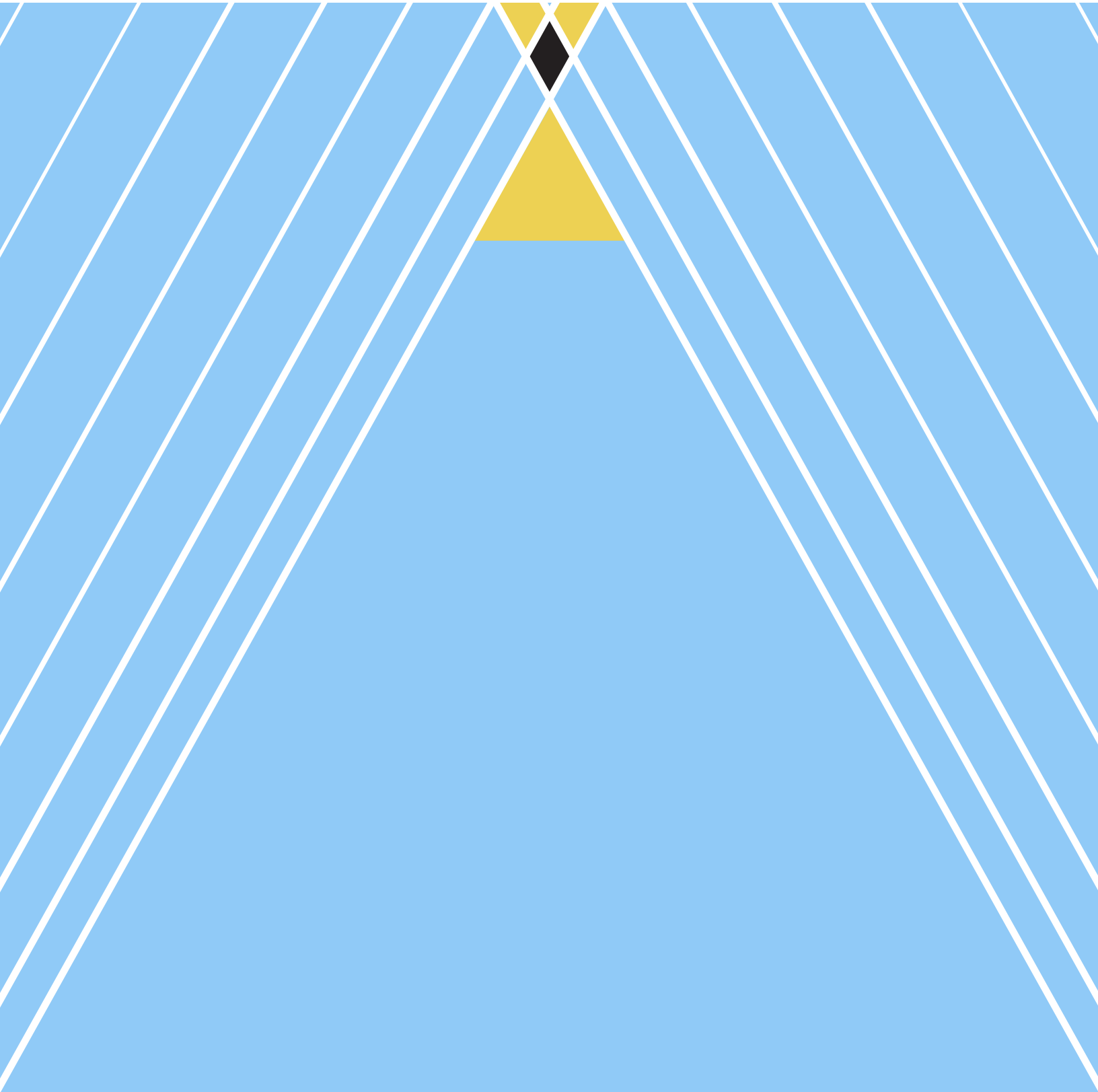




**GOVERNMENT OF SAINT LUCIA**  
MINISTRY OF HEALTH, WELLNESS  
AND ELDERLY AFFAIRS

**Saint Lucia  
Health Financing  
Policy and Strategy,  
June 2024**



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# Acronyms

BBP	Basic benefit package
DRGs	Diagnosis-related groups
FFS	Fee-for-service
GDP	Gross domestic product
GOSL	Government of Saint Lucia
GST	Goods and services tax
HFPS	Health Financing Policy and Strategy
HR	Human resources
HSSP	Health Systems Strengthening Project
IT/IS	Information technology and information systems
KWPF	Korean World Bank Partnership Facility
M&E	Monitoring and evaluation
MOF	Ministry of Finance, Economic Development and the Youth Economy
MOHWEA	Ministry of Health, Wellness and Elderly Affairs
MPI	Master Patient Index
NIC	National Insurance Corporation
OOP	Out-of-pocket
PBF	Performance-based financing
PER	Public Expenditure Review
PFM	Public finance management
PHC	Primary health care
SLUHIS	Saint Lucia Health Information System
SSBs	Sugar-sweetened beverages
UHC	Universal health coverage
VAT	Value-added tax
WHO	World Health Organization

# Acknowledgments

The primary goal of the Health Financing Policy and Strategy (HFPS) is to enable the achievement of universal health coverage (UHC) by ensuring that necessary resources are available for the delivery of a Basic benefit package (BBP) in an efficient and equitable way. This can only be accomplished through a robust health financing model that includes strategic interventions in revenue collection, risk pooling, and strategic purchasing.

The HFPS was produced under the guidance of Sheila O'Dougherty, Consultant, engaged by the World Bank. The development of the strategy was a collaborative effort involving the Ministry of Health, Wellness and Elderly Affairs (MOHWEA) and representatives from various agencies. These agencies included the Ministry of Finance, Economic Development and the Youth Economy, the Office of the Accountant General, and the Office of the Prime Minister, all of whom were key contributors to the work detailed in this document.

The MOHWEA extends its heartfelt thanks to World Bank Officials Dr. Edit Velenyi (Senior Economist, Task Team Leader) and Cointha Thomas (Consultant) for their active participation and facilitation in the development of the HFPS. The document has benefited from technical peer review from Moulay Driss Zine Eddine El Idrissi (Lead Economist) and Pia Schneider (Lead Economist) of the World Bank. Workshops and consultations have been supported under the World Bank-supported Saint Lucia Health System Strengthening Project.

Lastly, the MOHWEA expresses immense gratitude for the financial support from the Korean World Bank Partnership Facility (KWPF) that made this initiative a successful reality.

Dr. Alisha D. Eugene-Ford  
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# Executive Summary

**The Saint Lucia Health Financing Policy and Strategy (HFPS) introduces purchasing of basic benefit package (BBP) services for the entire population to address health financing and service delivery challenges hampering movement towards universal health coverage (UHC).** A new health purchaser within the Ministry of Health, Wellness and Elderly Affairs (MOHWEA) will purchase BBP services by using a national pool of general revenue funds and a shift from input- to output-based provider payment to contract for health services with both public and private providers. Strategic purchasing of BBP services will address the challenges of health system inefficiency, particularly low utilization of cost-effective public primary health care (PHC) services, accelerating divergence of public and private health financing and service provision differentiating care for richer/healthier and poorer/more vulnerable populations, and high out-of-pocket (OOP) payments that undermine equity and financial risk protection and movement towards UHC.

**The HFPS covers 10 years and contains three phases of implementation starting April 1, 2026 (the beginning of the fiscal year).** The three phases sequence both health revenue increases and pooling and purchasing reform with corresponding realignment of public finance management (PFM) for health expenditures.

**Phase I** is two years, contains relatively small general revenue increases to invest in strengthening PHC and corresponding efficiency gains, focuses on purchasing BBP for all frontline integrated PHC services, and overlaps with and is informed by the introduction and institutionalization of performance-based financing (PBF). The HFPS envisions well-functioning public PHC providers receiving output-based payments and motivated by facility autonomy and accountability to better manage frontline, integrated PHC services responsive to community and individual needs.

**Phase II** is three years, also with relatively small general revenue increases, and focuses on purchasing selected or minimum BBP outpatient specialty and inpatient hospital services using public funding with pooling and purchasing arrangements including output-based payment and provider autonomy. Implementation of the purchasing BBP outpatient specialty and hospital services will be based on Phase I development of plans and preparation. Phase II will be the key timeframe for solidifying the alignment of health purchasing and PFM systems and processes to institutionalize PBF for sustainability.

**Phase III** is five years and extends until March 2036 or the end of the HFPS. It is the phase in which health revenue increases and the benefits of strengthening health purchasing and service delivery converge. Revenue increases convert OOP payments to prepayment mechanisms to increase equity and financial risk protection and move towards UHC. A payroll tax for the formal sector, mandatory premiums for informal sector, and general revenue subsidies for the poor are envisioned. During Phase III, purchasing of BBP<sup>1</sup> services funded by general revenue is also solidified and BBP+<sup>2</sup> is added to expand outpatient specialty and inpatient hospital services.

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1 The basic benefit package (BBP) is all primary healthcare services and selected outpatient specialty and hospital services.

2 The basic benefit package plus (BBP+) is BBP plus additional outpatient specialty and hospital services.

**There is also an HFPS preparatory phase dedicated to strategy and plans to institutionalize PBF in the MOHWEA.** The preparatory phase focuses on parallel activities for PBF pilot implementation and PBF institutionalization until the start of Phase 1, on April 1, 2026. The intent is to perform the steps necessary to prepare for scale-up and expansion in HFPS Phase 1. It is already clear that investment in technical methodology, information technology and information systems (IT/IS), training, and operations management will be needed in HFPS Phase I and the MOHWEA should start planning for this process now.

**PBF institutionalization strategy and plans will help ensure retention of PBF experience and expanded, consistent, and sustainable progress in health financing reform to increase use of services in a strengthened PHC sector, and create efficiency gains, equity increases, and movement towards UHC.** It consists of five elements: (i) align PFM systems and processes for output-based payment, specifically PHC per capita/PBF payment; (ii) invest general revenue funding to maintain, scale-up, and expand PHC center management and service delivery results from purchasing BBP PHC services; (iii) align and integrate into the MOHWEA other health system and program elements including service delivery, quality improvement, and use of information; (iv) build on experience and lessons learned in PBF alignment of both PFM and program functions and tasks to begin design of MOHWEA health purchaser structure, roles, and relationships; and (v) envision how PBF institutionalization will enable longer-term HFPS implementation.

**The HFPS contains 15 specific strategies—with two concerning revenue collection, two on pooling of funds, six on health purchasing, three on governance and roles and relationships, and two on communications and monitoring and evaluation (M&E).** These specific strategies are as follows:

#### **Revenue Collection Strategies**

- ◇ Strategy 1 is to gradually increase general revenue allocated to the health sector.
- ◇ Strategy 2 is to shift the type of revenue from OOP payments to prepayment mechanisms providing better financial risk protection.

#### **Pooling Strategies**

- ◇ Strategy 3 is to maintain pooling of public general revenue funds at the national level.
- ◇ Strategy 4 is to pool public general revenue funds and compulsory contribution funds at the national level to purchase BBP services equally and equitably.

#### **Purchasing Strategies (both what to purchase and how to purchase)**

- ◇ Strategy 5 is to specify the BBP to which people are entitled.
- ◇ Strategy 6 is to specify what people are entitled to in BBP+.
- ◇ Strategy 7 is to introduce a PHC per capita payment system including PBF to improve purchasing of BBP PHC services.
- ◇ Strategy 8 is to introduce new hospital inpatient, outpatient specialty, and other service payment systems to improve purchasing of BBP and BBP+ services.
- ◇ Strategy 9 is to integrate or make interoperable health and finance information systems and directly link their corresponding operational processes.

- ◇ Strategy 10 is to address complex issues in payment or procurement of specific inputs including human resources (HR), drugs, and capital.

### Governance and Roles and Relationships Strategies

- ◇ Strategy 11 is continuous development and refinement of health financing policy and the legal and regulatory framework.
- ◇ Strategy 12 is establishing a national health purchaser as a legal entity under the MOHWEA.
- ◇ Strategy 13 is gradual movement towards establishing public health facilities as autonomous and accountable entities with improved financial management systems and processes.

### Communications and Monitoring and Evaluation Strategies

- ◇ Strategy 14 is to develop and implement a communications strategy.
- ◇ Strategy 15 is to monitor HFPS implementation and strengthen M&E.

Table 1 summarizes the steps in the HFPS and their sequencing.

**Table 1. HFPS Steps and Sequencing**

Description	Phase I (Y1–2)	Phase II (Y3–5)	Phase III (Y5–10)
What to purchase	BBP (PHC focus)	BBP (add OP specialty, hospital)	BBP+ (expand OP specialty, hospital)
Beneficiaries	All citizens	All citizens	All citizens
Revenue sources	GGR plus ST increase to invest in strengthening PHC	GGR	GGR, payroll tax, mandatory premiums
Pooling of funds	One national pool	One national pool	One national pool
Managed by	New purchaser under MOHWEA	Purchaser under MOHWEA	Purchaser under MOHWEA
Provider payment	Formula-based PHC per capita with PBF element	PHC per capita/PBF, likely hospital case-based, OP specialty FFS	PHC per capita/PBF, likely hospital case-based, OP specialty FFS
Related measures	Align PFM, HIS, facility autonomy, governance, prepare Phase II	Align PFM, HIS, facility autonomy, governance, prepare Phase III	Align PFM, HIS, facility autonomy, governance, reduce OOP payments
Risks	Low GGR, BBP not focused on PHC, PFM not aligned to output-based payment, health purchaser not established, PHC not enabled to increase service use and quality.	Low GGR, BBP not realistic with limited OP specialty and hospital services, PFM not aligned to output-based payment, purchaser and PHC still developing.	Low GGR, informal sector premiums, BBP and BBP+ not realistic and coordinated, fragmented national pool of funds, PFM not aligned to output-based payment, purchaser and PHC still developing.

Note: BBP = basic benefit package, which is all primary healthcare services and selected outpatient specialty and hospital services; BBP+ = basic benefit package plus additional outpatient specialty and hospital services; FFS = fee-for-service; GGR = government-generated revenue; HIS = health information system; MOHWEA = Ministry of Health, Wellness and Elderly Affairs; OP = outpatient; OOP = out-of-pocket; PFM = public finance management; PHC = primary health care; ST = short-term; Y = year.



# Introduction

**The purpose of the ten-year Saint Lucia National Health Financing and Policy Strategy (HFPS) is to move towards universal health coverage (UHC) by implementing health financing, governance, and management reform and improvement policies and strategies.**

The Government of Saint Lucia has prioritized the HFPS to underpin broader UHC policy. It is related to three policy documents concerning national health sector policy, UHC, and primary health care (PHC), respectively.

The Government of Saint Lucia (GOSL) and the Ministry of Health, Wellness and Elderly Affairs (MOHWEA) National Health Sector Policy provides a framework for decision-making in health and governing the functioning of the health sector.<sup>3</sup> The national policy builds upon the goals, objectives, and commitment of GOSL to provide to the people of Saint Lucia a health care system that is accessible, affordable, equitable, sustainable, and of the highest international quality standard. GOSL envisages a health care system focused on providing care that is integrated, comprehensive, continuous, and accessible at all levels of the health system throughout the life course of individuals.

**The HFPS is built on the foundation of UHC and a PHC approach.** UHC builds on the principle of solidarity and signals the government's commitment to improving access to a specified package of health services for its population and ensuring that it is done in an equitable manner with sufficient financial risk protection, as well as securing sustainable financing for these services. GOSL has embarked on ambitious reforms to accelerate progress toward UHC and has prioritized health financing reforms to support health systems strengthening and service delivery improvement in the country's health sector. UHC and health financing reform include the first step of implementing performance-based financing (PBF).

**The PHC approach is built upon the principles of equity, solidarity, ethics, and the right to health.** It places significant emphasis on prevention, health promotion, the use of appropriate technologies, and the empowerment of families and communities as equal partners with health professionals in the decision making about health services provision. The PHC approach means being attentive to and addressing various factors in the economic, social, and physical environment that affect the health of individuals. These include but are not limited to lifestyle, income, education, workplace, diet, housing, culture, and the environment.

**Under the Health Systems Strengthening Project (HSSP) and the grant from the Korean World Bank Partnership Facility (KWPF), the World Bank is supporting GOSL to develop a comprehensive approach to strengthening the country's health system** by helping to address: (i) demand and supply-side constraints; (ii) issues of financial protection, through establishing systems for fair, efficient, and sustainable financing; and (iii) service coverage by ensuring equitable access to affordable, quality health services. Technical assistance for HFPS development was supported by KWPF<sup>4</sup> in coordination with implementation of the HSSP and performance-based financing (PBF) pilot.

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<sup>3</sup> The statement of intent, goals, objectives, principles, and values is taken from MOHWEA Draft National Health Sector Policy (NHSP) "Safeguarding Health."

<sup>4</sup> KWPF through the World Bank and Results for Development (R4D) consultancy (Sheila O'Dougherty).

**The HFPS is a policy and strategy document for both the public and private sectors, with an accompanying detailed implementation plan, developed in a consultative manner led by the MOHWEA.** The MOHWEA UHC Unit, established under Cabinet Conclusion No. 129 of 2022, serves as the secretariat for all UHC policies, including the HFPS, and is headed by the UHC Director who is responsible for the development process and managing the strategy through public consultations. The strategy has been developed over the past 1.5 years, with consultations engaging a wide range of stakeholders from various ministries. The MOHWEA has paid particular attention to consultations with the Ministry of Finance, Economic Development and the Youth Economy (MOF), including offices of the Accountant General, Budget Director, and Director of Finance, to engage them early in the revenue mobilization and public finance management (PFM) aspects of the strategy. The process also included an onsite workshop in February 2023; four remote workshops in April–June 2023; developing a draft of the HFPS in June 2023; extensive onsite dialogue and a workshop (November 21–December 1, 2023) focused on PBF institutionalization strategy, short- and longer-term revenue increases; an HFPS review workshop (December 2023); and production of a revised draft of the HFPS (also December 2023).

**The HFPS includes specific strategies grouped around three fundamental health financing functions: revenue collection, pooling of funds, and health purchasing.** Revenue collection is the source and level of funds; pooling is the accumulation of prepaid revenues on behalf of a population and purchasing is the transfer of pooled funds to providers on behalf of a population.<sup>5</sup> This introductory section is followed by sections on background and situational analysis; the HFPS approach; revenue collection; pooling of funds; health purchasing; governance and institutional roles and relationships; and communications and monitoring and evaluation. An underlying HFPS theme is “double shock, double recovery”—meaning that the health and economic shock of COVID-19 needs to be matched by health and economic recovery. Fiscal constraints will make the task difficult, but GOSL is motivated to open the necessary fiscal space to reverse the deteriorating health and social conditions, especially given the effects of the COVID-19 pandemic.

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5 WHO/EURO/Joe Kutzin; Health Financing Policy: A Guide for Decision-Makers; 2008



# Background and Situational Analysis

This brief background and situational analysis section is primarily based on the 2021 Public Expenditure Review (PER),<sup>6</sup> MOF data sources, the International Monetary Fund World Economic Outlook Database (Country Data Documentation), and World Bank presentations on the macro-economic and fiscal situation.<sup>7</sup> In addition, specific PER recommendations are incorporated into appropriate sections in the strategy. As an upper-middle income country in the Caribbean with a population of 180,000, Saint Lucia has achieved reasonable results in terms of key indicators including life expectancy (75 years) and the under-five mortality rate (14 per 1,000 live births). However, for the last decade, Saint Lucia has faced upward pressure on health spending with limited advancement in access to care and out-of-pocket (OOP) spending indicators.

**The HFPS will address challenges to the level and composition of health revenue and inefficiencies in health expenditure management that contribute to poor financial risk protection and low utilization of services, especially at PHC level, making it difficult to move towards UHC.** Specifically, reducing OOP spending to move towards UHC requires taking advantage of opportunities to address risks including low general revenue funding, maintaining national pooling of funds to avoid fragmentation, and shifting to strategic purchasing of a basic benefit package of services through output-based provider payment including realigning PFM and gradually increasing facility autonomy and accountability. The subsections below outline the challenges or risks and corresponding opportunities in health revenue and spending and disease burden trends, health service utilization, and allocation of health expenditures. For reference, a summary of the macro-fiscal situation is provided in Appendix 1.

## ► Health Revenue and Spending<sup>8</sup>

Total health financing in Saint Lucia was estimated at EC\$290.0 million in 2019 which represented 5.1 percent of gross domestic product (GDP). Over the past two decades, there has been very little change in spending prioritization for the health sector: declining slightly from 5.4 percent of GDP in 2000 to 5.1 percent in 2019. Saint Lucia lags behind other nations in terms of per capita health expenditure. Across a sample of 11 Caribbean countries, the per capita spending was estimated at US\$1,023 (purchasing power parity), about 55 percent higher than the level observed in St. Lucia.

According to international recommendations and estimates on the cost to offer an essential benefit package to all, the public health expenditure or budget target (“Abuja target”) would be 15 percent of the total government expenditures.<sup>9</sup> **As shown in Figure 1 below, health represented**

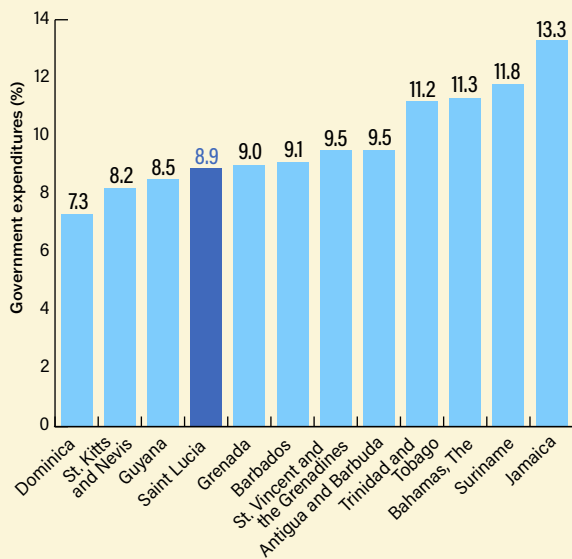
6 Public Expenditure Review Report dated February 24, 2021.

7 World Bank Group, 2022, *Saint Lucia: Urgency to Strengthen Fiscal Sustainability and Growth*, June; World Bank Group, 2021, *From Double Shock to Double Recovery: Implications and Options for Health Financing in the Time of COVID-19*, May.

8 Review of Public Sector Health Expenditures, Including Recommendations for Efficiency Gains and Improvements in Equity, and Development of National Health Accounts. RFP No. 006/CS/HSSP/18 Government of Saint Lucia. Deliverable 4: Public Expenditure Review. Final Version. February 24, 2021.

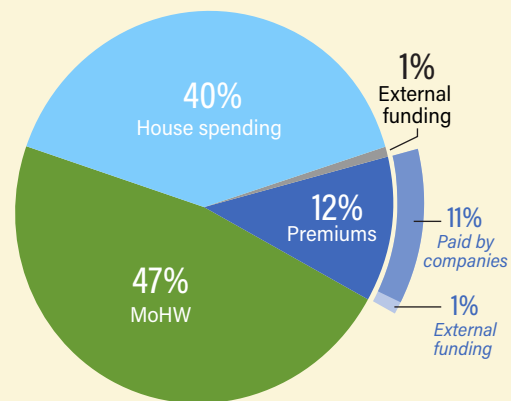
9 Organization of African Unity (2001), “Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Diseases,” OAU//SPS/Abuja 3, <https://au.int/sites/default/files/pages/32894-file-2001-abuja-declaration.pdf>.

**Figure 1. Health Expenditures as a Percentage of Government Spending, 2017**



Source: World Bank Development Indicators database

**Figure 2. Distribution of Total Health Expenditure, by Category, 2019**



Source: Ministry of Finance, Economic Development and the Youth Economy, and Household Survey

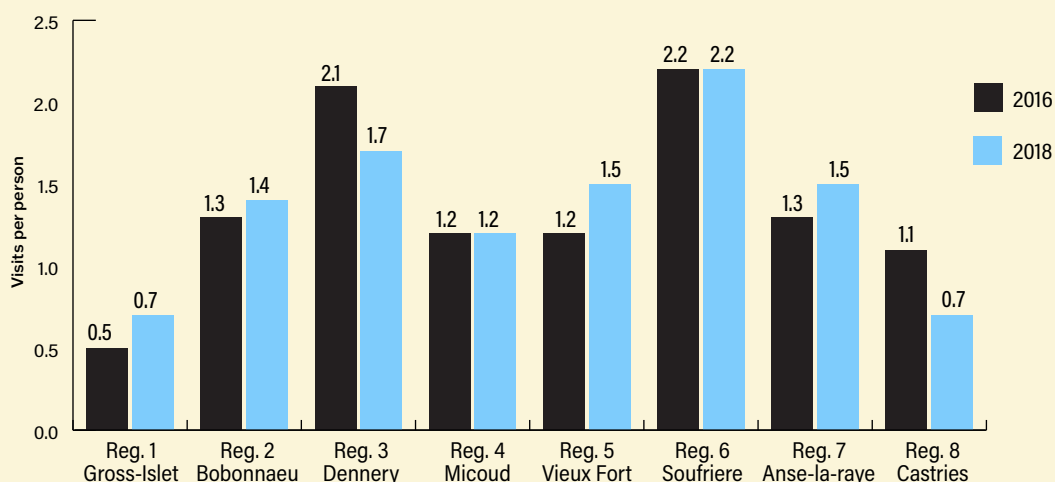
**8.9 percent of government spending, ranking low among countries in the region.** There is space to increase the share of government expenditures for health. For context, in fiscal year 2022/2023, the health sector budget was EC\$142m (US\$53m).

As shown in Figure 2, approximately 50 percent of total health expenditure is public and 50 percent is private. MOHWEA public expenditures are 47 percent of the total. Private expenditures are 52 percent of expenditures, with the remaining 1 percent external spending. Categories of private expenditures are 40 percent household OOP and 12 percent premiums (11 percent prepaid by companies and 1 percent by individuals). This composition is not consistent with UHC; the high OOP spending compared to the percentages of either public general revenue budget or prepaid private spending likely results in a lack of financial risk protection, especially for the poor and underserved. This is a barrier to accessing health care services.

► **Disease Burden Trends, Health Service Utilization, and Allocation of Health Expenditures**

For disease burden trends, the HFPS draws on a burden of disease study conducted by the MOHWEA (2014) and international estimates from IHME. A recent analysis by IHME (2020) shows there have been only minor changes in the overall composition of the top 10 causes of mortality, but the percentage increase from noncommunicable diseases is notable: stroke, diabetes, heart disease, and others all increased by nearly 50 percent on average from 2009 to 2019. This highlights the urgency of strengthening the PHC system so these preventable or chronic diseases (NCDs) can be managed through population health programs, improved screening, and wider access to the medication and life-style changes that will cost-effectively reduce the burden of disease. Failure to strengthen PHC and increase NCD coverage is likely to lead to exploding health costs in the future for the population and the government.

**Figure 3. Annual Visits Per Person, by Region, 2016 and 2018**



Source: Data from the Ministry of Health, Wellness and Elderly Affairs presented in Public Expenditure Review 2021.

**The public network of providers is substantially underused; this is perhaps the most critical challenge in terms of overall performance.** Overall, clinical activity or service utilization in Saint Lucia is low in comparison with Latin America and the Caribbean nations. This low sector utilization extends across health system levels, types of services, and indicators. In per capita terms, the average number of visits was estimated as 1.2 visits per person per year, a figure that ranks far below international evidence that usually places it in the range of 2.0–4.0 visits per person. In addition, as shown in Figure 3, visits per capita averages vary widely across regions within Saint Lucia.

Based on Public Expenditure Review (PER) analysis of the average volume of patients per day, there are 2,200 square feet of infrastructure per patient visiting a PHC center. In some facilities, the productivity per staff full-time equivalent (FTE) does not reach two patients per day. For some services, the level of production moves in the opposite direction of the burden of disease. While chronic diseases have been growing substantially in the past three decades, the total number of preventive and chronic disease control visits is generally not increasing. On variation across geographic areas, most regions showed a contraction in utilization of health services between 2016 and 2018. The PER survey showed this was driven by a combination of low patient engagement, limitations in drug supply, equipment and diagnostic capacity, and perceptions on cost of care in clinics.

**As in most of the countries in the region, hospital spending accounts for half of the MOHWEA budget. In terms of allocative efficiency, PHC is notably underfunded given its cost-effectiveness, contribution to UHC, and importance in service delivery including addressing the country's disease burden.** In 2014–2018, PHC received an average of 12.8 percent of spending

and 1.1 percent of capital spending. Recurrent PHC spending represents only 0.26 percent of GDP. The World Health Organization (WHO), when addressing PHC and the goal of universal access, stated that:

*Countries must increase spending on PHC to at least 1 percent of their gross domestic product (GDP) if the world is to close glaring coverage gaps and meet health targets agreed in 2015...*<sup>10</sup>

**If this is the point of reference, then St. Lucia should quadruple PHC spending over the 2014–2018 average.** When looking only at high middle-income countries, WHO estimates that PHC should be in the range of 0.8 percent to 1.7 percent of GDP to achieve UHC. In the lowest case scenario, Saint Lucia would need to spend approximately US\$28.2 million (at minimum triple its 2014–2018 average) to reach the recommended WHO target.

**A theme throughout the HFPS is that if public PHC centers do not function well, it is hard to increase efficiency to extend coverage, improve equity, and financial risk protection to move towards UHC or improve access to high quality health services.** Increasing PHC resource allocation and improving expenditure management are central for both PBF introduction and broader health financing strategy.

In terms of the structure or composition of spending, PER analysis shows the MOHWEA budget in 2016–2017 and 2017–2018 had a high concentration in four expenditure types or categories: emoluments and wages, grants, supplies and materials, and capital investments. The largest category was emoluments and wages at 37.3 percent, followed by grants at 22.2 percent, capital investment at 18.2 percent, supplies and materials at 11.9 percent, and other at 10.4 percent. Administrative expenses are high: accounting for one in seven dollars of recurrent spending; this is a place to explore savings and efficiency options and/or spending reallocation.

**Within the expenditure categories, human resources (HR) and drug inefficiencies and issues underlie a variety of sector performance problems.** Staffing levels and the wage bill are lower than other Latin America and the Caribbean countries although the relatively high level of grants may underestimate the true staffing level and wage spending. HR issues and inefficiencies beyond low service utilization and staffing levels include: 17 percent unfilled positions (mostly nurses); declining average salary per worker (a trend not frequently observed in public budgets and may reflect hiring focused on low-wage categories without significant clinical or service delivery value-added or a growing gap in remuneration and difficulty competing with private facilities); the relationship between financing and the evolution of service delivery—for example, the introduction of digital health tools would assist in improving productivity and reduce the need for in-person home visits; issues concerning transparency and management of non-established (subcontracted) staff; issues with incentive structures; and inequities in the distribution of staff across regions.

**Saint Lucians are spending large amounts on drugs and medical visits; this could be avoided if the public system operated more efficiently.** Pharmaceuticals and medical visits are the top two OOP expenditures. Public spending on drugs in Saint Lucia is lower than other countries

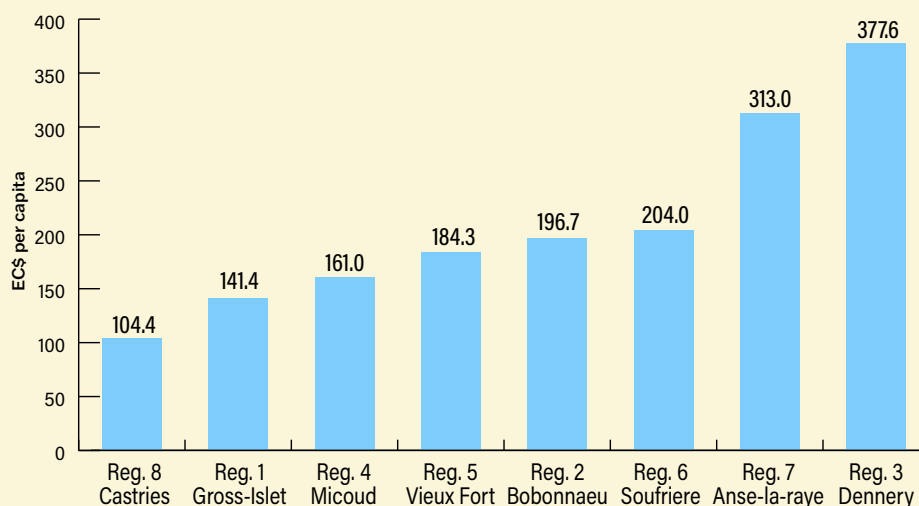
<sup>10</sup> See World Health Organization (2019), "Countries Must Invest at Least 11% More of GDP on Primary Health Care to Eliminate Glaring Gaps," press release, September 22, <https://www.who.int/news/item/22-09-2019-countries-must-invest-at-least-1-more-of-gdp-on-primary-health-care-to-eliminate-glaring-coverage-gaps#:~:text=Countries%20must%20increase%20spending%20on,Assembly%20high%2Dlevel%20meeting%20on>

in the region. The lack of availability during the PER survey underscores the limited access to drugs in public facilities. In addition, the distribution of drug expenditures varies widely across regions. These findings are consistent with low utilization and excess capacity in public health facilities and with inefficiencies in the administration of drugs. Drug non-availability is the main reason survey respondents gave for preferring private pharmacies. At the same time, most regions report that 3–10 percent of all drugs are wasted. PER drug spending inefficiencies observed include a high share of prescriptions that are not dispensed and estimates that using a different price catalog to purchase generic pharmaceuticals might save about US\$1 million for the top 20 drugs.

**As shown in Figure 4, there are substantial differences in per capita health spending allocated across regions within the country.** Per capita disparities across regions have many explanations including remoteness and population density, burden of disease, and health service needs. However, institutional and financing aspects rooted in the health delivery system structure and health budget formation and execution mechanisms may also affect equity and efficiency in the distribution of resources. Addressing this situation is a comparative advantage of purchasing BBP services through output-based payment because it is directly tied to policy objectives and service outputs received, not infrastructure or historical budgets.

**Performance-based financing (PBF) helps to drive health financing reforms.** Health financing reform in Saint Lucia started with the introduction of performance-based financing (PBF) in 2023. PBF supported moving towards UHC by strengthening health financing, management, and service delivery at PHC facilities. PBF principles include building comprehensive purchasing reform, avoiding fragmentation, and using existing systems. The introduction of PBF initiated a shift from input-based budgeting and payment for infrastructure to output-based budgeting and payment purchasing benefits/services for the entire population. The early and proactive focus on PBF institutionalization triggered productive dialogue on how to avoid fragmentation and

**Figure 4. Regional Per Capita Spending, 2018**



Source: Data from the Ministry of Health, Wellness and Elderly Affairs presented in Public Expenditure Review 2021.

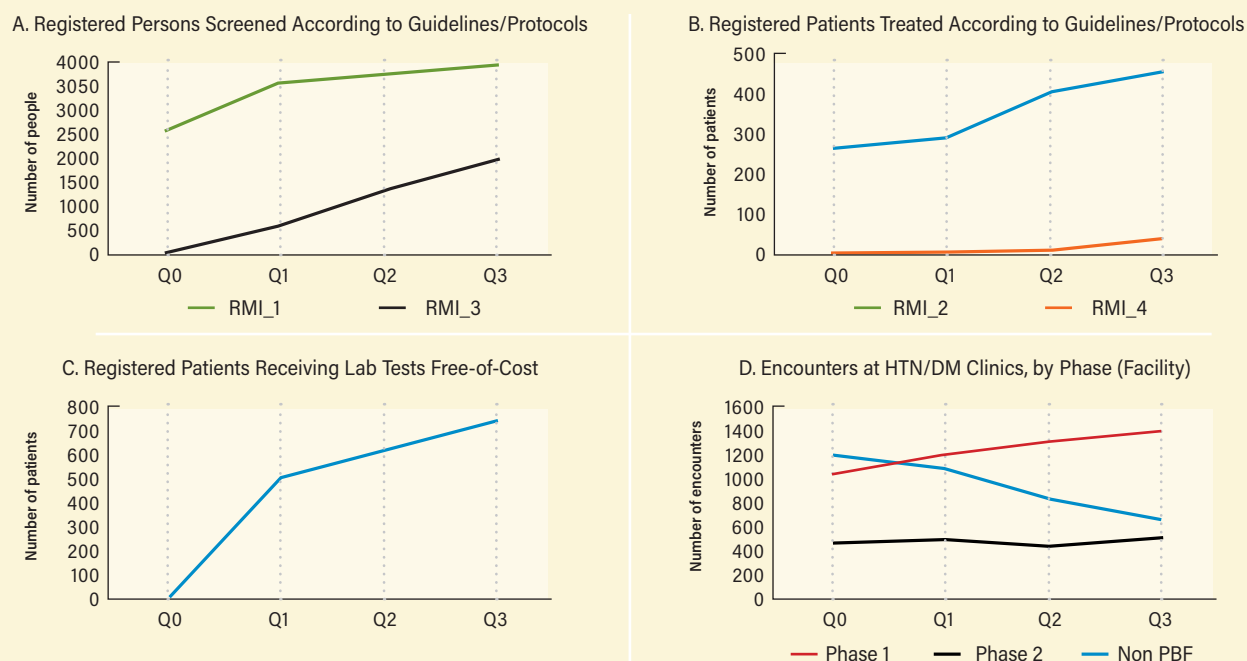
realign PFM to establish PBF as the foundation of broader long-term health financing reform strategy and sequencing.

**PBF has actively purchased and incentivized increased utilization, extended coverage, and improved quality for priority noncommunicable disease (NCD) services for hypertension and diabetes mellitus.** Specifically, the intent was to improve early detection and timely treatment for hypertension and diabetes as they severely affect quality of life and cause premature death. PBF introduced a mixed provider payment model including population-based per capita payment to shift resources to PHC providers, incentive payments based on performance of PHC providers, and fee-for-service to pay for laboratory tests.

Saint Lucia has eight administrative health regions. Half of them (Dennerly, Micoud, Soufriere/Chouiseul, and Anse La Raye/Canaries) are participating in the initial PBF implementation, including the pilot and first phase of scale-up or expansion. **In August 2023, the PBF pilot was launched in eight PHC facilities. In May 2024, PBF expanded to nine additional PHC facilities. The 17 participating facilities comprise half of the public PHC facility network, which consists of 34 facilities.**

**PBF and its associated financing, management, and service delivery interventions quickly began to transform how essential PHC services are delivered, starting with hypertension and diabetes.** Early results (see charts in Figure 5) showed increased utilization; higher quality of care (compliance with protocols); increased lab tests; better access to drugs; and strengthened record keeping, accountability and planning functions at the facility level. For example, preliminary assessments show an increase of almost 33 percent in the use of hypertension and diabetes services compared to the baseline.

**Figure 5. Performance-Based Financing Early Results, July 2023–April 2024**



Note: DM = diabetes mellitus; HTM = hypertension; Q/QR= quarter; RMI = results monitoring indicator.

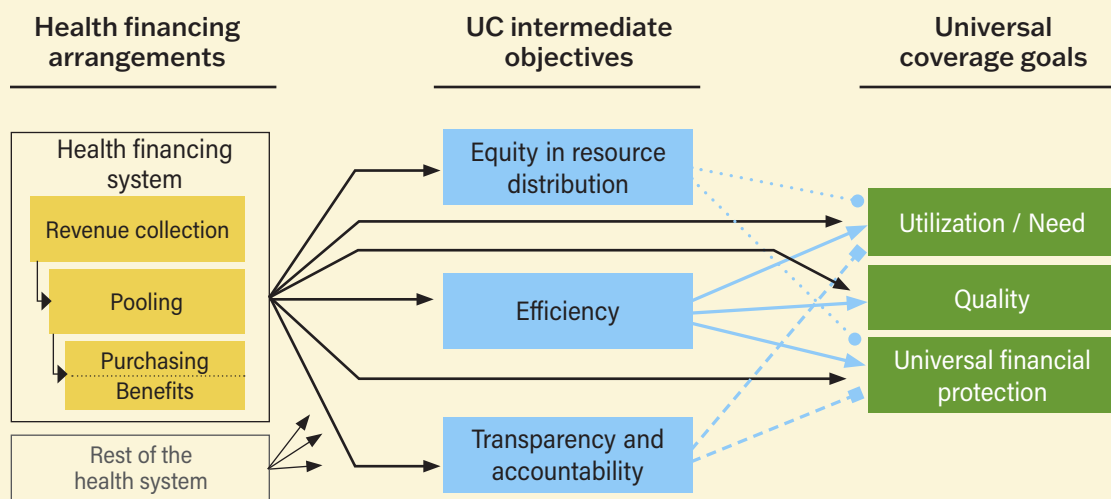
# Approach to the Health Financing and Policy Strategy

## ► International Concepts and Experience

Over the last decade, global health policy has raised the visibility of the goal of attaining **universal health coverage (UHC)**. The 2010 World Health Report<sup>11</sup> states that financing systems should be specifically designed to provide all people with access to needed health services (including prevention, promotion, treatment, and rehabilitation) of sufficient quality to be effective and ensure that the use of these services does not expose the user to financial hardship. UHC goals embedded in this definition include equity in service use or utilization based on need, quality, and universal financial protection.

As shown in Figure 6, there is a strong and direct relationship between health financing arrangements; the UHC intermediate objectives of equity in resource use, efficiency, and transparency and accountability; and UHC goals. Because it is organized around the three health financing functions of revenue collection, pooling of funds, and health purchasing, this conceptual relationship is also practical and can be used to portray Saint Lucia's HFPS vision.

**Figure 6. Relationship between Health Financing Functions UHC Goals and Objectives**



Source: World Health Organization (2017), *Developing a National Health Financing Strategy: A Reference Guide. Health Financing Guidance No. 3.*

Note: UC = universal coverage; UHC = universal health coverage.

<sup>11</sup> World Health Organization (2010), *The World Health Report: Health Systems Financing: The Path to Universal Coverage*, World Health Organization, <https://apps.who.int/iris/handle/10665/44371>.

**Countries cannot simply spend their way to UHC. It is important to get beneath commonly used labels such as “tax-funded systems” or “social health insurance”. Pathways to UHC increasingly stress moving from schemes to systems, not compromising equity, and prioritizing strategic health purchasing as the main health financing instrument for promoting efficiency in the use of funds.**<sup>12</sup> This emerging international experience and consensus is consistent with government policy and serves as the foundation of the Saint Lucia HFPS.

## ► Overarching Health Financing and Policy Strategy and Sequencing

### Overall Options

**Saint Lucia is at a crossroads, facing a choice between two overarching health financing/health purchasing strategies to realize its commitment to UHC. The first option is to retain the existing system of input-based budget and payment for public providers.** The public health sector has good health system structure and public finance management (PFM) but the system is fraying around the edges with low PHC utilization in public facilities and a decreasing proportion of public funding (increasing private funding). If this trend continues, the road to UHC is hard to envision.

Input-based budget and payment systems can function well if the public funding for the public system approaches 100 percent. However, with only about 50 percent of total funding (population private out-of-pocket payments are also close to half of total funding), the health sector begins to fragment into separate public and private systems with the public system primarily responsible for poorer and less healthy populations and the private system serving richer and healthier populations. In addition, citizens may consult public providers but be forced to pay for private services or products (e.g., lab tests, drugs) if they are not available in the public system. This fragmentation directly impacts the UHC goals of universal financial protection and utilization of quality services based on need.

**The second overarching option is to shift to purchasing basic benefit package (BBP) services for all people using output-based budgeting and provider payment.** Output-based payment defines service outputs, allocates funds to providers based on service outputs (as opposed to budget line items or inputs), and increases provider autonomy and accountability with the right to determine the best mix of inputs delegated to providers together with the responsibility to perform sound financial management.<sup>13</sup> This option enables health purchasers to “buy the right thing,” better match payment to prioritized services, and use financial incentives to improve performance. Contracting or the conditions included in payment system specification allows public money to contract for BBP services with private providers and private money to contract with public providers.

**The HFPS is based on option two because strategic purchasing of BBP services for all citizens enables Saint Lucia to move towards UHC,** level the playing field for public and private financing and service provision, shift out-of-pocket (OOP) payments to pre-payment mechanisms, motivate health providers, strengthen PHC, and improve performance of the entire

<sup>12</sup> Joseph Kutzin (2012), “Anything Goes on the Path to Universal Health Coverage? No,” *Bulletin of the World Health Organization*, Nov. 1, 90(11):867–868, doi: 10.2471/BLT.12.113654.

<sup>13</sup> WHO (2022), *Direct Facility Financing: Concept and role for UHC*, Geneva: World Health Organization, licence: CC BY-NC-SA 3.0 IGO.

health system. In addition, this option enables the achievement of two critical and concrete aspects of the overarching health financing strategy: improving the financing and functioning of public PHC providers, and institutionalizing performance-based financing (PBF) for sustainability (see section below).

**Strengthening frontline PHC services lies at the heart of both moving towards UHC and the relationship between health financing and service delivery.** No country can afford a system where people access most of their health services through higher level outpatient specialty and inpatient hospital providers. Empowering public PHC providers (Level 1–4 PHC facilities) to function at the same or higher levels than private PHC providers is vital to maintain and increase equity and efficiency in health service delivery. This option is consistent with ongoing PBF implementation and positions the HFPS to enable institutionalization of PBF for sustainability, a process that many countries have been unable to accomplish.

## Strategy and Sequencing

**Figure 7 and Table 2 portray a vision of the Saint Lucia health financing strategy and its sequencing in which GOSL offers and manages a BBP for the entire population.** Encompassed in three phases of health financing reform are health revenue, national pooling of funds, BBP population entitlement (which health services to purchase), and output-based provider payment to contract with both public and private providers (how to purchase BBP services). The black-lined box, which covers the three phases of HFSP implementation, contains all health services that are fully or partially funded by public funds (BBP and BBP+ or supplemental benefits). The brown-colored box beyond the black-lined box shows additional health services outside the BBP and BBP+ population entitlement; they are completely funded by private non-compulsory insurance or OOP payments.

**Phase I (dark blue bottom box in Figure 7) is two years; it overlaps and is informed by PBF introduction.** It focuses on purchasing all frontline, integrated PHC services. The foundation of Saint Lucia’s commitment to UHC consists of using public funds to purchase a BBP that contains all frontline PHC services free for the entire population. As described throughout the HFPS, a condition of realizing this commitment is well-functioning public PHC providers receiving output-based payments and motivated by facility autonomy and accountability to better manage frontline, integrated PHC services that respond to community needs. PHC per capita payment is at the heart of purchasing BBP and key to strengthening PHC as it pushes resources for the entire population to frontline PHC services. The mixed payment model will not result in fragmentation because the PHC per capita payment formula will include a performance element (consistent with initial PBF design of 60 percent capitation and 40 percent incentive payments). Phase I will also include preparation for Phase II reform of purchasing BBP outpatient specialty and inpatient or hospital services. Phase I will most likely continue to use existing input-based budget payment systems, but the evolution to output-based payment could begin (e.g. case-based hospital payment).

**Phase II (light blue middle row in Figure 7) is three years.** It focuses on purchasing selected or minimum BBP outpatient specialty and inpatient hospital services funded by public general revenue with pooling and purchasing arrangements including output-based payment and provider autonomy. Purchasing BBP outpatient specialty and hospital services will be based

on Phase I development of plans and preparation. Phase II will also be the time for completing the alignment of health purchasing and PFM to institutionalize PBF for sustainability.

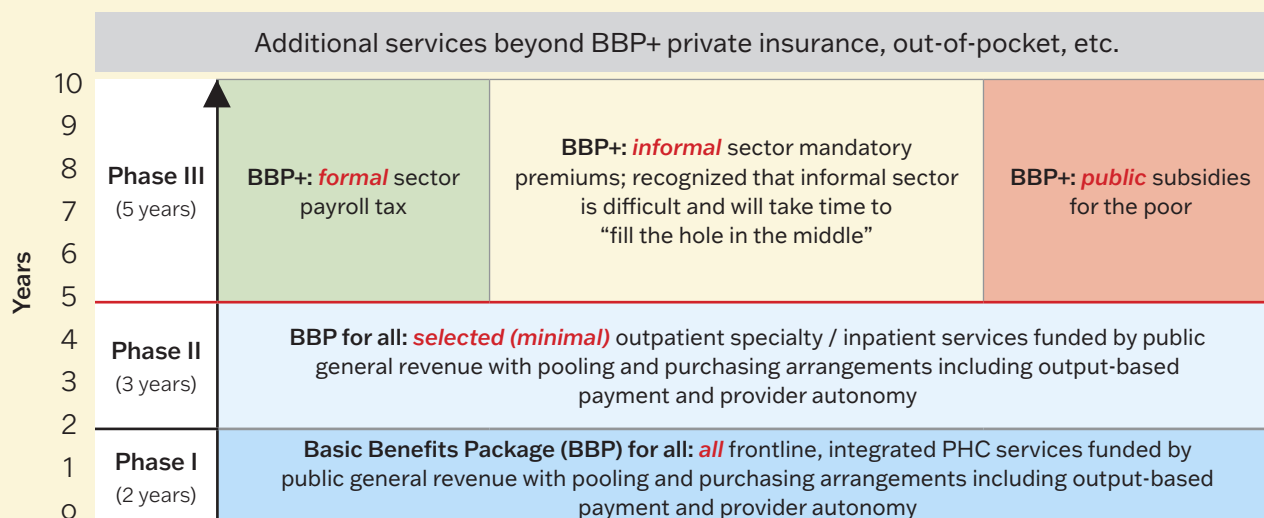
**Phase III (top row—green, yellow, and red—in Figure 7) is five years.** It is the phase where larger health revenue increases converge with strengthened health purchasing and service delivery. During this phase, general revenue for BBP and BBP+ is increased to expand outpatient specialty and inpatient hospital services. However, It is unlikely that general revenue increases will be large enough to substantially reduce OOP payments. The colored boxes show the type of pre-payment mechanism to use to achieve the HFPS objective of reducing OOP payment—which is essential to equity, financial risk protection, and movement towards UHC.

**The green box is the formal sector, and its funding source is a mandatory payroll tax.**

The red box covers poor and underserved populations who are unlikely to be able to afford a compulsory contribution; funding will come from public general revenue subsidies. The yellow box is the informal sector who will pay mandatory or compulsory premiums. Global experience demonstrates that collecting compulsory contributions from the informal sector is difficult. The HFPS will address this problem by promoting the substantial investment of public funding in BBP and BBP+, leaving a relatively low compulsory premium and recognizing that it will take time to fill the gap or “fill the hole in the middle” of BBP+ funding. The red line can move up or down depending on country policy decisions on the proportion of general revenue versus prepayment mechanisms.

**Phase III will also solidify pooling and purchasing arrangements, refine information systems, and use better data from provider payment operating systems to analyze and cost BBP and BBP+ services to improve health purchasing and forecasting of revenue requirements.** In summary, the sequencing of Saint Lucia’s health financing reform first invests small general revenue increases to reform health purchasing and service delivery for the population, and then adds larger general revenue increases and shifts to pre-payment mechanisms. A better functioning health system delivering quality health services will increase population demand and satisfaction and ensure value for money from increased public funding and a shift to pre-payment mechanisms. In a small country like Saint Lucia, it is critical to maintain national pooling and avoid initiatives that may cause fragmentation and escalate transaction costs. BBP and BBP+ are intended to be new program budget line items managed by the same entity, the new health purchaser.

**Figure 7. Health Financing Strategy and Sequencing: Phased BBP Purchasing Chart**



Source: HFPS In-Person Launch Workshop, February 13–17, 2023.

Note: HFPS = Health Financing Policy and Strategy; UHC = universal health coverage.

**Table 2. HFPS Steps and Sequencing**

Description	Phase I (Y1–2)	Phase II (Y3–5)	Phase III (Y5–10)
What to purchase	BBP (PHC focus)	BBP (add OP spec, hospital)	BBP+ (expand OP spec, hospital)
Beneficiaries	All citizens	All citizens	All citizens
Revenue sources	GGR plus ST increase to invest in strengthening PHC	GGR	GGR, payroll tax, mandatory premiums
Pooling of funds	One national pool	One national pool	One national pool
Managed by	New purchaser under MOHWEA	Purchaser under MOHWEA	Purchaser under MOHWEA
Provider payment	Formula-based PHC per capita with PBF element	PHC per capita/PBF, likely hospital case-based, OP specialty FFS	PHC per capita/PBF, likely hospital case-based, OP specialty FFS
Related measures	Align PFM, HIS, facility autonomy, governance, prepare Phase II	Align PFM, HIS, facility autonomy, governance, prepare Phase III	Align PFM, HIS, facility autonomy, governance, reduce OOP payments
Risks	Low GGR, BBP not focus on PHC, PFM not aligned to output-based payment, health purchaser not established, PHC not enabled to increase service use and quality.	Low GGR, BBP not realistic with limited OP specialty and hospital services, PFM not aligned to output-based payment, purchaser and PHC still developing.	Low GGR, informal sector premiums, BBP and BBP+ not realistic and coordinated, fragment national pool of funds, PFM not aligned to output-based payment, purchaser and PHC still developing.

Note: BBP = basic benefit package; BBP+ = basic benefit package plus additional outpatient specialty and hospital services; FFS = fee-for-service; GGR = government-generated revenue; HIS = health information system; MOHWEA = Ministry of Health, Wellness and Elderly Affairs; OP = outpatient; OOP = out-of-pocket; PFM = public finance management; PHC = primary health care; ST = short-term; Y = year.

**The Saint Lucia HFPS and its sequencing are consistent with international best practice as shown by a comparison with the WHO UHC cube (Figure 8).** The UHC cube visualizes three dimensions for expanding coverage: to individuals previously not covered, to services previously not covered, or to reduce the direct payments needed for each service. Saint Lucia has already covered the entire population with health services and maintaining national pooling should help ensure preservation of this comparative advantage.

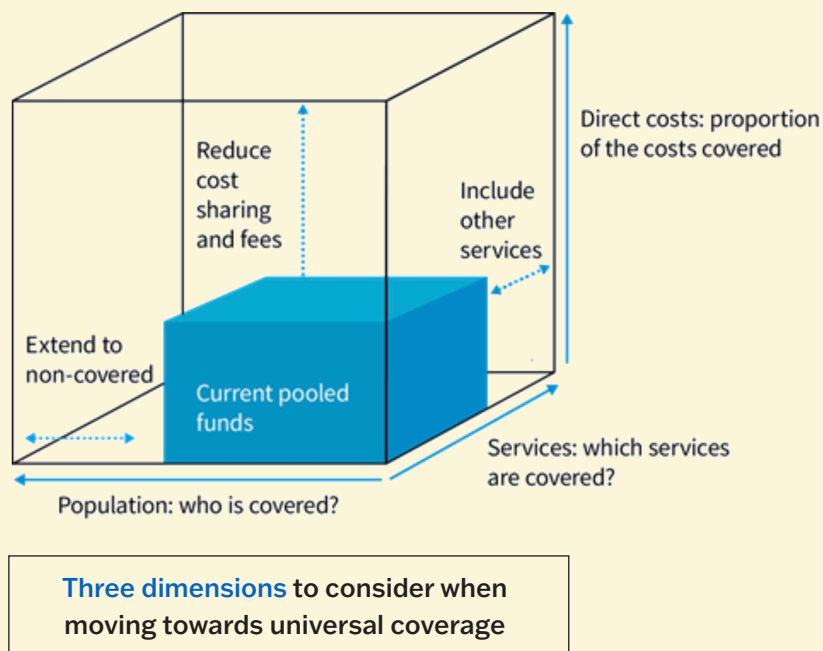
**On the services covered dimension, Phases I, II, and III of HFPS implementation envision a gradual expansion of services** covered: with Phase I emphasizing all frontline, integrated PHC services, Phase II covering a limited or minimum set of BBP outpatient specialty and inpatient services, and Phase III adding BBP+ to expand outpatient specialty and inpatient hospital services. On the cost sharing dimension or reducing the direct payments needed for each service, Phase III envisions a big push to both increase general revenue funding and shift to pre-payment mechanisms for OOP payments following the establishment of pooling and purchasing mechanisms intended to improve equity, efficiency, transparency, accountability, and management of quality of health services.

**Figure 8. Health Financing Strategy and UHC Cube**

**Population covered:** all covered, maintain advantage of national pooling

**Services covered and cost-sharing:**

- ◇ BBP dark blue box frontline PHC: Phase I and II cover all services for free, Phase III expands scope of services
- ◇ BBP light blue box of outpatient specialty and hospital services and BBP+: Two Phase II and III options:
  - Phase II prioritize selected minimal outpatient and specialty hospital, Phase III add services
  - Phase II most outpatient specialty and hospital with copayments, Phase III reduce copayments (pre-payment)



Source: R. Busse and S. Schlette, editors (2007), *Focus on Prevention, Health and Aging, New Health Professions*, Verlag Bertelsmann Stiftung: Gütersloh, Germany; and World Health Organization (2010), *The World Health Report: Health Systems Financing*.

Note: BBP = basic benefit package; UHC = universal health coverage; WHO = World Health Organization.

## Implementation Dynamics

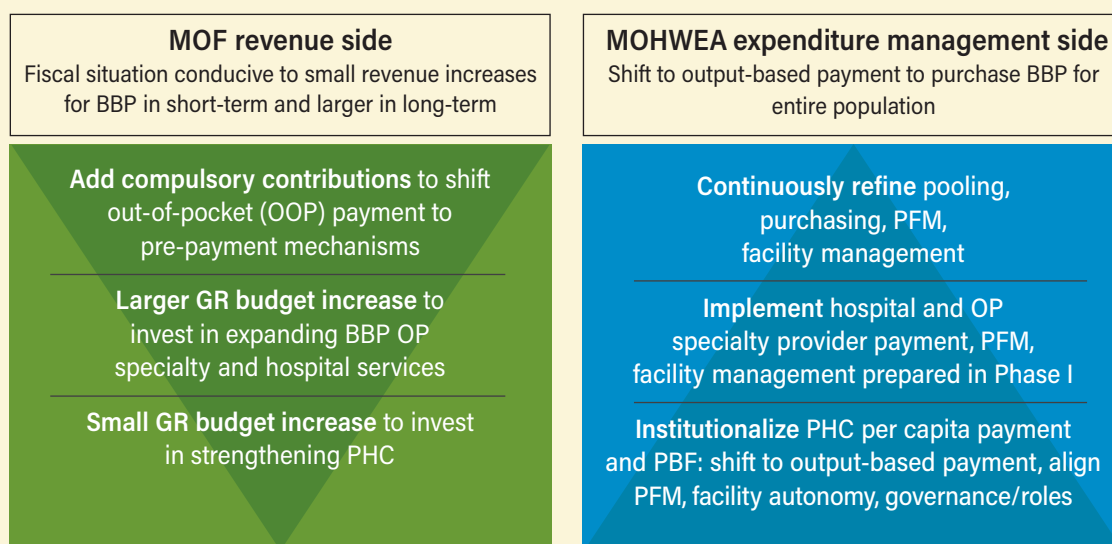
**The phased BBP purchasing chart (Figure 7) is a conceptual, two-dimensional representation of the overarching health financing strategy and its three-phase revenue and expenditure sequencing.** Figure 9 adds a third dimension under the BBP purchasing chart, showing the engine driving HFPS implementation dynamics. The inverted pyramid on the left represents the MOF and the revenue side of the health financing strategy. The regular pyramid on the right represents the MOHWEA and the expenditure management (pooling and purchasing) side of the health financing strategy. Both pyramids portray time and money investments that move from broad and extensive interventions to narrow and routine operations or vice versa. The regular and inverted pyramids fit together to create implementation dynamics that convert two constraints into opportunities.

**The first constraint is the fiscal space issues currently faced by Saint Lucia** (see Background section). It will be difficult for the MOF to substantially increase general revenue allocation to health in the short term. However, relatively small but vital general revenue budget increases could be invested in strengthening frontline PHC services. This investment will begin the continuous service delivery improvement cycle by shifting health services to the PHC level to obtain the equity and efficiency gains required to extend service coverage while holding outpatient specialty and hospital providers harmless by not reducing their budgets. Gradual increases in general revenue should occur in Phases II and III to fund BBP and BBP+ outpatient specialty and inpatient hospital services. In Phase III, the addition or solidification of compulsory contributions including public subsidies for the poor will support BBP+ services and shift OOP payments to pre-payment mechanisms to increase financial risk protection.

**The second constraint is on the MOHWEA expenditure management side.** It is the substantial amount of time it takes to reform health pooling and purchasing arrangements, adapt PFM systems and processes, and build capacity at the system and provider levels. Being realistic about the amount of time required to implement output-based provider payment systems, adapt PFM including budget formation and budget execution processes, and realign governance and roles and relationships (including establishing a national health purchaser and provider autonomy and accountability for financial management) will increase the probability of success. These Phase I and Phase II purchasing and PFM interventions at both PHC and outpatient specialty/hospital levels have already begun through the introduction of PBF and will be solidified by institutionalizing PBF for sustainability.

**The inverted and regular pyramids will create implementation dynamics whereby the MOHWEA invests time in Phase I and Phase II to develop the pooling and purchasing mechanisms in preparation for increased MOF and private investment in Phase III.** The dynamics will establish the health and PFM systems and processes for equitable and efficient purchasing of BBP services and then gradually increase the general revenue funding and convert OOP payments to pre-payment mechanisms. In clinical terms, first establish the blood vessel and then gradually increase blood flow to create seamless implementation dynamics that gather momentum over the three phases of health financing strategy and sequencing.

**Figure 9. Health Financing Strategy Implementation Dynamics**



Source: HFPS In-Person Launch Workshop February 13–17, 2023.

Note: GR = government revenue; MOF = Ministry of Finance, Economic Development and the Youth Economy; mgmt = management; MOHWEA = Ministry of Health, Wellness and Elderly Affairs; OP = outpatient; PBF = performance-based financing; PFM = public finance management; PHC = primary health care.

## Institutionalizing PFB for Sustainability

**Health financing reform in Saint Lucia began with the introduction of PBF and output-based payment to finance production and delivery of service outputs and performance against goals. Institutionalizing PBF for sustainability is a high priority** to both retain the improvements it has triggered and to drive the three HFPS phases.

**PBF institutionalization serves as a preparatory phase for the three HFPS phases, and it is a vital aspect of implementation strategy and sequencing.** The prep phase focuses on parallel activities for PBF pilot implementation and PBF institutionalization until the start of Phase 1, on April 1, 2026. The intent is to use this phase to perform the steps necessary to prepare for the scale-up and expansion that will be done during HFPS Phase 1. It is already clear that investment in technical methodology, IT/IS, training, and operations management will be needed in HFPS Phase I and the MOHWEA should start planning for this process now.

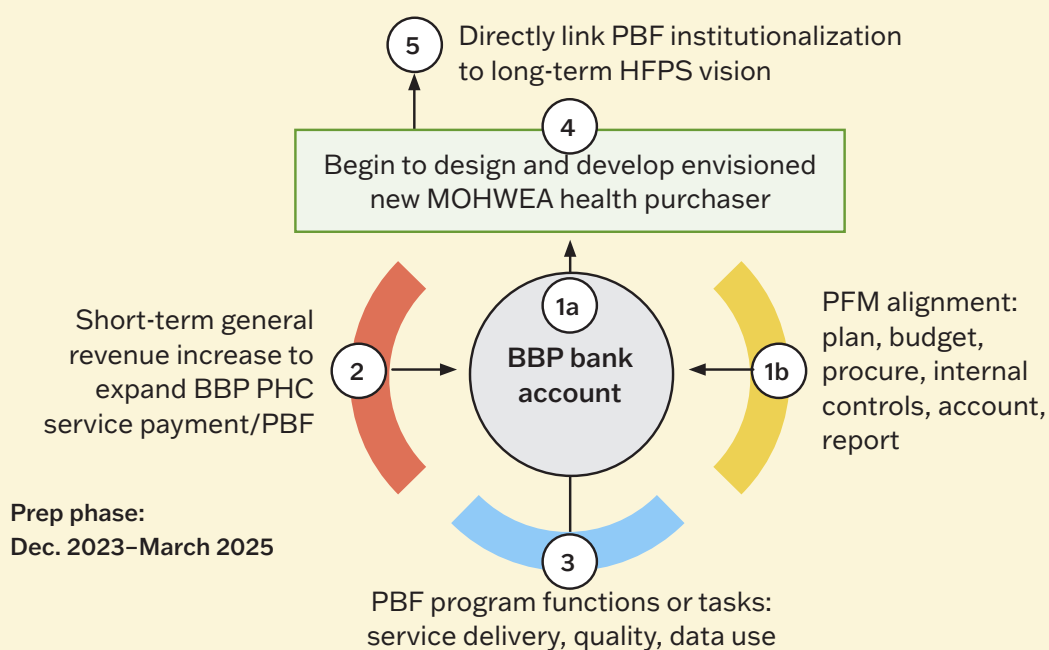
**Figure 10 is a roadmap on how to achieve the key HFPS objective of institutionalizing PBF for sustainability.**<sup>14</sup> The strategy and plans will help ensure retention of PBF experience and expanded, consistent, and sustainable progress in health financing reform to create efficiency gains, equity increases, and movement towards UHC. The roadmap consists of five elements:

- ◇ **Align PFM systems and processes** around purchasing BBP PHC services using output-based payment, specifically PHC per capita/PBF payment.

<sup>14</sup> Based on extensive HFPS dialogue during World Bank health financing mission November 21 to December 1, 2023. November 21–24 meetings with MOHWEA PS/departments, HSSP, MOF, and other stakeholders resulted in development of PBF institutionalization strategy. A November 28–29 workshop reviewed and revised the draft HFPS.

- ◇ **Invest in a short-term, general revenue increase** to maintain, scale-up, and expand results from purchasing BBP PHC services and improved PHC center management.
- ◇ **Align and integrate into the MOHWEA the strengthening of other health system or program functions** including service delivery, quality improvement, and use of information.
- ◇ **Build on experience and lessons learned in PBF alignment** of both PFM and program functions and tasks to begin design of MOHWEA health purchaser structure, roles, and relationships.
- ◇ **Envision how PBF institutionalization will enable longer-term HFPS implementation.**

**Figure 10. PBF Institutionalization Chart**



Note: BBP = basic benefit package; HFPS = Health Financing Policy and Strategy; MOHWEA = Ministry of Health, Wellness and Elderly Affairs; PBF = performance-based financing.

**Element 1. The first PBF institutionalization element is to link, harmonize, and align health purchasing and PFM systems and processes.** During the introduction of PBF, the specification of the long-term PHC per capita payment formula and system with its embedded PBF payments is a powerful step towards a seamless transition from a short- to a long-term health financing strategy. However, additional measures are also needed to achieve the goal of institutionalizing PBF for sustainability. Broader health purchasing and PFM systems and processes should be linked, harmonized, and aligned to avoid fragmentation, inefficiency, and conflicting incentives. PBF must be integrated into (i) the PFM functions of budget formation, budget execution, and accounting and reporting, and (ii) the health financing functions of pooling of funds and health purchasing including procurement.

**The MOHWEA and the MOF Accountant General have engaged in productive dialogue on PFM alignment for purchasing BBP PHC services using output-based payment, specifically PHC per capita/PBF payment.** A new MOHWEA bank account will be established—converting the PBF pilot supported by the HSSP to a long-term MOHWEA basic benefit package (BBP) program with a BBP bank account.

**Specific plans to align PFM with gradual increases in PHC center autonomy and accountability have also been developed.** PHC centers would become cost centers (spending units). They would not have bank accounts in the early phases of health financing reform, consistent with the MOF PFM strategy to consolidate bank accounts. Nevertheless, clearly separating financial management functions would lead to increased autonomy to develop plans and budgets, authorize and initiate procurements, as well as increased accountability to continuously improve management using new facility level systems and processes. Specifically, PHC centers would (i) determine their budget ceilings based on calculations of PHC per capita payment amounts and estimated performance payments; (ii) develop plans and budgets; (iii) be able to manage petty cash up to EC\$1,500–\$2,000; (iv) have access to the MOF *SmartStream* system to specify and authorize procurements over EC\$200 (also MOHWEA regional and national, MOF signatures); and (vi) receive goods or services paid under MOF purchase orders (see HFPS specific strategy 7 on PHC per capita payment, strategy 12 on health purchaser, and strategy 13 on PHC facility autonomy).

**Tensions between health purchasing and PFM functions can arise but so can synergies, whereby health purchasing/output-based payment and PFM align to enable better separation of functions (duties), better system and provider level financial management, and improved program or service delivery performance and results.** The HFPS will prioritize health and finance authority dialogue from the beginning to ensure that PBF operates within country PFM systems rather than in a fragmented manner or outside the systems, which would likely create inefficiency, operational difficulties, and high administrative costs (see specific strategy 9).

**Element 2.** The second PBF institutionalization element is a short-term general revenue increase to initiate HFPS Phase I of purchasing BBP PHC services and to invest in strengthening and expanding the most cost-effective health service as the driver of sector efficiency gains and coverage extension for UHC (also see longer-term revenue increases). The Public Expenditure Review found that PHC is notably underfunded compared to the relative importance the services should play in addressing the country's disease burden: PHC received only 12.8 percent of the current spending and 1.1 percent of the capital spending. The recurrent PHC spending represents only 0.26 percent of GDP. The WHO stated that countries need to increase PHC spending by at least 1 percent of their GDP to close glaring coverage gaps and meet health targets agreed to in 2015.<sup>15</sup> If this is the point of reference, then Saint Lucia should almost quadruple the average PHC expenditures compared to the levels observed in 2014–2018. When the analysis is limited to high middle-income countries only, the WHO estimates that PHC spending should be in the range of 0.8 percent to 1.7 percent of GDP to achieve UHC. Taking this point of reference, in the lowest case scenario, Saint Lucia would need to triple its spending on PHC.

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15 World Health Organization (2019), *Primary Health Care on the Road to Universal Health Coverage*. 2019 Monitoring Report. Conference Edition, Geneva: WHO, [https://cdn.who.int/media/docs/default-source/documents/2019-uhc-report.pdf?sfvrsn=9b66d994\\_2](https://cdn.who.int/media/docs/default-source/documents/2019-uhc-report.pdf?sfvrsn=9b66d994_2)

In the HFPS dialogue, the MOHWEA suggested an investment of EC\$27 million as the short-term general revenue increase required to institutionalize and expand PBF to all PHC services as the first step in long-term health financing reform. The rationale is to add \$EC150 per capita for PHC to the current spending of EC\$91 on PHC to bring total PHC public spending to EC\$241, which is about 75 percent of the target of EC\$316. The MOHWEA and MOF dialogue will be ongoing. The MOHWEA intends to add this investment into the 2025–2026 budget request. In addition, the MOHWEA will review and solidify budget allocation processes for the EC\$8 million in 2024–2025 budget to fund the November 2023–March 2024 gap following the end of the HSSP (see HFPS specific strategy 1 on general revenue increases).

**Element 3. PBF focuses on the health financing function of purchasing health services, but it is intended to stimulate improved performance in all health system or program functions; that is the third element of PBF institutionalization.** The HFPS dialogue led to incorporation of many health system or program functions or tasks into detailed PBF institutionalization plans, including: (i) developing a process to define BBP PHC services; (ii) integrating all service delivery and quality improvement processes into the routine operations of the MOHWEA and PHC centers (e.g. planning, clinical practice guidelines/protocols/standard operating procedures, referral relationships and systems, quality assurance and audit processes including verification, facility level quality improvement techniques including supportive supervision and other mechanisms); (iii) further reinforcing the importance of IT/IS investment and the integration of health and financial management information systems; and (iv) prioritizing and building capacity to analyze and use data to improve performance. This process will occur both top-down through the MOHWEA and bottom-up through the PHC centers—with substantial support from regional supervisors performing a variety of key functions including supportive supervision and training, mentoring, and coaching PHC staff.

Early PBF experience identified referral issues and contributed to the revitalizing of referral systems and processes: for example, ensuring that the results of lab tests are reported back to PHC centers that support their patients to access the entire continuum of care. Progress was also made in differentiating and framing quality assurance versus quality improvement as part of PBF institutionalization into MOHWEA departments. The HFPS will enhance the process of differentiating quality assurance interventions (compliance, audit, licensing, certification, utilization review, verification) and quality improvement interventions (possibly accreditation, supportive supervision, and other facility-level techniques to help improve management of service delivery and clinical practice performance including consistency with guidelines, protocols and standards) for public and private providers. PBF lessons learned are cross-cutting and will be used to enhance other aspects of service delivery (e.g., human resources, drug supply chain) in HFPS implementation.

**Element 4. The fourth element of PBF institutionalization is to build on PBF experience and lessons learned to engage in dialogue and initiate development of a new MOHWEA health purchaser structure, as well as roles and relationships.** Shifting from input- to output-based provider payment realigns roles and relationships across all government institutions and levels because, by definition, output-based provider payment delegates to service providers the right to determine the best mix of inputs to produce the desired service output. Establishing a national health purchaser and making health providers more autonomous and accountable are vital steps to institutionalize PBF for sustainability. Dialogue is ongoing, but the HFPS envisions

that a national health purchaser will be established under the MOHWEA to pool funds, operate provider payment systems, perform quality assurance functions, and aggregate financial reports from providers and submit to the MOF (see specific strategy 12).

**Element 5.** The fifth element of PBF institutionalization is confirming its consistency with HFPS strategy and sequencing. The HFPS dialogue verified PBF institutionalization will serve as the HFPS preparatory phase and feed directly into HFPS Phase I. The process side of any reform is important; this includes capacity, communication, coordination, and collaboration. Words such as match, link, connect, relate, and integrate pervade the HFPS and those approaches will be crucial to its implementation. PBF can initiate the process side of health financing reform by (i) stimulating productive health and finance authority dialogue; (ii) enabling the alignment of PFM around output-based payment; (iii) preparing for the changes in roles and relationships across the system when a health purchaser is established and health provider autonomy is increased; (iv) beginning to build capacity to improve financing and management of health services; and (v) creating synergies across both health financing functions, and health financing and PFM functions. These process considerations are inherent in all of the HFPS sections and strategies described below.

**In addition to the five PBF institutionalization elements described above, three health purchasing/provider payment technical methodology and system tasks are key to a seamless transition from the HFPS preparatory phase (PBF pilot and institutionalization) to Phase I (BBP purchasing for all PHC services).** These three tasks are described below and included in the relevant specific strategies.

### **1. Design the formula for the long-term PHC per capita payment system**

PBF commonly uses a version of the type of output-based provider payment system generically labelled fee-for-service (FFS). FFS is a pre-set fee (i.e., provider payment type) for each unbundled service (consultancy) or procedure (lab test). It creates a strong and direct incentive for the provider to produce more of the services or procedures eligible for payment. This is a powerful and beneficial injection into a non-responsive or underutilized system, but over time it can lead to supplier-induced demand, overproduction especially of diagnostic tests, and cost escalation.

**The HFPS implementation approach answers the questions of how to introduce and institutionalize the type of provider payment system used in PBF to stimulate system performance while also avoiding the longer-term harmful effects of overreliance on FFS, service delivery distortion, and cost escalation.** The first step is to position PBF to add it on top of the core provider payment systems to avoid fragmentation and leverage all health funding not just the PBF pool. The second step is to design the longer-term PHC per capita payment formula during PBF introduction with PBF FFS embedded as a performance element within the payment formula (rather than standing alone) that can be used in the future to purchase all PHC services for the entire population.

**Saint Lucia already positions PBF on top of core payment systems: 40 percent of payment is based on a per capita formula and 60 percent is performance-based payment.** However, the PHC per capita payment formula specification could be broadened now to both cover all of the population and all services in the future and to target the poor. Designing longer-term provider payment formulas and systems during initial PBF implementation will help ensure all

stakeholders understand how PBF fits in the broader health financing and purchasing framework, are aware of short- and longer-term plans, and are able to continuously adapt their management to policies and incentives and take advantage of the benefits of FFS payment while avoiding its disadvantages. This is a pillar of the HFPS foundation and it is reflected throughout the strategy. The longer-term PHC per capita payment system with PBF embedded as a performance element or adjustor can be developed at the beginning of financing reform and can guide PBF institutionalization for sustainability (see specific strategy 7).

## **2. Design, develop, and implement a population enrollment system for PHC payment**

**Developing population registration and enrollment systems/databases is critical for PBF institutionalization and HFPS Phase I implementation.** This system is necessary to calculate PHC per capita payments for the entire population in HFPS Phase I starting April 2026. The HFPS dialogue with many MOHWEA departments, the Ministry of Public Services/Division of Public Sector Modernization, the HSSP team, the World Bank, and external consultants resulted in the following strategy, sequencing, and plans: (i) population registration for BBP to be included in the Government Digital ID platform no later than April 2030 (HFPS Phase III including population compulsory contributions); (ii) the MOHWEA will be responsible for using population registration data to determine population enrollment or assignment to PHC centers for PHC per capita payment; and (iii) the population enrollment system will be ready for implementation no later than April 1, 2026 (HFPS Phase I) and developed by enhancing the Saint Lucia Health Information System (SLUHIS) and the PBF system (see specific strategy 7).

## **3. Ensure health and finance system interoperability and other IT/IS priorities**

IT/IS for health financing reform emerged as a theme of the HFPS dialogue—specifically, the **development of both health purchaser-level and facility-level (PHC center, hospital) financial management systems that are integrated or interoperable with health/clinical information systems.** This includes (i) IT/IS (encompassing all digital technologies) that are not standalone but rather are encompassed in the alignment of institutional roles and relationships, and (ii) the HR capacity needed to purchase BBP services. IT/IS design, development, and implementation is a high priority for HSSP support for short-term PBF institutionalization. It is also required for longer-term HFPS implementation, and it is encompassed in many of the specific strategies described below. Finally, the HFPS must closely coordinate with other IT/IS priorities, including the development of patient health record security mechanisms.



# Specific Health Financing Strategies and Major Activities

The specific HFPS health financing strategies and their major activities are described in the sub-sections below, grouped into five categories: revenue collection, pooling of funds, health purchasing, governance and roles and relationships, and communication and monitoring. The HFPS consists of 15 specific strategies, each with corresponding major activities.

## ► Revenue Collection

Revenue collection strategies are intended to ensure equitable and sustainable financing to move towards UHC. The objectives of revenue collection and resource mobilization include stable and predictable revenue together with gradual increases in revenues as the health sector should benefit at least proportionally from any Saint Lucia revenue increases. It can be argued that the share should increase slightly, given the moderate share of GDP and of the government budget that Saint Lucia currently spends on health and also given the significant expansions of coverage envisioned. Two specific strategies focus on general revenue, including health taxes and shifting population copayments to compulsory contributions. Any remaining population copayments are expected to be targeted more to advance behavior change than revenue collection. They are directly related to BBP and BBP+ specification (see Health Purchasing section).

**Strategy 1** is to gradually increase general revenue allocated to the health sector. As discussed in the overarching strategy and sequencing section above, general revenue will increase gradually from Phase I to Phase III. Gradual increases will reflect fiscal constraints and will take advantage of efficiency gains, increases in equity and financial risk protection moving towards UHC, and service delivery improvement from the investment in PHC strengthening and health purchasing reform. The extensive HFPS dialogue on health revenue has included considerations for short- and longer-term increases.

### Phase I Short-Term General Revenue Increases

In Phase I, relatively small general revenue increases (translating into proportionately large PHC sector revenue increases) can initiate the process of purchasing BBP services through output-based payment including PBF, shifting funds to frontline PHC, and strengthening cost-effective PHC services for the entire population. Notwithstanding fiscal constraints, this investment is critical to trigger PHC reform and improvement while holding other health programs and providers harmless in the short-term. The phase I investment to strengthen PHC will produce longer-term efficiency gains, reduce cost escalation, and enable service coverage expansion by expanding the scope of PHC services and reducing referrals to higher, more costly levels of the health system.

The WHO has concluded that countries must increase their spending on PHC to at least 1 percent of GDP if the world is to close glaring coverage gaps and meet targets agreed in 2015. For upper middle-income countries, the recommended range is 0.8–1.7 percent of GDP. Taking this point of reference, Saint Lucia would need to at a minimum, triple its spending

**on primary health care financing** to support the purchasing of the BBP for the population (see blue box in Figure 7). Using 2019 economic and health financing data (a representative recent reference point), an additional allocation of EC\$150 per capita would bring PHC spending to EC\$241, around 75 percent of the target (EC\$316). This requires an estimated additional funding of around EC\$27 million in the short term. A new health and security levy of 2.5 percent on goods and services was put in place in 2023, initially for two years. It is hoped that a portion of this levy will be designated to support short-term investment in strengthening PHC for UHC. A key element of the HFPS preparatory phase is starting budget formulation actions requesting the EC\$27 million in time for the 2026/2027 fiscal year.

## Phase II and Phase III longer-term general revenue increases

**The Background and Situational Analysis section (above) depicts a mixed picture concerning the potential to increase general revenue allocated to the health sector in the mid- to long-term timeframe**, including during HFPS Phases II and III. On the one hand, there are fiscal constraints in the macro-fiscal situation (discussed further below). On the other hand, health represented only 8.9 percent of government spending, which is low in comparison to other countries in the region. Health and finance authorities engaged in extensive dialogue and will continue to engage in dialogue to develop concrete plans to increase the priority of health in government expenditures and realize health sector prominence in the country's medium-term development plan. The next few paragraphs summarize the extensive MOHWEA and MOF HFPS dialogue on longer-term revenue increases.

**The macro-fiscal context was examined. The MOF presented selected statistics for Saint Lucia entitled “Financing UHC in an Inflationary Environment.”** The GDP growth rate was -25.4 percent in 2020, 18 percent in 2022, and projected to be 1.9 percent in 2024. Inflation, although declining, remained high at 6.4 percent in 2022, driven by housing, water, electricity, gas, and other fuels categories. The unemployment rate decreased to 16 percent, including youth unemployment of 26 percent. On the fiscal side, it was noted that growth in expenditures has outstripped growth in revenues for some time. This has resulted in overall deficits, which are anticipated to continue to average 2–3 percent per year. However, the debt-to-GDP ratio has been improving, and Saint Lucia remains committed to attaining the prudent ratio of 60 percent by 2035. Consequently, measures that are likely to impact its ability to attain this target are being examined carefully. It was also noted that the ratio of revenue from taxes to GDP of 16 percent is low compared to peers, and well below the 25–28 percent target recommended by the OECS Commission. Closing this gap could support future general revenue increases for health. **Overall, macro-fiscal stabilization and leveraging further revenue sources will open opportunities for the sustainable financing of BBP and BBP+ moving towards UHC. This assumes ongoing dialogue and strategic planning between the MOHWEA and the MOF and a gradual approach over the medium- to long-term.**

Building on the PER, during the HFPS dialogue and health financing missions, documented lessons from international experience were shared with the MOHWEA and the MOF. It was noted that UHC goals and its intermediate objectives (efficiency, equity, transparency) are influenced by health financing (revenue mobilization, pooling, purchasing) within the overall health system. The discussion on revenue collection focused on how to raise sufficient and sustainable revenues in an efficient and equitable manner to increase access to health services and financial risk protection. Saint Lucia's reported health financing trends and facts as well as the comparison

with regional peers were reviewed. The review revealed some notable observations that form the basis for the case for investing in health, including:

- ◇ Pre-pandemic health spending in the Caribbean and Latin American regions was 6.8 percent of GDP. In 2019, Saint Lucia's spending ranked lowest at 4.3 percent of GDP.
- ◇ In 2020, government expenditure on health as a share of general government expenditure was 8.7 percent, well below the 15 percent proposed by the WHO.
- ◇ Spending on PHC has been low, at 12.8 percent of total health expenditure (recurrent expenditure 2014–18 average). Recurrent spending in PHC represents 0.26 percent of GDP.
- ◇ Out-of-pocket (OOP) payments have remained high (37.1 percent of total health spending in 2021), above the averages for Caribbean (30.6 percent) and Latin American countries (28.1 percent).
- ◇ Health coverage is low and skewed to the better-off.
- ◇ Low levels of total health expenditure indicate that the Caribbean region was under-resourced and less prepared to face the challenges of the COVID-19 crisis (e.g., the association between higher health expenditure per capita and low excess deaths).
- ◇ Like many countries during COVID-19, Saint Lucia saw an increase in recurrent health expenditure. However, when this is extracted from the trend, it was observed that there were very marginal increases over the review period. The return to pre-pandemic expenditure levels holds true for Saint Lucia.

**Why is investment in health in Saint Lucia important? The health sector PER (2021) noted little change in the health system over time. Deliberate investment is needed to modernize, increase efficiency, and build resilience.** Evidence shows that when countries invest in the range of key reforms necessary for UHC, it improves health impacts (more health for money) and system resilience, which is critical as shown by the pandemic and to prepare for climate-change and a sustainable health agenda. It was further noted that aspects of fiscal space are within GOSL's control, and the development of a health financing policy and strategy lays out a path to UHC. Developing a health financing investment case for Saint Lucia is important in order to orient GOSL decision-making, including short-run and longer terms options.

**A range of options (public and private) for raising revenue were discussed in the HFPS dialogue:**

#### 1. General tax revenue

- ◇ Direct taxes: personal income taxes, corporate profit taxes, property taxes, wealth taxes
- ◇ Indirect taxes: sales taxes, excise taxes (tobacco, alcohol, sugar-sweetened beverages, gasoline), value-added taxes (VAT), import duties, export taxes
- ◇ Other government revenues: a new health tourism tax

#### 2. Contributory or external financing

- ◇ Compulsory payroll tax earmarked for health (social health insurance)
- ◇ Mandatory premiums or insurance contributions especially for the informal sector
- ◇ Private or voluntary insurance
- ◇ Community financing

- ◊ Overseas development assistance, especially for capital expenditure
- 3. Direct company-level financing and provision of health services
- 4. Medical savings accounts
- 5. Out-of-pocket payments

**Health taxes are excise taxes applied to products such as tobacco, alcohol, and sugar-sweetened beverages (SSBs) that cause health-related harm by creating issues for individuals, as well as society at large.** Because excise taxes can be used to target specific goods and services, they differ from other types of indirect taxes such as a value-added tax (VAT) or a goods and services tax (GST). Health taxes are one of the most cost-effective policy measures for reducing the consumption of these products and associated mortality and morbidity. To this end, the economic framework for health taxes on tobacco, alcohol, and SSBs has three goals: (i) reduce externalities related to consumption (e.g. publicly funded healthcare costs related to noncommunicable diseases, secondhand smoke and alcohol-related traffic accidents, violence and gender-based violence); (ii) cut “internalities” related to individual harm, including death and disability and issues such as youth addiction; and (iii) generate revenue to meet fiscal needs.

**Saint Lucia has implemented excise or health taxes on tobacco and alcohol. In the context of HFPS development, the MOF and the World Bank engaged in dialogue and did a rapid assessment.** Tobacco imports have been on a downward trend since 2017. Mirroring the gradual decline in tobacco imports, total tax collections fell to approximately EC\$11.0 million in 2022 from a high of EC\$14.1 million in 2017. Saint Lucia periodically changes its tax structure and has the highest rate of tax on cigarettes in the region. An increase in the excise tax rates on tobacco is projected to yield additional revenue between EC\$4.8 and EC\$13.4 million. The rapid assessment concluded the internal analysis was thorough, tobacco excise or health tax specification and operation reflects policy and procedures addressing key issues, the revenue projection model could be refined to ensure revenue projections are not overly ambitious, and incorporating benchmarking could be considered in future policy.

Recent underlying trends show an increase in the value and volume of alcohol imports (mostly wines), yielding EC\$40 million in taxes in 2022. Domestic production of alcoholic beverages was valued at EC\$37 million in 2022, yielding EC\$4.5m in excise tax collections. An EC\$0.50 per liter increase in existing tax rates is under consideration. It would raise government revenue but add to inflationary pressures, create an outcry from domestic distillers, spark resistance from tourism sector, and possibly encourage smuggling. The rapid assessment perceived some space for policy, tax specification, and operational improvements given the substantial complexities and variations in alcohol content, prices, and alcohol tax rates. Saint Lucia does not envision implementing a SSB tax in the short-term, although dialogue is ongoing. Analysis, awareness-raising, and dialogue on SSB will be ongoing, especially given the rapid growth of noncommunicable diseases including diabetes.

**In summary, broad-based taxes are preferred to support the principle of solidarity inherent in UHC.** Acknowledging that UHC should be financed primarily from government general revenue, Saint Lucia, like many other countries, should consider a mix of options—weighing carefully the key objectives and likely impacts of those options. Specific considerations include cross-sub-

sidies for those most in need, sustainability of revenue flows, and flexibility and resilience to withstand the impact of health or economic shocks.

*Major general revenue increase activities include:*

- ◇ The MOHWEA and the MOF engage in policy dialogue on types and levels of short-term revenue increases
- ◇ Invest short-term general revenue increases in strengthening PHC and structural health financing reforms required to establish systems and processes to purchase BBP services, obtain efficiency gains, and extend coverage for UHC (preparatory phase and Phase I)
- ◇ Develop, strengthen, or refine the longer-term health financing investment case
- ◇ In the context of both fiscal constraints and relatively low percentage of total public spending for health in comparison to both international indicators and countries in the region, engage in dialogue with both public and private partners on longer-term gradual increases in the health budget from general revenue taxes including VAT and health taxes
- ◇ Collaborate with development partners including the World Bank to further analyze and refine specifications for health taxes (tobacco, alcohol, and possibly SSB)
- ◇ Engage in multisectoral advocacy and promotion of results to contribute to increasing revenue and mobilizing resources

**Strategy 2 is to shift the type of revenue from out-of-pocket (OOP) payments to prepayment mechanisms that provide better financial risk protection.** The Phase III colored boxes in Figure 7 portray the expected type of prepayment mechanism to use to achieve the HFPS objective of reducing OOP payments, which is essential to equity, financial risk protection, and movement towards UHC. Mandatory or compulsory contributions are planned because it is hard to get to UHC through voluntary health insurance (the population may also purchase private health insurance to fill any remaining gaps in coverage). Dialogue during HFPS implementation will determine specifics of compulsory contributions; exemplary decisions include the following:

- ◇ People in the formal sector (approximately 55 percent of the population) are National Insurance Corporation (NIC) beneficiaries for retirement, survivor, funeral, maternity, and sickness benefits. Their payroll tax contribution would increase from 1 percent to a to-be-determined percentage.
- ◇ People in the non-poor informal sector (approximately 20 percent of the population) would pay mandatory premiums.
- ◇ The unemployed (approximately 25 percent of the population) would be covered by general revenue subsidies.

**The HFPS will develop and approve details of the policy and the legal and regulatory framework for compulsory contributions.** In addition, operational mechanisms, systems, and processes will need to be designed, developed, and implemented to collect revenue and transfer to the MOHWEA health purchaser and its national pool of funds purchasing BBP and BBP+ services.

*Major prepayment mechanism and compulsory contribution activities include:*

- ◇ In Phase I, policy dialogue and decisions on compulsory contributions

- ◊ In Phase II, develop mechanisms for the collection and transfer for pooling of compulsory payroll taxes and premiums contributions, and establish contribution rates
- ◊ In Phase III, implement and refine the shift of OOP payments to prepayment mechanisms and compulsory contributions
- ◊ Ongoing dialogue with public and private partners to identify and mobilize other revenue sources

## ► Pooling of Funds

**Strategy 3 is to maintain the pooling of public general revenue funds at the national level.**

Pooling of funds or the accumulation of prepaid revenues on behalf of a population has a direct relationship to equity and financial risk protection and enables health purchasing—thus improving efficiency, quality, and transparency. Pooling of funds is used to increase the the redistributive capacity of prepaid funds and to align different revenue sources for complementarity. Pooling issues can be categorized as horizontal (the fragmentation of pooling across the government level) or vertical (the fragmentation across revenue sources or funds flows).

**Currently, Saint Lucia pools public general revenue funds for health in the MOHWEA at the national level.** General revenue does not include compulsory contributions (e.g. payroll taxes, mandatory premiums), but it does include excise or health taxes imposed on tobacco, alcohol, and sugar-sweetened beverages. Specific budget line items for health including salaries may have variations in funds flows, but the intent is pooling funds at the national level to purchase health services.

**Given the island’s geography and population size, fragmenting the pooling of general revenue funds by decentralizing to the regional or district level is not an optimal health financing policy and could undermine Saint Lucia’s comparative advantage in this health financing function.** The current policy of national pooling arrangements helps to ensure equity in resource distribution across the entire population, a cornerstone of the HFPS and movement towards UHC.

**Consistent with the health financing strategy of purchasing BBP services using output-based payment to health facilities, private funds paid to public facilities (population user fees or copayments, voluntary health insurance) currently transferred or pooled in the Treasury will be retained at the health facility level.** Together with public funds paid to facilities to purchase health services, the health facilities will use these private funds to deliver health services to their clients and communities. International evidence is well-known about the impact of user fees on access to services—especially for the poor (even when imposed for practical reasons including funding constraints). However, there is also evidence that facilities are not motivated to collect user fees when they are not allowed to retain them. The question of pooling versus retention of user fees is directly related to public health facility autonomy (see the Health Purchasing section and Governance, Roles and Relationships section).

*Major pooling of general revenue funds activities include:*

- ◊ Refine MOF and MOHWEA general revenue funds transfer and pooling mechanisms to enable purchasing of BBP services at the national level

- ◇ Assess pooling of budget line items or inputs to service delivery outputs including salaries and adapt as necessary to enable the purchasing of BBP services
- ◇ Assess and align the pooling of user fees paid at health facility level in the context of the shift to purchasing BBP, output-based payment, public-private contracting, and increased facility autonomy including user fee retention

**Strategy 4** is to pool public general revenue funds and compulsory contribution funds at the national level to purchase BBP services equally and equitably. The implementation of mandatory health insurance (also called social or national health insurance) often results in fragmented pooling arrangements for compulsory contributions and general revenue funds. Different sources of funds may be perceived as supporting different types of programs rather than purchasing services for one BBP entitlement covering the entire population (see the Overarching Strategy section above).

**PFM systems and processes may be more flexible for compulsory contributions than for general revenue funds, but the disadvantages of different PFM rules across types of public revenue or funds flows are substantial and include fragmentation, inefficiencies and inequity, making it hard to move towards UHC.** Saint Lucia is not burdened with the historical artifact of different PFM rules and should take advantage of the opportunity to pool funds if new types of health revenue, including compulsory contributions, are added to purchase BBP services for the population (see the Health Purchasing and the Governance and Roles and Relationship sections).

**A key question for the Phase I policy dialogue and decision-making is whether the health purchaser expected to be created under the MOHWEA will establish a “Fund” to pool all funds to purchase BBP or whether PFM and one standard accounting system will be used to manage all revenue sources,** funds flows, output-based payment, and financial management procedures.

**A second vertical pooling question relates to health revenue collection and pooling in other government ministries.** On the question of how contributions from the Ministry of Justice and National Security (police, fire) and the Ministry of Equity, Social Justice and Empowerment (poor) will be pooled, no change is envisioned in Phase I (funds remain with these ministries); a long-term decision will be made in Phases II and III consistent with overall pooling of funds to purchase BBP services. Factors to be considered in the related dialogue include collective bargaining agreements, the relationship to private health insurance (including for overseas services), and contributions for the poor (including medical assistance).

*Major pooling of general revenue and compulsory contributions funds activities include:*

- ◇ In Phase I and Phase II, engage in policy dialogue, make policy decisions, and design and develop the concept, mechanisms, and methodology for fund pooling arrangements for general revenue and compulsory contributions. Key policy dialogue and decision topics include the structure of the BBP pool of funds and the corresponding MOHWEA health purchaser, and how NIC payroll tax revenue is transferred and pooled to purchase BBP services.
- ◇ In Phase III, implement pooling of funds at the national level for all public revenue sources and funds flows
- ◇ Engage in dialogue and coordinate pooling and services with the Ministry of Justice and National Security and the Ministry of Equity, Social Justice and Empowerment

## ► Health Purchasing

### What to Purchase: Basic Benefits Package Specification

**Strategy 5 is to specify the basic benefit package (BBP) population entitlement.** The first step is to determine the BBP structure. The MOHWEA will develop and refine the BBP structure with exemplary service categories of PHC (including community-based services); outpatient specialty; hospital inpatient; rehab, palliative or hospice, skilled nursing, or other long-stay care; dental and vision services. The BBP structure or categories of benefits are important because that defines the services to which the population is entitled and enables clear and consistent communication of benefits along the continuum of care, and links to provider payment as different types of payment systems are used for different types of benefits. In addition, BBP structure decisions tend to tie together implicitly or explicitly the issues of what to purchase and how to purchase it because different types of provider payment systems are often better suited to purchase different types of services or BBP categories such as PHC, outpatient specialty, and hospital inpatient services.

**BBP PHC services will be specified as frontline, integrated, and emphasizing basic services for priority programs (e.g., maternal and child health, noncommunicable diseases, infectious diseases), prevention, and promotion, including community-based services.** In Phase I and Phase II of HFPS implementation, and potentially permanently, the BBP PHC category will be specified by level of care as defined by MOHWEA regulation on the type of PHC services available at Level 1–4 facilities rather than by a list of specific services for individuals. The exact consultations and diagnostic tests included in frontline PHC services versus outpatient specialty services will be specified. All consultations with health professionals will be free. The majority of PHC lab and diagnostic tests available in facilities will also be free, although some may require user fees or copayments specified in the BBP.

**Unlike frontline PHC services (which will be fully funded in all HFPS phases), even with gradual increases, general revenue funding will not fully fund all BBP outpatient specialty and hospital inpatient services in Phase I and Phase II** (see BBP+ strategy for Phase III). Therefore, BBP outpatient specialty and hospital inpatient services will need to be detailed in their respective benefit categories to identify and match payment to these services. One of two BBP service specification options will be selected—a positive list stating what is covered or a negative list stating what is not covered.

**The BBP will include specification of population user fees or copayments.** Copayments will be minimal for frontline PHC services and more substantial for outpatient specialty and hospital inpatient services. Based on BBP service prioritization, copayments will vary across types of outpatient specialty and hospital inpatient services. Health facilities will be able to match type of service and type of payment at the facility level to understand and manage their financing. Clarity and transparency about what public funds pay for and what private funds pay for enables matching services and payment at the health facility level to make both the BBP and exemptions work. Making them work requires facility autonomy and user fees or copayments to be kept at facility level (see other Health Purchasing sections and the Governance and Roles and Relationships section).

**A key PFM realignment is to shift health budget formation and placement in approved yearly budgets from an input-based line-item budget format (e.g. separate budget line items for**

**salaries, medicines, supplies) to one BBP line item with all the expenditures of delivering BBP services to the entire population.** The total budget or cost of this single line-item can start with existing funding. The BBP costing methodology can be refined over time based on better data obtained from purchasing for the BBP through output-based payment. Other health programs will exist outside the BBP, which consists only of health services delivered to individuals. Other health programs include public health, health professions education, science and research; and it is likely they will continue to be paid using input-based line-item budgets.

*Major BBP specification activities include:*

- ◇ Develop BBP structure or benefit categories. Policy decisions include the BBP categories and use of positive lists (state all benefits received) versus negative lists (exclusions).
- ◇ Specify BBP frontline PHC services in Level 1–4 facilities
- ◇ Specify BBP outpatient specialty and hospital inpatient services with population co-payments (at least in Phase II before shifting OOP to prepayment).
- ◇ Align PFM by establishing the BBP as a single budget line item.
- ◇ Establish other health budget programs for budget formation (e.g., public health, education, science)

**Strategy 6 is to specify the population entitlement in BBP+.** The purpose of BBP+ is to designate supplemental benefits planned to be funded by converting OOP payments to prepayment mechanisms in Phase III of the health financing reforms. BBP+ services will be in addition to the BBP largely funded by general revenue for the population. In Phase I, several options will be considered, and decisions will be made on BBP+ specification including whether it will be a separate legal program or incorporated under the BBP umbrella (one or two national budget line-items), and whether to specify BBP+ when prepaid compulsory contributions are implemented or earlier in the reform process where it will be regulated by the government but funded exclusively by private payments. BBP+ will add outpatient specialty, hospital inpatient services, and other services (not frontline PHC services as they are all encompassed in BBP). It is expected that BBP+ outpatient specialty and hospital inpatient services will be specified by a positive list of services covered.

*Major BBP+ specification activities include:*

- ◇ In Phase I, engage in dialogue and make decisions on the BBP+ legal framework.
- ◇ Specify and refine BBP+ outpatient specialty and hospital inpatient services and their funding by OOP payments or conversion to compulsory contributions.
- ◇ Align PFM budget formation to establish the BBP+ as a budget line item.

## How to Purchase: Output-Based Provider Payment

**The overarching health financing strategy is to purchase BBP services for all citizens. The strategy envisions public and private funds being used to contract with public and private providers to purchase BBP services using output-based budgeting and provider payment.**

Four HFPS assumptions underlie the design, development, and implementation of output-based provider payment systems to use public funds to purchase BBP and BBP+ services from public or private providers. These assumptions are: (i) the level of bundling as a key factor in the choice of the payment system; (ii) the use of formula-based payment systems rather than flat fees including appropriate design features; (iii) aligning the purchasing/provider payment and PFM systems and processes; and (iv) the importance of not duplicating health and finance information systems.

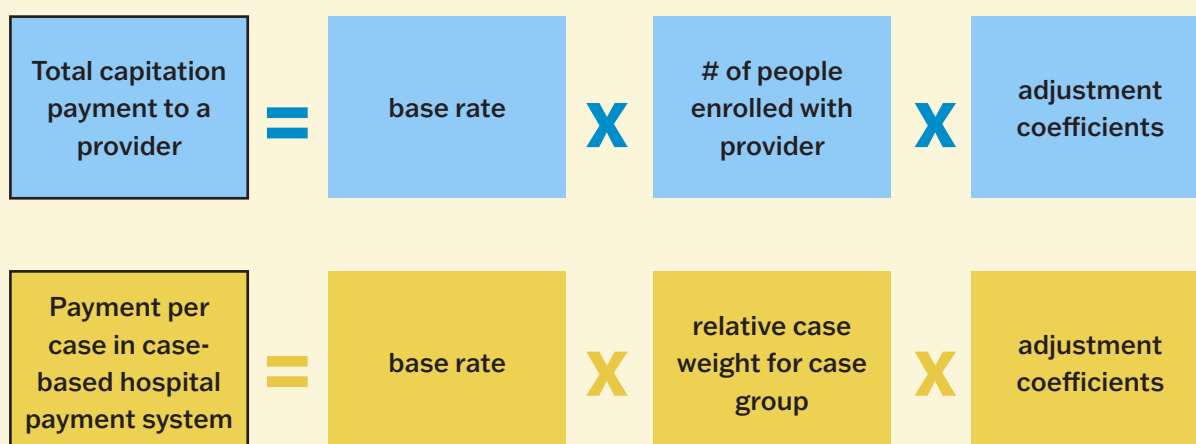
The types of output-based payment systems can be characterized along a spectrum indicating the **level of bundling of the services for provider payment purposes**. It ranges from bundling all services (PHC per capita payment for all PHC services for one person for one year) to unbundling all services (fee-for-service for a specific service or procedure) to payment systems with an intermediate level of bundling (case-based payment for one discharged hospital patient). More bundling of services creates greater financial risk for the health provider and less bundling of services creates greater financial risk for the health purchaser. It is assumed Saint Lucia will bundle health services and consider purchaser and provider risk sharing as a factor in selecting the most appropriate type of payment system services in each phase of the reform process.

A second assumption is to **specify provider payment systems with payment formulas not flat fees**. A flat fee pays the same rate for all services for all people in a category and does not vary payment for either cost factors differentiating the service or for desired policy objectives. A formula-based approach has the advantage of incorporating both budget neutrality and payment adjustors for facility- or individual-level cost differences or other desired policy objectives. The purchaser should establish an output-based provider payment formula and a system that pays standard rates to a group of service providers who deliver the same type of services incorporating the same types of costs. These payment rates should reflect average cost across service providers, which provides the financial incentive to increase efficiency.

The main design features of payment systems are the determination of: (i) the services paid for using the payment system (BBP specification); (ii) the types of providers that can be paid to deliver services using the payment system; (iii) the basis for payment or the primary unit of payment and other parameters used to compute payments to providers; (iv) the adjustment coefficients or coefficients applied to the base payment rate to adjust for systematic cost differences associated with certain patient or provider characteristics (as discussed throughout the HFPS, payment can be adjusted for performance through PBF and PBF can be incorporated into the overall payment formula to institutionalize for sustainability); and (v) the cost items or the categories of costs covered by the payment rates (e.g., supplies, medicines, salaries, utilities).

Take, for example, payment formulas for PHC capitation payment and case-based hospital payment shown in Figure 11. The capitation method for PHC payment uses the enrolled or assigned person as the primary unit of payment (for all covered services for a fixed period of time). The payment parameters include the base rate (fixed payment per person) and the number of people enrolled with or assigned to the provider. The payment formula is the base rate multiplied by the number of enrolled persons multiplied by any adjustment coefficients.

Figure 11. Specification of PHC and Hospital Payment Formulas



Source: C. Cashin, ed. (2015), *Assessing Health Provider Payment Systems: A Practical Guide for Countries Working Toward Universal Health Coverage*, Joint Learning Network for Universal Health Coverage.

**Aligning the purchasing of BBP services and the PFM cycle, systems and processes is a priority, and it cuts across health financing functions and HFPS sections.** Budget formation is contained in the BBP specification and output-based provider payment sections by establishing BBP as a single budget line item. Planning and budgeting for services at both the health purchaser and health provider levels is based on the total BBP budget ceiling. **Budget execution** is contained in both the health purchasing/output-based payment sections and the governance/roles and relationships sections because they include the systems and processes used to pay providers to purchase BBP service outputs, make expenditures, procure inputs, and perform internal controls. **Accounting and reporting** are also contained in both the health purchasing/output-based payment sections and governance/roles and relationships sections because they include the systems and processes used to account for funds, produce financial reports, and link to internal and external audits. Aligning the purchasing of BBP services and PFM can help separate functions (authorization, payment) and increase transparency. Extending PFM systems to the provider level in health facilities and schools will enable these management entities to improve financial management and service delivery, better use data for decision-making, and improve the quality of data throughout the system.

**Purchasing BBP services through output-based payment will create a new intersection between health financing and PFM.** Budget formation will determine the total health budget level while provider payment together with procurement rules will execute the budget to purchase BBP services. The purpose of the new intersection is to maintain good financial management while removing PFM rigidities or barriers that often undermine payment, incentives, and performance. In other words, public sector systems should match payment to priority services and populations while ensuring good financial management and control of public funds. This is done by shifting from input-based budget line items to lump-sum payment directly to providers based on a formula calculating a payment amount for each output they produce. It will result in optimizing efficiency gains, purchasing the right thing, and improving public sector service delivery.

The fourth overall assumption also cuts across health financing functions and HFPS sections; it is to **avoid duplicating health and finance operating and information systems**. Finance systems are described in the HFPS sections on pooling of funds, health purchasing/output-based payment, and governance/roles and relationships, while health information systems are described in the sections on health purchasing/output-based payment, and governance/roles and relationships. Two aspects of health and finance systems are emphasized throughout HFPS: (i) the information required for invoicing or billing under output-based payment is extracted from health information systems also serving clinical management and health statistics purposes; and (ii) the finance operating and information systems for planning, budgeting, procurement, internal controls, accounting, reporting, audit, and HR not only service financial control purposes but also support service delivery management improvements.

**Strategy 7 is to introduce PHC per capita payment including PBF to improve the purchasing of BBP PHC services.** As described in the Overarching Strategy and Sequencing section earlier in this report, HFPS Phase I focuses on purchasing all of the frontline, integrated PHC services contained in the BBP. A PHC per capita payment system is well-suited to purchase PHC services consistent with the Saint Lucia UHC policy and strengthening the most cost-effective level of the health system. The PHC per capita payment system will provide incentives for prevention and promotion services and will push consistent and predictable levels of funding to the PHC level to enable better management of service delivery. The entire population will be included in PHC per-capita payment, starting with catchment area assignment, and gradually moving towards open enrollment as the information systems develop. It will cover all services defined by the BBP as frontline PHC delivered in Level 1–4 facilities.

**PBF will be used to trigger the shift to output-based payment purchasing PHC services, and PBF will be placed on top of core output-based payment by embedding it within the broader PHC payment system formula.** Incorporating PBF as a performance adjustor within the core output-based payment system helps to avoid extensive fragmentation from the separation of input-based budget payment and PBF (fee-for-service) with its accompanying inefficiencies, high administrative costs, and perverse financial incentives. The development of this longer-term PHC per capita payment system with PBF embedded as a performance element or adjustor started in the HFPS preparatory phase (see PBF institutionalization section) and will be completed at the start of HFPS Phase I. This comprehensive first step will stimulate and motivate facility performance; avoid the longer-term harmful effects of FFS addiction, service delivery distortion, and cost escalation; leverage all funds; and increase sustainability by ensuring a seamless evolution to comprehensive purchasing of all frontline, integrated PHC services.

**The payment formula will be consistent with the general specification shown in Figure 6.** In addition to the calculation of base rate multiplied by population unit of service, need, equity, and performance factors will be used to adjust the payment amount at the individual level to help ensure payment is fair and meets policy objectives. The performance adjustor is specified in PBF implementation. Policy dialogue will determine additional factors with options including age-sex adjustors for need and the proportion of underserved populations or remoteness of facilities as an equity adjustor. **A priority will be the use of formula-based provider payment systems (PHC per capita and possibly hospital case-based) with payment adjustors for equity and other policy objectives to target the poor and increase the individual level fairness of the provider payment rates.**

**Existing social protection identifiers will support identifying and targeting the poor for general revenue subsidies for BBP+ mandatory contributions and copayment/user fee exemptions. The Saint Lucia instrument to assess the population's living conditions is SL-NET V3.0.** It uses the country's official measure of multidimensional and expenditure by the poor, built by the Central Statistical Office (CSO). SL-NET V3.0 captures individual and household information including identification data and socioeconomic variables related to housing, health, education, and labor. The survey has seven sections: (i) household identification, which includes location of the household (GPS coordinates, district, neighborhood, and brief description of location), and interview respondent information; (ii) housing conditions; (iii) food security; (iv) public assistance and household banking, which includes the household members listing; (v) health; (vi) education for people 3 years-old and above; and (vii) labor conditions for people 15 years-old and above. The identification process consists of three main tasks. First, the SL-NET V3.0 thresholds are applied to determine general eligibility for social programs. Second, field information is collected and centralized using a household-by-household administrative register. Third, the collected information is analyzed using a management information system that assigns a score per household and determines which households are eligible for social programs.

**The types of costs included in the PHC per capita payment system will evolve across the three phases of the HFPS.** Phase I costs will include administrative supplies and equipment (office stationery, pens/pencils, phones, tablets, printers), printed material for community prevention and promotion outreach and services, travel, food, medical supplies not centrally procured, drugs not centrally procured, small equipment and renovations under threshold amounts, contracted labor, and maintenance. Costs included will gradually expand in Phases II and III based on experience and lessons learned in Phase I.

**Health purchaser payments to providers to purchase PHC services in the BBP will flow through PFM systems as a single line item.** Providers will use applicable PFM laws, regulations, systems, and processes to procure inputs for the services they deliver to individuals and communities. Accounting and financial reporting will also not change, although roles and relationships including PHC facility autonomy will be realigned as described in the Governance/Roles and Relationships section of this report.

**Developing population registration and enrollment system/databases is critical for PBF institutionalization and HFPS Phase I implementation.** This system is required to calculate PHC per capita payments for the entire population in HFPS Phase I starting April 2026. The HFPS dialogue with many MOHWEA departments, the Ministry of Public Services/Division of Public Sector Modernization, the HSSP team, the World Bank, and external consultants resulted in the following strategy, sequencing and plans: (i) population registration for BBP will be included in the Government Digital ID platform no later than April 2030 (HFPS Phase III including population compulsory contributions); (ii) the MOHWEA will be responsible for using population registration data to determine population enrollment or assignment to PHC centers for PHC per capita payment; (iii) the population enrollment system will be ready for implementation no later than April 1, 2026 (HFPS Phase I) and developed by enhancing the SLUHIS and PBF systems (see PBF institutionalization). Information and operating systems are cross-cutting, and their design, development, implementation, and refinement are covered in this strategy, health and finance information system strategy, and also in the governance/roles and relationships strategies outlined below.

**This specific strategy is at the heart of health financing reform and improvement.** As described throughout the HFPS, a condition of realizing Saint Lucia's commitment to UHC is well-functioning public PHC providers receiving output-based payments and motivated by facility autonomy and accountability to better manage frontline, integrated PHC services responsive to community needs.

*Major PHC purchasing activities include:*

- ◇ Based on PBF pilot experience, complete design and development of the long-term PHC per capita formula and payment system—with PBF embedded as a performance element or adjustor to sustainably purchase all BBP frontline integrated PHC services
- ◇ Design and develop PHC per capita payment operating systems including the population registration database, registration processes (e.g. PHC center, outreach, public health events, schools, QR codes, public services administration link), PHC center enrollment choice and database, GPS assignment of non-registered people to PHC centers by catchment area, and calculation of payment amounts (invoicing) for each PHC center
- ◇ Implement and refine PHC per capita payment formulas with embedded PBF elements and corresponding enrollment and operating systems to purchase BBP PHC services
- ◇ Align PFM and output-based payment to purchase BBP PHC services

**Strategy 8 is to introduce new hospital inpatient, outpatient specialty, and other service payment systems to improve the purchasing of BBP and BBP+ services.** Phase I will include preparation for the Phase II reform of purchasing BBP hospital inpatient services, outpatient specialty, and other health services. A major difference from payment for PHC is that not all hospital inpatient services or outpatient specialty services will be covered by the BBP during Phase I and Phase II or possibly even by BBP+ in Phase III. This heightens the importance of distinguishing and matching payments to each BBP service.

**Grants that are largely made to hospitals represent 22 percent of total health expenditures. These grants that pay hospitals to deliver services could be either input- or output-based payment depending on how the budget for the grant was formed.** This strategy will purchase BBP hospital inpatient services by determining the optimal type of hospital payment system, designing the system, and implementing it—including converting grants to output-based payment and incorporating additional funds as appropriate.

Consistent with the assumption concerning bundling for provider payment (outlined in the introduction to this section), a hospital case is an appropriate unit of service for hospital payment. Hospital cases can be clearly defined by admission and discharge dates. In addition, consistent with the second assumption outlined earlier, a provider payment formula is appropriate for hospital payment.

**Two options for hospital payment** are (i) direct payment to hospitals for each discharged case; and (ii) use of case classification and relative payment weights to form a global budget paid to hospitals. Key principles of case-based hospital payment include paying a group of hospitals a fixed payment rate for each case that falls into one of a set of define categories of cases, and reimbursing hospitals the average expected cost for the case group to provide an incentive to increase efficiency. Direct case-based payment is possible in Saint Lucia, but the small number

of hospitals increases the risk of it functioning as hospital-specific payment (approaching fee-for-service payment), which could reduce incentives for efficiency and drive cost escalation.

**A third decision on the type of provider payment is what system to use to purchase outpatient specialty services.** Unlike hospitals and PHC services, it is hard to specify the outpatient specialty unit of service or output. If the unit of service is unbundled to separately list each visit, test, or procedure, cost escalation will likely result. However, determining a bundled outpatient specialty unit of service is also not easy because when it starts and ends and what services are included can be complex questions. HFPS implementation will include continued dialogue on options including fee-for-service, capitation (either separate or combined with other types of services), some type of ambulatory groups, and global budgets. Finally, the HFPS will also engage in dialogue on, design, develop, implement, and refine other health service payment systems (e.g., public health, ambulance, rehab, or other long-stay) with global budgets a likely option and possibly even continuation of input-based provider payment.

**Related to the key assumptions or factors in the output-based payment introduction, hospital inpatient and outpatient specialty payment systems will cover services to the entire population and be delivered in all public or contracted private providers licensed to deliver the services;** the types of costs included in the payment to providers will evolve across the three phases of the HFPS. Alignment of the PFM cycles for hospital inpatient, outpatient specialty and other service payment will be similar to PHC services—with BBP as one budget line item, use of PFM systems and processes for procurement, accounting, and financial reporting, and increased health facility autonomy and accountability.

**The primary information system activity supporting payment system operations is ensuring that the hospital information system Cellma (or a comparable system) is implemented and that includes the clinical data required for hospital payments.** Health financing reform will coordinate with other hospital information system activities including the MOHWEA-owned Master Patient Index (MPI) and referral system functionality, including results of lab and other diagnostic tests. Also see activities in the Health and Finance Information System strategy, and the Governance/Roles and Relationships strategies that reflect the cross-cutting nature and importance of information systems in institutional development.

*Major hospital inpatient, outpatient specialty, and other service purchasing activities include:*

- ◇ Design, develop, implement, and refine the hospital inpatient payment system to purchase BBP services; options include direct case-based or diagnosis-related groups (DRGs) and global budgets based on cases or DRGs
- ◇ Design, develop, implement, and refine the outpatient specialty payment system to purchase BBP services.
- ◇ Design, develop, implement, and refine other health service payment systems to purchase BBP services (e.g., public health, ambulance, rehab or other long-stay services).
- ◇ Implement and refine hospital inpatient, outpatient specialty, and other health service information and operating systems including Cellma, MPI, and the patient referral system
- ◇ Align PFM and output-based payment to purchase BBP hospital inpatient, outpatient specialty and other health services

**Strategy 9** is to integrate or make interoperable health and finance information systems and directly link their corresponding operational processes. In general, each HFPS specific strategy also includes relevant information and operating system activities. For example, information systems to operate PHC or hospital payment systems are contained in the PHC and other health service payment system sections. Exceptions are to integrate or make interoperable health and finance information systems in this strategy. In addition, develop a comprehensive management information system for the health purchaser and health providers. This is also considered in the Governance and Roles and Relationships section.

**This strategy focuses on integration or interoperability between health and finance information systems for invoicing or billing operations on the front end of the provider payment process and for accounting and financial reports at the back end of the service delivery and financial management process.** Health information and invoicing or billing systems for provider payment can be integrated or made interoperable to collect the clinical information (e.g. ICD-10 codes, procedure codes, other patient information) required to determine payment categories and amounts for individual patients. At the back end of the process, PFM systems used for financial management and control in health institutions can also be used to account and produce financial reports for payments made by the health purchaser. Financial management systems will enable better health service delivery management by supporting health facilities to better plan, budget, procure, account, report, prepare for internal and external audit, and manage their human resources.

**Another critical aspect of the integration or interoperability of health and finance systems is the linkage to private provider systems to ensure that the MOHWEA and the health purchaser receive the appropriate health statistical and financial information if contracting with private providers.** The HFPS will support dialogue on the types of information to be submitted by private sector providers using a defined format or data exchange standards.

Major integration of health and finance information system activities include:

- ◇ Design, develop, and implement integrated or interoperable health/clinical information systems and purchaser invoicing/billing systems
- ◇ Develop and implement plans to use health facility-level financial management systems to account for and report to the health purchaser for BBP service payments
- ◇ Dialogue with the private sector on the type of clinical, health statistics, and financial information to submit using what systems, format, or data exchange standards

**Strategy 10** is to address complex issues in the payment or procurement of specific inputs, including human resources (HR), drugs, and capital. Phase I anticipates including in output-based payment small operating costs representing large numbers of transactions. For example, 80 percent of total expense/accounting transactions might represent only 20 percent of the total costs but be well-suited for facility-level management. In purchasing services through output-based payment, large ticket inputs including salaries and drugs have layers of complexity related to their specification, allocation, and procurement. Therefore, HFPS interventions will address these input-related complexities to position salaries and drugs for gradual incorporation into output-based payment systems.

**HR/salary and drug costs can gradually be incorporated into output-based payment, but the complex issues surrounding them should be addressed using a multipronged approach.** A first step is to align HR planning, budgeting, and allocation (both employee and non-established or subcontracted staff) consistent with use or need rather than facility infrastructure or historical budgets. This will better match salary costs to the type and volume of facility service outputs. Other HR issues or inefficiencies that can be at least partially addressed by health financing and purchasing BBP services include wage scales and other civil service regulation; developing a better mix of type and level of staff; reducing unfilled positions; improving incentives; reducing regional inequities; links to priority programs, evidence-based clinical practice or service delivery quality improvement; HR production; and HR management including facility-level performance reviews enabling facilities to motivate and manage their staff to deliver high-quality health services. In addition, a key and complex issue that will need to be addressed, particularly in Phase III, is how to contract and pay private providers for labor costs.

**At the start in Phase I, most drugs and medicines will be centrally procured such that facility-level drug procurements will be relatively small.** Plans will be developed for a gradual evolution in Phase II and Phase III to include more medicine costs and funding in payments to facilities. Steps to include medicines in facility payment and procurement will balance the volume/price advantages of central procurement with the motivation, responsiveness, and service output management advantages of direct facility financing. A focus will be the establishment of national framework contracts for selected drugs whereby facilities order and pay at a set price for a nationally negotiated volume of drugs. HFPS implementation will explore and develop the best option(s) for Saint Lucia, considering the unique island environment and transportation costs. In addition, steps to include medicines in output-based payment rates will be linked and coordinated with ongoing improvements to increase public expenditures on drugs to closer to regional levels so as to improve the availability of drugs in public health facilities, increase utilization and efficiency, reduce OOP costs, improve drug procurement, ensure all drugs procured are dispensed, and reduce wastage.

**Equipment and infrastructure (building and renovation) costs fall into both operating and capital cost categories as delineated by a threshold investment amount.** Small equipment, renovation, repair, and maintenance costs will be included in Phase I output-based payments to health facilities. They could represent a sizable portion of total facility costs as they also include contract labor and will focus on ensuring that equipment and facilities are functioning, that they are appealing to clients, and that delays for repairs and maintenance are minimized.

**It is unlikely that capital costs will be included in direct payment to health facilities in any phase of the health financing reform.** Large capital costs are not well-suited for small facility expenditures and capital projects should be planned system-wide or across health facilities. The capital planning, investment, and procurement function, systems, and processes will remain in the MOHWEA and not be transferred to the health purchaser. Improvements would be made to capital investment systems and processes, equipment and buildings inventory and depreciation, and replacement cost analyses. Inventory systems would be extended from the national level to the health facility level to ensure accurate, aggregated documentation and management of capital assets. PER analysis also recommends deeper evaluations in the planning and execution of infrastructure projects that take longer than expected and usually demand a higher proportion of resources for administrative purposes than international recommendations.

*Major health human resources, drugs, and capital finance and management activities include:*

- ◇ Design, implement, and refine HR/salary mechanisms to improve HR allocation and management and enable the gradual incorporation of salaries into output-based payment BBP purchasing
- ◇ Design, implement, and refine drug procurement interventions to balance output-based payment and facility rights to procure with national contracting and procurement designed to ensure optimal volume, price, and quality of drugs; also, ensure appropriate management of dangerous drugs or drugs and products with public health ramifications (e.g. vaccines, HIV and tuberculosis drugs, insulin)
- ◇ Assess and improve coordination of facility-level health service management and pharmacies and improve linkages between health and drug information systems
- ◇ Strengthen capital planning, investment, and procurement systems and processes, and improve the management of inventory, depreciation, and asset replacement cost analysis

## ► **Governance, Roles and Relationships, and Monitoring and Evaluation**

**Strategy 11 is continuous development and refinement of health financing policy and the legal and regulatory framework.** The specific objectives are improved policy, increased stakeholder participation, clear and well-executed laws and regulations, and public accountability. Health financing policy will be consistent with Saint Lucia country development strategies, the Health Sector Medium-Term Development Plan, and other Government of Saint Lucia and MOHWEA strategies and plans. The legal and regulatory framework will be amended as required by evolving health financing and PFM policy and operational experience.

*Major policy development and legal and regulatory framework activities include:*

- ◇ Strengthen health financing policy dialogue mechanisms and processes to ensure open, transparent, and participatory dialogue including both public and private partners
- ◇ Make policy decisions and refinements
- ◇ Amend and implement the legal and regulatory framework to codify health financing and PFM policy decisions
- ◇ Incorporate feedback from M&E into evidence-based policy dialogue

**Health financing reform, particularly shifting to output-based payment, requires realigning institutional roles and relationships across national institutions, government levels, and the entire health system.** Realignment of all roles and relationships to both institutionalize PBF for sustainability and implement the HFPS will be a priority, with a focus on two specific strategies: establishing a national health purchaser and public health facility autonomy.

**Strategy 12 is establishing a national health purchaser as a legal entity under the MOHWEA.** While dialogue on its nature and location is ongoing, it is anticipated that the new health purchaser will be established within the MOHWEA to avoid undermining movement towards UHC by fragmenting the pooling of funds, to value the interrelated nature of health system functions (including service delivery and quality improvement), and to allow the health purchaser to grow and build institutional systems and capacity at a practical pace guided by PBF institutionalization

leading into HFPS Phase I. The HFPS envisions the MOHWEA retaining most health financing functions and roles under its ministerial umbrella. However, how the health financing functions and tasks are separated or delegated across MOHWEA entities (agencies) and departments will evolve during HFPS implementation.

**A new health purchaser will be established to receive transfers from different revenue sources, pool these funds, and use them to purchase BBP services.** As outlined in the Pooling of Funds section of this report, the critical decision of whether to establish a new “Fund” to pool funds and purchase services will be made during HFPS implementation. Regardless of the legal status and name of the new MOHWEA national health purchaser, it must have its own bank account, be able to receive and pool funds from different sources, carry funds across years and maintain insurance reserves, disburse output-based payments directly to health facilities to purchase BBP services, and perform financial management and quality assurance tasks including accounting and financial reports submitted to its revenue source responsible parties. Establishing a new MOHWEA bank account converting the PBF pilot supported by HSSP to the long-term MOHWEA BBP program will trigger and align health purchaser development (see the Institutionalizing PBF for Sustainability section).

**The HFPS dialogue on health purchaser structure, roles, and relationships has built on experience and lessons learned from PBF in both health purchasing/PFM and broader health system/program functions and tasks.** Key conclusions from this initial dialogue on the health purchaser include the following. First, the task of BBP specification is best assigned to a MOHWEA department other than the health purchaser (possibly the UHC department). Second, the core service delivery and quality improvement functions in the PBF program should not be integrated into health purchaser but rather into other MOHWEA departments. Third, the MOHWEA could upgrade overall IT/IS functions by establishing a new general IT department, while health purchaser and other departments/units would be responsible for the operation of their applied systems and better use of data for analysis and decision-making. Fourth, other cross-cutting functions, including communications and M&E, could also use this matrix management model to ensure functional expertise is applied to all programs.

**The MOHWEA may establish or expand regional health authorities.** Regional health authorities or staff are not expected to perform the health financing functions of pooling funds and purchasing health services. Rather, they are expected to support the management side including oversight of both financial and service delivery management, training and mentoring, systems and data aggregation, and continuous quality improvement.

The establishment and development of a MOHWEA national health purchaser is a big task and will require developing strategic and operational plans. The institutional structure should be established, including the type and legal status of organization, its fit within the ministry, governance structure, and the management structure including the number and type of departments. Staffing will be crucial, including identifying the type of expertise required (new disciplines may need to be trained or converted), designing staffing and recruiting plans, hiring staff, developing job descriptions and other documentation, and performing initial training of new staff. Ongoing staff training will also be vital and capacity building plans will be developed.

*Major policy development and legal and regulatory framework activities include:*

- ◇ Determine the legal status of the new national health purchaser and its placement in the MOHWEA structure
- ◇ Perform a functional specification determining what health financing functions and tasks will be performed by the national health purchaser and other MOHWEA departments; also engage in dialogue and establish roles and relationships between the national health purchaser and other GOSL ministries and agencies including the MOF
- ◇ Establish the MOHWEA national health purchaser including governance and management structure
- ◇ Develop the MOHWEA national health purchaser including staffing and capacity building.

**Strategy 13** is gradual movement towards establishing public health facilities as autonomous and accountable entities with improved financial management systems and processes.

Most hospitals and polyclinics already have autonomy as statutory bodies contained in the country chart of accounts (spending) with their own bank accounts. Therefore, this strategy focuses on solidifying autonomy and improving financial management and accountability for hospitals and polyclinics.

**PHC center autonomy was discussed extensively during the development of the HFPS and policy dialogue will continue in HFPS operational planning and implementation.** A productive MOHWEA/MOF Accountant General dialogue reached consensus on the starting point for PHC center autonomy. That starting point will be in the first PBF institutionalization element of PFM alignment for purchasing BBP PHC services using output-based payment—specifically PHC per capita/PBF payment (see the PBF institutionalization section).

**This strategy assumes gradual increases in PHC center autonomy.** In Phase I, the process will build on PBF introduction by strengthening providers' development of their own plans and budgets and by delegating procurement authority to PHC facilities. Autonomy and accountability will expand over time in Phases II and III, possibly including statutory bodies and/or bank accounts to receive, retain, and manage output-based payments from public and private sources. Improving separation of functions (authorization, payment) and increasing transparency will be a focus area. Introducing or extending PFM systems to the provider level in health facilities (and schools) will enable these management entities to improve financial management and service delivery, perform responsibilities (procurement, internal controls, accounting, reporting), better use information for decision-making, and improve the quality of data throughout the system.

**Ongoing HFPS dialogue will include defining the exact legal, governance, management, staffing, and operational details as PHC centers become more autonomous over time.** Dialogue on public PHC center autonomy options should also consider the structure of the public PHC sector. Table 3 shows the number, region, and level (1–4) of all public PHC centers. The HFPS dialogue concluded that Level 1 PHC centers would not have full autonomy or bank accounts since they are affiliates of other PHC centers that could perform their financial management functions. Whether any broader networks would be formed between Level 2–4 PHC centers is a question for ongoing dialogue, analysis, and policy decisions. Inherent in the dialogue is clarity in definitions and terminology including networks, cost centers, and spending units.

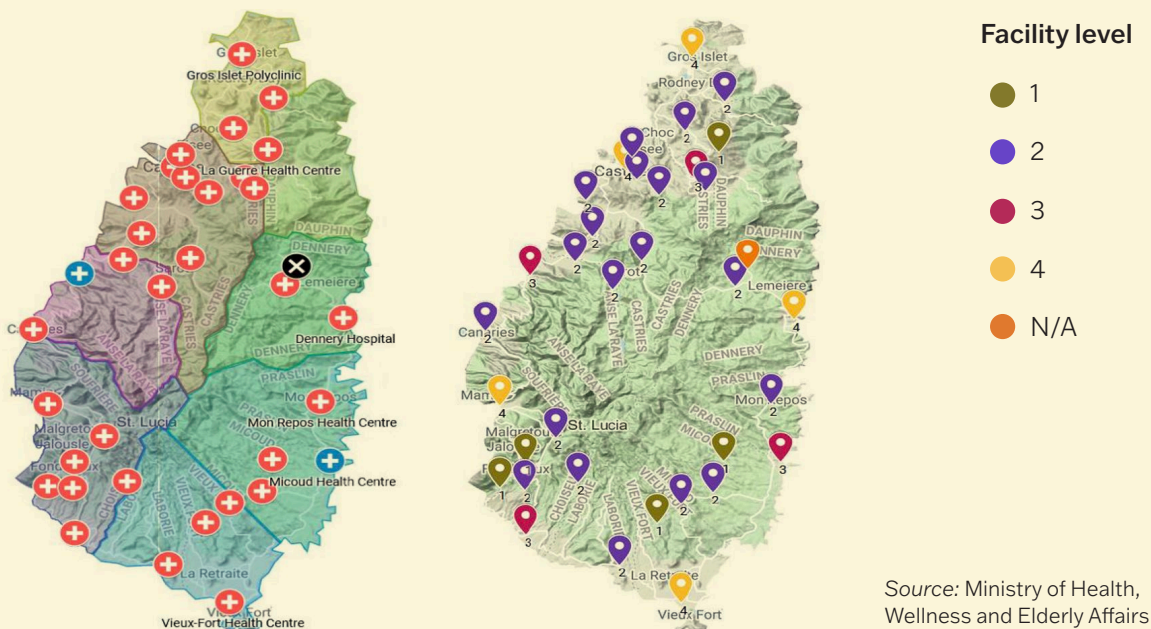
**Table 3. Number, Region, and Level (1–4) of All Public Primary Health Care (PHC) Centers**

Region	Level 1	Level 2	Level 3	Level 4
1. Gros Islet	--	Monchy Grand Rivière	--	Gros Islet
2. Babonneau	La Guerre	Fond Assau	Babonneau	--
3. Dennery	--	La Ressource Richfond	--	Dennery
4. Micoud	Ti Rocher-Micoud	Desruisseaux Mon Repos	Micoud	--
5. Vieux Fort	Grace	Belle Vue Laborie Saltibus	--	Vieux-Fort
6. Soufrière	Etangs Delcer	Mongouge Fond St. Jacques Canaries	La Fargue	Soufrière
7. Anse La Raye	--	Vanard La Croix Maingot Jacmel	Anse-la-Raye	--
8 Castries	--	Bexon Ciceron La Clery Ti Rocher Entrepôt	--	Castries

Source: Ministry of Health, Wellness and Elderly Affairs

**Consideration of public PHC center autonomy and accountability options will also encompass the types of accounting and financial management staff required**, starting with existing staff performing these functions and moving towards a PHC center accountant including staff contracting with more than one entity to perform financial management functions. For reference, Figure 12 contains maps of all public health facilities and PHC centers, and Table 4 provides more detailed information on each public PHC center, including catchment population, encounters (visits), persons accessing care, and percent of catchment population accessing care.

**Figure 12. Maps of All Public Health Facilities and PHC Centers**



Source: Ministry of Health, Wellness and Elderly Affairs

**Table 4. Detailed Information on Public Primary Health Care (PHC) Centers**

Name	Catchment (2020 pop)	# of encounters (2021–to date)	# of people who accessed care	% of persons accessing care of WC catchment pop
Castries Wellness Center	14,529	18,897	9,000	61.9%
Vieux Fort Wellness Center	14,016	17,092	9,010	64.3%
Entrepot Wellness Center	10,909	4,559	1,832	16.8%
Grand Riviere Wellness Center	10,228	4,925	1,905	18.6%
Gros Islet Polyclinic	9,037	26,799	18,800	208.0%
Ciceron Wellness Center	7,509	5,276	1,803	24.0%
Babonneau Wellness Center	6,280	5,917	2,543	40.5%
Bexon Wellness Center	6,220	5,212	1,880	30.2%
Soufriere Hospital	5,851	5,113	2,793	47.7%
La Clery Wellness Center	5,835	690	617	10.6%
La Ressource	4,851	--	--	0.0%
La Croix Maingot Wellness Center	4,785	4,034	1,784	37.3%
Monchy Wellness Centre	4,623	3,079	1,163	25.2%
Desruisseaux Wellness Center	4,498	2,996	1,213	27.0%
Mon Repos Wellness Center	3,881	2,860	1,238	31.9%
Richfond Wellness Center	3,762	5,502	2,331	62.0%
Fond Assau Wellness center	3,509	2,319	781	22.3%
Dennery Hospital	3,355	7,570	3,876	115.5%
Laborie Wellness Center	3,230	3,771	1,544	47.8%
Micoud Wellness Center	3,176	4,465	1,726	54.3%
La Guerre Wellness Center	2,857	2,081	814	28.5%
Jacmel Wellness Center	2,752	4,181	2,181	79.3%
Ti Rocher (Micoud) Wellness Center	2,712	2,625	980	36.1%
La Fargue Wellness Center	2,682	2,765	1,014	37.8%
Vanard Wellness Center	2,644	2,418	821	31.1%
Ti Rocher (Castries) Wellness Center	2,513	2,151	898	35.7%
Mongouge Wellness Center	2,169	1,929	642	29.6%
Saltibus Wellness Center	2,098	2,439	793	37.8%
Grace Wellness Center	1,916	1,623	599	31.3%
Anse La Raye Wellness Center	1,774	3,289	1,196	67.4%
Fond St Jacques Wellness Center	1,692	2,017	545	32.2%
Canaries Wellness Center	1,635	2,881	831	50.8%
Delcer Wellness Center	1,409	2,257	657	46.6%
Belle Vue Wellness Center	951	2,245	882	92.7%
Etangs Wellness Center	794	1,977	845	106.4%

Source: Ministry of Health, Wellness and Elderly Affairs

Note: pop = population; WC = wellness center

**Regardless of the policy dialogue and decisions on options and plans to gradually move towards public PHC center autonomy and accountability, all public health facilities will require better PFM systems and processes to enable movement towards UHC,** perform financial management functions, and improve service delivery and quality to a level comparable to or above private health facilities. HFPS activities will identify requirements, design, and develop new systems or extend existing systems to the facility level to perform functions and tasks including planning, budgeting, procurement, internal controls, inventory as necessary, accounting, financial reporting, auditing, and HR management. This process will start in PBF implementation and accelerate through HFPS Phase I to Phase III.

**Capacity building will be a priority regardless of public PHC center autonomy dialogue and decisions on options and plans.** On-the-job training directly linked to implementation and ongoing mentoring will be a priority. International experience has shown that many countries wrestle with the ideological or philosophical side of public PHC center autonomy in addition to the political, technical, and operational aspects. One perspective is that public PHC centers can be trusted to step up and manage service delivery for their clients and communities if they are unleashed or given greater autonomy. Another perspective is that they will always need to be controlled or will require extensive capacity building. Each country must select the option best suited to their environment and that will lead to the better functioning public PHC centers vital to moving towards UHC. All options must include building capacity to manage finances and service delivery, to better use data to improve performance, and to increase population confidence and utilization of these facilities in order to move towards UHC by increasing equity and efficiency and extending access and service coverage.

**In summary, Phase I and Phase II preparation for Phase III implementation—characterized by shifting OOP payments to prepayment mechanisms or compulsory contributions—requires gradual movement towards public PHC center autonomy and accountability.** Otherwise, it will be difficult to realize the overarching health financing strategy and sequencing through the envisioned pooling and purchasing arrangements encompassing gradual increases in general revenue, shifting OOP payments to compulsory contributions, pooling general revenue and compulsory contributions, purchasing BBP and BBP+ services using output-based payment and unified health and PFM information and operating systems and processes, strengthening health facility financial management, and optimizing public and private financing and service delivery relationships with private money flowing to public facilities and public money to private facilities.

*Major public health facility autonomy and accountability activities include:*

- ◇ Follow-up on specific PHC center-level systems developed in the HFPS preparatory phase for PBF institutionalization—including automation of facility plan development and establishing simple financial management or accounting systems and processes to manage petty cash and procurement and analyze budget versus actual expenses including expenditures made by the MOF
- ◇ Ongoing dialogue and decisions on options and plans for public PHC center autonomy and accountability
- ◇ Establish structural, governance, and staffing arrangements for more autonomous public PHC centers

- ◇ Develop and implement facility-level PFM systems and processes to improve financial management in public hospitals, polyclinics, and PHC centers
- ◇ Build financial and general management capacity in public hospitals, polyclinics, and PHC centers to enable better management of service delivery to clients and communities

**Strategy 14 is to monitor HFPS implementation and strengthen monitoring and evaluation (M&E).** It includes a variety of M&E interventions and their feedback of evidence-based information into next-generation policy dialogue. Indicators will be developed for routine HFPS monitoring, and health expenditure reviews will be strengthened. Regular monitoring will be incorporated into broader health policy and planning processes. M&E will be institutionalized at all levels of the system and information fed back into next-generation policy dialogue, enabling the continuous refinement of interventions, improving transparency, promoting results, and increasing sustainability.

*Major M&E activities include:*

- ◇ Develop an HFPS performance framework and monitoring indicator package
- ◇ Monitor HFPS implementation including indicator data collection, analysis, and regular indicator results reporting and dissemination
- ◇ As necessary, design and perform periodic policy analysis, operational research studies, or evaluations to generate evidence for policy dialogue and review
- ◇ Strengthen mechanisms for active feedback of M&E information and evidence into next-generation policy dialogue

## ► Communications

**Strategy 15 is to develop and implement a communications strategy.** The purpose of the communications strategy is to inform and educate stakeholders; promote health sector results; and advocate for resource mobilization, financial risk protection, efficiency gains, and quality improvement. The rationale for and the impact of policy decisions and consequences of decisions will be communicated to all stakeholders. Positive health sector results will be promoted to policymakers, health providers, and the population. Capacity will be increased—enabling the health sector to effectively advocate for resource mobilization, health system barrier removal, efficiency gains, service delivery improvements, and increased population involvement in their own health.

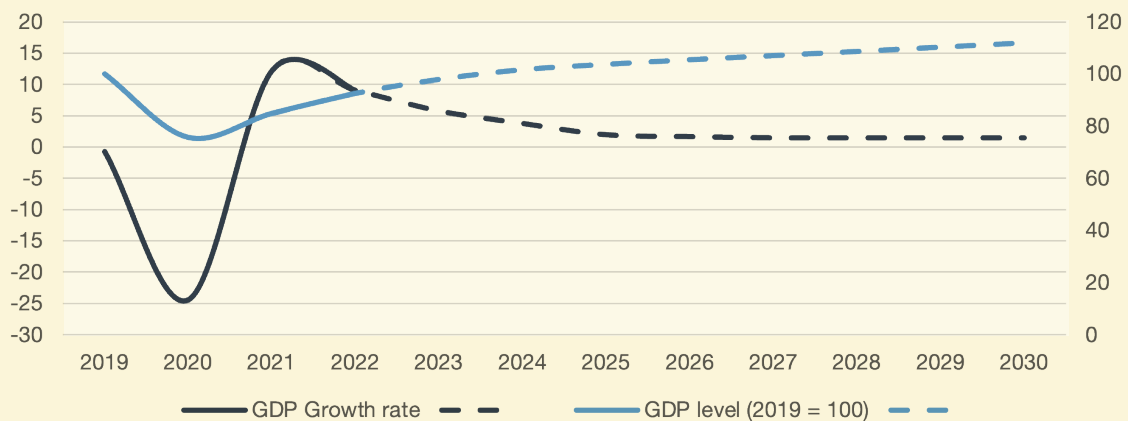
*Major communication activities include:*

- ◇ Design and develop a communication strategy to communicate policies, promote health sector results, and advocate for health sector priorities to all stakeholders
- ◇ Implement the communications strategy

# Appendix 1: Macro-Fiscal Situation

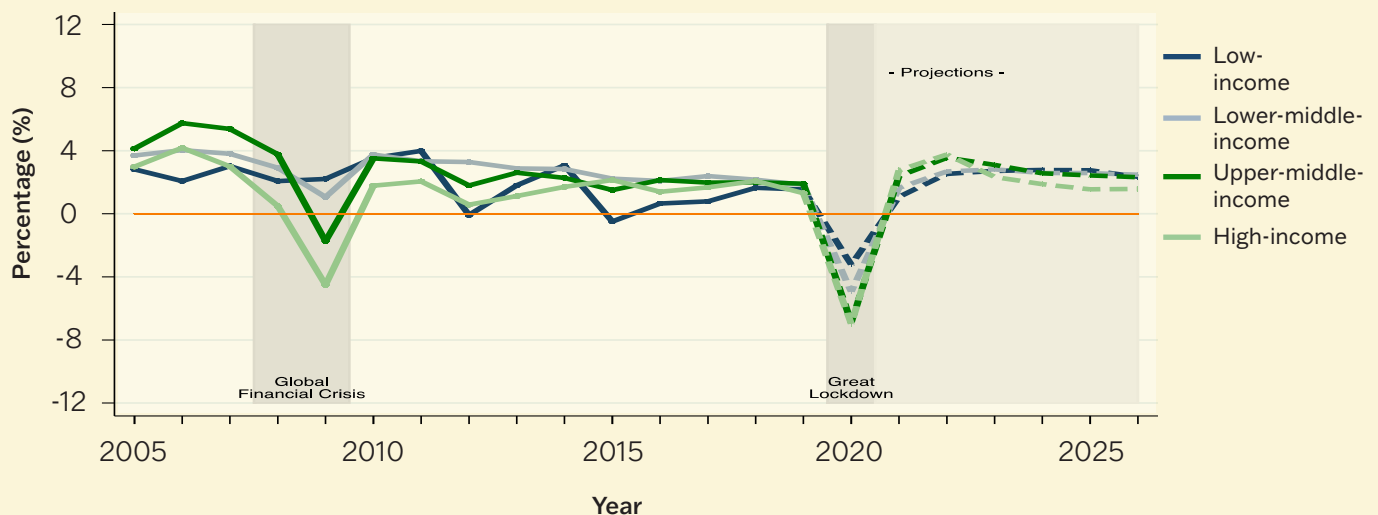
In 2019, the per capita gross domestic product (GDP) in Saint Lucia was estimated at EC\$31,506, just over US\$11,000 per year per person. The COVID-19 pandemic had an enormous impact on GDP in Saint Lucia as the lockdown shuttered tourism and many of the other growth drivers from the previous years. As shown in Figures A1.1–A1.2 below, following the sharp contraction in 2022, the pre-COVID GDP level was not expected to be attained until 2024.

**Figure A1.1. Gross Domestic Product (GDP) Levels and Growth Rates, Saint Lucia (2019–2030)**



Source: MOF Research & Policy Unit

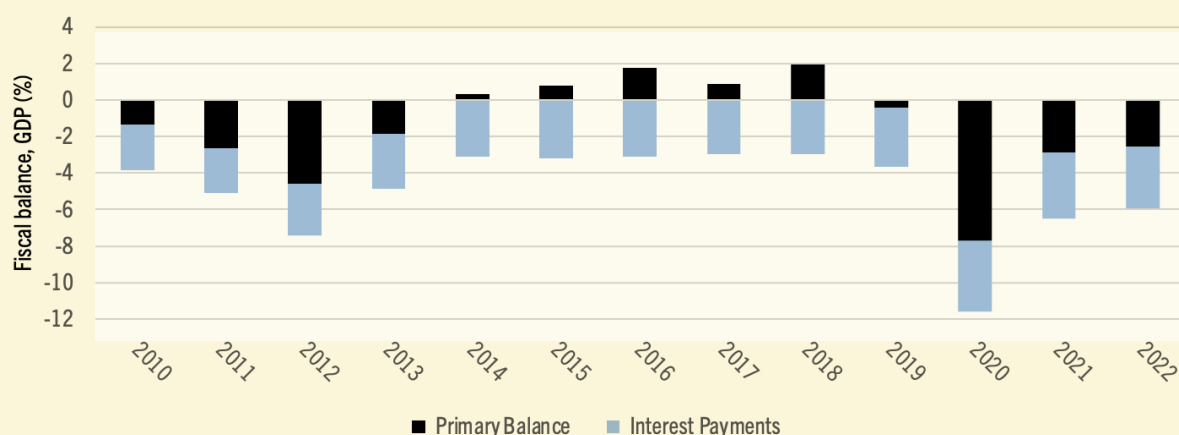
**Figure A1.2. Per Capita Gross Domestic Product (GDP), 2006–2026**



Source: MOF Research & Policy Unit

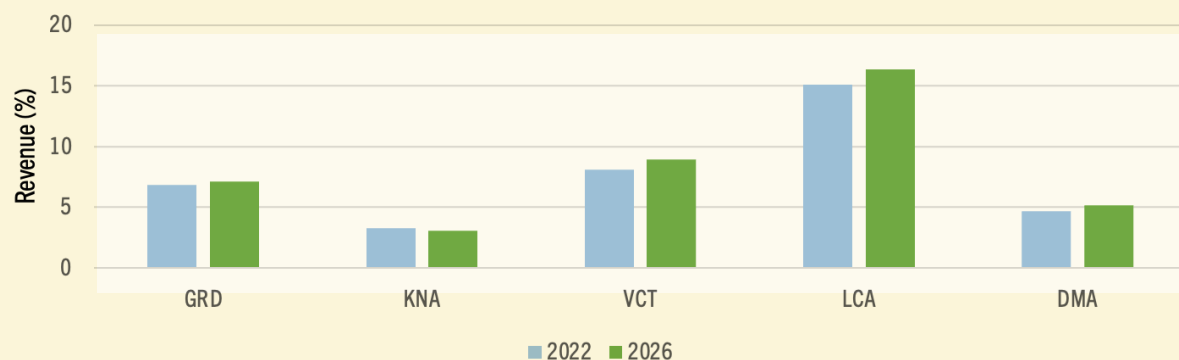
As shown in Figures A1.3–A1.4 below, the fiscal deficit and public debt in Saint Lucia increased rapidly owing to COVID-19, with interest payments weighing on the deficit and high in comparison to other Caribbean countries. A drop in fiscal revenues, combined with additional direct health and social expenditures, temporarily increased the fiscal deficit and financing needs. The fiscal deficit declined in 2021 as revenues increased with the recovery while COVID-related spending was partially rolled back, but there was no significant improvement in 2022. Public deficit reduction halted in 2022 as authorities worked to address inflation and mitigate the impact of rising energy and food prices on poor households’ purchasing power. Despite recent improvements provided by Saint Lucia Net 3.0, there is still room to strengthen targeting of social spending. In summary, given fiscal constraints, the HFPS must include realistic expectations of the potential for short-term general revenue increases for health services.

**Figure A1.3. Fiscal Balance, Saint Lucia (2010–2022)**



Source: MOF Research & Policy Unit  
 Note: GDP = gross domestic product.

**Figure A1.4. Interest Payments, Selected Countries (2022, 2026)**



Source: MOF Research & Policy Unit  
 Note: DMA = Dominica; GRD = Grenada; KNA = Saint Kitts and Nevis; LCA = Saint Lucia; VCT = Saint Vincent and the Grenadines.

