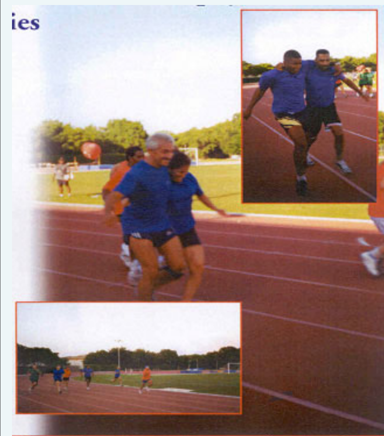
SPORTS DAY RESCHEDULED

The Health Services Sports Day, which was scheduled for October 19, has been postponed to a date to be announced in early 2003.

The Government's Sports Office has informed us of plans for a series of inter-department sports events for 2003, including a Sports Day in April.



As a result, the decision has been taken to postpone the Health Services Sports to a date closer to the Government's April event to allow for the selection of our best athletes to represent the HSA.

Members of staff who were already in training for Sports Day should continue their training programme to ensure that the Health Services team is fit, healthy and ready to take home the trophy in the first Government inter-department Sports Day.

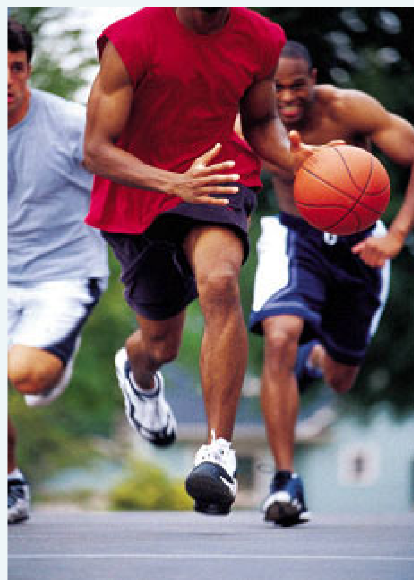
There are also plans for other sporting activities including:

Basketball Tournament
October 7th - December 14th

Volleyball Tournament
January 15th - March 15th

Track Meet
April 12th - April 19th

Cricket Tournament
May 1st - July 1st



Members of staff who are interested in representing the Health Services in any of the above sports events should contact the Public Relations Officer as soon as possible.

Announcement
Changes in Patient Financial Services

It is with pleasure that the Patient Financial Services Department introduces their newly appointed Team Leaders who will headline the Department's daily operational activities.

Dorcas Watson, Registration Team Leader.

Contact Dorcas at extension 2589 for enquiries regarding Patient Registration Services, Financial Counselling, Cash Collection Reconciliation.

Colin Palmer, Assistant Registration Team Leader.

Contact Colin at extension 2536 for enquiries regarding Patient Registration technical activities, Agency accounts, Staff Scheduling

Winston Huggan, Collections Team Leader

Contact Winston at extension 2847 for enquiries regarding insurance and/or cash collections patient accounts, Collections and Financial Statistical Data.

Melissa McLean, IT/Insurance Billing Team Leader 2577

Contact Melissa at extension 2577 for Overseas Visitor account enquiries, billing/invoicing enquiries, chargemaster enquiries (charge codes), Billing Forms, Account Posting activities.

Team Leaders report to the A/R Consultant, Manager, Patient Financial Services Carole Appleyard.

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•Dr. Gerald Smith appointed Ch ief Medical Officer.

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•Sports Day rescheduled.

Published monthly for employees of the Cayman Islands Health Services Department

CHAIRMAN ANNOUNCES RESTRUCTURING OF THE HEALTH SERVICES AUTHORITY

The Chairman of the Health Services Authority, Mr. Kel Thompson, on Friday, October 18 announced a restructuring of all areas of the Health Services on Grand Cayman to create a more efficient and effective health system.

The HSA Chairman along with the Deputy Chairman, Mr. Lewis Ebanks and the Chief Executive Officer, Mr. Mervyn Conolly, told members of staff at a special meeting that the restructuring had become necessary to make the health services a viable entity, following years of huge financial losses which has worsened in recent times.

As a result of the restructuring, the Health Services will have a new organisational structure which will result in the elimination of 20% of the current workforce. Mr. Thompson said the restructuring will affect all areas of the Health Services including senior management.

The Health Services will be divided into five main operational centres, each of which will be headed by a Physician. The HSA Chairman said details of the new operational divisions will be announced shortly.

The senior management team of the Health Services will be conducting an extensive review of all staffing positions over the next two weeks and all employees will be evaluated based on their job performance in determining their continued employment with the Authority, said Mr. Thompson.

He gave the assurance that the employee assessment and reviews will be carried out by at least two senior

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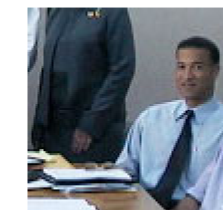
Mr. Lewis Ebanks appointed Managing Director of the HSA



The Board of the Health Services Authority (HSA) has announced the appointment of Mr. Lewis Ebanks as Managing Director of the HSA effective October 1, 2002.

Mr. Ebanks who is also Deputy Chairman of the HSA Board will assist the Chief Executive Officer (C.E.O.) in carrying out the policies of the Board.

In making the announcement, the Chairman of the HSA, Mr. Kel Thompson said that with the urgency to effect certain policy decisions and to carry out a quick turnaround in the finances of the Authority, it was necessary to have someone at the Board level assisting the C.E.O. in carrying out these decisions expeditiously.

Mr. Ebanks will represent the Board of Directors and ensure that its directives are complied with on a day-to-day basis, the Chairman stated.

Mr. Ebanks will also oversee the restructuring exercise within the Health Services and also the financial operations and budget of the Authority. He will also guide the development of the HSA's Business Plan.

Mr. Ebanks has a Masters Dgree in Commercial Law (LL.M) from Cardiff University in the United Kingdom where he also studied and holds qualifications in Business Administration.

He is a partner in the company management firm CS Consulting, as well as co-owner of four other companies. Mr. Ebanks is also a Director of Caribbean Utilities Company (CUC).

Health Services News joins in welcoming Mr. Ebanks to the team.

From the Chairman

As you well know, these are times of great change within the Health Services Authority. As I outlined to members of staff at our recent meeting, our challenge is to strike a balance between delivering sustainable health care to our patients while at the same time resolving our deficit issue.

There will be no easy choices as we assess the alternatives in respect to balancing our budget. The Government has very clearly outlined the limit of its willingness to subsidize the HSA. Therefore, we have no choice but to restructure so that we can continue to meet our obligations. Simply put, because the HSA was formed without cash reserves, we must ensure that every time payroll is due, we have earned and collected enough revenue so that along with Government's help, we will have sufficient funds in the bank to cover the cheques we issue.

We recognize that there have been tough decisions which undoubtedly will be painful and traumatic, but, given our current situation, these are unavoidable. You should understand that the Board decision to reduce the number of staff was not taken lightly. The Board recognizes that those who will be made redundant will suffer the loss of their positions, not because of any fault on their part, instead, they will suffer as a result of a change in the Government's philosophy and its own financial constraints. Though this may be of little comfort to those who will be made redundant, delivering the message regarding the restructuring was one of the most distasteful duties I have ever had to perform.

What's more, many difficult decisions will have to be made within a compressed timeframe. This pace of change will not be easy for any of us. There will be shifts in some of our programmes and services, job losses, and other changes. I have no doubt, however, that all of you within the Health Services Authority - staff, managers, physicians and other health care providers - are up to the challenge. We will need to call upon our collective expertise, creativity, and caring in the future as we work together to renew our health care system. I thank you for your courage and your professionalism - these will be at the heart of our rebuilding process.

It is encouraging to know that even in these difficult times our people understand that without exception, we must maintain compassion and care for our patients and for each other.

There will undoubtedly be the usual "marl-road" rumours, and we ask that you seek clarity on any issue which you may have questions about. We will give every effort to clarify information as quickly as possible.

We recognise that communication and feedback are important. One of our keys to success will be our ongoing commitment to open and effective communication. As information becomes available and decisions are made, we are committed to communicating with you in a timely way. At the same time, there will be instances where we need to make informed, but expeditious decisions, to ensure that we do not carry a major deficit into next year.

We will continue to update you regularly with staff bulletins, staff forums, and through other special meetings. Remember, you can always communicate with us through the staff questionnaires, which have already been circulated throughout the service.

One thing remains clear - our fiscal challenge is still a major priority. There has been considerable discussion and work done to find ways to address this budget deficit. In the coming weeks, we will update you further on our financial situation. But rest assured, we will succeed.

As you can appreciate we will continue working on identifying cost savings and revenue opportunities, including such efforts at consolidation of services. Every aspect of how we provide patient care is under review.

I have recently asked the senior management team to develop action plans to guide the organization's priorities. Our short-term plans include:

1. To begin working on the 2003-2004 budgets and deficit management plan;

2. To develop and put in place a new organizational structure;

3. Launch a series of performance assessments across the organization and through all management levels;

4. To put into action a comprehensive internal and external communications plan to ensure that all our stakeholders are aware of, and involved in, the changes to come;

5. To determine the best way to move forward while focusing on sustainable health service delivery and;

4. The expansion of revenue generation strategies.

We will attempt to minimize the adverse affect on staff, physicians and most importantly the people we serve. I trust that together we can make a difference for the future, and I truly look forward to working with everyone.

The road ahead to transform our health care system will challenge us all, and there will be bumps along the way. We know we face hurdles, and there will be many pressures. But the goal -a fiscally healthy health care system that enables us to put the patient first - is worthy of all our energies. We are all up to this challenge, we will not waiver from it, and with your support and co-operation we will deliver.

QUESTIONS & ANSWERS

Following the announcement by the Chairman of the restructuring of the HSA, no doubt many of you will have questions and we encourage you to submit those questions to the Public Relations Officer. In the coming weeks regular bulletins will be issued which will seek to answer and clarify those questions which you may have.

Q Will the health care professionals' expertise be solicited in the restructuring?

Yes. There are several supporting planning processes. The Board is guided by the advice from the senior management team and will ensure a policy of openeness and fairness in the restructuring exercise.

It is also expected that during this process managers involved in the process will seek input from staff.

Q Will we be receiving information that describes the new structure and an explanation on how it will impact those who are working within the new structure?

Yes. There will be a process of on-going communuication on all issues that will impact employees of the Health Services Authority.

Q Is the next step to look at all services and activities in each area and start cutting services?

We do need to move quickly to determine the appropriate combination of care and cost, but it is too early in the process to speculate on the types and services to be affected. As a first step, we will reduce the size of our workforce by 20 per cent. Our main focus has to be on the provision of health care.

Q How will this restructuring improve patient care?

Patient care is our priority. The restructuring will help to bring the decision-makers closer to our patients. We are currently examining a number of strategies to enhance patient care including reducing waiting times in our clinics and greater access to our servies through an improved appointment system.

Q How much will this restructuring save the Health Services Authority?

The restructuring is projected to save the HSA approximately $6.5m annually.

Q Do you plan to lay off any more staff in the future? If so, how many and when?

We are doing this now in order to avoid the need to lay-off even greater numbers next year. However, no one can guarantee what may or may not happen in the future.The Board of the Health Services Authority will continually review the organisation and the services provided. The suggestions many of you have made in the Staff Questionnaire will also be looked at carefully as we strive to improve overall patient care. This could result in fewer positions over time, potential savings from these and other changes will be reallocated to improving patient care. However, we do not expect more lay offs anytime soon.

Q Do you plan to close any hospitals or beds?

Again, patient care is our priority. Once we have completed the organisational review we will be able to determine the needs of our facility needs.

Q The Board has indicated that it will try to find positions for those affected by the reduction in force. Do you have any more information regarding that?

The Health Services is working together with the Personnel Department and the Employment Relations Division on plans to lessen the impact of the reduction in our workforce. We are in the initial phases on the planning effort and as more details develop, they will be shared with all employees.

Q Is the creation of the Health Services Authority a cost cutting exercise?

The Board of the Health Services has a legal obligation to ensure that the HSA remains a viable entity. In the discharge of its duties the Board has to considers all aspects of the HSA's operations to ensure it is financially stable.

It is also beleived that as an Authority overall patietn care would be improved.

CHAIRMAN ANNOUNCES RESTRUCTURING OF THE HEALTH SERVICES AUTHORITY

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managers in their respective departments.

Mr. Thompson emphasised that the restructuring exercise will seek to minimise any job loss of Caymanian employees who have performed creditably over the years.

He emphasised that the Board of the Health Services considered several options but eventually had no choice but to make the decisions it has arrived at in order to guarantee the sustainability of the health services.

He acknowledges that this will be painful and traumatic for those employees who will be leaving the service.

He disclosed that employees will be offered generous redundancy packages and systems will be put in place to provide counselling and assistance in finding alternative employment for those who will be displaced.

Mr. Thompson says the organizational changes is a first step towards creating a quality health care system that is sustainable for the future.

The HSA Chairman says that in line with the changes being undertaken are measures to improve patient satisfaction and reduce waiting times.

Among the initiatives being considered are improvements in the appointments and scheduling of patients; greater access to specialist services and more convenient times for the operations of our clinic.

Release of Information Policy

The Board of the Health Services Authority is currently reviewing policies and procedures governing the conditions of service of all members of staff of the Authority. In the meantime, it is important for all members of staff to be aware of the policies regarding the release of official information from the Health Services Authority.

No member of staff of Health Services Authority is authorised to make any public statements or comments on behalf of the Authority or make any reference to the business of the Authority without prior approval from either the Chief Executive Officer or the Chairman of the Board.

PROTECTION OF OFFICIAL DOCUMENTS. No member of staff may, without the written approval of their immediate Supervisor or Senior Manager communicate to unauthorized individuals, any documents, papers or information which may come into their possession in an official capacity or make private copies of any such documents or papers. Every member of staff is required to exercise due care and diligence to prevent unauthorised access to or disclosures of such documents and information.

OFFICIAL CHANNELS OF COMMUNICATION.

(1) No employee of the Authority may correspond or communicate directly or indirectly with any officer of an Overseas Government without the approval of the Chief Executive Officer first being informed and a formal request made to the C.E.O. and the nature of correspondence disclosed.

(2) Official channels of communication within the Authority are through an employee's immediate supervisor. On personnel matters the communication must be sent via your senior manager to the Human Resources Manager.

(3) Elected Members of Executive Council and other members of the Legislature will, from time to time, visit Government units sometimes accompanied by Permanent Secretaries or Heads of Departments or both or neither. If the Chief Executive Officer is not present then the unit/section supervisor must report the visit as soon afterwards as possible to his/her senior manager giving as briefly as possible an account of the visit. If the visiting politician or Permanent Secretary wishes any information to be sent in as a result of the visit it shall be compiled and forwarded through the senior manager to the Chief Executive.

POLITICAL ACTIVITIES. Employees of the Authority are expressly forbidden to participate actively on behalf of any party or candidate in any election to the Legislature. They are expressly forbidden to act as agents, sub-agents or canvassers at elections of this nature.

I expect that all employees will comply with these regulations.

Kel Thompson
Chairman
Health Services Authority

NEWS FROM HEALTH AND MEDICINE
COSTS AND PREVENTION OF DIABETES

Worldwide, diabetes is projected to become one of the main disabling diseases and killers within the next twenty-five years. As the worldwide number of people with diabetes grows, the disease will become an ever-increasing burden to national health care systems and will be responsible for an increasing proportion of national health care budgets.

Without primary prevention, the diabetes epidemic will continue to grow. Therefore, immediate action is needed to reduce diabetes and to introduce cost-effective treatment strategies to reverse this worldwide trend.

Diabetes is a costly disease because of its chronic nature, the severity of its complications and the means required to control them. It not only affects the individual and his/her family, but also the national health care sector and society as a whole.

Studies from the USA and India suggest that in families with a diabetic person, between 10% and 25% of the income may be used for diabetes care. The total health care costs of a person with diabetes in the USA are between two and three times those for people without the condition. The overall cost of treating diabetes in the USA in 1997 was estimated at US$ 44 billion.

In the Western Pacific region a recent analysis of health care expenditure has shown that: 16% of hospital expenditure was on people with diabetes. In the Republic of the Marshall Islands, this figure was 25%. In Fiji where facilities for the care of diabetics were not available, patients had to travel elsewhere and 20% of "offshore expenditure" on health by Fiji was on diabetes related complications. These high proportions of health care budgets represent considerable sums for countries who can ill afford high expenditures on preventable conditions such as diabetes.

Direct costs to individuals and their families include medical care, drugs, insulin and other supplies. Patients may also have to bear other personal costs, such as increased payments for health, life and automobile insurance.

Direct costs to the healthcare sector include hospital services, physician services, lab tests and the daily management of diabetes - which includes availability of products such as insulin, syringes, oral hypoglycaemic agents and blood-testing equipment. Costs range from relatively low-cost items, such as primary-care consultations and hospital outpatient episodes, to very high-cost items, such as long hospital inpatient stays for the treatment of complications.

Overall, direct health care costs of diabetes range from 2.5% to 15% of annual health care budgets, depending on local diabetes prevalence and the sophistication of the treatment available.

For most countries, the largest single item of diabetes expenditure is hospital admissions for the treatment of long-term complications, such as heart disease and stroke, kidney failure and foot problems. Many of those complications of diabetes are potentially preventable given prompt diagnosis of diabetes, effective patient and professional education and comprehensive long-term care.

Recent cost estimates suggest that the cost per year to treat diabetes for Brazil is US$ 3.9 billion, for Argentina it is US$ 0.8 billion and for Mexico it is US$ 2.0 billion. We must also remember that these annual figures are rising as the prevalence of diabetes is increasing in Latin America.

There are also **indirect costs,** such as lost productivity associated with diabetes, as a number of diabetics may not be able to work at all or have to work less then before the onset of their condition. Productivity losses may happen as a result of sickness, absenteeism, disability, premature retirement or premature mortality.

Estimating the costs to society of lost productivity due to diabetes is not an easy task. However, in many cases where estimates have been made, these costs of lost productivity may be

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COSTS AND PREVENTION OF DIABETES

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as great or even greater than the direct health care costs of treating diabetes and its complications. For example, in addition to the already mentioned US estimate of US$ 44 billion in direct costs of treating diabetes, an estimated US$ 54 billion of lost productivity during the same year (1997) was also estimated.

The combined cost estimates for 25 Latin American countries suggests that in developing countries the costs of lost productivity may be as much as five times the direct health care costs. This may be because in these countries there is limited access to high quality care and consequently there is high incidence of complications, disability and premature mortality. Families too, suffer loss of earnings as a result of diabetes and its consequences.

Intangible costs of diabetes that are not easy to quantify in term of monetary value, such as pain, anxiety, inconvenience and generally lower quality of life, affect everyone, everywhere. Intangible costs also have a great impact on the lives of patients and their families and are just as important as the direct and indirect costs.

Some of the intangible costs may include discrimination in the workplace. Obtaining jobs may be more difficult, and professional life may be shortened because of complications leading to early disability and even death.

Personal relationships, leisure and mobility can also be negatively affected. Diabetes treatment, particularly insulin injection and self-monitoring, can be time-consuming, inconvenient and uncomfortable.

Effective prevention of diabetes and its complications by means of more cost-effective healthcare systems is the way forward. This may be done through the prevention of the onset of diabetes itself (primary prevention) or by the prevention of its immediate and longer-term consequences (secondary prevention).

Primary prevention protects susceptible individuals from developing diabetes. It has an impact by reducing or delaying both the need for diabetes care and the need to treat diabetes complications. Examples of primary prevention come from studies undertaken among susceptible groups in China.

These studies suggest that appropriate diet, increased physical activity and consequent reduction of weight, supported by a continuous education programme, achieved a reduction of almost two-thirds in the progression to diabetes over a six-year period. Preventive measures that trigger changes in life style such as those mentioned, are likely to be cost effective if implemented. These measures will also have benefits beyond diabetes since it has been demonstrated that changes in diet combined with increased physical activity reduce obesity and consequently cardiovascular diseases and certain forms of cancer.

Secondary prevention includes early detection, prevention and treatment. Appropriate action taken at the right time is beneficial in terms of improved quality of life. Secondary prevention is also cost-effective, especially if it can prevent complications and consequent hospital admission. Secondary prevention measures include:

- The treatment of high blood pressure, raised blood lipids and the control of blood glucose levels. These can substantially reduce the risk of developing complications and slow their progression in both types of diabetes.

- The prevention of foot ulceration and amputation. Effective foot-care reduces both the frequency and length of hospital stays and the incidence of amputation in diabetes patients by as much as 50%.

- Screening and early treatment for retinopathy. This is a very cost-effective measure, given the enormous and devastating direct, indirect and intangible costs of blindness.

- Screening for protein in urine followed by appropriate treatment can help prevent or slow down the onset of kidney disease and consequent kidney failure.

- Measures to reduce / eliminate the consumption of tobacco will also assist in the management of diabetes. In addition to being associated with several forms of cancer, cigarette smoking has been found to be also associated with poor control of blood glucose and it is related to hypertension and heart disease in people with diabetes as well as those without.

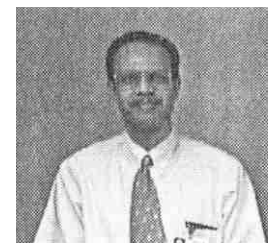
Contributor: P. Rodrigues (Ph.D.) - H.S. Research Officer.

Sources:

- WHO Press Release, Fact Sheet N° 236, Revised September 2002, <http://www.who.ch>.

- Barcelo, A., and Rajpathak, S., **Incidence and prevalence of *diabetes mellitus* in the Americas**, Pan Am J Public Health, 10(5), 2001, 300-308.

Dr. Gerald Smith appointed Chief Medical Officer



Dr. Gerald Smith has been appointed by His Excellency the Governor, Mr. Bruce Dinwiddy, as Chief Medical Officer of the Cayman Islands with effect from 16 September.

Following discussions between the Health Services Authority, the Ministry of Health Services and the Government Legal Department, it was decided that in order to avoid any suggestion of conflict of interest, it was undesirable for one person to simultaneously hold the posts of Medical Director of the Health Services Authority and Chief Medical Officer (CMO) of the Cayman Islands Government.

Dr. Bryan Heap, who was the CMO of the Health Services Department, became medical director when the changeover from a department to a Health Services Authority took place on 1st July, 2002, says Permanent Secretary in the Ministry of Health Services, Miss Andrea Bryan.

Following upon this changeover, Dr. Gerald Smith has been appointed by His Excellency the Governor, Mr. Bruce Dinwiddy, as CMO with effect from 16 September until further notice.

"Dr. Smith has sprung into action and is already dealing with matters such as patient referrals to private practitioners and registration of health practitioners," notes Miss Bryan, adding that Dr. Smith had previously served as CMO.

She explains that once Health Services ceased to exist as a government department and became a private authority, its employees also ceased to be civil servants.

Their employment status was automatically transferred to the authority, and some positions were modified to be more in line with those of a private health facility. Instead of a CMO, therefore,the authority has the position of Medical Director (MD) in charge of physician services.

Dr. Smith in his role as CMO will now perform those duties required by General Orders and various laws, most notably the Health Practitioners Law, explains Miss Bryan. In addition, under General Orders, only the CMO can refer civil servants to local private practitioners or overseas medical specialists; there are also specific duties for the CMO under the Misuse of Drugs Law, as well as the Mental Health Law. The Medical Director of the Authority is not authorised to fulfil these functions.

Furthermore, Miss Bryan acknowledges that keeping the posts separate avoids conflicts of interest. The CMO postholder is the chair of the Health Practitioners Board, which issues rulings on cases involving both private- and public-sector practitioners. Meanwhile, the Medical Director is, by law, a member of the Health Services Authority's Board.

"As supervisor of the Authority's physicians, the medical director would most likely be involved in any matters coming before the Board that would involve one of them," she explains.

"To have one person in the dual posts of CMO and Medical Director would therefore potentially pose a threefold problem.

"First, the person would chair the Health Practitioners Board proceedings as CMO; second, he would be a member of the Health Services Authority Board as Medical Director; and third, the person may be involved as supervisor of the health practitioner whose case is being heard.

This would present a blatant case of conflict of interest," she asserts. Following consultation with the Legal Department, it is considered that given the statutory functions of each post, it is questionable whether one individual could properly discharge one function without compromising duties in the other.

Saying that he "very much welcomes" the new arrangements, Dr. Heap notes that they remove any potential conflict of interest on his part. "As Medical Director of the Health Services Authority I have a role in establishing and monitoring clinical standards, and reporting to the Health Practitioners Board should serious concerns with regard to professional misconduct arise," he remarks. "It is therefore not at all appropriate that I should chair a board which has to consider and judge any such concerns."

Comments Dr. Smith, "Having acted as chief medical officer in the past, I am pleased to assist in resolving the conflicts that were present in the former roles of the CMO. I look forward to assisting the Ministry of Health in undertaking the roles of the CMO as set out in our various laws."

Health Services News congratulates Dr. Smith on his appointment and extends our best wishes in his new role as CMO.