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Joint Procurement of Medicines in the Eastern Caribbean: A Model of Regional Cooperation

Insights from Francis Burnett

By Santiago Vásquez and Daniel López

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1. Executive Summary

Access to essential medicines at affordable prices is a critical challenge for small and low- and middle-income countries, especially in island nations with small pharmaceutical markets. This paper analyzes the experience of the Pharmaceutical Procurement Service of the Organisation of Eastern Caribbean States (PPS/OECS), a joint procurement mechanism created in 1986 that consolidates the demand of nine countries in order to negotiate medicines and health supplies on the international market. Based on its historical evolution and an interview with its Interim Head, the paper describes its institutional design, centralized financial scheme, and participatory governance, as well as its main achievements, including sustained reductions of close to 20% in medicine prices, significant annual fiscal savings, expansion of the product catalog, and improvements in availability and access for the population. The text also identifies persistent challenges, such as delays in national reimbursements, scale limitations, and the need to measure impact on the end user, and it draws key lessons for replicating the model in other regions, underscoring the importance of political commitment, technical standardization, financial discipline, and regional cooperation in strengthening equitable access to medicines.

2. Introduction

Ensuring access to essential medicines at affordable prices is a common challenge for many low- and middle-income countries worldwide. This challenge is even more acute in small island nations, where pharmaceutical markets are limited and lack the bargaining power of larger countries. One effective strategy for addressing this problem has been joint or pooled procurement of medicines, in which several countries combine their demand to make bulk

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purchases, obtaining better prices and supply conditions. A prominent example of this strategy is the Pharmaceutical Procurement Service of the Organisation of Eastern Caribbean States (known by its acronym PPS/OECS), a consolidated purchasing mechanism established by Eastern Caribbean countries in 1986 (OECS, 2017).

Over nearly four decades, the OECS/PPS has proven to be a successful model of regional cooperation in the health sector, achieving significant reductions in the cost of medicines and improvements in the availability of medical supplies for the populations of its member countries. This article analyzes in detail the origin, structure, achievements, challenges, and lessons learned from the OECS PPS, based on an interview conducted with Francis Burnett, Interim Head of the PPS. It also explores opportunities and considerations for other regions or groups of countries to replicate this model, adapting it to their local contexts. The Eastern Caribbean experience offers valuable lessons on how regional integration can strengthen the supply of health products, particularly in resource-limited settings, and serves as a reference for similar initiatives in other parts of the developing world.

3. Context and Creation of the Joint Procurement Mechanism in the OECS

The **Organisation of Eastern Caribbean States (OECS)** is a subregional grouping made up of small Caribbean islands whose individual pharmaceutical markets are very limited due to their small populations (together they total around 1.4 million inhabitants across 12 member and associate countries). Historically, these countries faced very high medicine prices, since each one negotiated separately with international suppliers. In response, in 1986 the six original OECS member countries decided to join forces to consolidate pharmaceutical demand into a single purchasing bloc. The premise was simple but powerful: by pooling their needs and entering the market collectively, they could obtain more competitive prices and more favorable supply conditions by leveraging economies of scale and greater bargaining power.

Thus, the Eastern Caribbean Drug Service (ECDS) was born, later renamed the **OECS Pharmaceutical Procurement Service (PPS)** in 2001 (WHO, 2014). Initially, it received external financial and technical support: the United States government, through USAID, provided a grant of US$3.5 million for the first four years (1986–1990) in order to launch the mechanism (WHO, 2014). As a condition, each country was required to demonstrate local financial commitment: each State deposited in advance approximately one-third of its national medicines budget into a special account administered by the Eastern Caribbean Central Bank (ECCB) (UNOSSC/UNDP, 2019). This seed fund at the regional bank guaranteed the liquidity needed to pay suppliers on time as the first joint purchases were made. In addition, the heads of government of the participating countries signed a binding legal agreement that laid the foundation for collaboration, defining the rules of the pooled procurement system and ensuring long-term political commitment. It is worth noting that, although the OECS currently has 12 members (including United Kingdom and French territories), the PPS focuses on the nine English-speaking countries that fully participate in the Eastern Caribbean economic union (UNOSSC/UNDP, 2019) with a combined population of approximately 0.7 million people

At the outset, the PPS focused on a harmonized list of essential medicines, mostly generic drugs, jointly defined by the participating countries. The initial procurement basket covered 59 high-demand (class A) pharmaceutical products, which accounted for the bulk of medicine expenditure (Huff-Rousselle & Burnett, 1996; UNOSSC/UNDP, 2019). Not all OECS countries joined immediately: the mechanism began with six founding members in 1986, and three additional countries (including Anguilla, the British Virgin Islands, and Antigua and Barbuda) joined gradually as they recognized the benefits of the mechanism. In this way, by the end of the 1980s the PPS was already operating formally with all OECS countries, consolidating regional demand for medicines under a single institutional umbrella.

4. Structure and Operation of the PPS

The success of the PPS lies in its institutional and operational design, which balances centralized procurement with the participation and ownership of member countries. Some key components of its operation are as follows:

- **Medicines list and consolidated purchases:** The countries agree on a single harmonized list of essential medicines for the region, which facilitates the consolidation of requirements. Ministries of Health submit their needs for each medicine for a two-year period, and the PPS aggregates those demands into a single international tender (OECS, 2017). This joint forecasting approach makes it possible to leverage larger volumes to negotiate better unit prices. Importantly, governments assume an exclusive purchasing commitment (sole source commitment): once a medicine is included in the joint tender, each country commits to acquiring it only through the PPS and not through parallel channels, thereby guaranteeing the awarded supplier that the total forecast volume will actually be purchased by the bloc. This volume guarantee is fundamental in encouraging suppliers to offer discounts.
- **Tendering process and suppliers**: The PPS conducts restricted international tenders periodically (traditionally every two years). A regional tenders committee evaluates bids based on price, quality, and previous supplier performance. Beforehand, supplier prequalification is carried out, ensuring that only manufacturers and distributors that comply with good manufacturing practices and have robust regulatory authorizations can participate (PAHO, 2007). In fact, the PPS implemented a common pharmaceutical quality assurance program for the nine countries, harmonizing standards and controls over procured medicines. In its early decades, most selected suppliers came from competitive generic markets: according to Burnett, today approximately 80% of medicines come from India and 20% from Europe, generally purchased through regional distributors in the Caribbean. Currently, the mechanism has a registry of more than 40 qualified suppliers, of which around 20 are usually awarded contracts in each procurement cycle. This supplier pool has evolved over time: some suppliers (especially from the United States or Canada) left the program due to payment delays, but new suppliers from Asia and other regions have joined, maintaining a broad base that ensures competition and supply resilience.

- **Financial mechanism and payment to suppliers**: One innovative aspect of the PPS is its centralized financial arrangement. Each participating country maintains a national account at the Eastern Caribbean Central Bank (ECCB) dedicated exclusively to joint procurement. When the PPS places purchase orders with suppliers (based on tender awards), payments are made from these centralized ECCB accounts upon delivery of goods, preferably using hard currencies (U.S. dollars or euros). All OECS countries share a common currency, which significantly simplifies multilateral transactions and eliminates exchange-rate risks within the bloc. Each government is required to reimburse its central bank account for the funds used for its orders within an established time frame, typically using resources from its Treasury or Ministry of Finance. This arrangement ensures timely payment to suppliers, a critical factor in maintaining their trust: "there is no point in negotiating low prices if the supplier is not then paid on time," Burnett emphasizes. The PPS finances itself through a 9% administrative surcharge applied to each transaction (Burnett, 2017). This surcharge was introduced at the inception of regional procurement in 1987 and covers the operating costs of the central procurement unit (WHO, 2014). It is notable that PPS became fully self-financing in 1990, coinciding with the cessation of USAID seed funding. In practice, this revolving fund-type model was designed to work in such a way that countries pay in advance (via deposits at the ECCB) and then draw down those funds with each purchase, replenishing their ECCB accounts monthly. Currently, member states are billed for purchases and reimburse their accounts after procuring medical products.
- **Governance and country participation**: The OECS has established formal bodies for the oversight and decision-making of the PPS, ensuring the participation of member States in the process. There is a Tenders Sub-Committee composed of the national directors of medical supplies from each country, responsible for reviewing bids and recommending awards (Huff-Rousselle & Burnett, 1996). In parallel, a Technical Advisory Committee made up of clinical experts periodically reviews the medicines list, adding new drugs and eliminating obsolete ones to keep the joint formulary up to date. In addition, a Policy Board composed of the Ministers of Health of the countries meets at least once a year to review system performance and address strategic issues. This high-level council is where commitments are reaffirmed (for example, urging governments to keep reimbursements to ECCB accounts current, as discussed later). Through its Commission, the OECS provides the central procurement unit based in Saint Lucia, which acts as the technical secretariat of the PPS (responsible for coordinating tenders, contracts, logistics, monitoring, and training). In short, governance combines operational centralization with shared control, which has fostered a strong sense of ownership among countries and the long-term political sustainability of the mechanism.
- **Technological integration**: Over time, the PPS has incorporated technological tools to streamline its processes. It currently uses an electronic procurement platform (e-procurement) called ePPSS, which enables online management of purchase orders, tracking of deliveries, and easier communication with suppliers. Digitalization has helped improve efficiency and transparency, reducing manual procedures and enabling full traceability of transactions. Purchase orders are transmitted automatically and smoothly

to vendors through this system, ensuring speed and accuracy in the process. This modernization was identified as an important factor in the program's current success, since it optimizes the management of such a broad portfolio of products.

Taken together, these elements form a robust operational model: consolidated demand, a single regional list, competitive tendering with quality suppliers, guaranteed centralized payments, and a participatory governance structure. The OECS experience shows that careful **institutional architecture** is necessary for joint procurement to function properly and build trust both among member countries and between them and suppliers.

5. Achievements and Benefits

After nearly 40 years in operation, the PPS has achieved results in terms of economic efficiency, access to medicines, and strengthening of the supply system in the Eastern Caribbean. The main achievements are highlighted below:

- **Substantial reduction in medicine prices**: One of the most frequently cited indicators of the PPS's performance is the reduction in the cost of medicines for governments. Since the mechanism was implemented in 1986, the market price of medicines in the region has been reduced by an average of 20% compared with the previous situation (OECS, 2017; WHO, 2014), collectively saving regional governments an average of US$4 million per year (OECS, 2017). This relative saving has been sustained over the years, with total annual procurement values rising from US$10 million in 2004 (WHO, 2014) to an estimated US$11–12 million at present, according to Burnett. In the initial phase, however, the impact was even more pronounced: during the first procurement cycle (1987–88), the mechanism achieved a weighted average reduction of 44% in net unit costs across the six participating countries, with savings ranging from 16.1% in Montserrat to 66.1% in Saint Lucia (Huff-Rousselle & Burnett, 1996). In the second cycle (1988–89), prices dropped an additional 18%. This sharp reduction resulted from the combination of aggregated purchasing with a shift toward multisource medicines instead of expensive branded products, which drove prices down while maintaining pharmaceutical quality. The success of the PPS strengthened trust in quality generics in the region, showing that with reliable suppliers subject to inspections and regulatory oversight, generics can offer the same therapeutic efficacy at a fraction of the cost of branded medicines.
- **Cumulative financial savings**: Added up over the decades, the savings have enabled countries to reinvest freed-up resources in other priority areas of their health systems, or purchase a greater quantity of medicines and supplies with the same budget, thereby expanding coverage. The PPS collectively saves regional governments an average of US$4 million per year (OECS, 2017). In addition, by negotiating fixed biennial prices in the tender, the PPS contributes to budgetary stability: countries know in advance the unit cost that will apply to each medicine during the contract period, facilitating health-sector financial planning.

- **Expansion of the therapeutic formulary and supply availability**: The scope of the PPS has expanded considerably over time. The initial procurement basket covered 59 high-demand (class A) pharmaceutical products, which accounted for the bulk of medicine expenditure (Huff-Rousselle & Burnett, 1996). The joint product catalog grew to around 400 items by the mid-1990s, reached 840 by 2014—covering pharmaceuticals, contraceptives, medical supplies, and radiological products (WHO, 2014)—and has reached approximately 1,100 products in 2025, according to Burnett. As early as the late 1980s, in response to emerging health challenges, the mechanism incorporated disposable medical supplies (gloves, syringes, cotton) to support the response to HIV/AIDS. In later decades, it added radiology supplies (X-ray films), contraceptives, and other reproductive health products. More recently, laboratory reagents and supplies (tubes, diagnostic kits) were incorporated. According to Burnett, by 2023 the PPS formalized joint procurement of laboratory supplies and some minor equipment, which proved useful during the COVID-19 pandemic for procuring diagnostic tests and personal protective equipment in a timely manner for all member countries. The growth of the procurement portfolio reflects the capacity of the PPS to adapt to changing public health needs. Thanks to this, OECS health systems today have a broader range of essential medicines and supplies available in a reliable manner. The availability of essential medicines has consistently been above 85% since 2010 (WHO, 2014), and reports indicate that medicine availability in public pharmacies is satisfactory (Government of Saint Lucia, 2017). This implies that the vast majority of priority medicines are within patients' reach when they need them, reducing the chronic stockouts that previously affected the region.
- **Improvements in equity and access for the population**: By achieving lower prices and a more stable supply, the PPS has contributed to improving access to essential medicines for populations in the Eastern Caribbean. In many of these countries, medicines provided through the public sector are dispensed free of charge or at subsidized rates. The savings achieved through joint procurement therefore increase the capacity of public systems to provide treatment to more people without imposing catastrophic expenditures. The OECS reports that citizens have reliable access to the medicines they need to sustain their health care (Government of Saint Lucia, 2017). This is consistent with pooled procurement experiences in other regions: the PAHO Revolving Fund, for example, allows 41 countries in the Americas to access vaccines that would cost up to 75% more if purchased individually (PAHO, 2023), which has been crucial for equity in immunization. Similarly, health indicators such as continuity of treatment for chronic diseases and the availability of supplies for emergencies have improved thanks to the existence of a regional supply chain.
- **Strengthening of capacities and regional cooperation**: Beyond the economic and material results, the PPS has generated institutional benefits. Joint management has fostered the standardization of procurement practices and common staff training across countries. Market intelligence is shared among members—information on global product availability, changes in international prices, health alerts—which strengthens the collective negotiating position and response to shortages. Countries have also developed

a common therapeutic formulary and aligned their national essential medicines lists with the regional list, facilitating treatment harmonization in the subregion. These elements have consolidated an ecosystem of cooperation among OECS health authorities, extending the benefits of integration beyond procurement itself. This cooperation has made it possible to better confront challenges such as the COVID-19 pandemic: during the crisis, the PPS channeled international supplies and donations valued at over EC$2 million (OECS, 2020), including contributions from Direct Relief and the Government of Brazil.

- **Monitoring and evaluation:** A less visible but important challenge is ensuring that the benefits of joint procurement translate into improvements for patients and the health system. It is not enough to save money; it is necessary to monitor whether those savings expand treatment coverage, whether procured medicines are used appropriately, and whether supply is consistent in the last mile—hospitals and clinics. Burnett stressed the importance of measuring outcome parameters. Monitoring and evaluation has several applications, including designing and planning interventions, defining budget requirements, monitoring changes in systems and the impact of interventions, comparing the performance of programs between OECS countries, and facilitating reporting, accountability, and transparency. The PPS has evaluated Member States' public pharmaceutical systems for efficiency and effectiveness using standardized measurements that meet statistical criteria of measurability, reliability, and validity. Among the key performance indicators measured annually are: the average percentage of available medicines, the average time indicator medicines were out of stock, the service level for prescribed antihypertensives, antidiabetics, and anti-lipid medicines, and warehouse assessments. Continuous monitoring would make it possible to identify bottlenecks and demonstrate the value of the PPS beyond financial savings, in terms of health outcomes. This focus on the end user ensures that the initiative remains centered on its objective: improving population health.

Table 1. Evolution of the OECS Pharmaceutical Procurement Service (PPS)

Key indicator	Start of PPS (1986)	Current situation (2025)
Participating countries	6 countries (founding OECS members)	9 countries (all OECS members)
Products in catalog	59 high-demand (class A) pharmaceutical products	~1,100 products (medicines + medical supplies)[6]

[6] The catalog reached 840 products in 2014 (WHO, 2014) and approximately 1,100 products in 2025 (F. Burnett, personal communication, 2025)

Categories included	Essential medicines (mainly generics)	Medicines, disposable medical supplies, laboratory supplies, X-ray supplies, contraceptives, etc.
Suppliers in the pool	Not available (support from ~30 suppliers in the early years)[7]	>40 qualified suppliers; ~20 contracted per cycle
Procurement mechanism	In-person tenders, manual management	ePPSS electronic platform; automated orders[8]
Operational financing	Initial USAID grant (US$3.5 million, 1986–90); advance country contributions (1/3 of budget)	Self-financed via 9% surcharge on purchases; national accounts at ECCB for payments[9]
Price reduction achieved	previous situation: very high prices	~20% lower than international market prices; up to 40% lower after introducing generics[10]
Estimated annual savings	-	~US$4 million/year collectively saved (~EC$8–9 million annually in 2020)[11]
Demand coverage	Fragmented by country, frequent shortages	85% of essential medicines centrally managed[12]; satisfactory availability in services [13]
Main challenges	Aligning initial political will, building trust	Delays in country reimbursements; loss of some suppliers; maintaining political commitment

Source: Author's own elaboration based on the interview and OECS/PPS data

[7] (Huff-Rousselle & Burnett, 1996)
[8] https://procurement.oecs.org/epps/home.do
[9] (Burnett, 2017)
[10] (OECS, 2017)
[11] (OECS, 2017)
[12] (F. Burnett, personal communication, 2025)
[13] (Government of Saint Lucia, 2017)

6. Challenges Faced by the OECS PPS

Despite its undeniable successes, the OECS joint procurement mechanism has had to deal with important obstacles throughout its trajectory, some of which persist to this day. Identifying these challenges is crucial, since they provide lessons learned to improve the model and alert other similar initiatives to issues they should anticipate. Among the main challenges are:

- **Delays in reimbursements and financial sustainability**: Financial compliance by countries has historically been a challenge for the system. Although the arrangement requires governments to replenish the funds used in their central bank accounts, in practice many Ministries of Finance delay reimbursing medicine payments. The causes are usually budgetary: funds for buying medicines compete with other national fiscal priorities, and treasuries sometimes delay transfers even when the legal obligation exists. This problem, which Burnett describes as "the biggest challenge of the program even 40 years later," has been recurrent since the beginning. When reimbursements do not arrive on time, ECCB accounts are left without sufficient liquidity and supplier payments may be delayed, undermining the credibility of the mechanism. Although the PPS has established clauses and continually reminds ministers of their commitment at each annual meeting, national liquidity constraints sometimes override these agreements. In recent years, the financial situation of some countries has become more fragile (public debt, natural disasters, economic shocks), exacerbating the risk of arrears. To mitigate this, the PPS has had to adjust its cash management and, at times, negotiate payment extensions with suppliers or prioritize certain payments. Nevertheless, the persistence of this challenge makes clear that national political will and fiscal discipline are critical factors in the sustainability of a joint procurement system. Possible solutions that have been considered include the creation of an emergency revolving fund or regional payment guarantee mechanisms, although these require deeper financial integration.
- **Supplier retention and payment conditions**: Directly linked to the above is the challenge of maintaining the trust and participation of quality suppliers. The PPS initially succeeded in attracting many international suppliers interested in serving the entire OECS bloc. However, some suppliers have withdrawn due to delays or inconsistencies in payments received. In particular, companies from the United States or Canada, accustomed to stricter commercial arrangements, stopped bidding when payments were not made on time. This could have compromised the diversity of offers and competition in certain product categories. Fortunately, the PPS has been able to bring in new replacement suppliers, especially from emerging markets, maintaining a broad roster (currently more than 40). In addition, several distributors and manufacturers have remained loyal to the mechanism for decades, due in part to the "ecosystem of trust" that has been built. To reinforce that trust, the PPS seeks to make payments as punctually and transparently as possible. Even so, payment conditions remain a sensitive point in the relationship with suppliers. Unlike large international funds (which sometimes pay in advance or have multilateral guarantees), in this model suppliers assume a certain degree of credit risk from governments. The consolidation of that "community of trust" has required open communication and a reputation earned over years of performance.

Therefore, maintaining payment discipline is crucial not only financially but also for preserving the competitiveness of the tenders.

- **Scale limitations and local production**: Ironically, the very factor that motivated joint procurement—the small size of national markets—remains a structural limitation. Even after bringing together nine countries, the total scale remains modest in global terms: the consolidated OECS pharmaceutical market amounts to only about US$11–12 million per year (F. Burnett, personal communication, 2025). This figure, equivalent to the annual medicine consumption of a single medium-sized city in larger countries, means that there is not enough critical mass to attract local manufacturing investment. OECS authorities have explored the possibility of promoting domestic pharmaceutical production (establishing some generic manufacturing plant in the region) in order to reduce external dependence. However, the conclusions have been realistic: "it is still more cost-effective to procure from outside the region," Burnett notes, given that around 0.7 million inhabitants do not justify the economies of scale required by an efficient plant. During the COVID-19 pandemic, disruptions to global supply chains revived this discussion on health and industrial security, but the local option did not prove viable in the short term. Consequently, the OECS will continue to depend on imports, with the associated risks (international price variability, delivery times, foreign quality issues). To mitigate these risks without local production, the PPS geographically diversifies suppliers and maintains buffer stocks whenever possible. Likewise, cooperation is being considered with larger neighboring countries (e.g., Barbados,) that do have some manufacturing capacity, for possible regional supply agreements. This scale challenge is relevant for other small regions wishing to replicate the model: integration expands scale, but perhaps not enough to make the bloc self-sufficient, so external dependence must be managed strategically.
- **Expansion into new product categories**: Another challenge has been defining how far the basket of jointly procured goods should be extended. Success with medicines and basic supplies has led to demands to include more complex or costly products, such as larger medical equipment or high-priced specialized medicines (e.g., oncology treatments,). Including these items could generate additional savings, but it also presents complications. Also, those with very low demand (e.g., certain therapies for rare diseases) may not be suitable for joint procurement because their need varies by country. Burnett commented that the PPS procures approximately 85% of the more commonly prescribed medicines, leaving each country to manage separately approximately 15% of items (Huff-Rousselle & Burnett, 1996). An ideal medicine for regional procurement is insulin—a vital medicine for diabetes—accounting for approximately 12% of countries' pharmaceutical budget, making it the single largest expenditure item. Procurement of large equipment (e.g., X-ray machines, MRI scanners, and laboratory analyzers.) entails standardization, maintenance, and cost challenges that may exceed the current mandate. In the interview, the option of centrally arranged equipment leasing models was discussed, a practice that some countries have used to reduce initial costs and ensure maintenance. Although still incipient, this idea could be implemented for certain devices, but it requires assessing the receiving infrastructure in each country. In short, defining the limits of the optimal catalog is a strategic challenge: incorporating new areas must weigh the benefit against the added

complexity. The OECS has opted for gradual and careful expansion: recently it was planning to include "dental supplies, dialysis solutions, small medical devices, and validated blood products" as the next categories to be added. These are areas where joint regional demand may be advantageous and manageable.

In summary, the challenges facing the OECS PPS include financial, operational, and strategic aspects: the need for fiscal discipline among participants, the maintenance of a competitive supplier pool, the constraints of being a small market, decisions about what to include in joint procurement, and the measurement of its real impact. Despite these challenges, the fact that the mechanism has endured for nearly 40 years suggests a capacity for adaptation and resilience. Each obstacle overcome has yielded valuable lessons that can guide both the future evolution of the PPS and the design of similar schemes in other regions. The next section examines precisely the lessons learned and opportunities for replicating the OECS/PPS model in other country coalitions.

7. Lessons and Opportunities for Other Regions

The Eastern Caribbean experience with its joint medicine procurement mechanism offers multiple lessons applicable to other regional contexts seeking to improve access to medicines through cooperation. Although each region has its own political and economic particularities, the fundamental principles of the OECS PPS can serve as guidance. Below are the main recommendations and opportunities derived from this success story, with a view toward replication in other countries or blocs:

1. **Political commitment and a clear legal framework**: A decisive factor in the launch of the PPS was strong political backing at the highest level. Heads of State/Government signed a binding agreement that sealed mutual trust and established clear rules from the outset. For any joint procurement initiative, it is essential to have a legal framework or intergovernmental treaty that defines the obligations of each party (what is procured jointly, how it is financed, how disputes are settled) and ensures loyalty to the mechanism. Without this legal umbrella and political commitment, the risks of noncompliance increase (for example, countries abandoning joint procurement if they find an apparently better bilateral offer), and credibility with suppliers is undermined. Therefore, the first lesson is to formalize the cooperation agreement with the greatest possible legal and political weight. This entails prior diplomatic work to align the countries' visions, but it guarantees long-term stability.
2. **Incremental scope and adaptability**: The OECS showed that it is not necessary for all potential participants to join at once, nor for the product basket to be comprehensive from the outset. They started with six countries and 200 medicines, and then added more members and expanded to more than 1,000 products as confidence and capacity grew. This phased approach is advisable: starting with a pilot project or a subset of the most committed countries can generate quick wins (early savings) that encourage others to join later. Likewise, beginning with a limited list of essential medicines (for example, the 50–100 most critical drugs) allows processes to be consolidated before expanding the

catalog. Adaptability is key: the model must be able to incorporate new participants and adjust to the environment (as the OECS did by adding new categories in response to emerging needs). In short, progressive growth is recommended, with flexibility to scale both geographically and in the range of products, learning and adjusting along the way.

3. **Solid technical foundations** (single list, demand consolidation): A replicable technical pillar is the development of a single regional essential medicines list and rigorous demand consolidation. This requires harmonization of pharmaceutical policies across countries: standardizing treatment protocols, agreeing on common strengths and dosage forms, etc., just as the OECS implemented with its regional medicines formulary. If countries use different medicines for the same indication, purchasing power is diluted; hence the importance of standardization. It is also vital to establish reliable joint forecasting mechanisms so that tenders reflect realistic volumes. Experiences in Africa have shown that alignment among multiple buyers is complex but feasible: in East Africa, a unified list and treatment guidelines were developed as the basis for a shared procurement mechanism. Having regional technical committees (pharmacists, physicians) review and update the joint list ensures that the formulary responds to the health priorities of all. This strong technical foundation improves the efficiency and legitimacy of the process for all stakeholders.
4. **Volume guarantee and discipline in joint procurement**: One mistake made by other initiatives has been to allow excessive flexibility for participants not to buy through the pool, which undermines collective negotiation. The OECS avoided this through the sole-source purchasing commitment: countries are required to acquire each included item only through the mechanism. This lesson is fundamental: purchasing solidarity must be inviolable in order to send clear signals to the market. If suppliers suspect that members of the group may pull out and buy elsewhere (through individual offers), they will not offer their best prices to the pool. Therefore, other regions should establish "all or nothing" policies for agreed products, or at least penalties if a country fails to comply. At the same time, it is important to ensure supply quality so that countries have no reason to seek outside alternatives: this implies rigorous supplier selection, quality control of delivered products, and rapid response to stockout problems. When the mechanism proves reliable, countries trust it and keep their purchases within it, reinforcing the virtuous circle.
5. **Shared financial mechanism and reliable payments**: The common fund model at the regional central bank worked well for the OECS and can inspire others, especially blocs with monetary or exchange-rate unions. Having a centralized financial platform facilitates transactions and gives security to suppliers (who receive payments from a single entity rather than from multiple parties). In the European Union, for example, some joint procurements are paid for through shared institutions or with community guarantees. Now, as we have seen, the challenge lies in the timeliness of reimbursements. Other regions could innovate with regional revolving funds supported not only by governments but also by development banks or donors, to temporarily cover shortfalls and avoid delays in supplier payments. It is also advisable to explore insurance or payment guarantee schemes: for example, a guarantee fund to which suppliers can turn in the event of

extreme arrears by any country. In any case, the lesson is that the financial design must anticipate liquidity risks. The OECS has shown that a small surcharge (9%) (Burnett, 2017) can sustain operating costs; other regions could adjust that percentage according to procurement volumes to achieve sustainability. In addition, taking advantage of common currencies or exchange-rate arrangements (as the OECS did with the Eastern Caribbean dollar pegged to the U.S. dollar) reduces volatility and facilitates financial management.

6. **Transparency and good governance**: Trust among countries and with suppliers is built through transparency. Publishing tender results, awarded prices, and achieved savings helps ensure accountability to authorities and citizens. The OECS PPS presents annual reports to its Council of Ministers showing, for example, how much was purchased and how much was saved by country. This accountability is key to maintaining political and public support. Likewise, having external audits or regional oversight (e.g., by the regional organization's secretariat) helps prevent corruption or favoritism. To replicate the model, clear rules must be established on tendering, conflict-of-interest management, and complaint mechanisms, so that the integrity of the process is not questioned. A reputation for clean processes will encourage more suppliers to participate and governments to continue ceding part of their procurement sovereignty to the joint entity.
7. **Strengthening local capacities**: A positive side effect of the OECS model was the development of technical capacities in countries (training procurement professionals, shared information systems, etc.). Any initiative of this type should include a capacity-building component: from training national officers in needs planning and logistics management to sharing electronic management systems (for example, implementing regional inventory control software). South-South cooperation is relevant: the OECS has willingly shared its experience with other regions and countries (it is currently advising African countries on this topic). Likewise, regions replicating the model could request technical assistance from international organizations. The goal should be that, after a few years, the joint initiative raises the standard of pharmaceutical management in all member countries, leaving installed capacities that outlast the project itself.
8. **Measurable results and communication of benefits**: To sustain cooperation politically, its added value must be continuously demonstrated. It is advisable to define success indicators (financial savings, improved availability, patient satisfaction, etc.) and monitor them. Publishing success stories, such as how much has been saved and what has been achieved with those savings, helps make the importance of the pooled effort visible. The OECS issues press releases highlighting the growth and strengthening of the PPS, which keeps the initiative on the public agenda with a positive narrative. In other regions, an effective communication strategy around the early and ongoing wins of joint procurement can build the political capital needed to deepen integration.
9. **Considering specific regional conditions**: Although the OECS model is replicable, each region must adapt the design to its own circumstances. The OECS benefited from a favorable context: similar languages, geographic proximity, a common currency for most members, and the prior existence of an active regional organization. Other regions may have greater diversity (linguistic, legal) or lower levels of integration. However, this does

not prevent cooperation in health. For example, in West Africa (Francophone and Anglophone), attempts have been made at joint procurement of medicines against priority diseases, coordinated by the West African Health Organization (WAHO). In the Gulf Cooperation Council (GCC), six Arab countries have for decades carried out centralized medicine procurement through a GCC Health Committee, achieving reduced prices on certain drugs. In other words, analogous models exist in different regions, and each has had to adapt to local institutional realities. In Latin America, mechanisms such as the Central American consolidated procurement of medicines (coordinated by the Council of Ministers of Health of Central America, COMISCA) have also drawn inspiration from the OECS to jointly negotiate expensive medicines for HIV, hepatitis C, and so on, with promising initial results, achieving nearly US$120 million in cumulative savings for SICA member States (SICA, 2023). These experiences suggest that almost any group of countries can benefit in some way from joint procurement, provided there is willingness to cooperate, and the mechanism is designed to fit the context (whether through an existing regional institution, specialized agencies, or even informal agreements at the outset).

10. **A vision beyond procurement**: regional health integration: Finally, the PPS/OECS case illustrates how joint procurement can be a starting point for broader health integration. Cooperation on medicines opened the door to collaboration in training, information systems, shared policies, and even coordinated emergency responses. Other regions could leverage similar initiatives not only to save on medicines but also to build inter-country trust that facilitates addressing common challenges (harmonized pharmaceutical regulation, regional marketing authorizations, joint outbreak responses, etc.). One example is the recent African Medicines Agency (AMA) created by the African Union, which seeks to harmonize regulation and could eventually support regional procurement. A joint procurement mechanism can also be complemented by international revolving funds (such as the WHO/PAHO Strategic Fund for medicines) or other tools, creating global synergies. In summary, the opportunity lies in seeing these procurement alliances not as isolated efforts, but as part of a broader strategy of regional health sovereignty.

8. Conclusions

The experience of the OECS Pharmaceutical Procurement Service (PPS) demonstrates that regional cooperation in the procurement of medicines is not only possible, but highly beneficial for participating countries. Faced with the limitations that small nations experience individually—tiny markets, almost no bargaining power, vulnerability to high prices and stockouts, the collective response has generated economies of scale, lower costs (~20% lower prices on average, with millions of dollars in annual savings), and a substantial improvement in population access to essential medicines. After nearly 40 years, the OECS PPS stands as an exemplary case of health integration, whose pillars have been mutual trust, appropriate institutional design, and continuous learning in overcoming obstacles.

The path traveled offers valuable lessons: the importance of strong political commitment and a foundational legal agreement; the need for a rigorous technical approach with unified lists, purchasing guarantees, and reliable suppliers; the prudence of starting small and growing on the basis of demonstrated success; and the importance of maintaining financial discipline and transparency. It also highlights challenges that serve as warnings: without shared fiscal responsibility, any such mechanism faces risks; without flexibility to adapt, it may stagnate. The PPS has navigated these pitfalls with resilience, even innovating with electronic tools and expanding its scope to new categories according to regional needs.

For other regions of the world, the question is no longer whether joint procurement of medicines works, but how to implement it effectively in their own context. The OECS initiative provides an adaptable template. Whether it is a group of African countries seeking to reduce the cost of medicines for prevalent diseases, small Pacific islands joining forces to secure medical supplies, or even states/provinces within a federal country coordinating procurement, the principles of consolidated volume, rigorous selection, and solidarity in purchasing can be replicated with the necessary cultural and administrative adaptations.

The OECS experience shows that sustained cooperation in pharmaceutical procurement can deliver measurable results even at a modest scale. For other regions facing similar constraints—small markets, limited bargaining power, dependence on imported medicines—the model offers a practical and adaptable framework, provided the institutional, financial, and political conditions are addressed from the outset. Nearly four decades after its creation, the PPS remains operational and self-financing. The challenge going forward is not only to maintain these gains but to deepen them: strengthening monitoring systems, broadening the product portfolio, and ensuring that the savings achieved translate into better health outcomes for the populations the mechanism was designed to serve.

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