

PROJECT INFORMATION DOCUMENT (PID) CONCEPT STAGE

Report No.: PIDC37171

Project Name	Health Sector Project (P149920)
Region	EUROPE AND CENTRAL ASIA
Country	Bosnia and Herzegovina
Sector(s)	Health (75%), Public administration- Health (25%)
Theme(s)	Health system performance (100%)
Lending Instrument	Investment Project Financing
Project ID	P149920
Borrower(s)	Republic of Bosnia & Herzegovina
Implementing Agency	RS Ministry of Health and Social Welfare, FBiH Ministry of Health
Environmental Category	B-Partial Assessment
Date PID Prepared/ Updated	16-Nov-2015
Date PID Approved/ Disclosed	19-Nov-2015
Estimated Date of Appraisal Completion	
Estimated Date of Board Approval	20-Oct-2016
Concept Review Decision	Track II - The review did authorize the preparation to continue

I. Introduction and Context

Country Context

Bosnia and Herzegovina (BiH) is an upper middle income country with a population of 3.8 million inhabitants. Its per capita income of US\$ 4,700 (2014) is less than half of the global average, about one fifth the average per capita income in the European Union, and 15 percent lower than its non-EU neighbors in South-East Europe (SEE).

BiH was the most ethnically diverse and one of the poorer republics in Yugoslavia. It is comprised of three major ethnic groups: Bosniaks (44 percent), Serbs (31 percent); and Croats (17 percent). The country's economy stagnated in the 1980s and was severely affected by the collapse of communism in Eastern Europe and the collapse of Yugoslavia, which was followed by the war in BiH in the 1990s. The Dayton Accords of December 1995 brought peace to BiH and established a decentralized political structure, with a Council of Ministers at the central government (often referred to as "State" level), and two largely autonomous entities: the Federation of Bosnia and Herzegovina (FBiH) and the Republika Srpska (RS). FBiH has 10 cantons and 79 municipalities,

while RS has 7 regions and 63 municipalities. Finally, the constitutional architecture also includes the autonomous Brcko District.

BiH experienced stable economic growth during the 2000s, at an average of about 5 percent per year. Since the crisis however, growth has averaged less than 2 percent per year due to a combination of barriers including a weak business environment, high labor taxes and strict labor market policies, inadequate transport infrastructure, inefficient public expenditures, and vulnerability to catastrophic risks.

Growth in BiH has been generally pro-poor, but inequality remains among the highest in Western Balkans. Between 2004 and 2007, when BiH economy experienced high growth rates, poverty fell and incomes of the bottom 40 percent of the income distribution grew rapidly, and at a higher pace than the incomes of the highest three quintiles. Poverty fell from 17.7 to 14 percent of the population between 2004 and 2007, but remained largely stable since then. Poverty incidence is highest among the young and in large households, and its prevalence in these groups increased since 2007. Poverty is a predominantly rural phenomenon, where people are twice as likely to be poor as in urban areas. This presents a particular challenge since BiH remains mostly rural (60 percent of the total population). Unfavorable demographics combined with lack of labor market opportunities in cities create incentives for out-migration from the country rather than urbanization.

The complex health system structure results in substantial duplication, makes policy coordination more difficult, and contributes to inefficiency. BiH has 13 Ministries of Health (MoHs), health insurance funds (HIFs), and public health institutes (PHIs). The FBiH health sector includes the FBiH Ministry of Health (MoH), the 10 cantonal MoHs, the Federal Solidarity Health Insurance Fund (HIF), the 10 cantonal HIFs, and 11 Public Health Institutes (IPH). In contrast, the RS health system is centralized, so responsibility is shared only between the Ministry of Health and Social Welfare of the Republic of Srpska (RS MoHSW), a single health insurance fund (the Health Insurance Fund of the Republic of Srpska - HIFRS), and a single Public Health Institute (RS PHI). In addition, the District of Brcko also has a Department of Health and a separate HIF. In general, most health facilities in the Federation are established and owned by the cantons, while in RS municipalities own primary health care facilities and the central entity government owns hospitals.

Sectoral and Institutional Context

In the past two decades, life expectancy in BiH has increased from 62 years for males and 74 years for females in 1990 to 74 years for males and 79 years for females in 2013. Life expectancy remains lower than the EU average (77 for males and 83 for females in 2013), however, the gap between BiH and the EU has increased in the last decade. The WHO estimates that 95 percent of premature deaths in BiH are attributable to four major non-communicable disease (NCD) groups - cardiovascular diseases, cancers, diabetes, and chronic respiratory diseases. Cardiovascular disease (CVD) alone accounted for over half of all premature deaths in 2008, rising to nearly two-thirds of total deaths in 2013. These NCD's are also the leading cause of ill health and disability in the country. This epidemiological pattern is the result of the demographic transition facing the country (population decline and aging) but also the fact that BiH has one of the highest rates of smoking prevalence in the world. Dietary risks, high blood pressure and alcohol use are also important risk factors, the latter particularly among adults aged 15-49. Despite progress in child health, neonatal mortality is higher than average for southeast Europe, vaccination rates are above 80 percent, but below EU averages, and child obesity rates are high and increasing (18 percent), including among the poor. Roma children have lower coverage of vaccination and preventive services, and continue

to be affected by under nutrition and stunting.

Public and private health expenditures have grown substantially in recent years. Total health expenditures are now estimated to have increased from 7.1 percent of GDP in 2000 to an estimated 9.9 percent of GDP in 2012, a level similar to the average for EU countries and higher than many of BiH's neighbors. Government spending on health as a percentage of GDP (7 percent) is the highest in SEE, and significantly higher than the average for the EU or upper middle income countries as a group (about 4 percent of GDP). Health outcomes are lower than would be predicted by the level of health spending, suggesting shortcomings in both the allocative and technical efficiency of health expenditure. The health system is still heavily focused on acute and hospital-based care. In the period 2009-2011, while the share of total health expenditure spent on inpatient care (35 percent) decreased, it was higher than the expenditure on outpatient care (25 percent) contrary to most EU countries. The total health spending on prevention and public health as a percentage of total health expenditure is relatively low at about 1 percent. Thus, relatively high in-patient spending indicates opportunities to improve health spending efficiency by shifting to outpatient services and promoting a greater focus on health promotion and prevention.

Both the RS and FBiH have taken steps to improve the quality of health care, including passing legislation on quality of care and establishing health care accreditation agencies, which operate mandatory certification programs and voluntary accreditation for health care institutions. Progress on accreditation has been modest, however, and the overall systems for monitoring and strengthening quality needs to be further strengthened, including through more systematic benchmarking of performance at primary care and hospital level, linking quality improvement to payment systems, and strengthening systems to more systematically monitor technical quality of care and adherence to evidence-based clinical practices. While many providers in primary, secondary and tertiary care have established electronic medical record systems, they are not linked among providers. Thus, patients are primarily responsible for ensuring sharing of health information. This constraints the integration of care and limits the ability of health managers to monitor and improve quality and efficiency of care.

The family medicine (FM) model has been the single largest reform implemented in the health sector in recent years, achieving a coverage rate of over 80 percent of the total population by family medicine teams. Available evidence suggests that these reforms have contributed to the quality of primary care to improved patient satisfaction. However, screening and clinical management of chronic diseases remains inadequate. Per capita financing for primary care has been implemented in RS, but is not yet fully implemented in FBiH. While the Health Sector Enhancement Project (HSEP) supported a successful pilot to test performance based payments for primary care in four cantons in FBiH, performance payments have not be scaled up or integrated into payment systems by Health Insurance Funds (HIFs) in either FBiH or RS.

The hospital sector is inefficient, despite progress on hospital reforms in RS, including introduction of Diagnostic Related Group (DRG) payments. The number of acute hospital beds (3.45 per 100,000) remains within the same range as the OECD and EU averages. At 10.9 per 1000 population, the number of hospital discharges in BiH is comparable to that of Southern European countries such as Spain or Portugal, and below regional averages. Bed occupancy rates are low, particularly in the FBiH where they averaged at 51 percent in 2013. Average length of stay in hospitals in FBiH is above EU averages, but is closer to EU averages in RS. In both entities, however, hospitals have accumulated substantial arrears to both private suppliers and the public

sector (including pension and health insurance contributions). Arrears data are not systematically collected or monitored, but available data suggest that many hospitals are close to bankruptcy, and that health sector arrears pose a significant fiscal risk in both entities. There is thus both an urgent need to address the short-term arrears crisis, and considerable room to reorganize service delivery across and within hospitals to improve efficiency while maintaining access.

Spending on pharmaceuticals is relatively high in BiH, representing about 30 percent of total health spending. This is about double the average for OECD countries. Problems include fragmented procurement systems with little or no use of reference pricing; inadequate monitoring systems for prescription and dispensing practices; pricing policies that do not provide incentives for dispensing lower-cost drugs; and limited mechanisms to evaluate the cost-effectiveness of new and expensive drugs before including them on the health insurance reimbursement list. As a result, prices for medicines and medical devices are frequently double international reference prices in both RS and FBiH.

An inefficient health financing system threatens sustainability and hinders efforts to increase employment. Public health insurance is funded by a mixture of contributions collected from employers, from the salaries of employees and general revenues. Overall, individuals' health costs are reasonably well covered with fairly low levels of catastrophic expenditures and low poverty increases as a result of out-of-pocket expenses (the poverty headcount is estimated to increase by around 1 percentage point in 2011 as a result of out-of-pocket (OOP) health expenditures, from 15 to 16 percent). OOP were above 25 percent of total expenditures for around 2 percent of households. OOP spending represent 28 percent of total health costs in 2012. Health insurance payroll taxes are high in both entities, creating a burden on the small percentage of population with formal employment, while over 50 percent of those who receive health insurance coverage are exempt from paying personal contributions (mostly pensioners, the unemployed, the disabled, and war veterans), and their health insurance is financed by transfers from other extra budgetary funds and from general revenues. The effectiveness of the Public Employment Services is undermined because many who are working in the informal sector or who are not looking for work register as unemployed to receive health insurance. Separating unemployment from health insurance while developing financially sustainable approaches to universal health coverage would be a critical reform for both health and job creation.

Relationship to CAS

The objective of the proposed health project is in line with the Country Partnership Framework (CPF) FY16-20, which aims to improve the fiscal sustainability of social benefits and improve public service delivery. The new CPF recognizes that public services, including health services, represent an important area for improving public sector efficiency. Indeed, government spending on health as a percent of GDP is the highest in the region, which has prompted both governments to express an interests to rationalize health spending and improve quality of care to reduce future costs to the system. By focusing on strengthening health promotion and prevention, integrating separate levels of care through technology, improving efficiency of the hospital sector, promoting innovation and enhancing quality of care, it is expected that the proposed Project will effectively reduce costs, while contributing to improved health outcomes. The proposed Project would also build on the World Bank's involvement through the HSEP (closed on December 31, 2014), which focused on supporting primary health care and improving management capacity in the health sector, and would complement reforms supported by Development Partners.

II. Proposed Development Objective(s)

Proposed Development Objective(s) (From PCN)

The proposed Project Development Objective (PDO) is to help improve efficiency and quality of health service delivery by strengthening systems for quality assurance, monitoring, and integration of care, improving hospital efficiency, and strengthening strategic purchasing of health care.

Key Results (From PCN)

The PDO indicators under consideration include the following:

- (1) Percentage of registered adult patients in health centers (DZs) with hypertension under treatment for whom the last recorded blood pressure (measured in the preceding one year) is \leq 140/90 mm Hg;
- (2) Increased percentage of day surgeries carried out in hospitals;
- (3) Percentage of health centers financed on capitation basis, adjusted for patient risk profile and quality of care;
- (4) Percentage of hospitals in RS and FBiH for which acute care is financed on the basis of Diagnostic Related Groups (DRGs), adjusted for quality of care;
- (5) Reduction by 20 percent the average price of the (i) 50 most commonly prescribed outpatient medicines; and (ii) 20 most commonly used hospital medicines.

III. Preliminary Description

Concept Description

The proposed Project would include the following three components:

Component 1: Strengthen quality and integration of health service delivery

This component would focus on improving the quality and integration of health service delivery. Proposed activities include: (i) supporting the development of an information sharing system that links health care institutions, and would support integrated monitoring of efficiency and quality; (ii) development of performance scorecards for primary care and hospitals, which could be produced at least annually and shared with facility managers, policy makers, and the public; and (iii) strengthening of mechanisms for quality monitoring and quality assurance, including clinic audits, licensing, and accreditation. The focus will be primarily on noncommunicable diseases (NCDs), particularly improved integrated screening and management of NCDs such as hypertension, diabetes, and cervical cancer. The project may also support mechanisms to strengthen prevention and outreach services for maternal and child health at primary care level, including for vulnerable groups such as the Roma.

To improve the integration of care and monitoring of quality across levels, this component would support the development of an information sharing system that links all relevant health institutions. This would include health care providers, health insurance funds, public health institutes, pharmacies, etc., to allow for efficient information flows in accordance with patients' needs. It would build on the IT supports to primary care provided under the HSEP as well as extend support

to secondary and tertiary care levels and promote interoperability between systems at different levels of care. This area would also support implementation of e-health systems, telemedicine solutions and diagnostic equipment, particularly for developing self-care and home-care.

Activities would be complemented by Component 3, including reforms to introduce quality-adjusted payment systems at primary care and hospital level. The component also would complement prevention and health promotion activities supported by the Reducing Health Risk Factors in BiH supported a Trust Funds financed by the Swiss Development Cooperation (SDC).

Component 2: Modernizing the hospital sector toward efficiency

This component would focus on providing support to address a number of challenges facing the hospital sector in both entities, which currently represents the largest share of health expenditures. Modernization would involve strengthening financial management and accountability of hospitals, as well as shifting the role of hospitals to focus on intensive, lifesaving care while other functions would be ensured through outpatient polyclinics (specialized diagnostic and treatment), and primary care (integration of specialized care and family health as well as palliative and home-based care into primary health care teams (“health homes”). The component would support: (i) strengthening of management and accounting systems for hospitals; (ii) technical support for policy reforms to strengthen hospital accountability and autonomy; and (iii) management strengthening and skill development. It may also finance targeted investment to improve efficiency of care in selected hospitals, including limited financing of equipment to enable increased use of day surgeries, or to transition excess acute care beds to long-term or social care. This support would be contingent on hospital management adopting a rationalization plan, including addressing hospital arrears.

Component 3: Strengthen health system strategic purchasing and governance

This component would aim to strengthen strategic purchasing and governance of the health system, including support for: (i) introduction and scaling up of quality and risk-adjusted capitation payments for primary health care; (ii) introduction of Diagnostic Related Group (DRG) payments for acute hospital care in FBiH, and introduction of quality adjusted hospital payments in both RS (which has already introduced DRGs) and FBiH; (iii) strengthening capacity and coordination of the health insurance funds in both entities for strategic purchasing and health service monitoring; and (iv) supporting reforms for the pharmaceutical sector to improve efficiency and access of both generic and patented drugs. If agreed by the authorities, the project could provide technical support for reforms to help improve Universal Coverage of health care, including enhancing portability of health insurance among cantons or entities, or de-linking of health insurance from employment status.

This component would also support the operational costs of implementing the proposed Project. This would include project coordination and supervision, fiduciary management and monitoring and evaluation. The component would finance technical assistance, surveys, studies, hiring and training of consultants under the project implementation units (PIUs) of each entity, limited office equipment and recurrent costs. It would also help support institutionalization of health surveys to collect information at household level.

IV. 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	

V. Financing (in USD Million)

Total Project Cost:	22.00	Total Bank Financing:	22.00
Financing Gap:	0.00		
Financing Source			Amount
Borrower			0.00
International Bank for Reconstruction and Development			22.00
Total			22.00

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