# Project Information Document (PID)

Concept Stage | Date Prepared/Updated: 03-Dec-2019 | Report No: PIDC28114

## BASIC INFORMATION

### A. Basic Project Data

| Country | Project ID | Parent Project ID (if any) | Project Name |
|---|---|---|---|
| Bosnia and Herzegovina | P171150 | | Bosnia & Herzegovina health sector reform project (P171150) |
| **Region** | **Estimated Appraisal Date** | **Estimated Board Date** | **Practice Area (Lead)** |
| EUROPE AND CENTRAL ASIA | Jun 08, 2020 | Sep 23, 2020 | Health, Nutrition & Population |
| **Financing Instrument** | **Borrower(s)** | **Implementing Agency** | |
| Investment Project Financing | Ministry of Finance, Federation of Bosnia and Herzegovina,Ministry of Finance, Republika Srpska | Ministry of Health and Social Welfare, Republika Srpska, Ministry of Health, Federation of Bosnia and Herzegovina | |

**Proposed Development Objective(s)**

To support improvement in the efficiency of resource management in the health sector, including a road map for the clearance of arrears, to enhance the delivery of care in Bosnia and Herzegovina.

## PROJECT FINANCING DATA (US$, Millions)

### SUMMARY

| | |
|---|---|
| **Total Project Cost** | 75.00 |
| **Total Financing** | 75.00 |
| **of which IBRD/IDA** | 75.00 |
| **Financing Gap** | 0.00 |

### DETAILS

**World Bank Group Financing**

| | |
|---|---|
| International Bank for Reconstruction and Development (IBRD) | 75.00 |

| Environmental and Social Risk Classification | Concept Review Decision |
|---|---|

| | |
|---|---|
| Low | Track II-The review did authorize the preparation to continue |

Other Decision (as needed)

NA.

## B. Introduction and Context

Country Context

**1. Bosnia and Herzegovina (BiH) is an upper-middle income country, with a GDP per capita of US$5,951, and a complex governance system with devolved responsibility for design and implementation of public policy.** Per capita income is approximately six times lower than the average per capita income of the European Union. Approximately 60% of BiH's 3.5 million inhabitants live in rural areas, with the north and central areas being most densely populated. The 1995 Dayton Peace Accords afforded the country a degree of stability but created a complex administrative system which consists of two entities (the Federation of Bosnia and Herzegovina [FBiH] and the Republika Srpska [RS]), and one autonomous district (Brcko District). All three have their own constitutions and governments and are politically, administratively, and fiscally autonomous The FBiH has 10 autonomous cantons and 79 municipalities; Republika Srpska has 7 administrative (non-autonomous) regions and 63 municipalities.

**2. While BiH achieved GDP growth of 3.1% in 2018, the economy still faces the challenges of unemployment and high poverty rates.** On average, between 2011 and 2017, BiH experienced relatively low (1.9%) GDP growth (World Bank, 2019). Supported primarily by consumption and public investment, economic growth is projected to gradually increase to 4% by 2021. However, structural challenges remain in relation to unemployment and poverty. Although unemployment rates have decreased since 2016, in 2018 the rate of 18.4% (Labour Force Survey) remains significant. The poverty rate also remains high, with 16.9% of the population living below the national poverty threshold (World Bank, 2015). In addition, 32.9% of the rural population is at-risk-of-poverty, compared to 17.3% of the urban population (Ceriani and Ruggeri Laderchi, 2015). Since this broader macro-economic environment limits fiscal space for the health sector, it is critical that efficiency and value-for-money is achieved.

**3. The complex political structure and weak mechanisms of BiH for inter-government cooperation pose a challenge to effective policy reform and implementation.** In 2017, the state-level and FBiH parliaments met sporadically, and political tensions slowed the reform momentum. Uncertainty over the formation of a new government following the 2018 elections, and challenges (such as the need for electoral legislation for the Federation's House of People's) have also presented barriers to the smooth implementation of reforms. There is also a marked lack of horizontal coordination between the FBiH and Republika Srpska entity governments and between the FBiH cantons, as well as a lack of vertical coordination between the BiH government and FBiH and Republika Srpska entity governments, and between the entity and cantonal governments in FBiH. The persisting absence of an agreed coalition government in the FBiH following the 2018 elections further complicates the picture.

**4. BiH's public finances are not well managed - accumulation of arrears has been a major challenge for decades.** Arrears are a symptom of weaknesses in governance and accountability and contribute to a lack of progress in reforms to improve the efficiency of public services. Whereas pervasive payment delays of salaries and salary contributions point to low fiscal discipline in the system and the inability of the state to enforce

collection of tax and social security contributions, payment delays to suppliers mean that the latter are effectively providing financing to the public sector. This inevitably means increases in prices to compensate for financial costs as suppliers integrate the cost of payment delays upfront into their supply and service offers. The accumulation of arrears also hinders restructuring or privatization. As such, resolving the arrears issue in BiH is key to improving the planning and execution of macroeconomic policy and the functioning of private-public relations.

Sectoral and Institutional Context

**5. Reflecting BiH's complex political constitution, health care insurance and health care services are highly fragmented.** In general, most health facilities in the Federation are established and owned by the cantons. The entity-level MoH in FBiH has a limited (mainly coordination role) in policy setting and implementation: cantonal MoHs are primarily responsible for the design and delivery of health care insurance and health care services. Closely related to this is the problem of duplication of functions and unclear mandates. The Republika Srpska health sector has a more unitary character, with a single, central MoH owning hospitals (although municipalities own and operate primary care facilities). The health insurance funds (HIF) are semi-autonomous institutions. They are the main purchaser of health services, and the MOH and municipalities (in Republika Srpska) or cantons (in FBiH) are the founders (owners) of hospitals and primary care facilities, respectively. Founders, however, do not effectively hold facility managers accountable for financial performance or quality of care. At the same time, the ownership structure means that the HIFs do not have authority to require facilities to implement rationalization or other cost saving measures.

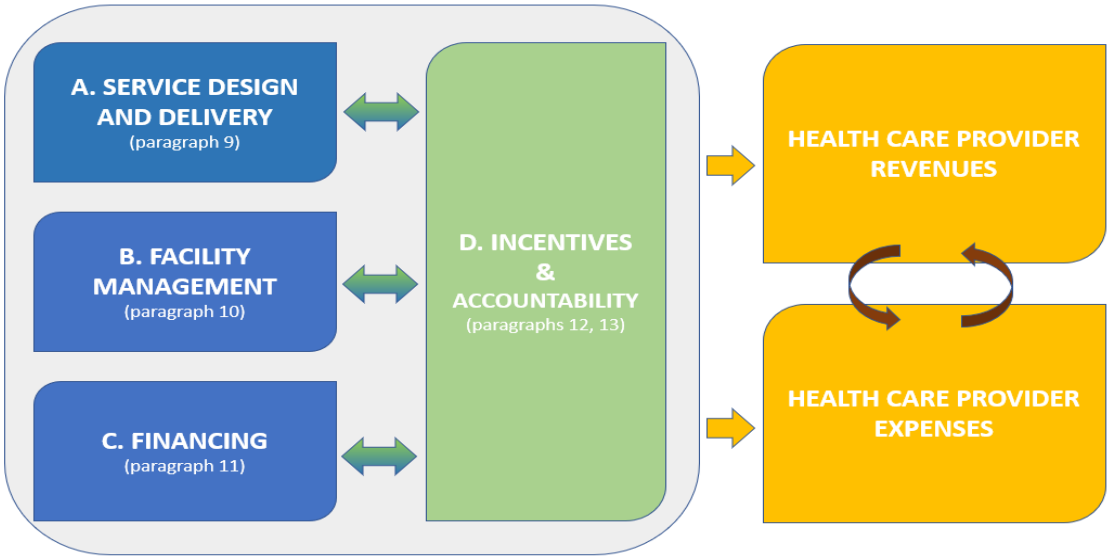
**6. Poorly planned services and weak governance negatively impacts quality of care**. Despite the existence of hospital master plans in both entities, no significant merging or restructuring of hospital capacity has been undertaken in practice. This is not only wasteful, but directly impacts on quality and outcomes of care. In Republika Srpska, for example, there are hospitals which treat patients with a heart attack as rarely as twice a month. Survival rates for these patients are substantially worse than those seen in hospitals with busier cardiac units. Furthermore, although agencies for quality monitoring and improvement are well-established in both entities, their impact on day-to-day clinical work or strategic thinking remains limited. Accreditation currently focusses on the achievement of minimum standards, rather than more ambitious goals of continuous quality improvement. Both agencies have also developed systems for benchmarking of family medicine teams based on key health outcomes (such as management of hypertension). This information, however, is not yet made public or used for payment. Additionally, health insurers' contract and payment arrangements with health care providers do not optimize incentives for quality or efficiency.

**7. A recent poll on WBG social media found that almost eight out of ten people are quite dissatisfied or very dissatisfied with the health care system – a remarkable figure**. People frequently stated that the health care system has never been worse, signaling an urgent need for reform. Common reasons for dissatisfaction were staff being rude or not knowledgeable, but respondents also cited concerns about money being wasted. Corroborating this WBG study, the EBRD Life in Transition Survey, 2016 found that around three quarters of the population were satisfied with the quality and efficiency of health care in Slovenia, Turkey and Croatia; in BiH, the figure was less than half.

**8. The current system poses important fiscal risks for the country and become increasingly unaffordable, including concerns about health sector indebtedness.** Arrears pose an immediate threat to the sustainability of the health care sector. Earlier ASA (P161510: *Health Care Arrears in Bosnia and Herzegovina*, completed FY2018)

estimated that in FBiH arrears were approximately 230 million BAM in 2015. In Republika Srpska, the report found that liabilities amounted to over 1.1 bn BAM, of which arrears amounted to 469 million BAM. Figure 1 provides a conceptual framework for analyzing the drivers of health sector arrears, in terms of immediate causes (financing, service design and delivery, facility management) and deeper determinants (incentives and accountability). The *Health Care Arrears in Bosnia and Herzegovina* report examined each of these drivers in turn; its findings are summarized in paragraphs 9-13. This thematic approach to the causes of arrears points to the actions needed to improve sustainability of the health sector, both in the short and long term. Accordingly, the shaded area in Figure 1 (boxes A, B, C & D) defines a boundary of the project.

**Figure 1: Conceptual framework & project boundary: the drivers of health sector arrears and indebtedness**




Source: adapted from Arur and Somanathan, 2018

**9. Service design and delivery (box A in Figure 1) is compromised by inefficiencies in the hospital network, the allocation of activity and the lack of payment systems to incentivize high quality care.** In-patient care in hospitals settings consumes almost half of total expenditures, compared to an OECD average of 30 percent, forgoing the opportunity to allocate funds to more cost-effective primary care settings. Key indicators, such as the number of beds per doctor and bed occupancy rates, vary widely among comparable hospitals indicating scope for rationalization in some facilities. For instance, number of beds per doctor varies from 2 in Nevesinje to 3.7 in Bijeljina. Bed occupancy rates are also low compared to western European standards, varying from 51% in Zvornik to 82% in Clinical Centre Banja Luka. In both entities, payment structures do not adequately incentivize performance of quality. There are no stimuli for following clinical pathways, guidelines or for the provision of preventative care. Similarly, where DRGs are in use in the Republika Srpska, they do not incentivize outpatient care because outpatient care is underpriced relative to inpatient services. In addition, decisions around capital investments – both infrastructure and investments in diagnostic equipment – were made without reference to current cost implications or the challenges of the duplicated health service network.

**10. Poor management of hospitals and primary care centres (box B) further exacerbates indebtedness.** Health facility managers who accumulate deficits and arrears are not penalized, and managers who take steps to improve efficiency and reduce arrears are not rewarded. There are gaps in the legal framework – notably the

Health Insurance Law places most responsibility for arrears on the HIF – but other accountability measures are not being enforced. For example, many hospitals are not submitting annual performance reports, despite a requirement to do so; many facilities are not paying salary contributions; and there were no consequences or follow up for negative audit findings of health facilities. Systems to appoint and train qualified managers also need to be strengthened to build a different culture and provide a supply of managers who can balance the financial and quality related needs of the sector.

**11. Financing (box C) is constrained by the wider macroeconomic environment while service delivery and governance challenges mean that the system is foregoing opportunities to provide high-quality care and maximize scarce resources.** In 2014, BiH spent 14% of government revenue, equivalent to almost 10% of GDP, on health. Remarkably, for a lower-middle income country, these figures match EU averages. Per capita spend, however, is low ($484 per person per year), meaning that BiH's stretched health care resources should be used as effectively as possible. This is not currently the case. The structure of the contracting system, for example, foregoes opportunities to optimize efficiency: in FBiH, the diagnosis-related group (DRG) payment system is barely used, and in the Republika Srpska the system does not currently benefit from a process for systematic tariff revision, so reimbursement is not well calibrated with actual costs and incentives for high-quality care. In addition, the hospital network has not been rationalized (in either entity) and the current allocation of activity compromises quality and raises costs. Too much of complex, chronic care is managed, at high cost, in hospital settings, rather than proactively, at lower cost, in primary health care settings.

**12. Poor governance further undermines the health sector's financial position (box D).** In the Republika Srpska, the rate of mandatory health insurance incomes contributions was reduced in 2013, from 12.5% to 12% for the employed (compared to 15% in 2001) and from 2% to 1% for the retired (compared with 3.75% in 2009). The HIF estimates a total revenue loss of 81mn BAM between 2013 and 2016. Crucially, these decisions to reduce the funding envelope were not aligned with expenditure decisions. Central decisions to increase wages and a lack of planning around capital investments and the lack of an evidence-based approach to the benefits package, have further contributed to arrears. For example, centrally mandated salary increases for staff, particularly in 2008 (86%), created an additional annual burden of 80mn BAM for facilities, but without an increase in financial allocations. The HIF took out loans to cover the gap, but the 67 health facilities were responsible for repayments.

**13. Governance is further weakened by a lack of accountability and responsiveness to citizens is not used to steer the system.** The institutional framework and capacities for monitoring health sector efficiency and quality are not adequately defined and supported – in each entity, the MOH, HIF, health care quality and accreditation agency, and audit authority. The combination of weak governance, political patronage and limited citizen engagement means that health systems are not held to account for providing good care. In addition, patients have little choice over where they can get care, so cannot 'vote with their feet'. Using data and finance as management levers and building accountability mechanisms would be significant, and technically feasible reforms.

**14. A package of measures will be necessary to tackle the problems of poor quality, poor facility management and poor system governance.** This project will support BiH's health systems to achieve the twin aims of reforms to improve health sector efficiency and tackling the immediate issue of indebtedness**.** It will focus on feasible but foundational actions which put the health sector on the path towards continuously improving clinical and financial performance. Specific activities qualifying for World Bank (WBG) assistance were identified with counterparts through a structured process. The foremost criterion was firm political commitment to enact reforms, signaled by items included in the *Republika Srpska Economic Reform Programme* and *Joint*

*Economic Reform Programme for 2019-2022*. Reforms that would be difficult to achieve without WBG assistance were also prioritized. Other criteria included the need to predominantly finance new policies, practices and behavior (rather than goods or works, except where this would lead to better health care quality or efficiency, such as enabling day-case surgery); the need for coherence across entities and cantons in the selection of activities; catalytic potential (the potential to spread to other public services or, within FBiH, to spread across cantons); and, ideally, positive impact on vulnerable groups. Project activities are also aligned with the recommendations made in the *Health Care Arrears in Bosnia and Herzegovina* report. This set out a strategy for arrears clearance, focused on verification, clearance and prevention of further accumulation through reforms at system- and facility-level to ensure that cleared debts do not simply reaccumulate, as summarised in Annex 1 of Concept Note.

**15. Without effective action now, population health in BiH is likely to worsen.** Despite the problems outlined above, several measures of population health in BiH compare well with the six countries in the Western Balkans (WB6) and seven in the Small Transition Economies of Europe group (STEE7; see Table 2). One in seven of the population rate their health as good or very good, exceeding levels reported in all WB7 and STEE7 countries apart from Montenegro. These metrics, whilst currently reassuring, are threatened by low-quality care and wasteful spending.

**Table 2: Population health outcomes in BiH and other countries**

| | **BiH** | WB7 | STEE7 | EU28 |
|---|---|---|---|---|
| Life expectancy at birth (years) | **77.1** | 76.1 | 76.9 | 81.0 |
| Infant mortality rate (per 1 000 live births) | **4.9** | 6.6 | 3.6 | 3.4 |
| Under-5 mortality rate (per 1 000 live births) | **5.7** | 7.5 | 4.4 | 4.1 |
| Mortality rate from NCDs between ages 30 and 70 (%) | **17.8** | 18.9 | 18.5 | 14.0 |

**16. Governments in each entity have recently restated their commitment to health sector reform as a national priority.** In the *Joint Socio-economic Reforms for the Period 2019-2022* document, issued by both entities in October 2019, the governments of Republika Srpska and FBiH listed 4 areas that were jointly held as priorities for reform. One of the four areas is “comprehensive reform and improved quality of the health care system”, and the document lists nine commitments jointly made by the entities, including “urgent steps to halt the growth of health sector arrears and achieve financial stability” and “provide for well-managed and good quality accessible public health care for all citizens”. It also describes specific challenges facing the health sector, including the need to improve the fiscal sustainability and identify additional funding sources, to improve service delivery as well as health sector governance and accountability. The WBG is the only development partner mentioned and specifically identified as a partner in this area.

Relationship to CPF

**17. The 2016-2020 Country Partnership Framework identified an efficient public sector and targeted health sector reform as high priorities;** the identification of the health sector as a priority area was included in the 2015 Systematic Country Diagnostic (SCD). This was both in terms of the importance of ensuring the fiscal sustainability and quality of service delivery, as well as the importance of improving services for the benefit of citizens’ health and productive capacity. In addition, the CPF notes the importance of targeted interventions to improve health care services.

**18. Prioritization of the health sector is expected to be a continuing theme in the upcoming CPF and SCD, which will take effect towards the end of project preparation and throughout implementation.** The health sector team has actively participated in these discussions; the relationship between healthy societies, fiscal sustainability and a more efficient and productive BiH is likely to be a consistent theme, given its importance to the country's development and the focus expressed by the government and other development partners.

## C. Proposed Development Objective(s)

**19.** The proposed Project Development Objective is to **support improvement in the efficiency of** resource **management in the health sector and deliver better quality of care in Bosnia and Herzegovina.**

**20.** The PDO addresses the most urgent issue of financial stability in the health care sector, without promising financial balance or guaranteeing sustainability. Instead, "*improve(d) efficiency of resource management*" is an outcome for which the project can be held accountable, given its duration, resources, and approach. Specifying "*better quality of care*" identifies the principal intended outcome for the key beneficiaries: patients using BiH's publicly-funded health care systems. The project aims to improve both the financial position of BiH's health sector, as well as the quality and efficiency of health care services, to improve public satisfaction and ensure that debts cleared today do not reaccumulate tomorrow. This is a necessary first phase in a longer-term programme of work that BiH must undertake, which will most likely also need to include eventual expansion of the revenue base for the health sector.

### Key Results (From PCN)

**21.** It is proposed that the project will measure success in achieving the PDO through four indicators:

a) At least xx% of health care providers achieving specified liquidity ratio, indebtedness ratio (or some other recognized indicator of prudent financial management) at the end of the FY;
b) At least xx% reduction in annual avoidable hospital admission[1] rate;
c) At least xx% of health care providers demonstrating quality gains through a defined set of indicators that are publicly disclosed; and,
d) At least xx% of health care providers using patient satisfaction measures and service-user engagement in business planning, including publicly-disclosed patient satisfaction rates.

The proposed indicators directly relate to the PDO, addressing resource management (indicator 1) as well as the efficiency and quality of clinical care (indicators 2 and 3), as experienced directly by the key beneficiaries of the project, i.e. patients and their carers. The final indicator also addresses key beneficiaries, by focusing on citizen feedback as an accountability mechanism to improve health system performance.

**22.** In addition, the project will use four to six Disbursement Linked Indicators (DLIs) to incentivize results. The DLIs will be achievable but challenging at the same time, combining ambition and feasibility so that the financial risk attached to each DLI would have the right impact. The DLIs will have different results (Disbursement Linked Results-DLRs) for Republika Srpska and for FBiH. Potential DLIs include:

a) Improved financial reporting for the health care sector, including verification and publication of the extent and nature of arrears in the health care sector; prioritization for clearance of arrears; and a

commitment control system established in each health care provider as they are introduced into the Treasury System;
b) Updated payment system that incentivizes efficient care for four clinical conditions (selected from those that impose a high cost on the health care system, i.e. complex, chronic conditions such as diabetes);
c) Updated care pathways and clinical guidelines for four clinical conditions (the same as those benefitting from an updated payment system);
d) Differentiation of beds in public hospitals into acute and long-term care beds, with re-contracting to ensure appropriate and efficient use.

**23.** Analysis, actions and indicators to **address gaps between males and females and improve women's empowerment** are considered in Annex 2 of the Concept Note. These will be developed further during pre-Appraisal.

## D. Concept Description

### A. Concept

1. Description

**24. This project represents the first step in a lengthier process of securing the long-term sustainability of BiH's health care systems**. The longer-term vision for health sector reform in BiH should be that of people-centered and performance-focused health care insurance and health care services. A primary focus in the Republika Srpska health system is to clear arrears and prevent further accumulation. This project will offer a package of technical and financial assistance that invests in quality and efficiency improvements for front line services, alongside the flexible financing needed to stop the accumulation of health sector arrears without compromising service access and quality. Crucially, the project will construct a network of incentives, both financial and non-financial, positive and negative, short- and long-term, in the areas of FM and service quality, thereby laying the foundations for longer-term and more challenging reforms in Republika Srpska and FBiH, such as functional or structural integration of the HIFs. A road map for the clearance of health sector arrears in the Republika Srpska is given in Annex 5.

**25.** Three components are envisaged:

a) Component 1: **supporting quality and efficiency gains**;
b) Component 2: **supporting focus on results**; and
c) Component 3: **project management, monitoring and evaluation**.

**26. Component 1: supporting quality and efficiency gains (estimated US$ 7.0 million for FBiH, US$ 17.0 million for Republika Srpska).** This component support redesign of health care services to optimize the service network (including increased primary care and day-care where appropriate), improve service delivery, and enhance quality monitoring and improvement, including targeted support to weaker health care providers. More detail on the interventions to be supported by this component (selected using criteria described earlier) are shown in Box 2. The component will finance technical assistance; goods (including but not limited to medical equipment, computers/tablets, office equipment, specialized equipment and consumables); and rehabilitation works (no new construction is anticipated, only minor rehabilitation/small works in existing facilities).

**BOX 2: Proposed Investments to Enable Quality and Efficiency Gains in BiH's Health Systems** (Box A in Figure 1)

**1. IMPROVING SERVICE DESIGN AND DELIVERY IN THE PUBLICLY-FUNDED HEALTH SECTOR**

*a) Support to redesign services and improve service delivery*

- **optimize the service network**, including increased primary care and day-care where appropriate, and concentration of specialist services into fewer providers;
- develop **patient-level costs** and based on this, **repricing of selected services** within the DRG system; and
- develop **manager-clinician teams to improve patient pathways** for specific clinical conditions, with **training on improving clinical and business performance** in individual clinical units.

*b) Support for enhanced monitoring and improvement of clinical quality*

- strengthen the ***assurance* of minimum standards, *monitoring* of health care quality and outcomes**, and ***improvement* of the quality of care for priority conditions,** through
  - wider **collection, verification, analysis and dissemination of quality benchmarks**;
  - financing, technical assistance and training to **strengthen the role of the health care quality agencies** in each entity; and
  - **targeted support** to weaker primary care providers and hospitals.

**2. IMPROVING MANAGEMENT IN THE PUBLICLY-FUNDED HEALTH CARE SECTOR** (Box B in Figure 1)

*a) Support to enhance managerial accountability and skills for improved efficiency and quality*

- develop a robust and repeated **measurement of management quality** in health facilities (based on the World Management Survey), with **management improvement activities** based on findings; and
- establish **Performance Innovation Units in health care providers, health insurance funds and MoHs** to provide a pool of financial and human resources to strengthen internal needs analysis, reform planning, piloting and evaluation of reforms.

*b) Support to improve reporting and information sharing for enhanced accountability and transparency.*

- develop robust **management information and communication technology** such as integrated hospital dashboards to provide information on resources, activities, and key performance indicators;
- enhance **public accountability** of health care providers and health insurance funds for clinical and business performance through **balanced scorecards** and **citizen report cards**; and
- enhance **citizen engagement** to gather users' views on satisfaction with health care and health insurance.

**3. IMPROVING FINANCIAL MANAGEMENT IN THE HEALTH CARE SECTOR** (Box C in Figure 1)

*a) Stock-take of existing arrears in health care providers and in the health insurance funds*

- develop an **arrears data collection methodology**, by broad expenditure category, maturity, and cause of accumulation;
- establish a publicly-accessible **database of arrears** by health care provider; and
- establish a publicly-accessible **procedure to define priorities and sequence** for arrears clearance.

b) *Prevention and control of new arrears by improving financial management in health care providers and in the health insurance funds*

- purchase **hardware, software and training to allow health care providers to implement the Treasury financial information system,** and thereby improve their reporting on arrears, liabilities and financial risk;
- strengthen the **legal and regulatory framework** applying to financial management in health care providers and the health insurance funds;
- apply **business process re-engineering** as necessary to comply with Treasury System requirements; and
- provide **financial management training** to directors/managers to improve capacity in financial analysis, reporting and planning

c) *Clearance of verified arrears*

- incrementally **transfer health care providers and the health insurance fund to the Treasury System** (i.e. the general government budget) in the Republika Srpska and possibly, in FBiH.

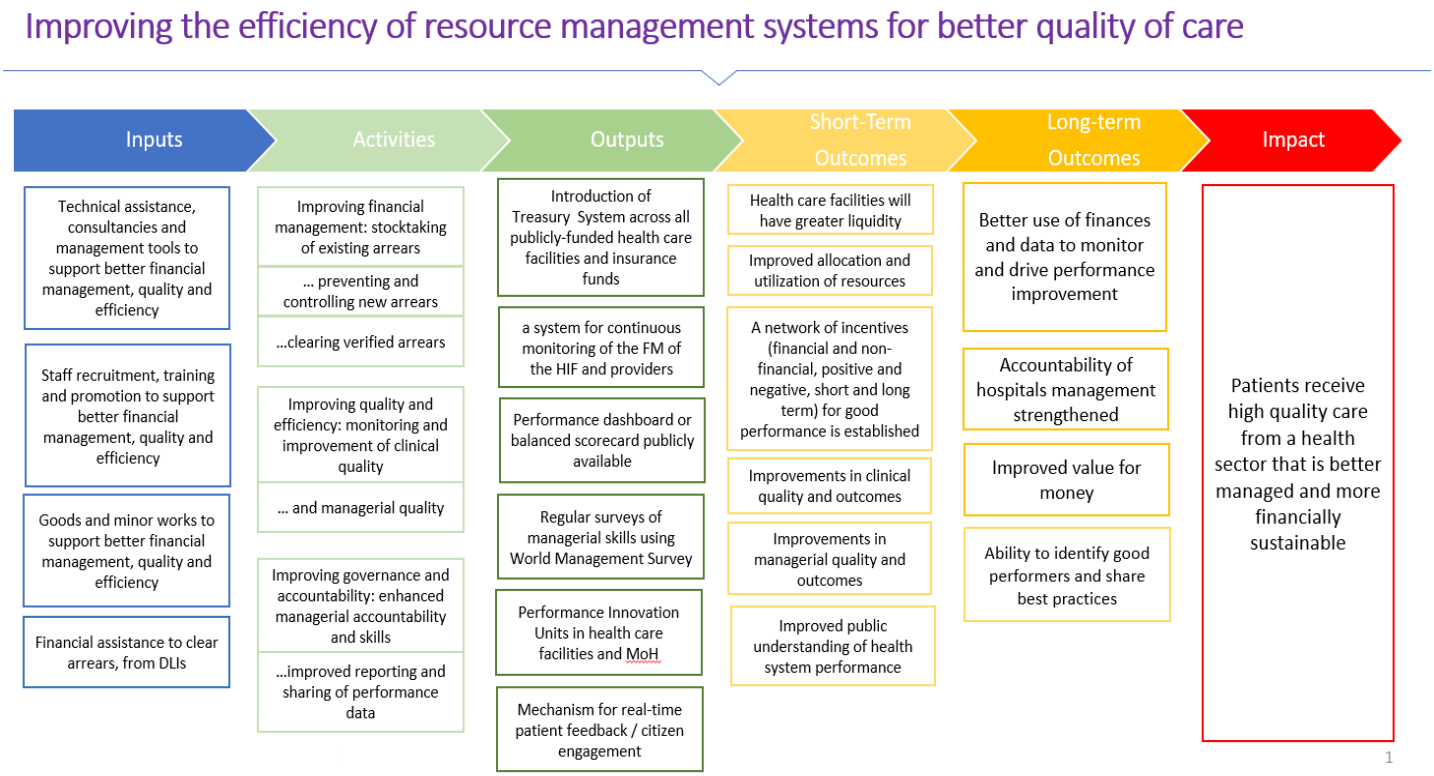
**27. Component 2: supporting focus on results (estimated US$ 15.0 million for FBiH, US$ 30.0 million for Republika Srpska).** This component will focus on the governance reforms needed to secure quality and efficiency gains (Box D in Figure 1). It aims to provide incentives that reward the government and other relevant health system authorities for making changes in incenti es and accountability mechanisms that will support improved clinical and financial performance. Financing for this component will be provided based on results tracked by four to six DLIs; each one will include two to three DLRs. The DLIs will be designed to target regulatory and institutional bottlenecks to improving health sector performance, including fragmented and limited accountability for results, and thereby synergize with the investment component. During preparation, a detailed list of DLIs and DLRs will be developed and include DLI targets, timelines, verification, disbursement schedule, and scalability. Potential eligible expenditures under Component 2 will be identified through their relevance to the DLIs and to the PDO. For example, eligible expenditures may include financing to HIFs to support coverage for the poor, unemployed or other groups insured through the Government budget. A robust DLI verification mechanism (using an independent partner agency such as the World Health Organisation) will be agreed.

**28. Component 3: project management, monitoring and evaluation (estimated US$ 3.0 million for FBiH, US$ 3.0 million for Republika Srpska).** This component will support technical and operational assistance to two Project Implementation Units (PIU) responsible for project management and implementation, one in FBiH and one in Republika Srpska. Technical assistance is expected to be necessary to support some PIU posts, such as Project Coordinator, Procurement Specialist, FM Specialist, Monitoring & Evaluation Specialist, Communications Specialist and Administrative Assistant. Financing may also be necessary to cover equipment, furniture, and operating costs, such as travel, to support supervision. Where feasible/practical, technical assistance will be shared across the two PIUs.

**Preliminary technical assessment.**

**29.** A potential results chain was developed with the immediate counterparts (Figure 2), which was then tested with a broader range of stakeholders in three thematic Working Groups during the just completed mission. Brainstorming sessions on possible metrics and critical assumptions for each results chain were also conducted.

**Figure 2: Results chain for the project**




**30. The emphasis of this project is on improving performance within the current resource envelope whilst laying the foundations for longer term sustainability.** It is anticipated that complementary structural reforms – including reforms affecting revenues, coverage, and equalization mechanisms for mandatory health insurance -- will be addressed through IMF support. Discussions have commenced with the IMF to harmonize efforts in this regard.

**Financing instrument, overall project cost and financing**

**31. A number of approaches were considered, and an IPF with DLIs was found to be the most appropriate financing instrument for the proposed package of technical and financial assistance.** A PfR is deemed inappropriate at this time because the sector still needs several investments to strengthen its foundations, as well as regulatory reform; also, DLIs would allow for stretch goals. Investment is needed to bring about new ways of organizing and managing health care services, so that debts do not continue accumulating. At the same time, counterparts' foremost priority is to address health sector indebtedness, and financial assistance to do so is the primary basis of their request for WBG engagement. An IPF with DLIs can support both aims: the IPF component enabling investment, and the DLI component acting as an incentive to enact difficult reforms and achieve 'stretch goals' beyond simply procurement and implementation of activities, whilst releasing liquidity. A PfR is not appropriate at this time because the sector still needs several investments

to strengthen its foundations, as well as regulatory reform; DLIs also allow stretch goals. In Republika Srpska, this approach was agreed with the Prime Minister's Advisor, Minister of Finance and Minister of Health in April, and reaffirmed through official correspondence of October. In FBiH, the same approach has also been agreed with KS, HNK/Z and KT Cantons.

| Legal Operational Policies | Triggered? |
|---|---|
| Projects on International Waterways OP 7.50 | No |
| Projects in Disputed Areas OP 7.60 | No |

Summary of Screening of Environmental and Social Risks and Impacts

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## APPROVAL

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**Approved By**

| | | |
|---|---|---|
| Practice Manager/Manager: | | |
| Country Director: | | |

# Annex 1: Policy Recommendations from *Health Care Arrears in Bosnia and Herzegovina,* FY2018 (Analytical work completed in 2018, P161510)

**Health financing and purchasing:**

- ***Reestablish the credibility of the budget planning and contracting process*** by negotiating a credible medium-term revenue and expenditure framework for health sector; establish "hard budgets" for facilities linked to specific performance targets; establish legal and policy mechanisms to align decisions on the benefit package with available financing;
- ***Strengthen performance payment and contracting***. For primary care, link payments to effective management of chronic disease and avoiding unnecessary referrals; for hospitals, modify the Diagnosis Related Group (DRG) payment model to reduce incentives for hospitalization and enhance incentives for quality and outpatient care; strengthen legal and regulatory basis for paying managers and health workers based on performance; and
- ***Improve equity and sustainability of health sector revenues***, including through a more transparent system of subsidizing non-contributors; seek additional revenue sources to offset reduced contribution rates (e.g., excise taxes); enhance opportunities for facility revenues.

**Improve efficiency and quality of health service delivery:**

- ***Optimize the health care network***, through adoption and implementation of a health network plan, including clearly defining norms and what services will be provided at which levels of care;
- ***Reduce input costs***, including through reducing costs of pharmaceuticals and medical supplies. and reduce excess non-medical staff in both hospitals and primary care facilities; and
- ***Improve internal efficiency while ensuring quality***, including improving rational use of medicines and diagnostics; reductions in nonmedical staff; increased use of outpatient treatment and surgeries by hospitals; differentiated services for acute and long-term care and ensuring economy of scale and transparent and competitive procurement.

**Health system governance, stewardship and accountability:**

- ***Strengthen governance and legal accountability*** of facility managers and founders, both for financial performance as well as ***quality*** and provision of healthcare, including through stronger enforcement of existing legal requirements, and amendments to the Law on Healthcare, Law on Health Insurance, and related legislation;
- ***Enhance controls***: strengthen commitment controls in both primary care facilities and hospitals (preferably through decentralized commitment control systems); enforce payment of salary contributions; tighten regulation of loans taken by ***health*** facilities; strengthen HIF capacity for controlling and auditing service provision and spending; and implement government-wide public financial management reforms (such as requiring payments with 90 days of delivery);
- ***Strengthen systems for performance monitoring and accountability:*** establish an integrated health information system; create performance scorecards for primary care and hospitals; clarify institutional responsibilities and strengthen capacities for monitoring health service quality and financing; and
- ***Strengthening management,*** including through establishing merit-based system for selecting and promoting managers; ***strengthen*** health management training systems; and increase opportunities for lesson sharing among managers and teams.

# Annex 2: Potential Actions to Address Gender Gaps and Women's Empowerment

**1. Women's health risks and health outcomes in BiH compare favourably to men's.** Similar to the rest of the region, female life expectancy exceeds that for men. This is in large part because adverse health risks, such as smoking, unhealthy diet or excessive alcohol consumption are less prevalent amongst women (although still substantially higher than in neighbouring countries). BiH has also seen dramatic improvements in maternal mortality. The percentage of pregnancies attended by skilled birth staff reached 100% in 2012 and adequate antenatal care is also almost universal (although often paid for privately). Women's self-assessed health is, however, worse: the share of men assessing their health as "very good" and "good" is 27% and 41% respectively, compared to 22% and 37% among women. This gender gap is mainly driven by the cohort aged 30-50, and especially by the cohort older than 50; women aged 18-30 tend to assess their health as positively as men do.

**2. Women in BiH tend to work in the public sector but have less access to good jobs.** Female labor force participation, at 41%, is significantly lower than expected for BiH's level of development. Women in the bottom 40% are less than half as likely to have formal employment compared to wealthier counterparts (15% versus 32% employment rate) or compared to men in the same income bracket (42% employment rate). This gender gap is estimated to cause an aggregate national income loss of 16.4%. The discussion is relevant to the project because the health sector made a positive contribution to economic growth pre-crisis, because women opt mostly for secondary degrees in education, social sciences, health, business, law and services, and because women exhibit a preference for the public sector (which employs 37% of women). Yet women's employment levels trail men's at all ages: women face unequal opportunities due to social norms concerning the type of work and level of managerial responsibility. Women also face employment discrimination if they marry and have children, despite the existence of laws intended to prevent such discrimination.

**3. The project has potential to tackle barriers preventing women accessing good jobs in the health care sector.** As illustrated in Box 2 ("Proposed investments") there will be activities to measure and improve managerial skills and competence. Some aspects may be preferentially directed towards women. Analysis of the barriers and disincentives to hire and promote women, for example, could emerge from application of the World Management Survey to the BiH health sector, leading to policy actions to overcome these barriers. Activities to optimize service design and service delivery may also emphasize an expanded role for nurses (a job usually performed by women), to increase the competence and status of this profession within the health sector. The Bank manages a Trust Fund (supported by the Swiss Agency for Development and Cooperation) aimed at building a knowledge base and promoting evidence-based policymaking to tackle gender inequalities. The project will explore co-financing through this TF.

# Annex 3: Stakeholder and Citizen Engagement

**Stakeholder Engagement**

**1. We have engaged a wide range of stakeholders during the identification phase of the project, including meetings with each entity's nursing and medical associations** - groups that had not previously been invited by WBG to give their views on health sector challenges and opportunities. WBG has also developed close and effective collaboration with development partners (including UN agencies and several national development agencies and/or embassies) through a standing committee that discusses health sector issues, thus developing a single, coherent voice on priorities for reform. We have also engaged directly with BiH's politicians, presenting our proposals for health sector reform at two high-level fora where each of the main political parties were represented.

**2. We will maintain and extend this level of stakeholder engagement as the project develops.** A stakeholder analysis was conducted in both FBiH and Republika Srpska and based on this, Working Groups were established in both entities, comprising representatives from the Ministries of Health and of Finance, the health insurance funds, health care providers and professional associations. In our initial meetings, the Working Groups, were asked to participate in the identification of priority investments for the project as well as SMART indicators to monitor progress/achievement of the PDO. We will maintain engagement with development partners through the standing committee, and with politicians as and when appropriate.

**3. Groups representing patient or carers are virtually non-existent in BiH.** We have nevertheless made extensive effort to engage with citizens and health care users, described in detail next.

**Citizen Engagement**

**4. In the absence of established groups representing health care users or carers, we coordinated several innovative activities to better harness citizens' voices during the identification stage of the project.** These were developed with the Media and Communications team in the Country Office and included: structured interviews on health sector challenges and priorities with citizens drawn from diverse territories and socioeconomic groups, video-recorded and edited with interviewees' consent; a series of Facebook polls to reach out to citizens and ask what BiH citizens want from the health care system; and infographics and videos illustrating health system challenges posted on Facebook and other WBG social media.

**5. These tools have been useful to challenge the status quo and create a sense of urgency on the need for health sector reform.** One of the Facebook polls, for example, showed that 97% respondents wanted to be able to choose a doctor or hospital in a canton or entity that wasn't their own. Joining up BiH's multiple, fragmented health systems may seem an unreachable goal to some stakeholders in the country. Our 97% 'killer statistic', however, exposed the strength of citizens' feeling on the issue and has been used in several dialogues with policy makers, to start shifting fixed views.

**6. We will continue and extend citizen engagement during the project.** One planned investment, for example, is a platform to seek rapid feedback from health care service users on the quality of care, to strengthen citizen feedback mechanisms and managerial accountability for performance. An appropriate project grievance and redress mechanism will also be established.

We will also continue to work with the Media and Communications team in the Country Office to develop a good communications strategy, ensuring that the public are kept up to date with the progress of the project, and are consulted on key aspects of design and implementation.

# Annex 4: Potential Climate Co-benefits

**1. The project may offer the opportunity to pilot waste recycling and reuse in selected health care facilities, as a source of additional revenue and a climate co-benefit.** The Sarajevo Clinical Centre (a large university hospital) has already developed a recycling and reuse plan that would decrease waste management fees and generate revenues. One of the project team members helped produce the plan.

**2. The project may also offer the opportunity to pilot energy efficiency programs in selected health care facilities, as a way to reduce operating costs and as a climate co-benefit.** The Sarajevo Clinical Center has retrofitted its Orthopaedic Clinic to improve energy efficiency; data on the resulting energy and financial savings can be made available.

## Annex 5: Road map to clear health sector arrears in Republika Srpska, December 2019

**Background:**

- The health sector has accumulated BAM ~525m liabilities to suppliers, salaries, the health insurance fund and the tax authorities over the past twelve years (BAM ~44m/year on average; this estimates the "future flow" of health sector liabilities to suppliers, salaries, the health insurance fund and the tax authorities).
- The Ministry of Finance's wishes, in the first instance, to deal with BAM ~400m arrears to the health insurance fund and to the tax authorities (the "stock of arrears").
- WBG estimates that efficiency gains of ~20% can be achieved through network optimization (equivalent to BAM ~9m/year of the future flow of health sector liabilities to suppliers, salaries, the health insurance fund and the tax authorities), chart 1 below illustrates all beneficiaries of HIF.
- Annex 1 sets the main challenges contributing to accumulation of arrears in the health sector.

| | Objective | Action needed | Actor | Resources needed | Expected results | Timeline |
|---|---|---|---|---|---|---|
| **I. Dealing with the stock of arrears** | **Clear BAM 400m health sector arrears to the health insurance fund and to the tax authorities.** | WBG provides financial assistance to the RS Ministry of Finance and Ministry of Health | WBG | BAM 75-100m, subject to negotiations with the WBG. | Actions will restore liquidity to front line health care services and restore credibility with suppliers | As soon as possible<br><br>(Arrears clearance would start in early 2020 with DZ, Transfusion and Forensic Institutes, then hospitals, finishing with health insurance fund and UKC Banja |
| | | IMF provides financial assistance to the RS Ministry of Finance | IMF | BAM ~100 m per year (phased over three years), subject to negotiations with the IMF. | | |
| | | Adopt WBG Program for Arrears Prevention and Clearance: by March 2020 | Government of Republika Srpska | Policy reform | | |

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| | | Implement Program, using timeline set out in Annex 2.<br>Key steps:<br>- Implement health reform measures<br>- Implement PFM measures<br>- Conduct stocktaking of health sector arrears<br>- Arrears clearance | | | | Luka in 2022) |

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| **II. Dealing with the flow of arrears** | ***a*. Stop overspending** | Establish a system for controlling all types of commitments and accumulation of arrears making the head of a hospital/entity responsible for maintaining a robust and transparent system of financial management (see Annex 3). | Government of Republika Srpska<br>+<br>WBG | Largely regulatory and policy reforms.<br><br>(WBG financial assistance will be available where goods, works | Actions will prevent accumulation of new arrears by preventing health care providers from spending beyond their allocated resources. | 6-12 months |
| | | Strengthen a legal framework for future monitoring of commitments, arrears and liabilities (see Annex 4). | | | | |
| | | Strengthen assessment, analysis and reporting of fiscal risks for the health sector through automated data collection, including defined institutional responsibilities and respective roles of the MHSW, HIF and other stakeholders (see Annex 5). | | | | |

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| | | Enforce compliance with PFM laws and regulations, including stronger penalties for non-submission of prescribed reports and fiscal responsibility statement. | | or consultancy services are needed). | | |
| **II. Dealing with the flow of arrears** | ***b*. Spend more effectively** | **Pricing and payment systems reform:** update prices paid by the health insurance fund to accurately reflect costs of care; introduce payment innovations that reward quality and efficiency in both primary and secondary care. | Government of Republika Srpska + WBG | WBG financial assistance (amount t.b.d.) to invest in goods and works and/or procure technical assistance and consultancy services. | Actions will prevent accumulation of new arrears by achieving ~20% efficiency gains in the organization and delivery of health care services (equivalent to BAM ~9m/year). | 12-24 months |
| | | **Procurement Reform:** Revise contracting approaches for primary care and hospitals, including pay-for-performance; introduce new purchasing and monitoring mechanisms for high-cost medicines. | | | | |
| | | **Health care services reform**: Adopt updated health network plan to provide care at the most appropriate level | | | | |
| | | **Workforce Reform:** Optimize skill-mix and distribution of health care workers, introduce performance-related pay. | | | | |
| | | **Management reform:** introduce stronger incentives and accountability frameworks for managers of health care provider and the health insurance fund. | | | | |

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| **III. Sustainable health system financing** | ***a.*** **Deepen quality and efficiency reforms** | Options:<br>- Continue and extend reforms on pricing, procurement, services, workforce and management listed in section II *b.*<br>- Updating population health care benefits (through strengthened cost-benefit analysis and a robust system for determining the benefits list)<br>- Reprofiling of clinical and non-clinical health care workers (skill-mix, distribution, payment and incentive systems) | Government of Republika Srpska<br>+<br>WBG | Largely regulatory and policy reforms.<br><br>(WBG financial assistance will be available where goods, works or consultancy services are needed). | Actions will establish a sustainable financial base for the health care sector by meeting the estimated structural shortfall in health system revenue (equivalent to BAM ~35m/year). | 24-36 months |
| | ***b.*** **Address structural shortfall in health system revenue** | Options:<br>- Delinking health care insurance from employment status<br>- Switching to general tax revenue for the health insurance fund<br>- Revising categories of persons exempt from contributing to health care insurance and/or degree of exemption | | | | |