PROJECT INFORMATION DOCUMENT (PID)
CONCEPT STAGE

Report No.: PIDC17259

Project Name	DO-Health Sector Reform APL3 (P152783)
Region	LATIN AMERICA AND CARIBBEAN
Country	Dominican Republic
Sector(s)	Health (100%)
Theme(s)	Child health (20%), Health system performance (50%), Population and reproductive health (20%), Injuries and non-communicable disease s (10%)
Lending Instrument	Investment Project Financing
Project ID	P152783
Borrower(s)	Government of the Dominican Republic
Implementing Agency	MINISTRY OF HEALTH, CERSS
Environmental Category	C-Not Required
Date PID Prepared/ Updated	24-Nov-2014
Date PID Approved/ Disclosed	24-Apr-2015
Estimated Date of Appraisal Completion	19-Jun-2015
Estimated Date of Board Approval	28-Jul-2015
Concept Review Decision	Track II - The review did authorize the preparation to continue

I. Introduction and Context

Country Context

The Dominican Republic (DR) has achieved high economic growth since 1991, contributing to poverty reduction and improvements in the overall quality of life of its citizens. An upper middle income country with a GNI per capita in Purchasing Power Parity/PPP terms of US$11,150 in 2013, the DR's average annual GDP growth of 5.7 percent between 1991 and 2013 contributed to reductions in (a) its Gini coefficient from 0.51 in 2000 to 0.48 in 2011, as well as in (b) multi-dimensional poverty (the percentage of the population with more than three unmet basic needs), from 29.5 percent to 19.8 percent over the same period. Furthermore the DR's high economic growth has contributed to the steady improvement of its Human Development Index (HDI) score from 0.56 in 1990 to a high HDI score of 0.70 in 2013, placing the DR as 102 out of 187 countries in 2013 (UNDP 2014).

However, DR's economic growth has not led to a commensurate improvement in income-based

poverty and differentials in outcomes and access to quality services persist between rural and urban areas and across income quintiles. Between 2000 and 2011, the proportion of the transitory poor, i. e., persons with low incomes but who are not multi-dimensionally poor increased from 15 percent to 29 percent. Moreover, from 2003 to 2013, the average annual income increase of the bottom 40 percent of the DR population was 2.5 percent -- half of the average annual income increase of the bottom 40 percent of the LCR population (Ministry of Economy, Planning and Development/ MEPYD estimates cited in the Country Partnership Strategy/CPS 2014). In terms of differences in outcomes, there were more underweight children younger than 5 years old in rural areas (2.5 percent) than in urban areas (1.9 percent) in 2013 (Demographic and Health Survey/ENDESA 2013). In addition, only 48 percent of poor adolescents 14-18 years old attended secondary school, compared to 62 percent of the wealthiest (Employment Survey 2012). Finally, only 89 percent of women without any education gave birth assisted by a trained health professional compared to 98.4 percent of women with tertiary education (ENDESA 2013).

Social development is one of the four major pillars that support the Government's National Development Strategy 2010-2030. The Government long-term strategy envisions a society with equal rights and opportunities, guaranteeing universal access to education, health, decent housing and quality basic services, while promoting progressive reductions in poverty and inequality. Its medium term goals in the health sector aim to expand access to public health insurance and enhance the quality of services while, by 2030, the Government of the Dominican Republic/GoDR aims to: (a) ensure access to quality services, that promote health and preventive care, through an integrated National Health System; (b) guarantee universal access to health insurance to ensure access to services and reduce out of pocket costs; and (c) implement an integrated, transparent, and sustainable health and social security system.

Sectoral and Institutional Context

The DR has achieved positive results in key health outcomes over the past few decades but maternal mortality remains high and non-communicable diseases account for a major share of deaths. From 1990 to 2012, under-five mortality decreased from 60 to 29 per 1,000 births and infant mortality decreased from 46 to 24 per 1,000 births. During the same period, maternal mortality ratio (MMR) estimates decreased from 220 to 100 per 100,000 live births but remain much higher than countries with similar or lower incomes (World Development Indicators /WDI). While the country appears to have a chance to reach its under-5 mortality millennium development goal/MDG, it is not on track to reach its maternal mortality MDG. Chronic malnutrition (low height for age) in under-five children decreased from 9.7 percent in 2007 to 6.9 percent in 2012 while underweight (low weight for age) declined from 3 percent in 2007 to 2.0 percent in 2012 (ENDESA 2013). Moreover, both tuberculosis/TB incidence and Human Immunodeficiency Virus/HIV prevalence in the 15-49 age group decreased from 100 in 2000 to 62 in 2012 and from1.5 in 2000 to 0.7, in 2012, respectively (WDI 2013). Cholera cases significantly decreased from 20,851 in 2011 to 7,919 in 2012 and the cholera mortality rate dropped from 3.46 in 2011 to 0.67/100,000 inhabitants in 2012 (Ministry of Health/MOH 2013). Non-communicable diseases have emerged as a major cause of premature death. In 2012 (the latest nationally available data from the World Health Organization/WHO), cardiovascular diseases accounted for the largest share of registered deaths (35 percent), followed by cancers (17 percent), and then communicable, maternal, perinatal and nutritional conditions (16 percent).

Overall access to health services has increased and reflects some progress in reducing gaps but more effort is needed to improve certain indicators and to close coverage gaps between income quintiles

and urban/rural areas. ENDESA data collected from 2007 to 2013 show improvements in national-level coverage rates, as well as reduced coverage gaps between income quintiles and urban and rural areas. For example, the percentage of pregnant women who received prenatal care by a qualified health professional increased from 98.9 percent in 2007 to 99.3 percent in 2013, with an increase in the percentage of women in the poorest quintile who received this type of prenatal care from 87 percent in 2007 to 98.5 percent in 2013, significantly narrowing the coverage gap with women in the richest quintile (98.7 percent). Also, the percentage of births assisted by skilled professional increased from 97.5 percent in 2007 to 98.5 percent of births in 2013, with professionally assisted births for women in the poorest 20 percent of households increasing from 89 percent in 2007 to 97.2 percent in 2013, just slightly less than 97.8 percent of mothers in the richest income quintile in 2013. However, the percentage of children 18-29 months of age who received all their required vaccinations remained unchanged at 53 percent between 2007 and 2013, and a significant gap exists between children in the poorest quintile households (42.2 percent) and those in the richest quintile (58.8 percent). Adolescent pregnancy also remains high at 20 percent among 15 to 19 year old women, and the percentage of 15 to 19 year old pregnant women in the poorest income quintile is four times higher than the percentage of young pregnant women in the highest income quintile (DHS 2013).

While health insurance coverage has improved in the country due to the roll-out of the contributory and subsidized regimes, the GoDR has not yet attained its goal of universal coverage by 2011. Approximately 55 percent of the population has access to health insurance through the country's Social Security System, either through the Contributory Regime (CR), which is for formally employed workers, or through the Subsidized Regime (SR) which covers the poor. As of mid-2014, the CR had 3.07 million enrollees compared to 793,850 in 2007 while the SR had 2.47 million compared to 35,706 in 2004. The SR's current coverage rate is approximately 77 percent of its target population. To date, the Government has not initiated the Contributory Subsidized Regime (CSR) which is supposed to cover small businesses and the informal sector for an estimated 3 million persons.

Government efforts to improve the quality of primary level health services are producing promising results and these efforts need to be systematically expanded throughout the sector. To address quality gaps, the MOH is progressively equipping and staffing health facilities based on WHO guidelines. Moreover, in collaboration with the Social Cabinet (SC), National Health Insurance (NHI) and Executive Commission on Health Sector Reform (CERSS), the MOH introduced the Clinical Management System (CMS) in 2011 to monitor primary health care staff's compliance with established health protocols. The MOH has also been moving away from historical budgeting toward using results-based allocation of resources. With the support of the World Bank's Health Sector Reform APL2, the MOH is implementing results-based financing agreements (via results-based adjusted capitation payments to support a package of essential services for poor, uninsured persons) with regions 6, 7, and 8 using 10 coverage and quality based indicators at the primary level of care, focusing on maternal and child health and prevention and control of chronic diseases. Recognizing the importance of these agreements, the NHI has also adopted them in the same three regions in implementing the Subsidized Health Insurance Regime which is aimed toward the poor. Based on the positive results being achieved through this RBF mechanism at the primary level of care/PHC, the Government has decided to: (a) expand the RBF PHC scheme to other regions with the support of two loans from the Inter-American Development Bank; and (b) pilot a RBF scheme in hospitals, to improve the quality of continuum of maternal and child care, promoting better quality prenatal care, institutional deliveries and post-partum care with the support of the new

project or PARSS3.

Several actions to strengthen the institutional capacity of key sectoral stakeholders are underway, and the Government has requested the Bank's support in the areas of governance and evidence based planning and management. The MOH has been implementing various actions to strengthen its institutional capacity, such as improving its Health Management Information System (SIGS) which includes regularly fine-tuning the Clinical Management System which monitors health staff's application of health protocols during consultations in primary health centers. It also initiated the use of electronic family records nationwide. With the ongoing project's support, the MOH is also developing and/or revising tools and procedures for strengthening its stewardship role (for example, it is updating the norms for accreditation and rehabilitation of health facilities) and would need assistance to effectively implement these tools and procedures. Strengthening the MOH's stewardship capacity has become even more important because of the October 2014 Presidential decree paving the way for Congressional approval of the proposed law for the separation of functions in the health sector such that service provision will be under the Directorate of General Coordination of Public Services Health Care (DGCSS) in lieu of the MOH which will continue to perform its stewardship and essential public health functions. The NHI has also taken steps to improve its strategic purchasing function including enhancing its actuarial capacity and adoption of performance based contracts at the primary level of care and would need additional support in implementing these various changes. Moreover, PROMESE/CAL (Program on Essential Medicines and Center for Logistic Support) which has been mandated by a 2013 Presidential Decree to function as the sole central supplier of drugs, medical supplies and laboratory reagents to meet the demand of the National Public Health System, would need assistance in strengthening its management of the supply chain of drugs and medical inputs. Finally, the improvements and consolidation of various information systems with the support of PARSS2 is generating a significant amount of data that would need to be systematically analyzed to support the design and implementation of evidence-based policies and programs. As part of its institutional mandate, CERSS has begun implementing a health sector strategic monitoring program, that could be systematized to analyze available information for evidence based public policy and program design and implementation to improve efficiency and equity in the health sector and promote innovations.

Relationship to CAS

The proposed Project is consistent with the Results Area on Strengthening Social Services Delivery of the DR Country Partnership Strategy for the period FY15-18. In the health sector, the Project would support ongoing and proposed health reforms to further improve access and quality of health services and develop a strategy to reach the informal sector.

The Project also responds to the Government's goal of enhancing coverage and quality of health services, health financial protection of the poor and uninsured, as well as improving the quality of spending (or getting "good value for money spent") of public institutions working in the sector. Thus, in line with both the CPS and the GoDR's goals, the Project will: (a) expand results-based financing in hospitals and strengthen coordination across all levels of care in the public health network to improve quality of care ranging from prenatal care to safe deliveries, while continuing efforts to prevent and control NCDs; and (b) support activities that enhance sector governance and sector efficiency.

II. Proposed Development Objective(s)

Proposed Development Objective(s) (From PCN)

The Project's development objective is to support the Government to improve the performance of the public health system. This will be done through: (a) strengthening the capacity of regional health services and participating public hospitals to deliver quality services in a timely manner, focusing on maternal and child care and prevention and control of NCDs; and (b) enhancing sector governance and the institutional capacity of public sector institutions to strategically purchase goods and services, to develop and implement evidence-based policies and programs, and to respond to public health emergencies.

Key Results (From PCN)

Proposed development indicators could include the following:

For Component 1

a. Percentage of professionally attended deliveries that comply with pre-established quality criteria

b. Indicator to monitor appropriate functioning of the maternal and child healthservices network (this indicator is under discussion and will measure quality of referral and counter-referral system for MCH services)

c. Percentage of children younger than 15 months old within the target population who have received a complete vaccination package.

d. Percentage of individuals diagnosed with hypertension who are under treatment based on the national protocol

For Components 2 and 3

a. Three short-term health sector innovation/improvement sub-projects designed, implemented, and evaluated

b. MOH Monitoring and Evaluation Policy and Plan prepared and made official

or

Update of the Health Situation Analysis Report that is published by the Ministry of Health and the National Health Accounts at least once by end of Project.

III. Preliminary Description

Concept Description

The proposed project is the third investment loan (US$50 million) of a three-phased Health Sector Reform Adaptable Programmatic Lending/APL for the DR. In June 2003 the GoDR and WB signed a three-phased APL Agreement with the overarching objectives of improving maternal and child and reducing poverty, and supporting the implementation of health sector reforms. The first phase/APL1 (US$30M), implemented from 2005 to 2009, focused on strengthening health care infrastructure, reorganizing regional health systems, improving multi-year financial planning, and supporting actions to increase the number of poor enrolled under the Subsidized Health Insurance Regime. The second phase/APL2 (US$30.5M) began in January 2010. Using a results-based financing approach, it is focused on improving access to quality primary health care services, especially for the poor and those who have no access to health insurance. It also supports the institutional strengthening of the Ministry of Health, PROMESE/CAL, and the NHI which is the health care purchasing agent for the Subsidized Regime which covers the poor.

The third Project will build on the experiences and achievements of the ongoing Project. It will

continue to: (a) support the development and implementation of strategies and policies that improve health service coverage and quality, especially for the poor and those who have no access to insurance; and (b) strengthen the capacity of major health sector entities in responding to key sector priorities, especially those related to improving maternal and child health care and NCD prevention and control, enhancing efficiency and quality of health spending, and improving sector governance which includes public health emergency response.

The proposed Project will have three major components:

Component 1: Results-based Financing in the Regional Health Services (RHS) and participating hospitals, emphasizing the service network for maternal and child health and prevention and control of NCDs

The main objective of this component is to improve coverage and quality of health service provision based on a set of interventions that include the implementation of results based financing to: (a) strengthen the network of maternal and child health services provided by Regional Health Services 6, 7 and 8 in coordination with participating hospitals; and (b) continue to enhance the prevention and control of chronic illnesses at the primary level of care.

As with the ongoing APL2, this component will continue to support results-adjusted capitation payments at the primary level of care based on the attainment of targets for 10 coverage and quality based indicators; current indicators will be reviewed and adjusted during Project preparation. It will also expand the use of results-based incentives to participating hospitals in the three PARSS2 regions, and in the maternal and child health services network to promote institutional deliveries that comply with quality criteria. During Project preparation, in response to the MOH's request, the Bank and Government teams will jointly assess the feasibility of including in this component a national level referral hospital (for example, the Maternity Hospital of our Lady of Alta Gracia which is located in Santo Domingo) where a large proportion of births take place.

This component will also support the development of simplified protocols to promote the functioning of a coordinated network approach across the levels of care for maternal and child services (focusing on prenatal care, deliveries, newborn care, and post-partum care) in the participating regions and facilities, as well as training of health staff and provision of basic equipment to participating hospitals to enable them to provide the required maternal-child services.

Component 2. Improving the Quality of Public Spending on Health Care Goods and Services

This component aims to further strengthen the institutional capacity of public sector organizations to plan for, finance, purchase, monitor, and supervise health services and other key inputs needed to improve the quality of health care, with a special emphasis on the services and goods oriented towards the poor. Specifically, this component will support training and other activities for three main sectoral institutions: (a) the NHI to better perform its role as the principal public sector risk management agency, particularly in terms of improving its capacity to efficiently purchase health services and to ensure their quality under the Subsidized Regime (health insurance for the poor); (b) PROMESE/CAL to improve the management of the supply chain for essential medicines and medical inputs, with a focus on access and quality of medicines in the pharmacies of the people or "farmacias de pueblo" where the poor can have access to medicines under the Subsidized Regime; and (c) CERSS to enhance its capacity to perform its function of analyzing sector information and

monitoring progress in health sector reforms. This component could also support the implementation of small innovative health system improvement sub-projects via grants to government teams and, possibly, civil society groups; the Grant mechanism details will be worked out during the course of project preparation.

Component 3. Strengthening the MOH's Capacity to perform its Stewardship Role and its Legal Framework

This component seeks to: (a) improve the MOH's capacity to perform its stewardship function, particularly in planning, health regulation and accreditation, monitoring and surveillance, and in managing essential public health services including coordinating and responding to public health alerts and emergencies; and (b) review and update the legal framework of the national health system in general and that of the MOH, in particular.

Key activities that this component could support include: (a) the development, implementation, and monitoring of the MOH's National Development Plan 2016-2024 and (b) assessment of the status of envisioned Health Sector Reforms, identifying opportunities for improvement/action such as assessing the feasibility of implementing the Contributory-Subsidized Insurance Regime for the informal sector.

This component will also include a sub-component to assist the MOH in coordinating and swiftly implementing the national response to different types of public health threats including the current Ebola epidemic. It will finance consulting and non-consulting services, technical assistance, and goods including medicines, laboratory and protective equipment, reagents and other supplies, development and dissemination of information materials, training, and other public health emergency response related activities. It will build on lessons learned in implementing the established guidelines and procedures used in the ongoing Health Sector Reform Project for triggering the use of such funds.

IV. Safeguard Policies that might apply

Safeguard Policies Triggered by the Project	Yes	No	TBD
Environmental Assessment OP/BP 4.01		×	
Natural Habitats OP/BP 4.04		×	
Forests OP/BP 4.36		×	
Pest Management OP 4.09		×	
Physical Cultural Resources OP/BP 4.11		×	
Indigenous Peoples OP/BP 4.10		×	
Involuntary Resettlement OP/BP 4.12		×	
Safety of Dams OP/BP 4.37		×	
Projects on International Waterways OP/BP 7.50		×	
Projects in Disputed Areas OP/BP 7.60		×	

V. Financing (in USD Million)

Total Project Cost:	50.00	Total Bank Financing:	50.00
Financing Gap:	0.00		

Financing Source	**Amount**
Borrower	0.00
International Bank for Reconstruction and Development	50.00
Total	50.00

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