HEALTH FINANCING AND MANAGEMENT
IN BELIZE: AN ASSESSMENT
FOR POLICYMAKERS

A Compendium of Technical Notes

Volume IV: The Private Medical Sector

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By

GERARD LA FORGIA
The Urban Institute

HARRY CROSS
The Urban Institute

RUTH LEVINE
The Urban Institute

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Health Financing and Sustainability (HFS) Project
Abt Associates Inc., Prime Contractor
4800 Montgomery Lane, Suite 600
Bethesda, Maryland, 20814 USA
Tel: (301) 913-0500 Fax: (301) 652-7791
Telex: 312636

The Urban Institute, Subcontractor
Management Sciences for Health, Subcontractor

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ABSTRACT

The authors analyze the factors constraining expansion in the private medical sector in Belize. The recommendations in this report focus on increasing lower income groups access to private medicine. The private medical sector in Belize is limited in terms of the number of providers and range of services. The report identifies the factors contributing to the lack of growth in the supply of private medicine in Belize: among other things—licensing regulations that restrict the number of physicians authorized to practice privately, the proximity of higher quality services in Mexico, and low population coverage of group medical insurance.
**BELIZE COMPENDIUM**

**ABBREVIATIONS**

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tr>
<td>ALOS</td>
<td>Average Length of Stay</td>
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<tr>
<td>BCH</td>
<td>Belize City Hospital</td>
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<td>CDR</td>
<td>Crude Death Rate</td>
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<td>CGA</td>
<td>Citrus Growers Association</td>
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<td>CHW</td>
<td>Community Health Worker</td>
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<td>CMS</td>
<td>Central Medical Stores</td>
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<td>CRDTL</td>
<td>Caribbean Regional Drug Testing Laboratory</td>
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<td>CSO</td>
<td>Central Statistics Office</td>
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<td>CWHC</td>
<td>Cleopatra White Health Center</td>
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<td>DHS</td>
<td>Director of Health Services</td>
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<td>DMO</td>
<td>District Medical Officer</td>
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<tr>
<td>EAP</td>
<td>Economically Active Population</td>
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<td>EEC</td>
<td>European Economic Community</td>
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<td>ECDS</td>
<td>Eastern Caribbean Drug Service</td>
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<td>EDP</td>
<td>Essential Drugs Project</td>
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<td>FORMED</td>
<td>Fondo Rotario de Medicamentos Esenciales</td>
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<tr>
<td>FPPM</td>
<td>Fiscal Policy Planning and Management</td>
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<tr>
<td>FY</td>
<td>Fiscal Year</td>
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<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
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<tr>
<td>GNP</td>
<td>Gross National Product</td>
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<td>GOB</td>
<td>Government of Belize</td>
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<td>HFS</td>
<td>Health Financing and Sustainability Project</td>
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<td>HMO</td>
<td>Health Maintenance Organization</td>
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<td>ILO</td>
<td>International Labour Office</td>
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<td>IMF</td>
<td>International Monetary Fund</td>
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<td>IMR</td>
<td>Infant Mortality Rate</td>
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<td>IPC</td>
<td>Income per Capita</td>
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<td>MIS</td>
<td>Management Information System</td>
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<td>MMR</td>
<td>Maternal Mortality Rate</td>
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<td>MOF</td>
<td>Ministry of Finance</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<tr>
<td>MRHC</td>
<td>Matron Roberts Health Center</td>
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<tr>
<td>MSH</td>
<td>Management Sciences for Health</td>
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<td>MSO</td>
<td>Medical Statistics Office</td>
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<tr>
<td>NHI</td>
<td>National Health Insurance</td>
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<td>NTUCB</td>
<td>National Trade Union Congress of Belize</td>
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<tr>
<td>OPD</td>
<td>Outpatient Department</td>
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<tr>
<td>PAHO</td>
<td>Pan American Health Organization</td>
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<tr>
<td>PNO</td>
<td>Principal Nursing Officer</td>
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<tr>
<td>PS</td>
<td>Permanent Secretary</td>
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<tr>
<td>RN</td>
<td>Registered Nurse</td>
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<tr>
<td>SDD</td>
<td>Social Development Department</td>
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<tr>
<td>SI</td>
<td>Statutory Instrument</td>
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<tr>
<td>SSB</td>
<td>Social Security Board</td>
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<tr>
<td>SSCGDP</td>
<td>Social Security Costs as a Percent of Gross Domestic Product</td>
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<td>SSDF</td>
<td>Social Security Development Fund</td>
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<tr>
<td>TBA</td>
<td>Traditional Birth Attendant</td>
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<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>UNICEF</td>
<td>United Nations International Children’s Emergency Fund</td>
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<td>USAID</td>
<td>United States Agency for International Development</td>
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<tr>
<td>VEN</td>
<td>Vital, Essential, Necessary</td>
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EXECUTIVE SUMMARY

The Health Financing and Sustainability (HFS) Project undertook an analysis of the private medical sector in Belize in an effort to understand the current constraints to expansion of private medical services, and to identify opportunities for USAID/Belize to assist the Government of Belize in taking full advantage of all of the country's health resources. The analysis and recommendations in the report are oriented toward increasing access to private medicine by lower-income groups.

Unlike other countries in the Caribbean basin, the private medical sector in Belize is limited in terms of the number of providers and range of services. In 1989, there were less than 25 exclusively private physicians, and approximately 20 others who practice in the public and private sectors. At the same time, population characteristics (currently at 200,000) and relatively high per capita income, suggest that demand for private medical care is strong and growing.

Several factors contribute to the lack of growth in the supply of private medicine in Belize. These include: licensing regulations that restrict the number of physicians authorized to practice privately, the proximity of higher-quality services in Mexico, low population coverage of group medical insurance, the absence of group practices, and the absence of linkages between those who finance and those who provide health care. The use of public hospitals by government-contracted specialists to treat private inpatients also has contributed to the underdevelopment of exclusively private facilities.

There are important opportunities for USAID/Belize to provide policy analysis and technical assistance, with the intent of expanding medical coverage to low-income populations. Policy analysis will focus on the access and cost consequences of regulations that restrict the supply of physicians. The analysis will also demonstrate how the restrictions may stunt the development of medical practice in Belize. This, in turn, has contributed to the growth of utilization by Belizeans of offshore facilities, and may compromise the country's foreign exchange balance. Regarding this latter point, more in-depth macroeconomic analysis may be needed before more definitive statements can be made about the relation between offshore utilization and foreign exchange balance. Additional policy analysis can be undertaken to evaluate the costs and benefits of government tax credits to employers who contribute to health insurance plans for their employees.

In addition, through technical assistance, USAID/Belize could help insurance companies, service providers, and business/trade organizations (such as the Chamber of Commerce) to establish linkages for the purpose of designing and implementing low-cost managed care schemes.
1.0 OVERVIEW

This report examines the current condition of the private medical sector in Belize and recommends activities that will enhance its potential for future growth. The analysis and recommendations are oriented toward increasing access to private medicine by lower-income groups.

The authors gathered information from a number of sources: employers, insurance company executives and agents, Chamber of Commerce representatives, government and private physicians, private clinic managers in Belize and Mexico, employer association representatives, Social Security Board (SSB) officers, and government officials. Meetings over a several-month period produced a quantity of information, opinions, and conclusions on the factors that directly affect the development and growth of private medicine in Belize. These include: physician supply, insurance products, government and Social Security regulations, offshore facilities, and informal employer-based "insurance" mechanisms. (See Scope of Work, Appendix 1.)

The report is divided into four parts. First, using demographic and macroeconomic data, we show why the demand for health services will increase over the next two decades. The second part turns to the supply of services. Here, we examine types of services and providers available in Belize. The third part analyzes the constraints to the growth of private medicine. This section focuses on three factors: government regulations, competition from offshore providers, particularly in Mexico, and the lack of coverage through health insurance. The report concludes with a series of recommendations concerning policy actions and technical assistance.

2.0 THE DEMAND FOR PRIVATE HEALTH SERVICES

2.1 DEMOGRAPHIC FACTORS

Estimates of population growth and economic development suggest that the demand for private health services by Belizeans will increase substantially during the 1990s. These factors exert a strong influence on the total (private and public) demand for health services. Belize has one of the highest population growth rates in the world. The average Belizean woman has between five and six live births in her reproductive lifetime, compared to an average of 3.7 in Latin America and the Caribbean (Population Reference Bureau, 1990). Moreover, whereas the birth rate is declining in many developing countries, the birth rate in Belize remains at a high level.

If we assume that all people born in Belize remain there, the population would double in 20 years. Yet, during the past several decades, many Belizeans have migrated out of the country. This may have lowered the rate of population growth. The World Bank projects that migration is decreasing and that it will decline to a trickle in the next 30 years. Further, during the 1980s, Belize has received an undetermined number of migrants and refugees from Central America. Some migrate to seek work as seasonal agricultural laborers and soon return to
their native lands. Others have returned (or will return) depending on political conditions. Anecdotal evidence suggests that many have remained in Belize. A drop-off in migration out of the country, together with continued immigration of Central Americans, will dramatically increase the number of people living in Belize during the next three decades.

Exhibit 1 shows that the population of Belize will double in 30 years to 400,000 people. The trend suggests that 15 years later (by the year 2035), the country will contain half-a-million inhabitants. At that time, Belize City's population could approach 200,000. (Exhibit 1 is based on the following assumptions: 1) declining fertility: from a total fertility rate of 5.2 in 1988 to 3.5 in 2000, and 2.2 in 2035. 2) no change in age-specific death rates; and 3) declining migration rates, from -3.4 per 1,000 net migration in 1885-1990, to 0 net migration in 2035.)

Age structure, or the distribution of people by age, also influences the demand for health services. Different age groups have different demands for health services. Women of child-bearing age, together with older people, constitute a large portion of the demand for inpatient services. The former seek gynecological services, while the latter require care for chronic and degenerative diseases. The age groups that will grow the fastest in Belize are precisely these groups that consume the most health services. Over the next 25 years, women of child-bearing age will be the fastest-growing age group in Belize. Their numbers will double by the year 2010 (from 40,000 to 80,000). In approximately 20 years, the over-55 population will double (from 20,000 to 40,000).

2.2 ECONOMIC FACTORS

Finally, the demand for health services, particularly private health care, is strongly related to changes in income. Real per capita income has increased substantially in Belize during the past decade. It is likely that income will continue along the trend shown in Exhibit 2. Studies in Latin America have found that for every additional one percent of spendable income, a household will increase its private health care expenditures by at least one percent (Musgrove, 1983). If this holds true in Belize, and there is sufficient supply of private services to meet the growing demand, we can expect that expenditures on private health will increase at nearly the same rate as per capita income.
Without a household survey, it is difficult to gauge precisely the demand for private health services. Based on a 1980 survey of general household expenditures, it was estimated that the private sector accounts for approximately 45 percent of Belize's expenditures on health care (Central Planning Unit, 1980). Because of the deterioration of state services during the 1980s, it is safe to say that Belizeans are increasingly seeking care from private providers in and outside of the country. Indirect evidence suggests that Belizeans from all social classes exhibit a high demand for private services. For example, most upper- and middle-class Belizeans have purchased indemnity insurance plans that are designed to cover expenses for private services provided in Mexico, Guatemala, and the United States. Workers and other lower-income employees, the majority of the Belizean labor force (Ministry of Economic Development, 1984), make use of an informal insurance mechanism available through employers. Most employers routinely lend money to employees to cover private medical expenses. Insurance coverage and employer-based loans are discussed in greater detail in a later section.

In sum, specifying the demand for private medical care requires information on people's health-seeking behaviors during illness events. Household surveys are a generally reliable method to obtain this information. In lieu of survey-based data, indicators of population growth, age structure, and income suggest that the demand for health services in Belize will rise rapidly over the next three decades. Financed through insurance or employer-based loans, many Belizeans are already demanding private care from both domestic and foreign providers.

3.0 THE SUPPLY OF PRIVATE MEDICAL SERVICES

Unlike other countries in the Caribbean basin, the private medical sector in Belize is limited in terms of the number of providers and range of services. In 1988, there were 2,045 people per doctor in Belize compared to the Latin American and Caribbean 1984 average of 1,230 (World Bank, 1990). In 1989, the Health Ministry's Medical Statistics Office reported 95 registered physicians practicing in public and private settings. Approximately half (45) the physicians are exclusively private practitioners, or specialists who practice in both the public and private sectors. Anecdotal evidence suggests that a limited number of physicians, mostly unlicensed migrants from neighboring countries, practice privately. Contrarily, not all the registered private physicians are...
Currently practicing in Belize. Some have left the country and others are semi-retired and receive patients on an irregular basis.

Only 17 licensed specialists practice in Belize. Most of these (13) are located in Belize City. All work for the Ministry of Health and, with the exception of two anesthesiologists, practice privately. Exhibit 3 presents the distribution of physicians by specialty. Except for those under state contract in Belize City, most general practitioners elsewhere in the country maintain a private practice.

The private medical sector in Belize is for the most part limited to outpatient services. Most private doctors receive patients in storefront consultation clinics. In 1988, a group of five specialists opened a small outpatient clinic. These physicians, who work for the government during weekdays, hold consultation hours in the early evening and on Saturdays. The physicians who invested in the clinic do not constitute a group practice. As is the norm for most providers in Belize, these doctors practice independently. Any referral links among physicians are arranged on an impromptu and informal basis. Private diagnostic facilities consist of one laboratory and a recently installed radiology unit. Both are located in Belize City and are not affiliated with any outpatient or inpatient facility. The laboratory performs a full battery of basic tests. Samples are sent to the United States for more sophisticated tests requiring expensive reagents and equipment.

Some secondary care is provided for maternity cases and simple surgeries. Surgeons are permitted to operate on private patients in the Belize City Hospital (BCH). Since the closing of the Holden Memorial Hospital in 1978, private general hospital services have become scarce. During the 1980s, on at least three different occasions, physicians established modest inpatient facilities. These short-lived endeavors were unsuccessful in part because of the low volume of patients and the limited supply of physicians. Raymond et al. (1985:52) succinctly pinpoints the reasons for the closing of the Santiago Castillo Hospital in 1986:

The problems encountered at Santiago Castillo were not cost problems; private services can be offered competitively in the Belize market. Rather, the hospital’s problems were generated by a medical system which limited the hospital’s access to physicians and patients.

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<th>EXHIBIT 3</th>
<th>DISTRIBUTION OF PHYSICIANS BY SPECIALTY, 1989</th>
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<tr>
<td>SPECIALTY</td>
<td>NUMBER</td>
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<td>General Surgery</td>
<td>3</td>
</tr>
<tr>
<td>Pediatrics</td>
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<tr>
<td>Internal Medicine</td>
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<td>Ophthalmology</td>
<td>2</td>
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<tr>
<td>Anesthesiology</td>
<td>2</td>
</tr>
<tr>
<td>Orthopedics</td>
<td>1</td>
</tr>
<tr>
<td>Radiology</td>
<td>1</td>
</tr>
<tr>
<td>Total Specialists</td>
<td>17</td>
</tr>
<tr>
<td>General Practice</td>
<td>78</td>
</tr>
<tr>
<td>Total Physicians</td>
<td>95</td>
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Interestingly, a small group of physicians has recently set up a five-bed hospital in the same building that housed the Santiago Castillo hospital. The clinic offers general outpatient and inpatient services, including maternity care. However, laboratory and other diagnostic services are not provided. Clinic managers are currently seeking an anesthesiologist and equipment for an operating theater. In Corozal, another group of physicians recently established a group practice and are constructing a small hospital.

Within a two-hour bus ride from Belize City, in Chetumal, Mexico are two private hospitals/outpatient clinics. These are the Clínica de Especialidades y Diagnóstico de Chetumal, and the Clínica Fundación Médica de Quintano Roo. The former facility appears to emphasize outpatient services, while the latter, a recently inaugurated facility, features high-quality secondary and tertiary care.

The quality of care in the two clinics appears markedly superior than private services in Belize. The Chetumal facilities integrate outpatient, inpatient, diagnostic, and pharmaceutical services under one roof. Diagnostic services, operating theaters, and intensive care units are well-equipped. The recently constructed Clínica de Chetumal acquired sophisticated equipment to provide tertiary care, including traumatic and intensive care services. Approximately 20 physicians, representing a wide range of specialties and subspecialties, are affiliated with each clinic. Further, formal referral arrangements are established within each facility that allow a patient to visit two or more physicians (and obtain diagnostic tests) during the same day. Clinic representatives report that many Belizes cross the border to seek specialty services, particularly those services not available in Belize (such as cardiology, urology, and otorhinolaryngology). Pediatrics and general medicine, available in Belize, are not big demand specialties for Belizean patients crossing the border.

4.0 CONSTRAINTS TO THE GROWTH OF PRIVATE MEDICINE

Several factors contribute to the lack of growth of private medicine in Belize. These include: licensing regulations that restrict the number of physicians authorized to practice privately, the proximity of higher-quality services in Mexico, low population coverage of group medical insurance, the absence of linkages between financiers and providers of health care, and the practice of private medicine in Belize City Hospital. We take up each of these themes in turn.

4.1 PHYSICIAN LICENSING

The supply of physicians in Belize is artificially restricted by regulations and practices that make it difficult for newly arriving doctors, such as medical school graduates, to practice privately. The limited size of the medical corps contributes to high physician fees, which in turn deter utilization by low-income groups. In Belize City, most specialists charge US $15-18 for an outpatient visit. This amount represents 25 to 35 percent of the weekly salary of most blue-collar workers. The physician’s fee, together with the cost of a prescription drug or a diagnostic test, may represent over 50 percent of a week’s wages for most Belizeans.
As suggested above, nascent private facilities are unable to expand services in part because of a lack of physicians. Moreover, since most general practitioners are not permitted private practice in Belize City, the largest market for private medicine, a significant portion of services provided by high-priced specialists is routine primary care.

According to Belize Ordinance, Law 21 of 1973, an amendment to the Medical Practitioners Registration Ordinance (Chapter 20), licensing is granted through the Medical Council of Belize. The Council is made up of the Health Minister, two appointees (appointed by the Minister), and two representatives of the Belize Medical and Dental Association. Through the auspices of the Medical Council, elements within the Belize Medical Association appear to have restricted the entry of new doctors into the private medical market in Belize City. Since 1960, it is estimated by one source that fewer than 30 private licenses have been issued.

To obtain a license to practice privately, known as Full Registration, a physician must work two years for the government or have worked for a prescribed period in a rural area. Nevertheless, although the law is not clear on this matter, specialists are immediately permitted private practice if employed in the public service. This is a practice left over from the colonial period. General practitioners assigned to government facilities in Belize City are prohibited from practicing privately, and are even paid a small monthly compensation for this restriction. Currently, 25 general practitioners constitute this group. Seven Belize City general practitioners have been granted licenses through special government decree. They were exempted from the law because they were long-established practitioners or because of political influence.

Although the law was originally meant to guarantee a sufficient number of physicians for government facilities, this is no longer the case. Since government vacancies are limited, few recent medical graduates can obtain positions. Reportedly, during the last few years, this has happened on more than one occasion to young Belizean physicians (including specialists). The Medical Council also denied them a private license because of the government service requirement. They subsequently left the country. The Medical Council is also known to block or at least delay the licensing of physicians who have met the two-year public service requirement. Because of professional, ethnic, and political divisions within the Belizean medical corps, specialists and general practitioners already licensed to practice in Belize City have been able to control the Belize Medical Association and exert sufficient pressure on Health Ministers to maintain the status quo. Some may fear losing their already limited market share.

4.2 OFFSHORE MEDICAL CARE

Many Belizeans bypass the private medical sector in their country and seek services in Mexico, Guatemala, and the United States. As will be shown in the

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2As demonstrated in the 1989 elections, elections in Belize are decided by a small margin of votes. A group of 20 people can make up a political constituency. The Medical Association is considered a powerful interest group.
In the next section, most middle- and upper-income Belizeans have purchased indemnity insurance plans that are tailored to cover their offshore medical expenses. However, it appears that some offshore facilities are frequented by Belizeans representing all income groups. Insurance company executives, physicians, employers, and government officials admit that facilities in the city of Chetumal, Mexico attract patients from throughout Belize.

One Chetumal clinic estimated that in 1989, 18,000 consultations were provided to patients from Belize. The clinic's administrator reported that most of these patients represent middle- and low-income groups. Both clinics claimed that one-third of their bed-days were filled by Belizeans, though more precise figures were unavailable. An undetermined number of Belizeans seek services at solo practices that dot Chetumal. Prices at the Mexican clinics are highly competitive with the Belizean private sector. For example, an outpatient consultation with a specialist costs $20-25, compared to the $35 charged in Belize. Factoring in the $10 transportation costs (from Belize City), the prices are essentially equivalent. Hospital per diem is $110 compared to $95 in Belize's only private hospital. Based on the price lists and utilization information provided by the clinics, we estimate that Belizeans spend between $2 and $4 million annually for medical services in Chetumal alone.

Clinic directors in Mexico are eager to establish formal links to the Belizean private medical sector and to expand their catchment area. In fact, the medical director of Clínica de Chetumal suggested that they would provide discounts for inpatient services in exchange for incorporation into a provider network linked to a prepayment scheme. The clinic's principal marketing objective is to capture the patients (Belizeans and Mexicans) who go to Mérida, the regional capital, for secondary and tertiary care.

The Mexican Consul in Belize City reported that approximately 15 patients per month seek visas for medical reasons. However, he stated that probably many more do so, but do not list medical reasons on the visa application. Insurance company representatives in Belize concur that most patients who go to Mérida (eight to 10 hours by bus) seek tertiary care or sophisticated diagnostic services (such as computerized axial tomography).

4.3 HEALTH INSURANCE

The market for health insurance in Belize is limited to white-collar employees and a scattering of blue-collar workers. Six insurance companies sell group and individual indemnity plans. Although auto, casualty, and life insurance are their principal product lines, insurance company executives maintain that medical insurance sales have increased rapidly during the 1980s. Individuals or groups desiring a medical scheme are required to purchase some other type of insurance (usually casualty or life).

We estimate that private insurance covers from 5,000 to 7,000 Belizeans. Group plans are limited to firms such as banks, utility companies, financial service institutions, trading companies, etc. Many of these companies are

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3 All figures in Belize dollars unless otherwise noted: US $1 = BLZ $2
affiliates of large international firms. Of the approximately 50 firms covered by indemnity plans, dependents are covered in less than 50 percent of the schemes. On the average, the firms pay from 50 to 100 percent of the premiums for their employees.

As noted earlier, the benefit packages are fashioned to cover expenses for medical care acquired outside of Belize. Insurance company representatives state that most claims are for services provided offshore in part because of the limited facilities and services available in Belize. Column A of Exhibit 4 presents a high-cost generic scheme which would provide excellent coverage for most expenses incurred in Mexico or Guatemala. For example, based on the price list from the Clínica de Chetumal, an appendectomy requiring three bed-days will cost approximately $2,200 (including physician fees, anesthesia, laboratory tests, etc.). The scheme listed in Column A would reimburse the patient for all expenses except $90. Insurance companies also sell "executive" schemes that cover services provided in the United States. All companies have purchased reinsurance policies on the international market.

| EXHIBIT 4 | A COMPARISON OF A SAMPLE OF BENEFITS AND PREMIUMS FROM HIGH- AND LOW-COST GROUP Indemnity Plans1 (BLZ 1) |
|---|---|---|---|---|---|---|
| | (A) | (B) |
| **BENEFITS/PREMIUMS** | **HIGH-COST** | **LOW-COST** |
| **BASIC MEDICAL** | | |
| Hospital (room and board) | max per day | 85 | 40 |
| max per disability | 3,520 | 1,200 |
| **SURGICAL** | | |
| Surgical max | 1,600 | 800 |
| Anesthesia max | 400 | 300 |
| **DOCTOR'S VISITS (in hospital)** | | |
| max per day | 30 | 6 |
| max per disability | 420 | (covered under major medical rider) |
| **OUTPATIENT SPECIALIST** | | |
| max per visit | 40 | 30 |
| max per disability | 160 | 70 |
| **OUTPATIENT GENERAL PRACTITIONER** | | |
| max per visit | 25 | 202 |
| max per period of disability | 200 | 75 |
| **MATERNITY** | | |
| Normal delivery | 600 | 200 |
| C-section | 300 | 400 |
| Prescribed Drugs and Medicines | max per year | 300 | (covered under major medical rider) |
| Deductible each accident or illness | 5 | |
| **MAJOR MEDICAL** | | |
| Co-insurance | 20% | 20% |
| max lifetime benefit | 100,000 | 20,000 |
| Deductible—calendar year | 100 | 100 |
| **PREMIUM RANGE**2 (monthly) | | |
| Individual | 30-453 | 15-204 |
| Family | 50-1003 | 25-504 |

Notes:
1. Figures are not representative of any particular benefit package. Rather, for comparative purposes, they represent typical coverage limits for each benefit.
2. May exclude first annual visit.
3. Deducted after basic medical maximum limits are reached.
4. Amounts vary according to group size as well as age, sex, and occupational characteristics of the members therein.
5. Total premium payments are approximately $10 higher per month. Insurance companies require that firms also purchase some other type of insurance coverage (usually life insurance) to qualify for a group medical plan.
Taken together, payments for premiums, deductibles, and copayment levels are generally out of reach for the average worker, who earns between $400 and $600 monthly. The volume is generally too small to form a local risk pool. This contributes to higher premium levels. Most insurance companies insert their groups into an international risk pool based on sex, age, salary, and occupational characteristics.

As shown in Column A of Exhibit 4, family coverage can cost as much as $100 monthly, representing 20 to 25 percent of the earnings of many Belizean workers. It is important to note that premium payments are approximately $10 higher than those shown in Exhibit 4. Insurance companies will not sell a group medical policy unless a firm also purchases life insurance or some other type of coverage.

Typical of indemnity schemes, enrollees are required to first pay the provider out-of-pocket and then submit a claim for reimbursement. As evident in the above example, workers' income is often too low to make an up-front payment and then bear the invariable delay for reimbursement.

A few domestic firms have purchased group medical insurance to cover blue-collar or lower-income employees. Column B of Exhibit 4 provides an example of a low-cost benefit package. The scheme is designed to cover services offered within Belize, that is, physician fees for private outpatient services and for surgery performed in the Belize City Hospital. Only with the prior authorization of a Belizean specialist will the policy pay for a claim for services provided in Mexico or Guatemala.

Insurance companies have not sold many lower-end plans to companies employing blue-collar workers. The reasons are varied. First and foremost, most companies have instituted an informal health insurance mechanism. Firms routinely lend money interest-free to employees to cover medical expenses. Through interviews with employers, the authors found that five to 20 percent of weekly payrolls are comprised of repayments for loans. At any one time, anywhere from 15 to 50 percent of employees have loans outstanding. Company executives maintain that most of the loans are for medical reasons. Workers directly petition the firm's general manager or owner for a loan. The loans are repaid through scheduled salary deductions over a six- to 12-month period. Because this system depends on employer beneficence, the distribution of benefits (loans) is potentially inequitable.

Second, some employers incorrectly assume that Social Security (SSB) covers all sickness events. In fact, the SSB only covers work-related injuries and illness. Yet, according to Social Security regulations, patients are required to seek services in public facilities. Despite SSB coverage, many employers have purchased supplementary insurance to cover private medical expenses for work-related injuries. They maintain the employees often must miss a day's work due to waiting time in the Belize City Hospital or district hospitals. Moreover, the employees themselves prefer to receive attention from private providers.

Third, health benefits are usually not on the collective bargaining agenda for both owners and unions. (A low proportion of the labor force is unionized in Belize. Existing unions are considered to wield little political power and
rarely pressure employers for increased salaries and benefits.) Employers and employees consider the premiums too expensive for the (low) level of benefits of the low-cost schemes (such as the scheme presented in Column B of Exhibit 4). Employees question the rationale of paying premiums for low-quality treatment in public facilities, such as for surgery in the Belize City Hospital. Workers claim that they already have relatively free access to these services.

Finally, because of the bankruptcy of two (foreign) life insurance firms in the 1970s, many Belizeans lost confidence in insurance as a means of financial protection against life's risks. Although the situation is changing, any project to extend coverage to middle- and lower-income groups will require marketing as well as consumer education.

4.4 LINKAGES BETWEEN FINANCIERS AND PROVIDERS OF HEALTH SERVICES

As suggested above, insurance companies have yet to establish formal arrangements with providers in Belize. This responds partly to the nature of the insurance product they sell and partly to the lack of organization among physicians. Freedom of choice of providers is desired by most upper- and middle-income enrollees, but, at the same time, the resulting high premiums exclude the large volume of working-class Belizeans. The insurance schemes reimburse enrollees for services obtained in four countries—with few questions asked. Consequently, insurers are in a poor position to counter the adverse effects of over-utilization or moral hazard and provider fraud. Applying utilization controls and checking the validity of claims submitted for services rendered in offshore facilities is obviously difficult. Some insurance executives recognize the need to implement controls to reduce or contain costs. To incorporate workers and other lower-income groups into an affordable insurance scheme, which also includes cost containment measures, may require a different type of design—one linked to a specified network of providers.

Except for the recent initiatives of the Myo'on Clinic in Belize City and the Northern Medical Group in Corozal, there have been few attempts by physicians to organize group practices. As noted earlier, this responds to the restricted supply of physicians, and to a lesser extent, to ethnic, professional, and political divisions among the Belizean medical corps. Even if insurance companies desire to negotiate contracts with providers, there would be no group practice or partnership to turn to. Similarly, few links exist between physicians and employers. Some employers send employees with work-related injuries to solo practitioners. But these arrangements are informal and the firms pay on a fee-for-service basis.

4.5 PRIVATE PRACTICE IN PUBLIC FACILITIES

According to Law No. 2 of 1977, specialists are permitted to admit private patients to government hospitals as long as hospital services are unavailable in private facilities. Informants within Belize City Hospital, the country's principal inpatient facility, estimate that between 50 and 75 percent of elective surgery and maternity cases are private. Based on these estimates, in 1989, no fewer than 5,000 BCH discharges were private patients.
It is common knowledge that the quickest route to admittance to the BCH is through a specialist's private ambulatory clinic. In theory, private patients are required to pay special fees to the hospital for hotel, drug, and diagnostic services. In practice, these fees are not collected.\(^4\) Physicians charge fees for surgical procedures (performed in the BCH) and for pre- and post-hospitalization consultations (performed in private clinics). In effect, the government subsidizes private practice through underwriting the cost of hotel, operating room, diagnostic, and administrative services of the BCH.

The use of public facilities for private practice appears to contribute to a fragmented and underdeveloped private medical sector. Most physicians are solo practitioners and practice in storefront settings. A majority of specialists practicing in Belize have government contracts, and most of these are assigned to the BCH. They have little incentive to organize group practices or to invest in plant and equipment necessary to establish a private hospital. From the specialists' standpoint, treating private patients in the BCH makes perfect sense as long as the government picks up the tab for capital and overhead costs.

Fully private physicians (i.e., those without public contracts) claim that the aforementioned failure of three private hospitals in Belize City was due in part to a low volume of patients. The high volume of private patients channeled through Belize City Hospital contributed to the low utilization of these facilities. As described in Section 4.2 above, there is a high demand for private hospital services, as evidenced by the large number of Belizians seeking care in offshore facilities. These facilities offer "integrated services," e.g., hospitalization, laboratory, radiology, pharmacy, etc., under one roof. A comparable facility is absent in Belize. For those Belizians who are unwilling to utilize the dilapidated BCH for non-emergency hospital care, offshore facilities are their only option.

5.0 THE POTENTIAL FOR EXPANSION OF MEDICAL COVERAGE TO LOW-INCOME POPULATIONS

5.1. PRODUCT DESIGN

Insurance company representatives recognize that the market for higher-end plans is rapidly becoming saturated. Future growth will be linked to developing low-cost products and extending them to full-time, blue-collar workers and other lower-income employees and their families that make up the majority of Belize society. However, experience has taught them that schemes that feature limited benefits, high copayments, and complicated administrative procedures are difficult to sell to employers and employees alike. Moreover, few employees can afford the up-front, out-of-pocket expenditures inherent in indemnity plans. Insurance companies maintain that the elements of a successful insurance product for low income groups would include: comprehensive coverage, low copayments, dependent coverage, a large employer contribution to premium payments, and effective cost-containment systems.

\(^4\)Private practice in government facilities is discussed in greater detail in the HFS report on cost recovery.
5.2 MANAGED CARE

Many insurance representatives have expressed the need to work with organized groups of providers in Belize to establish prepaid managed care plans (similar to HMOs or PPOs) that integrate the financing and service delivery functions. Indeed, these arrangements offer considerable promise in the Belizean context. First, such arrangements have the potential to offer comprehensive coverage for relatively lower premiums than indemnity products. Second, they would also eliminate the need for large out-of-pocket expenditures and claim filing. The latter process is looked upon unfavorably by many employees, in part because of their experience with the slow-moving Social Security claims system. Third, managed care offers the potential for reducing fraudulent claims practices by providers and enrollees that currently plague the Belizean insurance industry.

Finally and most importantly, a managed care system allows for more control over expenditures (and thus lower premiums) partly because physician fees and other rates are predetermined. Currently, physicians tend to charge the maximum allowable in an indemnity plan. A restricted number of providers also permits closer oversight by claims analysts.

A prepayment plan linked to a network of providers offers several advantages. First, it allows for a greater amount of expenditures to remain in Belize. In the short run, the plan could require members to use those services that are available in the country (such as primary care, some specialty services, maternity, and some secondary care). Anecdotal evidence suggests that most Belizeans prefer Belizean physicians to their Mexican and Guatemalan counterparts and would seek private services in Belize if more adequate facilities existed. However, initially at least, the plan should not exclude providers in Mexico. The network should include Mexican providers, but only through a referral system. In other words, the plan can permit more appropriate (and controlled) use of Mexican clinics for services unavailable in Belize (such as tertiary care and more sophisticated diagnostic services). Second, in the long run, the increased volume could contribute to an expanded market for private medicine and to local capacity building.

Of particular interest is a prepaid plan recently initiated by the only private hospital facility in Belize, the Myo’on Clinic. Although it is too soon to assess this experiment, the scheme does provide an example of a type of low-cost plan that could attract cost-minded employers and employees. For $15 per month, the plan covers a wide range of basic outpatient services, including immunization, physician consultations, diagnostic tests, and basic dental care. The plan also covers hospital expenses for simple surgical procedures (maximum of eight days). Small copayments are required for most services. For example, enrollees pay $3 for an outpatient consultation (compared to $25 for a solo practitioner). Several of the details of the scheme have yet to be developed.

Some insurance executives consider the managed care option too risky unless information can be obtained on utilization patterns and other characteristics (such as age, sex, mortality rates, etc.) of the potential enrollees. In Belize, basic data on labor force characteristics, such as number of employers and employees, salary levels, occupation, residence, etc., cannot be found. As suggested earlier, insurance companies set rates based on data from international
risk pools or on U.S. mortality and utilization trends. Others consider the limitations of private medicine in Belize an obstacle to any managed care arrangement. We conclude that, without such a scheme, it is unlikely that the private sector will attract sufficient volume to generate growth.

5.3 RISK POOLS

Strengthening the private sector as well as extending coverage to lower-income groups will depend on incorporating a large volume of the latter population into insurance schemes. There is a need to find organizational arrangements which group large numbers of these potential beneficiaries. Large employers are relatively scarce in Belize. In fact, few firms have more than 200 full-time employees. Trade associations and business organizations are a possibility, however. We met with two groups who are interested in serving as intermediaries to form a risk pool. For example, the Chamber of Commerce currently has over 200 member firms. Many of these are small companies with less than 10 employees. The Cane Growers Association (CGA) in Corozal represents approximately 2,300 sugar cane producers in northern Belize. Most of these are small producers. During the harvest season, the farmers hire nearly 1,000 migrant laborers. Presently, neither farmers nor workers are covered by an insurance plan.

5.4 LOCAL SUPPORT

Interest is high among insurance executives, providers, and trade organizations in strengthening private medicine in Belize and designing alternative financing and delivery mechanisms that extend these services to the working uninsured. They respond favorably to the recommendation to establish managed care arrangements in Belize. One physician group, affiliated with the Myo' on Clinic, is in the process of initiating a prepayment scheme. In 1989, a group of doctors in Corozal established a group practice. Moreover, representatives of the clinics in Mexico are eager to enter into an agreement whereby they provide services (at a discounted price) that are unavailable in Belize.

6.0 PLANS FOR TECHNICAL ASSISTANCE

Based on the above findings, the Health Financing and Sustainability (HFS) team is proposing two types of activities: policy analysis and technical assistance. The purpose of these activities is twofold: to stimulate the growth of the private sector and extend private coverage to lower-income workers and their families.

- Policy Considerations: The policy activity will consist of an analysis showing the access and cost consequences of regulations that restrict the supply of physicians. The study will also demonstrate how the restrictions have stunted the development of medical practice in Belize. This has contributed to the growth of
offshore facilities and has compromised the country's foreign exchange balance. The paper will propose how to best ease restrictions and rework the current legislation.\(^5\)

- **Promote Managed Care:** We will also provide technical assistance to insurance companies, service providers, and large group organizations (e.g., Chamber of Commerce, Cane Growers Association, etc.) to establish linkages for the purpose of designing and implementing low-cost managed care schemes. Because indemnity insurance is not well understood in Belize, it is too costly for most employers and employees, and it invites excesses. Prepaid schemes linked to a provider network may be a more promising means for expanding the insurance net to blue-collar workers. The above-mentioned Myo'on Clinic has already requested assistance regarding the design of their prepayment scheme. Moreover, referral linkages with the Chetumal clinics are worth exploring. Another group of general practitioners seek to establish a group practice catering to the health needs of low-income families. Of related interest, the Chamber of Commerce seeks to create a risk pool through its 200 member firms and their employees. The effort has the potential to attract a relatively large volume of enrollees that could be incorporated into a managed care arrangement. HFS is currently assisting the Chamber in the design of an employer survey.

- **Promote Tax Credits:** Employers are generally unwilling to foot the bill for the high-cost indemnity schemes offering comprehensive coverage to blue-collar workers. Some insurance executives see a need for employer tax credits for purchasing group insurance plans. Currently, the tax laws allow for a $1,400 income deduction for individuals who purchase life insurance (Chapter 46, Section 21 of Income Tax Ordinance).

  A case can be made for the government to grant tax credits to employers who contribute to health insurance plans for their employees. In addition to stimulating the insurance industry and extending coverage to lower-income groups, the measure will encourage expansion of the private medical sector. This could lead to additional tax revenues in the future. HFS proposes a cost-benefit analysis of the effects of a tax incentive.

- **Increase Investments in Low-Cost Private Health Services:** Finally, physicians and insurance executives recognize the need for sources of capital for private providers. A physician who desires to start a group practice estimates that he needs at least $10,000 to remodel a small building and purchase small instruments. Currently, lines of credit are limited. The absence of alternative insurance mechanisms and group practices, public sector domination of inpatient services, and foreign competition have contributed to the

\(^{5}\)Policy recommendations concerning the practice of private medicine in Belize City Hospital are discussed in the HFS cost recovery report.
reluctance of investors to provide credit to private providers. HFS recommends that Social Security could be a source of soft loans for providers seeking to upgrade or establish private facilities. This theme is taken up in the companion paper on Social Security.
APPENDIX 1: SCOPE OF WORK

Private Sector Participation

One of the objectives of Project -0045 will be to increase the participation of the private sector in the provision of health care services. To lay the groundwork for this initiative, HFS will provide a health care private sector specialist or a health economist for a three-week consultancy. There is a common perception in Belize that restrictive policies discourage increased private sector provision of curative health services. This consultant will be responsible for reviewing and analyzing eligibility requirements, regulations, and practices, all prior studies carried out by the Government of Belize and the donor community on private sector participation, and estimating current and future supply and demand under different scenarios.
REFERENCES

Central Planning Unit, 1980. The Belize Household Survey.


