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HEALTH CARE FINANCING IN LATIN AMERICA AND THE CARIBBEAN
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Exploratory Report: Options for Health Care
Financing Studies in Belize

Prepared by:

Jeremiah Norris

Submitted to:

State University of New York at Stony Brook

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International Resources Group, Ltd.
100 North Country Road
Setauket, NY 11733 USA

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I INTRODUCTION

During the period April 20 - 30, 1986 International Resources Group consultant, Jeremiah Norris, visited USAID/Belize to complete the following scope of work:

1. To meet with directors of the Santiago Castillo Hospital (private) and assess potential options and strategies for keeping this facility open;
2. To meet with the Minister of Health and assess the nature of the Government of Belize (GOB) requests to USAID;
3. To meet with the director of the Banana Control Board and discuss his plans for extending health services for farmers;
4. To meet with such other officials in the public and private health sectors as deemed appropriate by USAID; and
5. Based on the above interviews, suggest a strategy for USAID assistance, initially utilizing centrally funded AID/W contracts through the State University of New York or John Snow International.

The trip report is divided into four sections (following this Introduction): Section II, Observations, is drawn mainly from the field interviews summarized in Annex A. Section III describes two recommendations to USAID/Belize. The first deals with a feasibility study to determine the potential for establishing a Consortium on Health Services Development, while the second outlines a health cost study for the Ministry of Health. Section IV, Scope of Work, suggest how the recommendations might be implemented in the near term and lists requirements for consultant staff in labor time and broad qualifications. Alongside Annex A, mentioned above, Annex B is a list of persons and institutions interviewed, and Annex C is a bibliography of materials used during this consultancy. Throughout the field trips the IRG consultant was accompanied by Mr. Sam Dowding, USAID/Belize Health Officer.

II OBSERVATIONS

Based on the interviews listed in Annex A, there are two major program possibilities in health care organization and finance for USAID/Belize. First, there is a high degree of interest on the part of the Banana Control Board (BCB) to be part of an organized on-going fee-for-service delivery program to their members, including a formal linkage to external referral sources for in-patient care, physician services on a rotating basis, emergency care, medical supplies, and management assistance. It is felt by the BCB that other commercial ventures, i.e., Coca Cola, Hershey and the Citrus Growers Association, would join the Consortium. At any rate the BCB is going to establish its own outpatient delivery system with or without this consortium being organized.

The second opportunity involves a cost study for the Ministry of Health. At the present time, all patients using public facilities are supposed to pay for their care on a sliding fee basis (those who can afford pay more than those who are indigent, who are not required to pay). The tariff structure was originally printed in 1973 (when Belize was British Honduras) and has never been changed since. In the Belize hospital, which is the main Ministry of Health facility, collections average BZ 11,000* per month against an average patient discharge of 20 per day. Thus, given these figures, collection income equals BZ 132,000 per annum for 7,300 patient discharges, or BZ 18 per discharge. If lengths of stay were a conservative 6 days on the average (actual figures not available), then on a bed-day basis collection income would equal BZ 3, an amount apparently insufficient to justify the management/accounting costs involved in even fee collection.

* exchange rate was BZ 2 = US\$1.00

A related problem is that the Ministry of Health provides health services to the Social Security Board for an annual flat fee of BZ 50,000, which is paid to the Ministry of Finance. The Minister of Health did not know what his actual costs were to this population group, but our own observations indicated that this fee was probably low in comparison to the services delivered. For instance, in 1983, the Board honored 1,701 sickness claims, 649 employment related injuries, 1,107 maternity grants, and 30 disablement grants (total health related is 4,039). Against these claims, the Board paid the Ministry of Finance BZ 12.4 per patient treated. The Board indicated that the number of patients treated for employment related injuries alone rose to 2,900 in 1985, but the flat fee paid to the Ministry of Finance still remained fixed at BZ 50,000.

We estimate that in 1986 the Ministry of Finance is receiving well under BZ 10 per patient treated by the Ministry of Health from the Social Security Board. There are approximately 33,000 full time members paying into Social Security and an additional 15,000 who pay in on a seasonal work basis. This, the Board is guaranteed work-related injuries health coverage to all of its members for an annual fixed fee of BZ 1.04 per member. This prepaid health program benefits those most able to pay at the expense of those least able to afford services of any kind.

III RECOMMENDATIONS

Prior to departure from Belize on April 30, two recommendations were discussed with the Ministry of Health and with the USAID/Director and his staff. Both received initial approval pending this report. They are:

1. Belize Consortium for Health Services Development

In the past few years, the GOB has moved to encourage private investment in the country. The private farms now serviced by the Banana Control Board were state-owned until recently. Hershey has extensive new acreage in cocoa; Coca Cola recently purchased thousands of acres for citrus production; and the Citrus Growers Association is now in production (an enterprise much like to Banana Control Board). Each of these entities has planned expansion programs. The BCB, which now has some 800 members (with an average of 3.5 per family member) plans to have 2,000 by 1988. In Belize, with a total population of 160,000 people, these numbers represent a considerable portion of the work force.

As commercial production moves forward on an accelerating basis, there is a concern among this leadership, as exemplified by the BCB, that health services must keep pace. Although this is seen primarily from the viewpoint of insuring high productivity from the farmers, there is also a social consciousness to provide basic programs in immunization for mothers and young children, and disease control programs, such as spraying for malaria control.

In Belize City itself, some experiments in group practice are underway but in danger of failing or have already failed. There are many reasons for this, including lack of government support (refusal to license new physicians, etc.), attitudes of physicians towards disclosure of income, and perhaps most importantly, the lack of management and organizational know-how.

In this regard, it should be mentioned that the Santiago Castillo Hospital closed its doors on April 30 with a large, uncollectible accounts receivable on its books; the Community Drug Stores group practice was started without a demand study, and marketing of new ideas once they are developed, such as the Regent health insurance plan, is almost non-existent.

There is an entrepreneurial spirit in Belize to try new ventures in the health sector. Yet, once difficulty is encountered there appears to be no technical resource these groups can turn to for assistance on a when-needed as-needed basis. We proposed to various groups the formation of a Consortium (see Figure 1) which would allow individual units to conduct their own activities, and, at the same time, it would also integrate them into a larger, centralized system in which constituent parts benefitted from economies of scale. For example, it would be difficult for the BCB to retain a full time physician because of its remote location. However, acting in concert with other members of the Consortium, arrangements could be made for physician services out of Belize City on a rotating basis to the outlying members. The physician(s) could use commuter air services (which is quite good) and be something of a "circuit rider" to members in the BCB, Coca Cola, etc., without having to give up their practice(s) in Belize City. As it is now, each of the outlying units would have to make individual arrangements for physician services and medical drugs/supplies.

This plan envisions the core (Belize City) acting as the bulk purchasing agent for units at the periphery. The Community Drug Store (CDS) now operates a group physician practice (of sorts), and its staff is underutilized. CDS has had much commercial success in operating drug stores throughout the city, has import licenses, experience in retailing drugs, medical supplies, warehousing experience, and retail knowledge for medical supply distribution and sales. Thus CDS, or some other central entity, could play a pivotal role in this Consortium.

Since the GOB and USAID are encouraging the Chamber of Commerce to play a more active part in creating a positive climate for private sector investment, it is recommended that the Chamber be involved in this Consortium. The types of services which could be offered through the Consortium are as follows:

1. Purchase of drugs/medicines and other supplies for the members' clinics from a central source;
2. Provision of a rotating physicians' service on a regularly scheduled basis, and when needed for emergency care;
3. Recruitment of nurses/nurse mid-wives both for resident positions with the outlying units, for temporary assignments and for special campaigns (immunization, well-baby health education, mobile clinic visits, ORT programs, etc.);
4. Act as an in-patient referral center for cases coming in from the periphery;
5. Provide technical assistance on a wide range of clinic management problems, from accounting to patient flow management, and from nurse supervision to planning and scheduling special campaigns, targeted at the control of specific diseases, i.e., malaria, diarrhea, neo-natal tetanus, etc.;
6. Assist in the formation of a consistent patient records system which would record age/sex profiles of patients being treated, and relate these data to specific morbidity records and costs for treatment; and
7. Related to item 6, be designated as an official treatment center by the GOB in order to receive reimbursements for services delivered to Social Security Board members. (At the moment, only the Ministry of Health hospitals/clinics are so designated.)

There are three key functions which the Chamber of Commerce could provide to the Consortium:

1. Insure government/corporate support to the Consortium;

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2. Provide initial source of loan financing (or access to sources) to establish a private health delivery system for wage-based workers in agriculture; and
3. Guide and support institutionally this effort within the professional medical society, government and the corporate sector by extolling the virtues of a healthy work-force and its impact on creating a favorable climate for increased private sector investment in Belize.

2. Cost Studies

As discussed previously, the Ministry of Health is unaware of its actual costs for the delivery of services to the population. A fee schedule is in place and it is a requirement of law for people to pay for services received on a sliding scale basis. But the law and the tariff are both largely unenforceable at present. This situation is made all the more difficult by the GOB granting a subsidy to members of the Social Security Board. In return for a flat fee paid to the Ministry of Finance, Board members receive all their health care for work related injuries and maternity in Ministry of Health hospitals/clinics. Yet, with 33,000 full time members (with an average of 3.5 per household), this effectively removes 2/3rds of the population from direct fee-for-service payment to these same facilities as required by law (which superceded the statutes for the Social Security Board).

The Minister of Health realizes that the tariff on medical care is out-moded and rather useless, and that his costs to Social Security members is higher than the flat fee paid to the Finance Ministry. But he needs technical help to determine the actual costs of service delivery within the Ministry of Health system, and within that, he can then break-out actual costs to Social Security recipients. Armed with this cost data study, the Minister feels he would be in an informed position to take this critical issue before Parliament and argue for changes in public health finance policy.

We mentioned to him that cost determination was but one element in establishing an effective system for collection, and that management and organization needed a great deal more attention. In this regard, he responded that these issues were on his mind also and he thought one way to address it was to remove the cashiers at the hospitals/clinics from the public payroll. In this way, he went on to say, their salaries would be dependent on a percentage of their collection. That is, he wanted to change the incentive system of the cashiers and in this way increase collections at the same time that his own overhead costs would be lowered through reductions in personnel.

Thus, we recommend that USAID assist the Minister of Health to conduct a cost study of service delivery, both curative and preventive, in-patient and outpatient care, throughout the public and private system. Part of this cost study should deal with the management systems which would have to be set in place to operate an efficient collection system, and outline public policy options the Minister might employ to encourage the Parliament toward a reviewing of present laws which proscribe retention of these funds by the facility charged with securing collections from patients. At the minimum, such a study would provide the Ministry with up to date information on the actual costs for its services, and permit it to present a more forceful and informed case to the Parliament documenting the real cost of health services to Social Security beneficiaries.

In 1985, the Social Security Board's reserves were greater than its collections from payroll, and far greater than the Ministry of Health's budget (approximately BZ 15 million vs BZ 9.7 million, respectively). The Ministry can only continue to fall behind in service delivery, in maintenance of equipment and capital stock, and in public health measures when those in the wage-based population most able to pay jump the tariff system and purchase health care through a fixed annual fee equivalent to BZ 1.04 per member. The Minister must present a new cash each

year to Parliament to win his budget; the Social Security Board need rely only on statutory provisions of the law which set aside a certain percentage of payroll as a mandatory contribution. Undoubtedly, the consequences of this dual system were unintended; a cost study would be a useful first step in assisting the Minister to find practical solutions to the restoration of a measure of equity in health services delivery.

IV SCOPE OF WORK

The following scopes of work are divided into two tasks, one dealing with the Consortium and the other with a cost data base for the Ministry of Health. Following the descriptions for the scopes is a suggested time frame and types of consulting services which would be needed in the conduct of these activities.

TASK ONE: DEVELOP ORGANIZATIONAL BASIS FOR THE CONSORTIUM ON HEALTH SERVICES DEVELOPMENT

Objectives:

- o To interview leadership of commercial ventures (other than the BCB), such as Coca Cola, the Citrus Growers Association, Hershey, etc., and determine willingness to participate in Consortium;
- o To propose level of health services which can initially be provided through clinics at the periphery;
- o To suggest criteria for determining staffing patterns in different clinics, and at the core;
- o To estimate, as feasible on the basis of observation, the service workload which may be expected in various clinics;
- o To review proposed service functions of all relevant staff involved in service delivery in view of tasks that can be realistically trained for and supported at each level;
- o To identify potential constraints to achieving any given level of service output, especially those that might arise from shortages of qualified staff;
- o To examine and describe the existing structure of organization, management and administrative procedures used to implement the Consortium concept;

- o To make recommendations concerning the requirements of project management, both at the core and at the periphery;
- o To estimate costs (both recurrent and capital) of implementing the Consortium and a cost standard for supervision, supply and logistic support;
- o To project total costs of Consortium implementation to achieve, initially, at least 60 percent coverage in clinic areas;
- o To estimate, as feasible, optimal patterns and paces of implementation under various costs and personnel constraints for the Consortium;
- o To estimate costs to the agricultural communities of supporting fee-for-service health care, and to assess their ability and willingness to incur and sustain costs;
- o To estimate cost of training under various staffing patterns (both clinical and management training).

Thus, on the basis of information provided from the above items, to select that staffing pattern and pace of implementation for the Consortium that is both affordable in the long term and capable of being effectively managed from the start. Then, on the basis of policy and program determination, to finalize job descriptions of each category of worker within the Consortium, and duties and responsibilities of all staff.

Resources and Level of Effort:

- o Organization and Management Consultant, with marketing experience: 6 weeks
- o Program Analysis with experience in costing outpatient services: 6 weeks
- o In-country coordinator: 8 weeks
- o Local counterparts and support services

TASK TWO: DEVELOP COST DATA BASE FOR MINISTRY OF HEALTH

Objectives:

- o To establish a data base on health care costs by systematically gathering and analyzing information about the GOB's pattern of health spending;
- o To calculate government expenditures on health activities (these data would be developed to show overall trends in spending and in relative share of national and per capita income spent on health);
- o To develop unit cost estimates for public sector outputs;
- o To develop unit cost estimates for private sector outputs (these data when compared to public sector outputs could be useful in determining the appropriate pattern of public sector spending so that private sector activities are complementary and not duplicative);
- o To gather information on health resource allocations and costs in Belize in as complete and comprehensive a fashion as possible;
- o To gather such information broken down by level and agency of government authority, source of financing, method of payment, category of expenditure, and organized according to criteria that will produce policy-relevant data;
- o To prepare analyses of the levels, categories, trends, and patterns of expenditures, distinguishing between capital and recurring costs, on health related activities.

Such analyses will focus in particular on several areas of emphasis:

- The share of national resources allocated to health services and the role of public spending in determining that allocation of resources.
- The extent and causes of divergence between amounts budgeted for health and the amounts actually expended.

- Methods of financing private personal health care services.
 - Projections of future health care costs based on past trends and current spending levels, with particular attention to commitments of future operating costs implied in present capital spending levels.
 - The extent of service utilization by Social Security beneficiaries;
 - The effect of past and present donor assistance to Belize's health sector and direction of resource allocation for health.
- o To use the information gathered in order to obtain a fix at one point in time as to current trends and their predictive value for the future. This fix could give both the GOB and USAID the capacity to make rational judgements on loan/grant investments and their probable impact on the direction of the health system over the next ten years;
 - o To determine if a relatively simple procedure can be developed for assimilating cost information with national accounting processes and for utilizing these data in a more informed planning process. This would lead, perhaps, to the establishment of improved health policy analysis techniques within the Ministry of Health;
 - o To disaggregate Social Security's real costs from that of the general Ministry of Health population;
 - o To examine existing mechanisms and criteria used in decision-making on resource allocations to health in order to develop suggestions for new methods that would make use of analytical techniques developed from this cost study and that would facilitate most efficient and beneficial use of donor aid.

Thus, the intent of this cost study is to provide the Minister of Health with a contemporary data base on costs so that he can be in an informed position to deal with Parliament on the need to adjust the tariff so that it reflects present economic conditions (particularly for Social Security beneficiaries).

A secondary intent is to provide policy relevant knowledge about the GOB's health care system in order to assist the government in the allocation of resources to health in a more effective manner and in channeling donor assistance into program areas which best complement the scope and direction of the government's health policy.

Resources and Level of Effort:

- o Health Economist with experience in the analysis of national budgets and pricing: 8 weeks (2 trips)
- o M.D. with experience in costing of health services: 6 weeks (1 trip)
- o In-country coordinator: 8 weeks (1 trip)
- o Local technical counterparts and support services.

ANNEX A

FIELD INTERVIEWS

The substance of the interviews with key individuals in the public and private health sectors is as follows:

1. Hon. Elodio Aragon, Minister of Health, Labour and Sports

The Minister was quick to state that his main concerns were:

- a. Supply of medicines,
- b. Medical equipment maintenance,
- c. Transportation

He went on to amplify item (a), but didn't have the opportunity to get back to the others as he had to leave for another meeting. The supply of medicines, he said, was a symptom of the problem. That is, "we need to find alternative financing mechanisms ... the funds in our budget are not sufficient to run the system". He then diverted somewhat by saying he was interested in establishing a fee-for-service system but was very concerned about the effects such a system would have on a) health status, b) accessibility to the health system, and c) equity. "If we begin to charge, what will this do to our total delivery system?"

This line of discussion led him to comment on the present system by saying that users are required by law to pay for health services in public facilities but collected funds had to be remitted to the Treasury. Thus, the incentives for collection insured low receivables. The Minister returned to subject (a) by commenting that PAHO had initiated a revolving drug account, but after the second purchase the fund stopped functioning. (I was not clear why, but he intimated that PAHO "goofed".)

He discussed private medical doctors in Belize, saying there were some 34 in private practice. "When they use government hospitals ... they do not pay the Ministry of Health." He went on to mention that his own medical doctors are suppose to work 8 hours a day, but generally put in 4 hours. The same held true for government nurses.

He was asked about the health budget for 1986, and he responded that it was BZ 9.7 million. The subject of Social Security health coverage came up, and he responded that while the Ministry of health provides medical treatment for injured workers, and maternity care and facilities, no direct payments are received from the Social Security Board or the worker. Instead, the Board pays a flat fee of BZ 50,000 to the Ministry of Finance each year, and "the law stipulates that injured workers must be treated in MOH hospitals/clinics".

As the interview neared its end, the Minister asked the

consultant to return and continue the discussion after he had visited the Banana Control Board and the Social Security Board. He ended the interview by saying that the Santiago Castillo Hospital extended a lot of credit to patients. "The medical doctors got paid for their services, but the hospital itself was left with a lot of accounts receivable which were uncollectible."

2. Mr. Norberto Depaz, Administrator of Personnel, Social Security Board

Mr. Depaz began by saying that the Board started in 1981 and now has approximately 48,000 covered workers. He amended this figure to a lower number of 33,000 by explaining that the difference between the two numbers represented seasonal workers. Thus, 33,000 is a fixed base of covered workers in Social Security. In 1982, he said some 1,000 work related injuries were experienced. This figure went up to 2,900 in 1985. He confirmed that the Board paid the Ministry of Finance a fixed fee of BZ 50,000 per annum, saying "this is o.k., it covers the Ministry of Health's costs and we were able to determine that by a study we conducted". (He did not have a copy of the study for us.)

Mr. Depaz explained that the Board only pays medical bills for those who are injured on the job, in addition to 60 percent of salary while they are being treated as in-patients or off the job as a result of an injury. If a covered worker is in the hospital for a delivery, then the Board only pays 60 percent of base salary, but not the medical bills. It does pay a flat maternity benefit also. In closing the interview, Mr. Depaz mentioned that the Minister of Health had approached the Board with a request for its covered members to pay for their own drugs while in the hospital. In response to a question about the disposition of this request, he said that "on average, the BZ 50,000 payment to the Ministry of Finance is o.k."

3. Statistical Office, Ministry of Finance, (name unavailable).

During our visit to the Social Security Board, we inquired about information on household expenditures for health. The Board suggested we try to follow this line of questioning at the Ministry of Finance. During this brief visit, the Finance official secured a household survey from a 1980 study which showed that the national average on health expenditures at the household level at that time was BZ 297.3. Thus, with an average of 3.5 members per household, per capita health expenditures were BZ 85. The official stated that he knew of no recent studies which might update this figure. At that time, the Ministry of Health's budget was approximately BZ 9 million for an estimated population of 153,000. Thus, per capita health expenditures, both public and private, were estimated at BZ 144 in 1980.

4. Messrs. David Usher and Victor Usher, Finance Manager and President, respectively, of Community Drug Stores..

The Usher brothers are successful businessmen, in Belize City,

mainly in the operation of private drug stores. A more recent venture is a group practice outpatient clinic. They took us there because the operation was in great difficulty and they needed some advice on how to salvage the investment. Basically, the idea was to rent suites to physicians, then provide them with on-site laboratory, drugs, x-ray, and other services which could be purchased on a fee-for-service basis. In return for the suite rental, the borthers would do all maintenance, housekeeping, and advertising.

Although there was a large waiting room, clean and well-appointed, no patients were on hand. The Ushers explained that the average patient flow was 12-15 patients per day for 3 physicians and 1 dentist. In response to a question as to why no patients were in the waiting area, they explained that the physicians did not trust one another and therefore required their patients to wait in the hallway immediately outside their offices. This response led to a long series of questions, reflecting much anxiety on their part. As it turned out, they had conducted no demand studies on the potential for this venture, saying that 20 years ago, a physician operated a successful practice "just like this and he was our role model". However, they were quick to point out that this physician was also a good administrator and businessman, who subsequently closed the medical practice to invest in commercial farming.

Although their original idea was to conduct a group practice with salaried physicians, that idea never took off. The Ushers explained that physicians do not want the taxing authorities to know their incomes, and refused to accept the suites on that basis (as salaried employees) in the facility. Knowing that, the Ushers nevertheless opened the facility and accepted the physicians on their own terms.

They then asked "how do you conduct a demand study ... how do you determine if there is a market? Why can't we sell our services? These questions were followed by the comment that "we need the physicians ... they don't need us".

After saying this, they went on to state that physicians were not doing well (economically) in Belize. They felt this was the reason that the Medical Council would not approve the entry of foreign physicians, or even an ENT specialist, and why the medical profession seemed to be against group practice situations. That is, the physicians who are in Belize feel threatened and new physicians were not welcomed, and that the entry of new physicians, particularly specialists, would pose a threat to their entrenched market position. This elicited a comment that there was a "lot of leakage in the government hospitals ... people can pay but why should they when they can get the services free of charge".

5. Jose Encalada, Administrator, Santiago Castillo Hospital

This hospital, which was opened in 1982, has 20 beds, a 30-40 percent occupancy rate, 1 resident physician, and 14 nurses. The high rate for a room is BZ 100 per day, which includes air conditioning; BZ 75 for a room with a fan; and BZ 65 for a bed in a general ward. The hospital, which has one operating theater and a delivery room, appeared to be clean and orderly--if quite empty on the day of our visit. Mr. Encalada impressed us as someone who had given it a good hard try, but could not understand why the scheme hadn't worked. He mentioned five ideas he had put forward to make the hospital a viable operation:

- a. offer it to the Social Security Board as a facility for their injured workers, and for deliveries;
- b. offer it to groups like the Banana Control Board, etc.;
- c. offer it as a place to conduct physicals for people leaving the country;
- d. offer it as a referral center for private physicians practicing in government hospitals
- e. offer it as the referral facility for private health insurance schemes to wage-based workers.

Some of his proposals, such as to the Social Security Board, were never answered, while he wasn't sure what had happened to the rest. He gave us a copy of the health insurance policy that a local firm (Regent) had developed for the hospital, but he didn't know if any policies had been sold. He felt that one of the key reasons the hospital was in financial trouble had to do with its failure to compete with government physicians using public facilities to conduct private business. He had a strong, and probably justified, opinion on this subject. He felt this practice (permitted by the government) was a simple conflict of interest and, basically, "a double taxation for me ... and triple when the government hospital borrows my medical equipment and returns it broke seven months later".

Mr. Encalada said that four years ago he had conducted something of a demand study, well, "not really, it was a gut reaction ... some business people told me it could work and I went ahead on that ". At the time of this visit, the hospital was being kept open by Harrison Ford's film crew on location for "Mosquito Coast". He didn't know what the future held after the film crew left on April 30, but he was not optimistic, saying "the Medical Council will not license an ENT specialist ... "the Council has been my main problem ... I lose my only physician on April 30 because her permit from the Council expires the same day the film crew is due to leave. The Council will not renew it ... this is where the power is in Belize. Only a group of MDs who are already licensed by the Council could make this hospital work."

6. Ms. Maggie Brown, Administrator, Government Hospital, Belize City.

This is Belize's main hospital. It has 189 beds and a bed occupancy rate of 75 percent. She showed us a copy of the

government tariff schedule for hospital services, printed in 1973. It has not been revised during the intervening years. Ms. Brown said that when she took on the position as Administrator, collections were averaging BZ 8,000 per month; she has been able to increase them to a monthly average of BZ 11,000 per month.

She commented extensively on the fee schedule, saying that it was outdated, that people have developed a fixed attitude about keeping them low, (that is, low fees have become a political necessity), and that patients were only informed of the fees at time of discharge. However, in respect, to the last point, she mentioned the common practice of discharging patients on Saturdays, Sundays and holidays ("which we have a lot of") because on these days the cashier was not on duty and therefore bills could not be paid. In the context of this discussion, she intimated that physicians consciously discharge on these days for a consideration. Moreover, government physicians in the hospital only have to work 8 hours; after that, they can do private work on a fee-for-service basis in a public facility.

The fee schedule is set up on a sliding scale basis, or an ability to pay. That is, the hospital makes the determination as to ability of patients to pay depending on annual income. However, because no one wants to report income, fearing that the information subsequently will be fed to the income tax bureau, this makes it extremely difficult for her office to enforce the tariff. A second reason she mentioned is that patients run to the Social Security Board and, using that as their representative, claim they cannot pay. In the context of this discussion, she intimated that the Board has a lot of political clout and patients don't hesitate to use it to their advantage.

7. Mr. Craig Griffith, Manager, Banana Control Board (BCB), Big Creek, Belize

The visit to the BCB also included field visits to members' farms in the area, to the processing and packing plant, and to the site being cleared for the BCB health clinic. The BCB, as it was explained to us, purchases the crop produced on private farms, processes, packs and ships to European markets. The Board itself is a quasi governmental authority, but the farms (which were until recently state-owned) are privately owned and operated, with the exception of one tract which is operated as a cooperative. The Board also provides technical information to the farmers, and maintains and operates two spray planes for aerial insecticide programs.

Mr. Griffith explained that there are presently 750-800 banana farmers in the BCB, with an average of 3.5 members per family. He expects new acreage to be put into production in the near future, and this should increase membership to 2,000 by 1988. All members now contribute to social security.

We asked him how job-related injuries and other health problems were presently handled by members. He said that the nearest public health assistance was in Deiga, about two and a half hours by car or bus. However, the injured person frequently had to be accompanied on these trips and often it required an overnight stay, with an average cost of BZ 130. He went on to say that with 12-14 work-related injuries each week, productivity was being affected. We asked if he understood that since all the farmers paid into social security the cost of their care should be delivered at no charge. He responded in a rather surprised manner, saying "we pay a lot into that program but I didn't know work-related injuries were covered".

Mr. Griffith took us out to see the proposed site for the health clinic, which had already been cleared. He explained that the BCB was giving the land, would construct the clinic, including quarters for the nurse, and provide the initial stock of medicines and medical supplies. After that, the clinic had to operate on a fee-for-service basis. At this point, Mr. Griffith said "this is where we need help ... can you provide us with a set of design plans for a clinic, can you help us set up the management systems to run the operation, help us recruit a nurse"?

We asked Mr. Griffith if he thought an arrangement with the Santiago Castillo hospital would be helpful. That is, the hospital could be used as a referral center for the BCB, send out a physician on weekly calls, as well as on an emergency basis, and purchase medical supplies and drugs on a bulk basis. But more importantly, it could assure a steady and routine provision of medical stores. He responded favorably, saying he would also like this kind of a tie-in with Dr. Reddy in Deiga, and that if the BCB could act as a spark-plug on this idea, Coca Cola and the Citrus Growers Association would also come in. We inquired about the possibility of mobile health units in the area. He described a recent immunization campaign in which the BCB turned out an unexpectedly high 115 percent of the children at risk for a MOH mobile unit. He laughed and said "we had more kids than we thought here ... there is a lot of interest in health". We asked if the proposed clinic could conduct operations of this nature, that is, organize campaigns aimed at mothers and children. His response was an enthusiastic "yes, of course".

He suggested we follow-up this line of thought by meeting with Steve Sherman of Health Talents International, a group which was in the process of establishing a mobile drug unit.

8. Mr. Steve Sherman, Field Director, Health Talents International, Big Creek, Belize

Steve's group began planning a mobile drug distribution program in January 1986. Fourteen communities were targeted, and the program envisioned training 28 community health workers on a volunteer basis. Health Talents currently has one pick-up and a

truck to do mobile drug deliveries. The plan is to have mobile visits once every two weeks in a community. The drugs are imported from the States duty free and supplied to the community health workers, who can then charge patients. Health Talents plans to operate the program for two years or so; he didn't know how long the volunteers would stay on after training, or after his program terminated. Since the program had not yet started operations, it was difficult to make any assessment of its potential.

9. Mr. Colin Gibson, Regent Insurance Company, Belize City

The Administrator of the Santiago Castillo Hospital had engaged Mr. Gibson to underwrite a health insurance policy which could be marketed to employers in Belize. However, Mr. Encalada, the Administrator, did not follow-up on this initiative and was unaware of how many policies were sold. For his part, Mr. Gibson had wondered what happened to Mr. Encalada and the Santiago Hospital, since he heard from neither after he had persuaded his London office to spend a considerable sum in actuarial fees to design the policy.

Mr. Gibson said his company got into health insurance some 18 months ago, but had not sold many policies since he had heard the Santiago Hospital was in danger of closing. We asked if he would have to cancel policies already sold, since a private hospital was a necessary prerequisite for an effective policy. He responded that this was precisely the case and he was not marketing with any vigor until Santiago was resolved. If the hospital closed, he would have to cancel all existing policies.

He went on to say that he and others in the commercial community were trying to find a way to keep the hospital open. In this respect, he had approached the Belize Insurance Board for cooperative support to subsidize the hospital because if it closed, liability coverage would increase for all their clients. However, he didn't have much hope that the Board would come through with funds sufficient to keep the Santiago hospital open, saying its losses were some BZ 1,500 per week.

Mr. Gibson felt the health insurance policy was viable as long as a private hospital could service the clients. In this regard, he seemed somewhat let-down that the hospital had not followed through with its initial contact to organize a joint marketing plan for the policy, reiterating that the actuarial studies had set his company back quite a bit. (Undoubtedly, he did not come off too well in the deal, having convinced his London office to do the study and then subsequently firing a blank on its sales.)

10. Messrs. Victor & David Usher, Community Drug Stores (2nd visit)

In this discussion, we wanted to sound out the Usher brothers on some ideas which had emanated from previous visits. We asked

them if they could take over and run the Santiago Castillo Hospital. They demurred somewhat, and without being too direct they intimated that it would be difficult to get physicians licensed to work in the hospital. They then went on to say that they had made an offer to the hospital but had heard nothing yet in return. We asked if they were willing to take over its x-ray and operating theater. They said this was a possibility and that both components were in their own Phase III plan for the group practice clinic. That is, their physicians were to refer patients to Santiago when these procedures were needed.

We described the BCB, Coke and other commercial operations outside of Belize City, saying these groups needed a central source of referral, physicians on regular/emergency call, and medical supplies and drugs. "Could the Community Drug Stores play this role". Initially, they had a lot of questions about this, saying "why don't you send us some professionals for 2 years or so to show us how to do it, how to manage our own group practice plus this idea you are promoting". We declined to get into program specifics and instead pressed on the basic idea. They finally said "that's an interesting concept, but we need help to manage it".

11. Board of Directors, Santiago Castillo Hospital

We met with the Board after their meeting, which was called especially to deal with the future of the hospital. The Board Chairman, Mrs. Castillo, told us that the decision of the Board was to reluctantly close the hospital, effective April 30. We asked if the decision was irreversible and she replied "if you have another proposal to keep it open, we will listen". We explained that the BCB, the Insurance Board, and the Community Drug Stores were interested in finding ways to keep the hospital open but that nothing firm had materialized at this date. She thanked us for our concern but said the hospital and all of its equipment would go on sale the next day. Another Board member interjected "besides, the one physician we have is on a temporary license which expires tonight and it will not be renewed. Thus, even if we wanted to stay open, we would have no resident physician".

12. Hon. Elodio Aragon, Minister of Health, and Douglas R. Fairweather, Permanent Secretary, Ministry of Health.

At this meeting, we briefed the Minister on our previous visits and mentioned to him some likely recommendations for further action. In this regard, we discussed the consortium of commercial groups (BCB, Coke, Hershey, etc.) linking into a central source of both referral services and supply of drugs and medical supplies. Secondly, we discussed the need to do a study of actual costs for Social Security patients using government facilities, and the actual cost of ministry services so that a charge (tariff) list could be devised to reflect present operating expenses. He endorsed both of these ideas.

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At this point, we discussed the fact that the Santiago Hospital was closing, and that this signaled an end to competition in the hospital sector. The Minister took quite a different view, stating that this showed how badly the country needed a replacement hospital. He then went on to explain his plans for a new government hospital to replace the present aging structure. Thus, he reasoned, "we need a replacement hospital, not a new hospital". He then excused himself for another meeting.

However, Mr. Fairweather stayed on and discussed in more detail the ramifications of Santiago's closing. He cited Belize medical law, which specified that public physicians in government hospitals were not permitted to charge fees if it could be demonstrated there was in fact a private alternative. "With the closing of the only private hospital in the country, physicians can now charge and collect private fees in government hospitals after today." To make certain we understood this, he provided us with a copy of the relevant statute.

ANNEX B

List of Persons Interviewed

- Hon. Elodio Aragon, Minister of Health, Labour and Sports
2. Mr. Douglas R. Fairweather, Permanent Secretary, Ministry of Health
 3. Mr. David Ronald Usher, Financial Manager, Community Drug Stores
 4. Mr. Victor Edward Usher, President, Community Drug Stores
 5. Mr. Jose Encalada, Administrator, Santiago Castillo Hospital
 6. Mr. Colin Gibson, Managing Director, Regent Insurance Co., Ltd.
 7. Mr. Steve Sherman, Field Director, Health Talents International, Big Creek
 8. Mr. Craig Griffith, Manager, Banana Control Board, Big Creek
 9. (Staff member), Statistical Unit, Ministry of Finance
 10. Mr. Norberto Depaz, Administrator of Personnel, Social Security Board
 11. Ms. Maggie Brown, Administrator, Government Hospital, Belize City
 12. Board of Directors, Santiago Castillo Hospital

ANNEX C

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