



Technical Assistance Consultant's Report

Project Number: 41664 (7257-PHI)
June 2013

Philippines: Public-Private Partnership in Health (Financed by the Japan Special Fund)

Prepared by SMEC International Pty Ltd
Canberra, Australia

For Development Bank of the Philippines
Department of Health and Philippine Health Insurance Corporation

This consultant's report does not necessarily reflect the views of ADB or the Government concerned, and ADB and the Government cannot be held liable for its contents. (For project preparatory technical assistance: All the views expressed herein may not be incorporated into the proposed project's design.

Asian Development Bank



TA 7257-PHI Public-Private Partnership in Health

FINAL REPORT

Submitted by SMEC International Pty Ltd

June 2013





Suite 2, Level 1
243 Northbourne Avenue
Lyneham Canberra ACT 2602
Telephone +61 2 6234 1900
Facsimile +61 2 6234 1966
www.smec.com

30 June 2013

Attention: Ms. Emiko Masaki
Social Sector Economist, Social Sector Division
South East Asia Department
Asian Development Bank (ADB)
6 ADB Avenue, Mandaluyong City
1550 Metro Manila, Philippines

Subject: TA 7257-PHI: Public-Private Partnership in Health – Final Report

Dear Ms. Masaki,

We are pleased to submit herewith three (3) copies of Final Report for the above captioned ADB Technical Assistance project. Another three (3) copies have been sent to the Development Bank of the Philippines (DBP), as required in our consulting services contract with ADB.

The Report describes the accomplishments of the TA Consultant Team since the TA started in January 2011. It also presents the following: issues and concerns encountered in TA implementation; overall assessment of the TA vis-a-vis the accomplishments and issues met; lessons learned; and recommendations going forward particularly at post-TA phase.

Should you have enquiries in regard to the report, please contact the Team Leader Dr. Jaime Galvez-Tan (email: jzgalveztan@gmail.com) and/or Phillip San Jose (email: phillip.sanjose@smec.com).

We look forward to receiving your comments for consideration and/or inclusion in the Final Report. Thank you very much.

Yours sincerely,

Trevor Temple
General Manager
Urban and Social Development Group
SMEC International Pty Ltd

cc: Mr. Benel D. Lagua,
Executive Vice President, DBP
Head Program Development II

LIST OF ACRONYMS USED

ADB	Asian Development Bank
AHA-UHC	Aquino Health Agenda: Achieving Universal Health Coverage
BCC	Behavior Change Communication
BOT	Build-Operate-Transfer
CBHCP	Credit for Better Health Care Facility
COA	Commission on Audit
CSC	Civil Service Commission
DBP	Development Bank of the Philippines
DMF	Design and Monitoring Framework
DOH	Department of Health
F1	FOURmula 1 for Health
FGD	Focused Group Discussion
GBPP	Global Budget Payment Program
GOP	Government of the Philippines
HSRA	Health Sector Reform Agenda
IRR	Implementing Rules and Regulation
JSF	Japan Special Fund
JV	Joint Venture
KII	Key Informant Interview
M&E	Monitoring and Evaluation
MCHC	Maternal and Child Health Care
MDG	Millennium Development Goals
MMR	Maternal Mortality Ratio
NEDA	National Economic and Development Authority
NGO	Non-Government Organization
NHIP	National Health Insurance Program
PGNS	Provincial Government of Northern Samar
PHIC	Philippine Health Insurance Corporation
PPP	Public-Private Partnership
PPPH	Public-Private Partnership in Health
RUH	Rural Health Unit
SHCIP	Sustainable Health Care Investment Program
TA	Technical Assistance
TOR	Terms of Reference

TABLE OF CONTENTS

I.	INTRODUCTION	1
II.	OVERVIEW OF PUBLIC-PRIVATE PARTNERSHIPS FOR HEALTH IN THE PHILIPPINES	2
A.	Definition and modalities.....	2
B.	Health sector priorities and the need for PPPH.....	3
III.	THE CREDIT FOR BETTER HEALTH CARE PROJECT (CBHCP) AND THE ACCOMPANYING TECHNICAL ASSISTANCE PROJECT.....	5
A.	The CBHCP.....	5
B.	ADB TA 7257-PHI: PPP in Health	5
C.	Approach to TA implementation	7
IV.	ACCOMPLISHMENTS	10
A.	Output 1: Development and promotion of PPP modalities in the health sector	10
	KRA 1: Diagnostics conducted for specific projects identified and pre-cleared by DBP	10
	KRA 2: Documents prepared in support of identified and pre-cleared PPPH subprojects	12
	Activity 2: Assess demand for health care services in the catchment area.....	13
	Activity 3: Assess the competitive dynamics in the catchment area and review of infrastructure facilities and relevant structures	13
	KRA 3: PPPH subprojects developed jointly with LGUs for DBP approval.....	15
B.	Output 2: Development of policies and implementing guidelines for the PHIC global budget scheme for PPPH.....	16
C.	Output 3: Monitoring and evaluation and capacity development for the promotion and implementation of PPPH.....	17
V.	ISSUES AND CONCERNS	19
VI.	OVERALL ASSESSMENT	21
VII.	LESSONS LEARNED AND RECOMMENDATIONS	22

I. INTRODUCTION

1. In order to help the Philippines achieve the MDGs 4, 5 and 6 (reduction of child mortality, improving maternal health, and control of communicable diseases, respectively), the Asian Development Bank (ADB) approved the Credit for Better Health Care Project (CBHCP), a loan to the Government of the Philippines (GOP) executed through Development Bank of the Philippines (DBP).
2. The CBHCP (ADB Loan 2515-PHI)¹ credit facility, which supports DBP's existing Sustainable Health Care Investment Program (SHCIP)², amounts to US\$63.36 million and is meant to address the inadequate and inefficient public expenditures in health care by mobilizing additional off-budget credit for pro-poor investment. Through DBP as the government financial intermediary, the facility will leverage private participation and improve funding allocation toward investment priorities. Among the priorities are maternal and child health services, control of communicable diseases, services to improve access to basic healthcare, and referral services inclusive of laboratory and other diagnostic services.
3. In order to support the sub-borrowers under the CBHCP, ADB has made available Technical Assistance (TA) 7257 - PHI: Public-Private Partnership (PPP) in Health which would aid in enhancing modalities for PPP, including (i) innovative strategies to improve efficiency, access, and quality of services; (ii) assisting small-scale health providers with access to credit to support health-related Millennium Development Goals (MDGs); and (iii) mobilizing private resources for achieving the MDGs. DBP is the executing agency of the TA.
4. ADB engaged the services of SMEC International Pty. Ltd. to provide the consultancy services required under the TA through a contract dated January 11, 2011³.
5. This Final Report describes the following: (i) accomplishments of the TA per outputs identified in the Design Monitoring Framework (DMF); (ii) factors that contributed to the attainment or non-attainment of outputs and other targets set in the DMF; (iii) impact and benefits from TA interventions; (iv) lessons learned from TA implementation; and (v) recommendations for future project planning and implementation. The contents of this Final Report draws heavily from the earlier submitted Draft Final Report.

¹ADB. 2009. Proposed Loan and Administration of Grant Credit for Better Health Care Project (Republic of the Philippines). *Report and Recommendation of the President to the Board of Directors*. Manila. February 2009.

²SHCIP is available to local government units and the private sector through (i) direct retail lending for LGUs and larger private sector sub-borrowers and (ii) wholesale direct lending to accredited financial intermediaries (microfinance intermediaries, rural and thrift banks) for small private sub-borrowers. SHCIP is financed from DBP's own resources and supplementary funds of development partners, and supports both capital investments and working capital.

³The SMEC TA Team consists of: Dr. Jaime Galvez-Tan as Team Leader (TL), Ms. Perla S. Soleta as Banking and Credit Expert (BCE), Ms. Merlinda Belicario as Procurement Specialist (PS), Dr. Juan Ma. Pablo Nañagas as Hospital Management/Monitoring and Evaluation Specialist (HM/M&ES), Mr. Jose Miguel dela Rosa as Social Marketing Expert (SME), Ms. Mary Anne Velas-Suarin as Knowledge Management Specialist (KMS), Ms. Daisy Morales as Knowledge Management Specialist (KMS), Atty. Bayani Agabin as Legal Expert (LE), Mr. Wilfredo Atienza as Enterprise Development Expert (EDE), and Dr. Hilton Lam as Health Finance Specialist (HFS). ADB directly recruited Dr. Alvin Caballes as Health Economics Specialist (HES) under the TA.

II. OVERVIEW OF PUBLIC-PRIVATE PARTNERSHIPS FOR HEALTH IN THE PHILIPPINES

A. Definition and modalities

6. A PPP is a cooperative venture or contractual arrangement between public agencies and private sector partners towards clearly defined public or social needs. It utilizes built-in expertise, experience, and human resources available in the private sector in the provision of services that are normally the responsibility of government. PPP involves a sharing of resources, risks, and benefits between the public and private providers based on clearly defined terms of agreement. A PPP arrangement includes a clearly defined financial arrangement which defines how the initiative will be financed and whether financing will be shared or not. It needs strong management information and monitoring system to support the definition of targets and performance evaluation.
7. In the Philippines, the emerging PPP's in Health (PPPH) include the following:
 - outsourcing of clinical or technical (ancillary) services to private enterprises/organizations;
 - outsourcing of support services, including laundry, transportation, logistics, security, janitorial, and food and nutrition services;
 - contracting out the direct provision of certain health services to a private provider (e.g., tuberculosis treatment, health education); and
 - contracting or integrating private insurance schemes to cover specific populations, especially in low-income areas.
8. Three PPPH modalities are common in the Philippines. These are (i) contracting out of services, (ii) joint ventures, and (iii) franchising. Several models of contracting out to the private sector are available, and they include the following:
 - collaboration initiated by private companies or non-government organizations (NGOs) to develop or deliver health services for specific public health maladies and diseases in specific groups, such as vaccine manufacturing, TB-DOTS, maternal care, child health services, parasite control, malaria and HIV/AIDS;
 - contracting for integrating private insurance schemes to cover specific populations; and
 - outsourcing of clinical or technical (ancillary) services to private sector enterprises or organizations.
9. A Joint Venture (JV) involves sharing of profits, losses, and risks and are either corporatized (i.e., a JV stock corporation is formed) or covered by an executive JV agreement and PPP institutional arrangements. In a JV, the government agency contributes physical assets (e.g., building, land, hospital, facilities) and is a minority shareholder, but retains significant control over the use of the property. The government's share generates income or dividends, and the agency may benefit from better market conditions in the future. Performance standards are established and monitored.

10. Franchising involves a franchisor-franchisee relationship built on standardized contractual arrangements. It requires (i) standardization of products and services; (ii) standardized procurement, packaging, and distribution; (iii) standardized accounting, billing, and payment system; and (iv) common branding.

B. Health sector priorities and the need for PPPH

11. Twelve years after the signing of the Millennium Declaration, the Philippine Department of Health (DOH) said that it is generally on track in meeting MDGs 4 and 6, but admitted that MDG 5 is the “least likely to be met.”⁴ While catch-up efforts are still needed to deliver interventions that will reduce the neonatal mortality rate,⁵ DOH expressed confidence that the Philippines will meet MDG 4 by 2015.
12. The scenario of MDG 5 is different. Based on the 2011 Family Health Survey, DOH has recorded a maternal mortality ratio (MMR) of 221 deaths per 100,000 live births—a significant increase from an MMR of 162 in 2006 and a far cry from the 2015 MMR target of 52 deaths per 100,000 live births. According to DOH, the poor health outcome is due to inequities in access to maternal and child health care, leading to poor utilization of health services, lack of appropriate facilities and skilled health personnel, and insufficient financial resources for health.⁶
13. Per an October 2010 data, DOH disclosed that only 52% of the entire population is covered by the National Health Insurance Program (NHIP), public hospitals and health facilities have deteriorated due to inadequate budget, and close to 900 rural health units (RHUs) and almost 100 government hospitals have yet to be accredited by the Philippine Health Insurance Corporation (PHIC).
14. To address these perennial problems, President Aquino launched in December 2010 a new comprehensive health reform strategy, the Aquino Health Agenda: Achieving Universal Health Coverage (AHA-UHC) for All Filipinos. The AHA-UHC is a focused approach to health reform implementation in the context of Health Sector Reform Agenda (HSRA) and FOURmula 1 for Health (F1) to ensure that all Filipinos, especially the poor, receive the benefits of health reform. It has three strategic thrusts:
- financial risk protection through expansion in NHIP enrolment and improving the benefit delivery ratio of NHIP;
 - improving access to quality hospitals and health care facilities by upgrading of government-owned and operated hospitals and health facilities to expand their capacity and provide quality services to help attain the MDGs, attend to traumatic injuries and other types of emergencies, and manage non-communicable diseases and their complications; and
 - attainment of the health-related MDGs through public health programs focusing on reducing maternal and child mortality, morbidity and mortality from tuberculosis and malaria, and the prevalence of HIV/AIDS in addition to preparing for emerging diseases and prevention and control of non-

⁴Ona, E.T. 2010. Lecture delivered at the Second Florentino B. Herrera, Jr. Memorial Lecture, Science Hall, Philippine General Hospital, University of the Philippines (UP) Manila, 27 October 2010.

⁵2006 figures show that the country has an under-5 mortality rate of 32 deaths per 1,000 live births as against the target of 27.7 deaths per 1,000 live births by 2015.

⁶The share of the gross national product (GNP) spent for health from 1993-2007 ranged between 2.75% and 3.5%. The *Global Strategy for Health for All in the Year 2000* of the World Health Organization (WHO) recommends that at least 5% of GNP be spent for health.

communicable diseases.

15. To attain these thrusts, six strategic instruments will be optimized:

- *Health financing*: to increase resources for health that will be effectively allocated and utilized to improve the financial protection of the poor and vulnerable sectors;
- *Service delivery*: to transform the health service delivery structure to address variations in health service utilization and health outcomes across socioeconomic variables;
- *Policy, standards, and regulation*: to ensure equitable access to health services, essential medicines, and technologies of assured quality, availability, and safety;
- *Governance for health*: to establish the mechanisms for efficiency, transparency and accountability, and prevent opportunities for fraud;
- *Health human resources*: to ensure that all Filipinos have access to professional health care providers capable of meeting their health needs at the appropriate level of care; and
- *Health information*: to establish modern information systems that will provide evidence for policy and program development and support the immediate and efficient provision of health care and management of province-wide health systems.

16. Two of the major concrete strategies of DOH aimed at helping the country in achieving its health-related MDGs are the: (i) planned reforms in PHIC accreditation to ensure access to health services for PHIC members; and (ii) adoption of the PPP modality to support its aggressive program on health financing.

17. DOH plans to unify licensing and accreditation of health facilities. While DOH licensure is a prerequisite for PHIC provider facility accreditation, birthing homes are exceptions inasmuch as the latter can obtain PHIC accreditation without prior DOH recognition. Ideally, once a facility is licensed by DOH, it is automatically accredited by PHIC. All government health facilities will be given provisional accreditation even as they are in the process of being capacitated to enable them to comply with PHIC accreditation requirements. Needless to say, provider facilities need to be accredited by PHIC so they can cater to the anticipated expanded PHIC membership and receive reimbursement payments from PHIC for the services rendered.

18. To upgrade health facilities such as RHUs, district hospitals, provincial hospitals, and DOH retained hospitals, DOH is giving high priority to PPP. With limited government resources, the current administration “needs to tap into the wealth of experience and the available resources from the private sector... Public-private partnerships will be (the DOH’s) thrust in augmenting the meager resources of government.”⁷

19. Against that background, it was apparent that there is much potential for the TA to support DOH’s thrust in PPP as a means to facilitate the attainment of the goals and objectives of the AHA-UHC.

⁷Ona, 2010, *ibid*.

III. THE CREDIT FOR BETTER HEALTH CARE PROJECT (CBHCP) AND THE ACCOMPANYING TECHNICAL ASSISTANCE PROJECT

A. The CBHCP

20. The CBHCP's expected impact is improved overall health status, especially in relation to MDGs 4 and 5, by 2015. Its outcome is increased use of basic health care and referral services by the poor, in general, and by women and children, in particular, in the subproject sites. The Project has a nationwide coverage, except NCR⁸.
21. The CBHCP has four outputs, namely: (i) local government units (LGU) health services upgraded through construction and/or rehabilitation of health facilities and procurement of equipment, referral networks developed to strengthen MCH services, and hospital standards and efficiencies improved as per their commitment to DOH's F1; (ii) health care delivery systems made more efficient, through PPP and innovative strategies, to build an integrated health care delivery system and improve efficiency, quality, and cost-risk sharing; (iii) small-scale private health providers' access to credit for better maternal and child health care (MCHC) services improved; and (iv) DBP's institutional capacity enhanced in health sector lending, lending product performance, social marketing, and supporting PHIC contractual arrangements with sub-borrowers.
22. Under Output 2, both public and private providers will be given access to credit for capital investment and/or working capital. CBHCP will lend to about three to four subprojects. PPP options may include health care facility construction, financing, management, and service delivery. The types of eligible subprojects include: (i) outsourcing of technical, medical (e.g., to cooperatives), and ancillary services; (ii) outsourcing of support services (e.g., security, housekeeping, food services, laundry); (iii) contracting out the management of a public facility; (iv) contracting private providers to deliver health services; and (v) contracting public insurance schemes for specific populations.

B. ADB TA 7257-PHI: PPP in Health

23. The TA for PPP in Health, which is piggybacked to CBHCP, is intended to support sub-borrowers, including LGUs and private providers, by enhancing PPP modalities, including:
- innovative strategies to improve efficiency, access, and quality of services;
 - assisting small-scale providers gain access to credit to facilitate the attainment of MDGs 4 and 5; and
 - mobilization of private resources for achieving the MDGs.
24. *Impact, outcome and outputs.* The TA's expected impact is improved maternal and child health by 2015. The expected outcome is PPP modalities with demonstrated

⁸ At the time of writing the TA's draft final report, there is a proposal to include NCR as a CBHCP beneficiary area.

potential to increase the use of maternal and child health referral services tested in selected PPPH sites.

25. Below are the three output areas of the TA as originally stated in the TA contract:

- *Output 1:* PPP modalities in the health sector developed and promoted by (i) conducting an assessment; (ii) assisting in the preparation of PPP policy, regulations, guidelines, and a handbook; and (iii) identifying preliminary PPP health subprojects for potential support;
- *Output 2:* Incentives and operational strategies for PHIC accreditation of small-scale health providers in rural, underserved areas developed; and
- *Output 3:* Contracting systems for health service providers under PHIC technically supported through M&E.⁹

26. It should be noted that Outputs 2 and 3 underwent revision in response to realities on the ground and guided by pragmatism on how the TA can contribute most to helping translate PPPH from concept to reality. These outputs were re-formulated as follows:

- *Output 2:* Incentives and operational strategies developed for PHIC in light of the global budget system in support of PPP in health initiatives;
- *Output 3:* M&E established and capacities developed for promoting and implementing PPP in health.

27. The TA DMF incorporates these changes. In particular, Output 2 was revised in response to the request of PHIC President Eduardo Banzon, installed in November 2011, for the TA to develop incentives and operational strategies for PHIC in light of the global budget system.

28. *Executing and implementing agencies.* The TA executing agency is DBP (through the Program Development Department) while the implementing agencies are DOH¹⁰ and PHIC.

29. The TA had an original budget of US\$1.1 million, of which US\$1 million is financed on a grant basis by the Japan Special Fund (JSF), and US\$100,000 is in-kind contribution from DBP. Of the US\$1 million, originally only US\$700,000 is allocated for the services of consultants hired through a consulting firm; the rest has been allocated for the services of individual consultants¹¹ engaged to undertake related PPPH policy work.

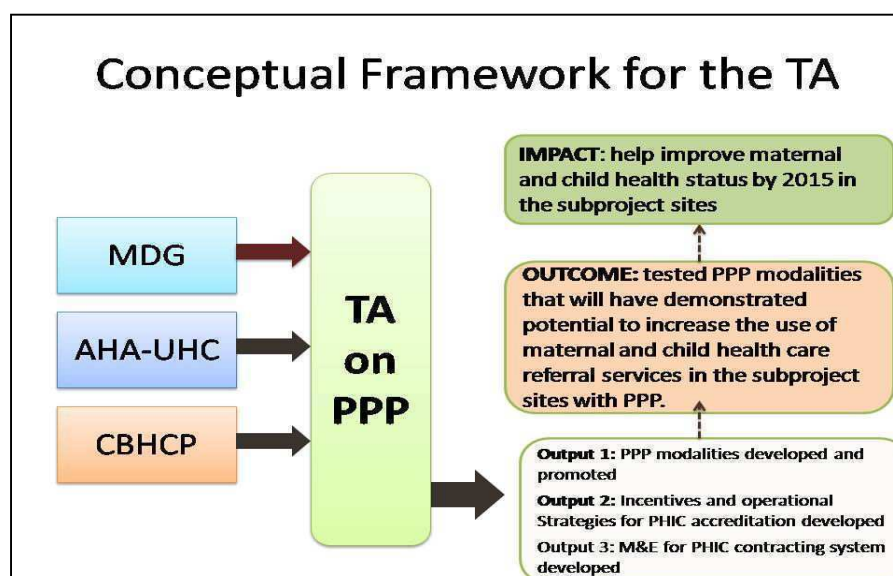
⁹In the CBHCP RRP, Output 3 of the TA is "develop and initiate the contracting modality for health services to improve quality and efficiency of health services." However, in the Consultant's TOR attached to the SMEC contract with ADB, Output 3 is "provide technical support in (sic) M&E of the contracting systems for health providers under PHIC."

¹⁰The Bureau of International Health Cooperation (BIHC) was the DOH focal unit originally designated in the RRP. It was replaced by the newly formed DOH PPP Task Force under Undersecretary Teodoro Herbosa (who is the Chair of the Task Force).

¹¹These are Mr. Bernt Andersson, international Health Policy Expert, and Dr. Alvin Caballes, national Health Economics Specialist.

C. Approach to TA implementation

30. As shown in the figure below, the original framework for the TA is provided by (i) MDGs 4 and 5 on MCH, (ii) AHA-UHC and its call to harness the strength of PPPH services, and (iii) the CBHCP, Output 2 of which is “more efficient health care delivery systems through PPP and innovative strategies.” The attainment of the three TA outputs is expected to result in tested PPP modalities with demonstrated potential to increase the use of MCHC referral services, inclusive of Basic Emergency Obstetric and Newborn Care and Comprehensive Emergency Obstetric and Newborn Care and possibly other priority local health services in CBHCP PPP subproject sites, which will contribute to improving the country’s MCHC status by 2015.



MDGs 4 and 5 and the Aquino Health Agenda for Universal Health Care (AHA-UHC)

31. *TA focus.* Given the limitations to TA resources vis-à-vis the urgent need of potential CBHCP sub-borrowers for technical support in their proposed PPP projects, the TA Team initially focused on Output 1. As an initial step, the TA Team, working closely with their DBP counterparts, identified priority LGUs to support in developing PPP proposals into a form that is acceptable for credit review and appraisal. The LGUs initially identified were the provinces of Northern Samar and Sarangani. Technical assistance and support for Output 2 implementation was provided mainly by the Health Economics Specialist (e.g., assisting PHIC in the crafting of guidelines for the global payment system), while that for Output 3 was provided mainly by the M&E Expert, Knowledge Management Specialist and Social Marketing Expert (e.g., capacity development training and knowledge management products).
32. *Holistic approach.* The TA Team utilized a holistic approach to provide the consulting services. While each member of the TA Team served as lead person in the implementation of a specific activity, the other team members who have related expertise and experiences were also tapped to further strengthen and enrich the execution of project activities. The TA Team worked in close partnership with its DBP counterparts, achieving synergy through a dynamic process of teambuilding, mentorship and participation. The inception workshop, which was conducted in late

February 2011, set the stage for close interaction between consultants and their counterparts and other key project partners. Continuous planning and coordination followed through regular strategy sessions and mini-workshops.

33. *Action research approach.* An action research approach was adopted by the TA Team in implementing the TA. The TA Team worked with actual projects, which have been identified by LGUs or their prospective private sector partners, for development and implementation under a PPP scheme. Thus, rather than solely conducting a review and assessment of the overall policy and financial environment of PPPHs, for example, the TA Team conducted a focused assessment of the policy and financial environment for specific PPPH's identified and pre-cleared by DBP for possible financing under the CBHCP.
34. Furthermore, instead of developing model legal agreements and bidding documents for different PPP modalities, the TA worked with DBP to draw up legal agreements and tender documents tailored to specific PPPH projects. In that sense, the TA 'shepherded' the selected PPP investment proposals of interested LGUs or private entities from concept to reality while carefully documenting the process so that lessons can be drawn for application to future projects. In cases of PPP subprojects that are approved for loan financing within the period of the TA, the TA provided technical advice and assistance to the subproject proponents in various areas of competence (e.g., legal, procurement, enterprise development, financial, banking, credit, social marketing, knowledge management).
35. *Transfer of knowhow.* The TA was committed to the institutional and capability strengthening of target stakeholders through the transfer of technical and administrative knowhow and skills to sub-national government staff and project beneficiaries (including private and public small-scale health service providers). These knowhow and skills primarily relate to project development, project management, and monitoring and evaluation. To realize skills transfer and ensure sustainable project implementation, the TA mentored relevant staff of the LGUs and small-scale health providers in developing their investment proposals and preparing the required documentation for submission to DBP for credit application and processing.
36. *Approach to enterprise development.* The TA's enterprise development approach uses market-oriented and demand-driven methodologies to identify PPPH project models or social enterprises (including those of small-scale health providers seeking PHIC accreditation). Specific subprojects were identified in Northern Samar and Sarangani. Through a series of dialogues and assessment meetings among the TA Team, DBP, DOH, PHIC, LGUs and potential private sector investors, opportunities for PPPH investments were explored in three modalities, namely:
 - contracting of health facilities and services, including management of provincial, district, and rural health units and medical, ancillary, and other support services;
 - franchising of medicines and pharmaceutical products, medical supplies and equipment, laboratory and ancillary services, and primary health care; and
 - JV through private-public corporatization and/or executive JV agreement, including its variant investment alternatives.
37. The focus was on the relative assessment of the strengths and constraints, level of commitment of the proponents, business and health services outreach transactions and potentials for long-term partnership between collaborating public and private sector entities. Project design and preparation were mainly informed by the identification, elaboration, and sharing of resources, risks, benefits, and rewards among PPP players. The TA also considered the impact of the subprojects on the

quality and efficiency of medical services, potential coverage of the service providers, and health and wellness of poor clients in underserved areas. It was deemed imperative that the potential PPP subprojects go through a pre-investment assessment vis-a-vis existing market demand and the potential to reach out to target maternal and child care mortality reduction clients.

38. *Approach to social marketing.* The TA adopted an integrated marketing communications platform with two distinct strategies: push marketing and demand generation via behavior change communication (BCC). The push marketing approach will enable DBP and PHIC to achieve their goals. For DBP, it is to provide LGUs and the private sector with access to its credit facility for health PPP projects, and for PHIC, it is to promote accreditation among small-scale health providers, both private and public. The BCC (demand generation) approach enables the LGUs and their private sector partners to generate demand, change attitude, and promote positive behavior in favor of any product or service offered by the PPPH projects, thereby ensuring their sustainability.
39. *Approach to knowledge management.* Knowledge management is the systematic and explicit management of four types of knowledge assets (i.e., people, processes, structures, and technology) in such a way that it creates value and benefit for stakeholders in PPPH's. To achieve this goal, tools and techniques were deployed to promote the cycle of knowledge innovation and sharing. In the context of the TA, the innovation cycle involved working with DBP and partner LGUs in developing their tacit knowledge on five health PPP modalities (collaboration, contracting, outsourcing, joint venture, franchising) into a more structured form, and embedding it within process, products, or services.
40. *Approach to monitoring and evaluation.* The overall approach for the M&E design was to initially set clear statements of measurable project objectives and describe how the project expects to achieve them. This TA, while designed to attain long term goals, had immediate objectives that are readily measurable. From these objectives and goals, the structured set of indicators was developed, which would include input, process, and output (of goods and services) generated by the project as well as impact on the target beneficiaries. The M&E design provided the methodology and tools for data collection, analysis plan, and an overall timeline. Once the data collection methods were established, arrangements were proposed for gathering, analyzing, reporting, feedback, and capacity building to sustain the M&E system.

IV. ACCOMPLISHMENTS

A. Output 1: Development and promotion of PPP modalities in the health sector

KRA 1: Diagnostics conducted for specific projects identified and pre-cleared by DBP

41. To facilitate the identification, selection and prioritization of LGUs that will be targeted by the PPPH through the CBHCP loan, a set of criteria was adopted based on LGU accomplishments related to MDGs 4 and 5, local chief executive commitment, and the strengths of the local healthcare delivery system, among other factors. Particular focus was given to the LGU's capability to improve its health indicators associated with high maternal and infant/child mortality rates, malnutrition and food insecurity, and prevalence of communicable and poverty-related diseases. Logistics networks were also considered such as the presence of private sector players and development partners (including local, national, or international NGOs and civil society organizations) and funding of LGUs for health reforms.
42. Ancillary to the identification of LGUs for the CBHCP loans, the TA conducted a study to identify reasons for the delay of loan implementation. Analyzing market strategies, pricing mechanisms, institutional constraints, area of coverage and eligible projects, several reasons were pinpointed as follow: (a) higher interest rate for CBHCP loan compared to other loan programs, (b) change in LGU decision, and (c) refinancing is not allowed. Another determinant was the exclusion of Metro Manila-based subprojects from eligible beneficiaries.
43. Consultations with various private entities and NGOs were made in regard to the promotion of PPPH. These consultations encourage the involvement of these entities (i.e., community-based pharmacies, pharmaceutical distributors, birthing clinics and private hospitals) in the CBCPH and elicit concerns on PPPHs. Concerns raised include availability of business managers in the area, profitability and sustainability, local political situation, and the tenurial status of the current hospital staff should hospital management outsourcing be pursued.
44. *Identification of LGUs.* Several LGUs were identified, each of which has expressed interest in availing of loans from the CBHCP. These LGUs are the provinces of Bohol, Davao, Northern Samar, Rizal, Camarines Sur and Sarangani, and Butuan City. Field visits were made in Northern Samar, Sarangani, Camarines Sur, and Rizal wherein focused group discussions (FGDs) and key informant interviews (KIIs) were conducted with key health sector players (local executives, potential partners and investors).
45. For the Provincial Government of Northern Samar (PGNS), consultations with Governor Paul Daza and other officials resulted to a discussion of a potential PPP for hospital pharmacy and laboratory services. A field visit to Catarman, Northern Samar enabled a direct assessment of the province's hospital infrastructure and management, which validated the LGU's need for the proposed PPPH. For the Provincial Government of Sarangani, consultations with Governor Miguel Dominguez and other officials yielded a proposal for the construction of a 200-bed capacity provincial hospital.

46. For the Provincial Government of Rizal, Governor Casimiro Ynares III expressed interest in several PPPH projects such as outsourcing of the management of the province's existing hospitals and the construction of two new district hospitals. The LGU's concern on the higher interest rate associated to CBHCP vis-a-vis other loan options from another government bank was raised.
47. Discussions with Governor El Rey Villafuerte of the Provincial Government of Camarines Sur were also made. Governor Villafuerte expressed interest in the establishment of a provincial hospital with a PPP component. For Bohol Province, the Provincial Government led by Governor Edgardo Chatto expressed interest in a pharmacy PPPH model. Governor Johnvic Remulla of the Provincial Government of Cavite expressed his interest in a PPPH for laboratory and diagnostics inside the Cavite Export Processing Zone.
48. The TA Team also extended assistance to the CBHCP during DBP's conduct of site inspections in 5 private hospitals expected to become sub-loan applicants. The hospitals are:
- Citi Care Medical Center in Malinta, Valenzuela City (13 January 2012)
 - Gentry Medical Center in General Trias, Cavite (12 February 2012)
 - Global Medical Center in Cabuyao, Laguna (28 February 2012)
 - Medical Center of Taguig City (16 March 2012)
 - Pamana Hospital in Calamba, Laguna (11 April 2012)

KRA 2: Documents prepared in support of identified and pre-cleared PPPH subprojects

49. The diagnostics processes utilized to develop major documents necessary for the execution of PPPH subprojects were fieldwork, review of literature and consultations with LGUs. Informed of the diagnoses, the provinces of Northern Samar and Sarangani initiated moves for their respective PPPH.
50. Knowledge products were developed to facilitate PPPH implementation in pharmacy services, hospital management, laboratory and diagnostic services, and birthing centers. With the initiation of the PPPH in Northern Samar and Sarangani, terms of reference (TORs) for hospital operation and management, pharmacy, laboratory and diagnostic services were developed. Procurement and contract templates were prepared for these PPPH projects. An e-Portal www.partnersforhealth.ph has been developed to serve as an information and resources hub for PPPH in the Philippines¹².
51. Social marketing products were developed to provide partners with basic information on the CBHCP loan and promote private sector investment and participation to the PPPH projects. Distribution of these products were made at several fora and conferences organized by the TA.
52. One such event is the three-day stakeholders' and investors' forum entitled "PPPs in Health Manila 2012: Developing Models, Ensuring Sustainability - Perspectives from Asia and Europe" held at the Asian Development Bank on 23-25 October 2012. The regional learning event featured case studies and best practices in Asia, Europe and in other parts of the world, initiated a policy dialogue on the adoption of PPPs in addressing key health problem, and discussed the main barriers to the successful implementation of PPPH. The forum was attended by Philippine and international participants from the business sector, development aid, government, academia and civil society organizations. From the Philippine government, DOH, PHIC, Commission on Audit (COA) and National Economic and Development Authority (NEDA) were well-represented.
53. To reinforce the course of PPPH in the national executive setting and build the capacity of the DOH in PPPH management, the TA assisted in the crafting of DOH Administrative Order (No. 2012-0004 entitled "Policy Framework for Public-Private Partnerships in Health") and its Implementing Rules and Regulations. This was signed in March 2012 by Health Secretary Enrique Ona.
54. A framework for long-term capacity development for PPPH implementers was developed in collaboration with the Development Academy of the Philippines (DAP). This partnership resulted in course curricula for health business planning, social marketing and knowledge management.
55. For the pharmacy PPPH project in Northern Samar, a business plan for the outsourcing of the pharmacy management was developed. The plan includes estimates on revenue, profit potential, equity capital requirements and return on equity. Business plans were also prepared for birthing centers and the proposed establishment of Camarines Sur Provincial Hospital.
56. Aside from COA (through Commissioner Heidi Mendoza), the TA also consulted with Civil Service Commission (CSC) through Commissioner Francisco Duque to discuss issues and recommendations arising out of PPP initiatives for public and

¹² This portal is subject to full online activation.

private hospitals. These issues and recommendations were included in the analysis of PPPH decentralization in the PPP in Health Manila 2012 forum.

57. The TA also supported the undertaking of market study for the modernization of facilities and services of Quirino Memorial Medical Center (QMMC). PPP modality is being explored to modernize the facilities and services of QMMC.
58. The TA through SMEC has sub-contracted the University of Asia and the Pacific-Center for Research and Communication (UAP-CRC) to undertake the market study. Select TA team members worked closely with the UAP-CRC team for supervision purposes. The TA ensured that the research approach, methodology and outputs of the UAP-CRC team shall be able to inform the subsequent financial feasibility analysis for the QMMC modernization¹³. The market study was conducted in January-June 2013 period.
59. The details below specify the activity and sub-activities associated to this market study:

Activity 1: Describe policy context of PPP hospitals in the Philippines

The sub-activities are:

- a. Describe the existing regulatory environment (including policies, institutions, etc.).
- b. Analyze the future direction of health policy on hospital care services in the country, including the aspects of universal health care, public private partnerships, and the national and local government hospital referral system.

Activity 2: Assess demand for health care services in the catchment area

The sub-activities are:

- a. Define the catchment area.
- b. Characterize the general profile of the catchment area in terms of population dynamics, disease profile, purchasing power and segments, health care spending per segment and disease, and other health care profiles.
- c. Assess the demand for rooms.
- d. Analyze the projected demand for selected non-room key health care services within the catchment area based on population trends, disease profiles and trends, incomes, and policy demand-drivers.
- e. Assess hospital services utilization, patients and flow.

Activity 3: Assess the competitive dynamics in the catchment area and review of infrastructure facilities and relevant structures

The sub-activities are:

- a. Assess the performance of critical health care providers-competitors (e.g., hospitals) within the catchments area in terms of market served and services provided:

¹³ A financial feasibility analysis for QMMC modernization has been proposed and may be supported by the Private Sector Operations Department of ADB.

- i. Supply analysis (i.e., volume and types of health services provided, rates and range of key services, types of rooms, current and future, if any, number of rooms and its segmentation);
 - ii. Demand analysis (i.e., occupancy rates, average length of stay, patient traffic, key positioning in the area or industry, and perceived competencies).
- b. Review the current and future infrastructure facilities and relevant structures in the area (e.g., roads, subdivisions, land use plans, institutions). This review will generate the following analyses:
 - i. Current and future accessibility;
 - ii. Proximity to major demand generators.

KRA 3: PPPH subprojects developed jointly with LGUs for DBP approval

60. The TA in coordination with the DBP made significant strides by way of raising the interest in PPPH of LGU partners and potential private sector partners. The development of TORs, business models, bid documents, and contract templates for the PPPH projects undertaken in selected LGUs provided impetus for implementation.
61. *Northern Samar Province.* For the PPP in pharmacy management for the province of Northern Samar, the TA prepared a business case, detailed terms of reference, bid processes and guidelines for use by the Northern Samar PPP Selection Committee. Subsequently, the contract for the pharmacy PPPH was signed between the PGNS and Planet Pharmacy on 10 October 2012. The TA also developed financial models for the Allen District Hospital in the same province.
62. *Sarangani Province.* The TA assisted the Provincial Government of Sarangani in its hospital management PPPH. Consultations with the TA for the construction of the Sarangani Medical Center led to the development of the TOR for a feasibility study and the procurement of services of the feasibility study contractor. The contract for the feasibility study was awarded to Infoshares Management Systems. As of November 2012, the said firm completed the draft report entitled “Feasibility Study for the Development of a PPP Tertiary Hospital for Sarangani Medical Center” which was submitted to the Sarangani LGU.
63. *Camarines Sur Province.* The TA Team held initial discussions with Governor El Rey Villafuerte at the DBP office in Manila in regard to PPP arrangement for the Camarines Sur Provincial Hospital. A field visit was conducted by the TA in June 2012. However, upon review of the province’s eligibility for the CBCHP loan, the provincial LGU withdrew consideration for a PPPH in the province.¹⁴
64. *Rizal Province.* Initial proposal for the construction of a hospital with a PPPH component was made by the Provincial Government of Rizal. Due to concerns related to logistics (i.e., bank accessibility) and higher interest rate of the CBHCP compared to other loan programs, the Rizal LGU withdrew its interest in securing a CBCHP loan.
65. *Bohol Province.* No PPPH project was progressed by the Province of Bohol despite earlier expression of interest and the eligibility of the province for a CBCHP loan.
66. *Cavite Province.* While the Cavite LGU expressed interest and had discussions with the TA for the construction of a hospital with a PPP component, the Provincial Government of Cavite decided to defer the implementation of medium- to large-scale PPP projects.

¹⁴ Camarines Sur is no longer qualified for a loan against internal revenue allotment as the province has already fully committed its existing allocation (only 20% can be utilized for loan servicing).

B. Output 2: Development of policies and implementing guidelines for the PHIC global budget scheme for PPPH

67. In the initial stages of the TA, Output 2 focused on the development of incentives and operational strategies for PHIC accreditation. Following consultations with PHIC President Edgardo Banzon, Output 2 was re-contextualized by mid-term of the TA to extend to PHIC's adoption of Global Budget Payment Program (GBPP). The PHIC envisioned GBPP to stimulate a more effective and efficient delivery of health services particularly by government facilities.
68. Through a two-day writeshop in July 2012, the TA assisted the PHIC in drafting the GBPP policy guidelines, which was officially approved in August 2012 as PHIC Board Resolution No. 1630, s.2012. The workshop made possible the incorporation of important details for the effective implementation of the GBPP, a key element for enabling the wider adoption of PPPH's as it will engender a less financially risky environment for the health sector. Following a request from the PHIC for assistance in M&E, the TA provided initial inputs to the M&E framework of the GBPP.
69. PHIC Circular No. 037, s. 2012 describes comprehensively the GBPP structure and implementing guidelines. A number of LGUs and government hospitals have started application to become part of the GBPP. The commencement of the implementation of the GBPP for 2012 started on 1 November 2012 until 1 December 2012.

C. Output 3: Monitoring and evaluation and capacity development for the promotion and implementation of PPPH

70. In the initial stages of the TA, Output 3 focused on the development of an M&E framework in anticipation of PHIC contracting systems. With the re-contextualization of Output 2 and the development of the GBPP, Output 3 was scoped towards monitoring and evaluation and capacity building for promoting and implementing PPPHs.
71. The TA placed a strong emphasis on capacity development as this ensures the sustainable implementation of PPPH modalities beyond the term of the TA. A general M&E framework was developed as well as particular M&E systems for the PPPH projects (i.e., for Northern Samar and Sarangani). This framework has likewise incorporated the development of knowledge management products
72. Specifically, the following are the knowledge management products that have been generated by the TA:

Printed materials

- Frequently Asked Questions on PPP in Health¹⁵
- Guidebook on How to Develop a PPP in Pharmacy Services¹⁶
- Guidebook on How to Develop a PPP in Hospital Management¹⁷
- Resource Book on PPP in Birthing Homes
- Resource Book for Capacity Development (Training) (focus on Social Marketing and Knowledge Management)
- Brief on PPP in Health Applications (monograph)
- Legal and Policy Issues in PPP in Health (monograph)
- Financing Options in PPP in Health (monograph)
- Procurement Process for PPP in Health (monograph)
- Social Marketing and Knowledge Management (monograph)

Online portals

- Partners for Health website - <http://partnersforhealth.ph> (subject to full online activation)
- PPP in Health Manila 2012 website – <http://pppinhealthmanila2012.com>

Audio-visual presentation (AVP)

- AVP entitled “Partnerships for Health”

73. Capacity building trainings on social marketing and knowledge management for PPPH were provided in Northern Samar (April and May 2012) Sarangani (July 2012) and PHIC (November 2012).

74. The TA provided expert inputs to several external/stakeholders activities such as the Eastern Visayas Regional Governors Forum (July 2012), Health Summit for

¹⁵ The publication Frequently Asked Questions and other TA-produced monographs has been proposed to be supported by the Philippine Department of Health.

¹⁶ The publication of this Guidebook has been proposed to be covered by the TA 7257 funds.

¹⁷ The publication of this Guidebook has been proposed to be supported by the Department of External Relations of ADB.

LGUs (March 2012), MDG5 Summit with LGUs and DOH (March 2012), and Zuellig Foundation Forum (April 2012). Three brown bag seminars were also organized by the TA.

75. A sharing and turn-over workshop of PPP in health partner agencies (DOH, PHIC, DBP and NEDA PPP Center) was held on 13-14 November 2012 at the ADB Headquarters. The workshop aimed at systematically handing over the knowledge, experience, processes and skills accumulated by the TA to government agencies concerned with health PPPs. This activity clarified amongst the participants their agencies' role and situation in regard to PPP in health. More importantly, the participants from various agencies were able to discuss areas of synergy and/or cooperation in progressing PPPs in health.
76. The TA spearheaded the organizing of the PPP in Health Manila 2012 international conference at the Asian Development Bank (ADB) Headquarters in the Philippines on 23-25 October 2012. The TA worked closely with its counterparts from ADB, DOH, PHIC, DBP, United Nations Economic Commission for Europe, World Health Organization, and private sector partners to organize this conference of more than 250 international participants from Asia Pacific, Europe and North America.
77. With a theme of "Developing Models, Ensuring Sustainability: Perspectives from Asia and Europe", the conference showcased international best practices in health PPPs, initiated policy dialogue on the adoption of PPPs in addressing key health problems, and discussed the main barriers to the implementation of successful PPP projects in health. Presentation of internationally renowned PPP and health specialists were provided. The participants visited health PPP sites in Manila to demonstrate best practices in the field (e.g., National Kidney and Transplant Institute and the Hospital of Makati). An investors forum for the modernization of the Philippine National Orthopedic Centre was also held. Major private companies providing health services and products participated in a marketplace. A cocktail reception on 23 October 2012 was staged to welcome international participants in the Philippines. The opening remarks of the conference were given by Philippine Health Secretary Enrique Ona and ADB Vice President for Operations Stephen Groff.

V. ISSUES AND CONCERNS

78. In the course of TA implementation, several issues and concerns were encountered. These issues impeded to a certain extent the smooth implementation of PPPH projects. The Province of Rizal, for example, found the CBHCP interest rate as not competitive so it cancelled its prospective PPPH project under the CBHCP. Similar to Northern Samar's procurement of pharmacy PPPH, inherent bureaucracy in both local and national levels extended the time of processing of documents thereby delaying PPPH implementation. The following paragraphs explain the issues and concerns in detail.
79. *Inherent bureaucracy.* The TA team anticipated the relatively tedious pace of government bureaucracy in procuring PPPH projects. The project development stage is in itself a complex process considering that available resources (of public and private stakeholders) and market feasibility of projects needs to be ascertained. The conceptualization and implementation of PPPH projects should consider the political dynamics especially at the local government level. The usual issue is whether the potential next local government executives (given the forthcoming elections in year 2013) will support with same vigor the PPPH projects.
80. In the case of Northern Samar, a PPP local code was developed to ensure the sustainable implementation of PPPH projects. Moreover, its local officials are proactive and cooperative which demonstrates that they are genuinely interested in pursuing PPPH. The Northern Samar LGU awarded in October 2012 a contract to Planet Pharmacy for a pharmacy PPPH. (In Sarangani, the Provincial Government awarded a contract for the feasibility study of the construction and operations of Sarangani Medical Center under PPP arrangement.)
81. *Lack of national policies.* National policies and regulations for PPPH that can be used as guideposts by LGUs and national government agencies (DOH, COA) are generally absent. These policies and regulations would standardize the implementation of PPPHs and clarify to both the 'public' and 'private' aspects of the partnership their responsibilities and benefits under the engagement. These policies and regulations should therefore minimize the risks and maximize the outputs of a PPP arrangement. The TA contributed to addressing this concern by assisting DOH in crafting Administrative Order No. 2012-0004 entitled "Policy Framework for Public-Private Partnerships in Health" and its Implementing Rules and Regulations. This was signed in March 2012 by Health Secretary Enrique Ona.¹⁸
82. *Private sector concerns.* Apprehensions in regard to PPPH have been repeatedly raised by some private sector organizations. Common concerns include: contract security (i.e., will contract still be honored by the next local executives if there will be a change in the local government administration); tenure of LGU employees in establishments that may be potentially managed by the private sector (e.g., hospitals and pharmacies); and availability of competent managerial and medical staff from the provinces.
83. Despite PHIC's universal health care policy, some health service providers from the private sector remain skeptic over PHIC's payment scheme due to delayed payments and inconsistencies in the implementation of guidelines for

¹⁸ The existing policies, implementing rules and regulations, and guidelines are for large-scale infrastructure projects like roads, bridges, seaports and airports (under the Build-Operate-Transfer law).

reimbursements. This may eventually lead to cash flow problems of the private providers which adversely affect their liquidity position. The operationalization of the PHIC's GBPP serves as a significant initial step in solving the reimbursement concern of the private sector.

84. Large investors also noted that the lack of scale of some PPPH projects and the carving out of potentially lucrative parts of hospital operations (e.g., pharmacy and laboratory/diagnostics) make unattractive a hospital/facility operations and management PPPH.
85. *CBHCP interest rate and procedures.* The issue of the high interest rate of CBHCP facility, among other items, has not been adequately addressed, much less resolved. An assessment of the TA pointed out the many limitations that work against the loan's wider utilization. The TA noted a comment from the National Governing Board of the League of Provinces of the Philippines that the facility's interest rate is not acceptable. It can be anticipated that such a concern will be exacerbated should definite proposals involving the relatively higher interest rates be brought before provincial boards. At the same time, there is the additional apprehension regarding the facility's rigid procedures and procurement processes. At the time of writing this report, CBHCP does not cover subprojects in Metro Manila. This is inopportune as several potential subprojects are located in Metro Manila.
86. *CBCHP marketing.* Even as several LGUs have expressed interest in and had preliminary involvement with the CBCHP, these are still but a handful. The TA has been instrumental in promoting awareness of and potential engagement with CBHCP but such has occurred only within a short period of time given that the CBCHP established 2009. The inherent constraints brought about by the facility's interest rate and attendant procedures have been raised. While these need to be addressed, the marketing of the project also requires improvement. DBP marketing officers have to be thoroughly familiar with typical PPPH projects and the CBHCP initiatives. Promotional materials, inclusive of web-based references, have to be made current and readily available.
87. *Post-TA actions and directions.* The DOH and PHIC had both institutionalized the TA outputs wherein the DOH issued an administrative order and implementing rules and regulation on the PPPH framework policy and PHIC executed the GBPP¹⁹. With the gains of the TA at the national and local levels of policy development and implementation, the question remains whether the government can sustain these efforts in light of the issues that have surfaced. There still are important unresolved issues such as with the COA. Since the PPPH often entails novel approaches, the current systems in the COA may not be completely suitable to a PPPH project.²⁰

¹⁹ The TA has established good relationship with the International PPP Specialist Center for Health in the Philippines, which is affiliated to the Philippine Department of Health and supported by the United Nations Economic Commission for Europe. The PPP Specialist Center for Health is a specific Philippine-based organization that can carry on the initiatives started by the TA and those others relating to PPPH in general.

²⁰ DOH administrative order therefore serves only as a primary basis of the COA's ongoing strategy to address and resolve its PPPH issues in a definite and proactive manner.

VI. OVERALL ASSESSMENT

88. The TA improved the momentum by which PPPH in the country is conceptualized, and implemented. With the development of knowledge products and the approval of related departmental orders of DOH and PHIC, a governmental “backbone” for PPPH has been made in place.
89. This assessment of the TA is based on the DMF as well as on the comments and suggestions of various stakeholders. Through the course of the TA, various issues were encountered and it can be said that most were resolved.
90. Output 1 centered on the development and promotion of PPPH projects in line with the CBHCP. With the successful contracting of two PPPH in the provinces of Northern Samar (pharmacy) and Sarangani (feasibility study provider), this output and its key results areas are satisfactorily accomplished.
91. Several PPPH proposals were forwarded by the LGUs of Northern Samar, Sarangani, Rizal, Bohol, Camarines Sur and Cavite. Consultations with the local government officials were made to clarify expectations, determine their commitment, and assess the feasibility of the potential PPPHs based on TA’s defined criteria. While customized interventions and assistance per LGU were made according to local political, financial and regulatory dynamics, assistance at the national levels helped pave the way for a synergistic approach. Several concerns on CBCHP program (as abovementioned) constrained the involvement of other LGUs despite interests shown and availability of private investors.
92. For Output 2, the approval of the GBPP policy guidelines (per PHIC Board Resolution No. 1630 s. 2012) and the operationalization of the GBPP (per PHIC Circular No. 037 s. 2012) provided the impetus to strengthen PPPH for government health care facilities. The output is, therefore, also successfully achieved. Although the PHIC requested for an extension of assistance for its GBPP M&E, constraints in TA resource limited this assistance to preliminary M&E inputs.
93. For Output 3, capacity building was accomplished with the conduct of several capacity building trainings, brown bag seminars, consultations with stakeholders, and institutional support made. The question of long-term sustainability was taken, and partnership with DAP and NEDA was made to produce future leaders and experts on PPPH especially in areas of social marketing and knowledge management. In addition, COA and CSC involvement in PPPH was clarified which resulted to recommendations leading to a more conducive setting for health sector partnerships.
94. With the goals of achieving the MDGs in mind, it is left to be known what the impact and contributions of the TA in the MDGs’ attainment are—however, the efforts of the TA in PPPH guidance, promotion and development have so far given significant mileage for PPPH in the country.

VII. LESSONS LEARNED AND RECOMMENDATIONS

95. With the assistance provided by the TA, the PPPH situation in the country has been elucidated at an extent that favored the development and implementation of several PPPH. Original approaches made by the TA for the projects served will later guide subsequent PPPH endeavors. From its methodology design to its comprehensive and extensive outputs, the TA has directed the “fledgling” PPPH area in the country—readying both local and national levels of governance for PPPH, and equipping LGUs and partners with the necessary tools.
96. The TA gained several insights on the legal bases and feasibility of the PPPH projects, development of the PPPH in respect to LGU constraints, limitations of the CBHCP, PPPH social marketing and procurement challenges. Several issues pointed out, likewise, provided learning on present challenges of the PPPH in the country. These lessons resulted to recommendations on how the potentials and benefits of PPPH can be further maximized.
97. *Legal framework for the PPPH.* The execution of any PPP revolves and is rooted around fundamental legal requirements. In the case of PPPH implementation, this will depend on the PPP modality. If the PPPH modality is one of the contractual arrangements under the Build-Operate-Transfer (BOT) Law, then the process and requirements in the BOT Law and its Implementing Rules and Regulations (IRR) should govern. In this regard, the IRR sets out specific parameters and requirements with respect to: (a) identification of eligible projects, evaluation, review and contract approval and implementation; (b) bidding, bid evaluation and award for solicited proposals; and (c) evaluation, bidding and award for unsolicited proposals.
98. In contrast, if the PPPH modality is not among the contractual arrangements under the BOT Law (i.e. lease, joint venture or a management contract), then the process for identification, approval and award is not covered by the BOT Law. It is assumed and submitted that, pursuant to the powers granted to, and autonomy conferred by the Local Government Code, local government units have a wide latitude in the manner by which it identifies, approves, bids out and awards PPP projects.
99. With respect to PPP projects in the health sector, the policy guidelines in DOH Administrative Order 2012-004 should provide the basic principles, which include, among others, fair competition and transparent process. Adopting the procedures and requirements in the BOT Law and the IRR, in so far as it may be applicable, would also be a prudent approach.
100. *Social marketing for PPPH.* There are misconceptions associated to the development and implementation of PPPH. These normally include ownership, personnel displacement, and cost of services.
101. *Ownership.* The common perception of PPPH is government assigning the responsibility of healthcare to the private sector. Thus, all the trimmings of privatization come to play and some stakeholders criticize PPPH as an abrogation of government’s responsibility for health services to the general public. The challenge posed therefore is to clearly inform the public that PPPH is a partnership program where health services remain to be the responsibility of government and the entry of a private sector partner is aimed at improving the quality of health service and elevating the efficiency level of such service. The issuance of policy

instruments such as executive orders and administrative orders and, eventually, a contract between the government and the private sector partner will address this unfounded fear as it is expected to contain clear terms of engagement that are beneficial to both parties.

102. *Personnel displacement.* In introducing PPPH in a government setting, the immediate reaction of public health workers is the fear of losing their jobs since there is a general perception among them that they lack the confidence of measuring up to qualification standards usually set by the private sector. This is best addressed by the program administrators, in the case of hospitals, and local executives, for local government units, who will assure the health workers affected by the PPPH that: (i) their tenure of office and their civil service rights will be respected; and (ii) that options such as absorption by the private sector, transfer of positions within the government structure, and early retirement or separation packages are available.
103. *Cost of services.* PPPH may result in slightly higher cost of services owing to the fact that the quality of service will be raised. Equipment, inventories such as medicine and supplies, and facilities are expected to be improved under a PPP implementation regime. In addition, the regular return on investment that the private sector usually aims for will be factored in. The government has to negotiate a reasonable package with the private sector partner and guard against excessive returns that would unduly raise the costs.
104. The above misconceptions are difficult to correct if the program implementers have no capability to market PPPH. The government, with the support of the private sector partner, should have the capability to launch a social marketing program before, during, and after the implementation of a PPPH project. Ideally, there should be a task force composed of regular officers of the government and the private sector partner that would communicate the benefits of PPPH and address recurring issues that might be raised by the concerned stakeholders. The social marketing plan of PPPH implementers should be developed and implemented early on (i.e., when the PPPH project is still being designed). This will allow program managers to anticipate roadblocks and criticisms and respond to them positively. It also allows the government to carefully select its private sector partner.
105. *Procurement challenges for PPPH.* In the course of partnership between the TA and the provincial LGUs for PPPH, several procurement challenges were observed. A number of these issues are simple and involved only technical and intra-LGU intervention while others involved a higher level of intervention extending to national policies and guidelines. In Northern Samar for instance, it was noted that the BAC is not acquainted with the type of bidding documents to prepare and the bidding procedures to employ. Since the PPPH modality is novel, current policies and processes could not completely account for the project. For example, the operational definition of Approved Budget for the Contract as defined in the IRR of Republic Act 9184 could not be strictly applied to Northern Samar's PPPH pharmacy project and the nature of the project likewise affected the interests of the bidders (since they had no prior understanding or experience with the modality).
106. Bids and awards authorities should regularly assess the pre-bid submission status and the consequent bidding rounds for each project. This proves beneficial as it is better to close a contract on a good deal than ceaselessly extending and postponing one for want of the best deal

107. Guidelines at the LGU level for revenue sharing arrangements for PPPH need to be developed. Said guidelines should be able to respond to concerns such as reasonableness of cost of services and profit sharing. There is likewise a need to develop PPPH-specific bidding documents that the LGUs can refer to when planning their PPPH projects. Although the TA has developed guidelines, TORs and templates for PPPH areas such as hospital construction and management, pharmacy and laboratory services, service outsourcing and birthing stations, these outputs do not completely cover all potential PPPH projects.
108. Generally, a robust and extended advocacy should precede the procurement activities knowing that the project is novel and will be implemented the first time. Guidance on what type of harmonized bidding document to use, how the bid and performance securities will be calculated, and how the contract cost will be estimated are only a few of the items to reckon in procuring PPPH.
109. *Multi-stakeholder participation.* The success of the two PPPH projects in Northern Samar and Sarangani entailed close partnerships at multiple levels. While the roles of government bodies (e.g., DOH, COA) are imperative, it is the LGU that has the bigger responsibility towards the realization of its PPPH proposal. The products left in place by the TA for DOH (i.e., policy framework for PPPH and its IRR) only serve to streamline the DOH's participation in this vast network of partners; whereas the products developed for both the LGU (the "public" part of PPPH) and investors (the "private" part) mainstream and advertise the PPPH as an important aspect of improving healthcare delivery and bettering lives, and as an easy and profitable endeavour.
110. The proactive and committed participation of these entities provide the synergy needed for a successful PPPH. This synergy can only be maintained through constant efforts to build and renew partnership between the "public" and "private" sectors, as supported by fair and transparent policies and regulations. While the TA has pursued the development and promotion of PPPH to a commendable extent, the potential future projects under the PPPH remain tremendous. Not all difficulties can be foreseen and this synergy should be in place if these roadblocks will be overcome.

APPENDIX

ADB TA 7257: PPP in Health Final Report

A. Documents

1. DoH Administrative Order No. 2012-004 on the Policy Framework for Public-Private Partnerships in Health
2. ADB TA 7257: PPP in Health - Design and Monitoring Framework
3. Sarangani Province
 - i. Feasibility study for (Sarangani hospital operation and management) service provider procurement documents (EOI invitation, ToR, draft contract)
4. Northern Samar Province
 - i. Procurement/bidding documents for Northern Samar pharmacy management (EOI invitation, ToR, draft contract) (NOTE: Already in QPR5)
 - ii. Contract signed between Provincial Government of Northern Samar and Planet Pharmacy
5. Business Plans
 - i. Camarines Sur Provincial Hospital
 - ii. Northern Samar Hospital Pharmacy Management
 - iii. Guide for Assessing the Financial feasibility of Birthing Clinics
6. ADB TA 7257: PPP in Health - TA Schedule of Activities
7. Knowledge Resources on PPP in Health
 - i. Frequently Asked Questions on PPP in Health
 - ii. Guidebook on How to Develop a PPP in Pharmacy Services
 - iii. Guidebook on How to Develop a PPP in Hospital Management
 - iv. Resource Book on PPP for Birthing Care Facilities
 - v. Resource Book for Capacity Development (Training) (focus on Social Marketing and Knowledge Management)
 - vi. Brief on PPP in Health Applications (monograph)
 - vii. Legal and Policy Issues in PPP in Health (monograph)
 - viii. Financing Options for PPP in Health (monograph)
 - ix. Procurement Process for for PPP in Health (monograph)

- x. Reflections on Social Marketing and Knowledge Management (monograph)
8. Lending Guidelines for Midwives
9. Trainings and Knowledge-Sharing Sessions Facilitated and/or Delivered by the TA
10. PPP in Health Manila 2012 Conference
 - a. Event Brief
 - b. Programme of Activities
 - c. Attendance Sheet
 - d. Exhibitors Guide
 - e. Convenors and Partners Profile
 - f. Investors Forum Brief – Modernization of Philippine National Orthopedic Center
 - g. Travel Guide
 - h. Brief on UNECE International Center of Excellence on PPP in Health
 - i. Presentations of Speakers
 - A Closer Look at PPP Financing – by Jungwook Kim
 - Best Practices in PPPs Health Sector- by Isabelle Waschmutt
 - Can Governments Do It? A Closer Look at Local and National Capacity Development in PPPs in Health – by Juan Antonio Perez III
 - Clinic Session 2: Suppliers Hour – by Matthew Koory
 - Delivering Healthcare through P3- by Jill Jamieson
 - Good Health and PPPH's: Good Economics – by Hilton Lam
 - Health Services Devolution: Bane or Boon - Are PPPs Adversely Affected by It? – by Aquilino Pimentel
 - How Can the Gaps in Local and National Capacity Development Be Addressed – by Magdalena Mendoza
 - Monitoring of PPPs in Health: UNECE PPP Toolkit – by David Dombkins
 - PPP Experiences in Europe- by Geoffrey Hamilton
 - PPP in Health in Northern Samar, Philippines – by Paul Daza
 - PPP in Health: Perspectives from the Private Sector- by Matthew Collingridge
 - PPPs in Health: In Search of Excellence – by Geoffrey Hamilton
 - Prospects for eHubs in PPP in Health – by Ramon Isberto
 - Public-Private Participation Health: Asian Experience- by Kai Hong Phua
 - Risk Allocation in Healthcare PPP's – by Alberto Germani
 - Social Marketing: What Do We Want to Communicate? – by Florentino Solon
 - Strengthening PPP in Health Policy Environment- by Enrique Ona
 - This is GE Healthcare – by Ivan Arota
 - Universal Health Care under a PPP Regime: Ensuring that the Health Insurance System Works – by Eduardo Banzon

- j. Proceedings of the PPP in Health Manila 2012 Conference
- 11. Philippine Health Insurance Corporation (PHIC) Circular No. 037 s. 2012 on Global Payment Program
- 12. Documentation of ADB TA 7257: PPP in Health Sharing and Turnover Workshop (13-14 November 2012)
- 13. Report on Study on the Assessment of the Demand for and Supply of Health Services in the Quirino Memorial Medical Center Catchment Area

B. CD Attachments (electronic copies)

- 1. Audio Video Presentation entitled “Partnership for Health”
- 2. Audio Video Presentation of Planet Drugstore on Ospital ng Makati Pharmacy PPP Project – presented by Erwin Schornack during the PPP in Health Manila 2012 conference
- 3. Electronic copy of Final Report and its appendices