`MINISTRY OF HEALTH, WELLNESS, HUMAN SERVICES

AND GENDER RELATIONS

Draft National HEALTH SECTOR Policy (NHSP)

"Safeguarding Health"

Prepared for Ministry of Health by:

Abbreviations and Acronyms

CAAMPH Caribbean Accreditation on Authority for Education in Medicine and other Health Professionals

CBOs Community Based Organizations

CDs Communicable Diseases

CHMC Community Health Management Committee

CMO Chief Medical Officer

CPU Corporate Planning Unit

GOP Gross Domestic Product

GOSL Government of Saint Lucia

GROs Grass Roots Organizations

EPHF Essential Public Health Functions

HDI Human Development Index

HIS Health Information Systems

HMIS Health Management Information Systems

HPE Health Promotion and Education

HRH Human Resources

HSTF Health Sector Task Force

ICTC Information Communication and Technology

IMR Infant Mortality Rate

MDA Ministries Departments and Agencies

MDG Millennium Development Goals

MIPT Ministry of Infrastructure Port Services and Transport

MOH Ministry of Health

MOFEA Ministry of Finance and Economic Affairs

NCDs Non Communicable Diseases

NHA National Health Authority

NHSC National Health Sector Commission

NHSP National Health Sector Policy

NIC National Insurance Co-operation

NMWC National Mental and Wellness Centre

NNH New National Hospital

NSPH National Strategic Plan for Health

PAHO Pan American Health Organization

PHC Primary Health Care

PPPH Public Private Partnership in Health

PS Permanent Secretary

RSLPF Royal St. Lucia Police Force

SIDs Small Island Developing States

SIF Strategic Initiative Fund

TA Technical Assistant

USAID United States Agency for International Development

VH Victoria Health

WASCO Water and Sewage Company

WHO World Health Organization

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Abbreviations and Acronyms

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1. Introduction

The National Health Sector Policy (NHSP) builds upon the commitment of the Government of Saint Lucia in providing a health care system that is accessible, affordable, equitable, sustainable and of the highest international quality standard for the populace of the country. The Government envisages a health care system that is focused on providing care that is integrated, comprehensive, continuous and is accessible at all levels of the health system throughout the live course of individuals.

To this end the National Health Policy will provide a framework for decision making in health and govern the functioning of the Health Sector. The Health Sector Policy will form the basis for national health planning and will provide the guide for all stakeholders operating in the health sector. In addition it will serve as the roadmap for health care workers, health care providers (public and private) and stakeholders in implementing reforms of the health care system.

The National Health Sector Policy is built on the foundation of the Primary Health Care Approach (PHC). The foundation of the PHC Approach is built upon the principles and values of equity, solidarity, ethics and the right to health. The PHC Approach places significant emphasis on prevention, health promotion, the use of appropriate technologies and the empowerment of families and communities as equal partners with health professionals in the decision making about health services provision. The PHC Approach means being attentive to and addressing various factors in the economic, social and physical environment that impact on the health of individuals. These include but are not limited too lifestyles, income, education, workplace, diet, housing culture and the environment.

2. Situation Analysis

2.1 Health Situation

The health sector has realized gains in key indicators such as increase life expectancy to 75 years (2012), high rates of immunization coverage (99%), decreased incidence of communicable diseases, improvements in the nutritional status of children, expansion of health and social services and improvements to physical infrastructure. The changes in health are taking place within the context of a new thrust for health reform, increasing decentralization of health services and within the context of national political and economic reforms.

However, Saint Lucia like many other Caribbean islands is experiencing both an aging population and a double burden of disease. This situation is now evident in the changing disease profile which includes increases in both new and emerging communicable diseases along side an increase in chronic non-communicable diseases. Currently, chronic non-communicable diseases (CNCDs), cardiovascular diseases, cancer and diabetes, have been the leading causes of death for the last five years and a review of 2012 utiliztion rate indicate that they are responsible for higher utilization of health services at the primary care level.

For the period under review, 2007-2012, cardiovascular diseases, cancer and diabetes were the leading causes of mortality and cancer was responsible for 17% of all deaths recorded with a 62% increase in recorded deaths from cancer from 2011 to 2012[1]. From 2007-2012, infant mortality in St. Lucia have ranged from 22 deaths in 2007 to 43 deaths in 2012, showing a steady increase over the last five years. Approximate two-fifths of the deaths that occured during the first year of life were neonatal deaths. In addition, the burden of diseases is increasingly being

[1] Epidemiological Unit, Ministry of Health

defined by trauma, death and disability due to crime, accidents and violence against women, children and the elderly. This situation, in addition to rising levels of poverty serves to place more demands on the health and other sectors and services on the island.

In addition to the above mentioned, there are several other challenges facing the health sector which has significantly impacted on the ability of the sector to be consistent in the provision and delivery of quality health care services. Some of these challenges include:

- The rising rates of social issues affecting the most productive age group which is expressed by increases in violence and injury, accidents, substance abuse.
- Global financial and economic crisis which impacts on the ability of the health sector to access resources on both a regional and international level
- The rising cost of health care and the ability of the government to ensure adequate financing for the sustainability of health services including the maintenance and upkeep of health care facilities and medical equipment.
- Duplication of service provision in both the public and private sectors does not allow for the efficient use of resources in a resource poor environment amidst economic challenges
- The increasing need for adequate numbers of skilled health professionals in the provision of health services
- Inefficient governance structures to guide the management and organization of health services.
- Inefficient national quality management standards for monitoring and evaluating care practices.
- Increasing vulnerability to natural disaster and international health outbreaks

3. Policy Framework for NHSP

The NHSP framework draws on the WHO definition of health - a state of complete physical, mental and social and spiritual wellbeing and not just the absence of disease and infirmity - acknowledging that good health is intrinsically desirable and is a vital ingredient for socio-economic development. It embraces the holistic view of health care encapsulated by the following ideals:

- Health improves productivity and creates wealth and is therefore a major societal resource and asset
- Health promotion and nutrition ensure that people remain healthy and stay out of hospitals, thus reducing the burden on secondary and tertiary care
- Healthy environments and healthy lifestyles play a key role in ensuring healthy individuals, families, communities and the nation and therefore provides incentive for a strong value base; i.e. reaching the highest attainable standard of health
- Health delivery is more than health service delivery; it is every body's business, it is affected by individual lifestyles and it depends on multi-sectoral action
- Protection and promotion of health of all the people is vital in the spirit of the Primary Health Care (PHC) approach in the spirit of the Alma -Ata Declaration (1978)
- Health and action to improved health is more than just the responsibility of one sector but includes the involvement of Non Health Sectors based on the *Adelaide Recommendations on Healthy Public Policy* and the *Ottowa Charter for Health Promotion*
- Supporting good health and its social determinants throughout the life-course leads to increased healthy life expectancy as well as enhanced well-being and enjoyment of life. A Life Course Strategy will be employed to improve population health.

3.1 Main Features of the Policy Framework

In keeping with the values and principles of the PHC approach the Ministry of Health has developed a new Model of Care (MoC). The National Model of Care (MOC) broadly defines the way in which health services must be delivered and forms the foundation upon which services are delivered to the populace. The broad objective of the Model of Care is to ensure that people get the right care, at the right time, by the right team and in the right place. This broad objective allows for greater focus on client centered care which emphasis on improving quality and outcomes and allows for the better use of resources based on best practices

National Vision	National Mission	National Goal	National Values	National Principles
A proactive, health conscious, healthy and productive society	To lead through heightened awareness of promotive, preventative and mitigative health sustaining approaches, and increased access to affordable, quality health services.	To Produce a National of empowered and healthy People	• Equity • Quality • Sustainability • Ethics • Solidarity • Respect & Dignity • Compassion • Working together for clients	• Access • Social Justice • Quality- driven • Client focused care • Community Involvement • Affordability • Accountability • Collaboration • Responsiveness • Evidence-based • Timeliness

The NHSP will therefore be based on a policy framework that will be geared towards the significant improvement of the health and well being of all Saint Lucians. With the spotlight on reaching out to many different people within and outside of the government to provide inspiration and direction on how to better address the complex health challenges of the 21st century.

4. National Priority Areas for Action

The review of the health system and situational analysis identified a number of challenges that need to be urgently addressed through policy guidance. An NHSP will cover the vision and broad policy directions and would take into account a link with medium term and national developmental plans for the country. The situational analysis and priority setting provide the ideal opportunity for enriching the policy dialogue. The main priority areas are:

- Leadership and Governance
- Investment in Health
- Promoting Wellness
- Service Delivery
- Building resilience and supporting environments

These priority areas are interlinked, interdependent and mutually supportive - for example, action on service delivery, investment in health and promoting wellness will assist in containing the epidemic of non-communicable diseases, as well as stronger public health capacity. MOH will achieve higher health impact when it links the promotion of wellness, investments in health, services delivery and resilience, all focusing on reducing inequalities as well. The policy takes into account a combination of governance and leadership approaches that promote health, equity and well-being. Approaches to governance and leadership include management through public policy and regulation as well as new forms of collaboration with civil society organizations, independent agencies and expert bodies. It alludes to the need to apply evidence to policy and

practice, observe ethical standards, expand transparency and strengthen accountability in such areas as privacy, risk assessment and health impact assessment. Furthermore, it draws on knowledge from the social, behavioral and policy sciences including social marketing, behavioral economics and neuroscience.

Priority Area 1: Leadership & Governance

The principle challenges facing the health system in terms of a changing demographic profile with respect to an aging population, changing epidemiological profile with respect to increasing rates of chronic non-communicable disease, the emergence of new diseases etc requires a health system that is responsive to addressing these challenges and the changing health needs of the population. The current organization and management framework does not allow the health system to respond in a proactive, cost effective, efficient and timely manner.

In order to achieve significant improvement in the health status of the population and to become more responsive to the changing health landscape the leadership and governance functions of the MOH must be strengthened. The Ministry of Health recognizes that there are many actors in the provision of health care services to the population. It therefore becomes important that there is a clear policy on how health services will be organized and managed in the health sector. To this end the MOH will retain the role of setting policy direction, service delivery, regulations, quality standards etc of the health sector.

4.1.1 Policy Objectives

1) To ensure an enabling policy environment through an integrated governance and management approach.
2) To strengthen the regulatory, enforcement, monitoring and evaluation function of the MOH

4.1.2 Policy Measures/Strategies for Leadership & Governance

In order to achieve these policy objectives government shall:

- ❖ Restructure and strengthen the MOH to better align the organizational structure

and incentives to its new roles and functions.

- Enable increased managerial and operational autonomy for health facilities and continuously explore the use of contracting out to the private sector and other purchasing bodies
- Provide a framework of appropriate incentives and sanctions that enable performance and promote accountability
- Strengthen the regional health services system so that it carries out its responsibilities in a more efficient manner.
- Emphasize integration as central to planning and service delivery at all levels and efforts to deliver through the health system in an integrated manner
- Establish and implement a health system governance framework or forum (National Health Sector Commission) (NHSC) that reflects a multi- sectoral stakeholder approach.
- Build capacity of the MOH to allow it to more effectively execute its public health mandate and in addition to strengthening its ability to execute its regulatory role.

Priority Area 2: Investment in Health

The government has adopted and signed onto international agreements on health such as; The Alma Ata Declaration (1978), the Ottawa Charter for Health Promotion (1986), the Millennium Development Goals (2000), Primary Health Renewal (Montevideo Declaration, 2005) and the Sustainable Development Goals (2015). By being a signatory to these international mandates the government recognises that good health forms the foundation for national economic and social development.

In addition, these international agreements focus on emphasis being placed on prevention and wellness in service delivery. As a result it mandates governments to undertake the steering role to combine their efforts and resources to reducing the inequalities that exist in health and ensuring social protection for the most vulnerable groups in society whilst ensuring universal access to health care services for the entire population. As a result there must be adequate and sustainable investments in the health sector to ensure that the system is capable of meeting the current need, the future needs of the population and sustaining the health gains made over time.

4.2.1 Policy Objective

To mobilize resources and ensure equitable, accountable, transparent, efficient and sustainable investment in the health sector

4.2.1.1Policy Measures/Strategies for Health financing

In order to achieve this policy objective government shall:

- Provide increased and sustainable financing in health promotion and PHC, human resources, infrastructure in relation to maintenance and EPHF
- Promote alternative health financing mechanisms other than government

budgetary provisions including community health financing mechanisms and investment fund.

- Promote the increasing efficiency of expenditure in health
- Implement financing mechanisms that promote private sector growth
- Strengthen programming for external funding for health through improved harmonization, alignment to sector priorities and improved reporting
- Develop comprehensive strategies for resource mobilization from all sources including domestic and international
- Provide increasing financial decentralization and autonomy, with opportunities for health facilities in the public sector to be self-financing where possible
- Promote and develop a contributory national health insurance to encourage investment in health machinery, equipment etc in the health sector
- Promote the accreditation of health facilities in order to position Saint Lucia within the health tourism niche market.

4.2.2Human Resources for Health

In any health care system, the availability of appropriately skilled and trained health professionals is critical to the delivery of quality health care services. Human resources are the most important resource for defining the performance of the health system. The Ministry of Health must ensure that it has the right people with the right skills, competence and clinical experience and who are appropriately place to deliver quality health care services to the population. The focus of the Ministry of Health will be on developing the skills and competencies of the workforce so that the organization and individual employees can accomplish

their goals in service to customers

4.2.2.1Policy Objectives

I. To increase availability of an appropriately trained health work force in sufficient quantity and quality at both professional and technical levels in order to meet the health needs of the people of Saint Lucia.

II. To increase productivity and performance of the human resource through the development and efficient utilization of the health workforce

4.2.2.3Policy Measures/Strategies for Human Resource Management and Development

Objective 1

In order to achieve this policy objective government shall:

- Increase the recruitment of health care workers in partnership with the private sector and develop incentive schemes for the deployment and retention of health care workers.
- Strengthen coordination and partnership between public and private sectors through participatory development of strategic plans for training and management of health workers for the effective provision of quality care

4.2.2.4Policy Measures/Strategies for Human Resource Management and Development

Objective 2

In order to satisfy this policy objective government shall:

- Strengthen management and leadership skills at all levels to ensure clear roles and responsibilities for health staff
- Ensure fair and transparent career development path for all workers in the health system based on performance and achievement

- ❖ Develop and implement a safe working environment to minimize health, occupational and security risks for the human resources and the clients
- ❖ Develop effective ways of increasing health workers' accountability towards clients and communities
- ❖ Engage and partner with leaders of health care professions to determine and enforce acceptable standards of professional practice and develop robust processes to challenge poor standards of practice whenever and wherever they appear
- ❖ Encourage the orientation and mobilization of other professionals, including but not limited to, teachers, agricultural extension workers, in contributing to and promoting good health practice

4.2.5Guaranteed Health Care Package

For Saint Lucia, the minimum health care package shall take into account the most cost-effective priority health care interventions and services that seek to address the high disease burden, acceptable and affordable within the financial envelope of the sector. The composition of the package shall be revisited periodically taking into consideration changes in the disease burden, availability of new interventions to address these conditions, changes in the cost effectiveness of these interventions and the total resource envelope available for service delivery. This package shall comprise the following:

• Diabetes & Hypertension	• Sexual and Reproductive Health
• Cancer	• Respiratory Disease
• Cardiovascular Diseases	• Sickle Cell Anemia
• Communicable Diseases	• Trauma & Injury
• Dental Health	• General Services (Tonsillitis, Appendicitis, Hernia)

• Hearing Health	• Mental Health & Substance Abuse
• Eye Health	

4.2.5.1Policy Objective

To ensure the provision and increase the utilization of the minimum health care package consisting of preventive, curative and rehabilitative services for all priority areas and conditions, to all Saint Lucians, with emphasis on vulnerable populations.

4.2.5.2 Policy Measures/Strategies for Guaranteed Package of Services

In order to achieve this policy objective government shall:

- ❖ Promote defined and cost effective packaging of preventative, diagnostic, therapeutic, rehabilitative and pharmaceutical services to be provided through the private and public sectors, within the framework of a strengthened and integrated community services network linked to a functional referral system.
- ❖ Ensure that the minimum package shall be used at all levels of service provision for overall planning, budgeting and resource allocation.
- ❖ Ensure that at all times adjustments concerning the package be based on the best possible combination of available options for equity, efficiency and quality of services.

4.2.6 Health Infrastructure and Technology

Significant investments have been made in the construction of new facilities and the rehabilitation of existing facilities. Having a network of health infrastructure that is safe and functional forms a critical component in improving the quality of care offered at health facilities and also improves and motivates health care providers. It is imperative that longer term life of finishes, plant and medical equipment is achieved and that a suitable standard of working conditions at all health and wellness facilities are maintained.

4.2.6.1 Policy Objective

To provide and maintain a network of functional, efficient, safe and sustainable health infrastructure and technology

4.2.6.2 Policy Measures/Strategies for Health Infrastructure and technology

In order to achieve this policy objective government shall:

- Strengthen the MOH with the appropriate personnel to plan, procure and maintain health infrastructure in collaboration with the MIPST
- As a matter of priority adequately finance renovations and maintenance programs of existing health infrastructure, in particular, PHC facilities
- Prioritize investments in buildings, equipment and transport required to operationalize the health sector priorities of this policy
- Provide the necessary logistical support, including transport, communication and IT equipment to establish an appropriate and efficiently functioning referral system

4.2.7 National Health Information and e-Health System (HIS)

The governance of the health system depends on the availability of quality, relevant and timely information and knowledge. Health information provides the information support to the decision-making process at all levels of the health system. It is particularly vital for resource allocation and public health action in countries like Saint Lucia where resources are limited.

A strengthened and modern, ethical and integrated national health information system ought to follow the recommendations of WHO in its Health Metrics and Network Framework and Standards, with priority attention being given to data management, the information technology infrastructure, the coordination and planning mechanisms, the financial and human resource allocations and very importantly, the ethical, legislative, regulatory and policy frameworks which are necessary for supporting a robust and effective NHIS as well as e-health applications.

4.2.7.1 Policy Objectives

1. Timely implementation of integrated national, ethical, electronic health information system that supports opportune and efficient data management to produce quality health information for evidence decision making at all levels of the national health system.

2. Promote the generation and use of evidence for decision making, program development, resource allocation and management through research, statistics, information management and deployment of ICT.

4.2.7.2 Policy Measures/Strategies

In order to achieve these policy objectives the government shall:

- Develop a policy framework and set up multi-sectoral coordination mechanisms to guide any further investments and development of health information systems
- Increase investments in the development and deployment of HIS including ICT
- Increase the training and deployment of the requisite human resource mix required for effective data management and dissemination as in epidemiologists, statisticians, demographers, computer experts and data base administrators
- Define a core set of sector wide indicators comprising health system, health status and health determinants indicators as well as indicators for measuring the performance of components of the health system
- Support the development of an integrated and consolidated national health information system and e-health system linked to sub-systems in agencies at all levels of the health care delivery system
- Continue to strengthen:
    - population- based data resources comprising vital registration and surveys
    - Health service – based records comprising administrative records, service records and health and disease records
    - Surveillance systems drawing on the combination of data resources as appropriate
- Develop a monitoring and evaluation plan based on data needs and data resources
- Strengthen monitoring and evaluation functions and their integration into the national managerial process through the implementation of effective information systems
- Health related data will be guided and protected by the Health Records Bill

- ❖ Mandate the completion of vital registration forms
- ❖ Support Integrated Disease surveillance to include non-health actors (eg. Ministry of Agriculture)
    - o Supports "One Health, One Medicine"
    - o Make CNCDs reportable conditions

4.2.8.1 *Private - Public Partnership in Health*

4.2.8.2 Policy objective

To effectively build and utilize the full potential of the private and public partnerships in Saint Lucia's national health development, by fostering, supporting and strengthening participation in all aspects of this NHSP and other areas of endeavor and at all levels.

Policy Measures/Strategies

In order to achieve this objective government shall:

- ❖ Guarantee continued participation of the private sector in the process of policy development, planning, implementation, quality assurance and other pertinent areas of endeavor, with the aim of building consensus and sharing ownership of plans and policies
- ❖ Establish and implement guidelines on private public partnership in health (PPPH) in line with existing laws and regulations
- ❖ Establish appropriate legislative frameworks, guidelines and policies to facilitate and regulate the private sector in line with existing laws and regulations

- Support the adoption of HMIS by the private health providers to improve completeness of national data, planning and health financing
- Strengthen collaboration and firm up an agreement between private off –shore universities and colleges and MOH to facilitate greater integration with community and hospital services
- Establish an accreditation policy aligned to the standards of the Caribbean Accreditation Authority for Education in Medicine and other Health Professions (CAAMHP)
- Promote consultation and coordination with other ministries on health issues relevant to the development of the country.
- Actively promote the participation of communities in health service delivery and management in an effort to promote resilience at the level of the family and community in general.

Priority Area 3: Promoting Wellness

The World Health Organization defines health promotion as the process of enabling people to increase control over and to improve their health. This definition moves beyond a focus on individual behavior towards a wide range of social and environmental interventions required to ensure the well being of the population. This definition places the responsibility for the well being of the population not solely on the health sector but demands a coordinated approach by all the other sectors functioning in an economy. Therefore the environment in which wellness ought to be promoted is the physical, biological and socio-cultural - including political and legal settings - in which individuals and populations live, work, attend school and play. Promoting wellness therefore demands that health be mainstreamed in the policies of all sectors and that each sector is aware of the consequences that certain actions impacts health and that they accept their responsibility for the overall health outcomes of the population.

4.3.1 Policy Objective

To create a supportive environment that enables individuals to maximize health promoting behaviors, minimize harmful behaviors and adopt healthier lifestyles.

4.3.2 Policy Strategies/Measures for Wellness

In order to achieve this policy objective, Government shall:

- Facilitate the empowerment of individuals, households and communities to make informed choices for their health through provision of information, education and

capacity building initiatives.

- Develop standards and implement programs and initiatives for promoting healthy settings as in:
    - Healthy homes by collaborating with local government authorities, Ministries of Physical Planning and Housing to develop standards for housing.
    - Healthy communities in collaboration with local government, WASCO, NGOs, CBOs and GROs and other development agencies and community leaders to ensure improved standards of water quality and access. In addition advocated for the creation of safe recreational spaces such as community parks.
    - Healthy Schools by collaborating with the Ministry of Education to facilitate the adoption of healthy lifestyles among students through the curriculum strengthening, mandatory physical education, and environmental sanitation. Strengthening of the school feeding program to through the development of Healthy food policies to regulate what is fed to and marketed to children.
    - Healthy work places by collaborating with the Ministry of Labour to develop and implement programs on occupational health and safety.
    - Road safety by strengthening collaboration with the Ministry of Infrastructure, Road Transport Board and the Royal Saint Lucia Police Force to implement a road safety campaign.

- Ensure food safety by promoting collaboration with the Environmental Health Department and the Royal Saint Lucia Police Force to develop and enforce standards for the production, storage, sale and handling of food and drink in markets, restaurants among others
- Using existing community infrastructure such as wellness centres, schools and human resource development centres as training centres to facilitate increased physical activity.
- Promote lifestyles free of addictives and substance abuse by establishing designated no- smoking public areas, dissemination of legislation on drug abuse and tobacco control, and enforcement of penalties.
- Include an action on trade policies and agreements and it effects on food security, imports etc.
- Ensure that all users and providers of services understand their health rights and responsibilities through comprehensive IEC programs
- Progressively implement and strengthen the self-care approach especially at the primary care level, for selected health problems and patient categories.

Priority Area 4: Service Delivery

The Government is committed to ensuring that the population has comprehensive, integrated and continuous health services, through the different levels of care within the health system and according to their needs throughout the life cycle[2]. The aim of the Ministry is to ensure access to quality health care services which are provided in safe, secure environments, which are affordable and equitably distributed and provided in a cost effective manner.

Further, the Ministry of Health is focused on moving away from the traditional medical model of providing health care where the focus is on treating the disease. The move is towards a care model that is focused on the individual as a whole[3] and where care is integrated across disciplines. Client and family involvement in the health care plan is highly valued and must be practiced. In the holistic care approach the Ministry is emphasizing greater personal responsibility for health from clients. Therefore clients must be equipped with the necessary information and skills to make informed decisions about their health in joint consultation with health care team. The utilization of the multi- disciplinary team approach to the provision of health care services is critical to the improvement in health care outcomes.

Strengthening a people-centered health system and public health capacity requires appropriate organization and management of an integrated health delivery system. The NHSP will focus on the achievement of high-quality care and improved health outcomes within the broad framework

[2] The World Health Organization. Integrated Health Services, 2008.
[3] Takes into account the physical, spiritual, mental, economic and social needs of the individual

of the EPHF and PHC approach.

4.4.1 Policy Objective 1

To ensure equitable access to good quality and integrated health, population, nutrition and pharmaceutical services that are safe and secure and that will improve health outcomes, respond to people's legitimate expectations and are financially fair.

4.4.1.1 Policy Measures/Strategies for Services Delivery

In order to achieve this policy objective, Government shall:

- ❖ Ensure that ensure that health services practices and equipment are standardized throughout the health sector to reduce on the variations in treatment and outcomes of clients.
- ❖ Support the development of a holistic gender-sensitive, integrated and seamless health service comprising allopathic and alternative providers, the private and public sectors, home-based care, community based-services, facility-based services (wellness centers, polyclinics and all categories of hospitals) and preventative, diagnostic, therapeutic and rehabilitative services.
- ❖ Ensure the strengthening of core public health capacities for surveillance and response.
- ❖ Strengthening systems for continuous monitoring and assurance of quality, efficacy and safety of medicines, including traditional medicines.
- ❖ Ensuring improved financing of essential drugs and logistics in the national

budgets

- Re-engineering and modernization of effective and efficient systems for procurement, storage and distribution of supplies and logistics
- Fill gaps in service delivery particularly in deprived areas by investing in the provision of relevant services as part of an integrated network of service providers and strengthening emergency services, including the provision of national coverage for ambulance services using both public and private ambulance operators
- Facilitate the empowerment of clients and communities as it relates to roles and responsibilities through the establishment of formal information and communication structures.
- Ensure compliance with the maintenance and servicing of health facilities, equipment and supplies will be ensured through the development of health facilities legislation and regulation and enforcement of the Occupational Health and Safety Act
- Support the implementation of continuous quality improvement programs in health institutions and institute an effective regulatory environment that will enforce sanctions and provide appropriate incentives
- Formulate a National Medicines Policy (NMP) to guide the development of pharmaceutical laws and regulations and establish the roles of key stakeholders
- Provide increasing managerial autonomy to public heath institutions within a strengthened framework for public accountability, with a view to achieving

overall efficiency in service delivery, reducing waste and improving responsiveness to local needs

- ❖ Work continuously to reduce the financial, geographic and socio-economic and socio-cultural barriers to health services faced mainly by the poor and disadvantaged.

4.4.1.2 Policy Objective 2

To find appropriate solutions to the security, safety and risk issues at all levels of the sector in order to enhance the quality of care

4.4.1.3 Policy Measures/Strategies

- ❖ Conduct periodic assessments of the security, safety and risk issues relevant to all levels of the sector with a view to implementing relevant technology to minimize security and safety risks at the various health institutions

- ❖ In collaboration with the RSLPF formulate and implement a comprehensive policy regarding the safety and security of physical plant, buildings, clients and HRH in the health sector

Priority Area 5: Building Resilience & Supportive Environments

According to the Merriam-Webster dictionary resilience means "t*he ability of people, households, communities and countries to mitigate, cope, recover or adapt to shocks or life's challenges"*. Creating resilient communities and supportive environments across the island will be a key factor in protecting and promoting health and well-being at both the individual and community levels. People's health chances are closely linked to the conditions in which they are born, grow, work and age. As a result, this NHSP considers periodic systematic assessments of the health effects of a rapidly changing environment- especially related to technology, work, urbanization, changing values and lifestyles and the like – as an essential element which must be followed by action to ensure positive benefits to health.

The new challenges in this regard are multifactor, multidisciplinary and require a range of strategies and commitment from multiple and diverse stakeholders. Thus involvement of civil society and generating individual and community ownership of health issues must be a priority, as resilient communities respond proactively to new or adverse situations. They are also better prepared for economic, social and environmental change and can better respond to crisis and hardship. In the WHO Healthy Cities and Communities movement, there are extensive examples on how to build such resilience including involving local people and generating community ownership of health issues. Health promoting schools and work places are other examples of resilient-based national community culture. The pathway of building a culture of interdisciplinary and intersectoral collaboration will enhance the effectiveness of the health system.

The need for the development of adaptive policies, resilient structures and foresight to effectively anticipate and deal with public health emergencies is equally crucial. Thus the NHSP will reflect the complexities of causal pathways and the need to respond quickly and innovatively to unpredictable events, such as communicable disease outbreaks. As recommended by the IHR, Saint Lucia will have to implement a multi-hazard, inter-sectoral and cross-border approach to public health emergencies and be prepared to effectively manage health related aspects of emergencies and humanitarian disasters.

4.5.1 Policy objective

To increase the capacity of individual and communities to respond quickly and effectively to new challenges and improve their ability to address and reduce risk

4.5.2 Policy Measures/Strategies

- Develop the capacity of individuals, communities and local authorities to risk reduction and resilience plans
- Emphasize approaches that increase the knowledge, skills and abilities of individuals and communities to prepare, mitigate, and response to adverse situations
- Provide access to interventions that build psychological coping skills especially among the poor and vulnerable groups
- Ensure that persons are informed and have access to social safety net and financial protection programs.

- Advocate for improvements in the social and economic conditions of vulnerable populations
- Build the capacity of communities, households and individuals to take responsibility for their own health and well being and actively promote their participation in health service delivery and management.

5. NHSP Implementation Framework and Arrangements

It has been established that the attainment and maintenance of good health and well being extends beyond the purview of the MOH and its agencies. Other MDAs have a role to play in ensuring that Saint Lucia has a health literate population imbued with a positive attitude towards protecting their own health and environment. It has to be understood that the responsibility for one's health and environment is not a government responsibility per say. The MOH will therefore provide leadership in mobilizing support for health from the myriad of players, and in sustaining partnerships for health development with other MDAs, civil society and the private sector.

6.1 MOH and Agencies

In a combined effort, the MOH and its agencies will be responsible for the formulation of health service policies and the regulation and oversight of activities in the health sector. The MOH shall translate government policies on health into sector policies to guide the implementation of such policies using a system wide perspective. To ensure effective implementation of the policy the MOH shall:

- Mobilize resources and ensure that these are in sync with the national priorities on health
- Provide evidence through routine and research data to support the review and formulation of policies
- Formulate policies aimed at periodically enhancing access, quality and effectiveness of health services

- Conduct a health impact assessment of major projects and programs to make sure that the health of the population is not placed at risk
- Conduct periodic provider and client satisfaction surveyors to evaluate the quality of the health care delivery system
- Monitor the implementation of all health policies, plans and programs
- Collaborate with other MDAs in population-based research (Census, Poverty Assessment)

5.1.2 Agencies responsible for finance and economy

These include the Ministry of Finance and Economic Planning responsible for managing the economy. Additionally, they are charged with the responsibility for ensuring the availability of resources to secure the welfare and livelihood of all Saint Lucians. MOH will collaborate with these agencies to mobilize and allocate resources equitably for promoting and maintaining good health and for the prevention of ill health

5.1.3 Agencies responsible for infrastructure and environment

These include inter alia: the Ministries of Infrastructure, Port Services and Transport; Physical Development, Housing and Urban Renewal; Public Services, Sustainable Development, Energy, Science and Technology and Development Control Authority as well as Housing Authority. Poor health indices can be attributed to the lack of adequate and appropriate infrastructure such as roads, transport and communication, particularly in our rural areas. Deaths from road traffic accidents are some of the major health issues that can be minimized by improving the planning infrastructure and by investment in a healthy

environment. Improvements in the communication infrastructure have also been identified as a key requirement in support of the current drive to improve access to health care across the country and in the effort to improve the quality of health service delivery. Consequently, in the implementation of this NHSP, agencies responsible for infrastructure and the environment will be called upon to:

I. Design and implement infrastructure development to minimize accidents an
II. Create conditions that will prevent diseases, disability and death
III. Give priority to the planning of human settlements and sound environmental practices to enhance the quality of life and well being of Saint Lucians

5.1.4 Agencies responsible for the social services and protection of the vulnerable

These include the Ministries of Social Transformation, Local Government and Community Empowerment; Youth Development and Sports, Education and Human Resource Development and Labor; the Family Affairs and Human Services Division as well as the Gender Relations Division of the MOH. These services promote the well being of the individual, the family and the community by ensuring availability and access to social services including education and health. To support the implementation of the NHSP, agencies responsible for social services shall:

I. Ensure that health, healthy living and the averting of risk factors to poor health have a prominent place on the education curricula at all stages education
II. Formulate and implement systems for the identification and procurement of health services for the poor and vulnerable
III. Implement a strategy for the mobilization of the population for the promotion and

adoption of healthy lifestyles in a sustained manner

IV. Take into consideration an effective social safety net program to minimize the adverse situations that vulnerable groups are likely to face, and to manage the risks to healthy outcomes

V. Consider the importance a comprehensive strategy for tackling the conditions in which people are born, live, grow, work and age, shaped by the unequal distribution of wealth, power and resources.

5.1.5 Donor Participation & Coordination

The policy objective is to implement NHSP through a sector-wide approach. This strategy addresses the health sector as a whole and allows for effective coordination of efforts among all donor and international NGO partners in Saint Lucia's national health development. It also serves to increase efficiency in resource allocation and utilization. This has to be accomplished against the backdrop of equity in the distribution of resources available for health and effective access by all Saint Lucians to efficient quality health care.

In this regard, government shall:

- Cultivate a partnership arrangement for implementation of the NHSP which shall be supported by strengthening external aid coordination at national and sectoral level
- Energetically pursue donor support for health - related programs in all sectors
- Take the necessary steps to enhance the role of donors in monitoring and evaluation of all health programs

6. Monitoring and Evaluation Strategy

A systematic approach to the evaluation of the effectiveness of this NHSP will be built into the policy implementation process. In this way MOH and its partners will determine how well the existing policy meets the objectives and conduct an assessment of the implementation rate. Population based Data will be conducted on an annual basis to make recommendations for review.

It is also recommended that this NHSP adopts a monitoring and evaluation strategy that focuses on three elements: a multi phase approach; cross sectoral monitoring; and periodic evaluation. In order to achieve this however, the MOH must spearhead a participatory planning process through its CPU. The approach will be one of collaborating with the various sectors to develop harmonized multi-sectoral and integrated plans that respond to the challenges identified in this policy. It must be emphasized that such plans ought to be derived from the mandates of each sector that mirror as far as possible each sector's annual plans, financed from each sector's own budget.

This will set the platform for the adoption of a multiphase approach to monitoring the implementation of the NHSP. It will involve to a large extent, the principle of peer review applied to a cross–sectoral assessment of the implementation of the policy. In addition, there shall be independent reviews and intersectoral performance assessments. These will precede finalization of performance in key areas identified as critical to the NHSP.

Cross- sectoral monitoring will focus on sector commitments to health development through

sectoral plans and budgets and on their attainment of the national goals and targets. Specific efforts will be made at reviewing priorities and financial commitments to programmes that impinge on health at all levels.

It is strongly advised that periodic evaluation complements the aforementioned. This should be based on an agreed annual format outlined in the common management arrangements and plans for the implementation of the NHSP.

7. Conclusion

This NHSP outlines the principles and objectives for improving the health of the population and reducing inequalities in health in Saint Lucia. It provides a framework, foundation and model for future action in the health sector. The aims of the NHSP will be achieved through a combination of individual and collective efforts by people and organizations across Saint Lucia: government, NGOs, civil society, the private sector, health professionals, communities – and every individual. There must of necessity be a coalition of commitment across sectors and communities in order to safeguard the nation's health.

This approach will add value through partnerships – but key to its success will be our working closely together, engaging and reaching out to partners in the region and internationally. This will assist in increasing policy coherence, contributing to shared policy platforms, shared health data sets, join forces for surveillance, and provide support for new types of networks and even web –based cooperation. In addition, linking with new and evolving types of partnerships for health at various levels of governance across the region will only serve to provide greater support.

Working with civil society will strengthen advocacy for implementing the NHSP. The MOH which will lead and conduct where policies will be utilized and implemented as regulatory and health development tools, has to play a supporting role in the valuable contribution of stakeholders for implementation at all levels. Securing a stronger commitment to health from

private sector actors and rewarding their social responsibility are important goals that ought to be taken into consideration. Strategic actions and detailed operational plans for implementing the actions identified in this NHSP shall be developed. Implementation shall be coordinated, monitored and governed by multi-sectoral stakeholders.

This is an adaptable and practical health policy which requires political commitment to its processes and the setting of realistic targets. In today's world, a complex assortment of global, regional and domestic forces challenge people's health and its determinants. The future prosperity of this country and the region as a whole will depend on the willingness and ability to seize new opportunities to enhance health and well-being of current and future generations. This NHSP supports and encourages MOH and GOSL to bring stakeholders together in a shared effort for safeguarding health and ultimately the future of Saint Lucia.

Appendix 1

Methodology

The methodological approach in formulating this NHSP incorporated qualitative and quantitative data analyses. An in-depth qualitative, semi-structured interview schedule was used to solicit information from primary and secondary stakeholders, as well as public agencies (e.g. related ministries) of the system. It took the form of organized individual as well as focused group discussions where appropriate. In some instances, telephone interviews were also conducted. The consultant was ably assisted by the staff of the Corporate Planning Unit (CPU) in the scheduling and organization of such interviews and discussions. Discussions with the Acting National Epidemiologist yielded assistance with the analysis of existing quantitative data including the available epidemiological and social epidemiological data. Interviews and focused group discussions were complemented by extensive analysis of pertinent documents and other material both from MOH and related agencies, published and unpublished (see reference section for list of documents).

Information gleaned from the aforementioned activities formed the foundation of the review

report and ultimately the point of departure for this NHSP. During the interview process, emphasis was placed on gains made following the execution of the NSPH (2006-11), as well as the gaps and challenges that remain since implementation. Participants' views were also solicited on the way forward to deal with these gaps and challenges. The input of all key stakeholders was secured at various stages of the development of this deliverable.

Appendix 2

Situation Analysis (Expanded Version)

Saint Lucia can be described as an open economy whose membership of CARICOM and the OECS provides benefits in the areas of policy development - including health - and resources or technical assistance. The economy is led by tourism which is its biggest employer.

Like most other small island developing states of the region, Saint Lucia has not been spared the effects of the global financial crisis that began in 2008. An economically vulnerable state, its main sources of revenue are highly susceptible to the vagaries of variable exchange rates. In addition, natural disasters including hurricanes, threaten its main industries of agriculture and tourism. This is exacerbated by its limited manufacturing, which though recording an increase of 1.6% for the fiscal year 2011, continues to be affected by rising costs including cost of fuel, electricity and other materials (GOSL, Budget Statement, 2012-2013).

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Saint Lucia experienced modest growth of 0.6% in the year 2011, led by expansion in the construction and manufacturing sectors as well as continued growth in the hotel and restaurant sub- sectors. This was complemented by increases in the distributive trade sub-sector. After two years of consecutive decline, the construction industry driven by public sector investments, recorded 2.1% increase; this situation was not however mirrored in the private sector (GOSL, Budget Statement, 2012-2013).

Like many of its counterparts in the Caribbean, Saint Lucia continues to battle the albatross of an unsustainable fiscal deficit that is growing at a faster rate than those in recent times. In this regard, the country experienced a four-fold deficit increase from 1.9% of GDP in 2007/08, to 7.6% of GDP in 2011/2012. At the end of 2011, it recorded a public debt – to- GDP ratio of 68.5%. This was projected to increase to 68.9% by the end of March, 2012.

Saint Lucia has been ascribed the status of an upper middle-income country by the World Bank and has a ranking of 83 on the human development index (HDI) (UNDP, Human Development Reports, 2013). A poverty assessment conducted in 2005 however, found that 28.8% of the population lived in poverty signaling the inequities that the society continues to encounter. This records increases from 25.1 one decade earlier, with indigence also showing a decline from 7.1 to 1.6% over the same time period (KARI Consultants Limited, 2008).The assessment also revealed that poverty is essentially a rural phenomenon with many rural quarters exceeding 35%. The growing inequities experienced by rural areas can be attributed to the decline of the banana industry which was largely based in the rural areas. In Saint Lucia, it is also apparent that poverty disproportionately affects the young. According to the Saint Lucia Housing and Population Census of 2010 preliminary assessment, total unemployment was estimated at 22% with youth unemployment at 35%.

Demographic and lifestyle Changes

The 2010 Housing and Population Census suggests a 5% growth in the population of the island state over a ten year period from 2001-2010. The estimated household population is 166,526 comprising 83,600 females (50.2%0 and 82, 926 males (49.8%) (See table 1). The census report also revealed that 165,595 lived in households and 931 in institutions (GOSL, Dept. of Statistics, 2011). There are two noteworthy features of the population in relation to their impact on the current health status of the population that is of considered significance in relation to the formulation of this policy. The first is the consistent movement of individuals towards the urban centres as seen over the last 20 years, with almost three-quarters of the population living in rural areas; the second is the aging population in the face of a declining fertility rate from 6.7 in the

early 1960s to 1.9 in 2009. The drop in the fertility rate has been partly explained by the delay of first pregnancies as a result of increased educational opportunity for women, increased family planning interventions and opportunities for social mobility. It is however evident that despite the decrease in teen births over the years, teenage pregnancy remains a challenge for the island state (World Bank, 2011).Between 1991 and 2001, the country's population grew by 1.2% as compared to between 2001 and 2010, where preliminary estimates reveal an increase of 5.3%. This has been attributed to the number of live births exceeding the number of deaths (GOSL, Central Statistics Office, 2011). Average life expectancy was 73.2 in 2007 with males registering 70.8 and females 75.8. This represents a decline when compared with 2001which recorded an average life expectancy of 74 live births per 1000 population. For the period 2006-2010, the number of births decreased progressively (MOH, 2010)

Health Situation

The impact of poverty on Saint Lucia is of particular concern in terms of gaining access to care and also in responding to health needs. There is indeed a common assumption that those in greatest need of health care are the most underprivileged in a society. The aforementionedpoverty statistics in Saint Lucia reveal the strong possibility that health services may not be responding to specific groups within society in particular, women, youth and the unemployed. It would therefore appear that the link between poverty and access to health care in Saint Lucia is an area worthy of further investigation.

Mortality

Leading causes of death were malignant neoplasms, followed by diabetes mellitus and diseases of the circulatory system (including cerebrovascular and heart disease). Assault and motor vehicular transport accidents featured among the top 10 causes, accounting for 4.5% and 3.9% of deaths in 2011 (see table 3.2.3).

Table 3: Top Ten Principal Causes of Death

Rank	Principal Cause of Death (ICD 10 Code)	Total	Percent
1	Malignant neoplasms (C00-C97)	153	17%
2	Diabetes mellitus (E10-E14)	129	14%
3	Heart Diseases (I05-I09, I20-I51)	120	13%
4	Cerebrovascular diseases (I60-I69)	88	10%
5	Hypertensive disease (I10-I15)	47	5.3%
6	Assault (X85-Y09)	44	4.9%
7	Perinatal causes (P00-P96)	40	4.5%
8	Motor vehicle transport accidents (V01-V89)	35	3.9%
9	Chronic lower respiratory diseases (J40-J47)	29	3.2%
10	Diseases of the liver (K70-K76)	16	1.8%
Total 10 Principal Causes		**701**	**78%**

Source:Epidemiology Unit, Ministry of Health, Saint Lucia 2013

3.2.2 Morbidity

It would appear that accessing morbidity data from both the hospitals and primary care institutions constitute a challenge for the health system owing to the difficulty experienced by hospitals and primary care institutions. Childhood morbidity data obtained through syndromic surveillance did reveal that gastroenteritis, undifferentiated fever, respiratory symptoms were conditions frequently treated at outpatient departments, accident and emergency units and wellness centers in 2009 and 2010 (PAHO, 2012). According to the Health in the Americas Pan American Health Organization (PAHO) Report of 2012, Saint Lucia experienced an

extraordinary increase of 30.6% in the general number of primary care visits in 2009. This was attributed to the outbreak of pandemic influenza A (H1N1) that year. Admission records from the St. Jude and Victoria public hospitals located in the south and north respectively, showed that non-communicable diseases accounted for nearly 29.4% of admissions annually between 2007 to 2009 (see table 3.2.4).

TABLE 4: Hospital Admissions, by Cause and Year, St. Jude and Victoria Hospitals, Saint Lucia, 2007–2009

Cause	2007	2008	2009
Hypertensive diseases	**804**	**957**	**1,007**
Other cardiovascular diseases	**817**	**684**	**907**
Diabetes Mellitus	**883**	**585**	**839**
Malignant neoplasms	**260**	**134**	**242**
Asthma	**211**	**144**	**170**
Renal failure	**186**	**227**	**229**
Sickle cell disorders	**150**	**147**	**173**
Subtotal	**3,311**	**2,878**	**3,567**
Other conditions	**8,069**	**5,289**	**7,958**
Total admissions	**11,380**	**8,167**	**11,525**

Source:Epidemiology Unit, Ministry of Health, Saint Lucia 2013

General Health Situation Trends for Saint Lucia

The health situation in Saint Lucia parallels that of its counterparts in CARICOM and by extension, the Americas. It is characterized by the co-existence of the consequences of communicable diseases with those of chronic - degenerative illnesses (PAHO, Health Agenda of the Americas, 2008-2017). Violence, trauma and mental illnesses are also the order of the day.

The health landscape now has to contend with the aforementioned that has apparently replaced communicable diseases as the leading causes of death and disease. Saint Lucia, despite the gains over the last few years, faces traditional threats such as tuberculosis which have re-merged (22 cases in the first quarter of 2013), and the island state cannot boast of being free from new agents such as HIV/AIDS and the influenza virus. Saint Lucia currently faces the danger of a group of diseases that are the consequence of poverty as a major health determinant, and generally result in stigma. The preventable and curable nature of these diseases with drugs that are easily administered provides little assurance that the challenge of managing or controlling them is over.

Despite the fact that in recent years Saint Lucia has experienced some improvement in some of its principal indicators (although IMR as discussed previously is a source of great concern), disconcerting differences apparently remain within the population in the country. Significant differences remain with respect to inequalities in health. These are related to differences in age, gender, income distribution, educational level and the rural -urban divide.

The health sector has to be commended for its progressive actions in reducing early and avoidable mortality. This has been registered mainly in primary care attributable to increased vaccination coverage, family and sexual reproductive health planning. Maternal mortality has declined, while pregnancies among adolescents continue to pose a minor challenge for the health system as well as the future fathers and mothers and these children. Mortality by certain preventable conditions such as cervical cancer, breast cancer, and acute respiratory infections can be reduced through the integrated approach of primary health care coverage and effectiveness.

It is now largely understood that while progress can be achieved by specific actions on the part of the health system, such action is limited if risk factors that require intervention and are

associated with the principal causes of disease and death are outside the direct control of the health sector. An excellent example of this is mortality from exogenous factors such as living conditions, lifestyles and behavior. Illnesses such as cardiovascular disease, diabetes, pulmonary disease and HIV/AIDS fall into this category. The response to this situation resides in a review and action on the major determinants and risk factors of the principal health conditions and problems. This would require an approach based on evidence -based decision making which at the moment appears to be highly unsatisfactory for the island state. This approach will have to take into account, an analysis of the evidence to inform policy decisions. Additionally, the formation of strategic alliances or partnerships from both an inter-sectoral and interagency/inter-institutional point of view has to become part of the organizational culture of the health system in order to guarantee the efficacy of interventions.

Central to the efforts of the MOH which manages the health system, has to be the promotion of the maximum development of children's potential that can notably be the vanguard of change. A new frontier in health has to take into account the latter's contribution to a more equitable distribution of health as well as the overall developmental agenda of the island state. The ground work for access to productive employment opportunities for our future generations accompanied by greater social mobility has to be seriously looked into. It is recognized that the lack of opportunities is manifested early in childhood.

The Health Services

This section will provide a general overview of the health system and examine its component parts. From the outset it has to be recognized that the health system in Saint Lucia comprises a

mix of the public and private sector. It also comprises primary, secondary, and tertiary levels of care with services equally divided between the public and private sectors.

Organization and Management of the Health Sector

MOH is responsible for policy formulation, planning, programming regulation, expenditure control and personnel matters. It focuses on providing maximum quality of life for all of the country's citizens. Among other actions, the MOH has set its priorities on health policies and plans that attempt to target the poor and at risk sections of the population, children and the elderly and tries to assure gender equity. The ministry has an administrative and technical arm - the former is headed by the Permanent Secretary (PS), while the latter is led by the Chief medical Officer (CMO) who is responsible for the health of the nation. The sole provider of primary and secondary health care services in the public sector, the MOH spearheads the government's efforts to strengthen the health sector within the national, regional, social, political and economic contexts and to position it as a major driver of social and economic development.

The Public Health Delivery System

The current data provides a crude estimate of approximately 80,000 who access primary care services and 9,000 hospital and secondary inpatient care systems on an annual basis (PAHO/WHO, 2011). In examining the structure of the public service delivery system, there are three main levels of care services offered by the island state. At the primary care level, there are 32 public wellness centres, one polyclinic, two district hospitals and two hospitals that offer secondary and limited tertiary care services - one main hospital in the north (Victoria Hospital) and one parastatal in the south (St. Jude's Hospital). Organized into eight geographical regions,

the public health system provides an estimated 50% of the primary care services. The system suffers the challenge of the overutilization of the A&E departments. This occurs in the face of the limited opening hours of wellness centres where care of a nurse or nurse practitioner is available until 4:30 pm and one half day per week. MOH reveals that physicians are available on select days with select hours. In addition, there seems to be a lack of confidence and trust in the primary care facilities by consumers. It is anticipated that with the strengthening of PHC and the onset of the new NNH, there will be improvement in the situation. The recommendation calls for the extension of primary care hours and /or the establishment of strong referral systems mechanisms.

Ninety percent of the secondary care services offered on the island for residents and visitors are provided by the state-run health system. These secondary care services are shared among the hospital institutions of Victoria Hospital with 160 beds, St. Jude's Hospital with 70 beds and Tapion Hospital, by contrast, a privately funded hospital with 30 beds. The New National Hospital (NNH) about to be commissioned (during the formulation of this policy) by the GOSL to replace the Victoria Hospital is projected to house 116 beds.

Outpatient services are provided at medical clinics, at wellness centres (health centres) two district hospitals (Soufriere and Dennery; Dennery district hospital has been temporarily relocated to a health centre in the Mabouya Valley owing to damage suffered from Storm Tomas, in 2010), one polyclinic in Gros Islet in the North of the country and through the casualty or emergency departments of the acute general hospitals. In addition, two specialized institutions offer services on the island; the Saint Lucia Mental Wellness Centre - a psychiatric facility - and

Turning Point, a substance abuse rehabilitation centre.

Most tertiary care facilities are provided through health facilities in the region primarily Martinique, Barbados and Trinidad and Tobago. The National Insurance Corporation (NIC) provides assistance to older persons, the physically challenged and the indigent whether or not they are contributors to the Corporation. It receives contributions from persons aged 16-60 who are in the labour force and provides benefits such as insurance coverage for sickness, disability, maternity, maternal and occupational injuries as well as death benefits. In addition, it pays an annual fee to MOH to cover in-patient hospital fees for its members. According to figures provided by the Corporation for the 2010 period, the economically active insured population stood at 49,158, representing 72.6% of the labour force. Of this total, male registrants comprised 23, 571 or 68.8%, while females represented 25,587 or 84.1% of the female labour force. The MOH also plays its part in relation to assistance to the poor and indigent members of the public, while the remainder is funded out- of- pocket with private insurance covering the insured.

A WHO/PAHO 2011 assessment of the health system and private sector in Saint Lucia concluded that the island state has an adequate number of health facilities in both the private and public sector to supply services to its populace. This is readily facilitated by high levels of education and literacy among the population and adequate infrastructure including roads, electricity, water, and sanitation and telecommunication services. These ancillary services to health care provision make good access to and strong demand for health services possible with an estimated almost 50% of the population seeking health care annually according to the ST. Lucia Health Systems and Private Sector Assessment Report of 2011.The report went on to

suggest that there was ample access and availability to PHC and secondary level services provided by the three hospitals on the island, to be eventually complemented by the establishment of the NHH. There is concern in certain quarters that the establishment of this new institution could exacerbate impediments for the current service delivery situation. As outlined in the national strategic plan for health (NSHP, 2006-2011) however, this new entity could serve to make service delivery more efficient if anticipated plans are well executed.

In relation to the current status of the service delivery of the system, stakeholders and service providers have expressed the following concerns:

- Inadequate quality assurance and quality improvement systems
- Absence of efficient referral systems that promote the use of primary care services
- Inadequate coordination and collaboration between the public and private sectors.

Ironically, the PAHO/WHO Assessment report of 2011 has registered those concerns as key gaps in the service delivery systems.

In the NSPH, a proposal was put forward regarding the restructuring of the system to allow for greater emphasis on PHC as opposed to management of chronic diseases through the country's hospitals. Mention was also made regarding the classification of facilities to four levels, therefore reducing the number of higher level facilities within each health region. An additional objective was the provision of a standardized package of services. Unfortunately, the original suggestion that health teams be formed has not been implemented.

Governance and Management

The MOH has a fairly strong policy environment, a supportive regulatory framework and the

requisite skilled staff in place to carry out the stewardship roles of the MOH. There are however, limited resources (human and financial) to enforce regulations. Consideration of a governance structure for the MOH is outlined in the NSPH, but this requires the development of a model for presentation to the directorate. In addition, the lack of human resource capacity continues to hamper the planning and coordination of activities across the health landscape. Stakeholder interviews indicated a willingness to re-engage the MOH following the lull experienced on completion of the NSPH. MOH has indicated a strong desire to strengthen stakeholder partnerships through formal arrangements in order to deepen trust and improve relations. Similarly, NGO and private sector leaders are committed to dedicating time and staff to participate in policy and planning. A health partnership forum could be a step in the right direction to coordinate efforts between the private and public sector periodically convened by the MOH. This forum should include: private sector, NGOs, donors as well as representatives from the national and sub-national level. In addition, a private sector and NGO desk can also be actively considered by the MOH for coordination and collaboration.

Human Resources in Health (HRH)

The MOH has a human resource (HR) structure which currently focuses on routine HR administrative functions. Most of the personnel function at the PHC level in the primary health care units. These are handled centrally by the MOH. On the other hand, the hospitals have their own HR structure and they report directly to the Ministry of the Public Service. Recognizing the importance of skilled medical and health professionals to fulfilling its mandate, the MOH noted the need for appropriately trained and motivated medical, nursing, dental, nutrition, pharmacy, paramedical and ancillary workers in the correct numbers, as vital for the cost effective delivery

of quality health services in Saint Lucia (NHSP, 2005-2011).

The current HRH profile for Saint Lucia reveals that human resources for health are a major input in the health system and accounts for 75% of the MOH current budget. Proportionately, it is second to the Ministry of Education in the entire public service. An assessment conducted by a Technical Assistant (TA) attached to the MOH for two years (through a Commonwealth Fund for Technical Cooperation with GOSL) found that 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 particularly with the onset of the NNH which is to be commissioned (Draft Proposal and Justification for the Restructuring and Strengthening of HRH Structure in MOH, 2013).

Further evidence suggests that the current HRH structure in the MOH lacks sufficient capacity to ensure the availability and management of an effective and sustainable health work force for the provision of suitable and quality health services to the population. Other challenges include:

- Varied professional backgrounds of staff
- Lack of formal training and background in HR
- HRH structure in MOH does not fit its purpose and does not have the clout to influence policy directions
- HRH Structure fails to operate at a strategic level (operates solely at administrative and operational level)
- Weak coordination and synchronization at related HR structural levels (i.e. hospital, MOH and service units levels)

- Lack of continuity and capacity building owing to transfers by the Ministry of the Public Service.

The country developed a detailed HRH plan as part of its NHSP. According to MOH officials, however, the MOH has not found the resources to fill approved posts or implement the plan. This has resulted in the obvious inadequacy of numbers and distribution of technical and administrative staff to meet the present and anticipated needs of the health system. In the face of these challenges however, the MOH has been able to retain its human resources in the health sector, particularly at the primary care level. The resourcefulness of the management team of the MOH and the wider health services has been instrumental in meeting the manpower needs of the system. Strategies havetherefore been devised in the face of the constraints of a freeze on hiring, delays in public service appointments and approvals, and MOF budget allocations. The system has as a consequence depended on: retired professionals working on a sessional (month –to - month basis), part-time contract staff members who currently form the majority at some levels of staff in the system. This is illustrated by the fact that 68% (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 main hospital facility –VH- the majority of administrative, nursing, clinical support, ancillary and maintenance staff is in approved, funded and permanent positions. A focus group session with the consultant physicians and Medical Director however revealed that specialist physicians are on temporary contracts of between one and two years' duration. While a number have had contract extensions, concern was registered over the short term contract policy. A

similar situation of tenure obtains at the Soufriere Hospital, where two medical officers and one District medical Officer are on temporary contract.

Apart from the issues of tenure expressed by individuals, there are the significant gaps in specialist personnel in the public services, which have prompted MOH to look to outside assistance for the development of a proposal to train specialist health care workers. Psychiatry represents one of the areas of deficiency, with only one psychiatrist who is on a two-year contract. Currently, there are no existing posts for community mental health nurses. Emergency medical technicians, nurse anesthetists, pharmacists, dentists, and laboratory technicians are categories of specialties needed in the public health services based on a recently concluded review of the HRH plans by the MOH.

With data indicating that NCDs are the main disease burden, there is a need for an increased and stable specialist workforce including: community health nurses, family nurse practitioners, district medical officers, and specialist as well as health educators. MOH reveals that the current cadre of various categories of health worker comprise the following: 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 total population of approximately 165, 595 persons. The implications of the aforementioned are the availability of specialists to service other priority areas in the system, in an effort to address the growing NCD burden that is anticipated. Burn out by existing health personnel can indeed compromise the quality of care required.

As health promotion and education assume greater importance in the face of the health system's response to the prevention, care, treatment and management of NCDs, the number of individuals working in this area of specialty is cause for concern. At present, there are six field staff workers in this area of expertise and four family life educators. It would appear that some regions are underserved or not served at any time.The current team of six educators is inadequate manifested by poor coverage, over-extension of officers and the complete neglect of some communities by the BOHE. This further hampers the desired proactive nature of the unit in its undertakings.

It can therefore be concluded from the above assessment that at all levels of the public service the human resource cadre is limited and lacks the capacity to maintain the coverage and quality of services needed for the country. It is anticipated that the current situation will be exacerbated by the staffing demands of the NNH as well as the National Mental and Wellness Centre (NMWC) lessons already having been learnt from the latter where understaffing remains a challenge and the envisioned provision of model and quality care is yet to be realized. There is nonetheless a great opportunity for public- private sector partnerships in this human resource endeavor that would call for strong policy initiatives.

Recognizing the need for new and improved health personnel competencies to optimize health worker motivation and productivity, and the discrepancy between the disease burden of Saint Lucia and the profile of the health workforce, MOH is dedicated to the training of specialized health workers. It is expected that these workers will play a leading role in the maintenance and improvement of the health and well-being on the population of Saint Lucia. In devising a comprehensive HRH plan, consideration will have to be given to strategies to maximize the

cadre of professionals in the public and private sectors particularly taking into account the NNH. There will also be the need for a plan to address staff tenure, recruitment, succession planning, management, supervision and service quality control. This is currently being looked into by the TA from the Commonwealth of Nations Secretariat contracted to restructure and strengthen the HRH structure in the MOH. Such planning capacity for the HR of the system ought to be sustained within the MOH beyond the two year stint of the TA.

Health Financing

In the Saint Lucian context, health services delivered in the public sector are financed by general tax revenues and the contribution of EC$5m per year form the NIC for services to currently employed NIC members. Other sources include out - of- pocket-payments and health insurance. Donor funding currently plays a minor part in funding on-going health services in the country as the donor support landscape has changed from the provision of funds to more technical assistance. This has implications for the sustainability of health services in the country.

User fees are charged for many hospital services except in cases where patients are exempt or covered by the NIC. There is a policy on exemptions for the poor and essential public health and safety workers, including nurses, police and fire officers. At the PHC level, there are free services save for a few selected services.

The health assessment team (USAID, 2012) also noted the challenges of conducting a sound financial analysis in relation to the adequacy of annual budgets relative to disease burden and services accessed on an annual basis. This it attributed to the absence of data for the costing of

services, and where such data was present (data on public and private health expenditures), a somewhat ambiguous picture was presented. Estimates by the USAID team (2012) revealed that in 2009, total GDP was approximately EC$2.565 billion with MOH expenditure alone beingEC$74 million. This was reported as 9.4% of government expenditures and would equal 2.9% of 2009 GDP. Estimating that private sector expenditures were 41.2 % of the total, as suggested by 2008 WHO data, then total health expenditure would be 4.9% of GPD well below the recommended amount of 6.8% of GDP reported by WHO for 2009. Furthermore, at 4.9 percent of GDP, this per capita spending works out to EC$740 (US$274), well below the health spending of EC$1, 828 (US$677) reported by WHO in 2008. This level of expenditure which ranges from 4 - 5% of GDP is rather below reported public and total expenditure levels of the island's counterparts in the region. It therefore suggests the need for GOSL to allocate more funds towards health. This situation in turn creates a challenge for the country's health system in so far as the attempts to even consider the addition of services or new facilities, or potentially consider whether to contract such services to the private sector.

The budgetary projection for health is one of a substantial increase once the NNH operation is underway. - an estimated total budgetary requirement of EC$ 117M or an increase of 58% from three years earlier; this would add more than 1% of GDP (EC$ 43M) to annual health expenditures in Saint Lucia (PAHO, 2011). The island state needs to consider the financing of both the expansion of its primary care services and its chronic disease efforts. It has been well over a decade that the decision has been made to make health care more universally acceptable and affordable. This resulted in the early proposals of Universal Health Care (UHC), for the provision of services via the public and private sector institutions within a social insurance

framework. The suggestion was a clear demarcation between the provision and the financing of services. The current proposal on the table is seemingly a lot more limited and designed to provide the requisite funding for the NNH. A report coming from PAHO (2011), did not find favor with the aforementioned approach citing the large informal sector in the island's economy which would make it difficult to reach payroll-based premium deductions or taxes. For PAHO, a superior arrangement recommended includes additional VAT revenues and a tobacco tax that would be covered to cover the increased costs. This same report further suggested that the current NIC contribution to the MOH would be replaced by these new funding arrangements. As part of its policy thrusts, the MOH/GOSL needs to make a final decision with respect to these critical funding issues. Policy decisions will also have to be made in regard to the gap to be filled on National Health Accounts (NHA) analysis or full household health expenditure studies to provide up-to-date data on total health expenditures.

Pharmaceutical Management & Procurement

Key findings reveal that the pharmaceutical management component of the health system enjoys a strong Pharmacy Act (No. 8 of 2003) that regulates the practice of pharmacy. This act however fails to address the regulation of importing medicines into the country. It addresses dispensing only as only pharmacists are allowed to dispense. In addition, there are vacant positions for pharmacists which are difficult to fill because of the short supply and the fact that there are no training facilities on island. As revealed by the Pharmacy Council and Association, the area of pharmacy is not on the training priority list of the government. A very disturbing trend is the self –regulation of private pharmacies because of inadequate MOH enforcement and oversight capacity. While it is true that MOH has employed one drug inspector, it may be necessary to

appoint more than one for more adequate oversight and enforcement of regulations.

Health Information System (HIS)

An examination of the current situation in the health information sector reveals that the there are systems of routine reporting across the public health facilities which generate important data. In addition there is seemingly a good technical infrastructure in place across health facilities that are capable of supporting the HIS. There is also strong evidence of the political will to pursue a modern HIS as seen from the electronic HMIS system that has already been purchased, supported by a strong project management team that has been leading the effort to put the HMIS into operation.

As indicated previously the efforts are nonetheless severely marred by limited staffing and limited funding to complete all the projected phases of the HIS. Part of the challenge registered has also been the nonexistence of a unique patient identifier. As a consequence, the capacity of the HIS in the country to track patients would be severely limited. Added to this deficiency is the concern over the timeliness of data consolidation and dissemination. This serves to further weaken the effectiveness of data driven policy and decision making. A critical area of concern is the sharing of data and information between the public and the private sector which to all intents and purposes, is extremely limited. This calls for more dialogue and engagement between the two sectors.

Private- public Sector Engagement

Both the private and public sub-sectors acknowledge the need to collaborate and engage on a more regular and official basis. The evidence points to the fact that the private sector occupies a prominent position on the health landscape, maintaining a ubiquitous presence. It is also evident that the private sector deals with a full range of clients no matter the socio-economic status. Reasons proffered for such among stakeholders included: the perception of quality, confidentiality, availability of a wider variety of drugs and access to specialists. To some extent, the private sector pharmacies seem to have on offer key drugs that are affordable.

Against the backdrop of the absence of transparent regulations for governing the private and public sectors, the additional challenge to be considered is one of capacity to monitor and enforce sanctions should such regulations are to be put in place.Currently, a situation of self-regulation has become the order of the day, opening the door for abuses in the system. The feeling of exclusion and lack of recognition of contributions made, places the entire health system in danger of an unfulfilled mandate. Exclusion leads to resentment and ultimately a breakdown in communications and interactions. Such an atmosphere risks polarizing the two sectors rather than engendering coordination so critical for the delivery of quality services.

The undocumented and unofficial engagement of the private and public sector is however manifest, evidenced by sharing of equipment and supplies, limited sharing of information, limited participation in policies and discussions and the sharing of expertise, contracting of services and equipment. These areas of limited engagement provide opportunities for deeper, more substantive and official engagement. This can be facilitated by a unit or body tasked with

the responsibility of oversight, such as a Public-Private Partnership Unit or as suggested by private sector stakeholders, a private sector advisor.

The lack of trust and the resultant tension that exists hurts private - public sector relations. The public sector needs to partner with the private sector to effectively deliver quality services to the population. As one stakeholder elegantly summarized it, the public and private sector must work in tandem. It is clear that the public sector will not be able to provide every need and this recognition should place the MOH on a path of negotiating a harmonious synergy in the interest of the citizenry of Saint Lucia. As part of its mandate, the public sector also needs to regulate the private sector.

Appendix 3

Other Ministries, Departments and Agencies (MDAs)

Other MDAs critical to the implementation of this policy are agencies responsible for good governance and leadership and include inter alia:

- Ministry of Legal Affairs, Home Affairs and National Security
- Ministry of Finance and Economic Affairs
- Ministry of Agriculture, Food Production, Fisheries, Rural Development and Cooperatives
- Ministry of Infrastructure, Port Services and Transport
- Ministry of Education, Human Resource Development and Labour
- Ministry of Commerce, Business Development, Investment and Consumer Affairs

- Ministry of Justice
- Ministry of Physical Development, Housing and Urban Renewal
- Ministry of the Public Services, Sustainable Development, Energy, Science and Technology
- Ministry of Social Transformation, Local Government and Community Empowerment
- Ministry of Youth Development and Sports
- Ministry of Tourism, Heritage and the Creative I`ndustries
- The Royal Saint Lucia Police Force
- Judiciary
- Cabinet
- Parliament
- WHO/PAHO and other related international agencies.

MOH will collaborate with these agencies to develop and monitor policies and programs geared towards the enforcement of health related internal and international laws and encourage overall adherence to national commitments towards global, regional and sub-regional agreements and initiatives.