Deloitte Touche Tohmatsu

Evaluation of REDSALUD and USAID/DR Strategic Support to Reform of the Dominican Health Sector

Submitted by:
Deloitte Touche Tohmatsu Emerging Markets, Ltd. (Emerging Markets Group)

In Association With:
The International Science and Technology Institute (ISTI)

Under Contract No.:
GHS-I-800-03-00031-00, Order No. 02

Date:
May 28, 2004

TABLE OF CONTENTS

EVALUATION TEAM

Dr. Cesar Chelala

Dr. Jaime Arias

Ms. Cindi Cisek

Mr. Alejandro Moline

Ms. Karen Cavanaugh (USAID)

LIST OF ACRONYMS

AD	Acute Diarrhea
ARI	Acute Respiratory Infection
ARS	Health Risk Administrators
CERSS	Executive Commission for Health Sector Reform
CMS	Dominican Medical Association
CNS	National Health Council
CNSS	National Council for Social Security
CONEP	National Council of Private Companies
DIDA	Department of Information and Defense of Affiliates
DPS	Provincial Health Department
DR	Dominican Republic
ENDESA	Demographic and Health Survey
GDP	Gross National Product
HIV/AIDS	Human Immunodeficiency Virus / Acquired Immune Deficiency Syndrome
IADB	Inter-American Development Bank
IDSS	Dominican Social Security Institute
INSALUD	National Health Institute
INTEC	Technology Institute of Santo Domingo
MRHSP	Modernization and Restructuring of the Health Sector Project
OAU	User Care Offices
OCT	Office of Technical Coordination
ORU	Oral Rehabilitation Unit
PAHO	Pan-American Health Organization
PAI	Broad Immunization Program
PCU	Primary Care Unit
PHSDP	Provincial Health Services Development Project
PROMESE/CAL	Essential Drugs Program/Center for Logistic Support
PROSISA	Program of Reinforcement of the Health System
SENASA	National Health Insurance Agency
SESPAS	Secretariat of State and Public Health and Social Assistance

SISASRIL	Superintendence of Health and Labor Risks
TB	Tuberculosis
TSS	Social Security Treasury
UMDI	Modernization and Institutional Development Unit
USAID	United States Agency for International Development

EXECUTIVE SUMMARY

The United States Agency for International Development (USAID) collaborates with the Dominican Republic (DR) in various areas. In the health sector, its strategy is directed towards a sustainable improvement of the health of the most vulnerable populations through various projects. One of these projects is REDSALUD, a 5 year project initiated in July 2000 with Abt Associates Inc. for an amount of US$13.3 million. The REDSALUD project seeks to support reform and decentralization within the Dominican Republic health sector. USAID hired Deloitte Touche Tohmatsu Emerging Markets, Ltd. and the International Science and Technology Institute (ISTI) to evaluate the strategy and activities implemented by REDSALUD. This evaluation was carried out in the Dominican Republic between March 16th and April 4th of the present year. The results of this evaluation are described in this document.

Reform Context

In the late 1980s a discussion of the possible reforms to the health and social security sectors in the DR was initiated; in the year 2001, Congress approved the 42-01 (Health Sector Reform) and 81-01 (Social Security Reform) laws. During the 1990s, the country lived in economic prosperity with an increase in the GDP above 6.5%, but in 2003 there was a currency crisis that generated difficulties in health financing and in the implementation of the new social security and health systems.

Current Situation

Although there have been improvements in some reform processes, this has not extended to all areas. For example, in the creation of a new regulatory legal framework, in the structure of the institutions designed under the social security law, and in the partial initiation of the subsidized regimen of Family Health Insurance in Region IV, there are a series of disturbing factors which raise doubts as to the imminent and complete initiation of the reforms. During the current year, presidential elections will be held in the country. These elections create uncertainty due to possible changes in government which, in turn, could affect the continuation of the reform process. In addition to these contextual factors, there has been a lack of clear leadership in the execution of these changes, and concern by some players as to the costs of the Basic Health Plan (PBS) and professional fees within the sector.

Major Health Problems in the Dominican Republic

The DR has a traditional health system characterized by low coverage, deficient quality of some services, fragmentation of financing plans and benefits, low insurance levels, high and unequal out of pocket expenses, inefficient use of resources, emphasis on hospital care and curative care, and very poor government regulation, control and surveillance. The evaluation team found that the main structural problems are: low coverage, inequity, a very centralized system with minimal autonomy in the regions and provinces, inefficiency due to poor management, and weaknesses in the public health programs.

As result, the DR shows very high infant and maternal mortality rates, dissatisfaction of the users, simultaneous presence of illness and infections associated with poverty (AD, IRA, HIV-

AIDS, Malnutrition, TB and others) while degenerative illnesses such as cancer, trauma and hypertension appear among the most common causes of doctor visits and hospitalization.

Response of the Reforms

The reforms are intended to address the most critical problems in implementing the following policies and measures: expansion of coverage and improvement of equity, strengthening of the supervisory body, regulation and surveillance, separation of functions, decentralization, changes in the financing of supply and demand; unification of insurance plans financing, collection and benefits; support of basic medical care; support of public health programs; improved efficiency and competitiveness, greater social participation in the system, application of efficient management tools and adoption of integrated information systems.

Findings on USAID Strategy and the Activities of REDSALUD

The evaluation team found that USAID's strategy has been correct, coherent and viable, and that its sustainability depends on the reform course and the health policies of the country. The focus of USAID's program is relevant and has been executed according to plan. In regards to REDSALUD, the evaluation team found that both the original design and the changes made during the course of the project were reasonable. The five demonstration generations of the project have worked adequately. There was clear satisfaction among the Health Region V provincial and regional employees, as well as the health authorities at the central level and within the social security system. In order to guarantee viability, some projects need to be further developed in the next two years and others need to be maintained for a longer period of time.

Recommendations

The **short-term** (2004 to 2005) recommendation for REDSALUD is to provide support to the new health sector authorities who may come in to office after August; to consolidate the achievements of Region V; to support the acquisition of personal identification documents for potential subsidized members; to ensure the sustainability of the activities undertaken and to systemize and share the successes of the program.

For the **medium-term**, the recommendation is that USAID continues to provide support to the three lines of action: support to local management in Region V; support to the central level (SESPAS and new entities); and support in the political sphere.

For the **long-term**, the recommendation to USAID is that prior to evaluation of the health sector in 2006, USAID continue to promote reform activities by maintaining its active participation in dialogues and supporting the most committed key players; coordinating efforts with other agencies; looking for synergies with other USAID programs; supporting the creation of "Think Tanks;" and strengthening public health programs that target improvement of the health of the most vulnerable populations (such as reproductive health, maternal and child health, HIV-AIDS, etc).

I. INTRODUCTION

The reform process of the Dominican Republic Health Sector was initiated in the 1990s and its main goals were: extension of coverage, increased equity, and improvement of the quality of health services. In the year 2001, The General Health Law and the Social Security Law were approved, establishing a legal framework for future reforms within the sector. Afterwards, on November 1, 2002, the subsidized regimen of Family Health Insurance was initiated in the country's Region IV. The subsidized regimen refers to the part of the national health system that includes individuals who qualify for subsidized health insurance.

The United States Agency for International Development (USAID) collaborates with the Dominican Republic in various important areas and its strategy for the health sector focuses on sustained improvement in the health of vulnerable populations. In July 2000 USAID signed a five year, US$13.3 million contract with Abt Associates Inc. to implement the REDSALUD project. Designed to support the reform and decentralization of the Dominican health sector, REDSALUD contributes to USAID's Fourth Intermediate Result (IR4) and national strategy aimed at increased efficiency and equity of basic health care services at the local level.

USAID hired the firm Deloitte Touche Tohmatsu and the International Science and Technology Institute (ISTI) to evaluate USAID strategy for health sector reform and activities implemented by REDSALUD in contribution of this strategy. Deloitte Emerging Markets and ISTI formed an evaluation team, composed of four international consultants, a local specialist in health reform and an assessor from USAID with extensive experience in the health sector and the REDSALUD project. This team conducted its evaluation in the Dominican Republic from March 16th to April 4th, 2004.

II. OBJECTIVES AND METHODOLOGY OF THE EVALUATION

A. OBJECTIVES

The objectives of the evaluation, specified in the Statement of Work are the following:

1. Evaluate recent progress in the design and implementation of the reforms and point out the key problems of the Dominican health system, placing special emphasis on its relevance, coherence, viability and sustainability.
2. Examine the relevance, coherence, viability and sustainability of the USAID strategy and the activities implemented by the REDSALUD project.
3. Make short, medium and long-term recommendations that may be used to re-design or adjust the strategies and interventions supported by USAID.

B. METHODOLOGY

The evaluation process began with the review and analysis of extensive documentation related to the reform sector. This included the General Health Law--which serves as the basis for creation of the new Dominican Health System of Social Security--as well as the main regulations and documents of the REDSALUD project, which included the plans, programming and results of yearly exercises.

At the beginning of the evaluation, meetings with the USAID/DR and REDSALUD personnel were held, and a series of visits and in depth interviews were conducted with key players from the Secretariat of State of Public Health and Social Assistance (SESPAS), the National Council for Social Security (CNSS), the Superintendence of Health and Labor Risks (SISASRIL), the Board of Directors of the Department of Information and Defense of Affiliates (DIDA), the Pan-American Health Organization (PAHO), the Dominican Medical Association (CMD), the Executive Commission for Health Sector Reform (CERSS), the National Health Insurance Agency (SENASA); the National Health Institute (INSALUD) and other relevant entities. In addition, managers from the World Bank, the Inter-American Development Bank, Prosisa and the European Community Program were interviewed in order to gain other perspectives and a fuller understanding of the issues.

Once the evaluation team analyzed the information from these interviews, the team conducted Health Region V field visits in order to meet some of the local authorities, tour the clinics, and liaise with community organizations linked to the activities of the project. Furthermore, a provincial hospital in Health Region I was visited, with the purpose of comparing results, and provincial SESPAS employees were interviewed. See Attachment I for a list of interviews conducted.

When the field information was processed and organized, meetings among the members of the evaluating team were held; a preliminary version of the report was written and a presentation to be shown to USAID/DR was prepared for receiving observations and suggestions. As a final step, this report was prepared.

III. CONTEXT OF THE REDSALUD REFORM

A. ECONOMIC ENVIRONMENT

According to information from the Dominican Central Bank, at the end of the 1990s, the Dominican Republic had a 9.4% economic growth rate, sustained by a strong flow of public and private investment. Health expenses (mainly private) remained at near 6.5% of the Gross National Product (GDP), yet no sustainable improvements were made in the principal health indicators. The current decade has not maintained the economic growth of the 1990s, and during 2003 GDP declined 0.4% due to the depreciation of the national currency, the high cost of fuel and the banking crisis that shook the national financial system.

The crisis and macroeconomic imbalance of the recent past forced the government to turn to the International Monetary Fund (IMF) on February 11 of this year. The IMF Board of Directors gave their approval to an agreement between the IMF and the Dominican Republic. This agreement presents several conditions and controls, which will impose restrictions and discipline in the fiscal and monetary sectors. Most importantly, it will necessarily affect the government's investments in social sectors and will negatively impact public spending in health.

B. POLITICAL ENVIRONMENT

The Dominican Republic is a representative democracy with separation of the Executive, Judicial and Congressional branches. The country has made institutional advances after long years of dictatorship, becoming a more open political society, yet still shadowed by the interests of the political parties, particularly during the pre-electoral season.

This political environment has a strong influence on the public sector, where many institutions are submerged in a functional lethargy during the pre-electoral season; for example, some officials leave their duties to become involved in political campaigns, which spreads an air of uncertainty throughout the sector. In 1991 the country enacted the law of Administrative Career and Civil Service, which sought to address some of these issues. However, the law has had a slow application, particularly in the health sector, due in part to the complexity of the human resources component.

Last year, Congress eliminated the legal restriction to presidential reelection. Presidential elections will be held May 16 with the most likelihood of success among the candidates of the Dominican Liberation Party (PLD), the Dominican Revolutionary Party (PRD) and the Reformist Social Christian Party (PRSC). If a change in government should occur, a turnaround in the high echelons of the governmental institutions in the health sector is quite likely; these changes at the national level often reach the regional, provincial and local levels, and could affect the continuity of current reform activities. In Annex II we present a summary of the participation of the recent governments in the Dominican health sector reform process.

C. THE HEALTH SYSTEM

ORGANIZATION OF SERVICES

The health services system, a mixed one by nature, is made up of public institutions, the private sector and NGOs. The public sector includes a series of institutions such as the Public Health and

Social Assistance Secretariat (SESPAS), the Essential Drugs Program/ Center for Logistic Support (PROMESE/CAL), and the Dominican Social Security Institute (IDSS), as well as new entities established by the 2001 law. SESPAS is a government department organized at the central, regional and provincial levels. It encompasses nine Health Regions, over 30 Provincial Health Directorates, and the Directorates of Health Areas.

Urban and rural clinics and physicians' offices constitute the first level of care. These health facilities are the center of the PCUs (Primary Care Units) of which there is one or more per facility. The second level of care includes the municipal and provincial hospitals, and the third level is made up of regional hospitals. According to SESPAS's records for 2002, there were six specialized hospitals, eight regional hospitals, 107 municipal hospital, 22 provincial hospitals, 615 rural clinics, 90 medical dispensaries, 30 health centers and 159 physicians' offices.

CARE MODEL

The current predominant care model in the country is curative, with an emphasis on hospitalization. Health establishments offer a total 12,057 beds, i.e., one bed per every 720 inhabitants. It is estimated that in 2002 there were an average of nine doctors for every 10,000 inhabitants. These statistics indicate that good quality public heath services could be provided to the entire population. However, even though the average number of doctors is adequate in general terms, this resource is concentrated in urban centers. In regards to professional nurses, there are too few, and a large percentage of them are not adequately qualified for their duties.

The public sub-sector's care model has been characterized by the free provision of health services through state funding, even though other care provision financing models have been introduced, such as a cost-recovery fee. Expenditure analyses show that users are obligated to make considerable out of pocket contributions. Another issue is that public health care is designed for groups in extreme poverty, but a large percentage of the non-poor population uses these free public services, especially in cases of hospitalization, surgery and high-cost treatments.

The country has an important private health care provision sector that is fundamentally supported by direct payment. Over the past few decades, a pre-paid care system has been growing, mainly through medical stipends that also serve as insurance. While SESPAS's facilities expand throughout the national territories, the IDSS, some NGOs and private clinics primarily focus their activities in the country's urban areas. The NGO sector plays an important role in the provision of primary care services, particularly in sexual and reproductive health programs, aimed towards low-income populations in marginal areas.

CURRENT HEALTH SITUATION

The Dominican Republic has experienced a reduction in morbidity by transmissible diseases. According to the Pan-American Health Organization (PAHO), the five main reasons for seeking medical consultation are Acute Respiratory Infection (ARI), Acute Diarrhea (AD), Arterial Hypertension, pregnancy and skin diseases. Malnutrition remains a serious problem among the most poor, particularly children, and the rate of diarrhea and respiratory diseases remains high among children under five years of age. The infant and maternal mortality rates are higher than those of other countries with a similar degree of socioeconomic development. According to

official sources, the estimated infant mortality rate is 34.4 per 1,000 born living for 2000-2005 (Basic Health Indicators 2002. Dominican Republic, SESPAS, PAHO).

Maternal mortality is a useful indicator in measuring not only the health situation, but also the access to and quality of care. It is important to point out that despite the fact that approximately 98% of births are institutional, the maternal mortality rate remains very high. According to the statistics provided in the 2002 Demographic and Health Survey (ENDESA) mortality during the first year of life for 1997-2002 was estimated at 31 for every 1,000 born living and the rate of maternal mortality for the period 1992-2002 was 178 for every 100,000 births. Inadequate nutrition in pregnant women causes a high percentage of low birth weight babies, which reduces their chances of survival.

The health sector shows a series of inequities in insurance coverage, levels of expenditure and quality of service. For instance, only 4.2% of the low-income population have health insurance coverage, compared to 41% coverage for these services in the mid to high level income populations. In regards to expenditure in health, the poorer populations spend a greater percentage of their income on health services than do the richer populations. For example, it is estimated that about 30% of the income of the poorest homes are spent on health services, which is higher than in the richer sectors. In addition, it should be noted that 30% of the population in the higher income sector uses SESPAS's services, while at the same time 30% of the poorest fifth of the population have to pay for services in the private network. By 1995, the main sources for health financing in the Dominican Republic were each home's personal finances (75.1%), with the State having a very low level of participation (14.4%). The low coverage from health insurance, (particularly for the poorest individuals) the high out of pocket expenses for health care, the high rate of diarrhea and respiratory diseases in children under five, and the high infant and maternal mortality rates contributes to an environment of inequity and low quality of services.

D. PROJECTS THAT SUPPORT THE REFORM PROCESS

World Bank (WB)

The World Bank provided support to health reform in the Dominican Republic with the Provincial Health Services Development Project (PHSDP). This project included a $30 million loan and a $12 million grant for a total value of $42 million; it began in 1998 and is scheduled to end June 30th, 2004. The project has three components: the first is to finance new ways of offering basic services to unattended populations; the second is to develop mechanisms to strengthen financing and resource allocation in the health sector and to promote local hiring; and the third is to support SESPAS's policymaking and service regulating functions. The project is applied intensely in Heath Region IV. The project has aided SESPAS's vaccination efforts, hospital rehabilitation, training in hospital reform, introduction of a computerized information system, strategic planning for the reorganization of the health service network, an inventory of the health personnel for the provinces in Region IV, and vehicles acquisition.

Inter-American Development Bank (IADB)

The Inter-American Development Bank has supported health sector reform with the Modernization and Restructuring of the Health Sector Project (MRHSP). Approved in 1997 with

financing of US$75 million, the project began in 1998 and will conclude in 2005. The project has four components: policy formulation; aid to SESPAS and PROMESE; support to the IDSS and the Social Security System; initiation of pilot programs in primary and specialized care areas.

European Union (EU)

The European Union supports health reform through the Program of Reinforcement of the Health System (PROSISA), which began in 2000 and will end its operations in 2005. This program has a European Union donation of 12 million Euros, and a 1.5 million euros donation from the National Controller of European Development Funds. PROSISA has three components: institutional support; resource management; and medication. The program is implemented in the Northeast region of the country.

United States Agency for International Development (USAID)

USAID supports health sector reform with the $13.3 million Health Reform and Decentralization Project (REDSALUD) that began in 2000 and continues to 2005. The project has three components: the first is to support the local management of health services, implemented solely in Region V (Eastern Region); the second is to provide support to SESPAS at the central level; the third is to provide support at the national policy level. The project is implemented through a contract between USAID, Abt Associates and five partners—Development Associates, the National Health Institute (INSALUD), Family Health International, George Washington University and American Manufacturers Export Group (AMEG).

E. NEW LEGISLATION APPROVAL

In March and May of 2001 two seminal laws were approved, which set the legal framework for a new phase in the health and social security field -- the General Health Law (42-01), and the law that creates the new Dominican Social Security System (87-01). The 42-01 law establishes that the health system supervisory body is SESPAS, while the 87-01 law establishes that the supervisory body of the social security subsystem will be the National Council for Social Security (CNSS).

In addition, the General Health Law dictates that SESPAS must promote a gradual separation of the supervisory and service provision functions, indicating that its health establishments must conform to a new modality of service provision. In addition, the law calls for the creation of the National Health Council (CNS) as an entity for social participation, assessment and support for SESPAS. Consequently, the law establishes that SESPAS be the highest health authority, responsible for the design and application of health policy and plans throughout the country. The law creates general provisions concerning the accreditation and functioning of the health services provision institutions, be they private or public.

The Social Security law determines the financing of the system, the general health provisions and the way in which members will have access to them. The goal is to have the entire population's basic health needs covered through a universal social security system, that does not discriminate by condition or affiliation within the system.

To foster development of the system, the law mandated the creation of several entities such as: The National Social Security Council (CNSS), the Superintendence of Health and Labor Risks (SISASRIL), the Social Security Treasury (TSS), the Directory of Information and Affiliate

Defense (DIDA) and the National Health Insurance Agency (SENASA), among others. The National Health Insurance initiative began with the subsidized program of Family Health Insurance in Region IV, on November 1st, 2002. Restructuring of public health services has already begun in the region and presently there are 35,000 members that have been recognized by the TSS.

IV. STRUCTURAL PROBLEMS THAT INITIATED THE REFORM PROCESS

A series of structural problems brought on a crisis in the Dominican Health System, which then motivated modernization and reform proposals of the system. Among the problems, are the following:

a) Insufficient Coverage and Lack of Equity

The coverage of basic health services has been insufficient and deficient for Dominicans, particularly for the poorest groups, who make up almost half of the population. Several studies estimate that organized and regular health services barely reach three fourths of the population. Despite the fact that the country has allocated a great quantity of doctors and hospital beds, these have been distributed inequitably, privileging major urban centers and the most developed areas.

There has been a marked difference in opportunity, integrity, effectiveness and quality among the services received by the richest and the poorest populations. At the same time, the country has also exhibited high infant and maternal mortality rates and a high incidence of transmissible diseases that have affected the poorest groups. Over 80% of the population –91% in the rural zones—lacks any form of health insurance, which escalates the impact of health care on family expenditure.

b) Vertical and Centralized Health Institutions

An analysis of the structure that until recently prevailed in SESPAS allows for the conclusion that the institution has been organized according to the traditional model of Health Ministries in the region. This entails a concentration of functions in a rigid and vertical structure, with little capacity to effectively adapt to the modifications of a changing environment and with leadership limited by the rigid internal structure. In addition, there was very little institutionalism and transparency in general operations, along with the strong presence of a paternalistic and client-centered culture in the management of financial and human resources.

c) Inefficiency and Management Problems

Administrative inefficiency manifests itself through low human resource, equipment and infrastructure productivity, as well as underutilization of hospital beds, operating rooms, etc. Management problems have also become evident in the use of outdated systems for managerial operations, an authoritarian organizational culture, little space given to community participation, the existing minimum obligation for accountability on the part of the authorities, the deficient selection systems and promotion of personnel, and the low utilization of controls and information management systems.

d) Multiplicity of Insurance Schemes

In the Dominican system several insurance schemes have coexisted, each with their own method of organization and financing. For example, the richest groups are insured with stipends or in private insurance plans; some workers are affiliates of the IDSS; military and police have their own services, as do others from the public financial sector such as educators, doctors and nurses;

and a vast majority of the population lacks any formal insurance. It is clear that the insurance sector has functioned in a fragmented manner and without regulation schemes.

e) Insufficient and Inadequate Public Health Spending

According to statistics from National Accounts (Cuentas Nacionales), national health expenditure in 1996 was 6.5% of the Gross National Product (GDP), with 1.5% of that figure from the public sector. Annual expenditure in health per capita was US$72, of which hospitalization was 20%, consultation 60% and only 10% going towards preventative care. In addition, according to the same source, 61% of the total expenditure in ambulatory family care was for medications.

f) Weaknesses in Public Health Programs

There is a large high-risk population that has been unprotected, due to the fact that in general collective care programs have been administered only at the national level and operated vertically. There are various programs that are maintained with international support, but if international support was suspended, these programs would become unsustainable or irrelevant. The sanitary situation is deplorable in many zones of the country, particularly in relation to the disposal of trash and waste, zoonosis transmission and potable water supply.

V. THE REFORM'S RESPONSE TO THESE HEALTH CHALLENGES

Once the structural problems in the Dominican Health System were identified at the end of the 1980s, a series of projects and programs were designed in order to effectively respond to them. While revising and analyzing proposals for these new projects--including the Health Sector Modernization and Reform Program--along with the existing legislation, health sector officials identified a series of common strategic courses of action with the following key objectives: equity, efficiency, effectiveness and quality. These are presented bellow.

a) Expansion of Coverage

An expansion of coverage, at least of the priority health services, is the main goal and is at the center of almost all the reform proposals. The aim is not only to offer integrated and higher quality services, but to also ensure that these services are provided through formal insurance.

b) Separation of Functions and Reinforcement of the Health Sector Governance, Regulation and Supervision

The Dominican Health System has been characterized by a few centralized and vertical institutions that carry out a wide array of functions, which makes them inefficient and ineffective. The reforms contemplate the separation and specialization of functions in a smaller, rational and horizontal structure that will allow the different entities to concentrate on the exercise of their specific functions with greater quality and efficiency. The proposed separation of financing and provision of services is particularly important, because with this modality resource allocation can generate a type of buyer/seller relationship with better quality services and transparency in the use of resources. The proposed model aims to reinforce the central role of the state institutions for the exercise of regulation and supervision functions. For a complex system composed of so many institutional entities, it is very important to train employees and supply state institutions with adequate technical instruments, so they are better able to perform their functions.

c) Changing from Supply to Demand Financing

Historically, the Dominican public health system has directed financing towards the supply of services and not towards the demand. The budgeting model that prevailed for years was merely historical and institutional, without considering variables in production. The implied modality in the proposed reforms would generate a variation in the system, allowing financing to be carried to the health centers by the users, which would be subsidized. This shift seeks to create healthy competition between the care centers, which would represent a progressive improvement in the levels of quality and user care.

d) Public Health Strengthening

One of the objectives of the separation of functions is the strengthening of the essential functions of public health, which would emphasize SESPAS' role as supervisory body and regulator, as well as those relating to important works in collective health. A substantial part of

the 42-01 Law deals with the modernization of the structure and functions of the public health sector, and would be considered an updated Health Code.

e) Normative Centralization and Operative Decentralization

Another goal is to progressively transfer the decision and operation management powers to the local levels, since they are closer to the users and have better information and more motivation to serve the public. However, with the de-concentration and decentralization of functions, there should still be an adequate normative frame and an effective supervision system at the central level that can guarantee security in the transparency and effectiveness of the use of resources throughout the health system. Norms, general policies, administrative systems and standard procedures will have a central definition. Even when the Decennial Health Plan is instituted, the planning and operation of services will be de-concentrated and decentralized.

f) Resource Allocation by Results, Penalization and Incentives

Instruments such as agreements and contracts will mediate the acquisition of services and resource allocation; the terms and conditions of the agreement shall be established within them. These agreements and contracts will define the payment by results and establish penalizations and incentives, depending on the level of compliance between the parties.

g) Development of a Formal Universal Insurance System with a Basic Health Plan and Capitation

An integrated universal insurance system will be implemented, with a basic care package for all affiliates, which uses a capitation payment mechanism for the Health Risks Administrators (ARS) as well as for other forms of public and private insurance.

h) Higher Levels of Social Participation and Accountability

The spirit of participation, control and accountability intersects all the proposed reforms; moreover, the legislation establishes various instances for exchange, coordination and negotiation between players. Also, the reforms look at the possibility of social management and supervision in various situations.

i) Activities that Benefit Primary Care

The reform's legal framework, its programs and projects, and a large number of institutional proposals and actions all aim for the development and reinforcement of health promotion and disease prevention activities. It is understood that this orientation will result in better health levels for the population and, in a context of material and economic difficulties, will promote more cost effective interventions in the country. The Social Security Law establishes primary care as the entry point to the system with the assumption that this will result in a high level of service rationalization and cost containment.

j) Development of Extensive and Integrated Information Systems

The Dominican Health System suffers from deficiencies in the recording, processing and utilization of information when making decisions. The reform considers information a fundamental asset and a key to effective management. In this sense, it seeks to arrange a single

Information and Epidemiological Vigilance System for the health sector, as well as a single Affiliation and Information System. The information systems should be automated, so that equipment, networks and specialized software can be easily procured. The systems would be standardized so that there are no differences between them and the systems could be easily integrated.

k) Development of a Single System for Collection and Affiliation

It is proposed to have a single system for collection that controls duplicity and multiple affiliations, as well as manages integrated information, and can be easily controlled and supervised.

VI. MAIN ACHIEVEMENTS OF THE REFORM PROCESS

At present, the reform process can only exhibit some intermediate achievements that are primarily process-oriented. In addition, these achievements have not yet demonstrated a significant impact on the fundamental variables of coverage and quality. The main identifiable achievements during the study are presented in a specific and detailed manner in this document's Annex II. The following are a general description of these achievements:

a) Establishing a New Legal and Regulatory Framework

With the passing of the General Health Law (42-01) and the law that created the new Dominican Social Security System (87-01) the country built the basic legal framework that sustains the health sector reform process in a coherent an integral manner. In addition, the regulations required for the operationalization of both laws have been developed, a significant percentage of them have been approved and published, and almost all the rest are in the process of being approved.

b) Creation of the new Social Security System's Institutions

The New Social Security System includes a vast constellation of official institutions, which already have been created and are functioning in an initial phase of development. The most important among these new institutions are the National Social Security Council (CNSS), the Superintendence of Health and Labor Risks (SISALRIL), the Social Security Treasury (TSS), The Directory of Information and Defense of Affiliates (DIDA) and the National Health Insurance Agency (SENASA). All institutions have basic and adequate equipment and supplies, and are staffed with personnel with appropriate technical and administrative skills

c) Generation of Spaces for Social Coordination, Negotiation and Supervision Among the Sector's Main Players

Both laws are equipped with an ample democratic and participatory spirit. The laws have clearly promoted numerous opportunities for normative and operative institutional plural spaces of coordination, negotiation and supervision, where the government, representatives of the systems' users, business guilds, the Medical Association, syndicates and civil society participate. The functioning of the National Health Council (CNS) and the National Social Security Council are evidence of this.

d) General Awareness of the Reform Process

Practically all the players are positively sensitized to and understand the general benefits of the health reform process and Social Security. Past ideological contradictions about the basic health system model have given way to confrontations between corporate interests or concrete technical aspects. However, this does not signify universal antagonist differences, but rather occasional differences that can be overcome through collective negotiation.

e) Initiation of the Subsidized Regimen of Family Health Insurance in Health Region IV

On November 1st 2002, the subsidized regimen of Family Health Insurance in Health Region IV began. This formal event started a process that has shown some achievements. Among these are

the following: the reorganization activities of the region's Primary Care Units (PCUs) in order to be able to supply care corresponding to the Basic Health Plan; the formal compliance and internal efforts to create SESPAS's country-wide network of establishments, such as the Sur Profundo Regional Health Service; the signing of the first Management Agreement between two public institutions--SENASA, as buyer, and the Sur Profundo Regional Health Service, as seller; the provisional supply of the public network and other health establishments made by SESPAS in the region; the affiliation of close to 35,000 subsidiaries of SENASA in the region and provision of the first social security identification cards to these members; and the fulfillment of the first payment by SENASA to Sur Profundo for services provided to their members after the presentation of an invoice.

f) Separation of SESPAS's Functions

Slowly but irreversibly the separation of the main functions concentrated in SESPAS has begun. In a way, the de-concentration of governing functions and service provision functions began with the approval of the regulation and authorization from central level SESPAS for the formation of Deep South Regional Heath Service, by allowing this regional health service to manage the financing obtained from SENASA from the agreement for sale of its services.

g) Initial Preparation of a Critical Mass of Technical and Administrative Personnel

Both the extensive training activities and the experiences gained from the process itself have been instrumental in fostering the development of key personnel in the technical and administrative areas of the system's institutions. This personnel development and formation is one of the most important legacies of the process. This critical mass of qualified personnel is still a minority in relation to the whole system, but it is an institutional asset that will likely make a major contribution to the process.

h) Improvements in Infrastructure, Equipment and Implementation of Software

Although this was not a central objective, the reform's activities have led to periodic contributions to the infrastructure of public institutions within the system, both at the central and local levels. In addition, a positive accumulation of intervention activities can clearly be seen in the endowment of computer equipment, communication networks and automated information systems. These improvements provide important support to the institutional strengthening activities.

VII. FACTORS THAT HINDER IMPROVEMENTS OF THE SYSTEM

The section outlines the main general factors identified as current obstacles to the reform process, including implementation of a viable social security system in the health sector.

a) Social Security Financing Problems

During the last year and a half, the U.S. dollar, a fundamental variable in the price level due to the high external component of the goods and services produced in the country, has practically tripled. This generated an inflationary process, which has unfavorably altered the cost of the Basic Health Plan (PBS). Likewise, the Dominican Republic has signed an agreement with the International Monetary Fund (IMF), which restricts government-spending possibilities. Furthermore, more than 40% of the National Budget will have to be allocated to external obligations. Such factors considerably question and threaten the possibilities of an extended financing of the subsidized system by the Government. This is exacerbated by the fact that the crisis that the country is undergoing has elevated unemployment, which reduces the contributory mass and increases the financing volume, which the State would have to contribute. On the contributory side, salaries have been increased to a maximum that does not exceed 20% and studies indicate that employee and employer budgets are not enough to cover the per capita amount required with the new estimates of PBS.

b) Overlap of Roles and Conflicts among the System's Main Players

The definitions of the functions of some of the institutions created with the new Social Security Law have led to certain confusions among the governing and regulatory roles; this in practice tends to generate overlap and conflicts among them. These conflicts, exacerbated by an excess number of players, have obstructed the coordination needed to start the system.

c) Lack of Leadership and Coordination among the Projects and Programs of the Reform

The system lacks an evident and localized leadership, which contributes to a diffusion of the main players. This lack of leadership has hindered the necessary construction of a systematic vision which would allow for the programming and harmony of the efforts made by the different institutions that work in the management and implementation of the system. The reform process lacks an adequate strategic vision of implementation since neither SESPAS nor any other State institution has assumed this function in practice. The non-existence of a strategic reform plan and the lack of a true space for coordination of the reform projects and programs have led to non-coordinated efforts; in fact on occasion efforts have been contradictory, redundant and duplicative.

d) Lack of Sufficient Trained Personnel to Implement a Very Complex Process

In the meetings and interviews held, the evaluation team found that the majority of players with important responsibilities in the system were qualified, both in technical and executive functions. However, this is not the case for all personnel in the system, and the country may encounter difficulties due to insufficient critical managerial mass to impulse a change process with such high levels of complexity, particularly at the regional, provincial and local levels.

e) Absence of a Clear Course of Action for the Reforms

In the area of social security, the country has established deadlines for the start of the system, which have not been met. There are apparent difficulties in the identification of the key necessities, the answers that should be given to them, and the monitoring of the fulfillment of the agreed responsibilities; this is just a reflection of certain weaknesses in the leadership and global management of the process and the absence of a critical route for the introduction of reforms.

f) Labor Instability

The changes in government every four years and occasional replacement of the leadership of an institution within one government causes personnel changes; this often means that experienced government employees in the technical and administrative areas must exit. Thus, parts of the training efforts achieved are lost; furthermore, the possibility of generating a historic memory--which identifies and registers the progressive change of its institution--is lost.

g) Low Institutionalization of SESPAS

The Public Health and Social Security Assistance Secretariat (SESPAS) is the key institution in the health sector reform process. However, there are a series of weaknesses which prevent it from properly assuming the leadership of the process. Likewise, there exists a great internal inertia, which resists or does not incorporate in sustainable form many of the current reform activities. Furthermore, there has not been an internal socialization process that would allow for the active integration of its personnel into the process of change and modernization.

VIII. COHERENCE, VIABILITY AND SUSTAINABILITY OF THE PROCESS

In attachment IV a table is shown which clearly outlines the main historical structural problems of the Dominican Health System, strategic approaches to address these problems, and general results. From its analysis, it can be said that the reform actions have been coherent with relation to the system's structural problems and that important improvements have been achieved, even when not definite. The process is viable and sustainable when backed by political support.

THREATS TO THE REFORM

The reform process and social security initiatives have improved slowly due to factors that may threaten the current viability of the process and its future sustainability. Some of these are:

a) The economic situation, particularly the increases in the exchange rate that have affected the initially defined budgets.

b) Unemployment, which decreases the number of employed potential contributing members and increases the subsidy burden of the government.

c) The ambiguousness of the professional fees and the cost of the Basic Health Plan (PBS).

d) The government's fiscal commitments related to external debt payments limit the availability of resources for the subsidized healthcare regimen – both in terms of the government's contribution and the co-contribution of individuals in the subsidized program.

e) That the government institutions continue without effective coordination and that the State continues to present itself as weak and fragmented when confronted with a series of key decisions for the improvement of the process.

f) Uncertainty about the continuity of the process by the new authorities if there is a change in government.

g) Some sectors may abuse their veto capacity in the National Social Security Council (CNSS), to promote their own particular interests.

Both social security and the transformation and modernization of the health sector are implemented under a gradual scheme that works to progressively generate the necessary conditions of the process without producing unexpected and catastrophic traumas in the main players of the system. The universal access, the financial equilibrium of the system, the efficient provision of services, and the improvement in the health conditions of the population would be the key factors that could make the process sustainable. To achieve this requires effective leadership from the governing entities at the highest levels: namely SESPAS and the new social security management entities.

IX. USAID/DR HEALTH STRATEGY

Since the 1970s, USAID has supported the Dominican Republic's efforts in the health sector and has been the main support organization for national programs in reproductive health (RH) and family planning (FP), which has allowed for important advances in these areas. In addition, USAID has been a key supplier of resources and assistance for the improvement of infant-maternal health. For example, USAID supported the Dominican government in the implementation of the primary care programs after the Alma-Ata meeting. USAID was also the main source of resources and assistance for the launch of the HIV/AIDS prevention program at the end of the 1980s, and continues to make a fundamental contribution in this area.

In 2002, USAID defined its Health Sector Strategy for the period 2002-2007, with its main objective being sustained improvement in the health of vulnerable populations in the Dominican Republic. As part of this strategy, it has identified four areas of action/intermediate results (IRs). The first three areas respond to high risk health situations for the Dominican population, such as: prevention and care of HIV/AIDS, infant survival and reproductive health/family planning. A fourth area is the reform of the health sector, which cuts across all three IRs and serves as their organizational basis. Even though the "sustained improvement in the health of vulnerable populations in the Dominican Republic" will not be achieved solely with USAID's efforts, it is expected that this organization can substantially contribute to the reduction of these health problems.

USAID's strategy focuses particularly on vulnerable populations (defined as those that live below the poverty line) placing emphasis on children, adolescents and women of reproductive age. Consequently, interventions in HIV/AIDS will also be aimed at high-risk populations. It is clear that improvements in the health of the population will contribute to the reduction of poverty; that is, a healthy workforce will have to spend less on medication and will be productive for longer periods of time, which will allow families to maintain their income. The health sector reform strategy is inextricably linked with larger political and social reforms that promote civil society participation and local government, both municipal and provincial. In addition, the health strategy supports USAID's efforts in related topics such as reduction of poverty, policy reform, civil society, local governance and strategic collaboration with other organizations.

USAID's strategy is based on the assumption that other financial institutions' programs--such as the Inter-American Development Bank and the World Bank, along with donors such as the European Community and the technical support organizations' programs, such as the Pan-American Health Organization (OPS), the United Nations Children's Education Fund (UNICEF) and the United Nations Population Fund (UNFPA)--continue their activities without any major delays or alterations. It is also expected that future governments will continue to maintain and foster the reforms that have been carried out under the current president's administration, and that the positions of the current technical personnel are stable.

USAID has three important reasons to support health reform in the Dominican Republic. First, USAID wants to ensure that its efforts and programs are sustainable, which is only guaranteed through a financially stable system that can provide basic services to the population. Second, it promotes a focus on infant-maternal care, reproductive health and combating infectious diseases, especially HIV/AIDS, tuberculosis and malaria, with an emphasis on the most vulnerable populations. Third, the relationship between the Dominican Republic and the United States is an important one; USAID's support for Dominican health reform will contribute to a more democratic society and an economy better prepared to face globalization and fight poverty.

X. THE REDSALUD PROJECT AND ITS IMPROVEMENTS

A. THE ORIGINAL DESIGN OF THE REDSALUD PROJECT

A team of consultants from the Latin American Center of Health Systems Investigations conceived of the REDSALUD Project in December 1998. The original design emphasized the need to have flexibility to adjust the priorities and orientation according to the changes that may arise during the execution of the project, as well as the importance of the diversification of risks to achieve diversity in governmental and non-governmental players. Also, the consultants created "funds" to stimulate and impel organizations willing to take the initiative in the implementation of reform activities. The conceptual design has two main components: 1) strengthening the decentralization process and 2) creation of positive conditions for health policies and long-term reform with governmental and non-governmental players. The design was successful and has established the basic program framework, allowing for adjustments as necessary.

B. THE REDSALUD STRATEGY

USAID hired Abt Associates for the implementation of the REDSALUD Project, which presented a proposal with three primary strategies: 1) implement innovative health service networks in 14 DPSs, 2) strengthen the capacity of SESPAS to support decentralization, and 3) develop a favorable political environment at the national, provincial and local level.

Although the original project contemplated the participation of REDSALUD in a maximum of 14 DPSs (Provincial Health Departments), in actuality local supporting actions are held in five provinces that make up Region V of the country. The concentration of REDSALUD efforts in this region was a result of a government initiative to organize the health reform support projects. REDSALUD's strategies are described in more detail below.

1. IMPLEMENT INNOVATIVE HEALTH SERVICE NETWORKS IN THE PROVINCES

REDSALUD developed several generations of demonstration projects, which are shown below:

1st Generation: Innovative activities to strengthen public health

The focus of the first generation of demonstration projects has been to fundamentally strengthen the managerial capacity of those responsible for these programs: the DPS and the first level providers. The programs have been used as a vehicle to introduce and develop support interventions to management, with the hypothesis that better management would help improve the programs and their impacts; and that it would also improve the execution of current programs.

In the El Seibo Province, REDSALUD supports various Primary Care Units (PCUs) to strengthen the effective treatment of acute diarrheic illnesses (AD). The Provincial Health Department (DPS) identified this as a priority due to various environmental causes. The project also helped hospitals and the PCUs in the installation of Oral Re-hydration Units (UROs) to treat dehydrated children. Also, in the La Romana and Hato Mayor provinces, REDSALUD is helping strengthen the Broad Immunization Program (PAI) to extend coverage of vaccines. These projects have been successful in increasing coverage of vaccines as well as in reducing the

incidences of diarrheic illnesses. Another important component of this strategy is the creation of community support groups around the PCUs. The purpose of such groups is to promote the services, offer information and education, and supervise the care given.

2nd Generation: Innovative activities for the encouragement of a user-focused culture

REDSALUD helped install User Care Offices (OAU) in 14 hospitals of the region. This support has allowed the furnishing of the offices, including the installation of internal and external signs, computer training for personnel, human relations courses and the design of a verification of rights program (patient registry), as well as discussions and sensitivity meetings for the hospital personnel. It is important to highlight that this idea grew in the region as a result of activities undertaken by the FONHOSPITAL project in the Antonio Mussa Hospital; due to its success and relevance, it was extended and offered to other hospitals. The OAUs' Regional Committee's main responsibility is to oversee the development and proper functioning of these offices in the hospitals. This committee also develops the internal regulation and strategies to respond to the reform process.

The team had the opportunity to visit various OAUs in Region V, and noted that the users appear to value them highly. The majority of the offices are working well and their usage will be increased with the introduction of the social security system. It is important to point out that an OAU in the Antonio Mussa Regional Hospital was unstaffed during the visit by the evaluation team and in others it was noted that there is still a need to further develop the user-focused culture. In general, the achievements depend greatly on the capacity and disposition of local agents, and the experiences vary in every facility in the region.

3rd Generation: Activities that foster hospital management

REDSALUD has signed seven agreements with 14 hospital establishments to analyze the service portfolio and determine costs, productivity, prospective budgeting and improvement of the management information system. REDSALUD has already finished the services portfolio exercises and costs and productivity analysis; the next step is the prospective budgeting training. Based on the information obtained through the work of portfolio services, costs and hospital productivity determination, a negotiation workshop with SENASA was held in which they determined the type, quantity and quality of services Region V could offer the Public Health Risks Administrator.

The postgraduate program in health services management also represents a key contribution to the future of the health system in the region. The evaluation team witnessed several examples of the motivation of personnel who participate in the program, and their capacity to apply what they are learning in their daily work.

4th Generation: Activities to support initiation of social security

The essential goal of this project is to support the creation and development of the necessary conditions for social security to be initiated in Region V. Many of the activities of this project have supported the new social security institutions. For example, support was provided to SISLRIL in defining its operational structure, in the elaboration of its basic rules, and in the definition and costing of the Basic Health Plan (PBS). Likewise, REDSALUD has supported SENASA in gathering information from the subsidized members of the region, in the design of

software for its registry, and in the definition and payment of the service packages that will be purchased from the various providers, and in the development of payment and contracting mechanisms. REDSALUD has also supported the DIDA in the definition of its strategy for organization and defense of the social security affiliates in Region V, and in its general information, education and communication strategy.

The subsidized regimen of Family Health Insurance officially began in Region V on April 1, 2004. However, there is still a lot of work that remains to be done before the system functions properly in the region.

5th Generation: Activities to foment the creation of a service network

This recent project objective is to foment the creation of a Service Network in Region V. This includes the design of an administrative and control platform, services, human resources, physical and financial resources, and information so that the health facilities in Health Region V can begin to function and organize themselves as a network of providers.

2. STRENGTHEN SESPAS'S CAPACITY TO SUPPORT DECENTRALIZATION

The main objective of this component is to support SESPAS in the development of its strategy of de-concentration and decentralization, along with the development of its role as a supervisory body. Moreover, this component seeks to promote SESPAS's transition from a centralized and inefficient entity to a more flexible, horizontal and better qualified institution for the exercise of essential functions. In interviews during the evaluations several players pointed out that initially technical support by REDSALUD to the Central SESPAS was difficult, because the entity resisted the concepts of decentralization; in addition some said that the interest of the project was to privatize health services. With time, these confusions were clarified and currently, this component's purpose is to serve as a link between the support to the local management and the central level. This collaboration has culminated in a mechanism that can replicate and institutionalize the successful results achieved by the demonstration projects.

3. DEVELOP A FAVORABLE POLITICAL ENVIRONMENT

The objective of this component is to contribute to better understanding and coordination among technical and political players in the health sector, and to create a favorable environment for the planning and execution of the reform process. REDSALUD supported, through technical assistance, the participation in commissions, the formation of coalitions and promotion of proposals, and the formulation and approval of two large legislations within the system, along with the complementary regulations. This component has also contributed to the social participation and the political viability of Region V's demonstration projects. In addition, it has carried out a continuous training process on the topic of reform, aimed towards the players in the health system, community organizations and journalists.

C. MAIN FINDINGS OF THE REDSALUD PROJECT

The following matrix demonstrates the correspondence between USAID/DR strategy and the structure of the REDSALUD project.

CORRESPONDENCE BETWEEN USAID/DR HEALTH STRATEGY AND THE REDSALUD PROJECT STRUCTURE	
USAID Strategy	**REDSALUD**
IR 4: Increase efficiency and equity of basic health care services at the local level.	**General Objective:** Contribute to the improvement of access, equity, quality and sustainability of basic health services, especially for the most vulnerable.
Strengthen management capacity in the areas of health and the provincial directorate.	a) Support the strengthening of local health
Increase the heath system's capacity to implement an effective decentralization strategy.	b) Provide support to SESPAS at the central level.
Improve the health policy environment for reform.	c) Support the development and sustainability of a policy environment favorable to health sector reform.

As shown in the above table, there is a strong relationship between REDSALUD project components and USAID/DR Intermediate Result 4. In analyzing REDSALUD's activities, it can be concluded that the efforts and results have been consistent with USAID/DR's strategy, even if they have not been achieved in totality. These represent significant contributions within a complex process that surpasses the dimensions and duration of the project. It is important to note that REDSALUD's activities in Region V support not only public health at the primary care level, but also at the specialized level. For this reason REDSALUD actually surpasses IR 4's scope because IR 4 only deals with primary care services.

With the current state of the Dominican Health system reforms, it is difficult to find significant results in the coverage and quality of services. However, the REDSALUD project can show many intermediate results, mainly through the technical contributions it made in Health Region V. This region is presently in the process of preparing for the transformation required by the introduction of the Social Security System. Its preparation level is superior to other regions, which led CNSS to select it as the second region to be incorporated into the new system. Without a doubt, the difference between Region V and some of the other Health Regions in the country is clearly due to the support offered by REDSALUD.

One of the main results that the evaluation team observed in Region V was intangible, but of great importance—there was a complete change in mentality and total support for the reform process, which was revealed by every person interviewed.

In analyzing the evidence of this evaluation, it can be affirmed that the REDSALUD project has made and is making important contributions to health sector reform in the Dominican Republic, and that all key players within the system who were interviewed have proclaimed their appreciation and clear satisfaction with the project.

In addition, the REDSALID project is staffed by very capable and professional personnel who showed a good understanding of the activities, players, geography, culture and organizations that work with the project. The legacy of these national human resources, trained and formed during the execution of the project, will be an additional contribution to the system.

The following paragraphs show more specifically the results of REDSALUD's actions, as found by the evaluation team.

- Support to PCUs in strengthening effective care of acute diarrheic diseases (AD).

- Installation of Oral Rehabilitation Units (ORUs) to attend to dehydrated children.
- Strengthening the Expanded Immunization Program (PAI) in order to improve management and increase coverage.
- Support in the creation of community support groups for the PCUs.
- Installation of User Care Offices (OAU) in 14 hospitals within the region.
- Symposiums and workshops for the sensitization of the hospital personnel.
- Organization of the OAU Regional Committee.
- Signing of seven agreements with 14 hospital establishments for the:
  - Analysis of the portfolio of services.
  - Determination of costs and productivity.
- Support for SISALRIL in:
  - The definition of an organic and operational structure.
  - The elaboration of basic rules.
  - The definition and costing of the Basic Health Plan (BHP).
- Support for SENASA in:
  - Gathering information from the subsidized affiliates in Region V.
  - Designing software for recording this information.
  - Definition and costing service packages to be acquired from different suppliers.
  - Elaborating a contracting and payment mechanism.
  - Relating experiences from two important Latin American contexts (Chile and Colombia).
- Support for DIDA in:
  - The definition of an organizational and defense strategy for Social Security members in Region V.
  - The development of information, education, and communication strategy.
- Support of the discussion and dissemination of topics on the Dominican health reform process.

XI. RECOMMENDATIONS FOR THE SHORT, MEDIUM, AND LONG TERM

Short Term: the remaining 15 months of the REDSALUD Project; from April 2004 to July2005.

FOR REDSALUD

The recommendations for the remaining 15 months of the Project are aimed at consolidating the improvements in the Region V environment and establishing the basis for the next phase from 2005 to 2007.

a) Provide support to the new health sector authorities who may come into office after August 2004.

It is suggested that REDSALUD elaborate and develop an explicit strategy of support that provides orientation and training to the new professionals responsible for Health Region V and the national level. Such a strategy should continue to be available in case there are any authority personnel changes after August of the present year. It is also recommended that this be applied to other bodies that contribute to the reform (such as CERSS and PROSISA).

b) Consolidate the achievements in Health Region V

It is recommended to continue the actions already initiated and those about to begin, such as the ambulatory medication service and the referral system, among others. Furthermore, it is also recommended that the community support experience, which has been supporting the Acute Diarrhea Illnesses (AD), and the Broad Immunization Program (PAI) be expanded to other areas such as HIV/AIDS, maternal and child health, and reproductive health.

Special emphasis should be placed on technical support to the structure of the Regional Health Service in the Eastern Region, so that the Provincial Health Departments (DPS) are established with the needs of provincial supervision and public health of the region in mind.

c) Support the acquisition of documents for Social Security registration of the subsidized populations in Region V

It is common that people lack personal identification cards or birth certificates in the subsidized population of the Region; however personal identification will be necessary to register in the new social security system. Thus it is suggested that REDSALUD support any regional initiative that aims to speed up as well as facilitate the acquisition of such documents.

d) Assure the sustainability of REDSALUD's Programs

To guarantee the sustainability of the activities which REDSALUD has been carrying out, the following is suggested:

- Analyze with INTEC the possibility of institutionalizing the postgraduate program in health services management and/or expand it to a master's degree. If possible, support INTEC in the formulation of a business plan to achieve sustainable financing of such program.

- Analyze the viability of computer use in the primary care units that have low volumes of users, low electricity flow, and poor security conditions. Also, analyze the possibility of correcting underutilization by looking for complementary uses, as well as the possibility of transferring responsibility for maintenance of the information equipment to the users themselves.
- Expand links with organized civil society like FINJUS, Foro Ciudadano, Participación Ciudadana, ANJE, and COPADEBA, so they assume and support health reform.
- Analyze whether it is appropriate for the Project to support the creation of a consensus concerning critical subjects, such as, lack of agreement on the costing for the Basic Health Plan, the delay of the beginning of the contributory regimen, and the financial viability and sustainability of the system.
- Study the possibility of hiring personnel that reside in Region V since the transportation burden is very large if the entire team lives outside the region.
- Analyze the possibility of having an advisor on political matters since these require special attention, particularly a year from now when, whatever the results of the elections, great changes are anticipated.

e) Systematize and share the positive experiences of the Project in Region V

It is recommended to document, evaluate, systematize, and share the experiences and tools which have worked well in the region, highlighting the changes which have resulted from innovations. For its dissemination, turn to the health system, along with the universities, the press and other means. Among the experiences, the following can be emphasized:

- The analysis of cost accounting exercises in hospitals, including the training process, the exchange of experiences, and incentives which have been used to recognize those who have performed very well
- The functional and practical orientation of the postgraduate program and the competitive selection process of the participants
- The User Care Units as a mechanism to improve the quality of service and the organization of visits. Furthermore, the information system installed in such units allows for the identification of members of the social security system and supports invoicing
- The Community participation with the PAI and EDA

FOR USAID

In the short term, the following is recommended:

a) Take advantage of available opportunities to spread the advancement of health sector reform, as well as discussing certain important topics such as:

- The civil service and the public health sector administrative career track based on Decree 1282-100
- The decentralization and strengthening of the Regional Health Services

- The family health insurance affiliation problem due to a lack of identification documents, which especially affects poor women and children
- The social security public financing guarantee for subsidized members, public contributors, and subsidized contributors

b) Assure that other activities in the health area, such as Project CONECTA, work in firm collaboration with the reform process and with the anticipated changes in the health system.

c) Encourage SESPAS, as a supervisory institution of the sector, to assume the coordination of cooperation and external financing activities; be it through the Institutional Modernization Unit or at the request of any other body.

d) Support the collection, analysis and dissemination of health sector performance information that feeds the debate and improves decision making, such as the national health accounts, studies based on Endesa, user satisfaction studies, services costing, productivity analysis, and public investment in the construction and the furnishing of hospitals.

Medium Term: the 26 month period between the conclusion of the REDSALUD Project in July 2005, and the end of the actual USAID strategy in September 2007.

FOR USAID

It is recommended that in the medium term USAID should continue the three lines of action established in the REDSALUD Project: a) support to local management in Region V; b) support at the central level; and c) support to the political environment. Furthermore, in view of the needs of the new institutions that have arisen with the social security system, supporting them is suggested, which in practice has already begun under REDSALUD.

a) Support the management of Health Region V in:

- Strengthening and replicating tools and processes developed through REDSALUD
- Consolidating local supervisory public health functions of DPS's
- Services management, including services portfolios, costs, budgets, accounting, and invoicing
- Legal and operational consolidation of the Regional Health Service
- The active participation of the community
- The modernization of hospital management systems
- Strengthening the technical, financial, and clinical auditing systems
- The creation of alliances among the public and private sectors to make the health services more agile and efficient

b) *Support to the central level of the SESPAS in:*

- The design and development of the monitoring and evaluation system of the Decennial Health Plan
- The supervisory functions (surveillance, regulation, norms)
- The essential functions of public health
- The provision of public facilities, starting in Region V
- The direction and formation of human resources, including the implementation of civil service and management career tracks
- The coordination of external cooperation
- The definition and standardization of operational instruments, as well the implementation de-connected and decentralized requests (DPS and Regional Health Services)

c) *Support to the political environment*

- The evaluation team suggests that USAID take advantage of every opportunity to insert the administrative career theme and the topic of decentralization of the regional services in the national dialogue. They could also disseminate the experience of merit based recruiting, such as in the justice, environment and public ministry sectors.
- Provide support to organized civil society in:
  - monitoring the health system's performance, especially in regards to out of pocket expenses, the access and use of public and private services according to income level, the problem of citizens without personal identification, and the productivity of public services
  - disseminating information and defining a strategy with clear means of communication
  - developing human resources training initiatives in health and nursing management
  - mobilizing and integrating communities and management in requests for management and supervision of health system performance

d) *Support the new social security institutions (CNSS, SISLRIL, SENASA, DIDA)*

- Through technical assessment and support for institutional development activities and technical assessments
- In the development and implementation of the subsidized regimen, including its promotion, the identification and affiliation of higher risk people, organization of provider networks, hiring of services, auditing, etc.
- In initiatives that search for sustainable financing of the system.

Some of the options that USAID would need to undertake in order to continue supporting reform in the medium term can be found in Attachment V.

Long Term: The seven to ten year period will begin after the elaboration of the next USAID strategy in the year 2007.

RECOMMENDATIONS FOR USAID

It is difficult to anticipate the support needs of the system for the long term in an unstable and changing environment. Furthermore, a diagnosis of the health sector in 2006 would be necessary in order to create the new strategy. By all means, the evaluation team considers that USAID, in the long term, should continue to support the country in the reform process and public health, which improves the living conditions of the poorest and most vulnerable groups. For the public health sector, the team's recommendation is a concentration on the priority services of reproductive health, maternal and child health, and the combating of infectious diseases including HIV/AIDS. In the area of reform, key considerations are presented:

- USAID should maintain its place at the dialogue table in regards to health reform.
- USAID should support players who are highly committed and well-oriented in the efforts of change.
- USAID should coordinate efforts with other cooperation and financial agencies, avoiding duplication.
- USAID should look for contacts and synergy points with USAID projects in other sectors, especially democracy and governance.
- USAID should promote extensive social participation in the reform process.
- USAID should support the creation of independent "think tanks" to generate a critical mass of civil society members who can participate in the health sector and contribute to the creation of political consensus during the next stages of reform.

BIBLIOGRAPHY

SESPAS/ONFED/UE/PROSISA. *Una Reforma para estar en salud.* República Dominicana. 2004.

Rathe, M. *Salud y Equidad: Una Mirada al Financiamiento de la Salud en la República Dominicana.* Macro International Inc. 2003.

Consejo Nacional de Salud. *Reglamento de Provisión de las Redes de los Servicios Públicos de Salud.* República Dominicana. 2003.

Consejo Nacional de Salud. *Reglamento de Rectoría y Separación de Funciones del Sistema Nacional de Salud.* República Dominicana. 2003.

Consejo Nacional de Salud. *Reglamento Sobre los Regímenes de Contratación de la SESPAS Para la Provisión de los Servicios de Salud Pública.* República Dominicana. 2003.

Consejo Nacional de Seguridad Social. *Reglamento del Régimen Subsidiado del Sistema Dominicano de Seguridad Social.* República Dominicana. 2003.

SESPAS/DIGEPI. *Análisis de Situación de Salud de la República Dominicana 2003* (Borrador). 2003.

SESPAS/OPS. *Indicadores Básicos de Salud 2002.* República Dominicana.

CNSS/DIDA/CERSS. *Cosas Que Hay Que Saber Sobre la Seguridad Social.* República Dominicana. 2002.

OPS. *Perfil del Sistema de Servicios de Salud de la República Dominicana.* República Dominicana. 2001.

REDSALUD. Planes *de Trabajo y Acciones llevadas a cabo desde el comienzo del proyecto* (2001-2004).

Ley General de Salud No. 42-01. 2001.

Ley que crea el Nuevo Sistema Dominicano de Seguridad Social No. 87-01. 2001.

Saltman, R.B. y Figueras, J. *Reformas Sanitarias en Europa.* Ministerio Español de Sanidad en Europa. 1998.

Oficina de Coordinación Técnica (OCT). *Salud: Visión de Futuro.* República Dominicana. 1996.

ANNEXES

ANNEX I LIST OF INTERVIEWS

WEDNESDAY 03/17/04

9:00 a.m. Meeting to coordinate team

4:00 p.m. Mr. Patricio Murgueytio – REDSALUD-

THURSDAY 03/18/04

8:30 a.m. Mr. David Losk, Mrs. Sarah Majerowicz, Mrs. Marina Taveras -USAID-

12:00 p.m. Dr. Manuel Tejada - SESPAS –

3:00 p.m. Mr. Patricio Murgueytio and the REDSALUD team

FRIDAY 03/19/04

9:00 a.m. Evaluation team meeting

Saturday 03/20/04

9:00 a.m Dr. Ignacio De Oleaga Usategui - PROSISA-

10:00 a.m. Alberto Fiallo – Former Executive Director of CERSS-

MONDAY 03/22/04

9:00 a.m. Lic. Chanel Rosa - SENASA –

10:00 a.m. Dr. Mena – ANDECLIP -

11:00 a.m. Dra. Socorro Gross, OPS Representative, Dr. Gerardo Alfaro

3:00 p.m. Mr. Patricio Murgueytio – REDSALUD-

5:00 a.m. Mrs. Jaqueline Gonzalez, Consultant SENASA, Mrs. Maria Elena Tapia, SISUM Coordinator, Dr. Adolfo Sagredo, PROMESA

7:30 p.m. Dr. Fulgencio Severino, Manager of the SS in the Dominican College of Medicine

TUESDAY 03/23/04

11:00 a.m. Dra. Alma Bobadilla – SENASA-

4:00 p.m. Dr. Bernardo Defilló – SISALRIL-

WEDNESDAY 03/24/04

9:00 a.m. Lic. Nélsida Marmolejos - DIDA –

10:00 a.m. Lic. Arismendy Díaz Santana – Gerente General SS-

1:00 p.m. Gisela Quiteria -BANCO MUNDIAL-

2:30 p.m. Josué Ceballos – BID-

7:30 p.m. Carmen Adames -INSALUD-

THURSDAY 03/25/04

9:00 a.m. Dra. Martha Butler, Director of CONECTA

2:15 a.m. Sarah Majerowicz, Marina Taveras -USAID-

3:00 a.m. Luis González, Manuel Ortega, Don Harrinton, Lissette Dumit -USAID-

FRIDAY 03/26/04

9:00 a.m. Work-team meeting

SATURDAY 03/27/04

9:00a.m. Work-team meeting

SUNDAY 03/28/04

Trip to Bayahibe, Region V

MONDAY 03/29/04

8:30 a.m. Visit to Los Mulos, Meeting with community representatives and technician

10:00 a.m. Hospital Provincial La Altagracia, Higuey, Meeting with Dr. Héctor Peguero, Director.

12:00 a.m. Dr. Mercedes Torres, Director of El Seybo Province

2:00 p.m. Dr. Francisca Gil, Director, El Seybo Provincial Hospital

3:30 p.m. Miches Rural Clinic

TUESDAY 03/30/04

9:30 a.m. Provincial Management of Hato Mayor, Meeting with Dra. Raquel Ogando

11:00 a.m. Villa Ortega Rural Clinic, Hato Mayor

12:00 a.m. Visit of Antonio Mussa Hospital, San Pedro de Macorís, Dr. Mazzara, Director.

WEDNESDAY 03/31/04

10:00 a.m. Dr. Milton Ray Guevara - State Secretariat of Employment -

THURSDAY 04/01/04

10:00 a.m. Nuestra Señora de Regla Hospital, Baní

4:00 p.m. Team Meeting

5:30 p.m. Foro Ciudadano

FRIDAY 04/02/04

8:00 a.m. Sarah Majerowicz, Marina Taveras USAID

11:00 a.m. Report Presentation, USAID-REDSALUD

SATURDAY 04/03/04

Team Meeting

ANNEX II THE DOMINICAN GOVERNMENTS AND HEALTH REFORM

During the administration of ***Joaquin Balaguer***, an environment for health reform began to grow, due to accumulated deficiencies and dissatisfaction with the current system, and through the reform example set by other countries in Latin America. Likewise, reform processes in the education sector following the Decennial Plan paved the way for reforms in other areas. In 1992, the government of Joaquin Balaguer arranged for technical assistance through the United Nations Development Program (UNDP) to analyze the health sector and to propose answers to its problems. This assistance was led by Dr. Guido Miranda, a consultant from Costa Rica, with the participation of approximately 50 Dominicans.

Based on the results of this process, the government formed the National Health Commission (CNS) under the leadership of the then Minister of Health. This commission was staffed through the Technical Coordination Office (OCT) with the leadership of Dr. Fernando Rojas. In 1993, the government solicited support from the World Bank and The Inter-American Development Bank to support the CNS and its OCT in the formulation of an investment plan to improve the Dominican health system. The OCT, with the support of the WB and the IDB, formulated the influential health document: *A Vision of the Future/Una Vision del Futuro*, which contained a proposal for wide reform. Furthermore, the Pan-American Health Office (OPS) provided technical assistance to a group of technicians from SESPAS to formulate a plan for the reforms. INSALUD sought the participation of NGOs in formulating any reform. Meanwhile, the business sector, through the National Council of Private Companies (CONEP), was attempting to change the Social Security system since many companies were receiving double quotes; one from the Dominican Institute of Social Security (IDSS) and others from the insurance or medical stipend, which they also paid.

In 1996, the administration of ***Leonel Fernández*** began by focusing on the decentralization of the central government. This was reflected in the health sector by the creation of the Provincial Health Management Units (DPS's) in 1997. Based on the technical assistance arranged by the previous administration, the government of Leonel Fernández signed and initiated the operation of loans from the World Bank and the IDB to support the reform, and in 1998, the Executive Commission for the Health Sector Reform (CERSS) was created and these newly created health sector institutions began operations.

The current administration of ***Hipólito Mejía***, which began in the year 2000, continues the previous efforts of reform, signaled in great part by the approval of the General Health Law and the creation of a new Social Security System. The year 2000 also marked the start of the PROSISA and REDSALUD projects. Later, on November 1, 2002, the Family Health Insurance subsidized scheme in Region V of the country began operations.

ANNEX III MAIN RESULTS OF THE REFORM PROCESS

REGULATION

a) Development of evaluation/rating/authorization/accreditation norms, placing responsibility for this function within the Authorization and Accreditation Unit of SESPAS, and initiation of the provisional accreditation of establishments.

b) Development and diffusion of the healthcare norms.

c) Development of the 220 pharmaco-therapeutic protocols with the cooperation of the societies of the main pathological clinics.

d) Development and dissemination of healthcare prevention and treatment norms for the primary diseases present in the country.

STATE SECRETARIAT OF PUBLIC HEALTH AND SOCIAL ASSISTANCE

Internal Unit of Modernization

a) Launch of the Modernization and Institutional Development Unit (UMDI) of SESPAS, which is currently fully operational.

Health Plan

a) The Decennial Health Plan, which will establish the main objectives of the health sector for the next 10 years and the necessary actions to achieve them, is in progress.

Organizational Structure

a) The new organizational structure of the Secretariat was designed and implemented.

Financial Management

a) Formulation of the 2003 and 2004 budgets with a new methodology that is based per program on the national and institutional health priorities.

b) Implementation, in Central SESPAS, of a financial management computer system.

c) Assets inventory of the institution and installation of the computer system for asset management. This system covers Central SESPAS and its hospitals.

DE-CONCENTRATION AND DECENTRALIZATION

a) In 1997, 38 Provincial Managements (DPS) and Health Areas (AS) were established, which initiated the institutional decentralization process. The structure, function, position profiles and teams' performance expectations within these organization were also defined.

b) Promulgation of the Separation Regulation of SESPAS, which legally establishes the separation of the governing/management of public health and the provision of individual service delivery.

General Information System

a) Conceptual Design of a single system of epidemiological information and surveillance.

b) Development of the Geographic Health Information System.

c) New Payroll System

Health Services

d) Completion of a statutory proposal that defines the organization of the regional health services.

e) The basic functions of public health were defined and an institutional commitment was made to assume such functions.

f) A new model of care has been defined which emphasizes and establishes territorial service delivery areas, each with a population between 500 and 700 families. Various basic instruments of the operation of primary healthcare services have been defined as well as developed: family files, community participation guide, file processing system, etc...

g) Implementation of pilot primary care experience with a mixed network of supply, a new method of financing and top user satisfaction in the Azua, San Juan and Elias Piña provinces benefiting approximately 250,000 people.

h) Development and support for the signing of six management agreements with five of the main clinical establishments of the country. However, these agreements did not receive proper follow up or an effective evaluation.

i) Establishment of an office and a user care system in six hospitals of Health Region V.

j) Various modernization activities in the area of hospital management have been executed. The six hospitals of the FONHOSPITAL project and of Jaime Mota can be highlighted. Also, a Hospital Management Strengthening Project in Health Region V is being carried out.

Human Resources System

a) Human Resources census and development of the computer system for the handling of the database. The database is currently not updated.

b) Design of six human resources subsystems. However, there are no implementation actions currently in place.

MEDICINE AND SUPPLY SYSTEM

a) Promulgation of the Presidential Decree 991-00 which converts PROMESE into a Logistical Support Center (CAL).

b) New public procurement methodologies in PROMESE/CAL that since 2002 have increased transparency of the procurement process and the quality of the acquired medicines.

c) Advanced phase of the development of new rules for medicines.

d) New organizational chart, procedure manuals, product approval/ homologation guide, physical modernization and new management module of the PROMESE/CAL warehouse.

e) Experience in 20 pharmacies of the main hospitals of the country, which has allowed the rationalization of the acquisition, dispensation and storage of supply. Likewise, the dispensation of unitary doses (UNIDOSIS) has been initiated.

f) Equipping, new organizational structure design, identification of basic functions, and furnishing of the Pharmacy and Drugs Division of SESPAS in order to execute a management role within medicines subsystem.

g) Reorganization, furnishing and training of personnel at the Dr. Defilló National Laboratory.

THE DOMINICAN INSTITUTE OF SOCIAL SECURITY (IDSS)

a) Separation of funds by Business Units.

b) Structuring of the Secure Health ARS (Salud Segura –ARS).

c) Institutional preparation for administration of the Labor Risks Insurance.

d) Creation of Analytical Management Units in the main office, 17 hospitals and 28 policlinics (outpatient clinics) and execution of productivity and cost studies for these establishments.

TRAINING

a) Large quantity of technical and administrative training activities.

b) Various working days have been approved for formal training such as Master's degree and postgraduate studies work.

ANNEX IV PRINCIPAL STRUCTURAL PROBLEMS OF THE DOMINICAN HEALTH SYSTEM, STRATEGIC APPROACH OF THE REFORM AND GENERAL ATTAINED RESULTS

STRUCTURAL PROBLEM: INSUFFICIENT COVERAGE

Strategic Approach of the Reform:

- Coverage Extension
- Change from Supply Financing to Demand Financing
- Regulatory Centralization and Operative Decentralization
- Allocation of Resources by Results, including Penalties and Incentives
- Development of a Formal Universal Insurance System with a PBS (Basic Health Plan) and training
- Focus on Primary Care

General Results of the Reform Process:

- Creation of a new legal and regulatory framework
- Generation of social coordination, negotiation, and supervision among the main players of the sector
- Creation of the New Social Security System Institutions
- Initiation of the Subsidized regimen of Family Health Insurance in Health Region IV

STRUCTURAL PROBLEM: LACK OF EQUITY

Strategic Approach of the Reform:

- Coverage Extension
- Change from Supply Financing to Demand Financing
- Reinforcement of the State Governing Function, Regulation, and Supervision
- Strengthening of Public Health
- Normative Centralization and Operative Decentralization
- Development of a Formal Universal Insurance System with a PBS and Training
- Greater Levels of Social Participation and Accountability

General Results of the Reform Process:

- Creation of a new legal and regulatory framework
- Creation of the New Social Security System Institutions
- Initiation of the Subsidized regimen of Family Health Insurance in Health Region IV
- Separation of SESPAS functions

STRUCTURAL PROBLEM: CENTRALIZED AND VERTICAL HEALTH INSTITUTIONS

Strategic Approach of the Reform:

- Separation of Functions
- Regulations Centralization and Operative Decentralization

General Results of the Reform Process:

- Creation of a new legal and regulatory framework
- Separation of SESPAS functions

STRUCTURAL PROBLEM: INEFFICIENCIES DUE TO POOR MANAGEMENT

Strategic Approach of the Reform:

- Separation of Functions
- Change from Supply Financing to Demand Financing
- Strengthening of Public Health
- Regulatory Centralization and Operative Decentralization
- Allocation of Resources by Results, including Penalties and Incentives
- Greater Levels of Social Participation and Accountability
- Focus on Primary Care
- Extended and Integrated Information Systems
- Encouragement of New Management Methods
- Development of a Single Collection System

General Results of the Reform Process:

- Generation of social coordination, negotiation and supervision among the main players of the sector
- Creation of the New Social Security System Institutions

- Preparation of a critical mass of technical and administrative personnel to manage the system
- Improvement of the infrastructure, furnishing, and implementation of the computer systems
- Separation of SESPAS functions

STRUCTURAL PROBLEM: MULTIPLICITY OF INSURANCE SCHEMES

Strategic Approach of the Reform:

- Develop a formal Universal Insurance System with a PBS and Training
- Develop a single Collection System

General Results of the Reform Process:

- Creation of a new legal and regulatory framework
- Creation of the New Social Security System Institutions
- Initiation of the Subsidized regimen of Family Health Insurance in the IV Health Region

STRUCTURAL PROBLEM: LACK OF COMMUNITY PARTICIPATION IN MANAGEMENT AND SUPERVISION

Strategic Approach of the Reform:

- Greater Levels of Social Participation and Accountability

General Results of the Reform Process:

- Creation of a new legal and regulatory framework
- Generation of social coordination, negotiation and supervision among the main players of the sector
- General public awareness of the reform process

STRUCTURAL PROBLEM: INSUFFICIENT AND INADEQUATE PUBLIC HEALTH EXPENDITURE

Strategic Approach of the Reform:

- Separation of Functions
- Shift from Supply Financing to Demand Financing
- Strengthening of the Public Health sector
- Regulatory Centralization and Operative Decentralization

- Allocation of Resources by Results, Penalties and Incentives
- Development of a formal Universal Insurance System with a PBS and Training
- Greater Levels of Social Participation and Accountability
- Focus on Primary Care
- Encouragement of New Management Methods

STRUCTURAL PROBLEM: WEAKNESSES IN THE PUBLIC HEALTH PROGRAMS

Strategic Approach of the Reform

- Separation of Functions
- Shift from Supply Financing to Demand Financing
- Reinforcement of the State Governing Function, Regulation, and Supervision
- Strengthening of Public Health
- Regulatory Centralization and Operative Decentralization
- Allocation of Resources by Results, Penalties and Incentives
- Focus on Primary Care
- Extended and Integrated Information Systems

General Results of the Reform Process

- Preparation of a critical mass of technical and administrative personnel to manage the system
- Improvement in the infrastructure, furnishing, and implementation of the computer systems
- Functional separation within SESPAS

ANNEX V USAID OPTIONS TO SUPPORT THE REFORM IN THE MEDIUM TERM

There are various ways in which USAID can continue its support of the reform process in the midterm.

1. Extend REDSALUD's Contract

This option has the advantage of the project already operating, a highly experienced team, and continuous contact with key players in the process. A disadvantage may be that an extension without competition could be negatively perceived by alternative technical assistance contractors. Furthermore, if USAID wishes to redirect its support, it will be more difficult with a team which already has a defined approach.

2. Exercise the option of reform support that the CONECTA contract contains

The advantage of this option is that the mechanism is already established and that the project is already operating in the country. Given that REDSALUD and CONECTA are executed by some of the same agencies (Abt and FHI), an easy transition can be expected. Another possible advantage is that the integration of support activities to the reform process under CONECTA could lead to a larger focus towards reform within the CONECTA project. There is the risk, however, that the process may be altered if the multiple CONECTA lines of action and priorities dilute or hinder an adequate orientation towards reform support activities.

3. Acquire technical assistance through field support from the Global Health Bureau

The advantage of this option is that various projects with health reform components already exist and are already operating with highly experienced teams. It could also be easily executed by USAID. Depending on the focus given to this phase, USAID could use PHRplus, POLICY, M&L, Measure Evaluation, QAWD and/or others.

4. Acquire technical assistance through a task order under TASC II

In addition to the current projects mentioned above that have health reform experience, the Mission has the option of looking for a tailored response through the TASC II IQC mechanism. The advantage of this mechanism is that it includes a wide range of possible contractors who are already pre-qualified, which allows the Mission to save time and effort. The Mission could also consider issuing a task order with an extension option to continue the activities under the new strategy as long as they are compatible. The disadvantage of this mechanism is that the Mission would not have access to all possible contractors who may have experience in health reform, since there are a limited number of TASC II contract holders.