



Draft Design and Monitoring Framework

Project Number: 41664
January 2008

PHI: Support for Sustainable Health Care Investment Project

A design and monitoring framework is an active document, progressively updated and revised as necessary, particularly following any changes in project design and implementation. In accordance with ADB's public communications policy (2005), it is disclosed before appraisal of the project or program. This draft framework may change during processing of the project or program, and the revised version will be disclosed as an appendix to the report and recommendation of the President.

Asian Development Bank

DESIGN AND MONITORING FRAMEWORK

Design Summary	Performance Targets/Indicators	Data Sources/Reporting Mechanisms	Assumptions and Risks
<p>Impact Health related Millennium Development Goals (MDG)</p>	<ul style="list-style-type: none"> - Reduced Maternal Mortality Ratio by 50% (from 162 per 100,000 live births in 2006 to 80 by 2013) - Reduced Infant Mortality Rate by 16% (from 24 per 1,000 live births in 2006 to 20 by 2013) - Reduced Tuberculosis prevalence rate by ??% (from ?? in 2006 to ?? by 2013) - Premature death from NCD reduced by 20% (from ?? in 2006 to ?? by 2013) - Reduced out-of-pocket expenses for health care by 15% (from 47% of total health care costs in 2006 to 40% by 2013) 	<ul style="list-style-type: none"> - Demographic Health Survey - National Health Accounts - Burden of Disease 	<p>Assumptions</p> <ul style="list-style-type: none"> • The existence and compliance of a supporting national policy on maternal and child health, and control programs for infectious diseases including TB, HIV-AIDS and Malaria, among others. • The existence and compliance of a supporting and consistent recurrent (salary and non-salary) and capital investment budgets from national and local government units for health related programs. • The allocation of appropriate budgets by national and local government units, and enrollment of all the indigents into the PHIC. <p>Risks</p> <ul style="list-style-type: none"> • Loss of health human resources in the country to opportunities outside the Philippines. • Epidemic that re-directs health budget, increases health care cost burden on the population. • Economic downturn, high inflation, etc. affecting household disposable income, and health budget
<p>Outcome Effective access to primary medical care</p> <p>Effective access to secondary medical care</p>	<ul style="list-style-type: none"> - Increase in the relatively poor and underserved household's (q3,q4,q5) use of PHC health facilities (by type and ownership by expenditure quintile and demographics) by 50% - Improved patient satisfaction (e.g. reduced waiting time, availability of health care provider, medicines, etc.) by 25% - Increase in the % births delivered at health facilities (BEMOC, CEMOC) by 50% - Increase in the relatively poor and underserved household's use of first level referral care: secondary hospitals (by 	<ul style="list-style-type: none"> - PHIC dataset [needs baseline] - Hospital dataset [needs baseline] - Household Expenditure Survey (from the National Statistics Coordinating Body) - Demographic Health Survey - National Health Accounts - Consumer Satisfaction Survey/hospital exit surveys 	<p>Assumptions</p> <ul style="list-style-type: none"> • GOP/LGUs continues to increase budget allocation for PHIC premiums to enroll the indigents • PHIC reimbursements are increased (making it attractive for health providers to seek accreditation status), financially protecting the poor for health costs • PHIC benefits packages are improved and marketed (thereby attracting health providers to accredit their facilities under PHIC) <p>Risks</p> <ul style="list-style-type: none"> • High travel costs, or limited access to services, hinder the patients from using modern health facilities • Cultural factors hinder the

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<p>Cost efficient innovations (contracting model)</p> <p>Effective access to credit</p>	<p>type and ownership by expenditure quintile and demographics) by 25%</p> <ul style="list-style-type: none"> - Improved patient satisfaction (e.g. reduced waiting time, availability of specialist care, diagnostic services, medicines, etc.) by 25% - Increase in the contracting between PHIC and health care providers to monitor quality of services - Increase in the % PHIC claims submitted within 30 days by 50% - Increase in the % SHCIP lending for public sector (12% in 2006) to at least 50% -- target = \$25mll - Increase in the % SHCIP lending for PHC, MCH services and for laboratory and diagnostic services to at least 30% - target = \$15mll - Increase in the % SHCIP lending to LGU 3-4, 5-6 and municipalities to at least 50% (??) 		<p>patients from using modern health facilities</p> <ul style="list-style-type: none"> • Households continue to bypass primary health care facilities and self-refer to hospital care (lack of gate-keeping at PHC and lack of incentives by providers and beneficiaries)
<p>Outputs</p> <p>1. Effective access to primary medical care (ppp)</p> <p>2. Effective access to secondary medical care</p>	<ul style="list-style-type: none"> - # clinics newly accredited (by type of ownership) - # public clinics newly partnered with private providers (e.g. GPs) - # private clinics newly established in underserved areas catering to the low income groups - # private clinics/ hospitals newly established with maternity care (including BEMOC /CEMOC) program - # private clinics/hospitals newly established with newborn care (including child immunization) program - # private clinics/ hospitals newly established with TB-DOTS program - # of drug retails selling generic drugs established/ expanded (e.g. <i>botika ng bayan</i>) - # secondary hospitals newly accredited (by type 	<ul style="list-style-type: none"> - PHIC accreditation database - DOH licensing database - Philippines Hospital Association - Private Hospital Association of the Philippines - Annual Provincial Health Office Report - Project related monitoring system 	<p>Assumptions</p> <ul style="list-style-type: none"> • LGUs and private health entrepreneurs willing to borrow at DBP (or MFI) terms • Borrowers agree to terms stated in the PHIC contracts to provide quality health services • Private health care facilities are accredited (in a timely manner) <p>Risks</p> <ul style="list-style-type: none"> • Public clinics are unable to retain health providers • Private health entrepreneurs unwilling to partner on DOH PPP strategy to support public agenda • Drug stores unwilling to sell generic drugs at PHIC reference pricing • Delay in project effectiveness and thereby loss in momentum from political forces and from private borrowers

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<p>3. Streamlined Information system</p> <p>4. Effective access to credit</p>	<p>of ownership)</p> <ul style="list-style-type: none"> - # hospitals newly upgraded from primary to secondary level - # secondary care hospitals newly established with diagnostic/ laboratory services in areas - # secondary care hospitals newly established/extended MCH care facilities - # public hospitals/clinics newly established with private providers (to complement the shortage of health human resources in the original plan of the hospital) - # hospitals newly established with consignments of drug stores selling/distributing generic drugs (e.g. <i>botika ng lalawigan</i>) - # hospital business plans prepared with financial sustainability assessment <ul style="list-style-type: none"> - # hospitals with HMIS/ FMIS investment to improve claims processing/ patient management system - # providers engaged in telemedicine, offering/ receiving diagnostic support to/from other hospitals and PHC clinics <ul style="list-style-type: none"> - # marketing programs conducted to promote SHCIP among wholesale lenders and borrowers, retail borrowers, LGUs and municipalities - # training programs conducted for MFI/rural or thrift banks and others on promoting SHCIP, transparency of information, client orientation and on appraising health projects - # training programs conducted for midwives and others on banking literacy and preparing business proposals and planning - # workshops held on credit guarantee 		<ul style="list-style-type: none"> •

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<p>5. Strengthened project management and monitoring</p>	<p>information to form partnership between LGUs and other institutions</p> <ul style="list-style-type: none"> - partnerships formed in lending with MDFO - partnerships formed in lending with DOH on F-1 - partnerships formed with PHIC on collection of loan repayments and timely reimbursements from PHIC - partnerships formed with LGUs on credit guarantors <p>- Project monitoring (exit survey) briefings provided to borrowers on an annual basis, and information posted on DBP website for its transparency</p> <ul style="list-style-type: none"> - Project monitoring discussions held with advisory committee and decision made on progress or next steps of the subprojects on a semi-annual basis - Project monitoring Quarterly Reports submitted to ADB with output data of project investment and its beneficiaries in a timely manner 		
<p>Activities with Milestones</p> <p>Health Policy Framework</p> <p>1.1 DBP project Advisory Committee established before loan is effective</p> <p>1.2 DBP SHCIP Health Policy framework established, and monitoring guidelines prepared within first six-months of loan effectiveness</p> <p>1.3 Project Advisory Committee meeting held on a quarterly basis during project life</p> <p>Contractual Agreement</p> <p>2.1 Memorandum of Agreement (MOA) established between PHIC/DOH/DILG/League of Provinces/DBP before loan is effective</p> <p>2.2 Draft sub-loan agreement for health sector lending submitted to ADB for comments and NOL within first six-months of loan effectiveness</p> <p>2.3 Sub-loan agreement established between DBP and borrowers before start of investment</p> <p>Marketing of SHCIP</p> <p>3.1 DBP prepared its marketing strategy before loan is effective</p> <p>3.2 DBP marketed the SHCIP within first six-months of loan effectiveness</p> <p>3.3 DBP conducted an evaluation of the impact of the marketing strategy within first year of project implementation, and continues to refine and market the SHCIP during project life</p> <p>Rationale investment (DBP to ensure this is submitted to them by borrowers)</p> <p>4.1 Certificate of needs received from DOH for the various hospitals that are to receive investment for new construction or new equipment before investment is initiated</p> <p>4.2 Province-wide health care delivery plans including private sector feasibility prepared (with assistance of DOH) to identify need for further expansion (and location) of hospitals in the province before investment is initiated</p>			<p>Inputs</p> <ul style="list-style-type: none"> • ADB lending = \$50 million • Cofinancing {KfW} lending = \$50 million • ADB Grant TA = \$0.5 million • DBP = staff and operations costs to support project management and monitoring • LGUs =10% equity • Private sector =20% equity

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<p>4.3 EIS reports (for category A) or IEE report (for category B sensitive) subprojects submitted to ADB for NOL before investment is initiated</p> <p>Project Management</p> <p>5.1 DBP has recruited and set-up the core project management and monitoring team before loan effectiveness</p> <p>5.2 DBP has recruited and set-up the supporting project management and monitoring team within first year of loan effectiveness</p> <p>5.3 DBP has conducted the training of DBP staff to build capacity for environmental assessment and monitoring and marketing before loan effectiveness (or within first six-months loan of effectiveness)</p> <p>Project performance monitored (could be independent monitoring – outsourced)</p> <p>6.1 baseline data on health service use and patient satisfaction reported before investment initiated (within first six-months of investment initiated)</p> <p>6.2 Exit surveys conducted at hospitals where DBP investment has been provided on an annual basis until end of project life</p> <p>6.3 Beneficiaries impact assessment of health investment conducted within last six-months of project life</p>			