



# Project Information Document/ Identification/Concept Stage (PID)

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Concept Stage | Date Prepared/Updated: 13-Feb-2018 | 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	13-Feb-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

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**Financing (in USD Million)**

**SUMMARY**

Total Project Cost	0.00
Total Financing	0.00
Financing Gap	0.00

**DETAILS**

**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.

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## 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

**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.

## Strategic 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.

**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 other 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 limited financial protection of Philhealth is closely related to the provider payment system which is Fee For Service.** Since the beginning of the implementation of the National Health Insurance in 1997, Fee For Service (FFS) benefit payment was used to reimburse inpatient care. Philhealth realized that FFS payment scheme will not address the bulging out-of-pocket expenses of their members at the same time will put at risk PhilHealth's financial solvency.

**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 realized that the path towards Universal Health Coverage is thru sustainable health financing.** Philhealth, in mid 2015 signified its willingness to scientifically group the cases through full implementation of the Case-Mix system due to the problem incurred in the implementation of the ALL Case



Rate. The review is guided by the Department of Health's "Health Financing Strategy 2010-2020" which sets a clear vision of how to enhance allocate efficiency through clarifying "who should pay for what and how to improve technical efficiency through reforming provider payment arrangements. The funding of health care services remains fragmented, particularly funding of pharmaceuticals and personnel costs. While all case rates (ACR) have replaced fee-for-service payments to cover inpatient services, providers' ability to "balance bills" beyond the case rate is still rampant and uncontrollable.

**Philhealth is looking at a provider payment reform that will help them move the agenda for better and more affordable health care for all.** Dismay with the impact of ACR, Philhealth eventually decided that the best way to address fraud, moral hazard of both providers and members, poor quality of care and high cost of health care is to shift to new Provider Payment Mechanism perhaps to recall the earlier decision to shift to Diagnosis Related Grouping and Global Budget. Among the issue raised were "how ready is the system (electronic/IT infrastructure and administrative) in Philhealth as well as at the provider level to adopt the DRG?" Other issues raised were Philhealth governance, policies and leadership support to new Provider Payment Mechanism.

### Claims Management

**Claim management processing is still slow, insufficiently automated, with a high rate of "human touches", excessively paper-based, without systematic and thorough audit control in place.** The most processing difficulties come from manual work and poor patient identification data (often without PINs). International Diagnostic Coding Standards (ICD-10) is used from the most providers, but it is not a clear level of encoding quality because as stated before the audit process is not methodical. In addition, the problem is the processing and the control of primary care benefit (PCB) from rural health units (RHU) on PHIC side. One of the reasons is that due to the technical difficulties and lack of effective project management, implementation of Electronic Claims Submission (eClaims) system is in delays on provider's side. Hospitals complain that PHIC does not provide enough up-to-date information on the rights of the PHIC's members (Online Claims Eligibility Verification), so it may happen that the patient uses the same benefits in more places than he/she is eligible for. Analysis of how much unjustifiable reimbursement annually PHIC has paid to the health care provider (HCP) because of incurrance of data is not known during this review.

### 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 provider payment reform, for example, diagnosis related grouping (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.

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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 through 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 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 three components: (i) strengthening key performance





indicators and analytics, (ii) improving process, systems, and quality assurance mechanisms on e-claims, and (iii) supporting the hospital provider payment system reform.

***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.

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) has 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: Improving 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.

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;
- The 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.

Outputs for 3

- Report and policy recommendation on the outcome/analysis of validation process on DRGs using selection criteria, and the results of simulation activity;
- Updated tariff per group and expansion of existing groups;
- Business requirements for DRG implementation identified and implemented, and Implementation strategy and design for DRG implementation developed;
- Functional and technical specifications for the DRG Grouper software tool identified

**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.

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**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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