



Dominican Republic: Plateauing progress on family planning

As with other upper-middle income countries, the Dominican Republic has a mature family planning (FP) program. From 1965–2009, USAID support helped to nearly triple the modern contraceptive prevalence rate (mCPR) [1]. From 2000–2007, use of modern contraceptive methods among women married or in union increased from 62.5 to 70 percent. However, between 2007 and 2014, mCPR declined slightly, to 68 percent, while unmet need remained at 11 percent. There is some geographic variation in mCPR, ranging from 64–74 percent across regions (Figure 1); less variation is observed across wealth quintiles (65–71%). Surprisingly, mCPR is lowest in the predominantly urban, southeastern regions—including the Santo Domingo metropolitan area (65%)—and highest among the second-poorest income quintile (71%).

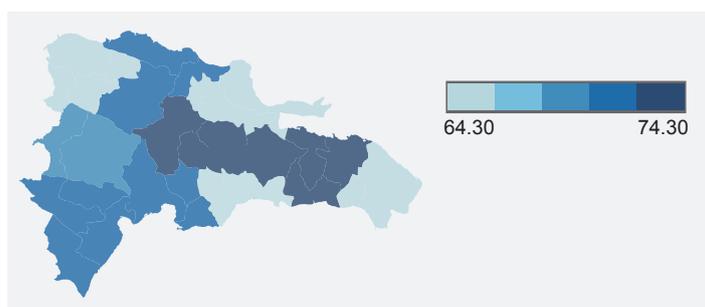
KEY FAMILY PLANNING INDICATORS	
CPR, modern methods (2014)*	68.0%
Unmet need (2014)*	11.4%
TFR (2013)	2.5
FUNDING SOURCES FOR FP COMMODITIES (2015)	
Households	59.6%
Government	40.4%
SOURCE OF MODERN METHODS (2013)	
Public sector facility	52.6%**
Private facility or retail outlet	45.1%**
MODERN METHOD MIX (2014)*	
Female sterilization	59.9%
Oral pill	26.2%
Injectable	6.3%
Intrauterine device	3.7%
Male condom	2.1%
Others***	1.9%

Sources: [3], [4], [8]

CPR = contraceptive prevalence rate, TFR = total fertility rate

*Women married or in union ** Values do not sum to 100% because 2.4% of respondents did not know source or identified the source as "Other" ***Other methods in use include: implants (1.5%), male sterilization (0.3%), and female condoms (0.1%)

Figure 1: mCPR by region



Source: [8]

Increases in mCPR have been closely associated with health sector reform and insurance scale-up between 2000 and 2010. Despite high insurance coverage, more than half of all FP services are still obtained free of charge through public clinics and hospitals. Even with the expansion of FP access through social health insurance, gaps in service provision remain for women both with and without insurance coverage. With mCPR plateauing, the Dominican Republic must consider how to address these gaps to further reduce unmet need for family planning, while continuing to increase financial protection through greater health insurance coverage.

Health financing in the Dominican Republic

Health expenditure in the Dominican Republic is divided equally between the public and private sectors. In 2013, 50 percent (US\$1.7 billion) of funding for health came from public sources, compared to 49 percent from private sources (US\$1.6 billion). The Dominican Republic implemented subsidized public health insurance in 2002, followed by a contributory regime in 2007. Between 2007 and 2013, the percentage of the population with health insurance more than doubled, from 27 percent [2] to an estimated 57 percent [3] (Figure 2). Half receive coverage through public sector insurance and half through private providers, purchased either by employers or individually. Between 2007 and 2012, the country consolidated various public schemes into the Seguro Nacional de Salud (SENASA)—which, as of 2013, accounted for 93 percent of those enrolled in government-provided insurance—and increased enrollment from 1.2 million to nearly 2.8 million total affiliates. Public insurance schemes, including SENASA, receive 41 percent of government funding for health.

High insurance coverage has greatly increased financial protection and kept out-of-pocket (OOP) health expenditure low, at 21 percent of total health expenditure [4]. SENASA's subsidized regime primarily insures low-income households. Insurance coverage overall varies from 42 percent in the poorest income quintile to 70 percent in the highest. As coverage under these schemes grows, the Dominican Republic is implementing decentralization of its health sector, granting more autonomy to the regional and provincial levels. Despite improvements in public sector service provision, there is need for greater integration of FP services into existing coverage schemes, including social and private insurance.

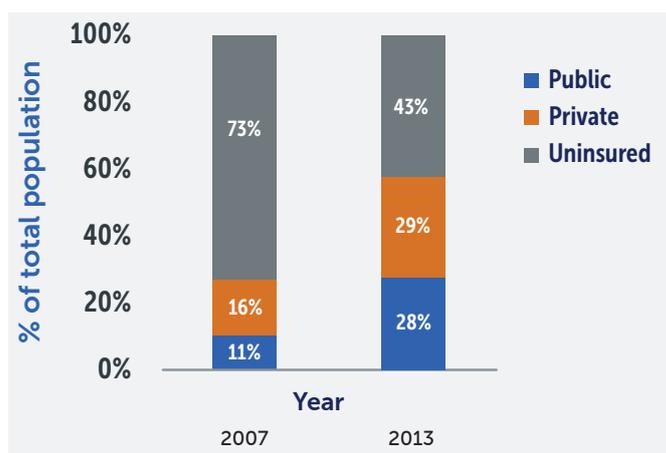
Financing family planning services

Family planning services and key financing schemes

In theory, both SENASA and Ministry of Public Health (Ministerio de Salud Pública, or MSP) clinics provide female sterilization, intrauterine devices, implants, condoms, and oral and injectable contraceptives free of charge. However, stockouts of certain methods remain problematic. SENASA receives contraceptive commodities by donation from the MSP and does not procure them with its own funds [5]. SENASA's coverage of low-income women has played a major role in increasing access to and use of FP methods. An estimated 41 percent of women in the poorest quintile are covered by SENASA, compared to 14 percent of women in the wealthiest. Among poor women, insurance access is significantly



Figure 2: Insurance Coverage by Type



Source: [3]

associated with increased FP use, with mCPR highest among this group (Figure 3). Among the lowest three income quintiles, insurance coverage is associated with an average increase in mCPR of 24 percent, compared to just 2 percent among the highest two quintiles. However, minimal variation in mCPR between insured and uninsured wealthy women may be attributed to a lack of FP coverage by private insurers. Although many private plans claim to include family planning, female sterilization is the only method regularly covered.

Access to family planning and financial protection for uninsured women

Uninsured women in the three lowest income quintiles remain most in need of access to family planning. Among this group, mCPR averages only 61 percent and 16 percent have unmet needs. Despite the theoretical free provision of FP services in public facilities, a large proportion of women using modern FP methods pay OOP. These costs can pose a significant financial barrier to poor households, of which nearly 27 percent face catastrophic health expenditures [6].

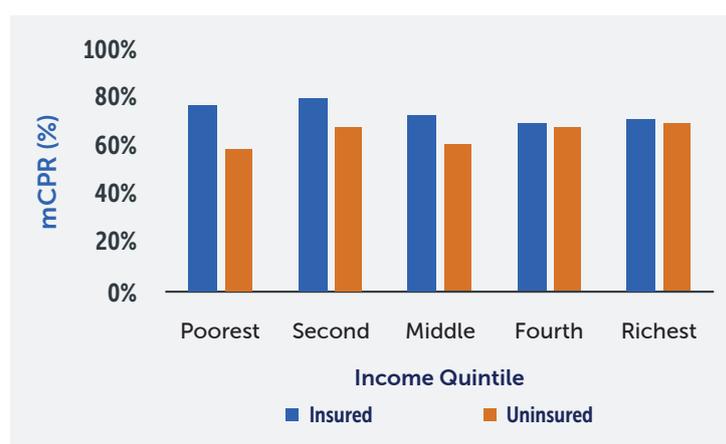
Government policies to increase affordable access

The MSP has adopted a target to reduce unmet need for family planning to 5 percent by 2018 [7]. However, in 2014, the MSP had a budget of US\$1.5 million for FP commodities, which experts consider insufficient to avoid stockouts at the national level [5]. Further increases in FP access will require not only additional funding for FP commodities, but also continued expansion of SENASA enrollment among the poorest women. Advocacy for the inclusion of FP benefits in private insurance will be necessary to raise access among middle-income women, one-quarter of whom are covered by private schemes.

Summary

Despite relatively equitable access to family planning, mCPR in the Dominican Republic has leveled off since 2007 and unmet need remains at 11 percent (up to 17% for uninsured poor and

Figure 3: mCPR by Wealth and Insurance Coverage



Source: [3]

middle-income women). Increasing insurance access has proved successful in increasing FP use. However, gaps in benefits, specifically for private insurers, have left many women without access to FP services and may explain why mCPR is paradoxically higher among poor, insured women. Closing these gaps and continuing to expand access to public insurance schemes is necessary to reduce OOP payments that many women still face.

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