SAINT LUCIA HEALTH SYSTEMS AND PRIVATE SECTOR ASSESSMENT 2011

January 2012

This publication was produced for review by the United States Agency for International Development. It was prepared by Michael Rodriguez, Barbara O'Hanlon, Abigail Vogus, Rich Feeley, Carol Narcisse, and Jodi Charles for the Health Systems 20/20 Project and Strengthening Health Outcomes through the Private Sector Project.

Health Systems 20/20 Mission

The Health Systems 20/20 **cooperative agreement,** funded by the U.S. Agency for International Development (USAID) for the period 2006-2011, helps USAID-supported countries address health system barriers to the use of life-saving priority health services. Health Systems 20/20 works to strengthen health systems through integrated approaches to improving financing, governance, and operations, and building sustainable capacity of local institutions.

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Cooperative Agreement No.: GHS-A-00-06-00010-00

SHOPS Mission

The Strengthening Health Outcomes *through* the Private Sector (SHOPS) Project is a five-year **cooperative agreement** (2009-2014) with a mandate to increase the role of the private sector in the sustainable provision and use of quality family planning, HIV/AIDS, and other health information, products, and services.

Cooperative Agreement No.: GPO-A-00-09-00007

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Recommended Citation: Michael Rodriguez, Barbara O'Hanlon, Abigail Vogus, Rich Feeley, Carol Narcisse, and Jodi Charles. January 2012. *Saint Lucia Health Systems and Private Sector Assessment 2011*. Bethesda, MD: Health Systems 20/20 project, Abt Associates Inc.

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ACRONYMS

A&E	Accident and Emergency
AAF	AIDS Action Foundation
ADR	Adverse Drug Reactions
AIDS	Acquired immune deficiency syndrome
AIM-U	American International Medical University
ARV	Antiretroviral
CAREC	Caribbean Epidemiology Center
CARICOM	Caribbean Community
CDB	Caribbean Development Bank
CIDA	Canadian International Development Agency
CME	Continuing Medical Education
CPG	Clinical Practice Guidelines
CPU	Corporate Planning Unit
CRDTL	Caribbean Regional Drug Testing Laboratory
EC	European Commission
EC$	Eastern Caribbean Dollar
EDF	European Development Fund
E-GRIP	E-Government Regional Integration Programs
EHR	Electronic Health Record
EML	Essential Medicines List
GDP	Gross Domestic Product
GIS	Geographic Information System
HEU	Health Education Unit
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HMN	Health Metrics Network
HRH	Human Resources for Health
HSA	Health Systems Assessment
HSS	health systems strengthening
ICT	Information and Communications Technology

ILO	International Labor Organization
IT	Information Technology
LAC	Latin America and the Caribbean
M&E	Monitoring and Evaluation
MD	Medical Doctor
MOF	Ministry of Finance
MOH	Ministry of Health
MOPS	Ministry of Public Service
MSM	Men who have sex with men
MSMW	Men who have sex with men and women
MOU	Memorandum of Understanding
NACC	National AIDS Coordinating Committee
NAPS	National AIDS Program Secretariat
NCD	Noncommunicable disease
NGO	Nongovernmental organization
NHA	National Health Accounts
NIC	National Insurance Corporation
NMP	National Medicines Policy
NNH	New National Hospital
NMWC	National Mental Wellness Center
NSPH	National Strategic Plan for Health 2006-2011
OAS	Organization for American States
OECS	Organization of Eastern Caribbean States
OPSR	Office of Private Sector Relations
PANCAP	Pan Caribbean Partnership Against HIV/AIDS
PAHO	Pan American Health Organization
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PLHIV	People Living with HIV
PMTCT	Prevention of mother-to-child transmission
PPS	Pharmaceutical Procurement Service
PRISM	Performance of Routine Information Systems and Management
PSA	Private Sector Assessment
RDQA	Routine Data Quality Assessment

SLMDSA	Saint Lucia Medical and Dental Association
SLUHIS	Saint Lucia Health Information System
SHOPS	Strengthening Health Outcomes *through* the Private Sector
STI	Sexually Transmitted Infection
TB	Tuberculosis
TLC	Tender Loving Care
UHC	Universal Health Care
UK	United Kingdom
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USAID/EC	United States Agency for International Development/Eastern Caribbean
USD	United States dollar
USG	United States Government
VAT	Value-Added Tax
VCT	Voluntary counseling and testing
WHO	World Health Organization

ACKNOWLEDGMENTS

The assessment team is grateful for the support from the Ministry of Health in Saint Lucia. Particularly, the team would like to thank Permanent Secretary Barnabas Annius, PAHO Country Representative and former Health Planner Xysta Edmunds, National AIDS Program Coordination Nahum Jn. Baptiste, and Chief Pharmacist Donna Daniel for their assistance throughout the process. The team is thankful for the opportunity to collaborate in this assessment with the Corporate Planning Unit and would like to specifically thank Ms. Kerry Joseph, Ms. Jackie Joseph Mills, and Mr. Darnville Nelson for the time they devoted to assisting in this assessment and reviewing the draft report. The team would also like to thank Ms. Jacqueline Matthew for her coordination of logistics during the assessment.

The team would like to thank Ms. Danielle Altman, Ms. Catherine Connor, and Dr. Laurel Hatt of Abt Associates and Ms. Kendra Phillips from the United States Agency for International Development (USAID) for their review and guidance in the process.

Numerous individuals gave of their time to provide information through key informant interviews. We are extremely grateful for the input and insight we received from individuals at numerous ministries, health facilities, and organizations, including:

- Government: Ministry of Health, Ministry of Finance, Ministry of Economic Affairs, Ministry of Social Transformation
- Public sector health facilities: Victoria Hospital, Vieux Forte Health Center, Basseterre Health Center
- St. Jude Hospital and Tapion Hospital
- National Insurance Corporation
- Nurses' Association
- Nongovernmental and civil society organizations
- Doctors in private practice and private pharmacies
- Private insurance companies
- Private businesses
- Private medical training institutions
- Private laboratories

This assessment report was prepared collaboratively by the different members of the assessment team. Abigail Vogus drafted the country overview and Pharmaceutical Management chapters; Jodi Charles, Barbara O'Hanlon, and Abigail Vogus drafted the Governance chapter; Rich Feeley drafted the Health Financing chapter; Carol Narcisse drafted the Human Resources for Health chapter; Michael Rodriguez drafted the Health Information Systems chapter; Leah Eckbladh drafted the Service Delivery chapter; and Barbara O'Hanlon drafted the Private Sector chapter.

FOREWORD

In 2009 the United States Government (USG) supported a process to develop the U.S.-Caribbean Regional HIV and AIDS Partnership Framework 2010-2014 together with twelve Caribbean countries: Antigua and Barbuda, the Bahamas, Barbados, Belize, Dominica, Grenada, Jamaica, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, and Trinidad and Tobago. Development of the Framework involved participation from Ministries of Health, national AIDS programs, regional organizations such as the Pan Caribbean Partnership Against HIV/AIDS (PANCAP) and the Organization of Eastern Caribbean States (OECS), and nongovernmental and private sector stakeholders. The framework is aligned with national strategic plans and the PANCAP Caribbean Strategic Framework.

A major goal of the Partnership Framework is to move the region toward greater sustainability of HIV/AIDS programs. Obtaining results in this area will be challenging, given that most country governments currently provide limited national budget resources to their own HIV/AIDS programs, relying to a large degree on external aid. While there are six USG agencies supporting implementation of the Framework, USAID/Eastern Caribbean (USAID/EC) provides support for health systems strengthening (with particular emphasis on health financing) and private sector engagement. Both these efforts are closely linked to sustaining the HIV response in the region.

As a part of the Partnership Framework, USAID/EC asked the Health Systems 20/20 (HS20/20) and the Strengthening Health Outcomes *through* the Private Sector (SHOPS) projects to conduct integrated health system and private sector assessments in Saint Lucia, Grenada, Saint Kitts, Antigua, Dominica, and Saint Vincent and the Grenadines. The assessments identify opportunities for technical assistance, which are aimed at improving the capacity of these countries to effectively lead, finance, manage, and sustain the delivery of quality health services, including HIV prevention, care, and support.

USAID/EC has requested that the SHOPS project, USAID's global flagship private sector engagement project, establish a baseline of private sector engagement in HIV/AIDS that will inform future regional and country support for maximizing contributions from this sector in the Eastern Caribbean. USAID/EC has asked Health Systems 20/20, USAID's global flagship health systems strengthening project, to determine opportunities for improving health financing systems, ensuring the sustainability of funding for the HIV/AIDS response, and strengthening financial tracking and management procedures in the region. The integrated health system and private sector assessment approach is specifically used to pinpoint areas where the private sector can be leveraged to strengthen health systems, sustain national HIV responses, and contribute to improved health outcomes.

The assessment methodology is a rapid, integrated approach, covering six health systems components: health financing, pharmaceutical management, governance, health information systems, human resources for health, and service delivery. Special emphasis is placed on the current and potential role of the private sector within and across each health system building block. An extensive literature review was conducted for each country, and in-country interviews with key stakeholders were used to validate and augment data found in secondary sources. The assessments are guided by an intensive stakeholder engagement process. Following the preparation of a draft assessment report, preliminary findings and recommendations are validated and prioritized at in-country stakeholder workshops. Stakeholders interviewed and engaged throughout the assessment process include government representatives, development partners, nongovernmental organizations, professional associations, health workers in the public and private sector, civil society organizations, and private sector businesses.

The assessments have been conducted in close collaboration and cooperation with the Pan American Health Organization, the Health Resources and Services Administration, the International Training and Education Center for Health, and the Caribbean HIV/AIDS Regional Training Network. Representatives of these organizations joined assessment teams, contributed to the assessment reports, and have assisted with identifying opportunities for technical assistance. Health Systems 20/20 and SHOPS wish to express gratitude to these organizations, to the Ministries of Health in participating countries, and to all in-country stakeholders for their intensive engagement and contribution to the assessments.

EXECUTIVE SUMMARY

BACKGROUND

As a part of the United States-Caribbean Regional HIV and AIDS Partnership Framework 2010-2014, USAID/Barbados and the Eastern Caribbean (USAID/EC) asked the Health Systems 20/20 and the Strengthening Health Outcomes *through* the Private Sector (SHOPS) projects to conduct an integrated health systems and private sector assessment to identify priorities for technical assistance. This effort seeks to improve the capacity of Saint Lucia to effectively lead, finance, manage, and sustain the delivery of quality health services, including HIV prevention, care, and support services. This capacity is reflected in the strengths and weaknesses of the entire health system, inclusive of the private sector. While the broader health system was the focus of the assessment, attention was paid to the HIV response in particular (see Annex D for a summary of HIV-related issues).

In the late 1990s, the government of Saint Lucia embarked on a comprehensive strategic planning process to improve its existing health system. The Ministry of Health (MOH) played a key role in reaching out to a wide range of stakeholders from all regions of the country to solicit feedback on perceived strengths of and challenges for the Saint Lucian health system. Based on feedback from key stakeholders, a comprehensive review of existing systems, and extensive research on various models for health system reform, a health sector reform committee developed the National Strategic Plan for Health, 2006-2011(NSPH). The NSPH called for the development of a more decentralized service delivery model that emphasizes preventive care, with comprehensive health teams located at health centers to address common health issues within each of Saint Lucia's communities. Key priorities included responding to the growing problem of chronic noncommunicable diseases (NCDs), the upgrading of two district hospitals to polyclinics supported by ambulance transport, and the implementation of a universal health coverage strategy to facilitate access to a basic package of health care services in a financially sustainable way.

One of the key findings of the research supporting the NSPH was the over use of the Saint Lucia hospital emergency department for nonurgent care. More than 75 percent of patients presenting in the Saint Lucian Accident and Emergency Departments did not have any urgent or severe problem (MOH 2000). Strategic objectives within the NSPH therefore emphasized making preventive care, including HIV services, more accessible across the country via community-based health centers staffed with comprehensive clinical health teams. To strengthen overall health infrastructure, a new centrally located secondary hospital was envisioned under the NSPH to replace the aging Victoria Hospital. The old Victoria Hospital site will be converted to house the Castries urban polyclinic. Another key finding of this health system and private sector assessment is the success with which Saint Lucia has effectively integrated HIV/AIDS services into regular clinics held across the country. The HIV/AIDS clinic rotates to sites outside of the capital three days per week, which has greatly simplified access for patients, according to patients and providers alike.

The health systems and private sector assessment summarized in this report found that many of the key components of Saint Lucia's NSPH have not been implemented. For example, a decentralized model of care with more authority has not proceeded, comprehensive clinical teams at the health center level have not been put into place, and only one of the four planned polyclinics in the NSPH has been opened. The New National Hospital (NNH) being built in Castries with European Commission (EC) grant funding is nearing completion. The conversion of Victoria Hospital to a polyclinic, however, has not

proceeded, which makes it likely that the NNH will still be flooded with non-urgent patients seeking primary care services. A paper entitled "Universal Health Care Policy Review and Analysis" was undertaken with Pan American Health Organization (PAHO) support earlier this year. This policy analysis makes recommendations for the implementation of the Universal Health Care (UHC) program and suggests how additional funds could be generated for the sustainability of health services in the health sector. No formal financing plan has yet been adopted and the absence of a sustainable financing mechanism poses an immediate threat to the sustainability of the entire Saint Lucian health system and its ability to continue to provide and expand upon service delivery.

These recommendations were discussed and prioritized by Saint Lucia health sector stakeholders during a dissemination workshop held October 11-12, 2011. A report outlining the discussions and results of this workshop and the prioritization is provided in Annex D of this report.

KEY FINDINGS AND RECOMMENDATIONS RELATED TO THE NEW NATIONAL HOSPITAL

Saint Lucia's health system leaders face severe time and financial constraints in responding to these challenges given the proposed opening of the NNH in the second quarter of 2012. Without knowing the true costs of operating the NNH, the opening of the hospital next year has the potential to (1) lead to cost escalation in hospital expenditures while sapping government spending on priority public health services and diverting resources from the primary care level to cover unanticipated costs at the NNH, (2) drain human resources from the existing effective public sector primary care system, and/or (3) disappoint Saint Lucia's hopes for expansion of secondary and tertiary services. Without proper planning, none of the potential benefits of this new facility will be realized. Key primary care-based services, such as those for NCDs and HIV, which are currently provided by Victoria Hospital-based staff who rotate out to community health facilities, may suffer from reduced prioritization.

The Corporate Planning Unit (CPU) in the MOH has developed a sound plan for the health systems strengthening necessary to support the NNH (Edmunds 2009), but key policy decisions have not been made regarding the management, funding, or staffing for the NNH. Highlighted below are key issues that this health systems and private sector assessment recommends that the MOH prioritize to prepare for this new facility:

Management decisions: Decision and actions need to be taken in three areas:

- **NNH autonomy:** As planned and equipped, the NNH will be providing more complex health services than Victoria Hospital. The planned specialty services at the NNH, which currently do not exist elsewhere in the public sector, will require more highly technical staff. The existing civil service and government accounting procedures in Saint Lucia cannot respond adequately to the complex needs of tertiary health care institutions. The MOH understands the need to afford the NNH greater flexibility and independence, as it has done with Saint Jude Hospital and has proposed making the NNH a statutory entity. The MOH is in the process of reviewing the recommendations made in the National Strategic Plan on the governance structure of the NNH in order to present the most feasible and appropriate structure to the Cabinet of Ministers for a final decision.
- **User fees:** Interviews with key stakeholders and much of the literature available to this assessment team during its review of Saint Lucia's health reform efforts suggest that user fees should be abolished at public hospitals, including the NNH, as a part of the ongoing national health insurance development (Barrett 2011, ILO 2003, MOH 2005c). Although politically appealing, the removal of fees typically results in increased demand for public services. This is worrisome at a time when the availability of health sector funding is uncertain. Increases in demand are likely to come from patients

who avoided care because of the cost and from patients who sought care in the private sector when there was only a modest differential in cot. ***The assessment team believes that not enough analysis has been conducted*** to determine the impact on the NNH's financial viability if user fees are lifted before opening the new hospital.

- **Victoria Polyclinic:** The MOH has appropriately identified the need to convert Victoria Hospital into a polyclinic to avoid swamping the NNH with routine primary care patients. The MOH needs ***to establish a separate line item budget to protect the funds*** needed to convert Victoria to a polyclinic and increase hours into evenings and Saturdays. It will also be important to define how the rotating specialty clinics (i.e., sexually transmitted infections, diabetes, HIV) will be impacted by the conversion. Also, the MOH would benefit from putting into place an ***enforceable referral policy*** to divert patients from the NNH to the polyclinic for appropriate outpatient and after-hours primary care.

Funding decisions: The recent PAHO-funded report on universal health coverage estimates that the total budget needed to run the MOH in 2012, including the operational costs of the NNH, will be EC$117 million[1], up 58 percent from the MOH budget three years earlier (Barrett 2011). In addition to the operational costs of running the NNH, the PAHO report identified three other significant new expenditures that will result from the NNH opening: (1) creation of the polyclinic at the Victoria Hospital site, (2) expansion of primary care services to address the growing burden of chronic diseases (such as diabetes and hypertension) and avert costly hospitalizations, and (3) increase in the budget for drug purchases from EC$4 million to EC$6 million per year. These estimates do *not* include funding of depreciation that will ultimately be necessary to replace equipment purchased by the EC.

The PAHO report also calculated that the government would have to increase public spending in health by more than 1 percent of gross domestic product (EC$ 43 million) to adequately resource the health system once the NNH opens (Barrett 2011). This estimate does not take into account the proposal to suspend user fees at the NNH, which is likely to increase demand for public services and increase further the need for public funding. At the writing of this report, the MOH has a proposal before Parliament to allocate 2.5 percent of the proposed 17 percent value-added tax (VAT) toward health (Barrett 2011). Based on information gathered for this assessment, including interviews with the Ministry of Finance (MOF), the MOH has no other plans in place to increase public funding if the VAT is not passed by Parliament soon. The MOH is constrained in developing an alternate plan because there are currently no data on the sources and uses of funds in the health sector to plan rationally for its future. **In brief, the MOH is in urgent need of detailed cost data to make informed funding decisions regarding the NNH in the short-term and to plan funding of the health system over the long run.**

Human resources planning: Lessons learned from the experience of staffing the new psychiatric hospital should guide plans for staffing the NNH. Currently, the large, new psychiatric hospital is understaffed and not able to provide the model and quality of care that was envisioned in the NSPH because of limited human and financial resources. In the case of the NNH, MOH respondents estimated that the MOH must increase the number of public health personnel by approximately 60 percent to meet the hospital's operating requirements. This is a colossal effort given the cumbersome and slow hiring process in Saint Lucia. Recruitment and deployment of staff is largely managed by the Ministry of Public Service (MOPS) requiring a multistep process that relies on approvals from cabinet, MOPS, and MOF. As a result, the MOH relies heavily on temporary

[1] This text refers to the XCD (East Caribbean dollar) as EC$ and USD (United States dollars) as US$ throughout. At current rates of exchange, US$ 1 = EC$ 2.70.

contracts with technical personnel for already approved posts to accelerate the hiring process. In addition to hiring up quickly, the NNH will require staff with new skills that are currently not available in the public sector.

A Human Resources for Health (HRH) plan for the NNH is urgently needed in order to avoid repeating the experience of the new psychiatric hospital. The absence of an HRH manager at the MOH will make the formulation of an HRH plan challenging. One opportunity to fill this void temporarily is through support from the Commonwealth of Nations; this is not, however, a long-term solution nor can the hospital HRH plan be delayed. The MOH leadership needs to put into place an HRH staffing plan for the NNH as soon as possible.

Private sector resources might be available to help minimize the risk to the health sector posed by the opening of the NNH. Currently the MOH is not tapping into nor exploring how to leverage private sector resources to address many of the challenges associated with opening the NNH. Possible areas noted by the individuals interviewed for this assessment included the following:

- **Human resources:** Many of the specialist and management skills needed for the NNH are not available in the public sector. The MOH could tap into a number of skilled private sector specialists through contracts or other arrangements before recruiting off-island and/or sending patients offshore for treatment. The NNH also requires operational systems and staff with hospital management skills to manage a complex and new facility. Saint Jude Hospital operates as a parastatal under Saint Lucian law, which, among other things, allows it to collect and keep revenue. Tapion Hospital, a privately run hospital in Castries, has the most recent experience in how to open a new hospital; it also has the management, financial, and quality systems in place that have led it to be accredited internationally. Both Saint Jude and Tapion have offered to share their lessons learned with the MOH.
- **Equipment**: Tapion Hospital and private laboratories have the most sophisticated diagnostic equipment in Saint Lucia. The MOH could potentially reduce future recurring depreciation and maintenance costs for its hospital equipment by exploring partnering strategies with the private sector.
- **Financing:** Although data on how much money is spent in the private sector has not been fully analyzed, there are several signs indicating that private expenditures in health are very large. There is no firm data on the percentage of the population covered by private health insurance but a widely cited estimate being used is 15 percent. At this level, health insurance premiums are estimated to equal more than a third of MOH expenditures in the 2009-2010 budget year. The MOH could explore pursuing reimbursement from insurance companies for services currently provided freely to insurance beneficiaries receiving services at public clinics.
- **Public-private collaborations:** Currently, relations between the MOH and private sector health providers are very tense. There has been little follow-up engagement with the private sector since developing the Universal Health Care program in 2003 and the NSPH in 2006 with little recognition of the private sector's role in the health sector. Nevertheless, many private sector leaders expressed willingness to return to the table to discuss important policy and health sector issues, such as the opening and operation of the NNH.

While the NNH will clearly provide an improvement over the facilities at the century-old Victoria Hospital, the government of Saint Lucia needs to ensure that operational problems encountered at the old hospital do not persist at this new facility. A smooth transition to the NNH can be effected with careful planning. In this moment of resource constraints created by the NNH, it is urgent that the MOH consider the private sector's current and potential contributions to health service delivery and financing.

Failure to do so could result in the MOH duplicating costly services already available in the private sector. Potential savings and efficiencies could be achieved by rationalizing resources across the entire health sector. In recognition of the large risks faced, this assessment team recommends that the MOH take immediate actions needed to ensure that the NNH does not jeopardize the Saint Lucian public health system or fail to effectively leverage the private health sector.

BROADER HEALTH SYSTEMS FINDINGS AND RECOMMENDATIONS

While the challenges presented by the opening of the NNH are of primary concern for the government of Saint Lucia, there are additional recommendations to be considered stemming from this health systems and private sector assessment. Some of the key recommendations to strengthen quality, efficiency, and equity across the six building block domains are as follows:

GOVERNANCE RECOMMENDATIONS

- **Resume participatory approaches to policy, planning, and budgeting:** As past experience in Saint Lucia has demonstrated, the private sector and civil society have played constructive roles in updating the legal and regulatory framework, drafting the NSPH, and designing the UHC policy. There are multiple opportunities to involve nonstate stakeholders: (1) include representatives from the private health sector and civil society as standing members of working groups that address specific health system challenges, (2) invite senior leadership from these sectors to participate as committee members to review annual budgets and/or develop annual operational plans, and (3) create forums for diverse advocacy groups (e.g., the AIDS Action Foundation and the Saint Lucia Diabetic and Hypertensive Association) to raise and discuss concerns and to develop possible solutions to increase access, improve quality of care, and share information.
- **Strengthen the CPU's capacity to analyze and engage the private health sector:** The CPU has a strong tradition of engaging and working with all stakeholders in the health sector. Given the urgent need to reengage the private sector, an individual and/or unit within the MOH needs to be assigned as the private sector liaison so that the MOH can consistently and productively engage with stakeholders outside of the MOH.

FINANCE RECOMMENDATIONS

- **Conduct regular household health expenditure surveys; develop and periodically update National Health Accounts:** The relative burden that out-of-pocket health expenditures place on the poor in Saint Lucia is largely unknown due to the absence of routinely captured expenditure data. Regular surveys of household health expenditures should be conducted, either as stand-alone surveys, or as part of routine research on household expenditure and income, such as a national poverty assessment. The results from this work should be incorporated in periodically updated National Health Accounts (NHA). NHAs should also show budgeted public expenditures, private and public health insurance expenditures, estimated offshore medical spending, and (if HIV subaccounts are conducted) detailed expenditures for HIV/AIDS services across all sources. Having this financial data is a critical step toward determining the viability of key programs, while simultaneously evaluating the relative burden accessing such services places on each health care consumer.
- **Partner with the private sector:** The MOH should enter into negotiations wherever it may be possible to buy health services from the private sector at lower cost and at quality equal to that provided in the public sector. To do this, there must be realistic understandings about costs across both public and private sectors. Ministry budgets, for example, do not include depreciation and

employee fringe benefits, often leaving them incapable of supporting necessary maintenance and supply costs. When realistically estimated, the cost of running an MRI or a CAT scanner in the MOH may be more than the price at which an existing private facility could provide the service for referred publicly funded patients. In such an arrangement, the private sector should offer the service at a price that reflects the lower unit cost achieved with a higher number of patients (public and private) using the service.

SERVICE DELIVERY RECOMMENDATIONS

- **Develop clinical practice guidelines across the continuum of care:** As NCDs are the main burdens of disease in Saint Lucia, clinical practice guidelines (CPG) for these diseases should be widely disseminated to all levels of the health system in both the public and private sectors, but especially at the primary level. Staff at Tapion Hospital stated that they worked closely with the MOH on developing these CPG to adapt international best practices to work in the local setting with available resources. It is recommended that the MOH develop and implement a process to adopt and use practice guidelines. Clinical practice guidelines should also link across levels of care (primary health care, polyclinics, hospitals). To strengthen quality across the continuum of care, guidelines should be expanded to identify the responsibilities and qualifications at each level of care, referral criteria, and responsibility for referral back to original point of care and follow-up care. The MOH could recruit experts from the private health sector to be spokespersons and trainers to help disseminate and build capacity in these CPG.
- **Monitor health system outcome data to identify and remove system-level barriers to quality improvement:** Although supportive supervision processes identify potential areas for quality improvement that are under the direct control of providers, many of the conditions necessary for quality improvement must be created by the health system, outside of the control of providers (such as availability of drugs and financing). A health system performance monitoring system (relying on data collected routinely from the existing health management information system [HMIS]) can be used to track overall performance and results, and to identify priority areas to be targeted for improvement by individual facilities and the system as a whole. The outcomes monitoring system would contain five basic elements: (1) strategic framework; (2) performance indicators; (3) data sources; (4) process for data collection, analysis, and interpretation; and (5) communication of monitoring results and links to action.

HUMAN RESOURCES FOR FEALTH RECOMMENDATIONS

- **Fast-track recruitment and hiring of HRH director:** Every effort should be made to hire the HRH director so that this individual can immediately develop the HRH staffing plan needed for the NNH. Also, the new HRH director can work closely with the NNH management team to put into place the new HRH systems for the hospital.
- **Develop and implement partnership strategies to meet needs for specialists and workforce training:** As a small island, Saint Lucia may not have the fiscal space and economies of scale to be able to support the costs of full-time specialists in a wide range of areas or in on-island preservice and in-service training facilities and/or programs. There are, however, opportunities to create strategic partnerships to meet the human resource needs in health. The MOH should contract with local medical and allied specialists in private practice and regional (OECS, the Caribbean Community [CARICOM]) partnerships for medical and nursing staff and consultants as well as for delivering training via on-line videoconferencing and other technologies. In addition, partnerships with nonprofit and corporate entities, including the media, can strengthen the health promotion efforts of the MOH.

PHARMACEUTICAL MANAGEMENT RECOMMENDATIONS

- **Prioritize the hiring of inspector(s):** Legislation and regulation for pharmaceutical management and personnel are only as effective as the ability to enforce the legislation. The hiring of an inspector is essential for the Pharmacy Council to establish a separate and dedicated entity for enforcement. The funding and approval of this post requires other agencies to understand the urgency of filling this position. High-level leadership inside the MOH should advocate with the cabinet and Ministry of Public Service to allow for more effective enforcement of legislation and ensure the quality of medications available.
- **Reduce approvals needed for laboratory purchases:** The authorizations to purchase reagents and make repairs to laboratory machinery pass through too many layers, resulting in stock-outs on reagents and downtime on machinery. These issues can cause delays in getting test results for patients, making patients less likely to return for the results (particularly for HIV tests) and take action to improve their health. Streamlining the budget approval process for these specific items can increase the efficiency of the public laboratory's work and ensure continuous testing.
- **Develop formal mechanism for coordinating with and/or procuring from private sector to mitigate reagent stock-out:** The local laboratories already coordinate informally to share resources when stock-outs of reagents occur or lab equipment malfunctions. Formalizing this relationship through a Memorandum of Understanding (MOU) that incorporates an agreed-upon price schedule for such services could relieve stock-outs in the short term. This type of MOU could also be developed with private pharmacies or distributors as a formal backup to the Pharmaceutical Procurement Service should the delayed shipments become worse. The MOU could produce more economies of scale by purchasing in conjunction with one of the larger pharmacy chains on the island, thereby reducing the unit price overall.

HEALTH INFORMATION SYSTEMS RECOMMENDATIONS

- **Develop regional partnership for technical support on the Saint Lucia Health Information System:** Saint Vincent and the Grenadines have acquired and are implementing the same software system (ACSiS) for their electronic HMIS backbone. Both Saint Lucia and Saint Vincent have very limited staff for development, training, implementation, and technical support. Leveraging human/technical resources across the two countries would potentially reduce their individual burdens; this has added urgency before the MOH brings the NNH online with the Saint Lucia Health Information System (SLUHIS).
- **Leverage the SLUHIS to engage the private health sector:** Minimal data on routine health services are being provided to the MOH by the private sector. The cost of acquiring the SLUHIS software has already been paid, so no ongoing licensing costs are required. The MOH could potentially offer the SLUHIS software for free to private sector providers as a means of incentivizing them to report data to the MOH. An initial dialogue should be facilitated to ascertain the private sector's interest in such an arrangement, while also identifying the data that private providers would like to receive.
- **Initiate dialogue with private sector providers around telemedicine opportunities:** There are numerous specialty areas that are largely under-resourced in Saint Lucia, due in part to the absence of a sufficient patient base to support a full-time, on-island provider. Psychiatry provides a clear example of this type of need. Tapion Hospital has been utilizing teleradiology with a partner hospital based in Miami, Florida, USA. Similarly, the hospital has begun utilizing telemedicine for distance learning opportunities for its medical staff. Telemedicine presents an opportunity to initiate a public-private dialogue around common areas of interest, with an emphasis on meeting service delivery needs for the Saint Lucia health system.

The findings and recommendations of this report were validated and prioritized by the stakeholders in Saint Lucia. A summary of the workshop proceedings can be found in Annex C. Among the assessment's recommendations, the participants at this workshop identified five priority areas that would both move the planning for the NNH forward and address health systems gaps: (1) HRH Capacity Building, (2) Managing Patient Flow, (3) Quality Improvement, (4) Governance Structures, and (5) Defining the Costs of Services.

1. ASSESSMENT METHODOLOGY

Health Systems 20/20 and Strengthening Health Outcomes *through* the Private Sector (SHOPS), in collaboration with the Ministry of Health (MOH), used a combination of the Health Systems Assessment (HSA) and Private Sector Assessment (PSA) approaches to undertake a rapid assessment of the Saint Kitts and Nevis health system. The HSA approach was adapted from USAID's *Health Systems Assessment Approach: A How-to Manual* (Islam, ed. 2007), which has been used in 23 countries. The HSA approach is based on the World Health Organization (WHO) health systems framework of six building blocks (WHO 2007). The standard PSA approach has been used in 20 countries and SHOPS is currently developing a how-to guide for future assessments.

The integrated approach used in Saint Kitts and Nevis covered the six health systems building blocks: health financing, pharmaceutical management, governance, health information systems, human resources for health, and service delivery. Special emphasis was placed on the current and potential role of the private sector within and across each health system building block. Additionally, the health system's ability to support the HIV response was examined throughout each dimension.

The objectives of the assessment were to accomplish the following:

- Understand key constraints in the health systems and prioritize areas needing attention
- Identify opportunities for technical assistance to strengthen the health system and private sector engagement to sustain the response to HIV
- Promote collaboration across public and private sectors
- Provide a road map for local, regional, and international partners to coordinate technical assistance.

1.1 PHASE 1: PREPARE FOR THE ASSESSMENT

During the preparation phase, the assessment team worked with the MOH and the National AIDS Program to build consensus on the scope, methodological approach, data requirements, expected results, and timing of the assessment. Recognizing the importance of building strong partnerships among the government, donors, private sector, and nongovernmental and community organizations, team members held a preassessment workshop, in conjunction with the MOH, to meet with stakeholders. The objectives of the half-day workshop were (1) to explain the methodology to be used, (2) identify key issues for further investigation during data collection, and (3) clarify expectations for the assessment.

A team of technical specialists for priority areas identified in the stakeholder meeting was assembled. These priority areas included health financing, governance, and health information systems. The team of seven consisted of representatives from Health Systems 20/20, SHOPS, the International Training and Education Center for Health, and the Pan American Health Organization (PAHO).

1.2 PHASE 2: CONDUCT THE ASSESSMENT

The majority of health systems data was collected through a review of published and unpublished materials made available to the team by the MOH and development partners and obtained online. Team members produced a literature review for each of the health systems building blocks to develop an initial understanding of the system and identify information gaps. Semistructured interview guides were developed for each building block based on the noted information gaps, standard PSA interview guides,

and the indicators outlined in the HSA approach. The Corporate Planning Unit in the MOH assisted the team in preparing a preliminary list of key informants and documents for the assessment process.

Key stakeholders in both the public and private sector were invited to participate in key informant interviews to provide input and validate what has been collected through secondary sources. Key informants also provided additional key documents and referred the team to other important stakeholders. During the one-week data collection period, the in-country assessment team interviewed 73 stakeholders. Interviewees included representatives of government, professional associations, health training institutions, nongovernmental organizations (NGOs), private businesses, health providers, pharmacists, and many professionals from the MOH. Site visits were conducted to verify data from key informants. These visits included public hospitals and health centers, private hospitals and practices, and private pharmacies. Responses were recorded by the interviewers and examined for identification of common themes across stakeholders while in-country. The team presented a preliminary overview of the emerging findings and recommendations to the MOH prior to the team's departure.

1.3 PHASE 3: ANALYZE DATA AND PREPARE THE DRAFT REPORT

Following the in-country data collection, the assessment team transcribed the responses of the stakeholders and reviewed the additional documents collected. The lead for each building block and the private sector lead drafted a summary of the findings and recommendations for their respective areas. The team lead, together with input from the rest of the team, identified key findings and cross-cutting issues and further developed recommendations. The results were compiled in an initial draft and submitted to quality advisors in the Health Systems 20/20 project and USAID for review. A final draft was submitted to the MOH for review and approval.

1.4 PHASE 4: VALIDATE FINDINGS AND PLAN NEXT STEPS

The assessment team used the findings in the draft report to conduct a workshop at which the MOH and key local stakeholders discussed and validated assessment findings and prioritized the recommendations. Special emphasis was placed on looking at the strengths and weaknesses of the health system and the recommendations to strengthen it and the role of the private sector. The team has used the results of the prioritization to identify areas of technical assistance for USAID.

2. HEALTH SYSTEM PROFILE AND BACKGROUND

This section provides an introduction to Saint Lucia, covering basic information that will help readers understand the context in which the health system operates. Topics covered in this section include the political organization of the island, epidemiological profile, political and economic context, the business environment, and a snapshot of the key stakeholders in Saint Lucia's health system.

2.1 OVERVIEW OF SAINT LUCIA

Saint Lucia is a part of the Windward Island chain located in the Eastern Caribbean. Its neighboring islands include Saint Vincent and the Grenadines to the southwest, Barbados to the southeast, and the French territory of Martinique to the north. The 238 square-mile island of Saint Lucia is known for its volcanic peaks and lush tropical climate. Saint Lucia is divided into 11 administrative regions called quarters, with eight operational health districts, see Figure 2.1.

FIGURE 2.1: ADMINISTRATIVE DISTRICTS OF SAINT LUCIA

Number	Quarter
1	Anse-la-Raye
2	Castries
3	Choiseul
4	Dauphin
5	Dennery
6	Gros Islet
7	Laborie
8	Micoud
9	Praslin
10	Soufrière
11	Vieux Fort

Saint Lucia is the most populous of the six countries in the Organization of Eastern Caribbean States (OECS), a political and economic body joining the small developing islands in the Eastern Caribbean. Most of the population lives along the coast in the less mountainous regions of the north and south. Saint Lucians are predominantly of African or mixed African-European descent and largely Roman Catholic in faith. While English is the national language, French patois is also commonly heard, a reflection of France's early influence on the island.

Population Dynamics

Preliminary findings from the 2010 Housing and Population Census indicates a 5-percent growth in the Saint Lucia population over the 10-year period between 2001-2010, with an estimated household population of 165,595 (Ministry of Finance 2011). By contrast, the World Bank estimated the population of Saint Lucia in 2009 to be approximately 172,092, as shown in Table 2.1. The district of Castries accounted for 40 percent of the total population. While nearly three-quarters of the population lives in

rural areas, there has been a consistent movement of people toward urban areas over the last 20 years. The population has also been aging over time as the fertility rate has dropped.

TABLE 2.1: DEMOGRAPHIC INDICATORS IN SAINT LUCIA COMPARED WITH LATIN AMERICA & THE CARIBBEAN (LAC) REGIONAL AVERAGE

Health System Indicator	Source of Data	Saint Lucia	Year of Data	LAC Average	Year of Data
Population, total	WDI-2011	172,092	2009	19,520,385	2008
Population growth (annual %)	WDI-2011	1.1	2009	1.1	2009
Rural Population (% of total)	WHO-2011	72.16	2008	36.95	2008
Urban Population (% of total)	WHO-2011	27.84	2008	63.05	2008
Population ages 0-14 (% of total)	WDI-2011	26.26	2009	28.09	2009
Population ages 65 and above (% of total)	WDI-2011	6.8	2009	6.77	2009

Source: World Bank World Development Indicators (WDI) 2011 and the World Health Organization (WHO), Global Health Observatory 2011; Health Systems Database, http:/healthsystemsdatabase.org

Reproductive Health

Until the 1960s, Saint Lucia had high fertility rates and a relatively high mortality rate. Fertility rates have declined significantly, from 6.7 in the early 1960s to 1.9 in 2009 (see Table 2.2). Part of the reason for the drop in fertility has come from delaying of first pregnancies as a result of increased education for women, increased family planning interventions, and increased socioeconomic status. Although teen births have decreased significantly over the years, teenage pregnancy remains a challenge for the country. In 2009, the adolescent fertility rate was 59.5 births per 1,000 women aged 15-19, which is below the Latin America and the Caribbean (LAC) average of 72.5, but well above the average 28.6 births per 1,000 for an upper middle-income country.

TABLE 2.2: REPRODUCTIVE HEALTH INDICATORS IN SAINT LUCIA COMPARED WITH LATIN AMERICA & CARIBBEAN (LAC) REGIONAL AVERAGE

Health System Indicator	Source of Data	Saint Lucia	Year of Data	LAC Average	Year of Data
Contraceptive prevalence (% of women ages 15-49)	WDI-2011	47	1998	74.7	2009
Total fertility rate (births per woman)	WDI-2011	1.9	2009	2.2	2009
Pregnant women who received 1+ antenatal care visits (%)	UNICEF Childinfo	99.2	2005	95.01	2009

Source: World Bank World Development Indicators (WDI) 2011 and the World Health Organization (WHO), Global Health Observatory 2011; Health Systems Database, http:/healthsystemsdatabase.org

HIV and AIDS

Through the end of 2009, the national registry recorded 760 cases of HIV in Saint Lucia; however, seroprevalence data on HIV/AIDS are not available. In the 2010 Country Progress Report for the United National General Assembly Special Session on HIV/AIDS (UNGASS), the National AIDS Program Secretariat (NAPS) used the national register to estimate prevalence at 0.28 percent based on reported cases and deaths (Day 2008). However, it is recognized that this figure is likely to be greatly underestimated. As of 2008, 36 percent of the general population had been tested for HIV within the previous 12 months and knew their results (Jules et al. 2009). Saint Lucia's epidemic is believed to be concentrated among certain high-risk groups and to have low prevalence among the general population. The main route of transmission is believed to be heterosexual intercourse through various forms of transactional sex: sex in exchange for support or gifts, sex for drugs, and sex for money. It is also believed that men who have sex with men (MSM) and men who have sex with men and women (MSMW) are particularly vulnerable. Over time, the ratio of male-to-female cases of HIV have evened out (58 percent/42 percent) and recent data show that HIV incidence is higher among men than women. Most of the Caribbean region, however, has experienced higher incidence among women. Data on most at-risk populations are lacking. Data available from the NAPS show 17 percent of crack cocaine users were tested and know their results. No data were available on commercial sex workers, and 100 percent of surveyed MSM had been tested within the last 12 months and know the results (Jules et al. 2009). (The MSM figure may not be reflective of trends in the wider community given the NAPS challenges in reaching MSM). The MOH believes that most cases are undiagnosed as a significant number of cases reporting are in advanced stages, but no data are available for estimated number of people needing treatment. As of 2009, there were 124 people on antiretroviral therapy drugs (ARVs), but the NAPS does not have a model available to determine what proportion of those needing treatment this figure represents.

Causes of Morbidity and Mortality

Life expectancy in Saint Lucia had gradually increased since the 1960s, but recently has experienced a slight decline, likely attributable to the rise in noncommunicable diseases (NCDs). In 2002, life expectancy at birth was 74 for the population (72 for males and 76 for females). The latest available data from 2005 show a slight decline in life expectancy among men, currently at 70 years and total population life expectancy at 73. Mortality indicators are shown in Table 2.3.

TABLE 2.3: MORTALITY INDICATORS IN SAINT LUCIA COMPARED WITH LATIN AMERICA & CARIBBEAN (LAC) REGIONAL AVERAGE

Health System Indicator	Source of Data	Saint Lucia	Year of Data	LAC Average	Year of Data
Life expectancy at birth, total (years)	WDI-2011	72.74	2005	73.59	2009
Mortality rate, infant (per 1,000 live births)	WDI-2011	18.8	2009	18.92	2009
Mortality rate under five (per 1,000 births)	WDI-2011	19.8	2009	22.55	2009
Maternal mortality ratio (per 100,000 live births)	IHME-2010 WDI-2011	46.8	2008	103.46	2008

Source: World Bank World Development Indicators (WDI) 2011 and the World Health Organization (WHO), Global Health Observatory 2011; Health Systems Database, http:/healthsystemsdatabase.org, Institute for Health Metrics and Evaluation (IHME) 2010.

Saint Lucia has been successful in combating many infectious diseases and today chronic diseases dominate the top causes of mortality (see Table 2.4). Based on available data, the most common causes of illness and death are diabetes, heart disease, and cancer, and this emphasizes the need to focus on healthy lifestyles promotion. Nonhealth-related causes such as assault and traffic accidents accounted for the greatest number of potential life years lost in 2003 for men.

TABLE 2.4: TOP CAUSES OF MORTALITY IN SAINT LUCIA, 2005

PRINCIPAL CAUSE OF DEATH	2005	
	Rank	Total
Diabetes	1	93
Hypertensive iseases	2	86
Heart failure & complication, ill-defined heart diseases	3	80
Cerebrovascular diseases	4	79
Ischemic heart diseases	5	75
Influenza and Pneumonia	6	43
Ill-defined and unknown	7	36
Chronic lower respiratory diseases	8	35
Malignant neoplasm of the digestive organs	9	30
Malignant neoplasm of the prostate	10	30

Source: Ministry of Health, Epidemiology Unit: Health Situation and Trends – 2005.

2.2 POLITICAL AND MACROECONOMIC ENVIRONMENT

Saint Lucia became independent from Britain in 1979. In addition to the British, the Dutch and French also tried to gain control over the island from the native Arawak tribes. British rule began in 1815, and during the 20th century Saint Lucia experienced gradual gains in self-government until its independence. The Queen of England, however, remains the official head of state.

The government is a bicameral, parliamentary democracy based on British model. Queen Elizabeth as head of state appoints a governor general as her local representative, which is mostly ceremonial. The prime minister, currently Mr. Stephenson King, and his cabinet lead the country. The House of Assembly is composed of 17 members. The prime minister is appointed by the governor general from among the members of the House, generally from the majority party. The House of Assembly is elected by popular vote. The Senate consists of 11 members appointed by the governor general. The major parties in the country are the United Workers Party and the Saint Lucia Labour Party. The current prime minister was appointed to the position in May 2007 when the then Prime Minister Sir John Compton fell ill and was no longer able to fulfill the post. Previously, Mr. King was the Minister of Health and Labor relations.

Saint Lucia has a market economy and is a member of two important regional bodies: the Caribbean Community (CARICOM) and OECS. These entities play a vital role in developing policy (including health) and are often the recipients of resources or technical assistance on behalf of their member countries in the region.

Tourism is the main source of income and the island's largest employer. Saint Lucia's location, in addition to being advantageous for tourism, also allows for easier ocean access for export compared to islands surrounded by the Caribbean Sea. Saint Lucia is located among the higher traffic trade routes along the Atlantic coast between the Americas and Europe. Banana production is a major revenue source, although it has been declining in recent years due to the loss of preferential trade agreements

with the European Union. Farmers are being encouraged to diversify their crops. Saint Lucia has the most diverse manufacturing sector in the Eastern Caribbean area.

Like most small-island developing economies, Saint Lucia's economy is extremely vulnerable. The main sources of revenue are highly susceptible to fluctuating exchange rates. Natural disasters like hurricanes threaten both the agriculture and tourism industries and, as an island with limited manufacturing, importation increases the expense of doing business in the country. The effects of the global financial crisis that began in 2008 continue to hurt Saint Lucia and the rest of the Caribbean. Although Saint Lucia experienced a decrease in economic growth in 2009, preliminary reports in the 2010 Economic and Social Review show an increase in real gross domestic product (GDP) growth in 2010. Hurricane Tomas struck the island in October 2010, causing severe damage to roads, crops, and many parts of the country's infrastructure. Saint Lucia is expecting growth throughout 2011 partially driven by ongoing reconstruction. Table 2.5 illustrates how Saint Lucia's economic indicators compare to the regional average.

TABLE 2.5: ECONOMIC INDICATORS IN SAINT LUCIA COMPARED WITH LATIN AMERICA & CARIBBEAN (LAC) REGIONAL AVERAGE

Health System Indicator	Source of Data	Saint Lucia	Year of Data	LAC Average	Year of Data
GDP per capita (constant 2000 US$)	WDI-2011	4,774.00	2009	4,823.00	2009
GDP growth (annual %)	WDI-2011	-3.84	2009	-2	2009
Per capita total expenditure on health at international dollar rate	WHO	677	2008	787.54	2009
Private expenditure on health as % of total expenditure on health	WHO	41.2	2008	43.36	2008
Out-of-pocket expenditure as % of private expenditure on health	WHO	94.6	2008	68.78	2009
Gini index	CDB-2008, WDI-2010	42.6	2005/6	51.28	2007

Source: World Bank World Development Indicators (WDI) 2011 and the World Health Organization (WHO), Global Health Observatory 2011; Health Systems Database, http:/healthsystemsdatabase.org; Caribbean Development Bank (CDB) Country Poverty Assessment 2008.

Saint Lucia is considered an upper middle-income country by the World Bank and ranked "high" on the human development index, but national averages hide inequities. A Caribbean Development Bank poverty assessment in 2005 found 28.8 percent of the population was living in poverty, up from 25.1 in 1995. Indigence has decreased from 7.1 to 1.6 percent over the same period (Kairi Consultants Limited 2008). Poverty is concentrated in rural areas with many rural quarters having more than 35-percent poverty: Anse-la-Raye, 44.9 percent; Soufriere, 42.4 percent; Choiseul, 38.4 percent; Laborie, 42.1 percent; and Micoud 43.6 percent. Growing inequities in rural areas are likely a response to the decline of the banana industry, which was largely based in the rural areas. Poverty in Saint Lucia also disproportionately affects the young. The 2010 Economic and Social Outlook estimated unemployment to be 20.6 percent.

2.3 BUSINESS ENVIRONMENT AND INVESTMENT CLIMATE

With the decrease of preferential trade agreements, Saint Lucia struggles to compete on the international market because the cost of goods and services is often much higher due to small economies of scale and the remoteness of the island. The government has focused on diversifying the

economy with the decline of the banana industry. In recent years, tourism, petroleum storage, and transshipment have attracted more business, mainly due to the presence of an educated workforce and infrastructural improvements in areas such as roads, communications, water supply, and sewage and port facilities. The stability and low inflation rate of the Eastern Caribbean dollar is also attractive.

The Heritage Foundation (2010) ranks Saint Lucia 26th in the world and second in the region for having the most economic freedom. The country is above average in business freedom, freedom from corruption, and monetary freedom. The government and regulatory environment generally fosters private sector development and is efficient and transparent, although tax rates are relatively high at a 30-percent corporate tax rate. The perceived barriers to business are tariff and nontariff barriers and limited access to financing. The average tariff rate in 2007 was 7 percent, and import bans and restrictions, import fees, and paper-based import/export licenses add to the cost of doing business. Currently, the country does not have a value-added tax, but there are proposals to establish one. Credit to the private sector has grown in recent years but financial access remains a challenge. A large portion of the population does not use the formal banking sector.

The government of Saint Lucia has made efforts to encourage private business. In 1998, the government established the Office of Private Sector Relations (OPSR) to promote private sector development, particularly in response to the decline of the banana industry, and to create a forum for dialogue. The European Community has helped finance this effort and continues to do so through its Private Sector Development program. OPSR, which sits within the prime minister's office and has significant autonomy for its work, has nine staff members and provides technical assistance grants to businesses, capacity building for business associations, and institutional strengthening for government agencies to work with the private sector. The office also underwrites research and sponsors legislation to improve the business environment. OPSR has primarily focused on increasing tourism since this is where the economic growth has been seen in Saint Lucia; health tourism is a component of that focus. In the past, OSPR has provided grants to dentists and to Tapion Hospital to purchase new equipment, hire staff, and remodel. OSPR is encouraging dialogue between the medical colleges, medical professionals, and hotels to work together to build the health tourism industry.

Saint Lucia also offers a number of financial incentives to investors. The Financial Incentives Act of 2005 allows for tax holidays for manufacturing enterprises, tax relief on exports outside of CARICOM, and duty-free concessions on imports of machinery and raw materials. The Tourism Incentive Act also provides for tax concession for construction of hotels and other capital expenditure write offs.

2.4 HEALTH SYSTEM OVERVIEW

The health sector in Saint Lucia is a mix of public and private sector. The contributions of the private sector, however, are not as well-known or well-documented as in the public sector. It is estimated that the public sector only provides half of the primary care in the country but 90 percent of secondary care (Barrett 2011). The public health sector is organized into eight health regions delivering services through a combination of health centers, district hospitals, a polyclinic, pharmacies, and two general hospitals. As envisioned, polyclinics would provide a higher level of services than health centers, such as laboratory, x-ray, and after-hours services. One of these two hospitals, Saint Jude Hospital, located in Vieuw Fort on the southern coast, is a parastatal entity. The main hospital, Victoria Hospital, located in Castries in the north, serves as the base for the HIV program, which has rotating clinics that go out to four health centers/district hospitals each week. The New National Hospital (NNH) is under construction and was designed to provide quality health care services to all clients in an efficient manner. The NNH is currently slated to open in the second quarter of 2012. It was anticipated under the National Strategic Plan for Health 2006-2011 (NSPH) that Victoria Hospital would be converted to a polyclinic and the district hospitals upgraded to polyclinics when the NNH opens. However, the two efforts have not proceeded in tandem.

The private sector provides services at all levels, as is described in detail in the Service Delivery Section (5.3) below. The private sector has doctors providing primary care, many of whom also work in the public sector. The private sector also operates polyclinic/clinic-type services (including outpatient services at hospitals and medical centers), pharmacies, laboratories, and a general hospital. HIV care and treatment services are known to be provided by private doctors, particularly at Tapion Hospital. NGOs, such as the Blind Welfare Association and Planned Parenthood, also provide targeted health services.

In terms of financing, the MOH and the National Insurance Corporation (NIC) provide the main revenue streams for the operation of public health services. Currently, limited data are available on the amount of money spent in the private sector and on the number of people with private health insurance. There are, however, a number of private insurance providers, privately run corporations, and hotels that contribute to wellness and insurance plans for their employees (see the Health Financing and Private Sector sections).

The MOH has been trying to undertake health sector reform for over a decade. The NSPH outlines the vision of health reform and guides health policy. As described in the NSPH, the MOH envisions itself moving away from the delivery of services toward a role of coordination, regulation, and evaluations. The reform was prompted by concerns of poor management of services at health clinics, which had been decentralized in the 1980s to increase access to service at the community level per the Alma Ata Declaration. Although services were decentralized, management authority was maintained centrally and services were not meeting the demands of the local communities. The NSPH outlines a plan for greater community participation, greater administrative power and authority to regional health area managers, greater intersectoral collaboration, increased evidence-based decision making, and quality improvement.

In the early 2000s, the government of Saint Lucia also pursued Universal Health Care (UHC) as a means to ensure all people have access to services regardless of ability to pay and to ensure the quality of services. Access to health care prior to reform was uneven with the distribution of services skewed toward urban areas. UHC was also explored as a better way to finance the public health system because users seemed willing to pay for quality services through premiums but appeared more resistant to paying cash on delivery of services.

The health system is currently overwhelmed with priorities. It is facing the impending opening of the NNH, which will require strong health systems for support; however, the core components of the NSPH to strengthen the health system have not been implemented. Many decisions have yet to be made surrounding the opening of the NNH, including staffing and management structure. The MOH has been faced with several human and financial challenges that have hampered its ability to take action on key decisions. The rise of chronic disease is putting a large burden on the health system at a time when resources are more limited. The MOH must also find a means to sustain HIV program funding as donor funding for HIV programming has ended.

2.5 DONOR COORDINATION

Donors, while limited, have made major contributions to the health sector in Saint Lucia, particularly in financing the construction of new facilities such as the European Commission (EC)-funded NNH and the National Mental Wellness Center supported by China and Taiwan (albeit at different stages). Saint Lucia has developed a system for coordinating donor funds; however, this process is primarily used for capital investments and not for technical assistance.

2.5.1 COORDINATION PROCESS

Saint Lucia has relied heavily on creditors and donors to achieve many of its development goals. Major contributions from donors, particularly for capital investments, are coordinated by the Ministry of Finance (MOF), within the Economic Affairs and National Development departments. The MOF

produces a national development plan that identifies priority sectors and then pursues donors based on those priorities.

Once the Department of National Development identifies donors who can assist the government in its priorities, the Department of Economic Affairs coordinates the donors to ensure there is no duplication of investments. Economic Affairs identifies a focal person within the relevant ministries to report back and encourages donors to coordinate their reporting processes to follow the quarterly reports required by the MOF. Donor-required reports are reviewed by Economic Affairs but are written by the line ministries themselves. It is important to note that technical assistance for health from governments through bilateral aid is coordinated through MOF; however, when technical assistance (and not funding) comes from a regional entity such as PAHO, this coordination is often done directly by the MOH and then reported back to the MOF.

2.5.2 DONOR CONTRIBUTIONS

The Caribbean Development Bank (CDB) is a major crediting partner for Saint Lucia. CDB is currently contributing to the development of the electronic national health management information system (HMIS), providing both funding and technical assistance through project management. CDB has also facilitated the rehabilitation of 14 health centers, including components that will support the rollout of the national HMIS. The EC is also a major funder. The EC has financed the building of and equipment for the NNH and health sector reform studies in previous agreements under the European Development Fund (EDF). The current EDF, EDF 10, makes major investments in private sector development outside of health. From 2004-2010, Saint Lucia received a US$6.4 million loan to fund its HIV program from World Bank. The World Bank loan focused on advocacy and policy development, care for people living with HIV (PLHIV), prevention, and the strengthening of national capacity to deliver an effective multisectoral response. In 2007, donor funding, largely from this World Bank loan, covered 78 percent of AIDS expenditures (UNAIDS 2008).

During the interviews for this health system and private sector assessment, the donor database at the Ministry of Economic Affairs had not been functional for some time and current Saint Lucia estimates of funding were not available (available donor data from donor websites is provided in Table 2.6).

Many of the development partners working in Saint Lucia do so through regional mechanisms, such as donating to the CDB,as the Canadian International Development Agency – CIDA has done, or through the United Nations Development Program based in Barbados. Saint Lucia also has received funding through the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) as part of Round 9 with the Pan Caribbean Partnership Against HIV/AIDS (PANCAP) and Round 3 with the OECS. Through the United Nations Population Fund, Saint Lucia has benefited from regional programs on HIV/AIDS prevention (2004-2006), sexual and reproductive health programs for youth (2002-2007), and general population and development strategies to improve data collection and advocacy. The United States Governments (USG) supports Saint Lucia health sector through the U.S.-Caribbean Regional HIV and AIDS Partnership Framework 2010-2014 (Framework). Saint Lucia is one of twelve Caribbean countries signed on to the Framework was developed with twelve Caribbean countries.[2] A major goal of the Framework is to move the region toward greater sustainability of HIV/AIDS programs. Support is primary through technical assistance. Each USG agency focuses on a particular aspect of the Framework, with USAID mainly supporting health systems strengthening, particularly health financing, and private sector engagement. The Centers for Disease Control and Prevention focuses on laboratory and health information systems strengthening; the Health Resources and Services Administration focuses on human resources for health and capacity building, the Department of Defense supports HIV prevention

[2]The twelve Partnership Framework countries are Antigua and Barbuda, the Bahamas, Barbados, Belize, Dominica, Grenada, Jamaica, St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines, Suriname, and Trinidad and Tobago.

activities; and Peace Corps supports individual and institutional capacity building for prevention programs.

Based on the Saint Lucia government's report to UNAIDS, in 2007 the government spent US$166,380 (or 22 percent of HIV spending) from domestic sources on HIV programming while US$605,638 (or 78 percent of HIV spending) was spent from donor funds. The majority of government funds, 58 percent, went toward HIV prevention efforts in 2007, while 18 percent went to program management, 10 percent went to care and treatment services, 10 percent went to orphans and vulnerable children's services, and 4 percent went to research.

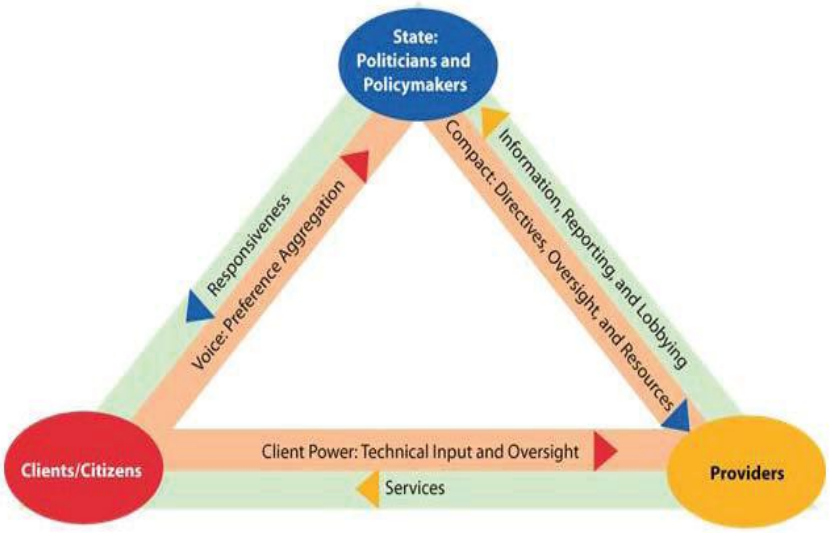
TABLE 2.6: RECENT DONOR CONTRIBUTIONS FOR HEALTH PROJECTS

Donor	Timeframe	Amount	Type of Aid
Caribbean Development Bank (through Basic Needs Trust Fund/Social Development Fund, includes support by CIDA)	2002-2010	4,450,813 USD	Financing – grants available for community groups to support poverty reduction programs including emphasis to support PLHIV
World Bank	2004-2010	6,400,000 USD	Financing – loan for HIV/AIDS program
European Commission	1990-1995 EDF 7 1995-2000 EDF 8 2000-2007 EDF 9	2,900,000 Euros EDF 7 5,400,000 Euros EDF 8 4,050,000 Euros EDF 9	Financing – EDF 7 -- feasibility studies and health sector reform studies; EDF 8 – hospital construction; EDF 9 -- health and completing new hospital
PAHO			Technical assistance
Taiwanese and Chinese governments	2005-2009	~ $6,000,000 USD	Financing – consturction of a new wellness and mental health center. Project was initiated under the Chinese government but change of party in Saint Lucia in 2007 resulted in switched alliances to Taiwanese.
USAID – PEPFAR	2010-2014		Technical assistance for HIV/AIDS programs, health systems strengthening, private sector partnerships building, anti-stigma policies, human resources capacity building, monitoring and evaluation

3. GOVERNANCE

The quality of overall governance in a country directly affects the environment in which health systems operate and the ability of government health officials to exercise their responsibilities. Effective governance for health is the ability to competently direct resources, manage performance, and engage all stakeholders toward improving the population's health in ways that are transparent, accountable, equitable, and responsive to the public. The success of health interventions requires not only instituting effective policymaking but also ensuring that the process is transparent, accountable, equitable, and responsive to all stakeholders. The section on governance examines a variety of factors among the three primary actors in the health sector – the state, health providers, and citizens (as presented in Figure 3.1 below) – and proposes strategies to improve health governance.

FIGURE 3.1: PRIMARY ACTORS IN HEALTH GOVERNANCE



Source: (Brinkerhoff and Bossert 2008)

3.1 OVERVIEW OF GOVERNANCE IN SAINT LUCIA

As an independent state, Saint Lucia ranks relatively well on the World Bank governance indicators, both globally and within the Caribbean region. In particular, the country has made significant progress since 1998 in voice and accountability and government effectiveness but has made only moderate progress on regulatory quality (see Table 3.1). Regionally, Saint Lucia also ranked well compared to other eastern Caribbean states on the Worldwide Governance Indicators in 2009, particularly in voice and accountability, government effectiveness, and control of corruption. The World Bank Worldwide Governance Indicators are composite indicators that draw on a wide variety of sources to score six different elements of governance. Percentiles show the percentage of countries in the world that scored lower than Saint Lucia on the selected indicators and are shown in Table 3.1.

TABLE 3.1: SAINT LUCIA PERCENTILE RANK (0-100) AMONG ALL COUNTRIES FOR GOVERNANCE INDICATORS

Governance Indicators	1998	2004	2009
Voice and Accountability	81.7	69.7	91
Political Stability	55.3	93.3	72.6
Government Effectiveness	47.1	64.1	78.1
Regulatory Quality	60	60	65.7
Rule of Law	41.4	71	75
Control of Corruption	60.7	62.6	86.2

Source: http://info.worldbank.org/governance/wgi/sc_chart.asp

[1] Country's Percentile Rank among all countries in the world, 100 is the highest score, 0 the lowest.

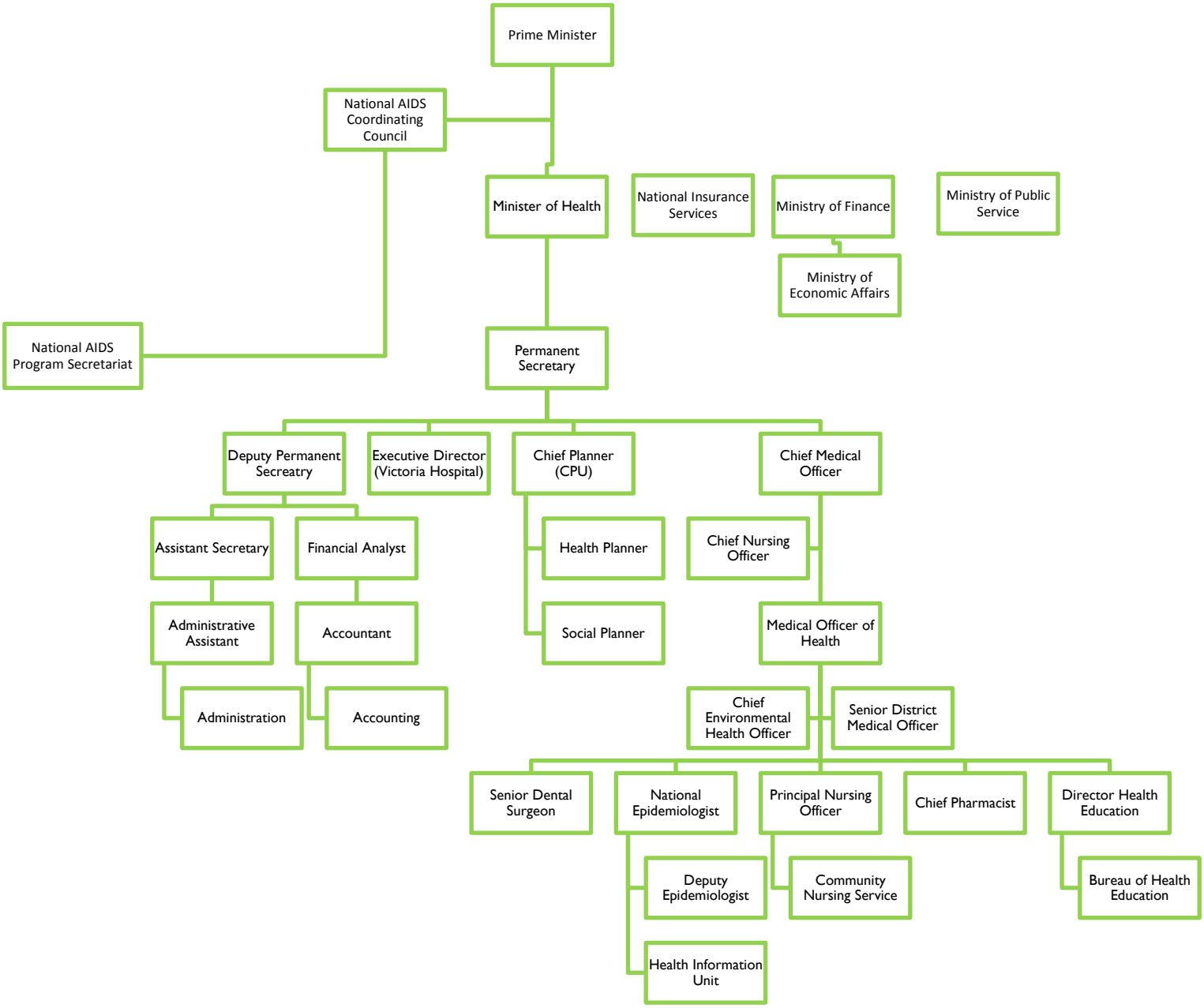
3.2 OVERVIEW OF MINISTRY OF HEALTH GOVERNANCE

3.2.1 MOH STEWARDSHIP ROLE AND STRUCTURE

The MOH holds the responsibility for public health. The MOH provides, finances, and regulates health services and sets public health policy, but does not have the autonomy to make decisions or manage these issues on its own. The MOH must work in tandem with the Ministry of Public Service (MOPS) for human resources issues and the MOF for budget issues and must seek approval from the cabinet for changes in the structure of the ministry.

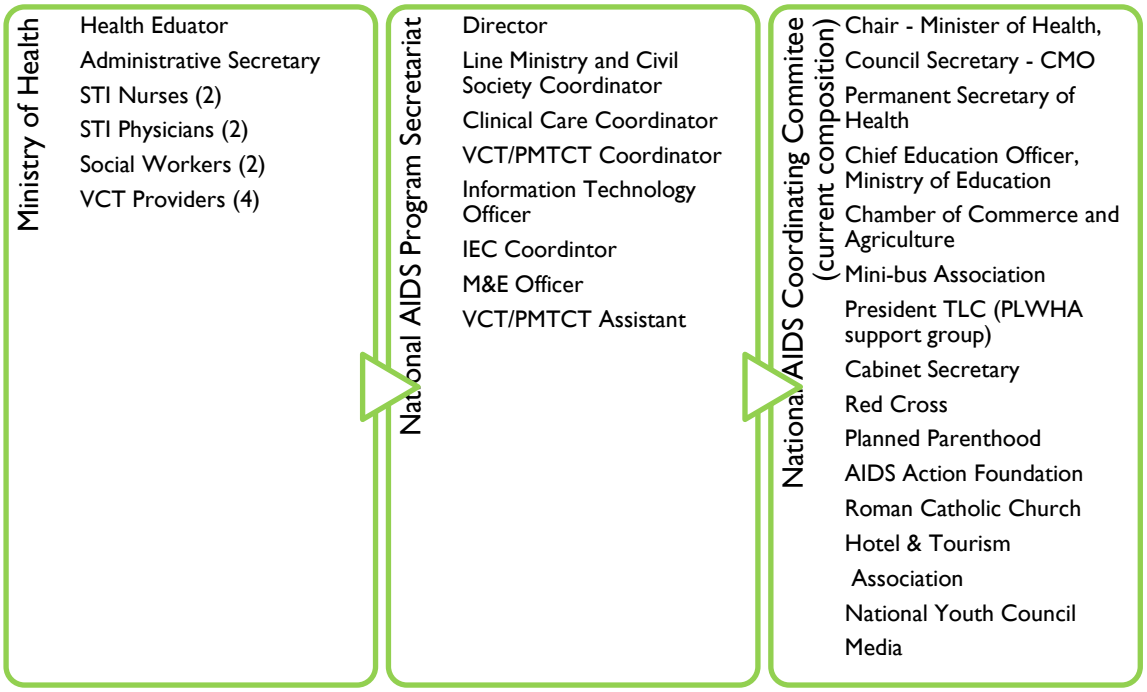
The MOH regulates the sector through the Public Health Board, the General Nursing Council, the Medical and Dental Council, and the Pharmacy Council. The permanent secretary has general oversight over all programs and serves as the chief accounting officer. Program development and health planning fall under the direction of the chief health planner, within the Corporate Planning Unit. The delivery of primary and public health services falls under the chief medical officer. Although the MOH currently is the main provider and financer of the health sector, its strategic vision is to reduce its role as a health services provider and act more as a coordinator and regulator. Figure 3.2 provides an overview of the structure of the MOH.

FIGURE 3.2: MINISTRY OF HEALTH STRUCTURE



The National AIDS Coordinating Committee (NACC) was established in 2005 to have oversight of the National AIDS Program; it is officially headed by the prime minister, chaired by the minister of health, and has 40-percent private-sector membership. Figure 3.3 depicts the organization structure and membership of the National AIDS Program. The private sector portion includes representatives from the Red Cross, Planned Parenthood, the Catholic Church, and the Hotels and Tourism Association (Jules et al. 2009).

FIGURE 3.3: SAINT LUCIA AIDS RESPONSE ORGANIZATIONAL STRUCTURE



Source: 2010 UNGASS Country Progress Report, MOH St. Lucia

The NAPS was established in 2005 and became fully functional in 2006 to implement the decisions of the NACC. Its purview extends beyond that of the MOH to encompass oversight of the full, multisectoral national response. The NAPS is the functioning secretariat and is headed by a director as a unit within the MOH. The current national strategic plan expired in 2009 (period 2005-2009).

3.2.2 HEALTH REFORM PRIORITIES – NSPH AND UHC

Health sector reform has been an MOH priority for more than a decade. The government has had responsibility for policy, regulation, financing, and service provision but has not been able to perform all of these tasks adequately (Health Sector Reform Secretariat 1998). The government has been hampered by financial constraints, changing epidemiological profiles, increased public expectation on the level of health care available due to increased technology globally, escalating health care costs, and limited human resources. In light of these issues, the government undertook a long, consultative process to develop two major initiatives: UHC and the NSPH.

The idea for UHC was first raised in 1996 when a bill was passed to allow for social health insurance (ILO 2003). User fees in both the public and private sector for certain services appeared to limit access to secondary and tertiary services, particularly because so few users had access to other financing mechanisms such as private health insurance. National health insurance has been viewed as a better funding mechanism as opposed to patients paying on a fee-for-service basis. A task force was established to discuss options for a national health insurance plan in 2002. UHC has recently been proposed as a supplementary financial mechanism to cover the costs of hospitals and pharmaceuticals while the Consolidated Fund would provide resources for other aspects of the sector. However, the details of how such a plan would be financed are still under discussion.

The second major initiative was the NSPH. The NSPH outlines the vision of health reform and policy. It was created through a year-long consultative process with all stakeholders, including both the public and private sector. This plan was the culmination of stakeholder engagement with public and private sector

actors at all levels and research by various international and regional experts that had taken place since the late 1990s as a part of health sector reform. The process resulted in important decisions for the future role of the MOH and other actors in the sector. As described in the NSPH, the MOH envisions moving away from the delivery of services role toward a stewardship role of coordination, regulation, and evaluation. By allowing more autonomy for management at the facility and regional levels, the MOH believed services would improve, be more responsive to community needs, and allow MOH officials to spend more time in regulation and policy planning. Seven strategic directions were identified in the NSPH:

1. Strengthen the organization and management of health and social services
2. Improve and sustain the health gains and well-being for all residents
3. Achieve greater equity, cost-effectiveness, and efficiency in the allocation and use of health resources
4. Ensure a cadre of well-trained and motivated staff
5. Develop an effective health information system to support evidence-based planning
6. Ensure an effective quality improvement system to monitor standards and hold stakeholders accountable
7. Improve health infrastructure to support health reforms (including restructuring of facilities to become polyclinics).

Stakeholders also identified key strategies to effectively implement the plan, which, in addition to the directions listed above, included greater community participation, decentralization, intersectoral collaboration, and technology assessments. As part of strategic objective 3, the stakeholders identified UHC as an efficient mechanism for improved health financing.

The NSPH articulates a broad vision for the MOH to be "the nation's leader in facilitating optimal wellness within the entire population." Within this broader vision, the ministry explicitly prioritizes 12 health areas (Table 3.3).

TABLE 3.3: PRIORITY HEALTH AREAS IDENTIFIED IN THE NHSP

Health Priorities
1. Communicable diseases (includes Dengue, Leptospirosis, TB, and HIV/AIDS/STIs)
2. Noncommunicable diseases (includes cancer, diabetes, and hypertension)
3. Sexual and reproductive health
4. Child and adolescent health
5. Environmental health
6. Oral health
7. Emergency medical services
8. Mental health and substance abuse
9. Food and nutrition
10. Violence and injury
11. Eye health and disabilities
12. Social protection

Source: National Strategic Plan for Health 2006-2011

The NSPH vision, however, has never come to full fruition. Within the MOH, the Corporate Planning Unit (CPU) has taken the lead in defining a plan for health systems strengthening (HSS) based on the NSPH. The leadership capacity at the ministry and the government level has not been forthcoming to carry out its goals for HSS. The CPU, and more broadly the MOH, does not have the autonomy necessary to fully monitor or mobilize resources, which requires approval from other ministries. These other ministries include Finance, Public Service, and the cabinet. Initial delays in implementation of the NSPH activities stemmed from the change in political administration and further delays in MOPS approvals and/or lack of funding for key positions. Interviews during the assessment indicated that since the development of the NSPH in 2006, there have been a number of implementation challenges related to limited government resources – human, institutional and financial – and competing political priorities outside of health. The result is that the CPU has had a well-developed plan for HSS since 2006 that has only been partially implemented, important posts have gone unfilled due to budget restrictions or long approval processes, and decision making concerning the most looming issue the MOH faces has been paralyzed (i.e., the opening of the NNH). The longer term policy decisions such as human resources management and decentralization have been sidetracked, despite their importance in supporting the operationalization of the NNH and protecting the drainage of resources away from the rest of the public health system. In addition, Saint Lucia is still recovering from Hurricane Tomas, which struck the island in late 2010.

Because of the delays in implementing key components of the NSPH, stakeholder engagement with the process has ceased. The CPU has continued to facilitate the implementation of the strategic plan activities in addition to supporting the activities related to the opening of the NNH. It was unclear to private sector stakeholders who were interviewed for this assessment what services will be provided at the new facility, but many feared the services would duplicate services already available in the private sector. Many private sector stakeholders interviewed feel that their participation in the NSPH development process was not valued and they were somewhat hesitant to reengage in dialogue. The distrust toward future partnerships with the MOH is an obstacle that will need to be overcome to ensure that the MOH can staff, operationalize, and provide services efficiently for the NNH, the NSPH, and UHC in partnership with the private sector.

3.2.3 HEALTH SYSTEM STRENTHENING AND REFORM CAPACITY

The success of HSS activities, to some extent, depends on the capacity of the organizations that are aimed at strengthening health systems. The MOH has shown that it can successfully deliver health services, as demonstrated by health coverage and utilization rates. However, delivering services is only one part of the HSS process. HSS requires that the full complement of appropriate enablers is present, including leadership, research, technical assistance, training, an effective advocacy mechanism, and a standards-setting body.

The internal capacity for research in Saint Lucia is weak; however, the MOH has been able to leverage donor opportunities and its membership in the OECS, CARICOM, and the Commonwealth of Nations Secretariat to provide evidence for its HSS and health reform activities. Donors like the EC have also made major contributions, including the analysis prior to the writing of the last national strategic plan in which HSS was one of the main components. Regional entities such as PAHO, the Caribbean Health Research Council, and the Caribbean Epidemiological Center (CAREC) are also valuable research partners. The MOH has shown its ability to create a framework for data collection and needs more resources to make the data more complete. The rollout of the electronic national HMIS will add to this ability. Currently, the use of the data produced in Saint Lucia is a weakness in the health system. Data are not regularly analyzed for use in the decision-making process by policymakers and available data are not shared in a manner that polic makers can effectively use in making decisions. This challenges stems, in large part, from the low number of staff available to engage in data analysis.

CPU staff have the competency for HSS analysis and implementation; however, there are many challenges that inhibit the rate at which the health reform recommendations can be implemented. Limitations of human resources capacity have hampered the rate of implementation of reform activities. The capacity of the MOH needs to be strengthened with the introduction of a quality coordinator, a legal advisor, and a Human Resource Department in order to achieve the objectives of the NSHP.

Saint Lucia has limited access to health policy and economics experts both locally and regionally. NGOs, such as the Diabetes and Hypertensive Association, Planned Parenthood, and the Blind Welfare Association, provide strategic partnerships, mostly in service delivery and advocacy. Training in areas like health economics or health policy does not exist on the island. The Sir Author Lewis Community College and new partnerships with the American International Medical University provide opportunities for nursing and medical training, respectively, but limited opportunities for public health, as will be described in the Human Resources Section 6.5.2 . The University of the West Indies does offer these types of courses for the region and PAHO has been supporting e-governance programs.

3.3 POLICY ENVIRONMENT

Saint Lucia has recently revised many outdated pieces of legislation to reflect the changing health context. The cornerstone piece of legislation governing the health sector, the Public Health Act of 1975, was revised in 2001. The Public Health Act established the role of the MOH and its core function. Updates to the Medical Registration Act, Mental Hospitals Act, Public Hospitals (Management) Act, and the Registration of Nurses and Midwives Act were also made in 2001. In 2003, the Pharmacy Act established the Pharmacy Council with a mandate to regulate the pharmaceutical sector. The Health Practitioners Act (2006) sets requirements for licensing and practice for doctors and dentists, with the content of those requirements determined by the appropriate councils. Currently, a National Mental Health Policy is under review in the attorney general's office, which would create a community-based approach to mental health care. A key strength of the health sector is the up-to-date policy and regulatory framework that reflects the realities of the Saint Lucian health sector. Policy gaps remain, such as the need to formalize the referral system, to develop of more clinical practice guidelines, toincrease supportive supervision structures, and to establish facility accreditation, that if addresse,d would help ensure that both public and private providers deliver quality health services.

3.3.1 REGULATION

Policies are in place to give the MOH authority to regulate the entire health sector, but capacity to implement regulations and enforce policy is limited. The role and function of councils are clearly defined in the legislation and the councils are fully functional. The legislation clearly outlines the system of sanctions for violations, and providers are well aware of the regulations. The key constraint is the limited public funding and human resources allocated for inspectors to ensure compliance within the public and private sector. Without this, the legislation has no enforcement mechanism.

There is no specific body within the public sector, such as a private sector advisor or a Public-Private Partnership Unit, which is responsible for the oversight of the private health sector. Governance of the private sector is divided among different entities within the MOH: Medical and Dentist, Nurse, Pharmacy, and Laboratory Councils. These councils regulate their respective health area across the sector. The councils keep a current list of registered professionals that is updated by the yearly or biannually relicensing requirements, but they do not specify if the provider (or facility) is public or private.

Quality of care in the private health sector as a whole is not known. Currently, there are no standards of care that are required or enforced in either the public or private sector and there is no ministerial body that ensures private providers meet a minimum standard of care, whether it is for NCD care or HIV services. In the absence of standards of care, many professionals rely on their medical training and

standards in the country where they performed their residency or internship. Adherence to the standards and guidelines is purely voluntary. The various councils serve as disciplinary bodies to investigate patient complaints about providers in the private sector, but this only serves to punish extreme cases, as opposed to providing a systemic approach to quality assurance.

The Medical and Pharmacy Councils offer continuing medical education (CME) training in partnership with the provider associations. Annual or biannual renewal of a provider's license is conditioned on meeting a minimum number of hours of approved CME courses (see section 6.3 Human Resources for Health Policies for details on requirements). Compliance is high among private providers, given that it is a requirement for relicensure.

A significant gap in private sector oversight is in the area of dual clinical practice. There are no guidelines outlining possible areas of conflict between one's public duties and private practice, resulting in individual interpretation. Although Victoria Hospital has contracts with its providers outlining terms for dual practice, Victoria Hospital management states that these contracts have little binding authority, leaving room for potential abuse such as the consultants not completing their full shifts at the public hospital prior to leaving for their private practices. The public health care managers interviewed for this assessment believe that dual practice is pervasive and occurs mostly among physicians. The data reviewed do not support this interpretation. Based on registrations and staff tracking data from the MOH, the assessment team determined that only 15 percent of physicians are in dual practice; in fact, most physicians (61 percent) work only in the private sector. Also, approximately 10 percent of nurses and midwives are in dual practice.

3.4 CIVIL SOCIETY PARTICIPATION IN THE HEALTH SECTOR

3.4.1 CIVIL SOCIETY

Key health stakeholders outside of the MOH – in civil society and the private health sector – are well organized and have strong capacity to dialogue and participate in policy and planning, although they are not always engaged. A strong democratic tradition creates the foundation for civil society's role in all aspects of the government including health. For example, the AIDS Action Foundation (AAF) has exerted considerable influence in Saint Lucia's National AIDS Program and has been able to use the media to gain attention for the issues of marginalized populations. Members of AAF have also been active in regional bodies as well. Professional associations give private providers the opportunity to advocate for health issues and provide feedback into the policy process.

There are several associations representing and advocating for each profession. They include the Saint Lucia Medical and Dental Association (SLMDSA), Pharmacy Association of Saint Lucia, Allied Professionals, and Independent Laboratory Association of Saint Lucia. All associations have been active with their partner council in developing and promoting CME courses for providers irrespective of sector.

Based on interviews with key stakeholders and organizations themselves, most other NGOs appear to participate in service delivery rather than advocacy, despite having the ability to advocate. Many civil society organizations are also well-funded through business enterprises and private donations, indicating well-developed skills in fundraising, finance, and business management. The government is currently re-reviewing legislation for a Freedom of Information Bill. Although a Freedom of Information Bill was passed last year and signed into law, it has not yet been implemented.

3.4.2 CLIENT POWER

Client power examines the extent to which citizens, watchdog groups, and clients of the health care system are able to monitor and oversee the actions of health providers, and ensures that health services

are accessible, high quality, and equitable. The Health Complaints and Conciliation Act is designed to support provider accountability and provide a mechanism for clients to report serious cases of malpractice and malfeasance. However, key stakeholders indicated there have been no reported cases of malpractice and limited mechanisms for reporting lesser offenses. The professional councils, including the Medical and Pharmacy Councils, provide mechanisms to investigate public complaints of malpractice. However, the councils are parastatal organizations that may not be fully objective in their examinations of consumer complaints.

For the HIV/AIDS community, the AAF has established a Human Rights Desk. This independent, nongovernmental mechanism is responsible for recording reports of HIV/AIDS-related human rights violations by persons infected or affected by HIV/AIDS. In addition, AAF and Tender Loving Care – the PLHIV support group – have provided advocacy and legal support with additional donor funding.

Media outlets also play an open and positive role in Saint Lucia. There are a number of sources – print, Internet, television and radio – that provide critical feedback on the public health system. However, there is very little engagement between the MOH staff and journalists on public health issues. The MOH provides very little health information directly to media outlets, and the information reported by journalists is often gleaned from nongovernmental sources.

3.4.3 GOVERNMENT RESPONSIVENESS

In the past, the MOH has been very inclusive with civil society and private sector providers. The principal examples of government participatory planning were the development of NSPH and the UHC policy. For some time, the MOH actively provided updates on UHC through a website and community forums. However, in recent years, this active engagement has slowed down partly due to multiple priorities and limited human resources available to actively pursue stakeholders. The lack of engagement, particularly with private providers regarding health financing policy and planning for the NNH, has created friction between the private and public sectors. The lack of an approach by the MOH to address the private sector's concerns could potentially derail the government's plans to launch the NNH. There is an opportunity for the MOH to engage the private sector in discussion to ensure the successful operations of the NNH.

The notable exception to the lack of engagement with nongovernment partners is the National AIDS Program. The NACC actively engages civil society in HIV/AIDS policy and program planning and in the development of United Nations progress reports. For both the NAPS and the development of the NSPH, external resources have been available to expand the number of stakeholders involved in the process. With the decline of external funding for HIV over the last several years, this type of collaboration has become more difficult for the MOH.

Information plays a critical role in promoting government policies and programs to civil society. The government of Saint Lucia has a functional and informative website (www.stlucia.gov.lc) that provides public access to many key documents, press releases, and annual reports. Many line ministries, including the MOH, are linked to this site; a review of the site, however, indicates that the site is not well maintained and many documents/links are out of date. Providing regular, updated information and critical data to health providers or nongovernmental sectors is not done on a routine basis.

3.4.4 STATE OF PUBLIC-PRIVATE ENGAGEMENT

Information sharing and policy dialogue between the public and private sector exists but is not optimal. Private providers reported having the most contact and information with the professional associations and councils. Such communications and involvement between the professional associations and councils center around policies and protocols related to the specific profession. Currently there is no government body that systematically engages the private sector on general issues related to the health

system such as health financing, training, and data collection. The CPU has stepped in to play this role from time to time but is not officially charged with the task of engaging all key stakeholders in the health sector.

The MOH has been challenged to sustain the dialogue with the private sector and improve these relations. According to private sector stakeholders interviewed during this assessment, they have not been regularly informed of changes to the initial NSHP, particularly over the last two years. The private sector would like to be more actively engaged to provide feedback throughout the policymaking process. There has also been limited discussion between the public and private sector on the rationalization of health services, staff and/or equipment. With the development of the NNH, ensuring an effective public-private dialogue has become an even more critical issue.

From the public sector point of view, there is increasing recognition that the private sector has an important role to play. However, some stakeholders acknowledged that a strong and important minority within the leadership of the public sector still view the private sector with suspicion. The challenge remains as to how to build on this emerging recognition of the private sector's role to improve public-private dialogue in a way that allows the private sector to play a larger role.

3.5 INFORMATION, REPORTING, AND LOBBYING

3.5.1 PROVIDER REPORTING

Reliable, timely information on trends in the health sector is needed to ensure key actors, such as public and private healthcare providers, are held accountable to policies, regulations, sector priorities, and client needs. Although the MOH is currently rolling out an electronic national HMIS and solid infrastructure exists for the nationwide flow of information, the culture of information sharing, particularly from the national to the subnational levels and the governmental to the nongovernmental sectors, is weak. Data are collected at the public facility level, but are not always utilized for policymaking. Private sector providers, outside of reporting positive HIV tests and other few other communicable diseases, have no requirements to share information and do not systematically provide it despite their willingness to do so. It is clear that much of the population is receiving services in the private sector, but these contributions are not documented and incorporated into MOH planning and coordination of resources.

Sharing information is critical for both public and private health care providers so that they can better plan resources and coordinate efforts across the sectors. Information regarding quality and costs (true costs) of health services in the public sector, when available, is not disseminated in a standardized way to nongovernmental stakeholders or clients. Private sector infrastructure and plans are not shared with the MOH leadership. As a result, there is duplication of services aimed at the same client groups and duplicative procurement of expensive equipment.

3.5.2 CLIENT FEEDBACK

Client complaints about the management of the health services gave rise to health systems reform in the late 1990s.Despite these reform efforts and the NSPH prioritization of decentralization, management of the public health system remains highly centralized. The MOH initiative to devolve management so that the districts could become more responsive to client needs has been sidetracked by other competing pressures in the MOH such as limited resources and the opening of the NNH.

There is limited information flow and feedback between service providers and clients in the public sector. Although clients can easily access information on hospital fees as regulated by the Public Hospitals Management Act, other information is more difficult to obtain. Moreover, a culture of discussing consumer's perspective of quality of care does not exist. The Health Complaints and

Conciliation Act provides a legal framework for the handling of formal complaints. The MOH has not put into place a mechanism encouraging greater provider-client interaction or incentives tied to customer feedback. Interviews with public sector providers indicate that significant limitations of time and money have created strong disincentives to improve client communications. Finally, there are no MOH systems in place to collect information on client satisfaction or client perception of quality across either the public or private components of the health system.

Private sector providers, on the other hand, have strong incentives to communicate and interact with their clients since these health consumers "vote with their feet." Increasingly, a number of private providers have websites that give information on services provided and accompanying fees. In nearly all facilities – consulting rooms and pharmacies – hours, locations, services, and prices are visibly posted or in brochures. Names and degrees of physicians are listed as well. Private providers collect consumer feedback through multiple channels (e.g., suggestion boxes, questionnaires, consumer studies).

3.6 KEY FINDINGS AND RECOMMENDATIONS

3.6.1 KEY FINDINGS FOR HEALTH GOVERNANCE

Table 3.4 summarizes the key findings in health governance. It is a Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis.

TABLE 3.4: SWOT ANALYSIS FOR HEALTH GOVERNANCE

Strengths	Weaknesses
• Strong policy environment and supportive regulatory framework • Multiple entities within MOH (e.g., CPU, councils) with skilled staff in place to carry out stewardship roles • Prior history and skills in participatory governance	• Policy directions in health financing, opening of NNH and rationalizing health inputs (staff, infrastructure) not discussed and shared with all key stakeholders • Limited resources (human and financial) made available to enforce regulations • Policy decisions on the governance structure for the MOH remains an outstanding issue • Lack of human resource capacity to plan and coordinate activities across public and private sectors
Opportunities	**Threats**
• NGO and private sector leaders willing to reengage MOH • Despite current tensions, NGO and private sector leaders are committed to dedicating time and staff to participate in policy and planning	• NNH risks draining MOH financial and human resources with continued inaction on policy decisions • Limited MOH engagement of private sector has led to strained relations and strong mistrust between public and private sectors

3.6.2 GOVERNANCE RECOMMENDATIONS

Short-term to Medium-term Recommendations

- **Facilitate coordination of the health sector:** Given MOH's limited resources to fulfill its existing commitments, including the opening of the NNH, the MOH urgently needs to immediately return to the table with private sector counterparts – commercial and not-for-profit – to map out a plan that coordinates resources (funds, staff) and rationalizes infrastructure. In the short term, the focus of the discussions between the public and private sector could be coordination of resources to launch the NNH along with identifying concrete opportunities for partnerships.

Medium-term to Long-term Recommendations

- **Establish a standing Health Partnership Forum:** To assist the MOH in developing and prioritizing plans and policy in the longer term, a Health Partnership Forum could be created. The forum would include multisectoral partners, private sector, civil society groups (including support groups for PLHIV and other priority conditions) and donors as well as representatives from the national and subnational levels. The CPU could be charged with the mandate to organize and convene these meetings, which one would hope would not require extensive time commitments with quarterly or biannual meetings. A critical output could be annual health reviews, which have

been supported by International Health Partnership (IHP+) and other advocates of the Paris Declaration, country-led planning, and participatory governance (World Health Assembly 2010).

- **Resume participatory approaches to policy, planning, and budgeting:** As past experience in Saint Lucia has demonstrated, the private sector and civil society have played constructive roles in updating legal and regulatory framework, drafting the NSPH, and designing the UHC program. There are multiple opportunities to involve nonstate stakeholders: (1) include representatives from the private health sector civil society as standing members of working groups that address specific health system challenges, (2) invite senior leadership from these sectors to participate as committee members to review annual budgets and/or develop annual operation plans, and (3) create forums for diverse advocacy groups like PLHIV groups to raise and discuss concerns, brainstorm on possible solutions to increase access, and improve quality of care and share information.
- Institute an annual health review with partners as a possible mechanism to involve more actors in planning and reviewing performance: The annual meeting would not only review donor assistance but also key private sector and civil society stakeholders to provide a more complete picture of resources in the health sector. The annual review would also provide the opportunity to review the prior year's progress toward health sector goals and plan priorities for the upcoming year. Annual reviews can take many forms, be resource lean or intensive, and be as flexible or structured as required by the context and stakeholders.
- **Strengthen the CPU's capacity to analyze and engage the private health sector:** The CPU has a strong tradition of engaging and working with all stakeholders in the health sector. Given the urgent need to reengage the private sector, an individual and/or unit within the MOH needs to be assigned as the private sector liaison so that the MOH can consistently and productively engage with stakeholders outside of the MOH.

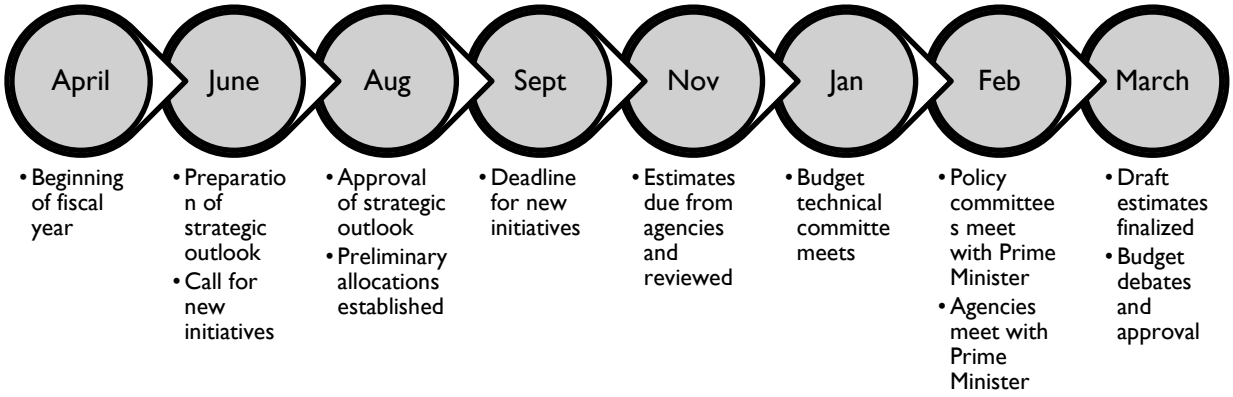
4. HEALTH FINANCING

The main purpose of health financing is to pay for health care to ensure that all individuals have access to effective public health and personal health care services and goods (WHO 2000) and ultimately to improve the health of individuals and the general population. Health systems financing comprises three interrelated functions: revenue collection, risk pooling (leading to resource allocation), and purchasing of interventions. The main challenge with health care financing is designing and implementing technical, organizational, and institutional mechanisms that are able to carry out these functions and protect people from catastrophic health expenditures. By definition, a catastrophic health expenditure occurs when personal financial contributions to the health system are equal to or exceed 40 percent of personal income remaining after subsistence needs have been met. Studies have indicated that when the out-of-pocket health spending is less than 15 percent of the total health spending, few households are affected by catastrophic payments (WHO 2010).

4.1 RESOURCE ALLOCATION PROCESS

Saint Lucia uses performance-based budgeting to plan resource allocation (Daniel 2003). The process is based on a 24-month cycle, the first part dedicated to planning and preparation and the second part to implementation and monitoring. Figure 4.1 depicts the major milestones of the budget planning part of the allocation process. During the planning phase, the MOF prepares a macroeconomic outlook for the upcoming fiscal year and sends out a request for new initiatives to the ministries. Once fiscal targets and revenue projections are established, the MOF issues an Estimates Call. First the new initiatives are collected and recommendations from the MOF are given to the ministries. After this, the MOF collects and reviews estimate requests with the ministries at technical budget committee meetings. Once the MOF has finalized the draft of the budget estimates, the MOF presents it to the cabinet. After cabinet approval, the MOF develops the budget papers based on the estimates. The attorney general uses these estimates to draft the Appropriations Bills, which is approved and debated in the House and Senate and finally vetted by the governor general. After this, the MOF can release the allocations to the ministries on a quarterly basis. The release of funds is based in part on the revenue performance of the ministry, the availability of loans or grants, and the status of projects. Each ministry must submit monthly revenue reports and quarterly performance reports to the MOF. Saint Lucia has had a budget freeze that has prohibited ministries from hiring new public sector workers; Saint Lucia's government revenues (particularly from tourism) have been severely affected by the global recession.

FIGURE 4.1: SAINT LUCIA BUDGET PLANNING PROCESS



4.2 PUBLIC HEALTH EXPENDITURES

In Saint Lucia, all health services delivered in government-owned health facilities are financed by general tax revenues. User fees are charged for many hospital services unless the patient is exempt or covered by the NIC. Exemptions are made for the poor and essential public health and safety personnel such as nurses, police officers, and firefighters. Most services at the primary care level (health centers) are free, but there are user fees for select services such as contraceptives and vaccinations for yellow fever. Because user fees paid by patients are returned to the MOF, they do not increase budgeted public expenditures on health, although they are an out-of-pocket cost to patients. The current MOH budget also includes the payment of EC$5 million per year from the NIC for services to currently employed NIC members.

From the costing of services perspective, there's an absence of data in Saint Lucia with which to work. This data gap makes it difficult to fully analyze the adequacy of the current MOH budget relative to the burden of disease and the services accessed on an annual basis. It also creates a challenge for the MOH in attempting to consider the addition of services or new facilities to the health system and/or potentially considering whether to contract such services with the private sector. As the NNH comes closer to completion, the pressure to compile relevant cost data for planning purposes will continue to grow.

Data on public and private health expenditures in Saint Lucia that were reviewed for this assessment present a somewhat confusing picture. Although WHO publishes data on total public and private health expenditures, no National Health Accounts (NHA) analysis or full household health expenditure study has been conducted in the current Saint Lucian health officials' memory. In the absence of up-to-date data on total health expenditures, the assessment team developed some estimates of health expenditures for the purposes of this review. In 2009, total GDP was approximately EC$2.565 billion[3]. MOH expenditures alone were EC$74 million. This was reported as 9.4 percent of government expenditures and would equal 2.9 percent of 2009 GDP. If private sector health expenditures were 41.2 percent of the total, as suggested by 2008 WHO data, ***then*** *total health expenditure would be 4.9 percent* of GDP, well below the amount of 6.8 percent of GDP reported by WHO for 2009.

[3] For the purposes of this estimate, the rounded population figure of 170,000 was utilized; also, 2009 per capita GDP of US$8,880 (X EC$ 2.7 to US$) was used.

At 4.9 percent of GDP, this *per capita spending works out to EC$740 (US$274),* which is well below the health spending of EC$1,828 (US$677) reported by WHO in 2008. Total health expenditure in the range of 4 to 5 percent of GDP is somewhat below reported public and total health expenditure levels in other Caribbean countries, which suggests that the Saint Lucian government should allocate more funds toward health.

4.3 PRIVATE FINANCING OF HEALTH

Although there is a strong tradition of free and accessible primary care in Saint Lucia, a substantial amount of private financing exists to support a growing and dynamic private health sector. There are two forms of private financing of health in Saint Lucia: individual out-of-pocket payments and health insurance. The price charged for private physician visits is consistent throughout the island – EC$100 for a general doctor's visit and EC$150 for a specialist. When asked how the rate was determined, the interviewees stated, "that is the going rate" or "that is what the patient expects to pay." Most offices visited had the prices for a doctor's visit and other services prominently displayed. All private clients pay out-of-pocket for the doctor consultation and other services. When asked about the clientele, all private physicians interviewed indicated they receive clients from "all walks of life" and from "all different socioeconomic levels." All private physicians interviewed also have patients with private health insurance. Depending on the location, the percentage of clients with private health insurance is 30 percent in downtown offices compared to more than 60 percent in a Rodney Bay location. Private physician staff members assist patients in completing the required paper work so they can get reimbursed.

There are no current NHA or household expenditure survey data that would reflect out-of-pocket payments or the current size of the private health insurance industry. WHO data suggest that 95 percent of private health spending is out-of-pocket, which seems inconsistent with the level of reported private health insurance coverage[4] and the observed private sector market for drugs, physician services, and hospital care. One indication of healthy growth in privately funded health care is the expansion of Tapion Hospital. A site visit to Tapion Hospital provided the assessment team with a first-hand review of the construction underway, which is expected to double the usable square footage of the facility. Tapion Hospital administration reports 60-percent inpatient occupancy during the tourist season and 45-percent occupancy during the rest of the year. Private health expenditure estimates are almost certainly inaccurate since there has been no recent household health expenditure survey.

4.4 DONOR FUNDING

Donors play a minor part in funding ongoing health services in Saint Lucia. However, they are the primary source of capital investment in the health care system, and, as such, have a major influence on the future structure and costs of the overall health system. Donor agencies include the European Union, CDB, and the World Bank. Two examples of major capital projects funded by external donors are the New National Mental Wellness Facility sponsored by the Chinese and the Taiwanese governments[5], and the NNH funded by the EC.

The EC funded construction of the NNH. Recently the EC has also agreed to fund the purchase of all the medical equipment for the facility. In 2010, total public funding for health activities in Saint Lucia was EC$80.6 million, and capital investments in health, primarily for the NNH, were EC$68.8 million (Barrett 2011). Between 2005 and 2010, annual capital investment in health increased by EC$55.5

[4] Most private insurance policies are structured to reimburse beneficiaries for medical expenses. These reimbursements may not be included in the WHO data.

[5] The Chinese initially funded construction of the facility but when the Government of Saint Lucia recognized Taiwan, the Chinese withdrew support. The Taiwanese government funded the completion of the facility.

million. High capital expenditure levels will continue through 2012 as the NNH is outfitted, but likely will decrease thereafter (Barrett 2011).

Operationally, the expanded plant and equipment from the NNH will require additional maintenance, utilities, and supplies, as well as additional staffing, all increasing overall health system costs. Operating expenditures for hospitals (Victoria and Saint Jude) already increased by 44 percent (EC$24.5 million) between 2005 and 2010. Properly staffing and operating the new hospital is estimated to require at least EC$20 million more than the 2010 budget for Victoria Hospital, while a budget of EC$5.5 million has been recommended for the Victoria Hospital polyclinic that would divert primary care patients from the NNH. Funding of depreciation to replace equipment purchased by the EC for the NNH is not included in any of the cost estimates reviewed by the assessment team.

4.5 FINANCING OF NNH

The 2011 PAHO report estimates a total budget requirement of EC$117 million for the MOH once the NNH is up and running, an increase of 58 percent from three years earlier (Barrett 2011). In addition to the operational costs of the NNH, the PAHO report identified three other significant new expenditures to consider:

- Cost of creating a polyclinic at the current Victoria Hospital complex to prevent routine primary care cases from swamping the Accident and Emergency (A&E) Department at the NNH. The opening of a new hospital in Antigua in 2009 had that exact scenario play out. Saint Lucia should ensure that the new polyclinic at Victoria Hospital is operational (including clinic hours extended into the evening) before the new hospital opens, which will come with its own costs.
- Funding a program of increased testing and primary care to address the growing burden of chronic disease (e.g., HIV, diabetes, hypertension) and to avert costly hospitalizations. An increase in demand for inpatient dialysis in the new facility could result from the growth in diabetes in Saint Lucia.
- An increase from EC$4 million to EC$6 million per year in the MOH budget for drug purchases. Public drug expenditures in Saint Lucia have been covered by supplementary appropriations over the last few years as actuals have far exceeded budgetary appropriations. If the government were to repeal user fees for drugs, there is a real danger that the EC$6 million cost would rise substantially, as patients currently purchasing in the private sector may wait to have their prescriptions filled in the public sector if there is no charge.

The additional money to accommodate the NNH and related programs, as suggested by the PAHO consultant, would add more than 1 percent of GDP (EC$43 million) to annual health expenditures in Saint Lucia (Barrett 2011).

There may be some potential budget offsets with the opening of the NNH, although these are not expected to be dramatic. For example, the NNH can potentially avert some offshore referrals for specialty care; however, the MOH only budgeted EC$400,000 in payments for offshore care in 2010-2011. Private health insurance plans in Saint Lucia that currently pay for private sector or offshore care could also potentially be redirected to the NNH, creating new revenue streams. Detailing such projected costs, however, is difficult to do in the absence of reliable cost of services data from either existing or anticipated health services.

If the NNH retains user fees and insurance payments, the required tax funding for its activities would be reduced. An analysis of utilization by NIC members and retirees could justify an increase in the NIC subvention for hospital care, also reducing required tax funding. But this would likely require an increase in the NIC contribution by employees and employers.

The government has proposed ending user fees with the opening of the new hospital, and this may divert patients from the private to the public sector and further increase costs in the public sector. If the

proposed Victoria Hospital polyclinic does not provide extended hours and high-quality primary care services, demand for outpatient services at the NNH will likely grow significantly. Demand for services at Tapion Hospital may decrease due to the opening of the NNH, while a duplication of some costly services (such as high-tech imaging) across the public and private sector will likely continue without a dialogue on service rationalization taking place in the near future. If the NNH meets the desired levels of quality, middle-class Saint Lucians may forgo private health insurance and rely on the public health system for hospital care.

The opening of the NNH presents both a significant opportunity and a significant threat to the Saint Lucia health system, depending on whether the right funding and cost structure are achieved. By any criterion, running the NNH and the related programs needed to make it effective will require a major increase in government health spending in the public sector. There is a basis (in Britain and elsewhere) for increasing public health funding through hypothecated value-added tax (VAT) and a tobacco tax, as is presently being proposed in Saint Lucia. It is not the purpose of this report to challenge this funding method. However, it may prove easier to restrict the use of new funds specifically to health care if additional revenue is achieved through social insurance and an increase in the NIC contribution rather than through general revenue increases. Regardless of the source used to generate additional funds for the public health care system, it is clear that several actions are necessary and must be taken immediately. Otherwise the MOH will negatively impact its primary care system in order to operate the NNH at the very time that it needs to strengthen primary care to deal more effectively with chronic diseases, including HIV/AIDS.

4.6 HIV/AIDS FUNDING

The most recent UNGASS report estimates HIV prevalence in Saint Lucia at 0.28 percent, consistent with 20 deaths per year before the ready availability of ARVs on-island (Jules et al. 2009). Even if this is underestimated by 50 percent, the number of HIV-positive persons on the island is on the order of 300-400. AIDS-related deaths averaged 15-20 per year in the decade prior to 2007, and then dropped below five per year.

External funding for HIV/AIDS is relatively low, although Saint Lucia benefits from regionwide funding from international donors (e.g., for ARVs, technical assistance, etc.). In 2007, donor-supported spending on HIV was approximately EC$1.62 million (US$600,000) while domestic HIV spending was only EC$448,200 (US$166,000) (UNAIDS 2008). HIV expenditures in 2007, including prevention and education, were therefore on the order of US$2,000 (EC$5,400) per infected individual, with much of this going into prevention and education. The total cost of supporting the HIV program is not high compared to the cost in other nations with a higher burden of the disease. As long as ARV drugs continue to be purchased regionally and are available at the low prices negotiated by the Clinton Health Access Initiative, it should be possible to treat PLHIV for approximately EC$1,350 (US$500) per patient per year, or an annual total of EC$540,000 (US$200,000). Long-term estimates of the true costs for continuing HIV treatment, care, and prevention programs (beyond the term of externally available grants) should be a key consideration as Saint Lucia evaluates sustainability of these services.

The high ratio of donor-to-government funding sources (US$600,000 to US$166,000) in the HIV/AIDS sector is unusual in Saint Lucia where the donor support for funding ongoing health services is relatively low. Because of Saint Lucia's status as an upper middle-income country, it is likely that prospects are limited for receiving significant external donor funding moving forward. There are concerns that as donor funding declines in the future, the strengths of the current system might dissipate. Opening the NNH without the amount or source of the extra funding required has the potential to put pressure on public funds currently allocated to the primary care system, including to basic HIV/AIDS services.

4.7 HEALTH INSURANCE

As opposed to the patient paying a provider directly, pooling resources to cover health expenditures offers the possibility of spreading the risk of incurring health costs across a group of people. Pooling can contribute to equity and access if the healthy members of the pool subsidize the sick and the wealthy members subsidize the poor. Both social health insurance and private health insurance mechanisms are in operation in Saint Lucia.

4.7.1 NATIONAL INSURANCE CORPORATION

The NIC covers 50,000 formal sector workers, collecting a 10-percent payroll tax on salaries (5 percent from employer, 5 percent from employee), up to EC$5,000 per month. NIC also pays pension benefits to 4,000 retirees. NIC covers maternity benefits, employment injury, short- and long-term disability, and pensions. Although the focus of NIC is the provision of pensions and disability insurance, it currently pays EC$5 million annually to the MOH to cover hospital services provided to its members (but not dependents) at Victoria Hospital and Saint Jude Hospital. The EC$5 million is a negotiated amount (recently increased from EC$3 million) and is not based on actual billings to the NIC by the hospitals. The annual contribution is designed to cover only active workers and there is no NIC coverage for primary care expenditures, drug, or offshore medical care. In return, the MOH waives hospital user fees for NIC-covered workers. The NIC has no specific provisions excluding the payment for the hospital services of people living with HIV, nor does it have specific provisions ensuring them. There are NIC provisions limiting short-term disability payments if the claimant falls sick through his/her own misconduct, including drug and alcohol abuse, which could be broadly interpreted. This ambiguity of protections is a cause for concern as many people living with HIV in Saint Lucia face employment discrimination (Day 2008).

4.7.2 PRIVATE HEALTH INSURANCE

A small percentage of Saint Lucians are covered through private health insurance. Table 4.1, from the 2005/06 Poverty Assessment, shows the total percentage of the population covered by private health insurance, employee medical, the national health insurance scheme, or social welfare. Only a quarter of the population has some form of health insurance – public or private – leaving three-quarters without health insurance coverage. The population groups covered by health insurance are concentrated in the two richest income quintiles, raising issues of equitable access to quality care.

TABLE 4.1: PERCENTAGE OF POPULATION WITH HEALTH INSURANCE COVERAGE IN SAINT LUCIA

Covered by Health Insurance	Per Capita Consumption Quintiles					All Saint Lucia
	Poorest	**II**	**III**	**IV**	**Richest**	
	%	%	%	%	%	%
Yes	5.7	21.7	16.1	31.6	40.9	26.3
No	92.8	75.9	83.9	67.5	57.8	72.5
Not Stated	1.5	2.3	-	.9	1.4	1.2
All Saint Lucia	100	100	100	100	100	100

Source: Saint Lucia Poverty Assessment 2005/06

Private health insurance clients include individuals, small groups (3-9 employees) and large groups (10+) in the financial, hotel, and manufacturing sectors. Many of the larger enterprises – holding companies, financial institutions, international and local hotels – carry health insurance for their employees and dependents. The structure of the private health insurance industry is changing rapidly due to the financial problems of some agencies. In Saint Lucia, four firms are actively writing private health insurance policies, including SAGICOR, Demerara Mutual, Trinidad and Guyana Mutual, and American Life. It appears that SAGICOR is the primary private health insurer on the island – the company is growing as it picks up accounts from Colonial Life Insurance Company (CLICO) (in receivership) and the British American Insurance Company (BAICO) (bankruptcy). CLICO is paying some but not all claims as the receivership process proceeds. Demerara Mutual does not offer their own health insurance policies but functions as an agent (representative) for Trinidad and Guyana Mutual. It appears that health insurers are subject only to the usual regulations for casualty insurers regarding surplus, reserves, and accounts submitted. In other words, there is no special health insurance regulation identified in Saint Lucia.

SAGICOR currently has group policies with the Civil Service Association (the public servants' association) and teachers. In fact, many civil servants, including MOH staff, buy private insurance to supplement the national social insurance scheme, NIC. SAGICOR estimates their company insures 150 groups, which equates to approximately 5-10 percent of Saint Lucia's population. Combining the other three health insurance companies' beneficiaries, private health insurance coverage would be approximately 5-15 percent of the total population. Given the reported premiums (about EC$90 per person per month), annual revenue in the health insurance industry could range from a low estimate of EC$9[6] million per year (5 percent of population covered) to a high of EC$27 million per year (15 percent of population covered). At the higher level, health insurance premiums are equal to more than one-third of MOH expenditures in the 2009-2010 budget year.

4.7.2.1 BENEFITS PACKAGE AND PRICING

The existing private health insurance programs are basically fee-for-service controlled through such factors as deductibles and coinsurance allowing insurance holders to go to any provider. In the case of overseas referrals, however, the health insurance programs do use managed care programs, offering insurance holder a network of health providers across all of the Caribbean. Beneficiaries pay a higher percentage of overseas bills if they do not stay in network.

The two major carriers – SAGICOR and Demerara Mutual – offer similar benefits: major medical policy that includes physician, hospital, diagnostic, overseas care, prescription drugs, with options for dental, optical, and life insurance (see Table 4.2). Private medical insurance offered in Saint Lucia is similar to

[6] 5% * 170,000 population * EC$90/month * 12 months

those policies sold in other OECS countries. The typical deductible per insured ranges from EC$250 to EC$2,000 per annum.

Rates vary for insured individuals, insured individuals plus one dependent, and family coverage. Companies in Saint Lucia cover the employee while the employee pays for his/her dependents. Typical rates for a smaller group would be EC$108 per month for an individual, EC$272 per month for a family. Group policies are, of course, cheaper, and do not require all members of a group to join. There are some exceptions, such as a few locally owned hotel companies, where signing up for medical health insurance is a requirement of employment.

The lifetime limits present a dilemma for the privately insured requiring expensive treatments. For example, when a private dialysis patient hits the resettable lifetime limit, then he/she has to self-pay or get public/charity care until the three-year period passes and the limit is reset. Private health insurance in Saint Lucia provides some coverage for AIDS-related health services; however, interviews with stakeholders in Saint Lucia indicate the coverage is subject to a lifetime limit.

TABLE 4.2: PRIVATE HEALTH INSURANCE BENEFITS DESCRIPTION IN SAINT LUCIA

Benefit Category	Typical Coverage (EC$)
Lifetime amount for major medical	$500,000 to $1,000,000 (option to "roll over" unused benefit within limit and to reset period for the maximum every three years)
Annual preventive care, maternity benefits, diagnostics, prescription drug, ground ambulance, AIDS and AIDS-related treatment, organ transplant, psychotherapy	Up to 100% reimbursement
An annual deductible per insured	Premium varies inversely with the size of the deductible
Vision and dental	Optional
Overseas care expenses including air ambulance	90% of first EC$50,000 100% of over EC$50,000
Copayment within network Out of network	80% insurance/20% patient 60% insurance /40% patient

4.7.2.2 CLAIMS

The burden of getting reimbursed falls on the individual. Most private sector health providers (physicians, pharmacies, and laboratory) stated to the assessment team that they are not set up to handle insurance claims and they therefore ask the individual to pay up front and submit the paper work to their insurance carrier. The insurance companies have been known to reimburse the public hospital and individuals on their claims in as little as 48 hours after submission. SAGICOR has started an e-claims settlement system with a select number of health providers in Saint Lucia. The providers can use a web-based system to predetermine what SAGICOR will pay on a particular service and then collect only the patient liability directly from the patient. SAGICOR has consolidated and centralized its claims processing system for the Eastern Caribbean in Barbados.

Private health insurance packages cover user fees at Victoria Hospital; these fees are waived for NIC policy holders. However, some NIC policy holders also purchase private health insurance because it pays surgeon and/or private attending physician fees, which are NOT covered in the user fees charged by the government hospital. Private health insurance companies occasionally see claims from Saint Jude Hospital; they do not receive claims from Victoria Hospital, which may be because all privately insured patients presenting there are NIC covered and user fees are waived for these individuals. Another

possible explanation is that Victoria Hospital has no incentive to bill the private insurers because the hospital does not keep the revenue.

4.7.2.3 HIV/AIDS AND PRIVATE HEALTH INSURANCE

SAGICOR has a lifetime limit of EC$50,000 of coverage for PLHIV. Currently, ARVs are available free of charge in the public sector because they have been largely funded by external grants. In addition, the OECS has been able to negotiate lower unit costs for the drugs. However, without free provision of ARVs, the EC$50,000 limit would allow someone living with HIV to purchase several years' worth of ARVs if the medications were available at the government's current unit cost, provided other HIV-related services do not absorb part of the limit. Treatment for opportunistic infections is covered in private health insurance and includes hospital care. Claims are paid up to whatever maximum limit is specified in the policy. Insurers were not clear about whether HIV services are covered in individual plans. The lifetime limit of a private health insurance plan is insufficient to support an AIDS patient for life, but there will likely be very few privately insured patients in need of the coverage, given the nature of the epidemic in Saint Lucia.

4.8 FINANCING HEALTH – UNIVERSAL HEALTH CARE AND OTHER PROPOSALS

For more than a decade, Saint Lucia has been considering ways to make health care more universally accessible and affordable. Early proposals for UHC suggested the possibility that public and private institutions might provide services within a social insurance framework, with a clear split between provision and financing of services. The current proposal is much more limited and designed solely to provide increased funds for the NNH. Social and private health insurance will not fund belated expansion in primary care services and chronic disease prevention efforts. The possibility of additional financing based on social insurance was specifically rejected by a recent PAHO report because of the large informal sector in the Saint Lucian economy, which would not be reached by payroll-based premium deductions or taxes (Barrett 2011). Instead, the report recommends additional VAT revenues and a tobacco tax that would be allocated to cover the increased costs. In fact, the 2011 PAHO report seems to suggest that the current NIC contribution to the MOH would also be replaced by these new funds. As of this writing, no final decisions had been made on these critical funding issues.

4.9 KEY FINDINGS AND RECOMMENDATIONS

4.9.1 KEY FINDING FOR HEALTH FINANCING

Table 4.3 summarizes the strengths, weaknesses, opportunities, and threats to the health financing sector.

TABLE 4.3: SWOT ANALYSIS FOR HEALTH FINANCING

Strengths	Weaknesses
• Strong tradition of free and accessible primary care • Current major capital investment needs met by donors • Realistic additional budget identified for NNH • Active private health insurance industry • Social insurance mechanism in place (NIC) covering 50,000 workers and providing EC$5 million/year in funding for public hospital services	• True costs of providing publicly funded health services is unknown • Current hospital management structure of Victoria Hospital does not allow the hospital the flexibility needed to be responsive to the hospital's urgent needs, particularly for staffing and purchase/repair of supplies and equipment • Structural planning from donor investments further advanced than operational and financial planning • Little consideration about how to leverage private sector to complement public sector services • No data on extent of private sector health expenditures, or burden of health expenses at different income levels • Public funding of health appears very low compared to other Caribbean countries. Minimal prospects for increased public revenues except for possible VAT
Opportunities	**Threats**
• Precedent established for parastatal hospital (Saint Jude) for NNH • Recognize the danger of flooding new hospital with routine cases. MOH has developed a plan to expand polyclinic hours to divert patients • Despite current tensions, NGO and private sector leaders are committed to dedicating time and staff to participate in policy and planning • Anticipation of NNH creates impetus to determine true costs of services and reevaluate administrative structure of hospitals	• Delays in decision making on incremental health funding and statutory status for new hospital • Current funding proposal suggest abolishing user fees at public hospitals without clear understanding of impact. May result in initial rush on the NNH and diversion from other providers • NNH risks draining financial and other MOH resource; plan for full NNH funding and staff still unclear

4.9.2 HEALTH FINANCING RECOMMENDATIONS

Short-term to Medium-term Recommendations

- **Structure New National Hospital as a statutory body (parastatal) and establish the necessary management systems:** The NNH will be even more complex than Victoria Hospital. Such institutions are usually the most complex activity that an MOH in a developing country undertakes. Civil service and government accounting procedures do not respond adequately to the complex needs of tertiary health care institutions. The NNH must have greater flexibility to hire (and discipline) staff, to move funds between budget line items, and to contract for goods and services. Reasonable procedures can be developed to meet all these needs and retain accountability, but it will take time to build them. The best example of the "model" to which the NNH should aspire is the "trust" hospitals, which have developed within the British National Health Service. In the British system, services are funded through the national health insurance scheme but the hospitals compete for this funding and have autonomy over their financials and management. This allows the government to allocate resources to those facilities providing quality services but allows the facilities the autonomy to manage their day-to-day operations as necessary for service delivery and meet the needs of the community they serve. The assessment team recommends *immediately* passing a law that will make the NNH a statutory entity that retains these management powers.

  In addition, Saint Lucia should obtain a retired (or seconded) hospital administrator from the United Kingdom (UK) who took a British hospital through this process of becoming a "trust" hospital. He or she can develop the management systems while the planning for the physical move to the NNH and the expansion and training of staff are underway. In the process, he or she can develop a Saint Lucian counterpart to manage the NNH in the long term.

- **Pass necessary legislation to increase dedicated health funding to 10 percent of government revenues:** If the currently proposed route (VAT and tobacco tax) is used, there must be a commitment to route this funding to health care. The MOF should also commit to continuing current levels of funding from existing tax sources. Public health spending must rise well above 10 percent of government revenues. Prompt action is necessary, because the money will be needed next year as the transition to the NNH occurs and parts of Victoria Hospital will remain open as a polyclinic. An alternative could be to increase the national insurance contribution rate, with the NIC paying the full cost of care for current enrollees and retirees. Tax funding would be used for public health functions and the care of those not covered by the NIC.

- **Protect current levels of primary care funding:** The immediate need is to establish a separate budget for public health functions in the laboratory at the NNH. The lack of a separate budget creates the risk that the purchase of reagents, which are necessary for diagnosis and monitoring of critical conditions like HIV and cholesterol level, will be deferred in order to direct those funds toward other priorities. The absence of these reagents can result in routine testing not being available through the public sector and/or increased costs for the public sector to purchase these services from the private sector. Based on similar assessments by team members, this is a common problem seen in other OECS countries. This can be prevented by setting a dedicated budget for public health and primary care laboratory functions at the NNH.

- **Be cautious of removing user fees in the short term:** It is politically appealing to remove user fees from public facilities. This usually results in increased demand for public services. Some of the additional demand will come from patients who avoided care because of the cost. Additional demand will come from patients who sought care in the private sector when there was only a modest differential in cost. If the cost of care in the public sector is zero, and the perceived quality improves (as is likely with the NNH), private patients will likely shift to the public system for health care. This will increase the number of visits and the cost of drugs that the MOH must purchase. It is

politically difficult to reinstate user fees once they have been withdrawn. If the cost of the additional services demanded exceeds the available budget, quality will inevitably decrease, and outcomes may worsen. Given the size of the increase in expenditures with the NNH, the ministry should wait until the NNH has been up and running for some time before reducing user fees. Fee decreases should await completion and analysis of a household health expenditure survey defining the size and use of the private sector and the actual burden of health expenditures on the poor. This will provide the MOH some idea of the likely increase in demand for public services if fees are abolished.

Mid-term to Long-term Recommendations

- **Conduct regular household health expenditure surveys; develop and periodically update NHA:** It is clear that no one really knows the relative contribution of public and private expenditures to different categories of medical care, or the relative burden that out-of-pocket health expenditures place on the poor in Saint Lucia. Regular surveys of household health expenditures should be conducted, either as a stand-alone survey, or as part of routine research on household expenditure and income, such as a national poverty assessment. The results from this work should be incorporated in periodically updated NHA, which also show budgeted public expenditures and private and public health insurance revenues and expenditures, and estimate the actual amount of offshore medical spending.
- **Partner with the private sector:** The MOH should enter into negotiations wherever it may be possible to "buy" a service from the private sector at lower cost and at a quality equal to that which the public sector can offer. To do this, the public sector must be realistic about its costs. Ministry budgets do not include depreciation and employee fringe benefits, and are often inadequate for necessary maintenance and supplies. When realistically estimated, the cost of running an MRI or a CAT scanner in the MOH may be more than the price at which an existing private facility would provide the service for referred public patients. The private sector should offer the service at a price that reflects the lower unit cost achieved with a higher number of patients (public and private) using the service. It should not "gouge" the public sector when taking referred patients. To avoid duplication, other services can be offered at the NNH, but qualified private physicians should have access to these services for their patients, and the full costs of the service should be billed where appropriate (i.e., tourists, wealthy Saint Lucians without NIC coverage). On an island of 170,000 people with an aging population, this is the only way that the country can afford to bring "on shore" additional services that are now only available in other countries.

5. SERVICE DELIVERY

Section 5 assesses health service delivery in the public and private sectors. Health service delivery is the most visible aspect of the health system because it is often where the users interface with the health system. Service delivery is "concerned with how inputs and services are organized and managed, to ensure access, quality, safety and continuity of care across health conditions," locations, and time (WHO 2007).

5.1 OVERVIEW

Saint Lucia has a sufficient number of health facilities, both public and private, to accommodate its citizens all across the country. There is adequate availability and access to primary health care (PHC), and secondary level services are provided by the three hospitals on the island. Tertiary level care in some cases is treated at Tapion Hospital for paying customers, but otherwise is primarily referred to facilities off-island in Barbados and Martinique. The establishment of the NNH could complicate the current service delivery situation, but if handled strategically, could facilitate health system efficiencies outlined in the NSPH (also referred to as the "rationalization plan"). The key gaps in the service delivery system are (1) quality assurance and quality improvement systems, (2) referral systems that promote the use of primary care services, and (3) adequate coordination and collaboration between the public and private sectors.

Immunizations and antenatal care appear universal with nearly all deliveries occurring in hospitals with a trained midwife. Table 5.1 shows other service delivery indicators for Saint Lucia.

TABLE 5.1: SERVICE DELIVERY INDICATORS IN SAINT LUCIA

Health System Indicator	Source of Data	Saint Lucia	Year of Data
Number of hospital beds (per 10,000 population)	WHO	28.30	2007
Births attended by skilled health personnel (%)	WDI-2010	97.90	2006
DTP3 immunization coverage: 1-year-olds (%)	WHO	96.00	2008
Contraceptive prevalence (% of women ages 15-49)	WDI-2010	47.00	1998
Pregnant women who received 1+ antenatal care visits (%)	UNICEF Childinfo	99.20	2005
Life expectancy at birth, total (years)	WDI-2010	72.74	2005
Mortality rate, infant (per 1,000 live births)	WDI-2010	13.10	2008

Source: Health Systems Database, http:/healthsystemsdatabase.org

High levels of education and literacy among the population and adequate infrastructure (roads, electricity, water and sanitation, and phone service) facilitate good access to and strong demand for health care services. It is projected that approximately 80,000 persons access the primary care system and 2,000 the hospital secondary care system annually. This estimate is considered robust as the health center estimate corresponds with the number of persons recorded in 2006 when all patients attending community health centers were screened (the total amounted to 31,481). The estimate suggests that a significant proportion of the population – almost 50 percent – seek health care annually (Barrett 2011).

The NSPH proposed restructuring the Saint Lucia health system to put greater emphasis on community-based prevention and primary care services, rather than managing chronic diseases through the country's hospitals, and by classifying facilities to one of four levels. Based on data showing the overabundance of higher level facilities in Saint Lucia (in particular, district hospitals), the NSPH recommendations were to reduce the number of higher level facilities within each health region. Another objective was to ensure that each level of facility provided a standardized package of services (MOH 2005b). Unfortunately, the regional health teams as proposed in the NSPH were not implemented, nor has the planned national quality coordinator within the CPU been implemented. The latter issue is due to a public sector hiring freeze for economic reasons.

Table 5.2 presents the number of facilities by categories and ownership based on MOH records on public and private sector facilities. The private sector owns and manages the majority of the facilities, 116 out of the 195, most of which are private physician and dentist offices.

TABLE 5.2: TYPE OF HEALTH FACILITY BY OWNERSHIP

Facility Level	Public +	Parastatal +	Private *	Subtotal by Facility
Health centers	32	0	0	32
Consultation room (MDs only) **	0	0	77	77
Polyclinic ++	2	1	5	8
District hospital	2	0	0	2
General hospital	1	1	1	3
Laboratories++	2	1	5	8
Pharmacies++	36	1	25	62
Subtotal by sector	75	4	113	192

Sources:
+ MOH data
++ Number includes polyclinics (including outpatient services available at hospitals and private medical centers), labs, and pharmacies on-site at all three hospitals. Number also includes all pharmacies at MOH health centers that have limited hours compared to facilities at Saint Jude and Tapion.
* Based on Medical and Pharmacy Council registry of physicians and pharmacies
** Based on MOH number of physicians and count of yellow page directory of consulting rooms. May be underestimated due to lack of complete data for private sector.
For a description of which private sector services are considered polyclinics, please see Annex A.

5.2 STRUCTURE OF THE PUBLIC SERVICE DELIVERY SYSTEM

There are three main levels of health care services in Saint Lucia:

1. Health centers (primary care)
2. Polyclinics (primary care support and community secondary care services with extended hours)
3. Hospitals (secondary and limited tertiary care services)

A network of 32 public health centers, one polyclinic (Gros Islet), and an outpatient department in each of the three main hospitals deliver PHC in Saint Lucia. Care by a nurse or nurse practitioner is available five full days (until 4:30 p.m.) and one half-day per week. Physicians are available on select days with select hours. Those in need of care after the clinic is closed must go to hospitals for care. This leads to an overutilization of the A&E departments at the hospitals (see Table 5.3). This situation will likely be exacerbated further with the new hospital unless certain steps are taken such as extending primary care hours or establishing strong referral mechanisms.

5.2.1 PRIMARY CARE

PHC at the health center level primarily includes maternal and child health services; adult, infant, and child sick visits; nutrition services; health education services; diabetic and hypertension services; sexual and reproductive health services; dental care on select days; and phlebotomy services for screening done in a referral laboratory. Health centers hold specialized clinics on a weekly basis or more frequently for the management of diabetes, hypertension, psychiatric disorders, and birth control. Health care providers specializing in sexually transmitted infections (STI) and HIV travel to primary care sites to conduct clinics (and to distribute ARVs) in communities across the island on a weekly basis. Based on interviews conducted for this assessment, the system seems to effectively reduce stigma and travel distances for patients. The PHC system is strong in the areas of maternal and child health care and infectious diseases as evidenced by nearly universal immunization, antenatal and postpartum coverage, and low mortality from infectious disease. Health centers provide pharmacy services on select days; if a patient needs a drug on a day when the pharmacy is not open he/she can obtain the drug with prescription at the nearest referral hospital or at a private pharmacy. Large employers (e.g., resort hotels) have a nurse on site or doctor on contract who provides health services to its employees, but such programs account for a small share of the island's health service delivery. NGOs and community groups involved in health primarily conduct health education activities; an exception is Planned Parenthood, which provides a notable share of family planning services and commodities on the island.

One early study of the Saint Lucia health system noted that over 75 percent of patients in the A&E Department did not have any urgent or severe problem (MOH 2000). As envisioned in the NSPH, polyclinics were expected to be established throughout the island in order to ease the workloads of the A&E departments that were flooded by those bypassing health centers and make clinical services more available to the people. Polyclinic functions were planned to cover major geographic areas: Gros Islet Polyclinic (already established), Victoria Hospital (slated to transition into a polyclinic in conjunction with completion of the NNH), Soufriere Hospital, and Dennery Hospital.

The patient volumes across the PHC have been steadily increasing over the last few years, with data showing more than one patient visit for every Saint Lucia resident (on average), as presented in Table 5.3 (Barrett 2011).

TABLE 5.3: SAINT LUCIA – PRIMARY HEALTH CARE VISITS BY CLINIC TYPE

	2007	2008	2009
Community Health Centers			
Casualties (nurse visits)	44,073	66,072	64,417
Cancer	2,906	2,878	3,228
Diabetes	3,913	3,735	3,681
Hypertension	12,620	13,063	12,175
Diabetes/hypertension	9,918	9,760	10,691
Medical clinic (doctor visits)	72,545	78,148	84,580
Subtotal CHCs:	145,975	173,656	178,772
Hospitals			
Victoria Hospital (A&E)	21,257	24,197	21,645
Saint Jude Hospital (med clinic)	733	1,148	982
Subtotal Hospitals:	21,990	25,345	22,627
Total Visits Across PHC:	**167,965**	**199,001**	**201,399**
PHC visits as a percentage of SLU population:	***101%***	***120%***	***122%***

Source: (Barrett 2011)

5.2.2 SECONDARY AND TERTIARY CARE

More advanced secondary care and very limited tertiary care is delivered at the three hospitals on the island: Victoria Hospital, Saint Jude Hospital (parastatal), and Tapion Hospital (private). The occupancy rates and average length of stay (see Table 5.4) at both Saint Jude and Victoria hospitals indicate that the facilities' inpatient services are underutilized. The international best practice efficiency benchmark for hospital occupancy is 60-90 percent. Victoria Hospital's occupancy rate in 2009 was 68.3 percent while Saint Jude's was 43.8 percent for the same time period.

TABLE 5.4: OCCUPANCY OF GOVERNMENT-FUNDED HOSPITALS AND AVERAGE LENGTH OF STAY AND OCCUPANCY FOR VICTORIA AND SAINT JUDE HOSPITALS

	Victoria Hospital			Saint Jude Hospital		
	2007	**2008**	**2009**	**2007**	**2008**	**2009**
Average length of stay (days)	5.0	4.6	4.4	3.7	3.5	3.5
Average occupancy	69.2%	68.3%	62.6%	45.4%	48.1%	43.8%

Analysis of the Victoria Hospital occupancy figures shows substantial variation in the occupancy levels for the individual wards (see Table 5.5) (Barrett 2011). These four wards show average occupancy levels of almost 80 percent, suggesting they may have exceeded 100-percent occupancy rate on occasion. These results point to the need for an examination of the capacity of the facility and the need for it to

be realigned to meet the requirements of its patient population. It is important that this be done in organizing the clinical structure of the NNH. The clinical load of the 160-bed Victoria Hospital is being transferred to the 116-bed NNH, indicating that the NNH should have an average occupancy at or above 80 percent (Barrett 2011).

TABLE 5.5: ANALYSIS OF VICTORIA HOSPITAL WARD OCCUPANCY 2008

	Maternity	Medical	Pediatric	Surgical	Total
Inpatient service days	8,191	7,745	2,379	7,906	**26,221**
Average length of stay	3.8	5.3	2.2	5.2	**4.2**
Admissions	2,132	1,465	1,106	1,514	**6,217**
Bed complement	34	25	9	23	**91**
Bed days	12,410	9,125	3,285	8,395	**33,215**
Average occupancy	*66.0%*	*84.9%*	*72.4%*	*94.2%*	***78.9%***

Victoria Hospital is currently the main trauma facility in Saint Lucia, with 160 beds operating on a 24-hour schedule. The A&E ward has six acute care beds and one resuscitation room. X-ray, dialysis, and a diagnostic lab are available. The hospital reports having a staff of physicians and surgeons specializing in nearly every area of medicine, with many physicians also practicing at Tapion Hospital, the island's sole private hospital. The wait time in the A&E depends on the patient's medical condition, as patients are triaged in order of priority. More than 200 nurses are on staff. There are no ambulances at the hospital. The fire department provides the ambulance service and the crews are allowed to perform basic emergency medical technician functions.

Victoria Hospital has been slated to transition into a polyclinic upon the completion of the NNH in 2012. The STI, HIV/AIDS, and leprosy programs operate out of Victoria Hospital, which is indicative of the ability to operate outreach and primary care support programs from the existing hospital. Currently it is unclear whether these services will remain at Victoria when it becomes a polyclinic or whether they will be transferred to the NNH. All protocols and procedures for all departments at Victoria Hospital are being reviewed by the head of nursing and the human resources focal point, and process mapping for workflows is also being done in preparation for the transition to the NNH, although no staff have been formally advised whether they will be moved over or not. No formal quality assurance or improvement systems seem to be in place for either the existing Victoria Hospital structure or for the proposed new polyclinic structure.

Victoria Hospital's management structure is typical of most hospitals in the English-speaking Caribbean. The management team is comprised of a hospital administrator, principal nursing officer, and medical superintendent. This system of management does not provide clearly identifiable leadership, and therefore creates blurred lines of responsibility. Strong vertical ties to the MOH serve to further confuse the operational management. Key decisions rest with the MOH, and staffing and purchasing procedures are too slow to be responsive to the hospital's needs.

For the most part, the specialized care that is reported to be lacking at Saint Jude and Victoria hospitals is available at Tapion Hospital. Many of the specialists on the island practice at both Victoria Hospital and Tapion, but they see the majority of their specialty cases at Tapion. The Saint Lucian health sector could potentially gain significant cost savings and efficiencies by the MOH contracting with Tapion or elsewhere in the private sector for these specialty services rather than sending patients offshore or trying to recruit full-time specialists for Victoria (and Saint Jude as well). Resources could be reallocated from offshore specialty care to Tapion through a contract with the MOH or directly between hospitals.

In that kind of restructuring, patients normally unable to pay the usual private sector fees could still be seen at Tapion Hospital under arrangements with the MOH rather than be sent offshore.

Specialized treatment services in interventional cardiology and neurology are not available on the island. Patients who need such services can apply for financial assistance from the chief medical officer's office to receive treatment abroad. The decision concerning which patients to sponsor is highly discretionary and based on a review of the patient's financial situation, the urgency of the condition, and the availability of funds in the budget for off-island treatment. Key stakeholders interviewed reported to the assessment team that they typically run out of money for such referrals by mid-year.

5.2.3 NNH'S IMPACT ON PHC

The opening of the NNH has demanded the attention of the MOH since the agreement with the EC was signed in 2002. There is tremendous uncertainty among most providers, public and private, about the effect the hospital's opening will have on the health sector, especially on PHC. According to key stakeholders interviewed, the MOH was not involved in the initial decision-making phases regarding the financial plans for the new hospital, as the MOF makes initial negotiations for capital investments (see Section 2.5.1 Coordination Process). MOH has been involved, however, in other aspects of the NNH planning since its inception and will be responsible for the long-term planning and operationalization of this facility. Thus far, the MOH has been so overwhelmed with the demands of health sector reform, UHC, and the NNH that the MOH is virtually paralyzed from making and implementing the decisions necessary to ensure that the NNH will function well alongside the currently strong PHC system. There is still no approved operational plan for funding or staffing at the new facility.

Many key stakeholders at the primary care level are concerned that staff will be reallocated to the NNH and resources will be diverted from primary care. A plan for rationalizing the services between the public and private sector has not been developed but potentially offers solutions to the limited staffing and budget of the public sector. The purchase of equipment for the NNH that is already available in the private sector has intensified the private sector's frustration with cooperating with the public sector. Although the MOH is committed to relieving the financial burden for clients needing access to specialized medical technologies or services, the MOH has not done the cost-benefit analysis to determine whether it would be more cost-effective to contract with the private sector for key services that the MOH does not provide rather than purchase the equipment or provide the services directly.

5.2.4 REFERRALS

There are several overarching concerns with the functioning of the referral system in Saint Lucia. Patients routinely seek care at the hospital for minor conditions that can be treated at health clinics. The main reasons cited during interviews for this pattern of self-referral to the hospital are the following:

- Inconvenient opening hours of public health centers (close at 4:30 pm, which poses challenges for full-time workers)
- No doctor on the premises during clinic's operating hours and/or supplies may be inadequate to deliver some services
- Perceptions of better quality of care at Victoria or Saint Jude hospitals
- Low-cost access to ambulatory hospital services for those who choose to self-refer.

Unless measures are taken to address the problem of self-referral, such as the opening of additional polyclinics, extending hours at primary care facilities, or creating a financial disincentive for users, the situation will likely become more acute with the opening of the NNH.

PHC and hospital staff lack a system for effective case management and patient referral between the primary and secondary care level. An essential ingredient for efficient and quality service delivery is a well-functioning referral system between the primary and higher levels of care. A referral system ensures that the primary care level (the health center)serves as a gatekeeper for higher level services. The referral system should be designed so that patients first see a primary care provider and then, if the lower level facility cannot provide the level of care needed, the patient would be referred to the hospital. Quality of individual patient care also hinges on effective follow-up of patients referred by the primary level for specialized/inpatient treatment and of patients who are referred back to the primary level for follow-on care after hospital discharge. Although public health centers keep individual patient files on site that are updated at each visit, patients are expected to ensure that their file is updated with case management information for care obtained at another facility. Strategies to improve this issue include an integrated patient information system to support the cross-referral process.

5.2.5 COMMUNITY OUTREACH SERVICES

The MOH Health Education Unit (HEU) is responsible for health education and promotion and is currently comprised of two health educators, four family life educators, one information/technology staff person, one secretary, and one graphic artist. Health educators are often in the field delivering messages with community health aids and the community health nurse. Topics covered include communicable and noncommunicable diseases and healthy lifestyles. Program elements are based on data from the epidemiology and public health departments. Health promotion in the field includes public displays, lectures at centers (schools, churches, or community), house to house (e.g., disseminating water sanitation tablets after Hurricane Tomas), outbreak investigation (in cooperation with the epidemiology department), in conjunction with businesses or civil service organizations (e.g., the police), health booths at local fairs and celebrations, and occasional mobile health teams.

Systems and policy changes related to the health sector are also communicated through the HEU once the decisions are final. As such, the HEU serves as the MOH's communications arm. Unfortunately, the information officer position is currently vacant and will likely remain so until the hiring freeze is lifted. The community has a voice through its community health officer or nurse, and this helps drive health education programs based on the community's request.

The HEU does have partnerships with NGOs (Cancer Society and Diabetes and Hypertensive Association) and the commercial private sector (media companies that donate airtime). However, these partnerships are not fully exploited because the HEU does not have media equipment that is digitally compatible. Therefore, getting messages from the field disseminated to the public is difficult and rarely done. Monitoring and evaluation (M&E) for the HEU is not funded, therefore, it is hard for the HEU to know if its methods are working. There is also no funding for knowledge, attitudes, and behavior surveys.

Interviewees across the private sector facilities and providers indicate a near-universal desire to help the MOH disseminate health messages, but they are often left out of communication loops. For example, none of the private facilities or providers interviewed for this assessment were contacted during the dengue outbreak and yet said they would have helped spread prevention and treatment messages through their channels had they been contacted by the Health Promotion Unit. Several private facilities also noted that they approached the MOH to help and that the MOH did not respond.

5.2.6 LABORATORY SERVICES

The two public laboratories in Saint Lucia are located at Victoria Hospital and Gros Islet Polyclinic (the environmental health lab). However, they collect samples at Dennery and Soufriere. There appears to be substantial informal cooperation between the public and private health sectors. For example, if one lab suffers a stock-out, it is often helped by another lab with the understanding they will be paid back at

a later time and the public sector makes arrangements to refer to the private sector for a test if one of their machines is down or supplies to operate the machine are unavailable. The private sector labs have expressed willingness to share costs with the public sector, such as for a service visit for a piece of machinery that they have in common. The MOH, however, has been prohibited from doing so due to restrictive government of Saint Lucia tendering procedures.

Public laboratories on the island perform some tests for free, such as for TB, HIV, and STIs. A fee is charged, however, for many NCD tests, including for cholesterol and diabetes. The indigent poor are fee exempt, but not all pensioners are exempt.[7] The public health lab conducts CD4 counts, but cannot conduct tests for viral loads. These tests are sent to Barbados, while TB drug-resistance testing is sent to CAREC in Trinidad and Tobago.

Reportable diseases from the lab tests are sent directly to the MOH epidemiologist and to the ordering physician. There is also some public/private coordination regarding reportable diseases. For example, HIV positive results from tests done in the private sector are confirmed by a national public lab. Total volume of private HIV tests are reported to the HIV program, but no other reporting of private test volumes is shared.

Some proficiency tests (e.g., for syphilis) are supplied from offshore locations (e.g., in Canada). The calibrating of machines performing tests is done by the equipment suppliers. The private sector has no problem accessing reagents through its distributors if accounts are current. However, reagents can be a problem for the public sector due to underbudgeting or incomplete or untimely paper work. The public sector cannot sign annual maintenance contracts. Expenditures for the public health lab can be squeezed by other needs at Victoria Hospital.

5.3 PRIORITY SERVICE AREAS

With major health improvements over the last 50 years and a move away from high burdens of communicable diseases, Saint Lucia's major health concerns have become chronic NCDs, obesity, HIV/AIDS, and mental health.

5.3.1 NONCOMMUNICABLE CHRONIC DISEASES

The most common causes of illness and death on the island are heart disease, cancer, and diabetes. Chronic NCDs will become the biggest burden on the health sector as the population continues to age and obesity becomes more prevalent in the population. The Saint Lucian population is experiencing a growing number of amputees due to uncontrolled diabetes. At the primary care level, influencing patients' control of diabetes has been a major challenge in Saint Lucia, and nurses are not formally trained to manage diabetes cases. A fee is charged for many NCD tests done at the primary level, including tests for cholesterol and diabetes, and this serves as a disincentive to obtain the tests. The very poor are fee exempt from such tests, but not all pensioners are exempt.

5.3.2 HIV/AIDS

HIV counseling and testing has been well integrated into the primary care system in Saint Lucia, as has antiretroviral therapy, through mobile community clinics. As with any service that may require higher levels of care as the disease progresses, strengthening referral services will be a key activity moving forward in Saint Lucia. Ensuring strong surveillance to improve evidence-based programming will also benefit the country if the disease continues to spread and move from high-risk populations into the general population. There is no official MOH HIV/AIDS training program for health professionals at this

[7] The assessment team was not able to obtain written documentation defining the criteria for fee exemptions.

time in Saint Lucia. Although HIV tests are conducted at no cost to patients, according to the 2010 UNGASS report, only 25 percent of HIV tests had both pretest and posttest counseling, and only 23 percent of people return for their test results (Jules et al. 2009). Saint Lucia laboratories conduct CD4 counts, but are not equipped to test viral loads. These tests are sent to Barbados. ARVs are distributed for free in the public sector to registered patients, but less than half of known PLHIV were enrolled in care in 2009; it is not known if the nonenrolled are not accessing services at all or accessing services in the private sector or overseas (Jules et al. 2009). One of the weaknesses of the National AIDS Program, as identified by the secretariat, is the inability to reach vulnerable populations, and therefore limited data are available on the status of these groups.

5.3.3 MENTAL HEALTH

Mental health on the island continues to be an area of concern. Mental health care has not been integrated into the primary care system. In recent years, the National Mental Wellness Center has replaced the Golden Hope Hospital. The National Mental Wellness Center has 84 beds for psychiatric patients and 24 for neurological patients and is situated adjacent to the NNH currently being constructed. On a visit to the new facility, the assessment team observed that there were insufficient staff, linens, and physical beds for the patients present. Adult and juvenile patients were not separated. The NSPH recommended a community-based mental health services network integrated into primary care services (as part of the standard health package) and connected to the appropriate social services agencies, ministries, and the private sector. There was a one-year community-based mental health pilot financed by the government of Saint Lucia as a result of the NSPH, but the program was cut due to funding constraints. The current condition of services in this new facility highlights the threat that the NNH faces without adequate planning in the immediate future.

5.4 PRIVATE HEALTH CARE SERVICES

The assessment team conducted a quick analysis of private physician offices from publicly available information and estimated that there are approximately 77 private physician offices in Saint Lucia; 80 percent of them are located in the north. The consulting rooms range from a modest storefront office to a state-of-the art group practice facility with multiple physicians in similar or differing specialties. A few of the more modern facilities also offer on-site x-rays, electrocardiograms, ultra-sounds, and laboratory and pharmacy services.

During key stakeholder interviews, a number of reasons were cited as to why patients might prefer to seek care in the private sector despite free services in the public sector. The primary reasons cited were convenience (location and longer hours), perceived quality (attractive facilities, friendlier staff), and more time with the doctor. For PLHIV, the confidentiality and convenience are important factors for where they seek care. The MOH-funded HIV clinics are conducted on a rotating basis at health centers in different regions by staff who are based centrally at Victoria Hospital. ARVs are distributed to patients during these rotating clinics at the health centers. If the day of the STI/HIV clinic is not convenient or the patient wishes to maintain greater confidentiality by not visiting the center on that day, then he or she may elect to access the private sector services. Another reason cited during interviews with providers on why Lucians seek medical care in the private sector is access to specialists. Private physicians offer a wide array of general medical services at their office locations, including care for HIV. Table 5.6 shows the range of specialties available in the private sector. Although some of these same physicians work in the public sector, the majority of specialists work exclusively in the private sector (see Figure 6.1 in the Human Resources for Health section). Patients with HIV, given their immunocomprised state, tend to have far higher need for specialty services, such as neurology, dermatology, and cardiology.

TABLE 5.6: RANGE OF HEALTH SPECIALTIES IN THE PRIVATE SECTOR

The

- Anesthesiology
- Cardiology
- Dermatology
- Ear, nose, and throat
- Endocrinology
- Internal medicine
- Neurology
- Obstetrics/Gynecology
- Oncology
- Ophthalmology
- Plastic surgery
- Pediatrics
- Urology
- Surgery (ENT, general, orthopedic, vascular)

scope of this assessment did not permit an extensive assessment of the private dentistry. However, a cursory view of the available directories indicates that there are 17 dental offices in the north section of Saint Lucia and five in the south. Only one private dentist maintains an office both in Castries (north) and Vieux Fort (south).

5.4.1 PRIVATE LABORATORIES

There are six private laboratories on the island – five are for-profit and one is parastatal. Some of these private labs expand their services by locating collection centers in secondary cities, such as Blue Coral and Soufriere. The government does not require a license to operate a private lab, and this creates possible risks for the health sector.

Both public and private labs charge patients for tests conducted. In most cases, the public lab fees are cheaper, but not always. Despite the higher fees charged in the private laboratories, the private labs are quite busy and see a wide range of clients from all socioeconomic levels. All of these clients pay out of pocket. However, more than 25 percent of private lab clients have private insurance coverage. Similar to private physician patients, the burden of reimbursement falls on the client. The private labs assist clients with completion and submission of insurance claim forms.

The lab at Tapion Hospital, which is owned and managed by Laboratory Services and Consultation Ltd., is an example of the advanced testing and quality services available on the island. The hospital lab is well-equipped and seemingly well-run. The labs also rarely experience down time due to equipment breakdowns. If the lab staff cannot repair the equipment following a telephone consultation, the supplier sends a technician to Saint Lucia within 24 hours.

5.4.2 PRIVATE HOSPITALS

There is one fully private hospital in Saint Lucia; Tapion Hospital, located in Castries, is a commercial, for-profit hospital. There is, however, also a parastatal hospital operating in Vieux Fort.

TAPION HOSPITAL

Tapion Hospital, the first and only completely private hospital in Saint Lucia, was founded in 1996 by a core group of 10 physicians and lawyers. The original group of investors has grown to more than 60 shareholders. The hospital has a formal governance structure with an executive director who reports to a seven-member board of directors. It is completely independent of the government of Saint Lucia.

Located in a former hotel building, Tapion Hospital is a well-maintained, 26-30 bed facility with major expansion underway. With over 40 doctors on staff, Tapion Hospital provides general, emergency, and specialist services. Several other private physicians with offices located close to the hospital also have admitting privileges there. Tapion Hospital staff members report having an active outpatient department but a low inpatient census (60 percent during peak tourist season and 45 percent in nontourist season).

Tapion also has an extensive radiology facility owned and operated by Gablewoods Medical Center. The radiology center performs routine x-rays to complex radiological procedures. The facility has an MRI, CT scan, fluoroscopy, ultrasound and Doppler scanners, computerized mammography, and x-ray. The facility conducts approximately two to three MRI screenings per day. With local bank financing, Tapion is undergoing a major expansion. The expansion will include additional beds, a PET scan, more laboratory space, a new cardiac catheterization lab, and training facilities. A key area of note in the expansion is the training space in the new wing, which will have capacity to provide remote CME through onisland and external telecommunications connections.

Tapion Hospital leadership expressed an interest in greater collaboration between the public and private hospitals by sharing resources, expertise, and equipment to help improve the health for all. Tapion Hospital administration believes, however, that improved and consistent communications with the MOH is needed to facilitate greater collaboration.

SAINT JUDE HOSPITAL

Saint Jude Hospital is a semiprivate secondary hospital owned by the government of Saint Lucia with an original capacity of approximately 88 beds. It is located in Vieux Fort and was established in 1966 under the auspices of the Sisters of the Sorrowful Mother, a Franciscan religious order based in Oshkosh, Wisconsin, USA. The Sisters managed Saint Jude until 1992, at which time the MOH awarded a management contract to Mercy Medical Center in Des Moines, Iowa, USA. In 2003, the Saint Jude Hospital Act No. 7 was passed, providing for an independent board of directors to manage the hospital and granting the facility the right to charge and retain patient revenue in order to cover a portion of its operating costs. In addition, the MOH provides Saint Jude with an annual grant to support the provision of services.

A 2009 fire destroyed the surgical wing at the existing hospital site, leading the hospital to begin operating in the sports stadium near the airport. The facility is being rebuilt with support from the Taiwanese government and a project management team from the MOF. Saint Jude management expected that the facility should reopen around the end of 2011 with an adjusted capacity of approximately 34 beds (at publication, the new facility had not opened). Staffing remains a challenge for Saint Jude, particularly in filling vacant positions for specialists. Saint Jude fills the gap in specialists through its extensive network of overseas volunteer physicians who rotate into Saint Lucia on a frequent basis. Saint Jude management is working with the Medical Council of Saint Lucia to simplify the process for obtaining temporary licensure for the foreign volunteers/visitors (e.g., accepting faxes of key documents rather than originals).

Future plans include strategies to improve quality and financial sustainability. After the hospital relocates to the rebuilt facility, hospital management plans to get accredited. International Medical Corps has provided some preliminary advice on the process and preparation needed to become accredited. Saint Jude also plans to become a regular provider of accredited CME on the island. The hospital has already conducted several training courses with offshore partners at its site.

In addition, Saint Jude is exploring various strategies for increasing its cost recovery. One approach is based on attracting private, paying patients, which has led the hospital to explore establishing a few private rooms in the newly renovated facility. Recognizing that Saint Jude's current fees do not reflect full cost, management will have to revise the fee schedule to reflect full cost of private care.

5.5 SERVICE DELIVERY ACCESS, COVERAGE, AND UTILIZATION

As discussed previously, geographic coverage of health services in Saint Lucia is excellent, with good access to both primary and secondary care available across the island. However, it would be useful for Saint Lucia to gather and analyze data on the per capita number of outpatient or PHC visits, which

would provide some insight into actual utilization levels. Saint Lucia has achieved virtually universal immunization coverage, antenatal care, and skilled birth attendant coverage.

Some barriers to access still remain in Saint Lucia. Income determines ability to purchase private insurance, which may mean the difference between being able to afford or not afford to seek tertiary care internationally, or to use specialized services at Tapion Hospital. Primary health center hours are limited, and thus people must either take time away from work to visit the health center or must inappropriately use hospitals for after-hours primary care. Medical doctors are only available at public health centers on certain days for certain hours. As a result, many patients who are eligible for subsidized care in the public system resort to paying out of pocket for services in the private sector.

Geography does not appear to be a great barrier to access. All levels of facility – public and private – are located in both northern and southern districts. The largest number of facilities is concentrated in the north (122 vs. 74 in the south) due to the higher concentration of middle to higher levels of income in the population. Despite the larger number of people living in the south – about 44 percent of the population is in the north and 56 percent in the south – there are still a fair number of all types of health facilities available in the south. Specifics on type of health facility by ownership and geographic distribution can be found in tables 5.2 and 5.3.

5.6 QUALITY OF CARE

The quality of health care services is determined by a combination of factors, including adequacy of infrastructure, drugs, and supplies in health facilities; availability of trained health workers who receive regular skills updates and adequate supervision; and procedures for producing, enforcing, and monitoring use of up-to-date clinical standards. Quality assurance standards and processes must be in place for all of these factors to promote high-quality health services.

5.6.1 INFRASTRUCTURE AND SUPPLIES

Generally, infrastructure and supplies on the island are in good condition and in adequate supply. The government's rationalization plan envisioned turning Soufriere Hospital and Dennery Hospital into polyclinics; it is also anticipated that Victoria Hospital would be transitioned to a polyclinic once the NNH is complete. This transformation of facilities will allow secondary care supplies to be moved accordingly to other hospitals and will aid in the infrastructure upkeep, as polyclinics will be easier to maintain than full-service hospitals.

5.6.2 CLINICAL PRACTICE GUIDELINES AND STANDARDS

The PHC system has a full range of services according to the 12 priority health areas[8]. There are clinical guidelines for some of these services but not all. Those services with guidelines are updated every 10 years via an intersectoral technical committee. For example, in 2011 the committee reviewed and revised the guidelines for maternal and child health. It was reported during interviews that clinical practice guidelines (CPG) for NCDs such as hypertension have not been either developed or disseminated (yet it is important to note that private providers stated these CPG have been updated). Given the burden of disease for NCDs, HIV, and mental health, the review committee may want to prioritize these CPG for development, revision, or dissemination and training. Lacking service delivery standards, it is difficult to set quality targets that can be monitored to guide quality improvement.

[8] Communicable diseases, NCDs, sexual and reproductive health, child and adolescent health, environmental health, oral health, prehospital emergency, mental health and substance abuse, food and nutrition, violence and injury, eye health, and disabilities and social protection.

5.6.3 LICENSING AND CERTIFICATION OF STAFF

There is minimal monitoring and enforcement of quality among private providers. All physicians are required to receive their license to practice from the Medical and Dentist Council. Private physicians are also required to keep up with 40 CME hours. It appears that all private physicians are licensed and most fulfill their CME requirements. But neither the Medical Council nor the SLMDSA track private provider licenses or monitor private provider compliance with CME hours. The absence of quality standards and structure supporting private practice is cause for concern since the majority of private practitioners work exclusively in the private sector with no access to donor-funded or ministry-supported training.

All medical personnel – public and private – on the island are registered through their respective professional council upon successful completion of commensurate examinations. A medical professional's license is then up for renewal, again through the councils, upon completion of a number of CME credits: 40 credits every two years for physicians and 40 credits annually for nurses, midwives, and nursing assistants. Allied health professionals are required to complete 25-30 credits for license renewal. The licensing system appears to be working well; however, there are some issues due to the wording of the new Health Practitioners Act. The act only covers 24 disciplines, which causes two problems: (1) there is not enough expertise in all 24 disciplines on the island so there are no standards developed for each discipline, and (2) some practitioners are not covered among one of the 24 disciplines and therefore cannot officially register to practice. For example, presently, there is no way to register ophthalmic radiologists in the country. For such a small island, it is not realistic to require all these subspecialty registrations. A general registration (doctor, dentist, nurse, allied health professional) and then recognition of subspecialty through accreditation (by the United States, UK, or Canada) could be a more realistic plan.

5.6.4 FACILITY ACCREDITATION

Health facility accreditation standards for services are still under development by the MOH with technical assistance from PAHO. Tapion Hospital is the first and sole institution in Saint Lucia to be accredited from an international organization (Accreditation Canada International). To remain current on the latest technologies, Tapion is affiliated with international hospitals, such as the Baptist Health South Florida Hospital System. Staff at Tapion utilize telemedicine referrals, sending digital radiology images to its U.S.-based partners for review. Tapion also has arrangements with offshore medical schools in Saint Lucia for clinical rotations. Saint Jude and the NNH have plans to pursue accreditation, but they are still working to meet critical standards. As accreditation was one of the seven strategic directions in the NSPH, it is clear that more guidance on how to prepare for accreditation is warranted.

5.6.5 SUPERVISION AND QUALITY IMPROVEMENT

Supervision across the Saint Lucian health system is provided by the senior medical officer, principal nursing officer, or head of department. However, there does not appear to be a standard supportive supervision or quality improvement system in place at either the facility level or the national level. Supportive supervision is the data-driven process of guiding, helping, and encouraging staff to improve their performance so that they meet defined standards of performance of their employer. When asked about such a system, most interviewees stated CME and relicensure are the main quality oversight features in the country. There is one notable exception and that is in the nursing arena. In the 1980s, two nurses who were trained in quality methods pioneered the concept of quality nursing teams to conduct performance audits against national standards. The standards were developed for the clinic level and the teams performed audits using observation guides and interview instruments. This process has largely broken down, however, with the limited number of trained nurses available to fill positions, including those for quality nursing teams, and the severe budget cuts in recent years. However,

interviews with key stakeholders indicate that some elements of quality assurance are still happening at the health center level with the more senior nurses.

On the PHC side of nursing, there are nine official nursing supervisors: two for Castries and one for each of the other seven regions. Nursing supervisors visit facilities, at a minimum, twice a week to conduct record reviews, perform clinical observations, and monitor staff in the execution of their duties. Supervisors submit reports by facility on a monthly and quarterly basis. M&E for quality over time or across facilities is being done but not through a structured system within the Saint Lucia PHC system.

5.6.6 QUALITY ASSURANCE AND MONITORING THROUGH DATA ANALYSIS AND USE

Facility-level data for routine health statistics seem to be comprehensive and complete, but there is sometimes a significant delay in getting data to the central level. The main method by which surveillance data are reported from the facility to the MOH is through the nursing supervisor and through the head nurse who reports data via phone to the chief epidemiologist, then this is followed up by the submission of a weekly surveillance report. Standard surveillance manuals and reporting forms are used at the facilities to report health outcomes, but there is no system or process by which these data are analyzed to drive quality improvements. Quality of surveillance data coming from a facility back to the MOH by way of the chief epidemiologist is validated through a field investigator or supervisor. This is done weekly at the hospitals and as needed at health centers. Annually, staff at the facilities are trained on how to fill out routine data reporting forms and registers and then per request if problems are seen in the data during validation checks. Monthly reports are generated by the epidemiology department to the chief medical officer, chief health planner, and others who are then responsible for disseminating the information throughout their respective departments. This dissemination is all done via e-mail. Currently, there is no annual report being compiled on service statistics or epidemiological trends in Saint Lucia . Data trends – whether they are positive or negative – are reported back to the facilities by phone and any negative trends are followed up by the regional staff. According to informants, this follow-up was often timely but did not always translate into support for quality improvement or resolution of problems. They reported it was not easy to look at data trends over time or across catchment areas to monitor areas of improvement and capitalize on ways to address issues across cadres, or facilities. In short, supervision visits were not maximized in a way in that could easily translate into quality improvements over time.

5.6.7 ROLE OF PROFESSIONAL COUNCILS AND ASSOCIATIONS

There are several professional councils and associations on the island, including a General Nursing Council, Medical and Dental Council, and Allied Medical Council. The councils' mandates are to monitor and evaluate the training of medical professionals, develop the standards of practice for a particular cadre, regulate the practice of professional conduct of persons registered (including disciplinary investigations), register and relicense medical professionals, and advise the MOH on professional issues. As noted earlier, however, this function is not currently being implemented by the councils. The associations function more as an advocacy body and help negotiate contracts between health professionals and the government. There is no common body of councils. The MOH appoints council members, including the chief medical or nursing officer, an attorney, and two medical practitioners (plus two dentists in the case of the Medical and Dental Council).

5.7 KEY FINDINGS AND RECOMMENDATIONS

5.7.1 KEY FINDINGS FOR SERVICE DELIVERY

Table 4.3 summarizes the strengths, weaknesses, opportunities and threats to service delivery in Saint Lucia.

TABLE 5.3: SWOT ANALYSIS FOR SERVICE DELIVERY

Strengths	Weaknesses
• Strong primary care, particularly for infectious diseases, maternal and child health, and chronic diseases • Adequate number of facilities, distributed evenly across the country • Much specialized tertiary care available in-country, particularly in private sector • Body exists to expand and update service delivery practice guidelines • Professional councils are engaged and could potentially take on a quality/accreditation role. • All professionals licensed after successful completion of CME credits every two years	• Gaps in patient referral process. Informal referrals, limited follow-up within the public sector, limited public-private referrals • Management of Victoria Hospital does not give hospital the independent authority to make decisions that are responsive to its needs in a timely fashion • No systematic quality improvement or assurance processes at any level of the service delivery system • Public hospitals are not ready for accreditation • The range of clinical care guidelines is incomplete
Opportunities	**Threats**
• Ripe for public-private partnerships to expand secondary and some tertiary level services • Facility-level data are being collected and aggregated and could be systemically used to monitor quality of care • Computer and cell phone access in facilities provides opportunities for simple tech upgrades to monitor services more efficiently • Infrastructure and technology literacy ripe for automated supervisory and quality systems as well as telemedicine programs • Quality improvement and clinical supervision systems do not have to start from scratch; build upon system and tools from the nursing sector	• Bypassing of PHC system continues. Without clear referral policies, this could affect quality of care • Gatekeeping and follow-up are weak and result in poor outcomes (e.g., amputations for poorly managed diabetics) due to the absence of a referral system • Feedback loop after referrals is inconsistent at best • No mental health services at the community level • NNH risks draining MOH resources • Limited MOH engagement of private sector has led to strained relations and strong mistrust between public and private sectors • Without autonomy in the management structure of the NNH, processes that plague the delivery of services at Victoria Hospital likely will occur at the NNH

5.7.2 SERVICE DELIVERY RECOMMENDATIONS

Short-term to Medium-term Recommendations

- **Avoid routine primary care patients overwhelming NNH**: The Victoria Hospital polyclinic, operating into the evening and on Saturdays, will be necessary to divert patients from the Emergency Room at the NNH. An enforceable referral policy must also be implemented. To ensure that patients use the appropriate primary care facilities, those who seek primary care at the NNH without a formal referral should pay a fee approximating the full cost of the visit unless there is a genuine emergency.
- **Facilitate coordination of the health sector:** The NNH presents a real threat to the MOH's quality PHC services. Given the MOH's limited resources and expertise to open a new state-of-the-art hospital, it is imperative for the MOH to resume coordination and cooperation between the public and private sectors immediately. As proposed in the Governance section, the different stakeholder groups – public, commercial, and not-for-profit – can work together to map out a plan that coordinates resources (i.e., funds and staff), leverages expertise, and rationalizes infrastructure and equipment.
- **Scenario planning for NNH:** Scenario planning will allow the MOH to picture an uncertain future by planning for a number of scenarios. This strategic planning tool may not lead to the adaption of the perfect policy, but it can help the MOH to prepare and deal with factors beyond its control.
- **Contract out specialty services to Tapion Hospital:** It was reported that there is a dearth of specialists on the island, although many were found practicing at Tapion Hospital. It could be more effective and efficient to contract out select specialist services to Tapion Hospital rather than try to create or attract new specialists for the public sector to Saint Lucia or send patients offshore for care. Contracting out some services for HIV or creating a reimbursement system for private providers treating HIV patients could also provide greater confidentiality at an affordable price for PLHIV.
- **Consider changes in the working hours of the health centers:** For example, develop a two-shift system, extend hours in select clinics, or also consider late hours on alternate weekdays among clinics in adjacent areas. Adjusting hours could make visiting the health centers more accessible to people who work during the day and would otherwise access services in the hospital setting. Prior to the opening of the NNH, pilot the approach in one to two health centers with higher patient loads, with a central location, or with easily changeable working hours (e.g., due to staff availability). Establish strong monitoring systems during the pilot and make necessary adjustments before scale up.

Medium-term to Long-term Recommendations

- **Use a standing health partnership forum to facilitate coordination of health services and necessary input:** As described in the Governance section, the forum would include multisectoral partners, private sector, civil society groups, and donors, as well as representatives from the national and subnational levels. One of the forum's long-term purposes could be to coordinate health services to ensure universal coverage and rationalizations in health sectors inputs.
- **Develop clinical practice guidelines across the continuum of care:** As NCDs are the main burdens of disease in Saint Lucia, CPG for these diseases should be widely disseminated to all levels of the health system in both the public and private sectors, but especially at the primary level. Staff at Tapion Hospital stated that they worked closely with the MOH on developing these CPG to adapt international best practices to work in the local setting with available resources. It is recommended that the MOH develop and implement a process to adopt and use the CPG. CPG should also link across levels of care (PHC, polyclinics, hospitals). To strengthen quality across the

continuum of care, guidelines should be expanded to identify the responsibilities and qualifications at each level of care, referral criteria, and responsibility for referral back to original point of care and follow-up care. The MOH could recruit experts from the private health sector to be spokespersons and trainers to help disseminate and build capacity in these CPG.

- **Establish supportive supervision system at the facility level:** The supportive supervision system should address all three levels of the health system (facility, district, and national) to assess the quality of services. This would improve services for all conditions, including HIV. Because of the high availability of Internet connectivity and mobile phone service, the system could potentially be automated. The system should in some fashion address the following four steps:

  1. Assess and monitor actual performance through a series of observations and questions (part of supportive supervision process). This is done quarterly by the supervision team at each facility.
  2. Rapidly assess the results of the observations and questions in step 1 by comparing critical indicators against preset standards. The results are then coded as critical or noncritical and responses can be monitored over time.
  3. Set plans for corrective action. Here the supervision team reviews the rapid results in step 2 and works with the facility to take corrective action. These plans detail what should be done, by whom, and by when. These plans are then closely monitored and supported before the facility is again assessed.
  4. Conduct follow-up visits. After the facility is assessed, the supportive supervision team (or member of the team) will either call or visit the facility again to support the activities needed to fulfil the action plan in step 3. Importantly, in these visits data will be collected on the effectiveness of the quality improvement intervention.

- **Monitor health system outcome data to identify and remove system-level barriers to quality improvement:** Although supportive supervision processes identify potential areas for quality improvement that are under the direct control of providers, many of the conditions necessary for quality improvement must be created by the health system, outside of the control of providers (such as availability of drugs and financing). A health system performance monitoring system (relying on data collected routinely from the existing HMIS) can be used to track overall performance and results, and to identify priority areas to be targeted for improvement by individual facilities and the system as a whole. The outcomes monitoring system would contain five basic elements: (1) strategic framework; (2) performance indicators; (3) data sources; (4) process for data collection, analysis, and interpretation; and (5) communication of monitoring results and links to action.

- **Strengthen/reinvigorate quality improvement systems and link to HMIS:** It is recommended that quality improvement teams be reestablished at the facility level and have a formal relationship with the MOH's reporting system/HMIS. The teams will be responsible for selecting indicators for performance, developing and standardizing performance monitoring tools, collecting and analyzing data uniformly and consistently, using the data to develop quality improvement projects, and making changes and continuing to monitor performance over time and across facilities. These data should be integrated into the HMIS.

- **Work toward international accreditation status for all health facilities**: It is recommended that clear expectations for performance measurement and improvement be set for the organizations and that these expectations be built into annual operating plans. The MOH could partner with Tapion to help prepare public sector hospitals for international accreditation.

- **Establish and enforce a referral system from community health centers to hospitals:** This should be accompanied by introduction of incentives that discourage self-referral to hospitals

for minor health issues (such as enforcement of fees for nonreferred ambulatory patients in the Emergency Room setting).

6. HUMAN RESOURCES FOR HEALTH

The MOH recognizes the importance of skilled medical and health professionals to fulfilling its mandate. In the Saint Lucia National Strategic Health Plan section on Human Resources for Health, the MOH notes the following:

> *The availability of appropriately trained and motivated medical, nursing, paramedical and ancillary workers in the correct numbers is vital for the cost effective delivery of health services in Saint Lucia.* (MOH 2005a)

Not only do the human resources in health impact the cost-effective delivery of services, they also impact the quality of health care and, ultimately, the health outcomes in a country. As such, an examination of the situation with the human resources engaged in the health delivery process is a critical component of a comprehensive health systems assessment.

This section seeks to determine the status of Saint Lucia's Human Resources for Health (HRH) and to make actionable recommendations for improvement. For the purposes of this analysis, the team uses the WHO definition of HRH (also known as the health workforce): "all people engaged in actions whose primary intent is to enhance health" (Islam et al. 2007). This includes those who promote and preserve health as well as those who diagnose and treat diseases; those in health management, who support workers, and who educate health workers.

6.1 THE HRH PROFILE OF SAINT LUCIA

As part of its NSPH, Saint Lucia developed a detailed HRH plan. The plan included an analysis of needs by sector and recruitment and training targets extending over the five-year period. However, this assessment found that the MOH generally has not had posts approved or funds allocated to be able to implement the plan. As a consequence, the number and distribution of technical and administrative staff in approved posts is inadequate to meet the present and anticipated needs of the health system, especially as the NNH is to be commissioned in 2012.

Notwithstanding the challenges, the retention of human resources in the health sector is relatively stable, especially at the primary care level. The management team of the MOH and the wider health services have been resourceful in meeting the manpower needs of the system. They have devised strategies within the constraints of a hiring freeze, delays in public service appointments and approvals, and MOF budget allocations. The system has benefited from the commitment of retired personnel who return to service and from contract staff working on a sessional basis, meaning they have month-to-month contracts. Part-time, contract staff have been used to fill gaps in the established numbers and are now the majority of staff at some levels of the Saint Lucia health system. At present 68 percent (21 of the 44) community health nurses work sessions and another seven are on month-to-month contracts, making this nursing cadre of part-time and/or temporary staff the norm.

At the Victoria Hospital the majority of administrative, nursing, clinical support, ancillary, and maintenance staff is in approved, funded, and permanent positions. However, the hospital's medical staff, surgeons, and specialist physicians are on temporary contracts of between one and two years' duration. A number have had contract extensions. The staff of the Soufriere Hospital is of similar tenure. Here, too, the two medical officers and one district medical officer are on temporary contract.

In addition to issues of tenure, there are also significant gaps in specialist personnel in the public health services. In the area of psychiatry, for example, there is only one psychiatrist who is on a two-year

contract and there are no existing posts for community mental health nurses. While renal dialysis nurses are in place at the general hospital, there is a permanent, full-time nephrologist employed by the MOH. A nephrologist is loaned to the Saint Lucia MOH on a rotating two-year basis by the Cuban government. Emergency medical technicians, nurse anesthetists, pharmacists, dentists, and laboratory technicians are other specialists needed in the public health services based on a review of the HRH plans.

Data now indicate that NCDs are the main disease burden in Saint Lucia, underscoring the need for an increased and contractually stable specialist workforce. For example, the cadre of community health nurses, family nurse practitioners, district medical officers, specialists and health educators will need to be increased. There are currently 10 district medical officers (all on contract), 45 community health nurses, 69 community health aides, nine family nurse practitioners, and nine nursing supervisors serving 36 facilities across eight health regions with a combined estimated population of 165,595 persons. Addressing the increased NCD burden will require existing specialist and nursing staff to be stretched thinner, with implications for the availability of staff to address other priority areas such as HIV.

Although health promotion and health education assume a great importance in a health system's response to the prevention, care, treatment, and management of NCDs, the number of staff currently working in this capacity in Saint Lucia is limited. The staff complement consists of six field staff covering the eight health regions, two health educators (out of eight staff positions established), and four family life educators (out of seven staff positions established). This staffing arrangement means that there are three regions which are not served or are underserved at any time. This assessment indicates that at all levels of the public health system the human resource cadre is limited and stretched in its capacity to maintain the coverage and quality of services needed for Saint Lucia.

Under the present circumstances, it will be an extraordinary task to meet the staffing needs of the NNH to be commissioned in 2012. The example of what occurred at the new psychiatric hospital is instructive. Based on a site visit to the new psychiatric hospital, the National Mental and Wellness Center (NMWC) is understaffed and not able to provide the model and quality of care that was envisioned. Urgent planning is needed to avoid the same occurring at the new general hospital. Without such planning, the likelihood of the primary health services being placed at risk is real, as staff may be pulled from that level to fill gaps at the secondary care level. This is especially a possibility for the sessional and contract staff on which the primary services now heavily depend. In this regard, there is a strong opportunity for public sector partnerships with the private sector where there are general practitioners and both resident and visiting specialists offering health care across the island.

Table 6.1 illustrates the distribution of some key health personnel across the public and private sectors in Saint Lucia.

TABLE 6.1: NUMBER OF SELECT HEALTH CADRES BY SECTORS

Health Professional Cadre	Public Only	Saint Jude Only	Private Only	Dual Practice	Total
Physicians	56	28	98	33	215
Dentists	0	0	24	5	29
Nurses	188	48	79	1	316
Midwives	106	26	64	9	205
Pharmacists	20	3	57	11	91
Ophthalmologist	0	0	5	1	6

Source: MOH data

An updated, comprehensive HRH plan would include strategies to enable Saint Lucia to maximize the cadre of professionals in the public and private sectors. The NNH makes this need all the more urgent. A plan is also needed to address staff tenure, recruitment, succession planning, management, supervision, and service quality control.

Recently, the Commonwealth of Nations Secretariat has agreed to provide funding for two years to hire an HRH director for the MOH. This person is expected to be in place by the end of 2011 and will be crucial to the planning needed for the transition to the new general hospital. It will be important for the planning capacity to be sustained within the MOH beyond the Commonwealth's funded period. Every effort should be made to make provisions to have the position become permanent within the Establishment Office, which approves government positions, going forward.

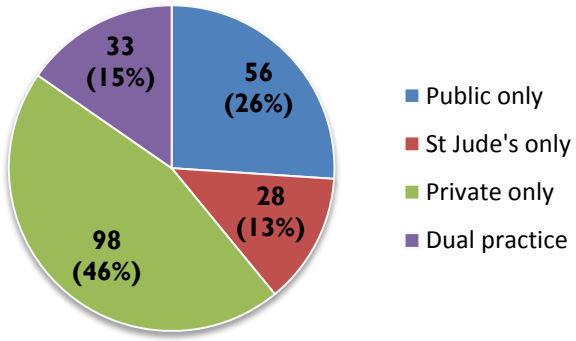
6.2 ALLOCATION OF HEALTHCARE WORKERS

The MOH maintains detailed data on HRH that lists all public sector personnel, human resource information from Saint Jude Hospital, and all of the councils. This pool of HRH data is largely a result of the European Union-funded strategic planning process used to develop the NSPH. As a result, the MOH has a complete set of HRH data, permitting comparisons of HRH trends across the public and private sectors. These numbers are one-year old, however, and may be already out of date. However, they are sufficiently current to illustrate staffing trends between the sectors.

6.2.1 PHYSICIANS

According to the MOH data, there are 215 licensed physicians in Saint Lucia. The majority (60 percent) of Saint Lucian physicians work in the private sector, as shown in Figure 6.1. There are 98 physicians in private practice and 28 employed at the parastatal Saint Jude Hospital. In contrast, there are 56 physicians who work only in the public sector. It is interesting to note that only 33 (or 15 percent) of the physicians are in dual practice, a considerably lower number than anticipated by the assessment team. Private sector physicians are predominately general practitioners, but there are also many specialists, such as general surgeons, gynecologists, obstetricians, internists, and pediatricians. Other specialists in cardiology, cardio-vascular surgery, and oncology are in

FIGURE 6.1: TOTAL # OF PHYSICIANS BY SECTOR, 2010



215 Total # of Physicians

dual practice. The private sector has access to many specialists that could be tapped into for the public sector needs.

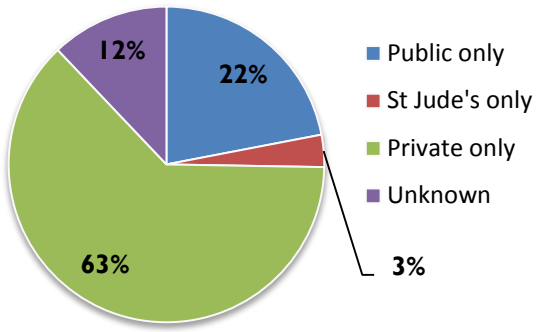
6.2.2 DENTISTS

In the case of dental services, four of every five dentists operate solely in private practice while five dentists are in dual practice. The dentists in dual practice split their time between public and private practice and/or public service and employment at Saint Jude. It is interesting to note that there are no dentists that work exclusively for the public sector.

6.2.3 PHARMACISTS

The MOH data review shows that the majority of pharmacists are employed in the nongovernment sector – 63 percent in the commercial and 3 percent in the parastatal sector as depicted in Figure 6.2. The MOH employs 22 percent of the pharmacists. The Pharmacy Association noted that there are no pharmacists in dual practice and 12 percent of pharmacists in their registry are listed as unclassified.

FIGURE 6.2: DISTRIBUTION OF PHARMACISTS, 2010



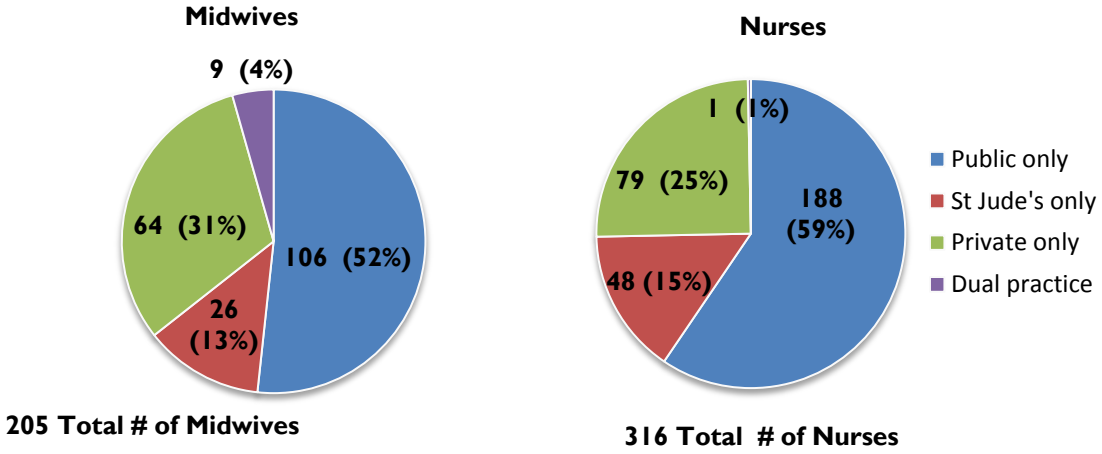
91 Total # of Pharmacists (2010 data)

Recruiting pharmacists is a challenge for both public and private sector pharmacies. Training programs are not offered on the island. All pharmacists are trained overseas, primarily in Guyana and Jamaica. The few practicing pharmacists that are Saint Lucian work in the public sector. Interviews with key stakeholders indicate that there are few Saint Lucians planning to become pharmacists. Both sectors are left with no option but to recruit from abroad. One pharmacist interviewed noted that he had to close his business because he could not find a pharmacist to relocate to Saint Lucia after a year of searching. Other pharmacy managers noted that certain regulations and practices create additional obstacles for hiring. For example, the Pharmacy Council requires a face-to-face interview and will only agree to an in-person interview if there are at least three applicants that can be interviewed at the same time. This adds considerable expense and time delays in the pharmacist recruitment process.

6.2.4 NURSES

Nurses and midwives are the backbone of Saint Lucia's PHC system. As the data reveal, the MOH depends heavily on nurses. Currently over 52 percent of midwives and 59 percent of nurses work exclusively in the public sector (see Figure 6.3). The for-profit sector also employs a significant number of nurses and midwives: 31 percent of midwives and 25 percent of nurses work in private physician offices, small clinics, private homes, and hotels. According to the data reviewed, there is a small cadre of nurses and/or midwives working in dual practice, probably because there is high demand for nursing skills in both public and private sectors. Anecdotal evidence suggests there are more nurses engaged in dual practice and that it is merely underreported because there is no regulation requiring nurses to report their dual employment status.

FIGURE 6.3: TOTAL # OF MIDWIVES AND NURSES BY SECTOR, 2010



6.2.5 LABORATORIES[9]

As is the case with pharmacists, recruiting qualified staffing to work in laboratories is an ongoing challenge for both the public and private sectors in Saint Lucia. The primary reason is that there are no training opportunities on the island to become a pathologist or a lab technician. Options for programs of study exist in Barbados, Jamaica, and Trinidad. The government of Saint Lucia does not prioritize resources to train medical technologists so people must self-finance. Because of the relatively low pay and high debt from educational loans, most trained Saint Lucians wind up working in Bermuda, the Cayman Islands, or Canada. Lab staff generally depend on equipment suppliers for in-service training opportunities. One private medical technician noted that he has participated in webinars while others have turned to distance learning for medical updates, but have typically not continued because of the lack of courses specific to lab techs.

6.3 HUMAN RESOURCE FOR HEALTH POLICIES

The NSPH, with its series of related subplans, set out a strong framework for the health services of Saint Lucia. The plan identifies HRH as one of its priorities for strengthening, including ensuring a cadre of well-trained and motivated staff (MOH 2005a) and human resources development and training in

[9] There were no comparable data on pathologists and medical technologists in either the public or private sector.

public health.[10] The key targets and programs laid out in the NSPH have not yet been realized. The CPU, senior technical and administrative staff, and other key stakeholders interviewed for this assessment exhibited a clear grasp of the HRH needs of the Saint Lucia health system. At different levels of the system, management staff have done the detailed analysis of recruitment needs and are very aware of specific training needs. The CPU, which has overall responsibility for monitoring the implementation of the NSPH, has sought to ensure the right size and competence of staff. The MOH plans training for technical staff based on a needs analysis conducted annually and assists in meeting needs for specialist services by sourcing volunteers from Martinique and Taiwan, among other countries, and through collaboration with Saint Jude Hospital, which hosts a cadre of volunteer specialists from abroad to work at its facility.

These HRH efforts are limited by the fact that, at present, the MOH does not have a dedicated HRH focal point with capacity for comprehensive HRH planning and M&E and to guide and advocate for increased HRH in the health sector. Although there is an HR officer within the MOH, the role is primarily to oversee day-to-day personnel matters related to such issues as employment, leave, and termination, and not to recruitment.

Despite the limitations in its HRH planning capacity, the MOH has made very good progress in establishing a regulatory framework for human resources. The post of chief nursing officer was established in 2007 with responsibility for developing standards of practice for nurses at all levels of the health system and ensuring articulation between the professional and clinical practice standards and other developments in the health system. For example, it was identified that the planned decentralization of management of the health services would necessitate an amendment to the scope of nursing practice in order to include additional functions.

The Medical Practitioners Act, passed in 2006 and published in 2009, established a Medical and Dental Council, as well as an Allied Health Professionals Council. The Medical and Dental, Allied Health Pharmacy, and the General Nursing councils oversee the registration and regulation of technical personnel. Under the Medical Practitioners Act, medical personnel are required to renew licenses every two years and must complete a minimum of 40 hours of continuing education over the period. As noted earlier, tracking CME by the council is not done rigorously. Reregistration of a license requires a fee of EC$600.

The Allied Health Council sees to the registration of practitioners across the 24 disciplines now listed in the act. The fact that some practices are not covered, however, as well as the diversity of disciplines, is presenting a challenge for the development of standards of practice. In response, the Allied Council is in the process of researching international standards and is taking legal advice on possible amendments, which could serve to strengthen the Medical Practitioners Act.

Nurses are required to have passed the regional examination to be registered to practice in Saint Lucia. Nurses from overseas must submit transcripts as part of the registration process. An annual relicensure is required for nurses based on 40 hours of continuing education specific to their area of specialization/practice. There are established standards of nursing practice and related manuals that have been developed. Since 1993, nurse practitioners in Saint Lucia have had prescription rights limited to a schedule of four types of drugs.

6.4 HUMAN RESOURCE MANAGEMENT

Although the NSPH envisions the MOH, districts, and general hospitals playing a greater role in HRH management, the recruitment and deployment of human resources in the health sector is largely

[10] HRH was among the weakest components identified in the Evaluation of Essential Public Health Functions, PAHO, 2002, report.

managed by the MOPS and the Public Service Commission. A multistep process is required for hiring of technical staff. The MOH determines needed posts. This is subject to cabinet approval, MOPS approval of posts, MOF approval and allocation of funds, and a recruitment process managed by the Public Service Commission. The MOH has some latitude in hiring administrative and ancillary staff, and its recommendations to the Public Service Commission are generally accepted. The MOH is able to enter into temporary contracts with technical personnel for already approved posts, subject to the oversight of MOPS, and this is done regularly.

Through the efforts off the HR officer, CPU, and management personnel for the various categories of staff, there is comprehensive, up-to-date and readily available information on the total existing and needed complement of staff, by category, in the health services and MOH. This information is important to inform human resource planning, recruitment, and deployment.

In relation to deployment, the MOH is able to deploy technical staff as needed within their classification level; however, the MOH has less control of the placement of administrative staff whose deployment is the purview of MOPS and who are subject to being redeployed within the public service, often with little or no notice to the individual or to the MOH. This is an area of concern for the MOH, as such movement often results in loss of institutional capacity and important aspects of institutional memory. In addition, the frequency in movement of personnel was reported to have significantly impacted the MOH's capacity to implement the NSPH.

An important aspect of human resource management is supervision. The existing complement of supervisory staff is dedicated to discharging their duties but their numbers are limited. At the primary care level there are nine nursing supervisory staff across the eight health regions (one is subdivided) and 36 health facilities, including the district hospitals. These nine supervisors have responsibility for the management of staff and functioning of the facilities, and for ensuring that professional and clinical practice standards/protocols are maintained. Two nursing supervisors were trained in quality assurance in 2008 and a quality team, which included other staff, was established. It was reported that this team carried out annual audits but has not been functional in recent years. The supervision of medical officers is also limited at the primary health level.

Staff appraisals were reported to be done twice annually as required by MOPS. In addition, new nursing staff were reported to have departmental orientation and a monthly evaluation by supervisors. MOPS is piloting a new performance appraisal system in four ministries. The MOH is not among those four and therefore is awaiting completion of the evaluation process for the new instrument to be shared more broadly.

Job descriptions are in place and are kept current with periodic reviews by the community nursing unit. Descriptions for primary care staff were last revised in 2009. In anticipation of the NNH opening and with a thrust toward integrated PHC, job descriptions, staff grades, and associated compensation have recently been undergoing review and revision. In addition to implementing and monitoring regulations for licensing/registration and reregistration of medical, nursing, and allied practitioners, the professional councils also have responsibility for monitoring medical malpractice insurance and are establishing a committee to monitor complaints.

6.5 HUMAN RESOURCE DEVELOPMENT

6.5.1 NURSING EDUCATION

Nursing education on the island is strong and this is reflected in the competency of the graduates, many of whom serve well beyond their retirement age. Sir Arthur Lewis Community College offers an associate's degree in general nursing. This three-year program combines course work on campus with guided clinical practice in various health care settings across the island. Tuition is EC$1,000 per year per

student, and the government pays the remaining costs. For those who cannot pay the EC$1,000, need-based stipends are available. The program also tries to admit students from each district in Saint Lucia so that the communities can best relate to the graduates when they are placed.

Nurses get a great deal of hands-on practice: three rotations four times per year in pediatrics, obstetrics, mental health care, and acute and chronic adult care. The rotations are offered frequently to ensure each student can go through each rotation with sufficient client exposure and without overburdening the clinical site. Rotations include evening hours so that the students get exposure to all types of clientele. Students are also taught to practice in lower resource settings during these rotations and to take responsibility and leadership for high-quality care no matter the circumstances. Practica are closely monitored and each student is required to journal his or her experiences and describe how he/she would improve his/her quality of practice in a given site or situation.

Students are evaluated not only on their clinical core competencies, but also on relationship building, ethics, communications, problem solving, and decision making. Each student must pass coursework in each of these areas as well as in clinical areas to graduate from the program and sit for the national exam. Upon successful completion of the program, the graduate is able to practice nursing on the island and abroad once he/she passes the required licensing examinations. In 2012 the general nursing program will be offered at the baccalaureate level.

Eligibility for study involves the successful completion of five Caribbean Examination Council subjects grade I or II, including three compulsory subjects. Two rounds of interviews are also conducted before applications are accepted or denied. On average, 24 students are selected for the year I class. The program is competitive and heavily subscribed, therefore, qualified non-nationals are considered ONLY if there are spaces available.

There is a dearth of faculty at the master's level. Sir Arthur Community College would like to approach this problem regionally, and, in order to take advantage of distance learning opportunities, the college has piloted a program with the University of the West Indies. Sir Arthur Community College has also worked closely with Case Western University, with whom they have a pending Memorandum of Understanding (MOU) to pilot advanced-level nursing distance learning courses.

6.5.2 MEDICAL EDUCATION

Except for offshore medical schools, which offer a very limited number of scholarships for Saint Lucian students, there is no national medical school or training program for allied professionals in Saint Lucia. Such training is obtained at regional institutions but with limited government scholarships and other bursaries. Out-of-pocket costs are a barrier for most Saint Lucians interested in the medical and allied professions. The main option for medical training is in Cuba, where scholarships are provided for training in medicine and other health-related areas. The language of instruction is Spanish, which can be a significant barrier. There are currently 154 Saint Lucian nurses in training in Cuba.

There are four private offshore medical universities and colleges in Saint Lucia. Costs of these schools may be prohibitive for swaths of the general public to apply. The focus of the medical schools also seems to be preparation for international, regional, and local students to practice in the United States. The American International Medical University (AIM-U) in Saint Lucia is an independent affiliate of AIM-U International Group, serving in the areas of health care training and teaching. The school curriculum and academic programs are prepared and monitored by members/specialists of medical councils, including the Medical School Accreditation Approval and Monitoring Committee, Education Commission for Foreign Medical Graduates, and the Medical Council of India. AIM-U is recognized by the Saint Lucia MOH and accredited by the Ministry of Education and Culture. The MOH allows the university to provide four-year and five-and-a-half-year programs for degrees in medicine (MD) for Lucian and international students (see Table 6.2 for full list of programs offered). After successful completion of the

MD program, graduates can practice medicine in Saint Lucia, the United States, and other international locations with the approval of the respective licensing authorities. The School of Medicine at AIM-U is the ninth largest contributor of international medical graduates to U.S. practice (American International Medical University 2010). Tuition at the university ranges from US$6,500-$8,500 per semester (depending on the program) for international students, US$4,000-$5,000 per semester for regional students, and US$3,000-$4,000 per semester for Saint Lucian students.

TABLE 6.2: PROGRAMS AT AMERICAN INTERNATIONAL MEDICAL UNIVERSITY

Degree programs	Doctor of Medicine Degree • 4-year MD degree program • 5.5-year MD degree program • Associate degree in Nursing
Diploma programs	• Diploma in Ultrasound Technician • Diploma in Ultrasound Technician Specialist • Diploma in Dialysis Technician • Diploma in Emergency Medical Technician and Paramedic
Certificate programs	• Ultrasound Technician • Dialysis Technician • Emergency Medical Technician and Paramedic
Nursing programs	• Associate Degree in Nursing

There are several opportunities for in-service professional development. These are frequently organized by the MOH, by PAHO, by the general hospital, at the health centers, by the professional associations, and by NGO service providers. It was reported to the assessment team, however, that there is a challenge in releasing staff from duty for training given limitations in staff to continue the delivery of services.

The combined challenge of limited fiscal space resulting in such measures as a hiring freeze in the public service, inadequate numbers of technical staff to fill already approved and needed posts, and the growing disease burden of NCDs supports the case for developing a comprehensive HRH training and workforce development plan in Saint Lucia. In addition, the MOH is moving in the direction of fully integrated PHC, and this requires that staff receive training in crucial knowledge and skills.

6.6 KEY FINDINGS AND RECOMMENDATIONS

6.6.1 KEY FINDINGS FOR HUMAN RESOURCES FOR HEALTH

Table 6.3 summarizes the strengths, weaknesses, opportunities and threats to HRH..

TABLE 6.3: SWOT ANALYSIS FOR HUMAN RESOURCES FOR HEALTH

Strengths	Weaknesses
• The MOH has well-trained and committed nursing staff • A significant number of specialists in several disciplines are on the island in private practice and to a lesser extent in public practice • Retention of human resources in health is relatively stable, especially at the primary care level • The CPU has a comprehensive and organized HRH database system that includes all health personnel – public and private – on the island • Service statistics are strong and scopes of service maximize staff competencies	• There are significant gaps in the complement of staff in permanent, approved positions in the public health sector • Approximately 68 percent of community health nursing cadre work on a sessional basis or on month-to-month contracts • All medical staff of the general hospital are employed on one- to two-year contracts • The MOH does not have a dedicated HRH management focal point
Opportunities	**Threats**
• Saint Lucia is well placed to meet the specialist care needs for its population if it establishes a framework for and pursues increased public-private partnerships to meet staffing gaps • The Commonwealth Secretariat is providing the MOH funding for two years for an HRH consultant that can serve as an interim measure until the MOH can fully fund this position • The MOH management team is resourceful in meeting the manpower needs and devising strategies within the constraints of a hiring freeze and delays	• An approximately 60-percent increase in staff will be needed to meet the operating requirements of the NNH set to be commissioned by the second quarter of 2012. No plan is in place to address this expected need.

6.6.2 HUMAN RESOURCES FOR HEALTH RECOMMENDATIONS

Short-term to Medium-term Recommendations

- **Prioritize the recruitment and hiring of an HRH director:** Every effort should be made to hire a HRH director so that this individual can immediately develop the HRH staffing plan needed for the NNH. Also, the new HRH director can work closely with the NNH management team to put into place the new HRH systems reflecting its status as a parastatal hospital, if this is the chosen policy.
- **Strengthen HRH planning capacity of the MOH:** While the Commonwealth Secretariat's funding will allow for an interim HRH Director, it is imperative that the post become a permanent part of the MOH structure. This will ensure sustainability in future planning. The approvals and long-term funding for this position should be sought out immediately, allowing for an overlap between the Commonwealth-funded consultant and the eventual person filling the post in the longer-term. It will also be important for the consultant to focus on transferring skills to other within the planning unit for a smooth and timely succession.
- **Develop and implement partnership strategies to meet needs for specialists and workforce training:** As a small island, Saint Lucia may not have the fiscal space and economies of scale to support the costs of full-time specialists in a wide range of areas or on-island preservice and in-service training facilities and/or programs. There are, however, opportunities to create strategic partnerships to meet the manpower needs in health. For example, the MOH could partner with local medical and allied medical professionals currently working in private practice on the island; The MOH could also look for partnerships with regional institutions such as the OECS and CARICOM for medical or nursing consultants and also for distance training opportunities In addition, partnerships with nonprofit and corporate entities, including the media, can strengthen the health promotion efforts of the MOH.

Medium-term to Long-term Recommendation

- **Develop a comprehensive HRH implementation plan and strategy:** The leadership of the health system, particularly technical officers, human resource/personnel officers, and hospital directors, should have HRH planning and management training, including in systems, tools and procedures for quality assurance, and monitoring and evaluation. Here, too, existing online training resources could be maximized. Systems and policies are needed to facilitate tracking health professionals by category, contract type, seniority, level of training, and other areas. A robust HRH plan would include policies to address the following issues:
    - Staff recruitment and retention (including incentive strategies) –Currently, the public sector hospital facilities have limited authority to increase and maintain its staff. This will likely be a challenge for operationalizing the NNH. A more efficient model would grant the hospital more autonomy to manage human resources to meet the changing needs of the hospital. Saint Jude Hospital currently has this type of authority.
    - Staff deployment – Staff allocations at health facilities currently do not necessarily match the demands of the region served. A policy should be in place that includes transfer procedures to correct for shifts in the region and matching the staff complement to the needs of the health regions (e.g., size and population health status in the region) and service demand (numbers, time of day, demographic, and health trends) of various facilities.
    - Training requirements to meet staff needs by category (preservice and in-service) – The CPU is aware of the needed training for health professionals; however, policies are not in place to ensure that staff get the needed training. A HRH plan should include mechanisms to align staff skills and specialization with the populations needs based on the current health

situation and changing technology. Ongoing monitoring would ensure the staff are meeting the training requirements outlined to keep their skills current and ensure the health system has the appropriate skill mix.

- Succession planning – Planning for the retirement of key personnel is necessary to maintain continuity in programming. This will require a plan that looks ahead to ensure a younger generation is being recruited, trained, and mentored to meet future needs.

7. PHARMACEUTICAL MANAGEMENT

Access to essential medical products and technologies that are of high quality and cost-effective are a critical component of a well-functioning health system. Addressing public health needs requires the availability of pharmaceuticals, which can be costly to purchase and distribute; therefore, effective pharmaceutical management is important. This section looks at the activities aimed at ensuring the availability and appropriate use of safe, effective medicines and medical products.

7.1 OVERVIEW OF PHARMACEUTICAL MANAGEMENT

The escalating costs of medicines and the increased burden of NCDs in Saint Lucia has forced the country to look for more efficient procurement, management, and distribution systems for medicines to ensure everyone has access. Finding lower priced medicines challenges a country with a small population because there are limited economies of scale in purchases. In an effort to increase efficiency, Saint Lucia participates in the OECS's Pharmaceutical Procurement Service (PPS). The PPS has assisted all OECS countries in reducing the cost of medicines and has also provided more regulation and oversight of procurements. The PPS office, which is based in Saint Lucia, plays a critical role in ensuring access to medicines for the public sector.

At the national level, the public pharmaceutical sector in Saint Lucia consists of pharmacies at three hospitals, the polyclinic, the parastatal hospital Saint Jude, and 32 government health centers (Abbott and Bannenberg 2009). The government health center pharmacies do not operate every day. There are also 25 private pharmacies many of which have extended hours and are open on the weekend (Pharmacy Council of Saint Lucia 2011). There are five drug wholesalers/distributors on island, but no local manufacturing.

According to the Pharmacy Council, there were 81 registered pharmacists as of September 22, 2011. Many pharmacists are trained in Guyana, as Saint Lucia lacks an institution with pharmaceutical training on island (Abbott and Bannenberg 2009). Pharmacy technicians and assistants most often receive their training online through the Penn Foster Career School, a nondegree-granting school of independent study. Many of the pharmacists in the private sector are immigrants from Guyana. Pharmacists are scarce on the island, and the process to register foreign pharmacists to work in Saint Lucia is quite long, some reporting up to six months to complete this process. This creates a barrier for the private sector because a licensed pharmacist is required on the premises for dispensing drugs. Key stakeholders interviewed noted businesses closing due to the lack of a pharmacist or the hiring a part-time pharmacist to work in the interim.

The private pharmacy retail market has grown rapidly in the last five years despite an overall economic downturn in Saint Lucia. According to Pharmacy Council records, there are 25 registered commercial pharmacies and one pharmacy in Saint Jude. The growth in the retail pharmacy market has occurred among retail chains at the expense of individually owned pharmacies. The largest private sector pharmacy chains in Saint Lucia are M&C Drugstore, R & J Clarke, LTD, and Super J Pharmacy.

Growth in retail pharmacies has leveled off. A few of the pharmacy owners/managers shared that competition is very tough with the expansion of the pharmacy chains. Also, it was observed during multiple pharmacy visits that clients aggressively shop across pharmacies for prices for the same drug. While conducting pharmacy interviews, the assessment team observed many clients purchasing some

drugs in one pharmacy and others in a second one in order to receive the best price on each item. As a result, private pharmacies are reducing their margins and offering the same formulaic at different price points to attract and retain more customers.

7.2 POLICY FRAMEWORK

Saint Lucia's policy and regulatory framework for pharmaceuticals is much stronger than many of its OECS counterparts as there is recent legislation in the sector; there are still, however, areas for improvement. Saint Lucia does not have a National Medicines Policy (NMP) to guide the development of pharmaceutical laws and regulations and establish the roles of key stakeholders. Pharmaceuticals require careful stewardship because of their implication on the economy and people's health (WHO 2004). The high cost of medicines can conflict with the desire to ensure access to all people. An NMP provides a clear framework to ensure that the overall goals of a health policy are met. Without this, regulations and laws can be incomplete or inconsistent.

Although Saint Lucia does not have an NMP, other laws provide some guidance to designate the roles, rights, and obligations of stakeholders in relation to medicines. The Public Health Act of 1975 gives the MOH the authority to regulate drugs. The Patents Law of 2001 includes regulation on intellectual property that addresses medicines and access to medicines. The law is compliant with the World Trade Organization's Agreement on Trade-Relation Intellectual Property Rights; however, it is not being enforced largely due to a lack of coordination among the relevant sectors (for further discussion on related issues, see Abbott and Bannenberg 2009).

7.3 REGULATORY SYSTEM

Saint Lucia's pharmaceutical sector is regulated by the Pharmacy Act of 2003 and the Pharmacy Regulations of 2007. The Pharmacy Act established the Pharmacy Council of Saint Lucia. The council is designed as an independent body and the chief pharmacist serves as the council's secretary. The council's mandate includes managing and controlling registration for pharmacists and pharmacies, advising the MOH on issues related to the inspection of pharmacies, and managing and controlling pharmaceuticals. Regulations on the physical space for registered pharmacies are not generally enforced in the public sector; however, the legislation does not differentiate between the public and private sector. The regulations fail to address registration of local drug distributors, the importation of drugs into the country, or advertising of pharmaceuticals.

As part of the licensing of pharmacists, the Pharmacy Council requires professional CME. Professionals are required to complete 12 CME annually to ensure continued professional development and quality of care: six from the council, two face-to-face sessions, and six credits from other mediums (mostly online), all from an accredited CME provider.

The Pharmacy Act also establishes a position for a pharmacy inspector to monitor the law. Pharmacy inspectors are to be appointed by the Public Service Commission in consultation with the Pharmacy Council. However, the position for the inspector has yet to be approved by Public Service despite a request soon after passage of the act. Because the inspector position created a change in government structure, it was subject to approval by the cabinet prior to receiving the Public Service Commission's support. In lieu of an official inspector, the Pharmacy Council has conducted the initial inspections prior to pharmacies opening and when pharmacies change ownership. The Pharmacy Council is limited in its ability to periodically drop in for follow-up inspections, which limits the effectiveness of the regulations in place.

7.3.1 REGULATION OF THE PRIVATE SECTOR PHARMACIES

The Pharmacy Regulations of 2007 prescribe a tiered schedule of drugs and rules for dispensing. The first schedule is controlled drugs, including narcotics; the second schedule covers over-the-counter medicines and diagnostics; the third schedule describes pharmacist-assisted drugs, which includes contraception. Nurse practitioners may dispense these three schedules of drugs. Fourth schedule drugs are prescription only and may only be dispensed under the supervision of a pharmacist. The Pharmacy Act, however, provides an exemption for medical doctors to dispense a 48-hour emergency supply of medicines. According to key stakeholder interviews, many doctors are dispensing full prescriptions in spite of the regulations.

By all appearances, private pharmacies comply with MOH guidelines. Private pharmacies are required by law to obtain a facility license, which includes an inspection. All private pharmacies are required to have a fully licensed pharmacists present to dispense drugs. It appears that all pharmacies do in fact comply with this regulation and often have two pharmacists on duty. When asked about compliance, almost all private pharmacists interviewed said they are aware of the guidelines and in fact many showed them to the interviewers. But many private pharmacists usually follow the guidelines and practices learned in Guyana or Jamaica. A few of the interviewees reported quality issues among private pharmacies, such as a few pharmacies dispensing drugs without prescriptions and stocking substandard drugs.

There is a collaborative and coordinated relationship between the Pharmacy Council and the Pharmacy Association. A small core of pharmacists rotates between leadership positions for the council and the association, helping to provide continuity and consensus on policy directions in the pharmaceutical sector. However, there appears to be minimal private sector participation in the association due to tension between public and private pharmacists. This tension appears to stem from the divide between Saint Lucian pharmacists in the public sector and Guyanese pharmacists in the private sector, which persists even though many of the foreign pharmacists have been in Saint Lucia for more than 15 years. The association has attempted to bridge this divide but reports having been unsuccessful to date.

A common theme among all private pharmacists was a desire to interact more with the MOH. Possible areas of collaboration proposed by interviewees included public health emergencies, such as the recent dengue outbreak, and health promotion, particularly around NCDs. Private pharmacists indicated a willingness to share information on total volumes and report on specific prescriptions. Given that most private pharmacies use electronic systems, it would be very easy for them to produce this kind of information on a regular basis. Private pharmacists confirmed that the Pharmacy Association would be the appropriate mechanism to inform and engage private pharmacies.

7.3.2 MEDICINES REGULATION

Although the Pharmacy Council is responsible for oversight of the sector, its mandate is mostly aimed at the regulation of the practice and not the medicines themselves. There is no body officially empowered with the regulation of medicines (registration/market authorization, post-market surveillance, etc.) in Saint Lucia. All medicines in the public sector are purchased through the PPS, which has prequalified suppliers and conducts sample testing prior to procurement. PPS performs limited post-market surveillance but does attempt more rigorous testing for any new suppliers.

Saint Lucia itself does not have a quality control lab in-country. Outside of the PPS, medicines in Saint Lucia are tested when there are reports of adverse drug reactions (ADR) or product complaints, but testing is not done periodically to maintain quality. Samples are usually sent to the Caribbean Regional Drug Testing Laboratory (CRDTL) in Jamaica or to a lab in Canada. The CRDTL is the regional lab used by many CARICOM countries, and key stakeholders reported some difficulties with delays in testing due to volume at CRDTL and quality issues. The CRDTL average turnaround time was 108 days in 2010 (OECS-PPS 2011). Funding scarcity limits the use of more postmarket drug testing.

The Pharmacy Act does not establish guidelines for the importation of medications; therefore, the private sector is left to self-regulate its imported products or purchases from local distributors. Although most private sector key stakeholders took this responsibility seriously and avoided purchasing from unknown suppliers, they also conveyed concern about the ease of bringing medicines into the country. Only narcotics and psycho-pharmaceuticals are required to be registered. The Organization of American States (2006) has noted that Saint Lucia also does not have any regulations or legislation in place to control the sale and distribution of pharmaceutical products over the Internet nor is there any public education program available regarding the safety of Internet sales.

7.3.3 PHARMACOVIGILANCE

Pharmacovigilance is necessary to detect, assess, understand, and prevent ADR. Key stakeholders interviewed noted that pharmacovigilance in Saint Lucia was "terrible" and ADR are underreported. Saint Lucia participates in the OECS's pharmacovigilance system, which is a spontaneous reporting system. Outside of PPS itself, Saint Lucia was the only OECS country to request lab tests due to ADR (OECS-PPS 2011). Guidelines for ADR, as well as forms, are available for both pharmacists and district medical officers. Forms are sent out by the Pharmacy Council to all registered pharmacists. An officer within the pharmacy division of the MOH is designated to liaise directly with private sector pharmacies and provide hard copies of the forms. During the assessment, however, when asked about ADR, none of the private pharmacies mentioned forms and indicated that they only called the prescribing doctors when an ADR occurs. Within the public sector, the urgency in reporting has been lost. There has not been ongoing training since the OECS 2006 exercise.

7.4 MEDICINES AND MEDICAL PRODUCTS SUPPLY

7.4.1 PUBLIC SECTOR PROCUREMENT, STORAGE, AND DISTRIBUTION

Public sector procurement in Saint Lucia is centralized. The Central Procurement Department has the responsibility for procuring all pharmaceuticals for the public sector. Central Procurement purchases nearly all of their pharmaceuticals through the PPS. Purchases outside of the PPS are infrequent but do happen for specialized drugs, particularly for cancers or specific antibiotics that are outside the PPS formulary or when PPS suppliers delay delivery. Key stakeholders noted that some visiting doctors from Cuba or other countries often have preferred prescription practices that require orders outside of the PPS formulary. There is a national procurement committee to coordinate the procurement of biomedical equipment (Abbott and Bannenberg 2009). Vaccines are procured through PAHO's Revolving Fund (Abbott and Bannenberg 2009).

PPS has a formal competitive bid process that includes sample testing. When Saint Lucia purchases outside of PPS, the Central Procurement uses a competitive bid process with local and international suppliers for the first time purchase. The PPS system has greatly reduced the cost of procuring drugs in the OECS; late payments to PPS suppliers, however, threaten the system and Saint Lucia's supplies. Countries, including Saint Lucia, have often been late in replenishing their accounts with the PPS. Since suppliers view PPS as one unit, late payments to the PPS from any country can be used to withhold an order to any of the OECS countries, regardless of that country's account balance. There is also concern among key stakeholders that, in addition to delayed delivery of supplies, the quality of drugs will diminish as competition among bidders decreases. Budgetary constraints limit the funds available upfront to put out bids and PPS is developing a reputation among suppliers for late payments. Higher end suppliers are not as willing to take the risk on such small tenders. The lower end suppliers do not have the same reputation for quality products, and given that postmarket testing is limited, there is concern that suppliers can send lower quality goods after passing the qualifying sample test.

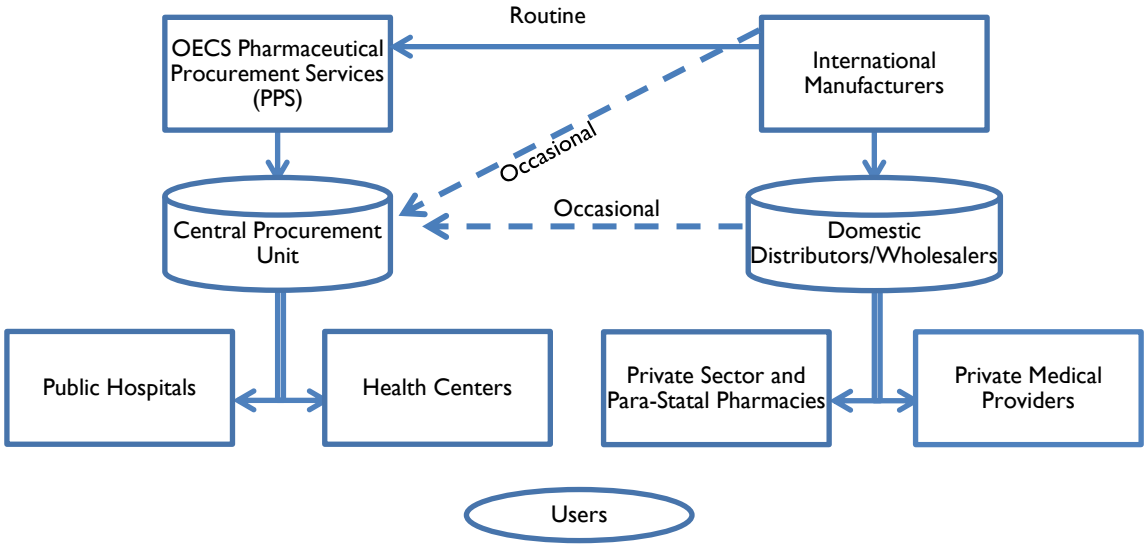
While stock-outs in the public pharmacies are not common in Saint Lucia, forecasting is weak. When stock-outs do occur, they usually occur in storage at Central Procurement rather than in pharmacies themselves. The cause is often suppliers withholding supplies from PPS due to late payments.

Currently, Central Procurement uses a paper-based system to track inventory in which bin cards are pulled and data entered manually into a spreadsheet for tracking. This makes the process time consuming for staff and therefore it is only done to set up budget allocations. Forecasts are generally made from historical consumption data. According to the 2010 PPS Annual Report, Saint Lucia's record keeping demonstrated good inventory management, but key stakeholders felt that few public sector employees had inventory management skills to support the Central Procurement Unit. A new electronic HMIS being rolled out across Saint Lucia will include an electronic supply chain management component that will alert pharmacies when they reach a minimum or maximum stock level. The new system will only track supplies once they have reached the country, not backorders or purchase orders.

Stock-outs in the laboratories are more common because reagents and equipment are purchased outside of the PPS on an as-needed basis. The main public lab must make purchase requests through Victoria Hospital. Stock-out of reagents is common due to the time it takes for orders to be approved and funded. Private sector labs often assist in filling the gaps so testing can continue, but this arrangement is not formalized. Maintenance on laboratory equipment in the public sector also requires a very long approval process. The private sector labs often inform the public sector labs when a hired technician is coming to the island to service private sector equipment so that the public sector can also have its equipment repaired, without paying the full travel costs of bringing the technician. The public sector labs are often not able to take advantage of these offers from the private sector to use these visiting technicians because of the delays in approval of funding.

Central Procurement stores and distributes medicines and products for the public sector (with exception of vaccines). Supplies are sent to facilities after a formal request to Central Procurement. Figure 7.1 depicts the supply chain for pharmaceuticals and supplies in Saint Lucia. Community Nursing Services is in charge of ordering, storing, and distributing vaccines (PAHO 2010). ARVs are available at Victoria Hospital and through mobile clinics outside of Castries. Central Procurement has one driver to deliver orders to public facilities. There is a written distribution policy, and transportation requirements provided by manufacturers are generally followed. The challenge for the Central Procurement team is the timely clearance of medications from the ports. Additionally, the cost to transport the medicines from the docks to the central store is expensive as they must hire a company with the appropriate type of vehicle (e.g., those with refrigeration) to carry the goods when they do not have the appropriate vehicle to meet the transport requirements or load size. This is not done through a formal contract with a single company but ad hoc as needed.

FIGURE 7.1: PHARMACEUTICAL SUPPLY CHAIN FOR SAINT LUCIA



7.4.2 PRIVATE SECTOR SUPPLY, STORAGE, AND DISTRIBUTION

The private sector in Saint Lucia procures pharmaceuticals directly through international and domestic distributors. All private pharmacies procure through private distributors located in Barbados, the United States, UK, and Canada. All private pharmacists interviewed stated they only work with "reputable" distributors and/or drug manufacturers that are Food and Drug Administration approved or WHO prequalified. They do not follow any written guidelines from the MOH as none exist. The private pharmacies import very few generics from places such as India as there is limited postmarket surveillance to ensure quality. Some of the distributors used are the following:

- Barbados (Armstrong, BioKal, Brighton/Schering, Carlisle, Collins, and Stokes)
- UK (Ziotis)
- United States (Knox, Masters)

The pharmacy owners/managers interviewed stated they are able to purchase a considerable portion of their supplies/drugs through the five local distributors. Prices vary for the same products among the local distributors, allowing for choice. If the pharmacy owner/manager cannot find a drug or if the price is not competitive, then he/she procures from regional and international distributors.

While the private sector purchases almost exclusively outside of the public sector system, there are a few exemptions that allow them to purchase through PPS. According to key stakeholders at Saint Jude, as a parastatal entity, there is an option to use PPS, but it requires a large buy-in to the revolving account (US$250,000). One local distributor procures diabetic and hypertensive medications through PPS. This arrangement was made as part of a special program to reduce the cost of priority medications for these two diseases. Central Procurement made the offer to all five local distributors, but only Renwick & Company decided to take advantage of the offer. As part of the pooled procurement agreement, only certain medications in the PPS formulary are available and the mark-up on the medicines is limited.

ARVs are also purchased through the PPS as a part of the PANCAP and OECS Global Fund grants. Private providers at Tapion Hospital are able to access ARVs through the PPS mechanism for their patients at zero cost. Private sector pharmacies use either electronic inventory management systems or paper-based systems. Smaller branches of some retail chains record inventory on paper and send the figures to their main branch for recording in an electronic system. Storage of drugs in the private sector is regulated in the Pharmacy Act.

Saint Jude has a fully operational pharmacy, although it is not computerized. The hospital primarily purchases its drugs through international suppliers rather than local suppliers as it is cheaper. Saint Jude does not participate in the PPS program because they do not have the US$250,000 to buy into the revolving fund. The on-site pharmacy at Tapion is well organized and has a private counseling room built to offer privacy and confidentiality to patients, including those on ARV treatment. Pharmacy staff use a computerized system to maintain and control drug inventory; Taipion is in the process of installing an electronic ordering system. The pharmacy carries a wide range of brand name drugs and generic drugs, mostly procured from offshore supplies. As is the case with most private sector pharmacists, the chief pharmacist is Guyanese and has been at Tapion for 15 years.

7.5 ACCESS TO MEDICINES

While nearly all residents of Saint Lucia must pay for medicines, affordability was not found to be a major impediment to access, although some challenges remain. The public health system in Saint Lucia does not deny services or essential medicines due to inability to pay. The MOH has put programs in place to ensure affordability of medications. Populations identified as indigent qualify for an exemption card, which gives the holder access to free medicines. The exemption applies to all public sector pharmacies but many private sector pharmacies will exempt or reduce prices for these groups as well. Diabetic and hypertensive patients receive free medications for their diabetes as well as for hypertension in the public sector. A local distributor that supplies private pharmacies also offers reduced prices through an agreement with the MOH to purchase through PPS.

Outside of Castries and the two district hospitals, pharmacy hours can limit access to affordable medications as the health center pharmacies do not operate every day. Options for accessing these medications are to wait until the pharmacy opens, travel to Saint Jude, or go to a private pharmacy where prices are less affordable. While competition among private pharmacies generally keeps prices down in the private sector, there are no price controls to regulate this, and therefore areas with fewer pharmacies may not benefit from the competitive pricing driven by proximity.

The source of a prescription may limit one's ability to easily access low-cost drugs, despite exemption programs. Policy stipulates that, unless there are extenuating circumstances, such as a known stock-out, public pharmacies may not fill private sector prescriptions. Many patients' access private services because of the greater availability of doctors or extended hours in private facilities and the providers will discount their services to assist these individuals. Although prices are competitive in the private sector, they are generally not as affordable as the public sector. Table 7.1 shows price comparisons on some of the top selling items in the private pharmacies compared to the public sector and Saint Jude. Prices for ARVS and drugs to treat STIs were not available for comparison because these are not among the top selling items in the private sector and thus not reported. ARVs are currently free but Table 7.1 reflects the public sector's unit cost for the drug, not the price charged. .

TABLE 7.1: RETAIL PRICE COMPARISON AMONG PUBLIC, PARASTATAL, AND PRIVATE SECTOR FOR SELECTED PHARMACEUTICALS

Medication/Treatment	Public Sector Price (EC$)	Saint Jude Price (EC$)	Private Average Price (EC$)
Glyburide/diabetes	$.05/5 mg tablet	$.10/5 mg tablet	$.15/5 mg tablet
Amlodipine/hypertension	$.50/5 mg tablet	$.70/5 mg tablet	.60/5 mg tablet
Amoxicillin/antibiotic	$.30/500 mg capsule	$.60/500 mg capsule	$.60/500 mg capsule
Ciprofloxin/antibiotic	$1.00/500 mg tablet	$2.00/500 mg tablet	$2.00/500 mg tablet
Bendrofluazide/hypertension	$.05/2.5 mg tablet	$.10/2.5 mg tablet	$.12/2.5 mg tablet
Salbutamol/asthma	$10.00/100 mcg inhaler	$25.00/100 mcg inhaler	$14.95/100 mcg inhaler
Lisinopril/hypertension	$.50/10 mg tablet	$.25/10 mg tablet	$.62/10 mg tablet
Ibuprofen/fever-pain reliever	$.05/400 mg tablet	$.25/400 mg tablet	$.20/400 mg tablet
Zidovudine (300mg) /Lamivudine (150mg) /Nevirapine (200mg) –ARV	$.70/ combination tablet	NA	NA
Lopinavir (200mg) / Ritonavir (50mg)	$7.50/ combination tablet	NA	NA
Efavirenz	$.70/200mg tablet	NA	NA

Source: Public sector – price list; Saint Jude – price list; private sector – prices provided by pharmacists during interviews
NA – not available due to limited sales in the private sector. Private pharmacies were asked to report their top selling products for comparison. ARVs are not available at Saint Jude.

The private pharmacists interviewed said they serve clients from all socioeconomic groups. Despite the higher cost of drugs in the private sector, customers fill their prescriptions in the private sector for convenience (location, longer hours, open on weekends), wider range of drugs available, confidentiality, and availability (almost no stock-outs, particularly drugs needed for chronic diseases). When asked why public sector clients go to a private pharmacy, the response was choice – private pharmacies sell name brands and certain generics not offered in public pharmacies. Depending on location (e.g., close to Victoria Hospital), private pharmacies provide upwards of 60 percent of their prescriptions to public sector while others estimate it is as low as 30 percent.

7.6 RATIONAL USE

Saint Lucia does not have a formalized rational drug use policy but many elements of such a policy exist. The country has used the PPS regional formulary to create its own Essential Medicines List (EML) and formulary. Public sector practitioners must use the EML and there is a committee to update it regularly. The limited number of drugs available on the EML is one of the reasons that public sector patients may seek prescriptions in the private sector. The public sector also adheres to a generics policy. Over 90 percent of pharmaceuticals in the public sector are interchangeable generics (PAHO 2010). Generics use is encouraged in the private sector and through a generics substitutions clause in the Pharmacy Act. Customers also encourage generics use through bargain shopping for reduced rates on their prescriptions. However, the private sector is more likely to carry brand names to fit the demands they get and the prescribing practices by doctors. The Pharmacy Association and the Pharmacy Council do promote rational drug use and have offered trainings on the topic.

Saint Lucia has developed treatment guidelines for diabetes, hypertension, and avian influenza. These guidelines were created to align prescribing practices between the public and private sectors. They also follow CARICOM's guidelines for HIV/AIDS treatment. Currently, the Pharmacy Council and the Pharmacy Association are working to develop guidelines for psychiatry and have recognized a need for sickle-cell anemia treatment guidelines. The need for guidelines for psychiatry has arisen out of the overprescription of valium from foreign and foreign-trained doctors on island, which is affecting the

accuracy of their forecasting. The barrier to developing these guidelines is the lack of human resources to spend the time writing and then enforcing the protocol. Enforcement is challenging for the guidelines currently in place.

7.7 FINANCING

Financing for pharmaceuticals comes from the government's consolidated fund. Key stakeholders estimated that the annual actual expenditure for pharmaceuticals is approximately EC$6 million. Annual budget allocations of around EC$4 million never meet the estimated need. Generally, however, the government makes supplemental allocations to meet the additional budget request throughout the year. The program for free diabetic and hypertensive medications has increased the financial burden. Table 7.2 shows the most recent expenditure data available from WHO, which is quite outdated and likely to be a gross underestimation of the total expenditure on pharmaceuticals given the proliferation of private pharmacies in recent years.

TABLE 7.2: FINANCIAL INDICATORS FOR MEDICINES AND MEDICAL PRODUCTS IN SAINT LUCIA, 2000

	Source of Data	Saint Lucia	Year of Data	Latin America & Caribbean	Year of Data
Total expenditure on pharmaceuticals (percent total expenditure on health)	WHO-The World Medicines Situation-2004	16.1	2000	23.2	2000
Total expenditure on pharmaceuticals (per capita at average exchange rate) in US$	WHO-The World Medicines Situation-2004	36	2000	41.79	2000
Government expenditure on pharmaceuticals (per capita at average exchange rate) in US$	WHO-The World Medicines Situation-2004	21	2000	12.21	2000
Private expenditure on pharmaceuticals (per capita at average exchange rate) in US$	WHO-The World Medicines Situation-2004	15	2000	32.45	2000

Source: Health Systems database

The assessment did not find evidence that the EC$6 million allocation for pharmaceuticals is inappropriate. Prices in the public sector are generally affordable with exemptions for the most vulnerable groups. Prices in private pharmacies are relatively affordable for most Saint Lucians and consumers keep the prices low through comparison shopping. Removal of user fees for pharmaceuticals in the public sector would likely create additional demand that the government's coffers could not fulfill.

With few exceptions, pharmaceuticals are not free in the public sector; there are, however, price controls. In the public sector, the user fees associated with medications is equivalent to the actual cost plus tariff costs, with slight rounding to allow for easier calculations. This structure does not recover the full cost for the MOH associated with providing the drugs.

There are also exemptions from user fees for pharmaceuticals for essential public health and safety personnel. Professionals such as nurses, firefighters, and police are exempted from fees at public pharmacies. Poor populations are given an exemption for medications but they must present an identification card at pharmacies.

ARVs are available free of charge in Saint Lucia, as a result of donor funding. The OECS Round 10 proposal was not approved and funding from previous rounds expired in early 2011. The Round 9 grant to PANCAP has recently agreed to fund first- and second-line ARVs for two years with an increasing government contribution to the purchase price each year. There are a few AIDS patients who require third-line drugs, which the government will subsidize, but funding has yet to be identified. Brazil has an agreement with PPS to provide free first-line ARVs through 2013 with shipment costs picked up by UNICEF. No key stakeholders interviewed were able to discuss plans for financing the cost of ARVs after the Global Fund grants and the Brazilian donations run out. A plan for protecting funds for ARVs will need to be addressed in the very near future to avoid gaps in supply after these donations end. This will be particularly important because Saint Lucia's economic classification as an upper middle-income country limits available options for subsidized medications and opportunities for foreign aid. Given the small number of PLHIV on the island, it seems that this would not be an unmanageable cost for the government but does require active planning to avoid discontinuation in treatment.

Currently there are discussions within the MOH to ensure that drugs on the EML are exempted from the VAT when it is introduced. If this policy comes to fruition, it would help keep pharmaceutical prices lower for the private sector as well as the public sector.

7.8 KEY FINDINGS AND RECOMMENDATIONS

7.8.1 KEY FINDINGS FOR PHARMACEUTICAL MANAGEMENT

Table 7.3 summarizes the strengths, weakness, opportunities, and threats in pharmaceutical management.

TABLE 7.3: SWOT ANALYSIS FOR PHARMACEUTICAL MANAGEMENT

Strengths	Weaknesses
• Strong Pharmacy Act that regulates the practice of pharmacy. • Strong and active Pharmacy Association representing primarily public sector pharmacists' interests. • Rapid growth in private pharmacies, increasing access and range of medicines at different price points. • Pharmacy Council and Pharmacy Association are well aware of the gaps that remain in the legislation and are working to address them.	• Pharmacist positions are difficult to fill as there is a short supply and no training facilities in-country. • Cumbersome and lengthy process for foreign pharmacists to become licensed to practice in Saint Lucia. • Pharmacy Act fails to address the regulation of importing medicines into the country and dispensing by other medical professionals. • Bottlenecks in the processing of purchase requests for laboratories causes stock-outs of reagents in the public laboratories.
Opportunities	**Threats**
• The Pharmacy Council has strong working relations with both public and private pharmacists. • The private sector helps fill reagents for public labs through professional courtesy. • Private sector pharmacies are willing and able to provide information to the MOH.	• Failure to get approval to hire the inspector position undermines the Pharmacy Council's ability to enforce the law. • Private pharmacies self-regulate because of lack of MOH enforcement capacity. • Late payments to PPS has the potential to undermine quality and reliability of drug supplies in the region.

7.8.2 PHARMACEUTICAL MANAGEMENT RECOMMENDATIONS

Short-term to Medium-term Recommendations

- **Prioritize the hiring of the inspector position(s):** Legislation and regulation for pharmaceutical management and personnel is only as effective as the ability to enforce the legislation. The hiring of an inspector is a priority for the Pharmacy Council to establish a separate and dedicated entity for enforcement. The funding and approval of this post requires other agencies to understand the urgency of filling this position. The highest positions inside the MOH should advocate with the cabinet and MOPS to allow for more effective enforcement of legislation and ensure the quality of medications available.
- **Reduce approvals needed for laboratory purchases:** The authorization for purchase of reagents and repairs to machinery for the laboratory pass through too many layers, creating stock-outs on reagents and downtime on machinery. These issues can cause delays in getting test results for patients, making patients less likely to return for the results and take action to improve their health. Streamlining the budget approval process for these specific items can increase the efficiency of the public labs' work and ensure continuous testing.

- **Streamline the registration process for foreign pharmacists:** Pharmacists are in short supply in Saint Lucia and the registration for foreign pharmacists is a burden for the private sector. The assessment was not able to probe into the reasons for the long registration times for foreign pharmacists; however, the Pharmacy Association or Pharmacy Council could likely identify issues and provide suggestions to expedite the process. The Pharmacy Council could also consider allowing for temporary registration to foreign pharmacists with proof of registration in their home country or certification from a qualified institute. This would allow the pharmacist to begin dispensing and then formally register when the temporary permit is expired. The MOH may want to consider working with the Caribbean Association of Pharmacists to develop a cross-registration process, whereby registration in one country would permit the registered pharmacists to work as a registered pharmacist in Saint Lucia. This would allow Saint Lucia to more easily attract pharmacists and eliminate the delays in registering foreign pharmacists prior to working in Saint Lucia. The Caribbean Association of Pharmacists could help Saint Lucia identify countries with appropriate registration processes that would ensure the quality of dispensing would not be degraded by cross-registration.
- **Revise the Pharmaceutical Act and develop a National Medicines Policy:** The Pharmacy Council has already recognized the deficiencies in the current legislation, specifically the lack of regulation on distributors/importation and physicians dispensing pharmaceuticals. The council is working toward correcting this. The revisions of the Pharmacy Act offer an opportunity for the MOH to work with the council to develop an NMP that would guide other revisions. Saint Lucia already has many elements needed to implement an NMP but the vision for the management and access to medicines has not been articulated in policy. The process of creating an NMP would allow the MOH to establish the appropriate roles and responsibilities, for both public and private sectors. This could be an opportunity to discuss how to control the quality (e.g., requiring WHO precertified producers only) and cost of drugs in the private sector (price controls). Including the private sector through trusted entities like the Pharmacy Council and the Pharmacy Association would encourage dialogue between the sectors.
- **Build capacity for pharmaceutical management:** The Central Procurement unit is understaffed and the current process for inventory management is quite burdensome. With a new electronic inventory management system in place, this process can be improved. New data will be more easily available but staff must know how to use that data. The private sector or PPS could provide the expertise for training.
- **Develop formal mechanism for coordinating with and/or procuring from private sector to mitigate reagent stock-out:** The local laboratories already coordinate to share resources when stock-outs of reagents occur or lab equipment malfunctions. Formalizing this relationship through developing an MOU and agreeing on a price schedule for such services could relieve stock-outs in the short term. This type of MOU could also be developed with private pharmacies or distributors as a formal back up to PPS should the delayed shipments become worse. The MOU could allow for more economies of scale by purchasing with one of the larger chains on the island thereby reducing the unit price.

Medium-term to Long-term Recommendations

- **Initiate dialogue on expanded regional procurement:** Many OECS countries, not only Saint Lucia, face challenges in maintaining a reliable stock of reagents. The OECS pooled procurement system has allowed OECS countries to reap the benefits of volume-based discounts for pharmaceuticals, but reagents and most medical equipment are not a part of the system. Exploring the willingness and feasibility of regional procurement of these items could also result in discounts for bulk purchases. This, however, may require conducting a regional inventory of the lab equipment in the region and the standardization of equipment over time. If feasible, pooled procurement could help reduce stock-outs on reagents and reduce the challenge of bringing maintenance teams to the region as the cost could be shared across islands with the same brand of equipment.
- **Explore the possibility of the establishment of a subregional independent regulatory body for OECS:** The cost of operating independent regulatory bodies for medicines is inhibitory for small island states. Establishing a subregional regulatory body will be cost-effective and provide the needed protection of lives. It will also make it easier for pharmaceutical companies to deal with a single body and have access to multiple countries versus individual country-level regulatory bodies for product registration. It will offer cost savings and make the subregion more attractive to the pharmaceutical companies.

8. HEALTH INFORMATION SYSTEMS

A health information system (HIS) is defined as a "set of components and procedures organized with the objective of generating information that will improve health care management decisions at all levels of the health system" (Lippeveld et al. 2000). The HIS typically serves four functions: (1) data generation, (2) data compilation, (3) data analysis and synthesis, and (4) data communication and use (Health Metrics Network 2008). The HIS collects data from the health sector and other relevant sectors; seeks to analyze the data and ensure their overall quality, relevance, and timeliness; and converts the data into information for health-related decision making. The functioning of the HIS at the national level provides a strong indicator of the overall health systems functioning. The following section provides an overview of the key structures, findings, and recommendations relevant to the Saint Lucia HIS.

8.1 OVERVIEW

The HIS in Saint Lucia today is reliant on manual data capture and reporting, with limited central staffing capacity to aggregate, analyze, and disseminate timely health information for effective decision making. Saint Lucia has been on the cusp of rolling out a national electronic health information system to capture data from all public health facilities for the last four years. They have struggled due to the lack of sufficient human resources, constrained national budgets, and the involvement of a complex mix of stakeholders.

8.2 STRUCTURE AND RESPONSIBILITIES

There are two primary units within the Saint Lucia MOH that are responsible for HIS, as defined above: the National HMIS Unit and the Office of the National Epidemiologist. The National HMIS Unit within the MOH is led by a project manager, who reports directly to the chief health planner. There are currently seven full-time, permanent staff members in the National HMIS Unit, primarily focused on planning and information and communications technology (ICT) support. The National HMIS Unit is also supported by contracted employees in the roles of developers (two people), system analyst (one), development/training/specifications specialist (one), and customer support (four). The National HMIS Unit is responsible for implementing the electronic national HMIS, which is being rolled out across the country in phases. One staff member from the National HMIS Unit also sits on the national-level ICT Technical Working Group, which is responsible for coordinating information systems strategies across Saint Lucia's ministries and departments.

Surveillance data are collected by the Epidemiology/Surveillance Unit, which consists of five people: the national epidemiologist who oversees the unit; a deputy director who does case control and field investigations; and three statistical staff, one of whom does statistical analysis and the other two classified as data clerks. One data clerk is performing at a more analytical level; however, getting that position reclassified to a higher level is a challenge due to multiple layers of procedures. Field investigations of notifiable cases are a challenge given the limited number of staff in the unit, as is compiling and analyzing data. The PEPFAR Program, through the Centers for Disease Control and Prevention, has agreed to fund two positions within the unit: one for biostatistics and one for surveillance. PEPFAR will only fund the positions if Saint Lucia agrees to fund and absorb the positions at the end of the two-year commitment. The Cabinet in Saint Lucia has yet to give approval for these positions and continues to review the PEPFAR Program's conditions.

8.3 EXISTING PLATFORMS AND RECORD KEEPING

Data reporting on routine health statistics is done at the health facility level on paper, with forms sent to the Epidemiology Unit. All data are aggregated at the central level, when staffing availability allows, into Excel databases. The last chief medical officer's report that provides an in-depth analysis of the health situation and trends was produced in 2001. Data are currently being complied on a quarterly basis. There were reports of paper reporting forms being in limited supply, with health centers frequently relying on making copies rather than receiving supplies from the central level. Copies of the monthly and quarterly reports are kept at the health facilities.

Saint Lucia received a World Bank Loan in 2006, a large part of which was intended to acquire and implement an electronic health record (EHR)-based HMIS. The lead agency in Saint Lucia for this effort was the UHC organization, which had responsibility for developing the universal health coverage program. In the early vision for the electronic HMIS, the health facilities would capture patient information (from demographics to clinical diagnose to treatment plans) in the EHR, which would then allow for aggregated reporting to the MOH. The proposed model for this system was the Belize Health Information System, which is built on an EHR platform known as ACSiS from the Canadian company, Accesstec, Inc. In September 2006, Accesstec, Inc., submitted a proposal to the UHC organization to implement a national HMIS based on its proprietary software with the following modular components/functions:

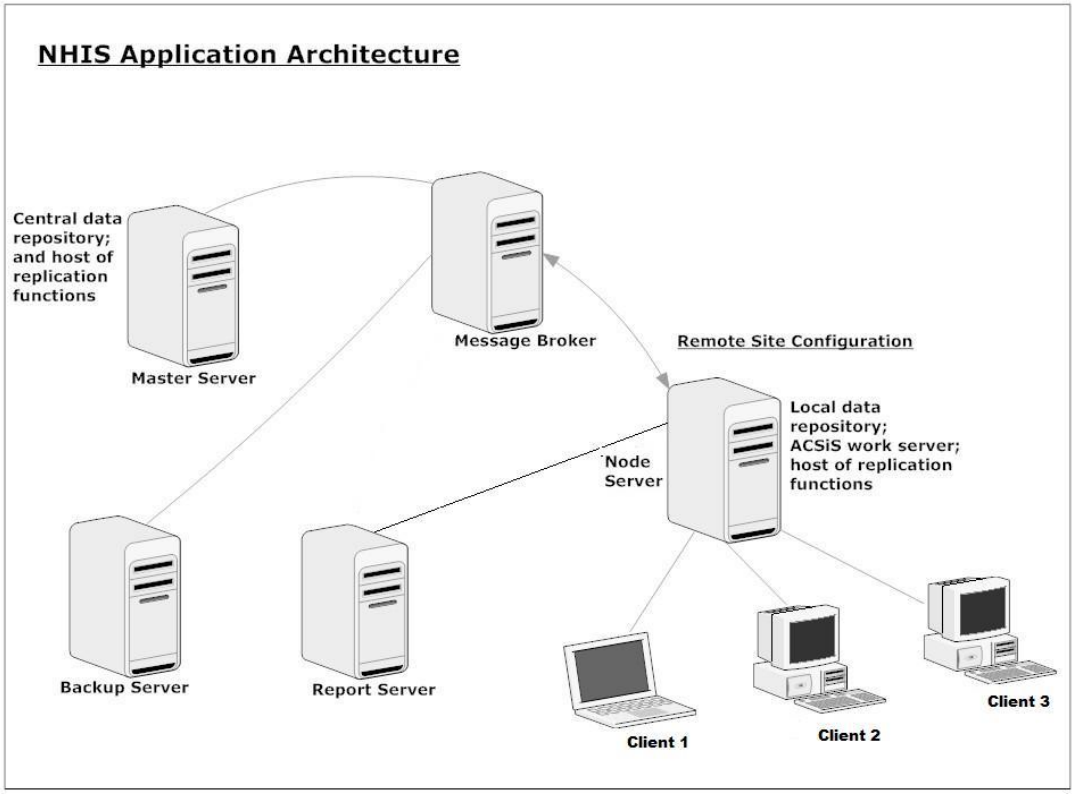
- ACSiS-EHR – Patient Registration and Tracking
- ACSiS-ADT – Admissions Discharge and Transfer (Encounters)
- ACSiS-COE – Clinician Order Entry
- ACSiS-LAB – Medical Laboratory
- ACSiS-SCM – Supply Chain Management and Inventory Control
- ACSiS-MCH – Maternal Child Health
- ACSiS-HIV – HIV-AIDS
- ACSiS-PH – Public Health
- ACSiS-HR – Human Resources
- ACSiS-FIN – Financial transactions and accounting
- ACSiS-CM – Content management and publication
- Third-Party Reporting engine

The contract was awarded to Accesstec and then executed in October 2006. In addition, Accesstec was required to build Blood Bank and Social Services Modules as part of their contracted scope of work. There were two notable exclusions in the contract award. Number one, the contract did not include development of any data exchange mechanisms (either interfaces or integration) between ACSiS and any existing or future information systems in use in Saint Lucia, thus limiting the ability to share information between systems. Number two, the contract called for the use of a third party's reporting engine rather than one built by Accesstec or incorporated into ACSiS. The reporting function, using an Open Source software package, has not been an implementation priority and it is not clear when this functionality will be fully incorporated into ACSiS.

A key functional benefit of ACSiS for Saint Lucia is that it's a web-based system with the consolidated Open Source database installed on a central server. This architecture minimizes the technical infrastructure requirements at each installation site, simplifies technical support, and streamlines the updating process. All that is needed for access at any location is a computer, a secure Internet connection routed to the database server, and the appropriate user access rights. At the same time, ACSiS will create a local replication of the database, allowing the users to work offline when access to the central server is not available and then to automatically synchronize the records databases when there is connectivity. A diagram of the system architecture is provided in Figure 8.1.

Source: (Holder and Henry 2009)

FIGURE 8.1: DIAGRAM OF THE NHIS APPLICATION ARCHITECTURE



Based on the work plan and project plan for this HIS design and implementation, the SLUHIS (as the national electronic HMIS in Saint Lucia is known) was initially expected to be fully implemented and operational within an 18-month timeframe. Based on the contract signing date and the proposed timeline in the Accesstec proposal, the EHR was initially expected to be implemented by April 2007. The first phase, a pilot implementation of the basic Admission, Discharge, and Transfer function at five locations within Region 1 – Victoria Hospital, Gros Islet Polyclinic, Grande Riviere, and Monchy Health Centers – began in early 2007. Facility staff there were trained and the SLUHIS was implemented at these locations, but with only marginal success, according to an external evaluation commissioned by the OECS in 2010. The two primary roadblocks to a successful pilot cited by the evaluators were "*the limited staff in the IT Unit was insufficient to deal with all issues raised by the different facilities involved in this phase of the project…[and]…the lack of standardization amongst pilot sites, particularly hospitals, posed major challenges and has led to bottlenecks and delays, since there was no mechanism for arriving at a consensus amongst the different institutions. This was particularly acute with respect to standard operating procedures,*

since the MOH is yet to initiate a programme to rationalise the use of standards across the health sector" (PAHO 2009, p. 28).

Interviews with staff at Victoria Hospital indicated severe limitations for data reporting. Victoria Hospital should be reporting service statistics to the Epidemiology Unit at the MOH and morbidity statistics to the Central Registrar on a monthly basis. Victoria Hospital was one of the initial HMIS pilot sites, which should allow hospital staff to report their data electronically directly into the HMIS. However, staffing limitations have significantly delayed summarizing and reporting these statistics. Staff absenteeism and a lack of staff cross-training of additional staff in this reporting process have limited the effectiveness of this reporting structure.

Patient medical records are currently maintained in paper files at Victoria Hospital. The electronic HMIS was intended to replace the paper and manual records process. The medical record numbers are assigned at admissions using a six-digit numbering system and maintained in a central storeroom with severely overcrowded carrels. There is no national patient identifier, which medical records staff noted leads to significant duplication of records. Staff report that as many as 7 out of 10 medical records are duplicates. As will be discussed further, there is no unique patient identifier utilized across the country and therefore across health facilities and programs.

Significant delays in the rollout of the system have occurred, caused by numerous factors ranging from limited staff who can support the contracting and equipment procurement process, to restrictions that have been placed on the software code, which has delayed the customization of the system to the Saint Lucian context. The code customization is being done by MOH information technology (IT) staff who were trained on the development platform in Canada. This was envisioned as a key to long-term system sustainability that has been thwarted by the code restrictions. The anticipated rollout of the EHR system is expected to include all 32 health centers, the public hospitals, and the polyclinic. Although it was raised as an option for consideration several years ago, there are no current plans to include the private sector health providers in the rollout of the SLUHIS.

8.4 INDICATORS

In-country interviews with key stakeholders indicated that a draft set of essential health indicators had been developed through a consultancy, but these indicators have not been finalized. For the HIV/AIDS program, based on the requirements from program funders, there are over 75 distinct indicators to be reported. Efforts have been started by NAPS to streamline these requirements, but to date this has not been completed.

8.4.1 VITAL STATISTICS IN REPORTING

The Statistics Department of the MOF comprises the Demographic, Mapping, Survey, and Front Office sections. The purpose of the Statistics Department is to collect, compile, and disseminate national statistical information relevant for policy decision making in a timely and efficient manner using cost-effective cutting edge technology. The Demographic Section is responsible for the collection, compilation, and dissemination of vital statistics. This section is responsible for providing population figures to the public as well as for producing an annual data publication called *The Vital Statistics Report*. However, the most recently published report in Saint Lucia is for statistical year 2006 and the most recently available report on the Statistics Department's website is for 2003 data. The Statistics Department is currently working on compiling the 2007 report.

The Statistics Department has 40 employees, eight of whom are statisticians. There are no biostatisticians currently employed by the department, but the department does have access to staff with geographical information systems (GIS) technical expertise to support the development of health maps, as needed. Three of the GIS resources are department employees, one is a consultant.

Statistical information on births, deaths, marriages, and divorces are collected from the Registrar of Civil Status and the MOH. The vast majority of the births in Saint Lucia (more than 99 percent) take place in a hospital, which is where the primary information on births is initially captured. Family members are required to register births (and deaths) with the local registrar, which triangulates the reported information with that captured by the hospital, and then the local registrar reports them to the Central Registrar. The Central Registrar reports that the system sometimes results in conflicting information being recorded. For example, a parent can register a child's birth without actually naming the child, or with a name may be misspelled or recorded illegibly, resulting in a mismatch of information at the different levels. Every parent in Saint Lucia has six months from the date of birth within which to register the birth of their child. The hospitals report the birth statistics (in duplicate) to the District Health Office, which in turn reports the data to the central MOH; a copy is also kept for hospital records, which become the primary data source should there be a discrepancy between various data users. Deaths are reported in similar fashion and are supposed to be coded according to the International Classification of Diseases, Version 10. This coding and reporting are not currently being done, however, in large part due to the absence of appropriately trained and certified medical coders.

There is currently no centrally located and commonly agreed-upon database with primary data of each citizen in Saint Lucia that could be utilized to assign a unique patient identifier. There are various databases owned by such entities as the NIC, the Central Registrar, the MOH, the Electoral Commission, and the UHC system. The data in each of these databases are widely considered inconsistent and not fully trusted. Another common primary source of vital information in Saint Lucia are baptismal certificates issued and kept by the churches. However, a primary defect of this document is that it does not state the place of birth, which presents a problem in determining whether an infant was actually born in Saint Lucia. Citizens have to present a government-issued birth certificate for many official government actions, such as student registration at a school, applications for exams, and the like. The absence of a unique national identification process poses a threat to the ability of the SLUHIS to maintain a distinct record for each patient over time. Ensuring quality of care issues, such as reviewing drug to drug interactions, is more challenging when there are known duplication of health records in the system.

8.4.2 SURVEYS AND THE CENSUS

The Statistics Department participates in a relatively limited number of health-related surveys. These health-related surveys are intermittent and have included morbidity surveys (2004 and 2006), monthly consumer price index surveys, household budget surveys, and the national census. The morbidity surveys were only conducted in 2004 and 2006. The consumer price index surveys only reflect health issues when drug costs account for more than 1 percent of total household expenditures. The household budget survey are conducted every five to eight years, while the national census is every 10 (see Annex B for a summary of relevant surveys). A more frequently occurring household budget survey could provide useful information for trending the health expenditures by patients. Saint Lucia census data from the 2001 exercise is available on the Statistics Department website, and includes the base data files. A review of the data files from 2001 during the assessment revealed significant data errors. The 2011 census data was collected earlier this year and preliminary data have been released on the department's website (see: http://www.stats.gov.lc/). The full set of cleaned data files is expected to be released within the next few months.

8.5 REPORTING RESOURCES

8.5.1 FINANCES

The National HMIS Unit has specific line items in the MOH budget and the National HMIS Unit can make an annual request for funding. Discussions with National HMIS staff indicate that the request is

usually not fully funded. As an example, the National HMIS Unit requested EC$3.2 million in funding last year but only received EC$1.1million, EC$600,000 of which was salary support and therefore not discretionary. MOH has also submitted specific requests to increase its staffing through the budgeting process, but these requests have not been approved due to financial constraints. Although a detailed national HMIS budget was not available for review, other documentation reviewed and stakeholder interviews indicate significant financial constraints are likely to further slow the rollout of the SLUHIS. The National HMIS Unit and MOH as a whole have relied on significant external funding for capital expenditures, such as infrastructure support from the CDB and funding for the SLUHIS from the World Bank. Interviews during the assessment indicate that it is unclear what prospects exist for identifying and accessing additional resources to further support HIS in Saint Lucia.

8.5.2 POLICIES AND REGULATIONS

The primary policy in place in Saint Lucia relevant to HIS is the Statistics Act. The act requires that the census be conducted every 10 years. Timeliness and breadth of dissemination of this information is not addressed under the act, however. In principle, all information collected from the public health sector is available to those who request it in Saint Lucia. The Freedom of Information Bill was submitted to the Saint Lucia Parliament for review in March 2010, passed, and signed into law. Implementation of the supporting regulations has not taken place and stakeholders interviewed indicated that the bill is expected to be rewritten and the process of passing the bill started again. Similarly, a Privacy and Data Protection Bill has been developed and submitted to Parliament, but the bill remains under consideration.

8.6 DATA COLLECTION

8.6.1 AVAILABILITY

The stakeholders interviewed for this assessment strongly agreed that health data are widely available; however, the challenge is that these data are not aggregated, analyzed, or disseminated in a timely manner. Stakeholders repeatedly cited limited staff capacity within the MOH to perform these duties as the as the primary cause for data going unused.

8.6.2 DATA FLOW AND CONSOLIDATED REPORTING

Syndromic surveillance data are reported on a weekly basis by a staff member from health facilities by telephone or fax. If the data are not received by the Epidemiology Unit, the unit's data clerk then tracks down the missing data by calling sites. Surveillance Unit staff indicate that more than 90 percent of the facilities regularly report, but this information could not be verified by a review of logged reports. The private hospital in Castries, Tapion Hospital, reports its laboratory tests to the Surveillance Unit that confirms notifiable conditions, such as STIs and/or HIV positive cases. For the remainder of the private sector, there are no formal procedures, nor is there consistency in the type and frequency of health data shared with the MOH.

A monthly report of epidemiological statistics is sent to the chief medical office, principal nursing officer, and all department chiefs. The summary of statistics, known as the "CMO's Report," is supposed to be published annually but has not been published in more than five years. This is primarily due to the absence of someone to take on the task within the Surveillance Unit. Under a World Bank-funded HIV/AIDS project, an M&E officer was hired at NAPS; when funding ended, the position was maintained at the registered nurse level within the MOH. Cabinet-level review is pending to approve the position as a higher level M&E position. HIV/AIDS data represent a separate flow of data from the health facilities to the national level. HIV data are collected across health facilities in the Patient Monitoring System, an electronic database. Data reporting is done at the central level as the staff from the STI Clinic located at

Victoria Hospital operate the rotating STI/HIV clinics that take place in the communities across Saint Lucia. The STI Clinic staff collect patient-level data during each clinic, returning with the records back to the central STI Clinic on Victoria Hospital campus, where the data are captured and reported electronically. The Epidemiology Unit sends out a data clerk to Victoria Hospital to compile the data from the facilities once a week, although this has not been happening on a consistent basis.

8.6.3 QUALITY

There are no formal procedures in place to evaluate and improve data quality across the Saint Lucian health system. A number of informal processes, however, do take place to review data submitted through the various reporting streams to the central level. For example, community health aides collect service statistics on the care that they provide and report it manually to the health centers across Saint Lucia. The health centers in turn report the data to the District Health Office, where the community health nurse reviews the data for quality before forwarding it on to the principle nursing officer at the MOH. If data issues are found, the community health nurse discusses them with the community health aides before the data are finalized. This type of review does not emanate from any written, formal guidelines addressing data quality, such as timeliness, accuracy, and completeness.

8.6.4 REPORTING PRIVATE HEALTH SECTOR ACTIVITES

Aside from HIV/AIDS, there is almost no private sector reporting to the government. There are a few exceptions: physicians and medical technicians who are in dual practice understand the importance of health data and report to the MOH. Despite the lack of reporting, private sector providers indicated in interviews a willingness to share information with the MOH. Private facilities – pharmacies, labs, and even a few private medical offices – are well equipped to report to the MOH because they use computerized systems for record keeping and other administrative functions. In addition, the private sector would appreciate more information from the MOH. Many complained that they do not receive updates on outbreaks (e.g., the recent dengue outbreak) and other important health trends. Also, those interviewed do not know what are the health priorities and ministry strategic directions because they have not been involved in the planning process or the information is not shared through the professional associations. The main source of information on the health sector is the news via the newspaper, the Internet, and TV.

8.7 DATA ANALYSIS

The National HMIS Unit and the Office of the National Epidemiologist both suffer from very limited staffing. The primary areas where shortages of staff exist are in the domains of M&E and data analysis. There appears to be fairly good capacity in place to capture and report data from the facility level to the central level. However, the capacity to analyze these data and compile comprehensive reports with the results is very limited. The CPU recognizes this as a central factor in its ability to promote more extensive dissemination and usage of health data. As noted above, there are two positions (biostatistician and surveillance officer) pending approval that could potentially fill some of this void if they are filled.

There are very limited local opportunities in Saint Lucia for training in data analysis, M&E, and health information systems. Many staff noted that the absence of local training capacity in these domains is a key barrier to improving the culture of information and demand for data in Saint Lucia.

8.8 USE OF INFORMATION FOR DECISION MAKING

8.8.1 PLANNING AND BUDGETING

The NSPH called for a comprehensive HIS development process based on an enterprise resource planning model. Such models typically incorporate a wide range of functional components, from product planning, finance, and supply chain management, to project management, human resources, and inventory management. The NSPH suggests an enterprise resource planning model that would allow various departments and ministries within the Saint Lucia government to adopt the modules appropriate for their programs and work flows, with data across programs and clients (as the case may be) integrated across distinct databases through linked identifiers. Based on the health systems and private sector assessment conducted, it does not appear that this model was adopted by the MOH.

There are other national-level work plans that provide a vision for HIS in Saint Lucia. *The National ICT Strategic Plan of Saint Lucia, 2010–2015,* developed by the MOPS and released in December 2010, frames the vision as follows: "Enable greater equity in the allocation and use of health care resources by exploiting ICT-enabled mechanisms to promote quality health care delivery and management" (Ministry of the Public Service and Human Resource Development 2010). This vision includes implementing a national electronic HMIS and comes with a US$6 million (or more than EC$16 million) price tag, funds which the MOH has only been able to partially piece together in drawn out stages. Table 8.1 describes the projected budgetary need for HMIS initiatives.

TABLE 8.1: PROJECTED BUDGETARY NEEDS FOR CURRENT HEALTH INFORMATION SYSTEMS INITIATIVES IN SAINT LUCIA

e-Health Administration	Budget (USD)	Targets	End Date
Health information portal	$30,000	Launch of website	Dec-10
HMIS enhancement (including ongoing training)	$3,000,000	Implement the Health Management Information System in 11 facilities	Mar-12
ICT infrastructure upgrade	$3,000,000	30 facilities networked	Dec-13
Legislative reform	$40,000	Draft revised legislation	Dec-10
Ongoing awareness & sensitisation	$50,000		Ongoing
Total	**$6,120,000**		

Source: Saint Lucia National ICT Strategy

The CDB committed to supporting the rollout of the SLUHIS to 11 health facilities (EC$718,000) through the summer of 2012, yet the financing will come up well short of the anticipated financial needs for this phase under the National ICT Strategic Plan. There was no indication from stakeholders interviewed or from documentation reviewed as to where the remaining funds would be coming from.

8.8.2 POLICIES AND GOVERNANCE

OECS has been supporting Saint Lucia under a World Bank-funded initiative to implement the E-Government Regional Integration Programs (E-GRIP). The loan awarded US$2.4 million to each OECS country but the loand can only be accessed through the OECS as directed by the E-GRIP team. E-GRIP primarily is focusing on common frameworks for integrating commerce across the OECS countries, such as uniform customs clearance processes. Health components are also specifically called out in the E-GRIP documents:

Subcomponent 2.5 E-Government in Health and Other Social and Productive Sectors – (US$830,000)

"This subcomponent will provide assistance in the implementation of a ***regional pilot project in health management information systems***, ….The core health elements of this subcomponent will explore options, in synergy with existing efforts, for implementation of standardized hospital facilities management systems and electronic patient records, including key linkages with national identification systems and civil registries, as well as regional epidemiological monitoring programs.

The subcomponent includes the following activities: (a) Implementation of a regional e-government pilot project in the health sector through, in particular, the design and implementation of a regional health management information system, which may include facilities management systems, electronic patient records, regional information network and on-line tools for Health Ministries; (b) Preparatory activities and/or complementary support to existing e-government initiatives in other social and productive sectors, notably agriculture and tourism, as well as education, postal sector, or others as may be identified in the early stages of the project" (OECS E-GRIP 2008, p. 19)

As noted here, the vision for E-GRIP within health has been on creating a regional HMIS. Toward that end, E-GRIP has engaged external consultants to facilitate both an assessment of the national HIS (for all OECS countries, including Antigua and Barbuda, Dominica, Grenada, Saint Kitts and Nevis, and Saint Vincent and the Grenadines) using the Health Metrics Network (HMN) framework and tools and the application of the Performance of Routine Information Systems and Management (PRISM) framework and tools, which focuses specifically on determining the organizational, behavioral, and technical determinants of the routine HIS performance. To implement both assessments, the external consultants have trained OECS country teams on the frameworks, methodologies, and tools, with the countries then expected to lead the assessments in their respective countries. Based on discussions with the Saint Lucia HIS stakeholders, the overall objectives of the E-GRIP initiative and the benefits to each individual country have not been clearly articulated. For example, although the HMN and PRISM assessments were completed in the spring of 2011, the SLU team had still not seen the data or the results by late June 2011.

8.9 KEY FINDINGS AND RECOMMENDATIONS

8.9.1 KEY FINDINGS FOR HEALTH INFORMATIONS SYSTEMS

Table 8.2 summarizes the strengths, weakness, opportunities, and threats to HIS in Saint Lucia.

Strengths	Weaknesses
• Electronic HMIS system has been purchased • Strong project management team leading efforts to rollout electronic HMIS • Routine reporting taking place across public health facilities, generating data • Good technical infrastructure in place across health facilities to support SLUHIS	• Limited staff to support needs of a nationally implemented electronic HMIS • Absence of unique patient identifier nationally limits capacity of SLUHIS to track patients • Poor timeliness of data consolidation and dissemination limits effectiveness of data driven decision policy making • Limited funding to complete all projected phases of SLUHIS rollout

Opportunities	Threats
• Leverage the E-GRIP work plans and team to move the dialogue on a national identifier forward • Timely data from health facilities using the SLUHIS increases the ability to drive demand for data • Leveraging fledgling telemedicine efforts at Tapion Hospital for broader purposes (internal and external to Saint Lucia)	• Weak functional specifications process at early stages of SLUHIS acquisition limiting ability to match functions to needs • Delayed focus on reporting capacity of the SLUHIS may lead to further delays in consolidating data • Unknown data quality may weaken value of SLUHIS rollout • Technical support requirements of the SLUHIS will be beyond the manpower capacity of the HMIS unit

8.9.2 HIS RECOMMENDATIONS

Short-term to Medium-term Recommendations

- **Develop regional partnership for technical support on SLUHIS:** Saint Vincent and the Grenadines has acquired and is implementing the same software system (ACSiS) for their electronic HMIS backbone. Both Saint Lucia and Saint Vincent have very limited staff for development, training, implementation, and technical support. Leveraging human/technical resources across the two islands would potentially reduce their individual burdens; this has added urgency before the MOH brings the NNH online with the SLUHIS.
- **Leverage the SLUHIS to engage the private health sector:** Minimal data on routine health services are being provided to the MOH by the private sector. The cost of acquiring the SLUHIS has already been paid, so no ongoing licensing costs are required. The MOH could potentially offer the SLUHIS for free (in terms of purchase price) to the private sector as a means of incentivizing them to report data to the MOH. An initial dialogue should be facilitated to ascertain the private sector's interest in such an arrangement, while also identifying their interests in having more data shared with them.
- **Initiate dialogue with the private sector around telemedicine opportunities:** There are numerous specialty areas largely under-resourced in Saint Lucia, due in part to the absence of a sufficient patient base to support a full-time, on-island provider. Psychiatry provides a clear example of this type of need. Tapion Hospital has been utilizing teleradiology with a partner hospital based in Miami, Florida, USA. Similarly, they have begun utilizing telemedicine for distance learning opportunities for their medical staff. Telemedicine presents an opportunity to initiate a public-private dialogue around common areas of interest, with an emphasis on meeting service delivery needs for the Saint Lucia health system.
- **Convene technical working group to review and harmonize indicators (particularly for HIV):** A recent review of HIV indicators noted that more than 75 distinct indicators were required from various funding agencies. A separate review was initiated to review and recommend a minimum set of health indicators, which should be collected and reported on a routine basis. As the rollout of the SLUHIS expands, it is important to ensure that only useful information is being data captured. It is recommended that a technical working group fast track this process to ensure that the SLUHIS rollout and indicator definition processes are synchronized.

Medium-term to Long-term Recommendations

- **Explore opportunities to leverage mobile phones for surveillance reporting:** The current reporting of notifiable conditions and/or disease outbreaks is done via fax or telephone and data are recorded by hand. This has been cited as a time-consuming and labor-intensive undertaking by key HIS stakeholders in Saint Lucia. Given the relatively small data set, the broad coverage and availability of mobile phones, and the available tools to leverage mobile phones for data reporting, mobile phone reporting merits consideration for Saint Lucia. A core team involved in the data capture and evaluation process should convene to explore the options for mobile phone reporting directly to a centralized database.
- **Develop formal staffing plan to support the SLUHIS long term.** The HMIS unit in the MOH continues to be short-staffed for its current activities. With the rollout of the SLUHIS, the work load will only increase. It is recommended that the MOH develop a formal HMIS staffing plan that ties to the projected activities, defines the specific roles and responsibilities of each position, and includes a recruitment and retention component. Where skills for the required positions do not exist, the development of training programs to create the long-term cadre of workers should be explored.
- **Implement the Routine Data Quality Assessment (RDQA) tool across the system:** There are currently no formal data quality assessment processes in place with respect to data being reported to the MOH. There are tools available, such as the RDQA tool, that incorporate both data review and feedback components in their process. Implementing an RDQA mechanism in Saint Lucia will likely improve the quality of data being reported, while also creating a feedback structure between central and district levels, and district and facilities levels. The RDQA also has a complete set of user guidelines and training materials that would simplify its implementation in Saint Lucia.

9. PRIVATE SECTOR CONTRIBUTIONS TO THE HEALTH SECTOR

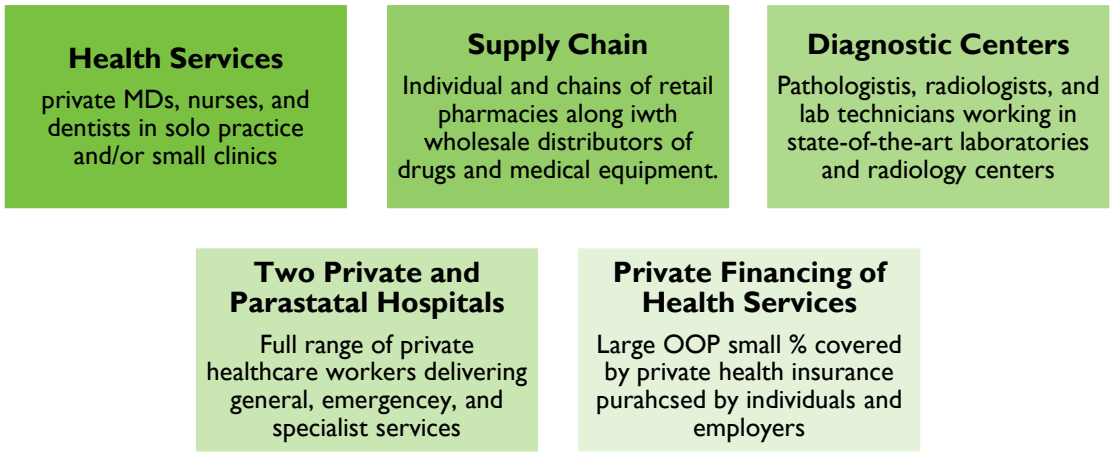
This section gathers all the assessment data reported elsewhere in the report to provide an in-depth description of the private sector and the challenges it faces. It describes the private health sector's size, scope, and clientele. In addition, the section examines the government's capacity to govern the private health sector and its willingness to partner and engage the private sector in a variety of stewardship areas such as policy and planning, finance, and service and product delivery. Finally, the section concludes with recommendations on how to better coordinate and integrate the private health sector into the overall health sector, harnessing the private sector's resources to complement public sector's priorities.

9.1 OVERVIEW OF THE PRIVATE HEALTH SECTOR IN SAINT LUCIA

The private sector in Saint Lucia is vibrant and growing, with an increasingly important role in the health sector. As Figure 9.1 illustrates, Saint Lucia has a full range of actors in the private health sector:

- Private physicians and dentists in solo or group practice supported by nurses and assisted by technicians (clinical, dental)
- Laboratory and radiology services with sophisticated equipment staffed by pathologists and radiologists assisted by technicians
- Retail pharmacies operating as an individual pharmacy owned by a pharmacist or multiple pharmacies owned and managed by a holding company
- Medical equipment and drug distributors enabling private providers to procure needed supplies locally in addition to regionally and internationally
- State-of-the-art, private-for-profit hospital with on-site pharmacy, laboratory, and radiology center delivering general, emergency, and specialty care
- A parastatal hospital offering a full range of services and diagnostics at affordable prices
- Significant private financing of health from two sources: individuals paying out-of-pocket and private health insurance purchased by individuals and employers

FIGURE 9.1: LANDSCAPE OF PRIVATE SECTOR STAKEHOLDER GROUPS



9.2 GOVERNANCE OF THE PRIVATE HEALTH SECTOR

9.2.1 REGULATION OF THE PRIVATE HEALTH SECTOR

There is no specific body within the public sector, such as a private sector advisor or a Public-Private Partnership Unit, that is responsible for the oversight of the private health sector. Governance of the private sector is divided among different entities within the MOH – Medical and Dentist, Nurse, Pharmacy, and Laboratory Councils. These councils regulate their respective health area across the sector. The councils keep a current list of registered professionals that is updated regularly through annual or biannual relicensing requirements, but they do not specify if the provider (or facility) is public or private.

Several associations represent and advocate for their respective professions. They include the SLMDSA, Pharmacy Association of Saint Lucia, Allied Professionals, and Independent Laboratory Association of Saint Lucia. All associations have been active with their partner council in developing and promoting CME courses for providers irrespective of sector.

Quality of care in the private health sector as a whole is not known. Currently, there are no standards of care that are required or enforced in either the public or private sector and there is no ministerial body that ensures private providers meet a minimum standard of care, whether it is for PHC or HIV services. In the absence of standards of care, many professionals rely on their medical training and standards in the country where they performed their residency/internship. Adherence to the standards and guidelines is purely voluntary. The various councils serve as disciplinary bodies to investigate patient complaints about providers in the private sector, but this only serves to punish extreme cases, as opposed to a systemic approach to quality assurance.

The Medical and Pharmacy councils, in partnership with the provider associations, offer CME training. Annual or biannual renewal of a provider's license is conditioned on meeting a minimum number of hours of approved CME courses. A certain number of hours has to be through in-person training offered by the council, in-person training provided by the association, and long-distance learning offered by approved CME provider. Compliance is high among private providers given CMEs credits are a requirement for relicensure.

The other gap in private sector oversight is of dual practice. There are no guidelines outlining possible areas of conflict between one's public duties and private practice, and this results in individual interpretation. Although Victoria Hospital has contracts with its providers outlining terms for dual practice, the hospital's management notes that these contracts have "no teeth," leaving room for potential abuse. The extent of this problem may be limited given the small percentage of health care professionals in dual practice. The public health care managers interviewed anticipated that dual practice would be pervasive and would occur mostly among physicians. But the data do not support this belief (see section 6.2 Allocation of Health Care Workers). Only 15 percent of physicians are in dual practice. In fact, most physicians (61 percent) work only in the private sector, while approximately 10 percent of nurses and midwives are in dual practice.

9.2.2 STATE OF PUBLIC-PRIVATE ENGAGEMENT

Information sharing and policy dialogue between the public and private sector exists but is not optimal. Private providers reported having the most contact and information with the professional associations and councils. Such communications and involvement between the professional associations and councils center around policies and protocols related to the specific profession. There is not a government or MOH body that systematically engages the private sector on general issues related to the health system such as health financing, training, or data collection. The CPU has stepped in to play this role from time to time but is not officially charged with the task of engaging all key stakeholders in the health sector. The most notable examples of public-private engagement were spearheaded by the CPU to develop the UHC policy document review and to develop the NSPH beginning in the late 1990s. Private providers were satisfied with their contribution and participation in these policy and planning initiatives.

The MOH has been challenged to sustain the dialogue with the private sector and improve these relations. According to private sector stakeholders interviewed during this assessment, they have not been regularly informed of changes to the initial NSHP, particularly over the last two years. The private sector would like to be more actively engaged to provide feedback throughout the policymaking process. There has also been limited discussion between the public and private sector on the rationalization of health services, staff, and/or equipment. With the development of the NNH, ensuring an effective public-private dialogue has become an even more critical issue.

The private sector provider continues to express willingness to work with the public sector on areas of mutual concern – dengue outbreaks, high cost of drugs, and health promotion, to name just a few examples. Other private sector providers indicated they would return to the table to discuss important policy and health sector issues but only if the MOH actively and continuously interacted with the private sector as full partners. As one private provider shared, "this is a small island with limited resources…we can't afford to compete against each other – we need to work together to ensure the health of all Lucians."

From the public sector point of view, there is increasing recognition that the private sector has an important role to play. However, many of the key stakeholders acknowledged that a strong and important minority within the leadership of the public sector still view the private sector with suspicion. The remaining challenge is how to build on this emerging recognition of the private sector's role to improve public-private dialogue in a way that allows the private sector to play a larger role.

9.3 PRIVATE FINANCING OF HEALTH

Although there is a strong tradition of free and accessible primary care in Saint Lucia, there is a substantial amount of private financing to support a growing and dynamic private health sector. There are two forms of private financing of health in Saint Lucia: individual out-of-pocket payments and health insurance. In addition to private individuals paying for health care, a small percentage of Lucians are covered through private health insurance (see section 4.3 in Health Financing). Accurate estimates on

private expenditures on health do not exist as no household health expenditure surveys have been conducted in recent years. Despite the lack of verifiable data on the amount of private sector expenditures on health, most interviewees in both the public and private sector agree that a substantial amount is spent in the private sector and is not captured in the policy and planning for health financing of the overall health sector. The lack of detailed estimates of private health financing underscores the urgent need for health expenditure data to provide a more realistic picture of how much money is spent on health and the percentage from private sources.

9.4 PRIVATE FACILITIES AND HEALTH SERVICES

9.4.1 TYPES OF PRIVATE FACILITIES

Table 9.1 presents the number of facilities by categories and ownership based on MOH records on public and private sector facilities. Doctor/dentist offices and clinics are estimated[11]. The private sector owns the majority of facilities: 116 of the total 160, most of which are private physician/dentist offices. Still, the private sector manages six out of eight laboratories, and two out of three hospitals in Saint Lucia.

TABLE 9.1: TYPE OF HEALTH FACILITY BY OWNERSHIP

Facility Level	Public +	Parastatal +	Private *	Subtotal by Facility
Health clinics	32	0	0	32
Consultation room (MDs only) **	0	0	77	77
Polyclinic ++	2	1	5	8
District hospital	2	0	0	2
General hospital	1	1	1	3
Laboratories++	2	1	5	8
Pharmacies++	36	1	25	62
Subtotal by sector	**75**	**4**	**113**	**192**

Sources:
+ MOH data
++ Number includes polyclinics (outpatient services at private hospitals and private medical centers), labs, and pharmacies on-site at all three hospitals. Number also includes all pharmacies at MOH health clinics that have limited hours compared to facilities at Saint Jude and Tapion.
* Based on Medical and Pharmacy Council registry of physicians and pharmacies.
** Based on MOH number of physicians and count of yellow page directory of consulting rooms. May be underestimated due to lack of data for private sector.
For a description of which private sector services are considered polyclinics, please see Annex A.

9.4.2 GEOGRAPHIC DISTRIBUTION OF FACILITIES

The team conducted an analysis of health facilities – public and private alike – by geographic region[12] to determine the location of private facilities. As tables 9.2 and 9.3 reveal, private sector providers and facilities are located in both northern and southern districts. The largest number of private sector facilities are concentrated in the north – 94 facilities in the north compared to 21 in the south. This is consistent with the fact that the highest concentration of Saint Lucia's wealthiest population also reside

[11] Number of consulting rooms estimate is based on the number of registered private physicians and dentists and corresponding addresses in telephone directory.
[12] For the purpose of the analysis, the team grouped the districts as follows: North: Castries, Babameau, Gros Islet, Dennery; South: Anse-la-Raye, Soufriere, View Forte, Micoud.

in the north. Approximately 20 percent of all private sector facilities are located in the south – considered the poorest region in Saint Lucia. There is, however, sufficient income in the south to support a full range of private health services, including private physicians in consulting rooms, private pharmacies, a private laboratory, and a parastatal hospital. A small percentage of private physicians – particularly specialists – maintain offices in both Castries and Vieux Fort.

TABLE 9.2: TYPE OF HEALTH FACILITY BY OWNERSHIP AND GEOGRAPHIC DISTRIBUTION (NORTH)

NORTH (55,112 population)				
Facility Level	**Public +***	**Parastatal +**	**Private ***	**Subtotal by Facility**
Health clinics	11	0	1	12
Consultation room (MDs only) **	0	0	63	63
Polyclinics++	2	0	4	6
District hospital	0	0	0	0
General hospital	1	0	1	2
Laboratories++	1	0	5	6
Pharmacies++	13	0	20	33
Subtotal by sector	28	0	94	122

North includes Gros Islet, Babonneau, and Castries health regions

\+ MOH data

++ Number includes polyclinics (outpatient services), labs, and pharmacies on-site at all three hospitals. Number also includes all pharmacies at MOH health clinics that have limited hours compared to facilities at Saint Jude and Tapion.

* Based on Medical and Pharmacy Council registry of physicians and pharmacies

** Based on MOH number of physicians and count of yellow page directory of consulting rooms. May be underestimated due to lack of data for private sector.

For a description of which private sector entities are considered polyclinics, please see Annex A.

TABLE 9.3: TYPE OF HEALTH FACILITY BY OWNERSHIP AND GEOGRAPHIC DISTRIBUTION (SOUTH)

SOUTH (69,153 population)				
Facility Level	**Public +***	**Parastatal +**	**Private ***	**Subtotal by Facility**
Health clinics	21	0	0	21
Consultation room (MDs only) **	0	0	14	14
Polyclinics++	0	1	1	2
District hospitals	2	0	0	2
General hospital	0	1	0	1
Laboratories++	1	1	1	3
Pharmacies++	23	1	5	29
Subtotal by sector	47	4	21	72

South includes Dennery, Anse La Raye, Micoud, Vieux Fort, and Soufriere health regions.
+ MOH data
++ Number includes polyclinics (outpatient services), labs, and pharmacies on-site at all three hospitals. Number also includes all pharmacies at MOH health clinics that have limited hours compared to facilities at Saint Jude and Tapion.
* Based on Medical and Pharmacy Council registry of physicians and pharmacies
** Based on MOH number of physicians and count of yellow page directory of consulting rooms. May be underestimated due to lack of data for private sector.
For a description of which private sector entities are considered polyclinics, please see Annex A.

9.4.3 PHYSICIAN AND DENTIST OFFICES

The team conducted a quick analysis of private physician offices and estimated there are approximately 77 private physician offices in Saint Lucia, of which 8 out of 10 are located in the north. The consulting rooms range from a modest storefront to a state-of-the art group practice with multiple physicians in similar or differing specialties. A few of the more modern facilities also offer on-site x-rays, electrocardiograms, ultrasounds, and laboratory and pharmacy services.

Clientele: The price charged by private physicians is consistent throughout the island – EC$100 for a general doctor's visit and EC$150 for a specialist. When asked how the rate was determined, the interviewees stated "that is the going rate" or "that is what the patient expects to pay." Most offices visited had the prices for doctor's visit and other services prominently displayed. All private clients pay out-of-pocket for the doctor consultation and other services. When asked about the clientele, all private physicians interviewed indicated they receive clients from "all walks of life" and from "all different socioeconomic levels." All private physicians interviewed also have patients with private health insurance. Depending on the location, the percentage of clients with private health insurance is 30 percent in downtown offices compared to more than 60 percent in the Rodney Bay location. Private physician staff assist patients to fill out the required paper work so they can get reimbursed.

Private physician office in Soufriere

Box 9.1 Range of Services Offered in Physicians' Offices

- Acute and chronic care
- Well and sick child care, including immunizations
- Family planning and reproductive health services, including pap smears and breast exams
- Antenatal care
- Comprehensive medical exams
- Diabetes clinics
- Hypertension clinics

Services: As Box 9.1 illustrates, private physicians offer a wide array of general medical services at their office locations. Reasons cited why patients prefer to seek care in the private sector despite free services in the public sector include the following:

- Convenience (location/longer hours)
- Perceived quality (attractive facilities, friendlier staff)
- More time with the doctor

Another reason why Lucians seek medical care in the private sector is access to specialists. Table 9.4 shows the range of specialties available in the private sector. Although some of these physicians also work in the public sector, the majority of specialists work exclusively in the private sector.

TABLE 9.4: RANGE OF HEALTH SPECIALTIES IN THE PRIVATE SECTOR

Health Specialties	
• Anesthesiology	• Obstetrics/Gynecology
• Cardiology	• Oncology
• Dermatology	• Ophthalmology
• Ear, Nose, and Throat	• Plastic Surgery
• Endocrinology	• Pediatrics
• Internal Medicine	• Urology
• Neurology	• Surgery (ENT, general, orthopedic, vascular)

Quality: There is minimal monitoring and enforcement of quality among private providers. All physicians are required to receive their license to practice from the Medical and Dentist Council. Private physicians are also required to keep up with CME hours. It appears that all private physicians are licensed and most fulfill their CME requirements. But neither the Medical Council nor SLMDSA tracks private provider licenses or monitors private provider compliance with CME hours. The absence of quality standards and structure supporting private practice is a concern since the majority of private practitioners work exclusively in the private sector with no access to donor-funded or ministry-supported training.

Outlook: The private health sector is so dynamic – with numerous facilities and a wide range services – that a completely independent and parallel private health system is emerging. Indeed, many of the private physicians indicate they almost never interact with the public health sector because they can find all the following services they need for their patients in the private sector:

Private Medical Group Practice in Rodney Bay

- Private lab for testing
- Private specialist for additional diagnosis and treatment
- Private pharmacies with a wider range of generic and brand name drugs
- Private diagnostics (MRI, PET SCAN, etc.) centers

- Private hospital
- Private insurance to pay for all of these services in the private sector.

All interviewees, however, indicated they would prefer to have greater interaction with the MOH and to feel they are contributing to the overall health in Saint Lucia.

The scope did not permit a comprehensive assessment of the private dentistry. However, a cursory view of the yellow pages indicates there are 17 dentist offices in the north and five in the south. Only one private dentist maintains an office both in Castries and Vieux Fort.

9.4.4 PRIVATE PHARMACEUTICAL RETAILERS AND DISTRIBUTORS

The private pharmacy retail market has grown rapidly in the last five years despite the overall economic downturn in Saint Lucia. According to Pharmacy Council records, there are 25 registered commercial pharmacies and one pharmacy in Saint Jude. The growth in the retail pharmacy market has occurred among retail chains at the expense of individually owned pharmacies. The largest private sector pharmacy chains in Saint Lucia are M&C Drugstore, R & J Clarke, LTD, and Super J Pharmacy.

Clientele: The private pharmacists interviewed said they serve clients from all socioeconomic groups. Despite the higher cost of drugs in the private sector, customers fill their prescriptions in the private sector for convenience (location, longer hours, open on weekends), wider range of drugs, confidentiality, and availability (almost no stock-outs, particularly for drugs needed for chronic diseases). When asked why public sector clients go to a private pharmacy, the response is choice – private pharmacies sell name brands and certain generics not offered in public pharmacies. Depending on location (e.g., close to Victoria Hospital), private pharmacies receive upwards of 60 percent prescriptions from the public sector while other pharmacy locations estimate public sector prescription fulfillment is as low as 30 percent.

Procurement: Private pharmacies in Saint Lucia procure from both domestic and international sources. The pharmacy owners/managers interviewed stated they are able to purchase a considerable portion of their supplies/drugs through the five local distributors. Prices vary for the same products among the five local distributors, allowing for choice. If the pharmacy owner/manager cannot find a drug or if the price is not competitive, then he or she procures the drug from regional and international distributors located in Barbados, United States, UK, and Canada. Some of the distributors used are the following:

- Barbados (Armstrong, BioKal, Brighton/Schering, Carlisle, Collins, and Stokes)
- UK (Ziotis)
- United States (Knox, Masters).

All private pharmacy owners interviewed stated they only work with "reputable" distributors and/or drug manufacturers that are FDA/EMA approved or WHO prequalified, but they do not necessarily follow MOH procurement guidelines.

Quality: Saint Lucia put into place a Pharmacy Act. The act established a Pharmacy Council and created the tools needed to enforce and/or sanction unlawful and unethical practices. Key among them is the facility licensing and professional CME requirements. Professionals are required to complete 12 CME annually to ensure continued professional development and quality of care: six courses from the Pharmacy Council, three face-to-face sessions, and three from other mediums (mostly online) also from an accredited CME provider.

By all appearances, private pharmacies comply with MOH guidelines. Private pharmacies are required by law to obtain a facility license, which includes an inspection. All private facilities are initially inspected but

few have experienced a subsequent government inspection. All private pharmacies are required to have a fully licensed pharmacist present to dispense drugs. It appears that all pharmacies do in fact comply with this regulation and often have two pharmacists on duty. When asked about compliance, almost all private pharmacists interviewed said they are aware of the guidelines and in fact many showed copies of the regulations. Many private pharmacists, however, tend to follow the guidelines and practices learned in Guyana or Jamaica where they received training. A few interviewees reported quality issues among private pharmacies such as a few pharmacies dispensing drugs without prescriptions and stocking substandard drugs.

There is a collaborative and coordinated relationship between the Pharmacy Council and the Pharmacy Association. A small core of pharmacists rotates between leadership positions for both the Pharmacy Council and the Pharmacy Association, helping provide continuity and consensus on policy directions in the pharmaceutical sector. However, there appears to be minimal private sector participation in the association due to tension between public and private pharmacists. This tension appears to stem from the fact that public pharmacists are Saint Lucians while private pharmacists are from other locations (mostly from Guyana), which is a tension that persists even though some of the foreign pharmacists have been in Saint Lucia for more than 15 years. The association is working to bridge this divide but has been unsuccessful to date.

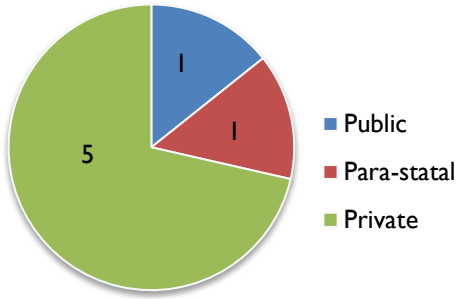
Outlook: Growth in retail pharmacies has leveled off. A few of the pharmacy owners/managers shared that competition is very tough with the expansion of the pharmacy chains. Also, clients aggressively shop for best price for a drug, visiting many pharmacies to price items before purchasing. While conducting pharmacy interviews, the assessment team observed many clients purchasing some drugs in one pharmacy and others in a second one. As a result, private pharmacies are reducing their margins and offering the same drug at different price points to attract and retain more customers, offering both generic and brand names.

A common theme among all private pharmacists was a desire to interact more with the MOH. Possible areas of collaboration proposed included public health emergencies, such as the recent dengue outbreak, and health promotion, particularly in NCD. Private pharmacists are also willing to share information on total volumes and report on specific prescriptions. Given that most private pharmacies use electronic systems, it would be very easy for them to produce this kind of information on a regular basis. Private pharmacists confirmed that the Pharmacy Association would be the appropriate mechanism to inform and engage private pharmacies. However, there is some tension between public and private pharmacists that needs to be addressed before the association can effectively integrate and engage private pharmacists. This divide still persists even though many of the foreign pharmacists have been in Saint Lucia for more than 15 to 20 years.

9.4.5 PRIVATE LABORATORIES

There are six private laboratories on the island – five are for-profit and one is parastatal. Some of these private labs expand their services by locating collection centers in secondary cities, such as Blue Coral and Soufriere. The private sector has six of the island's seven health labs (not counting the environmental health lab at the polyclinic).

FIGURE 9.2: NUMBER OF LABORATORIES BY OWNERSHIP, 2010



Laboratories appear to be the only area with substantial cooperation between the public and private sectors, albeit informal. The fact that both sectors serve on the National Laboratory Advisory Council greatly facilitates the collaboration. Examples of public/private cooperation include the following:

- Stock-outs: The public sector experiences regular stock-outs of reagents due to budgeting shortfalls and paperwork. Also, lab budgets sometimes get squeezed by other needs at Victoria Hospital. When either a public or private laboratory is out of a reagent, the labs share among themselves and pay later.
- Out-of-commission: When the public lab is not operating because their machine is down, the public sector makes arrangements to refer its patients to the private sector for a test.
- Reporting: Private laboratories do report certain conditions, such as HIV and abnormal pap smears, to the MOH epidemiologist at the same time the result is returned to the ordering physician. But there is no other reporting of private test volumes. See Box 9.2 for information on private sector AIDS testing.
- Equipment repairs: The public sector has problems with lab budgets, which often results in delays and funding shortages to purchase reagents or repair equipment. Private sector labs have offered to "share" costs of a service visit with the public sector but cannot because of MOH tendering procedures.

Pathologist at Tapion Hospital Lab

The other health areas – medical, pharmaceutical, and hospital – would greatly benefit from the example of public and private labs' coordination and cooperation. Both public and private labs charge for tests. In most cases, the public lab fees are cheaper, but not always. Despite the higher fees charged in the private laboratories, the private labs are quite busy and see a wide range of clients from all socioeconomic levels. All of these clients pay out-of-pocket. However, more than 25 percent of private lab clients have private insurance coverage. Similar to private physician patients, the burden of reimbursement falls on the client. The private labs assist clients with insurance to complete claim forms.

Box 9.2 Private Sector AIDS Testing

- All HIV positives conducted in the private sector are confirmed by the national public lab.
- Private sector reports total volume of HIV tests to the National AIDS Program

The lab at Tapion Hospital, owned and managed by Laboratory Services and Consultation Ltd., is an example of the advanced testing and quality services available on the island. The hospital lab is a well-equipped and seemingly well-run lab. The Tapion lab is also a leader in its field:

- The lab was the first to establish integrated computerized information systems that interfaces to its laboratory machines.
- The lab continuously introduces previously unavailable laboratory tests.
- The lab maintains offshore links for proficiency testing and referral of tests they cannot perform themselves.
- The lab is the first medical laboratory to receive international accreditation (Accreditation Canada International, June 2010).

Private labs also rarely experience "down time" due to equipment breakdowns. If the lab staff cannot repair the equipment after a telephone consultation, the supplier sends a technician within 24 hours.

The government does not require a license to operate a private lab, and this creates possible risks for the health sector.

9.4.6 PRIVATE HOSPITALS

There are two private hospitals in Saint Lucia: one fully private and one parastatal. Tapion Hospital, in Castries, is a commercial, for-profit hospital, while Saint Jude, located in Vieux Fort, is a privately managed hospital with a government subvention.

SAINT JUDE HOSPITAL

Since a 2009 fire that destroyed the surgical wing at the existing hospital site, Saint Jude has been operating in the sports stadium near the airport. The facility is being rebuilt with support from the Taiwanese government, other donor agencies (including individual Saint Lucian donors), and a project management team from the MOF. Saint Jude management expects that the facility should reopen around the end of this year.

Picture before and after the fire at Saint

For the purposes of this report, Saint Jude is considered a parastatal entity given its legal status and operations. Previously, Saint Jude was run by a Catholic Order. In 2003, the government approved an act establishing Saint Jude as a statutory body with a board of directors appointed by the MOH. The hospital has financial and personnel autonomy. Annually, the Saint Lucian government pays a set amount toward Saint Jude's budget, which primarily covers the salary costs. Saint Jude staff reported that amount received is usually less than is budgeted.

Saint Jude's annual budget requirement is around EC$25 million, of which EC$14.6 million is allocated to salaries (see Box 9.3 for details of Saint Jude staffing). After negotiation, Saint Jude receives an MOH subvention of EC$12.6 million. To make up the shortfall in its operating budget, Saint Jude relies on patient fees and charitable donations. Saint Jude fees are comparable, if not a little higher, to those at Victoria Hospital. Saint Jude collects fees from all patients except the very poor, police officers, and/or prisoners. They are also willing take in-kind payment if necessary. Saint Jude does collect from private insurance but not directly from the NIC. Hospital services for NIC members are provided freely and the MOH is compensated with an EC$5 million per year in a lump sum that goes toward the MOH budget but is not reflected in the revenues for Saint Jude or Victoria Hospital.

Staffing remains a challenge for Saint Jude, particularly in filling vacant positions for specialists. Saint Jude is sometimes able to fill the gap in specialists through its extensive network of overseas volunteer physicians. Hospital management is working with the Medical Council to simplify the process of obtaining a temporary license for the foreign volunteers/visitors (e.g., accepting a fax for key documents). Box 9.3 provides an overview of staffing positions and vacancies. It is important to note that the quality manager position still remains vacant.

Saint Jude has a fully operational pharmacy, although it is not computerized. The pharmacy purchases its drugs through international suppliers rather than local suppliers because the prices are reportedly lower. Saint Jude does not participate in the PPS program because it does not have the US$250,000 to buy into the revolving fund.

Box 9.3 Saint Jude HR Staffing

- MDs: 34 positions including 15-17 senior house officers and 6 vacancies.
- Nurses: 82 nurses and 3 vacancies. Have student nurses awaiting exams while doing ward duty under supervision
- Pharmacists: 3 positions and 1 vacancy.
- Overall 21 vacancies for 300 positions.

Future plans include strategies to improve quality and financial sustainability. After the hospital relocates to the rebuilt facility, hospital management staff plan to get accredited. International Medical Corps has provided some preliminary advice on the process and preparation needed to become accredited. Saint Jude also plans to become an accredited regular provider of CME on-island. The hospital has already conducted a couple of training courses at its site with offshore partners.

In addition, Saint Jude is exploring different strategies for cost recovery. One approach is to attract private-paying patients. Saint Jude management is exploring establishing a few private rooms in the new facility. Recognizing Saint Jude's current fees do not reflect full cost, management will have to revise the fee schedule to reflect full cost of private care. Another possible cost-recovery mechanism is to offer procedures not available at Victoria/NNH. Offshore partner specialists can perform these surgical procedures on their behalf.

Box 9.4 Range of Services Offered at Tapion Hospital

- Internal medicine (cardiology, rheumatology, etc.)
- General surgery
- Pediatrics
- Dermatology
- Ear, Nose, and Throat
- Ophthalmology
- Pathology
- Obstetrics & Gynecology
- Orthopedics
- Urology
- Pacemaker/Defibrillator
- Laboratory Service
- Radiology (including CT scanning, color Doppler and MRI machines)
- Nuclear medicine
- Laparoscopic Surgery

TAPION HOSPITAL

Tapion Hospital, the first and only fully private hospital in Saint Lucia, was founded in 1996 by a core group of 10 physicians and lawyers. The original group of investors has grown to more than 60 shareholders today. The hospital has a strong governance structure with a seven-member board of directors.

A former hotel, Tapion is a 26-30 bed facility, with major expansion underway. Tapion, with over 40 doctors on staff, provides general, emergency, and specialist services (see Box 9.4). Several other private physicians – many have offices located close to the hospital – have admitting privileges. Tapion has an active outpatient department but low inpatient census (45 percent occupancy during and 60 percent occupancy out of tourist season).

Tapion Hospital is the first and sole hospital in Saint Lucia to be accredited from an international organization (Accreditation Canada International). To remain current on the latest technologies, Tapion is affiliated with many international hospitals, such as the Baptist Health South Florida Hospital System. Staff use telemedicine on

referrals, sending digital radiology images to its U.S.-based partners. Tapion also has arrangements with offshore medical schools in Saint Lucia for clinical rotation.

The on-site pharmacy is well organized and has a private counseling room built to offer privacy and confidentiality to patients, including those on ARV treatment. Pharmacy staff use a computerized system to maintain and control inventory; they are in the process of installing an electronic ordering system. The pharmacy carries a wide range of brand and generics, mostly procured from offshore supplies. As is the case with most private sector pharmacists, the chief pharmacist is Guyanese and has been at Tapion for 15 years.

Tapion also has an extensive radiology facility – owned and operated by Gablewoods Medical Center. The radiology center performs routine x-rays to complex radiological procedures. The facility has an MRI; CT scan; fluoroscopy, ultrasound, and Doppler scanners; computerized mammography; and x-ray. They conduct two to three MRI screenings per day.

16 slice CT Scanner

For a description of Tapion's lab, see Section 9.4.5.

Many of Tapion's patients have private insurance. The hospital has negotiated an arrangement with CLICO and SAGICOR in which Tapion can estimate the insured's liability and collect only the amount that is not insured. The insurance company pays the rest directly to hospital. The hospital is also working with CLICO on a system where the insurer will pay the full amount due and then collect copayments from the patient (rather than Tapion collecting full payments from the patient).

With bank financing, Tapion is undergoing a major expansion. Major expansion will include PET scan, more laboratory space, catheter lab, and training facilities. The expansion does include more beds. A key area of interest is the training space in the new wing. The training center will have capacity to provide remote CME.

Tapion Hospital has a strong commitment to "giving back to the community" and created a foundation for its public works. The foundation delivers free medical treatment to cardiac patients in need, trains health care providers in new technologies, and offers community health programs. Tapion Hospital has an active dialysis center, with many dialyzed patients covered by private insurance. Once insurance is exhausted, Tapion Hospital continues the services for the patient at a discount until the lifetime maximum within their insurance policy is reset. The hospital also serves some patients who can only afford one treatment per week. Recent relations between Tapion Hospital and the MOH have been somewhat strained, although Tapion Hospital leadership expressed an interest in greater collaboration between the public and private hospitals – sharing resources, expertise, and equipment – to help improve the health for all Lucian patients.

9.5 PRIVATE SECTOR HEALTH PROFESSIONALS

The HRH chapter provides an in-depth discussion of the public/private mix of health professional by each cadre. Table 9.5 provides a macro picture of major health professionals. One can observe that there are fewer health professionals in dual practice than believed by those interviewed in the public health sector. Moreover, the private sector is a major employer across the different health professional cadres, including nurses and midwives. Finally, as noted in a prior section, many of the specialists missing in the public sector can be found in the parastatal or private sector.

TABLE 9.5: NUMBER OF SELECT HEALTH CADRES BY SECTORS

Health Professional Cadre	Public Only	Saint Jude Only	Private Only	Dual Practice	Total
Physicians	56	28	98	33	215
Dentists	0	0	24	5	29
Nurses	188	48	79	1	316
Midwives	106	26	64	9	205
Pharmacists	20	3	57	11	91
Ophthalmologist	0	0	5	1	6

Source: MOH data

9.6 REPORTING PRIVATE HEALTH SECTOR ACTIVIITES

Aside from HIV/AIDS, there is almost no private sector reporting to the government. There are a few exceptions: physicians and medical technicians who are in dual practice report health data to the MOH. Despite the lack of reporting, private sector providers indicated a willingness to share information. As one private pharmacist shared "if the MOH asked us, we would report data to the MOH." Private facilities – pharmacies, labs, and even a few private medical offices – are well equipped to report to the MOH because they use computerized systems for record keeping and other administrative functions.

In addition, the private sector would appreciate more information from the MOH. Many indicated that they do not receive updates on outbreaks (e.g., recent dengue) and other important health trends. Also, those interviewed do not know what are the health priorities and ministry strategic directions because they have not been involved in the planning process or the information is not shared through the professional associations. The main source of information on the health sector is the news – newspaper and TV.

9.7 KEY FINDINGS AND RECOMMENDATIONS

9.7.1 KEY FINDINGS FOR THE PRIVATE HEALTH SECTOR

Table 9.6 summarizes the strengths, weakness, opportunities, and threats for the private health sector.

TABLE 9.6: SWOT ANALYSIS FOR THE PRIVATE HEALTH SECTOR

Strengths	Weaknesses
• Private health sector substantial (current estimates from MOH data) • Private facilities are located throughout the island but mostly concentrated in Castries • Private sector sees full range of clients – poor and rich. Reasons include convenience, perceived quality, confidentiality, availability of a wider range of drugs and access to specialists • Private pharmacies supply different price points for key drugs making them affordable	• There are up-to-date and transparent regulations governing both public and private sectors but there is little MOH capacity to monitor and enforce sanctions • Almost all private providers are aware of regulations and actively reregister and comply with CME requirements • Currently self-regulate (pharmacies more organized), leaving possible opportunities for abuses

Opportunities	Threats

• Private providers recognize system constraints and are willing to help
• Private health care providers offer pro bono work for poorer patients
• Private labs share equipment and supplies with public sector labs
• Private sector wants to do more to contribute, including:
  - Get involved in health promotion
  - Share information with MOH
  - Participate in policies/discussions on quality standards and regulations
  - Share expertise, contracting services, and equipment
• Private sector organized into active professional associations, making it easier for the MOH to communicate with the private sector and identify partnership opportunities
	• Private sector providers believe their contribution to the overall health system is not recognized nor valued by the public sector
	• Private sector feels excluded from major health reforms (e.g., movement from UHC to VAT for health) and resent not being involved or kept current on policy reforms affecting their private practice
	• Breakdown in communications and interactions risks polarizing the two sectors when it is critical for greater coordination to help launch the NNH

9.7.2 PRIVATE SECTOR RECOMMENDATIONS

The following are a series of recommendations to address the strain in relations between the public and private sector as well as strategies to better coordinate technical expertise and resources between the sectors. They are organized by health sector building blocks.

GOVERNANCE

- **Normalize relations between public and private sector:** Improving the strained relations between the public and private sectors is a top priority. Not only is it important to return to the table to start the dialogue in order to improve relations, it is absolutely critical for the two sectors to come together in preparation for the opening of NNH. Both sides, public and private alike, expressed a need and desire for better communication and more interactions between the sectors. Willingness for engagement exists. In the near term, the assessment team proposes the following actions to jump start the dialogue process and to help institutionalize public/private interactions:
  - Document and acknowledge private sector contributions in the health sector**.** As this report illustrates, the public and private sector currently collaborate together on a wide range of activities. This report can start the process of documenting and formalizing these activities. But a more comprehensive "inventory" of public-private coordination and collaboration is a good first step in understanding the quantity and range of partnership between the sectors. Moreover, consider having the public sector publicly acknowledge private sector contribution as an act of good faith in improving relations. The MOH can work with the various medical professionals associations to develop this inventory and to publicly acknowledge the private sector role during associations' quarterly meetings.
  - Start involving the private sector in MOH meetings. To start the dialogue, set a goal (once/twice per month) to identify opportunities to invite private sector participation (e.g.,

meeting, inaugurations, etc.) and act upon them. A "quick-win" would be to bring together the public and private sectors – through their respective associations – to discuss how to better share information between the sectors. This activity is described below. Another "quick win" is to involve the private sector – health and communications – to help the MOH in public awareness campaigns. Many private companies expressed an interest in doing more for their communities and would welcome working with the MOH. Moreover, almost all private providers – physicians and pharmacists – consider public education on key health topics part of their job but do not have the information and/or tools. Once again, the MOH can work with the associations to promote partnerships in public health information and communication.

- Start involving the private sector in MOH planning. The MOH has a solid track record in stakeholder engagement with the UHC and Strategic Plan. Now is the time to go back to the MOH's participatory planning model. There are two areas of importance to both sector where the private sector can play an important role: (1) preparation for the new MOH hospital and (2) standards of quality of care.
- The MOH faces many challenges, with limited resources such as time, staff, money, expertise, in opening the new hospital. The private sector, on the other hand, has many resources – staffing, facilities, equipment, expertise, and experience – that can be mobilized to help the MOH with this monumental task. A first step would involve bringing together senior MOH and private sector leadership to inform them of the current plans for opening the hospital, discuss some of MOH challenges ahead, and explore areas where the private sector can assist. A good example of public-private coordination would be to ask Tapion Hospital or one of the major hotels to "lend" one of its senior administrators to help MOH staff charged with the planning and logistics of staffing and equipping the hospital. Concrete strategies to better coordinate resources between the sectors are proposed in the following section, but the first step is to explore interest and willingness to work together on harmonizing resources and mobilizing for private sector expertise to help with the new hospital.
- A second area where the private sector has expertise is in quality of care. Consider forming a committee composed of representatives from the public and private sectors in health and consumer groups to assist the MOH to define standards of care to be used across the health sector. The MOH can mobilize this committee through the associations and NGOs. Other countries, such as Australia, can provide examples of best practice in using multisectoral groups to define quality levels. The MOH can refer to these best practices in designing a consultative process that will result in agreement on what quality health services mean in Saint Lucia.
    - Consider assigning the responsibility of engaging with the private sector on cross-cutting policy issues to the CPU within the MOH and assign one to two staff people with this task (herein referred to as the private sector coordinator). The CPU has demonstrated its ability to work effectively with all the stakeholders in the health sector. This new responsibility will require a small budget to disseminate information and to convene meetings with private provider associations. The cost and effort of disseminating and debating policy changes and working together on cross-cutting health policy issues could be shared by the private provider associations but the activities would be coordinated by the MOH. The private sector coordinator(s) would also become the focal point for issues that the private health sector wants to bring to the attention of the MOH, ensuring that communication flows both ways. Individual government programs can and should

continue to engage with private providers as they have in the past to develop new treatment protocols, facilitate access to training and new information, etc.

INFORMATION SHARING

- Consolidate information on the private sector. The MOH has unusually good data on HRH professionals. A few additional steps would help consolidate the MOH's understanding and therefore facilitate monitoring of the private health sector.
    - First, request the councils to ask all providers where they work (e.g., government, Saint Jude, private practice) to obtain a more accurate number of health care workers in the private sector. This question will capture the number of private consulting rooms since they do not require licensing.
    - Second, develop an inventory of all health facilities – public, private and parastatal – based on all the council's facility licensing records. Supplement the information with the yellow pages if needed.
    - Third, using web-based technology, survey all providers and facilities to confirm the following information: (1) private provider name, (2) degree, (3) type of facility, (4) services offered, (5) staffing, (6) location, (7) hours, and (8) contact information. The MOH can hire a university student to gather all this information and put it into the new HMIS system. Also, consider downloading this information into a searchable data base linked to a GIS system. The GIS will become an important planning tool to help coordinate services and improve access.
- **Work with the private sector to agree on health indicators to report.** Private sector professionals indicated they would be willing to report to the MOH on key health indicators. The MOH can work with the associations to complete this task. The associations can convene their membership and/or the MOH can attend one of their regular meetings to solicit their input on what the private sector information needs are. At the same time, the MOH can inform the private sector of the MOH's reporting needs. This type of forum can, engage both sectors in an open discussion on how both sectors can get what they need, ,reach consensus on what type of information to share and how to start sharing it. Reducing the amount of data to the most essential items and permitting providers to use email or Internet portals to submit data could improve reporting. The MOH should also think of ways to incentivize more timely and accurate reporting from the private sector. If the accreditation system described above is linked to a financing mechanism, then timely reporting of data could be included among the criteria needed to obtain and maintain accreditation.

HRH

- **Strengthen regulations on dual practice.** MOH and professional associations should conduct a systematic review of policies on dual employment practices to ensure ethical practices for providers working in both sectors. The MOH should also consider measures to strengthen supervision of providers working in both sectors to ensure that providers are not neglecting their public sector duties or that patients are not inappropriately steered toward private practice. Policy should permit the greatest degree of patient choice and allow for treatment in both sectors for different aspects of care.
- **Increase private sector access to in-service training.** Public sector in-service training curricula could be adapted to the private sector to be delivered in shorter sessions spread over several evenings and weekends, to encourage more participation of private providers. When appropriate, the public sector and private associations can jointly sponsor training events that leverage the

investment in curricula made by the public sector while allowing private providers to benefit from the training for CME credit.

- **Support private sector training to use telemedicine for CME.** Tapion Hospital is building a new training center with state-of-the-art communication equipment to strengthen its linkages with U.S. and Canadian institutions. Tapion's administrators have expressed keen interest in developing a partnership with the MOH to use their training facilities. This new facility will be opened late this year. The MOH should explore with Tapion the terms of this potential partnership.

SERVICE DELIVERY

- **Rationalize services and equipment between the sectors**. Saint Lucia is too small to duplicate investments in specialists and high end medical equipment. Saint Lucia has a long history of public sector purchasing of specialty services and diagnostic equipment. Currently, the private sector in Saint Lucia has the largest number of specialists as well as partner arrangements with U.S.-based and Canadian-based medical institutions to access specialists. Moreover, the private sector in Saint Lucia has heavily invested in state-of-the art lab equipment, radiology machines, and medical devises (e.g., heart pacemaker). The small size of the health sector in Saint Lucia does not warrant and cannot support double of everything in the public and private sectors. MOH can undertake a systematic review of opportunities to contract services and equipment from the private sector. Immediate opportunities for contracting include the following:
    - Purchasing use/time of Tapion's diagnostic equipment (MRI, PT SCAN) instead of purchasing new equipment for the NNH
    - Purchasing specific tests and supplies from private labs
    - Contracting services from specialists (e.g., there is one clinical podiatrist who is specialized in diabetes – the MOH can contract her to train MOH staff in identifying the conditions to avoid amputations).

If administrative procedures need to be changed to streamline tendering processes and payments to providers, these should be considered within the principle of good financial management.

While Saint Jude is in the process of rehabilitating its facilities, it may be more efficient and effective (in terms of cost, HR, and service delivery) to transform Saint Jude into a polyclinic, thereby minimizing duplication of the same services offered at the new NNH and Tapion. The polyclinic would provide general health services but also expand its emergency services with improved transport from the area to Saint Jude and from Saint Jude to Victoria. Also a portion of the facility could be dedicated to inpatient beds for long-term elderly care and for others requiring long rehabilitation, filling a demand for the population in the South.

- **Standardize equipment to create efficiencies in the health sector.** Another area for coordination that will lead to cost savings and efficiencies is standardization of equipment. The public and private sector buy different types of equipment to perform similar functions. Equipment maintenance and repair is an enormous expense for both sectors. Standardizing equipment would help ensure the different equipment and systems talk to each other and can create economies of scale in sharing the expense in maintaining and repairing equipment (e.g., recall the example of offers to share visiting technicians for lab equipment cited in the Section 7.4.1Public Sector Procurement, Storage, and Distribution).

10. SYNTHESIS AND RECOMMENDATIONS

The findings within each of the six building blocks are specific and important to address in order to strengthen each aspect of the health system and increase its ability to offer sustainable, quality health services to meet the needs of the Saint Lucian population. Looking across the health system, there are a number of underlying issues that impact its functioning and, if addressed, could have wide-reaching positive impact on the system in the long term. This chapter identifies the key cross-cutting issues and recommendations.

The assessment team found that highest priority for ensuring an efficient and equitable health system is laying the appropriate support structure for the opening of the NNH. The Saint Lucian health system is under severe time constraints with the proposed opening of the NNH in the second quarter of 2012. Without knowing the true costs of operating the NNH, the opening of the hospital next year has the potential to (1) cause total government health expenditures to rise at the expense of other public health services, particularly at the PHC level where HIV services are being integrated; (2) drain human resources from the effective primary care system in the public sector; and/or (3) disappoint Saint Lucian's hopes for expansion of secondary and tertiary services. Worse yet, all three unfortunate outcomes could materialize. The four key cross-cutting issues presented here reflect the weaknesses of the health system as they are affecting the commissioning of the NNH. Table 10.1provides specific short-term recommendations to minimize the potential risks to the health system when the NNH opens.

1. **Policy Leadership and Management:** The MOH has effective plans on paper but has not been able to execute the needed policy changes to support the NNH. The urgency for the planned reforms appears to have lost momentum among the highest levels of government at a time when it is most crucial. Management decisions must be made regarding the level of autonomy for the NNH, retention of user fees, and the conversion of Victoria Hospital to a polyclinic.
    - NNH autonomy: As planned and equipped, the NNH will be providing more complex health services than the old Victoria Hospital. The planned specialty services at the NNH, which currently do not exist in the public sector, will require more highly technical staff. The existing civil service and government accounting procedures in Saint Lucia do not respond adequately to the complex needs of tertiary health care institutions. The MOH understands the need to afford the NNH greater flexibility and independence, much as it has done with Saint Jude Hospital, and has proposed making the NNH a statutory entity. However, there has been no movement to draft and approve the needed regulation.
    - User fees: Information gathered from key stakeholders interviewed and much of the literature reviewed on Saint Lucia's health reform suggest that user fees be abolished at public hospitals, including the NNH, as a part of the ongoing national health insurance development. Although politically appealing, removal of fees could result in increased demand for public services at the NNH at a time when funding is uncertain. Increases in demand will come from patients who avoided care because of the cost and from patients who sought care in the private sector when there was only a modest differential in cost. Not enough analysis has been conducted to determine the impact on the NNH's financial viability if user fees are lifted before opening the new hospital.

- Victoria polyclinic: The MOH, numerous prior reviews, and this assesment team have identified the need to convert Victoria Hospital into a polyclinic to avoid swamping the NNH with routine primary care patients. The MOH needs ***to establish a separate budget to protect the funds*** needed to convert Victoria to a polyclinic and increase hours into evenings and Saturdays. Also, the MOH needs to put into place an ***enforceable referral policy*** to divert patients from the NNH to the polyclinic for appropriate outpatient and after-hours primary care.

2. **Health Financing:** Once the NNH opens, the MOH will require additional resources not only for the new facility's operation but also for converting Victoria Hospital to a polyclinic to avoid overutilization of the NNH for primary care. Additional resources will also be needed for increased testing and primary care to address the growing burden of NCDs and increased drug purchases. Current estimates of the additional EC$117 million needed to operationalize NNH do not take these additional costs into account nor do they incorporate depreciation on the new equipment purchased. A dedicated funding source must be put into place. A proposal for an earmark of the new VAT is before Parliament; however, it is unclear if this 2.5 percent earmark will be enough. The MOH is constrained in developing an alternate plan because there are no data on the sources and uses of funds in the health sector to plan rationally for its future. In short, MOH is in urgent need of detailed health services cost data to make informed funding decisions in the short term as well as to plan funding of the NNH over the long run.
3. **Human Resources:** For the MOH, filling positions is a challenge due to limited funding for positions and the slow process of approval of new posts. Further, there is neither an HRH plan nor an HRH manager within the MOH who can formulate such a plan. This plan is urgently needed to ensure that the NNH can meet its HR needs, which are anticipated to expand public health personnel in the Saint Lucia health system by 60 percent.
4. **Public-Private Coordination:** The MOH currently has an untapped resource in the private sector that could help alleviate the burden of commissioning the new hospital. The private sector has a number of specialists who could be contracted out to help fill human resources gaps. There are also private hospital administrators who could be tapped for strategic planning. State-of-the-art equipment is also available in the private sector and the MOH could defray its future recurring costs of depreciation and maintenance of its hospital equipment by exploring partnering strategies with the private sector. The efficient commissioning of the NNH will require coordination between the sectors, and the private sector is willing to reengage in a dialogue around the NNH and UHC despite current tensions.

TABLE 10.1: SHORT-TERM RECOMMENDATIONS TO MINIMIZE NNH RISKS

Leadership	• **Normalize relations between public and private sector:** Improving the strained relations between the public and private sectors is a top priority. Not only is it important to return to the table to start the dialogue in order to improve relations, it is absolutely critical for the two sectors to come together in preparation for the opening of the new MOH hospital. Both sides, public and private alike, expressed a need and desire for better communication and more interactions between the sectors. • **Establish a mechanism to coordinate and rationalize resources:** Given the MOH's limited resources to fulfill its existing commitments, much less opening the NNH, the MOH ***urgently*** needs to return to the table with private sector counterparts – commercial and not-for-profit – to map out a plan that coordinates resources (funds, staff) and rationalizes infrastructure. In the short term, the focus of the discussions between the public and private sector could be coordination of resources to launch the NNH with the objective of identifying concrete opportunities for partnerships. • **Conduct scenario planning for NNH:** Scenario planning as a technique will allow the MOH to picture an uncertain future by modeling for a number of scenarios with both dependent and independent variables. This strategic planning tool can help the MOH to prepare and deal with factors beyond its control. In a sense, scenario planning is preparation for multiple possible futures.
Management	• **Structure NNH as a statutory body (parastatal) and establish the necessary management systems:** The NNH will be even more complex than Victoria Hospital. Such institutions are usually the most complex activity that an MOH in a developing country undertakes. Civil service and government accounting procedures do not respond adequately to the complex needs of tertiary health care institutions. The NNH must have greater flexibility to hire (and discipline) staff, to move funds between budget line items, and to contract for goods and services. Reasonable procedures can be developed to meet all these needs and retain accountability, but it will take time to build them. The best example of the model to which the NNH should aspire is the trust hospitals, which have developed within the British National Health Service. The assessment team recommends **immediately** passing a law that will make the NNH a statutory entity that retains these management powers.

Financing	• **Pass necessary legislation to increase dedicated health funding to 10 percent of government revenues:** Prompt action is necessary because the additional health funding are partly needed to finance the transition to the NNH and maintain parts of Victoria Hospital as a polyclinic. If the currently proposed route for additional resources (VAT and tobacco tax) is used, the MOF must commit to and allocate 2.5 percent of the VAT to health. In the long term, the MOH needs to work with the MOF to increase public funds from the 8.3 percent reported for 2009/2010 to around 10 percent of government revenue, and to commit to continuing current levels of funding from existing tax sources. The alternative plan would be to increase the NIC contribution reimbursement rate for those insured, with the NIC paying the full cost of care for current enrollees and retirees. Tax funding could then be used for public health functions and the care of those NOT covered by the NIC, providing greater cost recovery for all facilities, including the NNH when it opens. • **Protect current levels of primary care funding and avoid swamping new hospital with routine primary care patients**: The MOH needs to protect funds to maintain a polyclinic at Victoria Hospital that is open evenings and Saturdays to divert patients from the Emergency Room at the NNH. Funding decisions should be complemented with designing and implementing an enforceable referral policy to ensure that patients use the appropriate primary care facilities. • **Be cautious in removing user fees:** Given the size of the increase in expenditures with the NNH, the MOH should wait until it is up and running for some time before reducing user fees. Also, plans to remove fees should wait until after the MOH has completed an analysis of household health expenditure survey data, which will define the size and use of the private sector, and completed analysis of the cost for providing specific services.. Only then can the MOH have an idea of the likely increase in demand for public services if fees are abolished.
Services	• **Rationalize services and equipment between the sectors to meet the NNH needs:** The small size of the health sector in Saint Lucia does not warrant and cannot support duplication of equipment and services in the public and private sector. Currently, the private sector in Saint Lucia has the largest number of specialists as well as partner arrangements with U.S.-based and Canadian-based medical institutions to access specialists. Moreover, the private sector in Saint Lucia has heavily invested in state-of-the art lab equipment, radiology machines, and medical devices (e.g., heart pacemaker). MOH can undertake a systematic review of opportunities to access services and equipment from the private sector and determine what would be the most appropriate mechanism (e.g., contracting, leasing, etc.) to rationalize services. To procure services from the private sector, the MOH must be realistic about the cost involved and include other direct costs incurred by the private sector, such as employee fringe benefits. The private sector should offer the service at a price that reflects the lower unit cost achieved with a higher number of patients (public and private) using the service. It should not be viewed by the private sector as an opportunity to gouge the public sector when taking referred patients. While Saint Jude is in the process of rehabilitating its facilities, it may be more efficient and effective (in terms of cost, HR, and service delivery) to transform Saint Jude into a polyclinic, thereby minimizing duplication of the same services offered at the NNH and Tapion. The polyclinic would provide general health services but also expand its emergency services with improved transport from the area to Saint Jude and from Saint Jude to Victoria. Also, a portion of the facility could be dedicated to inpatient beds for long-term elderly care and for others requiring long rehabilitation, filling a demand for the population in the south. • **Standardize equipment to create efficiencies in the health sector:** As the

	MOH contemplates purchasing equipment for the NNH, another area for coordination that will lead to cost savings and efficiencies is to standardize equipment. The public and private sectors buy different types of equipment to perform similar functions. Also, equipment maintenance and repair is an enormous expense for both sectors. Standardizing equipment would help ensure the different equipment and systems "talk to each other" and can create economies of scale in sharing the expense in maintaining and repairing equipment.
HRH	• **Prioritize the recruitment and hiring of HRH director:** Every effort should be made to hire the HRH director so that this individual can immediately develop the HRH staffing plan needed for the NNH. Also, the new HRH director would work closely with the NNH management team to put into place the new HRH for the hospital. • **Develop and implement partnership strategies to meet workforce training:** The MOH may not have the fiscal resources, space, and capacity to support on-island preservice and in-service training facilities and/or programs. Currently, Tapion Hospital has existing telemedicine facilities and exchanges with several Canadian and U.S. teaching hospitals, and the hospital is in the process of building a state-of-the art training facility to offer training using web-based training sites, videoconferencing, and other technologies. The MOH should explore a partnership with Tapion to use its training facilities.

ANNEX A: LISTING OF PRIVATE SECTOR PROVIDERS

PRIVATE SECTOR LABORATORIES	
NORTH	**SOUTH**
Tapion Hospital 758-459-2212/758-451-9330 Email: gmedical@hotmail.com **Global Clinical Laboratories** Mongiraud Saint Box CP 6405 Conway Castries 758-451-6120 Email: clinical@candw.lc **Fitz Saint Rose Medical Centre –Lab** 52 Micoud Saint Box 1587 Castries 758-452-3333 **Microlab Inc** Chaussee Rd Box 820 Castries 758-453-2085 Email: microlabinc1994@yahoo.com	**Alpha & Omega Laboratory Services** Clarke Saint Vieux Fort 758-454-8047 Clarke Street Vieux Fort 758-454-5309 **Saint Lucia Blood Bank** Saint Jude Hospital Vieux Fort 758-454-3976

PRIVATE SECTOR CLINICS	
Bay Medical Centre Tapion P O Box GM712 Castries 758-459-2640 **EMCare** K & D Investments Inc Bldg Mongiraud Box RB 2412 Gros Islet 758-453-2552 **Rodney Bay Medical Centre** Integral Health Care Medical Clinic Rodney Bay Gros Islet Box RB2305 Rodney Bay 758-452-8621 Website: www.rodneybaymedicalcentre.com Email: info@rodneybaymedicalcentre.com **Tapion Hospital (Outpatient Clinic)** 758-459-2212/ 758-451-9330 Email: gmedical@hotmail.com	**Saint Anthony Medical Center** Clarke Lane Box 249 Vieux-Fort 758-454-4040 -Dr Richard Burt General Surgeon- -Dr Christine Neil -Burt Pediatrician- -Dr Christopher Beaubrun- -Dr David Bristol-

PRIVATE NURSING AND REHAB

NORTH	SOUTH
Liberty Nursing and Support Services Intl. Ltd Marisule, Gros Islet P.O. Box 1898, Castries 758-452 8845, 712-4129, 384-1518, 714-1052 Email: nursing_ss@yahoo.com	

PRIVATE PHARAMACIES

NORTH		SOUTH
M&C Drugstores Bridge Saint Box 99 Castries 758-458-8147 **M&C Drugstore** Gable Woods Mall Castries **758-458-8151** **M&C Drugstore** Baywalk Mall Rodney Bay Castries 758-458-8514 **Marcellin's Pharmacy** 61 Micoud Saint Box 809 Castries 758-452-1473 **People's Discount Drug Ltd** Laborie Saint Box 960 Castries 758-451-6070 **People's Discount Drug Ltd** Cnr Saint Louis & Chisel St 758-452-4281 peoplesdiscountdrugs@candw.lc **People's Discount Drug Ltd** Rodney Bay, Castries **Pharmacy 2000** 9 Chisel Saint Castries **758-453-0077** **Pharmacy Plus Inc** Cadet Saint Castries 758-450-4739 www.pharmacyplus.cbt.cc	**R&J Clarke LTD** Cnr Wm Peter Blvd & Bridge Saint Castries 758-452-2727 **R&J Clark** Rodney Bay Branch Castries 758-456-0361 **Super J Pharmacy** Choc Estate Castries **758-457-2000** **Super J Pharmacy** Cul De Sac, Castries **Super J Pharmacy** Gable Woods Mall, Sunny Acres 758-457-2265 **Super J Pharmacy** Rodney Bay, Gros Islet 758-457-2090 **Super J Pharmacy** Rodney Heights, Gros Islet **758-457-2227** **Super J Pharmacy** Waterfront, Castries 758-457-2334 **Tapion Hospital Pharmacy** Box 1780 Castries 758-459-2400/758-459-2401 www.tapion-hospital.com Email: tapion@candw.lc **White Rock Pharmacy** Grande Riviere Gros Islet 758-450-3511 Email: eugenet23@gmail.com	**Alexis Pharmacy** Bridge Saint Soufriere 758-459-7257 **Total Health Care Pharmacy** Charlery's Bldg Cnr Clarke & Laborie Sts Vieux-Fort 758-454-8055 **M&C Drugstore** Daher Mall Vieux-Fort 758-458-8155 **M&C Drugstore** Excelsior Mall Soufriere 758-458-8159 **Richfond Pharmacy** Dennery **Super J Pharmacy** La Tourney Vieux Fort 758-457-2323/758-454-5970

PRIVATE CONSULTATION

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24 Mary Ann Saint Box 5024 Castries
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Health Service Centre
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La Clinic Du Corps
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ANNEX B: TABLE OF SAINT LUCIA SURVEYS

Survey/Census	Periodicity	Time of Year Conducted	Form/Questionnaire (available via Internet)
Population and Housing Census	Every 10 years	May (2001)	2001 Population and Housing Census Household Questionnaire
			2001 Population and Housing Census Person Questionnaire
		May (2011)	Pending
Survey of Living Conditions/ Household Budget Survey	Every 5-8 years	Aug - Dec (in 2005)	SLC and HBS Household Questionnaire 2005
			SLC and HBS Person Questionnaire 2005
Labor Force Survey	Quarterly	Continuous	Saint Lucia Labour Force Survey Questionnaire
Youth Unemployment Survey	Quarterly	Continuous	Youth Unemployment Survey Questionnaire
National Accounts Survey	Annually	February - August	National Inquiry Form
Balance of Payments Survey	Annually	March - July	Balance of Payments Annual Survey Form (For Hotels)
Earnings and Hours Worked Survey	Annually	November	Yearly Survey of Employment, Earnings and Hours of Work Form
Foreign Trade Price Indices Survey	Quarterly	Continuous	Quarterly Price Collection Survey For Price Indices Questionnaire
Business Opinion Survey	Quarterly	To be announced	ECCB and Chamber of Commerce Business Outlook Survey Questionnaire
Prices Survey	Monthly	2nd week of each month	
Industrial Production Survey	Monthly	Continuous	

ANNEX C: VALIDATION AND PRIORITIZATION WORKSHOP SUMMARY

USAID funded the Health Systems 20/20 and Strengthening Health Outcomes *through* the Private Sector (SHOPS) projects to conduct a joint Health Systems and Private Sector Assessment in Saint Lucia in July 2011. A workshop was held in Saint Lucia on October 11-12, 2011, to engage stakeholders in the validation and prioritization of the assessment findings and recommendations.

10.1 OBJECTIVES, AGENDA, AND ATTENDEES

The objectives of the workshop were for participants to do the following:

- Review and provide feedback on the key findings from the Health Systems and Private Sector Assessment
- Use mutually agreed-upon criteria to prioritize the assessment's recommendations
- Create a roadmap for action to operationalize the prioritized next steps to address system gaps

There were 46 Saint Lucian stakeholders who participated in the workshop, in addition to the facilitation team. The stakeholders were fully engaged for the day-and-a-half workshop; they reviewed and discussed the findings and recommendations, prioritized recommendations based upon agreed criteria, developed draft action plans to move activities forward, and outlined roles that they would be willing to play in that process. A listing of the participants who attended the workshop is provided at the end of this annex.

10.2 VALIDATION OF FINDINGS AND PRIORITIZATION OF RECOMMENDATIONS

Participants were asked to work in a variety of small groups (i.e., by thematic expertise and in mixed expertise) at assigned tables in order to prioritize the recommendations that they had validated. Participants were asked to rank the recommendations based on the criteria of importance, feasibility, risk, affordability, and impact. The groups were also asked to focus on the following questions:

- Based on the criteria, which recommendations do you agree should be kept on the list?
- Which recommendations do you believe should not be kept on this list?
- Are there other recommendations that are missing from this list?
- After this discussion, using the criteria, develop your top 3-5 priority recommendations to be addressed.

Participants expressed the desire to see a Saint Lucia health system that is quality driven, integrated, and cost-effective. The participants then broke into six small groups for the purpose of identifying their top priorities for implementing key recommendations from the assessment report. What emerged from the small group discussions was a framework for action. Within this framework they hoped to see preparations for the New National Hospital that would ensure the proper systems are put in place for it

to function: an effective governance structure, a comprehensive human resources staffing plan, a detailed financing strategy, and a wide-ranging communications plan to all stakeholder. At the same time, this framework applies to the larger Saint Lucia health system and can be addressed over the long term. A summary of the top priorities from the six groups is provided in the Table C-1 below:

TABLE C.1: PRIORITIZED RANKING OF RECOMMENDATIONS BY SMALL DISCUSSION GROUPS

	PRIORITY 1	PRIORITY 2	PRIORITY 3	PRIORITY 4	PRIORITY 5
GROUP 1	Quality Improvement	Manage Patient Flow	Costing	Stakeholder Forums	Strengthen Hrh Planning Capacity
GROUP 2	Hire HR Director	Define Health Service Costs	Manage Patient Flow	QI Guidelines	USE IT FOR DATA COLLECTION AND PLANNING
GROUP 3	Modify Governance Structure	Define Quality Improvement Guidelines (Clinical Gov. Framework)	Define Costs	Manage Patient Flow	Leverage Partnerships For HRH Needs
GROUP 4	Costing & FinancE	Governance Structure For NNH	Information & Data	Manage Patient Flow	HRH Capacity
GROUP 5	Governance For QI & Policy Leadership	HRH Plan	Costing & Financial Planning	Manage Patient Flow	Maximize Partnerships/ Technical Working Groups
GROUP 6	Costing Private Sector Services (Re: Contracting)	Quality Improvement	HRH Plan	Modify Governance Structure For NNH	--------

A key message from the workshop participants early on was that they were eager to see the action steps taken that resulted from the assessment, draft report, and validation workshop. On the second day of the workshop, participants asked to create action plans for each of the priority recommendations, identifying what steps needed to be taken next, who should be responsible for these actions, and what resources were needed to complete the action step. The priority areas identified were (1) HRH Capacity Building, (2) Managing Patient Flow, (3) Quality Improvement, (4) Governance Structures, and (5) Defining the Costs of Services. Participants closed the workshop by discussing what they could do individually to ensure that these priority recommendations and action steps happened.

ANNEX D: HEALTH SYSTEMS AND HIV IN SAINT LUCIA

HIV/AIDS health care is deeply connected to the strengths and weaknesses of the broader health system. Saint Lucia's basic HIV services are well-integrated into the primary care system. The country provides free antiretroviral drugs through the public sector; public-private partnerships and civil society groups actively contribute to HIV prevention and treatment; and HIV/AIDS data are transmitted via electronic systems. The sustainability of Saint Lucia's gains in the HIV/AIDS arena are of paramount concern, however, as donor funds for the region decrease and expenses to operationalize the New National Hospital (NNH) in Saint Lucia increase.

Background on HIV in Saint Lucia

The 2010 United Nations General Assembly Special Session report estimates adult HIV prevalence in Saint Lucia at 0.28 percent based on case data. This rate is believed to be artificially low as the epidemic is believed to be concentrated among certain high-risk groups on which little data exist: men who have sex with men, and men who have sex with men and women. In 2009, data from the National AIDS Program Secretariat (NAPS) database also indicated that the HIV incidence rate is slightly higher for men than for women (58 percent vs. 42 percent), setting Saint Lucia apart from other Caribbean countries where incidence is typically higher among women.

Strengths of Saint Lucia's HIV/AIDS Health Care System

Saint Lucia has active public-private collaboration and civil society participation within its HIV/AIDS health care system. For example, among all of Saint Lucia's many strong civil society organizations, the AIDS Action Foundation (AAF) has exerted considerable influence in Saint Lucia's National AIDS Program, leveraging the media to bring attention to the issues of marginalized populations. The AAF has also established a Human Rights Desk that provides an independent, nongovernmental mechanism for recording reports of HIV/AIDS-related human rights violations. In addition, the AAF and Tender Loving Care (a people living with HIV support group) have provided advocacy and legal support to people living with HIV.

The National AIDS Coordinating Committee (NACC) has strong private sector representation. Although headed by the prime minister, 40 percent of its membership comes from the private sector, composed of representatives from the Red Cross, Planned Parenthood, the Catholic Church, and the Hotels and Tourism Association. NACC also has direct oversight of the government's National AIDS Program. To ensure that this body is effective, the government of Saint Lucia also established NAPS to implement the decisions of the NACC. Though it is a unit within the Ministry of Health (MOH), its oversight extends beyond the health sector to encompass oversight of the full national response. The organization of this unit within the MOH in 2005 demonstrated a commitment to sustainability since the MOH subsumed costs for some NAPS staff.

Data collection mechanisms within the Lucian public sector are particularly strong in the HIV/AIDS program domain. Currently, HIV/AIDS data flow via the Patient Monitoring System, an electronic database, while health facility-level reporting for other routine health statistics is done on paper. There are limited examples of effective information flows between public and private sectors in Saint Lucia. One notable exception is Tapion Hospital's reporting to the Surveillance Unit of NAPS confirming notifiable conditions resulting from its laboratory tests. This reporting from Tapion covers areas such as sexually transmitted infections and HIV-positive cases. For the remainder of the private sector there are

no formal procedures nor is there consistency in the type and frequency of health data shared with the MOH.

Public sector basic HIV services in Saint Lucia have been integrated into the existing, well-functioning primary care system. Specifically, HIV counseling and testing, as well as antiretroviral therapy services, are parts of Saint Lucia's primary care system, with mobile HIV clinics traveling periodically to primary care sites. This system increases confidentiality, which has the potential to reduce stigma, as well as increase access for more remote patients who are no longer required to drive into the central referral hospital (Victoria Hospital) on a regular basis for counseling, testing, or treatment service. CD4-count tests and antiretroviral drugs are both free in the public sector, and viral load tests, which are not possible to be run in Saint Lucia laboratories, are sent to Barbados.

Sustainability Concerns

The sustainability of Saint Lucia's HIV/AIDS programs is in jeopardy. Based on a report by the government of Saint Lucia to UNAIDS, 22 percent of public HIV spending (US$166,380) was attributed to domestic financing sources in 2007, while 78 percent (US$605,638) was attributed to donor funds. Saint Lucia continues to benefit from donor contributions at a regional level, particularly for antiretroviral drugs and technical assistance. However, as Saint Lucia is an upper middle-income country, donor funding options are diminishing. There are concerns that, as donor funding fades, the strengths of the current system might dissipate. It is urgent that Saint Lucia prepares estimates of the true long-term costs for continuing HIV treatment, care, and prevention programs, beyond the term of externally available grants. These estimates are currently unavailable.

Another concern relates to the sustainability of national financing for health in general. As a recent USAID-funded Health Systems and Private Sector Assessment report details, opening the NNH without understanding the total amount of extra funding required, or identifying its source, might put pressure on public funds currently allocated to the primary care system, including basic HIV/AIDS services. It is for this reason that the report strongly advises immediate action to identify and implement new financing mechanisms and ensure that existing programs do not suffer as the NNH and Victoria Hospital transition to their new roles in Saint Lucia's health system.

Health Systems Recommendations for the HIV Response

- Protect current levels of primary care funding, so that basic, good-quality HIV prevention and treatment through the public sector can be maintained. This can be ensured in part by setting aside a dedicated budget for public health and primary care laboratory functions at the NNH.
- Manage HIV as a chronic disease. Ensure that strong referral services and appropriate hospital-level care are in place with sufficient budgets. This is particularly important as those who are HIV positive will require higher levels of care as the disease progresses.
- Continue to prioritize prevention. When funds are limited, funds often go to those already sick. It is important to maintain Saint Lucia's strong prevention focus and maintain the level of funding (58 percent of HIV funds in 2007) for prevention. It is significantly more cost-effective to prevent an infection than to treat one.

ANNEX E: BIBLIOGRAPHY

Abbott, R., and W. Bannenberg. 2009. *Regional Assessment of Patent and Related Issues and Access to Medicines.* Brussels: Health Research for Action (HERA).

American International Medical University. 2010. *Why AIM-U*. St. Lucia: AIM-U. http://aimu-edu.us/whyaimu.php.

Barrett, Raphael D. 2011. *A Policy Review and Analysis of the Saint Lucia Universal Health Care Initiative*. Castries: Saint Lucia Ministry of Health and PAHO.

Brinkerhoff, Derick W. and Thomas J. Bossert. 2008. *Health Governance: Concepts, Experience, and Programming Options*. Washington, DC: U.S. Agency for International Development, Health Systems 20/20.

Daniel, Ivor. 2003. *Government of Saint Lucia Budgeting Process*. Government of Saint Lucia Website. http://www.stlucia.gov.lc/primeminister/bdget_process.htm.

Day, Marcus. 2008. *UNGASS Country Progress Report Saint Lucia 2008*. Castries: National AIDS Programme Secretariat.

Edmunds, Xysta. 2009. Accelerated Health System Strengthening Strategy. St. Lucia Ministry of Health, Wellness, Family Affairs, National Mobilization, Human Services and Gender Relations (MOH). Castries: MOH.

Health Metrics Network. 2008. *Framework and Standards for Country Health Information Systems - Second Edition*. World Health Organization: Geneva.

Health Sector Reform Secretariat. October 1998. "Report on Prepartory meeting for Health Sector Reform: The First Consultation." Accessed July 2011. http://www.stlucia.gov.lc/agencies/health/healthreform/hsr.htm.

Health Systems 20/20. 2011. Health Systems Database.

Heritage Foundation. 2010. *2011 Index of Economic Freedom*. Accessed July 2011. http://www.heritage.org/index/.

Holder, Yvette and Melchoir Henry. June 2009. *Final Joint Report on Assessment of Status of Implementation of the National Health Information System, Saint Lucia.*

Hogan MC, Foreman KJ, Naghavi M, Ahn SY, Wang M, Makela SM, Lopez AD, Lozano R, Murray CJL. "Maternal mortality for 181 countries, 1980-2008: a systematic analysis of progress towards Millennium Development Goal 5." The Lancet. 2010 May 8; 375:1609–1623. (data tables accessed online at www.healthmetricsandevaluation.org).

International Labour Organization (ILO). 2003. *Issues Related to Universal Health Care Coverage in Saint Lucia*. Geneva: ILO.

Islam, M., ed. 2007. *Health Systems Assessment Approach: A How-To Manual*. Submitted to the U.S. Agency for International Development in collaboration with Health Systems 20/20, Partners for Health Reform*plus*, Quality Assurance Project, and Rational Pharmaceutical Management. Plus. Arlington, VA: Management Sciences for Health.

Joint United Nations Program on HIV/AIDS (UNAIDS). 2008. *AIDS spending by categories and financing sources (2008)*. Geneva: UNAIDS. Accessed February 2010. http://data.unaids.org/pub/Report/2008/rt08_sal_en.pdf

Jules, Erma, Marcus Day, Natasha Lloyd-Felix, Nahum Jn. Baptiste. 2009. *UNGASS Country Progress Report Saint Lucia.* Castries: National AIDS Programme Secretariat.

Kairi Consultants Limited. 2008. *Country Poverty Assessment - Dominica: Volume 1 Main Report.* Tunapuna: Caribbean Development Bank.

Kaufmann D., Kraay A., Mastruzzi M. 2010. *The Worldwide Governance Indicators: Methodology and Analytical Issues.*

Lippeveld, Theo, R. Sauerborn, and C. Bodart. 2000. *Design and Implementation of Health Information Systems*. Geneva: WHO.

Ministry of the Public Service and Human Resource Development. December 2010. *National ICT Strategy of St. Lucia, 2010-2015.*

OECS E-Government for Regional Integration Program (EGRIP). 2008. *Project Appraisal Document.* Castries: OECS.

Organization of American States (OAS). 2006. *Evaluation in Progress of Drug Control*. OEA/Ser.L/XIV.6.2 MEM/INF.2006 Add.28.Washington, DC: OAS.

Organization of Eastern Caribbean States – Pharmaceutical Procurement System (OECS-PPS). 2011. *OECS/PPS 2010 Annual Report*. Castries: OECS.

Pan American Health Organization (PAHO). 2009. *Final Joint Report on Assessment of Status of Implementation of the National Health Information System, Saint Lucia.* Reference No. PAHO/SAL/61.2/09.03. Washington, DC: PAHO.

PAHO. 2010. *Health System Profile 2008*. Washington, DC: PAHO.

Pharmacy Council of Saint Lucia. 2011. *The Pharmacy Council of St. Lucia.* Castries: Pharmacy Council. Accessed June 2011. http://pharmacycouncilslu.org.

St. Lucia Ministry of Finance, Central Statistics Office. 2011. *2010 Population and Housing Census, Preliminary Report*. Castries: Central Statistics Office.

St. Lucia Ministry of Health, Human Services, Family Affairs and Gender Relations (MOH). 2000. *Health Sector Reform Proposals: Quality Services for Life*. Castries: MOH

St. Lucia Ministry of Health, Human Services, Family Affairs and Women (MOH). 1998. *Report on Preparatory Meeting For Health Sector Reform October 1998*. Castries: MOH. Accessed June 2011. http://www.stlucia.gov.lc/agencies/health/healthreform/hsr.htm.

St. Lucia Ministry of Health and Labor Relations (MOH). 2005a. *National Strategic Plan for Health: Quality Health Care for Life 2006-2011*. Castries: MOH.

---. 2005b. *National Strategic Plan for Health: Quality Health Care for Life 2006-2011 – Volume 3: Regional Health Services*. Castries: MOH.

---. 2005c. *National Strategic Plan for Health: Quality Health Care for Life 2006-2011 – Volume 5: Health Financing*. Castries: MOH.

St. Lucia Ministry of the Public Service and Human Resource Development. 2010. *National ICT Strategic Plan of Saint Lucia, 2010–2015*. Castries: MOH.

World Bank. 2011. *World Development Indicators*. Washington, DC: IBRD/World Bank. Accessed September 2011. http://data.worldbank.org/.

World Health Assembly. May 2010. *IHP+Results Update*. Geneva: World Health Assembly. http://www.internationalhealthpartnership.net.

World Health Organization (WHO). 2000. *The World Health Report 2000. Health Systems: Improving Performance*. Geneva: WHO. http://www.who.int/whr/2000/en/whr00_en.pdf.

---.2004. *The World Medicines Situation*. Geneva: WHO.

---. 2007. *Everybody's business: strengthening health systems to improve health outcomes: WHO's framework for action*. Geneva: WHO. Accessed September 2010. http://www.searo.who.int/LinkFiles/Health_Systems EverybodyBusinessHSS.pdf.

---.2010. *The world health report: health systems financing: the path to universal coverage*. Geneva: WHO.

---. 2011. Global Health Observatory database.