

PA-ABF-508

HEALTH CARE FINANCING IN LATIN AMERICA AND THE CARIBBEAN
USAID Contract #LAC-0632-C-00-5137-00

Exploratory Report: Options for Health Care
Financing Studies in the Dominican Republic

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Submitted to:

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June, 1986

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I.

INTRODUCTION

This is a report of an exploratory visit in the Dominican Republic undertaken on June 11-25, 1986 as part of the HCF/LAC Project on Health Care Financing in Latin America and the Caribbean. During the visit 33 interviews were held with top personnel of the MOH, social security, HMOs and private clinics, various governmental agencies, USAID-DR and other international agencies, and local experts and scholars. In addition, some 46 documents, and other statistical/bibliographic materials were checked and analyzed and most of them collected for HCF/LAC.

Objectives of the visit were: to undertake preliminary analysis of the social security system including the possibility of greater private sector provision of services; to explore the application of user fees in the public sector; to assist USAID with a project geared to strengthen HMOs and particularly in the organization of an in-country seminar for HMO managers; to review ongoing research projects related to HCF/LAC interests; to develop scopes of work for two possible HCF/LAC studies; and to identify host-country professional counterparts for such studies.

Due to reasons explained in this report (a last minute decision of USAID-Washington to undertake research on one of the subjects tentatively chosen for a HCF/LAC study) it was decided, in consultation with Stony Brook and USAID-DR, to develop a potential third topic for study. Due to severe time constraints, however, the scope of work of the additional study could not be developed as in much detail as the other two. In view of the interest expressed by DR officials and the USAID mission health division, as well as the

feasibility of the studies, the three projects were ranked in order of importance and priority as follows: (A) extension/improvement of health coverage through HMOs in conjunction with social security; (B) user fees in the public sector; and (C) health costs and productivity.

At USAID-DR request and with HCF/LAC approval, I devoted extra time to report on the preliminary findings -- from interviews and bibliographical materials -- as well as to undertake some statistical calculations on the subjects of social security/HMOs and user fees. This work is included under sections 2 (Background) of Projects A and B.

II.

ACTIVITIES CONDUCTED DURING EXPLORATORY VISIT

June 7: All materials sent from Stony Brook on HMOs were read and notes taken. Materials available at ^{The University of Pittsburgh} ~~PH~~ on DR health and social security were perused.

June 9: Telephone briefing by Richard Skolnik, HNPB-World Bank, on the first draft of a population, nutrition and health study conducted in 1985 in the DR by Karen Hall. He promised to send us a copy when available.

June 11: Travel to DR.

June 12: Visit to USAID-DR and meetings with Lisa Early, Health Division; review and approval of scope of work, decision on priorities and time table, arrangements for appointments at various institutions. Meeting with Manuel Ortega, USAID-Population, collection of information and arrangement of meeting at IEPD.

Meeting with Henry Welhouse, USAID Economist, to identify household income/expenditure survey, collection of available information at USAID Library and arrangement of meeting at Central Bank.

June 13: Visit to the MOH (SESPAS) and meeting with Dr. David Guzman, Under Secretary of Administration and Dr. Miriam Gonzalez Bello, Director of Medical and Hospital Care. (Dr. Guzman promised to help our project if he remains in MOH). General discussion on DR health conditions and major problems as well as on specific issues such as costs, efficiency, user-fees. Collection of available MOH documents and identification of major studies conducted outside of MOH. Identification of topics for HCF/LAC potential research projects in

DR; he suggested a cost/efficiency study and another on user fees. Selection of three major national hospitals and the national laboratory for visits and arrangement of appointments. Inquiry on probable chief health officials in the new government.

Meeting with Henry Molina, trade union leader, former congressman and currently Advisor on Social Security to the President of the Republic and author of the 1983 social security legal draft. Collection of materials. Discussion on the general financial situation of IDSS and especially of the health program, as well as the reasons for the failure of the draft to get congressional approval in 1983-80, possibilities for a revival under the new government, and labor attitudes vis-a-vis cooperation with private sector. Identification of social security (IDSS) knowledgeable officials and arrangement of appointments. Although he didn't explicitly suggest it, Molina implied that IDSS was in great need for a financial-actuarial study.

Meeting with Dr. Luis Fernandez Martinez, President of Asociacion de Iguales Medicas (HMOs) and director of one of the main HMOs. Discussion on the Igual²s position vis-a-vis the 1983 social security legal draft and the role played by the former to defeat the latter, as well as on private health sector views on the SESPAS/IDSS and possible collaboration in the future. Long conversation on HMOs Seminar; date, participants, topics. Identification of other HMOs leaders and arrangement of collective meeting with them. He suggested that HCF/LAC should study how private medicine could collaborate with IDSS.

June 14: Reading and analysis of collected materials. Meeting with Dr. Pablo Nadal and Dr. Lup² Hernandez Rueda, lawyers working with the private sector ^{3rd} ~~of~~ authors of books on social security and labor

issues. Identification of probable top officials in SESPAS and IDSS in the new government. Inquire about private sector (particularly employers) views on health and social security as well as functioning of HMOs (Iguales). Collection of materials and exploration of research topics. Discussion on legal issues related to user-fees and provision of HMO services to those insured at IDSS. Nadal identified as a topic for HCF/LAC how to finance a system of coordinated peripheral clinics within the private sector with a linkage to a nuclear referral (public) system.

June 15: Study and analysis of materials gathered.

Meeting with Dr. Julio Cross Beras, sociologist trained in USA who has worked on public health and is a member of the transitional team to install the new government. Collection of materials. Discussion on HCF/LAC priority topics. Exploration with Cross Beras on whether he would be interested in being one of the host country professional counterparts (HCPC). Identification of probable new MOH Minister and IDSS Director and arrangements for appointment.

June 16: Meeting with Dr. Rafael Gonzalez Gautreaux, Director of the National Laboratory, a user-fees success story, and potential model for national replication. Inquiry on legal basis, services where user-fees are applied, amount of fees, end use and results, income test for the low-income users, and personnel's and user's attitudes (within the Nat'l Lab) and of the reasons for poor results in other MOH hospitals. Discussion on the State Agency on Pharmaceuticals (PROMESE), its successes and difficulties. Identification of one topic for HCF/LAC project (user fees standardization and universalization in the public sector) and of candidates for MOH

ministry.

Meeting with Dr. Hugo Mendoza, Director of Children Hospital Robert Reid Cabral (the most important of its kind in DR). Comprehensive discussion on user fees and divergent results in services in his hospital, ^{so} problems with physicians. Conversation on the role of Patronatos (Private Foundations) as an additional source of health-care financing, and on this hospital innovative program on bulk buying of medicines on credit and their ^{if} selling the users with a small margin and how this was used as a model for PROMESE. Inquiries about potential topics for HCF-LAC project (he suggested a study to introduce budgetary programming in SESPAS) and new health officials in DR. Identification of new materials.

Meeting with Dr. Guillermo Torres, FAHO Representative in DR. Gathering of FAHO recent reports (one of particular importance and extremely critical) and identification of current health projects financed by them. Discussions on the need to regulate DR schools of medicine and obstacles it has faced, and other administrative problems of MDH. He felt strongly that a HCF/LAC study on health costs will fill a serious vacuum.

June 17: Meeting with Dr. Alberico Hernandez, Director of General Hospital Luis Aybar, who has an antagonistic stand on user-fees and represents the position of the Dominican Medical Association (AMD). Discussion on the legal base of the fees and on his views against user fees and why despite those views he applies them in outpatient consultation, as well as their end use and results (poorer than in other institutions). He also gave his view on outside factors -- besides user fees -- which contributed to the success of hospitals in which such fees exist.

Meeting with Dr. Jocelyn Gross, Administrative Coordinator and Dr. Liliam Gomez, Technical Coordinator, PROMESE. They gave me a brief history of this state agency and analyzed its accomplishments and failures. They also discussed PROMESE relations with the private sector (first antagonistic and later on more cooperative), the role of the PROMESE pharmacy stores (boticas populares), and the deterioration of such agency in recent months. They suggested that a HCF/LAC demand study on pharmaceuticals could improve PROMESE performance in the future.

Identification of potential HCPCs by calling various universities' schools of economics and public health. Updating meeting with Lisa Early.

June 18: Meetings in IDSS. Meeting with Arismendi Diaz Santana Technical Advisor, who explained an apparent shift in IDSS attitude (at least his own) vis-a-vis the Iguilas and how this has resulted in an internal draft which facilitates a more cooperative relationship (it was not feasible to obtain a copy of such a draft). He also explained the polarization which provoked the defeat of the legal draft. He suggested a HCF/LAC study on financial ways to facilitate collaboration between IDSS and the private sector.

Meeting with Ing. Fredis Emilio Romero and Ing. Ana Marta Quesada, IDSS actuaries. They reviewed the poor statistical, financial and actuarial bases of the IDSS and unsuccessful attempts to improve them, and we analyzed available coverage and financial data. Collection of all pertinent materials. He suggested that HCF/LAC study the financial situation of IDSS and ways to improve it.

Meeting with Dr. Julio Cesar Castillo Vargas, Manager of Health

Services IDSS. A total waste of time; he provided data directly from a 1983 PAHO study (with information up to 1982) which I already had, argued that there were no up-to-date statistics available and then demanded that I submit an official request for such information.

Meeting with Isis Duarte, sociologist who has worked on several surveys, as well as on social security and health issues, Institute of Population and Development Studies (IEPD). Collection of materials from IEPD and a Duarte's forthcoming book. Checking of a draft of an IEPD forthcoming book on public health, social security and private sector which could not be copied because it is not final yet (this book should be obtained on a next visit). I explored Duarte's availability as a potential HCPC.

June 19: Meeting with Dr. Vinicio Calventi, Director of Maternity Hospital Altagracia (the most important of its kind in DR). Review of the improvements and problems faced by his hospital as well as his experience with limited application of user fees. Discussion on PROMESE and how its performance could be improved.

Visit to National Statistical Office, library check and gathering of materials.

Meeting with Dr. Gumersindo del Rosario Mota, Advisor of the Central Bank Governor to inquire on the state of processing of national household income/expenditures surveys conducted in 1976-77 and 1984. He promised help for the HCF/LAC project if he holds his job at the Bank.

Collective meeting at the Dominican Association of Private Hospitals and Clinics attended by eleven physicians who are officials of the Association and/or directors of Iguales or private clinics (see List of Institutions/Persons Visited). The major themes of discussion

were their relationship with both USAID and IDSS, and the HMO Seminar: date, participants and topics. In a lengthier separate discussion with Dr. Luis H. Betanc^eps he informed me about an upcoming (May 1987) joint meeting in Sto. Domingo of two Latin American associations of private clinics.

June 20: Meeting with Dr. Rafael Gautreaux whom most experts consider to be the next MOH Minister (Dr. Cross Beras accompanied me). He spoke as an individual and insisted that he doesn't know whether he will indeed become the Minister. He reviewed the current state of public health, reported that a team of 400 physicians have prepared a plan for the new government and summarized the major goals of such a plan. He assured his support to a HCF/LAC project in case he ultimately becomes the Minister.

In spite of Dr. Cross Beras' effort it was not possible to meet Dr. Ney Arias Lora (a physician and former MOH Minister), who, it is rumored, will be appointed Director of IDSS. He is reported to be very cautious, to avoid interviews and be quite reserved.

Telephone conversation with Carlos Rafael Ramirez, BID-Health, who reported on the projects they are currently financing including a study (just starting) that may touch health costs and financing. He promised to send a summary of such a project but never did. This should be checked by USAID-DR or by HCF/LAC.

Meeting with Lee Hougen, Director USAID Health Division, who had just returned to the DR and Lisa Early for a very preliminary overview of my work.

Review of USAID files (from a recent competition for a health sector assessment project) to select additional candidates for HCPCs,

and selection -- in consultation with Lisa Early -- of the best. Phone and personal interviews were conducted during my stay with several of the candidates including (in addition with those already mentioned) Jose Miguel Bisso, Alberto Veloz, Juan Llado, and Alberto Montero.

June 21-22: Preparation of the trip report, lists of documents and visits, and preparation of preliminary draft of scopes of work for Projects A and B.

June 23: Meeting with Lee Hougen and Lisa Early to discuss drafts of scopes of work and budgets. Hougen believes that the user-fees study to be done by USAID-Washington will not be a profound one but that it probably is a fact-finding general study to support positions in a forthcoming Conference on Health to be held in Washington. He suggested that we ignore this study. Hougen made several recommendations to improve Projects A (HMOs/IDSS) and B (user fees in MOH) which he considered the most useful for USAID; he gave a lower priority to Project C (health costs).

After this meeting, Lisa and I discussed the strategy to follow. Only one day of my visit was left, and still I had to write the scope of work of Project C and introduce changes in the scope of work of the other two projects. Therefore we decided to give priority to Projects A and B but to write a brief scope of work of Project C to have an alternative in case it is decided to drop Project B.

June 24: Preparation of scope of work of Project C and revision of scopes of Projects A and B.

June 25: Meeting with Lee Hougen, Lisa Early and Hank Bassford, USAID Mission Director, for a final discussion of this report. I reported to Mr. Bassford on my activities and proposed topics. He expressed interest particularly in the policy implications of our potential

studies. Lee Hougen reiterated his interest especially in projects 1 and 2 and in the possibility I return to undertake the study of IDSS/HMOs.

Return to the United States.

June 26: Phone briefing to Dieter Zschock on exploratory visit. Books and other materials will be mailed by USAID-DR.

III.

SEQUENCE OF ACTIVITIES AFTER EXPLORATORY VISIT

1. Conduct feasibility USAID-DR study of HMOs as soon as possible, hence USAID should identify source of funding.
2. Hold HMOs Seminar from two to four weeks after the change in administration. Identify potential U.S. speakers, prepare list of participants and themes.
3. HCF/LAC should select the two projects to be undertaken, identify international consultants to conduct such studies and check on their interest and availability.
4. If new top officials (SESPAS, IDSS) are known before August 16, USAID-DR officials should meet with them and discuss the proposed studies. Immediately after August 16 official letters should be sent to the new SESPAS Minister, and IDSS Director to request approval of the two selected studies. A check should be made ^{with} ~~on~~ the Central Bank (Gumersindo del Rosario or his substitute) on the status of the household survey data processing and to secure their support especially if the cost study is selected.
5. If necessary, revision and adjustment of scope of work in September. Decide on tentative dates for studies. Check with candidates for HCPC on their availability and make final selection also in September. Make final arrangements with international consultants.
6. Visit to DR (if necessary by Mesa-Lago) in October, probably for one week, to complete final agreements, contracts with selected personnel and other arrangements.
7. Initiation of first study in late October or early November.

Initiation of second study in late November or early December.

IV.

LIST OF INSTITUTIONS AND PERSONS VISITED

USAID: U.S. Embassy, Sto. Domingo

Tel. 6822171
x 364, x 365

1. Dr. Lee Hougen
2. Lisa Early, Health
3. Manuel Ortega, Population
4. Henry Welhouse, Economist

Ministry of Health: Secretaria de Estado de Salud Publica y Asistencia Social (SESPAS), Ave Tiradentes, Sto. Domingo

5. Dr. Daniel Guzman, Sub-Secretario Administrativo (565-1264/6378)
6. Dra. Miriam Gonzalez de Bello, Directora General de Atencion Medica y Hospitalaria
7. Dr. Rafael Gonzalez Gautreaux, Director Laboratorio Nacional de Salud Publica, Santiago y Fialla Cabral Streets (682-2479, 688-7895).
8. Dr. Hugo Mendoza, Director Hospital de Ninos Robert Reid Cabral (533-1584)
9. Dr. Alberico Hernandez, Director Hospital General Luis Aybar, Federico Velzaquez St. (682-5212)
10. Dr. Vini^o Caventi, Director Hospital de Maternidad Altagracia (682-9294)

State Pharmaceutical Agency: Programa de Medicinas Esenciales (PROMESE), Calle H #15, Herrera, Sto. Domingo (533-7798/7650).

11. Dra. Joselyn Gross, Coordinadora Administrativa
12. Dra. Liliam Gomez, Coordinadora Tecnica

Social Security: Instituto Dominicano de Seguro Social (IDSS).

13. Dr. Arismendi Diaz Santana, Asesor Tecnico

14. Ing. Fredis Emilio Romero, Actuario (565-1054)
15. Ing. Ana Marte Quesada, Actuario (565-1054)
16. Dr. Julio Cesar Castillo Vargas, Gerente Servicios de Salud
17. Dr. Sergio Taberas Fermin, Asistente Tecnico - Administrativo
Salud
18. Sr. Henry Molina, Asesor Seguridad Social, Presidencia de la
Republica (600-8306).

Transition to New DR Government: Transicion de Gobierno

19. Dr. Rafael Gautreaux (rumor is that he will be new Minister of
Health)

Centro de Gastroenterologia, Ave. Bolivar 195 (689-7626)

20. Dr. Julio A. Cross Beras, Cii-Viviendas, Inc., Ciudad Ganadera,
Apartado Postal 20328 (533-7676/2191/2192)

Pan American Health Organization (at SESPAS) San Cristobal y
Tiradentes), Apartado Postal 1464

21. Dr. Guillermo Torres, Representante de la OPS en la Republica
Dominicana (566-2705)

Central Bank: Banco Central, Pedro Henrriquez ^{Ur} ~~U~~ena (685-9111)

22. Dr. Gumersindo del Rosario Mota, Asesoria de Governacion, 11th
Floor - Sr. Jose Berea Basil, Division de Estadisticas y Encuestas,
Depto. de Estudios Economicos

Institute of Population & Dev't: Instituto de Poblacion y Desarrollo
(IEPD), Dr. Pineyro #160, apartamento 302 (533-7382)

23. Lic. Isis Duarte, labor sociologist (she also works on social
security and health)

Inter-American Development Bank: BID

24. Dr. Carlos Rafael Ramirez (562-6400)

HMOs Association: Asociacion Dominicana de Iguales Medicas, Ave.

Laborales, Apartado 30323 (562-2565)

32. Dr. Delgado Bellini, Decano Facultad de Ciencias de la Salud,
Universidad Nacional Pedro Henriquez Urena (UNPHO) (562-6601)

33. Dr. Raymundo Jimenez H., Decano Facultad de Ciencias de la Salud,
Instituto Tecnológico Santo Domingo (INTEC) (567-9271, x256)

World Bank (Washington)

34. Telephone interview with Richard Skolnic (HPND)

V LIST OF DOCUMENTS COLLECTED OR CHECKED*

All documents collected are being mailed by USAID-DR to Stony Brook. Documents checked (*) were not mailed either because they are not essential or could not be xeroxed; many are available at USAID-DR Library. All documents listed were read by the consultant who took notes of the most relevant aspects.

A. Public Health

1. Secretaria de Estado de Salud Publica y Asistencia Social (SESPAS), Politica de Salud: Periodo 1973-1980, Santo Domingo, September 1973.*
2. _____, Salud Publica, Cuatro Anos de Gobierno (1978-1982), Sto. Domingo, 1982.*
3. _____, Politica de Salud del Gobierno de Concentracion Nacional, 1983-1986, Sto. Domingo, 1983.*
4. _____, Estadisticas de Salud, several issues 1979 on *
5. _____, Memoria 1983, Sto. Domingo, 31 diciembre 1983.
6. _____, Memoria 1984 (copy of original sent to printers)*
- 6a _____, Memoria 1985 (copy of original sent to printers)*
7. _____, El Hospital Dominicano dentro del Contexto "Salud para Todos en el Ano 2,000," Memorias del Primer Congreso Nacional de Hospitales," Santo Domingo, Febrero - Marzo 1984*
8. _____, Statistics on SESPAS Hospitals and Other Facilities by Region, 1986
- 8a _____, Regulations SESPAS (user fees)
9. _____, Secretariado Tecnico de la Presidencia, Oficina Nacional de Planificacion/OEA, Estudio de Base del Sector Salud = Nutricion = Farmacos, Sto. Domingo, November 1983*
10. _____, Organizacion Panamericana de la Salud (Mario Gomez Ulloa), El Sistema de Salud en la Republica Dominicana, 1985
11. USAID Mission to Dominican Republic, Health Sector Assessment for the Dominican Republic, February, 1975

12. USAID (Lawrence Bartlett), "Financial Analysis" and "Financial Management Systems within SESPAS," Santo Domingo, August 1983
13. USAID (Washington) wire to USAID-DR on User Fees Study
14. USAID-DR Memo on Doctors Strike and new Taxes, June 14, 1985*
15. Martita Maria Marx, "The Effects of Medical Services on Health Status in a Developing Nation," Doctoral Dissertation, UCLA 1978 (author worked on A-11 and her dissertation repeats part of that information, however appendices includes health questionnaires on Household Demographic Survey conducted by USAID in 1974 which is not available in A-11).*
16. Linda S. Harder and Michael R. Reich, "Hospital Jose Maria Cabral y Baez," Harvard School of Public Health, 1984.
17. Nelson Ramirez, Carmen Gomez e Isis Duarte, Salud y Poblacion, Santo Domingo, IEPD, forthcoming 1986. (has excellent sections on demography, public health, social security and private health)*

B. Social Security

18. "Perspectivas de la Legislacion sobre Seguro Social Vigente en la P.D. y Motivaciones del Nuevo Proyecto," n.d.
- 18a Hernando Perez Montas, "Plan de Desarrollo de la Seguridad Social 1974-1978," [? : 1974].
19. Amendment to Social Security Law, 1985
20. IDSS, "Proyecto de Ley sobre Seguridad Social Presentado al Senado de la Republica," Sto. Domingo, n.d.
21. Luis Henry Molina, Nuevo Sistema de Seguridad Social, Sto. Domingo, Instituto Nacional de Estudios Laborales, 1983
22. OPS, Investigacion Operativa de los Servicios de Salud, Santo Domingo, September 1983 (also includes information on SESPAS, but data on IDSS are the most important).
23. Pablo Nadal, "Nueva Vision de la Seguridad Social," Sto. Domingo, Instituto Nacional de Estudios Laborales, 1986
24. IDSS, "Estimados Actuariales Definitivos del Ante-Proyecto de Ley sobre el nuevo Regimen de Seguridad Social," Agosto 1983*
25. IDSS, Informe Estadistico (with various names), 1984-1985 (only 1985 attached)
26. Alfredo Conte Grand (ILO Regional Advisor), "La seguridad

social," Revista de Ciencias Juridicas, 1:9 (Mayo 1985): 271-276

27. Isis Duarte, Trabajadores Urbanos: Ensayos sobre Fuerza Laboral en la Republica Dominicana, Santo Domingo, UASD, forthcoming 1986), only attached is the section "La Seguridad Social y la Problematica Salarial."

C. HMOs

28. USAID (Linda S. Harder), Report 1: "An Overview of Alternative Health Care Providers and Potential Beneficiary Groups for a Self-Financing Health Care Project," September 30, 1985
29. _____, Report 2: "An Overview of Health Maintenance Organizations in the Dominican Republic," June 10, 1985
30. _____, Report 3: "An Overview of Cooperatives and Community, Agricultural, Worker and Employer Associations in the Dominican Republic: Their Structure and Potential to Provide Alternative Health Care Services," July 5, 1985
31. _____, Report 4: "An In-Depth Look at Potential Provider and Beneficiary Groups for an Aid Health Project," August 19, 1985
32. _____, Report 5: "Findings and Recommendations Regarding a Self-Financing Alternative Health Care Project," September 12, 1985.
33. _____, "A Preliminary Feasibility Study for a Self-Financing Health Project," November 8, 1985
- 33a USAID (Thomas Ramey), "Consultant's Report on Private Sector Pre-Paid Health Project for Dominican Republic," October 10, 1985.
34. USAID, "Draft Concept Paper for Private Sector Project," March 1986
35. _____, "Draft Statement of Work for HMO Feasibility Study," May 1986.
36. Luis H. Betances M., Asociacion Nacional de Clinicas y Hospitales Privados, Inc., Seguridad Social y la Medicina Privada en la Republica Dominicana, Trabajo presentado en dos asambleas en Buenos Aires, 13-18 abril 1986
- 36a CEDOIS, Directorio de Instituciones Privadas de Interes Social de la Republica Dominicana, 1984-85, Sto. Domingo, 1985

D. Household Surveys Including Data on Health Expenditures/Access

37. Amino Perez - Mera y Julio Cross Beras, Patrones de Consumo y Estructura Social en Santo Domingo, Sto. Domingo, Fondo para el Avance de Ciencias Sociales, 1981 (summary and analysis of household survey of 1959, includes data on health)*
38. Banco Central de la Republica Dominicana/Oficina Nacional de Estadistica, Primera Encuesta Nacional de Ingresos y Gastos de las Familias en la Rep. Dominicana (1 mayo 1976- 30 abril 1977), n.d. (Questionnaire includes health, chapter IV)*
39. _____, Primera Encuesta Nacional de Ingresos y Gastos de las Familias en la Republica Dominicana: Resultados Preliminares, Sto. Domingo 1978 (this publication does not include any data on health)*
40. _____, "Segunda Encuesta Nacional de Ingresos y Gastos de las Familias en la Republica Dominicana," (taken on November 1984, questionnaire includes health).*

E. Population, National Accounts & Other Data

41. ONE, Censo Nacional de Poblacion y Vivienda 1981: Resultados Preliminares Obtenidos por Muestra, Marzo 1983.*
42. ONE/CELADE, Republica Dominicana: Estimaciones y Proyecciones de Poblacion, 1950-2025, Mayo 1985*
43. Nelson Ramirez et al, "Poblacion y Mano de Obra en la Republica Dominicana: Perspectivas de la Fuerza de Trabajo... en el Periodo 1980 - 1990," IPD, Boletin, 1:2 (Julio-Octubre 1982).
44. "Tendencias Recientes y Perspectivas de la Situacion Ocupacional en D.R.," IPD, Boletin, 3:9 (enero-marzo 1985)
45. ONE, Republica Dominicana en Cifras 1964 to 1985*
46. Banco Central, Boletin Mensual, 1980 to 1985*

VI.

RECOMMENDATIONS ON IN-COUNTRY SEMINAR FOR HMO MANAGERS

In interviews held with members of the Asociacion Dominicana de Iguales Medicas and the Asociacion Dominicana de Hospitales y Clinicas Privadas, including a meeting of the latter attended by eleven members, the following features of the HMO Seminar were suggested. It became apparent in the meeting that there were several conflicts among participants, e.g., between Iguales that have their own clinics (group model or direct) and those which don't (IPA model or indirect), between HMO conservative managers that are reluctant or ambivalent on taking risks (e.g., changing methods, extending coverage) and those who are willing to take such risks, and between divergent political affiliations among members. This is a rather diverse group with significant sources for tension and confrontation and this should be taken into account in the organization of the seminar.

1. Date: A few weeks after the inauguration of the new government, in order to have an impact on policy. The beginning of September was suggested as an ideal date.

2. Participants: Suggestions on number of participants ranged from 35 to 200. I feel that the number should be kept relatively low (about 50) to avoid losing control and facilitate active participation. Presidents (or their representative) of both Iguales and Private Clinics should be invited. Although there was initial hesitation on whether to allow "outsiders" to participate, eventually, there was consensus on the convenience to invite: the President of the Republic, the Minister of SESPAS, the Director of IDSS, and the President of the Dominican Medical Association (or their

representative). Other potential guests suggested to be invited were representatives from the employers associations, the major union confederations and the major universities with schools of medicine/public health. Many in the meeting/interview felt that the Seminar should not be exclusively technical but have an additional objective: to influence potential policy decisions of the new government.

3. Length: In view of the time-demands on the potential participants a one-day seminar is suggested.

4. Topics: (a) Financing to avoid obsolescence of equipment (due to high cost of imports and lack of preferential exchange^{rate} and credit), review of means such as soft loans, preferential exchange rates, renting with buying option, etc. (b) Extension of coverage to lower income groups; this issue induced reservation among some HMO managers who argued that such an expansion will be very difficult to finance; a few suggested that incentives should be provided to new groups (taking advantage of physicians' unemployment (underemployment) to develop low-cost HMO's in poor areas, as well as relations with the public sector and universities; the need to consider private clinics - not only Iguaras - was suggested as a mechanism for coverage extension. (c) Preventive medicine; it was mentioned that the bulk of the Iguaras' patients are affected by gastroenteritis but that this is difficult to prevent by HMOs (e.g., poor environment, sanitary conditions); at least one HMO manager indicated that he provides vaccination in his plan but does not know if such practice reduces his costs (in terms of loss morbidity), hence a suggestion was made to conduct a comparative study of effects on morbidity of HMOs with and without vaccination plans. (d) Common services for diagnosis,

expensive equipment, vaccination and treatment of certain diseases were suggested to make some of such services/devices, accessible to HMOs and to reduce their costs. (e) Association of local HMOs with an U.S. HMO for investment and/or technical assistance purposes. (f) Ways to improve HMOs organization, efficiency, marketing and public relations. (g) Ways to assure quality control; in relation to this, some participants suggested the need to set minimum standards (or basic rules of the game) amongst HMOs although maintaining competition and flexibility (e.g., to set various packages with different prices).

5. Organization of the Seminar: A strong, skilled moderator must be chosen to enforce rules of discussion in the seminar, especially to avoid lengthy or irrelevant interventions and to keep the discussion within the themes of the seminar.

6. U.S. Speakers: I don't feel qualified to make suggestions on this; Dieter Zschock should be a better source than me.

VII.

SCOPES OF WORK

PROJECT ~~1~~: EXTENSION OF COVERAGE AND IMPROVEMENT OF HEALTH SERVICES THROUGH INCREASING USE OF HMOs IN CONJUNCTION WITH SOCIAL SECURITY

Subject of Study

Analysis of comparative health care costs, efficiency and quality of services between IDSS and the private sector -- particularly HMOs igualas (if Project ~~2~~ is not conducted) and study of a potential extension of population health coverage through greater private sector provision of services in conjunction with IDSS, through alternative means particularly allowing employer/insured choice of affiliation to HMOs instead of IDSS.

2. Background

Very little information is available on health care costs, efficiency and quality of services in both the IDSS and the private sector (particularly igualas). There are few studies available on IDSS and the existing ones have scattered financial/productivity statistics. IDSS itself has published a regular statistical report since 1948 but it was interrupted in 1971, reestablished a few years later and then halted in 1979; thereafter there are annual reports available for 1983 and 1984 and the first trimester of 1985 but the latter two have not been published yet [V-25]. These reports provide data on active insured population coverage and, in a few instances, gross estimates of dependents' coverage based on arbitrary ratios of wife/children per insured; furthermore, IDSS only grants maternity coverage for the insured's wife and pediatric care for children below

8 months, hence actual dependent coverage is even more difficult to estimate and a new registration has not been made in 21 years [IV-14, 15]. The IDSS statistical reports usually provide data on income and expenditures but not accurate and disaggregated enough to allow for serious analysis. Scattered data are given on the number and efficiency of IDSS hospitals and other facilities but, again, too aggregated to support an accurate analysis of efficiency or to calculate unit costs. The 1976-77 and 1984 national household surveys on income/expenditures -- when available -- could provide health cost data (see Project 1).

In 1983 a legal draft was elaborated to drastically change the current social security system, including: (a) extension of coverage to the insured's dependent family (expanding coverage on health care to the spouse and children below 18 years of age); (b) extension of coverage to all salaried employees or wage earners regardless of their salary/wage amount (hence totally eliminating wage ceilings for compulsory coverage that were RD\$233 up to 1979, RD\$303 in 1979-85 and has been RD\$429 since 1985); (c) extension of coverage to state/autonomous agency employees and IDSS pensioners (both types currently excluded) as well as to the self-employed, domestic servants, home workers, unpaid family workers and members of production cooperatives (the first three groups are technically covered by the law but in practice they are not and the last two groups are originally excluded); (d) increase of the total wage contribution (of insured, employer and state) from 12% to 20% and enforcement of the state tripartite contribution (which has seldom been paid) hence generating a huge cumulative state debt to IDSS [IV-22]; (e) merger of the occupational accident insurance program

(currently autonomous but housed in IDSS) with the health-maternity program, and addition of coverage on professional diseases (currently nonexistent); (f) provision of a solid financial and actuarial base to the IDSS; (g) introduction of the civil service career to provide skilled and stable personnel; and (h) totally revamping the IDSS organization and administration [V-20].

The publication of the legal draft generated a lively controversy and rapid polarization. The focus of the debate was article 16 (art. 15 in the final legal draft) which regulated the relationship between IDSS and the private sector. According to one source there was an initial consensus (in 1982, at the time of the presidential inauguration) among major union and employer federations and the government on a legal draft to universalize social security coverage [V-27]. Another source reports that after some initial disagreement, there was a commission to deal with this issue appointed by the President which included a representative each from the Executive, the private health associations, and the author of the draft -- the social security advisor to the Presidency. The commission reached a consensus to review and modify the article of controversy and the agreed upon text was accepted by the President, but when the final draft was submitted to Congress the modifications introduced in such article were not included [V-36].

The final version of the article stated that "health care will be provided only at IDSS' own facilities... and only in the cases and conditions established in IDSS regulations; such care could be provided in private clinics and other centers with whom IDSS has contracted [but only on base to] the fees and tariffs set [by the IDSS]." [V-20] Rather than establishing a collaborative attitude the

stiff text of the draft made private participation an exception and left its regulation unilaterally to IDSS officials. The result of this was an open confrontation in Congress, and through the news media between the government and private clinics/igualas. The private health sector accused the government of "socialization" and of attempting to wipe them out [30] while supporters of the law reacted criticizing their opponents as "health merchants and intermediaries" ("many of whom cut services and hire bad physicians") which have become a "bourgeoisie" promoting the "privatization of social security" [IV-27]. An official document considered enterprises which paid igualas (on top of social security) as an "irregularity" which "weakens the IDSS" [V-18]. The acrimonious debate split the government party, protracted congressional approval of the draft and practically defeated it. [There is an unconfirmed allegation that many civil servants opposed the draft because they are not actually covered by IDSS but through igualas, hence the law would have reduced the level of their health care].

In retrospect, the current technical advisor of the IDSS believes that art. 15 "was too restrictive, ... ignored the installed capacity of the private sector and the important role it plays in health care -- due to poor IDSS services -- as well as its political muscle". This official considers that the support of the private sector is "inevitably needed to extend IDSS coverage, otherwise such extension will not be more than a tax without providing any services". Furthermore, according to said official, art. 15 involved a dramatic shift in the state position which had first stimulated and subsidized the private sector to later on attempting to reduce or eliminate it. Finally, the IDSS technical advisor argues that the extension of

coverage and elimination of the wage ceiling would have meant that higher income groups would pay but not use IDSS poor services hence increasing users' frustration [IV-13]. The controversy is not settled, thus the author of the defeated draft still maintains that the total reform of the IDSS would have eliminated most of its flaws and allow it to effectively extend coverage with improved services; he also believes that the private sector will have to eventually accept state regulation [IV-18]. There seems to be a consensus that sooner or later the government will try again to extend IDSS coverage (partly for optimistic reasons but also under serious financial pressure due to IDSS recurrent deficits); the question is what role the private sector is expected to play in such an extension.

There seems to be also a consensus, even among selected IDSS personnel and social security supporters, that this institution is in financial chaos, that it is grossly inefficient and that its health services are very poor, all of which has facilitated the expansion of the private sector. Apparently the majority of employers/employees affiliated to IDSS also pay igualas in order to receive adequate health care. An evaluation of IDSS major flaws follows.

According to my own estimates [based on IV-14,15 and V-42,44,45,25] social security coverage of the EAP (the most accurate since it is based on active insured) increased from 8.9% to 11.3% in 1970-86. Using these figures and a 1980 comparison among all Latin American countries, it appears that the DR had in 1980 and probably now the lowest coverage in the region, after Haiti (the same coverage as El Salvador). My estimate of total population coverage (per force inaccurate due to improper estimates of dependents, and probably inflated due to provision of only minor health services to such

dependents), shows an increase from 3.7% to 6.1% in 1970-86. Once again, in 1980, DR had the lowest coverage of the region (except for Haiti). The wage ceiling (currently DR \$529 monthly) excludes the higher income groups while the lowest income groups are also excluded. Hence IDSS probably covers a middle-income group of the population, highly concentrated in industry, with a very small proportion in agriculture and personal services [V-17]. Partly because pensioners are not eligible for health care, about 40% of insured of 60 years of age and over do not retire but keep working, hence reducing job opportunities in an economy with 25% unemployment [V-22]. Geographic coverage of the total population fluctuates from 0.4% in Bahoruco (most rural province) to 7% in Santo Domingo (the capital city) and 36% in La Romana (which has a high proportion of its labor force salaried and unionized [V-22]). About half of the active insured are temporary (seasonal, migratory) workers, and annual fluctuations in the number of total active insured are significant, e.g., a 10% decline in 1981 and a 15% increase in 1983; contradictions in figures are also frequent (e.g., a difference ranging from 17% to 24% in two statistical sources published for 1978-79). When the previous comments on the inaccuracy on the insured's dependent figures are also taken into account, it is obvious that IDSS does not really know how many insured it has, in spite of its limited coverage. Accurate calculations of average costs are therefore extremely difficult unless population coverage data are improved.

Several sources assert that about 40% of IDSS health services are provided to non-insured (without being recorded) through political patronage, bribery and other illegal means; from 10% to 15% of patients are officially treated for "scientific interest" a very high

percentage indeed. All these practices increase costs and reduce quality of services to the insured; they may also explain at least part of the enormous IDSS bureaucracy. (V-23, 30, 36).

About 90% of IDSS emergency cases are allowed to use private facilities and IDSS also contracts with the private sector for 6% of its beds [V-18a]. These figures are a decade old but recent data suggest that IDSS indirect services have declined, thus in 1977-80 the percentage of IDSS expenditures going to contracted services decreased from 3% to 1.8%. Part of the explanation may be the refusal of many private clinics to provide services to IDSS due to the fact that the latter seldom pays them or delay its payments [IV-25].

IDSS is without doubt one of the least efficient social security institutions in Latin America if not the most inefficient. According to various estimates, administrative expenses took anywhere from 27% to 62% of IDSS total expenditure in 1980-86, depending on the year and what budgetary lines were included in the calculations [V-22, 23, 27]; even the most conservative of those estimates places DR well above the region and sets a hemispheric record. In the first quarter of 1986, IDSS average hospital occupancy was 51.7%, one of the lowest in Latin America while the average length of hospital stay was 10.4 days, one of the highest [V-25]. If the latter figure had been reduced to a more reasonable 5 days of stay, hospital occupancy would have dropped to 24.8%, the lowest in the hemisphere. The number of IDSS employees per 1,000 total insured is 15.1 one of the highest in Latin America, but if only active insured are used (a more accurate estimate for the reasons given before) the ratio reaches the astonishing figure of 20.5 per 1,000 insured: a historical record in the region [author estimates based on IV-16, V-23 and insured data].

About 60% of the IDSS employees are in the health sector and the ratio of physicians per total and active insured are respectively 25.6 and 34.8 per 10,000 - certainly the highest in the region. In 1980 about 57% of IDSS expenditures went to pay physician salaries and fringe benefits, this before the doctors strike of 1985 resulted in a big jump in their salaries. Physicians officially work only 4 hours daily but in practice they work only about 2 hours. IDSS services are highly concentrated in Santo Domingo which has 27% of the IDSS insured but from 42% to 51% of the doctors, 57% to 65% of all employees, and 40% of beds [V-18a, 22]. The quality of IDSS services is so bad that a 1984 private survey reportedly found that 91.8% of the insured were critical of such services and didn't want to use them if they had an alternative [V-23].

Evasion is quite high due to poor registration, collection and control, lack of individual accounts and accurate statistics, and no effective mechanisms for enforcement and sanction. In 1986 the IDSS actuary estimated evasion at 30% to 35%; and rising after the increase in the wage ceiling [IV-14,18]. Sanctions to evaders are very lenient, e.g., RD \$100 to 1,000 for registered employers, who delay payments, and RD \$10 to 100 pesos for non-registered employers (hence stimulating clandestine enterprises) [V-27]. The state does not have to pay contributions as employer (because civil servants are not covered by IDSS), but legally has to contribute 2.5% of insured wages, such contribution has been paid ^{at} ~~and~~ only a fraction of the due payment) in five out of 39 years of the IDSS existence. As a result, the cumulative state debt to IDSS reached RD\$ 95 million in 1980 equivalent to the combined total IDSS expenditures in 1978-80; with high inflation in the 1980s the debt should be even higher [V-22].

Investment revenues (as a percentage of total IDSS revenues) declined from 2.9% to 1.1% in 1977-88 and are almost negligible now [V-22, IV-14,15].

IDSS health expenditures are difficult to calculate due to the lack of separate accounting but I have estimated them at RD\$ 31 million in 1980 or 66% of total IDSS expenditures [based on V-22]. The occupational accident program generated in 1970-79 a cumulative RD \$43 million which was mostly transferred to the health-maternity program, and practically all IDSS investment goes to health facilities and equipment [V-27]. In 1976, 1979 and 1985 the IDSS budget ended in deficit (basically induced by the health program) and Congress quickly resorted to increases in the wage ceiling. The 1985 deficit reached RD\$ 21 million. After six months of the 75% increase in the wage ceiling which resulted in almost 20,000 additional active insured and a 29% increase in revenue (a projected additional RD\$ 20.4 million for the year 1986) the IDSS is in trouble again. Reportedly, IDSS does not have funds to pay employee salaries (significantly increased by the doctors' salary raise) and is borrowing to meet such obligations and considerably delaying the payment of monetary benefits. According to the IDSS actuaries, in June 1986 the IDSS reserves were about equal to or less than the IDSS debt, hence there were no real reserves. The latest actuarial study was conducted in 1980 with 1979 data and it is obvious that the actuarial deficit must be enormous [V-14,15]

The lack of reliable data makes impossible any serious estimate of the cost of expansion of IDSS health coverage. For instance, the 1983 legal draft set a total salary contribution of 20% (vis-a-vis the current 12%) but an outside actuarial report estimated that the

premium should be 23.6% and the ILO calculated a premium of only 15.4%, a difference of 53% between the latter two [V-26]. The number of total insured estimated to be covered, if the 1983 draft had been approved, fluctuated from 808,000 [V-24] to 1,689,200 [V-21] for a difference of 97%. Finally, the estimates of the increase in annual revenue resulting from the 1985 raise in the wage ceiling ranged from RD\$ 24 million [V-14,15] to RD\$ 130 million [V-24] for an amazing difference of 442%! According to the two IDSS actuaries the IDSS statistical system was messed up in 1984 and currently it is impossible to estimate separate costs for health-maternity and occupational accidents. Then³⁰ technicians tried three times to reintroduce the proper statistical system but subsequently failed as the Director of IDSS changed three times during the current administration. The chief actuary was sent to be trained in Spain only to come back and "do nothing for two years." [IV-14] A final anecdote can give an idea of the financial/administrative disaster of IDSS: the chief actuary wanted to xerox and give me the latest statistical report (not printed); after several requests to the Director's office explaining that this was needed for an USAID mission[^], the actuary had to supply the needed photocopy paper and sign a request for such services.

The deteriorating health services of the IDSS have largely contributed to the development of private health care in the DR. From June 1985 to May 1986 USAID has commissioned seven studies related to the private health sector in search for an optional mechanism which could be strengthened to expand and improve health care in the country. After a detailed inventory, survey and evaluation of 84 private non profit and profit providers and beneficiary groups (38

primary care organizations, 16 HMO's and 30 other organizations) USAID-DR has identified HMO-like organizations (Iguallas) as the most feasible mechanism to extend a pre-paid self-financing, affordable system of health care to groups of the population (basically in Sto. Domingo) with adequate but still relatively low disposable income who currently don't receive such care. The iguallas, however, were established in DR as a means of providing patients for physicians (many of them underemployed) rather than as a means of controlling or reducing health care costs. HMOs also have some limitations and face some problems: they are currently caught in a cost-price squeeze, have limited access to capital to upgrade equipment and facilities, lack experience in managing preventive/PHC programs, and need more efficiency in administration, marketing, etc. (some HMOs are of the IFS type hence don't have their own facilities). A preliminary draft concept paper and statement of work for HMO feasibility study (finished in early 1986) propose that USAID-DR, provide to HMOs: (a) US\$3 million for technical assistance in cost control and marketing to increase their capacity utilization; (b) US\$5 million in a loan fund to finance HMOs new equipment, outpatient care centers, develop prevention and promotion, and cover deficits incurred as a result of service expansion; and (c) attempt to assure the collaboration of a US HMO as an investor in or technical advisor of local HMOs. If implemented the project is expected to achieve the following results: increase enrollment in 5 years (starting in 1987) from 250,000 to 500,000, plus an additional 45,000 monthly low-income wage earners in Santo Domingo; as well as to reduce costs and develop more affordable benefit packages [V-23 to 35].

Proposals

3. Current Information

The information in the previous section demonstrates the chaotic state of IDSS health services and the poor possibility for rapid, substantial improvement. It also indicates that sooner or later the DR government, partly pressured by the grave IDSS financial crisis, will attempt again to extend its coverage. The history of the 1983 social security draft shows that confrontation and polarization should be avoided and a fruitful collaboration hopefully worked out between IDSS and the private health-care sector. The development of igualas in the DR is a positive event but they face difficulties and limitations to expand coverage particularly to lower income groups. USAID-DR is willing to strengthen those HMOs to make them capable of expansion. Still, information on the cost of health services in IDSS and HMOs and a comparative study of such costs would be useful both on technical and political grounds to show which institutions are the most capable, both in terms of costs and benefits to accomplish such an extension. In addition there is a need to find out, in a systematic way, what is the opinion of current and potential users on both IDSS and Igualas services and the capacity of such users to afford prepaid health systems. Finally, it is important to gather information on the target population for coverage expansion, as well as to explore potential mechanisms for IDSS/HMO collaboration.

There is a strong consensus among most government officials and private sector leaders of the need for this study and for recommendations that could influence policy in the new government. USAID-DR considers that this study will be very valuable in their current plans vis-a-vis HMOs particularly in terms of the

identification of a target population and its capacity to pay, as well as the mechanisms which could allow an effective collaboration between IDSS and HMOs.

el. Specific objectives (not clear)

Should go here.

4. Specific Objectives

The proposed study will: (a) review the current legislation and custom related to IDSS contracting of services, as well as the 1983 legal draft and other legal projects (one prepared by the IDSS technical advisor could not be obtained); (b) discuss with IDSS new chief officials their receptivity to a significant HMO role in the provision of health care to their current and/or future insured; (c) review various potential mechanisms for an IDSS-HMO effective and mutually beneficial relationship and select the most feasible one after consultation with interested parties; (d) conduct -- taking into account limitations of IDSS statistics and dispersion of HMO data-- a comparative study of health costs and efficiency; and (e) find out the opinion of current and potential users (as well as employers, physicians and other relevant groups) on the services provided both by IDSS and the Iguales, their attitude versus a potential shift from one to the other, and the ~~the~~ capacity of ^{the} target population to afford pre-paid health care. In addition the study will make recommendations on the best way to expand HMOs role in social security, and roughly estimate the potential coverage expansion as well as savings and improvement in services if such incorporation were to take place.

5. Scope of the Study

The study will gather available data on IDSS and attempt to produce needed but non-available data (for this purpose, the household national survey of 1976-77 and 1984 may be useful). The study also will include a survey of current and potential IDSS and HMO users in Santo Domingo with special focus on low-income groups. The sample should include: (a) users who are insured of IDSS and also are members

of an iguala; (b) users who are only insured of IDSS; and (c) users who are only members of an iguala. If feasible, those of relatively low income ^{are} are not covered by either institution but could be potentially covered in case of an extension of coverage, should also be included in the sample (e.g., free custom zones). The decision on the number and the selection of the institutions will be made at a later date, taking into account the need to represent various types of institutions and users.

6. Methodology

The study will use four methods: (a) collection and analysis of all available primary and secondary data (including the national household surveys of 1976-77 and 1984); (b) conducting a limited number of informal interviews with IDSS and government officials, politicians, labor leaders and HMO association leaders; (c) designing and conducting a survey, and processing and analyzing its results; and (d) conducting observation visits to the institutions chosen for the sample in order to check their services according to a set of pre-established criteria. All these materials will be integrated in the final report and recommendations based on the findings.

The study will be done in two stages. In the first, the HCPC will collect all available data, hold the informal interviews, conduct and process the survey (this in contact with USAID-DR and the international consultant), and perform the observation visits. In the second stage, the international consultant will analyze all the data collected and with the HCPC will produce a preliminary draft of the report. This draft will be discussed with USAID-DR health officials and the needed revisions introduced. The final document will be

8,9,10. Personnel and other Resources Needed

	<u>Pesos</u>	US Dollars <u>2.77% 1</u>
i) <u>Personnel</u> a_/		
1 Host country Prof. Counterpart		
44 work days (fee) 225 pesos/day	9,900	3,574
In-country transportation	1,000	361
Per-diem when travelling (10 days) 130 pesos/day	<u>1,300</u>	<u>469</u>
Sub-total	12,200	4,404
b_/		
1 International Consultant		
30 work days (fee) US\$ 260/day		7,800
21 in country days (per-diem) US\$ 70/day		1,470
Airfare		630
In-country travel & others		<u>375</u>
Sub-total		10,275
ii) <u>Other Personnel</u>		
4 interviewers (fee)	3,000	1,080
Per-diem	2,400	870
1 Secretary (one month)	800	290
1 Research assistant	<u>3,000</u>	<u>1,080</u>
Sub-total	9,200	3,320
iii) <u>Other Resources Needed</u> c_/		
Data processing	20,000	6,220
Miscellaneous	<u>2,770</u>	<u>1,000</u>
Sub-total	22,770	7,220
iv) <u>Summary of Resources Needed</u>		
Personnel		13,824
Per Diem		2,809
Transportation		1,366
Miscellaneous		<u>7,220</u>
Total		\$25,219

a Country Counterpart: sociologist or economist with experience in health and/or social security as well as on survey design, administration, processing and analysis

b International Consultant: health/social security economist

c This sum is grossly insufficient to pay for market cost of data processing in DR hence it is necessary to reduce it by either doing this work in Stony Brook or in the HCPC's institution

edited and reviewed by HCF/LAC key staff and the USAID project officer, in accordance with the terms of the contract.

7. Principal Activities

Planning will consist of: gathering of available data; selection of institutions for the survey, preparation and testing of the questionnaire and selection and instruction of the survey takers; preparation of the observation - visit checking criteria; and communication with local participating units. Collection will consist of administration of the survey, conducting the informal interviews and performing the observation visits. Processing will consist of verification, codification, recording, tabulation and computation. The analysis will be conducted by the IC with the collaboration of the HCPC.

Insert new app. 30-40

Project 2: FINANCING AND IMPROVEMENT OF HEALTH SERVICES IN THE PUBLIC SECTOR (MOH) THROUGH USER FEES

USAID - Washington has decided to undertake a comparative study of user fees in four Latin American and Caribbean countries: Dominican Republic, Haiti, Honduras and Jamaica. The DR study is planned to start in July (involving two experts for three weeks each) and to cover practically all services, i.e., outpatient consultation, hospitalization and pharmaceuticals. Following instructions from Dieter Zschock, I have maintained user fees as a research topic for HCF/LAC. Furthermore, Lee Hougen feels that the USAID - Washington study will not be as thorough as the one here proposed, but that its purpose is to gather general information for a forthcoming Health Conference in Washington, D.C. It would be ideal if the two USAID experts that work on this subject in July, continue the work of this first exploratory visit, expanding it in terms of interviews with more

MOH institutions both in Santo Domingo and the rest of the country. They could prior to their visit study this document, reading materials and designing a format to systematically request information on user fees which later on could be compared. This would reduce part of our initial work in this project.

1. Subject of Study.

1. Subject.

The following is a preliminary design of a country case study of user fees in the public health sector (SESPAS or MOH) including their institutions which collect such fees, their amount and use, the quality of services provided by such institutions, their rate of utilization, their client base and opinion of users, and the feasibility of expanding their use in the public sector and mechanisms to accomplish such a goal.

2. Background

To the best of my knowledge there are no specific, sophisticated studies of user fees in the DR public health sector although references are made to this subject in reports of international organizations and the MOH. Nevertheless user fees are widely used in the DR although with significant variation in terms of their application and yields. A 1940 regulation (still in force) established fees (actually quite high for the time but low for today) for many health services, e.g., laboratory exams, x-rays, etc. [8a]. The MOH Under Secretary of Administration confirmed that user fees are currently applied in public hospitals, clinics and subcenters in: outpatient consultation, laboratory exams, x-rays, blood transfusions, use of hospital beds, surgery and medicines [IV5, 6]. (Fees are not

used in IDSS). A recent mission of the World Bank has reported that patients undergoing surgery have to bring instruments, septical materials and even food [IV-34]. The Dominican Medical Association (AMD) opposes user fees arguing that they violate the Constitution (art. 17) which establishes the state obligation to provide free medical and hospital care to "those who have scarce means and request such services free" (notice that the Constitution indirectly permit to charge users with means). As a result of this conflict, the AMD and some physicians oppose user fees and the government has been reluctant to regulate them fearing political effects. There is not even unanimity to the terminology of user fees: in some hospitals they are called donations ("donaciones") and in others "recovering fees" ("cuotas de recuperacion"). Work on a new Health Code (which could include user fees) have started in the MOH to update the obsolete and inoperative Code of 1946 (which does not regulate user fees [IV-5, 6]).

As part of the exploratory visit, five MOH national health units were chosen for a check in order to have a preliminary view of the importance and effects of user fees. The following reports are based on the sole opinion of the director of each unit.

- i. National Laboratory (LN) [IV-7]. This is a success story in user fees and could be a model to be applied all over the country. The Director took over LN in 1981. The LN is a state institution of referral which makes all types of diagnostic tests and services through a national network of labs, hospitals, ambulatories, etc. The fees are charged for all LN services according to a standardized tariff; fees are equal to all patients but those who lack resources are briefly questioned (in about 15-20 minutes) and usually exempted from payment or assigned a lower fee.

Before the standardized introduction of the fees, the few lab tests that were performed at LN took as much as 2 months, patients had to wait in long lines and the results were unreliable. In cases where fees were charged they often were pocketed by the providing personnel. Now the services are performed fast (often results are available on the same or the next day), there are no waiting lines, and results are highly reliable (even high-income groups resort to LN when needing complex tests not easily available elsewhere; before, they sent the samples to the USA or traveled there). User-fee revenues are employed in: hiring specialized personnel (SESPAS' appointed personnel is often unskilled, unreliable and undisciplined but health unit directors lack the power to dismiss them), supplies, purchase and maintenance of equipment, and construction of new facilities. Revenue goes to a special bank account submitted to frequent auditing. The quality of services is high and users are satisfied and seldom complain about the fee or the service; prior to the use of the service in question the patient is educated on the reason for the fees and their positive results.

The Director of LN asserts that the constitutional principle is not violated by the fee, because only users with means are charged, and that the time is ripe -- due to the chaotic state of public services and the fact that fees are actually charged in most units--to institutionalize, regulate and universalize the fees. Community participation, vigilance, control and education should be vital elements in the system. According to the Director, fees have not worked in other places because of the following reasons: (a) lack of understanding of ^{administrations,} employees and users; (b)

inefficiency and corruption of administrations^{or;}; (c) failure to reinvest fee revenues in the same services which were charged (hence not improving their quality) but in other activities; and (d) lack of adequate financial control.

ii. Children Hospital Robert Reid Cabral [IV, 8]. This is a national hospital, the most important children hospital in the DR and one of the best administered in the country; the current Director has been in the job for 18 years but is going to step down soon to take another position. User fees are applied to laboratory tests, x-rays, cardiology and outpatient consultation. Results have been positive and a surplus is generated to hire personnel and for supplies and maintenance (but not for buying equipment). Fees were discontinued in surgery because many physicians wanted to collect the fees for themselves; now the Director has reached an agreement with physicians and the fees will be deposited in a special fund to be controlled by him. Patients without resources are briefly questioned and normally exempted from payment. There are divergent results between fees on certain services and others; the most efficient fees are administered by a nun who is quite dedicated and frugal (until 1980 all public health institutions were administered by nuns but this practice has discontinued and only a few remain).

In addition, this hospital in 1976 initiated a program to buy medicines wholesale on credit, resell them to patients with a 1% profit, and then pay the suppliers. With the small profit they hire personnel and still there is a surplus for other hospital expenses. (In 1985 they sold RD \$150,000). All users have to pay (there is no exemption) although apparently there is little or no protest; they supply a few generic medicines free, except for the cost of the bottle

or package. They would like to buy directly abroad but lack the needed resources (in advance) and authorization to do this. This program inspired the creation of PROMESE and Boticas Populares (see IV below).

The Director of this hospital has also been instrumental in the creation of private foundations ("patronatos") funded with contributions from local enterprises and individuals as well as external donations to support specific projects. In 20 years of operation the Foundation of this hospital has raised about one million pesos; Dr. Mendoza is about to become its President.

The Director of this hospital believes that fees should be standardized at the national level and that the AMD has lost some power (due to political waste) and maybe unable to defeat that project.

iii. Maternity Hospital Altagracia [IV-10]. This is a national hospital and the largest of its kind in DR. User fees are charged for outpatient consultation and related services such as laboratory tests, x-rays, etc. Users without resources are exempted from payment after a brief interview. The reaction of users is mixed: most accept the fee but some are upset about it (this hospital does not educate patients on the need for or uses of the fee). From 10% to 14% of the total budget of the hospital is generated by the fees (from RD \$7,000 to \$10,000 annually). Only 20% to 25% of fee revenue ^{is} ~~are~~ reinvested in outpatient consultation, the rest goes to other hospital needs.

iv. General Hospital Luis Aybar [IV-9]. This is a national hospital, one of the largest and most overcrowded in Sto. Domingo and the Director was appointed only 8 months ago. The Director opposes

user fees because -- according to him -- they are unconstitutional, are not regulated (later in the interview he acknowledged the existence of the 1940 regulations but considered them ^{or} obsolete and the fees too high), and the AMD plus his hospital physicians oppose the fees. Apparently, fees were widely used in the hospital in the past but currently are limited to outside-consultation laboratory tests (no fees are charged for emergency or inside-consultation laboratory tests and only about half of the 1940 regulation fees is charged). Although the Director of this hospital was initially adamant against the fees he changed his position when I argued that the Constitution only makes mandatory full services for the disposed and indirectly allows to charge users with adequate income. He acknowledged that the hospital has a DR \$160,000 debt but blamed it on the lack of state support and excessive demand partly resulting from the closing of surgery units in other national hospitals. He reported that the hospital is overcrowded, that ^{use}queries for outpatient consultation start at 4 a.m., and that the hospital lacks vital equipment and medicines. I asked why he could not apply user fees to patients with means in order to generate extra resources to ameliorate some of the hospital grave difficulties. He answered that he would not oppose fees under those conditions and providing that there is a law regulating them.

v. State Pharmaceutical Agency (PROMESE) [IV-11,12]. This program was established in May 1984 independent from the MOH and assigned to the Presidency, when galloping inflation and the elimination of a preferential exchange rate for medicines created a crisis (prices of medicines increased three times when the exchange rate was increased from par to three to one). Over 75% of medicines in the DR are imported and another significant percentage is locally

produced with imported inputs. The government established a US \$20 million fund [18] for PROMESE to import 165 generic medicines at a 2:1 exchange rate. Due to the crisis PROMESE had first to buy locally or abroad but without open bidding; later on contacts were developed with numerous MNCs for effective international bidding. Medicines are imported in individual packaging ready to use, and officials argue that prices were cut dramatically (as much as 98% in some cases) and hence that private importers were making a fortune. PROMESE officials assert that imports not only pocketed the profit of the preferential rate but that, using such rate, they imported cosmetics and other non-pharmaceutical products hence increasing their profits. After PROMESE received the preferential exchange rate of 2:1 this treatment was extended to private importers with a maximum of DR \$10 million. This was done for political reasons (to avoid opposition) and to stimulate the import of generic medicines. PROMESE has used up its import quota at the preferential exchange rate but apparently private importers have not used up theirs.

PROMESE medicines are distributed through SESPAS hospitals, clinics and subcenters, plus a national network of newly established popular pharmacies ("boticas populares"), as well as hospital and private clinics. The price is the cost price, plus operative expenses and a small profit (the latter may be increased in some medicines to compensate for a low price in others). The original idea was that PROMESE would operate as revolving fund but it has practically depleted the initial fund, and is only buying 15% of what it used to buy at its peak. Officials give the following reasons for this crisis: (a) they have been forced to sell medicines to the state and

the latter has either not paid back or delayed payments; (b) initially they lost money because of buying in the local market and improper bidding, as well as lack of knowledge of the demand which resulted in stock piling in some cases; and (c) the loss of the preferential exchange rate (which cuts purchasing power by 50%).

To restore the initial impact of PROMESE, officials request the reopening of the initial fund and preferential exchange rate, combined with prompt payment of state purchases. They argue that PROMESE infrastructure is intact, and that their knowledge of domestic demand and the international market has increased significantly. Furthermore they believe that PROMESE competition has stimulated domestic pharmaceutical production from and reduce prices in the private sector and, hence, their relations have improved.

Although many outsiders acknowledge that the idea of PROMESE ^{is a good one} has reduced the price of some medicines, criticism of this agency is abundant: (a) lack of adequate consultation with hospitals and other units on their demand; (b) lack of a central warehouse and adequate distribution; (c) inconsistent open bidding which results in fraudulent "commissions" and higher prices (it was reported by one informer that sometimes the bidding is properly done but the order is not issued and, at the last minute, an emergency is declared and the medicines are bought arbitrarily); (d) lack of quality control of medicines imported; (e) administrative inefficiency and corruption; and (f) lack of certain basic medicines [IV-7,8,9,10,30].

3. Current Importance

The interviews with director-level officials at the MOH, national hospitals, the national laboratory and the state pharmaceutical agency, as well as with several experts, have clearly

shown the need to conduct a study of user fees and their results. Currently MOH budgetary allocation to its units are notoriously insufficient and the decline in the quantity and quality of its services is appalling. In spite of isolated criticism, user fees are widely spread and not regulated, with divergent effects. It appears that in some MOH units, fee revenues account for as much as 15% to 30% of total revenue and provide the badly needed flexibility to hire skilled personnel, provide maintenance and acquire badly needed supplies. The national program on pharmaceuticals is also a reality and all users must pay for them. There are neither systematic data on any of these practices, nor on causes for divergent performance. There is an urgent need for this information as a base for potential regulation, standardization and universalization.

USAID - DR gives first priority to this study and believes that it will be useful for policy purposes; special interest was shown in finding which would be the optimal mechanisms to spread this practice, i.e., regulations or guidelines, education, incentives, etc.

4. Specific Objectives.

The proposed study will: review the current legislation on user fees in the public sector; determine which institutions collect such fees, to what services are the fees charged, their amount and end use and client base; assess the effects of such fees in terms of quantity and quality of services, and identify causes behind divergent performance (e.g., which are the factors responsible for user fees success and failure); find out whether users without resources are exempted and the tests employed for that purpose; evaluate the effect of the fees on low-income groups, inquire how the fees revenues are

used, the efficiency of the collection and its administration; and search for the opinion of both users who actually pay fees and those who would become users if the services are expanded, on their perception of the services received, how much they would be willing to pay either for improved services or for additional services not currently provided. In addition, the study will suggest pricing of services -- fee amounts -- and whether and how they should be discriminated according to users' income; will recommend an efficient management system for collection of fees; and will roughly estimate how much revenue the fees would generate. Finally, the study will analyze the political environment, i.e., favorable conditions and obstacles for the regulation, standardization and universalization of the fees, and suggest adequate mechanisms for fees expansion.

5. Scope of the Study

The proposed study will review user fees in all health services, i.e., outpatient consultation, laboratory and other diagnostic tests, hospitalization and medicines. The study will consist of a sample of representative institutions which both apply and do not apply user fees, with national coverage but with emphasis on low-income users and urban-marginal and rural areas. Interviewees should include users, physicians and administrators. A selection of institutions should be made at the national, regional, area, local and rural levels (boticas populares should be included). If feasible, there should be a limited sample of user fees in the private non-profit sector for comparative purposes.

The definite number of institutions chosen will be established at a later date, taking into account the need to represent various types of institutions, detailed contents of the data to be collected,

complexity and volume of the collection and processing effort, and field work logistics. A tentative number of institutions could be 4 national, 4 regional and 4 local - rural for a total of 12 institutions.

6. Methodology

The study will use four methods: (a) collection and analysis of available primary and secondary data; (b) conducting a limited number of informal interviews with government officials, politicians and leaders of key organizations (e.g., AMD) to initiate a policy dialogue; (c) designing and conducting the survey instrument and processing and analyzing its results; and (d) an observation visit of the institutions selected for the sample in order to check the quality of its services (using a set of preestablished criteria). All these materials will be integrated in the final report which will also make policy recommendations based on its findings.

The study will be done in two stages. In the first one, the HCPC will collect all available data, hold the informal interviews, and process the survey, and perform the observation visit(s) (these activities will be conducted in consultation with USAID-DR and with the international consultant). In the second stage, the international consultant will analyze all the data collected and jointly with the HCPC will produce a preliminary draft of the report. This draft will be discussed with USAID-DR Health Division officials and needed revisions introduced. The final document will be edited and reviewed in HCF/LAC headquarters.

7. Principal Activities

Planning will consist of: gathering of available data;

selection of institutions for the survey, preparation and testing of the questionnaire, and selection and instruction of the survey takers; and communication with local participating units. Collection will consist of administration of the survey, conducting the informal interviews, and performing the observation visits. Processing will consist of verification, codification, recording, tabulation and computation. The analysis will be conducted by the IC with the cooperation of the HCPC.

*Project Report 8, 7, 10 (attached)
- 11, 12*

Project (3): HEALTH COSTS AND PRODUCTIVITY

1. Subject of Study

Estimate total and average costs of health care in the DR, in general, by sector, level, geographic areas, programs and functions; analyze health productivity in as many of the above categories as feasible; and make recommendations of ways to cut costs, to improve efficiency and achieve coverage extension.

2. Background

Health care coverage in the DR is distributed as follows: (1) the MOH (SESPAS) theoretically covers about 60% of the population but in practice most experts agree that coverage at best is 40%; (2) the social security institute (IDSS) covers 6% of the total population; (3) the armed forces covers from 3% to 4%, and (4) within the private sector, fee-for-service institutions cover 10%, igualas (HMO-like organizations) from 4% to 5%, and insurance companies about 5%. From 19% to 31% of the population is without real access to health services.

In spite of significant improvements in health status in the last 25 years (e.g., infant mortality reportedly declined from 125 to 69.7 and life expectancy increased from 52 to 65 years), still, the DR

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body of the questionnaire, ^{of selection} continuation of the survey, ^{and} communication with local participating units.

Activities will consist of administration of the survey, conducting the informal interviews, ^{and performing the observation visits.} necessary will consist of mobilization, coordination, recording, tabulation and interpretation. The analysis will be conducted by the IC ^{in the} cooperation of the HCPC

8, 9, 10. Personnel and Other Resource Needs (Preliminary Figures)

i) Personnel

1 Host Country Prof. Consultant [✓]

44 work days (fee) 225 pesos/day 9,900

In country transportation 1,000

Per diem when traveling (10 days) 130 pesos/day 1,300

Sub-total 12,200

US Dollars (2.77:1)

3,574

361

469

4,404

1 International Consultant [✓]

30 work days (fee) US\$200/day 7,800

20 in-country ^{travel} per diem US\$70/day 1,470

Airfare 630

In country board & other 375

Sub-total

10,275

ii) Other personnel

4 Intermittent (fee) 3,000 1,080
Per diem 2,400 870

1 Secretary (one month) 800 290
1 Research Assistant 3,000 1,080

Sub-total

9,200

3,370

iii) Other Resources

Data Processing [✓] 20,000 6,220

Materials (supplies, phone, questionnaires) 2,770 1,000

Sub-total

22,770

7,220

iv) Summary of Resources Needs

Personnel 13,824

Per diem 2,809

Travel 1,266

56

#1

Other resources

7,220

Grand Total

\$ 25,219

- b) International Consultant: health specialist ^{Specialty} with experience in USA for
- c) Country counterpart: sociologist or economist with experience in ^{public} health and or survey design, administration, processing and analysis.
- c) This sum is ^{gross} insufficient ^{to pay for market cost in DR, hence} and it is necessary to find out whether data processing could be done in Stony Brook or by the HPC's institution (e.g., a university) ^{at a reasonable cost}

11. Expected Results of Final Study

- After writing 40-60 pages of technical analysis, describing objectives, methodology, principal results and implications, conclusion and recommendations
- Copies of abstracts, ^{tables} question and answer ^{summary} results, ^{observation visit check list and its results,} bibliography, list of interviews.
- Copies of bibliographical materials, statistical data stored on diskette

12. Time Schedule and Flow Chart

Stages	Weeks									
	1	2	3	4	5	6	7	8	9	10
Planning	_____									
Data Collection			_____							
Data Processing						_____				
Review and Presentation								_____		

ranks behind most Latin American and Caribbean countries in terms of these indicators. Furthermore the economic crisis and mismanagement of health resources have induced a serious deterioration of health facilities and services in spite of substantial foreign aid. Private health care is of higher quality than both public and social security care but has been affected by spiraling inflation, increasing costs of importation of equipment, supplies and medicines, and loss of purchasing power of the population.

Data from the World Bank suggest that, in 1982, DR health expenditures as a percentage of total central government expenditures were about 11% higher than in ten out of eleven countries for which such data were available, including much more developed countries with higher coverage, quality of services and health status (e.g., Argentina, Brasil, Mexico). PAHO data for 1983 on central government health expenditures per capita show the DR ahead of seven out of 20 countries, including Argentina and Colombia, and only slightly lower than Costa Rica. But the PAHO data also show that the DR was one of two countries which suffered the sharpest decline in per capita expenditures: a 47% cut in 1980-84. In spite of the relatively high health expenditures -- at least until the crisis -- the MOH and IDSS are extremely inefficient and are reaching a truly chaotic situation.

The latest USAID comprehensive health care assessment of the DR was undertaken in 1974 and although it included financial data it did not provide an estimate of total health costs [V-11]. An excellent PAHO study, concluded last year, assesses the health situation in the DR but does not contain comprehensive and systematic financial data, much less cost estimates [V-10]. MOH annual reports and planning

documents are even more deficient in financial data, and the latest published yearbook is three years old [V-1 to 8]. Data on social security is even more scarce, unreliable and obsolete as discussed in Project 4.

A forthcoming health study of the Institute of Population and Development appears to be one of the most comprehensive ever made (including data on the public sector and social security) but does not fill the vacuum in terms of health costs [V-17]. The USAID-DR studies on private health institutions undertaken in 1985-86 are a significant step forward and the best available on this sector but do not provide estimates of their costs [V-28 to 35].

In the last eighteen years, three household income/expenditure surveys have been conducted in the DR including health data. The main objective of these surveys, conducted by the Central Bank and the National Statistical Office (ONE) has been to update the cost-of-living index, hence priority has been given to that objective and other data have been processed with great delay [IV-4]. (1) The 1969 survey was limited to Santo Domingo (605 homes) and included a section on health; the results have been published and include overall health expenditures as well as by level of income on outpatient consultation, hospitalization, diagnostic tests and medicines; there are scattered data on private services [V-37]. (2) The 1976-77 survey was national in scope (4,457 homes) and the questionnaire included one full chapter on medical care providing data on monthly frequency and expenditures of outpatient visits, clinics, surgery, maternity, dental care and medicines (private services are included but not systematically); cost of health care "premia"; expenditures for medical services and medicines provided by IDSS (gratis or charged) [V-38]. Although some

segments of this survey have been processed and published, health data have not been processed yet [V-39, IV-22]. (3) The November 1984 survey was also national in scope and the questionnaire had a health chapter similar to that of the previous survey; data from this survey are being coded which should be completed in July, and data processing will begin thereafter. The Bank is interested in rapidly processing data on cost of living (including health) from the last two surveys in order to measure the impact of IMF stabilization policies on living standards [V-40, IV-22].

3. Current Importance

The vacuum on health studies in the DR and the poor state and inefficiency of health services underline the need for this study. The current Under-Secretary of Health strongly supported a cost/efficiency study of public health and the directors of several MOH hospitals made evident the need for a better allocation of health resources and to improve hospital productivity. The actuary of IDSS also stressed the need for developing accurate data to estimate social security health costs in general and per unit in order to support protracted actuarial reviews.

USAID-DR officials also expressed interest in this topic, particularly in relation to the private sector; however they set a higher priority in Projects 1 and 2.

4. Specific Objectives

The proposed study will: (a) estimate total and average costs of health care at the national level (as well as a percentage of GDP and government expenditures) and by sectors (MOH, IDSS, Private), by programs (personal versus collective) by level (primary, secondary,

tertiary), by geographic regions and by population groups; (b) estimate and analyze the composition of public health costs by recurrent costs (labor, supplies, maintenance) and non-recurrent costs; and (c) assess productivity among sectors and units and identify causes of high/low productivity. In addition, the study will identify areas where cost containment can be achieved, recommend a better allocation of scarce health resources according to need, and estimate the incremental cost of expanding real coverage of the population under different schemes (MOH, IDSS, private sector, mixed).

5. Scope of the Study

The study will be national in scope, including aggregated data as well as disaggregated by sector, region and local units. It will particularly cover MOH, IDSS and the private sector; an attempt will be made, if feasible, to include other institutions such as the armed forces, CEA, etc.

6. Methodology

The study will hopefully count with ready data from the 1976-77 and 1984 household surveys and analyze them. If this were not the case, USAID-DR may request support from the Central Bank to expedite the processing of health data from such surveys otherwise the project may consider processing the data directly but costs of this operation would go well beyond the project budget. In addition, the project will gather, process and analyze data from all health institutions. In the case of the private sector, due to its dispersion, the project may consider alternative methods such as concentrating on the largest providers as a base for global estimates or taking a representative sample of such providers.

The international consultant, in view of the available data at