Issues Raised During Meetings between Pharmacies, Doctors, Insurance Companies and Pharmaceutical Importers and the St. Lucia Chamber of Commerce Industry and Agriculture to discuss the Universal Health Care System

The purpose:

To hear the general concerns and how the UHC proposals would impact the different private sector players in the Health-Care sub-sector

To understand the threats and opportunities the UHC posed and offered to each sub sector

To explore suggestions on the structure or operation of the UHC.

Four financing proposals were mentioned:

1. An increase to the rate of the Environmental Levy
2. A Sin Tax (increased taxes on alcohol, tobacco)
3. An extra percentage or two on the VAT
4. All salaried workers pay like a PAYE

However, the understanding is that the funding will be via a health and environmental levy mechanism which will be used first and, a possible move to VAT in the future.

QUESTIONS/ISSUES RAISED

1. **WHAT PACKAGE OF SERVICES WILL BE INCLUDED FOR COVERAGE BY UHC? WHAT ARE THE LIMITATIONS WITH THE KIND OF SERVICES? WHAT WILL BE OFFERED AND WHAT WILL NOT BE OFFERED? E.G. OVERSEAS TREATMENTS, MEDICATIONS AND WHAT TYPES.**

Attached is the spreadsheet on the package of services and the draft on the pharmaceuticals to give the details. To understand the package of services it must be read with the understanding of the following:

a. UHC will cover every thing presently done in the public service but will add some additional services in particular in the area of overseas care to complement the local package.

b. The approach as detailed in the package is using diagnosis-treatment pairs. The diagnosis and number of interventions per diagnosis included in the package of services is as per the existing services using Saint Jude hospital as the baseline and extrapolating to the general population. This approach to the package of services is further fleshed out when read in conjunction with the clinical protocols for care as per the diagnosis. All protocols exist but not all are documented. The task is to document clinical protocols for every diagnosis, this will be done as part of the overall implementation of the quality improvement initiative as overseen by the Canadian

Council on Health Services Accreditation (CCHSA). The overseas care package is determined as outlined by the protocols of care and will be further elaborated as outlined above and as part of the output of a French funded study for the development of a cooperation strategy between Martinique and Saint Lucia.

c. The broad areas to be covered by UHC in the first phase is divided into a number of discrete modules as follows

- Hospital services including inpatient care and outpatient care as linked to the inpatient services
- Overseas care (as listed in the attached package and as will be detailed in the protocols of care)
- Mental health services as for the Hospital services
- Blood Bank Services
- Emergency care services from pre-hospital to hospital
- Pharmaceuticals as per the attached pharmaceutical list

d. The UHC will operate in a level health market place. Meaning that the providers include public and private without prejudice meaning without subsidies or incentives or disincentive.

e. The packages are inclusive meaning they are detailed in the annual negotiated service level agreement a draft prototype service level agreement will be available for discussion by August 2005.

f. The principles involved are universal access without financial or administrative barriers to the package of services. The package is limited and detailed in all areas. The package can be delivered by any qualifying provider. The package outlined in the negotiated service agreements includes types, volumes, and quality of services; it also will detail mutual reporting and auditing obligations. Of course it will detail funding levels. (Attached is an example of a service-funding agreement form New Zealand, our service agreements will follow a similar format but will be tailored to our setting and the services we will be funding as outlined above)

2. AT WHAT LEVEL WILL UHC FOCUS? PRIMARY CARE (PRIVATE PRACTICE) VS. SECONDARY CARE (HOSPITAL)?

UHC will focus initially on secondary and tertiary care services. However UHC will also be focused on the relationship between Community and Hospital Services to implement incentives (financial, quality and governing) to ensure that Hospital Services are driven to support and develop integrated care services with community. Hence the rationale for the capitated form of payment with the incentive of retention of surpluses by the local hospitals. Also the quality improvement (accreditation) initiative assesses hospitals on a number of parameters including their support for and involvement in community services. The governing boards and UHC committees will involve Community and Ministry of Health representatives and the service agreements will detail the obligations of the hospitals to community service support and development.

In the future with experience gained in the first phase we can develop and implement a community service module within the UHC.

3. **AT WHAT POINT WILL AND WHEN WILL THE PHARMACY BE REIMBURSED? (THIS COULD LEAD TO A CASH FLOW PROBLEM). WHAT SYSTEM IS IN PLACE FOR TIMELY REIMBURSEMENT?**

The reimbursement times will be as detailed in the service agreements, this is one of the obligations on the part of the UHC. There will be penalties and systems of redress for breaches in the agreement from either party. For example the agreement can detail good business practice and could indicate that reimbursement must be within 30 calendar days from the issue of a claim. Depending on the level of sophistication of the information system the claim could be from the time of entry into the system from the participating pharmacy.

4. **WHO WILL BE PROVIDING THE HARDWARE AND SOFTWARE IN ORDER TO EFFECTIVELY OPERATE UHC? UCH SHOULD FUND THIS TOTALLY.**

The UHC and the Ministry of Health are presently collaborating on the development and purchase of an information system. The details of costs and who bears these costs will have to be further elaborated however our intention is to have the system owned by the UHC and therefore UHC will be installing and control the copyright if it is a designed system. The issue of hardware is relatively minor in that the assumption is that the software will run on regular PCs at the level of the provider, many, if not all providers already have PCs which can be used and if there is need to purchase PCs than this can be built in. The more we build into the UHC is the greater the budget that needs to be raised from new sources. The approach should be one of working together to create a win-win situation.

5. **WILL GOVERNMENT PURCHASE THEIR OWN MEDICATION AND THEN THE PRIVATE SECTOR BUY FROM THEM?**

There are options here. The Private sector could:

- participate directly in the PPS system
- or the GOSL could purchase from PPS and private sector purchase from GOSL,
- or the UHC could purchase and private sector purchase from UHC.
- Or there could be a national pharmaceutical consortium including PPS, UHC, private companies and GOSL which could negotiate and purchase and the pharmacies purchase from the consortium.

There are proposals from the NPTC of the UHC which will be ready for circulation within the next month for our discussion.

The objectives are:

- To create a simple system using existing resources and mechanisms as much as possible.
- To minimize the cost of pharmaceuticals while maintaining quality.
- To maximize patient access to necessary pharmaceuticals

- To allow private providers to operate profitable businesses focused more on volume then on high prices.

6. **PPS: WILL DRUGS FOR THE PRIVATE SECTOR BE PURCHASED FROM THEM? THE USE OF THE PPS WILL RESTRICT IMPORTATION BY THE PRIVATE SECTOR. HOW RELIABLE AND DEPENDABLE IS THAT.**

The PPS offers a very reliable service. There is however, nothing wrong with us improving its reliability or developing alternative mechanisms that can achieve our stated objectives.

7. **CLARIFICATION NEEDED AS TO THE PPS AND ITS IMPORTATION OF GENERIC DRUGS. BUT WILL THERE BE A RESTRICTION ON PHARMACIES PROCESSING BRAND DRUGS. PROBLEM: THERE WILL BE 2 OPTIONS WHEN PURCHASING DRUGS. THIS MAY RESULT IN DECREASE IN BUSINESS FOR DOCTORS AND PHARMACIES.**

The PPS has a policy of multisource drugs rather than generic. It is true that generic drugs form the bulk of their products. There are however WTO agreements that will impact on access to some generics. The UHC's stated objectives (modified as per consultations with private providers) do not discriminate against brand drugs. The issue will be how we can work with manufacturers and bulk retailers to achieve our objectives. There should not be a decrease in business, quite the opposite business volume will increase since more people will now have access to pharmaceuticals in the private sector. The task ahead is for us to work together to make it happen in the best interest of all, yes there will have to be compromise on both sides, and yes both sides will have to let go of certain ways of doing business, but with the right spirit and approach it could be phenomenally successful. Remember the objective for UHC is for the public to have access to the most effective drugs at the best price.

8. **PPS WILL SET RETAIL PRICE. MARK UP WILL BE DECIDED BY RELEVANT STAKEHOLDERS. THERE WILL BE ROOM FOR NEGOTIATIONS. PPS SOMETIMES RUN OUT OF BASIC MEDICINE THEREFORE HOW CAN WE PUT ALL THIS IN THEIR HANDS? THERE SHOULD NOT ONLY BE ONE SUPPLIER OF MEDICINE IN THE ISLAND BECAUSE OF THE THREAT OF SHORTAGES. (NOTE E.G. TRINIDAD) PRIVATE PHARMACIES SHOULD BE ABLE TO IMPORT DRUGS WITH NO LIMITED RESTRICTIONS.**

As stated above there can be options and alternatives, UHC is not averse to discussing and implementing different strategies, once our stated objectives are met.

9. **WHY UHC? WILL IT LEAD TO AN IMPROVEMENT OF THE HEALTH SERVICES? WILL THE COSTS OF MEDICATION DECREASE?**

UHC is necessary because there is a need to change the existing discriminatory, wasteful and poorly structured and poorly controlled mechanisms. UHC is a mechanism that will:

- adequately finance secondary and tertiary care services
- create universal access for the population to necessary health services
- establish a sensible and flexible mechanism for cost containment and rationing of health services
- prevent the bleeding of resources from community services and allow the GOSL to "ring-fence" community (including primary care) budgets
- create incentives (forces) to cause integrated care and support for community from hospital.
- create a quality improvement system in the health sector
- create a regime of sensible and flexible control of the health sector
- remove public private discrimination and allow an open health market place in which providers can operate
- create a system of decentralized authority that make public and private providers operate using good business practices and compete to achieve stated health objectives.
- achieve all the above and therefore will cause a significant (radical) improvement in health services and the costs of medications will decrease.

10. **WHAT IS THE TIME FRAME FOR THE IMPLEMENTATION OF UHC?**

18-24 months from April 2005. There are a number of critical events that must occur before UHC can be implemented viz. The establishment of:-

- the information system (consultancy ongoing now),
- the funding mechanism,
- the public hospital governing structures,
- the legislation
- human resource capacity building (training)

11. **WILL THERE BE A TRANSITION PERIOD?**

We are now in the transition period. This is the time for all to be involved in the design of policies and procedures.

12. **THERE WILL BE AN EXTRA 5% ENVIRONMENTAL LEVY ON PRIVATE SECTOR BUSINESS YET THERE WILL BE LOSS OF BUSINESS BECAUSE PHARMACIES WILL GO UNDER AS VOLUME OF BUSINESS WILL DECREASE AND PRICES WILL BE INCREASED NOT ONLY ON PHARMACY ITEMS BUT GROCERIES AS WELL.**

As stated before volume of business will go up not down in the pharmacies. The levy can be applied in a sensible manner as it is now. Essential items such as certain

pharmaceuticals and certain food items can be exempted. A socio-economic impact assessment of the UHC is now being done by the EU funded consultants. However by covering the necessary health expenses for all families in Saint Lucia there are many families that will have more disposable income this should have a positive impact on business in general. There is no doubt that the cost of certain items will go up. We await the results of the study to better evaluate what might happen.

13. **THERE SHOULD BE PRESCRIPTION FEE BECAUSE SERVICE TIME WILL INCREASE AS THE PAPER WORK REQUIREMENT OF THE UHC WILL BE SIGNIFICANT.**

Paperwork may not be increased; it depends on the system and procedures that are implemented. UHC will require documentary evidence of the prescription which is presently collected or the portion that was filled by the pharmacy (this is presently done by each pharmacy). The system may be electronic with a printed signed paper copy that follows etc. In other words the UHC is unlikely to require any more than is presently required in a well run pharmacy.

14. **IT WOULD APPEAR THAT UHC WOULD IMPOSE THE MORE EXPENSIVE MEDICAL COSTS ON THE PRIVATE SECTOR, WHILE IT WILL ONLY DEAL WITH THE LESS COSTLY TREATMENTS; INSURANCE COMPANIES SHOULD BE MADE AWARE OF THIS.**

The UHC is covering the basic necessary services. This is the bulk of health services that includes many of the more common expensive health treatments including some overseas care. UHC is taking much of what the insurance companies have indicated that makes them marginal or at a loss in the private health insurance industry. The private health insurance companies are welcome to tender for the overseas care package management. The private insurance will also be able to offer the services not covered by UHC and ensure their own profitability by marketing for choice (which is limited in UHC) and all services not covered that persons will want (e.g. private practitioner visits, private dental and eye care, certain outpatient diagnostic services (some labs and X-rays), low probability high cost interventions e.g. transplants etc.)

15. **SALARIED WORKERS ALREADY CONTRIBUTE TO TAXES THAT GO TO THE HEALTH SECTOR, ALSO, SOME OF THESE WORKERS HAVE HEALTH INSURANCE FROM WHICH THEY RECEIVE MORE HEALTH CARE COVERAGE FROM WHAT THEY WOULD RECEIVE FROM UHC. YET THEY WOULD HAVE TO PAY AN ADDITIONAL TAX TO UHC. THIS APPEARS TO BE GROSSLY UNFAIR, THEREFORE FUNDING THROUGH A VAT WOULD BE A BETTER AND MORE EQUITABLE SYSTEM TO USE.**

The funding mechanism being proposed is a universal transaction based tax like VAT or the environmental levy. We agree that salary deductions would be unfair.

16. **WHAT IS THE SCOPE OF THE BENEFITS OF UHC?**

This is covered in the answer to question 1.

17. **WILL EXISTING INSURANCES COMPANIES BE ALLOWED TO BID FOR PROVISION OF INSURANCE SERVICES?**

Yes as indicated above and any other module e.g. pharmaceutical if private insurance can provide the service more efficiently and effectively than UHC.

18. **MANAGEMENT OF HEALTH SERVICES IS VERY SPECIALIZED AREA, WILL EMPLOYEES OF PRIVATE INSURANCE COMPANIES BE POACHED OR WILL THE UHC SEEK HELP FROM OPERATING COMPANIES FOR TRAINING ETC.**

UHC is to a great extent not operating like private insurance companies and therefore is unlikely to be desirous of a large volume of private insurance expertise. UHC is essentially operating a capitated budget system. The areas that may be similar to private insurance systems today are outpatient pharmaceuticals which will be fee for service and possibly overseas care depending on how the overseas care package is negotiated.

19. **WHO IS ELIGIBLE AND HOW WILL NON-NATIONALS BE TREATED.**

Residents in the country (a defined by the Income tax Act) i.e. who have been present for six months more. The rationale is that persons must have contributed before being eligible. The corollary to this is that Saint Lucians (who are not dependents) who live outside Saint Lucia will not be eligible.

20. **WILL OVERSEAS HEALTH CARE BE LEFT OUT?**

No. Some level of overseas care is included.

21. **TIME FRAME FOR IMPLEMENTATION SEEMS TO BE TOO SHORT (END OF THE YEAR 2005).**

This is addressed above in question 10

22. **WILL THE SCHEME BE MANAGED BY NHI OR PRIVATE INSURANCES?**

The UHC programme will be managed by the NIC.

23. **WHAT ARE THE FINANCIAL COSTS AND LIMITS AND THE SCOPE OF THE PACKAGE OF SERVICES TO BE OFFERED?**

See answer to question 1 and the attachments.

24. **THERE APPEARS TO BE A RUSH INTO THE SCHEME AND THE FINANCING IS NOT EVEN IN PLACE**

No there is no rush. In fact we are discussing now before funding is in place to ensure that all the groundwork is done before we raise funds.

25. **HOW WILL UHC AFFECT LIFE INSURANCE AND GROUP MEDICAL PLANS?**

This is covered in questions 14, 17 & 18.

26. **THERE NEEDS TO BE AN ANALYSIS OF IMPACT ON COMPANIES: PUBLIC AND OTHER STAKEHOLDERS. THE CAYMAN ISLANDS EXAMPLE SHOULD BE EXAMINED.**

Agreed that is the reason for the groundwork and studies being done now.

27. **HOW DOES THE UHC PLAN TO DEAL WITH FRAUD WITHIN THE NEW SYSTEM (E.G. DOCTORS COLLUDING).**

Fraud has to be dealt with by having multiple information sources that cross reference each other, and by having good surveillance and auditing mechanism. Then there is the legislation which defines obligations and penalties including fines and incarceration for fraud.

28. **WHAT REQUIREMENTS WOULD DOCTORS NEED TO HAVE TO QUALIFY TO BE PART OF THE SCHEME? IS IT A SINGULAR DOCTOR OR A GROUP OF DOCTORS WHO COULD PARTICIPATE IN THE SCHEME?**

Doctors and their services as individuals or groups will in the first phase be contracted by the institutional providers contracted by UHC. That is the UHC is contracting with hospitals, pharmacies, emergency service providers etc. These entities will in turn have to contract doctors and their services within or even outside of the entity. UHC service agreements detail what is expected in terms of service delivery by the entities. The institutions must determine the best way to deliver and here is where the institutions negotiate with doctors. If or when community services are brought under UHC then doctors will be in a position to enter into service agreements with UHC. The Belize pilot experience shows that doctors need to form group practices if they intend to be able to contract and meet the necessary obligations and make a profit. The system would use a capitated form of payment for doctors as proposed for the hospitals, this system does demand some sophistication on the part of doctors to manage budgets, deliver services as they have agreed to by contract and meet their expenses and be able to pay themselves.

29. **THE COMMENT THAT A MEDICAL FACILITY WILL HAVE TO MEET THE CRITERIA FOR PARTICIPATION IN THE SCHEME, YET HE "MAY" BE EXCLUDED. ON WHAT BASIS WOULD THEY NOT OR IT NOT AUTOMATIC (COULD LEAD TO DISCRIMINATION).**

Criteria have to be clear and transparent. Presently it is proposed that providers would only be excluded on the basis of fraud or poor quality. The UHC is actually stating

that it wants to be non-discriminatory in contrast to the existing system. All institutions participating in UHC will have to be part of a process of accreditation. As you may be aware we have started the five institutions that are proposed to be contracted by UHC (Victoria Hospital, Saint Jude Hospital, Tapion Hospital, Golden Hope Hospital, Turning Point) have started on the process of accreditation with the Canadian Council on Health Service Accreditation (CCHSA). Ultimately as stated in the UHC proposals on the NHI task force report, all contracted entities by UHC will be accredited institutions.

30. THE LEVEL OF SERVICE RIGHT NOW AT THE NATIONAL HOSPITAL IS NOT COMPARABLE TO THAT RECEIVED FROM THE PRIVATE SECTOR. WHAT WILL HAPPEN WITH THE IMPLEMENTATION OF THE SCHEME?

As stated before the issue of quality is being addressed through a number of strategies. One is the accreditation process through the CCHSA, this process started in October 2004. Two is the issue of governance of the public hospitals and this is being addressed as one of the prerequisites for UHC implementation. Three is Human Resource training which is being addressed through the HR consultancy, almost complete, and the sector training plan that will be part of the HR development; HR training is ongoing and has already started but needs to be amplified as guided by the HR plan which will be ready by August 2005. Four the level of financial resources to be applied to equipment, supplies, buildings etc. this strategy is being addressed through the health infrastructure development (new hospitals) and through an enhanced national budget and ultimately through the UHC.

31. IF A PERSON IS PAYING FOR UHC THEY MAY ABANDON THEIR PRIVATE INSURANCE. COULD HAVE NEGATIVE IMPACT ON PRIVATE INSURANCE COMPANIES?

The issue of increasing the consumer's choice and bargaining power is a positive step. The UHC by restricting choice of provider and covering the necessary and common services leaves a lot of room for private insurance to be creative and profitable. Actually the insurance companies have often indicated that health insurance in Saint Lucia is not lucrative, working together with UHC developing complementary insurance products could make this area of insurance business lucrative.

32. WITH SOMEONE BECAUSE OF LIMITED INCOME BEING FORCED TO CHOOSE BETWEEN UHC AND PRIVATE CARE YET THEY MAY PAY THE SAME AMOUNT OR MORE AND GET LESS COVERAGE. WHO IS LIABLE?

There is no real choice between UHC and private care. UHC is proposed as a tax based system for universal access to necessary health services. The consumers choice is to have private insurance to complement UHC or not. I expect that persons with limited income will only have UHC.

33. WITH REGARDS TO COST, HOW WILL COST BE CAPPED TO ENSURE UHC TAX DOES NOT INCREASE UNCONTROLLABLY OVER TIME WITH A COMMENSURATE INCREASE IN UHC TAX?

The UHC package is defined and limited. Macroeconomic and fiscal responsibility suggests that we should maintain total health expenditure at a defined percentage of GDP (presently 5.5% target is 6.5%). UHC introduces a mechanism that gives more control over health expenditure than presently exists. Therefore the choice to spend more on health care becomes a more deliberate national choice through the UHC. This choice will be in the hands of the people and politicians as advised by technical information (health and economic). History shows that people do have a large appetite for health services and political pressure is created to give more benefit and therefore increase the allocation of GDP to health. It is necessary that we all are informed, responsible and vigilant.

34. TIMELY PAYMENT BY GOVERNMENT REMAINS A CONCERN.

The intention is to manage the UHC fund from the NIC. The provider's contracts with UHC should detail the times for payments. The UHC fund is presently designed to receive approximately 50% directly from source and 50% from the consolidated fund. These processes are proposed to address this concern of the timeliness of Government payments.

35. MALPRACTICE SUITS: WILL GOVERNMENT COVER DOCTORS FOR THIS INEVITABLE SITUATION?

The institutions will have to have malpractice insurance and this has to be done by the institutions. Presently Government covers (Victoria Hospital, Golden Hope, Turning Point) Saint Jude and Tapion have contracted their own coverage. Doctors are responsible for their own individual coverage. Presently fulltime doctors in the public hospitals are covered by Government. This will change as the Governance of the public hospitals change and as UHC is implemented. Institutions and doctors will become more self reliant and responsible for themselves with the advent of UHC. The Medical Protection Society of the UK has expressed interest in providing this coverage and they are visiting in May to gather information to prepare proposals. As noted at our chamber meeting this is an area for private insurances to gain new business.

36. WHO IS GOING TO PROVIDE FUNDING FOR THOSE PERSONS WHO REQUIRE GREATER CARE THAN PROVIDED UNDER THE SCHEME SINCE UHC PROVIDES FUNDING FOR ONLY BASIC CARE? INDIGENT, NO SUPPLEMENTARY INSURANCE, WARDS OF THE STATE ETC?

As stated UHC covers everyone for a defined package of services. This package is comprehensive enough to meet the health needs as presently exist. Outside of this package all persons regardless of their financial status will have to find other mechanisms to pay for extra services. This is one of the roles for private insurance. For indigent or poorer persons there are some existing mechanisms that could continue e.g. Laborie has a community fund for this, NCF is a mechanism that could

continue, Government may want to still have a medical assistance budget. However given the UHC package I anticipate that the demands from poorer, indigent and wards of the state will be few.

37. THE TERM "LIMITED OVERSEAS SERVICES" NEEDS TO BE CLARIFIED.

All services have to have a limit. The budget set for overseas care is EC $5 million per annum. With this budget overseas providers will be contracted directly by UHC or through private insurance (dependent on private proposals). The type and projected quantity of services is listed in the package of services. We are also waiting for feedback from the Medical and Dental Association on this package. There is also a proposed French funded consultancy to address this area in more detail.

38. WHAT ABOUT COMPANIES WHO HAVE GROUP INSURANCE AND WISH TO KEEP IT AS IT ALREADY COVERS BASIC PLUS?

As stated everyone is free to contract private insurances as they like. UHC merely gives consumer's more choice and bargaining power. How companies choose to exercise this is totally within their control.

39. THE BARBADOS EXAMPLE WHERE NO SPECIFIC TAX IS PLACED FOR HEALTH CARE BUT TAX RATES ARE JUST HIGHER AND COVERAGE IS PROVIDED ALONGSIDE PRIVATE HEALTH INSURANCE NEEDS TO BE EXAMINED? AS IT APPEARS NOT TO BE CONFRONTED BY THE ABUSE AND ESCALATION IN ACCESS THAT OTHER UHCS FACE.

Similarly the UHC is tax based, budgeted and therefore controlled. How we choose as a nation to exercise this control is up to us. Barbados actually spends 7.3% of GDP on Health (US$596 per capita per annum) our target is 6.5% (US$260 per capita per annum). This is significantly less and is actually a more controlled situation than Barbados.

40. THIS SYSTEM COULD LEAD TO A DISINCENTIVE FOR INSURANCE COMPANIES. THE MARKET COULD CONTRACT THEREBY LEADING TO GREATER COMPETITION WHICH COULD CAUSE INSURANCE COMPANIES TO LEAVE THE MARKET.

We have addressed this issue. The profitability and viability for private insurance remains, in our opinion. It is for us to manage the new system. Ultimately however we want to have controlled spending on health, purchasing the most cost-effective interventions and providing access to all residents. Private businesses, health and insurance, can thrive in the new system.

41. WHEN WILL THE RELEVANT LEGISLATION BE READY?

By December 2005 we should have finalized the legislation. Draft legislation for consultation should be ready by July 2005/

42. HOW DOES THE UHC FIT IN WITH THE RECOMMENDATIONS OF THE REPORT OF THE COMMISSION TO REVIEW THE TERMS AND CONDITIONS OF DOCTORS AND NURSES EMPLOYED IN THE GOVERNMENT HEALTH SERVICES.

There is no conflict between UHC and the Commission's report.

43. IF THE UHC MANDATES A SINGLE IMPORTER, PPS OF DRUGS FOR USE IN THE UHC, THEN THE PRIVATE IMPORTERS OF DRUGS WILL EITHER HAVE TO CLOSE DOWN OR DRASTICALLY REDUCE STAFF, INFRASTRUCTURE ETC.

Questions 5-8 above relate to this. The objectives of UHC are clear - best drug, best price, universally available. How this is achieved is not critical for UHC, PPS is one mechanism, private companies, PPS and UHS should come together and discuss the best way to achieve UHC objectives. UHC is not about creating monopolies or propping up public agencies because they are public. UHC focus is service and how best to deliver it.

44. THE FORMULARY DRUGS LIST DRAWN UP BY THE PHARMACY COMMITTEE IF IT IS PRIMARILY GENERIC DRUGS WILL EXACERBATE THE DEMISE OF PRIVATE IMPORTERS.

As stated above in previous answers. The objective is not to put companies out of business. There are many factors that will affect the source of drugs including recent WTO agreements with countries like India. Private companies should not panic, they should engage UHC and PPS in discussion to find a win-win way forward.

45. THE COST OF MAJOR BRANDS MAY RISE AS OVERALL VOLUME OF DRUGS IMPORTED AND SOLD BY PRIVATE SECTOR DECLINES TO COMPENSATE FOR LOSS OF VOLUME.

As stated above private companies need to engage and be engaged. Business and the marketplace will eventually dictate what happens. Let us reiterate UHC as a purchaser is looking for the best drugs at the best price and UHC has to comply with international, regional and local law and agreements. Private business knows the market and knows the business. Therefore let the business be done according to best business practice. Let us not look for artificial protection and subsidies,

46. ISSUE OF THE QUALITY AND EFFICACY OF DRUGS NEEDS TO BE PROTECTED FOR SAKE OF PERSON WHEN GENERIC DRUGS ARE BEING PURCHASED.

The quality of pharmaceuticals is an issue for all pharmaceuticals, we agree.

47. WHAT MECHANISM WILL BE EMPLOYED TO ENSURE THAT GENERICS ARE THERAPEUTICALLY EQUIVALENT TO THE BRAND DRUGS?

The policy is not to blindly buy generics but rather to buy proven quality drugs form any source at the best price. The mechanisms of quality assurance will be those of the PPS since this agency is the one we have with the mechanisms, relationships and access to recognized drug testing facilities. PPS also has the experience in the market. We would like private companies to engage with PPS.

48. WILL A DRUG TESTING FACILITY BE ESTABLISHED?

Drug testing facilities already exist we do not need to establish one here. We would propose to use existing facilities (e.g. in the United Kingdom)

49. IMPORTANT TO HAVE A PHARMACY ECONOMIST ON THE PHARMACY COMMITTEE OR A CLINICAL PHARMACIST.

Agreed.

50. MUST ESTABLISH AND REGULARLY REVIEW THE PROTOCOLS AND DRUG REGIMENTS FOR DOCTORS.

Agreed. There will be a mechanism to address this.

51. WILL PRIVATE IMPORTERS BE ALLOWED TO BRING IN GENERICS?

Yes, we are guided as said before by ensuring the quality of pharmaceuticals - Best drug at the best price.

52. UHC WILL DRIVE BUSINESS AWAY FROM BRANDED DRUGS.

Not necessarily, that depends on the response and engagement of private companies.

53. THE LOW PERCENTAGE OF ST. LUCIAN'S WHO CURRENTLY HAVE HEALTH INSURANCE AND THE LOWER PERCENTAGE WHEN UHC IS INTRODUCED WILL PUT PRIVATE PHARMACIES AND IMPORTERS OUT OF BUSINESS IN LARGE MEASURE.

Not necessarily. UHC will provide more people with access to drugs. The volume of drugs dispensed in Saint Lucia will rise. The source of these drugs is dependent on the purchasing arrangements, we have asked in answers to questions above for the private companies to get engaged.

54. WHO ARE THE FUND MANAGERS AND HOW WILL THEY BE SELECTED AND EVALUATED?

The NIC is the fund manager.

55. WHAT MECHANISM WILL BE PUT IN PLACE TO DEAL WITH BRAND MEDICALLY NECESSARY DRUGS THAT MAY NEED TO BE DISPENSED?

Any essential drug will be purchased and made available regardless of brand.

56. THERE IS NEED FOR COMPLETE AND CONSISTENT INFORMATION TO BE SHARED WITH THE PUBLIC, DOCTORS AND OTHER PLAYERS. COMMUNICATION ON THIS SUBJECT HAS TO BE IMPROVED.

Agreed, let us work together to ensure this.

57. WHAT PROVISIONS EXIST WITHIN THE UHC FOR OTHER "HEALTH CARE PROVIDERS" WHO WANT TO BE PART OF THE PROCESS TO JOIN IN? IS IT ENVISAGED THAT ONLY TAPION, ST. JUDE'S AND VICTORIA HOSPITALS WILL BE HEALTH CARE PROVIDERS.

UHC in its first phase is open to all institutions including all hospitals and pharmacies.

58. HOW DOES AN INTERESTED PARTY BECOME A HEALTH CARE PROVIDER? WHAT PROCESS AND CRITERIA HAS TO BE MET? WILL DETERMINATION BE DONE BY AN IMPARTIAL PARTY?

UHC will be impartial. The criteria are clear, they include:

- all institutions public or private in the business of providing the services to be covered
- the institutions must have the quality systems in place, financial/accounting, clinical and managerial.

59. GOVERNMENT SHOULD CONTRACT PRIVATE SECTOR HEALTH CARE PROVIDERS AND TAKE INTO CONSIDERATION THAT IF UHC WILL DEPEND ON THE CURRENT SYSTEM OF HOSPITAL ADMINISTRATION, THERE WILL BE MANY PROBLEMS.

As stated above the prerequisites for UHC is a change of the existing hospital governance.

60. HOW DOES THE UHC TAKE INTO ACCOUNT OUT-PATIENT SERVICES? HOW IS THIS GOING TO BE ADDRESSED?

Out patient services are defined as those linked by the provider to a particular inpatient condition. Persons have to be referred from their primary physicians or health care workers or persons enter the hospital through the emergency room. The emergency room triage determines genuine emergencies from non-emergency. It is noteworthy that UHC does not pay by visit of intervention. UHC pays an institution by a capitation determined budget. The institution in turn pays its staff (doctors etc.) as it has determined with them. The onus is on the institution to put the necessary control mechanisms in place. The capitated budget in this way also creates a major financial incentive for hospitals to works with community providers and general practitioners to keep their registered population well and out of hospital. Note the hospitals retains the surpluses from their budgets and conversely meet the shortfalls.

61. THERE APPEARS TO BE NO ROOM OR BENEFIT OR SERIOUS ROLE ENVISAGED FOR PRIVATE GENERAL PRACTITIONERS AND THEIR CLINICS.

As stated above the first phase is with institutions. The systems as proposed will cause hospitals to work more closely with GPs and community services. When we have developed the control systems and when GPS have developed the necessary institutional arrangements then private GPS can be brought into a capitated system. Note UHC will not be paying providers fees for service the process is based on budgets.

62. **IS IT ACCEPTABLE FOR GOVERNMENT TO FINANCE SPECIFIC PRIVATE HEALTH INSTITUTION USING PUBLIC FUNDS AND NOT OTHERS?**

UHC intends to be non-discriminatory (public and private). UHC will contract any provider that meets the criteria. UHC is being implemented in the first phase in pharmacies and hospitals. All private pharmacies are eligible and all private hospitals are eligible. The system of funding is exactly the same for any provider, public or private.

63. WHY AREN'T OTHER GENERAL PRACTITIONERS GIVEN THE SAME OPPORTUNITY TO PROVIDE THE SAME SERVICE? IS THIS A FORM OF DISCRIMINATION?

There are no general practitioners and no doctors contracted by UHC. UHC contracts institutions. The institutions contract the doctors. As stated above all institutions that provide the services required by UHC are eligible there is no selective discrimination.

64. DOES THIS SYSTEM HELP TO PAY OFF THE DEBTS OF THE HOSPITALS?

No. The UHC contracts the hospitals for services at a set budget based on the number of persons registered with that hospital (e.g. 1000 persons at $200 per annum = $200,000 annual budget to deliver all the stated services in the package.) The hospital

debts are the hospitals business. For the public hospitals we have indicated that they should enter UHC debt free.

65. **NO PRIVATE SECTOR HOSPITAL SHOULD BE INCLUDED IN UHC IN THE FORM OF A SUBVENTION. HOWEVER PERSONS SHOULD BE GIVEN A CHOICE TO CHOOSE THEIR HEALTH SERVICE PROVIDERS.**

We have stated above how the system is proposed to operate. Details are in the UHC document.

66. **THE FACT THAT MANY OF THE SAME DOCTORS WHO ARE AT TAPION HOSPITAL WORK AT OTHER HOSPITALS, DOES THIS POSE A CONFLICT OF INTEREST AND TO A CERTAIN EXTENT A CARTEL. THIS WILL POSE PROBLEMS FOR THE UNATTACHED DOCTORS IN PRIVATE PRACTICE**.

As stated Tapion does not especially benefit from the UHC. It merely has the option to participate as for example does a private pharmacy. The UHC does not pay doctors and as such the doctors contracts are the hospitals business. It is for VH, SJH and Tapion to organize their relationships with doctors to ensure that they can deliver the services the hospitals will be contracted to provide. Complaints and care issues will be examined and dealt with appropriately.

67. **HOW DOES THE UHC PLAN TO DEAL WITH AN EMERGING CSME THAT MAY ALLOW DOCTORS WHO MAY HAVE LESS EXPERIENCE AND WILLING TO WORK FOR LOWER FEES TO MOVE FREELY INTO THIS JURISDICTION.**

UHC has to comply with CSME agreements. UHC is contracting institutions therefore if Caribbean institutions enter the Saint Lucia marketplace UHC will have to treat these hospitals or pharmacies as local. We reiterate UHC is not contracting doctors, the institutions do that so the institutions and the regulatory authority (the Ministry of Health) will make the decisions on registration, licensing and hiring of "CSME" doctors.

68. **THE UHC DOES NOT APPEAR TO RESOLVE THE HEALTH SECTOR PROBLEMS IN ST. LUCIA.**

That is an opinion, we note it. We disagree, we think the UHC does address some of the problems in the health sector. This is a topic to debate.

69. **WHY COULDN'T THE UHC SYSTEM MIRROR THE PRIVATE INSURANCE COMPANIES SYSTEM AND ALLOW COST SHARING AND COST CONTROL USING THE EXPERIENCED EXPERTS IN THE FIELD OF HEALTH INSURANCE.**

The proposed system of UHC is following the internationally tried and tested system of capitation not the private insurance model as it operates in Saint Lucia. We have

opted for this based on our objectives which have been clearly defined and our belief that the proposed UHC fund and capitated budgets is the best way to achieve our objectives particularly in terms of cost containment and control.

70. THE UHC SHOULD TAKE ACCOUNT OF AND PROVIDE A SAFETY NET FOR THOSE WHO COULD NOT AFFORD AND ALSO FOCUS ON CHRONIC ILLNESSES (PREVENTATIVE HEALTH CARE).

Agreed. The preventative focus will be driven through providers especially since the capitated payment system encourages providers to keep patients well and out of hospital

71. WHAT ARE THE COST IMPLICATIONS OF THIS SCHEME?

Estimated figures to be verified before implementation.

Universal Health Care Budget	**EC$ millions**	**Payment Mechanism**
Victoria Hospital	22.3	Capitation
St.Jude Hospital	13.5	Capitation
Golden Hope	5.4	Global budget
Turning Point	0.8	Global budget
Essential Drugs	4.0	Global budget
Development of services	1.1	Global budget
Overseas care	5	Global budget
Pre-hospital emergency care	1.1	Global budget
Private Hospital	1.1	Capitation
Blood Bank Services	0.75	Global budget
TOTAL	55.05	
Administration	2	
Contingency (5%)	2.8	
TOTAL	59.85	
RESOURCES		
Consolidated fund (transfer to UHC fund)	29.7	
Shortfall (UHC raises from new sources)	30.15	

Health expenditure

	CURRENT	POST UHC
Total (millions)	100.45	115.50
%GDP	5.5	6.4
Public (millions)	60.45	82.65
Private (millions)	40	32.85

72. WITH REGARDS TO THE NEW HOSPITAL AND UHC: WILL THE NEW HOSPITAL BE MANAGED BY PUBLIC OR PRIVATE ORGANIZATIONS AND WILL THE RECOMMENDATIONS OF THE RICHIE HAYNES REPORT BE IMPLEMENTED AND THE ISSUES AND PROBLEMS IDENTIFIED RESOLVED BEFORE THE INTRODUCTION OF THE UHC?

The governance of the new hospital will be different and will be by a statutorised board (the exact composition and transition process is presently being defined with the stakeholders). Some of the recommendations of the Haynes report will be implemented and some will not. For example Saint Jude Hospital will not be downgraded.

73. WHY HAS THE CURRENT SYSTEM NOT BEEN FIXED RATHER THAN A TOTALLY NEW SYSTEM BE INTRODUCED?

UHC is part of the attempt to fix the existing system. Most of the problems in health are related to the existing system and the way it is used.

74. WHAT ROLE HAS BEEN IDENTIFIED OR CONSIDERED FOR THE MEDICAL AND DENTAL ASSOCIATION IN THE UHC PROCESSES. COULD THEY BE INVOLVED IN QUALITY CONTROL, PROGRAM OVERSIGHT, AND GENERAL PROGRAM MONITORING?

Yes and they have been engaged on UHC, The SLMDA needs to get more involved to ensure that the UHC is successful and that the SLMDA has a major role as has been outlined above.

75. K**ey Essentials:**

- ✓ **There should not be a single focus on tertiary care alone.**
- ✓ **Private institutions should not be funded with public funds.**
- ✓ **Patients should have a choice of health care providers.**
- ✓ **Health Care systems now have to be improved in order to prevent persons from falling outside the system.**
- ✓ **Private Doctors who are unattached should have an equal and fair chance to provide services to the UHC plan**
- ✓ **Financing and Cost Containment of UHC must be examined and studies need to be done to better understand the likely cost and cost escalations that one can expect.**