DESIGN AND IMPLEMENTATION OF HEALTH POLICY REFORMS
(TC-94-03-099)

EXECUTIVE SUMMARY

REQUESTER: Ministry of Economic Development

EXECUTING AGENCY: Ministry of Health

BENEFICIARIES: Government of Belize
Ministry of Health

FINANCING:

IDB:	US$1,800,000 (SF)
Local counterpart funding:	US$ 200,000
Total:	US$2,000,000

TERMS:

Execution period:	3 years
Disbursement period:	4 years

ENVIRONMENTAL CLASSIFICATION: The Environmental Management Committee, at its meeting of June 23, 1994, classified this as a Category II operation.

OBJECTIVES: The objectives of this operation are to increase the ability of the Belizean Ministry of Health to identify, design and evaluate strategies and policies to improve the efficiency, equity, and quality of the health care system.

DESCRIPTION: The technical cooperation includes three components: technical assistance for design and implementation of policy reforms; (2) training; and (3) preparation of an investment project. A Project Coordinator and a team of consultants will be contracted to provide technical assistance to the Government of Belize in designing and implementing health policy reform, and to manage a training component with both formal and informal training opportunities. The consultant team will include one long-term advisor who will reside in Belize supplemented by short-term consultants who will take responsibility for specific issue areas and analyses. On-the-job training will pair each of the consultants with the appropriate corresponding officer. Seminars and workshops for building consensus and imparting technical knowledge will be implemented in conjunction with specific reforms. Some short-term overseas training is included.

BENEFITS: The project will increase the capability of MOH to carry out strategic planning, management and policy analysis which would lead to increased efficiency, equity and quality of services.

RISKS:

The primary risk of the project is that substantial effort will go into the design of reforms, but actual implementation does not occur. In order to ameliorate this risk, the project includes opportunities for accumlating sufficient political and popular support, and the use of pilot tests to ease into new policies or systems or try out alternatives on a smaller scale before moving into national systems.

THE BANK'S COUNTRY STRATEGY:

The Bank's country strategy has identified the health and education sectors together with the lack of infrastructure as Belize's most significant development constraints. Prior to any additional investments in the health sector, however, broad reforms of the health sector must begin in order to improve the allocation of resources and address equity and delivery issues.

SPECIAL CONDITIONS:

The timing of project start-up will be specified in the respective agreement, as follows: Prior to first disbursement the GOB/MOH will convoke a policy roundtable to prioritize the reform agenda (para 3.8) and will present the TOR and contract to be signed with the Project Coordinator for IDB approval (para 5.5); the Project Coordinator will be contracted within 4 months and a consultant firm within 6 months of the date of the agreement (3.28), both subject to selection procedures, TOR and contracts acceptable to the Bank (paras 3.22, 3.24, and 3.26). GOB/MOH shall ensure the availability of local counterpart personnel to work with the consultant firm during the project (para 5.3).

To ensure clear and identifiable progression from the design of policy reforms to their implementation, the agreement will include special GOB/MOH obligations related to the timing between completion of the design of reforms; selection of options; implementation plan; and removal of any obstacles and the establishment of the institutional framework to implement reforms, with significant progress in the latter activities demonstrated to the satisfaction of the Bank as a condition for disbursing funds for implementation activities (para 3.29). A mid-term assessment of the project will take place within 9-12 months of the date of consultant firm contract (para 4.2).

I. BACKGROUND

A. Health Status Indicators and context of the Proposed Operation

1.1 Despite a growing and relatively high mortality associated with heart disease, hypertension, diabetes, and cancer, infectious and communicable diseases and malnutrition are still widely prevalent. In 1991, the infant mortality rate was estimated at 35 per 1,000 live births, and maternal mortality at 19.4 deaths per 10,000 live births. an influx of immigration populations, with different cultural backgrounds and inability to communicate in English, has contributed to Belize's health and medical problems.

1.2 The Government of Belize (GOB) and the Ministry of Health (MOH) are committed to the concept that health is a fundamental right and to ensuring equal access for equal need. Under pressure from a rapidly-growing population, influx of immigrants, an ineffective organization the public health system is rapidly deteriorating in quality and quantity.

1.3 Policy makers are aware they face a critical juncture. They must either undertake major health sector reforms, which most likely imply a shift away from socialized medicine as currently practiced, or face the political risk of a further deterioration. The proposed technical cooperation would provide policy makers with the technical tools needed to design and implement reforms aimed at improving the equity and efficiency of health care service delivery in Belize.

B. Health Infrastructure

1.4 The Ministry of Health is the government entity responsible for administering and providing all public health services in Belize. The health system consists of one national or referral hospital, six district hospitals, nine urban health centers, and over 40 rural health centers and posts. These facilities are staffed by approximately 760 personnel employed by the Ministry of Health. The health system is also complemented by a large cadre of almost 500 voluntary or part-time staff, and by private voluntary organizations (PVOs), non-governmental organizations (NGOs), religious groups, which largely underwrite the costs of primary health care, preventive and vector control programs, and private sector enterprises which offer specialized services to private patients.

1.5 The recurrent budget for health for the 1993/94 fiscal year

totalled BZ$20.8 million (US$10.4 million), approximately 10 percent of total government spending. Of this amount, 75 percent was directed toward personnel costs, with 17 percent allocated to materials and supplies, and 4 percent each to travel and maintenance. This budgetary allocation represents per capita health spending in Belize of approximately US$50.

1.6 For FY 93/94, Government of Belize (GOB) capital expenditures in the health sector totalled the equivalent of US$395,000, less than one percent of total GOB capital spending. External donors, including PAHO, USAID, the European Union and the European Development Fund, contributed US$9.6 million, or almost one fourth of total donor aid to the GOB.

C. Health Policy Issues and Constraints

1.7 The Belizean health system has already been well-studied. Previous analyses diagnosed the problems and suggested areas for reforms 1/. From these studies and recent missions to Belize in March and May 1994, the Bank has identified critical issues which jeopardize the public health system's ability to deliver health care services of adequate quality. These problems are: sector financing, allocation of resources, public and private sector roles, and quality and equity of health care services.

1. Financing the Health Sector

1.8 The Ministry of Health (MOH) has faced budgetary deficits in recent years. This problem is aggravated by the country's dependence upon outside donors to underwrite preventive care and vector control programs and capital investments in the sector. To make matters worse, cost recovery policies are ineffective. The latter recover less than two percent of
recurrent expenditures. Fees are very low even in relation to worker's salaries, there are high rates of exemptions, and staff have little incentive to collect fees because these are turned over to the Central Treasury. If current

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1/ See, for example, Health Financing and Management in Belize: An Assessment for Belize, a six-volume compendium of technical notes prepared by G. LaForgia, et. al., for U.S.A.I.D., 1991, and Belize Health Sector Assessment, G. LaForgia, Urban Institute, for the Inter-American Development Bank, 1993.

policies were fully enforced, fees would only cover 10% of costs. The reform program needs to address the levels, modalities and process of introducing effective cost recovery.

1.9 The newly-constructed Belize City Hospital (BCH) is scheduled to begin operations in early 1995. It is likely that the new hospital will operate in tandem with the old facility (which accounts for 21% of the sector's operating costs), thus creating significant new burdens on the MOH's already strained operating budget.

1.10 Lastly, there has been discussion of moving to a broader health insurance program for financing the sector, perhaps through the existing social security program. However, population coverage under existing social security is less than 20%, limited to relatively privileged workers, and health benefits are limited to treatment for work-related accidents.

2. Allocation of Health Sector Resources

1.11 There is an absence of resource allocation policy and planning that would allow GOB/MOH to determine the most appropriate and cost effective mix of services, e.g. preventive care vs. curative services, ambulatory care vs. hospital facilities. Resources available to the health sector have been allocated on an ad hoc basis and focused on curative care, personnel costs, and facilities within Belize City. Hospitals have dominated the attention of the MOH, leaving less than 10 percent of budgetary resources available to community and primary health care facilities and staff.

1.12 Many of the sector's resources are used in inefficient ways. Patients often seek unnecessarily high level care, and personnel demonstrate low productivity due to inadequate incentives and training. Moreover, given its small population and economic opportunities overseas, the Belizean health sector faces serious difficulties in attracting, training, and retaining adequate numbers of qualified personnel.

1.13 The sector is also plagued by frequent shortages of supplies and drugs, due in large part to the dominance of wage expenditures within the budgetary allocation. Lack of maintenance has resulted in crumbling infrastructure and

obsolete or inoperative equipment.

3. Public Sector and Private Sector Roles in the Health System

1.14 The roles of the public and private health sectors within the health system are unclear and overlapping. The private practice of medicine is restricted by i) current physician licensing practices and ii) the "free use" of public facilities by government-contracted physicians to attend to their private patients. It is difficult for the MOH to regulate the amount of time public sector physicians dedicate to their private patients rather than their public ones. Specialists admitting private patients to MOH facilities benefit from the subsidized use of public resources. There may also be opportunities for the Ministry of Health to contract out for specific services, thereby using its limited resources in a more cost-effective manner.

4. Quality and Equity of Health Care Services

1.15 There is currently limited access to some MOH services. Some require long waiting periods, unless one gains access through a specialist's private clinic, an avenue usually closed to the poor. Inequitable access also results from a means testing system which appears to protect the well-off rather than the poor. Additionally, there is both a perceived and a real lack of quality of public health services due to resource constraints and inattention to consumer preferences.

1.16 Prospects for reform of the health system are good. GOB and MOH officials understand the critical lack of quality service and equity in the current health care system. They are committed to reform, however, they lack an in-depth planning and policy framework, technical tools, and resources necessary to overhaul the current system. The proposed technical cooperation is designed to provide these elements and center the reform agenda around four broad policy areas. The project design does not predetermine the direction or outcome of the reform process which will be decided by a policy committee within the MOH.

D. Bank strategy

1.17 The Bank's strategy for Belize identifies the health sector as one of the country's most serious social problems. The CPP and PMP, approved by the Programming Committee in July

and August 1993 respectively, recommended that the Bank address the issues of limited coverage of health services and cost recovery through technical cooperation for policy and institutional support.

1.18 The Bank pipeline includes a 1995 loan for a Community Health Services and Education Project (BL-0005) to assist the MOH to develop a sustainable community health program nationwide and a 1997 investment project yet to be identified. The Profile I for the Community Health and Education Project was approved with the PMR on March 23, 1994. 2/ The project would focus on strengthening public health education and training at the community level in order to reduce the incidence of malaria, cholera, and other communicable diseases. It is important, however, that Bank assistance and the MOH resolve financing and management issues which affect the overall framework and strategy for the health system before initiating specific investments in community health programs or individual facility needs. Those needs would be considered within a framework of executed financial and management reforms, and within the context of improved performance of the public health system that should result from this technical cooperation. This conclusion was reached with representatives of the Bank and MOH.

II. OBJECTIVES

2.1 The objectives of this operation are to increase the ability of the Belizean Ministry of Health to identify, design, implement, and evaluate strategies and policies to improve the efficiency, equity, and quality of the health care system. This will be accomplished by providing technical support to the GOB to design and implement policy reforms which seek to address the management and financing issues identified above.

2.2 This technical cooperation also seeks to assist the Government of Belize to prepare a health sector investment project and the required documentation for a loan request to the IDB.

2/ The timing of preparation of BL-0005 will be discussed with authorities later this year.

III. PROJECT DESCRIPTION

A. The Project

3.1 A Project Coordinator and a team of consultants will be contracted to provide technical assistance to the Government in designing and implementing health policy reforms, and to manage a training component with both formal and informal training opportunities. The team will include one long-term advisor who will be based in Belize and serve as the technical liaison with the Ministry of Health. The long-term advisor will be supplemented by other consultants responsibile for specific issue areas and analyses. Terms of reference for the consultant team are in RE2/OD4 files.

3.2 This technical cooperation has three components: (1) technical assistance for design and implementation of policy reforms; (2) training; and (3) preparation of an investment project.

1. Technical Assistance for Design and Implementation of Policy Reforms

3.3 The technical assistance will focus on identifying options for reforms, choosing among alternatives, drawing up implementation plans, and implementing new policies, procedures, and systems. The health policy reform program will concentrate on four major issue areas:

a. **Financing of the health sector**--developing an MOH strategy for financing health services, with a focus on long-term sustainability;
b. **Allocation of health sector resources**--improving the use of financial, human, and material resources;
c. **Public and private sector roles in the health system**--assessing the respective roles the public and private sectors can play;
d. **Improving quality and equity of health services**--removing current inequities and improving the quality of all services provided.

3.4 Design activities will focus on identifying and analyzing concrete policy options. The design process will begin with a policy workshop to prioritize the sequence in which reforms will be addressed. The consultant team, in collaboration with MOH counterparts, will then assess the options and their advantages and disadvantages, and present their conclusions to a group of senior decision-makers in

policy workshops. The design process will conclude with the selection of specific options, and definition of a workplan for implementation.

3.5 Implementation activities will focus on the application of new policies, procedures, and systems. The consultant team will work closely with MOH counterparts to carry out the implementation plan. Work at this stage may include pilot tests of new procedures or policies, as a means of evaluating their viability on a small scale, while minimizing risks, prior to nationwide implementation. The policy implementation process will emphasize hands-on training and experience for MOH staff.

2. Training

3.6 This technical cooperation includes a training component, with both formal and informal training opportunities. It will involve both classroom training (short-term courses), in Belize and abroad, and on-the-job training, which will focus on developing Ministry of Health capabilities in strategic planning and analytical decision-making for the health sector. Areas of formal training will be defined as the technical cooperation is carried out, but are likely to include health economics and financing, financial management, quality assurance, and health insurance.

3. Preparation of health sector investment project

3.7 This technical cooperation includes US$100,000 for the preparation costs of a health sector investment project for 1997 which would be a logical outcome of the reform process. The terms of reference, cost estimates, timing, and consultant candidates will be submitted for the Bank's approval prior to contracting the study or work to be carried out.

B. Activities

1. Technical Assistance for Design and Implementation of Policy Reforms

3.8 Technical support for designing sector reforms will concentrate on developing and analyzing specific policy options. The workplan for the project, including priorities and sequencing of the reform agenda, will be developed during a policy workshop convened by MOH as a condition precedent to first disbursement of the technical cooperation (IDB technical staff will participate in this

policy workshop). Subsequently, the first phase of the technical cooperation will emphasize analytical studies as needed to develop concrete proposals, policy dialogue to reach consensus within the MOH and with other ministries and relevant entities, and definition of required steps for implementation of new policies or procedures. The technical assistance for implementing sector reforms will focus on trying out new systems and policies, possibly on a pilot test basis initially, and revising them as needed prior to nationwide implementation.

3.9 The progression from design to implementation of policy reforms is an important aspect of this technical cooperation. The design phase ends with the preparation of policy options to the MOH Policy Committee, selection of a policy option and definition of an implementation plan. It will be critical that the GOB/MOH take the necessary steps to move forward. This may include passage of new legislation, adoption of new policies, or establishment of new functional authorities. While it is not possible to define those specific steps now, these will become apparent when an implementation plan is drawn up. As a precondition for disbursement of funds for any implementation activities related to each specific reform, the MOH will demonstrate to the satisfaction of the Bank that significant progress has been achieved in removing any obstacles to the policy reforms, and in establishing the institutional framework required for the reform process.

3.10 Illustrative examples of design and implementation activities to be carried out include the following:

a. Execution of actuarial studies to assess the implications of extending social security coverage.
b. Assessment of current human resources constraints for the health sector, and development of medium- and long-term plans.
c. Assessment of the current legal/regulatory framework for the health sector and establishment of a public/private strategy.
d. Development of a feasible and effective means testing mechanism to ensure that the poor have access to health services.
e. Implementation of a public information campaign to raise awareness about the need for and benefits of a new cost recovery system.
f. Installation of improved financial and accounting systems at selected facilities.
g. Pilot tests of private sector contracts for the

provision of specific health care or ancillary services.

h. Implementation of a quality assurance and maintenance program at public health facilities.

3.11 The products of this component would include: an overall medium-and long term strategy for the health sector; plans for implementing and evaluating specific policy reforms; improved management and decision-making systems within the MOH and within the public facilities (hospitals, clinics, etc. it manages; strengthened analytical and planning capacity within the MOH; pilot tests of policy reforms, to be applied to the design of national policies; and improved maintenance of MOH equipment and resources.

3.12 The design and implementation of policy reforms to be supported under this technical cooperation requires 94 person-months of consultant services, including long- and short-term technical assistance, and project coordination services over a period of three years. Approximately $25,000 of computing equipment will be acquired in the early months of the project, for use by the Project Coordinator, the consultant team(s), and MOH counterparts. Equipment needs will be defined by the Project Coordinator and the MOH Policy Committee, and subject to IDB approval. The Project Coordinator will be responsible for procurement. Upon conclusion of the Technical Cooperation, all equipment will be transferred to the GOB/MOH.

2. Training

3.13 The consultant team and counterparts will develop an overall training plan, which asseses needs and priority areas, identifies criteria for selection of candidates, establishes a selection process, and determines appropriate sites for training. The training plan will be reviewed and approved by the MOH and the IDB prior to commencement of training activities. Selection of individuals will be done by the long-term advisor, the Project Coordinator, and the MOH Policy Committee.

3.14 Formal training will include 12 short-term courses of overseas training, in health economics, health planning, health management and administration, quality assurance, or other priority areas. The courses will be of three to six weeks duration, and will emphasize practical, hands-on training.

3.15 In-country training will include approximately four policy

workshops and four implementation workshops. The policy workshops will provide a forum for discussion of the technical, administrative, and political aspects of policy options, and will conclude with selection of a specific policy option. They will be attended by personnel from the MOH and other relevant ministries (e.g., Finance, Economic Development, Human Resources Development), and from other public and private sector entities involved in the policy reform process, such as the Medical Association, or the Social Security Board.

3.16 The implementation workshops will provide specific, hands-on training in high priority areas for health sector personnel involved in new procedures or systems. These may cover, for example, cost recovery, budgeting, health insurance, and quality assurance. Each of these workshops will involve approximately 12 MOH staff for one week. As a result of these workshops, key MOH personnel will be trained to implement new systems, and in turn, will be able to train other MOH staff.

3.17 The technical cooperation will emphasize on-the-job training provided by the consultant team to MOH counterparts. Each person-month of consultant effort will be matched by one person-month of counterpart effort, and the consultants' contracts will explicitly stipulate that their activities involve transfer of knowledge to and training of counterparts.

3.18 The general products of this component will include: trained personnel in key areas, including strategic planning, policy analysis, and management. Specific results will include: 12 persons trained in short- and medium-term training programs overseas; 20 persons trained through policy workshops; 48 persons trained through implementation workshops; and 80 person-months of on-the-job training to counterparts.

3.19 The training component will require a total of 8 person-months of consultant services, which will cover both in-country technical workshops and administration of the overseas fellowships. It will also involve 44 person-months of MOH staff participating in formal training process (policy and implementation workshops, overseas training) and 80 person-months of MOH staff receiving on-the-job training.

3. Project Preparation

3.20 In later stages of the reform process, an investment project will be jointly identified and prepared for IDB consideration. Project preparatory work would include, among other things, technical preparation, feasibility studies and environmental impact assessment.

C. Project Execution

3.21 The Executing Agency will be the Ministry of Health (MOH). The responsibility of MOH will be to ensure this technical assistance support is translated into policy reform (see para 3.28). MOH will identify and contract a Project Coordinator according to Bank policies and acceptable to the Bank; provide local counterpart funding for offices, local transportation and administrative support (detailed in Annex A) for the entire period of project implementation; and ensure the participation of local counterpart staff and training participants, as agreed with the Bank. Through the Project Coordinator, the MOH shall be responsible for the identification and contracting of the consultant firm (or firms if so approved by the Bank), according to Bank procedures and acceptable to the Bank; timely presentation of reports; proper control and use of Bank funds and overall supervision of the project.

3.22 The Project Coordinator will be responsible for general management of the Technical Cooperation, including coordinating meetings, organizing the work program and carrying out project administration duties. The Coordinator will oversee the process of hiring and installing the consultant firmor firms and will have support staff and resources provided by MOH and equipment provided with Bank resources. The candidate for Coordinator, the contract between MOH and the candidate, and the Terms of Reference for the Coordinator (Annex B) shall be subject to prior IDB approval.

3.23 The project will be implemented by a team comprising MOH management, a consultant firm (or firms as agreed within the Bank), and a Project Coordinator. Because of the size of MOH management and the traditional collaborative management style among staff, virtually all of MOH senior management will have roles in the policy reform process. Each will participate in Technical Cooperation activities as determined by his or her area of technical responsibility.

3.24 The consultant firm(s) will provide the technical support required for this Technical Cooperation, including both a long-term advisor based in Belize and short-term consultants to focus on specific policy issues. The services of consulting firm(s) will be secured through procedures acceptable to the IDB, with an anticipated total contract period of 30 months.

3.25 The primary counterparts for the consultant team's long-term advisor will be the MOH's Policy Committee, comprising the Minister of Health, the Permanent Secretary, the Director of Health Services, the Principal Nursing Officer, and the Director of Community Programs. Counterparts for the short-term consultants will be jointly selected by the Policy Committee, the Project Coordinator, and the long-term advisor.

3.26 The contract for consultant services will specify procedures to be followed by the consulting firm and the GOB/MOH relative to approving terms of reference, candidates, and timing for individual assignments. This contract between the GOB and the firm(s) shall be approved by the Bank as a condition prior to contracting the consultant firm(s).

3.27 The contract with the consulting firm(s) will stipulate that it provide a basic package of services to implement the training component, including organization and delivery of four policy workshops and four implementation workshops, administration of 12 overseas fellowships (including selection, travel, and stipend arrangements), and commitment to ensure on-the-job training for MOH counterparts. Training activities beyond the basic package would be subject to additional negotiations between the MOH and the consultant firm(s), and to IDB approval.

3.28 The implementation of the project according to the following schedule will be part of the conditions included in the respective technical cooperation agreement: Contracting of Project Coordinator, 4 months from the date of the agreement; contracting and work initiation by the consultant firm, 6 months from the date of the agreement; execution period for consultant firm work, 30 months from the date of its contract with GON/MOH; final report, 38 months from the date of the agreement; presentation of last disbursement request, 40 months from the date of the agreement.

3.29 It is important that there be a clear and identifiable

progression from design of policy reforms to their implementation as part of this technical cooperation. In each of the technical areas, as the consultants complete the design studies, a draft report outlining policy options will be presented to the MOH and the IDB for review. The time required for the design phase will vary for each reform issue on the agenda and may be as short as one week and as long as one year. Within 30 days, a policy workshop will be held to discuss the options. A specific option will be selected at this workshop (or in a subsequent one if additional technical work is required to reach consensus). Within 30 days of completion of the design phase and selection of an option, the MOH and the consultant team will define the implementation plan, outlining specific steps to be taken, their costs, and their timing. A copy of this implementation plan will be provided to the IDB, and technical comments, if any, will be provided within 30 days. If the definition of specific steps to be taken includes concrete actions by the GOB (e.g., revised legislation, new policy directives, assignment of personnel), the GOB/MOH will demonstrate to the Bank, within 60 days from completion of the implementation plan, that such steps have been taken to permit implementation of policy reforms. Funding for implementation activities from the proposed technical cooperation resources for each reform will be available upon presentation to and acceptance by the IDB of such evidence.

IV. REPORTING AND MONITORING

4.1 Monitoring of this project will take place through both regularly scheduled progress reports and technical reports as they are completed.

4.2 The Project Coordinator will submit semi-annual progress reports, documenting technical assistance and training activities during the preceding six months, issues, planned next steps, and any variations from the annual and overall project workplans. These reports will be submitted to the IDB within 30 days of completion of a six month period. A formal mid-term assessment of the technical cooperation will take place 9 to 12 months after the signing of the consultant contract. This mid-term assessment will evaluate progress made to date, and determine if any adjustments are required. The consultants will produce a draft final report summarizing the results of the technical cooperation, which will be submitted to the IDB for approval within 30 days of completion of activities. IDB

comments will be incorporated into a final version no later than two weeks after receipt of comments.

4.3 Because the pace of design and implementation will vary for the different issues, monitoring of each will be done through the progress reports and through technical reports. The consultants will provide the Bank and the MOH with draft technical reports detailing policy options. Bank comments should be incorporated within two weeks of receipt of comments. The MOH will review consultant reports and recommendations, and will present its opinions or alternative recommendations at the relevant policy workshop.

4.4 The executing agency will present annual independently audited financial reports on the uses of the contribution of the Bank and local counterpart funds. The audited statement will be presented within 90 days of the close of each fiscal year, according to procedures acceptable to the Bank.

V. COST

5.1 The cost of this three-year technical cooperation is estimated at $2.0 million, of which $1.8 million would be provided by the Bank, and $200,000 by the Government of Belize. These funds will finance 95 person-months of consulting services and 124 person-months of training support as part of the design and implementation of policy reform. This amount also includes $100,000 for preparation of an eventual investment project. Bank support will be provided on a non-reimbursable basis from the net income of the Fund for Special Operations (FSO).

5.2 The cost for each of the major components of the technical cooperation is summarized below. Details are shown in Annex A.

COMPONENT	IDB US$000	GOB US$000	TOTAL US$000
Technical Assistance	1,400	155	1,555
Training	300	45	345
Project Preparation	100		100
TOTAL	1,800	200	2,000

5.3 The Bank contribution will finance honoraria, transport, per diem, fellowships, and basic equipment. The national counterpart funding will cover the cost of office space, vehicle operating costs, secretarial and logistic support, office supplies, other local costs and provide local counterparts for the project. To ensure that the project remain a product of Belizean effort and that on-the-job training takes place, the agreement with the GOB will contain a specific contractual clause requiring the GOB/MOH to ensure the availability of appropriate local counterpart staff (estimated at 80 person-months over the three year period) to work with the consultant team.

5.4 The disbursements of the Bank's contribution, with the exception of the amount set aside for contingencies and US$100,000 for project preparation, will be administered by the MOH through the office of the Project Coordinator. Upon written request of MOH, the Bank may establish a revolving fund up to the equivalent of US$220,000 which represents approximately 10% of the Bank contribution, excluding contingencies and the amount set aside to contract for preparation of the investment project.

5.5 Prior to the request for first disbursement of Bank resources, the GON/MOH should present, to the satisfaction of the Bank, the following: a) a written communication indicating that the person or persons who will represent the GON in all communications with the Bank related to implementation of the project; b) a written request for disbursement of the revolving fund; c) the TOR and the draft contract to be signed with Project Coordinator and d) convene a sector workshop to initiate the reform process.

VI. BENEFITS AND RISKS

6.1 The expected results from this technical cooperation are increased MOH capability to carry out strategic planning, management, and policy analysis. These capabilities will lead to improved and sustainable policies resulting in increased efficiency, equity, and quality of services. Specific achievements might include design and implementation of an improved cost recovery system, establishment of a plan for long-term development of human resources, and examination of the potential for increasing non-governmental provision of health services.

6.2 The beneficiaries of this technical cooperation include the GOB and MOH, who will benefit from a more efficiently managed health system that may be less reliant on

government financing. Health care workers will benefit from training opportunities and improved management. Businesses and entrepreneurs may benefit from opportunities to expand private sector involvement in the health sector. The ultimate beneficiaries will be health care consumers who will have greater access to better quality services. In particular, disadvantaged populations including women, children, the elderly, and the poor, the primary users of publicly-provided health care services, will stand to benefit.

6.3 The primary risk of the project is that substantial effort will go into the design of reforms, but that implementation will not occur. However, this risk is small for several reasons: First, the design phase will build into the policy analysis process opportunities for accumulating sufficient political and popular support. Second, the use of pilot tests during implementation will help the GOB to ease into new policies or systems, by allowing it to try out alternatives on a small scale and learning from experience, before moving on the national level. Third, the presence of a long-term advisor within the Ministry of Health to work with the Policy Committee will help to keep the policy reform issues on the table, and to provide technical assistance in drafting new legislation or memoranda to the Cabinet, as appropriate.

Belize Health Policy Reform Technical Cooperation
Overall Budget
(In US$)

	Item	Total Cost	IDB	GOB
1.0.	Professional services firm(s)	1,217,000	1,217,000	
1.1.	Fees, travel costs 1/	652,000	652,000	
1.9	Overhead (150% of fees)	565,000	565,000	
2.2.	Consultant-Project Coordinator	105,000	105,000	
3.0.	Participant Training	116,000	84,000	32,000
3.1.	Overseas fellowships	60,000	60,000	
3.3.1.1.	International travel	12,000	12,000	
3.3.1.2.	Intl per diem/stipend	12,000	12,000	
3.3.2.1.	Local travel	8,000		8,000
3.3.2.2.	Local per diem	8,000		8,000
3.5.	Materials	16,000		16,000
6.0.	General Support	224,750	99,250	125,500
6.1.	Office rental	50,000		50,000
6.3.	Equipment-vehicles	40,000	40,000	
6.3.	Equipment-computers	16,000	16,000	
6.3.	Equipment-printers	4,000	4,000	
6.3.	Equipment-software	5,000	5,000	
6.4.	Supplies	13,750	8,750	5,000
6.6.	Support staff	50,000		50,000
6.9.	Transport/maintenance	46,000	25,500	20,500
96.	Other studies	100,000	100,000	
98.	Contingencies	237,250	194,750	42,500
	PROJECT TOTAL	**$2,000,000**	**$1,800,000**	**$200,000**

1/ Includes 60 trips at US$1,000 each, per diem (60 x 30 x US$120), and 60 person months at $6,270 each. Figures are rounded slightly based on estimate of $20,000 per person-month, inclusive of all fees, travel, and overhead. (See details of budget assumptions on pages A-5 and A-6.)

Belize Health Policy Reform Technical Cooperation

Budget -- Technical Assistance Component

(in US$)

Item	Units	Unit Cost	Total Cost	IDB	GOI
Professional services firm	52 pm	20,000	1,040,000	1,040,000	
Consultant-Project Coordinator	35 pm	3,000	105,000	105,000	
General Support			224,750	99,250	125,500
Office rental	36 months	1,388	50,000		50,000
Equipment-vehicles	2 vehicle	20,000	40,000	40,000	
Equipment-computers	4 computer	4,000	16,000	16,000	
Equipment-printers	1 printer	4,000	4,000	4,000	
Equipment-comp.software	10 packages	500	5,000	5,000	
Supplies	35 months	500	13,750	8,750	5,000
Support staff	68 pm	735	50,000		50,000
Transport/maintenance	34 months	1,338	46,000	25,500	20,500
Contingencies			185,250	155,750	29,500
TA Component Subtotal			$1,555,000	$1,400,000	$155,000

Belize Health Policy Reform Technical Cooperation

Budget -- Training Component

(In US$)

	Item	Units	Unit Cost	Total Cost	IDB	GOI
.	Professional services firm	8 pm	20,000	160,000	160,000	
.	Participant Training			116,000	84,000	32,000
.	Overseas fellowships	12 courses	5,000	60,000	60,000	
.1.1.	International travel	12 tickets	1,000	12,000	12,000	
.1.2.	Intl per diem/stipend	12 persons	1,000	12,000	12,000	
.2.1.	Local travel	8 workshops	1,000	8,000		8,000
.2.2.	Local per diem	8 workshops	1,000	8,000		8,000
.	Materials	8 workshops	2,000	16,000		16,000
	Contingencies			6,900	56,000	1,300
	Training Component Subtotal			$345,000	$300,000	$45,000

Belize Health Policy Reform Technical Cooperation

Budget -- Project Preparation Component

(In US$)

	Item	Units	Unit Cost	Total Cost	IDB	GOB
96.	Other Studies			100,000	100,000	
	Project Preparation Component Subtotal			100,000	100,000	

BELIZE HEALTH POLICY REFORM TECHNICAL COOPERATION

BUDGET ASSUMPTIONS

1.0 Professional services firm

Unit cost of $20,000 is estimated per person month of technical assistance. This is broken down as follows:

Consultant fees	$ 376,200
60 person-months @ $6,270/p-m (based on $285/day x 22 days);	
Per diem (60 x 30 x $120)	$ 216,000
Travel (60 trips x $1000)	$ 60,000
Overhead (150% of fees)	$ 564,300
Total:	$1,217,000
Cost per person-month:	$ 20,283

These costs include all required transportation, supplies, and logistical and administrative support, all of which are provided by the consulting firm. The technical personnel are assumed to have daily rates of $275-$300 per day.

2.0 Project coordinator

Unit cost of $3,000 per person month of technical assistance is estimated on the basis of Ministry of Economic Development suggestions (see correspondence dated June 7, 1994).

3.0 Participant training

Overseas fellowships: Covers course fees and lodging expenses, for courses ranging from three weeks to two months (an average is used).

International travel: Assumes travel from Belize to U.S. (Boston, Washington).

International per diem/stipend: Assumes limited expenses for participants during training program overseas. This is an average and will differ depending on length of program. However, lodging expenses will be covered within the cost of fellowships.

Participant level of effort: Assumes eight weeks (2.0 person months) per training course.

Local travel: Assumes approximately 20 participants for policy workshops, half of whom would be based in Belize City and not require travel costs. Assumes 12 participants for implementation workshops, all of whom would require local travel.

Local per diem: Assumes 20 participants for policy workshops of one to two days. Assumes 12 participants for implementation workshops of one week.

Participant level of effort: Assumes that four policy workshops will be held; each will involve 20 participants for two days each, for a total of 8 person-months. Assumes that four implementation workshops will be held; each will involve 12 persons for one week, for a total of 12 person-months.

Materials: Assumes preparation of handouts, overheads, and other supplies needed for both types of in-country training.

4.0 General support

Office rental: Assumes market value of space to be rented if MOH facilities are not available. Includes cost of utilities and communication.

Equipment-vehicles: Purchase of two vehicles for use by TC personnel, including the Project Coordinator and the long- and short-term consultants.

Equipment-computers: Assumes 3 desktop computers for project offices, and one laptop for short-term consultants. These will be purchased at beginning of the project.

Equipment-printers: Purchase of one printer for project offices.

Equipment-software: Assumes purchase of 10 packages of software for use with project computers.

Supplies: Assumes monthly cost of regular office supplies that will be required by project offices.

Transport/maintenance: Assumes monthly cost of local transportation for staff and consultants, and maintenance of project vehicles.

Support staff: Assumes 34 person-months of a Secretary and 34 person-months of a clerk typist, for the life of the project.

Counterpart level of effort: Each short-term consultant will work closely in conjunction with a Ministry of Health counterpart, and the long-term advisor will work closely with the MOH's Policy Committee. Assumes that each person-month of consultant time will be matched by a person-month of counterpart time.

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PROPOSED RESOLUTION

BELIZE. NONREIMBURSABLE TECHNICAL COOPERATION FOR THE DESIGN AND IMPLEMENTATION OF HEALTH POLICY REFORMS

The Board of Executive Directors

RESOLVES:

1. 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 agreements as may be necessary and to adopt such other measures as may be pertinent for the execution of the plan of operations referred to in Document AT-_____ with respect to a technical cooperation with Belize for the Design and Implementation of Health Policy Reforms.

2. That up to the sum of US$1,800,000, or its equivalent, is authorized for the purposes of this resolution, chargeable to the net income of the Fund for Special Operations.

3. That the above mentioned sum is to be provided on a nonreimbursable basis.