Quality Services for Life

MINISTRY OF HEALTH, HUMAN SERVICES, FAMILY AFFAIRS AND GENDER RELATIONS

HEALTH SECTOR REFORM PROPOSALS

QUALITY SERVICES FOR LIFE

" QUALITY OF LIFE IS DETERMINED BY CHOICES. IT IS ESSENTIAL THAT WE GIVE OUR PEOPLE THE TOOLS TO BE AWARE AND TO MAKE THE MOST APPROPRIATE CHOICES, THUS EMPOWERING THEM TO EXPERIENCE THE MAXIMUM QUALITY OF LIFE"

…Health Sector Reform, SAINT LUCIA

SAINT LUCIA
6th March 2000

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There are many people and organisations who deserve to be mentioned. We involved so many in this process over the last two and a half years and we thank everyone and every agency that contributed. Special mention needs to be given to some of the main players who went through the “grind” from beginning to end.

These are not confined to but include:

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We thank you.

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PART I

MESSAGE FROM THE CHAIRPERSON OF THE HEALTH SECTOR REFORM COMMITTEE

When we commenced the deliberations, in September 1997, we were essentially a group of naïve people who brought to the table varied experiences and expectations. Soon after the onset one of our members commented that this was a massive undertaking. He added that he thought we were going to help with some fixing here and there and he did not appreciate that we were proposing a restructuring of the Health System. He also added that this process would only be possible if we involved the Ministry of Health programme managers sooner rather than later.

It is important to note that September 1997 was merely four months after a major landslide victory for the Saint Lucia Labour Party (SLP) at the polls. The campaign of the SLP, if it could be encapsulated in one phrase, was the slogan "Time for Change". The spirit of change was powerful and we all felt that change was possible and therefore our ambitions were given free reign. The SLP had documented its policy direction during the political campaign in the form of the "Contract of Faith". This document was used as the basis for designing the reforms. There was and is considerable political support for health reform from all the Ministers but especially the Hon. Minister of Health, Human Services, Family Affairs and Gender Relations, Sarah Flood-Beaubrun, who participated in virtually every fortnightly meeting and the Prime Minister, Dr. Kenny Anthony, who constantly reminded us that he was a man in a hurry and that we must deliver soon. The support from these two leaders has been a critical factor.

When we started, others who had been involved in reform elsewhere, told us that the process is more important than the documents. This I did not understand at the time; although I thought I did. This is, however, a truth because when the process is followed faithfully there is entrenchment of a way of thinking in addition to concepts, and if done well, the process takes on a life of its own, and if this is done as widely as possible and the leadership encourages the process, chances of success are great. It is analogous to the saying, "Give a man a fish and he has food for a day, teach a man to fish and he has food for life".

The two and a half years that followed our first meeting have been eventful, and we are now no longer as naïve as we were at the beginning. The milestones of the path we followed are documented in the paper; it is important that I note the process and its spirit. We have been lucky because although we did not understand the power and importance of the process, we did, however, adopt a consultative approach, with workers, communities and stakeholders, and we did actively integrate the process into the Ministry's daily affairs. We did this as honestly as we could, attempting to be as straightforward and non-judgemental as possible. We tried to leave our pre-conceptions behind: This was not easy. The Health Sector Reform Committee and especially the Health Sector Reform Secretariat were invaluable in keeping this process on track. There were also many other people including heads of departments, programme managers, health workers, friends and the people in the communities who constantly fed and helped

the process. We listened to everybody and shared as much as we could. What I have understood now is that there are keys to success and these will become even more important in the next phase of implementation. These keys to success are:

1. Trust in the people, i.e. workers and public.
2. The development of a clear vision and an honest, consistent value system
3. Effective leadership
4. Ability to listen to everyone and remain flexible while remaining true to the articulated value system and vision.
5. Objectivity

One of my favourite memories is a discussion with the Secretariat on the "Spirit of the Process" when we agreed that having adopted the spirit of consultation we had to remain faithful to the process, occasionally venturing into places where we were uncomfortable, but confident that we would get closer to the truth and progress. In fact, what we found was that by adopting this philosophy we could go anywhere, discuss anything and interestingly it helped us grow. Regardless of what the future holds, we benefited from this process.

Our mandate is soon to be fulfilled with the presentation of our proposals to the Government. It would only be proper for me to express my concerns for the future. I outlined the five main ingredients for success and I am concerned that the executive of the Ministry will have difficulty ensuring that these five factors are in place and working in synergy and harmony. The source of my fear is that all five of these factors are counter to the public service culture that has developed over the decades. We have proposed that reform should be in the hands of the public servants, which we believe it should be. These public servants, however, will have to change their existing culture and attitudes. I would like to remind you that all meaningful change starts within you, to quote, Kendel "Straw" Hippolyte, "I cannot change the world; I can only change my world". This, to me, is the essence of reform. People who feel threatened are usually people who do not want to change regardless of the need for change. I do not think that the Government can afford to have persons involved who have no intention of embracing necessary change.

In closing, I wish to thank all who helped in this process especially the members of the Health Sector Reform Committee and the Health Sector Reform Secretariat. On behalf of all the people who contributed, I hope we have presented your concerns and your suggestions honestly. I hope that we can advocate effectively for you, when we are required to do so. I hope that the Ministry of Health can be successful as it moves forward with implementation. I trust that all concerned truly understand how important it is for the people of Saint Lucia to have a health service that can deliver the best to allow them to be "fit for life", capable of fulfilling their potential and achieving their goals and ultimately being happy. God Bless all concerned and thank you for engaging us as you did.

Dr. Stephen King FRCPC

EXECUTIVE SUMMARY

This paper articulates a philosophy and vision for health, human services, family affairs and gender relations. It outlines and expands on major policy and strategy to position the services to develop in the most sustainable and effective manner. Where it gives more detail, as in the area of organisation of the services, it does so to ensure that the necessary framework will be put in place. Attached is a list of documents, books and reports that provide detail in specific areas, which served to inform this paper and may serve to allow specific services to develop. We have purposely attempted to stay away, as much as possible, from technical details. The paper is organised in two main parts. The first documents the philosophy and vision of the proposed health system. An analysis of the existing system and the reform follows and then there is a section outlining the public's perception of the existing health services. The second part is divided into six numbered sections. These sections detail the policies and strategies for the way forward and are headed as follows:

1. Organisation of the Services
2. Environmental and Other Public Health Services
3. Financing the System
4. Quality Assurance
5. Regional, Inter-Ministerial and Intersectoral collaboration
6. Implementation Plan

This second part was organised in this way to parallel "the people speak" and provide the solutions in a similar format to how the people expressed their concerns about the sector. The conclusion attempts to summarise how the reformed service as proposed will deliver.

Health Sector Reform proposals have been developed on three principal pillars; equity, efficiency and effectiveness. The process of reform is a stepwise, purposeful implementation of policies and strategies that will result in a transformed health sector. The vision is a health sector that is designed to produce "wellness" in the comprehensive sense of mental, physical and social health. The underlying belief is that a people who are well "holistically" will be maximally productive and therefore in a position to fully develop themselves, their families, their communities and the nation. Essentially this sector is responsible for ensuring that the most valuable national resource, the people, will be well enough to allow for maximum human resource development.

The reform is to be implemented in phases. Phase 1 is the re-organisation of the service. During this phase it is proposed to increase the capacity for planning, evaluating and managing the sector. In addition the glaring service gaps will be addressed. There are a number of projects that will be strategically delivered throughout this phase to engender confidence and add impetus to the process e.g. the Accident and Emergency Services. Phase 1 provides the framework and capacity to allow phase 2 to be implemented. Phase 2 involves mainly a reform of the sector's financial system with the main objective of developing a sustainable, diversified financial system that creates the market forces that drive the services towards achieving the detailed objectives of the sector. Phase 3 is the elaboration of a comprehensive national plan with detailed service plans including

targets, costs and funding. These are not perceived to be discrete, mutually exclusive phases. Each phase will be implemented concurrently as the capacity for implementation is developed within the sector.

The health, human services, family affairs and gender relations divisions are to be re-organized and re-oriented to work together in a multidisciplinary team approach. Roles, responsibilities and lines of reporting will be clearly defined. There will be institutional strengthening and capacity building. To achieve this, leadership and management at all levels will be improved. The main thrust for all the services will be to develop more community based services, allowing decentralization with increased access by more people to more sophisticated services in the most convenient way.

The central office of the Ministry will become more focused on financial control, policy for and regulation of the sector, public and private. From the delivery point of view, the public sector will have three levels of service delivery: health centres, polyclinics and hospitals. The health centres are the community focal points for health development and will be the main institutions for wellness promotion. The polyclinics are institutional platforms for the delivery of more specialized care and will house the multidisciplinary team (health workers and social workers) to allow for the delivery of more sophisticated services to the communities. The hospitals will operate as support for the polyclinics and will provide the secondary and tertiary care services that cannot be delivered by the polyclinics. The system is an integrated, mutually supportive network of institutions and workers focused on providing services for the communities in the most comprehensive and convenient way with minimum duplication.

The hospital component is in need of upgrading. A new mental health facility will be constructed to allow the mental health services to be supported and developed in the most modern and efficient way. A new general hospital will be constructed to improve the level of service available and to reduce the existing inefficient duplication of services. The new general hospital, either as a replacement of Victoria Hospital or as the major general hospital, will be in a position to offer certain regional services to our OECS sisters. Planning will be improved with the creation and staffing of a planning unit and the improvement of the information systems including staff training and computerization. The concept of information systems development is along the lines of a digital neural network operating and integrated at all levels.

Human resource development is an essential component of the development of the sector and is a necessary part of capacity building. A human resource plan will be developed and implemented, being guided by the phased development of the services.

National programs targeted at the main health and social problems will be developed with programme managers being responsible for successful development and implementation. These programmes include: gender based violence reduction, care of the elderly, integrated childcare and protection, chronic non-communicable diseases (diabetes, hypertension, cancer etc.), communicable diseases (Expanded Programme of Immunisation, Sexually Transmitted Disease Program, food borne, water borne and

vector borne diseases). As a component of some of these, institutions will have to be built, bought or renovated; these include the shelter for women, the transit home for children and the senior citizens home. Included within these programmes are the intersectoral network development and the informing of policy in these areas. This includes:

- ?? Gender mainstreaming and support for the non-Governmental crisis centres
- ?? A national policy on aging and networking with NGOs involved in age related issues
- ?? The development of national policy on childcare and protection and the institutionalisation of the convention of the rights of the child
- ?? National policies and protocols to address communicable and non-communicable diseases.

Health financing is critical to ensure sustainability of the sector and its services. There are strategies that are being debated the options that will be implemented will be determined within this three year period. General Government revenue will remain a main component of financing the public sector. This will be complemented by the development of health insurance for personal health care. The NIS will have a role in this development and will be a major decision maker in the level of insurance to be introduced and the speed with which it can be implemented. Private insurance will have an enhanced role when the health costing studies are completed and charges for services are revised. The main concern is how to protect the poor within the proposed system, and this we are committed to doing.

Quality of services, protection of people and the environment are issues that need to be addressed. In order to ensure that the Ministry has the authority to act to ensure that this is delivered we will be reviewing and drafting pertinent legislation: The Mental Health Act, The Public Health Act, Complaints Commission Act, Health Services Act (including licensing of all health professionals and accreditation of all health facilities). In addition to legislation to ensure minimum standards we intend to institutionalise continuous quality improvement at all levels, with the planning unit providing co-ordinated quality assurance and support.

Having developed our services, public and private, we will be in a better position to participate in regional sharing of health services. Sharing of services is a something we do and will continue to do. During the reform process we will soon be in better position to be rational about how we develop local services vis-à-vis regional services.

The deliverables that the people expect of the health service, and therefore the proposed reforms are:

- ?? Increased access to health services
- ?? Improved quality of services in a system that ensures quality
- ?? Value for money
- ?? Equity in the service

We believe that as a result of a well functioning health service the people can deliver to the country a reduced burden of disease and enhanced productivity.

PHILOSOPHY

The cliché, “health is wealth”, becomes a reality when health is defined as a state of optimum mental, physical and spiritual wellness of every individual. Wellness of the individual, as outlined, allows a person to be maximally productive, capable of creating opportunity and making use of such opportunity. Spiritual and mental health not only allows for individual productivity but also produces social harmony, resulting in healthy communities. Productive individuals, living in healthy communities, produce a strong nation; thereby creating maximum attainable wealth. Put another way, health is not merely the absence of disease and health service is not merely the treatment of sickness. Health is the ability to achieve the maximum quality of life regardless of the physical, mental, social or spiritual condition of an individual and health service is the participatory delivery of this holistic care to human beings.

We recognise that health demands a multisectoral approach. We understand that all sectors of the country have an impact on and are impacted by the health sector. We cannot truly address health issues unless every ministry, agency and individual understand their role in promoting health. We intend to address health issues with the involvement of every sector since this appears to be the best, if not the only, path to sustainable development of the health sector. To underline the scope of multisectoral teamwork, consider the impact of violence and crime on every sector in the country, now, ask how should it be tackled? The answer lies in a multisectoral approach with the health sector intimately involved in management at all levels of the process. Health should be involved:

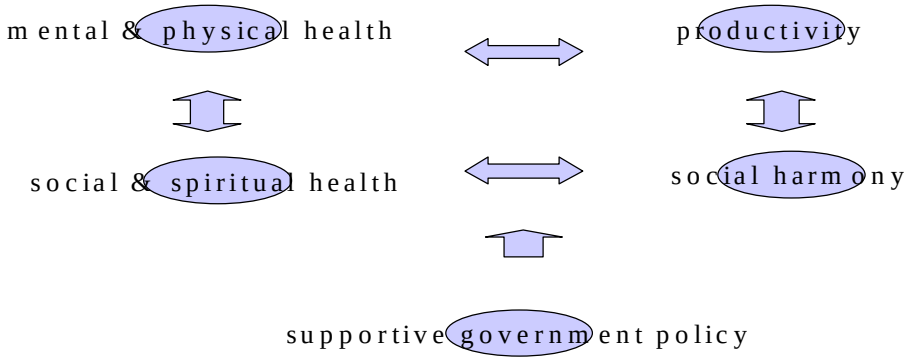
- in teaching life-skills to cope with conflict and anger management
- in teaching and reinforcing self esteem, care for others and social responsibility
- in early identification of persons at risk and directing appropriate interventions to prevent violence
- in mitigation of the effects of violence and rehabilitation of individuals affected, both victim and perpetrator.

This quick and superficial overview of Health’s role in violence and crime management shows clearly the close relationship required between the different sectors and agencies that should be involved in addressing this national crisis. These include Health, Human Services, Gender Relations, Education, Legal Affairs, Police, the Judiciary, community-based organisations etc.

If any democratic Government’s mandate was to be encapsulated in one phrase it should read, "Our objective is to improve the quality of life of our people". Health, as defined above, is paramount, if we are to improve the quality of life of the common person. Reforming health is only useful if it will deliver a service that can do this. In order to reform to achieve the objectives of universality, quality and integration we need to recognise the human condition and the unique system that exists in Saint Lucia.

We do not intend to discard the gains of the past. We recognise the strengths in our health sector and intend to build on these. We are cognisant of the constraints. We intend

to develop the health sector being guided by principles of equity, efficiency and effectiveness. The ultimate goal is to produce a nation of people who are safe, happy and productive.



INTRODUCTION

Definition of Health

Good health means many different things.

Health is no longer viewed within a narrow frame of reference involving simply the absence of disease and infirmity. Good health means that we can actually live longer and enjoy healthier lives. This involves good feelings in the body, mind and spirit, in our day to day dealings with others and about security at work and in our communities. It also includes our ability to make informed decisions, respond favourably to opportunities as they present themselves and take responsibility for our health and the health of our communities. When people are healthy they can be productive in their daily activities. Productive lifestyles can convert into better standards of living for people and a more prosperous economy.

The Determinants of Health

Our health is dependent on a multitude of factors.

Almost everything can impact on our health and determine the health status of the population. The broad range of factors which determine our health are personal, social, economic, political and environmental. Some of these factors are beyond our control, while others can be controlled. Some determinants of health are detailed in the table below.

Table 1 The Determinants of Health

Fixed factors	Personal Factors	Social and Economic Factors	Environmental Factors
Age Gender Genes	Lifestyle Diet Physical activity Smoking Alcohol Sexual behaviour Drug abuse	Poverty Employment Education Social services Transport and leisure Domestic violence Social Exclusion Relationships	Air quality Housing Water quality Food quality Social environment Work environment

Fixed Factors

Fixed factors such as age and gender are entirely beyond our control. Government efforts should be directed at minimising their predictable consequences. For example emphasis on preventive health will encourage more men and women to adopt healthy lifestyles to prevent cardiovascular diseases, cancer etc. Although genetic predisposition to diseases

was once considered irreversible, research in the field of genetic engineering may make it possible to control these factors.

Personal Factors

A healthy lifestyle is important.

How people live has serious implications for their health. Poor eating habits, lack of regular and appropriate exercise and an over indulgence in substances that may be harmful, will cause poor health. A weakened state of health may make us more susceptible to certain conditions of ill health, such as hypertension, kidney failure and obesity. Today, sexual behaviour is a very important feature of healthy living. The increase in sexually transmitted diseases, particularly AIDS, has become a major threat to our health. In order to encourage people to live healthier lives, the Government of Saint Lucia has adopted primary health care policies. These policies place emphasis on promoting disease prevention and wellness.

Social and Economic Factors

Health is wealth

Health contributes to human and economic development and at the same time benefits by this development. In order to accomplish the goals of the health services, strategies must be directed towards achieving social and economic well being for all.

Economic factors are powerful determinants of good health. Studies show that when people are employed they actually live longer and healthier lives. The employed are able to achieve social well being by improving their standard of living and engaging in leisure activities. The unemployed, on the other hand, are less able to provide for their health needs and that of their family and as a result, exhibit higher rates of ill health. Unemployed persons are not only less healthy, they are also more likely to engage in illegal activities and threaten the security of others and the social fabric of the society.

We need to continue to eradicate poverty and discrimination.

The health sector has made significant contributions to improved standards of living and longevity among all groups of the population. This is evident in the reduction of morbidity and mortality rates, control of communicable diseases and the introduction of primary health care that is accessible and affordable to all individuals.

However, the gains achieved in the health sector have not significantly reduced health gaps between socio-economic groups. The effects of health gaps are manifested in the high rates of ill health, illiteracy, and social ills (e.g. crime, drug abuse and teenage pregnancy) among the poorer groups of the population.

We need strategies to eradicate poverty and discrimination. These strategies should ensure that all groups in our society have access to basic social services, infrastructure and opportunities to earn a living, including health, education, social support services, proper roads, organised and efficient transport systems and employment opportunities. There are people without access to some of the above. This has serious consequences for the isolated individual or group. Social exclusion gives rise to social ills and psychological problems, which reduce the productive potential of our society. Hence efforts to reduce poverty and discrimination should be directed towards providing all groups with the requisite skills, physical and social amenities to make meaningful contributions to the social and economic development of our nation.

The Environment

A healthy environment is a prerequisite to improved health conditions on the island.

The condition of our physical surroundings is a very important determinant of our health. We cannot achieve good health while we exist in an unhealthy environment. Such factors as clean air, safe food, safe drinking water, adequate housing, healthy work environment are essential requisites for good health and social well being.

The social environment is defined as the quality of life enjoyed by individuals in their community and the extent to which they respect and support each other. The link between the social environment and health is complex. It is intricately woven into issues of poverty, employment, access to social services, infrastructure and leisure activities. The combined effects of these factors will determine the social environment in which we live.

Social engineering to improve health

Social and economic factors, which determine health, can be controlled through effective planning. This form of planning for health implies the use of an intersectoral approach, which involves players from all sectors of the society. The integrated approach is needed to provide the necessary support mechanisms, which are required to achieve the goals of the health services. These goals can only become a reality if various sectors in the society employ strategies and programs, which tackle inequalities that exist in the wider society and impact directly on health. Policies and strategies must address the health needs of all groups and aim to close the health gaps between the rich and the poor. This is fundamental in creating a climate for sustained attitudinal and institutional changes.

ANALYSIS OF HEALTH REFORM IN SAINT LUCIA

Health Sector Reform can only proceed as a component of the wider Public Sector Reform. The launching of the Green Paper on Public Sector Reform, 6th August 1999, has established the context within which this Health Sector Reform can proceed. We believe that the proposals made in this white paper are in tune with the proposals being made for public sector reform.

Health sector reform is a sustained process of policy, institutional and systems changes aimed at improving efficiency, equity, cost-effectiveness and quality in the health system, the purpose of the change being to promote the achievement of overall health policy objectives.

Saint Lucians have been enjoying relatively good health according to most definitions of the term "health". In the English-speaking Caribbean, Saint Lucia is second only to Barbados in life expectancy and infant mortality, the commonly used measures when comparisons of health status are made between countries. But as many of its CARICOM neighbours, the Government is re-examining policies in respect of the percentage of overall health care costs that should be borne by Government, how the system can be reorganised to provide care more efficiently and effectively, and so on. Suffice it to say that the process of health sector reform is well underway in Saint Lucia.

The rationale for seeking to reform the health system is to meet the health challenges facing the country, to address the growing dissatisfaction with existing services, the socio-economic conditions in the country and the need to move to a system of care that promotes wellness.

The decision to make primary health care (PHC) the cornerstone of the delivery system is not new. In fact it is over twenty (20) years old and was adopted not only by the then government of St. Lucia, but those of many developed and developing countries. In 1978 at a conference in Alma Ata (Russia) which dwelt on the successes and failures of different countries' health systems, delegates from 106 nations came to the conclusion that a delivery system based on PHC principles was the most adequate means of addressing the health problems of the day. The problems were seen as social problems inseparable from a country's socio-economic development. This perspective has not changed in the intervening years since the Declaration of Alma Ata which was signed by all countries attending the conference and many others subsequently. The premise that health for all can only be achieved through adoption of a PHC strategy has grown stronger with the passage of time.

In Saint Lucia health resources are still consistently directed at supporting the traditional curative medical care approach to the delivery of health services. This is best exemplified by government expenditure on the secondary care system (the hospitals), which over the past decade has averaged around forty-five percent (45%) of the annual recurrent expenditure of the Ministry of Health. The irony is that this sum of money is not enough to maintain these services at an acceptable level, given the health system as it is presently

structured and operated. There is considerable misunderstanding at all levels created by poor communication and inadequate health information. It is also of note that although some nineteen percent (19%) of the recurrent budget is spent on community-based care, very little of that amount is on preventive services and health promotion, the bulwark of a successful PHC strategy.

Negative manifestations emerging from persistence with the current model

Over the past decade or thereabouts, persistence with the traditional system of health care services has produced multiple negative consequences for the country. Significant manifestations of this state of affairs include:

- A shortfall of some 18% in the resources necessary to provide a satisfactory level of basic health cares services (the so-called resource gap).
- Deepening inequities in the distribution of, and access to, resources - such as spending on large urban hospitals has meant that rural, and usually poorer communities have had to do with less.
- The population at large views unrestrained and unregulated growth of the private health sector suspiciously.
- A steady stream of complaints by the clientele of deterioration in the quality of the public services offered.

Clearly these negative manifestations - particularly the last - have fuelled the Government's resolve to reform the sector. As stated above, the health problems have not changed appreciably since the Declaration of Alma Ata in 1978 - chronic noncommunicable diseases such as cancer, diabetes and hypertension continue to be the leading causes of morbidity and mortality. It is therefore not surprising that the drive to pursue a primary health care strategy has intensified not only in Saint Lucia, but the world over.

Appointment of a Health Sector Reform Committee

On assuming the reins of government in 1997, the political directorate appointed a Health Sector Reform Committee (HSRC) with a mandate to examine the Health Services and elaborate the steps towards the development of a white paper. The HSRC guided by policy outlined in "The Contract of Faith" produced a discussion paper outlining the following issues:

- Decentralisation of authority and responsibility through the creation of Regional and Institutional Management Units.
- Integration of services and the institutionalisation of the "team approach" at all levels of the system.
- The development of multidisciplinary health teams responsible for service provision and the respective budgets.
- The development of a Plan of Action for improving the health financial system.

- The development of Standards for Health Care and information systems to monitor outcomes.
- The institutionalisation of professional self-regulation mechanisms including licensing and accreditation.
- The establishment of a Complaints Commission with authority to handle health related complaints efficiently and justly.

It is clear from the above that the early thinking of the political directorate in respect of health sector reform for St. Lucia included:

- Decentralisation of management and functions
- Integration of the different levels of care
- Local management teams funded through a global budget mechanism
- Improved financing of the system
- Quality assurance
- Strengthening of the accountability mechanisms.

The above is proposed against the backdrop of a health system that is:

- Decentralised according to a deconcentration model, which emphasises central control with little autonomy to make decisions at the operations level.
- Characterised by care at two distinct levels - primary and secondary, with little articulation between the two.
- Budgeted through a program budgeting mechanism that leaves budgetary control in the office of the Permanent Secretary and sometimes the Ministry of Finance.
- Financed via out-of-pocket spending and general taxation, although some families have purchased indemnity-type private health insurance.
- Weak in terms of mechanisms that monitor quality and hold providers accountable for the services they give to clients.

The HSRC recommended the establishment of a health sector reform secretariat (HSRS) to conduct activities towards the development of the white paper.

Activities of the HSRS

An early testimonial of the Government's commitment to reforming the sector was the appointment of a Health Sector Reform Secretariat (hereinafter called "the Secretariat) comprising persons with backgrounds and experiences in multiple areas of expertise to include health education, sociology, communication, nursing, environmental health and medicine. Much of the planning and design work of reforming the health sector to this juncture is the result of the hard work and dedication of Secretariat staff.

Since its appointment, the Secretariat has engaged in a number of activities:

- Worked with PAHO and European Union commissioned consultants to provide advice and make recommendations on a number of critical issues related to the structure and functioning of the health system.

- Hosted a Preparatory Meeting on Health Sector Reform which participants included senior staff of the Ministry of Health and other Government Ministries, the private sector and non-Governmental organisations (NGOs).

- Held consultations with health workers in the public and private sector, held discussions with organisations and agencies whose work influence and is influenced by the Ministry of Health. The purpose of these consultations was to sensitise the various stakeholders on the importance of reforming the sector and to solicit early feedback on key policy issues and help develop strategies for the growth and development of the reform process.

- Held consultations with 26 communities across Saint Lucia to provide up-to-date information on health reform matters; and to take under consideration the health concerns that they may have including recommendations on how these may be resolved.

As stated in the definition early in the document, health sector reform is "a sustained process of policy, institutional and systems change". The process is also long and it may be a decade or more before the desired shift of public and private expenditures to high priority, cost-effective PHC solutions, is fully realised. The effort should be regarded as occurring in a series of distinct phases.

Phase 1 will include institutional strengthening and improved management at all levels. Information systems will be developed, pilot projects and studies will be conducted. Phase 1 will introduce changes that will orient the provision of services and allocation of resources within the health sector.

Phase II focuses primarily on developing a sustainable financial system. There will be full commissioning of polyclinics throughout the country and the re-organised health system should be well established with effective management, good information systems and established quality systems.

Phase III will witness the elaboration of the National Health Services Plan.

Throughout these phases there will be legislative issues and issues of governance that will have to be addressed and they should be addressed as the development demands.

Objectives of the Saint Lucian Health System

1. To provide efficient quality health care not only because a healthy work force is an essential element to improved productivity, but also more importantly, because healthy individuals are more likely to achieve their full human potential.

2. To maintain an adequate program of primary and preventative health care in which the importance and role of health promotion as a method of information and ultimately prevention, must be constantly emphasised. The programs should be designed to empower people to act and health promotion should occur at every opportunity and should commence as early as possible i.e. infant school.

3. To achieve greater equity in the allocation and use of health resources so that there is adequate coverage for the population with respect to basic health services, both curative and preventative.

4. To design and implement comprehensive and integrated programs for the detection, prevention and treatment of chronic disease and the rehabilitation of the disabled and the treatment and care of the elderly (disability includes the physically, intellectually and mentally disabled individuals)

5. To improve and sustain mental health services to the level of contemporary, international standards.

6. To reduce the incidence of environmental health problems by the employment of interventions that change the serious situation in respect of basic sanitation and waste management. To prevent chaotic development from having a negative impact on the environment, and to preserve the natural resources for future generations.

7. To promote a high standard of industrial and occupational health and safety.

8. To improve the financing of the system so that it is both affordable and sustainable.

BASIC STRATEGIES GUIDING THE REFORM PROCESS IN SAINT LUCIA

Health sector reform in Saint Lucia is guided by a number of fundamental processes. These basic principles permeate the thinking of the Government and persons guiding the development of the proposals. It is of note that they contrast sharply with the system of curative medical care that is currently in place and are as follows:

Community participation: the active and permanent participation of persons from diverse communities in Saint Lucia in all stages of the health development process. This includes the people's determination of their own perceived needs; their prioritisation of those needs; their definition of approaches to handle the problems; their formulation of the corresponding programs; their participation in defined responsibilities and authorities; and their supervision, evaluation and social control of health resources and programmes.

Decentralisation: that includes elements of delegation and devolution - the transfer of the authority and power to make decisions of all types to the periphery, including the shift of the corresponding administrative and technical tools. Primary care cannot evolve in the current highly centralised and bureaucratic systems that severely restrict the opportunities for community participation as described above.

Intersectoral collaboration: the sole means of dealing with problems that arise from a variety of causal factors. As stated earlier, currently the resources and activities are tied up in a single dimension - curative medical care, even though the multiple causality of the dominant health problems is accepted, at least in theory. Policies, programmes and action plans that are inconsistent with the theory will not lead to successful solutions; all sectors must become involved with the effort.

Evidence-based decision-making: Improvement in the decision-making processes will produce better decisions with better consequences. The evidence-based health system will be built on the foundation of a nation-wide health information system. The thrust is for health care providers, administrators, policy makers and patients, to have the most appropriate, balanced and high quality evidence on which to base their decisions.

Technology Assessment: careful appraisal of the mix of inputs - human resource and/or physical infrastructure and equipment, to be applied in addressing a technical problem to produce a specific health output, intervention or service at its lowest cost. Appropriate and viable new technologies will be developed and adapted to well defined technical and administrative standards. The appropriate technology will also be appropriate in the sense that it can be easily absorbed, understood and utilised by the people.

Quality Assurance: This includes for the short term measuring the quantity and quality of resources put into the service - input indicators; and the actual process of care - process indicators. And for the medium to long term - measuring the impact on health status – output indicators. The dependence of quality Assurance (QA) on the development of a health information system (HIS) should be apparent.

THE PEOPLE SPEAK

The people welcomed the opportunity to play an active role in determining the future of health development in Saint Lucia. Through the participatory approach health providers, users and groups and organisations involved in health directly and indirectly helped to identify critical areas of concern in the health system and also offered recommendations as to how these concerns may be addressed. The response to this process was overwhelming. It reflected a high level of commitment on the part of our health staff and a clear understanding of the concept of good health by the participants. This exercise will enable the Ministry of Health to better understand the health needs and priorities of the people.

Although the health concerns of the communities were numerous and varied, three main themes permeated the discussions. These included, the detrimental impact of poverty on health, the urgent need for more educational programs to better equip our people with the knowledge they need to live healthy lives and the important role for sectoral collaboration as a strategy to attain health goals and improve productive potentials island wide. The multitude of issues discussed during this consultative exercise has been encapsulated in five major categories. These are listed below as follows:

1. The general state of the health services
2. Environmental and public health services
3. Fees, payment and financing of the service
4. Management issues
5. Ethical and Regulatory concerns

Apart from the common problems summarised under the five main headings listed above every community had its own specific problems: Millet and Anse-la-Raye complained of a high incidence of snakebites, Aux Leon reported a general lack of facilities and amenities, and Canaries highlighted a lack of trained personnel to operate ambulance services. It became evident from the discussions that we need to develop systems that allow communities to address these problems and to influence the availability of services.

1. THE GENERAL STATE OF THE HEALTH SYSTEM

The contributions outlined under this heading included the growing dissatisfaction with existing services, the socio-economic conditions in the country and the need to establish a system of care that promotes wellness. The two main themes originating from this category included access to quality care and the provision of care for a diverse population with diverse health needs (e.g. poor, young, elderly, men and women, sports persons, the physically challenged etc.)

1.1 Primary and Secondary Health

" Health centres do not provide basic services to meet the needs of the of the people: they function at low levels; lacking in basic equipment"
…Resident Gros Islet

"Polyclinics would lead to better utilisation of human resources"
..Agriculture Ext. Off. – Desruisseaux

"The quality of care at Victoria Hospital is poor"
…Health Worker

These quotes depict the general perception of health providers and clients of the quality of the health services offered. Consultations further revealed that the public expected a higher level of performance from health institutions. They believed that health centres should offer more health services (for example laboratory tests, X- rays and specialist services) and should provide care after normal working hours, possess more medical personnel and basic equipment, and reduce waiting time to see doctors. The absence of these services has given rise to a situation where health centres and also district hospitals at Dennery and Soufriere are being bypassed even for minor ailments, persons preferring to go to the larger and more costly hospitals – Victoria and St. Judes. The resulting state of affairs is an overloaded and inefficient functioning of the Accident and Emergency and Outpatient Departments of these secondary institutions.

Other access and quality issues were directed at provider-patient relationships, a common issue being the attitude of medical staff to clients and the urgent need to improve relations between these two parties.

"The nurses don't listen to you. If you say, your mother did not take the medication they get vex. They don't give you a chance to explain yourself"
…Resident

"The doctors do not make time to explain to you what is wrong. They think they know everything."
…Resident

1.2 Mental Health

There were acknowledgements of mental health related problems within the community including drug abuse, undue pressure being placed on school children to pass the Common Entrance Examination, domestic violence and child abuse.

The negative perception of mental health was captured in the statement,

"People think that you are mad for life once you reach Golden Hope"
…Resident - Gros Islet

The residents of some communities were particularly concerned about community-based care for the mentally ill. One resident applauded the manner in which community based psychiatric services were organised in the past and made an appeal for the return of these services. In general there were calls for counselling services at the community level especially for the youth.

" My father was a mental patient. When we used to have community psychiatric services, he would get his medicine and he wasn't so sick."
…Resident Vieux Fort

2 ENVIRONMENTAL AND PUBLIC HEALTH SERVICES

"If our surroundings are not healthy how can we be healthy."
…Resident - Millet

This statement depicts clearly the absolute importance of environmental /public health to the success of health development on the island. The majority of these concerns were centred on improvements in the management of garbage and the treatment, storage protection, delivery of and access to water.

Other major concerns included sewerage management particularly where, as is the case in some communities, soil type, topography and poverty have caused this problem to become particularly acute.

"*You cannot put pit toilets in these areas. The type of soil will not let you do that."*
… Resident – Aux Leon

There were also pleas to review food handling and regulate sale of dated and unhealthy products to the public

2.1 The Social Context of Health

The participants possessed a remarkable understanding of social health. They spoke at length of all the social ills afflicting their communities and impacting on their health. They spoke of crimes, abuse particularly in relation to drugs and children, poverty, the conditions of the roads and noise pollution. In almost every community, it was suggested that social services should be included in the services provided by health centres and schools. With respect to school involvement in health, it was suggested that schools could play a major role in enforcing strategies to control contagious diseases. Health centres and schools could play a greater role in identifying cases of abuse. Equally important to these communities was the need for support mechanisms to enable individuals and families at risk to be removed from threatening environments and for referral of reports to competent trained staff

In the area of preventative care the communities identified the need for health improvement and maintenance programs to be more proactive. Clinical examiners could

be sensitised and trained to detect signs of domestic violence and child abuse and report any suspicions to the relevant authorities. In relation to the increase in sexually transmitted diseases, for example, there was a need for more education at the community level to control the spread of the disease. There was an expressed need to emphasise health promotion through sports and health education (e.g. life skills education).

In summary, there were calls for health services to address environmental health, chronic non-communicable diseases (e.g. diabetes, hypertension, and cancer), mental health, sexually transmitted diseases and trauma. More than half of these communities indicated that these health concerns should be given priority. There was also a call for improvements in preventive health, health promotion and emergency services, and particularly ambulance services.

3. FEES, PAYMENT AND FINANCING OF THE HEALTH SERVICE

"As soon as they come for the sick you must have their money ready for them because they will not take the sick to the hospital"
… Resident –

"*If we paying, we must get good service"*
…. Resident - Jacmel

In every community much concern was directed at the escalating cost of health care. The question of paying for health and financing the health system generated much discussion. Much discussion focused on the health package offered to National Insurance Scheme (NIS) contributors and the status of the National Health Insurance (NHI) scheme. It was evident from the discussions that health users were willing to pay for health care if these services were improved. Given the experience of the great difficulty in collecting medical fees it raises the question why this difficulty if persons are willing to pay? It was clear from discussions that people objected to a "cash on delivery service". They preferred pre-payment, insurance or taxation, or a billing system. It was also clear that people were not happy with the delivery of service in the public system and therefore also objected paying cash on delivery. Another factor is the cultural belief that public services are provided by Government and as such people should not have to pay for what they consider essential public services. The demand for medical services of a non-emergency nature throughout the day is manifest by the fact that over 75% of attendees to the Accident and Emergency Department did not have any urgent or severe problem. Generally speaking, people who could afford preferred to use private services because they perceived that these services were more responsive to their needs and they had more control.

The majority of the blue-collar workers indicated clearly that they preferred to commit money monthly to some fund, which would then reimburse providers, whenever they sought medical care. One necessary requirement of this fund was that it would have to cover family dependants - the unemployed and children. In the area of elderly care the majority of participants suggested that the exemption system should be extended to

elderly persons. Some stated that the needs assessment should remain the main criterion for determining the recipient of this welfare service.

In response to the financing of the health system some participants suggested that health tax or health lotto might be another way. The health workers also stated that a designated health fund, rather than the consolidated fund might be capable of directing more money to the Ministry of Health, through better-organised recovery mechanisms.

From the evidence above it is clear that there is need to change the system of payments so that clients who need care will not be required to pay for it before the service is delivered. It was also evident that there is need to develop a system that allows persons who cannot afford to pay to get health care when they need it.

4. MANAGEMENT

Effective Management and organisation of health care is crucial to the success of the reform initiative. The results of the consultations revealed that a large proportion of the problems experienced by the health system can be linked to ineffective management and organisation of scarce resources: human, financial and physical. Community responses examined the manner in which health care is delivered by medical institutions and the role of the community in the management of community health.

"*Too many things are done in Castries."*
…Resident - Laborie

"The health centres never have the medication. The nurse tells you all the time, they don't have anything."
…Resident - Aux Leon

" Why is it that a test for which the result is available from a private lab in one week would have to take three months at Victoria Hospital"
… Resident – Monchy

In response to the role of the community in the management of community health, there were mixed feelings. With the exception of Soufriere and Dennery most communities appeared a little overwhelmed by the sheer magnitude of the responsibility. It is worth noting, however, that every community gave clear indication that they would like to be more involved in the management of community health. The actual involvement of the community in health development will have to be based on the willingness and capabilities of the people and the extent of resources.

"*We would like to be more involved in the management of our health.*
I am sure our village council could be responsible for that."
… Resident – Dennery

"If you give Soufriere the resources, Soufriere would be ready."
… Resident – Soufriere

" We need more meetings like this so we can tell you what is wrong and ask about what is being done about what we said we needed."
… Resident - Millet

Suggested Managerial and Organisational changes include:

- Need to decentralise and remove the Castries focus and base of services.

- More involvement of communities in the management of community based health services.

- Involvement of community members in determining exemptions (needs assessment and means testing).

- The need to embrace policy development as a central function, involving all sectors. This should be informed from the field.

- Communication systems within the health service and between agencies need to be improved.

- The need to improve the referral system.

- Need to improve collaboration between the Ministries.

- Information systems need to be enhanced to allow appropriate information to be collected in a timely fashion and should be used by all to develop plans and evaluate program implementation and its effects.

- Accountability needs to be developed, with alignment of responsibility and authority.

- Conditions of Service to address workers' benefits, human resource development and occupational health and safety

- Clear organisational structure and lines of reporting

- Equipment & Building facilities need to be improved and properly maintained. The mobility of personnel and services should be addressed to allow services to be taken out to people. Health centres and hospitals are poorly equipped.

A summary of these issues points to the need for an evaluation into the way the health system is being managed and the need for more emphasis on community involvement in managing local health services. Given that different communities have different capacities the Ministry of Health in collaboration with all relevant parties will need to be aware of these differences and plan accordingly.

5. ETHICAL AND REGULATORY CONCERNS

Gross disparities in the price of drugs and in general the high cost of medicine was a common problem in all the communities. In addition the type of drugs prescribed by doctors was also of concern.

"There are clairvoyant doctors. They are able to diagnose your problem and give you a prescription before you even walk into the office"
…Resident – Canaries

"Price of drugs for private pharmacies in the area varies as much as eighty percent. Some kind of price control is needed"
… Resident – Vieux Fort

There appeared to be general consensus that the Ministry of Health needed to critically examine its various functions namely the organisation and management of health, the provision of health care and the financing of health. An analysis of the consultation

reports revealed the need for stricter regulations in all these areas of the health system. Issues relating to quality, equity and efficiency cannot be resolved without clear rules and guidelines by which to monitor and evaluate the activities of the health system as it attempts to achieve health goals and meet the health needs of the people.

A summary of the major areas in which people suggested regulation is presented below:

- Price and dispensation of drugs to ensure that prices are affordable and that the health and safety of the client are never jeopardised.

- Quality of care provided by doctors and other medical staff in the public and private sector (particularly where doctors straddle public and private practice).

- Access to health services at health institutions (opening hours, waiting times and access to doctors).

- The roles and functions of doctors in the delivery of health services.

- Handling and sale of food in public places (particularly outdated food items).

PART II

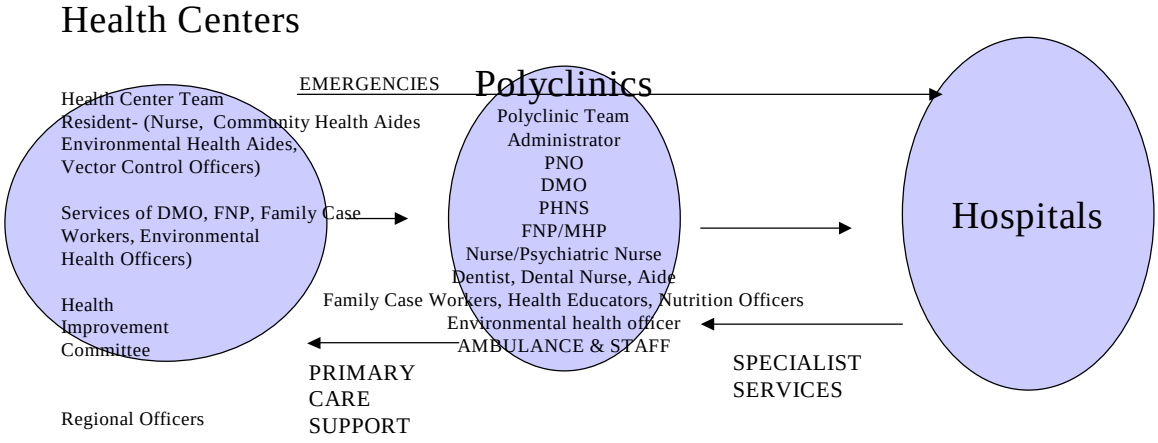
1. ORGANISATION OF THE SERVICES

Policy

The Health system and community-based services will be improved to meet the health needs of our people by providing opportunities for public participation in the planning and implementation of health improvement programmes and an integrated system that is capable of effectively responding.

Integrate mental well-being into all aspects of social life and integrate mental health services into the general system of service delivery.

The integrated regional services will be structured to achieve more equity in resource allocation, better use of resources and more access to higher quality services. The focus being primary care which through effective health promotion encourages people to be and remain healthy.



This is a "generic" model of a regional health network that we have designed for our services, based on existing infrastructure and resources. It is noteworthy that it is defined by the general hospital catchment areas. This model because it is generic and flexible can

be applied regardless of the number of hospitals. It will work with one or two general hospitals defining one or two health regions respectively.

1.1 Strengthening community-based health services

With the need to control the cost of any new initiative in mind, the options that appear most feasible for strengthening the performance of community-based services in the short term are as follows:

- Broadening the role and improving the quantity and quality of services available at the health centre so that it functions as a health development unit and not just as a clinical service point.

- Introducing polyclinics into the delivery system that will support the adjacent health centres; deliver a higher level of service (than the health centres), e.g. laboratory and X-ray; and provide after-hours care.

1.2 Health Centres as Health Development Units

Currently health centres operate for the most part as clinical service points delivering mainly curative medical care and preventive services. Chronic non-communicable diseases, sexually transmitted diseases and mental health care offer the opportunity for these community based institutions to initiate health programs and health development activities in response to the needs of the community in their respective catchment areas. The health centre will assume a larger role as the health development unit for the community, and will be the interface between the people and the health system.

As the health facility closest to most communities in Saint Lucia, the health centre will be programmed to:

- Respond to local needs and requests.

- Maintain an ongoing dialogue with individuals, families and communities.

- Work with other sectors in promoting activities and initiatives related to health.

- Function as a “health development unit” and not simply as a clinical service point.

- Provide equitable and quality health care to all in its particular catchment area.

- Provide a platform/base to operate health outreach programs for all vulnerable persons including the elderly and disabled and other persons with afflictions that restrict their mobility.

- Conduct periodic clinics as deemed necessary with the assistance of the community.

- Dispense medications as per prescription under direction of polyclinic pharmacists.

- Create and maintain a community health database, that tracks socio-economic and health data by household and individual.

1.2.1 The health centre is the focal point for community health issues

Health centre activities will be based on the fundamental principle that the health centre in collaboration with the community persons is responsible for the health of the community. This principle will be elaborated from an information and education nucleus, such elaboration being the responsibility of the Health Promotion Unit of a restructured Ministry of Health. An understanding of the health problems of the catchment area of the health centre will be required and would involve the collection, collation and analysis of community health data. The collection and maintenance of socio-economic and health information database on individuals and households will be the responsibility of the health centre. The health centre could be considered as a community source for other types of government information and action, especially since health centres are ideally located for use by other government agencies as community development units.

1.2.2 Health Centre Team

The ability of health centre staff to form well functioning health teams is central to the success of the program. With skill, effort and on-the-job training, health centres will extend their area of functioning through innovative actions with community workers and the whole range of community-based human resources - sometimes referred to as the "hidden resources for health action". The staffing pattern for a typical health centre (the team) will include a community nurse or public health nurse, community health aides, environmental health aides, vector control officers and support staff. The services of a medical officer, family nurse practitioner (FNP), mental health practitioner, psychiatric nurse, environmental health officer, health education officer, family life educator, family case worker and a field nutrition officer are available, when necessary, from the respective polyclinic. A community-based statistical clerk will assist the team. A Nurse's service will be available at all times in the community. During working hours a nurse will be at the health centre, after working hours a nurse living in the community will accept responsibility. Ideally the community nurse who is the health manager for the area and in charge of the health centre should be from and living in the community. The team should also receive support from other government officers and officers of statutory authorities.

Authority needs to be invested in the primary care team leader (nurse) to allow her to mobilise the resources needed to solve the community's problems. The health centre team also needs access to transportation. There is need to train more community nurses in public health and also provide training for health managers in fiscal, personnel and clinical service management.

Community Health Aides (CHA) are critical workers on the frontline. They are from and live in the community. It is proposed that community health aides are trained in areas of

social work and community-based rehabilitation (CBR). There is a course designed to achieve this available through the Human Services Department. The salaries should be upgraded accordingly and transportation needs should be addressed.

Proposals to ensure adequate nursing coverage include full-time staff supplemented by nursing sessions. The after hours community coverage can be provided by designated nurses who live in the community. These nurses should receive an on-call stipend and should have access to the health centre.

1.2.3 Establishing partnerships with the community

For health centres to assume the health and development role that really contributes to local developmental efforts, health centre staff must work in partnership with local communities. This should be reflected in the centre's governing structure. The exact form of the latter will be worked out through a consultative process involving representatives of the community, the Ministry of Local Government & Community Development and the Ministry of Health, Human Services, Family Affairs & Gender Relations. Joint management and shared responsibilities involving health centre staff and community representatives will be the aim of the consultation process.

The first step will be to establish "health" improvement committees in each community. These committees need not be new committees; it is advisable to work with existing community development committees, other existing committees, clubs and non-governmental agencies. It is important to identify the community "gatekeepers", i.e the influential community citizens who can be sensitised to become involved in this process. The health centre nurse will be instrumental in establishing and maintaining the committee that will consist of community residents, the nurse and any other agency representatives considered necessary by the community. This committee is to identify health issues and propose solutions with a primary focus on action. These committees and the nurse will need support at different levels. This includes support from government regional officers and community organisations, from local government structures, from the respective Ministries, statutory authorities and from the inter-ministerial committees (especially committee of Permanent Secretaries and committee of chief technical officers). A community resident should chair the committee. Experience from Dominica suggests that the committees need to be focused on targets and projects so that there can be demonstrable success. The health centre nurse is critical in maintaining the health focus and linking Government and the community thereby allowing the power of both to be in synergy to ensure success.

Key Recommendations

Convert health centres into community health development units, which involve the community, health personnel and other regional officers in the planning and delivery of health services.

Invest authority in the health centre nurse in charge to ensure that she has the ability to mobilise the required resources to address the community needs.

Establish community health improvement committees (using existing committees, groups and influential community leaders) that are action oriented – focused on projects and targets.

Develop the appropriate inter-Ministerial networks to support action at the community level.

1.3 Introducing polyclinic services

Many of the complaints about lack of care after hours and inaccessibility of doctors, specialists, laboratory and radiology services can be addressed with the introduction of polyclinics. The concept is not new to Saint Lucia: a polyclinic has been constructed at Gros Islet and now waits commissioning. These institutions share some characteristics with both local health centres and district hospitals but also differ from them. They offer first contact care in a non-hospital setting.

1.3.1 Providing primary care support for health centres

Polyclinics are open 24 hours a day for urgent medical care, may have beds for limited inpatient care, and can make referrals to secondary and tertiary care hospitals. They serve a defined population, usually but not always encompassing the catchment areas of several local health centres. The primary health care functions of the latter are supported by the polyclinic including the services of health officers necessary for the proper functioning of the health centre team e.g. social workers, environmental health officers, nutrition officers, mental health practitioners etc. The public health supervision/administration and certain training activities will be based at polyclinics. The training of persons in health and medical practice, administration and community organisation is another common activity to be found in these facilities.

The precise range and volume of polyclinic services will be dictated by local health needs, and the demands of the National Health Services Plan (NHSP). The NHSP is a quantified set of service targets based on an objective and quantified assessment of the health care needs and demands of the population. It will articulate what workload and patient throughput levels are planned for all health service locations and the levels and types of resources required to provide them.

1.3.2 Polyclinic Services

These will include general clinics of all types. There will be 24-hour emergency services co-ordinated by the respective hospital emergency departments. At the polyclinic the emergency medical technicians and the FNP will co-ordinate with the respective Hospital emergency room doctors to handle emergencies and after hours care. Additional services will include pharmacy, laboratory, X-ray, physiotherapy, electrocardiography, audiology

screening and dental services. The clinics conducted at the polyclinic will complement the health centre services and will be co-ordinated with the health centres served by the polyclinic. Specialist consultations will be arranged by appointment, and in the main will be through referrals by doctors and nurses working with defined protocols. Such consultations will include general medicine, surgery, orthopaedics, obstetrics, paediatrics, mental health and other specialities or sub-specialities determined to be necessary and cost-effective. The regionalisation of health services defined by a hospital catchment area allows the development of regional clinical protocols supported by the hospital services.

1.3.3 Inpatient Care & Ambulance Services

Selected polyclinics will also provide inpatient and maternal care (mainly childbirth) for patients requiring a bed for less than 24 hours. All polyclinics will have dedicated ambulance services stationed at each polyclinic to transport patients to higher-level facilities when necessary. These ambulances will be staffed with emergency medical technicians and first responders. The polyclinic will be the source of dispatch for the community ambulance services. Other services will be determined as the situation dictates, e.g. treatment of snakebites in communities located in the interior. As is the case of the health centres, the exact services to be offered by the polyclinic will be dictated by the disease profile of the catchment area served by the polyclinic.

1.3.4 Polyclinic Teams

The team in place at the typical polyclinic will include an administrator (contracted HA III), district medical officers, nurse practitioners, nurse midwives, registered nurses, dentist, dental nurses, dental aides, family case worker, pharmacists, a mental health practitioner, psychiatric nurse, environmental health officer, health educator, family life educator, field nutrition officer, and multipurpose technician(s). Specialists will be assigned to polyclinics, and in that sense will be part of the team. If the services to be accessed include physiotherapy, then persons with the necessary skills will also be considered team members. Multipurpose technicians are persons trained to take simple X-rays (long bones, chest, and skull) and perform routine laboratory tests including venipunctures. The amount of on-site testing to be done will be determined by needs, quality considerations and cost effectiveness. Sessions for all levels of health professionals should be considered as an option to create flexibility in staffing

1.3.5 Upgrading the Dennery and Soufriere Hospitals

Given the above, polyclinics are geared to provide a higher level of service than that which is presently provided at the district hospitals - Dennery and Soufriere. Because resources are limited, as they are everywhere, the Government must come to a decision on the fate of these smaller institutions. Hospitals handle life-threatening conditions whose treatment demands the use of sophisticated medical technology. They require a degree of capital investment and support services of a kind commensurate with the complexity of the medical conditions they treat and the procedures they perform. They also engage in the teaching of clinical medicine and research. The options for

Government are to upgrade the District Hospitals to the level of the preceding definition for hospitals, or to the level of a polyclinic with dedicated ambulance services. The latter option seems preferable and would be anything but novel. In 1994 Saskatchewan, Canada, closed 54 rural hospitals. Some of these were converted to community wellness centres (a form of community health centre). Barbados with a population of 260,000 persons has a single General Hospital (in the public domain), that supports a constellation of polyclinics strategically located in the more populous areas. Trinidad and Tobago with a population of 1,300,000 persons is replacing eight (8) district hospitals with thirteen (13) polyclinics.

From the foregoing discourse there are emerging three main levels of health care services in St. Lucia:

- Health centres (primary care)
- Polyclinics (primary care support and community secondary care services)
- Hospitals (secondary and tertiary care services)

To ease the workloads of the Accident and Emergency departments and make clinical services more available to the people, Government will apply the polyclinic concept countrywide, as is being done in other countries. In that event, in order to contain costs, the recommendation is that polyclinic functions similar to the ones described above, be established in five institutions, which are fortuitously geographically located: Gros Islet Polyclinic, Victoria Hospital, Soufriere Hospital, St. Jude Hospital and Dennery Hospital.

There is debate over locating polyclinics within Victoria and St. Jude Hospitals. The arguments for doing this are that these hospitals are strategically well located and it is less expensive to establish them at these sites since most of the infrastructure already exists. The recurrent expense of operating the polyclinics within the Hospital grounds will be less than stand-alone facilities away from the hospitals, since some mutual staff support and the proximity of 24-hour emergency rooms (allowing the polyclinics here to close at night e.g. after 10.00 PM). In fact, both general hospitals are presently developing these services adjacent to their respective emergency rooms. Programmes such as the STD and Hansen's programmes also operate out of Victoria Hospital, indicative of the ability to operate outreach and primary care support programmes from the existing Hospitals. The formalisation of the polyclinic function should allow the polyclinic services to be better developed and supported. The disadvantage of locating them within the hospital is the possibility of increased patient flow to the hospital/polyclinic combination and the possibility that the hospital administration may not give the necessary attention to the polyclinic function. The recommendation is to develop polyclinic functions at the two general hospitals with a polyclinic administrative structure similar to the stand-alone facilities with the primary care administrator (HA III) reporting to the Hospital Administrator (HA IV).

There is also debate on the suitability of the existing Dennery Hospital to allow for proper emergency care. It is being advanced that this facility is not ideally located since the access to it is difficult and the building is not functional for the demands that the upgrading will place on it. It has been suggested that an alternative location is identified and a modern facility constructed. Regardless of the timing of relocation, Dennery Hospital services need to be upgraded in budget year 2000. This upgrade includes at least one more DMO, three nurse/midwifes and a storekeeper.

1.3.6 Upgrade Soufriere Hospital

An option to be considered by Government is to establish the polyclinic concept at the Soufriere Hospital as a pilot. This will require the full co-operation of the Soufriere and surrounding communities, i.e. those communities that under normal circumstances would use the Soufriere Hospital as the point of first referral. The Soufriere Polyclinic will act as a source of reference for the Etangs, Fond St. Jacques, Canaries, Mongouge and possibly La Fargue health centres, providing comprehensive care as described above, while leaving the St. Jude Hospital to deal with referrals and more complex cases. It is a win-win situation since the residents of those areas will be receiving health services that do not now exist at the Soufriere Hospital.

1.3.7 Establish Gros Islet Polyclinic

Gros Islet polyclinic is partially completed, four of the seven buildings, and is ready to commence some level of service. The Government has committed to this project and should complete it. The need for a polyclinic in this area is supported by the health sector reform plan. The existing population in the catchment area of this polyclinic already justifies the completion and establishment of the polyclinic. Added to this is the realisation that this is also the fastest growing area in Saint Lucia. The Northern area served by the Gros Islet polyclinic also includes a significant proportion of the visitor (tourist) population. High quality polyclinic services, as being proposed, would enhance

the health services to locals and visitors. Gros Islet will be the only stand-alone polyclinic without beds. It will be supported by Victoria Hospital and will serve the people as far south as Corinth and Marisule.

Key recommendations

Five polyclinics, using existing facilities, should be established to provide; support to respective health centre networks, secondary care community services and 24-hour community emergency services. These emergency services are part of the regional health emergency services co-ordinated by the hospital emergency rooms and staff.

Soufriere Hospital should be upgraded.

Gros Islet polyclinic should be commissioned and established as a polyclinic in the new financial year.

Services at Dennery Hospital should be upgraded even while debate over relocation to allow proper emergency care continues.

Polyclinic functions should be established in conjunction with outpatient services at St. Jude and Victoria Hospitals in the new financial year.

1.4 Strengthening management and operations at the hospitals

Extensive physical renewal has been underway at Victoria Hospital for some time now: presently the focus is on completing reconstruction of the "L Block". Although this is desirable, experience elsewhere has shown that without strengthening the management and operations of a hospital, provision of new infrastructure is ineffective and wasteful. A process of strengthening of the management and operations of the whole hospital should be undertaken as soon as possible. Such a programme is presented below.

1.4.1 Present management structure

The hospital's management structure is typical of most hospitals in the English speaking Caribbean. There is a Hospital Board with some limited powers and a Management Team comprising a Hospital Administrator, Principal Nursing Officer (PNO) and Medical Superintendent. This system of management does not provide clearly identifiable leadership leaving a situation where lines of responsibility are blurred. Strong vertical ties into the Ministry of Health serve to further confuse the operational management. Key decisions rest with the Ministry of Health.

1.4.2 Modern Management requires a Chief Executive Officer

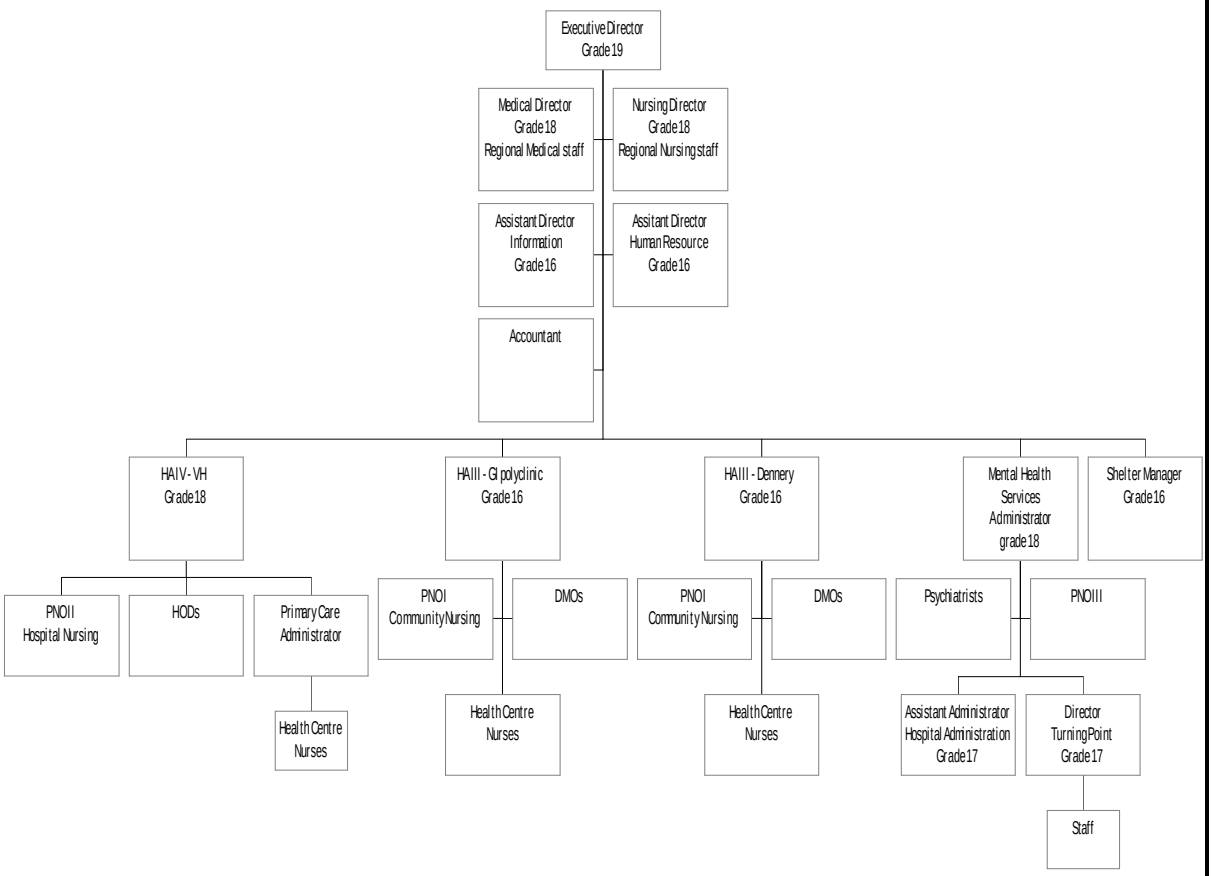
The general management approach has been the system of management in the United States and several other countries for a number of years, and was adopted in the UK in the early 1980s. The concept of a single individual being responsible for all the hospital services (medical, administrative, supportive, etc.) conforms with the basic management principle that in an organisation there should be clear lines of responsibility and authority. We intend to achieve this at two levels. At the regional level it is proposed that a grade 19 post of Executive Director (ED) be created. This officer will report to the Permanent Secretary and will be responsible for all personnel and services throughout the hospital catchment area (i.e. hospitals, polyclinic and health centres). Each of the two general hospital catchment areas will have an Executive Director based in each one (North – Victoria Hospital catchment and South – Saint Jude catchment). All hospital personnel and services will report to a Hospital Administrator IV (HA IV, grade 18), the HA IV reports to the Executive Director. In addition the polyclinic administrators who supervise the services in the polyclinic catchment area will report to the Executive Director. The Medical Director and the Nursing Director supervise the medical and nursing staff throughout the region and report to the Executive Director.

1.4.3 Devolving responsibility and authority to the Hospitals/Health Institutions

It would make little sense to clarify relationships within the institution and still have decision making centralised in the Ministry of Health. The options faced by the Government are to delegate appropriate authority to the Executive Director or to establish a Board and delegate authority to this board. It is proposed that maintaining the public service structure and status through the Executive Director is the best option. The hospital board should be an advisory board rather than a management board. It is also strongly recommended that all key positions especially all administrators should be contracted officers. It is also proposed the budget “envelope” concept be applied to the region, controlled by the Executive Director, and in turn to the hospitals and other institutions controlled by the respective administrators. These budget agreements should be clear-signed agreements with documented expectations of services, standards and funding. These agreements will clearly define the authority of the Executive Director and the respective Administrators and will allow these Administrators to operate the services within the defined parameters without interference.

In respect of delegation or devolution of responsibility to the Ministry and to the Executive Directors it is recommended that a team comprising representatives of the Ministry of the Public Service, the Public Service Commission, the Health Sector Reform Committee, Public Sector Reform, the Permanent Secretary and the CMO, be appointed to examine the issues and options and make recommendations to Cabinet.

FIGURE1


Executive Director Grade 19
Medical Director Grade 18 Regional Medical staff
Nursing Director Grade 18 Regional Nursing staff
Assistant Director Information Grade 16
Assitant Director Human Resource Grade 16
Accountant
HA IV - VH Grade 18
HA III - Glpolyclinic Grade 16
HA III - Dennery Grade 16
Mental Health Services Administrator grade 18
Shelter Manager Grade 16
PNO II Hospital Nursing
HODs
Primary Care Administrator
PNO I Community Nursing
DMOs
PNO I Community Nursing
DMOs
Psychiatrists
PNO III
Health Centre Nurses
Health Centre Nurses
Health Centre Nurses
Assistant Administrator Hospital Administration Grade 17
Director Turning Point Grade 17
Staff

1.4.4 Management strengthening and organisational development

A programme of management development will be designed and implemented through the vehicle of participatory workshops and work sessions. Staff from the various departments, institutions and units of the hospital will be involved in a range of disciplinary, inter-disciplinary and problem solving efforts. The programme aims to create a vision for the future Regional Service and each institution, and to promote a climate of change and opportunity. The sessions will focus on:

- goals and objectives
- policies and procedures
- workloads
- job descriptions
- problems and constraints
- training needs
- supply/equipment deficiencies
- communications

The objective is to create a policy and procedure manual for each department as well as a Departmental Organisation Plan. The exercise will also lead to the determination of performance standards/criteria for departments and the individuals who work in them.

Management development training will also be offered to the management level staff in the hospital with a heavy emphasis on participant's daily work situations to include subjects such as practice in problem solving, conflict management, team building, group dynamics, management styles and change management.

1.4.5 Developing operational procedures and protocols

Operational procedures and protocols will be developed for all key functions. Working with the relevant staff groups, drawing on other specific expertise as agreed will do this. The emphasis will be on developing good practice and in working with staff to implement this, rather than on producing elaborate documentation. Training needs will be identified and detailed.

1.4.6 Implementing a Patient Classification System

A series of events the complexity of which exceeds the bounds of this paper, have combined to produce a situation where nursing tasks at the Victoria Hospital are performed for the most part by registered nurses. Efficient utilisation of nurse manpower is a priority. Implementation of a Patient Classification System (PCS) will assist the determination on a scientific basis of nurse staffing requirements not only for hospital inpatients, but also for the public health/primary health care sector.

1.4.7 Hospital and Medical Staff By-laws

The Medical Staff at the Hospitals is presently engaged in the review of the by-laws which govern conduct in the discharge of responsibility to ensure that the hospital provides quality medical care. This exercise has created an urgency to review and update the Hospital By-laws to prevent and effectively resolve the inevitable problems that arise among the medical and other professional staff, administration, and the Ministry of Health. The proposed regionalisation of services demands that these regulations and by-laws be developed in the context of a regional service that extends beyond institutional boundaries.

1.4.8 Establishing clear contract agreements with doctors and improving supervision of medical staff.

It is necessary to develop clear contracts with detailed performance expectations between doctors and the Administration. It is recommended that a Medical Director be hired to supervise all medical staff including doctors and allied professional staff (radiographers, pharmacists, technologists, physiotherapists etc.). This person will be instrumental in detailing and negotiating contracts with medical staff and in developing protocols, regulations and so on.

1.4.9 Construction of a new hospital

The plans to date have focussed on the development of a new hospital at the existing Victoria Hospital site. The advantage of this option is the projected lower project cost (EC$ 40,000,000 – TVA final report). The disadvantages are:

- ?? The difficulty operating and improving the services in a hospital undergoing construction.
- ?? The constraints due to the site and existing buildings producing the difficulty in ensuring the most efficient structure with the consequent recurrent cost implications.
- ?? The inability to produce a new hospital at this site that will be capable of expanding and changing to effectively serve Saint Lucians into the future
- ?? The new hospital at this site will also limit options for the development of a hospital that can effectively participate in regional service provision and limits the options for the development of a national health system served by a single national hospital.

The recommended option is to build a new, modern general hospital just South of Victoria Hospital (suggested on lands made available by recent completion of the “tunnel road”). When the new hospital is completed, the existing Victoria Hospital can be used as the Castries polyclinic, Rehabilitation Hospital and step–down facility.

The implementation of this option will also allow the long term option of developing this new general hospital as the national general hospital and to convert Saint Jude to a

community hospital offering a range of services but referring to the main hospital for most elective and sophisticated service.

Key Recommendations

Improve management systems at the hospitals and delegate appropriate executive authority over all service within each hospital, to the hospital administrator with a regional Executive Director having the overall responsibility and the overall regional budget that he/she assigns to the regional institutions.

Appoint a team with representatives of the Ministry,of the Public Service, the Public Service Commission, the Health Sector Reform Committee, Public Sector Reform, the Permanent Secretary of Health, Human Services, Family Affairs & Gender Relations and the CMO. This team will examine the issues of governance of the hospitals in the context of the public service, reform and the plans for integrating health services in a regional manner.

Review and establish legislation for all health institutions and medical staff.

Establish clear contract agreements with doctors detailing the expectations of both parties.

Construct a new modern general hospital on a new site to replace existing Victoria Hospital and develop existing Victoria Hospital into the Castries Polyclinic, a Rehabilitation Hospital and a step-down hospital.

1.4.10 St. Jude Hospital

That the hospital provides a valuable service to the people of St. Lucia is without question. According to Health Policy Management Unit (Designing a national health insurance for St.Lucia: issues and options annex A1) figures more than one-third of all inpatient care in the country, is at the St. Jude Hospital. Long term recommendations of the Management Audit Team is that Government should decide whether it wants St. Jude Hospital to operate as a statutory body or whether it should be absorbed within the general services. In that respect, attention should be paid to the current efforts of Health Sector Reform and the role of St. Jude in this effort. These recommendations are on target and the future of the St. Jude Hospital is a major item under consideration.

Saint Jude Hospital is a government-owned institution operated and managed by the Mercy Medical Centre of Iowa under a Management Contract signed between the GOSL and the institution on April 30, 1993 for a period of five (5) years.

Of interest in the contractual arrangement is that:

- The Hospital Administrator (HA) is selected from current staff at Mercy Hospital Medical Centre (in Iowa), and that s/he remains an employee of the latter;

- The GOSL has a significant degree of control in the selection, appointment and compensation of the HA;

- A specified number of professionals and other staff of St. Jude's are hired by the HA but their salaries and other benefits are paid by the GOSL;

- The HA is in "sole charge of the administration and running of the hospital and is entitled to appoint personnel be they skilled, cemi-skilled or unskilled, voluntary or non-voluntary to work in the hospital in appropriate occupations and to terminate such appointments as provided for in the staff orders"

- On paper there is a significant degree of control by the GOSL of the HA's functions;

- The HA's personnel management function, e.g. hiring and firing staff, are subjected to "established government procedures and staff orders".

As can be discerned from the above, the terms of the contract leave considerable leeway for misinterpretation in their application, and there have been periodic disagreements over the years between the HA and the Ministry of Health. These disagreements have not been helped by a lack of effective communication between the Ministry of Health and Saint Jude Hospital. In 1998 a Management Audit of the institution by a Management Audit Team appointed by Cabinet concluded among other findings that "a number of ambiguities exist in the interpretation and application of the terms of the contract". Discussion of the audit team's findings exceeds the bounds of this paper. One conclusion that deserves immediate attention is that the employees at St. Jude do not fit the legal definition of "public officers". The option here is to classify St. Jude Hospital workers as civil servants to be appointed by the Public Service Commission. This should be done as soon as all concerned are clear that the Saint Jude Hospital should be embraced as a Government Hospital. If, on the other hand, the option is to "statutarise" or privatise the hospital then the option to not appoint the workers should be followed. This second option will in our opinion create considerable confusion and problems for the staff at Saint Jude hospital, it will be counter to the proposed reform for the Southern Health Region and therefore we recommend the first option, i.e. to appoint Saint Jude staff by the PSC and make the staff equal to all other Government workers.

As more autonomy in its operations is being considered for Victoria Hospital, there are many important lessons to be learnt from the continuing experiences of Saint Jude. There are issues of management, accountability, personnel, communication and management practices, all of which underscore the need to elaborate the issues and carefully explore the options prior to embarking on one form of decentralisation or another.

The immediate problem for the Ministry of Health is what to do with the management contract. The contract terminated in December 1997. A memorandum of understanding was submitted in August 1998 to the Sisters of Mercy. The option for the Government is whether to enforce the termination or seek extension of the contract for some defined period while the issues are being worked through. The operational and managerial issues

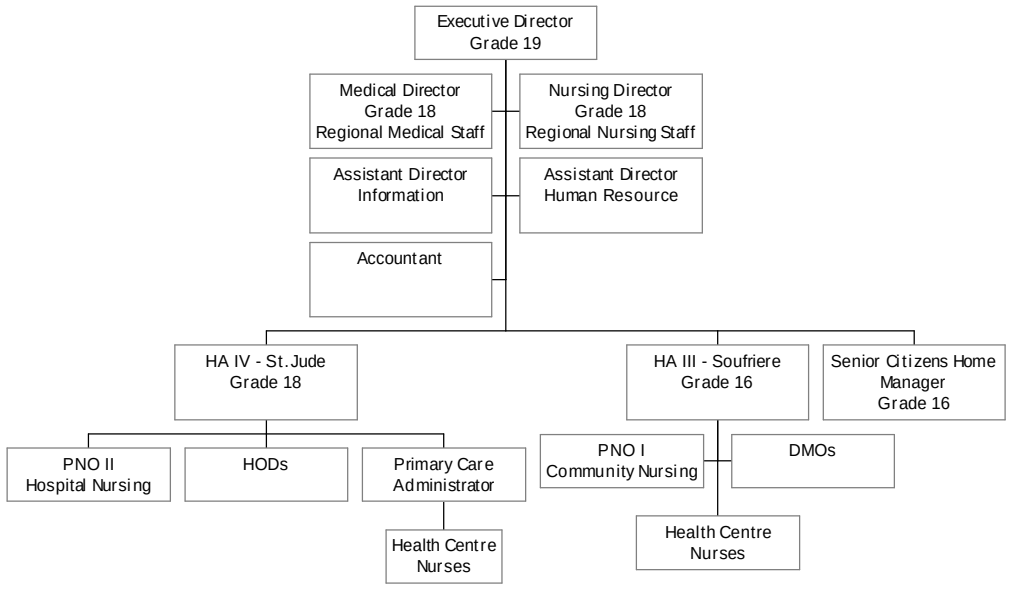
are the same for both hospitals, but the legal hurdles to be surmounted appear larger for Saint Jude.

Earlier in the document, a recommendation to Cabinet was that a task force comprising representatives of the Public Sector Reform, the Ministry of the Public Service, the HSRC, and the Ministry of Health, be appointed to study the Victoria Hospital issues in respect of governance, and to make recommendations. Programs and action plans were also outlined in respect of the management and operations of VH. The task force/committee should include St. Jude in its portfolio. The Government has little choice but to seek extension of the contract with the Mercy Hospital Medical Centre for some defined period.

Saint Jude Hospital has already launched initiatives that health sector reform is proposing for the future hospital sector. These include: inpatient psychiatric care, supporting community services and institutions e.g. the Senior Citizens Home and Saint Jude relationship, and the various Saint Jude outreach programmes. Saint Jude is also in the process of developing continuous quality improvement, especially in the design of critical pathways for major diseases e.g. Diabetes. Saint Jude has many lessons to teach and has the ability to move more quickly than Victoria Hospital to restructure its services to meet the needs of the future service.

Regardless of time frames and what is deliberated first, the goal is to have the two general hospitals functioning in an equivalent manner delivering equivalent service. Lessons from each one should be heeded in the design of what is appropriate, feasible and effective. In light of this it is proposed that Saint Jude and the catchment area of the hospital including the Soufriere Hospital, health centres in the Soufriere, Vieux Fort and Micoud areas should be integrated under the direction of an Executive Director as proposed for the Victoria Hospital catchment area.

FIGURE 2



Key Recommendations

Hospitals to be equivalent: service organisation and provision to be the same in the south as in the north with similar management structure.

Renew contract with Sisters of Mercy with detailed expectations and funding levels from the Ministry.

Challenge and work with Saint Jude to pilot integration of health services, linking Saint Jude with the Soufriere pilot project.

Confirm and appoint Saint Jude workers as civil servants

1.5 Strengthening Mental Health Services

The mental health services need to be understood as services designed primarily to produce mental "wellness" in all people resident in Saint Lucia. It is expected that 10% of people will become seriously mentally ill. Another goal of the mental health services is to cure or treat these persons and rehabilitate them back into society as productive, happy individuals.

This vision for mental health services is being offered against the backdrop of stigmatisation of mental illness, the mentally ill and mental institutions. This prejudice exists, unfortunately, at all levels in the society.

The mental health services, as for other health services, propose a community-based approach. The community program can be outlined under the following headings:

?? Prevention
?? Mental health promotion
?? Early detection of disease
?? Prompt, professional treatment
?? Rehabilitation
?? Adequate follow-up

The community team will need some full-time staff stationed in the community at polyclinics and will also depend on and provide support to the primary care health team at the health centre. The full-time staff at the polyclinic level includes mental health practitioner(s), psychiatric nurse(s) and counsellor(s). The services of a psychiatrist, clinical psychologist, occupational therapist, rehabilitation therapist, substance abuse counsellor(s) and social workers will be necessary to complement the full-time workers to deliver a comprehensive program.

The community mental health program, designed and controlled by the mental hospital staff, will be delivered from the platforms of the health centres and polyclinics. Community access to "preferred" medications will be dispensed in the community at health centres by mental health practitioners and psychiatric nurses. At the polyclinic level the pharmacist performs complete dispensing and oversees the dispensing of preferred medications at health centres. Child guidance clinics will be conducted at the polyclinic and will include a team networked with education, probation, paediatrics, psychiatry and human services.

The main mental health facility (tertiary level) integrates specialist psychiatric in-patient care, substance abuse treatment and rehabilitation. This facility supports and directs the community mental health program. There is need for a new facility of modern design, in an appropriate quiet, friendly location. A new facility should house all relevant specialist facilities (in-patient facilities, substance abuse facilities, sheltered workshop etc.). A facility designed for 200 inpatients is considered appropriate.

The general hospitals will also be included in the mental health programme and under the direction of the psychiatrists will see, admit and treat mentally ill persons considered appropriate to be handled in that environment.

There is need to train the primary care health team at the health centre in mental health promotion, disease prevention and early detection. In the training of other health professionals, doctors and nurses, there should be proper rotations in the mental health services. This should occur as part of undergraduate and postgraduate training.

Education programmes on mental health need to be developed to target all groups in the community (including lawyers, police, employers, parents, NGOs as well as the general public).

There are a number of general measures that need to be taken to support and develop the mental health programme. These include:

?? Employee assistance programme in all workplaces to provide for proper stress management, substance abuse treatment and rehabilitation of the mentally ill.
?? Development of anti-discrimination legislation to define and adequately protect the rights of the mentally ill.
?? Communities, employers and especially families should be educated and supported to take treated patients back into the community, work place and home. Partnerships with communities need to be forged to encourage communities to be involved in the rehabilitation of the mentally ill, partially treated patient back into the community and the work environment.
?? The public assistance programme should be further developed to help the unemployed, treated patients.
?? A need to conduct ongoing research and ongoing assessments of needs to allow planning and appropriate modifications of the mental health programs.

Key recommendations

Educate all levels of society to reorient the thinking of all to treat mental illness as we would any other illness recognising that mental illness can be prevented, treated and cured as is true of any other illness

Integrate the delivery of mental health services into the general health delivery system.

Develop strong community based mental health services networked with other social agencies/Ministries and the private sector. The community-based services are to be geared towards mental health promotion, early disease detection, rehabilitation and follow-up, with the necessary specialist mental health professional support. Specialist support is necessary for design of programmes, training of staff and to provide the appropriate treatment where necessary

Build a new comprehensive, modern mental health facility and increase levels and categories of staff for the community services and for the new mental health tertiary facility.

1.6 HUMAN SERVICES AND FAMILY AFFAIRS

The decision to combine the Ministry of Health and the Ministries of Human Services, Family Affairs and Gender Relations is a sound one, especially when one appreciates the concept of wellness that is being proposed in this paper. Unfortunately, to date, the potential power of this union has not been realised and rather there has been the perception of marginalisation of Human Services, Family Affairs. This must be corrected. It is not possible for us to develop a nation of well people unless we invest in the development of Human Services, Family Affairs and Gender Relations.

We propose that the staff structure be revised. We intend to have an arm of general family caseworkers, assigned to polyclinics, from which they operate. The family caseworker services are to be integrated into the delivery system as part of the multidisciplinary team. The work of the FCWs will be supported by the community health aides and the community nurses at the community level. The FCWs will be part of the polyclinic team networked to schools in the area and all other social and health institutions in the region.

The unit of Social Welfare will be housed in this department. In a similar fashion the public assistance officers will be assigned to polyclinics and will be part of the team involved in the delivery of “holistic care”. The Social Welfare officers report through a Social Welfare Officer III to the Human Services and Family Affairs supervisor.

We intend to develop specialist services within this department. The specialist services provide support to handle referrals of “complex” cases, they will design and develop programmes for the identified special populations and they will provide the resources for training other workers to be more proficient in handling problems in special cases. The special areas include the establishment of a unit of “child & family services”. This unit will be staffed with family caseworkers with expertise in each of the following areas: childcare & protection, family care and adolescent care. There will be two FCWs in this unit trained to deal with domestic violence. This is to ensure that the shelter for abused women has constant support and that national programmes to tackle domestic violence will be developed. This unit of child and family services will be responsible for the implementation of the integrated childcare and protection programme to be funded by The European Union through STABEX funds. The unit will be managed by a FCW III (Child & Family Services) who reports through the human services and family affairs supervisor who reports to the Director of Human Services, Family Affairs.

The second area of specialisation is the medical and psychiatric social worker arm. These FCWs trained in these areas operate in the North and South regions supporting the health institutions involved in psychiatric and medical services. These FCWs also report through the human services and family affairs supervisor to the Director.

1.6.1 Other special services

There are special areas that require analysis, programme support and/or development. Services in these areas need to be developed in collaboration with other agencies in Government and in the private sector. These include but are not confined to: the Ministry of Education, Dunottar School, Help Age, National Council for the Physically Challenged, National Council for Elderly Citizens, Homes for Senior Citizens, CARE, employers etc.

?? Aged and ageing related services

This demands an integrated programme aimed at creating a nation in which people age in a positive, healthy manner. The goal is for people to have a continuously improving quality of life, so that the "golden years" are golden. In order to achieve this, we need to teach our people, from the earliest age, from infant school on, how to respect older people, how to interact and learn from older people, how to develop themselves and plan for their ageing, and how to look after the needs of their older relatives.

Programs in this area will obviously involve many social partners. The recurring theme of this health sector reform returns forcefully in this area. We need to develop integrated programmes with multiple partners clearly emphasising the need for community responsibility and action.

We conceive that our resources and system, restructured as we are proposing, will be able to provide support, guidance and platforms for delivery of integrated programmes for ageing. The programme manager responsible for these programmes will be a senior field social worker (grade 15) who reports to the Director of Human Services, Family Affairs. In addition there is a need to develop programmes for other populations that will be developed in a similar fashion, these include:

?? Services for the intellectually impaired

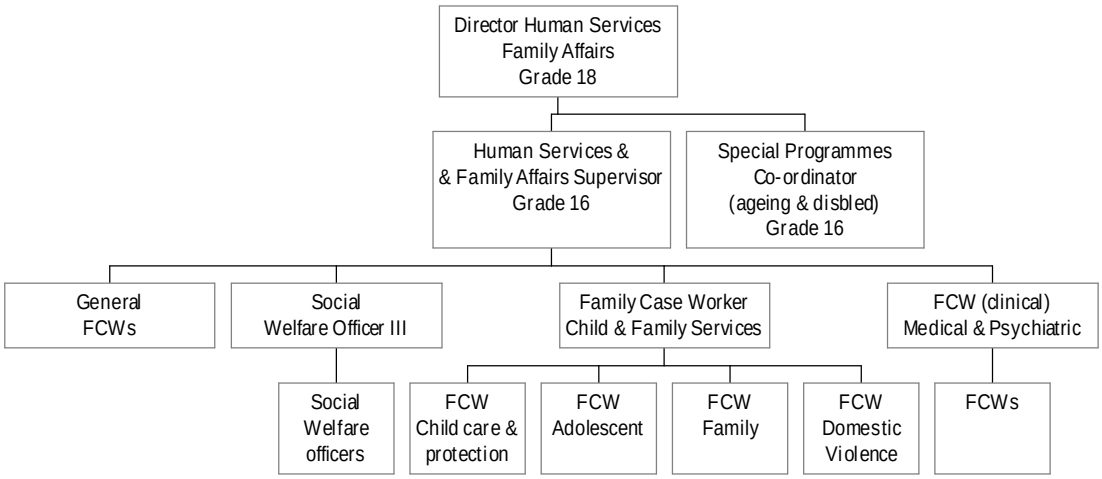
As outlined in the above section our approach to programs for the intellectually impaired will be one of effective partnering with social partners. Here we recognise the need for special education and we recognise our role in early detection, diagnosis, treatment, counselling and support; thereby, allowing teachers to educate a person for maximum productivity.

?? Services for the psychologically impaired, substance abusers & mentally impaired.

We anticipate that our mental health services, when restructured, will be in a position to guide the design and development of programmes to help in this area. The policy of partnering with other agencies and the community to deliver an integrated program will also be applied.

The Director of Human Services, Family Affairs will be upgraded to grade 18 and will be the central Director reporting to the Permanent Secretary on this department's services. This person will be the main conduit to allow for the development and implementation of national policy in this area of social development.

FIGURE 3



1.6.2 Shelter for abused women and children

A shelter will be established with the support of the European Union through STABEX funds. This shelter will be part of a comprehensive domestic violence programme. Human Services and Family Affairs will develop the programme with the help of Health Canada and PAHO. The domestic violence programme will only be successful if the necessary network with the Police, the Family Court, health institutions, private sector and the community is developed. The proposed restructuring of the health sector will facilitate this process. The shelter will be managed as an institution and will benefit from being administered by a shelter manager who reports to the Executive Director – North. The professional services to the shelter will be provided by the FCW trained in Domestic Violence and other health personnel as necessary.

1.6.3 Senior Citizens Home

There is a need to upgrade the facility and services at the Senior Citizens Home. The Home is seen as part of the programme to help and support the aged. We intend to develop community-based care for the aged, thereby reducing the need for institutionalisation. The programmes for the aged will not only involve the Senior Citizens Home and the Community, but also all the private homes and NGOs involved in care of the elderly. The Home Manager who reports to the Executive Director - South, will administer the Senior Citizens Home. This facilitates the support of the home from both the Soufriere and Saint Jude Hospitals. There is a need to develop medical, nursing and other personnel trained in Geriatric care. We are confident that integrating the Home with the other regional health institutions will cause the system to focus on developing these services.

1.7 GENDER AND DEVELOPMENT

With the emergence of new knowledge obtained through experience it has become evident that the concept of gender must be mainstreamed into development efforts if any governmental action is to benefit women and men equitably. This approach ensures that there is fairness and that no group benefits from any development intervention at the expense of the other. This would of necessity require a new approach to development planning, implementation and evaluation to include gender considerations.

This approach requires the development of an enabling environment where all personnel involved in the development, implementation and monitoring of policies, programmes, and projects have an understanding of the concept of gender and its relationship to the achievement of social justice.

The reform initiatives being undertaken in the public sector provide an excellent opportunity for the institutionalisation of this approach.

Gender can be defined as culturally prescribed social roles and identities of women and men, as well as the relationships emanating from these roles, which affect the way they experience their lives. Gender impacts not only male female relationships at the family level, but on all other aspects of their lives. Consequently gender equity involves more than just "including men" or focusing on the family. The approach focuses more on equity of outcome and less on equal treatment for women and men.

1.7.1 Gender mainstreaming

There is need for mainstreaming gender in all national policies and programmes. The tool to be employed is a Gender Analysis Framework in development planning, implementation, monitoring and evaluation. Gender analysis is a valuable tool in understanding social processes and is a key factor in ensuring that problems are adequately addressed. The whole purpose of this approach is to integrate, and not isolate, women and their activities.

"Mainstreaming looks beyond the promotion of projects and programmes for women, to the consideration of gender issues across all sectors, ministries and departments." (IDS, 1996)

This requires a transformation of institutional structures and planning procedures, which can effectively and efficiently transform policy into practice. Some of the measures necessary to promote the mainstreaming of gender in development policies and planning include:

- ?? The inclusion of gender issues in all development plans
- ?? Developing gender analysis guidelines and checklist for planning and evaluation
- ?? The promotion of gender awareness training

?? The use of gender-disaggregated data and indicators on issues such as violence and reproductive health, etc.

Information systems must allow for an adequate gender-disaggregated database to better inform programmes of existing services, so that they can benefit men and women in a more equitable and sustained way.

In this new paradigm the focus of the Division will have to be on:

?? Training to create a more enabling environment for gender mainstreaming
?? Research and analysis to inform the gender planning process
?? Establishment of gender indicators for social and economic development, in association with government ministries, agencies and the private sector.
?? Policy /Programme development, monitoring and evaluation to ensure the incorporation of principles of social justice and gender equity.

In order to effectively and efficiently fulfil this mandate it is necessary that the proposed Planning Unit of the "new" Ministry of Health, Human Services, Family Affairs and Gender Relations be structured to meet the needs for gender mainstreaming as outlined.

1.7.2 Engendering health sector reform

Gender Mainstreaming in the Health Sector Reform initiative requires that a gender perspective be included at all stages of the process. The very composition of the Health Sector Reform Committee & Secretariat had to incorporate gender analysis/planning competency and should have included the Dept. of Gender Relations. The consultative process that informed strategies and recommendations had to be done with a gender perspective to obtain "truthful" information. A deliberate and explicit attempt must be made to include this gender perspective, if we are serious about social equity.
Without an adequate information base of quantitative and qualitative gender statistics, it is difficult to incorporate a definitive gender perspective in this document (White Paper).

However, the following strategies are recommended:

?? Recognition and acceptance that gender is a determinant of the health of the individual

?? Increase the capacity of the Planning Unit for gender sensitive planning, analysis and monitoring

?? Strengthen research capability to ensure that quantitative and qualitative data are collected on gender and community differentials to better inform health interventions for the achievement of social equity

?? Increase capacity to identify health gaps not only between rich and poor, but also between men and women

?? Put mechanisms in place to ensure gender equity in "Community Health Improvement Committees" and gender analysis competency on the Interministerial Committee and all other health committees

?? Public Education which focuses on closing the gender gap in health, and improving gender relations in society and health workers at all levels.

1.8 REGIONAL INTEGRATION OF SERVICES FOCUSSED ON OUTCOMES

Ultimately the aim is to integrate the community-based health services, the hospital services and all other agencies involved in the development and maintenance of health. The objectives are:

?? To develop the necessary multidisciplinary approach
?? To pool resources on a regional, rather than institutional basis, thereby providing for more cost-effective utilisation of resources and less duplication
?? Challenge management to seek cost-effective interventions by budgeting an envelope on a regional, service output basis
?? To develop and structure a service sensitive at all levels to clients needs
?? To develop a system that is operating in concert as a mutually supportive system-wide team

This has been done in New Zealand where management and budgets are oriented towards specific services for a defined population rather than to health facilities. Service managers in that system are budget-holders accountable for achieving defined outcomes within a fixed budget. As such the managerial responsibilities cut across levels of care. The arrangement has led managers to place greater emphasis on prevention and primary services as the most cost-effective means of meeting their objectives within constrained budgets. We propose that the budget agreements with the Executive Directors should be developed in a similar format designed to achieve the above.

There is a need to rationalise services and clarify the respective roles, responsibilities, authority and relationships of all persons and institutions in the health sector and the partners in the process (Ministry of Education etc). This is essentially what the reform process, to date, is attempting to do, and this will be further elaborated in the phase 1 of the reform process.

Once the problems are resolved, it will become clear whether efforts at integration must proceed in the context of the establishment of Regional Health Service Boards (RHSBs) or whether the proposed Executive Directors reporting to the Permanent Secretary should remain. These will evolve from experience gained during phase 1 and discussions involving community persons, the Ministry of Local Government, the Ministry of the Public Service, the Public Sector Reform Commission and the Ministry of Health. In the interim it is proposed that Executive Directors are contracted to administer and develop services in the regional manner defined by the general hospital catchment areas, inclusive of polyclinics and health centres. These Executive Directors are contracted public managers at grade 19 responsible to the Permanent Secretary of Health, Human Services, Family Affairs and Gender Relations. The respective regional administrations (ED, MD, ND, Health information managers and accountant) should be housed in the region, preferably in the largest regional institution, to be available to the institutional administrators.

Key recommendations

All Health services in each general hospital catchment areas will be placed in one arm under the direction of respective Executive Director.

Rationalisation of services and development of clarity within the services is the first step towards integration.

1.9 RESTRUCTURING TO IMPROVE THE CAPACITY OF THE MINISTRY

The individual and institutional capacities, which currently exist in the Ministry of Health, Human Services, Family Affairs and Gender Relations, will not produce the efficient, effective and equitable operation of the Saint Lucian Health Care System that is desired by the decision makers and the public at large. To improve the functioning of the Ministry towards the achievement of these attributes will require not only augmentation of the present individual capacities, but also reorganisation of the corporate structure so that performance is geared to achievements of specified outputs and performance objectives. At present a mismatch exists between the policies, systems and institutional arrangements in place at the Ministry, and the plans and programmes that are being discussed to improve health status and health services. This situation must be corrected if health sector reform in Saint Lucia is to be successful. The Ministry must be improved to play a leadership role in the process.

1.9.1 Role of the Ministry of Health, Human Services, Family Affairs and Gender Relations

The main role for the Ministry is that of developing a health strategy for the country and ensuring that it is being delivered. The strategy will aim to achieve improved efficiency, equity and cost-effectiveness in the delivery of health services, and the production of quality services that are satisfactory to consumers. To be successful the Ministry must:

?? Determine national health and social priorities through needs assessment

?? Establish a system that will monitor for any changes in the latter

?? Formulate policies and broad programmes to address the prioritised problems

?? Allocate resources so that the problems are addressed in the most cost-effective manner

?? Collaboratively set targets and performance standards with the service providers/institutions involved in the implementation of the national policies and programmes

?? Improve the performance of systems - clinical, human resource, financial, etc.- to support the achievement of specified objectives

?? Co-ordinate the planning, design and implementation of an information system and management information system (MIS) to track whether resources are being deployed in the system as intended, and to monitor to ensure that the desired results are being achieved

?? Perform regulatory functions of all health services, including the private sector, that will be aimed at achieving specified quality and standards

?? Develop and oversee quality assurance systems including clinical audit;

?? Establish and maintain mechanisms for effective complaints resolution.

1.9.2 Building individual and institutional capacities

To carry out the role and responsibilities associated with the functions as outlined above, the Ministry will empower itself to co-ordinate and provide better management and leadership to the multiplicity of individuals and organisations involved in the delivery of health services. Services will have to be developed and/or acquired when and where needed in the following areas: epidemiology, health promotion, policy formulation and planning, human resource planning and management, quality assurance and clinical audit, quantity surveying, economic and financial management, negotiation and contract management. In addition leadership skills will be needed as well as capacity in communication and public relations.

1.9.3 Restructuring the Ministry

Merely acquiring staff with the above mentioned individual capacities will not automatically lead to optimal performance of the functions outlined in the prior section. The Ministry will be restructured to foster teamwork and interdisciplinary collaboration in the formulation of national strategies that will shift resources towards more cost-effective solutions. This restructuring will proceed from a base that is characterised by over-centralisation (most decisions on personnel and expenditure are made from higher up in the public service bureaucracy); and by a managerial staff that is more concerned with inputs than with the achievement of specific outputs and performance targets.

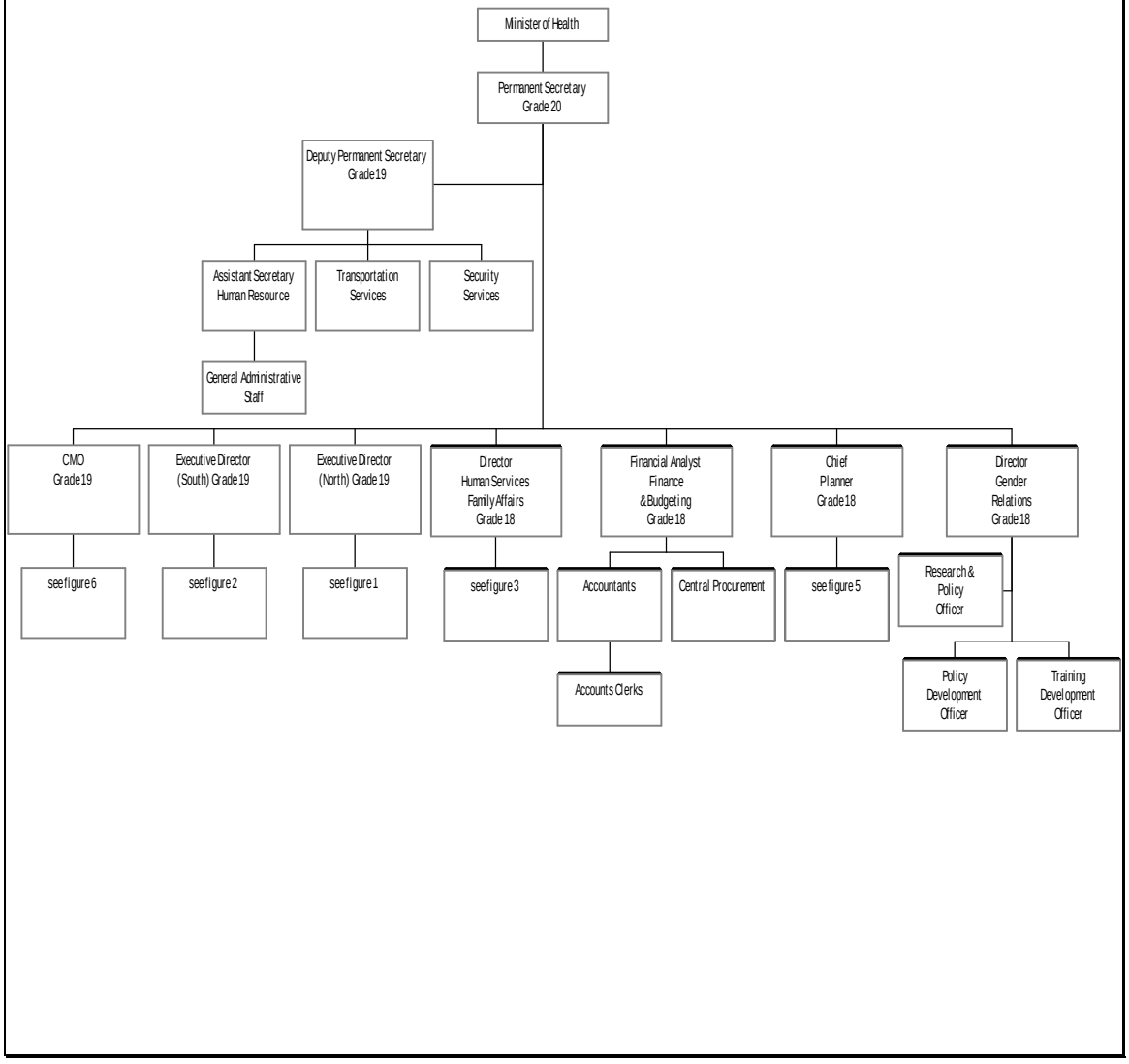
In the new structure, the current horizontal but parallel reporting lines - technical staff report to the CMO and non-technical staff to the Permanent Secretary, will be subsumed by a broader and flatter structure that is the hallmark of well managed organisations in the world of today. Epidemiologists and quality assurance specialists will collaborate with finance and human resource specialists in formulating new policies and designing and developing programmes to facilitate policy implementation.

While the PS will provide the corporate leadership and vision to the effort as s/he continues to support the Minister in the exercise of constitutional and political responsibilities; it is the service directors and technocrats who inform the new policies and programmes in the areas outlined in the last paragraph.

The existing culture in the public service leads to what workers have called “interference” in the operations of the service. It is anticipated that with the clear lines of authority this will no longer be the case. Administrators, directors and managers will hold persons reporting to them accountable and in turn will be accountable to their supervisors. No officer should be “bypassed”. Mechanisms to effectively deal with grievances will be put in place.

The Ministry will have eight major departments reporting directly to the Permanent Secretary:

FIGURE 4



1. Human Resource Management, general administration, transportation and security will be headed by the Deputy Permanent Secretary
2. Department of Public Health - Environmental Health Services and National Public Health programmes headed by the Chief Medical Officer
3. Northern Health Services – headed by an Executive Director
4. Southern Health Services – headed by an Executive Director
5. Corporate Planning and Information Unit, headed by the Chief Planner
6. Human Services, Family Affairs and Gender Relations, headed by a Director

7. Financial Services and Accounts headed by the Chief Financial Officer
8. Gender Relations headed by a Director

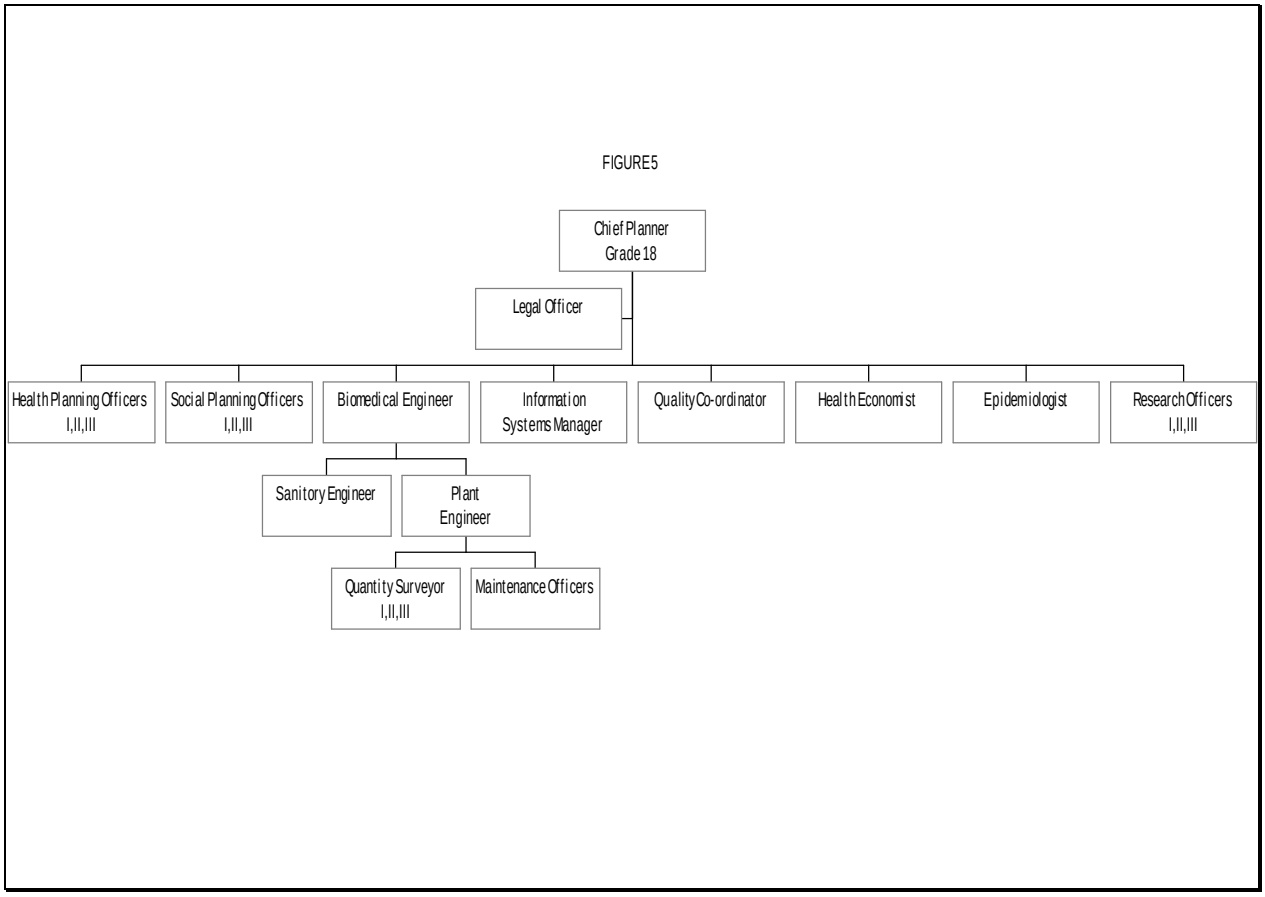
1.9.4 Establishing a Planning Unit

Without reliable and timely information, planning is reduced to an exercise in futility. In the new structure the prime focus will necessarily be on planning, and by extension the development of the information base for the proper performance of this function. Many countries are moving towards amalgamation of the two functions in their restructuring efforts by developing a Planning & Information Unit in the Ministry of Health. The Saint Lucia Ministry of Health will adopt a similar sub-structure. Staff has been identified and will be trained to perform the required functions.

The unit will be responsible for national information systems development and maintenance, quality systems co-ordination, planning, project development and research.

The unit will also be responsible for engineering and maintenance services. This centralisation of maintenance services should result in a pooling of national resources to allow for a better quality of service. Depending on workloads in different institutions, certain officers will be stationed at these institutions. One goal is to develop a high quality national workshop that will be used to fix and restore equipment while teaching.

FIGURE5



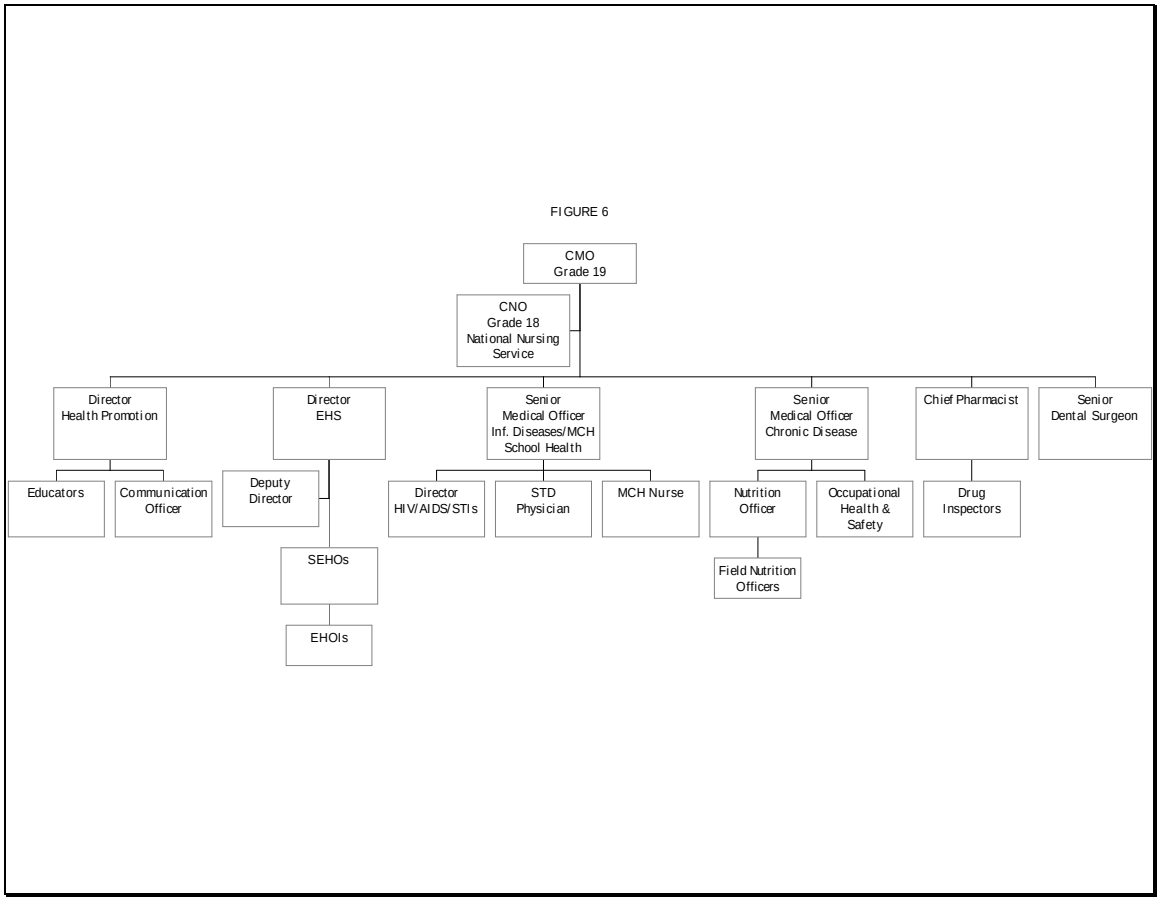
1.9.5 The Department of Public Health

The CMO is responsible the Department of Public Health which includes Environmental Health Services and all national health priority programmes (infectious diseases, chronic diseases as previously outlined).

The senior dental surgeon who reports to the CMO will develop the dental services. The dental staff will be deployed by assignment to each of the five polyclinics.

As stated earlier in the paper, a basic principle of health sector reform in Saint Lucia is involvement of the community in all aspects of the process. It is a major plank in the strategy to shift away from institutionally based health delivery models to community-based models that place increased emphasis on health promotion and prevention. The programmes and activities to accomplish this will revolve around an informational and educational nucleus that is driven by community concerns. A Health Promotion Unit will assist communities in developing communication and education strategies for health promotion. The Bureau of Health Education is the nucleus around which this unit will be developed. A communications professional will need to be hired to develop public relations and communication strategies. Additional training for health educators in health promotion, and in education strategies for other Ministry services (Human Services, Family Affairs & Gender Relations) is necessary.

FIGURE 6



1.9.6 Finance and Budgeting

The chief financial officer directs this department. The department is responsible for resource allocation, financial audit and control. The financial analyst will also co-ordinate central procurement of all supplies. The department will also be responsible for ensuring appropriate distribution, storage and inventory control.

Key recommendations

Strengthen the Ministry to allow it to effectively carry out its role as the policy maker, the regulator of the health sector (public and private) and the purchaser of services for the people.

Establish the new organisational structure and the new posts. The seven heads of departments, the Permanent Secretary and the Minister will be the executive committee of the Ministry of Health.

2. ENVIRONMENTAL AND OTHER PUBLIC HEALTH SERVICES

Policy

A healthy environment is the foundation on which health can be developed. The environment includes the physical environment, the social environment and the working environment.

Environmental Health and public health programmes will be designed and delivered in a comprehensive and integrated fashion involving multiple agencies and the communities.

The Ministry of Health will fulfil its leadership role expressing health sector needs and developing the intersectoral collaboration. The Ministry will also function as the regulator of the sector.

2.1 Sustaining and improving environmental health

2.1.1 The existing situation

The Environmental Health Division needs strong, effective leadership operating in a system in which the role of the Environmental Health Division is clearly defined. The role that the Division is expected to fulfil will determine the amount of authority and resources that the Division must be given to be successful. To date, little has been done to address these issues. Within the last decade many new agencies and Ministries have become involved in this sphere of activity, previously confined to the Environmental Health Division. The major players are; Solid Waste Management Authority, Ministry of Agriculture, Fisheries, Forestry and the Environment, Ministry of Planning, Water and Sewerage Company, Ministry of Community Development and Local Government, Ministry of Labour and of course the private sector. The Environmental Health Division has been placed in a position where it defaults to what is left after certain roles are "carved away". What appears to consistently remain with the Environmental Division is the regulatory role that naturally includes oversight and enforcement. Unfortunately this task is virtually impossible given the existing organisation, legislation and procedures.

2.1.2 Formalising the network

There is a need to formalise the network with all agencies involved in maintaining environmental health. The options for doing this include the implementation of an effective Environmental or Public Health Board, the powers of which should be determined by consultation with all parties. The other option is to have a committee of the agencies involved, which would provide a forum for harmonisation of policy and action. The committee is the faster and less threatening option, however it is also the weaker one. The existing Public Health Act does call for a Public Health Board and gives it considerable power. There is no doubt the existing Act will need to be revised, however in the interim the recommendation is for the Public Health Board to be activated to

provide an official forum for discussion to take place and joint decisions made. If the Environmental Health Division is to regulate this sphere of activity the Division needs to be elevated to a position that commands respect from the agencies involved. The execution of the existing Act with the formation of the Board is the most feasible way of achieving this.

2.1.2 Decentralisation of services

The main programme areas that the Division is responsible for are; Food Quality, Vector Control, Water/Waste Water, Solid Waste, Building Control, Port Health, Community Sanitation, Occupational Health & Safety. It is not far fetched to assume that soon we will be adding other areas of pollution control including; industrial effects, air quality etc.

There is no doubt that decentralisation of services is desirable, it is the sustainable way of ensuring community action for environmental health. The people, during consultation, asked for this to occur. We propose that the existing health institutions should be used as platforms for environmental health activities. The Environmental Health Aides and Vector Control Officers will be part of the Health Centre team. The goal is that every Health Centre will have at least one Environmental Health Aide and Vector Control Officer. Their function will be to monitor the assigned catchment area, providing advice and direction to the community, these officers must be visible and they must be given authority to enforce the environmental health legislation. These officers gather intelligence to be passed up to the Environmental Health Officers who provide the support and supervise a number of Environmental Health Aides and Vector Control Officers

The Environmental Health Officers operate from the base of the polyclinic complexes. They are part of the polyclinic team that supports a number of health centre teams in the catchment area of the respective polyclinic. The Environmental Health Officers provide the more sophisticated and specialised support for the services. They are the officers responsible for the management of the various programmes of the division in the communities. They supervise and support the Environmental Health Aides and Vector Control Officers in their daily activities. The Environmental Health Officers with specialist training in specific areas will contribute to these programmes as they are implemented in the proposed decentralised fashion outlined here. The policy is as far as possible to integrate programmes into general daily activities rather than having vertical programmes implemented by specialists.

The organisation of the health service will put in place a Health Improvement Committee that will bring to the Health Centre the community concerns many of which will be related to garbage, water and sewerage. Given the number of agencies involved it is proposed that the environmental health officer can liase with officers employed by other agencies MAFFE, WASCO or SLWMA to effect solutions. In addition the Board or inter-Ministerial committees (including the Permanent Secretaries) can address problems that require multi-agency action.

2.1.3 The enabling environment

The ability of the Division to be successful depends not only on the manpower and training; two critical factors for success, but also there is a need for modern legislation, information systems and technical support services (laboratory, communications, legal services etc.). The reform of legislation will need to articulate clearly the leadership, role and authority of the Division. There is an ongoing debate on the leadership. The existing legislation calls for a Medical Officer to be the leader of the Division. Consultations with the officers in the Division suggested that there is a need to recognise the modern role of the Division and have a Director trained in Environmental Health reporting directly to the Permanent Secretary. This as yet unresolved issue would need to be resolved prior to finalising new legislation. In the interim we recommend that a Director of Environmental Health (grade 18) as proposed be hired. Given existing legislation, this Director will report to the CMO. The definitive arrangement, including relationship with and role of a Board or not, will be articulated during the revision of the legislation. The objective must be to provide the Division with the most effective leadership. The qualities required of the Director will become more apparent when the role of the Division is clarified. The legislation will also need to allow faster mechanisms of enforcement in place, some suggestions that have surfaced, include a system of ticketing in the communities by Officers or Aides for offences. A second suggestion was to give the Environmental/Public Health Board the power to have hearings and determine penalties for certain offences without the necessity of using the regular court system.

The information system needs to meet the needs of the Division, the Ministry and other Agencies involved. The system needs to draw relevant information in a timely fashion from other parts of the health service and indeed from other Government agencies. Ideally an electronic system should be an integrated one in the form of the digital neural network that is programmed to draw the relevant data down to the attention of the Division, while allowing the Division to access and track their own specific data easily. Prior to electronic systems however, there is a need to organise and streamline existing data collection, processing and communication. We must develop the most appropriate indicators of environmental health problems and environmental health status, included in these must be the indicators of success. There is no doubt that electronic systems allow data to be collected, stored, analysed and transferred more efficiently and therefore ultimately we must develop the information system along these lines.

The laboratory services need to be upgraded to meet the needs of the Division. Discussions between laboratory directors and the Division should facilitate this.

There is need for legal services to be made available. The options are to contract legal services or to develop the capacity within the Ministry to provide these services. The recommendation is to create and fill the post of legal officer within the planning unit.

There are other services that will be developed and shared with other Ministry Departments. Public Relations, health promotional packages and communication for the Division need to be developed. We should develop this area in conjunction with other

Ministry Departments; the proposal is for a Ministry Public Relations/Communications Office as part of the Health Promotion Unit. The other reason for networking the Division with the Health Promotional Unit is the recognition of the importance of environmental health in primary health care. This mechanism ensures co-ordination and integration of health promotional programmes that will allow the production of more consistent, meaningful and powerful health promotion.

The Personnel and Accounting needs of the Division have to be met. If these services are to be shared then the mechanism must be put in place to meet the needs of the Division. The proposal is for the establishment of post of an Assistant Director to assist the Director with these administrative issues in addition to technical and district service issues. As with all other Ministry Departments there are issues that need to be addressed by the Ministry of the Public Service and Public Service Commission. The Division would like more control over training, hiring, disciplining, allowances and incentives for officers. It is proposed that the committee including (PSC, Ministry of Public Service, Public Sector Reform, P.S. Health, CMO, Health Sector Reform) should investigate and make recommendations to Cabinet on the amount of authority that can be given to Departments in these areas and the mechanisms that can be established to ensure fairness

2.2 Occupational health and safety

There is a need to network with the Ministry of Labour, Employers' Federation etc. to develop occupational health and safety programmes to address the working environment. These need to be developed with input from various health agencies (Environmental Health, Mental Health and general health teams). The programme developed should be comprehensive and include elements such as the employee assistance program, health screening and health promotion services. The options as to where the programme responsibility should be include, the Environmental Health Division, The Chief Medical Officer or his/her Senior Medical Officer, or indeed, with the Ministry of Labour. We recommend that this programme should be the responsibility of an agency of the Ministry of Health, preferably the environmental health division, this means that is preferable that the director possesses these skills. The diverse nature of this programme makes it yet another good example of the need for "horizontal" networking necessary for the implementation of an effective health programme

2.3 Develop family health programs (inclusive of Maternal & Child Health) under the direction of a Senior Medical Officer and MCH nurse manager

The antenatal care program will be strengthened to ensure that all pregnant women are enrolled early, appropriately screened and treated to give the foetus the best chance of developing properly. Within this programme we shall establish prenatal disease prevention programmes including protection from HIV. The antenatal programme will be developed jointly with the SMO, MCH nurse and the Obstetricians in the Region.

An expanded programme of immunisation will be maintained and expanded as necessary to cover at least 98% of all children for the recognised diseases as determined by PAHO and the Saint Lucia Government.

A school health programme will address the different needs of school children of different ages. This program demands close collaboration with the Ministry of Education and the community. We expect the health improvement committees, polyclinic and health centre teams to be very active in the implementation and monitoring of the school health programme. The school health programme will be developed jointly with the regional paediatricians, family caseworkers, mental health personnel and the primary care team. This programme will provide, among other things, hearing, vision, psychological and dental screening and treatment for all primary school children.

The school-feeding programme should involve the community. Co-operation between the health team, the school team and the community would result in a cost-effective, healthy school diet. The health team is instrumental in ensuring that the diet is healthy and the school administration is important in its implementation.

Support services including social investigation, counselling and treatment services to help implement programs such as the education social work program and programs designed to reduce substance abuse and violence will need to be established for each school. The health centre and polyclinic teams will be instrumental in providing resources for the schools to implement these services.

Life skills training and spiritual development should be included in the school curriculum; the health centre, polyclinic and Ministry's resources will be used to help teachers deliver this programme. As part of lifeskills training the Health services can provide avenues for school youth to be exposed to caring for elderly, sick etc. during holidays as part of this programme.

Truancy monitoring, prevention and correction will also be a joint effort with the community, the health team, teachers etc. It is anticipated that the household information database, which will be established at the Health Centre as a result of the health needs assessments, will allow workers to identify families at risk and allow early intervention to prevent anti-social behaviour.

Parenting programmes to educate adults on how to be better parents and to provide support in the community for them will be established. Single parent programmes that allow single parents to work and look after their children will be established. It is anticipated that structuring such programmes will allow government to advocate and provide incentives for employers to develop employment opportunities for single parents.

2.4 Establish violence and injury prevention programme

There is no doubt that motor vehicle accidents and other forms of injury are a major health problem. To reduce the impact of motor vehicle accidents we will have to network

with the Police, Ministry of Communications & Works & Transport Board to implement programmes to reduce driving under the influence, to ensure that roads are built safely and pedestrians protected, to ensure seat belt usage and proper vehicle usage.

To address the domestic violence issue we need to network with police, family court and other departments of the Ministry of Legal Services to identify families at risk for early intervention and to mitigate damage in families already affected (child witness programmes, sheltering, etc.).

Crime prevention is also an area that we anticipate our health centre team in collaboration with the health improvement committees and the police will be able to address. It is our hope that the family health programmes will eventually have a positive impact and reduce the amount of violence and injury in the long term.

2.5 National Health Programmes

National public health programs in areas of major morbidity and mortality need to be developed and structured. Apart from those mentioned above others are:

- Diabetes and Hypertension,
- Cancer,
- HIV/AIDS/STDs and infectious diseases.

The Senior Medical Officers in the department of Public Health will also manage these programmes.

The National Blood Bank Service is a national health programme that would benefit from central co-ordination. This allows for resource pooling and the development of standards. It is recommended that the Northern health region would develop the Blood Bank Service and the Southern region would “contract” these services from the North. The private sector should also contract these services. It is recommended that Blood Bank Services remain as public sector based services.

2.6 Organise intersectoral collaboration at two levels

The need for intersectoral actions cannot be overstated. Many of the problems e.g. stray dogs and pigs, the indiscriminate dumping of rubbish, washing of cars in the rivers, noise pollution, etc., can be taken care of at the local level by enforcement of laws that are already on the books. The exact mechanism for so doing - the local council, health improvement committee, more support for the EHO, etc., will have to be worked out. Other problems such as an inadequate water supply, accidents secondary to poorly constructed roads etc., will require action at higher levels, i.e. by Cabinet. We anticipate that establishing the system we propose will facilitate the appropriate action.

2.7 Improve and institutionalise health promotion

Health promotion has a significant role to play in resolving many of the low and some higher level problems. Programmes to promote health: family life education, nutrition, anti-smoking etc. should be elaborated from an information and education nucleus. Responsibility for developing suitable teaching materials, supporting personnel in the field and handling the overall logistics, should be a central responsibility, i.e. of the Ministry of Health. The functions of the Health Promotion unit of the Ministry of Health can be reoriented to accomplish this.

2.8 The leadership by Ministry of Health in health issues must be established

Leadership in resolving multisectoral issues that impact health should come from the Ministry of Health. Ministry personnel should assume the lead in bringing focus to particular health issues by calling meetings of the relevant technical and community personnel, sharing data on prevalence/incidence, inviting other Ministries to collaborate in seeking solutions, etc. It is anticipated that developing the machinery of the Ministry that allows for an effective planning unit will be a major step in giving the Ministry the ability to lead on health issues with the confidence of solid data and comprehensive analysis.

At Cabinet the focus should be on policy and in seeking ways to maximise the use of resources that are always scarce.

Key Recommendations

The Ministry of Health must assume leadership in issues affecting health, especially since the public health issues require multisectoral action. The Ministry of Health should be strengthened to allow it to perform the regulatory function effectively; the Environmental Health Division in particular will need strengthening.

The organisation of the health service allows the community to effect, influence and determine action to be taken through the Health Improvement Committee, Health Centre Team and Government Regional Officers. This action must be supported at the higher levels.

The organisation of the health services at the community level allows for and co-ordinates the necessary multisectoral collaboration at the level of action in the community.

National programmes to address major causes of morbidity and mortality need to be established and existing ones strengthened.

3. FINANCING THE HEALTH SYSTEM

Policy

Maximise the use of health resources and create a more efficient health system capable of providing quality health services in the most cost-effective manner.

Reduce the impact of poverty by making health care affordable and accessible to all in need of care.

Achieve a match between specific service requirements and available funding.

Focus resources on priority health needs.

Incorporate appropriate incentive and accountability frameworks into all agreements to ensure value for money.

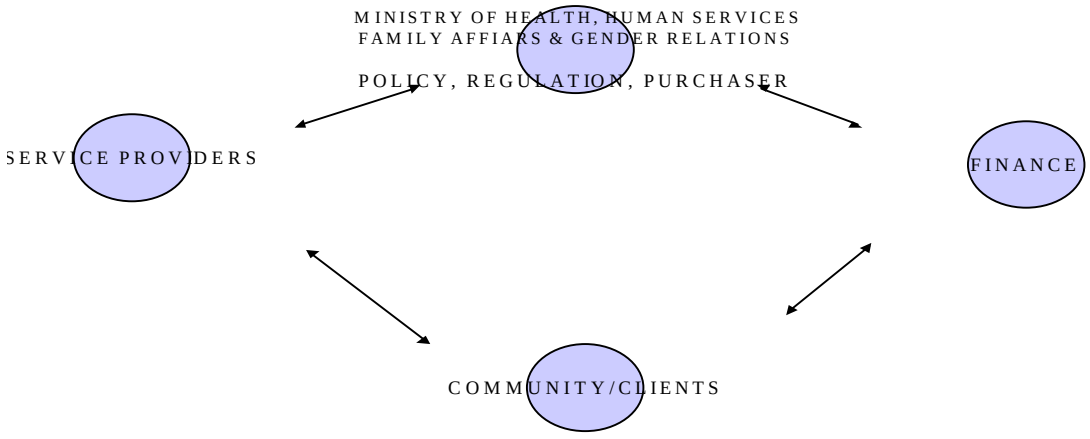
The finance component of the health system is crucial to the provision of quality and equitable services and the sustainability of the health system. It is a powerful incentive device capable of motivating providers to deliver quality health care. The main objective of the proposed financing system is to strengthen the finance component of the health system by developing a finance mechanism that is sustainable, diversified and capable of creating efficiency and achieving service goals.

Health resources like the resources of any other sector are limited and are constantly up against other competing demands. The Government should seek to maintain the health service while strategic investment into the planned reforms is done. When the system has been successfully restructured from its service organisation and delivery point of view (phase 1) then Government can consider how to better raise money and invest in health to produce designed and assured benefits. The policy prescriptions being proposed, as the main themes for reforming the finance component of the health system will reduce known substantial misallocation and inefficiencies, and improve quality and coverage. It is a fact that more moneys are needed to sustain the health system but to seek to generate additional resources without addressing the problems which plague the system will be tantamount to throwing money down the drain.

Discussions on the financing of a country's health services are influenced by how economic resources are or will be generated to pay for health care. Of equal importance in any such discussion though, is how cost-effectively and efficiently the resources so generated are being deployed in the system; and the extent of planning and market forces in the allocation of the resources. Appropriate attention must be paid to all three aspects if financing of the system is to be sustained over the long term. It should be clear from the prior sections that all the foregoing aspects of financing are being given due consideration in the current drive to reform Saint Lucia's health system.

3.1 Improved financial management – The Role of the Ministry of Health

The management of health funds including appropriate allocation is an important issue to be addressed. The Ministry of Health will have to play the main role in the allocation of funds and the monitoring of the financial system. There are a number of systems available to guide allocation of funds, the most popular, and probably equitable, ones are those based on the population served by the institution or entity to whom funds are allocated. Population based formulas need accurate information on the populations served and their needs. Regardless of how allocations are decided, there needs to be a system that makes administrators/institutions/boards or authorities, to whom allocations are made, responsible and accountable for their own budget. The system must also allow flexibility for these entities to provide services in the most cost-effective manner. It is this concept of the Ministry of Health managing the health funds and essentially purchasing service from entities responsible for service provision that is termed separation of finance from provision of service. By instituting this, the Ministry of Health can now develop purchaser-provider agreements or budgets detailed in the form of contracts or budget agreements that make clear levels of funding and expectations/targets etc. It also gives the Ministry of Health the flexibility to purchase services wherever it can get the best value for money (public agency or private agency). It is clear that before this can be implemented the Ministry will have to have a fully functioning information and planning unit with a good information system in place. The Ministry will also have to have developed its negotiating skills.



3.2 Need to determine expenditure on private health services

In addition there is the reality of growing private health care services that are preferred by the population. Recent surveys have shown that in Jamaica some 70% of total health expenditure is in the private sector; and in Trinidad and Tobago the figure is a little over

50%. These countries' public health systems have been under similar stress to Saint Lucia's public health system, a condition that drives persons to seek care in the private sector. With a steady rise in the number of physicians in private practice, growth in the number of private laboratories and the recent commissioning of Tapion Hospital, it will not be surprising if expenditure on private health services by Saint Lucians has grown in geometric proportions since 1990 - 1991 when such expenditure was calculated to be 13.6%.

Consideration of the financial system cannot proceed in the absence of knowledge on what the actual figure on private expenditure is today. More importantly the decision-makers will get a better perspective on what percentage of the GDP is being spent on health.

3.3 Operational research for the short term

The NIS should develop its present medical benefit service and administer this service along accepted health insurance lines. This will essentially be the pilot NHI. The extent to which this service is developed will be determined by examining the costs and results of this service. NIS will pay for services provided for NIS contributors to the Ministry of Health or service providers at the realistic cost of these services.

The institutions (hospitals and health centres) will need to analyze the cost of services and implement proper cost-accounting procedures. The Ministry will have to analyse the cost of public health services (promotion, prevention & environmental health), and all the ministry's programmes. Two financial consultants are in place for budget year 2000 to help in this area.

A health needs assessment will have to be done. It is proposed that the first step in this process is to collect baseline information via questionnaires administered by the Health centre nurses and their primary care teams. The data so collected will also form the health centre database. Additional information should be gathered from all the Ministry programme areas.

Saint Lucia is fortunate that the majority of doctors (over 90%) are on contract. The present contracts for doctors should be negotiated detailing expected levels of service and how the doctor will be compensated for the expected service. The Ministry can develop appropriate incentives within these contracts to develop the service the Ministry would like. At a future date these contracts could be taken up by the appropriate authority/board as determined by the evolving health service.

Both parties, to begin the process of developing institutional purchaser-provider agreements, should use the St. Jude/Mercy contract negotiations with Government as a template.

3.4 Developing a publicly guaranteed package of services

Government cannot provide all the health services for everyone. If it tries to do so the Ministry of Health will easily consume the recurrent budget for the entire country. A determination has to be made on what minimal or essential package of health services the country can afford. This package must be defined on the basis of detailed epidemiological, clinical and financial information, not available at this point in time. An early caveat in respect of any package is that in spending public money for health care, no interventions will be bought for non-poor people that are not available for the poor. Another is that health promotion and preventive activities must be included. One approach to the development of the publicly guaranteed package of services, is to include all health promotion and prevention services, all emergency services, mental health services and services outlined in the national priority programmes (Diabetes, Hypertension, Cancer, STDs, Infectious diseases, Trauma)

Until the reforms begin to produce the critical information referenced previously, it will be futile to attempt to project what must be included in an essential package of care for Saint Lucians. It is also evident that the cost of the package, and how to apply the available resources so that the system is sustained over the long term will also be dependent on this. With government expenditure seemingly at its uppermost limits, it is likely that any additional burden will have to be borne on the shoulders of the consumers. As stated earlier they appear willing to carry it, but the services must be improved and if care becomes necessary in the private sector, they must be able to access it.

3.5 Current financing of the System

At the moment health care in Saint Lucia is financed from the consolidated fund (mainly tax based revenues) and from out-of-pocket expenses by individuals/families. Contributions are also made by social insurance via a yearly NIS lump sum contribution to the Exchequer (average EC$ 3m. for the past 4 years); and by private insurance purchased by employers for their employees. It is of note that in 1990-1991 total private expenditure was estimated to be 13.6% of total health expenditure. In 2000 there is a strong likelihood that this figure is much higher. Estimates in 1995 suggested that 48% of total health expenditure was in the private sector.

3.6 Health Financing Options

3.6.1 General Government Revenues (“consolidated fund”)

This is the main mode of financing all health services and will remain as such for many years to come. As alternative modes are developed the consolidated fund contribution can be fine-tuned to the funding of services in the publicly guaranteed package of services and certain capital projects and strategic health investment. The future here will be determined by the developing health service and will be defined in phase II.

3.6.2 Out of Pocket Expenditure

This approach generates considerable debate and controversy. The issues here are that it is considered that any out of pocket payments for essential package services would disadvantage the poor and would be inequitable. It is also considered that revenue generation from this system has been marginal and there are fairly hefty transaction costs when compared to revenue generated. On the other hand proponents of this mechanism indicate that it is a form of limiting abuse of service and making consumers appreciate what they purchase. In Saint Lucia since 1992 first hand experience with this mechanism has been gained. It is our opinion that this mechanism will not be applicable to services outlined in the publicly guaranteed package of services. It may have a place as co-payments in services outside of this package.

3.6.3 Insurance

Private Insurance is established in Saint Lucia. After proper costing of services it is anticipated that these insurance plans will pay the public institutions the actual cost of service rather than the present subsidised cost.

Establishing NHI in Saint Lucia is an old concept that has been around since NIS was established in 1978. Through the years a number of studies have been done towards launching the scheme. The latest by the Health Policy Management Unit (HPMU) was published in 1995. This document identified many issues which needed to be addressed including:

?? Analysis of Household Income and Expenditure (HI & E) survey for the quantity and composition of medical care expenditures;
?? The private sector's capacity to provide care;
?? The development and implementation of an electronic patient account and billing system;
?? The development of standardised staffing patterns for the two hospitals based on treatment protocols and minimal productivity standards.

To the above can be added the problems posed by a growing number of non-salaried workers, the self-employed and those in unstable employment in Saint Lucia. The experience elsewhere is that persons who fall into those categories do not contribute what they should because their incomes are difficult to ascertain. This results in an inequitable burden falling on salaried employees. In addition the macroeconomic outlook for the country is not encouraging in terms of a quick turnaround towards a larger formal sector that will blunt this problem. This is a less than ideal situation for an insurance system dependent on employment.

Consultations revealed that in general people are not averse to health insurance but they wanted improvements in existing services and more coverage/benefits.

Government will have to consider the role of a public health insurance (NHI) vis-à-vis the role of private insurance. There are a number of proposals, one that is attractive is developing a public insurance to cover the "publicly guaranteed package of services" and allowing private insurance to function as supplemental insurance covering additional services not included in this package and making up the difference in cases where the public insurance does not meet the full cost.

It is becoming more and more apparent that NIS will be a leading institution in the development of an NHI programme along the lines of social insurance. Sharing of information and serious, constructive discussions with NIS are advisable sooner rather than later.

3.6.4 Earmarked Taxation

Persons also expressed willingness to contribute via earmarked taxation on certain products (e.g. cigarettes and alcohol). A recent review by the NHI board reveals that a 15-20% sales tax on alcohol and cigarettes would realise approximately EC$12 million per annum. Distributors and manufacturers could collect this tax. The advantage of this is the ease of administration and the general acceptability of this kind of tax on "unhealthy products". There are issues of trade agreements and the potential negative impact on the manufacturing sector of this proposal that will have to be considered.

There are other products and services that could carry a health levy; these include telephone bills and other utilities. This strategy also has implications to cost of living, business etc. and should not be implemented unless careful analysis is done.

3.6.5 Permits and licensing

These were raised during consultations as supplementary finance the feeling was they would be especially applicable for products or businesses that have negative health consequences, e.g. pesticides, pollution prone manufacturing etc. Food handler, restaurant, health care provider and health institution licenses were also seen as sources of revenue.

3.6.6 Rentals of space and equipment to the private sector and sale of services to private sector.

There are facilities and services within the public sector that could be rented to or provided for the private sector. For example, certain laboratory tests and forensic services can be purchased by the private sector. Space in health facilities for certain private practitioners can be rented and so on.

3.6.7 Health lottery

This was raised as a mechanism to generate money especially for capital projects.

3.6.8 Community fund raising

This was seen as another way of communities contributing to capital projects within the community. The Health Improvement Committees were seen as the vehicles for moving this mechanism.

3.6.8 Health Co-operatives

This mechanism was identified as another alternative to insurance; however, it was appreciated that there is need for considerable capacity in the body that would operate a co-operative.

Key recommendations

Develop cost accounting throughout the system, develop financial information systems and develop financial accountability at unit manager level.

Establish the realistic cost of each service.

Make definitive recommendations in phase II when more and better information is available including the results of the pilot projects and operational research.

Work with NIS to develop NIS medical benefits service as a proper public health insurance service.

4. QUALITY ASSURANCE

Policy

Promote client-focused care and ensure a people based approach to health development.

Develop systems that protect the public and encourage an evidence-based approach to decisions.

The quality of care at major health institutions is a primary concern of many individuals. Assuring quality is a key to providing a better service and improving public confidence. Specific functional areas include clinical audit functions; promotion of standards, protocols and procedures; health services' evaluation; research & development including technology assessment; and patient rights.

4.1 Developing norms and standards to guide inputs into the system

There are plans afoot to substantially renovate/replace the physical infrastructure and to introduce cost-effective technologies. To optimise the investment, substantial training and retraining of workers will be necessary. Norms and standards will be required to guide inputs into the system (personnel, equipment and supplies) as well as to monitor the process of health care delivery itself. In addition, the development of quality standards will be critical to the enforcement of the new organisational culture that will stress accountability. Protocols and manuals will be developed by and for the use of staff, and mechanisms put in place to ensure that they are being utilised and updated in the constantly changing scenario of contemporary clinical practice.

4.2 Develop total quality management/continuous quality improvement

Given the above, the Ministry of Health is intent on establishing Total Quality Management / Continuous Quality Improvement (TQM/CQI) programmes. The essential difference between the traditional quality assurance programme and TQM/CQI, is that the former relies on end point inspection to determine quality, while the latter focuses on the process of care delivery to identify areas for improvement. Research has shown that 85% of all quality problems lie in the process and not with the workers or product. Process control therefore, contributes more than inspection to assuring and improving quality.

The Ministry will need to have an officer (the quality co-ordinator) within the Planning unit dedicated to TQM/CQI. This person will assist health managers to establish CQI in their daily operations. This person will also be responsible for the auditing and the ongoing monitoring of performance.

4.2.1 Project inputs to set up TQM/CQI in the health system

The new organisational structure suggested for the Ministry of Health will demonstrate a concern about the quality of health services. Standards, protocols, procedures and regulations will be required for medical care, nursing care, allied professional services and specialist care. TQM policy and strategy will have to be developed almost from scratch given where things stand at the moment. Fortunately some departments and services have already started to analyse their processes and procedures. The anticipation though is that further down the road more expertise will be needed in areas such as the development and promotion of standards, and ensuring that regulatory functions are undertaken effectively. The overall responsibility for assuring quality in the health system rests with the Ministry of Health.

4.2.2 TQM Important at All levels of the System

The TQM approach will be institutionalised at all levels of the system - from health centres to the St. Jude and Victoria Hospitals. It should be noted that a perception of poor quality at the lower end of the system leads to bypassing of health centres and district hospitals for the more expensive regional hospitals. Those who can afford it go to the private sector. The end result is not only gross inefficiency, but creeping development of a two-tiered system of care: one for those who can afford it, and another for those who cannot (the latter overly represented by the poor and already disadvantaged). **No government in a democratic system can live with this!**

4.3 Quality focus at the health centre level

At the health centre level the approach must focus on the team: a desire to continuously examine their work, continuous quality improvement (CQI) being the objective. The focus will be on the prevention and treatment of the common acute and chronic conditions as well as the structural and organisational issues such as the quality of referral documents and the information system.

4.4 Technology Assessment

There is also an absolute requirement for continuous technology assessment. Global communications (the Internet, telemedicine, etc.) have sensitised providers and clients to new technologies such as organ replacement and magnetic resonance imaging; and the demand for their introduction in Saint Lucia is great. Each technology must be carefully assessed in respect of cost-effectiveness and the suitability to the local environment. Many countries have appointed technology assessment committees comprising technical and laypersons since there are ethical issues that must be addressed. It is important, however, that any such committee be backed up by suitable expertise. The Ministry is examining this approach with a view to determining how it can be applied in Saint Lucia.

4.5 Charter of Patient Rights

Having established standards of care and expected achievable outputs at every level of the service, a charter of patients' rights can be established and published. We caution that one cannot adopt a charter from another system or country. We need to establish our own. There is no doubt that charters published in other countries can guide us. This document must be seen, not as "window dressing", but as a serious contract with the people that the system is committed to.

4.6 Complaints Commission

The purpose of a complaints commission is to provide an avenue for rapid formal resolution of complaints arising within the health services. It has been shown (Victoria, Australia) that the establishment of a functioning commission can resolve the majority of complaints with minimal trauma. It avoids the often-negative effects of airing complaints via the public media. It also avoids the necessity of court action in many situations. There is in existence a parliamentary commissioner to hear complaints arising in the public sector. This mechanism does not appear to meet all the needs of the health services. Therefore this complaints commission should be mandated to hear complaints arising in the public and private sector.

Mechanisms to deal with patient complaints (easily discernible by the public) should be set up at all facilities, and the Charter of Patient Rights displayed in key patient care and flow areas of the hospitals, polyclinics and health centres. A Complaints Commission comprising technical and lay persons, will be set up to deal with any complaints arising in the health services that cannot be satisfactorily resolved through the regular administrative mechanisms.

Legislation and procedures will have to be designed for these complaints mechanisms to operate. In addition the Medical Staff By-laws referenced earlier, will contain very clear clauses governing medical staff. The Hospital & Institutional by-laws will contain similar provisions in respect of other hospital/institutional staff.

4.7 Licensing and Accreditation

There are three main bodies presently responsible for regulation, the Nursing Council, the Medical Council and the Medical Board. There is need to review and harmonise legislation to govern the practise of the healing arts (including allopathic medical practitioners, dentists, allied professionals, complementary/alternative practitioners and health facilities).

The Acts and functions of all existing regulatory boards and councils need to be reviewed. The Acts can be harmonised into a single health services act with separate components. The Nursing Council should stand and continue its existing role with minor amendments to cover certain nurse specialists (e.g. Nurse Anaesthetists, Family Nurse Practitioners etc.). The Medical Councils role can be expanded to include dentists,

complementary practitioners and allied professionals (laboratory, pharmacy, radiology, physiotherapy etc.). The alternative is to separate the allied professionals from the doctors, complementary practitioners and dentists, and have a separate council within the same health services act to govern these professionals. Consultations with complementary practitioners raised the suggestion for a separate complementary practitioners council. There is a need to introduce licensing and accreditation of professionals and institutions, public and private. This can be done within the health services act or by the establishment of a new Health Facilities Licensing and Accreditation Authority and Act.

The suggestion that would satisfy all parties is a harmonised health services act with separate councils for each of the following: allopathic doctors and dentists, complementary practitioners, nurses, allied health professionals and institutions. This act would provide for registration, licensing and accreditation by the respective councils (Medical, Nursing, Complementary Practitioners, Allied Health Professionals, Health Facilities)

There are other Acts including the Public Health Act that should be reviewed in the process of overhauling all the Saint Lucian health legislation. These acts must allow for a renewable licensing process, with provisions for auditing and appropriate penalties for breaches.

A number of countries in the region are presently updating and adding legislation in these areas. The most recent is the Commonwealth of the Bahamas.

The implementation of licensing for professionals can be achieved more quickly than accreditation for institutions since the accreditation system will be dependent on implementation of TQM/CQI and the appropriate information systems that will take time and take us into phase II or III. The licensing process can be implemented in phase I with appropriate legislation.

4.8 Complementary Medicine

There is need to develop a coherent policy and approach to complementary/alternative medicine. There is no doubt that this practice is in existence and there is public demand for these services. This area of medicine covers a wide range of services. The policy proposed here is to adopt an evidence based approach to how these services are “mainstreamed” into the public service. Services that have not been proven effective can be left in the private sector with appropriate regulation to ensure that the public is protected. Some areas should be incorporated into the main stream of the public and private service. Chiropractic and Acupuncture can be mainstreamed. Aspects of Herbal Medicine and Naturopathic Medicine can also be mainstreamed. Other areas will need further evaluation in our setting and internationally before we should consider mainstreaming them. They can, however, be allowed to function in the private sector with the necessary regulation (licensing etc.).

Key Recommendations

Implement TQM and CQI at all levels.

Establish regulation at the Ministry level for public and private services (including all practitioners allopathic and complementary)

Regulation creates a demand for legislation to be drafted to cover licensing and accreditation and the complaints commission.

Hospital and institutional legislation and medical staff by-laws need to be updated and drafted respectively.

Adopt an evidence-based approach to the services to be offered.

5. REGIONAL, INTERMINISTERIAL & INTERSECTORAL COLLABORATION

Policy

Facilitate sustainable national development by partnering with all concerned towards the delivery of quality health care with the emphasis on primary and preventative care to produce a people who are mentally, physically, spiritually and socially well.

5.1 Wellness Promotion

The concept of wellness is fundamental to the success of many of the programme initiatives of the Government of Saint Lucia. It is seen as a critical element of the social and economic development of its people. Therefore, it is clear that every Ministry's or sector's role in the society must of necessity be executed in a manner that places wellness promotion as a priority in the fulfilment of their mandate. The Ministry of Health should be considered a national resource in this area. This link will establish ministerial and sectoral relationships bearing in mind the construct that good health is fundamental to sustained social and economic development.

In order to maximise the efforts of the Government all Ministries will be required to incorporate into their programmes specific activities to promote health and wellness especially where the main programme areas may have direct implications for the health of our people. As a matter of policy, impact assessments should be required for capital works projects (public or private) that significantly impact on health and environmental issues, prior to the commencement of such projects so as to allow time for appropriate interventions to mitigate against such impact.

5.2 Networking

The benefits of appropriate networking strategies need to be underscored. Networking has the ability to create economic gains by introducing greater efficiency, reducing duplication and maximising the use of resources. Joint programme implementation in the pursuit of sustainable development and a safer environment is the policy.

5.2.1 Non-Governmental Organisations (NGOs)

There are many NGOs that are making valuable contributions to the development and maintenance of the health sector. The relationship between the Ministry of Health and these agencies needs to be organised and improved. Information sharing with the NGOs is an area that needs to be addressed in the short term. Involving the NGOs as advisors in policy and service development is desirable. Co-ordination of activities between different NGOs and Government agencies should be addressed. Proposals include:

- encouraging the formation of an “umbrella association” or Council of Health related NGOs to provide a forum for co-ordination and harmonisation
- establish/assign an office/r(s) at the Ministry to be the contact and liaison between the Ministry and NGOs
- in designing the information system involve NGOs to ensure that the system can meet their needs. In addition many NGOs have resources to help in this area.

5.2.2 The Government of Saint Lucia will strengthen the links between the various ministries of Government through collaborative strategies towards the following objectives:

Health and Agriculture and economic growth.	- Food production and consumption for improved nutrition - Consumption of wholesome and nutritious food - Public and Veterinary Health - Environmental Management including occupational health and safety
Health and Education, Youth and Sports Human Resource Development	- Health Education and Promotion - Healthy Lifestyles promotion - Sports Medicine - Human Resource Development Training

Health and Tourism	- Health tourism - General health services to support tourism
Health and Public Service	- Public Sector reform - Human resource training
Health and Commerce	- Public health safety/Consumer protection - Consumption and lifestyles
Health and Community Development	- Environmental awareness - Institution and capacity building - Development of communities
Health and Legal Affairs and Labour	- Development and review of legislation - Occupational Health and Safety
Health and Communication and Works, Transport and Public Utilities	- Development of safe transport and road infrastructure - Provision of high quality potable water
Health and Finance and Planning	- Co-ordination in identification and utilisation of all resources - Overall sector development

5.2.3 The role of the church

It is important to network with and involve the religious organisations in the development of policy and the implementation of certain programmes of mutual interest. This is especially important since in our definition of health we recognise the complete human being.

5.3 Regulation and Sector Co-ordination

The Government will continue to maintain the overall responsibility to ensure that quality health care is available to those who seek it. However, the system will be regulated such that the growth of the private sector will serve as a mechanism to improve quality care, promote healthy competition through the provision of services that would augment the capacity of the system and expand the range of services available throughout the country.

5.4 Community Empowerment

The thrust of the Government is to engage as many people as possible in the decision making process, thereby creating a high degree of transparency. Consistent with the efforts of the Government to institute local Government, communities will be encouraged to participate fully in the programme planning, implementation, monitoring and evaluation to ensure that the needs and concerns of the communities are adequately met.

5.5 Working with the private sector

The principal objective of this component of health reform in St. Lucia is to analyse and adjust the role of the Ministry of Health in harmonising private sector activities with national health system objectives.

According to a HERA 1998 report, the expansion of the private sector is posing numerous challenges to the public sector. While the exact impact of the private sector is not known, it is generally believed and accepted that facilities such as Tapion Hospital and some private labs, are being used as a yardstick to determine the quality of care and services offered by the public institutions. This is, however, only one dimension of private sector consideration; there are many others e.g. the increasing private practice of complementary medicine and provision of herbal and health products in health stores.

The only way to create harmony and synergy in pursuit of a national system that meets the needs of all concerned is through continuous open dialogue between the public and private sector. This relationship will allow for the development of appropriate regulatory mechanisms and incentives to cause services to develop as agreed. Government should never be a constraint on private sector growth, but rather a facilitator of appropriate private sector growth.

5.5.1 Policy formulation

There is a virtual absence of private sector representation in the process of policy development on health matters. Since the Government regards privatisation as one of the approaches it will adopt to “broaden and strengthen the scope and capacities of the private sector to contribute to the economic, social, educational and cultural development of Saint Lucia” (Saint Lucia Medium Term Economic Strategy), this will have to change. Mechanisms will have to be developed to incorporate private interests on boards, and committees and to foster networking with the private sector.

In addition in developing policies, every attempt will be made to synchronise the relationship between the public and private sectors so that they operate in the public interest. Such policies will necessarily include the enforcement of regulations that may take the form of:

?? Price controls and support for essential products and servcies: for example at the Vieux Fort community consultation it was revealed that the price of a drug may vary as much as 60% between pharmacies in the immediate area.

?? Quantity and distribution controls: such as controls on location to promote access to under served areas.

?? Quality controls: to ensure that profit margins are not increased at the expense of quality.

?? Licensing and Accreditation of practitioners and health facilities.

It should be noted that the establishment of public health insurance or specific purchaser-provider agreements would give the agency, selected to manage the funds control over the allocations to the various providers. This is a powerful tool: incentives can be offered to encourage certain activities by providers (and discourage others). Experience has shown that the ability to offer incentives as a carrot to foster the implementation of specific priorities is a more effective means of regulation than legal controls.

5.6 Partnerships

5.6.1 Competition

The private sector is continuously expanding - more physicians, more pharmacists, even a hospital, entering this style of practice, and competing with the public sector for the same resources. While healthy competition is necessary for the development of the health system, it will be monitored and where necessary controlled so that inequities already present in the distribution of, and access to, resources, are not made worse. For example, where access to the private sector is based on the ability and willingness to pay, a two-tiered system of care will develop unless government subsidises care in the private sector for those persons unable to pay; or raises the standard of care in its own facilities thus encouraging consumers to return. Both such actions are being discussed presently.

5.6.2 Joint Ventures

A principal objective of joint ventures is to facilitate the sharing of experiences and resources; it is particularly applicable to the pharmaceutical industry in St. Lucia. The vision for the purchase and distribution of pharmaceuticals and medical supplies is to make the products more available and at a cheaper price to the population. A joint venture between the private and public sectors will enable this. A recommendation coming out of the consultations with health workers is that the scope of the bulk purchasing by the Eastern Caribbean Drug Service (ECDS) be extended to include all medical supplies and that the private sector be supplied as well. These actions will translate into increased availability and reduced costs of drugs for consumers. Appropriate price control measures will be enforced as a matter of policy.

5.6.3 Contracts

Contracting between private sector businesses or individuals and the government to provide services within the public sector is ongoing. To ensure efficiency and effectiveness of the outputs, the Ministry of Health needs to include performance standards and expected outputs in the contract documents. The Ministry of Health in contract negotiations, and in contract management, will therefore acquire skills.

The most common complaint from communities across St. Lucia was cursory treatment by doctors contracted to provide services in clinics at the health centre level. Frequent were the anecdotes of a doctor prescribing a drug before the patient could properly disclose his or her ailment, and usually without the benefit of a proper examination. In addition, people complained about late arrival for clinic sessions, and early departure, with many doctors spending less than one hour per clinic session.

Fifty (50) patients are booked to see the doctor in a typical session, with many persons arriving very early to ensure that they make the cut-off. There appears to be little in the way of triage and sicker patients may be told to come back for the next session. Doctors complain of having to see too many patients, and being under-compensated for the expected effort. Both parties appear uncomfortable with the contractual arrangements as they stand at the moment; renegotiating appears to be a welcome move for both sides.

The doctors' contracts with the government average about two years in duration; for the most part though, routine renewal is the norm. The issues cited above could be resolved through negotiations, the results of which can be reflected in the doctors' contracts. As stated above, the Ministry of Health will move expeditiously to acquire the necessary skills in contract negotiations and contract management. MIS support as cited above, will assist with formulation of the necessary performance evaluation mechanisms that the situation warrants.

5.7 Special areas

Health Tourism is an area in which we need to have clear policy. This should be developed with private sector involvement and the Ministry of Health as the regulator. If we need to access any services developed as health tourism for our citizens then we do this via contract negotiation. We need to be guided by the principle that public money should not be spent on providing services for the non-poor unless we provide the poor with equal access to these services.

5.8 Shared Services

Presently we depend on Martinique, Barbados and to a lesser extent Trinidad for certain services, especially oncology, cardiovascular surgery, neurological and neurosurgical services and Magnetic Resonance Imaging diagnostic services. There is no doubt that we will always need to seek certain services from overseas providers, based on the inability to offer certain services in a cost-effective and quality manner because of the small volume of patients. On the other hand we can capitalise on this reform impetus and certain resources available to us to develop our services locally to participate in offering regional services. Quality, cost-effective services will attract regional patients especially from the OECS hence negating the constraint of the small volume of patients. Saint Lucia is well positioned to move to develop this now.

Key Recommendations

The Ministry must develop and maintain strong networks with clear objectives and expectations.

The Ministry of Health must take a leadership role and develop the capacity to negotiate and monitor contracts with service providers.

The Ministry must develop clear policy documenting its relationship with other Ministries, agencies and the private sector.

The Ministry must assert itself as the protector of and advocate for the health of the entire nation and all its people.

6. IMPLEMENTATION PLAN

Health sector reform is a sustained and purposive process of policy, systems and institutional improvements that will take many years to achieve the objectives of fully upgrading efficiency, effectiveness, equity and quality that is desired for the health delivery system.

PHASE I (1999 onwards)

The approach we propose is to invest mainly in management (personnel and systems) and major health gaps, while maintaining the services. The identifiable major gaps are in primary care services, polyclinic services, mental health services and human services.

It is anticipated that in this phase the health sector will be re-organised and proper management systems established. This will set the stage for the future development of the sector. The systems we propose to install should be able to guide decision-makers on what strategies to implement to achieve maximum productivity within the limits of the available resources. At this time many of the suggestions that one hears are based more on intuition and assumption rather than hard data and fact. In addition the ability to act quickly and effectively in the present system is poor. We believe that investing as proposed in phase I will resolve these problems that are paralysing the health services.

The detailed implementation plan is presented in this document.

PHASE II (the financial system)

There is a need to develop proper cost accounting and billing systems from the outset. This will be done as part of the information system development in phase 1. Costing of services provided will be done. Agencies presently paying for services (private insurance, NIS and Government Departments) should be billed for the realistic cost of services. Individuals who can pay should also be billed. Information on users should be collected, such that the cost of exemptions can be determined.

Having done costing of the services, when Government decides to implement realistic fees the Government should consider raising the threshold for exemption from the present $6000 p.a. per family to $20,000, or only applying realistic fees to the insured (public or private) in the first instance. This exercise is designed to provide information on costs of services, user profiles, and so on to guide phase II of health sector reform.

NIS should establish its existing medical benefits programme along established health insurance lines and purchase services from the Ministry of Health. Discussions between NHI and NIS are ongoing and should become focused on the above proposal.

A study on the impact and feasibility of introduction of an additional limited earmarked tax 10% on cigarette and alcohol sales collected by distributors and manufacturers should

be done. In addition a study on the impact and feasibility of introducing an earmarked tax on electricity or telephones should be done.

The treasury should establish a “health fund” into which all money earmarked for health (i.e. from NIS, MOH “budget”, and any ear marked tax). The performance of this fund can then be tracked.

The Budget process should be improved to become purchaser-provider agreements between the Ministry and its service providers.

With these activities underway, information gained can be used to design the most appropriate health financial system for Saint Lucia. We should aim to implement the new system by April 2002.

PHASE III

A comprehensive detailed National Health Service Plan will require more information than we presently have. The National Health Service Plan should be a detailed document of targets and resources required. It should detail short term (annual), medium term (three year) and long term (five year) plans for every programme of the Ministry. It will require that the health sector has been organised as outlined in this document. For the 2002 budget there will be the beginning of a NHSP. This budget will report on the success of programmes to date and the success and progress made in organising and rationalising the health sector. It will also itemise the resources required to take the process as outlined forward. It will present the new health financial system. In the financial year 2003 a NHSP can be elaborated and the Government can expect to implement a comprehensive new and sustainable health service.

DEVELOPMENT OF A MANAGEMENT INFORMATION SYSTEM (MIS)

Reliable and timely information illuminates planning activity and is the base for monitoring and evaluating the results of such efforts. Strategic management is supported and driven by the daily activities of resource and clinical management. The combination of these two areas of management activity influences the development of policies and drives the planning function and ultimately the operations within the hospitals and health centres. A comprehensive MIS supports resource management activities by identifying and measuring inputs, measuring outputs of the processes, and analysing key indicators to improve the managers' decision-making capabilities.

- **Appointment of Information systems managers at Central Ministry of Health and in each health region**

MIS will be developed at the hospital, polyclinics and health centre levels. Twelve (12) person-months of IS/IT expertise in the health area will be sought to assist with the planning and implementation of the system. National counterparts are also proposed with the persons selected assuming the position of an information systems manager within the planning unit of the Ministry of Health and information managers in each region. The consultant will assist the latter in defining the position, and is also expected to provide "hands on" assistance in developing the MIS.

- **MIS development at the hospital and polyclinic levels**

At the hospital level the information system manager will provide hospital managers with the following services:

- Education and training in the development of management systems including forms for data collection and producing the required reports on a regular basis;

- Support in the development of special reports to highlight and analyse specific problems;

- Education and training for producers and users of information - to understand what to do with the data once it is collected;

- Facilitation of the working relationship between each department head and the relevant hospital administrators in developing the MIS forms to capture and monitor the above departmental information each month;

- Training department heads to compare the monthly departmental performance to past periods and to budget projections, with the emphasis placed on accurately identifying the emergence of any pattern of irregularities and taking the appropriate actions.

The IS/IT expert will also assist the identification of systems to support the important Human Resource and Finance functions.

- **MIS development at the health centre level**.

At the health centre level the information systems mangers will co-ordinate a short training programme that will concentrate on the role of data in supporting the primary care functions of health centres; data sources; recording data and ensuring their quality; uses of data; and presentation and communication of data. The course was designed for and conducted successfully in Nigerian health centres, but can be easily adapted to the St. Lucian situation.

DEFINING AND CLARIFYING THE PUBLIC-PRIVATE MIX

The doctors' contracts with the government average about two years in duration; for the most part however, routine renewal is the norm. There is no good reason why the differences between doctors and the Ministry of Health could not be resolved through negotiations, the results of which can be reflected in the doctors' contracts. The Ministry of Health will move to acquire the necessary skills in contract negotiations and contract management. MIS support, as cited above, will assist with formulation of the necessary performance evaluation mechanisms that the situation warrants.

Since much of the dissatisfaction is focused in the secondary system, the opportunity is there to cover much ground through development and implementation of the Medical Staff and Hospital/Institutional by-laws that are included among the terms of reference of the Regional and Hospital Administrations. These administrations will also establish clear policy that will guide the operations of public services and how the public sector interfaces with the private sector.

Once agreement is reached on such issues as hours of work, work loads, indicators for performance measurement, and so on, the Ministry of Health will seek the assistance of the Ministry of Legal affairs to undertake the tasks of drawing up the contracts between the Ministry of Health and the contractors.

The development of health institutional legislation, policy, medical staff regulations and by laws will also help to clarify this area. The establishment of a complaints commission in addition to licensing and accreditation will also encourage the people to be more confident in the health system, public and private.

The Ministry will actively engage the private sector in the development of policy, legislation and service. The system as being proposed provides opportunity for the public and private sector to work together at the community level and at board and council levels.

ESTABLISHING INTER-MINISTERIAL COMMITTEES

The consultations bore out the need for an intersectoral approach to resolving their health problems. Community persons were concerned about the adequacy, safety and integrity of their community water supply - which is an issue that is in the domain of the Ministry of Public Utilities & WASCO; the state of their environment - many complaining about rubbish being strewn by stray dogs or the infrequency of collection. Solid Waste Management and perhaps the Ministry of Local Government/Community Development should address these problems. Others were concerned with the use of chemicals by farmers and how this was polluting the environment and water supply - problems that should be taken up with the Ministry of Agriculture, Fisheries and Environment.

It was established earlier in the document that intersectoral collaboration is best fostered at the community level, and this remains true. However, given the nature of some of the problems, an inter-Ministerial committee, consisting of the ministerial chief technical officers, CEO's of WASCO & SLWMA seems like a good idea. It is expected that the existing committee of Permanent Secretaries could also become active in this area being driven and supported by the technical officers committee. We anticipate that if these two high level committees could be made to function effectively, much intersectoral collaboration would occur and indeed the Cabinet would probably find itself relieved of many mundane issues.

HEALTH IMPROVEMENT COMMITTEES IN COMMUNITIES

We need to support the establishment of community health improvement committees operating at the level of the health centre to allow the community ongoing contribution to the development of health in the community from the beginning. These committees are to provide a forum for communities to identify issues, propose solutions, implement solutions and monitor results. These committees, which will be established and maintained by the community nurse, will need support from local government regional officers, community organisations, the respective Ministries and the inter-Ministerial committees. Channels of communication from health improvement committees will need to be established and may vary depending on the community, the local government structure and the development of local government in that community. One of the first tasks of the committee will be to identify the necessary support required for its function and the channels of communication required. The Ministry of Health as the initiator of this system needs to ensure that the support is established. The inter-Ministerial committees will be useful forums to assist in this area.

DETAILS OF THE ACTIVITIES AND THE INCREASE IN THE RECURRENT COSTS OF THE PROPOSED REFORMS

SUMMARY TABLE

NAME	RECURRENT COST - TOTAL FOR 3 YRS	RECURRENT COST - YEAR 1
I. Corporate Planning	$626,416	$396,484
II. Agency Administration	$335,124	$231,800
III. Environmental Health Services	$272,333	$133,533
IV. Mental Health Services	$1,154,058	$404,608
V. Saint Jude Hospital	$869,948	$579,946
VI. Victoria Hospital	$1,938,402	$1,531,275
VII. Human Services & Family Affairs	$772,688	$220,301
VIII. Gros Islet Polyclinic	$896,057	$646,768
IX. Primary Care Services	$1,376,700	$295,000
X. Soufriere Hospital	$247,397	$97,758
XI. Shelter for women and children	$260,147	$260,147
XII. Dennery Hospital	$391,236	$157,056
XIII. Gender Relations	$20,000	$20,000
	$9,160,509.00	$4,974,677.00

I. CORPORATE PLANNING

ACTIVITY	IMPLEMENTATION DATE	COST AND DURATION
Hire Chief Planner	August 2000	$35,466 (53,200)
Hire Health Planner II	August 2000	$35,370 (42,444)
Hire Research Officer	August 2000	$35,317 (39,989)
Hire Social Planning Officer	August 2000	$34,163 (40,996)
Hire Quantity Surveyor	August 2000	$35,370 (42,444)
Hire Legal Officer	August 2000	$35,466 (53,200)
Hire Information manager	November 2000	$21,000 (50,414)
Hire Quality Co-ordinator	November 2000	$19,905 (47,774)
Hire Biomedical Engineer	August 2000	$33,610 (50,414)
Hire 4 Maintenance officers (refrigeration technician, plumber, maintenance technician, biomedical technician)	November 2000	$46,700 (112,000)
Hire Secretary	August 2000	$17,117 (20,541)
Travel Allowance		$24,000
Quality assurance programme	November 2000	$25,000
Technical Assistance In Information and quality systems	July 2000	
Integrate epidemiology and statistics into unit	April 2000	

TOTAL COST FOR INITIATIVE: $627,416

TOTAL OPERATING COSTS

Items	Year 1	Year 2	Year 3
Number of Staff	14	-	-
Personal emoluments	$347,484	$205,932	-
Wages/Travelling	$24,000		-
Operating Costs	$25,000	$25,000	-
Total Cost	$396,484	$225,932	-

II. AGENCY ADMINISTRATION

ACTIVITY	IMPLEMENTATION DATE	COST AND DURATION
Hire Executive Directors – North - South	April 2000 April 2001	$75,600 $75,600
Hire Medical Directors	June 2000 April 2001	$85,000 (upgrade MS) $100,000 (upgrade MS)
Hire Nursing Directors – North - South	June 2000 April 2001	$16,200 (upgrade of PNO III) $16,200 (upgrade of PNO III)
Convert HA III to Assistant Director, Administration	April 2000 April 2001	NAC NAC
Hire Assistant Directors (Human Resource)	April 2000 April 2001	$5000 (upgrade DHA) $47,774
Hire Information managers (2)	April 2001	$95,550
Implement new Organisational structure	April 2000	
Make legislative Amendments	April 2000	Capital initiative
Office furniture, computers, fax machines and communications, office supplies	April 2000	$50,000

TOTAL COST FOR INITIATIVE: $566,924

TOTAL OPERATING COSTS

Items	Year 1	Year 2	Year 3
Number of Staff	3	6	-
Personal emoluments	$181,800	$335,124	-
Wages			
Operating Costs	$50,000	-	-
Total Cost	$231,800	$335,124	-

III. ENVIRONMENTAL HEALTH

ACTIVITY	IMPLEMENTATION DATE	COST
Hire Director of Environmental Services	May 2000	$48,533 (53,200)
Convert CEHO to Assistant Director Administration	May 2000	NAC
Hire seventeen Environmental Health Aides	October 2000 (5) April 2001 (5) April 2002 (7)	$35,000 $70,000 $110,800
Legislative reform	May 2000	Capital initiative
Implement new Organisational structure	April 2000	
Make legislative Amendments	April 2001	
Office equipment and supplies	May 2000	$50,000

TOTAL COST FOR INITIATIVE: $272,333

TOTAL OPERATING COSTS

Items	Year 1	Year 2	Year 3
Number of Staff	7	5	7
Personal emoluments	$83,533	$70,000	$118,800
Wages	-	-	-
Operating Costs	$50,000	-	-
Total Cost	$133,533	$70,000	$118,800

IV. MENTAL HEALTH SERVICES

ACTIVITY	IMPLEMENTATION DATE	COST AND DURATION
Hire Mental Health Services Administrator	April 2001	$53,200
Convert HA II to Assistant Mental Health Services Administrator	April 2001	$7,000
Create And Hire 2nd psychiatrist	April 2000	$80,000
Upgrade Director Turning Point	April 2001	$5,000
Upgrade PNO II to PNO III	April 2000	$5,000
Hire fifteen psychiatric nurses	April 2000 April 2001 April 2002	$144,180 $144,180 $144,180
Train five mental health practitioners	April 2002	$199,905
Hire a clinical psychologist	April 2000	funded
Hire two psychotherapists	April 2000 April 2001	funded $41,537
Hire three counsellors	April 2002	$135,000
Hire two Occupational Therapists	April 2000 April 2001	$31,428 $31,428
Hire and activation of storekeeper II	April 2000	funded
Hire four (4) Domestic Assistants	April 2000	$40,000
Hire five (5) ward orderlies	April 2000	$56,000
Transportation allowance	April 2000	$48,000
Develop Information systems and other programme development support	April 2001-March 2003	Capital initiative
Legislative reform	May 2000	Capital initiative
Implement new Organisational structure	April 2000	
Make legislative Amendments	April 2001	

TOTAL COST FOR INITIATIVE: $1,154,058

TOTAL OPERATING COSTS

Items	Year 1	Year 2	Year 3
Number of Staff	18	7	13
Personal emoluments	$356,608	$270,345	$479,085
Wages/Travelling	$48,000		
Operating Costs	-	-	-
Total Cost	$404,608	$270,345	$479,085

V. SAINT JUDE HOSPITAL

Objectives	Activities	Time	Cost
1. Improve Management & Administration	1.1 Finalise contract with Sisters of Mercy for three years	April 2000- 2002	Subject to negotiation
	1.2 Implement organisational structure as outlined in Southern region	April 2000	NAC
	1.3 Develop policies, procedures and guidelines in conjunction with ED - North and MOH	July 2000	Allow $2000
2. Improve Information system	2.1 Develop information system in conjunction with Northern region and IPU	August 2000	Capital initiative
	3.1 Develop human resource plan	October 2000	No cost
	3.2 Implement plan	October 2000	TBD
	4.1 Establish QA committee working with hospital and community	June 2000	$2000
3. Improve human resource management	4.2 Develop Medical staff policies in conjunction with – Northern region and MOH	October 2000	No cost
4. Improve quality systems and regulation	4.3 Develop Hospital legislation and regulations in conjunction with Northern region and MOH	January 2001	Funded in Victoria Hospital plan
	4.4 Develop Medical Staff by-laws and regulations in conjunction with CCS-North and MOH	January 2001	Funded in Victoria Hospital plan
	4.5 Develop proper contracts with doctors	May 2000	No additional cost (dependent on negotiations)
	4.6 Establish provider agreements as part of budget and contract agreements	April 2000	No additional cost
5. Improve equipment status	5.1 Perform equipment inventory	June 2000	$1000
6. Improve middle management	5.2 Develop maintenance plan	June 2000	
	6.1 Conduct middle management “on the job” training	June 2000 and on	Grant funds from PAHO to develop program (to be conducted at Sir Arthur Lewis)
7. Improve Emergency Services	7.1 Create 7 EMT posts and fill	July 2000 (4) April 2001 (3)	$79,960 $59,960
8. Improve general clinical services	8.1 Hire eight staff nurses	April 2000 (4) April 2001 (4)	$115,032 $115,032
	8.2 Hire three RNA’s	April 2000	$48,968
	8.3 Hire cytotechnologist	April 2000	$33,800

	8.4 Hire Physiotherapist	April 2000	$33,860
	8.5 Hire four consultants – three family practitioners and one orthopaedic surgeon	April 2000 (2) April 2001 (2)	$115,000 $115,000
	8.6 Hire one Accounts clerk	April 2000	$19,624
	8.7 Hire two junior clerks	April 2000	$28,712

TOTAL COST OF INITIATIVE: $869,948

TOTAL OPERATING COSTS

Items	Year 1	Year 2	Year 3
Number of staff	18	9	
Personal Emoluments	$474,956	$289,992	
Wages			
Operating costs	$5,000		
TOTAL COST	$579,956	$289,992	

VI. IMPROVING MANAGEMENT & SERVICES AT VICTORIA HOSPITAL

	Activities	Time	Costs
1. Improve senior management	1.1 Create HA IV post and hire HA IV	April 2001	Upgrade $6000
2. Improve human resource management	2.1 Develop human resource plan	October 2000	No cost
	2.2 Implement plan	October 2000	To be determined
	2.3 Implement free medical care for ancillary staff	April 2000	
3 Improve health information	3.1 Hire Statistical Assistant IV	April 2000	$31,428
	3.2 Upgrade to Statistical Assistant I	April 2000	$12,800
	3.3 Design Hospital Information system	October 2000	Capital initiative
	3.4 Develop & Implement HIS	April 2001 April 2002	Capital Initiative
4 Improve institutional regulation and quality assurance	4.1 Establish QA committee	April 2000	$2000
	4.2 Implement interim Organisational structure	Dec 1999	No cost
	4.3 Develop Hospital Policies	May 2000	No cost
	4.4 Develop Medical staff policies	May 2000	No cost
	4.5 - Develop Hospital legislation and regulations - Develop Medical Staff by-laws and regulations	January 2001	Capital Initiative
	4.6 Develop proper contracts with doctors	April 2000	No additional cost (dependent on negotiations)
	4.7 Establish provider agreements as part of budget agreements	April 2000	No additional cost
5. Improve equipment status	5.1 Perform equipment inventory	December 1999	$1000
	5.2 Develop maintenance plan	June 2000	
	5.3 Purchase X-Ray machine	June 2000	Capital
6. Improve middle management	6.1 Conduct middle management “on the job” training	June 2000 and on	Grant funds from PAHO to develop program (to be conducted at Sir Arthur Lewis)
7. Improve services	7.1 Oncall for maintenance staff	April 2000	$11,000
	7.2 Activation of seven medical technologists posts	April 2000 (2) April 2001 (5)	$43,092 $107,730
	7.3 Implement new staff structure and with nomenclature changes	April 2000	No cost
	7.4 Contract second orthopaedic surgeon	April 2000	$120,000
	7.5 Contract third surgeon	April 2000	$120,000
	7.6 Contract Senior Registrar (O&G)	April 2000	$78,000

	7.7 Contract Third Internist	April 2000	$80,000
	7.8 Contract 2nd A&E Consultant	April 2000	$120,000
	7.8 Increase in non-clinical support staff (6 orderlies, 3 domestic assistants and 4 laundry maids)	April 2000	$116,015
	7.9 Hire 15 RNs Hire 15 RNAs	April 2000 April 2001	$435,000 $246,190
	7.10 Hire 3 Night Supervisors	April 2000	$127,332
	7.11 Medical Social Work	April 2000	Funded in HS&FA
	7.13 Maintenance staff	April 2000	Funded in corporate planning
	7.14 Hire 3 EMTs Hire 6 first responders	April 2000 April 2000	$41,586 $59,152

TOTAL COST OF INITIATIVE: $1,938,402

TOTAL OPERATING COSTS

Items	Year 1	Year 2	Year 3
Number of Staff	58	20	-
Personal emoluments	1,528,275	$407,127	-
Wages	-	-	-
Operating Costs	3000	-	-
Total Cost	$1,531,275	$407,127	-

VII. HUMAN SERVICES & FAMILY AFFAIRS

Objectives	Activities	Time	Cost
1. Improve Management	1.1 Upgrade Director HS, FA to grade 18 and fill post - contract	April 2000	$2800
	1.2 Activate and fill social work supervisor post grade 16 and change name to supervisor human services & family affairs - contract	April 2001	$47,757
	1.3 Activate senior field social worker grade 15 and assign services for elderly and disabled to this officer	April 2000	$45,100
	1.4 Implement new organisational structure	April 2000	NAC
2. Improve family case worker services	2.1 Fill FCW III post, grade 14, and create unit of specialised FCW in child and family services	April 2001	$42,444
	2.2 Train FCWs in areas of child care & protection (1), adolescent care (1), family care (1) & domestic violence (2) and fill these five posts thereby creating the unit of child & family services	April 2000 (2) April 2001 (2) April 2002 (1)	$74,260 $74,260 $37,130
	2.3 Assign one general FCW to each polyclinic with regional responsibility	April 2000	NAC
	2.4 Hire an intake officer	April 2000	$20,541
	2.5 Train two medical FCWs and two psychiatric FCWs and assign one medical and one psychiatric to each region	April 2001 April 2002	$5,600 $5,600

3. * Implement Integrated child care & protection programme * ALL COSTS IN 2000-2001 WILL BE MET BY EDF	3. Implement integrated child care and protection programme inclusive of: - transit home for children in crisis - children's services support programme ($146,250) - national child abuse prevention and parenting education programme ($109,100) - juvenile offenders and young persons programme ($142,850) - community based health care programme for vulnerable children ($36,500) - treatment and support for victims of violence and traumatised persons ($51,400)	April 2000 " " " April 2001 " "	PS	1. House Mother ($45,100) 2. 4 security guards ($41,000) 3. 5 house assistants ($65,200) 4. Operations ($79,650) 1. Foster parents training ($22,000) 2. Emergency Assistance ($21,000) 3. Public Education ($13,800) 4. Abuse registry development & support ($12,000) 5. BTC programme ($39,200) 6. Upton Gardens programme ($38,240) 1. Community outreach and parenting programme ($23,500) 2. Lobby & protection workshops ($10,000) 3. Child abuse management workshops ($25,600) 4. Staff training on child welfare (overseas) ($50,000)	Ongoing Capital Building, furniture, transit home – ($865,000)

4. Improve public assistance/social welfare services	4.1 Create and hire two additional welfare officers and assign officers (six) to each of the polyclinic regions (5) with a central, senior officer (welfare officer III)	April 2000	PS	$74,260	Ongoing
5. Operating expenses	Fire Extinguishers, Air Conditioning servicing, Sanitation	April 2000	DHS &FA	$3,350	Ongoing

TOTAL COST OF INITIATIVE: $772,688

TOTAL OPERATING COSTS

Items	Year 1	Year 2	Year 3
Number of Staff	6	13	1
Personal emoluments	$216,961	$278,917	$42,730
Wages			
Operating Costs	$3,340	$230,740	
Total Cost	$220,301	$509,657	$42,730

VIII. GROS ISLET POLYCLINIC

Objectives	Activities	Time	Cost
1. Establish polyclinic administration & general support	1.1 Contract HA III	April 2001	$47,757
	1.2 Assign PNO II	April 2000	NAC
	1.3 Hire 1 Secretary IV	April 2000	$28,188
	1.4 Hire 1 handyman	April 2000	$9,900
	1.5 Hire Cashier	April 2000	$13,156
2. Establish 24hr ambulance service linked to VH	2.1 Hire 7 Emergency Medical Technicians	April 2000 (4) April 2001 (3)	$79,960 $60,000
3. Establish general clinic services (daily), support for primary care services of linked health centres and polyclinic primary care services	3.1 Hire 1 SMO	April 2000	$60,000
	3.2 Hire 1 DMO	April 2000	$45,000
	3.2 Assign 3 FNPs	April 2000	NAC
	3.3 Assign 3 District Nurses	April 2000	NAC
	3.4 Hire 12 Registered Nurses	April 2000 (8) April 2001 (4)	$230,064 $115,032
	3.5 Assign 3 CHAs	April 2000	NAC
4. Establish Dental services	4.1 Assign 1 dentist	April 2000	NAC
	4.2 Assign 1 dental nurses	April 2000	NAC
	4.3 Assign 1 dental assistants	April 2000	NAC
5. Establish professional support services and other specialist services	5.1 Assign 1 field nutrition officer	April 2000	NAC
	5.2 Assign 1 Health Educator	April 2000	NAC
	5.3 Assign 1 psychiatric nurse	April 2000	Funded under mental services
	5.4 Assign 1 family case worker	April 2000	NAC
	5.5 Assign social welfare officer	April 2000	NAC
	5.6 Assign 2 Environmental Health Officers	April 2000	NAC
	5.7 Assign 2 Medical Laboratory Assistants	April 2000	NAC
	5.8 Hire 2 radiographers	April 2000 April 2001	$26,500 $26,500
	5.9 Assign two pharmacists	April 2000	NAC
6. Operating costs, construction and training	6.1 Operating costs	April 2000	$150,000
	6.2 Train three multipurpose technicians	April 2001	TBD
	6.3 Train Mental health practitioner	April 2001	Mental Health Services
7. Develop Information system	7.1 Work with health information managers at IPU and hospitals to design and implement information system	April 2001	Capital initiative

8. Develop shared general services – transportation, maintenance, security, cleaning, kitchen & laundry 9. Establish quality systems	7.2 Develop "household folder" with health centres	April 2000	Capital initiative
	8.1 work with other regional institutions to develop these services	April 2000	
	9.1 Develop quality circles including polyclinic and health centre key personnel, work with quality co-ordinator and regional QA committees	July 2000	Allow $2000
	9.2 Develop policies, procedures and guideline in keeping with regional policy and procedures, and clinical protocols as developed by specialists	October 2000	Allow $2000

TOTAL COST OF INITIATIVE: $896,057

TOTAL OPERATING COSTS

Items	Year 1	Year 2	Year 3
Number of Staff	19	9	-
Personal emoluments	$492,768	$249,289	-
Wages			
Operating Costs	$154,000		
Total Cost	$646,768	$249,289	

IX. PRIMARY CARE SERVICES

Objectives	Activities	Time	Cost
1. Improve primary care services operations, establish primary care teams operating out of each health centre and provide twenty four hour access to a nurse in the community.	1.1 Hire one public health nurse supervisor (housed at a polyclinic)	April 2000	$40,000
	1.2 Hire six Family Nurse Practitioners (to be housed at polyclinics)	April 2001 April 2002 April 2003	$80,000 $80,000 $80,000
	1.4 Upgrade of Community Health Aides to $965/month	April 2000	$120,600
	1.5 Transportation allowance to Community Health Aides (100/month)	April 2000	$80,400
	1.6 Training of Community Health Aides in social work and rehabilitation	June 2000	Funded
	1.7 Training of community health nurses in management and upgrade to public health nurses	Over three years starting June 2000	Source PAHO support
	1.8 On call allowance for thirty four community nurses	April 2001	$625,000
	1.9 Hiring of 23 CHAs	April 2001 (12) April 2002 (11)	$150,700 $146,000
	1.10 Support for development of community participation	April 2000	$52,000
2. Develop Information system	2.1 Work with health information managers at Planning and Information Unit and hospitals to design and implement information system	April 2001 April 2002	Capital Initiative
3. Develop shared general services – transportation maintenance, security, cleaning, kitchen & catering	2.2 Develop “household folder”	April 2000	Capital initiative
	3.1 work with other regional institutions to develop these services	April 2000	
4. Develop quality systems	4.1 work with polyclinic quality circle to ensure development and implementation of policies, procedures and guidelines	April 2000	Allow $2000

TOTAL COST OF INITIATIVE: $1,376,700

TOTAL OPERATING COSTS

Items	Year 1	Year 2	Year 3
Number of Staff	1	14	13
Personal emoluments	$241,000	$230,700	$226,000
Wages		$625,000	
Operating Costs	$54,000		
Total Cost	$295,000	$855,700	$226,000

X. SOUFRIERE HOSPITAL

Objectives	Activities	Time	Cost
1. Improve administration	1.1 Train Senior Executive Officer for upgrade to HA III – contract	April 2000	$16,330
	1.2 Hire PNO II	April 2000	$40,000
2. Establish 24 hr. ambulance services linked to Saint Jude Hospital	2.1 Hire seven Emergency Medical Technicians	April 2001 (4) April 2002 (3)	$79,960 $59,679
	3.1 Assign 3 Family Nurse Practitioners	April 2000	NAC
	3.2 Assign 1 dental nurses	April 2000	NAC
3. Improve general clinic services, professional support, primary care support and primary care services.	3.3 Hire 1 dental therapist	April 2000	$31,428
	3.4 Assign 1 Family case worker	April 2000	NAC
	3.6 Assign social welfare officer	April 2000	NAC
	3.7 Assign 1 field nutrition officer	April 2000	NAC
	3.8 Assign 1 Health Educator	April 2000	NAC
	3.9 Train a mental health practitioner	April 2002	Mental Health Services
	3.10 Hire a psychiatric nurse	April 2000	Funded under mental services
4. Establish X-Ray services	4.1 Assign a radiographer temporarily until multipurpose technician trained	July 2001	$10,000
5. Train three multipurpose technicians	4.2 Purchase basic X-Ray machine	April 2001	Capital
	5.1 Create multipurpose technician posts and train the two Medical laboratory assistants	Start Sept 2000 and train one per year	$10,000
6. Develop information systems	6.1 Work with health information managers at PIU and SJH to develop and implement information systems	April 2000-2002	Capital initiative
7. Develop shared services – maintenance, transportation, security, cleaning, kitchen and catering	7. Work with other regional institutions to develop these services jointly	July 2000	

TOTAL COST OF INITIATIVE: $247,397

TOTAL OPERATING COSTS

Items	Year 1	Year 2	Year 3
Number of Staff	4	5	3
Personal emoluments	$97,758	$89,860	$59,679
Wages			
Operating Costs			
Total Cost	$97,758	$89,960	$59,679

XI. DENNERY HOSPITAL

Objectives	Activities	Time	Cost
1. Improve Administration	1.1 Train PNO II to upgrade to HA III	April 2000	$17,757
	1.2 Hire PNO I	April 2000	$39,981
	1.3 Activate clerk III	April 2000	$17,949
	2.1 Assign 3 FNPS	April 2000	NAC
	2.2 Hire three nurse/midwifes	April 2000 (1) April 2001 (2)	$37,130 $74,260
2. Improve general clinic services & primary care services	2.3 Assign one additional DMO	April 2000	NAC
	2.4 Assign 1 FCW	April 2000	NAC
	2.5 Assign 1 health educator	April 2000	NAC
	2.6 Hire MLA	October 1999	NAC
	2.7 Assign field nutrition officer	April 2000	NAC
	2.8 Hire seven EMTS	April 2001 (4) April 2002 (3)	$79,960 $59,960
3. Review existing structure and examine options for relocation	3.1 Conduct feasibility for relocation	July 2001	$20,000
4. Develop new programmes to support new prison population & Develop Information system	4.1 Establish the multidisciplinary team with the necessary tools and information systems	April 2001 April 2002	Capital initiative
5. Develop shared services – maintenance, transportation, security, cleaning, kitchen and catering	5.1. Work with other regional institutions to develop these services jointly	April 2000	

TOTAL COST OF INITIATIVE: $391,236

TOTAL OPERATING COSTS

Items	Year 1	Year 2	Year 3
Number of Staff	3	6	3
Personal emoluments	$157,056	$154,220	$59,960
Wages			
Operating Costs		$20,000	
Total Cost	$157,056	$174,220	$59,960

XII. SHELTER FOR ABUSED WOMEN & CHILDREN

Objectives	Activities	Time	Cost
1. Shelter Administration and support	1.1 Hire shelter manager 1.2 Hire five fulltime counsellors 1.3 Hire three part-time counsellors 1.4 Hire one senior counsellor 1.5 Hire one gardener	April 2000	$47,747 $72,000 $22,000 $35,000 $8,400
3. Operating costs	3.2 Utilities, supplies etc.	April 2000	$75,000

TOTAL OPERATING COSTS

Items	Year 1	Year 2	Year 3
Number of staff	11		
Personal Emoluments	$185,147		
Wages			
Operating costs	$75,000		
TOTAL COST	$260,147		

XIII. GENDER RELATIONS

Objectives	Activities	Time	Cost
1. Improve Management	1.1 Fill Director of Gender Relations post	April 2000	NAC
2. Review legislation on gender violence and sexual offences		April 2000	NAC will be done as part of criminal code review
3. Develop programme of assistance to NGO involved in Gender issues	4.1 Assistance to New Frontier and Crisis Centre	April 2000	$20,000

TOTAL COST OF PLAN - $20,000

CONCLUSION

Health sector reform as proposed is a purposeful evolution of systems and services. The process starts with the organisation of the sector into a flexible, disciplined service. The proposed organisation of service is able to accommodate two general hospitals or a single national hospital or any variation of this. The mechanisms proposed institutionalise the needs of the patients and community by formalising community participation in the development of services and in the delivery of services. The reformed services will address the following concerns expressed by the people and health workers:

1. Increased access to health services:

The communities want more sophisticated health services closer to them and more available at all times. This desire has to be balanced against resource limitations and resources required for more sophisticated health services.

Reform proposes that health centres should be re-programmed to be health development units and these units should work with the community, other government agencies and non-governmental organisations involved in community and health development. Every community will have nursing services available at all times, during regular working hours at the health centre and after hours the nurse living in the community will be on-call to meet the community needs in terms of triage.

Every Health Centre is supported by a polyclinic. Reform proposes five polyclinics strategically located – Gros Islet, Castries, Dennery, Soufriere, Vieux Fort. These polyclinics offer regular doctors clinics Monday to Friday all day and Saturday morning. They also offer twenty-four hour ambulance services and Family Nurse Practitioner services after hours supported by the respective hospital service. These polyclinic services are supported and co-ordinated by the hospital services in the region. Every polyclinic is attached to a Hospital. This system means that a patient will receive the appropriate level of care for his/her condition at whatever level the patient enters the service. Patients do not need to think about where they have to go. They merely have to arrive at the nearest polyclinic or go through their community nurse, living in their community. Polyclinics will also bring specialised services closer to the community, by offering regular specialist clinics and specialist services, e.g. minor surgery. Polyclinics will offer x-ray, laboratory and pharmacy services thereby providing the necessary support for proper diagnosis and treatment at these polyclinics. Patients will only have to travel as far as the nearest polyclinic for these services. The polyclinic houses a variety of workers with different skills, allowing the development of a multidisciplinary team and service.

The involvement of the community with the health centre staff will allow the development of services tailored to the community needs, and will provide for ongoing evolution of these services. The polyclinic services will be developed to meet the needs of the health centres thus developing the polyclinic services in a similar sensitive fashion. In addition the polyclinics determine the type of hospital services to be developed. Thus this system proposed results in mutual support and a cascading programming of services to meet the

needs of the individual communities with the communities constantly driving the refinements and evolution of services.

The pooling of resources in the regional system proposed will allow the development of a multidisciplinary approach with a more appropriate deployment of human and other resources. This will translate not only into better services but also more empowered, confident health workers who will also have better attitudes. The system proposed creates clarity of roles and responsibilities and also creates clear accountability. These attributes also result in a better worker attitude. In addition accountability allows for appropriate disciplinary action when necessary.

A patient's charter of rights will be developed such that everyone can know exactly what to expect in terms of service.

Reform proposes heavy investment in mental health services, in particular the development of community-based services. It must be noted that the mental services will be delivered along side other services, in the same institutions, in the same multidisciplinary way. There is an increased emphasis on counselling and other psychological services as adjuncts to existing psychiatric services. There is also an emphasis on early detection and detection of persons at risk to allow early intervention and the development of preventative services. It is anticipated that this approach will slowly but surely change the attitude of people to mental disorders and disability. The use of family case workers, community health aides, mental health practitioners, psychiatric nurses and community nurses as front line workers in this area of creating mental and social wellness needs to be highlighted as a critical component of the reformed health service.

The environmental health services will be approached in a similar multidisciplinary and community co-operative way with the environmental health officers being resident at polyclinics and moving within the community served. The health centres serve as monitors of the environmental health and platforms for action within the community. At the higher level of the central Government, environmental health will be given a greater voice to advocate for intersectoral and public action by contracting a qualified director of environmental health services, who will have a supportive information system and communication system.

The primary care services are seen by reform as the focus of the health service. These services are the ones that will create communities of people who are mentally, physically and socially well. This is why reform proposes heavy investment in this area of the service. The identification of the health centre as the unit responsible for primary care allows for more holistic, targeted strategies aimed at achieving the goals outlined for the primary care services. The central Ministry will also develop programmes that will guide the strategies to be employed for the major public health problems (diabetes, hypertension, cancer, injury, violence, sexually transmitted diseases and other infectious diseases). This approach allows for co-ordinated action employing effective strategies. It also allows for the necessary networking at central and community levels to implement the solutions. Health promotion will be delivered in a similar way, central co-ordination with decentralised

implementation. There will be considerable investment in school health and child health programmes in general. These health programmes will be holistic in terms of promoting mental, physical and spiritual wellness.

2. Improving quality and creating a system that guarantees quality

Reform proposes many strategies to improve quality and to guarantee quality. These include at the central level, the recognition that the Ministry of Health is the agency responsible for ensuring quality in the public and private sector. This demands that health legislation is drafted that ensures standards of care in both public and private sector. Licensing and accreditation will be implemented. Complementary practitioners will be brought into the regulatory system. An independent complaints commission will be established to rapidly address health complaints that are not resolved through the administrative system.

Continuous quality improvement will be implemented throughout the services and the Ministry will ensure central co-ordination, monitoring and auditing by contracting a quality co-ordinator and developing an integrated information system through the Planning Unit.

Budget agreements and contracts will be used as tools to ensure that performance standards are linked to funding, thereby creating incentive for quality service.

The quality of service is directly linked to the quality of the human resources. Health reform proposes investment in human resource management and development. This will be done by employing trained human resource managers at the central (Deputy Permanent Secretary) and regional (Human Resource Managers, north and south) levels. All administrators and all key services and management positions will be by contract to ensure that the leadership, management and service delivery can be guaranteed.

The people will experience a better quality service in the form of a more timely, more sophisticated and more responsive service.

3. Giving value for money

The proposed health sector will be one in which staff will be more easily mobilised and will make better use of existing staff.

Partnerships and networks will create synergy within the system and will cause mobilisation of presently “hidden” resources. This will have a cost benefit.

The system proposed is one of clear budget control and accountability which should result in cost containment.

Better management and the pooling of resources regionally will provide for better allocation of resources and more sharing of resources. This will result in a more cost-effective system.

When cost-efficiency is added to better quality service the result is “better value for money”. If people are given better value for money they are prepared to invest more of their money in the development of the service.

4. Equity in the service

Equity is an important principle in the reform process. The proposed system is equitable in that it decentralises services. It gives individual communities influence in determining how the health service develops.

The system also provides for equity in the allocation of resources by developing virtually identical regional services with responsibility for all services.

A publicly guaranteed package of services will be developed in conjunction with a patient’s charter of rights. This will guarantee that every Saint Lucian is assured of these health services.

5. Reduced burden of disease and more productivity

This is the ultimate goal of the service. We intend to provide a service that allows people to be well, mentally, physically and spiritually. We intend to develop a system that identifies people at risk of developing disease or social problems and intervenes to prevent the disease or problem. We intend to provide a service that detects diseases and social problems early and allows for rapid effective interventions to minimise the effect of the disease or problem. We intend to develop a system that rehabilitates people affected by disease or social problems.

The last paragraph encapsulates the reform process we propose which we expect will allow the development of a people who are safe, happy and productive.

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