Initial Poverty and Social Analysis

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Philippines: Build Universal Health Care Program (Subprogram 1)

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Asian Development Bank

CURRENCY EQUIVALENTS
(as of 15 May 2021)

Currency unit	–	peso/s (₱)
₱1.00	=	$0.0209
$1.00	=	₱47.7440

ABBREVIATIONS

ADB	–	Asian Development Bank
COVID-19	–	coronavirus disease
DOH	–	Department of Health
LGU	–	local government unit
MMR	–	maternal mortality ratio
OP	–	operational priority
OPE	–	out-of-pocket expenditure
PBL	–	policy-based loan
PHFDP	–	Philippine Health Facility Development Plan
PHIC	–	Philippine Health Insurance Corporation
SDG	–	Sustainable Development Goal
SRH	–	sexual and reproductive health
TA	–	technical assistance
UHC	–	universal health care

NOTES

(i) The fiscal year of the Government of the Philippines and its agencies ends on 31 December.

(ii) In this report, "$" refers to United States dollars.

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INITIAL POVERTY AND SOCIAL ANALYSIS

Country:	Philippines	Project Title:	Build Universal Health Care Program (Subprogram 1)
Lending/Financing Modality:	Policy-based Loan (PBL)	Department/ Division:	Southeast Asia Department/Human and Social Development Division

I. POVERTY IMPACT AND SOCIAL DIMENSIONS

A. Links to the National Poverty Reduction Strategy and Country Partnership Strategy

The proposed Build Universal Health Care Program (Subprogram 1) will address critical constraints facing the Philippines health sector. The program will pursue policy reforms to achieve the goals of the Universal Health Care (UHC) Act (passed on 20 February 2019) of equitable access to quality health care and protection from health-related financial risks. It will contribute to the achievement of Sustainable Development Goals (SDGs) including poverty elimination (SDG1), healthy lives for all to improve health outcomes and promote well-being for all (SDG3 and SDG5.6), reduced inequality (SDG10), and addressing climate change (SDG 13). The program will support the government's overarching development objectives as set out in the updated Philippine Development Plan, 2017–2022, for more inclusive growth with lower poverty incidence, reduced vulnerability for individuals and families, and assuring access to health services in all stages of life.[a] It will support the Asian Development Bank (ADB) Strategy 2030 operational priorities (OP) on (i) addressing remaining poverty and reducing inequalities (OP1); (ii) accelerating progress in gender equality (OP2); (iii) tackling climate change, building climate and disaster resilience, and enhancing environmental sustainability (OP 3); and (iv) strengthening governance and institutional capacity (OP6).[b] It will operationalize the first and third pillars of the ADB country partnership strategy for the Philippines, 2018–2023 by investing in people through a focus on human development and social protection.[c]

B. Poverty Targeting: General intervention

C. Poverty and Social Analysis

1. **Key issues and potential beneficiaries.** ADB estimated that, without substantial financial support to poor and near poor families, the poverty rate could increase from 16.7% in 2018 to 20.7% in 2020 as a result of the coronavirus disease (COVID-19) pandemic.[d] The key causes of poverty and vulnerability include high income inequality, insufficient human capital development, and exposure to various economic and social risks, both natural and human-induced. Protection from health financial risk is low, particularly for the poor and near poor. Out-of-pocket expenditure (OPE) for health has been persistently high, at 47.9% in 2019.[e] On average, 50.1% of OPE is spent on pharmaceutical products, 34.5% on professional services, and 15.8% on hospital services.[f] The poor in particular often do without health care owing to their lack of awareness or financial protection, indirect costs for transportation, and meager income. Catastrophic health care payments more than doubled from 2.8% of all health-care expenditure in 2000 to 6.1% in 2012. These continued to increase to 6.3% in 2015, when 6.4 million people spent more than 10% of their household consumption or income on health OPE. The number of people pushed below the poverty line by health care costs in 2015 was 840,000, or 0.8% of the national population, using the poverty line of $1.90 in 2011 dollars at purchasing power parity, or 1.5 million, or 1.4% of the population, using the $3.20 poverty line.[g]

2. **Impact channels and expected systemic changes.** The program will address key reform areas in financing, service delivery, and performance accountability of population- and individual-based interventions at the national and local levels. Policy reform will prioritize establishing health facility networks in underserved and unserved communities to make access to primary care services more equitable. Institutional capacity will be developed in the DOH and in provincial- and city-wide health provider networks. It will help the Philippine Health Insurance Corporation (PHIC) improve as a strategic health care purchaser and transition national health insurance towards UHC.

3. **Focus of (and resources allocated in) the transaction technical assistance (TA) or due diligence**. Analysis and due diligence will address (i) the macroeconomic policy framework, including public expenditure and management; (ii) comprehensive sector analysis, including options for health financing in a multilevel governance structure; (iii) poverty and social analysis; (iv) social and environment safeguards; (v) gender analysis; (vi) financial management, fiduciary and governance risk assessment; (vii) procurement risk and capacity assessment; (viii) disaster risk assessment of health facilities; and (ix) anti-corruption systems review.

4. **Specific analysis for the PBL.** The core development problem is inequitable geographic and financing access to high-quality essential health services, which results in poor health outcomes and financial hardship when accessing health services. The key constraints are (i) insufficient and non-strategic government health financing, (ii) inadequate and fragmented health service providers, and (iii) weak information management and accountability in national and local health systems. Despite prior health financing reform, the PHIC's share of current health care expenditure is only 18.8% in 2019. Financial protection for PHIC members is persistently low. Health care providers lack capacity to manage quality and cost, and the benefits coverage is not aligned with the country's disease burden.[f] Further, institutional arrangements between the national and local governments for health service delivery are weak and accountability poor, particularly among the local government units (LGUs) and the private sector. A programmatic policy-based approach is suitable to address critical institutional and policy health sector constraints through well-sequenced sets of policy actions that will significantly facilitate achieving UHC in the Philippines. The reform will help to improve access to high-quality health services for all Filipinos. The program will pursue three key reform areas: (i) sustainable financing and strategic purchasing for UHC; (ii) integrated delivery of quality health

services; and (iii) information management and performance accountability for UHC. These will address weak institutional capacity for population-based and individual-based interventions by: ensuring an adequate and equitable public expenditure framework and budget allocation for health; improving the purchasing of health services through PHIC; promoting equitable primary care services; regulating private health care markets; and clarifying the roles, information management and performance accountability of the DOH, the LGUs, the PHIC, and public and private health facilities and providers to strengthen the Philippine health system.

II. GENDER AND DEVELOPMENT

1. **What are the key gender issues in the sector and/or subsector that are likely to be relevant to this project or program?** While the Philippines has significantly improved its health status in the past 4 decades, major issues remain. The country's maternal mortality ratio (MMR) in 2017 at 121 deaths per 100,000 live births remains close to global MMR at 211 deaths per 100,000 live births in the same year.[h] This notwithstanding, adolescent fertility rate remains high at 55% as of 2018,[i] with 9% of women ages 15-19 have begun childbearing, 7% have had a live birth, and 2% are pregnant with their first child.[j] As women make up a large portion of the Philippine informal sector and are usually employed in more insecure forms of work which often lack social protection and access to health insurance,[k] high OPE on health care affect poor women the most in both urban and rural areas. In addition, COVID-19 has adversely impacted women's vulnerabilities to gender-based violence—both online and offline—magnified the incidence of adolescent and unplanned pregnancies, and increased the lack of availability of and access to sexual and reproductive health (SRH) care services due to quarantines and lockdowns.[l]

2. **Does the proposed program have the potential to contribute to the promotion of gender equity and/or empowerment of women by providing women's access to and use of opportunities, services, resources, assets, and participation in decision making? ☒ Yes.** Under subprogram 1, the PBL will ensure that (i) primary care benefits and access to health care providers are expanded to include availability of and access to services such as family planning procedures—intrauterine device and subdermal implant insertion—and maternal care package; (ii) 40% transfer of the Philippine Charity Sweepstakes Office's Charity Fund to the national insurance fund shall be attributed as part of the its Gender Equality, Diversity, and Social Inclusion Program, subject to applicable rules and regulations of Republic Act 9710 or the Magna Carta of Women; (iii) DOH's updated Philippine Health Facility Development Plan (PHFDP) includes the institutionalization of one nurse or midwife per health station and birthing facilities, recognizing the importance of providing every barangay access to maternal and child health care services; (iv) Health Promotion Strategic Framework is adopted, focusing on seven priority areas including SRH and safety and inclusivity consistent with the UHC Act's vision of healthy living, schooling, and working environments, in addition to DOH policies on continuous provision of essential health services, such as SRH to women, children, and adolescents especially during pandemics and emergencies, and on alternative work arrangements during pandemics and emergencies prioritizing provision of health/psychosocial interventions and giving schedule preferences to pregnant women; and (v) as mandated by the UHC Act, performance accountability by the key players to the UHC is ensured by strengthening the gender balance and technical expertise of the PHIC board. Under subprogram 2, the PBL will ensure that (i) regulations for private health insurance providers including health maintenance organizations will be issued to align with PHIC benefit and coverage rules, including coverage of diagnostic tests for women such as breast, cervical, and ovarian cancer screening and maternity care and deliveries; (ii) outpatient benefits respond to the needs of women, including access to primary SRH care services; (iii) payment reforms respond to the health needs of women; (iv) hospital licensing rules and subnational PHFDP include guidelines and/or standards for installation of gender-responsive health facilities;[m] (v) programs on providing technology-based mental health and psychosocial support to affected individuals and families of COVID-19 pandemic and other crisis situations are integrated to the primary care services provided by province- and city-wide health systems; (vi) mandatory annual performance reviews of PHIC and gender-sensitive annual household surveys on UHC are formulated and conducted;[n] and (vii) LGU health system performance scorecard, Seal of Good Local Governance, and hospital quality scores will be updated to be gender-responsive.[o] Under both programs, routine collection, sharing, and analysis of sex-disaggregated data will be established.

3. **Could the proposed project have an adverse impact on women and/or girls or widen gender inequality? ☒ No**. The PBL will provide an enabling policy framework for equitable access to primary health services, particularly for women and children.

4. **Indicate the intended gender mainstreaming category: ☒ EGM** (effective gender mainstreaming)

III. PARTICIPATION AND EMPOWERMENT

1. Who are the main stakeholders of the project, including beneficiaries and negatively affected people? Identify how they will participate in the project design. The main stakeholders are the DOH, LGUs, PHIC, and individual households and families.

2. How can the project contribute (in a systemic way) to engaging and empowering stakeholders and beneficiaries, particularly, the poor, vulnerable, and excluded groups? What issues in the project design require participation of the poor and excluded? The program will strengthen health system at LGU level. The vulnerable groups will be engaged through consultations with LGU at selected health facilities.

3. What are the key, active, and relevant civil society organizations in the project area? What is the level of civil society organization participation in the project design?

☒ Information generation and sharing (M) ☒ Consultation (M) ☐ Collaboration ☐ Partnership

4. Are there issues during project design for which participation of the poor and excluded is important? What are they and how should they be addressed? ☐ Yes ☒ No

IV. SOCIAL SAFEGUARDS

A. Involuntary Resettlement Category ☐ A ☐ B ☒ C ☐ FI

1. Does the project have the potential to involve involuntary land acquisition resulting in physical and economic displacement? ☐ Yes ☒ No The reform agenda being supported does not promote any land acquisition.
2. What action plan is required to address involuntary resettlement as part of the transaction TA or due diligence process? ☒ None ☐ Resettlement plan ☐ Resettlement framework ☐ Social impact matrix ☐ Environmental and social management system arrangement

B. Indigenous Peoples Category ☐ A ☐ B ☒ C ☐ FI

1. Does the proposed project have the potential to directly or indirectly affect the dignity, human rights, livelihood systems, or culture of indigenous peoples? ☐ Yes ☒ No
2. Does it affect the territories or natural and cultural resources indigenous peoples own, use, occupy, or claim, as their ancestral domain? ☐ Yes ☒ No
3. Will the project require broad community support of affected indigenous communities? ☐ Yes ☒ No
4. What action plan is required to address risks to indigenous peoples as part of the transaction TA or due diligence process? ☒ None ☐ Indigenous peoples plan ☐ Indigenous peoples planning framework ☐ Social impact matrix ☐ Environmental and social management system arrangement

V. OTHER SOCIAL ISSUES AND RISKS

1. What other social issues and risks should be considered in the project design?
No other social issues and risks are involved.
2. How are these additional social issues and risks going to be addressed in the project design? Not applicable.

VI. TRANSACTION TA OR DUE DILIGENCE RESOURCE REQUIREMENT

1. Do the terms of reference for the transaction TA (or other due diligence) contain key information needed to be gathered during transaction TA or due diligence process to better analyze (i) poverty and social impact, (ii) gender impact, (iii) participation dimensions, (iv) social safeguards, and (v) other social risks. Are the relevant specialists identified? ☒ Yes ☐ No
2. What resources (e.g., consultants, survey budget, and workshop) are allocated for conducting poverty, social, and/or gender analysis, and participation plan during the transaction TA or due diligence?
Staff consultants and resources under ongoing TA Facility.[p]

[a] National Economic and Development Authority (NEDA). 2021. *Updated Philippine Development Plan 2017–2022*. Manila; and Department of Health. 2017.
[b] ADB. 2018. *Strategy 2030. Achieving a Prosperous, Inclusive, Resilient, and Sustainable Asia Pacific*. Manila.
[c] ADB. 2020. *Country Operations Business Plan: Philippines, 2020–2022*. Manila; and ADB. 2018. *Country Partnership Strategy: Philippines, 2018–2023—High and Inclusive Growth*. Manila.
[d] ADB. 2020. *Philippines: COVID-19 Active Response and Expenditure Support Program*. Manila.
[e] Philippine Statistics Authority (PSA). 2020. *National Health Accounts 2019*. Manila.
[f] K. Obermann et al. 2018. The Role of National Health Insurance for Achieving UHC in the Philippines: A Mixed Methods Analysis. *Global Health Action*. 11(1).
[g] World Bank. Universal Health Coverage Data (accessed 22 December 2020); and World Bank. World Development Indicators (accessed 22 December 2020).
[h] United Nations Economic and Social Commission for Asia and the Pacific. 2020. *Measuring Maternal Mortality Using Civil Registration Data*. Bangkok.
[i] World Bank. 2018. *Adolescent Fertility Rate (Birth per 1,000 women ages 15-19) - Philippines.* Washington DC.
[j] PSA and ICF. 2018. *Key Findings from the Philippines National Demographic and Health Survey 2017*. Quezon City, Philippines, and Rockville, Maryland, USA: Philippine Statistics Authority and ICF.
[k] Philippine Commission on Women. 2019. *Enacting a Magna Carta of Workers in the Informal Economy*. Manila.
[l] NEDA. (nd). *Couples urged to continue family planning amid COVID-19 crisis*. Manila.
[m] In this context, gender-responsive health facilities recognize the different health needs and experiences of males and females e.g. providing dedicated triage areas for women's SRH needs; providing adequate screening for male and female specific non-communicable diseases; ensuring appropriate numbers of male and female health professionals to respond to cultural care requirements such as female birth attendants for certain religion and/or ethnic groups.
[n] Incorporating a gender-sensitive lens in the survey instrument and indicators includes considering the different roles, responsibilities, and access to resources of the respondents; recognizing their different health-related needs depending on their biological functions and lifestyle; and identifying female-headed households, among others.
[o] In this context, gender-responsive means that the indicators in the scorecard recognize the different needs and experiences of males and females, such as the inclusion of indicators on access to primary SRH services.
[p] ADB. 2016. *Technical Assistance to the Republic of the Philippines for Strengthening Social Protection Reform*s. Manila.

Source: Asian Development Bank.