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Health Equity and Access to Health Care in Trinidad and Tobago

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Abstract: Health inequity persists, particularly in developing countries. This study explores access to public health care and equity. This descriptive study was conducted using a review of the literature, print media, health reports, and patient experiences. Health accessibility links to equity were analysed, focusing on inequity in healthcare access, challenges in accessing services (long waiting times, non-available pharmaceuticals), poor public health (murder, rape, and other crimes, traffic accidents, traffic congestion, divorce, and unemployment), and misrepresentations of health guidelines. The necessary out-of-pocket spending disfavours the poor and favours the rich who, by purchasing basic health services, have greater access to public health services. The negative public health environment increases the health burden and imposes healthcare requirements which further disfavour the poor in particular, while informal networks favour the rich. Shortfalls in health services and public health necessitate out-of-pocket spending, which also dis-favours the poor and favours the rich.

Keywords: Basic Health Service, Equity, Healthcare, Inequity, Primary Constraints, Trinidad and Tobago

1. Introduction

Equitable health according to the WHO is the bedrock of a just health care system, which 'is built on having trained and motivated health workers, a well-maintained infrastructure and a reliable supply of medicines and technologies, backed by adequate funding, strong health plans and evidence-based policies' [1]. It involves the removal of obstacles in other sectors such as education, housing, or transportation [2] as well as alleviating difficulties in other social determinants of health, and is integral in delivering a quality health service. This, however, has not been adequately addressed in many developing countries, especially those with coexistent scarce resources, corruption, and lack of transparency. Reports and complaints continue of poor health care and of the failure of health care providers to meet the increasing challenges and expectations of their citizens [3]. Furthermore, limited resources and system inefficiencies have facilitated the development of an environment that nurtures inequity.

Research conducted in India [4] shows that major inequities exist despite modernisation and medical advancement. While there are cases of many citizens not receiving their just healthcare, some countries' health systems themselves promote inequities. For example, a study in Nepal reported the existence of a pro-rich distribution of healthcare utilization, both publicly and privately [5].

In Trinidad and Tobago equity is emphasised in the health sector reform initiative as part of its mission statement: 'to create a nation of individuals, families and communities empowered to achieve and sustain the highest standards of health and well-being through the provision of efficient, effective, equitable and collaborative services that support good health'[6]. However, inefficiencies and mismanagement rather than issues of fairness and justice or equity are the primary focus of reform. This paper is an exploratory study. Though it cannot quantify the size of the inequity problem, it sheds light on the 'issues and practices' of inequity in terms of access to Trinidad and Tobago's health care delivery system.

2. Methodology

The study was conducted in Trinidad and Tobago, a nation with a population of 1.4 million people, predominantly Indo-

and Afro-Trinidadians in roughly equal proportions. The public health system is free, with no fees at the point of care. The system offers a wide variety of services, such as both basic and specialised investigations, as well as the treatment of chronic diseases and specialised treatments such as dialysis, renal transplants, angioplasty, open heart surgery, laparoscopic surgery, and lithotripsy. Funding is made through government subventions to the regional authorities. There are other agencies that further facilitate health, such as a children's life fund for 'needy cases' and a number of government-funded privately-run services such as the Ministry of Health's (MOH) 'External Support Programme' to supplement or complement gaps in the public health system. There is also assistance from the medical social work department.

Data collection was based on a review of the literature, daily newspapers, and patients' and the author's experiences in the health service. Cases of inequity were analysed to determine patterns of access inequity. Numerous sites were explored for information, namely the Central Statistical Office (CSO) Trinidad and Tobago, Pan American Health Organization (PAHO), World Health Organization (WHO), and the search engines Google, Pub med, and EBCO using the search words *equity*, *inequity*, *justice*, and *fairness*. Information was gathered from patient feedback, customer satisfaction surveys, and national health indicators.

A descriptive analysis of health equity issues was undertaken in the main areas of access challenges: unavailability, rule mal-interpretation/misuse, public health status, and patient perception of health service. It may be hypothesised that patients who come from or are of low socio-economic status are subject to systemic disparities of health service accessibility.

3. Results

Accessibility inequity outcome (out-of-pocket spending)

In Trinidad and Tobago's health system, access inequity may arise from unavailability, a substandard public health environment, public policy dilemmas, or rule mal-interpretation (Figure 1) and patient's perception of the health service. Poor perceptions of or dissatisfaction with the health service affects a wider cross section of patients. These shortcomings have tended to affect the poor predominantly because of the need to use out-of-pocket funds.

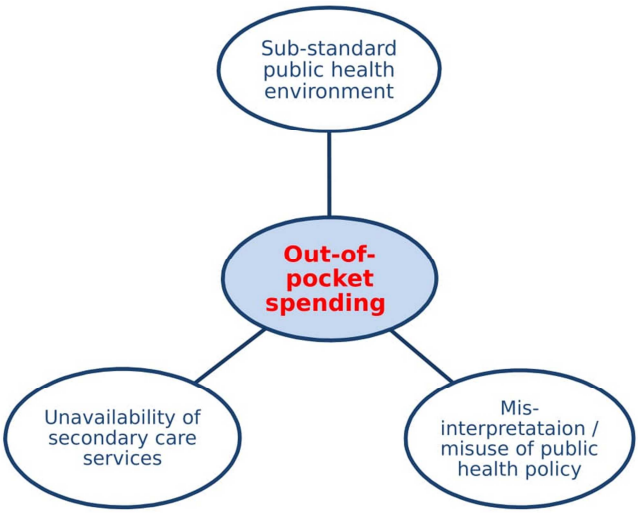

Figure 1. *Access inequity.*

3.1. Pathway 1: Service Availability

Poor health care has been reported in numerous reports as resulting from inefficiency, inadequacy, and poor management practices. Reports of inadequate or poor quality health care (drug shortages, unfriendly services, long waiting times, bed shortages, etc.) circulate in the media; both print and electronic (Table 1).

Table 1. *Media reports of inadequate or poor health care.*

Media Reports
1. 'Woman gives birth to baby on floor'[1]
2. 'Baby delivered in hospital toilet'[2]
3. 'Use the private hospitals or die'[3]
4. 'Patient dumped outside hospital to die'[4]
5. 'Pensioner fears going blind waiting on operation at Scarborough hospital'[5]
6. 'Patients told to bring their own blood glucose monitors and strips' to Hospital'[6]
7. 'Hospital horrors for highway crash victims'[7]
8. 'Visitor dies after turned away from Mt Hope'[8]
9. 'Ambulance horror'[9]
10. 'St James Hospital refused to help'[10]
11. 'Long waiting time, no courtesy or care'[11]
12. 'Shortage of medical supplies at SWRHA'[12]
13. '1,200 waiting for CT, MRI scans'[13]
14. 'Bed shortage at SFGH'[14]
15. 'Nightmare delivery for mom at Mt Hope'[15]
16. 'Nipdec to get $$ to address drug shortage'[16]
17. 'Cancer drug shortage'[17]

Media Reports
18. 'NCRHA confirms unavailability of drugs at hospitals' [18]
19. 'Drug shortage unacceptable' [19]
20. 'Bad treatment at hospital pharmacy' [20]
21. 'state funding for "medical mafia"'[21]
22. '…many patients die, not from the infirmities that they are afflicted with, but from lack of medication and vital equipment at the hospitals and health centres and from neglect and sometimes even criminal negligence by hospital staff' [22]

[1]Woman gives birth to baby on floor. Trinidad Express Newspaper. November 16, 1993.
[2]Baby delivered in hospital toilet - probe launched. Trinidad Express Newspaper. September 10, 2013. Retrieved November 15, 2017, from http://www.trinidadexpress.com/news/baby-delivered-in-hospital-toilet---hospital-launches-probe-223305791.html.
[3]Use the private hospitals or die. Trinidad Express Newspaper. July 14, 2015. Retrieved November 18, 2017, from http://www.trinidadexpress.com/20150714/news/use-the-private-hospitals-or-die.
[4]Dumped outside hospital to die. Trinidad Express Newspaper. June 7, 2017. Retrieved November 18, 2017, from http://www.trinidadexpress.com/20170607/news/dumped-outside-hospital-to-die.
[5]Pensioner fears going blind waiting on operation at Scarborough hospital. Trinidad and Tobago Newsday. November 7, 2017. Retrieved November 18, 2017, from http://newsday.co.tt/2017/11/07/pensioner-fears-going-blind-waiting-on-operation-at-scarborough-hospital/.
[6]Patients told to bring their own blood glucose monitors and strips to San Fernando General Hospital. Cable News Channel 3. October 26, 2017. Retrieved November 18, 2017, from http://www.cnc3.co.tt/news/patients-told-bring-their-own-blood-glucose-monitors-and-strips-san-fernando-general-hospital.
[7]Hospital horrors for highway crash victims. Trinidad Express Newspaper. March 12, 2014. Retrieved November 18, 2017, from http://www.trinidadexpress.com/news/Highway-crash-survivors-tell-horror-story-249729681.html.
[8]Dowlat R. Visitor dies after turned away from Mt Hope. Trinidad and Tobago Guardian Newspaper. May 24, 2017. http://www.guardian.co.tt/news/2017-05-24/visitor-dies-after-turned-away-mt-hope Retrieved December 1, 2017.
[9]Ambulance horror. Trinidad Express Newspaper. January 29, 2012. Retrieved December 1, 2017, from http://www.trinidadexpress.com/news/AMBULANCE_HORROR-138303654.html.
[10]Gonzales G. St James Hospital refused to help him. Trinidad Express Newspaper. April 3, 2017. Retrieved December 1, 2017, from http://www.trinidadexpress.com/20170403/news/st-james-hospital-refused-to-help-him
[11]Hassanali S. 'Long waiting time, no courtesy or care'. Trinidad and Tobago Guardian Newspaper. November 2, 2014. Retrieved December 1, 2017, from http://www2.guardian.co.tt/news/2014-11-02/%E2%80%98long-waiting-time-no-courtesy-or-care%E2%80%99.
[12]Clyne K. Shortage of medical supplies at SWRHA. Trinidad and Tobago Guardian Newspaper. September 3, 2015. Retrieved December 1, 2017, from http://www.guardian.co.tt/news/2015-09-03/shortage-medical-supplies-swrha.
[13]1,200 waiting for CT, MRI scans. Trinidad and Tobago Guardian Newspaper. June 15, 2017. Retrieved December 1, 2017, from http://www.guardian.co.tt/news/2017-06-16/1200-waiting-ct-mri-scans.
[14]Sookraj R. Bed shortage at SFGH. Trinidad and Tobago Guardian Newspaper. July 10, 2012. Retrieved December 1, 2017, from http://jupiter.guardian.co.tt/news/2012-07-09/bed-shortage-sfgh
[15]Hassanali S. Nightmare delivery for mom at Mt Hope. Trinidad and Tobago Guardian Newspaper. December 14, 2014. Retrieved December 1, 2017, from http://www.guardian.co.tt/news/2014-12-14/nightmare-delivery-mom-mt-hope
[16]Nipdec to get $$ to address drug shortage. Trinidad and Tobago Guardian Newspaper. July 12, 2016. Retrieved February 5, 2018, from http://www.guardian.co.tt/news/2016-07-12/nipdec-get-address-drug-shortage
[17]Cancer drug shortage. Trinidad and Tobago Newsday. June 11, 2016. Retrieved February 5, 2018, from http://archives.newsday.co.tt/2016/06/11/cancer-drug-shortage/.
[18]NCRHA confirms unavailability of drugs at hospitals. CNC3. June 23, 2016.
[19]Drug shortage unacceptable. Trinidad Express Newspaper. August 24, 2016. Retrieved February 5, 2018, from http://www.trinidadexpress.com/20160824/news/drug-shortage-unacceptable
[20]Bad treatment at hospital pharmacy. Trinidad and Tobago Newsday. December 28, 2016. Retrieved January 7, 2018, fromhttp://archives.newsday.co.tt/2017/01/03/bad-treatment-at-hospital-pharmacy/.
[21]State funding for 'medical mafia'. Trinidad and Tobago Guardian Newspaper. May 8, 2016. Retrieved November 26, 2017, from http://www.guardian.co.tt/news/2016-05-07/state-funding-%E2%80%98medical-mafia%E2%80%99
[22]Horrors at Mt. Hope Maternity Hospital. Trinidad and Tobago Guardian Newspaper. October 7, 1995.

The available services—infrastructural, pharmaceutical, and diagnostic—and process issues are also sub-optimal (Tables 2, 3 and 4).

Table 2. *Availability and accessibility of medical services (inadequate).*

Medical Services	
Lab services/ Investigations	
X-ray machines per 1,000 inhab. (1990 –2005)[1]	0.05
Ultrasound machines per 1,000 inhab. (1990–2005)[1]	0.01
Clinical laboratories per 100,000 inhab. (1990–2005)[1]	0.85
Blood banks per 100,000 inhab. (1990–2005)[1]	0.046
	Comment
CT/MRI	A large portion of the population is unable to access CT/MRI scans or must endure long waits on a wait list; '1,200 waiting for CT, MRI scans' [2]
Ultrasound	Sometimes unavailable or inaccessible. 'Mt Hope staffing woes affect ultrasound service' [3]

Medical Services	
Dialysis	Sometimes unavailable or inaccessible. 'Woes to get dialysis'[4]

[1]Health Systems Profile: Trinidad and Tobago. Monitoring and Analyzing Health Systems Change/Reform. Pan American Health Organization. 2008. Retrieved February 7, 2018, from http://www1.paho.org/hq/dmdocuments/2010/Health_System_Profile-Trinidad_Tobago_2009.pdf.
[2]1,200 waiting for CT, MRI scans. Trinidad and Tobago Guardian Newspaper. June 15, 2017. Retrieved December 1, 2017, from http://www.guardian.co.tt/news/2017-06-16/1200-waiting-ct-mri-scans.
[3]Mt Hope staffing woes affect ultrasound service. Trinidad and Tobago Guardian Newspaper. May 11, 2017. Retrieved February 5, 2018, from http://www.guardian.co.tt/news/2017-05-11/mt-hope-staffing-woes-affect-ultrasound-service.
[4]Woes to get dialysis. Trinidad and Tobago Newsday. October 16, 2012. Retrieved February 5, 2018, from http://archives.newsday.co.tt/2012/10/16/woes-to-get-dialysis/

Table 3. *Examples of situations where inequity exists within the healthcare service.*

Inequity Variable	**Comment**
Infrastructural	Overcrowding: Patients may frequently be observed waiting on a bed, and sometimes over 30 patients were sitting on chairs for days.[1]
Pharmacy Services	In 2008, 39.3% of the prescriptions were dispensed in April and 55.6% in December.[1] Medication problems include: unavailability, insufficiency, inconsistency, wastage, delayed dispensing, and delayed giving treatment to the patient
Diagnostic services	Inconsistent availability of investigative services such as: 1. Echocardiogram 2. CT 3. MRI 4. Bone marrow aspirate 5. Thallium scan 6. Blood analyses
Process services	Services include accessing certain investigations privately, accessing a bed, etc.
Appointments	Exceptionally long waiting times to obtain clinic appointments, investigations or operations.[1] Waiting times for services involving radiology, physiotherapy, and echocardiography, as well as stress testing, are also far from desirable at SFGH, sometimes ranging from a few months to years for the desired service. Waiting times for a first appointment to attend a clinic vary between one to sixteen months.

[1]Bahall, M. "Health services in Trinidad: Throughput, throughput challenges, and the impact of a throughput intervention on overcrowding in a public health institution." BMC Health Services Research. 2018; 18:129.b https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5819239/pdf/12913_2018_Article_2931.pdf. Retrieved March 19, 2018.

Table 4. *Services that are unavailable/inadequate.*

Inadequate Services
1. Lab reports[1,2]
2. Echocardiography[2]
3. Radiological services[3]
4. Medication of various types,[4] including insulin

[1]Trinidad and Tobago Quality Department, Ministry of Health (MOH). Annual customer complaints and feedback manual 2006-2007. Port of Spain: Ministry of Health; 2007.
[2]Bahall, M. "Health services in Trinidad: Throughput, throughput challenges, and the impact of a throughput intervention on overcrowding in a public health institution." BMC Health Services Research. 2018; 18:129.b Retrieved March 19, 2018, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5819239/pdf/12913_2018_Article_2931.pdf.
[3]Gaffoor, G., W. Hosein, Y. Pilgrim, G. Wilson, and G. Frankson. Report of the Commission of Enquiry into the Operation and Delivery of Public Health Care Services in Trinidad and Tobago. Port of Spain: Ministry of Health, 2007.
[4]Hunte, C. Lack of medication: Most common complaints throughout public health sector. Trinidad Express Newspaper. 2017. Retrieved March 19, 2018, from http://web.trinidadexpress.com/20170603/news/lack-of-medication.

The inability of health care providers to provide consistent basic services, such as exercise stress tests, bone marrow tests, and blood and radiological investigations [3] makes securing these largely the responsibility of patients, whose concomitant out-of-pocket funding amounted to 2.76% of the GDP in 2014 [7]. This need for private funding to secure access to basic services effectively debars many from continued appropriate care. Basic services or investigations are required for the continued care of patients.

Medical social workers' resources are inadequate to address the vast gaps in services and the needs of deserving patients. Many deserving cases fail to receive any treatment, with disastrous consequences such as disease complications and even death. However, the ability to provide such services allows many access to continued expensive services provided by the state, e.g. the performance of an angiogram or open heart surgery may depend on a stress test or an echocardiogram.

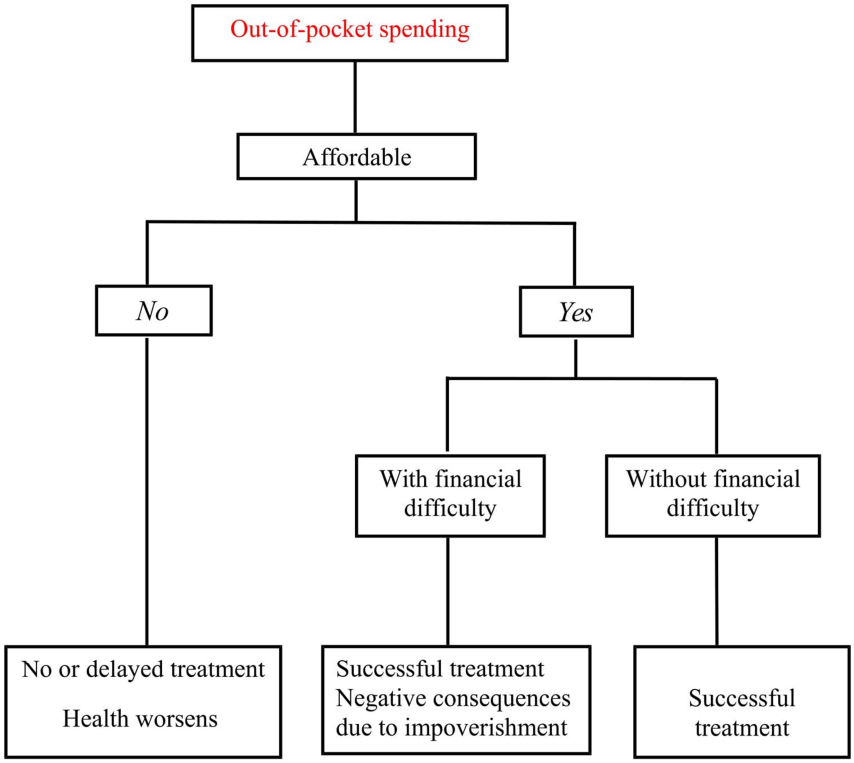

Figure 2. *Link between availability, financial affordability, and inequity.*

3.2. Pathway 2. Public Health Environment

Many communities like Laventille have a negative public health environment (narrow roads, outdoor latrines, water problems, crime) which is far different from that of the well developed areas with positive public health environments as exists in Valpark or West Moorings. In general, based on aggregate data for Trinidad and Tobago, negative social determinants are quite high (Table 5).

Residents of negative public health environment are subjected to ill-health practices which make them more prone to ill-health and thus requiring more health care. Poor public health infrastructure mainly affects the underprivileged.

Table 5. *Public health in Trinidad and Tobago.*

Indicator	
Lifestyle	Number
Total number of fast food outlets [1]	199
Estimated number of popular bars[2]	239
Socio - economic	Prevalence
Population below poverty line (2014 est.)[3]	20.0%
Unemployment rate for 2016[4]	4.07%
No. of Murders for 2017[5]	494
No. of Rape incidents in 2014[5]	829
Theft in 2014[5,6]	2592
Suicide rate per 100,000 in 2015[6]	14.5
Accessibility	Comment
Roadways	There is a high prevalence of bad roads throughout Trinidad and Tobago, especially in rural areas as opposed to cities; 'Protest in Williamsville over bad roads'[7] 'New Grant residents protest bad road'[8]
Road fatalities in 2014 [9]	243
Access to water	95% of population is listed as having access to water; however, 24 hr access is limited to certain areas[10] Inaccessibility to water still arises: 'Water crisis worsens in Tobago'[11] '8 months no water'[12]
Access to 24 hr. running pipe water [13]	58%
Access to sanitation facilities[14]	92%

Indicator	
Education	
Youth (15-24 years) literacy rate (%) 2008–2012*, male[15]	99.6
Youth (15-24 years) literacy rate (%) 2008–2012*, female[15]	99.6
Housing	NA
Transport	
Motor vehicles (per 1,000 people) in 2007[16]	353

[1]Caribbean Basin Food Service - Hotel Restaurant Institutional Trinidad and Tobago Food Service Sector Report. USDA Foreign Agricultural Service; 2012. Retrieved November 4, 2017, from https://s3.amazonaws.com/ProductionContentBucket/pdf/20120513184838932.pdf

[2]Trinidad & Tobago Bars. Tntisland.com. 2017. Retrieved October 23, 2017, from http://www.tntisland.com/bar.html

[3]Trinidad and Tobago Population below poverty line – Economy. Indexmundi.com. Retrieved February 20, 2018, from https://www.indexmundi.com/trinidad_and_tobago/population_below_poverty_line.html.

[4]Trinidad and Tobago: Unemployment rate 2012–2022. Statistic. Statista. Retrieved February 5, 2018, from https://www.statista.com/statistics/728918/unemployment-rate-in-trinidad-and-tobago/

[5]Trinidad & Tobago Crime Statistics. Ttcrime.com. Retrieved February 5, 2018, from https://www.ttcrime.com/stats.php.

[6]Suicide mortality rate (per 100,000 population). Retrieved February 5, 2018, fromhttp://data.worldbank.org/indicator/SH.STA.SUIC.P5?locations=TT&view=chart

[7]Protest in Williamsville over bad roads. Trinidad and Tobago Newsday. September 7, 2017. Retrieved February 5, 2018, from http://archives.newsday.co.tt/2017/09/07/protest-in-williamsville-over-bad-roads/.

[8]New Grant residents protest bad road. Trinidad and Tobago Guardian Newspaper. January 9, 2018. Retrieved February 5, 2018, from http://www4.guardian.co.tt/news/2018-01-08/new-grant-residents-protest-bad-road

[9]Road Traffic Accidents in Trinidad and Tobago. World Health Ranking. Retrieved February 9, 2018, from http://www.worldlifeexpectancy.com/trinidad-tobago-road-traffic-accidents

[10]Improved water source (% of population with access). The World Bank. Retrieved February 9, 2018, from https://data.worldbank.org/indicator/SH.H2O.SAFE.ZS?locations=TT

[11]Water crisis worsens in Tobago. Trinidad and Tobago Guardian Newspaper. August 8, 2015. Retrieved February 9, 2018, from http://www.guardian.co.tt/news/2015-08-08/water-crisis-worsens-tobago

[12]8 months no water. Trinidad and Tobago Newsday. January 10, 2018. Retrieved February 9, 2018, from http://newsday.co.tt/2018/01/10/8-months-no-water/

[13]The Post-2015 Development Agenda: Trinidad & Tobago Stakeholder Perspectives on a Water Goal and Its Implementation. Global Water Partnership, 2018. Retrieved May 20, 2018, from https://www.gwp.org/globalassets/global/about-gwp/publications/reports/country-consultation-reports/country-consultations-2014/trinidad-and-tobago-national-consultation.pdf.

[14]Improved sanitation facilities (% of population with access). The World Bank. Retrieved February 9, 2018, from https://data.worldbank.org/indicator/SH.STA.ACSN?locations=TT.

[15]Statistics. UNICEF. 2018. Retrieved February 7, 2018, from https://www.unicef.org/infobycountry/trinidad_tobago_statistics.html#0.

[16]Trinidad and Tobago: Motor Vehicles. Tradingeconomics.com. Retrieved February 10, 2018, from https://tradingeconomics.com/trinidad-and-tobago/motor-vehicles-per-1-000-people-wb-data.html.

3.3. Pathway 3: Policy/Guideline Interpretation

Many patients are deprived of just healthcare through inappropriate decisions. A typical case is the deprivation of a 1-year-old child from much needed surgery to prevent her from becoming deaf and dumb, with consequent psychological and social implications including lifetime financial dependency. The reply from the CEO to the father of the child was as follows:

Your application was assiduously reviewed by our panel of independent specialist doctors who unanimously agreed that she would indeed benefit significantly from a cochlear transplant procedure. We have been duly informed that a said cochlear implant programme is expected to commence in the North Central Regional Health Authority in due course. We are advised by our panel of independent specialist doctors that 'this child' would be an ideal candidate for same. On behalf of the Children's Life Fund Authority and from me personally, we wish her the very best in her course of treatment and in the future. [8]

This child was denied all state assistance on the basis of the possible commencement of a surgery which up to this time has not commenced. With respect to another case, one newspaper reported on a legal challenge against the decision of the Children's Life Fund Authority (CLFA), which had refused to fund two children suffering from blood disorders, on the grounds that a clinical assessment determined that the children's medical condition was 'not life threatening'. The legal team argued that the decision to refuse funding to the children is contrary to the provisions of the Children's Life Fund Act.

Each of these pathways results in patients requiring out-of-pocket spending to achieve at least basic health care. This leads to three potential outcome possibilities: poor outcomes, mixed outcomes, or a good/optimal outcome, depending on the patient's economic position.

3.4. Pathway 4: Service/Patient Perception

A unique category of discrimination occurs when patients feel reluctant to access or continue care in the free health institute because of the poor perception of the quality of care: overcrowding; medicine shortages; lack of available competent staff; and unfriendly staff. Dissatisfaction with health services has been reported for decades. In 1999, a study by Singh et al. revealed dissatisfaction levels of 13.4% and 48.0% for courtesy of doctors and waiting times, respectively [9]. A 2008 customer satisfaction survey revealed global satisfaction scores of 38.44% [10]. In terms of dissatisfaction with respect to courtesy, treatment, support services, hotel services, environmental care, and management issues, the aggregate percentage of persons generally

dissatisfied were 14.65%, 22.01%, 33.49%, 35.24%, 17.47%, and 38.91%, respectively [10] (Table 6). In a 2015 survey, 65% were dissatisfied with the management of healthcare [11].

Table 6. *Perceived satisfaction with health service.*

	Percentage,%	
From a study in 1999[1]	**Satisfied**	**Dissatisfied**
Assessment of doctors		
Courtesy and consideration by doctors	75.0	13.4
Skills and competence	74.0	-
Opportunities for seeing specialists	40.0	30.0
Doctor's advice	73.1	13.7
Waiting time after arrival at health centre	41.0	48.0
From 2008[2]		
Courtesy	76.13	14.65
Treatment	30.42	22.012
Support services	17.55	33.491
Hotel services	27.71	35.24
Environmental care	60.94	17.473
Management issues	33.986	38.915

[1]Singh, H., E. D. Haqq, and N. Mustapha. "Patients' perception and satisfaction with health care professionals at primary care facilities in Trinidad and Tobago." Bulletin of the World Health Organization. 1999; 77 (4). Retrieved February 5, 2018, from https://monroecollege.edu/uploadedFiles/_Site_Assets/PDF/Patients'%20Perception%20and%20Health.pdf.

[2]Bahall, M. An evaluation of the effectiveness of the decentralized health system in Trinidad and Tobago (Unpublished PhD dissertation). The University of the West Indies, St. Augustine; 2010.

Many patients therefore avoid hospital care or do so very late or seek private care at great cost to them. Some patients 'prefer to die home rather than go to the hospital'. Many discharge themselves without obtaining the required treatment.

Table 7. *Characteristics of the health care system: National health indicators of Trinidad and Tobago.*

Output Indicators	**Value**
Life and death	
Life expectancy at birth (yr) in 2017[1]	70.78
Annual no. of crude deaths per 1000 people in 2015[2]	9.5
No. of infant deaths per 1000 live births in 2016[3]	16.5
No. of maternal deaths per 100,000 live births in 2015[4]	63
Neonatal mortality per 1000 live births in 2016[5]	12.6
Infant mortality rate, 2017[6]	22.3
Fertility and childbirth	
Average no. of births per woman in 2016[7]	1.7
Births attended by skilled health personnel in 2013 (%)[8]	100
Pregnant women receiving any prenatal care in 2006[9] (%)	95.7
Prevalence of chronic diseases	
Prevalence of-self-reported hypertension in adults between 2008-2008 (%)[10]	30.2
Prevalence of diabetes in adults in 2015 (%)[11]	14.5
CAD deaths per 100,000 in 2017 [12]	2,436
HIV infection; adult prevalence rate in 2015 (%)[13]	1.2
Prevalence of lifestyle risk factors (%)	
Obesity—Adult prevalence rate (%) in 2014[14]	32.3
Overweight in children (5–18 years)[15]	25
Smoking prevalence in 2014[16]	21.1
Insufficient physical activity in 2010[17]	41.7
Alcohol consumption[18]	40.0
Other	
HDI in 2015[19]	0.78
HPI in 2006[19]	0.007

[1]Trinidad and Tobago Life expectancy at birth, 1950-2017. Knoema.com. Retrieved November 25, 2017, from https://knoema.com/atlas/Trinidad-and-Tobago/topics/Demographics/Age/Life-expectancy-at-birth

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4. Discussion

The study found an inequitable environment: accessibility gaps in public policy, public health, and secondary services which warrant out-of-pocket funding. This out-of-pocket funding for basic services which the poor cannot manage or can only pay at a tremendous burden gives an unfair advantage to others who can access more expensive and advanced services by literally purchasing basic services. Poor public health and ambiguous public policies further disadvantage patients of low socio-economic status, resulting in access inequity.

Out-of-pocket funds are necessary to supplement services or investigations of rate-limiting steps in order to continue care. It was seen that those who can invest a 'little' have gained enormously from continued care such as accessing certain specialised services, namely renal transplant, dialysis, and open heart surgery. The findings of this study corroborate other research of situations in which public expenditures on health favour the rich indirectly through the provision of services which the poor cannot access [12]. Such inequities have been reported by Gwatkin, whose study reveals that the better off have a higher probability of being favoured in tertiary and secondary hospital services [13], and Phiri et al., who found evidence of pro-poor inequality in public primary health care utilisation but a pro-rich inequality in hospital visits in Zambia [14].

The use of out-of-pocket funds to obtain unavailable government services can impoverish many because much of their savings are used in health care. Paying for health services utilises household finances or leads the poor to resort to selling assets or borrowing money to finance their medical treatment, thus leading to further poverty [15]. Kwesiga et al., who investigated out-of-pocket payments in Uganda, found that out-of-pocket payments led to a 4.2% rise in the poverty head-count ratio, or an increase of over one million more Ugandans being pushed below the poverty line [16].

Public policy misrepresentation disadvantages many patients who suffer immensely from such deprivations. The refusal of funding for an 11-month-old child to receive funding or the refusal to grant funding because cases are non-life-threatening demonstrates inequity. Such decisions may affect all, but the need for out-of-pocket spending is discriminatory by putting those in a low socio-economic status in a situation where they are unable to continue with their clinical care.

Noisy, polluted, crime-ridden areas; inconsistent water and waste disposal; lack of social amenities such as playgrounds, libraries, and leisure activities; and easy access to fast food outlets and sedentary pastime outlets encourage unhealthy lifestyles. Residents of such negative public health environments are subject to ill-health practices which make them more prone to ill-health and even more reliant on the out-of-pocket spending which is less available to them. Poor public health infrastructure mainly affects the underprivileged and encourages unhealthy lifestyles.

While the poor may have an unfair disadvantage, there may be an unfair advantage due to the pro-rich bias. This can be difficult to prove. Pro-rich inequity favours the rich through greater coverage and healthcare utilization [17], and because of the high corruption index [18], jumping the queue via informal connections [19] allows greater access to informal networks of healthcare. This occurs at all levels but particularly among those who have strong connections with health care providers. Jumping the queue happens from the very highest to the lowest, although there is a greater likelihood of such taking place at the higher echelons of society. Though there is no priority based on social status, one's connections can make a large difference that can trigger even greater benefits downstream. The informal network, though not official policy, benefits the well-off more because of their connections within the system, which is encouraged by the prevalence of corrupt practices in Trinidad and Tobago, whose corruption perception index was 35 points in 2016 [18].

Poor perception of the service has turned away many people who would otherwise stay to access treatment. Poor perception of medical services as a cause of inequity has been reported by Koehler et al. [20]. Equity is directly linked to patient satisfaction with health care, which is related to 'perceived quality, competency of providers and personal respect and treatment received during visits' [21]. Poor public perception of a health care system is associated with underuse. Delay or avoidance of needed services results in use of more costly services at a later stage of illness, with poorer outcomes and lost productivity [21].

The national indicators are poor compared to developed countries (Table 7). These overall or aggregate values for the nation, however, may not reflect the differences that may exist between the rich and the poor. In fact, the indicators for the poor may be worse while those for the rich may well be far better.

The analysis of inequity of access, according to Peters, involves four main areas: availability, acceptability, geography, and finance [22]. The demand to achieve equity and the 'right to basic health care' [23] is difficult through individual responsibility alone as enshrined in the patient charter of rights [24]. The use of cash transfers, health equity funds, regulatory approaches, and mixed institutional coproduction efficacy [22] have also been advocated. Reducing inequalities depends on addressing public health, personal health, and health services [25]. Economic slowdown should not be a prescription to decrease basic healthcare, which can worsen health inequalities, but instead one should provide more social protection [26].

5. Conclusion

Inequity of access to health care resulting from an inequitable environment (inefficient secondary care services,

mal-represented public policy, unhealthy public health and poor perception of the health service) largely affects the low socio-economic group negatively because of their need to use out-of-pocket money. The out-of-pocket spending for constrained services gives a further unfair advantage to the privileged, who would qualify for many more services. Proper and appropriate evaluation and monitoring should be emphasised to ensure equity. A health equity commission to measure, monitor and manage healthcare is needed to address inequity in health services.

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