

Monograph No. 6

Paying for Performance

*An Approach to Donor Funding
in the Philippines*



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*Paying for Performance :
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Donor Funding
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1

Introduction

“Every attempt at international development assistance, whether by governments or multilateral agencies, faces a unique set of factors and a unique political and cultural environment in the country receiving the assistance.”

International donor agencies are constantly re-evaluating the kinds of assistance they provide. One approach to donor funding which has been used by the United States Agency for International Development (USAID) in the Philippines with the Child Survival Program (CSP) is known as “performance-based disbursement”. This paper reviews the experience of this particular mode of disbursement of funds in the Philippines as a case study in order to identify the circumstances under which this approach is likely to be successful.

Every attempt at international development assistance, whether by governments or multilateral agencies, faces a unique set of factors and a unique political and cultural environment in the country receiving the assistance. This fact, however, should not discourage efforts aimed at determining what kinds of assistance work best and under what conditions.

In 1988, when USAID in the Philippines was deciding what kind of health sector assistance it was interested in providing to the Department of Health (DOH), there were a number of important developments in the Philippines that needed to be taken into account :

1. The “People Power Revolution” which ousted Ferdinand Marcos had occurred in 1986. The administration of Cory Aquino had been in power for only two years, but it had already demonstrated its commitment to the social sector by increasing the relative budget share allotted to health and education.

2. The Department of Health was led by Secretary Alfredo Bengzon and his Undersecretary and Chief of Staff Mario Taguiwalo. This new leadership in the DOH was committed to policy reforms and management changes,

including greater support for Child Survival and reducing high infant and child mortality rates in the Philippines.

3. The United States and the Philippines were beginning bi-lateral discussions regarding the continued presence of U.S. bases in the country. Politically this meant that the Philippines was in a favored status vis-a-vis other potential aid recipient countries, with a large budget for development assistance. In other words, there was lots of money available if the right projects could be identified.

4. The DOH appeared to be in a position to spend large sums of money effectively and efficiently. USAID funds already in the pipeline to the DOH, however, were moving slowly owing partly to USAID's complex contracting and procurement regulations. Given the DOH's own bureaucracy plus all the pertinent USAID regulations, it was clear that large sums could not feasibly be spent by USAID if provided through the usual "project" mode of assistance. A new approach was needed, and it was in response to this need that "performance-based disbursement" was adopted.

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What is "Performance-Based Disbursement" and why did USAID choose to use it for assisting the Philippine DOH?

"The performance benchmarks system means, in effect, that USAID is 'paying the GOP for performance' rather than monitoring how the Philippine DOH utilizes program resources."

Performance-based disbursement is one of the methods used by USAID to disburse funds to developing countries. It is not used very frequently, but when it is used it usually disburses large sums of money. In the case of the Philippine Child Survival Program the system of performance-based disbursement has worked as follows:

1. The Child Survival Program (CSP) is a sector assistance project which supports policy and institutional reforms to develop child survival related health services. A total of \$45 million in grant funds is being provided to the Philippine government over a 4 1/2-year period (September 1989 to March 1994) in performance-based disbursements.

2. With performance-based disbursement, annual releases are made on the basis of achieving "performance benchmarks". These benchmarks were mutually agreed upon by USAID and the DOH before the Child Survival Program began. The performance benchmarks are of two kinds:

Annual benchmarks which must be achieved and documented each year before the next tranche (payment) is made by USAID to the Philippine government. An example of such performance benchmarks for 1990 is "Information, Education and Communications (IEC) plan for Child Survival is issued". (See Appendix for a number of examples of performance benchmarks).

The second type of benchmark for the CSP consists of nine “**service delivery targets**” to be achieved throughout the Philippines by the end of 1993. An example includes, “85% of children fully immunized on their first birthday.” Achieving these nine targets will have a profound impact on maternal and child health in the Philippines. However, these nine service delivery targets are to be assessed after the last child survival payment from USAID to the Philippine government has been made. This means that whether or not the targets are achieved by the end of 1993, the flow of funds to the Philippine government is not affected.

3. Every November the achievement of the annual performance benchmarks for that year is formally reviewed by USAID and if documentation of their achievement is convincing, USAID approves the next tranche (usually in December). The review process has occurred three times (Nov. 1990, Nov. 1991 and Nov. 1992). Including the initial tranche (Dec. 1989), the entire \$45 million has been transferred to the Philippine government.

4. Once the Philippine government receives the check, the money is used to pay off Philippine government debt to U.S. institutions; the Philippine Department of Budget and Management (DBM) then provides the DOH with the equivalent (in pesos) of the dollars included in the tranche from USAID. DBM is **not required** by the terms of the agreement with USAID to provide the equivalent in pesos to the DOH. The type of performance-based disbursement (also known as “program mode of assistance”) being used by USAID in the Child Survival Program only requires that the dollars provided by USAID be used to pay off Philippine debt to U.S. institutions. The DOH and DBM, by means of an internal arrangement, agreed to have pesos provided to the DOH equal in value to the dollars provided by USAID. DBM in effect also supports Child Survival by arranging for this voluntary peso transfer.

5. The DOH then uses the money received from DBM in any way that it chooses consistent with Philippine government regulations. The one absolute is that the set of performance benchmarks for the following year **must** be achieved; if not, there will be no next tranche. The DOH has, in fact, used the money primarily to strengthen child survival at the central level and build the capacity of provinces and cities to plan and implement child survival activities at the local level.

6. USAID is not required by its own regulations to monitor how the pesos provided by DBM to DOH under the Child Survival Program are actually spent. It only requires that the performance benchmarks are met and that dollars are used by the GOP to pay off the specified debt agreed upon prior to each tranche.

CSP program management within the DOH has identified four categories for using the pesos received from the Department of Budget and Management. These pesos are equivalent in value to the dollars in the USAID tranches. The priority use for these pesos has been allocated to two categories, namely, (a) the budget augmentation requirements of the 10 child survival service delivery programs (such as immunization, maternal care, or diarrheal disease control) and (b) the budget augmentation requirements of the field units (such as provincial, district, and city health offices) implementing the programs. When the DOH decides how many additional pesos to give to each eligible program or field unit, it considers several factors, including what the programs need to meet the CSP benchmarks and what the field units need as revealed in their area-based plans.

The remaining two categories receiving the additional CSP pesos are (c) the activities that **support** programs for child survival health services and (d) related priority concerns of the DOH which have not been adequately met by its own regular budget.

The process of allocation begins with proposals put forward by the different programs and field units. These proposals are carefully reviewed and evaluated; based on this review the CSP management makes its funding recommendations to the Secretary of Health who, in turn, makes the final decision.

The performance benchmarks system means, in effect, that USAID is “paying the GOP for performance” rather than monitoring how the Philippine DOH utilizes program resources. USAID does not become involved in any of the decisions regarding the funds provided for Child Survival activities. Performance-based disbursement is a system which requires trust from the donor and involves mutual respect between both countries.

The original decision to use performance-based disbursement as the funding mechanism for the Child Survival Program was made jointly by the DOH and USAID in 1988. The decision was based on a number of factors, including:

- a) The Philippine DOH preferred to have control of the funds in order to maximize flexibility and to further develop its own priorities;
- b) USAID felt that the DOH was a “mature” organization with responsible leadership that knew what it wanted to do and how to do it but only lacked the resources to get the job done;

c) Both the DOH and USAID agreed on the major policy reforms and management innovations that were needed. The performance benchmarks could be used as a tool to get these critical changes implemented within the DOH. Since \$45 million was at stake there would be tremendous pressure within the DOH to carry out the necessary reforms;

d) The Philippine government, including the Department of Budget and Management (DBM), the Department of Finance (DOF), and the National Economic Development Authority (NEDA) were all supportive of child survival and the CSP;

e) USAID had a large amount of money that needed to be disbursed (child survival was a priority with the US Congress, USAID/Washington, as well as with the USAID mission in Manila). Performance-based disbursement (or program mode of assistance) would allow a significant transfer of funds without being affected by AID's usual contracting or procurement regulations;

f) The Philippine DOH and USAID/Manila had established an excellent working relationship over the years. The time was right for a new kind of assistance which would work only in a climate of trust and mutual respect.

3

Performance-Based Disbursement as a management tool

"The DOH ... made it clear to DOH officials that the \$45 million CSP grant funds were at stake and that the achievement of the performance benchmarks were an absolutely top priority"

The performance-based disbursement approach to the Philippine Child Survival Program has worked for several important reasons:

1. Not only were the annual performance benchmarks mutually agreed upon by USAID and the DOH before the CSP began, but the benchmarks were effectively used by the DOH as a means to get needed policy reforms and management changes approved and actually implemented. Without the existence of performance-based disbursement, these changes would have been much more difficult to achieve.

2. The DOH and USAID jointly developed a process, including a tracking system, for making sure the performance benchmarks were all achieved on time, and were fully documented. Other performance-based disbursement attempts by USAID have failed because of delayed or incomplete implementation of benchmarks.

3. The original policy implementation matrix developed by USAID and the DOH before the CSP began included the annual performance benchmarks for each year of the CSP (See Appendix). Some of the benchmarks were phased in gradually in such a way that the 1993 service delivery targets (which represented the actual impact that the CSP hoped to achieve in the Philippines) should have been achievable on time. For example, several performance benchmarks concern provincial plans that must allocate additional funds for child survival activities. For 1990, only the 27 "priority provinces" needed to demonstrate augmentation funding for child survival. For 1991, one-half (38) of all provinces were required to do

this. For 1992, all 75 provinces had to demonstrate extra funding for child survival.

4. The main reason performance-based disbursement worked was the absolute commitment on the part of the DOH to make it work. This commitment was not "personality-driven" since the four years of the CSP have taken place under three different Secretaries of Health and two Chiefs-of-Staff/ CSP Program Directors.

There were a number of performance benchmarks that were used as management tools to get policy reforms enacted that otherwise would probably not have happened or would have taken a very long time. For example:

1. A new approach to health planning at the local level, known as "Area Program-Based Health Planning" was implemented in all 75 provinces, 60 chartered cities, and 1,526 municipalities throughout the country within a one-year period. Performance benchmarks for this innovative planning approach were used as an effective means to speed up this process of nationwide adoption of a new planning methodology. The benchmark requirement for 1991 was that 50% of all provinces in the Philippines would submit an approved plan. This benchmark was actually used as a means to get all 75 provinces (100%) to submit approved plans in 1991.

2. The privatization of government hospitals was something the DOH wanted to consider but which was a political "hot potato". Once again, the CSP performance benchmarks were used as a "management tool" to make sure that the privatization option was thoroughly explored.

3. The DOH launched an experimental new program to train field epidemiologists for improved disease surveillance, disease outbreak investigations, and rapid response to disasters. A performance benchmark requiring that the field epidemiology program be permanently incorporated into the DOH structure was used to hasten what otherwise would have been a bureaucratically prolonged process.

Many other examples could be cited. The DOH, particularly through its Chief-of-Staff, repeatedly made it clear to DOH officials that the \$45 million CSP grant funds were at stake and that the achievement of the performance benchmarks were an absolutely top priority for the Department.

As explained by Mario Taguiwalo, former Undersecretary of Health and Head of the Child Survival Program for the DOH, "Setting appropriate benchmarks is essential so that the effort to meet the benchmarks does not detract from the underlying purpose of implementing the Child Survival

Strategy. Benchmarks should be such that when DOH meets them, then it implements its Child Survival Strategy. The close correspondence between CSP benchmarks and the substantive goals of the Child Survival Strategy should result from benchmark setting.

“Once DOH management is satisfied that the character and design of the benchmarks are consistent with and contributory to the underlying CS Strategy, the effort to achieve the benchmarks can properly be regarded as efforts to implement the strategy. In the CSP, benchmarks are taken as objectives of a planning, organizing, mobilizing and monitoring cycle. Program and field managers take these benchmarks and incorporate them as targets in their management of their operations. This ownership of the project goals is the key to successful implementation of the CS Strategy.

“The DOH regards the performance benchmarks incorporated in the annual targets and evaluation of the CSP as milestones that mark the progress in the implementation of the DOH Child Survival Strategy. Every year, the CSP provides an opportunity for DOH to re-state the directions it intends to move in implementing its Child Survival Strategy, establish specific points to be reached along that direction for that year, manage its affairs and resources to reach those points, assess the extent and consequences of reaching (or not reaching) those points, and link a substantial additional resource flow to the outcome of that annual exercise.”

4

Advantages and disadvantages of Performance-Based Disbursement

“Performance-Based Disbursement of the type utilized in the CSP truly empowers the recipient country....”

Following are several advantages of Performance-Based Disbursement, compared with the usual “project” mode of assistance.

1. Performance-Based Disbursement of the type utilized in the CSP truly empowers the recipient country (in this case the Philippine DOH) by enabling it to determine on its own how to allocate resources and spend development assistance funds. The usual project mode would have required the DOH to defer to USAID regarding spending priorities.

2. Performance-Based Disbursement without requirements for counterpart peso generation enables USAID to provide large sums of money in sector grants and have it spent relatively quickly without bureaucratic delays.

3. The relationship between USAID and its recipient counterparts is based on equality and mutual trust rather than on dependency and suspicion. Meetings between USAID and the DOH focus on larger issues of direction and priorities for child survival rather than on haggling over whether the project-funded vehicle should be a minivan or a jeep and other procurement-related issues.

4. Since the donor is “paying for performance” rather than paying for each project input one-by-one, both actors have the same rather than conflicting priorities – namely, to achieve the benchmarks on time, completely, and with full documentation. When it’s results that count, you are more likely to get results.

Performance-Based Disbursement also has its disadvantages compared with the usual “project” mode of assistance. Following are some of these disadvantages, including several that are only theoretical or hypothetical at this point, at least in the Philippines.

1. Performance-based disbursement requires that the importance of the “benchmarks” or performance required by the recipient is commensurate with the resources being spent by the donor. Paying for performance means paying for impact. If the benchmarks are not clearly connected with important policy reforms, institutional changes, or other critical needs, there can be an imbalance between resources invested and benefit received. Impact would then be minimal.

2. When performance-based disbursement without local counterpart currency generation is used, the donor loses a large measure of control over how money set aside to meet program activities is spent. In a country where corruption is rampant the donor may not trust the recipient to spend the funds wisely and may not expect the benchmarks to be realized. Performance-Based Disbursement also requires the commitment of the other important agencies — such as DOF, DBM, and NEDA in the Philippines — to program goals.

3. Performance-Based Disbursement requires a high level of commitment on both sides. There needs to be a meeting of the minds, a consensus established, so that appropriate benchmarks, mutually agreed upon, can be selected. When any of this is lacking or when successful performance depends largely upon one person (who may not stay in the same position for the duration of the program), performance-based disbursement may fail.

There is a risk that achieving performance benchmarks will be done with an eye to accomplishing the absolute minimum to qualify for the next tranche. This nominal (vs. true) achievement can render the whole approach almost meaningless. This can be avoided by having a scrupulous but fair review process to determine if the performance benchmarks were, in fact, fully achieved.

“There is a risk that achieving performance benchmarks will be done with an eye to accomplishing the absolute minimum to qualify for the next tranche.”

5

Lessons learned about Performance-Based Disbursement

*“Performance-Based Disbursement works when both the donor and recipient officials are like-minded about what needs to be done
... requires clearly defined, measurable, and appropriate performance benchmarks
... requires a clearly defined process of regularly reviewing progress”*

Some lessons have been learned about Performance-Based Disbursement, based on the experience of the Philippine Child Survival Program.

1. Performance-Based Disbursement works when both the donor and recipient officials are like-minded about what needs to be done and what performance benchmarks are required. In the case of the Philippine CSP, general agreement was maintained despite frequent personnel changes on both sides.

2. Performance-Based Disbursement requires **clearly defined, measurable, and appropriate performance benchmarks** that are developed in advance of the program. It turned out in the case of the Child Survival Program that every word, every nuance of these benchmarks were of immense importance, since the disbursement of \$45 million depended upon how the wording of each benchmark was finally interpreted during the annual benchmark review. Investing in clear and precise language and including clearly defined documentation requirements for proof of accomplishment was well worth the time and effort.

3. Performance-Based Disbursement requires a clearly defined **process** of regularly reviewing progress made towards achieving the annual performance benchmarks. Frequent meetings (at least quarterly) between the DOH and USAID were needed to identify, and for the DOH to subsequently

address, obstacles and constraints in the accomplishment of the benchmarks. In addition, the DOH established the Program Coordinating Unit to monitor benchmark performance. USAID also provided technical assistance to support the DOH in this process, but the bulk of the work done in benchmark documentation was done by the DOH itself.

6

Performance-Based Disbursement : When does it work and when is it likely to fail?

“...enormous good will ... can be generated when performance-based disbursement without counterpart currency generation is used as the funding mechanism.”

Recipient countries often perceive a major difference between multilateral-funded development assistance, which are usually loans, and bilaterally-funded assistance, which are usually grants. World Bank or Asian Development Bank loans are frequently perceived as loans “without strings attached” and therefore preferable to USAID grants which require the purchase of American commodities or airline travel on American carriers.

The experience with the Child Survival Program in the Philippines has demonstrated the enormous good will that can be generated when performance-based disbursement without counterpart currency generation is used as the funding mechanism. There are no “string attached”, and the Philippine DOH was in the driver’s seat. The DOH had to achieve the performance benchmarks to receive the assistance, but they were the ones deciding how to do it.

The program mode of assistance cannot, of course, be the only way USAID or other donors provide assistance. Performance-Based Disbursement is likely to be successful in situations that include the presence of the following:

1. A clear idea of what policy reforms or institutional changes are needed, shared by both donors and recipient country counterparts.
2. Policy reforms or institutional changes that are important enough to justify high funding levels.

3. Local currency funds that are voluntarily provided for program implementation but are not required as a condition for the grant.
4. Annual performance benchmarks that are mutually agreed upon in advance.
5. A deliberate process of regularly reviewing progress towards the achievement of performance benchmarks and revising those that need to be modified in light of changing circumstances.
6. Good working relationships between donors and recipient country officials.
7. A high level of commitment on both sides to make it work.

When some of these circumstances are lacking, effective implementation of Performance-Based Disbursement will be difficult.

Conclusion

“The use of performance-based disbursement ... has created a ‘win-win’ situation : the donors have been able to influence policy, the Department of Health has been in complete control of the funds, and the children of the Philippines reap the benefits of the CSP through improved health and reduced infant and child mortality.”

The Philippine Child Survival Program was able to successfully use performance-based disbursement as a funding mechanism and create a major impact on child health in the Philippines. Major policy reforms and institutional changes occurred as a result of this mode of assistance, since the threat of losing \$45 million in grant funds was a powerful stick with which to beat the bureaucracy.

Performance-based disbursement has allowed the Filipinos in the Department of Health to take control of program funds and spend the money in a manner that spelled the achievement of performance benchmarks. The use of performance-based disbursement in the Philippine Child Survival Program has created a “win-win” situation : the donors have been able to influence policy, the Department of Health has been in complete control of the funds, and the children of the Philippines reap the benefits of the CSP through improved health and reduced infant and child mortality.

Appendix

Child Survival Program Policy Implementation Matrix

Selected Performance Benchmarks : 1989-1993

Goal

To contribute to a reduction in the variances in infant and child mortality and morbidity rates among and within provinces and regions while simultaneously lowering the corresponding national rate

Purpose

To increase the availability, utilization and sustainability of child-survival-related services, including child spacing, particularly to underserved and high risk groups.

Strategy 1

To create conditions that foster the efficient delivery, increased availability and utilization of child-survival-related services, particularly to underserved areas and high-risk groups.

Categories of Policy Reform	Policy Objectives	Performance Benchmarks	Due Date	Documentation Required / Remarks
A. Targeting of Child Survival Services	Determination of priority underserved geographic areas.	1. Priority ranked list of provinces and cities, based on classification of provinces and cities using DOH-established high-risk and geographical access criteria.	Prior to release of first tranche.	1. Benchmark was achieved in November 1989.
	Budget allocations linked to program and geographic targeting.	2. Increased budget appropriations given to priority high-risk and underserved provinces and cities.	October 1990	2. Benchmark was achieved in October 1990.
	Determination of functional (programmatic) priorities for additional services and programs.	3. DOH provincial plans address priority child survival-related programs, including family planning and nutrition. a. Priority provinces	October 1990	3. a. Benchmark achieved in October 1990.

Categories of Policy Reform	Policy Objectives	Performance Benchmarks	Due Date	Documentation Required / Remarks
B. Increased delivery of child survival services	Supply of services from DOH, NGOs & private commercial sector increases in accordance with prioritized provincial plans	b. 50% of total provinces	October 1991	b. Benchmark was achieved in Oct. 1991. Submitted provincial plans of acceptable quality from 37 non-priority provinces that (a) addressed priority CS-related programs, (b) specified service priorities, service levels, commodities required, annual performance targets and required resources including staff, and (c) included inputs from provincial representatives of other GOP agencies, e.g., POP-COM, NNC. The same documentation will satisfy benchmarks 1-C.1 and 1-D.5. Also submitted a checklist developed jointly by DOH & USAID which prescribed the attributes of a plan of acceptable quality.
		c. 100% of provinces	October 1992	c. Benchmark was achieved in Oct. 1992. Submitted provincial plans for all 75 provinces. Also submitted evaluation checklist & ratings of all 75 plans re acceptable quality.
		1. Annual service delivery performance targets for priority provinces, based on national end-of-program indicators, set by DOH	Prior to releases of tranches 2, 3, and 4	1. Benchmark was achieved in Oct. 1991 and Oct. 1992. Submitted 1991 and 1992 provincial performance targets which were negotiated using a process that ensured that each province will

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Categories of Policy Reform	Policy Objectives	Performance Benchmarks	Due Date	Documentation Required / Remarks
		<p>2. Achievement of national end-of-program service delivery coverage indicators.</p> <p>a. Percent of all children at age one who are fully immunized increases from 65% (1988) to 85% (1993)</p> <p>b. Percentage of pregnant women with at least 2 doses of tetanus toxoid increases from 50% (1991 household survey) to 80% (1993)</p> <p>c. Percent of all births attended by trained personnel whether private or public including trained TBAs increases from 76% (1988) to 85% (1993)</p> <p>d. Percent of all pregnant women served by DOH with at least three prenatal visits increases from 48% (1991 household survey) to 80% (1993)</p> <p>e. Percent of DOH outreach workers trained to deliver a wide range of FP services increases from 59.5% (1990 FPS survey analyzed by UPPI) to 75% (1993)</p>		<p>contribute a fair share towards achieving the 1993 national service performance targets.</p>

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Categories of Policy Reform	Policy Objectives	Performance Benchmarks	Due Date	Documentation Required / Remarks
C. Decentralization	Decentralization of health planning to the regional & provincial levels	<p>f. Percent of DOH facilities delivering a broad range of FP services appropriate to the type of facility increases for :</p> <ul style="list-style-type: none"> ■ BHS from 1.9% (1990) to 40% (1993) ■ RHU from 0.5% (1990) to 50% (1993) ■ District hospitals from 0% (1990) to 25% (1993) <p>g. Percent of all midwives, nurses and doctors working at, or below the level of the district hospital trained in new ARI case management, increases from 0% (1989 excluding Bohol) to 40% (1993)</p> <p>h. ORT use rate in all cases of diarrhea among children under five years of age, increases from 25% (1991 household survey) to 60% (1993)</p> <p>i. Total Contraceptive Prevalence Rate for all program methods whether provided by the public or private sector, increases from 22% (1988 Contraceptive Prevalence Survey, UPPI) to 35%</p> <p>3. Regional and provincial health managers trained in health planning</p> <p>c. Priority provinces</p>	October 1991	<p>3.</p> <p>a. Benchmark achieved in October 1991.</p>

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Categories of Policy Reform	Policy Objectives	Performance Benchmarks	Due Date	Documentation Required / Remarks
		b. 50% of total provinces c. 100% of provinces	October 1992 October 1993	b. Benchmark achieved in October 1992. c. Benchmark achieved in October 1992. Submitted a report, for all 75 provinces, on the number & type of regional & provincial health personnel trained. Provincial staff trained: PHO; APH or Med. Specialist III. Regional staff trained: ARD; Chiefs of Technical Services & Health Manpower Div.; Supervisory Planning Officer.
	Integrated delivery of child-survival-related services at the provincial level	4. Distribution of integrated MCH operations guide to all regions.	October 1991	4. Benchmark achieved in October 1991. Submitted a distribution report of the integrated MCH operations guide. The manual was distributed to all the Municipal Health Officers.
	Integrated health information reporting at the local & national levels	7. New Field Health Service Information System (FHSIS) operational in all provinces, including an approved management policy statement identifying central, regional and provincial level staff responsible for FHSIS operations & monitoring	October 1990	7. Benchmark achieved in October 1990.
	Coordination of child survival-related programs at the national level	9. Designation of DOH Assistant Secretary or DOH official at comparable level for coordination of all GOP & foreign-assisted child survival-related activities.	October 1990	9. Benchmark achieved in October 1990.

Strategy 2

To ensure the sustained commitment to, demand for and financing of child survival services through both the private and public sectors.

Categories of Policy Reform	Policy Objectives	Performance Benchmarks	Due Date	Documentation Required / Remarks
A. Government Commitment	Program budgetting of DOH demonstrates funding for child survival activities	2. Activities planned by DOH to achieve performance targets are fully funded, as evidenced by advices of allotment a. Priority provinces b. 50% of total provinces c. 100% of provinces	Prior to release of : a. 2nd tranche b. 3rd tranche c. 4th tranche	2. Advices of Allotment a. Benchmark achieved in October 1990. b. Benchmark achieved in October 1991. c. Benchmark achieved in October 1992.
	AID-funded Field Epidemiology Training Program (FETP) institutionalized in DOH & used as a resource for targeted epidemiology-based planning	3. DOH organizational structure formally revised to incorporate FETP as division or service with permanent positions and budget established.	October 1992	3. Benchmark achieved in October 1992. Submitted 2 Administrative Orders signed by Secs. Periquet and Flavier, institutionalizing FETP as part of HIS. Also submitted an Institutionalization Plan for FETP and Revitalization Thrusts for HIS that includes the revised organizational structure of HIS which now prescribes its new mandate and staffing complement.
B. Internalizing the Demand for Preventive Health Services	Development of a strategy for internalizing promotive/preventive health behaviors	3. Adoption & execution of a strategy promoting smaller family size, delayed marriages, complete immunizations, breastfeeding & early illness/disease intervention, etc.	October 1992	3. Benchmark achieved in October 1992. Submitted a report that analyzed the degree to which DOH has met its target of promoting the internalization of promotive/preventive behaviors, as planned for in their family planning, EPI, breastfeeding, CDD & ARI programs.

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Categories of Policy Reform	Policy Objectives	Performance Benchmarks	Due Date	Documentation Required / Remarks
C. Financial Sustainability	Development of a cost containment strategy for DOH services	6. Development of a program of action for the implementation of identified cost-containment schemes in DOH facilities at the regional, provincial and district levels.	October 1991	6. Benchmark achieved in October 1991. Submitted a report that (1) documented existing cost-containment activities in selected DOH facilities; (2) described a methodology for classifying & measuring costs; and (3) identified possible areas for cost containment.
	Development of an improved cost recovery scheme for DOH facilities & services	7. Completed analysis of (a) existing user-fee & cost-sharing experiences in selected facilities & services; (b) potential of user fees to cover DOH recurrent costs; and (c) recommendations for strengthening user fee retention system.	October 1991	7. Benchmark achieved in October 1991. Submitted a report that (1) documented existing regulations & experiences on user fee & cost sharing; (2) analyzed the potential for user fees to cover recurrent costs of the DOH; and (3) identified areas for policy reform to strengthen the user fee system. As evidence that senior DOH staff responsible for policy formulation have discussed report findings & future policy actions, an annex of the report contained the documentation of the discussion held with senior staff & officials of the DOH last September 26, 1991.
D. Increased Private Sector Involvement	Development of plans for the privatization of the Philippine Heart Center, Philippine	1. Completed studies on (a) the policy, regulatory, & legislative framework for health services privatization and (b) the privatization	October 1991	1. Benchmark achieved in October 1991. Submitted reports on (1) the policy, regulatory/legislative, & political framework for

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Categories of Policy Reform	Policy Objectives	Performance Benchmarks	Due Date	Documentation Required / Remarks
	<p>Children's Medical Center, the National Kidney Institute, and the Lung Center of the Philippines</p>	<p>of the four specialty hospitals.</p>		<p>health services privatization; and (2) the feasibility of privatizing the four specialty hospitals.</p>
	<p>Stimulation & facilitation of HMO development</p>	<p>5. Proposed regulations & quality control guidelines for HMO operations</p>	<p>October 1991</p>	<p>5. Benchmark achieved in October 1991. Submitted (1) draft regulation, which included a Memorandum of Agreement (MOA) between the DOH & the Securities & Exchange Commission (SEC), & a DOH Administrative Order (AO); and (2) a report that documented the consultative process undertaken to formulate the regulation.</p>
	<p>Privatization of DOH services</p>	<p>7. Private sector entity contracted for field distribution of Hepatitis B vaccine.</p>	<p>October 1991</p>	<p>7. Benchmark achieved in October 1991. Submitted (1) the Notice of Award to the winning bidder for the field distribution of Hepatitis B vaccines; and (2) the Purchase Order for the services of Medtest, the winning bidder.</p>