfully take their place amongst the ranks of the senior clinicians in their country. And that is where my vision is.

The Chairman: Mm-hmm. And you obviously, as Chairman of the MDC and based on your public and power point presentation which I was privileged to attend, having investigated these courses to some depth, should be in a position to comfortably advise the Ministry how best to go about achieving some of this if they would only but entertain you the opportunity?

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: I think that is a reasonably fair statement. The underlying tone running through all of these interactions with these agencies I have reached out to is that we will happily train your people but it has to be funded.

The Chairman: Mm-hmm. As you are aware, I have brought this same thing to parliament, and the standard response in the media is: *Why should Government have to help them?* But again, we have immigration restrictions and anybody who watches the television will know that that is a very topical thing today and for the last week. But because most Caymanians who want to get this board certification don't have the privilege of being able to move themselves or their families to these jurisdictions and work their way through (so to speak), we need to find a way to finance it, but not necessarily as a freebie. Dr. Solomon suggested a bank loan. He talked about a commercial bank. Government has the Caribbean Development Bank which in itself has a human resource and scholarship component. So, I would think that that would be one of the ways that the Government and the Ministry of Health should seek to help these people.

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: The key ingredient in all of this, Mr. Chairman, is political will.

The Chairman: Mm-hmm. Well, I will agree with that but I also believe that this one in this case, there is a substantial lack of administrative will as well; both at the Ministry level and the HSA level in terms of seeing the long term benefits and the sustainability of having Caymanians trained. I mean, I was flabbergasted last night when I was looking at the accounts for the HSA and they did not spend $123,000 that was in their education budget, which could probably have trained one if not two of those ten Caymanians into a board certification programme. But there seems to be no commitment to this.

On the other hand we find the situation where the HSA invests in apartments to house visiting locums as opposed to spending that $700,000 to $800,000 they spend on these kinds of fellowships and board certifications for Caymanians. How do you as a practicing physician and as Chairman of the MDC feel about those kinds of situations?

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: Well, first of all, what I am advocating is not a short-term solution. And the difficulty that I perceive is that many things unfortunately are managed by knee-jerk. It is quite difficult to resolve but again it does require commitment to this. It is a long term thing, it will not happen overnight. We cannot get people board certified or the equivalent thereof in one year or two years, we are talking at least a three to five year period. Plans have to be laid for it, but at the same time we have got to balance the necessities of the service in the present.

The Chairman: Do you believe that there needs to be a shift in the way we grant scholarships for the medical field, in that it should not be a scholarship to just the university academic qualifications but a commitment of a scholarship of a Caymanian to do medicine should be much longer?

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: I believe it should. I believe there should be commitment from first day of medical school to exit qualification at board certification level when that doctor is able to take up appointment as a consultant; absolutely!

Mr. Winston C. Connolly, Jr.: Good afternoon Dr. Ebanks.

I would like to just ask a similar question that I asked Dr. Solomon. If you had the ability to do so, what would you prescribe as the ideal kind of entry to exit? And this is more so for the listening public. What, in your opinion, would be the appropriate training and programming to get someone from day one to exit and

be able to practice anywhere in the world as a competent doctor?

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: Through you, Mr. Chairman, I believe the question can be distilled down to: What is the modern day standard? As you know, we look at seven different jurisdictions to derive guidance on registration but in all of those jurisdictions the training has evolved. Much of our legislation is rooted in what occurred in the UK and the UK has undergone a rapid change in how they train their physicians. So, let's start there.

To become a general practitioner in the United Kingdom now, this modern day age, 2017, you are looking at medical school of five and a half years minimum in the UK. You then go through what is known as two years of foundation training; foundation year one and year two which some of the jurisdictions refer to as internship. It used to be known as a Pre-Registration House Officer Year (PRHO) and a Senior House Officer (SHO) year. Those terms have now been consigned to the dust bin of antiquity. And one now attains full registration in the United Kingdom after completing foundation year one. Now, that is an important point to note, that full registration in that context does not mean completion of training. It means that you have completed foundation year one of your very basic post academic training.

Beyond foundation years one and two, you then enter what is known as your core medical training which would run for another three years minimum and that is under the purview of the Royal College of General Practitioners. Having successfully completed that, you would then be awarded what is called a CCT or a Certificate of Completion of Training. It is then and only then that you may practice autonomously without the clinical oversight in the UK context.

Now, a similar thing pertains now in Jamaica where although it is not enforced as aggressively as in the United Kingdom, Jamaica now requires you in most instances, to complete at least two years of post-academic training before being allowed into independent clinical practice. The Bahamas requires three, Barbados requires three and Trinidad and Tobago requires three.

The Chairman: And in other words, the full registration simply allows you to be trained as a doctor?

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: Correct.

The Chairman: I guess, for insurance purposes and other clinical management purposes.

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: Correct.

Unfortunately, full registration is mistakenly construed as complete training within the context of our legislation which is not necessarily the case. Particularly when you are looking at sort of using other jurisdictions as a surrogate, you have to ensure that your terminology is aligned with what is used in those jurisdictions.

Mr. Winston C. Connolly, Jr.: Through you, Mr. Chairman, in terms of the legislation, if we are going to be put on par with jurisdictions like the UK which was the original genesis legislation and like you have said, they have progressed substantially since that, can you tell us whether or not you are aware that any legislation changes are forthcoming in this regard? And if so, is it intended to be in line with these international world standards? Or—

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: I am not aware of any impending change.

The Chairman: Do you believe that we need to make the necessary changes to bring us in line with that and to clear up some of these anomalies and the broad vagrancies that exist in the current legislation under which we licence physicians?

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: I believe so, yes, Mr. Chairman. I think that legislation must be sufficiently robust in order to withstand some of the attempted incursions that have occurred to date.

The Chairman: Give the Committee some insight into how the MDC handles this institutional registration from a practical standpoint because I want to ask some other questions about that.

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: The institutional registration, as was alluded to earlier, is registration granted to practitioners whose place of practice is restricted to one particular facility as is designated by Cabinet.

The Medical and Dental Council has received a gazetted order which tells us what qualifications we should use in order to satisfy ourselves as to educational attainment. And basically, that criteria, is someone who has graduated from a medical school listed in the Avicenna Directory or someone who in the opinion of the Council has attained a qualification to the standard of the Caribbean Association of Medical Councils (CAMC). Now, I would cautiously submit that both of those criterions speak only to basic medical training. Those two criterions cannot be extended to ratify specialist qualification. And it is for that reason why the Medical and Dental Council institutional registration lists those persons who are registered as doctors, as medical doctors only.

I note in the Auditor General's Report, a reference was made to the fact that no specialty was listed and the simple reason is that there is no tool given.

The Chairman: But is not that rather oxymoronic in that the whole institution as a tertiary level institution should in fact be employing only specialists at that level?

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: Well, at a tertiary level institution yes, there will have to be a preponderance of specialists but there will have to be support staff of junior practitioners who have not yet achieved that level of specialisation. However, there should be a mechanism to recognise those who have attained their specialisms even though it is not in one of the seven jurisdictions, but regrettably there is not, it speaks to one standard; that of having graduated from a medical school. Clearly, a senior consultant would have graduated from a medical school but so would have an intern.

The Chairman: What problems, if any, and conflicts do you see down the road from this whole idea of entertaining institutional registrations which by virtue of fact could not make it to our general list of registration that Caymanians have to aspire to?

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: I have always maintained that having more than one standard is not only going to be difficult to police but there will be unintended consequences that arise from that.

I have made written representation to that when I was president of the Cayman Islands Medical and Dental Society, that I recommended that there ought to be one standard for all health care facilities on the Island. I still maintain that point of view and this is not in any way any indictment on any facility; good medicine is good medicine but one standard should pertain for all.

The Chairman: Do you believe that there are sufficient mechanisms in place to monitor these institutions to ensure it is good medicine being provided?

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: I believe the remit of the Health Practice Commission needs to be extended. There are certain metrics that should be monitored on all health care facilities that is currently not being done. And perhaps from that viewpoint one could argue, *Well, there is insufficient resource.* But in order to maintain the integrity of the system, there has got to be that monitoring of important things such as length of stays, infection rate, mortality, physician quality reporting, disciplinary actions; these are the sorts of things that ought to be in the public domain to enable informed decision-making.

The Chairman: I agree.

Do you have any other questions?

Mr. Winston C. Connolly, Jr.: Mr. Chairman, through you again and going back to the one standard.

In terms of being able to access the institutions that can provide additional training and exposure, internships et cetera, I think Dr. Solomon or someone said that we have Caymanians abroad in institutions that are willing and able to assist in this. Again, is it the political will or some other shortcoming that stops the nexus to Cayman from facilitating this type of environment that you are advocating for?

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: Through you, Mr. Chairman.

I wish I knew the answer to that, Mr. Connolly. We do have great resources overseas. I mean, Dr. Neely Panton is a highly respected colleague who comes to mind immediately who I am confident would be a very, very valuable resource that we could draw upon. And I really do feel that there should be a redoubling of efforts to reach out to people of his ilk abroad in order to assist us.

Mr. Winston C. Connolly, Jr.: One final question from me, Mr. Chairman. And this is a question, I guess, on behalf of the Caymanian public. Should we be afraid to walk into some institutions or some medical practices in Cayman, not knowing what the standard is and if there is at least a minimum acceptable standard that is internationally recognised in the Cayman Islands? Meaning: Do we have to do extra homework, do our own due diligence and all of those sorts of stuff that we have the Medical and Dental Council that is supposedly there, the Ministry, the HSA, all the bodies that are supposed to be doing the vetting, the standardisation, et cetera, should we be afraid?

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: It would be very easy for me to tell you rest well but I do see loopholes that can be exploited, and that is my bone of contention unless those are closed. Be very careful.

The Chairman: Given the current makeup of the health systems and the private sector, are we approaching a danger position of over-subscription or over-supply of certain specialties which could lead to economic decisions which may lower the quality of the health care that we as Caymanians receive?

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: That is a very interesting question.

I have had sight of a 2005 document, the minutes of the then Health Practitioners Board which looked at certain categories of practitioner and recommended growth in some areas and restrictions in others. I don't believe those recommendations have been carried out for the simple reason that when one looks at the statue there is absolutely no provision to

be made to consider the number of practitioners in the field at the time.

Is there a danger of over-subscription? Absolutely! Will that lead to overutilisation? Absolutely!

The interesting paradox is that in health care the more persons we have practicing one particular area does not necessarily translate to cheaper care. In an environment of compulsory medical malpractice insurance, the more practitioners that you have discharging a particular line of clinical duty, the more is the risk of adverse events. Cayman cannot afford a medical malpractice crisis.

The Chairman: And therefore an increase in even the fees that you pay medical malpractice keeps the prices high.

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: Precisely!

The Chairman: It is not a situation where additional competition is likely to lower cost.

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: No, it tends to drive it up.

The Chairman: Are you concerned that when that particular situation approaches, one of the easier parts to exploit is over-prescription of medications particularly if you happen to be a beneficial owner of a pharmacy?

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: It could take many forms. It could be over-prescription of medications; it could be unnecessary procedures; unnecessary admissions; many of these things could occur.

The Chairman: As I understand it, your MDC registration criteria allow you for the institutional licences which are identified to a particular facility. And am I correct in saying that there is only—

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: There's only one—

The Chairman: One. There are other institutions which have received the Cabinet designation of medical tourism but have not yet utilised that ability to have institutional licence?

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: That is correct.

The Chairman: And then you have your list of practitioners and categories of physicians who are licenced and are practicing in Cayman. You have physicians who are licenced and practice occasionally in Cayman. You have physicians who are licenced who do not practice in Cayman at all.

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: Okay. So the registration categories are the institutional list which we spoke to, the provisional list and the principal list. And there are those practitioners who have retained their registration but have voluntarily relinquished their licence to practice. In the Cayman Islands, really the only difference between being registered and registered with a licence to practice is proof that you have medical mal-practice insurance.

For example, the UK criterion is much more stringent with revalidation criteria and so forth via the General Medical Council but that is another issue for another day.

Those on the provisional list may discharge a wide range of medical functions but they operate in environments where they are under supervision and they cannot practice independently, and that is to allow them the opportunity to gain the necessary experience to gradually migrate into that role of being autonomous clinicians.

The Chairman: But is your principal list or both of those lists broken down as to people who are practicing and are people who practice occasionally like visiting specialists?

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: All of the visiting specialists are on the principal list because they are all fully trained board certified level practitioners.

The Chairman: And do you have any people on the principal list who do not practice in Cayman at all but have applied and been granted licensure?

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: I would have to defer to the department and check those. But I can provide you with an undertaking to get that to you in writing.

The Chairman: What mechanism, if any, is at your disposal or you would like to have at your disposal which would allow you to make room for Caymanians coming back fully qualified in an environment that many of us think today is reaching to over-subscription level?

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: There would have to be an amendment to the statute on the section in the registration that takes into account the number of Caymanian practitioners who are already in that field, in the absence of any instruments such as, that the Medical and Dental Council has no power to do so.

The Chairman: Because when we look at the number of some of these specialists that practice here, if it is population it is alarming.

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: I've had a young Caymanian dental student approach me and say to me: *What am I going to do? When I finish and come home there will be nothing for me. What am I going to do?*

The Chairman: Do you have any concerns or what would be your take on this, which I believe is part of the current practice—but I am not licenced anymore so I don't really pay the kind of attention that I would have—where you have people who are sponsored by people who are not qualified by registration, qualified by specialty to perform any kind of supervisory role, yet they are purporting to you and to the (I would assume) Trade and Business Licensing Board, that this person is working under their supervision?

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: Yep. So, what you are speaking to falls under regulations 4 of the Health Practice Regulations which speaks to non-Caymanian practitioners replete of a Caymanian practitioner on the principal list of one of the councils.

I have often questioned what the function of that is. If there is not to be some degree of clinical governance, why is it there? For example, (no disrespect to any profession), a physical therapist cannot be reasonably expected to discharge adequate clinical governance over a neurosurgeon.

The Chairman: And I guess the lack of opportunity for you as Chairman of the MDC to have a regular conversation with the Chief Officer of the Ministry of Health does not give you an opportunity to voice these concerns which I believe need to be corrected.

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: As I said before, we have sent several written submissions on recommendations for changes. It would appear that the wheels turn slowly.

The Chairman: Would it be . . . well, it won't be.

Can you provide this Committee with copies date stamped when these recommendations were made and what, if any, responses you have gotten?

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: I can certainly do that.

The Chairman: Because I think somehow we need to be able to assert that there needs to be some action. I would be less (comforted is not the right word) . . . but if you made a submission and you got a response, *Look, we don't agree with you. These are the reasons why we don't agree with this,* even if I believe you made the right recommendations and you have gotten the wrong response, I would have some comfort that there is some functionality of governance and regulatory respect at the Ministry level. But for you to suggest to us that you have made a number of recommendations and . . . How long have you been Chairman of the MDC this time around?

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: I was appointed Chairman of the MDC in September 2015.

The Chairman: And none of these have come to fruition?

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: If I may offer up, I have a number of documents here which I would like to tender.

[Documents presented to the Chairman of the PAC]

The Chairman: I as the Chairman and because of my background am astounded to hear this. And certainly this kind of information, I believe, can assist us in making a strong case that this line of communication must be open and that the line of communication must be a two-way street and it must contain the kind of matrix and evaluation of your suggestions and evaluation of your performance.

You've been there over a year, has anybody said to you, *We like what you are doing. We don't like what you are doing?*

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: I've gotten intimations of the latter, not the former.

The Chairman: Don't like what you are doing. Okay. I can understand why they would do that, given this. Right?

We talk about the political will which is needed to do some of this. Of course, I have a little different take on some of this because it is easy to blame the transient politician, but I have had the Deputy Governor confirm that it is the sole responsibility of himself and the Civil Service Administration to implement laws that this Legislative Assembly pass, and also, to make recommendations, where necessary, to the political entity to make the changes that are needed to improve the situation and it is troubling to hear that that is not happening in something as important as the regulatory and the licensure of physicians in this country. But I thank you for this information.

Let me solicit a real bold response for you. Has there been any attempt to curtail or to chastise the decisions of the MDC in its interpretation of the Law by the administrative arm or the political arm?

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: Let me think carefully about that.

The Chairman: The reason I say that is because you used the term earlier that you were summoned. And I also noticed that you didn't say that you as chairman were summoned. You said the whole committee was summoned—

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: The entire Council was summoned.

The Chairman: —which from my point of view is wrong because I think what is being looked for there is so dissent.

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: Mm-hmm.

The Chairman: And to plant the seed of dissent which, in my view, would seriously disrupt the functionality of the committee. I think that if they feel you are smart enough to be chairman, they should have the discussions with you and have you translate that to your other board members. So, that is why I am asking the question based on that. And you don't need to be specific by name or anything. But it is needling at the back of my mind and I am one of those people that, you know, when my conscience bother me I just ask.

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: I feel there has been influenced exerted on the Medical and Dental Council which has been resisted. But there have been overtures made. For instance, I have been called and asked, *Well, why did you make this decision?* And I told the person, *If you keep talking you will hear your name on the 6 pm news when I file my report with the Anti-corruption Commission.* But yes, there have been attempts.

The Chairman: Good for you.

Any other questions from you.

Mr. Winston C. Connolly, Jr.: Mr. Chairman, I just want to echo that alarm that you raised in that again we have a board made up of practitioners and other people who are making recommendations to non-practitioners—people who are not in the trenches; people who are not kept up to date in practice with all of the technology and the advancements and the kinds of standards that are being set in first world countries and yet we are ignoring them not responding to them, not advancing the legislation. So, basically the function is a check-a-box function based on putting in place or administering the areas of the law that relate to that council but there is no reciprocation in terms of here is what trends we are seeing, here is how we can improve, et cetera. Is that a fair summary or—

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: Through you, Mr. Chairman, I think that would be a fair summary.

Mr. Winston C. Connolly, Jr.: Which again, Mr. Chairman, and through you, I think it is incumbent on this Committee to memorialise the evidence that we have gotten today and to ask for some response formally to these recommendations and observations, because I don't need to see that everything is being accepted but I need to see that the board for a specific purpose is actually getting heard and there is a least, *I don't agree with you* response. Because if not and we are sitting in these silos and we are not taking advantage of the expertise and the guidance that we have, then, why even have a board? Why not have an administrator in the Ministry check-a-box and do it? We have to have these functions working as they are intended. We have to take this report and put in the checks and balances, the communication, you know, the follow-up, all the things because if not we are going to have a substandard system and the only people who are calling it first world are us.

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: Through you, Mr. Chairman. I would like to thank you for that submission, Mr. Connolly. These documents, as far as I am concerned, are a good hard slap that we needed.

The Chairman: Well, we will try to . . . I agree with you that some of the concerns, particularly coming from yourself and Dr. Solomon this afternoon are troubling given the answers that we got from the Chief Officer this morning. I want to thank you and Dr. Solomon for being forthright in your answers to questions and your expressions of concern. I believe they are well-founded. I believe that your interest is in the interest of Cayman and the standards of health care in the country and I lament the fact that neither of you seem to be appreciated for the value you could add to these kinds of discussions. And I would just implore you to continue the fight. I can tell you that it is often frustrating, it's unrewarding but every now and again you will get a little victory and what I try to do is to file those victories in the back of my mind when I am fighting the other battles and I get to that point of frustration I go home and lay in my hammock and replay that tape of the victories that I had. It sounds like a silly technique but it works for me.

I am well aware of yourself and Dr. Solomon's attempted and strong interventions that you have put forward which have been ignored. And I hope that, as you say, this report, that this Committee can find a way to extract from the Ministry and the political arm

the response that we need in order to move the quality of health care forward.

Having said that, one of the things in the report is the absence of metrics and Dr. Solomon alluded to it; things like medical audit, pay review . . . medicine is not . . . although the difference is you are dealing with peoples' lives and not numbers on a piece of paper to be audited, but certainly I think it is patently obvious that we need to put these kinds of measurements in place—

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: Absolutely.

The Chairman: —so that we can be comfortable that the . . . and I don't think the answer to it is to say that I am certified by the GACHA. I don't think that that is the answer. That seems to be the accepted norm and if we have that we can ignore it.

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: What you are speaking of there, Mr. Chairman, is ongoing metrics and reporting and any credible health system would have that in place.

The Chairman: Thank you for your time sir.

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: Thank you very much.

The Chairman: We enjoyed your witnessing and thank you for your time.

Dr. Sidney Ebanks, Chairman, Medical and Dental Council: Thank you very much.

The Chairman: Just a few matters of house cleaning and to bring you up to date. It looks like we won't have any witnesses tomorrow morning because the persons whom we invited cannot make it and Mr. Donald McLean is travelling on behalf of the Olympic Committee and asked me if he could give a written submission and I told him yes that would be fine, I just would not be able to ask him the supplementary questions but at least we will get something from him.

The other person and since we now know that I will have a quorum for next week Thursday and unfortunately, Mr. Ruben, we will miss your presence and your wisdom, but we will only have two persons so that will just be a morning session for next week Thursday.

So, tomorrow the Committee will actually start its hearing at 1 o'clock instead of 9 o'clock. And then on Friday we will go back to the full day.

Thank you all.

The Committee is adjourned at 3:45 pm.

At 3:45 pm the Public Accounts Committee stood adjourned until Thursday, 2 February 2017.

Legislative Assembly of the Cayman Islands

THE STANDING PUBLIC ACCOUNTS COMMITTEE

MINUTES

Meeting held *with Witnesses*

Thursday, 2nd February 2017

1:00pm

Minutes and verbatim transcript of the meeting of the Standing Public Accounts Committee held in the Chamber of the Legislative Assembly Building, Grand Cayman on Thursday, 2nd February 2017 at 1:00pm.

Present:

- Mr. D Ezzard Miller, MLA – Chairman.
- Mr. Winston Connolly, MLA – Member.
- Mr. Joseph Hew, MLA – Member.
- Ms. Manesa Webb – Acting Clerk of the Public Accounts Committee.

Apology:

- Mr. Roy McTaggart, JP, MLA – Deputy Chairman.
- Capt. Eugene Ebanks, JP, MLA – Member.

Attendees:

- Ms Sue Winspear, Auditor General – Office of the Auditor General.
- Mr Ruben Martin, Director of Performance Auditing – Office of the Auditor General.
- Ms Angela Cullen, Acting Director of Performance Audit – Office of the Auditor General.
- Hon Kenneth Jefferson, Financial Secretary/Chief Officer – Ministry of Finance and Economic Development.
- Mr Matthew Tibbetts, Accountant General – Ministry of Finance and Economic Development.

1. Reference

In accordance with sections 73(1) and 77(4) of the Legislative Assembly Standing Orders (2006) Revision, witnesses were invited to appear before the Committee to discuss various issues set out in the following Reports of the Auditor General:

a) *Cayman Islands Health Care System – January 2017*
b) *Ensuring Quality in Health Care & Health Population – January 2017*

2. Meeting to Order

There being a quorum present, the Chairman called the meeting to order at 1:05pm.

3. Welcome

The Chairman gave a brief welcome to the Members of the Public Accounts Committee and the staff of the Office of the Auditor General and the Ministry of Finance and Economic Development.

PAC Member, Mr Roy McTaggart, was not in attendance. Excuse accepted and approved from 01-Feb-2017 upheld. (Acting Minister of Home Affairs & Culture until the 16 February 2017)

PAC Member, Capt. Eugene Ebanks, was not in attendance. No excuse given.

The Chairman acknowledged these absences.

4. Report of the Auditor General: –

Cayman Islands Health Care System – January 2017

The Auditor General made an opening statement on the above mentioned Report and the Hearing(s) commenced at 1:10pm. The Chairman then invited witnesses to the Chamber and asked them to state their names, the persons attending with them if any and department or organization they were representing. The Chairman then opened the floor for statements from the witnesses followed by questions from the Members of the Public Accounts Committee.

The following persons appeared in their named capacity as witness before the Committee for this Report:

- *Mr. Lonny Tibbetts- Chief Executive Officer, CINICO Management*
- *Mr. Frank Gallippi – Chief Financial Officer, CINICO Management*

At the conclusion of the Hearing, the Chairman thanked the Members of the Committee and the staff of the Office of the Auditor General, Treasury Department and the Ministry of Finance for attending. The Hearing(s) for this Report was suspended at 2:55pm.

5. Report of the Auditor General: –

Cayman Islands Health Care System & Ensuring Quality in Health Care – January 2017

The Acting Auditor General made an opening statement on the above mentioned Report and the Hearing(s) commenced at 3:10pm. The Chairman then invited witnesses to the Chamber and asked them to state their names, the persons attending with them if any and department or organization they were representing. The Chairman then opened the floor for statements from the witnesses followed by questions from the Members of the Public Accounts Committee.

The following persons listed below appeared in their named capacity as witnesses before the Committee for the Reports:

- *Ms. Lizzettee Yearwood- Chief Executive Officer, Health Services Authority*
- *Dr. Delroy Jefferson – Chief Medical Officer, Health Services Authority*

At the conclusion of the Hearing, the Chairman thanked the Members of the Committee and the staff of the Office of the Auditor General, Treasury Department and the Ministry of Finance for attending. The Hearing(s) for this Report was suspended at 4:43pm.

6. Any Other Business

There was no other business.

7. Adjournment

There being no other business the meeting was adjourned by the Chairman at 4:46pm.

OFFICIAL VERBATIM TRANSCRIPT
STANDING PUBLIC ACCOUNTS COMMITTEE
THURSDAY
2 FEBRUARY 2017
1:13 PM

"CAYMAN ISLANDS HEALTH CARE SYSTEM"
"QUALITY HEALTH CARE AND A HEALTHY POPULATION"

Verbatim transcript of the Standing Public Accounts Committee meeting held 2 February 2017, at 1:13 pm, in the Chamber of the Legislative Assembly Building, George Town, Grand Cayman.

Present: Mr. D. Ezzard Miller, MLA, Chairman
Mr. Winston C. Connolly, Jr., MLA, Member
Mr. Joseph X. Hew, MLA, Member

Absent: Mr. Roy M. McTaggart, MLA, Member
Capt. A. Eugene Ebanks, MLA, Member

In attendance: Mr. Kenneth Jefferson, Financial Secretary, Ministry of Finance
Mr. Matthew Tibbetts, Accountant General, Ministry of Finance

Audit Office: Ms. Sue Winspear, Auditor General
Mr. Martin Ruben, Director of Performance Audit
Ms. Angela Cullen, Acting Director of Performance Audit

Witnesses: Mr. Lonny Tibbetts, Chief Executive Officer, CINICO
Mr. Frank Gallippi, Chief Financial Officer, CINICO
Ms. Lizzette Yearwood, Chief Executive Officer, Health Services Authority
Dr. Delroy Jefferson, Medical Director, Health Services Authority

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The Chairman: Let the record show that we have a quorum present. I call the meeting to order at 1:05 pm. Again let me thank you all for coming.

This afternoon we have Mr. Lonny Tibbets and Mr. Frank Gallippi from CINICO, and we're dealing with "Ensuring Quality Health Care and a Healthy Population".

I guess the first question I would ask, Mr. Tibbetts is: Are you familiar with the NHPP, National Health Policy Strategic Plan?

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Good Afternoon.

Yes sir, familiar with . . . I think we were a part of the original group that put it together and assembled it with PAHO [Pan American Health Organization] representatives for the Ministry of Health a few years ago sir.

The Chairman: Okay. Because in the statement made by the Minister when it was tabled on the 13th of March 2013, he gave the strategic directions as follows. 1) Strengthen institutional capacity for leadership and governance. 2) Implement an equitable and sustainable health financing model. Now, I would suggest that you should be, and I hope you were, and I hope you are, and I hope you will be, intimately involved in that second strategy to implement an equitable and sustainable health financing model.

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Yes, Mr. Chairman. As you can appreciate, CINCO is currently the under the Ministry of Finance. CINICO's main role is to provide health insurance coverage primarily for the civil servants and the civil servant pensioners, the seafarers and veterans, the indigent. We also manage the indigent population for and on behalf of the Government. We also provide access to health care for individuals without health insurance coverage by who obtains a loan from the Ministry of Finance in a form of a medical loan, and we also, as per our licensing requirements, provide a plan to any individual in the public as well as small groups for the Standard Health Insurance Contract (SHIC).

The Chairman: And are you the secretary to the CINICO Board?

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: No sir. We have an individual secretary that per-

forms the minutes, but both the CFO and I are members of the board which are none voting roles.

The Chairman): Oh okay. Because how has the board . . . well, let me back up. What is the method of communication between CINICO Board and Ministry of Health, if there is any?

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Currently, under the Ministry of Finance we have a representative from the Ministry of Finance on our board. Previously, CINICO was under the Ministry of Health and the chief officer was present on the board during . . . was a member of the CINICO board during that period. Subsequently, when the new administration took over there was a change in the governance of CINCO, now moved from under the Ministry of Health to the Ministry of Finance and they maintain the same monitoring mechanism whereby a representative from the Ministry of Finance is on the board as a representative of the Ministry of Finance. There is presently no direct reporting relationship between CINICO and the Ministry of Health, however, we do suspect and being prudent in a number of our policies and functions, we do know that the representative of the Ministry of Finance does communicate with the Ministry of Health's Chief Officer.

The Chairman: Is the board guided in any of its policy decisions by the requirements of the NHPP to have a sustainable financial model for health care?

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Yes Sir. We, the management as well as board members and the chairman of the board also attended a health care cost review committee. I think it was originally chaired by the Ministry of Finance. A number of other stakeholders including the HSA as well as the Ministry of Health were the key stakeholders in those discussions and the formulation of those plans. And a number of those initiatives have been undertaken and also intergraded into CINICO's strategic plan, which I think we completed in 2004, through 2013. Actually, it was 2008 through 2013 (my apologies). And a number of these cost savings initiatives are in line with the NEPP, I believe, it is (my apologies not knowing the acronym), but are succinct with those same strategies but specific to CINCO based operations.

The Chairman: What mechanism or metrics do CINICO board and/or management have that they can demonstrate to the HSA that the clients of the HSA are getting the outcomes for which the Government is purchasing through output?

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Yes Sir.

CINICO currently utilises a medical case management unit; this has been part of our strategic plan and part of our health cost review strategy. These services were previously provided by the Mayo Clinic and Mayo Health Solutions Unit of the Mayo Clinic. We've now brought those services in-house.

Part of the gamut of services and programs that are offered to manage the health care of our members are we do utilise Apollo guidelines as well as Milliman [Care] Guidelines for the management and monitoring of inpatient stay, chronic diseases, and as the unit has just started, the unit is probably about 6 months old now, and we are starting to collect the correct data to see readmission rates, emergency visits and monitor the accuracy of care. In the next few months we will be implementing mandatory inpatient stay management at the HSA. Currently, we do perform those services but primarily on tertiary care at Health City and our overseas care in Jamaica or the USA.

The Chairman: Is your board involved in discussions on a regular basis as to the global effects or of the health insurance industry in the Island and whether the legislation supports that, does, in fact, meet the outcome that is intended to meet, that is, that people will have adequate insurance?

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Presently, from a local perspective, myself was a member of the Health Insurance Commission whereby we sat with the Commission and examined different scenario's and recognised essentially where the rubber met the road from both an insurance perspective as well as our members. I am currently not the representative on that. I do not work with that board as before, but during that time management had a good perspective on other key players in the industry and some of the issues that we were all, you know, collaboratively involved with.

The board also works with a number of our overseas providers, for example, United Health Care. We attended last year when they had an annual conference in California; myself, the CFO and our chairman attended the conference and recognised a lot of the global trends, a lot of the issues that we ourselves were experiencing and seeing that whilst it was of a larger magnitude on a US base market, it was very much a similar effect on a cost of our premiums, the cost of our health care and growing trends in care from the perspective of defensive medicines, new technologies, et cetera. These were factors that were driving up our cost. But it certainly gave us a perspective on what variables we could control within our gamut of services that we provide and what we could put into effect in reducing or maintaining or managing the health care cost. However, there are a significant number of other policies that are certainly outside of CINICO's remit that we would not be able to make that significant change to. But the overall cost of health care, the drivers behind that is what we looked

at managing and mitigating the cost to us and implementing the medical case management unit which monitors the accuracy of care, the collaboration of care. We have reduced overseas stay, and a number of strategies that we deploy essentially to maintain ourselves as best as we can within the cost that we the remit and the cost that we have been expected to produce.

The Chairman: I'll accept that you're doing all those things, but what I'm trying to get at is whether CINICO and the board see itself as a simple insurance provider through the Ministry of Finance or whether it believes it has any obligation or component to be involved in assisting the Government in ensuring quality health care and a healthy population in terms of the regulatory agencies and the legislation that is currently in place or needs to be put in place to assist with the Government being able to definitively assure the population that these things are being put in place.

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Yes sir, we have a very good working relationship with the Health Insurance Commissioner. There is a number of . . . which are both of the laws that he govern. There are number of communications that we made to them and we have a very, kind of, a case base communication protocol, something we identify an issue and we will certainly make our suggestions or provide feedback to Mr. Connolly and his staff. From the governing perspective we also recognize there are number of times when they are members who experience different issues that aren't really within the gamut of the law or outside or our policy needs, that we certainly will work with other government agencies to assist to make sure that the member gets the proper care and treatment.

So, we may not be to a certain extent . . . I don't know if one exist, maybe a special board or special committee, that maintains what I would consider a regularise meeting or a routine basic structure, however, we also communicate very well when an issue arises.

In addition, the role that CINCO plays on behalf of the Government, we've continued to perform very well for them. We have now five and half years with the same premium rate and that is, you know, we boast that because we think that we've done a very good job in reducing our cost, obtaining the best discounts and getting the cost care timely, mitigating levels or revisits, readmissions, et cetera, in both overseas and tertiary care and basically in a very cost-sensitive environment and very expensive undertaken sometimes. CINICO has done a very good job in tightening those valves (so to speak) that we have maintained our premium for the last five and a half years.

The Chairman: We were told yesterday by the chief officer that the Health Insurance Law has been reviewed regularly. Were you consulted on changes that were contemplated for that law, and asked for input?

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Not directly but I do suspect, Mr. Chairman, that the actual, some of our feedback that we've given to Mr. Connolly over the last two years or since that law was put in, he has possibly submitted to the Ministry of Health has part of his amendments. In conversations with him he has recognised these and said yes, that they are going to look at some of these and try to get them implemented.

The Chairman: At an earlier meeting of this Committee you tabled a report—"National Strategy to Manage High Risk Uninsurable and Medically Indigent Persons". Was this generated as a result of the strategies and policies of the NHPP or was this an own-initiative on CINICO's part?

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: It came out of the Health Care Cost Review Committee, sir.

The Chairman: Okay.

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: One of the features that the committee recognised was that currently there was almost a default mechanism for uninsured persons or underinsured persons to move directly to the indigent fund, and one of the things that the committee recognised was that there should be other opportunities or other mitigating circumstances before someone can be deemed indigent. We felt that it was somewhat a very liberal policy at the time and what was asked of CINICO is what we saw was the best methodology that persons could be vetted prior to this and alternatives to basically presenting straight on to the indigent fund.

The Chairman: At what stage is the implementation of this proposal?

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Yes sir, we presented to the Ministry of Finance and, at that time the budget had been passed and subsequently we understood that there was no funding for it set aside for some of those initiatives that were in there. So, currently, it is something to be considered. It was one of the suggestions that we made, however, none of it has been implemented.

The Chairman: So, are you and the CINICO board aware of the Ministry from a policy position and a legislative position making any changes to things like pre-existing conditions, the caps that are artificially placed on the insurance supposedly with the intention

and intent to reduce premium which never happens? And I don't know if you can answer this, but are you aware of any kind of association or any kind of meeting between the health insurance providers and the Ministry, in terms of looking at some of the things that the private insurers are allowed to do that fall in your lap and, I would suggest, that makes your job a little easier to do?

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: At the moment I am not aware of any actual meeting. We have made representation to the Ministry of Finance and also to the Health Insurance Commissioner whereby we have identified some scenarios where we felt that the playing field was not actually levelled (so to speak).

CINICO still retains its reputation as the insurer of last resort (so to speak). And we continue to get what I would consider a somewhat skewed demographic group of individuals that are either high risk or essentially uninsurable. So, it puts our capital and our assets at risk when we take on some of these individuals, somewhat unfairly as opposed to some of the other insurance companies that exist out there.

The Chairman: Have you or the board made any representation to either the Ministry of Health or the Ministry of Finance that that particular area needs to be looked at in terms of what the private health care insurance [companies] are allowed to do to try and balance the equation a little better?

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Yes sir, we have and we have had good feedback with regards to their looking at changing some components of the law. However, we are not sure of what stage it is at, at this time.

Mr. Winston C. Connolly, Jr.: Mr. Chairman, through you to Mr. Tibbetts.

In terms of CINICO's role in uninsurable persons, can you explain the process by which someone becomes uninsurable and how they pay for it through the CINICO channel?

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Through you, Mr. Chair.

Currently, one of the amendments that came about with the Health Insurance Law was previously the underwriting capacity of a health insurer that was specified under the form of a pre-existing condition. Essentially, once you completed the form, disclosed your health risk or any conditions that you currently have, the health insurer would essentially provide you coverage with the exclusion, essentially underwrite those items that you currently possess. For example, if you had a heart attack they may say we will not cover you for any cardiovascular based issues. If you have had cancer they would exclude oncology based coverage. So, what it did essentially, was to provide individuals with health insurance for risks that they were, probability of not, from a generic perspective, contracting or having on a normal statistical probability basis. However, the challenge with it was that the risks that they possessed, they were essentially exposed to at 100 per cent.

So, the amended law that came into effect in 2013 prohibited that ability for a Class A insurer to exclude or underwrite a pre-existing condition. However, it allowed the insurance company to provide you with coverage but what they would do now would be what is called a "risk-rating" of the individual and it would essentially provide the insurance company the ability to increase the price in your premium compared to an identical applicant (so to speak) but based specifically on your risk.

What it did from that perspective was that it provided . . . I've seen health insurance premiums that are based rate for the new SHIC specified at $168 per month. Once you applied a risk rating protocol and calculations to an individual applicant that had a pre-existing condition, you obviously had to cover that pre-existing condition. I've seen premiums come back on the calculation and accepted by the Health Insurance Commission for over $5,000 for the same plan.

The Chairman: But does that not in itself contradict the whole principal of health insurance?

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Unfortunately, the method that is being utilised on this individual based rating method is what exposes the individual to that type of premium, because you are looking at the individual and not as a collaborative group. In a group basis you would try to offset that amongst the other somewhat healthier members within the group. So, with a value of that size, usually what happens is the individual one obviously probably cannot afford the coverage or the premium for that. But secondly, the Health Insurance Commission would issue an uninsurable certificate for that individual.

The Chairman: And would an uninsurable certificate then fall to you to provide insurance at an acceptable rate?

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Correct.

The Chairman: Well, the question I have is: if you can provide it at an acceptable premium, why is not the private insurers required to provide it at an acceptable premium based on their total insured demographics? Because what you are suggesting is that we do not have group health insurance. What we have is individual health insurance multiplied by how many persons in the group. And we are allowing the private sector, which we do not allow you to do, to separate

an individual from the group under which he was insured and provide a risk rating on him because of a pre-existing condition.

The other question is: What happens if it is not pre-existing? I assume you are talking pre-existing, a condition I have prior to being employed by that company to be insured. Does the same situation apply to a person who gets sick after employment in that same group?

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Yes sir, from the two questions you asked, I will answer the first one and then the subsequent. The first question that you asked basically was, does the insurance companies that have a group plan, when they identify high risk persons, they kind of exclude them from the group and present them as an individual? Yes sir, we have seen instances where individuals are presented to CINICO to obtain individual coverage based on a challenge with the current group plan. We have presented these to the Health Insurance Commissioner and for the most part, I think he has been successful in holding the Class A to keep the person within the group. However, what we have seen sometimes is that they don't. And unfortunately, we have also seen some people lose employment because they can't get in the group or they can't obtain coverage by the insurer of the employer that mitigates their employability which is a significant issue in regards to what a group plan should be doing in mitigating. It should not be a factor.

The second question in regards to your pre-existing condition and after you have been insured if you have an event, the law does permit, as it is written right now, it is 30 days after . . . I can raise your premium on you at any time with 30 days' notice. So, after you have—

The Chairman: Individually or part of the group?

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Individually. So, as part—

The Chairman: Okay, the question I have now is: Does the flip of the coin apply?

If I am in the group and I am 18 years of age and have never been sick and you send me a premium of $200, can I make an application based on my history that I have never been sick, have no indication that I am going to get sick so I would like my premium cut in half and you separate me from the group and you reduce my premium?

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: We have never had such an application. I would not doubt that it could be presented to a . . . well—

The Chairman: My argument is that if the law is going to allow the insurance companies to separate me from a group when I am part of a group on which an actuary calculated what the premium should be based on the demographics, based on the risk for each person in the group, but I get sick and the insurance company can pull me out of the group and increase my premium, then, the person who is not sick and had no claim for the year should be able to request their claim's history; it is zero, so therefore I want my premium to go down.

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Statistically, from a basic perspective that does look somewhat palatable and reasonable, however, if the actuary has done a proper analysis on that group and understands the demographics and understands the traditional risk based on environmental factors, the 18 year old real risk may be $100 but their contribution of the other $200 is contributing to someone else that is paying $200 whose real risk may be $300.

The Chairman: My point exactly! But when you disturb that equilibrium by pulling one person out and punishing that person, which it is possible, and we have had health insurance from 1998—should have had it from 1991 but you know what happened—and from 1998 they have been healthy and have paid their insurance every month for all those years and no claims. Right? They have an incident. The insurance company can pull that person out and re-evaluate their premium and increase their premium?

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Within 30 days as the law is currently written, yes sir.

The Chairman: Are you aware of any recommendations made to the Government to look at preventing that from happening? In other words, if an insurance company takes on a group of 15 persons and it is based on the healthy ones contributing to the sick ones, that that particular section of the law be changed to prevent that from happening.

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: I am not aware of any specific focus on that or discussions of that. However, we have had those discussions with the Health Insurance Commissioner. We have actually experienced individuals that were somewhat cherry-picked out of a group on a temporary basis because they were pregnant (so to speak) and in this particular example, what they did was to put the individual on this plan—

The Chairman: Are you suggesting that being a woman is a high risk?

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: No sir, no sir.

The Chairman: There are many of us who do not consider pregnancy a sickness.

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: No, listen, I have objected forever about that being a pre-existing condition. I think that that should never have been in the law but it was previously.

However, the challenge that we have at this time under the current rules of the policy under the current law, an individual that presents must disclose that they are essentially . . . their medical condition; pregnancy being a disclosure that is required. I think it is section 12 or 13 of the form. But what happens at that point is risk insurance premium is based on the probability of a claim. When an individual is pregnant there is no more probability. It is going to have a claim, so you've now presented (for lack of a better term) that you are essentially buying fire insurance while your house is on fire. So, this in itself is what immediately presents an elevated premium for that individual unfortunately. But they should not have been excluded from the previous group that they were in which is what is currently weak, I think, in the current law. It limits Mr. Connolly's ability to go after group-based coverages which are usually above the Standard Health Insurance Contract (SHIC).

There is something that has to be looked at in that law because you almost tie the hands of the Health Insurance Commissioner once you present a policy that is above the SHIC. His real strength is anything below the SHIC. Anything above the SHIC policy really does limit Mr. Connolly's and the Health Insurance Commission's ability to go after any individual or any individual company that is providing group insurance, and it is something that needs to be looked at. There should be significant penalties and this cherry-picking of group covered members or their dependents when they have a medical event, it should not be allowed.

The Chairman: Are you suggesting that the Health Insurance Commission, by law, only has jurisdiction over the SHIC plan?

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: It has jurisdiction over all Class A insurers that provide health insurance. Its real strength is in the provision of the Standard Health Insurance Contract.

The Chairman: Why?

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Because that is the based minimum that you must provide in the country. Any violation below that or anything less than that or anything that is sub-par to that policy or that basic minimum is a violation of the law. But if you provide a group plan that is in excess, or any plan that is excess of the Standard Health Insurance Contract and somewhere in between that, you provide less than what that plan is but still above SHIC, the Health Insurance Commission, I have seen it struggle to enforce that rule.

The Chairman: But certainly he has the authority on the minimum requirements of the plan?

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Yes. But the minimum requirement of the plan does not have any specific force on group based capacity. So, once you provide a plan above SHIC in a group base and in an individual like we have described in this situation, an individual allows—

The Chairman: So, in truth and in fact, the public's belief that the Health Insurance Commission is regulating the quality and the cost of the health insurance provided in the Island is a myth. Because, as you just said, all any insurance company has to do is to convince the person they are selling it to, to go two or three items above the SHIC Plan and then the Health Insurance Commission feels it does not have sufficient regulatory authority over that?

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: As—

The Chairman: I would think that it should be the opposite. I would think that the higher the plan the more regulatory authority the HIC should have over it because people are paying for more and they should be a method of the Health Insurance Commission ensuring that they are getting more that they are paying for.

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Well, essentially if you look at this from a perspective of an automobile, if I am contracted or I said for the minimum automobile I must have two rear lights in this car for brake lights. If I provide you a car that has four and the law says I must have two, if one of those is out, what I am simply saying to you is that the police officer that has that law that says your rear lights must be two, does not have the ability to ticket me for having three, because I have the minimum too.

The Chairman: Yes, but using that same example the fact that I have paid him for four, I certainly have the expectation that I am going to be provided with four and I should be able to make a complaint to the police that this person has not honoured their contractual obligation to me and I am not getting what I paid for and the police must enforce the contract.

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Well, you will now see the weakness in the law because the law is governed under two lights, it is not governed under what you bought above the two lights. But that is what weakens Mr. Connolly's stance in a lot of these issues.

The Chairman: But I am suggesting that (and I am not a lawyer) some of that is self-limiting because you have the responsibility over all Class A insurances.

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Well, I do believe that the amendments—

The Chairman: Now, it might be a little more difficult, a little more complicated for the Health Insurance Commission to ascertain what is being done and what is not being done in a "better-than-plan". Right?

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Correct.

The Chairman: But that is part of their job.

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: But because of the group based capacity and the open market as you've described, the current law as it is written in the regulations is severely limited in the Commission's ability, from our perspective, to enforce maintaining someone in a group, not excluding them, not risk grading them or elevating the risk of the group because it is essentially that you subscribe to something above the minimum.

The Chairman: And I would bet my dollars against your doughnuts that that particular section of the law is at the behest of the private health insurers.

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: I have no opinion on that.

The Chairman: And it is time to correct it.
Sorry, Mr. Winston.

Mr. Winston C. Connolly, Jr.: Thanks for the intervention.

I am just following on with that theme in that CINICO then also covers the minor Caymanians, meaning somebody below the age of 16. It also does the indigent and we have always said it covers the uninsurable. When you are looking at this overall theme of the report "Ensuring Quality Health Care and a Healthy Population", how much of the population is covered under those categories where either they are below that age or they are uninsurable or indigent? Can you say that for the listening public please?

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Through you Mr. Chair.

CINICO's offering first of all to the public is limited essentially to the Standard Health Insurance Contract which is the SHIC Plan. Now I just want to clarify one thing for Mr. Connolly. The uninsurable certificate that is issued by the Health Insurance Commission for an individual with a risk that essentially deems them in that category, CINICO has been the default insurer, however, we do not have any specific funding from the Government or anyone or any matter for that risk. So, to date, we have not published or issued anyone any coverage under that specific coverage or under that category of the law. However, we have taken individuals that we know that are a high risk and provided them a premium based on our pool of about 1,500 individuals in the SHIC Plan, some healthy, some high risk, some uninsurable (so to speak) but we have provided a generic risk distribution of those within that group. And we find that the group is quite costly because there is, unfortunately, a national trend where individuals previously covered under group plans with their employers, once they reach retirement age of previously 60, the group plan would no longer retain them, so they would essentially have three months to maintain the coverage after they were retired from the employer and they would then present to CINICO to buy an individual health plan.

The Chairman: One question: What statue or what legislation allows employers to mandate that they are not going to provide health insurance beyond 60 [years of age]?

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Well, I—

The Chairman: Or that that is the retirement age?

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Well, it has now been moved to 65 [years of age].

The Chairman: No, there is no legislation that I am aware that mandates retirement age. It says that that is when you can get your pension.

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Correct.

The Chairman: And you can stop paying pension at that age but it does not say it is retirement.

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: What it does say is that an individual . . . the employer at that time no longer has to contribute to your pension at either the 60 or the 65. What most employers do under their contract of employment, their conditions of employment or their employment contracts will usually specify that at the retirement you will be retired at the statute based retirement age, meaning, we no longer employ you. I am not aware of any law that says the individual no longer can be maintained in a group plan post retirement or if they retain their employment within the company beyond the 60 or 65 years of age, I am not aware of any of those. So, it has become indirectly a standard practice. However, you are correct, there is nothing in the

law that says a person must stop working or an employer must no longer employ you at the age of 60 or 65, whichever the date is.

The Chairman: Or provide health insurance for you.

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: However, most of the contracts that I have seen from a previous government post, had their retirement date and age specified within the contract. So, it becomes a contractual issue, not necessarily a standard law.

The Chairman: Well, herein lies the big problem which shows up on the Financial Secretary's desk as post-retirement liability. Because, as the original architect of health insurance and pensions in the Cayman Islands, the intention at that time was that health insurance would become part of your pension requirement and that is the missing component, because we allow these people to stop paying pensions at 60 and top paying health insurance and dump the person on the Treasury. Even if they employ them sometimes they don't give them the health insurance or the pension, you know.

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: I would also like to add sir, Mr. Chairman, if I may. We have about 3,800 statutory employees in government companies and statutory authorities that are equally exposed to the same risk as the private sector of being out on the street at retirement age looking insurance.

The Chairman: Because that is a creature of the board that manages the statute. Because there is no requirement in any of those statutes that those people must have private health insurance which imposes that. What we need to put in the statutes is that they must have CINICO which they contribute to from the time they get employed so that when they get to retirement age they have contributed towards their retirement benefits which is capacity of the health care costs.

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: We have sat with the Health Insurance Commission. We have also presented to the Minister of Health, initially, basic synopsis of what we have been exposed to with a number of retiring statutory authorities, government companies employees, as well as private sector employees that upon retirement age are now without health insurance. They are now presenting themselves to CINICO with a full history of health risks and health claims and they are finding that their premiums based on their history and their current exposure and probability of a claim is essentially more than their pension per month.

The Chairman: And you see it is even worse in the Cayman scenario because in most employers—if you look at the report, it talks about the need for health insurance and the usage of health care—the predominant age group employed, particularly in the private sector are within the least risk group, that is, 25 to 45 or 50. And that represents 50 to 55 per cent of those people whom health insurance is compulsory for. And we allow these people to not have . . . the number of people that those companies would have to actually provide health insurance as a pensioners benefit in relation to the number of people that they have employed is less. And the demographics of that group, I suggest, is going to be heavily weighted by those who should be having the cheapest premium because they are not utilising the services.

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: That is correct.

For insurance there is a generic rule of 80/20. Eighty per cent of your claims are going to be 20 per cent of your population or 80 per cent of your claims are going to be the last 20 per cent of your life using the generic rules within the insurance hand.

The Chairman: One of the statistics that I would like to see unveil in order to put this whole thing in perspective is how many people, particularly in the private sector, actually retire in Cayman as a percentage of their employment population on an ongoing basis to which this insurance would apply if the law said that you had to continue the insurance as part of their retirement benefit because they remain a part of the group plan, so they got the benefit of all of the healthy people in the plan. Because what we are doing now is that we are simply increasing the opportunity for profit by the health insurance companies by allowing them to only insure people who are healthy within that demographic and when they get to where they should be getting the benefits, having paid health insurance for 15 to 20 years, they are told, *We are not going to insure you anymore.* And the ridiculous thing is that the Government then turns around and provides the bail out for these people out of poor people money.

What would be your suggestions as to how we could address this problem which would lessen the burden on CINICO of being stuck with an inappropriate proportion of people over 60 who are likely to get sick being insured versus having the continuum of insurance within the company that you work?

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Part of our strategic plan was the creation of a national policy, whether it be mandatory or whether it be an individual voluntary subscription. But the creation of a health retirement account whereby a percentage of your income would be paid either on a subscription of a different plan or whatever, would be contributed to a savings account from your first earn-

ing through your retirement age. The funds in that account then would be invested by the insurance company, either CINICO or any other Class A insurance that is out there, and the funds at retirement would be specifically used to contribute to a premium based pool as opposed to the individual health cost of the individual or a health claim cost.

It would probably take about five to seven years to bring the fund to what I would consider a substantive volume to kind of manage itself to a certain extent to mitigate impact, meaning any equitable injection in the shortfall would no longer be required if government had to shore it up. But, in my opinion, it is a long overdue requirement and need of our society as we are currently structured.

The Chairman: Are you suggesting that a high risk pool be confined to the individual private health insurers or to a global fund just created to which they can access based on certain conditions?

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: It would be essentially . . . as opposed to your current pension where you pick a provider and they take your pension contributions each month, invest them and then remit to you at retirement a specific amount, which seems to be a disconnect from your lifestyle but that is another argument. But these funds would be based on your subscription whether you would subscribe at a 70 per cent or 80 or 90 per cent in the future, and once those premiums are pegged, at the end of each month the funds would be used to pay your 70, 80 or 90 per cent and you then pay the alternative, maybe a component from your other pension. But currently the funds that are being put aside for pension and the amount that is being—

The Chairman: But why would you want to mix it with pensions? Why don't we keep the fund from what is generated by the health insurance?

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: No, No—

The Chairman: Oh, you're just using an example?

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Yes. So, because it was my understanding when the law was being put in place the amount of pension that you would be collecting back, each month would be sufficient to buy a basic plan to cover you, but the reality is that it is not. With the law changing and giving you risk rating mechanism on an individual basis it certainly skewed that perspective. So, it is very easy to find a 60 year old retiree having a basic plan, the SHIC [Standard Health Insurance Contract] Plan with a premium of $400 to $500 a month very easily, which it is my understanding, I think, it is $1,080 is what you are being paid from your pension companies—$12,000 a year, whereby 50 per cent of your pension would now be paid to pay an insurance premium.

The Chairman: When I talk about health insurance being a pension benefit, I am not talking about mixing the funds, I am talking about part of your retirement package (should be a better word rather than pension) should be that you remain in the health insurance pool that you were from the time you were 18 years of age if you work for the same company.

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Yeah, it could be a feature. It could be a vetting feature. Currently, the government will maintain you if you retire with 10 years of service. You would maintain your CINICO coverage as a retired civil servant. So, it could be something that could be looked at.

This is a capitalist society and I think we all recognise that we want to maximise our income and the same 8 hour shift. So, to tell someone to stay with this company because you lose this or lose that, to a certain extent it can reduce the value of the individual. But if we do create a health retirement account it should be completely portable, it should be yours not your employer's. As an employer you contribute a percentage of income for this individual based on their subscription as you do with the SHIC and the funds then sit there and accumulate to your value. What we examined gave a death benefit, gave an early retirement benefit gave actual different components to it. So, we gave a number of different scenarios to the health minister at the time and it was actually presented to the Health Insurance Commission, however, I am not aware of any further development since the concept.

The Chairman: This uninsurable person, how is that allowable, other than by specific provision or specific carve-out in legislation that makes life insurance compulsory?

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: I am totally unaware of why or how that occurred sir. The same law that says you have to health insurance gives you a scenario where you can be without health insurance in the form of the uninsurable, and with actually no provision or any access to alternative, other than being deemed indigent which is not specified in the law but that is the national trend.

The Chairman: Given the current machinations in our neighbour to the North under which several, if not many, of the local private health insurers provide, do you have any concerns of the repeal of the Affordable Care Act which many of the local providers prior to the affordable act were able to not provide many of these things because their excuse was that their head office did not allow them to do it because it is not mandated there. Do you see the possibility, or is this something

that you as an insurance company and the health ministry should have on its radar in case there is a repeal of the Affordable Care Act which would give the subsidiaries here an obligation to not offer some of the services that they are now offering?

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Again, that is an action that we would have to see come to fruition to see its full effect. However, our law, the subsidiary based agencies that are here, they are governed by our law and our law has a lot of similarities in the Affordable Care Act, therefore I don't suspect that any of them, if there is an appeal in the US, will have the capacity to basically underwrite an individual again or ostracise them in some way from coverage.

The Chairman: In other words, our legislation should allow us to say to that subsidiary, *If you want to continue to provide health care in this country you will need to do these things.* They will not have a choice, they either, provide it or they pull out.

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Yes, the affordable act does not apply to us here. We had some similar—

The Chairman: But you will agree that many of these things did not come into effect in our Health Insurance Law until the Affordable Care Act was legislated in the United States.

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Yes, it became—

The Chairman: And there was huge resistance prior to that.

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Unfortunately, the private sector has a profit based agenda and as you can appreciate a CEO of another Class A will mitigate risk as best as possible, and if they can identify a risk within a group or a particular set that is more costly to that insurance company or they are unable to attain the premiums that they would like from that and there is a way that they can off-set them from those books or their risks, it is natural for them to pursue that.

The Chairman: But you will also admit that part of the Government's responsibility in its policy and legislation is to mitigate those factors so that it is not all profit driven but there are certain conditionality that has to be met, even if it reduces your profit or not, but it goes to the fact of providing a better quality of life for our people.

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Anything that limits access to health care by a population should be a priority on any government's agenda to eliminate.

The Chairman: Winston.

Mr. Winston C. Connolly, Jr.: Just going back to the indigent now, moving on from the uninsurable persons. Who decides who is indigent? And what is the process by which that decision is made? Is there some sort of metrics involved?

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Through you, Mr. Chair.

The current process is the individual in the public or a Caymanian citizen or a Caymanian national can present to the Social Services Department that now utilises a unit within that department or the Department of Children and Family Services (DCFS) (my apologies) has a specific unit called the Needs Assessment Unit (NAU) and it is my understanding that they perform a set of vetting or scrutiny on the applicant regarding income, assets and other components to which I am not 100 per cent clear with, but I do believe that the Needs Assessment has a very clearly distinctly defined parameter. And once the person is essentially qualified,

What we have seen a greater trend in is the provision of indigent coverage for a temporary basis, three months, six months, and then the person comes off the list. Usually when they have a major or some type of medical event requiring some level of tertiary care intervention and the individual does not possess . . . . essentially, is not employed or does not have the wherewithal to manage or maintain health insurance coverage. We have seen that trend. But the actual qualification for indigent rests 100 per cent with the Department of Children and Family Services via the Needs Assessment Unit.

I would just like to add one of the concerns we have had with the individuals deemed uninsurable, a number of them have presented to the Needs Assessment Unit to now get indigent coverage because they are unable to obtain health insurance. But a number of these individuals are self-employed. And what happens is that because they are employed and have income they cannot qualify as indigent. So, they find themselves completely exposed unable to attain indigent coverage, unable to acquire a health insurance coverage, and we have personally experienced a most traumatic case via an individual because of this and it was not for a lack of trying. He was sincere in his efforts, just was unable to obtain any quality insurance coverage out there and could not qualify for indigent.

Mr. Winston C. Connolly, Jr.: So, just to get that straight—after you've gone to DCFS and NAU, they decide then who is indigent. They put you on the indigent list, you get whatever the coverage is for that

incident but after that incident, then, you can come back on, like the regular SHIC plan or whatever?

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Well, at that point the individual via their employer can obtain coverage or if they obtain a job or whatever methodology that qualified them in the first place to qualify for indigent. But we have seen individuals that have . . . many times we have seen people who require the Standard Health Insurance Contract but because the contract covers CI$100,000 a year, the current contract, the new one, we have seen $300,000 or $400,000 cases. So, they have then gone and supplemented that with acquiring indigent coverage and essentially the indigent fund has acted as a reinsurance cap for the SHIC Policy.

[Inaudible interjection]

The Chairman: But—

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Many times sir.

Mr. Winston C. Connolly, Jr.: How many ballparks are we talking about there? That is an alarming thing if it is a trend and a growing trend.

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Unfortunately, it is something that we have looked at, which is one of the reasons that we got the SHIC plan to be increased. If you remember it was $25,000 at first and it took a long time to get it to move to $100,000. I would say in the last two years, I think, we probably had about 8 to 10 cases that they capped their SHIC policy and then qualified as indigent.

Another trend that we are seeing the indigent fund used for is for the seafarers and veterans. As you are aware, the coverage for the seafarers and veterans is for tertiary care which can be Health City or it can also be overseas, but specifically tertiary care. They have a co-pay of 10 per cent. If you have a medial interaction where you are $50,000 that means the seafarer has to find $5,000 essentially. And that is always on the discounted. So, the case could be $200,000 that is discounted to $50,000, they still have to cover the $5,000. What we have found in a lot of instances is that the indigent fund is being used to cover that $5,000.

Mr. Winston C. Connolly, Jr.: Just going back to something you said before Mr. Tibbetts, in terms of the uninsurable, and I am linking uninsurable and indigent in terms of: How do you as an insurer account for these things that come up, I guess, in a growing trend but through the decision of another government entity; the NAU and DCFS where presumably you know after the fact? How do you, account for that? And then, you are saying that there is no payment from government for the uninsurable right now, no money going toward that pot. Do they do a throughout or something, at some point in time, with the indigent as well? Or is that just, *Here you go, you figure out how to deal with it?*

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Through you, Mr. Chair.

Actually, the indigent fund or the indigents that we provide coverage to is on an administrative services only agreement. We only manage the care, we collect the bills and then we submit the bills back essentially to DCFS or Social Services or through the Ministry of Health will then pay us for those services. So, it is just . . . we don't peg a premium on that and say we are going to cover them based on this. But we do have a policy format that maintains structure to the care being received by the individual that it isn't unlimited (so to speak) and it does have a cap mechanism in there. We have exceeded that cap sometimes and had to do special provision to cover it.

The Chairman: Do you provide the kind of reinsurance for cap excess?

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Not for the indigent plan sir.

The Chairman: Why not?

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Because—

The Chairman: I mean, I can see for the indigent plan because you are getting the cash from government anyway, and that is one of the things that I have always believed. But even for your regular people, do you provide reinsurance for risk beyond cap?

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Yes sir. Our current policy with the Government, we renegotiated with our reinsurers and we currently utilise a trigger point of US$700,000. Any civil servant or civil servant pensioner that has an episode of care that exceeds $700,000, we have that reinsured by a separate entity.

The Chairman: But if you have . . . Why are you not buying cap insurance for all risk beyond cap, whether they are uninsurable or your SHIC plan? In today's world $100,000 in health care is a couple of injections.

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: But we retain that risk. With the SHIC right now if you collect the $168.00 and you are going to try and get a . . . remember we cap at $100,000. Anything after $100,000 CINICO or any Class A insurer is responsible for the individual after that.

The Chairman: Yes, but—

Mr. Lonny Tibbetts, Chief Executive Officer, CIN-ICO: Anything above that it may be something that someone else will sell to someone else out there but it essentially means you just need a bigger policy.

The Chairman: But would it not be better and would it not lead to a better quality of life (which is what we are concerned with here) if you, in fact, provided that, even if it sends everybody's premium by $3 or $4?

Mr. Lonny Tibbetts, Chief Executive Officer, CIN-ICO: I totally agree.

The Chairman: How do you handle then . . . so, you are telling me if I am insured with you for the SHIC plan and I am in the hospital, I'm in the middle of a heart surgery and they need a catheter but the catheter is going to exceed the $100,000, they must just stop?

Mr. Lonny Tibbetts, Chief Executive Officer, CIN-ICO: No sir.

The Chairman: Because nobody is going to get paid for it.

Mr. Lonny Tibbetts, Chief Executive Officer, CIN-ICO: Well, you as the individual, all interactions with tertiary or medical facilities, the individual is originally and has always been the primary liable party. You sought the services, you are liable. The insurer's role is the third party in the middle of it that says, *We will cover Mr. Miller up to this. Anything in excess of that you need to go back to Mr. Miller.* So, we do have individuals in cases where—

The Chairman: But here is what we are doing now; they are not coming back to Mr. Miller, you're going to a separate account in government treasury to get me certified (although I am worth $1 million) indigent so you can give me coverage beyond $100,000.

Mr. Lonny Tibbetts, Chief Executive Officer, CIN-ICO: Yes sir, unfortunately, that is a trend—

The Chairman: But would it not be better if this was universal where it simply says that your normal premium . . . well, I don't think that you should have a cap period. But if we accept what exist out there, your cap per year is . . . in the private sector it is $25,000 per episode and $100,000 per year now?

Mr. Lonny Tibbetts, Chief Executive Officer, CIN-ICO: Yes sir, it has moved up to $100,000.

The Chairman: Which is basically arbitrary.

Mr. Lonny Tibbetts, Chief Executive Officer, CIN-ICO: Nowadays yes.

The Chairman: I would like to see the actuarial calculations to come up with that figure. Right? But anyway, we accept that the cap is $100,000. Would it not be better if the Government's legislation and policy mandated that there must be at least the availability of excess cap reinsurance to that person?

Mr. Lonny Tibbetts, Chief Executive Officer, CIN-ICO: Well, essentially the law could change the maximum annual benefit from $100,000 to $250,000.

The Chairman: The truth of the matter is that you and I both know that when the actuaries calculate the premium it is calculated on the $2 million lifetime benefit. There is very little, if any, adjustment to the premium based on $100,000 artificial limit per year.

Mr. Lonny Tibbetts, Chief Executive Officer, CIN-ICO: Unfortunately, it is actually the other way. The lifetime value of a policy does have contributing factors to that premium. But the annual cap, the real where the rubber meets the road essentially, where the dollar value is, it is kind of like your outpatient benefit versus your inpatient benefit. The probability of an outpatient benefit previously had to be a physician visit. We have now changed that. We have increased the amount but we have also now allowed you to claim prescriptions and even, I think vision is now a part of that. So, the probability of you using up that outpatient benefit which is now $400 is very likely. So, if you are scoring a plan you immediately say, *Whatever I peg, $400 I am not going to collect, that is gone.* And then you look at the risk of the individual and that is where the rest of the premium comes from on the demographic.

The lifetime value of the policy being $2 million will have some contributing factor but the big component is that first dollar that you claim which is that outpatient and then that annual benefit of $100,000 which should be looked at to be increased. With all due respect to Mr. Connolly and Ms. Ahearn, when they worked on the law to change it, I think the law was possibly 10 years old at that time and they were 5 years trying to get it to change then. So, when they pegged that change it was 5 years late and I think we are essentially 6 or 7 years late with what you would consider a true minimal value of a basic insurance plan significantly has to be moved again but again, the premium is going to have an impact on the cost of living.

The Chairman: What is your guesstimate savings on a monthly health insurance premium that has a one year, $100,000, and an episode $25,000? What is the reduction guesstimate in a premium by the introduction of that $25,000 episode ceiling?

Mr. Lonny Tibbetts, Chief Executive Officer, CIN-ICO: On the basic SHIC if you are paying $168.00 a year, that gives you $100,000 coverage. If you have a specific benefit in there that gives you a $25,000—I think cancer does. I think they do have an oncology component of $25,000. The difference in that is that you are probably talking maybe $30 to $40 but that is my best guess there. I wouldn't bet the house on that.

The Chairman: Here is the philosophical problem I have with what is being done in the health insurance industry. They calculate their premium based on the demographics and risk factor but then we allow them to introduce $25,000 cap on cancer which should, if you are going to do that, bring the premium down. But it does not. I would like to see the comparison of a premium that has no annual benefit, just a lifetime benefit, with the $100,000 annual benefit and with the $25,000 episodic.

Again, the incidents of cancer in that demographics which makes the majority contribution to the health insurance pool is fairly low in Cayman—I don't have the numbers here and it is not broken down by age group, although Mr. Ruben did a great job of putting all the factors together in the other document—but yet we allow the insurance companies to introduce all of these complications which cost money for them to administer. Think of how simple it would be if we did not have all of these codes but you simply was in the hospital and it was not anybody's business what you were in there for but we are going to pay $100 to the hospital, but in order to get that $100 the hospital staff did not have to introduce the 25 codes for everything that you got and the insurance company did not have to evaluate whether the 25 codes are right or not. Think of the administrative savings that could be accumulated because all of this is only smoke and mirrors, in my view, by insurance companies to extract more from the pool. And I think it costs more than they are making.

Mr. Lonny Tibbetts, Chief Executive Officer, CIN-ICO: Unfortunately, this is a very unique industry where you hire auditors or adjustors to review a claim and then hire auditors to examine the adjustors' work as well.

The Chairman: Because we have introduced all of these things. If it was a simple system of I am insuring for sickness. If I go to the hospital you are going to pay my hospital bill. It does not really matter whether I got two glasses of water or I was drinking Aquafina water or Perrier water, I was sitting at the hospital and I got treatment.

Mr. Lonny Tibbetts, Chief Executive Officer, CIN-ICO: From a simplistic term, yes, but the problem is some hospitals do serve Aquafina and some do serve Perrier. So, the problem you have is the cost of those two waters being different.

The Chairman: But that is usually . . . I mean, because the insurance companies have questioned whether you got Aquafina or Perrier.

Mr. Lonny Tibbetts, Chief Executive Officer, CIN-ICO: Yes, we do.

The Chairman: And pretending that that makes a difference in the quality of health care that you got, and because they purport to use all of that to set my premium, right? Why we have it in the first place? I drank a glass of water. Most hospitals you get tap water which, by the way, in most instances it is safer than the bottled water.

Mr. Lonny Tibbetts, Chief Executive Officer, CIN-ICO: Yes, the statistics have proven that.

The Chairman: It is just that these whole pages and pages and pages of codes which just leads to . . . anyway, I . . . But I think one of the things we need to do is instead of constantly looking for ways to justify to complication of the process and expense, it would be much easier to find ways to reduce the expense and simplify the reporting.

Joey, you wanted to ask a question? Sorry.

[Inaudible interjection]

The Chairman: Okay.

Mr. Winston C. Connolly, Jr.: Mr. Chairman, through you.

I wanted to touch on two things. The first one while we are kind of in that lane is the CayHealth programme. How involved are you or were you in the design of that? And, can you explain why it is just done on the indigent pool at this time and not in a wider setting? What could be some of the reasons for that?

Mr. Lonny Tibbetts, Chief Executive Officer, CIN-ICO: Through you, Mr. Chair.

The CayHealth programme is a programme I think that was . . . I had a couple of meetings with the now retired, Dr. Kumar, who was heading it up at the time. Essentially, it is a good idea. I think what happened is that there is probably a resource challenge with the number of individuals that consume the services, but there is also somewhat of a—I'm not sure how to describe it—disconnect with the members receiving the care and the use of overutilisation of the service.

Under the previous administration with the prior member of health, minister Scotland at the time, he and I had a number of discussions with the CayHealth programme and how effective it was work-

ing and what we were finding of trends in it. It was my understanding and I think the Hansard will probably show that it was first presented on a cap basis of cost and it would provide X amount of hours per week, per day, per month to a specific group of individuals that were deemed permanently indigent. They also were suffering from chronic non-communicable diseases; diabetes, hypertension and usually the trend (so to speak) was indigent and elderly. Both or one of those two was kind of where . . . but again it was specifically based on the needs of the health status of the individual. And I am not sure what the specific profile was or what yielded the true profile of the CayHealth recipient was.

What I understood from minister Scotland at the time was that what happened, a budget of $2 million was presented to the Ministry of Health, I believe, and it essentially ballooned to $5 million in a year and a half. And what they were finding was that individuals would go to a clinic in Bodden Town and seek care and treatment under the CayHealth programme and then also go to the GP at the George Town Hospital and get care again for the same issue. So, they saw duplication of cares, they saw individuals that were essentially overutilising their services. But it is not a novel idea. I think it has functionality and a capacity within our health system. I believe that for it to be effective it needs to be measured properly, In other words, profiles of each individual, kind of like an individual health plan needs to be developed in our system to monitor that and see. And I do believe the Cerner System has the capacity. I just do not know to whom they are reporting this saying, *We have seen 150 diabetics this month, we've gotten 10 of them off of dialysis or they have received kidney transplants or we have prevented this.* I am not sure what the measurable are within that, other than just the output to individuals.

So, the quality of care that is being achieved is what needs to be measured from my perspective, to say 1) whether it is effective and 2) whether it is something that can be a national rollout to other covered members or C.I. Government covered insured members.

Mr. Winston C. Connolly, Jr.: But I guess that is exactly what the Auditor General's report says as well, in terms of, you know, I am looking specifically now at page 26 of that report and talking about the Recommendation 8, and in that the recommendation is that: **"The Government should evaluate the design and performance of the CayHealth progarmme and, as appropriate, extend it to cover a wider population."** And I think you just touched on that issue in that, if there is no kind of reporting back mechanism and guidance all of that, then that is the fundamental flaw in all of it.

When looking at paragraph 86 talking about the surgical and obstetric care, again, without guidance from the Ministry to the health care providers for these things, how do we as a country, as a parliament, as a PAC and yourself as a CEO ensure that the procedures that are being paid by you as CINICO are reasonable? Where is the analysis and the information to allow somebody of those aforementioned groups to come up with that type of information?

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Currently, we CINICO are not a recipient of any type of reporting metrics, quality care metrics, any type of analytics to prove whether 1) it is effective. We essentially, because the CayHealth programme has been geared towards the indigent covered persons which we provide kind of a fronting coverage for but not an actual premium base, there is not a requirement to report to us or anyone that I am aware of, any of these types of analytics.

From our civil servant perspective and our seafarers that we provide premium risk coverage to, with our new medical case management unit and the monitoring of their care, we will demand those analytics and we will also be able to see them directly on both our comparative data of our claims as well as our case management records.

The Chairman: You keep referring back to you providing services for various government agencies, not on a premium basis. Why?

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: It has just been the current structure. If I may, since I arrived there we had a number of based level preliminary based discussions about pegging a premium for indigents. The struggle we have is the indigent population sir, is a component of temporary or what we call medically indigent where there is just a major event and they don't have coverage and they enroll them or qualify them. And then, there are those who are permanently qualified to that role.

We have talked about it for some time about segregating the two and providing a bona fide premium but it has never materialised.

The Chairman: But on the basis, on the whole philosophy of health insurance whereby the healthy pay and subsidise the sick. Why is the Government buying health insurance from you for civil servants who are basically healthy and have that demographic in it and not asking you to insure everybody and tell us what the premium is going to be and use the healthy people to reduce the premium for everybody and everybody then have health insurance? So, you don't get into this individual political decision making process because medical indigent is required the signature of Minister responsible for Community Affairs. Right?

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: I think the final approval is, yes.

The Chairman: Currently, government is supplementing the insurance that you provide through various funds to the tune of some $36 million?

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: That is correct sir.

The Chairman: Now, again, I am not an insurance expert. But I would think that $36 million annually should be able to pay a pretty premium for quite a few people.

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Yes sir.

The Chairman: Again, and I know there is a risk here, but if you had to insure all of these people, what is your guestimate of what the premium would be for everybody involved once you mixed all of the demographics together?

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: We did this exercise, Mr. Chair, about two years ago and it was basic simple equation. First of all, I just want to give you some kind of alarming statistics. The indigent population when we did this analysis had at the time, I think, just a little over 1,200 persons. Of the 1.200 persons, 200 of those individuals were what we considered medically indigent. They were in for three months or six months. So, on an average year we cover about 1,800 persons. Of that 1,800 . . . most time we maintain about 1,200 so we have different individuals coming in and out, sometimes twice a year. The remaining 1,000 persons that were left we would consider them permanent and the analysis that we did on them at that time was they claimed, the 200 persons that were temporary, consumed 46 per cent of the entire indigent fund for that year.

The Chairman: Because you are isolating high risk ones and accounting for them separately. If you mix it with everybody and everybody understand that I am going to get old one day too and I need to contribute a little bit now to those who are old and those people coming along who are young will contribute a little bit to mine. It has to be easier for you to manage all of these pools if the Government is insuring everybody for you for an agreed premium and we need to add Joe Brown to it for three months.

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Well, Joe Brown . . . in your example sir, is the biggest problem because we don't know who he is. We don't know his risk. So, CINICO would not have a problem. We could peg a premium sir for the permanent indigent but those, the temporary ones that have a catastrophic event that are now involved in some level of major intervention is—

The Chairman: No, but—

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: We did have this talk with the actuary. He said he would not even know where to start because you don't know what is coming through the door.

The Chairman: The point I am trying to make is that everybody should be insured prior to the medical event. That is what the law requires.

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Yes, I agree.

The Chairman: Okay? Now, I am not talking about somebody getting insurance in the middle of the medical event; that is what is causing the problem.

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Yeah, house on fire.

The Chairman: Because you don't have . . . you can only deal with that by government having this $37 million located in five or six different line items, votes, to compensate you on some kind of actual cost basis.

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Yes.

The Chairman: But if we had a situation where your group could be expanded, even beyond the civil servants, to other employers who could bring to the table again, the majority—and every one of these groups—are healthy. So, you would be getting more healthy people than you would be getting sick people. What we are saying to you now is that the Government has written legislation that allows somebody else to insure the healthy people but we are going to insure the high risk people and we are going to top that up by saying that we will provide additional cash for you for them to come in to the middle of the medical event. Now, there has to be something fundamentally wrong with that policy.

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Don't forget we are going to provide reinsurance for your low quality plan as well, because that is what indigents gets abused as well.

Mr. Winston C. Connolly, Jr.: We might as well just say that the private sector insures all the healthy people and government is responsible for everybody else and just try to simplify it as much as possible, because that is all I am hearing today, that we are double and triple paying at times in terms of these packages that we do, which really are lip service. At the end of the

day government has to find the money. And I ask the question all of the time: Why don't we do a captive where we just self-insure and we know what the pool is so we put it out there, apply the insurance and then at least at the end of the day, bring that money back into the coffers, a penny saved is a penny earned?

Just again going back to this theme of insuring quality health care in a healthy population: Are there any references to the NHPP and its goals in the ownership and purchase agreements that government has with CINICO?

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: No, there is none specific. If I may, there are indirect in regards . . . they are mostly . . . the output requirement, for example, the indigent is to provide this coverage and reimburse et cetera. The specific policies within . . . The indigent at this moment, the challenge that we have, there really isn't . . . The CayHealth programme was designed to help manage that group in trying to keep their cost down, but there is not any incentive in that current structure for the HSA to stop duplicating services to mitigate, you know, going to two different places, nor is there any real driver in there for CINICO, any incentive for us to maintain or manage cost. We do this out of what our prudent protocol is for our stakeholder. But from a performance measurement mechanism it is not one. And in a situation like this, in the United States they deploy the HMOs to perform this and you maintain a population of 1,000 persons with these and the number that you put here or maintain here or keep for this period of time is an incentive programme to the HMO and a reward mechanism by the government because they know that you are mitigating greater cost. Those are some of the metrics that we need to examine to incentivise all of the stakeholders in this process to make this happen. I think we have created the programmes but we have not created the measuring tool or the incentive to maintain the measuring tool.

Mr. Winston C. Connolly, Jr.: Absolutely.

So, if I say then there is nothing that has been specifically asked of CINICO to achieve the objectives and report back to the Ministry, that that would be accurate?

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: For the—

Mr. Winston C. Connolly, Jr.: In the NHPP.

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Yes, NHPP. However, the health cost review committee, we've had direct reporting requirements for that and both CINICO and the HSA have put in. Those are indirect (so to speak if I may) from the NHPP directives. But it has never been under the specific of, *we are doing this in line with this*, but I do believe they are indirect because I think all of us, both ourselves and the HSA recognise there were things that we could do from within our particular gamut of services to cut cost, as well as provide quality care, and those essentially would provide or achieve those goals but they were never represented to us to say, *We are monitoring you against output 4 of NHPP, et cetera.*

Mr. Winston C. Connolly, Jr.: I guess that leads on to the next thing. If we don't have that type of process and system in place, should not something like this report then be the starting point to at least question and provide answers on the basis of which this report was done going forward on a periodical basis. Because, to me, having the Auditor General's Office putting in the work and seeing that there was an absence of this in the first place, and thus, the performance audit and the financial audit, you know, going forward, then I would almost take this as a Bible (so to speak), best practice and you know, let's use the template. And from your individual perspective and your practical perspective to supplement it, I guess. But let's start doing something because like I said, I can't get my head around this and I can't say it enough. We are just paying for everyone that is unhealthy in the country no matter what, so what the systems and the casings that we have around it, all that is, is an administrative add-on. At the end of the day because of political and other reasons we are on the hook for it no matter what.

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: If I may, through you, Mr. Chair.

Mr. Connolly, you are pretty much very correct in that assessment or in your assumptions that you have achieved there.

Many times we have expressed concerns regarding even the co-pay for the seafarers and the veterans. It is an administrative nightmare to say we are covering 90 per cent. A lot of times they are unaware, they are getting bills, they are coming back at us for them. We are explaining why we can't cover it and then they are seeking indigent coverage to assist them. The seafarers and veterans also collect their monthly membership fee and they use that a lot of times to assist the members in offsetting some of these costs. I see little value in that many times in direct contracts that I have negotiated on behalf of CINICO. I've asked to waive that 10 per cent for a number of members. We achieved that with the ST. Luke's Cardiovascular out of the US, and I do believe that Health City, Cayman Islands, does offer it as well. So, it is a real value and a real cost that is there but it does certainly create bureaucracy in the process which—

The Chairman: Cost.

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Cost, and which may mitigate access to care. So, some of these things we have to examine.

I've said this before and it is something that we all need to be cognisant of. The cost of health care is not going to change. It is going to be the cost of the care. Who pays for it is where the decision—

The Chairman: And how.

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: —and how it is paid for really needs to be governed and that is what we said before.

The seafarer that had the $50,000 worth of care and CINICO covered the $45,000 and then the $5,000 is paid out of indigent, it is still the same $50,000 worth of care. So, it is something that we have to look at and see one . . . and I also believe that having an efficient and effective way, as you described earlier, of getting the care timely and within good parameters, is key. It is one of the things that we have utilised in the last three years with United Health Care. We have used DRG [Diagnosis Related Group] for pricing for a lot of our overseas tertiary care and that is the only thing that really helped us to really keep our premiums down.

Without the UHC contract and without the discounts that we achieve with the team out of United Health Care and the DRGs for a lot of them, we would not have been able to maintain that premium.

The Chairman: When you negotiate DRGs do you also bargain for discounts off of DRGs.

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: What we really see is, as you have described, that 15 page bill becomes one page essentially. And it is maintained within a parameter. And I will say—

The Chairman: It works.

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Sometimes we win, sometimes we lose it but most times, probably 99 per cent of the time we have won. We have seen DRGs where the care was DRG agreed and the care was a lot less than we anticipated, but we had to honour the contract. But most times—

The Chairman: But again, that is how it is arrived at. You win some, you lose some but overall the likelihood of losing more is reduced.

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Very much; seriously mitigated. And it is one of the reasons that we are going to re-contract with United Health Care again because of that. We have the capacity of five years and we are going to continue with them. But we have managed to maintain our overseas cost and stabilise (so to speak); for how long we don't know because CINICOs premiums are under significant pressure to maintain it. So, I think it will be six and a half years by the time this 18 month period is complete, and Frank and I are no short of grey hair because of it but we just wanted to say that—

The Chairman: You really need a trim.

[Laughter]

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: We really wanted to say that our staff, our team has worked really hard at it and we have now restructured our organisation to continue to keep our cost down and we are very pleased with the relationship and where we are going with it but we don't know for how long we can maintain those premiums because the pressure is there; six and a half years is very hard to say the premium does not increase.

The Chairman: All right, thank you, Mr. Tibbetts, and Mr. Gallippi for your time. Some interesting things have come forth. Thank you very much.

Mr. Lonny Tibbetts, Chief Executive Officer, CINICO: Thank you.

The Chairman: We will take a 10 minute break so we can get our desserts we didn't get for lunch.

Proceedings suspended at 2:53 pm

Proceedings resumed at 3:17 pm

The Chairman: Thank you.

I will call the meeting back to order and I want to welcome and thank Ms. Lizzette Yearwood and Dr. Jefferson for finding the time to come and appear before the Committee.

There are two reports that the Auditor General did and one is basically a summation of the Health Care Services that is provided and I think they did a very good job on that. But that is not what we are delving into with the witnesses. What we are delving into is the report of "Ensuring Quality Health Care and a Health Population" in terms of the regulatory functions and what legislation and policies need to be improved in order that the Government can with confidence say that we are providing high quality care. The Auditor General pointed out, in my view, some inadequacies, particularly, the absence of methodologies of evaluating and reporting which would lead to that.

I will start of by talking a bit about the National Health Policy and Strategic Plan. How familiar are you all with that plan?

Ms. Lizzette Yearwood, Chief Executive Officer, Health Services Authority: Mr. Chairman, good afternoon.

I would like to start by thanking the Auditor General and her team, if you don't mind, because I think this is the first time that we have ever had a report of this nature. And the public interest report is one of such that puts the framework of all of the health services that we have in the country and I think that that along with the quality health care performance report is very good, in that it gives us a foundation that we can use to audit the quality of health care, and that the Government can keep the providers accountable for the care that we provide. So, thank you very much.

Moving on to your question in regards to the National Health Policy and Strategic Plan document that was prepared, I am very familiar with it because I participated in that exercise. And even though it was not something that was formally rolled out, I have used that, as we have done our strategic planning at the Health Services, we have used that as a guiding document to ensure that all of our strategic and specific results in all of our strategic statements, essentially dovetails into the overall national statements and intended policies for health.

The Chairman: What is the formal mechanism of communications on policy between the administration of the HSA and the board? And, if you are aware, what is it between the board and the Ministry of Health?

Ms. Lizzette Yearwood, Chief Executive Officer, Health Services Authority: Essentially, on a monthly basis we have a report that I along with the senior managers prepare and we send that to the board and the board will review it and send that on to the Ministry of Health. So, that is an operational report. And any sort of policy matters would be included in that report. So, that is a communication mechanism that we maintain on a monthly basis.

The Chairman: How many policy directives have you received from the board or from the Ministry through the board or from the board itself based on their evaluations of your monthly submission to them?

Ms. Lizzette Yearwood, Chief Executive Officer, Health Services Authority: I don't have that number, Mr. Chairman, however, every month we have a board meeting and . . . well, let me correct that. We are required by law to have eight meetings for the year. So, at the end of the month we will have a meeting and out of that meeting there will be directives from the board and those directives are communicated in writing and those would be reported on by me at the following board meetings. So, those could be something that is communicated from the Ministry to the board or it could be set by the board, and it is usually items from the board that arises out of either the board report or other operational or strategic matters that arises during the course of the month.

The Chairman: Are you confident in saying that the Health Services Authority is meeting or hopes to meet the strategic directives contained in this policy?

Ms. Lizzette Yearwood, Chief Executive Officer, Health Services Authority: Mr. Chairman, we don't have an evaluation tool to align ourselves directly with the National Health Policy Statement, however, the main goals in regard to access to health and maintaining a healthy population, the overall goals, yes, we do believe that we are meeting and striving to continuously maintain those goals and objectives.

The Chairman: Let me refer to some of the specific strategies and you can tell me how the board and you have adjusted your operations to leadership and governance—strengthen institutional capacity for leadership and governance. What specifically has the board asked you to do that would move us towards achieving that goal?

Ms. Lizzette Yearwood, Chief Executive Officer, Health Services Authority: I think, Mr. Chairman, you can appreciate that not all of the strategies and objectives in the National Health Policy Statement would be pertinent to the Health Services in itself. The Health Services is more of a delivery type of service, so some of those things would be something that would be a deliverable, mainly from the Ministry of Health and that would be essentially one of them.

The Chairman: The HSA and the board being the main provider of health services to the Ministry, what has been done about health information and being able to demonstrate that you are developing a robust health information system which delivers the information that the board and the Ministry would need in order to alter policies?

Ms. Lizzette Yearwood, Chief Executive Officer, Health Services Authority: Mr. Chairman, that is a very good question and that is something that we are working on, on an ongoing basis. That is one of our strategies in the health services strategic plan because we believe it is important to have data in order to be able to inform care and the delivery and adjustment of it. And we have various outcomes that we measure and we are not just tracking and trending them, but we are in the process of also benchmarking them with other hospitals and other jurisdictions that are similar size to ours.

Some of those outcomes that we measure would be say, for example, readmission rate, infection control rate, patient falls; those are patient outcomes that we are measuring. Patient feedbacks are the things that we are measuring. And over the years we

have been measuring them and just tracking and trending them internally but, obviously, that is only one piece of the puzzle so we need to make sure we benchmark them to see how we are doing against other organisations, and that is something that together with the management team we have been expanding on. And there is still more work to be done, obviously, but we are happy with the progress that we are seeing in that regard.

The Chairman: To Dr. Jefferson specifically. I know you have been working on medical staff bylaws for some time which would tend to improve and strengthen the institution. Where are we with the implementation of those bylaws?

Dr. Delroy Jefferson, Medical Director, Health Services Authority: Mr. Chairman, thanks for inviting me.

We have recently completed the medial staff bylaws. The bylaws were passed on to all the relevant senior staff and also members of the board for their input. It was also sent to legal counsel for their input as well. We have had two rounds of legal counsel's input and that is completed. And a few weeks ago the final document was handed to the board's secretary.

The Chairman: So, it is awaiting board approval now?

Dr. Delroy Jefferson, Medical Director, Health Services Authority: It is awaiting board approval.

The Chairman: Will that include measurement such as medical audits and peer reviews through which you can identify overutilization, length of stays, et cetera?

Dr. Delroy Jefferson, Medical Director, Health Services Authority: It does. It includes all of that. It includes a number of indicators that are necessary in order to measure the quality of service that is provided. Also, it basically includes various risk adverse issues that one needs to address in the setting of a hospital. All of that is included.

The Chairman: Do you envisage having put those mechanisms in place that you will be able to influence policy decisions from the Ministry in terms of where you invest in human capital development, how it is invested, et cetera?

Dr. Delroy Jefferson, Medical Director, Health Services Authority: This is the hope: The hope is that having gotten the data that is needed in order to advise decision, having obtained the data, that could be fed to the Ministry so that that information could then be used in order to determine where best to place the emphasis on capital. And so, that is one of the intentions.

The Chairman: The other side of it is: What participation are you allowed or requested from the Ministry in terms of policy putting in place and/or adjustments to legislative . . . are you consulted or are you encouraged to recommend changes to legislation that would . . . and can you give us examples of when you were allowed to exercise that and how long it took to get the policy or the law in place?

Dr. Delroy Jefferson, Medical Director, Health Services Authority: Yes, as the Medical Director I have been invited to sit on a number of policy committees, working groups. For example, the most recent one is the cannabis legislation. I was invited to sit on that and prior to that I sat on when we had meetings for the National Strategic Plan for health. I was invited as well to sit on that committee. So, the Ministry has used the opportunity to encourage participation from my perspective and from some of the other staff as well.

The Chairman: In your case, Ms. Lizzette, in terms of . . . I guess his would be more related to quality care and yours would be more related to costing and stuff like that. But, for instance, when is the last time the HSA did an actual costing exercise as in relation to what you charges are, so that we can have some assurance that your charges are actually related to cost?

Ms. Lizzette Yearwood, Chief Executive Officer, Health Services Authority: Good question, Mr. Chairman. Actually we are about to perform that exercise soon. That is one of our objectives in the course of the next year, to do a costing exercise and to really align our charge master to look at all of the codes as well to make sure that we are charging appropriately according to the CPT-4 codes that are in the charge master. So, we aim to do a comprehensive review of our charge master. That is quite an onerous exercise but it is a necessary exercise. It is one that we kind of been holding off from for a number of years because we felt that if we conducted the exercise, it is costly one, human resource as well as financial. But at the same time we felt that we needed to do something with the information and you don't always have the ability to influence the prices because you know we have a very lengthy process in order to be able to change the prices in our charge master. But it is important that we are able to know with some confidence that we are charging appropriately, for our shareholders as well as the public.

The Chairman: Why is it so lengthy and so difficult to have a change to the charge master? If it is going to take a couple of years you could lose thousands of dollars on one transaction or millions of dollars on the whole thing. I would think that one of the things that the board would want is a very efficient and effective system to adjust your charge master.

Ms. Lizzette Yearwood, Chief Executive Officer, Health Services Authority: Absolutely. Yes, it is not something that is . . . it is a process that is lengthy because the board thinks it should be lengthy. It is just a number of steps that it has to go through because it has to be gazetted and it has to go through—

The Chairman: Okay, but—

Ms. Lizzette Yearwood, Chief Executive Officer, Health Services Authority: Sorry, just let me finish.

So, the process takes . . . we have to make the recommendation to the board, the board then takes it to the Ministry, the Ministry takes it to Cabinet and Cabinet then needs to see the need to take it forward to the Legislative Assembly. And ultimately, I think the reason why it is not something that is adjusted without a lot of thought and concern is because any changes that we make in our prices, obviously, could potentially influence the cost of insurance for a number of people throughout the country and I think that that is something not taken very lightly.

The Chairman: But that concerns me and worries me because, why do Cabinet and the Legislative Assembly need to approve your changes to your charge master when you are charged under the law to effectively and efficiently manage the Health Services Authority?

Ms. Lizzette Yearwood, Chief Executive Officer, Health Services Authority: Currently, that is the process as is gazetted by our Health Services Law, in that it has to go through that process.

The Chairman: I've been here now a couple of years and I don't remember any changes coming to the Legislative Assembly. You mean, it has been eight years or longer that you have not changed your charge master? I would proffer that the changes and the cost of health care are much more rapid than that and I would think that that is one of the things that as a matter of urgency you need to make urgent representation to your board to change that format, and the board having been charged under the legislation, I think, should be the final arbiter of your cost.

Ms. Lizzette Yearwood, Chief Executive Officer, Health Services Authority: Yes, I think the last change that was made on our charge master was probably about four years ago. We had all of our procedural prices that were increased up to the standard health insurance fees. But, like I said, this is something that is seen as a priority by the board.

The Chairman: Did you say four years ago your charges were brought up to the standard health insurance fees?

Ms. Lizzette Yearwood, Chief Executive Officer, Health Services Authority: Absolutely.

Dr. Delroy Jefferson, Medical Director, Health Services Authority: Yes.

The Chairman: Well, why would you be charging that is less than the standard health insurance fees? In fact, the modus operandi is that you should be 20 per cent over so that you collect your real cost. But is that still the current situation that there are charges on your card that are below the standard health insurance charges? So, what happens if I come there with my insurance card and your charge is $100 but the standard health insurance charge is $150? You are only charging me the $100 and not the $150?

Ms. Lizzette Yearwood, Chief Executive Officer, Health Services Authority: Mr. Chairman, I just said that all of our prices have been brought up the standard health insurance fees so if the standard health insurance fee is $150, we are charging $150.

The Chairman: Now?

Ms. Lizzette Yearwood, Chief Executive Officer, Health Services Authority: Yes sir.

The Chairman: But if the standard health insurance fees float again, do you have the mechanism in place? And are you authorised at board level to adjust those fees, or do you have to go through this process of convincing the Ministry?

So, the charges at the hospital are more related to political will than they are to actual cost? Is that a fair statement?

Ms. Lizzette Yearwood, Chief Executive Officer, Health Services Authority: Mr. Chairman, as I mentioned earlier when we started this conversation about the fees, we are going to be undertaking an exercise to review our charge master so that we can say with some confidence whether or not the charges reflect what they should be or whether they are not. I can't with any confidence that they don't reflect at this point in time.

The Chairman: I'm a little bit off base. I'm being tilted here. I would think that the larger basis for the standard health insurance prices would be what the hospital charge because it should be safe to make the assumption that the hospital is charging the real cost with a minor profit in the end to look after your bad debts and other things. Are you suggesting that the possibility exist that the private providers of health care have more influence on the standard health insurance cost than the HSA?

Ms. Lizzette Yearwood, Chief Executive Officer, Health Services Authority: No sir.

Mr. Chairman, I don't suggest that at all because when the Health Regulatory Services conduct their exercise with their actuaries they ask HSA for all of their prices and we provide all of the prices that we currently charge. Now, obviously, we provide the prices that we charge, so, that is why it is important to make sure that we do this costing exercise to be able to say with some confidence that the prices that we charge accurately reflect what we should be charging. But they certainly take into consideration all of our prices. Because like you said, we probably represent the broader cross section of the standard health insurance fees.

The Chairman: What other mechanisms, other than what Dr. Jefferson referred to as to medical staff by-laws medical audit . . . Do you have in place any form of metrics that monitors for you on an administrative level, so that you can represent in your monthly report to the board whether you are in fact achieving outcomes that you are expected to achieve by the board or therefore the Ministry?

Ms. Lizzette Yearwood, Chief Executive Officer, Health Services Authority: In regards to quality of outcomes, Mr. Chairman?

The Chairman: Quality of outcomes, costing, spending . . .

Ms. Lizzette Yearwood, Chief Executive Officer, Health Services Authority: Yes sir, we do have various components. We do have components to our quality programme and we have financial components to that monitoring and we report on those on a monthly basis and some on a quarterly basis. And, like I said, these are things that are also monitored by various committees, especially, when it comes to quality, we have various committees that feed that information up to our quality programme as well and our patient safety committees. And we have peer review committees that monitor these things because, obviously, you being a clinician know that quality is everybody's business and we have to make sure that everybody is focused on quality to ensure that we protect our patients, our staff and we mitigate any sort of financial loss that we should be.

The Chairman: Obviously, you have included in those metrics infectious rates et cetera, and you can demonstrate that you have proper infection control and mechanisms and all of those in place.

Ms. Lizzette Yearwood, Chief Executive Officer, Health Services Authority: Yes sir, like I said, we are working on building a one page score card so that we can show, not just those quality rates but also have them benchmarked so that we can actually show how we benchmark those and how we reflect against other organisations of similar size within the region.

The Chairman: When it comes to frequency on indices of disease, are you going to separate Caymanians from non-Caymanians so that we have a better picture of what are real in comparison to what the international benchmarks are? And the reason I asked that is because in the Auditor General's report he points out that a large percentage of our population is largely transient and if you look at the total amount, it shifts it, in my view, in the wrong direction. So, I was just wondering if you will make that adjustment.

Ms. Lizzette Yearwood, Chief Executive Officer, Health Services Authority: To be honest, Mr. Chairman, we actually haven't had a meeting to discuss that point but that is a very interesting point that was brought out in the report. And I think with the information system that we have, I think we can extract that information and just report on that differently. I think we can.

The Chairman: You wanted to say something Dr. Jefferson?

Dr. Delroy Jefferson, Medical Director, Health Services Authority: No, Mr. Chair, I am supporting the CEO on that one. That is something that our current electronic medical record system allows us to be able to do that. In fact, just yesterday I had a meeting with the IT department along with the Medical Officer of Health to look at the incidents of chronic non-communicable diseases and to formulate a framework where we would be able to list all of the chronic non-communicable diseases, the ones that are of the highest incidences, and also to report on it. In fact, the Ministry of Health has provided some funding to assist in providing the software that we are going to be in need of.

Yesterday we had a stakeholders meeting. We did not actually, at the time, thought of dividing it into Caymanian versus non-Caymanian. We were looking at a number of other demographics, but having read the report it definitely would be a useful thing to do so we could have that information as well.

The Chairman: I know that the HSA provides a certain public health component to government. How is that requirement of the public health legislation and reporting mechanisms from private physicians? And do you as the HSA report your information to the Public Health and that is kept separately so it can be analysed? Or does everything come to you because you are providing the service to government?

Ms. Lizzette Yearwood, Chief Executive Officer, Health Services Authority: I will take that one, Mr. Chairman.

Mr. Chairman, the Medical Officer of Health performs that function on the behalf of the HSA and also the Ministry of Health through that output. And all of that data from the private sector as well as HSA is collated through that office and reported to PAHO and WHO.

The Chairman: Is that confined currently from the private sector to communicable diseases? Or do you get any information as to the incidences of the non-communicable diseases?

Ms. Lizzette Yearwood, Chief Executive Officer, Health Services Authority: Good question.

Mr. Chairman, that information is really only the communicable diseases and that is the reason why the Medical Director just pointed out that the next step now is for us to include non-communicable diseases because realistically we don't have a good grasp as to what that information is right now. Anecdotally we know that we have a high incidence of some non-communicable diseases but we don't have with any confidence that data to say exactly what that is. So, we are establishing that database now, so that we can collate that information from all the various entities.

The Chairman: Dr. Jefferson to you.

What are your concerns with the advent of medical tourism? And do you believe you, or your medical officer of health, have the legislative authority to request that kind of information from the institutions that are licenced to provide medical tourism?

Dr. Delroy Jefferson, Medical Director, Health Services Authority: Okay, Mr. Chair, just prior to answering the question with respect to following up on the previous question, again, just yesterday, as I mentioned, the Medical Officer of Health and I met with some stakeholders and we decided that it was necessary to have the chronic non-communicable diseases where the problem is now in the region. In fact, the CARICOM health desk has been focusing on non-communicable diseases and has said that that is where we ought to be focusing.

Now, what we have decided to do is to work in conjunction with all the other providers of health care, including the providers of medical tourism to obtain the information that is needed to be placed in a national database. And so, we have put a plan together to meet with the various stakeholders within the private sector so that their data could be collated with data out of the HSA and use that information for the purpose of reporting.

With respect to obtaining the information that is going to advise the Government as to what is happening nationally, I don't have a lot of concern with respect to getting the information from the other stakeholders, including the provider of medical tourism. So, from that perspective I am pretty confident.

Recently, we have been having dialogue with the provider of medical tourism, with one of the key stakeholders in medical tourism and they have indicated their willingness to work along with us to ensure that that data and the various indicators are obtained. So, I wouldn't say I'm very anxious about that now.

The Chairman: Does the plan include using that information to request policy directives and legislative changes from the Ministry through the board, both on the treatment side and on the preventative side? And what likelihood do you believe that that can be achieved?

Dr. Delroy Jefferson, Medical Director, Health Services Authority: Well, we are hoping that having obtained the data, that data is of no use if it is not going to be used to achieve something. And it is not just data for the sake of data. We are hoping that having had the data, that that will inform change. So, having obtained the data it is our hope that the Government will then use that data to direct the resources in the right places. So, that is the intention. And we are hoping that the various players within the private sector will be willing to provide the data freely so that it will be useful and will be meaningful.

Mr. Winston C. Connolly, Jr.: Mr. Chairman, through you.

Specifically looking at page 22 under "The Performance of the Cayman Islands Health System is not known and accountability to the Legislative Assembly and the public cannot be rendered"—in terms of the targets and objectives or the lack thereof as set out in the report, if the Ministry has not provided targets and objectives for areas like those mentioned here—quality of care, health outcomes, access to care, how does the HSA deliver an appropriate level of care and know that it is meeting expectations?

The second part to that is: Has it been considered or has it been done that the HSA then communicates back to the Ministry and says, *Hold on here, we don't have any of these set objectives, can you send them down?*

Ms. Lizzette Yearwood, Chief Executive Officer, Health Services Authority: Mr. Chairman, through you.

I think even in the absence of rolling the implementation plan for the National Health Policy, the HSA has continued to have its own strategic policy and strategic plan that we review on an annual basis. And because we have a cross section of stakeholders when we review our national strategic plan, we are able to be informed about some of these objectives

and are able to report to the Ministry on them. If there are certain things that are flagged that we have resource issues on, then we will communicate them through to the Ministry of Health.

Mr. Winston C. Connolly, Jr.: Mr. Chairman, through you.

In your experience then, what occurs after you do that reporting? Is there any kind of suggestions that your own strategic plan is on-side or offside, the kind of government and ministry strategic plans? Meaning, the level of communication—If you send something up the chain, is it coming back saying, *okay, you are doing what we hope you would do or you are doing it in accordance with government policy, the Government of the day policy?*

Ms. Lizzette Yearwood, Chief Executive Officer, Health Services Authority: Mr. Chairman, through you.

That communication would usually come through to the board to make sure that the strategic policies are on par with what is expected from the Government. That type of communication does not necessarily come directly to the operational side unless it is something in regards to resources. For example, if I request increase in funding for a particular output, that would be something that we would communicate directly.

The Chairman: Like mammogram machine. Anyway, . . .

Ms. Lizzette Yearwood, Chief Executive Officer, Health Services Authority: Let's . . . yeah. I would prefer not to go there.

The Chairman: We'll get it.

Ms. Lizzette Yearwood, Chief Executive Officer, Health Services Authority: We'll talk about that.

Mr. Winston C. Connolly, Jr.: Mr. Chairman, through you, just asking a question on the CayHealth programme.

We were told earlier today in an earlier testimony that at times there are double payments because there is no real tracking of the clinics versus the hospital. So, sometimes people are going to the clinics for one thing and then going to the hospital for the same thing and there is a double payment, especially because it is the indigent population we are talking about, and there is a pass through to the government for those costs. Is there any mechanism at the HSA coming out of this report and testimonies like that where you can assure this Committee and the public that more attention is being taking on the double payment aspect that was the head of CINICO's testimony?

Ms. Lizzette Yearwood, Chief Executive Officer, Health Services Authority: Mr. Chairman, through you.

I would beg to disagree with that description as a double payment. In that example that you have just described, if the individual has actually seen two practitioners, it is not in essence a double payment because we are being paid for two different services. But perhaps the utilisation is inappropriate. There is overutilisation and that is exactly one of the targets that we had. That is one of the objectives of the CayHealth programme, because we recognise that that is the case with all of the people of the Cayman Islands; we perhaps overutilise the care. We utilise health care. So, we started with that population because we felt it was a manageable population, around 1,200 people. And we said one of the things . . . the two objectives were 1) to improve outcomes and reduce the cost by assigning every individual to a primary health care provider. So, you would have your name, general practitioner, and that general practitioner would have ownership and would have an overall understanding of your total health care and would have some sort of ownership as to making sure they follow you up to see why you didn't attend your appointments, to make sure that they were your first point of contact. And to make sure that they do your annual screens, if necessary, depending on your age group.

We have actually had some really good statistics as a result of that. So, much so, we are embarking on the next phase now. We are going to be rolling that out to a next group, to the civil servants. And hopefully by June we will have civil servants in line with their own primary health care provider. Again, because for one it is best practice and we have seen positive outcomes; so, just to show you some of the data that we have seen from that. We started this programme in 2010 and this is 2017.

So, we've had the general practice encounters increased from 44 per cent to 67 per cent. And the specialist clinic encounters, they decreased from 37 per cent to 21 per cent. But that is what we wanted. We wanted people—

The Chairman: Yes, but the first question I am going to ask you there is: Has the health of the patient improved?

Ms. Lizzette Yearwood, Chief Executive Officer, Health Services Authority: Yes. Yes, Mr. Chairman, that is a very good question, because we also measure their other stats. We measure their blood pressure, their HBA1c. We look to see whether or not more people are actually coming into the dialysis unit, so those things. So, it is not just the cost, because obviously the cost is aligned to where they access the service, right? But it is also, whether or not we influ-

enced their numbers, whether their numbers are improving.

In order to make sure that we are . . . I mean, obviously, there are other reasons that could influence their statistics, right? But we try to keep that same population because we knew that if new people came into that group you would be entering other new factors, right? So, we kept the same population that entered to the CayHealth programme in 2010 and we have monitored them throughout that.

Now, we are also into discussions as to how do we include the other indigents who have now come on board as well, because we want them to be part of this success as well. But because this was the first programme we wanted to make sure that we could be accurate as possible in measuring our outcomes, so we kept that same cohort of patients that joined the programme in 2010.

The Chairman: Here is my concern: You say you hope to roll it out to the civil service by June, but we have other ministries in government that is contemplating charging civil servants co-pay and giving them freedom of choice, which means that you are not going to have them as your captive audience in such a group. And this is the concern of the Committee, that there are too much silos because here we have an underground programme by yourself that has produced certain successes and you should be congratulated on it, but then you have the other programme being evaluated slowly on the finance aspect of it, and we are looking as to how . . . because you are not going to be able to coordinate those people if they can go to a private physician which is what they all are going to do, which is what they are going to be encouraged to do by their government employer because they can get a better appointment system and they can get seen better and they believe the savings in employee time will offset those charges. So, this is our concern in terms of you at the ground level having a clear channel of communication up to the Ministry of Health for policies that will prevent that kind of diversion (so to speak)

Ms. Lizzette Yearwood, Chief Executive Officer, Health Services Authority: Mr. Chairman, I totally agree with you and that is why that concern is there, but at the same time, we are very confident that if we provide a good level of care, a good service, the patients will continue to come to the HSA. And you are right, there are areas of improvement. We all know that and we have to continuously work on those areas to improve the access of care and the patient satisfaction, et cetera, and we are diligently doing that. But ultimately, the programme will be available to all those persons who would be willing and would like to access it, because we do believe that the programme works. And this is something that any provider can offer, because we want the people of the country healthy. It is not about HSA. And I think that is a beautiful thing about being in the public health arena, that it is not just about the bottom line, it is about the health of the people.

Mr. Winston C. Connolly, Jr.: Surely, the bottom line is important as well, and it is the people's money to begin with.

Ms. Lizzette Yearwood, Chief Executive Officer, Health Services Authority: Absolutely.

Mr. Winston C. Connolly, Jr.: In terms of this reporting itself, has the HSA Board taken on board its points and is there a plan now to perhaps use it as the basis of the kind of information gathering, reporting and all the other aspects that it has pointed out here? I think in the absence of anything it should be a good starting point that you can build on.

Ms. Lizzette Yearwood, Chief Executive Officer, Health Services Authority: I may be speaking a little bit out of turn, Mr. Chairman, through you, but I know my board well enough to know that they will embrace this because this report only came out last Friday, I believe, and we haven't had a board meeting since that time. But I know that the board will definitely embrace this and will definitely be focusing a lot on this because, like I said in the beginning, it is the first time that we have had a report like this that we can actually use as basis for some of the improvement and we will be able to report back to see how we have improved on this in years to come.

Mr. Winston C. Connolly, Jr.: Well, that is comforting because I think that that is the kind of checks and balances in reporting that it is necessary for the people of the Island to think and feel that the money that is being spent, because we see the skyrocketing cost and all the outlay, but how do we track that there is value for money? How do we track that people are being cognizant at each step? I think this will do that, so, recommendation to the board will be to follow what you have just said because, you know, I think it is just prudent to do that.

Again, just publicly, I'd like to congratulate the Auditor General's Office and the team for putting together, because in reading it as a layman and just a dumb politician, I was able to grasp some of those things that are from a performance standpoint, from a financial standpoint, from a strategic standpoint, that we need to be cognisant at all times. And it will certainly help someone in my position down the road to also make some strategic decisions, both at the government policy level, at the civil service level and for people in general to be more aware of how the whole system works and what is available, and some of the trends if you couple it with the other report that the country is seeing.

I just want to switch gears a bit and talk about capacity building. Yesterday in the testimony we had a number of discussions about the capacity building, particularly, doctors and what the appropriate standard of qualification should be. I am sure if you had not listened to it, you probably been apprised of it so far. Can you explain the system as it stands, of how doctors qualify to that appropriate standard that is acceptable to the HSA, the Ministry and the Government now?

Dr. Delroy Jefferson, Medical Director, Health Services Authority: Mr. Chair, through you, thanks a lot Mr. Connolly for asking that. And also, I just want to add to you appraise of the Auditor's report. I think it is indeed a very, very good document and it serves as a baseline. We at the HSA can use this document in order to advise where we go, and also in order to assist the Government from our perspective into where the focus should be and how to reach there.

With respect to the qualifications of the physicians, I am very passionate about having qualified physicians in the Cayman Islands, generally. I mean, one of my passions is quality and having quality benchmark, and we cannot have quality and very good outcomes if we are not using well good decent and qualified physicians. So, that is one of my passions.

Another passion is to see Caymanian physicians adequately qualified. I don't want to ever be in a situation later when I am old and grey that I am having sub-par physicians looking after me. I want to ensure that there is adequate capacity built into the system so that we have well trained physicians who are running the service.

That being said, at the HSA we have recognised that there was, in fact, in 2013 (I will just give a little background so that you are aware) there was a difficulty, for example, in obtaining internship training for Caymanian physicians. There was a crisis in the sense that the University of the West Indies, whereas they originally turned out 100 physicians, they were now turning out 300 trained physicians. In that year there was no available vacancy for the Caymanian trained physicians for internship. Now, once you are trained as a physician there is a two year period of internship that provides you with adequate exposure at the very basic level before you go on to post graduate training. It is my hope and the hope of several of the colleagues that all the physicians would at least get to post graduate training.

Now, because of the inability to find posting for some Caymanian physicians, the then minister of Health along with myself and some other stakeholders got in touch with the University of the West Indies and with some other key stakeholders in the regional regulating body, and suggested that they looked at what we have here to see whether or not we could do one of the two years of the internship training at the HSA. And through that initiative we had some of the senior physicians from the University of the West Indies, from Kingston Public Hospital, we had the Chief of Staff from the university, the then CEO from the university, the Dean of the faculty of medicine along with the Registrar of the Regional Registering body that came and looked at our system. At that time we thought if we were to train our interns in internal medicine and general surgery, then our interns would only need to be trained in paediatrics and obste/gynae [obstetrics and gynaecology] elsewhere. So, if we could get the hospital approved, accredited for those two specialties, then, at least, it would be less of a burden on Jamaica and elsewhere to provide for the other six months.

So, the internship programme is two years. The first year is three months rotation, and then there is a second year that they choose to do what they want. So, if we could get at least those two, medicine and surgery approved, then it would be easier to find posting for the other two.

Well, when the accreditors came to the HSA we had to go through two days of surveying, and they looked at our system. They said, "You know, we came with the intention of accrediting you to look to see if you were accreditable for surgery and internal medicine, but having reviewed your system and your processes and the consultants that you have and the calibre of the consultants that you have, there is no reason why you cannot be accredited for all four, paediatrics, obste/gynae surgery and internal medicine. And so after two days of deliberations they decided that we were adequately qualified to be accredited for all four. And so that was the birth of the internship period.

However, it was recognised by the senior colleagues that because of the volume of patients in the Cayman Islands and the depth of expulsion, since that, we don't have the diversity of cases to allow for adequate exposure for a young physician, we decided after the first year they had to go to a higher volume facility. Now, higher volume facility means somewhere in the UK, somewhere in Jamaica, somewhere in Barbados, anywhere where it is much higher to be trained for their second year.

I subsequently contacted the Jamaica stakeholders and they agreed to facilitate that second year. They were less willing to facilitate the first year because they had their own first year students that they were not able to place. But they were able to facilitate the second year with one condition, that that second year, those interns be paid for by the Cayman Islands Government. That was agreed with the Ministry, and so now, we've had the second year interns, they are now being sent to Jamaica for their second year experience. And we have had ten persons through the internship programme so far. And they have, in my opinion, all except one, have done very well. I think there are a few that have not gone into post graduate training. One of the very first interns from our pro-

gramme, she got a post in the United States in one of their internal medicine programme and is a shining star in that programme in the United States.

So, we have had some successes from the internship programme. Initially we had our teething pains. We had our difficulties but we've had some successes.

With respect to post graduate training, we've had some challenges with respect to obtaining funding for post graduate training but we have used the resources that are available to us to encourage and to get some sort of assistance for post graduate training. The HSA has worked along with the Education Department, with the Seafarers, for example, and recently last year we got three post graduate physicians sponsored for post graduate in various institutions. We definitely would love to see a greater, you know, more being done in that respect, but some progress is being made.

I don't know if I answered your question but the bottom line is that we are definitely not going to be decreasing the standard of physicians that are brought into the Cayman Islands under any circumstances.

The Chairman: We are very concerned about that. You know the barn door that was punched into the whole registration process which I didn't agree with, still don't agree with and never will agree with.

Our concerns are in terms of sustainability, in terms of . . . well, the question Mr. Winston asked is building the capacity. What is the resistance, if there is, from the Ministry of Health in providing adequate funding for post graduate training for Caymanians? And I am talking about for Caymanians only. Anybody else would have to get it on their own. Because, as you are aware and I am aware, there are agreements that the Ministry of Health could foster with other countries like Canada, UK, even Barbados and Jamaica at the governmental level which will enhance and reduce the cost of those post graduates getting those trainings. But the information we have—and we tried very diligently to nudge the chief officer in the Ministry of Health yesterday of the importance of moving in that direction but unfortunately there seems to be, from my point of view, and I can't understand the resistance of wanting to do that. But there was demonstrated resistance and reluctance to go down that route.

I wonder if you have, in fact, put such a proposal to your board with the request that the board put the proposal to the Ministry that the Ministry of Health accepts the responsibility for instituting a policy that allows you to provide and organise that they will fund that kind of needed post graduate training for Caymanian physicians. Their constant response was that that is a matter for Education and they must apply for a scholarship. Now, you and I both know that US$20,000 a year is not going to get you into a post graduate course. So, I wonder if you have gone through that exercise and not been successful and if you haven't, if you would be prepared to accept a recommendation from this Committee that you, as a matter of urgency, put such a proposal to your board to be sent to the Ministry for them to make a decision on the government policy.

Along with that for future use, if the Ministry of Health is not going to do it because they regard education as a responsibility of another Ministry, is that you use an alternative route to the Ministry of Education, so that when a Caymanian is given a scholarship to do medicine, that scholarship includes the cost of the post graduate work. And we understand that it is a 12 to 13 years commitment and not a 4 year commitment, because we have been told by a certain sector that if you do 4 years of academic and you go and pass CAMC exam—and I see proposals in the paper now, we are going to train physicians in urgent care facilities—that that is adequate for Caymanians in terms of us being able to sustain the quality of health care that we have.

Ms. Lizzette Yearwood, Chief Executive Officer, Health Services Authority: Mr. Chairman, I will take that one. I think what you have outlined is very important and we will definitely take that on. I think what you have described and what Dr. Jefferson has just outlined, is probably just the birth of capacity building for physicians in the country, because what he described that we saw in Jamaica in 2013 is what we are seeing in Grand Cayman as well. We are seeing a number of persons who want to enter into the profession of health care and in particular, in medicine. So, what this is going to require is really a national approach with input from all the stakeholders. And it is not just to fund anybody who wants to enter into the medical profession. We really need to look and see what the specialties are that we require as a country because we don't want to just—

The Chairman: Which, statistics will demonstrate that you do need.

Ms. Lizzette Yearwood, Chief Executive Officer, Health Services Authority: Exactly. So, we don't want to fund any and everybody into just one set profession. We want to make sure the country is adequately provided for in the future as well. So, it is not something that we put forward before on a cohesive basis. You used the word "organised". We haven't done that as one proposal but what we have had is individuals with both the Ministry of Health and the Education Department in not just the individual basis but the cost because even the Education Council, they really didn't have a good understanding of the process as well as the cost. So, they're interested and asking questions and they ask for the input of both the CMO and the Medical Director. They sit on the panel

when they do interviews and that sort of thing, but that dialogue has just started and it really has not been a very cohesive process up until now, but I think it is necessary for us to do that in order for us to be able to plan the adequate resources in years to come because it is not just for this year. But if you send 4 physicians out there at $100,000 a year, you need to make sure you plan for them for the next four years because you need to sustain them.

In years past we've talked to physicians who have been in those specialty programmes in prior years and because there haven't been that many physicians in other hospitals in the region, they have actually been paid a stipend, so they could kind of sustain themselves but no longer are they able to get stipend. If they are going to get placement in these hospitals in other countries we have to be prepared to be able to support them. So, we take that on.

The Medical Director, I must actually publicly congratulate him because he is very passionate and has done a phenomenal job in working within our constraints, working with stakeholders in other jurisdictions to kind of make something out of nothing almost. And what he has also done is work with the other jurisdictions where we have had students who've had dual citizenship. So, if they had a Jamaican citizenship we have worked with that to make sure that Jamaica would actually give them a placement, so that Cayman did not have to support them for that placement. So, I must congratulate you, Dr. Jefferson, because he is very passionate about building the capacity for the physicians and he does try to do that on an individual basis and collectively we do need to put forward something that the Government can use to plan.

The Chairman: The response that that is their responsibility is really a very shortsighted and unacceptable response, because even out there in the financial industry you come back with an accounting degree. The firm that you are working with sponsors your CPA and your training and everything else. It is not entirely indifferent to that. So, we need to get a programme in place that takes care of those who have been waiting for so long. And we all know that every year you wait it becomes more difficult to do it for other reasons. I'm glad to hear that you will take that on.

One other question is: In your bylaws, in your facilitation of privileging according to credentials, are you going to invite private sector physicians to be privileged to your hospital according to their credentials?

Dr. Delroy Jefferson, Medical Director, Health Services Authority: Yes, Mr. Chair, definitely. The private sector physicians in the current situation, they are given privileges depending on their credentials and we intend to continue that. With the current bylaws we will be even scrutinising a little bit more. And there are certain conditions they have to meet in order to maintain the privilege. It is all about ensuring quality that is coming out of the facility, and so definitely the intention is that they have to maintain that quality that they are coming with. So, they have to come in with good quality and they have to be maintaining that quality in order to keep their privilege status.

The Chairman: Is there any consideration being given by the HSA to creating its own captive health insurance for malpractice?

Ms. Lizzette Yearwood, Chief Executive Officer, Health Services Authority: Mr. Chairman, every year when we go out to market to source malpractice insurance, that is one of the things that we have explored. And it is not something that we have embarked upon as yet but it is always something that we have explored and is still a possibility.

The Chairman: I would think that the first three or four years you may have to . . . there's some risk, but once you get beyond the fifth year, it is basically money in the bank. And Cayman being (is this true Mr. Financial Secretary?) is the leading place in the world for health care captives?

Mr. Kenneth Jefferson, Financial Secretary/Chief Officer, Ministry of Finance: Yes, Mr. Chairman, that was mentioned as recent as this morning at the CEO Conference by the Head of Cayman Finance.

The Chairman: So, it just seems wrong that we don't have one for ourselves when we are providing this for everybody else, because the rest of the world can't be wrong and we are right. And I would suggest that we seek out through—call the chairman of Cayman Finance and say, *Listen, we need some support here and some free consultation and we need you to help us set this up.* And maybe it is something that you could run it through the Cayman Health Services Foundation. Is that up and running yet?

Ms. Lizzette Yearwood, Chief Executive Officer, Health Services Authority: Mr. Chairman, yes, we do have the Foundation that is up.

Mr. Winston C. Connolly, Jr.: Mr. Chairman, not to keep beating a dying horse but just going back to the qualifications and the standards. If someone goes through the first year here, goes off for the second year, internship, and then goes to the post graduate training and they've done part of that in Cayman at the Cayman Islands Hospital, would they be able then to go anywhere in the first world and practice as an independent doctor?

Dr. Delroy Jefferson, Medical Director, Health Services Authority: Mr. Chairman, through you to answer that question, it is yes. We have had evidence of

that already, even though the internship programme started just a few years ago. We've had doctors from our internship programme who are currently in the States working. So, the answer is yes. Once they have done their internship here and they've done their SHO elsewhere and they have gone wherever to do their post graduate, they are qualified to work anywhere. Of course, if they want to work in North America they have to do . . . in Canada the Canadian Board and in the United States the States Board . . . the Boards there, the USMLE (United States Medical Licensing Examination]. But the answer is yes, so they are in no way sub-par if they are trained here.

Mr. Winston C. Connolly, Jr.: And how much collaboration do you do with the medical boards, the Medical and Dental Council and the other association type boards in terms of discussing quality and standards?

Dr. Delroy Jefferson, Medical Director, Health Services Authority: Mr. Chair, through you.

That is a very good question. In fact, we have gone through cycles. For example, when the internship programme was started, it was started in conjunction with the Medical and Dental Council. So, the Medical and Dental Council at the time was very involved in putting together the requirements for admission into the programme. They were the ones providing the guidance. To some extent I also reached out to some senior officials in other places, but by and large the Council was very involved.

Once the programme was up and running, the Council was less involved in what less involved in what was going on. There was an internship working group consisting of senior physicians who, they actually now make the decision. Lately, there has been collaboration now between myself and the current Medical and Dental Council in trying to understand and establish . . . in trying to seek out alternatives. For example, recently the Chair of the Council, as recent as two weeks ago, in fact, much recent than that as well, we have been having frequent informal breakfast meetings where we look at where we at as a nation with respect to the physicians and coming up with solutions. In fact, the Chairman recently got in touch with a colleague in the Bahamas and through that link we are able to establish some working relationship where now we will, if all goes well, be able to send for some experience, some of our junior physicians to the Bahamas. So, we are working informally.

We don't have a formal arrangement where once per week or so we meet, but we are working together in putting our heads together to see how we can actually make it work for the physicians who are here locally, at least until a formal structure is put in place that now provides for financing the post graduate training. And so, to the credit of the current Council, we have actually been brainstorming to see now, in lieu of not having the funding, what we can do as to how we can ensure that these guys get trained.

The Chairman: It is so unfortunate that you are, having, to work around not getting funding. You have no idea how much that upsets me, particularly when the Government declares it has $128 million surplus. And the reason I was asking all of the questions about influence in policy was because we have been presented with evidence that the Medical Council have been trying to get policy decisions and legislation going back to the 27th November, 2013, 18th February, 2014, 7th September, 2015, 8th March, 2016 to which they have had no response from the Ministry. Now, how can we have a ministry that is supposed to be constitutionally aerial in all the other legislation, responsible for policy and putting in place the regulatory mechanisms to do all of this and we have the Regulatory Authority corresponding with them asking for improvements with no response over a three year period?

So, I hope that by going through your board and going through to the Ministry with the support as I know you are working on with the Medical Council, that we can get these improvements in the standards and the requirements of qualifications to practice—because like you, and I am a little bit further ahead of you about getting old and worrying about when I get informed who is going to be giving me injections—and that we get to the point where the Government understands the absolute necessity to build capacity and to provide the funds to build the capacity. Because we have the expertise, the willingness, and the wherewithal, but for some unbeknownst reason we are not getting the funds and I find that difficult to comprehend.

Mr. Winston C. Connolly, Jr.: Yep.

Mr. Chairman, through you, yesterday, like I said, it was concerning when we heard the terms two-tiered system, the operational silos. And I think a lot of this was identified in the reports. The two-way communication is lacking and like the Chairman just said, letters go off but no responses come in. If the left hand does not know what the right hand is doing or you are duplicating efforts across hairs, then, money is being wasted, time is being lost and peoples careers are in limbo, because part and parcel as a country, as a government we do have a moral obligation to ensure that careers are enhanced to the point where capable people can take their place amongst senior practitioners in this country. And we heard some amounts that were being spent on visiting specialists for a short period of time and if Caymanian doctors could get to that level and those levels of salaries et cetera, not only would we have immense pride in our home grown talent but we would also be saving some of that money and putting it back to work within our own economy. So, this is not just about medicine and

qualifications and standards, it is also about economic policy and other things. It is such a wider breadth.

One last question . . . well, sorry, two questions: In terms of succession planning, can you describe how that works now for doctors, especially Caymanian trained doctors? Let's say they've hit all of the appropriate standards, they are back. How do we treat them post qualification when they are now fully qualified and doing their own thing?

Dr. Delroy Jefferson, Medical Director, Health Services Authority: Mr. Chairman, through you and thanks for that question.

When I took the post of Medical Director, one of the things that I developed was that I sort of tried to find all of the qualified Caymanian physicians that were out there. It did not matter whether they were fully qualified or if they were in training. I created a database of all the physicians, where they were, what they were doing, at least as many as I could. I sent out emails asking colleagues to find out whether or not there were others who were not on the list. And I created a list of Caymanian physicians that were out there. And at the time, I had 32 on the list. I also created what they were doing or what they were interested in doing, and I identified where the gaps were in our health care system. There are several gaps in terms of the availability of trained physician; Caymanian or non-Caymanian for some areas. For example, pathology has been an issue, radiology has been an issue. We've had problems with getting qualified, pulmonologists et cetera. And what I have done is I have contacted almost every single one on the list to encourage them, first, to find out what are their interests and to encourage into moving into one direction or the other, depending on where the need is greatest.

Almost on a weekly basis . . . yesterday I had one of the young Caymanians who is returning. She came to talk to me because she said I have just completed my SHO [Senior House Officer], I am now going on to post graduate training. I am applying to a number of universities. I want for you to guide me into which one of the universities you think is the best one to go to and she gave me a list. And the universities that she wanted to go to—she is one of ours that we trained as an intern—were all very good schools. In fact, the school that she was most interested in, I was very happy that she was choosing that school. But then she said she wanted to do intern medicine and I said to her, *Well, yes we have quite a lot of internist on Island. We have a lot of Caymanian internist but we don't have any pulmonologist. What about doing pulmonology?* She said *You know you are right.* I said, *We have no neurologists.* She said, *No, I don't want to do neurology but I will take on the pulmonology and I am going to be applying to do that or endocrinology.*

So, on an ongoing basis what I have done, there is every single one of the young Caymanian physicians at the hospital. One of the things that they have to do is report to me on an ongoing basis where they are, what they intend to do, when do they intend to get started and my role as medical director is to steer them into the direction of need, taking into consideration what their leaning is. In other words, I don't try to say, *Well, you want to become X and we have quite a lot of that.* But I gently encourage them in saying, *You know, we have enough of this, why don't you consider doing that.* So, from a succession planning perspective I have been mentoring the young physicians. We have about 12 young Caymanian physicians at the hospital who are all my responsibility as it relates to getting them into the right specialty.

To the other part of the question: Once they are qualified and they come home, they are treated like any other of the consultants. Once they are fully qualified and have had the experience, they are encouraged to take on the role of a consultant. And sometimes shortly after coming home they don't have the experience that is required to function fully in the role but with adequate handholding, usually over time these guys do well and we have examples of that.

Mr. Winston C. Connolly, Jr.: Thanks for that.

When I look at these things and I look at it across the board, because I am very passionate about Caymanian advancement on merit but with proper guidance, handholding, exposure and all of those things that make for the transition. We can't put somebody in a dark room, leave them there and ten years down the road say, *Oh, they haven't done anything* when you have not done your part. So, thank you for elucidating on that.

When I got my scholarship for undergrad many, many moons ago, there was a policy of the government of the day that basically did a priorities kind of profile of the gap filling; what the needs were for the country that were undersubscribed by Caymanians. And I was told at the time, there are scholarships available but they are available for these five things. So, unless you can pay for yourself and do whatever you want to do, here is where the need is and here is where the jobs will be if you take one of these five things. And I think that we need to get back down to that level where we say to the physicians out there, these are the areas that we are going to give the most money for; properly incentivise them monetarily. Again, because part and parcel of this is, if I know that I am going to get a full ride or a substantially full ride, that, might be a motivator to go into a certain vein of medicine that I had not considered before; if I know that I want to go into whatever is being an internist that I am going to get $20,000, but if I go into pulmonary I am going to get $80,000, that is a huge motivator. But what it would do as well is to fill these gaps in a strategic way so that the probability of someone taking up and filling that gap, I think would be greater.

When we looked at the budget figures and the appropriations, there was $128,000 left over. Can you explain why that is? Is it because people did not want to take up the opportunities? Or there were not people waiting in the wings at the time?

Ms. Lizzette Yearwood, Chief Executive Officer, Health Services Authority: Mr. Chairman, through you, that training item in the budget is internal training. That is training for continuing professional development of the current staff. So, it is not post graduate training. It is not special training. It is not for them to achieve degrees and all of those sorts of things because it is a small sum of money. Normally, it is under $300,000 a year for the entire staff. So, it is to send our people on conferences. There are specialty trainings, for example, say we need to train a physician in bariatric surgery on a procedure. So, it is more of a directed type of training. And in that particular year there was some customer service training that was done but was done in the latter part of the year and so it did not get drawn down right at the end of the budget period. But that is not for training that we would send physicians for post graduate training.

The Chairman: Dr. Jefferson, just give me a ballpark figure. What is a number that you need to have in place to put in place this wonderful programme that you are putting in place and that you want to put in place to build capacity?

Dr. Delroy Jefferson, Medical Director, Health Services Authority: Mr. Chairman, yes, for each of the post grad students, under normal circumstances, there are at least three physicians at least who are qualified per year for post graduate training. And it is approximately $100,000 per physician per year.

The Chairman: You're talking no more than $500,000—

Dr. Delroy Jefferson, Medical Director, Health Services Authority: Per year.

The Chairman: If the Government granted to the HSA half a million dollars, you could work with that to qualify your three to four board certified specialists that you need—

Dr. Delroy Jefferson, Medical Director, Health Services Authority: Annually.

The Chairman: —annually on a regular basis?

Dr. Delroy Jefferson, Medical Director, Health Services Authority: That is correct.

[Inaudible interjection]

Dr. Delroy Jefferson, Medical Director, Health Services Authority: Oh, right. Yes. That is correct.
The Chairman: Mr. Jefferson.

Mr. Kenneth Jefferson, Financial Secretary/Chief Officer, Ministry of Finance: Mr. Chairman, thank you sir.

That was precisely an area that I wanted to go to. Usually we don't ask questions on this side, we are here to answer questions. But I wanted to say to the Committee that looking into the central government's budget I do see for the 18 month period, there is a figure of $225,000 for 18 months, which, if you simply did that for 12 months, it would be $150,000. It is described as medical internship programme. The number of interns against which that is described is the number 3. So, the question I wanted to ask was: In relation to all of the discussion, the number of interns being 3 in the budget document, what was the desired number instead of 3? And the $150,000 works out to be $50,000 for a year. What does that $50,000 need to become? Does it need to become $60,000? I think Dr. Jefferson just said $100,000. So, I wanted to question to bring focus on the number of interns—

The Chairman: I think you are talking about two different things. That is what is funding your prequalification, one year internship at the hospital and the ability to send them overseas for that one year before they become qualified for what would be provisional registration and then one year supervision clinical and they get principal registration.

Dr. Delroy Jefferson, Medical Director, Health Services Authority: That's correct.

The Chairman: What we are talking about now is going beyond that qualification to board certification which is a two to three year programme. And what he is saying is that he could live with a half million dollars a year to fund that capacity and he would be able to do two or three physicians each year.

Dr. Delroy Jefferson, Medical Director, Health Services Authority: That is correct.

Ms. Lizzette Yearwood, Chief Executive Officer, Health Services Authority: Mr. Chairman, if I could just make one comment about where that funding is placed. It is really probably irrelevant but the funding that the veterans and seamen gave, for example, instead of giving it to the Health Services Authority, since we already had a mechanism in place at the education department, the Education Council had a mechanism to do the interviewing and to assign scholarships and all like that. We had them give that scholarship money to the education council, the education department, and then we participated in that

process of selection. So, we would be fine if that money was earmarked—

The Chairman: No, no, I don't want it done that way.

Ms. Lizzette Yearwood, Chief Executive Officer, Health Services Authority: Okay.

The Chairman: I want to give it to him because I am going to hold him responsible and accountable and I am going to count how many people each year he gets board certified with the funding. If you put it to the education council it is going to be extremely difficult to monitor it, extremely difficult to hold them accountable within the framework of all the other scholarships that they are doing which are probably in the region of hundreds of people right now. So, what I am looking for is a specific funding for specifically to building the capacity of board certified Caymanians through the HSA and the Financial Secretary (not me because I might not be around) will be able to hold Dr. Jefferson, as the Medical Director, responsible for the outcome of that half a million dollars in terms of getting people board certified. If they fail the exam it is not your fault but at least you get them there to do it.

Ms. Lizzette Yearwood, Chief Executive Officer, Health Services Authority: Okay, Mr. Chairman.

I do respectfully disagree with you that you can't hold the education council accountable because when we gave them that money from the veterans and seamen to say this is for two scholarships they delivered on that and they do have a very vibrant process and it has been a process that has been worked and reworked a number of times, so I was happy to use that process rather than us creating in-house. But I take your point.

The Chairman: But you see this is a little different because he is going to be able and be responsible as medical director for the evaluation of these people having gone through the one year internship under him and his senior physicians and he has organised for them to go for the one year and he also supervised them for the one year of clinical supervision in order to get their principal registration and then, he will be in a position to choose the people and influence them into the areas of need for the HSA. And I will talk to you a year from now about the education council because I am still trying to get for about three or four years how many qualified accountants come back each year.

Mr. Winston C. Connolly, Jr.: Mr. Chairman, through you just switching gears for a bit.

Ms. Yearwood, you spoke about customer service before and I see in the report where (specifically page 29 on paragraph 100) you started surveying patients to talk about their experiences and the scores show that there needs to be improvement. What specifically have you done since those surveys to address the results of those surveys?

Ms. Lizzette Yearwood, Chief Executive Officer, Health Services Authority: Thank you very much and Mr. Chairman, through you.

Yes, we embarked a couple of years ago in regards to a patients' satisfaction survey. First it was administered by email. However, we had minimal responses and there were various limitations that were relating to the email, that we felt the responses were not really necessarily representative. So, the method was not really as useful as it had been expected. So, just recently we have embarked upon using telephone surveys and we feel like that has enabled us to reach a wider cross-section of patients and therefore obtain better and more valuable feedback. And, you know, this feedback is usually collated and we can use the numbers overall. And there are various feedbacks in regards to, say, for example, the customer service that we deliver at the pharmacy, and we have used feedback in order to modify the service that we have delivered there, as far as dropping off prescriptions for refills. We take the feedback. I mean, something as simple as not having a water cooler in the pharmacy, little things like that we can—

The Chairman: Three lines.

Ms. Lizzette Yearwood, Chief Executive Officer, Health Services Authority: Sorry?

The Chairman: Three lines.

Ms. Lizzette Yearwood, Chief Executive Officer, Health Services Authority: Yeah. So, it is simple things that we can actually make modifications because we have to meet the expectations of the patients. And it goes a step further than that, that they can actually give us specific feedback. So, the patients themselves may say, *Well, you know I had a bad experience in this area because I did not get a response from this department* They will actually give us the contact information of that patient and will enable the patients service team to contact that patient to try to remedy that relationship. So, that is particular is very, very useful to us.

The Chairman: Any other questions?

I guess just to thank you all very much and I guess what has transpired here this afternoon is that it is so unfortunate that all the recommendations the Auditor General made have only been "noted" by the Ministry. And I think that from what you have told us, you seem very well organised to deliver and wish to deliver many of these that want to be done. Thank you all very much for your time.

Ms. Lizzette Yearwood, Chief Executive Officer, Health Services Authority: Thank you very much too, Mr. Chairman, and we thank you for the time that you are putting in to drilling down because we in health care are very excited about outcomes obviously. That's why we are in the business and we really look forward to seeing the results in future years.

Dr. Delroy Jefferson, Medical Director, Health Services Authority: Thank you.

The Chairman: Be careful what you wish for; election is coming up.

The Committee is adjourned at 4.46 and 23 seconds.

At 4:46 pm the Public Accounts Committee stood adjourned.

Legislative Assembly of the Cayman Islands

THE STANDING PUBLIC ACCOUNTS COMMITTEE

MINUTES

Hearing held *with Witnesses*
Friday, 3rd February 2017
9:00am

Minutes and verbatim transcript of the meeting of the Standing Public Accounts Committee held in the Chamber of the Legislative Assembly Building, Grand Cayman on Friday, 3rd February 2017 at 9:00am.

- **Present:**
  - Mr D Ezzard Miller, MLA – Chairman.
  - Mr Winston Connolly, MLA – Member.
  - Mr Joseph Hew, MLA – Member.
  - Ms Manesa Webb – Acting Clerk of the Public Accounts Committee.

- **Apology:**
  - Mr Roy McTaggart, JP, MLA – Deputy Chairman.
  - Capt. Eugene Ebanks, JP, MLA – Member.

- **Attendees:**
  - Ms Sue Winspear, Auditor General – Office of the Auditor General.
  - Mr Ruben Martin, Director of Performance Auditing – Office of the Auditor General.
  - Ms Angela Cullen, Acting Director of Performance Audit – Office of the Auditor General.
  - Hon Kenneth Jefferson, Financial Secretary/Chief Officer – Ministry of Finance and Economic Development.
  - Mr Matthew Tibbetts, Accountant General – Ministry of Finance and Economic Development.
  - Ms Ann Owens, Deputy Chief Officer – Ministry of Finance and Economic Development.
  - Ms Gloria Myles, Deputy Accountant General – Ministry of Finance and Economic Development.
  - Mr. Julius Aurelio, Audit Manager, CIG - Office of the Auditor General

1. Reference

In accordance with sections 73(1) and 77(4) of the Legislative Assembly Standing Orders (2006) Revision, witnesses were invited to appear before the Committee to discuss various issues set out in the following Reports of the Auditor General:

a) *Cayman Islands Health Care System- January 2017*
b) *Ensuring Quality in Health Care & Healthy Population – January 2017*

2. Hearing to Order

There being a quorum present, the Chairman called the Hearing to order at 9:00am.

3. Welcome

The Chairman gave a brief welcome to the Members of the Public Accounts Committee and the staff of the Office of the Auditor General and the Ministry of Finance and Economic Development.

PAC Member, Mr Roy McTaggart, was not in attendance. Excuse accepted and approved from 01-Feb-2017 upheld (Acting Minister of Home Affairs & Culture until the 16 February 2017.)

PAC Member, Capt. Eugene Ebanks, was excused due to a medical appointment.

The Chairman acknowledged these absences.

4. Report of the Auditor General: –

Cayman Islands Health Care System – January 2017

The Auditor General made an opening statement on the above mentioned Report and the hearing(s) commenced at 9:35am. The Chairman then invited witnesses to the Chamber and asked them to state their names, the persons attending with them if any and department or organization they were representing. The Chairman then opened the floor for statements from the witnesses followed by questions from the Members of the Public Accounts Committee.

The following persons listed below appeared in their named capacity as witnesses before the Committee for this Report:

- *Dr. Ethel Elisabeth McLaughlin- Chief Medical Officer, Health Services Authority*
- *Mr. Jonathan Tibbets – Chairman, Health Services Authority*

At the conclusion of the Hearing, the Chairman thanked the Members of the Committee and the staff of the Office of the Auditor General, Treasury Department and the Ministry of Finance for attending. The Hearing(s) for this Report was suspended at 12:00pm.

5. Report of the Auditor General: –

Cayman Islands Health Care System & Ensuring Quality in Health Care – January 2017

The Auditor General made an opening statement on the above mentioned Report and the hearing(s) commenced at 1:06pm. The Chairman then invited witnesses to the Chamber and asked them to state their names, the persons attending with them if any and department or organization they were representing. The Chairman then opened the floor for statements from the witnesses followed by questions from the Members of the Public Accounts Committee.

The following persons listed below appeared in their named capacity as witnesses before the Committee for the Reports:

- *Ms. Doreen Whittaker- Chief Officer, Ministry of Community Affairs, Youth & Sports.*
- *Ms. Felicia Robinson- Director, Department of Children & Family Services.*
- *Ms. Judith Seymour- Director, Department of Counselling Services.*
- *Dr. Collin Anderson Medford, Chief Pharmacist, Health Services Authority.*

At the conclusion of the Hearing, the Chairman thanked the Members of the Committee and the staff of the Office of the Auditor General, Treasury Department and the Ministry of Finance for attending. The Hearing(s) for this Report was suspended at 3:50pm.

6. Scheduling of Next Meeting

The next meetings were confirmed for:

- Thursday, 9th February 2017 at 9:00am

7. Any Other Business

There was no other business.

8. Adjournment

There being no other business the meeting was adjourned by the Chairman at 3:57pm.

OFFICIAL VERBATIM TRANSCRIPT
STANDING PUBLIC ACCOUNTS COMMITTEE
FRIDAY
3 FEBRUARY 2017
9:06 AM

Meeting with Witnesses

"CAYMAN ISLANDS HEALTH CARE SYSTEM"
"ENSURING QUALITY HEALTH CARE AND A HEALTHY POPULATION"

Verbatim transcript of the Standing Public Accounts Committee meeting held 3 February 2017, at 9:06 am, in the Chamber of the Legislative Assembly Building, George Town, Grand Cayman.

Present: Mr. D. Ezzard Miller, MLA, Chairman
Mr. Winston C. Connolly, Jr., MLA, Member
Mr. Joseph X. Hew, Member, MLA, Member

Absent: Mr. Roy M. McTaggart, MLA, Member
Capt. A. Eugene Ebanks, MLA, Member

In attendance: Mr. Kenneth Jefferson, Financial Secretary/Chief Officer, Ministry of Finance
Mr. Matthew Tibbetts, Accountant General, Ministry of Finance
Ms. Gloria Myles, Deputy Accountant General, Ministry of Finance
Ms. Ann Owens, Deputy Chief Officer, Ministry of Finance

Audit Office: Ms. Sue Winspear, Auditor General
Mr. Martin Ruben, Director of Performance Audit
Ms. Angela Cullen, Acting Director of Performance Audit
Mr. Julius Aurelio, Audit Manager

Witnesses: Dr. Elizabeth McLaughlin, Chief Medical Officer, Health Services Authority
Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board
Ms. Dorine Whittaker, Chief Officer, Ministry of Community Affairs, Youth and Sports
Ms. Felecia Robinson, Director, Department of Children and Family Services
Ms. Judith Seymour, Director, Department of Counselling Services
Mr. Colin Anderson Medford, Chief Pharmacist, Health Services Authority

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The Chairman: Good morning, Dr. McLaughlin. Thank you for coming to the Public Accounts Committee. Wnd we want to question you in your role as Chief Medical Officer (CMO).

We are considering the report by the Auditor General, "Ensuring Quality Health Care and a Healthy Population" Auditor General's Report. I guess we could start if you would define for us what the role of Chief Medical Officer is in relation to regulatory functions within the Ministry.

Dr. Elizabeth McLaughlin, Chief Medical Officer, Health Services Authority: Good morning sir.

The role of the Chief Medical Officer is part of an advisory role to the Ministry in contact with regulatory functions, discussions with them and interacting across the sections of the regulatory arms. For the regulatory boards there is no formal position allotted to the chief medical officer. But we try to reach across in terms of discussions once we are made aware of issues and the Ministry will send me information for input.

The Chairman: Are you familiar with the NHPP [National Health Policy and Strategic Plan]?

Dr. Elizabeth McLaughlin, Chief Medical Officer, Health Services Authority: Yes, I am.

The Chairman: How does your role assist the Ministry in particular, in trying to achieve the strategies that were laid out in that?

Dr. Elizabeth McLaughlin, Chief Medical Officer, Health Services Authority: Really, the role should be able to . . . from the functions and inform the strategies, look at theme, analyse, look at the steps that have been suggested from the meetings and see how

we can establish monitoring as well as to evaluate how we are moving forward. That would be what would be expected of most chief medical officers, yes.

The Chairman: Does your role lean more to the overall global public health situation as opposed to being more involved in the governance of the HSA?

Dr. Elizabeth McLaughlin, Chief Medical Officer, Health Services Authority: My role has nothing much to do with the governance of the HSA in terms of the HSA structure at all as the chief medical officer. I should qualify that it is a part-time role and I have a full substantive post at the HSA. But for the chief medical officer that is a responsibility to the Ministry, and so it has more to do with the public health arm and the other aspects for it.

The Chairman: Does the medical officer for health who is the kind of line person responsible for the public health aspect of it, as I understand it, report to you on a regular basis in terms of the level of achievement in the general health as to percentage of immunizations and that kind of stuff?

Dr. Elizabeth McLaughlin, Chief Medical Officer, Health Services Authority: We have worked since I have started . . . so what we try to do is we try to meet each at least every three months to get an update of what is happening. And also, if there is something that is going on like when we had the Zika and the Ebola, we automatically become part of the team. So, we have tried to keep . . . although there is no written formal that says this is what you should do, we have decided that after discussions with previous CMOs this is certainly clearly what should happen so we have been trying to do it.

The Chairman: So, there is no formal requirement or do you have an agreed job description of for CMO and how you report that to the Ministry? Or you have a position and if they feel like calling you they will call you or they leave it to your ingenuity to be involved with the public health aspect of it?

Dr. Elizabeth McLaughlin, Chief Medical Officer, Health Services Authority: Not quite. I think historically what has happened is that the CMO has been a part-time post for well over a decade and so, as a result the general consensus has been to make sure that the work gets done and the Medical Officer of Health has largely covered that whereas the CMO has done more with the referral process for CINICO, because you simply can't do everything in the job description as a part-time and do it properly. So, in many ways parts of the CMO role as also with the Medical Director, we kind of . . . it has historically been what . . . because it was almost like . . . Dr. Kumar and Dr. Smith left, so we decided that as the younger people coming in, this is what we would try to do within the confines we have and report back to the Ministry as we can.

The Chairman: Do you see this position of CMO needing to be enhanced and more of a function that should belong in the Ministry where there would be greater opportunity and participation in influencing policy? It appears to me that in addition to your regular clinician job as an emergency physician you are being asked to . . . particularly with the referral systems again you are getting into clinical aspects of when a person needs to be referred and I would think that the role of CMO should be more of a global health policy advisor to the Minister and the Ministry.

Dr. Elizabeth McLaughlin, Chief Medical Officer, Health Services Authority: The role of the CMO technically is designed as you have defined it. Within the Caribbean most CMOs actually hold part of the referral process because you are acting partially as a gatekeeper to try to step away and say this referral is appropriate or not. So, some clinical involvement is helpful because it also helps to keep you aware of what is happening and what is in the environment, both in the public sector and the private sector. So, that is beneficial from that perspective. But technically speaking, I think as time has developed the role of the CMO in terms of improving the governance of health care will have to be addressed further.

The Chairman: I think one of the trends in the Auditor General's report appears that there is that lack of medical expertise in an appreciation for the intricacies of the whole health care field and it appears that there is a knowledge vacuum currently at the Ministry level, which in most countries would be fulfilled by the chief medical officer and I don't think it is sufficient. From the report it does not seem that being a part-time position is achieving the kind of constant monitoring of health policy, legislation, regulatory facilities that, in my view, should fall more to the CMO.

Dr. Elizabeth McLaughlin, Chief Medical Officer, Health Services Authority: On a level I would agree. I mean, I will say that the Ministry does feed me into things to work on but in truth there is a limit to how much a part-time is going to really be able to do all of that and so it is a reasonable criticism yes.

The Chairman: And in a current situation, as I understand it, and I think the report bears it out in terms of some of the shortcomings as is identified, the Medical Officer for Health as well is now doing more clinical work than administrative and policy monitoring than the Auditor General believes is necessary. Is that a fair statement?

Dr. Elizabeth McLaughlin, Chief Medical Officer, Health Services Authority: I think the difference is that he does minimal clinical work because we have seen sometimes the deficit when you become what physicians call a paper doctor and not a real doctor; that sometimes when you get too far from the clinical it does actually cause decisions that don't necessarily achieve what we are trying to achieve which is good quality care. So, in a small jurisdiction with limited numbers of people who have that capacity, it is trying to find the balance of what can do that and I would say both Dr. Williams and myself are at that point where we are trying to see what is the best, recognising that at the moment changes do need to take place.

The Chairman: Yes sir, Mr. Connolly.

Mr. Winston C. Connolly, Jr.: Mr. Chairman, through you to the Chief Medical Officer.

Dr. McLaughlin, in terms of some of those discussions that you have been having with Dr. Jefferson, do you think that there should be a formal place on the HSA Board for the Chief Medical Officer as well? Or is that too far out of the remit?

Dr. Elizabeth McLaughlin, Chief Medical Officer, Health Services Authority: Through you, Mr. Chair, that is an interesting question. Currently, as it is devised I think that would be an inherent conflict where in terms of how the CMO has currently existed (and I am not talking about myself, I am talking about the role)—

The Chairman: Yes, the position.

Dr. Elizabeth McLaughlin, Chief Medical Officer, Health Services Authority: The position, because all of the successive ones have technically been the Medical Director and the CEO of the HSA as their boss. So, when you are sitting on the board there would be a sort of conflict in those things because of the clarity. I mean, as it is, I often ask them who they invited to this meeting. Is it the ER Head or is it the CMO? Because then I can align my roles. I know then what level of authority I am sitting at the table with. So, it is a consideration but it does require restructuring. For it to happen it would require a change in how the CMO role is defined.

Mr. Winston C. Connolly, Jr.: Thank you for that because when I looked at the role in other places, primarily in preparing for this meeting, the UK version is talking about them sitting on the NHS Board and I don't know whether it is an executive capacity or non-executive capacity. But from a governance model if at least someone who know what they are talking . . . well, from a professional standpoint, also guiding the board even it if is just on an invitation basis, you know, a normal invitation basis, I would think from a policy and carry out of things like the NHPP that there could be the tweaks and you know, interventions as needed so that some of the things in this report would be addressed in a systematic way. But thanks for that.

In terms of the capacity issues at the hospital in overall public health, can you give us a kind of status quo, meaning, what is the situation now? Who assists you? Do you have a deputy chief medical officer? Do you have a team when you are looking at public health across the Island and some of the things from the NHPP? Basically what I am asking is what kind of assistance do you get in your role?

Dr. Elizabeth McLaughlin, Chief Medical Officer, Health Services Authority: How the system has been designed currently, the medical officer of health has the primary day to day functioning and role for the public health arm. So, in many ways he functions as the deputy for the chief medical officer, simply by definition of the roles of a medical officer of health and a chief medical officer, and the interactions across and by the law that governs what can happen and not happen. So, in many ways, for the chief medical officer, technically the deputy would be the Medical Officer of Health and that is what has been happening recently more often.

The Medical Director of the HSA also, because of his past experience as well, will sometimes act as the chief medical officer depending on current availability, if I am not available. But generally speaking we are moving more to it becoming Dr. William and then, if either he or I are not available for some unknown reason, it would be the Medical Director of the HSA. So, we are trying to separate that out a little clearer.

Mr. Winston C. Connolly, Jr.: Just one more, Mr. Chairman, for this.

In terms of some of the statistics that we see on the non-communicable chronic disease, the heart disease, the high blood pressure, the diabetes, all of those things, how involved are you in terms of setting those recommendations up to the Ministry and having them come back with, I guess, not a rubber stamp per se, but how are your recommendations dealt with at the Ministry level and then disseminated back out to the rest of the HSA and the country?

Dr. Elizabeth McLaughlin, Chief Medical Officer, Health Services Authority: The primary health care which is what is largely dealing with the NCDs, the director of primary health care is also the medical officer of health. So, I work in conjunction with him and that is how we assimilate the information up to the Ministry and also back down and through him to the public health. So, most of that is work he does on a daily basis in terms of the management of NCDs.

The Chairman: The Public Health Law has gone through (it is quite an ancient law in itself) a number of revisions by the Law Review Commission. I think in 2007 there was a committee established to look at rewriting the law to bring it more in line with modern practices. Do you know what happened? And I know that predates your time but we are still with the 2002 Revision. Am I correct?

Dr. Elizabeth McLaughlin, Chief Medical Officer, Health Services Authority: Yes, as far as I am aware.

The Chairman: Do you know of any plans by the Ministry to review that legislation with a specific purpose of making it more modern to facilitate the kind of things that we are currently talking about?

Dr. Elizabeth McLaughlin, Chief Medical Officer, Health Services Authority: At the moment I am not aware.

The Chairman: Because I believe that part of what comes out in the Auditor General's report is because of the position you find yourself in as CMO. And the Medical Officer for Health often finds himself under that law because the CMO is one of those (I don't want to call it a dinosaur) that at one time it was chief and bottle washer and everything else and it has retained some of that expectation with no regulatory or legislative authority, in my view, to properly define its function which I believe should be more towards policy and an overall review and analysis of what the state of health of the country is. Do you feel there's urgency? Would it be your recommendation to this Committee that one of our recommendations could possibly be that there needs to be some urgency in reviewing the Public Health Law and better defining the role of the medical officer of health and whether we do in fact need to keep chief medical officer if we do in fact define and give the necessary legislative and regulatory authority to the medical officer of health in that public health environment?

Dr. Elizabeth McLaughlin, Chief Medical Officer, Health Services Authority: There is certainly a need to look at modernising the Public Health Law. The presence of a medical officer of health is largely charged with working with specific areas of the Public Health. Generally speaking, public health is not the only responsibility of the chief medical officer. So, there is an overarching responsibility to the health of the nation that comes with the chief medical officer.

It has been questioned but every country has found some other name or something but they still, even countries that took it out, have brought it back in, because if we don't have that overarching view, we will end up having the silos—

The Chairman: I agree with you entirely, and what I am trying to get at is: In your view, do we need to better define and I would proffer, enhance and expand the role of the chief medical officer in that global view as opposed to it being something that you think about when you don't have clinical responsibilities to do, which I know from your current role it does not happen very often?

Dr. Elizabeth McLaughlin, Chief Medical Officer, Health Services Authority: I think that looking at the whole component of it, the time has come. I think what has done and what has gone before has done well for that time. It is just that currently the world is in a lot of change and chaos and we have to change to adapt to be able to get to where we want to be.

Mr. Winston C. Connolly, Jr.: Mr. Chairman, through you.

Can you explain the role and relationship with CINICO in terms of your interaction with them as Chief Medical Officer when it comes to referrals? And maybe just touch on the process that you go through in looking at Cayman's tertiary care centre versus overseas care centres and does it depend on a case by case basis.

Dr. Elizabeth McLaughlin, Chief Medical Officer, Health Services Authority: Through you, Mr. Chairman.

The role of the CMO for the referrals process is to assign the medical necessity of each referral. And that is defined within the constraints of this CINICO agreement. So, that means that each referral is looked at on a case by case basis, assessing the medical needs of that person in relation to their requirement. The general process is if the services are available at the HSA then that is where it happens. If not, we are locally and then we are tertiary locally and then we are overseas. So, for me, overseas is the last—

[Inaudible interjection]

Dr. Elizabeth McLaughlin, Chief Medical Officer, Health Services Authority: It's not only just the cost, but people look at me strangely when I tell them that we are the only country I know of where it is considered a norm that your care should not end within the borders of your country. And it has been a blessing. I am not saying that we should not have done that but we have far more resources available here locally and I always use the word "l-o-c-a-l-l-y". Every year, every six months, something else, some new process that was once overseas, then should be transitioned by right back here if the care is available from that process.

Mr. Winston C. Connolly, Jr.: Mr. Chairman, the reason why I asked is that you hear anecdotal conversations about, *Oh well, people prefer to go to various institutions* and what I am trying to ascertain is: Does the buck stop with you in that you decide based on the medical need and the resources here and not necessarily the preferences or the leanings to patients and their families? I am trying to figure out, how much of that do you encounter and if you do encounter that, then, what was the protocol in determination? Or does that aspect of it, that is, the patients preferences basically not come into play at all?

Dr. Elizabeth McLaughlin, Chief Medical Officer, Health Services Authority: Patients preferences are considered but it is not the primary component. Like all insurance companies there may be preferences but all insurance companies have a limit to what you as the user can do. So, the institution, usually, unless I think that that institution is the only one that can meet that need, the institutions because of the financial component would follow under the remit of the network that CINICO has. Occasionally, we will say our medical experience. So, it is a case by case. So, the preferences of patients are considered if it can be accommodated reasonably, yes. If it is an unreasonable combination or it is a complete breach of the current guidelines which I function under, then the answer is no.

The Chairman: Continuum of care would be important to that, if the person had already received care at a particular institution and it is a matter of continuing, that would be—

Dr. Elizabeth McLaughlin, Chief Medical Officer, Health Services Authority: Continuum of care is certainly considered but at this time we also look at . . . you know, there are certain factors. The complexity of the care that had to be delivered is definitely going to be considered in terms of continuation. If you have stabilised, become a routine case and you are only going up every six months to say "hi" to the doctor, then there comes a point where we will say, *Can I have a medical summary so we can see?* And if we now have that specialist on Island, then we can say, *Well, should we transition the care back home?* So, continuum of care is a component but not the final one totally.

Mr. Winston C. Connolly, Jr.: Thanks for that.

I guess what I was trying to get at is: Do we need again recommendations from this Committee to beef up those procedures if that was some kind of buttress to that system, meaning, you know, do you have enough of the parameters in that agreement to hold the line and your call then, kind of, is paramount or, you know . . .?

Dr. Elizabeth McLaughlin, Chief Medical Officer, Health Services Authority: Well, agreement is an agreement. CINICO has written with the civil service and that is the line I function within. I mean, contrary to popular beliefs, CINICO's coverage is probably the most generous insurance company I have ever seen. So, there are certain things that may need to be revisited within that between CINICO and civil servants and, you know, with input from Health arm because obviously we don't want the decisions being made that don't make any sense medically.

From that point, we can always buttress up things to try to make them clearer for the general public, certainly. And even for the people who are working because it does take a little time to understand the system. However, each case is still going to end up . . . once it comes to a referral it is going to have to require . . . you can never take a patient and not look at them on a case by case; that would just not be good medicine.

Mr. Winston C. Connolly, Jr.: Mr. Chairman, through you again.

In terms of the outcomes, the report said that generally we perform well in a lot of the . . . when we are comparing ourselves against the OECD [Organization for Economic Cooperation and Development] nations et cetera. How much of your role is internationally . . . you know, reporting and liaison with regional and external countries just to gather statistics, report statistics and benchmark the Cayman Islands?

Dr. Elizabeth McLaughlin, Chief Medical Officer, Health Services Authority: The reporting system that has been in place that is currently using . . . I mean, I have the responsibility to report to PAHO [Pan American Health Organization] and to CARICOM [Caribbean Community] on the health issues. The data is usually collected via HSA. What I think we will certainly need to look at is moving to bring the private sector data through because it is no longer that the HSA is seeing 80 per cent of the population. So, as the health care field has expanded, so should be the data that is coming from the private sector to see that. But largely speaking, because of the criteria that is being asked, most of that care is still delivered via HSA. So it is still sound data. I don't want anyone to think I am saying it is not sound. But I think for forward planning, not for now, it would be helpful to see what is happening in that . . . and it is usually the employed people sector in terms of health for the nation.

Mr. Winston C. Connolly, Jr.: Thanks for that answer because when I am reading this and see the differences between the Caymanian population, the expat population, private sector, public sector, my thoughts are that it should be mandatory that all physicians across the Island feed up information because it is only when we get that complete picture that we can

really give more valuable data. I know you said it is still valuable but I think it is time to consolidate that information because if you are reading this report, there seems to be some recommendations that a) you have to distinguish but b) you still have to consolidate that information.

The Chairman: And to your point, we were told yesterday afternoon that they are actually in the process of getting the necessary software to do exactly that and design a reporting system for the private physicians.

I guess on a broader . . . because another thing that runs through this report is there seems to be some disconnect between the private sector and health care and the public sector. What is your experience or relationship with the private sector in terms of being able to influence the quality of the care that they deliver? And also, the economic burden that they placed on you to make these decisions as to where they go locally or overseas, are you getting sufficient information, sufficient support from the private sector to enable you to be in a better position to make decisions that affect them?

Dr. Elizabeth McLaughlin, Chief Medical Officer, Health Services Authority: I do have some good relationships among the private sector. We did try and . . . I think it's been demands of time where we tried informal meetings with the CIMDS [Cayman Islands Medical and Dental Society], the MDC [Medical and Dental Council], the CMO, and the Medical Director of the HSA to try to improve communication across. Certainly, it does need to improve on both ends, private to public, public to private. I don't think there is any debate about that; it is certainly true.

Obviously, as the person who is charged with gatekeeping the referral process, at times I am not their best friend and at times I am their best friend. It is the nature of the beast. And one thing they, I think, eventually learned, I may say it as clearly as I can but the information has to be there, and when I say "information" the credible medical information, not the other peripheral information or such. But we certainly do, I think, need to improve that acceptance across the borders that regardless of the general impression the standards used within the public sector are equivalent to anyone else's standards. Can you find anecdotal cases where it has failed? Yes. But, as I say, if you find a physician who has never made a mistake they never practiced a day in their life.

The Chairman: And that is why even after you have been there 20 years we still refer to you as a practicing physician.

The reason I asked that question is because I think that one of the things that leads to this belief that the HSA is just a third-class facility is the fact that the HSA does not promote itself with all the good things that it does because I know that many of the things other people get credit for, it was your intervention that saved a person in the first place. And all we hear about publicly is the horror stories of the HSA. And I have had this conversation with the HSA themselves, in that they need to find a way to use more of what the private sector is using in terms of not calling it advertising but call it informational but they are on the radio explaining how good they are. Right? And may things they are claiming as first inventers on the Island, we have been doing a long time.

Dr. Elizabeth McLaughlin, Chief Medical Officer, Health Services Authority: Yes, what you said is a true statement. The HSA is not very good at promoting itself. Some of that, I guess, I work for the HSA and kind of understand, but some of it is the mind-set of the people who choose to work within a public system. They are more about working, *let me see.* Also, some of it is the volume of patients they are actually seeing which is usually more significant and therefore at times they don't have three hours to go on the radio because if they did that, that is patients waiting even longer in a burden system. But at the same time, the guards are changing. Change has to take place and, you know, probably kicking, screaming, whichever way, we will have to figure out how to actually . . . And what physicians will always tell you is, *But that is my job. I was supposed to do that. What is there to promote about saving a life? That's what I joined.* So, it is difficult. And when people come and ask me I tell them the same thing—*That's what I'm supposed to do. What is there to promote about that?* So, it is changing that mind-set in all public . . . well, not all but in the majority of the public people to realise that what people are asking for nowadays is a different approach to how you've always done what you have done.

The Chairman: And I think what is happening is that a lot of the improvements or a lot of the additional services that have been available at the HSA over the last five years to a decade, we still see it as what it used to be 20 years ago because it is not enough—and promotion is not the right word—exposure to the public of the enhancement of these services that has taken place at the HSA over the last five years, for instance. And that is why people (and Mr. Winston was talking about it), their first choice is, *Listen, I need to go somewhere else because this is what happened to my mother 20 years ago and I don't want to fall in that so I need to go there because they can't handle this.* But in truth and in fact, we now have the capacity and the expertise and the personnel to handle many of the things we could not handle before.

Dr. Elizabeth McLaughlin, Chief Medical Officer, Health Services Authority: Yes sir, you've said it better than I did.

The Chairman: Well, I am saying it because it needs to be said publicly on television and the radio. And you all are not in the position to say it. I think it is very important and I think that one of the positive of things that can come out of this report is that we have the opportunity now to do exactly what we are doing, which is to expose the shortcomings but get commitments that we are fixing them. But also at the same time, to be able to give credit where credit is due and explain to the public that, *Listen, this is not the 1970s Hospital that we had. We are far beyond that.*

Dr. Elizabeth McLaughlin, Chief Medical Officer, Health Services Authority: Very far.

Mr. Winston C. Connolly, Jr.: Mr. Chairman, through you again.

The CayHealth programme we see in the report that it is an example of leading practice but it is isolated to a smaller group and in terms of rolling that out to a wider cross section of the public and exposing them to that leading practice type programme, can you give us any indications of where that is, what is going on with that programme and how it is being disseminated?

Dr. Elizabeth McLaughlin, Chief Medical Officer, Health Services Authority: Well, CayHealth is a best practice programme and it was really started in the particular group that it was because that is also the highest burden on the expenditure of health care per person, kind of thing. And they have done that first cohort. They are starting another one but I also know they have been looking and working and trying to see how we can spread it beyond just there and which group . . . you know, spread that. Because it is a platform that it should not matter whether it is a private person or a public person because it is looking at your standards of health for conditions that we as a nation are automatically at higher risk to have. So, it is something . . . I think it has been a . . . it is kind of a little expensive and so that has been of the issues they have said. And I presume the expenses in the back end of trying to pull the data out of the system, not necessarily in . . . because you are still seeing the patients. It is not like you are going out and recruiting people to come in; this is a part of your normal health care.

Mr. Winston C. Connolly, Jr.: Specifically in terms of page 25, paragraph 79 of the report, the Auditor General's Office asked or said they were seeking to answer to those questions. In terms of, again, just your role, how much of those (counting), one, two, three, four, five questions would you be advising Government on pushing in the HSA itself and formally responding to those specific questions?

Dr. Elizabeth McLaughlin, Chief Medical Officer, Health Services Authority: As I said before, the primary care system, currently how it is structured has the primary care director who is also the MOH. So, the vaccinations and those form largely his direct hand pushed and plugged. I am involved but more from an overall portion, not sitting there directing it.

Certainly, we did discuss the (and I am almost afraid to say it because it brought such an outcry) need for standard cancer registry which created such a public outcry. And I understand all of the concerns the public have but without it having the things that make it equivalent to any other cancer registry in the world, then you don't actually have data you can report anywhere or data that you can actually say is credible. We certainly need to look at that. You know, the census does show that neoplasms are one of the primary top three killers of our population. We can't get around that.

They are certainly talking more and more about these registries for chronic health diseases as a part of trying to understand what is happening within each nation's population because those conditions of chronic diseases, and even cancers that are moving more and more into a chronic disease for a lot of the cancers, are what eats a large portion of your health care budget. But it also eats into your social services budget. It eats into the productivity of your workforce. It affects every aspect of the nation. So, if you stop to think about it, that is why they started saying health in all policies because we just can't get around it any more worldwide, not just locally.

The Chairman: In the absence of specific legislation for cancer registry, could we not extract some of that information if we did an amendment to make some of the non-communicable diseases such as cancer, a reportable disease to the medical officer of health as we do now with the communicable, the STDs and the Aids and everything else. Because I think you would still get a lot more information that you are getting now and the patient might not see it so much as their personal exposure. Part of the concern that was expressed to me as a Member of the Legislature, is that with the legislative framework for the cancer registry was that they did not want their own personal [information] out there. But if we require the government physicians and the private physicians to report some of these non-communicable diseases similar to how the communicable ones are reported, could you not get the data that you are looking for?

Dr. Elizabeth McLaughlin, Chief Medical Officer, Health Services Authority: Yes, if it still comes with the identifier. The difficulty is the . . . and I think people don't understand the identifier does not go anywhere. That is really used to ensure and understand. Patients live between the private and public sector and so, if Dr. X sees them and they are a newly diag-

nosed diabetic and sends the data in and it is only sent in as a number but that person has been followed up for his diabetes at the HSA and they have sent in the number, that one person has been counted now as 2, as 3, so, I guess the conversations are that we are no longer a little tiny . . . we're tiny but we have evolved. And the reality is that that data goes into a system and nobody sees it because what is produced out in any domain, even for researchers, is the condition of age, sex, nothing to do with the person at all. That would never be released out in a public domain like any other registry of anything.

It is an innovative idea to—

The Chairman: Because with the communicable diseases there has to be the same thing. There has to be some way of identifying—

Dr. Elizabeth McLaughlin, Chief Medical Officer, Health Services Authority: Identifying, right. I mean, for anything you have to trace it. I just wondered about whether human rights would have a field day with that one.

The Chairman: Well, they probably would but, you know, there are human rights and there are human rights. And oftentimes in this particular field they cross the line.

Dr. Elizabeth McLaughlin, Chief Medical Officer, Health Services Authority: They do cross the line but I mean no one should be . . . What we are trying to do is to see how we can monitor patients, how we can keep us healthy, how you don't have your stroke at 50, you are not on dialysis at 45 and how can we enjoy our lives. Because we know that people are living longer but we are living longer because of better health but also because of the other arm of health, the one that is most expensive, all of the tertiary intervention. Are we living a better quality of life?

The Chairman: That is the key. And that is what we want to get to, that we are not only extending our lives but we are extending the quality of our lives and monitoring it.

I would invite you and the Medical Officer of Health to look at whether you could achieve what you need to achieve by simply making them reportable diseases as we do now in terms of getting the information, because for some reason there is a huge concern and like you, I know that it should not be that level of anxiety and concern about since in truth and in fact with the information you are also able to ensure that that person who allowed it to be reported can get a better quality of care.

Dr. Elizabeth McLaughlin, Chief Medical Officer, Health Services Authority: Yes.

The Chairman: Because it is continuum and you know.

Mr. Winston C. Connolly, Jr.: Mr. Chairman, through you.

We also talk about the Mental Health in the report and the kind of lack of published mental health; care guidelines and various protocols. How much are you involved in that in terms of public health and tracking people with mental issues and their care after diagnosis?

Dr. Elizabeth McLaughlin, Chief Medical Officer, Health Services Authority: Well, certain categories of mental health persons, their care requires the chief medical officers approval under the regulations of the Mental Health Law. So, I am actively involved in that.

In their policies and guidelines that they are working on, not so much, but usually in terms of the clinical data of the policy and the guidelines, the mental health experts are working on that. But they do involve me quite a bit in the involvement. So, I am involved from knowing about the institutions that they need, and also simply because I see the ramifications to the country for some of the lack of capacity we currently have in the mental health field.

Mr. Winston C. Connolly, Jr.: I promise this is my final questions. I said that about five questions ago.

Again, in terms of wellness in general and wellness programmes, we heard from the chief officer this week that government is making in-roads and they have bespoke programmes throughout the civil service and that they are trying to communicate that prevention is better than cure and doing regular just wellness exercise and other things kind of assist in the overall health and wellbeing of the population. In your role as the kind of public health head, what programmes specifically would the HSA or the hospital be doing at this time? And, is that something that again should be communicated to some of the patients that you are having to then do referrals et cetera? How much of the wellness comes into your role?

Dr. Elizabeth McLaughlin, Chief Medical Officer, Health Services Authority: Wellness is a part of everybody's role. There are many aspects to wellness and there are certainly many things that have been done with wellness throughout government and the private sector. What is probably not so well done is the linking of these to try to limit too much duplication. There needs to be a little bit of duplication for choice and also to be effective with it.

The HSA does provide certain wellness education and in all of the different categories, they provide it through maternity, their diabetics, their hypertensives the general information that is available. And they will announce the smoking cessation that they

had on the radio and all of these things. So, it goes across to beyond just . . . because wellness impacts on everyone and you need it all. It is not just the HSA alone or the public health arm of government or the Ministry of Health. It requires that.

I can remember when we were actually discussing this same strategic plan since I was CMO, that one of the things everyone felt was that we know we have a lot of things already in existences; it is how do we figure out to highlight they are there and then scale them up if needed or scale them down because somebody else is doing it. It is that intricacy that often gets . . . because you actually need a physical body to sit there and say, *Please go and pull that data, pull that,* and that is where it starts to get knocked down into . . . You know, it is wonderful to sit and think and talk but you actually need physical bodies to go and do the work and that is where it starts to get a little iffy.

The Chairman: Is there currently any regulatory review of the effectiveness or the outcomes of all of these various wellness programmes that go on? Are we to the stage where if we get the data we can predict that there is a longer period for a diabetic [person] before they go on dialysis et cetera? Is there that kind of monitoring to influence policy? Or is it just that we know if you exercise (and don't look at me, okay?) that you would be more-healthy? Or do you envisage us hopefully getting to the point where we shall have data that we should be able to say to the insurance companies, for instance, that if a person is involved in this kind of activity the likelihood of them having claims should be reflected in your policy and therefore the premium could be lower?

Dr. Elizabeth McLaughlin, Chief Medical Officer, Health Services Authority: That is a difficult component because wellness is critical no matter whether you have a chronic disease or not. Activity is important. If you have arthritis the more you keep moving the better you are despite the fact that your arthritis is still going to give you grief in the morning.

There are many factors that impact on when one person will . . . and even modern medicine . . . we know that if you control your diabetes you delay . . . exactly whether you delay it by two years, 10 years, that is where it gets very difficult because there are other factors that come in; your genetic potential; something else happens, the environment may impact on it and no one knows yet that that environment has a negative component to it. But, generally speaking, you can look and certainly you have the data, it is just that you have the data that obesity increases your risk of having these conditions. Obviously, if you are staying active you are less likely to be obese. Notice I said "less likely" because there are other components of obesity. And that is what makes health care such an insurance risk; the uncertainly in health care exists within it. But if you widen these things across larger populations you then decrease that uncertainty to a more manageable bed. So, definitely, if you can show that as a general trend instead of where we are seeing high obesity rates in childhood and we know that has gone down and therefore people are moving more and these are things that are happening through education and the diet, through this, through that.

There are a lot of intangibles but if you can then show that your population (and that is where CayHealth comes in), if it is done to everyone, whether you are diabetic or not, hypertensive or not, and you can show that your population's blood pressures is generally staying here, their H11c is going there, and you then have a more marketable project to your insurance companies to say, *You need to lower these programmes as a whole we are of a lower risk.*

The Chairman: And you also need to fund them because it is to your advantage to fund them.

Dr. Elizabeth McLaughlin, Chief Medical Officer, Health Services Authority: Yeah, well, that is the difficulty. We all know what to do for health. We also know that it is not going to happen without the funding capacities that exist.

The Chairman: Do you have any other questions?

[No audible reply]

The Chairman: All right, thank you very much Dr. McLaughlin. It was very informative and we appreciate you taking the time to come. Thank you very much.

Dr. Elizabeth McLaughlin, Chief Medical Officer, Health Services Authority: Thank you.

The Chairman: We will take a short break because we are finishing . . .

Proceedings suspended at 10:07 am

Proceedings resumed at 10.30 am

The Chairman: I will call the meeting back to order and will invite Mr. Tibbetts to come into the Chamber please.

Not you, the Chairman of the HSA Board.

[Short pause as witness enters the Chamber]

The Chairman: Mr. Tibbetts, thank you very much for taking the time to come to appear before the Committee. Today we are looking into the Auditor General's report entitled "Ensuring Quality Health Care and a Health Population". And most of the things we want to talk to you today about are what kinds of lines of communication do you have with the Ministry in terms

of government policy as opposed to operational matters of the HSA?

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: Good morning, Mr. Chairman. Thank you for having me today.

Recently, we have had meetings with the Ministry on a quarterly basis and what we have done recently is we have actually gotten the Ministry to put representatives on the HSA board so that there is a direct communication now between the HSA and the Ministry. In fact, the first sitting in January of this year has had two members, one from the Ministry of Finance and one from the Ministry of Health sit on the board as an invited guests to the HSA board.

The Chairman: But sitting on the board, are they going to be more involved with the operational aspect of the HSA?

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: Well, as you are aware, Mr. Chairman, the board itself does not get involved with the operational matters. We deal with policies and procedures. So, basically the idea is that the communication is more open between the Ministry of Finance and the Ministry of Health and the HSA itself. Therefore, the delay that sometimes seems to be the case in the past will hopefully be either eradicated or more streamlined.

The Chairman: I think you are misunderstanding the question I am asking. I understand fully that the board, when it comes to the operation is responsible more for policies and procedures that the HSA is to follow. What I want to do is to distinguish between the operation and the functioning of the HSA as an entity to delivering health care versus the board having a role in advising government on policies based on your operational issues that you might have that would lead . . . What method of communication do you have formally where you . . . How do you get guidelines from the Ministry? And how do you respond or propose policy changes to the Ministry in terms of the overall health care?

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: Okay. So, communication would be from directives issues by the Ministry, either through the Councillor or the Chief Officer and then passed on to myself and the board as a whole. We then, of course, discuss the best ways to implement those and in discussion with senior management . . . and in reverse, very similarly, any queries or concerns senior management, the board then corresponds back with the Ministry through the Chief Officer, through Councillor McTaggart and that is how we have communication between the two. Basically it is a chain that works both ways for the organisation.

The Chairman: What monitoring or mechanisms exist at the Ministry level to determine whether you are in fact achieving the outcomes intended by the policy? How do you demonstrate to them that you are achieving those?

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: So, what we have done in the last six months since September 2016 is that we have created an "action item" log, so for every single meeting that we have whether it is for a sub-committee or a formal board meeting there are action items that have been identified with timelines, outcomes and so forth listed and people responsible for those actions. Those are then conveyed back to the Ministry so that they are aware of when they are completed, scheduled completion times. That has been something that we put in place like I said, in the last six months and we found it to be very helpful.

We have actually, through that, found out that there are items outstanding going back years and we are working and have closed a number of those items off in just the last three months alone. But we are working to finish up all of those from the previous chairmen on the board and working to give a better more transparent information to the Ministry so that they are well aware of their directives being pursued and worked after and can see the actual timeline for when they are going to be delivered to them.

The Chairman: Do you include timelines for the Ministry as well when you request things from them?

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: Any requests give a deadline or timeline as to an expected return. So if . . . yeah.

The Chairman: What is your experience in terms of the Ministry making your—

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: The Ministry has been . . . especially Councillor McTaggart, has been very efficient. We tend to get responses quickly; not always the response we want necessarily but we do tend to get responses. Like I said, the Chief Officer and Councillor McTaggart have been very, very efficient, either in email or WhatsApp or by phone conversation to get responses back to us. I must credit them with always being available to the HSA. I've never had an opportunity to when I've called they have not answered or return the call expediently.

The Chairman: In terms of the HSA accommodating the public health function, has the board encountered any problems in being able to deliver that output or outcome to the Ministry?

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: I would have to say every area have its little nuances. In public health it is no different. We have had some instances, especially with the recent Zika outbreak where we had to go back to the Ministry and work with them to get some of the outcomes delivered to being able to test locally and so forth, for Zika has been an issue. So, we worked with the Ministry on that, found a workaround to be able to make it happen. You know, always the communication is the issue and once you are able to communicate which, I think, this board, this senior management team has been very good in being able to communicate with the Ministry. Like I said, I cannot say enough for the chief officer and the councillor in their communication with the board as well. The councillor several times coming to visit with the board and being able to sit at the board meetings has been very helpful for us. He has been invited on two occasions and being able to come so it has been very nice to have that openness with the Ministry. But as far as public health in particular, that was the only major instance I would say of any issues when it comes to be able to deliver the outcomes. And like I said, a quick meeting with the board, the senior management, the chief officer and the councillor was able to rectify it and find a solution.

The Chairman: What policy now have you recommended to the Ministry and what policy has been put in place to reduce the need or to better enable you to deal with something in the future like a Zika outbreak without having to go back to them for operational guidance?

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: With the chief officer sitting on the board now as an invited guest and the Ministry of Finance having a representative there, that would eliminate the need of having to go back and recommunicate because she would therefore have instant access to what is available.

The Chairman: Do you not see any conflicts in having the chief officer actually sitting on the board that she is expected to have oversight over in terms of performance?

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: She sits on as an invited guest. She is a non-voting member and as such, she is there for information gathering, basically where she will be able to better understand discussions and communication between the board and other entities. You know, if there comes a time where there is a conflict as far as the board having to make communication with the Ministry, she would have to be excused at those times.

The Chairman: Do you not see any risk in the fact that she is sitting there for information gathering? Or is that an admission that the information that she needed to have from the board was not forthcoming and available and therefore we have never amended the law to make her sit on the board? Did you see a risk in not having a formal method of informing the Ministry as opposed to the person sitting there and the expectation then is, *Well, you were here, you should have heard what they said and you should have done something about it*?

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: Mr. Chairman, the idea has never been that the information was not forthcoming; the idea was to expedite any kind of decision-making so that the chief officer herself could say, *I have the information, there is no need to wait another three weeks to have another meeting or the following month and so forth.* So, there was never the issue of the Ministry not getting the information. Everything the board does is openly transparent for anyone. And—

The Chairman: You're not suggesting that putting the chief officer on the board, there is an expectation by you as board chairman that they are going to make decisions in the board meeting representing the Ministry of Health?

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: No, the Ministry makes their own decisions and they pass them on to us formally in writing. The chief officer would never come to pass a directive onto us. She would share information if she has it from the Ministry and we would request information from her as well from the Ministry.

The Chairman: And what is the purpose of requesting that policy change to have somebody from the Ministry of Finance sitting on the board as well? What is the genesis of that request?

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: With the Ministry of Finance, in meeting with Minister Archer, it seems to have been disconnect throughout many of the ministries and there is an indigent risk and so . . . or indigent population in the output that we need to deal with as well as CINICO and all the other insurance needs. So, the Ministry of Finance representative is there to again, better or more efficiently transfer the information back and forth with us to the Minister of Finance. It allows us to be able to get information on outputs as far as what is still available quicker, rather than having to send emails or take the time to have another meeting with another . . . well, basically the same representative that could be sitting there. So, it allows a better, more efficient reporting method. It allows us to get information as well, quicker than having to wait a

month or two months to get back from someone that may be on vacation or whatever the need is. So, the entire purpose is to improve efficiency.

The Chairman: You are confirming my concerns; that you have put these people there and you are expecting them to, at the meeting, make decisions—

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: No sir, I said to give information.

The Chairman: Because you are still going to have to go so you are going to duplicate the effort then. You will have them sitting there—

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: To pass information is what I said. I did not say to make decisions. They are not—

The Chairman: But what is the point of them being present to pass information if it is not to enhance the decision making process?

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: There are many reasons for the information to be passed along to us. It may enhance our decision as a board but it is not going to . . . they are not on the board to be able to make a decision. They do not vote, they don't give or make decisions on behalf of the Ministry of Finance or the Ministry of Health. It is for information and streamlining information.

The Chairman: You do not see any conflicts or intimidation possibility of having these two high level people above as part of your independent board even though they can't vote, sitting there?

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: They do not sit on that board and I do not view them as above me in that case because they are invited by my board to attend. And at any time we can remove the invitation.

The Chairman: So, we have gone to the extent to request a policy change to amend legislation to put those two people on the board but the reason for that was not based on them being able to get information that they were not getting and being able to more effectively make a decision and you reserve the authority to say to those two members that we need to leave the room so we can make a decision?

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: That could be conveyed to any board member actually, you know, if they need to be recuse for a reason.

The Chairman: That can only be . . . there are only certain conditions—

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: Right. There are certain conditions and conflicts.

The Chairman: —under Robert's Rules of Order that you could invoke that. If you tried that with me as your board member you had better have your ducks in a row.

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: That's what I am saying. And it could be myself as the chairman. It depends if there is a conflict.

The Chairman: No, we are not talking here about personal conflicts or—

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: Business conflicts.

The Chairman: —anti-corruption conflicts. What we are talking about here, is people to whom you should have a client relationship. In many respects these two people, you are their client and you should be making decisions independently based on the outputs that they have purchased from you to deliver a certain outcome. But you have now gone and put them on the board— right?—

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: Mm-hmm.

The Chairman: —as non-voting members and you do not see any inherent conflicts of that?

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: There's always the potential for conflict but to say that it is apparent and inherent, you know, I don't see that being the issue in this case. It is for information, the reason why they are on the board. It is not for decision making as far as their Ministries are concerned, but for our information.

The Chairman: How do you separate the two at board level?

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: Well, you know, if they need to be questioned as far as specific outcomes or potential future legislation or whatever it is, it allows us a quick and direct communication with those ministry representatives.

As far as I am aware, Mr. Chairman, the board chairman is responsible to the Ministers themselves. So, I don't see a chief officer necessarily as a

conflict. I see them as the chief person in the ministry but, you know, it is at the pleasure of the Ministers.

The Chairman: But constitutionally—I don't have the HSA Statute before me—is it not the Ministry and the person who has administrative control over you as a board chairman, the chief officer, and not the Minister? The Minister is more conferring to policy.

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: I would have to look at that, I don't know for sure.

The Chairman: So, these things were not considered when—

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: Well, as far as when I signed the purchase agreement on behalf of the HSA with the Minister. So, I am not sure where the chief officer falls as far as whether she would sign it or not.

Mr. Kenneth Jefferson, Financial Secretary/Chief Officer, Ministry of Finance: Mr. Chairman, good morning sir.

Just to obviously say that when the government's annual budgets are debated by the Legislative Assembly and examined in Finance Committee, those budgets are set out in the form of an appropriation bill which when passed obviously becomes an appropriation law. The appropriations in the law obviously are arranged with reference to the responsibility for those budgets to Honourable Ministers and Official Members of the Government, the Attorney General and the Deputy Governor and so forth. So, the responsibility budget wise rest with an Honourable Minister and a Official Member.

In the case of our discussion now, obviously with the Minister of Health, the relationship between the Minister who is responsible for the budgets and the Chief Officer, the chief officer has to present the Minister with essentially a monthly billing to say to the Minister, This is what the Ministry of Health has done for the Ministry on a monthly basis and I need you to authorise payment of these services that have been provided on behalf of the Ministry and the Minister then examines those details and if he is satisfied he would sign and then the treasury on behalf of the Cabinet would actually fund the Ministry of Health for those services performed. I hope that is helpful sir.

The Chairman: Yes, it is helpful and I appreciate it. But I am still trying to get at the rationale to put these two persons on the board which drove the policy which drove the legislative changes if it was not because they themselves felt that they were not getting the kind of information to drive their decisions from the board on a regular basis.

Mr. Kenneth Jefferson, Financial Secretary/Chief Officer, Ministry of Finance: Mr. Chair, let me speak very briefly to the Ministry of Finance involvement with the HSA Board. It is my understanding that it was felt desirable that a Ministry of Finance representative should be on the HSA Board if we would like to add to financial decision making processes as best as possible to help the HSA improve its financial standing. It was for that very simple reason is my understanding. As to why the Financial Secretary/Chief Officer of the Ministry of Finance or his nominee have been invited to . . . I think my nominee has attended one meeting thus far.

The Chairman: Getting back to the position, I accept and accept that that is a good rationale, but why would you put the person there and not give them voting rights? Because if they are there to influence and to help the board make better financial decisions, I would think that they would be more effective if they could vote unless (and I don't want to sound too cynical) you are leaving a back door to say that when they make an incorrect decision you can say, *Well, my person did not vote so we are still going to hold you responsible,* although he gave advice to do otherwise.

Just from an administrative managerial governance concern, I have concerns when you put people to whom you report and put people who perform for the board on the board.

Mr. Martin Ruben, Director of Performance Audit: Mr. Chair, if I could just add to the conversation here. Again, going back to our 2013 Governance Report where we discussed the relationship of SHECs to Ministries and through to the Minister, we recognised the practice of having ministry officials on boards was not an ideal situation. What you are looking for is full accountability of the boards for their actions and for their operations through the Ministry to the Minister, and then more importantly (and this is where it comes down to) if you put ministry officials on the board, no matter whether they are voting or non-voting, the ability to hold those boards accountable at the end of the day becomes blurred and becomes less—

The Chairman: Because your representative was a part of the decision making process whether they voted or not.

Mr. Martin Ruben, Director of Performance Audit: Decision making process even though he . . . that's correct. Thank you very much.

The Chairman: And that is the same reason why we keep politicians off of the boards. But everybody is quite happy to keep them off but we keep seeing this creeping back in charge of and part of by the civil service administration.

We want to deal today, as I've said, more with the policy, your responsibility.

Are you familiar with the NHPP?

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: I am aware of it, yes.

The Chairman: You are aware of it. Well, that is an indication that it has not been presented to you as government policy with which you are expected to comply.

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: Mr. Chairman, from my understanding of the NHPP, it was something that was done prior to my time on the board, however, we are working through the board and the senior management of the HSA to continue to implement the points of the NHPP. To say that I can list off the points, I cannot list off the points, but certainly, I am aware of it.

The Chairman: No, no, I don't expect you to commit this kind of stuff to memory, but in your orientation, which I assume you had an orientation when appointed chairman.

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: Yes sir.

The Chairman: Did the Ministry not present the NHPP to you as government policy authorised by the highest authority in the land as government policy meaning the sitting Legislative Assembly and therefore, there was an expectation that your operational decisions would be based on these strategic directives in terms of achieving what they want?

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: Yes sir, it was not specific. I don't think they specifically said that this is the NHPP, and to make sure all of these directives are followed. They said these are the directives the Ministry has, please make sure they are delivered. And so, that is what we do, we go through it and we deal with the directives and from time to time the Ministry will add directives as the need changes as well, So, we are aware of them. We are working through them, more so in the last year, I think, rather than even in the previous years.

The Chairman: The directives that you received from the Ministry, are they more policy, i.e. we want to make sure that you are developing your human capital to a sustainable level et cetera in order to function properly in the global health system? Or are those directives more operational that we worry that you are overspending in the indigent component or—

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: Strictly policy, Mr. Chairman.

The Chairman: Strictly policy?

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: Yes sir.

The Chairman: Could you give us an example of one of those policy directives?

If you don't have it with you, you can send to us.

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: Yeah, I will have to send to you.

The very overarching as far as the health of the Island and so forth as opposed to very specific or operational matters they are not financial related necessarily as far as saying, you know, cut spending or anything like that; that is not it at all. It is policy as far as deliveries of health to the Cayman Islands.

The Chairman: When you send the Ministry your annual audited accounts, do you send them a report along with that or do you just send them the audited accounts in terms of how you have managed to meet their strategic guidelines and where there are shortcomings or what kinds of metrics do you report achieving those policies?

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: There would be a report from the Board of Directors accompanying it and stating where we realise there are shortfalls and so forth and also identifying where we would be going in the future as far as being able to meet the remaining strategies.

The Chairman: What kind of response to that report have you been getting from the Ministry in terms of facilitating you to meet the outcome that they are looking for?

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: Well, for example, if a specific outcome is identified that there is a major shortcoming, that will usually entail a follow-up meeting with the Ministry to identify how we can approach it best, whether it is a national health issue, whether it is perhaps a . . . we've had issues with delivery of service because of other institutions and certifications and so forth. So, all of those that need to be identified and address, there would be follow-up meetings with the Ministry. We meet with the Ministry on a quarterly basis face to face and we communicate with them monthly.

The Chairman: One of the strategies that the report itself is concerned about is building capacity and particularly human development capital. We were told

between Wednesday and yesterday that there is a desire to make sure that Caymanian physicians are properly and professionally qualified to international standards. The Ministry indicated that they did not see the training of those physicians as part of the Ministry's responsibility but they thought that the way for them to get that training was to apply for an education scholarship.

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: Correct.

The Chairman: What has been the board's response to that policy decision?

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: What the board has done is that we have actually met with the Education Council and identified specific needs of the organisation and therefore for the health of the country itself as to how further training can assist through scholarships and so forth. So, we have actually had sit down meetings with the Education Council in this regard.

The Chairman: What has been the Education Council's response to the specific need expressed by the board for board certification post graduate training?

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: I can't give details of particular doctors, for example, but I do understand—

The Chairman: I don't want it for individual—

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: Right. But I am just saying I can't say they have given X amount of dollars but I can say that I do know several of our doctors have been able to receive funding from the scholarship secretariat to be able to meet the requirements for international standards.

The Chairman: Without being specific, can you say you have five persons off now doing board certification funded by the HSA or one or—

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: By the HSA?

The Chairman: No, no, by the Scholarship—

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: I can't say how many. I do know, like I said, we have made representation to them and several have been given the option. I don't know if it is (counting) 1, 2, 5, 10, I don't know how many. But I do know that . . . whether they have taken up on it I don't know that. But I do know that they were identified.

The Chairman: Ms. Winspear.

Ms. Sue Winspear, Auditor General: Sorry, just for clarity: Does that mean that within the guidelines for rewarding scholarships there has been a change to the definition of what constitutes an award? Or is it a discretionary thing within the existing guidelines?

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: As far as to the Scholarship Secretariat?

Ms. Sue Winspear, Auditor General: Yes.

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: No, it would be within the existing guidelines I would think.

The Chairman: Other witnesses have indicated that the existing guidelines are hopelessly inadequate to fund specialist training. So, if your representation to the scholarship authority has not led to them accepting the need to amend their guidelines, then how are they accommodating your people?

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: The scholarship does not have to be a full scholarship as far as being able to cover all the costs. For example, I know in the past the scholarship secretariat has offered scholarship and in conjunction with other funding people have been able to attain their certifications.

The Chairman: So, you are satisfied that . . . I think the standard . . . the maximum award—

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: It is like $20,000.

The Chairman: Right.

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: Correct.

The Chairman: You are satisfied that in the instances where your board and the HSA itself needs to enhance its human capital that you can find other methods of funding, the $80,000 that is needed above the $20,000?

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: I'm not satisfied with it at all. I think it should be if we are going to train our people that we get proper funding from, whether it is through the scholarship secretariat or if Government so indicates that they want to identify through HSA a specific channel or outcome, that they do that.

The Chairman: Has the HSA looked at its operational profit?

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: To see if we can fund . . . yes.

The Chairman: And the question I was asking is that in the absence of the secretariat changing its guidelines, are you confident that the HSA can provide the remainder of the cost to develop the staff.

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: Training is always a big issue and budget for training is a big issue. In any organisation I am sure the HSA is not special compared to many others as well, suffering with the same issues.

To say that we are comfortable to be able to complete training for the Caymanian doctors and the specialists that we would like to, I can't say we are comfortable, but it is something we have identified within the organisation that we need to increase our budget. If I remember correctly, the budget amount is very small for training and our HR Director has worked very hard along with our Finance Director to increase that budget so that we can accommodate further training.

The Chairman: Well, I think if you look at your most recent audit accounts it was in the region of $300,000 but you only spent 40 per cent of it over the year.

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: That's what I'm saying, the budget is always . . . training (sorry) is always the first thing to be cut in the budget. It is inadequate in any stretch of imagination. So, the money that was in for training—

The Chairman: No, but this is not a situation of where you cut training; this is where you had a budget allocation of $300,000 approved but you only managed to spend . . . you did not spend, I think, $128,000 out of the $300,000 which comes out to about 40 per cent or somewhere around that.

What is the explanation of that when we are told from this report and by other witnesses of the need to enhance capacity, particularly in the medical field? Because the continued use of locums is a very expensive route to go.

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: Right.

I would have to get direction from the CFO to find out why or where the balance of the budget was either not spent or what it was reallocated to.

The Chairman: So, were those questions not asked when you saw the accounts and saw that it was not spent?

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: No.

The Chairman: You were just okay with it going to profit?

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: No sir, they were not asked.

The Chairman: Winston, do you have some questions?

Mr. Winston C. Connolly, Jr.: Good morning, Mr. Tibbetts.

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: Good morning sir.

Mr. Winston C. Connolly, Jr.: Mr. Chairman, through you.

In terms of, I guess, the lack of a formulated strategy to carry out the NHPP, can you explain how the board looks at international standards and holds itself accountable to those when carrying out their functions in terms of benchmarking the activities of the hospital and personnel and things like that?

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: Through you, Mr. Chairman.

What we have done in the last . . . it has been about 18 months now, we have actually signed on with some organisations that allow us to use benchmarks for similar size organisations with similar backgrounds as ours to be able to determine if the HSA doctors, for example, are performing and if patients are satisfied. You may have received, as I have, calls regarding the surveys and so forth about the quality of care and so forth. So, that is something that this board has done in order to see if we do measure up to international standards.

Further, as far as the lab is concerned we are internationally accredited and so forth and one of the only forensic labs in the area that do meet the accreditation for forensics.

Mr. Winston C. Connolly, Jr.: In terms of formulating strategies for the HSA, ensuring accountability, kind of shaping the overall culture, how much influence does the board have up the chain in terms of Ministry? How receptive are the recommendations and suggestions from the board to the Government arm and the political arm? I mean, do you find that it goes up and then comes back down the way that you have suggested and recommended in most instances? Can you explain that relationship?

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: Through you, Mr. Chairman.

The board has, in many cases, sent requests through the Councillor to the Government in regards

to whatever the need may be at the time. Most of the time, the response is met to the request in a very timely manner. There have been times when the Government has said, *No, this is not the approach we want to take* and therefore we have had to revisit to see the best way to look at achieving strategies that the board is trying to accomplish. So, I would say that the majority of times they are met with a positive response. And again, that is due to very close communication with the Councillor in the Ministry and being able to kind of getting an understanding for where the Ministry wants to go with the HSA.

Mr. Winston C. Connolly, Jr.: The report identifies several opportunities to improve the quality of care et cetera. How has the board received this report and what has been done or is being done post this report? I know it is early days but have there been any discussions about the report and the way forward based on some of the findings?

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: Through you, Mr. Chairman.

We were only given the report actually this week so it is fairly new to us. We were made aware of some of the findings and then being able to read through it has helped. From a board standpoint we have obviously identified several issues as well from prior to even the audit report going out.

One in particular, customer care, the organisation has instituted a complete training programme to train every single staff, from the housekeepers through to the CEO, as far as our customer care service is concerned, in being able to provide a higher level of service. This is headed by our HR Director, Ms. Karie Bergstrom, who you all may know is a HR Manager for a local firm and certainly very well versed in these trainings. So, board members have been invited to visit with the trainings to see what is going forward with the organisation and how best we can implement it. But that is going through the entire organisation. We have basically been able to get our own people trained and they turn around and train another set of six people and so forth until every single person in the organisation is trained.

Not to say that we won't have loopholes. As with any organisation you will find one or two that there are issues with but we have identified several of the areas as well, as has been identified in the audit, and I think the report is very fair. And we began the process of reconciling them and improving services as far as quality, as far as customer service and most recently getting a clean opinion for the financial side.

Mr. Winston C. Connolly, Jr.: I note that some of that training budget went to the customer service aspect and that is important. I see that you are also doing surveys and we heard yesterday that those are kind of being followed up on and, you know, reviewed periodically.

In terms of the mental health aspect of the HSA and some of the recommendations as well in the report, but just, you know, we have discussed these now for the last three and a half years about the lack of capacity in that sector, bedding, the lack of bifurcation of youth and separating them from the adults. What is the board doing in regard to that in terms of trying to suggest more resources, managing the resources that you have and trying to put that strategic direction firmly in the pathway of looking at mental health as a component of delivery of health service?

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: Through you, Mr. Chairman.

The board has not actually dealt specifically with the mental health aspect of it, outside of requesting the Government look at it on a national scale, because we do believe that it is more than what the HSA in particular can handle. And, as you stated, that there needs to be early identification and assistance to whether they are youth or wherever they can be identified in order to help. And we are not sure that the HSA is perhaps the best place to house such a facility, but there has been representation made that on a national level we do need to identify and work with institutions that are set up to deal with mental health because it is a bit different, in fact, completely different from perhaps pharmaceutical and drug related needs of patients. And I don't mean to say that mental health patients will need drugs or don't need drugs, I am saying if there is an illness, usually there is a drug to go along with it. Mental health could be a multitude and a ray of different needs.

The Chairman: But you expect that there is a medical and clinical component of mental health that the HSA needs to address?

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: Absolutely! Yes sir, that is correct. And we currently do as you are aware. Our concern is that the problem is bigger than what we are able to deal with at the HSA in the sense of it needs to be addressed specifically on a national level from government.

The Chairman: In terms of what?

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: In terms of housing, in terms of staffing to properly deal with it. You know, there have been instances—

The Chairman: In terms of other issues related to the medical—

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: No, not the medical side. No sir. No, no, no.

The Chairman: I just wanted to give you the opportunity to clear that up.

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: Physical constraints is what I am referring to. I apologise; the physical constraints of the actual site or sites that we currently use at the HSA.

Mr. Winston C. Connolly, Jr.: Thanks for those answers.

Moving now to the financials and looking at specifically the allowance for bad debts and that is [$]95 million as of June 2016 as to the report. Can you explain to me how the board is looking at that and helping shape what strategies are to reduce that allowance and where do we go from that figure and what are we trying to move to?

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: Through you, Mr. Chairman.

This has been the number one priority of the board now for the last six months, so much so, that we are in the process of—and in fact I have just hired on a temporary basis, another specialist to the CPA to come in and work with us. And also, given the directive, an RFP is being drafted to bring in a firm to assist with cleaning up our audit, however, this is very closely related to bad debt and the bad debt issue, first of all, is not going to go away completely based solely on the nature of the HSA and the fact that it is a government based facility. What we would like to do is minimise it. The board has taken a number of steps to minimise, including a payment policy for the pharmacy where we were seeing $5 million per year lost, we have seen a 45 per cent reduction in losses in the pharmacy with a goal to extend up to over 90 per cent in this calendar year.

We have also looked at in bringing a firm to get a clean audit opinion formalising all of the policies and . . . sorry, all of the procedures that are taking place in as far as revenue capture is concerned. Some of these issues that are dealing with bad debt are evolving because of incorrect, whether it is coding or insurance claim numbers and so forth, and therefore they get sent back after the time period has elapsed and we end up in a situation where money is then placed into a bad debt account. So, if we have formalised procedures in place as to exactly how revenue is being captured or should be captured, we feel that this will greatly minimise the bad debt per year and therefore allow it to be within a region that we can work with through local collection agencies and being able to identify how to stop some of the leaks that are happening in the HSA.

The Chairman: But what timeframe are you placed—

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: April 1st.

The Chairman: Because this has been an ongoing thing now for a number of years and we keep getting the same—

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: April 1st 2017 is the deadline for the firm which was selected to begin the process of formalising the—

The Chairman: I'm not worried about when it is going to start, I'm worried about when it is going to finish.

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: Well, as I stated, to say that we will never have bad debt I think is not a fair statement based on the nature of the HSA; it being the primary health care provider.

The Chairman: I would proffer that through the various allocations in the budget to which the HSA has access, other than the incidents of incorrect coding and none of those should be classified as bad debt because once you make the claim with the insurance company before the 90 days has expired, then it continues to be processed and you should eventually get paid, otherwise, you go to court because you have a legitimate claim. The problem is if you don't file it within the 90 day period, then, you can't file it.

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: Correct.

The Chairman: As recent as last night in my district council meeting in North Side, I had persons who reported to me, asking if I could not do something about them because when they go to the HSA they can't pay their bill and then they get a claim from the insurance several months later. And the example they gave to me is that they went there four or five times and each time they want to pay before they leave and they eventually got a bill months later for a total of over $1,000 which they happily paid but they would have preferred to have paid it at the time. So, in your reviewing of these procedures, can you give us the commitment that . . . well, first question is: Do you have a discharge procedure for the HSA now which includes a paying of a settling of the account in one form or another?

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: Mr. Chairman, it depends on where the person is being discharged from, whether there will be ongoing charges still or not. There is a discharge policy in place where our patient financial services representatives do go to the patient and provide

the information as the bill is concerned. And again, this is only in certain areas. You can accept that there will be other needs perhaps that are ongoing where we can't say this is the final bill.

The Chairman: But the ongoing should be charges that are generated after the discharge fact. You should be able to say what the discharge amount is because that is already incurred, and have that addressed in its totality.

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: From my understanding, if it is a patient that is in the hospital and they are to be discharged because their care is now finished, they do get a final bill on the discharge bill. That completes their encounter. However, as I said, there are many different areas that could be ongoing and perhaps developed and so forth. And sometimes doctors will not drop the charges until later in the evening and so forth, so they may not get the bill that particular day. This is why the board felt it necessary to bring in a firm to formalise the procedures that need to take place so that at the end of an encounter the patient has their final bill and can be discharged appropriately.

I understand your thought process and I did not understand it at first either, and the medical specialist would be the better one to ask as far as what kind of examples but there are—

The Chairman: My friend, the last person you want to get financial advice from is a doctor.

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: Not financial advice sir. What I am suggesting is the health advice where they say that the person—

The Chairman: Yeah, but you understand the point I am making is that anybody discharged will have a continuum of care but the financial aspect of that continuum of care is to be incurred after the discharge. That should not affect your ability to have in place a proper discharge procedure that finalises a bill and demands that it be settled in one form or another, even it is a promissory note. Right?

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: There is a discharge procedure in place and a bill would be given at discharge. If there are individual instances, then those should be taken up with the patient representative.

Mr. Winston C. Connolly, Jr.: Mr. Chairman, through you.

I'm looking at the report now on page 17 paragraph 48. In there the HSA, the executives and the professional staff are reported to have expressed concerns about the available level of staff support. The report talks about the doubling of the population but the size of the staff and a number of the staff in the public health programming had not changed. It also talks about the difficulties recruiting physicians because of the appropriate salary level or the offered salary level, especially with specialists, physicians when compared to other jurisdictions or the private sector. I'm trying to find out what the board has done in this regard to address this particular concern. And the two parts to this question goes back to something that the chairman raised about the capacity and the board certifications of doctors and the cost involved. Does the board ever get into an analysis of where the gaps are in terms of physicians, be it Caymanian or otherwise in Cayman and then use that information to perhaps push or suggest the push to physicians going into those areas where we have the gaps on in the country?

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: Through you, Mr. Chairman.

Firstly, a cap had been placed on the HSA as far as the number of full time employees could be, and that was at 840 employees I do believe. We saw the need in the last year to hire additional and we had to go to the Ministry for approval on that which they granted it in particular cases because, as you stated, the population increased and yet, the number of employees had not increased proportionally. So, we did and we were able to get approval for the cap to be touched on, but it worked out that we didn't even need to, due to attrition and some other employees moving along. So, we do identify and recognise that there are needs as far as staffing are concerned.

Financial constraint is one area. Again, this board has said that this is what we need to move forward on. We need to be able to hire the doctors, hire the nurses, hire the specialists, whatever the position is, whether it is housekeeping, whatever we need in order to deal with the needs of the country. To me, as chairman, those needs can easily be met through collecting the bad debt and that is why there has been a push to start as of April 1st, as I stated, with a new vigour to get a clean opinion by December 2018. And in getting that clean opinion the goal will also be to clean up the bad debt accounts. So, we will be able to use money that the HSA makes in order to hire and provide appropriately.

As far as the training for doctors, the clinical sub-committee of the HSA identifies areas where doctors are needed. If we can put in a Caymanian doctor, that is the ultimate goal and the number one priority of that sub-committee. I co-chair that particular sub-committee at this time until the medical specialist whom we have invited is able to join us. But I do know that that is the goal and priority for the clinical sub-committee. That sub-committee then reports back to the board with reference to whatever hires we can

make as far as new Caymanian doctors are replacing doctors that are retiring or leaving for other reasons with Caymanian doctors.

Additionally, Dr. Jefferson would be responsible for meeting with potentially new doctors in saying and suggesting, *This is what we would need and this is how we could best fit you in, in the organisation.* And I know he has done that in several instances with young doctors in helping to guide them in an area of specialty so that they can fit in with the direction of the HSA that is needed and intending and ongoing.

The Chairman: You say that you only saw this document a couple days ago?

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: If this is the most recent one, yes sir.

The Chairman: The one that we are dealing with "Ensuring Quality Health Care and a Healthy Population", the audit report.

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: I think Monday evening I got it, yes sir.

The Chairman: Well, your HSA has identified to provide the implementation or solving three of the nine recommendations that the Auditor recommended that needs to be addressed. Are you telling us that you were placed in that position in this response of the Auditor General without discussion as to whether you have the capacity to do so or whether you are willing to do so or—

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: As far as the recommendations go?

The Chairman: Yes.

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: The board was not consulted on the recommendations prior to release.

The Chairman: I want to get back to this— I am a little concerned about the blurring of the lines of authority and responsibility and accountability between the Ministry and the board because you keep referring to a good relationship with the councillor in the Ministry. And the feeling I am getting is that a lot of this is happening kind of by the by and discussions and passing and meetings, but my concern is that there is adequate documentation which will allow for evaluation of what has been decided in terms of whether it achieved the outcome or the goal or not.

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: We have formal meetings with the councillor and chief officer every quarter. And when I say "we" I am referring to the deputy chair of the board, myself, the CEO, the chief officer and the councillor. Their formal quarterly meetings, all minutes, of course, are sent through to the Ministry. So, they are not haphazard conversations. And I refer to the good communication with the councillor because the councillor is very quick to respond to any requests for information or direction when needed from the board; not that they are haphazard conversations or behind the doors conversations, these are all formal requests from the board that the councillor or the chief officer, either one, both are excellent in responding to us for any information needed or direction needed.

The Chairman: And in that capacity, either you, as chairman and the board or the Ministry could look at those formal communications a year down the road and say, *Well, we communicated this directive to you, what has happened? This was our expectation of what would result from this directive.* Because one of the things that the report strongly indicates is that that kind of metric and evaluation process is very low, if it exists at all.

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: Right. As stated, our action item logs that we now keep on our minutes that are submitted would identify to the Ministry where we are at with each of the directives and strategies. And so, they now have, like I said, as of September 2016, all the information as far as what the directives are being worked on and timelines and so forth and persons responsible for these. So, a year, two years, whenever down the road, they can look and say, *Okay, this was completed at such and such a date. This was the person or persons responsible for the completion of this* and who signed off on it. So, that is now part of the communication with the Ministry on a monthly basis.

The Ministry, again, it is F-viable. If anybody would like copies of that information it is available and it is something we put in place, like I said, in the last six months because we felt as the Auditor General would identify, that there was not a clear level of accountability when it came to the actions that needed to be taken. So, the board has put in place where we now identify on a monthly basis where we are at, updates, if timelines need to be changed and so forth, all of that is logged and attached to the minutes on a monthly basis.

The Chairman: One of the recommendations that the Auditor General made is item 3 on page 34—**"The Government should strengthen its relationship with private health care providers and two-way communication required for it to develop an effective health care system."** The response from the

Ministry is the "recommendation is noted." The responsibility is Ministry of Health, Department of Health Regulatory Services and the Health Services Authority.

What, if anything, has been done during your tenure to enhance the communication between the private sector and the HSA?

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: Mr. Chairman, the Medical Director, Dr. Jefferson, has had numerous formalised meetings with other private providers around the Island and those reports have come back to the board. So, we have instructed the Medical Director to meet with other organisations and supply us perhaps whatever we can use to be a benefit to the patient in order to better work with the private institutions on the Island. And in some cases formal service level agreements have been signed.

Ms. Sue Winspear, Auditor General: Sorry, Chairman, my mind was going back to the last item we were talking about; so, a comment and a question, if I may.

Firstly, the comment is that this report came out quickly. It was made public on Friday and therefore I appreciate that for the chief officer the communication would have been through the Chief Executive Officer of the HSA just in accordance with trying to keep it tight before it goes public or prior to publication; so, just to put that bit of context around it.

The second, which relates back to the ministerial directives and monitoring performance against them and how you as a board does that and report back to the Ministry. That's all good and fine because it sounds very much like it is progress against actions. So, a task list of things to do.

I suppose the thing that that earlier conversation begs from me is: How, as the board chairman of the HSA, do you assure yourself that the performance of the HSA is contributing to improving the health and wellbeing of the population? How is that connected then to health outcomes in the stated aims of this policy and strategic plan?

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: Through you, Mr. Chairman.

First of all, it is certainly not an easy task to say immediately that all directives would directly relate to, or effect, the health of a particular patient. It may be related to experience they have in receiving health care. So, those are some of the things that we look at. Through the directives we are able to identify that as these directives and action items have been completed, we are able to monitor and get updates on them to know that they have not just been put in place and once used, but monitored on a regular basis through the responsible persons. Again, I had stated every action item has a person or persons responsible for completing or implementing the action. So, it is not a matter of just putting these items out there and no one is responsible for it.

There is also a report back time as to when the people who are responsible for it would report back to the board or their supervisor for these items to be either adjusted if need be, because as we are aware, we met this in the past with the pharmacy software issue when that was installed. It was quickly understood that this was not working and so we did have to make a quick re-evaluation of it. So, we have put in place timelines, persons responsible, reporting timelines and so forth to be able to identify whether they are being met.

To finish off the question you asked in regards to the health of the country, you know, some of those things will take time to be able to measure. So, I can't say that there is a specific rubric that we are able to use to measure to say that this directive has helped in this way, but each of the action items are tied to the directives so that we can identify that we are meeting as a board, the directives from the Ministry.

Ms. Sue Winspear, Auditor General: Mr. Chair, through you, I may follow up on that.

Because I was hearing that the directives were things to do and do those things produce better outcomes was one part of the question. But the other part was, forgetting the ministerial directives and the monitoring of those, what management information, what do you as board chairman have that helps assure you that the health and wellbeing of the population is improving? So, I'm just trying to get the management information that the board gets.

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: The reports from the medical director as far as patients and needs of patients coming to the board would be the closest that the board itself gets in order to assist if there is an identified need from the medical specialist that, you know, for example, there is an increase in hypertensive needs and so forth. That would be brought to the board's attention and in conjunction with the medical director we would identify the quickest and best way to move forward with addressing those needs. So, medical needs would come from the medical director or the clinical sub-committee.

The Chairman: Do you have a follow-up?

[No audible reply]

The Chairman: Can you give me how your board is made up now of who are the members?

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: Yes sir. Would you like a list of each of them?

The Chairman: Yes.

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: Myself as the Chairman, Karie Bergstrom, Deputy Chair, Gordon Madison as Finance Director, Arthur McTaggart as the IT Director, Christiana Kirkcaldie as the HR in clinical, as a member we have Ms. Jenny Manderson, HR again, and Mr. John Meghoo as far as legal representative.

The Chairman: That is a curious makeup given that one of the things clearly identified in here is the lack of communication between the private sector health care and the public health care. I am constrained to ask you how you could justify recommending the Ministry have the chief officer sitting on the board and the Ministry of Finance have somebody sitting on the board but we do not have any representation from CIMDS or private sector physicians.

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: Mr. Chairman, I stated earlier that the we are in the process of getting a doctor to sit on the board as a consultant and that is something that they would be able to assist us with chairing. It is minuted in our meetings as well that they would be assisting with chairing the clinical subcommittee as well. So, there would be an aspect of private sector inclusion.

The Chairman: So, that specialist is coming from the private sector?

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: That's correct.

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: But that specialist is going to be handpicked by whom?

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: The HR Director, Ms. Karie Bergstrom, has been in communication with several doctors who are willing to serve on the board.

The Chairman: Do you see any risk or conflicts in that kind of a process as opposed to having a person who represents the private physician or the medical fraternity as a whole being recommended by the Cayman Islands Medical and Dental Society?

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: I understand what your point is, Mr. Chairman, however, there has to be the issue addressed of how or why would that person in particular sit on the board that could determine many things as far as the health and the particular organisation when you have someone that is working at a private institution and they sit on the board, there could be a lot of information that could be divulged that may be proprietary. So, we have to look at both sides, whereas if we have an invited guest to say, *Can you come and attend these meetings, we need some consultation, what is the private sector feeling and so forth*?—it then allows us to have a little bit more control over what information is given out per se.

Mr. Winston C. Connolly, Jr.: Mr. Chairman, through you and I guess following up on the Auditor General's intervention about the management information that you guys are having or that the board is receiving and then making decisions on.

On page 29, paragraph 99, it says that the "HSA tracks a number of patient complaints" and that given benchmarks with the Miami area et cetera, scores of about 75 out of a total of 100, meaning 100 is high satisfaction, for the period of January to July 2016 the trends at the HSA services, the score was below 50 per cent. What is the board doing with that information and addressing those types of data that it receives.

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: Through you, Mr. Chairman.

Our patient representative is receiving additional help from another management member in working with our patients who are not satisfied. Now, the CEO herself has been involved with several of these cases as instructed by the board for her to get involved to make sure that the patient leaves in a satisfactory manner. So, that has been identified. If I am not mistaken, Mr. Chairman, it was in June 2016 when that particular issue was looked at from the board's perspective and it noted that there was a concern that patients were not satisfied when there was a complaint and the CEO had been instructed at that time to become involved in those matters if the need arose. So, in other words, she was to make herself available to patients who had complaints that were not being satisfied by our patient representative.

Mr. Winston C. Connolly, Jr.: In terms of total health expenditure . . . and we heard yesterday from CINICO that basically government assumes responsibility for the unhealthiest sector of the population and private sector basically then takes the healthy cohort. As a board, have you ever come back to government with suggestions in terms of — Why are we being charged with taking on the worst case scenario and presumably that would lead to (I'm trying to couch this in the best possible way) some of the issues that you are facing, meaning, if people are very unhealthy, they're coming in, your results are going to be lower in terms of overall turnaround and effectiveness? Does the board ever look at that cohort and go back to government and say, *Well, here is some note items that we need in any kind of evaluation of our performance services et cetera; we need to put asterisks on the*

type of patients that we are getting in general? Or does that never come into play?

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: Through you, Mr. Chairman.

We do not turn away patients regardless of their health condition, as I am sure you are aware. And we cannot say *no* to people regardless of their health.

One of the things the board has recognised is that there is a larger audience out there. And through the addition of communication managers, two recently, we are in the process of revamping our public relations and attempting to get business from the private sector as well, as you have stated, realising that we can provide for them, perhaps better than their current provider. So, the board has recognised that and we are on a campaign to work towards that.

Mr. Winston C. Connolly, Jr.: That was point as well, in that we heard from the Chief Medical Officer this morning, that there are so many services and enhancements and other things at the HSA. And while it is good that we have a place where our sickest, or unhealthiest or that side that the population go to, in terms of revenue and the financial side of things, part and parcel of trying to balance that out is to a) inform the public of all the services, b) market the services. I mean, we attend all of these health conferences that come in and we see, you know, the Florida Hospitals advertising all of their services but we do not necessarily see the same HSA advertising and things like that. So, that counterbalance would be to go after some of that; the healthier ones that are coming in for maybe sometimes elective or other services to support that mix.

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: Mr. Chairman, through you.

One of the areas identified, as I said, is the fact that we don't tell our own story very good. And the hiring of two communication managers, one internal and one external, to allow us to tell our stories better and more frequently is something that the board had identified and is now in place. So, you will see going forward a lot more positive results as far as the stories being told coming out of the HSA. You will also be made aware of the services provided, because, as the Member has definitely and correctly stated, a lot of people are not aware of all the services we provide at the HSA and to what extent. Many of the things being touted by other institutions on the Island have been done at the HSA for many, many years. And so, the goal for the communication and public relations aspect and public awareness aspect is to let the general community know what is available, how easily it is to access it. The fact that we are central you do not have to travel far away to deal with it and you can recuperate right into your own home. So, those are some of the things the board has identified and is looking forward to being able to produce or continue to produce as it has already started in the last few months.

Mr. Winston C. Connolly, Jr.: Mr. Chairman, my last question for the morning is: Given the comprehensiveness of this report, and I would recommend, I guess, to the board really delving down into the findings, the recommendations and perhaps using this in terms of that governance and strategic side of what the board should be doing, because I think if some of these things are taken on place, a) the analysis, b) the reporting, c) the outcomes will be better, kind of identified, tracked and, you know, tweaked from time to time. Because having read it as a layman and not being on any kind of health related boards, I think it was a great starting point baseline to at least have the parameters outlined where it could be used as a template going forward to build on, but that would be my recommendation from viewing it.

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: Through you, Mr. Chairman.

Thank you, Member for that recommendation and certainly we will continue to look at how best the HSA can implement the recommendations. We've had two strategic retreats in the last two months identifying on the best way forward to improve the services, to provide the outcomes and to be able to track changes and make the organisation one that is to be envied as such, by other institutions. So, I certainly appreciate and take into account your recommendation.

The Chairman: On page 29 of the report we are dealing with, the Auditor General compared the number of physicians and other support. Does the board feel any need to influence government policy . . . or does the board have any concerns that we may be approaching the point of oversubscription in provision of some of these areas which is going to lead to escalation in cost?

For instance, we have in Cayman, almost double the number of physicians per 10,000 that Canada and the United States have. We are down a bit on nurses. We are higher in dentists, yet, at the HSA the dental appointment schedule is running three, four, five months, can't get an appointment to see a dentist. Do you feel any urge or responsibility in trying to influence the policy of the Ministry in terms of limiting these . . . providing any limits to this through the MDC and other places?

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: Mr. Chairman, you know, I do recall reviewing the particular chart. There are, of course, some basic needs with the economies of scale, as you are well aware. The Faith Hospital in the Brac, I don't think there is anywhere in the world that has the doctors per a population as good as that. Perhaps

Little Cayman may be better but as you can appreciate, four fulltime doctors for 2,000 people, certainly, is a very good ratio. But there are certain basic needs that we have with a community this size, and then again, with being able to grow the organisation to handle the ever increasing needs of the population to improve quality of life and so forth.

As far as limits go, I think the organisation itself has identified and recognised that there are perhaps areas that we need to look at, more so than others. As you have stated, dentistry is one area we need to address and I know personally that the board has taken that into consideration and is working on several areas to improve appointment times and so forth, as well as women's health. So, we do know that there are particular areas. Having a high number of doctors for 1,000 people is only as good as having the right type of doctors per 1,000 people. So, that is one area we are working on, realising that if we have plenty doctors but in the wrong area it is of no use to the community. So, I don't know that we would make a recommendation to the Government but rather internally reorganise to be able to meet the needs of the community.

The Chairman: Do you have any questions Joey?

[No audible reply]

The Chairman: Okay, Mr. . . . Oh, sorry, sorry.

Mr. Martin Ruben, Director of Performance Audit: Thank you, Mr. Chair.

Just as a matter of clarification and with regard to the audit process that you were discussing with Mr. Tibbetts. When we are conducting our audits and clearing our reports we respect the accountability framework in place, and that is very important to us. So, for example, when we are auditing core government we are discussing our audit findings and our concerns from the evidence that we collect from the chief officer or Mr. Manderson, depending on the situation. At the SAGC level we are dealing with the CEO. However, in both cases we expect, obviously, when we are raising the matters and there are concerns that in responding would be, you know, there might be issues but providing a response to the Auditor General in terms of the recommendations we fully expect the CEO or the chief officer to discuss that with the Minister just to make sure that, you know, I mean, that is just common sense, but from our perspective our role would be to ensure that the report is cleared, which all clearance takes place with the senior administrative official.

The Chairman: And it is also fair to say that while the public unveiling of it was the short space of time given. The development of the report and the opportunity to respond, there were no short periods of time. Nobody was restricted and it took the normal course. In fact, I think this took a couple of months longer than it would normally because you were waiting on that expectation to take place. So, there is some disappointment that they heard about it, from the Committee's point of view.

Ms. Sue Winspear, Auditor General: But again to be fair, Mr. Chairman, the recommendations do not come until a later stage in the report because inevitably we need to do all the field work first. So, this has been quite a truncated process.

The Chairman: The point I want to make is that you did not give them the recommendations and wanted . . . they would have gotten a shortened window to respond to the recommendations. The normal timeframe was given.

Mr. Tibbetts, thank you very much for coming and we appreciate you taking the time. Thank you very much.

Mr. Jonathan Tibbetts, Chairman, Health Services Authority Board: Thank you, Mr. Chairman.

The Chairman: We will suspend and reconvene at 1 pm.

Proceedings suspended at 12:07 pm

Proceedings resumed at 1:12 pm

The Chairman: We want to welcome Ms. Dorine and her team of experts, the Director of Children and Family Services, Ms. Felicia Robinson, and the Director of the Department of Counselling Services, Ms. Judith Seymour. Thank you all for coming.

We are looking at the Auditor General's report on Ensuring Quality Health Care and a Healthy Population. And one of the things that . . . and we are looking here for—

Mr. Joseph X. Hew: Sorry, Mr. Chairman. Sorry, to butt in sir. I noticed earlier and perhaps now with the ladies here, to remind them to say their names because I would hate to have issues with the minutes.

The Chairman: Yes, thank you very much.

One of the issues raised by the Auditor General is that a number of the services that you provide are, in fact, delivering health care but you are not appropriately licenced or inspected, so we would like to hear from you on both cases.

Ms. Dorine Whittaker, Chief Officer, Ministry of Community Affairs, Youth and Sports: Mr. Chairman, Dorine Whittaker, Chief Officer, Ministry of Community Affairs, Youth and Sports.

When the initial contact was made with the department about licensing the homes, they saw the

homes not as health facilities, and I will get the director to speak a bit more about that. And so, the Senior Management of DCFS met Health Services to come up with a policy that would deal with caring homes and then follow-up with the legislation that would cover that. So, we actually have the draft policy and a legal opinion on it. But for the next steps I will let the Director of the Department of Children and Family Services address that.

Ms. Felicia Robinson, Director, Department of Children and Family Services: Felicia Robinson.

The homes that are being referred to within the report are health facilities which are actually social care facilities. Our emphasis in not in providing health care per se but on providing personal care services for the protection and support of children and adults in need or at risk. And some of these needs obviously arise out illness, old age or poverty. So yes, we do support them in terms offering health care while they are residents in these facilities but they are not primarily health facilities.

The Chairman: But you do deliver some health care within those facilities?

Ms. Felicia Robinson, Director, Department of Children and Family Services: For nursing we have a registered nurse who oversees the programmes and yes, some community health nurses will come in and see the residents as needed but we also have our residents going to the hospital as needed for the services that are required.

The Chairman: So, I think the concern is whether we need to have those facilities inspected up to the level of health care that you are delivering within the place itself. In other words . . . let me see if I can come up with a reasonable example. For instance, you have senior citizens who have various ailments and you have nurses coming in to do treatments, is there sufficient monitoring of infection control? Is the room being cleaned to a standard that is unlikely to . . . I don't know whether you have a sick bed in there which they would move into before they move on to the hospital or there is a room that the nurses would do bandaging, for instance, in case of diabetic ulcers and stuff like that, which are not at the acute level that they would need to go to the hospital, but whether your nurses are in fact doing those kinds of treatments we need to make sure that have you in place (and this is what the inspection would provide) sufficient protocols for things like inspection control and storage of medications and bandages and all of those sorts of stuff. Not intending that you would have to have an inspection at the level of a clinic or hospital but in order to make sure that we have some protocols in place.

Ms. Felicia Robinson, Director, Department of Children and Family Services: Okay. The facilities are staffed primarily by care workers, not nurses, except for the nursing supervisor of the programme who is required to have a nursing qualification. That responsibility for monitoring the standards falls upon that nursing care manager. But we also have continuous oversight through our community health nurses who will come in if there is a need for particular services. So, to the extent that we have got that oversight and service being provided by the health care professionals from within the hospital, I think we do meet a level of quality of nursing care services. And there is no acute services actually provided within the residences themselves because the residents are taken to the hospital for those types of services.

The Chairman: What mechanisms do you have in place that you can demonstrate that those protocols are being followed, that the nurse is asking them to do?

Ms. Felicia Robinson, Director, Department of Children and Family Services: Okay. There are standards with respect to things such as storage of support medication. There are standards in terms of the level of supervision of nutrition meals. We also look at things in terms of the follow-up with the medical protocols. So, there is a level of oversight that is provided to ensure that we are meeting the health obligations.

The Chairman: And you are comfortable that you can monitor those and that the reporting mechanism and the record mechanism are in place, that would allow, and you would pass inspections if they came about?

Ms. Felicia Robinson, Director, Department of Children and Family Services: I am comfortable at this point given our staffing capacity in the level of staffing that is there, that we are doing the best that we can. But I would agree that there is room for improvement but we will need to upgrade our staffing quality from just caregivers to a different level of support within the home. But given our resources and our current job descriptions and framework for delivering the services, I think that we have put in place a level of oversight to ensure that the wellbeing of the residents is appropriately addressed. And we have the relationship with other providers in terms of doctors coming to visit. We've got the relationship with the hospital to ensure that the health of the residents is appropriately taken care of.

The Chairman: When the doctors' visit the caring homes, do they visit the patients in their normal bedroom or is there a special room that they would their visitation in?

Ms. Felicia Robinson, Director, Department of Children and Family Services: We don't have special rooms so the patients are seen in their room.

The Chairman: Okay.

The same for the Counselling Centre.

Ms. Judith Seymour, Director, Department of Counselling Services: Judith Seymour, Director, Department of Counselling Services.

Mr. Chairman, the department engaged in the process of registering our facilities with the Council for Professions Allied with Medicine (CPAM) starting in 2011. We were physically inspected at that time and at that time a determination was made that the national standards inspection checklist A is what would be relevant for us, and so, that speaks to things like public information, management and personnel, premises and facilities. Some of it is not relevant to us in terms of we don't handle hazardous waste, those kinds of things.

At the time of the inspection we were asked to correct minor concerns like uneven paving at Caribbean Haven which all has been done. In that process what we discovered was despite the fact that we had gone through the rigorous inspection process, there was a glitch in having our facilities registered because the law required that the facility had to be registered under the name of a person who was registered with the Council for Professions Allied with Medicine.

As the director of the department when I sought my Masters qualification in 1998 there was no registering body for our profession in Cayman at that time. There was therefore no need for me to pursue licensure, certification and/or registration (lcr) with any affiliate body in the US where I had studied, partly because each state has its own varying requirements. I had no intention of ever practicing in either, of the 51 states, so there was no value to me maintaining membership with any of those affiliate associations at that time.

There is, for example, multiple ways one can be licenced or registered in the US. You can go through the American Association of Marriage and Family Therapy, you can become a licenced professional counsellor, and you can become a registered social worker. There are lots of different areas within the field of mental health and counselling. So, at that time I chose not to pursue that; there was no requirement for me to do so here. I then found myself in a position where, because I was not myself registered with CPAM and as their licensing . . . (let me correct myself) their registration requirements indicated that I had to be registered in one of seven jurisdictions. I was not able to be registered. I flagged that in communication with the then chair of CPAM who was Dr. Foley, expressing my concern also for the Caymanian staff that were in my department and who did not have the ability to do so. That issue has not been resolved to date.

I am aware that the Council for Professions Allied with Medicine does register Caymanians now. I'm not sure how they have chosen to get around the requirements which still remain. I have attempted to have meetings with them to have conversation about how do they then assess someone as being eligible to be registered but I have not met any success with that.

In relation to the registration of my staff, most if not all of whom who fill the role of counsellor do have a professional affiliation with somebody whether that is a licencing or registering body in the country that they come from. And I should also point out that in our field it varies from jurisdiction to jurisdiction whether you have licensure, whether you have registration or whether you simply get a membership in an affiliate organisation depending on the field that you are in.

When we registered some of the staff the issue of payment of fees came up. That also came up at a time when we did not have funding in our budget to do so. I then set about trying to understand the process through which I could ask for those fees to be waived. At first, no one recognised that that provision existed in the law, so I then had to point the provision in the law out, which clearly states that that is possible for staff employed in the government that are not operating in private practice. However, there was no process delineated for how that should happen. It said that the responsibility lay with the Governor.

I set about trying to figure that out. I was then told that it had—eventually, this is many years of trying to manage this process—to be done through the Ministry of Health by a Cabinet paper. That Cabinet paper was drafted. It went through the process of consultation through the various ministries. It got held up unbeknownst to me. I thought because it is not my ministry, I assumed it was going through and when I followed up to find out if a decision had been given, I was told it was being held up by one ministry that had queries in relation to my budget and whether I had fees to pay or not. I then resolved that and the Cabinet paper and started the process again and eventually we were given permission to waive the fees in June 2016.

I have subsequently reached out to the chairman of CPAM again because I have questions in terms of how to register my staff given some of the anomalies that exist with registrations that I am aware that have happened. We have people who are practicing in other organisations that are registered as Masters level psychologists that would never be able to be registered as such in another jurisdiction. So, I have questions about how to register my staff. What are the appropriate categories under which to register them? And, unfortunately, I didn't get a response from the chair and when we reached out the Health Practice

Commission I was referred to the website which does not actually answer the questions that I have. And so, it has unfortunately reached the point where we are at a stalemate.

I am concerned though, that there is a suggestion in the report that because the professions are registered through the Health Practice Commission, that ensures some kind of standard. To the best of my knowledge, once the professional is registered there is no inspection to determine: Is that person in compliance? Are they only practising within the registration that has been granted to them? I am aware, for example, that there are persons who have a designation as a counsellor in mental health and addictions who are working with young people, with children that they are not qualified to work with. I have reached out to the Health Practice Commission to try to understand the process to make a complaint in relation to our profession and some concerns that I have for things may be happening and was told that I would have to contact the person directly and speak to them even though I have no authority over them.

The Chairman: How can the Council for Professions Allied with Medicine tell you or tell any Caymanian that they have to be registered in one of seven jurisdictions? Obviously, the intent of that law is that if you are not Caymanian we will accept your registrations from one of those jurisdictions.

Ms. Judith Seymour, Director, Department of Counselling Services: I think my concern, Mr. Chairman, is that the seven jurisdictions listed are also so varying, that in essence to suggest that having those seven countries standards as our standards we may as well not have any.

I could also point out sir that I know when the Mental Health Commission which is also referenced in the report was introduced in 2013, I believe, there was a conversation at a meeting of all of the practitioners and at that meeting the question was asked whether it would be more appropriate for the Mental Health Commission to be the body that oversees our profession and that was met with a resounding *yes*. But I think as you can see from the report of the Auditor General, they are not sufficiently staffed to take on the function either. Because I think that is another concern that I have, is that the standards that are in place, for example, the Code of Practice does not meet a Code of Ethics, similar to the one that I have in place in my department.

The Chairman: Have you passed the need for this matter to be addressed through your Ministry to the Ministry of Health for a policy decision which would accommodate what you need?

Ms. Judith Seymour, Director, Department of Counselling Services: The issue of the waiver of fees was directed through my Ministry and eventually reached the Ministry of Health and was then dealt with. My other concerns have not been passed on formally. I have discussed them but I have not done so formally in terms of putting in writing all of those concerns. That is something that I can seek to do now that the matter is on the floor of the Public Accounts Committee and as a matter of record.

The Chairman: Yes, we think you should go that route because we think it needs to be resolved and we need to make sure that we find a way to. And, I can tell you that as the architect of the 1974 Health Services Law which was the first time that Caymanians could get registered in their own country, the inclusion of those seven countries was not what we would expect, except if you had it, but once you came up to the standard you did not have to go and get registered in one of them in order to be registered. That was not the intent of the law.

Ms. Judith Seymour, Director, Department of Counselling Services: And I think my concern, sir, is that in 2013 some amendments were made but there was not anything made despite the fact that the issue had been flagged to accommodate what formal process there should be for the Caymanians who find themselves in the position that they are.

The Chairman: Okay. We would certainly invite you to pass that suggestion up the chain of command and try and help you out, monitor it through the AGs Office that it gets done.

Ms. Judith Seymour, Director, Department of Counselling Services: Mm-hmm.

The Chairman: Do you have any questions?

Mr. Winston C. Connolly, Jr.: Mr. Chair, through you.

In terms of Recommendation 5 on page 19—and I guess maybe this may be for the chief officer. The Recommendation is that the Government should review policies and practices and the inspection of health care facilities which will take steps to ensure that all qualified practitioners are appropriately registered. The note in the back in Appendix 2 with regard that Recommendation, says; **"Review is to be completed by end of July 2017".** And the responsibility is with the Ministry of Health and the DHRS. And one of the management responses to that Recommendation is that it is difficult to monitor and enforce which you have given adequate reason why, but that it is also due to limited resources was the response. If you got more resources it would not necessarily make it easier given what you have just said in terms of . . . unless we change the criteria that is there, the defini-

tions that are there and applied some changes to the overall legislation. Is that fair to say?

Ms. Judith Seymour, Director, Department of Counselling Services: I'm not sure whether that Appendix is speaking to me having resources or the monitoring—

Mr. Winston C. Connolly, Jr.: I think it is the monitoring at the Ministry level.

Ms. Judith Seymour, Director, Department of Counselling Services: But that is the Ministry of Health, as I understood you to say.

Mr. Winston C. Connolly, Jr.: Yeah. That is why I said it may be for the chief officer when I was asking the question.

Ms. Dorine Whittaker, Chief Officer, Ministry of Community Affairs, Youth and Sports: That would be the Chief Officer of Health. I am the Chief Officer of Community Affairs.

Mr. Winston C. Connolly, Jr.: So sorry.

The Chairman: We have been told in several other PAC Committees that there is this chief officer meeting that happens on a regular basis. Are these not the kinds of matters that come up in those management meetings which would lead to cross-concerns being addressed and met?

Ms. Dorine Whittaker, Chief Officer, Ministry of Community Affairs, Youth and Sports: Mr. Chairman, our fist cross-ministerial where two chief officers would sit or write to each other on the issue and then that would be brought to the two Ministers in terms of changes that needs to happen.

With the Department of Counselling Services we have flagged the waiver and we have gotten that done. What needs to occur is that we have suggested changes that need to go the Health Practice Law and the Health Insurance Law. And so, when the director writes her recommendation to me, the first thing is to sit with the chief officer because we are all on the same floor.

In terms of the chief officers meeting, if it is something that is across that will affect other ministries, we could then bring it across but it should be that the two chief officers are able to sit and both should sit with their relevant ministers if there are legislation changes to be done.

The Chairman: The reason I am flagging that up, is because in response to the Recommendations made by the Auditor General which addresses some of these concerns, nowhere is it in here suggested that your Ministry or the Children and Family Services are going to be involved or have any responsibility for it. So, I think we need to ensure that when they are in fact making some of these changes and improving them, that you take the initiative to say, *Well, here we have caring homes and we have the counselling services that falls under us and we need to be involved in what you are developing because we want to make sure that our professionals have the opportunity to be licenced and that we can have in place monitoring mechanisms,* whether that includes your Ministry being involved in not only the performance monitoring but also in the quality assurance with reference to the DHRS which is the Department of Health Regulatory Services.

So, I think that given where we are at, and you are not identified as one of the areas that would be involved in solving the problems, I would certainly invite you to take the initiative to make sure that your areas get adequately represented when they are coming up with the solutions. Because we don't want the situation to happen where they develop a solution in absentee of you and when it comes to you then, it is entirely not applicable because of the things that your director of counselling just identified in terms of the various specialties that exist (for want of a better word) within that environment.

Ms. Dorine Whittaker, Chief Officer, Ministry of Community Affairs, Youth and Sports: Mr. Chairman, I undertake to do so. We, like I said initially, between us and the Health Services were involved in the discussions about the homes at DCFS and we will open the conversation on the Department of Counselling Services. But for the audit purposes, I just got a copy of it when I was called to PAC so I will follow up afterwards sir.

The Chairman: Question for the audit department: When you do individually (for the want of a better word) an audit and you deal with the chief officer and/or the Deputy Governor, is it your expectation that those reports, although they may be specific to a particular ministry, that they are shared across, because oftentimes they would be recommendations that it might not be specifically, but knowing of the recommendation could enhance the governance and other structures within the other ones?

Mr. Martin Ruben, Director of Performance Audit: Thank you, Mr. Chair.

When we are clearing our report we clear it with our primary contact and our primary contact, it is known to them that they are to engage anyone within government who they are involved with, with respect to the report. However, I will take the opportunity to add that there are references to outside parties here, that that is our responsibility when, for example, an organisation is mentioned in our reports and that activities are, you know, specifically related to our find-

ings, then, it is our responsibility to do the clearing. But when it is within the government we do ask that our primary contact . . . in this case here it was the Chief Officer of the Ministry of Health who . . . we got the data. We actually spoke to some of the people here but still at the clearance level it is her responsibility.

The Chairman: Okay.

Joey, do you have any questions?

[No audible reply]

The Chairman: Well, thank you all. Your get-out-of-jail free card this evening is early. Thank you all for coming and we think it is important that we try to . . . we are talking here about raising the standards and getting things . . . not only raising the standards and getting things right but also putting in place metrics and measurements that we can use to determine if we are getting there.

Ms. Judith Seymour, Director, Department of Counselling Services: Mr. Chairman, if I could just clarify one point further before you close. I do not want anyone to walk away with an understanding or an impression that the department does not have standards in place. In fact, the department has a requirement for clinical supervision to take place to monitor the performance of our staff. I believe that is something that is not a requirement, for example, under the Council for Professions Allied with Medicine. We also have our own code of ethics that the department and staff have to adhere to, and we have our clinical and administrative procedures that are in place, that staff are expected to adhere to. So, I just want to correct any—

The Chairman: But those are—

Ms. Judith Seymour, Director, Department of Counselling Services: Those are departmental standards appreciated.

The Chairman: Right. And what I am suggesting is that those are the kinds of things that we need to raise up to the level so that you will have legislative authority, because you could have difficulties enforcing those, although I am sure it is included in the contract that they have to follow them and all of those sorts of stuff. But if you got reference to a code of law we might have difficulty for you having things and requiring higher standards that are not necessarily represented in the Department of Health and Regulatory Services under which you should fall for certain things.

Ms. Judith Seymour, Director, Department of Counselling Services: Certainly! And I had addressed the issue of enabling legislation for my department with the chief officer, I think, just last week, and suggested that that is something that we actually need to pursue at this time. Our field is growing more complex and I think that it is time for us to have that in place here, and obviously, those kinds of standards would be falling under that.

Mr. Winston C. Connolly, Jr.: Sorry, Mr. Chairman, through you.

Just following up on that: In terms of international best standard, is that the level that these policies are at? And if so (which I see you saying yes), how much communication then between your department and the Ministry go on in terms of devising that or formalising those best practice goals? I mean, I am just trying to figure out the two-way communication, if you could just talk to that.

Ms. Judith Seymour, Director, Department of Counselling Services: Are you asking about my own Ministry or the Ministry of Health?

Mr. Winston C. Connolly, Jr.: Your own ministry.

Ms. Judith Seymour, Director, Department of Counselling Services: Certainly. I have regular briefings with my chief officer and I would hasten to say she relies on me because of my expertise to ensure that the policies that I have in place do meet the best practice standards. But we do have dialogue about what is in place, what the expectations are of the staff, regularly.

The Chairman: Our concern there is the appearance of silos and what we want is to find is a mechanism where the two ministries, with your Chief Officer and the Chief Officer of Health, that there is more co-operation, coordination and to make sure that we are in fact putting the right stuff in place.

Ms. Judith Seymour, Director, Department of Counselling Services: Certainly, Mr. Chairman, because quite often in other jurisdictions my services would fall under the Ministry of Health, and so, I am in a bit of an anomalous position where I don't report to the Ministry of Health.

Ms. Dorine Whittaker, Chief Officer, Ministry of Community Affairs, Youth and Sports: Mr. Chairman, in terms of the legislation this was the next set of legislation that we thought was important to have in place and so, the director has brought it to my attention. And just for the record, the Chief Officer of Health and I meet regularly. So, I will be meeting with her to address the issues that were brought out today sir.

The Chairman: Thank you all very much.

Sorry, you wanted to say something, Mr. Ruben.

Mr. Martin Ruben, Director of Performance Audit: Mr. Chair, the following paragraph 56 talks about inspections and other facilities that are not run directly by government but obviously they do receive possibly government funding, and I was just wondering in light of the testimony given here today, what their roles and responsibilities are with respect to these facilities and whether or not the standards and the requirements that are being discussed here, should they follow and be implemented in these facilities as well.

Ms. Dorine Whittaker, Chief Officer, Ministry of Community Affairs, Youth and Sports: Mr. Chairman, we do give a substantial grant to the Pines. And this policy that is in place for Caring Homes was they were also part of that. As part of receiving their funding through their purchase agreement, they are inspected by DCFS and before their funding can be released each month, we get an inspection report from the Department of Children and Family Services.

Mr. Martin Ruben, Director of Performance Audit: But not from the Department of Health Regulatory Services though?

Ms. Dorine Whittaker, Chief Officer, Ministry of Community Affairs, Youth and Sports: We only have answerability if anything comes up in the LA. For the Pines it is separate from us. What we do is we bring them in, in terms of any legislation that we are considering, and this legislation that we are considering for Caring Homes, the Pines would be very much a part of that.

The Chairman: I guess what we are suggesting is that maybe you may want to expand the purchase agreement for that funding to say that they also have to be, at some point in time, on some regular basis, be inspected by the personnel of the health inspector if they . . . because I believe the Pines would be doing a lot more or just as much in-house medical treatment of their clientele, as you would be doing. So, we want to make sure that somewhere along the way on a regular basis there is some inspection by the Health Regulatory Authority to ensure that they have proper protocols in place as well. And not only does it say you must clean the room, it must say how the room is to be cleaned and, you know, if you go into the room and there is mould growing on the ceiling, then, you know something is wrong. What I am saying is we want metrics, a way that we can measure it, if you see where I am going.

Ms. Dorine Whittaker, Chief Officer, Ministry of Community Affairs, Youth and Sports: Mr. Chairman, I have been assured by the Director of DCFS that this is something that she can start putting in place.

The Chairman: Thank you.

Are there any other questions from anyone?

[No audible reply]

The Chairman: All right. Thank you all very much.

[Pause as witnesses leave Chamber and next witness enters]

The Chairman: Good afternoon. I would like to thank you, Mr. Medford, or is it Anderson-Medford?

[Inaudible interjection]

The Chairman: Okay.

We'd like to thank you for coming to witness before the Public Accounts Committee.

We are looking at the Auditor General's report on Ensuring Quality Health Care and a Healthy Population. And one of the things that came up in the report was the absence of a new pharmacy law as part of the regulatory regime. So, could you give us an update and fill us in and why it is taking so long to get a pharmacy law in place? And when you answer the question just give us your name and your title for the record.

Mr. Colin Anderson Medford, Chief Pharmacist, Cayman Islands Health Services Authority: My name is Colin Anderson Medford. I am the Chief Pharmacist of the Cayman Islands Health Services Authority. I am also a member of the Cayman Islands Pharmacy Council and the pharmacy council . . . well, as a backdrop, according to the document we have here, the Pharmacy Law which is now in use is quite old. It was brought into being in 1979 and because of that, it is quite outdated.

There was an attempt in 1991 to make a more updated law to suit that time and what has happened in recent times is that the council has taken upon itself now to form a pharmacy law review committee, a subcommittee, using the council as the lead for the change or changes, and using the 1991 Law as a preamble.

The current Law has been sent to the Ministry and we have had quite a few changes made to it since we have done that. Some things have been added and some things have been taken away to be current with the international standards for pharmacy practice and also to taper it to the needs of the Cayman Islands. It also delves into future pharmacy activity on the Island, so it is quite involved. However, it has come back to us with some misgivings that were not passed by the Government attorneys, I think it is. I stand corrected on who it is that sent it back, but I do know it has been returned to us for further review, as well as some suggestions that they made that proba-

bly would be more appropriate for the writing of the Law as it applies to the Cayman Islands.

The Chairman: We note on page 25 of the Auditor General's report, item 85 . . . sorry, page 26, item 85, that, you have put in some protocols at the HSA for the management of certain criteria. Do those protocols carry the legislative weight of regulations under the '79 Law or they are just in-house policies that . . .?

Mr. Colin Anderson Medford, Chief Pharmacist, Cayman Islands Health Services Authority: Absolutely! They are in-house policies for the HSA. Some private institutions choose to use our standards as proper practice and we have no problems with that. But we have pretty much written our own protocols based on the UK guidelines from the UK Ethics Annual Review as well as the Canadian Law, the American Law and also Jamaica. I've brought samples of our protocols and so on, if you would like to see those.

The Chairman: Please, if you would table them to the Committee it would be appreciated.

Mr. Colin Anderson Medford, Chief Pharmacist, Cayman Islands Health Services Authority: If I may say this, the document was a bit limited when they said that we had only had protocols for antibiotics in paediatric use and acute pain for adults, because we do have a very . . . I just brought a sample and I could not bring more, there's just so many. And we are also in the process of daily updating these protocols. I've brought a sample of chemotherapy and anticoagulation therapy and the general outpatient dispensing process as well.

Mr. Winston C. Connolly, Jr.: Mr. Chairman, through you while he is looking for those.

Can you tell us if you are satisfied that these are the best practice international standards that we are using, just for the record?

Mr. Colin Anderson Medford, Chief Pharmacist, Cayman Islands Health Services Authority: We do have some limitations, obviously, because there are some things that we do not have the infrastructure to implement. But for the most part, the standards I would say, and I say this based on my training in Scotland, Barbados and to a lesser extent, Canada, that based on the criteria that comes out annually we have got a fairly high standard of practice on the Island considering that there are limitations as far as the law is concerned. We seek to fill the gaps of the law at the hospital; that is the best way I can put it.

Mr. Winston C. Connolly, Jr.: But surely, I mean, you know, for the listening audience and also government, the fact that we are missing laws and proper procedures that have been formerly set out, both in '85 and '86, and I know that part is not on yours but the [INAUDIBLE] care, I would hope that the Government would take this report and now move with haste to encompass this new pharmaceutical law and the best practice procedures and let's get it done. If you are saying that this is 1979, it is time to modernise and memorialise the procedures in a one-stop document.

Mr. Colin Anderson Medford, Chief Pharmacist, Cayman Islands Health Services Authority: The new Pharmacy Law is very inclusive and it will also be a very good aid for Customs as well, because it deals a lot with the importation of drugs by persons who are not permitted to do so, which is not in any of the other versions of the law. And obviously it is a problem with trafficking and so on.

These are the references and protocols. And these are just a handful of the guidelines that we have formulated ourselves; some over the years and some in recent times. And that would include also our own hospital formulary which is currently being updated.

[Samples of references and protocols laid on the table of the PAC Committee]

The Chairman: And these will all be represented in the new modern Pharmacy Law?

Mr. Colin Anderson Medford, Chief Pharmacist, Cayman Islands Health Services Authority: No, this is just HSA.

The Chairman: Yes, I know but the requirement, or it will be addressed to the law in a way that will enable this to carry weight.

Mr. Colin Anderson Medford, Chief Pharmacist, Cayman Islands Health Services Authority: The law encompasses proper practice using best practice solutions as well as evidence-based medicine. So, because of encompassing criteria from countries that have established lots, we've tapered it to our practice on the Island for both private and public practice.

The Chairman: What seems to be the delay, because I happen to know that this has been in train for at least, I am aware of the last eight to ten years?

Mr. Colin Anderson Medford, Chief Pharmacist, Cayman Islands Health Services Authority: Yeah, the 1991 Law, I don't think it ever reached the legislature.

The Chairman: No, no, no, it was passed into law. I have it in my hand.

Mr. Colin Anderson Medford, Chief Pharmacist, Cayman Islands Health Services Authority: I'm not sure. We've never been able to use it.

The Chairman: It was suspended by the . . . there was a change in the elections in 1992. And the law was not brought into force properly for various reasons, which I suspect are the same reasons that you are encountering the impediments and the stumbling blocks that you are now in terms of getting in place adequate legislation to be able to give the public the confidence that the profession of pharmacy is being conducted in a modern professional way and it has in it the necessary controls and the ability to write in-house protocols which will carry the weight and the support of legislation.

Mr. Colin Anderson Medford, Chief Pharmacist, Cayman Islands Health Services Authority: Absolutely!

One of the things we did to circumvent the deficiencies of the law was we developed, I think, about six or eight years ago, maybe six years ago—the council as well developed something called "The Standards of Practice" which pretty much helped to taper the practice of pharmacy broadly, island wide, for all practitioners. And within the remits of the standards of practice we were able to extrapolate some of the practice issues that we had encountered by both private and public pharmacies.

Mr. Winston C. Connolly, Jr.: But that is a voluntary code; that is not mandatory?

Mr. Colin Anderson Medford, Chief Pharmacist, Cayman Islands Health Services Authority: Well, it is adhered to by the practitioners but it is, by no means can replace a law.

The Chairman: And it can't carry consequences? Does it have offences for which there are consequences?

Mr. Colin Anderson Medford, Chief Pharmacist, Cayman Islands Health Services Authority: The consequences would have to come at the discretion of the councillor I believe.

The Chairman: For licensure?

Mr. Colin Anderson Medford, Chief Pharmacist, Cayman Islands Health Services Authority: Licensure or malpractice or breach of the codes.

Mr. Winston C. Connolly, Jr.: Mr. Chairman, through you.

In terms of your role in monitoring statistics on drugs, narcotics, forecasting inventory and importation requirements for the country, can you explain that role and again as to what the kind of wrapping around that is in terms of where do you get your mandate and how do you report that or who do you report that to and then what happens after you make those reports?

Mr. Colin Anderson Medford, Chief Pharmacist, Cayman Islands Health Services Authority: Absolutely.

First of all, we follow the United Nations Convention for International Narcotic and Psychotropic Drugs; handling, shipping, manufacture, producing. We follow that very closely and I must say that we do that in tandem with the National Drug Council (NDC). The National Drug Council pretty much do the data analysis for us and they have been doing that now for the last, I think, about five years.

As far as the process is concerned (if I may get into that) the Convention was enacted by the International Narcotics Control Board (INCB) based in Austria which is a sub-arm of the United Nations as well as a subsidiary of the World Health Organisation (WHO). And what they sought to do was to bring the entire world into a control . . . a legal framework for controlling narcotics and psychotropic drugs. Along with that, each country has to set up a competent office which deals with the process from start to finish. They deal with both importation and exportation. For Cayman, we do not export narcotics and obviously we do not manufacture or grow (as far as I know) any medicinal narcotics or any kind of narcotics for legal commercial purposes. But what the framework has done is that it has presented very stringent control using statistics and these statistics are weighed against what you've ordered, against what you've manufactured, against what you've produced, against what you've exported and it is all balanced and tabulated by the International Narcotics Control Board.

They also have another arm that deals with other drugs called Psychotropic drugs and these would include things like Benzodiazepines and so on. But what they have done is made sure that government bodies have a competent authority or a competent office that is answerable for the movement of narcotics in the country. And one of the important things to note is that the statistics are also taken from the police force as well as customs; seizures or whatever you may call it. Whatever statistics they have, they are asked to forward to the National Drug Council (NDC) in order to go into the annual . . . the reports are done four times a year. There are the quarterly reports and then there is the annual report.

The Chairman: Do you sign off on the quarterly reports as the Government's Chief Pharmacist now for the narcotics?

Mr. Colin Anderson Medford, Chief Pharmacist, Cayman Islands Health Services Authority: Well, I don't really sign off the reports; that is done by the

Chief Medical Officer. I work under the Chief Medical Officer in this capacity and she is the person who would pretty much be the director or manager of the narcotic control of the Cayman Islands.

The Chairman: I am sure you would have been as alarmed as I was to see that it looks like they are business people who expect to be able to import medicinal cannabis and the law currently requires that narcotic control. So, I think there needs to be some kind of press release to make it clear that the way the law is drafted currently, that that is not possible to happen legally.

Mr. Colin Anderson Medford, Chief Pharmacist, Cayman Islands Health Services Authority: The thing is, I think, when you look at other jurisdictions, Jamaica, Canada, most of the other countries, if not all, and some of the ones that are pretty obscure, well, I mean, tiny, is that you realise one thing—they all have an office that only deals with this. So, in my capacity as Chief Pharmacist at the HSA, I am a bit tenuous to say this but there is some conflict of . . . well, the INCB has not given any disapproval of what we are doing because I've actually outlined it to them. But at the same time I am purchasing for the hospital, just like any other pharmacy, and I am, at the same time, regulating and so, there is nobody really monitoring me besides the chief medical officer who is literally getting the information from me.

So, what happens in other jurisdictions is that there is an office set up. In Jamaica it is the narcotics . . . I think they call it dangerous drugs but they are moving away from that terminology now for the sake of the patients that is. But the dangerous drugs, Department of the Ministry of Health, and what they do is . . . that is all they do. They look after the recording, the movement, the balancing. There is an inspector who goes to every pharmacy and he looks at those books at random and that would include me if he came around, he would be looking at my books as well.

Now, in 2002, I think, when the hospital became a statutory corporation we lost that empowerment and I think that office sort of . . . I don't know much about it because I was not in the fray at the time, but what I do know is that we did have that inspector in place and I think we did have the formation of a board. I don't know how active the board was but the pharmacy board would have been regulating those things with the inspector in tandem.

The inspector also inspected for other reasons; setting up a new pharmacy, pharmacy practice whether or not your place is locked up, no pharmacists are there, simple things like that. But essentially we do not have that office right now and I think that is one of the things that (sorry if I am digressing) I think is essential to good pharmacy governance and practice. We need to have somebody who oversees the Chief Pharmacist of the HSA and somebody who oversees all of the pharmacists on the Island and keeps them in check according to expected guidelines. So, we can have a law and we can have the code of practice and everything else, but if we do not have somebody who enforces that, then, we are still going to have problems.

The Chairman: Yes, one of the things that we talked about a bit earlier this morning was moving the role of CMO up to the policy level, the Ministry level where that person could have themselves or have under them the necessary staff to do that kind of thing so that there would not be operational people like yourself having to regulate yourself.

Mr. Colin Anderson Medford, Chief Pharmacist, Cayman Islands Health Services Authority: Absolutely. And that is worrisome.

The Chairman: Yeah, yeah, yeah.

Mr. Colin Anderson Medford, Chief Pharmacist, Cayman Islands Health Services Authority: Getting back to the INCB, the INCB also enforces this. So, if you don't submit your documents on time, if you don't submit your quotas on time, if you are reporting documentation is deficient in any way, they will write to you several times and each time they write to you they will tell you that this is your fourth and your third or fifth warning, whatever. And then they will tell you that if you have any problems you need to get in contact with their home office where they will help you to resolve the problems. And I find they are very patient even though they are enforcing it, but at the same time there is an ongoing body that oversees the movement of medicinal narcotics worldwide.

The Chairman: Do they still use your annual statistics in order to grant your request? In other words, it there you try to get too big an increase they will question why—

Mr. Colin Anderson Medford, Chief Pharmacist, Cayman Islands Health Services Authority: Absolutely! Yes, that has happened to us for oxycodone. Oxycodone has increased exponentially. The use of it has increased. In fact, if I may say, I don't have exact statistics but our narcotic use on the Island in comparison to let's just say 2010, maybe 2012, has increased exponential by my opinion. And that happened to us when we went from 300 grams to 800 grams because we had to. And we had to provide documentation to prove why it was so.

The Chairman: In your opinion, is that because doctors are using it genuinely for acute pain? Or, are they using it to wipe out minor pain so there is a perception that he is a good doctor?

Mr. Colin Anderson Medford, Chief Pharmacist, Cayman Islands Health Services Authority: That is something that I would not be able to say. What I can say is that we've got a lot more physician and pharmacist confidence with the proper use of narcotics. We have also got more pain specialists, we've got anaesthetist who are also pain specialists in their own right. We've got a much higher level of patient care as far as pain is concerned. We've got the Hospice. And because of these things, we are seeing things like fentanyl patches and so on, moving a bit more than they used to when I first started years ago. And the confidence that has been rooted in training for doctors and pharmacists and nurses as well, nowadays, has given rise to more use of the drugs.

The other thing too is that we've got patients who are overseas referrals and they go to the hospitals overseas and the doctors, they use them widely in the United States and to a lesser extent, England. I'm not too sure how England does it but I know they use it to a much lesser extent. But Canada, the US, patients will come back and they will want refills, and obviously—

The Chairman: Do you have any way of determining whether there is any abuse that might lead to addiction or are you not seeing those turning up?

Mr. Colin Anderson Medford, Chief Pharmacist, Cayman Islands Health Services Authority: You will see it in patient patterns. You will see it in the way patients behave to risk getting the drugs or the things that they will do to get the drugs and so on. But when it comes to solid investigation we have not ever done that really. What I can say is that there is a very high level of communication between all the pharmacies.

The Chairman: Good.

Mr. Colin Anderson Medford, Chief Pharmacist, Cayman Islands Health Services Authority: So, if you see somebody who is coming every week to you for oxycodone or for something else, you would call the other pharmacy and say, *Look, you know,* . . . even if you don't call the patient's name you will say, *We have a patient and if it continues we will give you a call.* And we have done this on several occasions and it is very effective. We closed them down . . . well, the patients, we stop them.

The Chairman: Yeah, yeah.

Mr. Winston C. Connolly, Jr.: Mr. Chairman, through you.

Is it right to say that there is no shared pharmacy information system right now to ensure that the patients are not receiving the multiple prescriptions from the different physicians and obtaining them? I mean, it is good that you can call but there is no tracking, I guess, of pharmacies this month issued that much more oxycodone that would start triggering, you know, the data would start triggering some action.

Mr. Colin Anderson Medford, Chief Pharmacist, Cayman Islands Health Services Authority: There is no computer system on island in place at the moment to do that. It is available in the United States; I know they do that. But as . . . well, I don't want to say archaic, but as complicated as it is, I think we must give credit to both the doctors and pharmacists on the island that helped to stem the habits of some patients. And I can say that this is something that happens almost monthly where we can come across one of these cases somewhere where someone was halted in their efforts to obtain a narcotic or a psychotropic drug against the wishes of the physician. So, we don't have a system, which would be better and which would obviously be much better, but we don't have that at the moment.

The Chairman: Is the holdup on the new Pharmacy Law related to economic factors or related to professional provisions in the law?

Mr. Colin Anderson Medford, Chief Pharmacist, Cayman Islands Health Services Authority: Based on what I have understood is there are some requirements that were placed in the law. Now, remember that we as laypeople as far as the law is concerned, were the ones who pretty much made the changes and forwarded those to the high authorities.

I think in some cases our requirements were not up to par with what is expected as far as the national law is concerned. And we were asked to review as well as to consider inserting certain things that would make that law much more applicable.

The Chairman: I guess I can understand the legal phraseology but I am a little concerned that we have the pharmacy council itself preparing drafting instructions which is basically what you would have prepared in legislation. And your decisions on what needs to be in the law are being second-guessed by laymen or even by attorneys. So, I am hoping that they are not trying to remove things that you want in the law but it is just a matter of the way it should be written legally.

Mr. Colin Anderson Medford, Chief Pharmacist, Cayman Islands Health Services Authority: I'm not absolutely sure. I just know that there were changes requested. Honestly, I haven't seen the request but I do know based on our discussions in council that we are at the drawing board again for certain things.

The Chairman: I hope that this Law gets put into place fairly rapidly because I fully understand the ramifications and the need to put it in place. And I also, I guess, am unduly cognisant of the stumbling blocks

that you are up against having had to endure them myself both as chief pharmacist at the hospital and as minister of health who piloted it in the '91 legislation. So, I am acutely aware of what you are getting up against and I hope that we find a way around it in short order that does not lead to any compromise in the professional ethics and standards and the ability to regulate the industry.

Mr. Winston C. Connolly, Jr.: One final question from me: Again, is it accurate to say that someone travelling abroad that would get a prescription from an overseas doctor, there is no account for these drugs being brought back in, like, meaning customs, no requirements for them to report that to the HSA or anybody and therefore there is a risk that you could go away and get your oxycodone and other things from an overseas doctor or pharmacy and you then would not have any indication of that patient's drug history?

Mr. Colin Anderson Medford, Chief Pharmacist, Cayman Islands Health Services Authority: It is possible. That is a problem with the lack of regulation as far as drug acquisition and importation is concerned. And when I say "importation" meaning somebody with a legitimate prescription coming from a doctor overseas that has written it and they bought it at CVS or somewhere. We don't have any controls. We don't have controls to say that you can't import X, Y, Z. In Jamaica and other jurisdictions there are some drugs, if they are not on your register you can't bring them in, it does not matter who needs it. You just can't bring them in without going through the vigorous process of trying to get it registered to be in the Island or in the country. And the lack of a law has caused this to fall into that trap, pretty much where the purchase of drugs is open—and this is the legal purchase of drugs by suppliers now. It is open to anything. You can purchase anything from anywhere.

Now, as far as to patients coming back from overseas are concerned, we have situations, and I must say that we work very closely with customs. Every so often and very often they call us for help with identifying or trying to figure out whether something is a prescription drug, whether or not it was acquired, whether or not the patient has gotten more than would be expected to come in on a prescription. And that happens quite often. But what we have seen is that yes, patients can go overseas and collect the drugs and so on. I don't think there is a Customs law that stops that. But customs, at the same time, does do quite a bit of seizure and quite a bit of searching that turns them up. I don't think they will catch everybody; I doubt very much. But to say that there is nothing being done is kind of a stretch. We don't have any legal framework for it to be dealt with. We don't have that yet. It is included in the new Pharmacy Law but obviously we don't have that.

Mr. Winston C. Connolly, Jr.: That was going to be my next question, meaning, if not, then hopefully that is a part of the recommendation and something that has been accepted and not pushed back.

Mr. Colin Anderson Medford, Chief Pharmacist, Cayman Islands Health Services Authority: Yes, importation by the correct sources is a huge section . . . well, a huge part of the law.

The Chairman: Are there currently any local suppliers of medicines that do not have a pharmacist on staff?

Mr. Colin Anderson Medford, Chief Pharmacist, Cayman Islands Health Services Authority: Not to my knowledge, no.

[Inaudible interjection]

Mr. Colin Anderson Medford, Chief Pharmacist, Cayman Islands Health Services Authority: Not to my knowledge.

The Chairman: Okay.

Mr. Colin Anderson Medford, Chief Pharmacist, Cayman Islands Health Services Authority: No, not at all. If it is not owned by a pharmacist, the drug area is run by a pharmacist.

The Chairman: Okay.
Any other questions?

[No audible reply]

The Chairman: Okay sir, thank you very much and we wish you the best. And we will be making some recommendations that we hope will enhance your batting average.

Mr. Colin Anderson Medford, Chief Pharmacist, Cayman Islands Health Services Authority: Thank you very much.

The Chairman: Thanks for coming.

[Pause as witness leaves the Chamber]

The Chairman: The Committee will now adjourn until 9 o'clock.

Mr. Winston C. Connolly, Jr.: Can I just do one intervention?

The Chairman: Mm-hmm.

Mr. Winston C. Connolly, Jr.: In terms of this overall document . . . and it might be too pre-mature right now but if it is you can tell me otherwise. I think it is incum-

bent on us as a committee to strongly recommend to the Government that these set of reports and the protocols and criteria recommended be taking on and used as the baseline for reporting back on the issues raised, you know, if not annually at least bi-annually. And I would like to recommend that we do that in the final report.

The Chairman: Absolutely! I think it is a good base to standard and I would like to see the report updated. From my point of view, I think it should require an annual update because it also will drive the various agencies to put in place the necessary metrics to measure it rather than to just let it sit and say nobody has asked us to do a report and the next time we need it the Auditor General has to go through all kinds of drawers and cupboards and doors and alleys and what-not looking for files and papers. So, I agree that that should be a recommendation from the Committee.

So, the Committee is being adjourned until next week Thursday, 9th February, at 9 am.

VOTE OF THANKS

Mr. Martin Ruben, Director of Performance Audit: Mr. Chair, just if you could give me a second.

I would like to thank the Committee for the acknowledgement at the beginning of this session. And I would just like to also mention that it was a pleasure over the last eight years to serve this Committee and that it was a real honour to actually serve this Committee over the last eight years, especially the last few under your chairmanship, sir. So again, I bid you ado and thank you very much.

The Chairman: And Ruben, we wish you the best, and again, I will put on record our appreciation of your efforts and the standards to which you have raised, in particular, the performance reporting aspects and for that we will always be grateful. And we will do our best as long as I am around, to make sure it does not slide backward. But thank you very much and we wish you the best in your future endeavours.

We will adjourn until 9 am, Thursday, 9th of February.

At 3:05 pm the Public Accounts Committee stood adjourned until 9:00 am, Thursday, 9th February 2017.

Legislative Assembly
of the Cayman Islands

THE STANDING PUBLIC ACCOUNTS COMMITTEE

MINUTES

Hearing held *with Witnesses*

Friday, 9th February 2017

9:00am

The notes of the meeting of the Standing Public Accounts Committee held in the Chamber of the Legislative Assembly Building, Grand Cayman on Friday, 9th February 2017 at 9:00am.

Present: Mr. D Ezzard Miller, MLA – Chairman.
Mr. Winston Connolly, MLA – Member.
Ms. Manesa Webb – Acting Clerk of the Public Accounts Committee.

Apology: Mr. Roy McTaggart, JP, MLA – Deputy Chairman.
Capt. Eugene Ebanks, JP, MLA – Member.
Mr. Joseph Hew, MLA – Member.

Attendees: Ms Sue Winspear, Auditor General – Office of the Auditor General.

Mr Ruben Martin, Director of Performance Auditing – Office of the Auditor General.

Ms Angela Cullen, Acting Director of Performance Audit – Office of the Auditor General.

Hon Kenneth Jefferson, Financial Secretary/Chief Officer – Ministry of Finance and Economic Development.

Ms Gloria Myles, Deputy Accountant General – Ministry of Finance and Economic Development.

1. Reference

In accordance with sections 73(1) and 77(4) of the Legislative Assembly Standing Orders (2006) Revision, witnesses were invited to appear before the Committee to discuss various issues set out in the following Reports of the Auditor General:

a) *Cayman Islands Health Care System- January 2017*
b) *Ensuring Quality in Health Care & Healthy Population – January 2017*

2. Hearing to Order

The Chairman called the Hearing to order at 9:10am. However, as there was no quorum present, he declared that the Hearing be cancelled. He apologized for any inconveniences this cancellation may have caused to the witnesses, Mr. Mervin Connolly and Ms. Lyria Lawson-Josephs, the Auditor General and her Audit Team, the Financial Secretary/Chief Officer and the Deputy Accountant General. He requested that all of the parties present should collaborate with each-other to determine a satisfactory date to reschedule the Hearing. The Hearing was rescheduled for Monday, February 13th, 2017 at 2:00 pm.

The Chairman noted that as the Legislative Assembly Recording Technician, Mr Locksley Gould, was late, his apologies for cancelling the Hearing because of a lack of a quorum could not be recorded.

3. Scheduling of next Hearing

The next Hearing was confirmed for:

- Monday, 13th February 2017 at 2:00pm

4. Adjournment

The Hearing was adjourned by the Chairman at 9:20am.

Legislative Assembly of the Cayman Islands

THE STANDING PUBLIC ACCOUNTS COMMITTEE

MINUTES

Hearing held *with Witnesses*
Monday, 13th February 2017
2:00pm

Minutes and verbatim transcript of the Hearing of the Standing Public Accounts Committee held in the Chamber of the Legislative Assembly Building, Grand Cayman on Friday, 13th February 2017 at 2:00pm.

Present: Mr. D Ezzard Miller, MLA – Chairman.
Mr. Winston Connolly, MLA – Member.
Capt. Eugene Ebanks, JP, MLA – Member.
Ms. Manesa Webb – Acting Clerk of the Public Accounts Committee.

Apology: Mr. Roy McTaggart, JP, MLA – Member
Mr. Joseph Hew, MLA – Member.

Attendees: Ms Sue Winspear, Auditor General – Office of the Auditor General.
Mr Ruben Martin, Director of Performance Auditing – Office of the Auditor General.
Ms Angela Cullen, Acting Director of Performance Audit – Office of the Auditor General.
Hon Kenneth Jefferson, Financial Secretary/Chief Officer – Ministry of Finance and Economic Development.
Mr Matthew Tibbetts, Accountant General – Ministry of Finance and Economic Development.

1. Reference

In accordance with sections 73(1) and 77(4) of the Legislative Assembly Standing Orders (2006) Revision, witnesses were invited to appear before the Committee to discuss various issues set out in the following Reports of the Auditor General:

a) *Cayman Islands Health Care System- January 2017*
b) *Ensuring Quality in Health Care & Healthy Population – January 2017*

2. Hearing to Order

There being a quorum present, the Chairman called the Hearing to order at 2:32pm.

3. Welcome

The Chairman gave a brief welcome to the Members of the Public Accounts Committee and the staff of the Office of the Auditor General and the Ministry of Finance and Economic Development.

PAC Member, Mr. Roy McTaggart, was not in attendance due to his Acting responsibilities as the Minister of Home Affairs & Culture until the 16 February 2017.

PAC Member, Mr. Joey Hew, was not in attendance due to a late notification that he was off island attending departmental duties.

The Chairman noted their absences.

4. Report of the Auditor General: –

Ensuring Quality Health Care and a Healthy Population – January 2017

The Chairman made an opening statement on the above mentioned Report and the Hearing(s) commenced at 2:32pm. The Chairman then invited witnesses to the Chamber and asked them to state their names, the persons attending with them if any and department or organization they were representing. The Chairman then opened the floor for statements from the witnesses followed by questions from the Members of the Public Accounts Committee.

The following persons listed below appeared in their named capacity as witnesses before the Committee for this Report:

- *Mr. Mervyn Conolly – Director, Department of Health Regulatory Services*
- *Ms. Lyria Lawson-Josephs – The Registrar, Health Practice Commission*

At the conclusion of the Hearing for the above mentioned Report the Chairman thanked the witnesses and adjourned this session of the Hearing at 4:02pm.

5. Scheduling of next Hearing

The next Hearing was confirmed for:

- Friday, 17th February 2017 at 10:00am

6. Adjournment

The Hearing was adjourned by the Chairman at 4:03pm.

OFFICIAL VERBATIM TRANSCRIPT
STANDING PUBLIC ACCOUNTS COMMITTEE
MONDAY
13 FEBRUARY 2017
2:33 PM

Meeting with witnesses

"CAYMAN ISLANDS HEALTH CARE SYSTEM"
"QUALITY HEALTH CARE AND A HEALTHY POPULATION"

Verbatim transcript of the Standing Public Accounts Committee meeting held 13 February 2017, at 2:33 pm, in the Chamber of the Legislative Assembly Building, George Town, Grand Cayman.

Present: Mr. D. Ezzard Miller, MLA, Chairman
Mr. Winston C. Connolly, Jr., MLA, Member
Capt. A. Eugene Ebanks, MLA, Member

Absent: Mr. Roy M. McTaggart, MLA, Member
Mr. Joseph X. Hew, MLA, Member

In attendance: Mr. Kenneth Jefferson, Financial Secretary/Chief Officer, Ministry of Finance
Ms. Gloria Myles, Deputy Accountant General, Ministry of Finance

Audit Office: Ms. Sue Winspear, Auditor General
Mr. Martin Ruben, Director of Performance Audit
Ms. Angela Cullen, Acting Director of Performance Audit

Witnesses: Mr. Mervyn Conolly, Director, Department of Health Regulatory Services/Superintendent of Health Insurance
Ms. Lyria Lawson-Josephs, Deputy Director/Registrar, Health Practice Commission

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The Chairman: Good afternoon, I would like to call the Committee to order. Let the record show that we have a quorum present. I want to thank all those who decided to return after we were unable to meet on [Thursday]. This afternoon we will continue our hearings on "Ensuring Quality Health Care and a Healthy Population". We have invited Mr. Mervyn Conolly as the Director of the Department of Health Regulatory Services, and Ms. Lyria Lawson-Josephs, the Registrar of the Health Practice Commission.

Thank you all for coming. When you answer the first question, just identify who you are and what your responsibilities are for the record. Okay, I guess I'll start things off and your concern is with two areas, the Health Insurance Commission (HPC), and the Department of Health Regulatory Services (DHRS). So, I guess we will start with the Department of Health Regulatory Services. Have you have been given the full report?

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: Yes, I have

The Chairman: And you have noticed on the recommendation side that you have been identified as being responsible for the implementation of several of the recommendations, starting with recommendations 3, 4, 5, 6. You are part of those recommendations so those are the recommendations that we will kind of concentrate on.

On the health regulatory side, one of the things that we are a little bit concerned about is the Department of Health Regulatory Services licenced facilities. Does the facilities licence fall under that as well?

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: That's correct.

The Chairman: What is the current status of that? And how do you monitor the standards? So, if you could just talk to us a little bit about that. And, how do you maintain or assure that the standards you are granted for the licenced facilities are maintained? Do you do routine inspections, unscheduled inspections? What's the position of the facilities licence? Is it an annual licensure? And I have quite a few more questions, to follow up.

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: Thank you very much, Mr. Chairman.

I am Mervyn Connolly, the Director of the Department of the Health Regulatory Services and the Superintendent of the Health Insurance. Perhaps it may be useful for us to just have a little background on the department itself and then we can say exactly who will be responding to the questions.

So, just around mid-2008 the Health Insurance Commission was merged with the Health Practice Commission to perform the Department of Health Regulatory Services. At the time, the decision, as I understood, was purely from an administrative position, meaning that the two units were fairly small and it was felt by central government that if the two departments came together they could be managed more effectively and efficiently. So, at the time I was already wearing the hat of Superintendent of Health Insurance.

There's also another statutory position, the Registrar, which is obviously very key in regards to administering and supporting the Health Practice Commission Board and the Councils. So, Ms. Josephs is the Registrar.

In the department itself, on a day to day basis as the head of the department and superintendent, I really don't have a lot of day to day interactions with the Councils and the Health Practice Commission Board. I certainly have a lot of interactions with the Health Insurance Commission Board and, obviously, under the Health Insurance Law the superintendent is responsible for administrating the Health Insurance Law and Regulations.

The registrar doesn't necessarily have a similar function as the superintendent. The registrar provides more of a support, meaning, from the point of view of managing the minutes, making sure that all of the decisions that are taken by the councils and the board are properly documented and recorded. And certainly, the registrar is also responsible for entering the names of those persons who have met the criteria, and are able to be registered on the register. So, our interaction in regards to the department with the councils and the board is to provide administrative support and obviously technical advice to them on various matters.

With that in mind, the questions in regard to the maintenance of the standards, again, the standards . . . we actually employed the first health insurance inspector in 2009, and its actually one of the first duties that I undertook as head of the department to ensure that that post was first of all established in the budget and that we had sufficient funding to certainly cover that key post, meaning the health practice and facilities inspector.

Right around 2009 going into 2010, we started what we consider to be a public education process where we worked with the stakeholders, mainly the health care providers and health care facilities, to really give them as much information as we possibly could in regards to the standards that actually had been on the . . . I guess, on the books for perhaps 2-3 years prior to that time. So, in 2010 is when we really immersed ourselves into trying to pursue the inspection of health care facilities so that they would obviously then be certified and registered as health care facilities.

So, Mr. Chairman when you look at that we have, a little bit more than 5 years' experience since the first inspector was appointed, and I think basically what is done, we do have a schedule that has been set up for all of the health care facilities. And, as it is now, the Health Practice Commission Board made a decision that your license can actually be for one year, two years or three years, depending on your history and depending on how compliant been you know over the preceding period. So, the health facilities inspector is really required to maintain that schedule and then when an inspection is conducted, obviously, we apply the standards for that facility and a report is then provided to the Health Practice Commission Board, and the board would make a decision in regards to the whole issuing of the license for that particular facility.

The Chairman: Do you rely at all on what seems to becoming very popular is . . . I don't much remember all the acronyms but this joint accreditation, hospital joint accreditations, do you put a lot of reliance in that or you do your own?

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: No, I think we certainly rely on the joint commission standards. Again, that is very robust. It's tested and basically if a facility can prove that they met that type of standard, then, obviously, that is significant. Now there may be one of two variations in regards to the local environment, but by and large, that is what has been used to set the benchmarking and standards.

The Chairman: But even if a facility claims to have that, do you verify that with the supervising authority and you still do your inspections?

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: We still conduct our inspections.

The Chairman: Talking a little bit about the professional's themselves, we have had some evidence that there seems to be a difficulty in getting the Ministry and the political arm of Government to make necessary changes to improve the standards of raising the levels of the professional standards. Is that so or . . . ?

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: Well, I think from where

I sit, what I see is that obviously there are some facilities which came out in the report that are not currently registered, and certainly, they could have been considered health care facilities. The intent was that they were going to modify the existing standards to meet those facilities and that hasn't happened, unfortunately, because I think, in our opinion, certainly those facilities should be inspected, but I know that certainly there is some work in progress to have those standards revised so that they can capture these types of French type of health care facilities.

The Chairman: But one of the statements in the document on page 16, section 44, the Auditor General says: **"In relation to the Government's capacity for exercising its authority and effectively carrying out its roles and responsibilities, the most common concern express by the public as well as private sector executives and professionals we interviewed was about perceived serious capacity shortages in the Ministry, in the Department of Health Regulatory Services (DHRS) and in HSA."** Have you been given any support to improve your own department, in adding more staff in order for you to be able to cope with the work load that you have? It seems to me that not a lot of people are there now.

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: Yes, Mr. Chairman, that's an accurate observation in regards to our staff levels. But having said that, clearly, when we are preparing our annual budget there are parameters and constraints and we are pretty much given what the target number is, actually, before we even submit the budget documents. And I can tell you we've been through some very lean years where actually, the budget was extremely tight. That being said, obviously, we worked within those budgetary constraints in regards to performing our duties at the department level with the resources that we were provided with. The bottom line is that yes, we would certainly welcome additional staff, both from the Health Practice Commission side and from the Health Insurance Commission. But clearly, with the type of budgetary constraints that we've been faced with over the last several years, it has made it extremely difficult for us to achieve that.

The Chairman: Yes, and . . . Sorry.

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: Having said that, I have now been provided with an additional post in this annual budget, and hopefully we're now in the process of getting that position filled.

The Chairman: It's a matter of priorities because it's safe to say (although the budget office is here this afternoon) that year after year there hasn't been a reduction in expenditure. Each year, while they give you the parameters, they have spent more money each year; at least [according to] the documents that are brought down here year after year. So, we understand that there are competing forces, but we also believe that this is a very important area in government that has a serious impact on the country having the confidence that you have the resources to do your job.

If I could just ask a couple of questions . . . you want to ask some questions?

[Inaudible interjection]

The Chairman: Okay.

I am going to move on to the health insurance now, if you want to.

Mr. Winston C. Connolly, Jr., Fifth Elected Member for George Town: Mr. Chairman, through you.

In terms of the relationship with those four professional bodies that come under your umbrella in terms of the registration and licensing of health professionals, we had some testimony last week or week before from members of the, I think, it was the Medical and Dental Council regarding the professional qualifications, and whether or not they were internationally acceptable or lacking in there. When you hear that type of messaging coming from your councils or your boards, can you describe what the procedures are and the actions then flowing from that would be, that is, would you pass it up the Ministry responsible? Or would you make a determination and a recommendation to the Minister given that one of the roles that you have is also an advisor to the Minister of Health?

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: Through you, Mr. Chairman.

It's a very interesting question that you asked and I'm not going to go back too far. I think we all know that we recognise, basically, seven jurisdictions, and I think what the Health Practice Commission and the Councils recognise is that certainly, an individual who has obtained qualifications in one of those seven jurisdictions, that is what has set the standards, so to speak. And if you're registered there, obviously, then, when you come to the Cayman Islands we would certainly want to honor that type of qualification, that type of recognition of the experience and skills that that individual brings.

I think where it becomes a little more of a challenge is certainly when we have individuals who . . . let's give an example. For example, let's say we do recognise a UK qualification but if someone comes, let's say, from one of the eastern European countries, how do you then equate those because of the . . . well, currently still, the European Union, that type of arrangement.

I think the idea is that the councils want to still ensure that those individuals meet a minimum level of standards and that their qualifications are vetted. Again, it is vetted on an individual basis so that each individual that comes to be registered, their credential and qualifications and experience are certainly vetted based on what they have, and what they have.

If you don't mind, Mr. Chairman, for additional information, I could perhaps ask the registrar to provide additional information.

The Chairman: Sure

Ms. Lyria Lawson-Josephs, Deputy Director/Registrar, Health Practice Commission: Good Afternoon, Mr. Chairman. I am Lyria Lawson-Josephs, Registrar for the Health Practice Council of the Cayman Islands. I sit on the Health Practice Commission Board, and the four Councils. My responsibility is really to ensure that the actions and decisions that the Council takes on, are guided through the Health Practice legislation, and records of decisions maintained. For compliance, everything has to be in compliance with the Health Practice Law 2013 because that's where we are now.

A key responsibility of mine is verification of all documents that come in for every single practitioner which registers in this country. Sometimes it means that I have to make a phone call for even a professional reference or a personal reference. It means that I have to go to council, whether by email, for verification of authenticity of the notary public. So, every document that comes in before it's presented to council they are vetted, according to what's in the Health Practice Law. So, if it does not get past us, it doesn't get to the council.

We really do . . . because, say we have people that come with a Jamaican registration but you were trained in Spain or another country, one of the things your general . . . your first medical degree is recognised by the Caribbean Medical Association, and you can do an examination through them and gain Jamaican registration, but your specialty qualification from those countries are not recognised. Although it is listed on your qualifications from Jamaica, it is not recognised here, it is only recognised within the seven territories that we know are authentic. So, you'll come from Spain with a registration in Jamaica and they put dermatology on it but you will not be valid to practice dermatology in this country. You'll have to physically get it from one of the . . . you would have to do some training in Jamaica at the University of the West Indies which is where they recognise this specialty in Jamaica; only at the University of the West Indies. Or you would have to get it from the USA or the UK. But the special direct registration is not licenced eligible for the specialty registration but you must have a fellow . . . not a membership, but a fellowship within these organisations. Because I can be a member of anything but I need to sit an exam before my peers, and be examined and this is a valid document for us.

Oftentimes a lot of these countries are going to electronic systems so we get the documents from them but we still go back to the databases to check and validate them form the databases themselves because the database will tell you whether they are a medical doctor specialising in dermatology, subspecialty in pediatrics. So, we still go back again, double, triple confirmation of what we have to present before council as authentic documents.

Mr. Winston C. Connolly, Jr., Fifth Elected Member for George Town: Mr. Chairman, through you to Ms. Josephs.

In terms of— we've heard of the rigger that occurs. How often is that criteria reviewed in terms of the seven jurisdictions? Is it keeping up with best practice, those sorts of things, and when was the last review?

Ms. Lyria Lawson-Josephs, Deputy Director/Registrar, Health Practice Commission: Hello, through you, Mr. Chairman.

The most recent review was of the Medical and Dental Council guidelines because they wanted to ensure that individuals working here are not just medically trained first degree with limited experience and no specialty qualifications. The people of Cayman deserve more, they deserve quality and they deserve the best practice ever. We have a high doctor per capita in this country, so what we want to provide is more than basic training. That's what we want.

It was reviewed recently and they upgraded their guidelines to meet international standard and that is key for them, and it's frequently updated. The Nursing Council has upgraded their standards. It's incorporated as the Cayman Islands Nursing Group that's here at the University College of the West Indies, the Bachelor's degree program, and it also takes into consideration as well . . . right now they are currently updating their code of conduct . . . the code of ethics, sorry. So, all of those documents are vetted and compared to ICN [International Council of Nurses] standards. So, they are updating that.

Of course, you know that the Allied Council has a vast amount of professions, so what they do is that per profession, they update them accordingly. So, this year there may be 500 for massage therapists, they might want 500 plus 2 so they constantly update to meet international standards. And, of course, they also decide if they are going to take the US because their medical system is a little bit lax, or if they are going to keep Jamaica because they have not updated their Law since 19 whatever, or if they are going to keep the Jamaica Pharmacist Association or use the Bermuda Pharmacist Association to compare to see what they're doing. So, they do use regional compari-

son and international comparison to ensure. Australia is a great example they have used, and the forward thinking of the Australia process they have used that, and the medical dental council guide they practice. So, it's a constant update, and they do it to ensure the public is getting the best care possible.

The Chairman: Yes, sometime last year I think it was in the . . . could have been in the February session, the Government accepted a motion to upgrade certain of those guidelines to regulations. I can remember specifically part of that was the Standard English test. Has that been upgraded to regulations yet or is it still guideline?

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: Well, it certainly may not be in regulations as yet, but the councils are definitely utilising that standard in regards to the proficiency in English.

The Chairman: Is the council utilising it as a guideline which is kind of quasi enforceable not enforceable, whereas, a regulation carries the authority of Law, and therefore not only is it enforceable but there are usually penalties if you don't do it?

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: Yes.

The Chairman: So, is there any explanation for the delay in getting it done?

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: Mr. Chairman, I don't know if I will respond to the delay in regards to getting it in regulations, but certainly, the guidelines are there and my understanding is that the council is utilising the guidelines.

The Chairman: My concerns would be that if they challenge guidelines in court versus regulations the council might be in some difficulty.

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: That would be correct sir.

Mr. Winston C. Connolly, Jr., Fifth Elected Member for George Town: Mr. Chairman, through you.

In terms of the public policy, kind of view point, and this is basically to have a statement from the HPC to the wider Cayman audience—based on your professional qualifications and viewpoints, the law covers that that international standard and the people of the Cayman Islands can be well assured that doctors practicing in both public and private medical facilities have all met that standard.

Ms. Lyria Lawson-Josephs, Deputy Director/Registrar, Health Practice Commission: Mr. Chair, yes absolutely. Every single practitioner that walk through our doors, they will come in three, four . . . The process that we use for vetting the applications, we have the guidelines, as you know, that are on the website. They will come in with their documentation and we do we have a checklist. If they don't meet one on the checklist we circle it and we send it back. They will come in 10, 15 times if they have to, just so they will have to comply. Once they meet our standards, and according to the Health Practice Law, and what we recognise, then, they are sent to council. And remember now, they are only licenced eligible. It's not a right and it's not a guarantee, they are only eligible for the council to vet to see if they deserve to have that professional designation in the country. So, when it goes to council they also do their own vetting on it. Sometimes I might have to go back and double check something before it might be deferred and come back to the council. Or they might say it is deferred pending a document from professional reference clarification of the certification specialty registration. So, everything goes back and we will double and triple vet it and once that is done they are granted a registration, and once that registration is provided it doesn't mean that they go out there and put up their shingles, as Mr. Conolly would say.

No, they now have to go off and access malpractice coverage with that registration document, and we do what we call a [INAUDIBLE] switch. So, once you give it to me and we are happy that it is valid malpractice insurance and it's good, we then provide you with the registry, with the practicing license and now you can go and start practicing.

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: So, Mr. Chairman, I think it's fair to say that we have a very robust processing system, and certainly due diligence is conducted I think the registry said earlier that we don't just accept you know the documents we actually pursue to verify and confirm that those documents are really valid and legitimate documents.

The Chairman: What kind of monitoring goes on with the profession once they are licensed, that is, do you look for medical audit or peer reviews in terms of their performance? Or do you rely on complaints from patients for malpractice? And what is the process in dealing with patients' claims of malpractice or things that might turn up in medical audit peer reviews?

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: Mr. Chairman, excellent question.

If we are really being honest, I think this is an area that we need to improve on. Certainly, I can say to you that even from the other side, I guess, of the

balcony, and looking at it as a patient, I think this is an area we are lacking.

Unfortunately, we don't do that type of in-depth peer review. The council obviously makes the decision in regards to the complaints. So let's say a patient has a complaint, it would probably come to the department in the initial for us to document the complaint. The complaint is then actually taken to the Council or to Health Practice Commission Board for them to actually do the vetting and make whatever decisions they deem necessary on that. So, that is really not done at the department level. Unlike the health insurance commission side where the superintendent of health insurance have the authority under the law to actually go out and actually investigate the complaint and where necessary, we can issue a directive for it for the matter to be corrected and or other enforcement action where necessary.

So, we rely heavily on the councils, you know, through the professional peer, for them to actually look at these types of complaints and obviously make decisions in regards to what action is necessary. Again, the registrar and the health practice facilities inspector would be able to assist them in any investigation, but as far as what action that is determined to be suitable for that, that is done by the councils, and/or the board.

The Chairman: And that action is normally based on regulation?

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: I would want to say yes.

Mr. Winston C. Connolly, Jr., Fifth Elected Member for George Town: Mr. Chairman through you.

I'm heartened by that response in that when we heard these things two weeks ago it was kind of a shock in terms of thinking that they might be different levels of qualification which make certain routes to certification, and registration somewhat less than others.

In terms of the weaknesses that you have just accepted, in your role as advisor to the Minister, have these kind of areas been highlighted before or can this Committee help by highlighting some of those and putting them in our report? If the standard or the criteria can be raised and the vigilance robust after the process as well, tracking the malpractice suits and looking at where some of these people . . . the routes that are coming around, you know, tracking statistics. Is there one area or one route that has a higher number of complaints and malpractices? Because those are things that you can then take forward and really intensify the scrutiny, and the rigger which would allow the public to feel comforted that, not only do you do it before, during, but definitely afterwards as well. Has that occurred or can this Committee help in terms of highlighting some of those areas for more resources?

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: Through you, Mr. Chairman.

I think it would be fair to say that they have been some cursory discussions but nothing that has really been formalised. So again, as I said earlier, certainly this would be well in keeping with what the department would want to see happening in regards again to protecting the public and ensuring that you know the quality of care that is being provided is certainly of the highest quality.

The Chairman: How do you manage institutional registration? And what regulatory supervision do you have over institutional registration in its current format?

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: Thank you, Mr. Chairman.

Clearly, we do have a facility that has obviously been given that type of recognition. From the department point of view we have been given some guidelines and how we look at that those practitioners, and again we do—

The Chairman: Then those guidelines came from Cabinet or from the Council?

Ms. Lyria Lawson-Josephs, Deputy Director/Registrar, Health Practice Commission: From Cabinet.

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: So again, based on those guidelines we ensure from the department point of view that they go through the process and we do the due diligence to ensure that those individuals certainly have gone through the programmes, even if it's in one of the jurisdictions that is not necessarily recognised under the legislation. We do go back and ensure that those documents are certainly valid and that they are legitimate. And again, obviously, this is something that we feel very strongly about, and sometime it does cause delays in the registration of those practitioners, but based on the guidelines we ensure that they meet those requirements.

Ms. Lyria Lawson-Josephs, Deputy Director/Registrar, Health Practice Commission: Mr. Chairman, the individuals registered on the institutional list are only allowed to work in that particular facility. They are not allowed to work anywhere else in the Cayman Islands; only in that facility.

The Chairman: And that was part of the justification of the government of the day for bringing that whole barn door which lowered the standards beyond the wildest imaginations. But the truth of the fact is now, that according to their own statistics 90 plus percentage of their patients are Caymanians. Because when we were given this thing of institutional registration it was, *Well, we really don't need to have that high qualification because it is not working on Caymanians*—right? But, by their-own statistics the majority of their patients are Caymanians. How do we assure and how do we explain to Caymanians the difference in the levels of registration to give them the comfort that they have the same protections?

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: It's a very good question. Again, we rely on the guidelines that have been obviously approved. I can say to you again that certainly all of the practitioners there do meet those minimum requirements. But, having said that, let me say, some of the practitioners in that particular facility do meet the qualifications and requirements from one or the other recognised jurisdictions.

The Chairman: That's why it should never been done, because it wasn't necessary.

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: So, we do have. And also the facilities, we ensure that the facilities are certainly inspected so even though they present themselves as having met JCI [Joint Commission International] accreditation, we certainly then went back and utilised our standards for the inspections of the health care facilities.

The Chairman: One of the disturbing pieces of evidence that we got was, and we have that written evidence to support, is our situation where there has been communications from the Medical and Dental Council and from the Medical and Dental Society, going back until the 27 November 2013, 18 February 2014, 7 September 2015, and 10 September 2015, basically asking for the same consideration of matters, and the evidence put to us was that none of this has been responded to as being received, and that is very troubling to this Committee. And having reviewed what they're asking for, the things that they are asking for are not unreasonable, and certainly from where I sit, wearing a professional hat myself, I would support and agree with many of the recommendations and changes that they're having. This seems to be the common thread at the Ministry of Health level, both on the health practice side of it and on the health insurance commission side of it. I know it's unfair to ask you why it hasn't happened because it's not within your purview. But question I want to ask you is: Were you aware that this type of correspondence was being written?

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: I think It's fair to say that yes, we are aware. Yes.

The Chairman: Because you would have no knowledge if there was a response or not, unless it was copied to you, and I don't want to ask you that question.

We may cross back and forth as we go forward, but shifting now to the health insurance side of it, again, it seems to be, that the biggest complaint from the private sector and the public sector is the health insurance component of the health care field. Is this because of a breakdown in communication between your office and the Ministry or between the Health Insurance Commission itself? One of the things that troubles me from a strictly governance point of view is, there seems to be this belief and this practice in the Ministry that if we have somebody sitting on the board there is no need for formal communications which clearly delineate, separate, and hold accountable the agencies that are responsible. And there is this whole grey area that because somebody from the Ministry sits on the board, then, they take back, I would assume, their interpretation of what was discussed and whether there's any need to implement that or not. Is there a formal means of communicating from the Health Insurance Commission to the Ministry and the Minister?

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: Thank you very much, Mr. Chairman. I think it's fair to say that the system in regards to the funding of health care in the Cayman Islands is a fairly complex one, in that you have, obviously, commercial insurers who are providing health insurance products. And while the Health Insurance Law and regulations does provide some parameters, clearly, we have such a, first of all, a large number of approved insurers who are selling a large number of health insurance products. So, what the health insurance regulations have really set is more or less the parameters around the provision of the Standard Health Insurance Contract (SHIC) which is actually the basic plan. What the legislation does require though is that all of the supplemental plans have the benefits of the Standard Health Insurance Contract. In other words, you cannot sell a health insurance plan unless it has embedded in it the components of the SHIC.

Having said that, it's clear though, from where I sit, I see we have four major stakeholders. So, we have the health care providers that obviously provide the treatment and services to patients who have health insurance cover. We have the insurance companies which have to be licenced by CIMA; that is the

Cayman Islands Monetary Authority, and approved by the Health Insurance Commission to sell health insurance products. And we have employers who are required to provide health insurance for their employees, and then the fourth major stakeholder from the superintendent's point of view, is insured persons. So, depending on where you are as a stakeholder, obviously, you will see things a little bit differently.

Let's go back then to the health care providers and the insurers. It's fair to say that the approved insurers and health insurance companies are required to meet very stringent requirements to be able to sell health insurance products. We conduct, at least on an annual basis, on-site inspections and audits of their records, and on a monthly basis we receive significant amount of information from them. So, in my opinion, they are being closely monitored. But it's clear to say that their objective is to, at the end of the day, ensure that the premiums being collected are not outstripping the claims that they receive from health care providers.

The Chairman: No their job is to ensure that the premiums outstrip the claim. I think you indicated the other way around.

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: So, they have their premiums but they want to make sure that the claims do not, you know,—

The Chairman: Get more, yeah.

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: So, from that point of view, obviously, they apply a number of, I guess you could call it a number of initiatives to ensure that at the end of the day they are obviously sustainable, meaning they are in the black (so to speak). And I don't think we can fight them for that. Where I have a problem as Superintendent of Health Insurance is where an insured person has a plan of benefits which clearly meets the particular, let's say, episode of illness, and where those claims are denied with little or no justification, and in that instance where we obviously have that information, we will pursue that insurer to make sure that they do accept those claims from that health care provider.

Now, in the processing of making sure that the patient receives the care or treatment or service that is required, a lot of insurers also apply something called precertification or pre-cert as some people refer to it as. And the whole aspect of precertification is really not covered in the regulations. So, the way it operates now is that a health care provider can submit a claim, and the insurance company can say we need pre-cert on that, and obviously this would be in elective cases. In an emergency situation it is really not required until after the treatment is provided, but certainly, in elective cases they usually require a pre-cert, and there are varying standards that are applied to this precertification. I think this really frustrates the health care providers, meaning, that a health insurance company can use the pre-cert process to really 1) not necessarily deny the claim but delay the claim, and when they do that it means then that they are questioning the attending physician in regards to whether the care is medically necessary or not. The feedback I've gotten from the health care providers is that quite often they feel that the insurance companies are utilising other entities that are outside their office, or if they are employing those persons who are looking at these types of pre-certs, they are really not qualified to the level of a physician.

So, we have a non-physician who is questioning a physician about whether a treatment or service is medically necessary. And that is something that I see happening, certainly, in a business. And the Commission is now looking at that, and again, we're not quick to want to issue or introduce regulations where it may not be deemed necessary, but clearly where we have repeat complaints about the same matter, then it's clear that if the market itself cannot resolve it, we'll have no alternative but to introduce some type of regulation to address the matter.

If I could though, on the other side, now looking at the health care providers, obviously, they need to make money. It's important that they make money; not only for the overheads but also, so that they can continue to practice. I believe that one of the best things that came from the health care providers and brought to my attention is that they feel somehow constrained by the standard of insurance fees. And it is true that the standard health insurance fees are set to really try and establish some level of reasonableness in regards to the fees that have to be paid by insured persons and obviously the health insurance companies. But in the legislation there's nothing there that prevents a health care provider from charging fees that exceed the standard health insurance fees.

While we have, based on the last actuarial report that we received, approximately 45 per cent of the current health care providers are utilising the standard health insurance fees, and in many instances, in my interaction with health care providers, they would prefer to have fees that are higher than the current level of shift fees. But the feedback I get from, not all, but certainly a good percentage, is that *we can work with these fees.* The problem is that we need to be paid on a timely manner. So, if an insurer is taking an ordinary amount of time to process the claim, then, that is where I think the problem arises. So, we have two issues depending on which side of the balcony you're sitting on where the health care providers are felling that first of all, the fees should be increased, and secondly, they need to insure that the timeliness of getting their payments when they submit a claim, that that is improved.

On the other side of the balcony we have the insurers who are saying, *Well we have to make sure that there are no abuses* and not that type of thing going on. So, from the Superintendent's perspective, certainly, we make decisions based on what the legislation empowers us to do. And again, I feel that with the resources I have available, that we try our very best to ensure that all complaints, whether it's coming from an insured person, a health care provider, an insurer or an employer, that we deal with does complaints in an expeditious manner and certainly, fair and consistent.

The Chairman: Isn't it fair to say that when the insurance companies are having the premiums calculated actuarially, they use the health insurance fees as a huge component of that and really and truly the actuary should not normally take into consideration denied delay and refusal to pay? Their premium is based on a person claiming that based on the incidents and demographics and everything else and being paid those fees.

What is stopping the Government from putting in place legislation that requires real time verification followed by authorisation, followed by payment within 24 hours?

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: Mr. Chairman, to answer that question, clearly, we recognise the need for an electronic verification system. Again, to me it is one of those facilities in this day and age because I think as I've heard you said in previous forums, the technology is there.

The Chairman: Been there from 1990.

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: Exactly! And I think going back to 2012-13—and I don't want to rehash too much of this—clearly, I think the Government recognises that yes, this is something definitely needed. Unfortunately, again, we know what happened with that particular initiative and it's really unfortunate because the need is . . . I can't stress how much we need such a system. It would reduce, I believe, the number of complaints that we receive from health care practitioners, pretty much, I would say by 60 to 70 per cent, if not more. It would also help the insured persons, so that when you're presenting yourself the health care provider you will know exactly what your health insurance is covering and you what is required of you at the time that you are there receiving your treatment. So, unfortunately, again, the Government recognises that yes, that is definitely something that is very necessary. And one of the things that we need to do now—

The Chairman: You mean your department and the health insurance commission recognises that because I can't agree that the Government does because I have in my hand an amendment to the Health Insurance Law that's coming before Parliament on the 22 February and it is not included in that.

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: To make it, absolutely yes, it's certainly not covered inside there. But certainly it's a recognised need for the entire industry and I believe that if we were able to implement that, it would be some much better for all of our stakeholders.

The Chairman: Well, they might have to face such an amendment. Because it wouldn't be unreasonable, in my view, to include electronic real time verification and authorisation as a condition of the certificate that this legislation is purposing that the health insurance commission would grant, and that being one of the conditions under which the licensure . . . this thing could be withheld and/or withdrawn if it wasn't done.

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: But, Mr. Chairman, just a quick response on that. I think again we spoke earlier about the complexity of the system that we're obviously operating in, and I think one of things that perhaps make it a challenge is that we have nine approved insurers who are selling a myriad of different plans. So, it would mean that any system that we would have mandated that they approve—

The Chairman: But there's no need for us to mandate a system for them; they must produce a system.

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: Well, I mean, mandating—

The Chairman: I mean I might have to go the hospital and there are nine swipe card machines in front of me but each insurance company would have to produce their own. Or, the alternative would be to have somebody like the HSA provide the service for a fee to all insurance companies.

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: I think the latter would probably be better if we were able to pursue that.

The Chairman: I agree with you but we have to make it a requirement for each individual licenced insurer and as a part of their licensing process, and the continued certificate that they have to provide, and how they provide it, it's up to them to negotiate it.

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: Mr. Chairman.

The Chairman: One of the things that I believe is not only driving up cost, but driving up frustrations is the complications that we put on this and we keep talking about how it's such a difficult thing to do, when, if we had a simple system that didn't allow precertification, didn't allow preexisting conditions, you didn't have to have 995 CPT [Current Procedural Terminology] codes, you were either in hospital or you wasn't. It would probably in the end reduce the cost of health care because of all the administration that is required to meet all of these complications that they insist on installing in the system to allow deny, and when they can no longer deny, then they delay and when they delay and can't delay anymore, then they finally write a cheque that comes from some foreign company that takes two months to clear.

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: Mr. Chair, if I could note that there are one or two current approved insurers that have a system that they're using, but again, it is not robust enough where we have wide spread usage of that. So, I totally agree with you that anything we could do to get that system introduced would certainly be helpful for the entire health insurance market place.

The Chairman: One of the trends that I have noticed in the amendments to the health insurance legislation is that they seem to always be in favor of the insurer. In terms of what I see coming down here (and I've been here nearly eight years since this law has been in place) is that the majority, including this one, although you will get a little fee and you get some extra work out of it in having to issue certificates and monitor it, is just another way of them being able to say they got some changes that benefits them which is likely to lead to increase premiums again you know.

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: Mr. Chairman, I don't think there are actually welcoming these amendments because again, as you said, there are number of conditions which again there are currently being required but it will now be mandated.

The Chairman: And then there is probably more trouble about the individual coverage than they are about anything else.

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: And again that is an essential, Mr. Chairman.

The Chairman: But in truth and in fact, because they have precertification, they have pre-existing conditions, nobody offers group health. What they are offering is individual coverage discounted on a number of persons, because true group health requires none of that. You take the demographic and set the premium based on . . . and in most there's hardly . . . I can't think of any demographic here other than the indigents and over 60s and up that you would have more people in the group sick than healthy. In most workplaces the majority of people in the workplace, are healthy, and have very few claims between that age group of 25 to 40, 50, 55.

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: Mr. Chairman, just one matter.

Certainly, the current legislation doesn't . . . the approved insurers are not allowed to underwrite for the Standard Health Insurance Contract, except where permitted by the Health Insurance Commission. So, for the Standard Health Insurance Contract, again, as was actually done up until 2013, they could use the simplest of medical conditions to deny coverage.

Let's use, for example, diabetes or hypertension. The approved insurers are no longer able to do that. Now, there can be some slight modification in the standard rate, but there are required to provide those individuals coverage, including persons who may be pregnant, and so I think that amendment has really been proven to help a lot of our people.

Mr. Winston C. Connolly, Jr., Fifth Elected Member for George Town: Mr. Chairman, through you.

In terms of just the answers so far, I think that there are some specific recommendations that can be put forward to whatever government of the day there is, that would cure a lot of these issues, or at least it sounds so in the discourse so far. Is it because the insurers are so powerful, as a lobby group that some of these things fall on deaf ears?

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: Through you, Mr. Chairman.

I don't know if I have any evidence one way or the other on that matter. But what I can say to you which confidence, certainly from the department's point of view and certainly from the health insurance commission board and myself as the superintendent, we have no trouble in perusing an insurer where it is some violation or there's some infringement in regards to the health insurance legislation. We do not fear them. It's very clear that they are a key stakeholder but certainly, in compliance with the legislation as it is set out, is required by my office.

The Chairman: Would it make your . . . well, let me rephrase that. Would your office have additional authority that it could use if you were allowed to do administrative fines instead of having to appeal to, I guess, it would be DPP [Director of Public Prosecutions] to prosecute somebody.

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: Yes, Mr. Chairman.

In 2013 the Law was amended to allow some offenses under the legislation to be dealt with administratively, and I have been applying those as superintendent, obviously, on the behalf of the health insurance commission board. Now, can we add more fines or more offenses that could be fined administratively? I wouldn't want to hazard and say yes. I can say though that you know when we refer cases through the director of public prosecutions . . . let's put it this way, the wheels tend to move slowly, and again that can be with a lot of good reason. But from where I sit as superintendent, when I put forward cases, you know, I have a real person who has made a legitimate compliant and we would like to see those complaints expedited, because again, in many cases we are talking about uninsured medical expenses or where they have been deductions from peoples' salaries. So, those types of things we want to make sure that we send a very strong message that that will not be tolerated.

The Chairman: Why is it that you require a non-insured patient permission to report, or that the provider requires the patient's permission to report an uninsured individual to you?

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: Thank you, Mr. Chairman.

I think it is that relation between the health care provider and the patient and the health care provider perhaps not wanting to—

The Chairman: But there is nothing in the legislation that says they can't, right?

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: Absolutely not.

The Chairman: Right. And we are not talking here about—

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: And we encourage it from the Commission.

The Chairman: —a matter that would normally be expected to be covered under patient confidentiality because it is not a patient yet. They don't become a patient until they get admitted to get the service. And if they turn up and don't have health insurance, we need to have a mechanism that the health provider, who finds that, can report that to your office. And they should be able to report who their employer is as well if they are not self-employed.

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: Thank you, Mr. Chairman.

I want to agree with you on that matter because when you look at it from the health insurance point of view, when a policy is terminated, under law they are required to report that. Again, we have the situations where some health care providers do report but it is on a voluntary basis and it is very sporadic, in other words, because it is not a requirement, some months they report, other months they don't report it and from my office I really do not have any authority to go after them to say, *You must report this on an ongoing basis.*

The Chairman: Captain Eugene.

Capt. A. Eugene Ebanks: Thank you, Mr. Chairman.

Mr. Chairman, through you, I am not 100 per cent sure that this would fall under your responsibility but I know of cases where people have worked all their life for a particular company and as soon as they retire, they are automatically dropped from the insurance. Is there some way we can keep . . . I mean, when they really need the insurance is when they are being dropped from the insurance. What can we do to ensure that these persons, if they are able to continue the payments on the insurance, can continue being insured?

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: Through you, Mr. Chairman.

An excellent question and I can say to you that this matter has been under review consideration by the Health Insurance Commission board, probably, I would say for at least the past year. And we have come up with perhaps a few recommendations on the way forward. So, one of the things that we talked about and felt could probably work, which would mean that you would need to start paying into the plan while you are working, so that when you reach retirement age you would have access to that coverage, that medical benefit coverage through that mechanism.

The other thing we looked at, and in the US I think we are familiar with that, which is Medicare where they have the system set up that you can get health coverage once you retire. The bottom line is that the only other way around that would be for us to actually introduce a national plan where there is, again, contribution by every single person, and again, it would probably be done through some type of income tax and would require at least a single provider, meaning the health insurance cover. And then, you could probably set up a number of health care providers, meaning a network, once they are agreeing to accept that level of remuneration for services provided that they could be a part of the network to provide these benefits and services.

So, like I said, we have looked at three possible scenarios and it seems to me that the way forward is that we are going to have to find some way to have a direct contribution into a fund, whether we are looking at a fund that will be set aside just for senior citizens upon their retirement so that that would be automatically covering their health care needs, or whether we are looking on a more national plan where it would cover everybody regardless of your age.

The Chairman: But would it not be a simple solution to just simply say and put in the regulations that the person's health insurance coverage cannot be cancelled as long as they pay the premium? And then it would become a retirement benefit and if you continue to pay the premium to the insurance company they have to cover you. Because what we are doing now is that we are allowing people who, as Captain Eugene said, have paid health insurance for 20, 30, 40 years with these insurance companies but when they get to the magical number of 60 the insurance companies will say they are not covering them anymore. If the law simply said that they cannot cancel a person's insurance as long as they pay the premium, then, you would not have to get into all of these other machinations.

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: Thank you, Mr. Chairman.

The Chairman: That is what the 1991 Health Insurance Law said, you know.

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: Yes, yes. Thank you, Mr. Chairman.

I think, yes, that is a keen observation. However, I think we have two potential issues with that. We are aware that the health insurance coverage is driven through the employer, so the employer pays the premium for the employees and then they take it back out of their salaries or other remunerations.

The second part of the challenge would be that when a person reaches retirement age, a lot of times now we find that those individuals are not able to afford the cost of continuing to pay that premium. So, even if the employer were willing to make the coverage available to them through their plan, the employee is not able to afford the premium payment. So, that would be a potential—

The Chairman: Unless it was part of their retirement package from their employer, which is what I am suggesting, in that they stay in the group. Because the problem with being over 60, if you are not in a group that has a huge percentage of healthy young people in it, your premiums are going to go through the roof.

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: Yes.

The Chairman: What I am suggesting is that we keep them in that group and their premium should not increase.

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: So, Mr. Chairman, I think what we are saying is, is that while you are working you pay into that, so that when you retire you don't automatically fall off. And, as it is right now—

The Chairman: But I would argue that that is what I am doing now. I am not setting up a separate fund but the premium that I am paying is covering me as health insurance and it is a global group that I am paying and it has that actuarial demographic calculation in it. So, at age 20 I am not paying a smaller premium than I am paying at age 60 in the same company. We're all paying the same premium. The only difference is that between 25 and 50 the utilisation rate is very, very small. So, my argument is that I have contributed to that fund all of these years because the insurance company made profit on me every year. If we are saying that we are going to do that and then we have to make an additional payment into some fund when I 'm retired, I think it is onerous on the consumer.

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: Mr. Chairman, I take the point that you are making. But certainly from—

The Chairman: If each one of us on an annual basis, which we are entitled to, ask the insurer to give us a clean history, the majority of the years that you worked and paid that insurance, your premiums that you pay in, vastly exceed your claims on an individual basis.

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: On the individual basis but—

The Chairman: Until you get up to 56 then. Right?

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: But even while you—

The Chairman: If you are going to do that, then I want a cheaper premium based on my risk factor, because we are enforcing the risk factor on 55 and over, you know, by increasing the premium, but we are not admitting that the young person is a much lower risk and their premium should be less.

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: For the Standard Health Insurance Contract, as you know, the Com-

mission does regulate the premium for that. So, we have actuaries that actually determine what the premium rate should be and that is what is enforced.

The Chairman: And you will agree that they are based on the fact at the top end you are going to have higher utilisation than you are going to have down here, but the premium can be kept at this level because these people are paying way beyond what they are using, for those who are using more beyond what they are paying.

Captain Eugene, do you have a follow-up?

Capt. A. Eugene Ebanks: Thank you, Mr. Chairman:

The way I see it, Mr. Chairman, through you to Mr. Connolly, the insurance companies act as a cartel; whatever one does . . . you can't go from one to the other and think that you are going to get any difference. It is all the same. And it is totally unfair to the working man that the insurance companies can collect these premiums for 40 years and then when a person gets 60, even though he is able to continue paying the premiums, because you are at that retirement age they drop he or she because they are now becoming a higher risk.

I agree with the Chairman, that between the ages of 25 and 50 there are very few persons who make any significant claims, unless, of course, it is an accident or they get cancer or something like that. But that is few and far apart compared to the ones who are not claiming anything and the amount of premiums that the insurance companies are collecting. I agree the premiums they pay far exceed claims that they make. And there has to be some justification somewhere, somehow that will allow that person when they need insurance, to be able to have it. Whatever legislation that needs to come into effect, I think, it is on our shoulder as legislators to make sure that this has to change. It cannot continue like this. I don't know how it has gotten this far for so long without something being done about it. And I certainly will make every effort to have it changed. I can assure you.

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: Through you, Mr. Chairman, again, as I said earlier, I totally agree with you that this is a significant concern for the Health Insurance Commission. We see, obviously, the concerns and the issues and the complaints coming from persons who were not able to continue their health insurance cover at an age when they need it most. So, I would certainly endorse any initiative for us to try and correct this problem.

Mr. Winston C. Connolly, Jr.: Mr. Chairman, through you to Mr. Conolly.

In terms of some of the testimonies we got a few weeks ago, I guess the CEO of CINICO kind of succinctly put it this way when I put it to him—it seems like the private insurers are allowed to insure only the healthy and the government and CINICO take up everybody else. Is that a statement that you would echo? Or can you provide kind of a lay of the land in terms of statistics and other things that you gather through your office and the various boards that feed into your office?

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: Thank you very much, Mr. Chairman. Through you, I can say that while that may be a perception, I don't think it is the reality. CINICO is certainly not the largest insurer at this point in time. Based on the last report that I received in January, I think CINICO has approximately 15,000 insured persons. There is at least another insurer that has 20[,000] plus insured persons. So, in addition to that in regards to CINICO carrying all of the high risk persons, again, from my office, I don't see really where that is actually accurate.

We have made amendments to the legislation which required all approved insurers to accept providing coverage for all individuals regardless of their age and their medical condition. And I can say to you . . . let's use, for example, the issue of the high risk medical applications. We see that those applications are certainly not just going to CINICO or coming from CINICO; they are coming from other approved insurers, and certainly, including pregnancies et cetera. And I would say that if you had asked me this in 2012 I would probably be more leaning towards of that being a fact, but where we are in 2017, based on the data and statistics that I am seeing, I think the amendments in 2013 has made a huge difference.

Mr. Winston C. Connolly, Jr.: Thank you for that.

One last question from me in terms of, again, your role as an advisor to the Ministry and the Minister: Has it ever been a consideration to set up a captive for the Cayman Islands Government health insurance, kind of, claims?

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: Through you, Mr. Chairman, could I ask for additional clarification? Would it be from malpractice insurance?

Mr. Winston C. Connolly, Jr.: For malpractice as well but I am talking about in terms of overall claims versus what we pay out per annum on health in insurance for indigents, elderly, et cetera. Has there ever been any thought of self-insuring and seeing that some of those . . . if some of that money is not used in a budget here, does it come back to government?

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: Through you, Mr. Chairman, the answer is yes. As a matter of fact,

when we look at CINICO, the whole . . . I think, you know, CINICO was driven. The creational CINICO was driven by, at some point in time, that there would be what we refer to as an ASO where those groups would be properly identified. Their demographics and risk, et cetera, would have been sorted out and we would have established a plan of coverage for them, based on the group itself. In addition to that, we had envisioned that those groups would have been adequately managed, meaning that we would know exactly what level of facilities and care would be provided to those individuals and that they would be followed up to ensure that those patients and insured persons were closely monitored.

If you, for example, looked at the group right now that we call the medical indigent, based on the last information that I saw, we're averaging close to 42 million a month. And it seems to me . . . and that is the number of persons now on that medical indigent list is just around 1,300 persons. So, it seems to me that that is a group that we could easily look at identifying, setting up the parameters and having coverage, even if we had to put in some stop loss coverage, meaning, if there was a catastrophic event that exceeded, let's say, $200,000 or a quarter of a million dollars, that we would have stop loss coverage that would immediately kick in.

It seems to me that, you know, initially, I am certain that it would probably cost a lot to provide that group of coverage. But I believe that in a very short period of time, meaning, three to five years, that it would certainly pay off if we managed it properly.

Mr. Winston C. Connolly, Jr.: Mr. Chairman, through you, and thank you for that.

Again, when going to these captive health insurance conferences and I am sure you have been to a few here, we hear that Cayman is the mecca for this; we've got the expertise here, we've got the consultants, the administrators, all of the above. And it has occurred to me, especially in the last four years, that there is real merit in utilising those sorts of vehicles and if it means tweaking CINICO or whatever to do it, because, like you've said, it is not a very long period of time after that initial set up cost. The country is the beneficiary, the people are the beneficiaries and so, it does not even take a long term vision, it takes, you know, even if you call it a medium term, I mean, if you are talking political cycles, it is still worth at least going through the exercise crunching the numbers and considering something of that nature. Thank you for that.

The Chairman: No more questions?

[No audible reply]

The Chairman: Okay. Mr. Connolly Ms. Lawson-Joseph, thank you very much for coming and participating in the process and you are free to go.

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: Thank you very much sir.

Ms. Lyria Lawson-Josephs, Deputy Director/Registrar, Health Practice Commission: Thank you, sir.

Mr. Mervyn Conolly, Director, Department of Health Regulatory Services: I just want to add, Mr. Chairman, that obviously, I think the report provided by the Auditor General's Office is quite timely and certainly from where I sit, I see a number of recommendations et cetera that are extremely constructive and we are certainly going to be making some changes. For example, the reporting framework, I have already started discussions with the chief officer in regards to how we can certainly make our reports much more meaningful, including trend analysis, et cetera. So again, thank you for this opportunity.

The Chairman: Just one matter.

[Inaudible interjection]

The Chairman: Just one matter for the Committee. Would this Friday morning at 10:00 a.m. be okay to look at the draft report?

[Inaudible interjection]

The Chairman: Okay. So, we will reconvene at 10:00 Friday morning, the 17th to look at the draft report because we have to get it ready and submitted before the 22nd [February 2017].

Thank you all very much.

At 4:00 pm the Public Accounts Committee adjourned.

Legislative Assembly of the Cayman Islands

THE STANDING PUBLIC ACCOUNTS COMMITTEE

MINUTES

Meeting held
Friday, 17th February 2017
10:30am

Minutes of proceedings of the Standing Public Accounts Committee's meeting held Friday, 17th February 2017 at 10:30pm in the Large Conference Room of the Legislative Assembly Building, Grand Cayman.

Present:

Mr. Ezzard Miller, MLA – Chairman
Capt. Eugene Ebanks, JP, MLA – Member
Mr. Winston Connolly, MLA – Member

Ms. Manesa Webb – Clerk of the Public Accounts Committee

Apology: There were no apologies.

Absent: Mr. Joseph Hew, MLA – Member
Mr. Roy McTaggart, JP, MLA – Member

Attendees: Ms. Sue Winspear, Auditor General – Office of the Auditor General
Ms. Angela Cullen, Acting Audit Principal of Performance Auditing – Office of the Auditor General

1. Meeting Call to Order

There being a quorum present (Standing Order 77(2) refers), the Chairman called the Meeting to order at 10:30am.

2. Apologies

No apologies were offered by Mr. Joseph Hew, MLA – Member and Mr. Roy McTaggart, JP, MLA – Member.

3. Approval of Auditor General Invoices

- *Invoice No. 206953 dated January 2017 for the amount of 37,748.97*
  The above invoice was **approved** by a motion moved by Capt. Eugene Ebanks and seconded by Mr. Winston Connolly.

4. Approval of PAC Minutes

- *Thursday, 26th January 2017* Minutes was differed to Round Robin.

5. Matters Arising from Meetings

1. Recommendations by the Chairman on AG Report:

- The Public Accounts Committee (PAC) fully supports the nine recommendation made by the Audit Office and finds it quite troubling that the Management Response was that the recommendations were "NOTED."

- The PAC recommends that the Ministry re-assess the report and the committee invites the Ministry to carefully consider the nine recommendations and produce a plan to implement these recommendations.

2. The PAC is particularly troubled by the findings in the report that identified the following:

- The perceived serious capacity shortages in the Ministry, the Department of Health Regulatory Services and the HSA.

- Interviews of Officials looking to the Ministry for decisions, assistance or guidance showed that they had concerns about the Ministry's responsive.

- The lack of a performance management and reporting framework that allows for regular monitoring of outcomes from policy decisions.

- The lack of medical systems administrative knowledge at the ministry level was clearly demonstrated during the hearings.

The PAC therefore strongly recommends given the magnitude of the expenditures and the impact of these findings on the Health of the Country, that the Government address these concerns with some urgency.

3. The Ministry of Health with the advice of the Health Services Authority (HSA) Medical Director and in consultation with the Medical and Dental Council should issue a policy on: how to develop Caymanian Doctors to Board certification level; and provide a Grant to the HSA to fund these staff developments through proper training.

4. The Ministry of Health in consultation with the Health Insurance Commission should review relevant legislation to enable private sector coverage into retirement.

5. The HSA Medical Officer should collect relevant health data from the private sector as well as the HSA in the future and should report publically on both sets of data on a regular basis to help inform policy and decision making.

6. Review and Approval of the OAG Report(s)

- *Ensuring Quality Health Care and a Health Population – January 2017*
- *Cayman Islands Health System – January 2017*

7. Auditor General's Update

The Auditor General provided the Committee with an overview of the OAG Quarterly Report update:

- General Review of the Review Audit.
- Revenue Completeness Performance on Audit on Customs.
- General Report on the Workforce.
- The Airport Project as short term.
- Report of the New PAC.
- Land Registry - Transfer Document is a bond and signed by a JP. Lawyers abuse the situation. Simple solution is to number them.
- Hotel Tax Government – Losing money in the Cayman Islands. Example Airbnb is an online community marketplace that connects people looking to rent their homes with people who are looking for accommodations when visiting the Cayman Islands and other international destinations.
- Long Terms Contracts - Such as Airports and Security. Which has been a mystery and, nobody has notice or has been monitoring the long term contracts.
- On March 2-3, 2017 - The Auditor General will be traveling to India to attend a conference based on technology and environment.
- The Auditor Office - Confirmed that the final audits will be completed by the new PAC.

8. Any Other Business

There was no other business.

9. Scheduling of Next Meeting

The Committee has not scheduled a PAC meeting at this time

10. Adjournment

There being no further business, the Chairman adjourned the meeting at 11:04pm.