A PROPOSAL FOR ASSISTANCE WITH SPECIALIST MEDICAL SERVICES FOR THE SMALL STATES OF THE COMMONWEALTH CARIBBEAN

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Health services in the small states of the Commonwealth Caribbean are widely recognised to be grossly inadequate at all levels. There are shortages of personnel and equipment. Whilst the major efforts to assist these states are properly directed towards social and preventive medicine, and to providing an effective primary care service, these services cannot be appreciated by the affected populations unless an adequate secondary care service is also provided. An adequate secondary care service can only be provided by the availability of physicians and an adequate supply of allied health personnel.

This paper will concentrate on the supply of physicians for secondary and tertiary care, but must not be seen as in any way diminishing the importance of the training and retention of allied health personnel in the provision of these services as well as those in primary care.

At present, the secondary services in the small states in the English-speaking Caribbean have stagnated at best, and deteriorated in some places. This has led to governments and individuals seeking secondary services abroad. This is natural in some developing states, but when it leads to expenditure of scarce funds to seek simple secondary care services abroad, then there is a wastage of resources which compounds the original problem.

In discussing this problem at the 1979 Conference of Ministers responsible for Health in the Commonwealth Caribbean, the desire was expressed to find ways of getting specialist help for the small states. In considering this problem, possible solutions are compounded by a number of factors indigenous to the existing situation in the small states themselves.

There is no doubt that the desire of all these states is that there should be available resident specialist care. Resident specialists are seen as prestigious and a highly visible part of the service, providing care to the individual in the community, when the individual is most in need of medical services, namely, during a serious illness and in particular in emergencies. However, specialists in medicine can serve communities in less obvious and less individualistic ways. For example, they are invaluable in times of disaster.

In the Caribbean, disasters have been a part of our consciousness, and in recent times have included aircraft disasters, hurricanes, floods and volcanic eruptions. The need for a coordinated system of help for the under-manned small states has become clearly evident.

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Specialists can also provide invaluable continuing services in the organisation of health services, and in the training of physicians and other health personnel, as well as carrying out community programmes in care.

The low level of government salaries in small states has been a severe deterrent to the recruitment of specialists. When this is coupled with poor facilities, recruitment becomes difficult, and this extends to qualified nationals.

The programmes of assistance in the past have consisted of recruitment of non-nationals with their salaries boosted by more advantaged countries. This has not solved the problem. In some instances such assistance may have aggravated the problem by having non-nationals working in superior conditions of service; whilst on the other hand, when nationals have been recruited, the relatively poor salaries given ensure that they have to engage in private practice. The result is that the latter is often done to the detriment of the public service.

The limitations on recruitment of specialists may therefore be summarised to be:

(a) poor salaries, with the complication of an extensive private practice being required, and a resulting poor public service;

(b) poor facilities, which includes lack of equipment and professional contacts;

(c) policies of aid where conditions of service for non-nationals are superior to those for nationals.

This paper will put forward a programme which seeks, both in the short term and in the long term, to solve the problem of specialists working in the small states of the Commonwealth Caribbean.

The short-term solutions can be summarised as:

(i) the provision of visiting specialists for short and medium-term visits to provide service, education and professional contact, whilst working alongside existing specialists;

(ii) providing treatment facilities at regional centres for tertiary care and some secondary care problems.

The long-term solution depends on the atmosphere set by the short-term programme, and the rate of build-up of local facilities to attract nationals to be recruited into specialist positions in the small states.

SUGGESTED PROGRAMMES

Tertiary care services

Some of the states in the Caribbean now provide some tertiary care services, such as radiotherapy, to patients who are sponsored by governments of the small states. Some of these services are inhibited in their effectiveness by the bureaucracy that administers them; by an attempt to charge economic fees in some cases; and by negative attitudes of government and health personnel to such assistance in some instances. For these services to be more effective to the benefit of the peoples of the small states, the following suggestions are made.

(a) The Governments of Jamaica, Trinidad and Tobago, and Barbados should (as governments within the Caribbean Community with tertiary health care facilities) make a formal commitment to the Community to provide tertiary care services under the same conditions as obtain for their own citizens. We feel that such aid from the better-developed areas can only do good in the promotion of the spirit of economic and social cooperation within the Caribbean community.

(b) The University of the West Indies (UWI) should continue to give support for the services provided by governments in tertiary care services, and to stimulate a well-defined programme of continuing education related to the available services in the region.

Rotating specialist services

The dearth of specialists in the small states relates to poor facilities and lack of professional contacts. The boosting of salaries for overseas specialists has not solved the problem, in that it creates inequities locally which inhibit national recruitment and is associated with a poor public service commitment by nationals. It would appear that the better developed facilities of the more developed countries, along with the professional contacts and the international reputation of the Medical Faculty of the UWI, could act as a basis for the attraction of additional specialists into the region. Once attracted, a properly-coordinated programme of bilateral visits would promote the short- and long-term solutions outlined above. Thus, if extra posts are created in the UWI for this purpose, then departments of the faculty could provide a commitment to service short- and medium-term visits to the less well developed small states.

In order to carry out such a programme effectively, there will be a need for a programme coordinator with an administrative assistant. A programme coordinator could be appointed from among the specialist staff, particularly if these are increased as suggested in the outline below. An efficiently-run programme would not envisage any immediate increase in junior staffing, particularly in view of the following action in continuing and postgraduate education.

Continuing and postgraduate education

The UWI Faculty could, by means of the programme outlined above combined with a programme of junior staff fellowships and exchanges, provide an intra-Caribbean programme of continuing and postgraduate education. This will have enormous benefits in re-tooling the skills of existing specialists, and increasing the service and commitment to national services by junior staff. There is little doubt that prolonged postgraduate training outside of one's country is likely to diminish one's commitment to working in it, and therefore every avenue should be explored to do as much of this training as possible on the spot.

In conducting a programme in continuing and postgraduate education for health personnel in the small states, one envisages that during visits of academic personnel to these states they will help to organise, participate in, or conduct the following kinds of activities:

(i) consultation on patients and health care problems;

(ii) provide technical services alongside existing personnel within the available local resources, and by this means improve the skills of local personnel;

(iii) conduct short courses in specific problems in patient care and health problems, by means of seminars, conferences or lectures;

(iv) act as a link in providing educational material from the coordinating centres - e.g. books, copies of articles, tape-slide programmes or video-cassette material;

(v) use the experience obtained about local problems and resources to better orientate and train health personnel being trained in the coordinating centres, and also to make locally-produced educational materials more relevant.

Fellowships will allow both junior and senior personnel to spend periods of time in the corrdinating centres to benefit from the better facilities available there. These, combined with a well-coordinated exchange programme, could ensure that there is no service gap in the small states during such educational activity.

Methodology

It is suggested that regional coordinating centres be based at the teaching campuses of UWI - in Jamaica, Trinidad and Tobago,and Barbados. It would be desirable for each centre to have specific small states as their areas of responsibility, without excluding cooperation and assistance from any particular centre in carrying out the programmes.

Funds should be obtained to appoint additional academic staff and postgraduate training places at the UWI coordinating centres, providing that departments give commitments that:

(a) staff members will travel to small states to provide specialists services and continuing education courses;

(b) staff members could advise governments on their services and infrastructure, leading to the improvement of local services, with the aim of attracting nationals to remain in or to be recruited into the services;

(c) exchanges of staff at a specialist and postgraduate training level will be provided to allow staff based in the small states to carry out courses and to work in facilities in the better developed facilities at the coordinating centres, without interfering with the services in the small states.

The services that presently appear to be most in need of such a programme involving supernumerary appointments are in general medicine, general surgery, orthopaedics, otorhinolaryngology, pathology, radiology and primary care.

Thus a programme from a coordinating centre such as Barbados, serving several of the small states which have traditional communication lines to that country, could be looked at in the following manner, with the necessary budgetary provisions made.

Staff - 7 lecturer/senior lecturer posts
1 administrative assistant

Space - office space for staff with necessary equipment

Travel - 1 visit per month for each country in the scheme, i.e. approximately 85 visits per year of one week's duration or about 600 subsistence days and 85 return air fares.

Postgraduate and specialists student exchanges, 2 for each contributing territory each year of 6 weeks duration, i.e. 28 return air fares and 1180 subsistence days.

In summary, some 115 return air fares within the Caribbean and 1780 subsistence days.

Advantages

The advantages of such visits and exchanges and the placing of the additional specialists can be summarised as follows.

(a) For the small states

(i) an increased pool of specialists available to treat patients in their territories, and also in territories with better developed facilities;

(ii) on-the-spot continuing and postgraduate education of existing staff;

(iii) continuing advice and upgrading of facilities which should help in the long term to recruit nationals into specialist positions;

(iv) the provision of replacement specialists to allow leave for postgraduate courses of existing staff;

(v) the scheme does not involve local inequities in the conditions of service.

(b) For the more developed states

(i) the provision of more academic posts available for local teaching, service and research;

(ii) service of the additional staff member can be calculated to be at least half of the year locally;

(iii) the provision of more staff to assist in the coordinated assistance to the small states so necessary in maintaining the viability of the Caribbean Community, which has so far proved to be of greater benefit to the better developed states.

The local expenditures that would be required by the small states would be the provision of transport for visiting staff and assistance with their accommodation.

Expenditures that will be needed in the coordinating centres would be the provision of space, furniture and daily expenses related to stationery, telephones, etc.

Medical education in the less developed states

The programme of visits outlined above will provide the basis for up-grading of primary, secondary and tertiary services, continuing and postgraduate education. If this programme succeeds, then undergraduate education could be expanded in the small states by the expansion of more elective opportunities and possibly the introduction of limited clerkships, particularly in community medicine.

The increased presence of university academic personnel may also be seen as an opportunity to stimulate the implementation of local training and continuing education of a variety of allied health personnel, particularly those working in the field in primary care.

Funding

It is desirable that overseas agencies, such as the British Overseas Development Administration, should review their assistance programmes to include a programme of this sort, and that the better developed Caribbean countries should increase their contributions to UWI to promote a programme such as this. Budgeting for travel and subsistence would need to be included in such assistance. The capital requirements for space could be sought through agencies such as USAID and preferably could be included in other development projects such as the Mount Hope Complex and support hospitals. Such an inclusion would allow a better rationalisation of facilities and ensure that materials such as audio-visual aids are used to the maximum benefit of all professionals in the area in continuing and postgraduate education.