National Parliament of Solomon Islands

Special Select Committee into the Quality of Medical Services provided at the National Referral Hospital

Committee Report

NP-Paper No. 51/2009
Presented on 21 December 2009
National Parliament Office
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I am pleased to present the report of the Special Select Committee into the Quality of Medical Services provided at the National Referral Hospital.

This inquiry was instituted by the National Parliament of Solomon Islands in response to Members’ concerns regarding the operation and performance of the National Referral Hospital.

The Committee believes that parliamentary oversight of the Government’s provision of medical services to the people of Solomon Islands is a part of the Parliament’s proper role in reviewing and recommending improvements to important areas of government and public policy.

In this report, the Committee presents significant and concerning evidence regarding the parlous state of the National Referral Hospital. It is quite simply, at the current time, a national disgrace. The Committee strongly urges the Government to take urgent steps to address this.

On behalf of the Committee, I would like to thank all those involved in this inquiry, including the management and staff of the National Referral Hospital, government representatives, aid organisations, and interest groups, former employees including former doctors and nurses’, former patients and members of the public.

Thanks also to the Committee Secretariat and Hansard staff for supporting the Committee’s inquiry.

Finally, I would like to thank my fellow Committee Members and former Members for their participation in this important inquiry.

I commend the report to the Parliament.
Terms of reference

On Friday, 3 April 2009, on the motion of the Hon Peter Boyers, Member for West New Georgia and Vonavona, the House resolved:

1. That a Special Select Committee be established to inquire into and report on the quality of medical services provided at the National Referral Hospital and in particular how they are managed and administered and how they may be improved.

2. That the Committee report prior to the end of the budget meeting of Parliament in 2009 according to the provisions of Standing Order 72.

Notwithstanding anything contrary in the Standing Orders for the purpose of this inquiry:

3. The Committee shall comprise only Members of Parliament appointed by the Speaker.

4. Members may at any time be discharged from the Committee by the Speaker and other members appointed or added.

5. The Committee shall have power
   (i) To adjourn from time to time
   (ii) To adjourn from place to place
   (iii) To send for and examine persons, papers, records and things
   (iv) To make visits of inspection,
   (v) To request the attendance of and examine members of the House.

6. The Committee shall take all evidence in public unless the Committee decides otherwise.

7. The Committee may authorize the recording of its public hearings and require an official record to be prepared by Hansard.

8. Any persons of body may make written or recorded submissions to a committee with respect to the inquiry and the committee has power to authorize publication, before presentation to the House, of submissions received and evidence taken; and

9. The Clerk is to fix the time and place for the first meeting of the Committee in such manner as the Clerk thinks fit.
Recommendations

Recommendation 1

The Committee recommends that the Solomon Islands Government, through the budget process, reprioritise funding of the National Referral Hospital to allow the hospital to deliver a standard of health care commensurate with the hospital’s position as the primary health care service provider in Solomon Islands; and to immediately lift any reservation that may currently be on the health budget and exempt health from any future budget reservation.

Recommendation 2

The Committee recommends that with better funding of the NRH by the Solomon Islands Government, the NRH management progress the following initiatives at once:

- The establishment of a basic clinical governance framework at the NRH as a matter of priority to improve patient care and outcomes;
- The development of a quality control framework with a focus on the systems of the Medical Records Department, and an absolute priority placed on the implementation of the ICD 10 software package and associated clinical indicators in 2010;
- The establishment of absolute minimum staffing levels for key departments such as the Accident and Emergency Department, and the recruitment of personnel to meet those absolute minimum staffing levels as necessary;
- The immediate rectification of the current nurse to patient ratio to ensure adequate minimum care for patients of the NRH, including the development and immediate implementation of a scheme to re-engage retired nurses to assist with nursing responsibilities and training of nurses;
- The development of a human resource management system to ensure that all personnel, including nurses, have access to training and development opportunities, that all staff receive regular performance appraisal and reporting, that all staff follow the applicable rules (including the General Orders) on staff workplace attitude and ethics, and that where vacancies arise those vacancies are filled promptly on the basis of merit;
- The immediate implementation of a Patient Complaints Tribunal;
- The implementation of proper occupation health and safety procedures, laboratory procedures and infection control measures to ensure healthy and safe working environment for NRH staff, patients and visitors;
- The review of the hospitals security services including the implementation of a visitors register and the engagement of a private security firm to provide security services at the NRH;
- The development of systematic processes for the regular replacement and maintenance of key medical equipment, together with the replacement of other hospital equipment, notably mattresses; and
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<table>
<thead>
<tr>
<th>Committee Report: December 2009</th>
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<tr>
<td>• The immediate repair or reconstruction of the NRH’s sewage system in order to improve sanitation in the wards and bring an end to the current deplorable practice of pumping waste directly into the sea.</td>
</tr>
<tr>
<td>• Consider the development of a systematic process that allows doctors to be on duty after hours on a shift basis as opposed to being on-call.</td>
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</tbody>
</table>
Recommendation 3

The Committee recommends that the SIG, the MHMS and the NRH management work together to address the following matters:

- The viability and appropriateness of introducing a fee for certain patients of the NRH, especially as may be used to manage the presentation of non-urgent cases to the Accident and Emergency Department and ENT Department;
- The possibility of establishing a private ward at the NRH to ease the burden on the public hospital;
- The possible establishment of a chapel at the NRH;
- The possible establishment of a children’s hospital in the medium to long term;
- The possible long-term move of the NRH to a new site, and where that site should be located;
- The development of appropriate arrangement to guide doctors who carry out both NRH duties and private practice;
- The provision of assistance to staff of the NRH for housing and transport to and from work.
## Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AusAID</td>
<td>Australian Agency for International Development</td>
</tr>
<tr>
<td>CNURA</td>
<td>Coalition for National Unity and Rural Advancement</td>
</tr>
<tr>
<td>HSSP</td>
<td>Health Sector Support Program</td>
</tr>
<tr>
<td>ICD</td>
<td>International Classification of Diseases</td>
</tr>
<tr>
<td>IPAM</td>
<td>Institute of Public Administration and Management</td>
</tr>
<tr>
<td>MHMS</td>
<td>Ministry of Health and Medical Services</td>
</tr>
<tr>
<td>NRH</td>
<td>National Referral Hospital</td>
</tr>
<tr>
<td>ROC</td>
<td>Republic of China (Taiwan)</td>
</tr>
<tr>
<td>SICHE</td>
<td>Solomon Islands College of Higher Education</td>
</tr>
</tbody>
</table>
Chapter 1: Introduction

This chapter provides an introduction to the inquiry, including information on the Committee, the conduct of the inquiry and the structure of this report.

1.2 The establishment of the Committee

The Special Select Committee into the Quality of Medical Services provided at the National Referral Hospital was established under Standing Order 73 of the *Standing Orders of the National Parliament of Solomon Islands* 1982, which provides:

1. Parliament may, on the motion of any Member, appoint under this order or by an order specially made, a Special Committee to consider a matter of public importance upon which Parliament wishes the Government to initiate a Bill or take other legislative or administrative action.

2. Such Special Committee shall comprise both members and persons who are not Members but who have special knowledge of, or expertise related to, the matter to be considered by the Committee.

3. The Members to serve on the Committee shall be appointed by the Speaker; those persons to serve on the Committee who are not Members shall be appointed by the Speaker upon the nomination of the Minister to whom the Committee is required to report.

4. The motion moving the appointment of a Special Committee shall specify a Minister to whom the Committee shall deliver its report. The Minister shall appoint a secretary to the committee.

5. A Special Committee, before proceeding to any other business shall elect a Chairman who shall be one of the Members appointed to the Committee and who shall hold office during the life of the Committee. In the absence of the Chairman the Committee shall elect anyone of its members to temporarily act as Chairman.

6. When a Special Committee has considered its proceedings it shall present a Report to the Minister specified in accordance with paragraph (4) of this Order. As soon as the Parliament meets after receiving the Report of the Committee, the Minister shall lay the same on the Table together with his proposals as to the action which he proposes to take thereon.

7. Subject to the provisions of this Order, proceedings of a Special Committee shall be in accordance with Order 72.

The terms of reference of this inquiry are at page vii. As indicated, the terms of reference were adopted by the House on Friday, 3 April 2009, on the motion of the Hon Peter Boyers, Member for West New Georgia and Vonavona.

The terms of the reference superseded elements of Standing Order 73, including SO 73(2) (the appointment of non-Members to a special committee), SO 73(3) (the appointment of non-Members by a Minister), SO 73(4) (the reporting of the Committee to a Minister) and SO 73(6) (tabling of the report by a Minister).
1.3 The conduct of the inquiry

Election of the Committee Chair

At its first deliberative meeting on 1 May 2009 following the referral of the inquiry on 3 April 2009, the Committee elected the Hon Peter Boyers as Chair of the Committee.

Advertising

Also at the deliberative meeting on 1 May 2009, the Committee resolved to advertise for submissions from the first week of May 2009 until the second week of July 2009, a period of approximately six weeks. Advertisements were placed in both the Solomon Star and Island Sun describing the inquiry, providing the terms of reference and information about making a submission to the inquiry.

The same information was published by the Secretariat on the Parliament’s website.

The inquiry was also advertised through service messages broadcast by the Solomon Islands Broadcasting Corporation and on One News Television.

Submissions

The Committee received a total of 13 submissions from a range of individuals and organisations, including notably a submission from the National Referral Hospital and Ministry of Health and Medical Service. A list of submissions is at Appendix 1.

Visit to the NRH

On 7 September 2009, the Committee undertook a site visit to the National Referral Hospital (NRH). Upon arrival at the NRH, the Committee was welcomed by the NRH Chief Executive Officer and Medical Superintendent, together with the Permanent Secretary and Under Secretary from the Ministry of Health and Medical Services (MHMS). These officials accompanied the Committee throughout the site visit. They assisted in answering queries as well as providing background information on locations and the functions of each department.

The site visit provided the Committee an opportunity to engage directly with patients, doctors, nurses and associated support staff at the NRH, and enabled Members of the Committee to see first hand the conditions at the hospital, its physical infrastructure, equipment and daily operation.

Public hearings

Following the receipt of submissions and the site visit, the Committee undertook a series of 11 public hearings from 8 September 2009 through to 27 October 2009. All hearings were broadcast live by the Solomon Islands Broadcasting Corporation.

A list of witnesses is at Appendix 2.

The Committee wishes to thank all the witnesses for their willingness to assist the Committee by providing evidence during the public hearings.
Public forums

In addition to the 11 public hearings, the Committee also conducted three public forums. These were held in West Honiara on 14 October 2009, in East Honiara on 16 October 2009, and in Central Honiara on 19 October 2009. All public forums were broadcast live by the Solomon Islands Broadcasting Corporation.

The public forums provided members of the general public an opportunity to appear before the Committee and have their say concerning the quality of medical services provided at the NRH.

Once again, the Committee wishes to thank all the members of the public who attended the public forums and presented their views on the NRH to the Committee.

Transcripts

Following the hearings, the Committee resolved to have the official transcripts published and made available for public viewing. Transcripts of the hearings are available on the National Parliament website at www.parliament.gov.sb

1.4 Structure of this report

This report is in nine chapters:

- Chapter 2 provides background information to the National Referral Hospital, including an examination of the hospital’s history and development;

- Chapter 3 examines the NRH budget, together with the broader Ministry of Health and Medical Services budget, as allocated by the Solomon Islands Government most recently in the 2010 Appropriation Bill 2009.

- Chapter 4 discusses the clinical care accorded to patients when accessing the services provided at the NRH.

- Chapter 5 provides a discussion on the human resources management at the NRH.

- Chapter 6 examines the infrastructure and equipment at the NRH including maintenance, repairs, expansion plans and technical support for specialised tools.

- Chapter 7 provides an insight into the Hospital’s support services including pharmaceutical supplies, food, hygiene, security and communications.

- Chapter 8 discusses international aid assistance to the NRH and to the health sector in Solomon Islands more generally.

- Chapter 9 presents the Committee’s conclusions and recommendation.

Significantly, Chapters 1 – 8 of this report are purely factual – they simply present the views and evidence of different parties on particular issues raised during the inquiry. It is only in Chapter 9 where the Committee draws from this evidence its own findings and recommendation.
Chapter 2: Background

This chapter provides background information to the National Referral Hospital, including an examination of the hospital’s history and development.

2.1 The responsibility of the SIG for providing health care services

The Solomon Islands Government is responsible for providing hospital and primary health care to the people of Solomon Islands under the Health Services Act 1979.

Under the Hospital Services Act, the Minister for Health, with the support of the Ministry of Health and Medical Services (MHMS), is responsible for developing legislation, policies and standards for health care, for planning health facilities and the operation of hospitals such as the NRH. The Minister is in turn responsible to the Cabinet and Parliament.1

2.2 The role of the NRH

The Health Services Act 1979 defines a hospital as follows:

Hospital means an institution for the reception treatment of persons suffering from illness, including psychiatric illness, or requiring rehabilitation, and dispensaries and outpatient departments maintained in connection with such institutions.2

The NRH is the main hospital for the people of Honiara and Guadalcanal, and is simultaneously the only major referral hospital for people in the rest of Solomon Islands. Referrals are made from provincial hospitals, area health centres and nurse aid posts throughout the country. The hospital is also an onwards referral hospital to St Vincent’s Hospital Sydney.3

Ultimately, the NRH is intended to provide universal access to health services in the country.4

The Health Services Act (Cap. 100) defines the role of the NRH as two-fold:

- The provision of simple, effective and affordable health care services which guarantee universal access (to medicine, care and facilities) to the citizens of Solomon Islands; and
- To serve as a training institution for medical, nursing and other allied health staff.5

In its written submission, the NRH further submitted that:

The hospital’s vision is to provide efficient effective, high quality medical care services and to fulfil its role within the integrated health care system for the

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1 Submission 11, NRH, pp 6-7.
2 Cited in submission 11, NRH, p 7.
3 Submission 11, NRH, pp 26-27.
4 Submission 11, NRH, p 6.
5 Submission 11, NRH, p 7.
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Figure 2.1 below shows the NRH’s organisational structure.

**Figure 2.1: NRH organisational chart**

Source: Submission 11, NRH, Appendix 1.
2.5 The Auditor-General’s report of June 2006

In June 2006, the Auditor-General’s Department published the findings of a ‘Special Audit into the Affairs of the National Referral Hospital of the Ministry of Health and Medical Affairs’. The report, which contains 118 recommendations, included a key finding that:

.. the lack of adequate systems and processes and documents to evidence and support decisions in relation to administrative processes, clinical and other support facilities and other shortcomings were a major concern.9

In its submission, the NRH indicated that the bulk of the recommendations of the Auditor-General’s Department have since been addressed, with only a few remaining to be finalised.

The Committee notes that reference is made to the 2006 Audit report elsewhere in this report.

2.6 Impact of population increase in the Solomon Islands

The Committee notes that the challenges faced by the NRH, discussed in this report, occur against a backdrop of rapid population growth in Solomon Islands.

The population of Solomon Islands is currently growing at a rate of approximately 3.5 per cent per annum. This rate of growth places huge pressures on the hospital, health planners and the government to deliver health services.

For example, in the first six months of 2009 alone, the NRH experienced 3,508 admissions to the post natal ward, an increase of 75 per cent. This increase is unprecedented, and has not been matched by any commensurate increase in funding for the hospital. Inevitably, such pressures have serious implications for the level of service at the NRH.10

The impact of population growth was also raised repeatedly throughout the Committee’s public hearings. The Committee notes in particular the evidence of Dr Titus Nasi from the Paediatric Department:

Looking at the numbers 47 percent of the population is under 15 years and that comes under paediatrics, so if you take Solomon Islands 600,000 that’s about 300,000. 280,000 kids under the age of 15 years. That’s quite a lot for two paediatricians to manage, we have a birth rate at 3% some years ago, probably its 2.8%, 2.9%. So you expect about 16,000 babies throughout the country per year. And as they said in the National Referral Hospital we have two years ago its probably 300 babies, now we have more than 400 babies coming out every month like they have mention. So you have 5,000 kids coming out of NRH in one year. And at NRH the children’s mortality in general accounts for 45 percent of the kids that die at the National referral hospital. That’s from last year’s numbers, so we have the mortality in the wards. The children’s ward we have two wards one is the children’s ward and one is the special care nursery. They both are similar in

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9 Cited in submission 11, NRH, p 14.
10 Submission 11, NRH, p 24.
the sense that special care nursery has a death rate of about 6 to 7 percent of the admissions.\textsuperscript{11}

\textsuperscript{11} Dr Titus Nasi, Evidence, 14 September 2009, p 31.
Chapter 3: The NRH Budget

This chapter examines the NRH budget, together with the broader Ministry of Health and Medical Services budget, as allocated by the Solomon Islands Government most recently in the 2010 Appropriation Bill 2009.

3.1 The MHMS Budget

The SIG funding of the Ministry of Health and Medical Services is shown in Table 3.1 below, taken from the SIG 2010 Draft Recurrent Estimates.

<table>
<thead>
<tr>
<th></th>
<th>2008 ACTUAL</th>
<th>2009 ORIGINAL BUDGET</th>
<th>2009 REVISED BUDGET</th>
<th>2010 BUDGET ESTIMATES</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL</td>
<td>$170,982,006</td>
<td>$208,769,504</td>
<td>$204,077,543</td>
<td>$222,057,274</td>
</tr>
</tbody>
</table>


As shown in Table 3.1, funding for the MHMS has increased from SBD$171 million in 2008 to a budgeted SBD$204 million in 2009, with a budget estimate of SBD$222 million in 2010.

3.2 The NRH Budget

The SIG funding of the NRH is shown in Table 3.2 below, again taken from the SIG 2010 Draft Recurrent Estimates.

<table>
<thead>
<tr>
<th></th>
<th>2008 ACTUAL</th>
<th>2009 ORIGINAL BUDGET</th>
<th>2009 REVISED BUDGET</th>
<th>2010 BUDGET ESTIMATES</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL</td>
<td>$53,671,304</td>
<td>$47,621,247</td>
<td>$47,368,741</td>
<td>$55,144,254</td>
</tr>
</tbody>
</table>


As shown in Table 3.2, funding for the NRH fell from SBD$53 million in 2008 to a budgeted SBD$47 million in 2009. Funding for the NRH is budgeted to increase again in 2010 to SBD$55 million.

Payroll costs and operational expenditure at the NRH

The Committee notes that while the 2010 Budget estimates of funding for the NRH is SBD$55 million, a significant proportion of this, SBD$36 million, is spent in payroll charges (that is to say, salary for staff). Only approximately SBD$19 million is available as hospital operational expenditure. This is shown in Table 3.3 below.
Table 3.3: SIG Recurrent Estimates 2010 – NRH (Details of revenue and expenditure) (SBDS)

<table>
<thead>
<tr>
<th></th>
<th>2008 ACTUAL</th>
<th>2009 ORIGINAL BUDGET</th>
<th>2009 REVISED BUDGET</th>
<th>2010 BUDGET ESTIMATES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payroll</td>
<td>$47,438,898</td>
<td>$36,907,393</td>
<td>$36,907,393</td>
<td>$36,067,807</td>
</tr>
<tr>
<td>Other charges</td>
<td>$4,298,736</td>
<td>$10,811,854</td>
<td>$10,601,113</td>
<td>$10,281,447</td>
</tr>
<tr>
<td>Hospital equipment</td>
<td>$2,128,003</td>
<td>$0</td>
<td>$0</td>
<td>$9,000,000</td>
</tr>
<tr>
<td>TOTAL</td>
<td>$53,671,304</td>
<td>$47,621,247</td>
<td>$47,368,741</td>
<td>$55,144,254</td>
</tr>
</tbody>
</table>


A key point to note in Table 3.3 above is the allocation of SBDS$9 million in 2010 in funding for medical equipment at the NRH. This line of expenditure – specifically head 276-0390-3236 – was previously abolished in 2009, meaning that in 2009, there were no funds under the SIG budget to support procurement of medical and surgical equipment.\(^\text{12}\) Significantly, however, the Committee notes that this item of expenditure is listed in the SIG 2010 Recurrent Estimates as a ‘one off’.\(^\text{13}\) The Committee understands that the NRH had bid for SBDS$12 million for procurement of medical and surgical equipment.\(^\text{14}\)

Bolstered by the one-off SBDS$9 million available for medical equipment, funding for the NRH other than payroll charges will increase to SBDS$19,281,447, in 2010.

However, it should also be noted that funding for ‘other charges’ has actually fallen from SBDS$10,601,113 in 2009 to SBDS$10,281,447 in 2010. This funding is all that is available for the actual running of the hospital, and covers items such as repairs and maintenance, printing, fuel, office expenses, IT equipment, uniforms, drugs and dressings, food, house rent, protective clothing and training.\(^\text{15}\)

The Committee also notes that funding for payroll – that is for staff wages, allowances and overtime – has fallen from SBDS$36,907,393 in 2009 to SBDS$36,067,807 in 2010.

### 3.3 Additional funding for the NRH from AusAID

The Committee understands that the NRH also receives additional funding from AusAID.

Although data for 2010 is not available, in 2009, AusAID supported the hospital with a total of SBD $7.2 million in funding, comprising:

- SBDS$2 million for medical equipment;
- SBDS$600,000 for international patient transfers;
- SBDS$3.6 million for the refurbishment of the Accident and Emergency Department; and
- SBDS$1 million for information management software and training.

\(^{12}\) Submission 11, NRH, p 12.
\(^{13}\) SIG 2010 Recurrent Estimates, p 148.
\(^{14}\) Submission 11, NRH, p 20.
\(^{15}\) SIG 2010 Recurrent Estimates, pp 163-164.
3.4 Overall funding of the NRH

The Committee notes that in its written submission, the NRH made explicit reference to the lack of certainty and sustainability of budget funding of the NRH. Given the importance of this issue, the Committee reproduces the NRH comment in full:

All of NRH’s challenges have one common cross cutting factor and it is money. Over the last two years the NRH has been severely hampered by the actions of government in relation to the budget allocation. In 2008 slow release of final allocation caused major problems in terms of financial planning and a major medical equipment purchase. During 2009 the 10% and 25% effective cut in funds have severely curtailed management’s ability to properly run the Hospital. Government must show its seriousness in allotment of funds to health services because if services are not being delivered because of failed government commitments, there is no use running a sector that cannot deliver as what has been demonstrated in years past.16

Other parties also raised the issue of adequate funding for the NRH and medical services generally. In his evidence to the Committee, Dr Lester Ross, Permanent Secretary to the MHMS, stated:

There are a lot of things that will determine the good quality of services, good planning, management, organization but resources is so important, human resources and financial resources and I think if we are to improve the services for the hospital and respond to the concerns of the public that has been clearly raised I think we need a budget.....more than what we are told to have for next year.17

Also in evidence, Mr Douglas Ete, Chief Executive Officer, NRH, noted that the NRH is simply not provided with sufficient funding under the Budget to provide the required services.18

The 2009 Budget reservation

In the 2009 Budget, in the face of the global financial crisis, and a budget deficit, the SIG announced a 10 per cent reservation on recurrent expenditure across all ministries, with a further 25 per cent reservation for all ministerial decisions to be endorsed by the Central Tender Board. Recruitment was also frozen.

Commenting on the 2009 Budget reservation, the Hon Clay Soalaoi, Minister, MHMS, stated in evidence:

I must make an appeal here for the Ministry of Finance to think seriously about reserving the whole budget of the Ministry of Health. If there is any Ministry that should not be affected by the reservation it is the Ministry of Health. And I visited that several provinces after coming to the ministry. It is really affecting the provincial hospitals and part of the problems we experience in the National Referral Hospital is mainly due to the reservation. We are trying to operate out of limited funds we have.19

16 Submission 11, NRH, p 28.
17 Dr Lester Ross, Evidence, 27 October 2009, p 74.
18 Mr Douglas Ete, Evidence, 27 October 2009, p 76.
19 Hon Clay Forau Soalaoi, Evidence, 8 September 2009, p 63.
3.5 The NRH proposal to charge fees

In its written submission, the NRH indicated that the current policy of the SIG is that no charges should be levied for access to public health services.

The NRH hospital submitted that this policy puts enormous strain on the NRH. While as discussed elsewhere in this report, demand for services at the NRH continues to increase as population growth continues, the budget of the NRH remains static or even decreases.

In this regard, the NRH indicated that a proposal for the levying of fees at the NRH was furnished to the Permanent Secretary of the MHMS in April 2009. Proper consultation will need to be undertaken on the proposal.²⁰

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²⁰ Submission 11, NRH, p 14.
Chapter 4: NRH patient care and treatment

This chapter discusses the clinical care accorded to patients when accessing the services provided at the NRH.

4.1 The NRH as a referral hospital

As indicated previously in Chapter 2, the NRH is the main referral hospital for the people of Solomon Islands. In its written submission, the NRH indicated that there are four avenues by which the hospital receives ‘referred’ patients: from provincial hospitals; from area health centres; from nurse aid posts; and through self referral – patients present themselves without appointment or a referral form.

At the same time, the NRH is the main hospital for the people of Guadalcanal and Honiara city. These areas do not have a separate hospital, so they use the NRH as their main hospital responsible for the delivery of primary health care services.

It was pointed out in the NRH written submission that this inconsistency in the provision of both primary and referral health services at the NRH makes it difficult for the hospital to operate as a referral centre, as envisioned.21

This was reiterated by Mr Rex Foukona in his written submission. Mr Foukona observed that while the NRH is termed a referral hospital, it is in fact also providing primary community health services to the people of Guadalcanal and Honiara. He argued that once a separate hospital is established for the people of Guadalcanal and Honiara, it can take over primary health services for the people of Guadalcanal and Honiara, leaving the NRH to be responsible for referral health services only.22

The NRH submission also noted that the geographical layout of the Solomon Islands, together with the prevailing poor shipping services, have contributed to the poor referral system. Patients in certain areas in the country find it more convenient and cheaper to get to NRH by ship than to their provincial hospitals.23

Overseas referrals to St Vincent Hospital, Sydney

The NRH has an overseas referral agreement with St Vincent Hospital in Sydney under a memorandum of understanding signed between the Governments of New South Wales and the Solomon Islands Government. Under the agreement, formally known as the ‘Ten Bed Arrangement’, there is provision for Solomon Island patients to have access to 10 beds per year at St Vincent Hospital free of charge.

In its written submission, the NRH indicated that the process of referrals to St Vincent’s is set according to clinical criteria which include approval for a transfer from the Overseas Referral Committee chaired by the Medical Superintendent of the NRH. The Superintendent and Overseas Referral Committee decides individual cases for referral to St Vincent’s on merit.

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21 Submission 11, NRH, p 26.
22 Submission 10, Mr Rex Foukona, pp 2-3.
23 Submission 11, NRH, p 6.
The NRH indicated in its submission that it perenni ally has more patients in need of overseas referral than there are places available, and thus the hospital has exceeded its quota under this arrangement for some years. The submissions also noted that there are faults with the current procedure, and that the NRH Executive will review the process to ensure that there is transparency and accountability.24

In evidence, Dr Trevor Garland, Honorary Consul of Solomon Islands in Sydney and Coordinator of the Ten Bed Arrangement with St Vincent’s Hospital, indicated that one of the criteria used to qualify patients for St Vincent’s Hospital is the curability of disease:

The criteria being that these patients come to St Vincent’s Hospital are those with life threatening illnesses which are amenable to cure.25

4.2 Presentations to the NRH each year

In its written submission, the NRH indicated that in 2008, it managed approximately 110,000 patients (to be precise, approximately 110,000 patients were discharged from the hospital).26 These presentations include presentations to the Accident and Emergency Department and referrals from other hospitals and health centres.

Presentations to the Accident and Emergency Department

The Committee notes that of all presentations to the NRH hospital each year, a significant proportion, approximately 40 per cent, come through the Accident and Emergency Department.

In evidence, Dr Kenton Sade, Head of the Accident and Emergency Department, indicated that in 2007 there was a total of 45,147 presentations to the Accident and Emergency Department. In 2008, this number increased to 55,234, an increase of 10,087 cases. On a monthly basis, an average of 4,602 patients were seen at the Accident and Emergency Department in 2008. This represents 153 presentations each day.27

Patients presenting to the Accident and Emergency Department are categorised according to a triage system based on the level of seriousness of their injury or illness. There are five different triage categories. Patients in triage categories 1 and 2 are those with serious life threatening illnesses or injury and in need of immediate attention. Triage category 3 patients are those with a less serious illness compared to triage 1 and 2, while triage categories 4 and 5 are patients with the least serious cases for whom time can be taken to administer diagnoses.

Under the triage system, patients in triage categories 1 and 2 take top priority and receive the most resources, both human and medical. In evidence, Dr Sade gave as an example of a triage category 2, a patient with a case of acute shortness of breath. Resources are pulled together and allocated to such a patient until the patient’s condition is stabilised:

The team then concentrates all its effort and time to this patient until his acute shortness of breath is alleviated before we turn our attention elsewhere. This sort of patient can go from triage category (2) to (1) in a very short space of time. And

24 Submission 11, NRH, p 27.
25 Dr Trevor Garland, Evidence, 10 September 2009, p 3.
26 Submission 11, NRH, p 6.
27 Dr Kenton Sade, Evidence, 14 September 2009, pp 2-3.
if not attended to immediately, patient can die within a very short period of time.\textsuperscript{28}

Dr Kenton Sade pointed out in his evidence that the average time taken to assess a patient is approximately 10 minutes. Doctors are required to decide what to do with a patient within a further 10 minutes.\textsuperscript{29}

Dr Sade also observed that analysis of patients presenting to the Accident and Emergency Department showed that only 3 per cent of patients fell under category 1 and 2, category 3 accounted for 12 per cent, category 4 for 18 per cent, and category 5 for the balance of 64 per cent. Dr Sade argued that this analysis shows that patients seen in the Accident and Emergency Department are often patients that could seek medical services at their local clinics.\textsuperscript{30}

Following triage and treatment, patients presenting to the Accident and Emergency Department are dealt with in one of three ways:

- They may be discharged as outpatients, sometimes after collecting drug/medicine from the pharmacy;
- They may be admitted to the general wards as inpatients for further treatment; or
- Their bodies are taken to the morgue in the event that they die.\textsuperscript{31}

### 4.3 Admissions of patients to the general wards

The NRH in its written submission reported that in 2008, there were a total of 11,000 patients admitted as inpatients to the general wards at NRH.\textsuperscript{32}

The Committee also understands that at the end of July 2009, the NRH had 283 beds (305 established beds less 12 beds in a labour ward currently closed).\textsuperscript{33}

#### Bed occupancy rates

Figures from January to July 2009 reveal that inpatients admitted to the general wards had an average length of stay of seven days. The bed occupancy rate was 84.11 per cent, meaning that the hospital was operating at near capacity (ie on any one day, 84.11 per cent of beds in the hospital were occupied by a patient).\textsuperscript{34}

### 4.4 Care and treatment of patients

#### A clinical governance framework
The Committee notes that a key challenge facing the NRH is the development of clinical systems and processes both for patient care and to ensure the health and safety of hospital staff.

By way of example, in his evidence, Dr Kaini Agiomea, Director of the Anaesthetic Department, stated that:

we compromise all the time, especially when we are dealing with very sick ones and those with other medical problems who are having surgery, because our monitoring is very basic and sometimes inadequate.\textsuperscript{35}

Similarly, Mr Alfred Dofai indicated in evidence that the Medical Laboratory does not have policy and standard operating procedures in place to govern its operations and practices. Even, Health and Occupation Safety principles are not in place:

I must say that next thing this occupational health and safety and the place that we work in is very risky, hazardous. And at the moment as we speak, we have two of our staff down with tuberculosis; most of our staffs have been infected with hepatitis. One or two with typhoid in the past, so the level of risk there is very high, so we need a good control measure to safeguard our practices.\textsuperscript{36}

The Commissioner of Police in his written submission to the Committee cited as a case study of a failure of clinical systems an incident that occurred in April 2009 in the NRH. A life could have been saved if basic medical procedures had been adhered to. The case study is reproduced below:

In April 2009, a couple attended NRH because the wife was in labour. Information suggests that medical examinations were conducted by duty medical officers on the wife and it was recommended that the wife has to undergo an operation because the wife has certain complications. Information suggests that the operation was deemed as a success because the wife managed to deliver a baby boy. After the operation, certain medical formalities were completed and the wife was transferred to the NRH Labour ward at about 1400 hrs at that time. Information suggests that during the transferral process, the duty surgeon(s) and nurses failed to conduct a proper handing over to the duty nurses at the NRH Labour ward at that time and there were no medical documents pertaining to the condition of the wife prior to and after the operation. As a result, duty medical staffs at the Labour ward forgot to monitor the wife’s condition and/or inform the incoming shift that took over duties at 1500 hrs on that occasion. The new shift noticed the wife’s condition at about 1600 hrs but this was when the wife’s condition has drastically deteriorated. The wife was rushed to the theatre and attempts were made by the duty staffs to stabilize her condition but all medical measures taken at that time were unsuccessful and the wife passed away shortly. Only the new borne baby survived and was in good condition.\textsuperscript{37}

In its written submission, the NRH indicated that the development of a clinical governance framework to improve patient care and outcomes is one of the key priorities of NRH management over the next five years.\textsuperscript{38}

\textsuperscript{35} Dr Kaeni Agiomea, Evidence, 14 September 2009, p 18.

\textsuperscript{36} Mr Alfred Dofai, Evidence, 10 September 2009, p 34.

\textsuperscript{37} Submission 6, Commissioner of Police, pp 3-4.

\textsuperscript{38} Submission 11, NRH, p 25.
Ultimately, the NRH management would like to create a quality control framework whose function is to monitor, evaluate and provide feedback to management on all clinical indicators for the purposes of reviewing and planning for the services provided at the NRH.\footnote{Submission 11, NRH, pp 25-26.}

This was reiterated in evidence by Mr Tavalusu, manager of the Medical Records Department. Mr Tavalusu noted that there is no benchmark against which the quality of health services provided at the NRH can be measured. The hospital needs to set up information systems so that benchmarks can be set against which to measure the hospital’s performance. For example, there are no benchmarks for numbers of admissions, numbers of operations that doctors are doing, number of times operating theatres have been used and so on.\footnote{Mr Anon Tavalusu, Medical Records, Evidence, 23 September 2009, pp 38-39.}

As another example, Mr Tavalusu suggested that the majority of outpatients to the hospital are category 4 and 5 patients (ie the less sick) who come back to take additional treatments or with minor ailments. By contrast, Mr Tavalusu suggested that probably less than 20 per cent are category 1, 2 or 3 patients. Clearly, a system needs to be put in place to measure this, and to ensure that category 1, 2 and 3 patients are catered for as a priority.\footnote{Mr Anon Tavalusu, Medical Records, Evidence, 23 September 2009, pp 39-40.}

**The development of clinical indicators**

In its written submission, the NRH indicated that it has commenced a process of improving clinical services and working with all the departments of the Hospital to develop clinical indicators through the establishment of a Quality Committee.\footnote{Submission 11, NRH, p 15.}

All departments within the NRH will be required to develop and collect data on the quality of service provided by them. Some of the indicators being considered include:

- infection rates;
- waiting times;
- safety in use of medicine;
- surgery procedure outcomes;
- patient falls;
- reporting of sentinel incidents;
- timeliness in reporting of laboratory test results; and
- adverse drug and blood transfusion reactions.\footnote{Submission 11, NRH, pp 15, 18-19.}

**The ICD 10 initiative**

Proper planning of the delivery of services at the NRH requires information to be collected on the types of patient episodes presenting at the hospital.

\[footnotes\]
To achieve this, all patient care episodes at the hospital are coded according to the International Classification of Diseases (ICD). From this data the burden of treatment types required at NRH can be determined. The latest version of the ICD is called ICD 10.

In recent times, the NRH has taken steps to educate officers of the Medical Records Department in the use of ICD 10:

- In September 2008, two officers from the Medical Records Department were sent to Westmead Children's Hospital in Sydney for three months training on the use of ICD10;
- In April 2009, three officers were sent to the Queensland University of Technology for similar training.

The Committee understands that both training initiatives were sponsored by AusAID through HSSP funds.

The NRH plans to purchase and implement the ICD 10 software package in 2010, and to commence capturing hospital treatment data and mortality statistics. It is anticipated that this will significantly enhance planning and coordination of patient care services at the NRH.44

**Waiting times for surgery**

A significant problem confronting the NRH is the waiting time for surgery, particularly elective surgery. Currently there is a significant backlog of elective surgery at the hospital. The Committee understands that of the 5,000 patients booked for elective surgery in 2008, only 398 operations were carried out.45

In evidence, Dr Duddley Baerodo, Director of General Surgery, cited various reasons for the delays in elective surgery:

- There are three main operating theatres at the NRH. However, due to limited number of nurses and lack of necessary equipment, only two theatres are used.
- Elective cases booked for surgery are routinely postponed to allow treatment of emergency cases triage 1 patients.
- Medical staff attitudes to work also means that procedures booked in are sometimes delayed due to the late arrival of theatre staff.46

Dr Baerodo also indicated that waiting time for surgery can be further protracted by diagnosis back up where samples are sent overseas. X-ray, blood test and laboratory samples sent overseas for testing take about 6 weeks for receipt of results.47

**4.5 Discharge of patients**

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44 Submission 11, NRH, p 13.
45 Dr Duddley Baerodo, Evidence, 14 September 2009, pp 50-52.
46 Dr Duddley Baerodo, Evidence, 14 September 2009, p 52.
47 Dr Duddley Baerodo, Evidence, 14 September 2009, p 59.
During the Committee’s site visit, the Committee noted the large number of patients who had been discharged but who were waiting for transportation back to their home islands.

In evidence, Mrs Wate highlighted to the Committee that a significant number of patients who have been discharged from the NRH refuse to leave the hospital because they do not have relatives in Honiara to take care of them while waiting for transportation to their homes.\(^{48}\)

Mr Chris Laore, Director of Rehabilitation Services, stated in his evidence:

> We have a 13 beds rehab ward but it doesn’t look like it’s a rehab ward. It’s more like a rest house for some patients with disability. I think they tend to stay longer there, some of them are just waiting for transport but since transport is not available to go to Temotu because it takes longer, they stay longer. And they want to stay longer there because I think everything is provided for, so to discharge them is quite hard. So it becomes a rest house more than a rehab ward. I think it comes back to us from the hospital when somebody we discharge is we have to try and discharge back home and then he come in as an outpatient for exercise or whatever rather we keep him in and waiting for transport then it becomes a problem to us.\(^{49}\)

In its written submission, the NRH noted that the cost of repatriating all patients from the hospital is about $1.2 million per year.\(^{50}\)

### 4.6 The NRH Strategic Development Plan 2010 – 2015

In its written submission, the NRH indicated that following a two week National Health Conference in May 2009, the NRH has moved to develop the ‘National Referral Hospital Strategic Plan 2010-2015’.

The plan was developed to help focus the work of the NRH on delivering on its core business: providing good quality patient care which meets the needs of the community. To that end, the plan includes a number of objectives:

- An improved surgical service: including the introduction of a day surgery service and the opening of a fourth operating theatre.

- An enhanced paediatric service: including the opening of a 6-8 bed acute unit within the ward for very sick children, and recruitment and training of more paediatricians.

- An improved orthopaedic unit: including better training for orthopaedic surgeons and nurses, and the purchase of an image intensifier to manage cases better with less invasive intervention.

- A better radiology service: including the provision of ultrasounds services though a mobile service, the purchase of a CAT scan machine to enhance diagnostic capability and the implementation of a quality control handbook.

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\(^{48}\) Ms Rachel Wate, Evidence, 18 September 2009, p 28.

\(^{49}\) Mr Chris Laore, Evidence, 14 September 2009, p 75.

\(^{50}\) Submission 11, NRH, p.26
• An improved pathology service: including development of a national health laboratory policy, improvement in equipment, and better staff management systems.

• An expanded obstetrics and gynaecology service: including expanding post natal wards to cater for higher birth rates and examining expanding clinics and facilities elsewhere.

• Better internal medical practices: including decreasing preventable deaths by creation of acute care beds, acquiring of better medical equipment, and improved physical conditions to assist with treatment and patient flow.

• An expanded anaesthetic department: including a pre-anaesthetic clinic, better post-anaesthetic care and an acute pain service.

• An improved dental service: including the creation of dental sub-units (such as prosthetics) and construction of a new dental hospital.

The NRH indicated that the ‘National Referral Hospital Strategic Plan 2010-2015’ will be reviewed each year over the five years of the plan to ensure that the visions of the hospital are being realised.\textsuperscript{51}

4.7 \textbf{A private ward at the NRH?}

In evidence, Dr John Kure, a private medical practitioner, raised the need for NRH to have a private ward where those who can afford to pay can use such a facility.

He argued that private medical practitioners can be utilized to assist in duties at the NRH. For example, during the nights when their private clinics are closed, they can be scheduled to do on shift duties, particularly in the areas of general outpatient and the accident and emergency department.

In his written submission, Mr Rex Foukona, Solomon Islands High Court Judge, also suggested establishment of a private ward:

\begin{quote}
Private ward is important to serve business people, foreigners and Solomon Islanders who have money to spend. At least the Hospital is receiving something for the services it provided in this particular area.\textsuperscript{52}
\end{quote}

\textsuperscript{51} Submission 11, NRH, pp 9-11.

\textsuperscript{52} Submission 10, Mr Rex Foukona, pp 4-5.
Chapter 5: NRH human resource management

This chapter provides a discussion on the human resources management at the NRH. The chapter focuses on issues relating to doctors and nurses, capacity building, and issues affecting certain hospital departments.

5.1 Staffing of the NRH

In 2009, the NRH approved staffing was 535 established positions. The total of established and non-established positions in 2009 stood at 547. There were 46 doctors (not including interns), 284 nurses, 83 allied service workers and 82 corporate service workers (excluding non-established workers).

Significantly, the staffing of the NRH constitutes the bulk of MHMS approved positions for 2009 for the whole of Solomon Islands.\(^{53}\)

5.2 Doctors

The shortage of doctors at the NRH

During the inquiry, significant concern were raised at the number of vacant clinical positions at the hospital.

In evidence, Dr Tenneth Dalipanda, Medical Superintendent of the NRH, indicated that most clinical departments at the hospital have 50 per cent of their clinical posts, or even more than half, vacant. For example, at the time of his evidence, out of the four posts in the Obstetrics and Gynaecology Department, only one post was filled.\(^{54}\)

The shortage of doctors at the NRH reflects a broader shortage nationwide. In evidence, Dr Cedric Alependava, Under Secretary (Health Improvement), MHMS, indicated that Solomon Islands has a doctor patient ratio of 1:8,000. The World Health Organisation standard is 1 doctor for 500 people. Dr Alependava submitted that the government is not giving enough priority into training more doctors to meet the country’s growing population.\(^{55}\)

The Committee notes that the shortage of doctors, both at the NRH and more broadly within Solomon Islands, is compounded by the fact that many Solomon Islands doctors have moved overseas to find employment in the face of difficulties working at home. For example, in his written submission, Dr Lipson Sisiolo, a Solomon Islander working in the Australian College of Health Services Executives, indicated that he moved overseas to work due to poor management and poor decision making in Solomon Islands. Dr Sisiolo observed;

\[\text{I left Solomon Islands to work & live in Australia due to bias decisions in the posting processes that were influenced by administrators. I spent 13 years to work in five provinces of the country and was never given an opportunity to work in Honiara.}^{56}\]

\(^{53}\) Submission 11, NRH, p 8.
\(^{54}\) Dr Tenneth Dalipanda, Evidence, 8 September 2009, p 42.
\(^{55}\) Dr Cedric Alependava, Evidence, 8 September 2009, p 19.
\(^{56}\) Submission 12, Dr Lipson Sisiolo, p 2.
Training opportunities for doctors

The NRH provide training opportunities for medical students studying to be doctors. However, during the inquiry, the Committee was presented with evidence that these opportunities are sometimes not well coordinated.

In his evidence to the Committee, Dr Titus Nasi, Director of the Children’s Ward / Paediatrics, indicated that local students studying in Fiji and PNG medical schools come to the NRH for training. These students expect to learn from NRH doctors and nurses, but are often not given much assistance due to shortage of manpower:

They [medical students] come and do the ward rounds; they expect us to teach them because they are becoming doctors soon and they need support at the moment in my department I have nothing in line for them, for the medical students. They join me in the rounds. Whatever we see and learn that is what they get.\(^{57}\)

In turn, Dr Nasi highlighted in his evidence that learning opportunities for medical trainees at the NRH are not great:

I also have a group of students who are probably going to be going for medical training waiting to go to Fiji, Papua New Guinea or going to Cuba. This group, are mostly from form 7 waiting for the scholarship and when to go. I’m not sure how long the back log is, but from non-medical background and you throw them into the hospital and expect them to learn. I’m not quite sure about that, it probably doesn’t help them it doesn’t help us. We just made the number there, the patient get scared when you have 20 people coming to see you. It’s no privacy for the patient, the parents in a sense, so I’m not sure what the problem is but medical students who have scholarship suppose to go from form 7, that’s what I went through. Form 6, you go and do your foundation, you go and do medicine. Now you go and do form 7, you come and wait at the National referral hospital for 1 year wasting time and then you go for your medical training. It needs to be resolved somehow somebody needs to take on that.\(^{58}\)

Opportunities for ongoing on-the-job training for doctors

During the inquiry, questions were also raised about ongoing on-the-job training opportunities for doctors already working at the NRH.

In its written submission, the NRH indicated that it has been putting additional resources into ensuring that clinical staff have access to the latest medical information. A program facilitated by the Taiwanese Government called Continuing Medical Education is held every Friday in the hospital conference room whereby forums are made available for experts to present information to the staff.

The purpose of this is to enable staff to have access to the latest medical findings and treatments so that proper medical diagnostics can be made.\(^{59}\)

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\(^{57}\) Dr Titus Nasi, Evidence, 14 September 2009, p 42.

\(^{58}\) Dr Titus Nasi, Evidence, 14 September 2009, p 43.

\(^{59}\) Submission 11, NRH, p 13.
Separately, in evidence, Dr George Manimu, a private medical practitioner, suggested that recent graduate doctors should work in the country for at least four or five years before being assigned to further training. This would ensure that recent graduate doctors have practical experience in different departments at the NRH as well as hospitals in the provinces.\(^{60}\)

A particular issue raised during the inquiry was that of existing NRH doctors being awarded scholarships for further study. According to the submission by Ms Lai, scholarships for further training, whether internally or for international training, are awarded without due regard to appropriate selection criteria.\(^{61}\)

In response to this issue, in evidence, Mr Tione Bugotu, Permanent Secretary, Special Duties, Ministry of Education and Human Resources Development, explained procedures within the Ministry when awarding scholarships, including medical scholarships. Mr Bugotu outlined that:

> Each year the Ministry of Education through its National Training Unit reminds all ministries including the Ministry of Health to submit training projections to the Ministry of Planning and this is based on the Human Resource Development needs and the scholarship listing for any one year. An opportunity lists is then sent by [the Ministry of] Planning back to the Ministry of Education which indicates to the Ministry or the National Training Unit how many scholarships are available or are in need...I must point out here [that this] is one of the problems that the National Training Unit has actually been facing and particularly in the area of Health training. Last year for example, despite reminders being sent out to all Ministries, the submission that was sent through the Ministry of Planning revealed only Pharmacy providing their projections for training for the next 10 years. All other departments, [including] clinical departments fail to submit. Therefore the National Training Unit finds it very difficult to be able to allocate particularly in terms of priority where the priority is. This is just to point out that perhaps this is where the problem actually lies when it comes to training requirements.\(^{62}\)

**The employment of doctors from Cuba at the NRH**

To address the shortage of doctors at the NRH, the SIG facilitated a partnership program with the Cuban Government under which several Cuban doctors work at the NRH to provide clinical assistance.

In his evidence, Dr Carl Susuirara, Under Secretary of Health Care, MHMS, informed the Committee that currently there are a total of nine doctors from Cuba at the NRH, with one more yet to arrive. While this is a welcome addition to the resources of the hospital, he noted that one of the problems with the arrangement is the language barrier – the Cuban doctors need to be accompanied by a local staff member to overcome the language barrier.\(^{63}\)

During the inquiry the Committee took evidence from one of the Cuban doctors, Dr Israel Fernandez, in relation to his attachment to the NRH. He indicated that of the eight or nine Cuban doctors, most are general practitioners, while three are working in specialist roles in

\(^{60}\) Dr George Manimu, Evidence, 16 September 2009, p 6.

\(^{61}\) Submission 11, NRH, p 2.

\(^{62}\) Mr Tione Bugotu, Evidence, 16 September 2009, p 10.

\(^{63}\) Dr Carl Susuirara, Evidence, 8 September, pp 88-89.
anaesthetics, gynaecology and as a physician. A number of doctors are also working at local clinics such as Vura clinic, Rove clinic and the Kukum clinic.64

On the issue of language, Dr Israel Fernandez indicated that in terms of medical care, language is not necessarily important – it is the examination of a patient that is important. He further stated that one can diagnose the disease in a patient without the need for language. Nevertheless, Dr Fernandez appreciated the language training given to the Cuban doctors by the NRH.65

**Doctors employed at the NRH while also working in private practice**

During the inquiry, questions were raised concerning the issue of doctors being employed at the NRH while at the same time operating a private practise.

In evidence, Dr George Manimu, a private medical practitioner, argued that the practice of doctors working at the NRH and in private practice at the same time is illegal and should not be encouraged. He stated that doctors should engage in private practice only in their own time and not during government official working hours. Until it is approved by the government, doctors working as public servants should not be involve in private medical practice during official working hours.66

By contrast, in his evidence to the Committee, Dr James Auto, President of the Solomon Islands Medical Association, stated that he saw no conflict in doctors having a private practise. He argued that:

\[ ... I like to think of it this way that this doctor who is seeing patients both in the public or in the private sector is doing essentially what he is trained to do. It is not at all a conflict of interest. He is doing the consultation or offering this health service at these two different sites or three or how many number of places offered. So he is essentially doing what he has been trained to do. \]

Secondly, that the scheme signed in 2005 specified private practice for those who are consultants so defined as consultation under the current arrangement so these are those doctors who have received higher qualifications and in the position of being consultants at the hospital. So they can engage in private practice according to this current scheme.67

**5.3 Nurses**

**The shortage of nurses at the NRH**

As indicated previously, in 2009, the NRH approved staffing level included 284 nurses. The Committee understands that 69 of those positions were vacant at the time of the Committee’s inquiry.

In evidence, Mr Selwyn Hou, Director of Nursing at the NRH, pointed out that the 284 nurses (or less given vacancies) at the hospital have to cover duties across 9 different departments of

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64 Dr Israel Fernandez, Evidence, 27 October 2009, pp 16-17.
67 Dr James Auto, Evidence, 27 October 2009, p 144.
the NRH, including work in the demanding Accident and Emergency Department where patients in triage categories 1 and 2 need intensive care. Accordingly, Mr Hou submitted that nurses have been stretched beyond their capabilities. However, while this shortage of nurses has been identified as a chronic problem, requests for increase in the number of nurses at the NRH have not been met.\textsuperscript{68}

Mr Hou also noted a number of other challenges facing nurses at the NRH. They include lack of available housing,\textsuperscript{69} lack of transport to and from work, and inadequate equipment.\textsuperscript{70}

In turn, in her evidence to the Committee, Ms Rachel Wate, Assistant Director of Nursing, indicated that a vast majority of nurses are women. This causes problems in scheduling where many nurses also have commitments in their respective homes to their children and partners.\textsuperscript{71}

In response to the shortage of nurses at the NRH, the Retired Nurses Association argued in its written submission for a reduction in the number of nurses serving in the MHMS as administrators:

\textbf{Nursing Council manpower at the Ministry must reduce, release at least 2 of the staff there to go back to the hospital to be Ward Supervisors and to assist and help student nurses when they are rostered to the hospital /Ward, there are 5 staff at the Nursing Council.}\textsuperscript{72}

Another option put to the Committee to address the shortage of nurses is to try and re-engage retired nurses back to the hospital. In her evidence to the Committee, Ms Esmy Ata, a nurse at the NRH, indicated that different arrangements could be put in place to keep nurses due to retire from service in the hospital.\textsuperscript{73}

\textbf{Training opportunities for nurses}

Given the shortage of nurses at the NRH, a key issue during the inquiry was the training opportunities available to nurses in Solomon Islands, and at the NRH in particular.

The majority of nurses at the NRH receive training through the Solomon Islands College of Higher Education (SICHE). During the inquiry, the Committee took evidence from Ms Verzilyn Isom, Head of School of Nursing & Health Studies, SICHE. Ms Isom indicated that the main course offered by the SICHE to nurses is a Diploma in Nursing. The program is a six semester program with two additional semesters of clinical practice, mostly done at the NRH or other Honiara clinics. Graduates with the diploma are employed by the Ministry of Health as registered nurses.\textsuperscript{74}

However, Ms Isom raised concerns that the current diploma does not adequately prepare graduates for registered nurse practice in Solomon Islands, and that repeated calls have been made for redevelopment of the program. In particular, Ms Isom cited the findings of a 2008

\begin{footnotesize}
\textsuperscript{68} Mr Selwyn Hou, 10 September 2009, pp 24-25.
\textsuperscript{69} Discussed further in Chapter 7.
\textsuperscript{70} Mr Selwyn Hou, Evidence, 8 September 2009, pp 24-25.
\textsuperscript{71} Ms Rachel Wate, Evidence, 18 September 2009, p 29.
\textsuperscript{72} Submission 13, Retired Nurses Association, p 1.
\textsuperscript{73} Ms Esmy Ata, Evidence, 27 October 2009, pp 37-38.
\textsuperscript{74} Ms Verzilyn Isom, Evidence, 23 September 2009, pp 3-4.
\end{footnotesize}
World Health Organisation review that identified the need for development and implementation of competences for registered nurses. A key element of that is linking theoretical training for nurses to practical clinical experience, or vice versa, ensuring that there is adequate supervision and guidance for students who are actually at the NRH.\textsuperscript{75}

Ms Isom also noted that many of the trainee nurses undertaking the diploma are sponsored by the Ministry of Health. However, Ms Isom also indicated that the proportion of sponsored trainee nurses is declining. Of the 2009 first year trainee nurses, 31 of 69 are sponsored, compared to 30 of 41 second year students, and 40 of 46 third year trainees. In recent years, the number of students sponsored by the Ministry of Health has fallen to 30 each year, whereas in previous years all trainee nurses were sponsored. Other trainee nurses are sponsored by private sponsors like the churches, private institutions or, in some cases, by parents.\textsuperscript{76}

Separately, Ms Isom also suggested that there is no correlation between the numbers of trainee nurses accepted each year through the SICHE program and demand to meet the current shortage of nurses at the NRH and elsewhere. While there is a shortage of nurses, the number of nurses being sponsored through SICHE by the Ministry of Health is declining.\textsuperscript{77}

As a way forward on some of these issues, Ms Isom recommended the creation of a national committee on nurse training with representative from the Ministry of Education, Ministry of Health and SICHE to make policies and coordinate activities relating to formal education for nursing. She also advocated greater support through scholarships for nurse training and improved facilities and resources for training.\textsuperscript{78}

**Opportunities for ongoing on-the-job training for nurses**

While there are concerns about the training program for trainee nurses looking to join the NRH, the Committee also notes that concerns were expressed that there are insufficient opportunities for ongoing on-the-job training for nurses already working at the NRH.

In her evidence, Ms Hellen Orihao, Nurse Manager, Educator, NRH, expressed the concern that most nurses at the NRH do not have further qualifications in nursing beyond the basic level qualifications:

\textit{... there are total of 304 nurses and 5.5% of the nurses are on training, there are only 287 nurses working. 26.2% of the nurses are registered aides qualified with certificate nurses. About 7% of the nurses are registered with certificates and more than half have diplomas, around 5% have degrees and there is no one with a master’s degree with nursing.}\textsuperscript{79}

Ms Orihao subsequently attributed the lack of further study for nurses at the NRH to a tendency to send doctors rather than nurses at the NRH on further training opportunities. In relation to nurses undertaking further training, she observed that:

\textsuperscript{75} Ms Verzilyn Isom, Evidence, 23 September 2009, pp 3-5.  
\textsuperscript{76} Ms Verzilyn Isom, Evidence, 23 September 2009, pp 3-4, 6, 25.  
\textsuperscript{77} Ms Verzilyn Isom, Evidence, 23 September 2009, p 27.  
\textsuperscript{78} Ms Verzilyn Isom, Evidence, 23 September 2009, p 6.  
\textsuperscript{79} Ms Hellen Orihao, Evidence, 18 September 2009, p 33.
in 2002 we have 2, in 2005 we have 4 nurses, in 2006 we have 0, in 2007 we have 2 nurses, in 2008 have 4 nurses and in 2009 we have 2 nurses. We can see that there is no consistency in the training of nurses.\(^{80}\)

Ms Orihao further argued that the process for selection of doctors and nurses for ongoing training was biased against nurses. This she believes has demoralized nurses, resulting in poor performance.\(^{81}\)

5.4 The impact of staff shortages on various ward and departments

During the inquiry, the impact of staff shortages on specific wards and departments was raised. The Committee specifically noted the following departments.

The Accident and Emergency Department

In evidence, Dr Tenneth Dalipanda, Medical Superintendent at the NRH, indicated that the Accident and Emergency Department is significantly hampered by insufficient staffing. The Department operates on a shift system, for which the ideal number of doctors would be 15 or 16, to independently staff three 8-hour shifts. However, the Department does not have nearly enough doctors to do this, meaning that doctors are often placed on-call during shifts other than their own. The Committee understands that there are currently only five doctors working in the Accident and Emergency Department.\(^{82}\)

Similarly, in evidence, Dr James Auto cited the shortage of doctors in the Accident and Emergency Department, resulting in doctors working long hours during the day and often being on call after hours.\(^{83}\) Describing the operation of the on-call system, Dr Auto indicated:

> What it means is there is no doctor there 24 hours or to cover all the hours. So the nurses are there in the first instance and any patient that comes during emergency after assessment then she can call for the doctor. Usually these doctors who are on call are those who have worked throughout the 8 hour of working hours as well. And then they are now taking call during that night, not the sitting day in the A & E but from home ready to attend to any calls that a nurse gives them. So that is what happens at the moment. Ideal situation for any Emergency Department as we all know is for the doctor to be on site at all times. And to run the National Referral Hospital Emergency Department on 8 hourly shifts to be able to attend to emergencies which come quickly we need at least sixteen doctors there are at the Emergency Department and then amongst them they can roster the 8 hourly shift plus time off and annual leaves.\(^{84}\)

Similarly, in his evidence, Dr Carl Susuirara observed that:

> … emergency has 9 post, we need a minimum of 16 to cast the minimum to run a shift system there. To run a comfortable shift system down there, bearing in mind may be annual leave, sick leave, and may be two or three weeks study leave because we do not want our doctors to be isolated if there are conferences in Papua

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\(^{80}\) Ms Hellen Orihao, Evidence, 18 September 2009, p 34.  
\(^{81}\) Ms Hellen Orihao, Evidence, 18 September 2009, p 95.  
\(^{82}\) Dr Tenneth Dalipanda, Evidence, 8 September 2009, pp 84-85.  
\(^{83}\) Dr Auto, Evidence, 27 October 2009, p 158.  
\(^{84}\) Dr Auto, Evidence, 27 October 2009, p 158.
New Guinea, Vanuatu wherever for emergencies type medicine we would want them to attend. So for a comfortable roster which covers 24 hours we are looking more like 20 for emergency. And therefore we are well below half and the doctors we want in the emergency.85

In relation to nursing staff in the Accident and Emergency Department, Dr Sade stated in evidence that on paper there are 34 nursing positions in the Department. However, only 28 of those positions are filled. At the time of his evidence, of the 28 nurses, two were on study leave and four were on annual leave, leaving the department with 22 nurses. However, with three nurses undertaking administrative roles (one nurse manager and two clinical nurse consultants) only 19 nurses were available to do the three 8-hour shifts.86

Dr Sade also indicated that the Department has no qualified acute care nurse. Attempts have been made to send nurses for training but limited scholarship opportunities have prevented this:

We have tried since 2006 to at least get one nurse every two years to train as an acute care nurse; this is a qualified skilled training. However, we have not been able to get even one nurse since then up until now they made a short list at one point in time but they get knocked out when there’s only about very limited number of scholarships offered for in-service Public Servants.87

**The Histology and Cytology Laboratory**

During the inquiry, the Committee took evidence from Mr Alfred Dofai, Chief Medical Technologist, and Ms Anna Mose Se Manuapangae, Principal Technologist, in relation to the issues encountered by the Histology and Cytology Laboratory at the NRH. Many issues in relation to medical equipment at the laboratory are discussed in the following chapter, however, the Committee also took evidence in relation to the staffing constraints experienced by the laboratory:

- The unit lacks human resources. On her own, Ms Mose Se and one other staff member can only process a certain number of tests each week. In addition, the laboratory’s pathologist, Dr Maraka does not have any support; there is no other pathologist to offer a second opinion.88

- There are limited opportunities for staff training. While Ms Mose Se and the other staff members have undertaken training in the past, other opportunities for training and updating of skills are not funded. The training budget for the unit is only SBD$16,000, which prevents staff attending training offered overseas. In the past, Mr Dofai has sought and received funding support for training from international donors such as the World Health Organisation and New Zealand Red Cross.89

**The Obstetrics and Gynaecology Department**

85 Dr Carl Susuirara, Evidence, 27 October, 2009, pp 163-164.
86 Dr Kenton Sade, Evidence, 14 September 2009, p 9.
87 Dr Kenton Sade, Evidence, 14 September 2009, p 9.
In his evidence, Dr Levi Hou, Head of Obstetrics and Gynaecology Department, indicated that his Department also suffers from a significant nurse shortage. The current number of nursing staff in the Labor Ward, when distributed and assigned on night shifts rosters, is such that the Department can only afford to allocate one registered nurse and one nurse aid on any given night shift. Dr Hou submitted that this is not an ideal situation for delivering mothers with complications.\(^90\)

### 5.5 Staff attitudes towards work

During the inquiry, questions were raised concerning the attitude of some staff towards their work. It was variously suggested that some staff do not care about, or are lazy in, their approach to work.

For example, in its written submission, the Retired Nurses Association submitted that all medical workers must show professionalism, must dress appropriately, and must make every effort to arrive on time to their respective duty stations. It was submitted that:

- Doctors and Nurses must properly dress as professionals, Doctors and Nurses must be recognized by the standard of uniforms they wear.

- Doctors /Registered Nurses/Nurse Aids and Domestic cleaners must try to improve their arrival time to duty. Timing is very important where sick peoples’ lives are at stake.\(^91\)

Similarly, in her written submission, Ms Jocelyn Lai cited to the Committee a ‘no-care attitude’ and ‘laziness’ amongst staff. She submitted that dress codes must be applied to ensure respect for the medical officers.\(^92\)

Likewise, in his evidence, Dr George Manimu, a private medical practitioner, submitted that young doctors always lack proper discipline. He emphasised that young doctors’ attitudes toward work and even how they behave outside of work sometimes do not meet what the medical profession as well as the public expect of them. As such, young doctors as well as nurses need discipline to ensure that they attend to work, especially to sick patients, on time and provide proper care that patients need.\(^93\)

Timeliness for arrival at work was also raised during the Committee’s public hearings. In evidence, Mr Alfred Dofai, NRH Chief Medical Technologist, pointed out that one of the most important components of a quality health service is timeliness. Mr Dofai submitted that it is important that staff commence work on time.\(^94\)

Another aspect of this issue is the service provided at the hospital on weekends. In evidence, Dr Ronald Ziru, a retired dentist and former President of the Solomon Islands Medical Association, indicated that many NRH services are only available on Monday to Friday because many staff are not available during the weekends:

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\(^90\) Dr Levi Hou, Evidence, 10 September 2009, p28  
\(^91\) Submission 13, Retired Nurses Association, p 1.  
\(^92\) Submission 1, Ms Jocelyn Lai, pp 1-2.  
\(^93\) Dr George Manimu, Evidence, 16 September, p 23-24.  
\(^94\) Mr Alfred Dofai, Evidence, 10 September 2009, pp 30-31.
... there is obviously a reduced participation by most of the doctors over the weekends and this I think is also one aspect that needs to be looked into.\(^\text{95}\)

### 5.6 Remuneration of staff

In its written submission, the NRH noted that the hospital’s lowest paid workers play an important role to the institution. These workers ensure that the hospital is clean, that the food prepared and that linen is laundered. However, the submission noted that these workers earn only enough to buy a sack of rice a fortnight. The NRH argued that all line positions at the hospital should be at level 3/4 and above on the Public Service salary scale.\(^\text{96}\)

Similarly, in his evidence to the Committee, Dr Lester Ross, Permanent Secretary, MHMS, noted that one of the reasons why doctors were not satisfied with their conditions of service was that the NRH had for some time quite a lot of expatriate doctors and their salaries were significantly higher than those of local doctors. This resulted in a review of the scheme of service for doctors. However, Dr Ross indicated that many of the recommendations of the review have yet to be fully implemented. Dr Ross suggested that if they were, it would help to bring a lot of doctors back to the NRH.\(^\text{97}\)

### 5.7 Staff appraisal and reporting

In its written submission, the NRH indicated that annual staff appraisal systems have not been implemented for many years. This has resulted in some officers being unfairly overlooked for promotions or confirmation. Conversely, those who should have been disciplined or guided were not identified, or there cases ignored.

The NRH noted that in 2008 and 2009, management issued circulars informing heads of departments, supervisors and nurse managers that they needed to conduct proper staff appraisal and reporting, for promotion and confirmation purposes. However, this did not occur.\(^\text{98}\)

### 5.8 Disciplinary procedures

In its written submission, the NRH indicated that since the Auditor General’s Report into the NRH of June 2006, the NRH management has tightened its disciplinary procedures. The NRH noted that following the recruitment of a Technical Assistant in early 2009, a proper procedure has now been instituted that provides a fair opportunity to those accused of misdemeanour, misconduct and gross misconduct.\(^\text{99}\)

As a result of the 2006 Auditor General’s report, two officers were terminated for gross misconduct. More recently, in April 2009, a driver and senior cook were terminated; the cook for stealing food from the kitchen.\(^\text{100}\)

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\(^{95}\) Dr Ronald Ziru, Evidence, 24 September 2009, p 18.

\(^{96}\) Submission 11, NRH, p 28.

\(^{97}\) Dr Lester Ross, Evidence, 8 September 2009, p 44.

\(^{98}\) Submission 11, NRH, p 26.


\(^{100}\) Submission 11, NRH, p 26.
Despite these recent measures, however, in evidence, Dr Kaeni Agiomea, Head of the Anaesthetic Department, raised concerns that there is still a lack of enforced discipline at the hospital, with the result that certain doctors, nurses and paramedics have a tendency to skip work. However, Dr Agiomea argued that they are never disciplined. Dr Agiomea continued:

Now this failure of discipline is a self defeating and very destructive. Practicing it destroys potentially good people too and ruins the organization because when we fail to discipline somebody two things happen, one the person who is not disciplined gets worse and some good people they follow suit, because they are frustrated, why is that person not being disciplined and I am bearing all the work here. And then, once everybody starts behaving that way it’s difficult to discipline the whole lot of them because then we lose the manpower and the place becomes a mess.\(^{101}\)

### 5.9 Patient complaints

The Committee understands that there is currently no formal procedures for dealing with patient complaints at the hospital. Complaints are dealt with internally by each department on a case by case basis. As stated in evidence by Dr Tenneth Dalipanda, Medical Superintendent of the NRH:

There is no written policy for us to follow, where the complaint went to, but there are many types of complaints that come. If it deals with clinical day to day management of a particular case, a clinical head of that department is the right person to approach. And usually patients raise their issue to whoever doctors or nurses who are there at that point in time. And they usually bring it to the attention of the head of the department, which is if it’s a medical case it comes to me, if it’s a surgical goes to the head of surgery.\(^{102}\)

#### A Patient Complaint Tribunal?

In its written submission, the NRH raised the possibility of the establishment of a patients complaints tribunal or a health quality and complaints commission so that patients and their relatives have an opportunity to seek independent assessment of a complaint or issue. To achieve this, the Hospital suggested that the laws relating to the hospital might need amendment.\(^{103}\)

#### Legal recourse through the Public Solicitor

In his written submission, the Public Solicitor indicated that from time to time, the Public Solicitor’s Office has received requests for legal assistance from former patients of the NRH seeking damages or compensation from the SIG for alleged negligence in treatment at the NRH. Most of these requests have been in relation to the area of surgery.\(^{104}\)

However, the public solicitor indicated that he has not taken any such cases to the courts. The reason for this is that any such claims for negligence are generally untenable or unlikely to succeed under the so called Bolam test, as developed in Bolam v Friern Hospital Management

\(^{101}\) Dr Kaeni Agiomea, Evidence, 14 September 2009, p 23.

\(^{102}\) Dr Tenneth Dalipanda, Evidence, 8 September 2009, p 26.

\(^{103}\) Submission 11, NRH, p 20.

\(^{104}\) Submission 5, Public Solicitor, p 1.
The Bolam test essentially means that as long as a group of medical opinion is in favour of a medical practice adopted by the defendant doctor, no negligence can be attributed to the doctor’s conduct.\textsuperscript{106}

The Bolam test has since been somewhat modified. In \textit{Bolitho v City & Hackney Health Authority}\textsuperscript{107}, the UK House of Lords held that where a body of opinion relied upon by the defendant was not shown to be capable of withstanding logical analysis, a judge is entitled to hold that the body of opinion is not reasonable or responsible.\textsuperscript{108}

Nevertheless, in the Solomon Islands, the application of the Bolam test, despite any subsequent qualifications, means that cases claiming negligence against clinicians would not be likely to be successful. In addition, the medical community being so small in Solomon Islands, it would be unlikely that a doctor would be willing to be a witness against another colleague doctor.\textsuperscript{109}

In evidence, Mr Douglas Hou, Public Solicitor, reiterated these observations, citing specifically the difficulty of a doctor giving evidence against a colleague doctor, and the common law Bolam test. Commenting on the Bolam test, Mr Hou observed:

\begin{quote}
\ldots the test I have discussed is that the courts are denied the role to critically assess and evaluate the reasonableness of an alleged negligence by a doctor by taking into account all the relevant circumstances.\textsuperscript{110}
\end{quote}

In his written submission, the Public Solicitor also made reference to the statutory no-fault medical insurance system in New Zealand, where patients who suffer injury as a result of medical procedures receive compensation and assistance under a statutory system.\textsuperscript{111} Commenting on this arrangement in evidence, Mr Hou observed:

\begin{quote}
It is something that this nation and policy makers will have to consider whether or not we should look to New Zealand and see whether we can adopt their practice here. I think it’s good because the doctors know themselves and sometimes they will be reluctant to testify against another colleague doctor. Maybe that's something open that can be visited if there is a need.\textsuperscript{112}
\end{quote}

\section*{Investigations by the Ombudsman}

The Office of the Ombudsman is responsible for investigating complaints by the public against the Government in any field of public administration, including in relation to the operation of the health system and specifically the NRH.

In his evidence, Mr Joe Porowai, Ombudsman for Solomon Islands, indicated that only approximately five per cent of complaints received by his Office relate to the hospital system and the NRH. This is relatively low in comparison to other authorities and government

\begin{flushright}
105 [1957] 2 All ER 118.
106 Submission 5, Public Solicitor, p 2.
108 Submission 5, Public Solicitor, p 3.
109 Submission 5, Public Solicitor, p 4.
111 Submission 5, Public Solicitor, p 4.
112 Mr Hou, Evidence, 25 September 2009, p 5.
\end{flushright}
institutions. And of that five percent, a large proportion are from nurses themselves concerning work-related complaints such as salaries, allowances and other conditions or service. Such complaints are investigated by the Ombudsman and where appropriate a recommendation made to the relevant authority, such as the Ministry of Health or the Public Service Office, to address the complaint.113

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Chapter 6: Infrastructure and equipment

This chapter examines infrastructure and medical equipment needs of the NRH including maintenance, repairs, expansion plans and technical support for specialised tools.

6.1 Hospital buildings

In its written submission, the NRH indicated that the relatively new part of the hospital is now 15 years old, while other parts of the hospital are well over 40 years old. As a result, the hospital buildings are in many cases in poor repair or are too small.\(^{114}\)

Operating theatres

The NRH indicated in its submission that it has three major operating theatres and one small operating theatre. These theatres are used by all the clinical departments including Accident and Emergency, Obstetrics and Gynaecology, Paediatrics and Dental. The utilisation rate is at around 85 per cent capacity.

Accordingly, the NRH submitted that an additional operating theatre would significantly reduce waiting times and booking backlogs.\(^{115}\)

The Labor ward

In its written submission, the NRH indicated that in August 2009, the Gaby wing of the Labor Ward was shut down, with the loss of 12 beds, following concerns that the building may collapse.

NRH management have requested that architects design a new building. A tender process for the new building will be called.\(^{116}\)

In her written submission, Ms Ella Kauhue argued that the Labor Ward is often overcrowded and the temperatures can sometimes rise to very high levels.\(^{117}\)

The Special Care Nursery Ward

The NRH raised particular concerns in its submission in relation to the operation of the Special Care Nursery Ward for newborn babies. In 2008, 25 per cent of all mortalities at the NRH (that is, 64 of 257) occurred in the Special Care Nursery Ward.

The NRH submitted that the current ward is significantly overcrowded, resulting in secondary infections after birth, poor nursing care and incubator failures. Management has recommended that funding be set aside for the extension of the ward, and designs have been developed. However, no further progress has been made.\(^{118}\)

\(^{114}\) Submission 11, NRH, p 27.
\(^{115}\) Submission 11, NRH, p 22.
\(^{116}\) Submission 11, NRH, p 22.
\(^{117}\) Submission 4, Ms Ella Kauhue, p 2.
\(^{118}\) Submission 11, NRH, p 21.
The Psychiatric Ward

In its written submission, the NRH argued that there is an increasing need for a secure Psychiatric Ward at the hospital. An increasing rate of people are presenting to the hospital with psychiatric illness caused by abuse of narcotic substances, requiring secure facilities to accommodate them and ensure their safety and security, as well as that of staff of the ward.

Currently, the NRH indicated that aggressive patients are sometimes locked-up in police custody, which is clearly not the care and treatment that mentally ill patients need.\textsuperscript{119}

The Internal Medicine Department

In evidence, Dr Tenneth Dalipanda, Medical Superintendent of the NRH, indicated that the Internal Medicine Department has a general 32-bed ward, a separate diabetic clinic, and a separate 32-bed tuberculosis ward. He indicated that the Internal Medicine Department is always running at 85 per cent capacity.

Dr Dalipanda raised particular concerns that on some occasions, there has been an overflow from the general 32-bed ward into the tuberculosis ward, which is clearly not ideal for patients moved into the tuberculosis ward.\textsuperscript{120}

In its written submission, the NRH also noted that the diabetic clinic is coming under increasing pressure due to the rapid increase of diabetes in the community.\textsuperscript{121}

The X-ray Department

In his evidence, the head of the X-ray Department, Dr Aron Oritamae, argued that the current accommodation for medical imaging and radio graphic equipments is not suitable. Dr Oritamae raised concern that staff and the general public may be exposed to high doses of radiation coming through the doors and glass of the windows of the X-ray room.\textsuperscript{122}

The Dental Department

In its written submission, the NRH indicated that the present Dental Department building was donated by the British Government 20 years ago. The building was originally a residential premise but subsequently refurbished and made suitable as a dental clinic.

Since then, however, the building has deteriorated significantly. In 2008, it was deemed unfit for human habitation in a report of the Ministry of Health.\textsuperscript{123}

In evidence Dr Ellison Vane, Director of Dental Services, indicated that the Dental Department is constrained by a lack of equipment, including only three dental chairs, some of which do not work properly. The building is also very cramped with no room to expand services and no room for storage.\textsuperscript{124}

\textsuperscript{119} Submission 11, NRH, p 22.
\textsuperscript{120} Dr Tenneth Dalipanda, Evidence, 10 September 2009, p 19.
\textsuperscript{121} Submission 11, NRH, p 22.
\textsuperscript{122} Dr Aron Oritamae, Evidence, 10 September 2009, p 43.
\textsuperscript{123} Submission 11, NRH, p 21.
\textsuperscript{124} Dr Ellison Vane, Evidence, 10 September 2009, pp 48-52.
A new Accident and Emergency Department

In its written submission, the NRH indicated that a contract has been signed by the Permanent Secretary of MHMS for the construction of a new Accident and Emergency Department at the NRH. Construction commenced on 21 September 2009, and is expected to cost more than SBD$1.5 million.\textsuperscript{125}

It is anticipated that the new Accident and Emergency Department will provide a better treatment environment for patients, an improved working environment for staff and a more controlled and functional waiting and triage area.\textsuperscript{126}

Planning for a new hospital

The NRH indicated in its submission that the NRH Executive has started planning for the ultimate rebuilding and replacement of the current hospital on another site. The NRH submitted that:

- The current buildings are run down and in a state of disrepair due to chronic under funding over the years;
- The accommodation for patients is crowded and not conducive to good infection control.

The NRH further submitted that planning for the new hospital needs to commence now as the new hospital will take more than five years to plan and build.\textsuperscript{127}

The NRH also argued that another site would be more appropriate for a new hospital since the current site by the sea is exposed to natural disasters such as tsunamis. It is imperative that the only national hospital with capacity to cater for such a disaster as a tsunami is not vulnerable to that very disaster.\textsuperscript{128}

6.2 Water, sanitation and toilet facilities

In its written submission, the NRH indicated that there are major problems with the supply of clean water to all sites of the hospital. The NRH advocated that there should be one sink at least in every four-bed ward. This would significantly aid in the control of infections. However, currently, there is only one or two sinks for every 35 to 40 beds per ward.\textsuperscript{129}

To address this issue, in July 2009, the hospital commenced work on a project to install a large rainwater tank (60,000 litres), with the objective of supplying the whole NRH site with fresh water when town supply fails, as it frequently does when there is a prolonged power outage.

\begin{itemize}
  \item \textsuperscript{125} Submission 11, NRH, p 13.
  \item \textsuperscript{126} Submission 11, NRH, p 13.
  \item \textsuperscript{127} Submission 11, NRH, p 21.
  \item \textsuperscript{128} Submission 11, NRH, p 23.
  \item \textsuperscript{129} Submission 11, NRH, p 23.
\end{itemize}
The NRH also submitted that patient comfort and infection control is also affected by a lack of hot water. Currently most buildings have a solar hot water system but few, if any, are working.\textsuperscript{130}

Another hygiene issue is the sewerage system at the NRH. In its written submission, the NRH indicated that the sewerage system is routed to a central rotational biological system for treatment. However the system has not operated for more than 20 years, during which time waste has been, and continues to be, pumped directly into the sea. As stated by the NRH, ‘this is an environment and public health catastrophe’.\textsuperscript{131}

Cleaning services at the hospital are discussed in more detail in the next chapter, but an issue of particular concern that was raised during the inquiry was the cleanliness of the toilets at the hospital. In her written submission, Ms Ella Kauhue stated that:

\begin{quote}
One of the facilities of the Central Hospital I will pay more attention to is the toilet facilities. I would say that toilet facilities are often in an appalling condition.\textsuperscript{132}
\end{quote}

Similarly, in his submission, Mr Rex Foukona observed that showers and toilets are without doors, and that on passing through some corridors there is a distinct odour of septic tanks. Mr Foukona submitted that the drains need to be cleaned.\textsuperscript{133}

In his evidence, Dr Trevor Garland, Honorary Consul of Solomon Islands in Sydney and Coordinator of the Ten Bed Arrangement with St Vincent’s Hospital, described the hospital as lacking the most basic of provision for patients. Generally, the NRH is poorly lit, equipment is either run down or unavailable, and general maintenance of plumbing and sewage are, at best, poor and, at worst, disgraceful. Dr Garland observed that patients transferred to St Vincent’s Hospital from the NRH after an extended period of time of hospitalisation at the NRH generally arrived in a much compromised state, which is evidence of the lack of facilities available at the NRH.\textsuperscript{134}

### 6.3 Hospital equipment

An important aspect of quality health care is the access to and availability of proper medical equipment and machinery. As pointed out by Dr Kaeni Agiomea, Director of the Anaesthetic Department, even with the best qualified doctors in the world, where basic clinical diagnostic and monitoring equipment is not available, they will not perform to their full potential.\textsuperscript{135}

During the Site Visit, the Committee observed and noted the appalling conditions of the sterilising machines in the Central Sterilising Services Department (CSSD). The CSSD is responsible for decontamination and sterilisation of procedure instruments used by the NRH as well as the entire country. It was brought to the attention of the Committee that of the 4 sterilising machines installed in the department; only 2 are currently functional by means of the effort of the biomedical technicians. This has reduced the output by 50% but has doubled the usage and reliance on the 2 machines in use.

\begin{flushright}
\textsuperscript{130} Submission 11, NRH, p 23.
\textsuperscript{131} Submission 11, NRH, p 23.
\textsuperscript{132} Submission 4, Ms Ella Kauhue, p 2.
\textsuperscript{133} Submission 10, Mr Foukona Rex, p 7.
\textsuperscript{134} Dr Trevor Garland, Evidence, 10 September 2009, pp 4, 5.
\textsuperscript{135} Dr Kaeni Agiomea, Evidence, 14 September 2009, p 24.
\end{flushright}
Current clinical and diagnostic equipment

In its written submission, the NRH indicated that the specialist medical equipment within the hospital is of varying age and functionality.136

This was reiterated in evidence, when a number of senior clinicians at the NRH highlighted to the Committee the lack of basic clinical and diagnostic equipment at the hospital.

For example, in his evidence, Dr Tenneth Dalipanda, Medical Superintendent at the NRH, indicated that most of the diagnostic equipment at the hospital are either not functioning or obsolete.137 Similarly, basic tools such as monitoring equipment for patients with heart attacks, blood pressure machines, oxygen and infusion pumps are not available.138

In his evidence, Dr Kention Sade, Director of the Accident and Emergency Department, observed that basic clinical equipment such as blood pressure machines, periscopes (to check children’s ears) and glucometers (to check blood glucose level) are either shared between departments, malfunctioning or simply not available. As a result, it is often the case that patients have to wait to be attended to until a required instrument becomes available for use from another department, even if a doctor is available.

Dr Sade continued that other equipment, such as switcher trays, nebulizer machines, pelvic examination trays, cardiac monitors, pulse oxi-meters, electrocardiogram machines (for cardiac tests) are often available only in very limited numbers. However, in some instances, the scarcity of such equipment can be life threatening. Lives can be lost while waiting for sterilisation of instruments such as switcher trays.139

In turn, Dr Patrick Houasia, Director of the Orthopaedic Department, stated in evidence that wires, screws and plates needed for bone implants has never been purchased, even though orders are placed every year. The availability of a portable x-ray machine would also reduce infection rates.140

Dr Nasi, from the Paediatrics Department, cited to the Committee the lack of basic necessary items such as resuscitation trolleys, oxygen concentrators with pulse oxi-meters to indicate the oxygen concentration. Proper incubating tubes, phototherapy sets, apnoea monitors and other basic items are either unavailable or irreparable.141

The Director of the Anaesthetic Department, Dr Kaini Agiomea, observed in his evidence that his department lacks specialist equipment to monitor patients who have been anaesthetised; for example to detect a heart attack.142

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136 Submission 11, NRH, p 27.
137 Dr Tenneth Dalipanda, Evidence, 8 September 2009, p 16.
139 Dr Kenton Sade, Evidence, 14 September 2009, pp 10-11.
140 Dr Patrick Houasia, Evidence, 14 September 2009, p 14.
141 Dr Titus Nasi, Evidence, 14 September 2009, pp 34-35.
142 Dr Kaeni Agiomea, Evidence, 14 September 2009, p18.
In evidence, Mr Selwyn Hou, Director of Nursing at NRH, indicated that the hospital lacks sufficient basic equipment such as bed pan, urinals, bath basins, linen; not sufficient to cater for the number of patients admitted at the hospital.¹⁴³

The histokinette processor

During the Committee’s hearing on 23 October 2009, the Committee took evidence from Mr Alfred Dofai, Chief Medical Technologist, and Ms Anna Mosese Manuapangae, Principal Technologist, in relation to the Histology and Cytology Laboratory at the NRH.

The Committee understands that traditionally the NRH has not had the facilities to perform histology, cytology and pathology tests, both for patients at the hospital and on samples sent in from the provinces. Instead, since as early as the 1950s, samples were routinely sent to the Royal Brisbane Women’s Hospital pathology laboratory. Sometimes the delays were so long, anything from three weeks to six months, that by the time the results were returned to the clinicians, treatment was longer possible. Moreover, the cost of sending samples to the Royal Brisbane Women’s Hospital pathology laboratory was prohibitive.¹⁴⁴

In 2006, the NRH secured the services of Dr Rodger Maraka, a trained pathologist, who has been able to issue pathology test results within 24 hours, and histology test results within a week.¹⁴⁵

The Committee notes, however, that the Histology and Cytology Laboratory at the NRH still faces significant challenges:

- The laboratory has an antiquated histokinette processor,¹⁴⁶ donated from Australia. The machine is far slower than modern machines. A new machine would be far more efficient and reduce room for mistakes. However purchase of a new machine would cost about AUD$100,000.¹⁴⁷

- The Histology and Cytology Laboratory is poorly equipped, and does not meet safety standards. The use of the histokinette generates hazardous chemicals such as formalin, zylyn and absolute alcohol to which the staff are exposed. While attempts have been made to install exhaust fans and to move the histokinette to a smaller room, funding for the electricians and carpenters for the required work is still not forthcoming.¹⁴⁸

Thus, the Committee understands that while there have been significant advantages from the recruitment of Dr Rodger Maraka, the NRH still faces significant costs ranging from SBD$800,000 to SBD$1M each year associated with sending specimens overseas for testing. For example, all pap smears are still sent to Australia for testing.¹⁴⁹ The budget for these services is

¹⁴³ Mr Selwyn Hou, Evidence, 10 September 2009, pp 22-23.
¹⁴⁶ The Committee understands that a histokinette is an automatic, computer regulated device for dehydration of human, animal and plant tissues.
¹⁴⁹ Ms Anna Mosese Manuapangae, Evidence, 23 September 2009, p 16.
around SBD$700,000. In addition, for those patients whose tests still need to be conducted overseas, the waiting times can still be considerable.\textsuperscript{150}

Like other departments at the NRH, the Histology and Cytology Laboratory needs specialized training, equipment and improved facilities to provide high quality pathology laboratory services for the health system in the Solomon Islands.\textsuperscript{151}

As a solution to some of these problems, particularly the problems generated by the antiquated histokinette, Mr Dofai advocated setting aside dedicated funds for equipment replacement, and the purchase of new equipment as necessary, especially a new efficient histokinette. Mr Dofai indicated that access to a new histokinette would significantly reduce the need for samples to be sent to Australia for testing. While some samples would still need to be sent to Australia, for example complicated matters needing a second opinion, savings in the order of approximately SBD$600,000 to $700,000 on the laboratory services from overseas could be made through the purchase of a new histokinette.\textsuperscript{152}

\textbf{X-ray equipment}

In his evidence to the Committee, Dr Oritaimae, Director of the Radiology Department, emphasised the cost of some x-ray equipment. For example, an x-ray machine for mammography to screen for breast cancer costs AUD$120,000, excluding shipment and installation cost. Even spare parts are very expensive.

Even if the NRH has the capital to buy such expensive equipment, Dr Oritaimae was of the view that his department lacks appropriately trained personnel to undertake maintenance of the x-ray machines. The machines are very delicate and calibrated to a high degree of accuracy, and therefore require highly qualified specialists to maintain and repair them. Damaged and un-serviced x-ray equipment poses a hazardous radiation risk to people in the lab, including patients.\textsuperscript{153}

\textbf{Acquisition of new clinical and diagnostic equipment}

In its written submission, the NRH indicated that SBD$8.5 million was set aside in 2008 for acquisition of new clinical and diagnostic equipment for the hospital. However in 2009, as indicated previously in Chapter 3, this maintenance budget was abolished in the SIG budget, leaving no funds for procurement of such equipment.

As such, the only available funds for acquisition of new clinical and diagnostic equipment in 2009 were SBD$2 million made available by AusAID.\textsuperscript{154}

As previously indicated in Chapter 3, in 2010, the SIG made a one-off allocation of SBD$9 million in funding for medical equipment at the NRH.

\textbf{Maintenance of diagnostic equipment}

\textsuperscript{150} Mr Alfred Dofai, Evidence, 23 September 2009, p 5.

\textsuperscript{151} Ms Anna Mosee Manuapangae, Evidence, 23 September 2009, p 4.

\textsuperscript{152} Mr Alfred Dofai, Evidence, 23 September 2009, p 9.

\textsuperscript{153} Dr Aaron Oritamae, Evidence, 10 September 2009, p 45.

\textsuperscript{154} Submission 11, NRH, pp 12-13.
In its written submission, the NRH acknowledged that maintenance of diagnostic medical equipment at the hospital has in the past tended to be quite ad hoc.  

Separately, the NRH also noted that maintenance costs are quite high. For example, a recent haematology analyser that went out of operation cost over AUD$10,000 to repair. The repairs will be funded by AusAID.

Another strategy being pursued to ensure adequate maintenance of equipment is the employment of a specialist biomedical engineer from overseas to assist in strengthening the local engineering group. The Committee understands that the NRH is participating in a sharing arrangement involving an Australian Volunteer International with Vanuatu over a two year period. Starting in 2010, this engineer will spend five months in Honiara at a time, working alongside current staff to improve services.

In addition, Japanese Overseas Cooperation Volunteers have agreed to the secondment of a volunteer biomedical engineer for two years to start in July 2010 to assist with maintenance and training.

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155 Submission 11, NRH, p 27.
156 Submission 11, NRH, pp 17-18.
157 Submission 11, NRH, p 18.
Chapter 7: NRH corporate and support services

This chapter initially examines support services provided by the Corporate Services Division at the NRH. As shown in the NRH organisational chart in Figure 2.1, within the Corporate Services Division, there are a number of support services, including: the central stores department; the laundry department; transport services; housekeeping services; the catering service; the maintenance and repair service; and the security service.

The chapter subsequently looks at three departments that fall under the Clinical Services Division: the pharmacy, the medical records unit and the morgue (which operates within the Histology and Cytology Laboratory).

Finally, the chapter also examines whether the NRH should have a chapel and housing facilities for staff.

7.1 The Corporate Services Division

As indicated previously in Chapter 2 (Background), the Corporate Services Division is headed by the Hospital Secretary, Mr Cavanaugh Tanabose. Mr Tanabose appeared before and gave evidence to the Committee on 23 September 2009.

In his evidence to the Committee, Mr Tanabose indicated that the NRH Corporate Services Division has approximately 145 staff working in finance, administration, engineering, electrical engineering, plumbing, catering, housekeeping, laundry, transport and storage roles. All these officers support the clinical services provided at the NRH. The Committee understands that 8 of the 145 positions are currently not filled, and cannot be filled under the recruitment freeze currently in force across the Public Service.158

The Committee examines each of the support services below.

The central stores department

The central stores department at NRH is managed by the Central Stores Manager, Mr Brook Walalau.

In his evidence to the Committee, Mr Walalau indicated that the central stores department is responsible for managing items such as furniture, utensils, medical forms, stationary, cleaning equipment, bed sheets, calico and so on. In total, there are 506 items of equipment managed by the department.159

However, Mr Walalau raised concerns that there is no specific budget for procurement at the NRH. While there is a line item in the annual budget allocating procurement funding to the NRH, for reasons that were not clear to the Committee, the funding is insufficient to support the purchase of general stores such as photocopying paper.160

Symptomatic of this procurement difficulty, Mr Walalau raised particular concerns about the procurement of new mattresses at the NRH. Mr Walalau indicated that the quality of mattresses

159 Mr Brook Walalau, Evidence, 23 September 2009, p 21.
at NRH is currently very poor, with an urgent need for additional specialised hospital mattresses to be purchased from overseas. However, there is no funding available to do so. New mattresses have not been purchased for over four years.\footnote{Mr Brook Walalau, Evidence, 23 September 2009, pp 22-23.}

The Committee understands that prior to 2006, the practice was for 50 hospital mattresses to be replaced each year, with appropriate systems in place for their purchase and disposal. However, due to funding restrictions, this practice was discontinued in 2006.\footnote{Mr Brook Walalau, Evidence, 23 September 2009, p 60.}

On a related issue, Mr Walalau also argued that the hospital has insufficient bed sheets, although an order has now been placed for an additional 1,500 sheets.\footnote{Mr Brook Walalau, Evidence, 23 September 2009, p 25.} The Committee understands that there is only one day’s supply of linen available. The plan is to have at least three days’ supply of linen in reserve.\footnote{Submission 11, NRH, p 17.}

Mr Walalau also noted that staff have been trained in the use of MYOB for keeping track of stores, but are hampered by the availability of only three computers, bought 14, 11 and 7 years ago respectively. Inevitably they are very slow and need replacing.\footnote{Ms Margaret Wale, Evidence, 23 September 2009, p 27.}

**The laundry department**

The laundry department at NRH is managed by the Laundry Manager, Ms Margaret Wale. The laundry operation at the NRH is the largest in the country.

In her evidence to the Committee, Ms Wale indicated that the laundry department has 10 full time staff. The staff are organised into two teams: the first to collect dirty linen in the wards, take it to the laundry, wash it and then hang it on the line; the second to collect the clean linen, fold it and redistribute it to the wards. This routine is followed two or three times a day. The sheets in wards are changed four times a week. However, Ms Wale argued that an additional four or five staff members are needed to meet the workload, especially when staff are on leave.\footnote{Submission 11, NRH, p 17.}

The Committee understands that the laundry department has five industrial washing machines and three industrial dryers. The washing machines operate 8 hours a day, 7 days a week. However the NRH also stated that most of these machines are very old and therefore require frequent maintenance; and thus the hospital has plans that in the next five years the machines will be replaced.\footnote{Ms Margaret Wale, Evidence, 23 September 2009, pp 24-25.} The need for replacement of washing machines and dryers, together with linen trolleys, was reiterated by Ms Wale in evidence.\footnote{Submission 11, NRH, p 17.}

In her evidence, Ms Wale also raised with the Committee the lack of a suitable space in the laundry department away from the washing machines for staff of the laundry department to congregate, relax, eat their lunch and so forth.\footnote{Ms Margaret Wale, Evidence, 23 September 2009, p 27.}
Transport services

The transport services at NRH are managed by the Transport Manager, Mr Rolland Wale.

In his evidence, Mr Wale indicated that the transport section has only three vehicles: two land cruise rs and a bus. The vehicles are used in shifts – three shifts per day. They are also in constant use. For example, they are used early in the morning to pick up the cooks and cleaners; later to drop off the nightshift nurses; subsequently they are available for other departments to use (although one is garaged to reduce wear and tear); and in the evening they are used to pick up nurses for the nightshift.170

The lack of transport services at the hospital was also raised by Mr Walalau, the Central Stores Manager. Mr Walalau noted that the hospital does not have enough vehicles to provide transport for procurement services, and indicated that he is often hampered in obtaining stores for the hospital by the lack of available transport to and from the premises of suppliers.171

The Committee also understands that the NRH has only one ambulance, recently donated by the Government of New South Wales. Prior to that, the Hospital had a dilapidated ambulance that was purchased in 1999. The Committee also received evidence that there is no plan of maintenance for the donated ambulance.172

Housekeeping services

The head of the housekeeping service and infection control at the NRH is Mr Aloysius Mae. The Committee understands that the service has 45 staff, comprising 41 ward maids and four ground keepers.

In his evidence, Mr Mae highlighted to the Committee the volume of work required to be undertaken by the ward cleaners at the NRH. Inside the hospital there are 29 wards, 102 toilets and 73 bathrooms. Often these facilities are used not only by patients and staff, but by visitors. In many cases, members of the public tend to abuse their access to the facilities. As a result, the toilets are often unclean.

The issue of sanitation and cleanliness of toilet facilities was raised previously in Chapter 6 (Infrastructure and equipment).

The scale of the cleaning task at the NRH is on occasions further magnified by a lack of cleaning products. Mr Mae indicated that only between 2 and 4 litres of cleaning product are available for use in each ward each week. On some occasions, the cleaners have no option but to use water to clean when the supply of cleaning products runs out.173

Mr Mae also argued that his department needs more cleaners, especially to cover periods when many staff are on leave. He acknowledged that as things currently stand, cleanliness in the wards is not up to standard.174

170 Mr Rolland Wale, Evidence, 23 September 2009, p 41.
171 Mr Brook Walalau, Evidence, 23 September 2009, p 23.
172 Mr Rolland Wale, Evidence, 23 September 2009, pp 42, 74, 75-76.
173 Mr Aloysius Mae, Evidence, 23 September 2009, pp 63-64.
174 Mr Aloysius Mae, Evidence, 23 September 2009, p 49.
In relation to the work of the four ground keepers, Mr Mae indicated that their work involves not only general maintenance, but also disposal of infectious rubbish and food waste. They are hampered in that role, however, by the lack of transport.175

Mr Mae also expressed the concern that the general public visiting the hospital tend to litter the hospital grounds. On visiting the hospital, a visitor normally sees a lot of coconut shells and betel nut rubbish. Again, Mr Mae submitted that additional staff and equipment would be of assistance to keep the hospital grounds cleaner.176

In its written submission, the NRH argued that the hospital has enough cleaners to carry out cleaning duties and keep the hospital clean, but acknowledged ‘that there is some way to go to improve this service’.177

The catering service

The catering service at NRH is managed by the Kitchen Manager, Ms Salome Diatalau. The NRH provides three meals a day, seven days a week for NRH patients. The department has 16 staff: the kitchen manager, a dietician (Ms Sara Mua), a kitchen supply officer and the remainder cooks.178

In evidence, Ms Sara Mua representing the catering service suggested that the catering service at the NRH faces various challenges, notably inadequate equipment in the kitchen. The Committee understands that the kitchen has only one six-burner stove and one four-burner stove. In addition, there are always difficulties in catering for patients with special dietary needs.179

The NRH also faces difficulties with food supplies. In general, the Committee understands that the Hospital attempts to provide quality food and well balanced meals to the patients, however, when there are delays in payments or supplies, patients are required to eat tinned food.180 In his written submission, Mr Rex Foukona a one time patient of NRH, observed the general lack of vegetables and fruits in patient meals:

For three weeks I was admitted at the Hospital, only two meals (lunch on 7/9/09) - that patients were served with lunch and one slice pineapple. And on dinner on (8/9/09,) patients were served with two pieces of cucumber blocks plus dinner itself. Whilst we preach vegetables are healthy for human bodies that has not been the case at the NRH. Yet Solomon Islands has been blessed with varieties of vegetables such as water melons, banana, cucumber, pineapples etc etc. If money is our usual excuse then I suggest vegetables cost should be included in the budget for the Ministry of Health.181

Similar concerns were expressed by Ms Ella Kauhue in her submission:

175 Mr Aloysius Mae, Evidence, 23 September 2009, pp 46-49.
177 Submission 11, NRH, p 17.
178 Ms Sara Mua, Evidence, 23 September 2009, pp 42-43.
179 Ms Sara Mua, Evidence, 23 September 2009, pp 42-44.
180 Ms Sara Mua, Evidence, 23 September 2009, p 70.
181 Submission 10, Mr Rex Foukona, p 6.
So many times, I was present in the TB Ward, the food distributed to the patients (adults) was insufficient. The time I was there, very little vegetables with one piece of cassava or kumara was served for each adult patient. Two patients were saying to me that after they eat, they would go to the nearest canteen to buy something for them.\textsuperscript{182}

Separately, the Committee notes the evidence of the Hospital Secretary, Mr Cavanaugh Tanabose, that the budget for catering services was previously SBD$1.3 million, however with the 35 per cent budget reservation in 2009, this was reduced to SBD$900,000 from 1 July 2009.\textsuperscript{183}

The maintenance and repair service

The maintenance and repair service at NRH is managed by Mr Jim Ruben.

In his evidence to the Committee, Mr Ruben indicated that the department has 13 staff across four sections: the bio-medical section, the electrical section, the carpentry section and the plumbing section. The role of the department is to fix faults with medical equipment, as well as more general maintenance of the lighting and air conditioning systems, the drains and so on.\textsuperscript{184}

As with other witnesses to the inquiry, Mr Ruben suggested that his department needs more staff: at least two more bio-medical officers, two more electricians and an additional plumber. In addition, he argued that there is a the need for new accommodation facilities for his staff, noting that they are currently accommodated in the switchboard room, which is very small and crowded, and is also used for equipment storage.

Mr Ruben also suggested that the department would benefit significantly from access to a small utility vehicle, to enable staff to travel to hardware stores and purchase necessary equipment.\textsuperscript{185}

The security department

The security department at the NRH has 13 staff. Their role is to provide security for patients, doctors and nurses as well as protecting hospital property.

The grounds of the NRH are secured by an iron fence, with only one entry and one exit point to the hospital. However, during the inquiry, concerns were raised that despite the presence of security officers, there have been cases of drunken people accessing the NRH by climbing over the fence. As pointed out by Mr Rex Foukona:

\begin{quote}
I have observed during my three weeks in the hospital that the iron fence towards the main road in particular the metal bars are quite short. Often outsiders climbed up and jumped into and out of the hospital compound.
\end{quote}

The drainage system that leads out of the hospital compound, in particular at the back of Medical Ward, is a gap created that leads into the main drainage at the road side. This hollow has been allowing outsiders to creep in and out of the medical compound. On two occasions boys came in through the hollow with cans of beer, others came in to access ward showers, toilets and even spend night.

\begin{flushleft}
\textsuperscript{182} Submission 4, Ms Ella Kauhue, p 3.
\textsuperscript{183} Mr Cavanaugh Tanabose, Evidence, 23 September 2009, p 19.
\textsuperscript{184} Mr Jim Ruben, Evidence, 23 September 2009, pp 30-31.
\textsuperscript{185} Mr Jim Ruben, Evidence, 23 September 2009, p 31, 32.
\end{flushleft}
Others also penetrated security service by other means and stole mobiles, money and properties belong to the patients.  

In his evidence to the Committee, Mr Joe Porowai, Ombudsman for Solomon Islands, observed that the security service at the NRH is not very efficient. Thefts occur from time to time, and the security of doctors, nurses and patients is not what it should be. Accordingly, the Ombudsman advocated that either security guard at the hospital be trained properly, or that a private security firm be engaged to provide security services at the hospital.

### 7.2 The Clinical Services Division

As shown in the NRH organisational chart in Figure 2.1, within the Clinical Services Division there are various departments providing support services. These are examined below.

#### The pharmacy

The NRH pharmacy is the department responsible for the dissemination of drugs within the hospital.

During the inquiry, the Committee received anecdotal evidence that the pharmacy is often out of drugs, and is not operating efficiently. For example, Ms Ella Kauhue submitted that the pharmacy is often very crowded and that patients often have to wait for two to three hours to get their medication. On other occasions drugs are simply not available, and patients are provided with Panadol.

In its written submission, the NRH acknowledged that the supply of drugs at the hospital has caused difficulties in the past through problems with the annual drug tender process. As a result, the hospital pharmacy has in the past often faced situations of drug ‘stock outs’.

In response to these problems, however, the NRH indicated that the pharmacy has established and ‘essential items’ list of drugs with should never be allowed to run out. It also suggested that doctors and pharmacy staff are collaborating closely to address the issue. An imprest system – essentially a storage system which is pre-filled with an agreed selection and quantity of medicines – has been instituted.

In his evidence before the Committee, Mr Wale Tobata, Director of Pharmacy, observed that on some occasions in the past, pharmacy supplies had gone out of stock due to external and internal factors beyond the pharmacy’s control. For example, during the Western Province tsunami disaster, a substantial volume of medicine was mobilized to Western Province. As another example, Mr Tobata observed that the global financial crisis affected supplies when a shipment of supplies to Solomon Islands from Auckland was cancelled when the overseas supplier went into receivership while the shipment was en route to Honiara.

In turn, Mr Michael Nunan, NRH Chief Pharmacist, observed in evidence that since 2005 and the installation of a computerised inventory system which he called the “M” supply system,
drug supply at the hospital has improved considerably. He indicated that as of 2009, the pharmacy was averaging 636 scripts a day. At the same time, he indicated that waiting times are down to 30 minutes on average, which he rated as amongst the best in the world.\textsuperscript{191}

On a separate matter, the Committee also notes the evidence of Mr Joe Porowai, Ombudsman for Solomon Islands, that where private doctors prescribe drugs for private patients, often the NRH pharmacy will not accept the prescriptions, thereby inhibiting the operation of the private healthcare system, and again placing the burden on the public system.\textsuperscript{192} This concern was also raised by Dr Onity Sarue in his written submission:

The NRH pharmacy is meant to serve every patient (sick people in Solomon Islands). Sometimes in the past private doctor’s prescriptions were dispensed there without question. This has changed. This service is no longer available to patients who consult private doctors. I recommend that those who cannot afford their pharmacy medicines should be cared for by the hospital pharmacy. After all, private doctors are simply supplementing the government medical service to our people.\textsuperscript{193}

The medical records department

The medical records department at the NRH is managed by Mr Avon Tavalusu. The department has four officers in total. It is responsible for maintaining medical records and administration, including admissions, patient identification, retrieval of medical records, discharge procedures, maintenance of statistical records, and evaluation of medical services at the hospital.\textsuperscript{194}

In his evidence, Mr Tavalusu indicated that the medical records department faces a number of challenges. One is inadequate resources for coding patient diseases/ailments and reporting against them. As stated by Mr Tavalusu:

So now if you try to say what is our top 10 disease in the National Referral Hospital no one will know.\textsuperscript{195}

The Committee noted the ICD 10 initiative previously in Chapter 4 (NRH human resource management).

Another problem is that the computer system for managing admissions, discharges and transfers was developed as a stop-gap measure by Mr Tavalusu himself, after previous packages were not implemented or ceased to be supported by software companies. However, the makeshift system, which the Committee understands it essentially an excel spreadsheet, is only accessible from one computer terminal. It is also incapable of supporting the provision of health information and data. Repeatedly, new software systems have been proposed or implemented, but each time problems arose and the software was discarded. To address this issue, Mr Tavalusu advocated the adoption of a whole new software system for managing the

\begin{itemize}
  \item \textsuperscript{191} Mr Michael Nunan, Evidence, 10 September 2009, pp 56-57.
  \item \textsuperscript{192} Mr Joe Porowai, Evidence, 25 September 2009, pp 6-7.
  \item \textsuperscript{193} Submission 2, Dr Onity Sarue, p 4.
  \item \textsuperscript{194} Mr Anon Tavalusu, Evidence, 23 September 2009, p 34.
  \item \textsuperscript{195} Mr Anon Tavalusu, Evidence, 23 September 2009, p 35.
\end{itemize}
operation of the hospital based on an assessment of the specific requirements of the hospital, rather than trying to implement another system off the shelf.\footnote{196}{Mr Anon Tavalusu, Evidence, 23 September 2009, pp 36-37.}

A final problem raised by Mr Tavalusu in evidence is managing referrals from the provinces. While the department tries to emphasise that all patients who come in from the provinces should be admitted and should have a medical record created, sometimes those systems and processes are not followed.\footnote{197}{Mr Anon Tavalusu, Medical Records, Evidence, 23 September 2009, p 40.}

\section*{The morgue}

The Committee understands that the NRH morgue operates within the Histology and Cytology Laboratory directed by Dr Roger Maraka. The Chief Medical Technologist to the Histology and Cytology Laboratory is Mr Alfred Dofai.

During the Committee’s hearing on 23 October 2009, the Committee took evidence from Mr David Mealeua, the manager of the morgue at the NRH. He has worked in the morgue for 36 years. The Committee understands that Mr Mealeua previously retired twice, but each time has returned to work at the morgue. The Committee acknowledges this significant contribution to the NRH by Mr Mealeua.

In his evidence, Mr Mealeua indicated that he faces significant difficulties at the morgue: lack of proper equipment to do embalment, lack of staff (Mr Mealeua is the only staff member), and poor facilities. The facilities are small, lack ventilation, have only three coolers for corpses and have not been modified since 1974. There are no facilities for doctors to conduct post mortems.\footnote{198}{Mr David Mealeua, Evidence, 23 September 2009, p 29.}

The Committee notes, however, that in evidence, Mr Dofai, Chief Medical Technologist, indicated that plans have been submitted for a new morgue with a new histology and pathology laboratory attached.\footnote{199}{Submission 11, NRH, p 28.}

\section*{7.3 Housing}

In its written submission, the NRH raised concerns that the shortage of housing in Honiara affects the hospital’s workforce. All too often the staff finish work after an exhausting shift only to return to a house full of relatives, who, in some cases, need to be fed by the tired worker.\footnote{200}{Mr Harvest Meabule, Evidence, 18 September 2009, p 6.}

Similar concerns were raise in evidence. For example, Mr Harvest Meabule, Head of Nursing for Honiara City Council Clinic, stated in his evidence that many nurses at the hospital live far away from the hospital due to the difficulty of finding accommodation. This, however, means that they get home late after long shifts and face stresses at home.\footnote{201}{Submission 11, NRH, p 28.}

In his evidence, Dr Titus Nasi, a paediatrician at the NRH, pointed out that a number of clinicians are accommodated in motels where there is no privacy and no place for their children to play. He further stressed that housing rentals entitlements accorded to doctors are two to
three times less than the rental value of private properties that are available on the market for rent. He continued that this affects their performance:

Doctors or nurses who do not have a home or are not happy at home they do not come to work, they do not do the work you want. They do not perform to what you expect.\textsuperscript{202}

7.4 A Hospital chapel?

During the Committee’s hearing on 2 October 2009, the Committee took evidence from Father Malakai, a priest of the Anglican Church of Melanesia. Father Malakai has been the Hospital Chaplain for the past 10 years.

In his evidence, Father Malakai argued that the NRH needs a full-time chaplain, to provide spiritual healing to the sick, and at the same time a dedicated chapel or other space for pastoral and spiritual counselling as well as worship. Currently, pastors are obliged to place communion tables in halls and corridors in order to administer holy communion.\textsuperscript{203}

The Committee understands that under current arrangements, a pastor from the Church of Melanesia attends the hospital in the afternoons on Mondays to Thursdays, with devotions at 7.00 pm in the evenings. In addition, a holy communion is held on Wednesdays and Sundays.\textsuperscript{204}

\begin{flushleft}
\textsuperscript{202} Dr Titus Nasi, Evidence, 14 September 2009, p 40.
\textsuperscript{203} Father Malakai, Evidence, 2 October 2009, p 57.
\textsuperscript{204} Father Malakai, Evidence, 2 October 2009, p 59.
\end{flushleft}
Chapter 8: International aid assistance to the NRH

This chapter provides a brief discussion on international aid assistance to the NRH and to the health sector in Solomon Islands more generally.

8.1 AusAID

The Hon Dr Derek Sikua, Prime Minister of Solomon Islands, and the Hon Kevin Rudd, Prime Minister of Australia, signed the Solomon Islands-Australia Partnership for Development at the Special Pacific Islands Forum Leaders Meeting in Port Moresby on 27 January 2009. It established a shared vision for Solomon Islands and Australia to work together to meet common challenges and achieve improved development outcomes and sustainable improvements in the quality of life of all Solomon Islanders. Its duration is until 2013.

The Solomon Islands-Australia Partnership for Development sets out four initial priority outcomes:

- To improve service delivery by strengthening public health functions so they are responsive to community health needs and support primary and secondary care. The Partnership will also investigate options for provision of new Australian assistance to the education sector.

- To improve economic livelihoods by working to create long-term economic opportunities and livelihood security for Solomon Islanders, particularly those living in rural areas. The partnership will support more productive and sustainable utilisation of agricultural land, forests and marine resources, and the improved operation of markets.

- To improve economic infrastructure to facilitate market access and service delivery by increasing access to reliable transport, energy and telecommunication services.

- To address economic and fiscal challenges by increasing the effectiveness of public expenditure and assisting in the delivery of broad-based economic growth.

Under the first of these priority outcomes – improved service delivery including public health outcomes – Australia is funding four initiatives to assist Solomon Islands to work towards the Millennium Development Goals. Those four initiatives are:

- The Health Sector Support Program (HSSP) 2006-2010;
- The Pacific Malaria Initiative;
- HIV/AIDS prevention and education programs, and
- A water and sanitation program.\(^\text{205}\)

The largest of these four programs is the HSSP. It commenced in June 2008 and is delivered by AusAID. It is aimed at improving public health and moving towards the targets set in the

\(^{205}\) Submission 8, Australian High Commission, p 1.
In relation to the National Referral Hospital, the HSSP directly supports NRH in three key areas:

1. Provision of medical supplies and consumables;
2. Assistance with meeting NRH operational costs (e.g. electricity); and

Funding across these three areas is shown in Tables 8.1 and 8.2 below.

### Table 8.1: Expenditure under the HSSP in 2008

<table>
<thead>
<tr>
<th>Detail</th>
<th>SIG SBD$ (m)</th>
<th>HSSP SBD$ (m)</th>
<th>Total SBD$ (m)</th>
<th>% funded by HSSP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical supplies and consumables</td>
<td>$0</td>
<td>$22.99</td>
<td>$22.99</td>
<td>100</td>
</tr>
<tr>
<td>Operational costs</td>
<td>$4.37</td>
<td>$5.33</td>
<td>$9.7</td>
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</tr>
<tr>
<td>Capital development</td>
<td>$2.13</td>
<td>$0</td>
<td>$2.13</td>
<td>0</td>
</tr>
</tbody>
</table>

Source: Submission 8, Australian High Commission, p 2.

### Table 8.2: Budget under the HSSP in 2009

<table>
<thead>
<tr>
<th>Detail</th>
<th>SIG SBD$ (m)</th>
<th>HSSP SBD$ (m)</th>
<th>Total SBD$ (m)</th>
<th>% funded by HSSP</th>
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</thead>
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<tr>
<td>Medical supplies and consumables</td>
<td>$2.42</td>
<td>$24.5</td>
<td>$26.92</td>
<td>91</td>
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<tr>
<td>Operational costs</td>
<td>$10.90</td>
<td>$0.72</td>
<td>$11.62</td>
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<tr>
<td>Capital development</td>
<td>$3.50</td>
<td>$6.64</td>
<td>$10.14</td>
<td>65</td>
</tr>
</tbody>
</table>

Source: Submission 8, Australian High Commission, p 3.

An example of capital development funding that is made available to the NRH through the HSSP is the funding provided for the refurbishment of the Accident and Emergency Department at the NRH.

In addition to the financial support listed above, the HSSP is supporting the NRH by providing funding for a number of technical specialists operating at the Hospital. Currently there are nine technical positions funded by the HSSP and placed within the NRH. Of particular note, the program supports a hospital management specialist, Mr Greg Chapman, and a medical supply planning and tender specialist, Mr Peter Laing.

### 8.2 The Republic of China (Taiwan)

During the Committee’s hearing on 27 October 2009, the Committee took evidence from Mr George Chan, Ambassador of Republic of China (Taiwan) in Solomon Islands.

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206 Submission 8, Australian High Commission, p 2. See also Mr Justin Baguley, Evidence, 2 October 2009, p 22.
207 Submission 8, Australian High Commission, p 2. See also Mr Justin Baguley, Evidence, 2 October 2009, p 23.
In his evidence, Mr Chan noted the investment that the Republic of China (Taiwan) has made in construction of the new wings of NRH. Since the 1980s, the Committee understands that the Republic of China (Taiwan) has spent more than US$10 million on construction of the hospital. Most recently, in 2007 construction of office space, the conference room and library were completed.\textsuperscript{210}

Mr Chan also referred the Committee to the establishment of the Taiwan Health Centre in Honiara in October 2007. The main ways in which the centre helps the Solomon Islands health service and the NRH specifically are:

- The provision of free medical services to Solomon Islanders. Doctors and nurses from the Health Centre also visit Good Samaritan Hospital regularly to provide their services.

- Human Resources Development. Staff at the Taiwan Health Centre work with staff from the NRH to assist in their development. In addition, Solomon Islands doctors and nurses have been sponsored to travel to Taiwan for advanced study and short term workshops to improve their medical knowledge.

- Donation of medicine and equipment. The Taiwan Health Centre has donated necessary medicines and equipments to the NRH for improving the hospital’s capacity to provide quality services.\textsuperscript{211}

Mr Chan also provided information on other ways in which the Republic of China (Taiwan) is providing medical assistance to Solomon Islands, including:

- The annual mobile medical mission to Solomon Islands from the Republic of China (Taiwan). This medical mission has been dispatched annually since 2006. The mission usually comprises about 10 doctors, nurses and pharmacists. The mission visits rural areas outside of Honiara to provide medical services.

- The staging of public health programs. In 2009, the Republic of China (Taiwan) provided assistance for two public health programs: the parasite screening and prevention program to educate students in avoiding parasites, and the prevention of disease of high blood pressure, gout and diabetes program.

- The sister hospital of the NRH, the Kaohsiung Medical University Hospital in Southern Taiwan, has at various times dispatched volunteers to Solomon Islands to provide health information to various schools and social groups, for example on how to brush teeth correctly. The volunteers also assist women who have suffered domestic violence.\textsuperscript{212}

In addition to these forms of assistance, Mr Chan noted that there is a good working relationship between senior health officials from Solomon Islands and the Republic of China (Taiwan). The Republic has invited the Minister of Health and Medical Services (or the Permanent Secretary) to the Global Health Leaders Forum every year in recent years. In 2008, the Minister for Health from the Republic of China (Taiwan) visited Solomon Islands.

\textsuperscript{210} Mr George Chan, Evidence, 27 October 2009, pp 42-43.
\textsuperscript{211} Mr George Chan, Evidence, 27 October 2009, pp 43-44.
\textsuperscript{212} Mr George Chan, Evidence, 27 October 2009, pp 45-47.
In the future, Mr Chan noted that the Taiwan Health Centre will continue to invite doctors and nurses from the NRH to visit Taiwan for further medical training. The Republic will continue its work with public health projects to ease the burden on the NRH. In addition, Mr Chan noted the lack of biomedical equipment technicians at the NRH to repair and maintain medical equipment. In this regard, Mr Chan pledged to continue to work with the MHMS and NRH to assist in providing biomedical technical support to the hospital.213

8.3 Solomon Islands Red Cross

Solomon Islands Red Cross was founded in Solomon Islands in July 1983. It is legally recognised by the Solomon Islands Government by virtue of the Red Cross Act 1983. It operates as a voluntary aid society auxiliary to the public health authorities. Its work includes disaster risk management, health care, blood donor recruitment, welfare services, capacity building (which includes investing in people), branch management and fundraising. It has around 25 paid staff and 500 volunteers.214

In evidence, Mrs Nancy Jolo, Secretary General, Solomon Islands Red Cross, indicated that the involvement of the Solomon Islands Red Cross with the NRH is at three levels: the National Blood Transfusion Program, the Special Development Centre and the delivery of other welfare services.

In relation to the blood donor recruitment program, Solomon Islands Red Cross has worked in collaboration with the NRH, with funding assistance from the Embassy of the Republic of China (Taiwan), to re-establish and maintain the blood bank unit at the NRH in 2007 and 2008. In 2009 and 2010, funding is being provided by the Australian Red Cross. Solomon Islands Red Cross has entered into a memorandum of understanding with the Ministry of Health regarding the operation of the National Blood Transfusion Program. The memorandum sets out the responsibilities of the Red Cross in relation to the safety of blood products and to establish guidelines and regulations for the operation of the National Blood Service in Solomon Islands. The Red Cross also performs functions in relation to publicity and going out into the community to get people to donate blood. Ultimately the aim of the program is to improve blood supply and safety through an increase in the number of voluntary non-remunerated blood donors. Inevitably, however, there have been challenges from time to time such as the lack of transport for mobile blood drives at times, a lack of funding for refreshments for blood donors at times, and poor systems in place to coordinate blood supplies to meet patient demands. As a result, there are not always adequate blood supplies to the hospital at all times.215

The Solomon Islands Special Development Centre at the NRH provides services to children with a disability. In her evidence to the Committee, however, Ms Cathy Anilafa from the Red Cross Special Development Centre indicated that the Special Development Centre’s links to the NRH have broken down in recent times. In the early 1980s, the School of Nursing provided trainees with specific training in recognising and diagnosing the different disabilities affecting children. However, this training is no longer provided. In addition, Ms Anilafa indicated that the Special Development Centre no longer has a strong connection with the children’s ward at NRH. The only area where the Special Development Centre maintains strong links to the NRH is through the Community Based Rehabilitation Program – providing assistance to severely

213 Mr George Chan, Evidence, 27 October 2009, pp 48-50.
214 Ms Nancy Jolo, Secretary General, Solomon Islands Red Cross, Evidence, 23 September 2009, pp 7, 9.
disabled children in the community. The Special Development Centre provides physiotherapy exercises for these children, and training to workers on the Community Based Rehabilitation Program. Regrettably, however, the program is only available in Honiara.\textsuperscript{216}

As indicated, Solomon Islands Red Cross is also involved in the delivery of other welfare services. One is the provision of hearing testing at the ear nose and throat clinic at the NRH. The Red Cross has a trained audiologist who provides training to ear nose and throat nurses at the hospital. However, there is no ear nose and throat doctor at the NRH. Ms Anilafa argued that this should be a priority for the Ministry of Health and Medical Services.\textsuperscript{217}

### 8.4 Save the Children

In his evidence, Mr Baddley Nukumuna, Child Advocacy Program Manager from Save the Children, indicated that Save the Children has been present in Solomon Islands since 1986. Currently, Save the Children has two programs in Solomon Islands; a measles program and a HIV/AIDS program. The HIV/AIDS program is an awareness program for young people (defined as under the age of 18) trying to raise awareness of the risks associated with HIV/AIDS.\textsuperscript{218}

While Save the Children does not have any direct linkages with the NRH, it does have indirect linkages in that it is a strong advocate for health services that should be available for children whether in immunization, nutrition, HIV and Aids, or all aspects of health of the children.\textsuperscript{219}

However, Mr Nukumuna supported the suggestion that there should be a separate hospital for children, or possibly a separate unit at the NRH dedicated to children.\textsuperscript{220}

### 8.5 The International Post Graduate Paediatric Certificate

The International Post Graduate Paediatric Certificate is a program offered by the Westmead Children’s Hospital Sydney and the University of Sydney to assist develop the knowledge, confidence and skills of clinicians treating children. The program involves 111 hours of lectures and supporting material delivered as distance education on DVDs and the internet that provide a comprehensive review of current best practice in the treatment of children and young people. In 2008, the program was extended to Solomon Islands as a pilot project at the NRH. Three clinicians completed the program. In 2009, 16 nurses and clinicians from both the Paediatrics ward and Emergency Department at the NRH are involved in the program. It is likely that the program will be extended further, possibly beyond the NRH, in 2010.\textsuperscript{221}

In evidence, Associate Professor Kathryn Currow, Westmead Children’s Hospital, Sydney, cited to the Committee the enthusiasm and commitment that clinicians and nurses from the NRH have brought to the program, and the improvements in day-to-day practice and skills as a result.\textsuperscript{222} Similarly in evidence, Dr Hasham Gonasakera from the Westmead Children’s Hospital

\textsuperscript{216} Ms Cathy Anilafa, Evidence, 23 September 2009, p 17.
\textsuperscript{217} Ms Cathy Anilafa, Evidence, 23 September 2009, pp 17-19.
\textsuperscript{218} Mr Baddley Nukumuna, Evidence, 2 October 2009, pp 61-63.
\textsuperscript{219} Mr Baddley Nukumuna, Evidence, 2 October 2009, pp 63-64.
\textsuperscript{220} Mr Baddley Nukumuna, Evidence, 2 October 2009, p 75.
\textsuperscript{221} Assoc Prof Kathryn Currow, Evidence, 2 October 2009, pp 3-4, 14, 15.
\textsuperscript{222} Assoc Prof Kathryn Currow, Evidence, 2 October 2009, pp 3-4.
reiterated the dedication of health care professionals at the NRH to learning and development.\textsuperscript{223} Asked to comment further on the benefits of the program, Assoc Prof Carrow observed:

\begin{quote}
I think we were just talking previously and saying that this is in country training. For me the beauty of that is that it does not affect work force so that doctors and nurses can stay treating their regular patients. They don’t have to leave and leave their patients without a help care professional. It stops the family dislocation that can occur if people go away for prolonged periods of time. It enables those who are studying to reinforce their learning on a daily basis by putting into practice or bear new knowledge and benefiting the people they are treating on a regular basis. From a cost perspective if somebody is sent, I understand from the Solomon’s, say to Australia for a period of a year. It may cost a significant sum of money I have been told of the order of $200,000. Thirty-six people can be trained in country with that same cost.\textsuperscript{224}
\end{quote}

Assoc Prof Kathryn Currow also subsequently indicated that the International Post Graduate Paediatric Certificate has been provided as a full scholarship for all participants in the Solomon Islands to date, so there is no cost involved to the NRH.\textsuperscript{225}

\textsuperscript{223} Dr Hasham Gonasakera, Evidence, 2 October 2009, p 6.

\textsuperscript{224} Assoc Prof Kathryn Currow, Evidence, 2 October 2009, pp 7-8.

\textsuperscript{225} Assoc Prof Kathryn Currow, Evidence, 2 October 2009, p 10.
Chapter 9: Conclusions and recommendations

This inquiry was instituted by the National Parliament of Solomon Islands in response to Members’ concerns regarding the operation and performance of the National Referral Hospital.

The Solomon Islands Government has a responsibility to provide hospital and primary health care to the people of Solomon Islands. The NRH has a central role in delivering on that responsibility. As it currently stands, the NRH is the main hospital for the people of Honiara and Guadalcanal, while simultaneously being the only major referral hospital in the country.

Ultimately, the hospital is intended to guarantee the provision of universal high quality health services to the people of Solomon Islands.

Regrettably, as things currently stand, the hospital is unable to do this. Quite simply, standards of health care at the NRH are simply inadequate and unacceptable.

The problems besetting the NRH are many and varied.

First, population growth is placing an ever increasing demand on services at the NRH. As an example, during the inquiry, the Committee heard evidence about the increasing pressure being placed on the Labor Ward and the Special Care Nursery Ward at the hospital. Lives are being routinely lost due to overcrowding, lack of sanitation, poor infection control and related problems. In 2008, a staggering 25 per cent of all mortalities at the NRH (that is, 64 of 257) occurred in the Special Care Nursery Ward.

Second, patient care systems are simply inadequate. From the time that patients present at the hospital to their discharge, the clinical governance framework lets them down. The Committee heard stories of patients presenting to the Accident and Emergency Department and waiting for hours and hours to receive care – in some cases care that came too late. For patients that are admitted to the general wards, the patient management systems are haphazard. Medical record keeping appears haphazard. There is no quality control framework to monitor, evaluate and provide feedback to management on clinical indicators. For example, data on infection rates for example is not available. Even on discharge, the computer system for managing admissions, discharges and transfers is a stop-gap measure.

Third, human resource management at the hospital is poor. The staffing levels are inadequate – there is a critical shortage of both doctors and nurses in key positions such as the Accident and Emergency Department. Staff are paid poorly. Training opportunities for nurses in particular are constrained. There is no holistic approach to staff development; rather doctors and nurses are trained as the need arises without any departmental coordination. At the same time, management permits some practices such as doctors working at the hospital while also running a private practice. Staff moral is also low. In many cases staff are overworked, contend with very difficult conditions, and are denied promotion opportunities and training opportunities. At the same time, some staff clearly have attitudinal problems at work – turning up late and failing to take sufficient care of their patients.

Fourth, the NRH infrastructure is in a very poor state. During the Committee’s own visit to the hospital, it witnesses first hand the dilapidated state of some of the buildings. Wards have been closed because they are no longer safe. Sanitation and toilet facilities are clearly inadequate. While a new Accident and Emergency Department is planned, there is clearly a need to progress with planning for a whole new hospital.
Sixth, hospital equipment is sub-standard. It is almost unbelievable that clinical staff sometimes lack basic medical equipment such as bed pans, urinals, bath basins, linen and so on. The halting of the program of replacement for mattresses at the hospital has left the mattresses at the hospital in a very poor state. More complex medical machinery is also in short supply – wards often have to share scarce equipment. Large expensive items of equipment such as a new histokinette processor cannot even be contemplated, even though there would be clear economies to the hospital if it had a new histokinette processor and no longer needed to send as many samples for testing overseas.

Seventh, the support services to the hospital’s clinical departments are also extremely strained. The Committee noted that housekeeping services struggle to keep the hospital clean, especially the toilets, security services cannot adequately manage access to the hospital grounds – the Committee heard stories of people sleeping in the hospital off the street – the catering service operates with inadequate equipment and cannot always afford to provide nourishing meals to patients, the morgue is clearly inadequate in staffing and facilities. Other problems also abound. Of note, the Medical Records Department requires a significant injection of resources.

In noting this litany of problems at the NRH, the Committee recognises the fundamental constraint under which the NRH has been operating: insufficient Government funding. The NRH, the primary health care facility in this country, is simply inadequately funded by the Government. In the 2010 Budget, funding for staff salaries and overall running costs at the hospital were reduced, again. In 2009, the funding constraints imposed on the hospital were further accentuated by the financial reservations place on the hospital by the 2009 budget reservation. This at a time when demand for hospital services continues to increase.

In 2010, the Government has allocated an additional SBD$9 million for the purchase of medical equipment. While this funding is welcome, and should assist in addressing the dire inadequacies in medical equipment at the NRH, significantly, however, this SBD$9 million is listed as a ‘one-off’ payment for 2010. There is no indication that this funding will be available in future budgets.

The Committee notes that the NRH also receives significant supplementary funding or other forms of assistance from international aid donors, notably from AusAID through the HSSP and from the Republic of China (Taiwan). Ultimately, however, the Committee believes that the funding of the NRH is the primary responsibility of the SIG. The Government should not look to overseas aid donors to make up its shortfall in funding of the hospital. It is clear that currently, funding the hospital is not a priority for the Government. The result is that the NRH is currently a national disgrace. The Committee urges the Government to address this as a matter of priority in future budgets.

Recommendation 1

The Committee recommends that the Solomon Islands Government, through the budget process, reprioritise funding of the National Referral Hospital to allow the hospital to deliver a standard of health care commensurate with the hospital’s position as the primary health care service provider in Solomon Islands; and to immediately lift any reservation that may currently be on the health budget and exempt health from any future budget reservation.

In making these observations and recommendation, however, the Committee also believes that management of the NRH must also take some responsibility for the parlous state of the NRH. There is no doubt that the hospital has been severely constrained in recent years by funding restrictions. Nevertheless, management of the hospital has failed to deliver on any reasonable clinical systems, and it has apparently failed to provide opportunities for staff development and
promotion. Staff morale and attitudes to work are low, reflecting poor working conditions and leadership.

With better funding from Government in the future must come better management of the NRH. The Committee believes that there are several important initiatives that the NRH management should progress at once. They include:

- The establishment of a basic clinical governance framework at the NRH as a matter of priority to improve patient care and outcomes,
- The development of a quality control framework with a focus on the systems of the Medical Records Department, and an absolute priority placed on the implementation of the ICD 10 software package and associated clinical indicators in 2010;
- The establishment of absolute minimum staffing levels for key departments such as the Accident and Emergency Department, and the recruitment of personnel to meet those absolute minimum staffing levels as necessary;
- The immediate rectification of the current nurse to patient ratio to ensure adequate minimum care for patients of the NRH, including the development and immediate implementation of a scheme to re-engage retired nurses to assist with nursing responsibilities and training of nurses;
- The development of a human resource management system to ensure that all personnel, including nurses, have access to training and development opportunities, that all staff receive regular performance appraisal and reporting, that all staff follow the applicable rules (including the General Orders) on staff workplace attitude and ethics, and that where vacancies arise those vacancies are filled promptly on the basis of merit;
- The immediate implementation of a Patient Complaints Tribunal;
- The implementation of proper occupation health and safety procedures, laboratory procedures and infection control measures to ensure healthy and safe working environment for NRH staff, patients and visitors;
- The review of the hospital’s security services including the implementation of a visitors register and the engagement of a private security firm to provide security services at the NRH;
- The development of systematic processes for the regular replacement and maintenance of key medical equipment, together with the replacement of other hospital equipment, notably mattresses; and
- The immediate repair or reconstruction of the NRH’s sewage system in order to improve sanitation in the wards and bring an end to the current deplorable practice of pumping waste directly into the sea.
- Consider the development of a systematic process that allows doctors to be on duty after hours on a shift basis as opposed to being on-call.
Recommendation 2

The Committee recommends that with better funding of the NRH by the Solomon Islands Government, the NRH management progress the following initiatives at once:

- The establishment of a basic clinical governance framework at the NRH as a matter of priority to improve patient care and outcomes;
- The development of a quality control framework with a focus on the systems of the Medical Records Department, and an absolute priority placed on the implementation of the ICD 10 software package and associated clinical indicators in 2010;
- The establishment of absolute minimum staffing levels for key departments such as the Accident and Emergency Department, and the recruitment of personnel to meet those absolute minimum staffing levels as necessary;
- The immediate rectification of the current nurse to patient ratio to ensure adequate minimum care for patients of the NRH, including the development and immediate implementation of a scheme to re-engage retired nurses to assist with nursing responsibilities and training of nurses;
- The development of a human resource management system to ensure that all personnel, including nurses, have access to training and development opportunities, that all staff receive regular performance appraisal and reporting, that all staff follow the applicable rules (including the General Orders) on staff workplace attitude and ethics, and that where vacancies arise those vacancies are filled promptly on the basis of merit;
- The immediate implementation of a Patient Complaints Tribunal;
- The implementation of proper occupation health and safety procedures, laboratory procedures and infection control measures to ensure healthy and safe working environment for NRH staff, patients and visitors;
- The review of the hospitals security services including the implementation of a visitors register and the engagement of a private security firm to provide security services at the NRH;
- The development of systematic processes for the regular replacement and maintenance of key medical equipment, together with the replacement of other hospital equipment, notably mattresses; and
- The immediate repair or reconstruction of the NRH’s sewage system in order to improve sanitation in the wards and bring an end to the current deplorable practice of pumping waste directly into the sea.
- Consider the development of a systematic process that allows doctors to be on duty after hours on a shift basis as opposed to being on-call.
There is also a need for the SIG, the MHMS and the NRH management to work together in relation to joint concerns. They include:

- The viability and appropriateness of introducing a fee for certain patients of the NRH, especially as may be used to manage the presentation of non-urgent cases to the Accident and Emergency Department;

- The possibility of establishing a private ward at the NRH to ease the burden on the public hospital;

- The possible establishment of a chapel at the NRH;

- The possible establishment of a children’s hospital in the medium to long term;

- The possible long-term move of the NRH to a new site, and where that site should be located;

- The development of appropriate arrangement to guide doctors who carry out both NRH duties and private practice; and

- The provision of assistance to staff of the NRH for housing and transport to and from work.

**Recommendation 3**

The Committee recommends that the SIG, the MHMS and the NRH management work together to address the following matters:

- The viability and appropriateness of introducing a fee for certain patients of the NRH, especially as may be used to manage the presentation of non-urgent cases to the Accident and Emergency Department and ENT Department;

- The possibility of establishing a private ward at the NRH to ease the burden on the public hospital;

- The possible establishment of a chapel at the NRH;

- The possible establishment of a children’s hospital in the medium to long term;

- The possible long-term move of the NRH to a new site, and where that site should be located;

- The development of appropriate arrangement to guide doctors who carry out both NRH duties and private practice;

- The provision of assistance to staff of the NRH for housing and transport to and from work.
## Appendix 1: Submissions

<table>
<thead>
<tr>
<th>No</th>
<th>Author</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Ms Jocelyn Lai (Volunteer, Women Youth)</td>
</tr>
<tr>
<td>2</td>
<td>Dr Onity Sarue (Honiara Dental Centre)</td>
</tr>
<tr>
<td>3</td>
<td>Ms Annie Sam (SSEC Health Coordinator)</td>
</tr>
<tr>
<td>4</td>
<td>Ms Ella Kauhue (Live and Learn)</td>
</tr>
<tr>
<td>5</td>
<td>Mr Douglas Hou (Public Solicitor)</td>
</tr>
<tr>
<td>6</td>
<td>Office of the Commissioner of Police Submission</td>
</tr>
<tr>
<td>7</td>
<td>Surgery Department (National Referral Hospital)</td>
</tr>
<tr>
<td>8</td>
<td>Mr Frank Ingruber (Australian High Commissioner)</td>
</tr>
<tr>
<td>9</td>
<td>Dr Henry Kako (Health Director, Honiara City Council)</td>
</tr>
<tr>
<td>10</td>
<td>Rex Faukona (Puisne Judge, High Court of Solomon Islands)</td>
</tr>
<tr>
<td>11</td>
<td>National Referral Hospital and Ministry of Health and Medical Services</td>
</tr>
<tr>
<td>12</td>
<td>Dr Lipson Sisiolo</td>
</tr>
<tr>
<td>13</td>
<td>Retired Nurses Submission</td>
</tr>
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# Appendix 2: Witnesses

<table>
<thead>
<tr>
<th>Date</th>
<th>Name</th>
<th>Position and Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuesday 8 September 2009</td>
<td>Hon. Clay Forau Soalaoi</td>
<td>Minister, Ministry of Health and Medical Services</td>
</tr>
<tr>
<td>Conference Room 2, National Parliament Office</td>
<td>Dr. Cedric Alependava</td>
<td>Under Secretary Health Improvement, Ministry of Health &amp; Medical Services</td>
</tr>
<tr>
<td></td>
<td>Dr. Carl Susuairara</td>
<td>Under Secretary Health Care, Ministry of Health &amp; Medical Services</td>
</tr>
<tr>
<td></td>
<td>Dr. Lester Ross</td>
<td>Permanent Secretary, Ministry of Health &amp; Medical Services</td>
</tr>
<tr>
<td></td>
<td>Mr. Douglas Ete</td>
<td>Chief Executive Officer, National Referral Hospital</td>
</tr>
<tr>
<td></td>
<td>Dr. Tenneth Dalipanda</td>
<td>Medical Superintendent, National Referral Hospital</td>
</tr>
<tr>
<td></td>
<td>Mr. Selwyn Hou</td>
<td>Director of Nursing, National Referral Hospital</td>
</tr>
<tr>
<td></td>
<td>Mr. Steven Maesiola</td>
<td>Under Secretary Admin/Finance, Ministry of Health &amp; Medical Services</td>
</tr>
<tr>
<td></td>
<td>Mr. Michael Larui</td>
<td>National Director of Nursing Services, Ministry of Health &amp; Medical Services</td>
</tr>
<tr>
<td></td>
<td>Dr. George Kabuere</td>
<td>Vice President, Solomon Islands Medical Association</td>
</tr>
<tr>
<td></td>
<td>Mr. Greg Chapman</td>
<td>Hospital Manager Specialist, National Referral Hospital</td>
</tr>
<tr>
<td>Thursday 10 September 2009</td>
<td>Dr. Trevor Garland</td>
<td>Honorary Consul &amp; Coordinator for St. Vincent’s 10 Bed Arrangement</td>
</tr>
<tr>
<td>Conference Room 2, National Parliament Office</td>
<td>Dr. Tenneth Dalipanda</td>
<td>Medical Superintendent, National Referral Hospital</td>
</tr>
<tr>
<td></td>
<td>Mr. Selwyn Hou</td>
<td>Director of Nursing, National Referral Hospital</td>
</tr>
<tr>
<td></td>
<td>Dr. Levi Hou</td>
<td>Obstetrician Gynaecologist, National Referral Hospital</td>
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<td>Mr. Alfred Dofai</td>
<td>Chief Medical Technologist, National Referral Hospital</td>
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<td>Mr. Wale Tobata</td>
<td>Director Pharmacy Services, National Medical Store</td>
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<tr>
<td>Monday 14 September 2009</td>
<td>Dr. Aaron Oritaimae</td>
<td>Consultant Radiologist Specialist, Medical Department</td>
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<td></td>
<td>Dr. Ellison Vane</td>
<td>Director Dental Services, National Referral Hospital</td>
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<td></td>
<td>Mr. Michael Nunan</td>
<td>Chief Pharmacist, National Referral Hospital</td>
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<td></td>
<td>Mr. Simon Tavi</td>
<td>Chief Dental Therapist, National Referral Hospital</td>
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<td></td>
<td>Mr. William Horoto</td>
<td>National Medical Pharmacy, Honiara</td>
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<tr>
<td>Conference Room 2, National Parliament Office</td>
<td>Dr. Kenton Sade</td>
<td>Head of Accidents &amp; Emergency Department + General Practice Clinic, National Referral Hospital</td>
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<td></td>
<td>Dr. Patrick Houasia</td>
<td>Head of Orthopaedic Department, National Referral Hospital</td>
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<td></td>
<td>Dr. Kaeni Agiomea</td>
<td>Head of Anaesthetic Department, National Referral Hospital</td>
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<td>Dr. Deji Adu</td>
<td>Head of Ophthalmology Department, National Referral Hospital</td>
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<td>Dr. Titus Nasi</td>
<td>Head of Paediatric Department, National Referral Hospital</td>
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<td></td>
<td>Dr. Duddley Baerodo</td>
<td>Head of General Surgery, National Referral Hospital</td>
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<td></td>
<td>Dr. Rooney Jagilly</td>
<td>Oncology Cancer Registry, National Referral Hospital</td>
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<tr>
<td></td>
<td>Mr. Christopher Laure</td>
<td>Physiotherapy Department &amp; Rehabilitation Services, National Referral Hospital</td>
</tr>
<tr>
<td>Wednesday 16 September 2009</td>
<td>Dr. George Manimu</td>
<td>Private Practitioner, former Permanent Secretary of Ministry of Health &amp; Medical Services</td>
</tr>
<tr>
<td>Conference Room 2, National Parliament Office</td>
<td>Mr. Shadrach Fanega</td>
<td>Permanent Secretary, Ministry of Finance &amp; Treasury</td>
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<td>Mr. Tione Bugotu</td>
<td>Permanent Secretary (Special Duties), Ministry of Education &amp; Human Resources Development</td>
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<td></td>
<td>Mr. Selu Maezama</td>
<td>Director, National Training Unit, Ministry of Education &amp; Human Resources Development</td>
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<tr>
<td>Friday 18 September 2009</td>
<td>Dr. Henry Kako</td>
<td>Health Director, Health Division, Honiara City Council</td>
</tr>
<tr>
<td>Date</td>
<td>Name</td>
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<td>Conference Room 2, National</td>
<td>Mr. Harvest Miabule</td>
<td>Head of Nursing, Honiara City Council</td>
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<tr>
<td>Parliament Office</td>
<td>Ms Rachel Wate</td>
<td>Assistant Director Nursing (Management), Nursing Division, National Referral Hospital</td>
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<td></td>
<td>Ms Mary Wakio</td>
<td>Assistant Director Nursing (Clinical), National Referral Hospital</td>
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<td></td>
<td>Ms Helen Orihao</td>
<td>Nurse Educator, National Referral Hospital</td>
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<td></td>
<td>Ms Florida Pratt</td>
<td>Nurse Manager, Medical Department, National Referral Hospital</td>
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<td></td>
<td>Ms Eunice Kwanafia</td>
<td>Surgical Unit, National Referral Hospital</td>
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<td></td>
<td>Ms Nedlyn Ratu</td>
<td>Nurse Manager, Obstetrics &amp; Gynaecology Department, National Referral Hospital</td>
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<td></td>
<td>Ms Connie Panisi</td>
<td>Clinical Nurse Consultant, Diabetic Centre, National Referral Hospital</td>
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<td></td>
<td>Ms Margaret Soma</td>
<td>Clinical Nurse (Occupational Health &amp; Safety), National Referral Hospital</td>
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<td></td>
<td>Mr. John Sa’ohu</td>
<td>Assistant Infection Control Officer, National Referral Hospital</td>
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<td></td>
<td>Ms Delores Matanani</td>
<td>Clinical Instructor, National Referral Hospital</td>
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<td></td>
<td>Mrs Janet Wate</td>
<td>Nurse Manager, Operating Theatre, National Referral Hospital</td>
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<td>Ms Anna Pumae</td>
<td>Nurse Manager, Paediatrics Ward, National Referral Hospital</td>
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<td>Mr. Mcnold Tau</td>
<td>Nurse Manager, Emergency Department, National Referral Hospital</td>
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<tr>
<td>Wednesday 23 September 2009</td>
<td>Ms Anna Mosese Manuapangae</td>
<td>Principal Technologist, Histology and Cytology Laboratory, National Referral Hospital</td>
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<td>Conference Room 2, National</td>
<td>Mr. Alfred Dofai</td>
<td>Chief Technologist Laboratories, National Referral Hospital</td>
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<td>Parliament Office</td>
<td>Mr. Cavanaugh Tanabose</td>
<td>Hospital Secretary, Corporate Services Division, National Referral Hospital</td>
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<tr>
<td>Date</td>
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<td>Position and Organisation</td>
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<tr>
<td>Thursday 24 September 2009</td>
<td>Mr. Brook Walalau</td>
<td>Central Store Manager, National Referral Hospital</td>
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<td></td>
<td>Ms Margaret Wale</td>
<td>Head, Laundry Department, National Referral Hospital</td>
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<td>Mr. David Maelaua</td>
<td>Head, Morgue Department, National Referral Hospital</td>
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<td></td>
<td>Mr. Jim Reuben</td>
<td>Head of Maintenance, National Referral Hospital</td>
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<td>Mr. Anon Tavalusu</td>
<td>Medical Records Department, National Referral Hospital</td>
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<td></td>
<td>Mr. Roland Wale</td>
<td>Head, Transport Section, National Referral Hospital</td>
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<td></td>
<td>Mr. Aloysius Mae</td>
<td>Infection Control, Corporate Administration, Nursing Service, National Referral Hospital</td>
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<td></td>
<td>Ms Sarah Mua</td>
<td>Catering Service, National Referral Hospital</td>
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<td>Ms Ruth Maeafou</td>
<td>Infection Control, National Referral Hospital</td>
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<td>Mr. Paul Takika</td>
<td>Administrative Officer, Corporate Service, National Referral Hospital</td>
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<tr>
<td>Friday 25 September 2009</td>
<td>Dr. John Kure</td>
<td>General Practitioner, Natal Family Health Clinic</td>
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<tr>
<td></td>
<td>Dr. Ronald Ziru</td>
<td>Former SIMA President &amp; retired Dental Practitioner</td>
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<tr>
<td>Tuesday 29 September 2009</td>
<td>Mr. Douglas Hou</td>
<td>Public Solicitor, Public Solicitor’s Office</td>
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<tr>
<td></td>
<td>Mr. Joe Poraiwai</td>
<td>Ombudsman, Office of the Ombudsman</td>
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<tr>
<td>Friday 2 October 2009</td>
<td>Mrs Verzilyn Isom</td>
<td>Head of School of Nursing &amp; Health Studies, Solomon Islands College of Higher Education</td>
</tr>
<tr>
<td></td>
<td>Ms Nancy Jolo</td>
<td>Secretary General, Solomon Islands Red Cross</td>
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<td>Ms Cathy Anilafa</td>
<td>Red Cross Handicap Centre</td>
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<tr>
<td>Friday 2 October 2009</td>
<td>Ms Catherine Currow</td>
<td>Associate Professor, Westmead Children’s Hospital &amp; University of Sydney, Sydney, Australia</td>
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<td></td>
<td>Dr. Hasham Gonasakera</td>
<td>General Paediatrician, Westmead Children’s Hospital, Sydney</td>
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<td>Mr. Justin Baguley</td>
<td>Senior Development Officer, AusAid</td>
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<td>Mr. Baddley Nukumuna</td>
<td>Child Advocacy Program Manager, Save the Children Australia</td>
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<td>Fr. Malachi David</td>
<td>Hospital Chaplain, National Referral Hospital</td>
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<tr>
<td>Wednesday 14</td>
<td>Mr Tuita Toata</td>
<td>West Honiara Constituency</td>
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<tr>
<td>October 2009</td>
<td>Mr. Tony Qwarafi</td>
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<td>Rove Police Club,</td>
<td>Mr Walter Neil</td>
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<td>Mr Billy Joe Oge</td>
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<td>Friday 16 October</td>
<td>Mr Philip Ika Siles Jr</td>
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<td>Ms Hilda Rore</td>
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<td>Mr Casper Kaku</td>
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<td>Fr Divine Kaku</td>
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<td>Ms Leona William</td>
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<td>Mr Edward Limairadi</td>
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<td>Monday 19 October 2009</td>
<td>Mr William Manepolo</td>
<td>Central Honiara Constituency</td>
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<td>Mr Simon Houma</td>
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<td>Tuesday 27 October 2009</td>
<td>Ms Esmy Ata</td>
<td>Clinical Nurse, Gynaecology Department, National Referral Hospital</td>
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<td></td>
<td>Dr. Israel Fernandez Kimero</td>
<td>Physician Doctor (Cuba), National Referral Hospital</td>
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<td></td>
<td>H.E George Chan</td>
<td>Ambassador, Republic of Taiwan</td>
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<td>Dr. Carl Susuairara</td>
<td>Under Secretary Health Care, Ministry of Health &amp; Medical Services</td>
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<td>Dr. Lester Ross</td>
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<td>Mr. Douglas Ete</td>
<td>Chief Executive Officer, National Referral Hospital</td>
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<td>Dr. James Auto</td>
<td>Medical Superintendent (Acting), National Referral Hospital</td>
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<td>Mr. Greg Chapman</td>
<td>Hospital Manager Specialist, National Referral Hospital</td>
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<td>General Secretary, National Referral Hospital</td>
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<td>Mr. Selwyn Hou</td>
<td>Director of Nursing, National Referral Hospital</td>
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<td>Mr. Paul Belande</td>
<td>General Secretary, Solomon Islands’ Public Employees Union</td>
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<td>Hon. Clay Forau Soalaoi</td>
<td>Minister, Ministry of Health &amp; Medical Services</td>
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<td>Dr. Cedric Alependava</td>
<td>Under Secretary Health Improvement, Ministry of Health &amp; Medical Services</td>
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