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FINAL REPORT

END-OF-PROJECT EVALUATION OF THE PHILIPPINES HEALTH FINANCE DEVELOPMENT PROJECT

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ACRONYMS

APBHP	Area Program-Based Health Planning
BBP	Basic Benefit Package
CHCA	Comprehensive Health Care Agreement
DBM	Department of Budget and Management
DLLO	Department Legislative and Liaison Office
DOH	Department of Health
GHIP	Guimaras Health Insurance Project
GOP	Government of the Philippines
GSIS	Government Service Insurance System
GTZ	German Technical and Financial Assistance Project
HFDP	Health Finance Development Project
HMO	Health Maintenance Organization
HPDS	Health Policy Development Staff
IEC	Information, Education, and Communication
IPS	Internal Planning Services
IRR	Implementing Rules and Regulations
JCAHO	Joint Commission for Accreditation of Healthcare Organizations
LGC	Local Government Code
LGU	Local Government Unit
LHIO	Local Health Insurance Office
MHPF	Multisectoral Health Policy Forum
MIS	Management Information System
MSH	Management Sciences for Health
NEDA	National Economic Development Authority
NHA	National Health Accounts
NHI	National Health Insurance
NHIL	National Health Insurance Law
NSCB	National Statistics Coordination Board
NSO	National Statistics Office
OMS	Office of Management Services
OPHN	Office of Population, Health, and Nutrition
OWWA	Overseas Workers' Welfare Administration
P-I	Medicare Program for Formal Sector Employees
P-II	Medicare Program for Informal Sector Employees and Indigents
PHA	Provincial Health Accounts
PHIC	Philippine Health Insurance Corporation
PIP	Public Investment Program
PIU	Program Investment Unit
PMCC	Philippine Medical Care Commission
PPDO	Provincial Planning and Development Office
RHO	Regional Health Office
RUV	Relative Unit Value
SHINE	Social Health Insurance Networking and Empowerment Project
SLR	Standards, Licensing, and Regulations
SSS	Social Security System
TOR	Terms of Reference
UPEcon	University of Philippines Economic Foundation
USAID	United States Agency for International Development

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APPENDICES

EXECUTIVE SUMMARY

The Health Finance Development Project (HFDP) was initiated at an opportune time in Philippine history. In the early 1990s, at the time the project was being conceptualized, numerous factors were converging to create a social and political environment that was particularly receptive to major health care reform. Health services in the country had been chronically underfunded; it was becoming increasingly clear to the Department of Health (DOH) that the government did not and would not have the financial resources to adequately address the health needs of all Filipinos. If the health system were to improve, existing resources would need to be used more efficiently and new resources would have to be identified. Changes would require major shifts in health financing policy, a reshaping of the public health care system, and an expanded role for the private health care sector. Passage of the local government code was also imminent, calling for the devolution of health services to local authorities and altering the role of DOH from the principal provider of health services to the planner and regulator of the health care system. By remaining flexible and responsive, HFDP was able to play a catalytic role in supporting DOH's effort to successfully launch its reform agenda.

HFDP supported research that established a process of informed health policy formulation and decision making. The project sponsored studies, reports, and demonstration projects, adding valuable information about the country's health system and examining policy options and their implications. It supported training programs and site visits and engaged numerous local consultants, helping to create a local community of knowledgeable and experienced experts on health care issues. It also facilitated workshops, seminars, and conferences, creating a multisectoral forum where policy issues could be debated and reforms initiated. The project was not designed to implement reforms but was instrumental in providing the information and mechanisms needed by the Government of the Philippines and others to launch and continue the implementation effort.

These next few years may prove as pivotal in shaping the Philippine health care system as the last few years have been in launching a new direction. The National Health Insurance Law has been passed which was a significant accomplishment; it is not yet clear how its financial powers will be used to shape the health care system of the future. The role of DOH is changing, but it is still exploring how best to use its regulatory powers, how to manage retained hospitals, how to support and influence decentralized health services, and how to mobilize the resources of the private health sector. DOH will need to be both thoughtful and aggressive in assuming its new responsibilities. DOH needs a clear vision of what its new role should be and a strategic plan for how it will make that vision a reality. It needs to follow through with reengineering its organization to effectively address its new priorities. To be effective in its new role, DOH will need to assign capable people with clear and unambiguous responsibility to each major task—especially financing policy, managing retained hospitals, promoting primary care and prevention, and supporting the

devolution of health services. Much of what DOH needs to do can be accomplished using its own human and financial resources. At times, DOH will need to seek donor assistance to provide technical expertise not available within the organization, objectively facilitate the forums where issues of policy and program implementation will be debated and resolved, and provide training to further strengthen the capacity of officials in DOH, local government, and managers throughout the health system.

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I. PROJECT OVERVIEW

When launched in September 1991, the Health Finance Development Project (HFDP) was intended to introduce health financing reforms at both policy and operational levels. The project goal was to develop the health care market in order to improve health service quality, equity, coverage, efficiency, and private participation. The project purpose was to establish a process for formulating and implementing health care financing policies, regulations, and legislation supportive of health care market improvements. Originally, total project funding was projected at $20 million in support from the U.S. Agency for International Development (USAID), with an additional $6.8 million in contributions from the Government of the Philippines (GOP) to be allocated over the 5-year life of the project, concluding on September 30, 1996.

INITIAL PROJECT DESIGN

The initial project design included three major components. Component 1 was designed to support the development of a research-based, interactive, and transparent health policy formulation process. Component 1 activities were to be implemented through a cooperative agreement, totaling $5.1 million, with the University of Philippines Economic Foundation (UPEcon), a private non-stock entity based at the University of the Philippines School of Economics. Component 2 sought to improve the efficiency and expand the coverage of the national health care financing programs, with particular emphasis on reforming the Medicare program and encouraging an expanded role for the private sector in health care financing. Component 3 focused on improving the governance, management, and financing of hospitals in both the public and private sectors. Components 2 and 3 were to be implemented through an institutional contract, totaling $10 million, with a consortium headed by Management Sciences for Health (MSH) and including Andersen Consulting, Corporate Assistance and Research Associates and the Harvard Institute for International Development.

The initial design relied heavily on research and studies that would create the foundation for an information-based policy-making process. Demonstration projects would provide the opportunity for experimentation and testing of proposed financing policies and implementation methodologies. HFDP operated under the initial design until November 1993.

PROJECT REDESIGN

By the fall of 1993, three events combined to bring the project design under review. The local government code (LGC), enacted in 1991, mandated the devolution of the bulk of the Department of Health's (DOH) service, financing, and administrative functions to local government units (LGUs). As a result, DOH's role began to shift from the major provider of public health services to one of policy maker and health system regulator. In addition,

the election of President Ramos in May 1992, resulted in the appointment of Juan Flavier as Secretary of Health and a shift in DOH's approach toward health financing reform. At the time, HFDP's emphasis on long-term policy reform was not in agreement with DOH's immediate concerns with the budget and challenges of devolution. In August 1993, Secretary Flavier informed USAID of his desire for "a technical package of assistance that will dovetail with new priorities of my administration." And, as a result of U.S. government deficit reduction efforts, USAID's program budget in the Philippines was decreased sharply, necessitating a reduction in funding for HFDP, along with other USAID programs.

As a result, DOH and USAID agreed to a substantial redesign of HFDP, reducing USAID funding from the originally projected $20 million to $11.7 million, with a reduction in GOP contributions from $6.8 million to $3.9 million. The project was redesigned to focus on five major programs:

- National Health Insurance (NHI);
- Devolution;
- Public Resource Management;
- Standards, Licensing, and Regulations (SLR); and,
- Health Policy Process.

PROJECT OBJECTIVES

Even with a substantial redesign, the overall project purpose and goal remained unchanged. As a result of the reduced project budget, however, MSH's contract was decreased from $10 million to $5.7 million, and its term was shortened by one year, to conclude on September 30, 1995. The UPEcon grant was reduced from $5.1 million to $4.6 million, but still concluded on September 30, 1996. By necessity, the level of technical assistance was reduced. Project objectives were also adjusted, focusing on a precise set of performance indicators to measure end-of-project status:

- Proposed legislation for a NHI program will be presented and debated in Congress;

- DOH capacity for health policy, strategic financial planning, and SLR will be established through institutionalization of the health policy development staff (HPDS), systems development for budget and planning and organizational development of the standards, licensing, and regulatory functions of DOH;

- Linkages will be created with stakeholders in local governments, other government agencies, the private sector, and Congress to formulate health policy through the development of a multisectoral health policy forum and

the strengthening of the Department Legislative and Liaison Office (DLLO); and,

- Health care expenditure patterns will be quantified and tracked through the establishment of a national health accounts (NHA) system.

(A summary of end-of-project status is included in appendix A.)

The purpose of this evaluation was to determine the extent to which HFDP fulfilled its purpose and achieved its objectives. Numerous people who had been associated with HFDP or were familiar with its activities were interviewed during the evaluation. Resource documents were also examined. In addition, site visits were made to several provinces outside of Metro Manila. (Individuals interviewed and resource materials are listed in appendices B and C, respectively. The scope of work for the evaluation is contained in appendix E.) Specifically, three major factors were assessed: the project's management structure and processes, the project's impact in its five program areas, and the sustainability of project accomplishments. Recommendations that can help the GOP in its efforts to nurture and strengthen the gains achieved by the project are based on the findings of the evaluation.

II. MANAGEMENT STRUCTURE AND PROCESSES

The design and organization of HFDP and the strategies and processes used in managing its programs contributed significantly to the project's success. In spite of reduced funding and the resultant decrease in technical support and time, project objectives were largely met or even exceeded, as exemplified by the passage of the National Health Insurance Law (NHIL).

PROJECT DESIGN

HFDP's design remained flexible, adhering to its initial goal and purpose while adapting to DOH's changing role and priorities and adjusting to USAID's budgetary constraints. By intent, the project focused primarily on informing the health policy development process and building DOH's managerial capacity. In addition, many products and methodologies were designed and tested for strengthening the capacity of LGUs to manage local health programs. What is needed now is a continuing effort to assure that the project's many accomplishments are fully implemented and sustained.

The initial project design was appropriate. In the early 1990s, at the time HFDP was being conceptualized, the Philippine health care system was just entering a period of transition. Health services in the country had been chronically underfunded and the health profile of the population was beginning to shift from a predominance of infectious diseases toward increased chronic and degenerative diseases. It was becoming increasingly clear to DOH that the government did not and would not have the financial resources to adequately address the health needs of all Filipinos. If the health system were to improve, existing resources would need to be used more efficiently and new resources would have to be identified. Changes would require major shifts in health financing policy, a reshaping of the public health care system, and an expanded role for the private health sector.

By design, the project emphasized studies, research, and demonstration projects that would inform the policy-making process and build the capacity of DOH to manage its changing obligations. Intentionally, the project was not designed to stress policy implementation but rather to provide tools and methodologies that could be used to support ongoing implementation efforts. At the time, the original project design appropriately reflected the needs of the country and the philosophy and approach of DOH's leadership.

The redesign responded appropriately to changing priorities and financial constraints. In the redesign exercise, the project became closely aligned with the changing programs and priorities of the new DOH leadership. The project focused more directly than before on health financing policy and also became increasingly responsive to DOH's immediate operational concerns—particularly the impact of devolution. As a result, DOH leadership provided HFDP with consistently strong support.

Both the initial project design and the redesign appropriately addressed hospital strengthening. It was appropriate that HFDP address hospital strengthening since hospitals consume a substantial portion of DOH's annual recurrent budget. DOH needs to manage its retained hospitals to assure that its expenditures are well spent. Enhancing the ability of devolved hospitals to generate increased revenues and to implement other programs to improve their managerial efficiency is unquestionably needed. By rationing hospital-related expenditures, additional resources can be assigned to primary care activities. Still, while emphasizing hospitals, the project provided at least some focus on clarifying and strengthening the roles of DOH and LGUs in administering primary care programs. The *Comprehensive Health Care Agreement* certainly helped in this direction. The *Hospitals as Centers of Wellness Program* is a worthy example of redirecting hospital programs toward health promotion and prevention.

Neither the initial project design nor the redesign clearly describes the framework that integrates various program components. On the surface it would appear that each HFDP program area was treated separately and a framework for integrating financing policies, regulations, and legislation was not clearly defined. By design, HFDP did not place much overt emphasis on the interrelationship among the various project programs. Even so, the early monographs and papers provided an integrative framework for understanding the health policy formulation process and underscored the importance of health care financing policies in the Philippines. In addition, project managers devoted considerable attention to meetings designed to coordinate various project components. The multisectoral health policy forum (MHPF) and other means were also designed to provide an integrated approach. An articulated integrative framework would help provide an additional measure of continuity given the frequent changes in DOH leadership. Whatever direction the current Secretary of Health takes should be done in cognizance of DOH's basic mandate and vision as derived from a comprehensive framework which the HFDP outputs can provide when taken in total.

The redesign resulted in less attention to the role of the private sector. It placed less emphasis on the long-term goal of creating a policy environment that would stimulate increased private sector participation and investments in meeting national health financing requirements. MHPF created a venue in which the public and private sector could interact; however, few concrete recommendations have yet to be developed on how the regulatory environment might support further private sector development, how continuing education could raise the quality of health professionals in both the public and private sector, or on defining the conditions required for private providers to participate in serving the needs of the poor. Private resources already account for more than half of all health expenditures in the country; the private sector has considerable potential as a source for additional financial input.

ORGANIZATION AND LEADERSHIP

DOH leadership demonstrated commitment and initiative in pursuing project objectives. USAID showed remarkable responsiveness to changing governmental priorities and flexibility in adjusting to significant reductions in budgets and resources.

HFDP's administrative organization was structurally integrated with DOH. From the onset, each program component was administered within the corresponding DOH department, rather than by creating a separate HFDP office. This integrated organization led to close alignment of HFDP activities with DOH interests, created an increased sense of ownership of project goals among DOH staff and leadership, and led to increased capacity building within DOH. A disadvantage of the integrated approach was that it required more time to coordinate program activities; at times, project staff felt overwhelmed with meetings devoted to communication.

The individuals involved in HFDP were capable and highly motivated. Of the numerous people interviewed during this evaluation, all reported being pleased with their participation in the project and were complimentary to their colleagues. DOH was consistent in assigning capable staff to project activities and freeing them from conflicting assignments. USAID staff members are deserving of praise for their responsiveness to the changing needs of DOH. Their willingness to adapt to the desires of the new Secretary of DOH is quite remarkable. USAID's responsiveness reflects a strong commitment to maintaining a supportive role throughout the project, encouraging an open dialogue, and avoiding becoming overly involved in the project or being faithful to an outmoded project design.

HFDP overcame early delays in mobilizing technical assistance. During the first two years of the project, MSH had difficulty mobilizing the numerous research studies and demonstration projects called for in its terms of reference (TOR). In the midterm evaluation, MSH was cited for underestimating the skills and experience needed to comply with USAID contracting regulations, resulting in untoward delays in issuing contracts to local firms and individual consultants. In fairness, MSH's failure may have been due, at least in part, to an unrealistic schedule of work and deadlines. By late 1993, MSH's contracting problems began to abate. In retrospect, it is difficult to evaluate what might have been done to correct the problem at an early stage. What is important now, at the conclusion of the project, is that in spite of a slow start, the project is remarkable in terms of the number, quality, and usefulness of the studies and demonstration projects it sponsored and the reports and papers it ultimately produced.

RESOURCES AND TECHNICAL ASSISTANCE

The project was not large initially; during the redesign, budget reductions resulted in a significant decrease in technical assistance. Even so, the project was able to largely achieve its objectives, accomplishing a great deal with limited resources. Given its limited resources,

HFDP's accomplishments are impressive. The project was successful in achieving or exceeding nearly all of its objectives. It sponsored research and studies that helped inform the process that led to passage of the NHIL. It added a wealth of useful information on numerous health policy issues. It supported demonstration projects that will help improve the financing and efficiency of health services. And, it supported training and study tours that helped create a cadre of local health professionals who are knowledgeable about health policy issues. Considering the reductions that occurred during project redesign, the project deserves commendation for its accomplishments and for the way in which it was managed.

As evidenced by the number and quality of the studies and demonstration projects conducted, the reports produced under HFDP guidance, and the testimony of those involved, the quality and sensitivity of the technical assistance provided to the project appears to have been particularly high. Consultants were successful in maintaining a low profile by providing support and encouragement to DOH personnel while refraining from leading or directing program activities. Project consultants were consistently cited by DOH staff for the quality of their technical expertise and their responsiveness to local needs and expectations.

HFDP did not have the time nor resources to adequately build the capacity for implementing project gains. By design, the project was not intended to support the full implementation of the materials developed from research and demonstration projects. Rather, the project was to work with DOH in refining its processes, tools, and methodologies and building its capacity to manage further implementation with its own resources. Even so, near the end of the project, there was only enough time and technical support to begin the process of converting the vast store of knowledge gained from research and demonstration projects into implementable action plans. For example, many products were developed for improving hospital finances and management, such as revenue enhancement, organizational options, drug procurement streamlining, health insurance programming, and computerized management information systems (MISs). Efforts to apply these products to a sampling of devolved institutions were concentrated in the latter half of 1996, only a few months before the project was to terminate. While last-minute efforts appear to have been successful in raising the awareness of local authorities and initiating projects in a few areas, there was too little time and too few resources to do much about training DOH and regional officials on expanding the effort to a larger audience.

STRATEGIES AND ACTIVITIES

Even with limited resources, HFDP served as a catalyst for achieving significant change in the Philippines health care system. HFDP-sponsored research and demonstration projects contributed significantly to informing the policy development process. Because of time constraints, only a sampling of the numerous documents produced under HFDP's guidance were reviewed during the evaluation. (See appendix C. A complete list of HFDP publications is included in the *Annotated List of Benchmark Documents*.) It is evident from

the documents that HFDP created a wealth of substantive information on a wide range of health policy issues. According to the individuals interviewed during this evaluation, information and insights gained from these documents enriched the numerous workshops, seminars, and informal dialogues that were conducted during the project. Many of these documents are still relevant to the issues of the day and can be useful as a continuing source of helpful information to policy makers, researchers, and health care leaders.

Demonstration projects were useful in testing new ideas and providing examples of how innovations could be implemented. Demonstration projects were used to develop tools and methodologies for hospital revenue enhancement, MISs, streamlined drug purchasing, and other programs designed to improve the financing and management efficiency of hospitals and other health services. They provided practical, real-life experiences that are readily replicable.

The usefulness of research-based information in policy formulation was well demonstrated during the project. Recognition of the need for new legislation on NHI, followed by the drafting of the bill and eventually the garnering of support for its successful passage, can be attributed in large part to the availability of good information and a cadre of people who knew how to use that information persuasively. The contribution that good information can make to policy making was acknowledged by many of the respondents. The HPDS can continue to play an important role in supporting informed policy making, assuming it has organizational permanence.

An industry of informed health policy experts and consultants has been created within the Philippines. In conducting numerous studies and demonstration projects, sponsoring training and study tours, and involving a substantial number of local advisers, HFDP has helped create a cadre of people within the country who are sophisticated in applying research methodologies, knowledgeable about health care issues, familiar with the workings of DOH, and available for future contributions to the field. As a result of the project, the Philippines is far less dependent on foreign advisers and technical support for health policy research. In fact, the Philippines has become a focus of international interest because of its accomplishments in health sector reform. The country's experience in NHI and devolution are regularly cited as examples of health reform initiatives by the World Bank and other development agencies. In the last few years, the Philippines has hosted study tours of delegations representing health officials from Malaysia, Vietnam, Thailand, and other countries.

Many of those interviewed during this evaluation attributed much of the project's success to the numerous workshops and forums that were used to advance the project's agenda. At an early point in the project, workshops were used to help build a sense of teamwork among DOH, USAID, and contract advisers. A series of forums was used to create a policy dialogue among members of Congress, the Senate, and project personnel. Workshops were used to train participants in strategic planning methodologies and a traveling seminar was

used to familiarize DOH leaders with health financing alternatives in other countries. Multidisciplinary task forces were used to develop several hospital technical manuals and regular working meetings were used to plan how to advance the legislative agenda. While the number of meetings became occasionally burdensome, the end result was remarkably open communication and a sense of inclusiveness and ownership of project results.

Study tours were useful in orienting key individuals to important issues. Early in the project, a number of officials participated in a study tour to Korea, Thailand, and the U.S. to examine how other countries were working with health financing issues. The tours were instrumental in expanding the perspective of the participants and greatly enriched the dialogue that eventually led to passage of NHI. Later, a group visited the Joint Commission for Accreditation of Healthcare Organizations (JCAHO) to study accreditation methodologies which led to a study of DOH's approach to accreditation.

The use of benchmarks both enhanced and constrained project accomplishments. Benchmarks were used primarily as a management tool for documenting the information gathered from the numerous studies, demonstration projects, and workshops sponsored by the project—the main focus of the project design. Undoubtedly, establishing benchmarks helped assure that the information gained would be visible, would not be lost, and would create an extensive library of potentially useful information. But by design, benchmarks emphasized information gathering and policy making, and did not adequately stress information dissemination and application. Documents were often published in technical language and were sometimes difficult to understand and apply at the local level. Benchmarks would have been most useful if they had emphasized the setting of concrete goals for capacity building and implementation strategy to help guide and encourage DOH initiative.

III. NATIONAL HEALTH INSURANCE

In August 1969, Republic Act 6111 established the Medicare program, which was implemented on January 1, 1972, by the creation of the Philippine Medical Care Commission (PMCC). The PMCC was attached to DOH. Medicare was implemented in two phases: Program I (P-I) covers public and private sector employees, their dependents, retirees, and the self-employed; and, Program II (P-II) covers the informal sector. P-I was implemented through the Social Security System (SSS) for private sector employees and through the Government Service Insurance System (GSIS) for public sector employees. By 1990, an estimated 23.5 million Filipinos (38 percent) were covered by Medicare. In addition to the government health insurance programs, there are about 23 health maintenance organizations (HMOs) in the Philippines, organized along the lines of prepaid group practice, or individual practice associations. In 1995, it was estimated that 2 million persons (3 percent of the population) were covered by HMOs. By 1988, there were 102 private insurance companies providing health and accident indemnity insurance. By the mid-1990s, the Overseas Workers' Welfare Administration (OWWA) was added as a P-I.

P-Is were extensively analyzed in two HFDP monographs (6 and 7, respectively): *Health Insurance in the Philippines*, by Gamboa, R. et al., and *Results of Recent Research Concerning Medicare in the Philippines*, by Almario, E. et al. Among the findings of these two publications is that organizational, administrative, and management deficiencies impaired the effectiveness of P-I. The disjointed policy and management functions dispensed by the three agencies (PMCC, GSIS, and SSS) fragmented the program. The reports compare the GSIS and SSS programs in terms of their focus on benefits versus investment income, respectively (as well as differences in their financial reserves), differences in claims processing periods, lack of ability to contract with entities other than hospitals and doctors, failure to conduct research and development activities, and the regressive nature of the premium structure (employer and employee each pay 2.5 percent of salary up to a maximum). The organizations also suffered from fraud and abuse. Nevertheless, GSIS and SSS resisted reform initiatives under Medicare. Other HFDP research demonstrated that the Medicare program caused price inflation in the health sector. Specifically, providers, whether private or public, charged more to Medicare patients than to non-Medicare patients. As a result of these factors, P-I was unable to provide adequate financial support to insured members.

Similarly, Medicare has been unable to extend medical insurance coverage to the informal, non-wage-based sector. P-II existed for that purpose, but had not been implemented beyond sporadic, isolated, small-scale pilot projects. As a consequence, health insurance coverage is almost nonexistent for 40 million people in the informal sector. (See appendix D for further details on P-II pilots.)

In the early 1990s, policy makers began to think about the creation of NHI, whereby the state would address problems with the Medicare program and increase coverage to the entire population. Specific efforts to design a NHI program began in July 1993, with a forum at the Manila Hotel which was attended by both senators and congressmen. HFDP had orchestrated the forum such that the bills taking shape in the Senate and the House would benefit from the studies being conducted and about to be conducted by HFDP. At the end of the forum, Senate President Angara asked Secretary Flavier to draft a NHI bill.

Within the same month, the health insurance bill discussion group began a series of monthly meetings intended to result in a NHI bill. The group was chaired by the Under Secretary of DOH and Juan Nanagas (vice chairman of PMCC) and brought together representatives of PMCC (Melinda Mercado), HFDP (Jim Jeffers, Oscar Picazo, and Lyn Almario), DOH (Marl Mantala), and the Senate (Marilen Danguilan, and Dr. Mari Ortega). This group would not have existed or operated without HFDP. The task force's major contribution was to bring together in a small group representatives of large entities who were key players in NHI, and to integrate their focus so that they could return to their respective entities and advocate for the task force's opinions/recommendations. This group was of primary importance to the drafting and passage of NHI and carried out the following activities:

- Created a constituency in the public and private sectors,
- Increased awareness of NHI and pertinent issues among this constituency through publications and public forums,
- Brought other countries' experiences to bear on the Philippine experience through study tours,
- Bridged the Senate and Congressional versions of the bill,
- Developed costing models which were presented to political staff and actuarial societies,
- Prevailed against violent objections in the media (objections under business and insurance industry columns), and
- Stewarded the legislative process.

At some point, the process became self-sustaining and was affected by factors outside the group. For example, President Ramos was developing the concept of a minimum standard of assistance for all. Secretary Flavier was using NHI as a possible platform for running for the Senate. Clearly, this component of HFDP was an illustration of how a project could transform research into policy into legislation in a democratic process. It

brought about the greatest possible structural impact on the country's health care financing, using a mix of research studies, demonstration projects, conferences, and milestone activities for key players (for example, strategic planning and operational workshops for PMCC) to push, not just shape, the process until the NHI bill was signed into law on February 14, 1995.

The legislation contained many important provisions, including: universal coverage; a basic benefit package (BBP) which was eventually to include inpatient, outpatient, and emergency services; the insurance was budget constrained, rather than based on entitlement; and, flexibility regarding the means for contracting with providers, including HMOs.

By March 5, 1995, the legislation became effective. In accord with the NHIL, President Ramos selected Jose Fabia, an attorney, as the president and chief executive officer of the Philippine Health Insurance Corporation (PHIC). PHIC has the status of a tax-exempt government corporation attached to DOH for policy coordination and guidance. Mr. Fabia took office on August 1, 1995, at the same time that PHIC replaced PMCC, operating initially under the old PMCC implementing rules and regulations (IRR). At this time, a task force in DOH was considering new IRR for NHI. The IRR passed in December 22, 1996. The IRR included setting the premium and benefits of beneficiaries, abuse control, and quality assurance provisions. The IRR also indicated that the funds of the SSS and GSIS were to be transferred to PHIC within 60 days of the completion of the IRR. In addition, Congress was to allocate 25 percent of the incremental income from taxes such as alcohol and tobacco (estimated at P2.5 billion pesos) and additional funds from general revenues. Funding for indigent enrollees is to come from national and LGU sources, and after 5 years, 50 percent of the funding is to come from the LGU. Indigency and ability to pay are to be ascertained by means testing. For those paying, contributions are not to exceed 3 percent of their estimated salary income. At the same time, the SSS and GSIS are to continue to enroll beneficiaries, collect premiums, and process and pay claims until such time as PHIC is set up sufficiently to take over these tasks. Finally, the IRR recognize that there are two benefit packages: BBP; and, supplemental coverage for GSIS, OWWA, and SSS members, but stipulated that the differences in the BBP between indigents and these other groups were to be eliminated after 5 years of program operation. The supplemental package could still be provided for an additional fee. The NHIL calls for the development of local health insurance offices (LHIOs) for purposes of collections and claims management. It is likely that these offices will be based on the model of the regional offices of the SSS, and, in fact, PHIC may contract with SSS to provide field services early in implementation. PHIC has a health financing policy research office which will function like HFDP.

HFDP helped to create a new relative unit value (RUV) scale which received a science award. Incorporating this new RUV into provider contracts under NHI should help to control payments to providers given that there are other controls on the volume of services provided, for example, capitation, ceilings on the number of visits, and demand-side controls, such as copayment and coinsurance.

As of March 4, 1997, PHIC had signed a memorandum of agreement with 3 provinces, and 14 more were to be signed by the end of March in Malacanang with provinces which have committed and complied with the requirements of the NHI program. It is hoped that enrollment of beneficiaries will begin in April/May of 1997.

The PHIC, SSS, and GSIS are meeting to set up a plan for the transfer of funds and program responsibilities. Under the NHIL, the GSIS and SSS will be combined with PHIC within a period of 5 years after issuance of the IRR. Given the different accounting systems and objectives of the two organizations, the transfer of responsibilities will not prove simple, but once complete should provide increased efficiency in marketing, collections, and claims processing. Compressing this transition into 18 months, as is the current hope of PHIC, may not be feasible if a high-quality outcome is desired.

PROGRAM ACTIVITIES AND ACCOMPLISHMENTS

In the *Project Paper: HFDP*, the goal for the second component was to improve the efficiency and expand the coverage of the national health care financing program. Thus, during the first phase of the project, project activities and benchmarks were aimed at improving and expanding Medicare coverage. In addition, the project was intended to examine ways to encourage the development of private sector options for health care financing. The sequence of activities was to follow a particular format: diagnostic stage, design stage, demonstration stage, and policy stage. Specific outputs included papers, consultative meetings, design of demonstration schemes, policy proposals, workshops, needs assessments, training, and information, education, and communication (IEC) campaigns. Most of the project outputs were to be completed during the third and fourth years of the project. One notable exception was that the implementation of an areawide P-II model was to occur in the fourth and fifth years of the project, which was later dropped in the project redesign in order to focus on the NHI tasks at hand.

These activities and outputs remained largely unchanged with the modification of the project, except for the addition of activities related to the development of a NHI plan. The following project activities were outlined in the project amendment.

Policy Recommendations on Medicare

Program activities were to include: support studies and consultations aimed at improved compliance with P-I; expanding health benefits under P-I through inclusion of outpatient services; improving physician payment through development of a RUV scale; improving claims processing and reducing fraud and abuse; and, restructuring the P-I with the possible unification of functions currently dispensed by three entities (PMCC, SSS, and GSIS). The project will also provide for: technical assistance and implementation support for the reduction of fraud; improvement of accreditation and licensure; formulation of HMO regulation; development of a Medicare MIS; production of a monograph on the PMCC

health data system; and, organizational improvement and capacity building at PMCC. Accomplishments include:

- Activities for Fiscal Years 1991 and 1992 were geared towards contracting the institutional contractor and subcontractor and the cooperative grantee.

- A study on the PMCC-HMO tie-up project was carried out under the child survival project, and a second study was carried out under HFDP. No further activities were conducted in this area as work on the NHI bill had commenced and it contained provision for HMO participation.

- The P-I reform studies were not achieved in the first year of the project because, as noted in the *Mid-Term Evaluation of HFDP*, MSH had difficulty with the procedures for contracting for consulting services.

- Numerous studies were completed on various aspects of P-I: claims processing, expanded coverage, and employer-provided benefits.

- A study on public awareness and attitudes concerning Medicare was conducted and used in designing a public campaign of IEC.

- A series of reports on the PMCC health data system was prepared, assessing its effectiveness and recommending improvements.

- A study on the applicability of a RUV system for compensating physicians was completed.

- Reports were prepared on outpatient benefit packages and claims processing.

- Numerous workshops were held, with papers prepared in advance, to orient members of the PHIC board.

- A plan for the organizational design of PHIC was proposed and adopted.

Policy Recommendations on P-II

Program activities were to include: support for government-sponsored LGU-based health financing schemes in the provinces of Bukidnon, Quezon, and Guimaras; design of a pilot scheme on employer-provided health benefits; and, strategic planning on the coverage of the self-employed and urban poor. Accomplishments include:

- Publication of a manual of operations for the Bukidnon Health Insurance Project (BHIP);

- Preparation of a training manual for BHIP;
- Publication of *A Guidebook in Setting Up a Provincial Health Insurance Program*; and,
- A site visit to Bukidnon in July 1994, to help orient members of the core group.

Drafting a NHI Bill

Program activities were to include: support for the technical working group formulating the NHI bill; consultative discussions and technical support during the legislative debate on the bill, including the regular "Medicare Miting" series; development of a spreadsheet model (the "First Principles" project) that estimates the financial cost of alternative assumptions on NHI coverage and benefit packages; and, evaluation of the P-II pilot schemes. Accomplishments include:

- A draft bill was prepared, entitled *The National Health Care Act of 1994.*
- *First Principles of Health Care Financing: A Guide for Proponents and Evaluators of Reform Proposals* was published in September 1993.
- *National Health Insurance (A Costing Simulation Model)* was published in June 1994.
- A *Seminar on Health Insurance Principles, Experiences, and Issues* was held in July 1994.
- A *Technical Review Workshop on the NHI Costing Model* was held in July 1994.
- A series of seminars was held on various aspects of NHI.
- IRR were proposed, discussed, and ultimately adopted.

PROGRAM IMPACT

The project played a catalytic role in the passage of the NHIL. HFDP clearly had an impact on shaping the NHIL, IRR, and operating procedures of PHIC. This was accomplished through the preparation of analytical studies and operational manuals, expatriate and national technical assistance, and the activities of DLLO. However, the actual passage of the legislation and setup of the new system would not have occurred without a certain change in the attitudes among significant members of the executive and legislative

branches of government who wanted to pass NHI legislation. In addition, it occurred during a time when President Ramos was considering a minimum standard of coverage for all. By virtue of HFDP's human and financial resources, DOH was engaged in a somewhat different process of policy development than previously, one that was based on better research information, was more skillful in creating constituencies and consensus among important individuals, and was more astute in advocacy with the legislature. Previously, other important pieces of legislation which DOH had passed previous to the NHIL include the generic drug law and the magna carta for health workers. DOH's experience with passage of these pieces of legislation helped to prepare them for passage of the NHIL.

The project was instrumental in getting PMCC to focus on the development of the P-IIs. HFDP was instrumental in the design and startup of BHIP, the Guimaras Health Insurance Project (GHIP), and primarily through PMCC staff, the Sampaloc P-IIs. Unfortunately, the project was not able to create a replicable P-II model. Additional technical assistance would have been useful for the operation of the BHIP and GHIP to develop strategies that would make them less reliant on provincial subsidies. While HFDP technical consultants recommended providing additional resources to the BHIP to ensure installation of adequate administrative infrastructure, DOH management felt it necessary to allocate limited HFDP resources to other operational concerns/geographic areas. In addition, USAID was not able to provide an extension of the project, which would have been useful not only for follow up of the P-IIs but for other implementation activities. Had HFDP continued into a second phase as envisioned at the time of the project design, it might have been possible to design replicable models. As it stands, PHIC must put NHI in the field without the benefit of information from a successful pilot project. Nonetheless, the shortcomings of the P-IIs do offer some lessons learned for NHI.

SUSTAINABILITY

The sustainability of NHI will depend on several factors:

- The adequacy of the actuarial estimated premium for the BBP;
- The smoothness of the administrative transition from the SSS and GSIS to PHIC;
- The effective establishment of LHIOs within the LGC structure;
- Abilities of the LHIO staff in enrolling the indigent and monitoring their use of care, and monitoring the appropriateness and quality of providers' services;
- The level of national support provided to the program through the Department of Budget and Management (DBM); and,

- The level of LGU support, particularly over time, as they become increasingly responsible for paying the premiums for the indigent, and as indigent benefits improve.

The success of the NHIL is not yet certain. Given that PHIC has only been in operation for a year and a half and has not yet begun to enroll the indigent, nor has it taken control of the SSS and GSIS funds, it is too early to determine the success or failure of the program. The SSS holds the view that the actuarial estimates are unsound, and that the SSS investment fund will be used to pay for the benefits of the indigent in the short term. Further, they question whether PHIC will be able to develop the administrative capability to manage the program, even if a large number of current GSIS and SSS employees joins PHIC. Rather than accelerate implementation, as PHIC wants to do, SSS would prefer to decelerate implementation in order for further study to be made of their issues of concern. Additional evidence of the lack of support for NHI is the unwillingness of P-IIs, such as Guimaras and Sampaloc, to join NHI. NHI is just in its infancy and no longer has access to the type of technical and financial support that came from HFDP. Fortunately, the German Technical and Financial Assistance Project (GTZ) has developed the Social Health Insurance Networking and Empowerment Project (SHINE), which will support PHIC's MIS needs for indigents as well as some of the needs of the Health Finance Policy Research Office in PHIC. PHIC needs technical support in all areas of implementing insurance programs.

Several questions about NHI need to be resolved:

- Will the Congress and LGUs allocate sufficient funds to cover the insurance premiums of the indigent?

- What benefits will NHI bring those who do not have access to hospital services?

- How will the program change over time to allow for outpatient and emergency service coverage as included in the law?

- How will the program change over the next 5 years to allow the BBP for indigents to be equal to that of SSS and GSIS members?

BHIP and GHIP are not succeeding in becoming self-sufficient programs. Instead, BHIP is becoming a highly-subsidized program to finance health services for those who would incur higher medical bills than the premium, and has led the provincial government to request that the project staff take steps to make the project more self-sustaining than it is. In order to enroll the entire population in the program, GHIP will need to mount a new and intensive informational and educational campaign, as well as remunerate those enrolling new and old members in a timely manner. It has been suggested by a member of the Provincial Planning and Development Office (PPDO) that GHIP collect monies being collected by the

barangay health workers through the barangay, LGU, and provincial treasurers. This would eliminate the costs associated with the municipal clerks (P158,400 pesos per year). Overall, the administrative costs of these programs seem high; if they could be reduced, the financial status of the programs would be more secure than it is. HFDP assistance to these projects was insufficient to provide them with an information system that had the necessary networking capability; follow-up technical assistance was not provided. HFDP should have continued to have an active participation in the program in order to facilitate troubleshooting and adoption of practices that would make the program financially sustainable. To the extent that these programs could be taken as models for health insurance in rural areas of the Philippines, the failure of these programs to thrive (not the fault of its enthusiastic leaders and staff) does not hold much promise for the implementation of NHI for the poor, especially as Bukidnon is one of the financially stable provinces.

LESSONS LEARNED

The passage and implementation of the NHIL was not solely a technical task. Rather, political actors and events played at least as large a role in achieving such broad reform. The project provided needed technical input to the political process, and in a sense, created a demand for information-driven policy making. The project was unique because it was able to focus on a direction, incorporate research and technical assistance, and work through various public departments (for example, top management of the executive and legislative departments) and processes (for example, networking) towards it. Many interviewees reported that the HFDP was "the right project, in the right place, at the right time."

While policy reform took place quickly, its implementation will take time. Thus, while DOH has adopted some changes in the aftermath of devolution, it is not clear that the need for a project like HFDP, which supports policy research and forums for discussions, does not continue today. Perhaps to institutionalize some of the changes (for example, staffing of DLLO and HPDS with permanent staff, providing national financing for the indigent under the NHI), conditional assistance might be considered.

The passage of NHI legislation required vision on the part of its designers; so also does the implementation of the law. NHI will initially provide hospital care financing for about 40 percent of the population, and is to increase to 100 percent. The specific development of the insurance program, especially the addition of outpatient benefits, will have consequences for the shape and scope of the health sector for decades to come. (For example, Akin [1984] found that the institution of Medicare led to the increased provision of hospital care in the underserved areas of the Philippines.) The Secretary of DOH must maintain a high level of knowledge and critical thought about NHI to guide the development of the sector similar to the national health plan.

While not successful from the point of view of sustainability, the P-IIs do offer valuable lessons learned. Voluntary enrollment leaves open the possibility for adverse selection.

Compulsory enrollment, for a social insurance program, should be adopted. Fee-for-service reimbursement leaves open the possibility of physician-induced demand. Instituting capitation payments for outpatient care, or copayments, can help to minimize this problem. Raising the price of insurance may lower total revenues, if the demand for health insurance is elastic. Intensive IEC is required at the time of a price change to encourage membership. Measures to decrease administrative costs will aid in improving financial sustainability. Several respondents suggested that the P-IIs use the LGU treasurers for the collection of premiums, rather than rely on voluntary labor or pay additional staff.

P-II pilots needed additional technical and material assistance to move towards self-financing programs that would provide guidance for the implementation of NHI. Technical assistance that was provided at the end of the project (May through September, 1996) aimed at getting some of the HFDP products to the field might have been redirected at further assisting the P-II pilots with their design problems. However, it is likely that technical assistance needs will be required even after the end of the project. PHIC has to develop the inhouse capability to assist provinces and LGUs with technical issues or budget for outside technical assistance to do so.

RECOMMENDATIONS

The 18-month implementation timeframe to combine the PHIC, GSIS, and SSS (instead of the 5 years allowed in the NHIL) and to start implementation in 17 provinces by March 1997, should be reviewed. DOH and PHIC should reexamine the implementation plan for combining PHIC, GSIS, and SSS, and determine the wisdom of quick implementation (18 months) over a slower implementation (5 years for these tasks as provided in the law) that would allow for additional evaluation of efforts as they progress. Certain political considerations may play into the selection of the 18-month implementation timeframe. Issues such as use of the SSS and GSIS reserve funds, development of the LHIOs using SSS staff and the efficiency with which they handle collections and claims, the adequacy of the actuarial estimate for the BBP, the amount which will be forthcoming from the DBM and LGUs over time determining the spread of coverage/equity, and the feasibility of extending the BBP over time, should all be reviewed. Of importance is that NHI achieve its objectives of equity and efficiency over the long term, rather than achieve short-term political achievements.

The Secretary of DOH should take an active role as chairperson of the PHIC board. As it is expected that significantly greater funds will flow through the government insurance system in the future than in the past, the Secretary of DOH should see her role as chairperson of the PHIC board as one of the ways that she can shape the health sector. She should bring new ideas to the board regarding improvement of NHI, as well as critique the performance of PHIC in implementation. Technical assistance could be provided by the HPDS staff and/or outside consultants who are familiar with a broad understanding of the

health sector in the Philippines and with NHI. Funding for such technical assistance should be forthcoming from the GOP.

PHIC's Health Financing Policy Research Office and the GTZ SHINE project should proceed with rapid assessment of the Bukidnon and Guimaras experiences and determine what steps can be taken to make these programs financially viable. In addition, the initial provinces where PHIC will set up NHI programs should be monitored and evaluated frequently to obtain information relevant for program replication.

PHIC needs to mount IEC campaigns in provinces where implementation will take place to ensure that indigent beneficiaries are aware of their benefits and responsibilities. IEC campaigns should be targeted directly to the population.

Government and donor assistance should be sought for technical assistance for continued policy development and implementation assistance to PHIC. Government and donor support should be sought to help evaluate the soundness of the IRR and administrative orders for PHIC. This should occur both before launching the program as well as after the program has been underway, for at least the first 5 years. Local consultants who worked under HFDP could be hired for this purpose. GTZ is providing assistance to PHIC through the SHINE project which focuses on insurance system MISs for indigents in four provinces. The Asian Development Bank, through its Integrated Community Health Project, is providing $40,000 for each of six provinces to initiate insurance activities there. To a large extent, the types of technical assistance which will be required will depend on the number and type of personnel who shift to the PHIC from the GSIS and SSS, which are currently managing health insurance programs. If such staff do not join PHIC, then technical assistance will be needed to train others to carry out the required tasks. Other areas where technical assistance may be useful will be in developing capitation arrangements with physicians, hospitals, or HMOs.

IV. DEVOLUTION

The LGC of 1991 was signed into law and came into effect in 1992. This code called for the devolution of many governmental services, resulting in wholesale changes in the structure of government throughout the country. The purpose of the law was to bring basic services close to the people and to enhance the control of local government authorities. DOH was among the government agencies that were directly affected by this legislation. More than 600 provincial and local hospitals and a host of health clinics and services were transferred from DOH's supervision to provincial and municipal authorities. The DOH role changed significantly, retaining only 44 of the country's most sophisticated and specialized hospitals, greatly reducing its role as the major provider of public health services, and assuming a new role as planner and regulator of the health system.

Devolution posed several challenges, both at the department and local levels. The financing of health services shifted dramatically, with allocations for health going directly to local authorities, requiring new fiscal and regulatory mechanisms between DOH and LGUs. In addition, local authorities were not prepared to assume managerial responsibility for the operation of local hospitals and health services. Also, health workers who had been under the direction of DOH and subject to national wage scales were now under local direction. To help navigate the transitions brought on by devolution, DOH enlisted the resources of HFDP.

PROGRAM ACTIVITIES AND ACCOMPLISHMENTS

In the redesign of HFDP, the output of the devolution program was to be the development of DOH policies on public health financing under the LGC. Recommendations were to be made on general issues, such as fiscal policy on devolution, the implementation of the magna carta for health workers, and assistance for devolved hospitals. The program was to include the activities described in this section.

Assistance to GOP in the Devolution of Health Services

Formulation of Comprehensive Health Care Agreements (CHCA) between DOH and LGUs

The CHCA was to be the primary instrument by which DOH could influence the LGU provision of health services. The project was to assist DOH in the preparation and updating of its devolution strategy paper; the preparation of CHCA documents and conduct of prototype negotiations; and, technical assistance to the task force on devolution. Accomplishments include:

- A CHCA was developed and tested, and guidelines for its implementation were designed.

- A report documenting the development of the CHCA and its implementation was prepared.

- A study of how well the CHCA facilitated intergovernmental transfers was examined and a major paper was published.

- A system for monitoring the CHCA was introduced.

Fiscal Policy on Devolution

The project was to assist in crafting appropriate fiscal policies on devolution through studies that were to determine LGU fiscal behavior and policy tools to influence such behavior. The project also was to support draft fiscal policy proposals for legislative action. Accomplishments include:

- Policies and legislative initiatives that would address finances and resource mobilization were studied, with recommendations on DOH strategy and proposed legislation.

- A report on the hospital devolution study was prepared, describing the effects of devolution and offering several recommendations.

- A report, *The Impact of Devolution on Local Health Expenditures*, presented how decentralization affected local health care spending.

- Guidance was offered to policy makers on how financial transfers from central to local authorities should be managed.

- The effects of devolution on local health expenditures were examined in 12 provinces.

- The possible impact of Internal Revenue Administration incentives on local expenditures was examined.

- Technical assistance provided in Bukidnon and North Cotabato and LGU managers' training activities were documented. Three modules or training manuals were prepared on planning, budgeting, and references. In addition, 14 publications were produced on various demonstration projects, provincial health accounts (PHA), and other implementation efforts.

Development of Recommended Guidelines for Regional and Provincial Health Officers under Devolution

The project was to support demonstration projects at the regional (Region VIII) and provincial (Bohol Province) levels, seeking to field test mechanisms for health coordination and monitoring under devolution. Accomplishments include:

- The process of devolution in Bohol Province was documented.
- Mechanisms for regional health coordination were field tested and guidelines published.
- A *Manual for Regional Health Coordination* was prepared, based on experiences gained in Region VII.
- A *Strategic Plan for the Implementation of the Advanced Management Training on Decentralized Health System* was developed.
- How devolution had affected intergovernmental interactions was studied, with several recommendations offered.
- A report, *The Post Devolution DOH: Assuming a New Leadership Role*, was published in February 1996, suggesting a new role for DOH.
- Documentation was prepared of activities to build capacity in two regional field offices and eight provinces.

Conduct Pilot Course for LGU Managers

The University of the Philippines was to arrange a program through its College of Public Administration, under the auspices of the project. The pilot program for training local government officials, health managers, and implementers was developed.

Recommendations on the Implementation of the Magna Carta for Public Health Workers

The project was to support a study of the implementation of the magna carta and was to formulate a procedure for estimating its mandated benefits. Accomplishments include:

- A study of the impact of devolution on workers in 12 provinces, 8 cities, and 42 municipalities was conducted, resulting in publication of a paper, *Can Health Workers Ever Be Happy Under Devolution?*

- The issue of health workers was presented at the *Pesos for Health* conference held in December 1994.

Assistance to Devolved Public Hospitals

The project was to provide resources for the formulation of appropriate assistance to devolved hospitals. Project activities were to include: a study to determine the effects of LGC on devolved hospitals; a workshop for administrators of devolved hospitals; support for innovations in the management and/or ownership of devolved hospitals; assistance to LGUs on hospital management through a task order contract; and, technical assistance support for devolved hospitals. (Activities supporting retained hospitals are addressed in the SLR section of this report.) Accomplishments relating to devolved hospitals included:

- A workbook, *Management and Organizational Options for Devolved Hospitals*, was developed for local government officials and administrators of devolved hospitals.

- A how-to manual was developed to assist in the implementation of management and organizational options.

- A *Workshop for Devolved Hospital Administrators* was held in October 1993.

- A streamlined drug procurement system was designed and field tested in Negros Occidental and a report on the monitoring and evaluation of the new system was presented.

- Tarlac Province was given technical assistance to help improve the financial performance of its four devolved hospitals.

- Technical assistance was provided to Palawan Provincial Hospital to document the operation of its cooperative pharmacy program.

- The municipality of Imus was provided assistance to help operationalize its municipal hospital.

- Abstracts were prepared for several HFDP products for use by regional health officers, provincial governments, and devolved hospitals; suggestions on how the programs could be adopted were provided, also. TOR were issued for demonstration projects in Regions VII and X and an implementation project in North Cotabato. A manual on PHAs and a manual on provincial-level investment planning were published.

PROGRAM IMPACT

The devolution program contributed a great deal to understanding the challenges of devolution and to developing materials and methods for easing the transition. HFDP helped design and document activities needed to support the devolution process. The initiatives of the project were designed to support the financial institutionalization of the priorities of the Secretary of DOH as well as to provide models for successfully managing devolution. Development of the *Comprehensive Health Care Agreement* laid the foundation for negotiating new arrangements between the DOH and LGUs. Preparation of the *Implementation Manual for Managers and Organizational Options for Devolved Hospitals* provided local authorities with choices on how to organize hospitals under their jurisdiction. The experience gained in numerous studies and demonstration projects was used to prepare tools and methodologies for improving the financing and management of devolved hospitals.

HFDP helped develop replicable models of programs designed to support devolution. The feasibility and value of the hospital revenue enhancement, streamlined drug procurement, and MISs have been demonstrated. The experience at Ilocos Regional Hospital is illustrative. The hospital has been successful in generating increasingly greater revenues since starting the program 3 years ago, with steady growth in patient volumes. It has used the revenues to supplement its regular allocation, renovating and expanding its facilities, purchasing new equipment, and assuring the availability of essential supplies and drugs. At the same time, the hospital has instituted a program requiring indigent patients (or their family) to provide in-kind services in exchange for free health care. The Negros Oriental Provincial Hospital has had a similar experience. Revenue enhancement has considerable potential to enhance health financing at the local level and the program should be aggressively promoted.

HFDP helped demonstrate the applicability of devolution products at the local level. In mid-1996, as the project was drawing to a close, programs were launched in Regions VII and X to demonstrate how the various devolution products could be promoted and implemented. DOH worked with regional representatives to orient provincial governors and other local officials on the programs that were available, explained the resources needed to launch each program, and offered technical support to help implement programs that were selected. Provincial officials reported that the products addressed their needs. They were particularly receptive to programs that had a significant benefit with a minimum investment, such as the hospital revenue enhancement program. The approach used for Regions VII and X was shown to be applicable to other regions.

SUSTAINABILITY

The benefits of the accomplishments of the devolution program are substantial but have not been fully realized. DOH should continue its efforts toward implementing the products

that have been developed and building the capacity of LGUs to manage under the new system.

DOH will continue to be an important player in encouraging LGUs to assume expanded responsibility for health care programs. DOH has demonstrated the benefits of a number of useful devolution products or tools. But many LGUs do not place a strong priority on health care issues, are not well informed about the support that is available to them, or do not have the skills needed to adapt the tools to local conditions. DOH will need to maintain open communication with LGUs and will need to provide continuing training and technical assistance to help LGUs adapt to their new roles.

The devolution products developed with HFDP assistance should be periodically reviewed and updated to continue their relevance. The *Comprehensive Health Care Agreement*, the *Implementation Manual for Managers and Organizational Options for Devolved Hospitals*, the hospital technical manuals, and the several devolution products will continue to be useful in furthering the devolution process. At the same time, DOH should continuously evaluate the use of the materials and make adjustments and updates as required to maintain relevancy.

To sustain and further the devolution process, DOH needs to work closely with local political leaders. DOH should further promote the concept of "health care is good politics" as a way of gaining attention for health care issues among local government authorities, thereby encouraging the adoption of the devolution products developed under HFDP. Several local politicians have been able to use health care as an issue for gaining popular support. The Governor of Negros Oriental, for example, has gained considerable local and national visibility through his aggressive and creative support of local health boards. The Mayor of Sampaloc, in Quezon Province, has also gained visibility as an advocate for local health programs. However, even in these localities, and certainly in other communities, health care must continuously compete with other local priorities, such as education and the infrastructure.

LESSONS LEARNED

LGUs will not adopt innovative programs simply because they are well researched and documented or their success has been demonstrated elsewhere. As shown in the regional implementation exercises conducted in mid-1996, the various devolution products are seen by LGUs as valuable in addressing their needs. But LGUs have numerous challenges and priorities that compete with health care for funding and attention. The products need to gain visibility and their benefits need to be seen as worthy of the investment of time and resources. The proposed methodologies need to be compatible with local ways of conducting business and within the competence of local personnel. LGUs need to be fully informed on available programs and provided assistance until they feel confident managing independently.

DOH and most LGUs were not ready for the devolution that followed implementation of the LGC of 1991. For a period of time after the passage of the LGC, there were many individuals within DOH who thought they might be spared the need to implement devolution. Changes in DOH leadership added to the sense of uncertainty. As a result, there was little advance planning on how DOH was to proceed. Similarly, most LGUs were unprepared for devolution and many continue to struggle with how to deal with their new responsibilities. There are those who suggest that advance preparation for such a shift was impossible and that gradual implementation would have encountered even greater resistance. For now, given the approach that was used, it is imperative that DOH leadership maintain a consistently supportive stance toward devolution. Any hesitancy will be interpreted by those who are resisting the changes as an excuse for inaction.

Successful devolution of health services requires consistent political and bureaucratic support. DOH was hesitant to begin implementing devolution until unambiguous direction was given both within the DOH bureaucracy and at the highest political level. The law is clear, but continuity in implementation is compromised by frequent changes in DOH leadership and periodic turnover of local politicians. Newly elected local political leaders need to be informed about health issues and made knowledgeable about their options for managing local health services.

RECOMMENDATIONS

HFDP contributed significantly to the devolution effort, providing a variety of tools and methodologies that can help strengthen the capability of LGUs to manage their health service responsibilities.

DOH should continue its program to implement the innovations developed under HFDP. Tools and methodologies have been developed that address many of the needs of provincial and local governments, but their use needs to be promoted. DOH should work through its regional offices and local leagues to provide technical assistance, adapt products to local needs, support implementation, and build local management capacity.

DOH needs to develop strong linkages with LGUs. LGUs do not yet have the capacity to manage the health services now under their direction. LGUs need the continuing support of DOH in understanding the challenges they face, adapting devolution products to local use, and building local management capacity. In addition, if DOH is to be successful in fulfilling its expanded role of regulator for the health system, it will need an ongoing relationship with LGUs. Specifically, DOH should establish partnerships with local government leagues which could be useful conduits for feedback and information dissemination. League-sponsored seminars, publications, and training can assist in information sharing among local governments. Workshops should be held periodically to orient all newly elected local officials to essential health programs and to describe the kinds of assistance that can be provided to improve the financing and management of the health services under their

direction. In addition, DOH might establish an Internet home page which would create a communication link among LGUs that will become increasingly important as the needed technology is adopted locally.

Devolution products, the tools and methodologies developed under HFDP, should be reviewed for clarity and ease of application. Materials should be simplified and translated as necessary, creating more "how-to" manuals that can be appreciated in the countryside. Those with practical experience who have been involved in demonstration projects should be used as technical advisers and trainers, sharing their experience with others. Again, local leagues may prove to be useful partners in this effort.

DOH should document and publicize recent local innovations and successes. LGUs have continued to develop additional programs and innovations since HFDP's conclusion. DOH should continuously monitor these innovations, document their results, and communicate their findings with other LGUs, using local leagues and other means, as described above.

DOH needs to guide and support local programs in health promotion, prevention, and primary care. By design, the devolution program of HFDP focused largely on devolved hospitals. But LGUs also have increased responsibilities for managing programs in health promotion, prevention, and primary care. As illustrated by the recent measles outbreak, DOH is still seen as responsible for major public health programs, even though they are carried out under local direction. DOH needs to develop additional tools and methods that can guide and assist local authorities in managing their public health responsibilities, similar to the materials and strategies developed to improve the efficiency of devolved hospitals.

V. PUBLIC RESOURCE MANAGEMENT

Public resource management was introduced in the project redesign. In the early 1990s, public resource management at DOH was weak: the annual budget process lacked discipline and programmatic direction (the investment budget was not delineated from the overhead budget of the DOH); budgeting was usually on an incremental basis rather than on the basis of real needs; public investment criteria had a negative bias against health projects; priority DOH programs were identified but not the costs; and, the operations and logistics of the system had not kept pace with the requirements of a devolved system of health service provision. Finally, there was not a comprehensive national health plan.

PROGRAM ACTIVITIES AND ACCOMPLISHMENTS

The goal of the public resource management program was to seek to generate additional resources for health services in the public sector and to improve the allocative and operational efficiency in the use of these resources. The output for this component was to be a demonstrated capacity for strategic financial planning in the health sector. UPEcon was the sole contractor providing inputs to the resource allocation component of the project. Project activities, as outlined in the project amendment, were to include the following guidelines and recommendations:

Guidelines for the Public Investment Plan

A draft 10-year plan was to be submitted to the National Economic Development Authority (NEDA). Accomplishments include:

- A 10-year investment plan and an amended version were prepared and vetted with NEDA.
- The project prepared a framework for facility enhancement over the 5-year period, 1996-2000.
- An updated investment plan for the year 1996 was produced.

Guidelines for DOH Strategic Planning

The project was to develop guidelines; conduct workshops for budget and finance officers; plan for the 1994 and 1995 budgets; and, conduct performance and budget execution reviews. Accomplishments include:

- UPEcon provided technical assistance and conducted a number of workshops to improve planning and budgeting to Internal Planning Services (IPS).

- UPEcon continued to provide technical assistance to IPS, involving technical assistance, workshops, and development of documents and reports.

- From October 1995 to September 1996, three new contractual staff were hired by HFDP and added to the staff of IPS to form the program investment unit (PIU). In addition, HFDP provided: computers and other equipment; various furniture; training workshops for central staff on project planning, project appraisal, financial and economic analysis of projects, and health assessment; and, training workshops for central and regional staff on project development and project analysis.

- The project provided funding for interagency/office consultative meetings; support to priority DOH services and regional health offices (RHOs) for preparation of project proposals; funding to 13 RHOs for preparation of a 10- year investment proposal; funding to provide technical support for development of the investment plan; and, support for other miscellaneous activities, such as communication and transportation.

Recommendations on the Financing of Priority DOH Programs

The project was to prepare cost estimates for priority DOH programs; conduct cost-effectiveness studies; and, conduct a study of DOH-LGU cost-sharing in health programs. The expanded program on immunization and acute respiratory infection costing activities were undertaken by UPEcon and its consultants.

Improvement in the DOH Logistics System

The project was to produce a study on the DOH logistics system which will be used as the basis for an investment plan regarding logistics improvement. Specific documents were developed on improving logistics and drugs and medical supplies procurement.

Draft National Health Plan

The project prepared a draft of the national health plan, 1995 to 2020, which was recently published in 1997. A committee will be created to implement the plan.

PROGRAM IMPACT

The public resource management program was successful in helping to develop a public investment program (PIP) and in encouraging close coordination of the strategic planning and budgeting processes. The initial PIP is rudimentary and will require further development.

The draft national health plan serves as a broad strategic framework under which specific annual and 5-year plans can be delineated. The document provides descriptive information about the health sector in the 1990s, then sets out quantitative objectives for the country to the year 2020. The remainder of the plan sets out guiding principals for formulating broad strategies to achieve those objectives. Although part of the TOR for one of the long-term advisers, the plan does not contain any projections of the financial requirements of the sector. Since the plan has not yet been published, it is too early to determine its impact.

The 10-year PIP was designed to identify financing gaps for donors in major program areas, and to set out priorities for regions in developing their investment plans. Acting Secretary Tan wanted to follow the lead of the *World Development Report, 1993,* on "Investing in Health," which focused on programs which would bring about improvements in health status in the most cost-effective manner. The six main public investment packages identified are:

- Safe Motherhood and Women's Health,
- Child Survival and Development,
- Control of Prevalent Diseases Affecting the Workforce,
- Health Service Capacity Improvement,
- Safe Water and Healthy Environment, and
- National Health Insurance.

NEDA participated in drafting the PIP which was to be used as a basis for additional decentralized investment planning under devolution. It was desired that the PIP reflect the technical needs of the sector more than the political agendas of the time. It is easier to obtain government counterpart funding for ongoing projects which are part of a long-term plan. In addition, the sector was receiving many project proposals; it needed guidelines against which the proposals could be ranked in terms of priority. Specific investment plans are made annually to identify projects within the selected program areas for funding. IPS said that it was not possible to evaluate the impact of the PIP on the level of investment finance as it had just been published within the past year.

The PIP requires further development. The document only covered the 5-year period from 1996 to 2000. Nowhere in the document are the resources needed by the government to support the plan identified. The document did not include estimates of the recurrent resources required to sustain the programs after the end of the donor projects. Different documents and tables provide widely differing figures on the amount of donor investment in the sector for the next 5 years, not including the amount of additional investment requested for the same period. One set of figures suggests that the sector is seeking to vastly increase investment expenditure, but there is no documentation analyzing the absorptive capacity of DOH. In the interests of combatting poverty, it would seem that additional resources should be allocated to the poorest LGUs, but no indication of the geographical allocation of funds is provided.

Regional investment plans vary in the quality of analysis and presentation. The plans seem to suffer from many of the same problems as the national investment plan. A common framework for providing information about the regional investments plans does not appear to have been developed or used. Most of the regional plans do not distinguish between foreign or national resources; there is a vague relationship between the activities of a project and actual investment in a building or in manpower development. Few of the provinces attempted to identify their investment needs beyond the year 2000. A high priority in many of the regional plans was funding for construction, renovation, or equipping of health facilities.

Strategic planning and budgeting are now synchronized. In the past, the IPS handled planning for DOH and the Office of Management Services (OMS) handled preparation of the budgets. Often there was not a close correlation between the outputs of the two offices. During the project, training was carried out to enable IPS and OMS to engage in synchronized planning. Budgetary guidelines were provided to IPS before it attempted to collect information about the plans of different departments and regional offices. IPS and OMS collaborate at other times during the budget cycle.

The training programs were useful but additional training and follow up is required. The project adapted training materials prepared under the child survival project to improve planning at the regional and LGU levels. This area program-based health planning (APBHP) (retitled "LGU Manager's Course") aimed to orient LGU officials to the steps required in planning, such as problem identification, program analysis, operational plan and requirements, and budget planning. Implementation of these manuals was only carried out in select provinces of Regions VII and X during the final months of the project. Bukidnon officers indicated that they had benefited from the 9 days of training on strategic and investment planning, and were most likely to use the training in investment planning, as this was already part of the budgetary process. The time for the training was insufficient to do hospital investment planning; subsequently, the provincial officials were unable to follow up on whether any of the projects designed during the workshop had been funded.

SUSTAINABILITY

Sustainability of the public resource management component of the project will depend on the continuance of DOH's leadership to maintain the strategies of the national health plan, to encourage synchronized planning and budgeting, and to develop a public investment plan that reflects the technical needs of LGUs within the financial constraints of the sector. Under the current leadership, IPS and OMS are cooperating on the development of synchronized planning and budgeting. In addition, a PIU has been established in IPS and linkages have been created between IPS and NEDA for investment planning.

The investment plans developed by DOH and its regional offices do not include estimates of the recurrent costs of the investments to determine if these will be sustainable after the

end of donor financing. Investment plans should identify not only the amounts of recurrent financing required but also the sources of this financing, whether government or population based. Investments should not be undertaken, without redesign, if assessment of their long-term financial viability is questionable.

LESSONS LEARNED

The investment plan for the health sector in the Philippines targets DOH and donor interests. It is essential for the government to have a medium-term investment plan to guide donors to work in areas of priority for the country and for LGUs to be aware of areas where financing for their investments may be forthcoming. The medium-term plan can be improved by distinguishing between government and donor resources, investment and recurrent expenditures, and different areas of the country where investments will be made.

Developing a national investment plan for the health sector is difficult under decentralization. Beyond the difficulties of gathering sufficient information about the plans of each province is the difficulty of influencing the decision makers in Congress of the greater need to invest in some areas rather than others. Congress cannot dictate to the provinces and LGUs the purposes for which the allocated investment funds can be used. The development of the CHCA mechanisms which can act as a block-grant type program for investment expenditures is useful for guiding LGU investments.

RECOMMENDATIONS

A significant amount of work was completed in this program area and progress was reported by all respondents. Recommendations for further activity follow.

DOH should continue its efforts in synchronized planning and budgeting and in investment planning. These efforts should increase the efficiency with which resources are used and the equitable distribution of resources. It is recommended that DOH adopt reduced planning and budgeting schedules; for example, 6 years for the investment plan and 10 years for the health plan.

Specific programs and activities at the national, provincial, and LGU levels should be identified to achieve the objectives of the national health plan. The current document provides only general information about strategy; additional detail would help the reader know precisely what DOH envisions in its plan for the future.

The investment program should be updated, perhaps during the next NEDA investment planning period. Topics to include which would improve the investment plan include: identification of Filipino financial requirements and foreign financing, between investment and recurrent costs; and, determination of allocations to different geographic areas for equity purposes.

Training for LGUs in APBHP and budgeting should be continued by DOH. This could perhaps be carried out through the training of trainers at the regional and LGU levels.

VI. STANDARDS, LICENSING, AND REGULATION

Following devolution, the role of DOH began to change from the principal provider of public health services to the planner and regulator of the health care system. The bulk of the DOH service delivery system became the responsibility of LGUs, with DOH retaining responsibility for 44 of the most sophisticated regional and specialty hospitals and 12 RHOs. DOH also retained the responsibility for setting health standards, licensing health facilities, and regulating both the public and private health sectors. Historically, DOH has performed its regulatory functions through the Bureau for Licensing and Regulation; since devolution, its enforcement capacity in devolved facilities has been compromised.

With devolution, DOH needs to continue to provide financial and managerial control over its retained hospitals and accredit and license other health facilities. As noted in the project redesign, DOH "must now expand beyond its orientation towards facilities and infrastructure, to setting standards and regulating training, health services, manpower, laboratory, diagnostics, etc." In the redesign, the SLR program was introduced to assist DOH in defining and implementing its expanded responsibilities. Program outputs were to be DOH policies and standards for health facilities, a strategy for dealing with retained hospitals, reforms in health financing policy for retained hospitals, and protocols for improving hospital operations. In addition, HFDP was to assist DOH in developing strategic direction for its standards, licensing, and regulatory functions. Inputs were to include studies, technical assistance, and financial support.

PROGRAM ACTIVITIES AND ACCOMPLISHMENTS

The SLR program was designed to pursue activities in three areas: assistance to retained hospitals, design of improvements in hospital operations, and organizational development of standards, licensing, and regulatory functions in DOH.

Assistance to Retained Hospitals

HFDP was to support policy formulation activities for retained hospitals, including a study of their state after devolution, hospital strategic planning, budget review, revenue enhancement, the development of guidelines on revenue retention, and development of a handbook for small hospital operations.

With devolution, DOH became responsible, in effect, for the overall direction of a multi-hospital chain and needed to develop ways to improve the management of such a large system. DOH's efforts to manage retained hospitals have been focused in three areas: introducing improved strategic planning methods, enhancement of hospital revenue, and promoting the Hospital as Centers of Wellness Program. Accomplishments include:

- The *Strategic Planning Workbook,* designed to assist hospitals of all types in strategic planning, was published.

- A study was concluded in March 1994, recommending a number of measures for improving the efficiency and financial viability of retained hospitals.

- Two reports were prepared to address bureaucratic procedures for revenue retention and the utilization of retained hospitals. One report suggested alternative positions and steps for negotiating the IRR for Executive Order 258; the other contained draft IRR and suggested negotiating positions.

- Baseline research was completed on preventive and promotive health care programs in retained hospitals.

- Two reports were completed that laid the foundation for the Hospitals as Centers of Wellness Program. The first delineated the parameters of the program; the second described the methodology and tools for evaluating the program.

Design Improvements in Hospital Operations

Hospital financial reforms, including restructuring of the hospital sector, was one of the three major components in the original HFDP design. A major objective of the component was to find ways to actively involve the private sector in addressing the health needs of the Filipino population. Because of early administrative delays in launching activities related to this component and DOH's interest in shifting the project's emphasis toward the immediate problems of devolution, efforts to involve the private sector were deemphasized. HFDP was redesigned to support a limited range of activities to improve hospital management and operations, including design of a quality assurance program for emergency rooms; support for health prevention/promotion activities in hospitals; development of hospital manuals and training materials; development of a manual for budget preparation in LGU hospitals; and, the design of a prototype hospital MIS. Accomplishments include:

- A consultant's report (February 1994) recommended the implementation of a hospital information system in retained hospitals.

- Ten hospital operating and technical manuals were prepared and published for medical social workers, procedures for hospitals, procedures for small hospitals, pharmacy management, medical records, organization of procedures for administrative service, nursing service administration, preventive maintenance, signage systems, and dietary service.

- Reports were prepared on two hospital information systems demonstration projects: Ilocos Regional Hospital in La Union Province, and Rizal Medical Center in Metro Manila.

Organizational Development of Standards, Licensing, and Regulatory functions in DOH

HFDP was redesigned to support strategic planning for SLR; formulate the organizational structures, functions, and staffing needed by DOH to fulfill its role; develop manuals, training materials, and standards for specific hospital functions; and, develop prototype methods for conducting the field work necessary to support DOH's regulatory role. Accomplishments include:

- A workshop was held and a brief report prepared, suggesting how SLR functions could be improved that identified recommendations for improving current standards, licensing, and regulatory functions in DOH.

- Regulations governing HMOs which were initiated under the child survival project were made final under HFDP.

- Several DOH officials visited JCAHO to become familiar with accreditation methodologies.

- A JCAHO representative visited DOH to help prepare a plan for how DOH might fulfill its accrediting responsibilities. (The Asian Development Bank is currently assisting DOH in furthering its plans.)

PROGRAM IMPACT

The SLR program has been particularly successful in developing numerous materials that are potentially useful in helping strengthen hospital performance for both retained and devolved hospitals. Currently, these materials are not being used as much as they could be. The SLR program has initiated efforts to strengthen DOH's regulatory role, but additional efforts should be continued.

Numerous HFDP products have been developed that can be useful in improving the financing and management of retained and devolved hospitals. A considerable library of resources has been developed, based on research studies and demonstration projects. These resources provide thoughtful and well-documented guidance on improving the financial performance, operational efficiency, and management systems of hospitals and other health care institutions. Some of the most prominent materials are:

- **Strategic Planning:** The *Strategic Planning Workbook*, published in 1993, provides a useful tool for hands-on training in strategic planning

methodology for managers in DOH, retained and devolved hospitals, and private hospitals. The planning capabilities of those who participated in the workshops were strengthened. The workbook is conceptually sound and well designed and can continue to be useful as a module of a comprehensive program of management training for a wide audience of managers, including provincial health officers and managers from devolved hospitals.

- **Revenue Enhancement:** The revenue enhancement demonstration project was introduced as a way to test methods for improving the financial sustainability of public hospitals. Starting in mid-1994, demonstrations were conducted in two retained hospitals: Ilocos Regional Hospital in San Fernando, La Union; and, Rizal Medical Center in Pasig, Metro Manila. Following introduction of the trials, regulations were changed to allow hospitals to retain 100 percent of the revenues they generate. The results have been extremely encouraging, illustrating the willingness of people to pay for health services and demonstrating the ability of hospitals to substantially increase revenues without any appreciable decline in accessibility. In 1996, for example, Ilocos Regional Hospital generated over P7 million pesos, a substantial supplement to its P60 million peso budget allocation. As a result, Ilocos has been able to augment its medical equipment, renovate its physical plant, and noticeably improve the availability of supplies and drugs.

- **Hospitals as Centers of Wellness:** Based on a study, *Preventive, Promotive, Primary Health Care in DOH-Retained Hospitals*, conducted in 1993 to 1994, the conceptual framework and evaluation criteria were developed for the Hospitals as Centers of Wellness Program. The program encourages each hospital to create a position of wellness coordinator and to develop programming that promotes preventive, promotive, and primary care services. The program has been adopted by DOH and has been publicized and promoted among all retained hospitals and several devolved facilities. To improve their acceptance and utility, materials originally developed under HFDP sponsorship have been simplified and translated into Filipino by DOH. DOH continues to support the program and promote its further implementation, granting an award each year to the hospital that has shown particular initiative in implementing the program.

- **Hospital Technical Manuals:** By mid-1994, the project had assisted in the development and publication of 10 hospital and technical manuals. Taken in total, the manuals are well done, but their full potential as tools for improving hospital performance has not been realized. One restraint to their expanded use is the view held by some DOH officials that they add little new, a position colored perhaps by the first manual, but an unfair criticism

of subsequent publications. The first manual, *A Manual of Operations for Small Hospitals*, was essentially an updating of hospital procedures originally published in 1965, and added little in the way of new approaches. Subsequent publications, covering a range of administrative, clinical, and support services, were more innovative than the first. Each manual was thoughtfully developed by a multidisciplinary team to reflect both current practices and suggestions for advanced approaches.

- **MISs:** HFDP sponsored an effort to strengthen computerized MISs in retained hospitals. Technical assistance was provided to develop and install a PC-network MIS at Rizal Medical Center; a system was also developed at Ilocos Regional Hospital. The Rizal and Ilocos systems were documented, resulting in the publication of a series of user manuals for a variety of hospital support systems. The Rizal and Ilocos systems, with some modifications, undoubtedly can be applied in other public hospitals. The programs are worthy of continued promotion.

The full potential of HFDP hospital management products has not been realized. In June 1996, as the project was nearing completion, HFDP assisted DOH in launching an effort to introduce a variety of products to regional health authorities, including those noted above. Each product was designed to help improve hospital and health care financing and/or management efficiency. Because of a shortage of time and technical assistance, the program was offered in only two regions. Regional authorities were oriented to the various materials available with an explanation of the resources and time required to attempt their implementation. Regional officers judged the products to be useful in addressing their requirements, but again, because of resource and time constraints, they tended to select those products that were quickly implementable, required few local resources, and produced prompt results. The revenue enhancement program was received with particular enthusiasm in Negros Oriental, for example, but time was too short to follow through to program implementation. Since that initial effort, little emphasis has been placed on providing follow-on support or to promoting the program to additional regions.

The objective to strengthen DOH's role as a regulator of the health system was only partially fulfilled. Several activities were initiated under HFDP to help strengthen DOH's regulatory role. The publication of 10 hospital and technical manuals helped establish a foundation of common procedures among public hospitals. In December 1994, a workshop on hospital licensure standards was held, followed by a brief report, *Recommendations for Improving Current SLR Functions in Existing DOH Offices*. HFDP also sponsored a site visit to JCAHO to help orient DOH officials to accreditation practices. HFDP support for SLR activities terminated in September 1995. Interest in hospital accreditation remains high, and in 1996, DOH sponsored an additional site visit and a JCAHO study on accreditation practices. Some follow-on support for SLR activities is currently being provided by the Asian Development Bank.

SUSTAINABILITY

The SLR program accumulated a considerable wealth of information and experience from numerous studies and demonstration projects. DOH's capacity to carry on these programs on a sustained basis needs to be strengthened, however.

DOH needs to build its capacity to manage its retained hospitals as a sophisticated multi-hospital system. While DOH's service role has diminished with devolution, it still has direct responsibility for the nation's most complex and expensive specialty hospitals. DOH needs the capacity to manage group purchasing systems, sophisticated MISs, methods for procuring and maintaining complex biomedical equipment, and a program for renovating and upgrading existing facilities.

DOH is pivotal in helping LGUs build their capabilities to manage the devolved health services. DOH's regional offices do not yet have the technical capacity to pursue the implementation of the various devolution products. Provincial authorities appear to be receptive to the products offered but do not have the resources to pursue their adoption.

DOH's Bureau of Licensing and Regulation will need continuing support to continue its efforts to build internal capacity. The Bureau is actively studying its role in hospital accreditation; it will need to extend its efforts in examining its role in regulating the private sector.

LESSONS LEARNED

Demonstration projects have been effective in showing how innovations can be successfully implemented. In virtually all locales where demonstration projects have been tried, local authorities have been enthusiastic and creative in implementing and testing suggested methodologies. Those who have worked on the demonstration projects have gained a good deal of practical experience that can now be shared. This resource of talent and experience should be used by DOH as it pursues further implementation.

When developing materials and documenting demonstration projects, adequate resources should be devoted to planning how they can be applied to greatest advantage. A number of DOH officials mentioned that the materials that were prepared were technically sound, well documented, and logically presented. However, they criticized the materials as being too technical and formidable to those responsible for implementation. The *Hospitals as Centers of Wellness* report, for example, was simplified and translated into Filipino before it was widely distributed.

Technical manuals can be useful tools for management training but otherwise have little operational utility. They are rarely useful even as reference guides unless potential users have been thoroughly oriented to their contents and application. Hospital managers and local

authorities responded well to the few offers that were made near the end of the project. A formal effort to continue that effort needs to be pursued or the value of the products will begin to atrophy.

RECOMMENDATIONS

DOH should strengthen its capacity to efficiently manage retained hospitals. Retained hospitals continue to be a significant budgetary burden for the DOH and every effort should be made to assure that the resources are used efficiently. The management of retained hospitals needs to be addressed at both the departmental and institutional levels. Within DOH, the Department of Hospital Facilities, Standards and Regulations needs to develop the capacity to manage a large multi-institutional system. It should conduct study tours of similar systems elsewhere in Asia and in the U.S. It should learn how group purchasing and warehousing, MISs, equipment maintenance, capital financing, and other issues are managed by other large hospital systems. It should engage technical assistance and conduct workshops to develop its own management methods. At the institutional level, DOH should provide management training and technical assistance for the adaptation of improved management systems. It should encourage financial self-sufficiency and local decision making while encouraging increased attention to improving the quality of care provided.

DOH's attention to devolved hospitals should not detract from its responsibilities for guiding the provision of health promotion, prevention, and primary care services. While much of the country's primary care system has been devolved to local authorities, DOH will need to provide continuing guidance and coordination of nationwide efforts to improve health status. It would be inappropriate to lose sight of the fact that the Philippines still lags behind other comparable countries in infant mortality and other indicators of health status.

DOH needs to expand its efforts to strengthen the capacity of LGUs to finance and manage local health services. DOH should organize a series of workshops to orient local authorities to products designed to strengthen the financing and management of local hospitals and health services. DOH should work through its regional offices to provide technical assistance, adapt products to local needs, support implementation, and build local management capacity. The products (tools and methodologies) have already been developed that address many of the needs of provincial and local governments, but their use needs to be promoted. Materials should be simplified and translated as necessary, creating how-to manuals that can be appreciated in the countryside. Those with practical experience, who have been involved in demonstration projects, should be used as technical advisers and trainers to share their experiences with others.

The Bureau of Licensing and Regulations will need continuing support to build its capacity. The Bureau's current efforts to develop accreditation standards should be encouraged. Continued donor assistance should be sought to conclude the efforts now being

assisted by the Asian Development Bank. The Bureau's program to upgrade the skills of its field staff should be encouraged. The Bureau's development efforts need to be expanded to study how its regulatory powers can be used to help shape the private sector, encourage quality improvement, and restrain expensive duplication while encouraging access. Additional donor support should be sought for study tours, workshops, and technical assistance.

VII. HEALTH POLICY PROCESS

The health policy formulation program area was one of three major components of the original project design and remained a central program in the redesign. As initially envisioned, this program area was to involve the development of DOH capacity for research-based policy formulation and the development of mechanisms in the public arena which would allow access to the health policy process. Policy planning was seen as the first step towards developing the health care market. The program area sought to establish a process for formulating and implementing health sector policies, regulations, and legislation supportive of health-care market improvement. The DOH-policy process was envisioned to be an iterative, dynamic process leading to the design and promulgation of appropriate policies, regulation, and legislation to achieve national health goals. The information base for this policy process was to emanate from the NHA database and the health policy database. The NHA database was to track public and private sector health expenditures by source and category on an annual basis. The NHA was to be periodically updated to provide decision makers with time series trends. The health policy database was to provide a catalogue and listing of all existing laws, rules, and regulations regarding the health sector. The MHPF, on the other hand, was seen as a venue for a continuing health policy dialogue among major stakeholders in the health sector and a place to express their position on major health issues.

PROGRAM ACTIVITIES AND ACCOMPLISHMENTS

When the HFDP budget was reduced in 1993, policy planning was retained but restructured to correspond to the new organizational and programmatic priorities of DOH. Under the restructured project design, the program output was to be the formation of capacity for a transparent, private/public sector, and interactive research-based process for health policy formulation. To attain this output, the following program activities were initiated.

Development of the National Health Accounts (NHAs)

HFDP was intended to support the NHA data management unit of the UPEcon, including developing approaches and documenting the methodology for estimating NHA; collecting and assessing data for the NHA and estimating NHA entries; and, training DOH counterparts in NHA accounting. HFDP was also to support a range of research and analytical activities related to the NHA, including assistance to local institutions participating in NHA development, preparation of life table estimates, and organization of a research advisory team. Accomplishments include:

- An assessment was made of the NHA database and a conceptual framework developed. A report, *Documentation of Identified Data Sources for the National Health Accounts Database*, was published.

- Two reports were prepared which contained the design and work plan of the NHA, with one presented as part of the technical orientation seminar series on NHA. A report was also made on the available data for the NHA matrix, as well as a trip report on the results of discussions/meetings with the NHA database core technical team.

- Two reports were concluded with partial estimates of 1991 to 1993 NHA matrices and a report containing a list of accomplishments under the NHA benchmark.

- Staff members of the UPEcon are providing instruction to the staff of the National Statistics Coordinating Board (NSCB) who are assuming ongoing responsibility for the NHA database.

Health Policy Agenda

HFDP assistance was to involve the preparation of periodic health sector reviews; the development of a health policy database, a computerized compilation of health sector legislation; and, conferences/seminars on health care financing. Accomplishments were substantial, including:

- Technical papers on health outcomes, trends and determinants, and health care utilization were prepared and presented during project planning conferences.

- A report was prepared containing sources of policy proposals, a topical organization of the agenda, managing the agenda, and preparing a DOH legislative agenda.

- A compilation of technical papers was assembled and presented at the "Pesos for Health" Workshop held in September 1993.

- A consultative workshop, to update the health policy agenda, was held in August 1993.

- A 5-volume compilation of health laws and administrative issuances was completed.

- The *Health Sector Review* was updated in 1992, 1993, and 1994.

Institutionalization of the Health Policy Development Staff (HPDS)

HFDP was to provide assistance to HPDS in drafting issuances on the DOH policy process; developing a health policy monitoring and evaluation plan; and, formulating framework papers on policy monitoring. The project was also to assist DLLO in tracking legislation and communicating DOH policy decisions. Accomplishments included:

- A plan was prepared for institutionalization of the HPDS as part of the DOH organization.
- A study on the progress of implementing the DOH policy process was completed and a report was published.
- Five reports documenting institutionalization of HPDS, DLLO, MHPF, NHA, and the health policy database were prepared.

Multisectoral Health Policy Forum (MHPF)

HFDP was to provide assistance to the MHPF in organizing the forum and conducting policy discussions. It was also to fund a study on private hospital incentives. The forum is now well established, holding regular sessions on various health policy issues. Accomplishments include:

- Guidelines for the organization of the MHPF and its articles of incorporation were prepared and published.
- A report containing the institutionalization plan for the MHPF was drafted.
- The forum's articles of incorporation were adopted.

Training and Publications

Four core courses were to be conducted: health economics, health care financing, cost/ benefit and cost effectiveness analyses in health, and health policy analysis. Support was to be given for the administration of the project training plan, including: support of training institutions such as the University of the Philippines School of Economics, graduate fellowships, short-term overseas training, and workshops/seminars and publications. Accomplishments included:

- An initial project training plan was developed, containing training needs and plans for 1992-1993; the plan was later updated.

- Brochures for four core courses were developed, covering health economics for non-economists; a workshop on cost-effectiveness and cost-benefit analysis of health projects; financing health care; and, health policy formulation.

- The position of legislative liaison fellow was created.

- A report on HFDP-sponsored training activities was prepared.

- Thirteen major monographs were published in the areas of: health policy development, health sector financing, an updated 1993 health sector review, life table estimates, private medical sector, health insurance/Medicare research, hospitals as centers of wellness, the IEC campaign, and hospital revenue enhancement. Also published were 9 issues of the *Piso Newsletter*, from 1993 to 1995, and 10 documents containing HFDP technical briefs on a variety of topics.

PROGRAM IMPACT

The health policy process program was successful in establishing an information-based policy development process. The NHA database has been established. It was developed and tested for two sample years and is now permanently assigned to the NSCB. HFDP was able to harness a technical working group with members of government offices from DOH, NSCB, the National Statistics Office (NSO), NEDA, PMCC, SSS, and GSIS to mobilize and facilitate data collection. HFDP initiated the process for training a group of specialists in NHA. It also provided the support to undertake an exhaustive assessment of current data sources, modes of collection and processing for NHA estimation. Innovative ways of synchronizing data collection for NHA with the traditional functions of NSCB and NSO were undertaken. This included the institution of rider surveys to complement traditional survey tools, such as the inclusion of a health questionnaire in the Family Income and Expenditure Survey for 1994.

Research and technical papers laid the foundation for a DOH policy framework and agenda. The first monographs and technical briefs which were published set the direction that succeeding research studies were to follow. Specifically, the monographs, *Towards Health Policy Development in the Philippines* and *Health Financing in the Philippines,* provided an integrative framework for understanding the health policy formulation process and underscored the importance of health care financing policies in the Philippines. HFDP, as designed, however, did not place an overt emphasis on the interrelationship among the various program areas of the project. Each of the program areas was treated separately and the framework for integrating health care financing policies, regulations, and legislation was not clearly elaborated. Even so, project management devoted considerable effort to assuring that various components of the project were being pursued in a coordinated manner.

Frequent coordination meetings, forums, and workshops helped provide project continuity. However, frequent changes in DOH leadership jeopardize continuity in pursuing DOH's health reform agenda. The direction taken by the current Secretary of DOH should be consistent with DOH's basic mandate and a vision based on the comprehensive framework provided by various HFDP reports.

HFDP provided a wealth of useful research and technical support to assist DOH in instituting and maintaining the health policy process. Two papers produced in 1994 reflected efforts to analyze and understand the current health policy process in DOH. The first paper, *The DOH Health Policy Process*, published by HPDS in December 1994, described the current status and directions of the health policy process in DOH. The second was a report on existing and proposed DOH policies undertaken by the technical policy transition team, published in August 1994. This latter document sought to formulate a broad policy framework describing the role of DOH in a post-devolution setting. These papers, along with subsequent documents, contain substantive findings and recommendations, and are worthy of review each time there is a change in DOH leadership.

HFDP was successful in preparing for the institutionalization of HPDS, who has been instrumental in coordinating research and studies that supported passage of NHI and development of the health policy agenda. It can continue to play a significant role in supporting DOH leadership by identifying emerging policy issues, conducting research, and facilitating forums in which policy issues can be debated and resolved. HPDS has been institutionalized since 1993 through the creation of a permanent budget line item in the General Appropriations Act. Its budget has increased from P1 million pesos in 1993 to P4 million in 1995. It is not yet a permanent part of DOH and is unlikely to be until a DOH reorganization plan is formally adopted.

HPDS is currently assigned responsibility for three major functions: management of the health policy process, development of health care financing policies, and formulation of the health policy agenda. It is also responsible for establishing an interoffice policy secretariat and preparing for a regional policy secretariat. It has currently designated policy and legislative coordinators within each service of DOH. Through HFDP support, HPDS compiled a computerized database which contains all administrative issuances and executive orders from the president together with a list of current policy issues. HPDS has also been able to develop a list of priority policies in DOH according to key result areas pinpointed by the different offices within DOH. As part of its capability-building focus, HPDS has sponsored training programs for its staff and has used as resource persons HFDP consultants who are technical experts.

Through UPEcon, HFDP provided support for the day-to-day operations of DLLO. HFDP developed a manual of DLLO systems and procedures, developed position papers of DOH on health care finance and health-related matters, and sponsored advocacy meetings with Congress and other stakeholders. More importantly, DLLO created positions for policy

and legislative fellows who received training on health policy development and the law-making process. Most of the fellows professed to other positions in government agencies, such as NEDA or the technical staff of some lawmakers.

Full institutionalization of DLLO is needed to sustain the initial gains achieved through HFDP. Through HFDP, DOH was influenced to restructure its budget to create 8 to 10 line items for DLLO positions. In return, DLLO provided the groundwork for advocacy for higher budget allocations for DOH in Congress. To date, there are still improvements which can further strengthen DLLO. All DLLO personnel are in temporary positions, on loan from other departments within DOH. The highest position offered to head DLLO was an executive assistant (level-3) position. Designating the head of the department as an assistant secretary would greatly strengthen the office. The necessity for mutual trust between the DLLO head and the DOH spokesperson should be underscored to assure minimal conflict in policy pronouncements and lobbying efforts.

HFDP was successful in initiating the MHPF and holding regularly scheduled discussions where different stakeholders in the health sector were represented. The MHPF has been held in different locations, such as Manila, Cagayan de Oro, and Cebu. These discussions incited the interest of legislators, especially on crucial bills such as NHI. The forum also provided the venue for obtaining important comments from the private sector about relevant health issues. HFDP also supported publishing in the *Piso Newsletter* the results emanating from these forums. Currently, these discussions are sponsored by HPDS on a quarterly basis. The most recent was the policy forum on public-private partnership in managing health facilities and services, held in February 1997. There is a need to institute a mechanism whereby conference proceedings can be discussed in policy-making deliberations within DOH.

The formulation of a health policy agenda and the development and implementation of a health policy database were successful. Towards the concluding part of HFDP, maintenance of the system was not emphasized, possibly because the health policy database was already computerized and the initial health agenda was already established. However, implementing this agenda involves a dynamic process and modifications may have to be made to adjust it to current needs and demands.

SUSTAINABILITY

Continued attention should be given to HPDS and DLLO so that they can continue to be effective in their valuable advisory roles. The MHPF needs to be action oriented if it is to remain relevant as a focus for provocative dialogue.

Personnel positions in HPDS and DLLO should be made permanent. The sustainability of the initial gains achieved by HFDP in the health policy process will depend upon integration into the DOH organizational structure and functions. These include HPDS,

DLLO, and the NHA data management unit. It is imperative that DOH leadership be cognizant of the important roles of these offices in fulfilling DOH's new role as policy formulator and regulator of basic health services. It is with this enlightened leadership that concrete negotiations can be made with DBM on creating permanent staff positions in these offices. Furthermore, recognition by DOH political leadership of the vital role these offices perform will enhance their clout and impact on other departments.

Each DOH department should undertake initiatives to continuously develop and update the technical expertise in its staff. A core group of technical persons who will have the expertise to take charge of developing technical outputs (such as the annual health sector review) should evolve in these new units. Staff members need to find ways to minimize their administrative responsibilities so they can concentrate on developing technical briefs on important health policy issues. Linkages with academic institutions engaged in health financing research could provide additional labor sources needed to augment the current staff members in HPDS and DLLO. Funding assistance from external grants, such as the East-West Center, could be used to sponsor staff development programs.

Sustainability of the NHA database appears to be assured. The NSCB has approved a resolution institutionalizing NHA as part of the data it will compile on a regular basis. Ten persons from within NSCB have been assigned to regularly collate data needed and have been trained by UPEcon personnel. Despite these positive developments, there are still several things which are needed to sustain the initial gains of the NHA component. DOH management needs to show its keen interest in sustaining the momentum initiated by the development of NHA. DOH has the major stake in NHA and should develop its own core group of technical persons to monitor it. NSCB has also expressed some difficulty in extracting accurate information from the private sector, specifically in terms of health expenditure data. The NSCB staff has also expressed concern over the inability of the Commission on Audit to release data at the regional level. Overall, additional work is needed to assemble and synchronize the different data files available from national surveys—a process that may entail additional time and labor.

DOH should encourage LGUs to develop PHAs. At the provincial level, only one province (Bukidnon) has attempted to develop its own PHAs. HFDP provided funds and technical assistance for the initial setup of the PHA technology to the PPDO of Bukidnon. However, recent interviews with personnel from this office indicate several problems regarding the implementation phase of PHA technology. There is still a reticence in adopting computer technology due to a lack of hands-on training of the personnel concerned. There is a serious labor constraint in aggregating municipal data from various sources; no one is available to coordinate the data collected from different offices. Not all of the 22 municipalities in Bukidnon submit their health expenditure data on time. The current PPDO is swamped with other functions, especially with the start of the implementation of the Bukidnon Integrated Area Development Project. A need exists for additional authorized positions, or a reevaluation of existing assignments, in the Bukidnon planning office to

manage the additional duties entailed by PHA. Moreover, technical assistance is needed to ensure that there is adequate guidance to PPDO personnel in putting together the PHA. A mechanism for liaison is needed at the provincial level between the NSCB and the Bukidnon provincial planning office.

LESSONS LEARNED

The institution, formulation, and sustenance of a dynamic health policy process starts with a clear vision of the mandate and mission of DOH. HFDP produced excellent monographs to define a vision which need to be reviewed whenever there is turnover in DOH leadership. DOH needs to reexamine the policy documents that have been developed over these last few years, familiarize current office holders with their content, and develop a logical policy framework that will remain in place regardless of DOH leadership. The current efforts to reengineer DOH structure should be continued as the department adjusts to its newly defined role as policy formulator and health sector regulator.

The roles of HPDS and DLLO need to be nurtured. It is not enough that critical DOH policy-making departments are institutionalized via permanent budget allocations. Rather, the substance of these departments needs to be nurtured and developed by the continued attention and personal support of the highest DOH officials. Personnel of DLLO and HPDS need to be challenged to develop technical outputs reflective of their mandate as the core policy development groups in DOH. To achieve this, attractive incentives must be offered to those currently in these departments to remain and invest in additional skills. This would entail not only additional fund allocations for staff development but also changing the structure of their functions from administrative functions to technical functions. Expansion of the authorized positions to include health economists, health social scientists, and health managers should be considered.

The process of disseminating NHA technology requires additional time, commitment, and labor. The expertise of NHA is concentrated in the University of Philippines School of Economics. While there is no question this institution can continually produce the expertise to handle NHA matrices, there is a need to target those graduate students from the provinces or regions who are active in the adoption of PHAs. The contract agreements of UPEcon with regional research offices can also provide venue for additional training in the usage of NHA technology. If consideration is being given to the use of a core group of NSCB personnel to handle NHA accounts, there should be continuous rapport with the lead consultant in NHA to ensure sustainability of the accounts. Data sets needed for NHA should be made available for public consumption so that other stakeholders in the health sector can have access to such information.

A continuing campaign should be undertaken to attract the attention of DOH leadership to the gains instituted by HFDP. A part of the agenda during the DOH executive committee

meeting could be devoted to keeping the leadership updated on the status of the health policy-making bodies within DOH.

RECOMMENDATIONS

The policy-making process and supporting services that have been established require continuing support in order to maximize their contribution to future policy-making efforts.

DOH should establish a long-term policy agenda. Given that the NHIL has been passed and devolution is underway, DOH needs to continuously review the policies needed to shape the health system for the future. The long-term policy agenda should be based on a clear vision that is supported by high-level GOP leadership and should reflect the wealth of research and materials compiled under HFDP. The policy agenda should set out specific policy goals that guide DOH's relationship with PHIC, DOH's role in advocating the needs of the poor, and DOH's role as health system regulator. The policy agenda should be designed to provide greater continuity from one DOH administration to the next.

The role of HPDS should be reinforced and its capacity strengthened. HPDS played an active and critical role in supporting the development of the NHIL. With the law's passage, however, HPDS does not have the same clarity of purpose and sense of urgency. Its relationship with DOH's high-level management is also less intense than it was previously. Yet the implementation of NHI poses some of the most significant policy issues ever to be confronted by DOH. The money that flows through the NHI plan and how it is directed will be a primary factor in shaping the health system of the future. HPDS needs to be prepared to resume a central role in informing DOH's policy toward NHI implementation and how it intends to direct activities of PHIC. HPDS will need to enhance its internal technical expertise and open communication with the Secretary of DOH. Documentation of the policy development process should be reviewed and updated as necessary.

The roles of HPDS and DLLO need to be clarified. Both units play important but different roles in the policy-making process. HPDS's main function is to provide information to facilitate the development of policy by those who have policy-making authority. DLLO's main function is to communicate DOH's policy decisions to those in the legislature and to provide responses. Both units need to work in close cooperation; the potentials for conflict and duplication of effort are numerous. DOH leadership needs to assure that their roles are clearly defined. DOH should monitor their activities in order to maximize their respective contributions.

The MHPF should be outcome oriented. The MHPF is an active and useful venue for stimulating dialogue on vital health issues. It is likely to lose its vitality, however, unless it incorporates an agenda for action. Discussion for the sake of enlightenment alone will not sustain the interest of participants unless it ultimately leads to some result. The MHPF

should direct each of its sessions to producing recommendations based on its deliberations to be submitted to DOH or other appropriate organizations.

VIII. CONCLUSIONS AND RECOMMENDATIONS

HFDP was initiated at an opportune time in Philippine history. In the early 1990s, at the time the project was being conceptualized, numerous factors were converging to create a social and political environment that was particularly receptive to major health care reform. Health services in the country had been chronically underfunded and it was becoming increasingly clear to DOH that the government did not and would not have the financial resources to adequately address the health needs of all Filipinos. If the health system were to improve, existing resources would need to be used more efficiently and new resources would have to be identified. Changes would require major shifts in health financing policy, a reshaping of the public health care system, and an expanded role for the private health care sector. Passage of the LGC was imminent, calling for the devolution of health services to local authorities and altering the role of DOH from the principal provider of health services to the planner and regulator of the health care system. By remaining flexible and responsive, HFDP was able to play a catalytic role in supporting DOH's effort to successfully launch its reform agenda.

MAJOR ACHIEVEMENTS AND IMPACT

Project achievements are detailed in earlier sections of this report. A few of the project's most prominent accomplishments are cited in the following sections.

HFDP was instrumental in the passage of the NHIL. By helping to establish the NHIL, HFDP set in place a major component of the Philippine health care market, achieving a major part of the original project goal. Much of the money that flows into the health system will pass through the NHI system. Decisions on services, providers, and those insured will shape the health system of the future. HFDP did not attend much to the role of the private sector, the source of more than half the current health market spending. Through passage of the NHI bill and preparation and submission of the annual plans and budgets of DOH, the project established processes for formulating health care financing policies, achieving its original purpose.

HFDP helped prepare the documentation needed to support the devolution process. The initiatives of the project were designed to support the financial institutionalization of the priorities of the Secretary of DOH as well as to provide models for successfully managing devolution. Development of the *Comprehensive Health Care Agreement* was the basis for negotiating new arrangements between DOH and LGUs. Preparation of the *Implementation Manual for Management and Organizational Options for Devolved Hospitals* provided local authorities with choices on how to organize hospitals under their jurisdiction. The experience gained in numerous studies and demonstration projects was used to prepare tools and methodologies that can be used to improve the financing and management of devolved hospitals.

The draft national health plan serves as a broad strategic framework under which specific annual and 5-year plans can be delineated. The document provides descriptive information about the health sector in the 1990s. It then sets out quantitative objectives for the country to the year 2000, guiding principals for formulating strategies to achieve those objectives, and very broad strategies. Although part of the TOR for one of the long-term advisers, the plan does not contain any projections of the financial requirements of the sector. Since the plan has just been published, it is too early to determine its impact.

Many HFDP products have been developed that can be useful in improving the financing and management of retained and devolved hospitals. Considerable resources have been developed, based on research studies and demonstration projects, that provide thoughtful and well-documented guidance on improving the financial performance, operational efficiency, and management systems of hospitals and other health care institutions.

MAJOR RECOMMENDATIONS

In preceding sections of this report, recommendations have been offered in each program area. Overall program recommendations are provided in this section.

DOH should be proactive in providing leadership to PHIC. Because PHIC will have considerable influence in how resources are allocated in the health system, it will play an important role in shaping the health services provided and the providers. Decisions made by PHIC will ultimately influence how well DOH is able to fulfill its regulatory and service roles, how effectively governmental support is targeted to meet the needs of the medically indigent, and the private health sector's role in meeting national health objectives. To do this job well, the Secretary of DOH will need to maintain a close relationship with HPDS. It is also recommended that the Secretary of DOH select a principal adviser, either from among DOH staff or an external consultant, to spearhead the effort to guide PHIC activities.

DOH should strengthen its capacity to manage retained hospitals. The management of retained hospitals needs to be addressed at both the departmental and institutional levels. Within DOH, the Department of Hospital Facilities, Standards, and Regulations needs to develop the capacity to manage a large multi-institutional system. It should conduct study tours of similar systems elsewhere in Asia and in the U.S. It should learn how group purchasing and warehousing, MISs, equipment maintenance, capital financing, and other issues are managed by other large hospital systems. It should engage technical assistance and conduct workshops to develop its own management methods. At the institutional level, DOH should provide management training and technical assistance for the adaptation of improved management systems. It should encourage financial self-sufficiency and local decision making while encouraging that increased attention be given to improving the quality of care provided.

DOH's attention to devolved hospitals should not detract from its responsibilities for guiding the provision of health promotion, prevention, and primary care services. While much of the country's primary care system has been devolved to local authorities, the DOH will need to provide continuing guidance and coordination of nationwide efforts to improve health status. It would be inappropriate to lose sight of the fact that the Philippines still lags behind other comparable countries in infant mortality and other indicators of health status.

CONCLUSIONS

HFDP-supported research provided the basis for an informed health policy formulation and decision-making process. The project sponsored studies, reports, and demonstration projects which added valuable information about the country's health system and examined policy options and their implications. It supported training programs and site visits and engaged numerous local consultants, helping to create a local community of knowledgeable and experienced experts on health care issues. It also facilitated workshops, seminars, and conferences, creating a MHPF where policy issues could be debated and reforms initiated. The project was not designed to implement reforms but was instrumental in providing the information and mechanisms needed by the GOP and others to launch and continue the implementation effort.

The next few years may prove as pivotal in shaping the Philippines' health care system as the last few years have been in launching a new direction. The NHIL has been passed—a significant accomplishment—but it is not yet clear how its financial powers will be used to shape the health system of the future. The role of DOH is changing, but it is still exploring how best to use its regulatory powers, how to manage retained hospitals, how to support and influence decentralized health services, and how to mobilize the resources of the private health sector. DOH will need to be both thoughtful and aggressive in assuming its new responsibilities. DOH needs a clear vision of what its new role should be and a strategic plan for making that vision a reality. It needs to follow through with the exercise it started to reengineer its organization to effectively address its new priorities. To be effective in its new role, DOH will need to assign capable people with clear and unambiguous responsibility to each major task, especially financing policy, managing retained hospitals, promoting primary care and prevention, and supporting the devolution of health services. DOH can use its existing human and financial resources for much of the remaining work. At times, DOH will need to seek donor assistance to provide technical expertise not available within the organization, to objectively facilitate the forums where issues of policy and program implementation will be debated and resolved, and to provide training to strengthen the capacity of officials in DOH, local government, and managers throughout the health system.

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APPENDICES

A: PROJECT OBJECTIVES AND END-OF-PROJECT STATUS

B: PERSONS INTERVIEWED

C: RESOURCE MATERIALS

D: MEDICARE PROGRAMS FOR THE INFORMAL SECTOR

E: SCOPE OF WORK

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APPENDIX A

PROJECT OBJECTIVES AND END-OF-PROJECT STATUS

Project Goal: Develop the health care market in order to improve health service quality, equity, coverage, efficiency, and private participation.

By helping to establish the NHIL, HFDP set in place a major component of the Philippine health care market. Much of the money that flows into the health system will pass through the NHI system. Decisions on the services to be provided, who will be covered and the providers will shape the health care system of the future. HFDP did not attend much to the role of the private sector, the source of more than half of current health market spending.

Project Purpose: Establish a process for formulating and implementing health care financing policies, regulations, and legislation supportive of health care market improvements.

The project, through passage of the NHIL and preparation and submission of the annual plans and budgets of DOH, established processes for formulating health care financing policies. The project was less successful in building the capacity of the system to sustain the reforms that were achieved.

End-of-Project Status

Initial Project Design

National Health Care Financing Policy

- A process for private sector participation in health 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
- Improved flow of information to the private sector

The project placed little emphasis on the private sector and its role in overall health sector policy. Notation of a private-sector focus was eliminated in the redesign of the project. The project did improve health sector access to legislative and executive policy processes as exhibited through the creation of DLLO. The project also improved the

capacity of the private sector to conduct health finance research through contracting with UPEcon.

Improved Efficiency and Expanded Coverage of National Health Care Financing Mechanisms

- PMCC policy on P-I reforms
- GOP policy of encouraging broad private and public sector risk taking for health
- Demonstration of viable private sector options for health financing coverage
- Improved capacity in the private sector to recognize and respond to incentives for investment and growth in private financing mechanisms

The development of interest in NHI reduced the necessity of achieving PMCC policy reforms. In adopting NHI, the GOP committed itself to broaden private and public risk taking. The project did not set up or evaluate any private sector options for health financing coverage, nor did it provide a means for the private sector to respond to incentives for investment and growth.

Increased Efficiency and Effectiveness in the Financing of Hospitals

- 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
- A GOP policy of stimulating private hospitals to pursue national health goals

The project lacked a focus on the private sector which meant that the above goals were not met. The project did prepare a series of manuals on hospital operations which, taken as a whole, aimed to improve allocative and operational efficiency.

Project Redesign

Proposed legislation for a national health insurance program will be presented and debated in Congress.

The project not only facilitated the development of legislation for NHI, but assisted in its passage, and in the development of IRR and studies of other operational concerns.

DOH capacity for health policy, strategic financial planning, and SLR will be established through institutionalization of HPDS, systems development for budget and planning and organizational development of the standards, licensing, and regulatory functions of DOH.

DOH did partially institutionalize HPDS through allocating specific budget line items for its operation. Nevertheless, there are no permanent positions for HPDS and it is difficult to recruit the types of needed staff. DOH has also begun to synchronize its planning and budgeting cycle within DOH and to provide technical assistance to the LGUs to do the same.

Linkages will be created with stakeholders in local governments, other government agencies, the private sector, and Congress to formulate health policy through the development of a MHFP and the strengthening of DLLO.

Health care expenditure patterns will be quantified and tracked through the establishment of a NHA system.

NHAs have been prepared by UPEcon staff for the years 1991-1995. However, the maintenance of this activity is being passed to NSCB. NSCB has received training from UPEcon and continues to receive technical support. NSCB will start its calculations with the 1994 data, and continue forward from that point.

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APPENDIX B

PERSONS INTERVIEWED

DEPARTMENT OF HEALTH

Carmencita Reodica, Secretary
Milagros Fernandez, Under Secretary, Chief of Staff
Melahi C. Pons, Assistant Secretary, Project Director and Project Manager, HFDP
Margarita Galon, Under Secretary
Juan A. Perez, M.D., Director, Health Intelligence Service and Local Government Assistance and Monitoring Service, Program Manager, Devolution, HFDP
Zenaida O. Ludovice, Director, Internal Planning Service
Juanito D. Taleon, Chief, Plans and Programs Division, IPS
Nicolas B. Lutero III, Atty., Director IV, Bureau of Licensing and Regulation
Romeo M. Cruz, M.D., M.H.A., FPCR, Medical Center Chief, Rizal Medical Center, Project Manager, HFDP
Ruben Flores, M.D., Chief, Amang Rodriguez Memorial Hospital, Marikina, Program Manager, Hospitals as Centers of Wellness
Rodolfo Maceda, Adviser to the Secretary, Former Executive Director, Philippines Medical Care Commission
Maylene Beltran, Officer in Charge, Program Manager, Health Policy Development Service
Mariquita Mantala, M.D., Director, Tuberculosis Control Service, Former Chief, HPDS
Amado Maralit, Officer in Charge, DLLO
John Basa, Legislative Liaison Fellow, HFDP
Zenaida Ludovice, Director, IPS
Mary Lim, PIP
Erlinda Soriano, PIP

FORMER HFDP ADVISERS AND STAFF

Juan Pablo Nanagas, M.D., Physician and Consultant, Project Director, HFDP
Rhais M. Gamboa, President, Aetna HealthCare, Inc., Makati City, Technical Coordinator HFDP
Bernadette Cuevas, Project Coordinator, Couples for Christ—Angkop Foundation Inc., Officer in Charge, DLLO
Emilia Soriano Almario, Director, Filipinas Heritage Library, Ayala Foundation, Inc., Health Insurance Specialist, Andersen Consulting, MSH subcontractor
Alejandro Herrin, Project Coordinator, UPEcon
Mario M. Taguiwalo, Project Director, UPEcon
Rachel Racelis, NHA Adviser, UPEcon
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Melinda Mercado, Policy and Program, Office of the Chief
Jojo Pascal, Office of the President
Beth Leyva, Corporate Communications

SOCIAL SECURITY SYSTEM

Horacio Templo, Chief Actuary and Senior Administrator
Rizaldy Capulong, Assistant Department Manager

OTHER GOVERNMENT AGENCIES AND REPRESENTATIVES

Senator Freddie Webb, Chairman, Committee on Health and Demography
Victor Sd. Ortega, M.D., Senior Consultant, Committee on Health and Demography, Office of Sen. Freddie Webb
Jaime Z. Galvez Tan, M.D., Former Under Secretary, Chief of Staff, and Acting Secretary, DOH
Horatio Templo, Chief Actuary and Senior Deputy Administrator, SSS
Consuelo D. Manarsala, Manager, Medicare Claims Department, GSIS
Cecille Paulino, M.D., Program Manager, Public Resource Management, HFDP
Cora Buenaventura, Former Director, Economic and Social Statistics Office, NSCB
Estrella Domingo, Director, Economic and Social Statistics Office, NSCB
Gertrude Demmler, M.D., SHINE Project, GTZ, German Government
Patricia Moser, Project Economist, Education, Health and Population (East), Asia Development Bank; Former Chief, OPHN, Health and Nutrition Division

USAID/OPHN

Dr. Carol Carpenter-Yaman
Marichi de Sagun, Project Officer, End-of-Project Evaluation
Chat Remata

BUKIDNON, CAGAYAN DE ORO PROVINCE

Marilyn Golas, Deputy Director, BHIP
Mercedita Guillermo, Officer in Charge, Evaluation of Doctors' Claims, BHIP
Florenda Rodrigues, Computer Operator, BHIP
Dr. Po, Chairman of BHIP Advisory Council, physician and owner of a private hospital
Francis Xavier Intong, Provincial Health Administrator, Bukidnon
Dr. Carlos Gamboa, Administrator, Bukidnon Hospital

Gomersindo Diez, Senior Accountant, Bukidnon Hospital
Genato O. Leswe, Jr., Assistant Statistician, PPDO, Bukidnon
Oscar D. Belderol, PPDO, Bukidnon
Patricio P. Dait, Provincial Accountant's Office, Bukidnon

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Aurea Catchuela, P-II Coordinator, Sampaloc
Teofilo Dissanta, Barangay Captain, Sampaloc

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Juanito A. Rubio, M.D., Chief of Hospital
Ruben D. Aleta, Chief, Medical Professional Staff
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Agnes N. Villanueva, Cashier II
Flordeliza R. Robiles, Assistant Chief Nurse
Jess M. Pajimala, Health Education Promotion Officer II
Natividad R. Eslao, Radiology Technologist II
Digna E. Visaya, Medical Technologist II
Ma. Imelda G. Quinmosac, Chief Pharmacist
Ma. Teresa F. Sison, Social Welfare Officer I

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Cerifiu E. Ortiz, PPDO, DOH
Mary Lou Alipao, Provincial Health Officer II, DOH

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Marcuz P. Cattalan, Medicare P-II
Lily Habane, Senior Nurse, BTA-Extension Hospital
Gila Azueta, Casual Clerk, P-II
Wanita Betpetan, Social Dispensing and Collection Officer
Dr. Lorenzo Guavara, Physician, Nueva Valencia Hospital
Dr. Emelda Baingan, Physician, Nueva Valencia Hospital
Lorna Escacona, Beneficiary, Roadside Stand
Amelie Capero, Midwife
Nenita Gabo, Barangay Health Worker
Leticia Cabuncalig, Barangay Health Worker
Rhodora Calvez, Village Health Volunteer
Corazon Alansagay, Barangay Health Worker

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APPENDIX C

RESOURCE MATERIALS

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PROJECT DESIGN AND MANAGEMENT

Accomplishments Under the UPEcon Cooperative Agreement. UPEcon: February 1992-September 1996.

Annotated List of Benchmark Documentation. HFDP: 1996.

Cruz, Romeo et al. *A Performance Evaluation of the UPEcon Cooperative Agreement and the Management Sciences for Health Institutional Contract.* May 1992-September 1993.

Hermann, Chris et al. *Mid-Term Evaluation of the Health Finance Development Project.* USAID: July 1994.

List of Benchmarks. HFDP: 1996.

Management Sciences for Health: Final Report, October 1, 1992-September 30, 1995. MSH.

Project Directives. HFDP: 1996.

Project Paper: Health Finance Development Project, (492-0446). USAID/Philippines: September 1991.

MEETING AND WORKSHOP DOCUMENTATION

Almario, Emelia et al. *Results of Recent Research Concerning Medicare in the Philippines.* A Report Prepared as Background Material for PMCC Strategic Planning Workshop, February 18-20, 1993. HFDP.

Ang Medicare ni Mang Pandoy. Proceedings, Medicare Miting II. October 1993.

De Leon, Alejandro. *Background Paper: Hospital Strategic Planning Workshop.* HFDP: June 1993.

Health Policy Agenda Workshop, August 26-27, 1993. Meeting Summary.

New Directions in Philippine Health Care, August 20-21, 1993. Meeting Summary. American Managed Care and Review Association and the Philippine Medical Care Commission.

Medicare Para Sa Lahat - How Much Will it Cost. Proceedings, Medicare Miting 4. February 23, 1994.

Pesos for Health: Assessing Health Financing Reform Possibilities. September 1-3, 1993. Meeting Summary.

Proceedings of the Hospital Strategic Planning Workshop, July 1-3, 1993. HFDP.

Proceedings of the Project Management Enhancement Workshop, March 24-25, 1993. HFDP.

Team Building Workshop, April 4, 1994. Minutes. HFDP.

NATIONAL HEALTH INSURANCE

Alba, Michael, and Solon, O. *Dealing with Possible Adverse Systemic Responses to Universal Health Insurance*. Paper prepared for Pesos for Health, Part II: Emerging Results of Current Research on Health System Reform Conference, December 8-9, 1994, Sulo Hotel, Quezon City. HFDP: 1994.

Almario, Emelina et al. *Results of Recent Research Concerning Medicare in the Philippines*. HFDP Monograph No. 7. HFDP: April 1993.

Bukidnon Health Insurance Project, Manual of Operations, Version I. HFDP: June 1994.

Esguerra, Octavino. *An Actuarial Evaluation of the Initial BHIP Experience*. HFDP.

Gamboa, Rhais M.; Bautista, Cristina; and Beringuela, Luisa. *Health Insurance in the Philippines*. HFDP Monograph No. 6. HFDP: August 1993.

Gamboa, Rhais; Patao, Dinah; and Sabella, Teresita. *Summary of Technical Analyses and Recommendations of Findings of NHI Demonstration Activities*. HFDP Fiscal Year 1994-95 Benchmark 1.8. HFDP: August 2, 1995.

Implementing Rules and Regulations. National Health Insurance Act: 1997.

Medicare Program II, Quezon Province, Manual of Operations, 1st edition. HFDP: August 1994.

National Health Insurance Act of 1995. R.A. 7875. Government of the Philippines: July 1995.

National Health Insurance Act of 1995. R.A. 7875. PHIC: January 1996.

Patao, Dinah, and Gamboa, Rhais. *National Health Insurance Program: Alternative Benefit Packages and Some Estimates of Costs*. HFDP: October 1994.

PhilamCare Health Systems, Inc. *Final Report: Outpatient Benefit Packages under Fee-for-Service and Capitation (Design Phase)*. HFDP: December 1994.

Quizon-Ang, Letty. *Introductory Baseline Study for an Information, Education, and Communication Campaign of Medicare*. HFDP Monograph No. 13. HFDP: September 1995.

UPEcon-Philippine Health Insurance Corporation. *The National Health Insurance Program Manual of Procedures, Version I, Volume II*. Fiscal Year 1995-96. Benchmark 1.2.

UPEcon-Philippine Health Insurance Corporation. *PHIC Organizational Design, Volume I* Fiscal Year 1995-96. Benchmark 1.2. HFDP: March 1966.

Virata, Cesar; Bacungan, Froilan; and Guerrero, Linda. *Expanded Number of People Covered by Program I of Medicare. Final Report.* Manila: C. Virata and Associates, April 1994.

DEVOLUTION

Devolution Matters: A Documentation of Post-Devolution Experiences in the Delivery of Health Services. DOH: 1996.

Establishment of a Community Primary Hospital. Development Program Series No. 3. Office of the Governor. Provincial Government of Negros Oriental.

Local Government Code of 1991. Republic Act No. 7160. Government of the Philippines: 1992.

Nanagas, Juan R. et al. *Issues and Concerns: The Management of Philippine Hospital Services Post Devolution: Concepts, Strategies and Recommendations*. HFDP: March 1996.

Palma-Sealza, Elita; Escalante, Numeriano; and Bayog, Judit. *A Report on the Implementation of the 1994-95 Comprehensive Health Care Agreement (CHCA) in Four Provinces and Selected Municipalities of Region X.* August 1996.

Tarmase, Balane. *Implementation Manual for Management and Organizational Options for Devolved Hospitals*. Version 1. Alampay Law Office. HFDP: June 1994.

PUBLIC RESOURCE MANAGEMENT

DOH. *Investing in Equity in Health, the 10-Year Public Investment Plan for the Health Sector (1994-2004)*. Fiscal Year 1993-94 Benchmark 3.1. Manila: HFDP.

DOH. *Updated Public Investment Plan for the Health Sector.* Fiscal Year 1994-95 Benchmark 3.3. Manila: HFDP.

HFDP. *Activities to Sustain Public Investment Unit.* Volume 9. Fiscal Year 1995-96 Benchmark 3.2. HFDP.

HFDP. *Module I: Operational Health Planning under a Decentralized Setup.* Volume I. Trainer's Manual. Fiscal Year 1995-96 Benchmark 2.4. HFDP.

HFDP. *Module II: Health Budgeting and Financial Management under a Decentralized Setup.* Volume II. Trainer's Manual. Fiscal Year 1995-96 Benchmark 2.4. HFDP.

HFDP. *National Health Plan.* Fiscal Year 1994-95 Benchmark 3.2. HFDP: March 1996.

HFDP. *Updated Regional Development Investment Plans (RDIP).* Volume 4. Fiscal Year 1995-96 Benchmark 3.2. HFDP.

IPS. *Organization of a Functioning Investment Planning Unit in the Department of Health.* Main Report. Fiscal Year 1995-96 Benchmark 3.2. HFDP: September 1996.

STANDARDS, LICENSING, AND REGULATIONS

Manual of Procedures for Small Hospitals. Revised. DOH: 1992.

Manual of Procedures for Hospitals. Second Edition. DOH: January 1994.

Manual of Organization and Procedures for Administrative Service. DOH: May 1994.

Hospital Nursing Services Administration Manual. Second Edition. DOH: May 1994.

Hospital Medical Records Management Manual. Second Edition. DOH: January 1994.

Hospital Pharmacy Management Manual. Second Edition. DOH: January 1994.

Hospital Dietary Service Management Manual. Second Edition. DOH: January 1994.

Manual for Medical Social Workers. Fourth Edition. DOH: January 1994.

Planned Preventive Maintenance Manual. Second Edition. DOH: January 1994.

Signage Systems Manual for Hospitals and Offices. DOH: May 1994.

Recommendations for Improving Current SLR Functions in Existing DOH Offices. Documentation. Fiscal Year 1994-95 Benchmark 4.3. HFDP.

Rosello-Gates, Cristina. *Preventive, Promotive, Primary Health Care in DOH-Retained Hospitals*. The Hospitals as Centers of Wellness Program. HFDP: July 1995.

HEALTH POLICY AND PROCESS

Herrin, A. *Towards Health Policy Development in the Philippines*. HFDP: March 1992.

Herrin, Alejandro et al. *Health Sector Review: Philippines*. HFDP Monograph No. 3. HFDP: March 1993.

Herrin, Alejandro et al. *Health Sector Review: Philippines, 1994*. HFDP: January 1996.

Herrin, Solon et al. *Health Financing in the Philippines*. HFDP: March 1992.

HPDS. *The DOH Health Policy Process*. HFDP: December 1994.

Technical Policy Transition Team. *Proposed DOH Policies*. Techpol: August 1994.

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APPENDIX D

MEDICARE PROGRAMS FOR THE INFORMAL SECTOR

Medicare has a second program, P-II, for those employed in the informal sector. One of the outputs of the HFDP was a study to determine the characteristics of this population because not much was known about its socioeconomic and health characteristics. At least four P-II programs received attention and support from the HFDP: Bukidnon, Guimaras, Sampaloc, and Tarlac. It was hoped that the experience of these pilot efforts would illustrate ways to expand insurance coverage to the informal sector. Members of the P-IIs will be enrolled in NHI, as will be members of the SSS and GSIS. During this evaluation study, a period of 5 days was allocated for field visits to these pilot projects, allowing for more detailed description and analysis of these schemes.

Bukidnon Province: P-II Pilot (BHIP)

The concept for a Bukidnon P-II was initiated by Provincial Governor Fortich in response to a public information letter from PMCC. A number of intervening actions took place between the province and PMCC until a memorandum of agreement between PMCC, DOH, and the province, initiating BHIP, was signed on February 14, 1994.

Initially, BHIP provided each enrolled family a package of inpatient, outpatient, and dental benefits; the premium was set at P420 pesos per family per year. An early actuarial study of the BHIP experience estimated that the true cost of the BHIP package was P1,604 per household per year.

By 1995, the program was growing in terms of enrollments, but the level of expenditure was growing faster than the level of premium collections. Measures were adopted to attempt to address this problem: most importantly, that the premium was raised from P420 per family per year to P720. Subsequent to these changes, the number of enrollees per month dropped from 587 in 1994 to 303 in October 1, 1996, compared to a goal of 15,000 households (2 percent achievement of goal). (With an arc price elasticity of -1.22, the revenue will decline because of the drop off of enrolling members.) The average number of outpatient visits, inpatient admissions, and dental visits per enrolled household increased, suggesting either adverse selection, moral hazard, or doctor-induced demand among those electing to renew their BHIP membership. BHIP could take measures to control for these problems. For example, adverse selection could be minimized by enrolling groups rather than individuals. Alternatively, BHIP could institute a period of open enrollment and/or a waiting period before benefits could be accessed. Regarding the minimization of moral hazard, the introduction of copayments, deductibles, or utilization limits could help. For physician-induced demand, physician profiling can identify abusing physicians and penalize them for overuse or introduce capitation to place the physician at financial risk. Further technical assistance would help the province determine the combination of measures which would improve the financial viability of the program.

Although BHIP was to have been self-sufficient after the first year of its operation, it has become increasingly dependent on provincial government subsidies. Subsidies paid in 1994

were P1.0 million; in 1995, P6.8 million; and, in 1996, P11.8 million (estimated by subtracting premium income from total expenditure). This failure to thrive financially is in part based on poor actuarial estimates at the beginning of the project.

HFDP provided technical assistance over an extended period for project design, training in negotiating skills, support for workshops to train health counselors as promoters of membership in BHIP and collection of premiums, two computers, and technical assistance for the setup of their computer programs. Evidently the computer assistance occurred late in the project and no follow up was done to correct problems with the installed systems. Lack of sufficient financial resources and problems with the computer system are reasons why it takes BHIP up to 6 months to process a claim. The project enjoyed a highly collaborative relationship between Bukidnon provincial leaders, public and private, and HFDP consultants. This model of collaborative technical assistance was not adopted for the other P-II interventions.

Guimaras Province: P-II Pilot (GHIP)

GHIP began in May 1993 via a memorandum of agreement with PMCC. Since its initiation, the program has had only limited technical support from PMCC. The program aims to have 100 percent coverage of the 24,561 households (population of 133,000) in Guimaras by 1988. In 1996, the number of households actively enrolled was 7,371 (30 percent). One of the key objectives of the program is to encourage the population to become self-reliant.

Service and financial statistics for the program are difficult to interpret as they either do not add up in a rational way (for example, active enrollees compared to new enrollees, renewed enrollees, and dropouts) or pieces of significant information are missing, such as the amount of the provincial grant to the project and its allocation to beneficiary premiums versus administrative costs versus savings carried to the next year. The information does suggest that the program accumulated a P500,000 surplus at the end of 1996 minus the provincial grant of P900,000 in that year. The average amount paid per claim has risen from P305 to P538, and the availment rate of the program has increased from 1 to 4 percent (admittedly, a low base). The information also suggests that accounts payable has become an increasingly important problem as the program has matured.

In May 1994, HFDP held discussions with Governor Emily Lopez and her staff regarding assistance the project might provide. It was determined that HFDP would provide technical assistance in developing and refining the MIS as well as installing hardware and software for this purpose. By December 1994, the first two modules—the billing and collection monitoring system and the membership monitoring system—were installed. In January 1995, the last two modules—the physician and hospital monitoring system and the disbursements and claims monitoring system—were installed. Staff training was undertaken and a manual of the operations of the GHIP MIS were provided to GHIP. HFDP technical

assistance supervised the testing of the modules up to the printing of reports. Reportedly, the software installed was for BHIP and was not really suitable for GHIP. However, no further technical assistance to rectify this problem was provided as the assistance had been provided under an earlier child survival project which had already been completed. The GTZ SHINE project may provide additional technical assistance for the GHIP MIS.

In 1996, PHIC informed Guimaras that it had been selected as one of seven impoverished provinces to pilot NHI. After discussion among various parties in the province, PHIC was informed that the province wished to continue implementing the P-II. It was estimated that at least 25 percent of the population of Guimaras is poor. If this is so, then by the fifth year of the NHI program the province will owe P20 million for insurance coverage, an amount equal to about 29 percent of its total provincial budget in 1996 (P70 million). Given this projection, it is not difficult to understand why Guimaras would not want to participate in NHI.

Sampaloc Municipality: P-II Pilot

There are at least 12 P-IIs at the municipal level in Quezon Province. Given that the programs have different benefits and premiums, it has not been possible to put them under one provincial administration. The P-II in Sampaloc began in 1984, and as of October 1996, the program had 3,136 members out of a population of about 10,000 (roughly one-third). Other members of the community belong to the P-I. The local health board provides oversight to the P-II. The provincial government is less interested in the P-II efforts than the mayors in the province.

The average claim per patient was P452, and the fund balance at the end of October 1996 was P36,994.25. The administrative costs of the program are low as the P-II coordinator only works part-time for the program (about 3 days per month) and funds are handled by the municipal treasurer. The barangay health workers work free of charge. Costs of printing and meetings come out of the general funds of the municipality and cannot be attributed to the program.

The mayor, Anges Devandera, is opposed to the implementation of the new NHI in her area. As president of the League of Municipal Mayors, she lobbied the President to change the compulsory nature of the NHI bill to a voluntary one. On January 9, 1997, President Ramos sent a letter to PHIC asking for the names of the LGUs that had been selected for implementation of NHI. The letter did not mention anything about compulsory or voluntary enrollment.

According to the mayor, the Sampaloc P-II did not receive any assistance from HFDP. Rather, it was used as a site for field visits and evaluations. MSH indicated that HFDP conducted intensive work with Mayor Devandera and officials of 22 other municipalities to create a common scheme which would strengthen all the programs, which were all too small

to be viable above a certain level of benefits. These initiatives and studies did not convince officials that following a common scheme was useful.

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APPENDIX E

SCOPE OF WORK

(As Received from USAID/Philippines)

I. BACKGROUND

The Health Finance Development Project (HFDP) was designed and developed to respond to the increasingly important health care finance requirements in the Philippines. The goal of HFDP is to develop the health care market in order to improve health service quality, equity, coverage, efficiency and private participation. The purpose of HFDP is to establish a process for formulating and implementing health sector policies, regulations and legislation supportive of health care market improvements. The Project Agreement was signed on September 30, 1991. The PACD was September 30, 1996.

Without any change in the project's goal and purpose, HFDP was amended in March 1994 to accommodate reductions in USAID/Manila's program funding and to bring the project in line with GOP directions and priorities. Five program areas, derived from the projects' three major components, were identified to provide focus to HFDP activities and to make the project more responsive to the immediate operational issues confronting the DOH. These five program areas are: national health insurance; devolution; public resource management; standards, licensing and regulation; and health policy development.

A midterm evaluation conducted in July 1994 basically affirmed the refocussing of HFDP. In summary, the midterm evaluation concluded that:

- the five technical program areas are appropriate to current needs and conditions and should remain unchanged for the life of the project;

- through the refocussing exercise, HFDP has responded successfully to the demands brought about by changes in the project environment, i.e., the implementation of the Local Government Code and the Magna Carta for Health Workers, a new DOH administration with new priorities and directions, and USAID budget cuts;

- the project has successfully laid the grounds for realizing the goal and purpose of HFDP through processes initiated and studies conducted; however, transformation and dissemination of the results of the work in useable forms will be key to converting potential to actual impact;

- an evaluation strategy for the major demonstration activities being undertaken by the project that can be carried out beyond the termination of HFDP; and

- a strategy which guarantees the institutionalization and/or continuation of entities and organizational units (National Health Accounts, Multi Sectoral Health Policy Forum, Health Policy Development Staff) beyond the termination of HFDP has to be developed.

HFDP activities are managed by a DOH Project Management Team headed by an Undersecretary, a Project Director, and supported by a Project Manager as well as Program Area Managers. Activities have been implemented through an institutional contract with Management Sciences for Health and a Cooperative Agreement with UPecon.

II. PURPOSE OF THE EVALUATION

The purpose of this end-of-project (EOP) evaluation is to determine the impact or extent to which the Health Finance Development Project (HFDP) contributed to the achievement of five program area objectives and the efforts of the Government of the Philippines (GOP) in establishing a process for formulating and implementing health care financing policies, regulations and legislation supportive of health care market improvement.

The major purposes of the evaluation are:

1. To determine the extent to which the DOH accomplished the goal and purposes of the project as specified in the EOP indicators, measures of goal achievement and conditions that indicate purpose achievement (see HFDP Logical Framework as amended, 3/15/94).

2. To identify issues that need to be addressed and strategies that need to be employed in order for GOP to sustain the gains of HFDP.

3. To document important lessons learned from the Project.

III. SCOPE OF THE EVALUATION

The end-of-project evaluation will cover the period starting from project initiation (1991) until the PACD, September 30, 1996. It will cover the performance of all actors in the project and

include all elements of the project, namely: technical assistance, training, studies, demonstrations.

IV. KEY EVALUATION ISSUES

Task 1: Assessment of Management Structure and Processes

- To assess the HFDP design/redesign and implementation process. Were the revised project strategies and activities appropriate to meet the objectives? What were the effects of external and unanticipated actions and/or events on the project, such as change in DOH leadership and reduction in USAID resources? How did the DOH manage the implementation of the project and how effective was this management process? How did USAID manage the process from its end? Was it effective? Why or why not?

Task 2: Assessment of Project Impact

- To measure the extent to which HFDP has achieved its purpose level objectives. What impact on financing, access to and delivery of health services has the project made? For example:

  (1) What are the fund mobilization and ultimate cost implications of the development of provincial health financing models? What are the cost savings resulting from developing/implementing a health financing model?

  (2) How much revenue did the retained hospitals generate from implementing the model developed under the project (high, medium, low)? Were the hospitals allowed to retain such revenues and were the retained revenues utilized for upgrading the quality and management of health service?

  (3) How much revenue and other resources was the DOH able to lever in the form of increases in LGU expenditures on health in connection with CHCA? To the extent that net revenues were generated for health from such arrangements, what are the implications in terms of increased preventive and promotive services, improvements in quality of care?

(4) How much more funding did the DOH get from the GOP with an approved Public Investment Plan? How much less would it have gotten in the absence of an approved plan?

(5) To what extent were DOH budget procedures improved and what were the results?

(6) What is the project's impact at the policy level, i.e., what laws, Department Orders, and other policy instruments and tools can be attributed to the project?

(7) What is the project's impact at the programmatic level, i.e., what procedures (budgeting, etc.) and other operational improvements can be attributed to the project?

(8) What are the project's "demonstration" effects, i.e., what are the possible externalities of the project? Examples: It is possible that the project did not fully fund rural health insurance schemes but they may have been influenced by project models. Or it is possible that project inputs "pump-primed" other resources.

Task 3: Assessment of Sustainability

- To examine post - HFDP sustainability issues. What are the plans of the DOH for sustaining systems and measures developed under the project upon termination of USAID assistance? By looking at the current behavior of LGUs in the way that they are dealing with health financing and health care delivery concerns, what issues need to be addressed in order to conserve and sustain the gains of HFDP? What strategies can be employed to effectively deal with these issues?

- Financial sustainability - what were the real financial and economic improvements, e.g., efficiency savings, as in new physician payment system? Mobilization of resources as in revenue enhancement programs? New ways of generating health resources as in provincial/municipal/community based health insurance?

- Institutional Sustainability - of activities started by the project, e.g., National Health Accounts, MultiSectoral Policy Forum, Hospital Development Board, etc.; of new units created, e.g., Health Policy Development Staff, DOH Legislative Liaison Office, etc.

The evaluation may consider the following framework:

a) inputs

b) process

c) outputs

d) effect (i.e. perceptible and measurable during project implementation, or one to two years after project initiation; generally applicable to direct beneficiaries and to specific aspects of health care utilization and provision; e.g., increased hospital revenues, increased utilization, more service providers.)

e) impact (i.e. slow in happening but may produce changes not only on direct beneficiaries but also on the community's quality of life; e.g. reduce morbidity and mortality)

The following questions may be viewed as generic for each of the 5 HFDP program areas:

(a) What were the objectives of the program area?

(b) What were the parameters established to determine fulfillment of the objectives? How are the parameters to be measured?

(c) What were the benchmarks and activities pursued to meet the parameters?

(i) Were all the benchmarks and activities completed?

(ii) What were the key factors that hindered Benchmark implementation and completion? How were they addressed and resolved (if at all)?

(iii) What were the key factors that contributed to the achievement of the benchmarks/activities?

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(d) Questions re "inputs" utilized by each Program Area

(i) What were the inputs utilized? (identify and quantify whenever possible.) e.g.:

* funds (from) DOH/central government; LGUs; private sector; community groups/NGOs; donor agencies; others

* materials/equipment

* project staff (e.g. technical vs. administrative; DOH vs MSH/UPecon)

* consultant services

* training activities

* etc.

(ii) What were the key issues/problems encountered in mobilizing, allocating, and utilizing the inputs given the many activities in each Program Area? How were such issues addressed/resolved?

(iii) Which benchmark/activity utilized the most inputs (quantify)? Why?

(iv) What were the factors that facilitated the appropriate mobilization, allocation, and utilization?

(v) What were the key inputs that contributed to the fulfillment of Program Area benchmarks/activities?

(vi) Give recommendations on how inputs can be properly mobilized, allocated, and utilized in future projects of a similar nature to HFDP, or that can be adopted by DOH/USAID projects.

(e) Questions re "process" utilized by each Program Area (PA).

(i) What were the policy/procedural guidelines adopted by the project as a whole, and of the individual program areas (i.e. USAID, DOH, PMCC, MSH/CARRA, UPecon, etc.)? e.g.

* Benchmark/activity identification and approval

* activity quality assurance; technical and administrative clearances (e.g. TOR preparation; hiring of consultants, activity monitoring; activity final report acceptance; budget approval)

(ii) What were the key processes that helped in the satisfactory achievement of PA objectives?

(iii) What were the key processes that impeded the satisfactory/timely completion of objectives?

(iv) For activities that involved the participation of local communities/LGUs, what were the processes found effective and ineffective in terms of:

* obtaining and sustaining community participation?

* getting an outside entity/organization (like HFDP and its consultants) to be accepted?

(v) Recommend effective processes that can be adopted in future projects of a similar nature as HFDP, or that can be adopted by DOH/USAID projects.

(f) Questions re "outputs" of each Program Area (PA)

(i) What were the outputs of the PA? e.g.:

* For Program Area Management: organized project office; documented policies/procedures etc.

* For NHI PA: researches finished; demos established; systems designed and installed; etc.

* etc. (i.e. other PAs)

(ii) Do the different outputs complement each other and, taken together, contribute to the objectives of the PA?

Which output(s) best, contribute to the fulfillment of the PA's objective(s)? Why? Which output(s) least contribute to the PA's objective(s)? Why?

(iii) What are the key factors that contribute to quality output? Why? (Please define concept of quality.)

(iv) Were the outputs communicated to concerned stakeholders/potential users? Was the communication effort effective? Why or why not?

(v) Were the outputs utilized? By whom?

(vi) What were the communication materials/channels deemed effective and ineffective? Why?

(vii) Give recommendations to:

* properly communicate/disseminate HFDP PA outputs to concerned stakeholders or potential users;

* ensure/enhance quality and usefulness of outputs of ongoing/future DOH USAID projects.

(g) Questions re "effect" of PA

(i) What are the effects of the PA? Are they properly documented and communicated?

* provide qualitative and quantitative justification as appropriate

* identify positive and negative effects where appropriate (e.g. to DOH, USAID, LGUs concerned, other government entities, local community, service providers, general public, NGO, etc.)

* which activities may be considered as having the most (1) positive and (2) negative effects? Why?

(ii) Give recommendation(s) on

* how effects can benefit as many people/stakeholders as possible;

* documenting, communicating, replicating and sustaining the positive effects

(h) Questions re "impact" of PA

(i) What are the expected positive and negative impact(s) of the PA? Are they documented? If not, should they be documented?

* provide quantitative and qualitative justification as appropriate

V. THE EVALUATION TEAM

The EOP evaluation will require the services of a four-member team consisting of:

- one **Program and Policy Analyst**, (expat, for 33 person days) who will serve as team leader and be responsible for the overall evaluation and reporting requirements. S/he will be primarily responsible for project content and achievement in technical areas. S/he will be responsible for evaluating the impact of the financing reforms developed and implemented under the project, identifying sustainability issues, and making recommendations within the context of SO3. S/he will assign tasks to and oversee inputs of other evaluation team members to ensure completion of tasks 1-3 above. S/he must have broad experience in the evaluation of health policy activities. Knowledge of health care financing issues in developing countries is required. M.A. or Ph.D level training in health economics, policy analysis, public administration, management or social science and extensive experience in assessing health policy reforms in developing countries.

- one **Health Economist**, (Expat, for 30 person days) who will be primarily responsible for reviewing policy/program reforms made by the DOH/PMCC to determine their correspondence to the current grant agreement and to evaluate actual impact of the reform(s): did a real cause-effect phenomenon occur, positively affecting the delivery and/or utilization of health services; or was the reform in letter only. S/he will assess the policy process(es) and databases developed and implemented under the project and identify sustainability issues that need to be addressed by the various agencies involved in these activities. S/he must have broad experience in the evaluation of health policy analysis, development and

implementation. M.A. or Ph.D. level training in economics with specific emphasis on health economics.

- one **Organizational Development/Management Specialist**, (Filipino, for 26 person days) who will be primarily responsible for assessing the project's management structures (DOH, USAID, Institutional Contractor, Grantee), as well as the various entities and organizational structures instituted or established under the project (HPDS, MSF, HPPDB, NHA/NSCB etc.) and identifying sustainability issues regarding these structures. S/he must have broad experience in the assessment of organizational structures and management processes. M.A. or Ph.D. level training in management or social sciences, specific training in analyzing service organization and delivery, project management and/or institutional structures.

- one **Health Finance Specialist** (Filipino for 26 person days) who will be responsible for reviewing the various demonstration studies undertaken to determine their impact and identify sustainability issues that need to be addressed by the LGUs and various agencies involved in these activities. S/he must have broad experience in the evaluation of health care financing activities. M.A. or Ph.D. level training in economics, public administration, specific training or experience in analyzing health care financing activities.

The evaluation as well as the submission of all reports and deliverables shall be completed within the schedule indicated herein. It must be noted that , as part of the SOW, the Team will provide briefings and debriefings to USAID and DOH. A six-day workweek is authorized with no premium pay.

VI. DATA SOURCES AND REPORT FORMAT

The evaluation will rely on three main sources of information: 1) secondary data sources such as HFDP monitoring data and various project documents; 2) interviews with key officials and staff knowledgeable about the project; and 3) selected site visits.

Key documents to review will include the Project Paper (original and amended), the Midterm Evaluation Report,

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various monographs and reports written by consultants. USAID and the DOH, with the evaluators, will select representative LGUs for site visits to assess the policy, organizational and financial initiatives supported by HFDP.

The evaluation report should include: 1) the major findings of the team, noting where information was adequate or lacking; 2) the conclusions interpreting the findings of the topics assessed; 3) recommendations for the DOH and USAID on sustainability concerns.

The evaluation is expected to entail not more than 35 working days to be completed within 2 calendar months, with not less than 26 days spent in-country. This includes briefings and debriefings that the Team will provide for USAID and DOH. The Team Leader and the Health Economist will be allowed to spend 5 and 2 working days, respectively, in the U.S. to finalize the report. Data collection and report writing up to the final draft (including consultations for report revision) should be completed with no premium pay.

The evaluation report with tables and annexes should not exceed 50 pages. The report format will be as follows:

1. Executive Summary (to follow PES format) stating findings, conclusions and recommendations, not exceeding 3 pages;
2. Table of Contents;
3. Body of the Report which includes a brief project description, the environment in which the project operated, a statement of the methodology used, major findings, conclusions and recommendations, lessons learned, achievement of project purposes; and
4. Annexes

Annexes to be attached to the final report include the evaluation scope of work, a list of persons consulted, background supplemental materials useful for a fuller understanding of the report and an annotated bibliography of significant research reports/studies used or consulted.

VII. LOGISTICS

Individual contractors are responsible for their own travel, office space, research assistance and communications. In addition, the Team Leader is responsible for draft and final report development and reproduction as well as other eligible expenses associated with the completion of the final evaluation.