Project Information Document/
Integrated Safeguards Data Sheet (PID/ISDS)

Concept Stage | Date Prepared/Updated: 29-Sep-2017 | Report No: PIDISDSC21920

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Parent Project ID (if any)	Project Name
Peru	P163255		Peru Universal Health Coverage (P163255)
Region	Estimated Appraisal Date	Estimated Board Date	Practice Area (Lead)
LATIN AMERICA AND CARIBBEAN	Jan 10, 2018	Mar 23, 2018	Health, Nutrition & Population
Financing Instrument	Borrower(s)	Implementing Agency	
Investment Project Financing	Government of Peru	Ministry of Health	

Proposed Development Objective(s)

The objectives of this project are to (i) expand the scope and increase the quality of health services in selected areas and (ii) strengthen critical transversal support systems to increase the efficiency and governance of the health sector.

Financing (in USD Million)

Financing Source	Amount
Borrower	25.00
International Bank for Reconstruction and Development	125.00
Total Project Cost	**150.00**

Environmental Assessment Category	Concept Review Decision
B-Partial Assessment	Track II-The review did authorize the preparation to continue

Other Decision (as needed)

B. Introduction and Context

Country Context

1. **Between 2001 and 2016, Peru's high commodity price –fueled cycle of growth resulted in a drastic lowering of poverty from 54.8** (INEI Peru 2011) **to 20.7 percent** (INEI Peru 2017) **and a substantial increase in**

the public budget for health. Public health expenditure grew from 1.3 percent to 2.3 percent of GDP between 2000 and 2014. (World Bank 2017) In this context, Peru was able to launch a public health insurance system for the poor (Seguro Integral de Salud) that covered 44% of the population as of 2015 (Authors' calculations based on (INEI Peru 2016a)). Nevertheless, with the drop in commodity prices and the resulting fall in revenues, Peru is under pressure to maximize efficiency in the allocation of public expenditure while continuing to improve equity and service quality for the poor and vulnerable.

Sectoral and Institutional Context

2. **Peru made a solid progress in maternal and child health outcomes under the Millennium Development Goals.** In particular, Peru reached the goal of reducing infant mortality by two-thirds between 1990 and 2015: in 2013, the national average was 17 deaths for every 1,000 live births, down from 55 in 1992. (World Bank 2017) At the same time, the rate of chronic child malnutrition in children under five fell from 34 percent in 1991 (INEI Peru 2001) to 14.4 percent in 2015 (INEI Peru 2016b). However, these achievements are now followed with renewed challenges. Peru's demographic transition is characterized by greater life expectancy and population aging and comes in tandem with an epidemiological transition. Between 1990 and 2015, noncommunicable diseases have overtaken by a large margin communicable, maternal, neonatal and nutritional diseases in terms of burden of disease (Institute for Health Metrics and Evaluation 2017) (See figures 1 and 2). The concerns associated with this transition are twofold: On the one hand, a greater number of priorities could dilute attention given to maternal and child health; on the other hand, responding to the new health needs of the population will require a significant adjustment in the service delivery and financing models.
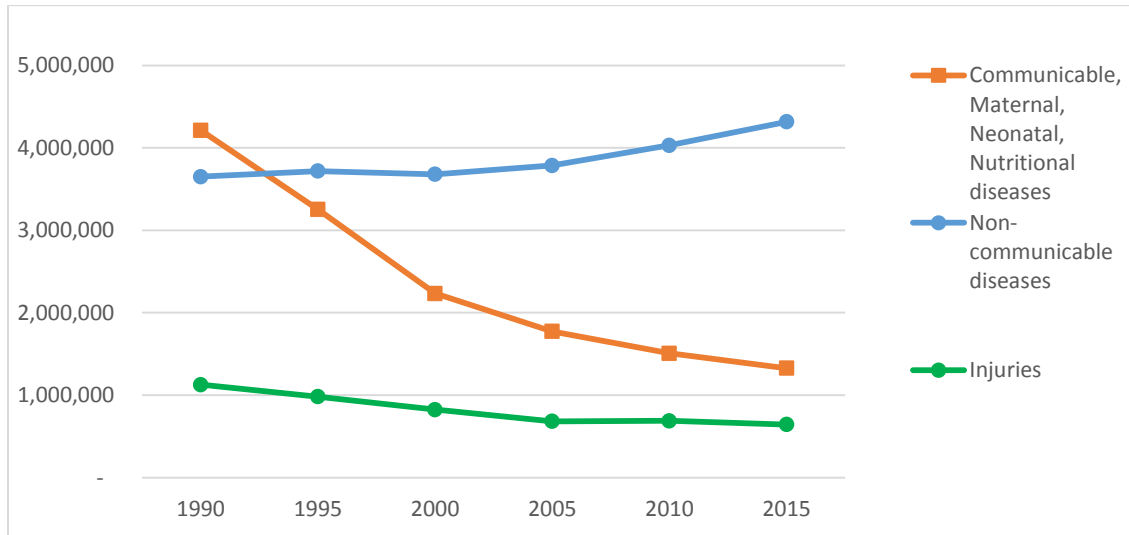
Figure 1: Main causes of loss of disability adjusted life years, Peru, 1990 vs 2015
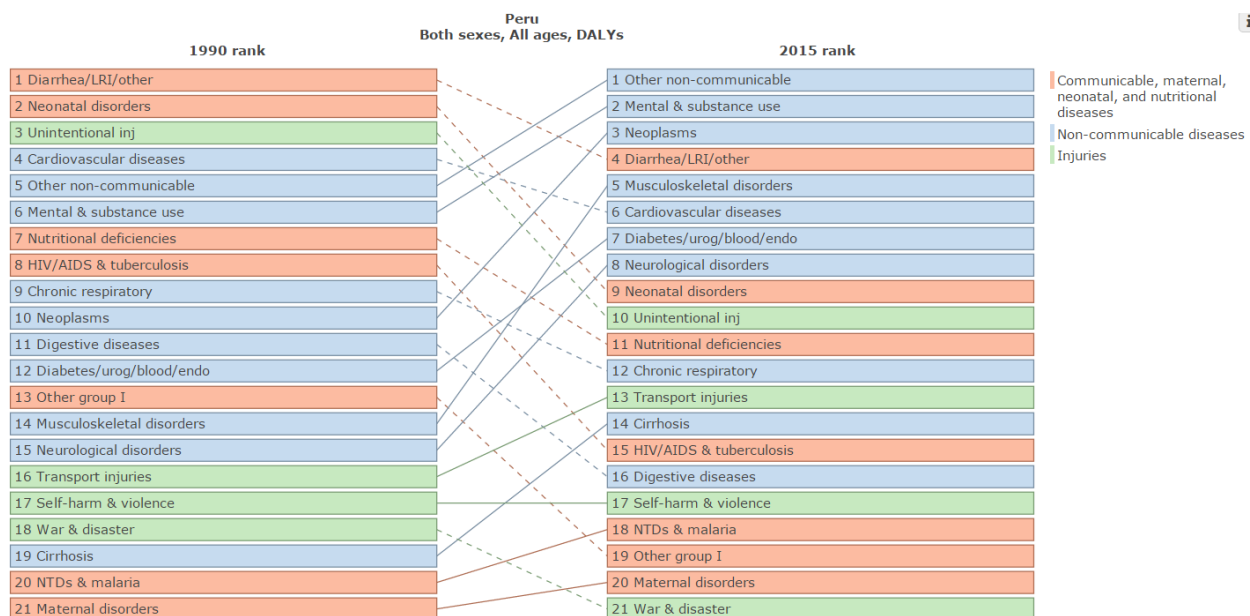
Source: (Institute for Health Metrics and Evaluation 2017)

Figure 2: Disability adjusted life years lost, by type of cause, Peru, 1990-2015

Source: (Institute for Health Metrics and Evaluation 2017)

3. **Despite the progress in maternal and child health indicators, the poor and vulnerable continue to face challenges in gaining effective access to health services**. They are less likely to use health services when they need them and more likely to pay for them when they do. For example, in the 2014 ENAHO data, 65 percent of the non-poor/non-vulnerable population that had an illness or accident in the four weeks preceding the survey received medical attention without paying out-of-pocket. For the poor population, the corresponding figure was only 37 percent. At the same time, there are great disparities in the availability of health services by geographical area: in general, human resources for health are scarce precisely where poor SIS members are located. (Vermeersch et al. 2016)

4. **Similarly to many other Latin American countries, Peru's health system is highly fragmented both in its provision and in its financing functions.** There is a multiplicity of institutions that administer health financing including the public insurer (*Seguro Integral de Salud*), Ministry of Health, social security (EsSalud), separate systems for the Armed Forces and Police (*Sanidades de las Fuerzas Armadas y Policiales*) and private insurers. The fragmentation is mirrored on the supply side: in general terms, EsSalud provides services through its own and separate network of providers, the public sector provides services through MINSA and Regional Government facilities, and the private insurers are associated with private providers.

5. **The public health sector provision is not fully prepared to respond to new and emerging needs of the population, resulting in inefficient use of resources**. In particular, most public service providers in the first level of care can only provide maternal and child health services. As a result, hospitals face a disproportionate demand for services that should be provided at the first level of care, in particular care for noncommunicable diseases such as diabetes, hypertension, and cancer screening. This results in inefficient use of resources, as care for very prevalent chronic conditions is provided in high-cost, low access environments (hospitals) instead of lower-cost, higher-access environments (primary care clinics).

6. **In order to be able to respond to the new population needs in an efficient way, Peru needs to build and implement a new service delivery model that is based on a strengthened and optimized network of primary care clinics that are able to respond to a wider scope of health needs, refocused hospitals, efficient support services and strong relationships between providers that facilitate continuity of care for patients.** In order to provide services in a continuous and efficient way, providers at all level have to have clarity about the expected content and location of care for the specific condition of the patient. In addition, primary care providers have to be able to refer patients up to the next level when required by the patient's condition (referral); second- and third level providers should focus on complicated cases and should be able to confidently return patients to primary care once for ongoing follow-up (counter-referral).

7. **In order for the public health system to migrate to a more efficient model of service delivery, it is necessary to build missing key tools and instruments on both the service delivery and financing side**, in particular standardized clinical care protocols and pathways, a framework for assessing and integrating health technology, and a service-oriented health information system.

8. **While the legal framework (AUS law 2009) defines a basic benefits package – the Essential Health Coverage Plan [*Plan Esencial de Aseguramiento en Salud,* PEAS] – that in theory could facilitate the prioritization of services and expenditures, in practice the package cannot be used effectively to plan/prioritize expenditure or to monitor or control service delivery.** In part, this is because the benefits package was created without having clarity on the services and procedures that should be used for specific health conditions (i.e. clinical practice guidelines and care pathways). This is itself related to the inexistence of a formal procedure on how to assess the rationale for publicly financing specific health technology (i.e. health technology assessment). The lack of guidelines and standards not only impedes efficient allocation of resources, but it also limits the options for measuring and improving quality of care. Health care pathways improve continuity or care, help to coordinate the health networks, facilitate training of human resources, and reduce inequities. Well defined evidence-based clinical guidelines for the most prevalent diseases and health conditions create a compilation of justified health services that should be the basis for the continuous adjustments of the basic package of services.

9. **Notwithstanding the efforts made, Peru's fragmented health information systems are still unable to support efficient local management of health care processes nor produce reliable information on the pillars of the health system.** While Peru has made notable achievements in information management in some areas, such as vital statistics, the National Registry of health insurance beneficiaries and the continuous and reliable collection of household surveys, most of the current health information systems have not advanced beyond the original goal of reporting of information to higher administrative levels (data entry) towards supporting efficient management of health services. In addition, due to the lack of information standards and connectivity, the systems produce fragmented, non-comparable information and multiply the data entry points. As far as health care is concerned, the current systems do not allow health providers to exchange the information needed to ensure continuity of care (eg. referrals and counter-referrals, prescriptions, lab results, medical imaging results) or efficient management of facilities, staff and inputs (eg. pharmacy management, appointments, shift management, billing). As far as financing is concerned, the systems do not support the purchasing function of health insurance (linking beneficiaries, services and payments), or accurate accounting of spending on different levels of care (hospitals – primary care) or inputs (personnel, pharmaceuticals, etc.).

10. **The Ministry of Health of Peru (*Ministerio de Salud* or MINSA) is preparing an investment program denominated "Reengineering Health Networks".** This program aims to transform and modernize public health service delivery, with the aim of improving the quality of patient care and ultimately the health of the Peruvian population, and strengthening the sector's governance and efficiency. To achieve this, MINSA will introducing a new model of care that expands the scope of first-level services beyond the current focus on maternal and child health to include chronic and non-communicable diseases, and reshape the roles and functions of the care networks.

Relationship to CPF

11. The Country Partnership Framework identifies as its sixth objective to "Modernize [the] delivery of health and nutrition services for the poor." Three priority areas were identified for the health sector: "First, it is necessary to adapt health services to the new epidemiological challenges, including infrastructure, technology, and reference systems. Second, human resources management system needs an overhaul, including moving to a merit-based system. Finally, improvements will require reforming the health insurance model and converting the Integral Health Insurance (SIS) system into a modern, efficient health insurance provider that can address both the primary and secondary health needs of the population, particularly the poor."

12. The proposed Project is in line with the first of the three priorities that were identified in the CPF: The Project would invest in the adaptation of the physical infrastructure of health services in 4 regions, with a view to expand the scope and increase the quality of services and better respond to the new epidemiological challenges. In addition, the Project would invest in the information technology and critical support systems necessary to the implementation of a new model of care and to the efficiency and governance of the health sector.

C. Proposed Development Objective(s)

13. The objectives of this project are to (i) expand the scope and increase the quality of health services in selected areas and (ii) strengthen critical transversal support systems to increase the efficiency and governance of the health sector.

Key Results

(i)   Number of primary health facilities that offer an expanded health services package in the intervention areas.
(ii) Percentage of women 25 to 60 years of age with a screening of cervical cancer in the last 3 years.
(iii) The Unique Health Information System is fully functional (at central level and in at least 20 health facilities in the intervention areas) including modules for clinical records, shared medical records, appointments.
(iv) At least 8 clinical protocols for most prevalent non-comunicable diseases are updated and enforced through the payment system.

D. Concept Description

14. The proposed project will finance the expansion of the new model of care to prioritized areas, as well as a nationwide component that will support the development of critical tools to increase the efficiency and governance of the health sector.

Component 1: Modernization of the health services network model in priority areas

15. This component will increase the resolution capacity of the first level and optimize the demand for the second level of care in selected regions/networks to respond with quality, efficiency and timeliness to the new health needs of the population, and reduce the current inequities in access and quality of care. The component will be implemented in four priority geographical areas: The Lambayeque region, the Ica region, and the geographical areas under the jurisdiction of the DIRIS of Lima North and Lima Center.

Component 2: Build critical support tools to increase the efficiency and governance of the health sector

Sub-component 2.1: Design and implementation of the Unique Health Information System and Tele-medicine

16. This sub-component will provide the technological tools needed to facilitate the management of the activities of health facilities, the coordination of networks, the monitoring of implementation of regulation and corresponding enforcement, the introduction of incentives and the efficient management of resources. The Single Health Information system will manage the collection, storage and exploitation of health data for local management, decision making and oversight. In addition, the System will provide the standards and platform for compatibility of information systems between EsSalud, Sanidades, MINSA, Regional Governments, and the private sector. This sub-component will also support the expansion of the tele-medicine program.

Sub-component 2.1: Strengthening of service delivery and financial management in the health sector

17. This sub-component will develop and implement clinical and administrative tools needed to improve the quality and continuity of care and the efficiency and equity of spending. In particular:

  (a) Evaluation and management of medical technologies, updating/standardization of clinical practice guidelines and care pathways.
  (b) Strengthening procedures for quality control of health services.
  (c) Modernization of procurement systems (including framework contracts) to reduce unit costs and strengthen standardization.
  (d) Strengthening / development of systems for management of drugs, supplies and medical devices.
  (e) Strengthening / development of systems for execution and monitoring of recurrent and investment spending.

Component 3: Project management

18. This Component will finance staff of a Project Coordination Unit (PCU) for project coordination, monitoring and evaluation, and financing of audits.

SAFEGUARDS

A. Project location and salient physical characteristics relevant to the safeguard analysis (if known)

The Project has three components. Component 1 will target in four prioritized regions: Lima Norte, Lima Centro, Lambayeque in the north and Ica in the south part of the country while Component 2 will be nationwide. Under Component 1, this Project will make investments in first-level health infrastructure (family health clinics and medical emergency care centers) in two regions (Ica and Lambayeque) and two parts of Lima (north and central). The infrastructure investments will include rehabilitation, remodeling, and tear-down and reconstruction of existing first-level health centers. These first-level centers are relatively small in size and provide basic health services. In some cases, health centers might need to be relocated to mitigate risks such as floods or landslides; in those cases, health centers may have to be newly built in a different location. The infrastructure investments are meant to (i) enable the expansion in the types of services provided in the health centers, expanding beyond maternal and child health services towards adult care and care for chronic and non-communicable conditions; (ii) improve the quality and safety of the infrastructure in first-level health centers. Hospital infrastructure would not be included under this component. The actual design of the centers will be determined during project implementation.

Under Component 2, this Project would invest in four data centers, whose location is to be determined. This would include: acquisition and/or construction of server rooms of adequate size for the proposed capacity and equipped in accordance with standard ANSI TIA/EIA-942 "Telecommunications Infrastructure Standard for Data Centers"; acquisition of estimated 130 physical blade servers, 6 database servers and 1 Petabyte of data storage for each data center; control room; backup power supplies, data communications connections, environmental controls such as air conditioning and fire suppression. The Project would also invest in the refurbishment and telecommunications equipment of a building to house the National Telemedicine Institute. The exact locations and final designs will be determined during project implementation.

Component 3 would include Project management; as such this component might include purchasing of office and IT equipment and minor refurbishing of office space for the project implementation unit.

Project works will likely occur in urban or semi-urban environments.

B. Borrower's Institutional Capacity for Safeguard Policies

The Ministry of Health of Peru (MoH) will be the Project oversight and implementing agency and will establish a Project Implementing Unit (PIU). The World Bank has had multiple investment with the MoH . Over time, the MoH has improved its institutional capacity to implement World Bank Safeguards Policies. In the case of this Project, the MoH has assigned staff to coordinate the Project preparation with the Bank, including the preparation and implementation of environmental and social instruments. During Project preparation, the Bank will assess the MoH and PIU safeguards capacity, and as needed, additional staff or support will be integrated into the PIU for implementation.

C. Environmental and Social Safeguards Specialists on the Team

Raul Tolmos, Environmental Safeguards Specialist
Carlos Tomas Perez-Brito, Social Safeguards Specialist

Robert H. Montgomery, Environmental Safeguards Specialist

D. Policies that might apply

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	According to OP/BP 4.01 this Project is classified as Category B because some adverse but manageable and short-term environmental impacts and risks are anticipated. These may consist of routine environmental and social impacts associated with small building construction (including some demolition) in urban environments (e.g., dust, traffic, noise, waste management, etc.). Component 1 infrastructure investments will include rehabilitation, remodeling, and tear-down and reconstruction of existing first-level health centers. In some cases, health centers might need to be relocated to mitigate risks such as floods or landslides; in those cases, health centers may have to be newly built in a different location. Under Component 2, the works involved construction of data centers. There are also potential environmental impacts and risks associated with the operation of the Component 1 and 2 facilities (e.g., solid and medical waste management, waste water, air quality, etc.). Since the exact final locations and designs are not know (will be determined during project implementation), the borrower will prepare an Environmental and Social Management Framework (EMSF) describing regulations, institutional arrangements and procedures and principles for environmental, health and safety (EHS) risk screening, categorization, management, and training (capacity building). The ESMF will address both construction and operation of Project facilities and will include both medical waste management plans and ICT waste management plans. The ESMF will reference applicable WBG Environmental and Health and Safety Guidelines (e.g., General, Health Care Facilities). The ESMF will include a section describing the public consultation with key stakeholders.
Natural Habitats OP/BP 4.04	TBD	OP/BP 4.04 is left as to be defined until the specific location of health facilities to be benefited by the Project is known. Some health or data centers facilities

		might be located in semi-urban or rural areas close to natural protected areas and their buffer zones. If the policy is triggered, the necessary management practices (including screening to ensure activities that involve conversion of natural habitats are not financed) will be incorporated with OP/BP 4.01 plans and procedures described in the ESMF.
Forests OP/BP 4.36	No	OP/BP 4.36 will not be triggered because the Project does not support conversion of forest habitats.
Pest Management OP 4.09	TBD	OP/BP 4.09 might be triggered depending upon the specific works to be determined and conditions of existing health facilities. If pest management practices are required, they will be incorporated with the plans and procedures described in the ESMF under OP/BP 4.01.
Physical Cultural Resources OP/BP 4.11	Yes	OP/BP 4.11 will be triggered because the Project will support infrastructure and civil works in health facilities located in regions with known presence of vast physical cultural resources (e.g. Lambayeque and Ica) and because some health facilities that will benefit from this Project may be considered physical cultural resources according to definition of cultural physical resources under this policy. The ESMF will include requirements for chance find procedures and management of physical cultural resources.
Indigenous Peoples OP/BP 4.10	Yes	OP/BP 4.10 will be triggered because some of the people living in the participating regions (Lambayeque and Ica) meet the OP4.10 requirements, including some afro-descendants communities. The Project is expected to generate more benefit than negative impact on IP communities. In fact, the Project aims to a) provide health services that appropriately respond to the range of epidemiological conditions of the population; b) improve the equity of access to care for chronic and non-communicable conditions, which is currently limited to persons able to access outpatient care in hospitals; c) standardize protocols for care, thereby reducing the gaps and inequalities in quality of care between facilities, population groups and geographical locations. In addition, the Bank will support the MOH to possibly extend the concept of culturally appropriate care beyond the maternal-child services area and start building capacity for preventing, mitigating and treating chronic and non-communicable diseases effectively in indigenous populations. Through the preparation of a Social

Assessment focus on the two region, the assessment will try to identify areas of opportunities to better integrate culturally appropriate care for IP communities. No potential negative impacts on IP communities are identified at this stage. Through the consultation and participation process, the Project will make sure that there is clarity among different communities of the overall goal of the project and the government's objective to reshape health networks in the most efficient and optimized way possible rather than in the historical setup. Since a reorganization of health services could result in a negative perception of reducing or limiting access to existing health services, the Project will make sure there is an effective communication and information strategy to clarify any doubts that communities might have. The Bank will also work with the MOH to develop an effective Grievance Readdress Mechanism through which communities can have the opportunity to present any grievances resulting from the project.

In addition to the Social Assessment and the government will carry out a consultation process with likely Project beneficiaries, including underserved and vulnerable groups to seek support for the Project from these groups and integrate their views in their project design. Once the Social Assessment is concluded, it will be the basis for preparing an Indigenous Peoples Planning Framework (IPPF) and also an Environmental Management Framework due to the fact that sites have not fully identified.   The key findings of the social assessment including the process to foster free, prior, and informed consultations in addition to the development of citizen engagement and grievance redressand mechanism will be incorporated in the Project design and reflected as part of the Environmental and Social Management Plan.

Involuntary Resettlement OP/BP 4.12	TBD	Triggering of this policy is left To Be Determined at this stage. The project might involve acquisition of land for construction of primary health care facilities as well possible investment in internet connectivity to ensure sustainability of the health information system, telesalud and telemedicine. As the team develops fully detailed components and activities, it will be able to determine whether the policy will be triggered. In any

		case, land acquisition will be the responsibility of the GoP and will not be financed by the project. As part of the preparation phase of the Project, an Rapid Health Infrastructure Assessment will be conducted and it will include land acquisition and resettlement needs. This report is expected to be concluded by November 29 by which time the team sould have enough information to define if the policy if triggered or not. If the policy is triggered, a Resettlement Policy Framework will be prepared.
Safety of Dams OP/BP 4.37	No	OP/BP 4.37 will not be triggered, because the Project will not support the construction or rehabilitation of dams, nor will it support other investments which rely on performance of existing dams.
Projects on International Waterways OP/BP 7.50	No	OP/BP 7.50 will not be triggered because the Project will not finance activities that affect water quality and/or water resources availability in international waterways.
Projects in Disputed Areas OP/BP 7.60	No	OP/BP 7.60 will not be triggered because the Project will not finance activities located in disputed areas as defined by the policy.

E. Safeguard Preparation Plan

Tentative target date for preparing the Appraisal Stage PID/ISDS

Jan 15, 2018

Time frame for launching and completing the safeguard-related studies that may be needed. The specific studies and their timing should be specified in the Appraisal Stage PID/ISDS

 Social assessment will be done as part of an overall rapid assessment of health services and infrastructure that will be done to define investment plans for implementation. An ESMF will be developed. The social assessment and ESMF will be completed by the time of appraisal.

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