HEALTH SECTOR REFORM PROGRAM

(BL-0014)

EXECUTIVE SUMMARY

Borrower and Guarantor:	Government of Belize	
Executing Agency:	Ministry of Health and Public Service (MoH)	
Amount and source:	IDB: (OC)	US$ 9.8 millions
	Co-financing:	
	Caribbean Development Bank (CDB):	US$ 4.716 millions
	European Union Commission (EUC):	US$ 1.600 millions[1]
	Local:	US$ 2.010 millions
	Total:	US$18.126 millions
Financial terms and conditions:[2]	Amortization Period:	25 years
	Grace Period:	4 years
	Disbursement Period:	4 years
	Interest Rate:	variable
	Supervision and Inspection:	1% of loan
	Credit Fee:	0.75% annually on undisbursed balance
	Currency:	US Dollars, single currency facility
Objectives:	The overall goal of the program is to raise the health status of the population by improving the efficiency, equity, and quality of health care services, and by promoting healthier lifestyles.	
Description:	To accomplish the objectives above, the Program will finance 3 components. **Component 1: Sector Restructuring**. The main objective of this component is the promotion of the development of institutional capabilities within the MoH so that it may exercise its role as a regulator and policy designer, and can effectively stimulate and support deconcentration towards newly created health regions and autonomous hospital bodies.	

[1] EUC will provide EUROS$1.7m, which represents US$1.6m as of July 26th exchange rate.

[2] It applies only to the IDB loan. Conditions of CDB financing: (i) amortization period: up to 30 years; (ii) grace period: up to 10 years; (iii) disbursement period: up to 10 years; (iv) interest rate: 2.5%; and, (v) supervision and inspection and credit fee: 0

Component 2: Services Rationalization and Improvement. This component will finance investment activities in infrastructure and medical equipment. Investment will be aimed towards improving the public supply of health care services by concentrating surgical and other key hospital services in a smaller number of regional centers (three) so as to increase the utilization of capacity and to improve quality. Investment will be tied to the implementation of performance agreements. This mechanism will forge the link between improvements in performance to infrastructure deployment. Hospital and central authorities will learn how to design, monitor and enforce such agreements.

Component 3: Support to the National Health Insurance Fund (NHIF). This component will provide support to the new NHIF in the acquisition of managerial and financial capabilities as a purchaser of services. To achieve the above purpose, the Program will finance technical assistance, training, and financing for running pilots aimed to develop purchasing skills (Innovation Fund).

Bank's country and sector strategy:

The Project is consistent with the Bank's strategy for Belize, which seeks to support the country in preparing for globalization. In the productive sectors, initiatives will focus on improving the legislative, regulatory, and incentive structures to promote private sector investment in the areas of agriculture, agri-business and tourism. In the social sector, the Bank's strategy is to support GOBL efforts to improve the health of the population and the productivity of the workforce. In the health sector itself, the Bank's strategy is to support sector reform, including institutional strengthening, cost recovery, and infrastructure rationalization and improvement, and to emphasize reproductive health services and community participation.

Furthermore, the Bank has approved a non-reimbursable Technical Cooperation (TC) operation via the Multilateral Investment Fund (MIF) to stimulate the private sector participation in Belize's health sector. As part of its content, this TC will finance strengthening the capacity of the MoH to regulate the private sector, and to develop the complementary purchasing ability needed by the NHIF in its role as the future single purchaser of health care in Belize.

Environmental/ social review:

The Project involves minimal environmental impact. Impact is almost entirely confined to the rehabilitation of existing buildings. No surplus equipment disposal is expected. However, some specific measures will be taken, as follows: (i) the project will finance the

design of environment protection measures, or EPM, to be added to the TOR for contracting rehabilitation of facilities in turn-key contracts, (ii) the PMU will obtain environmental licenses before starting all the bidding processes for construction works, (iii) a common strategy for hospital and domestic type disposal will serve as a basis for the definition of the EPM mentioned in item (i) (to be devised by consultants) and will take into account public health legislation currently in place, (iv) legislative review with an output that will include a review of the need for up-dated environmental regulation and enforcement methods, and (v) pilots for the development of purchasing skills. In this latter case, private contracts will make mandatory the implementation of waste disposal measures concordant with the current legislation.

Benefits: The program will enable GOBL to achieve better health status for the population and better value for money spent through the public purse and individuals. These overall benefits will be achieved through strengthened public policy making, the establishment of a strong purchasing capacity to spend public resources on the best available public and private services, and strengthened regulation. These reforms will reallocate expenditures to priority beneficiaries (women and the poor) and to priority services; reallocations prevented in the past by fixed costs, public service rigidities, and inefficient and inequitable out-of pocket expenditures by the poorest segments of the population. By pooling resources, a strong purchaser of services will act on behalf of the population to purchase high quality services, and to avoid the burden imposed on the system by individual negotiations.

Risks: In order to provide ample opportunities for consultations with the Civil Society, the Bank is recommending approval of the Loan before the SSB/NHIF is enacted. Although the GOBL is committed to an urgent approval of the legislation, delays cannot be ruled out whenever a consultation process is in place. To mitigate the risk the Bank will support the development and evaluation of the pilot, which will gather information and help build public support.

The main risks associated with the program are: (i) the opposition from interested groups to the structural reforms focused on public hospitals and the MoH; (ii) the receipt of subsidies from the Pension Fund by the new; (iii) a higher level of evasion of the system given the increase in contributions; (iv) a drive to informalization of the economy as a consequence of imposing an additional contribution to the formal sector of the economy; (v) a failure to achieve the shift in resources from the current out-of-

pocket private expenditure to the proposed payroll contribution, and (vi) accidents arising from lack of implementation of hospital waste and surplus equipment measures. In order to mitigate the above risks, the Program has been designed in such a manner that it will provide: (i) a public information strategy to forge coalitions to support the reforms and offer a transparent view of the benefits of the program, not only to the general population, but also to the civil servants involved in the process; (ii) an investment and technical assistance effort geared towards strengthening the capacity of the public sector to respond effectively to the challenges of autonomy and self-financing, while tying investment with a coherent performance oriented mechanism; (iii) technical assistance to develop information systems with the purposes of gradually improving controls on the contribution collections process and mitigating evasion; (iv) design and implementation of a monitoring mechanism to ensure permanent surveillance of the labor market performance and potential impact of the new contribution; (v) a legislative and organizational firewall to guarantee absolute financial separation between the new health fund and the pension fund, and (vi) a set of environmental protection measures aimed to devise and implement comprehensive strategies, that would range from reviewing the existing legislation to adding contractual clauses within the turn-key rehabilitation contracts.

Special contractual clauses:	1. The prior conditions for first disbursement will be (a) enactment of the Social Security Board/NHIF legislation; (b) approval of the Program Operations Manual; and (c) establishment of the Program Management Unit (PMU) (see par. 3.5). 2. The condition for first disbursement of component 2, in addition to those in item 1, will be the signing of contracts with CDB and EU for additional Program financing (see par. 3.14). 3. For component 3 there will be, in addition to the conditions in item 1 above, three special conditions: (a) signing of the contract with the firm that will be responsible for the concurrent audit (see par. 3.20); and (b) approval of the Operation Guidelines for the Innovation Fund; and (c) signing of the MOH/SSB performance agreement for operation of the NHIF (see par. 3.16) 4. Before accomplishing the conditions noted in items 1-3 above, and provided that the basic prior conditions established in the General Conditions of the loan contract have been met, it is recommended that the Bank may disburse up to US$700,000 of the loan to start key activities of the Program (including preparation of the Project manuals, the Initial Report, execution of the NHIF pilots, commencement of the labor market study and MOH/KHMHA institutional reforms) (see par. 3.17). 5. There will be annual progress reviews as well as mid-term and final evaluations (see pars. 3.23-3.29).
Retroactive financing:	Retroactively financing is recommended up to US$500,000 for eligible expenses incurred within 12 months prior to loan approval (from Loan resources) and up to US$300,000 from the local counterpart to cover expenses incurred 18 months prior to loan approval (see pars. 3.18-3.19)
Poverty-targeting and social sector classification:	This operation qualifies as a social equity enhancing project, as described in the indicative targets mandated by the Bank's Eighth Replenishment (Document AB-1704). (par. 4.11)
Exceptions to Bank policy:	None
Procurement:	International public bidding will be mandatory for: (a) goods and related services exceeding US$250,000; (b) public works exceeding US$1 million; and (c) consulting services at US$200,000 or more. Works and services that will be financed by the CDB will be procured independently according to the procurement rules of each respective institution (see par. 3.21).

I. BACKGROUND

A. Introduction

1.1 The proposed Program is the outcome of an ongoing dialogue between the Government of Belize (GOBL) and the Bank regarding the need to improve the health status of the population and the opportunities for structural reforms in the health sector. Discussions began in 1994 and, in 1996 the Bank approved the non-reimbursable Technical Cooperation financing ATN/SF-4686-BL for the preparation of studies for health sector reform. The studies carried out under this operation assisted the GOBL in analyzing options for: (i) the future delivery and financing of services and in identifying the fundamentals of a reform program; (ii) the senior Ministry of Health -MoH- staff received training in policy and planning functions to support project identification and execution; and (iii) a Policy Analysis and Planning Unit was established in the MoH to coordinate health sector reform activities.

1.2 **Macroeconomic and Social Context**. Belize has a land area of 23,000 square kilometers (8,867 square miles), making it the second smallest mainland country in the Western Hemisphere. In comparison to neighboring Central American countries, Belize's economy has been relatively stable. From 1964, when it obtained self-governing status, until 1981, GDP grew at an average of 5% annually. A drastic drop in sugar prices and other adverse economic factors resulted in a negative growth rate in 1982, but by 1984 the economy recovered with a GDP growth of 4.5%. Real GDP grew at a rate of 9.0% between 1986 and 1991, thus averaging 6.4% for the period between 1980 and 1989. From 1990 to 1997, real GDP grew by an average of 4.8% annually, while inflation averaged 2.7%.

1.3 The current government, since its inauguration in August 1998, has devised economic and financial policies aimed at reducing poverty through high rates of economic growth, investment in human capital and the introduction of well-targeted anti-poverty programs. To achieve this, it has opted for a policy mix of initially boosting public spending in housing and infrastructure, reducing taxes and promoting tourism and foreign direct investment. At the same time, the authorities seek to restrain the growth in the public external debt, which had increased sharply between 1995 and 1997. Thus, the government has begun to privatize the remaining public enterprises to help finance the additional capital spending and to raise economic efficiency. The authorities are also committed to maintaining the exchange rate peg at BZ$2 per US$1 (which has been in that level since 1976) to keep inflation under control.

1.4 The government's strategy is starting to have the desired effect. In 1999, Belize's economic growth accelerated from 1.5 percent a year earlier to 6.2 percent, led by increased output in agriculture, fishing, construction and tourist services. Consumer prices declined in 1999, as they did in each of the previous two years. The Central Government's fiscal operations in 1999/00 resulted in an overall

deficit of 0.8 percent of GDP, notwithstanding larger-than-planned capital outlays, and is well below the previous year's deficit of 1.8 percent of GDP. The fiscal gap was financed by foreign borrowing and net disbursements of existing loans from multilateral institutions. With a reduction in the government's domestic indebtedness, the consolidated banking system accommodated a rise in private sector demand for credit. The relatively high liquidity in the banking system put downward pressure on interest rates, which nonetheless remained high in comparison with interest rates abroad.

1.5 With respect to the external sector, last year was characterized by a pronounced widening of the current account deficit of the balance of payments, mainly as a result of a rise in construction-related imports, in machinery and equipment, and in consumer durable. The deficit, however, was more than covered by close to a four-fold increase in net capital inflows, a sizable portion of which was in the form of foreign-direct investment in the citrus and shrimp industries. Accordingly, there was a build-up of international reserves in 1999, compared with reductions in each of the previous two years.

1.6 Annual per capita income in 1989 was officially computed at US$1,598, and for 1993 it was estimated at US$2,555. The usual constraints attributable to low per capita income are aggravated in Belize by a relatively high cost of living.

1.7 A Pension plan under management of the Social Security Board (SSB) plan is financed from payroll contribution. The contribution currently consists of 7% (of which 6% is contributed by the employer and 1% is contributed by the employee, by law) on the earnings of paid employees with a ceiling of US$65 per week.

1.8 **Demographic Aspects**. The 1998 population was estimated at 236,975 with about 50% of the population living in the two central Districts of Belize and Cayo; 31% in the two northern Districts of Corozal and Orange Walk; and the remaining 19% living in the two southern Districts of Stann Creek and Toledo. Refugee immigration from civil wars in neighboring countries has regularly increased these numbers, especially in the south, although this situation has largely abated in the late 1990's. Nearly half the population lives in towns and cities, with a quarter of the population in Belize City alone. The rest of the population (about 52%) lives in villages and rural settings. Human settlements of 50 persons or more totaled 276 in 1991, with most of these having 50 to 300 households. The average household size was 5.3 in 1991.

1.9 **Health Conditions**. Overall health conditions in Belize compare favorably with neighboring Latin American countries but offer scope for considerable improvement. The infant mortality rate for example, a good indicator of overall health conditions, is estimated at 26 per 1,000 live births. The situation is much less favorable among the 33% of the population considered poor (by Ministry of Economic Development estimates) and there is an urgent need for improvement in important areas, such as child and maternal health.

1.10 The population is undergoing an epidemiological transition from diseases of poverty (communicable diseases, -diarrhea and some respiratory diseases) to those that accompany development (chronic diseases). Lower respiratory infections (communicable) rank first among causes of mortality followed by heart disease and cancer (chronic). Low quality of care is responsible for high maternal and perinatal mortality.

1.11 The epidemiological transition is not yet completed and communicable diseases, such as upper and lower respiratory infections, intestinal diseases, tuberculosis, and malaria remain a major concern. Twelve cases of cholera were reported during 1999. An increase in AIDS is likely as HIV positive cases convert to clinical AIDS and as a result of immigration from more heavily infected countries, primarily Honduras. Many of these problems can be effectively addressed through the provision of basic clinical and preventive services, including reproductive health services.

1.12 While the control of communicable diseases remains vital, road accidents are rising dramatically and the relative importance of chronic and degenerative diseases (mainly ischemic heart diseases, diabetes and neoplasm) is increasing. This is a result of changes in life style and in the demographic characteristics of the population as well as improved diagnosis. These diseases will increase in importance as the population ages. Mental health problems are also likely to grow in importance with urbanization and the increased awareness in the population about the symptoms and treatments. Health education programs can play a major role in reducing the burden of many of these problems.

1.13 The population groups at highest risk are young children and women of reproductive age, particularly among the poor. Little information is available on the health conditions among the poorest segments of the population, but limited access to quality care suggests conditions are much worse than among the better-off groups of the population. Therefore, a sound and permanent assessment is required to guide coherent policy formulation.

1. Provision of Services

1.14 **The public sector**. The government is the main provider of health services. The Ministry of Health, now the Ministry of Health and Public Service or MoH, operates a network of facilities, which includes the Karl Heusner Memorial Hospital (KHMH) a national referral hospital in Belize City, 6 District Hospitals, roughly 40 Health Centers, 30 Health Posts, and a mental health facility – the latter in deplorable condition. Services provided in these facilities are complemented by national programs for maternal and child health, public health and water safety inspection, health education and nutrition, disease (vector) control, and STD/AIDS. The public system also includes a nursing school, national laboratory, national equipment maintenance center, and various other central support services.

1.15 Nurses and other non-medical staff operating from health centers and health posts provide primary care. Medical specialists and general practitioners, together with nursing and other support staff, provide secondary care. All are public service employees. Non-public community nursing aides provide services in villages and are paid a small stipend.

1.16 **The Private Sector**. There are two small private hospitals offering about six beds each. Other services include numerous non-governmental organizations and religious groups providing outpatient services, about 73 private doctors offering general medical practice, and 38 specialists who provide outpatient services (mostly in Belize City), private laboratories and radiology services, numerous private pharmacies, and many midwives, traditional birth attendants, and non-traditional healers. In addition, an estimated 40 physicians who are full time employees in the public sector have their own private practice. This private sector is completely unregulated. In addition, many patients seek health services abroad, mostly at private facilities in Mexico (Chetumal and Merida), as well as in Guatemala, and Miami, among other cities in the USA. Overall, the private sector, both domestic and international, is the first choice of most citizens for their medical care, especially those with the ability to pay. Many of those in lower income groups still choose services abroad, particularly those living in the northern Districts and Belize City.

2. Financing of Services.

1.17 Public expenditure on health is funded almost wholly from taxation. The MoH recurrent expenditure is around US$14m for 1998 equivalent to about 9% of total GOBL expenditures. Private sector expenditure is largely out-of-pocket for diagnostic and hospital services overseas, and for primary care, specialist consultations, and diagnostic services in Belize. Private expenditure is roughly US$ 19.5 million, excluding travel, and roughly 40% of private expenditure is out of country. Total expenditure goes to US$ 33.5 million –all 1998 – giving about 6% of GDP and US$ 140 per capita

1.18 The existing Social Security Board (SSB) insures employees for job-related illnesses and has reported[1] that, on average, about US$ 1.3 million per year is spent on the provision of such services (US$ 0.5 million in Belize and roughly US$0.8 million in Guatemala or Mexico).

B. Problems and Challenges

1.19 **Inefficiency and Poor Quality in Public and Private Health Service Provision**. The problems of the sector, as perceived by the consumer[2], are primarily those of low quality in the public services manifested by long waits and the uncertain

[1] Annual Report 1998.
[2] 1998 Data provided by the Planning Unit of the MoH.

availability of staff and diagnostic and treatment services, unsympathetic staff attitudes and chronic supply deficits. In addition, the public sector has too many and poorly distributed hospital beds by modern standards of productivity resulting in an average bed occupancy rate as low as 33%[3] which represents a significant degree of technical inefficiency. Bed occupancy rates vary from 24.3% in Corozal and 49.5% in Orange Walk, but no facility surpasses 50%. In terms of hospital mortality, 1998 data shows a wide range of outcomes, from 0.015 deaths per discharge in San Ignacio to 0.05 in Orange Walk.[4] Furthermore, about 75% of the MoH recurrent budget consists of direct transfers for staff salaries and wages and 17% is spent on materials and supplies, including drugs, which is again a sign of inefficiency (more than 70% is considered internationally as a sign of problems of technical inefficiency).

1.20 **Organizational and Strategic Weakness.** In organizational terms, the public sector is unable to cope with the challenges of service delivery to a relatively small and dispersed population. The MoH and all the health provision facilities form an over-centralized organization in the classic civil service fashion. Budgeting and expenditure authorizations are undertaken by the central level of the MoH, staff are employed centrally by the public service and all matters of appointment, discipline, reward, and dismissal are administered by the Public Service Commission and not by managers responsible for providing services. Setting up numerous but dispersed units has promoted the objective of maximizing service access. However, this objective is unsuccessful due to staffing and supply failures (as noted by the figures which show a steady increase in out-of-pocket expenditure overseas). As a consequence of focusing mainly in managing the provision of services, the central MoH has not generated policy or strategic orientation for the sector, and its human resources are not trained to provide solid regulation and planning guidance.

1.21 **Inefficiency and Inequity in Health Sector Spending Pattern.** Historically, Belize has managed to allocate a relatively large amount of public expenditure to health. Under-funding is thus not the main problem that needs addressing, particularly with the inherent inefficiencies and under-utilization in the public sector. The major problems in sector financing concern the need for mechanisms to ensure that funds are raised equitably and spent effectively and efficiently. Private spending by consumers should result in better value-for-money and provider payment should not be an incentive for over supply or excess demand. As these problems are solved, it becomes more feasible to ask consumers to contribute any additional financing that may be necessary and to secure long term sustainability by diversifying sources of financing.

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[3] 1998 Data provided by the Planning Unit of the MoH.
[4] 1998 Data provided by the Planning Unit of the MoH.

1.22 A revenue model[5] shows that current total health care expenditure in Belize, including public and private, may account for US$33 million and the provision of a comprehensive package of health care services might cost US$28m for the whole population of Belize, which indicates an inefficient pattern of expenditure. Despite the fact that the model compares real expenditure with a predicted expenditure, there is evidently an efficiency issue involved.

1.23 Paying large amounts in an out-of-pocket fashion becomes a source of **inequity,** mainly for the middle class and poor population that cannot afford private health insurance and may have to negotiate individually with a stream of foreign providers under a severe degree of information asymmetry. Even though there is a problem of information attached to the above issue, the underlying issue is inequity based on insufficient supply and lack of collective bargaining for purchasing high quality services at reasonable prices.

C. Health Sector Reform Strategy

1.24 In 1995-96, the MoH developed a National Health Plan for the period 1996-2000. The Plan analyzed health conditions and determinant factors and presented a set of mission statements and goals to guide health sector policy development and planning. While not specific in either strategies or cost estimates, this Plan constituted an important step toward health sector reform reflecting GOBL commitment to improved equity, accessibility, quality, efficiency and effectiveness in the health sector – public and private.

1.25 As a strategy, the GOBL has expressed its commitment to (i) focus public finance on the poor and on public health, while (ii) stimulating a mix of public and private services. As part of their political manifesto, the current Government proposed the creation of a National Health Insurance Fund to provide health insurance to all Belize citizens, especially including the poor. A Health Policy and Planning Unit has been established and legislation has been drafted in support of health sector reform.

1.26 A series of studies and analysis have been carried out by the GOBL to assess alternatives to reform the health sector. One important issue has been identifying the best structure for achieving an efficient and effective level of administrative deconcentration, for regulation and for public provision of services. A technical review[6] of demographic, economic and service utilization patterns showed that 4 Health Regions would be appropriate for running a deconcentrated form of health management.

1.27 The GOBL has passed legislation to transform the Karl Heusner Memorial Hospital into a Statutory Authority (SA). This legislation creates the SA and

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[5] England Roger, Revenue model for Belize Health Reform Project 1999. Figures were calculated on the base of 1998.

[6] C.C.C. Consultant report. 1999

defines its new organizational structure. As a SA, the KHMH will become an autonomous body with financial independence, managed by an independent Board.

1.28 The GOBL has decided that the NHIF will be established as the prime financing instrument and purchaser of personal health care services, both public and private. The key function of purchasing will be developed within the new NHIF branch of the SSB. The GOBL thinks that there are advantages in creating a dedicated health fund through national health insurance. These advantages include the pooling of public and a large portion of private expenditure in one fund, and the creation of a strong central purchasing capacity for the cost-effective spending of that fund. This contrasts with the relatively disorganized ways in which individuals currently spend US$19.5 million of their own money in the private sectors of Belize and overseas.

1.29 An initial step to establishing the NHIF will be to set up a pilot project to build the technical and financial skills to fully implement the National Health Insurance Fund. By the time the pilot has been completed, legislation creating the NHIF will have been enacted, the NHIF organizational structure established, skills developed, and systems implemented. Enactment of the NHIF legislation will be a condition prior to first disbursement of the loan. When it is fully operational, NHIF will be funded by contributions from the employed and self-employed, utilizing existing SSB mechanisms. This funding will be complemented from government general taxation revenues to subsidize the poor. Small patient co-payments will be considered to avoid frivolous utilization of services.

1.30 **Bank intervention and priorities**: The Bank's Country Paper identifies support to the country in preparing the economy for globalization. In productive sectors, initiatives will focus on improving the legislative, regulatory, and incentive structures to promote private sector investment, particularly in agriculture, agri-business, and tourism. In the social sector, the Bank's strategy is to support GOBL efforts to improve the health of the population and the productivity of the workforce. In the health sector itself, the Bank's strategy is to support sector reform including institutional strengthening, cost recovery, infrastructure rationalization and improvement, and to emphasize reproductive health services and community participation.

1.31 The Bank has approved a non-reimbursable Technical Cooperation (TC) operation via the Multilateral Investment Fund (MIF) to stimulate the private sector participation in Belize's health sector. As part of its content, this TC will finance strengthening the capacity of the MoH to regulate the private sector and to develop the complementary purchasing ability the NHIF will have to develop in its role as the future single purchaser of health care in Belize.

D. Conclusion

1.32 In sum, the Belize population perceives that the public sector has been providing services that are poor in quality. The organization of the sector has been unable to cope with new strategic and policy orientation roles. Furthermore, sector financing has been inefficient; extensive private out-of-pocket financing caused by poor quality provided by the public sector has imposed an inequitable burden on the low-income population. Thus, the comprehensive strategy to overcome the above mentioned problems and challenges will include supporting the government in setting up a National Health Insurance Fund as a means to obtain a more efficient mechanism for sector spending and as a tool to obtaining insurance coverage not only for the formal sector of the economy, but also for those self-employed and the poor. Concurrently, GOBL will make the operation of the public facilities more efficient by increasing productivity and shifting the financing mechanism from the current historic budgeting to a more performance and output oriented mechanism, and by restructuring the whole sector through specialization by the MoH in policy guidance and regulation.

II. THE PROGRAM, COSTS AND FINANCING MECHANISMS

A. Objectives of the Program

2.1 The overall goal of the program is to raise the health status of the population by improving the efficiency, equity and quality of health care services and by promoting healthier lifestyles. The program strategy is based on utilizing concurrent approaches: (i) preparing the public sector providers to obtain autonomy and become self-sustainable and able to compete, and (ii) promoting a market-oriented sector improvement via creating a single purchaser[7] of services and parallel stimulation of multiple providers from the private sector. The overall outcome will be a more macro-efficient use of health expenditure in Belize.

2.2 The specific objectives are: (i) restructuring and strengthening the organizational and regulatory capacity of the central and regional level of the public sector to plan, organize, produce, deliver, and procure good quality and value for money services; (ii) rationalizing and improving the coverage and quality of services of public and private sectors by restructuring public facilities, purchasing selective services from the private sector to support the public supply, providing mobile services and transport in less accessible areas, training community nursing aides and other health professionals. Performance agreements will be designed, implemented and enforced in order to tie performance improvements to infrastructure deployment; and (iii) achieving an equitable and sustainable system of sector financing by helping to set up a National Health Insurance Fund and focusing public spending on the poor.

B. Program Structure

2.3 This is a four-year program aiming to complement improvements in public sector provision, and regulation improvement with a medium and long term financing strategy which will be the base for consolidation of health sector reform in Belize.

2.4 According to the strategy, the program will finance technical assistance, training, pilot programs and investment in hospital infrastructure and equipment. The program has three components. The first one is related to strengthening the MoH so it can exercise a regulatory and policy orientation role, and deconcentrate responsibilities to health regions and one autonomous hospital. The second component is focused on rationalization of the public health care network infrastructure by reorganizing services and investing in civil works and equipment. The third component supports establishment of a National Health Insurance Fund and provides this new institution with the administrative and strategic tools to manage the funds of the system and to become an effective purchaser of services.

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[7] Given the size of the country and its economy, creating competition to insurance and purchasing of services is not viable.

2.5 The following chart shows the relations between the problems previously identified in Chapter I, the strategy of the Program, and the designed components. Annex I contains the Logical Framework of the Program.

Table 2.1. Relationship between the Problems of the Sector, the Strategies of the Program and the Components

Problem	Strategy	Component
Inefficiency and poor quality in public health care provision ▪ low average occupancy rates ▪ high variation in occupancy rates ▪ 75% of MoH recurrent budget devoted to staff salaries and wages ▪ users not satisfied with staff attention ▪ long waiting lists.	Reorganization and rationalization of public health services to respond effectively to population demand and to improve productivity and technical efficiency	Component 2 (Services Rationalization and Improvement)
Organization and Strategic Weakness ▪ over-centralized decision centrally taken organization, budget and expenditure ▪ staff employed centrally and depending of a Public Service Commission ▪ MoH focused on providing services without strategic and policy-orientation strength.	Creation of 4 Health Regions to deconcentrate management and increase flexibility and responsiveness. Reorienting the MoH towards a role in policy and regulation. Supporting the development of an autonomous body to manage the KHMH, providing administrative and financial skills to pursue long-term stability. Promoting knowledge of behavioral change and developing a public information strategy to support the process and obtain consumer satisfaction	Component 1 (Sector Restructuring)
Inefficiency and Inequity in Health Sector Expenditure ▪ under-funding is not a problem ▪ high private, individual and unregulated out-of-pocket expenditure ▪ higher real expenditure than the predicted expenditure for purchasing a comprehensive package of services for the whole population	Supporting development of National Health Insurance Fund to become a sole purchaser of value-for-money services, fostering a public and private mix for services provision Creation of a temporary Innovation Fund to support the developing of purchasing skills within the NHIF and to give the private sector a clear signal of the long-term commitment of the GOBL.	Component 3 (Support to the NHIF)

1. **Component 1: Sector Restructuring** (US$1,4 Millions)

2.6 The main objective of this component is to promote the development of institutional capabilities within the MoH to exercise its role as a regulator and policy designer for the sector, and further stimulate and support deconcentration towards newly created health regions and autonomous hospital bodies. To

accomplish these objectives, the Program will finance its activities through five subcomponents.

a. Subcomponent 1a. Reorienting the MoH (US$154,000)

2.7 This Subcomponent will finance a stream of activities that will offer the MoH the legal framework, the administrative, management, and policy-making skills and organizational strengths necessary to implement its new strategic role and organizational structure. By means of technical assistance and training the Sub-component will develop the following activities:

i. Technical assistance for the development of the legal framework for creating the new structure of the MoH based on a rapid assessment of the current situation and the desired functions;
ii. Organizational development of the MoH at its central level under the new structure;
iii. Training on strategic planning, policy design, support to the health regions and development of technical skills to monitor public health needs and priorities, and to develop responsive policy initiatives at the Planning Unit of the MoH;
iv. Technical assistance for achieving strengthened licensing requirements, standards, basic protocols and procedures for investigating adverse events at the health care provision level;
v. Technical assistance for a legislative review with an output that will include a review of the need for updated environmental regulation and enforcement methods.
vi. Technical assistance to the MoH so it can coordinate purchases of drugs and medical supplies on behalf of autonomous and public providers through updating the formulary and negotiating bulk purchasing and pricing arrangements. Procurement and distribution of drugs and medical supplies will be substantially modified to involve the private sector in importing, storage and distribution.

b. Subcomponent 1b. Deconcentrating Operational Authority to Health Regions (US$513,000)

2.8 This Subcomponent will finance a set of activities geared towards the creation of Health Regions and to provide them with basic management and financial capacities. The role of the HR will be to coordinate all resources transferred to the region, command the planning process at the regional level, and foster and coordinate social participation. At the end of the Program, four Health Regions (HR) will be operating. The program will finance the following activities: (i) appointment and training of the technical teams working at the regional level for the first year of the program; (ii) technical assistance to develop the managerial tools at the regional level; (iii) organization of technical workshops for exchanging experiences; and (iv) organization of integration workshops to foster social participation and public information.

c. Subcomponent 1c. Piloting Autonomy with the Karl Heusner Memorial Hospital Authority (KHMHA). (US$366,000)

2.9 This Subcomponent will finance the activities that the new Karl Heusner Memorial Hospital Authority will need to develop in order to develop the capabilities to properly perform as an autonomous provider of health care services, hence maintaining financial stability in the long run. Activities will include the development of information technology tools for supporting relevant administrative and financial functions, and improvement of human resources management and training of personnel. By means of technical assistance, training and investment in information technology, this Subcomponent will develop the following activities:

i. Short term contracting and training for the new Board of the KHMHA on strategic and policy formulation and evaluation;
ii. Technical assistance for development of financial and administrative tools aimed to manage contracts with purchasers of services;
iii. Technical assistance for formulation and development of a human resource management strategy;
iv. Short term appointment of a technical management team to do in-job coaching on development of business plans and procurement procedures;
v. Technical assistance for formulation of a comprehensive and long-term information systems plan, development of new information systems tools, definition of technical specifications and procurement.

d. Subcomponent 1d. Public Information Strategy (US$105,000)

2.10 The Program will support the designing, implementation, and evaluation of a communication strategy aimed to ensure the success of all three components of the Program and specially inform the population on the progress and success of the pilots contemplated in component 3. A key task will be to find the most influential supporting groups and to forge solid and well-informed coalitions. The communication strategy will be based on relevant information gathered by the program about the attitude and expectations of different social groups. Hence, the program will finance: (i) technical assistance for gathering relevant baseline information, finding the supporting parties and developing the strategy for the formation of coalitions; (ii) workshops for strengthening of coalitions; and (iii) design, implementation and evaluation of communications strategy. The Program will train key personnel of the MoH in implementation and evaluation of public information strategies as part of the new role of the Ministry.

e. Subcomponent 1e. Promoting Knowledge of Behavioral Change (US$280,000)

2.11 This Subcomponent will finance the design, implementation and evaluation of a health communication strategy aimed to promote knowledge and behavioral change in targeted priority population groups including women, young children, the poor, isolated groups, and those with special needs including indigenous

groups. The health education strategy will rely on communication mechanisms promoting knowledge of health risks, adoption of healthier behavior, and care-seeking behavior mainly channeled through the education sector and the existing Health Education Bureau. The program will finance specifically the following activities: (i) design and implementation of base-line studies to identify the need for particular health behavioral change and associated social and individual constraints on healthier lifestyles to better design of the communication strategy; (ii) technical assistance for identification of target populations and designing of the media strategy, including printed and audio material; (iii) training of the MoH personnel (central and regional level), and personnel of public and private health care providers; (iv) special training and support for community nursing aides to participate in the promotion program; and (v) evaluation to measure the effectiveness of the interventions in terms of knowledge gain, perception and behavior changes.

2. Component 2. Services Rationalization and Improvement (US$12Millions)

2.12 The program will finance investment activities in infrastructure and medical equipment. The program aims for surgical and other key hospital services in the public sector to be reorganized into a smaller number of regional centers (3) (according to a review of the current utilization patterns and strategic approach of the GOBL towards health networks[8]) to increase capacity utilization and improve quality. Investment will be tied to the implementation of performance agreements. This mechanism will forge the link between improvements in performance to infrastructure deployment. Hospital and central authorities will learn how to design, monitor and enforce such agreements.

2.13 Rationalization will be achieved by means of a complete reorganization of the public network. At the end of the Program, the six district hospitals outside Belize City will be replaced by three regional hospitals at Orange Walk, Belmopan and Dangriga, providing the four basic secondary services: general medicine, pediatrics, general surgery (including basic orthopedics); and obstetrics and gynecology. The existing units at San Ignacio, Corozal, Punta Gorda (Toledo), and San Ignacio will be converted to Community Hospitals providing primary care including maternity. In addition to the services listed above, KHMH in Belize City will provide: ENT (Ear, Nose and Throat), ophthalmology, acute psychiatry, and some more specialized cover for the services in the other hospitals, including specialist medical cover for traumatology, radiology, and pathology. Total hospital beds will be gradually reduced from 384 to 271 as productivity is raised by 40% through grater specialization in the health care network and a pattern of supply more consistent with the current demand for services. This reduction of beds and the forecasted increase in productivity is consistent with the proposed concentration of facilities agreed upon during the

[8] HSLP. Consultant report, 1999

appraisal of the Program. All other specialties will be procured abroad through the NHIF.

2.14 This component will finance the design of environment protection measures, or EPM, to be added to the TOR for contracting rehabilitation of facilities in the turn-key contracts. EPM will be based on a common strategy for hospital and domestic type disposal devised at the beginning of the execution of the program.

2.15 The component will finance technical assistance for designing, implementing, monitoring, and evaluating performance agreements. Every health facility that will receive financing will sign a performance agreement. These performance agreements will be signed with the MoH and eventually when the Health Regions are legally capable; the agreements will be negotiated and signed between the health facility and its corresponding regional manager. Productivity improvement targets and output goals will be fundamental components of the agreements and will functions as mechanisms for enforcement. At the end of the program, 80% of all the health facilities currently under public management will be financed under performance agreements.

3. Component 3. Support to the National Health Insurance Fund (US$0,96 Millions)

2.16 This component aims to support the creation of a new National Health Insurance Fund, including establishing managerial and financial capabilities for the Fund to perform as purchaser of services. To achieve this purpose, the program will finance technical assistance, training, and financing for running a pilot aimed to develop purchasing skills (Innovation Fund). Two sub-components will be financed and implemented.

a. Subcomponent 3a. Technical Development of the NHIF (US$538,000)

2.17 This Subcomponent will finance technical assistance and training focusing on the following activities:

i. conformation and training of the Policy Committee of the NHIF;
ii. design and evaluation of the performance agreements[9] the Social Security Board will sign with the MoH, and the Management of the SSB will sign with SSB;
iii. training of the new management of the NHIF and technical assistance for development of information technology and management control systems (financial data and quality control data essentially) aimed to monitor contracts with health care providers;

[9] The performance agreements will include a set of relevant indicators, including accomplishment of the financial barriers between the health fund and the pension fund. Both the Policy Committee and the performance agreements will focus on preserving the independence of the NHIF, by means of monitoring indicators, setting guidelines and enforcing regulations.

iv. technical assistance for design, implementation and evaluation of a financial model aimed to forecast the financial performance of the NHIF;
v. technical assistance for design, implementation and evaluation of two planning tools. One is the national income and expenditure survey and the other is a permanent assessment mechanism to monitor the impact of the payroll contribution on the labor market;
vi. technical assistance to improve the administrative skills within the SSB to collect contributions, update databases, and install a comprehensive information system (combining affiliation, collection and utilization databases).
vii. Technical assistance for the design, validation and implementation of a tool for identification of the enrollees in the subsidized (population without ability to pay) segment of the NHIF.

2.18 At the end of the program, at least 80% of the formal sector of the economy is expected to be affiliated to the NHIF, which include almost all of the formal sector, as well as 50% of the self-employed and 50% of those without the ability to pay whom the government will subsidize.

2.19 The GOBL is committed to financing the NHIF through a payroll contribution. Presently a 7% is paid for by employers and employees (to finance a pension plan and other benefits). Given that a new and earmarked payroll contribution may impose a heavy burden on the competitiveness of Belize's economy and because of potential negative impacts on the labor market, the program will finance a baseline labor market survey and periodic monitoring mechanisms to ensure that relevant information is available during execution of the Program. As part of the Annual Reviews, results from the monitoring of the labor market will be analyzed and adjustments in the financing plan can be considered.

b. Subcomponent 3b. Innovation Fund. (US$420,000)

2.20 The second sub-component will finance the creation of a temporary fund, the Innovation Fund, to allow the NHIF to use loan resources to finance payments to health care providers under the execution of two pilots which will be fundamental to develop the purchasing model and acquire purchasing skills while offering the private sector a clear signal of the GOBL commitment towards stimulating long-term participation of the private sector in the provision of health care services.

2.21 The objectives of the Innovation Fund are:

i. enable the NHIF to initiate purchasing (through pilots) from the private sector before contributions are collected;
ii. signal the private sector regarding the type, volume and quality of services required, thereby reducing resistance and motivating providers to adopt required changes.

2.22 Eligible activities will be: purchasing medical (basic medical services through two pilots for developing purchasing skills) and ancillary services (contracting out

services to support the existing public supply (KHMH) from selected domestic private providers.

2.23 Requirements for use of funds: resources will be allocated by means of a competitive process where quality standards will be the critical factor. The GOBL will prepare Operation Guidelines (OG) for running the Fund.

C. Program Costs and Financing

2.24 The following table summarizes the investment costs of the program. The total cost of the program will be US$18.1m. The European Union (US$1.6m[10]) and the Caribbean Development Bank (US$4.7m) have pledged parallel financing in an effort to maximize grant and concessional funding and to reduce the debt burden on the Belize's economy. EU will fund the renovation of KHMH to agreed technical specifications once the KHMHA is operating. CDB will fund investment, technical assistance and training for developing components 1 and 2.[11]

[10] EUC will provide EURO$1.7m, which represents US$1.6m as of July 26th exchange rate.
[11] CDB will focus its infrastructure investment on community hospitals, and IDB on regional hospitals.

Table 2.2. Costs by Components (US$000)

COMPONENTS	IDB	CDB	EU	GOBL	TOTAL	%
Component 1. Sector Restructuring	**547**	**729**		**142**	**1,418**	**8**
1a. Reorganization MOH	70	50		34	154	
1b. Deconcentrating Operational Authority to Health Regions	90	423			513	
1c. Piloting autonomy with Karl Heusner Memorial Hospital Authority (KHMHA)	317			49	366	
1d. Public information strategy		101		4	105	
1e. Promoting Knowledge and Behavioral Change	70	155		55	280	
Component 2. Services Rationalization and Improvement	**6,188**	**3,193**	**1,600**	**1,066**	**12,047**	**66**
Civil works	3,808	1,984	1,600	1,066	8,458	
Medical and admininistrative equipment	1,705	1,209			2,914	
Management	303				303	
Ambulances/mobile units	372				372	
Component 3. Support to the National Health Insurance Fund (NHIF)	**832**			**126**	**958**	**5**
3a. Technical development of the NHIF	412			126	538	
3b. Innovation Fund [12]	420				420	
Administration	**322**			**352**	**674**	**4**
Total investment costs	**7,889**	**3,922**	**1,600**	**1,686**	**15,097**	**83**
Unallocated costs	649	392		272	1,313	7
Contingencies	379	235		162	776	
Cost escalation	270	157		110	537	
Financial costs	**1,262**	**402**		**52**	**1,716**	**10**
Interest	1,164	342			1,506	
Credit Commission		60		52	112	
Inspection and Supervision	98				98	
TOTAL COST	**9,800**	**4,716**	**1,600**	**2,010**	**18,126**	**100**
%	**54%**	**26%**	**9%**	**11%**		

[12] It will finance the pilot for the creation of the NHIF

III. PROGRAM EXECUTION

A. Execution Strategy

3.1 The borrower will be the Government of Belize and the executing agency will be the Ministry of Health and Public Service, with technical support provided by its relevant units and new institutions as these are developed. For purposes of project execution, a Project Management Unit (PMU) will be established within the Policy Analysis and Planning Unit of the Ministry. [13]

3.2 A Cabinet-appointed HSRP Steering Committee will have overall responsibility for guidance and inter-agency coordination of the program. Additionally it will oversee the whole implementation process and for that purpose it will monitor qualitative and quantitative targets of the HSRP. To do this, it will receive technical and other necessary support from the PAPU of the Ministry of Health, which will act as a Technical Secretariat to the Committee. The Committee will have the following membership:

- Minister of Health (Chairperson)
- General Manager of the Social Security Board
- PS Ministry of Finance
- PS Ministry of Public Service
- PS Ministry of Health
- A representative from the Belize Medical and Dental Association
- Health Sector Reform Advisor

3.3 The resources allocated to the project will be disbursed to the Government according to Bank procedures, with the Project Management Unit as the only agent responsible for the administration of the resources of the financing activities under execution.

3.4 The Program will finance execution of activities through technical assistance, training, financing innovation in purchasing health care services and investment in infrastructure, information technology and equipment.

3.5 Parliamentary approval of the new legislation creating the NHIF and its operational characteristics, guaranteeing financial firewalls between the pension and health funds; and approval by the Bank of (a) the Program's Operation Manual, and (b) establishment of the Program Management Unit (PMU) **will all be conditions prior to first disbursement of the loan**.

B. Administration and Management of the Program

3.6 The government will designate a National Program Manager for the HSRP, who will assume full responsibility for implementation of the program and will report

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[13] The establishment of the PMU will be a condition precedent to disbursements

directly to the Permanent Secretary of the Minister of Health. He or she will also coordinate the network of government officials designed as liaison officers in their respective institution/agency, which will constitute the Executive Committee of the program.

3.7 Given that project activities are contemplated in multiple institutions (SSB/NHIF, KHMH, Regional hospitals, and Ministry of Health), and that project activities will be implemented in multiple tiers (central and regional), all the different institutions involved and the health regions will have liaison officers.

3.8 The detailed administrative structure of project execution will consist of the following units located at different levels:

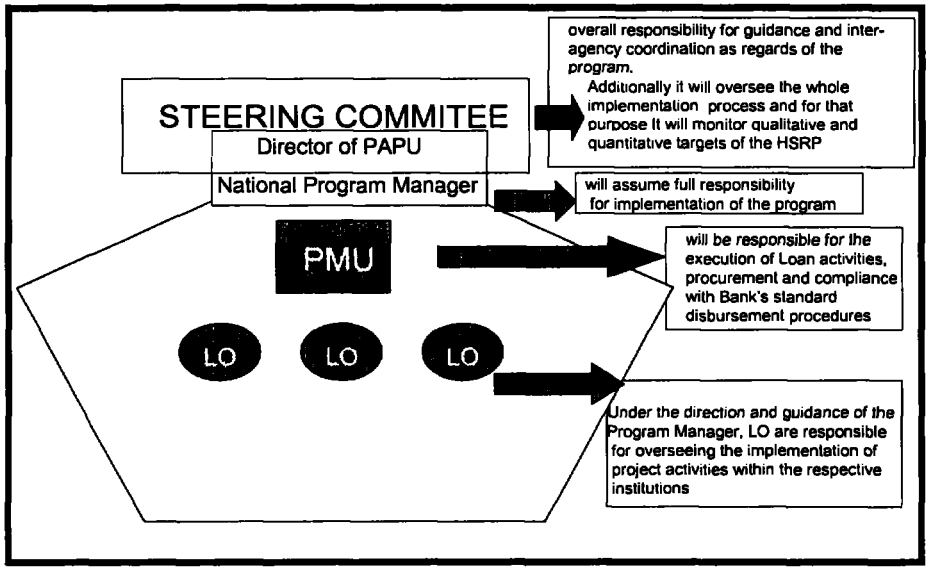
i. The Project Management Unit (PMU), headed by a Coordinator, will be responsible for the execution of Loan activities, procurement and compliance with Bank's standard disbursement procedures. Other members: Procurement Officer, Financial Administrative Director, and an Accounting Clerk/Secretary.

ii. Liaison officers (LO) will be chosen within each of the institutions targeted for project interventions (SSB/NHIF, KHMH and other centers). Under the direction and guidance of the Program Manager, LOs are responsible for overseeing the implementation of project activities within the respective institutions. The GOBL will issue the appropriate administrative instructions to enforce participation and accountability.

3.9 As part of the Operation Manual, a detailed description of the type of activities, level of responsibility, and information exchange mechanisms of the Executive Committee (including liaison officers) will be prepared.

3.10 Counterpart personnel from participating institutions (SSB/NHIF, KHMH, and Regional Health Management, including Liaison officers) will receive training in management and administrative techniques and orientation in their respective roles prior to assuming responsibilities for project-related activities in said areas.

3.11 The following chart shows the strategic and administrative structure of the program:



C. Execution of Specific Components

1. Component 1.

3.12 Component 1 will be executed according to the relevant Action Plan for technical assistance and training that will be developed and incorporated in the Initial Report of the project.

3.13 The main recipient of technical assistance and training included in this component will be the Policy Analysis and Planning Unit of the MoH, regarding not only the activities directly related with its regulatory role, but also all those activities focused on the development of the deconcentrated environment the Program aims to achieve.

2. Component 2.

3.14 **Component 2** will be executed by specialized firms through an international bidding process encompassing the civil works and equipment needs depicted in the action plan for this component that will be prepared and incorporated in the Initial Report of the project and based on the technical input provided by HLSP[14]. Based on the dimensioning of investment requirements performed during project preparation, the executing agency shall contract one firm to be responsible for the design, procurement and supervision of the execution of civil works, and another firm to procure and supervise the delivery and installation of medical equipment. This approach will be reflected in the terms of reference prepared for the bidding process. **For disbursement of component 2, conditions would be (a) contracts signed with CDB and EU.**

[14] HLSP consultant report. Plan of Action for rationalization of services.

3. Component 3.

3.15 Component 3 will be executed according to the relevant Action Plan for technical assistance and training that will be developed and incorporated in the Initial Report of the Project.

3.16 **There will be three special conditions for this component: (i) signing of the contract of the firm that will be in charge of the concurrent audit; (ii) approval by the Bank of Operation Guidelines for running the Innovation Fund; and (iii) signing of the MOH/SSB performance agreement for operation of the NHIF.**

3.17 Before meeting the various conditions prior to disbursement of the financing for the Project and for its specific components noted in this Project Report and provided that the basic prior conditions established in the General Conditions of the loan contract have been fulfilled, it is recommended that the Bank may disburse up to US$700,000 of the loan resources to start key activities of the Project (including, among other things, preparation of the Project manuals and the Initial Project Report, execution of the NHIF pilots, and commencement of the labor market study and the respective institutional reforms in the MOH and the KHMHA).

D. Financial Transfers

3.18 The Bank may retroactively finance up to US$500,000 for eligible expenses incurred within 12 months prior to loan approval to cover expenditures for consultant services, office equipment, and training carried out during the period, provided that the procurement procedures related to such expenditures conform to accepted Bank procedures and up to US$300,000 from the local counterpart to cover expenses incurred 18 months prior to loan approval.

E. Concurrent Auditing

3.19 Through the execution of the Program a specialized firm will be hired by the MoH to verify the following in a concurrent manner: (i) the accomplishment of the financial and organizational rules created to preserve complete independence between the funds belonging to the NHIF and all the other resources collected by the SSB; and (ii) the accomplishment of the terms included in the performance agreements signed between the management of the NHIF and the SSB, and between the SSB and the MoH. During execution of the Project, this activity will be financed with resources coming from the Bank loan. This firm shall be hired within six months after signature of the loan contract and will present to the Bank and the Government regular ongoing reports.

F. Procurement Procedures

3.20 International advertising, short-listing and evaluation to explicit criteria will be used to procure international technical assistance. Short evaluation reports will be prepared by the PMU. Local advertising followed by the same procedures will be used to recruit local technical assistance. All contracting of consulting services will be done in accordance to standard Bank policies regarding selection and contracting of consultants. Prior to the contracting of all consultant services, the Project Director, in consultation with personnel of the PMU and the HSR Steering Committee, should elaborate relevant technical documentation to be submitted for Bank approval. Acquisition of goods and services and contracting of civil works will be subject to the Bank's procedures. International public bidding will be mandatory for: (a) goods and related services exceeding US$250,000; (b) public works exceeding US$1 million; and (c) consulting services at US$200,000 or more. Works and services that will be financed by the CDB will be procured independently according to the procurement rules of each respective institution. Annex II includes the Procurement Table.

G. Disbursements

3.21 The following table shows the disbursement schedule by year and by source of funds. All the disbursements will be according to standard Bank procedures.

Table 3.1 Disbursements by year (US$)

SOURCE	2001	2002	2003	2004	TOTAL
IDB	1,743	3,316	3,600	1,141	**9,800**
CDB	422	2,015	1,979	300	**4,716**
EU		600	600	400	**1,600**
GOBL	327	615	627	441	**2,010**
TOTAL	**2,492**	**6,546**	**6,806**	**2,282**	**18,126**
%	**15%**	**36%**	**37%**	**13%**	**100%**

H. Monitoring and Evaluation

3.22 Monitoring and evaluation will be used to identify problems and opportunities, to require changes in implementation plans; or to reset targets. Program supervision will be performed by the Bank's Country Office with the support of the Project Team. Key elements of the monitoring and evaluation program are outlined below.

1. Start-up Workshop

3.23 Immediately after contract signature, the Executing Agency will conduct a Program Start-up Workshop with an agenda previously agreed with the Bank. The Workshop will involve all major participants in the Program, and will present and review the strategies and action plans for implementation.

2. Annual and Mid-term Reviews

3.24 Throughout the program execution period, the executing agency and the Bank shall carry out annual reviews of the program, the first review being held one year after the date of loan signature. Participants shall include the Ministry of Health, representatives of the Steering Committee, the Program Manager, the PMU and the Bank and will take the form of one or two-day meetings. The reviews will cover compliance by the SSB with the financial and organizational rules and performance contracts, the availability of counterpart resources, progress in achievement of project objectives and key performance indicators.

3.25 If as a result of the annual reviews and audits and the concurrent audits mentioned in paragraph 3.19 the Bank determines that the financial and organizational rules and performance agreements are not followed by the SSB, that adequate counterpart resources are not provided, and/or there is inadequate progress in achievement of key performance indicators, the Bank may withhold support for all new activities and of all new calls for bidding, price competitions, and any other form of contracting for the procurement of goods or services to be financed with resources of the loan, until adequate measures have been taken, to the Bank's satisfaction, to correct the situation.

3.26 The Terms of Reference for Annual Reviews and mid-term evaluation will be included in the Operation Manual.

3. Final evaluation

3.27 A Final Evaluation of the Program will be undertaken jointly by the GOBL and the Bank within six months of final disbursement. This will assess the Program's success in reforming key aspects of the health sector in relation to the Programs' original objectives and strategies, and those developed through Annual Reviews and the Mid-term Evaluation.

3.28 Preparation for this Final Evaluation will be completed by the Policy and Planning Unit during the last year of the Project and will provide useful basis for guiding continuing reform and development of the sector. In addition, this preparatory work will identify key areas for further reform and any needs for further financial or technical support and cooperation. A document recording this Final Evaluation will be produced within three months of the Evaluation meeting. This document will incorporate all the preparatory work agreed to and approved by the ex-post Evaluation.

I. External Audit

3.29 The executing agency will present annual financial statements on the expenditure of loan funds to the Bank. These statements will be submitted within four months of the close of each fiscal year and will be certified by a firm of independent public accountants acceptable to the Bank.

IV. VIABILITY, BENEFITS AND RISKS

A. Introduction

4.1 The proposed Program will be implemented within a fairly favorable political context given that the GOBL has identified improvement of the health sector as a very high priority. The new government was elected recently on the basis of a manifesto that promised improvements in the quality of health services through national health insurance. Since then, the GOBL has endorsed the directions of the reform program and has added further commitment to public sector reform and to a national health insurance system of financing that is consonant with the government's economic and social policies. Project financial design has taken into consideration the challenges for the country's small-scale and vulnerable economy by relying on a small ordinary capital loan articulated to concessional funding and grants.

4.2 Long-term sustainability will rely heavily on the capacity of the government to enforce accomplishment of the payroll tax as a source of funds for the pivotal role the NHIF will play, and simultaneously maintain or increment fiscal resources to subsidize insurance for the poor. As important as the above, will be the participation of the private sector, which will rely fundamentally on the stability and credibility of the delineated and implemented regulatory framework.

4.3 The PPU of the MoH has been strengthened through a Technical Cooperation operation to assume executing responsibility. Given the scarcity of trained personnel, long-term technical assistance is a key component of Program strategy. The sector reform Program requires support and action from the Cabinet and key ministries. Changes in financing arrangements and human resources are two key areas requiring such support. For this reason, a Health Sector Reform Steering Committee will direct the Program with senior representation from the two relevant ministries in addition to the MoH.

B. Technical Viability

4.4 The Program derives from the known weaknesses of the sector. These primarily are not related to insufficient resources, but more with incentives created by the prevailing organizational structures within which services are delivered and providers are paid. The Program is based on introducing changes to those structures: making KHMH autonomous; deconcentrating some managerial authority in the remaining public sector; and promoting and regulating the private sector. At the same time, services are to be rationalized to raise quality and productivity. A key new role for the MoH will be that of communications focused on encouraging behavioral change in the population. In addition, steps are to be taken to create a sustainable sector financing system with built-in incentives to spend public finance more cost-effectively. There are precedents in other countries for all these Components and the technical assistance and training

components of the Program will ensure that lessons learned from these are applied in Belize.

C. Environmental Viability

4.5 The Project involves minimal environmental impact. Impact is almost entirely confined to the rehabilitation of existing buildings. No surplus equipment disposal is expected. However, some specific measures will be taken, as follows: (i) the project will finance the design of environment protection measures, or EPM, to be added to the TOR for contracting rehabilitation of facilities in turn-key contracts, (ii) the PMU will obtain environmental licenses before starting all the bidding processes for construction works, (iii) a common strategy for hospital and domestic type disposal will serve as a basis for the definition of the EPM mentioned in item (i) (to be devised by consultants) and will take into account public health legislation currently in place, (iv) legislative review with an output that will include a review of the need for up-dated environmental regulation and enforcement methods, and (v) pilots for the development of purchasing skills. In this latter case, private contracts will make mandatory the implementation of waste disposal measures concordant with the current legislation.

D. Economic and Fiscal Analysis

4.6 Financial projections indicate that once service reforms and rationalization are in place, the total services required for the population could be provided for an expenditure of US$14.2m per year in the public sector plus a private out-of-pocket expenditure of US$13.3m (1997 prices). This compares with US$14m actually spent by the public sector (MoH) in 1998, plus US$19.5m out of pocket. In theory, an efficient purchasing agency spending US$28m per year and purchasing from a combination of public and private providers, including overseas providers, would provide the population of Belize with a full range of services of acceptable quality.

4.7 Those projections are based on expectations of compliance with the new financing mechanism[15]. For the formal private sector a compliance rate of 55% is expected and for the self-employed the expected compliance is 25%. Currently, the compliance rate for contributions to the pension fund run by the SSB is around 80%. Incentives for paying contributions to the pension fund are relatively higher than health insurance payments. This is due to the fact that the amount of contributions will be a determinant factor for the calculation of benefits at retirement, whereas affiliates to the health insurance plan will receive similar services regardless of the amount contributed. Those compliance goals will become key points to be evaluated during Annual Reviews.

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[15] 1999. Schenone, O.Belize: National Health Insurance: Financing

4.8 Revenue projections for NHIF based on conservative assumptions about contribution levels and compliance rates indicate that the GOBL will have to continue contributing the equivalent of the MoH budget in real terms, to the NHIF fund in the start-up year. This would rapidly decline after two or three years as compliance rates improved, and national health insurance could be self-financing within five or six years after start-up.

E. Benefits

4.9 The program will enable GOBL to achieve better health status for the population and better value for money spent through the public purse and individuals. These overall benefits will be achieved through strengthened public policy making, the establishment of a strong purchasing capacity to spend public resources on the best available public and private services, and strengthened regulation. These reforms will reallocate expenditures to priority beneficiaries (women and the poor) and to priority services; reallocations prevented in the past by fixed costs, public service rigidities, and inefficient and inequitable out-of pocket expenditures by the poorest segments of the population. By pooling resources, a strong purchaser of services will act on behalf of the population to purchase high quality services, and to avoid the burden imposed on the system by individual negotiations.

4.10 The ultimate beneficiary will be the population at large. Health care consumers will have affordable access to higher quality care and more competitive services both in public and private sectors. Providers of care will also benefit in the following ways:

i. public sector staff will participate in more responsive deconcentrated management and from fairer training;
ii. some public sector staff will join a new statutory authority with new terms and conditions of employment and opportunities for more rewards and job satisfaction; and
iii. private providers will have new market opportunities to provide services to defined groups of the public whilst receiving payment from public finances.

F. Social Equity and Poverty Reduction Classification

4.11 The project does not specify explicit performance indicators to measure poverty reduction. Regarding social equity enhancement, the project specifies explicit performance indicators (See par. 2.18 and Annex II).

4.12 **Impact on Priority Groups: The Poor**. Although not primarily a poverty reduction program, health sector reform will have a major positive impact on the poor. The government will pay a subsidy to the newly created NHIF to enroll and provide services to the poor. Currently, the poor are restricted to a low quality public service or, if they venture into the private sector, are likely to suffer serious consequences for family finances without assuring quality. The program will

significantly raise the quality of care available to the poor. First contact care will be strengthened through training and increased provision of general practitioners in selected health centers. Hospital services will be rationalized, providing larger groups of staff and higher activity levels. Specific problems of accessibility will be alleviated by transportation support.

4.13 There will be minimal charges at the point of service delivery: a small co-payment may be introduced as the financing system develops and as services improve. This will be a flat rate aimed at deterring frivolous use of services. It will not be based in the economic costs of producing the services needed and received.

4.14 **Women**. The program is designed to maximize the health impact on the population: efforts will be focused on high priority problems for which there is effective health care intervention available. One of the highest priorities concerns women's health and particularly reproductive health, in its widest sense. High maternal mortality will be reduced through the consolidation of obstetric services into higher quality. Well-practiced units and transportation support will ensure better access to these services. Strengthened health education and school health services will be focused on increasing reproductive health knowledge and behavioral change. These will be directed not only towards women of childbearing age, but also towards young males and community leaders.

G. Risks

4.15 Political and social pressures may prevent the rationalization of services. To the general public and some of their political leaders, the more hospitals and health centers there are, the better. There is limited understanding of the need to concentrate skilled staff and services in order to improve quality. The program seeks to reduce this risk by improving the quality at remaining service units, delivering some quick, if partial, results, and using communications efforts to ensure the public is aware of improvements.

4.16 In order to provide ample opportunities for consultations with the Civil Society, the Bank is recommending approval of the Loan before the SSB/NHIF is enacted. Although the GOBL is committed to an urgent approval of the legislation, delays cannot be ruled out whenever a consultation process is in place. To mitigate the risk the Bank will support the development and evaluation of the pilot, which will gather information and help build public support.

4.17 Organizational reforms may encounter opposition from interest groups, including civil servants and medical practitioners. Not all public service workers (and their union) may agree that services should become more autonomous or that management within the public service should be transferred and tightened. The program aims to reduce this risk by piloting autonomy, by assisting the management on this change with technical support and by a communications effort.

4.18 The introduction of compulsory and universal health insurance represents the greatest risk. Workers, employers, and the self-employed could resist making new contributions given the low prestige of pubic health services and distrust of government, despite a tradition of relying on government-provided services. To avert this risk, a transparent, autonomous and accountable NHIF agency is being established and collection will be started only once trust has been gained through well-designed public information campaign and pilots.

4.19 A related risk is the possibility of opposition by private medical providers to the purchasing of their services by the NHIF. These providers are used to a liberal, fee-for-service practice that will be threatened. Furthermore, KHMH personnel may see the purchase of some services abroad and partnerships with the private sector as a threat. To avert these risks, the Innovation Fund will be established to demonstrate decisiveness and long-term commitment on the part of government as well as the possibility of increasing private markets, albeit under a more regulated environment.

4.20 The financial viability of the program requires implementation of all parts of the Program; implementing new components without corresponding cost containment efforts will spread available recurrent finance too thinly and will result in an under-funding of key elements. The program aims to address this risk by linking capital investment to organizational and service delivery changes, and through review mechanisms and technical assistance.

4.21 A new payroll contribution may produce an undesirable effect on the labor market and on the competitiveness of the country. Furthermore, the revenue model under which the financial component of the Program is based may suffer distortions and revenue collection may become short. The periodic assessment of labor market performance will provide information to the GOBL and the Bank in such a way that proper and timely measures can be taken to make adjustments. The communication strategy the Program is supporting will offer a clear sign that the new contribution is obtaining solid and tangible improvements in health care access and quality and therefore paying contributions will be perceived by the population as a reasonable and economically wise decision.

LOGICAL FRAMEWORK
BELIZE
HEALTH SECTOR REFORM PROGRAM (BL-0014)

rative Summary	Performance Indicators	Means of Verification	Important Assumptions
ect Goals			Sustainability
Contribute to improving he health status of the population.			a. GOB redirects current (200 funding from curative servi
ect Purpose			Purpose to Goal
lity, efficiency and ity of health services roved.	1.1 100% of population has "adequate" physical and financial accessibility to health services by 2005. 1.2 Client satisfaction increases from X% in 2001 to Y % in 2005. 1.3 Nosocomial infections reduced by 50% in each hospital by 2005. 1.4 Perinatal mortality decreases from X% in 1998 to Y% in 2004. 1.5 Average throughput meets defined standards by end of 2001. 1.6 No. of cholera cases decreases from 12 in 1999 to 0 in 2005. (Quantification of indicators to be completed by the Initial Report)	1.1.1 Quality of life survey report 1.2.1 Annual statistical report	a.
ject Outputs			Output to Purpose
Ministry of Health restructured and capacity strengthening plan implemented.	1.1 Central MOH refocused toward policy and regulation, and no longer providing health services directly, by 2004. 1.2 Regulatory framework established and functioning, by end of 2001. 1.3 MOH restructured and staff trained, by 2004. 1.4 Karl Heusner Memorial Hospital is autonomous, by June 2000. 1.5 Four Health Regions established, each with autonomy with regard to human resources, financial management, provision of services, and contracting by 2004.	1.2.1 Annual review report 1.3.1 Copies of legislation	a. The 2000 Budget of the MOH remains constant i real terms during the project's implementation period. b. Parliament approves the establishment of the NHI by mid-2000. c. (Parliament approves a payroll tax of minimum 4% by the end of 2000). d. Health care providers

rrative Summary	Performance Indicators	Means of Verification	Important Assumptions
			cooperate and support th project.*
Plan for improvement and rationalization of health services implemented.	2.1 Three Regional Hospitals established, services expanded and managed under performance agreements between hospitals and Regional Managers, by end of 2001.		e. Minimum of 80% of the population registers with SSB by September 2000
	2.2 Three Community Hospitals in operation, by end of 2001.		f. Bi-national health agreements are effectivel maintained and policed.
	2.3 Services redistributed as per Technical Note, by 2004.		g. GOB redirects current (2000) funding from cur services to preventive services.
	2.4 Systems for assessing health needs and health care seeking behavior established and used for priority setting, by 2004.	2.4.1 Report of survey	
	2.5 Public health education program developed and implemented by 2004.	2.5.1 Annual review report	
	2.6 Buildings refurnished and equipment installed and operating, by 2004.		
Health sector financing strategy developed and implemented.	3.1 NHIF legally established under SSB and is prime financial instrument and purchaser of personal health services from public and private sectors, by end of 2004.	3.1.1 Copies of legislation	
	3.2 Payroll contributions for NHI reach 45% of total income, by 2004.	3.2.1 Concurrent auditing report	
	3.3 The compliance rate for payroll tax is 55% for the formal sector and 25% of the self-employed, by 2003.	3.3.1 Annual review report	
	3.4 All NHIF purchases are carried out according to standard procedures and use a standard performance contract, by end of 2001.		
(Project management)	4.1 NHI Policy Committee functions and meets regularly, as of end-2000.	4.1.1 Minutes of the Committee	

HEALTH SECTOR REFORM PROGRAM
BL-0014
SCHEDULE OF PROCUREMENT AND BIDDING

Main Procurement	US$ (000)	Method	Pre-qualification Requirements	Publications
A. Civil works	**2,848**			
RHMT Offices at Belmopan	130	LB	NO	IV/2001
Regional Hospital at Belmopan	1,000	ICB	YES	IV/2001
Community Hospital at San Ignacio	300	LB	NO	I/2002
RHMT Offices at Orange Walk	130	LB	NO	IV/2001
Regional Hospital at Orange Walk	100	LB	NO	IV/2001
Community Hospital at Corozol	113	LB	NO	I/2002
Community Hospital at Punta Gorda	70	LB	NO	I/2002
New Psychiatric Unit at KHMH	1,005	LB	YES	I/2002
B. Goods	**2,443**			
Computing equipment	230	LB	NO	IV/2001
Vehicles and ambulances	300	ICB	NO	IV/2001
Equipment and furniture	1,359	ICB	YES	I/2002
Medical equipment	429	ICB	YES	I/2002
Central Laboratory Equipment	125	LB	NO	I/2002
C. Consulting Services	**1,017**			
Services Rationalization and Improvement (Studies, Technical assistance, monitoring and consulting)	90	LB	NO	IV/2001
Technical assistance (Hospital management)	163	LB	NO	I/2002
Services Rationalization and Improvement (Studies,Technical assistance, monitoring and consulting)	20	LB	NO	IV/2001
National Programs (Performance contracts, Pharmaceutical study)	145	LB	NO	II/2001
Support to the National Health Insurance Fund (NHIF)				
• Design performance contracts	20	LB	NO	III/2001
• Labor Market Assessment Mechanism	38	LB	NO	III/2001
• National Income and Expenditure Survey	88	LB	NO	V/2001
• System of poor population's identification	86	LB	NO	V/2001
• Financial Modeling/Simulation	50	LB	NO	VI/2001
• Financial and Management Control Systems	50	LB	NO	VI/2001
Programme Management Unit (PMU) Administration, Monitoring and Evaluations	268	LB	NO	II/2001
C. Consulting Services (Training)	**82**			III/2001
PPU Orientation Workshops	50	LB	NO	III/2001
Piloting autonomy with Karl Heusner Memorial Hospital Authority (KHMA)	27	LB	NO	III/2001
Monitoring & Evaluation	5	LB	NO	IV/2001

ICB International Competition Bidding
LB Local Bidding

RGII-BL041P
BL-0014
Original: English

PROPOSED RESOLUTION

BELIZE. LOAN No. ___/OC-BL TO BELIZE

(Health Sector Reform Program)

The Board of Executive Directors

RESOLVES:

That the President of the Bank, or such representative as he shall designate, is authorized, in the name and on behalf of the Bank, to enter into such contract or contracts as may be necessary with Belize, as Borrower, for the purpose of granting it a financing to cooperate in the execution of a Health Sector Reform Program. Such financing will be for the amount of up to US$9,800,000 from the resources of the Single Currency Facility of the Bank's Ordinary Capital, and will be subject to the "Special Contractual Conditions" and the "Financial Terms and Conditions" of the Executive Summary of the Loan Proposal.