PN-ABW-672

LATIN AMERICA AND CARIBBEAN HEALTH AND NUTRITION SUSTAINABILITY:

Technical Support for Policy, Financing and Management

7200 Wisconsin Avenue
Suite 600
Bethesda, MD 20814
(301) 941-8490
FAX (301) 941-8449

This contract is implemented by:

International Science and Technology Institute, Inc. (ISTI)

Community Systems Foundation (CSF)

Development Group, Inc. (DGI)

University Research Corporation (URC)

URC is the prime contractor under Contract No. LAC-0657-C-00-0051-00 with the U.S. Agency for International Development.

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ASSESSMENT OF PRIVATE HEALTH SECTOR OPTIONS IN NICARAGUA

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Dene McGriff
Lewis Applegate

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Prepared for the U.S. Agency for International Development/Nicaragua
Health and Nutrition Sustainability Contract No. LAC-0657-C-00-0051-00
University Research Corporation/International Science and Technology Institute
1129 20th Street, N.W. Suite 706
Washington, D.C. 20036

I. INTRODUCTION

The objective of this consultancy was to review potential interventions to strengthen the private health sector in Nicaragua and make recommendations to USAID/Nicaragua as to ways in which feasible approaches may be developed.

Since the public sector is such a major provider of service and since so little is known about the private sector, USAID/Managua requested this brief assessment in order to prepare options for future project activity. The time allotted did not allow for a systematic review of the sector, but rather the consultants interviewed members of the private sector who had been identified by USAID and other contacts to provide an initial basis for possible program activity.

The consultancy took place August 2-14, 1992.

II. OVERVIEW OF THE PRIVATE SECTOR

Private Solo Practice

As in many countries in Latin America, most physicians in Nicaragua work in public health services during the morning and hold private clinics in the afternoon and evening. This individual private practice was not discouraged during the Sandinista period and continues on under the current government.

These clinics tend to be only offices for the individual physician rather than group health services. Private clinic services have reportedly high fees for each visit (US $20-40 per medical consultation).

Professional Associations

There are several professional associations that organize physicians, some with links to different political factions within both the government and the opposition. These associations are generally weak organizations, with low funding, and little administrative structure. Their professional activities are limited. The associations include the Colegio de Médicos y Cirujanos, Federación de Sociedades Médicas Nicaragüenses, Unión Médica Nicaragüense, and Asociación Médica Nicaragüense.

Hospitals and Group Practice

There are two major hospitals that have private participation:

-- the Trinidad Hospital, a publicly owned hospital which is managed by the Seventh Day Adventists (ADRA)

-- the Baptist Hospital

A new private clinic, Villa Fontana, is a group practice including many military physicians. The Military Hospital acts as a referral hospital for this clinic and has its own private wards. The Villa Fontana is a new clinic and currently is underutilized and isolated form population centers.

Several groups of physicians have plans for starting private group practice, including managed care plans. As noted below, these schemes are only in initial stages of development. It is not clear how these plans will be capitalized.

Health Insurance

The National Insurance Company has a monopoly on general insurance plans. Since private insurance is illegal, potential insurers (banks and commercial developers) are reluctant to enter the market dominated by this state-controlled monopoly, until legal changes are made.

The Social Security Institute, which was divested of its health facilities when the Sandinista regime united all public health facilities and social security health facilities under the Ministry of Health, is now exploring new options to provide health insurance. These options include using social security payroll deductions to purchase a private insurance plan. The financial status of the Institute, however, is precarious since during the 1980's many beneficiaries (approximately 19,000 veterans and their families) were added to the system as pensioners and permanently disabled without having paid in. It is likely that some resolution to the financial crisis of Social Security will have to precede the establishment of a health insurance scheme.

III. KEY ISSUES INVESTIGATED IN THE ASSESSMENT

The consultants reviewed the following specific issues:

1) legal restrictions on private practice and health insurance;

2) options for public/private collaboration in provision of services;

3) professional associations as potential vehicles for organizing private sector options;

4) options for loans to private providers and patients; and

5) options for managed care.

1. Legal Restrictions on Private Practice and Health Insurance

Private Practice

There are no legal restrictions on the private practice of medicine, nor are there any price controls on fees providers can charge. Few individual providers pay tax on their income. Individual physicians have maintained their private practice through all of the political changes of the 1980's. However, without open legal restrictions, during the Sandinista era, few private facilities were maintained. Some private facilities were taken over by the government (La Trinidad). The only private hospital that was allowed to function was the Baptist Hospital.

Since the Chamorro government came to power, a number of other small hospitals and polyclinics have opened or reopened. However, some laws and regulations continue to hinder their growth.

One major restriction has been the high levels of taxation imposed on medical imports. In the past, Baptist Hospital did not pay high import taxes or charges for services by the government (i.e., some supplies, electricity, water); however, currently it is paying both. The import tariffs and distribution markups on supplies such as bandages and medicines result in prices to the hospital that are often 60-70% over international prices.[1] Some providers are apparently having no problem getting medical equipment into the country; for instance, prior to July 30 1992, returning expatriates were allowed to bring equipment and goods into the country duty free. However, some of the established local groups have to pay import duties putting them at a competitive disadvantage. Whatever the rules, they are not being applied consistently. Import taxes might be reduced especially for goods which are needed for primary care activity and for materials not manufactured in the country.[2]

Charges for government-provided utilities appear to be unreasonably high. For instance, government charges for water and electricity have significantly increased. The cost of water for the Baptist Hospital increased to US$7,000 a month. The hospital now has its own well to avoid having to pay these charges. The cost of electricity is also high at US$9,000 a month.

Health Insurance

Private insurance was never fully developed prior to the Sandinista period, and now there is a single state-run insurance company. This company primarily provides life insurance. For health

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[1] Importers and distributors are allowed a 30% markup and the retailers are allowed a 30% markup, in addition to the 10% import fee.

[2] In contrast to this high level of taxation on private hospitals, general taxes on laboratories are not excessive. They pay 10% federal tax, 2% city tax, 1% property tax (on building and assets), and 10% tax on imported supplies.

claims it only acts as a financial intermediary, without charging premiums or sharing risks. In other words it insures the provider for a percentage of losses, and not for covered claims. Although there is some discussion of privatizing the state company or allowing competition, neither is currently permitted. Six new commercial banks may enter into a wide range of insurance schemes, including health insurance, if they are allowed to enter the field. Those who are investigating options for pre-paid plans are careful to call their plans "the provision of medical services," and not "insurance" for fear the government may intervene. There was some discussion of plans for introducing new insurance legislation, however, the consultants were not able to investigate the status of this proposal.

As noted above, the Social Security Institute is considering options to provide health insurance. One option would be to allow the current social security payroll deduction for health care to be applied to the purchase of a private health insurance plan, similar to the ISAPRE program in Chile. There is interest in this option both within the Social Security Institute and among employers. Currently the deductions do not provide any additional service for employees than what is available to any patient in public facilities. There is some indication that employers are refusing to pay social security payments. The President of the Chamber of Commerce of Nicaragua expressed interest in the Social Security plan to purchase private insurance. He was also in favor managed care health plans for workers for their member businesses (small and medium sized). It is not clear how these proposals will be implemented without a competitive market of private health insurance providers.

Employers do take some interest in providing for the health plans of their employees. While required to contribute to social security, employers do not feel that they get any benefits in return for this contribution. Some pay bills for workers and may loan them money to pay for family members. The president of the Chamber of Commerce suggested that employers would prefer to use the social security deduction to purchase private insurance. Without this incentive, it is not clear that employers are sufficiently interested in providing health insurance plans to be a significant market for private insurance companies. In any case, the legal restrictions that have imposed a state-run monopoly on insurance need to be changed before any initiatives are taken in this area.

2. Public/Private Collaboration

Under the guidance of USAID/Managua, the consultants did not meet with Ministry of Health (MINSA) officials, nor visit any of the public facilities. These limitations prevented a full investigation of options for public/private collaboration. Nevertheless, we were able to learn of two options of public/private collaboration: 1) private management and private wards at the public Trinidad Hospital; and 2) private wards in the Military Hospital.

The Trinidad Hospital has been returned to the Seventh Day Adventists with what appears to be an agreement to allow this private organization to manage the hospital, though the facility apparently remains under public ownership.

Another example of public/private collaboration in the country is the Military Hospital which operates a wing for private paying patients. The hospital also has referral options with the new Villa Fontana Clinic (see below) which are likely to provide additional patients and revenue. The Military Hospital has an outpatient area with 23 beds (17 beds in wards and 6 private). Even though the private program accounts for only five percent of the volume, it represents 20 percent of the budget. They work with Villa Fontana Clinic which provides the pediatric and obstetric/gynecological services which are not offered in the Military Hospital. The Villa Fontana Clinic in return, uses the Military Hospital for major surgery and medical cases.

The private program of the Military Hospital has 75 companies as subscribers, covering a total of 400 to 450 adults and children above the age of 14. They do not plan to market the program as a managed care health plan, but offer their services to companies on a fee-for-service basis. Seventeen of the 35 total doctors of the military hospital participate in the program on a part-time basis.

The Villa Fontana Clinic is run by four physicians who are the principal share holders and Board of Directors. There are 12 other physicians which make up the "cuerpo médico." They represent most of the medical specialties. They plan on opening up the staff to "asociados" from the community. The clinic has a surgery room which is mainly for outpatient surgery, a laboratory, x-ray, mammography, pharmacy and ten beds (in 8 rooms). According to them, they are averaging only about one surgery a day and 150 office visits a week, suggesting that currently the facility is underutilized. The clinic charges fees for services at a fee schedule which is at U.S. price levels. Each doctor sets his own fees, and the clinic handles the billing. They also are planning to market fee-for-service contracts with major business in Managua. Although they accept credit cards, most people pay in cash. The clinic has targeted a clientele from the upper and upper middle class.

We discussed some of the alternatives for public/private collaboration with USAID/Managua but they did not feel that the MINSA was ready to explore the options. The proposals might include allowing physicians to do private practice in the public clinics or setting up private wards in public hospitals. MINSA may want to consider charging more for user fees and keeping the money at the facility that collects it. This cost-recovery option would give the public facilities additional operating funds, and there is apparently considerable interest among many officials in this option. However, there is also significant resistance among MINSA officials to the idea of charging people fees. Some doubt that the fees collected will be used appropriately for the facility.

A physician took us on a discreet tour of the Policlínica Oriental. There were no drugs, antibiotics or supplies. The x-ray had not been working for a month. The facility was in total disrepair. There wasn't even a pediatrician on staff. The poor condition of this MINSA hospital creates a "catch 22" situation. Unless public hospitals are substantially improved, no one who can afford to pay is going to want to use them. The Sandinistas eliminated user fees according to "ability to pay".

Without significant interest in on the part of MINSA, there is little opportunity for public/private collaboration at this time. There may be sufficient options in the private sector for patients such that initiatives should be focused there.

3. Professional Association Options

Interviews with established physicians indicate that the professional associations are barely functioning. No real organization exists for any one of them. Some are reputed to be nothing more than "self declared" presidents of societies and do not represent a larger constituency. Only a few issues of medical journal were produced in 1988, and none is currently published. While a major role of professional medical associations is to provide for continuing education and certification for its members, these activities have not been part of the current professional association activity. There is a particularly crucial need for continuing education programs in clinical education and practice management.

We met with the head of the Federación de Sociedades Médicas Nicaragüenses, the union representing the Sandinista doctors, and the Vice President of the Colegio de Médicos y Cirujanos. Both were attending a meeting at the hotel for doctors of the different associations to begin discussions on whether the three associations could combine activities. There is another meeting planned in October.

Given the weak organizations and the preliminary nature of the efforts to coordinate association activities, we advise USAID to encourage the movement toward combining activities as a means to unite and strengthen the institutional capability of the professional associations. Until the associations resolve the political and personality conflicts that have emerged in the organizations, it is unlikely that they will be sufficiently strong to be used as a vehicle for additional efforts to promote private sector options (such as loan programs, continuing education, promotion of management and financial skills).

4. Loan Programs

One of the biggest problems providers have is in getting small loans for investments like medical equipment. Local banks charge 22 percent interest and expect loans to be paid off in 18 months. For many providers these rates are prohibitive. We met with physicians who wanted to either upgrade existing private hospitals and clinics or build new ones. All were blocked by their lack of access to credit.

For example, recently four doctors attempted to reopen the "Clínica de Especialidades," a small private hospital which was closed by the Sandinistas. They were unable to get loans for medical equipment at a rate they could afford. A proposal for the development of this facility was made to USAID/Managua about 8 months ago.

A second example is an optical laboratory that had all of its equipment expropriated by the Sandinistas. The owners recently tried for nine months to get a loan from banks to reestablish the laboratory. They finally went to the commercial finance section of USAID and were able to get a guarantee for a bank loan for US$190,000 at 14% interest with four years to repay it.

We met with bankers in Grenada and the new VISA company in Managua, and they suggested that currently there is no money available for the private provider to get loans on reasonable terms. However, as the example of the optical laboratory suggests, USAID might be able to establish a revolving fund or guarantee loans from existing private banks so providers can get lower interest, longer term loans (up to five years) for supplies and equipment. This program could focus on providing small loans for equipment that is reasonably needed for primary care.

For major investments such as new construction or rehabilitating and expanding existing hospitals, private operations should be made aware of the availability of international funding through the IFC. Such funds could assist the Baptist Hospital fund an planned 100 bed addition. Other physicians have plans for a 50 bed hospital. (see Annex A) USAID might consider providing technical assistance to assist these private groups prepare applications for international sources of funding.

A second initiative for loans is credit provided to patients to assist in paying for services. Consumer credit is just beginning to gain a foothold in Nicaragua. Providers we met with said that more people are beginning to pay for medical services with credit cards, although most still pay cash or have their services paid by direct billing to their employer. AVAL, a local company offering a Visa card, is the only Visa or MasterCard company functioning in córdobas. The other bank card companies are U.S.-dollar-based. AVAL offers credit at 4.7% interest per month to be paid in 8 months. The U.S.-dollar-based companies offer 7% interest per month and require payment in 4 months. AVAL first offered this credit to individuals with incomes of US$1500 a month or more, but have succeeded in reducing the level to US$500 a month, making the credit available to a larger market. Credit limits range from US$500 to US$1,500, which are sufficient to pay for most medical services in the private sector. AVAL is expecting to add 12,000 employed people a year, a significant potential private pay market. AVAL has their own bank but is reluctant to make loans for large items such as medical equipment because of the potential instability of the córdoba. They expressed interest, however in providing loans if they were guaranteed by another financial institution or a USAID-sponsored program.

5. Managed Care Options

In spite of the many difficulties described above, including the need for legal changes to allow the creation of private health insurance, there are a number of providers that are setting up managed care programs. We identified the following:

Baptist Hospital

The Baptist Hospital is in the process of initiating a "managed care" program. It is a basic 80/20 plan in which the insurance pays 80% of the fees for approved services and the patient pays 20%. This plan will be offered to groups, such as company employees. Priced at US$170 for US$5,000 worth of coverage per individual covered, it requires a US$60 copayment per service. For the last eight years they have offered a school insurance plan that sells for US$15 for US$800 coverage, with a US$60 deductible. For many years, the hospital has been the preferred provider of most of the oil companies, which pay for each service with a purchase order. The hospital hopes to attract these employers to buy into the prepaid scheme.

The "Baptist Hospital Health Plan" ("Plan de Servicios Médicos") is an important initiative in managed care; however, it has serious flaws. If these flaws are not corrected, they will soon be out of business. First, their benefits and premium package was established without actuarial analysis. They have no means of establishing underwriting guidelines to limit risk. Their program has focused on attracting individuals rather than risk pools, limiting their market and providing services mainly to the higher risk individuals rather than a pool of healthy and sick families in which the risks are shared.

In addition, the Baptist Hospital currently does not offer sufficient primary care and preventive programs. They need to understand that prevention and primary care can reduce costs of care in the long-run. Currently, their system of deductibles and copayments discourages people from coming in for primary care. Physicians are paid on a fee-for-service basis and have no incentive to control cost or volume. A person pays for the first US$60 of care for each visit. However if the cost goes to US$61, the plan pays 80/20 or US$12 out-of-pocket. The patient then has the incentive to make sure the bill (which includes the visit, ancillary charges and prescriptions) exceeds US$60 so he will not have to pay so much. The plan covers emergency care in Nicaragua and is not clear on whether it will cover them out of the country where expenses could be significantly higher. The benefit schedule needs to be tightened and clarified or they could end up with catastrophic (e.g., burns) and expensive chronic illnesses.

Without a well developed information system, they will not be able to manage and track their costs and track provider behavior. The patient, diagnosis, procedure, provider and cost all should be linked in a management information system that allows managers to contain costs and lower risks.

The current marketing program has incentives for the sales force which encourage them to bring higher cost, higher risk business, rather than attempting to reduce risk to the hospital.

It would be useful to provide technical assistance to Baptist Hospital to overcome these shortcomings[3]. In particular, experts could assist in the following areas:

1) developing an effective and targeted marketing strategy;

2) establishing enrollment criteria for individuals and groups, including underwriting guidelines and rating groups;

3) selecting an appropriate waiting period before a policy is in force to give time for underwriting;

4) designing appropriate premium loading, co-payments, deductibles and exclusions;

5) developing a manual and automated management information system; and

6) providing on-the-job training and orientation of managers in managed care principles and programs.

"Roldán and Márquez" Primary Care Health Plan

Two Puerto Ricans, Luis Roldán and Jorge Aponte Márquez, are setting up a health plan that offers coverage only for ambulatory care, with a strong emphasis on prevention and family medicine. While it is important to orient managed care programs toward prevention and primary care, we feel that it is difficult to attract clients for plans that offer such limited services. In our experience, people are most concerned about the catastrophic costs of health care. It is unlikely that Nicaraguans will be willing to pay a premium price for prevention.

Furthermore, the plan is not currently attractive in the marketplace. It will charge more on an annual basis than Baptist Hospital's health plan which offers coverage for inpatient as well as ambulatory care (although as noted above, that plan is flawed and should be priced higher to be solvent).

Finally, the plan is currently inefficient. Only a third of the premium collected goes for health care and the rest to operations and marketing costs. While start-up costs and administrative expenses for ambulatory programs could be more than for hospital plans, this level appears excessive.

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[3] The consultants left a brief memo with the Baptist Hospital outlining their findings and specific recommendations and suggesting that the director of the Medical Plan receive additional training or technical assistance in this area.

"Fletcher Gurdián" Polyclinic Health Plan

Another group of providers is planning to start a managed care program building from the base of a Polyclinic. Two of the doctors, Fletcher Gurdián and Marvin Lund, worked in Brazil with managed care companies. They have experience and seem to know how to set up a schedule of benefits, price it and underwrite business (how to price the products according to age, sex and type of business). In other words, they have the technical "know how" that Baptist Hospital lacks, but they have no facilities. They lack capital to develop a multispeciality group practice/polyclinic.

Their idea is to use outpatient facilities as much as possible, including outpatient surgery (which they have already identified) and contract with the Military Hospital for inpatient care. They have identified an experienced sales person and have made preliminary contact with major companies to investigate their interest in a health plan. The plan would be targeted to employees of firms and would not be marketed to individuals.

This group does offer an interesting pilot project for a USAID-funded project. These two doctors could be useful to USAID/Managua because of their experience in managed care. They represent the most solid knowledge base to build upon. It may be possible to get them to work together with other groups that have facilities, although they appear to prefer developing their own facilities.

"Zapata and Bolaños" Low-Cost Polyclinic Health Plan

Two doctors, Drs. Roberto Zapata and Francisco Bolaños, both endocrinologists and Sandinista supporters (one being the head of the Sandinista physician's association), are concerned that most of the private health schemes are just for the upper and upper middle classes and that there is no affordable alternative for the middle and lower middle classes. They have developed a plan for a polyclinic and health plan that is priced to meet the needs of these groups. The total cost of the project, including the polyclinic, salaries and the first year operations is projected to be only US$300,000. It is expected to break even by the end of the first year. The thing that sets them apart from others is their commitment to provide affordable private health care.

USAID should consider this group for a potential pilot project, perhaps assisting them gain access to loans. They are the only group that is interested in developing a health plan for the middle and lower middle class. Their proposal to develop a program utilizing a polyclinic that employs physicians represents the least expensive and most efficient form of delivery in the long run. This plan could be a basis for developing a Nicaraguan version of the Bolivian PROSALUD model of private primary care.

General Options in Managed Care

There is a need for continuing education and technical assistance to developing managed care systems. Some will need assistance in plan design, product pricing, systems for membership eligibility, claims processing and tracking of cost and utilization.

It appears that several of the groups have complementary skills and access to facilities. For instance, while Baptist Hospital has the facilities, established clients and some funding, it lacks experience and necessary skills in managed care. On the other hand, Doctors Lund and Gurdián, who have the experience and skills in managed care, have no facilities or access to funds. USAID might consider having a meeting of the different groups that are beginning health plans to see if these complementarities could be developed.

IV. CONCLUSIONS AND RECOMMENDATIONS

The private sector is beginning to develop in Nicaragua. While it will probably be some time before indemnity insurance is introduced, private providers are actively developing managed care organizations. USAID could be a catalyst for this sector by providing technical assistance and loan guarantees for these fledgling health plans. Technical assistance is particularly needed for developing and pricing health benefits, marketing and underwriting, management and management information systems, and plan design.

Most private providers including polyclinics, hospitals, laboratories and individual practitioners are having difficulty getting access to capital for equipment, supplies and construction. USAID should consider providing loan guarantees so that providers can obtain reasonable terms for small scale loans. In those cases where major construction is contemplated, USAID could provide technical assistance in seeking international funding.

Private health plans could be further encouraged by a change in government policy which would allow people to take the amount deducted for Social Security to purchase a private health plan. This would spur growth in the private sector and encourage the participation of employers in providing health care benefits for workers.

Specific Options:

1. **Establish a loan or loan guarantee program for health care providers for equipment and minor renovations.**

   This is a central problem inhibiting the growth of the private sector. Providers need lower interest, longer term loans.

2. **Provide technical assistance to providers who are developing health plans in the areas of marketing, underwriting, product design and pricing, staff training, and systems.**

   This technical assistance could be provided singly to each viable group -- such as the Baptist Hospital -- or it could be offered to all interested groups. USAID might initiate this activity by sponsoring a meeting of all of the groups identified by this consultancy.

3. **USAID should provide technical assistance to identify governmental policy changes which will foster growth of the private health sector.**

   Examples of areas where specific studies would be useful are:

   1) tax relief for the private sector for importing medical equipment and supplies,

   2) the use of Social Security tax funds to purchase a health plan,

   3) import tax relief for new businesses,

   4) health insurance laws and regulations, and

   5) regulation options (reserve requirements, etc.) for assisting the growth of managed care plans.

4. **Provide funding for hardware and software to newly developing managed care programs for their management information systems.**

   Start-up health plans usually cannot afford computerized management information systems. Yet, without a well designed and functioning system, the plan managers will not be able to control cost and utilization.

5. **Provide technical assistance for private sector providers who are interested in major hospital or clinic expansion or new construction.**

   Providers are not aware of the availability of international funding and have no idea how to go about getting it.

PEOPLE AND ORGANIZATIONS CONTACTED

Dra. Adriana Zamora, Dental Surgeon
China Palace, Managua

Dr. Efraín Zapata, Optometrist
Optica Visión

Lic. Denis Reyna, Director
Hospital Militar Escuela
Programa de Asistencia Médica Especializada

Dr. Justo Pastor Zamora Herdocia
Physical and Rehabilitation Medicine

María Isabel Argüello Martínez, General Manager
Centro Clínico Villa Fontana

Dr. Fletcher Gurdián, Gastroenterologist
Clínica San José, León

Dr. Carlos Cárdenas Calales, Internal Medicine
Policlínica Médica Occidental

Marvin Lund, MD, MPH
Asesor Presidencia Ejecutiva, Instituto Nicaragüense de Seguro Social y Bienestar

Dr. Edwin Mendieta Herdocia, Obstetrics/Gynecology
Consultorios Médicos Bolonia

Robert S. Hans
Edward J. Kelly
Cabana Corporation

Dr. Roberto Calderón, Director
Instituto de Radiología

Sergio Maltéz Rivas, Director Ejecutivo
Profamilia de Nicaraga

Dr. William Abdalah, M.D., Medical Director
Baptist Hospital, Managua

Pedro Alvarado, Chief Financial Officer
Baptist Hospital, Managua

José Adán Aguerri, Director of Credit Department
AVAL Card, Managua

Luis A. Roldán, President
Jorge L. Aponte Márquez, Vice President
First Central American Corporation, Managua

Dr. Roberto Zapata
Facultad de Medicina and President
Federación de Sociedades Médicas Nicaragüenses

Dr. Francisco Bolaños
Centro de Especialidades

Dr. Alejandro Ruíz, President
Chamber of Commerce

Gilberto Martínez, Oral Surgeon
Managua

Dra. María Luz Martínez
Dental Surgeon

Dr. Gilberto Martínez Gonzáles, Oral Surgeon
Centro de Especialidades

Dr. Abraham Montealegre, Gastroenterologist
Vice President of the Colegio de Médicos and Cirujanos

ANNEX A

Options for Major Investments

The main private hospital is Baptist Hospital. It currently has only 40 beds. However, there are plans to expand it to 140. They have approvals from the city but lack the money to carry out the new construction. It is running at about 70 to 75% occupancy. They do about 180 surgeries a month (five operating rooms: four for general surgery and one for ophthalmology). About 4 to 5 babies are delivered a day. There are between five and six thousand outpatient visits per month. Four general physicians are salaried by the hospital. There are 28 specialists that practice primarily at the hospital with another 250 "external" affiliated physicians. Rooms range from US$72 for a private room, US$54 for a semi-private and US$44 for a four-patient ward. Baptist Hospital has the base to build from and should look for funding from the International Finance Corporation (IFC), the Interamerican Development Bank or USAID to fund their expansion. It is doubtful that they have enough operating capital to fund the expansion. They also need an ambulance.

Their expansion plans call for roughly 2,100 square meters for administration and ancillary services on the first floor and 3,100 square meters for 100 beds on the second floor. The cost of the expansion is estimated at US$1,856,000. They plan on funding the expansion out of operations, mission donations and loans. It occurred to us that the IDB or IFC may be interested in participating in a hospital construction project. The Hospital already provides both inpatient and outpatient care on an ability to pay basis. The Hospital Director said that about half of their business is full pay and subsidizes the other half.

The Centro de Especialidades has 17 beds and wants to expand to 50 beds. It does not have adequate staffing to handle more difficult surgeries. The Centro de Especialidades also gave us a copy of their expansion plans. Again, their biggest need is for financing. There are six major stock holders and investors and numerous associates The center offers internal medicine, surgery, obstetrics/gynecology, and pediatrics.

There are a number of other small hospitals (around 10 beds) that offer very limited services. One physician, Edwin Mendieta, had architectural plans for a 6 to 8 million dollar 50-bed hospital. Another group would like to develop a polyclinic and hospital for a managed care plan that would be marketed to groups.