

# HEALTH SYSTEMS PROFILE DOMINICAN REPUBLIC

MONITORING AND ANALYZING HEALTH SYSTEMS CHANGE

(Third Edition)  
October, 2007



**HEALTH SYSTEMS PROFILE  
DOMINICAN REPUBLIC**

**Santo Domingo, Dominican Republic.**

**October, 2007**

**(Thrid Edition)**

**PAHO HQ Library Cataloguing-in-Publication**

Pan American Health Organization  
Health systems profile of Dominican Republic.  
Washington, D.C: PAHO, © 2007.

ISBN 978 92 75 12823 7

I. Title

1. HEALTH SYSTEMS
2. ESSENTIAL PUBLIC HEALTH FUNCTIONS
3. DOMINICAN REPUBLIC

NLM WA 525

This publication was produced by the Health Policies and Systems Unit, Health Systems Strengthening Area (HSS/HP) of the Pan American Health Organization/World Health Organization (PAHO/WHO). This publication was made possible through support provided by the Office of Regional Sustainable Development, Bureau for Latin America and the Caribbean, U.S. Agency for International Development (USAID), under the terms of Grant No. LAC-G-00-04-00002-00. The opinions expressed in this publication are those of the author (s) and do not necessarily reflect the views of the U.S. Agency for International Development.

The electronic version of this document is available at the Web site for Health Systems Strengthening in Latin America and the Caribbean and can be accessed at [www.lachealthsys.org](http://www.lachealthsys.org). For any questions or inquiries regarding this document, please contact [info@lachealthsys.org](mailto:info@lachealthsys.org).

## ACKNOWLEDGEMENTS

The third edition of the Health System Profile of the Dominican Republic is the product of a joint work by professionals from the Ministry of Health and Social Assistance (SESPAS), the Executive Commission for Health Sector Reform (CERSS), the Health Statistics Department (DIES), and the Regional Office of the Pan American Health Organization/World Health Organization (PAHO/WHO) in the Dominican Republic. The work team, which consisted of Clara Ferrand, Aurora Rodríguez, Georgina Espinal, and Maritza Martínez, Rodríguez, was supervised by Ana Rafaelina Guerrero. Rafael Montero provided support to the bibliographic review. Francini Placencia, from the SESPAS, coordinated the process with the technical support of Gerardo Alfaro, PAHO/WHO Dominican Republic, Claudia Suárez, CA/SICA, and Priscilla Rivas-Loría, PAHO/WHO Washington, D.C. The technical revision was carried out by Bernardo Matías, Rafael Ortiz, José Lucas, Josefina Martínez, Julia Genao, Tirsis Quezada, and Selma Zapata. The PAHO/WHO Health Policies and Systems Unit (HP), Health Systems Strengthening Area (HSS), Washington, D.C., was responsible for the final revision and edition of this document.

## TABLE OF CONTENTS

<b>LIST OF ACRONYMS</b> .....	<b>1</b>
<b>EXECUTIVE SUMMARY</b> .....	<b>2</b>
<b>INTRODUCTION</b> .....	<b>4</b>
<b>1. CONTEXT OF THE HEALTH SYSTEM</b> .....	<b>5</b>
1.1. HEALTH SITUATION ANALYSIS.....	6
1.1.1. Demographic Analysis.....	6
1.1.2. Epidemiological Analysis.....	7
1.1.3. Millennium Development Goals.....	8
1.2. HEALTH DETERMINANTS.....	10
1.2.1. Political Determinants.....	10
1.2.2. Economic Determinants.....	10
1.2.3. Social Determinants.....	11
1.2.4. Environmental Determinants.....	12
<b>2. HEALTH SYSTEM FUNCTIONS</b> .....	<b>12</b>
2.1. STEERING ROLE.....	12
2.1.2. Implementation of the General Health Policy.....	14
2.1.3. Regulation.....	16
2.1.4. Evaluation of the Essential Public Health Functions.....	16
2.2. FINANCING AND ASSURANCE.....	17
2.2.1. Financing.....	17
2.2.2. Assurance.....	18
2.3. HEALTH SERVICES DELIVERY.....	19
2.3.1. Health Services Supply and Demand.....	19
2.3.2. Health Workforce.....	20
2.3.2.1. Human Resources Management and Employment Conditions.....	22
2.3.2.2. Governance and Organized Labor.....	23
2.3.3. Drugs and Other Health Supplies.....	23
2.3.4. Equipment and Technology.....	24
2.4. INSTITUTIONAL MAPPING OF THE HEALTH SYSTEM.....	25
<b>3. MONITORING HEALTH REFORMS</b> .....	<b>25</b>
3.1. IMPACT ON HEALTH SYSTEM FUNCTIONS.....	25
3.2. IMPACT ON THE GUIDING PRINCIPLES OF THE REFORMS.....	27
3.3. IMPACT ON THE HEALTH SYSTEM.....	29
3.4. ANALYSIS OF ACTORS.....	30
<b>BIBLIOGRAPHY</b> .....	<b>37</b>

## LIST OF ACRONYMS

<b>AMD</b>	Dominican Association of Medical Doctors
<b>ARL</b>	Occupational Risk Administrators [ <i>Administradoras de Riesgos Laborales</i> ]
<b>ARS</b>	Health Risk Administrators [ <i>Administradoras de Riesgos de Salud</i> ]
<b>BHP</b>	Basic Health Plan
<b>CAFTA-DR</b>	Central America–United States–Dominican Republic Free Trade Agreement
<b>CENCET</b>	National Center for the Control of Tropical Diseases
<b>CERSS</b>	Executive Commission for Health Sector Reform
<b>CNS</b>	National Health Council
<b>CNSS</b>	National Social Security Council
<b>DIDA</b>	Bureau of Consumer Information and Protection
<b>DIGECITSS</b>	Bureau for the Control of Sexually Transmitted Infections and AIDS
<b>DIGEPI</b>	Bureau of Epidemiology
<b>DPS</b>	Provincial Health Offices
<b>ENDESA</b>	Population and Health Survey
<b>EPHFs</b>	Essential public health functions
<b>EPI</b>	Expanded Program on Immunization
<b>GDP</b>	Gross Domestic Product
<b>GSS</b>	Social Security Management Secretariat
<b>GTZ</b>	German Agency for Technical Cooperation
<b>HAS</b>	Health Situation Analysis
<b>HDO/UNDP</b>	Human Development Office, United Nations Development Program
<b>HIV/AIDS</b>	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
<b>HR</b>	Human Resources
<b>HSP</b>	Health Service Providers
<b>IDSS</b>	Dominican Social Security Institute
<b>JICA</b>	Japan International Cooperation Agency
<b>LACRHSR</b>	Latin American and Caribbean Regional Health Sector Reform Initiative
<b>Law No. 42-01</b>	General Health Law of 08 March 2001
<b>Law No. 87-01</b>	Law Establishing the Dominican Social Security System of 09 May 2001
<b>NGO</b>	Nongovernmental organization
<b>NHS</b>	National Health System
<b>ONAPLAN</b>	National Planning Office
<b>ONE</b>	National Office of Statistics
<b>PAHO</b>	Pan American Health Organization
<b>PRISS</b>	Social Security Fund for Collection and Information [ <i>Patronato de Recaudo e Informática de la Seguridad Social</i> ]
<b>SDSS</b>	Dominican Social Security System
<b>SENASA</b>	National Health Insurance Authority
<b>SESPAS</b>	Ministry of Public Health and Social Assistance
<b>SISARIL</b>	Bureau of Occupational Health and Safety
<b>TB</b>	Tuberculosis
<b>TSS</b>	Social Security Treasury
<b>UNAIDS</b>	Joint United Nations Program on HIV and AIDS
<b>USAID</b>	U.S. Agency for International Development

## EXECUTIVE SUMMARY

In recent decades, the Dominican Republic has undergone enormous economic and social transformations, driven by global changes and their own internal dynamic. In the health sector, these changes have been prompted by the approval, in 2001 of the General Health Law (Law No. 42-01), enacted 8 March 2001 and the Law Establishing the Dominican Social Security System (Law No. 87-01).

These laws have laid the foundation for the creation of the National Health System (NHS) and the Dominican Social Security System, respectively. Law No. 42-01 regulates all activities that make it possible for the State to ensure the right to health while Law No. 87-01 lays the groundwork for the development of a social protection system with universal coverage, promoting the growth of insurance coverage via social contributions by employers, the State, and workers.

Moreover, this new legal framework mandates the necessary changes so that the functions of the National Health System—steering role, service provision, assurance, and financing—are divided and assumed by the different institutions that comprise it. These institutions include the Bureau of Occupational Health and Safety (SISALRIL), the Social Security Treasury (TSS), the National Health Insurance Authority (SENASA), and the Bureau of Consumer Information and Protection (DIDA), all of which began operations in 2002.

According to the 2002 census, the country has a population of 8,562,541 and a population density of 175.9 inhabitants per km. Urban dwellers account for 63.6% of the population and there is an observable decline in the annual growth rate of the population, from 1.73% in the period 1990-1995 to 1.61% in the period 2000-2005, which could be related to the decline in the total fertility rate and crude birth rate of both sexes. The total fertility rate has declined from 3.23 children per woman in the period 1990-1995 to 2.99 children in the period 2000-2004, representing a 0.24% reduction. Life expectancy has increased between these two periods, from 71.86 to 74.35 years. With regard to the health-disease profile of the Dominican population, the country is currently in a stage of epidemiological transition, characterized by a decline in infectious diseases and the growth of chronic noncommunicable diseases.

The 2005 ***Strategic Agenda and Critical Roadmap for Health Reform*** was developed as a coordination instrument for the implementation of the relevant actions of the various health sector institutions, with a view to advancing the reforms. This agenda proposes four major objectives for the health sector reform:

- 1 Strengthening the Ministry of Public Health and Social Welfare's (SESPAS) steering role, based on the *essential public health functions* (EPHFs) and the reorganization and transformation of public health programs;
- 2 Organizing and structuring regional public health services networks;
- 3 Ensuring equitable access to quality drugs; and
- 4 Guaranteeing universal insurance coverage for the entire population, with emphasis on the most disadvantaged groups.

With a view to fulfilling the Millennium Development Goals (MDGs), that same year SESPAS formulated and implemented its Zero-Tolerance Strategy, geared toward reducing the incidence of seven priority health problems: maternal mortality, infant mortality, vaccine-preventable diseases, dengue, malaria, tuberculosis, HIV/AIDS, and rabies.

## INTRODUCTION

The periodic evaluation of health sector reforms in Latin America and the Caribbean has contributed to new conceptual developments and made it possible to make adjustments to the agendas of the new reforms, thus facilitating the implementation and systematization of national efforts to strengthen health systems and the monitoring of impact in terms of achieving those objectives and goals originally proposed.

This document proposes an overview of developments in health sector reforms of the Dominican Republic: their beginnings, achievements, and deficiencies, as well as new challenges faced by health institutions as a consequence of the legislation underlying the creation of the National Health System (NHS).

This health system profile is based on the review of the available sources of information, and on the models for processing and analyzing this data, in accordance with the methodology developed by the Pan American Health Organization (PAHO) in collaboration with the U.S. Agency for International Development (USAID).<sup>1</sup>

Accordingly, this profile includes the description of the situation, trends, and determinants of health and disease profiles of the Dominican population, as well as the analysis of the demand for health services. It also describes the structure of health services and the situation of human resources in health.

One innovative feature of this profile is the mapping of actors, which makes it possible to identify the relevant health system actors based on the responsibilities assigned to each by the national regulatory framework, and to analyze their power, position, and capability for action with regard to the different strategies of health system development.

The end objective of this profile is to facilitate an analysis of the changes to the National Health System (NHS), with a view to becoming a valuable tool for decision-making.

---

<sup>1</sup> PAHO/USAID. *Methodological Guidelines for the Development of Health System Profiles and for Monitoring and Analyzing Health Systems Change*, Special Edition No. 18, Washington, D.C., 2006.

## **1. CONTEXT OF THE HEALTH SYSTEM**

The approval in 2001 of a new legal framework in health has marked the beginning of major reforms to the health system of the Dominican Republic. The General Health Law (Law No. 42-01, enacted 8 March 2001) and the Law Establishing the Dominican Social Security System (Law No. 87-01, enacted 9 May 2001) have laid the foundations for the creation of the National Health System (NHS) and the Dominican Social Security System, respectively. Accordingly, Law No. 87-01 prepares the ground for the development of a social protection system with universal coverage, promoting the growth of insurance coverage via social contributions by employers, the State, and workers for the most low-income groups.

This new legal framework holds the State accountable for guaranteeing the health of the entire population and mandates the necessary transformations so that the functions of the National Health System—the steering role, service provision, assurance, and financing—are divided and assumed by the different institutions that comprise it. Accordingly, SESPAS is tasked with the steering role of health and carrying out public health interventions.

Responsibility for financing the delivery of health care services to the low-income population is transferred, via supply subsidies, to the National Health Insurance Authority (SENASA), which purchases these services from health facilities organized into decentralized, regional public provider networks. Subsequently, these networks will form the Regional Health Services, which shall enjoy legal and administrative autonomy.

Articles 127 through 129 of Law No. 87-01 establish the plan of benefits and plan of health services to which the population will have a guaranteed right once the appropriate system of insurance has been identified and selected. Pursuant to the mandate provided under this legislation, the National Social Security Council (CNSS)—the regulatory agency charged with its enforcement—has specified the contents of the basic health plan (BHP) that the Dominican Social Security System (SDSS) must extend to the entire population, regardless of the system a person is affiliated to in function of his/her job situation. The BHP includes curative treatment at the three levels of care, as well as preventive personal health services.

Preventive population-based health services are explicitly excluded from the BHP financing, inasmuch as they are understood to be the responsibility of the State and should therefore be financed with public funds.

## 1.1. HEALTH SITUATION ANALYSIS

### 1.1.1. Demographic Analysis

According to the 2002 census,<sup>2</sup> the country has a population of 8,562,541 and a population density of 175.9 inhabitants per km<sup>2</sup>, with annual growth in the years since the last census (1993-2002) of approximately 1.8% per year (1.73 in the period 1990-1995 to 1.61 in the period 2000-2005).

DEMOGRAPHIC TRENDS

	1990-1994		1995-1999		2000-2005	
	Men	Women	Men	Women	Men	Women
<b>Total Population</b>	3,629,834	3,533,824	3,946,958	3,836,534	4,298,144	4,182,649
<b>% Urban Population</b>	49.2	52.5	56.0	59.1	60.2	63.4
<b>% Population Under Age 15</b>	19.9	19.2	19.2	18.6	18.2	17.5
<b>% Population Age 60 and Over</b>	2.7	2.71	2.83	2.84	2.97	3.01

Source: Dominican Republic. National Office of Statistics. Eighth National Census of Population and Housing 2002.

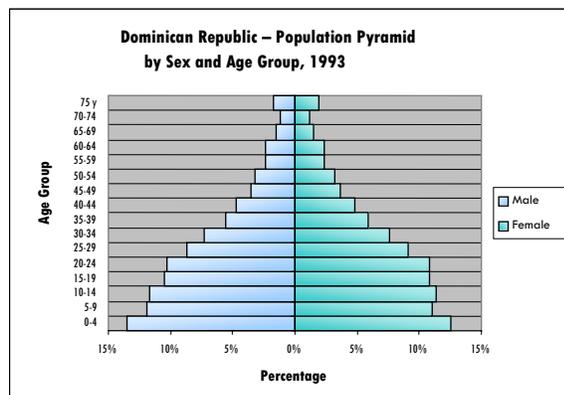
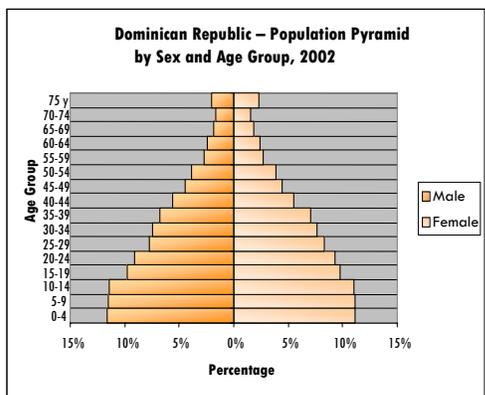
Also worthy of mention is that 63.6%<sup>3</sup> of the population resides in urban areas. The annual growth rate of the population is currently declining, from 1.73% in the period 1990-1995 to 1.61 in the period 2000-2005, which could be linked to a declining total fertility and crude birth rate for both sexes.

There has also been an observable decline in the total fertility rate, from 3.23 children per woman in the period 1990-1995 to 2.99 children in the period 2000-2004, representing a 0.24% reduction.

The crude birth rate per 1,000 population for both sexes has declined from 28.43 in the period 1990-1995 to 26.06 in the period 2000-2004. The difference in life expectancy at birth by sex has increased from 66.47 years in the period 1990-1995 for males to 68.11

<sup>2</sup> Dominican Republic, National Statistics Office. VIII National Census of Population and Housing (2002).

years in the period 2000-2004. For women, life expectancy has increased from 71.86 years to 74.35 years between the two periods, which is reflected in the population pyramids below.



Moreover, no significant change was observed in the crude death rate for the period 1990-1995 (5.87) with respect to the period 2000-2004 (5.51).

### 1.1.2. Epidemiological Analysis

The country is in a stage of epidemiological transition, characterized by a decline in infectious diseases and an increase in chronic non-communicable diseases; and declining malnutrition in terms of the increase in overweight and obesity. There are significant differences between urban and rural areas with respect to the annual prevalence of moderate and severe nutritional deficits among children under 5. For the period 1990-1994, the prevalence of these deficits in rural areas was 14.3, falling to 8.5 in the second 5-year period, and to 6.9 in the third; whereas the corresponding prevalence for urban areas fluctuated—from 7.7 in the first period, 3.9 in the second, and 4.3 in the third.<sup>4</sup> The prevalence of exclusive breast-feeding was 10% of live births during the first 120 days of life for the period 2000-2004.

In terms of annual cases of vaccine-preventable diseases, during the period 1990-1995 there were 568 confirmed cases. During 2002 there were a combined total of 1,111 confirmed cases of the following diseases: diphtheria, whooping cough, and non neonatal

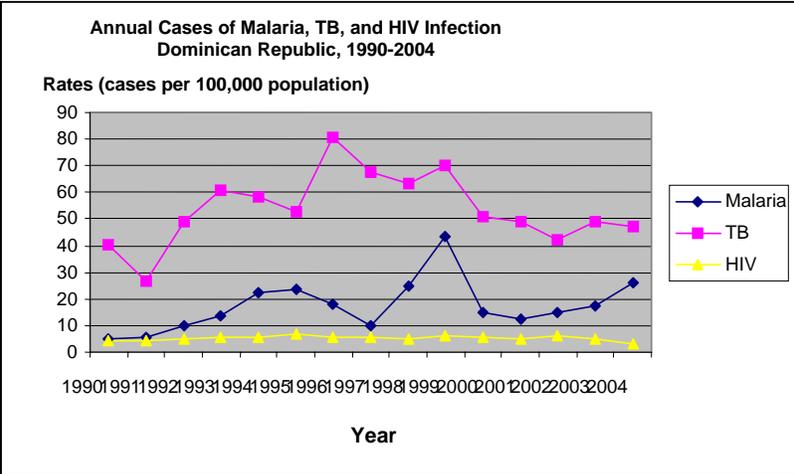
<sup>3</sup> Presidential Commission on the Millennium Objectives for Sustainable Development and the United Nations System. Dominican Republic (2004).

<sup>4</sup> Population and Health Survey: ENDESA 2002.

tetanus. These diseases have been reduced considerably since the 1980s, from rates of roughly 10 cases per 100,000 population to below 0.1. In 2002, there were 35 reported cases of diphtheria and 10 cases of whooping cough. In accordance with the data of the Expanded Program on Immunization (EPI), the percentage of the population under age 1 vaccinated against diphtheria, whooping cough, and tetanus in 2002 was 72.8%.

**1.1.3. Millennium Development Goals**

In order to meet the commitments assumed at the Millennium Summit, held at United Nations headquarters in September 2000, SESPAS formulated and implemented a “Zero Tolerance Strategy” to reduce seven priority health problems: maternal mortality, infant mortality, vaccine-preventable diseases, dengue, malaria, tuberculosis, HIV/AIDS, and rabies.



Source: DIGEPI/CENCET/DIGECITSS

The trend in the incidence of **malaria** cases has been on the rise. In the period 1990-1994 there were 4,088 confirmed cases of malaria, with 9,633 confirmed cases in the period 1995-1999, and another 11,287 in the period 2000-2004, for an annual average of 2,257 cases.

The annual incidence of **tuberculosis** for the period 1990-1994 was 45.24 cases per 100,000 population, and 65.8 cases per 100,000 population for the period 1995-2000.

In regards to **Dengue fever**, an increase in the number of cases has been observed and can be attributed to the strengthening of the epidemiological surveillance system, which

has confirmed 1,734 cases for the period 1990-1994, and 5,587 cases for the period 2000-2004.

The annual incidence of **HIV/AIDS** has been declining. In the period 1990-1994, some 1,800 cases of HIV infection were reported to the surveillance system; in the period 2000-2005 there were 2,324 new cases reported; and in the period 2000-2005 there were 2,110 cases reported. The man-to-woman ratio has ranged from 2.1 in the period 1990-1994 to 1.4 in the period 2000-2004.

With regard to **infant mortality** in recent years, estimated mortality has declined from 47 per 1,000 live births in the period 1990-1995 to 40 per 1,000 in 1995-2000, and according to the most recent population survey,<sup>5</sup> was 31 per 1,000 live births for the period 1997-2002.

The number of deaths due to **maternal mortality** in the country is significant, due to high underreporting and ill-defined causes. A 1999 study of the maternal mortality surveillance system captured 260 deaths that year, for a rate of 122 deaths per 100,000 live births. Assuming that the same level of underreporting applied to deaths reported in 2002, the estimated number of maternal deaths for that year would have been 283 or 124 deaths per 100,000 live births. There were 163 maternal deaths reported in 2002, for a reported maternal death rate of 71.4 per 100,000 live births. Toxemia was the leading cause of maternal mortality reported to the system.<sup>6</sup>

According to epidemiological surveillance system data on events monitored under the Zero Tolerance Strategy, maternal mortality reported to the system in 2006 accounted for 80 maternal deaths per 100,000 live births. According to ENDESA 2002, health professionals attended almost all pregnancies (99%) in the country. Ninety-seven percent of deliveries are attended in health facilities, 75.5% of which in public hospitals. However, the existence of elevated indices of maternal mortality together with a high level of health care coverage points to deficiencies in the organization and quality of care.

---

<sup>5</sup> Population and Health Survey: ENDESA 2002.

<sup>6</sup> Dominican Republic Health Situation Analysis, 2003.

## 1.2. HEALTH DETERMINANTS

As is the case worldwide, the health of the country's population depends on different factors that influence the behavior of health indicators—namely, the political, economic, social, and environmental determinants of health.

### 1.2.1. Political Determinants

In recent decades, the country has undergone enormous economic and social changes, driven by global changes and their own internal dynamic. These changes have been accompanied by periods of profound economic crisis and caused the country to establish new ways of relating to other countries through subregional trade agreements, such as the Central America-United States-Dominican Republic Free Trade Agreement (CAFTA-DR) and the Central American Integration System (SICA).

### 1.2.2. Economic Determinants

During the 1990s, the Dominican Republic led Latin America and the Caribbean in economic growth. The country's per capita income shot up from US\$1,410 in 1990 to US\$2,080 in 1999, accounting for a 47% increase, and in 2000 surpassed US \$2,100, with a gross domestic product (GDP) growth of 5.9% in the period 1991-2000<sup>7</sup>. However the most vulnerable groups did not benefit from this improvement of living conditions; in fact, poverty among this group increased. This was the situation according to data of the country's economic agencies and confirmed by the World Bank in a report stating that in 2002 some 2.7% of the country's urban population was living in extreme poverty and that by the end of 2004, 42 of every 100 Dominicans were poor and that of these 16 were living in extreme poverty.<sup>8</sup>

**INCIDENCE OF POVERTY IN THE DOMINICAN REPUBLIC, 2000-2003**

	ONAPLAN Category	Period			
		2000	2001	2002	2003
Poverty	% below poverty line	54.05%	54.30%	56.36%	61.70%
	Number of people below poverty line	4,679,331	4,823,245	5,132,451	5,714,738

<sup>7</sup> 2004-2015 Strategy for Reducing Poverty in the Dominican Republic.

<sup>8</sup> Dominican Republic and Latin America need to reduce poverty to promote growth. Press Release No. 2006/13/RDALC.

<b>Extreme poverty</b>	% below extreme poverty line	27.77%	26.43%	28.44%	33.01%
	Number of people below extreme poverty line	2,403,283	2,346,839	2,590,581	3,057,121
	Extreme poverty line (in current RD\$)	715	779	819	1,044

Source: HDO, with the Central Bank's Workforce Survey.

According to measurements based on National Health Accounts data, the country's expenditures in health amount to 7.3% of the GDP. Of this amount, 67.7% corresponds to the private sector, while only 32.3% is contributed by the public sector or 2.4% of the GDP. Of the total expenditures in health, out-of-pocket payments for 1997-1998 accounted for 75%,<sup>9</sup> while the corresponding figure for 2002 was 88.2%.<sup>10</sup>

### 1.2.3. Social Determinants

Economic growth in the Dominican Republic has not been associated with human and social development. Accordingly, there is no correlation between the production of wealth and the promotion of an environment that grants viability to the full exercise of human capabilities.

According to data of the United Nations Development Program's *Human Development Report 2004*, the Dominican Republic has lost ground in the Human Development Index, that year ranking 98th out of 199 countries, down from 94th in 2002 and 2003.<sup>11</sup>

Other social indicators to take into account include the population with access to drinking water, which was 87.6%<sup>12</sup> for the period 2000-2004, while 89.5% of the population had access to excreta disposal systems. The gross primary school enrollment ratio is 115 for boys and 109 for girls with a dropout rate of 5.7%. Moreover, 7.9% of the population in the 15-24 years age group is illiterate. With respect to child labor, some 9% of children in the 5-14 years age group perform some type of remunerated work.<sup>13</sup>

<sup>9</sup> SESPAS/PROSISA. A Reform for Health, Santo Domingo 2004.

<sup>10</sup> Economic Indicators in Health, 2002. National Health Accounts Unit, SESPAS

<sup>11</sup> United Nations Development Program; Human Development Report data (1990-2004).

<sup>12</sup> Population and Health Survey: ENDESA 2002.

<sup>13</sup> Health Situation in the Americas: Basic Indicators 2002.

#### **1.2.4. Environmental Determinants**

With respect to concerted environmental action the country is considered to be in its initial stages of development, since, prior to 2000, such action was carried out by a number of different institutions. That year, the Ministry of Environment and Natural Resources [*Secretaría de Estado de Medioambiente y Recursos Naturales*] was created by Law No. 64-00, conferring on the Ministry the authority to coordinate environmental action at the national level. Accordingly, Law No. 64-00 requires natural resources and environmental protection programs to be integrated into economic and social development plans and programs, thus facilitating the Ministry's interaction with the different state and private institutions involved in activities that impact the environment.

Such is the case of the Bureau of Environmental Health [*Dirección General de Salud Ambiental*], an agency of the Ministry of Public Health and Social Assistance (SESPAS), which is responsible for biotic matters or actions affecting the environment and the health of individuals i.e., the control of water and beverages for human consumption, food quality, vector and zoonosis control, and the emissions of gases.

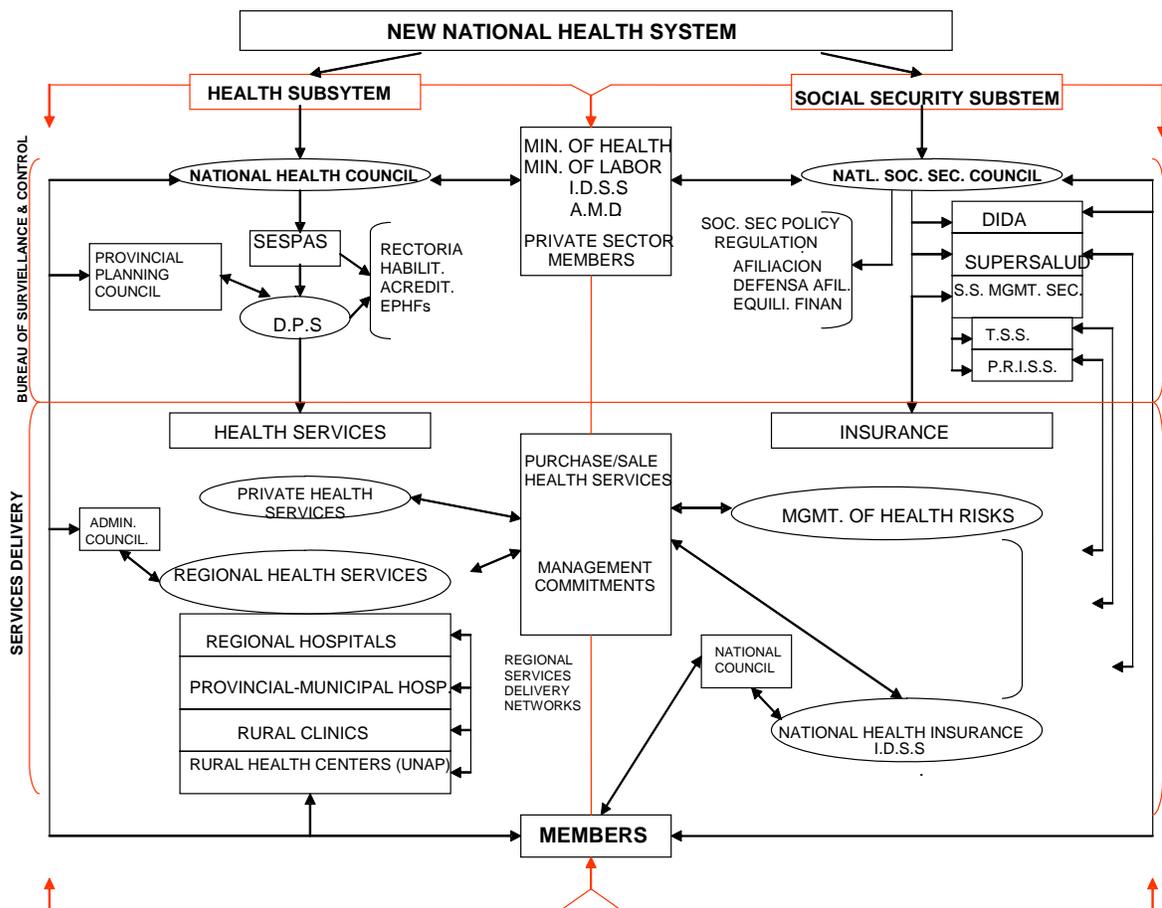
With regard to environmental health indicators, the country carries out specific activities in areas such as the monitoring of water quality, with a view to diminishing the occurrence of water-borne infections. These actions are protected under the General Health Law and Decree-Law No. 528-01 on the Regulations for the Safety and Control of Food and Beverages. These instruments, together with international agreements, govern the regulation and inspection of all aspects related to radioactive materials and toxic products that impact the environment and, consequently, the health of the population.

## **2. HEALTH SYSTEM FUNCTIONS**

### **2.1. STEERING ROLE**

Stemming from the current legal framework in health, Law No. 42-01 (General Health Law) and Law No. 87-01 (Law Creating the Dominican Social Security System – SDSS), new institutions and agencies of the health system are created, which constitute the foundation of the new National Health System (NHS). These institutions include the Bureau of Occupational Health and Safety (SISALRIL), the Social Security Treasury (TSS), the

National Health Insurance Authority (SENASA), and the Bureau of Consumer Information and Protection (DIDA), all of which began operations in 2002. Also included are collegiate bodies, such as the National Social Security Council (CNSS), the Social Security Management Secretariat (GSS), and the National Health Council (CNS).



Moreover, the legal framework in health has mandated a restructuring of existing institutions as a requirement of National Health System development. The Ministry of Public Health and Social Assistance (SESPAS), with a view to strengthening its steering role as the system's lead health agency, began the transition toward the separation of functions, deconcentration, and decentralization. This mandate has been in keeping with reforms at the central and territorial levels. At the central level, a restructuring of the functions of the main under secretariats was evident (i.e., the Office of the Undersecretary for the Health Care of Individuals, and the Office of the Undersecretary for Public and Technical Health), while at the territorial level efforts were geared toward providing the

Provincial Health Bureaus (local public health authority representatives) and the Regional Health Bureaus (responsible for the organization and management of health services networks) with the skills and resources necessary to fully carry out their respective roles.

Via legal decree, the Dominican Social Security Institute (IDSS) ceased to be responsible for the administration, regulation, and financing of the country's social security system. Accordingly, it became an administrative entity in charge of assessing health and occupational labor risks and for providing health services.

The emergence of the new institutions of the Dominican social security system has been accompanied by a redefinition of the system's functions. Formerly, SESPAS performed all social security system functions: as the lead agency, it was responsible for the steering role, financing (through funds issued by the central government), services delivery (through the nationwide network of establishments), with the exception of insurance, which, for the public sector, was offered through the Dominican Social Security Institute and for the private sector through prepaid health systems (*iguales médicas*) and retirement plans.

The new legal framework upholds SESPAS' steering responsibility, and affirms that SESPAS shall be responsible for the steering role of the National Health System at the regional, local, and technical levels. Accordingly, SESPAS' steering role is understood as its political capacity to regulate the social production of health, guide and institute health policies and actions; harmonize interests; mobilize all types of resources; monitor health; and coordinate the activities of the different public- and private-sector institutions and other social actors committed to the production of health, all with a view to ensuring compliance with national health policies.<sup>14</sup>

### **2.1.2. Implementation of the General Health Policy**

With a view to fulfilling the mandates established under the legal framework in terms of the organizational restructuring and strengthening of actions and activities that make it possible to meet the Millennium Development Goals (MDGs), the National Health Policy is

---

<sup>14</sup> General Health Law (Law No. 42-01).

geared toward increasing the people's access to the health services and reorganizing health services by the different levels of care, prioritizing the first level, based on the primary care strategy.

Another focus of the policy framework is to improve access to quality, low-cost drugs and to increase health insurance coverage. One of the backbones of the policy framework is to enhance human resources development through training, incentives, new forms of personnel contracting, and to strengthen information systems that promote transparency in sector activities in this regard.

Currently, the country is working to prepare a 10-year health plan which will be used as one of the main instruments to ensure the continuous, comprehensive, and systemic regulation of the social production of health. The plan is being prepared on the basis of the current health situation and the country's commitment to the Millennium Development Goals and incorporates the "Zero Tolerance Strategy," which mandates the surveillance and monitoring of communicable, preventable, and controllable diseases and events in the areas of infant and maternal mortality. A preliminary version of the plan is under consultation with different sectors and social actors for their input.

With respect to cooperation in health, the country receives technical cooperation from different international organizations and agencies, such as the PAHO, USAID, the Japan International Cooperation Agency (JICA), the United Nations Children's Fund (UNICEF), the European Union, the German Agency for Technical Cooperation (GTZ), the Joint United Nations Program on HIV and AIDS (UNAIDS), the Global Fund to Fight AIDS, Tuberculosis, and Malaria. The country also receives financial support through lending agencies such as the World Bank and the Inter-American Development Bank (IDB). To coordinate the efforts of these lending institutions, SESPAS created a Modernization and Institutional Development Unit (UMDI)<sup>15</sup> in 2003.

Decree No. 308-97 of 10 July 1997 created the Executive Commission for Health Sector Reform (CERSS), designed to promote reform of the health sector. The CERSS currently serves as a coordinating unit for reform projects implemented with funds from the international lending agencies.

---

<sup>15</sup> Cooperation Strategy with the Dominican Republic, 2007-2011.

### **2.1.3. Regulation**

The General Health Law confers on SESPAS, as the country's steering agency in health, the responsibility for regulating the health sector and authority to impose any necessary sanctions in cases when health is endangered. SESPAS maintains local offices to perform supervisory functions in its spheres of activity and to observe compliance with health guidelines, with support from the central authorities of SESPAS.

### **2.1.4. Evaluation of the Essential Public Health Functions**

An evaluation of the performance of the Essential Public Health Functions (EPHFs) was carried out in June 2001, yielding the following results.

The function related to public health surveillance, research, and the control of public health risks and threats scored higher than all other EPHFs, which can be attributed to the emphasis the country has placed on surveillance, both in terms of training and in operations. The second highest score obtained was for the function related to mitigating the impact of health emergencies and disasters.

The functions with the poorest performance were: citizen participation in health; human resources development and training in public health; and quality assurance of personal and population-based services.

Also the score obtained for the public health research function, which is essential for the development and implementation of innovative public health solutions, placed it in the lower intermediate quartile, which may indicate an apparent lack of attention to the research<sup>16</sup> function.

---

<sup>16</sup> Workshop to Evaluate the Performance of the Essential Public Health Functions, June 2001.

## 2.2 FINANCING AND ASSURANCE

### 2.2.1. Financing

Since 1996, the country has begun implementing measures to ensure transparency in all facets of health sector financing, with a view to the equitable distribution of available resources, in this way guaranteeing that the entire population has access to services. Within this framework, SESPAS' National Accounts Unit was created in 2004. The purpose for creating the Unit was to maintain an ongoing dialogue with authorities responsible for planning, monitoring, and executing the country's budget in health.

In 2002, the per capita health expenditure was US\$60, while the public expenditure in health accounted for 8.9% of the national budget in 1999, increasing to 11.07% (1.73% of GDP) and 9.53% (1.67% of GDP), respectively for 2000 and 2001. However, government spending in health for 2004 declined to 5.52% of the national budget, representing only 0.98% of GDP. In recent years the country's public expenditure on health as a percentage of GDP has remained lower than 2%, although different trends have been observed in specific years.<sup>17</sup>

If we look at health expenditures by function, we can see how health financing is broken down in the national budget. On the one hand, under the intermediary system, through which medical supplies are provided to hospital centers, hospitals receive an amount equivalent to 40% of the budget or "replaceable funds" that SESPAS allocates to each of its hospital centers.

These funds are allocated for curative services such as hospitalization, ambulatory care, drugs and administrative services, which, according to the National Accounts System, in its evaluation of health expenditures by function for 2002 (last available) is 41.2%, while preventive services account for 5.0% of the national health expenditure by function.

Private expenditures for the same period, according to the National Accounts Unit's evaluation of health expenditure by fiscal agent, accounted for 67.7% of the national health expenditure.

---

<sup>17</sup> Economic Health Indicators, 2002. National Accounts Unit, SESPAS.

### 2.2.2. Assurance

Health insurance for the population is extended through both public and private entities known as Health Risk Administrators (ARS), whose function is to assume the risk of guaranteeing that beneficiaries receive quality, timely, and satisfactory protection by streamlining service costs and achieving adequate levels of productivity and efficiency, which they obtain through contracts with health service providers. Insurance for low-income groups is provided by the Unified System of Beneficiary Identification (SIUBEN), a division of the Social Cabinet [*Gabinete Social*].

Article 149 of Law No. 87-01 creates the Health Risk Administrators, while Article 159 designates the National Health Insurance Authority (SENASA) as the public insurer responsible for covering all civil servants, employees of autonomous or decentralized institutions, and their family members.<sup>18</sup>

The Bureau of Occupational Safety and Health (SISARIL) is the country's insurance regulatory entity. SISARIL is in charge of regulating and overseeing the performance of institutions offering health care insurance in order to ensure they do not practice discrimination or adverse selection that will impact the right to health of members. Additionally, SISARIL is also responsible for ensuring that insurers have the necessary financial solvency to guarantee the quantity of health services their beneficiaries<sup>19</sup> demand.

The two newly enacted laws are designed to ensure that health system users and beneficiaries can exercise their right to health and establish the guarantee of a Basic Health Plan that contains all the necessary services, based on age group and risk. These services are the same for both the public and private sectors and include specific public health actions, such as immunizations for children under 5.

In addition, health system users have an agency that works to defend their rights: the Bureau of Consumer Information and Protection (DIDA), which has created mechanisms to provide information on and defend the rights of users.

---

<sup>18</sup> Law Creating the Dominican Social Security System (Law No. 87-01).

<sup>19</sup> Law No. 87-01, Article 148.

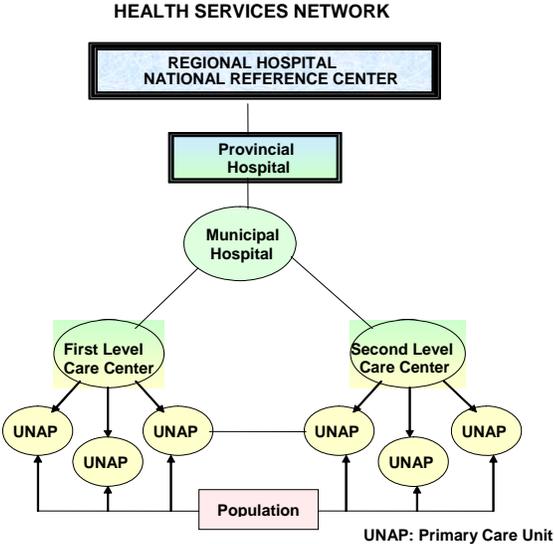
By 1996, 12.4% of the population had private health insurance coverage and another 5.4% had coverage through the Dominican Social Security Institute. This means that approximately 18% of the population had some type of insurance while 80.5% had none. Already by 2002, since the Social Security Law was enacted, 21% of the total population was covered by some form of insurance.<sup>20</sup>

## 2.3. HEALTH SERVICES DELIVERY

### 2.3.1. Health Services Supply and Demand

The new legal framework and its complementary regulations also prompted changes in the delivery of services. One such change was the approval of the model for the Regional Health Services (SRS) network in the Dominican Republic, pursuant to Internal Provision No. 24-05.

With respect to the delivery of health services, the health authority, through the SRS, is able to promote coordination among the different levels of care in the network, linked to the creation of the Family Health Insurance model:



The SRS provides health services to the population by their geographical distribution, in health establishments and services arranged by level of complexity or levels of care. To

<sup>20</sup> Population and Health Survey: ENDESA 2002.

this end, the SRS shall include, at minimum, three (3) levels of care:

1. Facilities of the **first level of care**—rural clinics, dispensaries, and physician's offices—must guarantee health care at a lower level of complexity that does not require stays in the hospital. Care at this level is based on the primary health care strategy.
2. Specialized basic level facilities of the **second level of care**, which include the **general hospitals** (municipal or provincial), must guarantee specialized health care of a lower level of complexity which may require stays in the hospital.
3. Facilities at the tertiary level of care include **Regional and Specialized Hospitals**, whose portfolio of services covers all in-hospital contingencies for the delivery of services of greater complexity, including those identified as services of national reference, specialized care centers, and diagnostic centers.

According to SESPAS' 2004 Annual Report, the public sector has 1,234 health centers (12 specialized hospitals, 40 provincial hospitals, 87 municipal hospitals, 739 clinics, and 324 physician's offices and dispensaries, of which the last three categories are included in the first level of care). That same year the country had 2.2 beds per 1,000 population.<sup>21</sup>

Services provided directly to individuals aim at covering the entire Dominican population, especially the most disadvantaged groups. According to ENDESA 2002, 60% of the population seeking medical care and hospitalization goes to public health facilities, especially SESPAS hospitals. The demand for these services is primarily associated with people living in rural areas and low-income urban dwellers.

### **2.3.2. Health Workforce**

The country's various professional associations report the following information on the number of health professionals: 18,450 physicians (20 per 10,000 population);<sup>22</sup> 3,603 nurses (3.9 per 10,000 population);<sup>23</sup> 2,946 bioanalysts (3.2 per 10,000 population);<sup>24</sup> 8,320 dentists (9 per 10,000 population);<sup>25</sup> 3,940 pharmacists (4.3 per 10,000 population);

---

<sup>21</sup> SESPAS. 2004 Annual Report.

<sup>22</sup> Dominican Association of Medical Doctors, April 2006.

<sup>23</sup> Dominican Nurses Association, April, 2006.

<sup>24</sup> Dominican Association of Bioanalysts, April 2006.

<sup>25</sup> Association of Dominican Dentists, May 2006.

and 15,511 auxiliaries/nursing technicians (15 per 10,000).<sup>26</sup> Over the last two years there has been a significant increase in human resources for health in all categories, with the exception of professional nurses and health technicians.

Between 1994 and 2004, the number of health professionals employed in all categories of the SESPAS increased across the board. Accordingly, the number of physicians increased from 5,626 to 9,204; nurses and auxiliaries from 8,600 to 11,333; dentists from 376 to 1,431; and pharmacists from 372 to 527. Information on the geographical distribution of human resources in the country is only available for the public subsector (2002), which varies from 5.6 physicians per 10,000 population in the province of Azua to 38.5 per 10,000 in the National District.<sup>27</sup>

Currently, 18 universities in the Dominican Republic offer one or more careers in the health sector. At the professional level, there are nine medical schools; 11 schools of nursing; six schools of bioanalysis; 11 schools of dentistry; and four schools of pharmacy. Enrollment in health areas has increased significantly: in only two years the number of students jumped from 30,360 (2003) to 40,479 (2005), and enrollment by sex is highly significant, inasmuch as 78% of students in health curricula in 2003 and 76% in 2005 were women. Medical school consistently attracts the greatest number of students, with 24,186 aspiring doctors in 2005. In addition to attracting the largest number of students, medical school enrollments grow at a higher rate than all other health sector careers.

With respect to graduate education, the country offers more than 40 specialty and subspecialty programs. During the first year of graduate school, SESPAS offers residency programs for more than 360 students. Medical residencies are carried out at 15 teaching hospitals. Currently offered are two masters' degree programs in public health, a masters program in bioethics, a masters in health management, and a specialty degree in health and social security reform, in addition to other programs in child, maternal, and adolescent health.

The prevailing trend in medical education continues to be specialization in clinical areas after medical school. In recent years programs for the study of family health have been

---

<sup>26</sup> Paid positions at SESPAS and the Dominican Social Security Institute, March 2004.

<sup>27</sup> SESPAS basic health indicators, 2003.

growing slowly. Consequently, there are not enough family doctors to meet the needs of the care model proposed by the health and social security reforms. However, the system is not effectively absorbing these doctors, and where it does, in most cases these doctors are not being placed where they are most needed.

### **2.3.2.1. Human Resources Management and Employment Conditions**

Despite the changes occurring in the health sector and the approval of the General Human Resources Regulations, established under Decree No. 732-04, the country lacks a human resources policy that includes among other aspects a career path in health and a salary system to reward work in the health sector.

Salaries are not based on qualifications, performance, or the achievement of work objectives. However, some incentives such as those associated with occupational risks, distance, and seniority have been established. Currently a review and reclassification of jobs is under way at SESPAS, which is being supported by ONAPLAN.

SESPAS is the health sector's biggest employer. In 1997, the Census of Civil Servants reported that 27% of the workforce was employed in the health sector. In 1999, SESPAS employed 64.6% of the sector's workforce. Of these 39% were concentrated in the country's capital city; 25% in the IDSS; 8.3% in the private sector, 0.8% in the Armed Forces; and 1.0% at NGOs.<sup>28</sup> SESPAS contracts physicians in one of three ways: by appointment by the Minister of Health; via contract with doctors undergoing training in medical specialties at the teaching hospitals; and through tests. The other modality is through competitive exams to fill vacancies for specialists; however, this modality has not been used for more than seven years now.

---

<sup>28</sup> Human Resources Observatory in Health in the Dominican Republic, 2001.

## HUMAN RESOURCES IN PUBLIC SECTOR INSTITUTIONS

Temporary Period	Period								
	1990-1994			1995-1999			2000-2005 (Ratio per 10,000 population)		
Institution	Physicians	Nurses	Nursing Auxiliaries	Physicians	Nurses	Nursing Auxiliaries	Physicians	Nurses	Nursing Auxiliaries
SESPAS	5,626	N/A	8,600	7,085	1,554	10,221	8.1	1.3	11.5
IDSS	N/A	N/A	N/A	3,108	911	2,556	2.8	N/A	2.6
<b>TOTAL</b>	5,626	N/A	8,600	10,193	2,465	12,777	<b>10.9</b>	1.3	14.1

Sources: SESPAS, ASIS 2003 and IDSS, 2004

### 2.3.2.2. Governance and Organized Labor

Professional and health worker organizations constitute an active group, which include the following organizations: 1) the Dominican Association of Professional Nurses (ADEG); 2) the Dominican Nurses Association of the IDSS (AEGIDSS); 3) the Association of Health Auxiliaries and Alumni of the IDSS; 4) the Dominican Association of Medical Doctors (CMD); 5) the Medical Group of the IDSS (AMIDSS); 6) the Dominican Association of Dentists (AOD); 7) the Dominican Association of Pharmacists (ADF); and the Dominican Association of Bioanalysts (formerly ADOPLAC).

The sector also has organized labor groups, including: 1) the National Association of Health Workers (ANTRASALUD); 2) the National Federation of Health Workers of the IDSS (FENATRAS); 3) the National Union of Nursing Workers (SINATRAE); and 4) the National Union of Dominican Nursing Services (UNASED).

The CMD and the nursing associations are the most active in terms of voicing their demands. Both groups are represented in the different entities created as part of the health and social security reforms (NHAS, CNSS, DIDA, and others).

### 2.3.3. Drugs and Other Health Supplies

Although the Dominican Republic lacks a drug observatory, it does have a clearly defined drug policy, which is backed up by legislation, the Regulation on Pharmaceutical Drugs (No. 246-06), and the country's Program of Essential Drugs and Logistical Support

(PROMESE/CAL), which is responsible for the procurement and distribution of essential drugs. Also in this regard, the country is supported by the Pharmacotherapeutic Guide of Essential Drugs of the Dominican Republic, which contains the basic schedule of Essential Drugs.

Despite all these achievements, some areas of weakness persist, such as the fact that not all health facility pharmacies or those of the private sector are staffed with professional pharmacist, due to a shortage of professionals in this area.

### DRUGS

INDICATOR	1990-1994	1995-1999	2000-2004
<b>Total number of registered pharmaceutical products</b>	398	1,348	7,647
<b>% of brand-name drugs</b>	81%	82,4%	65%
<b>% of generic drugs</b>	18.6%	17.5%	35.3%
<b>% of the public expenditure in health allocated to drugs</b>	N/A	N/A	20.6

Source: Pharmaceutical Registry Department, SESPAS

### 2.3.4. Equipment and Technology

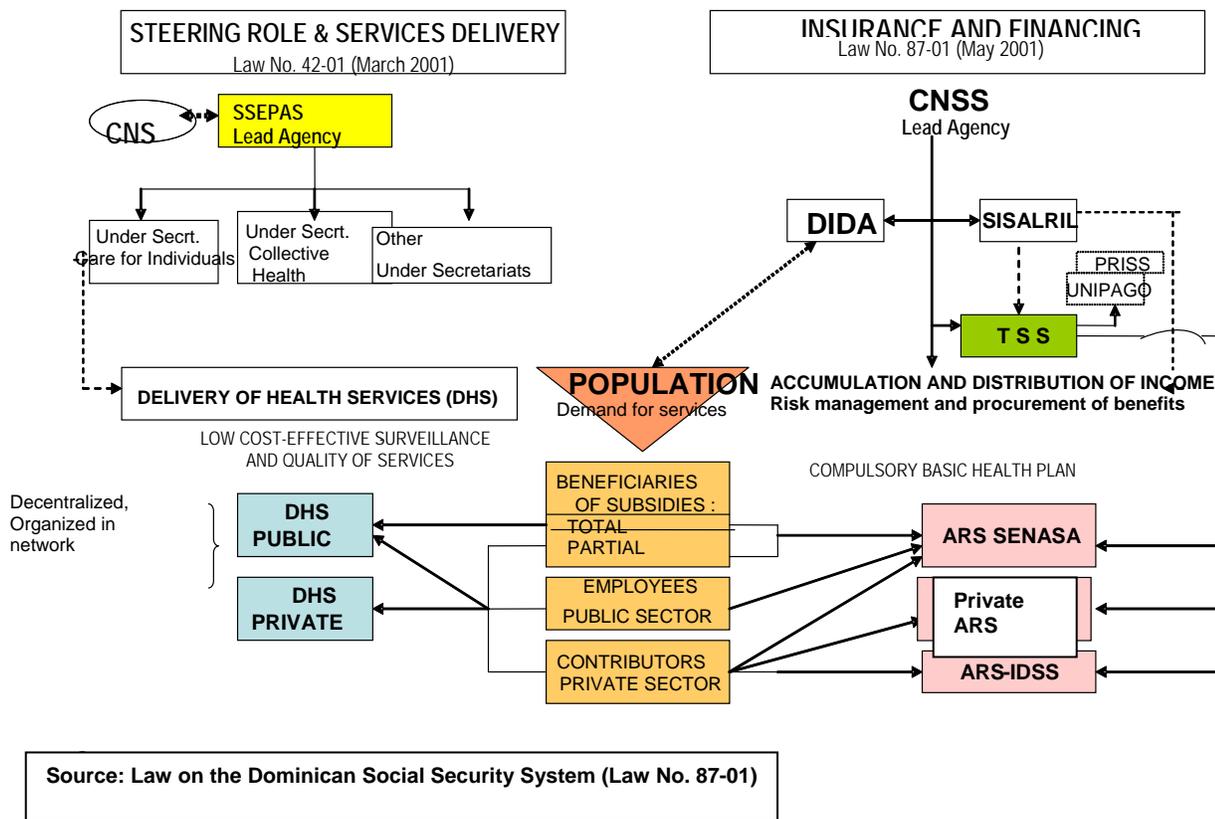
The SESPAS does not have information available on the amount of defective equipment in health establishments. This is attributable to the management culture, inasmuch as managers arrange for the repair of defective equipment directly with the manufacturers' representatives, with some exceptions.

### AVAILABILITY OF EQUIPMENT IN THE HEALTH SECTOR

Resource	Hospital beds per 1,000 pop.	Basic diagnostic imaging equipment per 1,000 pop.	Clinical laboratories per 100,000 pop.	Blood banks per 100,000 pop.
Subsector				
<b>Public</b>	2.2	N/A	2.37	0.34
<b>Private</b>	N/A	N/A	6.04 **	0.31
<b>Total</b>	N/A	N/A	8.41	0.65

Source: Blood Bank and Department, SESPAS (2003).

## 2.4. INSTITUTIONAL MAPPING OF THE HEALTH SYSTEM



## 3. MONITORING HEALTH REFORMS

### 3.1. IMPACT ON HEALTH SYSTEM FUNCTIONS

An analysis of the different stages of change and the incidence of the essential public health functions in the country would have required a methodology to evaluate health system functions, as well as the public, private, and social security subsectors over the successive five-year periods between 1990 through 2005. Because the health reforms have not been monitored in this way, it is impossible for the country to carry out this analysis. Nevertheless, below we present some landmark events that can help to shed light on the process of change in the country.

The first efforts to reform the “Health System” in the Dominican Republic date back to the early 1990s, as a result of the agreements reached between the Dominican Government

and the former Dominican Medical Association (AMD)—currently know as the Dominican Association of Medical Doctors (CMD)—at the end of a national strike that left the health sector paralyzed for more than six months. Accordingly, at that time a document was prepared describing the overburdened system and the need to reform it.

After the strike, a national team prepared a series of documents proposing programmatic reforms and a restructuring of state hospitals. One outcome of this effort was the creation of the National Health Commission, with representation of the different social actors of the system and whose responsibility it was to implement these proposals. After much study, the Commission produced another document at the end of 1996 that recycled some of the proposals of the previous effort. However, the document was more influenced by the World Bank's *World Development Report 1993: Investing in Health*, inspired on events in the rest of Latin America and based in the concept of “regulated competition” or “structured pluralism.”

The year 1994 marked the beginning of a new legislative period and the need for promoting health system reform in the Dominican Republic. Also that year a draft bill to reform the existing Health Code was introduced, which had been in effect since 1949. Despite intensive—and extensive—participation on the part of all health sector actors, the draft bill was not approved due to the inclusion of an article on abortion among other controversial articles.

A new administration took over the reins of government in 1996, offering society a whole new framework for restructuring the Dominican State. For this purpose, the State Reform Commission was created, which undertook the restructuring of the National Health Commission, establishing two programs for the reform of the health sector, to be financed with funding from multilateral agencies. Two loans—one for US\$75 million from the Inter-American Development Bank and the other for US\$30 million from the World Bank—were approved and used to transform the National Health Commission into the Health Sector Reform Commission, whose primary mission was to administer the funding for projects and provide technical support to those institutions of the sector identified for reform.

Most of the changes that were proposed in the early 1990s were implemented in 2001 through the General Health Law (Law No. 42-01) and the Law Establishing the Dominican Social Security (Law No. 87-01); two complementary and yet different processes—one

focusing on the construction of the National Health System and the other on the establishment of the Dominican Social Security System. SESPAS is responsible for the steering role and sector leadership for the first of these processes, based on Law No. 42-01, whereas the agencies of the SDSS (CNSS, SISALRIL and SENASA); are responsible for the second, based on Law No. 87-01.

In 2005 the “**Strategic Agenda and Critical Roadmap of the Health Reform**”, were defined, which set out four major objectives of the health sector reform:

1. Strengthening of SESPAS’ steering role, based on the essential public health functions and the reorganization and transformation of public health programs;
2. Organizing and structuring of the regional networks of public health services;
3. Ensuring equitable access to quality drugs; and
4. Guaranteeing health insurance for the entire population, with emphasis on the most disadvantaged groups.

### **3.2. IMPACT ON THE GUIDING PRINCIPLES OF THE REFORMS**

With regard to the principle of **equity**, the health system of the Dominican Republic is highly inequitable due to high out-of-pocket expenditures for households, which, in 1997 and 2002 accounted for 62 and 48%, respectively, of total health expenditures.<sup>29</sup> With regard to **coverage**, there have been no significant changes during the last 20 years. In fact, from 1996 to 2002, the percentage of the population with some type of insurance coverage went from 18 to 21% or an increase of only 3%.<sup>30</sup>

However, the fact that efforts to initiate health insurance coverage have gone forward in one of the regions of the country with the highest poverty rates (region IV) is an indication that the political will is in place to guarantee a response to these problems.

With respect to the **allocation of resources**, public spending on health and total public expenditure in health have been declining over the years despite the country’s economic growth. In regards to human resources, although the number of physicians per 10,000 population has been increasing from 1990 to 2005, the number of nurses per 10, 000 population has been declining. With regard to the number of hospital beds in the country

---

<sup>29</sup> Fundación Plenitud. Analysis of the National Accounts of the Dominican Republic, 2002. Final Report, November 2005.

<sup>30</sup> ENDESA 2002.

per 1,000 population, progress has been made toward reducing the existing gap: toward the end of the 1990s through 2000, there were 1.5 available beds per 1,000 population, increasing to 2.2 beds by 2004.

In terms of the **effectiveness of services**, based on the health reforms and indicators such as infant and maternal mortality, **infant mortality** has been reduced in recent years, although this has not been the case with respect to **maternal mortality**.

With regard to **malaria**, **dengue**, and **tuberculosis** the case incidence has been increasing, which in the case of the first two can be attributed to the strengthening of surveillance systems. Concerning **HIV/AIDS**, the annual case incidence has been declining.

To date, the health reforms have not resulted in any significant increases in sewerage or excreta disposal services.

According to the 2002 National Accounts, the percentage of the health budget spent on public health was 5.0% of the national health expenditure by functions. Data from years prior to 2002 are not broken down by heading.

The health reforms have legitimized the **institutions** of the National Health System, defining functions through the two main reform laws (Laws No. 42-01 and 87-01). It has also contributed to the allocation of financial resources, by identifying sources of financing for all system's functions and the capacity to negotiate and diversify these sources.

The 2001 legal framework in health provides for the broad **participation of society** in mechanisms for the co-management, control, and transparency in the delivery of health care services, through the Hospital Councils and Social Accountability Committees (*Comités de Veeduría Social*).

Before 2001, the key principles of the health reforms for the public, private, and social security subsectors were poorly defined. Thanks to the enactment of the laws underlying the reforms, clear definitions exist; however, no monitoring mechanisms have been established to evaluate their progress.

### **3.3. IMPACT ON THE HEALTH SYSTEM**

The right of citizens to health is guaranteed in the Constitution of the Republic and in the Trujillo Health Code (1956), the latter of which was repealed by the laws enacted in 2001, establishing the citizens' right to health through membership in the Family Health Insurance Program and creating a Basic Health Plan for the entire population, regardless of membership regime.

Law No. 42-01 establishes the Ministry of Public Health and Social Welfare as the lead agency of the health system and identifies the mechanisms for its regulation and management. It also establishes the separation of functions, the deconcentration of the steering role in health at the provincial level, and the decentralization of the delivery of health services by adjusting the model of health care networks to complement the different levels of care according to complexity, thus guaranteeing access to the Basic Health Plan.

Moreover the law establishes a Regional Public Health Service to satisfy the health needs of the population that belongs to the subsidized system in a timely manner and with quality services.

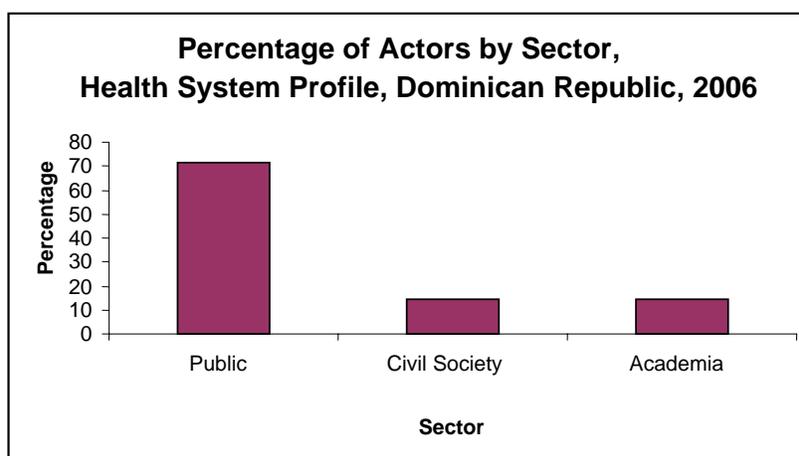
The health care networks produce changes in the labor market, creating structures and processes that require human resources trained in management specialties.

The new culture of the National Health System encourages civil society participation in the planning, implementation, and evaluation stages, as a means for promoting a strong institutional framework and good governance.

### 3.4. ANALYSIS OF ACTORS

The mapping of health sector actors began with an invitation issued by the Health Technical Department (*Subsecretaría Técnica*) to interview the key actors of the country's health system. Of all those actors invited to participate only seven were interviewed (approx. 50%), as the others were not available either because they were outside the country and had not delegated a representative who could participate or due to the limited time available to conduct the interviews.

Of those interviewed, 71.4% (five actors) were from the public sector, 14.3% (one) from civil society, and 14.3% (one) from academia.



Source: Direct interviews.

Regarding which sector was responsible for initiating the process of change: 42.9% believed that it was the health sector and roughly the same percentage believed that it was the private sector; 28.6% believed that it was initiated by the public sector, and 14.3% believed the economic and political sectors were responsible.

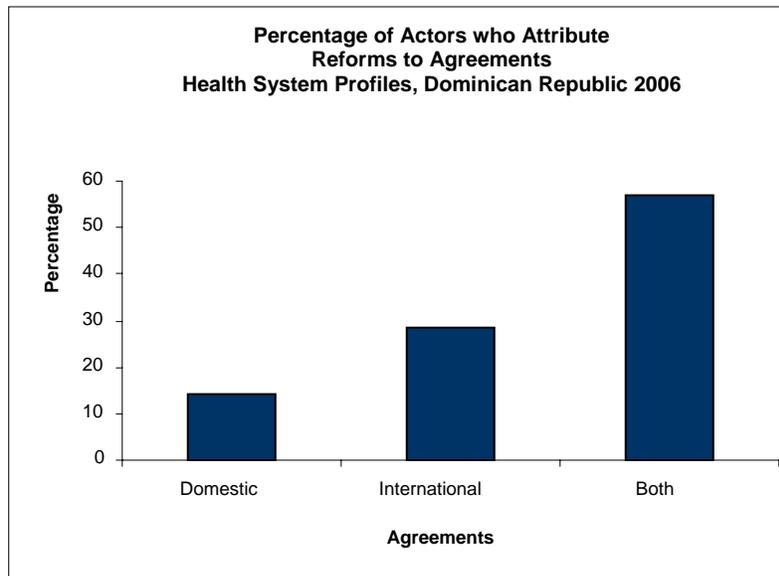
**Reform Process by Initiating Sector  
Dominican Republic, 2006**

Opinion	Sectors Initiated Process of Change									
	Economic Sector		Sector Public		Private Sector		Political Sector		Health Sector	
	No.	%	No.	%	No.	%	No.	%	No.	%
Yes	1	14.3	2	28.6	3	42.9	1	14.3	3	42.9
No	2	28.6	0	0.0	0	0.0	0	0.0	0	0.0
No data	3	42.9	5	71.4	4	57.1	6	85.7	4	57.1
Does not know	1	14.3	0	0.0	0	0.0	0	0	0	0
<b>Total</b>	<b>7</b>	<b>100</b>	<b>7</b>	<b>100</b>	<b>7</b>	<b>100</b>	<b>7</b>	<b>100</b>	<b>7</b>	<b>100</b>

Source: Direct interviews.

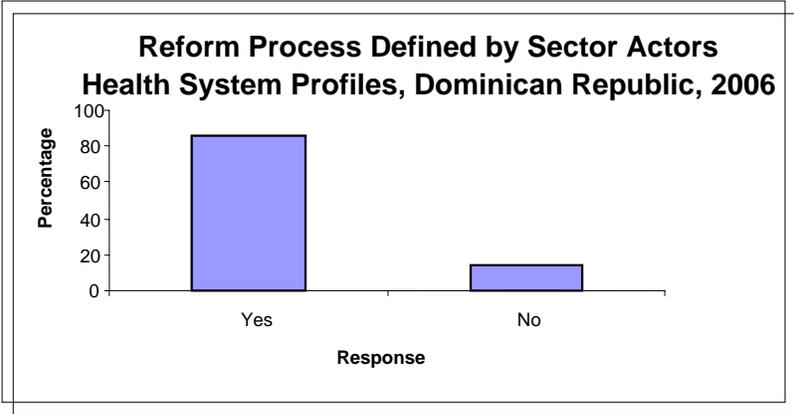
Other interviewees are of the opinion that sectors cannot be exclusive and that it began with the financial crisis of the 1990s, with the demands of the trade associations and society due to the deterioration in health services and deficient programs. Only 14.3% were unaware of who initiated this process.

With respect to the international agencies funding the reforms, interviewees mentioned the World Bank, Inter-American Development Bank, the Pan American Health Organization, the United Nations, and European Union, among others.



Source: Direct interviews.

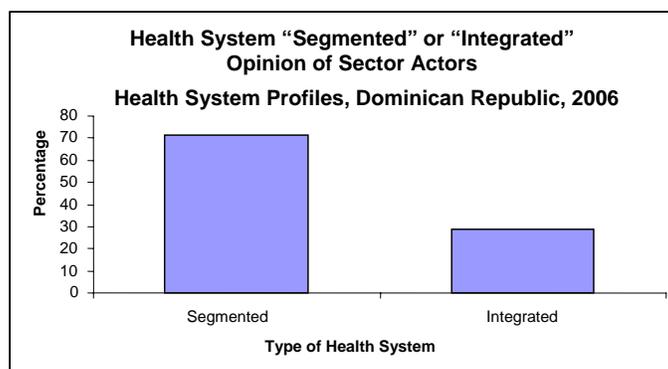
When asked if the reforms were attributable to national or international agreements, 57.1% said the reforms were due to both, 28.6% said they were due to international agreements, and remaining 14.3% said they were due to domestic agreements only. Generally speaking, those interviewed see the reforms as a product of globalization and the forces/interests at the international level, such as the World Bank and the Inter-American Bank Development.



Source: Direct interviews.

Some 85.7% of interviewees believe that reforms are the result of agreements between several actors, more than by a central entity. Some 14.3% consider that the reforms are not the result of this interaction. Others are of the opinion that some actors have more strength than others in the reform process, and that the Congress acted as an intermediary by approving the laws and, consequently, the central authority is not currently able to define the reforms.

Some 71.5% believe that the health system is segmented, while 28.6% believe it is integrated. Those who see it is segmented cite the duplication of functions distributed among several institutions; for example, the IDSS and the SESPAS are both health service providers. Others consider that the system needs to be coordinated or merged, while still others see it as centralized and in the process of decentralization.



Source: Direct interviews.

In terms of whether the proposal for the reforms adapts to the country's health system, 51.7% of interviewees said that it does not adapt and 42.9% said that it does. The reason given by those who believe the reforms do not adapt is because they are attempting to make substantive changes instead of adapting the reforms to the system, others believe that the reforms have not been able to adapt to the system, and still others believe that the reforms taken are not the ones needed.

When asked about where the funding for the reform processes comes from, 85.7% of interviewees cite state funds; the same percentage believes that funding is from international sources, and 100% responded that these are reimbursable funds with national allotment. Only 14.3% stated that the reforms are financed with private funds.

### **Financing of the Reform Processes Dominican Republic, 2006**

Financing of reform processes	Yes	%	No	%	N/A	%
<b>State Funds</b>	6	85.7	0	0	1	14.29
<b>International Cooperation</b>	6	85.7	0	0	1	14.29
<b>Private Sector</b>	1	14.3	4	57.1	2	28.57
<b>Reimbursable funds/national allotment</b>	7	100	0	0	0	0

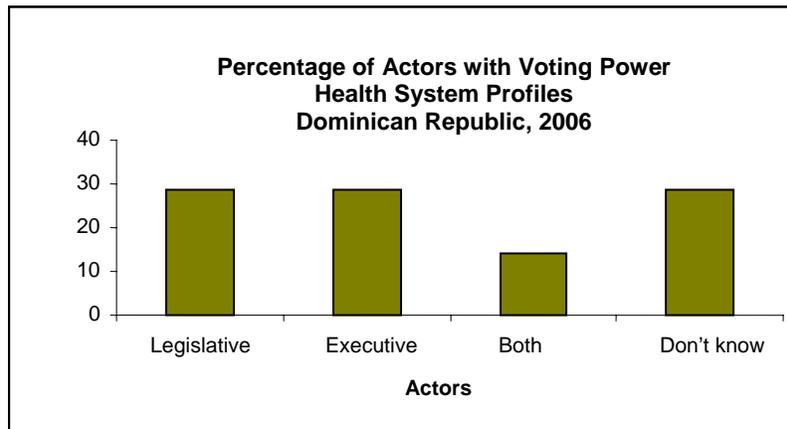
Source: Direct interviews.

**Actors Who Participated in the Reform Process  
Dominican Republic 2006**

Actors – Reform Process	Yes	%	No	%
Governmental	7	100	0	0
Legislative	6	85.7	1	0
Civil society (Health)	7	100	0	0
Civil society (General)	6	85.7	1	14.3
Private Sector	6	85.7	1	14.3
Academia	6	85.7	1	14.3

Source: Direct interviews.

With regard to the various actors who participated in the reform processes, 100% of interviewees cited the government as the main actor, as well as civil society organizations in the health sector. Some 85.7% considered the legislative branch, academia, general civil society groups, and the private sector participate in these processes. Some believe that other actors in addition to these have participated, such as political parties, the financial sector, the employment sector, and the international organizations.



Source: Direct interviews.

With regard to the actors who have veto power on decision-making, 29% responded that either the Legislative and Executive Branches have decision-making power in the reform process, 14.3% responded that both of the mentioned Branches have this power, and 29% reported not knowing who has veto power in decision-making. Others said that unions and employers have veto power, and still others state that it depends on the conditions under which the decisions are made.

The reforms in the health sector impact aspects of the democratic process in a favorable way. When questioned about some of these, 71.4% stated that the reform processes offer greater social control, free choice, and social participation, and decision-making, while 100% stated that they favor participatory management.

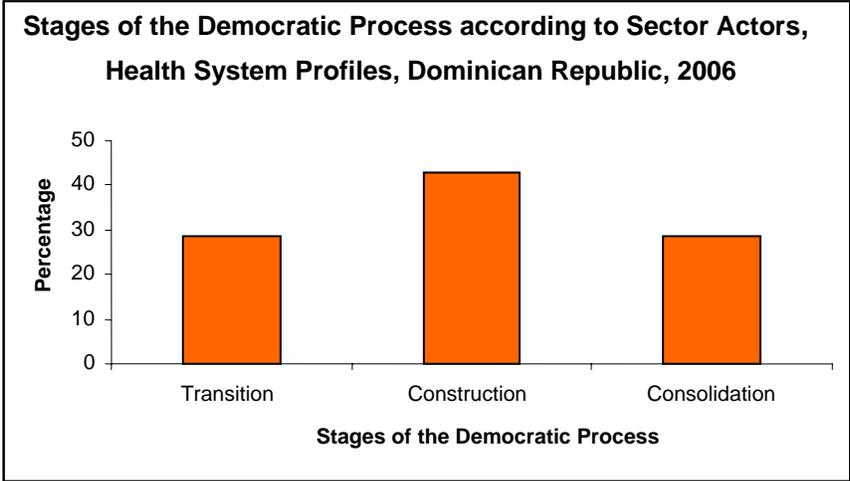
**Table 4**  
**Elements of the Democratic Process**  
**Dominican Republic, 2006**

<b>Aspects of the Democratic Process:</b>				
	<b>Yes</b>	<b>%</b>	<b>No</b>	<b>%</b>
<b>Greater Social Control</b>	5	71.4	2	28.57
<b>Free Choice</b>	5	71.4	2	28.57
<b>Social Participation</b>	5	71.4	2	28.57
<b>Participatory Management</b>	7	100	0	0
<b>Decision-making</b>	5	71.4	2	28.57
<b>Others</b>	4	57.1	3	42.86

Source: Direct interviews.

With regard to the stages of the democratic process, 42.9% believe that the country is in a construction stage, while 28% of actors believe that the country is either in a stage of transition or consolidation.

**Figure 6**



Source: Direct interviews.

**Responsibility of Actors Mandated by Laws,  
Dominican Republic 2006**

<b>LAW</b>	<b>ACTOR</b>	<b>FUNCTION OR RESPONSIBILITY:</b>
87-01	SISALRIL	<ul style="list-style-type: none"> <li>• Insurance Regulation</li> <li>• ARS Supervision</li> <li>• Oversight of Resources</li> <li>• Oversight of Occupational Insurance Risks</li> <li>• Distribution of Resources for Child Hospital Stays</li> <li>• Structure of and proposals for the Basic Plan Health</li> <li>• Penalization of System Actors</li> </ul>
87-01	ARLSS	<ul style="list-style-type: none"> <li>• Management and Administration Safe Occupational Risks</li> </ul>
87-01	TSS	<ul style="list-style-type: none"> <li>• Financing</li> </ul>
42-01	SESPAS	<ul style="list-style-type: none"> <li>• Steering Role, Separation of the Basic Functions of the National Health System, and Provision of Health Services Networks (Decrees Nos. 635-03 and 1137-03)</li> </ul>
87-01	ADG	<ul style="list-style-type: none"> <li>• Member of Organized Civil Society</li> </ul>

**Actors' Position regarding Reform Processes  
Dominican Republic, 2006**

<b>Position of Sector Actors:</b>	<b>Very much in favor</b>	<b>%</b>	<b>Somewhat in favor</b>	<b>%</b>
<b>With regard to capacity for action</b>	5	71.4	2	28.6
<b>With regard to access to information</b>	6	85.7	1	14.3
<b>Image and prestige of actor in society</b>	5	71.4	2	28.6

Source: Direct interview.

Sector actors figure prominently in the processes of reform. With regard to the capacity for action in reforms, 71.4% responded that their institution had a high capacity for action; 85.7% stated that access to information is obtained from the highest authorities of the organization, and 71.4% believe that the institution's image and prestige is important to its work, although no surveys have been conducted to specifically evaluate the role of image.

## BIBLIOGRAPHY

- U.S. Agency for International Development; Executive Commission for Health Sector Reform; Dominican Republic. Secretaría de Estado de Salud Pública y Asistencia Social; Macro International/DHS Program; Centro de Estudios Sociales y Demográficos. **Encuesta Demográfica y de Salud: ENDESA 2002**. Santo Domingo, 2003.
- U.S. Agency for International Development; Executive Commission for Health Sector Reform; Dominican Republic. Secretaría de Estado de Salud Pública y Asistencia Social; Macro International/DHS Program; Centro de Estudios Sociales y Demográficos. **Encuesta Demográfica y de Salud: ENDESA 1996**. Santo Domingo, 1997.
- United Nations Development Program. **Human Development Report** (1990-2004). Available at <http://www.idh.pnud.org>.
- Oficina Nacional de Estadísticas. **Proyecciones Nacionales de Población por Sexo y Grupos Quinquenales 1980-2050**, Santo Domingo 2006.
- Programa de Reforzamiento del Sistema de Salud; Unión Europea; República Dominicana. Secretaría de Estado de Salud Pública y Asistencia Social. **Sistema Dominicano de Seguridad Social, Rostro de la anhelada Protección Social**, Santo Domingo, 2005.
- Programa de Reforzamiento del Sistema de Salud; Unión Europea; República Dominicana. Secretaría de Estado de Salud Pública y Asistencia Social. **Una Reforma para estar en Salud**, Santo Domingo, 2004.
- Comisión Presidencial Objetivos del Milenio el Desarrollo Sostenible y Sistema de las Naciones Unidas, República Dominicana. **Objetivos Desarrollo del Milenio, República Dominicana** 2004, Santo Domingo, 2004.
- República Dominicana. Oficina Nacional de Estadísticas. **VIII Censo Nacional de Población y Vivienda 2002. Resultados preliminares**. Available at <http://www.one.gov.do/datos2002.htm>.
- República Dominicana. Oficina Nacional de Planificación. **Estrategia para la reducción de la Pobreza en la República Dominicana 2004-2015**. Santo Domingo, 2003.
- Secretaria de Estado de Salud Publica, Dirección General de Control de Infecciones de Transmisión Sexual y SIDA. **Registros del subsistema de Vigilancia Epidemiológica del SIDA, 1990-2002**. Santo Domingo, SESPAS 2006.
- Secretaria de Estado de Salud Publica. **Análisis de Situación de Salud de la Republica Dominicana, 2003**, Santo Domingo, 2003.

- Secretaria de Estado de Salud Pública. **Evaluación del Programa de Control de la Tuberculosis en la República Dominicana**. Santo Domingo, 2003- 2004.
- Secretaria de Estado de Salud Pública, Dirección General de Planificación y Sistemas de Salud. **Memoria Anual 2003**. Santo Domingo.
- Subsecretaria Técnica. Dirección General de Planificación y Sistemas de Salud. **Memoria Anual 2004**. Santo Domingo.
- Secretaria de Estado de Salud Pública, Dirección General de Epidemiología. **Estadísticas de Dengue y Malaria, 1990-2004**.
- **Ley No. 87-01 sobre Sistema Dominicano de Seguridad Social**, Santo Domingo, República Dominicana, 2001.
- **Ley No. 42-01 Ley General de Salud**, Santo Domingo, República Dominicana, 2001.
- Organización Panamericana de la Salud. **Observatorio de Recursos Humanos en Salud en la Republica Dominicana**, Mayo, 2001.
- Secretaria de Estado de Salud Pública, **La Movilización Tolerancia Cero a Nivel Desconcentrado**, Noviembre, 2005.
- Organización Panamericana de la Salud, **La Salud Publica en las Américas**, 2002.
- Secretaria de Estado de Salud Pública y Organización Panamericana de la Salud, **Indicadores Básicos de la Salud 2003 - Republica Dominicana**.
- Presidencia de la Republica Dominicana, **Reglamentos de la Ley General de salud (42-01) Volumen II**.
- Secretaria de Estado de Salud y Asistencia Social, **Guía Farmacoterapeutica de Medicamentos Esenciales de la republica Dominicana**, 1998.
- Comisión Ejecutiva para la Reforma del Sector Salud, Consultoría Análisis de las Funciones Criticas de Rectoría y Provisión de Servicios de Salud en la Reforma del Sector Salud, Santo Domingo, 2006.
- Organización Panamericana de la Salud, **Basic Indicator Health in the Americas Situation**. 2005.