SAINT LUCIA

UNIVERSAL HEALTH COVERAGE FINANCING POLICY PAPER

January 2025

Table of Contents

Acknowledgements

The Saint Lucia Universal Health Coverage (UHC) Financing Policy is the result of over a decade of research, collaboration, and consultation led by Dr. Kester Nedd, CEO of the JIPA Network. This effort engaged a diverse range of stakeholders—domestic, regional, and international—including professionals and institutions specializing in healthcare delivery and UHC implementation in small island developing states.

Key contributions came from the Ministry of Health, Wellness, and Elderly Affairs, Ministry of Finance, the Office of the Prime Minister, the Attorney General's Chambers, management teams of Saint Lucia's hospitals, and other essential partners. Special acknowledgment is given to Lydia Atkins, CEO of St. Jude Hospital, and John Osika, a World Bank consultant, for their pivotal roles in drafting the Saint Lucia UHC white paper, which served as a foundation for this policy. The World Bank's support and funding for the white paper were also instrumental.

This policy reflects insights gathered through workshops and consultations with public and private healthcare providers, private sector representatives, insurance companies, unions, the Financial Services Regulatory Authority, the National Insurance Corporation, and citizens. Their input shaped a framework aimed at achieving equitable and sustainable healthcare for all Saint Lucians.

Glossary

Bacille Calmette-Guérin (BCG): A vaccine primarily used to protect against tuberculosis (TB). It is included in Saint Lucia's immunization schedule, particularly for children, as part of the UHC effort to control communicable diseases.

Caribbean Public Health Agency (CARPHA): A regional health body that supports Caribbean countries, including Saint Lucia, in addressing public health challenges. CARPHA provides technical assistance, disease surveillance, and health policy support, playing a vital role in Saint Lucia's efforts to strengthen health systems under UHC.

Electronic Health Records (EHRs): A digital version of a patient's medical history that is maintained over time by healthcare providers. The UHC initiative in Saint Lucia includes a plan to implement EHRs across the country, allowing healthcare providers to share patient information, improve care coordination, and enhance the quality and continuity of care. The data system will need to be interoperable with other health care related technology platforms and will need to be governed by a regulated level of patient data privacy.

Electronic Medical Records (EMRs): Digital versions of patients' paper-based medical records maintained by healthcare providers. They contain comprehensive information about a patient's medical history, diagnoses, treatments, medications, test results, and other clinical data, primarily used within a single healthcare organization for patient care and management.

Essential Medicines List (EML) can also be referred to as a Pharmacy Formulary (PF): A list of medications deemed essential for addressing the healthcare needs of the population. Saint Lucia's UHC strategy includes ensuring that the medicines on the EML are readily available at public health facilities and are provided at no or minimal cost to patients.

Essential Package of Health Services (EPHS): The core set of health services provided under Saint Lucia's Universal Health Coverage (UHC). This package covers essential healthcare needs, including primary care, maternal and child health, noncommunicable disease (NCD) management (such as diabetes and hypertension), vaccinations, and basic diagnostic services. The EPHS aims to ensure equitable access to critical healthcare services, preventing financial barriers to care, especially for the most vulnerable populations.

Financial Protection: A key goal of UHC, ensuring that individuals are not exposed to financial hardship due to the cost of healthcare services. In Saint Lucia, financial protection will be achieved through reforms that reduce out-of-pocket payments, expand insurance coverage, and introduce performance-based financing models.

Gross Domestic Product (GDP): The total value of all goods and services produced within a country in a given year.

Health Financing (HF): The mechanisms by which funds are generated, pooled, and allocated to finance healthcare services.

Health Information System (HIS): The digital systems and databases used to collect, store, manage, and transmit health data. In Saint Lucia, the Health Information System is being strengthened to support UHC goals through improved data collection, health financial services management and transactions, electronic health records (EHRs), and real-time health monitoring. HIS is crucial for making data-driven decisions in healthcare planning and delivery. This is also referred to as Health Management Information Systems (HMIS).

Health Savings Account (HSA): These are financial accounts that allows individuals to save money specifically for healthcare expenses. Funds in the account can be used to cover medical costs, often with certain tax advantages depending on the country's regulations.

Human Resources for Health (HRH): Refers to the workforce responsible for delivering healthcare services, including doctors, nurses, midwives, pharmacists, community health workers, and administrative staff. In Saint Lucia, HRH is a key pillar of UHC, with efforts focused on addressing workforce shortages, improving training, and enhancing the retention of healthcare professionals.

Noncommunicable Diseases (NCDs): Chronic non-infectious diseases such as cardiovascular diseases, diabetes, cancers, and respiratory conditions. These are now the leading causes of death and disability in Saint Lucia. Addressing NCDs is a top priority for the UHC initiative, which includes preventive measures, early diagnosis, and chronic disease management as part of the Basic Benefit Package (BBP).

Out-of-Pocket (OOP) Payments: Direct payments made by individuals for healthcare services at the point of use, which are not covered by insurance or the public health system.

Performance-Based Financing (PBF) otherwise known as Pay-for-Performance (PFP) : A health financing mechanism where payments to healthcare providers are tied to specific performance indicators, such as quality of care, patient satisfaction, or health outcomes.

Primary Health Care (PHC): The first level of contact for individuals within the healthcare system, focusing on prevention, health promotion, treatment of common diseases, and management of chronic conditions. PHC is central to Saint Lucia's UHC strategy, with efforts to improve the accessibility, quality, and scope of services provided at health centres across the country.

Referral System: The process by which patients are transferred from one level of healthcare (e.g., primary care) to another (e.g., secondary or tertiary care) based on their health needs. An effective referral system is crucial for UHC in Saint Lucia to ensure that patients receive the appropriate level of care while avoiding unnecessary burdens on higher-level facilities.

Secondary Health Care: Specialized medical services provided by healthcare professionals who typically require a referral from a primary care provider. It includes more advanced diagnostics and treatments delivered in facilities like hospitals or specialist clinics.

Stakeholder Engagement: The process of involving key actors, including healthcare providers, patients, private sector entities, civil society, and international partners, in the design, implementation, and monitoring of UHC policies. Saint Lucia's UHC framework emphasizes active stakeholder engagement to ensure that the health system reflects the needs and priorities of all citizens.

Sustainable Development Goals (SDGs): A set of 17 global goals established by the United Nations to promote peace, prosperity, and sustainability by 2030. Goal 3 (SDG-3) focuses on ensuring healthy lives and promoting well-being for all, which includes achieving UHC. Saint Lucia's health policy aligns with SDG-3, emphasizing equitable access to healthcare and the elimination of financial barriers.

Telemedicine: The use of technology to deliver healthcare services remotely, allowing patients to consult with healthcare providers via video calls or other digital platforms. Telemedicine is part of the digital health strategy under Saint Lucia's UHC plan, especially to improve access to care in rural and underserved areas.

Tertiary Health Care: Highly specialized medical care provided by advanced hospitals or medical centres. It involves complex treatments, surgeries, and procedures for severe or rare conditions, often requiring specialized expertise and technology.

Universal Health Care: This is a healthcare system in which the government ensures that all citizens have access to healthcare services, typically funded through taxation or other public resources, regardless of their income or social status.

Universal Health Coverage (UHC): The principle that all individuals and communities should have access to the health services they need, without suffering financial hardship. UHC in Saint Lucia aims to provide a comprehensive range of healthcare services through the National Health Insurance Scheme ensuring coverage for all citizens, particularly the poor and vulnerable, and improving the overall efficiency and sustainability of the health system.

Executive Summary

This document outlines the framework for implementing Universal Health Coverage (UHC) in Saint Lucia, aiming to provide accessible, equitable, quality, and sustainable healthcare for all citizens. While Saint Lucia has achieved strong outcomes in areas like infant mortality, life expectancy, and maternal health, challenges are mounting. These include underfunded primary care, difficulties retaining healthcare professionals, a rise in chronic conditions such as diabetes and cancer, and the resurgence of communicable diseases.

Demographic changes, including declining birth rates, threaten labour market stability and future development. Additionally, the rising cost of healthcare delivery, a small population, and fragmented systems have limited economies of scale, leaving care, patients, and funding siloed.

The UHC model shifts away from the colonial legacy of a divided private-public healthcare system to a collaborative, value-based care approach. This model integrates primary, secondary, and tertiary care, fosters investment in modern healthcare delivery, and emphasizes quality care and measurable outcomes. By consolidating resources and promoting collaboration, UHC aims to improve patient outcomes, attract healthcare investment, enhance system-wide quality, and enable better planning and prioritization across Saint Lucia's healthcare system. UHC focuses on consolidation, universality across public and private providers, and eliminating discrimination based on age and pre-existing conditions. It transitions the healthcare system by:

- **Consolidated Model:** To ensure sustainability given Saint Lucia's small population, UHC will transition the healthcare system from isolated care and payment silos to a consolidated model. This approach integrates providers into networks, unifies payment sources within a stratified system, and spreads costs and risks across the population to enhance efficiency and support population health.
- **Reduced Out-of-Pocket Costs:** Shifting healthcare payments from households to insurance, reducing financial burdens without increasing taxation.
- **Care-Centric Model:** Shifting from benefits-focused to need-based care.
- **Diversified Funding:** Moving from tax-based funding with limited capitalization to a model that aggregates funding and reduces financial leakage.
- **Investment-Driven System**: Replacing underinvestment with incentives to strengthen healthcare at all levels—primary, secondary, and tertiary.
- **Healthcare Worker Retention:** Improving working conditions to reduce brain drain and promote retention.
- **Revenue Generation:** Transitioning from a budget-dependent model to one generating revenue and attracting diverse capital sources.
- **Expanded Payor Base:** Including private funding, self-pay, NIC, property and casualty insurance, and international insurers alongside government funding.

- **Smart Taxation Mitigation Polices:** Utilizing tax benefits and savings to encourage employers to participate in providing insurance coverage for their employees.
- **Equal Access:** Ensuring all societal strata can access both public and private healthcare options.
- **Digital Payments:** Replacing informal, cash-based transactions with traceable digital payments.
- **Information Technology:** A key aspect of transforming the health system and funding is shifting from paper-based to electronic data systems. This transition enables efficient information sharing, reduces operational costs, enhances transparency, minimizes fraud, improves quality and patient safety, and eliminates duplication of effort.
- **Standardized Costs:** Using data to standardize charges, improve transparency, and lower costs through economies of scale.

The UHC model strengthens the public healthcare system by enabling revenue generation akin to the private sector while fostering the development of advanced healthcare products and services. It promotes resource sharing and collaboration between public and private systems, reducing patient and payment outflows from the country. By consolidating healthcare financing, services, and care, the model achieves economies of scale and distributes healthcare costs across the population, minimizing the financial burden on individuals and families. Additionally, the UHC framework includes incentives to encourage participation from those in the informal economy, focusing on motivational tools rather than mandates to drive engagement and compliance among all stakeholders.

Cultural obstacles to consider during design and rollout include:

- The perception that low-income healthcare is solely a government responsibility.
- The view that public healthcare is for the poor, while private and overseas care is for the wealthy.
- Resistance from the informal sector, fearing UHC registration could expose them to taxation.
- Resistance from patients who want complete freedom to use multiple doctors and healthcare facilities as and when they wish.
- Resistance from providers preferring cash payments to avoid tax obligations.

Comprehensive reform is needed to address these challenges to meet the future needs of Saint Lucia. Key priorities include:

- Expanding access to primary care and preventative care to reduce long-term and catastrophic healthcare costs.
- Achieving greater equity in access between public and private healthcare services.
- Reducing out-of-pocket expenses, which currently hinder access to care.

UHC aims to enhance the nation's health, attract healthcare investment, reduce costs, retain spending locally, and support sustainable development in line with national and global goals, including those of the World Bank, the World Health Organization (WHO), and the Sustainable Development Goals (SDGs). It will be financed through a public-private partnership, fostering integration rather than operating as a solely government-funded system. UHC emphasizes data sharing and collaboration across public and private providers, consolidating resources into a cohesive, network-based system. Its funding model adopts a stratified, stacked approach, where funding sources share responsibility for payments within defined tiers, promoting integration and avoiding fragmented, disconnected financing.

The UHC model consists of three tiers:

- Tier 1 is government-funded, providing essential healthcare services to most of the population, with a focus on primary and secondary care.
- Tier 2 involves a mix of private insurance, employer contributions, and government support, catering to individuals and families who can afford additional coverage.
- Tier 3 provides coverage for complex and catastrophic healthcare needs, including overseas care when necessary, and will be supported by reinsurance mechanisms.

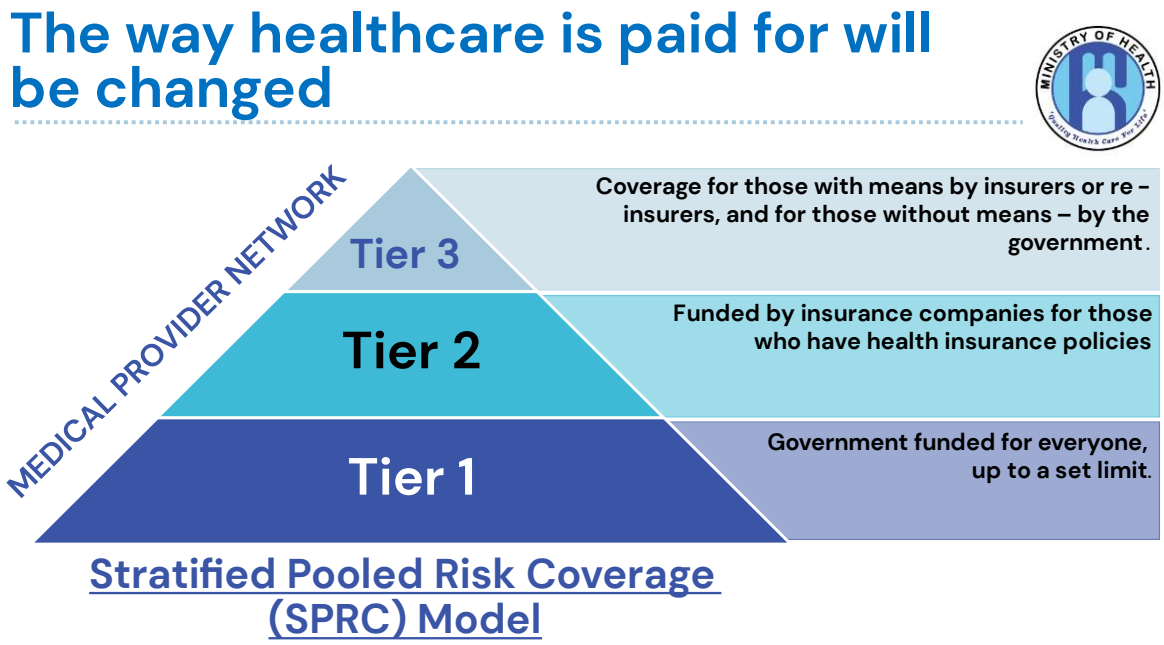


Figure 1: The three-tiered UHC funding structure based on the Stratified Pooled Risk Coverage (SPRC) Model

The proposed UHC funding structure consists of three tiers. Tier 1 funding will be sourced from a combination of the current government budget allocation and additional fiscal measures, such as VAT and health levies, covering an estimated 65% of total healthcare

expenditures. Tier 2 will rely on private sector health insurance and employer self-funded contributions, accounting for approximately 25% of expenditures. Tier 3, designed to fund catastrophic and high-cost care, will adopt a reinsurance model to cover the remaining 10%. This tier will operate above Tier 2 and can draw funding from government sources, third-party reinsurers, or other surplus revenues within the healthcare system. This structured approach ensures a balanced and sustainable financing framework for UHC.

This model of Stratified Pooled Risk Coverage offers the following advantages:

Value-Added Tax (VAT) in Tier 1, based on consumption, is a fair method for generating revenue, particularly given Saint Lucia's small tax base of low-wage earners. By tying taxation to consumption, those who utilize resources the most will contribute proportionately more to the system.

In Tier 2, tax mitigation measures, such as incentives for employers that fund health insurance premiums and Health Savings Accounts (HSAs) for their employees, will increase the resources available for healthcare. This approach not only encourages employer contributions but also strengthens the financial foundation of the health system.

The model aims to significantly boost health insurance coverage, increasing it from the current 12.2% to over 30% within three years. By providing universal access to primary care through both public and private facilities under Tier 1, private health insurance companies will no longer bear the administratively costly and complex responsibility of covering primary care. This reorganization will reduce insurance premiums and enable health plans to offer higher coverage limits, thereby improving accessibility and affordability for consumers.

Health insurance plans will also benefit from enhanced sustainability as the model shifts from a "benefit-covered" approach, which restricts care, to a "care-managed" model that focuses on coordinated and efficient care delivery. This change will lower risks and costs, particularly for high-risk populations such as the elderly and individuals with pre-existing conditions, ensuring long-term viability for insurance providers.

The implementation of capitation payments for primary care will further enhance predictability and cost control. Providers will be compensated on a per-person, per-month basis, allowing for fixed costs and distributed risk across the population. This model simplifies financial planning while ensuring access to primary care services.

To encourage participation from individuals in the informal economy, those capable of contributing but who do not pay taxes or purchase health insurance will face high deductibles when accessing private healthcare services. For those unable to afford contributions to Tier 2, the government will step in to cover their payments, ensuring equitable access while maintaining financial stability across the tiers.

The successful implementation of UHC in Saint Lucia will require close collaboration among stakeholders, including the Ministry of Health, the Ministry of Finance, the National Insurance

Company (NIC), the Financial Services Regulatory Authority, St Jude's Hospital, Millenium Heights Hospital, the Saint Lucia Social Development Fund (SSDF), the Saint Lucia Medical and Dental Association, (SLMDA), and private insurers, under the oversight of a statutory authority. UHC aims to reduce dependence on overseas care by improving the quality of local healthcare services, emphasizing preventive care, and ensuring comprehensive coverage for all citizens. This approach will mobilize capital and attract investments, fostering growth in the health sector. By consolidating funding into a superfund, UHC will promote equity-based investments over debt financing, thereby contributing to a lower debt-to-GDP ratio.

By pioneering a consolidated public-private healthcare financing model in the Eastern Caribbean, Saint Lucia positions itself as a regional center of excellence in healthcare. This leadership will not only improve domestic health outcomes and increase investments but also boost healthcare tourism, attracting patients from across the region and beyond seeking advanced healthcare services.

Additionally, a modern, IT-driven healthcare delivery system under UHC will enhance revenue generation by capturing increased payments from visitors, foreign workers, and tourists accessing healthcare services in Saint Lucia. This integrated approach will strengthen the country's healthcare system while positioning it as a hub for quality healthcare in the Caribbean.

Background & Rationale

The Government of Saint Lucia is at a pivotal point in transforming its healthcare system. Noncommunicable diseases (NCDs) like diabetes, hypertension, and cancer now dominate as leading causes of illness and death, surpassing communicable diseases. This epidemiological shift, coupled with inadequate health care systems, limited investment, an aging population, and growing demands from tourism, has exposed critical gaps, including unequal access to care, insufficient financing, and over-reliance on out-of-pocket (OOP) payments. The COVID-19 pandemic further highlighted these vulnerabilities.

Primary healthcare (PHC) is underutilized, with citizens favoring secondary and tertiary facilities, resulting in inefficiencies, overcrowding, and higher costs. Limited availability of essential medicines and diagnostics at PHC levels worsens delays and financial strain on patients, suggesting restructuring is needed at this level. Currently, 70–80% of healthcare spending is directed to tertiary care. Reform is essential to reposition the healthcare system for current and future challenges, attract investment, attracting and retaining a skilled healthcare workforce, and provide equitable, affordable coverage for all.

Saint Lucia's healthcare financing relies heavily on private spending, with out of pocket (OOP) payments accounting for 37.2% of total health expenditure in 2021[1], disproportionately impacting poorer households. Health Care spending remains low at 6.2% of GDP, compared to the regional average of 6.8%, the OECD's 8%, and higher rates in Germany (12%) and the U.S. (17%). This underfunding has created service gaps, particularly in primary care, and increased reliance on private and donor support.

To address these challenges, the government is implementing Universal Health Coverage (UHC), ensuring equitable access to quality care without financial hardship. Guided by global best practices like the UN's Sustainable Development Goals (SDG-3) and WHO recommendations, the UHC initiative includes a National Health Insurance Scheme (NHIS), a Basic Benefit Package (BBP), and Performance-Based Financing (PBF) reforms. Interoperable data systems will improve healthcare planning, budgeting, and attract investment while fostering a better environment for retaining healthcare professionals.

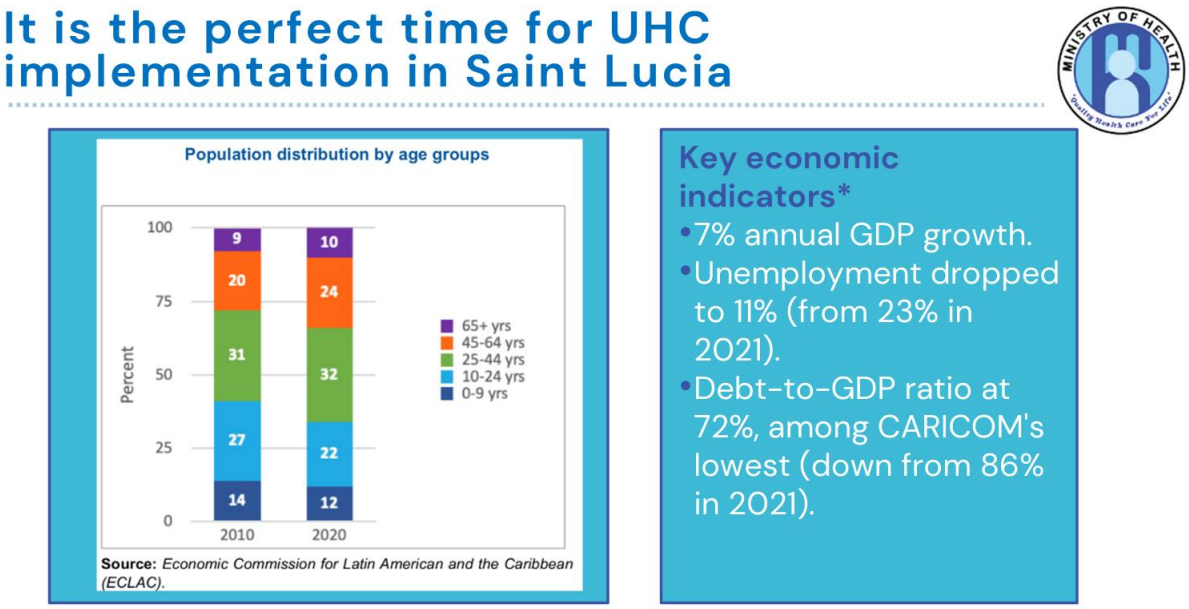
Achieving UHC is both a social and economic imperative, vital for productivity, poverty reduction, and equity. Without bold reforms, the current system will continue to fail vulnerable populations, exacerbate inequities, and undermine public health financing sustainability. The UHC White Paper provides a roadmap for addressing these gaps, building a resilient system capable of meeting current needs and responding to future public health emergencies and climate challenges.

[1] Global Health Expenditure Database, WHO; accessed 25/12/2024

Situational Analysis

Socio-Economic Context

Saint Lucia's socio-economic conditions significantly influence health outcomes and the effectiveness of its healthcare system, making this context vital for implementing Universal Health Coverage (UHC). Saint Lucia is currently enjoying an impressive 7% average real GDP growth rate over the last three years, 2021 to 2023[2], with unemployment down significantly to 11.0% in 2023 from a high of 22.9% in 2021.[3] The country's debt to GDP ratio is also one of the lowest in CARICOM at around 72% at the end of 2023.[4] In addition, well over 70% of the population is in the productive age range. Though the over 65 population is growing, it remains low at 10%. All of this combines to make Saint Lucia ready for a health care transformation that can transform the entire economy.



*Source: World Bank

Figure 2: Saint Lucia Key Socio-Economic Indicators

Saint Lucia is a middle-income country with an economy driven by the following sectors, tourism, agriculture, and services. Tourism is the single largest contributor to GDP and employs a significant portion of the population. However, the economy remains vulnerable to natural disasters, global downturns, and fluctuating demand. A major expansion of cruise ship port facilities aims to double cruise visits within 5–7 years, while the country also sees

[2] World Economic Outlook Database, IMF,
[3] Central Statistics Office, Government of Saint Lucia
[4] Economic and Social Review 2023, Government of Saint Lucia

growth in Business Process Outsourcing (BPO), manufacturing, and renewable energy initiatives.

Invest Saint Lucia promotes the country as an attractive investment destination, supported by a Citizenship by Investment program offering citizenship for investments of US$120,000 or more. Financial services are expanding regionally through banks and credit unions, though private health insurance remains underpenetrated, covering less than 15% of the population.

The COVID-19 pandemic significantly impacted the economy, with GDP contracting by 23.6% in 2020[5] due to travel restrictions and lockdowns. Although recovery efforts are underway with a projected 2.4% GDP growth rate for 2024 and unemployment tending to historical lows, challenges like unemployment and underemployment continue to disproportionately affect vulnerable groups.

Saint Lucia's workforce includes 97,394 workers, 85% of whom are National Insurance Scheme (NIS) compliant. In 2021, the NIS paid EC$116.5 million in benefits, including healthcare for work-related injuries.

Demographics

Saint Lucia has a population of around 180,000, predominantly Afro-Caribbean with a significant mixed-ethnicity group. The population is densely concentrated in urban areas, where most healthcare facilities are located.

A key demographic trend is the aging population and the declining birth rate, with the proportion of individuals aged 60 and older expected to rise significantly in the coming years. This shift will increase healthcare demands, as older adults are more prone to chronic diseases and require more comprehensive medical care.

Education and Employment

Education plays a crucial role in shaping health outcomes and access to care. Saint Lucia has a literacy rate of approximately 91%, with ongoing efforts to enhance access to quality education. Higher educational attainment improves health literacy, enabling individuals to better understand and navigate the healthcare system.

However, the employment sector poses challenges. A significant portion—30%—of the workforce is in the informal sector, particularly in tourism and agriculture, where workers

[5] World Economic Outlook, IMF

often lack formal health insurance and job security. This financial vulnerability forces many to rely on out-of-pocket payments for healthcare, increasing their risk of financial hardship.

Epidemiological Profile

Saint Lucia has transitioned from tackling communicable diseases like tuberculosis and HIV/AIDS to addressing noncommunicable diseases (NCDs), which now cause 85% of deaths. Key challenges include cardiovascular diseases, diabetes, cancers, and chronic respiratory conditions.

This shift is driven by urbanization, unhealthy diets, sedentary lifestyles, and tobacco and alcohol use, leading to higher healthcare costs, reduced quality of life, and lost productivity. The aging population further exacerbates these issues, with older adults being more vulnerable to chronic illnesses requiring prolonged care.

Health System Challenges and Opportunities

In the 2024/25 fiscal year, the government allocated a record EC$191.1 million to the Ministry of Health. These funds are critical for improving service delivery, increasing resource allocation, and enhancing outcomes across all levels of healthcare. To ensure sustainability, the current government budget allocation model must evolve to address key areas of healthcare financing, including payments for direct care, facility development and maintenance, health worker compensation, and procurement. This shift is essential for creating a robust and resilient healthcare system.

Fragmentation and Silos

Saint Lucia's health system is hindered by fragmentation, with poor coordination between payers, providers, and populations. UHC promotes integration, fostering information sharing, transparency, and efficiency to deliver better outcomes.

Healthcare Infrastructure

Saint Lucia's public healthcare system follows a 1950s UK National Health Service model, where the government primarily provides and funds healthcare. Services are subsidized at the point of delivery and financed through taxpayer contributions, with some reliance on user fees. Actual costs to deliver services are often not known because of a lack of data.

The Ministry of Health oversees policy development, regulation, funding, and service delivery. It operates public healthcare facilities and purchases private sector services to address gaps.

Key healthcare facilities include:

1. Millenium Heights Medical Complex: 200 bed hospital, plus the Saint Lucia Mental Health facility.
2. St. Jude Hospital: 50 beds (new facility will have 100)
3. Soufrière Hospital: Limited beds, providing basic and preventive care to the community (polyclinic/ district hospital)
4. Dennery Hospital (polyclinic) – observation beds, no admission
5. Dr. Betty Wells Urban Polyclinic
6. Gros Islet Polyclinic
7. 33 primary health centers
8. Tapion Hospital: Mid-sized private sector hospital – 30 beds
9. Other private polyclinics: Rodney Bay Diagnostic Centre, Saint Anthony Medical Centre, EM Care, Medical Imaging Inc, etc…

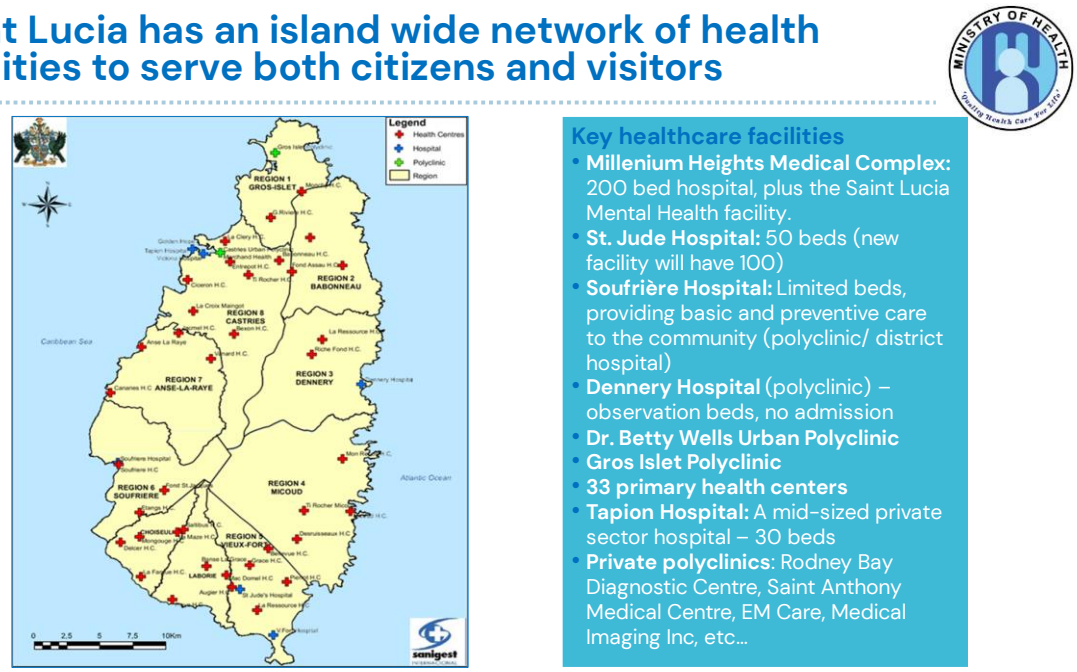


Figure 3: Map of Healthcare facilities in Saint Lucia

However, significant disparities in resource distribution and quality persist, particularly between urban and rural areas.

- **Urban vs. Rural Disparities:** Urban areas have better access to specialized care, while rural communities face longer travel times, higher costs, and understaffed health centers with inadequate supplies and equipment, limiting the quality of care.
- **Underfunded Public Health System**: Public healthcare relies heavily on government funding, currently at 6.2% of GDP—below the regional average of 6.8%. This underfunding leads to limited services, long wait times, and insufficient preventative

care. Additionally, high out-of-pocket costs (37.1% of total health spending) force many to forgo necessary treatment or face financial strain.

Access to Care

Access to healthcare is a crucial factor in health outcomes in Saint Lucia, but several barriers hinder timely and appropriate care:

- **Geographical Barriers:** Rural areas often lack adequate healthcare infrastructure, forcing residents to travel long distances for care. This isolation delays treatment, especially during emergencies.
- **Financial Barriers:** High healthcare costs and out-of-pocket (OOP) payments for services, medications, and treatments deter low-income families, who may prioritize basic needs over healthcare, worsening health outcomes.
- **Cultural and Social Factors:** Cultural beliefs, misinformation, and stigma around certain health conditions or services, such as vaccinations, discourage individuals from seeking preventive or necessary care.

Workforce Challenges

Saint Lucia's healthcare workforce faces significant obstacles that affect service delivery:

- **Shortage of Professionals:** The country lacks sufficient doctors, nurses, and allied health workers, especially in primary care, resulting in overburdened staff and limited-service availability.
- **Migration of Health Workers:** Many professionals leave for better pay and working conditions abroad, causing a brain drain and exacerbating workforce shortages. Any transformation of the healthcare system must pay attention to better working conditions for healthcare workers in the country to step this brain drain.
- **Training and Development Gaps:** Limited professional development opportunities hinder the ability of healthcare workers to deliver high-quality care and address evolving health needs.
- **Uneven Workforce Distribution:** Urban areas have more medical staff, leaving rural regions underserved, which contributes to inequities in care access and outcomes.

Addressing these challenges requires investment in infrastructure, training, equitable workforce distribution, and financial protections to ensure all citizens can access quality healthcare. Despite efforts to improve healthcare, significant gaps persist. Access to essential medications and diagnostic services remains inconsistent, especially in rural areas where pharmacies and laboratories are limited. Additionally, fragmented healthcare delivery leads to overlapping services, inefficiencies, and poor coordination among providers, reducing the system's overall effectiveness.

Healthcare Financing and Economic Challenges

Saint Lucia has historically struggled with high out-of-pocket (OOP) healthcare costs, which peaked at 57% of total health expenditure, the highest in the Caribbean. The figure is now below 40% but remains high. These costs disproportionately impact vulnerable populations, exacerbating poverty and limiting access to care. The global trend of catastrophic health spending is reflected in Saint Lucia, where many households spend over 10% of their income on healthcare, often at the expense of essentials like food and education (WEF, 2023).

Universal Health Coverage (UHC) aims to address these challenges by reducing financial barriers, ensuring access to essential services, and fostering health equity. Supported by the WHO and World Bank, UHC emphasizes a primary healthcare approach, requiring significant public sector investment and systemic reforms. Despite delays due to the COVID-19 pandemic, Saint Lucia relaunched its UHC initiative in 2023, gaining bipartisan support for its implementation.

Medical Products and Pharmaceuticals

Saint Lucia relies on centralized procurement through the Organization of Eastern Caribbean States Pharmaceutical Procurement Service (OECS/PPS) for most pharmaceuticals, with no local manufacturing. Challenges include procurement delays, distribution inefficiencies, and inconsistent availability of essential medicines. Policies for integrating new medical technologies and improving supply chain management are necessary. Consolidating purchasing with private healthcare would bring down costs further.

The introduction of digital health tools can streamline pharmaceutical distribution, improve monitoring, and ensure equitable access. By adopting global best practices, Saint Lucia can build a future-proof system that minimizes costs while enhancing quality and efficiency. Access to larger buying groups such as Group Purchasing Organizations (GPO's) will change the landscape for the health system.

Information and Research

Saint Lucia's Health Information System (SLUHIS) is among the best in the OECS region, but challenges remain in obtaining real-time data for identifying at-risk populations, clinical care management, strategic decision support, financial management and responding to public health emergencies. A 2023 assessment highlighted the need for modernization, including integrating Electronic Health Records (EHRs), enhancing data sharing, and leveraging analytics for predictive modelling and disease prevention.

Efforts are underway to strengthen SLUHIS, improve interoperability with the Cellma hospital system, and link laboratory information systems. A PBF (Performance-Based Financing) pilot has enhanced data platforms and analytical tools, enabling results-based payments and evidence-based management. Additionally, a Registration Policy is being developed to streamline enrolment, ensure data privacy, and facilitate interoperability for the seamless implementation of UHC.

UHC Universal Principles

Upon review of Saint Lucia's current health system, the implementation of **Universal Health Coverage (UHC)** is guided by several key universal principles that ensure equitable access to health services for all citizens. These principles are aligned with global health standards but tailored to address the specific needs and challenges of Saint Lucia. The goal is to create a health system that provides comprehensive care without financial hardship, while promoting health equity, sustainability, and accountability.

Equity in Access: UHC ensures equitable access to essential healthcare services for all citizens, regardless of socio-economic status, location, or demographics. Special focus is placed on reducing disparities for vulnerable groups, such as low-income families and rural populations, by distributing healthcare services more evenly across the island.

Comprehensive Coverage: UHC provides a broad range of services, including preventive, curative, rehabilitative, and palliative care. Priority areas include NCD management, maternal and child health, mental health, and public health programs like immunizations, addressing the diverse healthcare needs of the population.

Financial Protection: To eliminate the financial burden of healthcare, UHC pools resources through mechanisms like the Universal Health Coverage Fund (UHCF) to minimize out-of-pocket expenses. This ensures affordability and prevents financial hardship caused by medical costs.

Sustainability: The health system is designed for long-term viability, with secure funding mechanisms, efficient resource management, and a well-trained workforce. Sustainable financing models, such as taxation and insurance, aim to balance affordability and economic stability.

Quality of Care: High-quality care is central to UHC, emphasizing patient safety, effective treatments, and adherence to clinical guidelines. Regular healthcare professional training and outcome monitoring ensure services meet the highest standards.

Efficiency: Efficient use of resources reduces costs and improves service delivery. UHC streamlines care across primary, secondary, and tertiary levels, minimizes waiting times, and avoids duplication of services to optimize resource allocation.

Resilience: Building resilience ensures the health system can respond to crises, such as the COVID-19 pandemic, without disrupting essential services. This includes emergency preparedness, flexible systems, and trained personnel for effective crisis management.

Accountability and Transparency: A transparent, accountable system fosters public trust. Mechanisms for reporting, auditing, and public engagement ensure responsible use of resources and alignment with community needs.

People-Centered Care: UHC prioritizes inclusive, patient-centered care tailored to the cultural, social, and economic contexts of individuals and communities. This approach ensures healthcare services are accessible, respectful, and responsive to the population's needs.

By integrating these principles, UHC aims to provide equitable, high-quality, and sustainable healthcare for all citizens of Saint Lucia.

UHC Policy Recommendations

The following policy recommendations are necessary to achieve an effective, realistic, resilient and sustainable UHC:

1. Financial Ecosystem Policy
2. Legislation, Regulation Governance & Administration Policies
3. Benefit Plan for Universal Health Coverage to Include Commercial Insurance Arrangements
4. Provider Network Development
5. Health Care Sector Development and Population Health Care Management
6. UHC Information Technology System Policy
7. Physical Environment for ICT
8. Research and Knowledge Management

Financial Ecosystem

Policy Recommendations for the Financial Ecosystem

- **#1.1:** Government is desirous of implementing the Stratified Risk Pool Coverage (SPRC) model for UHC.
- **#1.2:** Redirect Budget Allocation to UHC. The government should reallocate part of the Ministry of Health's budget to the UHC to fund healthcare services. This would allow the Ministry to focus on essential public health functions and oversight, while UHC would manage healthcare financing and payments through Third-Party Administration. Funds will be distributed across public and private facilities based on actual costs, supported by new cost accounting systems.
- **#1.3:** Fiscal Measures to Capitalize UHC. The government will implement fiscal measures to sustainably fund UHC, utilizing both new and existing taxes while minimizing the impact on the population through strategic financial policies. Specific measures will be determined following the completion of the healthcare costing analysis.
- **#1.4:** Private insurance is recommended for Tier 2 and 3 coverage for privately insured individuals. Employees could contribute a small percentage of the employer-paid premium, potentially covering part or all of family members' insurance. Government health insurance contributions for its permanent employees and health insurance under unions should be redirected to UHC payments for Tiers 2 and 3 under the SPRC program either directly or through a health insurance plan or broker.

- **#1.5:** Non-resident workers and Saint Lucians living abroad must pay premiums to participate. A system will be established to facilitate travel insurance payments and collections from international insurers for services provided in Saint Lucia.

- **#1.6:** UHC should have the authority to offer Tier 2 and 3 coverage as an insurer for individuals who wish to purchase health insurance but lack access through a private health insurance plan. To achieve critical mass, individuals eligible for coverage under a private health plan could be given the option to enroll in a UHC-administered health plan instead. Alternatively, UHC should work closely with the Financial Services Regulatory Authority (FSRA) to regulate the participation of private commercial health plans in Tier 2 and 3 funding and benefit arrangements. This collaboration would ensure optimal coverage, efficiency, and alignment with UHC's objectives.

- **#1.7:** An employer-based payroll levy should be applied to employers who do not provide health insurance or self-funded contributions for Tiers 2 and 3. Initially, this could focus on Tier 2, with Tier 3 included over time. Employers could allow employees to contribute a small percentage, and a model with minimal employer contributions to premiums could be explored. Household or family member coverage should also be evaluated to address potential employer strain.

- **#1.8:** Health Savings Accounts (HSA) should be promoted with a tax exemption provided to encourage uptake on the part of financial institutions and consumers.

- **#1.9:** Means Testing or Social Work interventions should be applied in Tiers 2 and 3 for individuals who are unable to pay, are wards of the state, prisoners and otherwise classified as vulnerable.

- **#1.10:** UHC may obtain additional revenue from the collection of copayments, deductibles and other out of pocket fees.

- **#1.11:** To ensure the financial stability of UHC, it is essential to secure funding beyond what is generated through taxes. This includes enforcing payments from other responsible payers who are currently not being billed or reimbursing for care provided. Subrogation will play a critical role in this process, enabling UHC to recover funds from entities such as property and casualty insurance companies or NIC. Through subrogation, UHC can collect payments from these entities after covering the costs of care rendered to individuals for whom these payers are financially responsible. This mechanism ensures that UHC is reimbursed appropriately, strengthening its funding framework.

- **#1.12:** Establish a Superfund as a resource mobilization tool to attract equity capital for Saint Lucia's health sector. The Superfund aims to drive transformative change by

complementing government capital investment, making it a critical policy to stimulate growth and innovation in healthcare.

- **#1.13**: Establish a Non-Governmental Organisation (NGO)/Charitable body with a footprint in Saint Lucia, North America, Europe, Africa and Asia to mobilise resources by way of grants, research studies, donations, and/or technical assistance.

The Saint Lucia Universal Health Coverage (UHC) initiative is a transformative financial ecosystem designed to overhaul healthcare delivery in both public and private sectors. Inspired by the "Marshall Plan," it aims to rebuild and modernize the nation's health system, impacting healthcare, political, social, and economic development. Developed by the JIPA Network, this unique Caribbean model focuses on:

- **Consolidation of Resources:** Merging disparate healthcare financing and providers into a unified pool to support national development.
- **Economies of Scale:** Leveraging consolidation to lower healthcare costs through increased collective buying power.
- **Public-Private Integration:** Ethically and legislatively integrating public and private healthcare financing for mutual benefit.
- **Transformative Opportunities:** Positioning Saint Lucia to attract grants, investments, and concessionary funding, while serving as a model for Caribbean and developing nations.

The development process follows a stakeholder approach, engaging government, businesses, NGOs, academia, diaspora, and professional groups to ensure inclusivity. Based on lessons from other Caribbean and global health systems, the UHC model reflects collective input and experience in healthcare financing to create a sustainable, equitable system for all.

Elements of the Financial Ecosystem

Financial Ecosystem Elements	Policy Prescription
Universal Health Coverage (UHC)	It is recommended that Saint Lucia establish a Universal Health Coverage model which consolidates Government, Quasi-Government and Private Funding. Payment for individual health care services at public and private facilities will be made through a new statutory authority called the Universal Health Coverage Authority (UHCA). This agency will combine

	monies received from central government through existing taxation or new measures, monies received from private insurance and private or quasi-private sources of funding including reinsurance, international travel insurance, NIC and motor vehicle injury payments, to create a social benefit to where the population will universally have access to a package of high-quality affordable care with limited to no payments.
Equity-based Superfund Investment	It is recommended that a Superfund be established to finance the health care system associated with the delivery of health care, such as labs, pharmacies, hospitals, and specialist doctors, nurses and other skills. This fund is expected to utilise equity capital from the private sector to invest in health care equipment, technology, infrastructure and human resources. This Superfund is expected to complement resources to be provided to by the Universal Health Coverage and Government for capital improvement in health care.
Non-profit philanthropic, grants, non-governmental organisation (NGO) funding and Corporate Social Responsibility (CSR) funding.	It is recommended that the Universal Health Coverage Authority establish a charitable arm to mobilise resources for donations, grants, philanthropic, and Corporate Social Responsibility (CSR) funding. This involves the development of shovel-ready projects that lend well to philanthropic or grant funding.
UHC Special Fund (discussed in Policy section 2.0 below)	A separate statutory fund, managed by the UHCA, that will serve as the primary financing mechanism for UHC operations. It will collect and allocate government contributions, health insurance premiums, and other healthcare-related revenues to fund provider payments, claims processing, and enrolment services.
Friends of UHC Fund (discussed in Policy section 2.0 below)	A dedicated fund to receive and manage contributions from private sector, NGOs, and social sector donors. This fund will be used exclusively for UHC project implementation, including investments in infrastructure, IT systems, and capacity-building initiatives. It could be managed by the NIC before transitioning to the UHCA.

Policy Framework of the Financial Ecosystem

The capitalisation of the UHC plan will be tied to the revenue collection and expenditure distribution, together with a balanced budget to create and execute a sustainable plan moving forward. The general goal of the Saint Lucia UHC is to develop a viable and sustainable program. The plan combines the expenditure with a revenue model for UHC, with UHC as a collection and disbursement agency.

Policy Recommendation #1.1:

Government is desirous of implementing the Stratified Risk Pool Coverage (SPRC) model of Universal Health Coverage.

Policy Statement/Description:

The proposed financing model for UHC in Saint Lucia is a multi-payer system called "Stratified Pooled Risk Coverage" (SPRC) with UHCA functioning as the single point of disbursement.

Here's a summary of its key features:

- SPRC consolidates payments from multiple payers into a single payment system managed by UHC.
- There are three payment tiers: government-funded tier, commercial tier, and catastrophic care tier.
- The government-funded tier covers basic services for all citizens up to a fixed amount annually.
- Services covered by UHC in tier 1 are generally free for registered patients, with the possibility of co-payments based on policy decisions.
- The commercial tier kicks in when government funding reaches its limit, covering additional costs for those with private insurance.
- UHC can intervene if private insurers don't adequately cover preexisting conditions or older individuals, either through legislation supporting UHC as an insurer or negotiating coverage.
- The catastrophic care tier handles high-cost treatments like heart, kidney, stroke, and cancer care, with funding from reinsurance, government, and other sources.
- Individuals without private insurance can access tier 2 and 3 services primarily through public hospitals, with UHC coordinating payments to healthcare providers in both public and private sectors.

Overall, SPRC aims to streamline payments, ensure universal access to basic care, and manage costs across different levels of healthcare needs and financing sources as depicted in the diagram below.

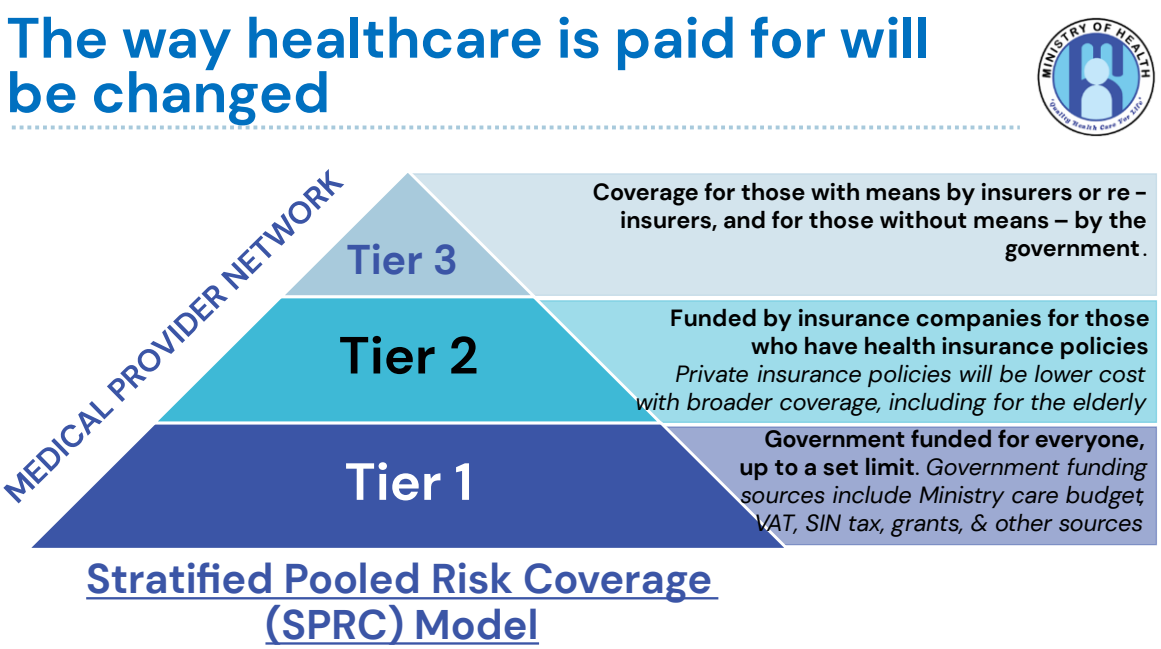


Figure 4: The three-tiered Stratified Pooled Risk Coverage (SPRC) Model

Policy Rationale

The SPRC model offers a sustainable solution for Saint Lucia by diversifying health financing beyond government funds. Integrating private sector contributions and other funding sources into a central pool reduces the strain on public resources. Centralized administration cuts costs, improves efficiency, and ensures pooled resources mitigate risk while distributing costs more equitably. Economies of scale achieved through consolidation optimize resource use, enhancing healthcare outcomes.

Impact

The policy aims to reduce financial outflows from the health system by reallocating funds toward strategic healthcare priorities. In the short term, this approach will enhance patient experiences. UHC will work closely with stakeholders, including the Ministry of Health, professional associations, and regional organizations such as PAHO and CARPHA, to establish clinical standards. Under a performance-based payment system, providers who meet these standards will be rewarded, while those who fall short will not receive incentives.

Encouraging providers to negotiate collectively will strengthen their bargaining power and promote a cost-conscious approach to healthcare financing. Over time, this model will foster shared responsibility for funding healthcare and drive greater efficiency across the system.

Emerging Policy Issues
Policy Implementation Challenges and Recommendations

Implementation Challenges:

1. **Coverage Consensus:** Reaching agreement on the tiers of coverage and their inclusions may be difficult.
2. **Public Perception:** Introducing co-payments and deductibles could face resistance, as many perceive healthcare as a free service.
3. **Means Testing:** Determining thresholds for government-funded healthcare for unemployed or low-income citizens may provoke backlash due to the expectation of free care.
4. **High-Risk Groups:** Without robust data, insuring high-risk populations (e.g., dialysis, cancer, or HIV patients) may deter private insurers and pose cost overrun risks for the UHC Authority.
5. **IT Infrastructure:** Implementing an integrated IT system for data sharing and accurate tier pricing is complex and currently insufficient to meet UHC needs.
6. **Private Insurer Participation:** Resistance from private insurers to engage in Tiers 2 and 3 may force UHC to act as an insurer, shrinking the pool available for private coverage

Policy Recommendation #1.2: Redirect Budget Allocation to UHC

The government should reallocate part of the Ministry of Health's budget to the UHC to fund healthcare services. This would allow the Ministry to focus on essential public health functions and oversight, while UHC would manage healthcare financing and payments through Third-Party Administration. Funds will be distributed across public and private facilities based on actual costs, supported by new cost accounting systems.

Key Features:

- Allocation from the consolidated fund becomes the primary Tier 1 contribution for universal healthcare.
- Cost recovery systems, including coding and charge master tools, ensure accurate pricing and transparent financial management.
- A gradual transition over three years is recommended, contingent on the implementation of IT systems and data analytics for decision-making.

Policy Rationale

Increased funding to the Ministry of Health has been undermined by rising communicable and non communicable disease burdens, infrastructure demands, and staffing needs. This has led to cash flow issues, maintenance challenges, and limited capacity to improve wages. Redirecting funds to UHC creates a dedicated revenue stream reinvested solely within the healthcare system, addressing these inefficiencies and ensuring financial sustainability.

Policy Impact

A gradual budgetary shift from the Ministry of Health to the UHC Authority will fundamentally change healthcare funding. To minimize disruptions:

- A cost accounting and data collection system must be in place before reallocating funds.
- Governance reforms will establish the UHC as a Statutory Authority, with hospitals and clinics transferred to a new Health Services Authority.
- Revenues will be reinvested directly into the health system, separate from the government's consolidated fund.

This approach ensures a sustainable transition while maintaining funding for critical Ministry functions and building capacity for UHC implementation.

Transition Period	Ministry of Health Budget to UHC
Time	Activity
2024-2025	- Implementation of Information Technology in the Health System to Collect Data – Including Required Codes for Disease, Procedures, Utilization, and Cost. - Implementation of Charge Master and Pricing System Based upon Cost
2025	- Implementation of a Cost Accounting System – Determining how the budgeted dollars are utilized based upon procedures performed, Disease Categories and Persons Utilizing the Health System.

	- Determination of the cost per person per month and the amount of Dollars from the Government that should be allocated per person to Tier 1 based upon utilization. - Setting up a Health Authority for the Health System and Completing the Setup of the UHC Authority.
2025-2026	- Begin the Transfer of the Funding Dollars from the Ministry of Health to the UHC under a tested and tried Cost-Accounting System between the Health System and UHC.

Emerging Policy Issues

Policy Implementation and Challenges

Effective implementation of this policy requires collaboration and leadership from both the Ministry of Finance and the Ministry of Health during the initial two years of UHC establishment and beyond. Key challenges include:

- Determining the proportion of the national budget to be retained by the Ministry of Health if funds are reallocated to UHC and assessing its impact on the Ministry's role.
- Addressing concerns about how reduced funding may affect the Ministry of Health's authority and status.
- Ensuring adequate resources for public health emergencies and outbreak mitigation.
- Clarifying the relationship between UHC and the Ministry of Health, particularly regarding responsibility for national health outcomes.

Policy Recommendation #1.3: Fiscal Measures to Capitalize UHC

The government will implement fiscal measures to sustainably fund UHC, initially utilizing existing taxes while minimizing the impact on the population through strategic financial policies. Specific measures will be determined following the completion of the healthcare costing analysis. New taxes, if required, will not be introduced until 2-3 years after the launch of UHC financing.

Policy Statement and Description

Post-COVID-19, the Caribbean, including Saint Lucia, has seen economic recovery driven by increased tourism. In Saint Lucia, a new SIN tax on alcohol, tobacco, and sugar has boosted revenues, offering potential support for UHC funding. To ensure UHC sustainability, predictable revenue from taxes and other sources must be secured through legislative measures.

The analysis of Saint Lucia's out-of-pocket health care spending reveals a significant amount, of approximately EC$100 million annually according to World Bank data. This translates to an average expenditure of EC$565 per person annually or EC$47 per person monthly across the estimated population of 180,000 individuals. To address the financial strain on individuals and bolster funding for essential health care initiatives like the UHC program and overall health system improvements, a comprehensive tax strategy is proposed.

Certain exemptions are recommended within this tax framework to alleviate the burden on essential health products, specific services currently exempt from VAT, and other predetermined categories. Furthermore, to augment the resources available for UHC, it is proposed to allocate 1-2% of the existing VAT system to the health care fund/UHC.

Beyond taxation, additional funding avenues are recommended, including allocation from lottery proceeds, and revenues generated from the so-called SIN tax on tobacco, alcohol, and sugar products. While these measures may have implications for sectors like tourism, they are deemed essential in addressing non-communicable disorders such as alcoholism and bolstering Saint Lucia's health care infrastructure amidst growing health challenges.

The SPRC model proposes tax mitigation strategies to fund UHC and strengthen Saint Lucia's health system:

- **Tax Relief for Health Insurance:** Offer tax breaks to companies providing employee health insurance, reducing reliance on new taxes while encouraging private sector contributions.
- **Tax Incentives and Concessions for Health Investments:** Provide incentives for businesses and individuals investing in health services and facilities to boost funding, including tax rebates and Citizenship by Investment.
- **Taxes on Harmful Goods:** Implement taxes on products like alcohol, tobacco, and sugary items to discourage unhealthy consumption and generate health-focused revenue.
- **Health Savings Accounts (HSAs):** Introduce HSAs with tax benefits to encourage individuals, employers, and families to save for health expenses. Establish a simple means for Saint Lucians in the diaspora to fund these accounts for their friends and family.
- **Tax Savings for Health Donations:** Incentivize philanthropic contributions through tax deductions for donations supporting health services.
- **Co-payments and Deductibles:** Introduce small co-payments and deductibles to distribute costs and generate funds for complex medical conditions.

These measures create a balanced funding approach, combining tax incentives, private contributions, and strategic policies to ensure the sustainability of Saint Lucia's healthcare system.

Policy Rationale

JIPA has identified various financial participation sources not currently integrated into the health care budget. The ability of the Government and UHC to consolidate these payments/revenues within the UHC framework will significantly impact its financial stability and necessity for taxation. A key aspect will be devising a strategy to minimise fund leakage from the country and the health care system, requiring the enactment of pragmatic tax laws to support these initiatives. Implementing managed health care focusing on cost containment and avoidance can retain more funds within the UHC, reducing the reliance on additional tax revenue. Supporting legislation for these strategies will help mitigate the need for increased taxation. Furthermore, adopting the SPRC model for payment and administration can lower administrative costs, thereby lessening the tax burden on the public.

Emerging Policy Issues

- The Ministry of Finance must balance UHC funding proposals with competing fiscal priorities and national development plans.
- Efficient tax collection systems are essential to avoid liquidity and cash flow challenges for UHC.
- Exploring the role of the NIC in collecting and distributing tax-based funding could improve efficiency, especially given the large informal employment sector in Saint Lucia.

Policy Recommendation #1.4

Private insurance is recommended for Tier 2 and 3 coverage for privately insured individuals. Employees could contribute a small percentage of the employer-paid premium, potentially covering part or all of family members' insurance.

Policy Statement/Description

Currently, it is estimated that 12.2% of Saint Lucia's population has some form of health insurance, whether group or individual.[6] The SPRC model aims to increase coverage for system viability. The government would fund Tier 1, reinsurance would handle catastrophic

[6] Saint Lucia Populationand Housing Census 2022, Central Statistics Office, Government of Saint Lucia

care in Tier 3, and private insurance would support Tier 2 by redirecting payments to UHC, which would distribute funds to providers at negotiated rates.

Private insurers focus on minimizing risk and liability to maintain profitability, often excluding older individuals or those with pre-existing conditions or charging higher premiums. In smaller markets like Saint Lucia, limited providers can drive up costs. While private insurers are not typically aligned with principles of universal access, consultations with local insurers have helped develop the SPRC model, tailored for small island states and micro-economies. This model addresses some of the challenges faced by private insurers, particularly in mitigating risks associated with catastrophic cases and ensuring industry stability.

The implementation of the SPRC Model's second tier is anticipated to mitigate risks for private insurers while promoting greater stability within the insurance industry. Historically, private insurers have regarded Tier 1 payments as high-risk and high-cost, with a heightened likelihood of fraud. By shifting the responsibility for Tier 1 funding to the government, administrative costs and medical loss ratios for insurers will be significantly reduced, creating a more predictable financial environment for these companies.

This change will also lead to lower health insurance premiums, enabling insurers to offer enhanced benefits to their customers. Reduced premiums are expected to increase employer-sponsored coverage rates and make it more accessible for individuals in the informal economy to purchase insurance.

The partnership between the insurance industry and UHC under the SPRC model will be further strengthened through three key areas of collaboration with the government, enhancing alignment and operational efficiency.

1. **Sharing of Risk:** Encouraging a larger number of individuals across all age groups to obtain insurance will expand private insurance coverage from the current 12.2% levels to an anticipated goal of 40% within the first three years and 50-60% in the subsequent three years.
2. **Risk Reduction:** The government's commitment to allocating a specified amount to each citizen and identified beneficiaries, coupled with negotiated prices with healthcare providers, will positively impact insurance pricing by reducing risks.
3. **Reduced Administrative Costs:** Streamlining administrative processes will contribute to cost reduction and operational efficiency for both the insurance industry and the UHC program.

Enhancing UHC Coverage

Coverage of Family Members: Most insurers cover only spouses and dependent children, and this definition is proposed for household coverage. However, Saint Lucia's family structure may require including close relatives living under the same roof.

Government health insurance contributions for its permanent employees and health insurance under unions should be redirected to UHC payments for Tiers 2 and 3 under the SPRC program either directly or through a health insurance plan or broker.

Policy Impact

With the SPRC model in place, it is anticipated that premium rates will decrease and/or insurance companies will provide enhanced benefits. As more individuals and families enrol in private insurance plans, this will result in significant premium contributions and payments to the UHC.

Emerging Policy Issues

- The UHC Authority must be established to negotiate contracts and implement the policy effectively.
- An assessment is required to ensure a sufficient number of private insurers can support expanded coverage.
- Insurer commitment is critical for successful collaboration with the UHC program.
- Limited data may deter insurer participation due to increased administrative burden and risk.

Policy Recommendation #1.5: Non-resident workers and Saint Lucians living abroad must pay premiums to participate. A system will be established to facilitate travel insurance payments and collections from international insurers for services provided in Saint Lucia.

Policy Description

Participation in Tiers 1-3 will require the payment of premiums, but challenges currently exist in collecting funds from visitors, expatriate Saint Lucians, and non-residential workers. Many of these individuals are covered by travel insurance or international plans, yet Saint Lucia's current system lacks the capability to collect payments from international insurance providers. To resolve this, the JIPA Network will assist the UHCA in developing a framework to enable the country to collect payments from international insurers. This will involve leveraging JIPA's third-party administration (TPA) services or similar entities to facilitate access to international payment intermediaries.

Accurate financial and coding data, gathered through the Provider Information System, will be essential for adjudicating claims and securing payments from these insurers. With the modernization of Saint Lucia's health information technology systems, the country will gain access to a previously underutilized revenue source from international payers. From a financial perspective, this represents a significant opportunity to bolster revenue for UHC and strengthen the overall health system.

Rationale

To encourage the inflow of resources and establish a collection system where the health care system is reimbursed for providing care to individuals travelling to or residing in Saint Lucia for tourism, work or school purposes.

Policy Impact

This would potentially provide a significant increase in revenues to the health system.

Emerging Policy Issues

The health system struggles to collect payments from international patients due to the lack of an IT system for generating accurate bills or claims. Implementing effective IT solutions and training personnel to use them is essential. Saint Lucia also lacks interoperability with international payers, and providers face challenges adapting to the shift from paper-based to electronic systems.

Policy Recommendation #1.6: UHC should have the authority to offer Tier 2 and 3 coverage as an insurer for individuals who wish to purchase health insurance but lack access through a private health insurance plan. To achieve critical mass, individuals eligible for coverage under a private health plan could be given the option to enrol in a UHC-administered health plan instead. Alternatively, UHC should work closely with the Financial Services Regulatory Authority (FSRA) to regulate the participation of private commercial health plans in Tier 2 and 3 funding and benefit arrangements. This collaboration would ensure optimal coverage, efficiency, and alignment with UHC's objectives.

Policy Description/Statement

Insurance companies have raised concerns about covering pre-existing conditions and the elderly. If these challenges arise, UHC should have the flexibility to act as an insurer. UHC could set fixed premiums for Tiers 2 and 3 to ensure comprehensive benefits and fund stability. With 16% of Saint Lucia's population aged 60+ and many citizens with pre-existing conditions, UHC could provide essential coverage for these groups. Premium adjustments based on age and health status would be necessary for sustainability.

Policy Rationale

This policy acknowledges that UHC aims to provide comprehensive coverage for individuals throughout their lives. While the model is designed to mitigate risk for participating insurance companies in Tiers 2 and 3, there may be instances where commercial insurers choose to withdraw from offering this coverage. To safeguard consumers and the UHC fund, the policy proposes granting the UHCA the authority to act as an insurer if gaps exist in the market from products that private insurers are willing to provide or segments of the population they are not willing to insure. However, this option would only be exercised under specific conditions that threaten the integrity of UHC's funding mechanism or negatively impact patients and the healthcare industry. This ensures a responsive and protective framework while maintaining stability within the system.

Policy Impact

This policy ensures accountability from insurance companies, requiring them to cover preexisting conditions and individuals across all age groups, while also supporting the UHCA's sustainability. Although the UHCA's primary goal in a public-private partnership is inclusivity to achieve economies of scale, the policy emphasizes the need for incentives and safeguards within the UHC framework to ensure long-term sustainability and effective risk management.

Emerging Policy Issues

Private payers may perceive UHC's potential role as an insurer as a risk, given Saint Lucia's small population and the already sufficient number of insurers on the island. Without consolidating membership under a few commercial payers, premiums could rise, and the risk of coverage could increase, limiting the range of additional benefits beyond those recommended by UHC.

If a decision is made to limit the number of private commercial payers participating in UHC, dissatisfaction could arise among existing private health plans. To address this, a "certificate of need" model might be considered, requiring health plans to reach a critical mass of insured members to remain financially viable. Plans with insufficient membership may not be sustainable. Implementing such measures would likely require changes or modifications to existing insurance and financial regulations. In the insurance industry, the size of the insured population is a key factor in ensuring stability and efficiency.

Policy Recommendation #1.7: An employer-based payroll levy should be applied to employers who do not provide health insurance or self-funded contributions for Tiers 2 and 3. Initially, this could focus on Tier 2, with Tier 3 included over time. Employers could allow employees to contribute a small percentage, and a model with minimal employer

contributions to premiums could be explored. Household or family member coverage should also be evaluated to address potential employer strain.

Policy Description/Statement

Employers without mechanisms to participate in Tiers 2 and 3 would contribute 2-4% of employee wages to UHC. Penalties and rewards, rather than mandates, may encourage compliance, requiring further discussion on penalty structures. Employers with existing Tier 2 and 3 insurance plans would be exempt and eligible for tax reductions.

The proposed 2-4% contribution would support UHC's top two tiers, covering specialty and catastrophic care. Employers would only be responsible for these contributions if they do not offer alternative insurance or self-funded plans. Entities paying NIS must also contribute unless exempted due to insufficient income, with eligibility determined through means-testing. While this proposal may encounter resistance, it is essential for establishing sustainable healthcare funding.

Given the limited financial data currently available, this program may need to be rolled out in phases. Employers unable to comply immediately will be granted a grace period, allowing them time to adapt. Meanwhile, the UHCA must be equipped with adequate time and resources to establish systems for monitoring, analysis, and processing to assess compliance and financial capability effectively.

Policy Rationale

The goal of this policy is to create a fair system that encourages broad employer participation and increases the number of insured individuals. While exceptions are expected to be rare, insufficient data makes it difficult to assess their frequency. Legislation should minimize mandates, focusing instead on incentives and disincentives. Employer size, revenue, profitability, and other means-testing criteria will be key factors in determining which employers are subject to the wage-based contribution.

Policy Impact

These policies aim to protect consumers and safeguard the fund by incentivizing contributions from those able to pay while considering those who cannot. Participants will benefit from tax incentives, while non-participants with the ability to pay will face a tax levy. Extending this policy to the informal economy could encourage broader participation from those who might otherwise opt out.

Emerging Policy Issues

This policy may be seen as unfair depending on its implementation and administration. While it may not be essential during the initial stages of the project, UHC should have the authority to enforce it if a substantial number of capable contributors refuse to participate while their employees access Tiers 2 and 3.

Applying this policy to individuals in the informal economy who can afford to contribute but choose not to may present significant challenges.

Policy Recommendation #1.8: Health Savings Accounts (HSA) should be promoted with a tax exemption provided to encourage uptake on the part of financial institutions and consumers.

Policy Description/Statement

Employers could utilize Health Savings Accounts (HSAs) through banks or credit unions to save funds for employee healthcare costs. These accounts could cover co-payments, deductibles, premiums, or out-of-pocket expenses, serving as a self-funding option. The Policy recommends tax exemptions, breaks, or credits for contributions made by employers, employees, friends, families, or donors. A mechanism should also be created to allow Saint Lucians abroad to contribute easily to HSAs of their family and friends. Further analysis with the Ministry of Finance, financial institutions, and Financial Sector Regulatory Authority (FSRA) is needed to determine the implementation of this system.

Policy Rationale

Health Savings Accounts (HSAs) provide consumers with a flexible option to save for out-of-pocket expenses, premium contributions, overseas care, high-cost treatments, and services not covered by UHC. While UHC may not directly finance certain services, consumers and insurers can use the UHC provider network, including the Independent Provider Network Organization, with UHC's third-party administration facilitating payments from HSAs**.**

Policy Impact

HSAs create an additional funding mechanism for healthcare and offer financial institutions opportunities to grow savings. They also encourage informal economy participants to engage in the system, using HSAs to pay premiums for Tier 2 and 3 services under UHC or private insurance.

Emerging Policy Issues

Administering HSAs can be complex, but if financial institutions manage them, it simplifies operations for UHC. However, establishing electronic connectivity between financial

institutions and UHC is essential for secure fund transfers, which requires collaboration and robust security protocols.

While HSAs can increase participation in the informal economy, implementing them may face challenges, particularly with means testing to ensure fairness.

Policy Recommendation #1.9: Means Testing or Social Work interventions should be applied in Tiers 2 and 3 for individuals who are unable to pay, are wards of the state, prisoners and otherwise classified as vulnerable.

Policy Description/Statement

UHC will use means testing through social services to identify individuals unable to pay for Tiers 2 and 3. These individuals will receive subsidized care funded by government allocations for essential services like dialysis. By years 3-5, 50-60% of the population is expected to afford premiums for Tier 2 and 3 through direct payments, health plans, or other arrangements, supported by economic growth, higher wages, and improved revenue collection systems.

Policy Rationale

Means testing ensures access to care for those unable to contribute, aligning with government policies and mandates for universal healthcare.

Policy Impact

This policy enables UHC to meet WHO and government of Saint Lucia mandates while providing a safety net for vulnerable populations. Reducing out-of-pocket costs minimizes poverty risk, while the SPRC model spreads costs and risks across the population, ensuring economic sustainability. Additionally, it creates new employment opportunities, such as social workers, within the healthcare system.

Emerging Policy Issues

Given the large number of individuals who through means testing might not be able to participate in Tier 2 and 3 at the onset, the Government of Saint Lucia may have to make a larger contribution to cover such individuals in both Tier 2 and 3 in the early stages.

Policy Recommendation #1.10: UHC may obtain additional revenue from the collection of copayments, deductibles and other out of pocket fees.

Policy Description/Statement

The University of the West Indies (UWI) estimates that $EC16 million could be collected annually for the UHC system by incorporating carefully designed co-payments, deductibles, and other out-of-pocket payments to boost revenue without burdening patients.

JIPA proposes a co-payment system where providers collect payments directly, with those amounts deducted from their reimbursements. Payments facilitated via a patient ID card, or a card issued by financial institutions, reducing cash handling and ensuring efficiency. Patients can use Health Savings Accounts (HSAs) to cover these costs.

The UHC will manage collections from facilities and providers, adjudicating claims and reimbursing providers accordingly. An administrative fee will be applied to funds handled, deducted from provider reimbursements for co-payments, deductibles and other out-of-pocket expenses, creating a streamlined and equitable payment system.

Policy Rationale

Co-payments and deductibles are important financing options that will serve to reduce payment expenses for consumers who pay high dollar amounts for healthcare, especially in complex and catastrophic care situations.

Policy Impact

The UHC Authority (UHCA) will utilise co-payments and deductibles to incentivize positive behaviours for consumers, providers, and the UHC, aiming to contain costs, encourage timely care-seeking, discourage excessive utilisation of certain facilities like the emergency room, and reduce out-of-pocket expenses for complex and high-cost care. This mechanism will distribute out-of-pocket expenditures across the entire population.

It's worth noting that these payments can also support Tiers 2 and 3 for those unable to afford them, as well as fund the cost of services provided by the UHC.

Emerging Policy Issues

This can be looked at as an additional tax. Copayments and deductibles, while important to control certain behaviours, may be looked at as a punitive mandate.

Policy Recommendation #1.11: To ensure the financial stability of UHC, it is essential to secure funding beyond what is generated through taxes. This includes enforcing payments from other responsible payers who are currently not being billed or reimbursing for care provided. Subrogation will play a critical role in this process, enabling UHC to recover funds from entities such as property and casualty insurance companies or NIC. Through subrogation, UHC can collect payments from these entities after covering the costs of care

rendered to individuals for whom these payers are financially responsible. This mechanism ensures that UHC is reimbursed appropriately, strengthening its funding framework.

Policy Description/Statement

The UHC will recover payments from local property and casualty insurers for injuries covered under their policies, such as motor vehicle accidents or property-related injuries. Since automobile insurance typically includes medical coverage for accidents, the UHC will subrogate claims to receive reimbursement for services rendered. In legal settlements, UHC should be the first to recover costs. Legislation, if not already in place, should be enacted to support this process.

The UHC will also seek reimbursements from the NIC for workers injured on the job under workers' compensation insurance. Similarly, the UHC will recover costs from commercial health plans, international insurers, travel insurance, and other organizations paying for Tier 1, 2 and 3 healthcare services. This ensures UHC is prioritized for reimbursement when third-party coverage is available.

Policy Rationale

Subrogation for recovering payments from those obligated to reimburse the UHC for services rendered is essential, as it provides a vital funding mechanism for the program. This will also offset uncompensated cost in the health system.

Policy Impact

Increasing funding to the UHC provides a way to pay for healthcare services without solely relying on the Government.

Emerging Policy Issues

The ability to subrogate from other sources can be challenging, as extenuating circumstances may exist that impact the ability of the entity required to make the payment.

Policy Recommendation #1.12: Establish a Superfund as a resource mobilization tool to attract equity capital for Saint Lucia's health sector. The Superfund aims to drive transformative change by complementing government capital investment, making it a critical policy to stimulate growth and innovation in healthcare. As part of the policy, the health sector should be included as one of the target sectors for Invest Saint Lucia, and investing in healthcare should become one of the eligible sectors for the Citizenship by Investment program.

Policy Description/Statement

The Superfund is designed as a strategic tool to transform Saint Lucia's health sector through innovative resource mobilization. Drawing from successful models used by other government-owned entities and leveraging the expertise of Invest Saint Lucia to structure, it combines public and private funding to drive investment in healthcare infrastructure and services. Focused on facility development, technology integration, and talent retention, the Superfund channels equity capital into critical areas to create sustainable, long-term improvements.

Operating on principles of inclusivity and efficiency, the Superfund brings together diverse stakeholders under a shared vision for advancing healthcare. By facilitating private investments and in-kind contributions, it enables active participation in shaping Saint Lucia's healthcare landscape while ensuring equitable opportunities for growth.

The Superfund emphasizes public-private partnerships, serving as a catalyst for systemic change by fostering collaboration between government-run facilities and private enterprises. These partnerships open new avenues for service expansion and innovation, improving healthcare delivery for all Saint Lucians.

The Superfund serves as a resilient and innovative financing mechanism, generating essential equity capital while fostering a sustainable healthcare system. Its strategic implementation paves the way for a healthier and more prosperous future for Saint Lucia. To enhance its impact, municipal-style bonds backed by government securities can be incorporated into the Superfund, inviting private citizen participation. This approach ensures broader engagement and investment, giving the population a tangible stake in the healthcare system's success.

Policy Rationale

The Superfund is a transformative resource mobilization vehicle designed to address the critical challenges facing Saint Lucia's health sector, including limited funding, fragmented infrastructure, and a shortage of skilled professionals. Traditional government funding, constrained by competing priorities and economic fluctuations, is insufficient to meet the growing demands of a modern healthcare system.

The Superfund bridges public and private sectors, leveraging equity investments, in-kind contributions, bond funding, and partnerships to rapidly expand healthcare infrastructure and services. It targets systemic issues such as underutilized facilities, outdated technology, and limited access to specialized care, focusing on service development, technology integration, and talent retention to ensure equitable and comprehensive healthcare for all.

By fostering public-private partnerships, the Superfund aligns incentives, shares risks, and promotes sustainable growth. Its emphasis on revenue generation and cost containment ensures long-term financial stability, reducing reliance on external funding. Additionally, prioritizing equity over debt financing helps lower Saint Lucia's debt-to-equity and debt-to-GDP ratios, strengthening the economy and enhancing the value of the EC dollar.

Policy Impact

The establishment of the Superfund marks a transformative step forward for Saint Lucia's health sector. The Superfund drives rapid modernization and expansion of healthcare infrastructure, equipping facilities with advanced technology, specialized services, and skilled personnel. This enhances care quality, improves health outcomes, and boosts patient satisfaction.

Focusing on public-private partnerships, the Superfund fosters collaboration between government and private entities, creating a seamless, integrated healthcare system. This approach ensures broader access to services, optimizes resources, and improves cost-effectiveness.

As an equity investor, the Superfund transitions healthcare into a sustainable, growth-oriented industry, generating employment and stimulating economic development. It mobilizes investments from the diaspora, local, and international stakeholders, laying the foundation to expand Saint Lucia's UHC model to other developing nations in the Caribbean and beyond. Consolidating healthcare facilities and professionals will achieve economies of scale, reduce costs, and improve access to complex and catastrophic care.

Emerging Policy Issues

- Establishing a Superfund as an equity investment may require drafting legislation and regulatory policies to address investment risk, transparency, and oversight by entities like the FSRA. Additional regulatory considerations may apply due to international investments. There may already be such legislation in play and will need to evaluate.
- Saint Lucia has limited experience with such investment strategies, and past attempts have failed, posing potential public relations risks.
- Expanding Superfund investments beyond Saint Lucia could reduce risk, but this may be perceived locally as diminishing benefits for Saint Lucians not in favor of external stakeholders.

Policy Recommendation #1.13: Establish a Non-Governmental Organisation (NGO)/Charitable body with a footprint in Saint Lucia, North America, Europe, Africa and Asia to mobilise resources by way of grants, research studies, donations, and/or technical assistance.

Policy Description/Statement

In response to the urgent need to strengthen Saint Lucia's health care system and address the broader health care challenges facing the Caribbean, the Caribbean Diaspora Philanthropic Foundation (CDP) could emerge as a beacon of hope and change. Grounded in the ethos of non-profit philanthropy and collaboration, CDP aims to mobilise resources through grants, donations, and technical assistance to catalyse a transformative shift in health care delivery.

The Role of CDP:

CDP envisions a future where health care in Saint Lucia and the wider Caribbean is characterised by accessibility, quality, and sustainability. Through strategic partnerships with philanthropic organisations, multinational corporations, and diaspora communities, CDP aims to raise US $100 million over 36 months to support health care initiatives.

Main Functions:

- Supporting the implementation of an integrated health care delivery system, prioritising wellness and prevention alongside treatment.
- Establishing screening programs and surveillance systems for chronic diseases and public health challenges.
- Expanding health care services for underserved populations and developing service line programs for critical conditions.
- Enhancing the capacity of health care providers and facilities, including the integration of public-private partnerships.
- Facilitating access to overseas care for low-income patients when local services are unavailable.
- Creation of a reserve fund for the UHC at start-up and on an ongoing basis.

Operational Structure:

The Caribbean Diaspora Philanthropic Foundation (CDP) aims to transform Saint Lucia's healthcare system by addressing systemic challenges and improving access and quality. Guided by an experienced executive team and board of directors, including healthcare professionals, academics, philanthropists, and business leaders, CDP leverages technology

and strategic partnerships to manage funds, allocate resources, and coordinate impactful initiatives.

CDP's focus includes organizational development, stakeholder engagement, fundraising, and strategic collaborations. By mobilizing resources through grants, donations, and technical assistance, CDP seeks to raise $100 million over 36 months to support initiatives such as screening programs, surveillance systems, capacity building, and public-private partnerships. Targeted media campaigns will inspire support and drive resource mobilization.

By partnering with diaspora communities, philanthropic organizations, and multinational corporations, CDP works to create integrated healthcare delivery systems and preventive measures. Its phased approach, rooted in transparency and accountability, mitigates risks while advancing sustainable healthcare solutions.

With a commitment to collaboration and innovation, CDP strives to optimize resource allocation and deliver measurable impact across Saint Lucia and the Caribbean. As it embarks on this mission, CDP aims to foster partnerships, inspire change, and enhance health outcomes, improving the quality of life for Caribbean communities.

Policy Rationale

Phased Approach:

CDP adopts a phased approach to its development, beginning with collaboration under existing donor advised funds before establishing itself as an independent non-profit organisation. This strategic progression ensures credibility, efficiency, and scalability in its operations.

Key Stakeholders and Partnerships:

CDP collaborates closely with diaspora communities, local organisations, governments, NGOs, and international entities to maximise impact and reach. By fostering partnerships and engaging stakeholders at every level, CDP creates a unified front in the fight for improved health care outcomes.

Policy Impact

Addressing the Health care Crisis:

The COVID-19 pandemic underscored the vulnerabilities of health care systems in the Caribbean, where limited resources and infrastructure strain the ability to meet the population's health care needs. With countries spending only a fraction of their GDP on health

care compared to developed nations, the region faces challenges in managing both communicable and non-communicable diseases effectively.

Mitigating Risks and Ensuring Transparency:

Recognizing potential risks, including political affiliations and resource limitations, CDP prioritises transparency, accountability, and stakeholder engagement. By implementing robust governance structures and effective communication strategies, CDP navigates challenges while staying true to its mission.

Emerging Policy Issues

- Legislation might be required for the existence of the CDP in the context of the health care system and the UHC. Such legislation will be needed for funds to be managed outside of a government structure. It may also require a separate board of directors and administrators for transparency, good governance, proper fund allocations, and reporting.

- A solid grant writing, development and grant management infrastructure will be needed. A highly developed marketing and business development plan, program and strategy will be required to achieve success.

Conclusion: Financial Ecosystem

Private Sector Contributions and Premium Adjustments

If 40% of Saint Lucia's population contributes 40% or more of the total annual premium, funding for Tiers 2 and 3 could come from health insurance plans, self-funding, union plans, or direct UHC contributions. Over the three-year ramp-up period, private funds could contribute between EC$51 million and EC$61 million, assuming successful private sector participation. Even with only 20% participation, JIPA projects private funding could at least break even.

Under the SPRC model, NIC and private insurance premiums could decrease from EC$150 to EC$70–$120 per person per month, depending on contributions and participation rates. These reductions would encourage broader participation, providing significant savings for companies, which could be redirected to additional benefits.

Catastrophic Care and Risk Distribution

JIPA recommends creating a philanthropic fund, supported by the Government and private entities, to assist with Tier 3 catastrophic care needs overseas during the program's first two years. The SPRC model distributes financial risk, allowing for tier adjustments if funding falls

short. For instance, Tier 1 shortfalls could be offset by adjusting Tier 2 and 3 benefits, or surpluses could extend Tier 1 coverage.

Capital Reserves and Data Integration

To ensure solvency, JIPA proposes building reserves by collecting surplus funds annually for five years and beginning collections three months before service rollout to expand reserves from three to six months. Real-time health data is critical for accurate budgeting. JIPA is collaborating with the Government to deploy data collection systems in early 2025, ensuring flexible UHC budgeting and service adjustments based on emerging data.

Legislation, Governance and Administration

Policy Recommendations for Legislation, Governance and Administration

- **#2.1: UHC to be governed by a Statutory Board/Authority.** The UHCA shall be established as a Statutory Authority with a Board having legal authority to operate and function subject to oversight by the Minister of Health.
- **#2.2:** Role and Functions of the UHCA.
- **#2.3:** The UHCA Board will not be a purely stakeholder representative body but will include other qualified individuals to ensure that the UHCA is functional, effective and accountable. In addition, the administration will also be representative of the functions needed to operate the UHC.
- **#2.4:** The UHCA is expected to collaborate with key government agencies.
- **#2.5:** The UHCA allows for private-public arrangements for payers in the Universal Health Coverage Initiative.
- **#2.6:** The UHCA should have the authority to function as a health insurer as determined by the Government of Saint Lucia.
- **#2.7:** The UHCA will manage the delegation of responsibility to certain service providers that are now administered under the Ministry of Health. Those responsibilities will be transferred to the Statutory Authority with oversight from the Minister of Health.
- **#2.8:** Ensuring access to critical data from the Health System and other relevant authorities is imperative for the successful implementation of the UHC. This data plays a crucial role in informing decision-making processes, optimizing resource allocation, and enhancing the overall effectiveness of the UHC program.

- **#2.9:** The UHC should be granted authority to implement public-private partnerships, including group purchasing, seamless provider participation between public and private systems, and government contracting with private entities.

Governance and Administration of the UHC Authority

The UHC Authority (UHCA) will function as an autonomous public entity under the proposed Universal Health Insurance (National Health Insurance) Act, which will outline its roles, powers, structure, and responsibilities for managing the UHC Special Fund and Benefits Plan. This legislation will align with existing laws governing entities like the Hospital Authority, data privacy regulations, and statutory bodies, ensuring a comprehensive and cohesive legal framework.

To adapt to the dynamic needs of UHC and stakeholder input, the Act will be implemented in phases. Phase one, targeted for Q2 2025, will establish foundational elements such as registration, governance, funding mechanisms, integration with the health system, system strengthening, and reporting. Phase two, to be finalized prior to UHC's official launch, will complete the legislative framework to support full implementation.

Until the UHCA is formally established, the UHC initiative will continue to be administered by the UHC Unit, led by Dr. Alisha Eugene and operating under the Ministry of Health, Wellness, and Elderly Affairs, headed by Permanent Secretary Jenny Daniel. Certain actions will require Cabinet approval, as provisions for the UHC directive are accommodated under prior legislation.

Key Governance Requirements

Success hinges on engaging qualified professionals with expertise in healthcare financing, risk management, capitalization, service delivery, care coordination, and social responsibility. Their participation will ensure effective management, compliance, and service quality, supporting the UHC's long-term sustainability and impact.

The UHC Authority will need to follow governance and administration principles with the following values and concepts:

Governance and Oversight

- Transparency in decision-making
- Adequate government oversight
- Avoidance of actual and perceived conflicts of interest
- Ombudsman to manage disputes
- Separation of powers
- Appropriate separation of functions

- Avoidance of excessive control by one or more parties
- Sustainability and Protection

Sustainability of the UHC Special Fund

- Protection of the fund
- Modification of the fund and program for sustainability and functional needs
- Low-cost governance and administration
- Ability to attract financing
- Fairness and Stakeholder Engagement

Participation of qualified industry leaders and stakeholder representatives

- Fairness and balance between stakeholders
- Trust built into the system
- Operational Effectiveness
- True ability to manage and delegate

Structure of the Administration

To establish efficient and sustainable governance in keeping with the laws of Saint Lucia, four levels of governance and administration are suggested for approval by the Parliament:

Level 1 Governance – The Cabinet of Saint Lucia – Legislative Arm of the UHC and for final approval of plans and financing.

Level 2 Governance – The Ministry of Health – Board appointments and reporting to the Minister of Health. Allocation of funding from the Government of Saint Lucia through the Ministry of Finance.

Level 3 Governance – UHC Authority – The Authority that governs and administers the UHC policies, operations, contracting, benefit plan and design, registration of membership and member services, provider and payer relationships, quality management and cost containment, claims and third-party administration, subrogation and collections and other functions as stipulated by the Act, The Ministry of Health and The Cabinet.

Level 4 Governance – Organisations appointed by, contracted or affiliated with the UHCA – They include the Independent Provider Association, Health and Hospital Authority, Medical and Dental Council, NIC and other consulting and contracted entities.

Policy Framework Legislation, Governance and Administration

Recognizing the historical precedence set by prior statutory Authorities established and operating as legally independent corporations of the Government of Saint Lucia, the UHC will pattern the required legislation, infrastructure, operations, governance, and administration

around existing Acts (legislation). The UHC program has already sought the participation of stakeholders and will continue to do so throughout implementation. Principles already set out in the introduction and executive summary of this document.

Policy Recommendation #2.1: UHC to be governed by a Statutory Board/Authority

The UHCA shall be established as a Statutory Authority with a Board having legal authority to operate and function subject to oversight by the Minister of Health.

Policy Statement/Description:

The Government of Saint Lucia will establish a Universal Health Coverage Authority (UHCA) and appoint a Board of Directors composed of stakeholders and qualified professionals to govern the UHC, under the oversight of the Minister of Health. The Ministry of Health will play a key role in selecting representatives from the healthcare industry.

To align with the health transformation agenda, the UHCA's legal establishment should include modifications to existing health authority legislation. The UHCA Board will report to the Minister of Health, who is accountable to the Cabinet. External oversight will include audits by external auditors, reviews by the Office of Internal Audit to ensure prudent management of public funds, and compliance with relevant regulatory authorities.

Adopting a statutory authority model will grant the UHCA autonomy enabling more efficient and flexible decision-making. The Ministry of Health will coordinate fiscal policies and partnerships with key agencies like the NIC to support the UHCA's operations.

There are several options for the legal set up of the UHCA:

1. **Establish the UHCA as a new, autonomous institution.** This ensures independence, aligns closely with the Ministry of Health's oversight, and shields other government entities from medical malpractice liability. However, it involves higher costs and longer setup time to become operational.

2. **Integrate the UHCA within the NIC.** This model reduces costs, speeds up operational readiness, and allows quick collaboration with the private sector by leveraging existing NIC systems, data, and processes. While this approach sacrifices some autonomy and increases NIC exposure to malpractice liability, these risks can be mitigated by establishing a separate board and maintaining legally distinct funds.

3. **Incubate the UHCA within the NIC before spinning it off.** This combines the advantages of cost-efficiency and rapid setup with a pathway to full autonomy and

legal separation of funds. It also preserves closer oversight by the Ministry of Health. A recommended incubation period for this option is three years.

Policy Rationale

Setting up the statutory board and Authority through legislation to establish governance and administrative functions of the UHC represents the bedrock of the UHC. Establishing the Authority also establishes the legitimacy of the UHC's existence as an independent statutory authority. Legislation establishing the Authority will catalyse transform of Saint Lucia's health care system, setting the basis for a sustainable payment system for health care services for the people of Saint Lucia.

Impact

The Authority and Board will enhance the country's ability to consolidate its resources in health care to achieve economies of scale and private-public partnerships to improve the quality of health care services delivered. The establishment of the UHC Authority and Board will foster the development of a health care industry creating new care and, administration infrastructure that meets the tenets of universal health care. The UHC legislative initiative of establishing a statutory body and administrative infrastructure will make health care more available, accessible and affordable.

Emerging Policy Issues

1. **Balancing Autonomy:** Defining the level of autonomy for the UHC is challenging, as professionals must make evidence-based decisions while considering stakeholder interests and the authority delegated by the government.
2. **Board Composition:** Selecting a UHC board that balances stakeholder representation with expertise in healthcare, financing, human resources, business strategy, technology, and socio-economic matters can be difficult especially considering changes in government over time.
3. **Ministry Oversight:** Placing the UHCA under the Ministry of Health may significantly reduce the Ministry of Health's budget. Clear collaboration with the Ministry of Health will be essential to provide health expertise, management, and alignment with national health policies.
4. **Transitioning Staff:** Moving employees and professionals from civil service to a statutory body may present administrative and operational challenges.
5. **Avoiding Duplication:** Establishing the UHCA as a separate authority from entities like the NIC may be perceived as duplicative, leading to concerns about increased costs and inefficiencies.

Recommendation #2.2: Role and Functions of the UHCA

Policy Statement/Description

Key Functions of the Universal Health Coverage Authority (UHCA)

1. **Fund and Benefits Management**
    - Establish and manage the **Universal Health Coverage Special Fund** and a **National Benefits Plan** to ensure accessible, affordable, equitable, and quality healthcare services for all eligible persons.
    - Maintain the solvency of the UHC Special Fund through sound financial management.
2. **Registration and Enrollment**: Register and enroll all eligible persons to receive benefits under the UHC Plan.
3. **Provider Contracts and Payments**
    - Set the terms for agreements with healthcare providers, including rates of payment, benefit plans, and risk adjustment mechanisms.
    - Negotiate and contract with providers through an **Independent Provider Association (IPA)** and manage payments for services delivered.
4. **Quality Management and Efficiency**
    - Establish and implement quality management mechanisms to ensure high standards in the delivery of UHC-funded healthcare services.
    - Promote efficiency and innovative methods for delivering healthcare benefits and services.
5. **Public-Private Partnerships**: Implement and maintain a sustainable UHC model through **private and public partnerships** in line with legal frameworks.
6. **Revenue Collection and Risk Management**
    - Act as a revenue collection and subrogation entity for healthcare services provided domestically and, in some cases, internationally.
    - Serve as a **Health Insurer (payer)**, functioning as a risk-bearing entity to offer healthcare benefits.
7. **Commercial Contracts**: Negotiate and manage contracts with commercial payers and other entities participating in the UHC system.

8. **Administration and Human Resources**: Establish and operate the UHC Administration (UHCA), including human resources policies, procedures, and operations.
9. **Investment and Funding**: Strategically invest UHC funds, secure funding through government negotiations, and obtain loans, grants, and collections where possible.
10. **Secure and Manage Alternative Funding from the Private Sector:** Establish the Friends of UHC Fund to attract and manage private and social sector contributions toward specific operational costs of the UHCA, reducing reliance on government funding. The Fund should be launched immediately—prior to UHCA's full implementation—and will enable companies and organizations that cannot or prefer not to donate via the Government's consolidated fund to contribute. The Fund could initially be housed under the NIC, transitioning to the UHCA once operational, helping fast-track key setup and operational activities.

This structured approach ensures the UHCA effectively delivers its mandate, balancing financial sustainability, quality care, and equitable access for all.

The Authority will be in charge of delivering:

1. Benefits Management

- Define the benefits provided under the UHC Benefits Plan.
- Register and enroll beneficiaries under the Plan.

2. Financial Management and Resource Mobilization

- Set payment rates, fix fee schedules, and administer risk adjustment mechanisms for benefits under the Plan.
- Mobilize resources and strategically invest UHC Special Fund assets.
- Operate the Friends of UHC Fund.
- Appoint an actuary to conduct actuarial projections, reviews, and calculate per capita costs, premiums, allocations, and payments.

3. Provider and Administrative Operations

- Contract healthcare providers for delivering services under the Benefits Plan.
- Appoint officers, employees, agents, or outsource administrative services as necessary.

4. Perform any additional functions as determined by the Government of Saint Lucia.

This streamlined structure categorizes UHCA responsibilities into clear groupings—**Benefits Management**, **Financial Management**, and **Provider Operations** and Quality and Utilization Management ensuring efficient oversight and execution.

Policy Rationale

The UHCA must have the authority to pool and disburse funds strategically to pay for health services from accredited and contracted public and private providers. Efficient administrative systems will be implemented to ensure existing funds designated for clinical health care services are appropriately channeled into the UHC Special Fund. These powers will operate independently of the Ministry of Health (MoH) and Ministry of Finance (MoF). The UHCA will hire technical staff and establish interdisciplinary and multi-sectoral committees as necessary to fulfill its mandate.

Impact

Establishing the UHCA's roles and responsibilities will enable the Authority to meet stakeholder needs by improving access to quality healthcare services. A robust infrastructure will build trust among patients, healthcare professionals, and investors, increasing confidence and encouraging greater investment participation in Saint Lucia's healthcare sector.

Emerging Policy Issues

Defining the UHCA's role poses challenges due to the need for comprehensive healthcare system transformation. Potential conflicts may arise between the UHCA and key entities such as the NIC, healthcare providers (Independent Provider Association), payer entities (e.g., insurance companies), and others, as the UHCA will manage fund disbursement, withhold payments, and require premium contributions.

Policy Recommendation #2.3: The UHC Board will not be a purely stakeholder representative body but will include other qualified individuals to ensure that the UHCA is functional, effective and accountable. In addition, the administration will also be representative of the functions needed to operate the UHC.

Policy Statement/Description

The composition of the UHC Board and the administration will mostly be based on experts in relevant fields which may include healthcare financing, health economics, public health, health policy and planning, investing and fund management, business management, strategy, monitoring and evaluation, epidemiology, union leadership with collective bargaining experience, statistics, health law, labour, actuarial sciences, taxation, social security, information technology, organisational management, communication and civil society/community engagement.

Policy Rationale

Both on the board of directors and the executive levels, the UHC functions similarly to a health insurance organization, requiring expertise in healthcare delivery, billing, claims administration, actuarial analysis, epidemiology, health laws, quality management, financial administration, IT systems, and human resources. Without individuals possessing the necessary qualifications to serve on the board and in management roles, the UHC will not achieve sustainability or operational efficiency.

Policy Impact

Appointing qualified individuals to the UHC board and management will establish a sustainable, industry-standard operation. A skilled team will ensure compliance with statutory requirements and alignment with international healthcare and UHC program standards, fostering credibility and efficiency.

Emerging Policy Issues

Conflicts of interest may arise as many professionals considered for the board may have ties to the healthcare and insurance sectors, including business ownership or affiliations that could impact impartial decision-making.

Political influence in board appointments poses additional risks, potentially undermining the UHC's stability and policies. Safeguards will be essential to prevent certain political interference and ensure the board operates independently and effectively.

Recommendations Policy #2.4: The UHC is expected to collaborate with key government agencies:

1. The Ministry of Health
2. Ministry of Finance
3. Financial Services Regulatory Authority
4. Hospital Authorities
5. NIC
6. Saint Lucia Social Development Fund (SSDF)
7. Tourism Authority
8. Invest Saint Lucia
9. Saint Lucia Development Bank
10. Any other relevant agencies as approved by the Government of Saint Lucia

Policy Rationale

The UHC represents a collaboration between stakeholders, the health care system and various government, regulatory and statutory bodies. The policy will stipulate the manner in

which collaboration will occur between these key agencies (eg. NIC and MOHWEA) and others.

Policy Impact

Collaboration with various stakeholder organisations will ensure sustainability and cost containment due to a reduction in the duplication of effort and inefficiencies. This collaboration will result in the further development of a health system that meets the needs of Saint Lucians. The key impact will be on the reduction of silos in health care that limit data sharing, access and collaboration.

The Ministry of Health and Health System Authority: The Ministry of Health will take the lead on and will collaborate with the UHCA on critical healthcare functions, including:

- Registering and contracting healthcare providers via the Independent Provider Association for payments, quality management, and care coordination within the provider network.
- Enforcing health-related laws and regulations, including environmental health and hospital/clinic registration.
- Certifying and accrediting institutions through bodies like the Medical and Dental Association and the Pharmacy Council, under Ministry oversight.
- Managing patient benefit services to ensure universal access to healthcare.
- Overseeing communicable and noncommunicable disease management while monitoring associated costs to ensure sufficient capital to meet national healthcare needs.

The NIC Authority: The NIC will collaborate with the UHCA to share data, operational methods, and IT systems for registration and payment management, particularly for injured workers. NIC may also participate in UHC funding and health system strengthening as a strategic investor in the potential Superfund. NIC investment in UHC and health system strengthening will be for nation building and for a guaranteed returns on investment, supporting healthcare system sustainability.

The SSDF: The UHCA will collaborate with the Saint Lucia Social Development Fund (SSDF) to oversee the solvency of the UHC plan and manage its interactions with commercial payer entities, including domestic and international health insurance plans, self-funded plans, brokers, and financial institutions. SSDF will also support the UHC in decision-making, data collection, and reporting of member coverage to improve collections, subrogation, and actuarial analytics.

Emerging Policy Issues

- Ensuring seamless coordination among SSDF, the Ministry of Health, and NIC to avoid overlaps and inefficiencies.
- Addressing potential conflicts of interest in shared data and investment strategies.
- Guaranteeing transparency in financial partnerships to maintain public trust in the UHC system.

Policy Recommendation #2.5: The UHC allows for private-public arrangements for payers in the Universal Health Coverage Initiative.

Policy Statement/Description

Commercial health care payers will participate in Tier 2 and 3 of the UHC program. They will continue to offer their benefits on top of what is offered in Tier 1, the Government tier. When the maximum dollar coverage is reached from Tier 1, then the UHC will subrogate the balance of the payment for health care services from the commercial payers.

Policy Rationale

To fulfill Universal Health Coverage (UHC) mandates and reduce financial leakage outside Saint Lucia, private commercial health payers, such as health insurance companies, are welcomed into the system. Excluding private sector insurance, as seen in other Caribbean nations, has led to cost overruns, unsustainable government budgets, and weakened health insurance and broker industries. Treating UHC solely as a safety net for the underserved is counterproductive, as it limits growth and development of the healthcare sector, particularly in small populations with limited capital contributions.

Policy Impact

Incorporating private health insurance into UHC will generate additional revenue, preserving the health insurance and broker industries, which stimulate commerce and employment. Commercial participation will also drive growth in the healthcare sector by introducing expertise, technology, and talent essential for system transformation.

Emerging Policy Issues

Shifting from a primarily government-funded and operated healthcare model may raise legal and political challenges, given its historical roots. Some entities may perceive this change as a loss of control or influence over the healthcare system.

Policy Recommendation #2.6: The UHC should have the authority to function as a health insurer as determined by the Government of Saint Lucia.

Policy Statement/Description

While private insurance often limits coverage based on age and preexisting conditions, the UHC, committed to universal healthcare access, ensures coverage for all individuals regardless of age, gender, preexisting conditions, or socio-economic status.

Policy Rationale

Under the UHC model, private insurers' reliance on premium pricing and benefit exclusions must not leave individuals without coverage. To prevent gaps, the UHC will have the authority to offer its own health plan, ensuring affordable options for lower-income individuals and those excluded due to age or preexisting conditions.

Policy Impact

Allowing the UHC to offer a commercial health plan incentivizes private insurers to include preexisting conditions and all age groups. Safeguards within the three-tier model ensure adequate private sector funding, enabling expanded coverage in the government-funded tier. The government will also cover complex and catastrophic conditions often excluded from private plans, ensuring comprehensive access for all.

Emerging Policy Issues

Private insurers may resist UHC operating as an insurance provider, viewing it as competition. Additionally, commercial providers may continue to exclude high-risk groups, placing an increased financial burden on the UHC.

Policy Recommendation #2.7: The UHCA will manage the delegation of responsibility to certain service providers that are now administered under the Ministry of Health. Those responsibilities will be transferred to the Statutory Authority with oversight from the Minister of Health.

Policy Statement/Description

The transfer of existing contracts and arrangements to the UHCA requires careful planning to resolve outstanding issues, such as vendor obligations, negotiated payment terms, and pending agreements. To ensure effective management of the UHC program, currently overseen by the Ministry of Finance, Economic Development, and Youth Economy, a Secretariat will be appointed to manage day-to-day affairs during the transition.

Policy Rationale

The complex design and operations of the UHC demand a skilled technical team, particularly during the critical 'Go Live' phase. Sustainable transition arrangements must be established to ensure smooth implementation and long-term functionality. This includes managing UHC operations, integrating technology, building infrastructure, and assembling on-the-ground management and technical teams. Consultants will play a key role in implementation and sustainability, with a phased approach leading up to the full launch.

Policy Impact

Given resource constraints in human capital, IT, infrastructure, and funding, leveraging existing vendor arrangements will enable the UHC to progress according to the JIPA Network's project plan. A 'soft Go Live' in March 2026, followed by full implementation by November 2027, will align with broader health system transformations, including the opening of the new St. Jude's Hospital and other system-wide improvements.

Emerging Policy Issues

Several budgetary and contractual challenges must be resolved for the UHC to function effectively. Uncertainties remain regarding the actual operational costs of the UHC and the government's ability to allocate sufficient capital for implementation and sustainability. Addressing these concerns will require ongoing dialogue as new information emerges. Critical priorities include passing necessary legislation, member registration, establishing the UHCA, and convening its board of directors and management team.

Policy Recommendation #2.8: Ensuring access to critical data from the Health System and other relevant authorities is imperative for the successful implementation of the UHC. This data plays a crucial role in informing decision-making processes, optimising resource allocation, and enhancing the overall effectiveness of the UHC program.

Policy Statement/Description

The UHCA will have legislative authority to collect, compile, and analyse data from both public and private sectors while strictly adhering to protocols for data privacy, sharing, and protection of personally identifiable information. Comprehensive data collection within the UHC framework is crucial for evaluating outcomes, public sentiment, cost-effectiveness, utilization, disease prevalence, service quality, and overall system performance. Clear goals, targets, and key performance indicators (KPIs) will be established and publicly reported through annual performance-based reviews to ensure transparency and accountability.

Policy Rationale

Effective data collection and analysis are critical for the successful implementation of UHC. Using standardized, globally recognized coding systems to categorize procedures by disease enables accurate cost estimation, budgeting, infrastructure planning, disease tracking, provider payments, benefits design, risk assessment, care coordination, and quality assurance.

Robust IT systems, currently being deployed through partners as a turnkey solution, are essential to support these functions. Ensuring stringent privacy policies and safeguarding patient data will be vital for the sustainability and security of these systems.

To address the change management challenges associated with UHC implementation in information technology, the following integrated and interoperable cloud-based systems are being considered under the contract with the UHC:

1. Customer Relationship Management (CRM) including directory of all persons and entities involved in the UHC.
2. Provider Information System – Clinical Data Collection. systems at the provider level
3. Third-Party Claims Administration and Insurance System – Systems to adjudicate and administer the payment and disbursement of payments to providers based upon the administration of benefits.
4. Electronic Data Interchange System – Transfer of Information for real-time data sharing between stakeholders.

Data Acquisition Systems and Policies:

1. Data systems in place where data could be mined (NIC, SLUHIS, CELLMA, EHRs, Epidemiology Unit, etc…).
2. Working with the Government and their consultants to develop and utilise systems to uniquely identify persons.
3. Working with the government on geocoding based upon address.

Data communication and telecommunication infrastructure will be integrated into the Government of Saint Lucia's data system and centre. A review of regulations is necessary to determine whether patient data can be stored on cloud platforms or must remain within the country. With the evolving methods of data storage and transfer, current data legislation will need updates to ensure robust protections while leveraging advancements in healthcare IT. Additionally, privacy and patient protection laws may require further strengthening to

support UHC implementation. Introducing a Patient Bill of Rights is recommended to formalize these protections and address related measures comprehensively.

Policy Impact

A technology and data-driven health care system will be the catalyst for a modern health care system in Saint Lucia.

Emerging Policy Issues

Saint Lucia currently lacks the data systems, policies, and infrastructure needed to support a modern, technologically advanced health system and UHC. Additionally, new regulations on data privacy, security, and cloud-based solutions must be considered. Public concerns may arise over health information stored on a government-managed system, with fears of privacy breaches or misuse.

Policy Recommendation #2.9: The UHC should be granted authority to implement public-private partnerships, including group purchasing, seamless provider participation between public and private systems, and government contracting with private entities.

Policy Statement/Description

The UHC will leverage its compensation and management program to encourage public-private partnerships through clear policies and legislation. Contracting arrangements will be established with public and private facilities for procurement and maintenance of supplies, pharmaceuticals, diagnostics, equipment, and technology. These arrangements will promote group purchasing, ensure competitive vendor pricing, and maintain quality and safety standards. Over time, facilities will be evaluated to meet local and international accreditation standards, with incentives to adopt risk management, quality, and safety guidelines.

Policy Rationale

The SPRC model emphasizes service consolidation to achieve economies of scale, lower costs, and reduced risk. Given Saint Lucia's small population size and the inefficiencies of siloed operations, public-private partnerships are essential for achieving long-term sustainability and cost-effectiveness.

Policy Impact

This policy will improve healthcare affordability, accessibility, quality, and availability while fostering collaboration between public and private entities to optimize resources and outcomes.

Emerging Policy Issues

- There are limited examples of successful public-private partnerships in the current health system.
- Rules and regulations must be developed to prevent misuse and ensure fairness.
- Monitoring and segregating funds between private and public sectors for accountability may pose challenges.

Benefit Plan for Universal Health Coverage to Include Commercial Insurance Arrangements

Policy Recommendations for Benefit Plan for UHC

- #3.1: Eligibility for benefit coverage under UHC will have to be established.
- #3.2: The UHC plans to have all benefits subject to the terms and conditions of the UHCA policy. The benefit plan for the UHC will occur based on the three tiers of funding as stipulated in the SPRC model.
- #3.3: Commercial Payers including but not limited to private health insurance plans, union plans, and self-funded employer-based plans must meet the requirements of the Saint Lucia Social Development Fund (SSDF) to provide insurance coverage through the UHC in Saint Lucia.
- #3.4: UHC will help consumers to manage their out-of-pocket expenses.
- #3.5: UHC will develop a model to address complex high-cost catastrophic conditions and overseas care coverage.
- #3.6: A benefits coverage strategy for Tiers 1 and 2 will need to be developed and adopted.
- #3.7: A Tier 3 benefit coverage plan will be offered through reinsurance.

Introduction

In the Caribbean, traditional health plans control costs by limiting access and coverage, particularly for older individuals and those with pre-existing conditions who require more care. Small island populations and limited insurance enrollment mean there are insufficient premium dollars to fund high-cost care. In Saint Lucia, only 12% of the population have health insurance, and for those who have health insurance the benefits are typically restricted. Consumers often expect extensive services despite limited premium contributions, leaving insurers struggling for financial solvency and forced on rationing benefits. While wages are rising, many Saint Lucians still cannot afford comprehensive health coverage.

Saint Lucia's Universal Health Coverage (UHC) will be the first regional model to partner with the insurance industry to make healthcare affordable, accessible, and equitable. Using the SPRC framework, it consolidates healthcare payments, providers, services, and the population, regardless of economic status or health condition.

The three-tier model (as shown in Figure 1 above) ensures:

1. **Tier 1:** Government funding covers basic healthcare for all qualified individuals and families, achieving universal coverage.
2. **Tier 2:** Individuals with private insurance can access care beyond government limits.
3. **Tier 3:** Complex and catastrophic care is managed through reinsurance and additional contributions.

The benefit plan is straightforward and inclusive, covering most healthcare services, except specific exclusions like plastic surgery. Each individual receives a maximum coverage limit, after which private insurance takes over.

This approach minimizes out-of-pocket costs, enabling consumers to seek care without financial worry. By prioritizing prevention and wellness, it reduces complex and catastrophic events, ensuring sustainability without discriminating based on age or pre-existing conditions.

Policy Framework

The key Objectives of the Benefit Plan Program for Saint Lucia UHC are as Follows:

- **Develop a comprehensive UHC benefit plan** that meets the healthcare needs of all Saint Lucians while ensuring long-term sustainability.
- **Establish a partnership between the UHCA and private insurers** to consolidate capital, spread risk across a larger population, and deliver lower costs with greater benefits.
- **Increase private insurance participation** by reducing insurer risk, with the Government assuming initial coverage (Tier 1) and complex or catastrophic care (Tier 3) managed through reinsurance and government support.
- **Implement a system for collections** to enable healthcare providers to recover funds from international insurers, NIC for injured workers, and property/casualty insurance for motor vehicle and related claims.
- **Prioritize national management of Non-Communicable Diseases (NCDs)** in alignment with WHO and PAHO objectives.

- **Support health system strengthening and sector growth** through strategic policies and investments.
- **Encourage provider participation** by linking payments to performance and outcomes under the UHC benefit plan.

Policy Recommendation #3.1: Eligibility for benefit coverage under UHC will have to be established.

Policy Statement/Description

See 'Policy Recommendation #1' under 'Health Care Sector and Population' Section

UHC Saint Lucia Benefit Rules of Engagement for Covered Persons

- **Registration Requirements:**
    - All eligible residents must register with the UHCA and provide details of any existing insurance or healthcare coverage.
    - Implement an automatic registration system for citizens and qualified individuals to reduce costs and streamline administrative processes.
- **Private Health Insurance Plans:**
    - Individuals may purchase **qualified private health insurance plans** that must provide UHC-mandated benefits.
    - Qualified plans must report additional benefits, healthcare encounters, and key data elements to the UHCA for analysis.
    - **Non-qualified health plans**, including property and casualty insurers, must report membership coverage and benefits, especially when paying for healthcare services.
    - Legal settlement proceeds must first reimburse the UHC for services rendered before being distributed to beneficiaries.
- **Access to Care:**
    - Members with qualified private insurance may seek care from public or private providers under the UHC.
    - Individuals using **non-UHC providers** will be responsible for payments unless authorized by the UHCA.

- Public and private providers must submit encounter data to the UHCA, which will bill private insurers, or the government based on the funding source for qualified benefits.

Policy Rationale

Clearly defining coverage criteria and eligibility rules is essential for the UHC framework. Leveraging existing data systems allows for automatic registration by capturing necessary demographic information. This system also helps identify individuals who can afford private insurance (Tier 2 and 3) and offer them appropriate options. For those unable to afford private insurance, means testing will ensure they receive the appropriate coverage under the UHC.

Policy Impact

The benefit impact stated in the section is covered in *Policy #1* under the Health *Care Sector and Population* section which defines that the population will receive services under the UHC infrastructure and how such services will be covered based upon various cohorts in the population.

Emerging Policy Issues

1. Determining eligibility and the conditions for coverage will be complex. Implementing means-testing to identify individuals qualifying for government support under a Safety Net arrangement will require new policies, systems, and human resources that are not yet in place.
2. Individuals and corporations required to make payments through health insurance or other mechanisms may face challenges. Means-testing for employees could also be perceived as intrusive.

Policy Recommendation #3.2: The UHC plans to have all benefits subject to the terms and conditions of the UHCA policy. The benefit plan for the UHC will occur based on the three tiers of funding as stipulated in the SPRC model. See the diagram below:

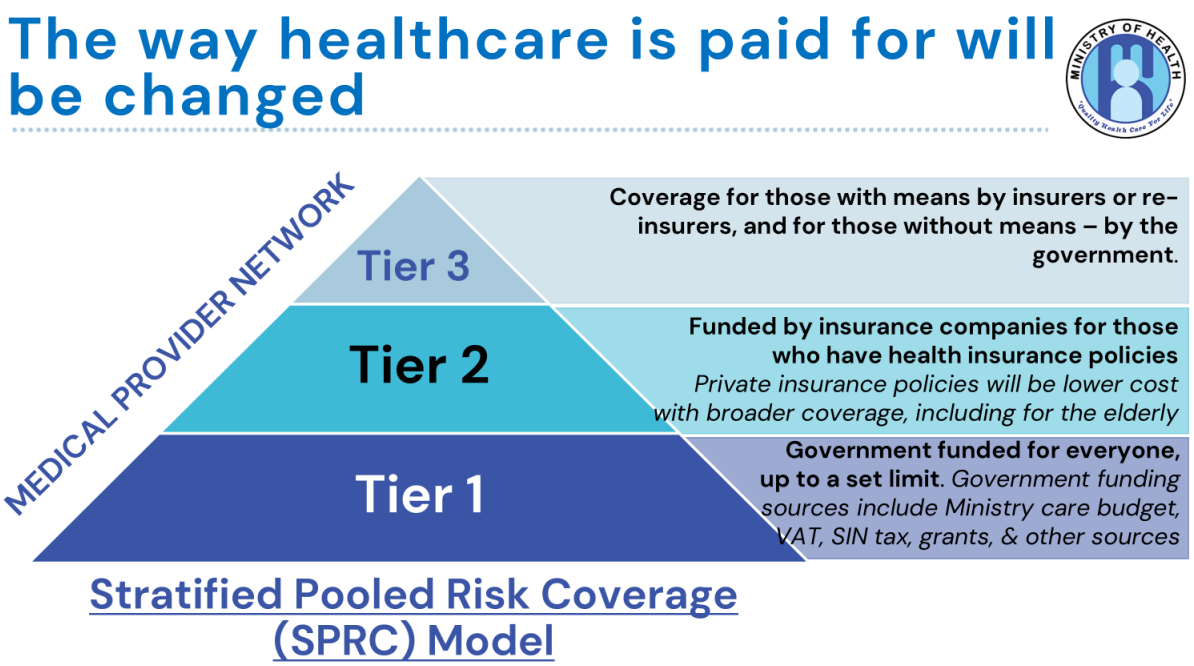


Figure 5: The three-tiered Stratified Pooled Risk Coverage (SPRC) Model

Policy Statement/Description

The three-tier benefit plan uses a stratified funding model with benefits tailored to each tier. Each individual will receive a minimum-to-maximum annual dollar allocation to cover necessary services, with exceptions where coverage cannot pay the full amount and the individual has the means to cover the rest. Coverage will apply to all qualifying individuals, regardless of age, gender, pre-existing conditions, or socioeconomic status.

Policy Rationale

The SPRC model prevents capital leakage by ensuring funds from both public and private payers remain within the healthcare system. Funds are held separately until services are rendered, with the UHCA subrogating payments from commercial payers for care covered in the second tier.

Policy Impact

Under this model, the UHCA pays providers directly and seeks reimbursement from insurers, removing the burden from patients to pay upfront and wait for reimbursement. This will significantly reduce, and in some cases eliminate, out-of-pocket costs for consumers.

Emerging Policy Issue

The absence of a robust electronic data collection system in Saint Lucia poses a challenge, as UHC operations rely on accurate data to determine payer responsibility. Implementing an effective data system will be critical to the success of UHC.

Policy Recommendation #3.3: Commercial Payers including but not limited to private health insurance plans, union plans, and self-funded employer-based plans must meet the requirements of the Saint Lucia Social Development Fund (SSDF) to provide insurance coverage through the UHC in Saint Lucia.

Policy Statement/Description

Qualified payers must meet SSDF's solvency requirements as outlined in their official contract with the UHC. If exceptions arise under SSDF registration, the UHC will adhere to those conditions. A standard benefits package for Tiers 2 and 3 will be developed in consultation with SSDF, which all insurers and private payers must meet. Insurers may offer additional benefits beyond the standard package, but these will also be administered through the UHC, domestically or internationally. International insurers operating in Saint Lucia will follow the same rules as local companies.

Subrogation and Visitor Coverage: Visitors to Saint Lucia will be encouraged to purchase a local health insurance policy. This can be made mandatory with the fee automatically added as part of a flight or cruise ticket fee or purchased voluntarily by the visitor through a local insurance broker. The policy will provide coverage starting from the first dollar up to the maximum benefit level, excluding Universal Health Care (UHC) funds. For uninsured visitors, payment arrangements will be established by the Universal Health Care Authority (UHCA) and the healthcare provider to ensure the sustainability of providers and the stability of UHC funds. Additionally, UHC will collaborate with international health insurance companies to integrate their coverage for visitors to Saint Lucia.

Collections System: If the UHC establishes a collection system for international insurers, it will provide an additional reimbursement avenue for providers. Negotiations with current and future insurers will progress in phases, culminating in ratified contracts. These contracts will define required benefits and any additional offerings beyond the standard package.

There are only a few commercial payers that do business under the health insurance plan.

They are as follows:

- Caribbean based health insurance plans:
  - Sagicor – Barbados-based company
  - Guardian Life – Trinidad-based company
  - Beacon Insurance Company, Ltd – Trinidad-based company

- Guyana Trinidad Mutual (GTM) Group of Insurance Companies – Guyana-based company
- International health insurance plans:
  - NAGICO – Saint Martin-based company
  - Pan-American Insurance – only provides health insurance indirectly through their personal accident insurance
- There are no local Saint Lucian insurance companies that provide health insurance.

Policy Rationale

Critical to the success of the UHC is a sustainable consistent method of payment. Making the payers of health care subject to certain financial and benefit requirement standards, ensures the solvency of the health plan and the security of the UHCA and the consumers of health care.

Policy Impact

This policy allows for collaboration between Saint Lucia Social Development Fund (SSDF) and the UHCA to where information sharing will allow for appropriate regulation of the benefits offered to consumers.

It will be in the best interest of the healthcare system, the UHC and the consumers to have as many persons registered for Tiers 2 and 3 being able to have private health insurance coverage. With more persons registered under a commercial or private payer, will result in more premium dollars available for covering complex care and conditions requiring overseas care. This will also result in lower cost premiums and more benefits to the consumer. Having the commercial and private payers involved will not only reduce leakage but will result in better solvency of the UHC. The presence of a three-tier arrangement with multiple payers allows for adjustments in each tier to accommodate reduced contribution in any tier, a key mechanism for sustainability.

Emerging Policy Issues

- It will be important to define the authority and role of SSRD vs the role of UHCA in this area. Further negotiations will be necessary as these two authorities will have to work closely.
- Actuarial data analysis to set policy, rates, establish solvency requirements as benefits and coverage changes together with premium payments and management will have to be a major consideration in those cases.
- Government allocation of funds can have a significant impact on private insurance plans' ability to be sustainable as the first tier of payment for coverage is highly dependent on the Government's contribution from taxes. Subject to the terms and conditions set out, it might be difficult to put the Government of Saint Lucia under similar terms as the commercial insurers to ensure that they meet their side of the

contribution. Strong suggestions are given for ensuring that these issues are addressed formally.

Policy Recommendation #3.4: UHC will help consumers to manage their out-of-pocket expenses.

Policy Statement/Description

Currently, close to 40% of healthcare costs in Saint Lucia are paid out-of-pocket, placing significant financial strain on individuals and families. Limited private insurance coverage, coupled with minimal benefits, makes reducing these costs a challenge.

The SPRC model addresses this issue by consolidating payer contributions across three tiers. Under this model, consumers are no longer required to pay healthcare providers upfront. Instead, the UHC will process claims submitted by providers, adjudicate payments, and reimburse them using funds from government contributions (Tier 1) and commercial payers (Tiers 2 and 3). The UHC will then recover these payments through subrogation.

While out-of-pocket expenses will decrease, some costs will remain, such as copayments, deductibles, and payments for brand-name medications when generics are available. Certain labs, diagnostics, and overseas care may also require out-of-pocket contributions.

To mitigate these costs, Health Savings Accounts (HSAs) through banks and credit unions will be encouraged, allowing employers, families, and donors to make tax-deductible contributions, particularly for Tier 3 expenses. Copayments and deductibles can be collected either directly by the UHC or at providers' offices, where they would be deducted from the provider's fees.

UHC members can seek care from public and private providers that agree to participate in the UHCA preferred provider program, subject to co-payments, capitation arrangements and other well-established managed health care programs

- Excludes UHC members on a Co-pay waiver list that is means-based.
- No co-payment for use of public facilities. Private insurance companies will be invoiced for the cost of their qualified plan participants using public health care services.
- Co-payment for the use of private health care services – claims submitted directly to private insurance plans (encounter report to UHCA).

Policy Rationale

As a measure of preparedness to manage health care in any country, high out-of-pocket expenditure is viewed as a barometer indication that a health system is poorly organised to meet the needs of the people.

Policy Impact

Reducing out-of-pocket expenditures to each consumer ensures they will have more money for their other expenses. Out-of-pocket expenditure will become a measure of positive outcomes for UHC and health care transformation.

Emerging Policy Issues

1. Introducing copayments and deductibles, even at low levels, may be perceived as an added financial burden or "tax," conflicting with past promises of free healthcare in Saint Lucia.
2. Establishing an effective system to collect copayments and deductibles could be complex and requires careful planning.
3. Shifting collection responsibilities to healthcare providers may be seen as an added burden, particularly if unpaid copayments are deducted from their reimbursements.

Policy Recommendation #3.5: UHC will develop a model to address complex high-cost catastrophic conditions and overseas care coverage.

Policy Statement/Description

Given Saint Lucia's small population, sustaining facilities and specialist providers for certain complex medical conditions is impractical. To address this, a structured and cost-effective overseas care program will be established. Pre-negotiated contracts and group purchasing with provider networks will reduce costs and ensure timely access to advanced care. UHCA will determine whether to contract directly with providers or through a network, depending on the complexity of the care required.

Efforts will prioritize providing as much care on the island as possible, but for services unavailable locally, prompt decisions will be critical to prevent deterioration and save lives. The cost of overseas care will primarily be covered under Tier 3, utilizing government funding, reinsurance, and philanthropy. Any unused funds from Tiers 1 and 2 will be applied before utilizing the tier 3 funding.

To ensure fairness, a bioethical committee should be established to define clear guidelines for overseas care, including patient eligibility, medical viability, costs, coverage limits, and fund sustainability. Philanthropic contributions and health savings accounts (HSAs) will complement UHC funds where needed.

Policy Rationale

Managing catastrophic and complex care, though expensive, must be systematic and well-planned. Such conditions can exceed the financial capacity of families and insurers, requiring clear policies on what is covered and to what extent. A structured approach will meet patient needs efficiently while controlling costs.

Policy Impact

While primary care remains a focus, catastrophic care can strain resources. Group purchasing and managed care approaches will improve cost efficiency and ensure fund sustainability. Analyzing UHCA and health system data will help plan for future services, enabling Saint Lucia to develop capabilities to treat conditions locally when feasible. Additionally, investments in regional services could attract medical tourism, further supporting the healthcare system. Public-private partnerships should be prioritized for such developments.

Emerging Policy Issues

1. Overseas care leads to significant financial leakage. Balancing cost reduction with the need for high-quality care in advanced centers remains challenging.
2. Decisions about overseas referrals can be contentious, involving resource limitations, political and community pressures, income loss for the local system, and the need to safeguard UHC fund solvency.

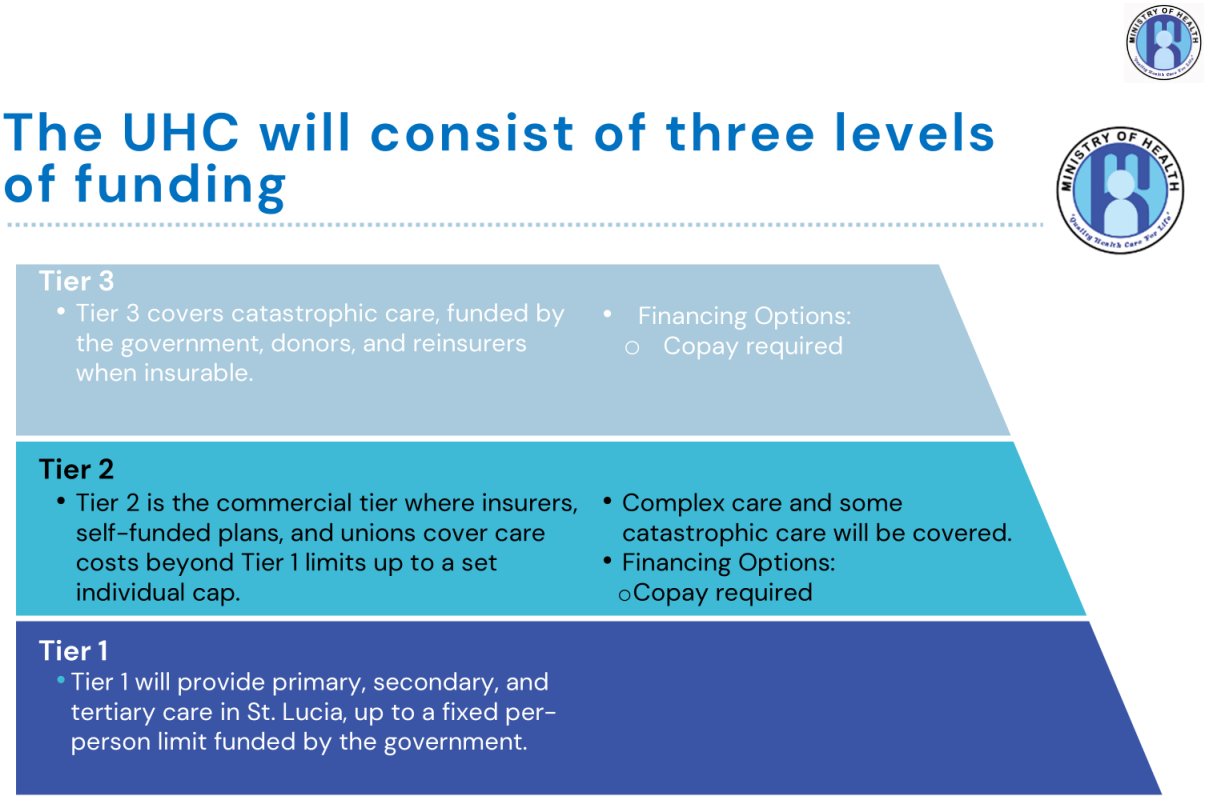


Figure 6: Who funds what in each of the three tiers

Policy Recommendation #3.6: A benefits coverage strategy for Tiers 1 and 2 will need to be developed and adopted.

Policy Statement/Description

Tier 1 Benefits:

Each tier will provide a defined minimum-to-maximum dollar and benefit amount per person annually, serving as the basis for shifting additional payments between tiers. **Tier 1** will primarily cover **primary health care** through capitation payments, where primary care doctors are paid a fixed **per-member, per-month fee (PMPM)** to manage care for an assigned community of patients. Final benefits under this model will be determined in collaboration with the Independent Provider Association (**IPA)** and **UHCA**.

Primary care capitation services may include:

- Wellness and preventive care (e.g., well-child and senior care programs)
- Personal prevention, including surveillance labs and diagnostics (results reported to UHCA).
- Pre-approved and contracted diagnostics and treatments.
- Sick and wellness exams with associated treatments.

Any care required beyond the capitation will be covered up to Tier 1's financial limit, after deducting the annualized capitation cost.

Tier 2 Benefits:

"Macro" Clinical Pathways for Non-Communicable Diseases, Communicable Diseases, Accident and more severe conditions requiring more complex care. This will be the first level of care for complex conditions as they may enter the health system fully well knowing that the ability to provide certain services might be limited.

All services required will be covered by tier 2 up to the maximum dollars spent after tier 1 and before tier 3. To protect the fund, certain copays and deductibles will be put in place as follows:

- Emergency Room Care
- Private Outpatient Services
- Inpatient Services
- Some type of umbrella benefit for unique situations

Services NOT Covered:

Services not covered under each tier will be listed with conditions associated with those services. Most services available in Saint Lucia will be covered up to the dollar limit of each tier but certain services will not be covered. Examples of services not covered would include, but are not limited to:

- Plastic Surgery for Cosmetic purposes
- Transplants
- Certain high-cost medications and diagnostic procedures – may be covered up to a certain limit and patient can cover the remaining out of pocket.
- Certain overseas care covered up to a limit and not covered when services are available in Saint Lucia.

Policy Rationale

Tiers 1 and 2 benefits are estimated to cover 65% and 25% respectively of the cost of care for any individual assuming certain levels of utilisation. The Tiers 1 and 2 benefits will promote primary and secondary care to reduce the burden of catastrophic conditions.

Policy Impact

Tiers 1 and 2 benefit arrangements will result in more persons seeking care and initially, there will be an increased cost, ultimately there will be a relative reduction in catastrophic and complex conditions because of improved wellness care and prevention.

Emerging Policy Issues

1. **Revenue Shortfalls**: During years of reduced income tax collection, government reallocations may strain **Tier 1 coverage**. While Tier 2 can absorb some pressure, there is no guarantee commercial insurers will expand benefits to offset government reductions.
2. **Public vs. Private Sector Balance**: If the private sector grows faster under UHC, this can potentially cause political or community backlash. Introducing benefit plans and **copayments** for private care can help mitigate this while generating additional funding for public facilities.
3. **Provider Challenges**: Managing benefits and payment allocations across both private and public sectors under UHC for providers that work in both systems may create administrative challenges for healthcare providers.
4. **Mandates vs. Incentives**: To ensure participation in Tiers 2 and 3, mandates, incentives, or disincentives may be necessary. Incentives alone may initially be ineffective until the program's value becomes clear. Starting with mandates could provide stability, with adjustments made over time. The UHCA board should have the authority to determine when mandates or incentives are appropriate with or without requiring Cabinet approval or new legislation, provided safeguards are in place.

Policy Recommendation #3.7: A Tier 3 benefit coverage plan will be offered through reinsurance.

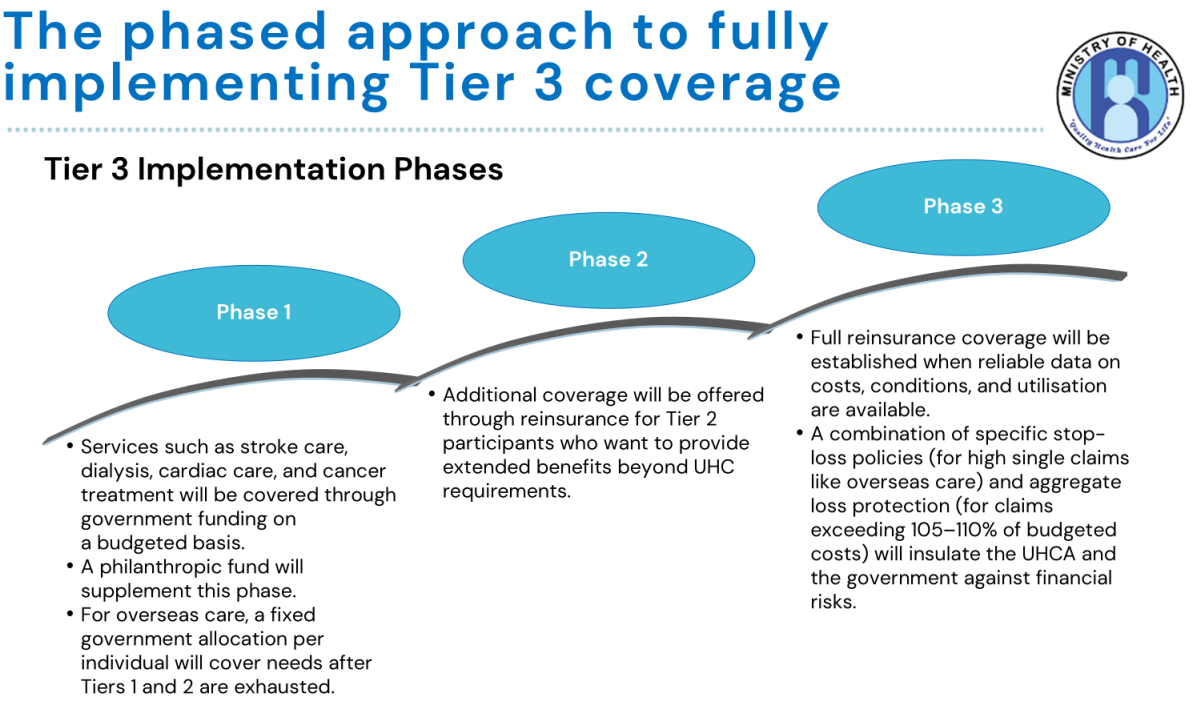


Figure 7: The three phased approach to Tier 3 implementation

Policy Statement/Description

Given current data limitations, implementing full Tier 3 coverage will require a phased approach. Initially, coverage will begin at a basic level and expand as more data and funding become available. An integrated provider information system will be essential to assess risk, costs, and resource needs for complex and tertiary care under UHC.

- **Phase 1:** Services such as stroke care, dialysis, cardiac care, and cancer treatment will be covered through government funding on a budgeted basis. A philanthropic fund will supplement this phase. For overseas care, a fixed government allocation per individual will cover needs after Tiers 1 and 2 are exhausted.
- **Phase 2:** Additional coverage will be offered through reinsurance for Tier 2 participants who want to provide extended benefits beyond UHC requirements.
- **Phase 3:** Full reinsurance coverage will be established when reliable data on costs, conditions, and utilization are available. A combination of specific stop-loss policies (for high single claims like overseas care) and aggregate loss protection (for claims exceeding 105–110% of budgeted costs) will insulate the UHCA and the government against financial risks.

Policy Rationale

Given limited data on utilization, costs, and disease conditions, Tier 3 cannot be fully funded initially. A phased approach will allow data collection to guide benefit coverage, risk management, and funding decisions over time.

Policy Impact

Tier 3 will create an organized, sustainable approach to complex care, including overseas treatment, while reducing out-of-pocket costs for patients and families. It will improve access to essential tertiary and catastrophic care.

Emerging Policy Issues

1. Decisions on what and how much to cover may be perceived as UHCA making life-and-death choices, particularly for conditions with poor prognoses or high costs. Significant public education will be needed.
2. A bioethical committee will need to be established to manage decisions on complex and catastrophic care and will require clear rules, standards, and reliable data to guide operations. No matter the decisions made, stakeholders can view decisions about care as unfair. Given the close family and friendship ties in a small country, it is often difficult to administer certain rules of engagement when it comes to deciding on who should receive care.

Provider Network Development

Policy Recommendations for Provider Network Development

- #4.1: A healthcare system should be established where local providers contract with the Universal Health Coverage Authority (UHCA) through Independent Provider Associations (IPAs), while non-Saint Lucia-based providers contract directly or via pre-approved networks in their respective countries. Providers must operate efficiently and responsibly, securely exchanging digital information with the UHCA and other providers to improve care delivery while complying with privacy and security regulations. Independent entities will ensure providers meet the legal requirements for contracting under the IPA framework. Patients will receive evidence-based care tailored to the local system's capabilities and have accessible, effective mechanisms for reporting grievances and complaints.

- #4.2: This policy defines the role of Independent Provider Associations (IPAs) in Saint Lucia as not-for-profit entities appointed by the UHCA, governed by a board operating under UHCA rules. IPAs will establish membership standards to ensure high-quality care, promote collaboration among providers, and lead efforts in population health management.

- #4.3: Public providers should be organized as independent entities under a Hospital and/or Health Care Authority. While a single Authority for the entire health system would be most efficient in terms of cost and administration, circumstances may warrant the establishment of two separate Authorities: one for hospitals and another for the broader health care system.

- #4.4: The UHCA will utilise its collective strength of organising the providers in an IPA structure to achieve economies of scale, improve data sharing, group purchasing, contracting and promote higher standards of care. It aims to align the interests of all stakeholders—UHCA, providers, payers, and beneficiaries—while fostering efficiency, quality, and equity. A progressive, staged implementation is recommended to ensure success.

- #4.5: Ultimately it is the goal of the UHCA to create and manage fair compensation for the health care providers and the sustainability of the UHCA and the health system.

Introduction

A central objective of the UHC is to enhance access to quality care while advancing and reorganizing Saint Lucia's health care providers to achieve excellence.

Providers are grouped into two categories:

1. **Institution-Based Providers**: Employed and paid by health care facilities (public or private), which are reimbursed by the UHC.
2. **UHC-Contracted Providers**: Independently contracted by UHC and paid directly under established compensation systems.

UHC will drive a new model of collaboration through an **Independent Provider Association (IPA)**. Providers retain independence while benefiting from group contracting to achieve economies of scale, cost-effectiveness, and guaranteed payments for services rendered.

This eliminates siloed care and promotes evidence-based, high-quality delivery, utilizing population-based health care principles.

Provider Organization Goals

- Define all UHC stakeholders interacting with providers or receiving payments.
- Set clear expectations for individual providers and facilities.
- Establish eligibility criteria and contracting processes for providers under the IPA.
- Outline operational, payment, and contracting structures for public and private providers.
- Explore compensation models suited to provider type and services delivered.
- Modernize practices through technology to improve quality, safety, and efficiency.

Provider Ecosystem

1. **Independent Providers**: Contracted directly with UHC for payments.
2. **Institution-Based Providers**: Paid through their employing facilities.
3. **Facilities**: Contract with UHC to deliver services.

This reorganization will meet rising consumer expectations, foster provider collaboration, and ensure a more efficient, sustainable health care delivery system.

Elements of the Ecosystem	Features of the Elements of the Ecosystem
UHC Contracted Professional Healthcare Providers.	This category includes private or public providers (e.g., physicians, specialists, nurse practitioners, and therapists) contracted by the UHC through the **Independent Provider Association (IPA)**. The IPA negotiates service delivery terms with the UHCA, focusing on evidence-based care, efficiency, and collaboration among members. To join the IPA and contract with the UHCA, providers must meet specific quality standards, such as licensing, ongoing medical education, and the ability to share data digitally with other providers and the UHCA. The IPA supports its members' interests while advancing national health system goals. Overseas providers may contract through the IPA or international networks to deliver care locally or via telemedicine. Providers receive direct payments from the UHCA based on their contracts.
Professionals private and public that provide care through an institution and are paid by the institution	These providers, such as physicians, nurses, social workers, and therapists, do not contract directly with the UHC. Instead, the facilities they work for act as the contracting entities, and the UHC reimburses the facility for services rendered. Providers in this category are compensated by the facility itself. For instance, a physician employed at a government hospital would be paid by the facility, not the UHC. Notably, a provider can operate under both independent providers and facility affiliated.
Facilities that contract with the UHC to provide services.	Private or public facilities that contract with the UHC are reimbursed for services rendered, including those provided by professionals employed at the facility. These facilities may align with the IPA or operate independently, such as hospitals or public health authorities. Professional providers bill for their services through the facility. Facilities can either join a separate **Facility IPA** or integrate with the **Professional IPA**.

Provider Network Development Policy Framework

The UHCA will establish a provider contracting entity to set terms, standards, and benchmarks for provider agreements, using data on cost, utilization, service availability, outcomes, and quality. Contracts will be negotiated between the UHCA and IPA(s), resulting in individual agreements with each healthcare entity. The IPA(s) may either directly contract with the UHCA or facilitate agreements between providers and the UHCA; further discussions will determine the most effective model. The IPA will represent providers in negotiations, enabling the implementation of quality standards and performance-based incentives (pay-for-performance) between the UHCA and providers. The IPA board will align public policy goals with provider interests, ensuring the sustainability of the healthcare community.

The IPA can accommodate providers who contract directly with the UHCA or through institutional arrangements, serving primarily as a contract management intermediary between the UHCA and healthcare providers in Saint Lucia.

Goals of Provider Network Development

The network aligns UHC objectives with healthcare delivery needs by ensuring quality, safety, and accessibility of services. The UHCA, as the payer, will implement payment systems that incentivize improvements in care quality, affordability, and access.

Reorganizing Providers for Sustainability

Provider consolidation is critical to achieving sustainability. The Caribbean healthcare system operates in silos, marked by fragmented employment, compensation methods, and payment structures. Existing workforce systems prioritize seniority over merit-based advancement, contributing to dissatisfaction and high attrition rates.

To address this, the UHCA and Health System Authority will promote merit-based workforce development, pay-for-performance incentives, and targeted training. This approach will enhance productivity, quality, and job satisfaction, stabilizing the healthcare workforce—a critical element for systemic sustainability.

Integrating Public and Private Healthcare

Public-private arrangements will promote resource and information sharing without conflicts of interest. Achieving equality between public and private providers will take time, but a phased approach will integrate and align workforce values across both sectors. Under this model, private providers can offer services in the public system and vice versa. Innovative contracting methods will reduce costs, minimize duplication, and address human resource limitations.

By fostering a unified, performance-driven workforce and optimizing contracting models, the UHCA will drive sustainable transformation across Saint Lucia's healthcare system.

Policy Recommendation #4.1:

Set up a health care system in which:

- Local providers contract with the UHCA via one or more IPAs.
- Non-Saint Lucia-based providers contract directly with the UHCA or through pre-vetted networks in their service countries.
- Providers are responsible for operating efficiently and responsibly.
- Providers securely exchange information digitally with the UHCA and other providers to enhance care delivery while adhering to privacy and security laws.
- Independent entities ensure providers meet legal standards for contracting with the UHCA through the IPA structure.
- Patients receive evidence-based care, considering limitations within the local health care system.
- Patients can easily and effectively report grievances and complaints.

Policy Statement/Description

This policy outlines the structure of Saint Lucia's health care delivery network to improve universal access, quality, efficiency, and sustainability of health services. The network includes the following stakeholders:

- **Providers**: Public and private health care facilities and professionals deliver services. Providers contract with the UHCA through an IPA or directly, depending on location, capacity, and performance. Public providers are government-run, while private providers are independently operated.
- **Independent Provider Associations (IPAs)**: Represent and support local providers in contracting with the UHCA, offering technical assistance, training, and quality improvement. While a single IPA reduces overhead, multiple IPAs may accommodate specific groups like primary care providers, specialists, or large organizations. The IPA negotiates contract terms with the UHCA and manages quality standards on behalf of providers.
- **Health Care and Hospital Authorities**: These bodies set policies and oversee hospitals and the health system. Unlike IPAs, they manage public and potentially

private facilities. Caribbean models (e.g., Bahamas, Trinidad, Jamaica) provide examples for this structure, which may require legal adjustments in Saint Lucia.

- **Public Authorities**: Public providers may fall under a Hospital Authority (managing public hospitals offering secondary and tertiary care) and a Primary Health Care Authority (managing public clinics offering primary, preventive, and rehabilitative care).
- **General Physicians (GPs)**: Operating in Primary Health Care Centers (PHCCs), GPs are the first point of contact and act as gatekeepers, assessing needs and coordinating care. Each patient under UHC picks or is assigned to a GP/PHCC to enable population health management and care continuity. Patients can change their GP once a year.
- **Patients**: Beneficiaries of the system, patients can choose providers, access quality care, and voice feedback or complaints. If no provider is chosen, the UHCA assigns one. Standards for switching providers are set by the UHCA.
- **UHCA**: The public agency responsible for financing the health care system and driving policies to improve quality, accessibility, and affordability. While not responsible for licensing, disciplining, or accrediting providers, the UHCA can withhold payments or contracts from those failing to meet standards.
- **Independent Entities**: Government-appointed professional health associations license facilities and professionals, enforce minimum quality standards, and resolve grievances escalated by patients, providers, or payers requiring corrective action.

Policy Rationale

The rationale for reorganizing the health care provider community is to:

- Ensure provider groups are represented based on their functions and needs, promoting consolidation to achieve economies of scale.
- Develop an interoperable information management system for seamless digital information exchange between providers.
- Implement quality measures, evidence-based standards, and compliance frameworks to improve outcomes.
- Enhance population health by ensuring universal access to evidence-based, high-quality care.
- Increase accountability and transparency through clear roles, responsibilities, and robust monitoring, evaluation, and feedback mechanisms.

- Empower patients with provider choice while preventing uncontrolled "provider hopping," ensuring informed consent, decision support, and mechanisms for feedback, as part of a patient bill of rights.
- Support local providers by fostering a conducive operating environment, offering incentives, resources, and assistance to enhance performance and care quality.

Policy Impact

The expected impacts of implementing these policies are:

- Reduced health inequalities, particularly for vulnerable and disadvantaged groups.
- Improved quality, safety, and patient satisfaction in health care services.
- Lower health care costs, reduced inefficiencies, and minimized waste.
- Increased coverage, accessibility, and utilization of health services.
- Strengthened health care workforce, infrastructure, and adoption of innovation and technology.
- Streamlined processes and reduced bureaucracy through provider consolidation while preserving their independence.

Emerging Policy Issues

The potential challenges in implementing these policies include:

- Resistance from providers and stakeholders who perceive threats to their interests, autonomy, or power.
- Concerns about intrusive financial controls, such as standardized pricing.
- Increased transparency potentially leading to higher tax obligations for providers.
- Insufficient prioritization of financial, human, and technical resources to support implementation.
- Complexity and uncertainty in the policy and health care environment, hindering coordination and innovation.
- Data and system gaps limiting effective monitoring, evaluation, and evidence-based decision-making.
- Cultural and behavioral barriers affecting acceptance and adoption by patients, providers, and stakeholders.

Policy Recommendation #4.2: This policy outlines the roles of Independent Provider Associations (IPAs) in Saint Lucia, which will:

- Operate as **not-for-profit entities** appointed by the UHCA, with a board of directors under UHCA rules.
- Establish **membership standards** to ensure high-quality care delivery.
- Foster **cooperation** among members.
- Act as a **driver of population health management**.

Policy Description/Statement

This policy establishes an Independent Provider Association (IPA) as a collective body for Saint Lucia-based providers to negotiate and contract with the UHCA. The IPA can represent both public and private providers or each sector independently, provided they meet membership criteria and quality standards. It will foster collaboration in areas such as medical training, knowledge sharing, policy development, and population health management, working closely with primary health care centers to deliver integrated care.

Key Features and Functions of the IPA:

- **Governance**: The IPA will operate as a private, member-owned entity with a board elected by its members. Non-majority government or public representation may be included to ensure broader stakeholder interests are considered. The board will oversee strategy, finances, and operations and represent the IPA in UHCA discussions.
- **Healthcare Goals**: The IPA will enhance the quality, efficiency, and sustainability of the healthcare system by aligning member incentives with UHC's mission.
- **Membership Standards**: Providers must meet criteria such as accreditation, licensure, training, and ethical conduct to ensure high-quality care delivery.
- **Contracting**: The IPA will negotiate with the UHCA, ensuring member payments reflect care quality and value over volume.
- **Collaboration**: The IPA will support member integration through platforms for knowledge exchange, joint training, referral systems, and shared resources, while promoting population health management through quality monitoring and feedback.
- **Cost Reduction**: The IPA will facilitate joint purchasing of services (e.g., liability insurance, bookkeeping) and medical supplies to lower costs and improve availability.
- **Data Sharing**: The IPA will enforce secure patient data sharing among members to ensure care continuity, reduce duplication, and prevent errors.

By leveraging the collective strength of its members, the IPA will drive improvements in healthcare delivery, efficiency, and outcomes.

Policy Rationale

The policy is based on the following reasons:

- The **IPA will strengthen providers' bargaining power** by enabling unified negotiations with the UHCA, giving them greater influence on UHC policies, system design, and fair payment terms, compared to negotiating as individual entities.
- The **IPA will improve care quality and efficiency** by setting and monitoring standards, promoting adherence to best practices and evidence-based guidelines, and reducing waste and inefficiencies such as duplicate tests, avoidable hospitalizations, and medical errors. Providers will be supported with incentives for quality improvement and innovation to deliver safe, effective, and patient-centered care.
- The **IPA will enhance provider collaboration and integration** by facilitating information sharing, best practices, resource coordination, and seamless referrals across care levels. This will foster teamwork, improve care continuity, and reduce system fragmentation.
- The **IPA will promote population health management** by encouraging a holistic, preventive approach to care. It will assist providers in addressing social determinants of health, managing community health needs, and shifting focus from reactive to proactive care. Providers will also engage and empower patients and communities to take greater ownership of their health and well-being.

Policy Impact

The policy is expected to positively impact Saint Lucia's UHC system and stakeholders by:

- **Enhancing Accountability and Transparency:** The IPA will report member performance and outcomes to the UHCA and the public, enabling monitoring of care quality and holding providers accountable.
- **Improving Sustainability and Affordability:** The IPA will negotiate contracts based on care value and quality, aligning incentives with UHC goals, controlling costs, and ensuring financial stability.
- **Increasing Access and Equity:** The IPA will ensure universal coverage, reducing disparities and barriers regardless of income, location, or health status, while delivering culturally appropriate care.

- **Boosting Satisfaction and Trust:** By fostering better communication between providers, patients, and the UHCA, the IPA will improve patient experience, provider satisfaction, and trust in the system.

Emerging Policy Issues

Challenges to implementation may include:

- Provider Resistance: Some providers may see the IPA as a threat to autonomy, income, or flexibility and resist joining or complying with its standards. Addressing these concerns and highlighting benefits will be key.
- Resource and Capacity Needs: Establishing the IPA requires funding, staffing, and technical resources for administration, contracting, quality monitoring, and population health management.
- Complex Negotiations: The IPA and UHCA must align on payment models, quality standards, reporting requirements, and conflict resolution. Similarly, the IPA must establish clear membership terms, payment formulas, and cooperation mechanisms with its members.
- Risk of Fragmentation: While the IPA aims to foster collaboration, its structure could inadvertently create silos if control shifts within the system. Maintaining consolidation and alignment is critical.
- Cultural and Competitive Barriers: Overcoming provider competition and fostering a collaborative, trust-based culture is essential. The IPA must promote a shared vision and constructive relationships among providers, the UHCA, and other stakeholders.

Additionally, as a representative body, the IPA must balance advocating for providers while supporting UHC's sustainability, which could create tension between care delivery and payment rules.

Policy Recommendation #4.3: Public providers should be organized as independent entities under a Hospital and/or Health Care Authority. While a single Authority for the entire health system would be most efficient in terms of cost and administration, circumstances may warrant the establishment of two separate Authorities: one for hospitals and another for the broader health care system.

Policy Summary

This policy proposes reorganizing public healthcare providers, including hospitals and primary health centres, under a new independent Hospital and/or Health Care Authority. This authority would be funded by UHC for direct care services and by the Ministry of Health for non-direct care functions, such as facility maintenance, medical equipment needs, and

public health initiatives. Payments to providers would be based on services rendered, using cost-accounting principles, rather than relying entirely on direct budget allocations from the Ministry of Health or Finance. While both public hospital facilities (OKEU and St. Jude) currently operate under statutory bodies, a review of their structure and operations is recommended to ensure alignment with this proposed model. A statutory body that oversees both, would result in reduced cost and greater operational efficiency.

Key Changes

- Public providers will transition from Ministry of Health control to governance by independent Authorities accountable to the government but with autonomy over management, budgeting, and service delivery.
- Legislation enabling independent authorities must be implemented to define roles, responsibilities, and oversight mechanisms.
- Public providers can build financial reserves, reinvest profits, and access external funding (e.g., loans, grants) with government approval.
- Staff will be directly employed by the authorities, with flexibility to set employment terms, salaries, and incentives while negotiating with unions.
- Public providers will adhere to the same quality standards and payment mechanisms as private providers and compete for resources and contracts based on efficiency and performance.
- Authorities will facilitate collaboration with private providers, incentivize cooperation, and improve access to alternative funding sources.

Rationale

Organizing public providers under independent authorities will improve patient outcomes and experience, and also improve working conditions for the healthcare work force by:

- Improving responsiveness to system demands, such as disease outbreaks, population aging, and evolving technologies.
- Enhancing resource management by reducing dependency on government budget cycles, enabling timely procurement, infrastructure investment, and better stock management.
- Allowing merit-based staff compensation, boosting morale, productivity, and quality of care.
- Increasing flexibility to adapt, innovate, and foster collaboration with private providers while improving accountability and outcomes.

Policy Impact

- **Government**: Focus shifts to stewardship, regulation, and alignment with national health goals.
- **Providers**: Public and private providers operate collaboratively, improving service efficiency, quality, and sustainability.
- **Staff**: Timely access to resources enhances care quality and staff engagement.
- **Patients**: Greater access to affordable, integrated, and timely care with improved quality and choice.
- **Society**: Improved health outcomes, increased trust, and transparency in the health care system.

Emerging Issues

Challenges to implementation include:

- **Legislative Barriers**: Legal frameworks may require revision, facing delays or resistance from stakeholders.
- **Governance Gaps**: Ineffective management structures could create conflicts of interest or inefficiencies.
- **Financial Risks**: Authorities may face challenges accessing and managing resources, creating fiscal instability.
- **Human Resource Challenges**: Resistance to change, skills gaps, and difficulty retaining qualified staff.
- **Service Quality Concerns**: Maintaining standards, addressing access gaps, and ensuring integration with private providers.

Careful planning, robust governance, and ongoing monitoring will be essential to overcome these challenges and ensure the policy's success.

Policy Recommendation #4.4: The UHCA will utilise its collective strength of organising the providers in an IPA structure to achieve economies of scale, improve data sharing, group purchasing, contracting and promote higher standards of care. It aims to align the interests of all stakeholders—UHCA, providers, payers, and beneficiaries—while fostering efficiency,

quality, and equity. A progressive, staged implementation is recommended to ensure success.

Policy Elements

- **Contracting Providers:** The UHCA will contract public and private providers through IPAs based on negotiated prices and quality standards.
- **Electronic Data Interface (EDI):** Providers must use EDI for data exchange, enabling efficient monitoring, service authorization, billing, and payment processing.
- **Data Sharing:** Providers will share data with each other and the UHCA to identify best practices, improve quality, and manage population health.
- **Level-Appropriate Care:** Incentives will ensure primary care providers deliver basic care, while specialists focus on advanced care. Specialists will be prioritized based on certification and availability.
- **Outcome-Based Payments:** Providers will be reimbursed based on care complexity, quality, and outcomes, using a relative value unit (RVU) model adapted to Saint Lucia.
- **Training and Compliance:** Providers must pursue continuing medical education. Non-compliance may result in payment withholding or contract termination.
- **Accreditation Incentives:** Providers will be encouraged to seek international accreditation (e.g., JCI, ISO) with financial incentives for achieving and maintaining standards.
- **Support for Public Providers:** Public providers will receive preferential treatment during a transitional phase, including reduced or eliminated copayments, to build capacity and competitiveness.
- **Purchasing Strategy:** The UHCA will optimize procurement through group purchasing and inventory management, improving quality while reducing costs.
- **Funding Prioritization:** Resources will shift from unnecessary care to proven, high-quality services following international guidelines and best practices.

Policy Rationale

The policy will:

- Enhance efficiency, transparency, and patient outcomes through improved communication, data sharing, and collaboration.
- Strengthen UHCA's role as a strategic purchaser to align provider performance with UHC goals.

- Foster equity by reducing barriers to care and ensuring fair compensation for providers.
- Improve cost-effectiveness by reducing waste and duplication while focusing on high-value care.

Policy Impact

- **Beneficiaries:** Greater access to affordable, high-quality care with provider choice and improved patient outcomes.
- **Providers:** Stable income, increased capacity, technical support, and improved competitiveness through incentives for performance, training, and accreditation.
- **UHCA:** Reduced administrative costs, improved governance, and strengthened ability to monitor quality and outcomes.
- **Health System:** Enhanced collaboration, streamlined processes, and better resource management across public and private providers.

Emerging Challenges

- **Stakeholder Resistance:** Providers may resist pricing controls, quality monitoring, and EDI adoption, fearing loss of autonomy or market share.
- **Resource Needs:** Significant investments in IT infrastructure, training, and connectivity will be required.
- **Legal Barriers:** Regulatory challenges, conflicts of interest, or unethical practices in procurement and contracting must be mitigated.
- **Data Limitations:** Reliable data and decision-support systems are critical for evidence-based practice and monitoring.
- **Leadership Continuity:** Changes in government or UHCA leadership could disrupt the implementation process, undermining stakeholder confidence.
- **Balancing Interests:** Aligning the goals of beneficiaries, providers, UHCA, and government will require active stakeholder engagement and trust-building.

This policy sets a clear framework to drive efficiency, quality, and equity in Saint Lucia's health care system while addressing emerging risks with careful planning and phased implementation.

Policy Recommendation #4.5: Ultimately it is the goal of the UHCA to create and manage fair compensation for the health care providers and the sustainability of the UHCA and the health system.

Policy Description/Statement

The **UHCA of Saint Lucia** aims to ensure fair provider compensation while promoting quality, efficiency, and equity in the health care system. To achieve this, the UHCA proposes a flexible, outcome-oriented payment approach that aligns incentives with system goals and encourages positive behaviors among stakeholders.

Payment Methods

1. **Fixed Budget**
    - **Description**: Covers all provider costs based on an annual budget.
    - **Advantages**: Simple, predictable payments; adapts annually to system needs.
    - **Disadvantages**: Lacks cost-accounting; limited incentive for efficiency, quality, or outcome improvements. May lead to cost overruns, service delays, and equipment issues.
2. **Fee-for-Service (FFS)**
    - **Description**: Payment per service, typically based on CPT codes or Relative Value Units (RVUs).
    - **Advantages**: Simple billing and clear payment amounts.
    - **Disadvantages**: Encourages quantity over quality; limited cost control. Modified FFS can address some challenges.
3. **Capitation**
    - **Description**: Fixed per-patient payment (PMPM) for defined services within a contracted period.
    - **Advantages**: Promotes overall patient health management; predictable revenue for providers; reduces out-of-pocket costs for patients.
    - **Disadvantages**: Financial risk for providers if care costs exceed payments; may reduce care provision without proper monitoring.
4. **Episode-Based Payment (Bundled Payment)**
    - **Description**: Payment for a specific episode of care (e.g., by Diagnosis-Related Groups).

- **Advantages**: Encourages care coordination; predictable payments for hospitals and UHCA; shared risk ensures sustainability.
- **Disadvantages**: Defining episodes can be complex; disputes over episode scope may arise.

5. **Pay-for-Performance (PFP)**
    - **Description**: Incentives for meeting performance measures; payments adjust based on outcomes.
    - **Advantages**: Drives quality improvement without mandates; focuses on measurable outcomes.
    - **Disadvantages**: Requires robust data management; may prioritize measurable outcomes over unmeasured care aspects.
6. **Shared Savings**
    - **Description**: Providers share in cost savings achieved through effective care management.
    - **Advantages**: Rewards cost-effective care; potential for increased earnings.
    - **Disadvantages**: Financial risk if costs exceed targets; risk of compromising care quality to cut costs.

The payment system must incentivize positive behavior, ensuring high-quality, cost-effective care delivery while improving patient outcomes and satisfaction.

Within the UHC, a **blended payment approach** will be used to align the goals of improving access, quality, and affordability with fair compensation for providers. Payment methods will be tailored based on provider type, market conditions, risk, and desired outcomes.

Proposed Payment Approaches

1. **Public System Transition to Cost-Accounting**
    - Shift from budget-based payments to a cost-accounting model where procedures are priced under a charge master system.
    - Medical coding for diseases and procedures will occur at the point of service, ensuring hospitals are reimbursed by the UHC for services rendered.
    - Collaboration with the Ministry of Health and Ministry of Finance will support the transition under health care or hospital authorities.
2. **Hospitals**

- Operate under a **fixed budget** model with bonuses for meeting criteria such as volume, quality, and EMR utilization.
- Hospitals will submit billing/claims data to the UHCA for monitoring productivity and service delivery.
- Facilities involved in medical training will receive additional structural funding through UHC contracts.

3. **Laboratories**
    - Paid **per test performed** (fee-for-service) with incentives for collaborating with ordering physicians to ensure tests meet best practice standards.
4. **Pharmacies**
    - Compensated with a **fixed markup** on the import price of medications.
    - Incentives will be provided for reducing unnecessary drug use, particularly in multi-drug situations.
5. **Primary Health Care Centers (PHCCs)**
    - Paid through **capitation** as gatekeepers of the health system.
    - Additional incentives (e.g., shared savings) will be tied to:
        - Patient referral rates to specialists.
        - Medication and diagnostic test usage.
        - Process and outcome indicators for NCD prevention and treatment.
    - PHCCs will serve as hubs for population health management initiatives.
6. **Bundled Payments for Provider Groups**
    - Groups of providers can coordinate care around specific health problems (e.g., stroke care) and negotiate **episode-based payments** for delivering a comprehensive care package, promoting resource alignment and coordination.
7. **Other Providers**
    - Payment methods will be determined based on specific goals, services, and benefits for each provider group.
    - International insurers will be authorized to operate in Saint Lucia, and their policies honoured at participating UHC providers.

The UHCA will regularly review and adjust payment methods in consultation with providers to ensure alignment with UHC priorities and the evolving needs of the health care system.

Policy Rationale

Adopting a flexible and differentiated payment approach addresses existing challenges while creating opportunities for healthcare transformation:

- Current public-sector payments rely on outdated rates and patterns, failing to reflect actual costs, quality, or outcomes of care.
- Existing methods lack sufficient incentives for providers to improve efficiency, responsiveness, and quality of care.
- Limited collaboration between providers across sectors causes fragmentation, duplication, and gaps in service delivery.
- The UHC presents an opportunity to introduce payment methods that align financial incentives with goals such as universal coverage, quality improvement, prevention, and health promotion.
- The UHC framework encourages provider engagement through a transparent, participatory process, enabling mutual learning, feedback, and adjustments.

Policy Impact

The policy is expected to yield significant benefits for the healthcare system and stakeholders in both the short and long term:

- **UHCA:**
    - Ensures efficient and dynamic allocation of UHC funds by aligning payments with actual costs, quality, and outcomes.
    - Allows periodic reviews and adjustments to maintain relevance, moving away from outdated fee schedules.
- **Providers:**
    - Promotes fair compensation that reflects goals, performance, and organization.
    - Creates a motivating environment by rewarding quality improvement, collaboration, and innovation.
- **Population:**
    - Improves accessibility and affordability of care by eliminating financial disincentives.

- Encourages patient-centered care by incentivizing providers to deliver high-quality, responsive services tailored to patient needs.

- **Healthcare System:**
    - Supports integration and coordination of services across providers, fostering alignment across all care levels.
    - Builds a more sustainable and resilient system by driving transformation in line with UHC goals and national health priorities.

Using cost-accounting methodologies, UHC will implement Stratified Pooled Risk Coverage (SPRC), where government funding covers initial costs, and commercial payers assume secondary tiers. Reliable IT systems and accurate costing will help define benefit terms and payment limits for each payer.

Emerging Policy Issues

Key challenges to implementation include:

- **Data Gaps:** Limited reliable data on costs, quality, and outcomes may hinder the design and monitoring of payment methods.
- **Provider Resistance:** Some providers may view the policy as a threat to autonomy, income, or reputation, leading to mistrust of the UHC system.
- **Complexity:** Diverse payment methods may create confusion among stakeholders and require significant administrative capacity and technical expertise.
- **Unintended Consequences:** Risks include under-provision, over-provision, fraud, or abuse, as some providers may exploit system incentives.
- **Stakeholder Communication:** Continuous engagement and collaboration among UHCA, providers, and beneficiaries will be critical for acceptance and smooth implementation.

Effective communication, robust data systems, and careful monitoring will be essential to overcome these challenges and ensure the success of the policy.

Development of the Health Care Sector and Population Healthcare Management

Policy Recommendations for Development of the Health Care Sector

- #5.1: Defining the population that will receive services under the UHC infrastructure and how such services will be covered based on various cohorts in the population.
- #5.2: Supporting consumerism in health care through a patient-centred approach to care, health education, patient bill of rights and stakeholder involvement.
- #5.3: Developing the Health System around Value-based and Managed Health Care Principles. Even though these concepts are not as well developed in the region, without them, sustainability could not be achieved.

Introduction

The **Universal Health Coverage (UHC) project** in Saint Lucia marks the beginning of a transformative era in healthcare, aiming to strengthen the health system by improving **access, affordability, and service delivery**. The vision for **2035** is a fundamental shift from a reactive system focused on curing illnesses to a **proactive model** that prioritizes both treatment and health maintenance.

A key determinant of UHC's success will be the **clear definition of the covered population**, including citizens and non-citizens accessing care, and the restructuring of the health system to consolidate the population as a unit. This consolidation enables better prediction of trends, cost management, resource allocation, and risk mitigation, reducing the likelihood of catastrophic health events driving individuals into poverty. Proactive **prevention, wellness programs, and disease surveillance** will play a critical role in managing primary, secondary, and tertiary care.

Key Areas for Implementation

1. **Safety Net Coverage**: Identify and provide coverage for the poor and vulnerable using means-testing methods.
2. **Payment Methodology**: Implement payment systems for those who can afford care, with means testing for individuals unable to pay.
3. **Service Definition**: Clearly outline available service lines, care centers, and capabilities for local care, and contract care needed overseas, through telemedicine, or via visiting specialists.
4. **Patient Rights**: Establish a **Patient's Bill of Rights** and introduce an ombudsman to resolve disputes efficiently.
5. **Cost Management**: Address issues related to **copayments and out-of-pocket expenses** in both public and private health systems.

Achieving this vision requires careful planning, education, and change management to ensure a seamless transition to a comprehensive, sustainable, and equitable healthcare system for Saint Lucia.

This vision requires a comprehensive set of policies, grouped into four key areas:

- Health Education and Preventive Care
- Systemic Reforms – Strengthening the Health System
- Quality Standards and Accessibility
- Human Resources Development

Element 1. Health Education and Preventive Care	It is recommended that policies on Health Education and Preventive Care be developed to empower citizens with knowledge about their health and the impact of lifestyle choices. Increased funding for preventive services—such as regular check-ups, screenings, and vaccinations—will enable early detection of health issues and promote healthier living. A new provider arrangement and compensation system is proposed, using a pay-for-performance model where providers are rewarded for achieving better outcomes and prioritizing wellness and prevention. Under this system: Preventive care services will be free at the point of delivery, encouraging consumers to visit their providers regularly. Patients will no longer have to choose between essential health care and other financial needs, such as their children's school supplies. This approach ensures accessibility, reduces financial barriers, and fosters a proactive culture of health and well-being.
Element 2. Systemic Reforms	It is recommended that the health care system reforms be tied to the UHC implementation. Reforms in the health system will include but not limited to the following transformation initiative: 1. Implementation of a Hospital and Health System Authority. 2. Implementation of Provider Information System that is integrated at all levels and in various settings in the health care system.

	3. Increased investments in health care systems, infrastructure, and human resources to advance health care using modern creative financing methods with a strong equity plan to impact the gap in debt to GDP ratio and sustainable value. 4. Reforming the payment system to providers to provide security and sustainability. 5. Shifting the health care system towards a more private-public collaboration and consolidation to achieve economies of scale, lower cost, more efficiency, and sustainability. Shifting the health care system to a cost-accounting system where medical coding and information technology becomes central to costing, payment and procurement systems.
Element 3. Quality Standards and Accessibility	It is recommended that all healthcare stakeholders receive **education and training** in key areas, including: • **Accountability** and **quality standards** • **Access to services** and **transparency** • **Fair governance**, external reviews, and accreditation • **Utilization review** to minimize waste and inefficiencies. • **Key performance indicators (KPIs)** and outcome measurement **Research and education tools** will be implemented to monitor and evaluate these activities effectively (see section on Research)
Element 4. Human Resources Development	Though UHCA will play no role in employing healthcare personnel, there is a need to strengthen **Human Resource Development** in Saint Lucia's healthcare sector by prioritizing **continuous training** for healthcare professionals and creating an **attractive, competitive work environment**. This includes enabling the sector to offer improved salaries and working conditions to attract and retain skilled staff. These efforts will ensure consistent national standards across job roles, preserve institutional knowledge of the local health system, and promote cultural sensitivity in patient care.

The framework focuses on creating a **high-quality, accessible, and sustainable** healthcare system, with the UHCA as the driver for transformation through sustainable financing. Key elements include:

1. **Health Education and Awareness**: Implement school and community programs to promote healthy lifestyle choices, including nutrition, exercise, mental health, and substance abuse prevention.
2. **Preventive Care**: Increase funding for check-ups, screenings, and vaccinations, ensuring accessibility through low or no-cost incentives for providers.
3. **Shared Savings Programs**: Reward healthcare providers for improving patient health and reducing expensive treatments and hospitalizations.
4. **Digital Health Records**: Establish an integrated digital health record system with training to enhance care coordination and information sharing.
5. **Hospital Management**: Foster public-private hospital collaboration, share resources, and implement quality standards to ensure high-quality care.
6. **Rehabilitation Services**: Expand funding for home care and community-based rehabilitation to improve post-hospital recovery.
7. **Telemedicine**: Invest in telemedicine infrastructure to connect residents with specialists locally and internationally.
8. **Healthcare Workforce**: Offer continuous training and competitive salaries to attract and retain skilled healthcare professionals across the healthcare sector.
9. **Regional Cooperation**: Build partnerships with regional hospitals to share resources, expertise, and best practices. This includes Guyana where a cancer treatment Centre of Excellence is located, and OECS countries like Antigua and Martinique that have strong health systems.

These reforms emphasize **education, prevention, digital transformation, and collaboration**, ensuring better decision-making, reduced waste, and improved health outcomes for all Saint Lucians.

Policy Recommendation #5.1: Defining the population that will receive services under the UHC infrastructure and how such services will be covered based on various cohorts in the population.

Policy Statement/Description

Categories of Covered Persons under UHC

1. **Cohort 1 – Safety Net Population:** Citizens with insufficient or no income to pay for premiums or services. The Government will fund their care, supplemented by private sector contributions and fundraising.
2. **Cohort 2 – Insured Individuals/Groups:** Citizens with commercial health insurance or employer-funded plans. Tier 1 benefits are covered by the Government, while Tier 2 and 3 benefits are funded through their insurance.
3. **Cohort 3 – Non-Citizen Residents:** Includes international students, consultants, and transient individuals residing in Saint Lucia for 60 days or less who do not pay taxes.
4. **Cohort 4 – Visitors and Diaspora/ Expatriate Saint Lucians:** Short-term visitors and Saint Lucians resident abroad (in country for less than 60 days) with international/travel insurance or who pay directly for healthcare services.
5. **Cohort 5 –** Individuals covered under arrangements outside of government and commercial insurance, such as NIC or property and casualty insurance, will still be included if they are citizens.

Policy Rationale

Saint Lucia's UHC program ensures universal access to Tier 1 care funded by the Government while promoting sustainability through public-private collaboration. Those with private insurance can access additional benefits (Tier 2 and 3), ensuring more healthcare dollars remain in the local system and reducing out-of-pocket costs. This model supports the growth of the health insurance industry while capturing additional funds for the healthcare system.

Policy Impact

- Encourages private sector participation alongside Government funding.
- Shifts insured individuals from reimbursement-based payments to a system where the UHC directly manages payments.
- Reduces healthcare dollar leakage, keeping funds within Saint Lucia's health system except when services must be sourced abroad.

Emerging Issues

Public sector skepticism toward private sector collaboration remains a challenge, despite existing examples of successful partnerships in Saint Lucia. Strengthening trust and cooperation will be essential for the policy's success.

Policy Recommendation #5.2: Supporting consumerism in health care through a patient-centred approach to care, health education, patient bill of rights and stakeholder involvement.

Policy Statement/Description

The UHC aims to ensure **affordable, available, and accessible** healthcare in Saint Lucia through a **patient-centered care model**. Collaboration with stakeholders is essential for policy development, implementation, and public education. Programs will address wellness, prevention, safety, critical illness management, and disease surveillance for conditions such as stroke, cardiovascular disease, cancer, hypertension, diabetes, and communicable disorders. **Information technology** will be established across the health system to support these efforts.

Key Initiatives:

1. **Patient Bill of Rights**: A Bill of Rights will promote transparency, advocacy, and patient participation, with pay-for-performance incentives linked to provider compliance.
2. **Patient Access to Information**: A **patient portal** will enable communication with healthcare providers, fostering better outcomes and quality care.

Policy Rationale

Placing the **patient at the center** of healthcare transformation builds trust in providers, institutions, and the system. Treating patients as active participants is essential for system success.

Policy Impact

A **consumer-driven healthcare model** will foster national pride and economic growth. It will create jobs in social services, health IT, administration, patient care coordination, and technical fields, strengthening Saint Lucia's economy.

Emerging Issues

- Resistance to family and patient involvement in care decisions, such as questioning medications, treatments, or diagnosis.
- Challenges in implementing patient privacy standards and electronic communication systems.
- Need for clear standards on **informed consent** and patient information sharing.

Ensuring transparency and active patient participation will be critical for the success of Saint Lucia's UHC system.

Policy Recommendation #5.3: Developing the Health System around Value-based and Managed Health Care Principles. Even though these concepts are not as well developed in the region, without them, sustainability could not be achieved.

Policy Statement/Description

To ensure **UHC sustainability**, a value-based healthcare system will be implemented, where **lower costs** combined with **better outcomes** equal higher value. In a resource-limited environment, consolidating funding is insufficient without **efficient management** through a **managed care approach**. This involves:

- Prioritizing **prevention** to avoid costly catastrophic events.
- Organizing **primary care providers** into networks with compensation models tied to outcomes and quality.
- Managing end-of-life care, determining the system's capacity for complex cases, and identifying when overseas care is necessary.
- Utilizing **prearranged overseas care** and group purchasing to ensure cost containment and quality management.

Policy Rationale

For healthcare transformation to be sustainable, measurable value must be demonstrated by linking **investment** to **improved outcomes**.

Policy Impact

Under this model, Saint Lucia will transition to a **high-tech, efficient healthcare system** led by skilled administration. Research and education will serve as cornerstones, fostering opportunities to train a new generation of healthcare workers. Partnerships with educational institutions will support growth in the education sector and attract grants.

Emerging Issues

- Measuring **outcomes** to establish value in healthcare remains challenging, particularly in systems seeking quick wins.
- Without measurable results, political and public dissatisfaction may grow, undermining the UHC's success.

Clear metrics, discipline, and a focus on long-term value will be essential to overcoming these challenges and ensuring system sustainability.

UHC Information Technology System Policy

Policy Recommendations for the UHC Information Technology System Policy

- #6.1: Considering Saint Lucia's Data Protection Act, the GoSL is advised to integrate global IT standards with appropriate modifications to ensure the health system achieves accreditation and can communicate with international health financing systems.

- #6.2: The Government is advised to adhere to the global IT principles JIPA and the health care and IT leadership has identified as critical standards for effective health data management and health-related IT systems. The internationally accepted standard nomenclature for Interoperability in the health care IT world is, Health Level 7 (HL7).

- #6.3: The Government is advised to adhere to recommendations for the following Internal & External Health Care Information Technology (IT) Blueprint.

Introduction & Policy Framework

For healthcare transformation in Saint Lucia, a robust, **fully integrated Health Care Information Technology (IT) system** is essential. This system must address all key components of the healthcare system, enabling comprehensive, **360-degree IT infrastructure** to support UHC.

Policy frameworks will focus on **costing, acquisition, care management, service delivery, operations, implementation, data tracking, privacy, security**, and **risk management**. These policies will facilitate efficient information sharing and exchange among members, providers, and payors, while ensuring **interoperability**, clear rules of engagement, and contingency plans to address adoption barriers.

Key Areas of Focus

1. **Gold Standard IT Principles** for the Government of Saint Lucia's Health System.
2. **Blueprint for Internal and External Integrated 360° Health Care IT Systems** to enable seamless data exchange and decision support.

3. **Adoption, Acquisition, and Implementation** guidelines for IT systems.

Risk Management

The accompanying project plan outlines potential **IT implementation risks** with mitigation strategies and contingency plans. Relevant risks and recommendations are included to support successful policy adoption and execution.

This integrated IT infrastructure will be critical for the successful management and transformation of Saint Lucia's healthcare system under UHC.

Prioritisation Measures

To Optimize the prioritisation, we are using the following metrics and corresponding statuses:

- Impact Severity if not managed or resolved.
    - Catastrophic
    - High
    - Medium
    - Low
- Priority
    - High
    - Medium
    - Low
- Likelihood of Occurrence
    - High
    - Medium
    - Low

IT Behavioural Principles and how they will apply to IT Planning and Implementation:

To address risks and challenges during the development and implementation of Saint Lucia's National Health Insurance IT systems, the following process will be used:

1. **Identification**: Assign the identified risk or challenge to a team member for monitoring and contingency planning.
2. **Discovery**: Analyze the issue, its impact on implementation, and any required education or interventions for stakeholders, considering local perspectives.
3. **Research**: Conduct research on the challenge and potential solutions.
4. **Resolution Development**: Create comprehensive risk mitigation and contingency plans.

5. **Stakeholder Consultation**: Present solutions to stakeholders for input, refinement, approval, and next steps.
6. **Approval**: Secure approval from critical decision-makers as required.
7. **Implementation**: Execute the approved resolution plans.
8. **Measure & Monitor**: Use metrics to monitor and control risks, ensuring effective implementation.
9. **Human Resource Development**: Address the scarcity of local Health IT talent by developing sustainable programs for IT development, implementation, and management.

Systems

The list of addressable systems includes but is not limited to:

1. Clinical Management Information System and Electronic Medical Records System (EMR)
2. Hospital Information Systems
3. Practice Management Systems
4. Project Management
5. Provider, Payor & Member CRM
6. Care Coordination
7. UHC Administration
8. Third-party Administration and Claims Management

Gold Standard IT Principles for Government of Saint Lucia's Health System

Policy Recommendation #6.1: Considering **Saint Lucia's Data Protection Act** and the as yet not passed **Health Records Bill**, the GoSL is advised to integrate **global IT standards** with appropriate modifications to ensure the health system achieves accreditation and can communicate with international health financing systems.

Key International Standards:

1. **HIPAA** (Health Information Portability and Accountability Act):
    - Includes **Transaction**, **Compliance Standards**, and **Data Protection Regulations** for secure data collection and accountability.
    - Expanding the Saint Lucia Data Protection Act to align with HIPAA will strengthen health data management and equip the UHCA and health system for effective operations.

2. **GDPR** (General Data Protection Regulation):
    - A robust EU-originated framework ensuring compliance with international data protection and privacy requirements.

These standards are critical for managing health data securely, fostering interoperability, and positioning Saint Lucia's health system for global alignment.

Policy Statement/ Description:

JIPA proposes a **customized adoption** of select elements from the **Health Information Portability and Accountability Act (HIPAA)** and the **General Data Protection Regulation (GDPR)**. This approach expands Saint Lucia's **Data Protection Act (SLPA)** to specifically address **health data** needs, aligning with international best practices while tailoring to Saint Lucia's unique context.

- **HIPAA (US-based)**: Recognized globally as the gold standard for protecting sensitive health information, HIPAA sets rules for safeguarding patient data, including IT systems and day-to-day interactions with health records.
- **GDPR (EU-based)**: A comprehensive data privacy law focused on data collection, storage, and accountability, applicable to organizations managing EU patients' data.

Given the debate surrounding **US vs. EU standards**, JIPA emphasizes integrating elements from both frameworks, relying heavily on Saint Lucia's **existing legislation** for further refinement. Substantial alterations will ensure the standards meet Saint Lucia's unique needs, and **gradual adoption** is recommended to facilitate enforcement and provider compliance.

Policy Impact

- Establishes a **clear roadmap** for protecting sensitive health information as health IT systems evolve.
- Defines **rules of engagement** for providers and health workers, ensuring accountability in safeguarding patient data.
- Promotes **patient access** to their health records and control over data sharing, aligning with a **Patient Bill of Rights**. This improves information flow, reduces medical errors, and prevents unnecessary duplication of tests, diagnostics, and treatments.

HIPAA-Informed Guidelines for PHI Use and Disclosures

Introduction

These policies and procedures provide clear guidelines for handling, safeguarding, and disclosing **Protected Health Information (PHI)**. Health providers and entities are required to ensure patient privacy, adhering to established protocols to protect sensitive data.

PHI refers to all information (oral, paper-based documents, and electronic documents) that relates to an individual including but not limited to:

- Medical information
- Billing information
- Financial information
- Names and other identifying information such as:
    - Telephone numbers
    - Fax numbers
    - Electronic Mail addresses
    - Unique IDs
    - Medical record numbers
    - Master Patient Index (MPI)
    - Birth date
    - Date of death
    - Health plan beneficiary numbers
    - Account numbers
    - Certificate/license numbers
    - Vehicle identifiers and serial numbers, including license plate numbers.
    - Device identifiers and serial numbers
    - Full face photographic images and any comparable images
    - Any other unique identifying number characteristic, or code

Minimum Necessary Standards

Guidelines for Use and Disclosure of Protected Health Information (PHI)

1. **Minimum Necessary Standard**: Health service providers must make reasonable efforts to limit the use or disclosure of PHI to the **minimum necessary** to achieve the intended purpose.
2. **Exceptions to the Minimum Necessary Standard**: The standard does not apply in the following situations:

- Disclosures required by law.
- Disclosures made directly to the individual.
- Disclosures authorized by the individual.
- Disclosures to healthcare providers for treatment purposes.
- Disclosures to the Saint Lucia Public Health Authority and Ministry of Health (with limitations).
- Disclosures required for compliance with GDPR and adopted international standards.

3. **Key Considerations Before Disclosure**: Before using or disclosing PHI, ask:
   a. **How much information** is needed to fulfill the request?
   b. **Is any unnecessary information** being shared?

Example: If NIC requests documentation for a work injury (e.g., a broken arm), unrelated information, such as HIV status, should not be disclosed as it could negatively impact the patient's privacy.

Use and Disclosure for Specific Purposes

1. Treatment

- PHI may be used or disclosed to appropriate healthcare providers for patient treatment or medical services.
- The identity of anyone requesting PHI must be **verified**, and proper documentation provided to confirm their qualification for access.
- Health service providers must also confirm the **requester's authority** to access the PHI.

Requests by Public Officials:

- Verify identity using reasonable evidence (e.g., agency letterhead, ID badge).
- Confirm legal authority through written documentation describing the basis for the request.

2. Healthcare Purposes

PHI may be disclosed to authorized personnel for:

- Reviewing treatments and services.
- Evaluating provider performance in patient care.

3. Deceased Individuals

PHI may be disclosed to family members or individuals involved in the deceased's care unless this conflicts with the deceased's prior expressed wishes.

4. Serious Threat to Health or Safety

PHI may be disclosed to prevent a serious threat to a patient's health, safety, or the public, but only to those capable of mitigating the threat.

5. Required by Law

Providers must disclose PHI when legally mandated.

6. Permitted by Law

PHI may be disclosed to law enforcement officials for:

- Investigations of criminal conduct or crime victims.
- Compliance with court orders.
- Emergency circumstances.

These guidelines ensure the responsible handling, use, and disclosure of PHI while maintaining patient privacy and compliance with legal standards.

Recommendations for Accountability

Introduction

The General Data Protection Regulations created by the European Union provides a gold standard approach to accountability of health service providers and entities.

The European Union has put in place steep penalties for violations or non-compliance in protecting PHI. While UHC limits certain mandates, penalties and fines for non-compliance serves as a deterrence among health service providers and entities, therefore increasing the likelihood of compliance and enforcement.

Policy Recommendation #6.2: The Government is advised to adhere to the global IT principles JIPA and the health care and IT leadership has identified as critical standards for effective health data management and health-related IT systems. The internationally accepted standard nomenclature for Interoperability in the health care IT world is, Health Level 7 (HL7).

Policy Statement/ Description:

Interoperability and HL7 Standards

The **Healthcare Information and Management Systems Society (HIMSS)** defines interoperability as the ability of systems to **exchange and use health information** securely across organizational boundaries to improve healthcare delivery.

HL7 (Health Level Seven) is a globally recognized set of **messaging standards** for the transfer and sharing of administrative and clinical data, such as laboratory results, medical images, and patient demographics. Developed and maintained by **HL7 International** (an ANSI-recognized, non-profit organization), HL7 establishes the structure, language, and data types required for seamless integration between health IT systems.

Why HL7?

Healthcare systems—like Hospital Information Systems (HIS), Laboratory Information Systems (LIS), Electronic Medical Records (EMR), and Radiological Picture Archiving and Communication Systems (PACS)—generate data in **different formats**, creating communication gaps and inefficiencies. HL7 resolves these issues by enabling **standardized integration** and real-time communication across systems, resulting in:

- Reduced healthcare costs.

- Automated processes and workflows.
- Improved access to real-time information.

Impact of HL7 Adoption

- Provides a **single source** for clinical data architecture templates across multiple document types.
- Helps program analysts and policy managers understand the use of Clinical Document Architecture (CDA) templates across implementations.
- Enhances care continuity through **portability and interoperability**, improving the transfer of care between stakeholders.

HL7 standards are grouped into reference categories:

Section 1: Primary Standards - Primary standards are considered the most popular standards integral for system integrations, interoperability and compliance. Our most frequently used and in-demand standards are in this category.

Section 1a: Clinical Document Architecture (CDA®) - Clinical Document Architecture (CDA®) Products

Section 1b: EHR - Electronic Health Records - These standards provide functional models and profiles that enable the constructs for the management of electronic health records.

Section 1c: FHIR® - FHIR® – Fast Healthcare Interoperability Resources

Section 1d: Version 2 (V2) - Version 2 (V2)

Section 1e: Version 3 (V3) - HL7 Version 3 (V3) - a suite of specifications based on HL7's Reference Information Model (RIM)

Section 1f: Arden Syntax - The Arden Syntax is a formalism for representing procedural clinical knowledge to facilitate the sharing of computerized health knowledge bases among personnel, information systems and institutions.

Section 1g: CCOW - HL7 Clinical Context Management Specification (CCOW) is aimed at facilitating the integration of applications at the point of use, as a standard for both internal applications programming and runtime environment infrastructure that complements HL7's traditional emphasis on data interchange and enterprise workflow.

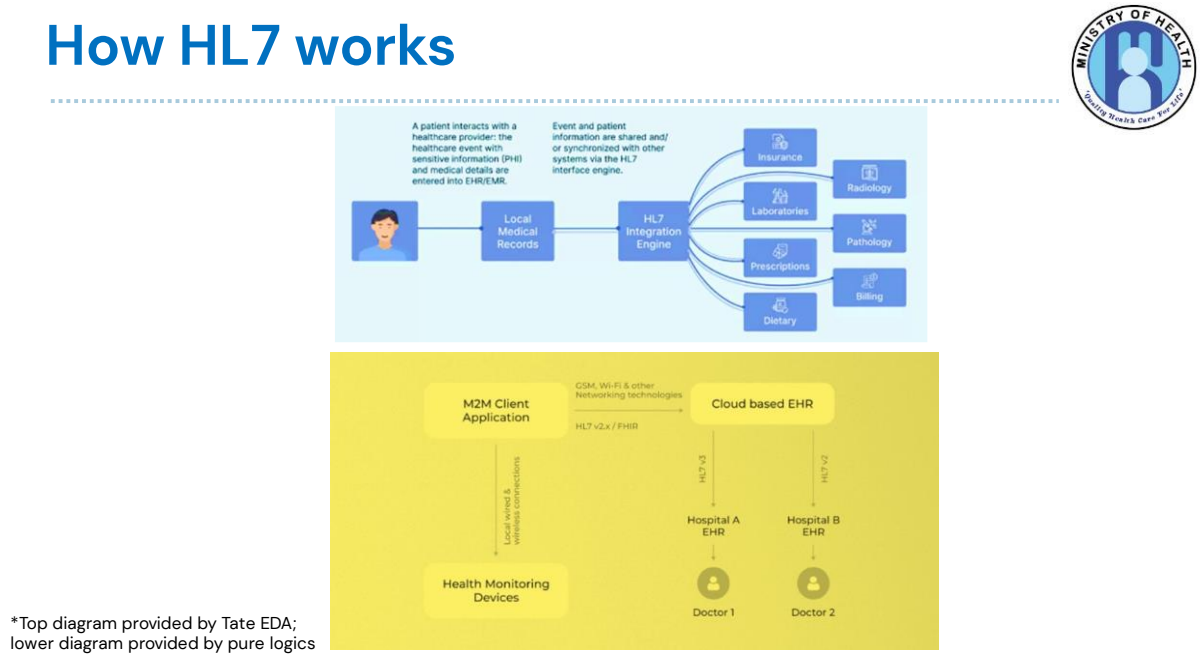
Section 1h: Cross-paradigm/Domain Analysis Models - Cross-paradigm/ Logical Level Standards e.g. Domain Analysis Models

Section 2: Clinical and Administrative Domains - Messaging and document standards for clinical specialties and groups are found in this section. These standards are usually implemented once primary standards for the organization are in place.

Section 3: Implementation Guides - This section is for implementation guides and/or support documents created to be used in conjunction with an existing standard. All documents in this section serve as supplemental material for a parent standard.

Section 4: Rules and References - Technical specifications, programming structures and guidelines for software and standards development.

Further access to the detailed HL7 standard recommendations is included in the references.



*Top diagram provided by Tate EDA; lower diagram provided by pure logics

Figure 8: How HL7 works

External and Internal Integrated 360 Health Care IT System Blueprint

Policy Recommendation #6.3: The Government is advised to adhere to recommendations for the following Internal & External Health Care Information Technology (IT) Blueprint.

Policy Statement/ Description

In keeping with the Government's desire to make Saint Lucia into a digital economy and with the need for advanced information technology to implement UHC and strengthen the health system, JIPA Network recommends the following elements for the UHC information system:

Elements	
Element 1 UHC Information System	This system serves as the backbone for UHC implementation. It features a comprehensive **stakeholder database**, housing critical **policy and procedural documents**, project management tools, and **timelines** with defined goals and objectives. Key functionalities include: • **Customer Relationship Management (CRM)** and project tracking to monitor progress. • Assignment of responsibilities to key personnel for smooth operations. • A **registration system** under review for potential integration or use in developing future registration platforms. • **Patient and provider management systems** to streamline patient flow and triage processes once UHC is live.

Element 2 Provider Management Information System	The **Provider Management Information System** includes **Hospital Information Systems** and **Professional Information Systems** deployed at the point of care.
	• **Hospital Information Systems**: Focused on **financial management** and operations, these systems include:
	  • Costing and charge master
	  • Revenue cycle management
	  • Appointments and scheduling
	  • Electronic Health Records (EHR)

	• Nursing and order entry • Diagnostics, radiology, and labs • Pharmacy and other critical operational components • **Professional Information Systems**: Designed for **physicians** and ancillary medical professionals, these systems feature: • Electronic Medical Records (EMR) • Practice management • Revenue cycle management • Connectivity to EDI, labs, pharmacy, radiology, and other systems These systems ensure seamless integration of clinical, operational, and financial workflows, supporting efficient care delivery.
Element 3 TPA & Insurance Management System	The third-party administration (TPA) and Insurance or Payer Management Information System consists of the financial system that runs the back end of the UHC for the purpose of payment claims submitted by providers, managing member, provider, benefits, contract information and transactions. It performs certain adjudication functions when rules of benefits administration are applied.
Element 4 Electronic Data Interchange System	This Element consists of the HIPAA transactions that includes the Internationally accepted Electronic Data Interchange (EDI) transactions that consists of electronic claims submission, referrals-authorization, electronic identification, verification of benefits,

	claims status and payments systems, electronic explanation of benefits and electronic remittance to payers after a claim transaction is paid. These transactions are already integrated with the JIPA Provider Information System and can integrate with compatible systems. In addition, it also connects in real-time with the TPA & Insurance Payer Systems.

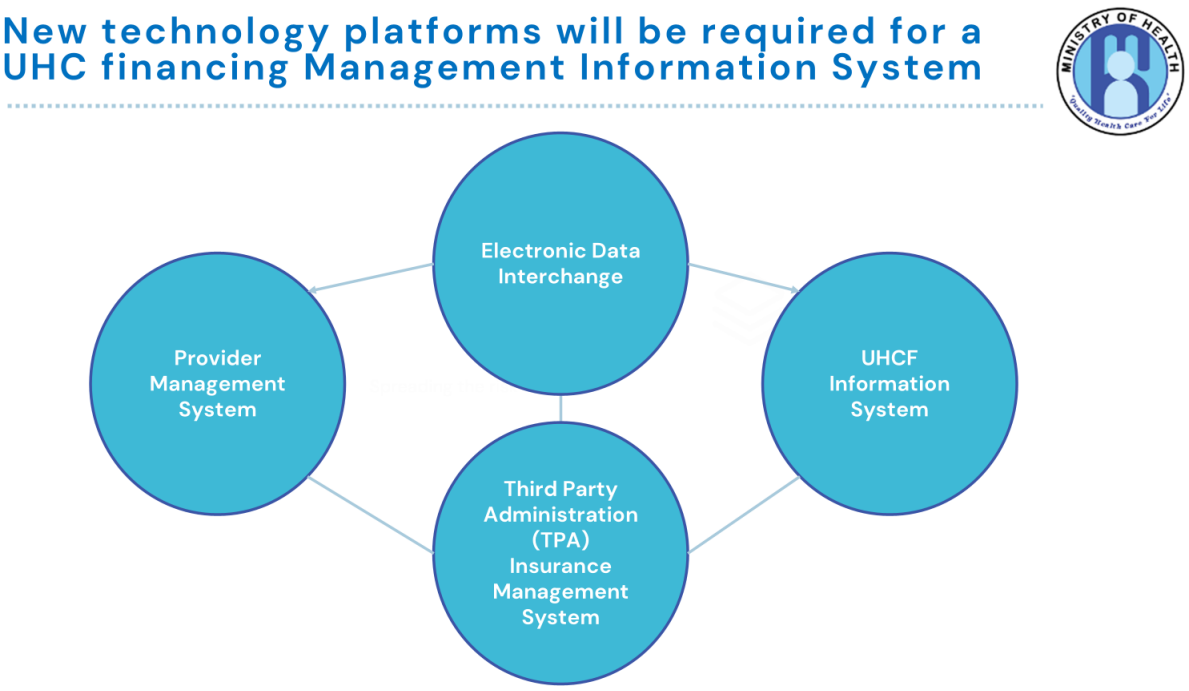


Figure 9: Requirements for the UHC Management Information System

Overview of IT Requirements for Saint Lucia's UHC Implementation

To support the Universal Health Care (UHC) program in Saint Lucia, a robust IT infrastructure is essential to manage operations efficiently and ensure compliance with international standards. The system must integrate financial management, patient and provider management, care coordination, and data analytics to deliver high-quality, cost-effective healthcare services.

Key IT Components for UHC

1. **UHC Information Infrastructure**:

- A comprehensive **database of stakeholders**, housing policies, procedures, and project timelines.
- Features **CRM tools** for patient and provider management, care coordination, and case management.
- Includes a **registration system**, integrated with national data sources, such as the NIC database, for population identification.

2. **Portal Systems with EDI**:
    - Patient Portal: Facilitates communication between patients, UHC, and providers.
    - Provider Portal: Supports **Electronic Data Interchange (EDI)** for claims submission, referrals, benefit verification, and payment tracking.
    - Integrates with **EHR/EMR systems** for seamless clinical and administrative management.
3. **Third-Party Administration System**:
    - Manages claims adjudication, benefits administration, and provider contracts.
    - Supports multiple payment models: **capitation, fee-for-service, DRGs**, and value-based payments.
    - Ensures compliance with international standards (e.g., **HL7, ANSI X12**).
4. **Provider Information System**:
    - For hospitals: Manages financials, EHR, scheduling, diagnostics, pharmacy, and operational systems.
    - For professionals: Supports EMR, practice management, and revenue cycle management.

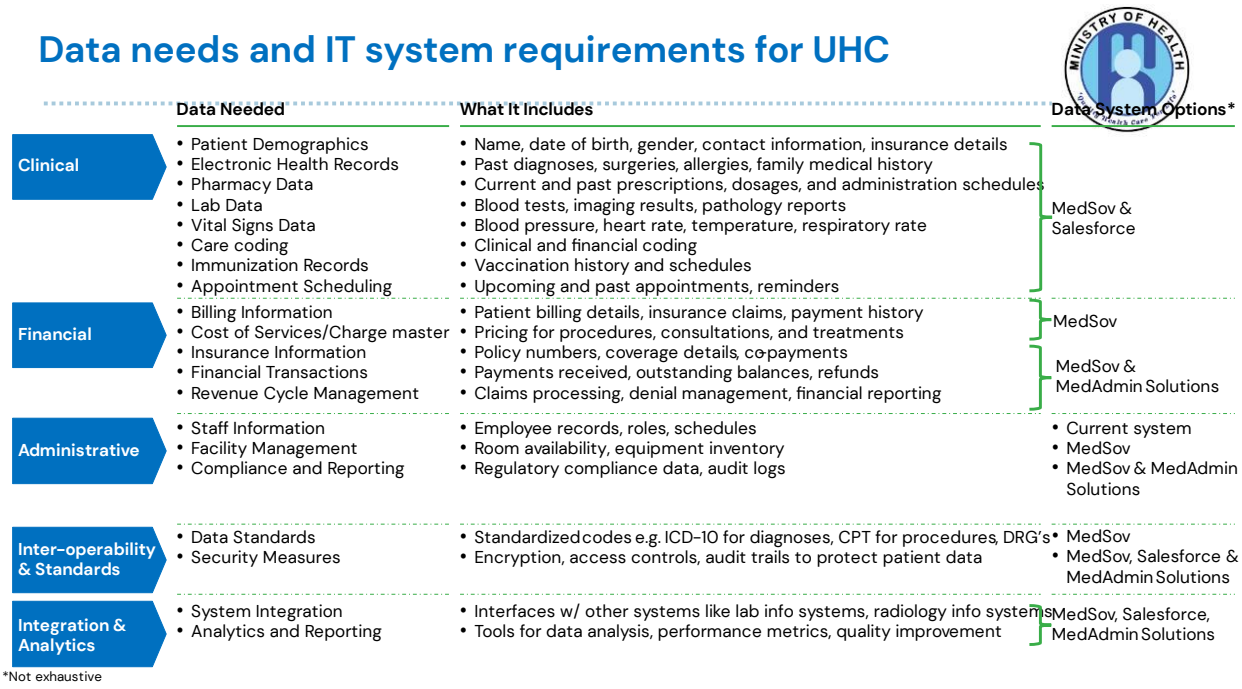


Figure 10: Data needs and IT system requirements for UHC

Policy Rationale

The success of UHC relies on an IT system designed to meet the healthcare needs of the population while ensuring data security, regulatory compliance, and seamless integration.

Nine Critical IT Components

1. **Payment and Financial Management Systems**:
    - Automates premium collection, claim payouts, and fraud detection.
    - Ensures compliance with financial regulations and transparent reporting.
2. **Insured Registration and Data Management**:
    - Centralized system for policyholder data with secure CRM tools for personalized service.
3. **Claims Processing Systems**:
    - Automated claim submissions, eligibility verification, and real-time tracking ensure efficiency and accuracy.
4. **Audit and Compliance Systems**:
    - Supports transparency and regulatory reporting, ensuring legal compliance and stakeholder trust.

5. **Process Documentation and Quality Management**:
    - Standardizes procedures and tracks performance metrics for continuous improvement.
6. **Data Analytics and Business Intelligence**:
    - Uses predictive modeling, data visualization, and reporting for informed decision-making.
7. **Care Coordination and Patient Engagement Systems**:
    - Integrates care pathways, supports patient engagement, and tracks outcomes for value-based care.
8. **Outcome Tracking and Value-Based Care Models**:
    - Monitors care quality and efficiency while prioritizing patient outcomes.
9. **Integrated System Design**:
    - Connects all IT components to ensure streamlined workflows and reduce duplication.

The Information Management System of the Universal Health Coverage shall be required to have the following overall functionalities:

a. Provide a web-based, user-friendly graphical interface.

b. Ensure user access security and data encryption.

c. Support concurrent access for multiple users.

d. Allow unlimited data entry and storage for beneficiaries (all legal residents of Saint Lucia), users, and providers.

e. Generate unique ID numbers for each beneficiary and provider.

f. Offer multi-level security access based on organization, department, user role, and rank.

g. Operate seamlessly across multiple locations.

h. Enable record search, sorting, and duplicate identification (e.g., names, prescriptions).

i. Support online inquiries and validation processes.

j. Audit the database for fraud (e.g., duplicate billing, excessive doctor visits, overlapping prescriptions).

k. Generate and schedule reports for user-defined time periods, services, or providers.

l. Provide comprehensive audit trails with internal checks and balances.

m. Integrate and interface with various systems, including MS Office applications (e.g., Excel, Word).

n. Facilitate quick data import/export.

o. Store and print ID cards and photos.

p. Support both batch and online processing.

q. Interface and share data with EMR systems and other Ministry of Health applications.

r. Store at least one year of information with easy archiving, backup, and retrieval capabilities.

Integrated technology system design

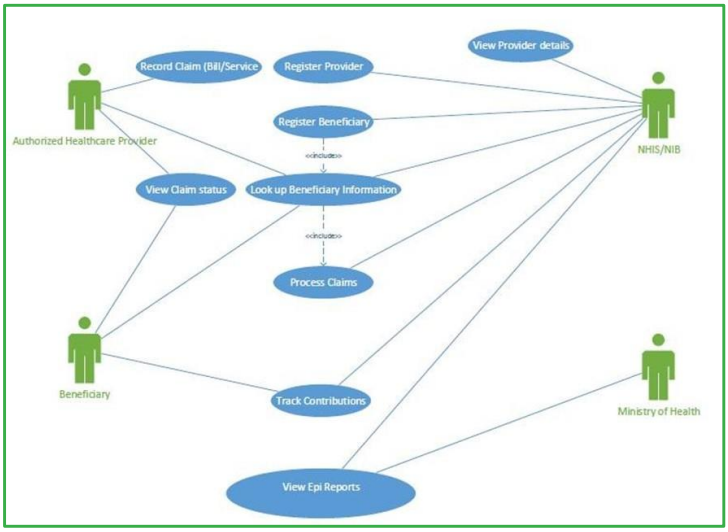


Figure 11: Integrated technology system design

Beneficiary Registration

The UHC IT system must facilitate the following for each beneficiary:

1. **Unique Identification and Account Creation:**
    - Generate a unique ID number and create an account for each beneficiary.
2. **Photo Capture and ID Card Generation:**

- Capture and save a photo of each beneficiary.
- Generate and print a photo ID card for each beneficiary.

3. **Database Search Capabilities:**
    - Enable searches using ID, name, or phone number.
4. **Storage of Beneficiary Demographics and Medical Information:**
    - Personal Information:
        - Name (including aliases), date of birth, marital status, gender, address, NIS number, and alternate IDs (passport, national ID, or driver's license).
    - Contact Information:
        - Phone number, email address, dependents, and next of kin details.
    - **Other Details:**
        - Insurance provider, nationality, and additional relevant data.
5. **Comprehensive Registration of Legal Residents:**
    - Register all legal residents of Saint Lucia, regardless of age, gender, income, health, or occupational status, including:
        - Newborns.
        - Students and unemployed residents.
        - All employed residents.
        - Retired individuals.

Demonstration and training required for new data systems

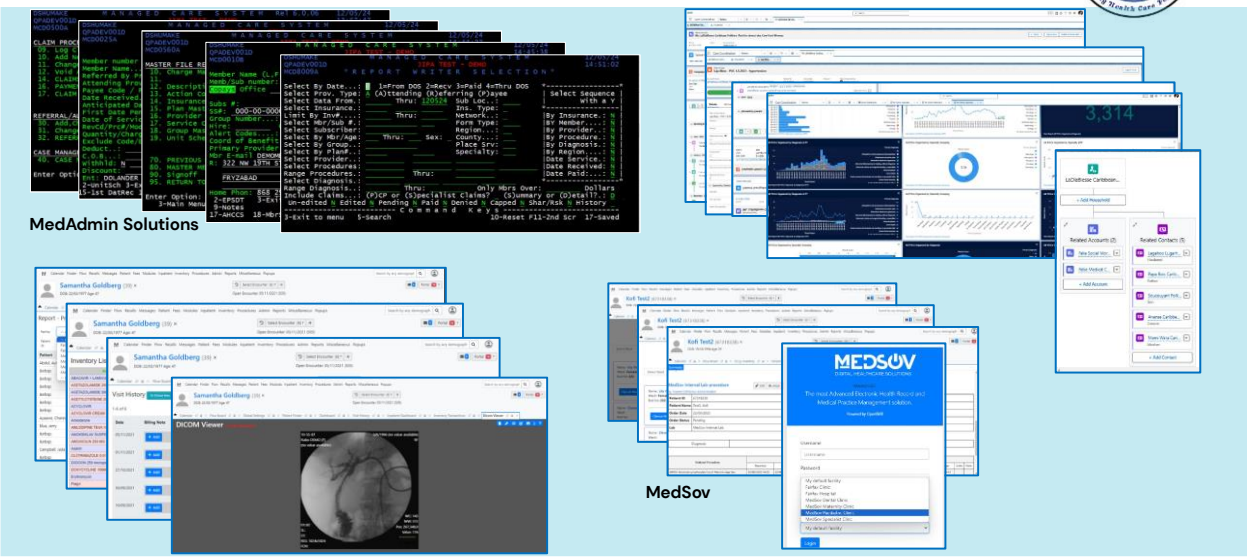


Figure 12: There are a variety of technology platforms to choose from. Training will be required to build expertise in utilizing these technologies.

Expected Impact

The implementation of this IT framework will:

- Enhance operational efficiency and reduce costs.
- Improve patient access, care coordination, and satisfaction.
- Enable evidence-based decision-making through advanced analytics.
- Ensure compliance with international health and data standards.

Emerging Challenges

- Integration of legacy systems with new IT infrastructure.
- Stakeholder training and adoption of new technology.
- Maintaining privacy and data security while ensuring interoperability.

Through a phased implementation and continuous evaluation, Saint Lucia's UHC IT system will set a new standard for delivering equitable and efficient healthcare.

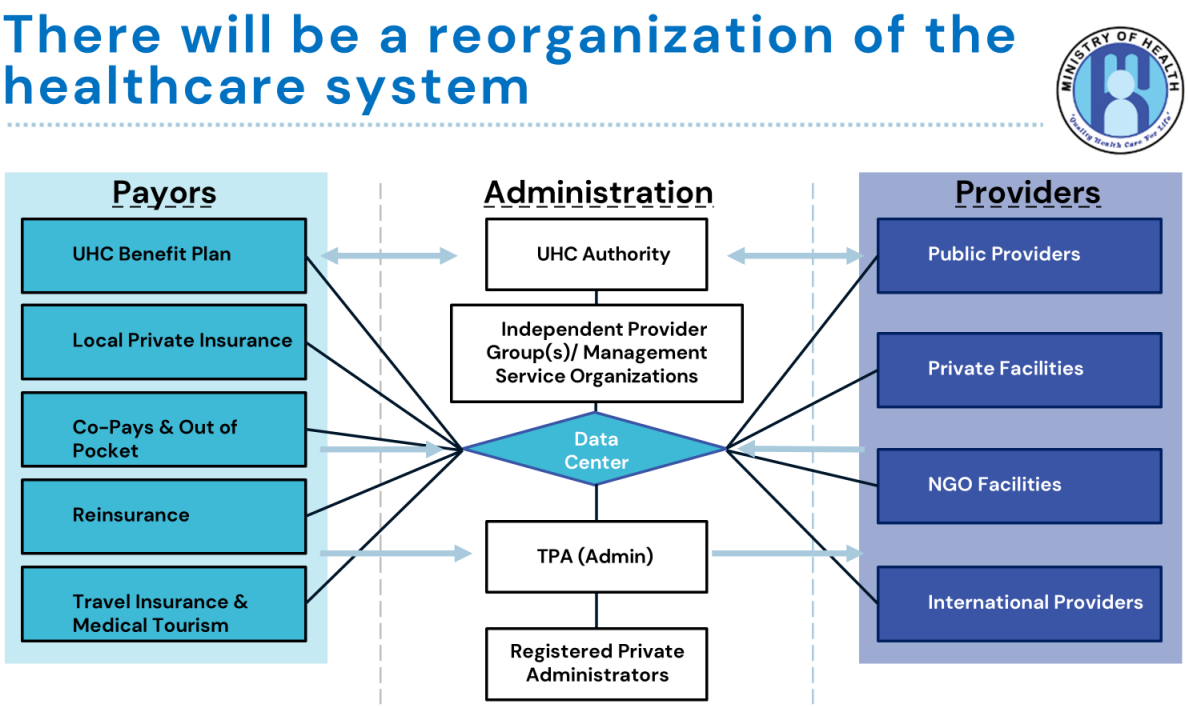


Figure 13: UHC financing structure by function

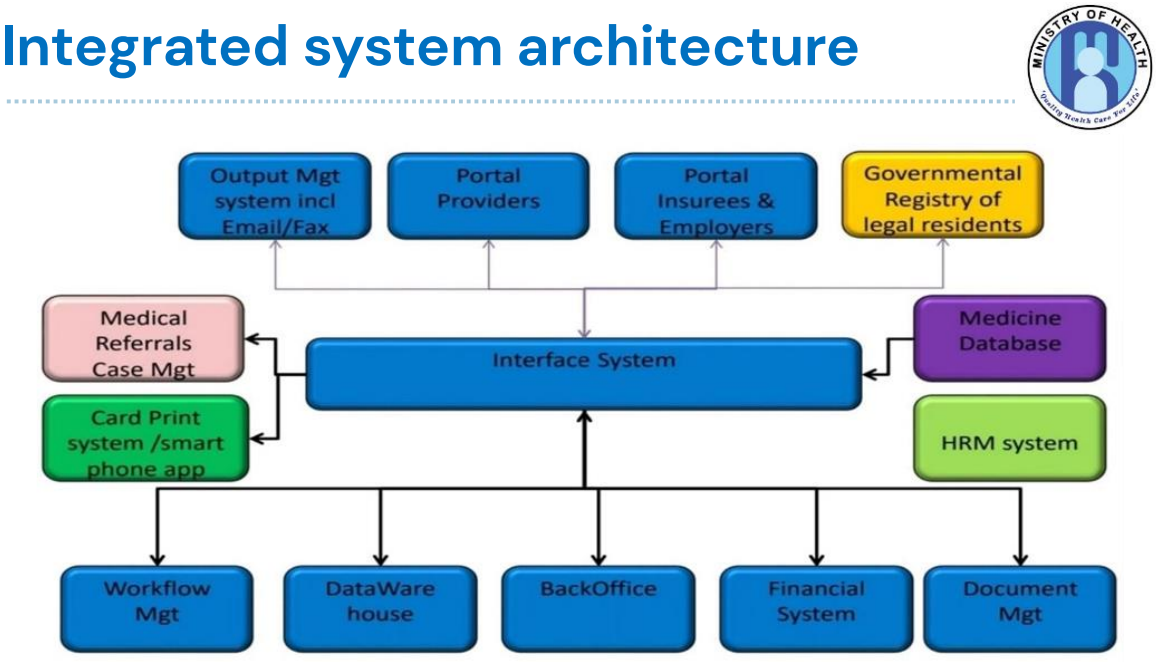


Figure 14: Integrated system architecture

Physical Environment for ICT

Policy Recommendations for the Physical Environment for ICT

- #7.1: To ensure widespread adoption of Electronic Medical Records (EMR) and related healthcare technologies, the Government is advised to implement an Incentivized Adoption Program

- #7.2: The Government is advised to adhere to the following recommendations for effective EMR Adoption: Computer Literacy & Support Adoption Programs

- #7.3: Government is Encouraged to Adopt a Minimum Data Set.

The **physical environment** of ICT serves as the foundation for an organization's technological capabilities, encompassing all hardware and facilities required to operate, manage, and use data and applications effectively. In today's cloud-centric landscape, a robust infrastructure is critical. **Outsourcing** ICT components can enhance efficiency and allow organizations to focus on core functions.

For the UHC system, the Government of Saint Lucia can choose to run it entirely on a **cloud-based infrastructure** or opt for a local deployment utilizing its existing **data centre**. The government can also establish its own cloud computing environment with robust security and access controls.

Benefits of a Cloud-Based System

- **Disaster Resilience**: Data backed up in multiple locations ensures access during hurricanes or natural disasters if internet access is available.
- **Continuous Backup**: Automatic synchronization protects against data loss.
- **Enhanced Security**: Industrial-grade firewalls and protection against piracy and illegal access.
- **Cost Efficiency**: Reduces the need for expensive IT infrastructure investments.

Hardware Requirements

- **Computers and Laptops**: User interfaces for data entry and application use.
- **Servers**: For processing and storage, either owned or outsourced.

- **Printers**: For generating hard copies.
- **Storage Devices**: External drives and NAS for data storage, with options for off-site management and local backups.
- **Networking Equipment**: Routers, switches, and hubs for connectivity, managed in-house or by third parties.
- **Data Centre**: Centralized IT infrastructure for processing and management, with outsourcing options.
- **Remote Connectivity**: Enables flexible and secure access to systems for mobile use.
- **Reliable Internet**: Essential for seamless operations.
- **Facilities**: Physical spaces for IT infrastructure, including leased co-location centres if needed.

By adopting a flexible and well-structured ICT environment, Saint Lucia can ensure efficient, secure, and resilient technological operations.

Policy Recommendation #7.1: To ensure widespread adoption of Electronic Medical Records (EMR) and related healthcare technologies, the Government is advised to implement an **Incentivized Adoption Program**.

Policy Statement

Adopting healthcare IT systems requires strong incentives and disincentives to encourage participation and compliance from healthcare providers. Key strategies include:

Incentives

1. **Pay-for-Performance**: Providers who adopt IT systems and meet defined compliance standards receive increased reimbursement rates. Non-compliance could result in reduced payments.
2. **Meaningful Use Programs**: Multi-stage programs to encourage the productive use of EMRs/EHRs and Health Information Systems (HIS). Providers meeting standards (e.g., prostate exams for 60% of males over 60 by year three) receive higher payments.
3. **Support Systems**: Introduce coders and scribes to assist with documentation and coding, employing local talent and boosting interest in health professions.

4. **Cost-Free Systems**: The Government should cover IT implementation costs for providers, ensuring universal adoption, seamless data sharing, and reduced system-wide technology expenses.

Disincentives

1. Reduced reimbursement for non-compliance.
2. Tax penalties or delayed payments for providers not adopting IT systems.
3. Increased frequency of quality audits for providers not using health information technology.

Implementation Plan

The adoption program will follow a structured rollout:

1. **Program Refinement**: Develop clear standards and guidelines.
2. **Public Presentation**: Gain stakeholder buy-in.
3. **Procurement and Training**: Equip providers and train them on usage.
4. **Compliance Standards**: Introduce meaningful use requirements for phased implementation:
    - **Stage 1**: Data capture and sharing.
    - **Stage 2**: Advanced clinical processes.
    - **Stage 3**: Improved outcomes.

Additional Incentives

1. Subsidies or tax breaks for early adopters.
2. Higher reimbursement rates for providers meeting IT standards.
3. Value-based outcome incentives for achieving measurable health improvements.

Policy Rationale

Strong incentives are necessary to overcome resistance and ensure IT adoption. Challenges with past implementations, such as with the CHS system, underscore the need for a robust and supportive approach. Internationally proven incentive programs can drive participation and compliance, even in smaller countries like Saint Lucia.

Policy Impact

Adopting healthcare IT will:

- Lower overall operational and administrative costs.
- Enable effective financial management and streamlined UHC operations.
- Improve access, reduce wait times, and facilitate disease tracking and health surveillance.
- Consolidate data, ensuring seamless communication and coordination across the health system.
- Ultimately reduce healthcare costs for the Government, UHC, and consumers.

By implementing a unified IT system, Saint Lucia can build a modern, cost-effective, and efficient healthcare infrastructure that benefits all stakeholders.

Policy Recommendation #7.2: The Government is advised to adhere to the following recommendations suggested for effective EMR Adoption: Computer Literacy & Support Adoption Programs

Policy Statement/ Description:

Recognizing that even highly skilled healthcare providers may lack basic computer literacy or possess varying levels of proficiency is critical. Failure to address this challenge effectively can hinder the adoption of EMR systems, making this an especially sensitive and important area to address.

Differences in computer literacy levels significantly affect the likelihood of successful EMR adoption. Computer literacy can be assessed using systems such as:

- Level 1 - Fundamental Skills (Typing, Mouse)
- Level 2 - Basic Computing and Applications.
- Level 3 - Intermediate Computing and Applications.
- Level 4 - Proficient Computing and Applications.
- Level 5 - Advanced Computing, Applications, and Programming.

SOLUTIONS & MITIGATION PLAN

1. Establish the metric system that will be used for measuring the computer literacy of providers Determining the metrics of computer literacy of pertinent providers and

their adoption of EMR systems that is sensitive to the cultural, generational, and professional nuances of Saint Lucia providers is critical.

2. Discovery & Evaluation of existing EMR program based on computer literacy. Discovery criteria to be finalized in conjunction with the previously mentioned computer literacy levels.
3. Medical Scribes Program. Program for the training and employment of medical scribes to assist medical providers in the effective documentation of medical notes. Great opportunity for partnership with the Ministry of Education as well as a win for producing new local jobs.
4. Strategic partnership in the development of the program(s)
5. Medical Billing & Coding Programs. Program for the training and employment of medical billers and coders to assist medical providers in the effective documentation of medical notes and claim management. Great opportunity for partnership with the Ministry of Education as well as a win for producing new local jobs.
6. Strategic partnerships in the development of the program(s)
7. Short- term & long-term solutions
8. Continued Education/ CME/ Computer and EMR Support Programs. Program for the empowerment of providers of all ages and backgrounds to get tailored support in learning to adopt and navigate new systems.
9. Strategic partnerships in the development of the program(s)
10. Policy Incentives for providers continued education and/ or successful adoption. Means of incentivizing the learning to use computers and more specifically the EMR for regular use.
11. Development of the policy inclusions that incentivize providers and numerous political stakeholders.
12. Reward system for providers that adopt EMR and penalty for those who do not.
13. Policy provisions for new jobs to support EMR adoption. Provisions for new workforce to support EMR adoption.
14. Establish the metric system that will be used for measuring the adoption based on computer literacy levels. Method and mode TBD
15. Monitor & Control. Plan TBD

Policy Rationale

This policy provides incentives and a way forward with providers of health care to implement information technology at the point of services.

Policy Impact:

Results in increased operational efficiencies and cost savings together with increased customer and provider satisfaction should implementation be a reality.

Policy Recommendations #7.3: Government is Encouraged to Adopt a Minimum Data Set.

Policy Description

Optimizing UHC implementation requires a focus on interoperability and seamless connectivity between provider information systems (e.g., physicians, hospitals) and UHC administrative systems. A robust policy framework is essential for supporting system evaluation, ensuring minimum data requirements, and strategizing for future advancements.

Solutions & Mitigation Plan

1. **Establish Minimum Data and Interoperability Standards:** To assist with the minimum data set, JIPA will work with the health system to develop and implement a comprehensive list of minimum data requirements (e.g., diagnosis, procedures, patients, claims) and interoperability standards (including HL7), aligned with meaningful use recommendations to incentivize adoption.
2. **Evaluate Existing Provider Information Systems:** A group of experts will work with the Hospital and Clinic IT and Clinical Stakeholders to conduct a thorough review of current Provider Information Systems including EMR systems to identify gaps and ensure readiness for full implementation of provider information systems.
3. **Develop Alternative System Elements:** Using the minimum data set standards, a group of technology experts will collaborate with the UHC team to perform a SWOT analysis, determining which capabilities are present, missing, and what other options are out there.

Policy Rationale

Saint Lucia is at a pivotal stage in developing its IT infrastructure for UHC. To achieve a fully integrated system that enables single-person identification, real-time data sharing, and interoperability, systems with proven compatibility and adherence to global standards should be prioritized. While existing investments and contractual obligations may limit immediate adoption of fully integrated solutions, careful analysis of cost, timeline, and UHC delivery goals is essential.

Policy Impact

Adopting minimum data set standards will streamline IT integration, reduce costs, and accelerate UHC implementation.

Research and Knowledge Management

Policy Recommendations for Research and Knowledge Management

- #8.1: To support the UHC program's development, operation, and sustainability, the GoSL should incorporate a digital infrastructure to organically produce data as evidence.

- #8.2: The Government is advised to build a health sector research and knowledge enhancement culture through a dedicated UHC Knowledge Creation and Management Unit.

- #8.3: The Government is advised to establish a knowledge bank and management platform to store and disseminate outputs on UHC and other core health indicators from academia and other local and regional research community sources.

Introduction

Research and Knowledge Management (RKM) for UHC in Saint Lucia
Overview:
Research and Knowledge Management (RKM) is critical for the successful implementation and sustainability of Saint Lucia's Universal Health Coverage (UHC) and is an emerging priority of the Ministry of Health. RKM ensures an evidence-based approach to health care, fostering a value-based, people-centric health infrastructure rooted in accountability, transparency, and good governance.

By expanding digital applications across medical and health care financial services, RKM will facilitate systematic evaluation of population experiences, health sector performance, and outcomes. This approach allows the identification of best practices to enhance the healthcare system and broader economy. A system of research and knowledge management is a true mark of health care transformation in any system where data is utilized to make critical decisions that allow for sustainability to where knowledge transfer can occur from one generation to the other.

Purpose and Scope:
The RKM framework will employ a systems-based approach to:

1. Track the progress and scale of UHC implementation.
2. Measure its impact on population health outcomes.

3. Support informed planning, policy development, and intervention design tailored to Saint Lucia's unique needs.

RKM infrastructure will integrate with all core UHC operations and align with peripheral activities of the Ministry of Health (MoH) and Ministry of Finance (MoF). It will focus on:

- Knowledge generation.
- Storage and processing of data.
- Knowledge transfer and utilization.

This system will support continuous improvements in UHC operations and ensure sustainable health care delivery.

Global and Regional Context:

In a November 2023 declaration, WHO underscored the importance of RKM: *"Health care is a knowledge-driven industry… A secure knowledge-management platform is essential for storing and sharing information, but it requires high-quality, complete data."* Earlier regional studies, such as Dominica's 2017 *Knowledge Management Strategy for Advancing the National Health Agenda*, highlighted significant gaps in knowledge flow, uptake, and storage within Caribbean health sectors. Saint Lucia's MoH and other stakeholders have implicitly worked on RKM-related activities, but UHC provides an opportunity to formalize and expand these efforts.

Policy Framework for RKM in Saint Lucia:

Effective RKM is essential for:

1. Designing UHC infrastructure tailored to the country's needs.
2. Integrating robust data collection, processing, and management to align with long-term health goals.
3. Enhancing the broader healthcare sector and health-financing initiatives.

Policy Recommendations:

1. **Strengthen Data Collection and Management:** Implement robust systems for data collection, storage, and analysis to inform evidence-based decision-making.
2. **Foster Knowledge Sharing and Utilization:** Develop platforms to promote the sharing of research, best practices, and policy insights across stakeholders.
3. **Invest in RKM Capacity-Building:** Train and equip personnel to manage and utilize health data effectively, ensuring alignment with international standards and practices.

By embedding RKM into UHC implementation, Saint Lucia can ensure a resilient, data-driven health care system that meets the needs of its population while positioning itself as a regional leader in health innovation. RKM under UHC is among the best evidence of Nation Building in

modern times and will transform Saint Lucia from a siloed system of health care to an integrated and connected health care system utilizing information technology as the driver.

Policy Recommendation #8.1: To support the UHC program's development, operation, and sustainability, the GoSL should incorporate a digital infrastructure to organically produce data as evidence.

Policy Statement/Description

Policy for Digital Research and Knowledge Management (RKM) Infrastructure Overview

JIPA proposes the development of an integrated digital RKM infrastructure to support Saint Lucia's UHC program, closely cooperating with the Ministry of Health's Research Unit. This system will expand on existing MoH data management and research platforms, such as registries and surveillance systems, to capture and analyze data from all clinical, financial, and management points within the UHC framework. Over time, this infrastructure can be extended to include other MoH and MoF activities influencing UHC operations. This could become the unit that leverages the expertise on UHC built in Saint Lucia to support the establishment of UHC systems in other countries across the Caribbean.

The RKM system will enable real-time data collection and analysis through routine information input, reducing the need for additional costly projects. Key UHC indicators such as healthcare costs, service gaps, waiting times, medical errors, practitioner knowledge, and user experiences will be captured to drive improvements in population health and system efficiency.

The infrastructure will feature a hierarchical structure for data input and accessibility, adhering to principles of autonomy, nonmaleficence, beneficence, and justice. Research policy guidelines will support academics, healthcare professionals, and others in utilizing the system's data effectively and responsibly.

Key Features

- **Real-Time Data Collection:** Automatically convert routine inputs into actionable data.
- **User Experience Feedback:** Capture beneficiary and provider insights to evaluate adoption, utility, and system value.
- **Interoperability:** Seamless integration with existing and future systems across the MoH and MoF.

- **Collaboration Opportunities:** Leverage partnerships with WHO affiliates (e.g., PAHO, CARPHA) and development organizations (e.g., EU, CDB) for technical support.
- **Secure Infrastructure:** Built by the Ministry of Information and Communication Technology to ensure efficiency, ergonomic design, and strong data protection.

Policy Rationale

A robust RKM infrastructure enables evidence-based decision-making, supports continuous improvement, and ensures the UHC program evolves to meet Saint Lucia's unique needs. Given the limited regional examples of UHC in the Windward Islands, Saint Lucia's system can serve as a model for small island states, generating knowledge for local and regional applications.

Currently, the MoH lacks systems for evaluating performance and productivity in the health sector. Embedding data collection and analysis within the UHC framework will fill this gap, offering real-time feedback and actionable insights to improve both UHC and the broader health sector.

Policy Impact

1. **Whole-Sector Reform:** The integrated system provides comprehensive data for holistic health sector reforms, avoiding fragmented solutions.
2. **Evidence-Based Decision-Making:** Data-driven policies ensure that UHC programs and health sector initiatives align with population needs and priorities.
3. **Institutional Memory:** Historical data enables long-term evaluation of UHC outputs, outcomes, and impacts, guiding future improvements.
4. **Enhanced User Satisfaction:** Documenting and addressing user feedback fosters a patient-centric approach, improving provider accountability and stakeholder confidence.

Developing a cross-cutting RKM infrastructure is pivotal for the success and sustainability of UHC in Saint Lucia. By leveraging real-time data and partnerships with regional and international stakeholders, this system can drive meaningful reform, optimize resource allocation, and set a benchmark for effective healthcare delivery across the Caribbean.

Policy Recommendation #8.2: The Government is advised to build a health sector research and knowledge enhancement culture through a dedicated UHC Knowledge Creation and Management Unit in close collaboration with the Ministry of Health's Research Unit.

Policy Statement/Description

The proposed Knowledge Creation and Management Unit will focus on collecting and analyzing data from the digital RKM system, disseminating insights to stakeholders in accessible formats, and transforming this information into actionable strategies to guide

UHCA implementation. A multidisciplinary team comprising data analysts, IT specialists, public health experts, clinicians, health planners, and policy experts will serve as a dynamic think-tank to advance the Unit's objectives. Broad stakeholder involvement will enhance ownership, improve knowledge utilization across organizational levels, and inform the development of UHC indicators and the RKM framework for tracking progress. Researchers identified by the Medical and Dental Council's Research and Ethics Committee, as well as those at Sir Arthur Lewis Community College, will be invited to collaborate.

Policy Rationale

The establishment of this Unit is critical for ensuring that UHC remains evidence-based, adaptable, and responsive to Saint Lucia's socio-economic and policy landscape. Effective knowledge management bridges gaps in data flow and dissemination that often hinder quality patient care and operational efficiency. Research highlights the challenges of fragmented systems operating in silos and the limited use of data for decision-making in Caribbean health sectors. This Unit addresses these issues by fostering data-driven planning, real-time monitoring, and continuous improvement of UHC and MoH programs.

Policy Impact

1. **Sustained Knowledge Utilization for Planning and Development:**
    - A dedicated Unit ensures accountability for knowledge management, enabling consistent data-driven planning and stakeholder engagement.
    - Structured operations support the sustainable creation and application of knowledge to guide the UHC program and broader health sector initiatives.
2. **Reduction of Medical Errors and Adverse Outcomes:**
    - The Unit can review medical errors and recommend systemic barriers and alerts to mitigate risks, resulting in fewer adverse outcomes.
    - Reducing medical errors not only improves patient safety but also lowers costs by minimizing the need for corrective care.
3. **Enhanced Learning and Organizational Performance:**
    - Functions as a learning hub for identifying and sharing best practices locally and regionally.
    - Supports stakeholder collaboration, improving performance across public health and primary care practices.
    - Facilitates the development of targeted interventions based on evidence, optimizing the financial and operational efficiency of the UHC system and MoH.

The Knowledge Creation and Management Unit will play an integral role in advancing the UHC program's success by ensuring data-informed decision-making, fostering continuous learning, and promoting collaboration. Its establishment will strengthen Saint Lucia's health

system, improve care quality, and position the country as a regional leader in UHC program development and implementation.

Policy Recommendation #8.3: The Government is advised to establish a knowledge bank and management platform to store and disseminate outputs on UHC and other core health indicators from academia and other local and regional research community sources.

Policy Description

Collaborating with academic institutions and regional health authorities is essential for Saint Lucia's UHC program to leverage shared resources, reduce redundancy, and optimize spending. By formalizing partnerships with organizations like PAHO, and the University of the West Indies, (UWI), the government can tap into existing research and data repositories, focusing on UHC and health-related indicators, including social determinants of health. Existing reports and publications on Saint Lucia and the Caribbean offer valuable lessons and practices that can inform UHC development and sustainability. These resources should be systematically reviewed, disseminated, and incorporated into UHC planning by the knowledge management entity.

A shared electronic knowledge bank, hosted on platforms like PAHO, could centralize UHC-relevant indicators and provide streamlined access to critical data. This system can initially focus on core UHC metrics and expand to additional areas over time. Sir Arthur Lewis Community College faculty and students can support data collection, and the repository should enable automatic thematic categorization for easy retrieval. Key social determinants—such as health literacy, income, employment, housing, and education—can be analyzed to guide evidence-based strategies for UHC implementation. WHO/PAHO support for building RKM systems should also be leveraged to strengthen this initiative.

The Central Statistics Office (CSO) can contribute data on social determinants of health, creating a shared repository involving academia, NGOs, and health organizations. Such partnerships would minimize costs while ensuring access to comprehensive, high-quality data. Formal MOUs should establish data-sharing terms, focus areas, and repositing conditions with the Ministry of Health.

Policy Rationale

Saint Lucia's MOH currently lacks a systematic approach to knowledge management, including dedicated research personnel or comprehensive documentation of UHC-relevant resources. Despite a wealth of regional and local research, these materials remain underutilized. Formalizing collaborations with research-driven institutions like the University of the West Indies and regional organizations can address these gaps, pooling resources to

support the UHC program while mitigating the MOH's financial and human resource constraints.

Policy Impact

1. **Improved UHC Efficiency:**
    - Healthcare professionals can work more effectively with access to evidence-based resources, boosting productivity and performance.
2. **Enhanced Cooperation:**
    - Formal partnerships with academia, NGOs, and private organizations foster a supportive network for the UHC program, improving its chances of success.
3. **Cost Savings:**
    - Sharing research outputs with academic institutions reduces the financial burden on the UHC and MOH while ensuring robust data for planning and development.
4. **Strengthened Research Capacity:**
    - Partnerships with key stakeholders expand ownership and support for UHC research priorities, driving a shared agenda for continuous improvement.
5. **Targeted Social Determinants Strategies:**
    - Using research to address social determinants of health allows for better resource allocation, problem identification, and evidence-based interventions.

Leveraging academic and regional expertise ensures the UHC program operates with access to high-quality, relevant data and knowledge. By pooling resources and formalizing collaborations, Saint Lucia can strengthen its UHC implementation, address social determinants, and foster an evidence-driven approach to health system transformation.

Conclusion

The Saint Lucia Universal Health Coverage (UHC) Policy Draft lays a comprehensive foundation for transforming the nation's healthcare system. The document identifies significant challenges, including fragmented service delivery, workforce shortages, underfunded infrastructure, and heavy reliance on out-of-pocket expenses, while proposing a robust framework to address these issues through a three-tiered UHC model.

This model aims to provide equitable, high-quality, and sustainable healthcare, leveraging stratified pooled risk coverage to ensure financial stability. Key elements include integrating digital health technologies, expanding insurance coverage, optimizing resource allocation, and establishing a strong governance structure. By aligning with global goals such as the Sustainable Development Goals (SDGs), the UHC initiative positions Saint Lucia as a leader in healthcare reform within the Caribbean.

The proposed implementation strategy emphasizes phased legislative reforms, stakeholder collaboration, and modernized funding mechanisms, such as a superfund and diversified revenue streams. These efforts aim to reduce financial burdens, improve patient outcomes, and attract investment to Saint Lucia's healthcare sector.

Next Steps

Legislative Finalization: Complete and enact the Universal Health Insurance Act to provide the necessary legal framework for UHC governance, funding, and implementation.

Infrastructure and IT Modernization: Prioritize the development of interoperable digital health systems, including electronic health records and financial management platforms, to support efficient data sharing and decision-making.

Stakeholder Engagement: Establish partnerships with private insurers, employers, and community organizations to align contributions and participation in Tiers 2 and 3.

Phased Implementation: Begin with foundational activities such as registration, governance setup, and public awareness campaigns, followed by full-scale rollout of services and payment models.

Workforce Development: Invest in training, recruitment, and equitable distribution of healthcare professionals to address current gaps and improve service delivery.

Monitoring and Evaluation: Develop a robust performance-based financing system to track outcomes, ensure accountability, and adjust policies as needed.

These steps will be critical for achieving the UHC vision of quality, accessible, equitable, and sustainable healthcare for all Saint Lucians.

References

Barroy H, Blecher M, Lakin J. How to make budgets work for health: a practical guide to designing, managing and monitoring programme budgets in the health sector. Geneva: WHO, 2021.

Cashin C, Bloom D, Sparkes S, Barroy H, Kutzin J, O'Dougherty S. Aligning public financial management and health financing: sustaining progress toward universal health coverage. Geneva: WHO, 2017.

Economic Commission for Latin America and the Caribbean (ECLAC)/International Labour Organization (ILO), "Towards the creation of better jobs in the post-pandemic era", Employment Situation in Latin America and the Caribbean, No. 28 (LC/TS.2023/70), Santiago, 2023.

Gaudin S, Smith PC, Soucat A, Yazbeck AS. Common goods for health: economic rationale and tools for prioritization. *Health Syst Reform* 2019; 5(4).

Gilchrist, C. (2020). A Strategic Approach to Financing Health Expenditure in Grenada in a Post Covid-19 Environment (Doctoral dissertation, Atlantic International University).

Government of Saint Lucia. (2019). *Final version*. www.nationalplan2030.gd. https://observatorioplanificacion.cepal.org/sites/default/files/plan/files/GRANADA-NSDP20202035.pdf

HEU, Centre for Health Economics, The University of the West Indies, St. Augustine Campus. (April 14, 2017). Proposal for the Provision of Consultancy Services for Advancing Action on the Design and Specification of a National Health Insurance System in Saint Lucia.

Humphreys G, Gabon gets everyone under one social health insurance roof. Bulletin of the World Health Organization 2013;91:318-319. doi: http://dx.doi.org/10.2471/BLT.13.020513.

Johnson D, D'Agostino M, Marti M, de Cosio FG. Knowledge management strategy for advancing the national health agenda in Dominica. Rev Panam Salud Publica/Pan Am J Public Heal. 2017; 41:1–5.

Knowledge management is key to public health planning, new study shows [Internet]. [cited 2024 Mar 29]. Available from: https://www.who.int/europe/news/item/13-11-2023-knowledge-management-is-key-to-public-health-planning--new-study-shows

Kraef, C., Juma, P., Kallestrup, P., Mucumbitsi, J., Ramaiya, K., & Yonga, G. (2020). The COVID-19 pandemic and non-communicable diseases: A wake-up call for primary health care system strengthening in sub-Saharan Africa. Journal of Primary Care & Community Health, 11, 2150132720946948. https://doi.org/10.1177/2150132720946948

Mansingh G, Osei-Bryson KM, Reichgelt H. Issues in knowledge access, retrieval and sharing - Case studies in a Caribbean health sector. Expert Syst Appl. 2009;36(2 PART 2):2853–63.

Ministry of Finance, Planning, Economic Development & Physical Development. (2023). *2023 budget speech*. Government of Saint Lucia. https://www.finance.gd/docs/2023/2023-Budget-Speech.pdf

More money for health, and more health for the money. London: High-level Taskforce on Innovative International Financing for Health Systems; 2009. https://www.uhc2030.org/fileadmin/uploads/ihp/Documents/Results___Evidence/HAE__results___lessons/Taskforce_report_EN.2009.pdf, accessed 1 April, 2024

Moreno-Serra R, Smith P. Does progress towards universal health coverage improve population health? The Lancet. 2012;

Office of Health Equity. (2022b, July 1). What is health equity? Centers for Disease Control and Prevention. https://www.cdc.gov/healthequity/whatis/index.html

Savedoff W et al. Transitions in Health Financing and Policies for Universal Health Coverage: Final Report of the Transitions in Health Financing Project. Washington: Results for Development Institute; 2012.

Stakeholder consultation with Saint Lucia Medical and Dental Council (GMDC) held 11 January 2020.

Stenberg K, Hanssen O, Bertram M, et al. Guide posts for investment in primary health care and projected resource needs in 67 low-income and middle-income countries: a modelling study. *Lancet Glob Health* 2019; **7:** e1500–10.

Universal Declaration of Human Rights, art. 25, 1948.

UWI, UNDP, International Labour Organization. (2021, January). *Transition from education to employment in Saint Lucia*. Undp.org. https://www.undp.org/sites/g/files/zskgke326/files/migration/bb/undp-bb-Transition-from-Education-to-Employment-in-Saint Lucia-January-2021.pdf

Wheatley A. The Link Between Health Costs and National Savings Rates. New York Times. 3 August 2009. http://www.nytimes.com/2009/08/04/business/global/04inside.html, accessed 13 March 2024.

Whiting, K. (2023, October 13). Progress has slowed on universal health coverage: Here's what needs to happen. Retrieved from: https://www.weforum.org/agenda/2023/10/health-servicesaccessstagnating/#:~:text=%E2%80%9CCatastrophic%20OOP%20health%20spending%20reduces,at%20the%20relative%20poverty%20line

World Bank. (n.d.). Population ages 65 and above (% of total population) - Saint Lucia. Retrieved May 22, 2024, from https://data.worldbank.org/indicator/SP.POP.65UP.TO.ZS?locations=GD

World Health Organization. (2008). The World Health Report 2008: Primary health care now more than ever. https://www3.paho.org/hq/dmdocuments/2010/PHC_The_World_Health_Report-2008.pdf, Accessed 25 April, 2024.

World Health Organization. (2013). Arguing for universal health coverage. World Health Organization. https://iris.who.int/handle/10665/204355, accessed 25 April 2024.

Appendix – Recommendations for HIPAA Compliant Computer Systems

Recommendations for Computer Systems – Adopted from HIPAA Informed

Introduction

This section describes the set of policies and procedures around usage of computer and communication systems. The organization will need to review its systems and implement needed changes in accordance with the final Security Standards.

PASSWORDS – Examples of terms that could be set for ID and Passwords

1. All systems will require a valid user ID and password

2. Examples of standards set for passwords:

    a. Passwords will be at least six characters long
    b. All user-chosen passwords should have at least two alpha (letters) and two numeric (numbers), or symbols.
    c. The use of control characters and non-printing characters is prohibited

3. It is recommended that all health care service providers that serve as system users change their passwords at least every six months

4. In the event of a suspected or actual password breach those passwords should be changed immediately

5. After three unsuccessful attempts to enter a password, the involved user ID should be suspended until reset by the system administrator

6. The display or printing of passwords should be masked so that unauthorized parties will not be able to observe or recover them

7. Passwords should not be stored in written or readable form

8. Upon termination all passwords for the health service provider will be immediately changed or deactivated

ACCESS

1. Computer screens should be positioned in a manner that only authorized users may see the information contained on the screen

2. All terminals should have a password protected screen saver that will be activated after ten minutes of inactivity

3. If computer equipment will be permanently taken out of service, the hard drive should be totally erased

4. Antivirus software's should be installed

5. Antivirus software should be updated every six months

6. Automatic logoff of systems should be after 30 min of inactivity

7. A notice, at system start-up, warning that only those with proper authority should access the system should be displayed initially before signing onto the system or a written notice with a warning that only those with proper authority should access the system should be displayed near the computer terminal

8. Individuals who are not employees, contractors, consultants, or health service providers or partners should not be granted access to any systems

9. Health service providers should logoff the system before going to lunch or taking breaks

10. Health service providers should logoff the system before they end their shift for the day

11. The room where the workstation is contained should be locked when not in use

12. All removable media (e.g. CD-ROMs. backup tapes, diskettes, and etc.) will be stored in a locked cabinet to prevent unauthorized use

13. All removable media (e.g. CD-ROMs backup tapes, diskettes, etc.) no longer in use should be reformatted or destroyed preventing any protected health information from being seen by unauthorized individuals

14. Printed versions (hardcopy) of protected health information should be shredded before it is discarded

15. System access should be reviewed annually to remove identification codes and passwords of users who no longer require access

REMOTE ACCESS

1. Remote access via modem should be through an approved security mechanism such as a dial back system, or only allowing modem connectivity from specified phone numbers

2. After three unsuccessful attempts to enter a password, the involved user ID should be suspended until reset by the system administrator

INTERNET

1. Use of the Internet via network should be primarily for business or professional development

2. Use of the Internet via network should not be permitted for personal use

3. A firewall should be installed to protect against unauthorized intrusion

E-MAIL (ELECTRONIC MAIL)

1. Prohibited use of the unsecured electronic mail system includes, but is not limited to:

    a. Disclosure of an individual's personal health information without appropriate authorization
    b. Transmission of information inside or outside of the organization without a legitimate business need for the information
    c. Use for marketing purposes without explicit permission of the patient

2. Patients will be informed about privacy issues such as:

a. Who besides addressee processes messages
    i. During addressee's usual business hours.
    ii. During addressee's vacation or illness.
b. That messages are to be included as part of the medical record.

3. The following types of transactions (prescription refill, appointment scheduling, etc.) and sensitive subject matter (HIV, mental health, etc.) should not be sent over unsecured e-mail.

4. Patients and health service providers will be advised to put category of transaction in subject line of message for filtering: "prescription," "appointment," "medical advice," "billing question."

5. Patients and health service providers will be advised to put the patient's name and patient identification number in the body of the message.

6. All messages will be stored in CRM, with replies and confirmation of receipt, and placed in patient's chart.

7. Health service providers will send a new message to inform the patient of completion of request.

8. The sharing of health service provider's e-mail accounts with family members is strictly prohibited.

9. Health Service provider should double-check all "To:" fields prior to sending messages.

10. Health service providers should perform at least weekly backups of mail onto long-term storage

11. The use of distribution lists for distributing confidential information should be strictly prohibited

12. The subject line should contain a notation referring to the confidential or sensitive nature of the information

13. Patient authorization should be obtained before forwarding protected health information to a third party such as a consultant or health plan

14. Patient e-mail addresses should not be supplied to third parties for advertising or any other use

16. Upon termination of health service providers within entities the e-mail account and user access should be immediately deactivated/ suspended.

Backup and Recovery

1. A full system backup to tape should be performed once a week

2. Incremental backups should be performed throughout the week

3. Backup and recovery procedures should be tested a least once a year
4. Cloud computing is popular and the vender storing the data should give assurances of privacy and access blocking for unnecessary users.

Unsecured PHI

We suggest defining unsecured PHI to include data that has not been:

1. Encrypted consistent with international standards
2. Destroyed in a manner that renders the information irrecoverable, such as shredding for paper records. Thus, while HIPAA does not require the use of encryption, encrypting PHI can reduce the risk that a covered entity will be required to provide notice of a security breach.

Recommend deployment of proper technologies and methodologies that will make PHI unusable, unreadable, or indecipherable to unauthorized individuals. Proper use of such technologies and methodologies will help prevent PHI from becoming Unsecured PHI.

There are two methods for making PHI unusable, unreadable, or indecipherable to unauthorized individuals:

I. Encryption
II. Destruction.

These are the guidelines for how these methods apply to the following data states:

1. Data at Rest - An encryption process for "data at rest" (i.e., data that resides in databases, file systems, and other structured storage methods). Refer to National Institute of Standards and Technology ("NIST") Special Publication 800-111, Guide to

Storage Encryption Technologies for End User Devices, for further elaboration on best practice standards.

2. Data in Motion - An encryption process for "data in motion" i.e., data that is moving through a network, including wireless transmission.
3. Data Disposed - "Data disposed" (e.g., discarded paper records or recycled electronic media) should be properly destroyed if:
    I. paper, film, or other hard copy media have been shredded or destroyed such that the PHI cannot be read or otherwise cannot be reconstructed, and;
    II. electronic media have been cleared, purged, or destroyed such that the PHI cannot be retrieved.

Under the ANSI X12 engineering standards, HIPAA has established globally recognized transaction standards that enable disparate systems to exchange critical data elements and functions in both real-time and batch processes. These standards are essential for managing the business, financial, and administrative functions of patient care.

For Saint Lucia's healthcare transformation into a modern, internationally aligned system, adopting these standards is critical. Their implementation will:

- Support accreditation from international bodies.
- Facilitate entry into the global healthcare marketplace, enhancing opportunities for health tourism.
- Strengthen revenue cycle management between healthcare providers, payers, and the UHC, increasing funding opportunities for healthcare services.

The diagram below outlines the HIPAA transaction standards widely used in internationally recognized healthcare software systems for data sharing between providers, payers, and employers.

Standardized data transaction diagram

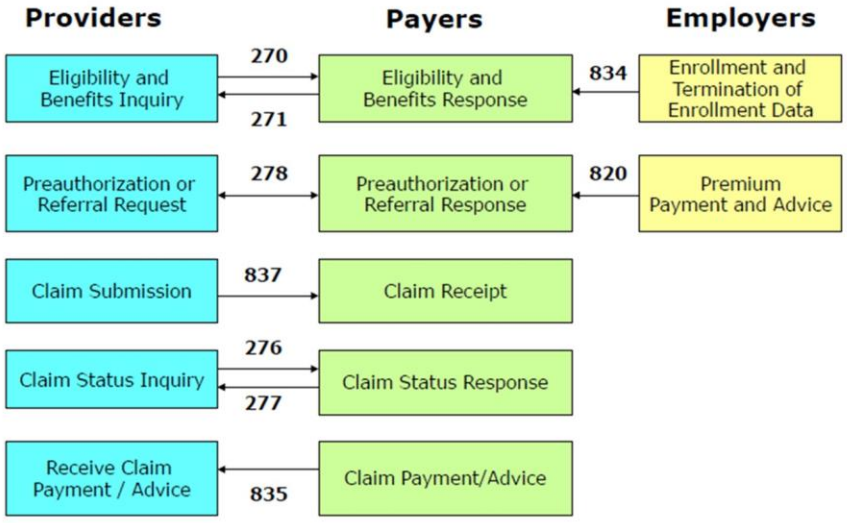


Figure 15: Standardized Data Transaction Diagram (HIPAA's Electronic Data Interchange {EDI} Transaction Standards)

HIPAA Informed Recommendations for Workforce Training for Health Service Providers and Entities

Introduction

These policies and procedures address workforce training in privacy and security for health service providers and entities. The workforce consists of but is not limited to the following: clinicians, employees, volunteers, students, trainees, and affiliates

Policies and Procedures

1. All current workforce members with access to protected health information (PHI) will receive **awareness training** on related policies and procedures.
2. New workforce members will complete PHI training within **60 days** of joining the organization.
3. Workforce members directly affected by **material changes** to privacy policies will be retrained within **60 days** of the change.
4. Upon training completion, workforce members must sign a **confidentiality agreement** certifying their understanding and compliance with privacy policies.
5. All health service providers will complete **HIPAA refresher training** every **2 years**.

Recommendations For Patient Rights

Introduction

These policies and procedures address patient rights. Patients should be guaranteed certain rights and protections for their privacy, regarding information maintained about them.

Policies And Procedures

1. **Access to PHI**:
    - Patients have the right to access their **Protected Health Information (PHI)** in electronic health records or formats such as MS Word, Excel, PDF, HTML, and plain text.
    - Patients may also direct providers to send a copy of their electronic health record to a **third party**.
2. **Provision of PHI**:
    - If PHI is requested in an **electronic form**, it must be provided in the requested format if readily available. If not, an agreed-upon electronic format (e.g., Word, Excel, HTML, PDF) will be used.
3. **Denial of Access**:

    Access to PHI may be denied under the following circumstances:
    - If access poses a risk to the **life or safety** of the patient or others.
    - The information constitutes **psychotherapy notes**.
    - Information is compiled for use in a **legal proceeding**.
    - Access is restricted under Saint Lucia Medical Association or parliamentary provisions.
    - Access for **inmates** may be denied if it jeopardizes security, safety, or rehabilitation.
    - Information obtained during **ongoing research** where access would compromise the study.
    - PHI obtained under a **promise of confidentiality** that could reveal the source.
4. **Notice of Privacy Practices**:
    - Must be provided during the first patient encounter.

- Must be available upon request and posted where services are provided.

Right to Request Restrictions on PHI

1. **Restrictions on Health Plan Disclosures**:
    - Patients may request that PHI **not be disclosed to a health plan** for payment or operations if the patient paid **out of pocket** for the service.
2. **General Restrictions**:
    - Patients can request limits on the use or disclosure of PHI for treatment, payment, or operations, or restrict disclosures to individuals involved in their care.
    - Providers are **not required** to agree to these requests, except for cases of out-of-pocket payments.
3. **Submitting a Request**:
    - Patients must submit written requests to the **Privacy Officer**, specifying:
      i. What information to restrict.

      ii. Whether the restriction applies to use, disclosure, or both.
      iii. To whom the limits apply.
4. **Approval and Documentation**:
    - Approved requests will be stamped and attached to the patient's file for visibility.
    - The Privacy Officer is authorized to approve and manage restrictions.
5. **Termination of Restrictions**:
    - Restrictions may be terminated if:
      i. The patient agrees or requests termination in writing.
      ii. The patient provides oral agreement, which is documented.
      iii. The practice notifies the patient, with termination applying only to future PHI.
6. **Emergency Situations**:
    - PHI may be disclosed for **emergency treatment** despite restrictions. Providers receiving PHI for emergencies will be asked not to disclose it further.

7. **Record Retention**:
    - All agreements to restrict PHI will be retained for **six (6) years** from creation or last effective date, whichever is later.

Right To Request Confidential Communications

1. Patients have the right to request that we communicate with them in a certain way or at a certain location.
2. To request confidential communications, patients must make their request in writing to the Privacy Officer.
3. We will not ask the patient the reason for the request.
4. We will accommodate all reasonable requests.
5. Patients must specify how or where they wish to be contacted.

Recommendations For Associates

Introduction

These policies and procedures address interactions with Business Associates.

A Business Associate is a person or entity that creates, receives, maintains, or transmits protected health information (PHI) in fulfilling certain functions or activities on behalf of a Covered Entity, but is not part of the Covered Entity's workforce. Health information that is created or received by the Covered Entity, identifies an individual, and relates to that individual's physical or mental health condition, treatment, or payment for health care is considered PHI when it is transmitted by or maintained in any form of medium, including electronic media. Subcontractors of a Business Associate that creates, receives, maintains, or transmits PHI on behalf of the Business Associate is also a Business Associate under HIPAA. Business Associates can be but are not limited to the following:

- Claims processors or administrators
- Lawyers
- Billing Agencies
- Accountants
- Benefit managers
- Collection Agencies
- Consultants
- Medical Answering Services
- Clearing houses
- Temporary Staffing Agencies
- Storage Facilities
- E-Prescribing Gateways

Business Associates are involved in the use or disclosure of protected health information while performing a function on behalf of a Covered Entity and are expected to adhere to the same standards for safeguarding PHI as the Covered Entity as to protected health information.

- Entering Business Associate Contracts with Business Associates to protect the privacy of PHI.
- Investigating when complaints or other credible evidence of violations by a Business Associate are received.
- Taking reasonable steps to correct a breach or terminate the contract with a Business Associate after becoming aware of a material breach by a Business Associate.
- Getting written assurances from Business Associates that they will adhere to the same standards for safeguarding PHI as the Covered Entity.

Policies and Procedures

1. **Safeguarding PHI**: We will ensure Business Associates provide satisfactory assurances to appropriately safeguard any Protected Health Information (PHI) entrusted to them.
2. **Business Associate Agreement**: Business Associates must sign an agreement confirming they will not use or disclose PHI in any way that is impermissible under privacy regulations for the Covered Entity.
3. **Assurances in Writing**: Written assurances will confirm compliance with privacy regulations.
4. **Business Associate Responsibilities**: Business Associates must:

- Use or disclose PHI only as permitted by contract or required by law.
- Implement safeguards to prevent unauthorized PHI use or disclosure.
- Report any contract violations to our **Privacy Officer**.
- Notify us of unauthorized access, use, or disclosure of Unsecured PHI, including affected individuals.
- Ensure any agents receiving PHI agree to the same restrictions.
- Provide a list of agents with contact details to the Privacy Officer.
- Demonstrate that employees and agents have been trained in PHI protection.

- Maintain and, upon request, provide a record of PHI uses and disclosures outside of treatment, payment, and operations. For electronic health records, maintain a log of all disclosures.

5. **Violation Management**:

- All violations of the Business Associate agreement will be documented and filed with the signed contract.
- If a **material breach** is identified, corrective actions (e.g., discussions, sanctions) will be taken. If the breach cannot be resolved, the contract will be terminated if feasible.