

DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

DOMINICAN REPUBLIC

SUPPORT FOR HEALTH SECTOR AND SOCIAL SECURITY CONSOLIDATION

(DR-L1073)

LOAN PROPOSAL

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REQUIRED	
1. Policy letter	http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=39244436
2. Means of verification	http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=39059137
3. Results matrix	http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=39059145
OPTIONAL	
1. Monitoring and evaluation	http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=39059166
2. Critical path	http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=39059197
3. Economic analysis	http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=39060409
4. Labor Sector Framework Document	http://publications.iadb.org/handle/11319/2639?locale-attribute=es
5. Policy note. Social security and pensions in the Dominican Republic (draft for discussion)	http://idbdocs.iadb.org/wsdocs/getDocument.aspx?Docnum=39000628
6. IDB -World Bank. Policy notes, Dominican Republic (draft for discussion)	http://idbdocs.iadb.org/wsdocs/getDocument.aspx?Docnum=38922689
7. Social Security Law 87-01	http://www.sipen.gov.do/documentos/norm_lev_87_01.pdf
8. Law 352-98 on Protection of the Elderly	http://www.comisionadodejusticia.gob.do/phocadownload/Biblioteca_Virtual/Envejeciente/Ley%20352-98,%20sobre%20Proteccion%20al%20Envejeciente.pdf
9. SIPEN bulletin 33 with information on SISPRE	http://www.sipen.gov.do/documentos/Boletin33_Sipen.pdf
10. SIPEN bulletin 42	http://www.sipen.gov.do/documentos/Boletin42_Sipen.pdf
11. Policy actions to enhance National Health System efficiency	http://idbdocs.iadb.org/wsdocs/getdocument.aspx?docnum=39199744
12. IDB support for the health sector in the Dominican Republic	http://idbdocs.iadb.org/wsdocs/getdocument.aspx?docnum=39199842
13. Fiscal impact analysis	http://idbdocs.iadb.org/wsdocs/getdocument.aspx?docnum=39199788
14. Relative importance of causal factors in low health sector efficiency and low SDSS coverage	http://idbdocs.iadb.org/wsdocs/getDocument.aspx?Docnum=39199781

ABBREVIATIONS

CNSS	Consejo Nacional de Seguridad Social [National Social Security Council]
DIDA	Dirección de Información y Defensa de los Afiliados [Participant Information and Protection Division]
EAP	Economically active population
GDP	Gross domestic product
MSP	Public Health Ministry
OECD	Organization for Economic Cooperation and Development
PDSS	Plan de Servicios de Salud [Health Services Plan]
PFA	Pension Fund Administrator
SDSS	Sistema Dominicano de Seguridad Social [Dominican Social Security System]
SENASA	Seguro Nacional de Salud [National Health Insurance]
SIPEN	Superintendencia de Pensiones [Superintendent of Pensions]
SISPRE	Sistema de Pensiones de Reparto del Estado [State Unfunded Pension System]
SIUBEN	Sistema Único de Beneficiarios [Master Beneficiary System]
SRS	Servicios Regionales de Salud [Regional Health Services]
TSS	Tesorería de la Seguridad Social [Social Security Treasury]

PROJECT SUMMARY

DOMINICAN REPUBLIC SUPPORT FOR HEALTH SECTOR AND SOCIAL SECURITY CONSOLIDATION (DR-L1073)

Financial Terms and Conditions			
Borrower: Dominican Republic Executing agency: Ministry of Finance		Flexible Financing Facility*	
		Amortization period:	17.5 years
		Original weighted average life (WAL)	12.73 years**
		Disbursement period:	1 year
		Grace period:	10.5 years
Source	Amount (US\$)	Interest rate:	LIBOR-based
IDB (Ordinary Capital)	150 million	Inspection and supervision fee:	***
		Currency:	United States dollars
Total	150 million	Credit fee:	***
Project at a Glance			
Program objective: The general objective of the program is to progressively consolidate social security coverage and improve health spending efficiency by deepening the reform being implemented by the Government of the Dominican Republic in the two sectors. This operation is the first in a programmatic policy-based series that will be comprised of two contractually independent but technically linked loans, in accordance with document CS-3633-1.			
Special contractual conditions: Disbursement of Bank financing will be subject to fulfillment of the policy conditions set out in Annex II (Policy Matrix) and the other conditions stipulated in the loan contract (paragraph 3.4).			
Exceptions to Bank policies: None			
Project qualifies as: SEQ [X] PTI [] Sector [X] Geographic [] Headcount []			

* Under the Flexible Financing Facility (document FN-655-1), the borrower has the option of requesting changes in the amortization schedule, as well as currency and interest rate conversions, subject in all cases to the final amortization date and the original weighted average life. The Bank will take operational and risk management considerations into account when reviewing such requests.

** The original weighted average life may be shorter depending on the effective signature date of the loan contract.

*** The credit fee and inspection and supervision fee will be established periodically by the Board of Executive Directors as part of its review of the Bank's lending charges, in accordance with the applicable provisions of the Bank's policy on lending rate methodology for Ordinary Capital loans.

I. DESCRIPTION AND RESULTS MONITORING

A. Recent macroeconomic performance and financing needs

- 1.1 The economy of the Dominican Republic has been one of the strongest performers in Latin America and the Caribbean (LAC). Between 1990 and 2013, gross domestic product (GDP) grew at an average annual rate of 5.1%, well above the average for the region (3.1%). This performance held during the first half of 2014, with growth of 5.2%. Nevertheless, the country has recorded a fiscal deficit since 2008, which worsened in 2012. Between 2008 and 2012, the central government's overall balance posted an average deficit of 3.6% of GDP. By the end of 2012, the deficit was 6.8% (compared with 2.6% in 2011), partly due to the increase in capital spending during the electoral cycle.
- 1.2 In 2012, the Dominican government implemented a fiscal consolidation program that included tax reform and adjustments in public spending. In 2013, fiscal revenues rose by 15.2%, public spending fell by 7.6%, and the central government deficit reached 2.9% of GDP. Although this progress reversed the upward trend in the deficit, it has only leveled out at pre-2012 levels. In addition to the adjustment in spending, resources were redirected to the social sector, increasing from 7.5% of GDP in 2011 to 9.4% in 2013. Of particular note were the increased allocation for education and higher resources to increase the coverage of subsidized health insurance and social assistance programs.
- 1.3 A deficit of 2.8% of GDP is expected in 2014. Fiscal revenues (including grants) will make up 15.5% of GDP, 0.5 percentage points higher than the estimate for 2013. This increase is explained by the entry into force of the articles of the tax reform scheduled for gradual implementation.¹ Expenditures are expected to total 18.3% of GDP.
- 1.4 This programmatic policy-based loan will provide budgetary support to finance the fiscal deficit, making it possible to manage the public debt more efficiently and reducing pressure to adjust spending, which would affect the government's social policy commitments. This operation will finance 5.5% of the fiscal deficit and nearly 2% of the public sector's gross financing needs for 2014.²

B. The Dominican Republic's social security and health systems

- 1.5 **Reforms in the social security and health sectors.** In 2001, the Dominican government launched a structural reform process in the social security and health sectors with the enactment of the Social Security Law (87-01), which created the Dominican Social Security System (SDSS), and the Health Act (42-01), which established the regulatory framework for the National Health System. The purpose of the reforms was to provide quality universal coverage.³ Prior to the reform, there

¹ For example, the increase in the value added tax on certain primary goods from 8% to 11%.

² Financing needs total US\$4.262 billion (6.9% of 2014 GDP as compared with 5.9% in 2013).

³ In 2001, only 7% of workers were covered by the Dominican Social Security Institute.

were isolated insurance systems, serving a minority, including various fragmented unfunded pension systems for public sector employees or supplementary pension funds, and private health insurance for workers in the private sector. Law 87-01 established three financing systems for pension and health insurance: (i) a contributory system for wage earners; (ii) a subsidized contributory system for self-employed individuals earning more than the minimum wage; and (iii) a subsidized system for self-employed, disabled, and unemployed individuals with earnings falling below the minimum wage.^{4,5}

- 1.6 **The Dominican pension system.** Of these, the contributory pension system is the only system that has been implemented. It is an individually-funded system with accounts administered by Pension Fund Administrators (PFAs), and financed by contributions from wage earners (30%) and their employers (70%).⁶ The new law created the Superintendent of Pensions (SIPEN) to supervise compliance with the pension law, and to oversee the solvency of the PFAs. In addition, although the law instituted the pension system as an individually-funded pension system, it allows preexisting state and private systems to continue operating with their preexisting participants, but closed to new participants. It also established that public unfunded systems would come under the State Unfunded Pension System (SISPRE), a subsystem of the SDSS under the Ministry of Finance.
- 1.7 **The National Health System.** The most important aspect of the 2001 Health Act was to separate the basic functions of the health care system (stewardship, financing, and delivery). The Public Health Ministry would exclusively act as the health care system's apex agency (although in practice this has not occurred yet). The Social Security Treasury (TSS) was made responsible for the social security contributions from payrolls and the government's contributions, and issues a per capita payment to the health risk administrators. Private health risk administrators provide insurance to those covered by the contributory system. The public health risk administrator—National Health Insurance (SENASA)—insures the subsidized population. The National Social Security Council (CNSS) is responsible for defining the health care services package, called the Health Services Plan (PDSS). With regard to health care services, the participants of the contributory system can choose between public or private providers. Subsidized system participants can only be treated in public establishments, managed by the Regional Health Services, which are deconcentrated units of the Public Health Ministry.

⁴ Law 87-01 keyed poverty to the minimum wage. In 2005, the criterion was changed for the subsidized health system, by a decree that considered the quality of life index of the Master Beneficiary System.

⁵ The legal framework of the SDSS created the various components of the social security system: the National Social Security Council, the Social Security Treasury, the Member Information and Protection Division, and the Superintendent of Pensions.

⁶ Workers' and employers' contributions are calculated on the basis of contributory earnings. The contributory system's old age, disability, and survivor insurance is financed with a 9.97% contribution from contributory earnings, and the contributory health insurance is financed with a 10.13% contribution from contributory earnings.

- 1.8 Although the Dominican Social Security System (SDSS), Pension System, and new National Health System were deployed over the last 13 years, implementation of these reforms has taken place in stages and key aspects still need to be improved.⁷ As a result, the scope of the expected benefits has been limited. A description of the main challenges for consolidating the reforms and the solutions envisaged by the Dominican government for addressing them follows.

C. Challenges of the social security system

- 1.9 The current state of coverage is partly attributed to the recent creation of the SDSS and also to the high levels of self-employment and informal employment in the Dominican labor market. The contributory pension system was launched in 2003, with one million wage earners enrolled in the first year (35% of the economically active population [EAP]).⁸ In 2013, 2.7 million were enrolled (55% of the EAP). However, the number of insured currently paying premiums has been stagnating, falling to 1.37 million in 2013,⁹ in relative terms, among the lowest contribution levels in the region (34% of the working population).¹⁰ Only 58% of wage earners contribute, signaling contributory system evasion. Moreover, only 15% of adults over 65 years of age currently receive an old-age pension. If no action is taken, even after the 2001 reform, coverage in 2050 will continue to be one of the lowest in the region.¹¹ The subsidized contributory systems, for both health and pensions, and the subsidized pension system have not yet been implemented.
- 1.10 The main challenge facing the SDSS with regard to pensions is to improve coverage based on criteria of efficiency and sustainability, so as to reduce their effects on the job market and on incentives for informal employment. In this connection, the Dominican government has identified a set of factors associated with this issue that need to be addressed, namely: (i) certain aspects of the Social Security Law constrain full implementation of the SDSS; (ii) regulations are needed to be able to launch the subsidized pension system; (iii) certain aspects of the SISPRE and the SDSS legal framework are not in alignment; (iv) there are shortcomings in the information and oversight channels that constrain increases in the coverage of the contributory system; (v) the SDSS needs a comprehensive monitoring and evaluation system; and (vi) the pension culture is weak, and the

⁷ The contributory pension system was launched in 2003. In 2007, the subsidized health system was expanded and the contributory health system was launched.

⁸ The EAP comprises the employed and unemployed populations. The unemployment level is one of the highest in the region (14.9% in 2014, holding steady at an average of 15% over the past 10 years). The country has the highest rate of self-employed workers in the region (43% in 2013).

⁹ The Superintendent of Pensions has conducted studies to determine the reasons for the decline in contributions, and found that many of the insured stop contributing because they lose their jobs, become self-employed, or lack information on employers' contributions, among other things.

¹⁰ See Bosch, Melguizo, and Pagés (2013) for a comparison with other countries.

¹¹ Lack of protection for the elderly has both social and fiscal costs (Bosch et al. 2013).

most important factors¹² are the fragmented design of the SDSS and the absence of the regulations needed to launch the subsidized system.

D. Determinants of SDSS low coverage and lack of efficiency

- 1.11 **The design of the SDSS regulatory framework needs to be adjusted.** It has been determined that key aspects of the SDSS design need to be modified in order to put long-term expansion of insurance on the right track; this will require amendments to the legislation. For example, the difference in subsidies for wage earners and non-wage earners, and partial implementation only for wage earners may be creating incentives for companies and workers not to contribute to social security and to operate in the informal sector.¹³ Moreover, the subsidized contributory system has not been implemented, meaning that most workers are uninsured. In order to overcome these possible adverse effects, key aspects of the design of the financing systems must be modified, and consideration given to the feasibility of implementing a system that covers all workers.
- 1.12 **The subsidized pension system has not been deployed.** The subsidized pension system is described in Law 87-01 as a solidarity support system covering the pensions of poor people above the age of 60.¹⁴ In general, this type of system requires well-defined criteria for allocating benefits and for determining the level of benefits in order to prevent efficiency losses due to disincentives the system may create for participating in the labor force and working in the formal sector, as well as to ensure sustainability.¹⁵ Given the Dominican government's budget constraints and the possible disincentives for contributing to the system, the challenge remains of developing an eligibility protocol for the subsidized system that targets beneficiaries while taking efficiency criteria into account. In recent months, steps have been taken to award the subsidized system's solidarity pensions on the basis of

¹² See [Optional link 14](#) on the relative weight of causal factors in low SDSS coverage.

¹³ Recent findings have shown that the incentives for contributing may be affected by the design of financing systems that segment workers by employment status. See Levy (2008), and also Bosch, Melguizo, and Pagés (2013), op. cit; Busso, Fazio, and Levy (2012).

¹⁴ According to estimates of the International Labor Organization (ILO), in 2013 the number of people over the age of 60 living in poverty and potentially eligible for the subsidized system was 315,137, of whom 72,250 were living in extreme poverty.

¹⁵ See Levy (2008), and Bosch, Melguizo, and Pagés (2013); Carvalho Filho (2008); Galiani and Gertler (2009).

regulations that use the quality of life index of the Master Beneficiary System (SIUBEN)¹⁶ as an eligibility criterion.¹⁷

- 1.13 **SISPRE is not harmonized.** Fragmentation within the SDSS generates inefficiencies through administrative cost overruns and duplication of functions. The systems that will make up SISPRE continue to function under the responsibility of the State without being brought into alignment with the framework of Law 87-01, and without a comprehensive approach to the other pension plans of State institutions, which operate outside the SDSS with limited oversight. In order to address this challenge, SISPRE needs to be organized under a comprehensive approach, and the general unfunded pension system for all active and passive participants that remain in this system needs to be regulated (Laws 379-81 and 1896). This adaptation will also enable the Finance Ministry to exercise better budgetary control of the different State pension plans still in operation, and their contingent liabilities.¹⁸
- 1.14 **Low density of contributions into the contributory system.** In the case of the contributory system, the number of contributing wage earners has stagnated; moreover, 42% of wage earners who should contribute are not doing so.¹⁹ Given the design of the SDSS and the current structure of incentives, an important means to increase contributory system coverage is to provide information to workers on the benefits they gain from contributing toward a pension. Instruments for accessing information have an immediate impact in terms of encouraging contributions and controlling evasion in the contributory system.^{20, 21} Thus, it is important that the entities making up the SDSS (DIDA, SIPEN, TSS) adopt measures to: (i) improve access to information for system participants and potential participants, particularly those in more remote areas; and (ii) develop new tools for providing information on contributions, return on pension funds, and participants' pension rights, e.g. pension

¹⁶ SIUBEN is charged with establishing eligibility for social protection and consumer subsidy programming. SIUBEN has socioeconomic information on 5.7 million people, updated to 2012, which makes its use feasible for the subsidized pension system.

¹⁷ According to the law, the pension amounts are equal to 60% of the public sector minimum wage, or RD\$3,070 (US\$70). The budget stipulated that the subsidized pension system was to begin in 2014, covering 1,500 pensions. With regard to the fiscal implications of the subsidized system, the Dominican government plans to initiate it very gradually, as strictly determined by strong budget constraints for this type of expenditure.

¹⁸ [Optional link 9](#) provides further information on the need to generate SISPRE regulations.

¹⁹ According to calculations based on information for 2013 from the National Labor Force Survey and SIPEN.

²⁰ In Chile, an OECD-backed experience that sent retirement information on account balances suggests higher compliance with legislation and a stronger retirement culture.

²¹ According to information provided by the TSS and SIPEN, there are cases where employers do not keep their contributions up to date, participants do not always receive their account statement from the Pension Fund Administrator (on the returns on their funds and other variables), or are not even aware of which is their Pension Fund Administrator and how their pension was calculated. According to the most recent data for 2014, AFP returns range between 9% and 12%.

calculator, information on account statements of people not yet receiving pensions, and consultations on the Pension Fund Administrator.

- 1.15 **The SDSS does not have a comprehensive monitoring system.** Each entity of the SDSS administers its own database, which generates duplications and incompatibilities among the system's key indicators. A comprehensive monitoring and evaluation system offers the advantage of reporting on performance indicators (worker by type of system, contributing businesses, among other things) and on the system's management processes, using standardized criteria. This can be used to guide SDSS supervisory functions and provide feedback for policy decisions, as well as information on the progress of measures being implemented so as to facilitate correction or adjustment of policies and programs.
- 1.16 **The population's pension culture is weak.** A fundamental aspect that affects enrollment and contributions to the Dominican pension system is the low value attributed to, and the lack of knowledge about, the benefits of saving for old age.²² According to data from the 2006 informal sector survey,²³ a significant percentage of wage earners, especially young people, has a high discount rate for the future ("it's not worth saving for so far into the future"). Moreover, 56% of the urban population surveyed stated they were not saving for old age.²⁴ In this context of a low perceived value and limited incentives to save, a highly informal economy, and the highest index of self-employed workers in the region, a plan is needed to strengthen the pension culture and financial education of the population regarding the benefits of saving and of participating in the system. The Dominican government has been making progress in this area at the interagency level with a view to fostering a pension culture among people of all ages.

E. Challenges facing the National Health System

- 1.17 Per capita public health spending is low in comparison with countries with similar incomes,²⁵ and the current level appears to be insufficient to expand coverage of the subsidized system.²⁶ In the current context of fiscal constraints, which limit

²² Bosch et al. (2013) discuss experiences with potential positive effects of creating a pension culture in the region.

²³ Secretary of Economy, Planning and Development; Central Bank of the Dominican Republic and World Bank. (2007). *La Informalidad en el Mercado Laboral Urbano de RD*. Santo Domingo.

²⁴ Only one quarter of the population said it was saving for old age.

²⁵ The average for Latin America and the Caribbean, excluding high-income countries, is US\$434 (versus US\$256 in the Dominican Republic). World databank and WHO Statistics 2012. In 2013, the Dominican Republic's health spending was 2.8% of GDP (Latin America and the Caribbean averaged 3.7%).

²⁶ Between 2007 and 2012 insurance coverage (subsidized and contributory) grew from 500,000 people (6% of the total population) to 5.3 million (56.5%); 54% are covered by the contributory system and the rest by the subsidized system (58% and 73% of the eligible population, respectively). The Dominican government's goal is to expand subsidized coverage from 2.7 million in 2013 to 3.7 million in 2016.

increases in health spending, it is appropriate to promote effective interventions to increase health spending efficiency.²⁷

- 1.18 The Dominican Republic receives a low yield on its investments in health. Countries in the region with a similar level of economic development have made better progress with maternal mortality rates, despite a lower per capita public spending in health.²⁸ DEA²⁹ estimates of the technical efficiency of health spending found that health expenditures in the Dominican Republic range between 30% and 83% of their potential performance, measured according to various health indicators.³⁰ Moreover, it was found that resource allocation is inefficient, with funds often not directed at more cost-effective interventions. In 2011, 39.65% of public spending on health was earmarked for curative services and only 3.76% for prevention and public health.³¹
- 1.19 Measures to create efficiency gains will not only free up limited resources but are also necessary to ensure that present and future resources earmarked for health yield greater health gains per peso invested. Moreover, efficiency gains can have the same potential effect as an increase in health funding, assuming that the savings from these improvements are kept and reinvested in the system.³²

F. Determinants of inefficient public health spending

- 1.20 **The separation of functions is an uncompleted task.**³³ Pursuant to the health sector reform, the Public Health Ministry is to concentrate on stewardship of the national health system, and to delegate the functions of service delivery and financing. SENASA would be the sole source of funding for the Public Health Services Network, which for its part would be managed and coordinated by the Regional Health Services. Yet this separation has not taken place to date and the Public Health Ministry continues to focus on direct service delivery. In 2014, 85% of the Public Health Ministry's direct budget was allocated to service delivery. In

²⁷ The objective of guaranteeing financing for Family Health Insurance and achieving universal coverage are challenges that can be addressed by the Dominican government in the medium and long terms.

²⁸ While the maternal mortality rate in Jamaica and Ecuador is 110 deaths per 100,000 live births, it is 125.9 in the Dominican Republic. Per capita health spending is US\$220 in Jamaica and US\$255 in Ecuador, and in the Dominican Republic it is US\$256.

²⁹ Data envelopment analysis (DEA).

³⁰ An analysis of 191 countries found that the Dominican Republic is 17 percentage points below the most efficient country in producing healthy life expectancy. (Evans DB et al. 2001). Another study situates the country at around 30% for life expectancy production, infant survival rate, years of life recovered after transmittable and nontransmittable diseases and external causes. Marinho et al. 2012.

³¹ National Health Accounts in the Dominican Republic: 2011 Public Spending Report. Public Health Ministry.

³² Chisholm and Evans. 2010. Improving Health System Efficiency as a Means of Moving Towards Universal Coverage. World Health Report (2010). Geneva: World Health Organization. Smith, Peter C. 2009. Measuring value for money in healthcare: Concepts and tools. London: The Health Foundation.

³³ Separation of functions is the most important factor needed to consolidate the reform. See [Optional link 14](#) on the relative weight of causal factors in low health spending efficiency.

order to separate functions, regulations are needed that mandate the Public Health Ministry to set aside service delivery.

- 1.21 **The way services are currently delivered limits the effectiveness of interventions.** The health system reform calls for service providers, both public and private, to operate in a context of functional networks, with primary care as the gateway. In practice, however, service delivery is organized in a very different manner. Studies indicate that treatment success at the primary health care level is very low, referral and counter-referral mechanisms are weak, and the service providers operate with little coordination. As a result, the population tends to go straight to secondary and tertiary care levels,³⁴ which increases the cost of services.
- 1.22 The literature has identified key interventions for preventing and managing a large percentage of health problems that comprise the double burden of disease.³⁵ There is also growing consensus that effective implementation of these interventions is improved when the primary health care approach is used to deliver services organized in integrated health care networks.^{36, 37} In this model, the focal point for addressing most users' needs is a regular primary care provider serving a specific population, equipped with adequate resources and technology, and coordinating care, when necessary, with other more specialized providers through referral and counter-referral mechanisms.³⁸ This model would have a significant impact on reducing costs, eliminating duplication, and increasing the efficiency of the system. Although the Dominican Republic already has a model designed according to these guidelines, it has not been officially adopted by the Public Health Ministry. The proposed model defines the new organizational structure, the principles and guidelines for health care service delivery, and the responsibilities and functions of all the actors in the sector.³⁹
- 1.23 **Stewardship development is lagging.** Stewardship includes the capacity of authorities to formulate and implement effective policies, engage in strategic planning, manage change, regulate goods, services, and inputs, generate and analyze information, and evaluate performance. Good stewardship creates the conditions that enable authorities to fulfill their responsibilities and move the

³⁴ *Consultoria I Gestió* (2012). *Adecuación del modelo de red a los SRS*. Dominican Republic, Public Health Ministry.

³⁵ See WHO (2012). "Improving chronic illness care through integrated health services delivery networks." Coleman, et al. (2009) "Evidence on the chronic care model in the new millennium."

³⁶ Empirical evidence from Latin America and the Caribbean associates the primary health care approach with better life expectancy and reductions in general and infant mortality, low birth weights, and avoidable hospitalizations (Macinko et al. 2011, Rosero-Bixby 2004, Borkan et al. 2010). Moreover, primary health care is correlated with lower costs and, by supporting the most vulnerable populations, reduces health inequities (Kringos et al., 2013, Lynch et al., 2004).

³⁷ See Bodenheimer 2008, Hans et al. 2012, Springer et al. 2010.

³⁸ Starfield, Barbara. 2011. Politics, Primary Healthcare and Health: Was Virchow Right? *Journal of Epidemiology and Community Health* 65 (8) (August): 653–5.

³⁹ See [Optional link 11](#) for more information.

system toward greater efficiency. Indeed, evidence shows that countries with better policies and institutions have a greater health impact⁴⁰ per additional percentage point of GDP invested.⁴¹

- 1.24 Evaluations have identified institutional weaknesses in the Public Health Ministry for fulfilling a stewardship role,⁴² including limited capacity to issue and implement regulations and to develop instruments for allocating resources according to health care needs, based on criteria of cost-effectiveness. This is because the Public Health Ministry still maintains the pre-reform structure, which is geared to service delivery and not to stewardship. For it to be able to assume its main function, the Public Health Ministry must define an organizational structure that reflects stewardship of the National Health System (sector leadership, health intelligence, regulation, and supervision) as its core function.
- 1.25 **A quality policy in health has not been implemented.** The absence of a quality policy in the Dominican Republic has an impact on the care received by the population. Only one third of primary care units meet licensing standards for operation, and studies have revealed medical errors and noncompliance with standards of care for pregnancy and childbirth. Childbirth protocols are not properly followed by 57% of physicians.⁴³ In order for the National Health System to provide quality care, the Public Health Ministry must establish a health policy that defines at least: (i) standards of quality for care provided by public, private, and semi-public health care providers (certification of health facilities at all levels; manuals and treatment protocols for health workers); and (ii) guidelines on medication security, safety, and efficiency, and on health technologies. Such regulations would facilitate actions to promote, monitor, and follow up on the quality of care.
- 1.26 **There is no policy for improving worker performance.** The health care career path, defined as standards and descriptions that regulate public employment in health and the labor relationship between workers and health institutions, is an important factor in attracting professionals and creating incentives for better performance.⁴⁴ The Dominican Republic does not have a career plan and a wage policy for health professionals. Nor does it have an ongoing education and training system or mechanisms for monitoring and periodically evaluating worker performance.⁴⁵ Due to the absence of an appropriate system of incentives and weaknesses in management capacities, the sector is subject to high staff turnover,

⁴⁰ Impact measured by child and maternal mortality, malnutrition, and tuberculosis mortality.

⁴¹ Wagstaff and Claeson. 2004. The Millennium Development Goals for Health: Rising to the Challenges.

⁴² *Resultados de la Evaluación del Desempeño y Fortalecimiento de la Función Rectora de la Autoridad Sanitaria Nacional en RD*. Juan Dolio, Dominican Republic, 2006.

⁴³ See Pérez-Then (2011), CERSS (2002), Miller et al. (2003), Pérez-Then (2008), Quiterio et al. (2008).

⁴⁴ Pan American Health Organization. 2006. Challenges to the management of human resources for health. 2005-2015. Area of Health Systems Strengthening Human Resources for Health Unit. Washington, D.C.

⁴⁵ Health in the Americas 2012: Country Profiles. PAHO 2012.

frequent absences, nonobservance of work schedules, and low motivation.⁴⁶ Thus, a regulatory framework is needed for the health care career path to facilitate an efficient assignment of human resources. This policy would also contribute significantly to the organization of health care delivery under the new model and the quality policy guidelines. [Link 11](#) details the principles that should frame an appropriate health care career path.

- 1.27 **The Health Services Plan (PDSS) catalogue is out of date.** Evaluations of the current PDSS catalogue uncovered deficiencies in its design and a lack of systematic updating, both with regard to content and costs.⁴⁷ For example, the amount for ambulatory drugs does not cover treatment of diseases that have a high public health impact, such as hypertension and diabetes. If kept up to date, this catalogue could be one of the main instruments for ensuring efficient and effective resource allocation through cost-effective interventions. However, it should be updated to reflect the epidemiological profile of the Dominican Republic and the health needs of the population.
- 1.28 **Management of subsidized health care system financing is weak.** Effective management of financing is essential to guarantee insurance coverage for the population enrolled in the subsidized health system.⁴⁸ SENASA, which administers this system, does not have the capacity to perform the actuarial analyses required for efficient financial management. Creation of an actuarial analysis division would provide SENASA with the information needed to consolidate its health risk management processes and its financial sustainability. The main functions of the division should include: (i) preparation of actuarial studies; (ii) claim rate analysis; (iii) calculation of beneficiaries' premiums; and (iv) development of reserves (unearned premium, reported claims, unreported claims, and catastrophic deviation, among others).

G. Bank support for the social security and health sectors

- 1.29 The Bank is supporting the health and social security sectors through various operations, the focus of which is to strengthen primary health care and promote preventive care. The objective is to improve the quality of health care and health spending efficiency. In addition, the Bank is providing support to strengthen stewardship and improve management of the sector, also with a view to improving its efficiency.^{49, 50} This programmatic policy-based loan deepens support in these priority areas. Moreover, to back fulfillment of the operation's policy commitments,

⁴⁶ Pérez-Then (2011) analyzed compliance with health care protocols at the secondary and tertiary levels.

⁴⁷ Case study of the Health Services Plan (PDSS) in the Dominican Republic.

⁴⁸ By 2013 the subsidized system served 2.75 million people (slightly more than 25% of the total population).

⁴⁹ Currently in execution are the multiphase program "Support for the Social Protection Program" (DR-L1039, DR-L1044, DR-L104, DR-L1053) and operations DR-L1067 and DR-L1069.

⁵⁰ Social security is supplemented by DR-L1072 "Formalization and Productivity Improvement Program."

two technical-cooperation operations will support the preparation of an explicit health care services plan and aspects of the social security and health care reform.⁵¹

H. Program rationale and strategic alignment

- 1.30 The commitments set out in the [policy matrix](#) contribute to promoting strategic actions that are already included in the Dominican government's plan but face challenges for implementation. There is a window of opportunity to address the social security and health sectors simultaneously, given the complementarities from the technical standpoint and the broad political and social consensus in favor of furthering both reforms. The conditions meet one or more of the following criteria: (i) they are recognized as good practices with the potential for improving the efficiency and quality of social security and health care provided to the population; (ii) the institutional capacity exists for implementation, and if these milestones are not met, they will be an obstacle for consolidation of the social security and health systems; and (iii) they have received the commitment from the highest levels of the Dominican government. These criteria are based on lessons learned by the IDB both in the Dominican Republic and in other countries.⁵²
- 1.31 The program is aligned with the strategic objective “improving the quality of health services and the financial management and sustainability of the sector,” and with the area of dialogue on social security reform in the IDB's strategy with the Dominican Republic for 2013-2016 (document GN-2748). It is also consistent with the National Development Strategy for 2010-2030, in its health insurance and pension objectives, and a unified and sustainable social security system. It is aligned with the IDB's health and nutrition and labor sector framework documents (documents GN-2735-3 and GN-2741-3, respectively), the objectives of which include strengthening health systems' institutional capacity to improve efficiency, and increasing the coverage of social insurance systems. The program will contribute to the financing priorities of the Ninth General Increase in Resources (document AB-2764) (GCI-9) of: (i) supporting development in small and vulnerable countries; and (ii) reducing poverty and enhancing equity, by providing pension coverage to the poor.⁵³

I. Objectives, components, and costs

- 1.32 The general objective of the program is to progressively consolidate social security coverage and improve health spending efficiency by deepening the reform being implemented by the Government of the Dominican Republic in the two sectors. The [policy matrix](#) spells out the policy conditions that need to be fulfilled in order for

⁵¹ DR-T1111 “Support for the Implementation of Health Sector Reform” and DR-T1098 “Support for Health and Social Security Sector Reform.”

⁵² Experience has shown the importance of reaching a consensus and gaining stakeholder support around the reform and of providing technical assistance to move forward with fulfilling the commitments (see [Optional link 12](#)).

⁵³ The program will contribute to the GCI-9's regional goals of reducing maternal and child mortality rates.

the proceeds of the first operation to be disbursed, as well as the triggers that will make it possible to consider a second loan operation.

- 1.33 **Component 1. Macroeconomic framework stabilization.** This component seeks to promote a macroeconomic context consistent with the program's objectives, through monitoring of the actions that the Finance Ministry commits to in the [policy letter](#) and that are described in the [policy matrix](#).
- 1.34 **Component 2. Social security system consolidation.** This component aims to gradually improve coverage through measures to complete implementation of the pension system with regard to its legal framework, operational aspects, monitoring systems, information programs, and financial education. In particular, it will promote: (i) adjustment of the SDSS legal framework in terms of the design of the social security financing regimes and functional strengthening of the entities in the system; (ii) a gradual increase in the coverage of the subsidized pension system with targeting criteria keyed to SIUBEN's quality of life index; (iii) organization and establishment of a new regulatory framework for SISPRE; (iv) a boost in contributory system coverage by providing information to workers; (v) a comprehensive monitoring system for the SDSS to standardize criteria and avoid scattering the efforts of the system's entities; and (vi) development of a pension and financial culture among the population.
- 1.35 **Component 3. Improved efficiency of the National Health System.** This component will provide support for regulatory measures to be issued and for management tools to be used to promote and facilitate the execution of priority strategies to improve health spending efficiency. Specifically, it will promote: (i) separating Public Health Ministry stewardship and service delivery functions; (ii) reorganizing service delivery according to a health care model of integrated networks and a focus on primary health care; (iii) strengthening stewardship by supporting the definition of a new organizational and functional structure for the Public Health Ministry; (iv) promoting the legitimization and dissemination of the quality policy in health care, in order to proceed to its implementation; (v) promoting the enactment of the Health Career Law for subsequent regulation and implementation; (vi) updating the PDSS catalogue in order to have cost-effective responses to the double burden of disease; and (vii) strengthening SENASA's capacity to generate actuarial analyses so it can monitor the evolution of the risk and cost profile, and perform effective financial programming.

J. Key indicators of the results matrix

- 1.36 The policy actions promoted under this operation are part of a series of interventions that, when maintained over time, will have a positive impact on SDSS coverage and on health spending efficiency in the medium and long terms. The [results matrix](#) proposes a series of indicators that will make it possible to evaluate program performance at the outcomes level. These indicators are proxies to measure improvements in: (i) the coverage of social security systems; (ii) the

response capability of primary health care centers; and (iii) spending efficiency in the health sector.

- 1.37 The [economic analysis](#) estimated all costs associated with the policy matrix activities, based on international benchmarks. The main direct benefits from those activities were also identified. In the health component, benefits were quantified as the savings obtained from interventions to improve efficiency. In the social security component, benefits were quantified as the economic growth generated by the effect of the pension system on the job and financial markets. The base case analysis was for a 20-year time horizon and a 12% effective annual discount rate, yielding a 93% internal rate of return and a net present value of RD\$30.855 billion. The result proved robust to the sensitivity analysis.

II. FINANCING STRUCTURE AND RISKS

A. Financing instruments

- 2.1 This operation is the first in a programmatic policy-based series that will be comprised of two contractually independent but technically linked loans, in accordance with document CS-3633-1. A programmatic series was selected in order to provide medium-term support to the Dominican government's program of reforms in the social security and health sectors, and to promote an ongoing technical dialogue and possible refinements to the implementation strategy. The amount of the present operation is US\$150 million.

B. Environmental and social risks

- 2.2 As this operation does not finance physical investments nor does it provide for activities with adverse impacts on natural resources, it does not require ex ante impact classification (B.13) under the Environment and Safeguards Compliance Policy (OP-703).

C. Risks and economics of reform

- 2.3 **Macroeconomic and financial sustainability.** One risk is the economy's vulnerability to external demand variations. The Dominican government has adopted measures to readjust public finances and modify monetary policy.
- 2.4 **Economics of reform.** Addressing these reforms concurrently in a less favorable macroeconomic context could generate opposition to the changes on the part of sectors of society. To mitigate this risk, technical cooperation operation DR-T1098 will support a broad process of consultation and consensus building among the main stakeholders.
- 2.5 **Public management and governance.** There is a risk of delays in preparing the preliminary draft of the SISPRE law. To mitigate this risk, a consulting firm has been hired to estimate the law's fiscal impact. The multisectoral nature of the interventions also poses a risk due to the need for political consensus and for close coordination among institutions to avoid delays in implementing the reforms. The

Finance Ministry was chosen as the executing agency because it has the capacity and authority to follow up with all the actors and ensure compliance with the policy matrix commitments, in accordance with the agreed [critical path](#). The Advisory Committee of the Ministry of the Presidency, which coordinates the social security and health care reform, will be responsible for ensuring coordination between the executing agency and the entities charged with carrying out the policy actions. There is also a risk associated with a delay in issuing regulations and operationalizing the Health Career Law. In this regard, a core implementation team will be created in the Public Health Ministry to guide the process.

- 2.6 The proposed reforms are expected to have little fiscal impact,⁵⁴ which makes it feasible for the government to absorb the costs of the measures without putting public finances at risk and also suggests that the measures will be sustainable over time. The strong political commitment of the Dominican government to consolidating these reforms also contributes to sustainability. The government's commitment is reflected in the 2010-2030 National Development Strategy (END), the 2013-2016 Multiyear National Public Sector Plan (PNPSP), and the 11% and 13.4% increase in funding for the health and social security sectors,⁵⁵ respectively.

III. IMPLEMENTATION AND MANAGEMENT PLAN

A. Summary of implementation measures

- 3.1 **Borrower and executing agency.** The borrower is the Dominican Republic. Program execution and use of the proceeds of the Bank's loan will be carried out by the borrower through the Finance Ministry, which will act as executing agency and will be responsible for coordinating fulfillment of the policy actions with all the actors involved with the program and for monitoring the critical path of policy matrix commitments.

B. Summary of measures to monitor results

- 3.2 The [monitoring and evaluation plan](#) agreed upon with the Dominican government establishes that the [policy matrix](#) and the [critical path](#) will be the instruments used to monitor program outputs. Outcome indicators will be monitored using: (i) the information system of the Public Health Ministry; (ii) the SIPEN information system; (iii) the DIDA information system; and (iv) the National Multiple Household Survey (ENHOGAR).

⁵⁴ Implementation of the Health Career Law and the Health Care Model represents only 0.01% of GDP, 0.067% of total public spending, and 0.42% of public health spending. See [Optional link 13](#) for the fiscal impact analysis.

⁵⁵ 2015 State Budget Act, approved on 11 November 2014.

C. Policy letter

- 3.3 In the [policy letter](#), the Finance Ministry sets out the macro and sector policy actions the country is presently implementing and those it plans to implement. These actions are consistent with program objectives.
- 3.4 **Special contractual condition.** Disbursement of Bank financing is contingent upon fulfillment of the policy conditions set out in Annex II (Policy Matrix) and the other conditions established in the loan contract.

Development Effectiveness Matrix				
Summary				
I. Strategic Alignment				
1. IDB Strategic Development Objectives		Aligned		
Lending Program		i) Lending to small and vulnerable countries; and ii) Lending for poverty reduction and equity enhancement.		
Regional Development Goals		i) Maternal mortality ratio; and ii) Infant mortality ratio.		
Bank Output Contribution (as defined in Results Framework of IDB-9)				
2. Country Strategy Development Objectives		Aligned		
Country Strategy Results Matrix		GN-2748	Improving the quality of health services and the financial management and sustainability of the sector.	
Country Program Results Matrix		GN-2756-2	The intervention is not included in the 2014 Operational Program.	
Relevance of this project to country development challenges (If not aligned to country strategy or country program)				
II. Development Outcomes - Evaluability		Evaluable	Weight	Maximum Score
		8.8		10
3. Evidence-based Assessment & Solution		10.0	33.33%	10
3.1 Program Diagnosis		3.0		
3.2 Proposed Interventions or Solutions		4.0		
3.3 Results Matrix Quality		3.0		
4. Ex ante Economic Analysis		10.0	33.33%	10
4.1 The program has an ERR/NPV, a Cost-Effectiveness Analysis or a General Economic Analysis		2.5		
4.2 Identified and Quantified Benefits		2.0		
4.3 Identified and Quantified Costs		2.0		
4.4 Reasonable Assumptions		2.0		
4.5 Sensitivity Analysis		1.5		
5. Monitoring and Evaluation		6.5	33.33%	10
5.1 Monitoring Mechanisms		1.5		
5.2 Evaluation Plan		5.0		
III. Risks & Mitigation Monitoring Matrix				
Overall risks rate = magnitude of risks*likelihood		Medium		
Identified risks have been rated for magnitude and likelihood		Yes		
Mitigation measures have been identified for major risks		Yes		
Mitigation measures have indicators for tracking their implementation		Yes		
Environmental & social risk classification		B.13		
IV. IDB's Role - Additionality				
The project relies on the use of country systems				
Fiduciary (VPC/PDP Criteria)		Yes	Financial Management: i) Budget; ii) Treasury; and iii) Accounting and Reporting. Procurement: Information System.	
Non-Fiduciary		Yes	i) Strategic Planning National System; and ii) Monitoring and Evaluation National System.	
The IDB's involvement promotes improvements of the intended beneficiaries and/or public sector entity in the following dimensions:				
Gender Equality				
Labor				
Environment				
Additional (to project preparation) technical assistance was provided to the public sector entity prior to approval to increase the likelihood of success of the project		Yes	The Bank has approved technical cooperations such as ATN/OC 14167 to support the sector. An additional one, DR-T1098, is currently being prepared to support this operation.	
The ex-post impact evaluation of the project will produce evidence to close knowledge gaps in the sector that were identified in the project document and/or in the evaluation plan				

The loan proposal presents a solid diagnostic and a clear logic. It identifies the financial restrictions faced by the country from a fiscal perspective, as well as the limitations in coverage of the pension system and the inefficiency of public spending in the health sector. The document identifies as causes of these problems prevailing failures in the social security and health systems, associated with a partial implementation of the reforms approved in 2001. It also presents data and concrete examples to justify the importance of such challenges.

The document proposes policy reforms that are aligned with the diagnostic presented and that will allow consolidating the pension system and improving the efficiency of the health spending. It also includes serious empirical evidence on the effectiveness of the proposed policy changes in other countries, and analyses its validity for the Dominican case based on national statistics and studies.

The project's results matrix is adequate. While it does not include impact indicators (because of the short execution period), it does reveal a clear vertical logic between the project's activities and its expected results. The product indicators are correct; they include a clear source of verification and are directly related with the policy matrix agreements.

The economic analysis annex presents an adequate general economic analysis that estimates the macro benefits of the proposed reforms and the costs associated with their implementation. The monitoring and evaluation plan is complete. It proposes to evaluate the project by replicating the economic analysis ex-post, mainly using administrative data.

The risk matrix is adequate. It rates the project's risks according to their magnitude and likelihood, and proposes mitigation measures with indicators to track their implementation.

POLICY MATRIX

Outcomes sought	Policy measures	
	Agreements Program I	Triggers Program II
Component I. Stable and sustainable fiscal and macroeconomic framework to support viability of program objectives		
(1) Suitable macroeconomic policy framework.	(1.1) A suitable macroeconomic policy framework is maintained.	(1.1) A suitable macroeconomic policy framework is maintained.
Component II. Support for consolidation of the social security system to improve coverage and efficiency		
(2) The Dominican Social Security System (SDSS) has designed financing systems that will enable it to expand coverage of the Dominican population with financial sustainability, promoting system comprehensiveness and efficiency.	(2.1) Amendments to Law 87-01 will have been drafted that, at a minimum: <ul style="list-style-type: none"> ▪ define the treatment of financing systems that have not been implemented, in order to avoid segmentation of insurance by employment status, ▪ authorize the TSS to sanction cases of evasion and avoidance of social security contributions, ▪ add functions to the DIDA for it to measure the quality and timeliness of benefits and information received by members, ▪ determine pension indexation with a specific frequency. 	(2.1) The draft bill of amendments to Law 87-01 on social security that includes the issues mentioned has been submitted to Congress.
(3) Implementation of the subsidized pension system has begun.	(3.1) Regulations will have been enacted on procedures for granting solidarity pensions, including the index of the Master Beneficiary System (SIUBEN) as an eligibility criterion for targeting.	(3.1) The roll of households eligible for the subsidized pension system has been determined, using the SIUBEN index as the main instrument of the implementation protocol.
(4) The SDSS is unified and has a state unfunded pension subsystem that is aligned with the new legal framework.	(4.1) An analysis will have been prepared of the fiscal cost of reorganizing the State Unfunded System (SISPRE).	(4.1) The draft bill on the State Unfunded Pension System (SISPRE) that organizes and establishes a new regulatory framework for SISPRE has been submitted to Congress.
(5) The coverage of the contributory system has increased.	(5.1) New information services will have been established, specifically to: <ul style="list-style-type: none"> ▪ Make available to beneficiaries electronic tools for accessing information, including at least: pension calculator, access to account statement. ▪ Open five new information kiosks, especially in more remote areas. 	(5.1) Information campaigns are conducted that have incorporated the changes promoted in the SDSS by this operation in order to inform and enlist the beneficiary population.

Outcomes sought	Policy measures	
	Agreements Program I	Triggers Program II
(6) The SDSS has a comprehensive monitoring system.	(6.1) An ad hoc intersectoral statistics committee will have been established with one representative from each of the following institutions: National Statistics Office (ONE), Superintendent of Pensions (SIPEN), Superintendent of Health and Occupational Risk (SISALRIL), Social Security Treasury (TSS), Participant Information and Protection Division (DIDA), National Health Insurance (SENASA), charged with designing and supervising implementation of the SDSS monitoring and evaluation system for its comprehensive development.	(6.1) The SDSS monitoring and evaluation system has been deployed.
(7) Different age groups of the population value and are aware of the benefits of social security and savings.	(7.1) The National Social Security Council will have set up an (ad hoc) interagency committee responsible for developing the standards, rules, technical and legal guidelines, and procedures for the formulation, evaluation, approval, and execution of the national agreement to promote a pension and financial culture.	(7.1) The interagency committee has developed the standards, rules, technical and legal guidelines, and procedures for the formulation, evaluation, approval, and execution of the national agreement to promote a pension and financial culture.
Component III. Improved efficiency of the National Health System		
(8) Separation of the Public Health Ministry (MSP) stewardship and service delivery functions has begun.	(8.1) Separation of the MSP's stewardship and service delivery functions will have begun through administrative, functional, and territorial deconcentration of the Office of the Deputy Minister for Individual Care, to be called the Public Health Care Services Coordination Bureau (DGCSPS), which will be charged with coordinating the regional health services, their health facilities, and the self-managed health service centers.	(8.1) The DGCSPS (previously the Office of the Deputy Minister for Individual Care) is coordinating regional service delivery and: <ul style="list-style-type: none"> i. a standardized management model for regional health services has been defined and implemented; ii. contracts and agreements signed by the regional health services have been approved; iii. the 2016 budgets of the regional health services, or the budgets for the year prior to evaluation of fulfillment of policy measures triggering Program II, have been approved.

Outcomes sought	Policy measures	
	Agreements Program I	Triggers Program II
(9) Service delivery has been reorganized, with primary health care as the gateway.	(9.1) The new health care model of the National Health System will have been made official and will contain: (i) definition of the new organizational structure for public service providers, with primary care as the gateway, functioning in a network with the other levels of care, (ii) definition of the principles, guidelines, and parameters to be used by the regional services when offering health services, and (iii) the responsibilities and duties of the sector's actors (MSP, provincial health divisions, insurance agencies, providers of individual and group health services, and, lastly, citizens, families and communities).	(9.1) The necessary resources (physical, human, technological) have been sized for developing the health care model at the national level (in the nine existing regional health services) and implementation has begun in at least three of these regional health services (implementation in the country will be done gradually).
(10) The MSP effectively performs its stewardship role.	(10.1) A new organizational and functional structure for the MSP will have been defined that reflects stewardship of the National Health System (sector leadership, health intelligence, regulation, supervision) as its main function, and the new structure will have been submitted to the Ministry of Public Administration (MAP) for approval.	(10.1) The new organizational and functional structure of the MSP, reflecting its primary stewardship role, has entered into effect. (10.2) A strategic plan has been approved for the MSP for 2015-2018, which will: (i) focus on the MSP's lines of action within the main dimensions of its stewardship role, namely: sector leadership, health intelligence, regulation, and supervision; (ii) be aligned with the strategic objectives set out in the National Development Strategy – 2030.
(11) The National Health System has a quality policy in health care.	(11.1) The MSP will have approved a quality policy in health care that includes: (i) the standards of quality for health care provided by public, private, and semi-public health care providers; (ii) guidelines on medication security, safety, and efficiency, and on health technologies.	(11.1) The MSP has implemented the quality policy in health care and has made progress in upgrading the health sector's facilities and defining parameters for monitoring the quality of maternal and child care, at all levels.
(12) The National Health System's human resources have incentives encouraging equitable geographical distribution as well as regulations governing professional practice.	(12.1) The Health Career Law will have entered into effect, establishing the labor relationship between public servants and the State, and is based on principles of efficiency and effectiveness, comprehensiveness, and merit-based selection and promotion.	(12.1) The supplementary regulations called for in the Health Career Law have entered into effect.

Outcomes sought	Policy measures	
	Agreements Program I	Triggers Program II
(13) The Family Health Insurance's Health Services Plan (PDSS) catalogue has been updated in accordance with the Dominican epidemiological profile and the health needs of the population.	(13.1) A call for bids will have been issued for an international consulting service to review and update the PDSS catalogue in accordance with the Dominican epidemiological profile and the health needs of the population.	(13.1) The PDSS catalogue has been updated.
(14) SENASA has the capacity to generate actuarial analyses and monitor the evolution of the risk profile and costs.	(14.1) An Actuarial Analysis Unit will have been created in SENASA, the main functions of which include: (i) preparation of actuarial studies to provide information for decision-making; (ii) calculation of beneficiaries' premiums, for each participant type; (iii) definition of new products for participants; (iv) analysis of SENASA's claim rate; and (v) development of the earned premium reserve, the reported claims reserve, the unreported claims reserve (IBNR), and the catastrophic deviation reserve.	(14.1) The Actuarial Analysis Unit is in operation.