

CHAPTER 5

Background Country Study for the Dominican Republic

One of the key development priorities of the government of the Dominican Republic is to restructure its fiscal spending by cutting non-priority administrative expenditure and certain subsidies and using these savings to increase spending on health and education (Albizu, Montás, and Bengoa 2007: 4).

The health sector is going through a major reform process. Passed in 2001, the General Health Law and the Social Security Law mandate the transformation of the National Health System (NHS), including the organizational separation of financing from the service provision function. At the end of this process, the Ministry of Public Health and Social Assistance (Secretaría de Estado de Salud Pública y Asistencia Social, or SESPAS) will be left with the stewardship role for the sector, and the newly established National Insurance Agency will buy services from autonomous, regional health service networks.

The reform has major implications for the management of human resources for health (HRH). First, SESPAS has to develop a robust regulatory framework for HRH. Second, HRH management has to be transferred from SESPAS to regional health services. Third, regional health services have to build managerial HRH capacity to effectively respond to changes in demand for services.

In that connection, one key area of the government's strategy is to improve the performance of the health workforce. The Dominican Republic has a relatively large health workforce, with 3.8 health workers per 1,000 people. The primary issue is not an absolute shortage of health workers—although in some provinces, it is certainly a key issue—but the management of the health workforce and how performance can be improved. The efficiency with which the health sector allocates and implements its wage bill resources needs to be improved.

In the past five years, the Dominican Republic has gone through a series of macroeconomic reforms that have important implications for the health workforce. In 2002, the Dominican economy entered a recession. The country's public finances were placed under strain after the government bailed out the country's third-largest bank following a major fraud. This action consumed significant government resources and led to an economic crisis. By the end of 2003, inflation reached 42 percent, unemployment stood at 16.5 percent, and the Dominican peso (RD\$) had lost more than half its value (Ribando 2005: 5).

As part of its fiscal response, the government implemented significant expenditure controls. One of the measures was a hiring freeze in the public sector. Interestingly, to partially reverse the recent compression in public sector real wages, the government increased nominal wages of central government employees by 30 percent. More important, the government's policy during this period of fiscal restraint was to protect spending in the social sectors—health and education (Albizu, Montás, and Bengoa 2005: 5).

The Health Wage Bill in the Dominican Republic

Most health workers are employed in the public sector in the Dominican Republic (in the NHS). Within the public sector, the largest employer is SESPAS, accounting for 64.6 percent of all health workers. The Social Security Institute (Istituto de Seguros Sociales, or IDSS) accounts for 25 percent, the private sector for 8.3 percent, the army for 0.8 percent, and nongovernmental organizations for 1.0 percent. The IDSS provider network will be integrated into the NHS umbrella. Currently, it is still separate because some issues remain to be resolved, such as the alignment of wage scales.

Each agency has different employment regulations and funding arrangements for health workers. This study limited its scope to the health workforce in SESPAS.

Process for Determining the Budget for the Health Wage Bill

Health workers employed in SESPAS are part of a national civil service. As a result, the health wage bill is paid from the public sector wage bill budget and is determined through a three-stage process.

When the government policy is to control spending on the public sector wage bill, the government will set a target level for the wage bill (covering all sectors), as it did after the financial crisis of 2002. In recent years, however, the size of the public sector wage bill has not posed any macroeconomic threat, and the government has not set any specific budget ceilings for the public sector wage bill (Albizu, Montás, and Bengoa 2007: 4). SESPAS is responsible for preparing the budget for the public sector based on the budgetary ceiling determined by the Ministry of Finance (MOF). Within this sector ceiling, SESPAS estimates the wage bill requirement for the sector, which is then included as a line item in the health budget. Sector budgets are consolidated, and negotiations within the government then determine the allocation of budgets to each sector, including the allocation of wage bill resources to particular sectors. Each of these stages is discussed. The process for determining the health wage bill is summarized in table 5.1.

Budget for the total public sector wage bill. Managing the size of the public sector wage bill level is important because it can cause macroeconomic volatility. High government wages and large employment can push up the wage bill and crowd out other spending. Government wage increases could feed into a general wage-price spiral that undermines competitiveness and could also result in fiscal slippages (Fedelino, Schwartz, and Verhoeven 2006).

Expansion of the public sector wage bill can limit fiscal space for implementing poverty reduction programs. However, it is equally important to strike a balance between macroeconomic targets and the need to increase budgets—including the wage bill—to expand coverage of key services to ensure the Dominican Republic achieves its development goals.

The Dominican Republic has a relatively small public sector wage bill relative to other countries in the region. As a percentage of gross domestic product (GDP), the public sector wage bill is quite low at 4.0 percent (figure 5.1). Figure 5.2 illustrates that the Dominican Republic public sector wage bill was 28 percent of total government expenditure in 2004, about average compared with other countries in the region.

As part of measures taken to resolve the financial crisis in 2002, the government implemented significant expenditure controls, including a hiring

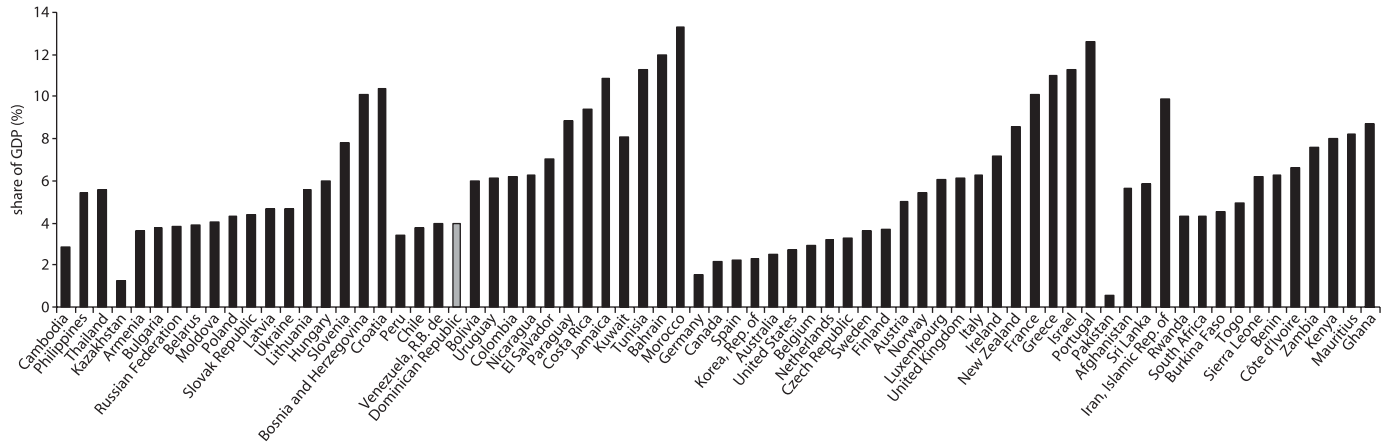
Table 5.1 Process for Determining the Health Wage Bill

<i>Actor</i>	<i>Process</i>
Planning Office at SESPAS, Regional Health Directorate, and Regional Health Services at the health establishments	At the end of the first semester of every year, SESPAS evaluates the budget execution and the accomplishment of targets. This analysis allows budget reprogramming for the last trimester and the identification of new targets for the following year.
Ministry of Planning and Development	The ministry evaluates the sector budget execution and the deviation from the budget to plan for new fiscal ceilings.
Ministry of Planning and Development and sectors	The ministry discusses with each sector its plans for coverage increases or improvement of services.
Health minister, Planning Office at SESPAS, and directors of the different programs	Financial and physical targets are discussed and negotiated inside SESPAS between the health minister, the Planning Office, and the directors of the different programs to meet national and international development goals.
Health minister and Planning Office	Budget premises are defined (such as wage increases, budget allocation to certain areas), and a preliminary proposal for fiscal ceilings is established for the discussion with the president.
Planning Office at SESPAS	This stage occurs only within SESPAS and entails the Regional Health System. The discussion and negotiation process inside SESPAS begins. Training activities for budget formulation are implemented, and instructives and forms are given out to the Regional Health System stakeholders to start the budget formulation process.
Health minister, president, and professional associations	The health minister and president then negotiate with the different professional associations and unions regarding wage increases, incentives and post openings, training activities, and medical residencies, among other issues.

Planning Office at SESPAS	The office collects from local authorities the needs for infrastructure, equipment, and human resources.
NHS Planning Office, local authorities, and Ministry of Planning and Development	The NHS Planning Office consolidates the demands into a preliminary proposal. With this proposal, the internal and external negotiation process with (a) local authorities and unions and (b) the Ministry of Planning and Development starts.
National Office of Planning and National Office of the Budget National Development Council Congress	The two offices consolidate the final proposal. The council is informed of the proposal. Congress receives the budget proposal and at the same time receives demands from organized social groups. It approves the budget for each sector.
SESPAS	After the budget is negotiated with Ministry of Planning and Development and approved by Congress, SESPAS informs the different areas, services, and programs about the approved budget.
SESPAS and international cooperation agencies	SESPAS shares the budget with the international cooperation agencies and discusses the fiscal and physical targets to complement the budget with other sources of funding.

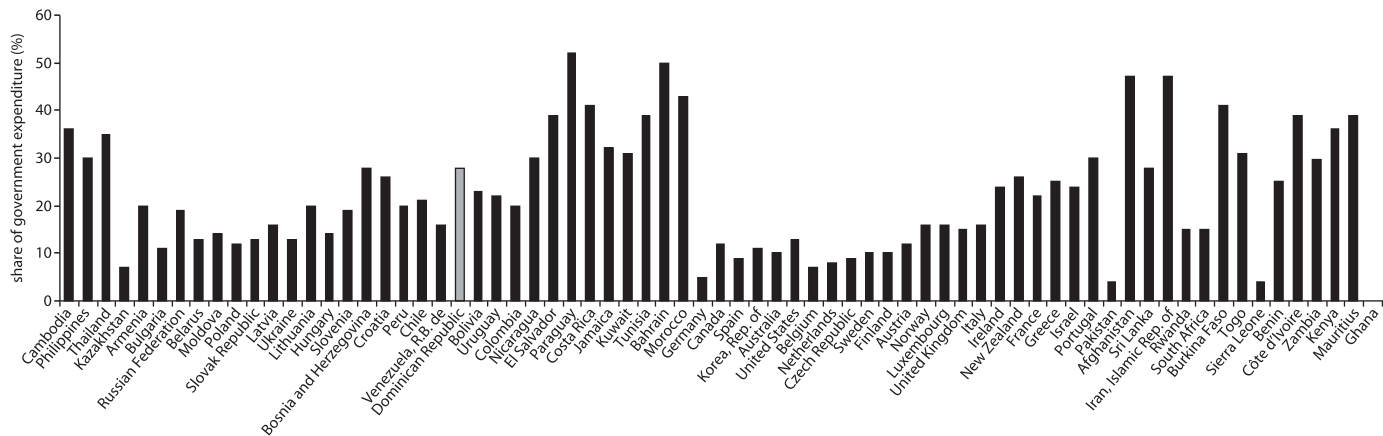
Source: Interviews conducted during the study.

Figure 5.1 Public Sector Wage Bill as a Share of GDP, by Country, 2005



Source: World Bank 2007.

Figure 5.2 Public Sector Wage Bill as a Share of Government Expenditure, by Country, 2005



Source: World Bank 2007.

Note: These numbers are based on World Development Indicator data for total public sector compensation. The definition includes all payments in cash as well as in kind (such as food and housing) to employees in return for services rendered and government contributions to social insurance schemes such as social security and pensions that provide benefits to employees. Slight differences in the definition of total public sector compensation can account for the small variation from Dominican Republic data.

freeze in the public sector. The hiring freeze, which remained in effect until 2006, applied to all sectors; priority sectors had no exemptions (Albizu, Montás, and Bengoa 2006: 4).

In 2005, during the hiring freeze, the government increased nominal wages of government employees by 30 percent. In subsequent years, wages remained frozen for government employees but not for health workers and teachers. This policy was implemented to compensate for inflation and partially reverse compression in public sector wages that had occurred in the years leading up to the fiscal crisis. The wage increases applied to all sectors, and because inflation was 27 percent in 2003, 51 percent in 2004, and 4 percent in 2005, this increase in nominal wages was necessary and still did not keep pace with inflation.

In 2006, Congress approved the 2006 proposed budget, which specified a zero deficit in the public sector. The budget provided a series of measures, including (a) keeping nominal wages unchanged for most central government employees, except in the case of agreements reached with doctors and teachers; (b) containing administrative expenses; and (c) reducing subsidies. These measures were designed to offset increases in spending that were partly due to significant increases in social spending to achieve the Millennium Development Goals (Albizu, Montás, and Bengoa 2006: 2).

During the fiscal cutback period, the government aimed to prioritize spending in the health and education sectors. The government's policy during this period of fiscal restraint was to protect spending in health and education (Albizu, Montás, and Bengoa 2005: 5). As the analysis in later sections shows, this protection actually did happen with regard to the wage bill: the health and education sectors received an increasing portion of the overall wage bill.

Budget for the health sector wage bill. The budgeting of the health wage bill in SESPAS occurs in multiple stages. SESPAS receives a fiscal ceiling, including a wage bill line item. The wage bill ceiling is set in accordance with the expenditures in the previous year and estimates of government revenue. The resulting percentage increase varies from year to year, but it has been averaging about 3 percent. The ceiling may be altered during the budgeting process as a result of negotiations with unions. Within the fiscal ceilings set by the MOF, SESPAS prepares a budget that includes the wage bill as a line item.

Congress makes the final budgetary allocations to different ministries, including wage bill allocations. The negotiation stage takes place in

Congress, which has the ultimate decision-making authority on the government budget. In practice, Congress often adjusts fiscal ceilings during the negotiation stage. Congressional approval of the budget prepared by the MOF is not a mere formality.

Currently, no specific guidelines exist on how the wage bill budget in each sector should be determined, reflecting the fact that the public sector wage bill is not a major issue or concern to the government. In practice, SESPAS budgets for a small increase in the wage bill from year to year to cover annual wage increases for the current staffing contingent, historically about 3 percent per year. In the Dominican Republic, the number of unfilled vacancies is small, and staffing levels are deemed quite adequate. Thus, the only additional resources requested for the wage bill are to cover the annual wage increases and posts in newly established infrastructure.

According to policy, the health and education sectors have been singled out in recent years as priority sectors for additional wage bill resources. Earlier, no clear policy existed. In 2002 to 2005, during the overall hiring freeze, no explicit policy of exempting the health or education sector from the recruitment ban was in place, and the wage increase to the health and education sector was the same as for all civil servants. In 2006, however, doctors and teachers were exempted from the wage freeze that was implemented on all public sector employees.

The staffing levels in SESPAS are considered generally sufficient for delivering key services. It has no need for additional wage bill resources to increase staffing. Rather, wage bill resources are needed to pay higher salaries. Salaries for health workers are negotiated separately from those for administrative personnel, to whom a generic public sector wage scale applies. Pressures from labor conflicts are considered the most influential factor in determining salary levels and thus the budget and actual expenditures. Many unions and organized professional associations exist at the same time; the most important ones are the Dominican Medical Board (Colegio Médico Dominicano), the Health Unions Coordinator (Coordinadora de Gremios de la Salud), Odontologists Association (Asociación de Odontólogos), the Professional Nurses Association (Asociación de Enfermeras Graduadas), the Dominican Odontologist Association (Asociación Odontológica Dominicana), the Dominican Bioanalyst Association (Asociación Dominicana de Bioanalista), the Psychologists Association (Asociación Psicólogos), and the Dominican Pharmacist Association (Asociación Farmacéutica Dominicana).

Labor conflict is usually related to demands for job stability and better wage conditions that are not related to productivity or performance.

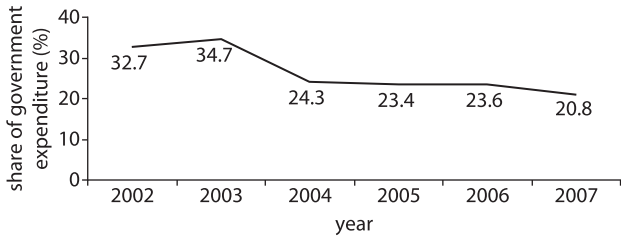
Authorities tend to accept these demands, given the social pressure and the potential for instability. Evidence shows an increase in expenses in the wage bill as a result of labor conflict and union agreements: in 2006, an increase of incentives for night shifts, distance, and years at work was successfully negotiated, and in 2007, a 20 percent increase in wages was agreed upon.

In sum, the public sector wage bill in health is primarily determined by (a) the historical budget for the wage bill, (b) additions to infrastructure, and (c) pressures from unions to increase salaries. Less important are international and national development targets.

Results of the Wage Bill Budgeting Process

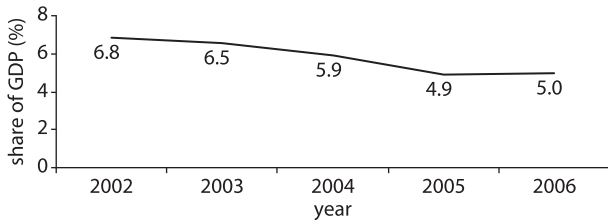
The government of the Dominican Republic has decreased the share of its spending devoted to wages dramatically, dropping from 32.7 percent in 2002 to 20.8 percent in 2007 (figure 5.3). This decreasing trend shows that the government is not prioritizing the wage bill and instead is focusing its increased expenditure on nonwage areas. The government wage bill as a share of GDP demonstrates a similar trend. It declined from 6.8 percent in 2002 to 5.0 percent in 2006 (figure 5.4).

Figure 5.3 Public Sector Wage Bill as a Share of Government Expenditure, 2002–07



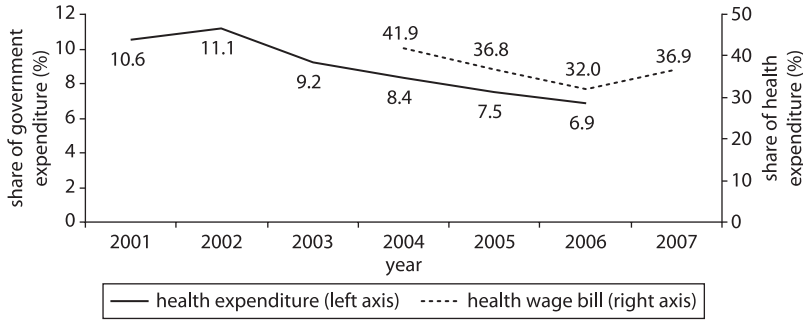
Source: Ministry of Finance.

Figure 5.4 Government Wage Bill as a Share of GDP, 2002–06



Source: Ministry of Finance.

Figure 5.5 Health Expenditure as a Share of Government Expenditure and Health Wage Bill as a Share of Health Expenditure, 2001–07



Sources: Budgets from the central government for 2002 to 2007, and from the National Office of the Budget and National Office of Planning of the Ministry of Economy, Planning and Development; from the Ministry of the Budget; and from the Central Bank of the Dominican Republic.

Government health expenditure as a share of government expenditure fell significantly during this same period, decreasing from 10.6 percent in 2001 to 6.9 percent in 2006 (see figure 5.5 and table 5.2). However, in real terms, government health spending increased from RD\$6.8 million in 2001 to RD\$16.4 million in 2006. The decline in health expenditure in relation to overall government expenditure shows that health was clearly not prioritized during this time and lost ground in relation to other sectors. Government health spending also fell in relation to GDP from 2001 to 2006, despite real GDP per capita increasing from RD\$41,198 to RD\$109,772.

In the Dominican Republic, 42 percent of the total budget in the health sector was allocated to salaries in 2004. This amount declined significantly to 32 percent in 2006.¹ The health sector wage bill is classically a big proportion of total health spending. Evidence shows that the wage bill in Latin American countries can reach 75 percent of the total budget in the health sector (Chen and others 2004). Although the wage bill constitutes a relatively large proportion of the SESPAS budget, the share of health spending going to wages has declined. This trend is projected to reverse between 2006 and 2007, with the health wage bill increasing to 37 percent of total health expenditure. The wage bill in the education sector also declined as a proportion of total government education spending, falling from 68.2 percent in 2004 to 59.1 percent in 2007 (figure 5.6). Education spending as a share of total government expenditure also fell from 2002 to 2005, showing that both the health

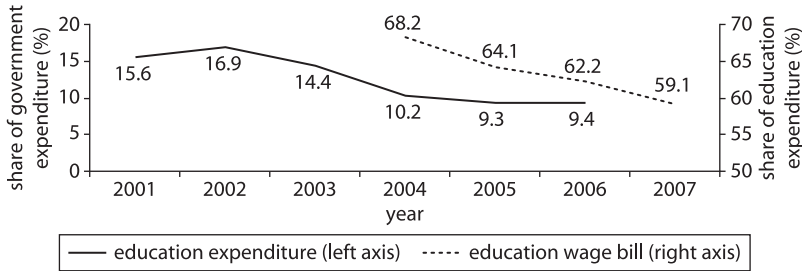
Table 5.2 Evolution of Public Spending in Health and Education, 2001–07

<i>Type of expenditure</i>	<i>Amount (RD\$ million), adjusted for inflation</i>						
	<i>2001</i>	<i>2002</i>	<i>2003</i>	<i>2004</i>	<i>2005</i>	<i>2006^a</i>	<i>2007^a</i>
Total public expenditure	64,312.20	73,850.00	93,650.25	142,038.93	189,551.49	239,430.75	258,479.53
Total public health expenditure	6,786.60	7,777.20	6,332.40	9,632.50	13,886.00	16,411.70	19,557.90
Public health expenditure as a percentage of total public expenditure	10.55	10.53	6.76	6.78	7.33	6.85	7.57
Total public education expenditure	10,011.70	11,772.40	9,899.60	11,774.40	17,196.74	22,363.18	27,563.60
Public education expenditure as a percentage of total public expenditure	15.57	15.94	10.57	8.29	9.07	9.34	10.66
Real GDP	366,232.10	402,432.40	503,300.00	777,187.50	884,939.00	1,055,427.00	1,165,407.40
Public health expenditure as percentage of GDP	1.85	1.93	1.26	1.24	1.57	1.55	1.68

Sources: National Office of the Budget and National Office of Planning of the Ministry of Economy, Planning and Development; Ministry of the Budget; and Central Bank of the Dominican Republic.

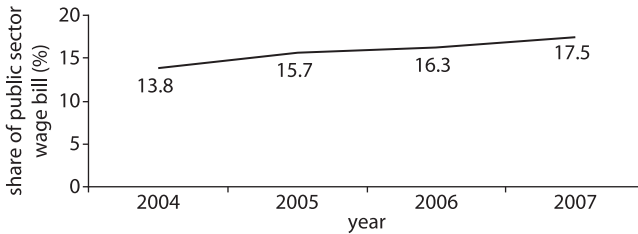
a. Figures for these years are projections.

Figure 5.6 Education Expenditure as a Share of Government Expenditure and Education Wage Bill as a Share of Education Expenditure, 2001–07



Sources: Budgets from the central government for 2002 to 2007, and from the National Office of the Budget and National Office of Planning of the Ministry of Economy, Planning and Development; from the Ministry of the Budget; and from the Central Bank of the Dominican Republic.

Figure 5.7 Health Wage Bill as a Share of Public Sector Wage Bill, 2004–07

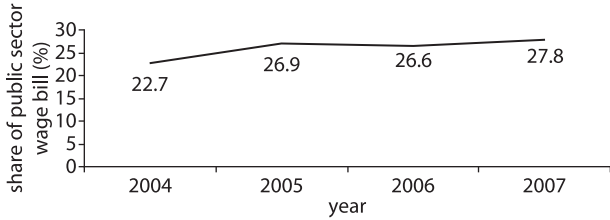


Sources: Ministry of Finance and SESPAS.

and education sectors, which were supposed to be priority spending sectors for the government, were actually somewhat targeted.

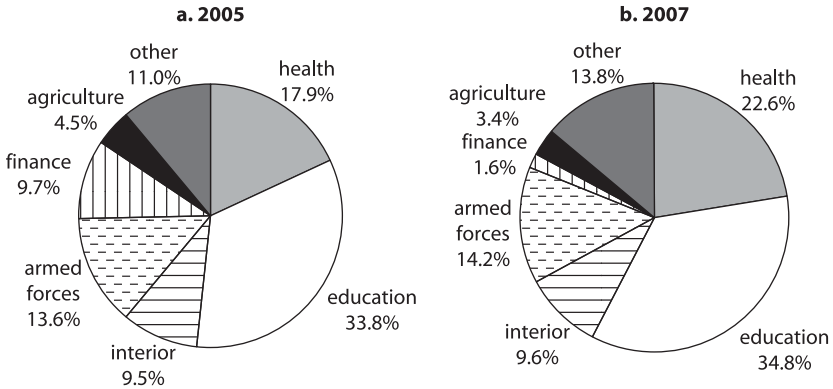
The health wage bill has accounted for an increasing share of the public sector wage bill, which indicates that the health sector has been prioritized within the public sector wage bill. This share grew from 13.8 percent in 2004 to 17.5 percent in 2007 (figure 5.7). While the government was cutting the public sector wage bill, the health sector seems to have been insulated from these reductions. The education sector again mirrors the experience of the health sector. The education wage bill as a share of the public sector wage bill increased from 22.7 percent in 2004 to 27.8 percent in 2007 (figure 5.8). As expected, the education wage bill is a larger proportion of the public sector wage bill than health because education is a more labor-intensive sector. Thus, the public sector wage bill decline has been focused on sectors other than education

Figure 5.8 Education Wage Bill as a Share of Public Sector Wage Bill, 2004–07



Sources: Ministry of Finance and SESPAS.

Figure 5.9 Distribution of Public Sector Wage Bill, by Sector, 2005 and 2007



Source: Central Bank of the Dominican Republic.

and health. Although health spending has declined, the health sector has been prioritized within the overall civil service.

The main conclusion is that health has been prioritized in terms of the public sector wage bill. However, this prioritization was not sufficient to maintain a constant ratio of wage-to-nonwage spending within the health sector. Moreover, had health spending not fallen as dramatically as it did, the ratio of wage-to-nonwage spending would have declined even further. This finding suggests that public sector wage bill policy could be an important factor constraining expansion of the health wage bill. The prioritization of health and education in the wage bill came mainly at the expense of the MOF and the Ministry of Agriculture (figure 5.9).

Budget execution of salaries is very high in SESPAS; however, execution of other remuneration, particularly allowances and incentives, is extremely unreliable and scattered (table 5.3). Budget execution of the

Table 5.3 Budgeted and Executed Wage Bill at SESPAS, 2004–06

<i>Wage bill structure</i>	<i>2004 wage bill</i>			<i>2005 wage bill</i>			<i>2006 wage bill</i>		
	Budgeted (RD\$)	Executed (RD\$)	Percentage of budget	Budgeted (RD\$)	Executed (RD\$)	Percentage of budget	Budgeted (RD\$)	Executed (RD\$)	Percentage of budget
<i>Total</i>									
<i>remuneration</i>	4,103,800,868	3,918,506,896	95	5,938,899,713	5,618,627,719	95	7,205,007,654	6,127,828,667	85
Permanent staff	3,102,589,884	2,876,674,890	93	4,213,503,467	4,307,617,088	102	5,230,025,795	3,773,467,514	72
Short-term personnel	208,644,059	222,381,507	107	465,178,272	361,586,163	78	601,575,339	508,098,284	84
Allowances and incentives	74,417,228	216,969,683	292	330,299,316	350,527,731	106	883,613,524	862,440,058	98
Seniority	0	211,559,821		0	39,320		0	33,832	
Compensation for food expenses	0	0		0	0		0	231,044	
Compensation for extra hours	0	2,294,015					0	495,917,976	
Compensation for other services	0	3,115,847			6,035,942			0	
Contractor fees	179,145,535	22,330,648	12	169,254,534	69,022,291	41	139,024,869	77,947,344	56
Representation expenses	0	1,149,973		1,379,968	1,365,926	99	1,925,711	0	0

(continued)

Table 5.3 Budgeted and Executed Wage Bill at SESPAS, 2004–06(Continued)

<i>Wage bill structure</i>	<i>2004 wage bill</i>			<i>2005 wage bill</i>			<i>2006 wage bill</i>		
	Budgeted (RD\$)	Executed (RD\$)	Percentage of budget	Budgeted (RD\$)	Executed (RD\$)	Percentage of budget	Budgeted (RD\$)	Executed (RD\$)	Percentage of budget
Benefits	257,254,106	259,036,896	101	223,513,095	283,562,164	127	0	525,880,413	
Social security contributions	281,750,056	102,993,616	37	535,771,061	238,871,094	45	348,842,416	379,995,054	109
<i>Allowances and Incentives</i>	<i>74,417,228</i>	<i>216,969,683</i>	<i>292</i>	<i>330,299,316</i>	<i>350,527,731</i>	<i>106</i>	<i>883,613,524</i>	<i>862,440,058</i>	<i>98</i>
Seniority		211,559,821		0	39,320		0	33,832	
Compensation for food expenses		0		0	0		0	231,044	
Compensation for extra hours		2,294,015		0			0	495,917,976	

Sources: National Office of the Budget, Ministry of the Budget, and SESPAS.

salaries for all types of workers remains very close to 100 percent from 2004 through 2006. However, budget execution of allowances and incentives ranges from 292 percent to 85 percent. The wage bill structure comprises wages for workers with tenure, wages for workers with short-term contracts, allowances and incentives, seniority in the job, extra hours at work, fees for services, representation expenses, benefits, and social security contributions. A large proportion of the health workforce wages corresponds to workers with permanent contracts. In 2006, about 76 percent of payroll spending went to workers with permanent contracts, while about 9 percent of the budget was allocated to pay workers with more flexible contractual mechanisms, and another 2 percent of the wage bill went to pay for allowances, which include recognition of extra hours and years at work.

The overruns in budget execution for allowances and incentives are not surprising, given the leeway SESPAS has to negotiate these amounts throughout the year with labor unions. SESPAS is able to reallocate funds from other areas of its budget to pay for additional allowances and incentives not previously in the budget. As seen in table 5.3, the amount budgeted for allowances and incentives increased dramatically from 2004 to 2006 as a result of negotiations with labor unions and large budget overruns in 2004.

Since 2005, recruitment of staff has fallen within SESPAS (table 5.4). In 2005, 2,278 staff members were recruited into SESPAS, falling to 1,860 in 2007 and 1,857 in 2008. These recruitment levels resulted in a net increase of staff of 2,073 in 2005, falling to just over 1,000 in 2008. Clearly, net recruitment levels are falling significantly within SESPAS, but as indicated earlier, the government's HRH strategy is not focused on scaling up the health workforce.

Table 5.4 Recruitment and Separation of Staff in SESPAS, 2005–08

	2005	2006	2007	2008
Total recruitment of personnel	2,278	2,704	1,860	1,857
Total separations of personnel	205	1,554	1,829	835
Net recruitment of personnel	2,073	1,150	31	1,022

Source: SESPAS.

Public Sector Employment of Health Workers

Within a given wage bill envelope, identifying areas where SESPAS can improve the efficiency of how wage bill resources are spent is important. The budget for the health wage bill comes out of the budget for the public sector wage bill. Thus, the health wage bill will always be constrained by the size of the public sector wage bill. In the future, the health sector needs to make the best use of existing resources. There is increasing consensus that restrictive contracting arrangements, rigidity in labor mobility, and a fixed structure of wages without incentive mechanisms are potential barriers to improving health workforce performance.

In the context of the Dominican Republic, 13 different procedures related to contracting arrangements, labor mobility, and allowances have been identified, among them, the Regulation for Human Resources for Health in the National Health System and the General Hospital Regulation. These regulations contain policies that regulate the hiring process of HRH, mobility, wages and post classification system, selection and recruitment, incentives and allowances, performance evaluation, and promotion.

This section describes how health workers are currently recruited, deployed, and managed in the public sector.

Creating Funded Posts in the Health Sector

SESPAS and other public institutions in the health sector define the number of posts for each professional category on the basis of a Post Map of health centers. This information is derived from input given by the directors of each health center, who are supposed to base their estimates on overall demand and needs. However, requests for additional posts from the local health centers are commonly ignored. Therefore, most additional posts are created at the central level and do not necessarily reflect the needs of the health centers.

In practice, most health posts are created as a result of either the construction of a new health facility or the departure of a current health worker. No large scaling-up effort is evident in the number of health workers. The public recruitment process is not based on an evaluation of needs and demands, and it is not strategically planned. This situation may change soon, however. The General Health Law and the Social Security Law place particular emphasis on primary health care. Most important, primary health care facilities will have gatekeeper functions. Therefore, a major effort can be anticipated to strengthen primary care services, including their staff base.

Before being approved by the MOF and subsequently filled, new positions as well as vacancies have to be confirmed by the Office of Personnel Management. Although this procedure provides a mechanism to control the wage bill and, furthermore, to ensure the efficient allocation of resources, confirmation criteria for the approval of new positions and vacancies have yet to be established and enforced.

Currently, the Office of Personnel Management is working to address these deficiencies by developing four distinct human resources policies for education, judiciary, health, and foreign affairs that will be independent from the law for civil servants. The intent of these policies is not only to make human resource management procedures more effective and transparent but also to define wage scales and career paths and to strengthen workforce planning.

Recruiting Health Workers in the Public Sector

Recruitment of health workers into funded posts is supposed to be managed regionally; however, in practice, most of the selection and recruitment processes are carried out at the central level. In only very few cases, the recruitment process follows a public selection process prescribed by the overall civil service recruitment procedures. Job openings are not typically advertised. Although SESPAS makes the final decision on selecting and appointing staff members, regions very often provide a short list of candidates and a recommendation for the top choice. The State Department approves SESPAS's selection, although this step is a formality. No data are available on the time that filling a position takes.

The recruitment process is heavily influenced by pressures from various professional associations and unions. The process is supposed to be based on objective criteria, including experience, background, continuing education and training, and research activities. Nevertheless, no public recruitments have been held in seven years to hire specialists (OPS 2007: 27) in the health sector. Only in a few cases was the selection process based on approved terms of reference and an evaluation process.

The Office of Human Resources for Health in SESPAS, which is supposed to regulate the hiring mechanisms for the health workforce, is currently concentrated on regulating the movements within SESPAS itself. In practice, the hiring process depends on the amount of the budget rather than planned increases in funded posts. This system provides a high level of discretion both in the selection process and in negotiations of the individual's salary and benefits.

Table 5.5 Skill Mix of Human Resources for Health, 2004–06

<i>Health worker category</i>	<i>2004</i>	<i>2005</i>	<i>2006</i>
Doctors	9,204	10,572	10,380
Nurses	11,333	11,093	12,088
Specialists	1,414	1,164	1,166
Psychologists	250	133	288
Pharmacists	527	588	619
Radiologists	61	163	200
Dentists and dental assistants	1,431	1,430	1,276
Other health personnel	5,875	3,172	4,091
Total health personnel	30,095	28,315	30,108

Source: SESPAS.

Because of weak strategic planning, the skill mix and geographic distribution of health workers is very poor (table 5.5). The proportion of untrained personnel among doctors and nurses is high. In 2005, according to SESPAS, 80 percent of nurses were assistant nurses and 25 percent of physicians were interns or residents. Additionally, relatively few licensed nurses exist when compared with physicians. The ratio of doctors (excluding interns and residents) to licensed nurses was 3.6:1 in 2006. The increasing number of assistant nurses, who are less expensive, suggests that less trained personnel could be replacing licensed nurses.

Human resources for health are concentrated in a few provinces in the Dominican Republic. This inequitable distribution is seen in table 5.6. Large variations in staffing levels are observed, especially among doctors and assistants.

The available information on skill mix, deployment, and distribution of health workers is incomplete and scattered. Even though SESPAS has a planning tool for human resources and equipment related to health needs, this tool has not been updated over the years. Hence, the information system currently in use is highly deficient and unsuitable for planning and management of HRH. Given this situation, the planning process for health workers in SESPAS is certainly not related to the identification of health demands or planning for adequate deployment and distribution of health workers around the country.

Even though some managerial instruments were identified, little coordination exists between these instruments, and they are out of date. Instruments include strategic planning for HRH and for the development of service networks as well as the identification of gaps between staffing and needs. Moreover, the planning process is subject to strong pressures from unions and politics. The actual recruitment process and the way in

Table 5.6 Concentration of Health Workers in Provinces, 2003

Province	Number of health workers per 10,000 inhabitants								
	Doctors	Nurses	Pharmacists	Assistants	Bioanalysts	Odontologists	Psychologists	Other	Veterinarians
Azua	146	7	3	279	16	10	1	4	0
Bahoruco	67	16	3	217	23	8	2	2	0
Barahona	151	38	3	422	25	12	1	6	2
Dajabón	56	10	3	178	5	10	0	3	0
Distrito Nacional	3,886	602	82	3,823	540	612	178	39	16
Duarte	296	85	4	563	30	24	5	2	1
El Seibo	86	11	2	123	5	6	0	3	0
Elías Piña	44	4	3	156	6	4	0	6	1
Españat	144	27	4	267	9	14	2	11	0
Hato Mayor	102	5	1	125	9	9	1	0	0
Independencia	51	8	2	208	9	3	1	3	1
La Altagracia	126	12	2	107	15	18	1	3	0
La Romana	127	12	1	122	9	15	1	1	0
La Vega	300	32	5	484	40	46	7	5	2
María Trinidad									
Sánchez	116	14	8	263	9	17	0	1	0
Monseñor Nouel	145	13	2	185	15	13	3	1	0
Monte Cristi	103	7	9	240	10	13	1	3	0
Monte Plata	132	5	5	171	7	14	2	1	0
Pedernales	23	2	1	40	2	2	0	1	0
Peravia	172	27	3	248	10	12	0	2	0
Puerto Plata	200	24	5	330	16	27	3	7	0
Salcedo	110	27	3	354	21	18	6	1	1

(continued)

Table 5.6 Concentration of Health Workers in Provinces, 2003(Continued)

Province	Number of health workers per 10,000 inhabitants								
	Doctors	Nurses	Pharmacists	Assistants	Bioanalysts	Odontologists	Psychologists	Other	Veterinarians
Samaná	84	8	4	181	21	7	1	1	0
San Cristóbal	395	89	8	533	38	33	5	5	0
San José de Ocoa	71	5	2	122	5	6	0	0	0
San Juan	195	35	2	555	13	26	2	8	1
San Pedro de									
Macorís	395	46	11	315	32	39	1	8	1
Sánchez Ramírez	137	22	3	277	19	13	0	1	1
Santiago	949	106	17	1,114	112	93	19	9	4
Santiago									
Rodríguez	60	13	2	166	8	7	0	4	0
Santo Domingo	0	0	0	0	0	0	0	0	0
Valverde	109	27	2	180	7	13	3	0	1
Country	8,978	1,339	205	12,348	1,086	1,144	246	141	32
Total	35.2%	5.2%	0.8%	48.4%	4.3%	4.5%	1.0%	0.6%	0.1%

Source: Executive Commission for Reform of the Health Sector.

Note: Examples of rural and underdeveloped provinces with household incomes below the national average include Dajabón, Barahona, Bahoruco, Monte Plata, La Altagracia, and Ellas Piña.

Table 5.7 Main Actors and Their Roles in the Process for Labor Mobility

<i>Main actor</i>	<i>Process</i>
Health worker	Makes requests to his or her superior to transfer to another health center. This request is then sent to the health center in question.
Health center director	Sends the request to the minister of health through the Office of Human Resources for Health in SESPAS, recommending worker be hired.
Office of Human Resources for Health in SESPAS	Verifies the vacancy of a funded post and evaluates the need to fill the post. If the need is approved, the office sends the request to the minister of health.
Minister of Health	Approves the request and informs the Office of Human Resources for Health.

Source: Interviews conducted during the study.

which the selection process is managed leads to large inefficiencies in the public sector health workforce.

Many actors and steps are involved for a health worker to transfer to another health center, thus creating distortions in the transfer system. Table 5.7 describes the various actors involved in the process. In theory, to transfer to another post, a health worker has to enter into an entirely new recruitment process and therefore find a new or vacated post to apply to. Furthermore, movements from outside the capital to Santo Domingo are strictly forbidden, given the shortages of HRH around the country. However, if they are already based in Santo Domingo, staff members are allowed to transfer outside the capital city. In practice, labor mobility is not necessarily related to distribution or needs, and transfers are usually allowed for reasons other than health priorities. To assist in assessing staffing needs, SESPAS has initiated a mapping study, which will be completed before the end of the year.

Terms of Work in the Public Sector

Terms of work include tenure, remuneration, promotion, and termination and sanctions.

Tenure. Within SESPAS, two main types of contracts are specified in the legal framework (that is, article 19 of the Regulation for Human Resources for Health in the National Health System):

- Short-term contracts, which are annual contracts that can be renewed
- Ordinary contracts, which in practice are permanent and pensionable, although the contract does not specify the length of service

The majority of employees in SESPAS are on permanent and pensionable contracts. A large proportion of the health workforce's wages corresponds to workers with permanent contracts. In 2006, about 76 percent of the health wage bill was accounted for by health workers with permanent contracts. Short-term contract employees accounted for only about 9 percent of the health wage bill.

Short-term contracts are used to a much larger extent than policy allows. According to SESPAS regulations, short-term contracts should be exclusively used in cases where posts are vacant for specific reasons, such as temporary leave for medical reasons, for maternity, or because of transfer to an administrative position. Ordinary contracts guarantee job stability and therefore the right to pensions, allowances, and other benefits. In practice, short-term contracts are used widely. For example, they are used to employ medical residents who are not covered by SESPAS employment regulations. They are also used to cope with inflexible hiring mechanisms and to pay for extra time. In contrast to ordinary contracts, for example, the number of hours worked under short-term contracts is not regulated, and flexible terms are used.

The employment of medical residents and medical students is not regulated, but in practice they are an important source of HRH and are usually employed on short-term contracts. In recent years, a sustained effort has been made to use medical residents or medical students instead of doctors to deliver services at the primary care level, particularly in underserved areas, often because doctors are not willing to work in these areas even though positions are funded. Besides not having the proper medical background to guarantee adequate provision of health services, medical residents or students may constitute a limitation in terms of service, because they are not allowed to prescribe medicines or diagnostic tests. The government is currently establishing estimates of the staffing gap in underserved areas and has commissioned work to render the current incentive scheme for rural areas more effective.

The required hours of work specified in the labor regulations is quite low and falling. Under ordinary contracts, health workers used to be required to work a minimum of 6 hours per day and a maximum of 30 hours per week. In response to the last health workers' strike, new contractual agreements have reduced these limits to a maximum of 20 hours of work per week—effectively a 33 percent increase in hourly wages. The labor unions and SESPAS are finding creative ways to increase remuneration. In situations where SESPAS is able to secure additional wage bill resources for the health sector, the union pressures for increased wages are

met with an increase in salary levels. In situations where SESPAS cannot secure additional wage bill resources, the union demands are met through reductions in hours worked. Both policy responses increase the hourly wage of health workers, but they have very different implications for the actual labor supply available in public facilities.

With reductions in maximum hours worked, health workers spend less time working in SESPAS facilities and more time working in the private sector. Dual practice is common in the Dominican health sector and in the Latin American and Caribbean region in general (Ferrinho and others 2004). With reductions in maximum hours worked, health care workers are able to increase their take-home pay by simply devoting more hours to dual practice. With the rollout of the National Insurance Scheme (NIS), the reduction in maximum hours worked is even more important to health workers, especially doctors. The NIS is expected to increase the demand for health services—and thus, for doctors—among the poor, who are currently being enrolled in the subsidized regime of National Family Insurance. Because the insurance scheme pays doctors on a fee-for-service basis, income opportunities associated with working in the private sector are considerable.

The focus of union demands has shifted with the plan to implement the NIS. Union pressures were focused on increasing salary levels. When persistent salary increases became unaffordable and SESPAS resisted, unions demanded reductions in hours worked. Now, with the maximum hours worked per week down to 20 hours, unions are focusing on lobbying to increase the fee schedule within the NIS. Given the increased hours available for dual practice in the private sector, increasing the fees will have a very large effect on income. Although this development will likely relieve some of the pressure on SESPAS to pay higher salaries, it will generate cost escalation within the NIS.

Remuneration. Health workers receive three types of remuneration: salaries, allowances, and incentives. According to SESPAS policy, salaries are determined by job characteristics; however, this policy is not strictly followed. Salaries vary widely from region to region, from individual to individual, and among individuals with the same responsibilities. The salary scale is not framed within the post classification system, meaning that no formal relation exists between salaries and job characteristics. Likewise, allowances and incentives are not paid according to SESPAS policies. A recent evaluation of the distribution of earnings within SESPAS shows a variety of inconsistencies in salaries, allowances, and incentives.

Table 5.8 Average Monthly Salaries for Health Workers in SESPAS, 2001–05

<i>Health worker category</i>	<i>Amount (RD\$, adjusted for inflation)</i>				
	<i>2001</i>	<i>2002</i>	<i>2003</i>	<i>2004</i>	<i>2005</i>
General physicians	11,950	11,965	9,269	11,195	17,439
Specialists	12,804	12,819	9,931	11,995	18,660
Medical residents	8,251	8,261	6,400	7,092	11,047
Graduate interns	11,381	11,395	8,827	9,782	15,237
Licensed nurses	5,928	5,935	4,598	5,553	8,650
Assistant nurses	4,869	4,879	3,780	4,565	7,111
Bioanalysts	5,691	5,697	4,414	5,331	8,304
Psychologists	5,928	5,935	4,598	5,553	8,650
Pharmacists	5,928	5,935	4,598	5,553	8,650
Social workers	2,034	2,036	1,577	1,905	2,968

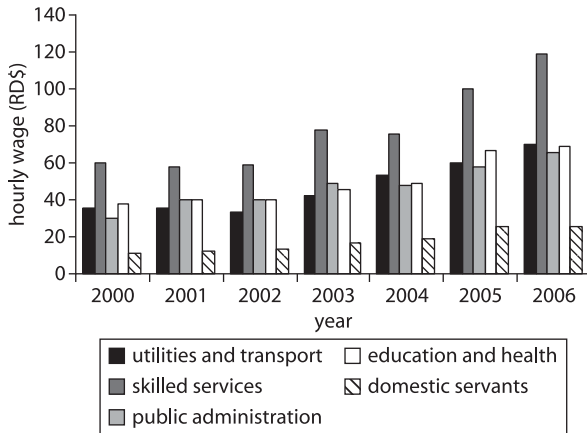
Source: SESPAS.

There are considerable differences in salaries for the same position, even within the same facility, in contradiction to the regulation. Variations in earnings are even more pronounced; for example, in the same health center, unlicensed nurses have earnings from RD\$2,039 to RD\$17,793.²

Unions play a major role in setting salary levels in the health sector. The salary scale for the health sector is separate from that of the civil service in general. Thus, SESPAS is free to change salary levels without any spillover effects into other sectors. Unions are very powerful in salary negotiations. Each year, within the budget cycle, the labor unions for each professional category negotiate with SESPAS to determine the salary levels of health workers. Strikes are very common in the Dominican Republic, as in the region in general, and the threat of strikes is a powerful force in shaping salary levels of health workers (Novick and Rosales 2006).

Real salary levels have increased in recent years, roughly at the same rate for all categories of health workers. Among the different health categories, physicians have the highest salary, followed by medical residents and graduate interns. Doctors make about twice the salary of nurses (see table 5.8). Real wages increased between 2001 and 2005 by 45 percent for both nurses and doctors.

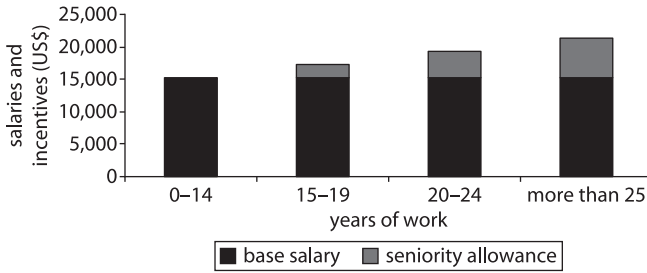
The increasing trend in health workers' salaries is consistent with increases in other sectors' wages. As shown in figure 5.10, health and education salaries are relatively comparable to wages in public administration, utilities and transport, and skilled services. These trends show that the increases in health wages between 2000 and 2006 are not specific to the health sector and instead reflect public sector wage bill pressures throughout the Dominican Republic.

Figure 5.10 Hourly Wage Comparison, 2000–06

Source: Socio-Economic Database for Latin America and the Caribbean, <http://www.depeco.econo.unlp.edu.ar/cedlas/sedlac/>.

Allowances make up a significant share of the overall earnings for health workers in SESPAS. In 2006, allowances and incentives constituted 14 percent of the overall wage bill. According to Article 20 of the Regulation for Human Resources for Health in the National Health System, health workers are entitled to certain allowances in addition to their regular salary. The purpose of these allowances is to attract, retain, motivate, and compensate health workers and to reward those who are outstanding and highly motivated. There are four primary categories of allowances. Fixed allowances are applied on the basis of seniority in the job and according to geographic location of the position. Variable allowances are based on performance and extra hours worked; they can vary across districts as well as from year to year. Short-term staff members do not receive allowances or incentives.

Fixed allowances are used to compensate those employees who work in more remote areas as well as to reward employees for years of service worked; they are included in the Regulation for Human Resources for Health in the National Health System. Allowances for years worked are relatively small and grow at a slow rate. As seen in figure 5.11, the seniority allowance does not begin until after 14 years of service for assistant doctors. Once a doctor puts in 14 years of service, he or she receives additional allowances for every 5 years of service after that point. Health workers have to work for many years to be so rewarded. For nurses, initial

Figure 5.11 Salaries and Incentives for Years at Work for Assistant Doctors

Source: SESPAS, May 2007.

allowances are given after 5 years of service, but they do not increase again until a nurse reaches 20 years of service. For assistant doctors and nurses working more than 25 years, the seniority allowance is 28 percent of their total compensation.

As in the case of salaries, allowances are subject to negotiations with unions. Results of negotiations are recorded in agreements signed by the unions and the government. Agreements vary from union to union; thus, allowances vary from cadre to cadre.

According to policy, allowances for working in certain geographic locations are supposed to be tied to the location, but in practice they are not. In contrast with the allowance for years of work, the geographic allowance is tied to certain positions in geographic areas. Rural allowances vary from cadre to cadre, as well as across locations. The allowance applies both to a newly hired staff member who fills a vacant position in a certain area and to a health worker who is transferred to a location eligible for the allowance. In practice, when the person leaves the location, the allowance turns into a permanent component of the worker's wage. This practice generates distortions in the objectives of the allowance. It also generates significant upward pressure on the budget allocated for rural allowances, because people keep claiming them even after leaving the original position. Additionally, the rural allowance is not enough to motivate health workers to reside and practice away from Santo Domingo.

Rural hardship allowances are provided to attract staff members to hardship areas, but these allowances are small relative to overall compensation. According to key informants, the allowances are unlikely to be adequate as a financial incentive for attracting staff members to these areas.

Variable allowances include incentives for good performance and working extra hours. These allowances are unpredictable and can vary

greatly both across districts and from year to year. Furthermore, in many instances they come as a result of union pressure and the threat of strikes by doctors. No clear regulation exists governing the amount of either of these two allowances, thus giving discretion to SESPAS to adjust them in accordance with the level of union pressure applied on an annual basis. The threat of strike by doctors is a predictable, annual event. Therefore, SESPAS expects that it will be forced to negotiate the level of these allowances on the basis of the pressure applied. This money is not allocated specifically for allowances in the budget; therefore, SESPAS funds it by reallocating funds away from other activities through a series of special transfers.

SESPAS has worked to develop a comprehensive framework for the performance-based allowance; however, it has never been fully implemented. Currently, much of the performance-based incentive scheme centers around institutional goals that are set with SESPAS. On the basis of a number of benchmarks, including number of patients seen, types of services provided, and level of facility, health facilities receive a certain amount of additional funds. These incentives are given as a fixed amount per person and as a percentage of the cost of a particular service, and they vary by type of facility. For instance, a specialized health center receives 7 percent of services provided, whereas a basic health center receives 5 percent of services provided. The scheme has never been implemented, and SESPAS is currently revising it.

The distribution and level of the allowance for extra hours worked allow the most discretion. For instance, evidence shows a dramatic increase of allowances in the form of recognized extra hours. These have increased from 2 percent of the total remuneration budget in 2004 to 14 percent in 2006. This large variation indicates this is the allowance the unions have the greatest power to influence through strike threats and other pressure. Given that health workers are required to work only 20 hours per week, unions can lobby to receive extra pay for a lot of potential extra hours.

Allowances do not provide clear incentives to health workers. In addition to the poor incentive structure, the implementation of the allowance scheme lacks transparency and equality. The seniority allowance is given only to those workers who have been working for 14 years or more, thus assuming that health workers will approach their careers on a long-term horizon. The rural allowance is not enough to draw workers outside Santo Domingo. The variable allowances are used as a way to appease union pressures instead of as a reward for performance or for working extra hours.

Promotion. The Regulation for Human Resources for Health in the National Health System states that promotions are to be governed by a performance evaluation system; however, because a performance evaluation system has never been fully implemented, promotions are based on other factors. Furthermore, the regulation lists a total of nine different steps of approval for a promotion to be granted. This intense level of bureaucracy makes receiving a timely promotion seem very difficult. Although SESPAS recognizes the need to change to a performance evaluation system, the lack of implementation can lead to low morale and frustration among health workers. Key informants suggested that promotion is based mainly on seniority and political favoritism. In addition, higher-level promotions are made directly by the president and are often independent of performance. The result is that high-level staff members have very short tenure, changing every four years or so.

Termination and sanctioning. A termination and sanctioning policy currently exists, but it is not followed. The employment regulations define conditions for contract termination. They clearly state that it will happen only in the event of disciplinary sanction, retirement, or voluntary termination of the contract. In practice, however, there is no evidence of significant layoffs among health workers as a result of sanctioning.

Key Messages

In response to an economic crisis and in line with recommendations of the International Monetary Fund (IMF), the government significantly reduced the size of the public sector wage bill. These wage bill cuts affected the health sector, but not as severely as other sectors.

The health sector accounted for a steadily increasing share of the overall wage bill. During the economic crisis, IMF recommendations were limited to targets for the public sector wage bill. In line with the wage bill targets, the government set sector-specific targets. No clear policy indicated which sectors were to be prioritized both during and after the economic crisis.

The health wage bill budgetary process is not very strategic and is politically driven. The experience highlights the importance of the budgeting process for allocating wage bill resources to different sectors. The health sector can be more strategic in its negotiations. It has to be seen how the new budget law will affect this process. In general, the new law stipulates the preparation of a results-based national development plan that will serve as the strategic framework for the annual budgeting process.

Not only for health but for all sectors, the budgeting process implies setting separate thresholds for the wage bill and nonwage expenditure, leaving SESPAS and regional health services with no control over how to allocate health spending resources across labor and nonlabor inputs. As a result, the share of nonwage health spending has fallen, despite more public sector wage bill resources being devoted to the wage bill. Whether this trend has had any significant implications for service delivery is unclear.

The final budget decision rests with Congress. In this approval process, strategic budget plans run the risk of being distorted by priorities set by parties and by pressures from local constituencies and labor unions.

In the absence of an explicit HRH strategy, wage bill resources have been used primarily to ensure that facilities are appropriately staffed. Unlike many other developing countries, the Dominican Republic has achieved almost universal geographic access to health services. Therefore, the government has made no major push to scale up staffing levels.

The Dominican Republic has one of the highest physicians per nurse ratios in the world. Partially the result of policies influenced by labor unions, this skill mix results in inefficiencies and is not conducive to the government's goal of strengthening primary care.

The government has had no explicit, comprehensive government strategy for HRH. In the absence of such a strategy, wage bill resources have been primarily used to ensure a minimum staffing of the public network of health facilities.

Negotiations between the government and labor unions have shifted to focusing on hours worked. Having approved a 10-year plan for the health sector, the government aims to develop an HRH strategy shortly. The development of such a strategy will, however, be hampered by a dearth of information on the performance of the workforce, including data on its size and distribution.

Limits on the expansion of the health wage bill, upward pressures on salaries from labor unions, and the implicit government strategy to ensure minimum staffing levels of the public health service network have led to several important developments in the labor market. Even though health has been prioritized within the overall wage bill, the health wage bill has not been growing fast enough to meet the salary demands of labor unions. The maximum hours worked stipulated in public sector contracts for health workers has decreased significantly to 20 hours per week. With such a low level reached, future upward salary pressures are unlikely to be diffused through decreases in hours worked.

Reduction of hours worked, in turn, has only been possible because the private sector is well developed and dual practice is prominent. With private sector work opportunities mainly located in urban areas, the current low-level equilibrium of pay and working hours is likely to be a major impediment to redressing geographic imbalances in the distribution of health workers.

The low-level equilibrium of pay and working hours has led to an increase in the use of temporary contracts. In many cases this contradicts present norms and regulations. For example, temporary contracts are used to pay health workers holding permanent contracts for extra hours. Currently, approximately 10 percent of the wage bill is used to pay for staff members contracted temporarily. Actual use of health resources for paying staff members on temporary contracts is likely to be higher than this number indicates, because resources flowing from the national health insurance are used for the same purpose.

There is scope to improve the recruitment process. Current recruitment and transfer policies as well as the current incentive structure for health workers—salary, allowance schemes, and promotion and transfer policies—are not conducive to addressing geographic distribution and staff performance. This problem leads to inefficiencies in how wage bill resources are spent.

The recruitment process is supposed to be managed regionally but is still carried out mostly centrally. It is also heavily influenced by pressures from various professional associations and unions.

The system of transferring staff is complicated, involves many actors, and is not based on needs assessments in different geographic areas. However, transfers to the capital—which has one of the highest staff per population ratios—are banned.

Salaries vary widely among individuals with similar responsibilities and from region to region, which is in contrast to the stated policy that salaries are to be determined by job characteristics. Labor unions play a large role in setting salary levels.

Allowances can be used more strategically. Approximately 15 percent of the wage bill is spent on allowances. However, the system is complex and does not provide incentives to address the major challenges of imbalances in geographic distribution, low productivity, and poor quality of care. Labor unions also heavily influence the use of allowances.

Sanctioning, promotion, and transfer practices are not carried out according to policy. They do not provide incentives for good performance.

Notes

1. Note that these numbers are for SESPAS only and not total government health expenditure.
2. This information has not yet been published and is still in the evaluation process at SESPAS.

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