HEALTH POLICY AND PLANNING; **14**(2): 115–126

Political analysis of health reform in the Dominican Republic

AMANDA GLASSMAN[1] MICHAEL R REICH,[2] KAYLA LASERSON,[3] AND FERNANDO ROJAS[4]

[1]Inter-American Development Bank, Washington DC, USA, [2]Harvard School of Public Health, Boston, USA, [3]US Public Health Service, Centers for Disease Control and Prevention, Atlanta, USA, and [4]Medical Doctor, Dominican Republic

This article examines the major political challenges associated with the adoption of health reform proposals, through the experience of one country, the Dominican Republic. The article briefly presents the problems of the health sector in the Dominican Republic, and the health reform efforts that were initiated in 1995. The *PolicyMaker* method of applied political analysis is described, and the results of its application in the Dominican Republic are presented, including analysis of the policy content of the health reform, and assessment of five key groups of players (public sector, private sector, unions, political parties, and other non-governmental organizations). The *PolicyMaker* exercise was conducted in collaboration with the national Office of Technical Coordination (OCT) for health reform, and produced a set of 11 political strategies to promote the health reform effort in the Dominican Republic. These strategies were partially implemented by the OCT, but were insufficient to overcome political obstacles to the reform by late 1997. The conclusion presents six factors that affect the pace and political feasibility of health reform proposals, with examples from the case of the Dominican Republic.

Introduction

In the early 1990s, countries throughout Latin America initiated the process of reforming their health sector policies. These efforts received unprecedented levels of financial support from multilateral institutions, especially the World Bank and the Inter-American Development Bank (IDB). World Bank lending in health in Latin America quadrupled in a five-year period, to over US $900 million a year in 1995 (World Bank 1995). IDB activity added to this total, increasing total lending in the Latin American health sector to nearly US $2.2 billion in 1995, with the expectation that IDB lending in education and health would continue to grow.

Yet little attention has been paid to the major political challenges associated with the adoption and implementation of health reform proposals. Reform is a profoundly political process that affects the allocation of resources in society, and often imposes significant costs on well-organized, politically powerful groups. This article presents a method of political analysis for health sector politics, and identifies key patterns in the politics of health reform proposals. The article uses the experience of one country, the Dominican Republic, to illustrate the political challenges of health reform.

Health sector reform has been variously defined. In this paper, we define health sector reform as those activities undertaken cooperatively between the international development banks and a national government to alter in fundamental ways the nation's health financing and health provision policies.

This limited definition focuses on the processes around the design and adoption of new health policies, occurring through an interaction between international lending agencies and national government bodies. The proposed policies usually seek to build a self-sustaining national health care financing system as the primary goal. Secondary goals include greater coverage for basic health services at a lower cost per person, rationalized decision-making within public sector health agencies, institutional reform, and expanded access for disadvantaged populations.

Health sector reforms are politically problematic. In many countries considering reform, the most powerful health sector actors are often satisfied with the status quo – despite serious problems in the distribution of health services, quality of care, patterns of utilization, efficiency, and equity. Moreover, the proposed policy changes are often perceived as politically and economically painful decisions in the short term. One of the most important and complex problems in the process of health reforms is the management of these short-term, concentrated costs, and of the powerful groups affected.

Reform proposals create the perception that a major redistribution of the benefits and costs within the health system will occur, but *how* and *when* that redistribution will occur is unclear. In contrast to education reform, which usually entails increasing budgets, building new schools, and hiring teachers, health reform seeks to radically alter the social contract between citizens and the government, changing physician payment schemes, introducing patient payments, and limiting reimbursable services to affluent social groups. Politically, health reform proposals resemble structural adjustment policies, but without the national mandate for change accorded to adjustment.[1] In addition, health reform policies confront more complex obstacles in implementation, compared to

structural adjustment policies, because of the nature of the decisions and institutions involved.

Both multilateral institutions and national health reform teams have experienced some difficulty in understanding and navigating the political economy of health sector reform. This paper reports on an effort to try to improve the understanding and the navigation. The paper first reviews a method for applied political analysis. We then explore the background of the Dominican health sector, and apply the method to the reform proposals in the Dominican Republic. Finally, we draw some general conclusions about the political processes of health sector reform.

Applied political analysis

The method of applied political analysis known as *PolicyMaker* was used in this project to assist decision-makers in analyzing and managing the politics of health reform in the Dominican Republic. The method provides a systematic analysis of the probable consequences of policy reform efforts, the positions of support and opposition taken by key players, the political, financial, and other interests of key players. It then assists decision-makers in initiating the process to design strategies for managing the politics of policy reform (Reich 1996; Reich and Cooper 1996).

In the software format, *PolicyMaker* uses a series of matrices to guide the analyst through five steps of political strategizing. The framework prompts the analyst to: (1) define the content of the policy under consideration; (2) identify political players, their interests and relationships; (3) analyze opportunities and obstacles to the policy in the political environment; (4) design political strategies; and, (5) assess the potential and actual impacts of proposed strategies. The analyst can complete each matrix, or can be selective according to the objectives of the analysis.

The method assists policy analysts with the political dimensions of policy change in five ways. First, the method provides a systematic assessment of the political environment in which health sector reform policies are formulated and implemented. At a minimum, the method provides a tool to describe the political dimensions of a policy decision, and then to organize and prepare the data for analysis. Second, the method provides practical assistance in the design of political strategies. The software includes a tool box of 31 'expert-suggested' political strategies that can be modified by the user. Third, if conducted by a team analysis, the method helps to make explicit the team's assumptions about how a new policy will be adopted, and forces the team to explain and justify those assumptions. This reflective process helps to enhance the coherence and feasibility of the policy. Fourth, if conducted with interviews of key stakeholders, the method helps validate the reform group's perceptions about other stakeholders, and helps the reform team view the policy from the perspectives of other stakeholders. Fifth, the process of performing the analysis helps create a sense of common language and mission for some reform groups. The analysis encourages reform groups to make their strategies explicit, and rethink the strategies, taking into account the interactions among policies, players, and positions. Finally, the process strengthens the reform group's capacity to advocate for reform policies.

Put another way, this method helps policy-makers and policy analysts do what they should do anyway: systematically analyze the support and opposition for a proposed policy; consult with the major stakeholders on their views; analyze opportunities and obstacles to change; design a set of creative and effective strategies for change; and assess and track the processes of implementing those strategies.

In the case of the Dominican Republic, three consultants (AG, KL, MRR) were financed by the IDB to work with the government's health reform group (headed by FR) to define the policy, interview key players, and propose strategies. The analysis was carried out by a team of 'insiders' and 'outsiders', in order to minimize analyst bias through group discussion and collective judgment. As with any social science methodology, however, the method cannot eliminate unpredictable elements in the policy-making process.

In this case, 35 guided interviews with key figures in the health sector were conducted in the Dominican Republic between July and November 1995. Both published and unpublished documents were collected and reviewed, and the national press was monitored closely for one year following the interviews. This paper presents some results of the analysis, and the conclusions reached.

The health sector in the Dominican Republic

The Dominican health sector

The Dominican health sector exhibits a number of systemic problems, typical of many countries in Latin America. These problems include inadequate financing, low coverage, inequitable distribution of services, an emphasis on curative care, fragmented vertical programming, redundant and underused facilities, inefficient institutions and personnel, corrupt bureaucracies, and unregulated private health services.

By the early 1990s, many Dominicans felt that the health sector was in crisis: preventive and curative services were low-quality, irregular, concentrated in the capital and in tertiary care facilities, and highly inefficient. The sector had experienced one of the largest and longest (8 months) strikes in the country's history, with the Dominican Medical Association (Asociación Médica Dominicana – AMD) showing its power to control the functioning of government health services. As in many other countries, doctors work in both the private and public sectors, usually squeezing their public sector obligations, where they are poorly paid, in order to attend to their private practices. Remuneration is not connected to performance. Physicians working in public hospitals regularly refer their patients to their private clinics for procedures, and some physicians use public sector facilities to conduct for-profit procedures.

The Secretariat of Health (SESPAS) and the Social Security Institute (IDSS), the largest institutional actors in the public

sector, have shown little capacity to respond to the major problems in the health sector. Both institutions have been used extensively for political patronage and have limited technical capacity. The average stay of a Health Secretary is less than eight months. Although almost 60% of the population falls below the poverty line, subsidized government services through the Ministry cover only 35% of the population (Santana and Rathe 1994). SESPAS is organized vertically by programme, and focuses mostly on curative, tertiary level care.[2] IDSS, with its own networks of hospitals and clinics, covers only 6% of the Dominican population. Many businesses now pay double for health care – an obligatory payment to the IDSS, plus payments to cooperatives of private providers for health insurance. Evasion of the IDSS scheme is widespread. As a result, the private sector has grown rapidly but with minimal regulation. The private sector now represents the primary source of health financing and service provision in the Dominican Republic. While health service infrastructure is plentiful in both the public and private sectors, access is highly inequitable since it depends on an individual's ability to pay. According to the 1991 Demographic and Health Survey, approximately 60% of persons who reported a serious illness in the past month did not seek medical care, principally for economic reasons.

Recent efforts at health reform

The Dominican Republic has experienced several waves of policy responses to problems in the health sector. In November 1992, SESPAS received funding from the United Nations Development Program (UNDP) to undertake a project of 'modernization' of the Dominican health system. For more than a year, a group of Dominican professionals elaborated policy proposals for reforms, in consultation with health sector players and with technical assistance from UNDP. Late in 1993, the results were disseminated to policymakers. The proposals included recommendations to rationalize human resources policies, including the introduction of new forms of physician payment, and a 'new model of care'. For political and financial reasons, including the absence of a forum in which to continue reform discussions, no follow-on activities resulted from this first wave of reform efforts.

The second wave occurred between October and May 1995, when the health commission of the national legislature introduced a 'National Health Law', written by deputies from the Partido de la Liberación Dominicana (PLD) with technical assistance from SESPAS and PAHO advisors. While recognizing many of the problems of the sector, the proposed law read like a long list of special-interest programmes. Each disease and programme priority was included, based largely on a 'traditional' public health paradigm, while little attention was paid to the methods for financing health services, the roles of existing health sector institutions, or the regulation of the private sector. The bill was intended to replace the Dominican Republic's 'Sanitary Code', which contains special provisions for regular salary raises for doctors working in the public sector. Although these provisions have never been implemented (since 1956), the new law was opposed by the AMD (OCT 1995b). Some perceived the bill as part of pre-electoral political positioning by PLD, rather than a genuine reform effort. Debate around the bill lasted nearly a year, and then died.

At about the same time, in January 1995, an executive decree created the National Health Commission (CNS) with a mandate to promote 'modernization' of the health sector. The Office of Technical Coordination (OCT) was created to design a health reform plan under the auspices of the CNS. The OCT operated primarily with project funds from the IDB and the World Bank, with occasional assistance from the Pan-American Health Organization (PAHO), the US Agency for International Development (USAID), and other donors. Initially, the OCT operated under the CNS; however, in 1997, the OCT was shifted organizationally to the SESPAS, although the OCT maintained separate offices in Santo Domingo away from the ministry.

In this third wave of health reform, the OCT was asked to draft a reform 'white paper' with technical assistance from consultants in the first half of 1995. The 'white paper' was to serve as the basis for assessing the technical feasibility of various reform initiatives and as a first attempt to change the discourse on health sector transformation in the country. Reform studies were commissioned by the OCT from national and international consultants using non-reimbursable technical cooperation monies from the IDB and donated funds from the Government of Japan through the World Bank and the UNDP.

Reform studies addressed the following topics, in chronological order: (1) hospital autonomy; (2) SESPAS re-organization; (3) SESPAS financing systems; (4) IDSS reorganization; (5) prepaid health systems (*igualas*); (6) incorporating NGOs into health sector reform; (7) survey on use of and satisfaction with health services; (8) financing of public expenditure in health; (9) health expenditure module as part of the DHS; (10) personnel administration systems; (11) burden of disease and basic package definition; (12) pharmaceutical and supply stocks at SESPAS; (13) accreditation and re-equipping health services; (14) decentralization of SESPAS; (15) design of a new social security system; and, (16) a legal and regulatory framework for social security reform in the Dominican Republic (OCT 1995a). As the product of intensive collaboration between the OCT and the multilateral development banks, with a great deal of autonomous leadership from the OCT, the studies were intended to lay the groundwork for implementing reform activities in these 16 specific areas. The OCT has monitored the progress of and payment for the 16 studies.

In addition, the OCT expected to manage the process of reform. For example, the OCT was expected to secure high-level political support for reforms among government leaders, especially the Secretary of Health, the Director of Social Security, and the President of the Republic. More broadly, the OCT was intended to prepare government agencies, other interest groups, and society at large for accepting and implementing the reforms. The reform studies were intended to play a major role in this preparation, and usually involved staff members from the affected institutions.

The OCT 'white paper' recommended the following reforms: (1) the separation of financing from provision of services within SESPAS and IDSS; (2) the massive expansion of IDSS coverage; (3) the definition of a cost-effective basic package of services to be financed by the public sector; (4) hospital autonomy; and, (5) linkage of productivity and incentives in the health work force (e.g. through physician contracts). This set of recommendations, published as *Salud: Una Visión del Futuro*, was taken as the 'policy' for this applied political analysis (OCT 1995a).

In 1995, the OCT had seven staff members, primarily technical, with one public relations person part-time. The CNS included 33 health sector 'actors' and had no clearly defined decision-making structure, but had taken most decisions through voting. All votes (through November 1995) were unanimous, and voting was initiated by the chair of the CNS, the Secretary of Health.

Political climate

In June 1995, the Dominican Republic was one of the poorest countries in Latin America. In 1988, it had the third lowest Gross Domestic Product (GDP) per capita in the Americas, after Haiti and Bolivia. Despite respectable economic growth rates in the 1980s, the economic crisis (followed by structural adjustment policies) impoverished the country in the 1990s. The Dominican Republic was one of the last of the aging dictatorships in Latin America. When health sector reform design began, Joaquín Balaguer had been president of the country for more than 50 years, off and on. The political system can be categorized as 'clientelistic'. As one study of Dominican political culture put it, 'The Dominican political system is theoretically organized along formal democratic principles, however, it is essentially informal operationally' (AG translation, Cross-Beras 1985). It is a limited pluralist system without accountability, and without an explicit political ideology. Most decisions, national or otherwise, were taken by the President personally.

Although SESPAS is the major public provider of health services, in recent years the Secretariat of the Presidency has become a significant source of health financing, especially for the purchase of plant, equipment, and supplies for SESPAS facilities. In 1991, for instance, the Secretariat of the Presidency was the source of 38% of public expenditures on health (IDB 1997). An unpublished study on the health sector found that SESPAS decisions on even micro-level budgeting and personnel issues lay with the President of the Republic (Perez Uribe et al. 1974). In June 1996, the Dominican Republic held democratic elections which resulted in the election of Leonel Fernández, a young US-educated lawyer.

In contrast to the longevity of the Presidency, other political leaders have a short duration in office. Few political appointees are able to acquire effective capacity to manage the technical or organizational challenges of their policy domain. Between 1930 and 1974, 37 people served as Secretary of Health. A similar turnover has affected the directorship of the IDSS: 21 vice ministers in the past two years. This lack of continuing leadership has left the poorly paid but stable bureaucracy in charge of the health system. The bureaucracy, however, is also very conservative, not well trained, accustomed to certain privileges (to offset the low salary) and fearful for their jobs. In this sense, any change in the system that could increase the degree of formal control or the grade of institutionalized procedures implies a significant reduction in the discretionary power of the bureaucracy. The bureaucracy, therefore, has tended to oppose reform in principle and in practice.

Analysis of the 1995 OCT reform proposal

This section analyzes the political circumstances around health sector reform using the *PolicyMaker* method. The analysis uses the OCT 'white paper' of July 1995 as the reform proposal, and considers the OCT its primary client. Two major objectives are: (1) to assess the political feasibility of the reform proposal, as of mid-1995, and (2) to propose strategies that could enhance the political feasibility of the reform process. Before designing strategies, *PolicyMaker* analyzes policies along three dimensions: policy content, players, and environment (opportunities and obstacles). These three dimensions frequently intersect. A player's position may emerge out of a complex combination of its reactions to the policy content, the player's interests, relative power, and relationships with other policy actors, and the internal and external organizational environment.

For this case study, we first review the content of the reform policy under consideration. Second, we analyze the players, by exploring the interests, power, and position of the dominant policy players, with reference to relevant aspects of the reform proposal. Third, we review the external opportunities and obstacles that the OCT faced in the policy environment. Finally, we present the strategies that were designed in the Dominican Republic, using the *PolicyMaker* method, for OCT to consider in managing the reform process.

(1) Policy content

Policy proposals for health sector reforms supported by the multilateral development banks are similar across Latin America, responding to similar challenges within public health bureaucracies. At the time of the analysis, proposals followed the ideas presented in the *1993 World Development Report*, and built on the World Bank's seminal 1987 policy study, *Financing Health Services in Developing Countries* (Akin et al. 1987). The reforms have usually included three levels of policy goals and mechanisms.

First, the reforms define broad governing principles. In the Dominican Republic, the principles were universal access, equity, solidarity, quality, freedom of choice, efficiency, efficacy, and transparency.

Second, strategic guidelines are developed that set out more specific parameters for a restructured health system. In the Dominican Republic, these guidelines included: (1) the design of a single system, organized functionally (regulation, financing, policy, provision); (2) a shift towards preventive services; (3) a strengthened regulatory role of the state; (4)

increased financing for the health system; (5) guaranteed benefits for affiliates; (6) efficient systems; and, finally, (7) the facilitation of social participation in the health system (OCT 1995a). These strategic guidelines represent policy goals, but they do not specify how to achieve the goals, which may have contradictory objectives.

The third level provides more specific policy mechanisms. In the Dominican Republic, policy mechanisms were defined in four areas, according to the OCT in 1995. Similar proposals can be found in other Latin American countries undergoing health reform:

1. development of a new model of rationally determined, publicly financed health services that would ensure a basic basket of cost-effective interventions, namely preventive services, available to the entire population;
2. decentralization and restructuring of the ministry of health and the social security institute;
3. transformation of the state's role from direct service provider to financer and regulator; and,
4. creation of managed competition through government contracting with both public and private sector providers.

(2) Players

Assessment of political feasibility requires an analysis of the stakeholders – the political actors affected by or affecting a given policy. These actors are called the 'players' in *PolicyMaker*. The field of policy analysis has not produced a single or simple method for assessing the characteristics of players involved in policy change (Reich 1996). *PolicyMaker*, therefore, combines a number of analytical methods. The basic analysis requires an assessment of each player's position on the policy (support, opposition, or non-mobilized position), power (resources available to use in the policy debate), and intensity of position (high, medium, or low, depending on the willingness to use available resources in the policy debate). In this analysis, a player can be either an organization or an individual, though the analyst might consider weighting these groups differently, according to their power resources.

In our analysis of health reform in the Dominican Republic, the players were divided into five key groups: public sector, private sector, unions, political parties, and other non-governmental organizations.

Public sector: SESPAS and IDSS

The reform proposal has profound implications for the public sector, especially the Ministry of Health (SESPAS) and the Dominican Social Security Institute (IDSS). Political resistance in the public sector was anticipated particularly around the issues of hospital autonomy and institutional restructuring.

A 1985 evaluation of SESPAS described it as a government agency suffering from 'overall inoperativeness'. SESPAS and IDSS lack the internal structures, formal lines of command, functional definition, administrative machinery and policy-making capacity to effectively execute current mandates or to meet longer-term institutional objectives. Decision-making is usually concentrated in an individual, and accountability is diffuse. An attempt at regionalization of SESPAS failed and local officials lack authority. Services are poor in quality, and coverage is low. Human and material management is deficient. Nearly all appointments are made at the central level by the Minister (or the President) without the knowledge of division chiefs or facility managers. Mismatches result between human resource supply and service demand. For example, several SESPAS facilities have up to 50% more medical personnel than necessary to meet demand, while other facilities are closed due to lack of personnel (IDB 1997).

Considerable confusion exists concerning the role of SESPAS within the sector because the Secretariat of the Presidency administers nearly one-third of government health spending, and little coordination of any kind exists among public sector health institutions. Linkages between the public and private sector are absent. Each institution makes policies, sets plans and implements programmes more or less independently. This, in turn, contributes to stratified access to health care, concentration of resources in large cities, duplication of infrastructure and service provision, and overlapping financial arrangements. For example, household surveys show that 50% of IDSS enrollees do not use IDSS services, while 50% of users of IDSS services are not enrolled in IDSS. In some rural areas, NGOs and SESPAS provide similar services to the same population groups. A significant percentage of the poor bypass 'free' SESPAS facilities, seeking care at fee-for-service private clinics.

Hospital autonomy

After the public release of the 'white paper' in 1995, the Secretary of Health and the OCT were accused of 'privatizing' the health sector. While it is true that the management of publicly owned hospitals through contracts is not privatization, especially since the government would guarantee subsidies for preventive services and basic ambulatory care (F. Rojas 1995), elements of autonomization can have (and can be perceived as having) the same political and social effects as privatization has had on other state industries. That is, hospital autonomization does imply that current government employees become employees working under contract, without a lifetime guarantee, which allows for discretionary firing and a complete break in the traditional relationship between the state and physicians. Hospital autonomization also implies that public sector hospitals would compete with the private sector to provide the basic package of services; that the hospital director would have discretion over budgets, and that the central SESPAS would not; and that any services provided in excess of basic ambulatory care would not be subsidized by the government.

For all these reasons, the SESPAS bureaucracy, though not fully cognizant of the potential implications of the reform, was extremely wary of the proposal. And the AMD was highly opposed to hospital autonomization, due to the loss of job security that physicians would face under this system. Hospital directors, who stand to gain in status and control,

were pleased with the idea, but were not organized. Overall, there were serious concerns about the technical capacity of hospital staffs to manage the process of autonomization and re-orient the hospital to a competitive environment.

Institutional restructuring

The processes of institutional restructuring present serious challenges. For the Health Secretary, restructuring could mean political suicide if the AMD were to mobilize against the plan. Any benefits from the policy reform are likely to be long-term and difficult to perceive as tangible. For the bureaucracy, restructuring is feared, because it would disturb the status quo, create a threat to job security, and upset established ways of doing things. For physicians, institutional restructuring places the AMD's organizational autonomy and negotiating power at stake. For hospitals, it represents a change from the status quo, which is so negative at present, that any change is perceived positively.

IDSS faces many of the same issues. Restructuring for IDSS has similar implications as for SESPAS, but with the added nuance that IDSS would be forced to stop its direct service provision altogether. Under the reform, all financing of health services for formal and informal sector employees would be provided through the IDSS. Many observers outside of IDSS were surprised that IDSS could be considered a responsible controller for funds, given its history of political patronage. Most likely, the reform proposal would be revised to remove IDSS (not government) from the collection and disbursement of funds.[3] However, if this were to occur, then IDSS would have few tasks remaining in health services.

This is not the first attempt to restructure the IDSS. Created in 1948 during a wave of Bismarckian-style social security, the IDSS was primarily a response to pressures from the cane-cutters union. Its political patronage functions have persisted over time. In 1982, the President, three of the major trade unions, and the main employers' association, with assistance from the International Labor Organization, endorsed a legislative draft to expand IDSS health care coverage to all salaried workers in both the private and public sectors regardless of salary level (removing a cut-off that exempted most white and blue collar workers from obligatory payment). The reform presented a politically viable solution, given the power of the AMD. A last-minute revision of the bill, prepared by a group of civil servants who did not want to be required to pay into IDSS instead of their current private insurers, restricted care to IDSS-owned facilities, which were notoriously poor quality. This revision eliminated free choice to use private facilities, a central element of the bill. The strong opposition of the private sector then defeated the bill in Congress. High-salaried employees, who would have been incorporated into IDSS after the projected elimination of the salary ceiling, also opposed the amendment because they would have been required to pay contributions but did not want to use IDSS services. The bill's defeat strengthened the private sector and contributed to further erosion of the IDSS public image (Mesa-Lago 1978, 1989, 1992).

In 1994, a private think tank and the association of employers published a plan for health sector reform that proposed the elimination of IDSS. The new IDSS director accepted the proposal, but was fired shortly thereafter. The position of the subsequent directors was not known officially. At the time of analysis (1995–96), IDSS's technical office questioned the value of contracting and seemed to reject the idea of eliminating its role as a direct provider of health services.

Transformation of the state's role

Bank-financed health sector reform is meant to transform the state's role from direct service provider to financer and regulator, but the details of this transformation are unclear. There is some ambiguity on how the state becomes 'financer and regulator'. At the time of our interviews in the Dominican Republic in 1995, 'separation of financing and provision' was interpreted in the press as the 'privatization' of health services provision and created reluctance among political leadership to support health sector reform with enthusiasm: political leaders of SESPAS (SecSal) and IDSS (IDSSDir) were thus classified as high-power actors in low support of the white paper. In the pre-presidential election period (September 1995 to May 1996), this reluctance was expected. In the post-election period, the issues were still unresolved. A distinction was also made between political leadership and SESPAS and IDSS bureaucracies in the analysis, as these groups had contrasting interests in the process. The SESPAS bureaucracy (SESPBur) was considered high-power and low-support at the time of the white paper, while the IDSS bureaucracy (IDSSBur) was medium-power and low-opposition, with potential to move to high opposition in the near future.

Private sector: private clinics and igualas

The private sector is highly opposed to regulation, having operated profitably during the progressive decay of public sector services. Approximately 15% of Dominicans, primarily formal sector employees, belong to employer prepayment plans, known as *igualas médicas*, which cover a basic package of 'equal' services. The plans compete on price, service quality, and completeness. In principle, consumers of *iguala* health plans would welcome government financing of these services, but would resist any attempt to be incorporated into government-provided services. If formal sector employees were obliged to contribute to the public sector (in order to finance the rest of the health system), then formal sector employers who are not already evading payment would be expected to resist further. This practice (the so-called *doble cotización* or double payment) has been identified as an agenda item for small and large business organizations.

Employer discontent (and evasion), along with the private sector's resistance to regulation and the formal sector consumer's aversion to government-related (financed or provided) services, make the decision to move towards a managed competition model difficult for the government. While the private sector is expected to gain under managed competition, the *igualas* would probably be more profitable if

they can continue to restrict plan entry to the relatively healthy and wealthy, which would probably occur more easily without reform. Private health sector players (private clinic/*iguala* owners – PrivClin – and employers – EMPLOYER), while expressing basic agreement with the reform's principles, were lukewarm towards the white paper, and based on an analysis of player interests were classified as moderately opposed, high-power players.

Unions: the AMD

A key feature of the Dominican health sector is the near-omnipotence of the physicians' association (AMD).[4] In the past, every negotiation between the government and the AMD has ended with government concessions. As part of this process, the AMD strikes frequently and for long periods of time. In 1996, for example, the AMD held an eight-month strike for higher wages and increased job security. This strike came after an extremely generous settlement, in which the government promised to double all doctors' salaries in the public sector, waive import taxes on vehicles, and provide public housing. The strike was perhaps precipitated by the government's inability to finance its health services, much less provide housing to doctors. During this time, the government agreed to pay doctors their salary for the time missed, and still, the AMD remained on strike pending resolution of the 'situation' of IDSS doctors. This situation is particularly deplorable since physicians are supposed to work eight hours a day legally, but typically work only two hours a day and spend an average of two minutes per patient (Mesa-Lago 1992). In addition, they are frequently absent, delay hospital dismissals, violate rules, and reject any effort to introduce planning, set work schedules, or enforce the budget (Mesa-Lago 1992).

The AMD is led by an experienced union organizer, and the Secretary of Health, usually inexperienced in negotiation given his short tenure, is the AMD's primary target. If the Secretary is unable to meet the AMD's demands, the organization has often been able to pressure the President to remove the Secretary. The AMD is also able to mobilize quickly against journalists and policy-makers who attack their interests publicly. The AMD was considered a high-power actor, highly opposed to the white paper in principle and in practice.

Political parties: Fernández and the PLD

Leonel Fernández, who was elected President as a member of the Partido de Liberación Dominicana (PLD) in 1996, produced an elaborately detailed, Bill Clinton-style governing plan. The plan placed health reform at the bottom of a 24-item list of priorities and left it undefined (Partido de Liberación 1996). During an interview conducted in August 1995 with the current vice-president, Dr Jaime Fernández Mirabal (then a PLD senator), the reform group was advised to stop using 'economic terminology' in their proposals and to focus on 'decentralization issues', consistent with the democratization rhetoric favoured by the PLD. Leonel Fernández's position on the AMD strike, which occurred before he took office, was that the President of the Republic should negotiate directly with the head of the AMD, and should continue to make concessions on most issues, rather than delegating this task to the Secretary of Health, thereby undermining the efforts of the Secretary of Health to be firm with the AMD. This position agrees with Dominican political culture, as described earlier, where power is concentrated in the President.

These expressions of position and power do not necessarily indicate that the President is fully opposed to the OCT 'white paper'. However, they do indicate that he is not supportive, and that he will not serve as an advocate. The Secretary of Health, who was replaced in January 1997, could be an important factor in the reform process. Thus far, however, the Secretary has been remarkably uninvolved in planning for reform. The passivity of Balaguer's last Secretary of Health could be linked to a protracted 'lame duck' period prior to the elections. In the case of the new government, the Secretary's tepid support is notable and could have significant consequences for feasibility. The President (PRES) at the time of analysis was classified as high-power with a non-mobilized position. The PLD, currently in office, was classified as a high-power, low-support player.

Non-governmental organizations (NGOs)

While NGOs were expected to be supportive of reform plans to expand coverage to the entire population and provide more preventive services, the interviews did not find much support for reform among NGOs. NGOs initially focused attention on the creation of a basic package of services using cost-effectiveness criteria. NGOs focusing on preventive care services felt that many elements of equity were not well served by an application of cost-effectiveness criteria, which were not connected to a concept of health as a right. NGO staff published press articles criticizing the OCT for using 'economic' criteria where they 'don't belong', that is, in the health sector (O. Rojas 1995a, 1995b). This criticism had the potential of associating reform with particular 'victims', such as children who would not receive emergency interventions that fall outside of the basic package. Other groups, which provided specialized forms of care and received government monies, such as the *Asociación Dominicana de Rehabilitación* or the *Liga Dominicana Contra el Cáncer*, feared that reform would decrease resources available to their work. While NGOs are generally not very influential on the national political scene in the Dominican Republic, they have sufficient resources to access the media, to shape public perceptions of health reform, and thereby to influence the reform process in the CNS. NGOs were classified as low-power, low-opposition players.

At the time of our analysis (July–November 1995), most political players were essentially non-mobilized with regard to the health reform proposal (the National Health Commission – CNS; beneficiaries – BENEFS; the press – PRESS; universities – UNIV; and the Church – CHURCH), although many players' interests clearly conflicted with the white paper. Even when players expressed nominal support (such as the Secretary of Health), the interviews suggested that most players preferred to wait for completion of the studies and proposals before taking a position. This lack of involvement forced the

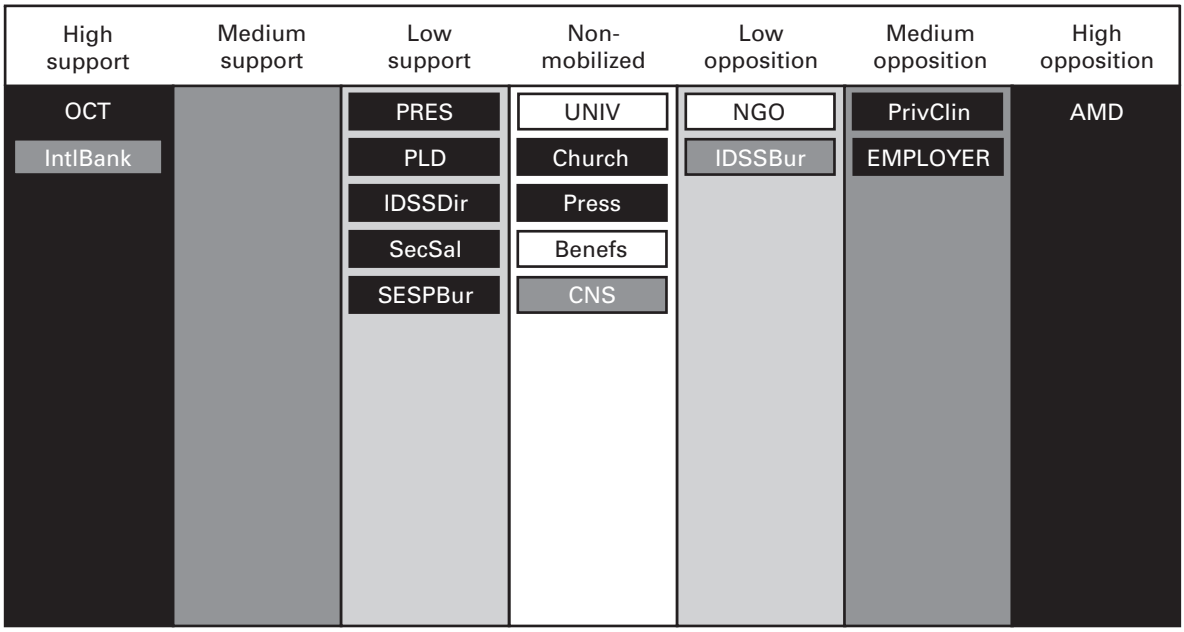

Figure 1. Position map for major players in health reform in the Dominican Republic in 1995 (abbreviations in text)

OCT and the Banks to become the main advocates for health reform, a politically problematic situation. (See Figure 1 for a position map for the major players in the Dominican health reform.)

(3) Opportunities and obstacles

The *PolicyMaker* analysis also produces a systematic assessment of opportunities and obstacles to the policy change under consideration. As many of the obstacles were discussed above, this section focuses on the opportunities. An important opportunity lay with the OCT, which had ample financial resources from international agencies, relative independence from other health sector players, excellent technical staff, and a vision of how health reform could work. These strengths created a good negotiating position for the OCT within the health sector and civil society. The small staff, however, limited the OCT's ability to respond quickly to political challenges in the media and the health sector. The reform process was just beginning, which gave the OCT substantial flexibility in planning.

In the larger political environment, there was broad consensus that the Dominican public health system suffered from multiple problems and needed serious improvement. This realization was occurring at the same time as the Dominican Republic approached its historic transition to democracy and the country's first democratic elections. The pre-electoral environment in late 1995 and early 1996 limited the willingness of politicians and political appointees to take a leadership position on health reform, but created the hope that a new government might adopt proposals developed by the OCT. Another opportunity was that the AMD and SESPAS had recently completed a negotiation that resulted in a favourable outcome for the AMD, which might facilitate the changes required in health sector reform.

(4) Strategies

PolicyMaker provides a tool box of 31 basic political strategies for enhancing the feasibility of policy reform and a matrix for defining strategy actions and associated risks, problems, and benefits. Strategies are usually designed with the client's full collaboration, to assure that the proposed strategies are relevant and realistic under the time and resource constraints. Table 1 provides a summary of the strategy design exercise for health reform in the Dominican Republic.

Facing competing priorities and upcoming elections, the OCT executed a selection of the strategies in Table 1. The OCT created common ground and vision (strategies 1 and 2) through the official debate and publication of the white paper by the CNS. An indicator of this success was the subsequent publication of institution-specific (SESPAS and IDSS) reform proposals that differed minimally from the original white paper (strategy 8). The mobilization and preparation of key actors was limited by the pre-electoral environment (strategy 4); however, the passive role of the Secretary of Health during this period seemed to activate debate within the CNS. Contrary to expectations during the analysis about the ineffectiveness of external commissions, the CNS provided an excellent sector-wide forum for discussion (strategy 10, 11). But the decision-making processes in the CNS were never fully defined (strategy 3), and its existence depended on a presidential decree issued under Balaguer. Consequently, the CNS did not survive under the new Administration.

Table 1. Summary of *PolicyMaker* strategies

Strategy name	Actions
Strategy #1 OCT: Create Common Ground	1. Seek common ground with other organizations. 2. Identify common interests. 3. Link different interests – invent new options. 4. Make decisions for opponents easier.
Strategy #2 OCT: Create a Common Vision	Keeping in mind that the principal obstacles to reform are not only technical: 1. Create an atmosphere of shared values, unified leadership. 2. Articulate a common vision of equity and the respective roles of the public and private sectors.
Strategy #3 Define the Decision-Making Process	At the time of the analysis, there was no formal procedure for decision-making in the CNS, so: 1. Formalize process for the approval of the 'white paper.' 2. Legal efforts to formalize this process may be fruitful.
Strategy #4 CNS: Mobilize and Prepare Key Actors	1. The Secretary of SESPAS should be positioned to take a strong position of leadership. 2. The Director of the IDSS should be prepared to take a clear position on the reform of the IDSS. 3. Key actors within SESPAS, IDSS, and the CNS should limit their discussion to the specific components under consideration.
Strategy #5 OCT: Initiate Pilot Studies	1. Select pilot study sites according to technical and political exigencies.
Strategy #6 OCT: Political Parties/ New Government	1. Meet with political candidates and their technical staffs. 2. Attempt to integrate health reform policies and the ideas of the 'white paper' into political debate and discourse.
Strategy #7 OCT: Initiate Strategic Communications	1. Initiate strategic contacts with the press, responding to critical attacks (except those of the AMD). 2. Place key decision-makers in the media.
Strategy #8 SESPAS and IDSS: Manage the Bureaucracy	1. Identify possible opposition and involve them in the technical design of the reform.
Strategy #9 OCT: Strengthen Alliances with International Organizations	1. Request technical-political assistance from the IDB and the WB in order to respond more effectively to common critiques of the WDR-style reforms. 2. Work together with PAHO in concrete areas. 3. Ask for donor support for the vision of reform articulated by the OCT and define their active participation in influencing key actors in the health sector.
Strategy #10 OCT: Involve 'Friends' in Planning	1. Hold informal consultations with 'friends' of the reform on the sequencing of actions and political strategy; draw on the experience of the education reforms. 2. Bring together public hospital directors to articulate an agenda.
Strategy #11 AMD and IDSS: Create Strategic Alliances	1. Create strategic alliances with key actors not usually involved in health sector policy debate (nurses' union, igualas, other unions, business associations, NGOs, churches, universities).

Pilot projects (strategy 5) in hospital autonomy were initiated during the pre-electoral period as planned, but the demonstration effects of the studies were limited due to the OCT's weakening relationships with the new Administration, especially with the new leadership in SESPAS. Subsequently, key technical staff in the OCT and in the Secretariat of the Presidency were replaced, reducing the feasibility of reform proposals as originally conceived. The limited political support of the new Administration for health reform showed the OCT's mixed success in working with political parties (strategy 6). A communications strategy (strategy 7) was launched with success; the debate in the press became more accurate over time, and the OCT was able to respond to editorials and attacks in a timely manner. Alliances with international agencies were strengthened during the design phase through the creation of working groups on specific themes such as human resources (strategy 9, 11).

Overall, the *PolicyMaker* exercise produced a set of strategies that achieved some success for the OCT, especially with regard to common ground, vision, and work with the SESPAS and IDSS bureaucracies. However, relationships with key political actors were particularly precarious in the post-election period, and presented an insurmountable challenge to

reformers. This exercise in systematic applied political analysis helped move the health reform process forward in the Dominican Republic, but did not result in full adoption of the health reform package. In short, applied political analysis may be necessary to promote WDR-style health reform efforts, but analysis alone is not sufficient for success, for reasons discussed below. In late 1997, the OCT repeated the *PolicyMaker* analysis, updating the position maps and setting out modified strategies. Whether this additional analysis will provide sufficient guidance to produce political and social acceptance of health reform in the Dominican Republic in the near future is an open question.

Conclusions

This analysis of the political dimensions of health sector reform processes in the Dominican Republic suggests some generalizations that may be relevant to other nations. Six factors seemed to affect the pace and feasibility of the health sector reform proposal in the country in 1995.

Factor 1: The leadership of the reform

The leadership vacuum in the Dominican Repubic in 1995 made decision-making on health reform difficult and incremental at best. The Secretary, facing the progressive decay of institutions and the near certain loss of his party in the coming elections, was unwilling to tackle health system change. Comprehensive health sector reform usually requires the full commitment of the Secretary of Health. In the Dominican Republic and elsewhere, leadership capacity is deeply affected by the system of government (new democracy versus aging dictatorship), the credibility of the government, political timing (the approach of elections), and the political effects of the technical content of reforms.

If the political leadership is inactive on health sector reform, the technical reform group and the Banks themselves become the policy advocates. To play this role effectively, leadership and resources are required within the reform group. The reform group must receive technical, strategic, and political support, above and beyond the standard studies conducted under Bank pre-loan processes. In a personalized political system in which decision-making is highly centralized, the reform group must create a critical mass of reform supporters, who can promote reform despite a turnover of leaders. Reform groups may need to create incentives for the Minister to become a fully engaged advocate for reform. Politicians need to find ways to navigate the political costs and benefits of health reform, through a combination of short-term gains and a supportive environment. In situations of uncertain political leadership, as shown by the case of the Dominican Republic, the prospects of health reform are greatly handicapped.

Factor 2: The political strategies adopted by the reform group

Health sector reform confronts a collective action dilemma: the small and delayed benefits for many people who are highly dispersed (and politically weak) are perceived as less important than the high and immediate costs felt by small groups that are highly concentrated (and politically strong). Explicit political strategies are needed to manage this distribution of the political costs and benefits of reform, especially in relation to key interest groups (the medical association and health workers' union), the government bureaucracy, and international agencies. Reformers need short-term concrete gains that can satisfy key constituents, especially if the expected benefits of reform are perceived as long-term, uncertain, or intangible. In short, reform advocates require political strategies to manage the perceived interests of key stakeholders. If there is a political leadership vacuum, then reform groups need substantial human and financial resources to plan for these non-technical dimensions of the reform process. Applied political analysis can assist the process of generating strategies for promoting reform, but analysis must be supported with the skills and resources for on-going consultation and negotiation with major stakeholders.

Factor 3: The location of the reform group

A structural dilemma exists in the organizational location of the reform group, reflecting a general dilemma about the location of advisory or policy analysis groups. A location within the agency can restrain the group's autonomy and ability to question basic assumptions of the leadership, making the advice serve the preconceptions of the leadership. On the other hand, a location outside the agency can produce weak links to decision-makers with a tendency to marginalization and irrelevance, while allowing the reform group more autonomy and capacity for independent analysis. At the time of this analysis, the OCT was located outside SESPAS and was seen as an outsider by the Health Secretariat's bureaucracy. This allowed critics of health reform to link the OCT symbolically with the development banks, and helped weaken the OCT's political legitimacy. After the election, the OCT was brought into SESPAS, only to be separated again several months later.

Factor 4: The ownership of the reform

For health reform to be adopted, the reform package needs to have strong ownership, usually by the Minister and by the government. But a dilemma also exists with ownership. If a reform is closely associated with a government, and the government changes, then a common political response of the new regime is to reject or reverse the reforms. The new government needs its own reforms, with material and symbolic benefits, and also needs to distinguish itself from previous power-holders.

The dilemma is this: an effort to raise ownership above the current government-in-power (through a multi-partisan commission, for example) may successfully diffuse ownership, but this process could lower the probability of achieving successful acceptance and implementation. Minister-driven reform can tie the change closely to one person and thereby raise the chances of adoption now and reversal later; but if not tied closely, then the reform may not happen at all. The goal is to create a reform with sufficient ownership by the current power-holders that it is likely to be accepted, and without so

much ownership that the next government will reject the reform and seek its own. Achieving this goal requires the creation of strong constituencies, within the bureaucracy and among interest groups, to mobilize supporters who will have an interest in continuing the reform and who will persist beyond changes in government.

In the Dominican Republic in 1995, prior to elections, the potential political owner of health reform had little chance of continuing in office, and therefore no effort was made to mobilize high-level political support for the reform. The Dominican Republic's approach of technical studies plus wait-and-see was effective in preserving some elements of the OCT after the election. But this strategy also reduced the probability that the reform proposals emerging from the study period would be adopted and owned by the new administration.

Factor 5: The political language of reform

Reform efforts often require new ideas that can change the political landscape, provide new perspectives on old problems, and create alliances among diverging groups. The political language of reform can create legitimacy by connecting the reform to international sources and the experiences of other countries. The promotion of 'equity and efficiency in health systems' is hard to oppose. Poor choices of political language can undermine efforts at reform. As shown in the Dominican Republic, an association with the word 'privatization', regardless of its technical accuracy, can undermine support for a reform effort and can put reformers in a defensive mode that is difficult to overcome.

Factor 6: The political timing of reform

The feasibility of health sector reform is often affected by political timing; whether a government is recently elected or is approaching the end of its term will affect its political capital and its willingness to take political risks. The approach of elections can complicate strategies to create political circumstances that would support reform. If the current government is unlikely to stay in power, or if the current Minister is unlikely to stay in power, then the power-holders may have limited political resources and limited interest in attempting a reform that entails high political costs.

The process of health sector reform involves a continual tension between the technical and political dimensions. Often, the proposed technical solutions are only partially constructed, with large ambiguities remaining in the institutions required and the implementation methods. The reform group may be highly qualified in a technical sense and acutely aware of the political implications of different reform options, but may be unprepared for analyzing and managing the highly political dimensions of the reform process. Applied political analysis can be helpful in organizing political data in a systematic way, in analyzing the political risks of health sector reform, and in constructing and selecting political strategies to manage the multiple players involved.

The case of health sector reform in the Dominican Republic shows that the WDR-style reform package creates multiple political challenges that are of significant size. These challenges require political leadership that is committed to reform and prepared to expend political capital, and political strategies that can manage the political costs of powerful stakeholders associated with the reform. The experience in the Dominican Republic suggests that applied political analysis can help identify strategic options, which may enhance the prospects for health reform. But the experience also demonstrates that analysis must be accompanied by an adept use of political power; otherwise the reform package is likely to languish as technically desirable but politically infeasible.

Endnotes

[1] Governments usually started adjustment with the tacit consent of the population, having been put into office to 'reverse economic collapse' (Lindenberg and Ramirez 1989). Health sector reform has not enjoyed such a mandate in Latin America.

[2] More than 70% of public (SESPAS, IDSS, Secretariat of the Presidency) spending on health is directed to hospital care (IDB 1997).

[3] In the most recent OCT document, money management would be the responsibility of the Central Bank.

[4] While politically powerful, it is interesting to note that the 1996 eight-month AMD strike, which resulted in the total shut down of public services, evoked little interest from the public. Private sector services seem to have absorbed most clients willing to pay. In fact, health indicators (infant mortality) actually improved during this same time period.

References

Akin J, Birdsall N, de Ferranti D. 1987. *Financing Health Services in Developing Countries*. Washington, DC: The World Bank.

Cross-Beras J. 1985. *Cultura Política Dominicana*. Santo Domingo: Instituto Tecnológico de Santo Domingo (INTEC).

Inter-American Development Bank. 1997. Dominican Republic: Health Sector Modernization and Restructuring Project Files, September 15.

Lindenberg M, Ramirez N. 1989. *Managing Adjustment in Developing Countries: Economic and Political Perspectives*. San Francisco: ICS Press.

Macro International and the Government of the Dominican Republic. 1991. Demographic and Health Survey. Columbia, MD: Macro International.

Mesa-Lago C. 1992. *Health Care for the Poor in Latin America and the Caribbean*. Washington, DC: Pan American Health Organization.

Mesa-Lago C. 1989. *Ascent to Bankruptcy: Financing Social Security in Latin America*. Pittsburgh: University of Pittsburgh Press.

Mesa-Lago C. 1978. *Social Security in Latin America: Pressure Groups, Stratification, and Inequality*. Pittsburgh: University of Pittsburgh Press.

Oficína de Coordinación Tecnica (OCT), Comision Nacional de Salud, Republica Dominicana. 1995a. *Salud: Una Vision del Futuro*.

Oficína de Coordinación Tecnica (OCT), Comision Nacional de Salud, Republica Dominicana. 1995b. Acta Segunda Reunión. Unpublished document.

Partido de Liberación Dominicana. 1996. *Programa de Gobierno*. Santo Domingo, Dominican Republic.

Perez Uribe. Study on SESPAS decision-making. Unpublished document, 1974.

Reich MR. 1996. Applied political analysis for health policy reform. *Current Issues in Public Health* **2**: 196–91.

Reich MR, Cooper D. 1996. *PolicyMaker: Computer-Aided Political Analysis Version 2.0*. Brookline, MA: PoliMap.

Rojas F. 1995. Autonomía no es privatización. Santo Domingo, Dominican Republic: *Hoy*, November 9.

Rojas O. 1995a. El futuro de la salud dominicana. Santo Domingo, Dominican Republic: *Hoy*, November 14.
Rojas O. 1995b. ¿Paciente o cliente? Santo Domingo, Dominican Republic: *Listín Diario*, November 9.
Santana I, Rathe M. 1994. Setting a new agenda for the Dominican Republic. In *Social Service Delivery Systems: An Agenda for Reform*. Aedo C and Larrañaga O (eds). Washington, DC: Inter-American Development Bank.
World Bank. 1993. *World Development Report: Investing in Health*. Washington, DC: The World Bank.
World Bank. 1995. Background Paper prepared for Regional Conference on Health Sector Reform in Latin America. Washington, DC: Pan American Health Organization.

Acknowledgements

The authors would like to thank the following for their thoughtful comments on the paper: Gerard LaForgia and Ruth Levine of the Inter-American Development Bank, members of the HSPH Health Policy and Politics Working Group, and an anonymous reviewer.

The views expressed in this paper are those of the authors and do not reflect the views or policies of the Inter-American Development Bank.

Biographies

Amanda Glassman works on health policy and financing reform issues at the Inter-American Development Bank. She holds a Master of Science from the Harvard School of Public Health, Department of Population and International Health.

Michael Reich is Taro Takemi Professor of International Health Policy and Acting Chair of the Department of Population and International Health, at the Harvard School of Public Health. He received his Ph.D. in Political Science from Yale University.

Kayla Laserson is an epidemiological intelligence officer with US Public Health Service based in Atlanta at the US Centers for Disease Control. She holds a doctoral degree from the Harvard School of Public Health, Department of Tropical Public Health and Department of Population and International Health.

Fernando Rojas is a medical doctor currently running a private clinic in the Dominican Republic. Dr Rojas was head of the Oficína de Coordinación Técnica during the *PolicyMaker* analysis.

Correspondence: Michael R Reich, Harvard School of Public Health, 677 Huntington Avenue, Boston, MA 02115, USA.