



Technical Assistance

TAR: PHI 39066

Technical Assistance to the Republic of Philippines for the Support for Health Sector Reform

September 2005

Asian Development Bank

CURRENCY EQUIVALENTS

(as of 5 August 2005)

Currency Unit	–	peso (₱)
₱1.00	=	\$0.0179
\$1.00	=	₱55.9350

ABBREVIATIONS

ADB	–	Asian Development Bank
CPG	–	clinical practice guidelines
DOH	–	Department of Health
EPI	–	Expanded Program for Immunization
HSDP	–	Health Sector Development Program
HSRA	–	Health Sector Reform Agenda
ILHZ	–	interlocal health zone
IMR	–	infant mortality rate
LGU	–	local government unit
MFC	–	Municipal Finance Corporation
NCHFD	–	National Center for Health Facilities Development
PhilHealth	–	Philippines Health Insurance Corporation
RHU	–	rural health unit
TA	–	technical assistance

TECHNICAL ASSISTANCE CLASSIFICATION

Targeting Classification	–	Targeted intervention
Sector	–	Health, nutrition, and social protection
Subsector	–	Health systems
Themes	–	Governance, Inclusive social development, Gender and development
Subthemes	–	Public governance, Human development, Gender equity in capabilities

NOTE

- (i) In this report, "\$" refers to US dollars.

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I. INTRODUCTION

1. The Government of the Republic of the Philippines requested the Asian Development Bank (ADB) for assistance to support the implementation of the Health Sector Reform Agenda (HSRA) in April 2004.¹ The ADB Fact-Finding Mission of May 2005 reached an understanding with the Government on the objectives, scope, cost estimates, financing plan, and implementation arrangements of the advisory technical assistance (TA).² The TA design and monitoring framework is in Appendix 1.

II. ISSUES

2. Overall, the health status of the population of the Philippines has improved in the past decade. The infant mortality rate (IMR) declined from 57 per 1,000 live births in 1990 to 50 per 1,000 live births by 1998,³ and is comparable with that of other countries in East and Southeast Asia. Maternal mortality ratio was 180 deaths per 100,000 live births in 1998, down from 209 in 1990, but still much above the regional average. Intracountry variations are evident: IMR is higher in Eastern Visayas (60), and IMR in rural areas is at least one third higher than in urban areas. The demographic and epidemiological transition has resulted in a dual burden (communicable and noncommunicable) of disease: the top 10 causes of morbidity are still communicable in nature, such as pneumonia, measles, and diarrhea. Other preventable diseases, such as tuberculosis, are on the rise. The top 10 causes of death among adults are, however, non-communicable, such as cardiovascular diseases resulting from changing lifestyles, demographics, and diets. The challenges faced by the health sector—devolution, public sector programs not prioritizing the needs of the population, and the recent budget crisis—are expected to result in a slower pace of improvement in health status, thereby threatening the country's chances of meeting the health-related Millennium Development Goals.

3. **Expenditures for Health.** Total health spending in the Philippines was estimated at 5% of gross national product in 2001, having increased from 3.5% in 1997. However, a large portion of health care cost compromises household out-of-pocket expenditures (43%), while the public sector's share of total health expenditure (of 37%: 17% from national and 20% from local governments) has declined, and the national health insurance program coverage remains low (8% in 2001). Most public resources are allocated to curative health care, while only 13% of resources are spent for public health programs.⁴

4. **Health Sector Reform Agenda (HSRA).** In view of these challenges, the Department of Health (DOH) initiated HSRA in 1999. Devolution, following the Local Government Code of 1991, had fragmented the health service delivery system, as administrative and financial responsibilities have been shared since then among central, provincial, and local authorities, without effective coordination and cooperation mechanisms in place. As a result, public health programs suffered most from an apparent lack of attention. The budget deficit of the national Government and declining public sector resources aggravated the situation. HSRA was introduced to help streamline the health service delivery system with a comprehensive program covering five broad areas of reform:⁵ (i) providing fiscal autonomy to hospitals, (ii) securing funding for priority public health programs, (iii) promoting the development of local health systems and ensuring their effective performance, (iv) strengthening capacities of health regulatory agencies, and (v)

¹ ADB. 2004. *The Philippines: Country Strategy Program Update*. Manila.

² The TA first appeared in *ADB Business Opportunities* (internet edition) in July 2005.

³ National Statistics Office. 1998. *National Demographic Health Survey*. Manila.

⁴ National Statistics Coordination Board. 2001. *Philippines National Health Accounts*. Manila.

⁵ The Health Sector Reform Agenda (HSRA) does not include two priority areas of human resource development, or improving the health information systems. HSRA-plus will include these two cross-cutting areas.

expanding coverage of the national health insurance program. In summary, HSRA was expected to improve the efficiency of the health service delivery system by integrating health care promotion and prevention, improving referral links, reducing the need for hospitalization, and thereby improving the allocation and use of resources.

5. **Hospital Reform.** The HSRA objective is to rationalize health service delivery, prioritize primary health care development over hospitalization, and introduce cost-efficient measures in hospital operation. Currently, at least 52% of hospital beds in the country are provided by the public sector. Several provinces have a surplus of hospital beds, and many hospitals face a low bed occupancy rate. Many hospitals have only from 10 to 25 beds, and therefore cannot benefit from economies of scale. The quality of these hospitals has been questioned; many of them are not accredited. Roles of core referral (district) hospitals and referral links wait to be defined, and their service mix identified. A large share of the national Government budget for health is allocated to hospital investment and operations; however, the share varies by province, and by local government. Hospitals do not have fiscal or managerial autonomy and lack incentives to improve service quality, as they are unable to retain or use savings even for operations and maintenance, or for staff performance incentives.

6. **Public Health Reform.** The HSRA objective promotes cost-effective public health interventions and their integration in the devolved health service delivery system. Public health programs, such as family planning (as part of reproductive health), tuberculosis detection, and healthy lifestyles, lack adequate financing despite the programs' many benefits for the poor and significant positive externalities for society. Several public health programs of DOH are not integrated within the devolved health service delivery system. Budget preparation is on annual, rather than multiyear basis, thereby preventing long-term planning and the continuity of program implementation. National Government subsidies allocated to local government units (LGUs) that are responsible for implementing public health programs are based on historical estimates and not LGUs' actual needs. Community-based care is reasonably well-regulated with regard to selected services (such as child immunizations), but many health care providers are inadequately trained or motivated. Few incentives are provided to encourage care providers to be aware of, and comply with, best practices. Despite progress in recent years, tremendous opportunities still exist to better involve the private and nonprofit health sector in public health programs.

7. **Local Health Systems Reform.** The HSRA objective is to strengthen the capacity for decentralized health service delivery. Many problems result from the complexities of devolution, which has created unfunded mandates for LGUs because the agreed-upon package of health services transferred to LGUs does not match budget allocations; there is no integrated and systematic health service referral network among LGUs; the national Government's package of technical assistance for devolved activities is insufficient; and quality assurance standards are not applied consistently. The concept of interlocal health zones (ILHZs) was therefore introduced to create an integrated referral network among a number of LGUs and to improve quality, efficiency, and effectiveness of health service provision. While some ILHZs have been piloted, integrated referral networks (public and private), which will prevent patients from bypassing the lower health facilities and consequently running up the costs of healthcare are yet to be set up. With devolution, DOH lost its budget to provide technical assistance for most devolved activities, and currently supports only relatively poor municipalities (fiscal category IV–VI out of 6). The Government is considering financing modality to assist LGUs in capital investment.

8. **Health Regulation Reform.** The HSRA objective is to streamline the regulatory framework for improved health service delivery. Regulatory responsibilities lie with DOH; however, many regulations are outdated (predating devolution) and implementation remains weak. With devolution, drugs and medical devices are procured at LGU rather than at provincial

level. As a result, prices for drugs are higher, since economies of scale or standardization cannot come into effect, and problems in quality control are created. Lack of guidance in coordinating with the private health sector has also resulted in missed opportunities for better complementarities and minimum duplication of services. In addition, although quality assurance standards exist to ensure good performance at rural health units (RHUs) and hospitals, standards differ between agencies—such as DOH for certification or licensing and Philippines Health Insurance Corporation (PhilHealth) for accreditation—and require harmonization and improved monitoring.

9. **Health Care Finance Reform.** The HSRA objective is to shift the burden of health care costs from household out-of-pocket expenditures to the public sector and to PhilHealth. The coverage of the population is to be expanded, especially to reach the poor (indigents) and the informal sector by providing packages of tailor-made benefits. PhilHealth coverage is still low overall, and very uneven among provinces. Nationwide, only 20% of indigents are covered. However, counting the enrolled poor is difficult as poverty data do not exist at municipal levels, and LGUs cannot appropriately map where the poor are. In addition, the current benefits package is limited, and does not provide preventive health care or basic curative care against catastrophic illnesses.

10. **Governance Reform.** The HSRA gives little attention to reform in the area of human resources. In 2003, the Government endorsed a rationalization policy for public sector employees. Each department is expected to justify its staff requirements and prepare a rationalization implementation plan in 2005. DOH has developed a health human resource master plan and is seeking assistance in implementing it. Among the issues highlighted in the master plan are (i) an inappropriate staff skills mix, (ii) lack of incentives, (iii) lack of a career development scheme, (iv) uneven distribution of medical and paramedical staff at local levels, and (v) the concentration of health professionals in urban areas, creating acute shortages in rural areas.

11. **Development Partners.** ADB, through the Health Sector Development Program (HSDP),⁶ is the first development partner to provide DOH with comprehensive support for implementing HSRA. The goal of the HSDP is to improve the health status of the poor by promoting cost-effective health interventions with an efficient, rationalized, and integrated health service delivery system. Several other development partners are supporting HSRA in specific areas: the World Health Organization in developing of performance-oriented budgeting for priority public health programs; the World Bank in hospital payment, performance-oriented budgeting for public health programs, and drug management; the European Commission in regulatory reforms and public finance; the German Technical Cooperation in health insurance; and the United States Agency for International Development in public–private partnership for public health programs.

12. **Rationale.** The primary challenge facing the health sector is identifying ways to improve the efficiency and effectiveness of health service delivery. The country is confronted with low public sector performance in the health sector, as it inadequately addresses (i) the health needs of the population at large; (ii) the financing or risk-sharing mechanisms and burden of health care cost; and (iii) the inefficiencies, and unnecessary cost burden of health care. Devolution has highlighted the limited resources and weak capacity at the LGU level. HSRA provides the strategy to overcome these obstacles. A rationalized health service delivery system is expected to lead to efficiency gains. Improved coverage under social health insurance will reduce household health

⁶ ADB. 2004. *Report and Recommendation of the President to the Board of Directors on Proposed Loans to the Republic of the Philippines for the Health Sector Development Program*. Manila (Loans 2136/2137-PHI for \$213 million) includes a 2-year program loan, and a 6-year investment loan.

care cost. Improved capacity for planning and implementation will introduce appropriate programs and budgets to address the dual-disease burden, and partnerships with the private and nongovernment sectors are expected to enhance the effectiveness of health service delivery.

III. THE TECHNICAL ASSISTANCE

A. Impact and Outcome

13. The TA will provide support to enhance the implementation of HSRA and increase the utilization of affordable and financially sustainable quality health services by the poor. The TA will help build DOH capacity to streamline policy and refine monitoring systems, and assist LGUs to initiate and implement these reforms. The TA will help the Government give HSRA a head start in the 15 selected convergence sites⁷ by streamlining policies; developing guidelines, concepts, and administrative orders; and harmonizing the processes between involved public actors at the central level. The TA will particularly accelerate HSRA implementation in up to five convergence sites under the HSDP.

B. Methodology and Key Activities

14. The TA will consist of two components: (i) support for HSRA implementation, and (ii) initiatives to enhance the capacity of the local health care system under HSRA. The TA team will work closely with the Government and other stakeholders to help strengthen ongoing HSRA activities, in a timely fashion, through a comprehensive methodological assessment, technical review building on international experiences, preparation of systems, and enhancing implementation capacity. The TA will have the following outputs:

- (i) **Improved efficiency in core referral hospitals.** Streamline mechanisms in core referral hospitals for improved performance by providing adequate incentives, such as fiscal and managerial autonomy to retain earnings and savings, and to appropriately monitor that autonomy through a strengthened hospital financial management system.
- (ii) **Improved quality of public health provision supported by adequate budgets.** Improve the quality of care in health service delivery by introducing cost-effective public health interventions, clinical practice guidelines (CPGs) in health facilities, and piloting multiyear programs and budgets for public health interventions in the LGUs.
- (iii) **Improved quality of health services delivery at the local level.** Provide an integrated framework for a rationalized health system at LGU level that includes primary health care, first and second referral levels in the context of each ILHZ; address priority needs related to the dual burden of disease; and explore measures to improve effectiveness of services like the procurement and deployment of equipments, drugs, and supplies. Develop a plan for health professionals' development—physicians, nurses, midwives, health administrators, and managers—and propose streamlined policies, programs, and incentive schemes, as well as refresher retraining program for health staff of LGUs.
- (iv) **Harmonized regulatory procedures.** Develop and experiment a pilot strategy for more cost-efficient procurement of drugs, including standardizing quality and prices of drugs.

⁷ In 2003, the Department of Health (DOH) identified 15 convergence sites, as the first set of 15 out of the 79 provinces to achieve HSRA. The convergence site approach is a DOH strategy for phasing HSRA implementation in the provinces over time.

- (v) **Increased coverage of beneficiaries under PhilHealth.** Propose new schemes to PhilHealth to increase enrollment of the poor and of informal sector beneficiaries, with a package of tailor-made benefits, including one for primary health care and for protecting these beneficiaries against the financial burden from catastrophic illnesses; and develop LGUs capacity for needs-based budgeting and for transparent fiduciary arrangements.
- (vi) **Financing modality.** Propose financing modality to the Department of Finance for capital investment to LGUs.

C. Cost and Financing

15. The total cost of the TA is estimated at \$1,430,000 equivalent, comprising \$440,000 in the foreign exchange and \$990,000 equivalent in local currency. The Government has requested ADB to finance \$1,000,000 (70%) equivalent, covering the entire foreign exchange cost of \$440,000 and \$560,000 equivalent of the local currency cost. The TA will be financed on a grant basis by ADB's TA funding program. The Government will finance the balance of the local currency cost, equivalent to \$430,000 (30%), through the provision of office space, furniture, counterparts, and workshop facilities. The detailed cost estimates and financing plan are in Appendix 2.

D. Implementation Arrangements

16. The TA will be attached to the undersecretary for external affairs of DOH, technically led by the director of the Bureau of Health Policy Development and Planning, and based at the HSRA resource center. A technical coordinating group will oversee the progress of the TA, ensure its coherence with government policy and the efficient delivery of the outputs, and guide and review the outputs of consultants.

17. The TA will be implemented in 18 months (September 2005–February 2007). A team of international and domestic consultants will implement the TA components. The consultants will be engaged either individually or through a firm under quality- and cost-based selection, using simplified technical proposals in accordance with ADB's *Guidelines on the Use of Consultants* and other arrangements satisfactory to ADB for engaging domestic consultants. Procurement of office equipment, computers, and printers will be in accordance with ADB's *Guidelines for Procurement*. Specialists will provide 18 person-months of international and 96 person-months of domestic consulting services. Consultants for the following areas will be recruited: district health planning and management, health systems, hospital financial management, health finance/social health insurance, public health, drug procurement management, human resource planning, and finance. The consultants' terms of reference and reporting schedules are in Appendix 3.

IV. THE PRESIDENT'S DECISION

18. The President, acting under the authority delegated by the Board, has approved the provision of technical assistance not exceeding the equivalent of \$1,000,000 on a grant basis to the Government of the Philippines for Support for Health Sector Reform, and hereby reports this action to the Board.

DESIGN AND MONITORING FRAMEWORK

Design Summary	Performance Targets/Indicators	Data Sources/Reporting Mechanisms	Assumptions and Risks
<p>Impact</p> <ul style="list-style-type: none"> Increased utilization of affordable and financially sustainable quality health services by the poor in the 15 Health Sector Reform Agenda (HSRA) convergence sites 	<ul style="list-style-type: none"> Reduced tuberculosis incidence among children under-5 years in the bottom income (or expenditure) quartile of population by 2008 Reduced incidence of risk factors (e.g., iron deficiency anemia) among pregnant women in the bottom income (or expenditure) quartile of the population by 2008 Increased utilization of public sector health facilities by the bottom income (or expenditure) quartile of the population by 2008 	<ul style="list-style-type: none"> National demographic health survey National health accounts Public expenditure reviews 	
<p>Outcome</p> <ul style="list-style-type: none"> Department of Health (DOH) to streamline HSRA policy and refine monitoring systems Local government units (LGU) to implement and sustain HSRA 	<ul style="list-style-type: none"> Increased proposed and endorsed budget (of 2007) for public health (as a proportion of total public sector health spending, and a contribution through public-private mix) in the Health Sector Development Program (HSDP) project sites by end of 2006 Increased utilization of accredited/licensed health facilities, especially primary health care (e.g., rural health units), and reduced hospital referrals and admissions in the pilot interlocal health zones (ILHZs) of the HSDP project sites by 2007 Improved enrollment of indigents (and the informal sector groups) in the Philippines Health Insurance Corporation (PhilHealth) in the HSDP project site by 2007 	<ul style="list-style-type: none"> National demographic health survey National health accounts Public expenditure reviews 	<ul style="list-style-type: none"> Public expenditures for health sector financing stagnate or are even reduced due to fiscal and financial problems of national government and LGUs. (R = risk) Quality of health service provision can be improved even in view of increased utilization of services. (A = assumption) Increased health awareness and health-seeking behavior of the poor result in higher utilization rate of primary and public health services. (A)
<p>Outputs</p> <ul style="list-style-type: none"> Improved core referral hospital efficiency Improved quality and adequate budget for public health activities Improved quality 	<ul style="list-style-type: none"> Core referral hospitals have fiscal autonomy and are allowed to retain and use savings in at least one of the HSDP project sites by 2007. ILHZs with their referral network (including public and private health sector services) are set up in at least one of the HSDP project sites by 2007. Priority public health programs with long-term budgetary needs are endorsed by national and local governments for the HSDP project sites by 2007. A strategy is developed and endorsed by LGUs to improve public-private partnership in tuberculosis directly observed therapy strategy detection (DOTS) rate in the HSDP project sites by 2007. Clinical practice guidelines (CPG) 	<ul style="list-style-type: none"> Consumer satisfaction surveys PhilHealth database Accreditation, licensing, Bureau of Food and Drug status reports Expanded Program for Immunization (EPI) reports Surveillance reports Health facility information systems 	<ul style="list-style-type: none"> Respective local governments support HSRA. (A) DOH provides the required leadership and coordination with PhilHealth and the other stakeholders in the health sector. (A) DOH and PhilHealth conduct effective social marketing, creating the appropriate demand for health services. (A) Administrative arrangements for ILHZs prove difficult to implement in practice. (R)

<p>of health service delivery</p> <ul style="list-style-type: none"> • Harmonized regulatory procedures • Increased coverage of beneficiaries under the Philippines Health Insurance Corporation (PhilHealth) 	<p>implementation plan is initiated in at least one of the HSDP project sites by 2007.</p> <ul style="list-style-type: none"> •Implementation plan for health staff training is initiated by the HSDP project sites by 2007. •Harmonized accreditation/licensing (of health facilities) procedure is implemented by HSDP project sites by 2007. •Reduced prices of (and standardized) drugs through pooled procurement are reported in at least one HSDP project site by 2007. •Benefit package approved and marketed by PhilHealth allows for inclusion of basic health services by 2007. •Implementation strategy and budgetary consideration are developed to increase enrollment of at least 60% of the bottom 25% of the population in the PhilHealth indigent or individually paying program for the HSDP project site by 2007. 		
<p>Activities with Milestones</p> <ol style="list-style-type: none"> 1.1 Strategy proposed and endorsed for fiscal autonomy in core referral hospitals within 6 months of inception of the technical assistance (TA). 1.2 Hospital financial management system prepared for selected core referral hospitals within 12 months of TA inception 1.3. Hospital financial management system piloted and its rollout strategy prepared and approved by government by month 15 of TA inception 2.1 Priority public health programs identified and endorsed by national and local governments by 3 months of TA inception 2.2 Indicators identified and monitoring tool developed to assess the quality of performance of the public health programs by 3 months of TA inception 2.3 Costing exercise conducted of priority public health programs (including EPI) in HSDP project sites within 6 months of TA inception 2.4 Needs-based, multiyear performance-based budgets prepared for public health programs in HSDP project sites within 12 months of TA inception 2.5 2007 public health increased budgets approved by the respective governments in HSDP project sites by month 15 of TA inception 3.1 ILHZs are organized and registered with Securities and Exchange Commission, or memorandum of agreement/local ordinance signed within 3 months of TA inception 3.2 Public-private partnership approaches developed in the ILHZ within 12 months of TA inception 3.3 Rationalized health services plan prepared for each ILHZ of HSDP project sites within 6 months of TA inception 3.4 Rationalization plan endorsed by the Government, and a strategy developed for its implementation by month 15 of TA inception 4.1. CPGs prepared and pilot-tested in HSDP project sites for ten priority illnesses within 6 months of TA inception 4.2 Training implementation plan prepared and endorsed on CPGs for rural health unit (RHU) and hospital staff, and training initiated in HSDP project sites by month 12 of TA inception 4.3 Monitoring tools developed, and evaluation of CPG use in selected health facilities conducted by month 15 of TA inception 5.1 Assessment of health human resource and training needs conducted and implementation plan prepared for HSDP project sites within 3 months of TA inception 5.2 Assessment of health human resource and training needs conducted, and implementation plan prepared for DOH within 6 months of TA inception 		<p>Inputs</p> <p>Asian Development Bank (ADB) = \$1.0 million</p> <ul style="list-style-type: none"> • Consultants = \$0.74 million • Studies and surveys = \$0.05 million • Training, seminar, and conferences = \$0.05 million • Reporting = \$0.005 million • Project administration = \$0.03 million • Equipment = \$0.005 million • Contingency = \$0.04 million <p>Government = \$0.43 million</p>	

<p>5.3 A strategy for health human resource rationalization prepared and endorsed by national and local governments within 12 months of TA inception</p> <p>5.4 Implementation plan for human resource rationalization and training endorsed by central and local governments by month 15 of TA inception</p> <p>6.1 Harmonization plan prepared for quality assurance of health facilities, and agreement reached between DOH, PhilHealth, and the other related agencies within 3 months of TA inception</p> <p>6.2 A strategy and a harmonized procurement procedure endorsed by the Government within 6 months of TA inception</p> <p>6.3 A streamlined and an efficient procurement mechanism pilot-tested and evaluated by provincial and local governments for (pooled) procurement of drugs and devices to ensure access to these supplies at RHUs and hospitals within 12 months of TA inception</p> <p>6.4 Results of the pilot test modified and streamlined, with a strategy developed for its rollout by month 15 of TA inception</p> <p>7.1 Mapping of the indigent population, and other marginalized poor and informal sector participants in HSDP project sites conducted within 3 month of TA inception</p> <p>7.2 Improved benefits package tailor-made for indigents and the informal sector groups prepared and endorsed by PhilHealth and other stakeholders within 6 months of TA inception</p> <p>7.3 Premium for PhilHealth estimated, including for poor households, and subsidies estimated for sponsored group within 6 months of TA inception</p> <p>7.4 LGU monitoring and evaluation system developed and pilot tested for sponsored groups within 12 months of TA inception</p> <p>7.5 Marketing strategy endorsed and information campaign of the revised benefits package for indigents implemented by month 15 of TA inception</p>	
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COST ESTIMATES AND FINANCING PLAN
(\$'000)

Item	Foreign Exchange	Local Currency	Total Cost
A. Asian Development Bank Financing^a			
1. Consultants			
a. Remuneration and Per Diem			
i. International Consultants	360.0	0.0	360.0
ii. Domestic Consultants	0.0	384.0	384.0
b. International and Local Travel ^b	60.0	14.0	74.0
c. Reports and Communications	0.0	5.0	5.0
2. Equipment ^c	0.0	5.0	5.0
3. Training, Seminars, and Conferences			
a. Facilitators	0.0	0.0	0.0
b. Training Program	0.0	50.0	50.0
4. Surveys	0.0	50.0	50.0
5. Miscellaneous Administration and Support Costs	0.0	30.0	30.0
6. Representative for Contract Negotiations	0.0	0.0	0.0
7. Contingencies	20.0	22.0	42.0
Subtotal (A)	440.0	560.0	1,000.0
B. Government Financing^d			
1. Office Accommodation and Transport	0.0	200.0	200.0
2. Remuneration and Per Diem of Counterpart Staff	0.0	200.0	200.0
3. Others	0.0	30.0	30.0
Subtotal (B)	0.0	430.0	430.0
Total	440.0	990.0	1,430.0

Notes: The technical assistance (TA) will be for a period of 18 months between September 2005 and February 2007. Cost estimates will be discussed and refined after further discussions between the Asian Development Bank (ADB) and the Government, including counterpart financing.

Remuneration and Per Diems: For international consultants, it includes daily rate, and per diems for accommodations and subsistence costs in the Philippines. For domestic consultants, it includes daily rate, and travel costs within the Philippines.

^a Financed by ADB's TA funding program.

^b International airfares for consultants, local government participants, and steering committee members, and per diem, gasoline and driver's salary for in-country transport.

^c Includes purchase of fax machine, photocopier, overhead projector, computers, printers, and communication equipment for TA office.

^d Government contribution in kind is provided by national and local governments.

Source: Asian Development Bank estimates.

OUTLINE TERMS OF REFERENCE FOR CONSULTANTS

1. A team of international and domestic consultants will implement the technical assistance (TA). The team will be recruited through an international consulting firm and will comprise international experts in health sector reform (team leader), health systems and social health insurance, and seven domestic experts in health administration (deputy team leader), district health planning and management, hospital financial management, health care finance, public health, drug procurement management, and human resource management. The TA team will be supervised by the Department of Health (DOH) director of the health policy development and planning bureau, and receive technical guidance from the project team leader of the Asian Development Bank (ADB)-supported Health Sector Development Program (HSDP). The overall deliverable of the TA is (i) preparation of Health Sector Reform Agenda (HSRA) national implementation plans including cross-cutting areas, (ii) preparation of HSRA local government unit (LGU) implementation plans for the HSDP project sites, and (iii) technical reports or studies to support policy matrix of the HSDP.

2. An inception workshop will be held 2–3 weeks after the start of the TA. A midterm review report will be presented at a workshop about 6 months after the inception workshop. The draft final report of the TA will be made available 2 months before a final workshop 3 weeks before the TA closes. Each consultant will be responsible for producing a final technical report based on the individual terms of reference. The team leader will be accountable for timely submission and quality of reports: (i) an inception report (within the first 2 weeks of the assignment), (ii) issues paper (6 months from TA inception), (iii) two progress reports (3 and 9 months from TA inception), and (iv) a draft final report (12 months from TA inception). The draft final report will be revised based on comments submitted by ADB and the Government. The report will provide a comprehensive document that includes recommendations and plans developed by the individual consultants. The report will also propose procurement, financial management and monitoring and evaluation arrangements under the HSDP.

3. The TA team will work closely with DOH, Philippines Health Insurance Corporation (PhilHealth), Bureau of Food and Drugs, LGUs, and related agencies and stakeholders. All consultants will work in close collaboration with ADB, and other development partners supporting HSRA such as European Commission, German Technical Cooperation, Japan International Cooperation Agency, United States Agency for International Development, World Bank, World Health Organization, and others.

A. Consulting Firm

1. International Consultants

4. **Health Sector Reform Specialist (team leader)** (6 person-months). The specialist will have at least 10-plus years of international experience in forwarding health sector and health systems reform in many countries. The consultant will help technically conceptualize and guide the activities under HSRA, and help accelerate HSRA through the HSDP, including the program loan, the investment loan, and the TA. The consultant will have an intermittent contract from inception to the end of the TA, and will have the following roles: (i) oversee and direct the technical work conducted by the TA team; and (ii) review, propose, and strengthen HSRA. The consultant will (i) provide the technical lead, (ii) work closely with the team, and (iii) liaise with the deputy team leader. The consultant will review the current policy and background strategy paper prepared by DOH for HSRA, and make recommendations on the current needs in the country, including HSRA implementation and monitoring. If HSRA is already addressing them, the consultant will review the regulatory framework under HSRA and propose updates for the outdated regulations and means to enforce implementation of updated regulations; and propose structure, function, role, and skills mix

for a HSRA resource center. The consultant will conduct technical discussions with various entities, such as DOH, PhilHealth, Department of Finance, LGUs, and special-purpose entities (SPE¹) to monitor the progress of the TA technical dialogue and activities; review reports of the TA consultants and guide their technical work, assess risks, constraints and bottlenecks, and help resolve these problems. The consultant will participate in the ADB review mission for the HSDP.

5. **Health Systems Specialist** (6 person-months). The specialist will have at least 10-plus years of multicountry international experience in health systems development, and will be responsible for setting up the strategic planning framework for health service delivery under HSRA. The consultant will (i) help central and local governments see the benefit of a rationalized health service delivery system, (ii) help develop the health service delivery system rationalization strategy and implementation plan under HSRA, especially proposals for each of the HSDP provinces, (iii) advise on the policies to adopt on governing boards of public hospitals, and (iv) consider various efficiency gain models including contracting out/in of services from the private sector. Each rationalization plan will refer to the most recent health care standards and guidelines of DOH, and specify how to improve the effectiveness, quality, and efficiency of the interlocal health zone (ILHZ) health service delivery system, particularly those of the primary health care facilities, as well as the first referral hospitals at the district level and the referral links. The consultant will also propose a strategy and negotiate with provinces and municipalities to provide fiscal autonomy to core referral hospitals, and set up a system for selected core referral hospitals to retain earnings and savings. In addition, the consultant will analyze human resource needs and gaps (providing guidance to the human resource specialist in the TA), and give an appropriate recommendation on a framework for human resource needs at central and local levels for a sustainable and efficient health service delivery. The consultant will work closely with DOH (bureaus of health policy development and planning, facilities and services, local health development, and Health Program Development) and PhilHealth.

6. **Social Health Insurance Specialist** (6 person-months). The consultant will have multicountry experience. He/she will (i) propose an improved benefits package for beneficiaries under PhilHealth, especially the indigents and those in the informal sector (generally, an enhanced package of primary care benefits has to be developed under PhilHealth); (ii) assist in developing actuarial forecasts on revenues and payments, and recommend a progressive premium; (iii) assess the beneficiaries' needs to propose the inclusion of services in the benefits package, and determine the feasibility of implementing the benefits package and its corresponding premium implications; (iv) verify the impact of the package on the beneficiaries; (v) assess and propose improved contractual arrangements (including public and private sectors); (vi) develop a performance monitoring system for the sponsored group; and (vii) document best practices for possible replication in other provinces. The domestic consultant on health finance will work closely with the consultant.

2. Domestic Consultants

7. **Health Administration Specialist (deputy team leader)** (18 person-months). The specialist will have a master's degree in public health or health services administration from an internationally accredited university, and at least 10 years of relevant experience in development and implementation in health sectors. The consultant will be well versed in the Philippines health care system and international health systems. The consultant will have two roles: (i) coordination/administrative, and (ii) technical. The consultant will (i) liaise with central, provincial, and local governments, private sector, nongovernment organizations, and the community, and other key technical persons in the country; (ii) assess needs to coordinate, help in planning and

¹ The Municipal Finance Corporation under the Department of Finance is considered as a special-purpose entity under the Health Sector Development Program.

monitoring the progress of needs and assignments; (iii) guide the other TA consultants on key issues and on key persons to meet, sources of information; and (iv) assist the TA consultants in meeting the objectives of the TA. In the technical role, the consultant will (i) consolidate the national and regional HSRA implementation plan working with the teams of experts in the TA; (ii) take the lead in developing the monitoring and evaluation unit of the HSDP; (iii) assist in strategic planning, project performance, and strengthening implementation; and (iv) monitor the progress of the HSDP investment loan, and address any bottlenecks and constraints.

8. **Hospital Financial Management Systems Specialist** (12 person-months). The consultant will have a master's degree in hospital administration and financial management from an internationally accredited university) and at least 10 years of relevant work experience in hospital financial management development and implementation. The consultant will work under the guidance of the international consultant on health systems, and with DOH and selected core referral hospitals in LGUs to help design a hospital financial management system for pilot-testing in some identified hospitals within the HSDP project sites, in particular to strengthen financial management in the hospital operations and management information system, a computer-based system for hospital management, developed through the National Center for Health Facilities Development and Information Management Service (NCHFD). The consultant will assist NCHFD to assess the current system, give recommendations, and determine the feasibility of developing a financial management system, initiate its development, pilot-test the module in at least one hospital in the HSDP site, evaluate and revise, and develop an implementation plan for its rollout.

9. **Public Health Specialist** (12 person-months). The consultant will have a master's degree in public health from an internationally accredited university) and at least 10 years relevant work experience in public health development and implementation. The consultant will work closely under the guidance of the international consultant on health sector reform. The consultant will (i) assist DOH and PhilHealth in preparing guidelines and training modules for clinical practice guidelines (CPGs) for 10 priority diseases and CPGs for tuberculosis in children; (ii) review the reproductive health program, and improve guidelines and training modules for these services; (iii) assist in developing a policy that is acceptable to DOH, PhilHealth, and health care providers by recommending the criteria for evaluating the quality of health care provided by PhilHealth-accredited facilities; (iv) propose ways by which CPGs can be used as incentive and disincentive mechanisms by PhilHealth; (v) develop and test mechanisms for disseminating, implementing, and monitoring CPG compliance in pilot hospitals of four HSDP provinces, and propose ways in which the use of CPGs for the cited purposes is acceptable to health care providers, recipients, and payers; (vi) assist DOH to develop guidelines and training modules for tuberculosis among children. In addition, the consultant will work with the district health planning and finance specialists to achieve the following: (i) assess the budgetary needs for public health services (including Expanded Program for Immunization [EPI]) in the LGUs; (ii) propose a multiyear performance-based budget for public health programs based on need, and (iii) in consultation with stakeholders, identify the available and projected sources and uses of funds and other financing scenarios with special consideration of impacts on access to health care services.

10. **District Health Planning and Management Specialist** (12 person-months). The specialist will have a master's degree in health administration, decentralized planning and administration from an internationally accredited university, and at least 10 years of relevant work experience in decentralized planning and implementation. The consultant will work closely under the guidance of the international consultant on health systems and will (i) develop LGUs' capacity to prepare plans and needs- and equity-based budgets, (ii) support local governments in preparing business plans as a means to rationalizing facility development in the HSDP project sites, and (iii) work with LGUs to form ILHZs: (a) plan and map the local health system for ILHZ provider network's organizational structure, management systems, business products (service packages), scale/quantities expected

to be produced and the key inputs, including the allocation of time, financial and human resource across individual facilities in the network; (b) assess the capacity of the ILHZ provider network to deliver quality services; (c) develop a template for ILHZ business planning; (d) propose a rollout plan and feasibility for business planning for the 15 convergence sites; (e) review and assess the implementation of ILHZ; (f) identify, describe, and analyze the existing incentives systems for sustainable ILHZ operations; (g) propose incentives, opportunity schemes, in consultation with stakeholders; (h) develop monitoring tool; (i) draft a policy for incentive structure; and (j) develop a sustainability package for a health system under each LGU. In addition, the consultant will work with the public health and health finance specialists to achieve the following: (i) assess the budgetary needs for public health services (including EPI) in the LGUs; (ii) propose a multiyear performance-based budget for public health programs, based on need, and (iii) in consultation with stakeholders, identify available and projected sources and uses of funds and other financing scenarios with special consideration of impacts on access health care services.

11. Health Care Finance Specialist (12 person-months). The consultant will have a master's degree in health economics from an internationally accredited university, and at least 10 years of relevant experience working in social health insurance, or health financing strategy and systems development and implementation. The consultant will work under the guidance of the international consultant on social health insurance to improve the coverage of indigents under PhilHealth, and the benefits package for the indigents. Generally, an enhanced primary care benefits package has to be developed under PhilHealth. The consultant will (i) assess the clinical needs to propose the inclusion of services in the benefits package and to determine the feasibility of implementing the benefits package and its corresponding premium implications; (ii) identify the necessary skills (technical, management, and administrative) to make rural health units (RHUs) a good provider of benefits; (iii) assess the performance of RHUs in the delivery of basic services; (iv) verify the impact of the benefits package on the beneficiaries; (v) improve the performance monitoring system for the sponsored group; (vi) develop the capacity of the locals staff working on insurance monitoring; (vii) assess the challenge to identify beneficiaries (indigents) and suggest mechanisms to improve identification; and (viii) document best practices for possible replication in other provinces. In addition, the consultant will work with the public health and district health specialist to achieve the following: (i) assess the budgetary needs for public health services (including EPI) in the LGUs; (ii) propose a multiyear performance-based budget for public health programs, based on need, and (iii) in consultation with stakeholders, identify the available and projected sources and uses of funds and other financing scenarios with special consideration of impacts on access to health services.

12. Human Resource Management Specialist (12 person-months). The consultant will have a master's degree in organizational behavior in business administration from an internationally accredited university), and at least 10 years of relevant work experience in health human resources rationalization and career development strategies. The consultant will work closely under the guidance of the international consultant on health systems. At DOH, the consultant will assist the human resource bureau in implementing the next steps of the health human resource master plan. The consultant will conduct (i) a skills-mix and training needs assessment of health human resources to support HSRA and LGUs for improved health service delivery and management; and (ii) institutional assessment to identify and assess the capacity of training at these institutions, and propose a retraining (continuing education) program to be adopted by the provinces. In addition, the consultant will assess the health staffing needs and training needs of HSDP provinces, and develop a training implementation plan for 5 years support under the HSDP.

13. Drug Management and Financial Specialist (6 person-months). The consultant will have a master's degree in the relevant field of work from an internationally accredited university), and at least 10 years of relevant experience. The consultant will work closely under the guidance of

international consultant on health sector reform. The consultant will work with LGUs to streamline and improve the efficiency of drug and vaccine procurement. The consultant will (i) assess the national drug formulary, and its inclusion of drugs needed for PhilHealth revised benefits package, and choice of contraceptive mix, (ii) assess the current system of drug and vaccine procurement and regulations, (iii) propose alternative cost-efficient management of procurement (including pooled procurement) to improve affordability, (iv) improve logistics arrangements for an efficient system, (v) suggest a monitoring tool to assess the shortage of and mechanisms for flow of drugs and vaccines to facilities facing shortage, and (vi) assess the vaccine management system and propose mechanisms for improvement in ILHZs/LGUs.

B. Individual Domestic Consultants

14. Two domestic consultants will be recruited by ADB as individual consultants.

15. **Health Systems Specialist** (12 person months). The consultant will have a master's degree in public health or health administration from an internationally accredited university), and at least 10 years experience in health sector development and implementation. The consultant will be well versed in the Philippines health care system and international health systems. The consultant will have two roles: (i) coordination, and (ii) technical. The consultant will (i) assist in aid coordination and facilitation since several development partners and government agencies are involved in HSRA; and (ii) liaise with various government agencies to follow up on the status of HSRA, and (iii) follow up on various analytical exercises to move HSRA forward. The consultant will work closely with and directly report to the ADB HSDP project team leader.

16. **Banking and Financial Sector Specialist** (3 person-months). The consultant will have at least 10 years of relevant experience in financial management of corporations or local authorities, be familiar with existing government rules and regulations on organizational and institutional aspects of government financial operations, and have undertaken similar work in the past or been involved in the area of organizational development, government financial institutions, and related fields in previous professional affiliations. The consultant will (i) help develop a transitional arrangement for operationalizing the Municipal Finance Corporation (MFC), and evaluate the situation under MFC to undertake the HSDP onlending operations; (ii) help MFC to develop an appropriate transitional operations model that MFC should adopt; (iii) identify key operating principles that will govern MFC operations; (iv) create a business plan, with necessary documentation, procedures, manuals, and systems for MFC operations, MFC's role as relending institution or as a financial intermediary; and (v) propose policy reforms that will strengthen MFC operations. In addition, the consultant will (i) prepare and document an approach specifically for the health sector operations; (ii) develop an approval system that defines the process, evaluation criteria, documentary requirements, and level of approval that should apply to the LGU clients under HSDP; (iii) design a practical funds flow mechanism; (iv) prescribe funds withdrawal arrangement and loan repayment scheme; (v) propose a system of monitoring and auditing of accounts; (vi) draft an operational set-up that should effectively carry out the processing of health-specific projects; and (vii) define duties, responsibilities, skills-mix and standards for evaluating performance of staffing for the essential operations of HSDP. All consultant proposals for operations procedures will be reviewed by ADB, World Bank, and the Government and their comments incorporated. The consultant will work closely with MFC and liaise with DOH and LGUs to ensure that the onlending activities for capital investment in the health sector (under the HSDP) follow appropriate procedures and in a timely manner. The consultant will also travel to the HSDP project sites to advocate onlending mechanisms, explain onlending procedures, and assess the challenges and strengths of LGUs for borrowing, and report its status to MFC, DOH (bureau of international health cooperation), and LGUs.