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**HEALTH FINANCE
DEVELOPMENT PROJECT
(492 - 0446)**

PROJECT PAPER

**USAID/Philippines
SEPTEMBER 1991**

**HEALTH FINANCE DEVELOPMENT PROJECT
(492-0446)
PROJECT PAPER**

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ACRONYMS AND ABBREVIATIONS

AHMOPI	Association of Health Maintenance Organizations in the Philippines
ANE	Asia and Near East
ASO	Administrative Services Only
BHS	Barangay Health Stations
CBA	Collective Bargaining Agreements
CHN	Core Hospital Network
DOH	Department of Health
ECC	Employees Compensation Commission
ECF	Employees Compensation Fund
GNP	Gross National Product
GOP	Government of the Philippines
GSIS	Government Service Insurance System
HAAI	Health and Accident Insurance
HCE	Health Care Expenditures
HCF	Health Care Financing
HFD	Health Finance Development
HIF	Health Insurance Fund
HMO	Health Maintenance Organization
HPDTC	Health Policy Development Technical Committee
HPDS	Health Policy Development Staff
IPA	Individual Practice Association
MAS	Management Advisory Service
MIS	Management Information System
NCHFD	National Council for Health Policy Development
NGO	Non-Government Organization
NHA	National Health Accounts
OCS	Office of Chief of Staff
OHFS	Office of Hospitals and Facilities Services
OPHN	Office of Population, Health and Nutrition
PCU	Project Coordinating Unit
PHA	Philippine Hospital Association
PMA	Philippine Medical Association
PMCC	Philippine Medical Care Commission
PPGP	Prepaid Group Practice
PPO	Preferred Provider Organization
PSC	Personal Services Contract (Contractor)
RAO	Regional Audit Office
RHU	Rural Health Unit
SIF	State Insurance Fund
SSS	Social Security System
TA	Technical Assistance
USAID	United States Agency for International Development

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AGENCY FOR INTERNATIONAL DEVELOPMENT PROJECT DATA SHEET			1. TRANSACTION CODE <input type="checkbox"/> A = Add <input type="checkbox"/> C = Change <input type="checkbox"/> D = Delete		Amendment Number	DOCUMENT CODE 3
2. COUNTRY/ENTITY Philippines			3. PROJECT NUMBER 492-0446			
4. BUREAU/OFFICE Asia			5. PROJECT TITLE (maximum 40 characters) Health Finance Development			
6. PROJECT ASSISTANCE COMPLETION DATE (PACD) MM DD YY 09 30 96			7. ESTIMATED DATE OF OBLIGATION (Under 'B.' below, enter 1, 2, 3, or 4) A. Initial FY 91 B. Quarter <input checked="" type="checkbox"/> C. Final FY 94			

8. COSTS (\$000 OR EQUIVALENT \$1 =)						
A. FUNDING SOURCE	FIRST FY			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AID Appropriated Total	2365	1135	3,500	8753	11247	20,000
(Grant)	(2365)	(1135)	(3,500)	(8753)	(11247)	(20,000)
(Loan)	()	()	()	()	()	()
Other U.S.						
1.						
2.						
Host Country						
Other Donor(s)	0	1247	1,247	0	6855	6,855
TOTALS	2365	2382	4,747	8753	18102	26,855

9. SCHEDULE OF AID FUNDING (\$000)									
A. APPRO- PRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) HE	520	520				1,000		12,500	
(2) PSEF	799	840				2,500		2,500	
(3) SAI								5,000	
(4)									
TOTALS						3,500		20,000	

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each)						11. SECONDARY PURPOSE CODE 582			
12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)									
A. Code		DEL		EQTY					
B. Amount									

13. PROJECT PURPOSE (maximum 480 characters).
 To establish a process for formulating and implementing health sector policies, regulations and legislation supportive of health-care market improvement.

14. SCHEDULED EVALUATIONS						15. SOURCE/ORIGIN OF GOODS AND SERVICES					
Interim		MM YY	MM YY	Final		MM YY	MM YY				
1 0 9 4		1 2 9 4		0 6 9 6				<input checked="" type="checkbox"/> 000 <input type="checkbox"/> 941 <input type="checkbox"/> Local <input type="checkbox"/> Other (Specify):			

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a _____ page PP Amendment.)
 Note: The provisions of the payment verification policy regarding methods of implementation and financing, financial capability of recipients, and adequacy of audit coverage have been adequately addressed in this document

17. APPROVED BY		Signature Malcolm Butler <i>Malcolm Butler</i>				Date Signed MM DD YY				18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION MM DD YY			
		Title Director USAID/Philippines											

J.C. Stanford
 J.C. Stanford, Controller

PROJECT AUTHORIZATION

Philippines Health Finance Development Project
 Philippines

Project No. 492-0446

1. Pursuant to Sections 104 and 106 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the Health Finance Development Project, Philippines (the "Project") for the Republic of the Philippines (the "Cooperating Country") involving planned obligations not to exceed Twenty Million United States Dollars (\$20,000,000) in grant funds over a four-year period from the date of authorization, subject to the availability of funds in accordance with the A.I.D. OYB/allotment process, to assist in financing foreign exchange and certain local currency costs of the project. The planned life of the project is five years from the date of initial obligation.

2. The Project will assist the Cooperating Country to establish a process for formulating and implementing health sector policies, regulations and legislation supportive of health-care market improvement. Funding will be provided for technical assistance, selected commodities, research, training, demonstration projects, and operational support costs.

3. The Project Agreement, which may be negotiated and executed by the officer(s) to whom such authority is delegated in accordance with A.I.D. regulations and Delegations of Authority, shall be subject to the following essential terms and covenants and major conditions, together with such other terms and conditions as A.I.D. may deem appropriate.

4.a. Source and Origin of Commodities, Nationality of Services

Commodities financed by A.I.D. under the Project shall have their source and origin in the Cooperating Country or in the United States, except as A.I.D. may otherwise agree in writing. Except for ocean shipping, the suppliers of commodities or services shall have the Cooperating Country or the United States as their place of nationality, except as A.I.D. may otherwise agree in writing. Ocean shipping financed by A.I.D. under the Project shall, except as A.I.D. may otherwise agree in writing, be financed only under flag vessels of the United States.

4.b. Other

Prior to any disbursement, or the issuance of any commitment documents under the Project Agreement, the Cooperating Country shall furnish in form and substance satisfactory to A.I.D., a plan for the institutionalization of Health Policy Development Staff in the Cooperating Country's Department of Health.

X

- 4.c. Prior to any disbursement, or the issuance of any commitment document under the Project Agreement to finance new activities each Project Year, the Cooperating Country shall furnish, in form and substance acceptable to A.I.D., an annual implementation plan.

Signature: Malcolm Butler
Malcolm Butler
Director
USAID/Philippines

Date : SEP 13 1991

Clearances:

OPHN:EVoulgaropoulos	<u>Draft</u>	<u>8/28/91</u>
DRM:JAPatterson	<u>Draft</u>	<u>8/22/91</u>
QPE:PDeuster	<u>Draft</u>	<u>8/28/91</u>
OFM:JStanford	<u>Draft</u>	<u>8/28/91</u>
OLA:LChiles	<u>Draft</u>	<u>8/29/91</u>
PESO:BCornelio	<u>Draft</u>	<u>8/28/91</u>
CSO:SHeishman	<u>Draft</u>	<u>9/6/91</u>

SUMMARY AND RECOMMENDATIONS

1. PROJECT TITLE AND NUMBER: Health Finance Development Project
(492-0446)
2. GRANTEE: The Government of the Philippines (GOP).
3. IMPLEMENTING AGENCY: Department of Health
Philippine Medical Care Commission
4. FUNDING LEVEL AND TERMS: U.S. \$20 million grant from Development Assistance (DA).
5. LIFE OF PROJECT: August 26, 1991 to September 30, 1996.
6. PROJECT PURPOSE: To establish a process for formulating and implementing health sector policies, regulations and legislation supportive of health care market improvement.
7. SUMMARY PROJECT DESCRIPTION: The Health Finance Development (HFD) Project is the initial step in USAID support for the complex task of restructuring the Philippine health sector. Recognizing the level of effort required, USAID is proposing a two-phased approach to health finance development assistance. The HFD project, is a five-year projectized package focused on capacity development, technology transfer, research and demonstration projects. A second phase, if appropriate, could consist largely of program assistance support for policy and administrative changes from the HFD Project leading to the attainment of sectoral policy and performance benchmarks.

The HFD Project has three interrelated components which address the need for a careful restructuring of the health sector to ensure a more equitable access to efficient and effective health services. Component 1 will develop GOP's capacity for private/public sector interactive and research-based health finance policy process. Component 2 will seek to improve efficiency and expanded coverage of the national health care financing program and develop options for other health financing schemes. Component 3 will focus on hospital sector restructuring at the macro level and hospital institutional reform at the micro level. Policy proposals resulting from Components 2 and 3 will be fed into Component 1 for appropriate health policy actions.

End of project purpose-level indicators for the HFD Project will include pluralistic development and demonstration of a core set of market-oriented policies which will serve as the foundation for health sector restructuring. Project assistance will finance technical assistance, training, policy studies and research, demonstration projects, limited commodities, monitoring, evaluation and audits.

h'

8. GRANTEE CONTRIBUTION: The GOP plans to provide the Peso equivalent of approximately \$6.825 million of GOP funds in support of the health financing policy process over the five-year life of project.
9. STATUTORY REQUIREMENTS: All statutory requirements have been met. (See Annex F.)
10. RESOLUTION OF PROJECT ISSUES: All project issues have been satisfactorily resolved; these are detailed in the Action Memorandum requesting Project Authorization.
11. RECOMMENDATION: Authorization of a grant of U.S. \$20 million, if negotiations do not significantly alter the Project in form or substance.
12. PROJECT COMMITTEE: The USAID Project Committee members are:
 - OPHN: Patricia Moser, Oscar Picazo
 - DRM: Fatima Verzosa
 - OPE: Gil Dy-Liacco
 - OFM: Catherine Placido
 - OLA: Lisa Chiles
 - PESO: MVillanueva
 - CSO: WReynolds

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I. PROJECT BACKGROUND AND RATIONALE

A. SITUATIONAL ANALYSIS

Infectious diseases persist as major health problems in the Philippines, but chronic and degenerative diseases are becoming more prevalent as a result of the demographic and epidemiologic transition and rapid urbanization. In financial terms, this means that the Philippines has to generate higher level of resources to meet not only the public-health needs of its increasing population but also the more costly medical-care requirements of the aging and urbanizing segment of its people.

Faced with this prospect, the nation may find it difficult to marshal the required capital investments and operating resources unless the Government of the Philippines (GOP) initiates comprehensive policy reform in health care financing (HCF). HCF policy reform is made urgent by current macroeconomic difficulties, the changing age structure of the population that ushers in the epidemiologic transition, problems in financing of health care, and inefficiencies in medical-care delivery -- all of which can potentially limit access to and utilization of health services which, in turn, have adverse impact on health status.

1. Macroeconomic Context

The Philippine economy continues to suffer from major structural weaknesses, a symptom of which is the persistent GOP fiscal deficit. The GOP deficit, in turn, has a direct impact on social service provision since appropriations for such services are usually the first to shrink in times of sluggish growth. Historically, the proportion of the GOP budget devoted to the health sector has been low. In 1983, it reached a record high of 4.5%, but on account of the economic slowdown spawned by the debt crisis in the mid-1980s, it fell to just 2.6% by 1987. The decline was due chiefly to the increasing demands for debt servicing: the proportion of GOP budget allocated to debt service grew from 15.1% in 1983 to 45.0% in 1987.

Although the economy has experienced some recovery in recent years, major structural weaknesses remain. Among the indicators of these continuing weaknesses are annual imports exceeding exports, foreign and local investments below structural requirements, a weak tax base and revenue generation, and continual growth in debt-servicing requirements. As a result, economic projections indicate a less-than-robust economic growth with GNP expanding only by 4-5% annually over the next few years. The fiscal shortfall is anticipated to continue, and the Department of Health (DOH) budget may be unable to expand in response to population growth, shifting health requirements, and cost inflation. These trends do not bode well for government-provided health services.

2. The Health Transition

The Philippine health profile still indicates the prevalence of infectious, and therefore preventable, diseases such as respiratory infections, measles, diarrhoea, tuberculosis, and malaria. These diseases typically afflict the young. The age structure of the Philippine population, however, is changing. By year 2000, 72.4% of the population will be 15 years or older, compared to 63.3% in 1980 and 66.2% in 1990. This demographic transition exacts a corresponding change in the nation's health profile. Already, the Philippines is beginning to experience the epidemiologic or health transition. In the past few years, degenerative and chronic ailments, notably cardiovascular diseases and malignant neoplasms, have become top-ten causes of illness and death. Urbanization and industrialization have also brought with them ailments associated with congestion and modern-day stress such as accidents, trauma, hypertension, and work-related disabilities.

The health transition has a profound impact on health financing requirements. First, diseases of aging and modern-day stress typically require hospitalization and personal care by a physician and are, therefore, more expensive to treat. Second, financing these new needs competes with the financial requirements of public health. Since the country continues to grapple with major public-health problems, careful and prudent financing reform must be undertaken such that these problems are not neglected in favor of the more visible, and therefore more politically demanding, problems of aging and urbanization.

3. Delivery of Health Services

A range of private and government practitioners and facilities provide health services.

a. Private Sector - The private sector includes pharmacists, physicians in solo or group practice, small hospitals and maternity centers, diagnostic centers, employer-based health facilities, health maintenance organizations, secondary- and tertiary-care institutions, traditional birth attendants, and indigenous healers. The modern private sector concentrates largely on the provision of curative and rehabilitative care to upper- and middle-income households.

About 45% of all hospital beds are in private hospitals. Although there are more private than public hospitals, private facilities tend to be either very small operations in towns or large facilities in urban areas, particularly in Metro Manila. Greater public-private cooperation has been initiated through hospital networks, sister hospital arrangements, and the privatization of support services in certain government health facilities.

Viability seems to be a major issue among private health service providers. Although private health sector investments are not well monitored, anecdotal evidence suggests that they are hindered by regulatory, policy, recurrent financing, and information constraints.

b. Public Sector - The DOH provides a range of preventive, curative, and rehabilitative services, mostly aimed toward low-income groups. At the lowest level are the primary health care facilities, consisting of barangay (village) health stations (BHS), with a midwife or paramedic, and rural health units (RHU), staffed by a team consisting usually of a physician, a nurse, and a midwife. There are 9,184 BHSs and 2,072 RHUs nationwide, making government health services available to about 70% of the population. BHSs and RHUs usually refer more complicated cases to the district hospital (with about 50 beds), provincial hospital (100-150 beds), or regional hospital (200-250 beds). A small number of medical centers (250 beds or more), mostly located in Metro Manila, provide more specialized care.

Since 1986, DOH has made major budget realignments towards increasing the funding of public health services. However, curative services continue to account for a large proportion of the yearly appropriations. The skewed allocation of health resources reflects, to a large extent, the legacy of pork-barrel accommodations. Better investment and budgetting rules need to be developed for the public sector. In the face of serious resource scarcity, misallocation means jeopardizing more cost-effective preventive interventions.

Government health facilities also lack financial sustainability. In 1989, public hospitals were able to recover only 10% of their recurrent costs. Pricing mechanisms have not been adequately used in public hospitals to generate resources, improve referral, and rationalize demand and utilization. Implicit subsidies and free-care practices cause overutilization of inpatient services.

While hospitals account for the major portion of the GOP health budget, the government has not devoted much attention into the way they use and generate resources. Due to bureaucratic inertia, legal rigidities, and lack of information, the implicit incentive and management structures within public hospitals have not been sufficiently examined and restructured to yield potential efficiency savings.

4. Financing of the Health System

The range of funding mechanisms that has evolved in the Philippines -- taxation, compulsory health insurance, prepayment through health maintenance organizations (HMOs), private health insurance, fee-for-service -- makes it sophisticated by developing-country standards. However, the health sector continues to suffer from resource scarcity. Policy reforms are required to steer government-mandated health funds and to stimulate the growth of private-sector financing schemes.

a. National Health Care Expenditures - Total (public and private) health care expenditure (HCE) as a proportion of gross national product (GNP) is only about 2.5%, lower than the 5% prescribed by the World Health Organization (WHO) for middle-income countries, and lower than that of Thailand and Malaysia (with at least 3%), China and India (with at least 4%), and South Korea (with 5%). The Philippine HCE per capita also lags behind such countries as Thailand, Malaysia, South Korea, and even Papua New Guinea. On the basis of these comparisons, the Philippine health sector is clearly underfinanced.

Government HCE represents less than a third of total HCE. Because they are drawn largely from tax revenues, government health resources are subject to the GOP fiscal situation. With the economic recovery in 1986, the GOP health budget more than doubled in nominal terms to Pesos 7.6 billion by 1990. However, this substantial increase was insufficient to offset inflationary pressures during the period. Thus, in real terms, not until 1990 did government HCE reattain the real per capita level established in 1983. Unfortunately, the recent Persian Gulf crisis has triggered severe reductions in the 1991 GOP budget, again resulting in declining health appropriation.

Private-sector HCE accounts for roughly 75% of total HCE. Trend analysis shows that whenever the GOP health budget is reduced, private HCE increases. While there is no inherent problem in the private sector financing the slack caused by GOP budget cuts, under the current structure, private HCE are primarily out-of-pocket, i.e., personal payment for services when utilized. Health insurance accounts for only about 5%. With 49% of the households below the poverty line, this arrangement is untenable: it pushes poor families to financial distress when a member gets sick, at a time when the government, because of budget reduction, is least able to help them. Clearly, there is a need to expand equitable risk-sharing arrangements to reduce out-of-pocket HCE at the time of illness.

b. Medicare Program - In 1972, the Philippines established a compulsory health insurance system. The current program (Medicare I) covers all civil service and private sector wage-earners, non-owner employees, and their dependents. Under Medicare I, employers and employees contribute 1.25 percent of their respective payroll and earnings (with a ceiling) to the Health Insurance Fund (HIF). The HIF is collected by the Government Service Insurance System (GSIS) for civil servants and by the Social Security System (SSS) for private-sector employees. The Philippine Medical Care Commission (PMCC) is the policymaking body for the Medicare Program.

Medicare I now covers 38% of the population. It currently covers only the wage-based economy; a parallel program for the informal sector -- farmers, fishermen, small-scale craftsmen, and traders -- remains to be implemented. To be sure, even among the formally-employed, Medicare is able to reach much less than its potential target.

While Medicare's coverage rate looks impressive, the insured still face significant financial risk because the benefit package covers only inpatient care and is not indexed against price increases. Inflation has gradually eroded the Medicare support value such that a typical patient in 1990 self-financed 70% of hospitalization costs, much higher than the 30% average cost-sharing in the early 1970s. The current benefit structure also provides incentives for costly hospitalization and disincentives for preventive care.

Medicare I serves as a financing instrument for government and private hospitals. The proliferation of private hospitals, especially in the 1970s, was probably due to Medicare. However, the absence of an adequate management information system seriously hampers program operation, resulting in fraud and abuse. Slow claims processing also inhibits individuals and providers from using Medicare. Hence, in 1985, Medicare accounted for only 3% of total HCE.

The HIF, however, is in healthy financial condition. As of 1990, SSS had reserves amounting to P4.5 billion while GSIS had P620 million. Translated into reserve capacity (i.e., the number of years current reserves can cover current levels of expenses), the HIF of SSS can last for 6 years compared to GSIS' 1.4 years, or a combined weighted average of 4.3 years, higher than the 2-3 years that private actuaries consider safe. From purely financial considerations, therefore, much can be done to improve the Medicare benefit package, even to include some preventive/outpatient care. Rendering these financial figures into actual benefits for enrollees, however, will require HIF policy and operational reforms. The differential reserve capacities of SSS and GSIS also need to be addressed. Over the longer term, the benefits of integrating the HIF of SSS and GSIS must be considered.

c. Employees Compensation Fund - The Employees Compensation (EC) Fund is a compulsory social-insurance scheme that gives tax-exempt benefits to employees' work-related disability or death. The health benefits of the EC Program are in the form of medical services for injury or sickness and rehabilitation service in cases of permanent disability.

Administratively, the EC Program operates very much like Medicare. The Employees Compensation Commission (ECC) is the policy formulating body under the Department of Labor and Employment; SSS and GSIS serve as the collecting and claims processing agencies. EC contributions are paid entirely by the employer, unlike Medicare where the employee shares 50% of the premium. As of 1987, EC covered an estimated 12.2 million workers, representing 59% of the employed and 21% of the Philippine population for that year.

A central issue that the ECC has to resolve is the excessive reserve capacity of SSS. As of 1988, SSS had total State Insurance Fund reserves of P3.9 billion, equivalent to 59 years of that year's level of expenses. The corresponding figures for GSIS for the same year were P386 million and 3 years. For both the EC and Medicare Programs, policymakers face the issue of beneficiary responsiveness vs. fund stability with respect to SSS, i.e., the optimum level of reserves that meets the twin requirements of financial viability and increased benefit package.

Overlaps also exist between the benefits provided by the EC Program and the Medicare Program. Hence, there is a need to review the possibility of integrating the EC's medical, ambulatory, and rehabilitative services with those of Medicare.

d. Private Health Insurance - As of 1988, there were 102 companies involved in health and accident insurance (HAAI) in the Philippines. Of these, 76% were domestic nonlife, 15% were foreign nonlife, and 7% were domestic life companies. Gross premiums collected by these companies in 1988 amounted to P469 million, of which 56.3% were for nonlife HAAI and 43.7% were for life insurance. Group health insurance premiums amounted to P146 million compared to P58.5 million for ordinary (family and individual) insurance. The predominance and faster growth of group health insurance to HAAI as a whole stem from the conscious effort of life insurance companies to focus on group accounts.

In terms of investments, the number of HAAI companies has not expanded considerably since the 1970s. Industry sources state that profits from health insurance products are typically lower than 2%, compared to 10% for life insurance. Industry cost analyses show that profits are reduced by high administrative and marketing costs. In addition, the industry faces pricing problems, regulatory rigidities, high premium taxes, lack of an industry association that can lobby for policy changes, difficulty of marketing to low-income households, low consumer awareness of the benefits of risk-sharing, and inadequate diversity of health insurance offerings. As a result of these difficulties, private insurance benefit accounts for only about 1% of total HCE.

e. Health Maintenance Organizations -

Philippine HMOs are either of the prepaid group practice (PPGP) or the individual practice association (IPA) model. In terms of ownership, HMOs can be investor-based, community-based, or employer-initiated. Some 19 HMOs offer services on an individual, family, or group/corporate basis. The major investor-based HMOs have banded themselves into the Association of HMOs in the Philippines (AHMOPI). In the first quarter of 1991, total HMO enrollment was estimated at 500,000, or roughly 1% of the population. There has been rapid growth in HMO enrollment over the past two years but there are no available data to show whether this growth has been at the expense of commercial indemnity insurers.

HMOs are optimistic about their potential growth. However, reported provider abuses inhibit many households from enrolling. Both the government and the industry association agree that regulation, now lacking, would alleviate these abuses and provide the framework under which HMOs can thrive. Such a regulatory framework should also define how tieups between PMCC and HMOs should operate.

f. Employer-Provided Health Benefits -

In addition to requiring contributions to the EC Fund, the Labor Code of the Philippines specifies the minimum medical, dental, and occupational-safety obligations of employers. Some companies (e.g. mining concerns, plantations) finance health services for their workers, either fully or with partial subsidy. In addition to what the Labor Code prescribes, collective bargaining agreements (CBA) usually specify health benefits that are due to employees, laborers, and their dependents, e.g., free or subsidized consultations, credit lines at pharmacies, and salary-deductible hospitalization expenses. Health benefits may also be voluntarily provided by companies without CBA as part of their corporate philosophy.

Information on these schemes, however, are largely unavailable. From a policy perspective, it is important to see the extent of these in-plant or off-plant employee-provided benefits, their operational constraints, and possibilities of linking them with other mandated health programs as cost-reduction or efficiency-enhancing strategies.

g. Community-Financing Schemes - Community health financing refers to community mobilization of resources to fully or partially support health services of its members. Early examples of these schemes involved donations of labor or materials to rural clinics and community drug funds -- all generally oriented towards the provision of primary health care. Because these are typically located in poor rural areas, their ability to cover the cost of comprehensive medical services is insufficient; these have to be supplemented externally. Thus, one review of worldwide experience in these schemes concludes that community financing should just be one element in a balanced financing approach.

Some novel community financing schemes, however, have emerged in the Philippines in recent years, e.g., cooperatives for health financing, patients with common illness (diabetes, cancer) grouping themselves for a variety of reasons. It appears that the chief strength of these schemes is in enrolling eligible members. Such strength is useful for the implementation of programs that provide grants to poor communities, or in tieups with existing pool of funds.

h. User Fees - User fees in government health facilities can be a substantial source of funds but their potential has not been extensively tapped. Public hospitals retain professional and pharmaceutical fees from Medicare patients, but because they must turn over all other revenues to the National Treasury, there is little incentive to collect them. The cost recovery rate in government facilities was only about 10 percent in 1989.

Fee-for-service is by far the most pervasive mode of financing private health care. In the absence or lack of risk-sharing mechanisms, this mode of payment tends to be inequitable, even to the non-poor. Fee-for-service funding also tends to constrain development of the health care market since it places the burden of health sector financing on the sick.

5. Access to Health Services

Uneven spatial distribution of health resources, increasing health care costs, and lack of sustainable financing mechanisms constrain access to private and government health services by a great number of Filipinos.

a. Physical Access - About half of all practicing doctors are in Metro Manila and Southern Tagalog, although these regions account for only a quarter of the country's population. The maldistribution of dentists is even more extreme with two-thirds of them in Metro Manila and Southern Tagalog. Midwives and nurses are relatively more dispersed. Lack of incentives and appropriate training in "grassroots medicine" prevent many health professionals from practicing in rural areas.

While public health facilities are well distributed, private clinics and hospitals are not. Among others, lack of financial incentives in poor rural areas drives them to high-income urban areas, as in other countries.

b. Financial Access - In addition to constraints posed by the predominantly fee-for-service HCF system, increasing medical costs also pose serious barriers to health services. Since 1977, the price index for medical services and supplies has grown at an average annual rate of 16.2 percent, higher than the 13.9 percent average annual increase in consumer prices for the same period. The current Medicare reimbursement system is neither intended nor able to control health care costs. In fact, Medicare authorities are wary of improving the benefit package because past improvements, among others, resulted in undue cost increase.

c. Access and Utilization - As a result of physical, financial, and possibly cultural and behavioral barriers to health services, data from the Vital Statistics Division of the National Census and Statistics Office reveal that in 1988, 59.4% of all deaths had no professional medical attendance. Access to and utilization of health services also vary widely by geographic area and income class.

B. PROBLEM STATEMENT

Philippine HCF trends show that the government cannot, now and in the future, be expected to adequately address the health needs of all Filipinos. Current national spending in health is low, even by developing-country standards. While there is consensus on the need to expand government health resources, macroeconomic problems make it difficult, if not impossible, to do so. Meanwhile, the Philippine population continues to grow at a worrisome rate of 2.4% per year, health care costs are increasing faster than ordinary households can afford, and health needs are shifting towards more expensive curative services.

The financial implications of these trends are substantial. The problem of health care financing in the Philippines, therefore, is how to increase the level of health-sector investments, rationalize their allocation, and enhance operational efficiency by improving the structure of incentives in the sector.

Given the above diagnosis, the Philippine HCF problem must be approached from the standpoint not only of resource and investment mobilization but also efficiency improvement. With the GOP budget impasse, additional health resources can come only from:

- * efficiency savings within the health sector;
- * incremental funds that can be generated by reforming and improving the incentive structure for existing health financing and delivery arrangements;
- * fresh resources that can be tapped by introducing new and creative financing mechanisms; and
- * tapping existing pools of resources (e.g., excess reserve capacities of mandated health funds) through policy change.

These new resources can be generated largely from the private sector. Thus, the Health Finance Development (HFD) Project concentrates on the examination of private sector constraints, the identification of viable private sector health financing schemes, and improving market mechanisms such that private investors see health as a productive economic sector and not only as a public-budget consumption item.

C. APPROACH TO THE PROBLEM

Increasing health investments and maximizing their effectiveness will require radical changes in the way health services are provided and financed. In the long term, this will require overall sectoral restructuring in which appropriate market incentives are established for quality, equity, expanded access to care, and greater private-sector participation.

To achieve these aims, it is imperative to (1) reorient the role of the government in the health sector and (2) involve private providers/financers of health care in the decision-making process, and provide them with the information necessary for efficient investment decisions. From being the major service provider, the DOH realizes that it has to take on developmental functions associated with the establishment of legal and regulatory framework which makes private investment and provision grow, and to administer public resources more efficiently in order to finance care for the poor. In the short-term, the DOH and PMCC plan to undertake a HCF policy reform program that assists them evolve as development-oriented health agencies, divest services that do not directly address equity and public-health goals, and create a market environment that widens financial participation in the sector.

For its part, the private sector must be attuned and responsive to structural changes and exercise voice in setting appropriate market directions. Current mechanisms for private sector participation and feedback in the GOP health finance policy process is informal and limited. Therefore, a major element in the DOH HCF policy reform program will be institutionalization of this wider participation.

To recognize and respond to different HCF incentive structures, the private sector also needs access to low-cost capital to demonstrate alternate delivery and finance systems and access to information on the sector. These will be made available through the HFD Project.

1. Future Role of Government in the Health Sector

Historically, DOH involvement in the health sector has been in health service delivery. For public health services, this is justified on the grounds of market failure, i.e., left to itself, the free and unregulated market tends to underproduce public goods such as public health. DOH health

services soon expanded into the provision of hospital services, and due to political and technical constraints, these services quickly absorbed a disproportionate share of the GOP health budget, even in the face of already existing private providers.

The DOH is aware that due to serious budgetary problems, it cannot be expected to meet rising national health requirements, especially with the impending health transition and rising health care costs. The private sector has to be stimulated to generate health investments and provide services to assist the government achieve national health goals. This approach necessitates creating a policy climate conducive to private sector growth. More fundamentally, it necessitates changes in the role of the government in the health sector. From service provision, the DOH envisions to take on paramount roles associated with the assessment of national health problems, the organization of health resources, and the setting of standards.

a. Assessment Function - The assessment function relates to the DOH's role in the identification of health problems at the national and subnational levels. Such role requires the marshalling of information and data to assess current health problems and forecast likely health scenarios based on trends in demography, epidemiology, urbanization, economic growth, and medical technology. These data are critical not only for purposes of national health planning but also for private investment scanning. A critical constraint to private-sector participation in health care has been the dearth of information required for health investment decisions, e.g., demographic and epidemiologic trends, mortality and morbidity bases for actuarial analyses, geographic location of existing health facilities, cost data. To pursue its assessment function, the DOH intends to strengthen epidemiological surveillance, health facilities mapping, and health data generation and analysis.

b. Organizing Function - The organizing function relates to the DOH's role in coordinating public and private health-sector activities, encouraging multisectoral interest and participation in the sector, and promoting investments in the health care market. It entails analysis of sectoral constraints, definition of the proper roles of the government and the private sector in health, and planning government resources carefully so that they do not compete with the private investments. More fundamentally, the organizing function requires the DOH to take the lead in identifying and crafting appropriate policies that address sectoral constraints so that resources flow effectively into the sector in support of national health goals.

c. Standard-Setting Function - Widening private-sector participation also requires that the DOH strengthen its role as health service regulator. Worldwide experience has shown that market forces alone do not efficiently allocate health resources toward meeting health status and development goals. Information asymmetry between provider and consumer, the probabilistic nature of the demand for health care, third-party payment systems, the exigency of need over demand, and medical quality standards -- these product characteristics require standards and regulations. The rise of third-party payment systems also requires legal and financial standards to protect

consumers and financiers. Hence, as the private sector becomes more involved in the health care market, the DOH and the PMCC know that they should assume greater regulatory responsibility.

The HFD Project provides the DOH with the unique opportunity to examine its role and craft policies that lead to the achievement of national health goals. The real goal, however, is not just to put new laws on the books but to achieve a lasting transformation of the role of the government and ensure that laws, policies, and regulations can be implemented.

2. HCF Policy Reform

a. Scope of Policy Reform - Shifting the role of the government and stimulating the growth of the private sector in health service provision and financing necessitate a deliberate policy reform program that addresses both the demand for and supply of health services.

On the demand side, the DOH and PMCC realize the need to craft reforms required to enable households and consumers to have financial access to health services and to reduce the financial risk of households in case of illness. For poor households, demand financing enables them to transform their health needs into health demands.

Demand financing entails improvement and expansion of Medicare and other mandated health programs as well as examination of the current and potential roles of HMOs, private insurers, employer-provided health benefits, community pools of resources, and other funding mechanisms. It also entails looking at ways by which the organization of government-mandated health programs and funds can be improved, and how private-sector providers and insurers can establish tieups to such already-established pools of resources.

Worldwide experience shows a wide range of generic policy instruments that can influence demand. Among these are:

- * Tax treatment of premiums and industry regulation of private insurers and HMOs;
- * Reimbursement rules, speed of payment, beneficiary base, and regulation of government-mandated health insurance program;
- * Coverage laws of employer-provided health benefits; and
- * Subsidies and indigent coverage.

On the supply side, the DOH intends to look closely at hospitals since they are the largest users of health resources. The reform interest is not in hospitals, per se, but in the improvement of the incentive structure and operating procedures in these institutions, both public and private, towards greater efficiency and effectiveness.

Hospitals are production units that employ factors of production (inputs) to produce health services (outputs). This framework provides a convenient way of identifying generic policy instruments that can be used to improve hospital efficiency and effectiveness. Among these are:

- * Decentralization and autonomy laws which impact on the way public hospitals are governed, managed, financed, and owned;
- * Facility licensing requirements and locational restrictions that impact on physical plant;
- * Credit policies, tax laws, and investment regulations that impact on the flow of financial capital;
- * Import tariffs, customs regulations, and trade restrictions that impact on equipment and supplies;
- * Professional licensing and employment regulations that impact on the supply of labor;
- * Various incentives/disincentives that impact on the geographic distribution of health facilities, including certification of need;
- * Public investment decisions with regard hospital infrastructure and support infrastructure such as roads, communication, and power; and
- * Pricing and reimbursement rules.

The HFD Project will provide DOH with resources to identify and use policy instruments that improve the demand and supply of health services.

The GOP's pincer-like approach to HCF policy reform -- i.e., demand and supply addressed in tandem -- is not only suitable; it is necessary. Parallel reforms in financing and provision are complementary and mutually reinforcing. First, demand financing encourages supply, as shown in the growth of private rural clinics and hospitals in the early years of Medicare. Second, financial access enables consumers to widen their choice of providers which, in turn, stimulates competition and efficiency. Third, demand financing without corresponding efficiency improvements in service delivery only drives up health care costs.

The HFD Project, therefore, considers assistance to the GOP in supply-efficiency improvements (Component 3) as important as demand financing (Component 2). Resource mobilization in health can be easily nullified unless cost containment measures are put in place. The Project provides resources for the examination of macro as well as micro issues in the operation of hospitals for the purpose of improving their efficiency.

b. HCF Policy Process - HCF policy reform is particularly difficult in the Philippines because of the high degree of pluralism, both in service delivery and financing. Pluralism adds a complicating dimension to the complex nature of HCF issues. Philippine society operates on the basis of consensus and Filipinos, in general, have high regard for decisions arrived at on the basis of broad-based and transparent consultation.

Because the Philippine HCF arena is filled with varying interests, it is imperative that the private sector -- professional societies, trade associations of providers and insurers, non-governmental organizations (NGOs), employer groups, and consumer and labor groups -- has broad access to the HCF policy process. More fundamentally, it is imperative that the HCF policy process is institutionalized and becomes an ongoing, dynamic, and iterative exercise. The development of this participatory policy process is the cornerstone of the HFD Project.

At present, the elements of the HCF policy process in the Philippines are not well developed. HCF changes are difficult to introduce due to:

- * the absence of an agreed upon national policy agenda and strategic framework that can provide sectoral direction;
- * the lack of rational and broad-based mechanisms that provide the means for the consideration and crafting of health policies, regulations, and legislation;
- * the scarcity of information needed for making critical decisions, building consensus, and evaluating alternative options at the macro and operational levels; and
- * the dearth of data and resources for demonstrating the viability of various modes of providing and financing health services.

The DOH envisions a health policy process that addresses these constraints. In September 1990, it launched a Health Policy Reform Initiative (HPRI) to establish a process for studying, testing, implementing, monitoring, and evaluating policy reforms in health care financing. Figure 1 outlines the DOH's policy process. The policy process provides mechanisms by which health finance policy initiatives can be:

- * Proposed and studied;
- * Demonstrated/pilot-tested, if necessary;
- * Recommended for policy action;
- * Implemented;
- * Monitored and evaluated; and
- * Revised, if necessary.

The health policy reform mechanisms proposed through the HPRI are:

- * A National Committee for Health Policy Development (NCHPD) composed of key policy advocates representing the various agencies and interest groups involved in the health sector, headed by the Secretary of Health and designated by the President through an Executive Order.
- * A Health Policy Development Technical Committee (HPDTC) composed of key policy analysts headed by the DOH Chief of Staff and designated by the Secretary of Health through an Administrative Order.
- * A Health Policy Development Staff (HPDS) composed of DOH personnel dedicated to managing the HFD Project and tracking the HCF policy reform process.

Inputs from the HPRI will come from a variety of sources as determined by the DOH. The HFD Project will be a major supporter of this health finance policy Reform Initiative.

3. Private Sector Response

To ensure the responsiveness of the private sector to structural changes in the health finance market, the DOH will develop mechanisms for involving the private sector in the formalized health policy decision-making process. To effectively participate, the private sector will need access to (1) the policy process; (2) information on the current health market; (3) financial capital and technical assistance to develop and demonstrate viable alternatives for health services delivery and finance; and (4) training and other capacity-building activities needed to assume new and more efficient roles in the sector. Promotion of these private sector directed activities is an important element of the HFD Project approach.

D. PROJECT RATIONALE

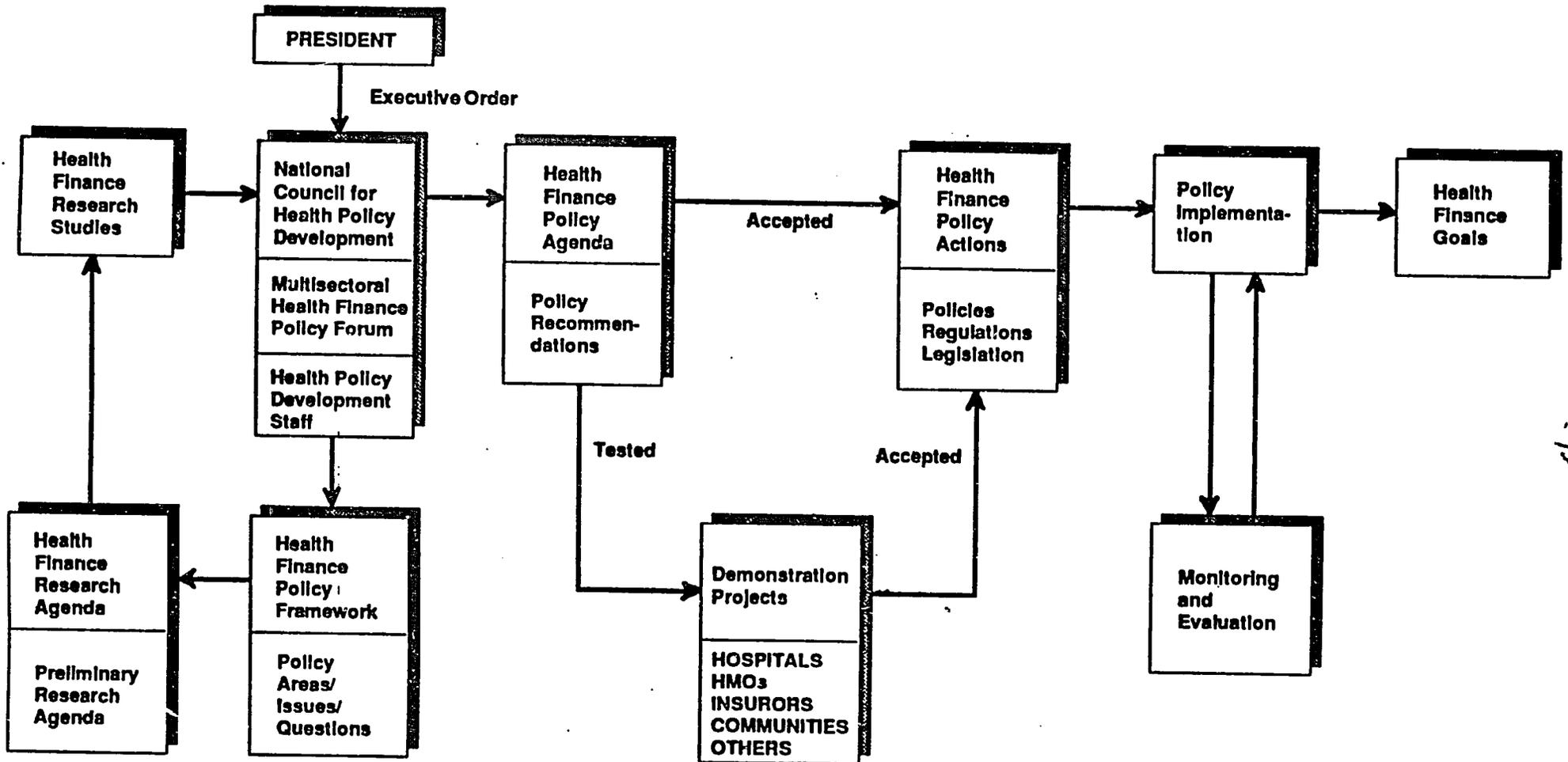
1. Relationship of the Project to USAID Strategy

The HFD Project's goal and purpose and anticipated outcomes directly reflect the thrust of the Asia and Near East (ANE) Bureau's FY 1990 HCF strategy, "Creating Resources for Health: A Strategy to Expand Development of Health Sectors in the ANE Region." In addition, the design reflects USAID's direction set in both the Philippines Assistance Strategy Statement (FY 1991-1995) of March 1990 and the Health Care Financing Strategy of April 1990.

a. ANE Strategy - The ANE Bureau's HCF strategy calls for the expansion of "financial pluralism in the health sectors in ANE countries such that governments have the opportunity to cost-effectively allocate public budgets to the poor most in need and to public health activities." Specifically, the objectives of the ANE Strategy are:

- * to increase efficiency and effectiveness by creating or improving financial management skills and institutional systems for health resource generation/recovery which drive the health care system toward cost-containment while motivating quality;

Figure 1
HCF POLICY PROCESS
 Department of Health



Notes:
 Large-scale policy implementation activities will be the scope of HCF Program Assistance (Phase II).
 Activities are not drawn to scale.

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- * to improve equity by creating/tapping plural pools of local resources for cost-recovery in both product and service aspects of health care provision; and
- * to extend coverage and access by expanding/creating plural pools of financial resources for investment in health care improvement or expansion, both of services and input products.

b. Mission Strategy - The Mission's overall country strategy and specific HCF strategy support the ANE HCF objectives. The Philippine Assistance Strategy Statement (PASS) places emphasis on the efficient and effective delivery of social services, on the one hand, and increased pluralism in economic activities, on the other. The Mission's HCF strategy takes into account the pluralism that is already in place in the Philippine health system and efficiency-improving initiatives being undertaken by the government and the private sector. Thus, the purpose of health sector assistance to the Philippines, as stated in the PASS, is to continue the diversification of health care financing and delivery focusing on the equitable and cost-efficient distribution of national health resources. In pursuit of this strategy, the HFD Project seeks to develop the health care market in order to improve health service quality, equity, coverage, efficiency, and private investment and financing.

Many of the elements of the HFD Project are being ushered in by the HCF benchmarks of the Child Survival Program. This Program provides a \$50 million grant assistance to GOP over a 5-year period, beginning 1990, conditioned upon the achievement of a set of performance targets.

The Child Survival Program has provided the venue for clarifying, focusing, and sharpening GOP strategy in the health sector in general and health care financing in particular. The pioneering HCF studies being undertaken as part of Program benchmarks will provide the DOH additional empirical inputs for the development of a national health care financing strategy. The Child Survival Program is assisting DOH to pursue policy objectives in the areas listed below. All of these activities will be continued and expanded under the HFD Project:

- * Cost containment for DOH services;
- * Improved cost-recovery for DOH facilities and services;
- * Privatization of DOH specialty hospitals and DOH support services;
- * Expansion of private-sector participation in health planning;
- * Increased role of the private sector in the provision of health services; and
- * Stimulation and facilitation of HMO development.

2. Relationship of the Project to GOP Strategy

The updated Medium-Term Philippine Development Plan (1986-1992) placed greater emphasis on developing the health sector and proposes to compensate for past neglect by expanding and improving health services. Key objectives of the Plan are to increase government resource allocation to the health sector, improve the sustainability of health services, expand private sector participation in health, and improve the sectoral policy and regulatory environment.

While obtaining more appropriations for the health sector continues to be a DOH strategy, the Department is also looking into possibilities of tapping extra-budgetary sources, including:

- * Expanding the coverage of Medicare to the informal sector;
- * Medicare-HMO tieups;
- * User fee generation and retention at public hospitals; and
- * Expanded role of local government units (LGUs) in the financing of health care.

The DOH also continues to place emphasis on organizational reforms designed to achieve greater efficiency in the delivery of health services, including the integration of health services at the field level and area-based planning to improve the identification of high-risk groups. The thrust towards greater private-sector participation is being realized through the privatization of health facilities, networking arrangements between DOH and private hospitals to address problems of scale; and continuing dialogue with private funders (e.g., HMOs) and providers.

3. Relationship of the Project to Other Donor Assistance

Although several major donors are supporting the Philippine health sector, only USAID has committed specific funding for health financing initiatives. With the exception of the World Bank-financed Philippine Health Development Project, which provides US\$600,000 for broader health policy studies and analyses, no other donor assistance is being provided in the field of health policy and health sector restructuring. The DOH is closely coordinating USAID and World Bank initiatives in the health policy arena. Other donor sector loans and grants for infrastructure improvements and technical assistance assume that the current structure of health services provision and financing will be maintained. Japanese aid has been focused on equipping DOH provincial hospitals (23 to date). German assistance, limited to the public sector, focuses on improving health information and management systems at the district level.

The DOH has begun to work with the Asian Development Bank (ADB) in the design of a health sector loan which is expected to upgrade current hospital facilities and rationalize the system. The ADB has provided \$400,000 for a study on a "Philippine National Hospital Service Development Plan." The ADB is contemplating a 5-year loan project in the sector for \$30 million plus some grant-financed technical assistance. The study and proposed ADB assistance are being developed by the DOH in concert with Component 3, Hospital Financing Reforms of the HFD Project.

WHO is providing limited technical assistance in health management and medical records. The International Labor Organization funded a May 1989 study of Medicare under the United Nations Development Programme's Technical Support to the Review of Social Security Policies and Administration Project.

The International Health Policy Program, a health research initiative funded by the Pew Trust, Carnegie Mellon, the World Bank and WHO, has developed local academic capacity in health finance and funded five health policy studies in the Philippines. Four of the studies deal with health care related matters including health manpower in the Philippines, hospital cost comparison, prepaid managed health care, and drug consumption behavior. The HFD will utilize resources developed under this Program in carrying out health finance policy related research.

II. PROJECT DESCRIPTION

**A. PROJECT GOAL, PURPOSE,
AND END-OF-PROJECT STATUS**

1. Goal and Purpose

The goal of HFD assistance is to develop the health care market in order to improve health service quality, equity, coverage, efficiency, and private participation. This goal will be measured by an increase in the utilization of health services in the five lowest income deciles. The goal is premised on the assumption that better access to and utilization of health services lead to better health status.

As a first step towards this goal, the HFD project purpose is to establish a process for formulating and implementing health sector policies, regulations, and legislation supportive of health-care market improvement. (See logical framework.) This improvement will be achieved through a careful restructuring of the health sector that results in more equitable access to efficient and effective health services delivered by private and public providers.

As the GOP meets success in developing appropriate financing policies to meet Project goals, USAID will consider development of an additional support mechanism at the mid-point of Project implementation. The purpose of this proposed HFD Program assistance would be to assist the GOP in implementation and institutionalization of a subset of priority financing policies to serve as the foundation for health sector restructuring.

2. Project Components

The Project has three interrelated components which are depicted graphically in Figure 2 and described briefly below.

- * Component 1 will develop the country's capacity for transparent, private/public-sector interactive, and research-based policy formulation process. This entails the establishment of mechanisms which allow private-sector access to the health care financing policy process. The existence of this health policy process is integral to the achievement of the outputs expected from Components 2 and 3 of this Project, making the three components interdependent.
- * Component 2 will seek to improve efficiency and expanded coverage of the national HCF program. This will be done via (a) reforms in the Medicare I Program, and (b) the development of strategic options for encouraging the growth of other HCF schemes such as private risk-sharing, employer-provided health benefits, and community financing schemes.

- * Component 3 will seek to improve the efficiency and effectiveness of hospital-based care provided through public and private hospitals. Activities will focus upon hospital sector restructuring at the macro level and hospital institutional reform at the micro level.

The policy proposals arising from both Components 2 and 3 must be fed into the health finance policy process established via Component 1 for the appropriate health policy actions.

3. End-of-Project Status

The outcome (end-of-project status) expected upon completion of this Project is an integrated set of policies and strengthened capabilities which will serve as a basis for health sector restructuring. These are divided into three areas to reflect Project components.

a. National Health Care Financing Policy

This end-of-project status will be a National Health Care Financing Policy and include:

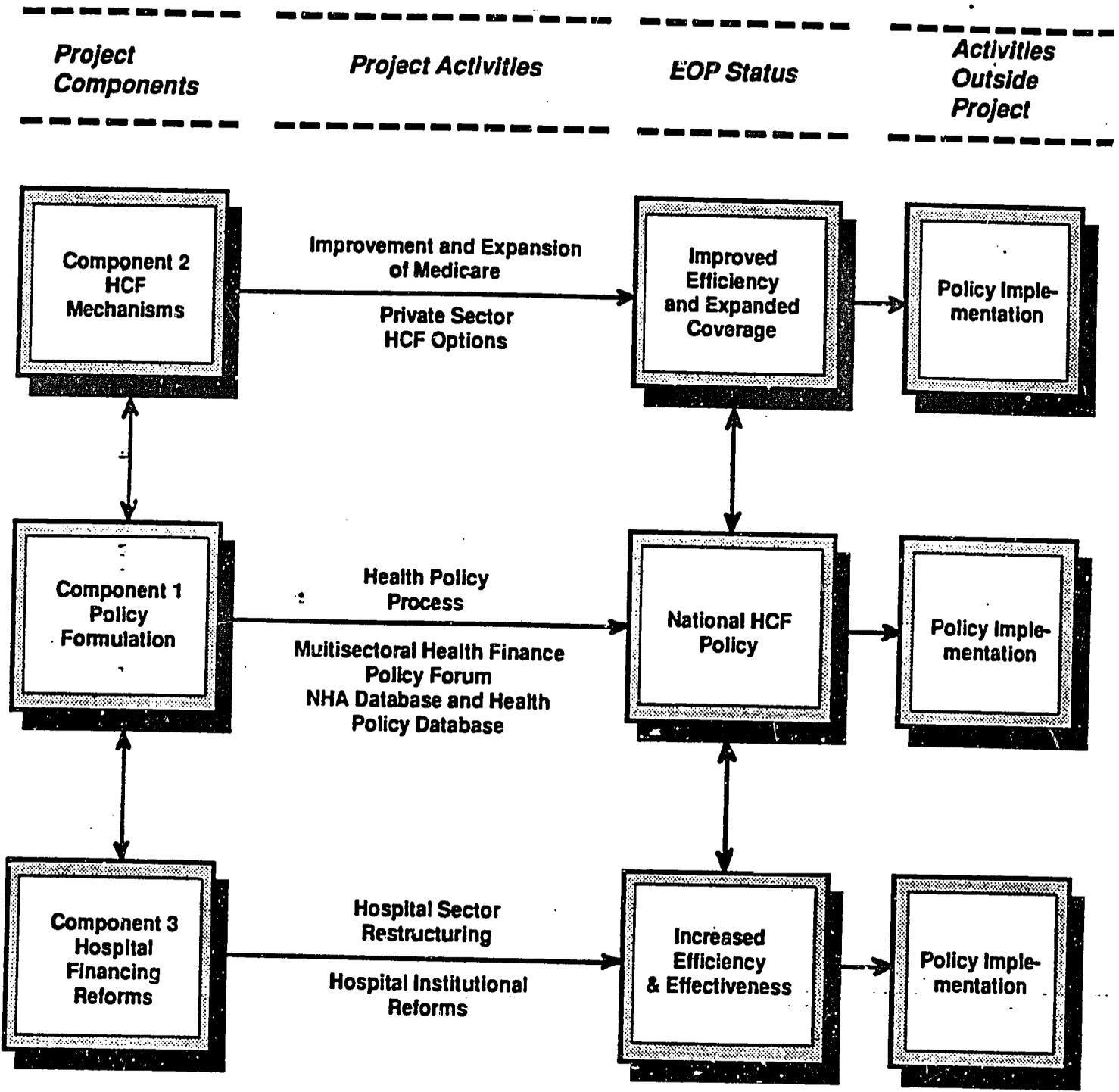
- * A process for private sector participation in health finance decision-making and access to health finance information;
- * Increased private sector capacity to conduct and utilize health finance research and sustain the health policy process;
- * Improved health sector access to the legislative and executive policy processes;
- * Increased private and public sector awareness of and advocacy for potential health finance solutions; and
- * Improved flow of information to the private sector.

b. Improved Efficiency and Expanded Coverage of National Health Care Financing Mechanisms

This end-of-project status will include the following:

- * PMCC policy on Medicare I reforms;
- * GOP policy of encouraging broader private and public-sector risk-sharing for health;
- * Demonstration of viable private sector options for health financing coverage; and
- * Improved capacity in the private sector to recognize and respond to incentives for investment and growth in private financing mechanisms.

Figure 2
HFD Project Components, Activities, and EOP



Note: Component and activities are not drawn to scale.

c. Increased Efficiency and Effectiveness in the Financing of Hospitals

Hospital sector end-of-project status will include:

- * Increased private sector capacity to efficiently manage the provision of health services given the structure of health financing;
- * Demonstration of alternative private sector health care delivery and financing mechanisms;
- * A strategic DOH plan for hospital financing, including sectoral and institutional reforms which promote allocative and operational efficiency; and
- * A GOP policy of stimulating private hospitals to pursue national health goals.

4. Subsequent Activities

Assuming successful implementation of the HFD Project, a second phase of HFD assistance may be proposed. This could consist largely of policy-based cash disbursements beginning in FY 1994 to support and offset the costs of implementation of a specific set of priority health finance policies developed under HFD Project assistance (see Figure 3).

Initial discussions for this proposed follow-on activity have highlighted the following potential areas for support:

- * Transition of the role of the Department of Health;
- * Implementation of a national health care financing policy;
- * Restructuring of the ownership, governance, financing, and management of DOH hospitals; and
- * Province- or region-wide demonstration of structural reforms in financing and provision of services.

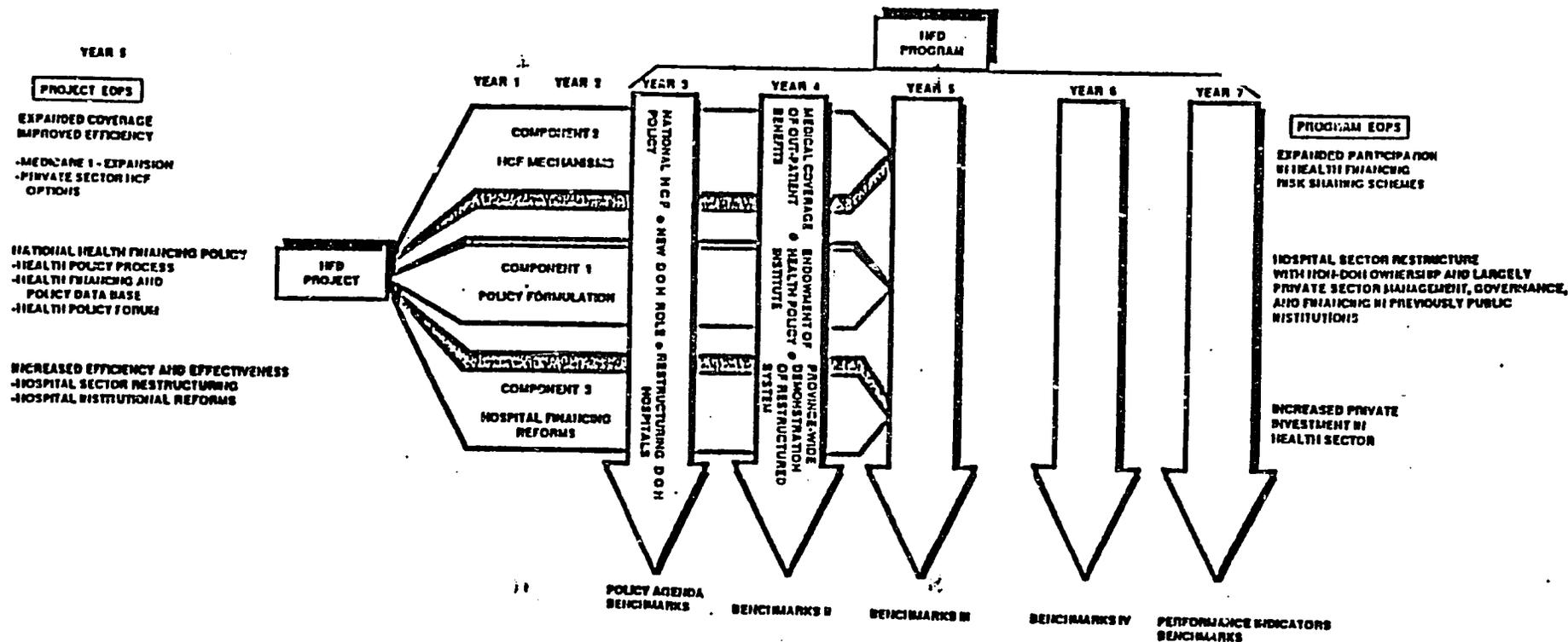
Preliminary budget estimates value this program at a minimum of US\$30 million over a five year period. If proposed, the HFD Program Assistance Initial Proposal (PAIP) would be scheduled for approval in January 1993, with Program Assistance Approval Document (PAAD) approval in August 1993. Initial disbursement would be scheduled for August 1994.

**B. COMPONENT 1 -
POLICY FORMULATION**

1. Project Output

The output of this component is the formation of capacity for research-based policy formulation and the establishment of mechanisms for an interactive and transparent HCF policy process. Project activities will

FIGURE 3
HEALTH FINANCE DEVELOPMENT PROJECT/PROGRAM ASSISTANCE
FY 91 - 98



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support the broader DOH health policy process -- an iterative, dynamic process leading to the design and promulgation of appropriate policies, regulations, and legislation needed to improve the health care market and thereby achieve national health goals. The Project will establish the multisectoral health finance policy forum which will be supported by information generated from the National Health Accounts (NHA) Database and the Health Policy Database.

2. Project Activities

Project assistance will fall into three categories: (a) support for the HCF policy process; (b) support for the multisectoral health finance policy forum; and (c) development of the NHA Database and Health Policy Database.

a. Support for the HCF Policy Process - The DOH has launched the Health Policy Reform Initiative to establish a process for testing, implementing, monitoring, and evaluating HCF policy reforms. To provide guidance for this Reform Initiative, a multisectoral National Council for Health Policy Development (NCHPD) will be established by an Executive Order with representation from the DOH, related government agencies, professional societies, the research and academic community, and trade associations of private providers and insurers. The Health Policy Development Staff (HPDS) being established within the DOH will take lead responsibility for the attainment of the expected output of this component. The Health Policy Development Technical Committee (HPDTC) will provide technical guidance for the HCF policy process. The steps in the HCF policy process are shown schematically in Figure 1 and described below:

(1) Development of a Health Financing Policy Framework

This framework will constitute the policy areas, policy questions, and policy issues that must be considered in order to effect necessary HCF policy reforms required to achieve national health goals. It will also document implicit policies which require consideration and identify the influential policy-makers who must be involved in the process. A preliminary health financing policy framework, developed by the DOH as input to the HPSC deliberations, contains the following five policy areas:

- * the priority areas for future public health budgets based upon epidemiologic, demographic, economic, and social trends;
- * strategies for encouraging the private sector to pursue national health goals;
- * measures for enhancing efficiency in the public and private sectors;
- * development of a national health insurance system; and
- * articulation of new perspectives on the health sector in the Philippines.

In developing the Policy Framework, the NCHPD will consider the situation at the national and subnational (regional and provincial) perspectives so that special geographic concerns are incorporated into the Policy Framework.

(2) Design of a Health Financing Policy Research Agenda

The policy areas, issues, and questions articulated in the Health Financing Policy Framework will inform the design of the research agenda. Considerable work has been done in this area. In 1990, the DOH, using funds from the Philippine Health Development Project (PHDP), commissioned the Philippine Institute for Development Studies (PIDS) to develop a comprehensive HCF research agenda in relation to Medicare II. The research agenda, completed in November 1990, identifies studies necessary to develop a national health care financing system. Six studies are also being completed as part of HCF benchmarks of the USAID-funded Child Survival Program of the DOH. Finally, background studies are being conducted as input to project design of the HFD Project. The studies that are either planned or already in progress are:

- * development and analysis of HCF baseline data;
- * background study on health insurance in the Philippines;
- * analysis of constraints to private sector participation in the health care market;
- * analysis of constraints in hospital management;
- * user fees and cost containment practices; and
- * patterns of local-national government sharing in the financing of health care.

(3) Health Financing Research Studies

The HPDS will coordinate these studies. Studies funded under the PHDP and the Child Survival Program represent the first wave of research efforts. Subsequent studies will be determined by the policy issues identified in the policy framework.

In addition to studies currently being done, the HFD Project will fund generic research which leads to the identification or clarification of HCF policy issues and eventually to the formulation of policy. Examples of such research are modelling exercises which forecast the impact of the epidemiologic transition; the cost-benefit studies of certain health interventions such as Vitamin A supplementation, iodine supplementation, and Hepatitis B vaccination if expanded nationally; or the epidemiologic and financial impact of current or emerging diseases such as AIDS.

(4) Development of a Health Financing Policy Agenda

The findings from the research studies will be channeled to the HPSC and its associated units to review policy implications and make policy recommendations. The policy recommendations emanating from this review process will constitute the official Health Financing Policy Agenda for the DOH. By their nature, certain policy recommendations can be proposed for immediate adoption as soon as careful analyses of their impact has been evaluated. These will be immediately proposed by the HPSC for promulgation of the appropriate level of policy, regulation, or legislation.

(5) Demonstration Projects

Certain policy recommendations will need to be tested and validated for their feasibility. For these initiatives, the HFD Project will support demonstration projects where the policies and their impact can be evaluated. The HPDS will oversee the demonstration projects, evaluate their impact, and then propose appropriate steps toward policy, regulation, or legislation.

(6) HCF Policy Actions

The final step in the HCF policy process is the promulgation of appropriate policy actions. There are four levels of policy actions that can be taken for any policy recommendation:

- * Constitutional Law;
- * Republic Acts;
- * Executive Orders; and
- * Administrative Orders

The HPDS will identify the appropriate action that must be taken for each policy recommendation and initiate the necessary administrative or organizational steps.

(7) Policy Monitoring and Evaluation

Once a policy action has been taken, the DOH will have to monitor it to assure that it has been implemented according to the correct operational guidelines. The DOH will also evaluate the impact of a policy action to measure its effectiveness and revise it if appropriate. Health policies must be dynamic, responding to the evolving needs and concerns of the health sector. The monitoring and evaluation function will guarantee this dynamism by creating a feedback loop where promulgated policies can be reconsidered in the Policy Framework for further study and revision, if necessary.

The Health Policy Reform Initiative is not intended as a rigid, sequential process. It should be viewed as a fluid, dynamic, and iterative process which can be accessed at any step. Certain policy issues may not require

further research in order to develop policy recommendations. Some policy recommendations may be so straightforward that policy actions can be initiated without demonstration. The major advantage of the health finance policy process is that it establishes a framework for policy formulation that can be accessed at the appropriate step in the process depending upon the policy issue.

b. Support for Multisectoral Health

Finance Policy Forum - In order to foster a continuing health policy dialogue that is independent of the health policy process described above, an independent forum for health policy will be created. The forum will have representatives from the Philippine Medical Association (PMA), the Philippine Hospital Association (PHA), the PMCC, the AHMOPI, pharmaceutical companies, the private medical sector, interest groups, the community at large, and the DOH, formed in a loose association to discuss and debate policy issues. This independent forum will guarantee all concerned parties access to the health policy dialogue and create a venue where ideas can be generated, issues raised, and positions argued in a neutral environment and consensus built for specific actions. Appropriate linkages of the multisectoral health finance policy forum to the policy process will be developed.

The Project will provide resources to establish the Forum, publish a regular newsletter on current health financing policy issues, and provide competitive small grants for forum members to complete research and demonstration activities.

c. Development of the NHA and Health

Policy Databases - Data on the sources and uses of funds in the health sector are anecdotal at best. As a result, it is difficult to assess the efficacy of health expenditures without a clear picture of allocations and expenditures. The project will assist the DOH to develop a National Health Accounts (NHA) Database which can track public and private sector health expenditures by source and category on an annual basis. Examples of data generated from this source are total annual health expenditures, public vs. private expenditures, capital vs. recurrent costs, primary care vs. secondary and tertiary care, expenditures by region and expenditures by type of service. The NHA Database will be updated periodically to provide decisionmakers with time series trends.

At present, there is no catalogue of existing health policies which can be accessed on a timely basis. Formulating new health policy is impossible without knowledge of existing policy upon which it must build. The HFD Project will create a Health Policy Database which catalogues and archives existing health policy for easy reference and access.

3. Project Inputs

a. Technical Assistance - The Project will provide domestic and expatriate technical assistance on a long-term and short-term basis for the following purposes:

- * technical support for the NCHPD, the HPDTC, and HPDS;
- * specific technical input to the health policy process, especially in the formulation of the Health Financing Policy Framework, Health Policy Research Agenda, and Health Financing Policy Agenda;
- * design of research methodologies and protocols and actual conduct of studies;
- * policy monitoring and evaluation;
- * technical support for the multisectoral forum for health finance policy;
- * technical support to domestic institutions to strengthen their HCF training, research, and policy analysis capacities; and
- * design of the NHA Database and the Health Policy Database.

b. Training - Project inputs for short-term and long-term training, both locally and abroad, will support the health policy process and the health policy research. The HFD Project will support the following training activities:

- * capacity-building workshops/courses on health finance policy development;
- * orientation visits for decisionmakers involved in the health finance policy process to the US and third countries with analagous experience in health policy development;
- * strengthening educational programs in health service administration and health economics offered by domestic institutions through the provision of fellowships, internships and scholarships;
- * collaborative arrangements with U.S. institutions through the provision of fellowships, scholarships, and internships which focus on the design, methodology, and data analysis of health financing studies.

c. Research - Much of the research to be supported by the HFD Project will be done through Component 2 and Component 3. For example, elements of the Medicare I evaluation, provider and beneficiary profiles, and the health care financing environment will be supported via Component 2 while sectoral and institutional diagnostic studies for hospitals will be supported via Component 3. Specific research which will be conducted under Component 1 includes:

- * primary data collection and secondary data analyses which contribute to the establishment of the NHA Database;
- * generic studies which contribute to identifying and clarifying health financing policy issues; and

the archiving and cataloguing of existing health policies in the Health Policy Database;

d. Commodities - The HFD Project will procure computers and accompanying software commensurate with the data management needs generated by the health financing research and the NHA Database. These commodities will be used by the HPDS and the local institution chosen as the locus of the NHA Database. An assesment of computer needs will be done immediately upon commencement of the Project to determine the amount and specifications of the hardware and software that will be needed in order to expedite procurement.

e. Local Costs - The HFD Project will provide local costs for the following purposes:

- * Additional administrative support required for Project implementation for the NCHPD, the HPDTC, and the HPDS;
- * Seminars and workshops to facilitate the health policy process, which will be held at critical junctures to raise awareness, gain consensus, obtain technical inputs, or formalize key steps in the policy process.
- * Support for health policy actions: Legislation will have to be crafted and consensus built within legislative bodies. Regulations will have to be drafted. Local costs will provide some additional administrative support to overcome obstacles at this final and crucial step in the health policy process.
- * Seminars, workshops, and publications to disseminate findings from HCF studies.
- * Seminars and workshops sponsored by the Multisectoral Forum for Health Policy.
- * Small grants to domestic institutions in support of seminars, workshops, training, research, and policy analysis.

C. COMPONENT 2 - HEALTH CARE FINANCING MECHANISMS

1. Project Output

The output of this component is improved efficiency and expanded coverage of the national HCF program. The activities under this component will seek to effect reforms in the existing Medicare Program to improve its equity, accessibility, and impact upon health status, and to encourage the development of private sector options for health care financing.

2. Project Activities

The HFD Project will assist in the following major efforts: (a) improvement and expansion of the Medicare program; and (b) private-sector HCF options.

a. Improvement and Expansion of Medicare -

The current compulsory medical insurance program, known as Medicare I, provides partial reimbursement for in-patient care for enrolled members in the wage-based sector. SSS administers the program on behalf of private-sector employees, and GSIS administers the program on behalf of civil servants and civil service retirees. PMCC provides oversight for both SSS and GSIS Medicare programs. Medicare I reaches about 38% of the population but contributes only 3% of total annual health expenditures. There is no Medicare coverage provided to the self-employed, the unemployed, and the poor.

Activities under this component seek to expand the number of people who receive Medicare coverage and increase the benefits it provides to its members. In addition, it will provide information on the nonwage-based sector. To reach those objectives, the activities under this component will be conducted in a sequence of Diagnostic Stage studies which produce policy recommendations; a Design Stage where policy recommendations are translated into concrete interventions, systems, and plans of action for their adoption; a Demonstration Stage where field trials can evaluate effectiveness and impact; and a Policy Stage where findings are fed into the Health Policy Process developed under Component 1. Figure 4 shows the conceptual framework for the improvement and expansion of Medicare.

The activities which will be carried out to improve and expand the Medicare program are:

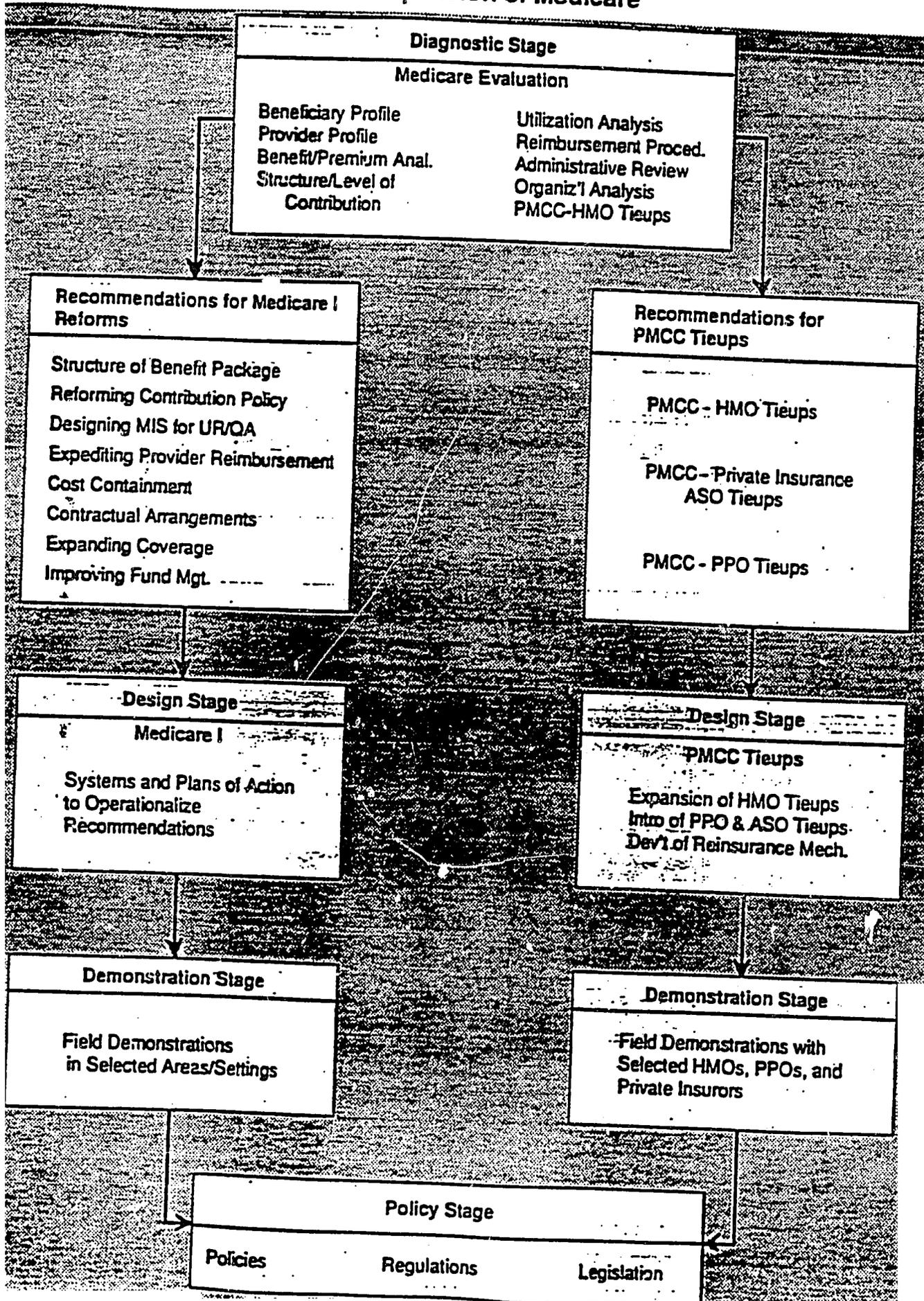
(1) Medicare I Reforms

There have been several studies on the strengths and weaknesses of administrative and operational aspects of the Medicare Program. While none of these studies have been comprehensive in scope, they have identified several distinct problem areas which need to be addressed immediately. For example, there is a need for a uniform management information system (MIS) which can track utilization and expenditures.

The HFD Project will assist the PMCC to examine the Medicare program in a more comprehensive fashion. The comprehensive assessment will focus on the following elements of the Medicare I program:

- * a profile of beneficiaries and providers;
- * an actuarial analysis of the current benefit package and premium levels;

Figure 4 Conceptual Framework for the Improvement and Expansion of Medicare



- * analysis of utilization patterns among different beneficiary segments and provider units;
- * structure and level of contributions;
- * analysis of reimbursement procedures;
- * review of administrative procedures such as collection of contributions, claims processing, disbursements, and management information systems;
- * assessment of PMCC role in coordination and oversight;
- * organizational analysis of roles, relationships, responsibilities, and authorities of the principal agencies implementing the Medicare I and other government-mandated health programs, i.e., PMCC, GSIS, SSS, and ECC; and
- * analysis of the impact of Medicare I reimbursement structure on the organization and delivery of health services.

Much of this evaluation can be done with secondary data from other studies. In some instances, the management information systems being one example, there is no need for further assessment since a consensus exists for immediate action. In other instances, primary data may be necessary to better define the problem and delineate options. The purpose of the Medicare I evaluation proposed through this Project is to provide a framework for a comprehensive review of the Medicare I Program.

The results of this assessment will generate recommendations aimed at improving the Medicare Program. It is anticipated that those recommendations will cover, at a minimum, the following areas:

- * modification in the benefit structure so that the package is expanded beyond hospital care and the compensation to the enrollee is increased;
- * making the contribution structure progressive rather than regressive;
- * proposals for expediting payment to providers;
- * proposals for cost containment;
- * contractual arrangements with providers which incorporate providers in the risk equation;
- * proposals for expanding Medicare coverage of the employed, wage-based sector;

- * policy for reserve requirements; and
- * proposals for reorganization and possible merger of government-mandated health funds.

Details of the Design Stage must necessarily await the specific recommendations emanating from the Medicare evaluation. The examples presented here are illustrative of the kinds of design work that will be necessary once recommendations have been accepted:

- * decentralized claims processing;
- * restructured benefit package and premium levels;
- * development of an MIS;
- * development of quality assurance and utilization review system
- * restructuring organizational forms
- * systems and procedures for cost containment
- * steps to improve fund management
- * plans for enrolling new members
- * development of a relative value scale to reimburse providers

The systems and interventions for Medicare I reform should be designed as components of a comprehensive package of interdependent interventions whose adoption and application will lead to the anticipated outcomes.

(2) PMCC Tieups

Since 1987, PMCC has worked with two HMOs on a trial basis to experiment with potential linkages between the Medicare Program as funder and HMOs as service providers. An evaluation completed in April 1991 lays the basis for the conceptual design of systems to improve and expand this linkage. PMCC has no experience collaborating with private insurers or provider groups. The project will support further in-depth evaluation of the HMO tieups, and examine the potential for linkages with private insurers and provider groups.

Based upon this evaluation, recommendations will be made for expanding PMCC's relationship with alternative administrative and reimbursement schemes. The HFD Project will pilot-test various options for private insurance linkages with Medicare such as:

- * expanded HMO tieups;
- * private insurance administrative services only (ASO) sub-contracts;
- * Preferred provider organization (PPO) tieups; and
- * provision of reinsurance mechanisms.

(3) Development of Medicare MIS

There is no reliable MIS for the Medicare program which can be used by PMCC and the Medicare fund administrators to monitor utilization and costs, validate claims, and control abuses in the program. The HFD Project will combine its resources with those from the PMCC, GSIS, and SSS to design and pilot-test an MIS that will allow PMCC to monitor utilization levels by provider and beneficiaries, assess quality of care, track revenues and expenditures, and control abuses. With these information at its disposal, PMCC can then appropriately evaluate new administrative and health delivery options

(4) Merging of Medicare and Other Mandated Health Funds

There are four separate corporate entities currently responsible for implementing Medicare and other government-mandated health funds: GSIS and SSS administer the Medicare funds on behalf of PMCC while the ECC provides workmen's disability compensation and attendant medical benefits for the formally-employed sector. This arrangement divides responsibilities, dissipates PMCC authority as the unifying organization responsible for policy and decisions, and weakens coordination of benefits among the health funds.

The HFD Project will undertake a study to assess the administrative, technical, and political feasibility of integrating the SSS-GSIS Medicare funds and the medical-care component of the EC fund under one umbrella fund managed by the PMCC or an analogous organizational entity. The results of this assessment will be reported to the PMCC and the HPSC for appropriate policy action.

(5) Profile of the Population Groups without Medicare Coverage

Large portions of the population still have no Medicare coverage. There has been no systematic effort to provide Medicare or any other health insurance coverage to the self-employed, unemployed, and the rural poor. Information on these population groups is inadequate or nonexistent. Until reliable data can be generated, it will be impossible to develop plans for providing health insurance coverage to these groups.

The HFD Project will support research activities that identify the noncovered population and develop their socioeconomic and health profiles. The research will cover the following areas:

- * beneficiary profile;
- * ability to pay;
- * eligibility criteria;
- * benefit and premium structures;
- * administrative systems requirements;
- * delivery systems; and
- * collection mechanisms.

b. Private-Sector HCF Options - The health insurance industry in the Philippines, excluding the Medicare Program, is still in its embryonic stage of development. Private health insurance, including coverage provided by HMOs, accounts for only 1% of total annual national health expenditures. Private companies self-insure their employees in a variety of ways, either through maintenance of free-standing clinics employing their own service providers, or through some type of reimbursement system. But very little is known either about the extent of this type of coverage or their annual expenditures on health. Community health financing schemes have been developed in some areas but they are poorly documented.

Interviews with providers indicate that many persons availing of public tertiary- and to some extent secondary-care services could afford to pay for these services in private hospitals if some risk-sharing financing mechanism requiring periodic premium payments existed. If a greater number of persons can have their care financed through risk-sharing arrangements, it would reduce demand and, concomitantly, government subsidy to tertiary-care and secondary-care facilities. This element of the HFD Project will address equity concerns by expanding the population covered by risk-sharing financing mechanisms, thus reducing demand on public facilities by persons who can afford health insurance and allowing government facilities to focus scarce resources on its real constituency, the population unable to pay under any circumstances.

Project activities will explore strategic options for health care financing outside of the Medicare program with a view toward encouraging alternative health financing mechanisms that incorporate risk-sharing arrangements among providers, beneficiaries, and insurers. It will explore strategies for public/private sector cooperation towards expanding the population covered with risk-sharing arrangements. Figure 5 shows the conceptual framework for activities in this subcomponent.

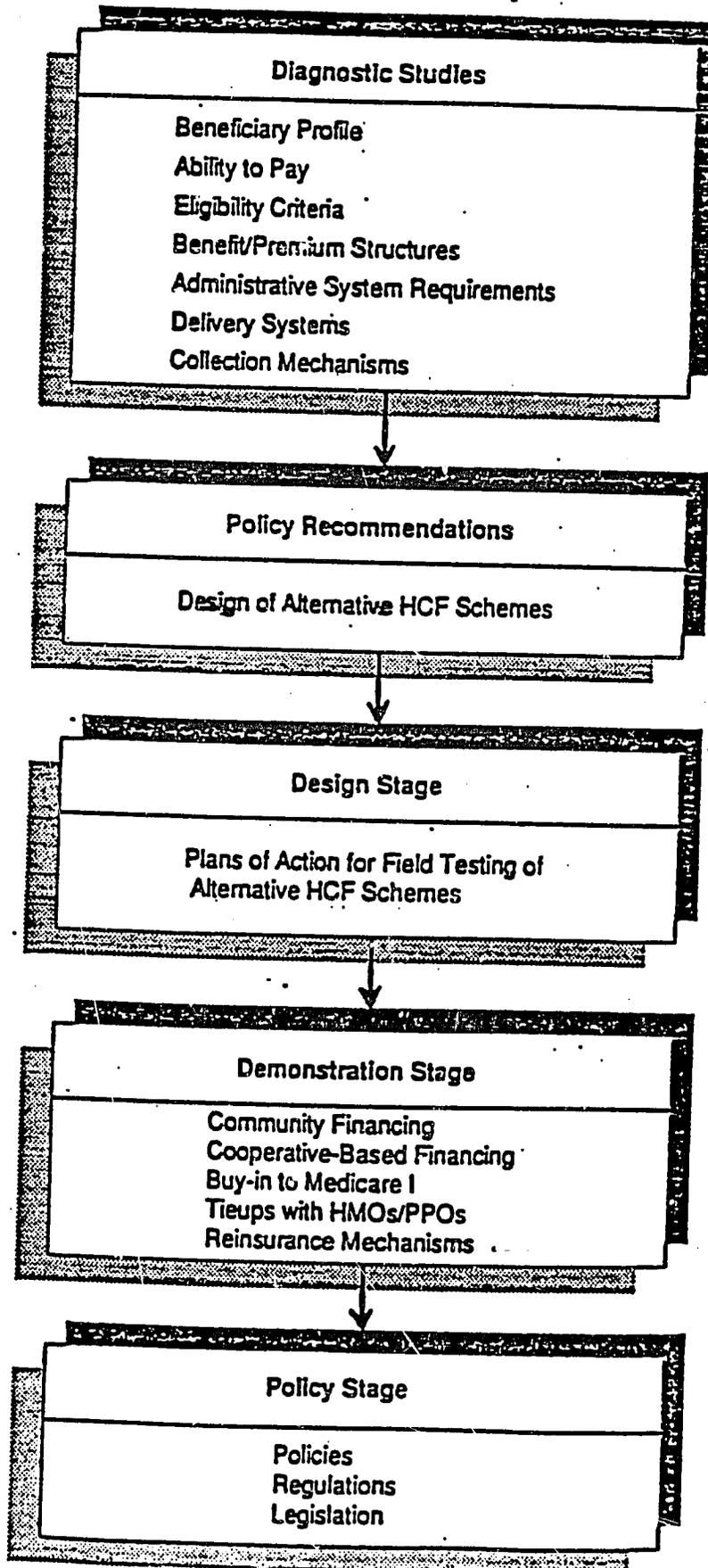
Private-sector activities will consist of: (a) risk-sharing arrangements; (b) employer-provided health benefits; (c) community financing schemes.

(1) Private-Sector Risk-Sharing Arrangements

The private sector is poised to play a larger role in health financing. However, the government must create an environment which stimulates private investment in the health insurance industry while guaranteeing that the private sector pursues national goals of cost containment and efficiency in the health sector.

Studies will be commissioned on the private insurance industry to construct profiles of population groups covered by private insurance, assess potential market segments where private coverage could be expanded, and identify policy and environmental constraints which impede further expansion of private insurance. These studies will lead to policy options which encourage expanded private involvement

Figure 5
Conceptual Framework for
Private-Sector HCF Options



Note: Activities are not drawn to scale.

in health insurance as long as efficiency and cost containment objectives are maintained. The HFD Project will also provide demonstration projects for the health insurance industry which promote further investment in this field, either through linkages with Medicare or independently.

(2) Employer-Provided Health Benefits

Studies will be commissioned to analyze the magnitude and types of employer-provided benefits, the policy and environment constraints under which such benefits are provided, and the current and potential impact of these schemes on the efficient delivery and financing of health services. The HFD Project will also explore mechanisms for integrating employer-provided benefit schemes either with Medicare or with private insurers.

(3) Community Financing

Community financing schemes offer mechanisms to extend risk-sharing financing arrangements to the self-employed, the unemployed, and the

poor. While successful community financing schemes exist, little has been done to document the operation or assess the reasons for success or failure.

The Project will take a systematic approach toward evaluating existing community financing schemes and examining either the policies or environmental constraints under which they operate. Resources will be available to test pilot schemes with potential to improve access and equity, contain costs, and increase efficiency. These might include schemes in which the local or national governments purchase health services on behalf of the poor and the unemployed through grants or contracts with private or public clinics/hospitals, HMOs, and community-managed health facilities.

(4) Generic Marketing of Risk-Sharing Concepts

The concepts of insurance and risk-sharing are quite complicated and are not well understood by either health care providers or consumers. Lack of information and understanding constitutes one of the greatest constraints to the expansion of health insurance and risk-sharing financing arrangements in the Philippines.

The HFD Project will support demonstration schemes such as a generic marketing campaign targetted towards decisionmakers, health providers, consumers, and the insurance industry which clarifies the concepts of prepayment, pooled risk, capitation, etc. This generic marketing campaign will support efforts by PMCC and private insurers to market their products to employee and consumer groups.

3. Project Inputs

PMCC will coordinate all inputs to be provided under this component of the HFD Project. The anticipated inputs to be provided are:

a. Technical Assistance - Local and expatriate technical assistance will assist the Project by providing technical support to the following activities:

- * Medicare evaluation, including analysis of secondary data, design of primary data collection instruments and data analysis, and policy or administrative recommendations;
- * design of HMO, PPO, and private health insurance tie-ups with Medicare;
- * design and evaluation of demonstration projects arising from Medicare evaluation;
- * design and analysis of background studies on noncovered population;

- * design of alternative administration and reimbursement schemes for health financing;
- * provision of options for merging the mandated health programs of PMCC, GSIS, SSS, and ECC;
- * design of studies and demonstrations on private risk-sharing schemes, employer-provided health benefits, and community financing schemes; and
- * design of generic risk-sharing marketing campaign.

b. Training - The HFD Project will support training activities in the following areas:

- * strengthening administrative capacities in the PMCC, SSS, and GSIS;
- * strengthening administrative and technical capacities of the HMOs, PPOs, and private insurers involved in Medicare I tieups;
- * study tours to observe social insurance schemes and managed care programs in other countries; and
- * strengthening the capacity of organized groups in the informal sector to engage in social insurance or in the private health insurance system.

c. Research - The HFD Project will provide resources for the following research activities:

- * Evaluation studies of Medicare I;
- * Evaluation of Medicare/HMO tieups;
- * Design of MIS for Medicare;
- * Assessment of GSIS/SSS/ECC/PMCC merger;
- * Profile of noncovered population; and
- * Assessment of private sector, employer-provided and community risk-sharing schemes.

d. Commodities - The hardware and software needed for the data management requirements of the MIS for the Medicare program may be procured via this input.

e. Demonstration Projects - Examples of the types of demonstration projects supported via this input are:

- * development of an MIS for the Medicare program;
- * associated reforms in the Medicare Program subsequent to the Medicare I evaluation;
- * expanding PMCC-HMO tieups;

- * introducing tieup arrangements between PMCC and PPOs or private insurers
- * merging of the Medicare Fund administered by SSS and GSIS and, possibly, Medicare with the medical-benefit component of the EC Fund;
- * community health financing schemes;
- * risk-sharing health financing schemes with cooperatives or other organized groups;
- * buy-in to Medicare I by organized groups in the informal sector;
- * tieups between organized groups and HMOs, PPOs, or private insurers;
- * reinsurance schemes for HMOs, PPOs, or private insurers; and
- * generic marketing campaign on risk-sharing concepts and health insurance.

e. Local Costs - The local-cost input will primarily support the following types of activities:

- * seminars/workshops to review findings from the Medicare I evaluation;
- * publications to disseminate findings of Medicare I evaluation;
- * workshops to design interventions for Medicare I;
- * seminars/workshops to review findings from diagnostic studies needed to design alternative financing schemes; and
- * workshops to review results of demonstration projects.

D. COMPONENT 3 - HOSPITAL FINANCING REFORMS

In 1989, the DOH developed a "Policy Framework for the National Hospital Development Plan" which provides guidelines for the formation of long-range development plans in the hospital sector. The Policy Framework analyzes the interrelationships among the DOH hospital system, the private hospital sector, the public health sector, and the operations of individual hospitals at the institutional level, and identifies five principal areas requiring policy:

Macro/sectoral issues:

- * DOH hospital system
- * Interface between private and DOH hospitals
- * Interface between hospitals and public health

Micro/operational issues:

- * DOH hospital institutional operations
- * Private hospital institutional operations

Using this framework, the DOH has developed a conceptual model for hospital reform package which addresses macro-level issues under the rubric of Hospital Sector Restructuring and micro-level issues under the rubric of Hospital Institutional Reform. The HFD Project will provide assistance in selected activities of the DOH hospital reform package.

1. Project Output

The output of this component is the improvement in the efficiency and effectiveness of hospital-based care provided through public and private hospitals in the Philippines. Efficiency and effectiveness in this context is defined as cost-effective production and delivery of services of acceptable standard of quality to meet health needs.

2. Project Activities

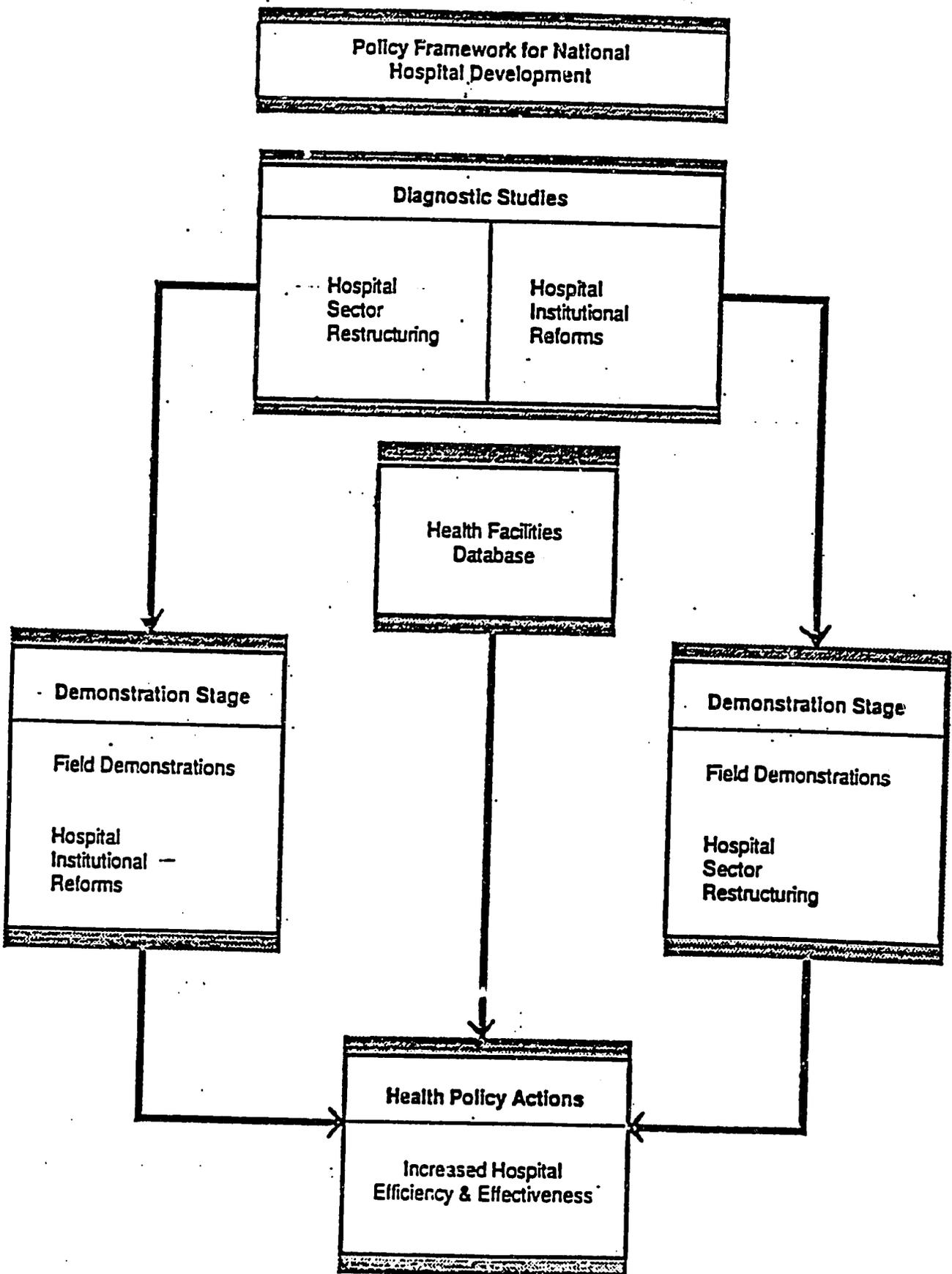
The HFD Project will assist in comprehensive hospital reform through activities at both the macro/sectoral and micro/institutional levels. At the macro level, the Project will provide resources for (a) bringing market discipline into the public sector via a range of privatization options for selected public facilities, and (b) influencing the private sector to undertake public health activities. This macro/sectoral restructuring will be complemented by micro/institutional improvement envisioned to increase hospital efficiency and effectiveness. The conceptual framework for this component of the Project is shown in Figure 6.

a. Sectoral Restructuring - Activities under this component will seek to effect policy changes which enhance efficiency and effectiveness in the delivery of hospital care by directing the resources of the entire hospital sector, both public and private, toward the achievement of national health goals. The following issues are of particular concern:

- * concentrating government resources on effective and efficient services for the poor who are most in need of public subsidy;
- * devolving authority and accountability of DOH hospitals toward more peripheral administrative levels;
- * engendering greater private investment in the provision of hospital care; and
- * providing the policy environment and incentive structures which encourage private hospitals to pursue national health goals.

The three activity areas under Hospital Sector Restructuring involve: (a) innovations in management and ownership of public hospitals; (b) private hospital system reform; and (c) public core hospital network (CHN) management.

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Figure 6
Conceptual Framework Hospital Financing Reforms



Note: Activities are not drawn to scale.

(1) Innovations in Management-Ownership of Public Hospitals

The current hospital system structure in the Philippines is generally viewed as consisting of two components: the public sector and the private sector. A closer look at the system reveals that the distinction is not that simple. When viewed from the perspectives of governance, management of operation, financing of hospital services, and ownership, public and private hospitals exhibit multiple permutations of management and ownership.

For example, some DOH hospitals have a corporate structure and operate like a private hospital with subsidy from government; other DOH hospitals have contracted some services -- janitorial, security, laundry, dietary -- to the private sector. On the other hand, some privately owned hospitals are financed through government financial institutions like the Development Bank of the Philippines, SSS, and GSIS, and many of these private hospitals contract beds to the DOH for the care of the indigent.

Figure 7 shows a conceptual framework for viewing hospitals along the spectrum of ownership, governance, financing, and management. The objective of the activities in this subcomponent is to find the proper mix of hospitals within this spectrum. The HFD Project will develop a taxonomy of government and private hospitals utilizing the criteria of governance, management of operation, financing, and ownership. Both public and private hospitals will then be classified within this management-ownership matrix.

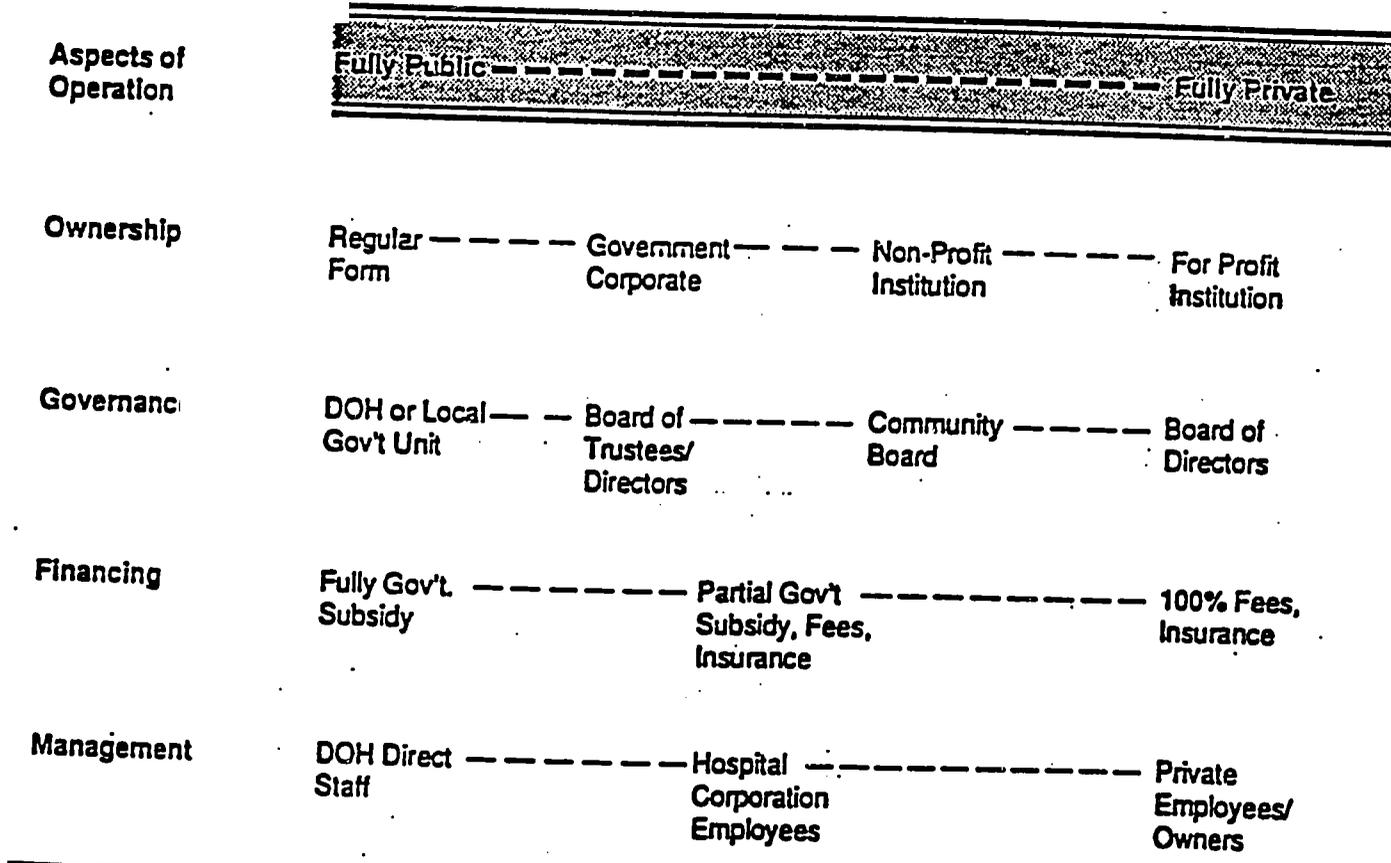
Examples of the kinds of functions that could be classified within the management-ownership matrix are:

- * revenue retention;
- * pricing and fee structures;
- * contracting services to private entities;
- * representation on the Board of Directors;
- * ownership of shares;
- * disposition of surplus or profits;
- * sourcing of capital;
- * status of employees; and
- * risk for loss.

Project activities will allow the DOH to experiment with alternative forms of governance, management, financing, and ownership which will serve as a basis for policies to move public and private hospitals towards a better management-ownership matrix mix. Among the management-ownership options for experimentation and demonstration are:

**Figure 7
Management-Ownership Matrix of Hospitals**

Public-Private Sector Mix



- * revenue retention and independent pricing in public hospitals;
- * private management of public hospitals;
- * private sector representation in public hospital governance;
- * public sector representation in private hospital governance;
- * corporatization of government hospitals;
- * limited public subsidy of private hospital beds;
- * full-cost private rooms within government hospitals; and
- * redeployment (sale and reinvestment) of public sector health assets via market mechanisms.

(2) Private Hospital System Reform

As part of overall private hospital system reform, this subcomponent will create the policy environment necessary for private hospitals to achieve economic and financial viability in response to the needs of the market, the health needs of the people, and national health goals. Project activities in this subcomponent will be initiated by a Diagnostic Study of the private hospital sector. From this study, specific policies will be identified for further analysis and demonstration. Interviews with private providers and DOH policymakers indicate that these policies may include:

- * improved networking between public and private hospitals;
- * reducing public sector competition for private-paying patients;
- * increasing access to capital at costs affordable by the hospital market;
- * providing incentives and tax concessions in return for provision of public health services;
- * reducing the burden on private hospitals for providing care to the indigent;
- * reforming the regulatory code for private hospitals;
- * coordinating procurement of capital intensive technology and providing incentives for rational acquisition; and
- * permitting private hospitals to receive philanthropic or in-kind donations without paying duties.

(3) Public Core Hospital Network Management

The DOH is responsible for 537 public hospitals which can be categorized into medical centers, provincial/general hospitals, district hospitals, municipal hospitals, and extension hospitals. These range from 1,000-bed specialty hospitals to 15-bed primary care facilities.

The DOH has undertaken a careful analysis of its entire hospital system and has identified 188 core hospitals that it considers the essential nucleus which guarantees its equity and service objectives. The core hospital network (CHN) includes tertiary regional hospitals/medical centers, secondary/tertiary provincial hospitals, and selected secondary district hospitals.

The DOH is giving priority to CHN hospitals in terms of operations upgrading. The DOH will seek to identify more efficient means of managing the remaining public institutions, including possible devolution of authority and management or complete divestiture.

The HFD Project will assist the DOH to create an appropriate network management structure for the CHN in which the DOH central office is analogous to the corporate headquarters and its core hospitals are analogous to branch offices. The network management structure will seek organizational and management mechanisms for closer collaboration among CHN hospitals in planning, financing, investment procurement, distribution, and human resources. The Project will also assist the DOH to pilot-test the CHN management structure on a demonstration basis.

b. Institutional Reform - As part of an overall package of hospital institutional reform, activities under this subcomponent will examine efficiency and effectiveness issues at the individual institutional level, both in public and private hospitals. There is a general consensus that measures must be taken to improve government hospital efficiency and quality of care over the long term, but there is no consensus regarding how that objective can be achieved. Although private hospitals account for 50% of the beds in the Philippines, data on the efficiency, quality, and accessibility of private hospital services are anecdotal at present.

The HFD Project will undertake diagnostic studies which will analyze operations of public and private hospitals at the institutional level. These diagnostic studies will include:

- * an Organizational Analysis which examines structures, functions, roles, relationships, responsibilities, and authority at the corporate, administrative, clinical service and support service level;
- * a Management Analysis which examines the planning, organizing, implementation, and control functions in hospitals;
- * a Clinical Service Analysis which assesses the range of clinical services and the quality of care being delivered;
- * a Financial Analysis which examines the budgeting, accounting, pricing, billing, and collection functions; and

- * a **Support Services Analysis** which examines personal management, dietary, laundry, medical records, pharmacy and other support services in public and private hospitals.

The findings from these analyses will be presented in the form of policy recommendations to the DOH for public and private hospital institutional reform. These recommendations will be fed into the Health Policy Process created via Component 1. The HFD Project will also design and field-test an institutional level hospital MIS as demonstration scheme for one basic input to institutional level management improvement.

c. Hospital Facilities Database - At present, the DOH has a rudimentary health facilities database which manually collects and compiles service statistics reported on a routine basis by public and private hospitals. Systems have been conceptualized to strengthen the analyses and enrich the information produced from this source, but the DOH lacks the human, financial, and material resources needed to convert the present service statistics collection system into a bonafide health facilities database.

The HFD Project will assist the DOH to develop a Health Facilities Database which collects routine information from public and private hospitals and which can merge the data with population, cost, expenditure, and other data to provide more detailed analyses. Assistance will be provided to DOH central office, where data will be compiled and analyzed.

3. Project Inputs

This component of the Project will be coordinated through the DOH's Office of Hospitals and Facilities Services. The process that will be used to achieve the expected output of this component will be similar to that process employed in Component 1 and Component 2, namely: a **Diagnostic Stage** of fact-finding and research studies which will define and clarify issues and produce recommendations for action; a **Design Stage** to produce concrete plans of action; a **Demonstration Stage** to assess efficiency and impact of policy recommendations; and a **Policy Stage** where findings can be channelled into the health policy process under Component 1.

The HFD Project will provide the following inputs:

a. Technical Assistance - Local and expatriate technical assistance will assist the HFD Project by providing technical support to the following activities:

- * development of a management-ownership matrix for hospitals;
- * design and evaluation of demonstration projects for the Hospital Sector Restructuring;
- * design of the methodology and research protocol for the sectoral-level and institutional-level Diagnostic Studies; and

- * design and installation of a Health Facilities Database at the central and hospital levels.

b. Training - Training activities which will be supported through the HFD Project are:

- * strengthening domestic training programs in hospital administration and management;
- * strengthening manpower capacities within the DOH on the design and management of a Health Facilities Database, and analysis and interpretation of data outputs;
- * in-country short-term training programs in hospital MIS; managed care; quality assurance; and budgetting, accounting, and pricing.

c. Research - Research activities to be conducted during the Diagnostic Stage of this Project will involve:

- * development of a management-ownership matrix to classify hospitals, and identification of options for seeking the optimum management-ownership mix for public and private hospitals;
- * sectoral profiles and industry studies of private hospitals;
- * development of policy options which encourage private hospitals to pursue national health goals;
- * institutional-level diagnostic studies of public and private hospitals.
- * development of a systems design for the Health Facilities Data Base; and
- * development of a core hospital network management structure.

d. Commodities - The hardware and software needed for data management and analysis for the Health Facilities Database will be procured through this input.

e. Demonstration Projects - Specific geographic areas (provinces or regions) will be chosen for all demonstration activities. The chosen area(s) should have a reasonably well-developed infrastructure and a strong commitment to change. Where appropriate, however, demonstration activities may be carried out outside of the demonstration area.

The field level demonstration projects which will be supported via this input are:

- * pilot-testing different permutations for management and ownership of government hospitals;

- * pilot-testing policy options which encourage private hospitals to pursue national health goals;
- * pilot-testing institution-level hospital MIS;
- * testing and operationalizing the Health Facilities Database; and
- * pilot-testing the CHN management structure.

f. Local Costs - The local-cost input will support the following types of activities:

- * seminars/workshops to develop diagnostic stage research protocols and to present findings;
- * publication of research findings;
- * seminars/workshops to support design and evaluation of demonstration projects;

E. BENEFICIARIES AND TYPES OF BENEFITS

Beneficiaries of this Project consist of both health-service consumers and health-service providers.

Consumers will realize benefits in any of the following ways:

- * Expansion of financial access through third-party payment systems, employer-provided benefits, and community financing schemes. Expansion of Medicare coverage to the informal sector will benefit the self-employed segment of the economy.
- * Expansion of the Medicare benefit package to include preventive services. This will benefit mostly women and children, who have significant preventive health requirements (family planning, immunizations, pre- and post-natal care).
- * Lower out-of-pocket expenses as a result of increased Medicare support values. This benefit will be of general application.
- * Containment of health care costs as a result of efficiency improvement in health service delivery and regulation of medical costs through updated relative value scale or other system.
- * Better quality of care resulting from hospital systems improvement and the formulation of appropriate health-service delivery standards.
- * Possible reduction in the burden of lower-income groups through the operation of cross-subsidy mechanism in the Medicare system. These benefits will be captured by households below the poverty line.

Health-service providers (doctors, clinics, hospitals) will realize benefits in any of the following ways:

- * Expanded clientele. As the informal sector is brought into the Medicare system, the number of patients with financial access multiplies, with direct positive impact on all providers.
- * Increased utilization of health facilities. The inclusion of preventive services as a covered Medicare benefit will increase the frequency of clinic visits which will benefit general practitioners, pediatricians, nurses, and midwives.
- * Removal of policy and operational constraints will benefit hospitals.
- * Cost containment schemes will benefit providers as a whole.

In the course of the HCF policy reform, however, it is likely that some health service providers will lose. The losses can come in the following forms:

100 Reduction in the incomes of high-charging doctors as a result of the application of relative value scales and other medical-cost regulations.

- * Possible reduction in the rate of hospitalization as a result of better preventive measures. This will adversely affect hospital-based doctors.
- * Inefficient health facilities and practitioners which may find themselves unable to compete in the health care market.
- * Redundant hospital staff (doctors, nurses, support employees) laid off as a result of a privatization program.

F. SUSTAINABILITY

Sustainability of health related activities is largely dependent on continued political will, including client advocacy; adequate financial resources available for the activity; and institutional interest and capacity to maintain and continue development of the activity. The HFD Project addresses each of these issues in the three areas of Project activity which need to be sustained for long-term, rational reform of the health finance system. These three areas are: 1) the research-based, participatory policy process to be established by the DOH with private sector involvement; 2) improved national health financing through reform of the Medicare I system and promotion of private sector financing options and 3) hospital finance reform for the public and private sectors.

For the policy process, and other Project areas as appropriate, political support is being built within and outside the DOH through participatory development of the HFD Project, mandating responsibility for this area to the DOH, public/private workshops on various health finance and health policy

topics, development of a health policy agenda and health finance sector directions, development of a formalized public health finance policy forum, and development of a health information database for public use. In addition, the DOH is institutionalizing a Health Policy Development Staff to provide leadership in this arena.

Financial resources to continue support for the heavy load of on-going research and database management, and for the policy forum are of concern although these items will represent less than .2% of the projected future DOH budget. Various means of securing longer-term financing for these items will be reviewed in Project implementation. Ideas to date include endowment of a private research institution and research grants as a condition of proposed HFD Program assistance and charging membership fees to private organizations for participation in and access to the policy forum and health databases. The planned inclusion of the Health Policy Development Staff positions as DOH staffing plantilla items will ensure their on-going support.

Development of institutional capacity to continue managing the policy process, conducting and utilizing research, and maintaining the databases is an important element of the HFD Project and a major element in ensuring the long-term sustainability of the restructuring process. Capacity will be developed through ensuring that technical assistance teams work with appropriate counterparts, training courses are developed as needed, opportunities for training are provided, and local firms and institutions are used to the extent possible in implementing Project activities.

In the areas of improving national health care financing and hospital reform, sustainability will depend largely on the continued political commitment to enact and implement policies and regulations, appropriate sector response to demonstrated changes, and availability of short-term capital to providers and financiers to implement reforms. In addition to the above means of improving the likelihood that Project activities will be sustained, the Project design has considered the following:

Financial support to the GOP for continued political commitment to and to offset the additional costs of implementing a subset of these policies on a broader scale through the HFD Program to be initiated in FY 1993.

Training courses developed to increase private sector capacities to respond to demonstrated changes will be on a fee basis as possible.

Replication of viable demonstration schemes on a broader scale will be largely dependent on interest and financing from the private and public sectors; however, design and evaluation of demonstration schemes will include review of sustainability issues related to the proposed scheme.

III. COST ESTIMATE AND FINANCIAL PLAN

A. COST ESTIMATE

Phase I of HFD assistance, the HFD Project, is estimated to cost US\$26.855 million over its five year life (Table 1). Project funds will be provided by USAID and GOP. AID will provide approximately US\$20 million (74% of total project cost) subject to the availability of funds and GOP is expected to contribute approximately the equivalent of US\$6.855 million (26% of total project cost).

Total USAID Project contribution will be used to finance technical assistance, training, research, demonstration projects, commodities and for monitoring, evaluation and audits.

Planned obligations of USAID Project funds are US\$3.5 million in FY 91, US\$3.0 million in FY 92, US\$7.0 million in FY 93, US\$4.5 million in FY 94 and US\$2.0 million in FY 95 (Table 2).

About 56% of the total USAID Project cost (or US\$11.247 million) will be local expenditures and the balance of 44% (or US\$8.753 million) will be foreign exchange (Table 3). Table 4 shows the projection of local and foreign exchange costs by project element over the five-year life of the project.

The GOP is expected to contribute the equivalent of US\$6.855 million. A study of the DOH's (implementing agency) financial position has determined it has the capacity to provide the expected counterpart contribution. This contribution will consist of DOH expenditure for salaries, commodities, and activities which lead to project implementation. Funds will be provided and expended through the regular GOP budgetary process.

B. METHODS OF IMPLEMENTATION AND FINANCING

Table 5 summarizes the methods of implementation and financing for the HFD Project. The Project will tentatively be implemented through:

- * A grant to a policy formulation consortium;
- * An institutional contract for demonstration projects;
- * One personal services contract (PSC);
- * Host country contracts for limited technical services, research, training, and commodities; and
- * USAID direct and limited host country contracts for monitoring, evaluation, and audits.

The contracting arrangements are discussed in detail in the next section (IV. Implementation Plan). The majority of financing will be through USAID direct payment. Funds disbursement methods and financial management systems for these contracts will follow standard USAID procedures.

On a limited basis, USAID will reimburse the GOP for local currency costs that the GOP will implement through host country contracting. Under this procedure, the GOP disburses its own funds to pay for operating requirements against implementation plans agreed upon by USAID and the GOP. The GOP is then reimbursed on the basis of certified financial reports submitted to USAID.

A recent USAID requested assessment of the DOH determined it has a 'satisfactory' contracting capability for contracts in the size range required for this Project. Additionally, USAID, through a contractor (CPA firm), is currently (1) assessing the capability of DOH to meet USAID's financial reporting requirements, and (2) developing a computerized reporting system of GOP counterpart contribution. Results of the study/assessment will be incorporated into Project implementation.

USAID's financial support for research and demonstration activities conducted by private-sector organizations will be implemented through a cooperative agreement with a local NGO that (a) is duly registered with USAID; (b) has acceptable financial management and accounting systems for control and use of USAID funds; and (c) has the ability to maintain procedures that will minimize the time elapsing between the transfer of funds and their disbursements. Financing will be disbursed to the NGO through the advance payment method.

C. FINANCIAL MONITORING

USAID will review the financial records and reports of the project. Through these reviews, USAID will be able to adequately monitor the financial activities of the project including the counterpart contribution. If necessary, funds will be used for financial monitoring or studies.

D. AUDITS

The project provides funds for non-federal audits of project activities following guidelines from the AID Office of the Inspector General. Primary responsibility for audits of AID-funded projects lies with the Regional Audit Office (RAO). However, RAO may contract non-federal auditors for this purpose.

Table 1
Illustrative Financial Plan
(\$ 000)

Project Elements	AID Grant			GOP	Total
	FY Current Obligation	Future Years Anticipated	Total Costs	LOP Contribution	LOP Costs
Technical Assistance	1,970	4,129	6,099	--	6,099
Training	222	2,180	2,402	--	2,402
Research	523	1,242	1,765	--	1,765
Demonstrations	662	7,931	8,593	--	8,593
Commodities	123	18	141	--	141
Monitoring, Evaluation, and Audits	0	1,000	1,000	--	1,000
Counterpart Contribution	--	--	--	6,855	6,855
TOTAL	3,500	16,500	20,000	6,855	26,855

Table 2
Planned Yearly Obligations and Expenditures
(\$ 000)

	Fiscal Years					
		1	2	3	4	5
	1991	1992	1993	1994	1995	1996
I. USAID						
LOP Funding	20,000					
Planned Obligations	3,500	3,000	7,000	4,500	2,000	0
Planned Expenditures	0	1,996	6,271	4,539	3,908	3,286
Projected Mortgage LOP-Cumulative Obligations	16,500	13,500	6,500	2,000	0	0
% Mortgage/LOP	82.5%	67.5%	32.5%	10.0%	0.0%	0.0
Projected Pipeline (Cum. Obl.- Cum. Exp.) (Pipeline/ Obl.)	3,500 100.0%	4,504 69%	5,233 39%	5,194 29%	3,286 16%	0 0%
II. GOP Counterpart						
In kind and Cash outlays	--	1,247	1,312	1,361	1,427	1,508
Total GOP Counterpart	6,855					

Table 3
Summary of Cost Estimates and Financial Plan
(\$ 000)

Project Elements	USAID		Total	Total
	LC	FX	USAID	GOP
Technical Assistance	2,160	3,939	6,099	--
Training	762	1,640	2,402	--
Research	1,236	529	1,765	--
Demonstrations	7,089	1,504	8,593	--
Commodities	0	141	141	--
Monitoring, Evaluation, and Audit	0	1,000	1,000	--
Counterpart Contribution	--	--	--	6,855
TOTAL	11,247	8,753	20,000	6,855

Details are shown in Table 4.

Table 4
Projection of Expenditures
by Fiscal Year and Project Element
(\$ 000)

Project Elements	Fiscal Years										TOTAL	
	1		2		3		4		5		AID	GOP
	LC	FX	LC	FX	LC	FX	LC	FX	LC	FX		
Technical Assistance	315	397	415	923	512	923	466	886	452	810	6099	--
Training	106	116	182	475	173	444	155	407	146	198	2402	--
Research	366	157	465	199	233	99	86	37	86	37	1765	--
Demonstrations	348	68	2881	344	1552	418	1440	369	868	305	8593	--
Commodities	0	123	0	18	0	0	0	0	0	0	141	--
Monitoring, Evaluation, and Audit	0	0	0	369	0	185	0	62	0	384	1000	--
Counterpart Contribution	1247	-	1312	-	1361	-	1427	-	1508	-	-	6,855
TOTAL	2382	861	5255	2328	3831	2069	3574	1761	3060	1734	20000	6,855

Table 5
Methods of Implementation
and Financing

Project Components	Method of Implementation	Method of Financing	Approximate Amount* (\$ 000)
Tech. Assistance	AID Direct Contract/Grant AID Direct/HC Contract	Direct Payment Reimbursable/ Direct Payment	\$5,349 750
Training	AID Direct Contract/Grant AID Direct/HC Contract	Direct Payment Reimbursable/ Direct Payment	2,041 361
Research	AID Direct Contract/Grant AID Direct/HC Contract	Direct Payment Direct Payment	1,265 500
Demonstrations	AID Direct Contract/Grant AID Direct/HC Contract	Direct Payment Reimbursable/ Direct Payment	7,089 1,504
Commodities	HC Contract	Direct Payment	141
Monitoring, Evaluation, and Audits	AID Direct/HC Contract	Direct Payment	1,000
	TOTAL		\$20,000 -----

IV. IMPLEMENTATION PLAN

A. ADMINISTRATIVE ARRANGEMENTS

1. Project Management

The HFD Project will be implemented and monitored with close collaboration at all stages among the four major participants -- USAID, the GOP, a policy formulation grantee, and the technical assistance contractors. (See Figure 8.) Collaboration will be essential as each will have a related role to play as dictated by the agreements and contracts that govern their relationships. Therefore, the GOP will be responsible for establishing appropriate coordinating mechanisms, such as regular meetings, to assess progress and identify and overcome constraints. Within this collaborative framework, the roles of the four major participants are discussed below.

a. USAID - USAID will assign the Chief, Health and Nutrition Division as the Project Officer for the HFD Project. She will be assisted by a project team including a full-time foreign service national (FSN) health care financing specialist who will serve as project manager, and three FSN health project management specialists (one health technical specialist, one financial analyst, and a project management assistant) who will work part-time on the Project. In addition to these incumbent OPHN staff, OE or project funded PSC staff may be required to work for the Project under the supervision of the Chief of the Health and Nutrition Division.

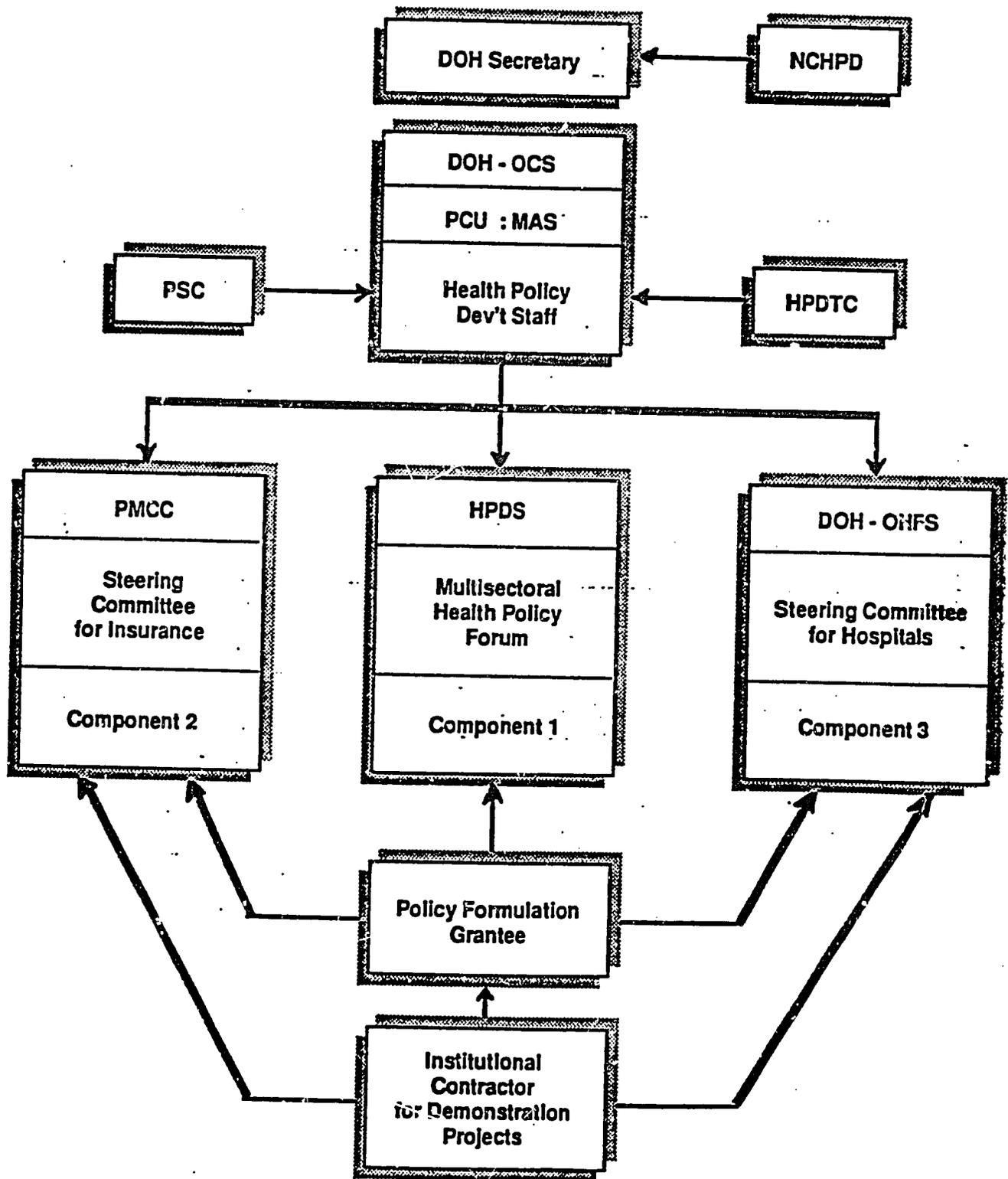
The project team will be supported by a USAID project committee including representatives from the Office of Development Resource Management (ODRM), the Office of the Legal Advisor (OLA), the Office of Financial Management (OFM), the Office of Program Economist and the Contract Services Office (CSO).

The project team will assist the GOP in project implementation and oversee project monitoring. It will work closely with GOP counterparts and be the main contact point between the GOP, the policy consortium, the TA consultants, and USAID. The project team will also be responsible for fulfilling USAID internal reporting requirements such as submission of quarterly project status reports and accrual reports. The project team will be assisted as required by other USAID offices, including staff personnel in ODRM, OFM, OLA, CSO, and the Executive Office.

b. GOP - NEDA will be the signatory of the Grant and will provide GOP technical oversight for project implementation. The Department of Health (DOH) will be the primary GOP counterpart agency, under which four DOH organizational units will have direct responsibility for the implementation of Project activities: the Office of the Chief of Staff (OCS); the Health Policy Development Staff (HPDS); the Philippine Medical Care Commission (PMCC); and the Office of Hospitals and Facilities Services (OHFS).

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Figure 8
Organizational Chart



Key:
 NCHPD - National Committee on Health Policy Development; HPDTC - Health Policy Development Technical Committee; HPDS - Health Policy Development Staff; OCS - Office of the Chief of Staff; OHFS - Office of Hospitals and Facilities Services; PCU - Project Coordinating Unit; MAS - Management Advisory Service

(1) DOH Office of Chief of Staff (OCS)

The Chief of Staff will have overall responsibility for GOP project management and for ensuring coordination and collaboration among all project participants. Two units in OCS will have principal roles in project implementation: the Project Coordinating Unit (PCU) and the Management Advisory Service (MAS). Initially, the PCU will (1) administer local currency financing provided by USAID; (2) monitor and report on DOH grantee/contractor progress; and (3) oversee the preparation of Project Implementation plans, the meeting of conditions precedent, GOP financial reporting, and other administrative actions as required. The MAS will assist PCU in its Project management functions.

(2) Health Policy Development Staff (HPDS)

During the initial six months of the Project, the DOH will broaden the mandate of the MAS to form the Health Policy Development Staff (HPDS). The HPDS will then take on responsibility for management of DOH donor-financed policy initiatives as well as institutionalization of the internal DOH policy process.

The HPDS will be managed by the Chief of MAS and will initially be staffed by three contract positions from the PCU and the Project-funded personal services contractor (PSC). In the first year of the Project, DOH plantilla position for a full-time health economist will be added. A plan for further development and institutionalization of the HPDS is in process.

The HPDS will implement Component 1 (Policy Formulation) of the Project and develop mechanisms to integrate Components 2 and 3 into the policy process. A National Council for Health Policy Development comprised of senior level decision makers from public and private sectors will provide policy guidance to the DOH and MDPS. A Health Policy Development Technical Committee comprised of technical experts from the health sector and academia will serve in a technical advisory capacity to the DOH and HPDS.

The HPDS will be assisted in Project management activities by a USAID-funded PSC. The HPDS will be responsible for the development and/or approval of all Project technical assistance requests.

(3) PMCC

PMCC will have primary responsibility for the implementation of Component 2 (Health Care Financing Mechanisms) of the Project. PMCC staff will prepare and submit to OCS annual implementation plans and monitor progress against these plans. To facilitate Project implementation, PMCC will develop an HCF Mechanisms Steering Committee to provide access to the broader health insurance community and to provide implementation guidance. This committee will be composed of representatives from public sector social insurance programs, health insurance trade organizations, HMO trade organizations, the hospital associations, among others.

(4) DOH Office of Hospitals and Facilities Services (OHFS)

Under the direction of the DOH Undersecretary for Hospitals, the OHFS will take responsibility for implementation of Component 3 (Hospital Financing Reforms) of the Project, for both the public and private sectors. OHFS will develop and approve annual implementation plans, provide overall direction to TA contractors and grantees, and coordinate with public and private hospital administrators and owners.

To support its role in these activities, OHFS will convene a Hospital Steering Committee comprised of representatives from local private and public institutions and Project TA contractors and grantees.

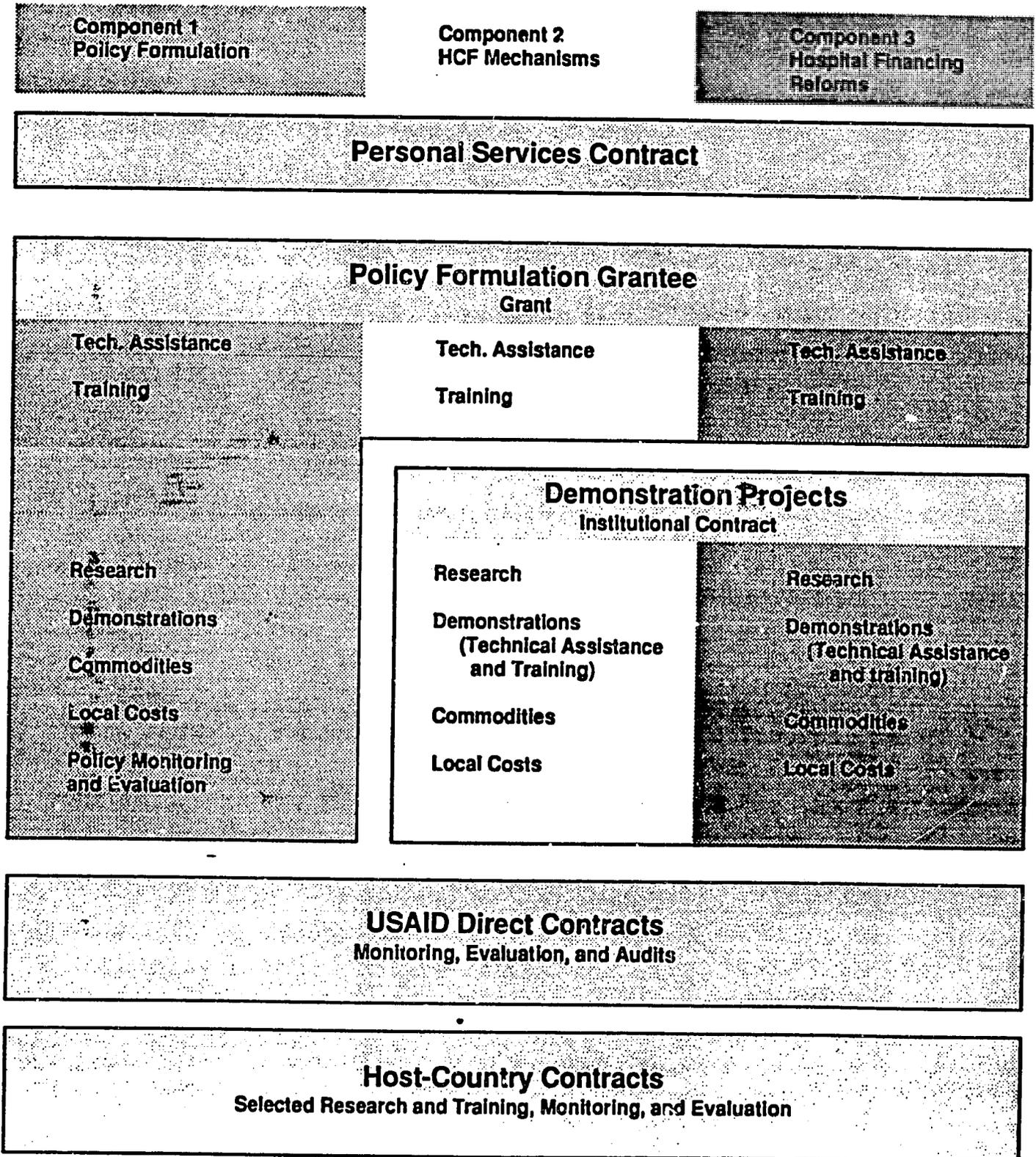
c. Policy Formulation Grantee- Assistance will be solicited from a domestic institution to assist the DOH with establishing and formalizing the Health Policy Process described under Component 1. A grant will be made to an institution with recognized capacity in health economics, health policy analysis, and health policy formulation; and which has established linkages to the key individuals and institutions which influence the health policy agenda in the Philippines. The Grantee will have responsibility for a) assisting the DOH with operationalizing the Health Policy Process, b) creating a National Health Accounts and Health Policy Data Base; and c) supporting the development of an independent forum for health finance policy.

d. Technical Assistance Contractors- In view of the complexity of the Project, the DOH and USAID have agreed that the bulk of project activities will be administered by technical assistance contractors, consisting of an institutional contractor for demonstration projects and a personal services contractor.

This arrangement will minimize DOH and USAID staff time otherwise required for Project administration. The Project contractors will have the following tasks:

- * provision of technical assistance or TA subcontracts;
- * procurement or funding of research services;
- * arrangement for in-country and overseas training;
- * design and management of demonstration projects;
- * procurement of commodities; and
- * arrangement for the delivery of all other goods and services required by the Project.

Figure 9
Scope of HFD Project Contract and Grant



Note: The magnitude of grant and contracts is not drawn to scale.

In the pursuit of these tasks, the contractors will be responsible for:

- * establishing links with public entities involved in the Project: DOH, PMCC, SSS, GSIS, ECC, and government health service facilities;
- * establishing links with private-sector entities: private providers and insurers, HMOs, professional societies, and NGOs;
- * channelling required resources for training, demonstrations, and commodities to the public and private sectors;
- * establishing arrangements with local and overseas research, academic, and consulting institutions;
- * providing technical and logistic support for units and committees established for carrying out the purposes of the Project; and
- * creating appropriate administrative setups so that each contractor's tasks are carried out expeditiously.

2. Demonstration Schemes

The Steering Committee for Insurance and the Steering Committee for Hospitals will be responsible for identifying appropriate demonstration schemes to be funded under the Project. These demonstration schemes will be tested in both private and public entities. The Steering Committees will (1) develop criteria for selecting demonstration schemes and the locus of these schemes, and (2) draw up guidelines for participation. The institutional contractor for demonstration projects will (1) provide technical advice on the design, budgetting, monitoring, and evaluation of these schemes, and (2) provide summary of findings and recommendations on these schemes to the policy formulation grantee and to the Health Policy Development Staff for possible policy, regulatory, and legislative action.

B. ACTIVITY SCHEDULE

1. Pre-obligation Actions

The Project is designed with a 5-year implementation period. Mission authorization and ProAg signing are expected not later than August 1991. Thus, the project activity completion date (PACD) is September 30, 1996.

To give the Project a headstart, the Mission has formulated the PSC's scope of work and the position is being advertised (Annex G). The Mission is also in the process of setting aside \$220,000 of PD&S as bridging funds to initiate Project activities, of which \$120,000 will be a grant to the DOH and

\$60,000 is reserved to fund a feasibility study of providing for child survival services in the Medicare benefit package. The study will assess the financial and health impacts of Medicare reimbursement for outpatient and preventive services (specifically child survival and family planning services) and develop utilization controls for these services. The study is part of the Medicare research agenda (Component 2) and is ranked high in the priority of PMCC, SSS, and GSIS.

2. Schedule of Major Events

Project planning, fund obligation, and project implementation activities all operate on annual cycles which closely follow the U.S. fiscal year. Project funds will be disbursed on a yearly basis subsequent to GOP and USAID approval of annual implementation plans and budgets. Table 7 presents the calendar of major events while Tables 8, 9, and 10 show the Gantt chart of major implementation events by component for the entire life of the Project. Project activities in the three Project components are expected to begin in September 1991.

C. PROCUREMENT PLAN

As agreed upon by the DOH and USAID, the Project will be implemented through a Policy Formulation Consortium (Grantee); an Institutional Contractor for Demonstration Projects; a PSC; direct USAID contracts for monitoring, evaluation, and audit; and host-country contracts for research, monitoring, and evaluation. The respective scopes of these contracts and grant are shown in Figure 9 and discussed below.

The grantee/contractors will work directly under the supervision and guidance of the DOH Chief of Staff and USAID. They are required to obtain clearance from the Chief of Staff and USAID for all major implementation actions in the Project. They are also required to submit quarterly and annual status reports and financial reports to DOH and USAID. The HPDS will manage these contracts.

The Policy Formulation Grant will be awarded to a local institution with predominant capability in policy research and formulation. The Institutional Contract for Demonstration Projects and the PSC will be awarded on a competitive basis. The USAID contracts for monitoring, evaluation, and audits may be accessed through existing IQCs. The host-country contracts will be awarded on a competitive basis.

Goods and services procured through this Project will have, as their source and origin, Geographic Code 000, the United States, and the Philippines. Procurement will adhere to A.I.D.'s Buy America Policy. Exceptions, as needed, will be requested on a case-by-case basis. A contract for the majority of professional services will be competitively awarded to a U.S. institutional contractor. A waiver to allow the U.S. institutional

contractor to subcontract with local firms for professional services in excess of \$250,000 will be requested at the point of contract signing. This is to ensure further development of local professional capacity which is an important element in the long-term sustainability of the policy process. Also, due to HFD Project commitment to continue development of local capabilities, and as allowed within the Buy America Policy, the Policy Formulation Grant will be awarded to a local institution. As commodities required will be minimal, it is expected that the institutional contractor and the local grantee will procure most commodities locally, off the shelf. Commodity procurement will also adhere to the Buy America Policy.

D. GRAY AMENDMENT

USAID will fully consider the potential involvement of small and/or economically and socially disadvantaged U.S. enterprises for services provided under this Project. Considering the magnitude and diversity of technical assistance required, the Project may consider a large contract with a consortium of U.S. companies and provide for a set-aside for subcontracts with 8(A) firms. Although it is likely that such technical assistance will be procured using open competition, special considerations will be given to proposals from firms that will utilize the resources of small and/or disadvantaged U.S. firms, including a requirement that firms submit along with their proposals a subcontracting plan that utilizes Gray Amendment entities.

E. GENDER ISSUES

Health programs are generally viewed as gender-sensitive. Statistics show the predominance of women as health providers and consumers of services. Because of a women's biological role, special attention is given to her person as childbearer and childcarer. This reality augurs well for women's participation in health care financing.

The HFD Project will likely have a highly favorable impact on women, both because women and their children are among the primary beneficiaries of the improved functioning of the health system and because women constitute the majority in almost all health-related professions, including the DOH where women occupy 66% of the medical and allied professionals at the central and field levels. Despite their numbers, however, only few women occupy key decision making and executive positions in the health industry. To ensure women's participation in the health policy process, the project will need to provide opportunities for women's groups and organizations to articulate women's interests and participate collectively in the policy process.

A potential negative effect of the Project may come from increased reliance on persons in income categories above the lowest deciles to pay for services, either as cost-sharers in the public system or as beneficiaries of an insurance scheme. As women in general are more economically disadvantaged than men in the Philippine workplace, women may shoulder a disproportionately larger burden of financing the sector. To ensure this is not the case, the policy development process will include gender disaggregated review of policy impacts.

Table 7
Calendar of Major Events

Action	Completion	Responsibility
<u>Year 1</u>		
PIOT for PSC signed; position advertised	June 1991	USAID
DOH letter of request for assistance sent	June 1991	DOH
NEDA letter of concurrence sent	July 1991	NEDA
Project authorized	Aug. 1991	USAID
ProAg signed, initial funds obligated	Aug. 1991	DOH/USAID
RFPs for institutional contractor issued	Sep. 1991	DOH/USAID
PSC on board	Sep. 1991	USAID
Initial CPs satisfied	Oct. 1991	DOH
Year 1 budget and implementation plan submitted	Nov. 1991	DOH
Year 1 project funds committed	Nov. 1991	USAID
Grant to policy consortium signed	Nov. 1991	USAID/Grantee
First meeting of HPSC held	Dec. 1991	DOH
Institutional contractor on board	Apr. 1992	DOH/USAID
Year 1 project accomplishments reviewed	July 1992	DOH/USAID
<u>Year 2</u>		
HFD PAIP preparation initiated	Aug. 1992	DOH/USAID
Year 2 budget and implementation plan submitted	Aug. 1992	DOH/Contractors
Year 2 project funds committed	Sep. 1992	USAID
HFD PAIP approved	Jan. 1993	USAID
Year 2 project accomplishments reviewed	July 1993	DOH/USAID
HFD PAAD completed	Aug. 1993	DOH/USAID
<u>Year 3</u>		
Year 3 budget and implementation plan submitted	Aug. 1993	DOH/Contractors
Year 3 project funds committed	Sep. 1993	USAID
RFP for midterm evaluation issued	Nov. 1993	DOH/USAID
Year 3 project accomplishments reviewed	July 1994	DOH/USAID
<u>Year 4</u>		
Midterm evaluation completed	Aug. 1994	Contractors
Initial HFD Program Tranche	Aug. 1994	USAID
Year 4 budget and implementation plan submitted	Aug. 1994	DOH/Contractors
Year 4 project funds committed	Sep. 1994	USAID
Year 4 project accomplishments reviewed	July 1995	DOH/USAID
<u>Year 5</u>		
Year 5 budget and implementation plan submitted	Aug. 1995	DOH/Contractors
Second HFD Program Tranche	Aug. 1995	USAID
Year 5 project funds committed	Sep. 1995	USAID
RFP for EOP evaluation issued	Dec. 1995	USAID
Closeout procedures initiated	Feb. 1996	USAID
EOP evaluation commences	June 1996	Contractors
PACD	Sep. 1996	
Project closeout completed	Mar. 1997	

Table 9
Major Implementation Events, Component 2

Benchmark	Year 1	Year 2	Year 3	Year 4	Year 5
1.1 Medicare I Reforms	AAAAAAAAAAAA	AAAAAAAAAAAA	AAAAAAAAAAAA	AAAAAAAAAAAA	AAAAAAAAAAAA
	BBBBBBBBBBBB	BBBBBBBBBBBB	BBBBBBBBBBBB	BBBBBBBBBBBB	BBBBBBBBBBBB
	CCCCCCCCCCCC	CCCCCCCCCCCC	CCCCCCCCCCCC	CCCCCCCCCCCC	CCCCCCCCCCCC
	DDDDDDDDDD	DDDDDDDDDD	DDDDDDDDDD	DDDDDDDDDD	DDDDDDDDDD
1.2 PMCC Tieups	AAAAA	AAAAA	AAAAA	AAAAA	AAAAA
	BBBBBBBBBB	BBBBBBBBBB	BBBBBBBBBB	BBBBBBBBBB	BBBBBBBBBB
	CCCCCCCCCCCC	CCCCCCCCCCCC	CCCCCCCCCCCC	CCCCCCCCCCCC	CCCCCCCCCCCC
	DDDDDDDDDD	DDDDDDDDDD	DDDDDDDDDD	DDDDDDDDDD	DDDDDDDDDD
1.3 Medicare MIS	AAAAA	AAAAA	AAAAA	AAAAA	AAAAA
	BBBBB	BBBBB	BBBBB	BBBBB	BBBBB
	CCCCCCCCCCCC	CCCCCCCCCCCC	CCCCCCCCCCCC	CCCCCCCCCCCC	CCCCCCCCCCCC
	DDDDDDDDDD	DDDDDDDDDD	DDDDDDDDDD	DDDDDDDDDD	DDDDDDDDDD
1.4 Merging of Medicare and Other Mandated Health Benefits	AAAAA	AAAAA	AAAAA	AAAAA	AAAAA
	AAAAA	AAAAA	AAAAA	AAAAA	AAAAA
	AAAAA	AAAAA	AAAAA	AAAAA	AAAAA
	AAAAA	AAAAA	AAAAA	AAAAA	AAAAA
1.5 Profile of Noncovered Population Groups	AAAAA	AAAAA	AAAAA	AAAAA	AAAAA
1.6 Private-Sector Risk-Sharing Arrangements	AAAA	AAAA	AAAA	AAAA	AAAA
	BBBBBBBBBBBB	BBBBBBBBBBBB	BBBBBBBBBBBB	BBBBBBBBBBBB	BBBBBBBBBBBB
	CCCCCCCCCCCC	CCCCCCCCCCCC	CCCCCCCCCCCC	CCCCCCCCCCCC	CCCCCCCCCCCC
	DDDDDDDDDD	DDDDDDDDDD	DDDDDDDDDD	DDDDDDDDDD	DDDDDDDDDD
2.1 Employer-Provided Health Benefits	AAAAA	AAAAA	AAAAA	AAAAA	AAAAA
	BBBBBBBBBBBB	BBBBBBBBBBBB	BBBBBBBBBBBB	BBBBBBBBBBBB	BBBBBBBBBBBB
	CCCCCCCCCCCC	CCCCCCCCCCCC	CCCCCCCCCCCC	CCCCCCCCCCCC	CCCCCCCCCCCC
	DDDDDDDDDD	DDDDDDDDDD	DDDDDDDDDD	DDDDDDDDDD	DDDDDDDDDD
2.2 Community Financing	AAAAA	AAAAA	AAAAA	AAAAA	AAAAA
	BBBBBBBBBBBB	BBBBBBBBBBBB	BBBBBBBBBBBB	BBBBBBBBBBBB	BBBBBBBBBBBB
	CCCCCCCCCCCC	CCCCCCCCCCCC	CCCCCCCCCCCC	CCCCCCCCCCCC	CCCCCCCCCCCC
	DDDDDDDDDD	DDDDDDDDDD	DDDDDDDDDD	DDDDDDDDDD	DDDDDDDDDD
2.3 Generic Marketing of Risk-Sharing Concepts	AAAAA	AAAAA	AAAAA	AAAAA	AAAAA
	BBBBB	BBBBB	BBBBB	BBBBB	BBBBB
	CCCCCCCCCCCC	CCCCCCCCCCCC	CCCCCCCCCCCC	CCCCCCCCCCCC	CCCCCCCCCCCC

Legend: A - diagnostic studies; B - design stage; C - demonstration stage; D - policy stage

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Table 11. Indicators of Progress and Benchmarks

OUTPUT 1	MILESTONE	BENCHMARK	INDICATOR OF PROGRESS	TIME
1. Capacity building for transparent, public-private sector interactive, and research-based policy formulation.	1. Institutionalization of Health Policy Process	1.1 Formation of health policy deliberating units	1.1.1 Executive Order creating HPBC	CP
			1.1.2 Administrative Order creating HPU	2 months
			1.1.3 Administrative Order, creating Health Policy Technical Group	
		1.2 Formulation of Policy Framework	1.2.1 Inventory of policy issues, questions, and areas	4 months
			1.2.2 Steering Committee report formalizing Health Financing Policy Framework	
		1.3 Formulation of Health Financing Policy Research Agenda	1.3.1 Workshop to discuss Policy Framework and prioritize research issues	4 months
			1.3.2 Steering Committee report formalizing Health Financing Research Agenda	2 months
		1.4 Formulation of Policy Agenda	1.4.1 Annual review of research issues	Annual
			1.4.2 Annual Steering Committee report on Policy Agenda	
		1.5 Policy Monitoring and Evaluation	1.5.1 Establishment of system for monitoring and evaluation	Annual
	1.5.2 Monitoring of promulgation of policy actions		Annual	
	1.5.3 Monitoring of conformance of policy changes with operations guidelines established in policy action		Annual	
	2. Creation of Health Financing and Health Policy Databases	2.1 Development of National Health Accounts (NHA) Database	1.5.4 Evaluation of impact of policy change	Annual
			2.1.1 Needs analysis to determine output indicators	1 month
			2.1.2 Systems design specifying data sources, data inputs, data processing, hardware, and software requirements	3 months
2.1.3 Identification of locus for NHA Database			3 months	
2.1.4 Design of primary data collection protocols and identification of secondary sources of data			12 months	
2.1.5 Data collection			6 months	
2.1.6 Computer procurement			6 months	
2.1.7 Data analysis and report			6 months	
2.1.8 Yearly update	Annual			

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Table 11, Indicators of Progress and Benchmarks

OUTPUT 1	MILESTONE	BENCHMARK	INDICATOR OF PROGRESS	TIME	
<p>1. Capacity building for transparent, public-private sector interactive, and research-based policy formulation.</p>		<p>2.2 Development of Health Financing Policy Database</p>	<p>2.2.1 Inventory of explicit and implicit policies at macro level (Executive Orders/Republic Acts)</p>	<p>0 months</p>	
		<p>2.2.2 Inventory of explicit and implicit policies at micro level (Administrative Orders)</p>	<p>0 months</p>		
		<p>2.2.3 Inventory of related financing policies from other countries</p>	<p>6 months</p>		
		<p>2.2.4 Classification of health financing policies</p>	<p>3 months</p>		
		<p>2.2.5 Cataloguing for access and retrieval</p>	<p>3 months</p>		
		<p>2.3 Generic Studies for Policy Formulation</p>	<p>2.3.1 Identification of determinants of future health status and their impact upon resources</p>	<p>4 months</p>	
		<p>2.3.2 Creation of a broad research agenda to address future health issues</p>	<p>4 months</p>		
		<p>2.3.3 Commissioning of research studies on a continuing basis</p>	<p>continuous</p>		
		<p>3. Establishment of Multi-Sectoral Forum for Policy Discussions</p>	<p>3.1 Creation of Multisectoral Forum for Health Policy</p>	<p>3.1.1 Identification of locus for the Forum</p>	<p>3 months</p>
		<p>3.1.2 Formulation of membership and governance guidelines</p>	<p>2 months</p>		
<p>3.1.3 Hiring of staff and procurement of equipment</p>	<p>3 months</p>				
<p>3.1.4 Development of annual plan of activities</p>	<p>1 month</p>				
<p>3.1.5 Conduct of routine activities</p>	<p>continuous</p>				

Table 11, Continued ...

OUTPUT 2	MILESTONE	DENCHMARK	INDICATOR OF PROGRESS			
			DIAGNOSTIC STAGE (A)	DESIGN STAGE (D)	DEMONSTRATION STAGE (C)	POLICY STAGE (D)
2. Improved efficiency and expanded coverage of the national HCF program	1. Improvement and Expansion of Medicare Program	1.1 Medicare I Reforms	36 months	36 months	36 months	40 months
		1.2 PMCC-Tieups	3 months	12 months	42 months	36 months
		1.3 Development of Medicare MIS	6 months	6 months	10 months	12 months
		1.4 Merging of Medicare and other Health Funds	12 months			12 months
		1.5 Profile of Noncovered Population Groups	12 months			
	2. Strategic Options for Health Care Financing	2.1 Private Sector Risk-Sharing Arrangements	6 months	24 months	36 months	12 months
		2.2 Employer-Provided Benefits	6 months	24 months	36 months	12 months
		2.3 Community Financing	5 months	24 months	30 months	12 months
		2.4 General Marketing of Risk-Sharing Concepts	6 months	6 months	24 months	

Table 11, Continued ...

OUTPUT 3	MILESTONE	BENCHMARK	INDICATOR OF PROGRESS			
			DIAGNOSTIC STAGE (A)	DESIGN STAGE (B)	DEMONSTRATION STAGE (C)	POLICY STAGE (D)
3. Improved efficiency and effectiveness in the hospital sector	1. Hospital Sector Restructuring	1.1 Innovations in Management/ Ownership of Public Hospitals	15 months	27 months	42 months	40 months
		1.2 Private Hospital Systems Reform	10 months			24 months
		1.3 Public Care Hospital Network Management	12 months	12 months	24 months	36 months
	2. Hospital Institutional Reform	2.1 Hospital Institutional Level Reforms	12 months	12 months	12 months	12 months
	3. Health Facilities Database	3.1 Health Facilities Database	2 months	14 months		

The social soundness analysis deals with the ways in which women and their families can benefit from pre-paid health care and the protection from having to pay unanticipated, large bills for curative care. Because small children are so frequently ill and the mothers normally bear the burden of child care, being covered by health insurance is both a financial and psychological benefit. The overall assessment for the impact of the project on women in the Philippines is very favorable.

F. ENVIRONMENTAL CONCERNS

A Categorical Exclusion from A.I.D.'s Initial Environmental Examination, Environmental Assessment and Environmental Impact Summary requirements has been granted this Project. This is in accordance with A.I.D. Regulation 16, Section 216.2(c)(2)(viii) which provides for categorical exclusion for "programs involving nutrition, health care or population and family planning services, except to the extent designed to include activities directly affecting the environment..." The Approval for Categorical Exclusion is included as Annex H, Initial Environmental Examination.

V. MONITORING AND EVALUATION PLANS

The purpose of monitoring and evaluation is to determine project status and progress. For the HFD Project, monitoring of Project progress, policy reform, and policy impact will be undertaken.

A. HFD PROJECT DATABASES

The Project will put in place three databases for Project monitoring and evaluation:

- * For Component 1, a National Health Accounts Database will be established to provide information on the sources and application of funds in the health sector. This database will permit analysis of the structure of health care expenditures and their trends over time.
- * For Component 2, the Medicare MIS will be established at PMCC to provide financial reports on the Medicare Program. As the database evolves, it is also envisioned to provide regular data on beneficiary profile, utilization patterns, and analysis of costs and expenses.
- * For Component 3, a Health Facilities Database will be established at the DOH Office of Hospital Operations and Management Services to provide regularly updated data on the location of health facilities, utilization patterns and, for sentinel facilities, basic health-service cost data.

These Project databases will support and complement existing surveys/databases that GOP regularly conducts. The Family Income and Expenditures Survey, conducted every 3-5 years, includes queries on household expenditures on health. The National Health Survey, conducted every 5 years, provides information on patterns of health service access. The Field Health Service Health Information System regularly provides information on the activities of DOH field units.

B. MONITORING PLAN

1. Project Monitoring

Periodic project monitoring will be conducted to assess the implementation of HFD Project activities. The DOH Chief of Staff, HPDS and other DOH implementing units, OPHN, and project grantee/contractors will have respective responsibilities for this task.

To ensure that project inputs are used for intended activities, HPDS will hold annual planning workshops with OPHN, DOH implementing units, and grantee/contractors to establish project deliverables and the resources required to achieve them. It will also require DOH implementing units and grantee/contractors to complete annual workplans and submit quarterly and annual performance and financial reports. HPDS will maintain a project monitoring system that provides regular flow of data on project resources and their use.

The Office of the Chief of Staff is responsible for overall monitoring of project outputs. Table - lists project benchmarks and the indicative number of months required for their completion. To ensure that these project benchmarks are met, the Office of the Chief of Staff will schedule regular meetings with OPHN, DOH implementing units, and grantee/contractors to assess benchmark status, identify possible constraints, and determine future courses of action.

OPHN is responsible for monitoring DOH and grantee/contractors adherence to the project implementation schedule; approving all workplans, terms of references, and scopes of work; and ensuring that planned USAID financial resources flow to the Project. If necessary, OPHN will contract management audits to determine issues and constraints related to project implementation.

2. Policy Monitoring

In view of the Project's emphasis on policy reform, policy tracking and policy impact assessment are designed as integral Project activities. The HPDS will be primarily responsible for HCF policy tracking. A Health Policy Database will be established under component 1, based at the HPDS, to provide an inventory of all existing HCF policies in the Philippines, catalogue HCF legislative initiatives in Congress, and compile GOP executive and administrative HCF issuances. This Database will monitor:

- * the promulgation of HCF policy actions in terms of Republic Acts, Executive Orders, Administrative Orders, or parastatal Board Resolutions;
- * the conformance of policy changes with operations guidelines established in the policy actions; and
- * remaining policy actions needed.

The Project provides resources to conduct HCF policy tracking and policy impact studies, following the Mission's macroeconomic policy model. These studies will focus on purpose-level indicators, namely: policy on Medicare I reforms; policy of encouraging broader private- and public-sector risk-sharing for health; strategy for hospital financing, including sectoral and institutional reforms which promote allocative and operational efficiency; and policy of stimulating private hospitals to pursue national health goals. The results of these HCF policy tracking and policy impact studies will be discussed in annual dialogues between DOH and USAID. These formal dialogues will also serve as venue for the assessment of the quality and pace of policy reform.

C. EVALUATION PLAN

Two project evaluations will be conducted: a Mid-Term evaluation to be initiated by early FY 1994 and a final evaluation three months prior to the Project Assistance Completion Date in FY 1996.

The mid-term evaluation will focus on progress towards meeting the indicators of the end-of-project status and the following areas of concern:

1. Assessment of the adequacy of project design, implementation processes, and the capacity of Project implementing units and grantee/contractors; and recommendations for revisions to improve implementation for the second half of the project and for HFD Program strategies.
2. Identification of specific policy instruments that encourage broader private and public-sector risk-sharing for health, and stimulate private hospitals to pursue national health goals.
3. Policy for and progress in implementing Medicare I Reforms.
4. Progress in DOH hospital restructuring.
5. Assessment of Private Options for Health Care Financing.
6. Assessment of the HFD assisted policy process with respect to issues of democratic pluralism.
7. Assessment of GOP capacity-building in Health Financing Policy Process as a result of the project.
8. Assessment of adequacy of information being gathered to meet final evaluation needs and update Project evaluation criteria as needed.

The final evaluation will examine the extent to which the goals and purposes have been achieved. It will focus on the end-of-project output indicators, the measures of goal achievement and the conditions that indicate that the purpose has been achieved (See Annex A. Logical Framework). It will also review issues of sustainability and identify additional GOP or donor activities needed to ensure long-term results.

The DOH will participate in the development of the scope of work for the mid-term and final evaluations, and is expected to actively contribute to the actual evaluation. The primary users of information collected under this project are USAID/Manila, GOP agencies (DOH, PMCC, ECC, NEDA), private sector groups, and other USAID missions that are considering the development of similar projects.

The mid-term and final evaluations will be completed by contractors independent of the TA contractors. USAID plans to contract with qualified 8(A) or Gray Amendment firms for these evaluations.

Table 12
End-of-Project Evaluation Indicators,
Sources of Information,
and Locus of Responsibility

Evaluation Indicators	Sources of Information	Responsibility
xx% increase in the utilization of health services by persons in the five lowest income deciles	National Health Survey Special Surveys	HPDS National Statistics Office
Policy on Medicare I reforms	Executive and DOH Administrative Orders	PMCC
Policy of encouraging broader private- and public-sector risk-sharing for health	DOH Administrative Orders	PMCC
Strategy for hospital financing, including sectoral and institutional reforms which promote allocative and operational efficiency	DOH Administrative and other Department Orders	OHFS
Policy of stimulating private hospitals to pursue national health goals	Executive and DOH Administrative Orders	OHFS

VI. SUMMARIES OF ANALYSES

A. TECHNICAL ANALYSIS

Extensive analytical work has been conducted over the past few years to define the problems of health care financing in the Philippines and identify technically appropriate methods of addressing them. Annex J provides a list of basic references used in the preparation of this Project. The following technical analysis assesses two major groups of technologies to be adopted in the Project: one dealing with demand financing, the other with improving provider efficiency and effectiveness.

1. Demand Financing

The Project seeks to promote third-party payment systems such as health insurance, managed care, and tieups to mandated health funds. The underlying technical premise is to shift the type of health spending from predominantly out-of-pocket (fee-for-service) expenditures to third-party payments. The theoretical and empirical literature indicates that due to the unpredictability of sickness, the substantial financial risks associated with sickness, and high incidence of medical indigency, fee-for-service arrangement is inequitable and unsustainable.

Health insurance and managed care arrangements, on the other hand, pool individual risks and therefore offer a better option for financing health care. Managed care systems extend the concept of risk-pooling further: by combining the financing and delivery of health care through capitation, HMOs place providers at risk, thereby establishing a built-in efficiency mechanism in health service delivery.

The Project takes cognizance of two major criticisms on third-party payment systems -- moral hazard and adverse selection -- which can lead to medical cost inflation and segments of the population without coverage. Moral hazard occurs in an insurance setting because both the patient and the provider know that someone else is paying the bill, hence theoretically there is an all-but-infinite demand for health care. On the other hand, adverse selection occurs because both patients and insurers know that people self-select to buy insurance, i.e., the sick are more likely to buy health insurance than the healthy. Similarly, insurers avoid anyone likely to have large health-service demand.

On closer scrutiny, the compulsory nature of the Medicare Program prevents adverse selection. In the case of private voluntary insurance, adverse selection can be dealt with by requiring insurers to operate more on community rather than individual rating. The Project addresses the issue of moral hazard and cost inflation through a range of policy instruments including uniform physician reimbursement through RVS or DRG systems, utilization control, peer review, and possible establishment of a monopsonistic mechanism in which Medicare becomes a major purchaser of services through annual cost agreements with professional societies and trade associations.

While cost inflation and adverse selection reduce the attractiveness of the health insurance option, a number of developing countries -- Taiwan, South Korea, Malaysia, Indonesia -- prefer the health-insurance or managed-care route in the development of their health care systems. No developing country reforming its health-care system has opted for the perpetuation of fee-for-service arrangement, or the expansion of a tax-funded national health service. It appears from these countries' preference that the benefits of a third-party payment system, such as its ability to generate resources, pool risks, and expand health-care access, far outweigh the costs.

2. Hospital Service Improvement

Many of the problems in the Philippine health sector arise from a poorly functioning health-care market. The government health system co-exists, and often competes, with private providers. This overlapping of roles and functions engenders wastage, inhibits resource generation, and often prevents the government from targetting its services to those most in need. On the other hand, private providers confront a range of economic disincentives that restricts their capacity to pursue national health goals.

The basic technical premise of this Project is to improve market mechanisms in order to stimulate investments and limit the role of the government into those activities in which it has a comparative advantage. With scarce resources, the government ought to limit its services to those with the greatest health impact (i.e., preventive services) and target the curative services it provides to those most in need. Incentives must also be provided (or at least disincentives must be removed) to stimulate the private sector.

To operationalize these principles, the Project will pursue strategies in privatization and core hospital network. As defined in the Project, the privatization strategy permits the government to shed off facilities or services in which it does not have a comparative advantage and which do not advance its equity objectives. It also permits government health facilities to achieve autonomy in revenue generation and use of resources -- two factors that have substantial impact on efficiency improvement. Worldwide experience shows that privatization is a technically sound strategy of bringing market discipline into the health system.

The core hospital network is a useful conceptual and operational tool devised by the DOH to select facilities for institutional upgrading and thereby concentrate on those hospitals and clinics which pursue its equity and public-health objectives. Through this strategy, government resources can be used more efficiently and with greater health impact. The networking arrangement inherent in this concept also addresses problems of scale and referral.

B. FINANCIAL ANALYSES

The operating financial systems under the project are familiar to both AID and the GOP and pose no anticipated problems. DOH has been recently assessed by an outside auditor to have the capacity to financially manage a project and conduct contracting on the scale required for HFD implementation. Long-term public sector resource requirements to sustain project activities are equivalent to .2% of the projected DOH budget, certainly within the realm of possibility given expected project benefits.

C. ECONOMIC ANALYSIS

The economic benefits of the project would arise from increased allocative and operational efficiency in the health sector. Improved policy formulation, expanded use of risk-sharing mechanisms, operational efficiency gains, and hospital institutional reform would likely yield a substantial financial cost savings. These gains would enable the DOH to expand preventive health care services that would decrease family health expenditures, and which add to the overall productive capacity of the economy through gains in worker productivity and the return to education. Economic growth would also be obtained from the expansion of the private health care sector.

The direct costs of the project include the costs of capacity building in health financing policy formulation, training, demonstration projects, research, data collection and analysis, and the purchase of computers and software for data management. The indirect costs include possible increases in health care costs due to the expansion of health insurance, the potential for decreasing access to health care for the poor, and the possibility that some government health care workers may be displaced.

The selected project approaches, using both expatriate and local expertise, and mainly conducting training in-country are cost-effective. The selected approaches minimize explicit and implicit costs in assisting the health financing development effort.

The economic benefits of the project are more than sufficient in size to offset the minimum required to cover the economic costs. Reductions in family health expenditures and the additional gross value added of divested hospitals would likely yield sufficient economic benefits to justify the project. Using a social discount rate of 15 percent, the project must achieve an annual economic return valued at \$3.3 million at 1991 prices for twenty years. Annual family health expenditures need only be reduced by .95 percent per year (\$.26 per family), and only 50 of 349 hospitals be divested to meet the minimum required benefits to cover the direct economic costs of the project.

D. SOCIAL SOUNDNESS ANALYSIS

The social soundness analysis (SSA) focused on the sociocultural feasibility of the three project components (i.e., health policy formulation, health financing schemes, and hospital reforms), anticipated social impacts particularly on women, spread effects and project sustainability.

The findings of the SSA support the following conclusions and recommendations:

- 1) Prevailing practices in the country reflect cultural elements which are congenial to the adoption of prepaid health schemes;
- 2) While the income levels of the greater majority of the population are low and insufficient to provide for future health needs, adequate information and explanation on the value and the protection of pre-paid health care can persuade some segments of this population to participate in social insurance schemes. There are documented NGO experiences attesting to the feasibility of pre-payment schemes among lower income populations.
- 3) There is a need for project activities to reach out to socially marginalized groups, the ultimate beneficiaries of the project, if these groups are to be involved more meaningfully in the policy making process envisioned in the project. There is a body of literature on appropriate training and popular education approaches evolved by NGOs and academic-support groups, that the project can effectively utilize. These approaches and methods are generally described as evocative and participatory, involving beneficiary groups as partners in research, advocacy and action.
- 4) The inability of some beneficiaries to avail of benefits provided under existing social insurance schemes is partly due to their lack of awareness of the nature of the benefits and the availment procedures required. Continuous information and education campaigns are necessary to optimize members' benefits from existing schemes.
- 5) Under the proposed Local Government Code, local government units are expected to play key roles in the health financing scene and that their entry into the process must be anticipated.
- 6) Innovations in public hospital management indicate that in urban areas, determination of levels of indigency after quality service has been provided can lead to substantial increases in the amounts given as voluntary donations.
- 7) Current programs attempting to expand benefits of Medicare members through a tie-up project with HMOs, underscore the importance of information dissemination to members as well as the need to resolve conflicting interests of some provides and HMO managers.
- 8) The primary beneficiaries of the project are women and young children since they are among the major users of health services, and suffer disproportionately from poor quality health services. They are expected to benefit from any attempt to increase resources and improve over all efficiency of the use of these resources for health care. Other beneficiaries are the poor in rural and urban communities who frequently incur debts to pay for unanticipated medical bills in case of serious illnesses.

9) Women play a critical role in health provision in the current system and the HFDP can further strengthen their participation in health policy formulation and financing. One way is to involve women's groups, alliances, and networks in policy research, advocacy, training, demonstration or pilot schemes for health financing.

10) The project's spread effects will depend to a large extent on the process and the outcome of the policy formulation process. Given the target beneficiaries of the improved policy formulation process, the expansion of current social insurance schemes and increasing the efficiency of hospitals, it is inevitable that depressed and disadvantaged communities will be able to gain access to health services which were otherwise inaccessible to them before.

11) In developing the database and social indicators to track the impacts of a national financing policy, special attention should be given to participation rates of specific population groups such as tribal communities, fisherfolk, low-income women and workers. Case studies and other qualitative research methods may be employed to monitor and assess social impacts of the project at individual, family and community levels.

12) On the whole, the project is considered socially sound and sustainable, particularly, if the processes proposed and the suggestions presented could be implemented in such a manner that socially marginalized groups will be more actively involved and followed-up on their health practices so that this information can be used to supplement aggregate data collected at macro levels.

E. INSTITUTIONAL AND ADMINISTRATIVE ANALYSES

The National Economic Development Authority (NEDA) will be the signatory on the Project Grant Agreement. Project resources will flow from USAID to the implementing agencies: the DOH, the local Policy Formulation Consortium grantee, and a U.S institutional contractor. The DOH Chief of Staff will provide overall direction to the separate Project components. Financial and technical administration for all Project resources will be mandated to the HPDS. Similar models of DOH administrative arrangements for transferring, using and accounting for Project resources have already been satisfactorily demonstrated through management of the Child Survival Program and the Family Planning Assistance Project. Selection of contractors and grantees will include review of their administrative capabilities.

Institutional and administrative capacities for managing the policy process, selecting and conducting appropriate research, and building private sector constituencies for reform will be developed through the HFD Project. Policy implementors will include various DOH Offices and the PMCC. Research capabilities will be strengthened in local academic institutions, professional societies, consulting firms, and NGOs through training and utilizing these groups to conduct research.

VII. CONDITIONS, COVENANTS AND WAIVERS

The following conditions, covenants and waivers are included in the Project Authorization:

**1. Source and Origin of Commodities,
Nationality of Services**

Commodities financed by A.I.D. under the Project shall have their source and origin in the Cooperating Country or in the United States, except as A.I.D. may otherwise agree in writing. Except for ocean shipping, the suppliers of commodities or services shall have the Cooperating Country or the United States as their place of nationality, except as A.I.D. may otherwise agree in writing. Ocean shipping financed by A.I.D. under the Project shall, except as A.I.D. may otherwise agree in writing, be financed only as flag vessels of the United States.

2. Other

Prior to any disbursement, or the issuance of any commitment documents under the Project Agreement, the Cooperating Country shall furnish in form and substance satisfactory to A.I.D., a plan for the institutionalization of Health Policy Development Staff in the Cooperating Country's Department of Health.

3. Prior to any disbursement, or the issuance of any commitment documents under the Project Agreement to finance new activities each Project Year, the Cooperating Country shall furnish, in form and substance acceptable to A.I.D., an annual implementation plan.

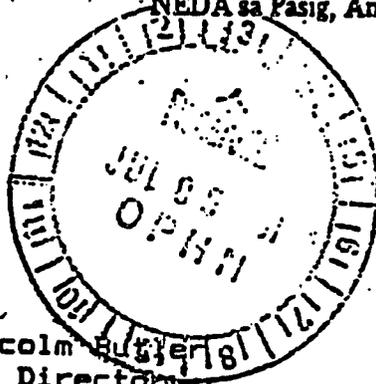
Waivers will be requested as required during Project Implementation.

Annex A
GOP Request for Assistance



REPUBLIC OF THE PHILIPPINES
NATIONAL ECONOMIC AND DEVELOPMENT AUTHORITY
 NEDA sa Pasig, Amber Avenue Pasig, Metro Manila

Cable Address: NEDAPHIL
 P.O. Box 419, Greenhills
 Tels. 631-0945 to 64



JUL 03 1991

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 USAID/C&R

RECEIVED

Mr. Malcolm Butler
 Mission Director
 U.S. Agency for International
 Development
 Ramon Magsaysay Center
 Roxas Boulevard, Manila

Dear Director Butler:

We wish to convey the request of the Government of the Philippines for \$50 million grant assistance to finance the proposed Health Finance Development Project.

To be implemented by the Department of Health (DOH), the project aims to increase equitable access to efficiently-provided health services in order to achieve improvement in the overall health status of Filipinos. The project will involve the formulation of a National Health Financing Policy which will facilitate equitable access to efficient health services delivered by both private and public providers.

The following specific components are envisioned for the project:-

1. Policy Formulation - which will involve the development of DOH capacity for research-based policy formulation and the development of mechanisms in the public arena which allow access to the health policy process;
2. Health Care Financing - which will work towards the advancement of social equity by improving the efficiency and coverage of the national health insurance program; and
3. Hospital Reforms - which will enhance efficiency and effectiveness of hospital-based care provided through public and private hospitals.

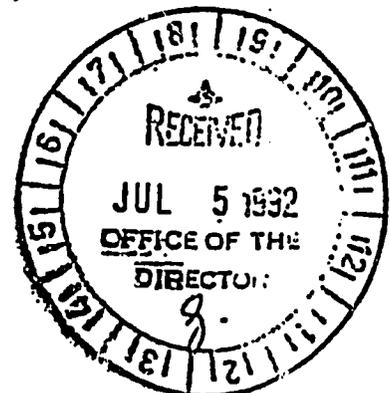
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OPAN	
OFFPVC	
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RIG1	
DUE DATE	
7-16-91	

ACTION TAKEN

By: NAU Date: _____

Type: _____ No. _____

Period: _____ Initials: _____



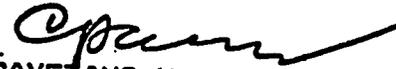
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The DOH is working closely with USAID in the formulation of the details of the project design. It is hoped that the final project design will be available in July for review and final clearance by the Investment Coordination Committee and the NEDA Board.

USAID's favorable action on this request for grant assistance will contribute greatly towards the achievement of the GOP's development goals in the health sector.

Thank you and best regards.

Very truly yours,



CAYETANO W. PADERANGA, JR.
Secretary for Socio-Economic Planning

cc: Secretary Alfredo R.A. Bengzon, DOH
Undersecretary Mario Taguiwalo, DOH

Annex B
Logical Framework

**PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK**

LIFE OF PROJECT:
From FY 1991 to FY 1998
Total U.S. Funding \$20,000,000
Date Prepared: July 24, 1991

Project Title and Number: HEALTH FINANCE DEVELOPMENT PROJECT (492-0448)

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS																																																
<p>(A-1) Program or Sector Goal: The broader objective to which this project contributes:</p> <p>To develop the health care market in order to improve health service quality, equity, coverage, efficiency, and private participation.</p>	<p>(A-2) Measures of Goal Achievement:</p> <ul style="list-style-type: none"> • Increase in the utilization of health services by persons in the five lowest income deciles. • 10% increase in proportion of DOH budget devoted to field health services (14.3% to 15.7%). 	<p>(A-3)</p> <p>National Health Survey</p> <p>Baseline and follow-up household health care demand surveys using RAT in project areas</p>	<p>(A-4) Assumptions for achieving goal targets:</p> <p>Better access and utilization lead to better health status.</p> <p>Stable political and economic conditions</p>																																																
<p>(B-1) Project Purpose:</p> <p>To establish a process for formulating and implementing HCF policies, regulations, and legislation supportive of health-care market improvement.</p>	<p>(B-2) Conditions that will indicate purpose has been achieved: End-of-Project Status.</p> <ul style="list-style-type: none"> • Policy on Medicare I reform. • Policy of encouraging broader private and public-sector risk-sharing for health • Strategic plan for hospital financing, including sectoral and institutional reforms which promote allocative and operational efficiency • Policy of stimulating private hospitals to pursue national health goals 	<p>(B-3)</p> <p>Project monitoring/evaluation</p> <p>- do -</p> <p>- do -</p> <p>- do -</p>	<p>(B-4) Assumptions for achieving purpose:</p> <p>Private sector is responsive to GOP policy initiatives.</p>																																																
<p>(C-1) Project Outputs:</p> <p>Output 1 - Capacity for transparent, private/public sector interactive, and research-based policy formulation.</p> <p>Output 2 - Improved efficiency and expanded coverage of the national HCF program</p> <p>Output 3 - improved efficiency and effectiveness of hospital-based care</p>	<p>(C-2) Magnitude of outputs:</p> <ul style="list-style-type: none"> • Formation of Health Policy Steering Committee and other deliberating units • Formulation of Multisectoral Health Policy Forum • Development of Health Financing <ul style="list-style-type: none"> - Policy Framework - Research Agenda - Policy Agenda • 30 % increase in the proportion of health care expenditures provided through risk-sharing mechanisms (8%-10.4%). • 10% increase in real budgetary expenditures to non-specialty core hospital network (CHN) • In one province, public hospitals reflect: <ul style="list-style-type: none"> - increased governance by boards with private sector members - 10% increase in financing from non-GOP sources - increase in the proportion of hospital expenditures in private contracts 	<p>(C-3)</p> <p>Project monitoring/evaluation</p> <p>-do-</p> <p>-do-</p> <p>National Health Accounts</p> <p>National Health Accounts Budget and expenditure data of non-specialty hospitals Project monitoring/evaluation</p>	<p>(C-4) Assumptions for Achieving Outputs:</p> <p>New GOP and DOH Administration in 1992 is receptive to the health policy initiatives identified by the current Administration.</p> <p>Demonstration schemes yield successful results.</p>																																																
<p>(D-1) AID Project Inputs:</p> <table border="0"> <tr> <td>1. Technical Assistance</td> <td></td> <td></td> </tr> <tr> <td>2. Training</td> <td>8,099</td> <td>2,470</td> </tr> <tr> <td>3. Research</td> <td>2,402</td> <td>393</td> </tr> <tr> <td>4. Demonstrations</td> <td>1,783</td> <td>0</td> </tr> <tr> <td>5. Commodities</td> <td>8,588</td> <td>2,737</td> </tr> <tr> <td>6. Monitoring, evaluation and audit</td> <td>141</td> <td>888</td> </tr> <tr> <td></td> <td><u>1,805</u></td> <td><u>249</u></td> </tr> <tr> <td>TOTAL</td> <td>20,000</td> <td>8,855</td> </tr> </table>	1. Technical Assistance			2. Training	8,099	2,470	3. Research	2,402	393	4. Demonstrations	1,783	0	5. Commodities	8,588	2,737	6. Monitoring, evaluation and audit	141	888		<u>1,805</u>	<u>249</u>	TOTAL	20,000	8,855	<p>(D-2) Implementation Target (Type and Quantity): (\$000)</p> <table border="0"> <tr> <td></td> <td><u>USAID</u></td> <td><u>GOP</u></td> </tr> <tr> <td></td> <td>8,099</td> <td>2,470</td> </tr> <tr> <td></td> <td>2,402</td> <td>393</td> </tr> <tr> <td></td> <td>1,783</td> <td>0</td> </tr> <tr> <td></td> <td>8,588</td> <td>2,737</td> </tr> <tr> <td></td> <td>141</td> <td>888</td> </tr> <tr> <td></td> <td><u>1,805</u></td> <td><u>249</u></td> </tr> <tr> <td></td> <td>20,000</td> <td>8,855</td> </tr> </table>		<u>USAID</u>	<u>GOP</u>		8,099	2,470		2,402	393		1,783	0		8,588	2,737		141	888		<u>1,805</u>	<u>249</u>		20,000	8,855	<p>(D-3)</p> <p>Project monitoring/evaluation (e.g. quarterly reports, financial reports, demonstration project evaluations)</p>	<p>(D-4) Assumptions for providing inputs:</p> <p>Timely availability of USAID and DOH funds.</p> <p>Contractors and commodities are available as needed.</p>
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Annex C
Project Matrices by Component

Component 1: Policy Formulation

Subcomponents	Research, Seminars & Workshops	Demonstration Projects	Training	Technical Assistance
SUPPORT TO THE HCF POLICY PROCESS				
* HCF Policy Framework, Policy Agenda, and Policy Actions (Locus: DOH).	Policy framework preparation Policy agenda formulation Consensus-building activities Identification of special geographic concerns, i.e., regional/prov'l HCF perspectives Policy impact monitoring and evaluation		Awareness-raising and capacity-building in identified key players and decisionmakers Training of Congressional staff in policy formulation and legislative drafting Development and retention program for HCF policy analysts	Experts visits to the Philippines Orientation to US and third-country HCF systems
* HCF Research Agenda and Research Studies (Locus: research & academic community)	Design of HCF research agenda Conduct of generic studies/fact-finding activities, e.g.: - sectoral modelling - HCF policy simulation - resource planning - impact of epidemiological transition - cost/benefit analyses of health interventions Research publication and advocacy		Long-term and short-term training programs in - health economics - health service admin. - health care financing	Collaborative arrangements with U.S. - universities & prof'l societies - trade asso. & comm'l firms - gov't agencies, e.g., HCFA

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Component 1: Continued...

Subcomponents	Research, Seminars & Workshops	Demonstration Projects	Training	Technical Assistance
SUPPORT TO THE MULTISECTORAL POLICY FORUM				
(Locus: interest groups)	<p>Consensus-building activities</p> <p>Generation and dissemination of issues papers</p> <p>Documentation and dissemination of systems innovation</p>	<p>Dev't of an independent forum for health policy as joint venture among</p> <ul style="list-style-type: none"> - prof'l and specialty societies (PMA, PNA, etc.) - trade associations (PHA, AHMOPI, drug companies) - consumer, labor, employers, NGOs, & other advocacy groups - DOH, PMCC 	<p>Support to local institutions</p> <ul style="list-style-type: none"> - interest determination and capacity assessment - improvement of linkages - upgrading of capabilities - training of Forum facilitators 	<p>Observation visits to other countries</p>
HCF DATA BASE				
* National Health Accounts (NHA) (Locus: ?)	<p>Assessment of existing sources of data</p>	<p>Development of a replicable National Health Accounts database</p>		<p>Design and evaluation of NHA</p>
* HCF Policy Data Base (Locus: DOH)	<p>Documentation of HCF policies</p> <ul style="list-style-type: none"> - in the Philippines - in other countries 	<p>Development of database on HCF policies made and status of ongoing policy, regulatory, and legislative initiatives</p> <ul style="list-style-type: none"> - Constitutional Law - Republic Acts - Executive Orders - Administrative Orders <p>Development of an HCF policy briefing module</p>		

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Component 2: Health Care Financing Mechanisms

Subcomponents	Research, Seminars & Workshops	Demonstration Projects	Training	Technical Assistance
IMPROVEMENT AND EXPANSION OF MEDICARE				
* Medicare I Reforms (Locus: PMCC)	Evaluation of Medicare I - beneficiary/provider profiles - benefit package & premium levels - utilization patterns - structure/level of contributions - reimbursement procedures	Pilot-testing of improved Medicare I benefits under existing type of providers Pilot-testing of alternative admin./reimbursement schemes - decentralized claims processing - dev't of RVS (relative value scales) - QA/UR systems (quality assurance and utilization review)	Training for PMCC, SSS, and GSIS: - gov't regulatory function - Medicare Fund management - admin. systems dev't	Design/evaluation of appropriate interventions/policies - rate and standard setting - QA/UR - risk assessment - benefit package design - reserve req'ts for insurers
* PMCC Tieups (Locus: providers and PMCC)	Evaluation of current PMCC-HMO tieups Design of other tieup arrangements	Pilot-testing and evaluation of PMCC tieups: - expanded PMCC-HMO tieups - private insurance ASO (admin. services only) subcontracts - PPO (preferred provider organization) option Provision of reinsurance mechanisms for - existing HCF schemes - alternative schemes	For PMCC, SSS, GSIS: - admin. systems dev't For HMOs, private insurers, PPOs: - ASO functions - QA/UR - claims payment - risk assessment	Design/evaluation of appropriate interventions/tieups Systems/measures for QA/UR: - preadmission certification - concurrent review - referral system Reinsurance options
* Medicare MIS (Locus: PMCC)	Systems analysis of MIS requirements - information needs analysis - data collection instruments - implementation options	Design and pilot-test - claims payment system - cost and utilization data system - quality assurance tools	Training programs on MIS and computer applications	Software and selected hardware for - claims processing - eligibility systems - accreditation systems - cost and utilization database

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Component 2: Continued...

Subcomponents	Research, Seminars & Workshops	Demonstration Projects	Training	Technical Assistance
* Merging of Medicare and Other GOP-Mandated Health Funds (Locus: PMCC)	Administrative, technical, and political feasibility study on: - the integration of the SSS and GSIS administered Medicare Fund - the integration of the Medicare Fund and the medical-services component of the EC Fund		Study tours to countries with unified funds	Legal and administrative requirements for the integration of health funds

PRIVATE-SECTOR HCF OPTIONS

* Private Sector Risk-Sharing Arrangements (Locus: private HMOs, insurers)	Background studies on: - the private insurance market - managed-care (HMO) arrangements - policy and environmental constraints	Demonstration of investment promotion - through linkages with Medicare - as independent private entities Generic marketing of risk-sharing concepts	Executive programs in managed care	Design of alternative product offerings of HMOs and private insurers
* Employer-Provided Benefits (Locus: employers)	Background studies on: - magnitude/types of health benefits provided - policy and environmental constraints	Mechanisms for integrating employer-provided benefit schemes - with Medicare - with private insurers/HMOs		
* Community Financing Schemes (Locus: communities)	Background studies on: - magnitude/types of schemes - existing/potential linkages with providers/funders - policy and environmental constraints	Pilot-testing and evaluation of novel financing/delivery mechanisms, e.g., where the gov't purchases health services in behalf of the indigent via contracts/grants with - private and public hospitals/clinics - HMOs - community-managed health facilities	Training programs to organize groups for - enrollment - eligibility Training programs to improve managerial and technical skills	Grant or contract development Systems development

Profile of noncovered population

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Component 3: Hospital Financing Reforms

Subcomponents.	Research, Seminars & Workshops	Demonstration Projects	Training	Technical Assistance
SECTORAL RESTRUCTURING				
<p>* Innovations in Management-Ownership of Public Hospitals</p> <p>(Locus: public hospitals)</p>	<p>Examination of critical aspects of public hospitals involving:</p> <ul style="list-style-type: none"> - governance - management of operations - financing of hosp. services - ownership of hospital assets <p>Dev't of taxonomy/matrix of management-ownership structures to analyze how public hospitals can move to an appropriate stage in the "privatization continuum"</p>	<p>Pilot-testing and evaluation of:</p> <ul style="list-style-type: none"> - decentralization of authority to LGUs, PVOs, or private proprietary entities - private management contracts - user fee generation and revenue retention - autonomous operation/corporatization - service contracting - chain operation of some public hospitals - private sector/community representation in boards - redeployment of gov't health sector assets via sale or reinvestment 	<p>DOH staff training in</p> <ul style="list-style-type: none"> - hospital admin. - financial/business planning - contract design, evaluation, and monitoring <p>Executive and staff training programs in</p> <ul style="list-style-type: none"> - managed care - business mgt. 	<p>Statutory revisions allowing autonomous hospital management</p> <p>Chain management of hospitals</p> <p>Dev't of specifications for demonstration schemes</p> <p>Experiences of other countries in public hospital restructuring</p>
<p>* System Reform in Private Hospitals</p> <p>(Locus: private hospitals)</p>	<p>Examination of critical aspects of private hospitals involving:</p> <ul style="list-style-type: none"> - policy and environmental constraints - financial viability - performance of public health tasks - care for the medically indigent - medical technology financing and acquisition - other constraints 	<p>Pilot-testing and evaluation of:</p> <ul style="list-style-type: none"> - gov't funding/provision of incentives to public health programs of private hospitals - bed subsidy program for the indigent - rationalization of medical technology acquisition and provision of incentives for proper spatial distribution - improved networking arrangements 	<p>Private-sector staff training on</p> <ul style="list-style-type: none"> - specifications of gov't-funded programs - monitoring requirements - medical technology financing 	<p>Design/evaluation of private sector demonstrations</p> <p>Medical technology assessment</p>

Component 3: Continued...

Subcomponents	Research, Seminars & Workshops	Demonstration Schemes	Training	Technical Assistance
* Public Core Hospital Network (CHN) Management (Locus: public and private hospitals)	Development of appropriate CHN: - management/reporting structure, e.g., relationship between DOH central office and indiv. hospitals - referral system - specification of CHN model hospitals at various levels of care	Demonstration of appropriate schemes to improve CHN operations	Network management	Chain operation of hospitals
	Assessment of current/potential networking arrangements between CHN and private hospitals	Pilot-testing and evaluation of - bulk purchasing - equipment sharing - training and research - other interhospital linkages	Network management	Design/evaluation of private-public networking arrangements
INSTITUTIONAL REFORMS				
* Institutional Management of Private and Public Hospitals (Locus: public and private hospitals)	Diagnostic studies - organizational analysis - management analysis - clinical service analysis - financial analysis - support services analysis	Pilot-testing and evaluation of appropriate schemes/programs based on diagnostic studies	Training programs in - hospital admin. - QA/UR programs	Systems design and installation Quality assurance/ utilization review programs
* Hospital Facilities Data Base (Locus: DOH)	Information needs analysis and dev't of output indicators	Pilot-testing and evaluation of central and facility-level information system	Training in data collection, analysis, and interpretation Systems maintenance	Systems design and installation

Annex D
PID Approval Cable and Response

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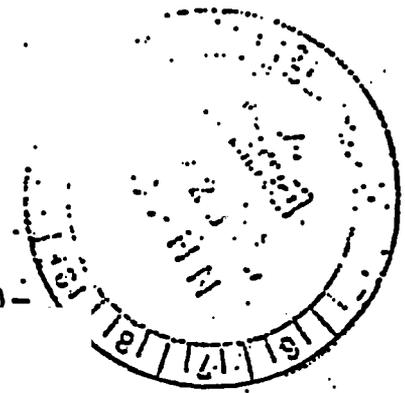
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SUBJECT: HEALTH FINANCE DEVELOPMENT PROJECT (492-0015)
PID APPROVAL



1. SUMMARY:

A. ENE VIEWS HEALTH FINANCE AS THE STRUCTURE OF INCENTIVES WHICH DRIVES QUALITY, DETERMINES EQUITY, AND LIMITS OR EXPANDS PEOPLE'S ACCESS TO CARE. WE ALSO SEE HEALTH AS A PRODUCTIVE SECTOR OF THE ECONOMY AND A COMPONENT OF MARKET-LED ECONOMIC GROWTH. THE STRUCTURE OF INCENTIVES AND, HENCE, GROWTH AND INVESTMENT IN THE SECTOR, ARE DETERMINED BY A FRAMEWORK OF LAWS AND REGULATIONS. AFTER MULTIPLE POST PID REVIEW EXCHANGES OF VIEWS WITH THE MISSION, WE AGREE ON MOST DESIGN ISSUES, BUT STILL HAVE TO NARROW DIFFERENCES ON SPECIFIC ACTIVITIES TO BE INCLUDED IN THE FIRST PHASE OF A HEALTH FINANCE PROGRAM FOR THE PHILIPPINES AND PLANS FOR DEVELOPING THE SECOND PHASE.

B. PROJECT DESIGN SHOULD PROCEED TO DETERMINE PHASE I OBJECTIVES AND WHAT PROJECT ELEMENTS BEYOND THE PID DESIGN ARE NECESSARY TO ACHIEVE THESE OBJECTIVES. IN

SETTING PHASE I OBJECTIVES AND ACTIVITIES, MISSION IS CAUTIONED TO CONSIDER THE SUSTAINABILITY OF PHASE I ACTIVITIES. WHEN THESE DESIGN DECISIONS ARE MADE, WE ASK THAT THE MISSION ADVISE HOW ITS DESIGN HAS BEEN MODIFIED SINCE THE PID, AND SEEK ENE BUREAU CONCURRENCE IN THE MODIFIED DESIGN APPROACH.

C. THE PID IS APPROVED FOR DESIGN OF A PROJECT PAPER (PP) WITH THOSE MODIFICATIONS. END SUMMARY.

2. ENE BUREAU REVIEW: THE ENE BUREAU PROJECT REVIEW COMMITTEE (PRC) MET JANUARY 11. ITS REVIEW OF THE PID SUGGESTED THAT THE MISSION'S PERSPECTIVE ON HEALTH CARE FINANCE WAS SOMEWHAT DIFFERENT THAN THE BUREAU'S, AND PERHAPS, THE DEPARTMENT OF HEALTH'S AS INDICATED BY THEIR VISIT OF OCTOBER, 1990. SUBSEQUENT EXCHANGES INCLUDING THE MISSION'S FAXES OF FEBRUARY AND MARCH AS WELL AS WASHINGTON DISCUSSIONS WITH THE MISSION DIRECTOR HAVE NARROWED THESE DIFFERENCES. THERE IS NOW FULL

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AGREEMENT THAT HEALTH CARE FINANCE IS NOT JUST TRYING TO GET MORE MONEY TO DO MORE THINGS; RATHER, IT IS A WAY TO RESTRUCTURE THE HEALTH SECTOR WITH INCENTIVES FOR QUALITY, EQUITY, EXPANDED ACCESS TO CARE AND GREATER PRIVATE SECTOR PARTICIPATION.

TO ACHIEVE THESE AIMS, THE PROJECT MUST HELP TO TRANSFORM THE ROLE OF GOVERNMENT FROM BEING THE MAJOR DIRECT PROVIDER TO SETTING THE LEGAL AND REGULATORY FRAMEWORK WHICH MAKES PRIVATE INVESTMENT AND PROVISION GROW. AND TO ADMINISTERING PUBLIC RESOURCES MORE EFFICIENTLY IN ORDER TO FINANCE CARE FOR THE POOR.

WE COMMEND THE MISSION FOR TAKING THE FIRST STEP TOWARD EXTENDING ITS POLICY REFORM AND PRIVATE SECTOR DEVELOPMENT OBJECTIVES TO THE HEALTH SECTOR. THE KEY TO THIS APPROACH IS RECOGNIZING THAT HEALTH IS A PRODUCTIVE AND GROWING SECTOR OF THE NATIONAL ECONOMY, NOT JUST A PUBLIC BUDGET CONSUMPTION ITEM.

WE SEE EXCELLENT OPPORTUNITIES FOR RESTRUCTURING THE HEALTH SECTOR IN THE PHILIPPINES. AS THE PID NOTES, MEDICARE I HAS ALREADY HELPED THE PHILIPPINES TO ACHIEVE A HIGHER DEGREE OF PLURALISM IN HEALTH FINANCE AND SERVICE PROVISION THAN IN MOST COUNTRIES, AND MEDICARE II, WHICH WOULD INCREASE HEALTH CARE OPTIONS FOR THE POOR IS ALREADY ON THE BOOKS. PRIVATE INSURANCE IS

WELL ESTABLISHED, PRESENTING FURTHER OPTIONS FOR PRIVATIZATION. THERE ARE GOOD TRAINING CAPABILITIES IN BASIC BUSINESS AND FINANCE AREAS TO WHICH HEALTH SPECIALIZATIONS COULD BE ADDED. POTENTIAL FOR FURTHER PRIVATE INVESTMENT, BOTH PHILIPPINE AND U.S., IS GOOD. WE RECOGNIZE THAT TACTICAL DECISIONS ABOUT HOW BEST TO FURTHER PHILIPPINE PROGRESS IN HEALTH RESTRUCTURING ARE CRITICAL TO THE SUCCESS OF THE PROGRAM. IN HIS DISCUSSION WITH THE AA/ENE, THE MISSION DIRECTOR AGREED TO REVIEW PROGRAM TACTICS CAREFULLY:

3. NEED FOR ADDED PROJECT ELEMENTS: THE PRC FOUND THE PID A GOOD START TOWARD TAKING ADVANTAGE OF THESE OPPORTUNITIES FOR RESTRUCTURING THE HEALTH SECTOR, BUT CONCLUDED THAT THE PID APPROACH STOPS SHORT OF CERTAIN PROJECT ELEMENTS NECESSARY FOR SUSTAINABLE RESULTS.

THE PID PROPOSES TO STUDY AND DEMONSTRATE POSSIBLE SCHEMES TO STIMULATE PRIVATE INVESTMENT, PRIVATE PROVISION, AND MORE EFFICIENT USE OF RESOURCES IN THE HEALTH SECTOR. THESE WOULD INFORM POLICY MAKERS AND

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BUILD CONSTITUENCIES FOR LEGAL AND REGULATORY REFORM.

HOWEVER, THE REAL GOAL IS NOT JUST TO PUT NEW LAWS ON THE BOOKS, BUT TO ACHIEVE A LASTING TRANSFORMATION OF THE ROLE OF GOVERNMENT AND ENSURE THAT THE LAWS CAN BE IMPLEMENTED. THE PROCESS DESCRIBED IN THE PID NEEDS TO BE A CONTINUING ONE, NOT A ONE-TIME EFFORT.

THIS REQUIRES THAT THE PROJECT STRENGTHEN CAPABILITIES:

- OF THE GOVERNMENT TO REGULATE THE HEALTH SECTOR AND TO ADMINISTER FINANCING OF SERVICES FOR THE POOR,
- OF THE PRIVATE SECTOR TO RESPOND TO A NEW STRUCTURE OF INCENTIVES TO DEVISE AND MANAGE FINANCING SCHEMES AND TO INVEST IN SERVICE PROVISION, FACILITIES AND INPUT INDUSTRIES,
- OF SELECTED FIRMS AND EDUCATORS TO CONDUCT TRAINING IN NEW AREAS OF SPECIALIZATION RELATED TO HEALTH FINANCE MANAGEMENT, AND ADMINISTRATION, AND
- OF GOVERNMENT AND PRIVATE SECTORS TO ACCESS U.S. HEALTH BUSINESS EXPERTISE.

THE TRANSFORMATION OF THE DOH FROM A LARGE HEALTH CARE PROVIDER TO AN INSTITUTION CAPABLE OF REGULATING AND MONITORING THE HEALTH SECTOR REQUIRES NEW SKILLS, AND REORIENTATION OF OLD ROLES AND ATTITUDES. GOVERNMENT CAPACITY TO MOBILIZE A BROAD CONSTITUENCY FOR THE NEEDED REFORMS OR TO DESIGN AND ADMINISTER REGULATIONS NECESSARY TO REWARD EFFICIENCY IN FINANCING AND PROVIDING HEALTH SERVICES MUST BE STRENGTHENED. BOTH GOVERNMENT AND PRIVATE SECTORS WILL NEED MORE SPECIALIZED SKILLS TO DESIGN, MANAGE, OR ADMINISTER MORE EFFICIENT -- BUT MORE COMPLEX -- FINANCING SCHEMES. ACCESS TO U.S. BUSINESS EXPERTISE IN HEALTH FINANCE AND MANAGEMENT, AS WELL AS POTENTIAL INVESTMENT AND TRADING PARTNERS, NEEDS TO BE STRENGTHENED.

UNLESS PHILIPPINE CAPABILITIES GROW IN THESE AREAS, THE STUDIES AND DEMONSTRATIONS PROPOSED IN THE PID COULD BE COMPLETED SUCCESSFULLY, BUT THE PROJECT WOULD NOT HAVE MUCH IMPACT ON THE ROLE OF GOVERNMENT, NOR WOULD IT SET IN MOTION A CONTINUING PROCESS FOR SECTORAL REFORM. THE PID APPROACH WILL BUILD CAPACITY TO SOME EXTENT, BUT WE SEE A NEED FOR EXPLICIT CAPACITY-BUILDING INPUTS IN PARALLEL WITH THE STUDY AND DEMONSTRATION INPUTS THE PID PROPOSES.

THERE ARE OTHER ELEMENTS WHICH ARE IMPLIED BY THE PID, BUT WHICH DESERVE GREATER EMPHASIS. IN ADDITION TO DEVELOPING A FAVORABLE CLIMATE FOR INVESTMENT, THE PROJECT SHOULD ALSO PROVIDE TA AND FUNDING FOR FEASIBILITY STUDIES AND BUSINESS PLANS WHICH COULD LEAD TO PHILIPPINE AND U.S. INVESTMENT IN HEALTH SERVICES, FACILITIES, OR INPUT INDUSTRIES. IF THE GOVERNMENT WISHES TO CONTRACT FOR PRIVATE INSURANCE FOR THE POOR OR

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TO CONTRACT OUT MEDICARE I COVERAGE TO PRIVATE COMPANIES, IT WILL NEED TO PURCHASE OR PROVIDE FOR REINSURANCE COVERAGE. OTHERWISE COMPANIES WILL FEEL THAT EXTENDING COVERAGE TO THESE NEW GROUPS IS TOO RISKY. THEREFORE, SUCH COVERAGE SHOULD BE CONSIDERED UNDER THE RISK MANAGEMENT COMPONENT OF THE PROJECT.

PRIVATIZATION OF HOSPITALS TOO, IS A COMPLEX UNDERTAKING. FOR EXAMPLE, THE PRIVATIZATION OF SINGAPORE GENERAL HOSPITAL WAS CONTRACTED OUT AT DOS 5 MILLION FOR TECHNICAL SUPPORT OVER FOUR AND ONE-HALF YEARS TO ADAPT INFORMATION AND COST ACCOUNTING SYSTEMS, TRAIN MANAGERS AND OPERATORS, AND OTHER NECESSARY

ACTIVITIES. THIS IS A PARTICULARLY LARGE (1,600 BEDS) AND COMPLEX EXAMPLE. IN THE EGYPT COST RECOVERY PROJECT NEARLY DOLS 1 MILLION WERE ALLOWED PER HOSPITAL. THE PROJECT SHOULD ALLOW FUNDS TO COVER SUCH CHANGE-OVER COSTS. SOME FUNDS SHOULD ALSO BE ALLOWED FOR SELECTED MEDICAL TECHNOLOGY TRANSFER TO IMPROVE EFFICIENCY. ALSO EXPERIENCE ELSEWHERE HAS SHOWN THAT ULTIMATELY THE RESTRUCTURING OF AN ENTIRE PROVINCE (INDONESIA) MAY BE NECESSARY TO TEST THE WHOLE STRUCTURE OF INCENTIVES AND DEMONSTRATE THE FEASIBILITY OF REFORM TO A BROAD CONSTITUENCY. WHILE NOT ALL DEMONSTRATIONS WOULD BE COSTLY, THESE INTERVENTIONS WOULD REQUIRE MORE TIME, MONEY AND ATTENTION THAN THE PID PROVIDES.

4. MISSION'S FAX ADDITIONS: WE APPRECIATE MISSION RESPONSE TO A DRAFT OF THIS CABLE. WE BELIEVE THE MISSION'S FAX OF MARCH 7 OFFERS A REASONABLE APPROACH TO INCORPORATING ADDITIONAL ELEMENTS NEEDED FOR PROGRAM SUCCESS.

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FEASIBILITY STUDIES AND BUSINESS PLANS, CHANGE OVER FUNDS FOR PRIVATIZATION EFFORTS, A RISK MANAGEMENT COMPONENT AND TECHNOLOGY TRANSFER FOR IMPROVED EFFICIENCIES IN PROVIDING HEALTH SERVICES, THE MISSION HAS CONSIDERABLY STRENGTHENED THE PID-LEVEL DESIGN. THE FAX ALSO ADDS A MOST IMPORTANT MISSING ELEMENT, CAPACITY BUILDING OF THE DEPARTMENT OF HEALTH IN HEALTH CARE FINANCING. IN ADDING SUCH ACTIVITIES, WE SHARE THE MISSION DIRECTOR'S CONCERN THAT THEY BE QUOTE, SAFE UNQUOTE INVESTMENTS, I.E. SUSTAINABLE IN THEIR OWN RIGHT. HOWEVER, WE CONSIDER IT MORE IMPORTANT THAT THE END OF PROGRAM STATUS RESULT IN A GOVERNMENTAL CAPACITY TO ENCOURAGE A HEALTH MARKET PLACE TO STIMULATE AFFORDABLE FINANCING SCHEMES AND PRIVATE PROVISION OF SERVICES. IT IS IMPORTANT THEREFORE, THAT PHASE I ACTIVITIES ESTABLISH A FIRM FOUNDATION OR EXPERIENTIAL BASE WHICH ENCOURAGES THE GOVERNMENT TO CONTINUE ITS EFFORTS TO RESTRUCTURE HEALTH CARE PROVISION ON A FINANCIALLY SUSTAINABLE BASIS.

5. NEED FOR ADDITIONAL RESOURCES: THE MARCH 7 FAX WHICH INCLUDES ADDITIONAL PROJECT ACTIVITIES IMPLIES A NEED FOR ADDITIONAL RESOURCES WHICH WILL BE ACCOMMODATED THROUGH A PHASED PROGRAM APPROACH. WE ACCEPT THIS APPROACH, BUT REQUEST THAT THE MISSION ADVISE AID/W AS

TO WHICH ACTIVITIES WILL BE INCLUDED IN PHASE I AND WHICH IN PHASE II.

BECAUSE IT WILL BRING ABOUT POLICY REFORM, STIMULATE PRIVATE SECTOR DEVELOPMENT, AND DEVELOP LINKAGES WITH THE U.S. PRIVATE SECTOR, THE PROJECT CERTAINLY QUALIFIES UNDER MAI OBJECTIVES. FOR THIS REASON, THE PP DESIGN PROCESS MAY CONSIDER SAI FUNDING FOR THIS PROJECT. THE MISSION MAY ALSO CONSIDER A MIXED PROGRAM MODE IF IT SEEMS APPROPRIATE FOR ANY OF THE COMPONENTS.

6. GOAL AND PURPOSE: THE PROJECT GOAL AND PURPOSE IN THE LOGFRAME (PID ANNEX 1) SHOULD BE RESTATED.

WHILE IMPROVING HEALTH STATUS IS AN OVERALL HEALTH SECTOR GOAL, THE PROJECT GOAL SHOULD BE MORE SPECIFIC AS TO THE CONTRIBUTION OF THIS PARTICULAR PROJECT. A BETTER PROJECT-LEVEL GOAL STATEMENT COULD BE TO DEVELOP THE HEALTH CARE MARKET PLACE IN ORDER TO IMPROVE QUALITY, EQUITY, COVERAGE, AND EFFICIENCY, AND INCREASE PRIVATE PARTICIPATION.

THE PROJECT PURPOSE STATEMENT SHOULD FOCUS ON HOW PHASE I ACTIVITIES WILL CONTRIBUTE TO THIS GOAL. FOR EXAMPLE, TO SET IN PLACE A PROCESS FOR FORMULATING AND IMPLEMENTING HEALTH SECTOR POLICIES, REGULATIONS, STANDARDS, AND LEGISLATION. (ALTHOUGH INCREASING PRIVATE INVESTMENT IN THE SECTOR WOULD BE AN OBJECTIVE, WE ALSO SEEK TO CONTROL THE COSTS TO GOVERNMENT, EMPLOYERS AND THE PUBLIC OF SERVICES AND INSURANCE.) THIS SHOULD BE REFINED IN FINAL PP DESIGN AROUND MEASURABLE OBJECTIVES, OR END OF PROJECT STATUS (EOPS).

INDICATING THAT A SUSTAINABLE PROCESS HAS BEEN SET IN
OTION. THE PROJECT OUTPUT SECTION SHOULD BE REVISED
CCORDINGLY.

INALLY IN ADDITION TO NORMAL PROJECT EVALUATIONS, THE
P SHOULD INDICATE HOW THE MISSION PLANS TO MONITOR
PERFORMANCE PERIODICALLY TOWARD THE REVISED GOAL AND
URPOSE. AS A MINIMUM THIS SECTION WOULD IDENTIFY THE
VARIABLES SELECTED TO MEASURE PERFORMANCE HOW AND WHEN
VARIABLES WILL BE MEASURED (SEMIANNUALLY, YEARLY), AND
WHO WILL UNDERTAKE MEASUREMENT (THE MISSION OR OUTSIDE
CONTRACTOR).

7. ENVIRONMENTAL ACTION: SEPTEL WILL ADVISE OF ENE

COORDINATOR ACTION ON THE IEE (PID ANNEX 3). BAKER

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ORIGIN: AID-3 INFO: AMB DCM AA ECON RA/S (OD DRM OPEN -2 C&R- 3)

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UNCLAS SECTION 01 OF 04 MANILA 16931

CLASS: UNCLASSIFIED
CHRG: AID 07/28/91
APPRV: OD: JAPATTERSON
DRFTD: OPEN: PMOSER: FCS
CLEAR: L.OPEN: EVOULGAR
OS
2.DRM: GIMEOFF
3.OIA: LCHILES
DISTR: AID (OD LRM
OPEN-2 C&R-3)
ORGIN: OGR

AIDAC

FOR ENE/TR, APRE/TR

E.O.: 12356: N/A.
SUBJECT: HEALTH FINANCE DEVELOPMENT PROJECT (HFD)
(492-2446) - PID APPROVAL RESPONSE

REF: STATE 174199

SUMMARY:

1. USAID/MANILA PROVIDES FOLLOWING IN RESPONSE TO REF ENE CABLE AND AS AN INFORMATIONAL CABLE ON HFD PROJECT FOR APRE.
2. USAID/MANILA APPRECIATES ENE REF COMMENTS IN SUPPORT OF HFD DESIGN AND MISSION APPROACH TO PARTICIPATION IN RESTRUCTURING OF PHILIPPINES HEALTH SECTOR. PROJECT DESIGN HAS EVOLVED OVER THE PAST 12 MONTHS AND HAS INCORPORATED BUREAU SUGGESTIONS ALONG WITH RESULTS OF MISSION GOP/PRIVATE SECTOR SERIES OF DIALOGUES. THE FOLLOWING PROVIDES FOLLOW-UP ON ISSUES IN REF WITH SPECIAL EMPHASIS ON PROJECT PHASING AS REQUESTED IN PARA 1.B. PHASE I IS THE \$20M HFD PROJECT. PHASE II IS PROPOSED AS A \$30M HFD PROGRAM TO BE AUTHORIZED IN FY 93. ALL OTHER ISSUES RAISED IN PARA 3-6 OF REF HAVE BEEN ADDRESSED AS NARRATED BELOW. MISSION REQUESTS ENE CONCURRENCE IN TWO PHASED DESIGN APPROACH AS SOON AS POSSIBLE. END SUMMARY.
3. AS PER REF PARA 1, MISSION VIEWS HFD AS INITIAL AND CRITICAL STAGE IN ASSISTANCE TARGETED AT LONG-TERM RESTRUCTURING OF HEALTH SECTOR FINANCE TO (A) MORE EFFICIENTLY PROVIDE SERVICES AND (B) PARTICIPATE MORE FULLY AS A PRODUCTIVE SECTOR IN THE ECONOMY. THE RESTRUCTURING OF HEALTH SECTOR FINANCE WILL REQUIRE A SUPPORTING POLICY, REGULATORY AND LEGISLATIVE FRAMEWORK TO SUSTAIN THE CHANGES, IMPROVEMENTS AND REFORMS THAT WILL DRIVE THE RESTRUCTURING. USAID PROPOSES A PHASED APPROACH. PHASE I WILL PROVIDE PROJECTIZED ASSISTANCE TO IDENTIFY AND DEMONSTRATE THE FEASIBILITY OF SPECIFIC IMPROVEMENTS AND REFORMS OF THE HEALTH FINANCING SYSTEM REQUIRED TO RESTRUCTURE HEALTH SECTOR FINANCE; ESTABLISH THE POLICIES, REGULATIONS AND LEGISLATION THAT WILL

ENABLE AND SUSTAIN THE RESTRUCTURING; AND DEVELOP THE MANPOWER AND TECHNICAL CAPACITIES TO MANAGE AND IMPLEMENT THE REFORMS. PHASE II WOULD PROVIDE PROGRAM ASSISTANCE TO INSTITUTIONALIZE AND REPLICATE SUBSETS OF THESE REFORMS IN COMPREHENSIVE PACKAGES THAT DEMONSTRATE THE EFFICIENCY AND EFFECTIVENESS OF THE RESTRUCTURING IN FINANCING AND DELIVERING OF HEALTH SERVICES.

4. PHASE I: PHASE I OF THIS ACTIVITY IS A PROPOSED FIVE YEAR, \$20M PROJECTIZED GRANT PACKAGE FOCUSSED ON CAPACITY DEVELOPMENT, TECHNOLOGY TRANSFER, RESEARCH, AND DEMONSTRATION PROJECTS. WITH REGARD TO COMMENTS RAISED IN REF PARA 6, THE GOAL STATEMENT FOR PHASE I HAS BEEN MODIFIED TO REFLECT THE SUGGESTED CHANGES. THE PROJECT GOAL IS TO DEVELOP THE HEALTH CARE MARKET IN ORDER TO IMPROVE HEALTH SERVICE QUALITY, EQUITY COVERAGE, EFFICIENCY AND PRIVATE PARTICIPATION.

5. THE PURPOSE OF PHASE I IS TO ESTABLISH IN THE PHILIPPINES HEALTH SECTOR A PROCESS FOR FORMULATING AND IMPLEMENTING ECF POLICIES, REGULATIONS, AND LEGISLATION SUPPORTIVE OF HEALTH CARE MARKET IMPROVEMENT. "END OF PROJECT" PURPOSE-LEVEL INDICATORS FOR THIS INITIAL PHASE WILL INCLUDE PLURALISTIC DEVELOPMENT AND DEMONSTRATION OF A CORE SET OF MARKET-ORIENTED POLICIES WHICH WILL SERVE AS THE FOUNDATION FOR HEALTH SECTOR FINANCE RESTRUCTURING. THIS WILL INCLUDE POLICIES IN THE FOLLOWING ARENA:

- (A) THE HEALTH REGULATORY AND POLICY ROLE OF THE DOH AND OTHER PUBLIC SECTOR INSTITUTIONS;
- (B) MEDICARE I REFORMS AND PRIVATE SECTOR PARTICIPATION;
- (C) BROADER USE OF RISK-SHARING MECHANISMS IN FINANCING AND PROVISION OF HEALTH SERVICES; AND
- (D) REORGANIZATION/DIVESTITURE OF THE DEPARTMENT OF HEALTH DELIVERY SYSTEM FOR HOSPITAL CARE.

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OVERRIDING THEMES DRIVING PHASE I OF THE PROJECT AND
USAID'S STRATEGIC APPROACH TO THE HEALTH SECTOR INCLUDE:

- A. PRIVATIZATION: PROMOTION OF PRIVATE SECTOR
- INVESTMENT IN AND PROVISION AND FINANCING OF
- HEALTH SERVICES, THIS INCLUDES IMPROVING THE
- REGULATORY AND POLICY ENVIRONMENT FOR PRIVATE
- HEALTH SECTOR GROWTH; PRIVATIZATION OF PUBLIC
- SECTOR SECONDARY AND TERTIARY CARE
- INSTITUTIONS; PROMOTION OF PRIVATE FINANCIAL
- RISK-BEARING MECHANISMS FOR HEALTH SERVICES;
- AND THE USE OF PRIVATE SECTOR FOR RESEARCH,
- TRAINING, AND OTHER POLICY PROCESS NEEDS
- THROUGH DOE CONTRACTING.

- B. DECENTRALIZATION: FINDING LOCAL GOVERNMENT
- REGULATION WILL GREATLY ALTER THE ROLE AND
- STRUCTURE OF THE DOH. THIS PROVIDES AN
- OPPORTUNITY TO GAIN HEADWAY IN CONVERTING THE
- ROLE OF THE DOH FROM ADMINISTERING AND
- PROVIDING SERVICES TO REGULATING THE BROADER
- HEALTH MARKET TO IMPROVE ITS EFFICIENCY AND
- FUNCTIONING. PHASE I WILL ALSO PROVIDE
- LIMITED SUPPORT FOR DEMONSTRATION
- SCHEMES AT A DECENTRALIZED LEVEL; THEREBY
- BUILDING CAPACITY AT THE DOH TO ENCOURAGE,
- EVALUATE, AND POTENTIALLY REPLICATE LOCALLY
- PLANNED, MANAGED AND IMPLEMENTED COMPREHENSIVE
- HEALTH SERVICES.

- C. DATA-BASED DECISION MAKING: AN OVERRIDING
- THEME OF THE PROJECT COMPONENTS IS THE
- ROUTINE COLLECTION AND USE OF HEALTH SECTOR
- DATA IN POLICY/REGULATION DEVELOPMENT AND
- MONITORING. MANY OF THE PROPOSED DATA RELATED
- TASKS REQUIRE THE REORGANIZATION OF DATA
- CURRENTLY COLLECTED FOR ADMINISTRATIVE PURPOSES
- INTO MORE USEFUL STRUCTURES FOR POLICY
- FORMULATION AND MONITORING, AS WELL AS CAPACITY
- BUILDING IN THE ANALYSIS AND UTILIZATION OF THIS
- DATA.

- D. TECHNOLOGY TRANSFER/CAPACITY DEVELOPMENT: THE
- GOP IS EMBARKING ON A MASSIVE TASK IN
- OVERHAULING THE ROLE OF THE PUBLIC SECTOR IN
- THE NATIONAL HEALTH MARKET. PHASE I OF THE
- HFD REPRESENTS DISCREET AND CRITICAL AREAS

- WITHIN THIS PROCESS IN WHICH WE HAVE
- DETERMINED, WITH ENR ASSISTANCE, USAID
- ACCESS TO U.S. TECHNICAL AND TRAINING
- RESOURCES PROVIDES UNIQUE ADVANTAGES FOR
- U.S. HEALTH ASSISTANCE. THESE INCLUDE THE
- MARKETING OF PRIVATE HEALTH INSURANCE AND
- REINSURANCE MECHANISMS; MOVEMENT TOWARD
- MANAGED CARE STRUCTURES; HOSPITAL
- INSTITUTIONAL AND SYSTEMS MANAGEMENT
- TECHNOLOGIES; AND COST-CONTAINING REIMBURSEMENT

- - TECHNOLOGIES. THE PROJECT WILL PROVIDE
- - MECHANISMS FOR THE GOP AND THE PRIVATE SECTOR
- - TO ACCESS THESE TECHNOLOGIES AND OTHER U.S.
- - HEALTH BUSINESS EXPERTISE. IN ADDITION, USE
- - OF U.S. RESOURCES TO DEVELOP THE TRAINING
- - CAPACITIES OF LOCAL INDIVIDUALS AND FIRMS IN
- - NEW AREAS OF SPECIALIZATION NEEDED FOR MORE
- - COMPLEX ORGANIZATION OF THE SECTOR WILL BE
- - EMPHASIZED.

7. PHASE I HFD PROJECT OUTPUTS IDENTIFIED AT THIS POINT IN PROJECT PAPER DEVELOPMENT AND RESPECTIVE OUTPUT INDICATORS ARE:

- (A) OUTPUT I - INSTITUTIONALIZED CAPACITY FOR
- TRANSPARENT AND RESEARCH-BASED HEALTH FINANCE
 - POLICY FORMULATION.
 - INDICATORS: FORMULATION OF HEALTH FINANCE POLICY
 - STEERING COMMITTEE, DEVELOPMENT OF MULTISECTORAL
 - HEALTH FINANCE POLICY FORUM, HEALTH FINANCING POLICY
 - FRAMEWORK AND RESEARCH AGENDA, AND RESEARCH AND
 - TRAINING CAPACITIES.

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- (B) OUTPUT II - IMPROVED EFFICIENCY AND EXPANDED COVERAGE OF NATIONAL ECF MECHANISMS.
- INDICATORS: IMPROVED ADMINISTRATION OF AND COVERAGE IN MEDICARE I PROGRAM, AND PROMOTION AND ESTABLISHMENT OF PRIVATE FINANCIAL RISK SHARING MECHANISMS.

- (C) OUTPUT III - IMPROVED EFFICIENCY IN THE HOSPITAL SECTOR THROUGH HOSPITAL FINANCING REFORMS.
 - INDICATORS: HOSPITAL DATABASE; DEMONSTRATED ALTERNATIVES TO PUBLIC SECTOR HOSPITAL MANAGEMENT, OWNERSHIP, AND FINANCING; IMPROVED INVESTMENT ENVIRONMENT FOR PRIVATE HOSPITALS; AND IMPROVEMENTS IN HOSPITAL MANAGEMENT TECHNOLOGIES.
- UNCLASSIFIED

8. PHASE II. AS AN ADJUNCT TO DEVELOPMENT OF POLICIES AND IMPLEMENTATION STRATEGIES AS PER ABOVE PARA 5 (A-D) IN PHASE I, MISSION WILL EXAMINE CONCURRENT IMPLEMENTATION OF PHASE II OF THE HFD BEGINNING YEAR THREE (FY 94) OF THE PROJECT. PHASE II WOULD CONSIST LARGELY OF PROGRAM ASSISTANCE SUPPORT FOR THE BROADER IMPLEMENTATION AND INSTITUTIONALIZATION OF THESE POLICIES AND DEMONSTRATED CHANGES, IMPROVEMENTS AND REFORMS OF THE HEALTH SECTOR. \$30M IN FY 95 AND BEYOND FUNDS ARE BEING PROPOSED FOR THIS HFD ACTIVITY.

9. END OF PHASE II INDICATORS WOULD INCLUDE: (A) RESTRUCTURED HOSPITAL SECTOR WITH NON-DOE OWNERSHIP AND LARGELY PRIVATE SECTOR MANAGEMENT, GOVERNANCE, AND FINANCING OF PREVIOUSLY PUBLIC INSTITUTIONS; (B) INCREASED PRIVATE INVESTMENT IN THE HEALTH SECTOR; AND (C) EXPANDED PARTICIPATION IN HEALTH FINANCING RISK-SHARING SCHEMES.

10. PHASE II PROGRAM ASSISTANCE WOULD BE DISBURSED AGAINST A MATRIX OF POLICY AND ADMINISTRATIVE CHANGES LEADING TO ATTAINMENT OF SECTORAL POLICY AND PERFORMANCE BENCHMARKS. PHASE II WOULD BE A FIVE YEAR EFFORT, PROVIDING A USAID COMMITMENT TO THE HEALTH SECTOR RESTRUCTURING PROCESS FOR A TOTAL OF SEVEN YEARS.

11. CURRENT DISCUSSIONS REGARDING PHASE II HAVE HIGHLIGHTED THE FOLLOWING TENTATIVE POLICY AGENDA:

- (A) NEW ICB ROLE:
 - FRAMEWORK FOR INSTITUTIONALIZATION OF DCH AS THE LEAD AGENCY FOR POLICY DEVELOPMENT, WITH FOLLOWING FUNCTIONS:
 - HEALTH STATUS ASSESSMENT;
 - COORDINATION/COORDINATION OF HEALTH RESOURCES;
 - SETTING HEALTH SERVICES STANDARDS; AND
 - ADMINISTERING HEALTH FINANCING FOR THE POOR.
- (B) NATIONAL HEALTH FINANCING POLICY:
 - REVIEW OF MANDATED HEALTH FUNDS AND PRIVATE CONTRIBUTIONS;
 - REVIEW OF PUBLIC AND PRIVATE SECTOR HEALTH

- - FINANCING RESOURCES; IMPROVED POLICY
- - ENVIRONMENT FOR FINANCING OF PREVENTIVE SERVICES.

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- (C) POLICY FOR RESTRUCTURING DOH HOSPITALS:
- - INCREASED PRIVATE MANAGEMENT STRUCTURE;
- - GOVERNANCE BY PRIVATE/PUBLIC BOARD;
- - FEE RETENTION;
- - COMMUNITY/LOCAL GOVERNMENT/PRIVATE OWNERSHIP.

12. EXAMPLES OF MEASURES OF POLICY IMPLEMENTATION WHICH WOULD BE USED AS BENCHMARKS FOR DISBURSEMENT FOR THE INITIAL TWO YEARS OF PROGRAM ASSISTANCE (YEARS 3 AND 4 OF PROJECT ASSISTANCE) INCLUDE THOSE LISTED BELOW. AS PER REF, PLEASE NOTE THAT IN RECOGNITION OF THE COSTS AND TIME REQUIRED FOR PRIVATIZATION OF DOH INSTITUTIONS, USAID PROPOSES PROTOTYPE DEVELOPMENT AND DEMONSTRATION OF RESTRUCTURED INSTITUTIONS UNDER PHASE I OF HEALTH FINANCE DEVELOPMENT ASSISTANCE. DEMONSTRATION OF THE PROTOTYPE ON A PROVINCIAL OR REGIONAL BASIS WOULD BE INCLUDED IN PHASE II.

(A) YEAR 3 (FY 94): APPROVAL OF THE PROGRAM POLICY MATRIX AND OTHER PROGRAM RELATED CONDITIONS PRECEDENT

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INCLUDING:

APPROVED NATIONAL HEALTH POLICY FRAMEWORK AND POLICY AGENDA WITH CLEARLY DEFINED NEW DOH ROLE;

GOP POLICY FOR INCLUSION OF OUTPATIENT PREVENTIVE AND FAMILY PLANNING SERVICES IN MANDATED HEALTH FUNDS;

GOP POLICY AND PLAN FOR IMPLEMENTATION FOR UNIFICATION OF MANDATED HEALTH BENEFITS FUNDS;

DOH POLICY AND LEGISLATIVE FRAMEWORK FOR RESTRUCTURING OF PUBLIC HOSPITALS, PLAN FOR IMPLEMENTATION, AND IDENTIFICATION OF PRIORITY INSTITUTIONS/ACTIONS.

(B) YEAR 4 (FY 95):

DOH DECENTRALIZED, AREA WIDE (PROVINCIAL/REGIONAL) HEALTH DEMONSTRATION SCHEME LINKING ALTERNATIVE FINANCING AND SERVICES PROVISION SCHEMES INITIATED TO TEST STRUCTURE OF INCENTIVES AND DEMONSTRATE FEASIBILITY OF REFORM;

GOP ENDOWMENT OF PRIVATE HEALTH POLICY RESEARCH INSTITUTE ON MATCHING BASIS;

MEDICARE POLICY ON REIMBURSEMENT FOR SELECTED OUT-PATIENT PREVENTIVE AND FAMILY PLANNING SERVICES;

LABOR CODE INCLUDES PROVISION OF OUTPATIENT PREVENTIVE AND FAMILY PLANNING SERVICES FOR COVERED POPULATION.

13. EXACT INDICATORS AND TARGETS AND ADDITIONAL YEAR BENCHMARKS WILL BE DEVELOPED DURING INITIAL TWO YEARS OF HFD PROJECT. AN UPDATE ON PROGRESS IN THIS AREA WILL BE PROVIDED IN OCTOBER 1992 AT THE CONCLUSION OF THE INITIAL YEAR OF THE HFD PROJECT.

14. DOLLAR AMOUNTS TO BE DISBURSED AND MECHANISMS OF DISBURSEMENT WOULD DEPEND ON THE NEED FOR (A) OFFSETTING SHORT-RUN COSTS OF REFORM AND/OR (B) INCENTIVES REQUIRED FOR LEVERAGING CHANGES OUTSIDE THE DOH STRUCTURE. SIZE, CONTENT, AND LENGTH OF THE REFORM PACKAGE WILL DEPEND ON AVAILABILITY OF USAID RESOURCES AND CONTINUED COMMITMENT OF GOP TO SECTORAL REFORM.

15. MISSION IS REVIEWING MEANS OF INCREASING THE LEVERAGE OF THE PROGRAM ASSISTANCE PACKAGE THROUGH (A) REVIEW OF OPTIONAL RECIPIENTS AND POTENTIAL FOR DECENTRALIZED PROVISION OF PROGRAM GRANTS AND (B) EARLY DISCUSSIONS WITH OTHER POTENTIAL HEALTH SECTOR DONORS.
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Annex E
Statutory Checklist

5C(2) - ASSISTANCE CHECKLIST

Listed below are statutory criteria applicable to the assistance resources themselves, rather than to the eligibility of a country to receive assistance. This section is divided into three parts. Part A includes criteria applicable to both Development Assistance and Economic Support Fund resources. Part B includes criteria applicable only to Development Assistance resources. Part C includes criteria applicable only to Economic Support Funds.

CROSS REFERENCE: IS COUNTRY CHECKLIST UP TO DATE

A. CRITERIA APPLICABLE TO BOTH DEVELOPMENT ASSISTANCE AND ECONOMIC SUPPORT FUNDS

1. Host Country Development Efforts (FAA Sec. 601(a)): Information and conclusions on whether assistance will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture, and commerce; and (f) strengthen free labor unions.

2. U.S. Private Trade and Investment (FAA Sec. 601(b)): Information and conclusions on how assistance will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).

Yes, Country Checklist is included in Annex C of the PEPS PAAD dated July 1991.

a. No
b. Yes. Private initiatives and competition in the health care financing sector are major considerations in project implementation.

c. Yes. The development of health care financing mechanisms include the use of cooperatives and private associations.

d. N/A

e. Yes, to the extent that commerce and industry are utilized to provide goods and services to the health finance sector.

f. N/A

The project has a budget of \$6M for U.S. technical assistance services.

3. Congressional Notification

a. General requirement (FY 1991 Appropriations Act Secs. 523 and 591; FAA Sec. 634A): If money is to be obligated for an activity not previously justified to Congress, or for an amount in excess of amount previously justified to Congress, has Congress been properly notified (unless the notification requirement has been waived because of substantial risk to human health or welfare)?

A Congressional Notification was submitted to Congress on 3/13/91; the waiting period expired without Congressional obligation on 6/22/91.

b. Notice of new account obligation (FY 1991 Appropriations Act Sec. 514): If funds are being obligated under an appropriation account to which they were not appropriated, has the President consulted with and provided a written justification to the House and Senate Appropriations Committees and has such obligation been subject to regular notification procedures?

N/A

c. Cash transfers and nonproject sector assistance (FY 1991 Appropriations Act Sec. 575(b)(3)): If funds are to be made available in the form of cash transfer or nonproject sector assistance, has the Congressional notice included a detailed description of how the funds will be used, with a discussion of U.S. interests to be served and a description of any economic policy reforms to be promoted?

N/A

4. Engineering and Financial Plans (FAA Sec. 611(a)): Prior to an obligation in excess of \$500,000, will there be: (a) engineering, financial or other plans necessary to carry out the assistance; and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?

a. Yes

b. Yes

5. Legislative Action (FAA Sec. 611(a)(2)): If legislative action is required within recipient country with respect to an obligation in excess of \$500,000, what is the basis for a reasonable expectation that such action will be completed in time to permit orderly accomplishment of the purpose of the assistance? N/A
6. Water Resources (FAA Sec. 611 (b); FY 1991 Appropriations Act Sec. 501): If project is for water or water-related land resource construction, have benefits and costs been computed to the extent practicable in accordance with the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq.)? (See A.I.D. Handbook 3 for guidelines.) N/A
7. Cash Transfer and Sector Assistance (FY 1991 Appropriations Act Sec. 575(b)): Will cash transfer or nonproject sector assistance be maintained in a separate account and not commingled with other funds (unless such requirements are waived by Congressional notice for nonproject sector assistance)? N/A
8. Capital Assistance (FAA Sec. 611(e)): If project is capital assistance (e.g., construction), and total U.S. assistance for it will exceed \$1 million, the Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability to maintain and utilize the project effectively? N/A
9. Multiple Country Objectives (FAA Sec. 601(a)): Information and conclusions on whether projects will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; and (c) encourage Refer to 5C(2)A.1.

development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.

10. U.S. Private Trade (FAA Sec. 601(b)): Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).

Refer to 5C(2)A.2.

11. Local Currencies

a. Recipient Contributions (FAA Secs. 612(b), 636(h)): Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars.

The host country contribution consists of 25% of project cost.

b. U.S. -Owned Currency (FAA Sec. 612(d)): Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?

No.

c. Separate Account (FY 1991 Appropriations Act Sec. 575). If assistance is furnished to a foreign government under arrangements which result in the generation of local currencies:

N/A

(1) Has A.I.D. (a) required that local currencies be deposited in a separate account established by the recipient government, (b) entered into an agreement with that government providing the amount of local currencies to be generated and the

terms and conditions under which the currencies so deposited may be utilized, and (c) established by agreement the responsibilities of A.I.D. and that government to monitor and account for deposits into and disbursements from the separate account?

(2) Will such local currencies, or an equivalent amount of local currencies, be used only to carry out the purposes of the DA or ESF chapters of the FAA (depending on which chapter is the source of the assistance) or for the administrative requirements of the United States Government?

(3) Has A.I.D. taken all appropriate steps to ensure that the equivalent of local currencies disbursed from the separate account are used for the agreed purposes?

(4) If assistance is terminated to a country, will any unencumbered balances of funds remaining in a separate account be disposed of for purposes agreed to by the recipient government and the United States Government?

12. Trade Restrictions

a. Surplus Commodities (FY 1991 Appropriations Act Sec. 521(a)): If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity?

N/A

b. Textiles (Lautenberg Amendment) (FY 1991 Appropriations Act Sec. 521(c)): Will the assistance (except for programs in Caribbean Basin Initiative countries under U.S. Tariff Schedule (Section

N/A

807," which allows reduced tariffs on articles assembled abroad from U.S.-made components) be used directly to procure feasibility studies, or project profiles of potential investment in, or to assist the establishment of facilities specifically designed for, the manufacture for export to the United States or to third country markets in direct competition with U.S. exports, of textiles, apparel, footwear, handbags, flat goods (such as wallets or coin purses worn on the person), work gloves or leather wearing apparel?

13. Tropical Forests (FY 1991 Appropriations Act Sec. 533(c) (3)): Will funds be used for any program, project or activity which would (a) result in any significant loss of tropical forests, or (b) involve industrial timber extraction in primary tropical forest areas?

N/A

14. Sahel Accounting (FAA Sec. 121(d)): If a Sahel project, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of project funds (either dollars or local currency generated therefrom)?

N/A

15. PVO Assistance

a. Auditing and registration (FY 1991 Appropriations Act Sec. 537): If assistance is being made available to a PVO, has that organization provided upon timely request any document, file, or record necessary to the auditing requirements of A.I.D., and is the PVO registered with A.I.D.?

N/A

b. Funding sources (FY 1991 Appropriations Act, Title II, under heading "Private and Voluntary Organizations"): If assistance is to be made to a United States PVO (other than a cooperative

N/A

development organization), does it obtain at least 20 percent of its total annual funding for international activities from sources other than the United States Government?

16. Project Agreement Documentation (State Authorization Sec. 139 (as interpreted by conference report)): Has confirmation of the date of signing of the project agreement, including the amount involved, been cabled to State L/T and A.I.D. LEG within 60 days of the agreement's entry into force with respect to the United States, and has the full text of the agreement been pouched to those same offices? (See Handbook 3, Appendix 6G for agreements covered by this provision).

Yes. A cable on this has been sent to

on _____.

17. Metric System (Omnibus Trade and Competitiveness Act of 1988 Sec. 5164, as interpreted by conference report, amending Metric Conversion Act of 1975 Sec. 2, and as implemented through A.I.D. policy): Does the assistance activity use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Will A.I.D. specifications use metric units of measure from the earliest programmatic stages, and from the earliest documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage?

N/A

18. Women in Development (FY 1991 Appropriations Act, Title II, under heading "Women in Development"): Will assistance be designed so that the percentage of women participants will be demonstrably increased?

Yes. The project's health care financing will increase equitable access to health insurance among women and other sectors which are not covered by any health financing mechanism.

19. Regional and Multilateral Assistance (FAA Sec. 209): Is assistance more efficiently and effectively provided through regional or multilateral organizations? If so, why is assistance not so provided? Information and conclusions on whether assistance will encourage developing countries to cooperate in regional development programs.

No. The project which will provide grant funds to GOP to improve health care finance policy process, develop health financing mechanisms and institute reforms in the hospital sector, is bilateral in nature.

20. Abortions (FY 1991 Appropriations Act, Title II, under heading "Population, DA," and Sec. 525):

a. Will assistance be made available to any organization or program which, as determined by the President, supports or participates in the management of a program of coercive abortion or involuntary sterilization?

No.

b. Will any funds be used to lobby for abortion?

No.

21. Cooperatives (FAA Sec. 111): Will assistance help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward a better life?

Yes. Project will encourage cooperatives to develop community financing schemes on health care.

22. U.S.-Owned Foreign Currencies

a. Use of currencies (FAA Secs. 612(b), 636(h); FY 1991 Appropriations Act Secs. 507, 509): Describe steps taken to assure that, to the maximum extent possible, foreign currencies owned by the U.S. are utilized in lieu of dollars to meet the cost of contractual and

N/A

other services.

b. Release of currencies (FAA Sec. 612(d)): Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?

No.

23. Procurement

a. Small business (FAA Sec. 602(a)): Are there arrangements to permit U.S. small business to participate equitably in the furnishing of commodities and services financed?

Yes. The project plans to contract with 8(a) or gray amendment firm and encourage open competition for the furnishing of commodities and services.

b. U.S. procurement (FAA Sec. 604(a)): Will all procurement be from the U.S. except as otherwise determined by the President or determined under delegation from him?

Yes.

c. Marine insurance (FAA Sec. 604(d)): If the cooperating country discriminates against marine insurance companies authorized to do business in the U.S., will commodities be insured in the United States against marine risk with such a company?

N/A

d. Non-U.S. agricultural procurement (FAA Sec. 604(e)): If non-U.S. procurement of agricultural commodity or product thereof is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity? (Exception where commodity financed could not reasonably be procured in U.S.)

N/A

e. Construction or engineering services (FAA Sec. 604(g)): Will construction or engineering services be procured from firms of advanced developing countries which are otherwise eligible under Code 941 and which have attained a competitive capability in international markets

N/A

in one of these areas? (Exception for those countries which receive direct economic assistance under the FAA and permit United States firms to compete for construction or engineering services financed from assistance programs of these countries.)

f. Cargo preference shipping (FAA Sec. 603): Is the shipping excluded from compliance with the requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 percent of the gross tonnage of commodities (computed separately from dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S. flag commercial vessels to the extent such vessels are available at fair and reasonable rates?

N/A

g. Technical assistance (FAA Sec. 621 (a)): If technical assistance is financed, will such assistance be furnished by private enterprise on a contract basis to the fullest extent practicable? Will the facilities and resources of other Federal agencies be utilized, when they are particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs?

Yes.

h. U.S. air carriers (International Air Transportation Fair Competitive Practices Act, 1974): If air transportation of persons or property is financed on grant basis, will U.S. carriers be used to the extent such service is available?

Yes.

i. Termination for convenience of U.S. Government (FY 1991 Appropriations Act Sec. 504): If the U.S. Government is a party to a contract for procurement, does the contract contain a provision authorizing termination of such

Yes.

contract for the convenience of the United States?

j. Consulting services (FY 1991 Appropriations Act Sec. 524): If assistance is for consulting service through procurement contract pursuant to 5 U.S.C. 3109, are contract expenditures a matter of public record and available for public inspection (unless otherwise provided by law or Executive Order)?

Yes.

k. Metric conversion (Omnibus Trade and Competitiveness Act of 1988, as interpreted by conference report, amending Metric Conversion Act of 1975 Sec. 2, and as implemented through A.I.D. policy): Does the assistance program use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Will A.I.D. specifications use metric units of measures from the earliest programmatic stages, and from the earliest documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage?

N/A

l. Competitive Selection Procedures (FAA Sec. 601(e)): Will the assistance utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?

Yes.

24. Construction

a. Capital project (FAA Sec. 601(d)): If capital (e.g., construction) project, will U.S. engineering and professional services be used? N/A

b. Construction contract (FAA Sec. 611(c)): If contracts for construction are to be financed, will they be lent on a competitive basis to maximum extent practicable? N/A

c. Large projects, Congressional approval (FAA Sec. 620(k)): If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed \$100 million (except for productive enterprise in Egypt that were described in the Congressional Presentation), or does assistance have the express approval of Congress? N/A

25. U.S. Audit Rights (FAA Sec. 301(d)): If fund is established solely by U.S. contributions and administered by an international organization, does Comptroller General have audit rights? Yes.

26. Communist Assistance (FAA Sec. 620(h)): Do arrangements exist to insure that United States foreign aid is not used in a manner which, contrary to the best interests of the United States, promotes or assists the foreign aid projects or activities of the Communist-block countries? Yes.

27. Narcotics

a. Cash reimbursements (FAA Sec. 483): Will arrangements preclude use of financing to make reimbursements, in the form of cash payments, to persons whose illicit drug crops are eradicated? Yes.

b. Assistance to narcotics traffickers (FAA Sec. 487): Will arrangements take "all reasonable steps" to preclude use of financing to or through individuals or entities which we know or have reason to believe have either: (1) been convicted of a violation of any law or regulation of the United States or a foreign country relating to narcotics (or other controlled substances); or (2) been an illicit trafficker in, or otherwise involved in the illicit trafficking of, any such controlled substance? Yes.

28. Expropriation and Land Reform (FAA Sec. 620(g): Will assistance preclude use of financing to compensate owners for expropriated or nationalized property, except to compensate foreign nationals in accordance with a land reform program certified by the President? Yes.

29. Police and Prisons (FAA Sec. 660): Will assistance preclude use of financing to provide training, advice, or any financial support for police, prisons, or other law enforcement forces, except for narcotics programs? Yes.

30. CIA Activities (FAA Sec. 662): Will assistance preclude use of financing for CIA activities? Yes.

31. Motor Vehicles (FAA Sec. 636(i): Will assistance preclude use of financing for purchase, sale, long-term lease, exchange or guaranty of the sale of motor vehicle manufactured outside U.S., unless a waiver is obtained? Yes.

32. Military Personnel (FY 1991 Appropriations Act Sec. 503): Will assistance preclude use of financing to pay pensions, annuities, retirement pay, or adjusted service compensation for prior or current military personnel? Yes.

33. Payment of U.N. Assessments (FY 1991 Appropriations Act Sec. 505): Will assistance preclude use of financing to pay U.N. assessments, arrearages or dues? Yes.

34. Multilateral Organization Lending (FY 1991 Appropriations Act Sec. 506): Will assistance preclude use of financing to carry out provisions of FAA section 209(d) (transfer of FAA funds to multilateral organizations for lending)? Yes.

35. Export of Nuclear Resources (FY 1991 Appropriations Act Sec. 510): Will assistance preclude use of financing to finance the export of nuclear equipment, fuel, or technology? Yes.

36. Repression of Population (FY 1991 Appropriations Act Sec. 511): Will assistance preclude use of financing for the purpose of aiding the efforts of the government of such country to repress the legitimate rights of the population of such country contrary to the Universal Declaration of Human Rights? Yes.

37. Publicity or Propaganda (FY 1991 Appropriations Act Sec. 516): Will assistance be used for publicity or propaganda purposes designed to support or defeat legislation pending before Congress, to influence in any way the outcome of a political election in the United States, or for any publicity or propaganda purposes not authorized by Congress? No.

38. Marine Insurance (FY 1991 Appropriations Act Sec. 563): Will any A.I.D. contract and solicitation, and subcontract entered into under such contract, include a clause requiring that U.S. marine insurance companies have a fair opportunity to bid for marine Yes.

insurance when such insurance is necessary or appropriate?

39. Exchange for Prohibited Act (FY 1991 Appropriations Act Sec. 569): Will any assistance be provided to any foreign government (including any instrumentality or agency thereof), foreign person, or United States person in exchange for that foreign government or person undertaking any action which is, if carried out by the United States Government, a United States official or employee, expressly prohibited by a provision of United States law?

No.

country's intellectual resources to encourage institutional development; and supports civic education and training in skills required for effective participation in governmental and political processes essential to self-government.

5. Economic Development (FAA Sec. 101(a)): Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth

6. Special Development Emphases (FAA Secs. 102(b), 113, 281(a)): Describe extent to which activity will: (a) effectively involve the poor in development by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology; dispersing investment from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using appropriate U.S. institutions; (b) encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women's status; and (e) utilize and encourage regional cooperation by developing countries.

7. Recipient Country Contribution (FAA Secs. 110, 124(d)): Will the recipient country provide at least 25 percent of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)?

a health regulatory and policy role. The project will provide capacity-building opportunities for both public and private sectors in health.

Yes.

Yes.

8. Benefit to Poor Majority (FAA Sec. 128(b)): If the activity attempts to increase the institutional capabilities of private organizations or the government of the country, or if it attempts to stimulate scientific and technological research, has it been designed and will it be monitored to ensure that the ultimate beneficiaries are the poor majority?

Yes, the ultimate beneficiary are the more than 60% Filipinos who have no access to health care financing.

9. Abortions (FAA Sec. 104(f); FY 1991 Appropriations Act, Title II, under heading "Population, DA," and Sec. 535):

a. Are any of the funds to be used for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions?

No.

b. Are any of the funds to be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilizations?

No.

c. Are any of the funds to be made available to any organization or program which, as determined by the President, supports or participates in the management of a program of coercive abortion or involuntary sterilization?

No.

d. Will funds be made available only to voluntary family planning projects which offer, either directly or through referral to, or information about access to, a broad range of family planning methods and services?

No.

e. In awarding grants for natural family planning, will any applicant be discriminated against because of such applicant's religious or conscientious commitment to offer only natural family planning? No

f. Are any of the funds to be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning? No.

g. Are any of the funds to be made available to any organization if the President certifies that the use of these funds by such organization would violate any of the above provisions related to abortions and involuntary sterilization? No.

10. Contract Awards (FAA Sec. 601(e)): Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise? Yes.

11. Disadvantaged Enterprises (FY 1991 Appropriations Act Sec. 567): What portion of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, colleges and universities having a student body in which more than 40 percent of the students are Hispanic Americans, and private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)? The project may consider a large contract with a consortium of U.S. companies and provide for a set-aside for sub-contracts with 8(a) firms.

12. Biological Diversity (FAA Sec. 119(g): Will the assistance: (a) support training and education efforts which improve the capacity of recipient countries to prevent loss of biological diversity; (b) be provided under a long-term condition in which the recipient country agrees to protect ecosystems or other wildlife habitats; (c) support efforts to identify and survey ecosystems in recipient countries worthy of protection; or (d) by any direct or indirect means significantly degrade national parks or similar protected areas or introduce exotic plants or animals into such areas?

a. No.
b. No.
c. No.
d. No.

13. Tropical Forests (FAA Sec. 118; FY 1991 Appropriations Act Sec. 533(c)-(e) & (g)):

a. A.I.D. Regulation 16: Does the assistance comply with the environmental procedures set forth in A.I.D. Regulation 16?

N/A

b. Conservation: Does the assistance place a high priority on conservation and sustainable management of tropical forests? Specifically, does the assistance, to the fullest extent feasible: (1) stress the importance of conserving and sustainably managing forest resources; (2) support activities which offer employment and income alternatives to those who otherwise would cause destruction and loss of forests, and help countries identify and implement alternatives to colonizing forested areas; (3) support training programs, educational efforts, and the establishment or strengthening of institutions to improve forest management; (4) help end destructive slash-and-burn agriculture by supporting stable and productive farming practices;

No.

(5) help conserve forests which have not yet been degraded by helping to increase production on lands already cleared or degraded; (6) conserve forested watersheds and rehabilitate those which have been deforested; (7) support training, research, and other actions which lead to sustainable and more environmentally sound practices for timber harvesting, removal, and processing; (8) support research to expand knowledge of tropical forests and identify alternatives which will prevent forest destruction, loss, or degradation; (9) conserve biological diversity in forest areas by supporting effort to identify, establish, and maintain a representative network of protected tropical forest ecosystems on a worldwide basis; by making the establishment of protected areas a condition of support for activities involving forest clearance or degradation; and by helping to identify tropical forest ecosystems and species in need of protection and establish and maintain appropriate protected areas; (10) seek to increase the awareness of U.S. Government agencies and other donors of the immediate and long-term value of tropical forests; (11) utilize the resources and abilities of all relevant U.S. government agencies; (12) be based upon careful analysis of the alternatives available to achieve the best sustainable use of the land; and (13) take full account of the environmental impacts of the proposed activities on biological diversity?

c. Forest degradation:
will assistance be used for: (1) the procurement or use of logging equipment, unless an environmental assessment indicates that all timber harvesting operations involved will be conducted in an environmentally sound manner and that the proposed

N/A

activity will produce positive economic benefits and sustainable forest management systems; (2) actions which will significantly degrade national parks or similar protected areas which contain tropical forests, or introduce exotic plants or animals into such areas; (3) activities which would result in the conversion of forest lands to the rearing of livestock; (4) the construction, upgrading, or maintenance of roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undergraded forest lands; (5) the colonization of forest lands; or (6) the construction of dams or other water control structures which flood relatively undergraded forest lands, unless with respect to each such activity an environmental assessment indicates that the activity will contribute significantly and directly to improving the livelihood of the rural poor and will be conducted in an environmentally sound manner which supports sustainable development?

d. Sustainable forestry: N/A
If assistance relates to tropical forests, will project assist countries in developing a systematic analysis of the appropriate use of their total tropical forest resources, with the goal of developing a national program for sustainable forestry?

e. Environmental impact statements: N/A
Will funds be made available in accordance with provisions of FAA Section 117(c) and applicable A.I.D. regulations requiring an environmental impact statement for activities significantly affecting the environment?

14. Energy (FY 1991 Appropriations Act Sec. 533(c)): If assistance relates to energy, will such assistance focus on: (a) end-use energy efficiency, least-cost energy planning, and renewable energy resources, and (b) the key countries where assistance would have the greatest impact on reducing emissions from greenhouse gases?

N/A

15. Sub-Saharan Africa Assistance (FY 1991 Appropriations Act Sec. 562, adding a new FAA chapter 10 (FAA Sec. 496)): If assistance will come from the Sub-Saharan Africa DA account, it is: (a) to be used to help the poor majority in Sub-Saharan Africa through a process of long-term development and economic growth that is equitable, participatory, environmentally sustainable, and self-reliant; (b) to be used to promote sustained economic growth, encourage private sector development, promote individual initiatives, and help to reduce the role of central governments in areas more appropriate for the private sector; (c) being provided in accordance with the policies contained in FAA section 102; (d) being provided in close consultation with African, United States and other PVOs that have demonstrated effectiveness in the promotion of local grassroots activities on behalf of long-term development in Sub-Saharan Africa; (e) being used to promote reform of sectoral economic policies, to support the critical sector priorities of agricultural production and natural resources, health, voluntary family planning services, education, and income generating opportunities, to bring about appropriate sectoral restructuring of the Sub-Saharan African economies, to support reform in public administration and

N/A

finances and to establish a favorable environment for individual enterprise and self-sustaining development, and to take into account, in assisted policy reforms, the need to protect vulnerable groups; (f) being used to increase agricultural production in ways that protect and restore the natural resource base, especially food production, to maintain and improve basic transportation and communication networks, to maintain and restore the renewable natural resource base in ways that increase agricultural production, to improve health conditions with special emphasis on meeting the health needs of mothers and children, including the establishment of self-sustaining primary health care systems that give priority to preventive care, to provide increased access to voluntary family planning services, to improve basic literacy and mathematics especially to those outside the formal educational system and to improve primary education, and to develop income-generating opportunities for the unemployed and underemployed in urban and rural areas?

16. Debt-for-Nature Exchange (FAA Sec. 463): If project will finance a debt-for-nature exchange, describe how the exchange will support protection of: (a) the world's oceans and atmosphere, (b) animal and plant species, and (c) parks and reserves; or describe how the exchange will promote: (d) natural resource management, (e) local conservation programs, (f) conservation training programs, (g) public commitment to conservation, (h) land and ecosystem management, and (i) regenerative approaches in farming, forestry, fishing, and watershed management.

N/A

17. Deobligation/Reobligation (FY 1991 Appropriations Act Sec. 515): If deob/reob authority is sought to be exercised in the provision of DA assistance, are the funds being obligated for the same general purpose, and for countries within the same region as originally obligated, and have the House and Senate Appropriations Committees been properly notified?

Not applicable at this time. However, should the need arise, the House and Senate Appropriations Committees will be properly notified.

18. Loans

a. Repayment capacity (FAA Sec. 122(b)): Information and conclusion on capacity of the country to repay the loan at a reasonable rate of interest.

N/A

b. Long-range plans (FAA Sec. 122(b)): Does the activity give reasonable promise of assisting long-range plans and programs designed to develop economic resources and increase productive capacities?

No.

c. Interest rate (FAA Sec. 122(b)): If development loan is repayable in dollars, is interest rate at least 2 percent per annum during a grace period which is not to exceed ten years, and at least 3 percent per annum thereafter?

N/A

d. Exports to United States (FAA Sec. 620(d)): If assistance is for any productive enterprise which will compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20 percent of the enterprise's annual production during the life of the loan, or has the requirement to enter into such an agreement been waived by the President because of a national security interest?

N/A

19. Development Objectives (FAA Secs. 102(a), 111, 113, 281(a)): Extent to which activity will: (1) effectively involve the poor in development, by expanding access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using the appropriate U.S. institutions; (2) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions; (3) support the self-help efforts of developing countries; (4) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (5) utilize and encourage regional cooperation by developing countries?

1) The project seeks to improve efficiency and expand coverage of the national health care financing program and will benefit a significant proportion of the poor population with no health care insurance coverage.

2) Demonstration projects include alternative financing schemes such as community health financing run by cooperatives.

3) N/A

4) Women will be major beneficiaries of the project.

5) N/A

20. Agriculture, Rural Development and Nutrition, and Agricultural Research (FAA Secs. 103 and 103A):

a. Rural poor and small farmers: If assistance is being made available for agriculture, rural development or nutrition, describe extent to which activity is specifically designed to increase productivity and income of rural poor; or if assistance is being made available for agricultural research, has account been taken of the needs of small farmers, and extensive use of field testing to adapt basic research to local conditions shall be made.

N/A

b. Nutrition: Describe extent to which assistance is used in coordination with efforts carried out under FAA Section 104 (Population and Health) to help improve nutrition of the people of developing countries through encouragement of increased production of crops with greater nutritional value; improvement of planning, research, and education with respect to nutrition, particularly with reference to improvement and expanded use of indigenously produced foodstuffs; and the undertaking of pilot or demonstration programs explicitly addressing the problem of malnutrition of poor and vulnerable people.

N/A

c. Food security: Describe extent to which activity increases national food security by improving food policies and management and by strengthening national food reserves, with particular concern for the needs of the poor, through measures encouraging domestic production, building national food reserves, expanding available storage facilities, reducing post harvest food losses, and improving food distribution.

N/A

21. Population and Health (FAA Secs. 104(b) and (c)): If assistance is being made available for population or health activities, describe extent to which activity emphasizes low-cost, integrated delivery systems for health, nutrition and family planning for the poorest people, with particular attention to the needs of mothers and young children, using paramedical and auxiliary medical personnel, clinics and health posts, commercial distribution systems, and other modes of community outreach.

The project will support demonstration projects for alternative low cost health financing schemes to increase efficiency and coverage of national health care financing programs.

22. Education and Human Resources Development (FAA Sec. 105): If assistance is being made available for education, public administration, or human resource development, describe (a) extent to which activity strengthens nonformal education, makes formal education more relevant, especially for rural families and urban poor, and strengthens management capability of institutions enabling the poor to participate in development; and (b) extent to which assistance provides advanced education and training of people of developing countries in such disciplines as are required for planning and implementation of public and private development activities.

N/A

23. Energy, Private Voluntary Organizations, and Selected Development Activities (FAA Sec. 106): If assistance is being made available for energy, private voluntary organizations, and selected development problems, describe extent to which activity is:

N/A

a. concerned with data collection and analysis, the training of skilled personnel, research on and development of suitable energy sources, and pilot projects to test new methods of energy production; and facilitative of research on and development and use of small-scale, decentralized, renewable energy sources for rural areas, emphasizing development of energy resources which are environmentally acceptable and require minimum capital investment;

b. concerned with technical cooperation and development, especially with U.S. private and voluntary, or regional and international development, organizations;

c. research into, and evaluation of, economic development processes and techniques;

d. reconstruction after natural or manmade disaster and programs of disaster preparedness;

e. for special development problems, and to enable proper utilization of infrastructure and related projects funded with earlier U.S. assistance;

f. for urban development, especially small, labor-intensive enterprises, marketing systems for small producers, and financial or other institutions to help urban poor participate in economic and social development.

24. Sahel Development (FAA Secs. 120-21): If assistance is being made available for the Sahelian region, describe: (a) extent to which there is international coordination in planning and implementation; participation and support by African countries and organizations in determining development priorities; and a long-term, multidonor development plan which calls for equitable burden-sharing with other donors; (b) whether a determination has been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of project funds (dollars or local currency generated therefrom).

N/A

C. CRITERIA APPLICABLE TO ECONOMIC SUPPORT FUNDS ONLY

1. Economic and Political Stability (FAA Sec. 531(a)): Will this assistance promote economic and political stability? To the maximum extent feasible, is this assistance consistent with the policy directions, purposes, and programs of Part I of the FAA? Yes
2. Military Purposes (FAA Sec. 531(e)): Will this assistance be used for military or paramilitary purposes? No
3. Commodity Grants/Separate Accounts (FAA Sec. 609): If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made? N/A
4. Generation and Use of Local Currencies (FAA Sec. 531(d)): Will ESF funds made available for commodity import programs or other program assistance be used to generate local currencies? If so, will at least 50 percent of such local currencies be available to support activities consistent with the objectives of FAA sections 103 through 106? N/A
5. Cash Transfer Requirements (FY 1991 Appropriations Act, Title II, under heading "Economic Support Fund," and Sec. 575(b)). If assistance is in the form of cash transfer: N/A
- a. Separate account: Are all such cash payments to be maintained by the country in a separate account and not to be commingled with any other funds?

b. Local currencies:

Will all local currencies that may be generated with funds provided as a cash transfer to such a country also be deposited in a special account, and has A.I.D. entered into an agreement with that government setting forth the amount of the local currencies to be generated, the terms and conditions under which they are to be used, and the responsibilities of A.I.D. and that government to monitor and account for deposits and disbursements?

c. U.S. Government use

of local currencies: Will all such local currencies also be used in accordance with FAA Section 609, which requires such local currencies to be made available to the U.S. government as the U.S. determines necessary for the requirements of the U.S. Government, and which requires the remainder to be used for programs agreed to by the U.S. Government to carry out the purposes for which new funds authorized by the FAA would themselves be available?

d. Congressional notice:

Has Congress received prior notification providing in detail how the funds will be used, including the U.S. interests that will be served by the assistance, and, as appropriate, the economic policy reforms that will be promoted by the cash transfer assistance?

CERTIFICATION PURSUANT TO THE UTILIZATION OF
GRAY AMENDMENT ORGANIZATIONS

I, Malcolm Butler, Director of Agency for International Development in the Philippines, having taken into account the potential involvement of small and/or economically and socially disadvantaged enterprises, do hereby certify that in my judgment the technical assistance required under this program can best be procured through open competition. However, all other factors being equal, preference will be given to firms that submit joint proposals with Gray Amendment-satisfying organizations are anticipated. My judgment is based on the recommendations of the Project and Mission Review Committees.



Malcolm Butler
Director

SEP 13 1991

Date

Annex G
Scope of Work for PSC
(Health Care Financing Consultant)

A. Background

USAID and the Department of Health (DOH) are due to sign a bilateral project on Health Finance Development (HFD) in August 1991. The purpose of the HFD Project is to assist the DOH formulate a National Health Financing Policy which generates equitable access to efficient health services of acceptable quality delivered by private and public providers. The Project will have three interrelated components. Component 1 will develop capacity within DOH for transparent, private/public-sector interactive, and research-based policy formulation process. Component 2 will seek to improve efficiency and expanded coverage of the national health care financing program. Component 3 will seek to improve the efficiency and effectiveness of hospital-based care provided through public and private hospitals.

Technical and administrative oversight for the Project will be provided by a team of long-term resident advisors and a personal services contractor (PSC) in the field of health care financing (HCF). Due to the long lead time involved in contracting for the long-term resident advisors, the HFD project committee has determined that a PSC must be hired as soon as possible so that project momentum is not stalled. This scope of work provides the position description and basic functions of the PSC in health care financing, reporting arrangements, duration of services, and logistical support to be provided.

B. Position Description and Basic Functions

The HCF Consultant will initially be based at the existing Project Coordinating Unit (PCU) of the DOH. He will be based at the Health Policy Unit (HPU) of the DOH as soon as the DOH creates this unit as part of the HFD Project.

The HCF Consultant will have major responsibility for providing technical guidance to DOH, the Philippine Medical Care Commission (PMCC), and private agencies in the implementation of the HFD Project. The job entails providing professional, technical, and advisory services in the identification, design, development, analysis, implementation, monitoring, and evaluation of HFD Project-funded activities.

The basic functions of the HCF Consultant are:

1. To assist the DOH in:

coordinating the tasks of the long-term resident advisors to be hired under the HFD Project;

- * alternative hospital financing and delivery systems including but not limited to privatization of hospital operations, management contracts, corporatization/chain operation of hospitals, and user fee generation and retention; and
 - * policy process and policy instruments required in HCF reform.
3. To act as resource person and participate in workshops, seminars, meetings related to the HFD Project.
 4. To perform other assigned duties related to the HFD Project.

C. Reporting and Logistics

The HCF Consultant will be under the direct supervision of the Undersecretary and Chief of Staff, Department of Health.

The DOH will provide the HCF Consultant with office space, supplies, secretarial/clerical services, and other logistical support required to carry out his/her functions and tasks.

All other logistical support will be provided for as specified in the "General Provisions of Contract with a U.S. Citizen or a U.S. Resident Alien for Personal Services Abroad".

Annex B
Initial Environmental Examination

INITIAL ENVIRONMENTAL EXAMINATION

- (A) PROJECT COUNTRY: Philippines
- (B) ACTIVITY: Health Finance Development Project (492-0446)
- (C) A.I.D. FUNDING: \$20 MILLION
- (D) PERIOD OF FUNDING: . FY 1991 - FY 1996
- (E) STATEMENT PREPARED BY: Fatima S. Verzosa
Fatima S. Verzosa, DRH/DI, USAID/Philippines
- (F) ENVIRONMENTAL ACTION RECOMMENDED: Categorical Exclusion under
A.I.D. Regulation 16, Section
216.2(c)(2)(viii)
- (G) ENVIRONMENTAL OFFICER CLEARANCE: ~~Kevin A. Rushing~~
Kevin A. Rushing, ORAD,
USAID/Philippines
- (H) DECISION OF USAID/PHILIPPINES DIRECTOR
APPROVED: Richard Johnson
DISAPPROVED: _____
DATE: 12/21/90
- (I) DECISION OF ANE ENVIRONMENTAL OFFICER
APPROVED: Ronald
DISAPPROVED: _____
DATE: 5/6/91

EXAMINATION OF THE NATURE, SCOPE AND MAGNITUDE OF THE ENVIRONMENTAL IMPACT

A. Description of Project:

The purpose of the project is to increase resource mobilization, efficiency and quality of health services by improving the processes and institutions for formulating and implementing policy changes in the health sector. The project will finance studies; technical assistance, training and limited commodities. Studies will include health financing demonstration schemes on a pilot basis and the formulation of a Health Sector Policy Framework and a Health Sector Research Agenda.

B. Recommended Environmental Action:

A categorical exclusion from A.I.D.'s Initial Environmental Examination, Environmental Assessment and Environmental Impact Summary requirements is proposed. This proposal is in accordance with A.I.D. Regulation 16, Section 216.2(c)(2)(viii), which provides for such an exclusion for "programs involving nutrition, health care or population and family planning services, except to the extent designed to include activities directly affecting the environment (such as construction of facilities, water supply systems, waste water treatment, etc.)." The proposed project will not include activities of this nature.

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Annex I-1
Technical Analysis

TECHNICAL ANALYSIS

Extensive analytical work has been conducted over the past few years to define the problems of health care financing in the Philippines and identify technically appropriate methods of addressing them. Many of these efforts were funded by USAID through experts' trips, background studies, and seminars and workshops. Some were sponsored by the World Bank, the International Health Policy Program, GTZ, ADB, and other donors. The rest emanated from DOH policymakers. Annex J provides a list of basic references used in the preparation of this Project.

The technologies to be promoted by the Project can be classified into two major groups: one dealing with demand financing, the other with improving provider efficiency and effectiveness. Section 1 of this technical analysis presents critical issues in the choice of financing technology and Project approaches to address them. Similarly, section 2 presents critical issues in the choice of organizational technology and Project approaches to address them.

1. Demand Financing

a. Financing Strategy - The Project seeks to promote prepayment through third-party payment systems such as health insurance, managed care, community financing schemes, employer-provided benefits, and tieups to mandated health funds. The underlying technical premise is to shift the type of health spending from predominantly out-of-pocket (fee-for-service) expenditures to third-party payments. The theoretical and empirical literature indicates that due to the unpredictability of sickness, the substantial financial risks associated with sickness, and high incidence of medical indigency, fee-for-service arrangement is inequitable and unsustainable.

Prepayment through health insurance and managed care arrangements, on the other hand, pools risks and thereby reduces the possibility of large financial loss for each individual arising from catastrophic illness. The risk pool also makes cross-subsidization between upper and lower-income groups possible, thus improving equity in the health system. Managed care systems extend the concept of risk-pooling further: by combining the financing and delivery of health care through capitation, HMOs place providers at risk, thereby establishing a built-in efficiency mechanism in health service delivery.

The government health system funded through taxation presents another financing alternative. Perennial government budget deficits and the generally regressive tax structure in the Philippines, however, make completely tax-funded care an unattractive option. National health service systems, as in the United Kingdom, ultimately lead to medical rationing, which is contrary to the avowed purpose of widening access to health care. The sustainability and equity of the government health delivery system can be improved by increasing third-party payments, with the government paying for the services rendered to the medically indigent.

Although third-party payment is superior to fee-for-service from the viewpoint of equity and sustainability (and in the case of HMOs, possibly efficiency), it is criticized for its tendency to increase costs on account of two major factors: First, third-party payment involves more complex administration and regulation. Second, the breaking up of the financial nexus between patient and doctor engenders problems not encountered in a fee-for-service system.

Fee-for-service is administratively simple as it involves only the patient and the doctor. In addition to these two parties, third-party payment involves a collection entity, a financial regulator, and in the case of HMOs, a service regulator. The administrative and regulatory costs of a third-party payment system can be substantial. Empirical evidence, however, shows that once a third-party payment system achieves optimum scale, the administrative costs begin to decline. What has not been adequately studied is the impact of regulation on health care costs. It appears from the American experience that heavy regulation engenders cost inflation.

Health insurance drives a wedge between the patient and the provider. Shifting the direct burden of payment from the patient to an intermediate agent brings about moral hazard: If a patient knows that someone else is paying the bill, he has no reason not to demand as much health care as he can get. Providers, in turn, will not have any incentive to control costs. The result, as with other goods that have an effective price of zero, is all-but-infinite demand for health care, a phenomenon known as moral hazard.

In the case of voluntary private insurance, another major criticism is adverse selection: The sick is more likely to buy health insurance than the healthy. Similarly, an insurance company has strong incentive to avoid anyone likely to have large health-service demand. In the extreme, it might rule out pre-existing health conditions, or set the premiums for those with pre-existing conditions so high that they are unable to afford coverage. In this case, the private insurance companies merely cream off the healthy population.

Cost inflation and adverse selection are critical issues that health policymakers have to contend with once a country embarks on the promotion of (private) health insurance. While these factors reduce the attractiveness of the health insurance option, a number of developing countries -- Taiwan, South Korea, Malaysia, Indonesia, to name a few -- prefer the health-insurance or managed-care route in the development of their health care systems. No developing country reforming its health-care system has opted for the perpetuation of fee-for-service arrangement, or the expansion of a tax-funded national health service. It appears from these countries' preference that the benefits of a third-party payment system, such as its ability to generate resources, pool risks, and expand health-care access, far outweigh the costs, mainly in terms of medical inflation.

b. Technical Approaches - What remains to be analyzed are the policy and management tools that the Project will employ to derive the benefits of a third-party payment system and mitigate its adverse impact on costs.

(1) Cost-Containment

The Project addresses the issue of cost inflation through regulation of physician reimbursement, utilization control, and possible establishment of a monopsonistic mechanism in the health market via Medicare.

Medicare already uses a relative value scale (RVS) to reimburse providers. The RVS provides an index of the relative complexity of each medical procedure and prescribes corresponding physician payment for each procedure performed on a patient. The Project will update this RVS to reflect current medical practices and real efficiency costs of delivering hospital services and to expand the RVS to include services not currently covered under Medicare reimbursement.

The Project will also promote the development of prospective reimbursement scheme such as diagnosis-related groups (DRG). Under this scheme, payments are based not on the costs incurred but on fixed prices per case, such prices updated regularly on the basis of cost surveys. The DRG system gives incentives for reduced lengths of stay and prudent use of laboratory tests.

Utilization control is another mechanism to be demonstrated by the Project as a cost-containment measure. This can be operationalized through the HMO setting, through limits on the frequency of consultations, certification requirement prior to admission, or peer review.

To countervail the monopolistic structure of professional medicine that appears to drive up medical costs, it is also possible to create a monopsonistic system under which Medicare becomes a single-buyer bargaining with provider societies/associations on behalf of consumers. This system works well in some countries and should be studied for its applicability in the Philippines.

(2) Scale

To succeed, insurance and managed-care arrangements need large numbers of enrollees. To achieve a viable size of operation, the Project will promote tieups between the Medicare Fund and private HMOs and insurance firms. It will also sponsor generic marketing of risk-sharing concepts in order to stimulate enrollment into the health insurance and HMO industry.

(3) Risk Reduction via Reinsurance

A major constraint in the expansion of third-party payment to the informal sector is the large degree of uncertainty faced by HMOs and insurers on this group. The Project will study the possibility of establishing reinsurance mechanisms through the Medicare Fund.

2. Hospital Service Improvement

a. Organizational Strategy - Many of the problems in the Philippine health sector arise from a poorly functioning health-care market. Private providers co-exist with the government delivery system but their roles have never been defined. The government is mandated to cater to the medically indigent but public hospitals frequently provide services even to those who can afford to pay. On the other hand, private hospitals often find themselves saddled with poor patients for whom government hospitals should provide services. This overlapping of roles and functions engenders wastage, inhibits resource generation, and often prevents the government from targetting publicly financed services to those most in need.

Free care policies have also distorted demand and utilization of health services without necessarily solving problems of access and inequity. The current organizational features of government health facilities -- overly centralized, inability to retain revenues, etc. -- do not provide incentives for efficiency.

The central issue that the Project will address is how to improve market mechanisms in order to generate resources and improve the efficiency of resource use and allocation. To achieve this, the Project will assist in (1) creating an environment that stimulates investments, and (2) limiting the role of the government into those activities in which it has a comparative advantage. With scarce resources, the government should concentrate its services on those with the greatest health impact (i.e., preventive services) and target the curative services it finances to those most in need. Incentives must also be provided (or at least disincentives must be removed) to stimulate the private sector to pursue national health goals.

b. Technical Approaches - To operationalize the above strategy, the Project will adopt the following approaches:

(1) Privatization

Privatization can be defined in any of the following ways: (1) the transfer of a function, activity, or organization from the public to the private sector; (2) turning over of a government activity or part thereof to a nongovernment entity, allowing government to provide services without necessarily producing them; or (3) arranging with the private sector to undertake a discrete task or set of tasks for the the government, e.g., grants to NGOs.

The Project's promotion of privatization as a strategy is anchored on the following arguments:

a. Financial considerations - The government budget is not likely to grow, in real per capita terms, over the next few years. There is a need to encourage private individuals, companies, and groups to invest in health so that some of the financial burden for health care is shifted from the public to the private sector at least for that segment of the population who can afford to pay.

b. Technical and efficiency considerations - Privatization engenders greater financial and management autonomy, decentralized operations, and greater flexibility. As a result of this better incentive structure, privatized health facilities produce services more efficiently and can respond to local situations more quickly.

c. Free care to the indigent can still be achieved with strong reliance on the private sector, e.g., through voucher or other reimbursement systems. Based on the experiences of other countries, if the government finances the health care needs of the indigent but allows the private sector to deliver care, it can spend less and at the same time improve the quality of care.

The experiences of Singapore, Yemen, Saudi Arabia, and Egypt speak well of the technical feasibility of undertaking privatization programs in the health sector in developing countries.

(2) Core Hospital Network

The core hospital network (CHN) is a useful conceptual and operational tool devised by the DOH to select facilities for institutional upgrading and thereby concentrate on those hospitals and clinics which pursue DOH's equity and public-health objectives. Government-hospital construction and improvement have historically been based on political considerations. The CHN strategy will provide rational technical basis for nationwide hospital development. Through this strategy, government resources can be used more efficiently and with greater health impact. The networking arrangement inherent in this concept also addresses problems of scale and referral.

The DOH envisions operating its CHN hospitals as a chain. While there are no documented developing-country experiences on the chain operation of government hospitals, the nonprofit chain of Daughters of Mercy hospitals in the U.S. provides an appealing model.

(3) User Fee Generation and Retention

User fees are effective instruments not only for financing government health services but also rationalizing the demand and utilization of such services. First, user fees could cover part of the costs of providing health care and thus ease part of the government's burden. Second, they would prevent the problems of overuse sometimes caused by free health care. Third, they play a complementary role in the development of third-party payment systems. (For instance, health insurance cannot evolve properly until fee schedules inherent in the development of user fees have been established.) Fourth, user fees inspire a sense of self-reliance and empowerment among consumers. Fifth, user fees insulate health services from contractions in government budgets resulting from economic crises. Sixth, cost-sharing among those who can afford partial payment for services can improve equity in access through cross-subsidization of the poorest.

The government usually resists any form of user charges for fear of excluding the poor from health care service, or in the belief that users will not understand the value of the service. In fact, the imposition of user charges can have a beneficial impact on health service utilization. For curative inpatient services, it prevents overutilization (e.g., free inpatient care usually extends confinement) and for preventive outpatient services, it increases the perceived value of services and therefore can increase the demand for them over alternative free care.

There are critical issues related to the imposition of user charges. Which among the hospital services should be charged? At what rate? Since user fees have a profound impact on demand, a critical activity in the Project will be the analysis of income and price elasticities of different health services. In general, a prudent design for user fees is to set such fees relatively low for highly cost-effective outpatient services particularly those oriented towards children, and to set them high for costly inpatient services. In this way, the price system can be used to encourage beneficial services (e.g., immunizations, prenatal care, treatment of diarrhea, malaria prophylaxis) and discourage less important ones (e.g., intensive care).

Annex I-2
Financial Analysis

FINANCIAL SUSTAINABILITY OF THE HEALTH FINANCE DEVELOPMENT PROJECT

SUMMARY

Upon completion of the Health Finance Development Project (HFDP), a strengthened health policy formulation process will be in place, having as initial specific outputs, policies on health financing mechanisms and hospital financing reforms. In the process, the Department of Health (DOH) will enhance its assessment capability, as well as gain a greater understanding and appreciation of its organizing and standard setting functions. The experience will be extremely valuable to DOH when it concerns itself with other health policy matters.

To sustain the gains and benefits derived from HFDP, DOH must continue to make available to the participating units on a permanent basis, inputs provided under the HFDP. Specifically, these inputs are:

1. Staff and other support to the coordinating units of the project, namely:
 - o Health Policy Steering Committee
 - o Health Policy Technical Group
 - o Health Policy Unit
 - o Philippine Medical Care Commission
 - o Office of Hospital Operations
 - o Office of Management Advisory Services.
2. Operations and maintenance costs of the various database centers set up for the collection, management and analysis of data on:
 - o National Health Accounts
 - o Health Policies
 - o Researches on Health Finance
 - o Health Facilities
 - o MIS for the MEDICARE Program
3. Technical assistance and support to the various coordinating units, as identified and/or needed.
4. Training to support the health policy process and policy research.
5. Researches involving generic studies to identify and clarify other policy issues.
6. Seminars and workshops to disseminate results of studies and drum up support for health policy actions.

When translated into monetary terms, the inputs are expected to approximate ₦ 18.9 million annually, equivalent to 0.20% of the projected total annual budget of the DOH in 1997. Considering the magnitude of the amount needed to sustain the benefits of the program, it appears that DOH will have no difficulty in including these items in its regular annual budget.

APPROACH AND ASSUMPTIONS

The HFDP is considered a "social infrastructure" project and as such, cannot be subjected to normal financial measures in order to demonstrate liquidity, profitability, and solvency. This section, therefore, will limit its discussions on the probable financial sustainability of the project in the post project period (N.B.- the sustainability of the project during its life is discussed separately).

The approach utilized to assess the project's financial sustainability has three stages:

- a. Determination of needed recurrent costs.
- b. Estimation of the magnitude of the recurrent costs.
- c. Comparison of estimated recurrent cost with the projected budget of the DOH on an annual basis.

The basic assumptions in the analysis are as follows:

- a. The DOH will utilize the policy formulation process in the format and design developed under HFDP.
- b. No additional capital investments will be made.
- c. The personnel attached, assigned, and hired for the project will be retained in their positions by the DOH at the termination of the project to carry out the implementation needs of the project.
- d. Implementation of policies formally developed and formulated under the project will be financed from separate budgetary appropriations and/or other sourcing facilities.
- e. DOH counterpart contributions in the five-year life of the project will be budgeted for the duration of the project.
- f. The funding from USAID and the counterpart funds from DOH will be sufficient to operationalize the health policy formulation initiative.

DETERMINATION OF NEEDED RECURRENT COSTS

Component 1 - Policy Formulation

The output from this component is the formation of capacity for research and data based policy formulation and the establishment of mechanisms which will allow the active participation of other sectors in the health policy process. To do this the project will provide assistance to support the DOH policy process, develop a multisectoral policy forum, establish a National Health Accounts (NHA) database, and a Health policy database. The inputs will be in the form of domestic/foreign technical assistance, training, research, commodities and local supports.

In the post project period, the following activities will have to be continued to keep the policy formulation process at the level of proficiency attained during the project's life:

1. The database, for NHA and Policy Formulation, must be continuously updated, reviewed, and expanded. Data collection methods perhaps will be modified to facilitate delivery of timely information.
2. Since policy framework, research agenda, health policy financing agenda, policy monitoring and evaluation process will have been developed, designed, and assisted by the end of the project, it is foreseen that further support will be needed only for researches, studies, demonstration projects and policy actions for major issues and actions other than for health finance.
3. Resources will be needed to maintain the Health Policy Forum, and health policy newsletters.
4. Training in the form of workshops/courses, orientation visits, fellowships, internships, scholarships and collaborative arrangements with US institutions need to be continued.

Component 2 - Health Care Financing Mechanisms

The specific outputs generated from this component are policy recommendations to effect reforms in the existing MEDICARE program and to encourage the development of strategic options for health care financing. These health care finance policy recommendations will be the major inputs that will be processed under Component 1.

This component clearly defines the reforms desired for MEDICARE I, PMCC tie-ups, Medicare MIS, and Health Fund Mergers. However, only collection of reliable data for the population groups not covered by Medicare is specified. Perhaps further studies/

researches will be needed to develop plans for providing these groups with health insurance coverage. The studies will be accomplished after the project.

Policy recommendations on strategic options for health care financing will necessarily involve the private sector which will include Health Maintenance Organizations, insurance companies, employers, and community organizations. The strategic options will entail incentives, organizing activities and regulatory responsibilities. Operational support will be required.

Implementation of policies on health care financing mechanisms is likely to be carried out by existing institutions and/or institutions which will be created for the purpose. In this case, financing requirements will be sourced independently by these units. However, the project will have to continue providing the training, researches and demonstration requirements.

Component 3 - Hospital Financing Reforms

Component 3 will effect sectoral and institutional reforms through interventions designed to improve efficiency and effectiveness of health care provided through public and private hospitals. These activities include diagnostic studies in management/ownership of public hospitals, private hospitals system reforms, and management of a public hospital care system. They also include analyses of operations of public and private hospitals covering organization, management, finance, support, and clinical services systems. To provide reliable information to the diagnostic studies, a health facilities database will be set-up.

Given the long-term nature of these reforms, it is clear that certain activities under the component should not cease upon termination of the project:

1. The operation and maintenance of the health facility data base to ensure availability of detailed and up-to-date information.
2. Training activities to strengthen manpower capacities in hospital management and administration, design and management of a health facilities database, and analysis and interpretation of data output.
3. Regular training programs in hospital MIS, quality assurance, budgeting, accounting, pricing and other operational aspects of the hospital business.
4. Researches for the diagnostic evaluation of other public/private hospital management concerns.

COST ESTIMATES

The annual recurrent cost of the program in the post project period is estimated to be equivalent to the local cost component of the program assistance in the fifth year of the project, net of expenditures for demonstrations and commodities. It is assumed that the level of activity in 1996 is the minimum level at which the project can be maintained operational. Thus, the estimated annual cost of continuing the project in the post project period is approximately US\$ 700,000 or about ₦ 18.9 million (₦ 27 = \$ 1.00). Details are shown in Table 1.

Table 1
Estimated Annual Costs
To Sustain HFDP in the Post Project Period
(In \$ 000)

<u>Item</u>	<u>Amount</u>	
Training Assistance	\$ 452	
Research	146	
Monitoring, Audit, and Evaluation	<u>12</u>	
Total	<u>\$ 696</u>	Rounded to US\$700

FUNDING

The cost of maintaining the project in the post project period will be shouldered by the DOH. The projected DOH annual budget, assuming a 5% increase per year, is ₦ 9.2 billion in 1997. The cost when viewed as a percentage of the annual budget, is only 0.2%. Thus, it will appear that the DOH can effect without difficulty the inclusion of these items in its regular annual budget after the completion of HFDP in 1996.

SUSTAINABILITY

From the foregoing, it will appear that on a financial basis, the DOH will be able to sustain the project in the post project period.

However, the viability of the HFDP is not only contingent on its financial sustainability, but also on the DOH's resolve to adopt and implement a rational and integrated health care finance policy. The DOH's commitment will manifest itself in its ability to create an atmosphere conducive to the acceptance of policies of radical reforms and institutional restructuring which may be perceived as infringements on the mandates of the participating institutions. It will also involve DOH's strict adherence to cost containment and efficiency enhancement incentives.

Specific instances wherein the DOH can demonstrate its commitment are as follows:

1. Securing Department of Finance's agreement to grant income and business tax incentives (including exemptions from import levies) to private sector investments in the health care financing program.
2. Encouraging employers to provide for the health care needs of their employees.
3. Unifying the government mandated funds to promote efficiency.
4. Mandating and coordinating regulatory measures.
5. Generating legislative and executive support where necessary.
6. Decisiveness in selecting and implementing demonstrated workable alternatives.
7. Securing the right to retain revenues generated from increased user fees in government hospitals.
8. Imposing cost-effective and efficiency-inducing management systems in public hospitals.
9. Stimulating the development of health maintenance organizations and re-insurance schemes.

Annex I-3
Economic Analysis

ECONOMIC ANALYSIS

A. INTRODUCTION

The aim of the Health Financing Development (HFD) project is to assist the Department of Health (DOH) in the formulation of a national health financing policy which generates equitable access to efficient health services of acceptable quality delivered by private and public providers.

The three interrelated HFD project components are:

- 1) **Policy Formulation:** The development of a capacity within DOH for research-based policy formulation, and the establishment of mechanisms which allow private sector access to the health policy process;
- 2) **Health Care Financing Mechanisms:** The improvement of the efficiency and expansion of the coverage of Medicare, and the expansion of the coverage from other risk-sharing options; and
- 3) **Hospital Financing Reforms:** The improvement of the efficiency and effectiveness of health care provided through public and private hospitals.

Expected economic benefits from the project would come in the form of economic growth as a result of improved health status from an increase in publicly provided preventive health care and from an expansion of the private health sector. This analysis will demonstrate the project's economic merits through: 1) a qualitative cost-effectiveness analysis; 2) a quantification of the minimum economic benefits required to cover project costs; 3) a quantification of the reduction in expenditures for family health care; and 4) a quantification of the gross value added from expansion of the private health sector.

B. ECONOMIC RATIONALE

1. Economic Benefits

The economic benefits of the HFD Project would arise from increased allocative and operational efficiency in the use of scarce resources for health care. Improved policy formulation, expanded use of risk-sharing mechanisms, operational efficiency gains in public hospitals, and public hospital institutional reform (including divestiture) would help to relieve the pressure on scarce DOH resources for the provision of public health care.

The financial cost savings from efficiency gains and hospital divestiture do not constitute direct economic benefits to the society. The proceeds from these reforms, however, would enable the DOH to expand preventive health care services for which the benefits to society as a whole are high, and which add to the overall productive capacity of the economy through gains in worker productivity and the return to education. Economic growth is obtained from these efficiency gains, and from the expansion of the overall health care sector through increased involvement of the private sector.

a. **Allocative Efficiency Gains in the Health Care Market**

There are well-defined economic conditions of market failure that justify government intervention to improve the efficiency of the market for health care. The cases of market failure that are most applicable to the health care market in the Philippines are:

- 1) the "public good" nature of certain health care goods and services that lead to positive externalities that justifies government provision;
- 2) an inadequate market for health care insurance that justifies the establishment and expansion of risk-sharing schemes; and
- 3) incomplete information for private producers and consumers of health care that justifies information gathering and dissemination.

The HFD project addresses each of these types of market failure, and would lead to a more efficient health sector in the Philippines. Specifically, the HFD project would:

- 1) shift the role of the DOH more toward the provision of health care goods and services that have a large public benefit;
- 2) expand the coverage of the Medicare Program and private risk-sharing schemes to provide a more complete and competitive market for health insurance; and
- 3) involve private providers of health care in the health system decision making process, and provide them with the information necessary for efficient investment decisions.

Shifting DOH Resources to Preventive Health Care

HFD Project activities would lead to a more efficient health care market in the Philippines because government resources would

be shifted toward the provision of health care that has a large public benefit.

Health care goods and services can be classified by who receives the benefits of their provision. At one extreme of a health care goods and services continuum are purely private goods, for which all benefits are captured by the person who receives the health care (e.g., mending a broken bone). At the other extreme are pure public goods, for which the benefits are equally received by everyone in the society (e.g., spraying for malaria control). Most health care goods and services are mixed public/private goods that fall somewhere in the middle of the continuum. For example, a vaccination provides a private benefit to the individual who receives it, and many others receive a benefit because they are less likely to be exposed to the illness.

The public/private good distinction is important in health care financing because consumers' willingness to pay for health care largely depends on who receives the benefit. People are willing to pay for health goods and services that are largely private goods because they can benefit highly from them. People are less willing to pay directly for public health goods and services because they do not receive the large share of the benefits.

Public and private health care goods and services, and therefore the degree of willingness to pay, often are equated with preventive and curative care respectively. In most cases the preventive/curative classification for public/private health care goods and services is correct and appropriate.¹ The HFD Project objectives are consistent with the public/private health care goods and services distinction, and would lead to a more efficient health care market in the Philippines. DOH cost savings obtained from operational efficiency gains in public hospitals would be shifted toward preventive health care with high public benefit. The proceeds from divestiture and privatization of public hospitals, that primarily administer curative health care (largely private goods), also would be targeted to preventive care.

Expansion of Risk-Sharing for Health Care

The expansion and establishment of risk-sharing schemes would help to complete the market for health care on both the demand and supply sides, and mobilize private health financing resources in

¹In some cases the correspondence is not exact. The benefits of some preventive health care, such as perinatal monitoring, probably accrue largely to the recipient of the care. The benefits of some curative care, such as the care for the carrier of a contagious disease, benefit the public in addition to the individual.

the Philippines. An inadequate health insurance market limits the ability of individuals to purchase some kinds of health services even when they would be willing, through insurance premiums, to pay the costs.

Expansion of risk-sharing schemes would help satisfy the demand for risk aversion. Under private out-of-pocket health financing, consumers are at risk of having to pay very large outlays for health care when they are sick. Under risk-sharing, consumers trade this risk for small, regular payments, thus spreading the risk over the insured group over time. On the supply side, expansion of risk-sharing would likely stimulate a positive response from the private sector. The Medicare Program is thought to have significantly increased the number of private hospitals in the Philippines in the past two decades.

The forms of risk-sharing for health care in the Philippines include: 1) government sponsored health insurance--the Medicare Program and Employees Compensation Commission; 2) private insurance--HMOs and private or commercial indemnity health insurance; 3) employer provided health insurance; and 4) preferred provider plans--community or cooperative shared-risk schemes. The Medicare Program is the largest health insurance program, covering about 40 percent of the population. All risk-sharing schemes combined in the Philippines, however, cover well less than 50 percent of the population.

The improvement and expansion of the Medicare Program and the promotion of other risk-sharing schemes through PMCC Tie-Ups would achieve operational efficiency gains in the administration of the Medicare Program; and help mobilize private sector resources for curative (private) health care goods and services. Resources from gains in efficiency and a reduced demand for curative services from the government would free-up DOH resources for preventive (public) health care goods and services provision.

Information Dissemination to the Private Sector

The responsiveness of the private supply side of the health care market to price signals in the health sector relies heavily on available mechanisms to correctly convey these signals. The HFD Project would develop capacity within the DOH for transparent, private-public sector interactive, and research based policy formulation. It would also allow private sector access to the health policy process, including information on the health system and sector not currently available in the Philippines.

Such information, for example, would identify gaps in the health care delivery system as a whole (both private and public) where opportunities for private sector investment in facilities and services can be stimulated. Information on the intentions of the

public sector to change the direction of current policy would inform the private sector well in advance of changes, and allow private resources to be put into place to take advantage of investment opportunities. For example, if redundancy of public and private health care facilities and services in certain geographical areas leads the DOH to divest facilities, the information would be known to the private sector to allow for advanced planning for private sector expansion.

b. Economic Growth

Figure 1 illustrates the direct and indirect pathways through which the HFD Project would lead to economic growth.

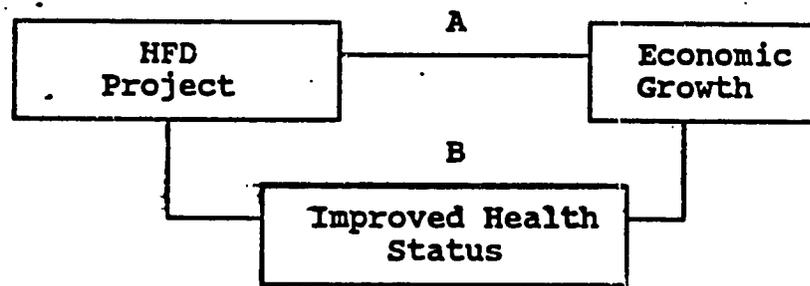


Figure 1. HFD Project Paths to Economic Growth

Investment in the HFD Project would lead directly to economic growth (Path A). HFD Project activities that lead to operational efficiency gains allow fewer DOH resources to produce the same level of health care output or, alternatively, financial gains resulting from increases in efficiency may be used to increase the level of health care output. For example, increased operational efficiency in hospitals would allow the same number of patients to be served at a lower cost, or would allow more patients to be served at the same cost. Moreover, expansion of the private health sector would lead directly to economic growth through private investment of additional resources that adds to gross domestic product.

Investments in the health system that lead to improved health status (Path B) also would lead to economic growth indirectly through returns to human capital. Resources invested in the improvement of health status, especially through preventive health care like immunizations for infectious diseases, are considered an investment in human capital. Increases in preventive health care lead to a reduction in the eventual demand for curative services, and adds to the productive capacity of the economy.

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Investment in health care, like investment in physical capital, is an investment that yields benefits over time. Improvement in the health status of the population results in both quantity and quality effects on labor supply. Such improvements in health status may result in an increase in the number of productive members of the society available for economic production at any point in time. Early preventive care improves the health condition of children and increases life span and, in turn, results in an increase of productive labor supply in the future. Health care investments in school age children reduces absenteeism, and increases the public returns to education later in life in terms of economic productivity. Preventive care investments for the working population decreases current and future absenteeism on the job, and also contributes to economic productivity. Such additions to the productive labor supply results in overall economic growth.

2. Economic Costs

The HFD Project reforms have their attendant direct and indirect economic costs. In order for positive economic benefits to be realized from the HFD Project, these costs must be less than the economic benefits achieved from the project.

The direct costs of the HFD Project include the costs of capacity building in health financing policy formulation, training, demonstration projects, research, data collection and analysis, and the purchase of computers and software for data management.

The indirect costs of the HFD Project reforms include: 1) possible increases in health care costs due to the expansion of health insurance; 2) the potential for decreasing access to health care for the 49 percent of the Filipino households below the poverty line; and 3) the possibility that some government health care workers may be displaced.

Health insurance programs in industrialized countries have undoubtedly contributed to rising health care costs. When risk-sharing schemes cover most or all costs, and patients and health providers perceive care as free, some unnecessary visits and unnecessary procedures are likely, leading to escalating costs in the system as a whole. To minimize cost inflation, compulsory insurance programs should avoid covering small, predictable costs (e.g., low cost curative care), and only cover catastrophic costs. Cost escalation in reimbursable systems would also be less likely if consumers pay a deductible and co-payments, and if there is competition among insurance providers.

Recent data on family expenditures for health care in the Philippines suggests that below-poverty-line families are able to pay for private curative health care and health insurance premiums, but the very poor may not be willing to pay, and may simply stop or

decrease their use of health services if public curative health care is severely restricted.

Hospital reforms designed to improve management efficiency through devolution of authority, management, and ownership may result in some government employees losing their jobs.

C. ANALYSIS OF BENEFITS AND COSTS

Traditional benefit/cost analysis requires, where possible, a quantification of the flows of incremental project benefits and costs over the life of a project, and the expected duration of post-project benefits and costs. The larger the discounted benefits over discounted costs, the more worthwhile the project. For benefit and cost categories that are not quantifiable, a qualitative approach is used.

The nature of the HFD Project poses difficulties for the application of traditional benefit/cost analysis. A major emphasis of the project is to shift resources toward preventive health care, thereby adding to human capital investment through improvement of health status. Conceptually, the benefit from additions to human capital is increased quantity and quality of labor supply, but the human capital approach ignores health as a consumption good. Empirically, the quantification of the benefits of investment in human capital requires extensive data that is not available for determining expected longer life spans, decreased absenteeism, increased returns to education, and marginal productivity by labor type to determine incremental additions to gross domestic product. For these reasons, traditional benefit/cost analysis is not appropriate, or possible, for the HFD Project.

The analysis that follows is conceptually consistent with the principles of benefit/cost analysis. The project's economic merits are demonstrated by: 1) a qualitative cost-effectiveness analysis; 2) a quantification of the minimum economic benefits required to cover project costs; 3) a quantification of the reduction in expenditures for family health care; and 4) a quantification of the gross value added from expansion of the private health sector.

The qualitative cost-effectiveness discussion addresses the appropriateness of the project approach to minimize explicit and implicit costs. The minimum economic benefits required to cover project costs provides a bench mark for comparison to the estimated reductions to family health care expenditures and gross value added from the private sector. The analysis demonstrates that the benefits of decreased health care expenditures and the gross value added from divested hospitals would be sufficient to justify the project.

1. Analysis Framework

The diagram below illustrates the underlying logic of the analysis of HFD Project benefits.

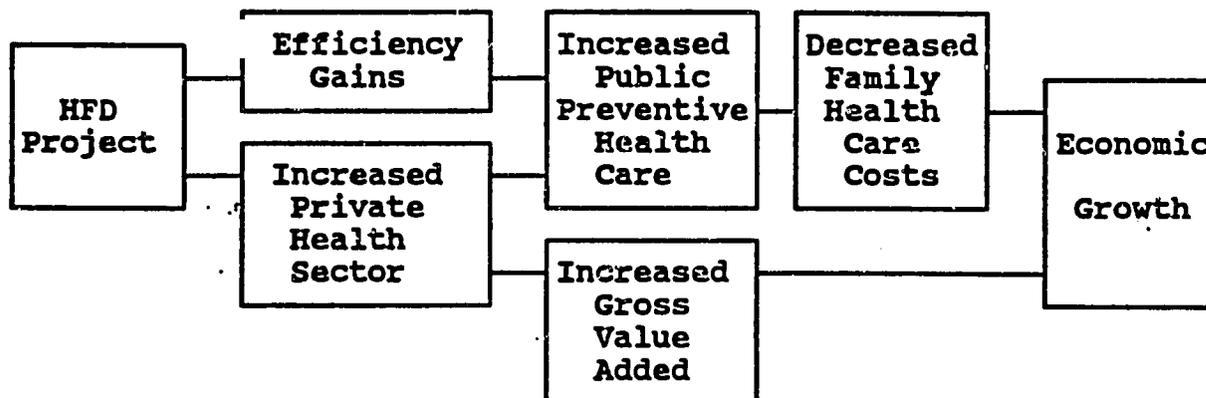


Figure 2. Analysis Framework for Quantification of Benefits

The HFD Project would result in more efficient delivery of publicly provided health services, in better targeting of public health services, and in reducing the costs of institutional operations. Improved management of existing public health care financing institutions, together with cost-containment incentives would lead to efficiency savings through reductions in wastage, fraud, the cost of monitoring, and litigation proceedings associated with fraud. Improvements in the efficiency and effectiveness of hospital-based care in public and private hospitals through sector restructuring and hospital institutional reform would result in cost-effective production and delivery of health services. Improved coordination and planning within the private hospital sector would improve capacity utilization, efficiency and growth of the private health sector.

The financial cost savings from efficiency gains would permit the public sector to increase the provision of preventive and public health functions, thereby increasing the outreach of public health services and increasing equitable access. These factors would lead to reduced household expenditures for obtaining health care. The improved health status of the population would help bring about reduced absenteeism from work and from school due to improved general well being. These, in turn, would result in improved worker productivity and increased returns to education and other forms of investment in human capital.

With an improved health policy and institutional framework, there would be a better delineation in the provision of services

between the public and private health sectors. Better price and investment signals arising from such role-delineation would enable the private sector to expand its services, lower its costs, improve the financial sustainability of its operations, and thereby provide more reliable access to health services. The expansion in the market share of the private sector in curative services would allow the public sector to concentrate its efforts on the provision of preventive and public health services. Divestiture and privatization of public hospitals would free-up scarce DOH resources for increases in preventive public health services. In addition, more efficient and productive health enterprises with private sector ownership and management would contribute to an increase in gross value added in the health sector.

As already stated, the financial cost savings from efficiency gains and hospital divestiture do not constitute direct economic benefits to the society. However, it is useful to note the order of magnitude of DOH resources that could be targeted to preventive care as a result of the HFD Project. The 1990 DOH budget for expenses incurred by curative hospitals amounted to P5.1 billion, and represents over 65 percent of the DOH budget. By comparison, preventive health services, including expenses for public health activities such as drugs and medicines, field health services, primary health care and aid to puericulture centers amounted to P1.1 billion, representing 14.3 percent of the 1990 DOH budget.²

The relatively large hospital budget component suggests that even modest efficiency gains in curative service provision, or hospital divestiture, would result in a significant addition to preventive health care. A 10 percent efficiency gain in curative services would amount to P510 million per year, and increase the preventive health care budget by 46 percent. Alternatively, P510 million could be targeted for preventive health from divestiture of 10 percent of the DOH public hospital budget. Combinations of efficiency gains and divestiture could obviously produce a significant increase in preventive care, and would likely lead to significant savings in family expenditures for health care and, in turn, would likely lead to economic growth through productivity gains.

2. Cost Effectiveness of the Selected Approach

The proposed HFD Project approach is the provision of necessary technical assistance, training, research, and other services as well as equipment. The approach taken is deemed appropriate for supporting health financing development activities because of:

²Office of Management Services, Department of Health.

- 1) the complexity of the process of reorientation of the role of the government in the health sector;
- 2) the dearth of public and private health sector data and information on which to base sound health policy decisions;
- 3) an existing nucleus of highly skilled and experienced domestic health policy researchers on which to build and strengthen health financing research and educational programs; and
- 4) the lack of sufficient computer hardware and software to support data management needs and health financing research.

Full utilization of expatriate services would be inappropriate because of high costs, availability of highly skilled local personnel for many of the tasks, and the need to be intimately aware of the existing DOH and GOP institutional framework and the government's current role in the health sector.

Full utilization of domestic sources for the effort would be equally inappropriate because of the need to have awareness-raising and capacity building in identified key players and decision makers, and to support training programs in health economics, health service administration, and health care financing. In addition, GOP and DOH personnel politically need to be in a position to decide at various stages of divestiture of public hospitals and preclude possible conflicts of interest that could arise if third parties are given freer play in crucial decisions.

The selected approach minimizes explicit and implicit costs in assisting the health financing development effort. Training, for example, will be conducted locally, thereby minimizing travel costs and maximizing the number of trainees for the amount budgeted. The overall project approach is to maximize the use of well-qualified domestic talent, both within and outside of the government, to accomplish HFD Project objectives and use expatriate assistance only where necessary and appropriate.

3. Minimum Required Benefits to Cover Direct Costs

In order to determine quantitatively whether the HFD Project is worthwhile, the minimum level of benefits required to cover all direct economic costs is computed as a threshold to be attained for project justification.

Several simplifying assumptions are used to determine the required economic impact to justify the investment in this project:

- 1) project funds are disbursed in five equal annual increments over the life of the project, beginning with the signing the grant agreement;
- 2) the economic return over a 20 year period will flow evenly for each dollar invested;
- 3) no new returns are attributed to the project after its completion;
- 4) recurrent costs are 5 percent of economic costs per year for years 6-20;
- 5) a long-term time deposit rate of 15 percent prevails; and
- 6) an exchange rate of P28.00:\$1.00 prevails.

The direct economic cost of the project is computed from the financial cost estimates excluding inflation as follows:

	<u>Total</u> <u>(\$000)</u>	<u>Per Yr</u> <u>(\$000)</u>
Financial FX Cost	\$7,827	\$1,565
FX Shadow Price Adjustment (20%) ³	1,565	313
Financial LC Cost	10,061	2,012
GOP Counterpart	<u>5,960</u>	<u>1,192</u>
Subtotal	\$25,413	\$5,083 (Yrs 1-5)
GOP Recurring Costs for Years 6-20	<u>19,060</u>	\$1,271 (Yrs 6-20)
Total	\$44,473	

The present value of the project direct economic costs are calculated by discounting the 20 year stream of costs by 15 percent, a conservative estimate of stable long-term time deposit rates in the Philippines.⁴ The present value of project economic costs is \$20.732 million.

Using the NEDA-estimated social discount rate in the Philippines of 15 percent (capital recovery factor for 20 years =

³For computational convenience and presentation purposes, the FX shadow price adjustment is made on the financial FX cost rather than its peso equivalent at the official exchange rate.

⁴Long-term time deposit rates have averaged around 17 percent in recent years.

.159761), the project must achieve an annual economic return valued at \$3.312 million at 1991 prices for twenty years. This means that the economic benefits of the project should attain at least a value of \$3.312 million or P92.741 million annually for twenty years as a result of the project. Otherwise, project funds should be invested in alternative activities.

4. Reduction in Family Health Expenditures

The 1988 Family Income and Expenditure Survey (FIES) in the Philippines indicates that, on average, a Filipino family spends 1.7 percent of its total expenditures on medical care. Given average family expenditures of P44,594 per year, a typical family will spend an average of P758 on health care in 1991.⁵ With the total number of Filipino families estimated at 11 million, total family expenditures on health care in 1991 is estimated to be P8.3 billion. This P8.3 billion can be reduced by the HFD Project from substantial increases in preventive health care provided by the GOP. In terms of the P92.741 million minimum benefits to justify the direct costs of the project, annual family health expenditures need only be reduced by 1.11 percent per year.

Family expenditures on health care in the Philippines vary significantly by urban/rural location and by income class (Table 1). Rural families in the lowest income group (less than P6,000 per year) spent only P86 in 1988 on health care, while urban families in the highest income group (more than P100,000) spent P2,325.

Accounting for these differences by weighting family health expenditures by urban/rural location and income group, total family expenditures on health care in 1991 is estimated to be P8.22 billion. Even when taking into account these health care spending differences, the total family health expenditures need only be reduced by 1.13 percent per year to meet the minimum required benefits of the project.

This means that as a result of the project, an average Filipino family need only reduce its expenditures on health care by P8.6 per year (\$.31 per year) to justify the project. Given this relatively minor required reduction of family health expenditures, it appears likely that the project is justified.

The required reduction in family health expenditures to justify the project should be viewed with some degree of caution, however. The USAID-funded Child Survival Program of the DOH and other donor projects are expected to reduce family health care

⁵Average family expenditures in 1991 were obtained by inflating 1988 FIES expenditures by the Implicit Price Index of the Gross National Product.

expenditures, as well. The marginal effect of an additional project, such as HFD, on family health expenditures may experience decreasing returns. It may be the case that each additional percentage reduction in family health expenditures would require increasingly larger amounts of preventive care. On the other hand, because these projects have independent but complementary objectives, and because real aggregate family health expenditures are likely to grow over time due to increases in population, the HFD Project is likely to achieve the necessary required reduction.

Table 1. Average Health Expenditures per Family, 1988

Income Class	Total Number of Families	Average Medical Expenditure (Pesos)
Urban - Total	3,985,145	804.08
< 6,000	21,428	91.83
6,000-9,999	73,118	124.62
10,000-14,999	195,255	193.89
15,000-19,999	303,804	291.22
20,000-29,999	717,648	361.70
30,000-39,999	596,910	472.57
40,000-59,999	802,197	738.80
60,000-99,999	752,794	1042.25
100,000 +	521,990	2325.96
Rural - Total	6,548,782	399.99
< 6,000	157,812	86.71
6,000-9,999	559,584	107.42
10,000-14,999	1,223,084	165.67
15,000-19,999	1,108,559	248.72
20,000-29,999	1,547,610	326.37
30,000-39,999	786,085	526.05
40,000-59,999	674,387	764.90
60,000-99,999	357,142	1265.99
100,000 +	134,519	1716.98

Source: Family Income and Expenditure Survey, National Statistics Office

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5. Gross Value Added from Divested Hospitals

A second source of economic benefits from the HFD Project is the contribution to gross value added (GVA) from the divestiture of public hospitals. Public hospitals would likely be more efficient and productive enterprises with private sector ownership and management, and positive returns to investment would be re-invested and lead to economic growth.

Private hospitals, with few exceptions, generate positive net after tax income and, therefore, positive gross value added. For the top institutions, average net after tax income in 1989 was P1.9 million for private hospitals, and P905 thousand for private medical clinics.⁶

On average, GVA for a private health care facility is estimated to be P3 million in 1991.⁷ Assuming that divested hospitals, through increases in efficiency, would generate a 10 percent increase in GVA over what is obtained as a public facility, the average divested public hospital would contribute an additional P.3 million per year in GVA. In addition, positive economic returns generated from divested facilities would lead, through private investment and multiplier effects, to economic growth.

The DOH has identified 188 of its 537 hospitals as the essential nucleus of the public hospital system. The remaining 349 public hospitals can be viewed as candidates for privatization. If only 50 of these hospitals are divested as a result of the HFD Project, an additional P15 million in economic benefits will be generated by the project.

6. Minimum Required Benefits to Cover Total Economic Costs

Given that the economic benefits of the HFD Project have been demonstrated by two sources of benefits to be more than sufficient in size to offset the minimum required benefit to cover direct costs, it is likely that indirect project costs would not compromise the economic viability of the project.

⁶The average was calculated for net after tax income from private hospitals, sanitarium, and other institutions, and from private medical clinics and laboratories ranked in the top 5000 corporations in the Philippines. Philippine Business Profiles, 1990-1991.

⁷Data on average gross value added per private health facility is from the National Statistics Office, Annual Survey of Establishments (Services) for 1987 as reported in Philippine Health Care Factbook 1990, Center for Research and Communication, (Table 94, Page 176). Average gross value added in 1987 is inflated to 1991 terms using the Implicit Price Index of the Gross National Product.

The indirect costs of the HFD Project obviously are very difficult to quantify. With the countervailing forces present in a democratic society that help reduce these risks, however, the "drag" on the economy from these costs is not likely to significantly decrease the size of the economic benefits.

In summary, reductions in family health expenditures and the gross value added of divested hospitals would yield sufficient economic benefits to justify the project. If a reduction of 1.13 percent of annual family health expenditures (P8.6) is achieved then the project has been demonstrated to be worthwhile.

Moreover, the contribution of additional GVA of divested hospitals decreases the required reduction in family health expenditures, and increases the likelihood that the project is justified. If 50 of 349 hospitals are divested, then the required reduction in family health expenditures falls to .95 percent, or only P7.2 (\$.26) per year.