Project Information Document/ Identification/Concept Stage (PID)

Concept Stage | Date Prepared/Updated: 21-Dec-2017 | Report No: PIDC126466

BASIC INFORMATION

A. Basic Project Data

Project ID	Parent Project ID (if any)	Environmental Assessment Category	Project Name
P164949		C - Not Required	Philippines Health Financing Strengthening
Region	**Country**	**Date PID Prepared**	**Estimated Date of Approval**
EAST ASIA AND PACIFIC	Philippines	21-Dec-2017	30-Mar-2018
Financing Instrument	**Borrower(s)**	**Implementing Agency**	**Initiation Note Review Decision**
Investment Project Financing	Department of Health	Philippines Health Insurance Corporation	The review did authorize the preparation to continue

Financing (in USD Million)

SUMMARY

Total Project Cost	1.69
Total Financing	1.69
Financing Gap	0.00

DETAILS

Total Government Contribution	0.34

B. Introduction and Context

Country Context

The population of the Philippines is exceeding 100 million people with annual growth rate 1.6 percent. About 45 percent of the population lives in urban areas. The population is relatively youthful, with an estimated 6 percent of the population aged 60 years and older in 2010. Average Life expectancy is estimated at 68 years in 2016.

The economic outlook for the Philippines is positive as GDP growth rate speeded from 5.9 percent in 2015 to 6.8 percent in 2016 being among the highest in the region. According to the World Bank projections the

real GDP will grow by 6.9 percent in 2017 and 2018. GDP growth rate has been accompanied with job creation and poverty reduction. Between 2012-2015, the average increase of income was 6 percent while the income of the bottom 20 percent increased at 16 percent. Still, rural poverty remained nearly three times as high as in urban areas.

Geographically dispersed population and decentralization adds to another set of challenges. The Philippines is an archipelagic country made up of more than 7,000 islands which are referred to in terms of three island groups: Luzon, the largest island (where Manila is located), the central Visayas islands, and Mindanao in the south. In total, there are 1,634 local government units (LGUs) including cities and municipalities enjoying high degree of autonomy.

The new Philippine Development Plan 2017-2022 adopted in February 2017 outlines an aspiring reform agenda with the focus on equitable tax reforms, boosting market competition and easing of doing business but although scaling up public investments to infrastructure and social services. The PDP has four areas for strategic action: (a) building a prosperous, predominantly middle-class society where no one is poor; (b) promoting a long and healthy life through quality and affordable universal health care and social protection; (c) becoming smarter and more innovative, through expansion of skill set in order to adapt to rapidly changing technology and work requirements; and (d) building a high-trust society, through people-centered, effective, and accountable government. This medium-term plan is anchored on Ambisyon Natin 2040, a 25-year long-term vision adopted by the current administration.

Sectoral and Institutional Context

Health Status

The Philippines health profile shows that country faces health challenges that are common to both – developed and developing countries: a high incidence of communicable diseases, rising burden of non-communicable diseases (NCD), and consequences of natural disasters that regularly affect the region. Cardiovascular diseases and diabetes followed by other NCD carry the highest burden of disease, while ischemic heart disease followed by stroke are among the top causes of adult death in the Philippines.

The Philippines' health sector has rather poor performance compared to countries with similar economies. Philippines was able to meet millennium development goals (MDG) for child mortality, and reversing the incidence of Malaria and Tuberculosis. The country was however unable to meet its MDG goals for maternal mortality, for access to reproductive health, and for HIV/AIDS. However, some health indicators have been improving outstandingly: under-5 child mortality (per 1,000 live births) is decreased to 28 in 2015 (near to the 2030 SDG target). However, the progress has not been so remarkable for other areas as maternal mortality (maternal mortality ratio is 114 per 100,000 live births in 2015), access to reproductive health, and for HIV/AIDS. Thirty percent of children under five are stunted and 20 percent underweight which is too high for a country of the Philippines' level of economic development.

Child immunization coverage is at its lowest point in ten years, with only 62 percent fully immunized children in 2013, down from 79 percent coverage in 1998. As the result, the Strategic Advisory Group of Experts on Immunization of World Health Organization has listed the Philippines among the 10 countries where most unvaccinated children live as well as one of the countries where coverage has declined considerably between 2010 and 2015.

Philippines has been able to achieve almost universal coverage in antenatal care (95 percent), and the percentage of facility-based delivery increased to 61 percent in 2013 from 44 percent in 2008. Still, vast geographical and economic variations exist: 72 percent in urban compared to 51 percent in rural areas.

Governance and institutional structure

At the national level, the Philippines has adopted comprehensive health strategies and policies but these are not effectively translated into program implementation. One of the key factors of modest implementation capacity is the highly fragmented and decentralized health care organization including service delivery and financing arrangements.

The Department of Health (DOH) plays the role of stewardship in the country being a regulator and implementer having the responsibility for many public health programs, such as immunization, HIV/AIDS, TB, Malaria. Additionally, it is the provider of many tertiary health care services. DOH provides its support to the LGUs through its central bureaus, regional offices, and staff at the provincial offices. While the majority of care is delivered by the public sector, private providers are also an important source of care.

The Philippines has a highly decentralized health system with substantial responsibility for health financing and service provision assigned to the local government units (LGUs). In the current set up for LGUs, (a) provinces are responsible for managing the local provincial hospital systems; (b) cities have a special position in that it has hospitals and city health centers; (c) while municipalities are responsible for the heart of the primary health programs, including among which managing rural health units (RHUs), disease control services, and access to hospitals; and (d) villages or barangays are responsible for managing the barangay health stations (BHSs).

Health services are purchased from a wide range of government and private sectors health facilities. The DOH currently operates 70 hospitals, including four government-owned corporations (GOCC) hospitals, 54 regional hospitals, and 12 other DOH hospitals. These DOH hospitals are among the 758 government hospitals, infirmaries and dispensaries accredited by PhilHealth as of December 2016, while the rest are presumably LGU-owned hospitals. There are more private hospitals and infirmaries accredited by PhilHealth, numbering 1,135 as of December 2016. For primary outpatient care, municipalities and cities operate rural health units (or health centers), and in 2016 PhilHealth accredited 2,557 of these for the Primary Care Benefit Package (PCB). For other primary care, PhilHealth also has accredited 3,102 facilities for the Maternity Care Package and 1,973 facilities for the TB DOTS package. Moreover, PhilHealth also purchases specialist outpatient care from accredited providers of providers of ambulatory surgical care, hemodialysis, animal bite package, and outpatient malaria package.

The Philippine Health Agenda 2016-2022 sets the ambitious reform plan with the aim to assure financial risk protection and good health outcomes for the population. The agenda focuses on guaranteeing all Filipinos equitable geographic and financial access to a comprehensive range of quality health services across different levels of care upon first contact with the health care system. This agenda builds on three pillars: (1) guarantee care at all life stages and reduce the triple burden of diseases, (2) ensure access to functional service delivery network, and (3) ensuring universal health insurance through expansion of health insurance coverage and improvement of benefit packages. Under the third pillar of universal health insurance coverage, key issues to address include: (a) persistent issues with balance billing and co-payments, (b) expanding the PhilHealth benefits package to include outpatient care and drugs that would add value for money, (c) contracting arrangements with service delivery networks, and (d) enrolling the formal sector through payroll taxes and informal sector through government subsidies.

DOH aims to achieve Universal Health Coverage by 2022 and has prioritized its Health Financing direction (2017-2022) to guarantee universal access to comprehensive care at primary care level and continuity of care through referral. These Health Financing directions built on 9 step approach in the following areas: (a) population coverage, (b) service delivery package, (c) role clarification (of various Departments, Agencies and Administrative levels), (d) revenue generation, (e) pooling, (f) resource allocation and strategic purchasing, (g) procurement, (h) salaries and compensation, (i) health facilities. The more streamlined Health Financing policy and practical roadmap is still under preparation.

According to the Philippine Health Agenda of 2016-2022 and in a proposed Universal Health Care bill recently approved by the lower chamber of Congress, PhilHealth is a main public purchaser for health care consolidating majority of the public funding. Pooling funds is a necessary step towards less fragmented public health financing system and gives better leverage for strengthening the PhilHealth as key strategic purchaser in the health sector and for changing provider behaviour.

Health system financing

REVENUE COLLECTION

The Philippine health spending is rather low as compared to the other countries of similar income. Total health expenditure per capita is $135 and total health spending as share of GDP is 4.7 percent in 2014. Government expenditure on health as a share of GDP has settled to 2010 level (1.6 percent) in 2014. In 2015, government health expenditure as share of total government expenditure was about 10 percent.

The Philippines health system financing relies heavily on private sources, mainly out-of-pocket expenditures. In 2014, public health sector expenditures constituted 31 percent, private sector 66 percent and external sources 1 percent of total health expenditures. The public health expenditure was financed through central government budget (34 percent), local government units (21 percent) and through social health insurance (45 percent) in 2014. The most important private source for health expenditures is out of pocket payments. The out of pocket expenditures comprise 56 percent of total expenditures which

undermined attempts to improve financial protection. Another private source is private insurance such as HMOs, who currently account for around 12 percent of health sector funding.

POOLING

In 2011, the national government started fully subsidizing the PhilHealth premiums of the poor identified through a national targeting system called National Household Targeting System for Poverty Reduction (NHTS-PR or *Listahanan*), implemented by the Department of Social Welfare and Development. This move helped end the previous highly politicized, discretionary, and unpredictable practice of LGU-sponsored identification and enrolment of the poor. This move was aided by increases and earmarked revenues from tobacco and alcohol excises from 2012, which enabled subsidizing 14.7 million poor and near-poor families or the poorest 40 percent of the population, increasing PhilHealth coverage to 91 percent by 2016 according to administrative records.

PhilHealth is covering nearly all population (91 percent by end of 2016) ensuring them reimbursements for some type of health services amongst indigents and other vulnerable groups are given priority. Many of covered people are contributing members and their dependents including those in the formal sector program (employed in the government, formal private sector, household help, enterprise owners and household drivers), informal sector (migrant workers, informal sector, self-earning individuals, organized groups) together accounting for 43 percent of members and 40 percent of beneficiaries (members plus dependents). About 53 million people benefit from free health insurance through the indigent and senior citizens programs financed by the national government.

There is a persistent gap between the health insurance coverage rates obtained from national administrative databases and the health insurance coverage rates reported in household surveys such as the National Demographic and Household Survey. Household survey produced self-reported coverage rates of 60 to 67 percent in 2013 and 2015, which is 20 percentage points lower than what the PhilHealth administrative data showed in those years. The gap reflects measurement issues and also the consequences of the policy of "automatic enrollment" of those who are subsidized by national government. One measurement issue is the tracking only the number of principal members until recently and using assumptions on dependency ratios (and changing assumptions resulted in inconsistent reports). This challenge was compounded when counting the number of families covered by the national government subsidized indigent program wherein the NHTS-PR tarteting mechanism assesses households while PhilHealth enrols poor families. Moreover, double counting is a huge possibility with families of spouses being counted twice and some persons belonging to more than one membership type in the database. The coverage gap due to "automatic enrolment," on the other hand, refers to the problem that PhilHealth administrative data only capture the number of people *entitled* to free health insurance, and not the number of people who *know* that they subsidized coverage.

A key challenge of the Philippines health financing system is its highly fragmented nature along with the heavy reliance on out-of-pocket expenditures. A fragmented set up of health care financing leads to the fragmentation in provider payment incentives. Even though hospital care is included to the national health

insurance benefit package, households pay for almost half (41 percent) of the hospital care. At the same time, PhilHeath covers only 14 percent of hospital care expenditures, while government pays for 24 percent of hospital care.

Also, the public health funds are highly fragmented which complicates PhilHealth position to become a strong strategic purchaser. PhilHealth, in its role as the national social health insurance agency, purchases services from public and private providers on behalf of its members. Still, government budget is used to subsidize direct health care service provision, as well as other functions such as training, regulation and strategic investments in infrastructure and human resources. Much of government budget flows through the DOH and other central agencies and institutions, such as the National Police, the Department of Defense and the University of the Philippines (all of which manage large hospitals), or through the Philippine Charity Sweepstakes Organization (PCSO) contributions to health sector activities. In contrast to PhilHealth which purchases services or medicines, the DOH subsidies are mostly used to pay for inputs (e.g. payroll and operating expenditures of DOH retained hospitals), rather than to purchase services from providers.

Government health care financing at the LGU level is fragmented, drawing on local and national financing streams, but depending on local priorities. Certain health programs are decentralized while certain remain the mandate of the central government authorities and which are then implemented through support of deconcentrated budget. LGU health offices are expected to implement certain national health programs following DOH guidelines, yet resource allocations for the sector have become subject to the overall budgetary constraints within each LGU.

The combination of a devolution of health service delivery and fragmentation of financing has created a number of challenges for health sector governance and service delivery at local levels. Among these challenges are ineffective local health planning and budgeting processes, with limited participation by local health officials and little reflection of actual LGU needs; weakened systems for inter-jurisdictional coordination among LGUs, with the administrative boundaries of LGUs rarely coinciding with the catchments areas of health facilities. Staffing levels are also inadequate due to difficulty in maintaining the minimum levels of staffing and compensation prescribed by DOH; and, insufficient and highly variable resource allocations to health care – including both underinvestment in health sector capital and limited allocations to operational budgets. Together, this translates into inefficient resource allocations for health that are neither in line with national priorities or efficient in terms of health needs.

PURCHASING

PhilHealth is a national purchasing agency and its role as a public purchaser is expected to increase in the future, especially with the passage of the UHC bill. Currently, health services are purchased by DOH, LGUs and by PhilHealth. For example, public health programs are financed by DOH and LGUs, hospital services by DOH, provinces and PhilHealth. Currently, about 90 percent of PhilHealth spending goes to finance hospital care (both public and private). Primary health care services have also been included to the PhilHealth program and purchased through capitation to the LGUs.

The no balance billing (NBB) policy was put in place in 2010 to enhance financial protection, especially among indigent and sponsored members. According to this policy, no other fees shall be charged or paid for by the PhilHealth indigent and sponsored patients availing of services paid on a case rate basis. For non-indigent patients, facilities can bill patients for the balance that is left after payments from PhilHealth are subtracted from their charges. For indigent patients, hospitals must cover any balance between charges and PhilHealth case rate payments from other revenue sources, e.g. DOH and LGU medical assistance funds.

PhilHealth inpatient benefit package is highly skewed towards inpatient care which accounts substantial part of PhilHealth payments. The inpatient benefit package covered by PhilHealth basically consists of all the services that licensed hospitals, infirmaries and dispensaries can provide. In 2015, inpatient payments at hospitals amounted to 77.5 percent of PhilHealth benefit payments. PhilHealth claims payment records indicate that 13 case types represent 52 percent of all claims and 42 percent of the value of all claims. However, the content of some of these key cost drivers indicate potential to increase the efficiency by transforming providers' and patients' incentives to ensure that care is provided in the appropriate setting (e.g. urinary tract infections, moderate risk pneumonia). Furthermore, the PhilHealth "Z-benefit package" (in place since 2013) includes a variety of conditions that are considered economically and medically catastrophic. PhilHealth's ambulatory care packages include less complex interventions as some day-surgery, radiotherapy, hemodialysis at freestanding clinics, outpatient blood transfusion and voluntary surgical contraception.

A primary health care benefit package is available only to indigent and sponsored beneficiaries and includes some common basic care and limited number of drugs which distorts all others beneficiaries demand towards inpatient care, rather than more appropriate outpatient care. The currently effective PhilHealth's primary health benefit package (PCB1) and it replaced (in 2013) previous Outpatient Benefit Package (OPB) which had narrower scope and provided no coverage for NCDs. In 2015, a next generation primary care package, *Tsekap*, was developed, including a broader range of NCD diagnostics and drugs. Though, its implementation was stopped. In addition to the PCB1, there are several vertical health programs to cover public health priorities as TB, malaria and HIV/AIDS.

Provider payment mechanisms

The capitation kind of payment is used to purchase PCP1, which combines "per family payment" and performance-related financial incentives. The per family payment is a fixed amount per family (50 PhP per quarter) that is paid to accredited government providers as a supplement to LGU facility budgets. Additional 75 Php per quarter is paid if the facility performs "health profiling" which includes basic demographics and social background data, medical history, family health history and immunizations. The payments are made quarterly into an LGU trust fund earmarked for use by the PCB accredited facility, from which the facility can periodically request funds through purchase orders.

Inpatient and specialist outpatient facilities are reimbursed by using case based system (named "all case rate" – ACR) which replaced previous fee-for-service payment and could be an appropriate first step in transition to the more advanced case based system such as DRGs. The ACR bases on the ICD-10 groups

(similar medical conditions are grouped) and combinations of relative value scales (surgical manipulations). In total, there are 330 rates for 4 600 medical case types. Z-benefits, ambulatory care packages, and the maternal and newborn care packages are also purchased on a case rate basis, but with more detailed specification of the exact package content and how they are to be paid than in the case of the ACR. Under the ACR providers are incentivized to increase volume of care, admit "profitable" patients, upcode clinical and refuse care for high cost patients. PhilHealth has limited possibilities to tackle it due to the lack of coding standards and relevant data quality assurance mechanisms.

Several attempts to move to DRG based payment system have not been succeeding by so far. The Philippines DRG was developed (2009/10) with technical support from the United Nations University in Malaysia and piloted in 19 volunteering hospitals. Series of trainings were conducted for PhilHealth staff and hospitals, through WHO and an EU Technical Assistance project. The preparations to evaluate Australian AR-DRGv6 were made but all activity was put on hold because of ACR implementations.

The ACR system's one of the major weaknesses is that it allows providers to charge the patient for the difference between hospital tariffs and the PhilHealth case rates. Hospitals continue to account the case costs based on previous fee for service system and charge patients the difference between fee for service charges and ACR tariff. This balance billing is not allowed for indigent and sponsored beneficiaries but this policy is poorly implemented by so far. Balance billing was a policy compromise to overcome the shortcomings of the ACR tariff setting which based on the historical PhilHealth charges, not the full cost of providing care.

PhilHealth is facing challenges to refine case rates regular bases due to the lack of transparent costing methodology and difficulties to get relevant cost data from the providers. Providers have historical fee for service mindset which is amplified by the PhilHealth collecting hospital charges data. However, these fee for service based charges do not reflect actual nor optimal cost to deliver care and are not the adequate source of information for tariff setting. This weakness is recognized by PhilHealth and several costing studies for priority interventions are ongoing. It is not clear if these different studies follow similar methodology to avoid discrepancies if they are used for tariff setting in later stages.

PhilHealth has been failing to put in place adequate cost control mechanisms while abolishing tools as utilization reviews and claims auditing used under fee for service system. Still, current system faces the old fee for service structure with the difference that the risk of overprovision of payments is shifted to the patients leading to the poor financial protection due to high out-of-pocket payments.

PhilHealth case rates do not reflect the evidence based best practice due to the lack of evidence-based treatment guidelines and patient pathways. This results in the wide variations in clinical practice by facilities and hinders PhilHealth ability to design proper financial incentives that support care provision in line with evidence based practice and in the right setting of care delivery.

Health facilities have different degrees of autonomy in term of how they can manage their revenues and organize service delivery. Some government facilities have been corporatized or transformed into enterprises and operate under high degree of autonomy. In addition, hospitals in the DOH ownership have

the right to retain income with some restrictions for its use. Most LGU hospitals and primary care facilities operate as government facilities with limited autonomy and several budget restrictions through line-items. In addition, PhilHealth applies expenditure ceilings by different cost categories for its payments in inpatient. Even for outpatient primary care, the 2012 PCB1 package rules defined that of the 500 Php per family payment, 20 percent was to be paid as honoraria for the staff and for improvements in their capabilities, specifically 10 percent for the physician, 5 percent for other health staff and 5 percent for non-health staff. In addition, a minimum of 40 percent should be allocated to pay for drugs dispensed at the facility (asthma, gastroenteritis and pneumonia), and a maximum of 40 percent for reagents, medical supplies and equipment, information technology equipment and staff capacity building.

DRG has previously not been implemented because of policy and leadership changes. While a lot had been done on DRG readiness some years ago, eventually the government decided not to implement DRGs but decided on an all case rate systems. Given the challenges faced in the all case rates and the cost burden falling on patients, the government has asked now to relook at the DRG starting with a pilot in 2020. This is now in the Philippines Health Agenda – medium term strategy (2016-22).

Philhealth's monitoring and oversight functions

Population based data is very necessary to monitor progress towards UHC: On financial protection - family income-expenditure survey (FIES) is currently led by the National Bureau of Statistics and conducted every 3-years. On service coverage - demographic health survey (DHS) is currently conducted every 5 years. For sampling, the population is represented at the regional but not province (or district level). There is ongoing discussion if the population representation can be at the province level. As administrative data remains weak, and to compliment, these surveys have been key to monitoring financial protection and health outputs and outcomes in the country.

Weak analytical capacity of PhilHealth is one of the key obstacles. This limits DOH and Philhealth's ability to improve their monitoring and oversight functions (a) to prevent potential manipulations, and (b) to adjust their contracting and payment arrangements to better manage undesired incentives. Moreover, **quality of collected data** is poor which is the result of non-existing coding standards and protocols and weak control mechanisms over data quality. Putting systematic efforts into improving quality of data is critical to move forward with, for example, DRG implementation.

Underlying cause of low quality data collection is the **fragmentation of both business processes and operational information systems supporting them**. Systems that manage the qualification and collection are separated and a lot of processes are manual. External systems that can allow automatic and reliable receiving of personal, income, property and other data are not connected. Existing electronic claims data collection is semi-manual resulting in low quality data sets. One of the obstacles is also lack of formal specifications of minimal reporting data sets (minimal content of data sets, minimal set of data definition standards and data exchange protocols/standards) to establish standardized data collection.

Relationship to CPF

Engagement areas. The CPS (2014-2018) is organized in five engagement areas. The first two engagement areas are relevant and aligns this small RETF grant project in health:

1. *Transparent and accountable governance*: strengthen public finances, fiscal transparency and financial accountability; strengthen public sector institutions; and strengthen demand-side pressure for government accountability.

2. *Empowerment of the poor and vulnerable*: improve poverty measurement and socio-economic data systems; improve health outcomes; improve quality of basic education and access for the vulnerable; and strengthen social safety nets.

C. Project Development Objective(s)

Proposed Development Objective(s)

To strengthen Philippines Health Insurance Corporation capacity for strategic purchasing with special focus on performance monitoring and payment methods.

Key Results

The small grant project supports Philippines Health Agenda that aims to achieve universal health coverage (UHC) and will specifically aim to provide technical assistance to strengthen national capacities to implement UHC policies and programs. This will include capacities to implement effective policies on health financing (mobilizing revenues and managing risk pools and strategic purchasing). The small grant project focuses especially on strengthening capacity and systems for strategic purchasing.

This small grant project seeks to support the Philippines Health Insurance Corporation (PhilHealth) transformation to a national single purchaser of individual health services by addressing some of the key challenges: (a) developing and implementing the tools to improve the data quality; (b) identifying and implementing key performance indicators and reporting standards; (c) increasing the PhilHealth analytical capacity; (d) supporting the validation and implementation of Philippines diagnosis related grouping (DRG) system; and (e) strengthening information governance around DRG.

During appraisal the Bank team will identify key monitoring indicators from among sustainable development goals, and from among government's key indicators, as identified also in the Philippines Health Agenda, and Philippines medium term strategy (2017-2022). Among preliminary monitoring indicators, may include:

(i) KPI health indicators endorsed through official government documents;

(ii) Strategy on the provider payment mechanism to be adopted with its objective/purpose endorsed though official government documents;

(iii) Report on turn around time for claims, including eclaims processing (target is set at less than 30 days, while 2016 manual reported data was at an average of 37 days).

D. Preliminary Description

Activities/Components

As the Bank team has been able to mobilize the PHRD Bank Executed Trust Fund (BETF), and now seeking PHRD recipient executed trust fund (RETF) to finance this small grant RETF project, the two funds can provide complimentary support to the government in moving this agenda forward. The BETF will concentrate in providing policy and technical engagement and global know how. While the RETF will conduct diagnostics, implementation support and capacity building.

The government of the Philippines is considering provider payment reform. It has introduced a capitation program for primary health care, and have requested assistance of others (other than WB) to provide technical assistance. The government of the Philippines has requested the assistance of the WB on a very specific area of provider payment mechanism (PPM) for hospitals. The RETF will concentrate on the hospital payment reform side, and will consider PPM that would have implications on the following: (i) integrated care (between PHC and hospitals), (ii) cost containment, (iii) transparency, (iv) efficient allocations, (v) quality of care, and (vi) financial protection.

The World Bank (grant) project focuses especially on strengthening capacity and systems for strategic purchasing. This World Bank (grant) project has four components: (i) strengthening key performance indicators and analytics, (ii) improving process, systems, and quality assurance mechanisms on e-claims, (iii) supporting the hospital provider payment system reform, and (iv) project coordination and management.

Component 1: Strengthening key performance indicators and analytics

The component will aim to support the development of the key performance indicators (KPI) as it relates to provider and PhilHealth performance and supports the Philippines Health Agenda (PHA) at the national, local government unit (LGUs) levels, and at the Philippines Health Insurance Corporation. It will identify key indicators, mechanisms to monitor through score cards, sources of information and its process of validation, and mechanisms to transparently report KPIs in the public domain. Population-based/Household and administrative data will be considered. It will also aim to strengthen analytical capacity by supporting the development of an analytics course (at a local learning institution) focused on beneficiaries at technical levels at DOH, PhilHealth, and the regional/local government unit (LGU) levels. The course will address the use of population-based and administrative data, including financial and non-financial data. The beneficiaries of this component are: DOH and Philhealth. The RETF will finance technical consultants, and subscription for the visualization software and also for the cloud to be uploaded on the dashboard through

cloud/software. DOH and PhilHealth will use its own resources to collect and validate data, and to cascade the analytical training of relevant technical staff.

Outputs for 1

- Methodological guidelines for KPI data collection and validation are developed and included in the official health sector monitoring guidelines
- Baseline data of monitoring tools uploaded and available for users, including in websites of DOH, PhilHealth, and Department of Interior Local Government (DILG) hhas applicable
- Management report using information from dashboard (or any analytic tool that will be developed)
- First round of compliance assessment visits conducted by one regional office and reports and analysis produced with specific set of action recommendations

***Component 2: I*mproving process, systems, and quality assurance mechanisms on electronic-claims**

This component will aim to improve quality of minimum data that is collected by PhilHealth through the claims managements system. Attention is required in the accurate and timely completion rate of the hospital claims forms, and in particular accurate filling of the ICD-10 codes. The component will help with the review of the ICD-10 codes policy, forms and database. It will also review the bottlenecks at purchase and provider level that might be affecting the timely and accurate completion of the claims forms. The component will design and implement at a few hospitals a quality assurance mechanisms (a non-financial incentive mechanism (nudge), such as a recognition/awards), to bring about behavior change and accountability at the provider level to improve claims completion rate. The hospitals to be selected for the pilot will come from various tiers/types of hospitals (including public/private, primary/secondary/tertiary, and such). The beneficiaries of this component include PhilHealth and selected providers. The component will provide consultants for conducting baseline, analytics, designing, monitoring and evaluating the pilot sites. DOH and PhilHealth will provide own resources for training, workshops, and logistics.

Outputs for 2

- Formal definition of the PhilHealth dataset and its revision procedure is developed; (a) Official library of ICD 10 with ICD-10 (Philippines modification) and surgical procedures classifications developed
- Coding standards for laboratory procedures and diagnostics, drugs and medicines, etc. to be reviewed and recommended to National eHealth Standards
- Key datasets defined and approved by the National eHealth Standards;
- Coding standards and procedures included in the standards catalogue of eHealth Standards and piloted in selected health care providers;
- Capacity/capability of PhilHealth and hospitals relevant staff have been enhanced in data standards and data management;
- hThe above outputs presented to the national eHealth Standardization Framework.

Component 3: Supporting the hospital provider payment system reform

The PhilHealth hospital payment reform is considering to improve transparency, efficiency and quality of hospital care, among others, to move to a diagnosis related grouping (DRG) based payment system, and when selecting the groupers, there is need to evaluate some possible groupers from other countries that may be relevant for the Philippines. A simulation will be conducted of the selected grouper(s), using hospital service/procedure/treatment costings related to the Philippines. DOH is already working on the costing aspects and which should help to run such a simulation. An organizational review may also be conducted to assess the readiness of staffing and skills for DRG pilot to be implemented by DOH/PhilHealth in 2020. A hospital readiness survey for the pilot testing of the DRG will be conducted, as well as the assessment of the hospital existing payment system and its implications on the provider performance, efficiency, transparency, quality of care and financial protection. Additionally, a DRG information governance sub-component will support the Philhealth information management unit to facilitate: the functional review of DRG implementation design, functional and technical design of DRG data processing (Grouper) and functional and technical deign of data collection (improvement of reporting from hospitals). RETF will support consultants, while DOH and PhilHealth will support software development, training, workshops and logistics. The beneficiaries are DOH, Philhealth, hospital association and selected hospital providers.

Outputs for 3

- Report on the baseline assessment of readiness of hospitals to implement DRG
- Report on impact analysis of All Case Rates
- Report and policy recommendation on the outcome/analysis of validation process on DRGs using selection criteria
- Report and recommendation on the results of simulation activity
- Updated tariff per group and expansion of existing groups
- Business requirements for DRG implementation identified and implemented
- Functional and technical specifications for the DRG Grouper software tool identified
- Implementation strategy and design for DRG implementation developed

Component 4 – Project coordination and management

The component will aim to support the management and regular reporting of the outputs of the project related activities. It will also include the technical and financial audits, procurement of goods and services, as per the small grant project governance requirement. It will include one technical lead recruited as individual consultant. Most other component consultants will be recruited through a firm. Both RETF and PhilHealth own resources will support this component.

SAFEGUARDS

E. Safeguard Policies that Might Apply

Safeguard Policies Triggered by the Project	Yes	No	TBD
Environmental Assessment OP/BP 4.01		X	
Natural Habitats OP/BP 4.04		X	
Forests OP/BP 4.36		X	
Pest Management OP 4.09		X	
Physical Cultural Resources OP/BP 4.11		X	
Indigenous Peoples OP/BP 4.10	X		
Involuntary Resettlement OP/BP 4.12		X	
Safety of Dams OP/BP 4.37		X	
Projects on International Waterways OP/BP 7.50		X	
Projects in Disputed Areas OP/BP 7.60		X	

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