PROJECT INFORMATION DOCUMENT (PID)
APPRAISAL STAGE

Report No.: PIDA372

<table>
<thead>
<tr>
<th>Project Name</th>
<th>Project Name: National Sector Support for Kalusugan Pangkalahatan (Universal Health Care) (P119069)</th>
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<td>Region</td>
<td>EAST ASIA AND PACIFIC</td>
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<td>Country</td>
<td>Philippines</td>
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<tr>
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I. Project Context

Country Context

While health outcomes are improving at the aggregate levels, there are significant disparities between the poor and the non-poor, urban and rural areas and across cities and provinces. These disparities are persistent and worsening over time. Despite the decentralization and universal coverage reforms, financial risk protection of the population is under threat and poor households spend more of their disposable income on health as compared to the non-poor. Utilization of health services is equally uneven. For example, utilization of skilled birth attendants among the non-poor is 94 percent as compared to only 13 percent among the lowest income quintiles (NDHS, 2008). There are different sources of data on health insurance coverage, but it is increasingly accepted it is in the range of 55-60 percent (lower than the 76 percent claimed by PhilHealth). The NDHS states coverage to be even lower for PhilHealth – only 38 percent. According to the NDHS, approximately 20 percent of poor families are covered through health insurance.

The World Bank Philippines Health Sector Review (Transforming the Philippine Health Sector: Challenges and Future Directions) finds that despite the many innovations, the reforms to date have not sufficiently addressed many of the structural deficits in the health sector. These include: (i) The continuing low levels, fragmentation and inequity in public financing, (ii) Limitations in PhilHealth’s performance in implementing universal social health insurance and using health financing as a lever to drive health sector development, (iii) Large gaps in service delivery capacity, particularly in some Regions, (iv) Limitations and Gaps in incentives and accountability arrangements and capacity in DOH hospitals and LGU facilities, (v) Gaps in the stewardship of the sector.

II. Sectoral and Institutional Context

The Government’s Program for the Health Sector: The new GOP administration has identified achieving universal health care (Kalusugan Pangkalahatan in Tagalog) within the next medium term plan (2011-2016) as its main health sector goal. Universal health care (henceforth referred to as Kalusugan Pangkalahatan or KP/UHC) is also included in the President’s 16 point program to operationalize the "Social Contract with the Filipino People." KP/UHC is defined as: “a focused approach to health reform implementation ensuring that all Filipinos especially the poor receive the benefits of health reform. It is a deliberate focus on the poor to ensure that they are given financial risk protection through enrollment to PhilHealth and they are able to access affordable and quality health care services in times of need.” Universal Health Care has three strategic thrusts: (1) Financial Risk Protection through Expansion in NHIP enrollment and benefit delivery: the poor are to be protected from the financial impacts of health care use by improving the Benefit Delivery Ratio/effective health insurance coverage (enrollment, utilization and financial protection) of the NHIP; (2) Improved Access to Quality Hospitals and Health Care Facilities – Government-owned and operated hospitals and health facilities will be upgraded to expand capacity and provide quality services, (3) Attainment of the health-related MDGs – public health programs shall be focused on reducing maternal and child mortality, morbidity and mortality from TB and malaria and the prevalence of HIV/AIDS, in addition to being prepared for emerging disease trends and prevention and the control of non-communicable diseases (NCDs).

III. Project Development Objectives

The project development objective (PDO) is to increase financial risk protection under the National Health Insurance Program (NHIP) for all Filipinos with a major focus on underserved populations identified through the National Household Targeting System for Poverty Reduction (NHTS-PR).

IV. Project Description

Component Name

Health Financing to support PhilHealth implement Strategic Thrust 1 of KP/UHC which focuses on financial risk protection under the NHIP with a special emphasis on poor households.

Service Delivery Transformations to Support a Reformed NHIP and DOH Public Health Program for Local Government Units.
VI. Implementation

The proposed project is a US$300 million Sector Investment and Maintenance Loan (SIM) to support results-based implementation of the Government’s KP/UHC Agenda. Disbursements shall be made against selected Department of Health budget line items referred to as Eligible Expenditures up to a capped absolute amount (annual and cumulative over five years of the project). The amount of credit disbursement shall be based on the achievement of pre-specified annual results based on the KP/UHC roadmap referred to as disbursement-linked indicators (DLIs) determined in partnership with the Government. Approximately 11 DLIs are proposed for each year of the operation – a total of 55 over five years.

The project consists of two components: (i) health financing, (ii) service delivery transformations. Monitoring and evaluation is a cross-cutting theme. These components are expected to achieve the stated PDO of the project.

Component 1: Health Financing (US$240 million): The objective of this Component is to support the Philippines Health Insurance Corporation (PhilHealth) implement Strategic Thrust 1 of KP/UHC which focuses on financial risk protection under the NHIP with a special emphasis on poor households. This will be achieved through the following sub-components: (i) expanding membership of NHTS-PR families into the NHIP, (ii) enhanced PhilHealth benefits and improved services under the NHIP which will benefit NHTS-PR households, (iii) organizational strengthening with the objective of increasing PhilHealth capacity to deliver greater value to customers, (iv) strengthened DOH stewardship of health financing. It consists of four sub-components:

Sub-Component 1.1: Increasing membership of NHTS-PR households into the NHIP. This subcomponent will support DOH and PhilHealth effectively enroll households on the NHTS-PR list into the National Health Insurance Program. It will ensure that PhilHealth personal identification numbers (PIN) are provided, and membership of these groups – subsidized from national government financing for the poorest quintile – is kept active through timely payment of premiums. As the evidence from the Philippines shows, navigators are key for poor households to understand and use PhilHealth benefits. Therefore, PhilHealth and DOH will expand programs such as PhilHealth CARES, DOH-lead Community Health Teams (CHTs) to inform families regarding their PhilHealth benefits.

Sub-Component 1.2: Enhanced PhilHealth benefits and improved services under the NHIP which will benefit NHTS-PR households. This subcomponent will support PhilHealth in implementing benefits package and provider payment reforms in the following areas: (i) an enhanced inpatient benefits package that is incrementally increased to cover no-balance billing for PhilHealth members, (ii) a primary care benefits package, initially for sponsored program, overseas foreign workers (OFW) and organized groups and eventually rolled out to all members, (iii) catastrophic health benefits for all NHIP members. In addition, PhilHealth will roll-out prospective payment systems such as global budgets, All Case Rates (ACR) based on the Philippines DRG, and capitation for primary care. Incrementally, as purchaser and provider capacity in information collection, analysis and reporting improves, pay-for-performance elements may be introduced over the next five years. Information technology (IT) upgrades for provider payments is a cross-cutting intervention under this sub-component.

Sub-Component 1.3: Organizational Change Management in PhilHealth. This sub-component will support Philhealth in organizational change management to transform PhilHealth into a cutting-edge social health insurance (SHI) agency that focuses on the customer and implements accountability for performance. Specifically, this sub-component will support PhilHealth in the implementation of the Corporate Dashboard and Balanced Scorecard to strengthen bottom-up and top-down performance accountability in PhilHealth.

Sub-Component 1.4: Strengthened DOH Stewardship of Health Financing. This sub-component will support the Health Policy Development and Planning Bureau of the Department of Health strengthen its capacities to effectively monitor, report and use health expenditure information to strengthen health systems performance in the context of KP/UHC. Specifically, it will support timely updates of the National Health Accounts (NHA), enhanced implementation of Local Health Accounts (LHA) and linking LHA data to LGU scorecard and performance grants. It will also support the HPDPB in carrying-out evaluation studies for KP, specifically on health financing related issues and using this information for sustainable health financing for KP/UHC.

Component 2: Service Delivery Transformations to Support a Reformed NHIP and DOH Public Health Program for Local Government Units (LGUs) (US$60 million): The objective of this component is to support the Department of Health (DOH) implement Strategic Thrust 2 of KP/UHC which focuses on “improved access to quality hospitals and health care facilities.” The health service delivery reforms identified under KP/UHC complement the health financing interventions. This component consists of the following sub-components:

Sub-Component 2.1 - Transforming DOH Hospitals: This sub-component would support the implementation of interventions to enable DOH hospitals to earn Centers of Quality or Centers of Excellence accreditation status from PhilHealth. Earning these accreditation status signals the strengthened management of DOH hospitals and the improved quality of care given to patients, particularly poor NHTS families who are PhilHealth members.

Sub-Component 2.2: Transforming LGU Provision of Hospital and Health-related MDG services: The sub-component would focus on the improved implementation of the Health Facility Enhancement Program (HFEP) and LGU performance grants to leverage improved service delivery by LGUs. This will also support the prioritization of DOH inputs in LGUs with the most numbers of NHTS poor families but also LGUs where gaps in vaccination, facility-based deliveries, and TB control are highest. These reforms are expected to lead to improved LGU provision of hospital and health-related MDG services for their constituents, particularly PhilHealth enrolled NHTS poor families.

Proposed EEs are as follows: (i) The premiums for NHTS targeted households under the expanded NHIP are the largest expenditures (total government expenditure for five years is US$2 billion of which the project will finance approximately 11 percent or (US$240 million)), followed by
the (ii) Maintenance and Operational (MOOE) budgets of the Bureau of Health Facilities and Services and the National Center for Health Facilities and Development (estimated costs for 5 years is US$17.2 million of which the Bank will finance approximately 29 percent or US$5 million), (iii) MOOE of the Implementation of the Doctors to the Barrios and Rural Health Practice program (this also includes financing for the RNHealth Program) (estimated costs for 5 years is US $ 300 million or Php 12.6 billion pesos of which the Bank shall finance 12 percent or US $ 35 million) and local health grants (estimated around US$85 million of which the Bank will finance US$20 million or 24 percent ), (iv) The local health grants may be used by LGUs to finance the purchase of medical equipment or to improve the health facilities to obtain PhilHealth accreditation. PhilHealth accreditation is a necessary pre-condition for service provision for NHTS-PR families enrolled in the NHIP.

Based on discussions with DOH and PhilHealth, and taking into account current organizational realities of joint DOH and PhilHealth implementation of many elements of KP/UHC, the Secretary of Health will be the Project Director. This is expected to ensure that the project is at all times fully aligned with the government’s focus for KP/UHC. The Secretary of Health will be supported by a high-level official (in DOH and PhilHealth) on project implementation issues. For PhilHealth, the President/Chief Executive Officer or P/CEO will be responsible and for DOH, the Assistant Secretary for the Health Financing Cluster. Each of these senior officials will be supported in day-to-day project issues by relevant departments in DOH and PhilHealth as well as the Bureau of International Health Cooperation (DOH) and International and Local Cooperation Department (PhilHealth).

There are several dimensions of sustainability to take into consideration: (i) economic/financial, (ii) institutional, and (iii) political sustainability. Economic and financial sustainability of the project is contingent on: (i) increased allocation of government budget for the health sector, (ii) the capacity of PhilHealth to strengthen revenue collection from the formal sector and the individual paying program, (iii) increased efficiency in the use of health sector resources (reduction in duplication and fragmentation in financing and delivery). The project includes an indicator (DLI) on increased public financing for the health sector consistent with the UHC costing exercise. Moreover, through strengthening DOH and PhilHealth capacity in developing and implementing benefits package and provider payment reforms as well as streamlined delivery of the LGU performance grants, the project will ensure financial sustainability. Institutional sustainability refers to the ability of DOH, PhilHealth, LGUs and health providers to continue the UHC reforms after the completion of the project. The results-based approach will help these agencies focus on a core set of reforms and build capacities around these reforms. Political sustainability of the project depends on the engagement of a wide range of stakeholders in the reform process (especially during implementation) as well as close tracking of results and sharing the results with a range of stakeholders. The results-based approach of the project is well targeted at the second objective. Moreover, most of the DLIs in the project require involvement of stakeholders. During the design phase, the DOH has undertaken various stakeholder engagements to build project support for UHC. This will be complemented by annual implementation reviews with health partners to review results and fine-tune the implementation roadmap.

The project takes into account lessons learned from past operations in the health sector in the Philippines, finds from the recent review of health sector reforms in the Philippines (Transforming the Philippine Health Sector: Challenges and Opportunities) as well as the extensive analytical work undertaken by the DOH and PhilHealth in collaboration with various development partners and the findings from a randomized control trial (RCT) which tested the impact of expanding effective coverage on child health (Quality Improvement Demonstration Project or QIDS), information from the implementation of health sector reform projects supported by the Bank in other countries as well as global good practices in health reforms. The main lessons learned and incorporated into project design are as follows: (i) The QIDS – an RCT completed between 2003 and 2008 – has shown that universal coverage as planned under KP/UHC leads to improved access to quality health services and improved health outcomes among children. The QIDS experiment tested: (i) whether intermediaries between poor families and the health system (called policy navigators) improves access to health service for these families, (ii) whether insurance coverage reduces delays in seeking care, (iii) whether bonuses for physicians improve quality of care, and (iv) whether universal coverage improves health outcomes. The results of QIDS have been positive. For example: (i) policy navigators improved enrollment in health insurance between 39 to 102% compared to controls, (ii) the cost of the policy navigator program was only 0.86 cents per enrollee, (iii) better insurance coverage through PhilHealth reduced delays in seeking care resulting in reduced cost of treating polio (measles) 1772 per episode without delay and 1905 with delay), (iii) a bonus system for physicians in hospital setting led to quality of care improvements and the cost of care dropped as quality improved, (iv) as the number of insured patients in public facilities improved, the quality of care in private facilities also improved, (v) expanded health insurance coverage for children led to improved health outcomes (measured by likelihood of wasting and infections).

(ii) In highly decentralized health systems, for comprehensive health sector reforms to be successfully implemented at the local level and generate results, central agencies must develop incentive and support systems to help local agencies implement these reforms. Universal health care in the Philippines will not be achieved unless the NHIP and DOH performance grants to LGUs are mobilized within an enhanced incentives and accountability framework for LGU and health providers. At the same time, it needs to be recognized that some LGUs will simply not have the capacity to transform service delivery arrangements at the local level to achieve universal health care. The components of the project are designed to achieve these broad objectives of a strengthened health financing framework and technical support to LGUs to achieve better outcomes.

(iii) The introduction of subsidized health insurance has the potential to yield major improvements but only if the benefits are well designed and beneficiaries are empowered to demand health services. The Philippines has been implementing a subsidized health insurance program for poor Filipino families since 1997. In essence the introduction of a subsidized regime for poor households embedded within a broader social health insurance program is a good practice from the perspective of health financing (enhanced risk pooling). But in reality, in the Philippines so far, these systems have not yielded the necessary results in terms of improved access to health services and financial protection. The main reasons are the very limited benefits package combined with a system of unregulated balanced billing and the fact that beneficiaries, especially poor households, often do not understand their rights and privileges. Therefore, an explicit focus of the project is on supporting an enhanced benefits package under the NHIP, complemented by a strong implementation framework that will link to community-based interventions to make beneficiaries aware of their rights. Other interventions such as the establishment of PhilHealth service desks in hospitals, implementation of community-health teams and a strengthened monitoring and evaluation system, including through the implementation of a citizen’s scorecard for universal health care will be supported under the project.

(iv) Implementation is key while taking into account political windows of opportunity and fiscal space. In most countries that have successfully implemented universal health care policies, strong implementation capacity was key, combined with monitoring and evaluation and taking advantage of political windows of opportunity. For example, in Mexico, the implementation of Seguro Popular which is currently covering almost 90 percent of the previously uninsured population of Mexico, implementation has been incremental, buttressed by the use of information and generating an evidence base. While the goal of universal coverage has remained the same in Mexico since 2003, the paths in getting there have
been adjusted to reflect political windows of opportunity and available fiscal space for UHC. In Turkey, which has also achieved universal health care, strong implementation capacity has been critical combined with flexible implementation in situations where anticipated reforms (hospital autonomy) did not progress as quickly as anticipated. By adopting a results-based approach, the project expects to keep the focus of the GOP on implementation, with the added benefit of a joint annual review to revisit plans in the context of political economy and implementation capacity and fine-tuning as needed for outer-year implementation, while adhering to the medium-term outcomes.

VII. Safeguard Policies (including public consultation)

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VIII. Contact point

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