Project Completion Report

PCR

Project Name: Health Sector Reform Program

Country: Belize

Sector/Subsector: SCL/SPH

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Project Number: BL0014

Loan Number: 1271/OC-BL

QRR Date: 16 June, 2011

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Acronyms and Abbreviations

CDB	Caribbean Development Bank
EU	European Union
GDP	Gross Domestic Product
GOBL	Government of Belize
HIS	Health Information System
KHMHA	Karl Heusner Memorial Hospital Authority
MOH	Ministry of Health
NHIF	National Health Insurance Fund
PAPU	Policy and Planning Unit
PBL	Policy Based Loan
PMU	Project Management Unit
PPMR	Project Performance Monitoring Report

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Annexes

I. Basic Information

BASIC DATA (AMOUNTS IN US$)	
PROJECT NO: BL0014	**TITLE: Health Sector Reform**
Borrower: Belice **Executing Agency (EA): Ministry of Health and Public Services**	**Date of Board Approval: 18 Oct 2000** **Date of Loan Contract Effectiveness: 10 Apr 2001** **Date of Eligibility for First Disbursement: 24 Jan 2002**
Loan(s): 1271/OC/BL **Sector: SA-PRG** **Lending: INV-ORC**	**Months in Execution** *** from Approval: 120** *** from Contract Effectiveness: 114**
	Disbursement Periods **Original Date of Final Disbursement: 10 April 2005** **Current Date of Final Disbursement: 10 Oct 2010** **Cumulative Extension (Months): 66** **Special Extensions (Months): 42 (from April 2007 to Oct 2010)**
	Loan Amount(s) *** Original Amount: 9.800.000** *** Current Amount: 9.800.000** *** Pari Passu (if applicable):**
Poverty Targeted Investment (PTI): No **Social Equity (SEQ): Yes** **Environmental Classification: C**	**Disbursements** *** Amount to date: US$9,613,988 (98%)** **Total Project Cost: US$19,989,272** **Original Estimate: US$18,126,000**
	Redirectioning **Has this Project?** **Received funds from another Project [ ]** **Sent funds to another Project [ ]** **N/A [x]** **On Alert Status** **Is project currently designated "on alert" by PAIS: No**

Summary Performance Classifications				
DO	[ ] Highly Probable (HP)	[ ] Probable (P)	[x] Low Probability (LP)	[ ] Improbable (I)
IP	[ ] Highly Satisfactory (HS)	[ ] Satisfactory (S)	[x] Unsatisfactory (US)	[ ] Very Unsatisfactory (VU)
SU	[ ] Highly Probable (HP)	[ ] Probable (P)	[x] Low Probability (LP)	[ ] Improbable (I)

II. The Project

Project context during preparation: Starting in 1994 the Bank and the Government of Belize (GOBL) conducted policy dialogue regarding the need to improve the health status of the population and the opportunities for structural reforms in the health sector, guided by a series of studies on health financing and delivery options, policy and planning functions of the Ministry of Health (MOH), the structure and organization of the health sector and alternatives for creating a health insurance scheme, all supported by a Bank financed TC, the Health Policy Reform Project (ATN/SF-4686-BL). A Health Planning Unit was established in the Ministry of Health and draft legislation was prepared to support health reform, especially the creation of a payroll tax to support a national health insurance scheme. Strategies were drafted to improve management and to reconfigure the hospital network. Key human resources were trained in policy and planning

functions. The main challenges in the health sector that prompted the Health Sector Reform Program loan were a health system ill prepared to face a frank epidemiological transition; low quality services, especially in rural areas, and low utilization of primary care facilities; over centralization of health service planning, organization, management and financing but atomized and dispersed service points; very low technical capacity in the public sector and an unregulated private sector of highly variable quality which struggles to compete with lower cost providers in neighboring countries.

During project preparation the GOBL determined to give high priority to improving the sector and focusing public financing on the poor and on cost-effective health interventions, and expressed commitment to target tax financing on the poor and on public health actions, while stimulating and regulating a mix of public and private providers. Political prospects were deemed good for the approval of legislation to support health reform measures. Project preparation began in mid 1998 and project approval was obtained in October 2000. During this period the country enjoyed relative economic stability, compared to neighboring countries. In the 1990's real Gross Domestic Product (GDP) was growing at an average of 4.8% annually, reaching 6.2% in 1999, and inflation was low. Yet, by the late 90's BL's public debt had increased sharply and Government had begun taking actions to contain its growth, with some success. The fiscal gap was being financed by foreign borrowing and net disbursements of existing loans from multilateral institutions.

Belize is a country of around 313,000 people, according to the 2010 census. A small population (less than 250,000 in 2000), a reduced market and small volumes of production and consumption are contextual factors that were analyzed during project preparation as risks to the creation of minimal critical mass in payrolls, payroll taxes, consumption of health services, demands for health insurance and other processes central to project design.

Project context during execution: The project obtained full eligibility in January 2002; from that date it executed in nine years. Date of last disbursement was November 2010. In general, during the decade of execution Belize's economy did not perform as well as in the preceding decade. 2003 was the last year in which real per capita GDP grew (5%); thereafter and through 2009 growth was zero or slightly negative. A considerable economic and political crisis ensued after an unsustainable debt accumulation due to public spending resulted in a near debt default. Dealing with the fiscal debt issue was a significant challenge throughout the decade and by the decade's end the government had taken several steps, including selling government assets, refinancing the external debt, increasing taxes and exercising continued expenditure discipline. By 2010 inflation was still low and the fiscal deficit had declined but public debt was 82% of GDP. Unemployment grew from 10% in 2002 to 14% in 2009. Overall poverty increased from 34% in 2002 to 43% in 2009 and extreme poverty from 11% to 16% in the same period.

a. Project Description

i. **Development Objective(s).** The goal was 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 did not contemplate any specific development objectives. The overall goal remained unchanged during project execution with no reformulations. An amendment to the loan contract, (requested in April 2003) was approved in August 2004; it removed some special conditions to disbursement and reduced the financing available for the third component that dealt with national health insurance and health sector financing. Two additional budget realignments occurred in February 2004 and July 2005, the last one transferring all remaining funds out of the third component. In late 2004 the outcome and output indicators were modified and the indicators being tracked in the Project Performance Monitoring Report (PPMR) changed as well.

ii. **Components.** Component 1, Sector Restructuring: This component was designed to promote the development of institutional capabilities within the Ministry of Health (MOH) so that it could exercise its role as a regulator and policy designer, and could effectively stimulate and support de concentration towards newly created health regions and autonomous hospital bodies. The component would result in a restructured MOH with strengthened installed capacity.
Component 2, Services Rationalization and Improvement: This component was designed to finance investment activities in infrastructure and medical equipment. Investment was to be

aimed at improving the public supply of health care services by concentrating surgical and other key hospital services in a smaller number of regional centers (3), so as to increase the utilization of capacity and to improve quality. Investments would be tied to the implementation of performance agreements. This mechanism would forge the link between improvements in performance and infrastructure deployment. Hospital and central authorities would be trained in the design, monitoring and enforcement of such agreements. The expected results were upgraded physical infrastructure and rationalized health services.

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). The expected result was a strategy for health sector financing under implementation.

b. **Quality -At- Entry Review (if applicable):** Does not apply.

Quality -At- Entry Review			
[ ] Highly Satisfactory (HS) – 1	[ ] Fully Satisfactory (S) - 2	[ ] Less than Satisfactory (LS) - 3	[ ] Unsatisfactory (U) - 4

III. Results

a. Outcomes

ACHIEVEMENT OF DEVELOPMENT OBJECTIVES (DO)	
Development Objective(s)	**Key Outcome Indicators**
1. The overall goal of the program was 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 did not contemplate any specific development objectives. *Classification: HP,P,LP,I*	
Planned Outcomes Baseline Intermediate End of Project 1.1 By the end of March 2007, 90% of population has "adequate" physical access to a basic package of primary care health services. 1.1B_**0**__ (2001) 1.1I____(date) 1.1E __**90**_ (Apr 2008) 1.2 A 40% increase in client satisfaction by December 31, 2007 1.2B_**x**__ (2001) 1.2I____(date) 1.2E _**x+40%** (Dec 2007) 1.3 Average throughput meets 50 % medical compliance to the defined clinical norms, standards and protocols of medical practices by December 31, 2006 1.3B_**x%** (date) 1.3I____(date) 1.3E __**50%**_ (Dec 2006) 1.4 The average waiting time for elective surgery reduced to a maximum of six weeks by December 31 2006. 1.4B__**6 months**_ (2001) 1.4I_**3 months**_(2007) 1.4E __**6 weeks** (Apr 2008) 1.5 Neonatal mortality decreases from 12.7/1000 in 2000 to 11.0/1000 by Dec. 31, 2007. 1.5B_**12.7/000** (2000) 1.5I____(date) 1.5E _**11/000**_ (Apr 2008) 1.6 Average throughput meets defined standards by December 31 2007. 1.6B__**no**_ (2001) 1.6I____(date) 1.6E __**yes** (Apr 2008)	**Outcomes Achieved** No data except as reported below 1.1 A 2007 consultant's report on the NHI pilot in Belize City reports that more than 90% of the population has access to a basic package of services, up from 44% in 2002 but does not assess how adequate the services are. In 2009 95% of the population in the Belize City pilot and 84% of the population in the southern district pilot were covered, although a measure of adequate coverage was not available. 1.2 No baseline data are available on overall client satisfaction. Results of a 2007 patient satisfaction survey of patients at the KHMH emergency room are: 74% satisfaction with the attention received and 73% satisfaction with the waiting time. Regarding satisfaction levels of NHI pilots' beneficiaries, in 2008, satisfaction rates were between 83 and 92% in Belize City and between 79 and 86% in the southern districts. 1.3 There is no evidence to suggest this indicator was measured. 1.4 MOH reported a waiting time of 8 weeks at KHMH in 2008 and the Program's final report states that waiting time for elective surgery has been reduced from 6 to 3 months at the KHMH, but no date is provided. There is no evidence available to suggest this indicator was measured in the central or the regional hospitals 1.5 5.8 (2008). Source: MOH statistics. 1.6 This indicator was not measured.
1.7 Reduce crude death rate by 5% by December 2006. 1.7B_**6.1/000**_ (2001) 1.7I____(date) 1.7E _**6.1 -5% =**	1.7 35% reduction, from 6.1/000 to 4/000 (2008). Source: MOH statistics.

5.8/000_ (Apr 2008) 1.8 Reduce the rate of tuberculosis increases by 25% based on 2001 -2002 estimates by March 31, 2006. 1.8B_**x**__ (2001-2) 1.8I____(date) 1.8E __**x-25%**___ (Apr 2008) 1.9 Reduce the rate of increase of HIV/AIDS by 25% based on 2001-2002 estimates by December 31, 2006. 1.9B_**x**__ (2001-2) 1.9I____(date) 1.9E _**x-25%**_ (Apr 2008) 1.10 Reduce IMR from 21.2 in 2000 to 20.4 by December 31, 2006. 1.10B_**21.2**_ (2000) 1.10I____(date) 1.10E _**20.4**_ (Apr 2008) 1.11 Maintain the number of maternal deaths below five cases per year by December 31, 2006. 1.11B____ (2001) 1.11I____(date) 1.11E __**<5**__ (Apr 2008) 1.12 A sustainable health care financing fully operational nationally by March 31, 2007. 1.12B__**no**_ (2001) .12I____(date) 1.12E _**yes**__ (Apr 2008)	1.8 No data are available to measure the reduction in the rate of increase in the prevalence rate. Nonetheless, it appears that the prevalence rate for TB actually went down between 2002 and 2007, from 14.1% to 6.3%. 1.9 No data are available to be able to measure if there was a decrease in the rate of increase in the prevalence of HIV/AIDS. 1.10 12 per 1000 live births (2008): Source: MOH statistics. 1.11 3 deaths (2008) and 4 deaths (2010). Source: MOH statistics. 1.12 Sustainable health care financing as described in the loan document, including some form of cost recovery through copayments, was not achieved.

Differences: 1.1 Adequate access was not defined. In fact, it appears in quotation marks, seeming to imply that it has a special meaning. This indicator could not be measured.

1.2 Client satisfaction surveys conducted for KHMH and NHI pilots only, not for all health services. The last client satisfaction survey for KHMH, 2007, reports improvement of over 30% in client satisfaction levels but no baseline figures are provided. The PPMRs of 2007 attribute this increase to the infrastructure improvements (financed by a loan from the EU) and to the institutional strengthening measures financed by this operation.

1.12 This indicator seems to have been defined to apply to the NHI scheme only, not to the whole health sector. If correct, it was not met. Although the GOBL had stated since 2005 and up to 2008 that the NHI scheme would be financed and the roll out (beyond the two pilots that have been going on since 2003 and 2005) would be effective in 2007 or 2008, these two goals have not been achieved. It should be noted that during project design the adoption of a payroll tax to finance the NHI rollout was determined to be both economically and politically feasible but this assessment was not borne out during the first years of project implementation, effectively leaving no financing mechanism for the NHI roll out.

Reformulation: [x] N/A

PPMR Retrofitting. Indicate if and when the PPMR was retrofitted and explain any changes resulting from this exercise.

[x] A supervision mission of Nov 2004 agreed to modify indicators for outcome and outputs. The PPMR was retrofitted in 2005 to accommodate these changes. In subsequent PPMRs indicators continued to be adjusted although no documentation was found that could explain these additional changes. As of Dec 2006 the indicators remained the same until project completion in 2010.

Summary Development Objective(s) Classification (DO):

[ ] Highly Probable (HP) [ ] Probable (P) [x] Low Probability (LP) [ ] Improbable (I)

Briefly justify DO classification, based on degree to which planned targets were met, explaining the differences between planned and achieved outcomes as well as any other relevant factors. Include references to evidence that can support these results.

Country Strategy. Given the results described above, briefly discuss how the project contributed to the Bank's strategy in the country: This operation was approved under the Bank's Country Strategy for Belize for 1999-2003 (GN-2019-2) which had as an objective to enhance Government's ability to provide quality social services on a sustainable basis by promoting reforms in the health sector, fostering innovations in the financing and delivery of reproductive health services (p 6). The program's design directly addressed the main challenges of health sector reform, including strengthening the stewardship and regulating role of the MOH. The program was successful in restructuring public health services, and somewhat successful in strengthening the MOH's roles, but less successful in fostering sustainable innovations in health financing that had the potential of benefiting a proportion of the poor beyond that covered by the pilots of the national health insurance scheme.

Externalities: Belize's Health Information System was designed and implemented using international standards, partly using funds from this operation. It adopts international standards and it is cited by WHO (WHO Bulletin, 2009;87:87–88) as a world-class system. The Health Information System (HIS) provides opportunities for important synergies with Belize's single beneficiary system, under implementation.

a. Outputs

IMPLEMENTATION PROGRESS (IP)	
Components (Outputs):	
1. Component 1: Sector Restructuring Total cost of Component: US$1,576,216 Counterpart: GOBL: US$109,251; CDB: US$370,390 IDB: US$1,096,575 IDB Disbursement: 70% Classification: U	
Key Output Indicators:	
Planned Outputs Baseline* Annual/Intermediate End of Project 1.1 Central MOH refocused toward policy and regulation and no longer providing health services directly by December 31, 2007 1.1B no (date) I____ (date) 1.1E yes (Apr 2008) 1.2 Regulatory framework established and functioning (based on the outputs of MIF/TC) by April 30, 2007. 1.2B no (date) I____ (date) 1.2E yes (Apr 2008) 1.3 MOH restructured and staff trained in new procedures by April 30, 2007. 1.3B no (date) I____ (date) 1.3E yes (Apr 2008) 1.4 Karl Huesner Memorial Hospital (KHMH) is autonomous by June 1st, 2003. 1.4B no (2001) I____ (date) 1.4E yes (Apr 2008) 1.5 Four Health Regions established and functioning, each with an approved level of autonomy with regard to human resources, financial management, provision of services and contracting by April 30, 2007. 1.5B **0** (date) I____ (date) 1.5E 4 (Apr 2008) 1.6 Public Information Strategy designed and conducted by April 30, 2007. 1.6B no (date) I____ (date) 1.6E yes (Apr 2008) 1.7 Health Promotion Strategy designed and conducted by April 30, 2007. 1.7 B no (date) I____ (date) 1.7 yes (Apr 2008)	**Outputs Achieved** 1.1 Yes, 2007: Current practice is that central MOH no longer provides health services directly and existing regulations facilitate de concentration and appointment of regional managers. 1.2 Yes, partly: established in April 2007. 1.3 Yes, partly: a new MOH organization chart is available and an MOH report states training was completed in Feb. 2009. 1.4 Achieved by decree in July 2005: a KHMH Authority Act deems the KHMH an autonomous institution. 1.5 4 Health Regions were created in Nov 2007 but not fully autonomous. 1.6 No (2010) 1.7 No (2010)

Briefly explain differences between planned and actual outputs (if applicable).

1.1 MOH regions continue to provide health services directly in 2010. PAPU is not fully staffed. Regulatory function improved during periods of project execution but certification and accreditation of health service and health providers was not achieved. Proposed legislation to create the Belize Health Authority and the Regional Health Management Authority was not approved by Cabinet in 2007.

1.2 Licensing & Accreditation Unit was established in 2007. Currently it has one director but is understaffed. Thus, although formally established it does not appear to be functioning.

1.3 There is no clarity as to which organization chart is in effect. Units such as PAPU and Licensing and Acreditation are not functional.

1.4 Under the HRSP the autonomous KHMH was to be responsible for the two major health centers in the Central Region. This did not occur. Additionally, service level agreements were not implemented; this resulted in the inability of the KHMH to collect data that would have been useful to monitor the throughput impact indicators of the HSRP.

1.5 Since the Regional Health Management Authority Bill was not approved and since the central MOH has not released authority to regional offices, the achieved level of autonomy of health regions was partial and lower than originally expected,. Although they achieved some administrative and financial autonomy, service provision and contracting are still managed centrally. All contracting occurs through the NHIF. In conclusion, total de concentration was not achieved

1.6 The public information strategy was designed but never implemented due to lack of financial and human resoureces in the MOH,

1.7 The MOH decided to implement health promotion activities itself, rathen than contracting out. The Bank increased funding for this activity from US$170k to US$370k in 2005. Training of MOH staff was partially completed. The health promotion strategy was not implemented due to understaffing at the MOH.

Restructuring. Indicate if this component was restructured (date of approval by Manager). Briefly discuss the consequences of these changes.

[X] N/A

2. Component 2: Services Rationalization and Improvement

Total cost of Component: US$ 15,636,608
Counterpart: GOBL: US$4,019,915; CDB: US$ 3,355,805; EU: US$1,492,567
IDB: US$6,786,321
IDB Disbursement: 43%

Classification: U

Key Output Indicators:

Planned Outputs	**Outputs Achieved**
Baseline* Annual/Intermediate End o Project 2.1 Three Regional Hospital established, services expanded and managed under performance contracts by April 2007. 2.1B **0** (2001) 2.1I____ (date) 2.1E **3** (Apr 2008)	2.1 3 in Nov. 2007
2.2 Three Community Hospitals in operation by December 2005. 2.2B **0** (date) 2.2I____ (date) 2.2E **3** (Apr 2008)	2.2 3 in Nov. 2008
2.3 Services redistributed as per Technical Note #2, Health Service and Infrastructure HRSP project document by April 30, 2007. 2.3B no (date) 2.3I____ (date) 2.3E yes (Apr 2008)	2.3 The indicator was not measured. MOH believes services redistribution has been 95% achieved.
2.4 Health Education and Community Participation Bureau (HECOPAB) strengthened with its public health program developed and implemented by December 31st, 2006. 2.4B no (date) 2.4I____ (date) 2.4E yes (Apr 2008)	2.4 No (2010)
2.5 Refurbishing and expansion of physical infrastructure completed, and equipment installed and operating by April 10, 2007. 2.5B no (date) 2.5I____ (date) 2.5E yes (Apr 2008)	2.5 No (2010)

Briefly explain differences between planned and actual outputs (if applicable)2.1 Service Level Agreements (SLAs) were adopted but their application is constrained by the low level of autonomy of the regional offices in charge of regional hospitals, especially regarding human resources and finance. Hiring and spending authorizations must be obtained from the central MOH, the Ministry of Public Service and the Ministry of Finance.
2.2 Change orders, inadequate supervision and procurement issues resulted in cost overruns and a 3 year delay in completion. Equipment has not been fully procured.
2.3 Technical note # 2, prepared by a consulting firm during project preparation in 1999,refers to the health regions in component 1, contains a plan for reconfiguration of services. It was not possible to ascertain to what degree the reconfiguration plan was implemented. 2.4 Strengthening plan designed but not implemented.2.5 Refurbishing and expansion of physical infrastructure suffered several changes and modifications along the 10 years of project execution. Modified refurbishing and expansion remain incomplete, especially that of two hospitals. Due to procurement issues (change orders and cost overruns) that could not be resolved the Bank stopped disbursements between Feb 2008 and mid 2009 while two audits were performed. The waiting period did not help in achieving the goals of the infrastructure and equipment plan. In addition, the GOBL had legal issues with some contractors that were taken to court for resolution. Last contracts for infrastructure works were still being closed in November 2010, immediately prior to the date of last disbursement. No data available on installation of equipment.

Restructuring. [x] N/A

3. Component 3: Support to the NHIF.

Total cost of Component 3: US$19,662
Counterpart: GOBL: US$19,662
IDB: 00

Classification: U

Key Output Indicators:

Planned Outputs	**Outputs Achieved**
Baseline* Annual/Intermediate End o Project 3.1 National Health Insurance (NHI) legally established under SSB to be the prime financial instrument and purchaser of personal health services from public and private sectors by April 2007. 3.1B_no__ (date) 3.1I____ (date) 3.1E _yes_(Apr 2008) 3.2 All NHI purchases are carried out in accordance with standard procedures and standard performance contracts by December 2006. 3.2B_no_ (2001) 3.2I____ (date) 3.2E _yes_(Apr 2008)	3.1 _Yes, partly: partial legislation approved in 2001 and 2007; statutory instruments approved in 2008. 3.2 Yes, Nov 2007

Briefly explain differences between planned and actual outputs: There were originally six planned outputs. Four were eliminated between 2004 and 2005 when the funds allocated to this component were realigned.
3.1 Partly achieved in 2008 with approval of statutory instruments. NHI is legally the prime financial instrument and purchaser, but the NHI cannot finance services unless the Ministry of Finance, through its yearly allocations to the MOH budget, provides GOBL financing in full.
3.2 2006 and 2007 performance-based contracts between NHI and health care providers were not adequate. Through the Social Policy Support Program (BL-L1004), a PLB, the Bank supported further improvements of the contracting instrument in 2009 and 2010. To date, double accounting of funds involved in contracts still exists and performace payments are made against the achievement of administrative indicators mostly.

Restructuring. [x] N/A

Summary Implementation Progress Classification:

[ ] Highly Satisfactory (HS) [ ] Satisfactory (S) [x] Unsatisfactory(U) [ ] Very Unsatisfactory (VU)

b. Project Costs: See tables below.

Explanation of main differences between planned and actual:
Component 1: Cost savings in subcomponent 1.1 due to a decision to do most of it in house. Consultancies for subcomponent 1.b and 1.c were much more expensive than originally envisaged. Subcomponent 1.e was not fully implemented/was paid with GOBL funds. Overall, increased costs for this component were driven by consultancies for deconcentration of operational authority to regional health offices and for strengthening and autonomy of KHMH.
Component 2: Cost overruns due to change orders in infrastructure works were mostly absorbed by GOBL.
Categories of investment for comp. 2 changed between loan agreement and the WLMS as of mid 2005 or 2006, the exact date is not clear. No documentation was found to justify or explain these changes.
Component 3: Although this component was never formally closed, all loan funds originally allocated were transferred to the two other components by 2005, with Bank approval.
Administration: Multiple extensions resulted in increased administration costs.
Financial costs: The Bank waived most the charges applied to inspection and supervision, yet the six years of extensions in the date of last disbursement increased the financial costs to the GOBL by 167%.

Table III. 1 Total Project Cost – Planned (US$000) (from Annex A of Loan Contract)

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 Op. Authority to Health regions	90	423			513	
1c. Piloting autonomy with KHMHA	317			49	366	
1d. Public information strategy		101		4	105	
1e. Promoting Knowledge and Behavioral Change	70	155		55	280	
Component 2. Serv. 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 administrative equipment	1,705	1,209			2,914	
Management	303				303	
Ambulances/mobile units	372				372	
Component 3. Support to the NHIF	**832**			**126**	**958**	**5**
3a. Technical development of the NHIF	412			126	538	
3b. Innovation Fund (includes creation of NHIF)	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%**		

Table III.2 Total Project Cost – Actual

COMPONENTS	IDB[1]	CDB[2]	EU	GOBL	TOTAL	%
Component 1. Sector Restructuring	**1,096,575**	**370,390**		**109,251**	**1,576,216**	**8**
Component 2. Services Rationalization and Improvement	**6,768,321**	**3,355,805**	**1,492,567**	**4,019,915**	**15,636,608**	**78**
Component 3. Support to the NHIF	**000**	**00**	**00**	**19,662**	**19,662**	**.1**
Administration	**577,092**	**181,012**	**00**	**687,726**	**1,445,866**	**7**
Total investment costs	**8,441,988**	**3,907,207**	**1,492,567**	**4,836,554**	**18,678,316**	**93.1**
Unallocated costs	000			00	00	
Financial costs	**1,172,000**			**138,956**	**1,310,956**	**6.9**
TOTAL COST	**9,613,988**	**3,907,207**	**1,492,567**	**4,975,510**	**19,989,272**	**100**
%	**48**	**20**	**7**	**25**	**100**	

Table III.3 Differences between Planned and Actual Costs

COMPONENTS	IDB	GOBL	TOTAL

[1] From WLMS
[2] For CDB, EU and GOBL from final audited financial statement of Nov. 2010

Component 1. Sector Restructuring	+96%	-23%	+11
Component 2. Serv. Rationalization & Improv.*	+9%	+277%	+29
Component 3. Support to the NHIF	-100%	-84%	-98%
Administration	+79%	+95%	+115%
Total investment costs	+7%	+187%	+24%
Financial costs	-7%	+167%	-24%
TOTAL COST	0	+137%	+10%

*Subcomponents (or categories of investment) and their amounts under Component 2 changed during execution, per WLMS, but no explanation was found in PPMRs or aide memoires regarding this change.

IV. Project Implementation

a. Analysis of Critical Factors

1. Project design was undertaken jointly with the Caribbean Development Bank (CDB) and the European Union (EU). During design all parties took measures to ensure a clear division of responsibilities and areas of investment, and that these investments were complementary and had the potential of creating synergies. The CDB and IDB contributions to the modernization of the country's main hospital were well thought out and dovetailed adequately. During execution both institutions made efforts to hold joint missions and compare notes on project execution. These efforts started failing when the IDB stopped conducting administration missions between Nov. 2004 and April 2008 (There is no evidence in the project files of any missions in the interim period). When a CDB held a mission, it usually met with operations specialists in the IDB's Country Office in charge of supervision.
2. Starting with the execution of an IDB TC 2 years before loan approval was a measure that resulted in early efforts to develop and install reform-pertinent competencies in the MOH.
3. Human resource constraints in the MOH affected project implementation from early on. The PPMRs for 2001 documented how staffing issues in the MOH's Policy and Planning Unit (PAPU), an entity created before the loan was approved, were hindering progress in meeting conditions prior. It is not clear whether the root of these staffing problems was short availability of qualified personnel in the country or challenges attracting qualified personnel to the public sector or other. These problems were fairly constant during implementation.
4. The Project Management Unit (PMU) lacked adequate equipment and infrastructure to work effectively; these constraints were also noted early on. The PMU suffered from regular staff turnover, restricted logistics and installed capacity throughout the implementation period, as documented in correspondence, PPMRs and progress reports. Accounting and record-keeping difficulties were documented in annual audited financial statements, and resulted in several reconciliation problems between the Bank's and the executing agency's financial data. Procurement issues arose, specifically in procuring the infrastructure activities of the 2nd component. The loan contract considered both Bank funds and counterpart funds for administrative costs and, overall, a little under US$1.5 million were destined to project administration (see table on actual project costs, above), including staffing the PMU; thus these difficulties arose due, possibly, to human resource constraints.
5. Since the PAPU was unable to fully perform its technical leadership and there was no technical entity in charge of execution, a weak PMU was de facto charged with project execution, with little oversight from a technical team within the MOH and sporadic direction from authorities. This situation is alluded to in action plans in several PPMRs throughout the execution period. In addition, the person filling the PMU's project coordinator slot changed several times and remained unfilled in interim periods. Since the second component was considered critical and given the vacuum in technical oversight and supervision of infrastructure works that resulted from the default of the consulting firm contracted with this purpose in 2002-2003, the decision was made to hire an engineer as project coordinator. This measure also resulted in weak technical direction for the 2 other components.
6. The project's steering committee, conceived as a mechanism to provide strategic and technical direction during execution, did not become functional. As early as 2003 the Bank suggested the creation of a project technical committee to take on some of the tasks of the steering committee. The technical committee did not become operational either. It is not clear from the project documents whether the establishment of these committees faced leadership, time, or other constraints, although the PPMRs refer to a lack of vibrancy and buy-in from their members. The fact that they did not operate as planned contributed to the weak technical direction of the operation.
7. The 2nd component, envisaged investments in infrastructure as secondary to and supportive of improvements in performance. Investments were to be tied to the implementation of performance

agreements between the central level, the regional offices and the hospitals. From early on, however, investments began to take precedent over the rationalization activities of the component, perhaps because they were particularly demanding, required large international public bids, and implied investments of large sums. The issues raised in point 3, above, also contributed. Works infrastructure and works, instead of facilitating the achievement of the component's aim, became its raison d'être.

8. The main execution agency, the MOH, had difficulty coordinating with its sister but autonomous body, the Social Security Board, regarding the execution of the NHI component. Specifically, the SSB decided to proceed with the NHI pilot in south side Belize City using its own resources before the MOH was able to produce the analytical pieces and consulting inputs that, according to the loan document, were necessary to design the pilot, for instance, conducting a survey to identify poor households and individuals that would be fully covered by the NHI scheme. Instead, the GOBL presented evidence that the 2003 poverty assessment had been conducted instead of the survey, and the Bank accepted this evidence. However, the poverty assessment was incapable of unequivocally identifying specific populations for targeting purposes.

9. Delays in activities financed by the CBD loan caused delays in the execution of the activities financed by the IDB, especially for the first 2 subcomponents in the 1st component.

10. The Bank provided sporadic technical oversight during implementation. The PPMR of June 2003 recommended a mission and the report of the portfolio review mission of October 2003 reiterates this recommendation. A mission was conducted in February 2004, the first since April 2002. Thereafter, there is no evidence that any administration missions were conducted between Nov. 2004 and April 2008. The portfolio review missions conducted during those years were not sufficient or adequate to address the operation's technical difficulties.

11. The Bank's PPMRs assessments regarding progress in implementation and probability of achieving the operation's objectives were consistently over optimistic. The June 2003 PPMR states that it is probable that by end of 2004 100% of population has "adequate" physical access to health services and financial access while at the same time documenting delays and constraints in execution that made evident that the project would not finish in April 2005, the original date of last disbursement.

12. Many of the procurement difficulties, cost overruns and other execution problems, including the Bank's decision to stop disbursements in mid 2008, were associated with the implementation of component 2, specifically with the infrastructure investments. These problems had their origin in suboptimal technical capacity, poor oversight and lack of supervision. The consulting firm originally subcontracted to undertake supervision did not perform well. The international firm contracted to design and execute the infrastructure works did not foresee infrastructure and equipment needs, some of which were there from the start (e.g., introduction of air conditioning in surgery room, generators for hospitals and management of rain water). Neither did the executing agency or the Bank. The Bank's supervision, including administration missions, did not include an engineer. Change orders ensued, some of them carried out without the Bank's prior no objection. The GOBL and some subcontractors had to settle their differences in court. The GOBL requested and the Bank approved a reduction of US$297k in the Financing for infrastructure in 2005, claiming there was no further need for the original amount due to reductions in the scope of several works. The Bank agreed. However, starting in 2006 or 2007 unauthorized changes in work orders resulted in cost overruns that had to be absorbed by the GOBL (see section on costs). The problems accumulated and between April 2008 and June 2009 project execution finally stalled when the Bank froze disbursements. The 2008 date of last disbursement expired while disbursements were frozen. Disbursements resumed once Bank management provided a retroactive special extension of the date of last disbursement. All these difficulties eroded the relations between the executing agency and the Bank.

13. Component 3, dedicated to creating and cementing the national health insurance scheme for Belize and, indirectly, to improving the financial prospects of the public health sector, was predicated on the creation of a payroll tax to sustain it. The GOBL did not approve the payroll tax or any other tax that could provide revenues to fund and extend the NHIF. The NHI pilot, which this operation was meant to finance, was financed with funds from the Social Security Board starting in 2002. This was short-term, non sustainable financing and eventually the SSB stopped funding the pilot. The Bank expressed concerns regarding this decision from early on during project execution. The GOBL stepped in by providing financing through the regular MOH budget, starting in 2003. Because the GOBL justified using its own resources to undertake the analytical and operational work required to design the pilot and the SSB financed the pilot, the Bank agreed, in 2003 and 2005, to realign all the funds

originally allocated to this component to the other two components, with no further analysis of the adequacy of the studies undertaken, the implications of this action for health sector financing or for reaching the program's objective. In retrospect, the work undertaken on costing and financing aspects of the NHI was not complete. The component was never formally closed but, in effect, the Bank's involvement was curtailed when the Financing was redirected. The original outcome and output indicators relating to the NHI and to health sector financing were reduced to two output indicators. PPMRs between 2005 and 2009 state that the GOBL would be rolling out the NHI in the near future. This roll out has not occurred and the pilot is now nine years old.

b. Borrower/Executing Agency Performance

Borrower/Executing Agency			
[ ] Highly Satisfactory (HS)	[ ] Satisfactory (S)	[x] Unsatisfactory (U)	[ ] Very Unsatisfactory (VU)

c. Bank Performance

Bank Performance			
[ ] Highly Satisfactory (HS)	[ ] Satisfactory (S)	[x] Unsatisfactory (U)	[ ] Very Unsatisfactory (VU)

V. Sustainability

a. Analysis of Critical Factors: The most outstanding sustainability issue in the program pertains to the future of the NHIF and, more specifically, to the pilot which continues to be extended indefinitely since 2003. The original project design envisioned around US$5 million to support the design and implementation of the NHI pilot and to generate analytical inputs to guide its design and implementation, such as the survey to identify household which would be eligible to full coverage by the NHI. In addition, originally the Bank was to aid the GOBL in designing a law for a payroll tax to finance the NHI scheme and its roll out to the rest of the country once the pilot was executed and its results analyzed. Upon considering the operation's Profile II, the Bank's Loan Committee (2000) requested that the project team prepare an issues note on the viability of the payroll tax from both a political and technical perspective (the small size of the BL population was viewed as a potential obstacle to reach a critical mass of tax contributors) and to further analyze the sustainability question and explore alternatives to the payroll tax. The Loan Proposal summarized these issues but concluded the payroll tax was highly probable. Alternatives to the payroll tax were still being systematically analyzed in early 2008, when the Bank embarked on the preparation of a social PBL for Belize. An additional consideration that has sustainability implications is the targeting of the NHI pilot, which provides services free of charge to beneficiaries and does not have a cost-recovery or cost-sharing mechanism, and the adoption of the same targeting mechanism in the event of a roll out. Geographical targeting is currently used to select beneficiaries who have previously obtained a social security number. This works relatively well in the southern districts of Stann Creek and Toledo which have the country's highest poverty rates (32% and 61%, respectively, in 2009), dispersed populations and little immigration. But in the south side of Belize City geographical targeting is not an adequate mechanism: obtaining a false proof of residence is commonplace, according to NHI authorities. Although no hard figures exist to this effect, it follows that providing free services to large numbers of people who do not qualify (as may be the case in south side Belize City) is a constant drain on the GOBL resources assigned to the NHI.

b. Potential Risks: Indefinitely maintaining the NHI pilot as the status quo, which is the de facto GOBL position, carries two risks: the first is that ending the pilot will be a forced decision when it can no longer be sustained, and there will be little gained from the experience, after a decade's work; the second is that the political pressure from citizens who see themselves as eligible to receive the NHI but do not live in the pilot areas will continue to mount until a crisis occurs. The GOBL is in a difficult situation: ending the pilot is not politically feasible as the country readies itself for an election, and expanding it with the current financing scheme is not financially feasible. A revamping of the NHI, including a real costing exercise, head count targeting, a cost-sharing scheme, improving quality of service provision, improved supervision and a viable financing mechanism, is the proposed way forward.

c. Institutional Capacity: The MOH continues to face important staffing challenges; both the PMU and the PAPU remain understaffed in 2011. Weak institutional capacity and staffing shortages reduce sustainability prospects for the reform measures in sector reorganization and, in the face of continuing fiscal constraints, for the maintenance of the works and equipment procured.

Sustainability Classification SU:			
[ ] Highly Probable (HP)	[ ] Probable (P)	[x] Low Probability (LP)	[ ] Improbable (I)

VI. Monitoring and Evaluation

a. **Information on Results**: Neither the GOBL or the Bank systematically collected data to report on the operation's indicators, despite the fact that the PPMRs stated that the parties had agreed on the need to collect data and that there were mechanisms in place to generate and collect data. As late as April 2008, an administration mission noted that baseline data were missing for the indicators that had been adopted during the prior administration mission (November 2002) and the respective aide memoire registers a commitment by the GOBL to collect and report such data. A final evaluation was not undertaken at the project's closing due to lack of consensus between the Bank and the executing agency regarding the use of loan funds to finance it. A last attempt was made during the preparation of this report to obtain data on the final (and, if feasible on the initial) values for outcome and output indicators.

b. Future Monitoring and Ex-Post Evaluation: None are envisaged.

VII. Lessons Learned

1. Design: A health sector reform project designed to be undertaken in four years, independent of the installed capacity, was an overly ambitious proposition. This operation had three different, challenging components and covered a wide gamut of reform issues, from stewardship and regulation to reorganization, hospital autonomy, innovation and sector financing.
2. Institutional capacity and training were addressed early on through a Bank-financed TC meant to create and strengthen MOH's competencies. However, these apparently well conceived and timed efforts were not sufficient. Sustainability of installed or growing institutional capacity was a challenge during most of the execution period, and was identified in the earliest PPMRs as an issue that required attention, especially from the GOBL. A restricted critical mass of professionals with the required skills in the country was possibly one of the factors that precluded the MOH from creating adequately staffed PAPU and PMU. The lesson learned is that structural or systemic conditions that pose challenges to project execution cannot be addressed with short term measures such as one-time training. Staff turnover and attrition eroded the trained and installed human resource capacity.
3. The Bank should proactively ensure that baseline data are collected during project preparation or shortly after approval. In this case, the Bank's timely technical and financial support to design and execute a monitoring and evaluation plan could have been offered to the executing agency soon after the first supervision mission, which noted that baseline data were not being collected.
4. When considering extending the date of last disbursement, it is advisable for the Bank and the Borrower to take into account the cost implications, especially the increases in project administration and financial costs to the borrower. In this case, in mid 2005, the Bank approved a budget realignment request that increased the amount originally allocated to project administration by 83%. Administration costs kept escalating from then until 2010. Six years of extensions of the date of last disbursement more than doubled the operation's administrative costs, especially to the GOBL.
5. The Bank's supervision of social sector operations with infrastructure components or investments would benefit from the participation of infrastructure specialists, consultants or otherwise. Social development specialists and operations specialists do not have the know-how required to adequately oversee the execution of infrastructure. In this operation, change orders that were required once the works' contracts had been signed were, in several cases, justified, according to a consultant's ex post report, and some of them could have been foreseen early on, had expert review been available. In this case, it is also true that the consulting firm that was originally contracted to provide oversight and supervision to the works' contracts did not perform well; this resulted in an additional oversight gap. Cumulatively, supervision weaknesses resulted in procurement problems.
6. The Bank's technical supervision should be performed by specialists with the right knowledge and skills. It should be recognized that supervision is more than administrative and fiduciary oversight. Continuity in supervision must be ensured, especially when team leadership changes frequently, by, for instance, better record keeping and filing. The loan contract contains standard clauses that allow the Bank to take measures during project execution to administer or mitigate risks and to manage problems, such as Clause 4.05 of the General Conditions. Project supervision would be more effective if Bank management was more inclined to apply these legal measures on a timely basis.

BELICE - HEALTH SECTOR REFORM PROGRAM (BL0014)
PCR

Quality and Risk Review (QRR) – Result and Procedure Report

A. QRR PROCESS

The PCR was distributed to the QRR requesting comments by June 9. The document was sent to: SCL-SCL; Office of the Manager - CID; Aldana, Maristella; Clarke, Caroline L.; Alonso, Laura Virginia; Martin, Dougal; Falkner-Olmedo, Katharina B.; Echebarría, Luis Estanislao; PDP-PFM; Goncalves, Antonio; Alvarez, Carola; Santelices, Cristian; SPD-SDV. Additionally, copy of distribution was sent to: Executive VicePresident; Office of the Vice President, Sectors & Knowledge; Office of the Vice President for Countries; Puig, Steven J.; Vice Presidency for Finance and Administration; ESRNET; Salazar Sanchez, Hector; Regalia, Ferdinando; Cabrera, Amelia V.; Pevere, Claudia Elena; Nieves, Isabel; Arzu, Harold. The comments received and subsequent actions have been documented in this report.

B. Unresolved Issues: None

C. COMMENTS

Name/Dept.	Topic	Comments	Answers
CID	Project context.	Would suggest removing the sentence It is widely accepted that the country was near macroeconomic collapse between 2004 and 2008 since the there is already sufficient description of the economic context.	The PCR team agrees the sentence is redundant. The sentence was removed.
	Administration missions	The document states that no administration missions took place between 2004 and 2008 (Section IV.a.10), however section VI makes reference to and administration mission taking place in April 2008. Please verify this information. Some administration missions may have taken place in 2008 together with the missions for preparation of the Social Policy Reform PBL.	The available information has been reviewed. The PCR team verifies that there is no evidence of any supervision missions being conducted between late 2004 and April 2008. The PCR has been adjusted to reflect that there is no evidence of missions between Nov. 2004 and April 2008. The PCR team reviewed the aide memories of missions to prepare the Social Policy Support Program (BL-L1004) and verified that none of the three missions included or reported on supervision of BL0014.
	Ratings	Some of the ratings have not been included, for example, at the development objective section, component 1. Is it possible to justify more why they cannot be rated, especially for Component 2, which is the largest component of the loan.	Additional data on achievement of planned outputs has been secured since the PCR was distributed to QRR on 9 June. The PCR has been updated and modified accordingly and ratings have been provided for components 1 and 2, which were the two previously missing.

Name/Dept.	Topic	Comments	Answers
	Lessons learned	The PCR provides an analysis of the critical factors that contributed to the poor execution. Many lessons learned can be drawn from these, for example: 1. The program supported the legal establishment of the National Health Insurance, without a clear idea of how it was going to be financed. What lesson can be drawn for future operations? 2. Another lesson regarding NHI is the importance of taking into account fiscal and macroeconomic constraints before embarking on a non contributory universal scheme. 3. What lesson can be drawn from the fact that the project did not have adequate technical supervision? Would a more hands on supervision help correct the problems identified or change course earlier? Were the numerous changes in team leaders a factor?	1. The PCR team is not full convinced that the program supported the legal establishment of the NHI without a clear idea of how it was going to be funded. The project files provided by the operation's team leader during preparation show that the program did consider the financial aspects of the NHI Fund and the Bank supported the creation of a payroll tax to finance the NHI Fund and its roll out. The Loan Committee approved the Profile II only after reviewing an issues note that dealt with the payroll tax and related issues. When the operation was approved the Bank and the GOBL had agreed to move forward with the payroll tax. Subsequently, conditions changed drastically in Belize and the payroll tax idea was no longer considered politically feasible 2. The PCR team has not found evidence to the effect that the NHI was conceived as a non contributory universal scheme. On the contrary, the design of the NHI scheme was based on the approval of a payroll tax, targeting of non contributing members through a head-count instrument, and the adoption of some cost recovery measures from contributing members and some co-paid services. These measures were not implemented or only timidly implemented during project execution and the consequences of these decisions are addressed in the PCR. Finally, the NHI never achieved the scope of a universal scheme. To this date it remains a service restricted to two pilots that have been extended indefinitely. The sustainability issues raised by this situation are also addressed in the PCR. 3. A lesson to this effect has been added to the appropriate section of the PCR.

Name/Dept.	Topic	Comments	Answers
Landáruzi-Levey, María Cristina LEG	Indicadores	El documento señala que no existen los datos en relación con la mayoría de los indicadores de resultados planteados por lo cual no se puede calificar el cumplimiento de los objetivos de desarrollo. Dentro de los 12 indicadores, la data que existe para 4 de ellos indica que solo 1 se ha cumplido. El documento explica los problemas encontrados con transparencia. El Contrato de Préstamo, Cláusula 4.05 establece que si como resultados de las evaluaciones anuales previstas para realizarse entre el Banco y el Prestatario anualmente, el Banco determina desviaciones de los indicadores acordados, el Banco podría requerir al Prestatario que se suspendan los llamados a licitaciones y cualquier otra actividad que implique compromiso de financiamiento de recursos con cargo al Préstamo. En algún momento se suspendieron las actividades por esta causa? Se consideró no seguir adelante con el financiamiento al haberse encontrado tantos problemas en el camino? Alguna lección aprendida en relación con este tema. Estaríamos especialmente interesados en saber si una cláusula como la pactada pareció útil durante la ejecución.	Se agregó una lección aprendida con relación al uso de las medidas legales que el contrato de préstamo otorga para manejar riesgos y problemas durante la ejecución. El PCR sí señala que el Banco congeló los desembolsos entre febrero 2008 y junio 2009 y que no aprobó retroactivamente las modificaciones a los contratos de obras que no fueron realizadas siguiendo los procedimientos. Vale mencionar que al menos dos especialistas encargados de la supervisión de la operación recomendaron a la administración la cancelación de la operación, entre otras medidas que no fueron aceptadas.
	Lecciones aprendidas	Considerar incluir como una lección aprendida la necesidad de contar con una línea de base y con un panorama claro de cómo se obtendrían los datos que se requieren para poder compararlos con los iniciales y para medir si se alcanzan o no los resultados y productos. También parecería que faltó del Banco mayor prolijidad en relación con el archivo adecuado de documentos como reportes de misión, archivos técnicos y otra documentación que permite dar seguimiento a las acciones tomadas en distintos momentos, con su justificación y antecedentes, entre otras cosas, que bien explica el documento.	Se agregó esta lección aprendida en la sección correspondiente del PCR. Se agregó este tema a una nueva lección aprendida sobre continuidad en la supervisión técnica durante la ejecución.
		El resto de lecciones aprendidas son útiles, gracias por compartirlas. Especialmente relevante el considerar el costo de administración de tener un programa en ejecución por 10 años al momento de tomar una decisión sobre continuarlo o no.	No requiere respuesta.

Name/Dept.	Topic	Comments	Answers
José Luis de la Bastida VPS-ESG	Componente 2	Inicialmente el Componente 2 de la operación estaba dirigido a la rehabilitación de infraestructura ya existe; sin embargo, dentro de la parte de "outputs" no está muy claro si se construyeron 3 hospitales regionales y 3 comunales. Si se fuese el caso de que se construyeron los hospitales, se hizo alguna evaluación ambiental tanto para su construcción y operación? Sería importante incluir en lecciones aprendidas algún punto referente a la intervención/construcción de infraestructura. Como se han manejado los asuntos ambientales a lo que se refiere a construcción, rehabilitación y manejo de hospitales. Se mejoró esta parte? Se han identificado situaciones que demuestren alguna debilidad en la parte ambiental, seguridad y salud laboral? Se han considerado los estándares ambientales internacionales y locales adecuados para el manejo de hospitales?	La explicación de los indicadores del componente 2 ha sido ampliada para dar cuenta del grado en que se logró rehabilitar y equipar los 6 hospitales. El equipo del PCR no pudo encontrar evidencia que indique que hubo problemas con las evaluaciones ambientales de estas obras, o que no se siguieron los procedimientos de salvaguardias ambientales vigentes en el momento en que se aprobaron los documentos de licitación respectivos. Por tanto, el equipo del PCR no cuenta con datos o documentos que le permitan formular lecciones relativas al tema de los salvaguardias ambientales de las obras de rehabilitación cofinanciadas por el Programa de Reforma del Sector Salud de Belice.
Suzanne Casolar ESRNet		The PCR clearly outlines the challenges faced by the project. While weaknesses within the executing agency were clearly identified, the lack of oversight and supervision by the IDB and co-financiers clearly contributed to the critical nature of the situation.	No answer required.
		The Social Sector finances an increased amount of projects with infrastructure components, and the inclusion of infrastructure specialists on the team is a solid lesson learned. Additionally, as projects in the Social Sector are low risk, often times an Environmental or Social Specialist from ESG (Safeguards) is not directly assigned to the team. ESG has noted this and will give particular attention to such education, health, and other projects in the Social Sector with infrastructure components.	No answer required.
		Additionally, ESG would like to mention that given the recent approval of OP-270 Gender Equality in Development, project teams could benefit greatly from the participation of Gender Specialists within ESG to monitor particular targets (IMR, MMR), gender breakdown of staff of MOH, health post and related agencies and institutions, and the design and implementation reproductive health strategy for the project, which was mentioned in the loan proposal but not mentioned in the PCR. Given the constraints of the project, it appears that the strategy was not implemented.	No answer required.

Name/Dept.	Topic	Comments	Answers
		OP-270 Operational Policy on Gender Equality in Development. The new gender policy was approved by the Board of Directors in November 2010 and became effective in May 2011. Within its proactive dimension, the Bank will seek opportunities to promote gender equality and empowerment through its operations. Within its preventative dimension the Bank will undertake strategies to prevent, avoid, and mitigate adverse impacts and risks of exclusion due to gender in its operations. The Bank will seek to promote gender equality in consultation and participation, respect for women's rights, and the application of OP-270 in the risk analysis phase of the project. The Guidelines for Implementation of the policy are currently under preparation.	No answer required.

Distribución autorizada:

Ferdinando Regalia, Jefe
SCL/SPH

Claudia Pévere, SCL/SPH
Secretary of QRR

PROJECT PERFORMANCE MONITORING REPORT (PPMR)

I. BASIC DATA (AMOUNTS IN US$)

PROJECT NUMBER: BL0014
TITLE: Health Sector Reform

LOAN NUMBER(S): 1271/OC-BL
Lending Instrument: Investment / Specific Investment Operation
Borrower: BELIZE
Executing Agency (EA): MINISTRY OF HEALTH AND PUBLIC SERVICES

Sector: HEALTH

Date of Board Approval: 18 Oct 2000
Date of Contract Effectiveness: 10 Apr 2001
Date of Eligibility for First Disbursement: 24 Jan 2002

Contacts:
Executing Agency:
Team Leader: NIEVES, ISABEL

Date of Current Update: 17 Mar 2009
Date Validated by Representative or Division Chief: 19 Mar 2009

PTI: [ ] Yes [X] No
SEQ: [X] Yes [ ] No
Environmental Classification:

Months in Execution:
* from approval: 105
* from contract effectiveness: 100

Loan Proposal, as approved by the Board: PR-2512

Disbursement Periods
Original Disbursement Expiration Date: 10 Apr 2005
Current Disbursement Expiration Date: 30 Apr 2010
Cummulative Extension (months): 60
Special Extension (months): 0

Loan Amount(s):
* Original amount: 9,800,000
* Current amount: 9,800,000
* Pari Passu: 2.73%

Disbursements:
* Amount to date: 9,178,311
* Percent: 93.66%

Total Project Cost:
* Original estimate: 18,130,000

Redirecting Of Resources:
* Has this project:
[ ] Received funds from another Project?
[ ] Sent funds to another Project?
[X] N/A

To Project Number	Via Sub-Loan Number	Amount
From Project Number	Via Sub-Loan Number	Amount

On Alert Status:
Is project currently designated "on alert": [ ] Yes [X] No

HISTORICAL AND CURRENT PPMR RATINGS:

Month Year	Jun 2008	Dec 2008	Jun 2009	Current
Implementation Progress	S	S	U	U
Risk	M	M	H	H
Development Objectives	P	P	P	P

II. ACHIEVEMENT OF DEVELOPMENT OBJECTIVES (DO)

If the operation has multiple purposes (DOs) then enter each one in a separate field. In such a case, each DO must have individual DO ratings. *Progress towards achieving each DO should be rated individually based on the corresponding outcomes achieved. The relative weight of each individual DO in the summary DO classification should be discussed with the Executing Agency.*

Development Objective(s)/Purpose(s)

1. To improve the quality, efficiency and equity of health services delivery so as to improve the health status of the Belizean Population..
Classification: Probable

Key Planned Outcome Indicators	Outcomes Achieved
1.1. Description: By project completion (April 2008), 90 percent of population has adequate physical access to a basic package of primary healthcare services. **Unit:** 90 **Baseline Target:** 0 (_____) **Annual/Intermediate Target:** **EOP Target:** 90 (10 Apr 2008)	0 (_____)
1.2. Description: 40 percent increase in client satisfaction by December 31, 2007 **Unit:** 40 **Baseline Target:** 0 (_____) **Annual/Intermediate Target:** **EOP Target:** 40 (31 Dec 2007)	0 (_____)
1.3. Description: Average throughput meets 50 percent medical compliance to the defined clinical norms, standards and protocol of medical practices **Unit:** 50 **Baseline Target:** 0 (_____) **Annual/Intermediate Target:** **EOP Target:** 50 (31 Dec 2006)	0 (_____)
1.4. Description: Average waiting time for elective surgery reduced to a maximum of six weeks	

Unit: 6 **Baseline Target** 0 (_____) **Annual / Intermediate Target** **EOP Target** 6 (10 Apr 2008)	0 (_____)
1.5. Description: Neonatal mortality rate decreases from12.7/1000 to 11/1000 **Unit:** 11 **Baseline Target** 0 (_____) **Annual / Intermediate Target** **EOP Target** 11 (10 Apr 2008)	0 (_____)
1.6. Description: Reduce crude death rate by 5 percent **Unit:** 5 **Baseline Target** 0 (_____) **Annual / Intermediate Target** **EOP Target** 5 (10 Apr 2008)	0 (_____)
1.7. Description: Reduce the rate of Tuberculosis increase by 25 percent based on 2001-2002 estimates **Unit:** 25 **Baseline Target** 0 (_____) **Annual / Intermediate Target** **EOP Target** 25 (10 Apr 2008)	0 (_____)
1.8. Description: Reduce the rate of increase of HIV/AIDS by 25 percent based on 2001-2002 estimates. **Unit:** 25 **Baseline Target** 0 (_____) **Annual / Intermediate Target** **EOP Target** 25 (10 Apr 2008)	0 (_____)
1.9. Description: Reduce IMR from 21.2/2000 to 20.4/2000 **Unit:** 20.4 **Baseline Target** 0 (_____) **Annual / Intermediate Target** **EOP Target** 20.40 (10 Apr 2008)	0 (_____)
1.10. Description: Maintain the number of maternal deaths below five cases per year. **Unit:** 5 **Baseline Target** 0 (_____) **Annual / Intermediate Target** **EOP Target** 5 (10 Apr 2008)	0 (_____)

Reformulation: Was the objective(s) of this project reformulated? [ ] Yes [X] No

If yes, indicate date of Board Approval: _____

Briefly describe the consequences of these changes. (If any changes were made to the outcome indicators/targets, describe it under the next section.):

Hyperlink: _____ (Hyperlink through IDBDOCS to documentation approved by the Board.)

Were there any changes to the outcome indicators or targets? [X] Yes [ ] No

If yes, indicate most recent date 08 Nov 2004 and who approved these changes: Loan Administration Mission.

Briefly explain any changes that were made. (If this was part of a retrofitting exercise, see below.)
Indicators and targets were revised and the timelines for their achievement were extended given the pace of execution at the time.

Hyperlink: _____ (Hyperlink through IDBDOCS to documentation approved by the Representative.)

Retrofitting: Was this PPMR retrofitted? [X] Yes [ ] No

If yes, indicate most recent date 08 Nov 2004

Briefly explain any changes resulting from this exercise.
Many of the targets and indicators were made more realistic given the prevailing circumstance in the operation at the time.

Summary Development Objective(s) Classification (DO):

[ ]Highly Probable (HP) [X]Probable (P) [ ]Low Probability (LP) [ ]Improbable (I)

Briefly justify the Summary DO Classification based on the degree planned targets were met, explaining the difference between planned and actual outcomes, as well as any other relevant factors. Cite reference for evidence that supports these results.
There have been two Loan Administration Mission for this operation within the last four years. On the last mission in November 2004, the executing agency requested a restructuring that resulted in a small reduction in scope for the project and a prioritization of activities in the civil works component. A two-year work plan for the operation was prepared at that time to support the request for extension and the EA also made changes in the major consultancy for civil works which has asist project execution. In December 2006 during the Portfolio Review Mission, agreement was made to consider a Special Extension of one year for this operation. In April 2007, the extension was realized and all resources under the operation was committed.. It is expected that no additional extensions will be necessary. With these developments, the outlook for project implementation has improved.

The Government of Belize has attached high priority on the health sector particularly the determination to complete the rollout of the National Health Insurance (NHI) to the rest of the country by December 31, 2007 In July 2006, it was rolled out to the Southern part and in 2007, it will be rollout to the rest of the country. Apart from the incidence of HIV/AIDS, some of the health indicators are showing some improvements. This is particularly so for maternal child health which compares favourably in the region.

The crude death rate target of reduction by five percent has been achieved; the waiting time for elective surgery has been reduced from six months to three months with the attainment of the target of six weeks very probable by the end of 2007.; the IMR has improved from 21.2 to 17..0 over the last year. The adherence of 50 percent to clinical protocols and norms was adversely affected by the inability of MOH to set up this department responsible for accreditation and certification of medical personnel and facilities. Recent indications are that this activity is now underway. Despite a slowdown in the proposed rollout of the NHI to the entire country the government has as its target 90 percent of population by the end of 2007. The NHI now covers about 30 percent of the population with the rollout to the southern region.

The public opinion on the services provided by the main hospital in Belize, the KHMH has been improving every year as indicated by customer surveys conducted by the Ministry of Health. The last survey conducted 2005 indicates a higher than 30 percent increase in client satisfaction at the KHMH. This resulted directly from the institutional strengthening activity under the project and remedial civil works carried out under the EU financing. It is expected that the construction and rehabilitation of hospitals will have positive effects on client satisfaction and service delivery and ultimately on the health indicators.

The project is nowl at a stage where the level of investment made is over 70 percent of total financing.

Country Strategy: **At the time of approval this project was expected to contribute to the following Country Strategy objective(s):**
Poverty Reduction

Given the results described above, briefly discuss how the project has contributed or will contribute to the Bank's strategy in this country:

Hyperlink to Country Strategy: _____

Sustainability Analysis:
There is overal concern about the sustainability of the activities initiated under this operation particularly relating to financing the operations of public health facilities and the National Health Insurance (NHI). It was originally envisaged that a payroll tax would be introduced to sustain the NHI. Instead the Government opted to finance the program from Social Security funds which are earmarked for other purposes. Additional funds have been allocated from the Ministry of Finance's budget. In the medium to long term these sources

are not sustainable.

Sustainability Classification:

[ ]Highly Probable (HP) [ ]Probable (P) [X]Low Probability (LP) [ ]Improbable (I)

Externalities:

III. IMPLEMENTATION PROGRESS (IP)

Components (Outputs):

Component Title: Health Sector Restructuring

Description: Ministry of Health (Public Health Sector) restructed and capacity strengthening plan implemented

Total cost of Component __ Counterpart: __ IDB: __ Co-financing: __

IDB Disbursement: __ Total amount committed: __

Classification: Satisfactory

Key Indicators for Planned Outputs	Actual Outputs
1. Description: Central MOH refocused toward policy and regulation and no longer providing health services directly by end of project. **Unit:** 0 **Baseline Target** 0 (_____) **Annual/Intermediate Target** **EOP Target** 0 (10 Apr 2008)	0 (_____)
2. Description: Regulatory framework established and functioning (based on the outputs of MIF/TC) by April 30, 2007. **Unit:** 0 **Baseline Target** 0 (_____) **Annual/Intermediate Target** **EOP Target** 0 (10 Apr 2008)	0 (_____)
3. Description: MOH restructured and staff trained in new procedures by April 30, 2007. **Unit:** 0 **Baseline Target** 0 (_____) **Annual/Intermediate Target** **EOP Target** 0 (10 Apr 2008)	0 (_____)
4. Description: Karl Huesner Memorial Hospital (KHMH) is autonomous by June 1st, 2003. **Unit:** 0 **Baseline Target** 0 (_____) **Annual/Intermediate Target** **EOP Target** 0 (10 Apr 2008)	0 (_____)
5. Description: Four Health Regions established and functioning, each with an approved level of autonomy with regard to human resources, financial management, provision of services and contracting by April 30, 2007. **Unit:** 4 **Baseline Target** 0 (_____) **Annual/Intermediate Target** **EOP Target** 4 (10 Apr 2008)	4 (16 Nov 2007)
6. Description: Public Information Strategy designed and conducted by April 30, 2007. **Unit:** 0 **Baseline Target** 0 (_____) **Annual/Intermediate Target** **EOP Target** 0 (10 Apr 2008)	0 (_____)
7. Description: Health Promotion Strategy designed and conducted by April 30, 2007. **Unit:** 0 **Baseline Target** 0 (_____) **Annual/Intermediate Target** **EOP Target** 0 (10 Apr 2008)	0 (_____)

In the case of unsatisfactory or very unsatisfactory ratings for this component, provide comments on its status focusing on the problems identified in attaining planned outputs. Other pertinent information may also be entered here:

Consultancy for the institutional strengthening of the KHMH has been successfully completed and customer surveys conducted over the past year indicate an increase by 30 percent in customer satisfaction.

KHMH has been autonomous since 2003. A Health Information System is currently being installed which will further strengthen the delivery of services to the general public. It was recently commissioned for internal reporting engine go-live. The completion of the BHIS is scheduled for March 2008.

As was designed, Service Level Agreements have been successfully developed for the provision of health services at the regional hospitals and for these hospitals to purchase services as well as sell services to the NHI scheme. The hospitals currently operating under the NHI scheme are utilising the service level agreements.

The Cabinet in March of 2005 gave the approval for the establishment of four regional authorities as was originally envisaged under the project instead of the alternative single authority that would centralize the management and delivery of health care service. The consultancy for the legal framework for this operation was completed in July 2007 and the revised Draft National Health Authority Bill and Cabinet Paper were also completed in July 2007. It is now the responsibility of the Ministry of Health to present it to Cabinet for approval. This will devolve authority to the regions in areas of human and financial resources. Meanwhile, the regional facilities are being staffed and operating according to the proposed framework.

The Public Information Strategy which was designed to market the activities of the Health Sector Reform program to the public experienced procurement difficulties and is delayed. This activity financed by the CDB commenced in October 2007 and is expected to be completed by December 26, 2007. Promoting Knowledge and Behavioural Change: This activity addresses the promotion of knowledge and the encouragement of behavioral change in targeted priority populations to be achieved through the educational sector and the Health Education and Community Participation Bureau (HECOPAB). The scope of work has been finalized and funds from the GOB have been identified to develop the strategy utilizing in-house trainers/facilitators with support from some government institutions and other social partners in health.

The training of the Regional Health Management Teams (RHMT) which is being financed by CDB began in October 2007 and is scheduled for completion in early April 2008. Under this activity, technical assistance will be provided to institutional strengthening the four Health Regions in the areas health services administration and government financial regulations to improve on the management of administrative issues and improve accountability for revenue and expenditures.

The training plan for the Policy and Programming Unit (PAPU) was modified for execution in-house. A local reform consultant assessed the training needs and made recommendations for a training program and strategy. The actual training program will include workshops aimed at orienting the staff to the new management procedures and processes resulting from reform. For both of these activities, assistance has been provided by PAHO, particularly in the revision of the TORs. The training began in July 2007 and is expected to be completed in April 2008.

Restructuring: Indicate if this component was restructured (approved by Operational Department): [ ] Yes [X] No

If yes, date: _____

Briefly describe the consequences of these changes:

Hyperlink to documentation approving restructuring, if relevant: _____

Component Title: Support to the National Health Insurance (NHI) Fund

Description: Health Sector Financing Strategy developed and implemented.

Total cost of Component	0	Counterpart:	0	IDB:	0	Co-financing:	0
IDB Disbursement:	0	Total amount committed:	0				

Classification: Unsatisfactory

Key Indicators for Planned Outputs	Actual Outputs
1. Description: National Health Insurance (NHI) legally established under SSB to be the prime financial instrument and purchaser of personal health services from public and private sectors by April 2007. **Unit:** 0 **Baseline Target** 0 (_____) **Annual / Intermediate Target** **EOP Target** 0 (10 Apr 2008)	0 (_____)
2. Description: All NHI purchases are carried out in accordance with standard procedures and standard performance contracts by December 2006. **Unit:** 100 **Baseline Target** 0 (_____) **Annual / Intermediate Target** **EOP Target** 100 (10 Apr 2008)	100 (16 Nov 2007)

In the case of unsatisfactory or very unsatisfactory ratings for this component, provide comments on its status focusing on the problems identified in attaining planned outputs. Other pertinent information may also be entered here:
The National Health Insurance (NHI) was established by GOB in 2003 following a pilot financed by The Social Security Board (SSB) on the southside of Belize City. Currently, the NHI caters to over 36, 000 citizens on the southside of Belize City and over 45,000 in southern Belize representing over 30 percent of the population. Early during the project, the GOB decided to forego the levying of a payroll tax as was originally designed to finance the NHI and decided instead to finance the programt using Social Security Board (SSB) funds and allocations from the national budget.

The GOB plans to rollout the NHI to the rest of the country by December 31, 2007. There is still the concern however over the sustainability of the program into the medium term given the current sources of financing and given that the payroll tax levy was rejected.

The MIF TC had assisted significantly in preparing the necessary regulations, protocols and purchasing plans for the operationalization of the NHI. Given that GOB used its own funds for the NHI, a request was received in 2003 for the reallocation of funds originally reserved for the NHI activities in component one such as the Health Information System which the MOH considers to be very pivotal for enhanced service delivery. Additionally, some of these funds have been utilized for the MIS for the NHI.. So far GOB has spent significant resources in the provision of NHI services. However it is still doubtful that the NHI will be implemented along the lines originally contemplated by the project.

The sustainability of the investment made in the health sector under this project rests on a feasible financing mechanism for health insurance.

Restructuring: Indicate if this component was restructured (approved by Operational Department): [ ] Yes [X] No

If yes, date: _____

Briefly describe the consequences of these changes:

Hyperlink to documentation approving restructuring, if relevant: _____

Component Title: Services Rationalization and Improvement

Description: Physical Infrastructure upgraded and related plans for improvement and rationalization of health services implemented.

Total cost of Component	0	Counterpart:	0	IDB:	0	Co-financing:	0
IDB Disbursement:	0	Total amount committed:	0				

Classification: Unsatisfactory

Key Indicators for Planned Outputs	Actual Outputs
1. Description: Refurbishing and expansion of physical infrastructure completed (6 facilities) , and equipment installed and operating by April 10, 2008. **Unit:** 6 **Baseline Target** 0 (_____) **Annual / Intermediate Target** **EOP Target** 6 (10 Apr 2008)	0 (_____)
2. Description: Three Regional Hospital established, services expanded and managed under performance contracts by April 2007. **Unit:** 3 **Baseline Target** 0 (_____) **Annual / Intermediate Target** **EOP Target** 3 (10 Apr 2008)	3 (16 Nov 2007)
3. Description: Three Community Hospitals in operation by December 2005. **Unit:** 3 **Baseline Target** 0 (_____) **Annual / Intermediate Target** **EOP Target** 3 (10 Apr 2008)	3 (16 Nov 2007)
4. Description: Services redistributed as per Technical Note #2, Health Service and Infrastructure HRSP project document by April 30, 2007. **Unit:** 100 **Baseline Target** 0 (_____) **Annual / Intermediate Target** **EOP Target** 100 (10 Apr 2008)	0 (_____)
5. Description: Health Education and Community Participation Bureau (HECOPAB) strengthened with its public health programme developed and implemented by December 31st, 2006 **Unit:** 0 **Baseline Target** 0 (_____) **Annual / Intermediate Target** **EOP Target** 0 (10 Apr 2008)	0 (_____)

In the case of unsatisfactory or very unsatisfactory ratings for this component, provide comments on its status focusing on the problems identified in attaining planned outputs. Other pertinent information may also be entered here:
The civil works sub-component of this component which represent over 60 percent of total budget was progressing too slowly. This was partially the reason for the adjustments made to the project in March of 2005 including the granting of a two-year extension. The proposal under the adjusted project includes the scaling down of some of the civil works based on a prioritized list of activities and the deferral of others on the basis of importance. This was the case for regional managers' offices, and a smaller halfway house in Belmopan. However, it was not practical to reduce the size of the San Ignacio Community Hospital. It also considered the replacement of the supervising consultant firm with whom the executing agency had experienced difficulties that resulted in poor estimates and a failed/ unresponsive bidding process. The Executing Agency in June 2006 contracted the services of two new Architectural and Engineering (A&E) consultants. This allowed for the simultaneous execution of services and works on all proposed facilities. The designs and bidding

documents for all six facilities were approved and tendered and contracts were signed in February 2007. One activity successfully completed under this component is the rehabilitation of the Orange Walk Hospital (Northern Regional) sewer system.

In late August/ early September 2007, the bank discovered that some original contract totals had been increased by virtue of some change orders unknown to the Bank. The specialist immediately called the PCU manager indicating that it was against Bank¿s procedures and a violation of the loan contract to make modification to the contracts without the Bank¿s no objection. The specialist further reminded the EA that given the Special Extension, there were no more funds to support any increase in contract even it were necessary. The specialist also explained that the Bank may give a no objection if the additional works were critical provided that the EA could guarantee that the necessary funds would be made available through counterpart allocations. The EA then wrote requesting a retroactive no objection for a series of additional works for three contracts: the Corozal Hospital, the Northern Regional and the Western Regional. The EA justified the need for the additional work in a letter requesting the no objection. The Bank responded to the EA on September 23, 2007 giving a provisional no-objection depending on the EA¿s ability to demonstrate the availability of counterpart funds. There was no corresponding response from the EA indicating the availability of funds to honor the changes. In several discussions with the EA subsequently, they indicated that the Ministry of Finance had given its approval to support the increases in cost. No written correspondence was forwarded to support this claim.

In February/March 2008, when the Government changed and a new Financial Specialist was assigned to COF/CBL, a meeting was convened with the EA¿s new CEO where a recommendation was made to suspend all new disbursements. During an administration mission In April 2008 it was agreed that both the EA and the Bank would hire different independent consultants (engineers) to do a rapid assessment of the works to determine whether the additional works subject to contract modifications were justified and critical, and to determine the value of these works. The original contracts under examination include: Corozal Hospital, the Northern Regional and the Western Regional Hospital and to a lesser extent, the Belmopan Half-Way House.

The two assessments were sent to the fiduciary department (VPC/PDP) of the Bank, who recommended that an independent audit of the contracts in question be carried out.

To date, the following information is still missing from the EA, in order to ensure the finalization of works and an extension of the disbursement deadline to early 2010: (i) Clarification, on the portion of expenditure-to-date already paid out of the IDB loan -- this information is crucial in order to ensure that the IDB expenditure to date plus the suggested distribution of the remaining IDB funds does not exceed the original amount for each of the works; and (ii) confirmation by the relevant authorities that the specified balances payable by GOB and CDB are either available or will become available for expenditure by the project in 2009 and beyond.

Seven patient transportation vehicles (ambulances) were successfully procured and deployed under this operation. This was completed in January 2007.

Restructuring: Indicate if this component was restructured (approved by Operational Department): [ ] Yes [X] No

If yes, date: _____

Briefly describe the consequences of these changes:

Hyperlink to documentation approving restructuring, if relevant: _____

Implementation Progress Summary Classification (IP):

[ ] Highly Satisfactory (HS) [ ] Satisfactory (S) [X] Unsatisfactory (U) [ ] Very Unsatisfactory (VU)

Briefly justify the Summary IP Classification based on the degree planned targets were met , explaining the difference between planned and actual outputs as well as any other relevant factors. Cite reference to evidence that support these results.

The execution of Component One (Health Sector Restructuring), particularly the institutional strengthening of The Karl Heusner Memorial Hospital (KHMH) and Deconcentrating Operational Authority to Health Regions have been relatively satisfactory- four health regions were successfully established and are functioning with approved though limited levels of autonomy. The KHMH is now autonomous. The current activity of establishing the Belize Health Information System is almost completed and along the lines originally contemplated by the project. Many of the reforms planned under the project are being implemented and do not require much financial investment to execute. They however require staff dedication and coordination for successful execution. In this regard, the Bank assisted the MOH through the provision of a Reform Consultant who consolidated efforts and assisted in accelerating the reform activities.

For the past three years the execution of Components two of this operation has been slow and unsatisfactory due to difficulties in consultant performance and and procurement problems. Government's commitment to this project is evidenced by the increased allocations made in this year's budget for the purchase of land for the San Antonio and San Ignacio Hospitals. Government has also pledged additional resources for the completion of the San Ignacio Hospital to accommodate the change in proposal from rehabilitation to new construction. In April, an agreement between the Government and the Bank resulted in the in the allocation of funds for the San Ignacio Hospital while Government would now take on the provision of equipment for the various health facilities. This needs to be monitored closely to ensure that the requisite funds are allocated by GOB for the procurement of equipment.

Overall project coordination has improved and there is a general positive spirit and a sense of urgency in MOH that is building momentum. The project is classified as satisfactory as it is expected that all activities underway will be completed within the current disbursement period. The executing agency requested a Special Extension in March 2007 and it was approved based on the recommendations of the Portfolio Review Mission of December 2006.

Check off critical factors/reasons for Unsatisfactory/Very Unsatisfactory IP Classification or Low Probability/Improbable DO classification, and reflect in section IV (Risk Profile), as needed:

[ ] Legislative approvals	[ ] Inter-agency coordination	[X] National policy changes
[ ] Borrower/executing agency commitement	[ ] Supplier/contractor performance	[ ] Executing agency policy changes
[ ] Counterpart funding shortfall/fiscal ceilings	[ ] Project/component design	[ ] Bank policy changes
[X] Executing agency institutional capacity	[ ] Bank efficiency (response delays)	[ ] Lack of monitoring/evaluation system
[X] Community/politial opposition	[ ] Environmental issues	[ ] Other:
[ ] Consultant services performance	[X] Cost overrun	

FIDUCIARY ISSUES PROFILE

[X] **Contractual Condition Compliance Delays.** List any delay and/or other problems in compliance with other important contractual conditions:
[X] The FAS was received in July 31, 2007.

[X] **Audited Financial Statements (AFS).** List any important qualified options of the auditor presented in the AFS:
The auditors expressed an unqualified opinion for the 2007 AFS report. Few observations/recommendations regarding internal controls. The external auditor reported differences among the records of the Executing Agency, the IDB records and the CDB

Observations of Financial Specialist, including comments on AFS and/or factors affecting the development objectives:
The Country Office prepared terms of reference in order to hire a cosultant with the objective to reconcile the differences among the records of the Executing Agency and the Bank. Currently, the executor is analyzing the mentioned terms of references

Relevant Hyperlinks:

Qualified opinions given by external auditors (AFS): _____

Project AFS Review Guide(AF320): _____

Timeliness of AFP Submission(LMS40): http://ops/lms/lms40.asp?UDRCode=CBL&LoanType=LON&AuditYear=2008

Documents/correspondence to and from the EA regarding non-compliance, if applicable: _____

[X] **Procurement difficulties, if applicable.** Briefly list any major procurement issues affecting implementation progress:
During the first three years of project execution there were procurement difficulties surrounding mainly the selection of architecture and engineering consultants and the first attempt at call for bids for the civil works resulted in bids far in excess of estimates.

Any additional observations of Financial, Sector and/or Procurement Specialist(s):

The AFS report for year 2007 was accepted by the Bank during September 2007. No material weakness were found by the auditors.

IV. RISK PROFILE

Key Risk:	Category	(a) Severity of Impact	(b) Likelihood of Ocurrence	(a x b) Classification
1. Bi-national Health Agreements are not effectively maintained and policed	Development effectiveness	3	30	90
2. Health personnel are not available in the quantity necessary for the needs of the National Health Insurance	Fiduciary and operational	3	70	210
3. The Government cannot sustain exiting levels of health budget	Fiduciary and operational	3	50	150
4. The works not finalized although the laon fully disbursed, due to cost increasing change orders that were not approved by the Bank	Fiduciary and operational	4	70	280

Summary Risk Classification (RI):

[ ]Very High [X]High [ ]Moderate [ ]Low

ALERT STATUS PROJECTS

Comments on relevance of "on alert" status for this project (if applicable):

V.PLAN OF ACTION FOR RISK MANAGEMENT AND TO ADDRESS IMPLEMENTATION PROBLEMS

RISKS

Risk:	Response:
0	Subsequent to the agreement made between the Bank and the MOH for the increase in allocation for San Ignacio Hospital, MOH agreed to allocate in exchange the requisite funds as counterpart for the purchase of equipment for the health facilities. The Bank will request MOH/MOF to provide evidence that this allocation has or is being made for the coming budget year. **Responsible unit:** Ministry of Health and Ministry of Finance **Date Action to be completed:** 31 Jan 2008 **Date Action Completed:** _____
0	MOH authorized adjustments to some civil works contracts that have increased the value of some contracts beyond what is available in the loan financing. There is a risk that adequate funds will not be available to complete these facilities as they were designed if the requisite funds are not allocated. MOH/MOF needs to provide evidence to the Bank that the necessary funds will be made available to execute the contracts fully. **Responsible unit:** MOH/MOF **Date Action to be completed:** 31 Jan 2008 **Date Action Completed:** _____
4	Confirmation that the specified balances payable by GOB and CDB to complete the program works are either available or will become available for expenditure by the project in 2009 and beyond **Responsible unit:** MOH/MOF **Date Action to be completed:** 30 Jan 2009 **Date Action Completed:** _____

IMPLEMENTATION PROBLEMS

Implementation Problem:	Action Plan:
1. Given the tight time-table for the execution of the project and the completion of all activities, the Bank will continue and even intensify its schedule of inspection visit to ensure that planned activities are completed on time.	**Responsible unit:** COF/CBL **Date action to be completed:** 31 Mar 2008 **Date action completed:** _____
2. Given that the operation is approaching completion, it is timely to now conduct the Final Evaluation of the project.	**Responsible unit:** COF/CBL **Date action to be completed:** 15 Feb 2008 **Date action completed:** _____

VI. LESSONS LEARNED

Add or fine-tune lessons learned that can be used to improve the programming, design, execution, as well as the monitoring and evaluation of other operations in the sector or country, as needed.

1. Closer collaboration and coordination among co-financiers is critical for effective project execution.

2. There is need for more realistic analysis among local stakeholders, namely the executing agency and the Ministry of Finance during project preparation particularly relating to budget estimates, financing and scope of works.

VII.MONITORING AND EVALUATION

When was the baseline information gathered for at least one outcome indicator?

[X] Before Board Approval [ ] Other Date: _____

When was the baseline information gathered for at least one output indicator, if applicable?

[X] Before Board Approval [ ] Other Date: _____

Does the borrower have a defined data gathering system in place?

[X] Yes [ ] No

Is the borrower maintaining performance data on agreed outcome indicators?

[X] Yes [ ] No

Is the borrower maintaining performance data on agreed output indicators?

[X] Yes [ ] No

Are there any *issues* or problems related to the quality, validity and timeliness of the data gathering system?

[ ] Yes [X] No

Start-up Mission:

[ ] Yes [X] No If yes, date: _____

Hyperlink(s) to relevant Aides Memoire(s): _____

Administration or Other Relevant Missions:

[X] Yes [ ] No If yes, date: 08 Dec 2004

Hyperlink(s) to relevant Aides Memoire(s): _____

Mid-Term Evaluation (MTE):

[X] N/A [ ] Planned [ ] Completed Date: _____

Briefly describe the main findings and results, as well as the principal conclusions/recommendatios of this evaluation:

Hyperlink(s) to MTE: _____

Final Evaluation: Is a final evaluation for this project foreseen?

[X] Yes [ ] No If yes, date: 16 Mar 2008

Hyperlink(s) to relevant Aides Memoire(s)and/or report: _____

Ex-Post Evaluation: Is an ex-post evaluation for this project foreseen?

[ ] Yes [X] No If yes, date: _____

DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK
NOT FOR PUBLIC USE

Simplified Procedure

PR-2512
26 September 2000
Original: English

To: The Board of Executive Directors

From: The Secretary

Subject: Belize. Proposal for a loan for a health sector reform program

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Basic information:
Borrower ..... Belize
Amount ..... up to US$9.8 million
Source ..... Single Currency Facility of the Ordinary Capital

Agenda: Board of Executive Directors, on 18 October 2000

Inquiries to: Mr. Juan Carlos de la Hoz (extension 1451)

Remarks: The operation was included in the country paper approved by the Board and its amount does not exceed the established ceiling for Group D countries.

References: GN-1838-1, GN-2019-2

Other distribution: Managers, Division Chiefs, Representative in Belize

DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK
NOT FOR PUBLIC USE

BELIZE

HEALTH SECTOR REFORM PROGRAM

(BL-0014)

LOAN PROPOSAL

This document was prepared by the project team consisting of: Juan Carlos de la Hoz, (RE2/SO2), Project Team Leader; José Juan Gómez, (RE2/OD4); Leon Harris, (COF/CBL); Bill Savedoff, (SDS/SOC); María Angélica Albino, (SDS/SOC); Dana Martin, (LEG/OPR); Sara Bojorge-Sáenz, (RE2/SO2), and Beatriz Jellinek, (RE2/SO2).

CONTENT

ANNEXES

APPENDICES

BASIC SOCIOECONOMIC DATA

The basic socioeconomic data for Belize is available on the Internet at the following address:

English:
www.iadb.org/int/sta/english/staweb/statshp.htm

Spanish:
www.iadb.org/int/sta/spanish/staweb/statshp.htm

INFORMATION AVAILABLE IN THE FILES OF RE2/SO2

PREPARATION:

1. HSLP. Technical notes and Action Plans
2. Roger England. Revenue Model for the NHIF
3. Osvaldo Schenone. Belize. National Health Insurance: Financing
4. Andrew Downes. The Design of a Monitoring Mechanism to Assess the Impact of the Payroll Tax on the Labor Market in Belize

EXECUTION:

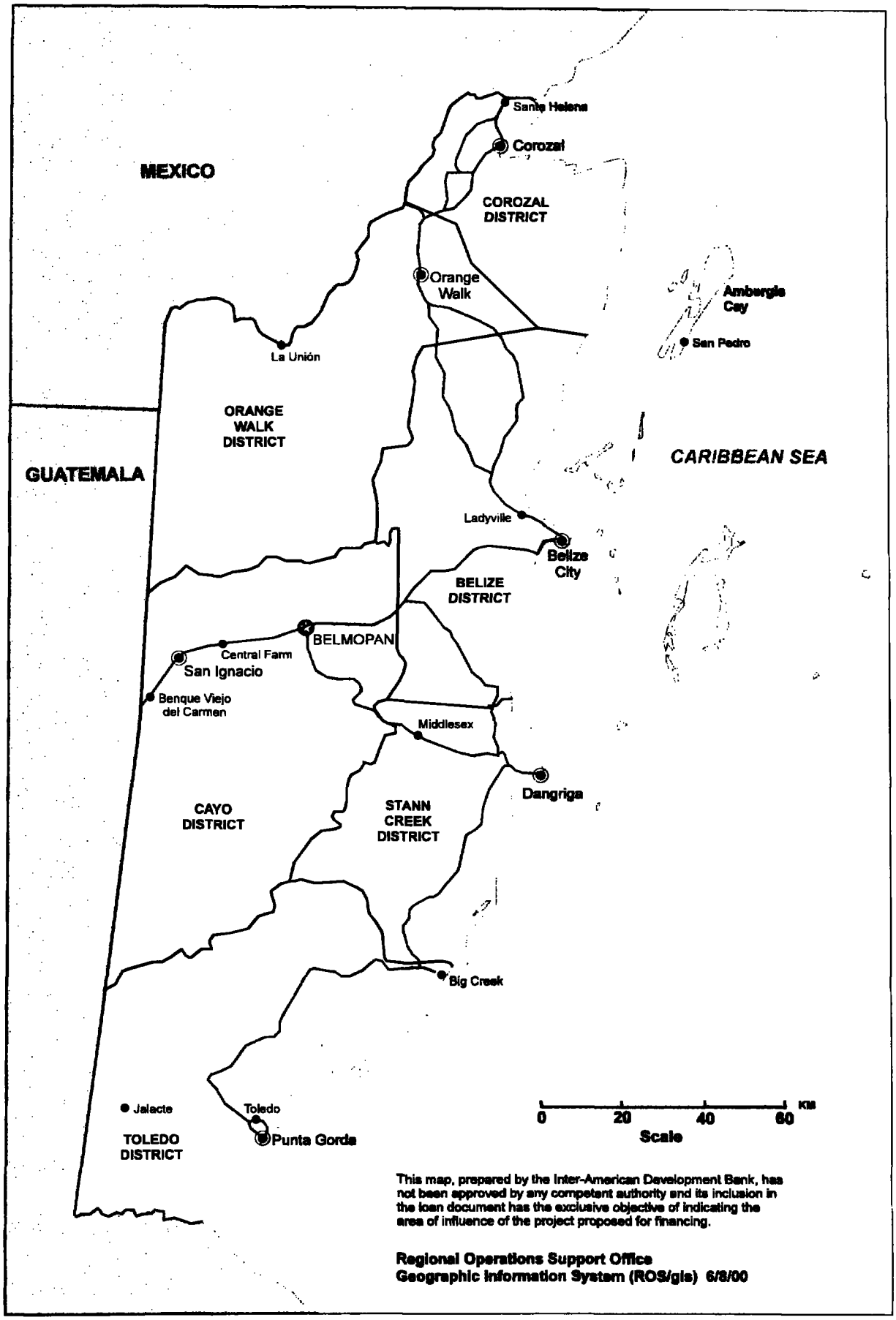
1. Nelson Hernández. Estructura financiera y plan de ejecución del Programa de Reforma del Sector Salud (BL-0014)

ABBREVIATIONS

BSSB	Belize Social Security Board
GOBL	Government of Belize
HR	Health Regions
KHMH	Karl Heusner Memorial Hospital
KHMHA	Karl Heusner Memorial Hospital Authority
LO	Liaison Officer
MoH	Ministry of Health and Public Service
MIF	Multilateral Investment Fund
NHIF	National Health Insurance Fund
PPU	Policy and Planning Unit
SA	Statutory Authority

BELIZE

HEALTH SECTOR REFORM PROGRAM (BL-0014)



This map, prepared by the Inter-American Development Bank, has not been approved by any competent authority and its inclusion in the loan document has the exclusive objective of indicating the area of influence of the project proposed for financing.

Regional Operations Support Office
Geographic Information System (ROS/gis) 6/8/00

INTER-AMERICAN DEVELOPMENT BANK
Regional Operations Support Office
Operational Information Unit

BELIZE

IDB LOANS

APPROVED AS OF AUGUST 31, 2000

	US$Thousand	*Percent*
TOTAL APPROVED	***55,435***	
DISBURSED	*8,789*	*15.9%*
UNDISBURSED BALANCE	*46,646*	*84.1%*
CANCELLATIONS	*0*	*0.0%*
PRINCIPAL COLLECTED	*0*	*0.0%*
APPROVED BY FUND		
ORDINARY CAPITAL	*55,435*	*100.0%*
FUND FOR SPECIAL OPERATIONS	*0*	*0.0%*
OTHER FUNDS	*0*	*0.0%*
OUSTANDING DEBT BALANCE	***8,789***	
ORDINARY CAPITAL	*8,789*	*100.0%*
FUND FOR SPECIAL OPERATIONS	*0*	*0.0%*
OTHER FUNDS	*0*	*0.0%*
APPROVED BY SECTOR		
AGRICULTURE AND FISHERY	*4,502*	*8.1%*
INDUSTRY, TOURISM, SCIENCE &TECHNOLOGY	*11,000*	*19.8%*
ENERGY	*0*	*0.0%*
TRANSPORTATION AND COMMUNICATIONS	*16,000*	*28.9%*
EDUCATION	*0*	*0.0%*
HEALTH AND SANITATION	*0*	*0.0%*
ENVIRONMENT	*2,600*	*4.7%*
URBAN DEVELOPMENT	*0*	*0.0%*
SOCIAL INVESTMENT AND MICROENTERPRISE	*21,333*	*38.5%*
REFORM &PUBLIC SECTOR MODERNIZATION	*0*	*0.0%*
EXPORT FINANCING	*0*	*0.0%*
PREINVESTMENT AND OTHER	*0*	*0.0%*

**** Net of cancellations with monetary adjustments and export financing loan collections***

INTER-AMERICAN DEVELOPMENT BANK
Regional Operations Support Office
Operational Information Unit

BELIZE

TENTATIVE LENDING PROGRAM

				US$ Millions	
2000					
	BL0012	TOURISM DEVELOPMENT		11.0	APPROVED
	BL0014	HEALTH SECTOR REFORM		9.8	
			TOTAL A	**20.8**	
	BL0017	LAND ADMINISTRATION II		9.0	
			TOTAL B	**9.0**	
			TOTAL 2000	**29.8**	
2001					
	BL0013	ENABLING ENVIRON. BUSINESS & INVESTMENTS		2.0	
			TOTAL B	**2.0**	
			TOTAL 2001	**2.0**	

INTER-AMERICAN DEVELOPMENT BANK
Regional Operations Support Office
Operational Information Unit

BELIZE

STATUS OF LOANS IN EXECUTION AS AUGUST 31, 2000

(Amounts in US$ thousands)

APPROVAL PERIOD	NUMBER OF PROJECTS	AMOUNT APPROVED	AMOUNT DISBURSED	% DISBURSED
1996 - 1997	2	3,502	2,834	80.94%
1998 - 1999	3	40,933	6,230	15.22%
2000	1	11,000	0	0.00%
TOTAL	6	$55,435	$9,064	16.35%

* Net of Cancellations . Excluding export financing loans.

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.

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[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:

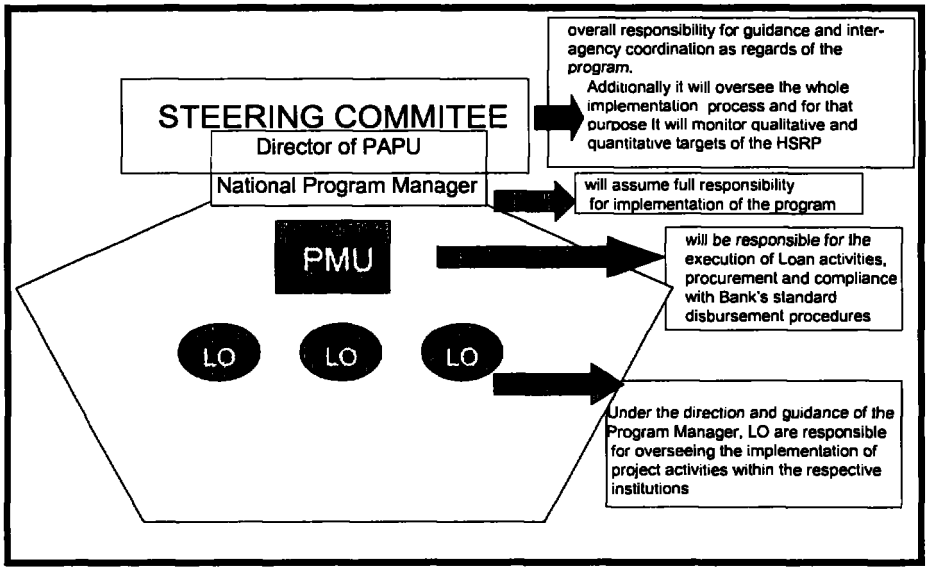
i. The Project Management Unit (PMU), headed by a Coordinator, will be responsible for the execution of Loan activities, procurement and compliance with Bank's standard disbursement procedures. Other members: Procurement Officer, Financial Administrative Director, and an Accounting Clerk/Secretary.

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.**

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[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.