



ST. KITTS AND NEVIS HEALTH SYSTEMS AND PRIVATE SECTOR ASSESSMENT 2011

April 2012

This publication was produced for review by the United States Agency for International Development. It was prepared by Laurel Hatt, Abigail Vogus, Barbara O'Hanlon, Kathy Banke, Taylor Williamson, Michael Hainsworth, and Shirley Augustine for the Health Systems 20/20 Project and Strengthening Health Outcomes *through* the Private Sector Project.



Health Systems 20/20 Mission

The Health Systems 20/20 **cooperative agreement**, funded by the U.S. Agency for International Development (USAID) for the period 2006-2012, helps USAID-supported countries address health system barriers to the use of life-saving priority health services. Health Systems 20/20 works to strengthen health systems through integrated approaches to improving financing, governance, and operations, and building sustainable capacity of local institutions.

SHOPS Mission

The Strengthening Health Outcomes *through* the Private Sector (SHOPS) Project is a five-year **cooperative agreement** (2009-2014) with a mandate to increase the role of the private sector in the sustainable provision and use of quality family planning, HIV/AIDS, and other health information, products, and services.

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DISCLAIMER

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development (USAID) or the United States Government.

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
BAICO	British American Insurance Company
CAREC	Caribbean Epidemiology Center
CARICAD	Caribbean Center for Development Administration
CARICOM	Caribbean Community
CDB	Caribbean Development Bank
CDC	Centers for Disease Control and Prevention
CHAA	Caribbean HIV/AIDS Alliance
CHART	Caribbean HIV/AIDS Regional Training Network
CHRC	Caribbean Health Research Council
CIDA	Climate Change and Environmental Management
CLICO	Colonial Life Insurance Company
CMO	Chief Medical Officer
CMS	Central Medical Stores
CSO	Civil Society Organization
DFID	United Kingdom Department for International Development
EC	European Commission
EC\$	Eastern Caribbean Dollar
EDF	European Development Fund
FACTTS	Facilitating Access to Confidential Testing, Treatment, and Support
FDA	U.S. Food and Drug Administration
GDP	Gross Domestic Product
HAPU	OECS HIV/AIDS Project Unit
HIS	Health Information System(s)
HIU	Health Information Unit
HIV	Human Immunodeficiency Virus
HRH	Human Resources for Health
HRIS	Human Resources Information System

HRM	Human Resources Management
HRSA	Health Resources and Services Administration
HSA	Health Systems Assessment
HSS	Health Systems Strengthening
HSPA	HIV/AIDS Service Provision Assessment
ICT	Information and Communications Technology
IFC	International Finance Corporation
IT	Information Technology
I-TECH	International Training and Education Center for Health
JNF	Joseph Nathaniel France (General Hospital)
LAC	Latin America and the Caribbean
M&E	Monitoring and Evaluation
MOF	Ministry of Finance
MOH	Ministry of Health
NACHA	National Advisory Council on HIV/AIDS
NACU	Nevis AIDS Coordination Unit
NAS	National AIDS Secretariat
NCD	Noncommunicable disease
NCI	National Caribbean Insurance Company
NGO	Nongovernmental organization
NHA	National Health Accounts
NIA	Nevis Island Administration
NSPH	National Strategic Plan for Health 2006-2011
OECS	Organization of Eastern Caribbean States
PANCAP	Pan Caribbean Partnership Against HIV/AIDS
PAHO	Pan American Health Organization
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
PMTCT	Prevention of mother-to-child transmission
PPP	Public-Private Partnerships
PPS	Pharmaceutical Procurement Service
PS	Permanent Secretary
PSA	Private Sector Assessment
QA	Quality Assurance

SHOPS	Strengthening Health Outcomes <i>through</i> the Private Sector
SNIC	St. Kitts-Nevis Insurance Company
STI	Sexually Transmitted Infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
USAID	United States Agency for International Development
USAID/EC	United States Agency for International Development/Eastern Caribbean Mission
USD	United States dollar
USG	United States Government
VAT	Value-Added Tax
VCT	Voluntary counseling and testing
WHO	World Health Organization

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- Government: Prime Minister's Office, Parliament, Ministry of Health (Nevis and St. Kitts), Ministry of Finance (Nevis and St. Kitts), Ministry of Tourism (St. Kitts), Attorney General's Office (St. Kitts), Ministry of Justice and Legal Affairs (St. Kitts), Ministry of Social Services (Nevis), Ministry of Social Services and Community Development (St. Kitts)
- Public sector health facilities: Joseph Nathaniel France General Hospital, Alexandra Hospital, Pogson Medical Center
- Social Security Board
- Nurses' Association
- Nongovernmental and civil society organizations
- Doctors in private practice
- Private pharmacies
- Private insurance companies
- Private businesses
- Private medical training institutions
- Private laboratory

This assessment report was prepared collaboratively by the members of the assessment team. Abigail Vogus drafted the country overview; Taylor Williamson drafted the Governance and Pharmaceutical Management chapters; Laurel Hatt drafted the Health Financing chapter; Michael Hainsworth drafted the Human Resources for Health chapter; Kathryn Banke drafted the Health Information Systems chapter; Shirley Augustine, Kathryn Banke, and Abigail Vogus drafted the Service Delivery chapter; and Barbara O'Hanlon drafted the Private Sector chapter.

FOREWORD

In 2009 the United States Government (USG) supported a process to develop the United States-Caribbean Regional HIV and AIDS Partnership Framework 2010–2014 (Partnership Framework) together with 12 Caribbean countries: Antigua and Barbuda, the Bahamas, Barbados, Belize, Dominica, Grenada, Jamaica, St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines, Suriname, and Trinidad and Tobago. Development of the framework involved participation from ministries of health, national AIDS programs, regional organizations such as the Pan Caribbean Partnership Against HIV and AIDS (PANCAP) and the Organization of Eastern Caribbean States (OECS), and nongovernmental and private sector stakeholders. The Partnership Framework is aligned with national strategic plans and the PANCAP Caribbean Strategic Framework.

A major goal of the Partnership Framework is to move the region toward greater sustainability of HIV/AIDS programs. Obtaining results in this area will be challenging, given that most country governments currently provide limited national budget resources to their own HIV/AIDS programs, relying to a large degree on external aid. Although there are six USG agencies supporting implementation of the Partnership Framework, the United States Agency for International Development /Eastern Caribbean (USAID/EC) provides support for health systems strengthening (with particular emphasis on health financing) and private sector engagement. Both these efforts are closely linked to sustaining the HIV response in the region.

As a part of the Partnership Framework, USAID/EC asked the Health Systems 20/20 and the Strengthening Health Outcomes through the Private Sector (SHOPS) projects to conduct integrated health system and private sector assessments in St. Lucia, Grenada, St. Kitts, Antigua, Dominica, and St. Vincent and the Grenadines. The assessments identify opportunities for technical assistance, which are aimed at improving the capacity of these countries to effectively lead, finance, manage, and sustain the delivery of quality health services, including HIV prevention, care, and support.

USAID/EC has requested that the SHOPS project, USAID's global flagship private sector engagement project, establish a baseline of private sector engagement in HIV/AIDS that will inform future regional and country support for maximizing contributions from this sector in the Eastern Caribbean. USAID/EC has asked Health Systems 20/20, USAID's global flagship health systems strengthening project, to determine opportunities for improving health financing systems, ensuring the sustainability of funding for the HIV/AIDS response, and strengthening financial tracking and management procedures in the region. The integrated health system and private sector assessment approach is specifically used to pinpoint areas where the private sector can be leveraged to strengthen health systems, sustain national HIV responses, and contribute to improved health outcomes.

The assessment methodology is a rapid, integrated approach, covering six health systems components: health financing, pharmaceutical management, governance, health information systems, human resources for health, and service delivery. Special emphasis is placed on the current and potential role of the private sector within and across each health system building block. An extensive literature review was conducted for each country, and in-country interviews with key stakeholders were used to validate and augment data found in secondary sources. The assessments are guided by an intensive stakeholder engagement process. Following the preparation of a draft assessment report, preliminary findings and recommendations are validated and prioritized at in-country stakeholder workshops. Stakeholders

interviewed and engaged throughout the assessment process include government representatives, development partners, nongovernmental organizations, professional associations, health workers in the public and private sector, civil society organizations, and private sector businesses.

The assessments have been conducted in close collaboration and cooperation with the Pan American Health Organization, the Health Resources and Services Administration, the International Training and Education Center for Health, and the Caribbean HIV/AIDS Regional Training Network. Representatives of these organizations joined assessment teams, contributed to the assessment reports, and have assisted with identifying opportunities for technical assistance. Health Systems 20/20 and SHOPS wish to express gratitude to these organizations, to ministries of health in participating countries, and to all in-country stakeholders for their intensive engagement and contribution to the assessments.

EXECUTIVE SUMMARY

PURPOSE OF THE ASSESSMENT

St. Kitts and Nevis is one of 12 Caribbean countries joining efforts with the United States Government in the United States-Caribbean Regional HIV and AIDS Partnership Framework 2010–2014. The United States Agency for International Development (USAID) is working through two projects, Health Systems 20/20 and Strengthening Health Outcomes through the Private Sector (SHOPS), to provide a variety of health systems strengthening technical assistance to countries in the eastern Caribbean as part of this Partnership Framework. To identify priority areas for support from regional partners and donors, the two projects conducted an integrated health systems and private sector assessment. Additional partners in this effort included the Pan American Health Organization (PAHO), the International Training and Education Center for Health (I-TECH), and the Caribbean HIV/AIDS Regional Training Network. The assessment described in this report is a first step toward improving the capacity of St. Kitts and Nevis to effectively lead, finance, manage, and sustain the delivery of quality health services, including HIV prevention, care, and treatment. Inherent in the country's capacity to carry out these roles is better understanding and catalyzing private sector contributions to health. Although the functioning of the broader health system is the focus of the assessment, particular attention was paid to sustaining the country's HIV response.

COUNTRY OVERVIEW

St. Kitts and Nevis is an upper middle-income country in the eastern Caribbean, with a population of approximately 50,000. Its primary care service coverage indicators are extremely strong, with universal coverage of key childhood vaccines and skilled attendance at delivery. The estimated prevalence of HIV is 1.1 percent, but stigma against individuals with HIV and AIDS persists and the true prevalence may be higher. Public sector health services in St. Kitts and Nevis are delivered through 17 primary health care centers (11 on St. Kitts and six on Nevis) in addition to four hospitals. Residents must travel off-island to obtain advanced care. Many residents also seek services from private physicians and pharmacists.

METHODOLOGY

Health systems and private sector experts from the SHOPS and Health Systems 20/20 projects, as well as I-TECH and PAHO, conducted an integrated rapid assessment of St. Kitts and Nevis's health system according to the "building blocks" of the World Health Organization (WHO) health systems strengthening framework: governance, health financing, service delivery, human resources for health, pharmaceutical management, and health information systems. Examination of the current and potential role of the private sector in the health system was incorporated into this approach. In an effort to promote efficiency, an extensive review of the literature pertaining to the health system, and HIV/AIDS services in particular, was conducted prior to the team's arrival in country. Existing information was then validated and expanded upon through interviews with over 90 key stakeholders representing the public, nonprofit, and for-profit sectors, and spanning the health system areas. Members of the assessment team returned in January 2012 to review the findings of the assessment and work with stakeholders from St. Kitts and Nevis to validate the findings and prioritize the recommendations. A summary of the workshop can be found in Annex B.

KEY FINDINGS AND RECOMMENDATIONS

Selected findings and recommendations for strengthening the health system for each of the WHO health systems areas are presented below. Full findings and recommendations (presented as short term and longer term) are presented in separate chapters for each health system area, as well as in a summary chapter on private sector contributions to health.

Governance

Effective governance of a health system ensures that rules for policy development, programs, and practices for the provision of care are implemented to achieve health sector objectives. This assessment looked at state actors, health service providers, beneficiaries of services, and regional entities to understand the way that they interact to guide health service delivery. As St. Kitts and Nevis is a two-island federation, ministries of health on both islands directly manage hospitals and public health centers through institution-based health services and community-based health services departments. Currently, much of the country's legislative framework for health is being updated, or is due to be updated soon, and many pieces of legislation remain in draft form or have not yet been fully enacted. This has resulted in weak regulations for some classes of health workers. Civil society organizations in St. Kitts and Nevis are mostly volunteer based and service delivery oriented; advocacy activities are limited. Few mechanisms, other than radio call-in shows, exist for citizens to express their concerns about the health system to policymakers or providers.

Key findings and recommendations in the area of health governance are as follows:

Findings	Recommendations
<ul style="list-style-type: none">• Key legislation is not in place nor updated to regulate changing health sector, including pharmaceuticals, dual practice, and continuous education for physicians.• Civil society organizations for health, while welcomed by the government to provide input, do not have the capacity currently to play a supporting role in decision-making or planning.• Public and private sectors do not communicate effectively with each other.• Few formal mechanisms exist for obtaining citizen input about the health system.	<ul style="list-style-type: none">• Improve the tracking of health legislation and move key legislation forward, including policies to prevent discrimination.• Develop a health communication strategy to ensure transparency and more widely disseminate health information.• Strengthen civil society input into health planning and build their capacity to advocate on behalf of their membership.• Engage stakeholders, including health care consumers, around policy and service delivery issues in more proactive ways.• Clarify and enforce guidelines on dual practice in the public and private sector.

Health Financing

Financing of the health system – specifically mobilizing, pooling, and allocating funds to cover the health needs of the population – is a critical element to ensuring access to quality health care. St. Kitts and Nevis's total health expenditure as a percentage of gross domestic product (GDP) was estimated at around 6 percent in 2009, similar to other countries in the region. However, public sector resource constraints are already being felt and will only become more binding going forward. A widespread sense

of entitlement to free public sector health care may be a threat to raising adequate revenues for health. There is universal access to low-cost primary health care and very good access to secondary care, but access to advanced care off-island is limited by socioeconomic status, with catastrophic costs potentially impacting vulnerable groups in particular. Understanding the costs associated with delivering health services is crucial to planning, and this was noted as an area of weakness for the country. St. Kitts and Nevis has never conducted a formal National Health Accounts (NHA) estimation. Gathering more comprehensive health expenditure and service utilization information – especially about the private sector – will be essential as plans for a new national health insurance system are developed.

Key findings and recommendations in the area of health financing are as follows:

Findings	Recommendations
<ul style="list-style-type: none"> • St. Kitts and Nevis is committed to a reasonable level of spending on health, but cost escalation is on the horizon. • High reliance on out-of-pocket spending to finance health care could limit access and increase risk of catastrophic expenditures. • Widespread interest in national health insurance is a hopeful sign. Careful work is needed to arrive at a workable, politically feasible, economically sustainable model. • Little health expenditure or cost data are available, especially from the private sector. This makes it difficult to conduct evidence-based health sector planning. • Available external funding for HIV/AIDS programs has decreased dramatically. 	<ul style="list-style-type: none"> • Conduct an NHA estimation and institutionalize capacity for NHA so that expenditure information is routinely available for evidence-based planning. • Move deliberately, and conduct necessary cost and demand analyses, before implementing any new insurance model. Accurate cost estimates are essential. • Strengthen billing systems at public facilities to recoup costs from private insurers and patients with ability to pay. • Formalize the application of user fees and exemptions. • Develop a financial sustainability plan for HIV/AIDS programming.

Service Delivery

Service delivery systems should aim to ensure access, quality, safety, and continuity of health care. St. Kitts and Nevis has good coverage of and access to primary and basic secondary health care as noted above. Tertiary care must be obtained off-island and thus access is limited. HIV/AIDS counseling and testing services are somewhat integrated into primary health care service provision, though ARVs are only available at the secondary level. The key gaps in the service delivery system are in the areas of quality assurance, efficiency of service provision, and coordination. As of 2007/2008, most people reported that they first sought care in the private sector for their last illness, yet coordination and communication between public and private sectors is poor.

Key findings and recommendations in the area of service delivery are as follows:

Findings	Recommendations
<ul style="list-style-type: none"> • There are high levels of access to primary health care services, but some inappropriate use of hospital services for 	<ul style="list-style-type: none"> • Establish a multidisciplinary, multisectoral Quality Assurance committee at the national level to develop guidelines for

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| <p>primary health care exists.</p> <ul style="list-style-type: none"> • A stronger formal referral system is needed to improve continuity of care. • Quality assurance systems are weak at all levels of the health system. • Many patients seek care from the private sector, but there is no monitoring of the quality of private service provision. • Decreased external funding for HIV/AIDS programs threatens efforts to prioritize HIV prevention and integrate services into routine primary care. | <p>care and rational use of diagnostics and medicines.</p> <ul style="list-style-type: none"> • Improve referral systems and coordination between health system levels and sectors. • Prioritize HIV/AIDS stigma reduction efforts for the community at large as well as public and private providers. Continue to promote integrated primary-level HIV services to enhance access and reduce stigma. |
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Human Resources for Health

Human resources for health (HRH) impacts the availability, costs, and quality of health service delivery. Although evidence collected through the assessment suggests there is a sufficient number of clinical care providers on the islands, significant personnel gaps and challenges exist. This is especially true in the complement of physician and nurse specialists, particularly in mental health, radiology, and health promotion. The Ministry of Health (MOH) recognizes the need, and has taken preliminary steps, to build its HRH planning, management, and training capacity. However, limited availability of administrative and management human resources has so far not been conducive to rapid capacity building and institutional change. The Human Resources Management Department in the Office of the Prime Minister is a key partner in human resource planning and management. A change in policy related to the mandatory retirement age of civil servants will contribute to health workforce retention.

Key findings and recommendations in the area of HRH are as follows:

Findings	Recommendations
<ul style="list-style-type: none"> • Although broad access to primary health care providers exists, there is a lack of specialists (e.g., mental health professionals, nursing specialists, radiologists, and health promotion specialists). • There is currently a shortage of nurses, driven by the low mandatory retirement age and young professionals’ lack of interest in nursing careers. • Training opportunities for health professionals are limited and occur mostly off-island. • Nurses are required to undertake 30 hours of continued nursing training annually, while doctors do not have in-service training requirements. 	<ul style="list-style-type: none"> • Introduce a national training database to track training and identify training needs. • Improve information on training opportunities for continuing education, especially via distance learning and on HIV. • Support introduction of an open-source Human Resources Information System, and link it with the training database. • Scale up efforts in schools to attract young people to health care careers; consider internship opportunities for youth and mentorship programs. • Access technical assistance to develop a government-wide human resources performance management plan, including an MOH HRH plan.

Management of Pharmaceuticals and Medical Supplies

Due to the increasing prevalence of noncommunicable and chronic diseases in St. Kitts and Nevis, efficient procurement, management, and distribution of medicines to the people who need them is more essential than ever. By participating in a pooled procurement system with other Organization of Eastern Caribbean States (OECS) countries, St. Kitts and Nevis has reduced the costs associated with importing drugs. Additionally, a Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) grant through the Pan Caribbean Partnership Against HIV and AIDS has made antiretrovirals accessible through distribution at the two main hospitals. Key challenges are shortages of certain products, such as glucose testing strips, hypertensives, statins, and insulin; poor tracking of drug inventories throughout the system; and bottlenecks in distribution between Joseph N. France (JNF) Hospital and other health facilities. Budgetary concerns make it unlikely that more money will become available for pharmaceuticals in the near future. As a result, St. Kitts and Nevis will have to consider how to ensure continued supplies of pharmaceutical products while containing costs.

Findings

- Participation in the OECS Pharmaceutical Procurement Service (PPS) has significantly reduced the costs of pharmaceuticals.
- Public sector inventory systems are not computerized and networked; inventory management systems are ill-equipped to handle procurement, tracking, and distribution of pharmaceuticals.
- Stock-outs are frequent at public sector pharmacies. Private pharmacies play an important role in ensuring access to essential medicines.
- There is limited pharmacovigilance to monitor adverse drug reactions.
- Policies are needed to ensure consistently low prices for treatment and diagnosis of priority diseases across the public and private sectors.

Recommendations

- Develop a computerized inventory management system in the public sector.
- Consider allowing Alexandra Hospital to procure directly from the OECS PPS.
- Develop a national medicines policy.
- Reconsider taxation policies for services and treatments for priority health conditions.
- Strengthen mechanisms for coordinating with and/or procuring from private sector pharmacies to mitigate stock-outs.
- Develop stronger pharmacovigilance mechanisms. Provide training on existing forms and processes.
- Prioritize passage of the Pharmacy Act to ensure adequate regulation of pharmacists and pharmacies.

Health Information Systems

Health information systems provide the basis for monitoring and evaluation of public health programs. They also provide early warning systems for disease outbreaks, support service delivery and health facility management, inform planning, and permit global reporting (WHO 2008b). In St. Kitts and Nevis, abundant routine health data are collected centrally via the Health Information Unit (HIU) of the MOH. However, this occurs via numerous parallel systems, and the HIU lacks an overall plan for coordination, data analysis and interpretation, dissemination, and use. Private sector facilities do not routinely report data, leaving national data incomplete, and thus the burden of key diseases cannot be accurately quantified. There is currently no unit in the MOH that systematically evaluates the quality of the information that the health system generates.

Key findings and recommendations in the area of health information systems are as follows:

Findings	Recommendations
<ul style="list-style-type: none">• The MOH HIU serves as a repository for various data, but an integrated system for systematic data collection and dissemination to lower levels of the health system and to the public is lacking.• Private sector does not participate in data collection and reporting.• Health centers lack infrastructure (Internet, computers) for reporting.• Checking the quality of reported health statistics occurs on an ad hoc basis – no standards or guidelines exist for data verification.	<ul style="list-style-type: none">• Suggest the MOH should conduct strategic planning for the HIU and for health information systems overall.• Work to increase private sector reporting into the health system, especially on HIV testing and a few key diseases.• Explore options for creating an electronic health information system (HIS) that integrates and links routine reporting forms.• Develop and implement a plan for systematic, routine health information dissemination – both to health care providers and the community at large.• Conduct a training needs assessment for the HIU; provide training on data analysis and use.

Private Sector Contributions to Health

Despite its potential to contribute to public health goals, the private health sector tends to be overlooked as a partner for health systems strengthening. Similar to other countries in the region, St. Kitts and Nevis is simultaneously facing domestic budgetary constraints, growth in noncommunicable diseases, and declining donor support for HIV/AIDS. Given these trends, the government of St. Kitts and Nevis may wish to consider more actively engaging the private sector to help address the country's health needs. Viewing the health system holistically – including both public and private sector elements – can help to identify ways in which the sectors might complement each other to improve overall health impact. This assessment began documenting the current size, scope, and role of the private sector, with a view toward identifying strategies to maximize collaboration between the sectors to address identified health systems gaps.

The private health sector in St. Kitts and Nevis is small but important. There are approximately 30 private physicians (mostly in dual practice with the public sector) and seven pharmacies. Most of the country's specialists work in the private sector. The sector is largely unregulated – a point of concern for both public and private sector stakeholders – and is not well integrated into the overall health system. Some informal cooperation exists, and private practitioners interviewed for this assessment signaled willingness to improve communication and collaboration with public sector counterparts in the interest of improved patient care.

Key findings and recommendations to promote private sector engagement are as follows:

Findings	Recommendations
<ul style="list-style-type: none">• Private practitioners see the full range of clients – poor as well as rich.• The private sector is increasingly being used to address public sector shortfalls (e.g., drug stock-outs, poor quality of care, inconvenient hours) but at a high cost for the poor.• There is little formal interaction, communication, or coordination between the public and private health sectors.• There is little regulation or oversight of the private health sector. This leaves room for noncompliant practices in the pharmacy sector and individual interpretation of dual practice policies.• The private health sector has resources and expertise available for the public sector to tap into.	<ul style="list-style-type: none">• Conduct a “mapping” of the private health sector to serve as a foundation for increased engagement.• Begin to normalize coordination between public and private sector actors. Establish a public-private forum that meets regularly.• Systematically include private sector actors in planning and policy processes.• Mobilize private sector champions to promote current policy proposals, such as the Pharmacy Act and National Health Insurance proposals.• Work with private sector to agree on routine health indicators to report.• Explore establishing a “desk” or part-time point person to liaise with industry on health matters.• Clarify and enforce guidelines on dual practice in the public and private health sectors.• Explore the feasibility of creating a truly private wing at JNF Hospital.

CROSS-CUTTING FINDINGS AND RECOMMENDATIONS

Although this report considers each of the six building blocks of the health system independently, a number of key, interrelated issues emerged that limit the health system’s ability to offer sustainable, quality health services. Overall, the assessment team identified the following key cross-cutting themes:

- Limited availability and use of data for evidence-based policy, planning, and advocacy
- Resource constraints and need for sustainable financing for the health sector
- Opportunities to engage the private sector as a partner
- Weak legal and regulatory framework for health

The assessment found that while the health system in St. Kitts and Nevis functions well, there are key areas that could improve the delivery of health care. Addressing these challenges holistically will result in positive and sustained impact and contribute to a more effective health system in the long term. To address these cross-cutting issues, the assessment team recommends the following:

- Invest in improving the availability and use of various types of data for evidence-based policy, planning, and advocacy
- Develop sustainable financing mechanisms for the health sector

- Pursue opportunities to engage the private sector as a partner
- Finalize the legal and regulatory framework for health

The assessment team returned in January 2012 to validate the report's findings and prioritize recommendations. Stakeholders also prioritized the assessment's four key recommendations and decided to highlight HRH management issues more prominently. Stakeholders also added a focus on primary health care. The two additional priorities that emerged from the stakeholder workshop were the following:

- Strengthen HRH planning and management to produce qualified, motivated HRH (including private HRH)
- Reengineer primary health care to address noncommunicable diseases.

I. ASSESSMENT METHODOLOGY

I.1 FRAMEWORK FOR THE HEALTH SYSTEMS AND PRIVATE SECTOR ASSESSMENT APPROACH

The Health Systems 20/20 and Strengthening Health Outcomes through the Private Sector (SHOPS) projects, in collaboration with the Ministry of Health (MOH), used a combination of the Health Systems Assessment (HSA) and Private Sector Assessment (PSA) approaches to undertake a rapid assessment of the Saint Kitts and Nevis health system. The HSA approach was adapted from USAID's *Health Systems Assessment Approach: A How-To Manual* (Islam, ed. 2007), which has been used in 23 countries. The HSA approach is based on the World Health Organization (WHO) health systems framework of six building blocks (WHO 2007). The standard PSA approach has been used in 20 countries and SHOPS is currently developing a how-to guide for future assessments.

The integrated approach used in Saint Kitts and Nevis covered the six health systems building blocks: health financing, pharmaceutical management, governance, health information systems, human resources for health, and service delivery. Special emphasis was placed on the current and potential role of the private sector within and across each health system building block. In addition, the health system's ability to support the HIV response was examined throughout each dimension.

The objectives of the assessment were the following:

- Understand key constraints in the health systems and prioritize areas needing attention
- Identify opportunities for technical assistance to strengthen the health system and private sector engagement to sustain the response to HIV
- Promote collaboration across public and private sectors
- Provide a road map for local, regional, and international partners to coordinate technical assistance.

I.2 HSA/PSA PROCESS

I.2.1 PHASE I: PREPARE FOR THE ASSESSMENT

During the preparation phase, the assessment team worked with the MOH and the National AIDS Program to build consensus on the scope, methodological approach, data requirements, expected results, and timing of the assessment. Recognizing the importance of building strong partnerships among the government, donors, private sector, and nongovernmental and community organizations, team members held a preassessment workshop in conjunction with the MOH to meet with stakeholders. The objectives of the half-day workshop were to (1) explain the methodology to be used, (2) identify key issues for further investigation during data collection, and (3) clarify expectations for the assessment.

A team of technical specialists for priority areas identified in the stakeholder meeting was assembled. These priority areas included health financing, governance, and health information systems. The team of seven consisted of representatives from Health Systems 20/20, SHOPS, the International Training and Education Center for Health (I-TECH), and the Pan American Health Organization (PAHO).

I.2.2 PHASE 2: CONDUCT THE ASSESSMENT

The majority of health systems data was collected through a review of published and unpublished materials made available to the team by the MOH and development partners and obtained online. Team members produced a literature review for each of the health systems building blocks to develop an initial understanding of the system and identify information gaps. Semi-structured interview guides were developed for each building block based on the noted information gaps, standard PSA interview guides, and the indicators outlined in the HSA approach. The National AIDS Program assisted the team in preparing a preliminary list of key informants and documents for the assessment process. Two local logistics coordinators assisted in further identifying informants and arranging interviews.

Key stakeholders in both the public and private sector were invited to participate in key informant interviews to provide input and validate what has been collected through secondary sources. Key informants also provided additional key documents and referred the team to other important stakeholders. During the one-week data collection period, the in-country assessment team interviewed 93 stakeholders. Interviewees included representatives of government, professional associations, health training institutions, nongovernmental organizations (NGOs), private businesses, health providers, pharmacists, and many professionals from the MOH. Site visits on both the islands of Saint Kitts and Nevis were conducted to verify data from key informants. These visits included public hospitals and health centers, private providers' offices, private labs, and private pharmacies. Responses were recorded by the interviewers and examined for identification of common themes across stakeholders while in country. The team presented a preliminary overview of the emerging findings and recommendations to the MOH prior to the team's departure.

I.2.3 PHASE 3: ANALYZE DATA AND PREPARE THE DRAFT REPORT

Following the in-country data collection, the assessment team transcribed the responses of the stakeholders and reviewed the additional documents collected. The lead for each building block and the private sector lead drafted a summary of the findings and recommendations for their respective areas. The team lead, together with input from the rest of the team, identified key findings and cross-cutting issues and further developed recommendations. The results were compiled in an initial draft and submitted to quality advisors in the Health Systems 20/20 project and USAID for review. A final draft was submitted to the MOH for review and approval.

I.2.4 PHASE 4: VALIDATE FINDINGS AND PLAN NEXT STEPS

The assessment team used the findings in this draft report to conduct a workshop in January 2012 at which the MOH and key local stakeholders discussed and validated assessment findings and prioritized the recommendations. Special emphasis was placed on looking at the strengths and weaknesses of the health system and the recommendations to strengthen it and the role of the private sector. The team will use the results of the prioritization to identify areas of technical assistance for donors and regional partners in health.

2. HEALTH SYSTEM PROFILE AND BACKGROUND

2.1 INTRODUCTION

The Federation of St. Kitts and Nevis is the smallest nation in the Americas in both size and population (estimated at approximately 50,000). St. Kitts is the larger island, covering 68 square miles, and hosts the capital Basseterre and 76 percent of the population. Nevis, separated by a strait that is 2 miles wide at its narrowest, is 36 square miles. The whole country is composed of 14 parishes. The islands are of volcanic origin and located in the Leeward Islands chain. While desirable for tourism, the location also makes St. Kitts and Nevis vulnerable to hurricanes in the Atlantic hurricane belt. Christianity is the most widely practiced religion, the Anglican denomination being the most predominant, and English is the national language.

2.2 POLITICAL AND MACROECONOMIC ENVIRONMENT

St. Kitts and Nevis achieved independence from the United Kingdom in September 1983 and has inherited much of its political and social systems from the British. Despite achieving independence as a twin island nation, relations are still somewhat tenuous between the two islands. Nevis residents sometimes feel their needs are unrepresented at the federal level, which is seated in St. Kitts. Federal-level leaders deal with national security, policy, and relationships with other international organizations and entities. The constitution gives Nevis considerable autonomy. Nevis has an island assembly, a premier, and a deputy governor general. The constitution also allows for secession, though the latest referendum to separate Nevis from the federation in 1998 did not achieve the two-thirds majority needed to pass.

The prime minister, currently Dr. Denzil L. Douglas of the Labour Party, is the head of government. St. Kitts and Nevis has a single National Assembly responsible for making laws, comprising 15 members. Eleven are directly elected representatives and three are senators appointed by the governor general (two on the advice of the prime minister and the third on the advice of the leader of the opposition). In addition, the attorney general automatically receives a senate seat. Of the 11 elected members, eight represent St. Kitts and the remaining three represent Nevis. The prime minister is appointed from among the representatives by the governor general.

Although the country is politically stable, party affiliation plays a major role in the life of the federation. Party affiliations are generally well known; informants in this assessment reported reticence in talking about politically charged issues in front of members of the other party or receiving donations from individuals known to support the opposition party. This is not specific to the ruling party, rather it is the case with members of both political parties.

St. Kitts and Nevis has a market economy and is a member of two important regional bodies, the Caribbean Community (CARICOM) and the Organization of Eastern Caribbean States (OECS). CARICOM, established in 1973, created a vision for common political, economic, and legal policies although the organization does not have supranational political powers. It now includes 15 member countries. The OECS was formed in 1981 by the six smaller island nations of CARICOM that desired

greater integration: Antigua and Barbuda, Dominica, Grenada, St. Kitts and Nevis, St. Lucia, and St. Vincent and the Grenadines. The OECS has successfully created a common currency and central bank (based in St. Kitts and Nevis) and it regulates banking and securities, telecommunications, and aviation. It has developed common foreign, defense, and security policies. The organization has also created common strategies to deal with regional concerns such as education, health, agriculture, tourism, and the environment (International Bank for Reconstruction and Development 2010).

Historically, the Kittitian economy was dominated by sugar cane farming. In 2005, changes to the African, Caribbean, and Pacific/European Union's Sugar Protocol, which gave preferential, guaranteed access to the European Union's markets and preferential pricing to nations, led the government to officially discontinue support of the sugar cane industry (Sugar Industry Diversity Foundation 2011). The loss of preferential access, lower market prices, and high production costs were all factors that contributed to this decision. Since 2005, St. Kitts and Nevis has attempted to transition away from a sugar-based economy by focusing on tourism and offshore banking (Greaves 2008). Nevis's economy, on the other hand, was historically dominated by cotton; the loss of the sugar industry has not affected Nevis as dramatically (Kairi Consultants Limited 2009).

Table 2.1 provides an overview of economic indicators as they relate to health in St. Kitts and Nevis compared with the Latin American and Caribbean region. As the table shows, St. Kitts and Nevis has a much higher gross domestic product (GDP) per capita and lower income inequality than other nations in the Latin American and the Caribbean (LAC) region. Economic growth, however, was severely restricted in 2009 and thereafter due to the recession.

TABLE 2.1: INCOME AND INEQUALITY INDICATORS FOR ST. KITTS AND NEVIS

	Source of Data	St. Kitts and Nevis	Year of Data	Latin America & Caribbean	Year of Data
GDP per capita (constant 2000 US\$)	WDI-2011	8,022.00	2009	4,030.56	2008
GDP growth (annual %)	WDI-2011	-8 4.6	2009 2008	4.22	2008
Gini coefficient	Kairi Consultants-2009 (St. Kitts and Nevis)/ WDI-2010 (regional)	39.7	2007/8	51.28	2007
Central Government Gross Debt (% of GDP)	World Economic Outlook Database -2011	155.79	2010	50.71	2010

St. Kitts and Nevis is stable economically, although high levels of national debt continue to be a challenge. Currently, the economy is highly dependent on tourism and vulnerable to external forces such as natural disasters and fluctuating exchange rates and commodity prices. Despite the discontinuation of the sugar industry, agriculture remains a major industry and offshore banking is developing, more strongly in Nevis than in St. Kitts (Kairi Consultants Ltd 2009). While the Eastern Caribbean Central Bank stipulates that members in the currency union should not carry a debt-to-GDP ratio higher than 60 percent, St. Kitts and Nevis's debt-to-GDP ratio was as high as 186 percent in 2005 and was 170 percent in 2007. Along with debt, public sector efficiency, poverty, and crime are major challenges. Country poverty assessments in 2007/2008 found almost 22 percent of the St. Kitts and

Nevis population living below the national poverty line. The poverty rate is greater in St. Kitts compared to Nevis, 24 percent versus 16 percent. Unemployment is 5.1 percent. Among the poorest quintile of the population, remittances account for over 30 percent of income in St. Kitts and Nevis (Kairi Consultants Ltd 2009).

There are considerable opportunities for investment in St. Kitts and Nevis given the stable exchange rate of the Eastern Caribbean dollar (EC\$), ample incentives offered by the government, and a generally well-educated population. However, despite these incentive programs, investment in St. Kitts and Nevis is hampered by its physical size and location. The lack of manufacturing on the islands means most goods must be imported, which increases the costs. Further, St. Kitts and Nevis has a talented but very limited resource pool for skilled workers. Many skilled workers explore opportunities in other Caribbean islands, in the United States, or in Canada.

2.3 KEY HEALTH INDICATORS

Table 2.2 provides a quick summary of key health service and health outcome indicators for St. Kitts and Nevis. Primary care service coverage indicators are extremely strong, with universal coverage of key childhood vaccines and skilled attendance at delivery. The true seroprevalence of HIV is unknown, but the estimated prevalence continues to be a source of concern. ART coverage is high among registered cases, but many affected individuals may not be captured by the public sector information system, given the severe stigma associated with HIV and AIDS.

TABLE 2.2: KEY SERVICE DELIVERY AND HEALTH STATUS INDICATORS FOR ST. KITTS AND NEVIS

Indicator	St Kitts and Nevis
Hospital beds per 1,000 ¹	6
Contraceptive prevalence (%) ²	54
DTP3* immunization coverage: one-year-olds (%) ²	99
Estimated prevalence of HIV (% of population aged 15–49) ³	1.1
HIV prevalence rate (actual recorded HIV cases) ⁴	0.46
ART coverage among registered cases with advanced HIV infection – 2006 WHO guidelines (%) ⁴	93%
Tuberculosis (TB) prevalence rate (per 100,000 pop.) ⁴	11
Pregnant women who received 1+ antenatal care visits (%) ⁵	100
Health care by trained personnel - prenatal (%) ¹	100
Health care by trained personnel - at birth (%) ¹	100

*DTP3 – Three doses of diphtheria toxoid, tetanus toxoid and pertussis vaccine.

Sources:

1 – PAHO *Health Situation in the Americas: Basic Indicators*, 2010d; latest available data.

2 – World Bank, *World Development Indicators*, 2011 (data from 2008).

3 – OECS country data taken from 2001 Joint CAREC-CDC estimates reported in OECS Round 10 Global Fund Proposal.

4 – UNGASS Report 2010.

5 – WHO, *Global Health Observatory*, 2011 (data from 2007). * 2006 data.

No. of facilities offering VCT	No. of facilities offering PMTCT	No. of facilities offering ART	No. of facilities offering Care and Support Services
21	18	3	4

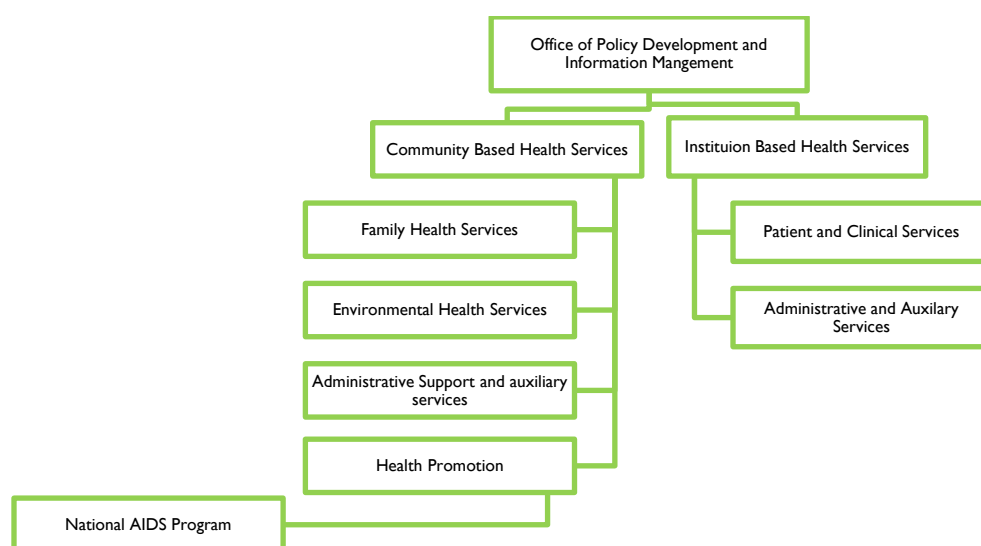
Sources: USAID, Office of the Representative to Barbados and MEASURE Evaluation. 2007. An HIV/AIDS Situational Assessment: Barriers to Access to Services for Vulnerable Populations in St. Kitts and Nevis.

2.4 HEALTH SYSTEM OVERVIEW

2.4.1 MINISTRIES OF HEALTH

As a twin-island federation, there are two ministries of health, one on each island. Each MOH is responsible for organizing and managing public health services and policy. The MOH on St. Kitts handles federal-level responsibilities, including reporting data, creating the national strategic plan, and administering procurement for the entire federation. Each MOH is divided into an administrative branch directed by the permanent secretary (PS) and a clinical branch, which is directed by the chief medical officer (CMO) in St. Kitts and the medical officer in charge in Nevis. The PS is responsible for finance, budget, and personnel decisions while the CMO advises on clinical matters and reviews policies to improve quality and promote health. Both ministries follow the same general organization; the structure for St. Kitts is shown in Figure 2.1. The minister of health, PS, CMO, principal nursing officer, and health planner are based in the Office of Policy Development and Information Management. The Community Based Health Services branch oversees primary care in community health clinics while the Institution Based Health Services oversees secondary facilities such as hospitals and nursing homes.

FIGURE 2.1: STRUCTURE OF THE MINISTRY OF HEALTH IN ST. KITTS



St. Kitts and Nevis's National Strategic Plan for Health (2008–2012) was developed based on the results of the Essential Public Health Functions evaluation conducted in conjunction with PAHO. The seven priority areas are chronic noncommunicable diseases (NCDs) nutrition, and physical activity; family health; health systems development; mental health and substance abuse; HIV/AIDS and sexually transmitted infections (STIs); health and the environment; and human resource development.

The government of St. Kitts and Nevis began addressing public sector reform in the late 1990s. The development of human resources and management capacity has been a main focus of the process. Health sector changes included establishing a health promotion unit to emphasize prevention, upgrading hospitals (largely funded by the European Union), upgrading primary care facilities to better accommodate a primary health care approach, increasing scholarships for human resources for health (HRH), increasing in-service training for nurses, restructuring nursing services to give greater autonomy to managers, and investigating user fees and national health insurance. National health insurance remains a priority.

2.4.2 HEALTH CARE FACILITIES

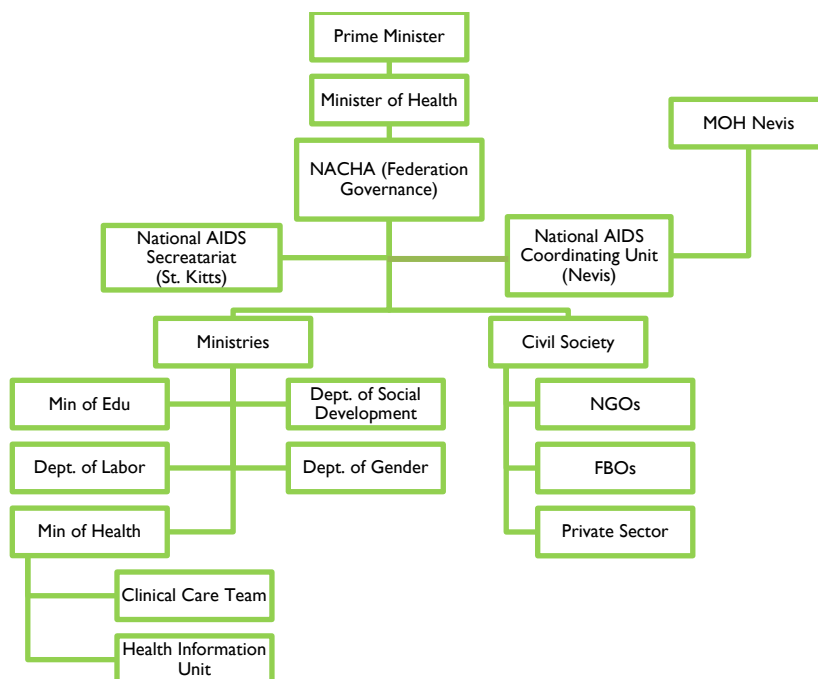
Public sector health services in St. Kitts and Nevis are delivered through 17 primary health care centers (11 on St. Kitts and six on Nevis) in addition to four hospitals. Each primary care community health clinic is located so that no one must travel more than 3 miles for care. The main referral hospitals are the 150-bed Joseph N. France (JNF) Hospital in St. Kitts and the 50-bed Alexandra Hospital in Nevis. There are also two district hospitals in St. Kitts, including the recently remodeled Pogson Medical Center in Sandy Point. There are no private hospitals. Those individuals needing tertiary care are referred overseas. Many solo private practitioners operate on the island, and there are private health facilities offering senior care.

For children receiving primary- and secondary-level care and seniors over the age of 62, health care services and medications are free. The public sector system is perceived by many to be targeted to these two populations, although there are no formal restrictions. Small user fees are charged for adults who use public facilities and purchase pharmaceuticals.

2.4.3 NATIONAL AIDS PROGRAM

As with the MOH, the National AIDS Program has units on both islands. The National Advisory Council on HIV/AIDS (NACHA) is responsible for overall direction, oversight, policy development, and resource mobilization. NACHA members include representatives from government and civil society, and NACHA advises the cabinet and prime minister. The National AIDS Secretariat (NAS) reports to NACHA and development partners on progress. NAS is responsible for programs in St. Kitts and for the federal program. The Nevis AIDS Coordination Unit has similar responsibilities, but only for the national program activities and partners in Nevis, and reports to NAS. Figure 2.2 provides a schema of this dual organizational structure.

FIGURE 2.2: ORGANOGRAM OF THE NATIONAL AIDS PROGRAM IN ST. KITTS AND NEVIS



2.4.4 KEY HEALTH SECTOR ACTORS

Table 2.3 provides an overview of the key actors in the St. Kitts and Nevis health sectors and summarizes their roles.

TABLE 2.3: KEY ACTORS IN ST. KITTS AND NEVIS HEALTH SECTOR

Health Services and Products	Role and Relationship
<p>Public</p> <ul style="list-style-type: none"> Ministry of Health 	<p>Policy and planning capacity; development of performance- based budgeting, strategic and annual operating plans. Regulatory authority restricted due to absence of Pharmacy Council and lack of funds for inspection and enforcement. The government is the primary provider of health care, and employs the majority of physicians and almost all nurses. The public sector delivers only primary- and secondary-level health care.</p>
<ul style="list-style-type: none"> Prime Minister’s Office of Human Resource Management 	<p>This office establishes and directs civil services policy and system and manages MOH personnel.</p>
<p>Private</p> <ul style="list-style-type: none"> Private physicians Private nurses Private pharmacies Private laboratory 	<p>Private health sector is primarily composed of physicians in solo practice. The majority of specialists are in the private sector. The estimated number of strictly private providers – 15 – underestimates the number of public providers with a private practice. Private pharmacies outnumber public sector pharmacies. A small number of private nurses work in a private practice under a physician’s supervision. There is only one private laboratory. There is ad hoc and informal coordination between MOH and the private health sector based on personal and professional relations. Private sector physicians “share” medical equipment, supplies, and staff when public sector experiences stock-outs, equipment failures, and/or staff shortage. They also make use of public hospital infrastructure.</p>
Medical Education Institutions	Role and Relationship
<p>Public</p> <ul style="list-style-type: none"> Clarence Fitzroy Bryant College School of Nursing 	<p>Clarence Fitzroy Bryant College falls under the auspices of the Ministry of Education. The college’s health science division offers a 3-year associate degree in nursing and an 18-month program for nursing assistants. A 15-month midwifery program is also included as it is a requirement for nurses to be registered in St. Kitts and Nevis. There are currently approximately 50 nursing students enrolled. The college is the primary source of nurses in St. Kitts and Nevis.</p>
<p>Private</p> <ul style="list-style-type: none"> International School of Nursing (SK) Windsor (SK) International School of Medicine and Health Sciences (SK) International School of Medicine (Nevis) 	<p>These private offshore medical education institutions cater primarily to foreigners and play a very limited role in training local medical or nursing school candidates. Although the schools offer ad hoc community health services and students provide some additional manpower in health institutions, currently they cannot be considered a significant asset in the provision of local health service delivery or human resources.</p>
Medical Insurance	Role and Relationship
<p>Public</p> <ul style="list-style-type: none"> National Caribbean Insurance Social Security 	<p>The government provides health insurance for its civil servants through National Caribbean Insurance. Beneficiaries can seek care in</p>

	<p>either public or private facilities. Benefits package does not cover spouse/dependents. Many civil servants purchase private health insurance.</p> <p>Social Security provides medical treatment for employment-related injuries.</p>
<p>Private</p> <ul style="list-style-type: none"> • Sagicor/St. Kitts-Nevis Insurance Company (SNIC) • BAICO • CLICO • Nagico 	<p>There is limited uptake of private medical insurance in St. Kitts and Nevis. The private insurance industry in the Caribbean is experiencing turmoil. British American (BAICO) and Colonial Life Insurance Company (CLICO) are under government receivership in all OECS countries. As a result, there is great uncertainty in the insurance marketplace.</p>
<p>Civil Society</p> <ul style="list-style-type: none"> • Red Cross • Diabetes Association • FACTTS (Facilitating Access to Confidential Testing, Treatment, and Support) • Medical Association • Pharmacy Association • Nurses' Association 	<p>Role and Relationship</p> <p>Few NGOs represent the “consumer” perspective in the health sector or advocate for patients’ rights. The Red Cross is one of the few NGOs that advocates for health issues. The Diabetes Association provides services, such as screening, in conjunction with the MOH. There are three professional associations in health, of which only the Nurses’ Association is active. The medical and pharmacy associations have both been dormant for several years.</p>
<p>Industry</p> <ul style="list-style-type: none"> • Major employers • Trade associations 	<p>Role and Relationship</p> <p>Several major employers in tourism, manufacturing, and finance industries offer health insurance to their staff. Few provide HIV/AIDS education and/or prevention and or have HIV/AIDS workplace policies in place.</p>

Note: SK=St. Kitts

2.5 INTERNATIONAL DONORS

St. Kitts and Nevis receives little foreign assistance in comparison to developing countries. In 2009, St. Kitts and Nevis received \$5.8 million in net official development assistance and official aid; the net overseas development assistance was equivalent to 1.1 percent of gross national income.

Coordination of donor assistance is managed through the Ministry of Sustainable Development. Most donors do not have representation on St. Kitts and Nevis itself but rather in regional offices located on Barbados. The European Commission and the Caribbean Development Bank provide some direct assistance to St. Kitts and Nevis while most other donors give financial support to regional entities with the intention of benefiting all member countries. The United Nations Development Programme (UNDP) and the World Bank have discussed initiatives to coordinate efforts in the Eastern Caribbean region through an online database, but the database does not appear functional. There are “Coordination Groups” under UNDP, with partner agencies taking the lead for each area: disaster management, climate change and environmental management (CIDA), governance and information and communications technology (ICT) (United Kingdom Department for International Development [DFID]), poverty and social sector development (UNDP), and trade and private sector development (formerly the European Commission and now the Caribbean Regional Negotiating Machinery). Despite these efforts, practical coordination among donors is still a challenge (World Bank 2009). Other issues

noted during the assessment included the lag between commitments for aid from certain donors to actual disbursement.

The United States Government (USG) supports St. Kitts and Nevis’s health sector through the United States-Caribbean Regional HIV and AIDS Partnership Framework 2010–2014 (Partnership Framework). St. Kitts and Nevis is one of 12 Caribbean countries that has signed on to the Partnership Framework.¹ A major goal of the framework is to move the region toward greater sustainability of HIV/AIDS programs. The Partnership Framework is aligned with national strategic plans as well as with the Pan Caribbean Partnership Against HIV and AIDS (PANCAP) Caribbean Strategic Framework and seeks to achieve results in HIV prevention, strategic information and laboratory strengthening, human capacity development, and sustainability. Each USG agency focuses on a particular aspect of the Partnership Framework, with USAID mainly supporting health systems strengthening, particularly health financing and private sector engagement. The Centers for Disease Control and Prevention (CDC) focuses on laboratory and health information systems strengthening; the Health Resources and Services Administration focuses on HRH and capacity building; the Department of Defense supports HIV prevention activities; and Peace Corps supports individual and institutional capacity building for prevention programs. Table 2.4 highlights key development partners for St. Kitts and Nevis.

At the country level, the Ministry of Sustainable Development coordinates all donations and aid for the country. This ministry has responsibility for donor coordination, public sector investment programs, the annual capital budget, and the implementation and coordination of the National Adaptation Strategy, which is the plan to diversify and reorient the country’s economy toward service-driven industries after the closure of the sugar industry.

TABLE 2.4: RECENT INTERNATIONAL DONOR SUPPORT IN ST. KITTS AND NEVIS

Donors in St. Kitts and Nevis	Activity
World Bank	St. Kitts and Nevis HIV/AIDS Prevention and Control Project (completed)
Global Fund for AIDS, Tuberculosis and Malaria	Grant to OECS funds antiretroviral (ARV) drugs; grant to PANCAP for technical assistance and regional policy setting
European Union	Previous St. Kitts and Nevis grants used for infrastructure and rehabilitation of hospitals.
U.S. President’s Emergency Plan for AIDS Relief (PEPFAR)	Technical assistance for HIV/AIDS programs, health systems strengthening, private sector partnerships building, anti-stigma policies, human resources capacity building, monitoring and evaluation
Taiwan	Financial resources, human resources, training, development of information technology services in JNF Hospital
Canada (CIDA)	Supports CARICOM, improves PPPs, disaster assistance
DFID	Financial resources for HIV/AIDS program; funding for Caribbean HIV/AIDS Alliance’s work with private sector
Cuba	Training, human resources
Australian High Commission	Financial resources for health, supports CARICOM in environmental health
Caribbean Development Bank	Health infrastructure upgrades
Brazil	Donations of first-line ARVs to OECS

¹The 12 Partnership Framework countries are Antigua and Barbuda, the Bahamas, Barbados, Belize, Dominica, Grenada, Jamaica, St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines, Suriname, and Trinidad and Tobago.

2.6 PUBLIC-PRIVATE PARTNERSHIPS

There are numerous examples of collaboration between the government of St. Kitts and Nevis and private businesses, although sustained commitment on both sides has been a challenge. The National Competiveness Council was recently developed to institutionalize public-private partnerships (PPPs) under the Private Sector Development Strategy. A number of PPPs already exist in the health sector. For example, the MOH has outsourced to the private sector to provide CT scans at the JNF Hospital. Private pharmacies receive tax breaks for insulin, which lowers the retail cost. The MOH has also partnered with retailer RAMS Ltd to provide dental and school nurse intervention programs. The Diabetes Association is actively involved in developing policies related to chronic disease. The National AIDS Program works to actively involve faith-based organizations in care and support for people living with HIV (PLHIV), though many of these organizations lack the capacity (both in terms of people available and skill sets) to take a lead in the HIV response. Examples of PPPs are shown in Table 2.5.

TABLE 2.5: SELECTED EXAMPLES OF PUBLIC-PRIVATE COLLABORATION IN ST. KITTS AND NEVIS

Private and Nonprofit Partners	Activity
Caribbean Broadcast Media Partnership	Outreach and social marketing
Rotary Club	Advocacy for diabetes, financial resources
Red Cross	HIV peer education
Caines Foundation	Equipment donations
RAMS Grocer	Sponsors dental and reproductive health school program, outreach screening for diabetes
Insurance companies	Financial support
Cable and wireless	Promotional items
St. Kitts Diabetes Association	Advocacy for diabetes, outreach and screening
Mental Health Association	Outreach and advocacy for mental health issues, financial resources
Reach for Recovery Breast Cancer Support Group	Breast cancer advocacy, mobilizing resources for treatment and emotional support
FACTTS (Facilitating Access to Confidential Testing, Treatment, and Support)	Advocacy for PLHIV, psychological and financial support for members

2.7 HEALTH SYSTEMS STRENGTHENING CAPACITY

The success of health systems strengthening (HSS) activities depends in part on the capacity of implementing organizations. In St. Kitts and Nevis, one of the major challenges is shortages of human resources at all levels. The MOH has the commitment and understanding of health systems to take on HSS and private sector initiatives but insufficient human resources to do so. Leveraging regional networks has been, and will continue to be, an approach that will allow the MOH to guide health system improvements. Table 2.6 demonstrates the challenges the MOH faces in gaining support in-country for HSS efforts.

TABLE 2.6: OVERVIEW OF EXISTING CAPACITY FOR HEALTH SYSTEM STRENGTHENING IN ST. KITTS AND NEVIS

Role and Function	Organization
<p>Leadership to set strategic direction, align stakeholders with the direction, mobilize resources, set standards, and monitor implementation</p>	<p>The MOH, in coordination with Ministry of Finance, Ministry of Sustainable Development, and the Prime Minister’s Office (Human Resources), sets the agenda for health. The MOH has strong support from the Prime Minister’s Office and strong leadership. However, MOH public servants play multiple roles and are stretched thin. As a part of the National Strategic Plan for Health, the MOH has committed to passing legislation to enable it to oversee a broader range of health functions; unfortunately, many of the efforts have been stalled in the Parliament.</p>
<p>Research to provide the evidence for health systems changes</p>	<p>There are no research institutes within St. Kitts and Nevis itself; however, St. Kitts and Nevis leverages its memberships in the OECS and CARICOM to benefit from the work of PAHO, the Caribbean Health Research Council, the Caribbean Epidemiology Center, and the Caribbean Food and Nutrition Institute. Internally, capacity for data analysis needs strengthening.</p>
<p>Technical assistance to address specific problems</p>	<p>St. Kitts and Nevis does not have a pool of consultants, NGOs, or universities to rely on to provide technical assistance. The offshore medical schools provide some resources to support staff at the medical facilities but do not provide strong support in terms of research. NGOs and other civil society organizations lack the numbers and capacity to provide strong technical support.</p>
<p>Training to develop professionals with expertise in strengthening health systems</p>	<p>Regionally there are capacity-building opportunities via the University of the West Indies and PAHO’s supported e-governance programs. On-island opportunities are limited.</p>
<p>Advocacy organizations to build support and hold government accountable</p>	<p>Although some civil society organizations exist, they are also constrained by human resource shortages. Many people leading advocacy associations are also leaders in the public sector. Many civil society organizations are constrained by the lack of professional, full-time staff ,which creates the reliance on volunteers with other full-time commitments.</p>

3. GOVERNANCE

Key Findings

- Key legislation needs updating to regulate a changing health sector, including pharmaceuticals, dual practice, and continuing education for physicians.
- Civil society organizations need greater capacity to play a supporting role in decision-making or planning.
- Public and private sectors do not communicate effectively with each other.
- No formal mechanisms exist for obtaining citizen input about the health system.

Effective governance for health is the ability to competently direct resources, manage performance, and engage stakeholders toward improving the population's health in ways that are transparent, accountable, equitable, and responsive to the public (Health Systems 20/20 Forthcoming 2012). In order to understand health governance in St. Kitts and Nevis, this assessment will look at three primary sets of actors (Brinkerhoff and Bossert 2008): the state, health care providers (whether public or private), and citizens.

State actors include politicians, policymakers, and other government officials. Together, they develop, implement, and enforce the rules and regulations that govern the health system, provide policy leadership and oversight, organize state-managed insurance schemes, and determine financing for significant parts of the health system. State actors are also responsible for responding to citizens' "voice," as expressed in elections or advocacy efforts. Providers are public and private sector health care staff and facilities and the organizations that support service provision. Their main role is to deliver services to clients and provide information to policymakers on health system performance. They also lobby state actors in support of their own interests. Citizens are consumers of health services. Citizens' interest in health extends to the societal benefits of health services, not only the health system's impact on individuals. Citizens can interact with providers as individuals, or can engage through civil society organizations that represent their interests. They seek to influence policy formulation and service delivery through advocacy, offering feedback to health providers, and demanding performance from both providers and governments.

The linkages between these three categories of actors constitute the core of health governance. This assessment seeks to understand the linkages between these actors in St. Kitts and Nevis, how structures reinforce or inhibit these linkages, and how these linkages influence the ability of the health system to meet performance criteria.

3.1 OVERVIEW OF GOVERNANCE IN ST. KITTS AND NEVIS

The World Bank Worldwide Governance Indicators are composite indicators that draw on a wide variety of sources to score six elements of governance. Percentiles show the percentage of countries in the world that scored lower than St. Kitts and Nevis on the selected indicators. These indicators give an overall picture of the strength of governance structures in St. Kitts and Nevis (see Table 3.1).

TABLE 3.1: ST. KITTS AND NEVIS PERCENTILE RANK (0–100) AMONG ALL COUNTRIES FOR WORLDWIDE GOVERNANCE INDICATORS

Governance Indicator	2000	2003	2005	2007	2009
Voice and Accountability	79.3	71.2	83.2	86.5	80.1
Political Stability	N/A	89.4	96.2	75.5	90.6
Government Effectiveness	54.4	43.2	80.1	74.9	75.7
Regulatory Quality	59	59	79	70.9	67.1
Rule of Law	64.3	66.2	74.3	74.3	71.7
Control of Corruption	60.2	63.6	82.5	79.2	83.8

Source: World Bank Worldwide Governance Indicators

In St. Kitts and Nevis, these indicators paint a typical picture for an upper middle-income country, especially one that has seen continual economic improvement over the last decade. On most of the governance indicators, St. Kitts and Nevis ranks in the top quartile among all nations in the world and has shown improvement since 2000. For example, the indicator “Control of Corruption” has seen steady improvement over the last 10 years, and is currently more than 20 points higher than 10 years ago. One minor exception to the positive results is the lower score for “Regulatory Quality,” which most likely has been brought down by weakness in business and financial market regulations.

3.2 POLICY, LEGISLATION, AND REGULATORY FRAMEWORKS

3.2.1 NATIONAL HEALTH SECTOR STRATEGY

The St. Kitts and Nevis National Strategic Plan for Health (NSPH) provides the MOH with guidelines for implementing health programs and addressing specific health issues. The NSPH is aligned with the Caribbean Cooperation in Health Phase II strategy, which outlines seven major priority challenges throughout the Caribbean, such as chronic disease, HIV, and mental health. In addition, the NSPH describes how findings from PAHO’s Essential Public Health Functions study will be addressed.

The NSPH recognizes many of the challenges to ensuring quality health services in St. Kitts and Nevis, such as the increased demand for chronic care, higher pharmaceutical costs, and the introduction of costly new technology. Health systems issues are addressed within each of the seven priorities areas. Common areas of concern include the need for legislative updates, improved data collection and use, better health promotion across a range of diseases, and stronger institutional systems for procurement, financing, and human resources. The NSPH outlines indicators and targets for addressing each of these issues. However, little mention is made of improving the regulatory environment for health professionals. The plan would be stronger if it articulated how the ministry will collaborate with private sector health providers, including pharmacies or doctors, and how the ministry will work with civil society to achieve health system goals.

3.2.2 POLICY AND REGULATORY ENVIRONMENT

Legislation contributes to the proper functioning of a health system by ensuring that providers, clients, and health managers can understand and follow the set of rules that guide the health system. Revising and updating laws to match changes in the surrounding environment is important to guaranteeing that the laws match changing needs, while enforcing these laws through regulatory bodies is critical to ensuring that the laws are followed.

Much legislation in St. Kitts and Nevis has been recently updated, is currently being updated, or is due to be updated soon. Legal reform is a priority of the MOH; the NSPH laid out indicators for enacting or updating specific laws. In spite of this commitment to reform, many pieces of legislation remain in draft form or have not yet been fully enacted. As a result, there are few regulations for some classes of health workers, such as pharmacists, and regulations for continuing education and facility inspection are weak or nonexistent. In addition, while the NSPH identifies strengthening care for NCDs as a priority, national legislation does not address how the increase in demand for services related to chronic care will be financed or provided (Greaves 2008).

3.2.2.1 EXISTING LEGISLATION

The legislative framework that guides the health sector in St. Kitts and Nevis is based on four major pieces of legislation: the Public Health Act, the Medical Act, the Institution-Based Health Services Management Act, and the Nurses and Midwives Act. This body of legislation provides the authority to the MOH to regulate all health providers and health institutions in St. Kitts and Nevis. The MOH exercises this authority through registering health professionals, overseeing hospital operations, ensuring sanitary standards, and regulating pharmaceutical products.

Most of this legislation is quite old, dating back to before St. Kitts and Nevis achieved independence from the United Kingdom. While age alone does not mean that the legislation is no longer relevant, there are specific gaps in both the framework and enforcement of these laws. For instance, the Medical Act provides for the registration of health professionals, including doctors, pharmacists, and dentists. However, it does not require that these professions renew their licenses, nor does it provide for a continuing education requirement or facility inspection.

In contrast, the newly developed Nurses and Midwives Act requires nurses to complete 30 hours of Continuing Nursing Education and renew their licenses annually. This act replaces a 1956 Nursing Act that did not have these provisions.

3.2.2.2 PROPOSED LEGISLATION

As noted above, the NSPH provides indicators and a timeline for relevant legislative updates. Of the seven pieces of legislation identified in that document, two have been passed into law, while the other five are in various stages of the legislative process (see Table 3.2). The proposed legislation seeks to update the laws that regulate the medical profession, pharmacies, medical laboratories, and environmental health in order to bring them in line with other legislation in the region. In fact, informants in this assessment noted the need for at least two of these pieces of legislation to be passed soon: the Medical Act and the Pharmacy Act.

The new Medical Act would replace the 1938 Medical Act, which has been revised and updated numerous times. While the bill has yet to be passed into law, some identified deficiencies in the old legislation included the lack of facility inspection provisions, lack of recognition of the role of private providers, and no continuing education requirements for doctors. These gaps are expected to be addressed by the new legislation, currently being finalized by the drafter. The new Medical Act, however, does not mandate an information-sharing system between the public and private sectors, so that private providers would be aware of national health trends and the government would receive regular reports from private providers on epidemiological trends. Currently, few private providers report health statistics to the MOH.

The Pharmacy Act is much further along in the legislative process than the new Medical Act, having had its first reading in the National Assembly. Currently, the provisions that regulate pharmacies and

pharmacists in St. Kitts and Nevis are found within the Medical Act. This act outlines registration provisions, qualifications, and penalties for noncompliance, which are enforced (to a limited extent) by the Medical Board. For the most part, the new bill was drafted by pharmacists using model legislation from other countries provided by PAHO, including Jamaica and Canada. It makes provisions for the establishment of a separate Pharmacy Board, continuing education requirements, and certification of pharmacies. It also develops a framework for controlling the distribution, storage, and sale of pharmaceuticals. These provisions are either missing or unenforceable under current law. Although there is broad agreement that this law is needed, the MOH has placed a hold on the bill until the Pharmacy Association provides comments. According to our informants, however, the Pharmacy Association has not met in three years, though some informants did note that they had received the Pharmacy Bill by email and had provided written comments.

More broadly, the weakness of civil society advocacy groups, including health provider groups in St. Kitts and Nevis, means that health legislation is largely driven by the MOH, not by associations that ostensibly represent the interests of their members. For a discussion on the role of the Pharmacy Association and the Medical Association, see section 3.3.2.

TABLE 3.2: STATUS OF LEGISLATIVE UPDATES

Legislation	Date to be Enacted*	Currently Enacted	Bill in Draft Form
Nurses and Midwives Act	2008	Yes	N/A
Environmental Health Act	2008	No	Yes
Medical Act	2009	No	Yes
Health Institutions Act	2009	Yes	N/A
Pharmacy Act	2009	No	Yes
Mental Health Act	2009	No	Yes
Laboratory Governance Act	2010	No	Yes

*According to the timeline in the National Strategic Plan for Health

3.2.2.3 REGULATION OF PRIVATE SECTOR PROVIDERS

The government provides little oversight of the private medical sector, as the Medical Council does not appear to have the resources (or mandate) to supervise and monitor the private sector. There were no examples of the council enforcing sanctions against noncompliant behavior in the private sector, according to informants in this assessment. Nonetheless, many private providers voluntarily keep up their clinical knowledge through long distance learning, even though there is no continuing medical education requirement. Private physicians also stated they would welcome the opportunity to participate in the weekly trainings provided at JNF Hospital for public sector staff.

Several areas would merit greater regulatory attention: dual practice (whereby publicly employed health care providers also work in private practice); use of public hospital space by private providers; and oversight of retail pharmacies. As key informants at the MOH in St. Kitts acknowledged, it is quite simple for a public physician to establish a private practice; almost no one has been denied approval. Once approved, there are no guidelines to minimize possible areas of conflict between doctors' public duties and private practice. There are no clear job descriptions in the public sector outlining specific hours, responsibilities, and performance indicators. Everyone interprets the practice differently, creating many opportunities for abuse of the privilege. Indeed, many informants commented that some physicians in dual practice set their own hours in the public sector, receive their private sector clients at public

facilities, and charge fees while receiving private clients in a public facility. According to informants, dual practice has created a double standard as well as resentment among physicians.

Accessing hospital privileges is another gray area. Since there is no private hospital, by default private doctors make use of public hospitals. However, there are no formal agreements on the terms and conditions for this privilege. The practice has evolved over time based on what has been done in the past. Currently, private physicians have full access to hospital rights in exchange for providing “pro bono” testing (such as pap smears), consulting with public sector patients, and sharing surgical and diagnostic equipment (such as fetal monitors). When private providers in this assessment were asked whether they should contribute further toward the cost and expense of using hospital facilities, all felt that their current contributions were sufficient. Some threatened they would leave the island if required to pay fees for hospital usage, while others stated they would be obliged to pass the expense on to the client.

Turning to the pharmaceutical sector, there is currently no regulatory framework to govern and supervise private retail pharmacies, leaving the MOH without the tools needed to enforce laws or sanction unethical practices. In essence, the private pharmaceutical sector is self-regulating. On the positive side, most pharmacists self-report that there are few of the problems observed in other developing countries, such as counterfeit drugs, drug resistance, “suitcase” pharmacies, black markets, or leakage of donated products. But when pressed, informants cited the following noncompliant practices prohibited in other Caribbean countries like Jamaica, Barbados:

- Unlicensed staff dispensing drugs
- Pharmacies dispensing drugs without a prescription
- Physicians establishing “mini-pharmacies” in clinics without proper licenses
- Pharmacies offering free medical check-ups on-site with discounts on drugs prescribed.

Systems to ensure accountability in the pharmaceutical sector are needed, including pharmacovigilance; requirements for continuing medical education and relicensing of pharmacists and pharmacist technicians, to ensure professionals remain current on medical technology; and routine facility inspections to ensure that pharmacies are properly staffed and store drugs adequately. Currently, the MOH does not expect reporting from pharmacies and therefore pharmacies do not report to the MOH.

There is more government oversight of the private lab in St. Kitts. The lab was properly licensed and has been inspected from time to time. The lab owner is working toward meeting international accreditation requirements (ISO1859), and the lab technicians and lab assistants voluntarily participate in webinars and long-distance learning to update their clinical skills.

3.2.3 GOVERNANCE STRUCTURES

As noted above, St. Kitts and Nevis’s federal structure means that the Nevis Island Administration (NIA) has responsibility for all health service provision on the island of Nevis. The NIA collects taxes on the island and participates in customs revenue sharing with the federation. Donor funding is divided, with approximately 70 percent going to St. Kitts and 30 percent to Nevis, according to one source.

Discussions with key informants indicate that this system leads to some level of duplication, but overall, it functions quite well. One of the main benefits mentioned is the ability of the Nevis MOH to be more responsive to the specific needs of the population on Nevis. Coordination around health issues between Nevis and St. Kitts is quite regular, though an often-mentioned challenge is holding joint meetings due to

the need for health practitioners to travel from one island to the other, often Nevisians traveling to St. Kitts. The response to the HIV epidemic is specific to each island as well, with Nevis having a separate HIV/AIDS Coordinating Unit. The separate units on Nevis and St. Kitts often share ideas, promotional materials, and work plans in order to ensure that similar work is being done on both islands.

The separation of authority on the two islands requires that governance structures on St. Kitts are sensitive to the needs of their counterparts on Nevis. For the most part, coordination is strong; however, individual cases of poor responsiveness exist. One example was found in pharmaceutical procurement, as Alexandra Hospital procured its drugs through central medical stores on St. Kitts. Key informants noted that shipments were often delayed, leading to stock-outs at Alexandra Hospital. For discussion on pharmaceutical procurement and distribution, please see the chapter on Management of Pharmaceuticals and Medical Supplies.

The three hospitals on St. Kitts are directly managed by the St. Kitts MOH, as they fall under Institution Based Health Services. As such, the hospitals make up one of the functional units of the ministry. Community Based Health Services oversees primary health care through the 11 health centers on the island. Mirroring the system on St. Kitts, the Nevis MOH has direct authority over Alexandra Hospital and the six health centers on Nevis. This structure is well-defined and individual informants understood their roles and responsibilities within the system.

3.3 CITIZEN VOICE, RESPONSIVENESS, AND TRANSPARENCY

This section will provide an overview of how citizens and civil society interact with all levels of government, and how the government responds to citizen demands and requests. In addition, the ability of civil society and citizens to act as credible partners with government in improving health services will be explored. Transparency is a key issue for this section, as government willingness to make key documents available to the general public and address specific questions is an indicator of the government's commitment to good governance.

3.3.1 CIVIL SOCIETY ORGANIZATIONS

Civil society organizations in St. Kitts and Nevis are mostly volunteer based and service delivery oriented. Many organizations rely on member-supported fundraising drives; little external support is available for nonprofit activities. Disease-oriented nonprofit organizations, such as the St. Kitts and Nevis Diabetes Association and FACTTS, are focused on their specific patient populations, and do not routinely partner with other groups. Short-term collaboration on specific activities or programs may occur, especially in terms of funding from the Rotary Club or the Lions Club. The St. Kitts and Nevis Red Cross Association provides a broader array of services and coordinates with other organizations more frequently. Many organizations are part of regional networks that provide a range of services to their members, including strategic direction, coordination, and funding. The organizations interviewed noted that they often access funding and promotional materials from regional partners.

Advocacy is not always a part of these groups' organizational missions. For example, FACTTS interviewees noted that they saw their role as providing emotional, and occasionally financial, support to their members. The organization had made a decision not to focus on national-level advocacy for people living with HIV and AIDS, in order to focus more on the specific needs of their members. The St. Kitts and Nevis Diabetes Association and the Red Cross do advocate to the government on specific areas of interest to them, including the availability of glucose test strips and public awareness needs regarding sanitation.

The Caribbean HIV/AIDS Alliance (CHAA) was active in St. Kitts and Nevis until the end of 2010, but was dormant at the time of this assessment due to its grant ending. CHAA was expected to reopen before the end of 2011. Key informants at the MOH noted that CHAA brought a great deal of technical expertise and knowledge to the island and that CHAA continued HIV programming that is no longer provided by the MOH, particularly for reaching out to vulnerable populations.

3.3.2 MEDICAL PROFESSIONAL ASSOCIATIONS

Professional associations play an important role in the health system as they give voice to the people delivering services in both the public and private sectors. Such associations can often help regulate their respective sectors. In St. Kitts and Nevis, the dissolution of the two health provider associations, the Pharmacy Association and the Medical Association, has left a gap in how providers can make their voices heard on health policy. Specifically, two very important pieces of legislation that affect both provider communities – the Pharmacy Act and the revised Medical Act – are working their way through the legislative process without a coordinated response from providers.

The Pharmacy Association has been dormant for at least three years. When informants were asked why there has not been a meeting despite the pressing need for a Pharmacy Act, some said the pharmacists did not have enough interest in attending a meeting. Others added that the association had become highly politicized (and therefore personalized), resulting in weak leadership. Contrary to some beliefs about a lack of interest by pharmacists, there is a small group of younger pharmacists who are still motivated and anxious to reconstitute the Pharmacy Association. In 2006, they successfully organized the Caribbean Association of Pharmacists' annual meeting in St. Kitts. The Pharmacy Association is the likely forum to openly discuss and advocate for the Pharmacy Act's approval. Since this organization is defunct, the draft Pharmacy Act has been circulated on a one-by-one basis. There appears to be limited leadership to get the act passed quickly despite its urgency.

Like the Pharmacy Association, the Medical Association is also dormant. There are many reasons for this dormancy, including the following:

- It is difficult for the association to assume its traditional role as advocate for the profession when the majority of its members are civil servants who are restricted by law from lobbying.
- The association has little convening power because there are no mandatory requirements for continuing medical education – no need to offer training opportunities to its membership.
- The association has also become politicized, making it difficult to reach consensus.
- Geography makes it difficult to create cohesion among its members who are located on two islands.

Without this forum in place, private sector physicians feel that their opinions and perspectives are not “heard” by the MOH. There does not appear to be much willingness among former members to reconstitute the association, however, as the perceived ineffectiveness and political conflicts outweighed any benefits received from the association.

A Nurses' Association continues to be active in St. Kitts and Nevis, with most of its activities focused on providing training opportunities for nurses, generally continuing education classes within the hospital. The association also had a strong role in the passage and implementation of the Nurses and Midwives Act. This association has managed to avoid many of the pitfalls of the Pharmacy Association and the Medical Association because most nurses in St. Kitts and Nevis work in the public system; therefore,

there is no divide between public and private providers. In addition, the Nurses' Association has steered clear of advocacy per se, engaging mostly in technical discussions around the Nurses and Midwives Act.

3.3.3 GOVERNMENT RESPONSIVENESS TO STAKEHOLDERS

The MOH has made admirable attempts to engage relevant stakeholders for input on national legislation and policies, despite weak capacity among civil society organizations in St. Kitts and Nevis. Pharmacists were involved in drafting the Pharmacy Act, and have had the opportunity to provide comments on the draft bill through email. In addition, the MOH regularly requests feedback and support from the St. Kitts and Nevis Diabetes Association on diabetes issues and activities. The CMO often goes on the radio to talk about specific health issues. On Nevis, the NIA regularly calls NGOs together to get input on activities and priorities through health policy seminars. Stakeholder engagement during the drafting of the National Health Plan (2008–2012) and the National Strategic Plan for HIV/AIDS (2009–2013) was strong and employed a wide range of NGO and private sector actors.

The Human Rights Desk for HIV/AIDS at the MOH is a formal mechanism for obtaining input and addressing grievances regarding HIV. However, in the three years of its operation, the desk has not had any grievances filed with it. As a result, the main role of the desk has been transformed into leading public awareness campaigns around stigma and discrimination issues.

3.3.4 INFORMATION SHARING

Providing information on health system performance to citizens and citizens groups so that they can formulate their own opinions on how best to address ongoing health system challenges is another important role of government. The government of St. Kitts and Nevis might improve its performance in this regard. Although data and information are available, there is no structured schedule for data dissemination, and no data dissemination strategy exists. As health governance is concerned with data transparency and availability, weak dissemination of health system information is a concern. Key informants noted that health information was hard to find, even when it existed. Media representatives noted that MOH leaders were willing to talk about health issues and statistics on record, but when they requested hard copies of information, they never received a response. Health statistics publications are compiled at the St. Kitts MOH, and actually are used by ministry officials, so the actual development of data does not seem to be the issue; rather, disseminating the information outside the ministry appears to be a challenge. Key informants noted that the lack of a Freedom of Information Act hindered their ability to request information from government sources, as the government is not legally required to provide information upon request.

3.4 GOVERNANCE AND SERVICE DELIVERY

Governance and service delivery intersect on issues of transparency and patients' rights. Although services are free at the 17 health centers in the federation and all hospital services are free for children, the elderly, and the very poor, other patients must pay nominal user fees. It is not clear how patients are identified as being very poor for fee exemptions. In addition, the cashier's desk closes in the evening, so people who are treated at night do not pay user fees. Another transparency issue relates to funds available from the St. Kitts Ministry of Social and Community Development for seeking treatment overseas. Although the amount of money available to each recipient is clearly defined, the decision-making process for determining who will receive the funds is not clear to citizens who need treatment, according to key informants interviewed.

Aside from the Human Rights desk, there does not seem to be a regular system of directly communicating with clients on service delivery issues in the public health system, either through

suggestion boxes, client committees, or focus groups. A planned effort to put in place a patient charter has the potential to inform the public about what service quality it should expect. To be truly effective, institutional structures would also be necessary for addressing service quality complaints, resolving grievances, and enforcing decisions.

3.5 SUMMARY OF KEY FINDINGS

Legislative framework in need of updating

- Key legislation is not in place or updated to regulate the changing health sector, including policies on stigma and discrimination, pharmaceuticals, dual practice, and continuous education for physicians.

Missed opportunities for broader civil society and public/private engagement

- Civil society organizations for health, while welcomed by the government to provide input, do not have the capacity currently to play a supporting role in decision-making or planning.
- Public and private sectors do not communicate effectively with each other.
- Few formal mechanisms exist for obtaining citizen input about the health system.

3.6 RECOMMENDATIONS

3.6.1 SHORT-TERM RECOMMENDATIONS

Prioritize passage of the Pharmacy Act

- Support passage of this legislation as a first priority, so that pharmacies and pharmacists have clear and enforceable guidelines on registration and operation.
- Encourage the MOH to take charge of finalizing comments and moving this bill forward. The Caribbean Association of Pharmacists could be invited to facilitate a participatory discussion between public and private sector stakeholders and consumers in St. Kitts and Nevis. A consultant from the association could also bring regional and international best practices to the discussion. Private pharmacists could be enlisted to help the MOH build support to fast track the Pharmacy Act. Ongoing tracking of the bill once it leaves the MOH is vital to ensuring that it continues to be a priority.

Normalize coordination between public and private sectors

- Improve communication and interaction among stakeholders in both sectors, public and private alike. One concrete approach would be to start involving the private sector in MOH operations. Set a goal (e.g., once per month) to identify opportunities to invite private sector participation, and act upon these opportunities. A “quick win” would be to invite the private sector to Wednesday trainings at JNF Hospital. Private providers said they would gladly participate as students as well as offer to teach, if the seminars could be held at a time more convenient for private providers.
- Mobilize private sector champions to promote current policy proposals. As noted in the recommendation above, the Pharmacy Act presents an ideal opportunity to involve the private sector and to tap into their expertise. Convening participatory discussions around this and other relevant pieces of legislation, such as the Medical Act, could provide a catalyst to engaging private sector stakeholders.

Develop a health communication strategy

- Develop a communication strategy to help the MOH decide how best to inform the public and civil society about health issues and health statistics. Identify effective methods for disseminating health statistics, such as online publishing, press conferences, press releases, and regular web updates on pertinent health information.

Systematize health legislation tracking

- Identify champions who are committed to seeing the legislation through the process and provide them the necessary support. Assign an MOH staff person the responsibility to track various pieces of legislation and ensure that they are not lost in the shuffle or stuck at a specific point in the process, and provide regular updates to the CMO.

Clarify and enforce guidelines on dual practice in the public and private sectors

- Engage in a process to establish clear and transparent guidelines. Identify a “third party” to facilitate negotiation between the public and private sectors. Steps include the following:
 - Convene a working group composed of public and private sector representatives to lead the process to draft dual practice guidelines
 - Review current regulations to determine if guidelines exist for dual practice
 - Examine other country examples, including those in the region, to identify possible approaches that would work in the St. Kitts and Nevis context
 - Negotiate with stakeholders to reach agreement on the guidelines and a process to implement them
 - Monitor implementation and compliance of the new guidelines.

3.6.2 LONG-TERM RECOMMENDATIONS

Strengthen civil society input and capacity

- Develop a small grants program to allow small nonprofit organizations to provide health information in schools or in health fairs, to strengthen the ability of these organizations to manage grants. For instance, the St. Kitts Diabetes Association is interested in providing diabetes education to school age children, due to increasing type 2 diabetes in this age group.
- Consider instituting a civil society forum in order to coordinate the messages of civil society organizations and improve their collaboration. In St. Kitts and Nevis, this could provide a mechanism for common issue advocacy, especially since the number of nonprofits may be small enough to achieve consensus.

Engage stakeholders, including health care consumers, around policy and service delivery issues

- Institute mechanisms for getting citizen input into health quality, through committees, health center days, town halls, or written feedback. The mechanism chosen should reflect the needs and capabilities of the health centers, hospitals, and ministry in improving quality based on citizen input. It is outside the scope of this assessment to recommend a specific approach; this decision should be made based on local capacity and demand.

4. HEALTH FINANCING

Key Findings

- St. Kitts and Nevis is committed to a reasonable level of spending on health, but resource constraints are real and will only become more binding going forward.
- There is widespread interest in national health insurance, but much work needs to be done to arrive at a workable, politically feasible, economically sustainable model.
- Data on health financing are limited, aside from basic budget estimates. There is a striking lack of information on health expenditures or health care costs, especially in the private sector, and little tracking of how service utilization is linked with expenditures or health outcomes. This makes it difficult to advocate for more resources for the health sector and challenging to conduct evidence-based health sector planning.
- Financial sustainability planning for HIV/AIDS programs is needed to ensure continued commitment to high-quality prevention, care, and treatment of HIV.
- The country employs traditional provider payment mechanisms (salaries, fee-for-service), which may not promote cost control or ensure high-quality and efficient service provision.

This chapter presents an overview of health financing in St. Kitts and Nevis. WHO defines health financing as the “function of a health system concerned with the mobilization, accumulation and allocation of money to cover the health needs of the people, individually and collectively, in the health system.” It states that the “purpose of health financing is to make funding available, as well as to set the right financial incentives to providers, to ensure that all individuals have access to effective public health and personal health care” (WHO 2000).

Health financing has three key functions: revenue collection (raising sufficient money for the health system), risk pooling (combining funds raised so that individuals are protected from catastrophic costs and the burden of health spending is distributed equitably), and purchasing of services (allocating funds efficiently and effectively to health service providers). This chapter addresses each key health financing function in turn.

4.1 RESOURCE MOBILIZATION AND REVENUE COLLECTION

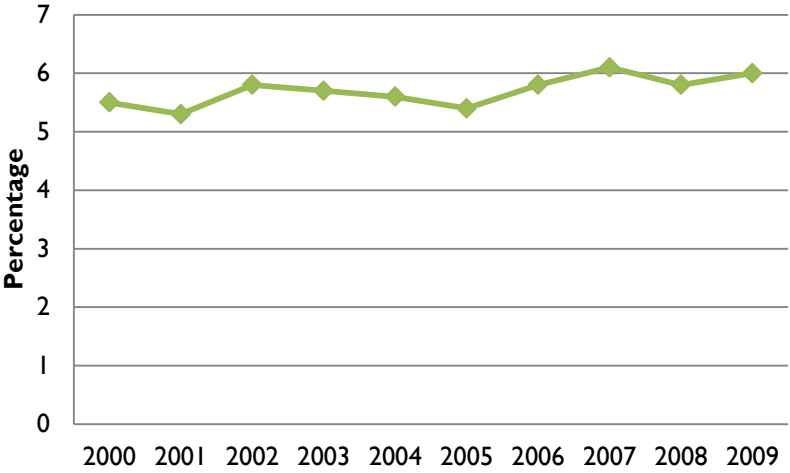
St. Kitts and Nevis has never conducted a formal National Health Accounts (NHA) estimation. This means that health expenditure indicators reported by the WHO’s Global Health Observatory (reported below) are estimates, based on government reports, broad assumptions about private sector spending, and WHO calculations. The figures reported below should therefore be treated with caution. Annex C summarizes trends in these indicators over the past decade.

Total health expenditure per capita was estimated at US\$634 in 2009; this is equivalent to \$839 per capita in international dollars. There has been a relatively steady increase in total health spending per capita since 2000, with a small dip since 2008. Because St. Kitts and Nevis uses the Eastern Caribbean dollar, whose fixed exchange rate with the U.S. dollar keeps inflation low (World Bank 2003), this upward trend over the past decade represents a real increase in the resource envelope for health.

Unfortunately, the global economic crisis since 2008 appears to be decreasing that resource envelope, both through decreases in public budgets and probably through reduced spending by households on private health providers.

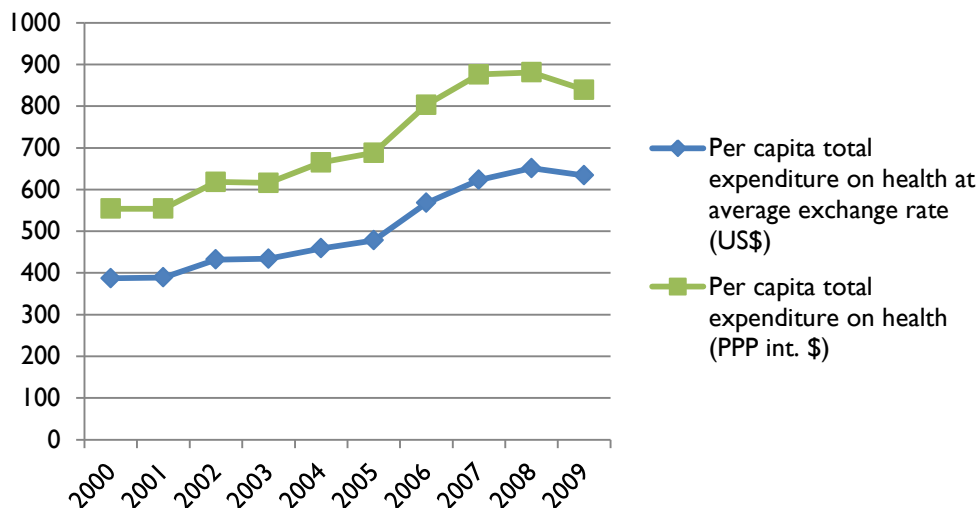
St. Kitts and Nevis's total health expenditure as a **percentage of GDP** was estimated at 6 percent in 2009 (see Figure 4.1). This is slightly less than the average for countries in the LAC region (6.7 percent) and upper middle-income countries globally (6.6 percent) (Health Systems 20/20 Project 2011). This indicator has also been rising very slowly over time; this is consistent with the country's positive income growth, which typically correlates with increased health spending relative to other spending, and an increasing burden of chronic diseases, which are costly to treat. The change in per capita health expenditures is shown in Figure 4.2. Several key informants interviewed during our assessment noted that chronic disease prevention and early diagnosis and treatment programs in St. Kitts and Nevis needed greater emphasis, as a way to control cost escalation in the health sector.

FIGURE 4.1: TOTAL EXPENDITURE ON HEALTH AS A PERCENTAGE OF GROSS DOMESTIC PRODUCT



Source: WHO, Global Health Observatory 2011

FIGURE 4.2: PER CAPITA TOTAL EXPENDITURE ON HEALTH

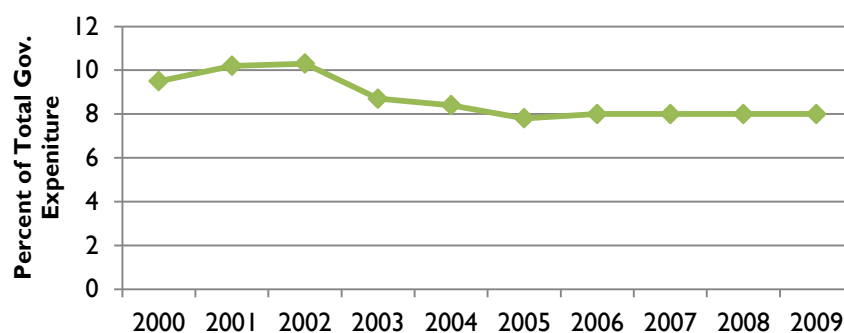


Source: WHO, Global Health Observatory 2011
 PPP int. \$ - Purchasing Power Parity in International Dollars

Government health spending in St. Kitts and Nevis was US\$376 per capita in 2009, a slight downward trend from 2008, which will likely continue given the economic crisis. In relative terms, government spending constitutes an estimated 60 percent of total health expenditure, a share that has remained relatively stable over the past decade. However, the true level of private spending on health is unknown because private health spending data are not collected through surveys or routine information systems.

As noted previously, government revenues are largely raised separately and kept on each island, with most donor funding and some federal-level revenues allocated between the islands according to a fixed ratio. Public funding for health primarily comes from general tax revenues. The country has allocated 8 percent of total government budgets to health over the past several years (see Figure 4.3). This is comparable to budgetary allocations to health in Grenada and Dominica, and less than those in St. Lucia (11.8 percent) or Barbados (10.8 percent). According to interviewees at the Ministry of Finance (MOF), the government aims to maintain approximately the same percentage allocation to health from year to year, though it was not clear how this proportion was originally established. Both health and education are reportedly considered high priorities by the current prime minister and cabinet. In addition, according to informants, the country faces pressure from the European Union to allocate at least 20 percent of the budget to social program spending, in order to maintain eligibility for European Union budget support. These are positive signs that the government prioritizes health relative to other budget items.

FIGURE 4.3: GENERAL GOVERNMENT EXPENDITURE ON HEALTH AS A PERCENTAGE OF TOTAL GOVERNMENT EXPENDITURE



Source: WHO, Global Health Observatory 2011

However, during this assessment many stakeholders expressed concerns about St. Kitts and Nevis’s economic situation and the strong budgetary pressures faced by the public sector. As was also noted previously, the country’s economy is extremely vulnerable – as in all the small island Caribbean states – to downward global economic trends, natural disasters, and its very high debt burden. Lower than expected tax revenues in 2010 forced the country to revise its planned 2010 and 2011 expenditures downward, in some cases substantially (Government of St. Christopher and Nevis 2010b). Health facility administrators also noted that the government’s cash flow problems were resulting in delays in funds transfers.

Some public sector revenue is collected directly from health care consumers in the form of small **user fees** charged at health centers, hospitals, labs and pharmacies. However, these revenues were equivalent to less than 7 percent of total government health expenditure in 2009 (Government of St. Kitts and Nevis 2010b), totaling approximately US\$23 per person. Although this percentage contribution is optimistically projected to increase slightly in the coming years (Government of St. Kitts and Nevis 2010b), facility-level cost recovery will not likely play a substantial role in revenue generation in the near future. Children under 18 and adults over 62 are exempted from all user fees, as are individuals with diabetes or hypertension, pregnant women, and those considered “indigents,” or the very poor. User fee revenue is not kept at health facilities, but must be returned to the treasury, so facility staff have little incentive to put effort into fee collection. Interviewees at health facilities noted that they lack requisite computer systems and staff time to improve fee collection rates. It is very difficult for them to verify who might have private insurance coverage, for instance, and following up with individuals who fail to pay is extremely time-consuming.

Perhaps more importantly, several stakeholders commented that there is cultural reluctance to paying user fees – partly stemming from the widespread belief that free health care is a right. “People think [government] health care should be free,” commented one informant. “Most often people come to the hospital without money.” There is widespread avoidance of payment and inconsistent application of fee exemptions, especially for the poor, implying both equity problems and the potential for misuse of authority when fees are applied arbitrarily. Clearly citizens value equity in access and wish to protect poor and vulnerable groups from burdensome health costs, and this is commendable, but it may make it difficult for the government to generate urgently needed revenue and challenging to use fees to limit inefficient use of public facilities.

Although only a small portion of public sector health funds are raised through direct fees to consumers, the vast majority of **private health spending** is estimated to be paid by households **out-of-pocket**. This should also be a source of concern to policymakers in St. Kitts and Nevis, for several reasons. Private spending plays a major role in health financing on the islands, but occurs in an unplanned, uncoordinated manner. The high level of out-of-pocket spending implies limited financial protection in health for many consumers and a risk that families could be impoverished by catastrophic costs. Over the past decade, the WHO estimates that up to 40 percent of all health spending (or around 95 percent of private spending) has been paid out-of-pocket at the time of using health services or purchasing medicines in St. Kitts and Nevis. This puts it close to St. Lucia (39 percent), Trinidad and Tobago (38 percent), and St. Vincent and the Grenadines (39 percent), but the level is higher than in Antigua and Barbuda (27 percent), Barbados (29 percent), or Dominica (32 percent). St. Kitts and Nevis's dependence on out-of-pocket spending is higher than in the LAC region (34 percent), or among upper middle-income countries worldwide (29 percent).

As a percentage of the total health resource envelope, **international donors** contribute a negligible amount to health financing in St. Kitts and Nevis. The PAHO and the U.S. Government (through agencies such as USAID, CDC, and the Health Resources and Services Administration [HRSA]) provide some technical assistance to the health sector. In addition, the Republic of China (Taiwan) has provided funding in recent years for health information systems and other infrastructure upgrades.

4.1.1 RESOURCE MOBILIZATION FOR HIV/AIDS PROGRAMS

Direct donor funding for HIV/AIDS-related activities has largely ended in St. Kitts and Nevis. The World Bank loan-funded "HIV/AIDS Prevention and Control Project" ended in 2009, having disbursed US\$3.4 million to St. Kitts and Nevis. Along with the other OECS countries, St. Kitts and Nevis also benefited from a multicountry Global Fund Round 3 grant that ended in 2010. The grant was used for prevention, care, and treatment, with a particular emphasis on voluntary counseling and testing (VCT), as well as for behavior change campaigns. The country continues to access free ARVs through the OECS Pharmaceutical Procurement Service, with funding from a multicountry Global Fund Round 9 grant, to the regional PANCAP. Phase I of this funding is slated to end by December 31, 2012.

It is unlikely that domestic spending on HIV/AIDS will be able to replace donor funding in the near future. Reports to the United Nations General Assembly Special Session on HIV/AIDS indicated that domestic sources accounted for between 17 percent and 49 percent of total HIV/AIDS spending between 2007 and 2009, which ranged from US\$1.2 million to US\$1.5 million (NACHA 2010a; NACHA 2008). In both 2010 and 2011, approximately US\$74,000 in domestic funds was allocated to support administration of the national HIV/AIDS response. In addition, a portion of the line item budget for health promotion and prevention is also allocated to HIV/AIDS prevention efforts in St. Kitts (total line item is US\$185,000), along with approximately US\$74,000 in Nevis. When these items are combined, this represents a sharp decline from previous levels of total annual spending with World Bank and Global Fund support. Key informants noted the need for more careful analysis and projection of resource needs for HIV/AIDS programs going forward, especially given the likely reductions in Global Fund support, tight economic times, and the growing burden of NCDs.

4.2 RISK POOLING AND FINANCIAL PROTECTION

In St. Kitts and Nevis, risk pooling mainly happens *de facto* through tax revenue-funded service provision at government health facilities. Primary health care services at health centers are free for local citizens,

including maternal and child health services, chronic disease management, and general medical care services. Fees charged at public hospitals and for medicines, lab tests, and x-rays are modest.²

In all the eastern Caribbean small island countries, one particularly burdensome category of health care costs is off-island care. Advanced tertiary care services (such as hemodialysis, cardiac surgery, and advanced cancer treatment) are not available on St. Kitts or Nevis. Individuals needing such care must seek services elsewhere in the Caribbean (such as Antigua, Trinidad, or Cuba) or in the United States (Miami), incurring higher treatment costs as well as travel costs for themselves and family members. Families are typically left to foot the bill themselves, unless they have private insurance coverage. As one stakeholder put it, “Income determines one’s ability to purchase medical insurance to access post-secondary care off-island.” Very limited financial support for off-island care is provided by the MOH in Nevis and by the Ministry of Social and Community Development in St. Kitts. The government allocations are intended for those who are in urgent need and who absolutely cannot afford to pay. The system of rationing this funding is not entirely transparent, as noted in the Governance chapter; respondents noted that it is based on budget resource availability, the family’s indigence, and the urgency of the case. There was consistency in the perception that the available funding is far less than what is needed or requested, and typically is exhausted partway through the year. The Nevis budget for off-island care, for instance, was about US\$80,000 in 2011 (NIA 2010). St. Kitts imposes a maximum per-person limit of US\$5,000. One government respondent commented that the government might pay for the first chemotherapy treatment, but not be able to support follow-up sessions.

Government employees receive free health insurance coverage, provided by the parastatal National Caribbean Insurance Company³ (NCI), as a benefit of their employment. Approximately 4,000 government employees, or 8 percent of the population, are covered through this scheme according to respondents at NCI. The employees’ dependents are not eligible for coverage. The plan covers basic and major medical care, including services received at public sector facilities or from private sector providers and off-island care when medically necessary and preauthorized. Premium rates are actuarially set and were US\$30 (EC\$80) per employee per month in 2011, according to NCI informants. Claims processing is a major undertaking – handwritten bills and receipts are common. One NCI respondent estimated that they handle about 50 claims per day and felt that the number of claims being submitted had increased over the prior five years, reflecting more cancers and cardiac problems. Major medical services require a 20-percent coinsurance payment from the consumer. This may expose some patients to burdensome up-front costs.

All employed and self-employed persons in St. Kitts and Nevis are required to contribute 5 percent of their wages to the Social Security Fund (Social Security Board [date unknown]). Employers contribute an additional 6 percent on behalf of their employees. The Social Security Fund is primarily an old-age pension program but also provides several other types of income protection: a sickness benefit (covering a portion of lost wages due to extended illness), maternity benefit (13 weeks of partial income replacement postdelivery), maternity grant (lump sum payment of US\$167 per child born), survivor’s pension, disability pension, and funeral grants. One percentage point of the employer’s contribution is allocated to an employment injury fund, which provides coverage for medical expenses incurred due to on-the-job injuries.

² For instance, hospital bed fees in the Joseph N. France General Hospital in St. Kitts are US\$7.40 per day in a six-bed room, and at Alexandra Hospital in Nevis, US\$9.25 per day. There is a US\$3.70 flat fee for any drug purchased at a government pharmacy. (JNF General Hospital brochure)

³ NCI is a subsidiary of the St. Kitts-Nevis-Anguilla National Bank, of which the government owns a majority share.

As noted in the previous section, there is little risk pooling of spending in the private health sector – most private health spending is out-of-pocket. Reliable figures for the percentage of Kittitians and Nevisians who have private health insurance coverage are not readily available. Estimates range from 2.5 percent (WHO Global Health Observatory 2011) up to about 16 percent (Kairi Consultants Ltd 2009 and author’s calculations). Major private health insurance providers include Sagicor (through its local agent, the St. Kitts-Nevis-Anguilla Trading and Development Company and subsidiary St. Kitts-Nevis Insurance Company) and Nagico Insurance. Individuals with private insurance are typically formally employed higher income earners whose insurance premiums are partially subsidized by their employer. The private insurance company representatives we interviewed noted that large employers in the financial services, construction, and education industries are most likely to provide private insurance benefits to their employees. Some government employees may purchase private insurance for their spouses and dependents, but otherwise few individuals buy private coverage.

Key informants in the insurance industry stated that until recently there had been relatively little government regulation of private insurers. The Financial Services Regulatory Commission has reportedly been playing a more active regulatory role since the recent financial failure of two prominent Caribbean insurers, British American Insurance Company (BAICO) and Colonial Life Insurance Company (CLICO). These highly publicized failures have left many individuals with financial losses, and suspicion of private insurance companies has intensified. Regulatory oversight mainly focuses on the financial health of the companies; the commission does not reportedly get involved in monitoring the quality of services provided, for instance.

Information on the incidence of catastrophic expenditures was not available during this assessment. The assessment team heard anecdotal reports of individuals whose pension benefits were wiped out by paying for chronic disease care.

4.2.1 PLANS FOR NATIONAL HEALTH INSURANCE

Both Nevis and St. Kitts have initiated processes to investigate the feasibility of, and develop plans for, a national health insurance scheme that would make affordable basic health care available to all citizens. Multiple key informants indicated that there is widespread interest in national health insurance and seemingly strong political will to move proposals forward. Nonetheless, there reportedly have been many discussions of national health insurance over at least the past decade that have not resulted in much progress, so it is difficult to assess the political viability of current efforts. There appear to be two major motivations for developing national health insurance: first, to find an additional, ideally more sustainable long-term source of revenue for the health system; and, second, to ensure that all citizens have access to affordable health care and are protected from burdensome costs.

As of May 2011 when this assessment was conducted, the Social Security Board had organized an internal steering committee to develop a proposal for universal health insurance, with a very ambitious timeline for scheme rollout, perhaps as early as January 2012. The Nevis MOH had hired a consultant to develop a similar proposal. Additional key players in discussions of national health insurance include leaders in the St. Kitts MOH and the two ministries of finance. The private insurance company representatives interviewed had not been included in any dialogue as yet, although they expressed interest in contributing to the development process. They noted that government leaders might be able to tap into private insurers’ expertise.⁴ The Social Security Board is being considered as a possible “home” for national health insurance, primarily because it has an existing revenue collection platform

⁴ For instance, Sagicor recently introduced online claims settlement for those with group insurance coverage. Their experience with electronic systems might be applicable to development of a national claims information system.

and some experience managing medical claims. Its steering committee has been organizing missions to other Caribbean countries, such as the British Virgin Islands, Jamaica, and the Cayman Islands, to learn about their approaches.

One proposed approach would start with a pilot program initially covering government employees (already insured under NCI) but adding coverage for their dependents as well as for senior citizens and the very poor. A payroll tax, amount yet to be determined⁵, would be levied on employees, with seniors and the very poor covered by the Ministry of Social Services budget; other revenue sources, such as “sin taxes,” could also be levied. Contributions would be earmarked to a Health Fund to pay for an approved basket of services. The specifics of this basket are yet to be determined, but one proposal reviewed included quite comprehensive on-island benefits (prevention, diagnosis, treatment, rehabilitation, palliative, and long-term care) along with selected services off-island. Smart-card technology with a robust information system would allow patient utilization to be tracked and claims to be submitted automatically. The proposal referenced the possibility of establishing a “preferred provider network,” including both public and private facilities – a hopeful sign that the private sector will be explicitly included, given the benefits that improved collaboration between the two sectors could generate. Some type of gatekeeping or approval for advanced-level care would be mandatory, and claims would be managed by a third party administrator (likely an existing private insurer) that would reimburse on a fee-for-service basis.

According to stakeholders interviewed in May 2011, many details had yet to be articulated (such as whether the benefits package should set a maximum value of benefits, or cover a set of specific illnesses). The preliminary ideas in the proposal described above seem reasonable and appropriate, with the one caveat that fee-for-service reimbursement without careful cost control and utilization management mechanisms is known to result in cost escalation over time. More generally, there are also downsides to payroll tax-based insurance systems. Such downsides include a tax on labor and the possibility that they may exacerbate tax avoidance or incentivize employers to hire workers on a temporary basis (World Bank 2003). It will be difficult to cover the portion of the population that is outside the formal sector (such as unemployed or informally employed workers, migrants, and children). Some key informants were appropriately concerned about affordability and sustainability, given the potential for rapid cost escalation if cost control mechanisms are not put in place from the start. Solvency of the old age pension fund is already a source of concern. More broadly, there is uncertainty about how much the scheme will cost, what the population can afford, and what people are willing to pay. The value-added tax (VAT) was imposed very recently, and instituting a new health “tax” seems nearly impossible. “Who will bear the cost of national health insurance?” one interviewed respondent in Nevis commented. “The culture of free care is very strong. There is uproar when you try to change this, and the politicians back down.” In general, moving from generalities to specifics and achieving consensus among varied political constituencies will be very challenging. Much work will be needed to arrive at a workable, politically feasible, economically sustainable model.

There appeared to be little enthusiasm for regional health insurance among senior-level public sector stakeholders at the time of our assessment. Despite interest in the concept – especially in the possibility of portable benefits or insurance that would cover care throughout the OECS – the “devil is in the details” and myriad political challenges persist, making progress very slow. For the moment, several interviewees felt that a national-level process was more feasible and could be achieved more rapidly.

⁵ One off-the-record estimate was 5 to 7 percent of payroll.

4.3 RESOURCE ALLOCATION AND PURCHASING

In this section we look at how health sector money is being spent in St. Kitts and Nevis, including resource allocation patterns, the process by which resource allocation decisions are made, and how payments are transferred to health care providers. These topics address *efficiency* and *cost-effectiveness* in the use of scarce resources.

4.3.1 RESOURCE ALLOCATION PATTERNS

St. Kitts and Nevis use different categories in their budgets, so their allocations are presented separately in tables 4.1 and 4.2 below. For instance, Nevis includes a separate line item for capital investments in health, whereas capital spending is included across budget categories in St. Kitts. The St. Kitts budget also covers some federal-level expenditure for the whole country in addition to island-specific expenditure on St. Kitts.

TABLE 4.1: NEVIS DISTRIBUTION OF HEALTH BUDGETS

Category	2009 actual	2010 estim.	2011 planned	2012 planned
MOH administration, health information, promotion, prevention	14%	12%	13%	14%
Community health services	22%	20%	19%	20%
Institutional health services	56%	50%	55%	57%
Capital investments	8%	19%	13%	9%
Total (%)	100%	100%	100%	100%
TOTAL (USD)	\$4,695,926	\$6,122,963	\$6,348,519	\$6,321,852

Source: Nevis Island Administration (2010)

TABLE 4.2: ST. KITTS DISTRIBUTION OF HEALTH BUDGETS

Category	2009 actual	2010 estim.	2011 planned	2012 planned
MOH administration	4%	5%	6%	7%
Health monitoring and environmental health	3%	4%	4%	4%
Health promotion and prevention	4%	1%	2%	1%
Community health services	30%	33%	32%	32%
Institutional health services	50%	47%	48%	47%
Support services, medicines, and supplies	9%	8%	8%	8%
TOTAL (%)	100%	100%	100%	100%
TOTAL (USD)	\$14,163,593	\$12,918,148	\$12,931,852	\$13,379,630

Source: Government of St. Kitts and Nevis (2010b)

In both St. Kitts and Nevis, there are indications that wages absorb a relatively high share of the overall health budget, potentially crowding out spending on consumables (drugs and supplies) as well as long-term infrastructure investments. Respondents on both islands noted that “covering salaries comes first” and that cash flow problems limit the ability to procure needed items. Nevis spends between 63 percent and 75 percent of its health budget on health worker compensation. Drugs and medical supplies

contribute an additional 7–8 percent, while capital spending ranges from 8 percent to 19 percent of total budgets. Comparable information on the wage bill in St. Kitts was not readily available, but drugs and supplies consume 8–9 percent of the total budget in St. Kitts, while capital investment was 6 percent of total expenditures in 2009. Questions about whether sufficient resources are allocated for pharmaceuticals, supplies, and maintenance of equipment and buildings have been raised since at least the early part of the last decade (World Bank 2003), so the concerns are not new. Respondents in this assessment expressed anxiety about rising pharmaceutical prices and the increasing share of the budget these inputs are likely to consume – while at the same time it is not considered politically feasible to reduce spending on wages.

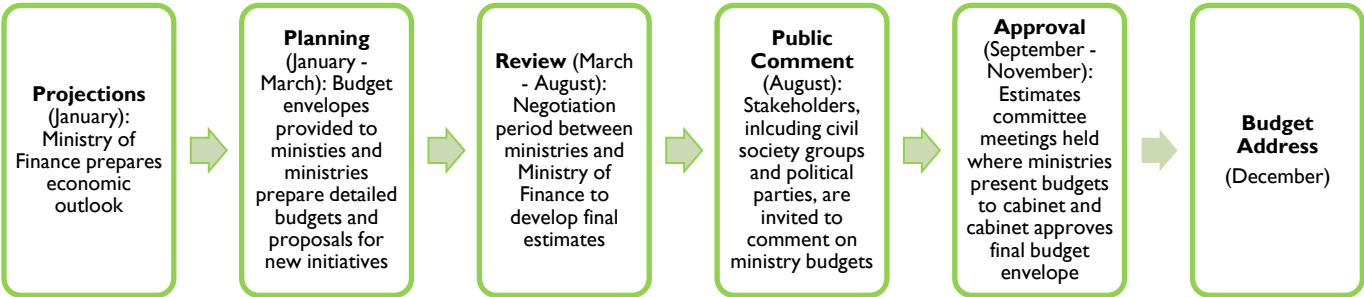
Hospital-based care absorbs approximately half of the health budget in the country, with around one-quarter to one-third of the budget allocated to health center-based services. Health promotion and prevention budgets seem low, given the growing burden of chronic NCDs in the country.

4.3.2 BUDGETING AND PLANNING PROCESS

The public sector budgeting and planning process happens separately on Nevis and St. Kitts. The MOH on each island uses historical budgeting, rather than planning based on the population’s health needs and estimates of resources required to meet them. As indicated above, a relatively constant percentage of the overall recurrent government budget is allocated to health from year to year; it is not clear why this percentage was set, or whether it is the “right” level. In contrast, the percentage allocated to capital investments varies from year to year based on the economic situation, according to MOF respondents.

The budgeting process basically happens in a top-down manner. Civil society organizations, private sector representatives, and political parties have the chance to provide formal input on draft budgets at a stakeholder consultation each August, but that is largely the extent of their involvement. Figure 4.4 depicts the annual budget process. Budgets are largely allocated to cover salaries first, with some minor adjustments to account for new programs or changing priorities. On a more positive note, both islands structure their budgets according to programs – with funding allocations linked to clear objectives, expected results, timelines, and performance benchmarks. Over the past decade, the Canadian government has provided training support to St. Kitts and Nevis in performance-based budgeting. The budget documents appear to be very well-organized and the budget development process seems to be functional.

FIGURE 4.4: ST. KITTS AND NEVIS ANNUAL BUDGET PROCESS



The main concern expressed by senior officials during this assessment was the lack of evidence-based planning in St. Kitts and Nevis, and the absence of information on the real costs of services provided

free through the public sector. This makes it difficult to project the likely benefits of a particular health program investment, to demonstrate to policymakers that the amount allocated for health is or is not “enough” to meet the population’s health needs, or to plan for major policy initiatives such as national health insurance. To make informed resource allocation decisions, health planners need to be able to link information about costs with information about utilization and health outcomes. As was also noted in the introduction to this section, NHA data are not routinely collected or analyzed in St. Kitts and Nevis. PAHO has previously provided some training on NHA, but the process has not been institutionalized.

In a similar vein, concerns were raised about cost escalation in the public health sector – but information about the drivers of cost escalation is lacking. It is difficult to assess whether rising health sector costs are due to increasing utilization of services in general, overutilization of certain services in particular, rising input prices, or inefficiencies in service provision. Specific problem areas cited, based on anecdotal reports, included the excessive use of the Accident and Emergency Department (especially for nonemergency after-hours care) and the increasing demand for mental health services. “There may be an increase in chronic diseases and service use, but it is not really being tracked,” one respondent noted. At the same time, occupancy rates and the average length of stay at public hospitals have been declining in recent years, implying some excess capacity. “If we were in the hotel industry we would shut down a whole wing of the hospital,” another respondent commented. Public sector health facilities lack computerized systems for tracking patient payments and inventory, resulting in difficulties with fee collections and unnecessary stock-outs.

There is also a glaring gap in information related to the private health sector. In essence, no one knows for certain how much money is being spent on privately provided health services. Information is lacking on service utilization patterns in the private sector (which illnesses treated? which providers visited? which services provided? and who is seeking care?), as well as the clinical outcomes of privately provided care. Given that perhaps 40 percent of all health spending occurs in the private sector, according to WHO (although this estimate is in itself of questionable validity), this absence of information should be of urgent concern to policymakers in St. Kitts and Nevis. Not only is there potential for better, more coordinated policymaking and planning if the private health sector is considered explicitly and engaged proactively, but understanding the current role of the private sector is essential in any discussion of national health insurance that might cover private sector care.

In sum, data on health financing are limited, aside from basic budget estimates. Information that links health spending with outcomes achieved is at the crux of the issue. It is hard to know what is being achieved with the resources currently invested and whether more could be achieved with a different pattern of investment. No one knows how much is being spent in the private sector, and this makes holistic, informed planning difficult.

4.3.3 PROVIDER PAYMENT

Provider payment refers to transferring funds to health service providers, ideally in a way that incentivizes efficient, high-quality, cost-effective service provision. As examples, health care providers may be paid a fixed salary; they may receive a fee for each service provided; or they may receive a fixed payment per month for providing treatment to a particular population group, adjusted for the characteristics of that group. Public sector entities may contract with private providers to provide a particular set of services for a fee. Various performance incentives, both financial and nonfinancial, may be employed to stimulate provision of certain high-priority services, to ensure that service are provided in a high-quality manner, or to encourage outreach to particular vulnerable population groups.

Public sector health care workers in St. Kitts and Nevis receive a salary. Some specialist doctors from other countries (such as Cuba) are hired on short-term contracts to fill human resource shortages. Private health care providers charge fees directly to their clients, or sometimes to private insurance companies. Aside from these payment mechanisms, the assessment team did not observe “innovative” provider payment mechanisms being applied. The St. Kitts MOH has outsourced to the private sector to provide CT scans at the JNF Hospital, but aside from this, the two ministries of health do not appear to engage in contracts with private providers. As noted in the governance section, many private doctors routinely make free use of public hospital facilities to treat their private clients, without paying any fees for this privilege.

Given the threat of health sector cost escalation, and especially as plans for national health insurance are developed, St. Kitts and Nevis should consider alternatives to fee-for-service and salary-based payment to providers. Salaries do not incentivize high-quality or highly efficient provider performance, while fee-for-service payment incentivizes overprovision of services and is frequently associated with cost escalation. Contracts with private providers may allow the public sector to finance certain high-end services more cost-effectively (if private provision is more efficient, and if the private sector is better able to maintain equipment or retain specialized staff). Such contracting out might also free up the public sector to focus on better managing high-impact public health programs.

4.4 SUMMARY OF KEY FINDINGS

Cost escalation is on the horizon

- St. Kitts and Nevis is committed to a reasonable level of spending on health and prioritizes health and education in the national budget. However, resource constraints are real and will only become more binding going forward. A widespread sense of entitlement to free health care may be a threat.
- Decisions will have to be made about tradeoffs: what other objectives can be traded off for greater health spending? Where can efficiencies be reaped? Who has the ability to pay more and who doesn't? How much is this population willing to spend?
- St. Kitts and Nevis employs traditional provider payment mechanisms (salaries, fee-for-service), which may not promote cost control or ensure high-quality and efficient service provision.

External funding for HIV/AIDS programming has decreased

- Financial sustainability planning for HIV/AIDS programs is needed to ensure continued commitment to high-quality prevention, care, and treatment of HIV.

There is good basic access to care, but high dependence on out-of-pocket spending

- There is universal low-cost access to primary health care and very good access to secondary care. However, many people use private providers for primary and specialist care, and pay for care out-of-pocket.
- Advanced care must be accessed off-island. Given the limited public resources available for off-island care, advanced care is likely associated with catastrophic costs that potentially impact vulnerable groups in particular (especially the elderly).
- There is widespread interest in national health insurance, but much work to be done to arrive at a workable, politically feasible, economically sustainable model.

Data on health financing are limited, aside from basic budget estimates

- There is a striking lack of information on health expenditures and health care unit costs, especially in the private sector, and little tracking of how service utilization is linked with

expenditures or health outcomes. This makes it difficult to advocate for more resources for the health sector, and challenging to conduct evidence-based health sector planning.

- The program-based budget is very well-organized and budget development process seems to be functional.

4.5 RECOMMENDATIONS

4.5.1 SHORT-TERM RECOMMENDATIONS

Ensure that complete health expenditure information is routinely available, and use it for evidence-based planning

- Conduct NHA estimation routinely, including HIV/AIDS subaccounts. Identify how health funds are actually being spent, including household out-of-pocket spending in the private sector. Determine whether this allocation is appropriate, or needs adjustment. Institutionalize capacity for NHA (either in country or through partnerships with regional entities) so that expenditure information is routinely available for evidence-based planning.
- Estimate the unit costs of providing high-volume and high-priority services in the public sector. Assess whether there are opportunities for contracting with private sector providers to reduce public sector costs, or to improve quality or efficiency.

Engage the full population in discussions of national health insurance

- Initiate a facilitated public discourse process to assess the population's willingness to pay for health care and priorities for health spending. Prioritize getting "buy-in" from the general population as much as the technical details. A national discussion on this topic seems necessary before the government can consider collecting additional revenues from households, and a technocratic "behind closed doors" approach is risky, especially if constituents may be asked to pay a new tax.
- Coordinate development of national health insurance on both islands. It is not logical, and likely not feasible, for St. Kitts or Nevis to "go it alone."
- Identify a "champion"—someone to own the insurance development process and keep momentum going. Given the many stakeholders involved, some type of regular forum and clear leadership are essential.

Conduct necessary analyses to ensure a strong design for national health insurance

- Move deliberately and conduct necessary financial and epidemiological analyses before implementing any model. Careful cost estimates are essential and the necessary data may not yet be available. The approach of starting with a pilot and scaling up makes sense.
- Consider a "mixed" insurance model. Social insurance may not be ideal in all contexts, especially when there is a large dependency ratio or large informally employed population. A mixed model may be most appropriate, combining general tax revenue-financed care for priority groups with a payroll tax-financed health fund, and private insurance as an optional top-up.
- Prioritize protecting what St. Kitts and Nevis has already, which is good access to basic services – it is important to ensure that escalating hospital care costs don't crowd out essential investments in prevention and primary care.
- Draw upon all available sources of technical capacity on the islands for insurance planning and design, including private insurers and MOF staff. Make use of international technical assistance for health financing.

Proactively plan for reduced external HIV/AIDS funding

- Develop a financial sustainability plan for the HIV/AIDS program now that World Bank and Global Fund funding have largely ended. Conduct a projection analysis of available domestic and external funds going forward.

4.5.2 LONG-TERM RECOMMENDATIONS

As national insurance is rolled out, convert user fees into copayments for those services prone to overuse.

- Develop a more effective targeting system, and formalize the application of fee exemptions. There are those who really can afford to contribute, and there are those for whom it will be a serious burden. To ensure equity, a system for distinguishing between these groups needs to be implemented. This will be true even as the country moves toward universal insurance.

Strengthen financial operations systems at health facilities

- Strengthen billing and collection systems at public facilities so that they can better recoup costs from private insurers and patients with ability to pay.
- Develop routine management information systems, ideally at the health facility level, for tracking health expenditures and linking them with service utilization and health outcomes.

Continue to participate in international discussions regarding regional insurance.

- The more each country in the OECS can move forward in a somewhat synchronized manner, the better.

Explore new approaches to provider payment

- Consider experimenting with innovative provider payment methods, such as capitation, global budgeting, or case-based payment, especially as plans for national health insurance are developed. Consider pilot testing performance-based incentives to increase efficiency and quality – providing financial and nonfinancial rewards to health facilities, groups of providers, or communities for achieving particular health target or service provision goal.

5. SERVICE DELIVERY

Key Findings

- There are high levels of access to primary health care services; some inappropriate use of hospital services for primary health care occurs.
- A stronger formal referral system is needed to facilitate monitoring patient continuity of care.
- Quality assurance systems are needed at all levels of the health system. Many patients seek care from the private sector, but there is no quality monitoring of private service provision.
- Decreased external funding for HIV/AIDS programs threatens the quality of HIV prevention and treatment activities, as well as efforts to integrate HIV services into routine primary care.

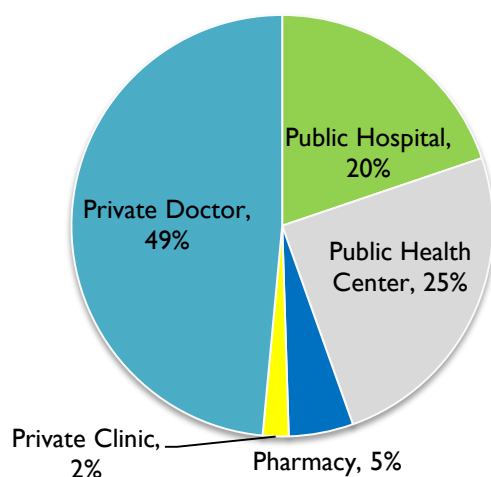
WHO defines service delivery as the way inputs are combined to allow the delivery of a series of interventions or health actions (WHO 2001). According to the WHO, “good health services are those which deliver effective, safe, quality personal and non-personal health interventions to those that need them, when and where needed, with minimum waste of resources” (WHO 2007). Health service delivery is the most visible aspect of the health system because it is often where users interface with the health system. This chapter presents a brief profile of the performance and process of health service delivery in St. Kitts and Nevis.

5.1 STRUCTURE OF THE SERVICE DELIVERY SYSTEM

Health services in St. Kitts and Nevis are provided by both the public sector and a growing private sector. NGOs are not substantial service providers. Key informants suggested that some of this private sector growth is related to perceptions of greater confidentiality and better amenities in the private sector, including shorter wait times and better customer service. Informants also noted a preference for the private sector in providing antenatal and women’s health care. According to data from the 2009 MOH Statistic Report, there are no private hospitals but there were 11 private pharmacies, compared to six public, and a private lab.

Figure 5.1 illustrates the source of health services for the population based on data from the country Poverty Assessment Report 2007/2008. The private sector serves slightly more than half of the population.

FIGURE 5.1: FIRST SOURCE OF HEALTH CARE IN ST. KITTS AND NEVIS



Source: Kairi Consultants Ltd (2009)

5.1.1 HEALTH FACILITIES AND LABORATORIES

As noted in the introduction, a network of 11 public sector health centers in St. Kitts and six in Nevis deliver primary health care (PAHO 2010). Every household is within three miles of a health center, and primary care services are free of charge at the point of delivery. These primary care services include maternal and child health, chronic disease management, and general medical services. The same services are available at both urban and rural centers, which are generally open from 8 a.m. until 4 p.m. Private physicians also offer primary care services although statistics on services provided are not maintained by the MOH. Private physicians are primarily based in Basseterre and Charlestown and operate as solo practitioners. This assessment's authors estimate that as many as 30 out of 47 physicians have private offices on the islands, indicating many are in dual practice.

Two public hospitals – the 150-bed JNF Hospital in St. Kitts and the 50-bed Alexandra Hospital in Nevis (to which the 36-bed Flamboyant Home for Senior Citizens Home is attached) – serve as the country's main referral centers. There are no private hospitals. On St. Kitts, two district hospitals (Mary Charles and Pogson) offer basic inpatient services. Although there is no private hospital, many private providers, particularly specialists, have hospital privileges (see section 3.2.2.3 of the Governance chapter for further discussion on regulations). Tertiary care is not available on either island and requires referral overseas.

Recently the need for senior care has grown. On St. Kitts, the public sector operates the Cardin Home and Saddler's Senior Citizen's Home. Flamboyant Senior Citizens Home in Nevis is both public and private. In addition, three private nursing homes operate on the islands: Grange Nursing Home and Health Care Facility, Brimstone View Nursing Home, and the St. Georges Senior Citizens Home (PAHO 2010).

Both of the main public hospitals have diagnostic laboratories, but they are limited in their capacity. JNF Hospital has an x-ray machine, blood bank, and diagnostics while Alexandra has x-ray and CT scan services (PAHO 2010). Maintenance on machines has been a challenge for the public sector facilities, which have few technicians to troubleshoot problems and must often wait for assistance from overseas

(PAHO 2010). There is one private laboratory –Avalon – in St. Kitts, with a blood “draw center” in Nevis. The laboratory performs a wide range of diagnostic services, including analysis of blood chemistry, urinalysis, serology, and other screening tests. The laboratory does not do HIV testing but does assist public sector labs to interpret or reconfirm complex HIV test results. It has relationships with labs in the United States and Barbados that can conduct tests that it is not equipped to perform. Avalon Lab provides services for the public sector when there are stock-outs or equipment malfunctions, particularly in Nevis.

5.1.2 INTEGRATION OF SERVICES, INCLUDING HIV SERVICES

Primary care health clinics offer antenatal care, postnatal care, family planning, growth monitoring, VCT for HIV, and chronic disease care, particularly for diabetes and hypertension. These services are provided on a rotating schedule, with each day dedicated to a particular service. VCT is reportedly available on a daily basis, while the psychiatric clinic is less regular (once a month). The local district medical officer is in attendance once a week. International best practice suggests that integrated care is the most appropriate method of service delivery so patients can address all their needs at one time at the primary care level (Islam, ed. 2007); however, this approach may not be feasible given the constrained human resources in St. Kitts and Nevis. In this case, service provision should focus on clustering services together that will accommodate as many patients as possible – for example, clustering well-baby check-ups with family planning services and ensuring that services aimed at men do not overlap with sensitive services for women. In the case of St. Kitts and Nevis, some clustering does appear to be happening with postnatal care and family planning clustered together and chronic disease clinics running together.

Integration of HIV services with other services has been a priority for the MOH. World Bank funding for HIV/AIDS prevention and treatment resulted in some verticalization of HIV programs. Since funding for this program ended in 2009, the MOH has recognized that stand-alone programs are difficult to sustain and has made attempts to integrate HIV with sexual and reproductive health services at the primary care level. A United Nations Population Fund-funded assessment in 2009 boosted this effort by identifying current linkages at the primary level (NACHA 2010a). In addition to improving cost-effectiveness, better integration of HIV services could reduce the stigma and discrimination that prevents many from accessing available services.

5.1.3 REFERRALS AND CONTINUITY OF CARE

Another important mechanism for ensuring coordinated delivery of health services is the referral system. The referral mechanism exists so that any patient examined by a primary or secondary care provider in a public or private institution, who is deemed to be in need of specialized consultation or treatment that cannot be provided at that level, is referred to the specialist or institution capable of providing what the patient needs. Informants reported a lack of formal referral systems in general in St. Kitts and Nevis, and an inability to consistently track patients at the individual level to monitor continuity of care. There are no formal referral systems between the public and private sector either, although for many private patients, their doctors also work in the public sector.

As previously noted, tertiary-level care (e.g., MRIs, chemotherapy, and radiotherapy) requires referral overseas. The cost of these referrals may sometimes be covered partially by public funds and/or insurance, but patients may also incur substantial out-of-pocket costs. In St. Kitts the overseas referral process is handled by the Ministry of Social and Community Development, while in Nevis it is handled directly by the MOH. Limited additional tracking of those patients occurs after they are transferred.

The HIV/AIDS program has instituted a unique identifier for HIV-positive patients to help ensure continuity of care and facilitate patient tracking. However, many practitioners do not refer their HIV-positive clients to the public sector HIV/AIDS program. Some clients prefer to remain with their private physician for confidentiality reasons.

The two MOHs in the federation coordinate their activities and have produced a single national strategic plan for health. While this coordination is strong, duplication does sometimes occur. A further level of coordination between the *divisions* within the ministries on each island – the Community Based Health Services Division and the Institution Based Health Services Division – would be beneficial. As noted in the Governance chapter, informants felt the divisions operate fairly independently and that prevention and health promotion activities are not adequately connected to clinical treatment activities.

5.2 PRIORITY SERVICE AREAS

5.2.1 HIV/AIDS SERVICES

Antiretroviral therapy (ART) is available free of charge in St. Kitts and Nevis, thanks to a Global Fund grant to the OECS. ARVs are only distributed from a single location on each island (JNF Hospital and Alexandria Hospital) to facilitate monitoring. A World Bank advanced HIV disease report (2009) indicated that many HIV-positive patients access services in the private sector or off-island due to the strong stigma associated with HIV; this impression was confirmed through conversations with informants, but data from private providers are not routinely submitted, thus tracking is difficult. Informants estimated that the proportion of clients seeking care in the private sector may be around 50 percent. The number of persons accessing care overseas is not known.

Although nutritional and social support services are available, they are not accessed widely. However, ART coverage among registered cases with advanced HIV disease is high (93 percent). It is difficult to evaluate quality of care because there is little feedback from clients and civil society participation is very weak. A knowledge, attitudes, and practices survey was conducted in 2010 with the Health Economics Unit, and results have not yet been released.

As noted in the health financing chapter, since the end of the World Bank loan dedicated to the HIV program, the National AIDS Program has been required to provide the same services with fewer resources. There is concern that the current economic crisis, which is decreasing the government's revenue, will further diminish commitment to HIV programming, especially prevention services.

5.2.2 CHRONIC DISEASES

Chronic diseases (particularly diabetes and hypertension) are currently a leading cause of morbidity and mortality in St. Kitts and Nevis. Of particular concern is the growing number of diabetes-related amputations and the growing number of young people diagnosed with type 2 diabetes. A variety of activities to respond to these public health challenges are coordinated by the MOH's health promotion units on each island, which undertake advocacy, community education, and health status monitoring (PAHO 2007). The Health Information Units (HIUs) of the MOH of both islands are attempting to develop registries for diabetes, hypertension, and cancer, but lack of reporting from the private sector means that the registry data are incomplete.

Nevis has a general shortage of specialists, with the result that patients often must travel to St. Kitts for specialty care. For instance, there is no podiatrist on Nevis; many diabetes patients go without proper foot care rather than arrange to see the podiatrist on St. Kitts. Similarly, Nevis has no nutritionist. There is also growing need for elderly care, given the aging population on both islands.

5.3 ACCESS, COVERAGE, AND UTILIZATION OF SERVICES

5.3.1 COVERAGE AND ACCESS

As discussed previously, geographic coverage of primary care services is excellent in St. Kitts and Nevis, with all households located within three miles of a health facility. However, there are no data on the per capita number of outpatient or primary health care visits, which would provide some insight into actual utilization levels. St. Kitts and Nevis has achieved virtually universal immunization coverage, antenatal care, and skilled birth attendant coverage (see section 2.3 of the Health System Profile and Background section).

Barriers to access still remain. Low-income individuals are usually unable to purchase private insurance, which makes it nearly impossible to afford to seek tertiary care internationally. Although there is very limited public assistance for overseas care, key informants on both islands report there is never enough funding to cover the requests received (see the Health Financing chapter for additional discussion). In addition, primary health center hours are limited, and thus people must either take time away from work to visit a health center, inappropriately use hospitals' Accident and Emergencies departments for afterhours primary care, or pay out-of-pocket for care in the private sector. District medical officers are only available at health centers for short periods, usually once a week.

5.3.2 UTILIZATION

According to key informant interviews, occupancy rates are approximately 36 percent at Alexandra Hospital and 45 percent at JNF Hospital. These are extremely low rates, implying substantial excess capacity and the potential for cost savings. Although access is considered good at district hospitals, key informants expressed concern that uptake of services may be inadequate. No data on uptake or utilization were available to review.

Table 5.1, based on the 2007/2008 country poverty assessment (Kairi Consultants, Ltd 2009), shows where the population accesses health services, according to quintiles of socioeconomic status. Nearly 55 percent of the population sought services from the private sector, either domestically or overseas. While poorer groups were more likely to seek medical attention from a public facility, a considerable percentage sought care in private facilities (39 percent of the poorest fifth and 50 percent of the next-poorest fifth). Nearly 42 percent of those in the wealthiest quintile receive subsidized care in the public sector. Key informants in the private sector confirmed that at least one-third of their patients are poor, and that in the last two years this proportion has been growing. Availability of services at the facility was the primary reason cited for selecting a facility (Kairi Consultants, Ltd 2009).

TABLE 5.1: FIRST PLACE VISITED FOR MEDICAL ATTENTION BY QUINTILES (PERCENT)

Place First Sought Medical Attention	Per Capita Consumption Quintiles					
	Poorest	II	III	IV	V	Total
Public hospital	23.7	23.7	18.2	17.7	20.2	20.2
Public health center	37.7	26.3	27.9	16	21.7	24.5
Private domestic doctor/dentist	24.5	46.2	41.0	46.2	44.4	41.8
Private overseas doctor/dentist/hospital	14.1	3.7	12.9	20.1	13.8	13.0

Percentages are rounded.

Source: Country Poverty Assessment 2007/2008, Kairi Consultants Ltd.

5.3.3 AVAILABILITY AND UTILIZATION OF HIV COUNSELING AND TESTING SERVICES

According to the St. Kitts and Nevis HIV/AIDS National Strategic Plan (2008–2013), VCT services for HIV are widely available, but demand remains low. Key informants confirmed this finding, stating that outreach testing is done in collaboration with the Community Health Department, but confidentiality concerns contribute to low uptake. JNF Hospital provides VCT for about 15–20 clients monthly. VCT is available at approximately 21 public sites, including all health centers and hospitals. Counseling and testing can be provided alongside other primary health services; for example, mothers can bring children into child health clinics and be tested at the same time. Key informants noted that more flexible hours at health centers would be useful for increasing access to counseling and testing services, as most sites are open only from 8 a.m. until 4 p.m. There are no stand-alone VCT centers. Only one lab processes blood tests for HIV. Some clients are lost between testing and receiving results since follow-up requires another trip to another site, which can pose logistical and financial constraints.

5.4 QUALITY ASSURANCE FOR HEALTH CARE

Overall, most MOH informants interviewed in this assessment rated service quality in the public sector as being generally good. Nonetheless, key informants at facilities (both health centers and hospitals) expressed concerns that infrastructure was inadequate (e.g., too small, lack of privacy, inadequate equipment or supplies) for high-quality service delivery.

A recurring theme that arose across all key informants was the lack of adequate quality assurance standards and activities at all levels of the system. There is a dearth of policy documents outlining clinical standards and norms. The CMO drafted a position statement on quality of care in February 2011 and submitted it to the MOH for consideration, but there has been no action on the statement to date. Quality assurance for private providers is ad hoc. Legislation was introduced in 2006 to help address some of the gaps in quality assurance, such as enforcement and accountability, but this legislation has not been finalized.

At Alexandra Hospital in Nevis, the quality coordinator position was open at the time of this assessment. Quality assurance activities are limited to the Nursing Service Department. The hospital did have a selection of quality assurance manuals, along with revision and auditing processes for those

manuals and their accompanying procedures. At the Charlestown Health Center, the quality assurance program was described as dormant, though some limited quality assurance work had been done at the facility in the past.

In recent years, the JNF Hospital has sought accreditation from Accreditation Canada, in order to certify the quality of services that are being provided; however, accreditation has not yet been awarded. The hospital plans to establish a multidisciplinary quality assurance committee under the leadership of a relatively new quality assurance coordinator. Key informants reported a desire for quality assurance training and noted that PAHO offers several trainings and training materials that might be useful. In 2006, a readiness assessment report was developed that outlined areas in which the hospital needed to improve in order to become accredited. A self-study was ongoing in 2008, but the accreditation process appears to have stalled due to poor follow-up on these two studies. Part of the accreditation process included the development of a patient charter, which will codify the rights of patients and outline what they should expect when they come to the hospital.

Some efforts are made to collect data on patients' perception of services at Alexandra Hospital: patients are given a written survey and providers try to ensure that these surveys are completed and submitted before patients leave. Most patients are happy with the clinical care they receive, but they tend to complain about lengthy waiting times and how staff members treat them. Customer service is seen as the major area of improvement required to enhance the services that the hospital provides. JNF Hospital has a comment box in each unit, but patient comments are not currently systematically analyzed, and no other quality assurance activities are conducted systematically. Previously a task force that included two community members would report quarterly on the comments received, but that task force is not currently operational.

Very little client or provider feedback on HIV/AIDS services is captured by the National HIV/AIDS Program on either island, making it difficult to evaluate quality of care. Policy documents are available in the HIV program and some health care workers have been trained in their use, but there is no monitoring to ensure adherence to the policies.

5.1 SUMMARY OF KEY FINDINGS

Access to care is good but there is inappropriate use of secondary care facilities

- There is good access to and coverage of primary and secondary care.
- There is some inappropriate use of hospitals for primary care seeking, due to limited operating hours at clinics and perceived better quality care at hospitals.

HIV/AIDS services are being integrated into primary care but threatened by decreased funding

- HIV/AIDS counseling and testing services are somewhat integrated into primary health care service provision.
- ARVs are only available at the secondary level.
- Decreased external funding for HIV/AIDS programs threatens the quality of HIV prevention and treatment activities, as well as efforts to integrate HIV services into routine primary care.
- Fears of stigma and discrimination continue, which prompt many PLHIV to access services outside the public sector.

Coordination between institutional and community health services could be improved

- Coordination between institutional and community health services could be improved.
- Referral continuity is limited, especially between public and private sectors.
- The clinical care team for HIV/AIDS has had some limited success. The mechanism was created to ensure the quality of services provided and confidentiality. It has been successful in identifying qualified professionals that many patients seek out in the private care setting, although it is believed that not all patients are referred to the system (NACHA 2010a).

Supplies and some equipment are perceived to be inadequate

- Limited supplies and equipment, particularly for laboratory diagnostics, often means that patients must send samples or go overseas for care. Limited capacity at the primary care level leads to increased use of the hospital Accidents and Emergency unit.

Quality assurance is limited

- Some policies and standards are available, but quality assurance activities are limited overall. Exceptions include quality assurance for HIV/AIDS programs and labs.

5.2 RECOMMENDATIONS

5.2.1 SHORT-TERM RECOMMENDATIONS

Prioritize quality assurance efforts

- Establish a multidisciplinary Quality Assurance (QA) committee at the national level. This committee could lead in the development of guidelines for care, treatment, and rational use of diagnostics and medicines. Ensure that private providers are represented on the committee and are addressed explicitly in QA initiatives.

Improve referral systems and coordination between community nursing and institutional care

- As a preliminary step in this process, encourage regular interaction through regular meetings between key personnel in each division or joint planning.

Continue to prioritize HIV/AIDS stigma-reduction efforts

- Continue these efforts for the community at large as well as for public and private providers. Continue to promote integrated primary-level availability of counseling and testing services as a means of enhancing access and reducing stigma.

5.2.2 LONG-TERM RECOMMENDATIONS

Establish a critical care team for NCDs

- Identify a limited number of public and private providers and pharmacies to participate as “NCD champions,” who could assist in the development of guidelines for the treatment and prevention of NCDs and develop messages for health promotion campaigns.

Develop patient charters

- Develop charters to help ensure that patients are aware of their rights and can hold providers accountable.

Consider developing new strategies for motivating nurses

- Motivate nurses through monetary and nonmonetary incentives.

6. HUMAN RESOURCES FOR HEALTH

Key Findings

- Although there is broad access to primary health care providers, there is a lack of specialists, including mental health professionals, nursing specialists, community health nurses, internists, radiologists, and health promotion specialists.
- Currently there is a shortage of nurses, driven by the mandatory retirement age and a lack of interest by young professionals in nursing careers.
- Local training opportunities for health professionals are limited and occur mostly offshore.
- Nurses are required to undertake 30 hours of continued nursing training annually, while doctors do not have in-service training requirements.

Human resources for health impact the costs and quality of health service delivery, and, ultimately, the health outcomes in a country. As such, an examination of the HRH situation is a critical component of a comprehensive health systems assessment. This chapter seeks to determine the status of HRH in St. Kitts and Nevis and to make actionable recommendations for improvement. For the purposes of this analysis, the team uses the WHO definition of the health workforce, which comprises “all people engaged in actions whose primary intent is to enhance health” (Islam, ed. 2007). This includes those who promote and preserve health as well as those who diagnose and treat diseases, health management and support workers, and those who educate health workers. The assessment addresses such factors as numbers and distribution of health personnel; the status of HRH policy, planning, and management; and leadership, education, and training.

6.1 HEALTH WORKFORCE

As described in the previous chapter, primary health care is readily accessible throughout St. Kitts and Nevis. For the entire country, there is a sufficient number of medical doctors although they may not be equally distributed across the islands. However, there are vacancies for nursing positions and there is a widely recognized lack of certain specialists, including mental health professionals, nursing specialists, radiologists, community health nurses, internists, and health promotion specialists (e.g., nutrition education, epidemiology). For more information on current and historical numbers of health workers by category and sector, see the discussion on public and private health care issues in section 9.1. Private Sector Health Care Providers.

6.1.1 RECRUITMENT/HIRING

Because of the limited pool of qualified national health professionals, St. Kitts and Nevis is required to recruit regionally. Most pharmacists and specialists are from elsewhere. Offshore schools (medical training institutions that primarily target students from outside the Caribbean) produce a very limited number of new graduates seeking and obtaining employment in the local health sector. There may be a need for more aggressive recruiting regionally or further afield. Establishment of bilateral agreements with other countries, such as Cuba, also helps fill certain health care provider needs.

6.1.2 RETENTION STRATEGIES

Several health care workers interviewed in this assessment did not believe that career path opportunities were clearly defined for health workers. The MOH does offer some opportunities for leadership development in the public health workforce: for example, nursing assistants can work up to become nursing attendants and eventually nurses, if they pass the regional nursing exam. A more formalized system of career development opportunities could be beneficial in terms of maintaining or improving job satisfaction as well as helping fill future health worker needs within the system. Providing clear career development opportunities could serve as a health worker retention strategy.

Supervision by and feedback from qualified senior staff is also important for job satisfaction and thus staff retention. In St. Kitts and Nevis, not every facility has a clinical supervisor, and supervisors are often required to provide clinical care, leaving them less available for mentoring their supervisees. Informants noted a general need for more capacity building and leadership training among staff. In addition, informants indicated that performance evaluation of health workers is not conducted in a way that provides useful feedback to health workers, nor is the information used to analyze the performance of the health workforce overall.

Retention of nurses is of particular concern in St. Kitts and Nevis, as it is elsewhere in the Caribbean. According to the St. Kitts and Nevis Health System Profile by PAHO (2010), there has been a steady decline in the number of registered nurses since at least 1991. Although migration of nurses to developed countries was previously an important factor in this reduction, currently the shortage is caused by a combination of obligatory retirement of nurses and an inability to attract persons who are interested in a career in nursing. The increasing number of nurses reaching retirement age (55 years old) is approaching a crisis when combined with the limited interest on the part of young people to pursue nursing careers. Civil service legislation to increase the retirement age to 62 is being considered. However, in the meantime, special dispensation can be made to allow some workers to continue working for a limited amount of time past retirement age. One option proposed within the MOH but not yet implemented is to develop a mechanism to retain older health professionals to serve as mentors to new graduate nurses. This would encourage a passing of knowledge and institutional memory, thus improving the clinical capacity of young nurses and retaining older nurses in a role that reinforces a feeling of importance and responsibility.

6.2 HUMAN RESOURCE MANAGEMENT AND PLANNING

According to the PAHO Essential Public Health Functions assessment conducted in 2010, the St. Kitts and Nevis MOH reported that it has a structure in place to evaluate current public health worker needs at the national and local levels, including by identifying the number of health workers needed to implement essential public health functions and delivering public health services and by defining required competencies and maintaining worker profiles. However, MOH informants in this assessment acknowledged that the country has not been able to conduct systematic planning to identify and fill current gaps nor to forecast and plan for future health workforce needs. Training and technical support to increase human resource management and planning capacity within the MOH have been identified as needs.

Overall management of human resources in St. Kitts and Nevis is led by the Human Resources Management (HRM) Department in the Office of the Prime Minister. This office is responsible for maintaining personnel records; facilitating hiring, promotions, and transfers; providing orientation and training to public sector employees (e.g., leadership, management, information technology [IT]); facilitating a limited amount of overseas training; providing oversight related to benefits; and providing support to ministries in disciplinary procedures and actions. Ideally, each ministry should have an

individual assigned to act as a liaison with the HRM Department. However, according to the HRM Department, nobody has been formally identified from the MOH to serve in such a capacity.

The HRM Department is currently undergoing a process to strengthen its capacity and develop and implement a national performance management system for all civil servants. With assistance from the Caribbean Center for Development Administration (CARICAD), the department recently led a jobs evaluation analysis across all ministries with a goal to update job descriptions, a necessary component of a performance management system and essential for conducting needs-based human resource planning. At the time of this assessment, the evaluation report from CARICAD was still not available. It is unclear whether CARICAD will be providing technical assistance to the government in the actual development of a performance management plan.

Currently, the MOH has a paper-based information system for managing its human resources. This makes it challenging to track the existing public health workforce (e.g., current staff competencies, capacity to adequately perform services, educational profiles), monitor wage structures and benefits, assess geographical workforce distribution by employment type (NGO, public, private), and review required educational profiles and competencies for health workforce needs. Although the National Strategic Plan for Health 2008–2012 originally called for the development of an electronic human resources information system (HRIS) within the MOH, that objective has been set aside following the announcement of the HRM Department's national performance management process described above. The HRM Department is receiving support from Taiwan to develop and install a government-wide HRIS. This process has been underway for several years, with finalization of the HRIS product expected in 2011. Nonetheless, there was a clear indication from the HRM Department that they would be open to receiving assistance to put in place an open-source HRIS that could link with other government systems – one that is more flexible, user friendly, and informative than the system currently being installed. Unfortunately, the system currently being developed was described as proprietary; it does not contain enough information fields for personnel records, uses limited preprogrammed reports, does not contain a user-friendly way to track training, has limited search capacity, and is not programmable by local IT staff to adapt to future needs. Government IT staff would prefer an open source HRIS.

Ultimately it is hoped that the national-level electronic HRIS will obviate the need for an MOH-specific system, but many challenges remain.

The human resource planning that does occur includes input from several levels of the health care system, including feedback from health facilities, leaders in public health, NGOs, civil society, and international agencies. The MOH does not reportedly incorporate input from other government agencies, academic institutions, professional associations, or ministries of education or labor. Human resource planning within the MOH does not appear to be conducted in a systematic way and is not based on a formal analysis of human resources capacity vis à vis epidemiological and service delivery needs. Key individuals at several levels in the MOH and elsewhere indicated a need for assistance in developing the skills and a formal process to plan for future human resource needs.

6.3 HUMAN RESOURCE DEVELOPMENT

6.3.1 PRESERVICE TRAINING

Local opportunities for training new health professionals in St. Kitts and Nevis are limited, consisting primarily of nurse training at the Health Sciences Division at Clarence Fitzroy Bryant College or weekly informal meetings at the hospital. Preservice training for health professionals other than nurses takes place off-island, primarily at the University of the West Indies and in the United States and the United

Kingdom. There have also been an increasing number of graduates trained in Cuban medical schools. A very limited number of scholarships is offered to nationals at the offshore medical schools located in St. Kitts.

The nursing school at the Clarence Fitzroy Bryant College currently offers three-year associate degrees in nursing and an 18-month program for nursing assistants. A 15-month midwifery program is also included, as it is a requirement for nurses to be registered in St. Kitts and Nevis. Currently, approximately 50 nursing students are enrolled, including 16 in the midwifery program who have already completed the nursing program and eight third-year nursing students. The government of St. Kitts and Nevis covers the cost of training at the school and students receive a stipend while attending.

The nursing school is undertaking an effort to upgrade its program to be able to offer bachelor's degrees in nursing as part of a regional effort in the Caribbean. However, establishing an accredited program has been difficult. Challenges that exist include insufficient physical infrastructure (such as a skills lab), an inadequate nursing curriculum, and lecturers who do not have a master's degree. There is likely no quick fix for this as it will require some existing lecturers to take leave to pursue a master's degree, or recruitment of qualified lecturers from off-island, which has cost implications. As an incentive, the MOH provides leave with pay for those who are willing and able to pursue advanced degree opportunities.

6.3.2 IN-SERVICE TRAINING

In-service training opportunities exist in both St. Kitts and Nevis. An in-service Education Unit at the JNF Hospital coordinates in-service training for nurses and other health personnel. On Nevis, in-service training is conducted at the hospital and in the health centers.

At several levels it was stated that nurses are required to undertake 30 hours of continuing nursing education annually to be able to renew their registration, and while it appears that nurses adhere to this, the source of this requirement is not apparent. Several people mentioned the Nurses and Midwives Act of 2005, however, there is no language in the act specifying this. It may be a requirement of the Nurses and Midwives Council, but the assessment team was unable to obtain confirmation of this. For physicians, there are no continuing medical education requirements. In-service training opportunities are widely appreciated by health professionals. But planning for in-service training opportunities for health professionals could be strengthened. There are no established guidelines on what topics should be covered, nor are specific topics required to be offered. Training is sometimes planned based on perceived needs of health care workers, but it is not based on a systematic evaluation of their competency needs. Establishing or improving dialogue and links with regional training institutions and organizations, even with offshore nursing and medical schools in St. Kitts and Nevis, could lead to better in-service training opportunities.

There is currently no mechanism that can adequately track past and current training for health professionals nor assist in identifying future planning needs. A training database that can be linked with an electronic HRIS would be beneficial and assist in the development of needs-based annual training plans.

6.4 SUMMARY OF KEY FINDINGS

Shortages of key personnel

- Although there is broad access to primary health care providers, there is a lack of specialists (e.g., mental health professionals, nursing specialists, radiologists, community health nurses, internists, and health promotion specialists).

- Currently, there is a shortage of nurses, driven by the low mandatory retirement age and a lack of interest by young professionals in nursing careers.

Need for more training opportunities

- Training opportunities for health professionals are limited and occur mostly off-island.
- Nurses are required to undertake 30 hours of continued nursing training annually, while doctors do not have in-service training requirements.

6.5 RECOMMENDATIONS

6.5.1 SHORT-TERM RECOMMENDATIONS

Prioritize development and implementation of human resources planning and management systems

- Access technical assistance to develop a government-wide human resources performance management plan, including an MOH HRH plan. This could involve collaboration with PAHO.
- Introduce a national training database to track trainings and identify training needs. Begin with an MOH pilot, then scale up to other components of the civil service. One possible database, the TrainSMART database developed by I-TECH, is in the process of being adapted for national use in the OECS countries.

Expand opportunities for training

- Identify, and disseminate more widely, information on training opportunities for continuing education for medical providers, especially via distance learning.
- Recommend the Clarence Fitzroy Bryant College School of Nursing; consider soliciting assistance from the OECS HIV/AIDS Program Unit, as well as the Caribbean HIV/AIDS Regional Training Network, for the development of an HIV/AIDS curriculum.
- Include the private sector in MOH trainings and updates
 - Reshape the “Wednesday updates” at JNF Hospital to include private sector participants
 - Invite private sector clinicians to offer trainings as well.

Explore creative partnerships for skills building

- Introduce a nurse mentoring program, such as the option proposed within the MOH. Older health professionals could be retained to serve as mentors to new graduate nurses. This would improve the clinical capacity of young nurses and retain older nurses in a useful role.
- Consider creating a “buddy” system between public and private practitioners.
 - Team private pharmacist managers with public counterparts to share management and systems expertise
 - Team private and public physicians and specialists for clinical training, case management review, etc.

6.5.2 LONG-TERM RECOMMENDATIONS

Engage in more strategic human resources planning and management

- Establish a St. Kitts and Nevis HRH Coordination Team or other similar mechanism to address HRH needs in management, planning, and development. Include appropriate representatives of the MOH, HRM Department, Ministry of Education, training institutions, private sector, and

others as deemed useful.

- Support the introduction of an open-source HRIS and link this with the training database described above. Although Taiwan has provided support to adapt a human resource database for the HRM Department, the department personnel indicated that they are not satisfied with the software and would like a more suitable nonproprietary database.

Scale up efforts in schools to attract young people to health care careers

- Scale up internship opportunities for youth among other creative approaches.

7. MANAGEMENT OF PHARMACEUTICALS AND MEDICAL SUPPLIES

Key Findings

- Participation in the OECS Pharmaceutical Procurement Service (PPS) has significantly reduced the costs of pharmaceuticals.
- Public sector inventory systems are not computerized, which makes the inventory management systems ill-equipped to handle procurement, tracking, and distribution of pharmaceuticals.
- Aside from JNF Hospital, stock-outs are frequent at public sector pharmacies, which causes individuals to use private sector pharmacies.
- There is limited pharmacovigilance to monitor adverse drug interactions.

Careful management of pharmaceuticals and other medical products is essential to meeting health system goals. Even so, many health systems and programs run into difficulty achieving their goals because they have not addressed how the medicines essential to saving lives and improving health will be managed, supplied, and used. Pharmaceuticals can be expensive to purchase and distribute, but shortages of essential medicines, improper use of medicines, and spending on unnecessary or low-quality medicines also have a high cost – wasted resources and preventable illness and death. Pharmaceutical management represents the whole set of activities aimed at ensuring the timely availability and appropriate use of safe, effective quality medicines and related products and services in any health care setting. Due to the increasing prevalence of chronic NCDs in St. Kitts and Nevis, there is a growing need for efficient procurement, management, and distribution of medicines to the people who need them.

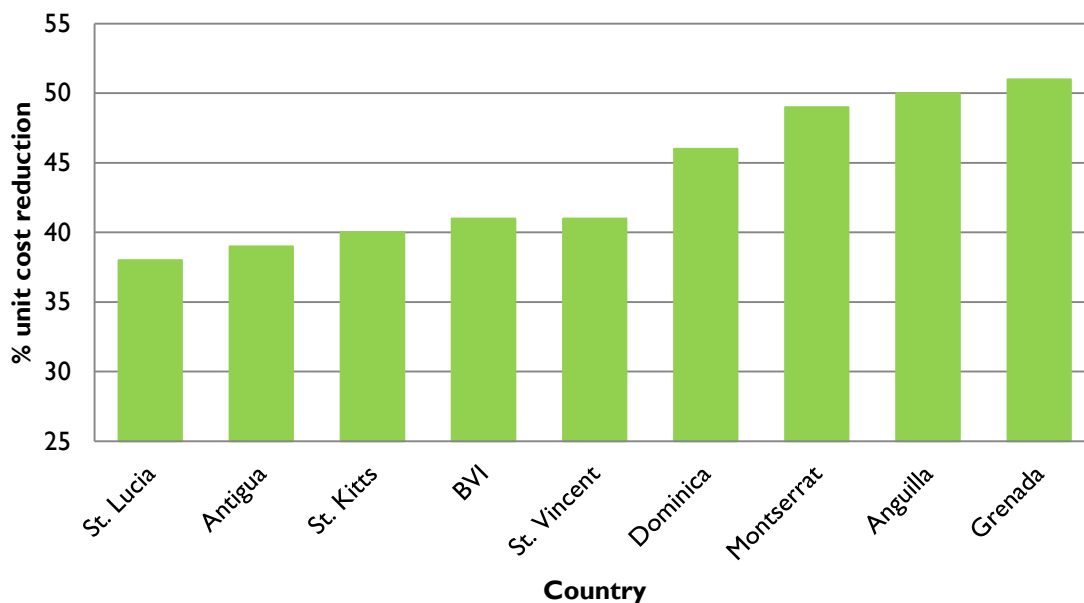
7.1 PROCUREMENT, DISTRIBUTION, AND STORAGE

7.1.1 PROCUREMENT

St. Kitts and Nevis participates in the OECS PPS, so that it can procure pharmaceuticals in larger batches along with other OECS member states. The manager of the Central Medical Stores (CMS) on St. Kitts noted that about 90 percent of public sector procurement goes through this mechanism, with the balance being made directly from the manufacturers. Direct purchasing typically only occurs when no other OECS member state needs to procure the same product. Whether or not the purchase is made through the PPS mechanism or directly with the manufacturer, the medicines for the public sector are delivered directly to the CMS's warehouse on the JNF Hospital's grounds in Basseterre; there is no intermediate warehousing. All medicines for both islands are stored and distributed from this warehouse.

The OECS PPS system has dramatically reduced the prices of drugs that OECS member states purchase, as bulk orders can be processed more cheaply than smaller orders from each country. While the OECS PPS received an initial \$3.5 million grant from USAID, the OECS PPS has been self-financing since 1989 through a 15 percent administrative fee that it levies on all pharmaceutical purchases (OECS 2001). As a result of the OECS PPS purchasing mechanism, St. Kitts and Nevis has decreased its pharmaceutical costs significantly, averaging 40 percent reduction in costs for a basket of 20 popular drugs (see Figure 7.1).

FIGURE 7.1: AVERAGE PERCENTAGE UNIT COST REDUCTION FOR A MARKET BASKET OF 20 POPULAR DRUGS 2001/2002 COMPARED WITH INDIVIDUAL COUNTRY PRICES



Source: OECS Pharmaceutical Procurement Service Annual Report 2001

Nevis’s Ministry of Health procures drugs through the CMS on St. Kitts. Delays and stock-outs at CMS sometimes force Nevis MOH to turn to the private sector for essential drugs, paying directly from the Nevis MOH’s drug procurement budget line. The Alexandra Hospital in Nevis either orders directly from a wholesaler based in Barbados, or orders small amounts from one of the private pharmacies in Charlestown. Procuring drugs in this fashion is more expensive than procuring through the PPS system, but also provides short-term supplies to avoid stock-outs.

Private pharmacies procure through private distributors located in Barbados, the United States, the United Kingdom, and Canada. Private pharmacy owners interviewed stated they only work with “reputable” distributors and/or drug manufacturers that are approved by the United States Food and Drug Administration (FDA) or the European Medicines Agency, or are WHO prequalified.⁶ The private pharmacies interviewed import very few generics from India.

⁶ Some of the distributors used in Barbados are Armstrong, BioKal, Brighton/Schering, Carlisle, Collins, and Stokes; in the United Kingdom, Ziotis; and in the United States, Knox and Masters,

7.1.2 DISTRIBUTION

In the public sector, once drugs are at CMS in Basseterre, the ministries of health operate a “pull” system to distribute drugs to public sector pharmacies. On Nevis, only one hospital operates a full pharmacy, Alexandra Hospital. On the island of St. Kitts, five public sector pharmacies exist: three in Basseterre, including JNF Hospital, and two in other parts of the island. As such, the distribution system does not need to be complicated. The pull system uses a requisition form that is sent from the pharmacies to CMS to request drugs. No public pharmacy has a computerized requisition system.

Actual disbursements of drugs appear to be influenced by proximity to CMS. Informants at the JNF Hospital noted that stock-outs were rare, only happened for certain items, and were typically very short. Since CMS and the JNF Hospital pharmacy share the same grounds, requisition forms can be approved and drugs supplied on the same day. Stock-outs only occurred at JNF Hospital if CMS did not have specific items in stock. However, interviews at other public pharmacies showed delays in receiving drugs and products from CMS.

There are several private pharmacies on both St. Kitts and Nevis islands, and the number has been growing, increasing from nine in 2006–2007 to 11 in 2009–2010 (MOH statistics). All private pharmacies are concentrated in Basseterre and Charlestown. Factors contributing to the growth in private pharmacies include the market entry of two large companies in St. Kitts into retail pharmacy as part of the companies’ diversification strategy, and a market response to fill the gaps created by frequent stock-outs in MOH pharmacies.

7.1.3 INVENTORY MANAGEMENT

Inventory management with public pharmacies is either paper-based or memory-based, depending on the pharmacy. Those pharmacists who managed their inventory based on their memory claimed that they had a clear picture of what drugs were coming in and going out of the pharmacy, based on their knowledge of how much of each drug was being consumed. When they saw that there were running low on a drug, they would reorder. Some pharmacies used a bin card system, where they would record each amount of drugs entering and leaving the pharmacy on a card that stayed with the drugs; they would also record each prescription given in a record book. No public pharmacy had a computerized inventory management system. One pharmacist noted that they had a computer but were unable to use it, due to the lack of appropriate software or Internet connectivity. In contrast, many private sector pharmacies had computerized systems in place for managing their inventory. Overall inventory management in the public sectors was weak. Key informants noted a need within the public sector to improve forecasting through the use of health statistics.

Inventory management appears to be one of the biggest weaknesses in the public sector. Although individual pharmacists may have a clear picture about what drugs are available in their pharmacy, there is no way to develop an overall picture of pharmaceuticals stocks across the country. Therefore, if one pharmacy has a large supply of certain drugs, but another is experiencing a stock-out, there is no way to redistribute drugs from one pharmacy to another. In a country where all pharmacies are relatively close by, reallocating supplies would not be a difficult task provided pharmacists had information on what drugs were available in which pharmacies. In addition, a computerized system with network capabilities would eliminate the need for paper-based requisitions, allowing CMS to see which drugs were available in every pharmacy in the country, develop PPS orders, and resupply pharmacies, as necessary. Networked pharmacies could potentially determine whether nearby pharmacies have drugs and could direct patients to pharmacies with available stock.

7.2 PHARMACEUTICAL POLICIES, LAWS, AND REGULATIONS

Regulations on pharmaceuticals are quite weak in St. Kitts and Nevis, according to key informants. The country does not have a drug regulatory authority, specific legislation regarding the use of pharmaceuticals or the regulation of pharmacies and pharmacists, nor an essential medicines list of its own. As a result, St. Kitts and Nevis relies on drug information from the United States, outdated legislation, and regional guidelines for prescriptions. Also notably missing is a national medicines policy to outline government objectives and strategies for improving the use of medicines to improve health outcomes. National medicines policies address issues such as essential medicines, affordability and pricing, financial sustainability, supply management, regulations, research agendas, human resources development, and M&E of the sector. Key informants felt that distinct policies were needed to ensure that national procedures conform to international best practice, that funding is continuous and reliable, and that there is an HRM plan to recruit, train, and evaluate the performance of pharmacists.

The relevant legislation that allows the MOH to regulate pharmacies and pharmacists is still the Medical Act of 1938. This act allows the medical boards to oversee the licensing of pharmacists, but does not address issues such as ongoing inspections of pharmacies, continuing education for pharmacists, or renewal requirements to practice pharmacy, as these are not covered under the outdated Medical Act. In order to address these gaps in statutory regulations, a Pharmacy Act has been developed and has already had a first reading in the National Assembly. For a discussion on the proposed Pharmacy Act, see the Governance chapter.

In practice, pharmacist licensure is as simple as showing the proper credentials, such as a B.Sc. in Pharmacy, to the MOH. There are very few pharmacists in the country and many of them know one another; a new pharmacy or pharmacist would be noticed by others in the profession.

According to informant interviews, it is difficult to open a private pharmacy as a new commercial business. First, the owner applies for a license with the MOH. Within a month the MOH inspects the facility and issues the license, usually within a week. Once the pharmacy has received a license from the MOH, then the owner applies for a business license with the MOF. Although the registration fee is not prohibitive, it can take up to one year to obtain the license.

7.3 ACCESS, AVAILABILITY, AND AFFORDABILITY

7.3.1 ACCESS TO PHARMACIES

As noted above, there are three public sector pharmacies in Basseterre, St. Kitts. Clients living outside Basseterre have access to pharmaceuticals through Pogson Medical Center at Sandy Point and the Mary Charles Hospital in Molyneux. On Nevis, the only full-time public pharmacy is at Alexandra Hospital in Charlestown. However, there is a health center with an equipped pharmacy outside of Charlestown, where a doctor provides services twice a week. Without a pharmacist on-site, however, patients who are seen by the doctor must travel to Charlestown to get their medications from the Alexandra Hospital. This requirement restricts access to medications for people seen by the doctor at the health center.

The private pharmacies on the two islands, like the public pharmacies, are clustered in Basseterre and Charlestown, with three in Charlestown and eight in Basseterre. There are no private pharmacies outside the capitals of the two islands. Informants commented that, as long as pharmacies had the medicines needed, distance to pharmacies was not a significant barrier to access, as both islands are quite small. Informants did note that if a public sector pharmacy was stocked out of certain items, traveling into one of the capitals to obtain a medication did present a barrier to access. Informants at

Pogson Medical Center said that clients from Sandy Point will often travel directly to JNF Hospital, rather than come to Pogson, because of the perception that JNF has more medicines available.

Private pharmacies are open longer hours and every day of the week. Two pharmacies in Nevis offer 24-hour service, providing a phone number to clients to call in orders after hours. As a point of comparison, public pharmacy hours are from 8 a.m. to 4 p.m.

7.3.2 AVAILABILITY OF MEDICINES AND SUPPLIES

As noted above, JNF Hospital rarely experiences stock-outs, while stock-outs are frequent at the other public sector pharmacies on the island. Stock-outs reportedly occur for commonly used items such as hypertensives, insulin, glucose testing strips, water for irrigation, antibiotics, and bandages, but also for less used items, such as activated charcoal.

The pharmacists interviewed noted that they will often wait weeks for products to come from CMS, and shipments frequently arrive without requested medications or without the specified dosages. At Alexandra Hospital on Nevis, the pharmacist noted that she will often reserve certain drugs for hospital use until a resupply arrives from CMS, prioritizing inpatients over outpatients.

In order to get around public sector stock-outs, clients visit private pharmacies to get the medications they need. As a result, private sector pharmacies play a significant role in making medicines available in St. Kitts and Nevis, primarily by filling gaps in public sector coverage. Informants said that patients will often choose to get drugs from private pharmacies rather than go without them, and end up paying higher prices. A private pharmacy is rarely out of drugs and if it does experience stock-out, the pharmacy can resupply the drug within 24 to 48 hours. Private pharmacies also carry a wider array of drugs than their public sector counterparts. Patients finding themselves in need of medications that are not stocked at public pharmacies have access to those medications at private pharmacies, again at significantly higher prices than in public pharmacies. Informants noted a need for greater collaboration and communication between the public and private pharmacies so that the private sector is aware of public sector stock-outs and can ensure they have ample supplies. Public sector pharmacies mainly offer generics while private pharmacies offer multiple brands in addition to the generics. Many consumers, including the poor, reportedly prefer brand names because they have little understanding of generics and private doctors prescribe brand name drugs. Some pharmacists interviewed commented that consumers do not mind generics; they do however prefer generics from the United States and the United Kingdom over those from India and China. Private pharmacies appear to carry the same range of products (generics and brands) on both islands.

7.3.3 AFFORDABILITY

The government of St. Kitts and Nevis makes medicines available for free or for a nominal price through public pharmacies. Until 2006, all medications obtained in a public pharmacy were free to the consumer. Since that time, a nominal user fee of EC\$10 (US\$3.70) was instituted in order to promote cost sharing, reduce drug misuse, and generate a small amount of revenue. Although children, the elderly, and the very poor are exempted from these fees for medicines, previous studies have suggested that the user fee had an impact on “consumer moral hazard,” in that people were less likely to use medicines inappropriately when they had to pay for them (PAHO 2010).

Customs, duty, and VAT are levied on privately procured drugs, and taxes vary depending on the drug. Private laboratory services also have VAT levied on them instead of the lower service tax (17 percent

versus 10 percent). Many drugs treating NCDs, and some medical equipment, are exempted from one or more of these taxes. Private lab services, however, do not receive exemptions. There is confusion among the private pharmacies (as well as physicians) on which exemptions apply for which drugs. Some key informants noted that exemptions for services and medicines do not align with the services and medicines needed to treat priority conditions identified by the MOH. These informants suggested that concessions could be offered to private providers to ensure lower prices for services and medications for priority conditions in the private sector. Both public and private sector informants reported the perception that tax exemptions, particularly for supplies and equipment, may be granted based on personal requests. The government allows pharmacies to purchase insulin through the PPS system in order to lower the cost. Beyond this formal collaboration, there are many instances of informal collaboration. As noted, the pharmacy at Alexandra Hospital purchases medicines from the private sector during stock-outs and clients tend to move easily between the two sectors.

There is a range in prices charged for drugs at private pharmacies, including those critical for common NCDs. Both pharmacists and physicians stated that some pharmacies “charge top dollar” while other drug stores are more affordable and cater to lower income clients. Prices were observed to be slightly higher on Nevis compared to St. Kitts. Clients must typically pay up front for drugs. Some pharmacies make arrangements to help very poor clients, such as repackaging the dosages into weekly installments or offering credit. One informant estimated that approximately 30 percent of the clients have some form of insurance – either through the medical insurance program offered to civil servants or private insurance offered to employees working for major companies/industries.

7.4 APPROPRIATE USE

St. Kitts and Nevis does not have an Essential Medicines List as such; rather, the MOH uses the OECS Regional Formulary Manual to determine which drugs to keep in stock. This manual contains a list of core essential drugs that was developed by all member states, as well as drug information to help pharmacists determine dosages and contraindications. The formulary is revised every three years, following consultations with OECS member states.

As noted above, St. Kitts and Nevis does not have a national medicines policy, again relying on OECS directives and guidelines to plan for pharmaceutical needs. In order to promote rational use, the formulary provides tools that providers can use, such as standard treatment guidelines and information on drug interactions. The formulary also helps providers offer consistent treatment for illnesses.

7.5 QUALITY AND SAFETY

Given its small size, St. Kitts and Nevis does not maintain its own drug regulatory authority. In order to monitor drug quality and safety, including recalls and adverse drug reaction information, CMS follows recommendations from the FDA. However, few medicines are actually procured from the United States; most medicines come through Barbados or the United Kingdom. One result is that safety information from the United States may not completely match drugs procured through the PPS system. Random drug samples procured through the PPS mechanism are sent to the Caribbean Drug and Testing Lab in Jamaica for analysis to ensure the quality of the drugs. Informants said that drug quality is usually not a problem, as the OECS PPS procures all medicines through WHO-prequalified manufacturers.

Although St. Kitts and Nevis tracks advisories from the FDA with regards to adverse drug reactions, pharmacovigilance (tracking adverse drug reactions) on St. Kitts and Nevis has been weak. In fact, private pharmacists identified pharmacovigilance as one of the most important weaknesses in St. Kitts and Nevis’s pharmaceutical management system. Although a standardized OECS reporting form for adverse reactions does exist, public sector pharmacists either do not have the form or do not know

how to use the form to report on adverse drug events. The private sector faces similar constraints, as no mechanism exists to get information on adverse drug events from private pharmacists to the MOH.

7.6 SUMMARY OF KEY FINDINGS

Significant benefits of pooled procurement

- Participation in the OECS PPS has significantly reduced the costs of pharmaceuticals.

Need for policies to better govern the pharmaceutical sector

- Distinct policies are needed to ensure that national procedures conform to international best practices, that funding is continuous and reliable, and that there is an HRM plan to recruit, train, and evaluate the performance of pharmacists.
- Policies are needed to ensure consistently low prices for treatment and diagnosis of priority diseases across the public and private sectors.

Weak pharmaceutical inventory management

- Public sector inventory systems are not computerized or networked; inventory management systems are ill-equipped to handle procurement, tracking, and distribution of pharmaceuticals.
- Stock-outs are frequent at public sector pharmacies. Private pharmacies play an important role in ensuring access to essential medicines.

Weak pharmacovigilance

- There is limited pharmacovigilance to monitor adverse drug reactions.

7.7 RECOMMENDATIONS

7.7.1 SHORT-TERM RECOMMENDATIONS

Explore creative solutions to address stock-outs

- Allow Alexandra Hospital to procure directly from the OECS PPS. Nevis pays for pharmaceuticals separately from St. Kitts, yet is reliant on shipments from CMS in Basseterre. Allowing Nevis to interact directly with the OECS PPS mechanism would relieve the burden on CMS to provide drugs for the hospital, allow the NIA to have more control over the drugs purchased, and relieve stock-outs at Alexandra Hospital.
- Strengthen mechanisms for coordinating with and/or procuring from private sector pharmacies to mitigate stock-outs. Pharmaceutical stock-outs in the public system erode confidence that the public system is equipped to play its role in the health system. They also deprive patients of needed medicines. In order to prevent stock-outs, Alexandra Hospital procures drugs from the private sector. Formalizing this relationship through developing a memorandum of understanding, agreeing on a price schedule, and expanding it to all six public sector pharmacies could relieve stock-outs in the short term.

7.7.2 LONG-TERM RECOMMENDATIONS

Develop a National Medicines Policy

- Creating a national medicines policy would allow the MOH to establish the appropriate roles and responsibilities in the pharmaceutical sector, for both public and private sectors. This could be an opportunity to discuss how to control the quality and cost of drugs in the private sector (price controls). It could also be an opportunity to align country-level procedures with

international best practices and develop plans for human resource management and financial sustainability in the sector.

Reconsider taxation policies for services and treatment for priority health areas

- The MOH has identified priority health areas, such as diabetes and STIs, and has developed programs to ensure that medicines and diagnostics needed for these services in the public sector are available free of charge. However, this policy does not consistently extend into the private sector and there is confusion among providers about exemption policies. Identified priorities should be consistent across both sectors and clearly articulated to public and private providers.
- There was also concern that laboratory tests are charged VAT instead of a service tax, and private providers have had to increase prices to cover the additional costs. Consistent pricing is needed to improve access to priority services, especially if there are frequent stock-outs of medications or testing reagents in the public sector. The MOH and MOF may want to reconsider VAT exemptions to ensure that medications, equipment, and diagnostic services needed to treat priority conditions are given exemptions or concessions for both public and private providers. The lower taxation burden on private providers should result in lower prices for these services. In addition, whatever policies are determined, clear communication of these policies is needed so that public and private providers understand the exemptions.

Develop stronger pharmacovigilance mechanisms

- The OECS has already developed an adverse drug reaction reporting form that is in use throughout member countries. Many pharmacists on St. Kitts and Nevis come from other islands, or were trained on other islands, and as such they have used reporting forms and understand the concept of pharmacovigilance. Instituting the use of the OECS standard reporting form in all public and private pharmacies would be a strong step toward integrating St. Kitts and Nevis into the OECS pharmacovigilance mechanisms. In interviews, private pharmacists seemed willing to report this information, especially if they saw a benefit from reporting, such as feedback from the MOH or the OECS.

Develop computerized and networked inventory management system for the public sector

- The current inventory management system is ill-equipped to handle the procurement, distribution, and tracking needs of the MOH. Stock-outs are frequent, and CMS has little knowledge of needs at the pharmacies until requisition forms are received. JNF Hospital has already recognized the lack of IT infrastructure as a challenge and is currently installing an electronic medical records system, with pharmaceutical inventory being a component of the system. Any system that is installed in other pharmacies and at CMS must be compatible with the system installed at JNF. Efforts should be made to use off-the-shelf systems or technical assistance from the private sector, rather than develop an entirely new system from scratch.

8. HEALTH INFORMATION SYSTEMS

Key Findings

- The MOH HIU serves as a repository for various data, but there is no integrated system for systematic data collection and dissemination to lower levels of the health system and to the public.
- The private sector does not participate in data collection and reporting; health centers lack infrastructure (Internet, computers) for reporting.
- Taiwan's government is providing support to the JNF Hospital to develop an internal electronic health information system, which would then be implemented in all health facilities and reach the community level.

A health information system (HIS) is defined as a “set of components and procedures organized with the objective of generating information that will improve health care management decisions at all levels of the health system” (Lippeveld et al. 2000). A HIS have four functions: (1) data generation, (2) data compilation, (3) data analysis and synthesis, and (4) data communication and use (WHO 2008b). HIS collect data from the health sector and other relevant sectors; analyze the data and ensure their overall quality, relevance, and timeliness; and convert the data into information for health-related decision-making. HIS data are the basis for monitoring and evaluation (M&E) of public health programs and also provide early warning systems (via surveillance). They support service delivery and health facility management, inform planning, and permit global reporting (WHO 2008b). Two assessments related to HIS were performed in St. Kitts and Nevis during 2010: the PAHO Essential Public Health Functions Assessment and the Caribbean Health Research Council (CHRC) Assessment of the HIV/AIDS M&E System. The current rapid assessment focused on confirming findings from these assessments and gathering new information that was not available in these existing assessment reports.

8.1 FINANCIAL, HUMAN, AND PHYSICAL RESOURCES FOR HIS

The St. Kitts and Nevis MOH Office of Policy Development and Information Management houses the HIU, which serves as a repository of health information for the country. An HIU also exists on Nevis, as part of the Health Promotion Unit. The MOH HIU is guided by the overall National Strategic Plan for Health, but does not have its own strategic plan or framework. There are no national M&E or Health Sector Technical Working Groups in St. Kitts and Nevis (Lloyd et al. 2010). The CMO has proposed that the current HIU be transitioned into a Health Research and Information Unit that would produce more information to inform policy and program development, implementation, and evaluation.

8.1.1 FINANCIAL RESOURCES AND TECHNICAL ASSISTANCE

Funding for the MOH HIU comes out of the general MOH budget; there is no specific HIU line item. Several agencies in the region (UNAIDS, CHRC, the OECS HIV/AIDS Program Unit (HAPU), the CHAA, and CDC/Caribbean Regional Office) have supported M&E-related activities in St. Kitts and Nevis, primarily in relation to HIV/AIDS monitoring (CHRC 2010). The Caribbean Epidemiology Center (CAREC) sent an epidemiologist in 2009 to sensitize providers on Nevis about the importance of quality

data, reporting, and evidence-based decision-making, but no real improvements in reporting were noted afterwards and no follow-up activities were implemented.

JNF Hospital has received support from the government of Taiwan to develop an internal electronic HIS. Phase 1 is currently operational and includes billing and collections data for patients. Phase 2 was to start in August/September 2011 and will expand to pharmaceuticals, medical supplies, and laboratory data. Phase 3 will include electronic medical records. Ultimately this initiative will be implemented in all health facilities and reach the community level.

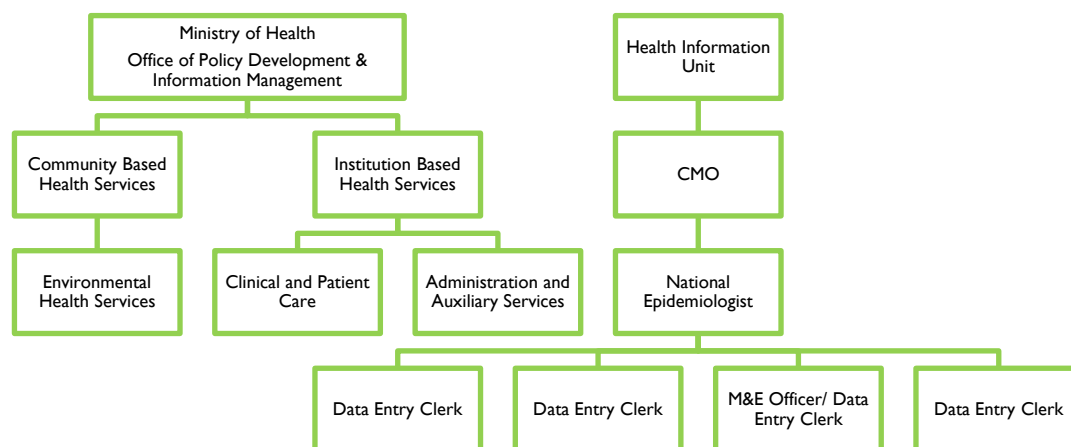
8.1.2 PHYSICAL RESOURCES

The HIUs on both St. Kitts and Nevis have adequate physical infrastructure for the collation and analysis of data, with Internet access, operating computers, and peripheral hardware. All hospitals have at least one computer, though actual usage (and condition of the computers and printers) varies among hospitals. Only two of the six public health centers on Nevis and none of the 11 public health centers on St. Kitts have computers or Internet access, though they do have telephones. Facilities have adequate reporting/recording forms and related supplies (e.g., registers, etc.) and can easily replenish them as needed. The ICT Strategic Plan (2006) noted that high-quality telecommunications services are expensive and thus, while St. Kitts and Nevis have a high proportion of personal computers per 100 population compared to other similar income countries, they have relatively low Internet use (St. Kitts MOF 2006). Lack of computers at the health facility level, and underutilization of those available in hospitals for data entry/reporting, have led to continuing use of a paper-based reporting system. Moving to an electronic system in which databases are networked will require investments in hardware as well as capacity-building for facility staff.

8.1.3 HUMAN RESOURCES

The HIU in the St. Kitts MOH is overseen by the CMO and national epidemiologist (Figure 8.1). There are four data entry clerks, one of whom serves as an M&E officer. On Nevis, the newly established (as of January 2011) Health Promotion Unit, which is responsible for both health education and information, has two data collectors, one M&E officer, one surveillance officer, and two health educators. Both units serve the broad M&E needs of the health sector and are not limited to HIV/AIDS reporting. According to the CHRC HIV M&E assessment in 2010, there are sufficient staff to fulfill the HIV/AIDS M&E functions in St. Kitts and Nevis. However, there is no doctoral-level epidemiologist or expert in research and quantitative analysis available at the national level (PAHO 2010). The national epidemiologist currently oversees data entry, compilation, and reporting, but outbreak investigation is conducted by the Environmental Health Services division of the MOH and as such is not clearly linked to the HIU.

FIGURE 8.1: ORGANOGRAM OF MOH HEALTH INFORMATION UNIT



8.2 DATA COLLECTION AND INFORMATION FLOWS

There are several types of routine health information collected. Weekly reports (case data/syndromic surveillance) are sent to the HIU, either directly from various providers or facilities or via the district medical officer. Reporting requirements and frequency vary by disease and program. For example, all health centers and hospitals send a monthly report on HIV counseling and testing to the HIU. The St. Kitts M&E officer visits facilities quarterly to complete and verify those reports, and then generates a quarterly report using Epilnfo that is sent back to the facilities. There is also an ARV treatment form that JNF Hospital completes and sends to the HIU each quarter. Additional reports include the monthly disease report, quarterly and annual HIV/AIDS reports, annual Tuberculosis report, annual communicable disease report, and outbreak reports and alerts as needed. A very small number of private providers contribute regularly to reporting.

All routine data are compiled to produce an annual report covering both islands. As of May 2011, the 2009 report was the most recent available; the 2010 report is still being finalized. A limited number of hard copies of the annual report are available and reside within the MOH.

8.2.1 DATA COLLECTION, REPORTING, AND MANAGEMENT

8.2.1.1 CENSUS AND VITAL STATISTICS

Census day was May 15, 2011. The last census was in 2001 when a total of 46,325 persons were counted in the federation. Of this number, 35,217 persons resided on St. Kitts while 11,108 persons (24 percent) resided on Nevis. Preliminary 2011 census results were anticipated in August 2011.

Vital statistics data are fairly comprehensive. The main challenge reported by informants is ensuring that appropriate causes of death are listed on death certificates so that they can be properly coded at the HIU.

8.2.1.2 SURVEYS

No demographic and health survey has been done in the country. An HIV/AIDS service provision assessment was conducted in 2005 and focused on the formal public health sector. In 2006, a behavioral surveillance survey was conducted in St. Kitts and Nevis along with five other OECS countries (CAREC 2007).

The HIU works with the Ministry of Sustainable Development's Statistics Department on all surveys. Due to conducting the 2011 census, it is unlikely that any large surveys will be fielded before 2012. Upcoming surveys may include an HIV/AIDS knowledge, attitudes and practice survey, a follow-up behavioral surveillance survey, and possibly a chronic disease risk factor survey.

8.2.1.3 SURVEILLANCE

Diseases requiring immediate notification include cholera, plague, yellow fever, severe acute respiratory syndrome, and any apparent outbreaks, clusters, or unusual events. Syndromic surveillance consists of weekly reports from the Accidents and Emergencies Department of facilities for acute flaccid paralysis, fever and hemorrhagic symptoms, fever and neurological symptoms, fever and respiratory symptoms (acute respiratory infections), fever and rash, gastroenteritis, and undifferentiated fever. The facilities practice zero reporting and must send a weekly report even when no cases have occurred.

In addition to the weekly surveillance reports, facilities provide monthly and quarterly reports on confirmed cases of other diseases of public health importance. Although the surveillance system collects data regularly on key diseases/conditions, it does not currently systematically provide feedback to all levels of the system and does not include information from private providers (PAHO 2010).

8.2.1.4 HEALTH MANAGEMENT INFORMATION SYSTEMS

Key informants reported that while St. Kitts and Nevis currently have components of an HIS in place, they would not consider that a true "system" is functioning. A lot of data are collected to meet various needs, but each report operates independently of the others; at the central level, multiple Excel-based spreadsheets are used to compile and report on the data. Streamlining the number of reports and integrating them into a more comprehensive and user-friendly database platform is an important next step to ensure that the country is able to readily and easily interpret, analyze, use, and disseminate the wealth of data that it currently collects. Additional information on NHA and other financial information should be integrated into this system.

8.3 DATA QUALITY, ANALYSIS, AND USE

There is currently no unit in the MOH that systematically evaluates the quality of the information that the health system generates (PAHO 2009). No guidelines or tools exist regarding data verification procedures, though the HIUs on both islands do conduct ad hoc verification exercises. Each data entry clerk is responsible for specific health information areas, and some are more disposed than others to verify their data (i.e., procedures vary substantially). The data entry clerks and M&E officers report a proportion of public facilities sending reports on time, but this may primarily reflect the fact that they are able to personally visit facilities when needed to obtain reports. They also report that the completeness and accuracy of reporting forms is fairly low, and they must follow up individually with facilities and providers to ensure that reported data are complete and accurate.

The general consensus of key informants interviewed in this assessment was that while St. Kitts and Nevis collects a lot of routine data, there is room for improvement in the analysis, interpretation, and use of that data. The CMO reports using the data for a variety of purposes, including for annual reports

and calculations and the presentation of four-year disease trends (the small size of the population makes annual trend data not very relevant or useful). However, some key informants expressed concern about whether policymakers were in fact reviewing key health data and making policy suggestions based on data.

Although the MOH produces an annual report that provides data on trends in health outcomes, it does not present the report to groups of key decision makers; provide communities with a common set of measures to help them make comparisons, prioritize community health problems, and allocate resources; or solicit and evaluate suggestions to improve this annual health profile (PAHO 2009). Key informants at the facility level reported that feedback from the central level on the data they report is infrequent. The CHRC 2010 assessment also noted that feedback on routine HIV monitoring data is not systematically shared at the facility level or with other line ministries or civil society organizations; there is no systematic method to provide feedback to those facilities and organizations that supply information for the reporting system. The HIU in Nevis reported an initiative to produce a quarterly report that would contain some data along with brief interest stories or highlights from within the MOH, but it has encountered some difficulties in engaging other MOH units in this endeavor. Overall, data and information are readily available but are not easily accessible to stakeholders (Lloyd et al. 2010). There is no structured schedule for data dissemination, and no data dissemination strategy exists.

8.4 SUMMARY OF KEY FINDINGS

Staff capacity needs strengthening

- Dedicated staff are working to collect and collate health information, and many of them look for opportunities to expand their skills and knowledge.
- There is limited capacity for analysis at the national level; much is done on an as-needed basis. Key staff could be trained to do more than simply collect and enter data.

Abundant data are collected, but the private sector is missing

- The MOH HIU serves as a repository of diverse routine health data. Coverage of public sector reporting is fairly complete, and reports are timely.
- Data from private health care providers are incomplete; private providers typically do not report. Without information from private providers, MOH leadership cannot get accurate picture of the country's disease burden, or develop usable registries for NCDs.

There is a need for an HIS vision and strategy

- There is no official strategic plan for the HIU. Various components of the HIS are in place, but they need to be strengthened, integrated, rationalized, and made usable.
- Data for various purposes are collected on separate forms and entered into unlinked databases, facilitating only ad hoc use rather than holistic evidence-based planning.

The new HIV program monitoring approach is promising

- The national HIV/AIDS program has initiated use of a patient monitoring system card – a standard card to track HIV care and ART provision to harmonize data for HIV patient monitoring. However, convincing all doctors to use this card has been a challenge.

Physical infrastructure needs exist

- The ministries of health and hospitals on each island have computers and Internet connections. However, only outdated or nonfunctioning computers are available, and there is no Internet connectivity at health center level. There is no electronic transmission of data and currently no

capacity for computerized data entry at the health center level. This results in HIU staff inefficiently spending time visiting facilities to retrieve data.

Feedback loops for information dissemination are needed

- Informants noted that there is inadequate sharing of analyzed health information from the ministry level back to lower-level facilities and other stakeholders (including private providers and the community at large). This disincentivizes routine reporting.

There are mixed lines of authority

- The national epidemiologist is located in the HIU. However, outbreak investigations are handled by environmental health officers who are part of the Community Based Health Services division and do not report to the epidemiologist.

8.5 RECOMMENDATIONS

8.5.1 SHORT-TERM RECOMMENDATIONS

Conduct strategic planning for health information systems

- Conduct strategic planning for the HIU (identify strategic direction, gaps, and solutions) and for HIS more broadly.

Improve data quality through training

- Develop standard data verification guidelines, and train data collectors to use them systematically.
- Train public and private providers to correctly use HIV Patient Monitoring System cards.

Increase private sector reporting into health system

- This could initially focus on HIV testing and a few key diseases. Steps to achieve this goal could include the following:
 - Convene a meeting with private sector stakeholders to reach consensus on priority health indicators to be reported (e.g., sexually transmitted diseases, HIV, NCDs)
 - With private sector stakeholders, develop “user-friendly” forms
 - Develop a reporting system and roll out to the private sector
 - Share reports with private sector stakeholders.

8.5.2 LONG-TERM RECOMMENDATIONS

Explore options for creating an electronic HIS that integrates and links routine reporting forms

- Coordinate this with the Taiwan-funded JNF Hospital HIS initiative.

Facilitate access to and use of routine information

- Develop and implement a plan for systematic routine health information dissemination.
- Improve the functionality of the MOH website and regularly post current data, reports, and other information products.

Strengthen stewardship and leadership of HIS

- Reach out to regional institutions (e.g., CAREC, CHRC) to engage technical assistance.
- Conduct a training needs assessment for the HIU; provide classroom training, on-the-job training, and mentoring on data analysis, interpretation, and use.

9. PRIVATE SECTOR CONTRIBUTIONS TO HEALTH

Key Findings

- The private health sector in St. Kitts and Nevis is small but important. There are approximately 30 private physicians (mostly in dual practice with the public sector) and seven pharmacies.
- Private practitioners see the full range of clients – poor as well as rich.
- The private sector is increasingly being used to address public sector shortfalls (e.g., drug stock-outs, poor quality of care, limited hours) but at a high cost for the poor.
- There is little formal interaction, communication, or coordination between the public and private health sectors.
- Limited regulation or oversight of the private health sector leaves room for noncompliant practices in the pharmacy sector and individual interpretation of dual practice policies.
- The private health sector has resources and expertise available for the public sector to tap into.

This chapter synthesizes data on the private sector in St. Kitts and Nevis, incorporating information presented in previous chapters supplemented by additional information to provide a comprehensive description of the sector. The chapter begins by describing the private health sector's size, scope, and clientele. It examines the government's capacity to govern the private health sector and its willingness to partner and engage the private sector in a variety of stewardship areas such as policy and planning, finance and service, and product delivery. The chapter concludes with recommendations on how to better coordinate and integrate the private health sector into the overall health sector, harnessing the private sector's resources to complement public health priorities.

The private sector in St. Kitts and Nevis, although small, plays an important and growing role in the health sector. The principal actors in the private health sector are private physicians in solo practice, private pharmacies, private diagnostic centers, and private insurers. Private households also finance health through individual out-of-pocket spending. There are no private hospitals or health centers in St. Kitts and Nevis.

9.1 PRIVATE SECTOR HEALTH CARE PROVIDERS

9.1.1 OVERVIEW

St. Kitts and Nevis is no different than other OECs countries in that most physicians work in the public sector. However, there is a significant number of public physicians who have a private practice as well. Table 9.1 shows the number of health personnel engaged in the private sector. Dual practice is most prevalent among physicians. Some pharmacists also work in both sectors. Unfortunately, there is limited record keeping on the number of physicians in dual practice. According to the MOH, there are only 15 exclusively private physicians in St. Kitts and Nevis. However, in speaking with the private physicians – both those exclusively in private practice and those in dual practice – the actual number of private

physicians may be twice as many. Our assessment team heard commentary from several dual practice providers indicating that they are considering leaving the public sector to work solely in the private sector because of various challenges faced in the public system, such as regular drug stock-outs, unclear guidelines on dual practice, and the perception of increasing politicization of staffing decision-making.

Many of the islands' specialists practice in the private sector: general surgeons, cardiologists, obstetrician-gynecologists, internists, and radiologists. Some of these specialists (e.g., internists) also work as generalists because of the high prevalence of NCDs needing routine care among their patients. A limited number of private physicians and pharmacists have been trained as part of an initiative to develop a clinical care team for HIV/AIDS and treat patients with AIDS.

TABLE 9.1: HEALTH PERSONNEL (ST. KITTS AND NEVIS)

Category/Year	1996	2000	2005	2009
Physicians				
Total # of physicians	48	46	54	47
# of private physicians	15	13	12	15
Nurses				
Total # of nurses		225	209	241
# of private nurses		N/A	N/A	N/A
Pharmacists				
Total # of pharmacists	19	17	17	20
# of private pharmacists	11	9	9	11
Laboratory Technicians				
Total # of technicians				5
# of private technicians				2
Dentists				
Total # of dentists	11	14	19	14
Total # of private dentists	5	9	10	5

Source: MOH Statistical Report 2009

Almost all nurses work in the public sector. However, some of the private physicians interviewed indicated they employ a full-time nurse on staff. There appear to be no nurses working independently in private practice and the few nurses in the private sector work under the supervision of a private physician.

The private sector employs about half of pharmacists (11 out of 20). This number may be underestimated given the trend of dual practice among pharmacists as well. There are fewer laboratory technicians and dentists in the private sector compared to the public sector.

Almost all private health personnel are concentrated in the two capital cities, Basseterre and Charlestown.

9.1.2 GOVERNANCE AND REGULATION

This section summarizes highlights from the Governance chapter. The government provides little oversight of the private medical sector, as the Medical Council does not appear to have the resources

(or mandate) to supervise and monitor the private sector. There were no examples of the council enforcing sanctions against noncompliant behavior in the private sector, according to informants in this assessment. Nonetheless, many private providers voluntarily maintain their clinical knowledge through long-distance learning, even though there is no continuing medical education requirement. Private physicians also stated they would welcome the opportunity to participate in the weekly trainings provided at JNF Hospital for public sector staff.

Several areas would merit greater regulatory attention: dual practice, use of public hospital space by private providers, and oversight of retail pharmacies. As key informants at MOH in St. Kitts acknowledged, it is quite simple for a public physician to establish a private practice; almost no one has been denied approval. Once approved, there are no guidelines to minimize possible areas of conflict between doctors' public duties and private practice. There are no clear job descriptions in the public sector outlining specific hours, responsibilities, and performance indicators. Everyone interprets the practice differently, creating many opportunities for abuse of the privilege. Indeed, many informants commented that some physicians in dual practice set their own hours in the public sector, treat their private sector clients at public facilities, and charge fees while treating private clients in a public facility. According to informants, dual practice has created a double standard as well as resentment among physicians.

Accessing hospital privileges is another gray area. Since there is no private hospital, by default private doctors make use of public hospitals. However, there are no formal agreements on the terms and conditions for this privilege. The practice has evolved over time based on what has been done in the past. Currently, private physicians have full access to hospital rights in exchange for providing "pro bono" testing (such as pap smears), consulting with public sector patients, and sharing surgical and diagnostic equipment (such as fetal monitors). When private providers in this assessment were asked whether they should contribute further toward the cost and expense of using hospital facilities, all felt that their current contributions were sufficient. Some threatened they would leave the island if required to pay fees for hospital usage, while others stated they would be obliged to pass the expense on to the client.

Turning to the pharmaceutical sector, there is currently no regulatory framework to govern and supervise private retail pharmacies, leaving the MOH without the tools needed to enforce laws or sanction unethical practices. In essence, the private pharmaceutical sector is self-regulating. On the positive side, most pharmacists self-report that there are few of the problems observed in other developing countries, such as counterfeit drugs, drug resistance, "suitcase" pharmacies, black markets, or leakage of donated products. But when pressed, informants cited a few noncompliant practices prohibited in other Caribbean countries, including the following:

- Unlicensed staff dispensing drugs
- Pharmacies dispensing drugs without a prescription
- Physicians establishing "mini-pharmacies" in clinics without proper licenses
- Pharmacies offering free medical check-ups on-site with discounts on drugs prescribed.

Systems to ensure accountability in the pharmaceutical sector are needed, including pharmacovigilance, requirements for continuing medical education and relicensing of pharmacists and pharmacist technicians to ensure professionals remain current on medical technology, and routine facility inspections to ensure that pharmacies are properly staffed and drugs are adequately stored.

9.1.3 PROVIDER ASSOCIATIONS

The Pharmacy Association has been dormant for at least three years. When informants were asked why there has not been a meeting despite the pressing need for a Pharmacy Act, some said there was not enough interest by the pharmacists in attending a meeting. Others added that the association had become highly politicized (and therefore personalized), resulting in weak leadership. Contrary to some beliefs about a lack of interest by pharmacists, there is a small group of younger pharmacists who are still motivated and interested in reconstituting the Pharmacy Association. In 2006, they successfully organized the Caribbean Association of Pharmacists' annual meeting in St. Kitts. The Pharmacy Association is the likely forum to openly discuss and advocate for the approval of the Pharmacy Act. Since this organization is defunct, the draft Pharmacy Act has been circulated on a one-by-one basis. There appears to be limited leadership to get the act passed quickly despite its urgency.

Like the Pharmacy Association, the Medical Association is also defunct. There are many reasons for this, including the following:

- It is difficult for the association to assume its traditional role as advocate for the profession when the majority of its members are civil servants who are restricted by law from lobbying.
- The association has little convening power because there are no mandatory requirements for continuing medical education; therefore, no need to offer training opportunities to its membership.
- The association has become politicized, making it difficult to reach consensus.
- Geography makes it difficult to create cohesion among its members located on two islands.

Without this forum in place, private sector physicians feel that their opinions and perspectives are not “heard” by the MOH. There does not appear to be much willingness among former members to reconstitute the association, however, as the perceived ineffectiveness and political conflicts outweighed any benefits received from membership.

A Nurses' Association continues to be active in St. Kitts and Nevis, with most of its activities focused on providing training opportunities for nurses, generally continuing education classes within the hospital.

9.1.4 PRICING AND SERVICES

Prices for consultations vary among private physicians. Some charge a higher fee (EC\$120–\$150) for first time visits and then a lower one (EC\$70–\$90) for follow-up visits. Most just charge a flat fee (EC\$70–\$90) for each visit. The price of a vaginal delivery was around EC\$700 while a caesarean delivery was priced at EC\$1200.

Private physicians see the full range of socioeconomic groups. According to informants, approximately 25 to 30 percent of their clients have some form of health insurance (government-sponsored or private). The clients pay out-of-pocket for the consultation and then submit the claim directly to the insurance company. Informants stated they prefer this approach because they are not staffed or equipped to submit the claims. Almost all private physicians interviewed try to help patients who cannot afford their consultation fees; indeed, many offer “pro bono” care for extremely poor clients and HIV-positive patients. Other arrangements include payment on an agreed-upon schedule. One provider has created an “Association for Maternal Health Fund” to raise funds to support free clinics and pap smears to the poor, as well as education campaigns on reproductive health and cervical cancer.

According to private providers interviewed, there are several reasons why even poor clients are willing to pay for health care with a private physician despite the lower cost in the public sector:

- **Convenience:** There are usually shorter waiting times to see a private doctor. Some doctor's offices take appointments as well as walk-ins. Also, private physicians often maintain longer hours (Monday–Friday 9 a.m. to 6 p.m., Saturdays 9 a.m. to 12 p.m.).
- **Better service:** The private physicians stated they can spend more time with their patients in private practice compared to public. Their facilities are considered more attractive by patients. Finally, many of the private physicians have needed diagnostic equipment on-site (e.g., ultrasound, x-rays, and in one case a small operating room).
- **Confidentiality:** Informants commented that patients feel the private sector affords more confidentiality. This is particularly important in such a small country where everyone literally knows each other. The few private physicians working with HIV patients stated, "They don't trust the public system."

9.2 PRIVATE LABORATORY

There is one private laboratory in St. Kitts, with a blood "draw center" in Nevis. The laboratory performs a wide range of diagnostics, including analysis of blood chemistry, urinalysis, serology, and other screening tests. The laboratory does not do HIV testing but does assist public sector labs to interpret or reconfirm complex HIV test results. It has relationships with labs in the United States and Barbados to purchase supplies, as well as to conduct tests that it is not equipped to perform.

There is more government oversight of the private laboratory than of private pharmacies. The laboratory was properly licensed and has been inspected from time to time. However, there are few incentives for quality improvement aside from individual initiative. The lab's owner is working toward meeting international accreditation requirements (ISO1859), and the lab technicians and lab assistants voluntarily participate in on-line seminars and long-distance learning to update their clinical skills.

The private laboratory sees the full range of socioeconomic groups, including the poor. As at private pharmacies, clients pay out-of-pocket for tests at private labs. Approximately 25–30 percent of the lab's client base reportedly has public or private medical insurance. Clients are responsible for submitting claims for reimbursement. Consumers reportedly utilize the private lab for a variety of reasons: (1) confidentiality, (2) perceived quality, (3) convenience, and (4) quick turn-around in test results (most are available the same day; a few within two days).

Laboratory informants noted that they recently increased their prices to accommodate the introduction of the VAT. Despite many efforts to be classified as a service, which would have made them subject to a 10-percent tax, the government classified laboratory tests as goods and they are therefore subject to the full 17-percent VAT.

9.3 PRIVATE HEALTH INSURERS

There are two sources of private financing for health in St. Kitts and Nevis: individual out-of-pocket payments and health insurance. For a more in-depth description of out-of-pocket payments, see the Health Financing chapter. A small, unknown percentage of residents (estimates range from 2.5 percent to 16 percent, with a probable level of about 5–6 percent) are covered through private health insurance. There are several private health insurance companies operating in St. Kitts and Nevis, including Nagico, Sagicor/St. Kitts-Nevis Insurance Company (SNIC), BAICO, and CLICO.

9.3.1 CLIENTELE

The team interviewed two private health insurance companies. Both companies serve similar clientele and offer comparable benefit packages. Clients include individuals, small groups (three to nine employees) and large groups (10+) in the financial, hotel, and manufacturing industries. All of the largest enterprises in St. Kitts and Nevis provide insurance for their employees. Despite the economic downturn, both insurance companies stated that business has remained stable, if not growing slightly.

9.3.2 BENEFITS PACKAGES AND PRICING

Most large employers offer a combination of health, including dental and vision, and life insurance to their employees (see Table 9.2 for description). Companies typically cover the employee while employees pay for their dependents. The monthly cost for an employee was reported by interviewed stakeholders to be around EC\$80–\$110.

TABLE 9.2: DESCRIPTION OF SAMPLE PRIVATE HEALTH INSURANCE BENEFIT PACKAGE

Lifetime maximum coverage for major medical care	EC\$1 million to \$2 million
Annual preventive care, maternity benefits, diagnostics, prescription drug, ground ambulance, AIDS and AIDS-related treatment, organ transplant, psychotherapy	80% to 100% reimbursement
Vision and dental	Optional
Overseas care expenses including air ambulance	90% up to EC\$50,000 100% over EC\$50,000
Co-payment within network (80% insurance/20% copay)	80%/20%
Out of network	60%/40%

The assessment team's impression was that most individuals still consider private insurance premiums too high. One of the islands' largest employers stated that only one-third of their employees take advantage of health insurance benefits.

In 2010, NAGICO launched a new product that included HIV/AIDS benefits, offering an additional EC\$20,000 for HIV treatment. To date, no one has enrolled in this program.

9.3.3 CLAIMS

Typically, the payment and paperwork burden – submitting claims and getting reimbursed – falls on the insured individual. Most private sector entities (physicians, pharmacies, and laboratory) stated they are not set up to handle insurance claims and therefore ask the individual to pay up front and have them submit the paper work to their insurance carrier. Insurance companies interviewed reported that they can process reimbursements as quickly as within 48 hours, though this could not be confirmed. Sagicor has initiated an e-claims settlement system with a small number of providers. A few physicians (seven or eight), two drug stores, one eye care provider, and one laboratory use this system. Some like it; another complained it was cumbersome.

9.3.4 REGULATION OF INSURANCE

The Financial Services Regulatory Commission is the regulatory body responsible for overseeing the health insurance market. As indicated in the Health Financing chapter, the regulatory environment for

private health insurance is experiencing upheaval. In 2009, two major insurance companies were declared insolvent – BAICO and CLICO – and are under judicial management. The collapse of these companies has affected multiple Caribbean countries, creating confusion and concern on how to reimburse policyholders’ investments and pay outstanding claims. In mid-2011, Eastern Caribbean governments launched the much-anticipated BAICO Health Insurance Support Fund that will provide some relief for policyholders. Trinidad and Tobago’s government is paying EC\$33 million to bail out CLICO, and in April a regional high court appointed a judicial manager to recover some of CLICO policyholders’ assets. As a result, the Financial Services Regulatory Commission in St. Nevis and Kitts is being extremely cautious, scrutinizing on-island insurance companies more carefully.

9.3.5 COMMENTS ON NATIONAL HEALTH INSURANCE

Private health insurance representatives interviewed in this assessment had little to say regarding possible national health insurance proposals. They are aware of proposals being developed, primarily through press coverage. The government has not “officially” asked them to participate in developing any proposals. Both companies interviewed were open to participating in a dialogue on national health insurance, stating it would be a good direction for the country because there is limited insurance coverage and high rates of out-of-pocket payments. Informants offered to partner with the government in designing an insurance proposal and offered their technical expertise in costing benefit packages, actuarial analysis, and in other areas.

9.4 PRIVATE INDUSTRY

The assessment team interviewed two large companies and one trade association to discuss their role in providing health services, health education, healthy workplaces, and financing for health. The larger company was part of a multinational corporation and offers health and life insurance to its employees, while the other heavily subsidized the cost of health insurance for staff. Both companies provide some on-site health promotion and education to their staff, mainly focusing on NCDs and childhood vaccination. Both expressed openness to doing HIV/AIDS prevention activities, but have not done so previously. Neither had an HIV/AIDS workplace policy in place.

The trade association interviewed had once tried to create a health plan for small employers in its sector, but the plan failed due to low uptake (size of risk pool too small and costs still too high). A private insurer approached the association after this experience to develop a product for smaller employers, but only one small enterprise enrolled in the program. The association is now looking to the government’s national health insurance initiative as a possible solution.

There is a tradition of “corporate social responsibility” among large employers in St. Kitts and Nevis. In addition to the on-site health promotion, many employers make donations to community activities (e.g., sports teams, refurbishment of schools and parks, scholarships). When asked, the companies interviewed stated they would be interested in and open to doing more in health, but do not know how they can contribute or help. Only one had been approached by the MOH to hold health outreach at its worksite or to donate funds or in-kind inputs.

9.5 EXAMPLES OF PUBLIC-PRIVATE ENGAGEMENT

Relationships between public and private sector entities appear to be informal and driven primarily by personal and professional relationships. As one informant said, “It is a small island and we have to help each other out.” There are several examples of public-private engagement worth mentioning.

Public sector hospitals may purchase drugs for their inpatients from a local private pharmacy, if their own stock runs out. The public pharmacy is often out of stock for drugs needed to treat NCDs, and may instigate a “run” on these products, creating stock-outs in private pharmacies. Fortunately, private pharmacies can usually resupply these drugs within a few days. Three private pharmacists agreed that if there were better coordination between public and private sector pharmacies, the private sector could increase orders for certain drugs in preparation for public pharmacy stock-outs.

The three laboratories coordinate routinely. At times, the Nevis public sector laboratory runs out of reagents and other supplies. It will send staff to either run the tests at the private lab or borrow the missing supplies. Similarly, the private laboratory relies on the Nevis public lab, and more recently on the St. Kitts public laboratory, to borrow supplies until theirs are replenished. The private laboratory’s staff also help the Nevis lab when they have a backlog and send out unusual tests to their United States testing site. The private laboratory is reimbursed for the tests they run but does not charge the public sector for the supplies.

Another area of collaboration is the sharing of medical equipment. As noted above, public lab technicians use the private lab’s facilities and equipment to run their tests when their equipment is out of service. Some private physicians have received tax exemptions when importing equipment that will be used at the public hospitals. There is an informal agreement that public clinicians can make use of this private equipment when the private physician is not using it. Private physicians also make use of the public operating theaters at the hospitals for their private clients.

Currently, the MOH has no formal strategy or policy on engaging the private health sector. Despite this, the assessment team perceived strong interest among MOH leadership to address these gaps and to work more closely with the private sector.

9.6 SUMMARY OF KEY FINDINGS

The private health sector is small but important

- There are approximately 30 private physicians (mostly in dual practice) and seven pharmacies. The private sector contains most of the country’s specialists, including general surgeons, cardiologists, obstetricians and gynecologists, and internal medicine specialists. There are also a substantial number of general practitioners.
- The most common health conditions treated in private practice are NCDs. A very small number of private doctors sees HIV/AIDS patients.
- Private sector providers see the full range of clients – poor as well as rich.
- The most commonly cited reasons why consumers go to the private sector are (1) convenience, (2) confidentiality (particularly for HIV/AIDS patients), and (3) availability of drugs and access to specialists. Increasingly, the private sector is being used to address public sector shortfalls (e.g., overcrowding, drug stock-outs, lack of specialists), but at a high cost for the poor.

The health market is not segmented equitably

- As described in the Service Delivery chapter, a large percentage of those in the wealthiest fifth of the population (42 percent) who can afford to pay are receiving highly discounted health care in the public sector, while 25 percent of those in the poorest fifth pay for care in the private sector when they can ill afford to.
- Private sector interviews confirmed how poor clients struggle to pay retail price for drugs and services.

- Private providers recognize the economic hardship and do make some accommodations, such as pro-bono care for the poor, including poor HIV-positive and other patients, and extending credit to others.

There is little formal interaction between the public and private health sectors

- There is limited communication and coordination. For example, many of the private pharmacies stated that if the MOH could advise them of potential stock-outs in key NCD drugs, then they could plan ahead and increase purchases. Communication that does occur is ad hoc, based on personal relationships, and, reportedly, is increasingly politicized.
- Because there is no formal coordination mechanism, private sector informants felt their contribution is not recognized by the public sector.

There is little regulation and oversight of private doctors and pharmacists

- Currently the private sector self-regulates, leaving room for noncompliant and unethical practices in the pharmacy sector and individual interpretation of key policies such as dual practice and hospital privileges.
- The private health sector is very desirous of clear and transparent policies and regulations. Private providers realize that clearly defined quality standards are good for business. The private sector representatives interviewed urgently want the Pharmacy Act approved and other policies in place to ensure quality.

The private health sector has resources and expertise available that the public sector could tap into

- As current experience demonstrates, the private sector is willing to share equipment, staff, and clinical and management expertise. The challenge is finding ways for the public sector to harness these resources efficiently and in a long-term, sustained, consistent way.

9.7 RECOMMENDATIONS

9.7.1 SHORT-TERM RECOMMENDATIONS

Conduct a “mapping” of the private sector to form a baseline

- Information gathered during this assessment can provide an initial inventory of private sector facilities and providers. Mapping the private sector can inform the development of a simple data base, which contains (1) provider’s name, (2) facility, (3) services offered, (4) staffing, (5) location, (6) hours, and (7) contact information.

Begin to normalize coordination between public and private sectors

- Stakeholders in both sectors, public and private alike, would like better communication and more interaction. In the near term, the following actions could help institutionalize routine public/private interactions:
 - Document and acknowledge private sector contributions to the health sector. The public and private sectors currently collaborate together on a wide range of activities. This report can start the process of documenting and formalizing these activities.
 - Set a goal (e.g., once per month) to identify opportunities to invite private sector participation and act upon these opportunities. A “quick win” would be to invite the private sector to Wednesday trainings at JNF Hospital. Private providers said they would gladly participate as students as well as offer to teach, if the seminars could be held at a time more convenient for private providers.

- Facilitate coordination between public and private pharmacies to ensure a steady supply of critical drugs for NCDs and facilitate greater coordination among all three labs.
- Mobilize private sector champions to promote current policy proposals. The Pharmacy Act and the designing of a national health insurance scheme also present ideal opportunities to involve the private sector and to tap into their expertise. The Caribbean Association of Pharmacists could be invited to St. Kitts and Nevis to facilitate a participatory discussion between public and private sector stakeholders and consumers, as well as to share regional and international best practices. Private pharmacists could be enlisted to help the MOH build support to fast-track the Pharmacy Act.

Work with private sector to agree on health indicators to report

- Private sector professionals indicated they would be willing to report to the MOH on key health indicators. A small group of MOH officials and private sector providers could be convened to agree on a short list of key health indicators and an easy and quick format for reporting.

Increase corporate contributions to health

- All of the businesses interviewed stated that they would like to tap into MOH expertise to improve their on-site health education programs. They also consider donating resources to the MOH a worthy cause, but need to know how to do this. Companies would like to see how their contribution makes a difference (e.g., through monitoring results) so they can report back to their staff and shareholders. A corporate social responsibility marketing plan could be developed that would better communicate MOH needs to local businesses. The MOH could possibly explore establishing a “desk” and/or part-time point person to interact with industry and keep track of the relations and “deals” in the making.

9.7.2 LONG-TERM RECOMMENDATIONS

Normalize coordination between public and private sector

- Establish a mechanism to formally convene and engage the private sector on a regular basis. Create a “neutral” forum that allows key stakeholder groups to come together and set the agenda of health sector priorities, explore strategies to resolve them, and facilitate regular and frequent communication.
- Systematically include private sector actors in planning and policy processes. The MOH has a set schedule of meetings to develop annual budgets, work plans, and strategic plans. The MOH should more proactively involve private sector and consumer stakeholders in these planning processes to incorporate their perspective and harness their resources.

Clarify and enforce guidelines on dual practice in the public and private sectors

- There is no clear guidance on terms and conditions for dual practice, resulting in individual interpretations and, occasionally, misuse of the privilege. Technical assistance may be available to help the MOH establish clear and transparent guidelines; external consultants could serve as a “third party” to facilitate negotiation between the sectors. Steps include the following:
 - Convene a working group composed of public and private sector representatives to lead the process to draft dual practice guidelines
 - Review current regulations to determine what guidelines for dual practice exist
 - Examine other country examples, including those in the region, to identify possible approaches that would fit the St. Kitts and Nevis context

- Negotiate with stakeholders to reach agreement on the guidelines and a process to implement them
- Monitor implementation and compliance of the new guidelines.

Establish, in stages, the terms and conditions for private provider use of public facilities

- The MOH and private sector need to reach agreement on terms for hospital privileges that are fair to both parties. But the process will not be easy or quick. The groundwork for dialogue must first be prepared by documenting existing arrangements (both on paper and in practice) and searching for other country examples. The feasibility of various options could then be explored with private sector stakeholders. Second, a neutral third party could assist both parties to reach agreements on terms – possibly in phases – starting with easier agreements on contributions and moving to the more difficult ones.

Explore opportunities to “privatize” a hospital wing to subsidize the public hospital

- During this assessment, both the MOH and private sector providers were very interested in exploring the feasibility of creating a truly private wing at the JNF Hospital. There are many successful examples for St. Kitts and Nevis stakeholders to draw upon in which government and NGO hospitals were partially privatized. One approach would be to take the following steps:
 - Share best practices from other countries on different approaches to “privatizing”
 - Examine the pros and cons of each approach from both the public and private perspective
 - Convene key stakeholders to discuss options and explore interests
 - Determine feasibility (e.g., political, regulatory, financial, health)
 - Draft a proposal for privatization.

10. SYNTHESIS AND CROSS-CUTTING RECOMMENDATIONS

This report has focused on the six building blocks of the health system, as well as the role of the private sector in each of those areas. Specific findings within each of the six building blocks are important to address individually. However, there are a number of key, interrelated issues that limit the health system's ability to offer sustainable, quality health services. The assessment found that while the health system in St. Kitts and Nevis functions well, there are key areas that could improve the delivery of health care. Addressing these challenges holistically will result in positive and sustained impact and contribute to a more effective health system in the long term. Overall, the assessment team identified the following key cross-cutting themes:

- Availability and use of data for evidence-based policy, planning, and advocacy
- Resource constraints and need for sustainable financing for the health sector
- Opportunities to engage the private sector as a partner
- Weak legal and regulatory framework for health.

The findings behind these cross-cutting themes and corresponding recommendations are presented in Table 10.1.

TABLE 10.1: CROSS-CUTTING RECOMMENDATIONS

Invest in improving the availability and use of various types of data for evidence-based policy, planning, and advocacy

Findings:

- Information is needed on:
 - Health expenditures and costs – overall, by public and private sectors, and for HIV/AIDS specifically
 - Use of health services and health outcomes achieved in public and private health sectors, especially linked to health expenditures
 - Human resources management – systems are needed to track current staff's training needs, competencies, performance, wages, etc.
 - Pharmaceutical management – computerized systems are needed to track pharmaceutical inventories and needs at public pharmacies
- Data dissemination outside the MOH is limited.

Recommendations:

- Conduct NHA routinely, including spending on HIV/AIDS and out-of-pocket spending in the private sector. Institutionalize capacity for NHA so that expenditure information is routinely available for evidence-based planning. Estimate the unit costs of providing high-priority services in the public and private sectors.
- Introduce a national human resources training database to track trainings and identify training needs. Support the introduction of an open-source Human Resources Information System and link this with the training database.
- Develop a computerized pharmaceutical inventory management system in the public sector.
- Improve the functionality of the MOH website and regularly post current data, reports, and other information products.

Develop sustainable financing mechanisms for the health sector

Findings:

- St. Kitts and Nevis is committed to a reasonable level of spending on health, but cost escalation is on the horizon and resource constraints are already being felt.
- High reliance on out-of-pocket spending to finance health care is regressive, could limit access, and increases the risk of catastrophic health expenditures.
- There is substantial momentum behind developing national health insurance, though a national discussion on the topic seems necessary before the government can consider collecting additional revenues from households.
- Health facility staff have little incentive (or resources) for effective fee collection. Fees and exemptions are applied inconsistently, and fees contribute minimally to total health sector revenues.
- Available external funding for HIV/AIDS programming has decreased dramatically.

Recommendations:

- Assess the population's willingness to pay for health care and priorities for health spending, to inform development of national health insurance.
- If appropriate, apply evidence obtained through NHA to advocate for more public sector financing for health.
- Consider a "mixed" national health insurance model, combining general tax revenue-financed care for priority groups with a payroll tax-financed health fund, and private insurance as an optional top-up.
- Convert user fees into copayments for services prone to overuse. Strengthen billing and collection systems at public facilities so that they can better recoup costs from private insurers and patients with ability to pay.
- Establish provider payment mechanisms that promote efficiency and incentivize quality, such as performance-based incentives, providing financial and nonfinancial rewards to health facilities, groups of providers, or communities for achieving particular health targets or service goals.
- Develop a financial sustainability plan for HIV/AIDS programming. Conduct a projection analysis of available domestic and external funds going forward.
- Evaluate opportunities for contracting with private sector providers to reduce public sector costs, or to improve quality or efficiency.

Pursue opportunities to engage the private sector as a partner

Findings:

- Public and private health sectors do not communicate or coordinate effectively with each other.
- Private health care providers do not participate routinely in health statistics reporting.
- Private health care providers, including physicians and pharmacists, are largely self-regulating.
- Stakeholders in both sectors, public and private alike, would like better communication and more interaction.
- The private health sector has resources and expertise available for the public sector to tap into.

Recommendations:

- Conduct a “mapping” of the private health sector to serve as a foundation for increased engagement.
- Begin to normalize coordination between public and private sector actors. Establish a public-private forum that meets regularly. Begin to include private sector actors more systematically in planning and policy processes, such as in the development of national health insurance.
- Strengthen mechanisms for coordinating with and/or procuring from private sector pharmacies to mitigate stock-outs.
- Work with private health sector actors to agree on routine health indicators to report.

Finalize the legal and regulatory framework for health

Findings:

- Key legislation is not in place or updated to regulate changing the health sector, specifically in the areas of pharmaceuticals, dual practice, and continuous education for physicians.
- There is little regulation or oversight of the private health sector. This leaves room for noncompliant practices in the pharmacy sector and individual interpretation of dual practice policies.

Recommendations:

- Prioritize passage of the Pharmacy Act to ensure adequate regulation of pharmacists and pharmacies. Identify champions who are committed to seeing the legislation through the process and provide them the necessary support.
- Mobilize private sector champions to promote current policy proposals, like the Pharmacy Act and national health insurance proposals.
- Clarify and enforce guidelines on dual practice in the public and private sectors. Engage in a process to establish clear and transparent guidelines. Identify a “third party” to facilitate negotiation between the public and private sectors.

The findings and recommendations presented in this report are intended to serve as a basis for dialogue between key stakeholders – representing both the public and private sectors – on the way forward toward strengthening the St. Kitts and Nevis health system. As reflected by the United States-Caribbean Regional HIV and AIDS Partnership Framework, USAID recognizes that country-led efforts to

strengthen national health systems and HIV responses are most likely to be sustained over the long term. To this end, the SHOPS and Health Systems 20/20 projects convened a wide spectrum of stakeholders in January 2012 to validate the results and findings of this assessment and, more importantly, to develop a plan of action to address critical health systems gaps and sustain the HIV response in St. Kitts and Nevis. Annex B provides a summary of that workshop.

USAID funding for technical assistance is available to support health financing activities, as well as efforts to engage the private sector to strengthen the health system and sustain the HIV response. PAHO, a partner in this assessment, is another key source of technical assistance for St. Kitts and Nevis, particularly in the areas of policy and regulatory environment and pharmaceutical management. PANCAP may also be able to provide support for strategic health planning. Other U.S. government agencies (such as HRSA and the CDC) and their implementing partners (such as I-TECH and the Caribbean HIV/AIDS Regional Training Network) also support health systems strengthening efforts, including HRH, lab strengthening, HIS, and stigma and discrimination reduction, and they may serve as additional resources for St. Kitts and Nevis.

ANNEX A: HEALTH SYSTEMS STRENGTHENING AND HIV IN ST. KITTS AND NEVIS

The government of St. Kitts and Nevis has made significant progress in addressing the challenges of HIV/AIDS over the last decade, but weaknesses in the health system threaten these successes. A Health Systems and Private Sector Assessment conducted in May 2011 highlighted these challenges and included the topics of sustainable health financing, stigma and discrimination, and weak civil society engagement.

BACKGROUND ON HIV IN ST. KITTS AND NEVIS

The Caribbean region has the highest incidence of HIV/AIDS in the Americas and the second highest prevalence in the world after sub-Saharan Africa. Within the small island nations of the eastern Caribbean, the HIV epidemic is believed to be concentrated among certain high-risk populations, but seroprevalence data are lacking. In St. Kitts and Nevis, the estimated prevalence rate was 1.1 percent in 2001 while the case-based prevalence rate was calculated at .46 percent in 2009. The most common route of transmission is unprotected sex, particularly in concurrent relationships. A lack of data makes it difficult for the government to determine the size, determinants, and distribution of the epidemic and to target an appropriate response.

STRENGTHS OF ST. KITTS AND NEVIS'S HIV/AIDS HEALTH CARE SYSTEM

The government of St. Kitts and Nevis is committed to limiting the effect of HIV on the health and development of the country. The National Advisory Council on HIV/AIDS (NACHA) is responsible for setting the overall direction of and mobilizing resources for the national AIDS program, and it is guided by the recently updated National HIV/AIDS Strategic Plan 2010–2014. NACHA members include representatives from various government ministries, the private commercial sector, and civil society. The National AIDS Secretariat (NAS) is responsible for coordinating the federal program and implementing activities in St. Kitts, while the Nevis AIDS Coordination Unit (NACU) implements program activities and partners in Nevis. This division allows NACU to tailor programs to the Nevisian context.

Over the last decade, in addition to allocating domestic funding to HIV programs, the government has sought external resources from the World Bank, the Global Fund to Fight Tuberculosis, AIDS and Malaria (Global Fund), and the U.S. President's Emergency Plan for AIDS Relief to strengthen its response. Funds have supported upgrading facilities, improving monitoring and evaluation systems, and strengthening pharmaceutical procurement and laboratory services. Voluntary counseling and testing services are available at 21 sites, including all primary care facilities and hospitals. Antiretrovirals (ARVs) are provided free of charge and 93 percent of registered cases of advanced HIV infections are receiving antiretroviral therapy. ARVs are distributed from a single location on each island (the JNF Hospital on St. Kitts and Alexandra Hospital on Nevis) to facilitate monitoring; however, private physicians are permitted to pick up prescriptions for their patients who desire greater confidentiality. The NAS has instituted a unique identifier for HIV-positive patients to help ensure continuity of care and facilitate patient tracking. The Ministry of Health has made the integration of HIV services into primary care a top priority to promote sustainability.

CHALLENGES FACED

Despite the expansion of quality services that St. Kitts and Nevis has achieved, the response to HIV is threatened by a lack of sustainable financing, ongoing stigma and discrimination, and the limited capacity of civil society to aid in the response.

Financial sustainability is a concern for the entire health system as health must compete with other priority issues in a constrained fiscal environment, but it has become an acute concern for the HIV response. Direct donor funding for HIV/AIDS-related activities has largely ended in St. Kitts and Nevis, and current Global Fund support that provides free ARVs in the eastern Caribbean is slated to end in 2012. It is unlikely that domestic spending on HIV/AIDS will be able to replace previous levels of donor funding in the near future. Reports to the United Nations General Assembly Special Session on HIV/AIDS indicated that domestic sources accounted for between 17 percent and 49 percent of total HIV/AIDS spending between 2007 and 2009. More broadly, there is a lack of information about costs and expenditures in the health sector, essential for rational financial sustainability planning.

Although funding is one limiting factor, the national HIV response is also hindered by stigma and discrimination. Within the small community on St. Kitts and Nevis (population 50,000), maintaining confidentiality of HIV status or stigmatized behaviors (such as sexual behavior or preference) is difficult. Nondiscrimination laws currently do not exist to protect people living with HIV or vulnerable groups like men who have sex with men and commercial sex workers. Some laws and regulations, such as the prohibition of “buggery” and the legal age for youth to access reproductive health services, create additional obstacles for prevention programs and drive vulnerable populations underground. As a result, there is low uptake of counseling and testing despite widespread availability. Doctors fail to record AIDS deaths to protect families. Few commercial businesses have HIV/AIDS workplace policies, and not a single grievance has been filed with the Human Rights Desk for HIV/AIDS in its three years of existence. In addition, private practitioners report that their HIV-positive clients avoid referral to the public sector HIV/AIDS program or clinical care team, preferring to remain with their private physician for confidentiality reasons.

Civil society organizations and private sector entities, including nonprofit organizations and provider associations, can play a valuable role in countries’ response to HIV. They may provide direct services for people living with HIV, outreach to marginalized populations, advocacy for programs to meet their needs, or additional financial resources. In St. Kitts and Nevis, better civil society and private sector engagement are particularly needed as ministry officials are overstretched. Civil society organizations for health, while welcomed by the government to provide input, do not have the capacity currently to play a supporting role in decision-making or planning. Little external support is available for nonprofit groups. Some have made an active decision not to engage in advocacy because of the resources required. Further, the ministry does not have many formal mechanisms for communicating and collaborating with private sector providers.

HEALTH SYSTEMS RECOMMENDATIONS FOR THE HIV RESPONSE

- Ensure that complete health expenditure information is routinely available, and use it for evidence-based planning – Conduct National Health Accounts (NHA) estimation routinely, including HIV/AIDS subaccounts. Institutionalize capacity for NHA (either in country or through partnerships with regional entities) so that expenditure information is routinely available for evidence-based planning.
- Proactively plan for reduced external HIV/AIDS funding – Develop a financial sustainability plan for the HIV/AIDS program. Conduct a projection analysis of available domestic and external funds going forward. Explore new resource mobilization options (“sin” taxes, insurance programs) and ways to stretch health budgets further (contracting with the private sector,

alternative provider payment mechanisms).

- Increase coordination with civil society organizations and the private health sector – Consider instituting a civil society forum in order to coordinate the messages of civil society organizations and improve their collaboration. Actively engage the private sector to help address the country's health needs. Normalize coordination between public and private sector actors by establishing a public/private forum that meets regularly.

ANNEX B: VALIDATION AND PRIORITIZATION WORKSHOP SUMMARY

This annex summarizes the workshop during which the assessment team validated the findings of the St. Kitts and Nevis Health Systems and Private Sector Assessment and facilitated the process of prioritizing recommendations. The results of this workshop informed revisions to the draft report and the prioritization of technical assistance that USAID and other partners may provide in the region.

OPENING REMARKS AND PRESENTATION OF FINDINGS

USAID/Barbados and the Eastern Caribbean's Health Team Leader, Ms. Kendra Phillips, opened the workshop by welcoming participants and thanking them for their engagement. The ministers of health from both Nevis and St. Kitts reflected on the current state of health and the health system as well as visions for the future. Nevis Minister of Health Hensley Daniel noted that the changing health profile in St. Kitts and Nevis requires a shift in focus toward chronic diseases and expressed the federation's desire that USAID be a partner in this transition. He also expressed Nevis's interest in improving collaboration and cooperation with the St. Kitts Ministry, as demonstrated by the strong presence of Nevisians at the workshop, and hoped that the workshop would help point the way forward.

The Federal Minister of Health, Honorable Marcella Liburd, commended all those present for their commitment to strengthening the health system. The minister expressed her eagerness to foster greater collaboration across all partners, including the private sector. She also outlined some federation health priorities, including passing the revised Public Health Act to ensure that there is no discrimination in health care provision or for health conditions, establishing predictable and sustainable funding through national health insurance, and improving evidence-based planning by creating an electronic health information system.



The Honorable Minister Hensley Daniel gives opening remarks while Ms. Kendra Phillips (USAID), Hon. Minister Marcella Liburd, and Dr. Laurel Hatt (Health Systems 20/20) take note.

Following the welcome, Dr. Laurel Hatt from Health Systems 20/20 highlighted the key findings and recommendations presented in the report. The presentation discussed the findings and recommendations for topics that included health governance, health financing, human resources for health, service delivery, pharmaceutical management, and health information systems. Within each topic, findings related to the private sector's role were also discussed. Participants asked questions to clarify the findings and recommendations.

Dr. Patrick Martin, Chief Medical Officer, gave a short presentation reiterating some of the findings from the report and highlighting areas where the Pan American Health Organization and the Ministry of Health (MOH) have already agreed to collaborate over the coming two years. Interestingly, many of the technical areas proposed in the biennial workplan reflect the preliminary recommendations from the

assessment. Dr. Martin also noted areas where he believed support from USAID and partners could strengthen efforts already underway. Some of these areas included implementing a performance management system; undertaking feasibility studies; planning for a national health insurance scheme; training staff in costing and quality assurance skills; supporting National Health Accounts (NHA); and developing an HRH plan.

VALIDATION OF FINDINGS AND RECOMMENDATIONS

DISCUSSION OF REPORT'S KEY FINDINGS

Following the presentation of the findings, participants were asked to consider the report's key findings and recommendations. Participants formed small groups based on their interests and specialties. The groups reviewed the report to verify whether its findings matched their experience and to add any points that they believed should have been included. The small groups focused on the topical areas of (1) health financing; (2) human resources for health and service delivery; (3) use of evidence for decision-making, which combined governance and health information systems issues; and (4) pharmaceutical management. Participants reported that the findings were generally accurate and made the following suggestions for strengthening each module.



Participants review the findings and recommendations on human resources for health and service delivery.

ADDITIONS AND EDITS TO FINDINGS

Health Financing	<ul style="list-style-type: none"> • Need to be consistent HIV rate reported; 1.1% used for generalized statistics versus 0.4% calculated rate. • Further discussion and recommendations could be made on the need to revisit user fee exemption categories, including giving one agency authority to determine eligibility and continuously monitor poverty status in situations where hardship is temporary. • The MOH needs a public relations department to promote issues and educate the public about health issues and services. Assessment did not highlight public education aspects as much as it could.
Human Resources	<ul style="list-style-type: none"> • Agreement that there is a lack of specialists. Add community health nurses and internists for Nevis to the list of specialists mentioned. • Emphasis should be placed on how little is being done to “sell” youth on nursing as a profession. Few incentives exist, especially for specializing in areas outside of midwifery. • Add concerns about the delays for nurses returning from training to receive postings with increased payment, incentives or promotions to reflect their additional training, and how this would encourage them to remain in position or stay on island. • Succession planning is lacking.
Service Delivery	<ul style="list-style-type: none"> • Qualify language on the level of access to primary care, which is geographically very accessible. Perceived poor quality at health centers encourages the use of the Accidents and Emergency Department of the hospital for primary care. Quality problems include: <ul style="list-style-type: none"> ▪ Most times a doctor available or on call in the hospitals, but not health centers. ▪ Clinics are only available once per week in health centers ▪ Health centers haven't been updated to be more patient friendly over the past few years and therefore the hospital is more pleasing for the clients ▪ Health centers not available after normal business hours

	<ul style="list-style-type: none"> • In addition to decreased external funding for HIV, fear of disclosure of HIV status also prevents further HIV service integration. • Quality assurance system exists, but is not adequately developed or implemented. The system is stronger at hospitals than at health center/clinic level.
Governance	<ul style="list-style-type: none"> • Leadership skills among senior management need further discussion as this area is perceived to need more strengthening. • Provide a more in-depth discussion on the challenges of dual practice.
Health Information Systems	<ul style="list-style-type: none"> • Include further discussion on data sharing between islands, which is not systematized by indicators or forms. • Assessment noted lack of infrastructure and equipment for an electronic health information system at health center level; this should be expanded to include all health facilities and agencies. • Private sector does participate in some data sharing, although it is selective; however, there are no standardized forms to gather data from private providers. • The HIV program has had a training assessment for data needs and this could be a model for other parts of the health sector.
Pharmaceutical Management	<ul style="list-style-type: none"> • Strengthen the discussions of labs and consolidate findings in one place. • Inventory management needs greater attention. There is no policy in place to ensure accountability of the staff within the department, which is resulting in poor inventory control. • The findings and recommendations should add “networked” to the computerization of the inventory management system. The Central Medical Stores and all other pharmacies should be networked to allow inventory to move among pharmacies to fill stock-outs as necessary. This could improve management, distribution, and forecasting. • Include greater discussion on collaboration between the public and private sectors. The private sector is perceived as a competitor instead of a part of the health care team. Sharing information regarding public sector stock-outs and offering some concessions on priority services should be recommended. • Note that pharmacists are in high demand but there is limited succession planning.

DISCUSSION OF RECOMMENDATIONS

The small groups then discussed the assessment’s recommendations. The groups considered whether the recommendations addressed the key findings presented, whether there were any concerns about the recommendations, and finally whether any recommendations were missing. The participants agreed with the recommendations listed and added or further specified some recommendations. The following table summarizes the groups’ feedback.



Dr. Kathleen Allen Ferdinand records the pharmaceutical management group’s discussion.

ADDITIONS AND EDITS TO RECOMMENDATIONS

Health Financing	<ul style="list-style-type: none"> • Create a public relations department in MOH. • Outline steps in moving toward national health insurance, which include: <ul style="list-style-type: none"> ○ Greater stakeholder participation ○ Identification of a timeline ○ Addition of a prescription plan. • Improve collection of user fees, which could include: <ul style="list-style-type: none"> ○ Creation of a 24-hour collection center at facilities ○ Improved billing systems at the hospitals that include follow-up reminders. • Conduct an out-of-pocket assessment to learn what is reasonable for user fee charges and revisit current fee schedule. • In recommendations to conduct NHA: <ul style="list-style-type: none"> ○ Collaborate with PAHO on NHA ○ Add subaccounts for diabetes and hypertension to HIV subaccounts analysis. • Detail suggestions on how to plan for continued financing of HIV.
Human Resources	<ul style="list-style-type: none"> • Include private sector training needs in the recommendation to introduce a national training database to track training and identify training needs. • Ensure private sector is also included in recommendation to improve information on opportunities for continuing education, especially via distance learning. • Change language on the recommendation from “consider” to “scale up” efforts in schools to attract young people to health care careers; “scale up” internship opportunities for youth and mentorship programs. These are already happening to some extent. • Increase opportunities for specialization in nursing beyond midwifery. • Directly link performance appraisals with job titles rather than generic indicators. • Link career and salary advancement with regular performance appraisals and training. • Develop recruitment, retention, and succession plans.
Service Delivery	<ul style="list-style-type: none"> • Introduce polyclinics to address access and use of hospital for primary health care. • Examine possibility of patient contributions to HIV/AIDS treatment costs. • Introduce use of chronic care model where every patient has a chart and the chart is tracked throughout their life. This could be in the form of a health passport, which exists for diabetes and antenatal care.
Health Information Systems	<ul style="list-style-type: none"> • Develop a systematic method for reporting and transferring information between the islands so we can speak on a federal versus island level. • Standardize reporting forms to encourage private sector information sharing and strategize about which indicators are important to collect from the private sector. • Develop a standardized form for private providers to report in on. Similar to patient monitoring cards for HIV. Need strategic participation from the private sector. • Provide a recommendation to develop a verification protocol or a mechanism (person maybe) to avoid double counting.
Governance	<ul style="list-style-type: none"> • Develop a health communications strategy. • Improve communication and joint planning efforts between the islands. Nursing provides an example of this. • Create client comment boxes to address issues of minimal client feedback.

- Put a pharmaceutical management system into place that has the following features:
 - Is independent of political environment
 - Has distinct policies and procedures that conform with international best practices
 - Recruits and manages human resources that are knowledgeable, competent, interested, and caring
 - Provides funding that is continuous and reliable to ensure quality service provision
 - Offers policies that are communicated among all health professions (pharmacists, doctors, nurses) to ensure compliance (i.e., pharmacovigilance)
- Align value-added tax (VAT) exemptions and priority health conditions in the public and private sector. Currently, VAT exemptions are not available for all health conditions on which the public sector exempts fees. Aligning these can allow the private sector to also reduce the cost of services for the nation's top priorities.
- Add to the recommendation for computerizing the health information system that the system must also include Internet access, training, and tiered levels of access, and must be available to both the public and private sectors.

PRIORITIZATION OF RECOMMENDATIONS

DISCUSSION ON CRITERIA TO PRIORITIZE

After agreeing on additions and changes to the findings and recommendations, the participants in a plenary session developed a set of criteria for prioritizing the recommendations. The group agreed that priorities would be based on whether the recommendations were (1) realistic, (2) affordable, (3) impactful, (4) data driven, and (5) transformative. A **realistic** recommendation would require that the timing be appropriate and the appropriate mix of skills be available to carry out the activity (on island or available through technical assistance). **Affordable** would mean having the funds to both start and sustain an activity. In looking for **impact** the participants wanted the activity to be highly visible and to truly make a difference in the health system. **Data driven** refers to interventions that have scientific evidence behind them, have current data available to support their need, and have measureable impact. Participants also wanted to see interventions that were **transformative** and represent a change in the way things have been done before.



PAHO country representative Patrice Lawrence Williams, Ag. Permanent Secretary Andrew Skerritt, Principal Nursing Officer Henrietta Douglas-Christmas and colleagues prioritize recommendations with the health financing group.

ALIGNMENT OF PRIORITIES WITH ONGOING MOH INITIATIVES

In small groups, the participants prioritized the recommendations within health systems topic areas. The facilitator collated and consolidated these priorities before the start of the second day. Many of the priorities corresponded directly with those proposed in the assessment report, with one main addition: to reengineer primary health care to focus on noncommunicable diseases (NCDs). The top priorities that emerged included the following:

- Develop a sustainable financing mechanism for the health system
- Invest in systems to generate quality data for evidence-based policy, planning, and advocacy

- Prioritize pending legislation for approval and implementation
- Strengthen human resources for health (HRH) planning and management to produce qualified, motivated HRH (includes private HRH)
- Formalize and strengthen coordination with and engagement of private sector
- Reengineer primary health care to address NCDs.

At the beginning of discussions on the second workshop day, Dr. Patrice Lawrence-Williams, PAHO's country representative based in St. Kitts and Nevis, gave an overview of PAHO's current biennial workplan developed in conjunction with the St. Kitts and Nevis MOH. She presented relevant portions of that workplan that overlapped or dovetailed with recommendations listed in the assessment report. The presentation was very informative and an excellent first step toward improving donor coordination in the country, and highlighted the fact that similar priorities emerged in both documents. She welcomed greater coordination between PAHO and USAID, as well as other partners, going forward.

The following table gives an overview of the working group discussions on how to align the assessment report's recommendations with ongoing MOH and PAHO initiatives. The groups also identified additional actions and resources needed to implement each recommendation, as well as champions to lead these efforts. Many of the priority recommendations still lack champions to be responsible for their success.

CROSS-CUTTING RECOMMENDATIONS

Priority Recommendation: Develop sustainable financing mechanisms for health system

What ongoing initiatives support this priority area? (e.g., MOH, PAHO, others)	What action steps have already been proposed?	Who will “own” (lead or be the champion) the next steps?	What resources are needed? What external resources could be mobilized?
<ul style="list-style-type: none"> • Discussions about national health insurance with Social Security Fund, Ministry of Finance, and MOH staff • Consultant hired to provide input on Nevis 	<ul style="list-style-type: none"> • Improve operational systems to support national health insurance scheme, such as health information data collection, accounting systems, billing systems • Improve interconnectivity of HIS (between St. Kitts and Nevis and between health centers and hospitals) • Unify the process on both islands 	<p>Permanent Secretary, MOH</p>	<ul style="list-style-type: none"> • Survey of out-of-pocket expenditures (Health Economics Unit at the University of the West Indies; PAHO is unable to fund this cost. • Link with UWI for technical resources on health insurance (Stanley Lalta, Roger McLean, Karl Theodore) • Technical assistance and funding from USAID
<p>What additional concrete next steps are needed?</p>			
<ul style="list-style-type: none"> • Hold consultation on national health insurance between St. Kitts, Nevis, MOF, MOH, Social Security Fund, private insurers, Chamber of Industry and Commerce, Ministry of Labor • Engage NGOs (such as Renal Society) for outreach about national health insurance • Develop communications strategy for informing and including the public about national health insurance • Strengthen the HIU through training; hire statistician • Conduct NHA • Develop linkages with Statistics Agency • Analyze results of the Country Poverty Assessment further (related to use of private sector, health expenditures) – see what information we can already get to feed into NHA • Hold NHA training for task force that includes both Nevis and St. Kitts staff 			

Priority Recommendation: Invest in systems to generate quality data for evidence-based policy, planning, and advocacy

What ongoing initiatives support this priority area? (e.g., MOH, PAHO, others)	What action steps have already been proposed?	Who will “own” (lead or be the champion) the next steps?	What resources are needed? What external resources could be mobilized?
<ul style="list-style-type: none"> • Assessment of data needs conducted • Surveys conducted • Informal surveys conducted (internal/external) on data gaps and needs • Taiwan government commitment to provide infrastructure but still not available 	<ul style="list-style-type: none"> • Taiwan government commitment to provide infrastructure but still not available 	<p>MOH/HIU - need to identify persons</p>	<p>Technical assistance and training to strengthen capacity in use of data for policy analysis and planning</p>
<p>What additional concrete next steps are needed?</p>			
<ul style="list-style-type: none"> • Conduct assessment of data collection methods • Review data needs from public and private sectors • Standardize data using international codes to list diseases • Computerize health info system with Internet access among all facilities • Finalize deal with Taiwanese government or seek another source 			

Priority Recommendation: Prioritize pending policies for approval and implementation

What ongoing initiatives support this priority area? (e.g., MOH, PAHO, others)	What action steps have already been proposed?	Who will “own” (lead or be the champion) the next steps?	What resources are needed? What external resources could be mobilized?
Pharmacy Act – 1st priority (2012 QTR 1)			
<ul style="list-style-type: none"> • 1st draft in circulation 	<ul style="list-style-type: none"> • Requires final review by outside expert to finalize draft • Conduct stakeholder meeting to bring public sector on board • Send to minister for signature (end of January) • Send to cabinet for sign-off • Secure parliament’s approval 	Ivor Carr and Rohan Claxton (two private pharmacists)	Resources for: <ul style="list-style-type: none"> • Outside expert to review • Consultative meetings to bring on board MOH stakeholders
Public Health Act – 2nd priority (2012 QTR 2)			
<ul style="list-style-type: none"> • 1st draft 	<ul style="list-style-type: none"> • Conduct internal discussions between the two MOHs to update Public Health Act • Update, through stakeholder consultations, the Public Health Act • Circulate to all stakeholders through different mechanisms (e.g., e-mail, consultative meetings) with sufficient time to formulate feedback • MOH integrates comments (reconcile meeting) • Circulate final proposal to all stakeholders • Finalize Public Health Act • Send to minister for signature • Send to cabinet for sign-off • Secure parliament’s approval 	CMO – Dr. Patrick Martin	Resources for: <ul style="list-style-type: none"> • Consultative meetings with outside stakeholders
Medical Act – 3rd priority (2012 QTR3)			
	<ul style="list-style-type: none"> • Conduct internal discussions between the two MOHs to update the Medical Act • Update, through stakeholder consultation, the Medical Act • Circulate to outside stakeholders through different mechanisms/e-mail and meetings with sufficient time to formulate feedback 	Minister Liburd	Financial resources for: <ul style="list-style-type: none"> • Consultative meetings with outside stakeholders

	<ul style="list-style-type: none"> • MOH integrates comments (reconcile meeting) • Circulate final proposal to all stakeholders • Finalize Public Health Act • Send to minister for signature • Send to cabinet for sign-off • Secure parliament’s approval 		
What additional concrete next steps are needed?			
Existing guidelines			
<ul style="list-style-type: none"> • Several guidelines have been approved – HIV/AIDs and different illnesses in NCDs • Other are still in draft – Quality of Care, Critical Care, Fee for Service in Hospitals • Urgency is to disseminate and help operationalize new guidelines 	<p>New activities to implement guidelines are:</p> <ul style="list-style-type: none"> • Conduct focus group discussions with relevant public and private stakeholders to assess needed resources (e.g., systems, tools, training) to support implementation • Use provider feedback to draft roll-out plan to implement new guidelines. Activities are: <ul style="list-style-type: none"> ▪ Widespread dissemination ▪ Consultative meetings to discuss how and when to implement ▪ In-service training ▪ Follow-up to monitor progress • Conduct workshops (short, brief, convenient time) to inform and identify process to roll out and implement. 	Need to identify champion	<p>Resources for:</p> <ul style="list-style-type: none"> • Production and dissemination of copies of guidelines • Consultative meetings to bring all stakeholders on board
Newly approved acts and policies			
<ul style="list-style-type: none"> • As the Pharmacy Act, Public Health Act and Medical Act are approved, MOH needs to implement them as well as inform and engage consumers and providers on the changes in health system 	<p>Implementers</p> <ul style="list-style-type: none"> • Conduct focus group discussions with relevant public and private stakeholders to assess needed resources (e.g., systems, tools, training) to support implementation • Use provider feedback to draft roll-out plan and to help implement new guidelines. <ul style="list-style-type: none"> ▪ Initial meeting (short) to inform and identify plan to roll out new guidelines ▪ Widespread dissemination ▪ Consultative meetings to discuss how and when to implement ▪ In-service training 	Need to identify champion	<p>Resources for:</p> <ul style="list-style-type: none"> • Expert to synthesize new acts for different target audiences • Production and dissemination of copies of guidelines • Consultative meetings to bring all stakeholders on board

	<ul style="list-style-type: none"> ▪ Follow-up to monitor progress 		
	<p>Consumers/general public</p> <ul style="list-style-type: none"> • Use VAT public campaign as model to raise consumer awareness on key policy reforms • Translate policies into user-friendly language • Use multiple vehicles to reach population (radio, call-in programs, press conferences) • Carry out a PR campaign to keep population updated on policy reforms and achievements 	<p>Need to identify champion</p>	<p>Resources for:</p> <ul style="list-style-type: none"> • Expert to synthesize new acts for consumers • Funds to carry out PR campaign

New Priority Recommendation: Develop and implement a clear HRH plan, policies, and guidelines

What ongoing initiatives support this priority area?	What action steps have already been proposed?	Who will “own” the next steps?	What resources are needed? External resources?
<ul style="list-style-type: none"> • PAHO biennial workplan • 2008–2012 National Health Strategy • PEPFAR regional partnership framework (SKN workplan) • PAHO 20 Goals baseline on HRH (report due out soon) • PAHO HRH core dataset activity (apparently conducted recently) 	<ul style="list-style-type: none"> • I-TECH/CHART in process of organizing a workshop to strengthen HRH planning and management in OECS countries • OECS HAPU to hire an HRH technical advisor to OECS members who will be supported by I-TECH/CHART • Several ongoing leadership initiatives (e.g., Caribbean Health Leadership Institute, MEASURE Evaluation) 	<p>MOH PS to negotiate or assign leadership regarding HRH planning (e.g., administrative officer or other)</p>	<ul style="list-style-type: none"> • Financial and technical resources available via PAHO and I-TECH/CHART • MOH needs to identify internal human resources able to dedicate sufficient time to move recommendation forward
<p>What additional concrete short-term next steps should be undertaken?</p>			
<ul style="list-style-type: none"> • MOH to identify a “champion” to lead a team to work on HRH planning • I-TECH/CHART to sensitize government of SKN regarding HRH capacity-building initiatives • Schedule meeting between MOH PS, HR Management Department (OPM), MOH administrative officers, PAHO, I-TECH/CHART to map out workplan to produce HRH plan and guidelines • Link leadership initiatives with HRH planning and management • Review and analyze 20 Goals baseline • Include data on private sector HRH • Draft HRH plan 			

Priority Recommendation: Pursue opportunities to engage the private sector as a partner

What ongoing initiatives already support this priority area? (e.g., MOH, PAHO, others)	What action steps have already been proposed?	Who will “own” (lead or champion) the next steps?	What resources are needed? What external resources could be mobilized?
<ul style="list-style-type: none"> • Stakeholder analysis in PAHO workplan • Need to expand stakeholder definition to include all internal actors and all local stakeholders – <ul style="list-style-type: none"> • Government – MOH and other government ministries • NGOs/CSO – representing consumers 	<ul style="list-style-type: none"> • Need to program time to carry out stakeholder analysis 	<p>Need to identify champion</p>	<ul style="list-style-type: none"> • Technical assistance to carry out stakeholder analysis and design engagement strategy • Funds to carry out mapping exercise and analysis • Training in how to conduct participatory planning
<p>What additional concrete next steps are needed?</p>			
<ul style="list-style-type: none"> • Currently MOH sends invitations to ad hoc number of private sector representatives; MOH with private sector partners can develop ListServ of private sector individuals to start inviting them to participate in policy and planning • Carry out mapping of private sector and inventory of existing partnerships and collaboration • While developing the strategy, MOH commits to carrying out two national health forums (evening receptions) with private sector to share information and exchange ideas • Once stakeholder analysis is complete, then develop a private sector engagement strategy that (1) defines goals and objectives, (2) identifies target groups, (3) selects limited but strategic areas to engage private sector stakeholders, and (4) develops calendar of engagement activities. Can base engagement strategy on current models used for HIV and NCDs. 			

New Priority Recommendation: Reengineer and strengthen quality of primary health services to address emerging health challenges

What ongoing initiatives already support this priority area (e.g., MOH, PAHO, others)?	What action steps have already been proposed?	Who will “own” (lead or champion) the next steps?	What resources are needed? What external resources could be mobilized?
<ul style="list-style-type: none"> • PAHO and MOH plan to establish a multisectoral QA committee 	<ul style="list-style-type: none"> • QA committee only operates at hospital level • Most procedures and protocols are in place (e.g., infection control) Several guidelines have been approved – HIV/AIDs and different illnesses 	<p>Need to identify champion (should be someone in Planning Dept.)</p>	<p>Require resources from PAHO and other agencies to:</p> <ul style="list-style-type: none"> • Establish and make functional the QA committee • Provide technical assistance and funds to operationalize new guidelines in both public and private sectors • Provide technical assistance to facilitate meeting and draft or reengineer a plan to renew primary health care to address NCDs

What additional concrete next steps are needed?

- Urgent need to disseminate and implement new guidelines. *Also need to involve the private health sector.*
- Activities to roll out QA committee are:
 - Widespread dissemination
 - Consultative meetings to discuss how and when to implement
 - In-service training
 - Follow-up to monitor progress
- Conduct workshops to plan how to restructure primary health care services to address NCDs.
- Conduct workshop on rational use of drugs for chronic care model.
- Establish mechanism to monitor quality in all sectors.
- Establish system for all sectors to report and share information on quality.
- Improve referral system between sectors on NCDs and other critical diseases.

NEXT STEPS AND CLOSURE

After the presentation of action steps by each group, Health Systems 20/20 and SHOPS thanked participants for their engagement in the validation and prioritization process. Health Systems 20/20 and SHOPS will use results of the workshop to revise the assessment report. The final report with priority recommendations highlighted will be shared with USAID's implementing partners in the region, many of whom were also present at the workshop, as well as other U.S. government agencies working in the region, PAHO, the Organization of Eastern Caribbean States, and UNAIDS, to further align technical assistance with the country's needs.

Acting Permanent Secretary Andrew Skerritt closed the workshop, thanking participants for their enthusiasm and USAID for creating the opportunity to discuss priorities.



Principal Nursing Officer Henrietta Douglas-Christmas speaks with journalist Pauline Nguryin

ANNEX C: HEALTH FINANCING INDICATORS

TABLE C.1: BASIC HEALTH FINANCING INDICATORS FOR ST. KITTS AND NEVIS, 2000–2009

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Gross national income per capita (PPP int. \$)	9720	9670	9730	9840	11130	12110	13240	14100	15490	
Total expenditure on health as a percentage of gross domestic product	5.5	5.3	5.8	5.7	5.6	5.4	5.8	6.1	5.8	6.0
Per capita total expenditure on health at average exchange rate (US\$)	387	389	432	434	459	478	568	623	651	634
Per capita total expenditure on health (PPP int. \$)	554	554	618	616	665	688	803	876	881	839
Per capita government expenditure on health at average exchange rate (US\$)	233	238	274	278	290	301	350	360	377	376
Per capita government expenditure on health (PPP int. \$)	334	339	392	395	420	434	494	506	511	498
General government expenditure on health as a percentage of total expenditure on health	60.3	61.2	63.4	64.2	63.2	63.1	61.5	57.8	57.9	59.3
Private expenditure on health as a percentage of total expenditure on health	39.7	38.8	36.6	35.8	36.8	36.9	38.5	42.2	42.1	40.7
Out-of-pocket expenditure as a percentage of private expenditure on	94.2	94.7	94.1	94.5	95.0	94.9	94.6	94.4	94.4	94.4

health										
Social security expenditure on health as a percentage of general government expenditure on health	0	0	0	0	0	0	0	0	0	0
Private prepaid plans as a percentage of private expenditure on health	5.8	5.3	5.9	5.5	5.0	5.1	5.4	5.6	5.6	5.6
External resources for health as a percentage of total expenditure on health	5.4	5.1	4.5	5.3	0	0	0	0	0	0
General government expenditure on health as a percentage of total government expenditure	9.5	10.2	10.3	8.7	8.4	7.8	8.0	8.0	8.0	8.0

ANNEX D: BIBLIOGRAPHY

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