DoH Administrative Order No. 2012-004 on the Policy Framework for Public-Private Partnership in Health

Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY

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ADMINISTRATIVE ORDER
No.2012-0004

SUBJECT: Policy Framework for Public-Private Partnerships in Health

I. BACKGROUND AND RATIONALE

In pursuit of the objectives of Universal Health Care or "Kalusugang Pangkalahatan (KP)", as defined in Administrative Order No. 2010-0036 (The Aquino Health Agenda: Achieving Universal Health Care for All Filipinos), the Department has committed to engage in more Public-Private Partnerships (PPPs) specifically to enable physical improvements in government health facilities. PPPs have also been looked upon by no less than the President of the Republic as a key national development instrument, the furtherance of which is therefore a priority of all government agencies, including the Department of Health.

The private sector is deemed to have intrinsically better capabilities in some areas, such as more timely financing, operational efficiency, highly-responsive services, and even dominant market presence. If optimally harnessed, more cooperative undertakings with the private sector may help significantly address some of the constraints and inefficiencies inherent in public-only provision of health services.

The Philippine government has long recognized the advantage of adopting PPPs in public sector undertakings, especially for large-scale priority infrastructure developments. The mechanisms for the latter had been laid out in the Republic Act 7718, otherwise known as the Amended BOT Law. While the latter account for several possible variants of PPPs, the included listing is still not exhaustive. Separate guidelines for Joint Ventures, another PPP modality, have been drawn up by the National Economic and Development Authority (NEDA).

The local PPP experiences in the health sector have thus far been varied. While many such endeavors have been documented, most of these have been found to be non-contractual in nature (with consequent minimal accountabilities and performance references), and many have been unsustainable. It also remains to be determined if existing and upcoming PPPs in health substantially address the fundamental UHC goal of enhanced access to health care for the country's poor. All these assume greater significance in the light of the reported United Nation's consideration of the Philippines as the Center of Excellence for PPPs in Health.

It is apparent from the foregoing that while the national policy on PPPs has been set, much remains to be clearly delineated and effectively adapted for health services. This Administrative Order has therefore been crafted in order to better define the applicability and prioritization of the relevant policies, streamline their implementation, and enable the continuing evaluation of PPPs in the health sector.

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II. SCOPE AND COVERAGE

This issuance shall apply to the entire health sector, from both the public and private sectors, the DOH bureaus, national centers, hospitals, and attached agencies especially Philippine Health Insurance Corporation (PhilHealth), which are involved in the support for and provision of health services.

III. GOAL AND OBJECTIVES

A. Goal

The establishment of Public Private Partnerships is to be encouraged and sustained in the areas of health care where these most contribute to the achievement of *"Kalusugan Pangkalahatan"*, and thereby ensure equitable access and better outcomes for disadvantaged Filipinos.

B. Objectives

The DOH aims to:

1. prioritize PPPs that meet national and local government objectives of addressing adequately the health service needs of the poor ;
2. promote and provide a focused approach that harmonizes the existing PPP-applicable legal and administrative mandates as well as internal strategies and procedures;
3. foster a culture that engenders transparency, fairness, and robust competition;
4. develop and integrate in the overall PPP efforts, incentives, which are aligned with both departmental goals and expected health outcomes; and
5. continually assess the collective experiences on PPPs in the health sector so as to be able to adapt public policies and approaches to new developments and needs to sustain accessibility to quality healthcare.

IV. DEFINITION OF TERMS

1. **Health sector** – refers to health systems, including all institutions, organizations, enterprises and entities, involved in actions that protect, promote or advance the health status of individuals or populations; conceptually includes all aspects of society that influence health status but operationally focuses on those entities specifically organized to provide or govern the provision of health services and goods.

2. **Public sector** – refers to health providers (individual practitioners, health centres, hospitals, organizational units, agencies) within the rules and regulations of the government and all providers under the administration and control of the DOH, other national agencies (DepED, DOLE, DND, etc) or local governments (provincial, city or municipal governments).

3. **Private sector** – refers to health providers and facilities (individual practitioners, clinics, hospitals, facilities, drug outlets) licensed and regulated under existing laws but otherwise operating outside the ownership or management of the government;

includes the drug and pharmaceutical industry, non-government organizations, as well as proprietary enterprises providing health services as part of their activities.

4. **Public-Private Partnership (PPP)** – a cooperative venture between the public and private sectors, built on the expertise of each partner, that best meet clearly defined public needs through the appropriate allocation of resources, risks and rewards.

5. ***"Kalusugan Pangkalahatan" (KP)*** – a focused approach to health reform implementation, ensuring that all Filipinos especially the poor receive the benefits of health reform; intended to ensure that the poor are given financial risk protection through enrolment in PhilHealth and that they are able to access affordable and quality health care and services in times of need.

V. GENERAL GUIDELINES

Cognizant of the still under-tapped potential offered by PPPs in expanding the provision, particularly in capital-intensive areas, of health services, the DOH will adhere to the following guiding principles to both facilitate and regulate these engagements:

A. **Consistency of Priorities:** PPPs in the health sector which are in line with key national, DOH, and even LGU developmental priorities will be favoured, in terms of the administrative, technical and operational support that may be provided by the DOH.

B. **Synergized Strategies:** All the relevant KP-related strategies, the implementation of which will cultivate an environment which is supportive of PPPs, are to be given more emphasis by the DOH.

C. **Comparative Advantage:** The DOH will actively promote the adoption of PPPs in health in areas where these are deemed to be the most meritorious option for the implementation of specific health programs or services.

D. **Sector Coordination:** The DOH will coordinate with the other concerned national government offices and agencies, LGUs and private institutions and organizations so as to expedite the processing and functioning of priority PPPs in health.

E. **Fair Competition:** To ensure a level playing field, as well as to be aligned with the nationally-defined strategy, contractual PPPs, entered into following a competitive bidding process, will be preferentially encouraged.

F. **Transparent Processes:** An informational and procedural clearing system will be established, which will be made accessible to all health-related PPP stakeholders.

G. **Conditional Incentives:** Technical, material, or financial incentives are to be developed and provided which are in concordance with both KP objectives and strategies as well as actual PPP performance vis-a-vis intended population health outcomes.

H. **Continuing Appraisal:** The DOH shall establish a repository of Health PPP performance and experiences, and utilize the data so collated to effectively fine-tune the relevant policies and procedures.

VI. SPECIFIC GUIDELINES

A. The determination of health programs or services which are to be given precedence, in terms of DOH-provided support, for PPP establishment shall be based on:
   1) KP goals and strategies
   2) Other DOH-set priority areas

B. The Department shall comply with the following legal and administrative instruments and frameworks in the promotion, implementation, and evaluation of PPPs:
   1) RA 6957, as amended by RA 7718 (BOT Law) and its Implementing Rules and Regulations
   2) RA 9184 (Government Procurement Reform Act)
   3) Batas Pambansa Blg. 68 (Corporation Code of the Philippines)
   4) RA 7160 (Local Government Code)
   5) EO 292 (Administrative Code of the Philippines)
   6) EO 226 (Omnibus Investment Code of 1987)
   7) NEDA Joint Venture Guidelines and Procedures
   8) NEDA Investment Coordination Committee (ICC) Guidelines
   9) Commission on Audit (COA) Guidelines
   10) Other related legal and administrative issuances

C. Even as the DOH assumes the lead in the establishment of strategic PPPs in the health sector, it shall coordinate with, as well as provide any necessary assistance, to the following entities:
   1) Public-Private Partnership Center of the Philippines, NEDA for medium to large-scale health PPPs
   2) LGUs and Local Development Boards for LGU-initiated PPP endeavors
   3) Development partners, financial institutions, NGOs and other parties interested in PPPs

D. The DOH shall endeavor to ensure that the financial environment for health-related activities is conducive to private sector participation by:
   1) Progressively increasing, in coordination with PhilHealth, membership in the social health insurance system, with particular emphasis on attaining universal coverage of the poor
   2) Putting in place more adequate and timely reimbursement mechanisms, also in coordination with PhilHealth
   3) Streamlining the PhilHealth accreditation of qualified health service facilities and providers
   4) Promoting efficiency and responsiveness among public providers of health services by encouraging their assumption of greater administrative and fiscal autonomy

E. Suitability, transparency and fair competition in the establishment of PPPs in health are to be advanced by the adoption of the following:
   1) Determination of the applicable clinical, administrative, and economic norms for PPP undertakings
   2) Publication of user-friendly procedural guides

3) Declared partiality for solicited bids in the setting up of PPPs
4) Development and dissemination of performance standards
5) Endorsing the inclusion of public disclosure clauses in PPP contracts

F. Assessment as well as incentives schemes are to be developed and are to be premised on:
1) The commitment by the Department to provide substantial technical, material, and financial support (through conditional grants or soft loans) as additional incentive mechanisms
2) The actual incentive mix is to be pre-determined for targeted types of or desired outcomes for PPPs
3) A system for periodic monitoring and evaluation is to be set-up purposely for both exclusive as well as comparative appraisal of PPPs in health
4) Regular publication of the performance assessments of initiated PPPs

VII. ROLES AND RESPONSIBILITIES

A. DOH, through the following offices, shall:

1) Office of the Secretary
   a. Provide policy directions for and ensure the Department's sustained commitment to PPPs for the health sector
   b. Commit resources to support the PPP undertakings of the Department
   c. Develop and implement the corresponding organizational framework, inclusive of lines of accountability, in support of the PPPs for health effort

2) PPP Task Force
   a. Serve as the point group for PPPs in the DOH
   b. Assume all the responsibilities for PPPs as listed in Department Personnel Order No. 2010-5150
   c. Support the establishment of the DOH Center for Excellence on Public-Private Partnerships in Health (DOH-CEP3H), which will eventually take over the Task Force's responsibilities as well as become the primary office concerned with the PPP-related initiatives and activities of the DOH
   d. Provide the primary link to the external network of government agencies and private entities which are involved or interested in PPP undertakings in health
   e. Recommend to the Secretary appropriate PPP measures for the furtherance of the UHC/KP goals and strategies

3) DOH Bureaus, Agencies, Hospitals, and other subsumed offices, particularly Center for Health Development (CHD)
   a. Identify and develop priority areas in their corresponding fields of operations where PPP arrangements will be appropriate
   b. Collaborate with the pertinent DOH offices, government agencies as well as private entities in the planning, implementation, and monitoring of PPPs in health

B. **Philippine Health Insurance Corporation (PhilHealth)** shall:

a. Ensure effective coverage of social health insurance through expanded enrollment of the sponsored and informal sector, widely accessible accredited facilities and better support value
b. Develop the contracting modality, case-based payments and other measures for timely and efficient payments of providers.

C. **Local Government Units (LGUs)** are encouraged to:

a. Consider the option of PPP whenever appropriate for the implementation of their Province-wide Investment Plan for Health (PIPHs)
b. Transfer more governance and fiscal responsibilities and capacities to their health facilities to enable these specifically to retain and appropriately utilize generated revenues
c. Adopt the appropriate incentive systems for developing and sustaining local PPPs in health
d. Coordinate with DOH agencies in the development, implementation, and monitoring of local PPPs in health
e. Utilize the guidelines and other instruments provided by DOH for the local development of PPPs in health

D. **Other Government Agencies, Development Partners, and Private Sector Organizations** are advised to:

a. Align their objectives and PPP-related activities so as to be consistent with KP goals and strategies
b. Coordinate with the DOH and concerned government agencies in the development, implementation, and monitoring of PPPs in health.

VIII. REPEALING CLAUSE

The provisions of previous Orders and other related issuances inconsistent with or contrary to the provisions of this Administrative Order are hereby revised, modified, repealed or rescinded accordingly. All provisions of existing issuances which are not affected by this Order shall remain valid and in effect.

IX. IMPLEMENTATION

The Implementing Rules or equivalent guidelines in line with this Order shall be developed within three months.

X. EFFECTIVITY

This Order shall take effect immediately.

ENRIQUE T. ONA, MD, FPCS, FACS
Secretary of Health

Design and Monitoring Framework

Design Summary (1)	Performance Targets and Indicators (2)	Data Sources and Reporting Mechanisms (3)	Assumptions and Risks (4)	Comments/ Status (5)
IMPACT Improved maternal and child health by 2015	Maternal mortality ratio of 81 by 2020 Under-five child mortality rate 26 per 1,000 live births by 2020 Infant mortality of 19 by 2020, by primarily focusing on reducing neonatal mortality	Provincial and national statistics and monitoring data Baseline surveys of beneficiary households conducted by independent contractor National Demographic and Health Survey (if provincial disaggregation is available)	**Assumption** Participating local governments are fully committed to MDGs 4 and 5 and provide the support and necessary resources to attain its intended impact and outcome **Risk** No PPP-related loans made before end of project due to policy and operational concerns	Only one loan (to Visayas Community Medical Center for construction and equipment acquisition) has so far been made mainly due to: interest rate issues; prospects of DOH financial grants to LGUs; and the coverage of the CBHCP (ie, only rural borrowers are allowed in the current program although there are efforts now to amend the coverage to include borrowers from urban centers). The risk also came about due to the reported slow processing of CBHCP sub-loan applications in the borrower's institution. Furthermore, only one loan materialized to date due to: difference in priority or conflict between and among the LGU officials/executives; LGUs' weak technical and financial capacity, particularly at the municipal level, to develop and implement the projects in accordance with ADB requirements; difficulty in securing documents/resolutions due to different political affiliations; and difficulty in securing Certificate of Borrowing which is one of the basic requirements of financial institutions in granting loans.

Design Summary (1)	Performance Targets and Indicators (2)	Data Sources and Reporting Mechanisms (3)	Assumptions and Risks (4)	Comments/ Status (5)
OUTCOME PPP modalities with demonstrated potential to increase the use of maternal and child health care referral services tested in the selected HPPP sites	Increased utilization of health facilities at the selected HPPP sites: • percentage population using health facilities • women delivering health facilities increased • increased consumer satisfaction with health service performance	Local government records DOH statistics Project monitoring reports	**Assumption** Improved facilities will attract mothers to deliver in and refer their children to public health facilities **Risk** Participating government agencies are not able to secure full community engagement in program implementation	No PPP initiative operating at this time therefore monitoring of indicators may not be feasible. Instead the LGU should be made aware of the indicators.
OUTPUT 1 PPP modalities developed and promoted	Project proposal documents prepared in support of the identified and pre-cleared HPPP subprojects based on the diagnosis Business case, TOR and contracts for PPP projects be adopted by local government units	Project reports Contracts of PPP subprojects	**Assumption** Policy and operational issues have been cleared to guide LGUs and private sector in actual contracting DOH, PHIC,COA, NEDA PPP, etc approval of guidelines	The Provincial Government of Northern Samar adopted the business case, terms of reference, and draft contract, prepared by the TA team. Bidding has been conducted using the procurement rules prepared by the TA team. A PPP contract in the lease, operations and management of the pharmacy of Northern Samar Provincial Hospital has been awarded to Planet Pharmacy. The parties have set to meet for the pre-implementation meeting.

Design Summary (1)	Performance Targets and Indicators (2)	Data Sources and Reporting Mechanisms (3)	Assumptions and Risks (4)	Comments/ Status (5)
			Risk LGUs will be convinced by competing banks to take out loans LGUs hesitant on undertaking PPPs because it is a new approach Long or delayed process in rolling-out projects because of unfamiliarity with the process (ie, how to identify projects, how to bid out, how to award, contract negotiations, etc) Local government unit not deemed creditworthy by DBP (IRA is fully allotted as in the case of Camarines Sur) or is not interested in taking out a loan	The TA team prepared a PPP business case and TOR for the operations and management of a new hospital for the provinces of Saranggani and Camarines Sur. The governors of both provinces decided not to pursue the project in view of the political situation. In light of the above, the TA team has liaised directly with the following provincial governors: P Daza (Northern Samar); M Dominguez (Sarangani); and L Villafuerte (Camarines Sur). Adoption by LGUs may be a better performance target since adoption by national agencies such as DOH, NEDA, and COA may involve time-constrained processes requiring a period beyond the life of the TA. The TA team undertook field visits to Rizal and Bohol provinces for discussion on possible PPPH projects with key stakeholders. The TA assisted DBP in assessing the acceptability of procurement procedures of various entities applying for loan for hospital construction under the CBHCP (City Care Medical Center, Gentri Medical Center, Global Medical, Taguig Medical Center). The TA team reviewed and provided inputs on the initial seven loan application for birthing clinics submitted to DBP under CBHCP. The TA team drafted the Lending Guidelines for Midwives under the CBHCP for adoption by DBP.

Design Summary (1)	Performance Targets and Indicators (2)	Data Sources and Reporting Mechanisms (3)	Assumptions and Risks (4)	Comments/ Status (5)
OUTPUT 2 Incentives and operational strategies developed for PHIC in light of global budget system in support of PPP in Health initiatives	Written policy on global budget, PCC's, and operational implications Recommendations for incentives to private and public small-scale health providers and facilities within a global budget Provide inputs for a suitable health M&E for global budget compatible with PHIC's reporting, billing and payment PHIC plans and strategies for formal adoption of global budgeting and PCCs system as national financing	PHIC records Technical reports Project monitoring reports	**Assumption** At least one (1) LGU approved for inclusion in the initial implementation of global budget system **Risk** Global budgeting has not been started	The policy guidelines have been drafted and then approved by the PHIC Board. About 3 LGU takers/applicants so far. About 3 government hospitals have initiated application process. Global budgeting mechanics and M&E are included in a PHIC circular on global budget that has been released. The circular is targeting provincial hospitals.
OUTPUT 3 M&E established and capacity developed for promoting and implementing PPP in Health	Structure, policies, procedures of PHIC global budget systems monitored	Project monitoring reports	**Assumption** Long-term capacity development program launched through NEDA PPP, DOH, and DAP	The global budget system has just been initiated such that actual implementation is not yet at a stage for actual monitoring. An M&E system is included in the guidebooks being developed by the TA for use of LGUs in their assessment of the performance of their PPP initiatives.

Design Summary (1)	Performance Targets and Indicators (2)	Data Sources and Reporting Mechanisms (3)	Assumptions and Risks (4)	Comments/ Status (5)
	Capacity development framework for PPP in health developed and steps initiated to institutionalize and implement it through DOH Capacity building training provided to key government institutions and LGUs in implementing PPP health activities Knowledge management activities conducted and KM resources developed	**Risk** LGUs' concerns with Commission on Audit due to the absence of national policies yet on PPP. The LGUs can refer/consult with their auditors but with the conduct of actual post audit, the auditors may come up with Audit Observation Memorandum (AOM) containing several disallowances regarding the project (e.g., case of East Avenue Medical Center).		A Basic Course on Social Marketing and Knowledge Management for PPPH was conducted for the LGUs of Northern Samar (1-5 April 2012) and Sarangani (4-7 July 2012). A follow-up workshop for Northern Samar LGU to assist in the development of PPPH social marketing plan was held 28-29 May 2012. Through the course training and with inputs from the TA team, the Provincial Government of Northern Samar was able to develop a social marketing plan for the province's PPPH projects. A capacity development intervention is currently being prepared for PHIC and DOH. The training module for PHIC is a practical course on communications and social marketing of PPP based on the findings from the training needs analysis. The TA and ADB assisted in the organising of PHIC Workshop on the New Global Payment Scheme at the ADB (16 July 2012). The TA team provided PPPH technical inputs in the workshop. The TA team provided PPPH technical inputs during the PHIC Public Relations and Marketing Forum in Clark Pampanga (3-5 September 2012).

Design Summary (1)	Performance Targets and Indicators (2)	Data Sources and Reporting Mechanisms (3)	Assumptions and Risks (4)	Comments/ Status (5)
				Two guidebooks have already been developed, namely, guidebook for PPP in pharmacy and guidebook for hospital management. Resource books for laboratory and diagnostics and birthing facilities are being developed. Monographs on financing options, legal/policy issues, and medical professional view of PPPH are also being developed. Three (3) brown bag seminars on PPPH were conducted (15 March 2012, 16 May 2012, 9 July 2012) with the support of Health CoP of ADB. The seminars gave an overview on PPP in health in the Philippines and discussed key issues and challenges such as policy and legal environment and leadership/governance challenges in PPP settings. The TA experts participated (primarily by giving technical inputs in the event or speeches) in various conferences / fora to promote PPPH: PPP in Health Investment Forum (21 June 2012, TA organized the event); 1st Easter Visayas Regional Governors Forum (18 July 2011); Health Summit for LGUs (9 March 2012); MDG5 Summit with Local Government Units and Health Secretary Ona (26 March 2012); Zuellig Forum (20 April 2012, TA set up a PPPH marketing booth). A regional learning event and marketplace on PPP in health will be held on 23-25 October 2012. Titled, “PPP in Health Manila 2012,” it will bring together about 220 policymakers, LGU executives, PPP experts and advocates, medical professionals, academicians, and health sector suppliers from Asia, Europe, and selected countries.

ACTIVITIES	INPUTS	
1. PPP modalities developed and promoted. 1.1. Diagnostics conducted and recommendations proposed for specific projects identified and pre-cleared by DBP, such as those covering: 1.1.1 Policy and regulatory matters governing PPP systems and procedures; 1.1.2 Financial environment and financing options including PHIC-related schemes; and 1.1.3 Procurement guidelines for PPP arrangements. 1.2 PPP in health subprojects developed and pilot-tested with the LGUs with DBP approval done through technical assistance in the following areas: 1.2.1 Project/enterprise development including formulation of robust financial models considering pricing policies and strategies, among other things; 1.2.2 Financing/health financing schemes and strategies under a PPP regime; 1.2.3 Regulatory/legal aspects in the light of the BOT law, Procurement Act, Local Government Code, and other governing policies; 1.2.4 Procurement and bidding procedures; 1.2.5 Capacity development including knowledge management; and 1.2.6 Social marketing and communications. 1.3 Based on pilot-tested projects and recommendations, knowledge management resources and documents prepared, such as: 1.3.1 Financial models that will assist LGUs in capturing/choosing the best PPP in health arrangements; 1.3.2 Monograph on financing/health financing schemes and strategies; 1.3.3 Legal/policy notes/papers in the light of the BOT law, Procurement Act, Local Government Code, and other governing policies; 1.3.4 Procurement and bidding documents and templates; and 1.3.5 Manual/guidebooks on PPP in health applications such as pharmacy, laboratory and diagnostics, hospital management, etc. with citations of case studies on good/best practices; and an ePortal for PPP in health initiatives in the Philippines.	**ADB (JSF):** **$1,000,000** **DBP:** **$ 100,000** **Total** **$1,100,000**	

ACTIVITIES	INPUTS	
2. Incentives and operational strategies for PHIC in the light of global budget system for PPP in health initiatives developed. 2.1 Global Budget scheme as a national financing strategy developed and initially rolled-out; 2.2 LOU system in the light of policy changes (including Global Budget scheme) within PHIC developed and initially rolled-out; 2.3 Accreditation policies, IRR, systems, social marketing, and procedures reviewed to facilitate private small scale health providers' PHIC accreditation and access to CBHCFP; and 2.4 DOH, DBP, LGUs (in PPP subproject sites), and PHIC consulted and assisted to support the above activities.		
3. M&E established and capacity developed for promoting PPP in Health. 3.1 M&E systems and proposed for the following: 3.1.1 PPP in health applications such as on pharmacy, laboratory, hospital management, etc.; 3.1.2 PHIC financial matters such as on LOU structures/systems, billing, and payment; and 3.1.3 PHIC organizational development matters such as on training, social marketing, and project implementation plans. 3.2 Training module on social marketing and knowledge management developed and pilot-tested in at least two LGU sites and one national agency (PHIC); 3.3 Long-term capacity development framework on PPP in health proposed; 3.4 Meetings (in support of 3.3) among stakeholders initiated; 3.5 Regional learning and dialogue event for PPP in health conceptualized and conducted.		