Validation Report
November 2017

Philippines: Credit for Better Health Care Project

Reference Number: PVR-537
Program Number: 41664-013
Loan Number: 2515
Grant Number: 0148
**ABBREVIATIONS**

ADB – Asian Development Bank  
DBP – Development Bank of the Philippines  
DOH – Department of Health  
HSIAC – health sector investment advisory committee  
IED – Independent Evaluation Department  
LGU – local government unit  
MDG – Millennium Development Goals  
PCR – project completion report  
PHIC – Philippines Health Insurance Corporation  
PPP – public–private partnership  
SHCIP – Sustainable Health Care Investment Program  
TA – technical assistance

**NOTE**

In this report, “$” refers to US dollars.

<table>
<thead>
<tr>
<th>Director General</th>
<th>M. Taylor-Dormond, Independent Evaluation Department (IED)</th>
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I. PROGRAM DESCRIPTION

A. Rationale

1. The Credit for Better Health Care Project aimed to help the Philippines achieve health-related Millennium Development Goals (MDGs), particularly to improve maternal health and reduce child mortality. Insufficient investment in the health sector precluded better access to higher quality services. Public health spending as a percentage of total health spending declined from 41% in 2000 to 29% in 2005, especially due to declining local government expenditures.\(^1\) This particularly impacted the poor even though a Philippine Health Insurance Corporation (PHIC) package covered their basic needs through accredited health facilities or providers. The

government wanted to mobilize additional financing for the health sector so that upgraded and better equipped facilities would get PHIC accreditation, more reimbursement, and further allow quality improvement and increased use. If PHIC can increase the number of its beneficiaries, the population health status of the poor, women, and children would improve.

2. In 2007, the Development Bank of the Philippines (DBP), a government financial institution, established the Sustainable Health Care Investment Program (SHCIP). This was a special credit facility for health sector investments to support the programs of the Department of Health (DOH). These relate to maternal and child health services, control of communicable diseases, better access to basic health care, and referral services. Funds under DBP’s SHCIP were available for practitioners in both public and private health sectors.

3. The Asian Development Bank (ADB) supported the government’s strategy for mobilizing off-budget resources. It “may provide loans to financial intermediaries to finance specific projects whose individual financing requirements are not large enough to warrant the direct supervision of ADB.” Since 1975, ADB had provided five loans to DBP to support the finance sector, fisheries, housing, industry, mining, and technical education. The DBP requested a $50 million equivalent loan from ADB for its health sector program.

B. Expected Impacts, Outcomes, and Outputs

4. The expected impact of the project was improved overall health status, especially MDG 4 (reduced child mortality) and MDG 5 (reduced maternal mortality ratio) by 2015. The expected outcome was increased use of basic health care and referral services in the subproject sites. The expected outputs were (i) upgraded local government unit’s (LGU) health services, (ii) more efficient health-care delivery systems through public–private partnership (PPP) and innovative strategies, (iii) improved access to small-scale private providers, and (iv) enhanced institutional capacity for health sector lending.

C. Provision of Inputs

5. In 2009, ADB approved a $50 million equivalent loan from its ordinary capital resources for health sector investment nationwide, excluding the National Capital Region, through DBP’s SHCIP. DBP was the borrower, and the loan was guaranteed by the Republic of the Philippines. The project cost was estimated at appraisal to be $63.4 million, but actual disbursements amounted to only $19.97 million. The balance of $30.03 million was canceled because of the unwillingness of LGUs to borrow from DBP (see para. 8). The loan became effective on 19 August 2009. The project was implemented over 6 years as planned, and the original loan closing date of 19 August 2015 was met.

6. A $1 million technical assistance (TA) financed by the Japan Special Fund was attached to the loan to develop PPP and innovative strategies for health services delivery. An international consulting firm and four individual consultants provided 17.5 person-months of international and 94.4 person-months of national inputs. The Gender and Development Cooperation Fund provided a $400,000 grant for Enhancing Midwives’ Entrepreneurial and Financial Literacy Skills in selected provinces. The environmental management system of DBP was assessed and only

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3 ADB. 2009. Report and Recommendation of the President to the Board of Directors: Proposed Loan to the Republic of the Philippines for the Credit for Better Health Care Project. Manila.
subprojects of category B or C could be financed through the financial intermediary. The project aimed at gender equity and a gender action plan was developed.

D. Implementation Arrangements

7. The DBP was the executing agency for the loan, the TA and the grant, DOH and PHIC were implementing agencies for the TA. DBP established a health sector investment advisory committee (HSIAC) with representatives from DBP, the Department of the Interior and Local Government (DILG), DOH, PHIC, and the private sector. DBP also set up a project management office under its SHCIP. The project complied with 24 of the 27 loan covenants, covering sector reforms, financial management, and environmental and social provisions. Exceptions were conducting exit and beneficiary impact assessment studies, timely submission of quarterly performance reports, and recruitment of consultants, which were only partly complied with.  

8. The DBP adopted retail and wholesale approaches to re-lend loan proceeds to sub borrowers. Retail lending was targeted to LGUs (output 1) and large private entities (output 2), and wholesale lending to accredited financial intermediaries (microfinance institutions, rural banks, cooperatives and nongovernment organizations) that would on-lend to small-scale private providers (output 3). Shortly after loan effectiveness, global interest rates fell, and lower cost loans were available on the domestic market. Furthermore, the decision of the newly elected Aquino administration in 2010 to provide grants to LGUs for investment in the health sector compounded the problem, and DBP recommended changes in the project scope and partial cancellation of the loan amount. LGUs were no longer interested in borrowing from DBP (output 1) and loan resources should be reallocated to fund private hospitals (output 2) and small-scale providers (output 3). No financial intermediary accessed project funds to re-lend to small-scale health providers (output 3) since they could also obtain lower borrowing rates in the local market. DBP tried to directly attract small-scale health providers by removing the $100,000 floor for retail lending, developing banking products specially designed for these providers, and providing loans directly to them through their regional branches.

9. Changes in project scope and cancellation of loan proceeds were approved by ADB. Targets and indicators in the design and monitoring framework were amended, and the loan amount was reduced to $26.3 million equivalent. Subprojects were eventually approved for a total of $19.97 million for seven private hospitals (loans ranging from $1.0 million to $6.1 million—revised output 2) and four small-scale private hospitals (loans between $0.06 million and $0.40 million—revised output 3). No PPP was developed but all (private) project hospitals outsourced ancillary services like laundry and food.

10. The TA was to support the project objectives and test PPP models to increase the use of maternal and child health care and referral services in the project areas. It was expected to (i) promote PPP in the health sector; (ii) develop incentives to encourage small-scale providers to attain PHIC accreditation in rural and underserved areas—later modified to develop the PHIC global budget system to support PPP in health initiatives; and (iii) develop contracting modalities to improve the quality and efficiency of health services—later revised to develop a monitoring and evaluation system and enhance the capacity of national and local government agencies for promoting and implementing PPPs in health. No PPPs were implemented but the TA was

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5 Under the Health Facilities Enhancement Program.
6 The first partial loan cancellation was approved in February 2013, the second in June 2015, and the third in August 2015.
successful in raising interest for PPPs and helping DOH develop a PPP policy framework and its implementing rules and regulations.\textsuperscript{7} The Gender and Development Cooperation Fund grant supported gender activities, training and helping midwives access loans to obtain accreditation.

\textbf{II. EVALUATION OF PERFORMANCE AND RATINGS}

\textbf{A. Relevance of Design and Formulation}

11. The project completion report (PCR) rated the project \textit{less than relevant}. The project was quite complex and involved several stakeholders (DBP and its supervising agencies, DOH and PHIC, LGUs). The rationale was well explained and the results chain was logical. The project’s intended impact and outcome were consistent with the country development priorities and ADB country and sector strategy.

12. The design, however, presented serious deficiencies in its assumptions, risk assessment, and mitigation measures. Project implementation was adversely affected by the global fall in interest rates, the cheaper lending in the domestic market, and the Health Facilities Enhancement Program of the Aquino administration. These changes in the lending environment should have been anticipated. The project was approved in 2009, while a global financial crisis was ongoing and a few months before the 2010 nationwide elections in the country that covered the president, vice president, national and local government representatives, including mayors, vice mayors, and councilors. Volatility in a financial crisis and changes in policies and priorities when a new administration takes power are not unusual. These risks could have been identified and mitigation measures proposed.

13. The project was ambitious and complex, with subloans expected to be provided to LGUs, private hospitals, and small-scale health providers. The selected lending modality—a financial intermediary loan project—met ADB guidelines (Operations Manual section D6) and was a good choice since it was assumed that coordination between agencies would occur through the HSIAC. The HSIAC was established to ensure coordination and collaboration among the various agencies which participated in the project. These agencies were typically not used to working together (DBP and its supervising agencies, DOH and PHIC, LGUs) and they did not work together during implementation. Significantly the LGUs were not systematically consulted during project preparation—a major omission. It was assumed that they would borrow and invest in health facilities, but due diligence was not comprehensive. The weak capacity of many LGUs and the short-term political mandate of the LGUs members should have been better assessed. Some supporting measures were included such as the project’s advisory committee and the PPP TA. But the advisory committee did not function as expected, and LGUs’ capacity for health was not sufficiently strengthened. Appropriate changes in scope were rapidly approved by ADB, but took about 1 year for the government to request these changes. Insufficient health data did not allow an appropriate assessment of the local needs (that could have prompted advocacy and social marketing) and measurement of results. For these reasons, the validation views the project \textit{less than relevant}.

\textbf{B. Effectiveness in Achieving Project Outcomes and Outputs}

14. The PCR assesses the project as \textit{less than effective}. By helping upgrade private health care facilities to improve service quality and secure PHIC accreditation (and thus reimbursement of services), the project partly achieved its intended outcome of “increased use of basic health

\textsuperscript{7} Administrative Order 2012–2014.
care and referral services by the poor in general and by women and children in particular, in the project areas. Overall supply of health-care services increased and data collected from hospitals supported by the project reported a rise in the number of in- and outpatients, including PHIC beneficiaries. However, assessing if outcome was achieved in the subproject sites is hampered by the lack of sex- and age-disaggregated data on the use of health services in the project facilities.

15. Not one LGU borrowed from DBP (output 1) and there was no wholesale lending to accredited financial intermediaries for relending to small-scale health providers (output 3). The revised targets, due to change in project scope for outputs 2 and 3, were only partly achieved. No PPP arrangements were established, but all subproject private hospitals outsourced ancillary services and initiated innovative strategies (e.g., management information systems). All private hospitals under the project are PHIC certified, offer maternal and child care, and generic drugs. There were workshops for enhancing midwives’ entrepreneurial skills but only few midwives achieved PHIC accreditation by project completion and only three DBP loans were granted, post-project, to private midwives. DBP institutional capacity for health sector lending improved (output 4), with market-based lending to six private hospitals and the development of innovative banking products for small-scale health providers. Several targets were either not met or only partly achieved, there were a small number of subprojects, and limited data prevented a realistic assessment of achievements of the subprojects. Therefore, the validation considers the project less than effective.

C. Efficiency of Resource Use

16. The PCR rated the project less than efficient. The economic analysis at appraisal assumed that project interventions would have a significant impact on maternal and child health. Indeed, country-level maternal and child health indicators improved but it is difficult to attribute the improvements to project activities. The analysis also did not consider the need for the borrowers to comply with ADB and the Government’s requirements for lending and procurement. These requirements contributed to delays for the final borrowers, which further reduced their interest in borrowing.

17. Since it was difficult to compute the economic benefits of the project, the PCR looked at the economic return on invested capital as a proxy efficiency indicator. Three subprojects with complete financial data showed economic returns well above the ADB standard social discount factor of 12.0%, indicating that these were viable. If a qualitative stakeholder analysis was undertaken, it could have reflected the efficiency of a financial intermediary loan project. Based on limited information, it appears that the number of private health sector stakeholders borrowing from DBP may have increased over time because of the new banking products developed by DBP. However, given the limited effectiveness of the project and lack of data supporting a qualitative stakeholder analysis, this validation assesses the project less than efficient.

D. Preliminary Assessment of Sustainability

18. The PCR rated the project as likely sustainable. The DBP ran a financial sustainability analysis on selected subprojects. DBP computed the financial internal rate of return (FIRR) for all selected subprojects (new construction and expansions) and the weighted average cost of capital (WACC) for the new construction. The computed FIRR were above the WACC of 6.3%, which

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indicates financial viability. Prudent hospital management and an increased number of patients brought higher financial revenues and contributed toward financial sustainability. Furthermore, DBP has shown management capability, flexibility, and is open to innovation. The sustainability of its SHCIP will depend on government policies and programs that do not undermine the lending terms of DBP, and upon the identification of potential markets for future private sector investment. Considering the results of the PCR economic analysis, the long-term nature of investments in buildings, and the willingness of DBP to maintain SHCIP and incorporate lessons from the project, this validation assesses the project as likely sustainable.

III. OTHER PERFORMANCE ASSESSMENTS

A. Preliminary Assessment of Development Impact

19. The improved health status of the population and reduced maternal and child mortality at the national level cannot be directly linked to the small number of subprojects. While the project raised awareness of the need to continue investing in health infrastructure and to strengthen LGU capacity, and demonstrated opportunities for involving the private sector to improve services, there is no evidence of development impact. The validation considers the development impact to be less than satisfactory.

B. Performance of the Borrower and Executing Agency

20. The PCR’s description of DBP’s operational and financial performance shows an institution with good corporate and financial governance, flexibility, and growing operations. DBP played a positive role from project preparation to implementation and completion, and is to continue providing support to subprojects not completed at the time of closure. This validation considers the performance of DBP as executing agency satisfactory. As a government-regulated financial institution, DBP was hampered by the complex governance structure surrounding the project. During implementation, DBP proposed timely changes to the project and suggested new approaches. But decisions were the responsibility of central government with their own internal processes and approval protocols. The limited involvement of government agencies that were important stakeholders in the project and the lack of leadership to assure coordination reduced the project effectiveness and efficiency. This validation considers the performance of the other agencies less than satisfactory. Balancing the performance of the borrower and government agencies, the validation considers the overall performance less than satisfactory.

C. Performance of the Asian Development Bank

21. The PCR rated ADB’s performance as satisfactory. ADB provided support and supervision in the preparation of the subprojects, and fielded joint review missions with DBP, DOH, and the National Economic and Development Authority twice a year. ADB responded promptly and in a flexible manner to requests for changes in scope and partial cancellations of loan proceeds. However, unexpected changes in the lending environment and government policies became key challenges for project implementation. These were risks that should have been considered and balanced.

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9 Decision making on project changes or new approaches lies within central government institutions such as the Bangko Sentral ng Pilipinas (the Central Bank), the Department of Finance, and the National Economic Development Authority, which in turn also have their own internal processes. As early as 2010, DBP flagged concerns about the lack of LGU uptake and suggested redirecting efforts toward the private sector. It was only in February 2013 that the DOF endorsed partial cancellation of P500 million. Another 6 months was needed for the government to approve the shift from LGU to private sector lending (approved in November 2013), and nearly 1 year after that (September 2014) to get subloans to private hospitals signed (PCR, footnote 28).
mitigation measures could have been proposed. During project implementation, there was a lack of continuity of ADB staff largely because of a number of changes in project officers. Given the nature of the project, the inclusion of ADB staff from other divisions (finance sector, private sector) as team members could have resulted in a better project design. Despite the efforts of the project division to implement the project, because of the reasons outlined above, this evaluation views ADB performance less than satisfactory.

D. Others (Governance)

22. The complexity of the project was compounded by the need to involve multiple stakeholders (DBP, DOH and PHIC, LGUs, private sector). DBP tried to facilitate coordination through the establishment of an advisory committee, the HSIAC. Despite the agencies’ shared objective to improve local health services quality and accessibility, the committee was not able to function effectively because of an unclear definition of its role, duties, authority, and reporting mechanisms.

IV. OVERALL ASSESSMENT, LESSONS, AND RECOMMENDATIONS

A. Overall Assessment and Rating

23. This validation agrees with the PCR in rating the project less than successful. The project was rated less than relevant as design had deficiencies in its assumptions, risk assessment, and mitigation measures. It is less than effective as several targets were either not met or only partly achieved, there were a small number of subprojects, and limited data prevented a realistic assessment of achievements of the subprojects. It is less than efficient as it was difficult to compute the economic benefits of the project. Also, no evidence was presented on efficiency of the financial intermediary loan. Lastly, the estimated FIRR of selected subprojects were above the weighted average cost of capital of 6.3%, which indicates financial viability, hence the rating of likely sustainable. The ratings are summarized below.

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<tr>
<th>Validation Criteria</th>
<th>PCR</th>
<th>IED Review</th>
<th>Reason for Disagreement and/or Comments</th>
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<tr>
<td>Relevance</td>
<td>Less than relevant</td>
<td>Less than relevant</td>
<td></td>
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<tr>
<td>Effectiveness</td>
<td>Less than effective</td>
<td>Less than effective</td>
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<tr>
<td>Efficiency</td>
<td>Less than efficient</td>
<td>Less than efficient</td>
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<tr>
<td>Sustainability</td>
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<td>Likely sustainable</td>
<td></td>
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<tr>
<td>Overall Assessment</td>
<td>Less than successful</td>
<td>Less than successful</td>
<td></td>
</tr>
<tr>
<td>Preliminary Assessment of Impact</td>
<td>Not rated</td>
<td>Less than satisfactory</td>
<td>No evidence of development impact can be linked to the small number of subprojects.</td>
</tr>
<tr>
<td>Borrower and executing agency</td>
<td>Not rated</td>
<td>Less than satisfactory</td>
<td>DBP performance was satisfactory, but the lack of coordination and participation of other agencies that were important stakeholders in the project hampered overall performance.</td>
</tr>
<tr>
<td>Performance of ADB</td>
<td>Satisfactory</td>
<td>Less than satisfactory</td>
<td>ADB performance was satisfactory during the</td>
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<tr>
<td>Validation Criteria</td>
<td>PCR</td>
<td>IED Review</td>
<td>Reason for Disagreement and/or Comments</td>
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<tr>
<td>Quality of PCR</td>
<td></td>
<td>Satisfactory</td>
<td>implementation stage of the project, but the lack of appropriate PPTA at the design stage affected overall performance of the project. ADB did not leverage its comparative advantage of being a multisector development institution comprised of staff with different skills and experience, which could have resulted in better project design.</td>
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**Note:** From May 2012, IED views the PCR's rating terminology of "partly" or "less" as equivalent to "less than" and uses this terminology for its own rating categories to improve clarity.

**B. Lessons**

24. This validation agrees with the lessons identified in the PCR, with some clarifications. In a decentralized health system, LGUs are important stakeholders, but they are not experts in the health system. Clear but concise information is required to mobilize interest and commitment of the decision makers. With decentralization, elected LGU officials must be correctly briefed on the local issues, and information needs to be based not only on qualitative and anecdotal observations but also on accurate quantitative data. Appropriate technical support to the LGUs during project preparation and implementation is required to strengthen political, longer-term commitment and ensure efficient resource allocation.

25. Private health providers can play an important role when developing a network of quality health services in rural and other underserved areas. The needs of private sector entities and small-scale health providers, however, are different. Easy access to credit by small-scale providers, in itself, is insufficient. Needs and constraints also should be addressed. This covers (i) technical support—referral networks, continuous training, and colleagues' advice; and (ii) family support—access to schools for children, work opportunities for the spouse, safety, and other needs and constraints. These must be identified and addressed to develop quality health services in rural areas. Among small-scale health providers, midwives are essential to reduce maternal and child mortality in underserved areas, and their specific needs must be identified and met. Innovative solutions are required to facilitate access to small credit without multiplying intermediaries—DBP, learning from experience, has now developed specific credit programs.

26. PPPs, in the health sector must offer value for money. The involvement of the private sector often improves efficiency, the quality of services, and peers' support. A PPP policy in the health sector must be designed within the context of local conditions. Outsourcing ancillary services is good practice for improving efficiency.

27. The project was complex and involved many stakeholders (DBP, DOH and PHIC, LGUs, private sector venture, small-scale private providers, and local beneficiaries). A careful stakeholder analysis involving consultations with all participants to identify needs, constraints,
and potential benefits could have improved the project design, its assumptions, and risk mitigation strategies.

28. Project ownership is important. With DBP, a financial institution as executing agency, DOH did not have primary responsibility for this health project. Inter-sector collaboration can bring significant benefits but is not easy: it requires significant efforts and a clear governance structure with specific reporting and coordination mechanisms. Leadership is essential and needs to be carefully established to ensure effectiveness and efficiency. The HSIAC should have been more actively involved and better coordinated the project.

C. Recommendations for Follow-Up

29. This validation supports the PCR recommendations. Despite a good rationale and design concept, the project was complex and ambitious with its nationwide coverage. Implementation, monitoring, and impact evaluation would be easier at local or regional level. Up-front consultations with target groups are necessary to ensure that the needs identified by the experts are also felt by the intended beneficiaries. Health sector projects need to also involve experts with skills in public governance, management, and finance for better project design; and to ensure effectiveness, efficiency, and equity of the health system.

30. The needs of the Philippine health system remain significant. With its experience and its multisector in-house expertise, ADB can provide multi-disciplinary support to the country for more effective and more efficient delivery of health services.

V. OTHER CONSIDERATIONS AND FOLLOW-UP

A. Monitoring and Reporting

31. The DBP is a government-controlled financial institution established in 1947. It has a long history of lending and a number of project loans with ADB. Its loan appraisal, approval, and disbursement procedures were reviewed by ADB for the project and were considered appropriate and sufficient. Nevertheless, two covenants, requiring an exit study for each subproject and the submission of quarterly performance reports on time, were only partly complied with. The PCR noted “a major shortcoming of the project was the lack of timely and relevant data.” Such data from the private sector are more difficult to obtain, and the PCR recommends that better mechanisms be developed for “collecting, monitoring, and reporting accurate data from the private hospitals and small scale providers.” This validation supports the PCR recommendation.

32. DBP continues to monitor subprojects, and the PCR indicates that opportunities remain to further develop health infrastructure, personnel services delivery, and the health system in general. Data-based decision making must become standard. Capacity building to collect and use data disaggregated by gender, age, poverty level, and vulnerable groups is needed.

B. Comments on Project Completion Report Quality

33. The PCR quality is satisfactory. It clearly describes and assesses the project and provides adequate explanations for its ratings. The PCR could have included additional information on gender and safeguards in the main text. Lessons and recommendations are appropriate and will benefit the activities of both ADB and DBP in their future operations in the health sector.
C. **Data Sources for Validation**

34. The following documents were reviewed for this validation: (i) the report and recommendation of the President, including selected supplementary appendices; (ii) the PCR of ADB; (iii) the PCR of DBP; (iv) minutes of the management review meeting and the staff review committee; and (v) mission documentation, including back-to-office reports of the midterm review and project completion review missions.

D. **Recommendation for Independent Evaluation Department Follow-Up**

35. None.