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DOMINICAN REPUBLIC

SUPPORT FOR HEALTH SECTOR AND SOCIAL SECURITY CONSOLIDATION II

(DR-L1079)

LOAN PROPOSAL

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ABBREVIATIONS

CNSS	Consejo Nacional de Seguridad Social [National Social Security Council]
DGCSS	Dirección General de Coordinación de los Servicios Públicos de Salud [Public Health Care Services Coordination Bureau]
DIDA	Dirección de Información y Defensa de los Afiliados [Participant Information and Protection Division]
END	Estrategia Nacional de Desarrollo [National Development Strategy]
GDP	Gross Domestic Product
ICV	Quality of life index
IDSS	Instituto Dominicano de Seguro Social [Dominican Social Security Institute]
IRR	Internal rate of return
MAP	Ministry of Public Administration
MSP	Public Health Ministry
NFPS	Nonfinancial Public Sector
NPV	Net Present Value
ONE	National Statistics Office
PAHO	Pan American Health Organization
PBL	Policy-based loan
PDSS	Plan de Servicios de Salud [Health Services Plan]
PFA	Pension fund administrator
SDSS	Sistema Dominicano de Seguridad Social [Dominican Social Security System]
SENASA	Seguro Nacional de Salud [National Health Insurance]
SIPEN	Superintendencia de Pensiones [Superintendent of Pensions]
SISPRE	Sistema de Pensiones de Reparto del Estado [State Unfunded Pension System]
SIUBEN	Sistema Único de Beneficiario [Master Beneficiary System]
SNS	Servicio Nacional de Salud [National Health Service]
SRS	Servicios Regionales de Salud [Regional Health Services]
TSS	Tesorería de la Seguridad Social [Social Security Treasury]

PROJECT SUMMARY

DOMINICAN REPUBLIC
SUPPORT FOR HEALTH SECTOR AND SOCIAL SECURITY CONSOLIDATION II
(DR-L1079)

<table>
<tr><th colspan="6">Financial Terms and Conditions</th></tr>
<tr><td colspan="3" rowspan="4">Borrower: Dominican Republic
Executing agency: Ministry of Finance</td><td colspan="2">Flexible Financing Facility[a]</td></tr>
<tr><td>Amortization period:</td><td>15.5 years</td></tr>
<tr><td>Original WAL:</td><td>12.73 years[b]</td></tr>
<tr><td>Disbursement period:</td><td>1 year</td></tr>
<tr><td>Source</td><td>Amount (US$)</td><td>%</td><td>Grace period:</td><td>11 years[b]</td></tr>
<tr><td rowspan="3">IDB (OC):</td><td rowspan="3">300 million</td><td rowspan="3">100</td><td>Inspection and supervision fee:</td><td>[c]</td></tr>
<tr><td>Interest rate:</td><td>LIBOR-based</td></tr>
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<tr><td>Total:</td><td>300 million</td><td>100</td><td>Approval currency:</td><td>U.S. Dollars from the Ordinary Capital (OC)</td></tr>
<tr><th colspan="6">Project at a glance</th></tr>
<tr><td colspan="6">Project Objectives/Description:

This is the second and last in a programmatic series of two operations with the overall objective of progressively consolidating social security coverage and improving health spending efficiency by deepening the reform being implemented by the Government of the Dominican Republic in the two sectors.</td></tr>
<tr><td colspan="6">Special contractual conditions:

Disbursement of Bank financing is contingent upon fulfillment of the policy conditions set out in Annex II (Policy Matrix) and the other conditions established in the loan contract (paragraph 3.2).</td></tr>
<tr><td colspan="6">Exceptions to Bank policies: None.</td></tr>
<tr><td colspan="6">Project classified as:[d] SV ☑ SD ☑ CC ☐ IC ☐</td></tr>
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[a] Under the Flexible Financing Facility (document FN-655-1) the borrower has the option of requesting changes to the amortization schedule as well as currency and interest rate conversions. The Bank will take operational and risk management considerations into account when reviewing such requests.

[b] The original weighted average life (WAL) and the grace period may be shorter, depending on the effective signature date of the loan contract.

[c] The credit fee and inspection and supervision fee will be established periodically by the Board of Executive Directors as part of its review of the Bank's lending charges, in accordance with the applicable policies.

[d] SV (Small and vulnerable countries), PE (Poverty reduction and equity enhancement), CC (Climate change, sustainable energy, and environmental sustainability), CI (Cooperation and regional integration).

I. DESCRIPTION AND RESULTS MONITORING

A. Background, problems addressed, and rationale

1.1 This is the second and last operation in a programmatic series of two operations under the programmatic policy-based loan (PBL) modality with the overall objective of progressively consolidating social security coverage and improving health spending efficiency by deepening the reform being implemented by the Government of the Dominican Republic in the two sectors. In the first operation (DR-L1073, 3382/OC-DR), the program supported increased coverage of the pension system through the social security component, and, through changes in the design and definition of policies, it improved the targeting of beneficiaries, opened up access to information, strengthened the system's monitoring and evaluation capacity, and promoted a pension culture and financial education. Through its health component, the first operation supported the preparation and approval of regulatory measures and key instruments to improve health spending efficiency. These included the separation of the stewardship and service delivery functions, the reorganization of the care model, a quality strategy, a Health Career Law, updating the health benefits plan, and strengthening the institution responsible for providing insurance for the poorest population segments. This second operation continues these actions, supporting the deepening of regulations, as well as promoting and facilitating the implementation of policies and strategies leveraged under the first operation.

1.2 **Recent macroeconomic performance and financing needs.** The Dominican Republic has been one of the region's most dynamic economies over the past decade. Between 2005 and 2014, gross domestic product (GDP) grew at an average annual rate of 5.8%, well above the average for the region (3.7%). In 2014 the Dominican economy grew by 7.3%, and the authorities estimate growth in 2015 will be between 5.5% and 6.0%.

1.3 The strength of economic growth has enabled the Government of the Dominican Republic to implement a gradual process of fiscal consolidation, following the serious deterioration in its fiscal position in 2012. This process included an increase in tax revenue from 14% of GDP in 2012 to 15% in 2014, together with a reduction in capital expenditure from 6.4% of GDP in 2012 to 2.9% in 2014. As a result, the nonfinancial public sector (NFPS) deficit came to 3% of GDP in 2014, smaller than the deficit posted in 2012 (6.6%). The government forecasts a deficit of 2.4% of GDP in 2015.

1.4 Despite the trend toward fiscal consolidation, the persistent NFPS deficit suggests a medium-term growth trend in public debt and gross public sector financing requirements. This is particularly so bearing in mind the fiscal commitments arising from public initiatives in the education and health sectors, and investments stemming from a pact for the electricity sector. Gross financing requirements equivalent to 5.8% of GDP (approximately US$3.84 billion) are projected for 2015. This programmatic PBL will provide US$300 million in budgetary support to finance the fiscal deficit, making it possible for the Dominican government to fulfill its public debt strategy. The amount of this operation represents up to 18.9% of the estimated fiscal deficit, and nearly 7.8% of the public sector's gross financing needs for 2015.

1. The social security and health systems

1.5 **Reforms in the social security and health sectors.** In 2001, the Dominican government launched a structural reform process in the social security and health sectors with the enactment of the Social Security Law (87-01), which created the Dominican Social Security System (SDSS), and the Health Act (42-01), which established the regulatory framework for the National Health System (SNS). The purpose of these two reforms is to provide effective universal coverage.[1] Prior to the reform, there were isolated insurance systems, serving only a minority. Law 87-01 established three financing systems for pension and health insurance: (i) a contributory system for wage earners; (ii) a subsidized contributory system for self-employed people earning more than the minimum wage; and (iii) a subsidized system for self-employed, disabled, and unemployed individuals on incomes under the minimum wage.[2]

1.6 **The Dominican pension system (SDP).** The SDP is an individually-funded system with accounts administered by Pension Fund Administrators (PFAs). The contributory pension system is the only system that has been implemented. It is financed by contributions from wage earners (30%) and their employers (70%).[3] The legal framework created the Superintendent of Pensions (SIPEN) to supervise compliance with the pension law, and oversee the solvency of the PFAs; the Social Security Treasury (TSS), as the body responsible for revenue collection; and the Participant Information and Protection Division (DIDA) to respond to beneficiaries' needs and promote the system. Although the law instituted the pension system as an individually-funded pension system, it allows preexisting state and private systems to continue operating with their existing participants, but closes them to new participants. It also established that public unfunded systems would come under the State Unfunded Pension System (SISPRE), a subsystem of the SDSS under the Ministry of Finance.

1.7 **National health system.** The most important aspect of the 2001 Health Act was to separate the basic functions of the health care system (stewardship, financing, and service delivery). The Public Health Ministry (MSP) would act solely as the health care system's lead agency. The TSS was made responsible for the social security contributions from payrolls and the government's contributions, and issues a per capita payment to the health risk administrators. Private health risk administrators provide insurance to those covered by the contributory system. The public health risk administrator—National Health Insurance (SENASA)—insures the subsidized population. The National Social Security Council (CNSS) is responsible for defining the health care services package, called the Health Services Plan (PDSS). With regard to services, the participants of the contributory system can choose between public or private providers. Subsidized system participants can only be treated in public establishments, managed by the Regional Health Services, which are deconcentrated units of the MSP.

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1 In 2007, just 7% of workers were covered by the Dominican Social Security Institute.

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

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

2. Challenges facing the social security system

1.8 The current low coverage of the pension system is partly a reflection of the recent creation of the SDSS, with some aspects of its implementation as yet incomplete, and a labor market with a high rate of informal employment. The contributory pension system—only for wage earners—was launched in 2003 with approximately half a million workers—equivalent to 18% of the working population—contributing to it.[4] This percentage grew by 12 percentage points up until 2010 (reaching 30% of the working population), remaining relatively stable or growing more slowly since then. At year-end 2014 the percentage of contributors was around 35% of the working population,[5] in relative terms, one of the lowest contribution levels in the region. Moreover, evasion is widespread, as only 64% of wage earners contribute to the system.[6] Additionally, just 15% of adults over 65 years of age currently receive an old-age pension. If no action is taken, coverage in 2050 will continue to be one of the lowest in the region.[7] In addition to the foregoing, it has not been possible to develop the SDSS in a comprehensive way. Implementation of the subsidized contributory systems, for both health and pensions, and the subsidized pension system has not yet begun.

1.9 These coverage and implementation challenges to the system are related to a series of factors described in the following section. These include: (i) certain aspects of the Social Security Law that constrain expansion of the coverage of the SDSS; (ii) certain aspects of the way the implementation of the subsidized system was designed; (iii) the need to establish the new regulatory framework for the SISPRE; (iv) the need to strengthen the channels of information to expand the coverage of the contributory system; (v) the lack of a single comprehensive monitoring and evaluation system for SDSS outcome indicators; and (vi) a weak pension culture. The aspects of the design of the SDSS legal framework are the most important issues.

3. Determinants of low coverage[8] and progress of the SDSS since the first operation

1.10 **The SDSS regulatory framework needs to be adjusted.** The first programmatic PBL identified the need to modify key aspects of the design of the SDSS requiring legislative amendments to guide a process of expansion of insurance in a more comprehensive way, with fewer distortions to the labor market, and strengthening the system's key institutions to improve the oversight of contributions and quality of services. In this regard, the current version of Social Security Law (87-01) needs to be modified in four main ways, to: (i) harmonize points in the Law that accentuate wage differences or employment status and which may cause distortions to the labor market by discouraging contributions by both workers and employers, and which hinder consolidated

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4 The Dominican Republic has one of the highest unemployment rates in the region (14.9% in 2014) and one of the highest rates of self-employment (42% in 2014).

5 The Superintendent of Pensions (SIPEN) has studied the reasons for the stagnation in contributions, and found that many of the insured stop contributing because they lose their jobs, become self-employed, or lack information on employers' contributions, among other reasons.

6 Average data for 2014, based on data supplied by the Central Bank and SIPEN.

7 The lack of provisioning for old age imposes social costs and increases the risks to the financial sustainability of the pension system (Bosch et al. 2013).

8 Optional electronic link 3.

implementation of a comprehensive system for all workers;[9,10] (ii) give the TSS the authority to penalize cases of evasion, avoidance, and under-declaration of wages in the contributory system, in order to make its supervisory actions more effective and improve compliance with contribution payments;[11] (iii) authorize the DIDA to measure the quality and timeliness of delivery of benefits to members;[12] and (iv) determine how often pensions are to be updated based on the consumer price index.[13]

1.11 With the support of the first programmatic PBL, the government showed its commitment to making progress in this direction by preparing draft amendments to this Law, including the issues identified in the first operation. For this second operation, progress was made toward the objectives set in the programmatic series with studies on the scope of the measures in the draft and the current law. This enabled complementary elements to be added to the original draft.[14] With this specific progress, the Dominican government is preparing the draft to be put before the National Congress, renewing its commitment to this programmatic series.

1.12 **The subsidized pension system has not been deployed.** The subsidized pension system is described in Law 87-01 as a solidarity support system covering the pensions of poor people over the age of 60. At the time of the first operation, the need to make progress on a sequence of steps to complete its implementation was identified. This type of system requires well-defined criteria for allocating benefits in order to prevent efficiency losses due to disincentives the system may create for participating in the labor force and working in the

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9 The partial implementation of the SDSS as regards the pension systems has widened the divergence between the obligations and rights of wage earners and the self-employed (who still lack a channel through which to join the system, even voluntarily).

10 The evidence suggests that the incentives for contributing may be affected by the design of financing systems that distinguish between workers based on their employment status. Levy (2008) and Bosch et al. 2013, op. cit.; Busso, Fazio, and Levy (2012).

11 Bosch et al., 2014 identify policies to expand coverage, including better oversight of compliance with contribution obligations. This publication mentions initiatives along these lines in countries such as Brazil and Argentina.

12 The role of protecting members in the Dominican Republic was assigned to the DIDA, but the current Law does not establish powers for monitoring quality of service. An example of the impact measures of this kind can have is the given by the case of Chile. The Superintendent of Pensions began to measure and publish quality of service in 2005, cutting old-age pension benefit processing times from between 20 to 53 days in 2006 to between 7 and 15 days in 2014, according to the Superintendent of Pensions' press releases (www.spensiones.cl).

13 In the case of survivors' pensions, disability pensions, and old-age annuities, the current Law establishes that they must be adjusted but does not define the frequency of adjustments, leading to potential uncertainty, and potential arbitrariness on a sensitive parameter.

14 During this second operation, on analyzing the text of the current law new articles were identified which could be revised in order to move toward a system with fewer labor market distortions and which should be added to the draft. For example, Articles 19 and 7 refer to a State subsidy for self-employed workers to "make up for the absence of a formal employer." This latter specification could create an incentive for microenterprise employers to conceal their existence to avoid contributions, or undermine the incentive to be an employer while the absence of an employer is subsidized. Article 31 indicates that one of the financing systems is for informal workers, which may discourage formal employment. Article 7 also needs to be updated following the entry into force of Decree 381-13, which establishes SIUBEN's quality of life criterion to determine the eligibility of beneficiaries of the subsidized system, while the Law still states that the criterion is the minimum wage.

formal sector.[15] In the first operation the Dominican government made significant headway on the design of targeting of solidarity pensions with a decree modifying the beneficiary population's eligibility criteria and establishing a regulation using the quality of life index (ICV) of the master beneficiary system (SIUBEN)[16] as a targeting tool instead of the minimum wage. This operation aims to provide support to enable the three remaining steps for the implementation of the subsidized system to be completed: (i) establishing a protocol for the allocation and issue of the list of people eligible for solidarity pensions, using the ICV;[17] (ii) identifying the roll of eligible households following the established protocol; and (iii) estimating the financial sustainability of the granting of solidarity pensions.

1.13 **SISPRE is not harmonized with the current legal framework.** The systems due to make up SISPRE continue to function under the responsibility of the State without being brought into alignment with the framework of Law 87-01, and without a comprehensive approach to the other State pension plans, which operate outside the SDSS under limited oversight. In order to address this challenge, the Dominican government identified the need for organizing SISPRE using a comprehensive approach, and regulating the State's general unfunded pension system for all active and passive participants remaining in this system (Laws 379-81 and 1896), taking into account the fiscal implications of the various measures. With the support of the first operation, the fiscal cost of the parametric changes included in the draft plan for SISPRE was analyzed.[18] This operation aims to support completion of the draft bill so as to include the results of the fiscal report and to put it before the National Congress. The fiscal cost analysis revealed the shortage of information on unfunded public pensions, necessary for this type of analysis. It also highlighted the need to make progress towards monitoring unfunded systems property, suggesting the implications of the possible parameter changes, and strengthening the information systems. This adaptation of unfunded pensions under SISPRE will also enable the Finance Ministry to exercise better budgetary control over the different State pension plans still in operation and their contingent liabilities.

1.14 **Low density of contributions into the contributory system.** The proportion of wage earners contributing to the system has stagnated in recent years; moreover, 36% of wage earners who should contribute are not doing so.[19] Given the design of the SDSS and the current structure of incentives, an important means of increasing contributory system coverage is to provide information to

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

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

17 According to Law 87-01, the value of pensions is equal to 60% of the public sector minimum wage, equivalent to US$70. The subsidized pension system was included in the budget to begin in 2014 by covering 1,500 pensions, but the best targeting criterion and protocol had yet to be determined. With regard to the fiscal implications, the Dominican government plans for a gradual roll out, in line with the strict budget constraints for this type of expenditure.

18 Isa Contreras, Pavel (2015) "*Costo fiscal de la propuesta del Sistema de Pensiones de Reparto del Estado en la República Dominicana*" [Fiscal cost of the proposed unfunded State pension system in the Dominican Republic].

19 According to calculations based on Central Bank and SIPEN data for the 2014 average.

workers on the benefits they gain from contributing toward a pension.[20] Instruments for accessing information have an immediate impact in terms of encouraging contributions and controlling evasion in the contributory system.[21] With the support of the first operation, the DIDA expanded its coverage with five new service offices in remote regions of the country. SIPEN set up electronic services so that members could find information about their status with the PFAs, obtain account statements, and calculate the value of their pension.[22] The support of this second operation is intended to enable these actions to continue and for DIDA information services to be strengthened nationwide, including information campaigns on the SDSS in the mass media, workshops, and mobile units.

1.15 **The SDSS does not have a comprehensive monitoring system.** Each SDSS entity currently administers its own database, which generates duplications and incompatibilities among the system's key indicators, hindering comprehensive and effective monitoring. In this context, a well planned and executed monitoring function is an essential tool for effective results-based planning and budgeting, enabling improvements to the institutional structure, governance, and comprehensiveness of the governance systems.[23] The 2014-2018 Social Security Strategic Plan defined a series of priority activities for the comprehensive development of the SDSS. These include setting up a monitoring and evaluation system allowing results-based decision-making processes to be improved so as to strengthen the stewardship, regulation, operation, supervision, and oversight of SDSS bodies.[24]

1.16 In the first operation, an intersectoral committee was set up charged with designing and supervising the project to create the monitoring system. The committee comprised all the entities with Dominican Social Security System

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[20] In their book "Better Pensions, Better Jobs", Bosch et al. (2013) identify "optimizing information and the perceived value of benefits" as one of the issues affecting incentives for generating savings through contributory systems. It also highlights Chile's experience, where a series of initiatives has begun to be implemented to relay pension information to workers so as to motivate them to participate fully in the pension system (page 130). Lastly, Behrman et al. (2012) establish that financial education yields greater accumulation of funds in a private pension system.

[21] According to information provided by the TSS and SIPEN, there are cases where employers do not keep their contributions up to date, participants do not always receive their account statement from the PFA (on the returns on their funds and other variables), or are not even aware of who their PFA is or how their pension was calculated.

[22] Measures of this type have only recently been introduced in the Dominican Republic, making it difficult to evaluate their impact. However, an increase in contribution density is expected, as there is evidence from various contexts of the positive effect of measures increasing the value placed on savings. In Chile, a trial supported by the OECD sending out pension information including pension forecasts had positive impacts on savings decisions. Fajnzylber, Plaza, and Reyes, 2009, in Working Paper 31: "Better-informed Workers and Retirement Savings Decisions: Impact Evaluation of a Personalized Pension Projection." Similar results to those of Chile have been found in the case of the impact of reminders on savings decisions, Karlan et al. (2012) "Getting to the Top of Mind: How Reminders Increase Saving." NBER Working Paper 16205.

[23] Arguments for the need to establish an effective M&E system can be found in: World Bank and IDB (2005) "Towards the Institutionalization of Monitoring and Evaluation Systems in Latin America and the Caribbean" and in Shack, N., 2008. "*Fortalecimiento de los Sistemas de Monitoreo y Evaluación en América Latina*" [Strengthening monitoring and evaluation systems in Latin America]. World Bank and CLAD.

[24] The 2014-2018 Social Security Strategic Plan includes operational plans to organize SDSS entities so as to set objectives, targets, and a timetable of activities for priority actions to develop the SDSS.

(SDSS) databases, including the National Statistics Office (ONE), SIPEN, the Superintendent of Health and Occupational Risks (SISALRIL), the TSS, the DIDA, and the SENASA, coordinated by the CNSS to monitor the 2014-2018 Social Security Strategic Plan. Once the committee had been set up, the roadmap to bring the system into operation was identified and the activities necessary for the first phase of implementation of the SDSS monitoring system were executed. These included: setting up a single SDSS database, analyzing system statistics, and running a pilot of the new information platforms. The Dominican government is strongly committed and has made progress on the targets of the work plan following the creation of the committee. This second operation aims to support the continuation of these actions by undertaking activities for the first phase of implementation of the monitoring system. The objective is also for the SDSS to have a comprehensive monitoring and evaluation system serving to measure progress on social security and health policies, and provide feedback for the timely correction or adjustment of policies.

1.17 **The population's pension culture is weak.** A fundamental issue affecting enrollment and contributions to the Dominican pension system is the low value placed on saving for old age and the lack of awareness of its benefits.[25] According to data from the General Economic and Financial Culture Survey (EGCEF),[26] although 83% of the surveyed population reported being concerned about "covering household expenses due to old age," the findings showed limited knowledge of pension funds.[27] Recognizing the need to develop a pension culture and provide the population with financial education, the 2014-2018 Social Security Strategic Plan included a financial education plan among its objectives. The first operation supported the creation of the Intersectoral Committee (comprising the CNSS and SIPEN), responsible for moving forward with the implementation of the financial education plan. In light of the foregoing, this second operation supports two essential operational measures necessary to carry out the project: (i) preparation of the annual work plan; and (ii) allocating a budget to it in order to move forward with project preparation. This allocation will make it possible to prepare the main activities for implementation, such as design of the curriculum and teaching materials.

4. Challenges facing the National Health System

1.18 Per capita public spending on health is low in comparison with countries with similar incomes,[28] and the current level appears to be insufficient to expand

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[25] Bosch et al. (2013) discuss experiences with potential positive effects on creating a pension culture in the region. For Chile, Landerretche and Martínez (2011) report that education on pension plans translates into increased savings and a greater likelihood of changing pension fund type. Hastings and Mitchell (2011) and Hastings, Mitchell, and Chyn (2010) observe that people with better financial education choose pension accounts with lower administrative costs.

[26] The EGCEF was run by the Central Bank in 2014.

[27] Thirty-four percent of respondents under age 60 stated that they are accumulating sufficient "savings and financial assets" for old age, but only 15% of the group aged over 60 reported having this capital.

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

effective coverage of the subsidized system.[29] In the current context of fiscal constraints it is appropriate to promote effective interventions to increase spending efficiency.

1.19 The Dominican Republic obtains poor returns on its investments in health. Maternal mortality rates in countries in the region with similar levels of economic development suggest that more progress can be made with lower per capita public spending on health.[30] DEA[31] estimates of the technical efficiency of health spending found that expenditures in the Dominican Republic range between 30% and 83% of their potential performance, measured according to various indicators.[32] Resource allocation was also found to be inefficient. In 2014, just 6% of MSP resources were spent on prevention and public health actions. Analysis of spending by the subsidized system reveals that SENASA devotes 86% of its spending to hospitals, as 90% of outpatient consultations take place in hospitals rather than primary health care centers.[33]

1.20 Measures to enable spending efficiency gains are essential to ensure that present and future resources earmarked for the sector yield greater health gains per peso invested. Efficiency gains can have the same effect as an increase in health funding, assuming that the savings from these improvements are retained and redistributed in the system.[34] The low efficiency of public spending is related to a series of determinants that are described in the following section. These include: (i) regulatory issues that limit the separation of the stewardship and service delivery functions, the effectiveness of benefit services, and achievement of improvements in service quality and incentives for health professionals; (ii) institutional weaknesses in the development of the stewardship and management of health care financing; and (iii) the fact that the catalogue of benefits is out of date.

5. Determinants of inefficient public spending on health

1.21 **Separation of the stewardship and provision functions is incomplete.**[35] Pursuant to the health sector reform, the MSP is to concentrate on stewardship,[36] while the Regional Health Services (SRS) are in charge of service delivery.

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29 Between 2007 and 2014 coverage rose from 500,000 people to 6.1 million (66% of the population); of these, 34% belong to the contributory system and 32% to the subsidized system. The goal is to expand subsidized coverage from 3 million in 2014 to 3.7 million in 2016. The resources mobilized by the subsidized system are small for its coverage, accounting for barely 3% of public spending on health. Rathe and Hernandez 2014.

30 While the maternal mortality rates in Jamaica and Ecuador are 83.4 and 60 deaths per 100,000 live births, respectively, the rate in the Dominican Republic is 108.7 (PAHO, 2014). Per capita health spending is US$220 in Jamaica and US$255 in Ecuador, while in the Dominican Republic it is US$256 (WHO, 2013).

31 Data envelopment analysis (DEA).

32 An analysis of 191 countries found that the Dominican Republic is 17 percentage points below the most efficient country in producing healthy life expectancy. (Evans DB et al., *2001).* Another analysis places it at around 30% on the production frontier for various health indicators. Marinho et al. 2012.

33 Rathe and Hernandez 2014.

34 Chisholm and Evans. 2010. Improving Health System Efficiency as a Means of Moving Towards Universal Coverage. Smith, 2009. Measuring value for money in healthcare: Concepts and tools. London: The Health Foundation.

35 Separation of functions is crucial to consolidate the reform. Optional electronic link 3.

36 Paragraph 1.26 on stewardship.

SENASA would be the sole funder of the service network, which would be managed and coordinated by the SRSs. In 2014 this separation had still not been completed, and the MSP allocated 63% of its direct budget to providing services. Moreover, due to the SRSs' insufficient institutional capacity, the MSP will remain directly involved in managing health care providers.

1.22 At year-end 2014, with the support of the first programmatic PBL, Presidential order 379-14 was passed, launching the separation of functions by creating the Public Health Care Services Coordination Bureau (DGCSS), which replaced the Office of the Deputy Minister for Individual Care under the MSP. The DGCSS remains organizationally integrated in the MSP and, on a transitional basis, is in charge of managing service delivery, Regional Health Services, and providers. Operational advances for the separation of functions include the formulation of separate budgets for the MSP and the DGCSS for 2016, the preparation of a management framework agreement between the MSP and DGCSS, and the definition of a management model for the Regional Health Services in line with regulatory changes. The assets and liabilities of the two entities are also being divided. However, as the DGCSS remains integrated in the MSP, there are still administrative limitations for it to take over the functions defined by the separation, such as the fact that the human resources in the primary health care units and hospitals are still on the MSP payroll.

1.23 The support of this second operation aims to accelerate the DGCSS's institutionalization, so that the separation of functions becomes permanent and sustainable, and to confer the necessary autonomy on the DGCSS for it to exercise its functions. A Law will be promoted institutionalizing the DGCSS, which will be renamed the National Health Service (SNS). The SNS will have administrative, financial, and technical independence to organize, coordinate, and manage the Regional Health Services and providers.

1.24 **The way service delivery is organized has limited the effectiveness of interventions**. The reform calls for public and private service providers to operate in networks, with primary care as the gateway. In this model, the focal point for addressing most users' needs is a regular primary care provider serving a specific population, equipped with adequate resources and technology, and coordinating care with other more specialized providers through referral and counter-referral mechanisms.[37] This model would have a positive impact on the system's efficiency, by reducing cost growth and eliminating duplication. It would foster the use of effective interventions to prevent and handle a significant percentage of health problems.[38,39,40]

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37 Starfield, 2011. "Politics, Primary Healthcare and Health: Was Virchow Right?" Journal of Epidemiology and Community Health 65 (8) (August): 653-5.

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

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

40 Bodenheimer 2008, Hans et al. 2012, Springer et al. 2010.

1.25 Studies indicate that treatment success at the primary health care level is low in the Dominican Republic, referral and counter-referral mechanisms are weak, and the service providers operate with limited vertical coordination. As a result, people tend to go straight to the secondary and tertiary care levels, increasing the cost of services.[41] The first operation supported approval of a new model of comprehensive care for the National Health System, which defines: (i) the new organizational structure for public service providers, with primary care as the gateway, functioning in a network with the other levels of care; and (ii) the principles, guidelines, and parameters to be used by the Regional Health Services to provide health care services. This second operation will support an assessment of the scale of the resources needed to implement the care model at national level, and the actions required to gradually roll out operations through the Regional Health Services.

1.26 **Delays in the development of stewardship.** Good stewardship creates the conditions that enable authorities to fulfill their responsibilities and guide the system toward greater efficiency. Evidence shows that countries with better policies and institutions have a greater health impact per additional percentage point of GDP invested in the sector.[42,43] Evaluations in the Dominican Republic identify institutional weaknesses in the MSP in terms of its ability to exercise stewardship.[44] Its capacity to issue and implement regulations, and develop instruments allocating resources according to health needs and based on cost-effectiveness criteria is limited. This is because the MSP still maintains the pre-reform structure, which is geared to service delivery. In order for it to take on this role, the MSP needs to define and implement an organizational structure placing stewardship of the National Health System at the center of its activities.

1.27 With the support of the first operation, a new organizational and functional structure for the MSP was defined and presented to the Ministry of Public Administration (MAP). This new structure reflects the MSP's responsibilities as regards stewardship, including sector guidance, health intelligence, and regulation. This second operation will support the implementation of this structure through the formulation and approval of an MSP Strategic Plan, which will guide the institution's next steps in relation to policy formulation and implementation, generation and analysis of information, and the regulation of goods, services, and supplies.

1.28 **The quality of the supply of health services needs to be improved.** The indicators of access to mother and child care services in the Dominican Republic are adequate. The country has a prenatal care rate of 95.4% and 97.5% of births take place in hospital.[45] However, maternal and infant mortality rates are among the highest in Latin America and the Caribbean,[46] which is indicative of the low

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41 *Consultoria I Gestió* (2012) *Adecuación del modelo de red a los SRS* [Adaptation of the network model to the SRSs]. Dominican Republic, MSP.

42 Impact measured by child and maternal mortality, malnutrition, and tuberculosis mortality indicators.

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

44 *Resultados de la Evaluación del Desempeño y Fortalecimiento de la Función Rectora de la Autoridad Sanitaria Nacional en RD* [Findings of the Evaluation of Performance and Strengthening of the Stewardship Function of the National Health Authority in the Dominican Republic], 2006.

45 ENDESA 2013.

46 108.7/100,000 and 24.8/1,000 live births, respectively, versus 62.8 and 15.7 in Latin America and the Caribbean (WHO, 2014).

quality of public health services.[47] For example, an observational study of physicians in second and third tier health care establishments[48] found that 57% did not follow delivery care protocols correctly.[49] Also, only one third of primary care units in the country meet licensing standards for operation.

1.29 The first operation supported the National Health Care Quality Policy. This established sector guidelines for: (i) licensing and accrediting health care facilities; (ii) establishing minimum quality rules and standards for management and the provision of health-care products and services; and (iii) monitoring and evaluation of the quality of the health care provided.[50] This second operation will support policy implementation, fostering advances in the licensing of second and third tier health-care institutions and defining parameters for the monitoring of mother and child care quality, the latter being a step toward improving access to safe and effective sexual and reproductive health services.

1.30 **Incentives to improve health practitioners' productivity and performance are lacking.** The health care career path, defined as standards and descriptions that regulate public employment in health and the employment relationship between workers and health institutions, is an important factor in attracting and retaining professionals and creating incentives for better performance.[51] Prior to 2014 there was no career plan or wage policy for health professionals in the Dominican Republic. Nor were there any mechanisms for periodically monitoring and evaluating employee performance.[52] The absence of an appropriate system of incentives has been a contributing factor in the sector's high staff turnover, high absenteeism, nonobservance of work schedules, and low motivation.[53]

1.31 To improve health professionals' performance, the first operation promoted the promulgation of Law 395-14, which instituted the Health Career for public health professionals. This Law establishes the employment relationship between civil servants and the State, and is based on principles of efficiency and effectiveness, comprehensiveness, and merit-based selection and promotion. It classifies the posts envisaged in the health career; specifies the content of human resource development plans; and defines the process of selecting and recruiting personnel. This second operation will support formulation of the Law's main regulations to move towards its implementation.

1.32 **The Health Services Plan (PDSS) is out of date.** The PDSS defines the minimum set of health care services that are to be guaranteed to the entire population enrolled in the Dominican Social Security System (SDSS). The current PDSS has not been updated since 2009 and the DIDA has been reporting a growing number of complaints about the services it includes or

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47 Study by the *Comisión Ejecutiva para la Reforma del Sector Salud* [Executive Commission for Health Sector Reform] (CERSS) in 2002, Miller et al. 2003, Pérez-Then 2008, Quiterio et al. 2008.

48 Pérez-Then 2011.

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

50 MSP**.** *Política Nacional de calidad en salud* [National Health Care Quality Policy]. Santo Domingo. October 2013, p. 15.

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

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

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

excludes. For example, the PDSS covers diagnosis, but does not guarantee the necessary surgical procedures. Evaluations of the PDSS find a bias towards curative and more complex treatments.

1.33 To ensure comprehensive coverage of the Dominican Republic's priority illnesses or health problems, the first operation under the programmatic PBL supported the contracting of an international consulting firm to review and update the PDSS catalogue, using participatory methods that involved representatives of all the entities in the sector. The process was rigorous and transparent, and there were significant changes to the catalogue, such as the inclusion of cost-effective promotion and prevention services. This second operation will continue supporting the updating of the plan, until a consensus-based final product is obtained, and validated by the main sector stakeholders.

1.34 **Technical capacity is needed to manage the subsidized health care system.** Sound management of health funding and risk is essential to guarantee effective insurance coverage for the population enrolled in the subsidized health care system, and the financial sustainability of its resources. The existence of a technical area dedicated to actuarial analysis is essential to accomplish this. SENASA, which administers the Dominican Social Security System's subsidized system, did not have the actuarial analysis capacity necessary for efficient resource management.

1.35 The first operation supported SENASA in the creation of an actuarial analysis unit that will provide information to guide health risk management processes. This unit's main functions include: (i) preparation of actuarial studies; (ii) calculation of beneficiaries' premiums; and (iii) development of reserves (unearned premium, reported claims, unreported claims, and catastrophic deviation), among others. Activities in this second operation will include supporting the implementation of the actuarial analysis unit, guaranteeing that it has the human resources and technical capacity to conduct the studies mentioned, estimate insured parties' premiums, and analyze SENASA's claim rate, etc.

6. Bank support for the social security and health sectors

1.36 **Operational work**. The Bank is supporting the health and social security sectors through various operations. The focus of health sector operations conducted since 2009 has been to improve quality of care and health care expenditure efficiency by strengthening primary health care and preventive services (optional electronic link 2); it also supports the strengthening of the sector's stewardship and improvement of the its management. Operations in the social security sector focus on the design and development of a comprehensive pension system in order to expand coverage, in an efficient, equitable, and sustainable way. For both sectors, the programmatic PBL complements the actions aimed at achieving the priority objectives.[54]

[54] The objective of the "Formalization and Productivity Improvement Program in the Dominican Republic" programmatic PBL (3326/OC-DR) was complementary to the support under this operation, emphasizing operational measures to control evasion and bring more workers into the formal sector, so as to boost the country's aggregate productivity. The loan was approved on 12 November 2014 and disbursed on 19 February 2015.

1.37 **Technical support.** Two technical cooperation operations are supporting the reforms. ATN/OC-14616-DR (Support for the Reform of the Health and Social Security Sectors) aims to support the Dominican government's efforts to deepen the current comprehensive reforms by funding activities to generate information on the design, regulation, and implementation of measures to enhance the system's coverage, equity, efficiency, and sustainability. To support this second operation, ATN/OC-14616-DR will support the analysis of measures included in the draft amendments to Law 87-01 and the solidarity pensions, as well as preparation of the regulations for the Health Career Law. Another technical cooperation operation (ATN/OC-14167-DR, Support for the implementation of the health sector reform) supported the review of the Health Services Plan catalogue (paragraphs 1.32 and 1.33).

1.38 **Lessons learned**. The first operation in this series and the technical cooperation portfolio (ATN/OC-14616-DR and ATN/OC-14167-DR) supplementing it promoted technical dialogue between the various key institutions of the SDSS, and between these institutions and the Bank, yielding the following lessons.[55] First, the definition of the strategic areas of the operation in a way that is aligned with the Dominican government's priorities facilitates the political commitment to developing the programmatic series (paragraph 1.39). Second, the support of the technical cooperation operations linked to the programmatic series has been rated by the counterpart teams as being critical for the resolution of technical and operational issues that could jeopardize the sustainability of the reforms, leading to the continuation of this support in the following phase. Third, active participation by the Ministry of Finance at the project preparation and monitoring stage facilitates coordination on decisions concerning the allocation of budgetary resources for implementation of the reforms. Fourth, expanding the coverage of health and social security systems should be accompanied by the regulatory support necessary for its implementation. In this operation this is reflected in the support for the preparation and application of standards for both sectors (paragraphs 1.29, 1.52, 1.10, 1.12, and 1.45). Lastly, the creation of interagency and intersectoral committees fosters effective dialogue and facilitates consensus-building among institutions. This lesson is applied to the process of formulating health career regulations (paragraph 1.52).

1.39 **Strategic alignment.** The program will contribute to the financing priorities of the Report on the Ninth General Increase in the Resources of the Inter-American Development Bank (document AB-2764) (GCI-9) of: (i) supporting development in small and vulnerable countries; and (ii) reducing poverty and enhancing equity by providing pension coverage to the poor and improving the efficiency of public spending on health. The program will contribute to the GCI-9's regional goals of reducing maternal and infant mortality rates. The program is aligned with the Strategy on Social Policy for Equity and Productivity (document GN-2588-4). The program is aligned with the strategic objective of "improving the quality of health services and the financial management and sustainability of the sector," and with the area of dialogue on social security reform in the IDB Country Strategy with the Dominican Republic (2013-2016) (document GN-2748). It is also consistent with the National Development Strategy (END) for 2010-2030, in its pursuit of health insurance and pension objectives, and a unified and sustainable social

[55] These lessons are consistent with good practices resulting from similar operations in the region (programmatic PBL "Results-based Management Program for Social Inclusion II," PE-L1154).

security system. It is aligned with the IDB's Health and Nutrition and Labor sector framework documents (documents GN-2735-3 and GN-2741-3, respectively), the objectives of which include strengthening health systems' institutional capacity so as to improve efficiency, and increasing the coverage of social insurance systems. Lastly, the program is aligned with the objectives of the Update to the Institutional Strategy 2010-2020 (document AB-3008), as it seeks to tackle the challenge of social exclusion and inequality through enhanced social protection mechanisms (i.e., health insurance and retirement pension systems), and to comply with the principle of multisectorality by adopting a comprehensive, interdisciplinary solution.

B. Objectives, components, and cost

1.40 The general objective of the programmatic series is to progressively consolidate social security coverage and improve health spending efficiency by deepening the reform being implemented by the Government of the Dominican Republic in the two sectors.

1.41 With the first operation the Dominican government undertook to promote strategic actions already included in its reform plan, but which faced the implementation challenges described above. The commitments agreed meet one or more of the following criteria:[56] (i) they are recognized as good practices with the potential for improving the efficiency and quality of services; (ii) the institutional capacity exists for implementation; and (iii) they have the backing of the highest levels of the Dominican government. This second operation maintains the objectives and structure of the original components the Bank agreed with the Dominican government at the start of the programmatic series, and introduces certain new elements into the conditions, strengthening the program. The Policy Matrix presents the policy actions proposed to execute the disbursement of resources in this second operation.

1.42 **Component 1. Macroeconomic framework stabilization.** The purpose of this component is to ensure a macroeconomic context consistent with the program objectives as established in the Policy Matrix. For this second operation, the same condition is maintained in the Policy Matrix.

1.43 **Component 2. Social security system consolidation.** The objective of this component is to gradually improve coverage through measures to complete implementation of the pension system with regard to its legal framework, operational aspects, monitoring systems, information programs, and financial education.

1.44 With the support of the first operation in the programmatic series, the Dominican government prepared a draft bill to amend the Social Security Law so as to improve the design of the SDSS. It promulgated a Decree introducing improvements in the targeting of solidarity pensions, analyzed the fiscal cost of reorganizing the SISPRE, expanded its information services by opening new offices in remote areas and utilizing electronic tools, and set up two intersectoral committees, one to move forward with the implementation of the SDSS Monitoring and Evaluation System, and the other to implement a financial education plan.

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[56] These criteria are based on lessons learned by the IDB in the Dominican Republic and other countries.

1.45 The second operation in the programmatic series retains the original objectives and continues the work carried out in the first phase with the fulfillment of the following conditions: 2.1 Presentation to the National Congress of the draft bill of amendments to Social Security Law (87-01) that covers the treatment of financing mechanisms, penalties for evasion and avoidance of social security contributions, responsibilities of the DIDA to measure the quality and delivery of services and benefits, and the specific periodicity with which pensions are indexed; 3.1 Determination of the roll of households eligible for the subsidized pension system using the SIUBEN index, safeguarding the financial sustainability and equity of the system; 4.1 Submission to the National Congress of the draft bill on the State Unfunded Pension System (SISPRE), organizing and establishing a new regulatory framework for SISPRE; 5.1 Inclusion of information campaigns on the changes in the SDSS being promoted by this operation to support dissemination to the beneficiary population; 6.1 Fulfillment of the work plan established for 2015, under which the monitoring system is to be deployed; and 7.1 Development by the interagency committee of action plans based on the SDSS Strategic Plan, including the relevant institutions, activities, and budget to promote a pension and financial culture. Four of the six conditions envisaged at the start of the programmatic series have been maintained. Certain adjustments have been made to the wording of the two conditions in order to strengthen them and improve their understanding. In two other conditions, individual actions aimed at achieving the objectives have been specified, as explained below (Comparative Matrix).

1.46 As regards condition 6.1, a monitoring system is due to come into operation for this second operation. With this objective, once the intersectoral committee had been set up, it was determined that a roadmap with annual targets needed to be followed in order to bring the system into operation. Execution of all the activities necessary to develop the first phase of system implementation and prepare for it to be brought into operation in 2016 was begun. Institutionalization of a monitoring and evaluation system requires multiple tasks, such as those identified when committee's work began and which have been developed with a high level of commitment by the seven constituent organizations coordinated by the CNSS, which monitors fulfillment of the targets of the 2014-2018 Social Security Strategic Plan.[57] The activities defined and on which progress is being made are: (i) consistency control and definition of a common glossary of indicators; (ii) creation of a single database from the various statistics produced by SDSS entities; (iii) the pilot of the new information platforms; and (iv) insurance of the quality of statistical output through the drafting of regulatory manuals and documentation on the Data Accelerator Program (DAP) for the sector's statistical operations. To account for this first phase of implementation identified at the start of the committee's work, this condition was modified in order to ensure that the activities of the Intersectoral Committee necessary to fulfill the targets proposed for the period of the programmatic series are executed (Comparative Matrix).

1.47 Condition 7.1 was modified to support essential operational measures identified when launching the actions of the intersectoral committee originating in the first operation. These operational measures include determining a budget and an

[57] The CNSS, ONE, Superintendent of Health and Occupational Risks (SISALRIL), SIPEN, DIDA, TSS, and SENASA.

annual work plan for the preparation of the contents of the financial education plan, prior to the formulation of the guidelines of the Financial Education Plan mentioned in the original condition (Comparative Matrix). Specifically, in the framework of the 2014-2018 Social Security Strategic Plan, which is monitored by the CNSS, the intersectoral committee undertook to design an annual work plan (AWP) and allocate a specific budget to the SIPEN that would allow more concrete progress on the preparation of the three main activities for implementation of the financial education plan: (i) the design of the content and materials necessary to incorporate the topic of social security into the curriculum; (ii) the design of teacher training content and materials; and (iii) the establishment of agreements with academic institutions specializing in social security topics.

1.48 **Component 3**. **Improved efficiency of the National Health System.** The objective of this component is to support the issuance of regulatory measures and the use of management tools to promote and facilitate the execution of priority strategies to improve health spending efficiency.

1.49 Through the first operation, the program supported approval of a Presidential order which launched the process of separating the stewardship and service delivery functions; approval of a comprehensive care model for the National Health System structured in integrated networks with a focus on primary care; approval of a new organizational and functional structure for the MSP centered on stewardship, approval of the National Health Quality Policy, approval of the Health Career Law for public health professionals; launch of an update of the PDSS catalogue; and creation of an actuarial analysis unit in SENASA.

1.50 The second operation in the programmatic series continues the work carried out in the first phase with the fulfillment of the following conditions: 8.1 The entry into force of the Law creating the National Health Service; 9.1 The assessment of the scale of resources necessary to develop the care model in the country's nine existing Regional Health Services and kicking off implementation in at least three of them; 10.1 Bringing the MSP's new organization and functional structure, focused on its stewardship function, into operation, and approval of a Strategic Plan for the MSP; 11.1 The entry into force of the health care quality policy and progress on licensing of health sector facilities, and the definition of parameters for monitoring the quality of mother and child care; 12.1 The preparation and submission for approval to the executive branch of the complementary regulations envisaged in the Health Career Law; 13.1 The updating of the PDSS catalogue; and 14.1 The entry into force of the SENASA Actuarial Analysis Unit. Five of the conditions envisaged at the start of the programmatic series have been maintained. The scope of two of the conditions was changed, as explained below (Comparative Matrix).

1.51 In relation to condition 8.1, during the first operation it was reported that the transitional nature of the DGCSS was causing administrative obstacles, limiting the full exercise of its functions. It is therefore necessary to give priority to ensuring the institutionalization and autonomy of the DGCSS, so that it is able to exercise its provision function and to make the separation of functions more sustainable. With this in mind, the original condition was strengthened for the second operation, and it was agreed that approval in the National Congress of a law putting the DGCSS on an institutional footing be promoted, with its being

renamed the National Health Service. This is a far-reaching measure supporting the sustainability of the process of separation of functions (Comparative Matrix)**.**

1.52 As regards condition 12.1, at the time of designing the programmatic series, the entry into force of the complementary regulations envisaged in the law was defined as a condition for this second operation. However, during the implementation of the first operation the need to rethink this condition was identified, with a view to strengthening the feasibility of its entry into force and subsequent implementation, and its sustainability over time, as it is a regulation that is a sensitive issue for the sector's professional bodies, involves multiple stakeholders, and its formulation is technically complex. This second operation will therefore support the Dominican government's commitment to formulate robust regulations that incorporate best practices from experiences in the region on developing health careers,[58] and lessons learned from updating the PDSS during the first operation. The regulatory development process[59] will foster the creation of an interagency team to develop and validate the law's proposed regulations. This will be coordinated by the MSP's Human Resources Division with various planning, service, record-keeping, and finance bodies in order for the regulations to be consistent with the new guidelines for human resources arising out of the effective separation of functions and the implementation of the health care model and quality policy. The preparation of the regulations will incorporate the viewpoints of the different stakeholders and professional bodies, will map responsibilities and roles, and will identify monitoring and evaluation mechanisms.

1.53 The changes in conditions 6.1, 7.1, 8.1, and 12.1 do not affect fulfillment of the proposed objectives under the programmatic series, since they promote actions that are better identified for starting up operation of a comprehensive monitoring system, creating a pension and financial culture, effectively separating the stewardship and service delivery functions, and creating conditions for improved distribution and use of human resources in the SNS.

1.54 At the end of the programmatic series, the Dominican government will have new legislative measures and institutional developments, which themselves generate capacities, incentives, and dynamics that provide continuity to the interventions under the programmatic PBL. For example, the new PDSS can be kept up-to-date because its design will include mechanisms and tools for that purpose, approved by the relevant stakeholders. Upon completion of the programmatic PBL, the technical cooperation support will also continue in order to respond to the technical and operational needs of future implementation stages of the social security and health reforms.

C. Results indicators

1.55 The policy actions promoted under this operation are part of a series of interventions that, over time, will have a positive impact on SDSS coverage and on health spending efficiency in the short and long terms. The Results Matrix

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[58] Report by the forum: "*Tendencias y desafíos en la definición e implementación de la carrera sanitaria*" [Trends and challenges in the definition and implementation of the health career] Editora Almonte, Dominican Republic, 2008. "*El proceso de construcción de las carreras sanitarias en la Región de las Américas*" [The process of construction of health careers in the Americas region], PAHO 2006.

[59] Supported by ATN/OC-14167-DR.

proposes indicators with which it is possible to evaluate the performance of the programmatic series, at the level of short-term results, which are indicative of improvements in the medium to long term in the following dimensions: (i) the coverage of social security systems; (ii) the quality of care of primary health care centers; and (iii) spending efficiency in the health sector. Progress on the results matrix indicators will be measured at the end of 2016.

1.56 **Economic analysis.** Building on international benchmarks, the Economic Analysis of the programmatic series estimated all the costs and identified the main benefits arising directly from implementation of the measures in the policy matrix. In the health component, benefits were quantified as the savings obtained from interventions to improve efficiency. In the social security component, benefits were quantified as the economic growth generated by the effect of the pension system on the labor and financial markets. The monetary costs and benefits of a scenario in which the programmatic PBL triggers and agreements in the policy matrix are effectively achieved and the targets described in the results matrix are fulfilled, were compared with those of a scenario assuming current trends in pensions savings and health spending remain unchanged. The programmatic PBL's measures were found to yield a net positive benefit through the increased growth in GDP, thanks to the effect on the labor market and capital markets, and the savings achieved from the measures increasing the efficiency of health spending. The base case analysis was for a 20-year time horizon and a 12% effective annual discount rate. The base case evaluated found the project to be cost-effective, with an IRR of 0.32 and NPV of RD$5.99 billion (US$132.2 million). The result proved robust to the sensitivity analysis.

II. Financing Structure and Main Risks

A. Financing instruments

2.1 This programmatic operation is based on the guidelines and directives established in the New Lending Framework: Assessment Report and Recommendations (document GN-2200-13). It is the second of two technically linked but independently financed operations, in line with document CS-3633-1 for the preparation and implementation of programmatic PBLs. A programmatic series was selected in order to provide medium-term support to the Dominican government's program of reforms in the social security and health sectors, and to promote an ongoing technical dialogue and possible refinements to the implementation strategy. The amount of this operation is US$300 million.

B. Environmental and social risks

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

C. Fiduciary risks

2.3 The executing agency has adequate levels of institutional development and performance to manage the operation, as illustrated by its solid experience and performance in the use of financial, administrative, and technical management mechanisms in accordance with the Bank's standards. Based on experience executing previous programs, no potential risks have been identified impacting

the management of a new operation, apart from noncompliance with the contractual terms and conditions in the loan agreement. To mitigate this risk close technical supervision will be maintained by the Bank.

D. Other risks

2.4 **Macroeconomic and fiscal sustainability risks.** The economy's vulnerability to external demand variations constitutes a risk. The Dominican government has adopted measures to readjust public finances and modify monetary policy.

2.5 There is also a risk relating to the potential fiscal impact of the reforms. However, analysis indicates that the gradual progress of the proposed health reforms will allow the government to absorb the costs of measures in a sustainable way without jeopardizing the public finances (Fiscal Impact Analysis). In the social security area, for those measures for which the cost has not yet been estimated, it has been agreed with the Dominican government that studies of their fiscal scope will be conducted.[60] The political commitment of the Dominican government to consolidating these reforms also contributes to the sustainability of the measures. The government's commitment is reflected in the 2010-2030 National Development Strategy (END), the 2013-2016 Multiyear National Public Sector Plan (PNPSP), and the 11% and 13.4% increases in funding for the health and social security sectors, respectively.

2.6 **Public management and governance.** The multisector nature and complexity of political economy of the interventions creates a risk of delays in implementation of the reforms due to the need for political consensus and close coordination between institutions. This is the case for the regulations for the Health Career Law and submission to the National Congress of the amendments to Law 87-01. To mitigate this risk, the Finance Ministry was chosen as the executing agency because it has the capacity and authority to play the leadership role in bringing together and monitoring all stakeholders and ensuring compliance with the policy matrix commitments, in accordance with the agreed critical path. The technical cooperation operations supporting the reforms (paragraph 1.37) incorporate intra- and extra-sectoral focuses and consensus-building in their design.

III. Implementation and Management Plan

A. Summary of implementation arrangements

3.1 The borrower is the Dominican Republic. The borrower will execute the program and utilize the Bank loan proceeds through the Ministry of Finance, which will be the executing agency. The Office of the Deputy Minister for Public Credit, within the Ministry of Finance, will be the body responsible for coordinating the policy and operational actions necessary to fulfill the commitments of the MSP, CNSS,

[60] For the social security area, fiscal cost studies were requested on the measures that could entail a spending increase. With the support of the first operation an analysis of the fiscal costs relating to the measures included in the draft bill for SISPRE was conducted, concluding that the fiscal cost of SISPRE was low compared to the cost of the existing system, even under more aggressive assumptions about the behavior of the number of people drawing pensions over the coming years when the burden could become significant. For this operation, a technical report will be financed on the scope of the draft amendments to Law 87-01, along with a report including the estimated fiscal costs of solidarity pensions, which the Dominican government plans to start gradually, depending on the strict budgetary restraints on this type of expenditure.

SENASA, SNS, and DIDA. It will have an expert devoted solely to this task to support the submission of evidence of fulfillment in due time and form.

3.2 Disbursement of Bank financing is contingent upon fulfillment of the policy conditions set out in the policy matrix and the other conditions established in the loan contract.

B. Summary of arrangements for monitoring results

3.3 Given the nature of the operation, the monitoring and evaluation plan agreed with the Dominican government consists mainly of verifying compliance with the policy conditions, and establishes that the policy matrix, results matrix, means of verification matrix, and critical path will be the instruments with which the program's outputs will be monitored. Outcome indicators will be monitored using: (i) the MSP information system; (ii) the SIPEN information system; (iii) the DIDA information system; and (iv) the National Multiple Household Survey (ENHOGAR). The means of verification will be compiled from the national systems and official documents. The Ministry of Finance will be in charge of compiling the operation monitoring data and consolidating it in reports for submission to the Bank in line with the agreements under the current plan (Monitoring and Evaluation Plan).

3.4 It was agreed that an economic evaluation would be conducted, consisting of the ex post cost-benefit analysis of the series of policy measures promoted by the programmatic series. The horizon of analysis will be the period between the start of implementation of the measures until the year in which the evaluation takes place, with the aim of measuring the medium-term changes, as there are policy changes whose effect will go beyond the time of the evaluation. The Bank will be responsible for this evaluation.

IV. POLICY LETTER

4.1 In the policy letter, the Finance Ministry sets out the macro and sector policy actions the country is implementing and those it plans to implement. These actions are consistent with the program objectives.

Development Effectiveness Matrix			
Summary			
I. Strategic Alignment			
1. IDB Strategic Development Objectives	**Aligned**		
Lending Program	**-Lending to small and vulnerable countries -Lending for poverty reduction and equity enhancement**		
Regional Development Goals	**-Maternal mortality ratio -Infant mortality ratio**		
Bank Output Contribution (as defined in Results Framework of IDB-9)			
2. Country Strategy Development Objectives	**Aligned**		
Country Strategy Results Matrix	**GN-2748**	**Improving the quality of health services and the financial management and sustainability of the sector.**	
Country Program Results Matrix		**The intervention is not included in the 2015 Operational Program.**	
Relevance of this project to country development challenges (If not aligned to country strategy or country program)			
II. Development Outcomes - Evaluability	**Evaluable**	**Weight**	**Maximum Score**
	8.8		**10**
3. Evidence-based Assessment & Solution	**10.0**	**33.33%**	**10**
3.1 Program Diagnosis	**3.0**		
3.2 Proposed Interventions or Solutions	**4.0**		
3.3 Results Matrix Quality	**3.0**		
4. Ex ante Economic Analysis	**10.0**	**33.33%**	**10**
4.1 The program has an ERR/NPV, a Cost-Effectiveness Analysis or a General Economic Analysis	**4.0**		
4.2 Identified and Quantified Benefits	**2.4**		
4.3 Identified and Quantified Costs	**1.2**		
4.4 Reasonable Assumptions	**1.2**		
4.5 Sensitivity Analysis	**1.2**		
5. Monitoring and Evaluation	**6.5**	**33.33%**	**10**
5.1 Monitoring Mechanisms	**1.5**		
5.2 Evaluation Plan	**5.0**		
III. Risks & Mitigation Monitoring Matrix			
Overall risks rate = magnitude of risks*likelihood	**Medium**		
Identified risks have been rated for magnitude and likelihood	**Yes**		
Mitigation measures have been identified for major risks	**Yes**		
Mitigation measures have indicators for tracking their implementation	**Yes**		
Environmental & social risk classification	**B.13**		
IV. IDB´s Role - Additionality			
The project relies on the use of country systems			
Fiduciary (VPC/FMP Criteria)	**Yes**	**Financial Management: Budget, Treasury, Accounting and Reporting. Procurement: Information System.**	
Non-Fiduciary	**Yes**	**Strategic Planning National System, Monitoring and Evaluation National System.**	
The IDB's involvement promotes additional improvements of the intended beneficiaries and/or public sector entity in the following dimensions:			
Gender Equality	**Yes**	**The intervention will contribute to improve the quality of strategic services for the sexual and reproductive health of women in the Dominican Republic, such as prenatal care, childbirth and postpartum. The high rates of maternal and infant mortality in the country indicate the low quality of care services. While prenatal care and institutional delivery services are virtually universal, maternal and infant mortality are among the highest in the region. For this reason, one of the objectives of the National Quality Policy is to define and institutionalize the indicators to be used in the monitoring and evaluation of maternal and child services.**	
Labor			
Environment			
Additional (to project preparation) technical assistance was provided to the public sector entity prior to approval to increase the likelihood of success of the project	**Yes**	**The Bank has been supporting the implementation of the policy conditions included in the operation through two technical cooperations. DR-T1098 supports the objectives of the project, through the hiring of consultants to support the process of separation of functions in the health sector and the elaboration of key studies in the area of social security. DR-T1111 supports the revision of the Catalog of Health Services Plan.**	
The ex-post impact evaluation of the project will produce evidence to close knowledge gaps in the sector that were identified in the project document and/or in the evaluation plan			

This is the second and last project of a programmatic series whose overall objective is to progressively consolidate social security coverage and improve health spending efficiency, by expanding the reform that is being implemented by the Government of the Dominican Republic in both sectors. Regarding the social security component, interventions proposed promote the improvement of the coverage and efficiency of the system. The main challenges identified are:(i) current Social Security Act limits coverage of SDSS (Dominican Social Security System) and the implementation of the subsidized regime (RS), (ii) lack of a new regulatory framework for the pension system, (iii) poor information channels with the population; (v) lack of a single system of monitoring and comprehensive evaluation of the SDSS;. and (vi) a low security culture. These challenges are supported by information from the Central Bank and the Superintendencia de Pensiones in relation to the low percentage of the working population listed and high informality rates.

The document in consistent with the analysis presented on the health sector technical note elaborated in the context of the Bank's country strategy with the Dominican Republic (2013-2016), as well as the analysis carried out for the first operation. The interventions will be implemented using the registry of eligible households, which will receive solidarity pensions and information services to guide the users on the benefits of being covered. The expected results of the project will increase the number of subsidized regime pensions and the number of people receiving counseling about the benefits of social security.

In the health component, interventions focus on the improvement of the efficiency of public spending in the sector. Public spending on health per capita is low in the DR compared with countries with similar income and the current level would be insufficient to effectively expand coverage proposed RS. Estimates also show technical inefficiency in public spending. The project proposes to implement a new model of medical care, the separation of the functions of governance and service delivery and an updated Health Services Plan. The results expected are: increase in the number of outpatient interventions that occur in the first level of medical attention, reduction in user´s spending on health and increase public health spending devoted to prevention services.

The document presents evidence of similar actions carried out in Latin America with positive results. The results matrix shows the vertical logic of the program. The document proposes an ex post cost-benefit analysis to assess the effectiveness of the program. The proposed mitigation measures include follow-up meetings, consultations, dialogues with the government and institutions.

POLICY MATRIX

Outcomes sought	Policy measures	
	Conditions fulfilled Programmatic PBL I	**Agreements Programmatic PBL II ***
Component I. Stable and sustainable fiscal and macroeconomic framework to support viability of program objectives		
(1) Suitable macroeconomic policy framework.	(1.1) A suitable macroeconomic policy framework is maintained.	(1.1) A suitable macroeconomic policy framework is maintained.
Component II. Support for consolidation of the social security system to improve coverage and efficiency		
(2) The design of the Dominican Social Security System (SDSS) financing systems will enable it to expand coverage of the Dominican population with financial sustainability, promoting system comprehensiveness and efficiency.	(2.1) Amendments to Law 87-01 have been drafted that, at a minimum: - define the treatment of financing systems that have not been implemented, in order to avoid segmentation of insurance by employment status, - authorize the Social Security Treasury (TSS) to penalize cases of evasion and avoidance of social security contributions, - add functions to the Participant Information and Protection Division (DIDA) for it to measure the quality and timeliness of benefits and information received by members, - determine how often pensions are to be indexed.	(2.1) The draft bill of amendments to Social Security Law (87-01) has been submitted to the National Congress. This bill: (i) defines the treatment of financing systems that have not been implemented, in such a way as to avoid labor market distortions, (ii) authorizes the TSS to penalize cases of evasion and avoidance of social security contributions, (iii) adds functions to the DIDA for it to measure the quality and timeliness of benefits and information received by members, (iv) determines how often pensions are to be indexed.
(3) Implementation of the subsidized pension system has begun.	(3.1) Regulations have been enacted on procedures for granting solidarity pensions, including the index of the Master Beneficiary System (SIUBEN) as an eligibility criterion for targeting.	(3.1) The roll of households eligible for the subsidized pension system has been determined, using the SIUBEN index as the main instrument of the implementation protocol, safeguarding the financial sustainability and equity of the system.
(4) The SDSS is unified and has a state unfunded pension subsystem that is aligned with the new legal framework.	(4.1) An analysis has been prepared of the fiscal cost of reorganizing the State Unfunded System (SISPRE).	(4.1) The draft bill on the State Unfunded Pension System (SISPRE) that organizes and establishes a new regulatory framework for SISPRE has been submitted to the National Congress.
(5) The coverage of the contributory system has increased.	(5.1) New information services have been set up, in particular: - Tools for access to information available to beneficiaries via electronic means, including at least: pension calculator, access to account statements. - Opening of five new information points, particularly in more remote areas.	(5.1) Information campaigns have incorporated the changes promoted in the SDSS by this operation in order to inform and enlist the beneficiary population.

* Comparative Matrix. Conditions agreed for the Second Operation vs. Conditions agreed for the loan proposal for the first operation under the programmatic PBL.

Outcomes sought	Policy measures	
	Conditions fulfilled Programmatic PBL I	Agreements Programmatic PBL II *
(6) The SDSS has a comprehensive monitoring system.	(6.1) An ad hoc intersectoral statistics committee has been established with one representative from each of the following institutions: National Statistics Office (ONE), Superintendent of Pensions (SIPEN), Superintendent of Health and Occupational Risk (SISALRIL), TSS, DIDA, National Health Insurance (SENASA), charged with designing and supervising implementation of the SDSS monitoring and evaluation system for its comprehensive development.	(6.1) The work plan established for 2015 for the monitoring system to come into operation has been complied with.
(7) Different age groups of the population value and are aware of the benefits of social security and savings.	(7.1) The National Social Security Council (CNSS) will have set up an (ad hoc) interagency committee responsible for developing the standards, rules, technical and legal guidelines, and procedures for the formulation, evaluation, approval, and execution of the national agreement to promote a pension and financial culture.	(7.1) The interagency committee has developed action plans based on the SDSS Strategic Plan, including: (i) the institutions responsible; (ii) their activities; and (iii) a budget defined for the promotion of the pension and financial culture.
Component III. Improved efficiency of the National Health System.		
(8) Separation of the Public Health Ministry (MSP) stewardship and service delivery functions has begun.	(8.1) The separation of the MSP's stewardship and service delivery functions has begun through administrative, functional, and territorial deconcentration of the Office of the Deputy Minister for Individual Care, to be called the Public Health Care Services Coordination Bureau (DGCSS), which will be charged with coordinating the regional health services, their health care institutions, and the self-managed health service centers.	(8.1) The law creating the National Health Service (SNS) has come into force, such that it is a public entity with its own legal status and administrative, financial, and technical autonomy to promote, coordinate, and manage the delivery of services, with the support of deconcentrated regional units (Regional Health Services, SRSs).
(9) Service delivery has been reorganized such that primary health care is the gateway.	(9.1) The new health care model of the National Health System will have been made official and will contain: (i) definition of the new organizational structure for public service providers, with primary care as the gateway, functioning in a network with the other levels of care, (ii) definition of the principles, guidelines, and parameters to be used by the regional services when offering health services, and (iii) the responsibilities and duties of the sector's stakeholders (MSP, provincial health divisions, insurers, providers of individual and group health services, and, lastly, citizens, families, and communities).	(9.1) The scale of the necessary resources (physical, human, technological) for the development of the health care model at the national level has been assessed (in the nine existing regional health services) and implementation has begun in at least three of these regional health services (implementation in the country will be done gradually).

Outcomes sought	Policy measures	
	Conditions fulfilled Programmatic PBL I	**Agreements Programmatic PBL II ***
(10) The MSP performs its stewardship role effectively.	(10.1) A new organizational and functional structure for the MSP has been defined that reflects stewardship of the National Health System (sector leadership, health intelligence, regulation, and supervision) as its main function, and the new structure will have been submitted to the Ministry of Public Administration (MAP) for approval.	(10.1) The new organizational and functional structure of the MSP, reflecting its primary stewardship role, has taken effect. (10.2) A strategic plan has been approved for the MSP for 2015-2018, which will: (i) focus on the MSP's lines of action within the main dimensions of its stewardship role, namely: sector leadership, health intelligence, regulation, and supervision; (ii) be aligned with the strategic objectives set out in the National Development Strategy – 2030.
(11) The National Health System has a health care quality policy.	(11.1) The MSP has approved a quality policy in health care that includes: (i) the standards of quality for health care provided by public, private, and semi-public health care providers; (ii) guidelines on medication and health technology security, safety, and efficiency.	(11.1) The MSP has implemented the quality policy in health care and has made progress on licensing health sector facilities and defining parameters for monitoring the quality of maternal and child care, at all levels.
(12) The National Health System's human resources have incentives encouraging equitable geographical distribution as well as regulations governing professional practice.	(12.1) The Health Career Law has taken effect, establishing the employment relationship between civil servants and the State, based on principles of efficiency and effectiveness, comprehensiveness, and merit-based selection and promotion.	(12.1) The supplementary regulations called for in the Health Career Law have been prepared and submitted to the executive branch for approval.
(13) The Family Health Insurance's Health Services Plan (PDSS) catalogue has been updated in accordance with the Dominican epidemiological profile and the health needs of the population.	(13.1) A call for bids has been issued for an international consulting service to review and update the PDSS catalogue in accordance with the Dominican epidemiological profile and the health needs of the population.	(13.1) The PDSS catalogue has been updated.
(14) SENASA has the capacity to generate actuarial analyses and monitor the evolution of the risk profile and costs.	(14.1) An Actuarial Analysis Unit has been created in SENASA, the main functions of which include: (i) preparation of actuarial studies to provide information for decision-making; (ii) calculation of beneficiaries' premiums, for each participant type; (iii) definition of new products for participants; (iv) analysis of SENASA's claim rate; and (v) development of the unearned premium reserve, the reported claims reserve, the unreported claims reserve (IBNR), and the catastrophic deviation reserve.	(14.1) The Actuarial Analysis Unit is in operation.