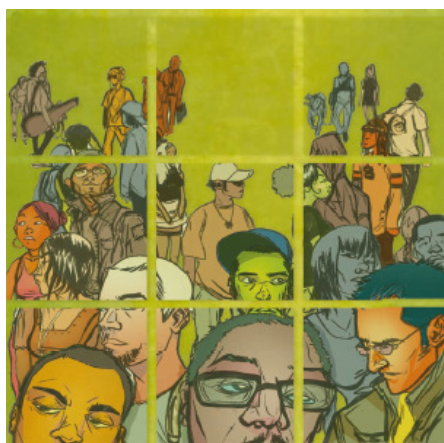




Dominican Republic: Can universal coverage be achieved?

Magdalena Rathe

**World Health Report (2010)
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Dominican Republic: Can universal coverage be achieved?

World Health Report (2010) Background Paper, No 10

Magdalena Rathe¹

¹ Director of Plenitud Foundation and Coordinator of the Health Observatory of the Dominican Republic (OSRD), affiliated to the Health Observatory of the LAC region. We are grateful to IDRC (Grant 103905-001), the Consejo Promotor Competitividad y Salud and the Mexican Health Foundation (FUNSALUD) for financial and institutional support for this work.

Introduction

Following more than ten years of consultations and discussions between all the national stakeholders, in 2001 an in-depth and integrated reform of the health system was approved in the Dominican Republic. It was guided by the principles of universality, equity and solidarity, based on the existing strengths and institutional experience accumulated by the country up till that point. Inspired by the Colombian reform process, the new law sought to overcome some of its weaker elements by establishing a universal and mandatory system, with central collections and per-capita payments (CNS, 1996).

Today, twenty years after the start of consultations and almost one decade after the law was approved, its implementation has been difficult – it started off slowly in the public system in 2002 and recently the contributory regime entered into effect by presidential decree at the end of 2007, and this also launched the process of coverage expansion. In summary, it can be said that the reform has lacked genuine political will and has been set back by the conflicts of interest between interest groups and the traditional lack of governance that predominates in the sector. This document sets out to illustrate the complexities of the health system and the practical difficulties of any institutional reform in a country like the Dominican Republic.

The context

The Dominican Republic has an income per capita of US\$4,798 (Central Bank, 2008), which puts it in the middle-income country category. However, there is a marked inequality when it comes to distribution, which has remained at a similar level over the last few decades, despite the country having experienced long periods of increased economic growth, sometimes the highest in the hemisphere (World Bank, 2008). In 2004, upper class and upper-middle class families possessed 56% of the national income, while lower class families received just 4%, a situation that is not believed to have changed in the last five years (IDB-WB, 2006).

In 2003 and with serious effects during 2004, the country was affected by one of the worst financial crises in its history, during which one and a half million Dominicans slipped into poverty and almost seven

hundred thousands of these were forced to reduce their consumption of basic food products to below the minimum subsistence level. Purchasing power for Dominicans was reduced by a third due to an 86% increase in the price of food and other consumer products (IDB-WB, 2006).

The country was barely starting to recover from the internal crisis when the effects of the international financial crisis began to be felt in 2008. As a result, in 2009 the economy grew by just 3.5% in relation to 2008, which reflects a substantial reduction in the verified pace of growth since 2005. It also experienced a serious deficit in the non-financial public sector, which rose to 3.5% of the GDP and a major deficit in the current account of the balance of payments, which reached 9.7% of GDP. This led to a negative performance in central government finances that were affected by the fall in income, resulting from a reduction in imports and internal demand, as well as international credit for financing the public expenditure. In effect, tax collections declined by 17%, which in turn, resulted in a reduction in funds being diverted to social assistance programs, which contracted by 22%. Another aspect that is important to highlight is the reduction in international remittances, which are a vital source of income for poor families, given that they represent two thirds of the income of 60% of families at the lowest end of the social scale (Central Bank, 2009).

This macro-economic context frames the potential of the health system reform to achieve the objectives it sets out for itself, to improve equity, quality and financial protection for the Dominican population.

In the last few decades, the DR has achieved some improvements in education and health indicators, succeeding in reducing infant mortality rates and increasing life expectancy, which rose from 46 years in 1950 to 71 in 2005 (UNDP, 2005). However, many health indicators are below the Latin American average, such as access to adequate health centers and the prevalence of epidemics like HIV (World Bank, 2008). This could be the result, on the one hand, of inequalities in income distribution, and on the other, of institutional deficiencies that hinder access to quality public services in the most distributive sectors, as is the case of health and education (Santana & Rathe, 1992).

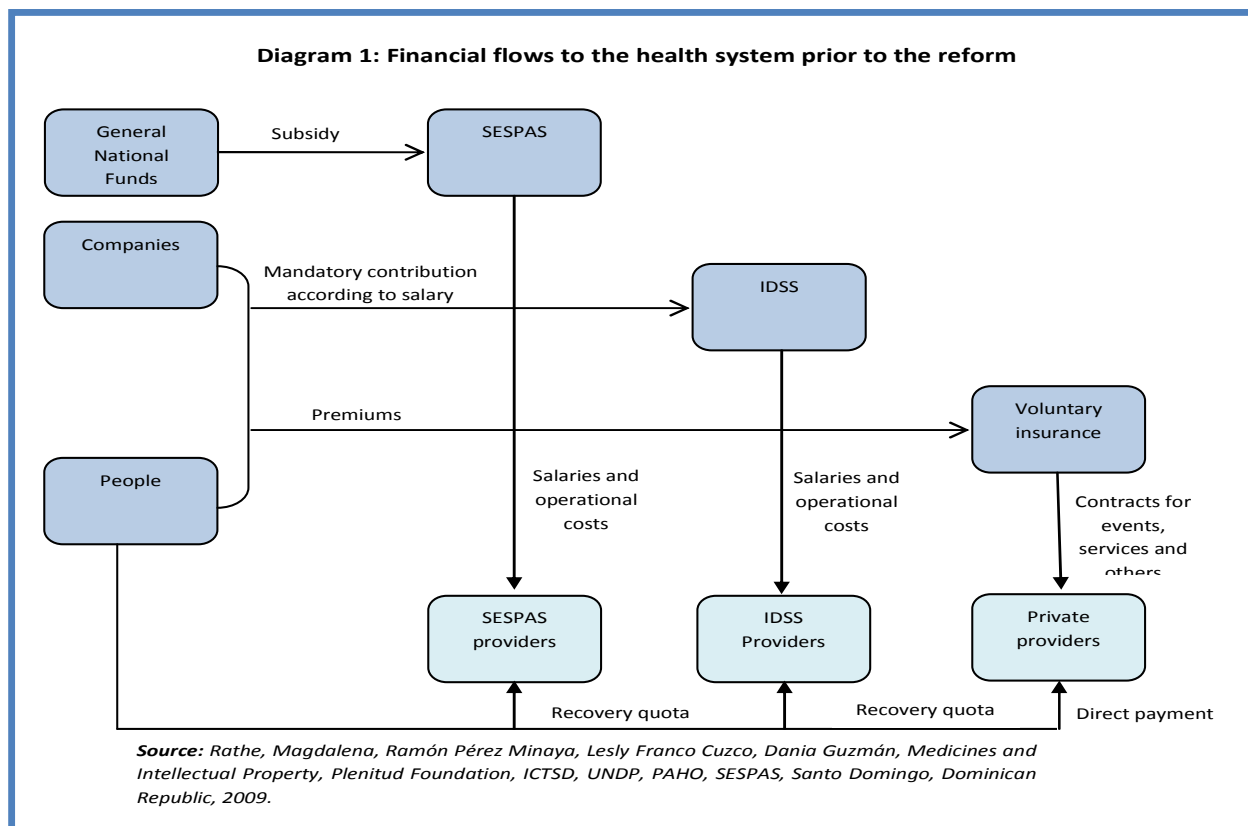
The epidemiological transition process in the Dominican Republic is getting under way, given that transmittable as well as non-transmittable diseases affected the country's health situation. In effect, mortality due to non-transmittable causes already has a substantially higher weight than deaths due to transmittable causes, rising to 73% of diagnosed deaths in 2005 (DIGEPI/SESPAS).

When it comes to mortality by cause, cardio-vascular diseases are in first place, followed by infectious diseases. In order of importance, these are followed by malignant neo-plasmas, peri-natal conditions and unintentional accidents. It is important to highlight the importance of asphyxia and birth trauma, which are probably responsible for the relatively high neonatal mortality rate (SESPAS/DIGEPI, 2009), despite the fact that 99% of births take place in health centers and with professional staff (CESDEM, 2007). The maternal mortality rate is also very high (159 per 100,000 inhabitants), although most Dominican women – 94% - attend at least four antenatal consultations (CESDEM, 2007). This suggests that there are problems with the quality of health services in the Dominican public system, which is where most births take place.

Nonetheless, if the health situation is analyzed from the point of view of years lost due to premature death and disability, the order of importance is different, with infectious diseases, especially AIDS in the first place, neuropsychiatric diseases in second, and asphyxia and birth trauma in third. Other main diseases are cardiovascular diseases, cancer and road accidents, and diarrhea and respiratory illnesses are still in the top ten (WHO, 2004).

The health system prior to the reform

Before the reform started, the health system was segmented and was not separated according to function. In theory most of the population was covered by an open public system, funded by general taxation, where the State Secretariat for Public Health (SESPAS) - the health ministry – directly executed service provision. The former social security system, also administered by its own providers, served a minimal segment of the low-income wage earning population. The lack of priority allocated to the health sector by the government over the decades was translated into deficiencies in the public provision schemes, which fostered the growth of the private sector, whose main source of income was direct payment (Rathe & Moliné, 2009).



As can be seen in the graph, the population is clearly segmented into three subsystems. The lower stratum in terms of income, the majority of the population, is served by the public services administered by SESPAS (Ministry of Public Health and Social Welfare). The Dominican Social Security Institute (IDSS), an entity that also lacks functional separation, barely covered 6% of the low-income salaried population. The higher strata as well as a large part of wage-earning informal sector workers were served by the private providers through direct payments or affiliation to voluntary pre-paid plans, these being the “cream of the market”.

In all cases, patients must pay a large part of the services they receive out of pocket, meaning that around half of national expenditure on health is funded by direct payment.

In effect, despite the fact the public services are supposedly free, in 2007 only 44% of those consulted confirmed this, while 36% had to pay all their costs and 12% reported that their insurance had covered all or a part. These values reflect a worsening situation since 2002, when 51% said that the healthcare had been completely free, 31% had to pay for it all and 12% had total or partial insurance coverage. Of course, a larger proportion of the people who did not use the services due to explicit barriers are in the lower

income quintiles, and the main reasons include lack of money for covering transport expenses as well as for health costs. These barriers tend to affect women, rural dwellers and older people to a greater degree (CESDEM, 2007).

The form of payment for hospitalization services in 2007 – also reveals the lack of trust that the population has in public services, and also, the lack of financial protection that affects the Dominican population. In effect, although the public hospitals serve most of the population and especially the poor population, 19% of the first quintile and 24% of the second prefers to be hospitalized in a private hospital. In addition to this, 35% and 36%, respectively, say they had to pay the total costs of hospitalization services, with money out of their own pockets (CESDEM, 2007).

At national level, the average of those who paid the entire cost is 39%, a higher figure than in 2002, when it was 28%. Only 35% of the population said that hospitalization had been free (compared to 52% in 2002) and 23% said that their insurance had paid some or all of their costs (19% in 2002). (CESDEM 2003, 2007)

The centralized management of the public system, which was aimed at the poor population, as well as acting as a multiplier of political inefficiencies and mismanagement characteristic of the public administration, created traumatic tensions between the authorities of the sector and the doctors' unions and those of other related professions. This was reflected in serious problems of governance, where demand for health professionals was controlled by one single demander (the authorities of the sector) and the supply by one single supplier (the Dominican Medical Association), that is, conditions were created similar to what is known in economics as a market controlled by a monopsony and a monopoly. In these circumstances there is a clash with the price determination mechanisms that work when there is competition between demanders and suppliers, and the conflict is usually resolved through a negotiated solution between the parties. For this reason, these conflicts are not of a circumstantial nature and thus become chronic, by obeying a structural condition of the system.

This institutional disorder led to a health system that was inefficient, poor quality and low capacity of resolution, highly inequitable and with reduced levels of financial protection (Rathe, 2010).²

² Rathe, Magdalena, *“Protección Financiera en Salud en la República Dominicana”* (Financial Protection in Health in the Dominican Republic), Plenitud Foundation / Latin America and the Caribbean Regional Health Observatory, Santo Domingo – Mexico, 2010.

Its low quality at the time that the reform started can be illustrated by the paradoxical situation the country was in during 2007, with high peri-natal mortality rates (22 per 100,000 DIGEPI/SESPAS) and maternal mortality rates (159 per 100,000, ENDESA, 2007) with almost 100% institutional birth coverage, with health professionals in attendance at specialized centers, and with at least four pre-natal consultations (ENDESA, 2007). The lack of financial equity is illustrated by the high rate of out of pocket expenses in the funding of the sector and the reduced government contribution, the lowest in the Latin American region (30% of national health expenditure in 2007, compared to an average of 55%, WHO, 2009). The low priority the government assigns to the sector is confirmed by the proportion of SESPAS health expenditure compared to the central government expenditure that has been declining from 10% in 2000 to 5.8% in 2007 (Rathe & Moliné, 2009).

The reduced level of financial protection could be exemplified by the insurance coverage, which only reached 27% of the population before the contributive regime came into effect. Among this group, only 15% of persons in the lowest quintile had insurance coverage, while 48% of those in the upper one were covered (ENDESA, 2007). Poor households have a greater propensity to experience catastrophic health expenditures, which can impoverish families or put at risk their most essential needs. In fact, according to estimates made for 2004, between 10-17% of Dominican homes incur health expenses that could be defined as catastrophic because they exceed 20% of their income. It is in this macroeconomic context, with the health results presented and with the characteristics of the Dominican health system summarized, that a comprehensive, profound and ambitious reform that aspires to achieve universal coverage in a relatively short period of time comes into operation. This key initiative, considered the greatest reform of the 21st century, is described below.

The reform of the health system

The law created the Family Health Insurance, which is aimed at providing comprehensive protection for the physical and mental health of affiliates and their families, as well as achieving universal coverage without exclusions for age, sex, social, work or territorial circumstances (Law 87/01). The following financing regimes were created, with their corresponding beneficiaries:

- ***Contributive regime:*** Comprises of public and private salaried workers and their employers. It is financed by the workers and their employers, including the state as an employer.

- ***Subsidized regime:*** For self-employed workers with unstable incomes that are below the national minimum wage, as well as for unemployed, disabled and indigent people. It is financed by the Dominican State.
- ***Contributive Subsidized regime:*** Protects independent professionals and technical workers and self-employed workers on average wages equivalent to or higher than the national minimum wage. It is funded through contributions from the worker and a state subsidy in lieu of an employer.

One of the principles of the legislation for the reform of the health system is the separation of functions. A summary of the way this implementation is proposed in accordance with the law follows.

Supervisory function: This comes under the responsibility of the National Social Security Council (CNSS), the body that administers the Family Health Insurance and decides on the form of financing, the contents of the obligatory services package to be delivered to the citizens, as well as the system's operating mechanisms. The Health Risk Administrators (ARS) and the Labor Risk Administrators (ARL) are regulated and supervised by the Health and Labor Risk Superintendence (SISALRIL), an autonomous public entity. SESPAS is in charge of supervision of the health system in all other aspects of the system (different to family health insurance), being part of the CNSS as well as of SISALRIL.

Financing function: According to Law 87/01, which created the Dominican Social Security System, its financing is of a public and mandatory nature. The CNSS is in charge of defining the amount of the contributions and the way they are collected. The Social Security Treasury (TSS), as delegated by the CNSS, collects the contributions based on the company payroll salaries, fixed at 10% of the salary (with a ceiling equivalent to 10 minimum wages). This entity also delivers the per-capita of its affiliated population to the ARS. According to the law, in ten years, i.e. in 2011 universal coverage must be achieved.

Coordination function: Within the contributive regime, people who are employed in the private sector, choose the Health Risk Administrator of their preference. The public and private ARS offer the Social Security Health Services Plan (PDSS), which is a reduced version of the PBS as required by the law, agreed through negotiation at the moment of starting the contributive regime, at the end of 2007. The employees freely choose their ARS and the employers send the contributions to the TSS, which pays the per-capita to the ARS on a monthly basis. The system covers the employees and their dependents.

In the public sector, the contributive regime works in the same way, with SENASA as the main public ARS, which includes most public employees because they were initially obliged to affiliate to SENASA. Another public ARS is the one that was created when the functions of the former Dominican Social Security Institute were separated, which remained with the affiliates it had at the time of the implementation of the system and is in a state of virtual obsolescence.

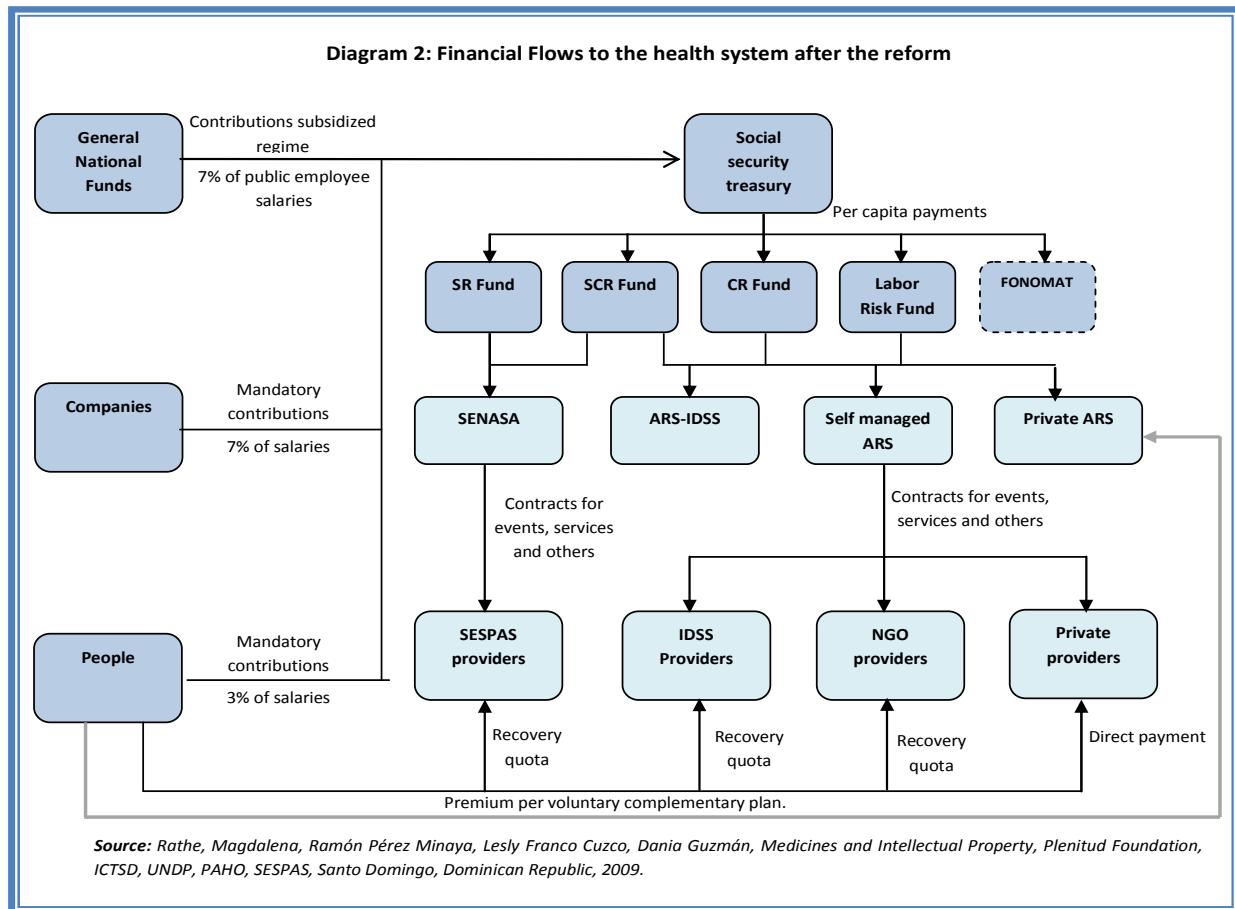
The subsidized regime (for people without the ability or limited ability to pay) is in the process of being implemented in several parts of the country. Poor people are identified through a beneficiary identification system – SIUBEN, which is part of the Social Cabinet for implementing cash transfers – and they are subsequently affiliated to SENASA. This entity started the coverage of the subsidized regime in 2002 at a slow pace and in the last two years it has been substantially extended. Affiliates to this regime must use public services, obligatorily. The TSS delivers the subsidized affiliates per-capita contributions to SENASA that are lower than the contributive regimes, as the public providers still receive resources from the National Budget.

The ARS contract providers with a range of payment mechanisms. There are reference fees for interventions and procedures, as well as different levels of co-payments, all of which are established by the system.

Provision function: Provision is carried out by a wide number of providers, both public and private, as well as the NGOs, some of which administer highly complex and specialized hospitals. The SESPAS and IDSS (former social security institute that became a public ARS) public network still receive financing through the offer, the first with funds from general taxes, and the second from work-employer contributions. A plan is under way to de-concentrate SESPAS, to decentralize the health regions and grant them more autonomy, with the aim of them creating comprehensive service provision networks. In addition, a proposal that has a great deal of official support, seeks to include all the SESPAS and IDSS establishments in unique service networks.

Diagram 2 shows how the system is organized in terms of its financing, when the process of reform implementation has culminated. As can be observed, a single fund receives all the resources that come from all the sources, classifies them into different funds, specifically those that correspond to the contributive, subsidized and contributive-subsidized regime, but other special funds are added for traffic accidents and labor risks, which have additional sources of funding. The TSS itself, which gathers all the funds, receives the people's affiliations (according to their choice) and according to this, transfers a per-

capita payment to the health risk administrators, who have the task of contracting the providers. These can be public, private or not for profit, except for the case of the subsidized regime, which is limited exclusively to the public providers.



Benefits package

The family health insurance delivers an explicit and comprehensive health services package that includes:

- Health promotion and disease prevention,
- Primary health care, including emergencies, out-patient and home services,
- Specialized care, complex treatment, hospitalization and surgical care,
- 100% of outpatient medicines for the subsidized population and 70% for the contributive and contributive subsidized,
- Diagnostic tests,

- Pediatric and preventive dental care,
- Physiotherapy and rehabilitation
- Complementary provisions, including apparatus, prostheses and technical assistance for people with disabilities (Law 87/01).

As indicated above, with the end of making viable the start of the Family Health Insurance in the contributive regime, the stakeholders agreed on a Health Services Plan (PDSS), inferior to the PBS, which needs to be developed gradually until it includes all the services that come under Law 87-01. Periodically, and depending on financial limitations, this package will be extended, increasing coverage, reducing the co-payments and increasing the number of interventions. In this way, the per capita payments to the ARS will be modified concurrently, should this be necessary.

The graphic shows the estimated composition of the cost of the interventions included, as calculated by SISALRIL at the time when the system went into effect. These estimated costs are based on the assumption of certain utilization rates, which are in a permanent state of revision, according to the evolution of the system's implementation process. 10% is also assigned to the ARS administrative costs, which does not appear in the graphic. There is a catalogue of contributions that clearly explains which are included, within each of the categories listed.

In relation to the outpatient medications, an express limit was agreed for the users of the contributive regime, totaling some RD\$3,000 per year (\approx US\$84) per person, within a list of established essential medicines. In the case of the subsidized regime, 100% of the outpatient medicines are included, but anecdotal information suggests that this is not completely achieved. Evaluations of the implementation of the subsidized regime are needed, that focus on the way the differences between the insured population and the non-insured population work on the ground in terms of quality.

The cost of the package for the contributive regime in 2010 totals RD\$721 per month, which is equivalent to US\$240 per person per year. The cost of the package for the subsidized regime is RD\$180 per month, equivalent to US\$60 per person per year (CNSS). When it comes to the contributive regime the big differences occur because the public system providers still perceive the bulk of their resources via historical budgets. In effect, SESPAS's expenditure in treating people during 2008 reached US\$326 million, which represents 60% of this institution's health execution.

As of January 2010, the CNSS approved an improvement in its services packages, by introducing the following modifications:

- An increase in the ceiling for Coverage for High-Cost Diseases and maximum level of complexity from RD\$500,000.00 to RD\$1,000,000, according to the sliding scale established in Law 87-01, its regulations and SISALRIL resolutions.
- An increase of 372 additional drugs for the Medicines List, according to a new list.
- A 5% reduction in co-payments by affiliates for surgery, i.e. 90% covered by the ARS and 10% by the affiliate.
- Elimination of co-payments in the baby delivery procedure in a normal birth, with 100% still covered by the ARS.
- A 10% reduction in co-payments by affiliates for hemotherapy, i.e. 90% covered by the ARS and 10% by the affiliate.
- RD\$90,000.00 annual coverage for bringing in new co-adjuvant Medicines in Oncological treatment, according to the sliding scale established in Law 87-01, its Regulations SISALRIL resolutions.

In terms of financial protection the public will benefit from the family health insurance plan and these improvements obviously extend this. However, at the same time, the differences between the contributive and subsidized regimes are increasing. Although the latter has – in theory – the same package content, the true beneficiaries are very different, given that the public system has serious quality problems.

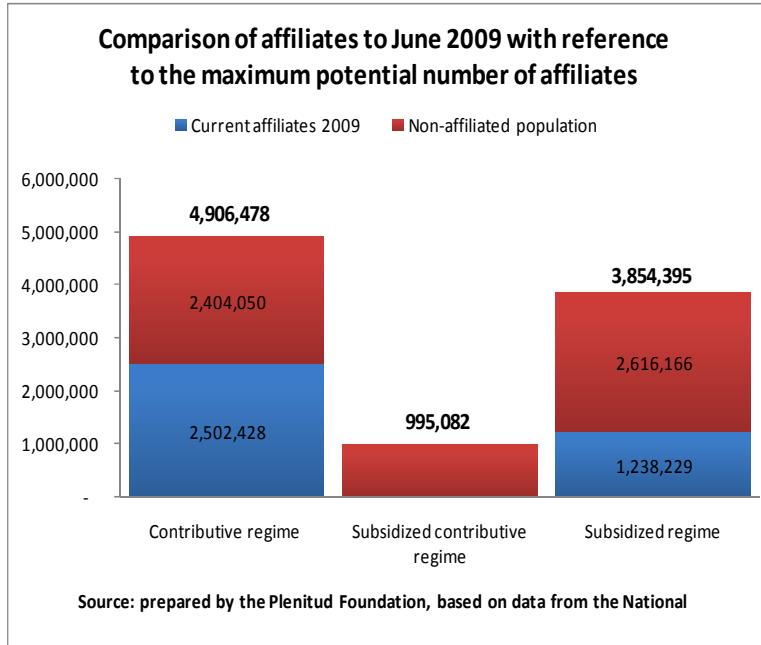
In the following section we can see the degree of progress in the implementation of this system and the prospects in the process of achieving universal coverage.

Can universal coverage be achieved?

As mentioned above, in 2007 insurance coverage stood at 27% of the population. In mid-2009, just two years after the launch of the contributive regime, it had risen to almost 40%. This represents a significant achievement and appears to indicate that the country is advancing towards the achievement of universal coverage at a steady pace. Nonetheless, the health system reform is a complex process, in which many factors come into play, some difficult to quantify, others impossible to predict, combined with major

challenges that involve difficult decisions and that require vision and political will. Let's examine some of these.

The first point to be taken into consideration is that of the population that still needs to be reached for the family health insurance. This graph shows an estimate in the advances of each of the three regimes, with reference to the potential population that each needs to cover. In the case of the contributive regime, it is estimated that it will be difficult to exceed five million people, and in fact this maximum number is likely to be lower. About half of the existing jobs in the Dominican Republic are in the

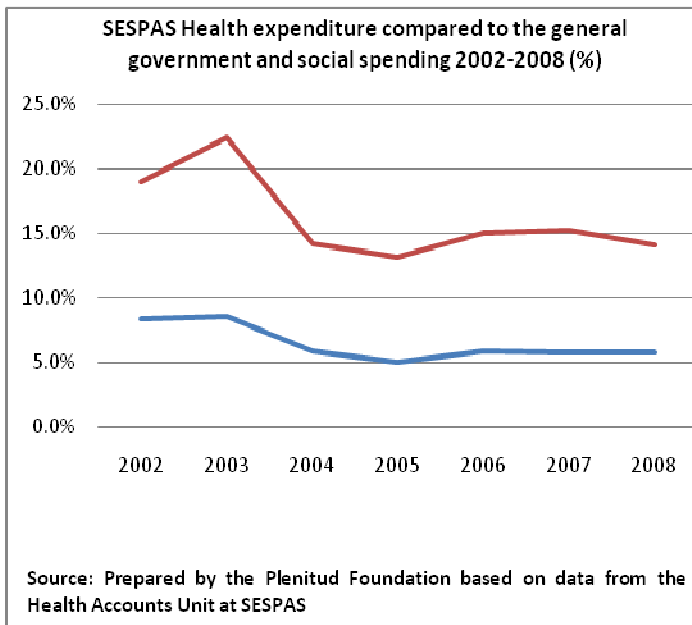


informal sector and a high percentage of these receive an income equivalent to or less than the minimum wage (ENFT, 2008). This firmly places a significant part of the population in the subsidized contributive and subsidized regimes, which require a large fiscal contribution. The first of these, which has not yet started, is difficult to implement, as it requires a great level of capacity in order to control evasion. As a consequence, almost half the population would fall under the subsidized regime.

If the government decided to cover the total remaining population in these two regimes today, it would have to distribute an additional US\$270 to US\$690 million, i.e. between 22% and 56% of the public health expenditure in 2008. The difference between both these figures is related to the different production structures between the public and private sectors. As has been noted, SENASA, the public insurer under the subsidized regime, receives a much lower per-capita due to the fact that the public providers have not yet been restructured so they can be totally financed through the offer. The assumption is that once this process is completed, the capita value will be equivalent in both regimes and they will have overcome the main differences that currently exist in terms of the quality and reliability of the services, as well as waiting times. The estimated figures of the fiscal cost, although important, are not unviable, given that the largest of these only represents 7% of the budget approved for 2010, meaning that it is a question of allocation of priorities.

Historically, what priority has the Dominican government assigned to the health sector? As can be seen in the graph, the Health Ministry expenditure, which represents around 80% of public spending, (excluding social security) in relation to the government's general spending in the same way as in relation to social spending, shows a downward trend over the last few years.

In 2008 this trend was substantially modified, when social security funds quadrupled. This can be explained by the fact that the social security contributive regime was launched at the end of 2007 and in 2008 subsidized regime coverage increased dramatically. This increase was partly due to a greater financial effort on the part of the State, but it also needs to be pointed out that part of the private funds that financed the voluntary pre-paid plans were accounted for as public funds (many of these plans became private ARS financed by public funds, as this is an obligatory contributive system). Thus public health expenditure as a percentage of GDP,



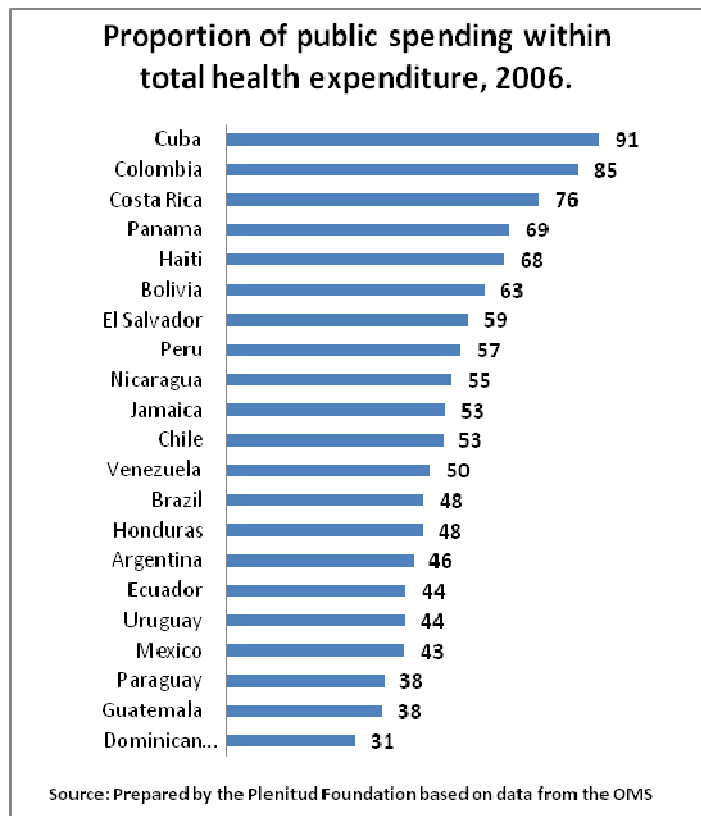
which was usually under 2% in the last few decades, went up to 2.6% in 2008. Although this represents progress, it is still well below the targets the nation set itself in the Ten Year Health Plan, which totaled 4%. (Rathe & Moliné, 2009).

Household expenditure, on the other hand, has historically made up a large proportion of health spending, sometimes over 50% and, over the last few years, around 40% - a significant proportion of this consisting of spending on medicines. This has been repeatedly cited as evidence of the great level of inequity in the health financing system in the Dominican Republic prior to the reform, where the proportion of public spending on total financing is the lowest in all countries in the Latin American region, as can be seen in the graph. When the public health financing levels are higher, so is the system's financial equity.

In fact, the lack of equity in the Dominican health system was one of the reasons for the reform and the financial results for 2008 begin to show a change in trends, without which it would not be possible to achieve universal coverage. The easiest part of this effort to extend coverage appears to have been achieved. The remaining challenges are more substantial.

As pointed out in a recent editorial in The Lancet magazine, “universal coverage means a strengthening of the health system and vice-versa. But in order for this to become a tangible reality, the FSS might also mean ‘a solution to health services’. Many poor people die because their local hospital cannot provide them with the services they need”. (Editorial in The Lancet, December 2009).

Solving the population’s health problems is an aim of the system, and for this to take place, it needs health services that work. As a consequence, the many challenges that the country has to face include re-structuring the public network, possibly the most important and at the same time one of the most difficult to resolve. The public health sector and the education sector are the main government employers and are frequently used to reward political favors. Decisions are taken at a centralized level, often without any decision by the actual sectorial authorities. Human resources are not adequately distributed, neither geographically or in terms of specialization. There are major problems with discipline, fulfillment of working hours, salary-related problems, all of which are reflected in constant strikes and lack of governance.



The current reorganization proposal would create regional public service networks whose administration would be at the level of each of the country’s regions. The key themes, related to financing and the transfer of authority in the area of human resources, have not yet begun to be implemented. On the other hand, the proposal in itself does not tackle the fundamental problem of employer-employee relationships,

that is, it does not grant autonomy, for example, to a hospital as a productive unit in the administration of human and financial resources – as in the case in the private, non profit or profit-making sector – but instead it passes it on to a sub-national bureaucracy. For this reason, it will be very difficult to solve the problem of governance, due to the fact that the monopsony-monopoly relationship will remain in place, but now at regional level, perhaps with fewer repercussions on public opinion, and without addressing the basic problem of efficiency, quality and capacity for resolution.

In fact, the description of the evolution of the Dominican health system reform illustrates the practical implications of conducting a reform to the health system, or any major institutional change, in an underdeveloped country. In reality, it is not always enough to define a law for modern, comprehensive, profound and well-intentioned reform. It is about a project whose implementation is made difficult by the concurrence, not always evident but determining, of all the social-political forces and the intricate connections of their components that are not easily perceived. In any case, understanding this requires a systemic focus that reveals the complex dynamics of the change process as well as a pragmatic sense that sustains effective decisions in order to unravel the nodal factors that obstruct the progress of institutional change.

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