

HEALTH SECTOR MODERNIZATION AND RESTRUCTURING

(DR-0078)

EXECUTIVE SUMMARY

BORROWER AND GUARANTOR: Dominican Republic

EXECUTING AGENCY: The Technical Secretariat of the Presidency

AMOUNT AND SOURCE:

IDB: OC/IFF	US\$61.2 million
Cofinancing:	US\$ 8.5 million
Local counterpart funding:	US\$ 5.3 million
Total:	US\$75.0 million

FINANCIAL TERMS AND CONDITIONS:

Amortization period:	25 years
Disbursement period:	5 years
Interest rate:	variable
Inspection and supervision:	1.0%
Credit fee:	0.75%
Currency:	US Dollars

COFINANCING:

Nordic Development Fund (US\$ 3.5 million):

Amortization period:	40 years
Disbursement period:	5 years
Grace period:	10 years
Interest rate:	0%
Service charge:	0.75%
Commitment fee:	0.50%

Organization of Petroleum Exporting Countries (US\$ 5.0 million):

Amortization period:	12 years
Disbursement period:	5 years
Grace period:	5 years
Interest rate:	3.75%
Service charge:	1.0%

OBJECTIVES: The objective is to improve the health status of low and middle-income Dominicans by supporting the Government's strategy to improve the efficiency, equity and quality of the health system through implementing policy, institutional and service delivery reforms. This will be accomplished through investments in technical assistance, training, service provision, infrastructure and equipment.

DESCRIPTION:

The project consists of four components:

Component I (Policy Development US\$ 3.5 million) will finance technical assistance to support the formulation and approval of policies oriented toward reforming the sector and institutions, development and approval of legislation to underpin these policies, and the design and implementation of standards and processes for accrediting health providers, insurers and medical supply producers.

Component II (Institutional Reorganization of SESPAS US\$ 9.8 million) will finance technical assistance, training and materials to restructure SESPAS. Consisting of three Subcomponents, it separates financing and provision functions, creates new institutional structures for policy making and other functions, introduces modern management information systems, establishes new resource allocation mechanisms, and introduces a demand-driven system for procurement and distribution of drugs and medical supplies.

Component III (Restructuring and Institutional Modernization of the Social Insurance-Financed Health System US\$ 7.5 million) will finance technical assistance, training and materials to extend social insurance coverage in health. Consisting of two Subcomponents, it will restructure current institutional arrangements, separate pension, accident and health funds, and establish a social insurance-financed health system in which insured families select a provider network among a menu of competing networks.

Component IV (Strengthening of Basic and Hospital Services US\$ 34.6 million) implements three pilot projects that provide services to people while introducing output and results-oriented financial incentives into the delivery system. Each of the three pilots corresponds to a separate Subcomponent. The first pilot partially finances the provision of a basic package of primary care services to poor, unserved populations by contracting providers from the public and private sectors. The second creates a subsidized insurance scheme that finances a semi-comprehensive package of primary- and secondary-level services to low-income uninsured informal sector workers by contracting organized private sector provider networks. The third transforms four public hospitals into model facilities that are autonomously governed and employ modern management tools and technologies. This pilot ties investments in

rehabilitation and medical equipment to management reforms and improvements in financial, administrative and clinical systems.

**ENVIRONMENTAL
CLASSIFICATION:**

The environmental assessment was reviewed by the CESI/TRG on August 15, 1997. Recommendations have been incorporated into the document.

BENEFITS:

The project will improve health status through reducing the disease burden by an estimated 20 percent for the direct beneficiaries in the four project regions, measured in reduced number of adjusted life years lost. For the target population, it is expected that infant mortality will be reduced by 10 percent. Also for this population, it is estimated that effective coverage for pre-natal care will increase from 83 to 100 percent, for well-child care from 23 to 90 percent, and family planning from 52 to 90 percent.

Equity will be enhanced by: (i) increasing social insurance coverage from 6 to 20 percent of the population; (ii) alleviating the financial burden of the cost of health care for poor families; (iii) protecting consumer interests and increasing fairness of the insurance market through insurance regulation; and (iv) reorganizing hospital cost recovery systems while introducing mechanisms to protect the poor.

The project will improve efficiency by: (i) consolidating functions and streamlining processes and procedures in SESPAS and IDSS related to financial and human resource management; (ii) defining service packages and establishing allocation mechanisms in the public sector that favor cost-effective interventions; (iii) implementing modern management tools in public hospitals; and (iv) reducing waste in drug and medical supply systems.

Quality will be improved through: (i) establishing and accrediting process that applies minimum quality standards to health care providers; (ii) introducing quality assurance programs in model hospitals; and (iii) improving the quality of drugs and medical supplies and strengthening therapeutic protocols.

RISKS:

The effectiveness and viability of any health reform initiative will require strong political support from higher levels of government. Although high-level authorities appear committed to reform, the government does not speak with a single voice regarding the nature, breadth and depth of change it supports. High turnover of government authorities is

another threat to project implementation. This may decrease government commitment to health sector reform and to project activities. Maintaining a critical mass of quality technical staff will be necessary for successful implementation. Another risk involves the ability of government to sustain financing for direct service provision.

To address these risks, the Government issued Presidential Decree No. 308-97 on July 10, 1997 creating the Executive Commission for Reform of the Health Sector (CERSS) to guide and oversee the reform process. The Decree establishes Government commitment to health sector reform. Presided by the President, the CERSS is responsible for integrating government policy-making efforts within a state modernization framework and provides political support for substantive change within the health sector. This will facilitate maintaining a critical mass of experts and afford some protection against the high instability of personnel observed within government health institutions. The project team developed a communication and promotion strategy targeted at members of Congress and other groups, has obtained strong commitment of Government for counterpart and bridge financing, and will establish coordinating and executing units financed through the credit. To reduce the risk of government failure to assume financial responsibility of direct service provision, the project design calls for the incremental transfer of financial obligations during the course of the project.

**THE BANK'S
COUNTRY AND
SECTOR STRATEGY:**

Government Health and Social Strategy: The government has presented a social sector strategy, known as the National Plan for Social Development. The overall objectives are to: (i) reduce poverty through ensuring economic access, ensuring provision and delivery of basic public services, supporting civic organizations, and facilitate the provision of goods and services to all; (ii) create productive employment; and (iii) integrate all groups, particularly vulnerable populations, into society. Government strategies related to the health sector correspond closely with those of the proposed project, including decentralization of decision making, reorganization of service delivery, restructuring of SESPAS and IDSS, hospital management reform; establishment of integrated information systems, and the development of policies, laws and regulations to support reform and institutional modernization.

Bank Strategy: The Bank's country strategy aims to improve economic growth, macroeconomic stability, social welfare and efficient use of productive resources. This will be accomplished through four strategies: (i) improving fiscal policies and management, (ii) stimulating private investment, (iii) reducing poverty, and (iv) modernizing public institutions. This project contains activities and instruments that contribute to the implementation of these strategies, with special focus on health and social insurance.

PROCUREMENT: Public international bidding will be required for goods over US\$250,000 and works over US\$1.5 million.

SPECIAL CONTRACTUAL CONDITIONS: Special Conditions Prior to Initial Disbursement - present to the Bank's satisfaction:

- a) Evidence that the CP has been established and staffed as agreed with the Bank (par. 3.7);
- b) The inter-institutional coordination agreements which the UCP has signed with PROMESE and IDSS, respectively, and evidence that it has formalized Project arrangements with SESPAS (par. 3.3); and
- c) The Project Operating Manual (par. 3.12).

Other Special Conditions:

- d) Prior to contracting consulting services or acquiring goods for Subcomponent 3a, other than to finance the studies agreed with the Bank, evidence that IDSS has separated the financial resources and management of the three types of insurance it currently administers (par. 2.25);
- e) Prior to contracting consulting services or acquiring goods for Subcomponent 3b, evidence that the legal and regulatory framework for the new social insurance system and the extension of coverage has been approved and promulgated (par. 2.28);
- f) Prior to acquiring computer equipment, documentation on the system design, and evidence that installation requirements have been completed and appropriately trained personnel are available (par. 3.16).

The loan contract shall also contain the Bank's standard provisions on procurement, auditing, disbursements, annual reviews, etc.

POVERTY TARGETING: This project is classified as poverty focused because it meets the following poverty targeting criteria, as stipulated in pars. 2.13 and 2.15 of the Report of

the Eighth General Increase in Resources and in the Review of Poverty Classification on IDB loans under the Eighth Replenishment (GN-1964-3): (i) the project geographically targets women and children lacking access to basic care with a package of primary care services; (ii) 100 percent of the beneficiaries of demand-side subsidies are poor; and (iii) low-income households will benefit directly from project interventions aimed at improving government health services, given that over 50 percent of the users of government providers are poor (pars. 4.2 to 4.7).

I. HEALTH SECTOR BACKGROUND 1/

A. Introduction

- 1.1 The Dominican health system is not meeting the expectations or needs of the population. Symptoms of this situation include: (i) rising infant mortality and high incidence of transmissible diseases; (ii) high consumer dissatisfaction with Government health services; (iii) excessive financial burden of health care on poor Dominican families; (iv) poor quality of medical care provided in both public and private settings; (v) low population coverage by the social and private insurance system, especially in the case of low-income families; (vi) discrimination against women and children by public and private insurers; and (vii) risk selection and exclusion of costly treatments and chronic diseases by private insurers.
- 1.2 This chapter describes underlying structural and organizational factors that contribute to the above problems. These factors can be categorized in three areas: (i) policy, legal and regulatory framework; (ii) institutional settings and financial arrangements; and (iii) health care organization and provision. Taken together, deficiencies across these categories generate disincentives for institutions, individuals and other actors within the system to perform in an efficient, equitable and high quality fashion.

B. Policy, Legal and Regulatory Framework

- 1.3 **Ambiguous Policy Framework:** Confusion exists concerning the mission, roles, and relationships of the principal institutions and actors in the health sector. While there is unanimity that the current health system fails to meet public needs, a positive consensus is lacking among Government authorities on a vision of what a reformed health sector should be, especially in terms of the role of government, public-private linkages and financial arrangements.
- 1.4 **Intrasectoral Fragmentation:** The role of the Health Ministry (SESPAS) within the sector is uncertain in part because the Secretariat of the Presidency (SP), administers nearly one-third of government health spending, and little coordination exists among public sector health institutions. Linkages between the public and private sector are scarce, except on an *ad hoc* basis. Each institution (SESPAS, SP, Dominican Social Security Institute (IDSS), The Social Security Institute for the Armed Forces and National Police (ISSFAPOL), and the Essential Drug Program (PROMESE) make policies, set plans, and implement programs more or less independently.

1/ The Technical Files contain a brief social and economic overview as well as a more in-depth health sector overview.

1.5 **Archaic Health Legislation:** The current health and social security codes represent obstacles to establishing a modern health system. For example, the Health Code, dating from the 1940s, is strongly centralist and patrimonial, fusing numerous and complex functions into a single state entity. Responsibilities and division of labor across departments and administrative units are ill-defined. The Code also weakens decision making authority of the Health Minister by requiring Presidential approval on many health-related matters. The social security law excludes public employees and private workers earning over a relatively low income level from social insurance protection, does not mandate coverage extension or family health coverage, supports the direct delivery of services, and melds the financing and administration of pension, health and work accidents programs into a single fund.

1.6 **Absence of Standards:** Accreditation standards and monitoring practices to ensure that minimum quality standards are met by health providers do not exist. This has resulted in the proliferation of small clinics that perform surgeries and treatments in unsanitary conditions and without adequate equipment or sufficiently trained personnel. Private insurers, pre-paid groups practices, and self-insurance plans operate within a regulatory void, threatening the integrity of the industry. There is no regulation to ensure financial solvency of insurers, protect consumers, control fraud, promote fairness and monitor performance. The lack of regulation has led to market failure in private insurance. Insurers exclude the elderly, do not accept persons with chronic conditions and disenroll members that acquire these conditions.

C. Institutional Settings and Financial Arrangements

1.7 **Institutional Weakness:** The main public sector institutions, SESPAS, IDSS, and PROMESE lack the internal structures, formal lines of command, functional definition, administrative machinery and policy making capacity to effectively execute current mandates or to meet longer-term institutional objectives. Decision making on nearly all matters is concentrated, but decisions are executed in a splintered and chaotic fashion through overlapping and transitory chains of command. Under these organizational conditions, accountability is diffuse. Policy making is non-existent while high-level micro management of day-to-day, low-level operations is common. The central bureaucracies in each institution lack clear functional divisions and corresponding responsibilities.

1.8 **Lack of Accountability:** In public institutions, standards for performance (e.g., quality and productivity) do not exist or are not enforced. Those who do not perform (hospital directors, administrators, physicians, nurses, etc.) are not sanctioned and good performance is neither acknowledged nor rewarded. Unregulated

and unorganized cost recovery systems in hospitals may punish the poor rather than protect them.

- 1.9 **Deficient Human Resource and Material Management:** Although administrative rules and personnel regulations governing hiring and placement practices exist, they are generally ignored. Nearly all appointments are made at the highest central level without the knowledge of middle and facility managers. This results in little match between the supply of human resources and demand for services and weakens responsiveness to line authority. For example, several SESPAS facilities have up to 50 percent more medical personnel than necessary to meet demand, while other facilities remained closed due to lack of personnel. Public sector health care institutions have become as much public employment programs as a health care delivery system.
- 1.10 The procurement and distribution of drugs and supplies is performed by several agencies in an uncoordinated fashion. Purchases are not programmed, economies of scale are not realized, bidding procedures are not transparent and quality control is absent. This results in high costs, long delays and waste. It is often the case that drugs are purchased and delivered to facilities that do not match the epidemiologic profile of its patients and often drugs delivered to facilities do not match orders. In the facilities themselves, inventory and distribution systems are inadequate. SESPAS patients must purchase these items out-of-pocket, usually from high-price suppliers located near the facility.
- 1.11 **Misallocation of Resources:** The impact of government spending on health status is limited. More than 70 percent of public spending on health (SESPAS/SP) is directed to costly hospital care and less than 5 percent to more cost-effective preventive and primary-level health services. SESPAS directs nearly 60 percent of recurrent spending to hospitals while the SP earmarks nearly all of its health resources to the same, mainly for infrastructure, equipment and drugs. Further, both SESPAS and IDSS have expanded their payrolls in recent years, generally responding to political pressures rather than demand.
- 1.12 The heavy emphasis on capital spending, coupled with expanding payrolls, has resulted in the under funding of drugs and medical supplies, maintenance activities, outreach services and special programs. Under-funded public health and health promotion programs are implemented irregularly, usually through campaign-style initiatives. Despite the large sums invested in equipment and infrastructure, facilities are deteriorating rapidly due to poor management, insufficient funding for maintenance and absence of maintenance systems. Similarly, in the IDSS per enrollee spending varies widely among similar IDSS facilities and bears no relation to outputs or enrolled populations.

- 1.13 **Ineffective Financial Management:** SESPAS and IDSS annual budgets, determined centrally, are based on historical patterns and not on priorities or service outputs. Facility input into the budget-making process is minimal. Budgetary mechanisms and bureaucratic procedures are unsatisfactory, and display little transparency, inhibit flexibility and provide a disincentive to optimal resource use. There is little integration of planning, programming, budgeting and accounting functions. One consequence of this situation is low budgetary execution. Also, the hiring process is independent of the budgetary process. Often staff are appointed and resources are then reassigned to cover the added payroll expense. Most hospital managers are unaware of their total payroll.
- 1.14 **Inequitable Distribution of Public Resources:** Nearly two-thirds of SESPAS non-administrative spending is concentrated in two regions containing large metropolitan areas (Santo Domingo and Santiago) where only 50 percent of the population resides. Nearly all IDSS and private sector spending is concentrated in the same regions. There is little relation between government spending on primary care and infant mortality across regions. Government does not target funding to special population groups or focus on more cost-effective interventions.
- 1.15 **Insufficient and Exclusionary Risk Pooling:** Only 7 percent of the low-income households have some form of insurance coverage compared to 35 percent of well-off households. Insurance coverage for women is disproportionately low. ^{2/} Private prepayment plans succeed through market segmentation, risk selection, high-copayments and disenrollment. They generally cover white collar and higher-income workers within a firm. These practices adversely affect the chronically ill, lower-income workers, and certain occupational groups, and in turn aggravate an already skewed income distribution.

D. Service Organization and Provision

- 1.16 **Inequitable Access and Coverage:** Available health indices for the Dominican Republic suggest unsatisfactory levels of health and health care coverage. The infant mortality rate (48 per thousand births), life expectancy at birth (67 years) and maternal mortality (180 per one hundred thousand births) compare poorly with other Latin American countries with similar levels of income per capita and spending. Inter-regional variations are considerable. For example, infant mortality is over 65 in the rural southern regions but drops to below 40 in large urban areas. Progress in improving these indicators has slowed during the last decade, while

^{2/} Only 27 and 42 percent of IDSS and private insurance enrollees respectively are female and receive comprehensive coverage. Female dependents of IDSS-insured are covered for maternity care only while children (infants) are covered until their first birthday. Private insurance schemes deny maternity coverage to single mothers.

interregional and rural-urban variations remain the same. An estimated 20 percent of Dominicans and 33 percent of the poor lack reliable access to health services. This is particularly the case for inhabitants of rural areas and peripheral neighborhoods.

- 1.17 **Productive Inefficiency:** Low internal efficiency characterizes the public facility network, particularly hospitals. Supplies are inadequate and work-shirking is endemic. Systematic information on costs, cases, per-physician caseloads, referral patterns, quality and outcomes is lacking. Productivity per physician in both SESPAS and IDSS has declined significantly over the last ten years. Facilities face the paradoxical situation of an oversupply of physicians combined with an undersupply of physician services. Under the current system, the way to increase or even maintain production levels is to add personnel. Studies estimate that public hospitals could function with significantly less medical staff with little effect on production. This situation results from: (1) lack of structure and mechanisms that promote incentives for efficient utilization of resources and higher productivity, and (2) the absence of modern management skills.
- 1.18 **Low Levels of Patient Satisfaction:** A recent household survey assessing perceptions of the quality of health services demonstrates broad dissatisfaction with the current system. Over half of the respondents consider that the system requires a major transformation. Services affiliated with private insurance and prepayment plans received the highest level of approval while the IDSS and SESPAS received the lowest. If given the choice, 72 percent of respondents claimed they would demand care from the private sector compared to 18 and 3 percent for SESPAS and IDSS, respectively. To be sure, the private sector is the major supplier of health services in the Dominican Republic, providing an estimated 59 percent of outpatient visits and 46 percent of hospital admissions.
- 1.19 **High Out-of-Pocket Spending:** The private sector represents nearly 70 percent of total spending on health care (excluding water and sanitation), and three-quarters of these expenditures are derived from out-of-pocket payments to solo, fee-for-service providers. While SESPAS is the major provider of care for the poor, the poor are also major users of private outpatient and hospital facilities. Nearly one-half of low-income families demand ambulatory care from private clinics and one-third utilize private hospitals, usually paying out-of-pocket. The dominance of out-of-pocket, fee-for-service financing coupled with dissatisfaction with public providers place an excessive financial burden on low-income Dominicans. A recent household survey demonstrated that the poorest 20 percent of the population spend 20 percent of household income on health.
- 1.20 **Low Levels of Technical Quality:** Technical assessments as well as news reports spanning 15 years have documented generally low levels

of technical quality of medical care provided by physicians and nurses in both public and private facilities. These include: unfamiliarity with basic treatment protocols, erroneous diagnoses and treatment patterns, lack of qualification and experience to perform complicated procedures, and substandard match between infrastructure or equipment availability and types of procedures performed.

E. Government Strategies

- 1.21 **Government State Modernization Strategy:** Soon after taking office in August, 1996 the Government launched the National State Modernization and Reform Program (PNMRE). This ambitious initiative seeks to transform the role of Government and its relation with civil society through the redefinition and transformation of public institutions. Executive Decree No.484 (1996) created the Presidential Commission on State Reform and Modernization. The Commission is responsible for developing a global framework and action plan to guide, oversee and coordinate the modernization efforts in public institutions.
- 1.22 The project is consistent with the strategies of the PNMRE, including (i) reorientation of government social spending to target resources to special populations with a focus on poverty reduction, (ii) reorganization of public agencies as a means to improve their efficiency and coverage, (iii) revamping of legal and regulatory frameworks, (iv) establishment of linkages between government and the private sector, and (v) decentralization of decision making on social service delivery and resource allocation. If implemented successfully, the proposed project will in effect represent the vehicle for achieving PNMRE goals in government health institutions.
- 1.23 **Government Health and Social Strategy:** The government has presented a social sector strategy, known as the National Plan for Social Development. The overall objectives are to: (i) reduce poverty through ensuring economic access, ensuring provision and delivery of basic public services, supporting civic organizations, and facilitate the provision of goods and services to all; (ii) create productive employment; and (iii) integrate all groups, particularly vulnerable populations, into society. Government strategies related to the health sector correspond closely with those of the proposed project, including decentralization of decision making, reorganization of service delivery, restructuring of SESPAS and IDSS, hospital management reform; establishment of integrated information systems, and the development of policies, laws and regulations to support reform and institutional modernization.

F. Bank Strategy

- 1.24 The Bank's country strategy aims to improve economic growth, macroeconomic stability, social welfare and efficient use of

productive resources. This will be accomplished through four strategies: (i) improving fiscal policies and management, (ii) stimulating private investment, (iii) reducing poverty, and (iv) modernizing public institutions. This project contains activities and instruments that contribute to the implementation of the latter three strategies, with special focus on health and social insurance.

- 1.25 **Previous Bank Experience in the Sector and Lessons Learned:** The Bank has implemented one health operation in the Dominican Republic, Loan 680/SF and ATN/SF-2057, disbursing approximately US\$20 million between 1983 and 1987. This investment project supported the construction and equipping of small hospitals and rural ambulatory clinics. The Technical Cooperation aimed to strengthen institutional capacity to operate and maintain the facilities constructed under the loan. An auditing report highlighted the low technical and managerial capacity of SESPAS to implement program activities. This was particularly the case for items such as consultancies and training. Delays of government contributions of matching funds stalled implementation considerably. Similarly, in Loan 930/SF-DR and 825/OC-DR for the Social Investment Fund (Procomunidad) small medical centers have been constructed, yet in some cases the absence of personnel and recurrent cost financing by SESPAS has jeopardized this part of the program. An important lesson learned relates to the need to link infrastructure and equipment investments to changes in how delivery systems are organized, managed, paid and supervised. An important corollary is that the most effective way to assure high benefits from infrastructure/equipment investments is to reform the policy and institutional framework and augment institutional capacity to respond to health care needs.
- 1.26 Since July 1995 the IDB has implemented ATN-5011-DR to support the development of health reform policies and the preparation of this project. This has been a successful experience in part because of SESPAS's delegation of program execution to a technically competent but external coordinating unit. This unit also is implementing a World Bank-administered Japanese Grant and PPF with similar objectives and complementary activities. A key lesson from this experience is the need to establish a stable but technically competent team to facilitate project implementation.

II. THE PROJECT

A. Policy Framework

- 2.1 The project aims to develop the following policy framework that will be implemented gradually during a five- to ten-year period:
- 2.2 A strengthened and reoriented SESPAS that focuses on policy-making, regulation, monitoring and evaluation. Government finances public health, prevention and promotional activities as well as subsidizes defined packages of individual health care services for the poor. Government is also responsible for setting levels of finance and resource allocation criteria. Public infrastructure will remain public but will be managed autonomously. Financial management functions will be decentralized to provincial territorial units that also are responsible for monitoring services. Services will be purchased from a mix of private and autonomous public providers who are responsible for service organization and management.
- 2.3 Under the leadership of SESPAS, a social insurance scheme will be established. The scheme will direct payroll tax revenues and government subsidies to public and private provider networks that integrate insurance and service delivery functions. The scheme is based on a managed competition model that includes the following features: standard benefit plan, individual selection of accredited provider networks, competition among provider networks for enrollees, and targeting of (demand-side) subsidies to low-income households. The system will also feature a single source payment system for both the contributory (payroll-tax financed) and subsidized (general revenue-financed) regimens.

B. Objectives and Concept

- 2.4 The objective is to improve the health status of low- and middle-income Dominicans by supporting the Government's strategy for the health sector which aims to improve the efficiency, equity and quality of health services through implementing policy, institutional and service delivery reforms. This will be accomplished through investments in technical assistance, training, service provision, infrastructure and equipment. Modernization and restructuring of the health sector will require several phases and perhaps eight to twelve years to implement. The present project will support the first phase (5 years).
- 2.5 In the short term, the project would: (i) develop the capacity of government to formulate and implement policies aimed at modernizing the health sector; (ii) initiate the reorganization of SESPAS and IDSS; define new roles and functions; (iii) provide a basic package of quality services to low-income, under-served populations through alternative finance, organizational and service delivery models; (iv) implement autonomous facility-based managerial and governance models in public hospitals while strengthening financial, clinical

and information support systems; and (v) establish links between the public and private sector regarding the management and provision of health services.

- 2.6 In the medium and long term, the project would: (i) establish policies and the corresponding legal and regulatory framework to support health sector reform; (ii) develop alternative financial transfer mechanisms; (iii) separate finance and provision functions through transferring decision making to decentralized units; (iv) extend social insurance coverage through system restructuring, introducing a new institutional configuration (with function separation), incorporating the private sector in risk management and service provision, and testing subsidized scheme for low-income informal sector workers and their families; and (v) contribute to the upgrading of equipment and infrastructure of public facilities.
- 2.7 The project introduces changes in the three principal domains of the system: (i) strengthening the capacity of Government to formulate and evaluate policies, assist in the revamping of the legal and regulatory framework to support these policies and fortify SESPAS' role as the lead institution within the health sector (Component I); (ii) supporting the redefinition, reorganization and restructuring of SESPAS, IDSS and PROMESE, including the decentralization of decision making on resource allocation and management (Components II and III); and (iii) introducing on a pilot basis alternative financial mechanisms and organizational arrangements that reward outcomes and performance while reaching underserved populations with a basic package of services (Component IV). Annex I contains a matrix that matches project strategies and components with problems in the health sector.

C. Project Areas

- 2.8 The project covers four SESPAS administrative regions with 16 provinces and 56 percent of the population. Table 1 presents summary indicators on the four regions. The remainder of the country (four regions) is covered by a parallel project financed by the World Bank. ^{3/} Two regions (V and VI) were selected because they contain high poverty indices or infant mortality rates. Incidence of communicable diseases is also high. In addition, one region (II) with the lowest levels of poverty and infant mortality is included. Region II contains relatively large numbers of IDSS enrollees or formal sector workers not enrolled in IDSS. Extending coverage to the latter group through reform of the social insurance-financed health system is an objective of the project.

^{3/} The World Bank project is complementary to the proposed Project. It focuses on human resource capacity building and strengthening service delivery of SESPAS in four additional regions.

TABLE 1: SUMMARY INDICATORS OF PROJECT REGIONS, 1995-96 4/

REGION	NO. OF PROVINCES	PERCENT OF NATIONAL POPULAT. (1995)	PERCENT IDSS-INSURED (1995)	PERCENT POPULATION LIVING IN POVERTY	INFANT MORTALITY PER 100,000	PERCENT CHILDREN W/ NUTRITIONAL DEFICIENCY
I	3	13	4	36	38.9	23
II	5	25	6	30	43.8	21
V	5	10	10	32	65.3	18
VI	3	8	1	49	66.9	28

D. Project Description

1. Component 1: Policy Development (Amount US\$3.5 million: 5 Percent of Total Cost)

2.9 Objectives: This component will finance consulting services, special studies, workshops, seminars and study tours. It will build capacity and support processes oriented toward policy dialogue and formation, drafting and approval of legal instruments, consensus building and dissemination of reform initiatives. This component will focus on the following areas:

- a. Define and approve policies as well as develop the supporting legal and regulatory framework, including a National Health Law and Social Security Health Law, for establishing: (i) new institutional roles and linkages to the private sector; (ii) alternative mechanisms for allocating resources, targeting subsidies, and paying providers; (iii) market structure and institutional configuration of a new social insurance system; (iv) human resource rationalization and management; and (v) the establishment of decentralized hospitals with semi-independent governance structures.
- b. Enhance quality by establishing processes, adopting standards, and developing the corresponding regulatory framework for handling of hazardous hospital waste and the accreditation of health care providers, insurers and medical supply producers.
- c. Garner support for health reform and modernization initiatives through design and implementation of strategies of dissemination, promotion and formation of strategic alliances.

2. Component 2: Institutional Reorganization of SESPAS (Amount: US\$9.8 million: 13 Percent of Total Cost)

2.10 Objectives: This component will support the *implementation* of policy, institutional and operational reforms at the central and

4/ The Technical Files contain additional tables of indicators on Project Regions.

provincial levels of SESPAS. Through the financing of consulting services, training, workshops, seminars, equipment and materials, this component finances activities that are divided among three subcomponents:

a) Subcomponent 2a: SESPAS Reorganization

- 2.11 The reorganization of SESPAS is based upon three strategies: (i) separation of financing and provision functions; (ii) decentralization of management and operational responsibilities to provincial units (for basic care); and (iii) the transformation of SESPAS into the lead institution of the sector. At the central level, the aim is to provide SESPAS with the capacity to: (i) design, articulate, and coordinate health policy; (ii) strengthen oversight and monitoring capacity; (iii) regulate health service delivery; and (iv) coordinate and manage information within the sector. The provincial level, will administer public health interventions and oversee provision in its area of jurisdiction and purchase services from public providers through performance agreements and from private providers through contracts. Hospitals and other providers will be largely self-managed entities responsible for service provision under contract with SESPAS.
- 2.12 This subcomponent will support four major activities:
- 2.13 **(1) Institutional Development and Central-level Restructuring:** An essential element of structural reform at the central level is the simplification and consolidation of functions. The proposed central level restructuring proffers the consolidation of nine functions currently spread across the institution in an inchoate manner. The project will reorganize SESPAS to perform the following functions: (i) policy formulation, (ii) planning, (iii) program development, (iv) financial management, (v) human resource management, (vi) administration, (vii) regulation, (viii) information, (ix) investigation and (x) support for decentralized management.
- 2.14 **(2) Decentralization:** The project will support the design and implementation of decentralized management of SESPAS services with special emphasis on the managerial and organizational needs of provincial units where pilot activities will be implemented. The project will support the reorganization of regional and provincial units and will improve the capacity of provincial officials to assume new roles to: plan, execute and audit budgets; allocate resources and pay providers and program and monitor contracts and other activities.
- 2.15 **(3) Human Resource Management:** This activity centers on human resource management and rationalization to support the implementation of new institutional roles and functions. It will: analyze and inventory human resource needs; redefine and

establish position profiles; design and implement a process of personnel transfer; design models and study options for downsizing central-level personnel; revamp recruitment, hiring and firing processes; test alternative models of contracting personnel; and establish support systems for human resource management.

- 2.16 (4) **Management Information Systems:** This activity will introduce modern management information systems (MIS) to improve the decision-making capacity and performance at all levels of SESPAS and IDSS systems. Through the financing of computers, software and accessories (modems, printers, etc.), additional telephone lines and cabling, and training in the effective use of information technology, the project will: (i) establish an affordable technological platform that will permit exchange of information within and across service and administrative units; (ii) create a technical support and maintenance unit for the MIS; and (iii) design and implement a series of modules that consider new institutional roles and specific needs of providers. These modules support activities contemplated elsewhere in the project, including hospital management, epidemiologic surveillance, central- and provincial-level administration, and procurement, stock control and distribution of drugs and supplies

b) Subcomponent 2b: Financial Management Reorganization and Strengthening

- 2.17 This subcomponent will support the following two activities:

- 2.18 (1) **Reorganization of Financial Management and Budgeting:** The project will: (i) structure and establish a financial management unit (FMU) within central-level SESPAS, consolidating finance-related activities now performed in an uncoordinated matter by several departments; (ii) deconcentrate the budgeting process from the General Treasury and National Budgetary Directorate to SESPAS; (iii) simplify the budgetary structure; (iv) introduce streamlined and transparent procedures to eliminate bottlenecks and delays in approving and issuing payments to suppliers; and (v) design and implement a training program for the FMU and provincial counterparts.

- 2.19 (2) **Design and Implementation of Alternative Resource Allocation Mechanisms and Provider Payment Systems:** This activity aims to establish a transparent and more equitable mechanism for transferring resources from central-level SESPAS to provinces through the use of formulas that allocate budgets on the basis of indicators of health status, special population needs, poverty indices, and management indicators. The project also will test the use of alternative payment

systems for hospitals that provide incentives to deliver quality services efficiently.

c) Subcomponent 2c: Modernization of Procurement, Inventory and Distribution of Drugs and Medical Supplies

2.20 The objective of this subcomponent is to improve access to and availability of affordable, quality drugs and medical supplies through structuring a transparent, integrated and efficient procurement and distribution system that responds to the needs of health care providers participating in project activities. Implemented through PROMESE, this activity will be achieved through the financing of consulting services, training, workshops and seminars for two activities:

(1) Support for the design, testing and implementation of a demand-driven system for the procurement and distribution of drugs and medical supplies in which purchasing responsibility is decentralized to the local and facility level. This will be achieved through designing and implementing pilot subprojects that: (i) convert providers into decentralized budget holders for the purchase of drugs and supplies; (ii) reorient PROMESE into a logistical support and intermediary agent for pooled ordering and purchasing; and (iii) build the capacity of providers to manage drug inventories.

(2) Introduction of quality control standards (e.g., certification, accreditation, revised product list, development of standardized therapeutic protocols) to ensure product safety and effective use.

3. Component 3: Restructuring and Institutional Modernization of the Social Insurance-Financed Health System (Amount US\$7.5 million: 10 Percent of Total Cost)

2.21 The principal objective of this component is to extend social insurance coverage from 6 percent to 20 percent of the total population during the life of the project. This will be accomplished through the implementation of policy, financial and institutional reforms aimed at reconfiguring the social insurance-financed health system and restructuring the IDSS to prepare it for new roles and functions. ^{5/} The component consists of two subcomponents, each corresponding to a separate implementation phase: (i) Institutional strengthening and Studies (years 1-2); and (ii) Configuration of a New Social Insurance-financed Health System and Extension of Coverage (years 3-5).

^{5/} See Technical Files for summary description of proposed reform of social insurance-financed health system.

a) Subcomponent 3a: Institutional Strengthening and Studies

- 2.22 Through consulting services, training, workshops and seminars, this subcomponent will finance the following two activities during the first two years of the project:
- 2.23 (1) **Targeted Institutional Development:** Since the eventual role of the IDSS within a reformed social insurance system will remain unknown at least during the first year of project implementation, this activity takes a targeted approach to institutional development. It aims to improve the performance of a limited number of functions that, if necessary, can be transferred to other agencies within a new institutional configuration. The subcomponent will concentrate efforts in the following areas: (i) inventory and redefinition of positions and personnel profiles; (ii) revamping (payroll) tax recollection, enrollee registration, billing and audit systems; and (iii) redefinition of the structure, procedures and management of the budgetary process.
- 2.24 (2) **Studies and Designs:** The project will finance a limited number of studies and systems designs to set the stage for the implementation of a reformed social security system. Studies will include: (i) define mission and organizational structure of IDSS; (ii) design personnel payment system that rewards performance, (iii) define norms and procedures for contracting private providers and insurers; and (iv) develop a plan for gradual coverage extension and guide the transition from the current to the new system.
- 2.25 Prior to disbursements for subcomponent 3a, other than to finance studies agreed with the Bank, the IDSS will show to the satisfaction of the Bank evidence of the separation of financial resources and management for the three types of insurance currently administered by the IDSS.

b) Subcomponent 3b: Implementation of New Social Insurance-Financed Health System

- 2.26 Once a policy framework and corresponding legislation have been approved, this subcomponent will finance the extension of social insurance health coverage through the configuration and implementation of a new insurance system. To achieve this goal and as specified in the Policy Letter (See Technical Files), the Government seeks to design and launch a social insurance-financed system based on regulated competition among integrated delivery networks from both the public and private sectors, coverage for a

standard benchmark service plan, capitated payments 6/ and enrollee choice of network. 7/

- 2.27 To this end, the subcomponent will finance consulting services, seminars, training and workshops for the following activities: (i) design and establish the institutional framework and corresponding governance, managerial and organizational structures related to major system functions, including planning and system oversight, supervision, regulation and accreditation, collection and allocation of funds, contracting and negotiation, subscriber enrollment, and information collection, analysis and dissemination; (ii) develop system standards, rules and procedures for the above functions; (iii) define and cost a benchmark service plan and corresponding capitation rate; (iv) strengthen the capacity of public and private delivery networks to assume risks, organize networks, contract physicians and other providers, manage utilization, track and contain costs, collect and analyze information, monitor quality and patient satisfaction, manage human resources and evaluate results; and (v) extend coverage through implementing pilots linking social insurance financing to (contracted) private and public networks.
- 2.28 Prior to disbursement for subcomponent 3b, the legal and regulatory framework that lays the foundation for structural, financial, and institutional changes for the new social insurance system and the extension of coverage must be approved and promulgated.

4. Component 4: Strengthening of Basic and Hospital Service Systems (Amount US\$34.6 million: 46 Percent of Total Cost)

- 2.29 The objectives of this component are to improve access, efficiency and quality of services delivered by SESPAS and IDSS with special emphasis on targeting low-income and underserved populations. In addition, this component will finance interventions in order to: (i) introduce results-oriented incentives for providers in a pluralistic health care network; (ii) ensure increased private sector participation; and (iii) pave the ground for a new system of social insurance and primary care provision. This will be achieved through the creation of three unrelated funds, each corresponding to a separate subcomponent: Primary Care Fund (FONAP); Solidarity Fund (FONSOL); and the Fund for Hospital Management and Upgrading (FONHOSPITAL). 8/

6/ Consists of a payment to cover the cost of providing a defined package of services to each person enrolled in a provider network.

7/ The Technical Files contain a description of the proposed social insurance system under consideration by Government.

8/ See Technical Files for diagrams of financial and service flows for each of these funds. The term "fund" is not used in the technical or legal sense of trust funds or social development funds, but simply to designate separate accounts identified for specific activities.

- 2.30 In the case of FONAP and FONSOL (Subcomponents 4a and 4b), financing will support the direct provision of defined packages of basic services with a special focus on mother-child interventions 9/ as well as technical assistance and training to provider organizations and networks contracted through the Funds. Both Funds will pay providers on a capitated basis to provide a service package to a defined (enrolled) population. The capitated payment is configured to cover salaries, supplies and pharmaceuticals. Providers will be under contract with SESPAS and the project. For both Funds, the Bank will finance capitated payments on a declining basis. 10/ Technical assistance and training aim to improve managerial, organizational and clinical capacity to provide services.

a) Subcomponent 4a

- 2.31 FONAP (Primary Care Fund) will finance an estimated 50 subprojects to provide a basic package of preventive and curative services directed at 300,000 women and children. The target population of FONAP are children and women of fertile age in low-income families residing in the four project regions. FONAP will subsidize 80 percent of the estimated annual per capita cost of this package (US\$19). Copayments for curative services will cover the remaining cost. The basic package will be delivered through an array of providers, including SESPAS health centers, NGOs, private clinics, organized community groups and municipalities.

b) Subcomponent 4b

- 2.32 FONSOL (Solidarity Fund) will finance an estimated three to five subprojects that will extend coverage to 50,000 low-income informal sector workers and their families in urban areas in Santo Domingo. Another objective of this program is to test an alternative finance, organization and delivery model that can serve as a basis for designing and implementing a reformed social insurance system. FONSOL will finance an expanded, semi-comprehensive package of preventive, curative and hospital services with an emphasis on mother-child services. The estimated annual per capita cost of the package is US\$54. Enrollees will contribute through premium payments and/or copayments an estimated 50 percent of the cost. Higher income enrollees will pay more. Beneficiaries will select certified (and existing) integrated delivery networks drawn mainly from the private sector. These networks will compete for enrollees through a transparent bidding process.

9/ The technical files contain a description of the packages and the methodology used to define and cost them.

10/ The project will finance 100 percent of the cost of the service packages during the first year of operation for each subproject while the government will assume financial responsibility incrementally during the life of the project. Government will assume full financial responsibility upon project completion.

c) Subcomponent 4c: Fund for Hospital Management and Upgrading (FONHOSPITAL)

- 2.33 The objectives of this subcomponent are to improve the quality, internal efficiency and financial solvency of hospital services through supporting the transformation of governance, organization and management structures and processes, and upgrading equipment and infrastructure. FONHOSPITAL ties investments in rehabilitation and equipment to management reforms and improvements in financial, administrative and clinical systems. The project will finance activities in up to four hospitals across the four project regions. If successfully implemented, these hospitals will serve as models for introducing management changes elsewhere in the public hospital network.
- 2.34 The project will focus on internal operations during a preliminary phase, introducing modern management tools, developing administrative capacity and upgrading infrastructure and equipment in the four "model" hospitals. Ultimately, "model" hospitals would manage human and financial resources and establish contractual arrangements with public purchasing agents and private third-party payers. This subcomponent consists of two activities:
- 2.35 (1) **Management Reforms:** Management interventions in both clinical and non-clinical areas will be financed through consulting services, training, workshops and study tours. Activities will concentrate in the following functional and programmatic areas: (i) autonomous governance and internal management structures; (ii) management of medical waste; (iii) quality and productivity improvements; (iv) management of pharmaceutical and medical supplies; (v) financial management, accounting and auditing; (vi) information systems; ^{11/} (vii) clinical training; (viii) maintenance systems for plant and equipment; (ix) reorganization of cost recovery with adequate protection of the poor; (x) contracting out of support services; (xi) sale of services to third parties; and (xii) roles and linkages within a provider network.
- 2.36 (2) **Rehabilitation and Equipment:** FONHOSPITAL will support investments in rehabilitation and equipment to: (i) improve capacity to increase productive efficiency, reduce costs of services already provided, or putting existing, but idle, and complementary services into use; and (ii) improve the quality of services already provided. Investments would be limited to rehabilitation of existing infrastructure and replacement of basic equipment up to US\$3 million per hospital. An estimated 60 percent of investments will be for rehabilitation and the remainder for equipment.

11/ To ensure the compatibility and integration of MIS, the activity will be implemented through a separate Subcomponent (Component II, Subcomponent 2c).

E. Project Costs and Financing

- 2.37 Project Costs: Total projects costs are estimated to be US\$75.0 million. The breakdown of project costs by component and subcomponent is summarized in Table 2. The distribution of project investments by type, year and source is presented in Table 3.
- 2.38 Financing Plan: Eighty-one percent of total project costs, equivalent to US\$61.2 million, will be financed through the proposed loan in US dollars from the single currency facility of the Bank's ordinary capital. The entire amount of the loan will be financed under concessionary terms through OC/IFF. Nineteen percent of total project costs, equivalent to US\$13.8 million, will be government counterpart to the operation, of which US\$3.5 million will be cofinanced by the Nordic Development Fund (NDF), and US\$5 million will be cofinanced by the Organization of Petroleum Exporting Countries (OPEC). Given that project activities target poor beneficiaries (Subcomponent 4A and 4B) and others will directly benefit the poor (Component 2 and Subcomponent 4C), the matrix is 90/10 according to paragraph 2.15 and 2.93 of Report on the Eighth General Increase in the Resources of the IDB.

TABLE 2: PROJECT COSTS AND FINANCING PLAN
(US\$ millions and percent)

CATEGORIES	BID/ OC-IFF (\$)	COF/ NDF	COF/ OPEC	LOCAL	TOTAL (\$)	%
Component 1: Policy Development	3.5				3.5	5
Component 2: Institutional Reorganization of SESPAS	9.8				9.8	13
Subcomponent 2a: SESPAS Reorganization	7.0					
Subcomponent 2b: Fin. Mngmt. Reorg. and Strength.	0.8					
Subcomponent 2c: Modernization of Supply System	2.0					
Component 3: Restructuring and Institutional Modernization of the Social Insurance System	7.5				7.5	10
Subcomponent 3a: Inst. Strengthening and Studies	3.7					
Subcomponent 3b: Implement. of New Soc. Insurance	3.8					
Component 4: Strengthening of Basic and Hospital Service Systems	22.3	3.5	5.0	3.8	34.6	46
Subcomponent 4a: Fund for Maternal Child Care	6.4	3.5		2.8		
Subcomponent 4b: Solidarity Fund	3.8			1.0		
Subcomponent 4c: Fund for Hosp. Mngmt. & Upgrading	12.1		5.0			
Contingencies	4.5				4.5	6
Administration/Executing Unit	8.0				8.0	11
Financial Costs	5.6			1.5	7.1	9
FIV	0.6					
Interest	5.0			0.2		
Commission				1.3		
TOTAL	61.2	3.5	5.0	5.3	75.0	100
PERCENTAGE	81%	5%	7%	7%	100%	

TABLE 3
DISTRIBUTION OF INVESTMENTS BY TYPE, YEAR AND SOURCE OF FINANCING
(US\$ millions)

SPENDING CATEGORIES	TOTAL					Year 1			Year 2			Year 3			Year 4			Year 5		
	Total	%	BID	COF	Local	BID	COF	Local	BID	COF	Local	BID	COF	Local	BID	COF	Local	BID	COF	Local
TOTAL	75.0	100	61.2	8.5	5.3	7.8	0.0	0.3	11.5	1.0	0.4	14.2	2.0	0.6	15.4	2.0	1.3	12.3	3.5	2.7
Administration (UCP)	7.9	11	7.9			2.1			1.5			1.5			1.4			1.4		
Infrast. & hosp. equip.	12.0	16	7.0	5.0					3.0			3.0	1.0		2.0	1.0			3.0	
Direct Health Services	16.0	21	12.2		3.8				1.0			2.8		0.3	4.9		1.0	3.4		2.5
Consultants	17.2	23	14.7	2.5		2.7			2.8	0.5		4.0	0.5		2.4	1.0		2.8	0.5	
Training	4.6	6	3.6	1.0		0.7			0.6	0.5		0.7	0.5		0.9			0.8		
Material and Equipment	5.6	7	5.6			1.6			1.1			1.2			1.1			0.7		
Contingencies	4.6	6	4.6			0.5			0.9			1.0			1.1			1.1		
Interest	5.2	7	5.0		0.2	0.1			0.5			0.9		0.02	1.5		0.06	2.0		0.13
Commission	1.3	2			1.3			0.3			0.4			0.3			0.2			0.1
FIV	0.6	1	0.6			0.12			0.12			0.12			0.12			0.12		

III. PROJECT EXECUTION

A. Organizational Structure for Project Implementation

- 3.1 The Project Executing Agency will be the Technical Secretariat of the Presidency through its Project Coordinating Unit (UCP). The UCP will coordinate execution of the Project's activities consistent with the reform mandates authorized by the Executive Commission for the Reform of the Health Sector (CERSS). The CERSS was constituted by Presidential Decree 308-97 of July 10 1997. It is the oversight body responsible for leading the reform effort, developing health policy, coordinating external assistance, and orienting executing units. The highest authority in each of the institutions participating in the proposed project - Technical Secretary of the Presidency, Secretary of SESPAS and the Directors of IDSS and PROMESE - are members of the CERSS. 12/
- 3.2 Given that: (i) Decree 309-97 grants the CERSS authority to define and direct the content and process of health reform; (ii) project activities are contemplated in multiple institutions (SESPAS, IDSS and PROMESE); and (iii) project activities will be implemented in multiple tiers (central, regional and provincial), the administrative structure of project execution will consist of the following units located at three levels. 13/ 14/

(1) Under the policy direction of the CERSS, the Decree appoints an Executive Coordinator (CE), to provide operational leadership regarding the implementation of sector reform and the coordination of external assistance. The CE shall also serve as the Director of the Project Coordinating Unit (UCP), which will be responsible for the technical coordination and execution of project activities and for the administration of Bank funds.

(2) Modernization and Institutional Development Units (UMDI) will be established in the central bureaucracy of each of the three institutions object of project interventions (SESPAS, IDSS, PROMESE). Under the direction and guidance of the UCP, UMDIs are responsible for overseeing the implementation of project activities within the respective institutions.

12/ The remaining members include: Secretary of Labor, Secretary of Education, Director of the Armed Forces Hospital, Executive Secretary of the Presidential Commission on State Modernization, President of the National Association of Private Clinics and Hospitals, and two representatives from non-governmental health care providers.

13/ The technical files contain a diagram of the administrative structure of project execution. Core professional staff for each unit will be financed through the loan and will consist of Dominican staff. They will be complemented by national counterpart staff employed by the participating institutions. Quality professionals are available for contracting.

14/ The organizational structure integrates the administration of the IDB and World Bank projects. The Banks will share the financing of staff and other administrative costs of the UCPO and UMDI/SESPAS.

(3) Provincial Technical Units (UTPs) will be located in Provinces where pilot activities will be implemented. The UTPs are responsible for coordinating project activities at the service delivery level and report to the UCP.

B. Project Coordinating Unit (UCP)

- 3.3 Technical coordination, financial administration and execution will be handled through the UCP under the direction of the CE. To assure clear distinctions between technical operational activities and financial administration and execution, the UCP will consist of two sub-units, with no more than twelve professionals (financed through the project) supporting the Executive Secretariat: the Technical Unit and the Financial Administration Unit, each with a Director named by the CE. The UCP will coordinate project activities with counterparts and authorities within SESPAS, IDSS and PROMESE at the central and the provincial levels and with other public and private institutions participating in the project. To carry out his responsibilities, the CE will be supported by a long term local Technical Advisor in Strategic Planning and Communication. As a condition prior to first disbursement, the UCP shall present to the Bank the inter-institutional coordination agreements signed with PROMESE and IDSS, and evidence of the formalization of the corresponding arrangements with SESPAS. These agreements set forth the responsibilities of each institution for project execution and the necessary inter-institutional coordination mechanisms.
- 3.4 The Director of the Technical Unit (DT) of the UCP will be responsible for coordinating and supervising all technical activities of the project. To assist in these activities, the project will finance a long term International Advisor for the life of the project. For the purposes of this project, the DT will be supported by three Technical Coordinators (CT). Each CT will be responsible for specific project activities as set forth in the operational guidelines.
- 3.5 The Director for the Financial Administration Unit (DAF) is responsible for providing administrative and financial support for all project activities, including the maintenance of accounting records, processing disbursements, maintaining administrative records, contracts, and the carrying out of related activities. The Unit will review all contracts, make payments for activities approved by the DT and his support staff. In addition to national counterparts assigned to the Financial Administration Unit, the unit will be staffed with professional and support personnel as needed. The DAF will consist of two subunits, separating administrative and financial activities related to the IDB and World Bank.
- 3.6 In order to carry out its functions, the UCP will be supported by a Committee on Bidding which will provide oversight and review for all national and international contracts and proposals. The

Committee will assure that all preparatory steps required under Bank norms are met, will preside over all public acts relating to the offering of bids, and will evaluate all proposals according to criteria that guarantee equity and transparency in the bidding process.

- 3.7 As a condition prior to first disbursement of the financing, the Borrower will present evidence to the Bank that it has: (i) created the UCP; (ii) staffed it with the following positions: Executive Coordinator of the CERSS, Financial Administrative Director, Technical Coordinators and the International Advisor; (iii) established the acquisitions committee; and (iv) created a Technical Directorate as agreed with the Bank.
- 3.8 Institutional Modernization Units (UMDIs): The UCP will coordinate institutional development activities with the support of UMDIs in each of the three key institutions affected by the project (IDSS, SESPAS, PROMESE). Each UMDI will have a Coordinator responsible for the timely and efficient execution of relevant project activities, and will participate and collaborate with the UCP and with counterparts in the respective institutions to assure smooth implementation. The Coordinators will report to the DT.
- 3.9 Provincial Technical Units (UTPs): Similarly, there will be in each Province where pilot activities will be implemented a UTP with a Coordinator who, in close collaboration with counterparts, the UCP, and the UMDIs, will support the execution, monitoring and supervision, evaluation and control of project activities in their respective provinces. The Coordinators will report to the DT. To assure the coordination and participation of relevant stakeholders in the design and implementation of project activities, there will be a Provincial Advisory Committee (CAP) in each province. Composed of the Provincial Director of SESPAS, a representative of IDSS (where necessary), and one representative from the private sector and another from the NGO community, this consultative body will convene periodically with the UTP, the UMDI, and the UCP in order to assure smooth and participatory implementation.
- 3.10 Counterpart personnel from participating institutions (SESPAS, IDSS and PROMESE) will receive training in management and administrative techniques prior to assuming responsibilities for project-related activities in said areas.

C. General Operational Guidelines

- 3.11 Action Plans: Project activities have been defined by the action plans prepared for each component and subcomponent of the project. These are available in the project files. These action plans serve as guides for project implementation, and will be revised annually by the UCP.
- 3.12 Operational Regulations: All functions, activities, and procedures of the UCP as well as the pilot subprojects (FONAP, FONSOL,

FONHOSPITAL and medical supply system) will follow operational regulations, a draft of which is found in the Technical Files. The final version of these regulations will be agreed upon between the Borrower and the Bank and included in an Operational Manual prior to first disbursement. The operational regulations will be elaborated upon to form the operational manual for the project, and may be revised as needed, subject to Bank approval. 15/

- 3.13 Recognition of Prior Expenses: The Bank may reimburse the Borrower with resources of the financing for eligible expenses incurred after loan approval and prior to loan effectiveness.
- 3.14 If as a result of the annual reviews referred to in paragraph 3.35 or of other reviews in which the Bank participates, the Bank determines that counterpart resources for the Project have not been provided on a timely basis by the Government, the Government and the Bank shall withhold authorization of all new projects and of all new calls for bidding, price competitions, and any other form of contracting for the procurement of goods or services to be financed with resources of the loan, until the Government has taken adequate measures, to the Bank's satisfaction, to fulfill its counterpart obligations and to ensure that future counterpart resources for the Project will be provided on a timely basis.
- 3.15 Procurement: Procurement of goods and services will be done according to Bank guidelines, as set forth in Annex B of the loan contract, and will be handled by the UCP. Public international bidding will be required for the procurement of goods over US\$250,000 and construction contracts over US\$1.5 million. In the operational annexes, guidelines and procedures pertaining to acquisitions under these amounts are presented. All contracting of consulting services will be done in accordance with Bank standard policies on the selection and contracting of consultants. Prior to contracting of all consultancy work, the DT in consultation with pertinent Coordinators, the International Advisor, and the Committee for Bidding, should elaborate relevant technical documentation to be submitted for Bank approval.
- 3.16 Prior to the acquisition of computer equipment for project support, the Borrower must present to the satisfaction of the Bank documentation on system design, that electrical and cabling requirements are completed, and that personnel required are available and trained in software applications to be utilized.

15/ Annex A of the loan contract will specify that the Operating Manual shall incorporate the Operational Guidelines for the Project Coordinating Unit, FONAP, FONSOL, FONHOSPITAL, and the Medical Supply System Pilot as well as the Acquisition Procedures for Small Purchases.

D. Execution of a Pilot Medical Supply System, FONAP, FONSOL and FONHOSPITAL

1. Medical Supply System (Subcomponent 2c)

- 3.17 The project will establish on a pilot basis a parallel, demand-driven supply system to serve a subset of SESPAS and IDSS facilities in the four project regions. Government will finance the purchase of drugs and supplies to be used for the pilot subprojects. The Operational Guidelines for this activity (See Technical Files) set out criteria for selection and appraisal of eligible providers together with procedures for budgeting, ordering, purchasing, stocking and distributing drugs and medical supplies to facilities participating in the pilots.

2. FONAP/FONSOL (Subcomponents 4a and 4b)

- 3.18 A Technical Committee, headed by the DT of the UCP will be created and vested with the authority for decisions outlined in the Operational Regulations. The UCP is responsible for technical oversight regarding promotion, assessing, selecting and processing of subprojects, including the preparation of subproject documentation for the Administrative and Financial Unit (DAF). The project will partially finance the cost of defined service packages on a declining basis with the Borrower assuming full financial responsibility upon project completion. ^{16/} The annual actions plans for each subcomponent will estimate the contribution from counterpart funds that will be included in the national budget.
- 3.19 The operating manuals for FONAP and FONSOL will specify the process and time frame regarding the allocation of counterpart funds to finance the subsidy for the service packages during years two through five of the subprojects.

3. FONAP (Subcomponent 4a)

- 3.20 In the selected areas the program will identify eligible providers with capacity to deliver the services and beneficiary communities eligible to participate in the program. Potential beneficiaries of subprojects will be identified by UCP in coordination with SESPAS, UTP and CAP: (i) through the identification of municipalities with high incidences of poverty and low levels of health service utilization and coverage, especially for mother-child care; and (ii) application of rapid household surveys to defined catchment areas by providers, to identify specific beneficiaries such as children under five and pregnant women.

^{16/} For each subproject, the project will finance 100 percent of the partial subsidy during the first year of operation, 75 percent in the second, 50 percent in the third and 25 percent in the fourth. Conversely, government counterpart financing will increase incrementally for each subproject (year 2: 25%; year 3: 50%; year 4: 75%; year 5: 100%).

- 3.21 FONAP will assist the beneficiary community and the selected provider to prepare a subproject to be submitted for financing. FONAP will provide technical assistance to the beneficiary community to improve its organization to participate in the subproject and to improve provider organizational and technical capacity in order to prepare the subproject.
- 3.22 In addition to the contracting of private providers NGOs and community organizations, the UCP will establish agreements or performance contracts with SESPAS providers interested in participating in FONAP. In the case of participating SESPAS providers, the financing of services not provided by the subproject will be maintained. SESPAS personnel participating in FONAP will be required to take a leave of absence without pay and will be compensated on a per capita payment.
- 3.23 All subprojects will be assessed and selected by means of transparent eligibility criteria, procedures and processes. Selection criteria include evidence of health needs and poverty of the beneficiaries, a target population of over 5,000 persons per subproject, community desire to participate in the subproject, minimal overlap with other providers and estimates of a significant expected impact. 17/
- 3.24 For all approved subprojects a contract will be signed by the executing agency, the community and the selected provider, stating the responsibilities of each party. An advance of funds will be made to the provider to start the subproject. Each provider will be monitored on a quarterly basis by a supervisor contracted by the UCP, and disbursements will be made to providers on a quarterly basis subject to satisfactory supervisory reports. Indicators will be developed to monitor and evaluate performance.

4. FONSOL (Subcomponent 4b)

- 3.25 FONSOL will identify eligible organized beneficiaries, that will select a provider network from a short list of eligible providers previously certified by the UCP. During a biennial, one-month enrollment period, individual beneficiaries will be permitted to change affiliation of provider networks. On the demand side, organized groups of informal sector workers will serve as intermediaries to enroll members, provide information to enrollees, and collect and channel premium payments to the DAF. 18/ Provider networks cannot market directly to the beneficiaries or their organizations.
- 3.26 Eligible organized provider networks from the private sector will compete for enrollees through a transparent enrollment and bidding

17/ The operational regulations for FONAP will note that documentation on the first ten FONAP projects must be presented to the Bank for its non-objection.

18/ At a latter stage, some of these functions will be turned to a purchasing agency or cooperative representing beneficiary organizations.

process managed by the UCP's Administrative and Financial Unit (DAF) that will disburse quarterly per capita subsidy payments to provider networks selected by the beneficiaries, based on enrollment reports completed by the provider, confirmed by the beneficiary organization, and certified by the UCP.

- 3.27 Selection and appraisal of the beneficiary organization and provider networks will follow criteria, processes and procedures set forth in the Operational Guidelines. Eligibility criteria for beneficiary organizations will include: (i) demonstration of the existence of 10,000 potential enrollees including dependents; (ii) willingness of a majority of membership to participate in proposed scheme and contribute premium and copayments; and (iii) existence of an organizational structure and financial management system able to collect premiums and maintain reliable data on beneficiaries. A special contract will be established between the beneficiary organization, the provider, and the executing agency establishing responsibilities for each partner. 19/
- 3.28 Selection of provider networks will consist of a two stage process as specified in the Operational Regulations. The UCP will produce and deliver promotional materials, contract models and conduct at least two seminars informing organized provider networks and medical groups in Santo Domingo of FONSOL. Interested networks will be asked to complete a written application. Based on a review of the written applications, the UCP will establish a short list of potential providers and then conduct an institutional and quality assessment to select eligible providers. Eligibility criteria for provider networks will include: (i) evidence of financial solvency; (ii) existence of provider network including at least one hospital with emergency services with sufficient capacity and complementary services to provide the package of services contemplated in the scheme; (iii) existence of (or commitment to contract) affiliated providers in areas close to workplace and residence of enrollees; and (iv) no less than five years of experience managing capitated payments.

5. SUBCOMPONENT 4c: FONHOSPITAL (Fund For Hospital Management and Upgrading)

- 3.29 A Technical Committee, headed by the DT of the UCP will have the authority for all decisions related to eligibility for each of the stages. The UCP is responsible for technical oversight regarding the assessing, selecting, processing and implementing of subprojects. The UCP's Administrative-Financial Unit (DAF) is responsible for administrative and financial oversight, including contract management and disbursements.

19/ The operational regulations for FONSOL will note that documentation on the first three FONSOL projects must be presented to the Bank for its non-objection.

- 3.30 Each hospital subproject will be implemented in three stages: (i) selection of eligible hospitals; (ii) provision of technical assistance and training to design Hospital Modernization and Investment Plans and initiate the former; and (iii) implementation of the Hospital Investment Plan.
- 3.31 In the first stage the UCP in collaboration with UMDIs, SESPAS and IDSS, will conduct an institutional assessment to identify eligible hospitals located in project regions with: (i) a demonstrated demand for services and a catchment area of over 50,000 persons; (ii) capacity of at least 100 beds with no less than fifty percent occupancy; and (iii) willingness to accept technical assistance and to participate in audit and control activities. An evaluation of each competing hospital will result in a ranking based on a point system to select the four hospitals participating in FONHOSPITAL. Other qualified hospitals will remain in a pool in ranked order as possible alternates or for future extension of the program.
- 3.32 To initiate the second stage, an agreement will be signed by executing agency, SESPAS or IDSS, and the hospital, clarifying terms and conditions of collaboration. During this stage hospital will design and initiate implementation of a Modernization Plan, consisting action plans for 12 activities aimed at improving administrative, financial and clinical management. In order to be eligible for the third stage, the Hospital will have to meet performance criteria established in the agreement that will be monitored by the UCP and the Bank. During this stage the hospital also will prepare an Investment Plan.
- 3.33 To initiate the third stage a second agreement will be signed by the executing agency, SESPAS or IDSS, and the hospital, stating terms and conditions for the implementation of the Investment Plan and the provision of supplementary technical assistance and training activities to complete the 12 management activities with specific performance indicators.

6. External Audit

- 3.34 The Borrower, through the Executing Agency, will present annually execution plans and the financial statement of the project certified through independent external audits acceptable to the Bank.

E. Supervision and Evaluation System

- 3.35 Semi-Annual Reports. During the execution of the project, the UCP will present progress reports on both physical and financial advances, which will include: status of fulfillment of contractual obligations; progress on each plan of action with impact indicators for all subcomponents; and indicators of progress as designed in the Logical Framework of the project. These reports should also include statements on activities programmed for the following review period, with terms of reference for studies and consultants.

- 3.36 Project Supervision. The Bank will carry out periodic supervisory missions to review progress and problems in project implementation. Annual Review- Within 45 days subsequent to the submission of every other semi-annual report, the Bank will carry out an Annual Evaluation of the project, which will entail meetings with members of the UCP, UMDIs, RTUs, SESPAS, IDSS, PROMESE and other relevant actors. These evaluations will cover the general advance of the project, work plans, investment plans for the following period, and progress in the activities of the project. Mid-Project Evaluation- Within 36 months of first disbursement, a Mid-Project Evaluation will be carried out by the Bank. This evaluation will include the general status of progress in the project, progress and impact indicators agreed upon with the Bank, and progress of reform actions. The purpose of these reviews is to monitor advances in the program and, if necessary, introduce corrective measures in project design and implementation. If as a result of these reviews it is determined that appropriate progress in project execution by SESPAS and IDSS has not occurred, the Bank may cancel portions of the undisbursed funds or may revise the levels of effort for any component or subcomponent.
- 3.37 End of Project Evaluation. Within 60 days of the final disbursement of all project funds, the Bank will carry out a final evaluation of the project. This evaluation will review progress and impact indicators agreed upon with the Bank, and the progress of actions toward reform.
- F. Complementary Activities to be Carried Out Prior to Initial Disbursement
- 3.38 The remaining uncommitted funds available from ATN/CI-5011-DR, estimated at US\$80,000 will be used to finance: (i) consulting services to prepare operational manuals; (ii) support the implementation of information dissemination and promotional activities in support of the reform program; and (iii) maintain a small cadre of technical staff to revise actions plans and prepare the first implementation plan.
- 3.39 A Technical Cooperation financed by the Spanish Fund, and in collaboration with SESPAS, IDSS and local teams, will design and implement a promotional and strategic communication strategy to inform key stakeholders of the scope and content of the Government's Reform Program supported by the IDB project.

IV. BENEFITS AND RISKS

A. Social and Environmental Impact Analysis

- 4.1 The principal beneficiaries of the project are the poor who rely on government health services or pay out-of-pocket for private services. Through financing packages of basic services for targeted unserved populations, the project will improve their health status. By introducing modern management techniques, the project will improve the efficiency and quality of public hospital services. By initiating a gradual process of restructuring and modernizing public institutions, reorienting financial flows, introducing output-oriented incentives and defining basic care packages, the project will improve the efficiency and equity of government resource allocations, raise the cost-effectiveness of service provision, and reduce the financial burden of health care on poor households. Through strengthening regulation and accreditation to ensure minimum quality standards, the project will raise quality and build consumer confidence in the health care system.
- 4.2 Beneficiaries: Impact on the Poor and on Women The majority of the 350,000 direct beneficiaries of FONAP and FONSOL interventions are poor households with special emphasis on women and children with high burden of disease indices. Both funds can be considered pilot projects that are expected to be continued and expanded by the government upon project completion.
- 4.3 FONAP will target the financing of a cost-effective basic package of services to low-income populations located in the four project regions with inadequate access to quality health services. The services financed through FONAP contain a number of interventions oriented to women and children, including, pre- and post-natal care, family planning, well-baby care, prevention of sexually transmitted disease, prevention and detection of AIDS, and prevention of cervical cancer.
- 4.4 Beneficiaries are targeted through a three-step process, combining geographical and household selection mechanisms. First, poor areas have been identified through available composite indices of unsatisfied basic needs. Second, based on available measures of child nutritional deficiency, a proxy for infant mortality, project activities will focus on fourteen "high incidence" municipalities where consumption of basic services is low. Finally, within the geographically targeted areas and municipalities, "at risk" households will be identified through a poverty map exercise conducted by contracted providers. This exercise also will assess problems related to access and utilization of basic services by the targeted beneficiaries.
- 4.5 FONSOL will subsidize a health insurance scheme for 50,000 low-income, informal sector microenterprise owners, workers and their

families residing in Santo Domingo. FONSOL will work with community organizations comprised mostly of women. The action plan for the partially subsidized program has identified members of a microenterprise lending association (ADOPEM) that provides credit for nearly 15,000 women-owned, subsistence-level microenterprises as the first to receive benefits under the proposed scheme. Emphasis will be placed on reaching "low-income" microenterprises based on measures available from microenterprises lending associations. Proxies for indentifying these enterprises include total revenues, revenue per worker and number of employees. For example, surveys show that over one-third of microenterprises in the Dominican Republic (and 43 percent of women-owned microenterprises) earn less than one minimum salary per worker.

- 4.6 Poor households are also indirect beneficiaries of management in public hospitals that will improve the internal efficiency and quality of care while reducing out-of-pocket spending. Approximately 60 percent of households from the lowest income quintile (annual family income of less than US\$240) demand inpatient and outpatient care from SESPAS hospitals. Women and children represent nearly two-thirds of users of SESPAS facilities. Approximately 35 percent of Dominican households are headed by women. However, because of the disorganization of clinical services and supply systems in SESPAS hospitals, users from this group pay on the average US\$8 per visit and US\$85 per inpatient stay, mainly for drugs and supplies. Out-of-Pocket spending by poor families on services included in the basic package covered by FONAP will decline by 60 percent.
- 4.7 Project design pays particular attention to ensuring that reforms of the private and social insurance systems improve access to special populations including women, children and uninsured workers. Under the current legal framework, IDSS does not cover either informal sector workers or dependents of formal sectors workers. Private insurers deny maternity coverage to single mothers. The action for extending social insurance coverage identifies dependents of insured workers as the first group to be enrolled in the new system.
- 4.8 Benefits: The project will result in four categories of benefits. Selected Benefits are presented in Table 4
1. Health Status
- 4.9 The project will improve health status through reducing the disease burden by an estimated 20 percent (from 218,000 to 174,000 disability adjusted life-years lost) for the direct beneficiaries of FONAP in the four project regions, measured in reduced number of

adjusted life years lost. ^{20/} For this target population, it is expected that infant mortality will be reduced by 10 percent. Also for this population, it is estimated that effective coverage for pre-natal care will increase from 83 to 100 percent, for well-child care from 23 to 90 percent, and family planning from 52 to 90 percent.

2. Equity

- 4.10 Equity will be enhanced by: (i) increasing social insurance coverage from 6 to 20 percent of the population; (ii) alleviating the financial burden of the cost of basic health care for poor families by an estimated 60% (through institutional reforms and system improvements); (iii) reducing out-of-pocket spending by the beneficiary population of FONSOL by one-third through the use of targeted subsidies; (iv) introducing transparent mechanisms for allocating budgets on the basis of health status and poverty; (v) protecting consumer interests and increasing fairness of the insurance market through insurance regulation; and (vi) reorganizing hospital cost recovery systems while introducing mechanisms to protect the poor.

TABLE 4
SUMMARY OF SELECTED PROJECT BENEFITS

OUTCOME/COVERAGE CATEGORY	PROJECT BENEFIT ^{1/}
<u>Outcome</u> Infant Mortality Under 5 Mortality "Disease Burden" "Financial Burden"	10% reduction ^{2/} 340 avoided deaths annually 530 avoided deaths annually ^{3/} 60% reduction ^{4/}
<u>Coverage</u> Well-baby Care Pre-natal Care Family Planning Social Insurance	23 to 90% 83 to 100% 52 to 90% 6 to 20% ^{5/}
^{1/} Unless noted, refer to beneficiaries of FONAP ^{2/} Deaths for 1,000 births ^{3/} Represents 20 reduction in disability Adjusted Life Years Lost ^{4/} Spending on interventions included in basic package ^{5/} Refers to health coverage for the entire population.	

3. Quality

- 4.11 Quality will be improved through: (i) establishing an accrediting process that applies minimum quality standards to health care providers; (ii) introducing quality assurance programs in model hospitals; (iii) introducing incentives for providers participating in FONAP and FONSOL that reward quality and patient satisfaction;

^{20/} Refers to reducing the disease burden associated with the pathologies that will be prevented or treated through the basic package. Reduction of disease burden will result in avoiding 530 deaths annually, including 340 infant and child deaths. See Technical Files for a discussion on disease burden and the design of the basic package of services.

and (iv) improving the quality of drugs and medical supplies and strengthening therapeutic protocols.

4. Efficiency

- 4.12 The project will improve efficiency by: (i) consolidating functions and streamlining processes and procedures in SESPAS and IDSS related to financial and human resource management; (ii) introducing a framework of financial and other incentives (through policies, regulations and pilot activities) that orient providers to produce quality outputs efficiently; (iii) defining service packages and establishing allocation mechanisms in the public sector that favor cost-effective interventions with special emphasis on maternal, child and family health care; (iv) implementing modern management tools in public hospitals; (v) improving hospital capacity to utilize infrastructure and equipment efficiently and putting idle complementary services into use; and (vi) reducing waste in drug and medical supply system.
- 4.13 Environmental Impact. The infrastructure components of the project are limited to rehabilitation and equipping of four hospitals, and are expected to have no negative environmental impact. Environmental construction and management norms for health facilities, including internal waste management, personnel health and safety provisions for the operation of equipment, are part of the program's operational regulations. 21/
- 4.14 Given the deficient environmental situation observed in public hospitals, project action plans will support the following specific activities, as set forth in the Environmental and Social Impact Statement: (i) as part of an overall accreditation process, the formulation and approval of norms, policies and enforcement mechanisms to control and manage liquid and solid waste in hospitals; (ii) development and implementation of training and environmental education programs on waste management for health authorities and hospital personnel; and (iii) rehabilitation of infrastructure and the installation of equipment and systems for the "self-contained" treatment of liquid and solid wastes in hospitals located in areas in which municipal systems lack infrastructure for adequate treatment. Also, hospitals receiving project financing will be required to establish training programs and systems for waste management.

21/ The Technical Files contain the Environmental and Social Feasibility Statement.

B. Economic and Financial Analysis 22/

- 4.15 The financial and economic analysis centered on: (i) the extension of primary and maternal/child care to low-income, underserved families through the FONAP and FONSOL pilots, (ii) cost-effectiveness of services included in the standard package; and (iii) the extension of social insurance (health) coverage through a reformed system that will cover a standard package of services through contracted provider networks. Regarding FONAP and FONSOL, the analysis aims to measure the extent to which interventions proposed in the project can reduce target beneficiaries' financial burden of health services. It also assesses the ability of the government to assume the financial responsibility for these two pilots upon project completion. In the case of social insurance extension, the analysis models the economic, labor, and fiscal conditions under which coverage can be extended to formal sector salaried workers and their families as well as low-income, informal sector workers and their dependents. The following summarizes the major findings. The Technical files contain the full report.
- 4.16 **FONAP:** Project benefits (project and government subsidies) will result in economic relief and improved welfare for the target population (300,000 women and children). Assuming a price elasticity of demand of -0.5 ^{23/} for poor families, the total quantity of services demanded will increase by 31 percent while per capita out-of-pocket expenditures will decrease by 60 percent of what households currently spend on primary care. Project benefits to target recipients will result in an increase of consumption of services and a reduction in health spending worth approximately 4.5 percent of per capita income by year five. In the project's final year, government spending on FONAP will be 0.7 percent of total health spending. Upon project conclusion, the government will assume a total annual cost equivalent to 1.8 percent of projected public health spending. This percentage will level off at about 2 percent over the following 10 years. Given projected expenditures, financing of FONAP can be absorbed without major shifts in spending patterns. SESPAS employees participating in the project will take an unpaid leave of absence to be remunerated on a capitated basis by the project. This will contribute to lower net government spending on FONAP.
- 4.17 **FONSOL:** Assuming a price elasticity of demand of -0.5, and that costs to be covered by beneficiaries are financed entirely through out-of-pocket fees, annual per capita spending on health services will decline by approximately 10 percent for the target population

^{22/} The analysis only briefly dealt with the recurrent cost implications of infrastructure and equipment investments from FONHOSPITAL (Subcomponent 4c). Since these investments will involve minor rehabilitation related to existing services as well as replacement of dysfunctional equipment, recurrent cost implications will be minimal. Also, hospital modernization plans will contain benchmarks for measuring improvements in efficiency and quality.

^{23/} Estimates are based on household demand studies of poor population in Latin America.

(50,000 informal sector workers and their families). Owing to project subsidies, however, beneficiaries would not only spend less on health care but would increase their consumption by 37 percent. Government subsidies for the project in the fifth year are expected to amount to 0.2 percent of total health public health spending.

- 4.18 **Cost-Effectiveness:** The analysis determined the cost-effectiveness of the package of services financed through FONAP. Outcomes are based on disease burden, as measured through disability-adjusted life years (DALYs). This measure combines healthy life years lost due to premature mortality and disability. The package contains 15 interventions that will provide the most value for the money in terms of reducing disease burden of the target population. Consumption of these services will result in an estimated 2,700 avoided deaths during the life of the project. The estimated average cost per DALY gained for this package is US\$179. ^{24/} The per capita cost is approximately US\$19. However, nearly 90 percent of DALYs gained are concentrated in four interventions (prenatal care, well-baby care, and the prevention and treatment of tuberculosis and rheumatic fever) with an average cost per DALY of US\$73. The results are consistent with cost-effectiveness studies performed elsewhere in Latin America.
- 4.19 The targeting of beneficiaries with a basic package through contracting providers and paying them on a per capita basis represents a shift in the structure of finance, organization and provision of government health services. Piloted through FONAP, this modality produces incentives to providers to deliver cost-effective and quality services efficiently, and is superior to other alternatives that work within current structures. As outlined in Chapter I, the current system lacks the incentive structure, targeting mechanisms, service (package) definition and provider payment systems to foster cost-effectiveness, efficiency or quality of service provision.
- 4.20 **Social Insurance Extension:** The project aims to extend social insurance coverage from the current 6 percent to 20 percent by project completion. Financial evaluations were performed to determine the feasibility of extending coverage through delivering a comprehensive package of health care services with an estimated

^{24/} Based on epidemiologic and coverage data of underserved populations in the four regions, the analysis determined the disease burden related to clusters of individual diseases. Effectiveness was defined by the number of DALYs gained through applying the corresponding interventions to these disease clusters. The costs refer to the additional investment needed to extend these interventions from current low coverage levels to nearly full coverage for the target population in the project's four regions. The Technical Files provide a summary analysis of the definition and cost-effectiveness of the package of services supported through FONAP.

annual per capita cost of US\$97. ^{25/} Financial equilibrium models simulated coverage extension and payroll tax rates based on assumptions concerning contributory ceilings, family size, economic growth, growth of formal sector employment and salaried income, tax evasion, number of contributors, copayments, and inflation. The results show that a payroll tax of approximately 9 percent will be required to fully finance the contributory scheme with modest copayments and a contributory ceiling of five minimum salaries. ^{26/} Under this scenario, within 10 years the contributory system could cover 47 percent of the population, mostly formal sector workers and their families. Achieving 20 percent coverage under a contributory scheme during the project is financially feasible assuming the approval of legislation mandating an increase in the payroll tax and compulsory enrollment of civil servants, current IDSS-insured enrollees and middle income formal sector workers. Critical to the success of this component will be the incentive structures for consumers and providers as well as efficiency of the administrative and institutional arrangements made to manage and implement a reformed social insurance-financed health system.

- 4.21 Increasing the payroll tax on the formal sector workers to cross subsidize the cost of the same comprehensive package of services for the rest of the (mostly low-income and non-salaried) population is not economically feasible. Instead, the analysis modeled the establishment of a subsidized regimen financed through general tax revenues which are reallocated from supply-side financing of facilities to demand-side subsidies of poor individuals. ^{27/} However, achieving universal coverage through such a scheme will be a long-term endeavor. The analysis shows that it will require the design of a less comprehensive (and less costly) package of services, the transformation of government health spending from supply to demand-side subsidies, and real increases in government spending on health. For example, assuming a service package with a per capita cost of approximately US\$68, the transformation of 70 percent of government spending from the supply to the demand sides, and real government health spending increases by 3.3 percent annually, the system could cover an additional 30 percent of the population in 10 years. Nevertheless, achieving 80 percent coverage (50 percent in a contributory regimen and 30 percent in a subsidized regimen), represents a significant advance over the current situation in which nearly 80 percent of households are without insurance coverage and 30 percent of the population do not

^{25/} This amount is lower than the current per-enrollee health spending by IDSS and corresponds closely to lower-end private market prices for a similar package of services. Coverage against catastrophic health problems is an attractive feature of the comprehensive package considered in a reformed system. Such coverage is often excluded by private insurers and prepayment plans in the Dominican Republic, resulting in the transfer of costs to the government health system in a regressive fashion.

^{26/} Currently, the IDSS levies a 7 percent payroll tax to finance health, pension and accident insurance programs.

^{27/} On a small scale (involving 50,000 people), such a scheme will be tested through the project (FONSOL).

have regular access to health services. Although the project aims to restructure the social insurance system and establish a subsidized regimen, it does not contemplate the extension of social insurance coverage to the poor beyond the beneficiaries of FONSOL. Expansion of social insurance coverage to lower-income populations may have to wait until information and lessons about FONSOL's costs and performance become available.

C. Risks

- 4.22 An initial political mapping exercise and consumer satisfaction survey demonstrated considerable support for reform among health service users, private medical sector, NGOs, business interests and labor groups. Over half of survey respondents agreed that the system requires a complete transformation. However, commitment within the IDSS and SESPAS bureaucracies and the principal physician association (AMD) is timid. Pressure to maintain the status quo will be strong. Many benefit from the chaotic nature of the sector and the well-documented disorganization, inefficiency and ineffectiveness of its public institutions. In short, the effectiveness and viability of any initiative will require strong political support from higher levels of government. Although high-level authorities appear committed to reform, the government does not speak with a single voice regarding the nature, breadth and depth of change it supports.
- 4.23 High turnover of government authorities is another threat to project implementation. This may decrease government commitment to health sector reform and to project activities. Maintaining a critical mass of quality technical staff will be necessary for successful implementation. Another risk involves the ability of government to sustain financing for direct service provision through FONAP and FONSOL.
- 4.24 Institutional modernization and reform in the health sector cannot stand alone politically, technically or operationally under current institutional conditions in the DR. Change will not be "internally-driven" by the institutions themselves. Superior levels of government and intermediary structures will have to nurture, guide, support and oversee the institution-specific processes within a broader framework of state modernization. In addition, reform requires a dramatic change in the organizational culture of these institutions.
- 4.25 Strong coordination among donor agencies that are interested in participating in the reform, including IDB, World Bank and USAID, will be required to assist Government in producing and implementing a unified program for the health sector.
- 4.26 To address these risks, the Government issued Presidential Decree No. 308-97 on July 10, 1997 creating the Executive Commission for Reform of the Health Sector (CERSS) to guide and oversee the reform process. The Decree establishes Government commitment to health

sector reform. The Decree also establishes an Executive Coordinator (CE) responsible for technical and administrative coordination of the National Reform Program and all donor assistance. The CE will head a coordination unit (UCP) located outside of the public institutions object of project interventions. This will facilitate maintaining a critical mass of experts and afford some protection against the high instability of personnel observed within these institutions.

- 4.27 Also in anticipation of these problems, the project has obtained strong commitment of Government for counterpart and bridge financing, and will establish coordinating and executing units financed through the credit. The project also provides substantial support and technical assistance for the development of a promotion and communication strategy for sector reform, as well as technical assistance and training for introducing and nurturing changes in the organizational culture of the institutions.
- 4.28 To reduce the risk of government failure to assume financial responsibility of FONAP and FONSOL, the project design calls for the incremental transfer of financial obligations during the course of the project. Government annual allocations increases gradually from less than US\$250,000 to US\$ 5 million during a four-year period. Also, during implementation resources will be available given that SESPAS personnel participating in FONAP will be required to take a leave of absence without salary.

ANNEX: CORRESPONDENCE BETWEEN HEALTH SECTOR PROBLEMS, PROJECT STRATEGIES AND PROJECT COMPONENTS
DOMINICAN REPUBLIC. HEALTH SECTOR MODERNIZATION AND RESTRUCTURING. DR-0078.

MAJOR SECTOR PROBLEMS/SYMPOMS	PROJECT OBJECTIVES AND STRATEGIES	PROJECT COMPONENTS/SUBCOMPONENTS
<ul style="list-style-type: none"> * Ambiguous Policy Framework * Intrasectoral Fragmentation. * Archaic Health Legislation. * Absence of Standards * Lack of Accountability 	<p><u>Define and strengthen institutional roles and functions</u>, supporting the definition and separation of roles among Government health institutions and strengthening Government's capacity to develop and implement sectoral policies.</p> <p><u>Set and enforce transparent rules of the game</u>, supporting the development of a legal and regulatory framework, establishment of accreditation and licensure standards, and quality control standards</p>	<p>Policy Development (Component I)</p>
<ul style="list-style-type: none"> * Institutional Weakness * Deficient Human Resource and Material Management * Misallocation of resources * Ineffective Financial Management * Inequitable Distribution of Public Resources. 	<p><u>Strengthen SESPAS role as leader</u>, restructuring the central level, separating finance and provision, decentralization, and enhancing policy making, planning, budgeting, auditing, supervisory, information and evaluation functions.</p> <p><u>Reorient government health spending</u>, implementing alternative resource allocation mechanisms and targeting subsidies, services with high externalities and to special populations.</p> <p><u>Improve access to and availability of affordable and quality drugs and medical supplies</u>, structuring transparent, integrated and efficient procurement and distribution systems.</p>	<p>Institutional Reorganization of SESPAS (Component II)</p> <p>SESPAS Reorganization (Subcomponent A)</p> <p>Financial Management, Reorganization and Strengthening (Subcomponent B)</p> <p>Modernization of Procurement, Inventory and Distribution of Drugs and Medical Supplies (Subcomponent C)</p>
<ul style="list-style-type: none"> * Institutional Weakness * Insufficient and exclusionary risk pooling. * Deficient human resource management. * Ineffective financial management. * High out-of-pocket spending. 	<p><u>Prepare IDSS for reform</u>, strengthening financial and human resource management functions.</p> <p><u>Extend Social Insurance Coverage</u>, developing and implementing reforms aimed at reconfiguring the social insurance system</p> <p><u>Make the system more responsive to clients</u>, promoting greater consumer choice in social insurance and prepayment systems.</p>	<p>Restructuring, Institutional Modernization of the Social Insurance System (Component III)</p> <p>Institutional Strengthening and Studies (Subcomponent A)</p> <p>Implementation of New Social Insurance-financed Health System (Subcomponent B)</p>
<ul style="list-style-type: none"> * Inequitable Access and Coverage * Productive Inefficiency * Low levels of Patient Satisfaction. * Low Levels of Technical Quality 	<p><u>Improve access to basic health services to unserved populations</u>, introducing alternative financial incentives linking provider payments to outputs.</p> <p><u>Establish linkages between public and private sectors</u>, supporting the establishment of alternative delivery systems that form partnerships among government purchasers, private providers and private insurers.</p> <p><u>Support the introduction of modern management techniques in health care providers</u>, developing and testing governance structures, payment mechanisms and management tools.</p>	<p>Strengthening of Basic and Hospital Services (Component IV)</p> <p>Fund for the Extension of Primary Care FONAP (Subcomponent A)</p> <p>Solidarity Fund for extension of insurance coverage to informal sector (Subcomponent B)</p> <p>Fund for Hospital Management and Upgrading (Subcomponent C)</p>

**LOGICAL FRAMEWORK FOR HEALTH SECTOR MODERNIZATION AND RESTRUCTURING PROJECT
DOMINICAN REPUBLIC 1998-2002**

Summary	Indicators	Means of verification	Assumptions
<p>Improvement of the health services in the Dominican Republic</p>	<ol style="list-style-type: none"> 1. Infant mortality rate reduced by 10% for the beneficiary population within 5 years 2. Disease burden reduced by 20% among beneficiaries targeted under project (to reduce the number of adjusted years lost from 218,000 to 174,000) within 5 years 	<ul style="list-style-type: none"> • Registration of vital statistics • User survey • Information system developed under project • Household survey 	<p>That a consensus be built re objectives and institutional s health sector through the ref</p> <p>That the government stands commitment to the social de strategy and the fight to elim</p> <p>That the exogenous variable remain unchanged or not w sanitation, water, girl educat</p>
<p>Improvement of the efficiency and capacity of the system to develop health policy and provide</p>	<ol style="list-style-type: none"> 1. Clear public policy framework established by the government for the health sector 2. New legal framework for social insurance in the area of health completed in 5 years 3. Operational restructuring of SESPAS at all levels completed and modern management systems introduced at all levels 4. Reallocation of public spending on health 5. Demand subsidies to finance cost-effective packages of basic services for low-income groups introduced 	<ul style="list-style-type: none"> • National Health Plan • User surveys • Project reports • Information system developed under project • Public policy paper 	<p>That the national authorities approve a new basic social area of health with adequate</p> <p>That public spending be red to the priorities established for the health sector</p>
<p>Improvement of the quality of health services and medical care</p>	<ol style="list-style-type: none"> 1. Number and type of suppliers receiving public funding increased 2. Higher user satisfaction with primary and hospital care 3. Accreditation systems for suppliers, insurers, and medical products companies created and introduced within 5 years 	<ul style="list-style-type: none"> • User surveys • Project reports • Project information system • Regional hospital registers • Accreditation systems 	
<p>Improvement of coverage, raise equity, and access to health services, maternal-child and reproductive health</p>	<ol style="list-style-type: none"> 1. Number of people in the country insured through the social security system increases from 6% to 20% within 5 years 2. Prenatal care rate increases from 83% to 100% in beneficiary population in 5 years 3. Well-child care increases from 23% to 90% of beneficiary population in 5 years 	<ul style="list-style-type: none"> • Registration of vital statistics • Project monitoring reports 	

Summary	Indicators	Means of verification	Assumptions
DEVELOPMENT. New used on new roles and ate relationships l and implemented, new regulatory framework and accreditation d processes ed.	<p>1.1 New legislation, regulatory framework, and regulations approved: General Health Law, Basic Social Security Law, Ministerial Decree on Decentralization, regulations governing special regimes, ministerial decree on hospitals</p> <p>1.2 Accreditation policies established and system functioning</p> <p>1.3 Public information program designed, year 1</p> <p>1.4 Public information program introduced, year 2</p>	<ul style="list-style-type: none"> •Semiannual reports by UCP •New laws and regulations 	Labor climate favorable to c Counterpart personnel freely out the program and willing authorities to implement pro recommendations.
<p>ONAL REORGANIZATION S</p> <p>anization and institutional tion of SESPAS at the el</p> <p>ent and administration of subsystems functioning and efficiently at the el</p> <p>n Resources nt</p> <p>ources system y with reclassification of nd professional training</p> <p>entralization nits functioning and ed with human resources ent and support systems</p> <p>gement Information</p> <p>etwork information ctioning in pilot hospitals, nd IDSS</p>	<p>2.1 SESPAS operating subsystems reviewed and functioning, year 2</p> <p>2.2 Reengineering program completed and new procedures functioning, year 2</p> <p>2.3 Number of subsecretariats reduced from 22 to 3 by year 5</p> <p>2.4 Automated personnel inventory, year 1</p> <p>2.5 Human resources subsystems redefined and in place with operations handbooks, year 2</p> <p>2.6 New human resources regulatory framework established, year 1</p> <p>2.7 Reassignment of SESPAS personnel at central level, years 2 and 3</p> <p>2.8 Reassignment of personnel in regions and areas (provinces)</p> <p>2.9 Adjustment of functions in regions/areas completed and regulated</p> <p>2.10 Agreements with NGOs signed</p> <p>2.11 Information system model in place in six months</p> <p>2.12 Pilot information systems plan for SESPAS, IDSS, and hospitals established at beginning of year 2</p> <p>2.13 Hardware and software in place in 4 hospitals, SESPAS, IDSS, and network established, year 4</p>	<ul style="list-style-type: none"> •Semiannual reports by UCP (UMDI) •New organizational structure for SESPAS •New automated inventory of positions and staff •Semiannual project reports •Staff inventories •Agreements with NGOs •Hospital reports •Semiannual reports by UCP •Evaluation of pilots 	

Summary	Indicators	Means of verification	Assumptions
<u>Financial Management</u> Modernization and Strengthening financial management established at the central	2.14 Integrated financial management system established and functioning with new approved budget, year 2 2.15 Financial information system automated, year 2 2.16 Break down of budget by health region and area according to beneficiary population effectively enrolled, year 3 2.17 Financial function separated from medical services function, year 3	•Semiannual project reports (UMDI, UTP) •Evaluation of financial information system •Evaluation of pilots •Annual audit of SESPAS	
<u>Modernization of Procurement, and Distribution of Drugs and Medical Supplies.</u> System that optimizes the distribution functioning	2.18 Basic table and medical form distributed, year 1 2.19 Social marketing pilots, with modernization of pharmacies functioning, year 2 2.20 Quality control pilot introduced, year 3	•Semiannual reports by UCP •In situ visits (pilot projects)	
<u>STRUCTURING AND ORGANIZATIONAL MODERNIZATION OF THE SOCIAL INSURANCE-FINANCED HEALTH SYSTEM</u> Organizational strengthening and reorganization for the	3.1 Analysis of management system and functions completed and new functions introduced, year 1 3.2 Reassignment of personnel, year 2 3.3 Legal framework and operating regulations for Superintendency established, year 2	•Semiannual reports by UMDI •Annual reports by IDSS	
<u>Implementation of New Social Insurance-Financed Health System</u>	3.4 Regulatory agency (Superintendency) functioning with trained staff, year 3 3.5 System for accreditation of suppliers and insurers established, year 3 3.6 Mechanisms for hiring and payment of administrators and suppliers developed, year 3 3.7 System to expand coverage designed and developed, year 3 3.8 Financial agency for the new system established, year 3 3.9 System for reallocation of resources in place, year 4	•UCP reports •Supplier/insurer survey •Annual reports by the Superintendency	

Summary	Indicators	Means of verification	Assumptions
<p>STRENGTHENING OF BASIC SERVICES</p> <p>coverage to include d infants in poverty so ge will apply to low- ups and the informal</p>	<p>4.11 Promotional program introduced in year 1</p> <p>4.12 Subprojects identified in year 2</p> <p>4.13 50 pilot subprojects financed and functioning for 300,000 women and children in 5 years</p> <p>4.14 System for monitoring Fund/projects established in year 1</p>	<ul style="list-style-type: none"> •Annual audit of the Fund •UCP reports •Fund evaluation reports •Fund monitoring system data 	
<p>EXPANDING COVERAGE</p> <p>coverage through a package of services for al sector in Santo</p>	<p>4.7 Organization of beneficiaries selected in six months</p> <p>4.8 Model for financing, organization, and supply introduced in year 1</p> <p>4.9 Promotional program introduced in year 1</p> <p>4.10 3 to 5 pilot subprojects functioning for 50,000 workers in the informal sector in Santo Domingo in 5 years</p>	<ul style="list-style-type: none"> •Annual audit of the Fund •UCP reports •Fund evaluation reports (mid-term and final) •Fund monitoring system data 	
<p>IMPROVING THE EFFICIENCY AND QUALITY OF HOSPITAL SERVICES</p> <p>hospital services through shment of FONHOSPITAL endent management</p>	<p>4.1 Regulatory framework for autonomous hospital introduced, year 1</p> <p>4.2 Hospital management modernization plans designed, year 2</p> <p>4.3 Hospital management modernization plans implemented, year 3,</p> <p>4.4 System for local management for human resources in years 3 to 5</p> <p>4.5 Waste management program established, year 3</p>	<ul style="list-style-type: none"> •UCP reports •Hospital accreditation system •Annual audit of hospitals •Modernization and investment plans for each hospital 	

Notes: See individual Action Plans for each component and subcomponent for further details of specific activities

RGII-DR031P
DR-0078
Original: Spanish

PROPOSED RESOLUTION

REPUBLICA DOMINICANA. LOAN ____/OC-DR TO THE REPUBLICA DOMINICANA
(Health Sector Modernization and Restructuring)

The Board of Executive Directors

RESOLVES:

That the President of the Bank, or such representative as he shall designate, is authorized, in the name and on behalf of the Bank, to enter into such contract or contracts as may be necessary with the República Dominicana for the purpose of granting a financing to cooperate in the execution of a Health Sector Modernization and Restructuring program. Such financing will be for the amount of up to US\$61,200,000, which are part of the resources of the Single Currency Facility of the Ordinary Capital, and will be subject to the "Special Contractual Conditions" and the "Terms and Financial Conditions" of the Executive Summary of the Loan Proposal.

RGII-DR032P
DR-0078
Original: Spanish

PROPOSED RESOLUTION

REPUBLICA DOMINICANA. PARTIAL PAYMENT OF INTEREST ON LOAN No. ____/OC-DR
TO THE REPUBLICA DOMINICANA
(Health Sector Modernization and Restructuring)

The Board of Executive Directors

RESOLVES:

That the President of the Bank, or such representative as he shall designate, is authorized, in the name and on behalf of the Bank, as administrator of the Intermediate Financing Facility Account, hereinafter referred to as the "account", to enter into such contract or contracts as may be necessary with the República Dominicana, as Borrower, and to adopt other pertinent measures to use the resources of the account to pay a part of the interest due by the Borrower on outstanding balances of the loan authorized by Resolution DE- /97, in accordance with the provisions set forth in Document FN-263-2, as amended, approved by the Board of Executive Directors on December 21, 1983.